

Overview: *The health care delivery system consists of those individuals and organizations that provide health care. Barriers to that care include inability to pay, lack of providers, and difficulty in getting to those providers. Health care can be evaluated in terms of quality and adequacy of services and the ability of provider and patient to communicate with each other.*

The health care delivery system may not be accessible to minorities because of such factors as geography, cost, or language. Health care providers must also be aware of cultural and language issues which may affect a person's ability or willingness to seek care and communication between provider and patient on the nature of the condition and the particulars of the required treatment. Efforts to encourage minority individuals to enter the health and allied health professions is one response to this problem of cultural and linguistic competence.

Health Risk: Access to Health Care

Access is “the ability to obtain appropriate, affordable comprehensive care in a timely fashion on a 24-hour basis, including referral for special service needs.”¹

Access to care is dependent on several factors:

- Availability of providers in sufficient numbers and locations;
- Elimination of barriers, such as the lack of health insurance (public or private) or lack of transportation; and
- Language and cultural issues.

“Barriers to health care access by Latinos new to this country include a lack of time to devote to their health (given other demands in their life), lack of health insurance, language barriers, and incomplete information or information not presented in a culturally appropriate manner.”

Quote from Ethnic Community Forum held in East Liberty, PA on September 10, 2001.

A. Health Insurance

Because they are able to pay for the health services they receive, people use these services more often and are more likely to use preventive and screening services.

- A 2000 study comparing the insured and uninsured, found that uninsured persons
 - Were 33% less likely to have routine physical examinations.
 - Among females, were 33% less likely to have a Pap smear and 60% less likely to have mammograms.
 - Were three times as likely to skip a recommended medical test or treatment.

- Found it more than three times harder to obtain mental health care.²

A Pennsylvania focus group study in 2000 found nine barriers that keep parents from enrolling their children in government-sponsored health care coverage programs:³

- Some parents were either unaware of the Children’s Health Insurance Program (CHIP) and Medicaid, or they knew of the programs but did not believe they were eligible.
- The information needed to apply is sometimes complex and hard to assemble, and parents found the application process intrusive.
- Parents had been rejected by a program or had lost coverage because of "minor" income changes. Others reported an inability to enroll because of paperwork lost by program staff or of being treated disrespectfully by staff or by health care providers.
- Parents feel that the application process will be humiliating and an invasion of privacy, or that enrollment is a sign of failure as a parent.
- Many families faced with the difficulties of applying will seek free care or pay for episodic care as needed.
- Parents reported that obtaining health coverage is a low priority unless their children are sick or injured. They avoid the hassles of applying, especially those with low literacy skills or who speak a language other than English.
- The family is seeking a bigger solution.
- Families seeking health coverage for everyone might not consider CHIP or Medicaid satisfactory, and they may continue exploring other possibilities rather than enroll children alone.
- National studies have also found that:
 - Hispanics were enrolled in Medicaid in comparable numbers to Whites, although they were three times as likely to be eligible. Reasons cited were immigrant fears; lack of translators (a problem cited by 35% of all persons), and not knowing how to apply.
 - The same study noted that Hispanics are also more likely to be unaware of the importance of health insurance in the U.S. in obtaining medical care and, so, have no insurance.⁴

“People are often troubled by public agency paperwork that keeps recycling through the system even after issues are settled.”

*Comment received at the
Ethnic Community Forum
held in Scranton, PA on
September 20, 2001.*

- Many Asian American and Pacific Islander immigrants, including refugees, fear that enrolling themselves or their children in Medicaid will affect their citizenship status.⁵

FACT: Ten percent of Pennsylvania children⁶ and 11% of Pennsylvania adults⁷ aged 18-64 have no health insurance.

