Differences in Immigrant and U.S. Native Born Patients' Experiences in the American Healthcare System: A Correlational Study

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BACKGROUND

Use of "herbs, teas, ointments and wonder pills from pharmacies in Mexico" are cultural home remedies immigrants may use in avoidance of hospital bills, insurance policies and untrusted physicians (Aparicio, 2008). Although these may help to mend common flu's and injuries, frequent avoidance of the doctor visits when healthcare or services are necessary can lead them to exhibit a declining health status. 'Immigrants' can be classified as non U.S. native born patients that have emigrated from their primary countries for reasons such as seeking asylum, family reunification, better health or education institutions, and political disruption. Given these widely varying instances for migrating, each immigrants' personal backgrounds and interactions with the U.S. system are complex. In addition to their individual complexities, immigrant patients' experiences in the healthcare system are highly contrasting amongst different races and ethnicities.

Overall, the vast immigrant population can face negative health outcomes when evading imperative health needs. Immigrants have been shown to underutilize health services in the U.S., with a $2,293 per capita difference in health spending between authorized immigrants and U.S. born individuals (Wilson et al., 2020). Acknowledged reasons for underutilization of healthcare are due to barriers in the healthcare system such as distrust between healthcare providers and institutions, spatial accessibility, and lack of access to a variety of health services (Naylor et al., 2019). However, when highlighting these disparities amongst the healthcare system, solely economic factors are considered and do not compare access between U.S. born natives and immigrants or the role healthcare providers/ institutions play in their experiences.

In areas of diverse demographics, socioeconomic factors should not be the only examined aspect due to the wide variety in possible experiences. Focusing solely on socioeconomic factors of immigrants does not yield efficient policy implications because it fails to reflect comprehensive reasoning for the underutilization of health care. To determine the areas in which barriers significantly inhibit utilization of healthcare, a correlational analysis will examine both socioeconomic statuses and U.S. born individuals.

As exhibited in the study conducted by Wilson et al., (2020), immigrants underutilize the healthcare system, despite their contribution to healthcare expenditures. Their study in addition to other research (Seo, 2011; Castañeda, et al., 2015; Samson, 2016; Adekeye, Adesuyi & Takon 2018, Wang, 2021) acknowledge the possibility of barriers inhibiting them to receive adequate services. However, research has not sufficiently addressed what areas of barriers immigrants are less likely to utilize in comparison to U.S. born natives to increase accessibility. The following sources will provide insight into the disconnect between immigrants and the American healthcare system and research in an attempt to bridge the gap.

INNER WORKINGS OF THE US HEALTHCARE SYSTEM

To efficiently examine the perceived barriers in the system, researchers such as Castañeda, et al. (2015) and her colleagues suggest considering immigration as a social determinant of health, which influences a person's health and quality of life. Considering immigration's significant effect on the health of individuals due to societal, political and economic conditions, it is still not considered or applied as a social determinant in public health research. Castañeda, et al reviewed

numerous published research on frameworks used in public health literature to argue for a broader examination of immigration populations. The author suggested addressing the impacts of social and policy-related factors that affect immigrant health outside of healthcare access. The studies included in Castañada's review disregarded the effect immigration has on their health. The US healthcare system is made up of several institutions, clinics, and private practices professionals and is faced to cope with the rising demand from both US born patients and immigrants. Portes, et al. (2009) and colleagues studied the relationship between the healthcare system and the surge of immigrants by applying basic concepts from a socioecological theory. The study determined handicaps immigrants face in the system are lack of English fluency, different cultural definitions of illness/ health, tenuous legal status and residential instability, poverty, and lack of insurance. The system deals with the rising demand from immigrants with these coping mechanisms: cannot provide healthcare due to ineligibility for public health programs (escapism), provide healthcare as a commercial good (profit-seekers), provide healthcare as a right (angels), provide healthcare as part of a "mission" (Good Samaritans). These approaches are deemed ineffective due to the still increasing number of immigrants facing limitations in accessing healthcare. The study concludes the systematic framework of institutions plays a larger role in health care's accessibility to immigrants than providers do.

National policy changes can also greatly influence the barriers in the system. After the implementation of a national policy guidance in 2003 which allowed for limited English proficient patients to access language services, it mitigated language barriers between providers and patients. After this major change, Schwei, et al. (2016) studied the state of language barriers in and out of the US since 2003 and compared the conducted research. The cross-sectional study analyzed 136 studies prior to 2003 and 426 studies from 2003 to 2010. Post-2003, more research examined either the provider's perspective or both the patient's and provider's perspective. The policy change allowed for progression past the acknowledgment of the presence of language barriers and conducting more useful research to provide sufficient care for immigrants.

