NCLR
NATIONAL COUNCIL OF LA RAZA

RESTORING EQUITY IN THE HEALTH CARE SYSTEM: ADDRESSING HEALTH DISPARITIES THAT LATINOS FACE

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Submitted by:

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Chairman Pallone, Ranking Member Deal, and members of the Subcommittee, thank you for providing me with the opportunity to testify today. I also want to extend special gratitude to Congresswoman Solis and the Tri-Caucus for their leadership in addressing health disparities that racial and ethnic minorities face within the national health care discussion by continuing to advocate for passage of H.R. 3014, the "Health Equity and Accountability Act."

I am Janet Murguía, President and CEO of the National Council of La Raza (NCLR). NCLR is a private, nonprofit, nonpartisan organization established in 1968 to reduce poverty and discrimination and improve opportunities for this nation's Hispanic community.* As the largest national Hispanic civil rights and advocacy organization in the United States, NCLR serves all Hispanic subgroups in all regions of the country and reaches millions each year through its network of nearly 300 affiliated community-based organizations.

Over the past decade, NCLR has focused on improving the health status of Latinos to enable them to pursue the great opportunities that this country offers—to excel academically, climb the economic ladder, open small businesses, and live healthier lives. NCLR was drawn into the area of health policy when Congress first proposed eliminating Medicaid eligibility for legal immigrants in the mid-1990s. Since then, NCLR has led coalition efforts to restore legal immigrant access to Medicaid, create access to the State Children's Health Insurance Program (SCHIP), and address the significant barriers to health care that Latinos face. In addition, NCLR's Institute for Hispanic Health has conducted health promotion and other health programs

* The terms "Hispanic" and "Latino" are used interchangeably by the U.S. Census Bureau and throughout this document to identify persons of Mexican, Puerto Rican, Cuban, Central and South American, Dominican, Spanish, and other Hispanic descent; they may be of any race.

with its Affiliates for more than 15 years. Through these efforts, we have come to understand the acute limitations in access to health care for Hispanic Americans and the enormous impact this can have on the well-being of the larger American population.

Latinos and other racial and ethnic minorities face considerable challenges within the health care system. Deep-rooted inequities have created obstacles to obtaining health coverage and the critical services that are needed to maintain good health. Recently renewed conversation about health care reform provides NCLR with optimism that leadership will develop new policies that guarantee affordable and quality health care for all Americans. However, to ensure permanent progress, it is essential that current weaknesses are addressed at every possible opportunity.

In my testimony today, I will provide background on the Latino community and health disparities to explain why it is important to focus on Latinos as part of the broader health care debate. I will then describe some of the issues that contribute to Latinos' poor quality of and access to health care. Finally, I will then provide recommendations to address each issue.

Background

The last decennial Census reported that from 1990 to 2000, the Latino community grew by 58%.[1] As of July 2007, there were an estimated 46 million Latinos in the U.S., constituting 15% of the total U.S. population.[2] The Latino community is expected to continue to flourish in the coming years, accounting for 60% of U.S. population growth between 2005 and 2050.[3] While data show that the U.S. population is aging, Latinos remain a relatively young group, with a

median age just under 28 years old, compared to a median age of 37 years for the entire U.S. population.[4] Further, more than one-third (34%) of Latinos are children under the age of 18.[5] These projections make it clear Latinos and their families will have increasing impact on this country in the coming years.

Like all who live in the U.S., Latinos will face difficulties in fully contributing to this country if they cannot sustain good health. There are many indicators that raise concern for the state of Latino health. Latinos are more likely to report a fair or poor health status than non-Hispanic Whites. For example, 13% of Latinos and 14.4% of non-Hispanic Blacks reported fair or poor health, compared to 8% of non-Hispanic Whites.[6] In addition, Latinos have a high risk of developing chronic diseases such as diabetes, overweight/obesity, certain pulmonary diseases, and stroke, all of which come with substantial long-term health consequences.[7]

Health Disparities: A Broad Overview

Latinos' health care status is characterized by inadequate access to and low quality of health care services. Each year, a report by the Agency for Healthcare Research and Quality (AHRQ) documents the challenges that American families face in receiving core health services. These challenges have increased each year for Latinos and other medically underserved communities. According to the 2007 National Healthcare Disparities Report (NHDR), disparities grew in 67% of the core measures of health care access between non-Hispanic Whites and Hispanics.[8] Latinos were less likely than any other measured racial or ethnic group to access a range of health services, including office visits, emergency room care, and dental care.[9]

Similarly, the gaps in quality of care between non-Hispanic Whites and Hispanics worsened in 60% of the core measures of quality.[10] There are compelling data demonstrating that Latinos are less likely to have interactions with their health care providers that would result in a fuller picture of their health and appropriate medical intervention. More than one in ten (12.2%) Hispanic adults felt their health providers sometimes or never listened carefully, explained things clearly, respected what they had to say, and spent enough time with them. Even when Latinos seek to meet most basic care needs, there are significant deficiencies. For instance, while Mexican American[†] adults had the second-highest levels of obesity nationwide (28.1%), they were less likely to be advised about engaging in physical activity by their doctor than any other racial or ethnic group. In addition, Latinos were less likely to be told that they were overweight.[11] An especially alarming finding from the research is that Latinos are not receiving critical primary care procedures, such as cancer screenings; going without care that is essential for detecting and treating disease before it becomes burdensome.[12]