- In 2000, 11% of White, 14% of Black, 14% of Asian/Pacific Islander, and 25% of Hispanic children in the U.S. had no health insurance.⁸
- In 2000 in Pennsylvania, 10% ($\pm 1\%$) of Non-Latino Whites, 19% ($\pm 6\%$) of Non-Latino Blacks, and 26% ($\pm 11\%$) of Latinos aged 18-64 had no health insurance.⁹
 - Among uninsured Hispanics in 1997 nationally, the rates were Central/South Americans 42%, Cubans 21%, Mexicans 39%, and Puerto Ricans 21%¹⁰
 - Among uninsured Asian/Pacific Islander non-elderly in 1997 nationally, the rates were Chinese 20%, Filipinos 20%, Japanese 13%, Koreans 34%, South Asians 22%, and South East Asians 27%.¹¹

FACT: For minorities, lack of health insurance is linked to type of work.

- Hispanics work in trades less likely to insure their workers. Among agricultural workers in the U.S., 64% of Whites have insurance, but only 38% of Hispanics. For construction workers, the rates are 67% for Whites and 47% for Hispanics.¹²
- The uninsured rates for Koreans and South Asians are so high nationally because disproportionate numbers of these groups are self-employed or work in small businesses less likely to provide health benefits.¹³

FACT: In the 1998-99 fiscal year, 61% of Pennsylvania's 1,555,022 Medical Assistance enrollees were White, 28% were Black, 8% were Latino, and 3% were Other Races.¹⁴

- Among Hispanic non-elderly on Medicaid or other public assistance in 1997 nationally, the rates were Central/South American 12%, Cuban 14%, Mexican 18%, and Puerto Rican 34%.¹⁵
- Nationally, the rate for Medicaid enrollment among Southeast Asian non-elderly is 20%.¹⁶
- As of December 2001, 118,047 Pennsylvania children were enrolled in CHIP.¹⁷
- In the 1998-99 fiscal year, 65.6% of CHIP enrollees in Pennsylvania were White, 24.1% Black, 7.1% Hispanic, 3.2% Asian/Pacific Islander, and 4.2% Other Race.¹⁸

FACT: In 2000, 7% ($\pm 1\%$) of Non-Hispanic White, 14% ($\pm 5\%$) of Non-Hispanic Black, and 16% ($\pm 8\%$) of Latino adults in Pennsylvania needed to see a doctor at some time during the previous year, but were unable to due to cost.¹⁹

B. Source of On-Going Care

An on-going source of care may be a doctor's office, clinic, health center, or other place where people receive health care advice and treatment, but not a hospital emergency room.²⁰

An on-going source of care can better serve minority clients by:

- Being aware of an individual's medical and family history and possible risk factors present, such as a family history of some condition;
- Being aware of cultural issues that may delay or prevent an individual from seeking care or impact on the effectiveness of the care given;
- Notifying the patient or family when preventive measures, such as childhood immunization, or testing for possible risk factors, such as high blood pressure, are due;
- Monitoring and treating existing conditions; and
- Being aware of existing conditions or treatments (e.g., a routinely taken prescription medication) that might impact on the treatment of a new disease or condition.

FACT: In 1998-99, 6% of White, 8% of Black, 14% of Hispanic, and 12% of Asian/Pacific Islander U.S. children under 18 years of age did not have a usual source of health care.²¹

FACT: In 1999, 12% of White, 15% of Black, 21% of Hispanic, and 17% of Asian/Pacific Islander U.S. children under 18 years of age had not made a health care visit to a physician's office or a clinic within the past 12 months.²²

FACT: In 1998, 9.8% of the Pennsylvania population had no access to a primary care provider.²³

- Nationally, the rate for Hispanics with no access to primary care is 70% higher than the rate for Whites.²⁴

FACT: In 2000 in Pennsylvania, 27% ($\pm 2\%$) of White non-Latino, 21% ($\pm 6\%$) of Black non-Latino, and 25% ($\pm 10\%$) of Latino adults had not had a routine check-up within the previous year.²⁵

- Hospital emergency rooms are still inappropriately used as providers of primary care.

- Nationally, 13% of all ambulatory care visits by Whites and 22% of all such visits by Blacks under age 18 are made to emergency rooms.²⁶
- Nationally, 10% of all ambulatory care visits by White adults and 18% of all such visits by Black adults are made to emergency rooms.²⁷

There are three components to prenatal care:

- Risk assessment,
- Treatment for medical conditions or risk reduction, and
- Education.

