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# **Latino Access to Health Care: The Role of Insurance, Managed Care, and Institutional Barriers**

J. Emilio Carrillo, Fernando M. Trevino, Joseph R. Betancourt & Alberto Coustasse

The health care system in the United States is the most expensive and yet arguably among the least cost effective in the developed world (Anderson, 1998). Despite the highest per person health care spending among the Organization for Economic Cooperation and Development (OECD) nations, the United States still ranks below many along a variety of health indicators (Woolhandler & Himmelstein, 1991). In a complicated health care system where the rules are many and economic forces drive both structure and function, the needs of vulnerable populations inevitably suffer. This chapter explores the consequences of these market forces on a vulnerable population--Latinos in the United States. First, the health insurance status of Latinos is reviewed in the context of employment trends and participation in various government-sponsored programs. Next, the chapter explores the impact of managed care on Latinos, as well as that of other institutional, organizational, and structural barriers that stand between this population and full access to health care.

The U.S. health care financing system is based on the premise that most working-age Americans (and their dependents) receive health insurance through their employment (Collins, Hall, & Neuhaus, 1999). A large proportion of citizens who are not covered through their employment are only partially covered by charity care, municipal health care facilities, or government-sponsored programs such as Medicaid and Medicare. Both of these assumptions break down in the case of Latinos, a population that tends to be clustered in jobs that are low paying, less stable, more hazardous, and less likely to have fringe benefits such as health care coverage (Del Pinal & Singer, 1997). In addition, as a fall through the health care "safety net." Even broad initiatives toward "universal coverage," such as those proposed by the Clinton Administration's Health Security Plan of 1992, left the undocumented without health care coverage. Lack of access to health care due to the widespread lack of insurance is arguably the most pressing health problem facing Latinos today.

Moreover, "access" to care through health insurance does not necessarily guarantee quality care. Researchers have tried to better define "access" by delineating where along the continuum toward obtaining quality health care specific barriers may exist (Bierman, Magari, Jette, Splaine, & Wasson, 1998). According to this perspective, "primary access" is defined as having health insurance. Latinos' higher uninsured rates clearly provide a primary barrier to health care. Latino populations that are insured yet at a socioeconomic disadvantage, or whose primary language and culture are not those of the mainstream, are subject to other powerful access barriers that are not as tangible as insurance status alone. For example, "secondary access" barriers occur for those who are insured yet face institutional, organizational, or structural barriers such as difficulty getting appointments, lack of access to after-hours medical advice, or long waiting times for referrals to necessary medical specialists (National Hispanic/Latino Health Initiative, 1993). "Tertiary access" barriers occur for those who are insured and secure a medical appointment yet face significant linguistic and cultural barriers in the medical encounter as they attempt to develop a successful and effective relationship with their health care provider.

In the 1980s employers and governments chose health maintenance organizations (HMOs) as a preferred vehicle for cost containment in health care. An HMO differs from a standard health insurance provider in that patients are required to see doctors and use hospitals and other facilities within the plan's network of providers. HMOs often require members to select a primary care physician who then controls what specialists can be seen. Managed care practices may exacerbate rather than relieve secondary and tertiary access barriers. Not only do patients with low literacy and limited English proficiency have difficulty with bureaucratically complex managed care enrollment and precertification practices for emergency room visits and hospitalizations, but they also face the hurdle of communicating with a provider who may not speak their language or value their cultural health beliefs and behaviors. The rapid spread of Medicaid managed care during the past decade poses a particular challenge to those who are not able to maneuver through a new and complicated health care system. In any of these settings, as is usually the case, the most educationally, economically, and educationally vulnerable patients will have the greatest difficulties navigating these complex systems. The rise of managed care in the 1980s and

1990s not only failed to relieve Latinos' rising uninsurance rates but also posed new challenges to the "safety net" that protects the uninsured through charity and municipal health care (United States Department of Health and Human Services and the Commonwealth Fund, 1999).

### **Primary Barriers to Health Care**

By 2025, the Latino population of the United States is expected to increase from thirty-one million (11 percent of the population) to fifty-nine million (18 percent of the population). Nearly 40 percent of Latinos under the age of sixty-five do not have health insurance. Latino children are perhaps the most vulnerable, making up 29 percent of the uninsured under age eighteen (compared to 11 percent of Whites in this age group). A quarter of the nation's forty-four million uninsured are Latino. In fact, Latinos are more than twice as likely to lack health insurance as the population overall. This gap persists despite a booming economy (Quinn, 2000). Cities with large Latino populations exemplify this trend. The four states with the highest concentration of Latino residents-California, Florida, New York, and Texas--account for 73 percent of all uninsured Latinos. Approximately 40 percent of Latinos living in California and Texas and more than one-third of Latinos in Florida and New York are uninsured (Quinn, 2000).

