Barriers to Health Care Encountered by Hispanics: A Case Study Using the Immunization Division of the Texas Department of Health and the Clinics of the Austin-Travis County Health and Human Services Department

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CHAPTER I
Introduction

ON A PERSONAL NOTE...

I am Hispanic. I don't necessarily fit the stereotype, however, and therefore can not completely relate to the struggles that many Hispanics do face. (For example, I have light brown hair, light skin and blue eyes. I have never been treated differently because of the color of my skin because most of the time people assume I am white.) Nonetheless, I am very aware that the struggles are real. I work for the Commissioner's Office of the Texas Department of Health and not a day goes by when I do not encounter first hand or hear about Hispanic people in need of health care services. More often than not, **they are** in **need of services that are available** but for whatever reason, they are not receiving them. This intrigued me tremendously.

After giving it some thought, the obvious came to mind. The Hispanic people I was encountering were not receiving the health care services they needed because of some type of barrier. Hence the topic for my applied research project. Barriers to health care are a problem because good health should not be based on people meeting certain criteria; good health care should be available for anyone who desires or needs it.

INTRODUCTION

Despite improvements in levels of access to medical care among Hispanics, there is an abundance of evidence that suggests this group continues to experience barriers to obtaining care.

> Because of such diversity, the ability to meet the health care needs of Hispanic communities has been a major challenge for health care professionals. In large part this is because health services models are based on conceptual frameworks developed for the general population. (COSSMHO 1995, 300)

The need to develop models to meet the specific needs of Hispanic communities is great. Health care professionals are realizing that there is no more time to waste as Hispanics are currently the second largest minority group in the U.S., with 21.4 million Hispanics representing an estimated 8.6 percent of the total population. By the year 2000, Hispanics will number an estimated 31 million, making them the largest minority group in the U.S. (Medrano 1993, 1)

RESEARCH PURPOSE

The purpose of this applied research project is three-fold. First, the barriers to health care encountered by Hispanics is detailed through a review of relevant literature, with special emphasis on the key barriers - demographics (socioeconomic status, educational achievement), language, and culture. Secondly, a case study utilizing the Immunization Program of the Texas Department of Health and clinics of the Austin-

Travis County Health and Human Services Department was conducted. A random survey was also conducted of clients of Austin-Travis County Health and Human Services Department immunization clinic(s). This survey measures client perceptions, if any, of the barriers that Hispanics face in obtaining health care services in general. Finally, recommendations to address the problem of barriers to health care encountered by Hispanics are developed. The recommendations are a synthesis of the empirical results of this study with expert recommendations discovered in the literature review.

REPORT STRUCTURE & CHAPTER SUMMARIES

Chapter I has provided a general overview of the paper and the research purpose. Chapter II details the Hispanic community regarding demographics (socioeconomic status and educational achievement), language, culture (including family and alternative treatment), health care status (including perception of illness), and utilization of health care services. The top three barriers to health care encountered by Hispanics will be highlighted. The chapter also details the conceptual framework of the applied research project.

Chapter III sets the tone for the research setting and offers an overview of the Immunization Division of the Texas Department of Health and its relation to the Austin-Travis County Health and Human Services Department. Although a case study was conducted, it was not done in the true sense of the word. The

Immunization Division and clinics of the Austin-Travis County Health and Human Services Department are used for their access to the Hispanic population. The case study highlights the clients of immunization clinics, which mostly serve lower income Hispanic populations, and thus allows for appropriate information to be gathered. The chapter also briefly touches upon Hispanic demographics in Texas.

Chapter IV provides insight into the research methodology and highlights the survey instrument used. The survey seeks to measure client perceptions, if any, of the barriers that Hispanics face in obtaining health care services. The method of choosing the sample is also highlighted.

Chapter V presents the findings from the empirical research and offers an analysis of such data. The chapter also discusses whether the findings supportlnot support the working hypotheses.

Chapter VI gives a summary of the applied research project and synthesizes the expert recommendations discovered from the literature review with the findings from the empirical portion of the research.

CHAPTER II
Literature Review

PURPOSE

The purpose of this chapter is three-fold: (1) to provide an overview of the Hispanic Community, (2) to detail the top three barriers Hispanics face in receiving health care services, and (3) to detail the conceptual framework for this applied research project. This chapter will contribute to the overall applied research project because it provides the means by which the working hypotheses were formed.

THE TERM HISPANIC: WHAT DOES IT MEAN?

Both in the popular press and the professional literature, the term 'Hispanic' is used in diverse and sometimes inconsistent ways.

Ginzberg (1991, 239) believes that

> the conventional health care paradigm in the United States has distinguished between the white majority and the sizable and easily identified black minority. Until recently, much less attention has been paid to the health care needs of Hispanics. The health status of Hispanics, by subgroup and by gender, has thus far been insufficiently analyzed because of the late start of federal and state bureaucracies in collecting health data based on ethnic background.

In fact, the term 'Hispanic' "is a generic term, officially created by the U.S. Bureau of the Census to designate persons of Spanish origin or descent. The term Hispanic barely existed in U.S. statistics prior to 1970…" (NCHHHSO 1990, 9)

> Although people of Hispanic origin are united by a common language, typically have a Catholic religious background, and are characterized as emphasizing family relationships, there is no one Hispanic culture. Country of origin, recency of immigration, and geographical location within the United States contribute to the cultural diversity within the Hispanic population. The Spanish language unites most people of Hispanic descent, but a wide array of preferences and ability exist among these people in their use of Spanish and English in speaking, reading, and writing. (CDC 1994, 5:7)

Because of such diversity, the ability to meet the health care needs of Hispanic communities has been a major challenge for health care professionals. In large part this is because health services models are based on conceptual frameworks developed for the general population. Frequently, in delivering health services, practitioners and planners depend on models that have been successful in non-Hispanic white communities rather than models developed to meet the needs of Hispanic communities. This results in the well-intentioned health provider often being frustrated with the lack of success these models have when dealing with Hispanic communities. (COSSMHO 1995, 300)

Evidence suggests that the Hispanic community has a high level of distrust for the health care system. Many believe that the system often discriminates

against them. For example,

- ✗ 27% believe they face discrimination in the quality of health care to which they have access;
- ✗ 30% believe they are not treated with respect at clinics; and
- ✗ 28% believe they do not have the same opportunities as others in obtaining health care information.

Overall, 22% of Hispanics believe they run into discrimination when seeking health care services. (COSSMHO 1995, 309)

Despite improvements in levels of access to medical care among Hispanics, there is an abundance of evidence that suggests this group continues to experience barriers to obtaining care. The barriers most often cited include low levels of education, occupational status, sociocultural predispositions, family reliance, cost of medical services, and lack of a regular source of medical care and health insurance. (Andersen, Giachello, and Aday 1986, 238-239) Each barrier will be discussed in further detail later in this chapter, with special attention paid to the top three (3) barriers - demographics (socioeconomic status/educational achievement), language and culture.

THE HISPANIC COMMUNITY

Novello, Wise and Kleinman (1991, 253) suggest that

> the term Hispanic is, too often, used simplistically refemng broadly to all populations with ancestral ties to Spain, Latin America, or the Spanish-speaking Caribbean. Such uncritical ethnic labeling can and may obscure

> the diversity of social histories and cultural identities that characterize these populations and, in turn, can influence health behaviors, the way care is accessed, and ultimately, health outcomes.

The Hispanic population has diverse national origins and cultures. Persons of Hispanic descent may have recently moved to the United States or their families may have lived in the United States for centuries. Hispanics may be bilingual, speak only English, speak only Spanish, or speak a little of both. (Council on Scientific Affairs 1991, 248) It is important to understand these differences in order to appreciate that Hispanics have a different need in receiving health care than the average population. This particular need is due to many factors; namely, differences in demographics, language, cultural beliefs and health care status.

Demographics

Currently the second largest minority group in the U.S., the 21.4 million Hispanics represent an estimated 8.6 percent of the total population. The age composition of the Hispanic community is marked by its youthfulness. The median age of the Hispanic population is 26.0 years, compared with 35.5 years for non-Hispanic whites. (COSSMHO 1995, 301) The young age of the Hispanic population, and the fact that its growth rate is seven times greater than the general population, will help shape the demographics of the nation in the

generations to come. By the year 2000, Hispanics will number an estimated 31 million, making them the largest minority group in the U.S.

Hispanics are broken down into five subgroups (See Table 2.1). Over three fourths of U.S. Hispanics trace their origin to Mexico (62.6%) and Central/South America (13.8%). (Medrano 1993, 1)

Table 2.1
Hispanic Representation by Subgroup
(Percent Distribution)

Subgroup	Representation
Mexican American	62.6%
Puerto Rican	11.1%
Cuban	4.9%
Central/South American	13.8%
Other	7.6%
TOTAL	100%

Although some Hispanics live in each of the 50 states, the vast majority (over 70%) reside in six of the most populous states: 34.4% reside in California, 19.4% in Texas, and less than 9.9% each in New York, Florida, New Jersey, and Illinois. (Ginzberg 1991, 238) Ginzberg also adds that compared with the non-Hispanic whites, Hispanics are concentrated in metropolitan centers, particularly inner cities.

Several linkages can be made between these geographic characteristics. For example, Ginzberg (1991, 238) asserts that the overrepresentation of

Hispanics within the inner cities of metropolitan areas suggest that most of them live relatively close to hospitals and clinics. This overrepresentation in inner cities relates to the fact that Hispanics have lower incomes and educational achievement than whites. The majority of Hispanics therefore tend to work blue collar jobs because they have attained less education than whites, hence, they are more likely to have lower pay and little or no health insurance. Their overrepresentation in areas that are relatively close to hospitals and clinics means that these hospitals and clinics are relatively convenient and offer them services that they could not otherwise get elsewhere. A closer look at Hispanics socioeconomic status and educational achievement can give a better picture of their plight to obtain adequate health care services.

Socioeconomic Status and Educational Achievement

"It has long been understood that the quality of health care, [including life], available to different groups is influenced by their socioeconomic status, specifically their level of education, occupational achievement and income." (Ginzberg 1991, 238) As is evident in Table 2.2, a particular disadvantage of the Hispanic population, many of whom are first generation in the U.S., is the large gap between their level of educational achievement and that of the white majority.

Table 2.2
Years **of Schooling** by **Racial Ethnicity** in **1987 (percentage)**

Race	< 5 years of school	≥ 4 years of HS
White	2.0	77.0
Hispanic	11.9	50.9
Mexican	15.4	44.8
Puerto Rican	10.3	53.8
Cuban	6.1	61.6
Other	5.7	61.5

The **9.9%**gap between Hispanics and whites with less than **5** years of school is staggering; as is the **27.9%**difference between Hispanics and whites with more than 4 years of high school.

It is often this below average educational achievement that in turn results in less favorable occupational status and lower income levels for Hispanics. Medrano **(1993: 1)** states that Hispanic families are **2.9** times as likely as white families to live in poverty. And even with a working householder, Hispanic families are 17% as likely to live in poverty, compared with **5.9%**for non-Hispanic whites. Hispanics' median income is **26.8%(\$22,330)** less than the median income of non-Hispanics **(\$30,513).** Less educational achievement may also contribute to the limited understanding of the U.S. health care system.