ACCESSIBILITY WITHIN IMMIGRANTS GROUPS

Given accessibility plays a vital role in the utilization of healthcare, Lu Wang (2021) evaluated the spatial accessibility amongst recent and long-standing immigrant groups to linguistically diverse physicians. The method employed English proficiency, distance, and physical availability to determine accessibility. It resulted in finding no consistent pattern between the two immigrant groups because same language physicians may not be as important as they hypothesized. Patients' English proficiency can improve or they can have their English-speaking children accompany them on visits. This study was one of the first to apply this approach when determining healthcare accessibility and similarly replicated in the US by Chi and Hancock, (2014), but employed broader factors. The study surveyed over 50,000 Californians and included socioeconomic factors. Integrating this into the data collection resulted in finding significant distinctions between recent and non-recent immigrant groups which were driven primarily by lack of insurance, financial resources, and English proficiency. This drove future research to find what factors inherently influence these limitations in the system itself. Naylor, et al. (2019) researched to compare spatial

accessibility of healthcare provider types to examine factors associated with higher spatial accessibility in the US. By using the 2014 National Plan and Provider Enumeration System, medical claim, and the 2010 U.S. Census data to provide for participants in the study, it resulted in widely differing spatial patterns throughout the country. Internal medicine physicians had the highest spatial accessibility in urban locales with population-dense areas. Nurse practitioners had their higher spatial accessibility in moderate population-dense areas and racially/ethnically diverse areas. Contrastly, family medicine physicians had their highest spatial accessibility in areas with the lowest population-dense and higher racially/ethnically diverse areas. The distributions of specific healthcare providers is unevenly present throughout the US and requires further examination of the maldistribution by implementing components beyond spatial accessibility, accommodation, affordability and availability.

KNOWN FACTORS DETERMINING ACCESSIBILITY AND BARRIERS

The component accessibility in the previous study can translate to patient's and provider's distrust because it plays an integral role in accessibility. Samson (2016), researched the specific component by examining the correlation between physician distrust, immigration-based diversity, and declining social capital. The study surveyed 1,080 adults and were asked to answer on a 5-point scale from strongly agree to strongly disagree about general statements about doctors assessing their overall trustworthiness. The study found immigration attitude predicts physician distrust. Over the last 50 years, the US has shown to exhibit a decline in physician distrust which could be a result of immigration attitude or declining social capital. Although to better understand this trend, future research could compare generalized trust in doctors to particular doctor trust. Lack of trust between patients and healthcare providers can cause doubt in the efficiency of provider's services. This could lead U.S. natives and especially immigrants to disregard their health concerns due to disbelief in professionals or declining social capital which will leave them to be uneducated about their health status.

To increase health literacy, the degree to which individuals are knowledgeable of important health information to carry out proper health practices, health fairs can be used as a method of outreach to increase awareness and help minority populations understand their health statuses. Disparities in health literacy are most prevalent among racial minorities, lower education levels, advanced age, and low economic statuses. Seo (2011) surveyed 1,701 participants in an annual Indiana Black and Minority Health Fair using a pre-posttest and 15-month follow-up health counseling. The survey investigated the relationships between key health indicators, behaviors, and socioeconomic statuses to evaluate the health fairs' effect. The study concluded those observed after the 15-month counseling sessions had meaningful improvement in their self-reported health statuses. Behavioral changes were not as prevalent between the baseline and pre counseling. This suggested the necessity of a follow-up component in health fairs to improve health literacy and health outcomes in individuals. The critical role health fairs play with follow-ups in educating people who are aware of basic health information/ practices was also shown in a study conducted by Adekeye, Takon (2018). Surveying 144 African-born immigrants aged 18 and older at a health fair. The survey examined if African immigrants were knowledgeable of barriers to healthcare,

common cancer, and cancer risks enough to utilize needed care. The study concluded well-organized and repetitive health fairs with participant follow-ups are effective in spreading awareness of health to people who may not have accessibility or do not seek access. Many participants within the study had limited contact with health care due to lack of health insurance and or unaffordability of medical costs, providing reasoning for their lack of accessibility. African immigrants are commonly grouped as African American or Black, which has subdued the effect of interventions and recommendation when attempting to fix the disparities amongst African immigrants. They are also the least studied immigrant group despite being included in research amongst immigrant populations to find disparities in the healthcare system. Omenka, Watson, Hendrie (2020) studied African immigrants to develop lines of inquiry using the identified knowledge gaps of African immigrant health.

