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The Tomás Rivera Policy Institute

Policy Brief

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Improving Multicultural Health in the U.S.

In the United States, inequalities in health care have a particularly negative impact on minority populations. This policy brief targets specific recommendations that can help to transform the health care system, and improve the health and wellness of people of all backgrounds, races and ethnicities, with a specific focus on Latino[1] and African American populations.

The well-documented disparities in minority health care are persistent and increasing. The 2006 National Health Disparities Report found that for all health care measures examined, minorities not only received worse care, but also that health care was getting worse rather than improving. This is particularly true for Latinos and the poor (AHRQ, 2006). Traditionally underrepresented minorities in the United States experience disproportionately poorer health outcomes regardless of income or insurance status.

The first priority area of this brief is establishing the link between education and appropriate health care. Latino and African American health care professionals are lacking in the United States, in part because of the overall lower levels of education and access to education experienced by these groups. Yet it has been demonstrated that more Latino, African American, and other minority health care professionals are necessary for the complete and competent care of these populations because they provide culturally and linguistically appropriate treatment and advice.

The second priority area is the training of health care professionals and administrators to speak Spanish or a language other than English, and the provision of cultural sensitivity training to health care professionals.

A third priority is to create healthy environments with equal access to resources for a healthy life.

DIVERSITY AND STAFFING

Unequal access to health care, or "health inequality", is a critical issue, encompassing everything from limited access to health care and a higher mortality rate, to a greater burden of disease. Health inequality also affects both ends of the patient/provider relationship at a systemic level by creating an unequal staffing ratio. The result is that the diversity of the U.S. population is not reflected in the national health care workforce.

Latinos, African Americans, Native Hawaiians and Other Pacific Islanders (NHOPIs), and Native Americans/Alaska Natives are underrepresented in the U.S. physician population. For example, Latinos make up 12.6 percent of the U.S. population, and 5 percent of the physician population, while African Americans make up 12.1 percent of the U.S. population, and 4.5 percent of the physician population (AHRQ, 2006) (see Figure 1). Non-Latino Whites and Asian Americans are overrepresented in the U.S. physician population. For example, Non-Latino Whites comprise 69 percent of the U.S. population and 74 percent of the physician population. Asian Americans comprise 3.6 percent of the U.S. population and 15 percent of the physician population.

1 TRPI uses the terms Latino and Hispanic interchangeably to refer to individuals who trace their origin or ancestry to the Spanish-speaking parts of Latin America and the Caribbean.

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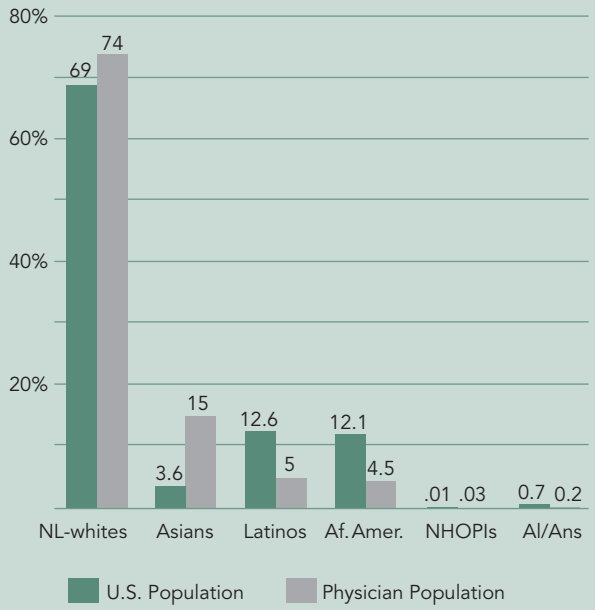
To download and view the complete report, visit www.trpi.org.

Figure 1

U.S. POPLULATION VERSUS PHYSICIAN POPULATION BY RACE/ETHNICITY IN THE U.S.



The shortage of minority physicians has resulted in critically low physician-patient ratios in poor minority communities. In an analysis of 51 rural and urban California communities, researchers found that lower physician-to-population ratios occurred in areas of poverty and in places that had high proportions of both Latino and African American residents, regardless of income level (Komaromy, et al., 1996). Table 1 illustrates differences in the patient profiles of physicians of various races and ethnicities. Though doctors of color tend to take a full patient load, a significant shortage of health care providers remains a problem that is in part born of a lack of minorities entering the health care profession.