The level of poverty among Hispanic families is not due to low participation in the labor force. In fact, Hispanics **(66.5%)** are just as likely as

blacks (63.3%) and whites (66.7%) to participate in the labor force. Rather, their higher incidence of poverty is due, in part, to their lower educational achievement. In addition, Hispanics are more likely (47%) to occupy blue-collar jobs where they have limited or no health insurance coverage. (COSSMHO 1995)

These demographic characteristics form the framework in which Hispanic families seek to improve their health and well-being. Overall, demographic data for Hispanic communities depict a large, diverse, youthful, and growing population. This population, while participating in the labor force, continues to face disparities with the general population. One such disparity is receiving inadequate health care services due to language barriers.

Language

As mentioned earlier, the Council of Scientific Affairs found that Hispanics may be bilingual, speak only English, speak only Spanish, or speak a little of both. Whichever is primarily spoken, numerous studies have found language to be one of the principal barriers to health care for Hispanics. Trotter (1988: 7) maintains that

> communication forms the basis for effective health care. It is important to ensure that people receiving health care are spoken to in their own language. And while a lot can be communicated nonverbally (respect,

> caring, concern), a need often arises for specific verbal communication in primary health care service delivery. These situations usually require translation.

Unfortunately, using a translator is not as easy as it sounds; it requires skill on the part of both the health professional and the translator.

Trotter (1988: 8-9) suggests that

> one major problem in translation is using someone simply because he/she knows the Spanish language. When using translation, it is important to use a translator who has been trained in conceptual transfer of information. Since no two languages are identical, the translator has to make sure that a conceptual transfer, not just a literal translation, has been made. In a health care setting, the transfer is often from technical clinical concepts in one language to acceptable social terminology in a second language. This means that the translator must know the technical concepts, preferably in both languages, and know how to change them into terms that the patient will understand.

Given the importance of interpersonal relationships, it becomes essential to have a match between a patient's language and the various health care providers who will care for them. Research indicates that 78.3% of Hispanics are likely to report a preference for speaking Spanish in a wide variety of settings, particularly the home. (COSSMHO 1995, 307)

Research also indicates that

> the quality of care afforded to Spanish-speaking patients is improved by having a language concordant physician. Hispanics are also more likely to be uncomfortable discussing their health concerns if they do not believe they have mastered enough English to express their feelings about their illness appropriately. (COSSMHO 1995, 307)

Despite this need for language concordant physicians, there is a shortage of Spanish-speaking health providers, and Hispanic health professionals in general. This situation is not expected to improve any time soon, because studies indicate severe underrepresentation of Hispanics' enrollments in professional schools, particularly medicine. (Andersen, Giachelli, and Aday 1986, 242)

Language barriers are only a part of the problem when English is the primary language spoken by health care staff. Spanish is a language, but it is also seen as a symbol of cultural tradition and existence as a social group. (Jaramillo and Erkel 1990, 24) Cultural differences are another major barrier that Hispanics face in receiving adequate health care services.

Culture

The National Coalition of Hispanic Health and Human Services Organizations (1995: 305) points out that

> to understand how pervasive the influence of culture is in health care, imagine yourself in need of health care in a part of the world where you don't understand the language spoken and very few of the locals understand the language you speak. Your physical characteristics cause you to stand out from the crowd. The values and beliefs of the local population are much different from your own. The health care system based on the values and beliefs of the locals seems hopelessly bureaucratic and sometimes hostile to you. Welcome to the culture of the U.S. health care system as viewed by many Hispanics.

Too often, health care providers do not take culture into account in the total scheme of providing adequate health care. The impact of culture needs to be seriously revisited because denying its impact has had and could have further implications for the health status of the Hispanic community as a whole.'

"Culture functions as a framework in which one operates throughout his or her daily life. It serves as a means of defining the relationship of the individual to the environment and to other individuals." (COSSMHO 1995, 305) Cultural differences help determine everything, including what foods to eat, what clothes to wear, how to behave toward certain people, and even where to go when ill. Such decisions are strongly influenced by the ideas, beliefs, and customs passed down to Hispanics by their families.

Family

Many people from Western cultures put the preservation of the family and their role in it above their own needs as individuals. This cultural theme is prevalent among Hispanics. The National Coalition of Hispanic Health and Human Services Organizations (1996: 306) states that

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1 It should be noted, however, that culture should not be seen as fully determinative of an individual's behavior. This information does not imply that Hispanics believe and behave in the same way. Simply, this information presents prevalent cultural behavior...the job of the health care provider is to become sensitive to the values and beliefs within the population and among the patients being served.

> in Hispanic culture the family is conceived of as more than the immediate family. Rather it is primarily thought of as...an emotional support system, composed of a cohesive group of lineal and collateral relatives, where members can find help on a regular basis and rely on relatives more than on external sources of support. This compares to the Anglo-American conception of family, in which the distinction between immediate and extended family is more sharply drawn. Family is commonly thought of to mean the nuclear number of extended family relatives. In addition, individualism is of ovemding importance among Anglo-Americans and does not easily allow subordination of individual interests to those of the family as a whole, as is common among Hispanics.

The Hispanic family plays a very significant role in the delivery of health care to Hispanics. The values of the extended family need to be considered when providing care to an Hispanic patient. It is also important for health care providers to understand the perceptions of illness and the expectations Hispanics have of a health care professional as a care giver. When Hispanics "evaluate care received, they value a good bedside manner as especially important in their treatment. They expect a curer to be reassuring, understanding, sympathetic and to care what happens to them. They believe that if the curer has no interest in the patient, the curer may not really be trying to help them." (Jaramillo and Erkel 1990, 25) For example, to validate this way of thinking, a study was conducted in 1976 by I.C. Lee of 50 Hispanic families who were asked if they preferred medical staff of their own ethnic background. Ninety percent of American- and Spanish-born groups answered that ethnic background did not matter as long as the medical staff were sincere in taking care of them.

Alternative Treatment

'Folk Medicine' evokes images of witch doctors. This picture is flawed, however. Folk medicine simply means 'lay medicine' or 'medicine of the people.'

Although some people who use folk medicine may belong to particular cultures, others are average middle-class Americans who use old family recipes or are seeking more natural remedies. In the Hispanic culture, folk medicine is known as ***'curanderismo,'*** one of the largest and most widely used formal systems of folk medicine.

> *Curanderismo* is a mixture of American Indian, medieval Spanish medicine and the Christian belief system. ***Curanderos*** (folk healers) are not formally trained, however they are members of the community that have learned its medical lore and, therefore, are regarded as specialists. (Jaramillo and Erkel 1990, 25)

Within this Hispanic subculture there are a different set of health beliefs and health practices. These health practices, for example, include the use of herbs, teas, home remedies and the use of *curanderos* for health care treatments. Health beliefs include (1) the belief that God can and does heal and that people with a special gift can and do heal in His name, (2) a belief in the existence of mystical disease, such as '*susto*' (fright or lost soul) and '*mal puesto*' (hexing), and (3) a belief in three levels of health and illness - the material, the spiritual, and the mental. (Marsh and Hentges 1988, 257) Not surprisingly, the

curanderismo system is seen by many Hispanics as having a 'cultural fit.'

> It meets the important needs of the sick person, often by involving the family in the healing process [therefore reaffirming the cultural importance of the role of the family]. The healer uses the same language and is usually from the same cultural background as the patient. Both share the same set of assumptions about causes of illness and treatments. (Jaramillo and Erkel 1990, 25)

The ***curandero's*** approach is to present treatment alternatives to the family then "simply to listen while the family decides on the best course of treatment and then to offer his support." (Reinert, 26-27) The ***curandero's*** treatment differs drastically from that of the mainstream physician who asks embarrassing questions, often does not take family view points and concerns into account, and then dictates the treatment.

The care and treatment by a ***curandero*** takes place in the community, is not limited to office hours, and is usually paid for in the form of a donation. This type of 'health care' is therefore generally within the means of indigent families when compared to the expensive scientific medical treatments.

Although the use of ***curanderos*** is still very much a practice in many Hispanic communities, it has been found that "Hispanic patients may consult a folk healer at any time during their illness, irrespective of contacts with orthodox medical practitioners." (Jaramillo and Erkel 1990, 25)

Jaramillo and Erkel (1990: 25) contend that "health care providers may be delivering less than quality health care if they ignore the cultural belief system of Hispanic patients, whether deliberately or through ignorance." In addition to demographic, language and cultural differences among Hispanics and non-Hispanics, there lies a difference in health care status and the perception of illness.

According to the experts, it is equally important to understand the Hispanic clients' views on what is and is not appropriate treatment by a health care provider. For example, "the Hispanic male is the traditional head of the family and his sense of ***machismo*** requires that he be consulted before any decisions are made." (Reinert, 30) Modesty is also important to the Hispanic patient. For example, discussion of issues involving certain body parts and sexual matters may put patients ill at ease if the health care provider is of the opposite sex.

The National Coalition of Hispanic Health and Human Services Organizations (1995: 309) states that

> to counteract negative experiences, health care providers need to be aware of and sensitive to the needs and concerns of Hispanic communities. If providers cannot accept the clients' belief system, they should at least listen and respect it, because...a thorough knowledge of these cultural factors will certainly offer physicians a unique understanding of the patient's conceptualization of his illness, and thus will give him a better chance of insuring treatment, compliance and cure.

Health Care Status

In order to understand how health care differs between Hispanics and non-Hispanics, it is important to compare their health care status differences. Table 2.3 offers a comparison of life expectancy between whites and Hispanics. (Medrano 1993, 1)

Table 2.3
Comparison of Life Expectancy between Whites and Hispanics

All White Males	71.8 years
All Hispanic Males	69.8 years
All White Females	78.6 years
All Hispanic Females	77.1 years

As is evident from the table, Hispanic males and females have lower life expectancy than their white counterparts. This may be due to differences between whites and Hispanics in other areas of illness. For example, cardiovascular disease, cancer and diabetes. The following charts depict such differences in health care status. (Office of Minority Health, TDH, 28-29) Note that the 'age adjusted death rate' refers to the fact that the death rates were statistically adjusted in order to make the three races similar in age distribution for comparison purposes.

