Barriers to Health Promotion and Disease Prevention in the Latino Population

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The Latino population of the United States is expected to increase substantially in the next 25 years. Although recent health promotion and disease prevention interventions have improved the health of the majority of Americans, the Latino community has derived less benefit from these advances. This is due to a number of interrelated factors, including a disproportionate representation of Latino Americans in the low socioeconomic strata and in the uninsured population. Even when insured, Latino Americans face significant barriers to health promotion and disease prevention. This policy analysis identifies barriers at the organizational and structural level of health care delivery, as well as at the level of the medical encounter. It provides a practical framework for intervention that is founded on the recruitment of Latino Americans into the health care workforce and leadership, the restructuring of health systems to be more responsive to the needs of diverse populations, and health care provider education on how to improve cross-cultural understanding and communication. By investing in a multifaceted approach that addresses barriers to health promotion and disease prevention in the Latino population, we can improve the quality of care delivered to this population and help eliminate racial and ethnic disparities in health care. (Clinical Cornerstone. 2004;6[3]:16–29) Copyright © 2004 Excerpta Medica.

INTRODUCTION
The Latino population of the United States is expected to increase from 31 million (11% of the population) to 59 million (18% of the population) by 2025. In addition to being one of the youngest populations (36% under the age of 18 years), the Latino population is one of the most rapidly growing groups in the United States. Although health promotion and disease prevention interventions have improved the health of the majority of Americans, the Latino population has benefited less from these advances. A review of the President’s Initiative to Eliminate Racial/Ethnic Disparities in Health by the US Department of Health and Human Services shows that, compared with the general population, Latino Americans have poorer outcomes in diabetes and HIV/AIDS, have lower rates of blood pressure control, and receive fewer childhood and adult immunizations. It is likely that if a greater Latino subgroup analysis of the data were undertaken, more disparities in health would be observed.
BACKGROUND
The term Latino refers to a very broad and heterogeneous group with distinct nationalities, religions, degrees of acculturation, and socioeconomic status. Recent studies suggest that differences between Latino subgroups (eg, Puerto Ricans, Cubans, and Mexicans) in sociodemographic characteristics, health status, and use of health services are sometimes of equal or greater magnitude than differences between ethnic groups. The health disparities faced by many Latino subgroups are the result of a number of complex interrelated factors. First, the poverty rate for Latino adults is at least twice that of the rest of the population, and more than one third of Latino children live in poverty. This puts them at risk for many negative social determinants of health, including low levels of education, living in dangerous neighborhoods and poor housing, and working in hazardous occupations, among others. Second, nearly 40% of the Latino population <65 years do not have health insurance. Latino children make up 29% of the uninsured under 18 years of age compared to 11% of white children. One quarter of the nation's 44 million uninsured are Latino—of these 11 million, 9 million have at least one family member who is employed. In fact, Latino Americans are more than twice as likely to lack health insurance as the population overall. Insurance alone, however, does not yield high-quality health care or appropriate access to health services. Beyond insurance, there exist other barriers to care, both at the organizational and structural level of health care delivery, as well as at the level of the medical encounter. Thus, even when insured, Latino Americans face significant barriers to health promotion and disease prevention interventions. For example, less acculturated Latino Americans whose health beliefs may diverge from the mainstream, or who may have limited health literacy and English proficiency, face great difficulty maneuvering through a complex and intricate health care system.

Given the health challenges facing Latino Americans today, it becomes imperative to better understand the state of access to health promotion and disease prevention for this population. This is particularly important given that the majority of the conditions that disproportionately affect Latino Americans are both preventable and treatable.

POLICY ANALYSIS
Many Latino Americans who attempt to gain access to the US health care system face organizational, structural, and/or provider-based barriers that preclude them from fully capitalizing on health promotion and disease prevention interventions. These barriers include institutional policies and procedures, the inability to get timely appointments, lack of after-hours medical advice, and long waiting times for referrals to necessary medical specialists and diagnostic and therapeutic interventions, among others. This results in decreased standard medical screening, a later stage at presentation of various medical conditions, and inappropriate and inadequate treatment. Together, these conditions have led to the significant racial and ethnic disparities in health outcomes prevailing today. For example, the diabetes morbidity and mortality rates for Latino Americans are almost 30% higher than for white Americans.