Table 1

PATIENT PROFILES BY PHYSICIANS' RACE/ETHNICITY

	PHYSICIAN RACE/ETHNICITY		
PATIENT CHARACTERISTICS	LATINO	AFRICAN AMERICAN	NL-WHITE
Proportion of residents from underserved minority groups	Significantly higher	5 times higher	Standard for comparison
Proportion of patients of physicians' own race/ethnicity	3 times higher	6 times higher (42.9% more)	Standard for comparison
Percent publicly insured	24%	45%	18%
Percent uninsured	9%	3%	6%

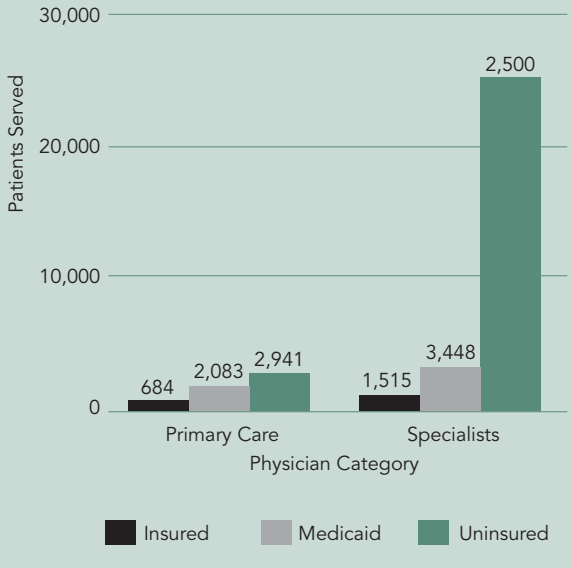
In addition to the lack of diversity, there are overall shortages in health care professionals to the extent that federally designated "Health Professional Shortage Areas" (HPSAs) exist throughout the country. The criteria for an HPSA are that the area exceeds a specified population-to-practitioner ratio, and that the available resources are over-utilized, excessively distant, or otherwise inaccessible. Approximately 20 percent of the U.S. population currently lives in an HPSA.

QUALITY CARE

Insuring patient safety is an overlooked issue. One safety issue is the miscommunication between caregivers and patients contributes to the relatively high rate of complications, misdiagnoses, and deaths associated with the U.S. health care system. In a cross-sectional survey of parents of children coming to the pediatric clinic serving a Latino population at an inner-city hospital, parents who spoke little or no English said they believed being treated by a medical staff who could not speak Spanish led to adverse health consequences for their children, including poor medical care (8 percent), misdiagnosis (6 percent), and prescription of inappropriate medications (5 percent) (Flores et al., 1998).

Figure 2

NUMBER OF PATIENTS PER SPANISH-SPEAKING PHYSICIAN FOR THREE LIMITED ENGLISH PROFICIENCY POPULATIONS IN 13 URBAN AREAS OF CALIFORNIA



In 2001, a survey was conducted of physicians practicing in 13 urban California counties. Results showed that only 26 percent of primary care and 22 percent of specialist physicians were fluent in Spanish. Yet the need is clear for more Spanish-speaking physicians to serve limited English proficiency (LEP) patients, as demonstrated in Figure 2 (Yoon et al., 2004).

PRIMARY PREVENTION FOR HEALTHY ENVIRONMENTS

To date, far greater research attention has been given to documenting racial and ethnic disparities in care than in understanding how to build health-creating environments. Almost all factors cited as health care problems among racial/ethnic minority populations are either preventable or remediable. The health care issues faced by minority populations across the United States are universal to uninsured populations and consist most often of diabetes, heart disease, and cancer. Asthma also is frequently cited in this study as a growing health concern among children. The etiology of disease today is diverse because of our increasingly deleterious environment. Considering that the highest disease rates in this country and now also the world are chronic, preventable diseases, it is worth shifting focus to developing drastically different models of agriculture, energy, transportation, and health care—all factors that influence how we relate to our environment.

An examination of disease by race and ethnicity consistently shows that U.S. immigrants become less healthy the longer they live here. This typically low-income population potentially would experience fewer diseases if they received adequate preventive advice and experienced fewer financial burdens. An additional consideration is that, according to a study by the Commission for Racial Justice, race was found to be a significant variable associated with the location of hazardous waste sites. The study also found that the greatest number of commercial hazardous facilities were located in communities with the highest composition of racial and ethnic minorities (Commission for Racial Justice, 1987). A 20-year follow-up study confirmed the same trends were true in 2007. Thus, it appears that disease for this population is related more to place and access to care rather than to biology or genetics.

