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Se Habla Español: The Health Disparity among the Latino Population

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Latinos are considered the fastest growing and the largest ethnic minority group in the United States.⁴ It is estimated that by 2050, 24% of the U.S. population will be Latino.² According to Census data, approximately 18% of the U.S. population age five or older speaks a language other than English at home, and current projections continue to show increases in U.S. immigrant and second-language groups nationwide.⁸ About half of that population self-reported that they speak English less than “very well.” Members of this population are referred to as individuals with limited English proficiency (LEP).¹ As the largest ethnic minority, 28 million of the 35 million Latinos speak Spanish at home.¹ However, the diversity among health providers does not match the diversity of the growing population. Research on racial/ethnic disparities in healthcare access and utilization consistently identifies Latinos as one of the most disadvantaged ethnic groups, using measures such as usual source of care, health insurance coverage, and the quality of care received.⁵ It is important for health providers to be aware of the health disparity among the Latino community and their health providers, to understand possible explana-

tions for this disparity, and possible solutions that could be implemented.

Patients with LEP undergo more unnecessary diagnostic tests than native English-speaking patients because of their lack of ability to provide accurate explanations about their symptoms or because they misunderstand health care providers' advice. They also spend more money for unnecessary tests and frequent visits to an emergency department than English-speaking patients.² Several studies report that Latinos have fewer physician visits, lower utilization of emergency services, and a lower likelihood of having a regular source of care than non-Latino groups despite the research that suggests that Latinos have greater likelihood of chronic disease.³ Evidence also suggests that Latinos in the United States are more likely to delay needed care for chronic conditions than other ethnic groups.²

The disparity among health professionals and LEP patients goes beyond the treatment intervention and into the after treatment care. LEP patients were four times more likely than English-fluent patients to misunderstand prescription labels when treated by language-discordant providers, compared with only 1.5 times more likely when treated by language-concordant providers.⁹ A study also established that LEPs whose physician did not speak their language were more likely to have difficulty understanding a medical situation, have trouble reading medication labels, and experience a bad reaction to a medication.¹ The ability of health care providers to communicate in the same language as patients may decrease medication errors.

There have been several studies that have examined

possible explanations for the healthcare disparities. A focus group study explored barriers to and facilitators of depression treatment in general as well as barriers to participation in depression telephone care management.⁴ This focus group study was conducted by two bilingual facilitators and subjects were all members of the Medicaid Health Plan. The generalizability to other Latino groups and other health related concerns is not identified but the study was able to generate ideas that could later be studied.⁴ The study revealed several reoccurring themes related primarily to barriers and facilitators of healthcare, including vulnerability, social connection and engagement, language, culture, and insurance/money.⁴ Participants in the focus group expressed concerns about feeling vulnerable because of their fear about the security of their private information. This stemmed from the lack of trust in other people, fear about violations of privacy or confidentiality and fear about information disclosure specifically regarding immigration status. Participants also expressed concerns about being victimized or discriminated against. Participants gave specific instances of mistreatment and times when they felt like they were treated like a number, rather than a human being. Because of the language barrier and their lack of knowledge of their rights, most participants experienced concerns about their fear of being taken advantage or scammed.⁴ Latinos value social engagement and face to face contact, as well as strong eye contact. Social engagement refers to having a personal connection with their physician; they would like their health providers to ask about their families and job. Establishing a connection with health providers allows for an opportunity of trust;

trust was seen as an essential aspect of relationships with healthcare providers.⁴ Participants discussed insurance/money and how it related to seeking or receiving care. Many spoke of their own or others' financial troubles.⁴

With respect to culture, participants talked about the ways in which cultural differences can serve as a barrier to treatment.⁴ Participants described a desire for cultural concordance, the desire to encounter medical office staff workers who are Latino. According to the Sullivan Commission report in 2004, people of color account for 9% of nursing professionals, 10% of nursing faculty, 6% of physicians, and 4% of medical faculty.¹ These racial and ethnic disparities result in worse outcomes and higher mortality rates.⁷ Racial concordance of patient and provider is associated with greater patient participation in care processes, higher patient satisfaction, and greater adherence to treatment.⁷ A review of 55 studies on diversity in the health professions suggested that minority health professionals were more likely to work in minority communities and that patients received better interpersonal care, when racial or ethnic concordance was present.¹ Researcher Haskins examined past research studies on recruitment and retention of students from minority groups in medicine and allied health. He came to the conclusion that successful recruitment and retention activities identified in the literature include: partnerships with elementary, middle, and high schools; prematriculation academic enrichment courses; comprehensive orientation and advising programs; peer, alumni, professional, and faculty mentorship; study skills assistance and academic tutoring; reading and critical thinking enhancement; stress-

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reduction strategies; licensure examination preparation; and cultural diversity in the curriculum.⁷ The literature on barriers that hinder minority groups from successfully attaining a higher level education is extensive however, a consistent mentor and strong support system are tools that help overcome barriers.

An emerging theme during group discussions was centered on the language barrier to receiving medical services.⁴ It is difficult when support staff or providers do not speak Spanish and they found it helpful if providers were able to speak Spanish. The Sullivan Commission determined that the discordance between patients' and health care providers' ethnicity and language is a major reason for health disparities.¹ Participants discussed an unmet need for interpreters in this community and shared instances in which there was loss of access to care because no interpreter was available when care was sought.⁴ There was lack of information and communication about the need of interpreters and when interpreters are present, the main concern was the accuracy of the translation.⁴

In order to help decrease the language gap, health care facilities are encouraged to provide ongoing employee training on working with patients with LEP by developing a formalized training module on working with patients to eliminate language barriers and include it as part of new employee orientation and annual employee training.⁸ It is also important to have written protocols for use of interpreters. Use of untrained interpreters tends to increase the likelihood of errors in interpretation which may impact clinical outcomes negatively.⁸ Despite the increased risk of communication errors and patient safety

risks, many hospitals do not provide interpreter services, often times due to limited funding, especially in rural areas. The lack of bilingual medical staff, trained medical interpreters, translated written materials, and cultural competency training contributes to the divide between LEP patients and the hospital system.⁹ The use of family members as translators at that point becomes easily accessible.⁷

Despite the increased risk of communication errors and patient safety risks, many hospitals do not provide interpreter services. This is largely due to high costs of medically trained interpreters, annual cost of interpreter services ranged from \$1,800 to \$847,000.⁹ Other tools used to educate and communicate with LEP patients include brochures 46.7%, posters 36.2%, cards 32.9% and telephone voice menus 27.6 %.⁹ These tools are not as effective as a trained interpreter.

As the Latino population continues to increase and the representation of health providers does not match the diversity of the population, health providers need to go the extra mile and learn more of the Latino culture as a whole and its subgroups, and make a conscious effort to be more patient when dealing with patients with limited English proficiency.

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