The earlier prenatal care begins, the more likely it is to be effective. The proportion of mothers receiving care during their first trimester of pregnancy can be used as a measure of both the availability of providers and clinics and access to them.

The National Center for Health Statistics defines adequate pre-natal care as the mother having her first prenatal visit with a health care provider during the first trimester and with additional visits as per the modified Kessner Criteria shown at right.²⁸

<u>Modified Kessner Criteria for Prenatal Visits</u>				
<u>Weeks</u>	<u>Cumulative</u>	<u>Weeks</u>	<u>Cumulative</u>	
<u>Gestation</u>	<u>Visits</u>	<u>Gestation</u>	<u>Visits</u>	
17	2	30-31	6	
18-21	3	32-33	7	
22-25	4	34-35	8	
26-29	5	36 or more	9	

FACT: In 1999, 72.5% of pregnant women in Pennsylvania had access to adequate prenatal care, 74.7% of Whites, 60.3% of Blacks, 64.4% of Latinos, and 67.2% of Asian/Pacific Islanders.²⁹

- Nationally, Korean and Vietnamese women were much more likely than Chinese or Japanese women to have no prenatal care or to start such care later than the first trimester. Korean women were also more likely to have less than the recommended number of prenatal visits.³⁰

FACT: In Pennsylvania in 2001, there are 88 primary care health professional shortage areas (HPSAs), including 13 serving specific facilities (usually state correctional institutions). These HPSAs serve a total population of just over 1.2 million.³¹

C. Ambulatory Care-Sensitive Conditions

Ambulatory care-sensitive conditions reflect the quality and availability of primary care services, since they are readily treatable without the need for hospitalization. There are differences in the hospitalization rate for ambulatory care sensitive conditions.

- In 1997-99, the hospitalization rate in Pennsylvania³²
 - For pediatric asthma (age under 18) was 23.9 per 10,000 persons, 14.1 per 10,000 for Whites, 84.2 for Blacks, 47.2 for Hispanics, and 9.2 for Asians.
 - For persons aged 18 to 64 with uncontrolled diabetes was 6.4 per 10,000 persons, 4.6 per 10,000 for Whites, 23.5 for Blacks, 9.0 for Hispanics, and 1.1 for Asians.
 - For persons aged 65 and over due to pneumonia or influenza was 7.2 per 10,000 persons, 7.4 per 10,000 for Whites, 5.4 for Blacks, 9.4 for Hispanics, and 2.3 for Asians.

D. Transportation

Although mass transit infrastructures in urban areas are extensive, in many parts of these cities it is difficult to travel to a health care provider.

- Routes are often indirect, so that one or more transfers are necessary.
- The number of vehicles per day may be limited, and schedules may not accommodate work schedules.
- Fares may be relatively high for low-income families.
- Equipment in some urban areas is aged and unreliable.
- This equipment may also not be accessible for aged or handicapped riders.

“In Harrisburg, the community is struggling to obtain mobile screening units due to transportation problems.”

Quote from the Ethnic Community Forum held in Harrisburg on September 20, 2001.

There are other barriers related to transportation.

FACT: In Pennsylvania in 1990 (last year for which minority data are available), 12.1% of White households did not have a car available, 45.1% of Blacks, 35.1% of Latinos, and 18.6% of Asian/Pacific Islanders.³³

- A 1995 study found that 57% of Pennsylvania residents in rural areas were not served by public transportation, while another 23% reported that use of public transportation was “below average;” that is, 25 or fewer trips per rural car-less household per year.³⁴

Related Healthy People 2010 Targets:

- **Increase the proportion of persons under age 65 with health insurance.**
[HP 2010 Target 1-1: 100%.] (Source: Bureau of Health Statistics, Healthy People 2010 Data Set)

PA Baseline (2000, Age 18-64): Whites 90% (± 1); Blacks 81% (± 6);
Hispanics 74% (± 11).