BEST PRACTICES AND PROGRAM INNOVATIONS

Data for this report was collected from organizations in five U.S. metropolitan areas and three rural communities with Latino populations. The goal was to examine innovations in the health care system that increase access to care for Latinos and other minority ethnic populations. These organizations were selected for offering innovative solutions that help meet the needs of their areas; in each case, health conditions, needs, and policies were studied to understand the organization's relationship with its multicultural community. This diverse group includes clinics, health centers, hospitals, coalitions, forums, non-profits, and health management organizations. The results are presented in the full report, available at www.trpi.org, as individual case studies that have had an effect on diversity, staffing, and cultural competency.

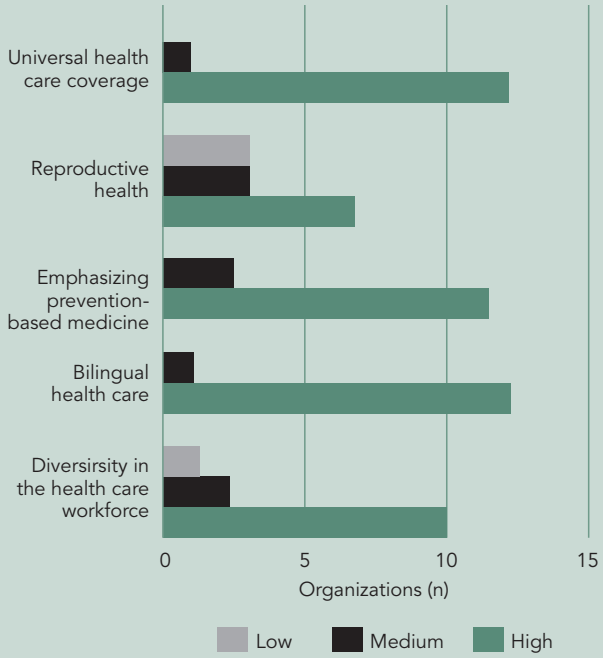
HEALTH ORGANIZATIONS' POLICY PRIORITIES

All interviewed stakeholders were asked to prioritize issues regarding increasing health care access for minority populations. The issues presented were taken from a prior literature review.

A total of out of 14 reviewed, 13 organizations responded; the only non-respondent belonged to a group dealing primarily with regulatory as opposed to policy issues. Most organizations ranked four of five previously-identified topics as high priority policy areas: universal health care coverage, prevention-based medicine, bilingual health care, and diversity in the health care work force (see Figure 3). Though reproductive health is considered an aspect of universal health care coverage and prevention-based medicine, it was listed separately to explore the specificity of this priority. Reproductive health was ranked a high priority among seven organizations and a medium priority by an additional three organizations.

Figure 3

POLICY PRIORITY AREAS FOR HEALTH ORGANIZATIONS (n=13)



Results of this study demonstrate that minority populations have medical needs spanning the spectrum of primary, preventive, specialty, and urgent care. Fourteen organizations identified 19 distinct health care needs of concern for their populations. Nine conditions overlap with priority health conditions previously identified in a report of best practices to eliminate health inequalities including 68 national organizations (Jacobson et al., 2007). In addition to the common health concerns identified (diabetes, asthma, cardiovascular disease, cultural competency/

multi-lingual care, STD/HIV care, dental, prenatal care, and cancer), areas that need to be addressed by programs working to eliminate health inequalities identified in this study are:

- hypertension
- mental health/depression, usual source of care
- affordability of pharmaceuticals
- pediatric care
- smoking cessation
- substance abuse
- violence
- pesticide-related exposure

The wider spread of diseases among the organizations in this study supports previous evidence that race/ethnicity inequalities in health conditions are persistent and increasing. Root causes of this wide array of chronic, environmental, and reproductive diseases are marginal access to care and environmental toxin exposure.

POLICY RECOMMENDATIONS

A number of racial and ethnic biases in our health care system demonstrate a cyclical pattern in which poor and minority communities (regardless of income status) receive deficient, substandard, or harmful care. Immigrant Latino and African American populations are particularly at risk. A diverse health care workforce with sufficient providers will build a system that can provide culturally competent, equitable and quality services to anyone, regardless of the language spoken. Concurrently, a critical priority is to create healthy environments with equal access to resources for a healthy life.

Policy Recommendation #1:

Universal health care

Universal health care is defined as care available to all regardless of language or citizenship. Universal health care is multi-lingual, single-payer, low cost or free, and provides comprehensive care including primary, preventive, specialty, and urgent care. Women and children are especially vulnerable populations to disease during the reproductive life stage. As part of universal health care, reproductive health should be provided with the goal of achieving health literacy on family planning and disease prevention. An adequate health care system would also ensure that health care providers and support staff exist proportional to the population.