Literature published in the English language between 1980 and 2016 was reviewed in five stages: question, relevant studies, screening, data extraction and synthesis and results. About 1,446 articles were identified through database searching and only 14 articles contained 14 articles. Within these 14 articles, the research concluded the two main recurring barriers to African immigrant health are cultural influences and adverse experiences with the US healthcare system. Lack of sufficient research has caused unidentified root causes of barriers.

METHODS

A mixed-method research design was employed to investigate the experiences of the diverse array of individuals accessing healthcare in the United States. The study aimed to address the question of whether the US healthcare system presents barriers to immigrant patients that US natives do not experience. The primary research method utilized a Likert scale and correlation scale to perform factor analysis, which was accompanied with correlational statistics. An experimental design allowed for comparative analysis of how immigrants and U.S. born individuals addressed specific factors during their interactions with healthcare services. All surveys included an informed consent form to ensure participants were knowledgeable of the data being collected, its purpose, and that their participation is completely voluntary with the ability to withdraw at any time. The participants' responses were kept anonymous to preserve confidentiality and any identifying information was not disclosed.

The sample population was sought out to be participants from various backgrounds to represent the mixed experiences when interacting with the healthcare system using convenience sampling. Individuals who reported being born outside of the US were identified as immigrants. Potential participants, aged thirteen and older, were recruited between March and April 2021 both online and in-person. Online recruitment was distributed via social media platforms, through Twitter and Instagram. In-person recruitment was done through soliciting households, medical offices/facilities and cultural restaurants all located in Woodbridge, Virginia. Participants were required to have received medical care and or encountered the US healthcare system.

The Likert scale gauged patients' experiences in five areas: access to healthcare, barriers to healthcare, healthy practices, relationships with healthcare providers, and relationships with health institutions. The survey can be found in Appendix A. Each of these factors were analyzed using

five questions per factor. The participants' experiences were quantified ranging from 1 to 5 (1= strongly disagree, 5= strongly agree). However, a duplication of a survey question occurred within the survey administered to US natives and immigrants. The resulting data served as the primary dataset for correlational statistics and factor analysis.

In addition to the survey administered to patients, a second survey was given to healthcare providers. The survey assessed healthcare providers' perceptions on the effectiveness of their care delivery and about the state of health institutions and the healthcare system currently in place. The experimental design addressed the quality and trust of interactions with their patients and the efficiency of their services, allowing for comparative analysis between patients and providers. The research method also utilized a Likert scale and correlation scale to perform factor analysis, accompanied with correlational statistics.

The sample population was healthcare providers aged eighteen and older and were recruited using convenience sampling. Individuals who identified as administering medical services to patients and having significant impact on the care patients receive in the healthcare system were considered healthcare providers. Potential participants were recruited both online and in-person, between March and April 2021. Online recruitment was distributed via social media platforms, through Twitter and Facebook. In-person recruitment was done through soliciting medical offices/facilities located in Woodbridge, Virginia.

The Likert scale measured providers' perceptions in two areas: their provided care and the state of the way health institutions operate. The survey can be found in Appendix B. Both of these factors were analyzed using five questions per factor. The providers' perspectives were quantified ranging from 1 to 5 (1= strongly disagree, 5= strongly agree). However, when conducting t-tests to compare the trust between providers/health institutions, US born natives, and immigrants, an adjustment to one factor in the interest of using uniform statistics in algorithms was made. This increases slight potential for error in the analysis of data

ANALYSIS

Correlation coefficients were calculated by comparing the scores of Likert questions within each factor (access, barriers, healthy practices and relationships with providers). The correlation coefficients were made including all U.S born natives and immigrants experiences. Further calculations were made by conducting two tailed t-tests of the Likert scores among the sub populations. These were done by comparing the scores of U.S. born natives with immigrants and comparing the scores of men and women. The second survey quantifying the beliefs of health providers' efficacy of their own services and current state of health institutions was compared to U.S. born natives and immigrants beliefs. This was done by conducting two tailed t-test scores of the correlation coefficients and the results of the survey from health providers. T-test scores were conducted comparing immigrants' belief of the efficacy of providers and institutions with that of the providers' beliefs. Similarly, t-test scores were conducted comparing U.S. born natives' belief of the efficacy of providers and institutions with that of the providers' beliefs.