- **Increase the proportion of persons who have a specific source of on-going care. [HP 2010 Target 1-4a: 96% all ages.] (Source: PA BRFSS, beginning with 2001 data)**

PA Baseline (pending, 2002): [Measures to be developed]
U.S. Baselines (1998-99)

All Ages: Whites 83%; Blacks 81%; Asian/Pacific Islanders 78%; Hispanics 71%.

Under Age 18: Whites 94%; Blacks 92%; Hispanics 86%; Asian/Pacific Islanders 88%.

- **Increase the proportion of women who receive prenatal care beginning in the first trimester of care. [HP 2010 Target 16-6a: 90%] (Source: Bureau of Health Statistics, Healthy People 2010 Data Set)**

PA Baseline (1999): Whites 87.6%; Blacks 71.6%; Hispanics 73.9%; Asian/Pacific Islander 80.9%

- **Reduce hospitalization rates for three ambulatory sensitive conditions. (Source: PA Health Care Cost Containment Council)**

[HP 2010 Target 1-9a (Pediatric asthma-age 17 and under): 17.3/10,000.]

PA Baseline (1997-99): Whites 14.1; Blacks 84.2; Hispanics 47.2; Asians 9.2

[HP 2010 Target 1-9b (Adult diabetes-age 18-64): 5.4/10,000.]

PA Baseline (1997-99): Whites 4.6; Blacks 23.5; Hispanics 9.0; Asians 1.1.

[HP 2010 Target 1-9c (Immunization preventable influenza or pneumonia-aged 65 and over): 8.0/10,000]

PA Baseline (1997-99): Whites 7.4; Blacks 5.4; Hispanics 9.4; Asians 2.3.

E. Dental Care

The discussion of the prevalence of oral health problems is in Chapter 4, "Family Health."

FACT: In 1997, 41.8% of non-Hispanic Whites, 32.4% of non-Hispanic Blacks, and 29.0% of Hispanics in the U.S. were covered by private dental insurance.³⁵

"Few dentists take patients with medical assistance. In some cases, people have to wait six to seven months to get dental appointment."

Quote from Ethnic Community Forum held in York, PA on September 26, 2001

FACT: According to the Department of Public Welfare, Office of Medical Assistance Programs, about 40% of all licensed dentists in Pennsylvania are enrolled in the Medical Assistance Program.

- Of those enrolled, only 54% actually participate in the program; and, of those, 50% provide almost all services received by eligible Medical Assistance enrollees.³⁶

FACT: Nationally in 1999, 75% of White children age 2-17 years had visited a dentist within the past year, 68% of Blacks, 71% of Asian/Pacific Islanders, and 59% of Hispanics.

FACT: In 1999 in Pennsylvania, 71% ($\pm 2\%$) of White non-Latino, 62% ($\pm 7\%$) of Black non-Latino, and 73% ($\pm 11\%$) of Latino adults had visited a dentist within the previous 12 months.³⁷

FACT: In Pennsylvania in 2001, there are 55 dental care HPSAs, including 5 serving specific facilities (usually state correctional institutions). These HPSAs serve a total population of almost 1.3 million.³⁸

Related Healthy People 2010 Targets:

- **Increase the proportion of children and adults who use the oral health care system (visited a dentist) during the previous year.**
[HP 2010 Target 21-10: 85%.] (Source: National Center for Health Statistics, National Health Interview Survey)

U.S. Baseline (1999):

Age 2-17:	Whites 74.5%; Blacks 67.6%; Asian/Pacific Islanders 70.8%; Hispanics 59.3%.
Age 18-64:	Whites 66.5%; Blacks 55.8%; Asian/Pacific Islanders 62.7%; Hispanics 50.6%.
Age 65 and over:	Whites 56.7%; Blacks 39.5%; Asian/Pacific Islanders 51.6%, Hispanics 44.0%.

F. Mental Health Care

The discussion of the prevalence of mental illness is in Chapter 4, “Family Health.”