A major reason why so many Latinos lack health insurance is that their employers do not offer them coverage. Nearly nine million of the eleven million uninsured Latinos are in families in which at least one person works. This proportion is similar to or exceeds that of other racial and ethnic groups (Quinn, 2000). According to a study by Hall, Collins, and Glied (1999), based on the 1997 Current Population Survey, 69 percent of White workers aged eighteen to sixty-four have health insurance through their employer as compared to 52 percent of African American workers and 44 percent of Latino workers. There are several factors that contribute to Latinos' low rate of employer-sponsored health insurance. Citizenship appears to play a role, as workers who are not U.S. citizens have lower odds of being insured by their employer than do U.S. citizens. Educational status is also a contributing factor, since individuals with more than a college education are about twice as likely to have coverage than those with less than a high school education. Workforce characteristics are also important, because individuals

employed in agricultural, mining, service, domestic, and construction industries are not as likely to be covered as those in manufacturing and "white-collar" industries. Many more Latinos are employed in the first four industries than in the latter two. Latinos also tend to have greater employment in small firms (those with less than 100 workers), which are less likely to provide health insurance to their employees than are larger firms. Within small firms or low-wage jobs, Latino workers are half as likely to have employer coverage and twice as likely to be uninsured as are White workers. Low-wage workers, regardless of firm size, are more likely than higher wage employees to be without insurance. The impact of lack of insurance is quite palpable (Quinn, 2000). In 1999, almost half of uninsured Latinos had not seen a doctor when sick, had gone without a prescription for needed medications, or went without recommended medical tests or treatments. About two-thirds had trouble paying their bills or were contacted by collection agencies for medical expenses.

### **The Development of Managed Care**

In the 1970s containing the cost of health became a national objective. The Health Maintenance Organizations Act of 1973 promoted HMOs as less costly and more efficient forms of health care delivery. The National Health Planning and Resources Act of 1974 created a certification system for these new types of organizations. HMOs began taking off in about 1976, as Congress reduced the mandatory benefits and other stringent requirements that had curtailed the program up until then.

By 1996 the total number of HMO members grew by an estimated 8.4 million people, to 67.5 million--or about one in four Americans. Since 1990, HMO enrollment has increased by 85 percent.

Commercial managed care organizations (MCOs) are not required by legislation or court mandate to collect racial and ethnic identifiers for people enrolled in their plans. In fact, the U.S. Health Care Financing Administration (HCFA), perhaps the largest health care payer and the one with the greatest leverage on MCOs, does not ask that racial or ethnic identifiers be provided under the Medicare program. In 1999, the Commonwealth Fund conducted an informal survey which found that not one of twelve large, for-profit MCOs collected race and ethnicity data (United States Department of Health and Human

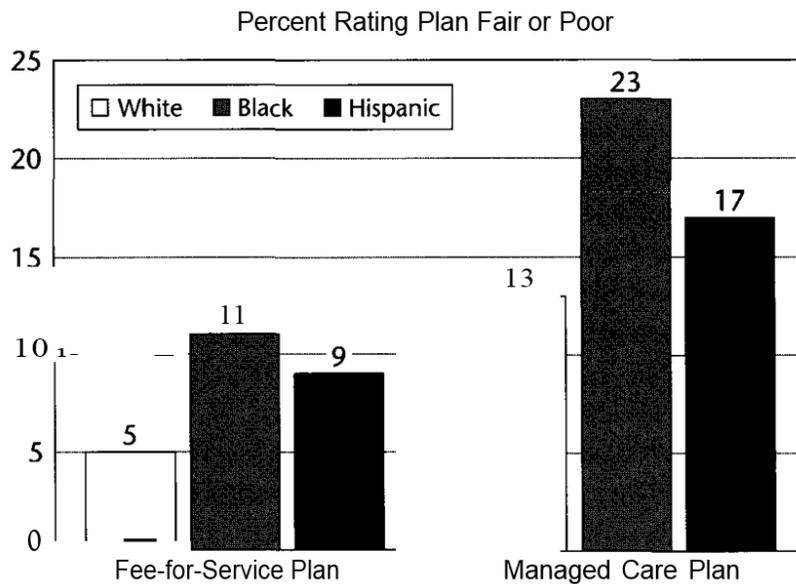
Services and the Commonwealth Fund, 1999). Some MCOs collect such data only as part of targeted quality-of-care research. Consequently, there is only a smattering of information on racial and ethnic profiles of commercial MCO members. A survey conducted in the states of Florida, Tennessee, and Texas revealed that 72 percent of low-income African Americans were enrolled in managed care as compared to 55 percent of Latinos and 63 percent of Whites (Leigh, Lillie-Blanton, Martinez, & Collins, 1999).