RESULTS

Factors such as access/barriers to healthcare services, healthcare provider relationships, execution of healthy practices, and health institution relationships were considered as part of the correlational inquiry. Correlational analyses and t-tests were tested amongst US-born natives, immigrants, men, and women using the healthcare system. The correlation coefficients and t-test values were then compared amongst groups to assess a possible relationship or lack thereof.
200 surveys were administered and 94 respondents were available for data analysis. Demographics of the 94 respondents are summarized in Figures 1, 2, and 3. Most were US-born natives (68.1%, n= 64), female (71.4%, n=67) and had a median household income of greater than 110k (39.4%, n=37).

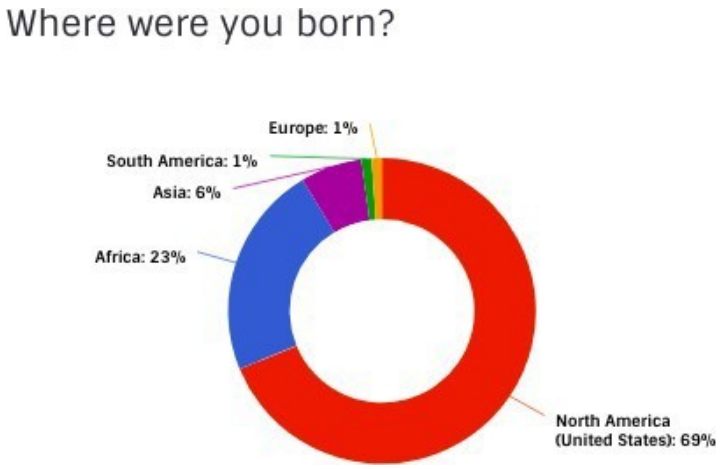

Figure 1: Users of the US healthcare system place of birth

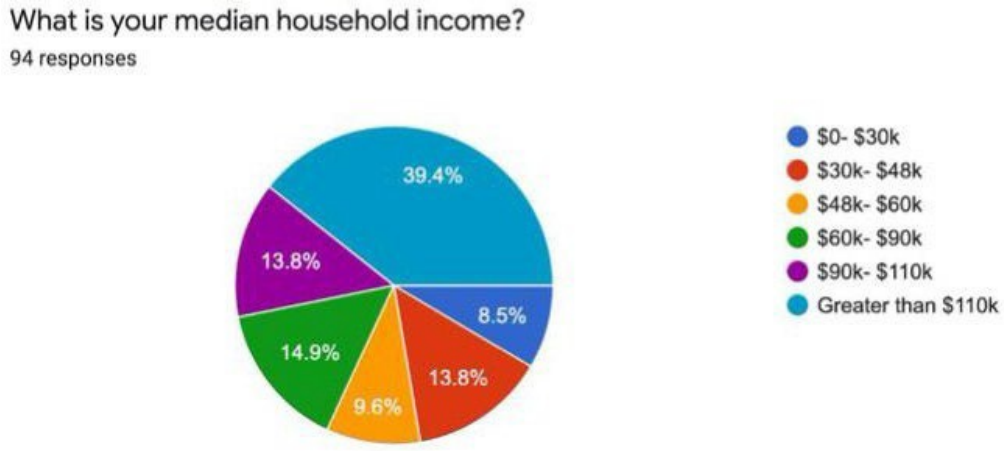

Figure 2: Users of the US healthcare system median household income

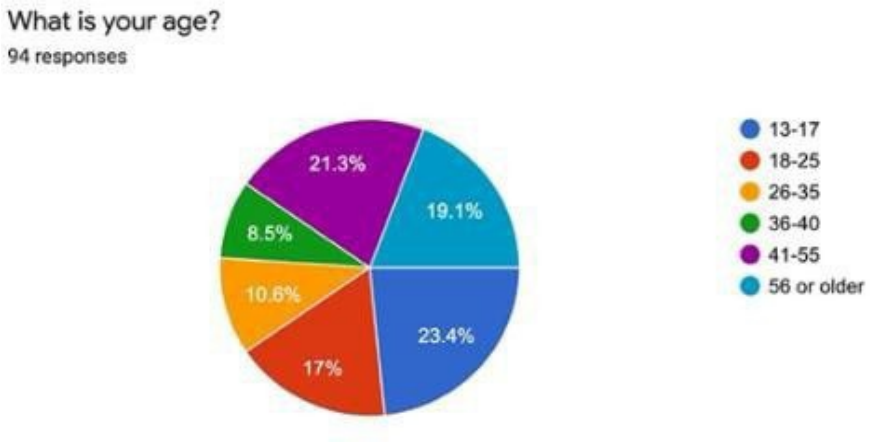

Figure 3: Users of the US healthcare system ages

Participants' responses in relation to their access to healthcare there was no significant difference between US born natives' and immigrants' (t= 0.35). Participants' responses in relation to the barriers they possibly face in healthcare were also not statistically significant (t= 0.26). Women tended to have more beneficial relationships with their healthcare providers (t= 0.05), a better connection to resources of health institutions (t= 0.03), and most notably their implementation of healthy practices was significantly different than that of men (t= 0.005). In comparison of their correlation coefficients, women have greater access when they have a positive relationship with health (0.59). Even though there were no significant differences between US born natives and immigrants, correlation coefficients highlighted distinctions between the two, as seen in Tables 3 and 4. Providers had a greater impact on the access patients received in healthcare in immigrants (0.63) than US natives (0.43). Barriers were also more positively correlated with health institutions in immigrants (0.21), in comparison to a negative correlation in US natives (- 0.38). Healthy practices had little to no effect on barriers to the healthcare system in immigrants (-0.08), while it more negatively correlated with barriers in US native (-0.27). Healthy practices did have a positive correlation with access to the healthcare system in US natives and immigrants. Providers had a negative correlation with barriers to the healthcare system in both groups.