Key Contributors to Latino Health Disparities

There are several key factors that impede Latinos' ability to access high-quality services. Some of the issues surfacing in the NHDR that Latinos experience include a lack of insurance or a specific source of ongoing care, patient-provider communication barriers, discrimination, and the lack of diversity in the health care workforce.[13] In order to ensure that Latinos receive health

[†] Mexican Americans represent approximately 60% of the Latino population, making them the largest subgroup of Latinos. Most national data collected on obesity and associated comorbidities are collected from this subgroup. While this data provides insight into health of the Latino population, it does not fully represent the diversity of Latinos.

care services that foster good health status, there must be a commitment to addressing all of these issues.

A. Uninsurance

Latinos are more likely than their peers to report a lack of health coverage as a major barrier to health care. In most health care scenarios, from filling medication prescriptions to scheduling a visit to the doctor, Latinos are more likely than their peers to report that they delayed a range of medical services due to financial or insurance reasons.[14] Latinos are 2.8 times more likely to be uninsured than their non-Hispanic White peers.[15] Most traditional pathways to health coverage are closed to Hispanics. While the Latino workforce participation rate is higher than those of their peers, they are much less likely to be offered insurance. In 2006, just 40% of Hispanics were covered by employer-based insurance, compared to 66% of non-Hispanic Whites and 49.2% of non-Hispanic Blacks.[16] This disparity persists across all income levels, regardless of industry concentration or eligibility for coverage.[17] In addition, while Medicaid and SCHIP provide approximately 10 million low-income or medically-needy Hispanics, Congress has barred a sector of the population from participating in these programs. Restrictions enacted in 1996 deny immigrants access to federal means-tested public benefits, including health care, for at least five years after obtaining legal residency, and some legal immigrants never become eligible. Thus, uninsured Latinos and immigrants are much less likely to access health care, including emergency care, than their insured counterparts.[18]

B. Language Barriers and Communication

Language barriers not only discourage Latinos and their fami lies from enrolling in health programs for which they are eligible, they can also lead to serious and potentially life-threatening health consequences in the health care setting, including misdiagnoses, poor medical care, and inappropriate prescriptions or hospitalizations.[19] These barriers affect Americans from all walks off life, regardless of citizenship status. Approximately 24 million people speak English "less than very well" or are deemed limited-English-proficient (LEP) when receiving health services. Almost half of those who are LEP are U.S. citizens.[20]

The effects of limited communication for LEP patients can be severe. In a study of hospitals accredited hospitals by the National Joint Commission accredited hospitals, researchers found that 49% of LEP patients who had access to care experienced an adverse event that caused some physical harm, compared to 30% of English-speaking patients.[21] Furthermore, LEP patients without access to language assistance were less likely to adhere to patient regimens. One major disparity exposed was that over one-quarter (27%) of LEP patients had trouble understanding their medication instructions, compared to 2% of LEP patients who had access to interpreters.[22]

C. Discrimination

Discrimination appears to be a factor in Latino access to health care, particularly among Spanish speakers. An NCLR study conducted by the Equal Rights Center in 2005 found that language barriers and related discriminatory practices at the District of Columbia's Department of Human

Services (DHS) have drastically limited access to such medical services as Medicaid for the District's large Spanish-speaking community. According to the report, 80% of Spanish-speaking Latinos who participated in on-site visits and telephone testing faced at least one serious hurdle in obtaining vital medical benefits at DHS.[23]

D. Provider Diversity

Minorities who participate in the health workforce have been shown to be more likely than their White counterparts to work in medically-underserved communities, including those of minorities. However, they are underrepresented in almost every sector of the health workforce. Latinos represent just 4.2% of registered nurses, 5.7% of physicians and surgeons, and 6.7% of physician assistants.[24] Investing in the diversification of the workforce will help increase capacity to provide culturally appropriate treatment to many populations and increase access to bilingual care.

Strengthening the Health Care System for Racial and Ethnic Minorities

The "Health Equity and Accountability Act" (H.R. 3014) addresses many of the underlying barriers that limit access to care for Latinos and other racial and ethnic minorities by considerably improving the health care infrastructure. NCLR believes that Americans will be best served by passing this legislation in its entirety. The provisions of this bill are particularly important to improving the health care system for Latino families because they:

- *Restore access to critical programs for some lawfully residing immigrant children and pregnant women.* H.R. 3014 restores federal Medicaid and SCHIP eligibility for vulnerable populations, such as domestic violence victims petitioning under the Violence Against Women Act (VAWA) and persons with Temporary Protected Status, improving the access that legal immigrants can have to important safety net programs. NCLR would also recommend that this program be extended to all lawfully residing children and pregnant women, as sponsors in Congress have intended.

