



# Improving health care for migrant populations using practice innovations and strategic alliances to drive change: The U.S. case

International Organization for Migration (IOM)

## Background Paper

*Developed within the framework of the IOM project  
"Assisting Migrants and Communities (AMAC): Analysis of  
Social Determinants of Health and Health Inequalities"  
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**Julia Puebla Fortier**  
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## Executive Summary

In the United States, the last decade has seen significant advancement in policies, programs and research that addresses the improvement of health care for culturally diverse populations. This paper examines the impact of different players and policy agendas that have played a role in advancing the cause of better health care for migrants and minority communities. These include the role of service delivery innovations and policy developments, and the work of individual sectoral efforts as well as the powerful strategic alliances between them. Taking into account the structural difference in health care systems, these advances may provide useful lessons for EU and other countries working to better accommodate the special needs posed by migrants and minorities in health care.

## Introduction

While the United States and the countries of the European Union have different health care systems, they both share the challenge of delivering health services to and improving the health status of migrant and minority populations. Many similar approaches to meeting these needs of these populations have developed on each side of the Atlantic. In the United States, the last decade has seen a widening acceptance by health care providers and policymakers alike of the importance of improving health care for culturally diverse populations.

This paper examines the impact of different players and policy agendas in advancing the cause of better health care for migrants and minority communities. These include the role of service delivery innovations and policy developments, and the work of individual sectoral efforts as well as the powerful strategic alliances between them. It primarily addresses systems-level barriers to health care, rather than barriers caused by lack of insurance or immigration status restrictions to health services. We begin with a look at the effect of broad social and historical forces that provided momentum for the successes along the way.



## A. Social and historical context

There have been a number of “movements” in the United States that have been used to advance health care improvements for migrant and minority populations. First and foremost is the “civil rights agenda”, begun in the 1950s to give African Americans equal standing in social and civic life. It broadened in the 60s and 70s to include Latinos, Native Americans, and Asians/Pacific Islanders, and from it came the drive to improve health status of these populations, under the banner of “minority health”.<sup>1</sup>

In a parallel movement, many health and social care providers began seeing large numbers of refugee populations starting in the mid 1970s. They developed adaptations to the usual methods of delivering services to meet the needs of migrant communities with distinctive cultural and linguistic profiles. Progress made under these two efforts led to the emergence of the field of “cultural competence”,<sup>2</sup> which refers to information and strategies that can be used by health professionals and health care organizations to reduce cultural and linguistic barriers to care and improve the health of culturally diverse populations.

Two important forces from the mainstream of health care in the 1990s – quality improvement<sup>1</sup> and the ever-elusive goal of cost-effectiveness<sup>1</sup> – both affected and were harnessed by those pushing for improvements in health care for migrant and minority populations. Improved regional and national data collection stratified by race and ethnicity showed that migrant and minority populations had distinctly poorer health status than the majority population. These “health disparities” received national attention through a series of reports and conferences, and health care providers were encouraged to make special efforts to improve quality of care to improve the health status of these populations.

While there are a number of different actors in each of these movements, a few can be identified as having enduring and influential roles:

Primary actors ↓	Movements → Civil rights and minority health	Cultural and linguistic competence	Quality improvement and cost-effectiveness	Health disparities reduction
Civil rights leaders	√	√		√
Local/state health departments	√	√		√
Front-line providers in diverse communities	√	√		√
Health services researchers		√	√	√
State and national policymakers	√	√	√	√
National health and quality organizations		√	√	√
Private foundations	√	√	√	√

These broad movements provided a spotlight on the health care needs of migrant and minority communities, and an impetus for ac-

tion. But there were other specific factors that helped advance the issue. We shall examine these in the following sections.

## B. The power of service delivery innovations

In the early years of the minority health movement, many members of minority and migrant communities were poor and often lived far from areas where insurance-reimbursed doctors and hospitals were located. To fill the gap, state and federal governments established and funded community clinics (starting in the 1960s)<sup>3</sup> and provided additional funding for public hospitals for low-income patients. These organizations, along with local and state health departments and community based organizations that ran screening and prevention programs, began to develop expertise in dealing with the unique issues raised by patients from particular socio-economic, educational or cultural backgrounds. This expertise evolved into specific service delivery and support innovations, including:

- Development of culturally appropriate health education and patient support programs;
- Patient/community involvement in clinic/hospital governance and planning;
- Cultural competence training for health care providers and staff;
- Medical interpretation and translation services, both on-site and by telephone;
- Use of cultural mediators/community health workers.