The recently released *Mental Health: Culture, Race, and Ethnicity —A Supplement to Mental Health: A Report of the Surgeon General* drew the following conclusions regarding Blacks:³⁹

- Blacks who are distressed or have a mental illness may show symptoms according to Black cultural presentations.
- Blacks use religion to cope with conditions that might result in mental illness; almost 85% of Blacks describe themselves as “fairly religious” or “very religious.”
- Blacks are more likely to seek alternative therapies.
- Access to mental health services is more limited.
 - Many Black workers do not qualify for public coverage, even though they are employed by businesses that do not provide coverage.
 - There is a shortage of Black providers, and feelings of mistrust and stigma or perceptions of racism may keep Black patients away from other providers.
 - Treatment is often sought from primary care providers, and many Blacks do not have a continuing source of primary care.
- Blacks may receive care in emergency rooms or psychiatric hospitals where the pattern of treatment may undermine the delivery of care, and Blacks also tend to leave treatment prematurely.
- Blacks are more likely to be mis-diagnosed than Whites.

Mental Health: Culture, Race, and Ethnicity drew the following conclusions regarding Hispanics:⁴⁰

- There are patterns of resilience among Hispanic immigrants:
 - Dual orientation, a comparison between conditions in the U.S. and those in their country of origin, that reduces the level of stress;
 - Strong patterns of extended family;
 - Desire to succeed not only for oneself, but also for the benefit of the family group;
 - Spirituality.
- It is also necessary to remember that there will be differences in mental illness between Mexicans, Central and South Americans, Puerto Ricans, and Cubans.
- Hispanics have two major barriers to care:
 - Financial barriers similar to those described above for Blacks.
 - Lack of providers with linguistic and cultural competence skills.

Mental Health: Culture, Race, and Ethnicity drew the following conclusions regarding Asian/Pacific Islanders:⁴¹

- Asian/Pacific Islanders have the lowest rate of utilization of any of the racial/ethnic minorities.
 - Severity of disorders is often high since persons often wait until the condition becomes extreme.

- There is a strong tendency to use alternative resources.
- Barriers to care include:
 - Stigma of using services;
 - Lack of financial resources;
 - Differing concept of health and treatment from those of Western medicine; and
 - Lack of providers who speak the language and understand the culture.

Mental Health: A Report of the Surgeon General made these additional points regarding mental health in minority children:⁴²

- Studies have found that Black children are:
 - Considerably more likely to enter the child welfare system,
 - Over-represented in arrests, detention, and incarceration in the juvenile justice system, and
 - Over-represented in educational classes for the severely emotionally disturbed.
- Hispanic children tend to remain in the foster care system longer than Whites. They are also more likely than Whites to be detained in juvenile justice facilities.
- Black and Hispanic children more often leave mental health services prematurely than do White children. Insensitivity of providers to the culture of the children and their families is often cited as the reason.
- Studies have shown that children of all ethnic groups are less likely to drop out of treatment programs that linked to community cultures.

FACT: In Pennsylvania in 2001, there are 29 mental health care HPSAs, including 4 serving specific facilities (usually state correctional institutions). These HPSAs serve a total population of over 1.7 million.⁴³

Related Healthy People 2010 Targets:

- **Increase the proportion of children with mental health problems who receive treatment. [HP 2010 Target 18-7: To be developed.]**
(Sources: PA Departments of Health and Public Welfare)

PA Baseline (N/A)

[measures to be developed]

- **Increase the proportion of adults with mental health problems who receive treatments. [HP 2010 Target 18-9: No target; this is a summary of several Targets.]**

Increase the proportion of adults, aged 18 years and older, with recognized depression.

HP 2010 Target 18-9b: 50%.]

(Sources: PA Departments of Health and Public Welfare)

PA Baseline (N/A)

[measures to be developed]

G. Access to Secondary/Tertiary Care

Secondary and tertiary care involves complex treatment such as hospitalization or surgery for acute or chronic conditions or illnesses. Disparities in access may be felt by both patients and by minority physicians who are less able to obtain necessary care for their patients.

