It has long been considered a New Jersey fact that the recent immigrant population, both legal and undocumented, suffers from inadequate quality of and access to comprehensive health care. While not addressing the quality of health care or any specific quality indicators of the care actually provided to these groups, Sanjay K. Pandey, Joel C. Cantor, and Kristen Lloyd in their article “Immigrant Health Care Access and the Affordable Care Act” make a valuable contribution to our understanding of the factors underlying access to health care by immigrants in New Jersey and, by extension, nationwide.

They make use of the “Anderson model” to better understand how two measures of health care access affect immigrant groups divided by time in the United States compared with the U.S.-born population. Data obtained from the New Jersey Family Health Survey prior to the implementation of the Patient Protection and Affordable Care Act (ACA) provided measures of perceptions of “unmet health care needs” as well as actual utilization (“whether or not the individual saw a physician in the last year”). This tool, well suited to the purposes of this evaluation, was designed and utilized by the Rutgers University Center for State Health Policy.

As the authors indicate, New Jersey has a long history of attempting to improve both the quality of and access to health care across the age continuum. Having spent more than three years as commissioner of health and senior services in New Jersey, I had a front seat to view many of those efforts. Early in my term, New Jersey enacted a law, sponsored by Senator Wayne Bryant, requiring every physician licensed in the state to take an approved course in “cultural competency.” Each September, Minority and Multicultural Health Month, events are scheduled to

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promote health issues throughout the state, including health fairs and public service announcements on television and radio. The Department of Health and Senior Services translates all public documents into four languages—Hindi, French Creole, Mandarin Chinese, and Spanish. While there are more than 100 languages spoken in New Jersey, these efforts reach a large proportion of the state’s non-English speakers. Because about 11 percent of the people in New Jersey have limited English proficiency, the University of Medicine and Dentistry of New Jersey as well as the Department of Health also promoted programs with medical interpreters and translators. In addition, we expanded and promoted primary care centers and Federally Qualified Health Centers (FQHCs) to the medical community as well as deep into the communities served.

Throughout all of these activities, the Rutgers Center for State Health Policy, under the excellent direction of Dr. Cantor—a coauthor of the article addressed here—served as a research center, data source, and valuable public policy advisor. Cantor’s role clearly added value to the article.

New Jersey is a very eclectic state, both in geographic diversity and in demographic variability. As the authors point out, the variability in country of origin of the Hispanic groups as well as the Asian population allows New Jersey to be a representative sample of the United States as a whole.

With wider implementation of the ACA, unavailability of insurance may have less impact on access to health care. One of the issues not raised by the authors is the availability of practicing physicians willing to see patients for the fees paid under the Medicaid program. The temporary payment of Medicare fees for these new Medicaid patients may be a counterweight to this reluctance, but time will tell.

The present charity care system, while beneficial to those hospitals seeing the uninsured, poor population, does not cover payment for physicians’ services at all. This concept of taking the work of physicians for granted has embittered some physician groups toward New Jersey government funding programs. While it is true that some hospitals have shared some of their charity care funding with their medical staffs, this has not helped reverse the negative attitude developed toward the government programs.

The ACA’s role in expanding FQHC coverage, as well as the improvement in funding for physicians’ graduate medical education training programs, may improve the physician supply in medically underserved areas and thus may improve access, but is not addressed in this study.

The assumption that providing increased Medicaid coverage will have a meaningful impact on barriers to access is problematic. The authors note work to support this premise, but my experience in New Jersey would suggest that real and meaningful improvement in access requires a much more multipronged approach. The ACA does address many of these issues in addition to improvement in public insurance coverage. Stimulation of public health care education programs, hospital public outreach, and more FQHC facilities, as well as addressing the issue of policy discussions regarding the medical care of the medically underserved starting early in medical school, are just some of the initiatives necessary for meaningful improvement. Should physician licensing be contingent on public service in this area, similar to pro bono requirements for lawyers? More work needs to be done. Pandey, Cantor, and Lloyd make a valuable contribution to this public debate.