KEY POINT
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ORGANIZATIONAL BARRIERS: LEADERSHIP AND WORKFORCE ISSUES
Our health care systems, structural processes of care, and health policies are, in large part, shaped by the leaders who design them. Furthermore, our health care system's success hinges on the workforce that carries out these policies and procedures. From this organizational standpoint, one factor that can affect both the availability and acceptability of health care for Latino Americans is the degree to which the nation's health care professionals and leadership reflect the racial and ethnic composition of the general population.

Institutional Leadership
Latino Americans are woefully underrepresented in health care leadership and decision-making positions (eg, state or county health officials, faculty in
In the absence of strong quantitative data, a plethora of anecdotal evidence suggests that lack of diversity in the leadership and workforce of health care organizations results in structural policies, procedures, and delivery systems that are inappropriately designed or poorly suited to serve diverse patient populations. Given their social and cultural understanding of the communities they serve, health care professionals from minority groups may be more likely to organize health care delivery systems to meet the needs of minority populations.

Examples of barriers to care include limited clinic hours of service that do not account for community work patterns, bureaucratic intake processes that create fear of deportation among the undocumented, and long wait times to make appointments and at the actual time of the visit. Data regarding diversity in leadership are quite revealing. For example, <2% of senior leadership in health care management is nonwhite. In academic health centers, underrepresented minorities (ie, Latino Americans, African Americans, and Native Americans) make up only 3% of the medical school faculty. In addition, 53% of the Latino medical school faculty teach in medical schools in Puerto Rico, highlighting the under-representation of Latino faculty in the continental United States. Similarly, despite the fact that minorities comprise 30% of the US population, <16% of public health school faculty positions are held by minority scholars, and only 17% of all city and county health officers are from minority groups (Figure 1).

### Health Care Workforce

The importance of racial and ethnic diversity in the health care workforce is well correlated with the ability of health care organizations to deliver high-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 were higher. Other work has established the preference of minority patients for minority physicians. The reason for this preference may be language-based. For example, it has been shown that Spanish-speaking Hispanic patients are more satisfied when their provider speaks Spanish.

A review of the data on racial and ethnic diversity of the health care workforce reveals that only 6% of all physicians in 1995 were Latino Americans. Approximately 24% of Latino physicians in office-based practices in California care for patients whose primary insurer is Medicaid (compared with 18% of white physicians), and 9% care for patients who are uninsured (compared with 6% of white physicians). The prognosis for the future is not much brighter. Data from 1997 show that enrollment of Mexican Americans and mainland Puerto Ricans into medical school dropped by 8.7% and 31%, respectively, and that in that same year, only 11% of all graduates were from underrepresented minorities.

Similar racial disparities are found in other health professions as well (Figure 2). For example, Latino

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**Figure 1.** Percentage of minority professional representation. Adapted with permission.
Americans represent only 5% of all practicing dentists. Unlike medical schools, which experienced an initial increase in minority enrollment in the early 1990s that subsequently tapered off later that decade, dental schools experienced a steady decrease in minority matriculation (as a proportion of total matriculation) throughout the 1990s. Despite gains in minority enrollment in baccalaureate nursing programs, minorities comprise only 3.2% of the current nursing workforce. Similarly, despite increases in minority enrollment in pharmacy schools in the 1990s, individuals from underrepresented minorities make up only 2.9% of the nation’s pharmacists and 3.8% of optometrists.

**STRUCTURAL BARRIERS TO CARE**

Latino Americans are significantly more likely than their majority counterparts to receive care in hospital outpatient departments (particularly academic health centers and public hospitals), community-based clinics, emergency rooms, and other safety-net providers. As a result, Latino Americans receive care in systems that often provide poor continuity, have dated medical record systems, maintain limited after-hours services (including telephone access to health care professionals), and depend on graduate housestaff (residents and fellows) as primary providers. To complicate matters, public hospitals and academic health centers are facing unprecedented fiscal challenges, which jeopardize their role as providers of care to vulnerable populations. These “at-risk” systems are not conducive to health promotion and disease prevention for Latino Americans.

The recent emergence of Medicaid managed care is likely to pose challenges to the Latino patient as well. Bureaucratic intake and appointment-making processes, limited choice of providers, and lack of information about these new systems are some of the possible challenges. Despite efforts to facilitate transition and enrollment into Medicaid managed care, people with limited English proficiency and/or those with limited experience dealing with complex health care systems will have difficulty selecting a primary care provider or maneuvering through a health plan. The barriers in commercial managed care organizations (MCOs) are not likely to be

![Figure 2](image-url)  
**Figure 2.** Latino health care workforce: Percentage of health care professionals who are Latino. Adapted with permission. 