FACT: In 1994, 8% of White U.S. adults reported a “major problem” in their access to specialty care, while the rates for minorities were Blacks 16%, Hispanics 22%, and Asians 26%.⁴⁴

- Within the Hispanic and Asian minority groups, nationally:
 - Among Hispanics, the rates were Mexican 19%, Puerto Ricans 24%, and Cubans 27%.
 - Among Asians, the rates were Chinese 41%, Vietnamese 8%, and Koreans 12%.⁴⁵
- A national study of Black and White differences in specialty procedure utilization among Medicare beneficiaries age 65 and older in 1993 found the following disparities:⁴⁶
 - Angioplasty: Whites 5.4 procedures per 1,000 beneficiaries, Blacks 2.5.
 - Coronary Artery Bypass Graft Surgery: Whites 4.8 procedures per 1,000 beneficiaries, Blacks 1.9.
 - Hip Fracture Repair: Whites 7.0 procedures per 1,000 women, Blacks 2.9.
 - Amputation of All or Part of Limb: Whites 1.9 procedures per 1,000 beneficiaries, Blacks 6.7.
 - Bilateral Orchiectomy: Whites 0.8 procedures per 1,000 beneficiaries, Blacks 2.0.
- A Pennsylvania study found that in 1997-99, 17% of White patients admitted to hospitals for conditions, which might require coronary artery bypass graft surgery, received the procedure; 9% of Blacks, 9% of Hispanics, and 19% of Asians.⁴⁷

- A national study found that:⁴⁸
 - In 1998-99, 8% of White physicians reported that they could not get medically necessary referrals to high-quality specialists for their patients, as opposed to 11% of Black physicians, and 12% of Hispanic physicians.
 - In 1998-99, 24% of White physicians reported that they could not obtain non-emergency inpatient admissions for their patients, as opposed to 32% of Black physicians and 29% of Hispanic physicians.

Related Healthy People 2010 Targets:

- **Reduce the proportion of families that experience difficulties or delays in obtaining health care or do not receive needed care for one or more family members. [HP 2010 Target 1-6: 9%.]**
(Sources: PA Departments of Health and Public Welfare, PA Health Care Cost Containment Council)

PA Baseline (N/A) [measures to be developed]

- **Eliminate racial disparities in the rate of total knee replacements. [H.P. 2010 Target 2-6: Developmental.]**
(Sources: PA Health Care Cost Containment Council)

PA Baseline (N/A) [measures to be developed]

Also, the first two Targets for Primary Care Services would apply here as well.

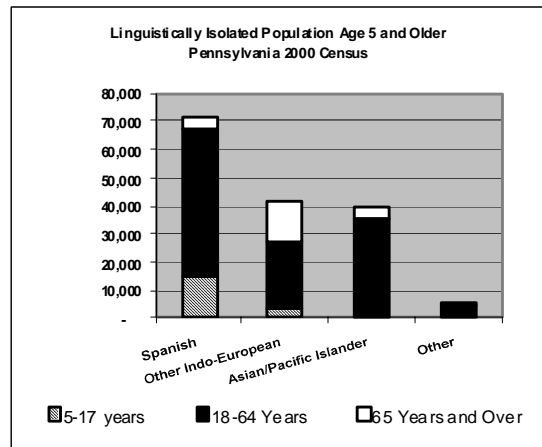
- **Increase the proportion of persons with health insurance.**
- **Increase the proportion of persons who have a specific source of on-going care.**

Health Risk: Lack of Cultural Competence

Health care providers need to be culturally competent; that is, aware of differences in the cultural background of their patients, for a number of reasons:

- Diverse belief systems exist related to health, healing and wellness;
- Culture influences help seeking behaviors and attitudes toward health care providers;
- Individual preferences affect traditional and non-traditional approaches to health care;
- Patients must overcome personal experiences of biases within health care systems; and
- Health care providers from culturally and linguistically diverse groups are under-represented in the current service delivery system.⁴⁹

FACT: As the chart at the right shows, there are roughly 160,000 Pennsylvanians aged 5 and over who are linguistically isolated; that is, who speak English less than well or not at all. These persons are grouped by their native language or language group and by age.⁵⁰



In 2000, the HRSA Office of Minority and Women's Health conducted a study of the linguistic services available at community health centers. Key findings were:⁵¹

- Most limited or non-English speaking health center consumers are low income, refugees, immigrants, or undocumented immigrants, whose legal or socioeconomic status increased the cost and complexity of providing services to these populations.
- A third of health centers responding did not distinguish culture from language; a third made efforts to address cultural competence in providing health care; and a third recognized culture as an added dimension to health care.