The correlation coefficients were strongly positive when considering the relationship between providers and institutions for US natives (0.65) and immigrants (0.69). This positive relationship between providers and institutions was also found in between men (0.68) and women (0.68). In addition, there was a strong positive correlation in the relationship with institutions and access to the healthcare system in US natives (0.57), immigrants (0.56), and women (0.59). There was a stronger positive correlation between access to the healthcare system and the relationship with providers for men (0.54). Consequently, greater access to the healthcare system was strongly negatively correlated with barriers for US natives (-0.68), men (-0.73) and women (-0.53) and less strongly for immigrants (-0.39).

NATIVES V IMMIGRANTS		
Factors	**T-Test Scores**	**Significant**
Access	0.35	No
Barriers	0.26	No
Providers	0.29	No
Health Practices	0.31	No
Institutions	0.29	No

Table 1: T-test values of US natives and immigrants using the healthcare system

MEN V WOMEN		
Factors	**T-Test Scores**	**Significant**
Access	0.76	No
Barriers	0.69	No
Providers	**0.05**	Yes
Health Practices	**0.005**	Yes
Institutions	**0.03**	Yes

Table 2: T-test values of men and women using the healthcare system

Color	Correlation
	1.00
	0.65 to 0.99
	0.50 to 0.64
	0.35 to 0.49
	0.25 to 0.34
	0.11 to 0.24
	-0.10 to 0.10
	-0.11 to -0.24
	-0.25 to -0.34
	-0.35 to -0.49
	-0.50 to -0.64
	-0.65 to -0.99
	-1.00

IMMIGRANTS	Access	Barriers	Providers	Health Practices	Institutions
Access	1.00	-0.39	**0.63**	0.53	0.56
Barriers	**-0.39**	1.00	**-0.14**	-0.08	0.21
Providers	**0.63**	**-0.14**	1.00	0.56	**0.69**
Health Practices	0.53	-0.08	0.56	1.00	0.52
Instituions	0.56	0.21	**0.69**	0.52	1.00

US NATIVES	Access	Barriers	Providers	Health Practices	Institutions
Access	1.00	**-0.68**	0.43	0.41	**0.57**
Barriers	**-0.68**	1.00	-0.30	-0.27	**-0.38**
Providers	0.43	-0.30	1.00	0.33	**0.65**
Health Practices	0.41	-0.27	0.33	1.00	0.37
Institutions	**0.57**	**-0.38**	**0.65**	0.37	1.00

Table 3: Correlation matrix of factors of US-born natives and immigrants

Color	Correlation		WOMEN	Access	Barriers	Providers	Health Practices	Insitiutions
	1.00		Access	1.00	-0.53	0.50	0.47	0.59
	0.65 to 0.99		Barriers	-0.53	1.00	-0.20	-0.22	-0.17
	0.50 to 0.64		Providers	0.50	-0.20	1.00	0.48	0.65
	0.35 to 0.49		Health practice	0.47	-0.22	0.48	1.00	0.53
	0.25 to 0.34		Institutions	0.59	-0.17	0.65	0.53	1.00
	0.11 to 0.24							
	-0.10 to 0.10							
	-0.11 to -0.24		MEN	Access	Barriers	Providers	Health Practices	Institutions
	-0.25 to -0.34		Access	1	-0.73	0.54	0.43	0.48
	-0.35 to -0.49		Barriers	-0.73	1	-0.41	-0.26	-0.25
	-0.50 to -0.64		Providers	0.54	-0.41	1	0.16	0.68
	-0.65 to -0.99		Health Practices	0.43	-0.26	0.16	1	-0.02
	-1.00		Insitutions	0.48	-0.25	0.68	-0.02	1

