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Health Care Access Among Hispanics: Implications for Social and Health Care Reforms

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Health Care Access among Hispanics: Implications for Social and Health Care Reforms

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'For recent immigrants … seeking health care often involves daunting encounters with a fragmented, bewildering, and hostile system… the remedy…is not immigrant bashing, but health care reform.'

(Susan Okie, M.D. and Flavia Mercado, M.D.)

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Abstract

Health care access is defined by the Institute of Medicine as, '*the degree to which people are able to obtain appropriate care from the health care system in a timely manner*'. Two key components of health care access are medical insurance and having a usual source of care. Recent national data shows that among Latinos 34% do not have health insurance and 27% do not have a usual health care provider. This paper identifies key barriers and solutions to the lack of health care access among Latinos.

Keywords: chronic care model; community health workers; cultural competency, health care; health insurance; Hispanic; immigration; Latinos; medical interpreters

Resúmen

El acceso a servicios de salud ha sido definido por el Instituto de Medicina como 'el grado de acceso que tienen los individuos a obtener cuidado adecuado de salud de manera oportuna'. Dos componentes claves del acceso a la salud son el seguro médico y el recibir atención en un lugar fijo. Datos nacionales recientes muestran que el 34% de los latinos no tienen seguro médico y el 27% no reciben atención en un lugar fijo. Este artículo identifica barreras y soluciones para mejorar el acceso a los servicios de salud entre latinos.

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Introduction

There are 48 million Latinos living in the U.S., 64% of which are of Mexican, 9% of Puerto Rican, 7.6% of Central American, 5.5% of South American, and 3.4% of Cuban descent, with the remaining Ethnic subgroups coming from diverse countries of origin. According to the U.S. Census Bureau, Latinos living in the U.S. represent at least 20 different Latin American countries and the Caribbean, with 40% having been born outside the U.S. Although Latinos still concentrate predominantly in the southwest, southeast, and the northeast, fast growing Latino communities have emerged over the past years in all regions of the U.S. Their presence has emerged in many areas, where until recently, Latinos have not had a significant presence. For example, the five states experiencing the highest Latino growth rate between 2000 and 2006 were Arkansas, Georgia, South Carolina, Tennessee, and North Carolina. Likewise, about 5% of the population in Alaska, and 8% of the population of Hawaii identify themselves as Latinos, showing the rapid growth in the even more geographically distant states. Demographic projections indicate that Latinos will account for the majority of population growth in the U.S. in the decades to come. Between 2010 and 2050 Latinos are expected to grow from 47.8 million (15% of US population) to 103 million people (24% of US population) (US Census Bureau, 2006 and 2007) (Figures 1a and 1b).

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For centuries Latinos have made and continue to make major social, economic, cultural, and political contributions to the U.S. Yet, they continue to

experience major disparities in health outcomes and their determinants. Compared to their White counterparts, Latinos experience significantly higher levels of poverty, food insecurity, lack of leisure-time related physical activity, obesity, and incidence of serious chronic conditions such as type 2 diabetes. They are also more likely to receive a late diagnosis for certain types of cancer. They are also more likely to work in jobs that increase the risk of physical injury, and poor mental health outcomes. Infectious diseases, such as HIV, are also more prevalent among Latinos. Violence, homicide rates, as well as mental health problems are also significantly higher in this ethnic group (Cabassa, Zayas and Hansen, 2006; Escarce, Morales and Rumbaut, 2006; Fitzgerald, Segura-Pérez, and Pérez-Escamilla, 2008; Flores and Tomany-Korman, 2008). Although Latinos arrive to this country with healthier lifestyles and better health outcomes than most Americans, these positive outcomes tend to deteriorate as a function of lifestyle changes associated with continued exposure to the mainstream American culture (Pérez-Escamilla and Putnik, 2007).

Health care access is defined by the Institute of Medicine (2006) as '*the degree to which people are able to obtain appropriate care from the health care system in a timely manner*' (Table 1). Two key barriers for health care access are lack of medical insurance and not having a usual source of care. Latinos are a medically vulnerable population without proper access to high quality and timely primary, secondary, and tertiary care. Given the current interest in health care and immigration reform in the U.S., it is important to improve our understanding of the disparities of health care access among Latinos. The objectives of this paper

are to: a) describe the epidemiology of health care access; b) identify key determinants of health care access; c) discuss specific challenges faced by non-English speaking and non-citizen Latinos; and d) make recommendations to improve health care access among Latinos.