Chart 2.1: Cardiovascular Disease
(Age Adjusted Death Rate)

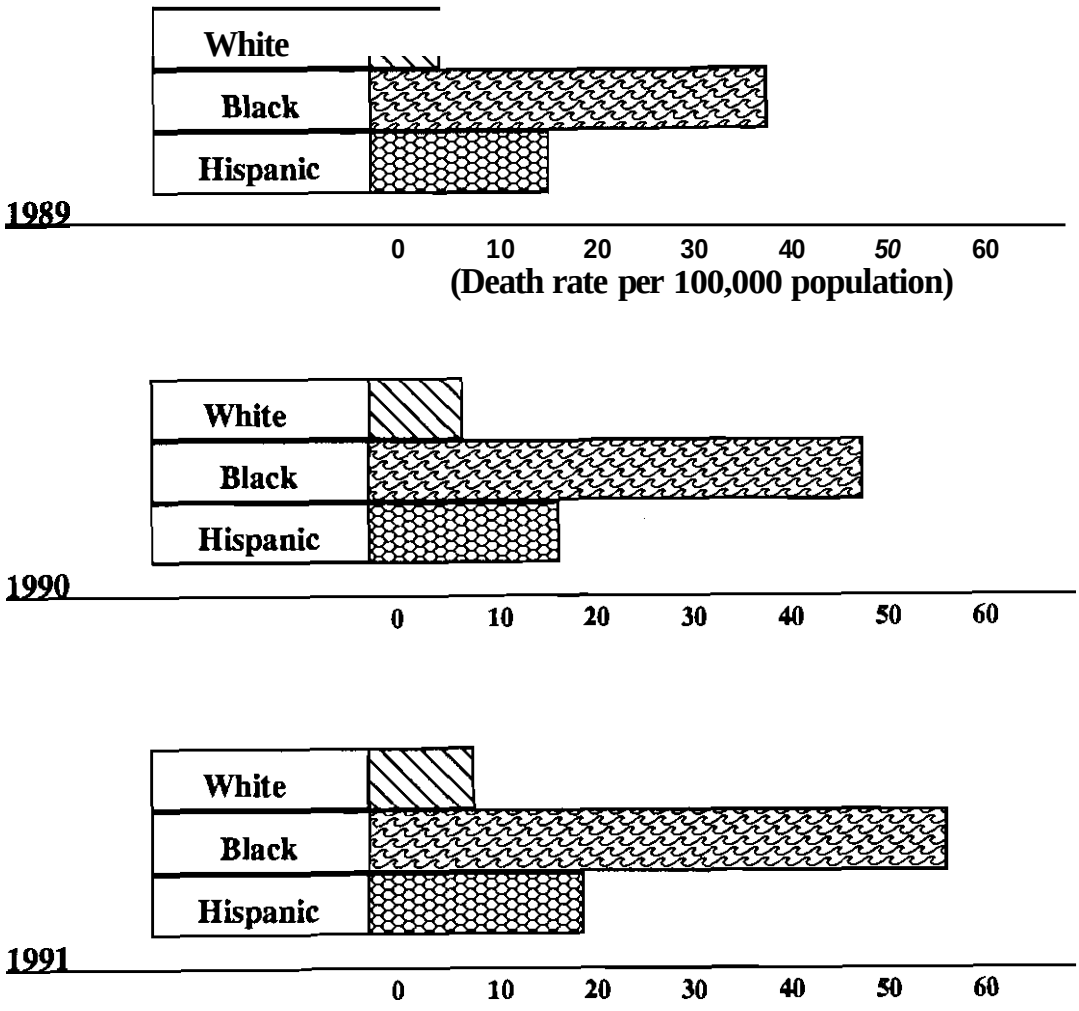


Chart 2.2: Cancer
(Age Adjusted Death Rate)

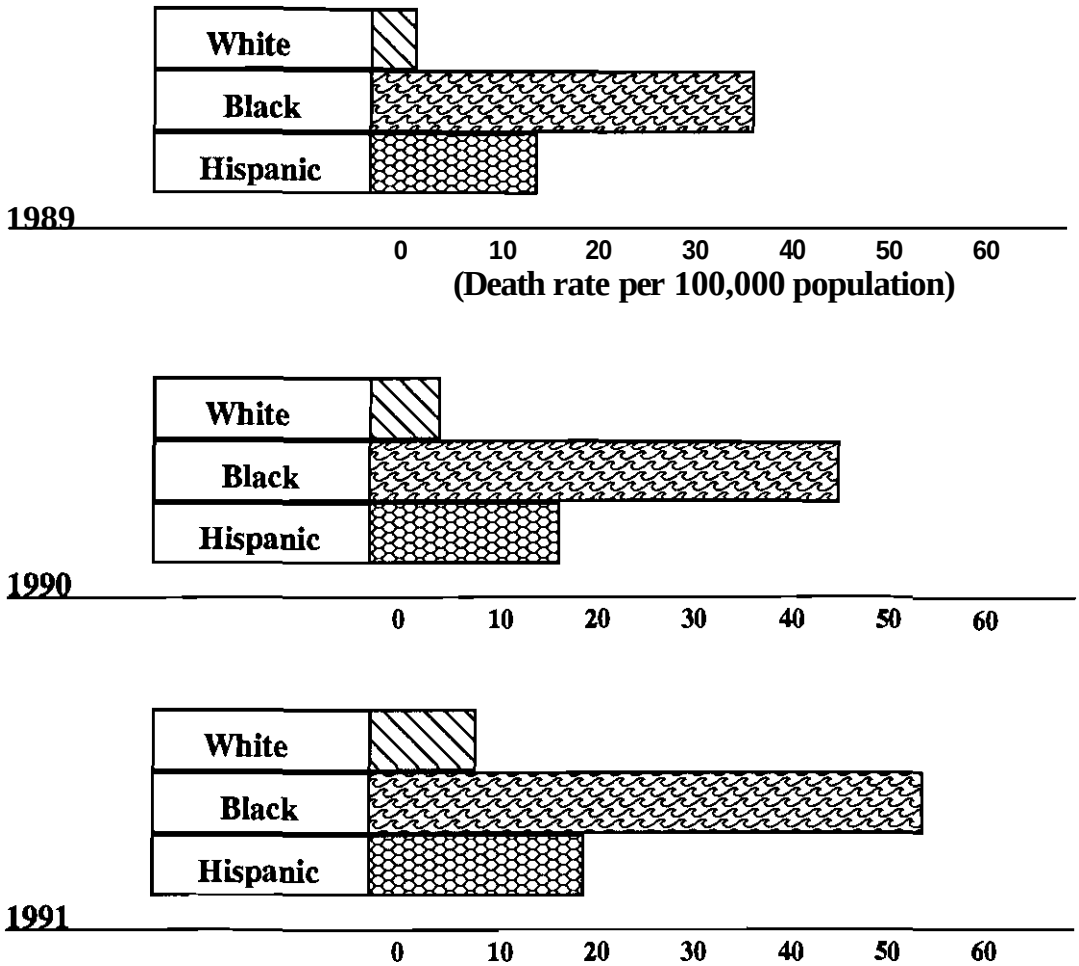
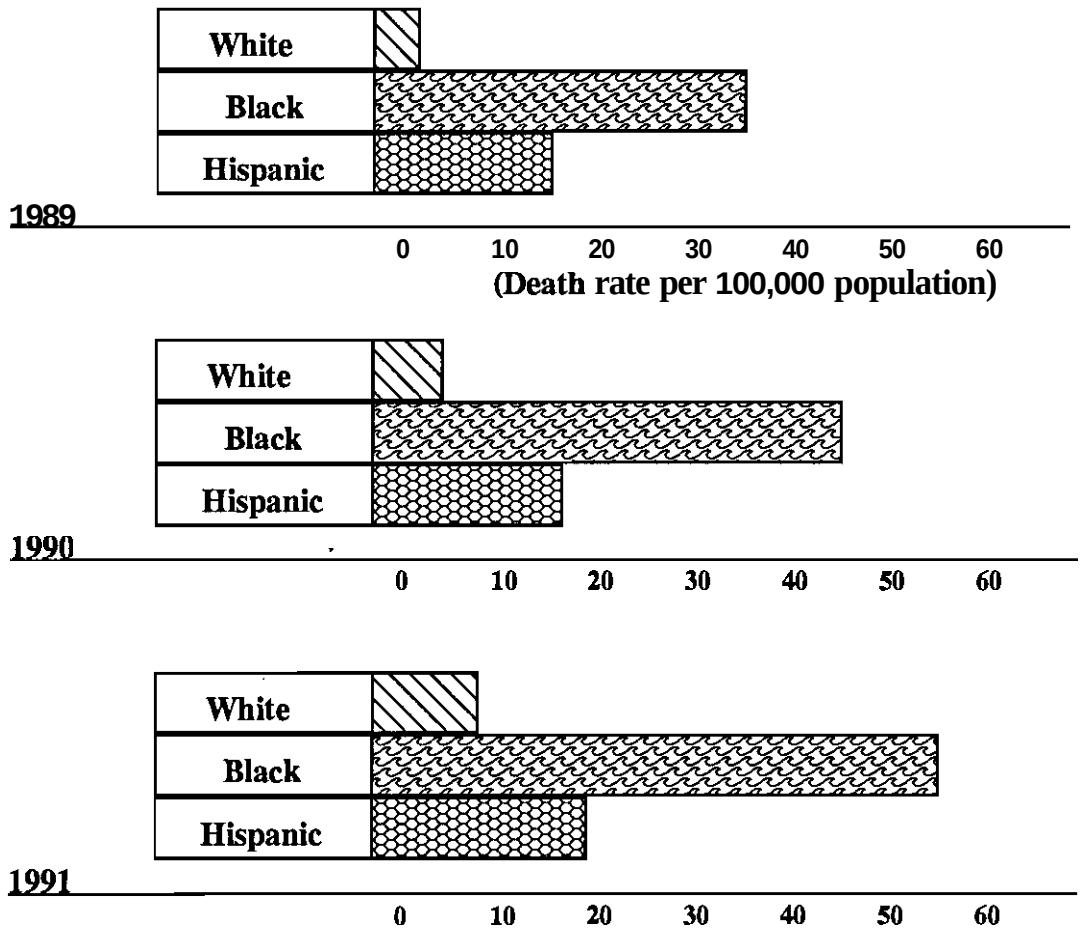


Chart 2.3: Diabetes
(Age Adjusted Death Rate)



As is evident from charts 2.1 - 2.3, Blacks have the highest death rates of

cardiovascular disease, cancer and diabetes but Hispanics have substantially higher rates than whites. This may be attributed to the fact that Hispanics' perception of illness differs as well.

Perception of Illness

Hispanics' perception of illness is as a state of discomfort.

> They see good health as a strong body, the ability to perform normal activities and the absence of pain and discomfort. Persons with disease that have no outward symptoms...are perceived to be healthy. This makes prevention a hard concept for Hispanics to accept. (Jaramillo and Erkel 1990, 25)

The implications of such a perception and the concept of preventive medicine can be great. Many Hispanics will try to be strong and deny illness until acutely ill. As such, many times preventable and/or treatable diseases are detected too late.

Another factor that influences the perception and concept of preventive medicine is the difference in drug laws between Hispanic countries and the U.S. Many foreign-born Hispanics may be use to obtaining drugs that require a prescription in the United States but are sold as over-the counter-medications in their country. (CDC 1994, 5:7) This ease in obtaining drugs has led to the increased likelihood of 'self-treatment' and as such, physicians are unable to observe problems in their earlier, more treatable stages.

Differences in perception of illness and the concept of preventive medicine between whites and Hispanics can also help to explain the differences between utilization of health care services.

UTILIZATION OF HEALTH CARE SERVICES

Despite steady improvements in the health status of Americans in general, Hispanics in the United States continue to be at greater risk for health problems. (Solis, Marks, Garcia and Shelton 1990, 11) This greater risk may be attributed, in part, from underutilization of health care services, particularly preventive services. Several hypotheses have been derived to try to explain this underutilization,

The first is that ***the levels of acculturation (theprocess of change that occurs as a result of continuous contact between cultural groups) of Hispanics influence their utilization patterns***. (Solis, et al, 1990, 11) These authors go on to state that

> although such a broad definition does not specify the types, degree, or direction of change expected, studies have largely presumed that Hispanics who have adopted the behavioral practices and values of the dominant society are more likely to utilize health services.

The second hypothesis is that ***the use ofpreventive health care services is***

attributed to access factors that influence the ease with which medical care can be obtained) to care. (Solis, et al, 1990, 11) For example,

> such factors include the availability of health insurance, having a routine place of care and a regular provider, the type of health care facility used and its proximity to residence. Evidence shows that compared to the general population, Hispanics are less likely to have health insurance coverage and less likely to have a routine place for obtaining health services. (Solis, et al, 1990, 11)

Other potential access barriers that have been identified in relation to low utilization of health care services by Hispanics include lack of transportation, geographic inaccessibility, financial constraints such as the cost of health care and limited health insurance coverage, and isolation from the mainstream culture.