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**KEY POINT**

Latino Americans are significantly more likely than their majority counterparts to receive care in hospital outpatient departments (particularly academic health centers and public hospitals), community-based clinics, emergency rooms, and other safety-net providers.
different. It is difficult to follow these trends, however, because Medicaid managed care and commercial MCOs are not required by legislation or court mandate to collect racial and ethnic identifiers for people enrolled in their plans. For example, although the National Committee for Quality Assurance’s Health Plan Employer Data and Information Set includes a focus on disease areas (eg, hypertension) or dimensions of performance (eg, quality of communication), it does not focus on quality of health care for minority patients, given that it does not report performance and outcomes separately by race or ethnicity. Similarly, at the level of hospital accreditation, the Joint Commission on Accreditation of Health Care Organizations performance measures are devoid of racial or ethnic identifiers (although hospitals must demonstrate their multilingual capacities, however rudimentary, using data that are neither aggregated nor benchmarked).27

Types of Structural Barriers

Structural barriers arise when patients are faced with the challenge of obtaining health care from systems that are inherently complex, underfunded, bureaucratic, archaic in design, or simply inaccessible by common means of transportation. Structural barriers can be divided into extramural—barriers patients experience from their home to the health care center—and intramural—barriers patients experience from the health care center to the provider’s office. Although many of the aforementioned structural barriers to care may affect whites, African Americans, and others of low socioeconomic status equally, several barriers are especially pertinent to the Latino population (Table).

Structural Barriers to Care in the Latino Population

Extramural Barriers

Latino Americans disproportionately reside in either urban or rural locations designated as medically underserved or health professional shortage areas. As a result, they often have to depend on public transportation and travel significant distances to see a health care provider. Moreover, certain health care facilities have limited operating hours and minimal telephone and after-hour access to providers. These factors have clear and direct effects on access to care:

- 30% of Latino Americans, compared with 27% of blacks and 16% of whites, reported that they have "very little" or "no" choice in where to go for medical care.6
- 53% of Latino Americans, compared with 47% of blacks and 30% of whites, use an emergency room, outpatient department, or clinic as a source of medical care.6
- A 1998 National Association of Public Hospitals & Health Systems survey of 25 urban safety-net hospitals reported that African Americans and Latino Americans had the highest number of visits, accounting for 40.9% and 31.7% of hospital visits, respectively.30
- 47% of Latino Americans in 1993 had a dental visit, compared with 64% of whites.6

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<tr>
<th>TABLE. STRUCTURAL BARRIERS TO HEALTH PROMOTION AND DISEASE PREVENTION INTERVENTIONS AMONG LATINO AMERICANS.</th>
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<td>Extramural</td>
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<td>Child care</td>
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HCF = health-care facility.
Intramural Barriers

Even when Latino patients complete the journey to a health care facility, they face several additional barriers to care. For example, bureaucratic intake processes and long waiting times for appointments limit access to health care providers. In addition, facilities that provide care to Spanish-speaking patients but lack interpreter services or do not provide culturally or linguistically appropriate health education materials severely compromise the quality of care delivered.

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PROVIDER-BASED BARRIERS

Provider–Patient Communication

Provider-based barriers to care emerge during the medical encounter, when sociocultural differences between patient and provider are not fully appreciated, accepted, explored, and/or understood. During the medical encounter, a provider's ability and willingness to communicate across language barriers and to understand sociocultural variations in health beliefs, values, and behaviors are critical to the delivery of high-quality health care. Given the small proportion of Latino physicians, Latino patients often receive care from 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 the following:

- Poor communication between patient and provider
- Patient dissatisfaction with care
- Poor compliance with both medications and health promotion and disease prevention interventions

Furthermore, differential treatment of Latino Americans (based on race/ethnicity or social class) may also affect health care delivery and outcomes. For example, studies have shown that Latino Americans are less likely than whites to receive certain procedures and surgeries such as coronary artery bypass graft, angioplasty, and kidney transplant.

The root causes of these disparities in care have not been fully understood, and addressing these challenges requires a multifaceted approach that includes improving health literacy, enhancing cultural competence in health care providers, and developing strategies to overcome language barriers.