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Methods

This review identified key studies and authoritative reviews through a Medline electronic search, and by contacting experts in the field. Priority was given to studies that were based on representative samples, and to comprehensive systematic literature reviews. Local studies based on convenience 'snow ball' sampling techniques were included to examine topics, such as health care access among undocumented immigrants, that can not be properly addressed through representative sampling techniques (Flores, Abreu, and Tomany-Korman, 2006; Nandi et al. 2008).

Results

Health Insurance

In 2007, 34% of the 44 million Latinos 65 years old or younger and living in the U.S. did not have health insurance compared to 12% of their White counterparts (Kaiser Commission on Medicaid and the Uninsured, and Urban Institute, 2008) (Figure 2a). The source of health insurance also differed dramatically across racial/ethnic groups. Among those with insurance, 64% of Latinos and 86% of Whites were covered by private insurance, the type of

insurance that has been consistently associated with better health outcomes. In the U.S., the main source of private insurance is employer based. Thus, it is remarkable that even though over 70% of Latino households have at least one member that is employed (Kaiser Commission on Medicaid and the Uninsured, 2006), 40% of employed Latinos are uninsured (Kaiser Commission on Medicaid and the Uninsured, and Urban Institute, 2008) (Figure 2b).

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Non-Citizens

Unauthorized Latinos are at much greater risk of not having insurance. National estimates indicate that in 2007, non-elderly Latinos who were non-citizens or who spoke Spanish were much more likely to be uninsured compared to their counterparts who were U.S. citizens (Figures 3a and 3b). The risk of lack of insurance did not change as a function of the amount of time non-citizen Latinos had been living in the U.S. (Kaiser Commission on Medicaid and the Uninsured, and Urban Institute, 2008). In Southern California, it has been estimated that between 68% and 84% of undocumented Latinos are uninsured. This issue is of great concern, in 2000 only 28% of foreign born Latinos were naturalized citizens **(**Escarce and Kapur, 2006**)**.

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Usual Health Care Provider

Recent national data **(**Pew Hispanic Center, and Robert Wood Johnson Foundation, 2008**)** shows that 27% of Latino adults lack a usual health care

provider. The problem becomes more pronounced among those who are: foreign born, males, younger, less educated, and uninsured (Figure 4). Accessing a regular health care provider can make a difference. For example, while almost 75% of Latinos with such a provider have recently had their blood cholesterol measured, this is true for only 44% without a primary provider. The corresponding figures for testing blood sugar levels among Latinos with diabetes is 90% vs. 67%, respectively.

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The primary reason Latinos give for not having a usual health care provider is that they 'don't need one,' presumably because they perceive themselves as healthy. This poses a major challenge for accessing primary prevention, and screening services capable of detecting conditions among Latinos, before being clinically diagnosed with a serious illness. Among Latinos receiving medical care in the recent past, 23% report having received poor-quality treatment, 31% of those attributing this undesirable outcome to their poverty status, 29% attributing it to their ethnicity/race, and 23% to their accent. Flores, Abreu, and Tomany-Korman (2006), conducted a multi-ethnic cross-sectional study in the Greater Boston area that included 900 Latinos who were parents of children under 18 years old. The community outreach sampling methodology, allowed the researchers to interview both documented and undocumented Latinos. The participants were predominantly from the Dominican Republic, Puerto Rico, and El Salvador. Their children were significantly more

likely than non-Latino children to lack health insurance. Among uninsured Latino children, 55.1% had one parent working, 33.1% two parents working, and only 9.6% had both parents unemployed. Among uninsured Latino children, 16.2% did not have access to a regular doctor compared with 0.7% of their insured counterparts ($p<0.001$). Multivariate analyses showed that uninsured Latino children were 24 times more likely than insured Latino children of not having a regular doctor. Key reasons given for not bringing a Latino child to get heath care when needed were: difficulty making an appointment, lack of insurance, too long a wait to see a doctor, unaffordable, doctor's office hours inconvenient, health care staff does not understand culture, and language barriers.