The cost of health care and limited health insurance coverage are two areas that need to be discussed further. Hispanics have lower incomes and tend to support larger families, hence they often have less disposable income to pay out-of-pocket expenses for health care. One segment of the population affected the most by this is the working poor - those who are not eligible for government programs because they make too much but still do not make enough to afford the high cost of medical care. "Despite their lower incomes, Hispanics spend proportionally more of their disposable income on health care. Yet as a group, Hispanics are more likely than the general population to be uninsured. (Council

on Scientific Affairs 1991, 249) Even those employers who offer some form of health insurance often offer it in limited amounts. In addition, co-payments are often so high that many Hispanics cannot afford to pay them.

Also, Hispanics receive the largest portion of their health care from large, public hospitals that have rotating staff, particularly for patients on Medicaid or other public funding. In such settings, patients can rarely experience continuity of care.

CONCEPTUAL FRAMEWORK

This applied research project is exploratory in nature and includes working hypotheses with descriptive categories. The descriptive categories are the top three barriers: (1) demographics (socioeconomic status/educational achievement), (2) language, and (3) culture. These barriers have been identified as the top three as a result of research conducted for this literature review.

The empirical research will test the following working hypotheses:

Demographic Factors WH1	It is expected that Hispanic clients of immunization clinics will maintain that **demographic factors** affect the quality of their families health care services.
Socioeconomic Status WH1a	It is expected that Hispanic clients of immunization clinics will maintain that **socioeconomic status** affects the quality of their families health care services.
Educational	It is expected that Hispanic clients of immunization

Achievement WH1b	clinics will maintain that their **educational achievement** affects the quality of their families health care services.
Language WH2	It is expected that Hispanic clients of immunization clinics will maintain that **communication** in **Spanish** influences the quality of their families health care services.
Culture WH3	It is expected that Hispanic clients of immunization clinics will maintain that **cultural differences** determine when, where, and if their family seeks health care services.

The following chapter will set the tone under which the research to test these hypotheses was gathered.

CHAPTER III
Research Setting

PURPOSE

The purpose of this chapter is to describe the research setting. It provides an overview of Texas demographics and a brief history of the Texas Department of Health (TDH). In addition, the reason clients of Austin-Travis County Health and Human Services Department clinics, in conjunction with the Immunization Division of TDH, were chosen to conduct the empirical research for this applied research project is explained.

TEXAS DEMOGRAPHICS (w/an emphasis on Travis County)

Texas is not only large, but offers much environmental, cultural, and economic diversity. With regards to health care it is just as diverse. Through TDH, Texas is divided into 8 public health regions (PHR): PHR 1 is located in Lubbock, PHR 2&3 in Arlington, PHR 4&5 North in Tyler, PHR 6&5 South in Houston, PHR 7 in Temple, PHR 8 in San Antonio, PHR 9&10 in El Paso, and PHR 11 in Harlingen. The Texas Department of Health and the Austin-Travis County Health and Human Services Department are geographically located in PHR 7.

PHR 7 contains the following counties: Bastrop, Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Caldwell, Coryell, Falls, Fayette, Freestone, Grimes, Hamilton, Hays, Hill, Lampasas, Lee, Leonl, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Washington, and Williamson. Although Travis County is geographically located in PHR 7, health care services are not provided by TDH because it has its own local health department for the fundamental provision of public health services. Services provided by and funding for the Austin-Travis County Health and Human Services Department are therefore independent of the Texas Department of Health. However, they are connected with TDH as a vehicle to the Centers for Disease Control and Prevention and for general program guidance.

The total population for PHR 1 in 1990 was 1,160,521. Table 3.1 depicts the population broken down by age and ethnicity. (Immunization Action Plan Grant Application, TDH, 1993) As the table shows, Hispanics are the least represented in PHR 1 in comparison with whites and blacks. Nonetheless, their presence in the Region is strong. For Hispanics in general, the largest representation is in the 'over 64' age category, followed by ages 18-44.

Table 3.1
Public Health Region 7 Population by Age and Ethnicity

Age	Anglo	Black	Hispanic	Total	Percent
0-5	68,689	17,946	20,983	107,608	9.11
6-17	162,566	32,664	25,283	220,533	18.68
18-44	393,075	65,277	57,084	515,436	43.65
45-64	156,623	17,839	13,518	187,980	15.92
Over 64	125,305	17,122	68,791	493,061	2.64
TOTAL	906,258	150,848	123,757	1,180,863	100

The average per-capita income for PHR 7 in 1990 was $11, 273.38. This average depicts a region with a high rate of poverty. In fact, 17.75% (206,020) of the population in 1988 lived below the poverty level; 43.06% (499,716) below the 200% poverty level. (Immunization Action Plan Grant Application, TDH, 1993)

THE TEXAS DEPARTMENT OF HEALTH

The Texas Department of Health was established in 1879 by the Governor's appointment of a State Health Officer. The States Health Officer's main duty was to execute all the requirements of the Texas Quarantine Act. The Texas Department of Health succeeded the Texas Quarantine Department created by the legislature in 1891. In 1903, the name changed to The Texas Department

of Public Health and Vital Statistics. Between 1903 and 1975, the name was changed again from The Texas State Department of Health to The Texas Department of Health Resources. Finally, in 1977, the name was changed to The Texas Department of Health (TDH), which remains to this day.

Each of the name changes reflect important and appropriate enlargements of the scope and purpose of Texas' public health agency. TDH bears the responsibility for coordinating and developing all of the state's health resources, with a mission to ***promote andprotect the health of thepeople of Texas."*** (TDH Immunization Action Plan Grant Application, 1993)

TDH operates under the direction of the Board of Health (Board), a 6 member board appointed by the Governor of Texas. The Board, in conjunction with the Governor, in turn appoint the Commissioner of Health.[2]

TDH is one of the largest agencies in the state of Texas, with over six thousand employees. About half of TDH employees work in the central complex in Austin, Texas, with the remainder located throughout the 8 regional offices, 2 hospitals and numerous sub-offices and clinics around the state. TDH has a client population of over 18 million people which it serves through the products and services of over 90 separate public health programs. Structurally,

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2 **As of January 1997,** the **first woman Commissioner of** Health **was appointed** by the **Board and the Governor to** serve **in an acting capacity until a permanent replacement is found.**

the organization is divided into 7 associateships: Health Care Delivery, Disease Control and Prevention, Environmental and Consumer Health, Health Care Financing, Health Care Quality and Standards, Information Resources and Business Management, and Human Resources and Support. (Appendix A depicts the TDH organizational chart; Appendix B the TDH Regions)

Within each associateship exist numerous bureaus, who in turn contain divisions and programs. The Immunization Division is housed under the Associateship for Disease Control and Prevention.

Immunization Division

The purpose of the Immunization Division is to

> achieve and sustain preventable disease-free environments, thereby improving the quality of life for the people of Texas and adding value to the State's economic base by avoiding substantial future health care costs and opportunity losses. (TDH Grant Application 1996, 1)

The Division's primary activities include:

1. Promoting age-appropriate immunization among Texans of all ages;

2. Supplying publicly-funded vaccines to public and private providers to ensure that immunization services are accessible and available for free or at a low cost;

3. Monitoring implementation and compliance of Texas laws mandating immunization;

4. Identifying, investigating, and controlling outbreaks of vaccine-preventable diseases through enhanced disease surveillance in conjunction with local and regional officials;

5. Assessing immunization rates of children by analyzing immunization records in health clinics and physicians' offices to improve overall immunization coverage measurement;

6. Enhancing and facilitating community and private sector participation and awareness through outreach and education; and

7. Developing and maintaining a statewide immunization registry (ImmTrac) of children's immunization histories.

Similar to the purpose of the TDH Immunization Division is the purpose of the Austin-Travis County Health and Human Services Department Immunization Program.

Austin-Travis County Health and Human Services Department

The Austin-Travis County Health and Human Services Department Immunization Program's purpose is to provide free immunizations, through the 'Shots for Tots' campaign, to children and adults throughout Austin. There are regular clinics in malls around Austin held each month, providing easy access to anyone who needs to be immunized. The clinics operate on a first come, first served basis. A total of 40+ hours of clinic times are available each week with 'user-friendly' times available in order to give working parents and non-working

parents alike an opportunity to visit the clinics.

Each clinic is staffed with a case worker and a nurse. (It is important to note that at the clinics the researcher visited for client interviews all were staffed with a Hispanic case worker and a white nurse.) The case worker is responsible for need assessment sessions. Once the immunizations needed are identified, the nurse will administer the vaccines. The case worker then follows up with paperwork and ensures that all information is accurate. The information gathered from the visit is crucial for follow-up to take place. This information is entered onto a database containing an individual's immunization records, which can be accessed by a doctor's office or school nurses at any time. This database is a cooperative effort among numerous state and local agencies in order to provide and store accurate immunization information on Texas children. Ultimately it is an effort to protect children from many serious diseases (including measles, mumps, polio, tetanus, hepatitis B and others) by ensuring that they are immunized at the appropriate ages (birth, **2, 4, 6** and **12** months, then at between **4-6** and **14-16** years of age).

CHAPTER IV
Methodology

Survey research is the method used to test the working hypotheses. Babbie (1989) is very supportive of the use of surveys for exploratory research. Survey research is particularly appropriate when the research purpose is in part to measure the perceptions of respondents to a particular question. However, Babbie (1989) does contend that survey research has both its strengths and weaknesses.

Survey research is a strong method in that it (1) provides for equal treatment of all respondents because of the use of a standardized tool, (2) provides for simultaneous analysis of a large number of cases, and (3) provides for a sample to be contacted within reasonable time constraints.

On the other hand, survey research is a weak method in that (1) its validity is generally felt to be poor, (2) the questions do not lend themselves to even minor modifications, and (3) they are somewhat superficial in terms of their coverage of often complex and large topics. This research topic is large and complex, however, the methodology chosen is most appropriate.

PURPOSE

The purpose of this chapter is to detail the methodology used for the applied research project. It highlights the survey tool used in a random survey conducted of a total of 25 clients from 3 separate Austin-Travis County Health and Human Services Department immunization clinics. The survey sought to measure client perceptions, if any, of the barriers that Hispanics face in obtaining health care services in general.

Case studies are unique in that it is possible to triangulate in order to answer the research question. A case study of the Texas Department of Health Immunization Division and the Austin-Travis County Health and Human Services Department Immunization Program was conducted, although not in the true sense of the word. It is a case study because the sample of respondents is so restricted. The Immunization Division of the Texas Department of Health was utilized for its access to Hispanic population data. In turn, the Immunization Division is utilized by the Austin-Travis County Health and Human Services Department Immunization Program for funding, as a connection to the Centers for Disease Control and Prevention, and for general program guidance. This case study was conducted assuming that clients who use the Austin-Travis County Health and Human Services Department immunization clinics obviously have children with health care needs. Therefore, these clients would have an

opinion about health care in general. The clinics visited are open to the public but tend to serve mostly a Hispanic population, thus allowing for appropriate information to be gathered.