Table 4: Correlation matrix of factors of men and women using the healthcare system

Providers

In the survey administered to healthcare providers/workers, all respondents consented and consisted of 36 responses for data analysis. Majority of respondents were female (69.4%, n=25), identified as Asian (44.4%, n=16), or Caucasian (41.7%, n=14) and ages mostly ranged from 26 to 45.

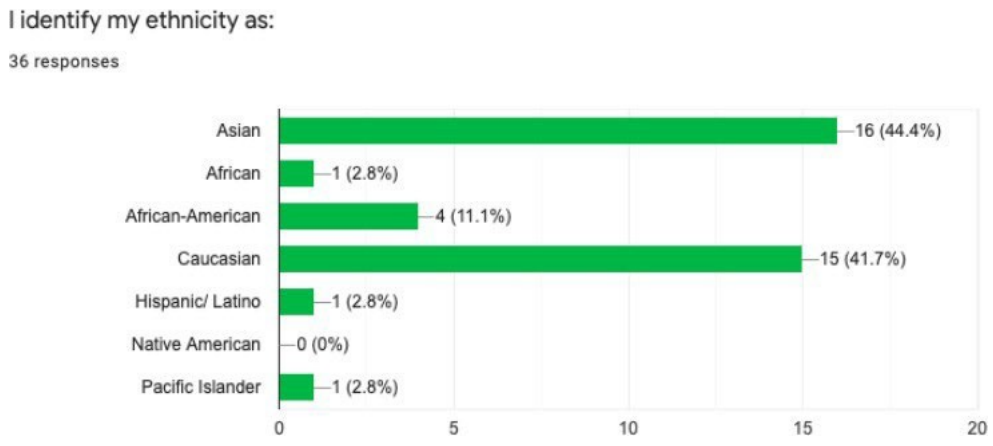

Figure 4: Healthcare providers' ethnicities

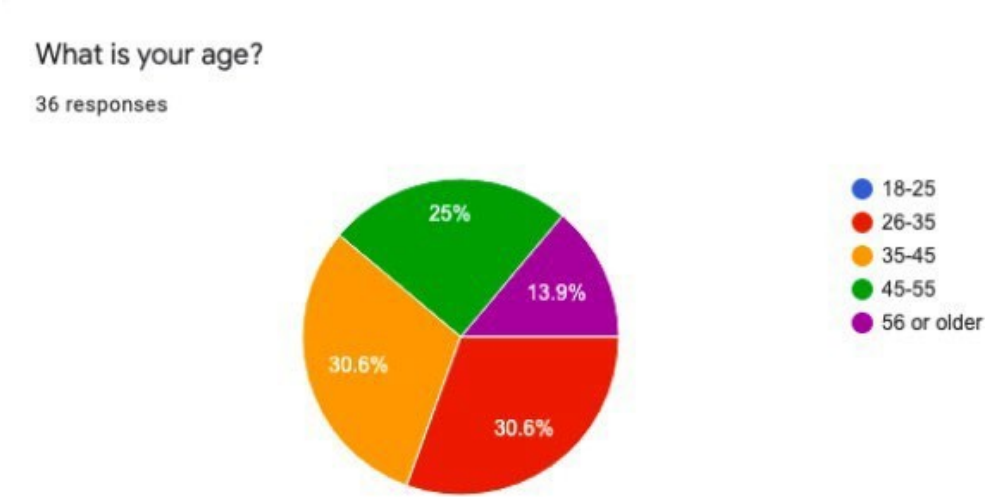

Figure 5: Healthcare providers' ages

Healthcare providers' belief in the efficacy of their services and belief in health institutions' influence on users of the US healthcare system were compared to user's responses who were asked about their experience with providers and health institutions using t-tests (see Table 5 and 6). There was a significant difference in providers' belief in the efficacy of their services and how much immigrants trust the efficacy of their services (0.0000002). A significant difference in the trust between providers and users were also found amongst US natives which was an even greater difference than immigrants (0.0000000008). Providers' belief in the administration of health services by health institutions were however not significantly different that US natives (0.08) or immigrants (0.42).