Oral Health

Oral health is a powerful indicator not only of the condition of the mouth, but of the body as a whole. More than 90% of systemic diseases, including HIV, diabetes, cardiovascular disease, and cancer have oral manifestations (Institute of Medicine, 2003). Using the data from the 2003-2004 National Survey of Children's Health, Flores and Tomany-Korman (2008), documented disparities in oral health care access among Latino children. In this survey, the proportion of Latino children (average age: 8 years), reported to be in very good/excellent health was 65% vs. 90% among their White counterparts. Likewise the proportion reporting having very good/excellent teeth condition was much lower among Latino than among White children (47% vs. 77%). Latino children were more likely to have never seen a dentist (17.8% vs. 13.1%), to have had no routine preventive dental care in the previous year (17.8% vs. 13.1%), and to have had

unmet dental care needs (5.3% vs. 2.2%). Among Latinos, the lack of medical insurance was cited as the main reason given (55.4%) for the child not receiving needed dental care.

Mental Health

According to the Institute of Medicine (2003), more than one in five people between the ages of 18 and 64 experience at least one common mental disorder, such as schizophrenia and affective disorders including different types of depression and anxiety disorders. Yet only 25% of them obtain diagnosis and treatment from the health care system. This compares to 60-80% of those with heart disease. Cabassa, Zayas and Hansen (2006), recently reviewed seven epidemiological studies seeking to understand mental health care access issues among adult Latinos. All of the studies were based on national or community level representative samples, and the majority was cross-sectional. Compared to Whites, Latinos are more likely to underutilize mental health care services, less likely to receive guidelines consistent with best practices care, and are more likely to rely on primary care services to cover their mental health care needs. Latinos are also more likely to be exposed to greater delays in receiving needed mental health care, to be in active treatment, and are less satisfied with the quality of mental health care received. Common barriers identified for accessing mental health care among Latinos included: lack of health insurance, lower levels of acculturation, and associated factors of being foreign born and not speaking English.

Language skills and preferences are likely to represent a complex mix of indicators relevant to understanding health care access disparities among Latinos. These include immigration status, poverty risk, as well as acculturation. For this reason the following section deals with the issue of language as a facilitator or barrier for accessing health care.

Language Preferences and Health Care Access

A recent study examined the influence of language on health status and health care access among Latinos (Dubard and Gizlice, 2008). These secondary data analyses examined data from the 2003-2005 Behavioral Risk Factor Surveillance System (BRFSS). The researchers compared health outcomes and health care access data between Hispanics who answered to the language phone survey in Spanish (n=17,827), and Latinos who answered it in English (n=27,249). Data was available from 20 states accounting for about 90% of the Latino population. Spanish-speaking respondents were more likely to not have completed high school than English-speaking Latinos (59% vs. 18%). Spanish-speaking respondents were also more likely to earn < $15,000 per year (36% vs. 15%). Consistent with this, English-speakers were more likely to have health insurance (77% vs. 45%); to have a usual doctor (58% vs. 29%); to have had a medical check-up in the previous year (64% vs. 55%); to have the economic resources to have access to a doctor when needed for a medical condition (81% vs. 73%); and to have visited a dentist during the previous year (65% vs. 50%). These differences remained statistically significant after adjusting for respondent's age, gender, and level of education. The worst access to health care

was found among Spanish-speaking Latinos living in states that have experienced a relatively high rate of population growth among Latinos in the past decade (e.g., Arkansas, Nevada). Compared to those states with a lower rate of population growth among Latinos, and with a large representation of Mexican-Americans (e.g., California, Texas), or a large representation of non Mexican-American Latinos: Puerto Rican, Cuban, Central and South Americans (e.g., Connecticut, Florida). This finding has important implications for the so called 'emerging Latino communities.' In parts of the country where this ethnic group traditionally has not had a significant presence but that is now rapidly growing (Kaiser Commission on Medicaid and the Uninsured, 2006); overall, and consistent with other studies (Kaiser Commission on Medicaid and the Uninsured, 2006), findings from this study indicate that language use matters among Latino Spanish speakers having much less access to health care then their English-speaking counterparts. Findings clearly showed that responding to BRFSS in Spanish was associated with lower socio-economic status, and it is known that poverty limits access to health care. However, the lower access to health care remained after controlling for level of education. Thus, it is possible that those who chose to respond in Spanish may have had more difficulties understanding how to navigate the system for gaining health care access because they were less or non fluent in English. Indeed, according to the U.S. Census Bureau, among Spanish speakers in the country (about 10% of U.S. residents), half of them report speaking English "less than well." It is also possible that Spanish language preference may reflect a higher likelihood of being undocumented, which can seriously limit access to

health care and social programs. In the U.S., public medical insurance programs, such as Medicaid, are not accessible for undocumented immigrants, or even for those who are legal but have been in the country for less than 5 years. This issue needs to be addressed in this study. Lack of access to health care was also found to be strongly related to lack of access to pneumonia and influenza immunizations and preventive screenings for relatively common and potentially serious conditions such as breast and prostate cancer.