## C. Policy framework for health care services for migrant and minority populations

As the “civil rights movement” strengthened the voice of migrant and minority populations in the policy arena, they began to advocate for more attention to their health care needs. A number of policy instruments evolved at both the state and federal level; we will focus on a few key examples.

The “minority health agenda” was a series of programs that evolved over several decades starting in the 1970s to focus on a number of health issues, including health education/disease prevention for diseases that disproportionately affected diverse communities, support for minority students interested in the health professions and funding for the institutions where they studied, and support for state and federal Offices of Minority Health. Over the same time period, a program of refugee resettlement support (including health and social services) was initiated by the Federal Government, providing funding to local and state agencies and community based organizations working towards the integration of refugee populations.<sup>4</sup>

A critical policy tool used to advance the establishment of bilingual, interpretation and translation services in health, social services and edu-

As these culturally diverse populations began to move into more integrated communities or obtained insurance that allowed them to see a wider range of providers, these community based clinics and hospitals were in a position to provide technical assistance to other health care providers on health/social/cultural/linguistic issues specific to migrant and minority populations.

It is important to recognize that community-focused providers had legal mandates to be responsive to the needs of underserved populations from the state or federal agencies that funded them. Their service innovations inspired and raised the performance bar for other health care providers, and over time, their models and track record of success drove the development of more comprehensive policy supports and additional funding.

cation was the Civil Rights Act of 1964. It was determined by the courts in the 1970s that all public and private entities receiving federal funds were prohibited from discriminating on the basis of national origin – including language. Individuals who did not receive services supported by federal funds in a language they could understand could file complaints with the Office of Civil Rights, which could take action against the agency to compel the provision of interpretation services and translation services. Hundreds of these complaints have been filed, especially against hospitals, instigating the creation of comprehensive language services departments in health care institutions across the country.<sup>5</sup>

Another key policy tool in advancing a comprehensive approach to meeting the needs of culturally diverse populations was the publication of the National Standards on Culturally and Linguistically Appropriate Services in Health Care – the CLAS standards.<sup>6</sup> Issued by the US Department of Health and Human Services Office of Minority Health, these standards recommend a number of actions health care organizations can take to improve the quality of care for migrant and minority populations.



These include:

#### **Culturally Sensitive Interventions**

- Cultural competence education for health care professionals and staff;
- Cultural mediators, community health workers and culturally competent health promotion;
- Race, ethnic and linguistic concordance between providers and patients;

#### **Language Assistance**

- Bilingual services, oral interpretation, translated written materials, along with written policies to ensure their timely provision;

#### **Organizational Supports for Cultural Competence**

- Management and policy strategies to address diversity issues;
- Ethnic community engagement in planning and evaluation of services;
- Ethnographic and demographic data collection for planning and evaluation;
- Culturally appropriate ethics and conflict resolution processes.

While the standards were not legally enforceable, they had an unexpected symbolic and practical impact. They offered a clear organizing framework that prompted many health care organizations to take action and raised the national profile of the issue, spurring discussion, refinements and controversy.

## **D. Efforts of sectoral actors**

The accomplishments of the service delivery sector and government agencies were facilitated in no small part by persistent activism on the part of NGOs<sup>III</sup> and private foundations.

NGOs have been involved in advancing the agenda of better health care for migrant and minority populations at many levels. As mentioned before, many community based organizations were engaged in service delivery innovations that offered models for replication by large health organizations. They were also involved in advocacy for more responsive policy at the local and state level. But there are also a number of NGOs that specialize in promoting the issue at the national level. They engage in:

- Research and tool development to enhance knowledge and good practice;
- Awareness-raising and advocacy to improve practices and policy structures;
- Consensus-building among stakeholders to advance key issues;
- State and federal policy analysis and policy formulation.

Among the national health care stakeholders influenced positively by the CLAS standards were three key health care quality and accreditation organizations: The Joint Commission for the Accreditation of Hospitals;<sup>7</sup> the National Committee for Quality Assurance (which accredits health insurance plans);<sup>8</sup> and the National Quality Forum (which develops consensus agendas on key health care quality issues).<sup>9</sup> Supported in large part by a group of private health foundations interested in these issues, each organization embarked on a series of research and policy development projects on how to incorporate elements of the CLAS standards into their quality and accreditation programs.