IMMIGRANTS V PROVIDERS				
Factors		**T-Test Score**		**Significant**
Providers		**0.0000002**		Yes
Institutions		0.42		No

Table 5: T-test values of immigrants using healthcare system and healthcare providers

US NATIVES V PROVIDERS				
Factors		**T-Test Score**		**Significant**
Providers		**0.0000000008**		Yes
Institutions		0.08		No

Table 6: T-test values of US natives using healthcare system and healthcare providers

DISCUSSION

In the analysis of the study's participants, differences between US native born and immigrants in the healthcare system were found in areas such as provider trust, health institutions relations, access regarding healthy practices, and significant differences even amongst men and women. Significant differences were also found in healthcare provider trust in both US natives and immigrants.

A significant difference was found between men and women in their relationships with health practices, healthcare providers, and health institutions. A similar correlation was found in a study conducted by Sood (2019) and colleagues, which found women had a higher self-efficacy in regards to maintaining a healthy diet. However, this difference was not statistically significant (Sood et al.). In addition to their less adequate health practices, in a systematic review of why men are less likely to seek healthcare, plenty of barriers contributed to their poor health-seeking behaviors (Yousaf, Grunfeld & Hunter, 2013). These included poor communication with providers, inability to build rapport with providers, and uncertainty in their credibility. Distrust in providers' ability to efficiently address their health concerns decreases trust in health institutions as well. As seen in the correlation analysis, a positive relationship with providers correlated with a positive relationship with health institutions in men (0.68).

An expected find was the prevalence of barriers in institutions inhibiting immigrants from receiving full access to care. Immigrant participants were subjected to more barriers in institutions (0.21) in comparison to US natives (-0.38), but there wasn't a significant statistical difference. Previous literature (Portes et al., 2009; Castañeda et al., 2015) argued studies do not take into account the systematic barriers imposed by the US healthcare system. Immigration affects multiple aspects of an individual's lifestyle and should be looked at as more than just one factor and as a social determinant of health as well.

Barriers within health institutions have been embedded into the system to prevent immigrants from full access. Health institutions' frameworks' inherent ways which inhibit care from immigrants led a study (Portes, Light & Fernandez-Kelly) to infer institutions play a larger role in healthcare's accessibility than providers do. As seen in this study's correlational analysis, health institutions have a higher correlation to barriers in immigrants (0.21) than providers do (-0.14).

Lack of English fluency was perceived as a barrier to access health care services, and also known to handicap individuals along with cultural differences, legal status, and poverty in a study conducted by Portes and colleagues (2009). However, with further research (Schewi, et al., 2016; Wang, 2011), the need to bridge this barrier has been mitigated with the implementation of a national policy to provide access to language services to those who need it. The patient's language proficiency can also improve over time or their children can speak on their behalf. The study stayed consistent with the lack of need for better communication between healthcare providers and immigrants. Immigrants; relationship/ trust with providers is positively correlated with access (0.63), even higher than that of US natives (0.41), and allowed for increased access within the healthcare system. US born natives may have a lower provider trust due to immigration attitude

relating directly with physician attitude (Samson, 2016). Those with a disdain for immigration were subject to higher distrust for physicians, and in addition, the US has been seen to decline in physician distrust due to declining social capital.

An expected trend was healthy practices correlating positively with access to health care in immigrants and US natives. This can be reasoned for using previous literature (Adekeye, Adesuyi & Takon, 2018; Seo 2011), which show health fairs with consistent follow-ups can help increase access to predetermined objectives by spreading awareness of accessibility to those who may not seek it and increase their health literacy. In doing so, it can expand knowledge of healthy practices to increase utilization of healthcare. If people, especially immigrants, are knowledgeable of healthy choices to protect their health, it will increase their chances in seeking care. However, if their access to care is inhibited through barriers, even with their knowledge of healthy practices, utilization of the healthcare system will not be as apparent. In addition, health practices and utilization may vary amongst different counties/cultures/sub-groups. As seen in a cross-sectional comparison of US county-level public health performances, grouping counties based on sociodemographic (rurality, socioeconomic status, race, ethnicity, etc.) linked to the outcome of interest, facilitates a deeper understanding of additional factors influencing prevalence of health outcomes (Wallace et al., 2019). Accounting for these differing measures and experiences, health institutions can better equip their services to cater to the other determinants of health which impact their practices in addition to being an immigrant. Intervention efforts to increase utilization rates will become meaningful in reaching targeted health outcomes because they are more tailored to the populations' experiences that may be impacted by the additional sociodemographic factors that are not considered if they are solely labeled an immigrant.