As indicated before, there is overwhelming evidence indicating that there are two determinants of Limited English Proficiency, (a) being a foreign born Latino, and (b) being a non-U.S. citizen, that are potent indicators for lack of health care access among Latino populations (Pew Hispanic Center, and Robert Wood Johnson Foundation, 2008; Kaiser Commission on Medicaid and the Uninsured, and Urban Institute, 2008). For these reasons the following section focuses on health care access barriers surrounding undocumented Latino immigrants.

Undocumented Status and Health Care Access

Undocumented immigrants fear that a visit to a hospital or clinic may end up in deportation (Okie, 2007). This prevents them from seeking timely medical care. The situation is compounded by the public perception that undocumented immigrants represent a burden on the U.S. health care system. Contrary to this perception, the evidence shows that undocumented adult immigrants account for only 1.5% of U.S. medical costs, a proportion substantially lower than expected.

It is estimated that undocumented adult immigrants account for 3.2% of the total U.S. population (Goldman, Smith and Sood, 2006).

Nandi and colleagues (2008), conducted a cross-sectional study in New York City that involved an in-person interview with 431 undocumented Mexican immigrants, which sought to identify the factors associate with health insurance, regular health care provider access (defined as 'going to a doctor's office or clinic, Medicaid or HMO, emergency department in a hospital, or drug treatment center and seeing the same [heath care provider] more than 90% of the time'), and use of emergency rooms. Multivariate logistic regression analyses showed that health care insurance coverage during the six months preceding the interview was associated with: living in a residence with fewer other adults, linguistic acculturation (lowest or highest level), formal income level, not sending money to family or friends in Mexico, higher levels of social support, and more days ill in the previous 30 days. Access to a regular heath care provider was associated with: being a woman, having fewer children, entering the U.S. before 1997, low formal income level (vs. no formal income), health insurance coverage, and not experiencing discrimination. Emergency department use was associated with: higher education level, formal income intermediate level, and more days ill in the previous 30 days.

Findings with children born to undocumented parents are consistent with what has been reported with adults, in spite of the fact that a significant proportion of these children were born in the U.S., and are U.S. citizens by law. Flores, Abreu, and Tomany-Korman, (2006) conducted a multi-ethnic cross-

sectional study in the Greater Boston area that included 900 Latinos who were parents of children under 18 years old. The community outreach sampling methodology, allowed the researchers to interview both documented and undocumented Latinos. Participants were predominantly from the Dominican Republic, Puerto Rico, and El Salvador. Latino children were significantly more likely than non-Latino children to lack health insurance. Among uninsured Latino children, 55.1% had one parent working, 33.1% two parents working, and only 9.6% had both parents unemployed. Among uninsured Latino children, 54.5% of their caregivers were undocumented, compared with 22.1% among insured Latino children ($p<0.001$).

As expected, among Latino immigrants, access to a routine health care provider has been associated with health insurance coverage, and this in turn has been associated with having a formal source of income (Nandi et al, 2008). Thus, future policy changes that promote the 'normalization' of undocumented Mexican immigrants, facilitate their access to formal sector jobs offering affordable benefits, which would likely increase their access to health insurance and the health care system in general. Findings show that among Latino immigrants more ill health is associated with emergency room use. Also, not having a regular health care provider illustrates the dire consequences the immigrants themselves and society at large face by not addressing, through sound legislation and policies, the major health care gap faced by undocumented immigrants.

Solutions

Understanding Latino health is a complex undertaking as it is affected by Latino sub-ethnicity as well as level of acculturation (Pérez-Escamilla & Putnik, 2007). However, several findings from this review apply to the great majority of Latinos, and thus lead to recommending several common solutions.