A year after the CLAS standards were released, the highly influential Institute of Medicine released a report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*.<sup>10</sup> Based on academic research and testimony from a broad range of clinicians, policymakers, advocates and researchers, the report highlighted the barriers to care experienced by minorities and migrants and the persistent low health status and disparity in health outcomes between minorities and white populations. It highlighted the effectiveness of some targeted interventions and called for additional research, funding and practice changes to close the gap. This report brought a new wave of attention to the need to improve care for culturally diverse populations and spurred a number of government and foundation initiatives. It also squarely placed responsibility on all health care providers to include the unique needs of minority and migrant populations in their overall quality of care programs.

Their efforts have provided inspiration to and garnered financial support from a variety of well-known national health foundations, including the California Endowment, the Robert Wood Johnson Foundation, the Commonwealth Fund, the WFF Kellogg Foundation, and a number of regional and community foundations. These foundations, whose grant-making runs to the hundreds of millions of dollars a year, have supported service demonstration and research programs on improving migrant and minority health, and also used their influence in national health policy discussions to raise awareness about the issues among more mainstream health organizations.

## E. Role of Strategic Alliances

A major strategy of those seeking to improve migrant and minority health was the decision to reach beyond traditional “advocates” for these issues and bring mainstream health stakeholders to the table. A key factor in this approach was the financial support and convening power of private foundations and government health agencies. The goal was to demonstrate the relationship between culturally diverse populations and emerging national health agendas (such as quality improvement, patient safety and patient-centred care). Tactics included identifying key power-holders in health policy circles, bringing

them to the table and demonstrating through research and health delivery models how their agendas could not fully succeed unless the health issues of diverse populations are acknowledged and addressed. In time, many of these stakeholders became allies.

Below is an illustration of some of the key mainstream health issues and stakeholders that were identified for raising the link between those agendas and the needs of migrant and minority populations:

Issue	Stakeholders	Sample intersections
Patient centred care	Medical societies, health professions, training institutions	Culturally diverse populations have special needs that must be addressed to enjoy patient centred care, and these concerns need to be integrated into treatment approaches and health professions training.
Quality of care	Health organizations, accreditation agencies, hospital associations	Health care organizations need to integrate cultural and linguistic issues into quality improvement strategies. They need to collect race/ethnicity/language data to track health disparities and target improvement efforts.
Patient safety/ medical errors	Institutional risk managers, legal departments	Patients who face language barriers are at higher risk of medical errors and treatment adherence failures without interpretation services and translated materials, including treatment consent forms.
Disparities reduction	National Institutes of Health, Agency for Healthcare Research and Quality, medical societies, health organizations, insurers	National disease and healthcare quality research agendas should both include special studies that target high prevalence diseases of migrant/minority populations, and broaden the scope of existing programs, including clinical trials to increase the participation of these populations. Health care providers should use targeted outreach and treatment support interventions to reduce disparities among their patient populations.
Effectiveness/ cost containment	Government and private sector insurance agencies, hospital managers and quality departments	Linguistic and cultural barriers can lead to delayed or inappropriate utilization of health care services and poor adherence to treatment, leading to poorer health status and higher costs to treat conditions that have advanced beyond the prevention and early treatment stage.

An example of how these relationships are built and bear fruit comes from the strategy to engage the Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations) on language access issues in hospitals. They were invited to a 1995 briefing on the subject convened by the Kaiser Family Foundation, the first time a group of mainstream health stakeholders not associated with minority and migrant communities were brought together.<sup>11</sup> In subsequent years, high level officials from the organization were invited to several national conferences on migrant and minority health to talk about how the Joint Commission standards addressed language access issues. They participated on the advisory committees that drafted

the National CLAS Standards and served on panels involved in developing research and toolkits to improve language access. The California Endowment gave them funding for the 2007 Hospitals, Language, and Culture report, which offers a snapshot of how 60 hospitals across the country are providing health care to culturally and linguistically diverse patient populations. With additional funding from The Commonwealth Fund, the Joint Commission is currently developing proposed national accreditation requirements for hospitals to advance effective communication, cultural competence, and patient-centred care – an indicator that the issue has risen to the mainstream of health care for them as a national regulatory agency.



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## Conclusions

While the social, political and financing systems of health care differ between the U.S. and the EU, the recent experience of the United States offers some insight into strategies that can be used to advance the agenda of improving health care quality for migrant and minority communities.

First, in order for change to be embraced at the legal and policy level, health care practitioners and organizations must offer successful examples of effective service delivery in the form of demonstration projects, evaluations and research. This can be a challenge in the early stages when funding may not be readily available to establish this practice and research base. Often small-scale examples from a variety of settings (or countries) can be adapted and expanded over time when initial results are positive.