RESEARCH

Three separate data collection periods of approximately 4 hours per session were conducted at each of the three immunization clinic locations. Unfortunately, during the time research was being conducted, no weekend clinics were offered. Research was conducted on Tuesday, March 11 at the Westgate Mall clinic, Thursday, March 13 at the Northeast clinic, and Friday, March 14 at the Northcross Mall clinic, all in Austin, Texas. These dates were chosen because they were during Spring Break and would offer the researcher an opportunity for a good sample. The age of the subjects interviewed ranges from 26 to 50 years of age.

THE SURVEY INSTRUMENT

In order to measure client perception of the barriers that Hispanics face in obtaining health care services, a questionnaire was developed with the assistance of a Texas Department of Health research associate, Rich Anne Roche, from the Associateship for Disease Control and Prevention. Ms. Roche has expertise in

the area of developing questionnaires and randomly selecting interview candidates.

The questionnaire (Appendix C) is composed of 17 items. The following table provides the operationalization of the descriptive categories and working hypotheses.

Table 4.1
Operationalization of Descriptive Categories and Working Hypotheses

Category/Hypotheses	Questionnaire Item	
General Information Gender/Age Background Information		
Birth Place	Q1	Where were you born? What about your spouse? If not in the U.S., how long have you lived in the U.S.? What about your spouse?
Parent's Birth Place	Q2	Where were your parents born? If not in the U.S., how long have they lived in the U.S.?
Quality of families health care services	Q3	How do you assess the quality of your families health care services?
WH1a: Socioeconomic Status It is expected that Hispanic clients of immunization clinics will maintain that socioeconomic status affects the quality of their families health care services	Q4	Are you currently employed?
	Q5	Is your family covered by insurance? If yes, what type? (Personal/Employer)
	Q6	The quality of my families health care services are influenced by socioeconomic status (employedlunemployed status).

WH1b: Educational Achievement It is expected that Hispanic clients of immunization clinics will maintain that their educational achievement affects the quality of their families health care services	Q7	What is the highest grade or year of school you have completed?
	Q8	The quality of my families health care services are influenced by my educational achievement.
WH2: Language It is expected that Hispanic clients of immunization clinics will maintain that communication in Spanish influences the quality of their families health care services	Q9	How well do you understand spoken English?
	QIO	How well do you speak English?
	Q1I	The quality of my families health care services are enhanced when I am communicated with in Spanish.
WH3: Culture It is expected that Hispanic clients of immunization clinics will maintain that cultural differences determine when, where, and if their family seeks health care services	Q12	The way I was raised as a Hispanic has determined at what point in a family members illness I seek health care services.
	Q13	The way I was raised as a Hispanic has determined where I seek health care services for my family.
	Q14	The way I was raised as a Hispanic has prevented me from seeking health care services for my family.
	Q15	The way I was raised as a Hispanic allows me to trust medical doctors (excluding curanderos).
	Q16	The way I was raised as a Hispanic means I sometimes take medications before consulting a medical doctor (excluding curanderos).
	Q17	I believe that curanderos are as effective as medical doctors.

ASSESSMENT OF THE SURVEY INSTRUMENT

The survey instrument was developed with questions based on the findings from the literature review to help support/not support the working hypotheses. It sought to measure the perception of barriers to health care encountered by Hispanics.

The general questions and those relating to WH1a (socioeconomic status), WH1b (educational achievement) and WH2 (language) were easily answered by the subjects interviewed. Questions relating to WH3 (culture), however, were a bit more challenging. The researcher believes part of the challenge was due to the majority of the subjects only having obtained an 11th grade education (although the questions were written with this in mind). Also adding to the challenge was the fact that cultural questions ask people about their innermost being, and therefore people have a harder time expressing themselves. Oftentimes there could be several answers to one question, with the answer depending on numerous factors.

This aspect was noted by the researcher as numerous subjects felt the need to elaborate and explain why they answered the way they did to certain questions. Their explanations included aspects of where they where raised and by whom (parents/extended family). In hindsight, the researcher believes that a separate section on the questionnaire for this type of elaboration would have

been appropriate. Such type of information would have given deeper insight into an individuals background that no closed-ended question could arrive at. Another section that might have been added in the questionnaire included asking the subjects what they would do/like to see done in order to minimize the barriers they face.

Overall, the researcher believes the survey instrument used for this applied research project measured what it was intended to measure.

THE SAMPLE

The method of selecting the sample was very basic. As previously mentioned, this applied research project is a case study because the sample of respondents is very restricted. The sample is also one of convenience. In other words, every Hispanic client who visited the clinics at the time the researcher was present was asked to be interviewed. After a brief explanation of the purpose of the interview the subjects were very willing to provide their opinions and 100% (25) of those asked to be interviewed complied.[3] The following chapter provides the findings of the interviews conducted.

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3 This may be attributed to the fact that the researcher used her Spanish maiden name and the subjects therefore felt more comfortable talking with her because they felt she could relate, or at lease understand, their opinions.

CHAPTER V
Findings

PURPOSE

The purpose of this chapter is to present the findings from the empirical research conducted of Austin-Travis County Health and Human Services Department immunization clinic clients. The findings will be presented in relation to each working hypothesis.

GENERAL INFORMATION ABOUT RESPONDENTS

Table 5.1 displays the findings from the general questions of the questionnaire. It lays the groundwork for the questions that relate to the specific barriers. Appendix D displays responses for the full sample regarding general information.

Table 5.1
General Information about Respondents

Relation to respondent	Birthplace USA	Mexico	Total (%)
Self	92%	8%	100%
Spouse	91%	9%	100%
Mother	84%	16%	100%
Father	76%	24%	100%
Average years in USA - self	22.3	NA	NA
Average years in USA - parents	30.0	NA	NA

The median age for the sample is **35.0** which actually mirrors the white population's median age **(35.5)** as a whole more so than the Hispanic population (26.0). (Refer to Demographics on page **8)** The majority **(18)** were female, while only 7 were male. The following sections will detail the results in relation to the specific working hypothesis.

DEMOGRAPHICS

Based on the literature review, it is evident that demographics have an impact on the quality of health care services obtained by Hispanics. For this research demographics specifically refer to socioeconomic status and educational achievement.

SOCIOECONOMIC STATUS

WH1a
It is expected that Hispanic clients of immunization clinics will maintain that socioeconomic status affects the quality of their families health care services

Table 5.2: Results for Socioeconomic Status

Employed		Insurance		Insurance Type		The quality of my families health care services are influenced by my socioeconomic status
Yes	No	Yes	No	Employer	Personal	
76% (19)	24% (6)	68% (17)	32% (8)	68% (17)	32% (8)	80% (20) Strongly Agree 16% (4) Somewhat Agree 4% (1) Did Not Know

It is evident that working hypothesis 1a is supported by these findings. Almost all (96%) of the subjects either strongly agreed or somewhat agreed that the quality of their families health care services are influenced by their socioeconomic status. An encouraging fact is that those who are employed (19) and have insurance (17), have insurance through their employer. Only 2 of those employed are not covered by employer insurance and are therefore having to obtain personal coverage.[4]

4 Note that personal insurance did not differentiate between just that and/or state assistance such as Medicare or Medicaid.)

EDUCATIONAL ACHIEVEMENT

WH1b
It is expected that Hispanic clients of immunization clinics will maintain that their educational achievement affects the quality of their families health care services

The range of highest grade or year of school completed was between 6th grade (elementary school) and 16 years of schooling (bachelor's degree). However, the average was 11.3. This average is very disturbing as it means that the majority of Hispanics are not graduating from high school. In fact only 9 (36%) of the 25 subjects graduated, and only 2 (8%) had a bachelor's degree. This leaves a total of 14 (56%) who achieved only an 11th grade education or less.

These results are even more alarming than those found in the literature review (refer to Table 2.2) from national 1987 data. Figures from the 1987 data show that 50.9% of Hispanics had an education greater than or equal to 4 years of high school. The figure from the sample is not so promising, as only 36% acquired an education greater than or equal to 4 years of high school.[5]

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5 It is important to note, however, that the clinics visited serve mostly lower-income Hispanic clients.

As with **WH1a,** almost all (96%)either strongly agreed or somewhat agreed that the quality of their families health care services are influenced by their educational achievement.

LANGUAGE

WH2
It is expected thd Hispanic clients of immunization clinics will maintain thd communication in Spanish influences the quality of their families health care services

Table 5.3: Results for Language Barrier

How well do you understand spoken English?				How well do you speak English?				Quality of families health care services are enhanced when communicated with in Spanish
Very Well	Pretty Well	Not Too Well	Not At All	Very Well	Pretty Well	Not Too Well	Not At All	
76% (19)	24% (6)	-0-	-0-	76% (19)	20% (5)	4% (1)	-0-	32% (8) Somewhat Agree 8% (2) Did Not Know 56% (14) Somewhat Disagree 12% (3) Strongly Disagree

Working hypothesis **2** is not supported by the findings. Only **32%** of the subjects 'somewhat agreed' with the fact that if they are communicated with in Spanish, their health care services are enhanced. Almost 70% of the respondents 'somewhat disagreed' with this statement meaning that just because

one is Hispanic does not mean Spanish is their language of choice.[6]

This working hypothesis perhaps was not supported because of the fact that 76% (19) of the subjects reported understanding the English language 'very well.' The figures for speaking the English language are a mirror image except that only 20% (5) speak it 'pretty well' while 1 speaks it 'not too well.' This lone figure understands the English language 'well' but speaks it 'not too well.' Evidence from the literature review depicts this fact to be very realistic for many Hispanics.

CULTURE

WH3
It is expected that Hispanic clients of immunization clinics will maintain that cultural differences determine when, where, and if their family seeks health care services

6 This does not mean that Spanish is never the language of choice - it could very well be the language of choice in the home. These results show that in a health care setting it is not.

Table 5.4: Results for Culture Barrier

Question	The way I was raised as a Hispanic...	Strongly Agree	Somewhat Agree	Do Not Know	Somewhat Disagree	Strongly Disagree
12	determines at what point I seek health care services	20% (5)	20% (5)	4% (1)	44% (11)	12% (3)
13	determines where I seek health care services	16% (4)	8% (2)	-0-	60% (15)	16% (4)
14	has prevented me from seeking health care services	12% (3)	-0-	-0-	32% (8)	56% (14)
15	allows me to trust medical doctors	12% (3)	56% (14)	-0-	32% (8)	-0-
16	means I sometimes take medications before consulting a doctor	8% (2)	8% (2)	8% (2)	52% (13)	24% (6)
17	allows me to believe that curanderos are as effective as medical doctors	-0-	12% (3)	8% (2)	16% (4)	64% (16)

Working hypothesis 3 is overall not supported by the results. Each question will be addressed separately. Question 12 sought to determine if the way a Hispanic was raised determined at what point in a family members illness helshe sought health care services. There was an almost equal distribution with

this statement: A total of 40% strongly and somewhat agreed with it but the majority (44%) somewhat disagreed with it.

The next question sought to determine where a Hispanic sought health care services for his/her family. The results are that 60% of the subjects 'somewhat disagreed' with this statement. Interestingly 16% 'strongly agreed' and equally at the complete other end of the spectrum, 16% also 'strongly disagreed.'

An inquiry was also made as to whether the way a Hispanic was raised prevented him/her from seeking health care services for the family. The clear majority (56%) 'strongly disagreed' with this statement, although a high number (32%) only 'somewhat disagreed.'