### **Quality-of-Care and Performance Indicators**

MCOs are evaluated by a series of quality-of-care and performance indicators. The National Center for Quality Assurance (NCQA), a nongovernmental organization founded by large health care payers for the purpose of evaluating MCOs on the basis of a set of measures of quality of care, has been the pioneer in this field. Their primary tool of evaluation, the Health Employment Data Set (HEDIS), measures a variety of quality indicators that are used to compare managed care plans. One key limitation of the current quality-of-care and performance indicators is that they fall short on key issues and measurements that may be particularly important to Latino populations. For example, HEDIS has no measures that evaluate health care workforce diversity, the presence of interpreter services, or the ability (in detail) of patients to successfully communicate with their providers. The Consumer Assessment of Health Plans Survey (CARPS), a tool used by the HCFA to obtain the consumer's perspective on the health care they receive, is also largely devoid of measures that could be important to Latino health. To its credit, in the "Adult Supplemental Questions" packet, the CARPS does attempt to address doctor-patient communication (one question) and the need for the presence of interpreter services (two questions). Fortunately, there is currently research being done on the development and psychometric testing of a "Spanish CARPS," which should better capture the issues pertinent to Latinos. This remains a crucial endeavor, as the Commonwealth Fund Managed Care Survey of 1994 found that minority Americans are less satisfied with the quality of managed care plans compared to that of fee-for-service (FFS) plans (see Figure 3.1).

Along these lines, the Kaiser Family Foundation and the Commonwealth Foundation jointly sponsored a study of low-income population's health coverage that demonstrated certain patterns. Surveys in the states of Florida, Tennessee, and Texas showed that with some notable exceptions, patients' views on their access to care and patient satisfaction with care are similar among Latinos and African American managed care and FFS enrollees. African American managed care enrollees are twice as likely as their FFS counterparts to report problems getting required medical care. Another exception is that Latinos in managed care rate their physician's concern about them as "fair" or "poor" at twice the rate of those in FFS plans (Leigh, Lillie-Blanton, Martinez, & Collins, 1999). Neither managed care nor FFS plans were found to be particularly effective in ensuring that Latinos and African Americans have access to the health care system. Roughly one in four Latinos and African Americans rate as "fair" or "poor" his or her satisfaction with care, measured by overall service, waiting time required to get a doctor's appointment, and physician concern for the patient. Ironically, despite managed care's aspirations to provide primary care and continuity, this survey

FIGURE 3.1. MINORITY AMERICANS ARE LESS SATISFIED WITH QUALITY OF MANAGED CARE



Source: The Commonwealth Fund Managed Care Survey, Louis Harris and Associates, Inc., 1994.

found that 42 percent of Latinos and 38 percent of African Americans in managed care plans did not have a regular provider, as compared with 52 percent of Latinos and 47 percent of African Americans in FFS plans. Spanish-speaking Latinos were nearly twice as likely as their English-speaking counterparts to lack a regular provider.

Continued efforts to better identify how Latinos define "quality" in the health care they receive will allow us to better develop systems to meet the needs of this young and growing population.

Several new initiatives directed toward developing quality measures that are responsive to the needs of minority populations have been launched in the last few years. The Henry Ford Health System and the Lovelace Clinic Foundation, in conjunction with the Center for Healthcare Improvement and the Commonwealth Fund, have begun working on and validating a "minority health report card" that would include various quality measures specific to Latino and other minority populations (Nerenz, 1999). As part of its Quality Improvement Standards in Managed Care, the Health Care Financing Administration (HCFA) has been working on "cultural competence quality measures," which include measurements of workforce diversity and patient satisfaction vis-a-vis doctor-patient communication, among others (Health Care Financing Administration, 1999). Finally, states have started to use their leverage in Medicaid managed care contracting to require MCO contractors to ensure that certain services and standards are put in place (interpreter services, diverse workforce) when they serve a part of the state that has a predominance of a particular population. For example, in California, as part the state's contracting with MediCal (a Medicaid MCO) contracting, specific requirements have been put into the contracts that address the needs of Latino patients. Health centers that receive a MediCal contract and that serve a predominately Latino population are mandated to maintain a diverse health care workforce and guarantee the presence of trained Spanish interpreters (Coye & Alvarez, 1999; Hinojosa, 1999). Similarly, some MCOs have begun to address the important issues of developing capacity to care for diverse patient populations. For example, Kaiser Permanente in California developed a National Diversity Council and

targeted initiatives in interpretation and physician education to better serve that MCO's diverse patient population (Kaiser Permanente National Diversity Council, 1996). In addition, Harvard Pilgrim Health Care has begun "diversity training" and also piloted new interpretation services (Stern, 1999).

As was previously mentioned, a major barrier to developing quality measures that are responsive to specific issues relating to Latino health is the lack of race and ethnicity data being collected by the government and MCOs. To hold the health care system accountable for the delivery of care and subsequent outcomes, the collection of race- and ethnic-specific data is essential. There is currently great resistance to collecting such data because of the fear of infringement on patient confidentiality or the risk of exclusion of patients (redlining) from enrollment in managed care plans because of their race or ethnicity. It is only through the collection of race and ethnicity data that progress can be made toward the development of new measures in Latino health so that progress in improving care to this vulnerable population can be tracked.