Advocates for migrant and minority health are increasingly well-informed about the needs of and strategies to reach diverse populations, but this awareness-raising and advocacy must reach out to a broad and influential mainstream health care audience. Research and practice innovations must be shared with these stakeholders, and they can be invited to help in the development, execution and evaluation of further demonstrations. Simultaneously, these stakeholders should be called upon to address how their organizations are addressing the needs of diverse populations.

Advocates must also begin to think about how the needs of diverse populations can affect progress on wider health care priorities. This intersection of issues should be raised in organizational and national dialogues, ideally with evidence from demonstration projects that have achieved results in addressing these issues in an integrated fashion.

## Note about the Author

**Julia Puebla Fortier** is the Executive Director of Resources for Cross Cultural Health Care, a U.S.-based NGO that offers policy analysis, research, resources and technical assistance on health care for diverse populations. Through RCCHC, Ms. Fortier has spearheaded the development of several key policy tools in this area. She was the principal author of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care for the U.S. Department of Health and Human Services, along with other key policy and research frameworks. Ms. Fortier developed and manages the DiversityRx website and co-produces the national conferences series "Quality Health Care for Culturally Diverse Populations". Ms. Fortier previously worked on the U.S. House of Representatives Subcommittee on Health and the Environment (Rep. Henry A. Waxman, Chairman). She lives in France, and is currently working to build collaborative relationships worldwide among those interested in the intersection of culture and health.

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## References

<sup>1</sup> The quality improvement movement in health care is an approach and a set of interventions for managing the quality of services in health care through goal-setting, development and monitoring of work processes, and measuring outcomes related to patient health and organizational improvements.

<sup>ii</sup> Cost-effectiveness analysis is designed to allow health spending decisions to be guided by considerations of cost in relation to expected benefits.

<sup>iii</sup> NGOs are typically called 'non profit organisations' in the United States, if they qualify for federal tax exempt status.

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<sup>1</sup> Stokes, Louis. Speech at the 15th Annual Symposium of Career Opportunities in Biomedical Research and the 25th AMHPS Anniversary Celebration [http://www.howard.edu/library/special/louis\\_stokes/AMPHS.htm](http://www.howard.edu/library/special/louis_stokes/AMPHS.htm).

<sup>2</sup> National Center for Cultural Competence. Definitions of Cultural Competence <http://www.ncccurrecula.info/culturalcompetence.html>.

<sup>3</sup> U.S. Department of Health and Human Services. What is a Health Center? <http://bphc.hrsa.gov/about/>

<sup>4</sup> U.S. Department of Health and Human Services, Office of Refugee Resettlement, <http://www.acf.hhs.gov/programs/orr/>.

<sup>5</sup> <http://www.usdoj.gov/crt/cor/lep/hhsrevisedlegguidance.php>  
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<sup>6</sup> U.S. Department of Health and Human Services, National Standards for Culturally and Linguistically Appropriate Services in Health Care (2000) <http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15>.

<sup>7</sup> The Joint Commission, Hospitals, Language and Culture <http://www.jointcommission.org/PatientSafety/HLC/>.

<sup>8</sup> The National Committee for Quality Assurance. Proposed CLAS standards within their overall standards framework: [http://www.ncqa.org/Portals/0/PublicComment/2010\\_Products\\_Update/Appendix\\_3\\_Creation\\_of\\_CLAS\\_Standard.pdf](http://www.ncqa.org/Portals/0/PublicComment/2010_Products_Update/Appendix_3_Creation_of_CLAS_Standard.pdf), [http://www.ncqa.org/Portals/0/PublicComment/2010\\_Products\\_Update/Appendix\\_2\\_Incorporating\\_Aspects\\_of\\_CLAS.pdf](http://www.ncqa.org/Portals/0/PublicComment/2010_Products_Update/Appendix_2_Incorporating_Aspects_of_CLAS.pdf).

<sup>9</sup> National Quality Forum. A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency. [http://www.qualityforum.org/Publications/2009/04/A\\_Comprehensive\\_Framework\\_and\\_PREFERRED\\_Practices\\_for\\_Measuring\\_and\\_Reporting\\_Cultural\\_Competency.aspx](http://www.qualityforum.org/Publications/2009/04/A_Comprehensive_Framework_and_PREFERRED_Practices_for_Measuring_and_Reporting_Cultural_Competency.aspx)

<sup>10</sup> Institute of Medicine. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (2003) <http://www.iom.edu/?id=16740>.

<sup>11</sup> Chang PH, Fortier JP. Language barriers to health care: an overview. *Health Care Poor Underserved*. 1998; 9:55–520.







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