Also asked was if how an individual was raised as a Hispanic allowed them to trust medical doctors (excluding curanderos). The clear majority (56%) 'somewhat agreed' with the statement. Another 32%, however, 'somewhat disagreed' with it.

Question 16 inquired as to whether a person was raised as a Hispanic meant that sometimes he/she took medications before consulting a medical doctor (excluding curanderos). Of the subjects, 52% 'somewhat disagreed' and 24% 'strongly disagreed' with this statement. The final question asked if a person believed that curanderos were as effective as medical doctors. The

majority (64%) of the subjects strongly disagreed with this statement.

Although culture is embedded in every Hispanic, it is embedded more so within each person depending on where helshe was raised. For example, for question 12, a clear majority 'somewhat disagreed' with the statement but a good portion was also at the other end of the spectrum. It could be appropriate to state, then, that where a person was raised determines at what point in a family members illness helshe seeks health care services. Also, the literature review clearly revealed that the use of 'curanderos' is prevalent among many Hispanics. However, the empirical research reveals that they are not believed to be as effective as conventional medical doctors. This again could be attributed to where a person was raised. (Reference Appendix D where it is evident that the majority of the subjects were born in the United States.)

CHAPTER VI
Summary and Qecommendations

PURPOSE

The purpose of this chapter is to provide a summary of the applied research project and to synthesize expert recommendations discovered from the literature review with those from the empirical research conducted. The recommendations will be presented according to each barrier.

SUMMARY OF APPLIED RESEARCH PROJECT

This applied research project sought to measure client perceptions, if any, of the barriers that Hispanics face in obtaining health care services in general. The gathering of this information was accomplished by conducting random interviews of Hispanic clients in the waiting rooms of Austin-Travis County Health and Human Services Department immunization clinics.

Based on the results of such interviews, only 1 (demographics) of the 3 working hypotheses was supported by the evidence. Working hypothesis 2 (language) was not supported by the evidence. Working hypothesis 3 (culture) was overall not supported by the evidence, however, several portions of it were. This hypothesis was the most interesting to work with because it inquired

about an individual's innermost feelings regarding how and where they were raised as Hispanics. Based on the literature review and the empirical research, the following recommendations are offered by the experts and the researcher.

RECOMMENDATIONS - Addressing the Top Three Barriers

Given the magnitude and scope of the health problems facing Hispanics, too few scholars and researchers are engaged in clarifying and solving them. Part of the explanation given for this is that national data sets on health status until recently did not contain Hispanic identifiers. Therefore, insufficient data has provided a weak foundation for research. Even with limited amounts of research, however, recommendations have been made by the experts to address the barriers that Hispanics encounter.

Tables 6.1-3 provide expert recommendations to address the top three barriers. Each table is followed by a discussion of the text and the researchers input based on the empirical research findings.

Demographics

Table 6.1
Expert Recommendations: Demographics Barrier

Number	Recommendation	Reference
1	Provide assurance of continuity of care for the economically disadvantaged who must use public clinics.	Solis, et al 1990, 17
2	Increase the availability of low-cost or no-cost medical services programs in low income Hispanic communities.	Solis, et al 1990, 17
3	Increase the availability of health insurance coverage as an employee benefit.	Solis, et al 1990, 17
4	lust as marketers are using demographic analysis to sell products within the diverse Hispanic population, public health practitioners need to tailor programs to meet the unique needs of the different subgroups within the Hispanic population.	CDC 1994, 5:8

Expert recommendations associated with Barrier 1 involve a monetary commitment. For example, providing continuity of care for the economically disadvantaged and increasing the availability of low-cost or no-cost medical services programs would require a substantial monetary commitment from the government. But given the current national budgetary crunch, it is unlikely that commitment for services specific to Hispanics will be implemented anytime soon without political organization. For employers to increase the availability of health insurance coverage is certainly realistic, although a lot easier said than done. By doing this numerous other factors would come into play. Namely, employers' profit margins would decrease due to higher insurance premiums for

their employees. Ultimately, this could lead to layoffs.

The most realistic suggestion, and one that could be accomplished without a large monetary commitment, is the fact that public health practitioners could tailor their programs to meet the unique needs of the Hispanic population. This could be as simple as rewriting policies or presenting their materials for services in a manner that appeals to the Hispanic population. Table 6.2 provides expert recommendations for the language barrier.

Language

Table 6.2
Expert Recommendations: Language Barrier

Number	Recommendation	Reference
1	Use health care providers who speak the same language as the patient.	
2	Plan for the use of specially trained interpreters instead of using a family member.	NCHHHSO 1990, 78
3	Expand a facility's language capability. Have bilingual proficient staff and offer in-service training in Spanish.	NCHHHSO 1990, 81
4	Be aware of inappropriate translations.	
5	Establish a consistent policy for maintaining records. This ensures continuity of care (particularly in relation to Hispanic names, as they can easily be duplicated).	NCHHHSO 1990, 81
6	Assess patient's language of choice during intake to determine whether the patient is most comfortable with English or Spanish, and whether written materials could be useful.	NCHHHSO 1990, 82

7	**If written materials are used, they should be appropriate. Health promotion literature designed for the Hispanic population must be tailored for the target group in terms of degree of assimilation into the U.S. culture, reading ability and language.**	**NCHHHSO 1990, 82**

Expert recommendations addressing Barrier 2 seem more realistic in that they can be initiated by health care professionals and service delivery providers themselves. Also, these recommendations are more unique to Hispanics.

As the findings indicated, Hispanics do not always prefer to be communicated with in Spanish. However, it is important for health care provider facilities to have someone available for those who do prefer Spanish. As found in the literature review, this person should preferably be a medical doctor or technician because using someone for mere translation is not as efficient. Also identified in the literature review, however, is the notion that there is a sever underrepresentation of Hispanic health care professionals, particularly doctors. Future trends do not indicate that this will soon improve as studies show that Hispanics' enrollment in medical schools does not meet the demand.

The next best solution, then, is to have language concordant staff. This includes medical doctors and staff who can speak Spanish or at least understand the Spanish culture. Because as stated earlier, Spanish is a language but it is

also seen as a symbol of cultural tradition and existence as a social group. Table 6.3 addresses the expert recommendations relating to the cultural barrier.

Culture

Table 6.3
Expert Recommendations: Cultural Barrier

Number	Recommendation	Reference
1	Use health care providers who come from the same or are familiar with the patients cultural background.	Medrano 1993, 2
2	Assess patients' views of 'locus of control' - factors that influence their own health rather than feeling that their health is controlled by the environment.	NCHHHSO 1990, 55
3	Include the family in both health services and preventive education.	NCHHHSO 1990, 55
4	Adapt policies to allow for more direct involvement of the extended family network. For example, Hispanics' expansive definition of family often runs counter to the assumptions of health institutions - i.e., hospital policies that limit patients to two visitors.	NCHHHSO 1990, 72
5	Reciprocate *respeto* (respect) which is given on the basis of age, sex, social position, economic status, and position of authority. Health providers, by virtue of their healing functions, education, and training are seen as authority figures and as such awarded *respeto*. If an Hispanic patient feels that the provider has violated the rules of *respeto* the patient may terminate treatment.	NCHHHSO 1990, 73
6	Establish *personalismo* - personal rather than impersonal or institutional relationships. Thus, many Hispanics expect health providers to be warm, friendly, personal and to take an active role in the patient's life.	NCHHHSO 1990, 74

Expert recommendations for Barrier 3 are similar to Barrier 2; they are more realistic in that they can be initiated by health care professionals and service delivery providers themselves. Also, these recommendations are more unique to Hispanics.

Culture is usually not taken into account in the total scheme of providing adequate health care, however, it necessitates serious attention because it "serves as a means of defining the relationship of the individual to the environment and to other individuals." (COSSMHO 1995, 305) In relation to health care, it should not be any different.

Of utmost importance in relation to culture is the need to acknowledge the patients family and their importance in the delivery of health care to the patient. Ultimately, it is not as important to the Hispanic patient what ethnicity medical providers are as long as the care provided by the doctor and the staff is sincere.

GENERAL RECOMMENDATIONS

Not relating directly to the demographic, language, or cultural barriers, the experts recommend the following:

(1) Increase the number of Hispanic health professionals, especially physicians, in order to improve access and utilization. This situation is expected to worsen due to studies indicating that severe underrepresentation of Hispanics' enrollment in professional schools, particularly medical schools. (Andersen, et al 1986, 242)

(2) Shift the burden of providing health care to regional and local efforts and to the strength and creativity of alliances among public and private organizations, businesses, and health practitioners.

(3) Make sufficient public and private investments in data collection, analysis and standardization of data collection methodologies to increase data comparability. (Furino and Mufioz 1991, 257)

(4) Complement special programs and education needs with technical assistance, specific economic incentives for locating practices in underserved areas, and ways of facilitating reimbursement for the care of Medicaid patients. (Furino and Mufioz 1991, 257)

(5) Increase the participation of Hispanics in policy making and educate them about how to use the U.S. health care system. (NCHHHSO 1990, 4:84)

(6) Provide transportation to and from clinics and hospitals to the isolated Hispanic communities. (Furino and Mufioz 1991, 257)

Furino and Mufioz (1991: 257) add that

> Hispanic health care issues must be translated into policy proposals that will capture the attention of the rest of the population. We must delineate what payoffs can be expected in terms of higher employment, less illness, greater productivity, and decreased health care costs if those health needs are met. The private sector could play a major role in improving the provision of health care to Hispanics, but it will need to understand clearly the benefits to be had from additional expenditures on health care or alternatively, given the expected size of the Hispanic work force, the economic impact of unhealthy workers.

Much can be accomplished if awareness of the barriers is heightened and the issues addressed. One way to heighten that awareness is through the development of health promotion strategies.

Developing Health Promotion Strategies

> Designing strong health promotion programs for the Hispanic community is particularly important because Hispanics have not been targeted by mainstream prevention initiatives yet are the lease insured of any major ethnic group. To develop strong health promotion efforts, establishing credibility with the community will be the key to success. (COSSMHO 1995, 308)

This entails a sustained sense of commitment in the form of

- ✔ identifying and working with community spokespersons and advisory boards;
- ✔ increasing the cultural competency of health institutions, providers and employers; and
- ✔ identifying and working with community-based institutional partners. (COSSMHO 1995, 308)

The most important strategy, however, that health providers and employers can use to provide better health care to the Hispanic community is to have an organizational commitment to the mission. "This is best implemented by having bilingual and bicultural persons as policy makers on the board, as senior managers, and as staff responsible for all levels of service provisions." (COSSMHO 1995,309)

It should also be understood that overcoming barriers to health care for Hispanics means more than just providing care. It means establishing trust and confidence between the Hispanic community, where such services are delivered, and the system.