### **Medicaid and Medicaid Managed Care**

Medicaid, enacted in 1965 as part of President Lyndon B. Johnson's "Great Society" program, is the largest health insurer in the United States in terms of eligible beneficiaries, covering medical services for some 41.3 million people. The Medicaid program is financed by the states and federal government and administered solely by the states. In 1997, Medicaid expended \$159.9 billion, or 12.4 percent of the total national health care expenditures, to pay for covered services for low-income people who were elderly, blind, disabled, receiving public assistance, or among the working poor (Iglehart, 1999). The growth in Medicaid expenditures, which almost tripled from the 1980s to the mid-1990s, has recently slowed. The major factor accounting for the spike in Medicaid spending in the early 1990s was not enrollment growth but rather the states' use of disproportionate share hospital (DSH) payments and other contributions as a way to substantially increase the federal matching funds for the state.

Being poor does not automatically make a person eligible for Medicaid. In 1997, Medicaid covered only 44.4 percent of nonelderly persons with an income of less than \$13,330 for a family of

three. Each state sets its own criteria for eligibility, following broad federal guidelines (Iglehart, 1999). The Republican Congress of 1995 set a major policy goal of devolving federal authority and money to state governments, particularly in the realm of social welfare. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 granted states the authority to operate their own welfare and work (now called "workfare") programs, largely with federal resources. The new state laws that resulted from this legislation severed the link between Medicaid and public assistance. Many people who have moved from public assistance to workfare programs may not realize that they still qualify for Medicaid. This knowledge gap and the complex process of filling out a Medicaid application has resulted in dramatic declines in the Medicaid rolls-and of course there are many Latinos within this group (Iglehart, 1999). Those who go beyond workfare and enter into the workforce often find employment in low-paying positions that do not provide health coverage. These transitions may serve to increase the already alarming rates of uninsured in the Latino population. In New York City, where a large proportion of the Medicaid population is Latino, Medicaid rolls dropped by 12 percent (200,000) over the period 1995-1999. During this time, 105,000 children lost Medicaid coverage.

Since the 1980s, many states have implemented some form of Medicaid managed care, largely as a means of limiting Medicaid expenditures. Medicaid managed care plans are those whose enrollment is at least 75 percent Medicaid. Originally, enrollment into these managed care plans was patient-driven and voluntary. Understandably, enrollment grew slowly under voluntary conditions, as these plans could not articulate clear benefits for the targeted recruits. In fact, managed care would actually limit the individual's choice of physician and hospitals and also place limits on other benefits such as use of specialists. One of the fundamental principles of managed care is the relationship of one physician to one patient. This tenet is not necessarily held by the consumer, who values choice and alternatives.

Many states have implemented mandatory programs in which all Medicaid recipients, with some categorical exceptions, are phased into managed care. Such transitions from voluntary to mandatory status required a special clearance by HCFA until 1997, when congressional legislation gave the states the freedom to implement mandatory programs once certain federal guidelines are met.

More than eight million of the 13.3 million Medicaid beneficiaries enrolled in managed care programs have enrolled in HMOs as of mid-1996 (in forty-six states). Approximately 19.9 million Medicaid beneficiaries were enrolled in FFS plans. From 1991 through 1996, the number of Medicaid recipients enrolled in Medicaid managed care programs more than quadrupled, from 2.7 million to 13.3 million.

Similar to the situation previously presented for commercial MCOs, only some of the state Medicaid programs provide racial and ethnic data to Medicaid HMOs operating in their respective states. Massachusetts and California have provided such data to Medicaid plans, while Tennessee has provided only racial but not ethnic data.

Medicaid managed care poses particular challenges to the Latino patient, as the rules are so arcane and complicated that even health care industry administrators are often stymied by them. Enrollment brokers have been set up in many states to facilitate the enrollment process. Yet, despite these efforts, people with limited English-language proficiency and skills at negotiating bureaucratic processes cannot exert choice because they may not understand the complex presentation of the program. In fact, many patients are not even aware that they are in a managed care plan. People do in fact sense the impact of Medicaid managed care whenever they try to change doctors or plans and also whenever they request doctors and services not included in their particular plan. HCFA has attempted to address some of these concerns by closely monitoring states' compliance with guidelines and regulations that are part of the process of mandatory Medicaid managed care implementation. Provisions are made for grievance and fair hearing rights as well as external review processes. Some notable differences between Medicaid and commercial managed care plans have been reported. For instance, a survey of 154 health plans in eleven states and the District of Columbia showed that the Medicaid plans were more likely to target programs to the specific needs of the Medicaid population than were the commercial MCOs (Landon & Epstein, 1999).

### **Access to the State Children's Health Insurance Program**

Congress enacted the State Children's Health Insurance Program (S-CHIP) in 1997 as a method of increasing access to health care for uninsured children. This program allocated \$20.3 billion in federal matching funds over five years to states to expand health insurance coverage to uninsured children under the age of nineteen in families with incomes below 200 percent of poverty. Children with private insurance or who are covered by or qualify for Medicaid are ineligible for S-CHIP. Undocumented and legally resident children arriving in the United States after August 22, 1996, are also ineligible for coverage but may qualify for emergency Medicaid assistance. States that choose to operate a separate state child health insurance program can establish eligibility based on geographic area, age, income and resources, residency, and disability status, as well as limit duration of coverage.