Health Insurance

An authoritative Institute of Medicine report (2009), together with a comprehensive recent literature review by Hoffman and Paradise (2008), support the conclusion that in the U.S., private and public health insurance facilitates access to and utilization of primary, secondary and tertiary health care, and continuity of care once a diagnosis is made or follow-up from a medical procedure is needed. These reviews also support the conclusion that health insurance access translates into lower morbidity and mortality related to chronic disease including cancer, heart disease, and type 2 diabetes. This is not surprising as health insurance has also been linked with significantly better access to preventive care (e.g., cancer, high blood pressure screenings dental care), state of the art medical procedures after diagnosis of a serious condition, medication access, and earlier mental health treatment. In 2006, 18% of the non-elderly U.S. population was uninsured, 61% was covered by employer-sponsored insurance, 16% by Medicaid or other public insurance, and only 5% was covered by private non-group insurance. Given the predominance of employer-sponsored insurance, the likelihood of being uninsured is negatively affected by poverty, low levels of education, and immigration status. Racial/ethnic minority groups, including Latinos, are much more likely to experience these conditions, and thus, are

heavily overrepresented among those without insurance. This indicates that government efforts at providing access to public insurance have come up short. To understand why this is and what to do about it, it is important to understand the health insurance system in the U.S.

Medicare's mandate is to cover all elderly and disabled people. Medicaid is the main government insurance available to non-elderly low income and severely disabled Americans. In recent times the State Children Health Insurance Program (SCHIP), has played an important role at increasing coverage among children and 'near poor' adults that have a higher income than that allowed by Medicaid. There is clear evidence that government insurance improves health outcomes among children and adults, although not always to the same extent as private insurance. It is possible that this is partially explained by the following three factors: a) insurance instability (i.e., people being dropped at different time points from public insurance) related to state cost saving policies, and/or individuals temporarily exceeding income guidelines; and b) the practice of health providers not participating in the Medicaid program, because of low reimbursement rates. Thus, key measures needed to improve health care access among nonelderly Latinos without employer-sponsored insurance are: a) guarantee affordable and stable government insurance; and b) improve Medicaid reimbursement rates for health care providers.

Improving access to health care among vulnerable groups will require private and public initiatives at the local, state and federal level (Institute of Medicine, 2009). Some states have covered recent and undocumented immigrants

through Emergency Medicaid. As an example, in North Carolina, a state experiencing major growth in emerging Latino communities, 99% of recipients of this benefit between 2001 and 2004 were undocumented, and 93% were Hispanic. The vast majority of services were for child birth and care associated with pregnancy complications (Dubard and Massing, 2007).

Recent Latino immigrants make major economic, cultural, and social contributions to our society. Preventing them from accessing timely screening and care pushes them to live in an 'emergency room' health care system where medical costs are likely to be three times higher than a primary care setting (Mohanty et al., 2005). Thus, on humanitarian, social and economic grounds, it is imperative to change public perceptions, and enact policies that facilitate access to health care among recent Latino immigrants. As indicated by Pediatrician Flavia Mercado 'the remedy …is not immigrant bashing, but health care reform' (Okie, 2007).

Improving Cultural Competency among Health Care Providers

Health insurance facilitates, it does not, however, guarantee access to adequate health care. For this reason it is important to consider options above and beyond heath insurance (Fontanarosa, Rennie, & DeAngelis, 2007). Cultural competency defined as 'effective understanding of language, thoughts, beliefs, values, and institutions among a variety of racial, ethnic, religious , or social groups' (U.S. Department of Health and Human Services, 2009) (Table 1), has been identified as key for addressing health disparities in the country (Institute of Medicine, 2002; U.S. Department of Health and Human Services, 2001).

Although the effectiveness of specific practices to improve cultural competency in the health care system still needs to be determined, there is a consensus among experts that linguistic competencies, efficient culturally appropriate communication skills are key for improving patient satisfaction, as well as the overall quality of physical and mental care among Latinos (Anderson et al. 2003, Betancourt et al., 2005).

Spanish speakers make up 60% of those who speak a language other than English, and of those, 64% are living with limited English proficiency in the U.S. (Flores, 2005). Thus, it is expected that Latinos will benefit more from health care providers, and health care institutions that are culturally skilled. Medical interpretation has been identified as a factor that significantly affects the quality of care among Latinos. According to Escarce, Kapur (2006), and Flores (2005), studies have shown, Latinos who only speak Spanish report significantly less patient satisfaction than their English speaking counterparts when comparing their health care experiences. Furthermore, Latinos that need medical interpreters and get a professional one are more likely to report better quality of care than those who do not get this service. Also, if they get an interpreter, they report care that is more patient-centered, and involves less medical errors with regards to diagnosis, treatment, and follow-up procedures. Thus, it is of concern the fact that only about half of the Hispanics needing a medical interpreter actually get one. The existing literature strongly supports the view that trained professional medical translators make a difference in terms of physical and mental health care quality among Latinos. This may not be the case with ad hoc interpreters such as relatives,

hospital or clinic staff, and janitorial staff. Of particular concern is the use of children as medical translators, this practice has been linked with the likelihood of serious medical errors (Flores 2005).