> Health delivery relationships are based on trust, and trust can only be formed through reciprocal understanding and acceptance of value systems. Employers and health care providers should seek to understand the role of the Hispanic as an individual, as part of a family, and as a member of a community. (COSSMHO 1995, 309)

CONCLUSION

In 1990, Americans spent more than $600 billion in health care, and there were 37 million people (1 in 5) who did not have any form of health insurance. The amount of money spent on health care represented more than 11% of the Gross National Product - a figure that was higher than that spent by any other nation for health care. Despite this high expenditure, however, people from the United States were no healthier than people from other nations. (Spector 1991, 73) Despite the tremendous advantages available to people in the "land of opportunity" health care is not necessarily one of those opportunities. Table 6.4 depicts industrialized nations who have and do not have national health programs. (Spector 1991, 74)

Table 6.4
Health Care Status for Industrialized Nations

Nations that HAVE a National Health Program			Nations that DO NOT have a National Health Program
Australia	France	Poland	South Africa
Austria	Great Britain	Portugal	United States
Belgium	Greece	Romania	
Bulgaria	Hungary	Spain	
Canada	Ireland	Sweden	
Czechoslovakia	Italy	Switzerland	
Denmark	Japan	USSR	
East Germany	Netherlands	West Germany	
Finland	New Zealand	Yugoslavia	

Of course the industrialized nations who do have a national health program have numerous other problems. But there is something to be said for their citizens' ability to obtain health care services when they are ill, regardless of their socioeconomic status, educational achievement, language or heritage.

Closer to home, Gamboa stated in 1993 that

> being a member of an ethnic minority [in the United States] can be dangerous to your health...[because] minorities are currently linked to the health care system by a very small, raggedy bridge and unless that bridge is improved, there will be more death, more illness.

It is now 1997 and the status for minorities hasn't changed much.

Fred Blair, a former state representative from Dallas, Texas, also stated in 1993 (as cited in Gamboa) that "if you consider the impact on the state, it's disgusting we're not doing more for minority health." Again, it is 1997 and the

Hispanic population has increased steadily since 1993, while the health status for minorities hasn't and is stagnant. Dr. David R. Smith, former Commissioner of Health agrees, and is on record as saying that

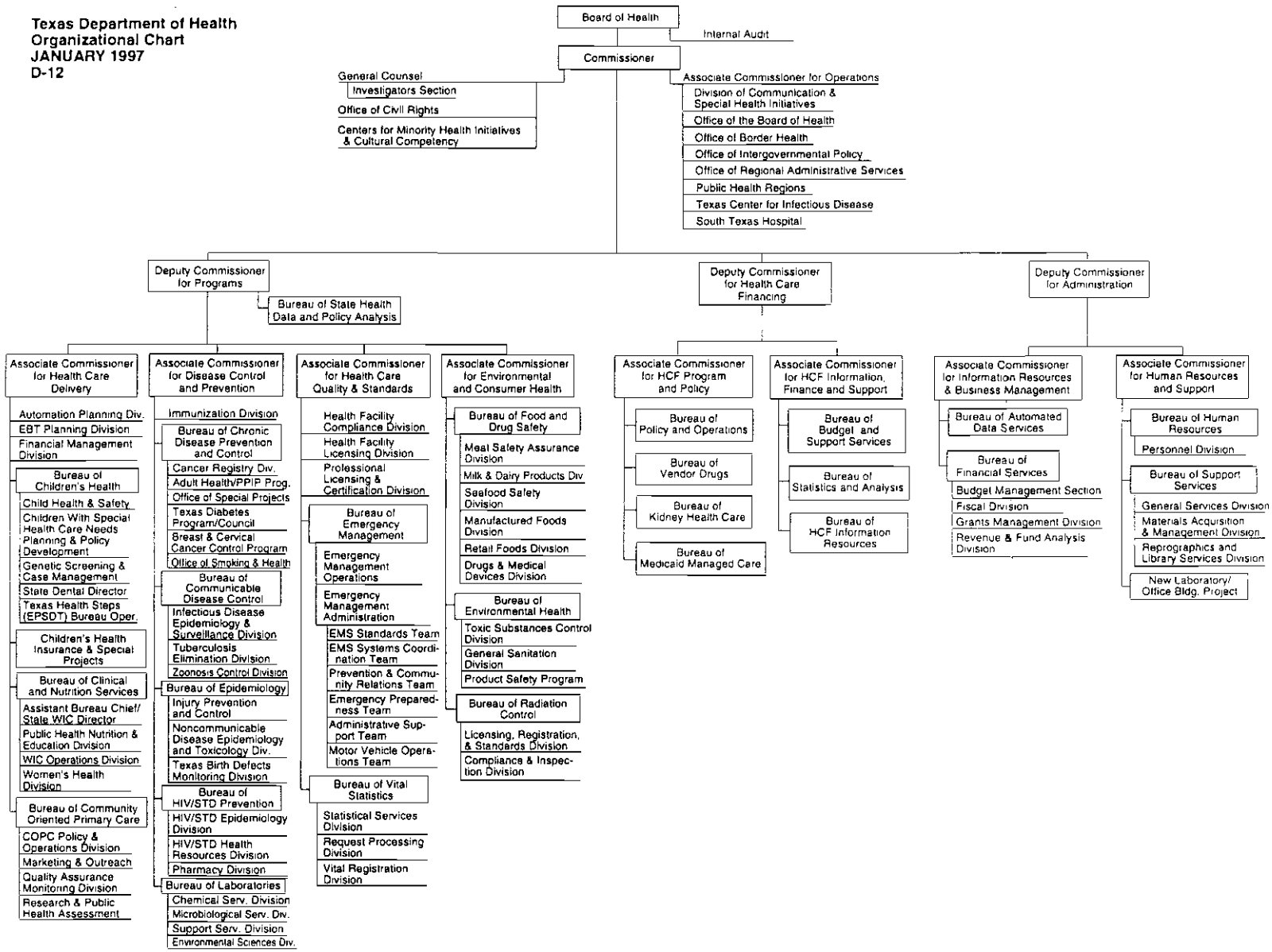
> the statistics do show disproportionate neglect, and neglect probably is the right word...we've got a disproportionate neglect that we're going to need to pay attention to if we're going to have this [Hispanic] labor force in the future. (As cited in Gamboa 1993)

Dr. Henry Louis III, president of the Association for Minority Health Profession Schools in 1993, summarized it well when he stated that "we [United States] have the most sophisticated and well-funded health care system in the world that is not delivering health care to the people who need it most." (As cited in Gamboa 1993) Whether that delivery of health care is to the general population or to target populations such as Hispanics, the issue is far more complex than simply delivering health care. The delivery of health care needs to be tailored to the target population. Health care professionals are the key to eliminating, or at least diminishing, the barriers that Hispanics face when obtaining health care services. These same health care professionals need to work with lawmakers to provide health care services to every man, woman, and child, regardless of race or socioeconomic status because health care services in the 'land of opportunity' should not be a privilege, but a right.

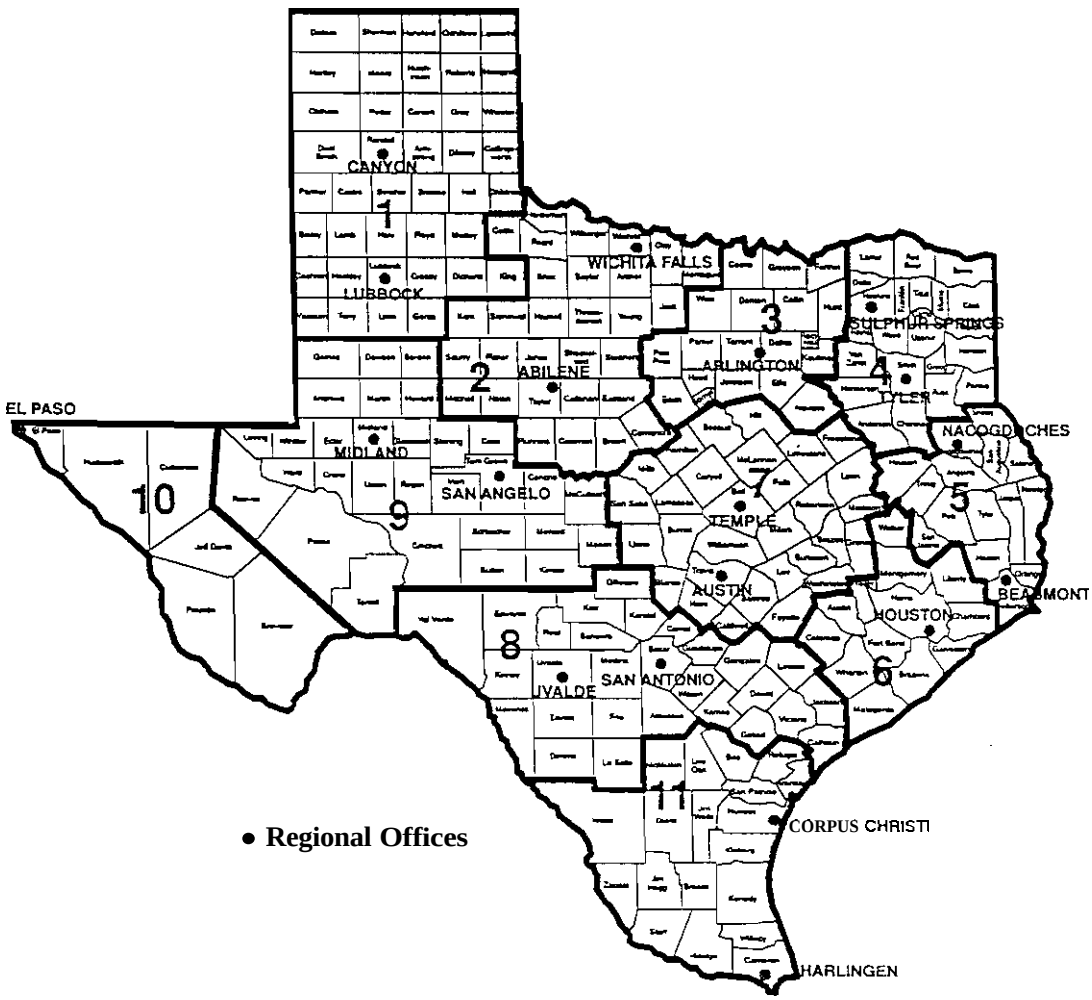
Appendices

Appendix A

Texas Department of Health
Organizational Chart
JANUARY 1997
D-12



Texas Department of Health
PUBLIC HEALTH REGIONS



• **Regional Offices**

Hello, my name is Rocío Peña and I am a graduate student at Southwest Texas State University and an employee of the Texas Department of Health. I am speaking with clients of this clinic with regards to perceived barriers to health care encountered by Hispanics. Your responses are confidential and will help me complete my masters degree. May I have a couple of minutes of your time?

Female_____ Male_____ Age_____

GQ 1. Where were you born? What about your spouse?

Female:	Male:

If not in the U.S., how long have you lived in the U.S.?
What about your spouse?

GQ 2. Where were your parents born?

Mother:	Father:

If not in the U.S., how long have they lived in the U.S.?

GQ 3. How do you assess the quality of your families health care services?

very good	good	don't h o w	bad	very bad

WH1a 4. Are you currently employed? YES NO

WH1a 5. Is your family covered by insurance? YES NO
If YES, what type? PERSONAL EMPLOYER

WH1a 6. The quality of my families health care services are influenced by my socioeconomic status (employed/unemployed status).

strongly agree	somewhat agree	don't h o w	somewhat disagree	strongly disagree

WH1b 7. What is the highest grade or year of school you have completed?