Poor and near-poor children are substantially more likely than middle- or high-income children to be uninsured. However, at each level of family income, Latino children are more likely to be uninsured than White or African American children. Poor and near-poor Latino children are least likely to have insurance (United States Department of Health and Human Services, Health Resources and Services Administration, 1998). The S-CHIP program was seen as a possible intervention to bridge this great disparity, yet states have struggled to promote it with various degrees of success. There may be large numbers of undocumented children who qualify for S-CHIP but who lack awareness of the program or access to the enrollment process. This could be particularly significant for Latino children because of social, cultural, and linguistic barriers.

### **Balanced Budget Act of 1997: Consequences to the Safety Net**

The Balanced Budget Act (BBA) was passed by Congress in 1997 in an effort to control overall spending and bring this nation's budget into balance. As part of this initiative, health care spending via HCFA and Medicare were targeted for reform. Through a series of new measures, cuts, and controls, the BBA is expected to result in significant savings to Medicare--some \$393.8 billion over ten years. The Medicare reforms contributed significantly to the goal of a balanced budget; in fact, changes to the program account for 73 percent of total savings. Over a five-year period, BBA provisions reduce

Medicare spending by \$16.4 billion. Much of this reduction (67 percent) will be achieved by limiting growth rates in payments to hospitals and physicians under FFS arrangements. Academic health centers and hospitals serving a disproportionate share of low-income Medicare beneficiaries will also receive additional limits in payment growth.

To ensure access to care for the millions of uninsured people in this country, the U.S. health care system relies on a makeshift system of "safety net" providers--public hospitals, community health centers, local health departments, and rural health clinics, as well as special service providers such as AIDS-based and school-based clinics. They often provide specialized services such as trauma care and medical education. To remain financially viable, many of these facilities depend on a patchwork of grants and subsidies that have become increasingly uncertain and insufficient (Institute of Medicine, 1999). Such facilities serve predominantly low-income communities that include substantial caseloads of Medicaid and uninsured patients--and correspondingly small caseloads of privately insured patients. For example, community health centers (CHCs) serve as the entry point to the health care system for millions of Medicaid beneficiaries, the uninsured, and people residing in medically underserved areas. Many of these users are members of minority groups and suffer disproportionately from health problems and disease. Of the ten million people served by CHCs in 1996, 41 percent were uninsured and another 33 percent were on Medicaid; also, 31 percent were Latinos and 27 percent were African American. Approximately 65 percent of CHC patients live below the federal poverty level, while another 20 percent live at 100--200 percent of the poverty level. According to the Bureau of Primary Health Care of the U.S. Department of Health and Human Services (DHHS), from 1990 to 1997 the number of uninsured patients at CHCs increased by 49 percent. Costs for uncompensated care at a sample of urban, safety net hospitals totaled \$4 billion and represented 26 percent of total costs in 1996. These costs were financed through state and local government subsidies (59 percent), Medicaid disproportionate share hospitals (DSH) payments (29 percent), Medicare DSH payments (9 percent), and cost shifting from privately insured patients (3 percent). Aside from local tax appropriations for indigent care, the Medicare and DSH programs are an important source of financial subsidies for providers willing to care for the uninsured, the underinsured,

and other low-income populations. The DSH program was originally intended to compensate hospitals for what were believed to be higher-than-average costs for treating low-income Medicare patients. The BBA cuts will have a significant financial impact on CHCs ability to serve these vulnerable populations.

In relation to public hospitals and academic health centers, the National Association of Public Hospitals and Health Systems (NAPH) reported that in 1995 Medicaid and uninsured patients made up 74 percent of discharges and 77 percent of outpatient visits in its member hospitals (Fagnani & Tolbert, 2000). Another study from 1996 found that Medicaid and uninsured patients accounted for 29 percent of discharges in academic medical centers in 1994. Public hospitals make up 7 percent of all hospitals in the nation's 100 largest cities but provide 18 percent of all outpatient visits and 19 percent of all emergency room visits, for an annual total in excess of 100 million visits (Coye & Alvarez, 2000). Furthermore, a 1998 NAPH survey of twenty-five urban safety net hospitals reported that 78 percent of its patients had incomes at or below 150 percent of the federal poverty level and that Latinos and African Americans had the highest number of visits, accounting for 31.7 percent and 40.9 percent, respectively. Coupled with declining local government appropriations and market forces that include managed care and an eroding Medicaid patient base, these BBA cuts will severely undermine the ability of safety net hospitals and academic health centers to remain financially viable. As a result of the BBA reforms, public hospitals and academic health centers are facing unprecedented fiscal challenges, which place their role as providers of care to vulnerable populations in great jeopardy.