“Keep in mind that different cultures have different attitudes with regard to health issues; understand taboos.”

Quote from Ethnic Community Forum held in Williamsport, PA on September 20, 2001.

- The U.S. health care system has a culture of its own that must be navigated with the patient to maximize cross-cultural communication.
 - The capacity to speak a language does not guarantee the skill to interpret accurately and meaningfully, nor to understand the cultural context of the language.
 - Communication networks within language and ethnic groups, including word of mouth, are highly effective means of outreach.
- Networking with other, local community-based organizations is a means of making health services known to a wider population.
 - Health centers should not totally rely on written materials for outreach, as many of the people they seek to reach do not often have a command of any written language.

In August 2000, the U.S. Department of Health and Human Services required that entities receiving federal funds, including Medicaid and CHIP, provide assistance for persons with limited language capabilities, as follows:⁵²

- Translated written materials, for each limited English proficiency group that constitutes 10% or 3,000 members of the eligible/affected population, whichever is less.
- Translated vital documents for limited English proficiency groups, which constitute 5% or 1,000 members of the eligible/affected population, whichever is less.
- Written notice in the primary language of any limited English proficiency group of 100 or more of its right to receive competent oral translation of written materials.

FACT: In 1994, 15% of U.S. adults made use of herbal medicine.⁵³

- Whites 12%, Blacks 17%, Hispanics 23%, and Asians 28%.
 - Among Hispanics, the rates were Mexican 23%, Puerto Ricans 24%, and Cubans 22%.
 - Among Asians, the rates were Chinese 32%, Vietnamese 17%, and Koreans 35%.

Related Healthy People 2010 Targets:

- **Increase the proportion of persons who report that their health care providers have satisfactory communications skills. [HP 2010 Target 11-6: Developmental] (Sources: To be developed.)**

PA Baseline (N/A) [measures to be developed]

- **Increase the proportion of Federal, Tribal, State, and local public health agencies that incorporate specific competencies in the essential public health services into personnel systems. [HP 2010 Target 23-8: Developmental] (Sources: To be developed; National Association of County and City Health Officials (NACCHO), Association of State and Territorial Health Officials (ASTHO).)**

PA Baseline (N/A) [measures to be developed]

- **Increase the proportion of Federal, Tribal, State, and local public health agencies that provide continuing education to develop competency in essential public health services for their employees. [HP 2010 Target 23-10: Developmental] (Sources: To be developed; NACCHO, ASTHO.)**

PA Baseline (N/A) [measures to be developed]