Consistent with previous authoritative reports (Institute of Medicine 2002 and 2003; Flores 2005), and the findings from Nandi and colleagues (2008), which suggest that improving the cultural skills of health care providers and their institutions as a whole, may lead to an increase in access to a regular health care provider, which is a key component of the definition of health care access. This is because individuals who felt that they had ever been discriminated against were less likely to have a routine health care provider. In this study 59% of respondents answered affirmatively to the discrimination question, the majority believing that their perceived discrimination was the result of their language, 'racial', or immigration status. Entering the U.S. before 1997 was also associated with more access to a health care provider. On the one hand, this finding may simply reflect the possibility that the longer the time in the U.S., the easier it becomes for undocumented immigrants to understand how to access health care. This would suggest that policies that facilitate access to peer navigators by new or recent arrivals may increase access to health care. On the other hand, this finding may also reflect the fact that 1996 was the year when major legislation changes limiting access to publicly funded health care insurance for undocumented immigrants, and those within their first five years of legal residence were passed (Goldman, Smith, and Sood, 2006).

Patient Navigators/Community Health Workers

Navigating the U.S. health care system is a daunting task, and where Latinos often face culturally insensitive environments that they perceive as hostile. This exposes the major deficiencies in the social support networks that they have access to in their communities. Community Health Workers (CHWs), promotoras, or peer counselors, defined as members of the target communities, who have experience themselves, prevented or successfully manage the condition, and/or have helped a close fiend or relatives do so, can help address this challenge. For decades now primary health care systems in developing countries have relied heavily on community health workers or community health agents (Patwari and Raina, 2002). Based on a systematic literature review, Perez-Escamilla and collaborators (2008), recently concluded that Latino CHW, 'promotora' or peer counseling models in the U.S. have been very effective at improving healthy behaviors (e.g., breastfeeding, adult and child nutrition) and health outcomes (e.g., type 2 diabetes). CHWs have performed different tasks in different programs. However, when properly integrated as part of health management teams they are able to not only provide outstanding social support to clients, but also actively participate in supporting the patient management of the medical condition(s) inside and outside the hospital/clinic walls. This strongly suggests that CHWs should be considered as a key component needed for the continuum of well coordinated clinical and community care, strongly advocated by the Chronic Care Model proposed here in the U.S. (Robert Wood Johnson Foundation, 2009; Wagner et al. 2001**)**. CHW models are indeed a very good fit for efforts that seek to expand or continue follow-up care at the community level

through networks of community health clinics targeting the physical, mental and oral health care, of our most disadvantaged populations.

Conclusions

This review has documented that lack of access, and utilization of health care services, which continues to be a major manifestation of the social injustices that Latinos continue to experience in our country. The problem is multifactorial, and solving it requires major immigration, health care, and education sector reforms that use public health outcomes as the key benchmarks for success. As part of these reforms, it is key to put into place an inclusive process that fosters the active participation and input from Latinos affected by lack of health care access. There is no doubt that academic institutions have much to contribute to this effort (Pérez-Escamilla et al. 2008b).

Policy Recommendations

The vast majority of inequalities in health outcomes among Latinos could be prevented if they are addressed through a good coordination of social and health care policies in the U.S. Comprehensive reforms are needed to improve the social and physical environments in which Latinos live, including public safety, access to healthy foods, and safe areas where leisure time physical activities can be performed. Timely access to primary prevention (public health), and secondary prevention (screening) health care services in the communities where Latinos live, and a strong referral system for follow-up care is also crucial for improving their quality of life. The following recommendations, derived from this review, may

help improve access and quality of health care, as well as patient satisfaction among Latinos (Table 2):

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- Develop a health care system that emphasizes primary and secondary over tertiary health care. The new health care reform needs to identify effective incentive mechanisms and policies to shift the emphasis of the U.S. health care from a curative (biomedical), to a preventive (public health) model. This effort will undoubtedly require the input from multi-sectorial coalitions that include the target communities themselves, health care providers, the private sector (health insurance and pharmaceutical companies, small and large business owners), government, academic institutions, and civil society a large.
- Develop a culturally skilled workforce. First, a major effort should be put in place to correct the major under representation of Latinos in the health professions. This investment is going to require forming a pipeline reaching out to Latinos in their early educational experience (K-12), and creating a supportive pipeline/educational environment thereafter. Convincing medical students to choose work in the area of minority health will require the implementation of attractive economic and professional reward mechanisms. These efforts should include addressing the high cost of medical education as well as loan forgiveness programs. Second, it is essential to put the right mechanisms in place that identify and motivate promising individuals who do not belong to racial/ethnic minority groups and who choose minority health as their areas of concentration.