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KEY POINT

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been fully elucidated. It is hypothesized that poor communication and patient preferences may play an important role. The effect of provider bias based on race, ethnicity, or social class, whether overt or subconscious, has been shown to affect medical decision making as well.\textsuperscript{52,53}

**Acculturation**

The role of acculturation (integration with the predominant culture) and its effect on health beliefs and behaviors such as compliance in the Latino population cannot be overemphasized. While this is just one of many factors leading to the vast heterogeneity of the Latino population, it has a particularly strong impact on health care. Latino Americans who have spent more time (years or generations) interfacing with the mainstream culture of the United States will often have different cultural beliefs and values than those who have just arrived in the country. The following research results illustrate this:

- High levels of acculturation have been correlated with high levels of adherence to medical therapy.\textsuperscript{51}

![Figure 3. Percentage of minorities reporting (A) difficulty in gaining access to health care specialists and (B) not having a regular doctor.](image-url)
• Low levels of acculturation among Latino Americans have been linked to low utilization of preventive measures and tests such as breast self-examination, Pap smear, and mammography and to poor health outcomes, including invasive cervical cancer.\textsuperscript{54-56}

• High acculturation levels have been shown to contribute to increasing the probability of high-risk behaviors such as alcohol abuse and smoking, particularly for Latina women.\textsuperscript{57,58}

• Provider-based barriers to care are accentuated when issues of acculturation are not recognized and handled appropriately by providers.

\begin{center}
\textbf{KEY POINT}

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\textbf{Perceptions and Expectations of Health Care}

Dissatisfaction with health care may lead to a reluctance to seek health promotion and disease prevention or to follow up with diagnostic or treatment plans. Further work is needed to understand Latino patients’ opinions regarding the qualities of a good health care system. In recent studies, it was shown that Latinos are:

• Less satisfied with the quality of their health care than are whites\textsuperscript{21,59}

• Inclined to feel they are more likely to be treated unfairly by health care practitioners and the health care system because of their ethnicity and limited language proficiency\textsuperscript{59,60}

Although these findings may not be generalizable, they do shed some light on the Latino experience with health care.

\textbf{DISCUSSION}

This policy analysis gives us a starting point from which we can critically analyze the barriers that limit the ability of Latino Americans to benefit from health promotion and disease prevention initiatives. Given a practical framework that focuses on 3 umbrella categories of interventions—organizational, structural, and provider-based—it becomes clearer how initiatives in this area could assist in the elimination of racial/ethnic disparities in medical care. Three main targets arise:

Target 1: Increasing the Representation of Latino Americans in the Health Professions and Health Care Leadership

There should be a significant national focus on research, policy, and programs that aims to both fortify the educational pipeline and strengthen the capacity of Latino health professionals to assume positions of leadership.

Target 2: Innovations in Health Care System and Structure Design

There are ample opportunities to address the many simple (yet pervasive) structural barriers to care defined herein. Efforts should include those that streamline health systems and make them more responsive to the needs of diverse populations, including Latino Americans; initiatives that aim to provide Latino Americans with culturally and linguistically appropriate information to make health care decisions; and mechanisms to ensure that, at a minimum, health care systems that care for large populations of patients with limited English proficiency have effective interpreter services available.

Target 3: Cross-Cultural Education

Given the underrepresentation of Latino Americans among health care providers, targeting providers’ attitudes and practices is a crucial part of overcoming the barriers to care that Latino patients face. The movement toward cross-cultural education of health professionals should be widely supported.

In addition, to effectively monitor any improvement in health promotion and disease prevention for the Latino and other underserved populations, health systems (including hospitals and MCOs) should be encouraged to collect race, ethnicity, and language-proficiency data. Without this provision, we severely limit the ability to measure the quality of care delivered to Latino Americans, and thus preclude systems innovations and quality improvement.
CONCLUSIONS

Latino Americans with health insurance face myriad barriers to health promotion and disease prevention. These include barriers related to their underrepresentation in the nation’s health care leadership and workforce; their difficulty navigating the complicated structural processes of the health care system; and their being cared for by providers who lack an understanding of their language or health beliefs. While there are no easy remedies, a targeted approach that focuses on programming, research, policy, advocacy, and outreach initiatives toward eliminating the organizational, structural, and provider-based barriers that Latino Americans face should help improve the health status of this growing population. Only by investing in a multifaceted approach that addresses barriers to health promotion and disease prevention specific to the Latino population can we ensure that this population obtains high-quality health care. The payoff, if the initiatives are successful, will be the eventual elimination of racial and ethnic disparities in health care and the improvement of health care not only for the Latino population but for all individuals in the United States.

REFERENCES


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EDITORIAL BOARD
Can’t much of the disparity in health care for Hispanics be explained solely by socioeconomic factors and lack of access?