Finally, the competition created by Medicaid managed care has also led to patients being siphoned away from their community providers, further endangering the safety net. A report on the health care safety net (Institute of Medicine, 1999) found that while patients did gain greater choice from Medicaid managed care, safety net providers lost 6 percent of their Medicaid primary care patients to competitors between 1995 and 1998. MCOs may also have financial incentives to exclude safety net providers from their networks because of the costly, high-risk, and very sick patients they serve. The fiscal pressures created by limits on public subsidies, expansions in Medicaid and Medicare managed care, and price competition in hospital markets may undermine the ability of safety net providers to

fulfill their missions. If these challenges lead safety net providers to close, some communities could lose their only source of care. In summary, the BBAs impact on safety net hospitals, safety net providers, academic health centers, and graduate medical education has posed a clear and present challenge to the well-being of the health of Latinos and other underserved racial or ethnic groups.

### **Secondary Barriers to Health Care**

The fact that many Latinos are likely to lack health insurance clearly has a major impact on their overall health outcomes. It is difficult to imagine how a patient without insurance can get the necessary battery of preventive examinations such as mammography, Pap smears, and screening for diabetes and colon and prostate cancer, among others; or how a patient with hypertension can be examined and treated regularly to prevent the cardiovascular complications that result from this condition. As a result, despite the health-promotion and disease-prevention interventions that have improved the health of Americans in general, Latinos have benefited much less from these advances (National Hispanic/ Latino Health Initiative, 1993). At the root of this problem is Latinos' lack of access to a source of primary care. Even Latinos who are fortunate enough to have "primary access" to care via some type of health insurance may face other barriers that preclude them from fully benefiting from what primary care has to offer. Ultimately, similar to their counterparts who are uninsured, many supposedly insured Latinos also have great difficulty accessing our health care system. There are several types of "secondary access" barriers to care-institutional, organizational, and structural- which greatly impact the Latino population's ability to get health care despite having insurance.

From the *organizational* standpoint, one factor that can impinge on both the availability and acceptability of health care is the degree to which the nation's health care professions reflect the racial and ethnic composition of the general population. The importance of racial and ethnic diversity in both the leadership and workforce of health care delivery systems has been well-correlated with the ability to provide quality care to socioculturally diverse patient populations. For example, for minority patients, it has been shown that in cases where there was racial concordance between the patient and the physician,

patient satisfaction and self-rated quality of care was higher (Saha, Komaromy, Koepsell, & Bindman, 1999). Other work has established the preference of minority patients for minority physicians (Moy & Bartman, 1995; Komaromy et al., 1996). As it relates to identifying the root cause of these preferences, it has been shown that Spanish-speaking Latino patients, for example, are more satisfied when their provider speaks Spanish (Cooper-Patrick et al., 1999), and in the case of African Americans, when their physician employs a more participatory and inclusive style of decision making (Bureau of Health Professions, 1990).

A review of the data on racial and ethnic diversity of the U.S. health care workforce reveals that Latinos made up only 2 percent of all physicians in 1990. Approximately 24 percent of Latino physicians in office-based practices in California care for patients with Medicaid as the primary insurer (versus 18 percent of White physicians), and 9 percent care for patients who are uninsured (versus 6 percent of White physicians). In academic health centers, underrepresented minorities (Hispanics, African Americans, and Native Americans) make up only 3 percent of the medical school faculty. Additionally, 53 percent of the Latino faculty are those who teach in the medical schools in Puerto Rico, highlighting the underrepresentation of Latino faculty on the mainland (Bureau of Health Professions, 1990). Similarly, despite minorities comprising 30 percent of this nation's population (United States Bureau of the Census, Census 2000 Redistricting Data), less than 16 percent of public health school faculty positions are held by minority scholars, and only 17 percent of all city and county health officers are from minority groups as well (Collins, Hall, & Neuhaus, 1999). The prognosis for the future is not much brighter. Data from 1997 show that enrollment of Mexican Americans and mainland Puerto Ricans into medical schools dropped by 8.7 percent and 31 percent, respectively, and that in the same year only 11 percent of all graduates were from underrepresented minorities (Association of American Medical Colleges, 1998). From 1996 to 1997, the drop in under-represented matriculates has been greatest in states with new anti-affirmative action policies: California, 16 percent decline; Texas, 29 percent decline; Louisiana, 13 percent decline; and Mississippi, 13 percent decline (Association of American Medical Colleges, 1998). Several initiatives of the Association of American Medical Colleges to address these

disparities have come up short in the last few years. For example, the "3000 by 2000 Project," founded on the goal of having 3,000 underrepresented minorities in medical schools by the year 2000, was unable to reach its target.

The importance of diversity not only applies to the medical encounter but in fact may be even more salient as it relates to leadership and representation within an organization's administration. In cases where there is lack of diversity in the leadership and workforce of health care organizations, the result may be structural policies, procedures, and delivery systems inappropriately designed or poorly suited to serve diverse patient populations. In summary, increasing underrepresented minorities in the health professions is an important way to improve both access to care and the health status of the nation's vulnerable populations.