- Lack of Spanish fluency, and/or skills associated with cross-cultural communication among health care providers, coupled with a lack of professional medical interpreters has been identified as a source of grievous medical errors and lack of patient satisfaction. Professional medical translation services need to be covered by private and government sponsored health insurance programs. Health care providers at all levels should be trained on how to work effectively with medical interpreters. Academic institutions where health professionals are educated need to be fully engaged with this effort.
- The great majority of uninsured Latino families are employed. It is essential to implement a system that facilitates their access to affordable and comprehensive health insurance through small business employers. Approaches considered to achieve this goal also need to take into account that the provision of this insurance also needs to be affordable by the small business employers. The new health care reform needs to develop a sound safety net of government sponsored insurance (e.g., Medicaid, Medicare, SCHIP), that leads to good health outcomes and patient satisfaction among Latinos without access to private insurance.
- Undocumented immigrants are at a very high risk of lacking access to health care. This issue needs to be addressed through a comprehensive immigration reform that addresses both the needs of those immigrants currently in the country, and those that will continue to be drawn into the U.S. as a result of job market demands. It is important that the governments of Mexico and the

U.S. work together on developing a portable health insurance model transferable across state and country lines. Electronic medical records will be needed for this effort to succeed.

- Many undocumented immigrants have children who are U.S. citizens. It is essential to make the medical environment less hostile towards them so that their children can take advantage of government sponsored programs available to them.
- Navigating the U.S. health care system is a daunting task and there is a major mismatch between clinical care and preventive or community based follow-up care. Incorporating and integrating clinic based patient navigators and community health workers, promotoras, or peer counselors into the formal health care system is likely to dramatically improve the quality of health care among Latinos. The upcoming health care reform should develop a reimbursement system, and establish policies and guidelines regarding the desired background, training, and certification system for community health workers.
- Latinos are not well represented in current health surveillance and monitoring systems, either as a whole or by ethnic subgroups. The U.S. needs to develop an effective surveillance and monitoring system that provides timely information, and represents well the current demographic profile of the nation. The elimination of health care access disparities in our country needs to be guided by efficient national and local surveillance management information systems that, among other things, accurately measure the ethnicity/race of

individuals (Institute of Medicine, 2004). These data can be used not only for mapping purposes, but also for understanding how social and health policies vary at a community level, and how individual-level characteristics affect access and quality of health care among the diverse groups that form the U.S., a nation of immigrants.

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Figures

Figure 1a. Hispanic Population in the United States: 1970-2050*

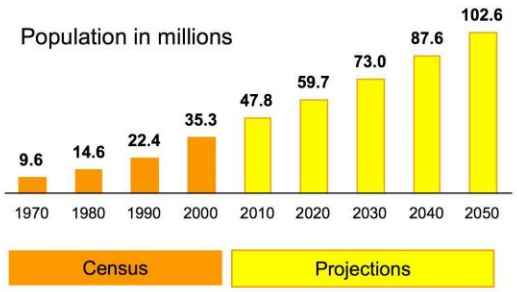
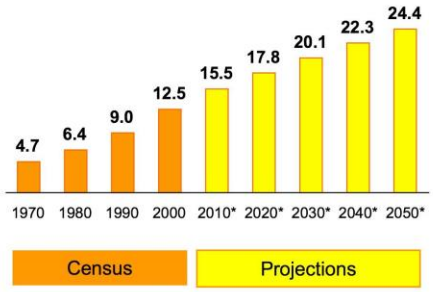


Figure 1b. Percent Hispanic of the Total Population in the United States: 1970- 2050*



*Source: U.S. Census Bureau, 1970, 1980, 1990, and 2000 Decennial Censuses; Population Projections, July 1, 2010 to July 1, 2050