Significant figures of distrust between patients and providers were found in the study which could also be due to immigration attitude or social capital in the US. Providers were assessed on the adequacy of the care they administered and their trust between their patients, and the patients were inquired of the same thing. There were significant differences in patients' trust with providers compared to providers' believed trust with their patients in both immigrants (0.0000002) and US natives (0.0000000008). The disconnect in trust level between patients and providers may be due to the sociopolitical environment of healthcare, such as the politicization of health practices, declining social capital and arguments over government involvement in healthcare systems. As seen in the current state of COVID-19 pandemic, mask-wearing is a prime example of health practices becoming politicized. In a study Young, et al. (2022) examining mask-wearing and its correlation with political beliefs, psychological reactance and conflict orientation, found conflict style and political preferences has implications on the "implementation of health messaging and health policy". This in turn affects the patient's willingness to practice proper health practices and behaviors. Health communication amongst health providers and public health officials with patients are further undermined and creates barriers in transparency. Distrust was shown in a study supported by the National Institute of Mental Health and the Robert Wood Johnson Foundation (2014) which did a review a historical polling data on public distrust in US physicians and medical

leaders and found even though the US has high patient satisfaction, it has low overall trust in providers (Blendon, Benson & Hero, 2014). This low overall trust, even with high patient satisfaction could be due to costs of care and or medical professions' lack of public effort to lower these costs. Providers' trust in the adequacy of health institutions was not significantly different than patients' trust in health institutions. This may be due to providers' understanding of the high expenses of healthcare imposed by health institutions.

CONCLUSION

The immigrant population in the US has demonstrated low utilization of the healthcare system which could impact their overall health outcomes. This could be attributed to the distrust between immigrant patients and their providers, which this study highlights a difference in patient's trust, and providers' perceived trust. The importance of improving patient-provider relationships for all demographics, especially men, is imperative because it can influence the behavior patients make in their personal health choices. This study displays a difference between native born and immigrants' provider trust, health institution relations, and access to exhibit healthy practices. However studies researching a larger cohort is necessary to draw a valid conclusion. This signals a distinction between the two groups and signifies that the US healthcare system should implement resources and enact services to reach a disserviced population of immigrants.

LIMITATIONS

Findings concerning both US born natives and immigrants were collected and distributed in the mid-Atlantic region which limits generalizability. It is also limited by its small sample size which may not adequately represent the broader populations of interest. Moreover, limited sample size heightens data variability and diminishes the ability to draw dependable conclusions or identify statistically significant variances. Consequently, findings derived from this study may exhibit diminished robustness. Additionally, it often yields wider margins of error, compromising the precision of the study outcomes and impacting the confidence level of conclusions drawn.

IMPLICATIONS AND RECOMMENDATION FOR FURTHER RESEARCH

Ensuring that immigrants have access to adequate care will not only benefit immigrants but will also benefit other marginalized groups within the US healthcare system such as African-Americans, ethnic minorities, and those with lower socioeconomic status. The system is overloaded with individuals lacking sufficient care, but if their concerns are appropriately addressed, their money can go towards the care they need and lessen the load on the system to provide care to the overwhelming number of individuals. Increasing the public's health literacy through health fairs, jobs, and schools will also decrease the demand of health institutions and better the overall health status of the public. The implications reach well beyond those noted in this research and require identifying how to combat the systematic barriers embedded into the structure of healthcare. The healthcare system requires intensive reform with policy implementation to allow for immigrants and marginalized groups to receive specialized care. Just as health care policy changes were implemented to counter language barriers, notable distinctions in care such as healthy practices,

health institution trust, and provider trust can be modified as well. This can be done by implementing proper health communication guidance to health professionals to ensure efficient modes of relaying information among patients and providers. This can alleviate the level of distrust and create meaningful relationships for patients to rely on for their health information.

For future research, the types of healthcare providers and way providers communicate with their patients should be studied to help mitigate the significant difference in trust between the two as seen in the study by conducting randomized controlled samples across the US to increase generalizability. Future research should also examine specific interactions healthcare providers have with different demographics, especially men and women, to find reasoning for their significant differences in interactions with healthcare providers/ institutions. Differences in men's and women's interactions with healthcare weren't aligned with the research study, but more research should be dedicated to investigating it. The general demographic of 'immigrants' can also be more detailed into identified populations by nationality or ethnicity and would be advantageous in specifying their relationships with providers.

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