From the *structural* standpoint, systems that provide care to Spanish-speaking patients but lack interpreter services or do not provide culturally or linguistically appropriate health education materials can severely compromise patient care to these populations. Doctor-patient communication, in the setting of even a minimal language barrier, is also recognized as a major challenge to health care delivery (Kirkman-Liff & Mondragon, 1991; Stewart, Grumbach, Osmond, Vranizan, Komaromy, & Bindman, 1997; Seijo, 1991; Perez-Stable, Napoles-Springer, & Miramontes, 1997; Erzinger, 1991). Research in this area has shown that Spanish-speaking patients discharged from the emergency room are less likely than their English-speaking counterparts to understand their diagnosis, prescribed medications, special instructions, and plans for follow-up care (Crane, 1997); less likely to be satisfied with their care or willing to return if they had a problem; more likely to report problems with their care (Carrasquillo, Orav, Brennan, & Burstin, 1999); and less satisfied with the patient-provider relationship (Baker, Hayes, & Fortier, 1998). Physicians who have access to trained interpreters report a significantly higher quality of patient-physician communication than do physicians who used other methods (Baker, Parker, Williams, Coates, & Pitkin, 1996). Latino patients with language-discordant physicians are more likely to omit medication, miss office appointments, and visit the emergency room for care (Hornberger, Itakura, & Wilson, 1997).

These organizational, intrinsic, and systemic barriers oftentimes prevent minority, socioeconomically disadvantaged, and limited-English-proficient patients with insurance from having true access to health care. Some examples of barriers include those within health care systems that (1) lack interpreter services and language-appropriate health education materials and signage; (2) have bureaucratic, complicated intake processes, long waiting times for appointments, and limited operating hours (including after-hours availability); and (3) are located outside the community, making them difficult to reach via public transportation (National Hispanic/Latino Health Initiative, 1993). These barriers all clearly complicate Latinos' ability to obtain quality health care. The result is patient dissatisfaction, poor comprehension of critical health messages, nonadherence to health-promotion and disease-prevention interventions, lower quality of care, and poorer health outcomes, even in those Latinos who supposedly have access. MCOs, given their complex organizations, policies, procedures, and systems of care, although founded on principles of health maintenance, may pose particular challenges to Latinos.

### **Tertiary Barriers to Health Care**

Within the medical encounter, a physician's ability to communicate across language barriers and understand sociocultural variations in health beliefs, values, and behaviors is critical to the delivery of quality care to racially and ethnically diverse patient populations. Given the small proportion of Latino physicians, Spanish-speaking patients are very often cared for by physicians who may not speak their language, understand their social situation, or value their cultural beliefs. As a result, cultural and linguistic barriers in the medical encounter may lead to poor communication, patient dissatisfaction, and poor compliance (to both medications and health-promotion and/ or disease-prevention interventions) (Manson, 1988; Stiles et al., 1979; Haynes, 1976; Stanton, 1987; Like & Steiner, 1986; Langer, 1999). Given this link between doctor-patient communication, patient satisfaction, compliance with diagnostic and therapeutic recommendations, and clinical outcomes, it might be hypothesized that in relation to health services, poor communication may lead to under- or overutilization of certain diagnostic and

therapeutic procedures, and ultimately poorer outcomes. Although managed care tools such as "utilization management" may pick up instances of service overutilization, they are much less likely to detect the underutilization of services that often affects Latino populations. Two studies of California patients suggest that disparities in the treatment of Latinos compared to that of Whites may be similar to those found between African Americans and Whites. Giacomini (1996) found among California adult inpatients that Latinos were less likely than Whites to undergo three of nine procedures: coronary artery bypass graft (CABG), angioplasty, and kidney transplant. Carlisle, Leake, and Shapiro (1995) found that for ischemic heart disease patients in Los Angeles County, Latinos were less likely than Whites to receive CABG and angiography, but were equally likely to receive angioplasty.

Two separate studies that surveyed Latino patients' satisfaction with their ability to communicate with their provider also provide interesting findings. David and Rhee (1998, p. 396) state "in cases where language barriers existed between physicians and patients, test ordering may replace dialogue in the medical encounter." Similarly, Morales, Cunningham, Brown, Liu, and Hays (1999, p. 414) contend that "poor communication between a physician and a patient, as indicated by dissatisfaction with provider listening and answering of questions, may result in excessive ordering of medical tests as a provider attempts to establish a diagnosis in the absence of an adequate patient history." This second study showed that both Latino patients who spoke Spanish as a first language as well as those who spoke English as a first language were more dissatisfied with their ability to communicate with health providers, as compared to White patients. In essence, physicians who are unable to communicate effectively with Latino patients, either because of language barriers or because of cultural barriers other than language barriers, face great challenges in their attempts to deliver quality care to Latinos and others with similar situations. Two interventions aimed at diminishing these critical "tertiary access" barriers to care are gaining broader national attention. First, the Office of Civil Rights of the U.S. Department of Justice is attempting to strengthen Title VI of the Civil Rights Act so that interpreter services become more widely mandated in health care. Currently, there are several loopholes within the law (Title VI) that allow hospitals and other health care facilities to use volunteer, untrained interpreters for their medical