- *Encourage effective communication in health care settings.* By increasing funding for the provision of language services, codifying national standards on culturally and linguistically appropriate care, and encouraging the development of new language assistance strategies for health providers, among a number of other provisions, this legislation improves opportunities for better communication that lead to positive health outcomes.

- *Increase accountability in health care.* H.R. 3014 ensures that the Office for Civil Rights (OCR) under the U.S. Department of Health and Human Service has the authority to pursue full enforcement of civil rights law for persons who are discriminated against in health care settings. It will foster accountability for disparate treatment of persons due to their national origin. Moreover, it ensures that OCR can create an action plan that protects those covered under Title VI of the Civil Rights Act.

- *Promote diversity in the health workforce.* This bill increases resources to foster the development of minorities in health professions, including through expansion of such programs as the Health Career Opportunities Program and Centers of Excellence, which are among the very few that currently facilitate minority access to health careers. The provisions contained within H.R. 3014 will also expose many health professionals to a diverse range of populations by providing resources for medical institutions to conduct cultural competence training.

- *Support community approaches to health care delivery.* Many community-based organizations have created models to address health care disparities that are culturally appropriate and tailored to the populations that they serve. This legislation increases support for these programs by helping to bring common community practices to scale. Programs are targeted toward different regions and populations, such as the rural community, to ensure that their unique barriers are addressed. Of particular importance, this legislation offers financial resources to ensure that community heath workers, known as *promotores* in the Latino community, have the ability create and conduct programs on health promotion and address disproportionate levels of chronic disease. Additionally, this legislation increased resources for Community Health Centers (CHCs), which are often at the center of care for the medically-underserved. Nearly 40% of the patient population of CHCs is Latino.

Conclusion

There are a multitude of barriers that prevent not just Latinos but also many other Americans from connecting with health care. However, the United States has the capability to guarantee equity within our health care system by supporting effective health care programs and ensuring the enforcement of civil rights programs. H.R. 3014 provides policymakers with a road map for closing gaps in health care. It opens several points of entrance to the health care system for Latinos and immigrants and encourages measures for culturally and linguistically appropriate services. H.R. 3014 also provides financial resources for proven community-based programs to conduct health promotion activities, particularly in communities with low health literacy, and to expand and enhance outreach and enrollment efforts that open health insurance channels for Latinos and other Americans. NCLR looks forward to working with the Committee and members of Congress to pass this important legislation.

Thank you for the opportunity to provide this testimony today.

Endnotes

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[3] Jeffrey S. Passel and D'Vera Cohn, "U.S. Population Predictions: 2005 to 2050" (Washington, DC: Pew Hispanic Center, February 2008), http://pewhispanic.org/reports/report.php?ReportID=85 (accessed April 21, 2008).
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[5] Ibid.
[6] National Center for Health Statistics, *Health, United States, 2007,* "Table 60: Respondent Assessed Health Status, by selected characteristics, United States, selected years, 2001-1006" (Washington, DC: GPO, December 2007), http://www.cdc.gov/nchs/data/hus/hus07.pdf (accessed June 19, 2008).
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[9] Agency for Healthcare Research and Quality, *National Healthcare Disparities Report, 2007*, "Appendix D: Data Tables," (Rockville MD: February, 2008), http://www.ahrq.gov/qual/nhdr07/index.html (accessed June 19, 2008).
[10] Agency for Healthcare Research and Quality, *National Healthcare Disparities Report, 2007.*
[11] Agency for Healthcare Research and Quality, "Appendix D."
[12] Examples of screenings and diagnostics that Hispanics are less likely to receive include mammograms, colon cancer screenings, pap smears, and cervical cancer screenings. Agency for Healthcare Research and Quality, "Appendix D"; National Center for Health Statistics, "Table 60."
[13] Agency for Healthcare Research and Quality, "Appendix D."
[14] According to the NHDR, 18.6% of Latino adults and 11.2% of Latino children reported that they sometimes or never received appointments for routine care as soon as they wanted, a rate higher than any other measured for a racial or ethnic group. Agency for Healthcare Research and Quality, "Appendix D."
[15] Agency for Healthcare Research and Quality, *National Healthcare Disparities Report, 2007.*
[16] Percent insured calculated by NCLR using data from U.S. Bureau of the Census, *Current Population Survey*, "Table HI01. Health Insurance Coverage Status and Type of Coverage by Selected Characteristics: 2006." Washington, DC, 2007.
[17] Kara Ryan, *Healthy Choices or Bad Medicine?* (Washington, DC: NCLR, forthcoming).
[18] Dana P. Goldman, James P. Smith, and Neeraj Sood, "Immigrants and the Cost of Medical Care," *Health Affairs* 25, no. 6 (November-December 2006): 1700-1711; Peter J. Cunningham, "What Accounts for Differences in the Use of Hospital Emergency Departments Across U.S. Communities?" *Health Affairs* 25, no. 4 (July-August 2006): 324-336.
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