Figure 2a. Health insurance among the non-elderly population (%), 2007*

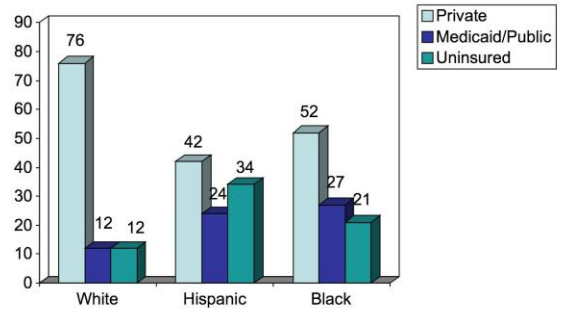
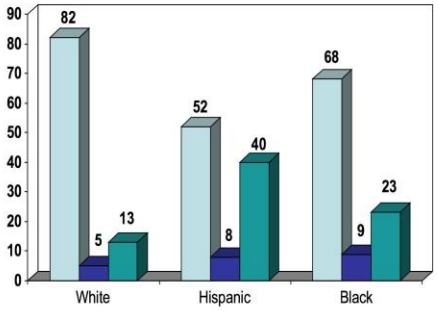
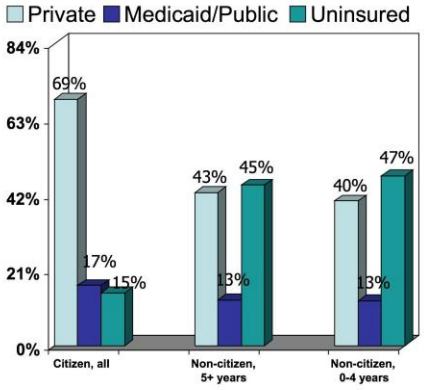


Figure 2b. Worker's health insurance among the non-elderly population (%), 2007*



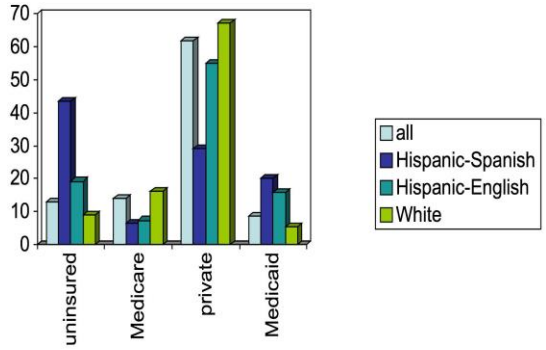
*Source: Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Figure 3a. Health Insurance Coverage by Citizenship Status, among the non-elderly population (%), 2007*



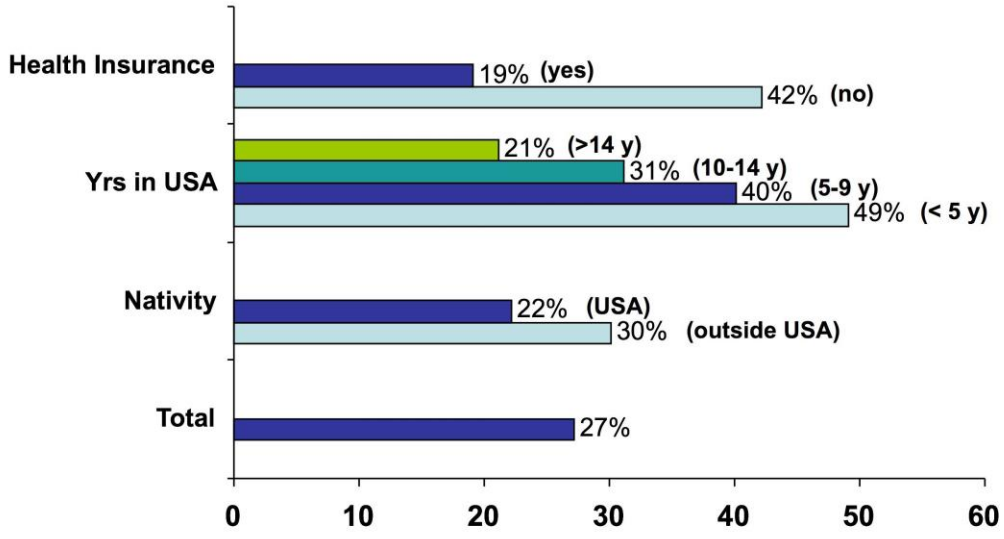
*Source: Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

Figure 3b. Health insurance coverage by Language Preference, 2000-2003, (%)*



*Source: US Census Population Survey Community Tracking Study

Figure 4. Likelihood of not having a usual health care provider among adult Latinos



Source: Pew Hispanic Center/ RWJ Foundation, 2008