encounters. These interpreters are selected either from the hospital workforce or from a volunteer pool. Most of the time, however, the AT&T Language Line, which is accessed via telephone, has served as a major source of interpretation services. Second, cultural competence training, a movement toward teaching medical students, residents, and physicians how to best understand and manage language barriers and sociocultural variations in health beliefs and behaviors, is rapidly growing in health care and medical education (Carrillo, Green, & Betancourt, 1999; Culhane-Pera, Like, Lebensohn-Chialvo, & Loewe, 2000; Culhane-Pera, Reif, Egli, Baker, & Kassekert, 1997). The overarching goal of cultural competence training is to provide physicians with the tools and skills to be able to deliver quality care to socioculturally diverse patient populations. Until the goals of these two interventions- interpreter services and cultural competence training-are realized, "tertiary access" barriers will persist and continue to compromise the care received by the "insured" portion of the Latino population.

### **A New Latino Health Policy Agenda**

A new Latino health policy agenda must address the primary, secondary, and tertiary barriers that this population faces in their pursuit of quality care. Efforts to improve primary access remain the most daunting task. The S-CHIP program is an intervention that if accessed to its fullest could significantly decrease the rolls of uninsured children. To date, however, S-CHIP has not reached its potential and has had particular trouble enrolling Latino children who stand to benefit the most from this policy. Similar initiatives, such as the Family Health Act of New York, a program to expand coverage to the working uninsured in a model similar to that of state children's health insurance programs, have prospered because of much popular and labor union support. These types of expansion of the safety net are needed, as is the need to closely guard the integrity of the safety net itself. Perhaps the intervention that could bring about the greatest benefit to the Latino population, however, is universal health care. Many have argued the merits of some type of universal health care coverage as being the foundation of any effort to improve minority health and eliminate racial and ethnic disparities (Woolhandler & Himmelstein, 1991). Given the current health insurance crisis facing Latinos in this country, any Latino health policy agenda must include strong advocacy of this major health care reform.

Despite some of the promising initiatives previously mentioned, several challenges currently persist. The BBA legislation poses a great risk to the health of the uninsured and underinsured, and could prove very harmful to academic medical centers and municipal health care facilities, which provide much of the uninsured care to the Latino population. The Medicaid programs, now in transition to managed care at the state level, have an entire new set of bureaucratic policies and procedures that preclude many Latinos, previously unused to such a complex health care system, from successfully accessing this care. Additionally, the lack of racial and ethnic identifiers at the governmental and private-sector level make it difficult to define quality of care for diverse patient groups and chart our progress in improving the care of our most vulnerable populations.

Various efforts that address secondary and tertiary barriers to care have been set forth over the last few years with the aim of improving the U.S. health care system, in general, and minority health care, in particular. For example, in 1998 President Bill Clinton set forth a major initiative to eliminate racial and ethnic disparities in health (the President's Initiative on Race; see United States Department of Health and Human Services and Grantmakers in Health, 1998). Six major areas of interest were delineated as targets of improvement: cardio-vascular disease, diabetes, HIV/AIDS, cancer screening and management, infant mortality, and immunization rates (United States Department of Health and Human Services, 1998; United States Department of Health and Human Services and Grantmakers in Health, 1998). As a result of this effort, a variety of new interventions have been developed to *eliminate* disparities in minority populations; improvements in diabetes, HIV/AIDS, and immunization rates stand to benefit Latino health the most. These goals are now reflected in the *Healthy People 2010* project, a departure from the previous goal of the *Healthy People* series that was simply to *reduce* disparities between racial and ethnic groups.

The Culturally and Linguistically Appropriate Services (CLAS) Project, sponsored by the Office of Minority Health of the U.S. DHHS, is also now being seen as a framework for culturally competent health care organizations (Fortier, 1998). Developed over two years with the assistance of national experts

in cultural competence, the CLAS standards aim to be the first iteration of how health care systems can be better prepared to deliver quality care to diverse patient populations.

To overcome all the barriers explained in this chapter, a new Latino health policy agenda must rely on a strategic approach that identifies the common political leverage points for action and activism. Latino health care can only be defended and improved by constant vigilance and coordinated advocacy. Quantitative research guided by a solid qualitative understanding of the various Latino communities will yield the basic foundation upon which coordinated advocacy may yield legislative and judicial benefits.

Lack of insurance in the Latino community is clearly a critical health care issue, which should be addressed with great urgency. The BBA has only begun to exert its pressure on a system that is bending but on the verge of breaking, with particular serious implications for all Latino communities. Managed care operations and protocols are not going away, so we must also address all the peculiarities that arise as a result of this system of care and its subsequent policies and procedures. Institutional, organizational, and systemic barriers will continue to contribute to racial and ethnic disparities unless addressed immediately. Addressing all of these factors in a structured, strategic, and political fashion can make for an effective new Latino health policy agenda.

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