BETANCOURT
Although lower levels of education, lower socioeconomic status, and inadequate access are all major contributors to disparities in health care and cardiovascular outcomes, these factors are clearly not acting alone. During my tenure working on the Institute of Medicine Report on Equal Treatment, it was readily apparent that after controlling for socioeconomic status and access issues, significant differences in the quality of care received varied by the patient’s race and ethnicity. Thus, even if they weren’t the most underinsured population in the United States, I believe that the language barrier as well as cultural issues would still place Hispanic families at higher risk for suboptimal health care.

EDITORIAL BOARD
If financial constraints allowed you to focus your efforts on only one of the factors responsible, which would give you the most “bang for your buck”?

BETANCOURT
Of the 44 million uninsured Americans, 11 million are Hispanic. Because Hispanics comprise 25% of the uninsured despite representing only 13% of the population, as a starting point I would probably invest in improving access to care. I can’t emphasize enough, however, that research has identified a number of challenges. Although it is important to make investments in access and improving economic opportunities, other improvements must be accomplished within the health care setting to reduce the disparities. Such interventions would not necessarily have to be tailored toward any particular population. For example, support of interpreter services and/or cultural competence training benefits all ethnic groups.

EDITORIAL BOARD
What are your thoughts about “acculturation”?

BETANCOURT
Acculturation has had a “mixed” impact on the health of Hispanic patients. On one hand, as people become more fluent in the language, more fluent in the customs, and gain a better understanding of how the health care system works, they tend to become more adherent with taking medication and will achieve better outcomes. On the other hand, acculturation also can have a detrimental effect on health. For example, it has entailed adoption of unhealthy eating habits and a diet loaded with fat and “fast foods,” which, in turn, has fostered obesity and the development of type 2 diabetes mellitus. Thus, acculturation has been a doubled-edged sword—by improving the navigation of our health care system and adherence to treatment, it has improved health; through adoption of our dietary practices, it has proved detrimental to health.

EDITORIAL BOARD
How prominent a position should ethnicity assume in the medical record?

BETANCOURT
Its inclusion is important because the collection of race and ethnicity data within health care allows us to better monitor disparities and outcomes. However, it has been largely debated as to where to put such information. Should ethnicity be included at the beginning of the medical record, “This is a 72-year-old Hispanic man, with a medical history of diabetes and hypertension...” or should it be added to the social history, “This gentleman is Hispanic and has come from this country and immigrated during this time...”? It’s played both ways. Some believe that putting this information in the
history of present illness might be an unnecessary tangent and thus would put it there only if it were relevant to the illness, for example, an African American with sickle cell. Although this issue still creates tension for many people, I think there is universal agreement that ethnicity belongs in the medical record.

EDITORIAL BOARD
Why do you think that groups like the American Association of Medical Colleges (AAMC) have been so unsuccessful in attracting Hispanics into the health care professions?

BETANCOURT
I think it's because the problem does not rest solely at the level affected by groups like the AAMC. Looking at the educational pipeline, you'll find that only ~50% of Hispanics graduate from high school, and as you move up the pipeline, the number of Hispanics decreases further. This problem is compounded by the fact that a few years ago, 10% of Hispanics who were accepted to medical school chose not to go. I think, as suggested in our last IOM (Institute of Medicine) Report, that greater attention and efforts have to be focused earlier in the educational pipeline. To have a greater impact, medical educators need to be more involved in the various programs nationwide that groom students at a young age and cultivate their interest in the sciences and future careers in health care professions, whether it is medicine, dentistry, nursing, psychology, or public health.

EDITORIAL BOARD
There is a subset of the population that might regard any effort to recruit minorities as a form of "affirmative action" and react negatively to it. How would you address such a response?

BETANCOURT
Some terms are "hot buttons"; once you say them, no matter how you explain it, it's difficult for people to get past that initial hot-button reaction. People bristle at the term affirmative action. To many, it means taking people who aren't qualified and, solely based on their race or ethnicity, moving them up, above others who are more qualified, or giving them an opportunity they don't deserve. That is not what we are talking about, which is why I think we try to choose our terms very carefully. We are aiming to develop and recruit a highly qualified pool of minority students to become physicians. Similarly with cultural sensitivity, I think the field has evolved significantly to
be about more than just political correctness, making people nicer, or teaching them the best ways to care for the Hispanic patient. Instead, it is now about giving providers a set of tools and skills to add to their tool bag, add to their review systems, and improve the social history, in a much more evidence-based fashion. We are positioning the issues of cultural competence and diversity in the health care system in these ways to make them more palatable.