WH1b 8. The quality of my families health care services are influenced by my educational achievement.

strongly agree	somewhat agree	don't h o w	somewhat disagree	strongly disagree

WH2 9. How well do you understand spoken English?

very well	pretty well		not too well	not at all

WH2 10. How well do you speak English?

very well	pretty well		not too well	not at all

WH2 11. The quality of my families health care services are enhanced when I am communicated with in Spanish.

stmngly agree	somewhat agree	don't know	somewhat disagree	strongly disagree

WH3 12. The way I was raised as a Hispanic has determined at what point in a family members illness I seek health care services.

strongly agree	somewhat agree	don't h o w	somewhat disagree	strongly disagree

WH3 13. The way I was raised as a Hispanic has determined where I seek health care services for my family.

strongly agree	somewhat agree	don't h o w	somewhat disagree	strongly disagree

WH3 14. The way I was raised as a Hispanic has prevented me from seeking health care services for my family.

strongly agree	somewhat agree	don't know	somewhat disagree	strongly disagree

WH3 15. The way I was raised as a Hispanic allows me to trust medical doctors (excluding curanderos).

strongly agree	somewhat agree	don't h o w	somewhat disagree	strongly disagree

WH3 16. The way I was raised as a Hispanic means I sometimes take medications before consulting a medical doctor (excluding curanderos).

strongly agree	somewhat agree	don't know	somewhat disagree	strongly disagree

WH3 17. I believe that curanderos are as effective as medical doctors.

strongly agree	somewhat agree	don't know	somewhat disagree	strongly disagree

THANK YOU FOR YOUR TIME!

Buenos dias/buenas tardes, me llamo Rocío Peña y soy una estudiante de Southwest Texas State University y empleada del Departamento de Salud de Tejas. Estoy hablando con clientes de esra clinica de obstáculos que Hispanos combaten al tratar de recivir servicios de salud. Su respuestas seran confidencial y me ayudaran complerar my maestría. Podre tomar unos minutos de su tiempo?

Mujer_____ **Hombre**_____ **Edad**_____

GQ 1. ¿Donde nacio usted? ¿Donde nacio su esposo/esposa?

Mujer:	**Hombre:**

Si no nacio en los Estados Unidos, caunto tiempo tiene viviendo aquí?
Y su esposo/esposa?

GQ 2. ¿Donde nacieron sus padres?

Madre:	**Padre:**

Si no en los Estados Unidos, cuanto tiempo tienen viviendo aqui?

GQ 3. ¿Como evalua usted la calidad de los servicios de salud de su familia?

muy bien	**bien**	**no se**	**mal**	**muy mal**

WH1a 4. ¿Está usted actualmente empleada(o)? SI NO

WH1a 5. ¿Está cubierta su familia por algun tipo de seguro? SI NO
¿Es seguro por su empleado o seguro personal? PERSONAL EMPLEADO

WH1a 6. La calidad de servicios de salud que recibe mi familia esta influenciada porque estoy empleada(o)/no empleada(o).

muy de acuerdo	**algo de acuerdo**	**no tiene opinión**	**no de acuerdo**	**completamente no de acuerdo**

WH1b 7. ¿Cúal es el ultimo año que usted ha completado en la escuela?

WH1b 8. La calidad de servicios de salud que recibe my familia esta influenciada por la cantidad de educación que tengo.

muy de acuerdo	**algo de acuerdo**	**no tiene opinión**	**no de acuerdo**	**completamente no de acuerdo**

WH2 9. ¿Qué tan bien entiende usted el Inglés hablado?

muy bien	**bien**		**no muy bien**	**no lo entiendo**

WH2 10. ¿Qué tan bien habla usted el Inglés?

muy bien	bien		no muy bien	no lo entiendo

WH2 11. La calidad de servicios de d u d que recibe mi familia esta intensificada cuando los doctores me hablan en Español.

muy de acuerdo	algo de acuerdo	no tiene opinidn	no de acuerdo	completamente no de acuerdo

WH3 12. El modo que yo fui criada como Hispana(o) a determinado a que tiemp de la enfermedad de un miembro de mi familia solicito servicios de salud.

muy de acuerdo	algo de acuerdo	no tiene opinidn	no de acuerdo	completamente no de acuerdo

WH3 13. El modo que yo fui criada como Hispana(o) a determinado donde solicito servicios de d u d para mi familia.

muy de acuerdo	algo de acuerdo	no tiene opinidn	no de acuerdo	completamente no de acuerdo

WH3 14. El modo que yo fui criada como Hispana(o) me a prevenido solicitar servicios de d u d para my familia.

muy de acuerdo	algo de acuerdo	no tiene opinidn	no de acuerdo	completamente no de acuerdo

WH3 15. El modo que yo fui criada como Hispana(o) me permite confiar en doctores (excluiendo curanderos).

muy de acuerdo	algo de acuerdo	no tiene opinidn	no de acuerdo	completamente no de acuerdo

WH3 16. El modo que yo fui criada como Hispana(o) quiere decir que hay veces tomo medicinas antes de consultar con un doctor (excluiendo curanderos).

muy de acuerdo	algo de acuerdo	no tiene opinidn	no de acuerdo	completamente no de acuerdo

WH3 17. Yo creo que curanderos son igual de efectivos que doctores.

muy de acuerdo	algo de acuerdo	no tiene opinidn	no de acuerdo	completamente no de acuerdo

MUCHAS GRACIAS POR SU TIEMPO!

Appendix D

Itemization of Respondents Answers to General Questions

Subject #	Male	Female	Age	Subjects/Spouses Birthplace	Time in US if not born in US (in years)	Parent's Birthplace (Mother/Father order)	Time in US if not born in US (in years)	Quality of families health care services
1		✔	26	Monterrey, Mexico North Carolina	22	San Antonio, TX Monterrey, Mexico	30	Good
2		✔	28	Laredo, TX San Antonio, TX	NA	Laredo, TX Laredo, TX	NA	Good
3		✔	30	Austin, TX NA	NA	Hondo, TX Austin, TX	NA	Good
4	✔		35	Corpus Christi, TX Kingsville, TX	NA	Kingsville, TX Kingsville, TX	NA	Good
5		✔	39	Michigan Laredo, TX	NA	Wisconsin Puerto Rico	NA	Good
6*		✔	41	Chiapas, Mexico Chiapas, Mexico	20	Chiapas, Mexico Chiapas, Mexico	NA	Good
7		✔	42	Indiana NA	NA	Mississippi Eagle Pass, TX	NA	Good
8		✔	44	Mathis, TX Los Olmas, TX	NA	Hebbronville, TX Mathis, TX	NA	Good
9	✔		46	San Antonio, TX San Antonio, TX	NA	San Antonio, TX San Antonio, TX	NA	Good
10	✔		50	Piedras Negras, Mexico Monterrey, Mexico	25 25	Monterrey, Mexico Monterrey, Mexico	50 50	Good
11	✔		45	Del Rio, TX Del Rio, TX	NA	Rainosa, Mexico Rainosa, Mexico	30	Good
12		✔	38	Houston, TX Houston, TX	NA	Houston, TX Houston, TX	NA	Good
13		✔	39	La Pryor, TX La Pryor, TX	NA	Eagle Pass, TX Eagle Pass, TX	NA	Good

Subject #	Male	Female	Age	Subjects/Spouses Birthplace	Time in US if not born in US (in years)	Parent's Birthplace (Mother/Father order)	Time in US if not born in US (in years)	Quality of families health care services
14	✔		39	Edinburg, TX McAllen, TX	NA	Edinburg, TX Edinburg, TX	NA	Good
15		✔	45	Harlingen, TX Harlingen, TX	NA	Harlingen, TX Harlingen, TX	NA	Good
16		✔	46	Dallas, TX Dallas, TX	NA	Dallas, TX Dallas, TX	NA	Good
17		✔	31	San Jose, CA San Jose, CA	NA	Monterrey, CA Monterrey, CA	NA	Good
18		✔	34	Edinburg, TX Edinburg, TX	NA	Guadalajara, Mexico Guadalajara, Mexico	10	Good
19	✔		30	San Marcos, TX San Antonio, TX	NA	San Marcos, TX San Marcos, TX	NA	Good
20		✔	32	Austin, TX Austin, TX	NA	Austin, TX Austin, TX	NA	Good
21		✔	30	Bastrop, TX Austin, TX	NA	Bastrop, TX Bastrop, TX	NA	Good
22		✔	35	Austin, TX Austin, TX	NA	Austin, TX Austin, TX	NA	Good
23	✔		28	Austin, TX Austin, TX	NA	San Antonio, TX San Antonio, TX	NA	Good
24		✔	27	Dallas, TX Austin, TX	NA	Dallas, TX Dallas, TX	NA	Good
25		✔	35	Harlingen, TX Harlingen, TX	NA	McAllen, TX McAllen, TX	NA	Good

* Only subject who chose to answer questionnaire in Spanish.

TDH
TEXAS DEPARTMENT OF HEALTH

Texas Department of Health

Patti I. Patterson, M.D
Commissioner

1100 West 49th Street
Austin, Texas 78756-3199
(512) 458-7111

Carol S. Daniels
Deputy Commissioner for Programs

Roy L. Hogan
Deputy Commissioner for Administration

February 19, 1997

Mr. Charles W. Mallory, B.S., M.A.
Director. Immunization Program
Austin-Travis County Health Department
15 Waller Street
Austin, Texas 78702

Dear Mr. Mallory: Charles

This letter is requesting approval for Ms. Rocío Brow to attend immunization clinics and conduct client interviews in the Austin-Travis County Health Department clinics. Ms. Brow is an employee of the Commissioner's Office at the Texas Department of Health and is enrolled in the Master of Public Administration Program at Southwest Texas State University. She will be graduating this semester and is in the process of completing her applied research project, titled ***Barriers lo Health Care Encountered by Hispanics: A Case Study Utilizing the Immunization Program of the Texas Department of Health.***

The interviews should be concluded by March 14, 1997, with each interview lasting approximately 15 to 30 minutes. Ms. Brow's strategy is to attend several immunization clinics and randomly interview 25 clients in clinic waiting rooms, unless a client requests privacy. No special provisions or help will be needed from the clinic staff.

The interview findings will provide insights as to the Hispanic client's perception of the degree that socioeconomic status, educational achievement, language. and cultural differences affect the quality of health care services available to them and their families. A copy of the questionnaire is enclosed. In May 1997, Ms. Brow will provide you with the results thar might be helpful to you as you strive to achieve 90 percent immunization levels by the year 2000 in Travis County's two-year-old children.

Please permit Ms. Brow to conduct interviews in the Austin-Travis County Health Department Immunization clinics. At your earliest convenience, please contact Ms. Brow at 458-7378. If you need to contact me, please telephone 458-7284 or pmail me a! TDHIMM/BCrider.

Sincerely,

Bob

Robert D. Crider, Jr., M.S., M.P.A
Director, Immunization Division
Texas Department of Health

Enclosure

Summary of Charts/Tables

Charts

2.1 Cardiovascular Disease
2.2 Cancer
2.3 Diabetes

Tables

2.1 Hispanic Representation by Subgroup (percent distribution)
2.2 Years of Schooling by Racial Ethnicity in 1987 (percentage)
2.3 Comparison of Life Expectancy between Whites and Hispanics

3.1 PHR 1 Population by Age and Ethnicity

4.1 Operationalization of Descriptive Categories and Working Hypotheses

5.1 General Information about Respondents
5.2 Results for WH1a
5.3 Results for WH2
5.4 Results for WH3

6.1 Expert Recommendations: Demographics Barrier
6.2 Expert Recommendations: Language Barrier
6.3 Expert Recommendations: Cultural Barrier
6.4 Health Care Status for Industrialized Nations

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