Policy Recommendation #2:

Diversity in the health care profession

Diversity and inclusiveness would be a vital step in building equality into the health care workforce. A baseline measurement for success would be that medical facilities are adequately staffed by people with race/ethnicities proportional to a community's population.

Evidence supporting the idea of diversity in health care education comes from a survey of graduating medical students. The survey showed that more minority physicians go into the types of practices that address the needs of minority populations, for example, providing primary care to underserved geographic areas. Nearly 51 percent of Black, 41 percent of Native American/Alaska Native, and 33 percent of Hispanic graduating medical students said they intend to practice in underserved areas. Only 18.4 percent of Non-Latino-whites had such plans (Ko et al., 2005).

Paying for a medical education can prove a major barrier to entry into the medical field, especially for minority groups that have been historically disenfranchised. By expanding programs that fund education in exchange for practice in underserved areas, federal funding could help to ensure full access to a medical education without the minority student acquiring debt. It will also be important to require state medical professional boards to collect race/ethnicity and language proficiency data to track the diversity of health care professionals.

Policy Recommendation #3:

Patient equity and safety in care

Equity in care entails eliminating practices that provide recipients of public assistance with a lower quality of care. Medical error also needs to be eliminated. At present, few health care sites have a system for reporting medical error. To ensure patient safety, health care sites should establish a systems-oriented approach to patient safety and create a safe environment that supports open dialogue about errors, causes, and strategies for prevention.

Policy Recommendation #4:

Primary prevention and freedom from disease

Provide broad-based societal infrastructure and development for a public health care system based in primary prevention. The goal of this development is health care available at the community-based and institutional level to the population at large.

Policy Recommendation #5:

Restoration of human and environmental health

A universal health care system is one aspect of disease prevention and optimal care. An efficient health care system is the other essential aspect of a growing a disease-free society. In addition to the quality improvements in medical care discussed above, legislation to restore ecological balance and to eliminate sources of pollution is necessary to attain human and environmental health. Currently, the health care industry is the second largest

contributor to carbon dioxide pollution (Health Care without Harm, 2008). Beyond the health care industry, all sectors of industry hold responsibility for reducing their dependence upon fossil fuels and toxic chemicals that result in human and environmental damage. Examples of environmental justice legislation previously introduced include toxic waste cleanups in minority communities and a moratorium on the permitting of new toxic chemical facilities.

CONCLUSION

The existing health care problems with regard to race and ethnicity are pervasive, well-documented, and growing. Although it is tempting to attribute the disparities that show up in this population to socioeconomic factors, a body of research shows that income, health insurance status, and socioeconomic factors explain only a part. Many of the barriers faced by Latinos, such as no insurance, low income, language/cultural barriers, and immigration status, appear to exist at the individual level. The provider-level barriers reflect larger systemic problems –shortages of physicians and health care professionals, bilingual professionals, and qualified medical interpreters.

Almost all factors cited as health care problems among racial/ethnic minorities are either preventable or remediable. Eliminating them should begin at the most basic level by emphasizing the provision of primary prevention and affordable, bilingual care. This population must receive adequate medical advice, have better access to the health care system, and be provided with culturally competent and understandable medical information from a staff who is culturally sensitive to the local population. Sufficient numbers of health care providers to serve this population will be achieved through the training of the Latino health care workforce using publicly funded bilingual and multicultural educational initiatives.

Population health will only improve with the long-term investment of universal health care to ensure that the entire population, regardless of language spoken or citizenship, lives in a healthy environment and produces healthy children. Elements of primary prevention work across all levels of society and government to ensure that people reside in homes and environments free of toxins, have a regular source of food and water, enjoy open spaces, and are provided with resources to alleviate any additional stress imposed by societal inequalities. Access to a reliable and trusted source of care for sickness completes the provision of universal health.

Public programs intended to provide health care for the poor should, at the very least, be highly accessible to the target population including easy enrollment into a support system of multi-cultural care that does not need to be supplemented. Additionally, greater accountability in the form of transparency in the health care system is needed to prevent the uninsured from unscrupulous business practices.

The intersection of the environment and human health is the combined policy approach needed to comprehensively address the race/ethnicity-based exposure to disease. Such a direction in policy-making will allow the United States to move from the interim health care situation of an unnecessarily diseased population to the goal of universal health care and healthy environments. It is through the healthy building of our environments and equitable building of our society that we shall grow healthy individuals.

Please visit www.trpi.org for the full report.

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The Tomás Rivera Policy Institute (TRPI) advances informed policy on key issues affecting Latino communities through objective and timely research contributing to the betterment of the nation.