Health Risk: Lack of Diversity in the Workforce

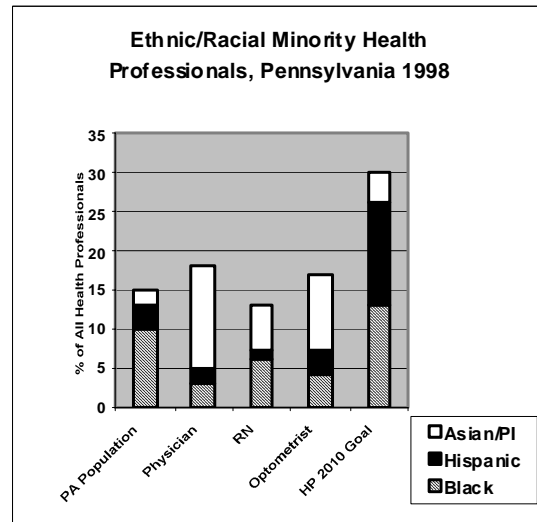
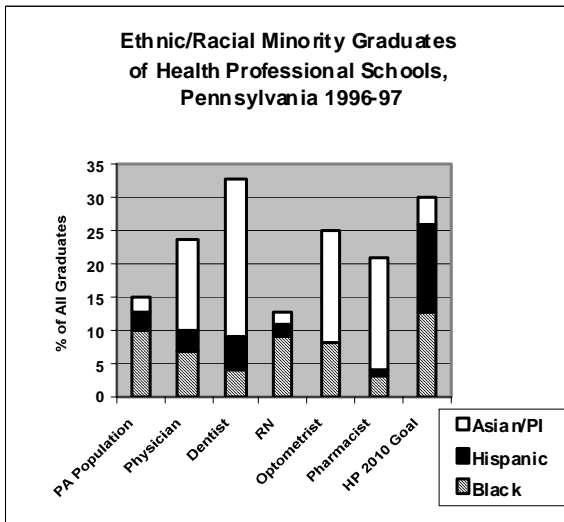
Workforce diversity in the health care delivery system is useful for three reasons:

- Members of an ethnic group are more likely to speak the language of that group, and so, better communicate with patients belonging to that group.
- Members of an ethnic/racial group are more likely to be aware of cultural factors that may prevent or delay a person from seeking health care, may cause a person to refuse care, or may impact on the effectiveness of care that is given.
- Patients are more likely to be comfortable receiving health care services from “one of their own.”

“Recruiting and retention of minority health care professions are crucial for the patients to be related, feel comfortable, and understand their health issues.”

*Quote from
Ethnic Community Forum
held in York, PA on
September 26, 2001.*

The two charts below show the percentage of graduates of health professional schools and the percentage of health professionals in Pennsylvania who are members of ethnic or racial minority groups. The only minority group that may be said to be over-represented is Asian/Pacific Islanders.⁵⁴



Related Healthy People 2010 Targets:

- **In the health professions, allied, and associate health fields, and the nursing field, increase the proportion of all degrees awarded to members of underrepresented racial and ethnic groups.**

[Health professions, allied and associate health fields**HP 2010 Target 1-8c: Black 13%****HP 2010 Target 1-8d: Latino 12%****HP 2010 Target 1-8b: A/IP 4%]****(Future Source: Pennsylvania Department of State, Bureau of Professional and Occupational Affairs)**

PA Baseline (1998):

Optometrists: Blacks 4%; Latino 3%; Asian/Pacific Islander 10%.

[Nursing**HP 2010 Target 1-8g: Black 13%****HP 2010 Target 1-8h: Latino 13%****HP 2010 Target 1-8f: A/PI 4%]****(Future Source: Pennsylvania Department of State, Bureau of Professional Licensure)**

U.S. Census Region III (DC,DE,MD,PA,VA,WV) Baseline (1998):

RNs : Blacks 6%; Latino 1%; Asian/Pacific Islander 6%.

[Health Professions**HP 2010 Target 1-8i: Medicine To Be Developed****HP 2010 Target 1-8j: Dentistry To Be Developed****HP 2010 Target 1-8k: Pharmacy To Be Developed****Note: Recommend that 13%/13%/4% Targets used above be adopted here.]****(Future Source: Pennsylvania Department of State, Bureau of Professional Licensure)**

PA Baseline (1998):

Physicians: Black 3%; Latino 2%; Asian/Pacific Islander 13%.

Recommendations and Strategies

Recommendation: The Department of Health should collaborate with other state agencies and other organizations and agencies to develop new programs to address the resource, access, and financial barriers to quality minority health care.

Strategy: The Department of Health should collaborate with other State agencies, the U.S. Department of Health and Human Services, community health improvement partnerships, and ethnic/racial community organizations to explore the availability of federal, state, and local resources, including the use of resources from private foundations, for programs by state or local government and by local community health improvement partnerships to address access barriers to quality minority health care.

Strategy: The Department should collaborate with ethnic/racial community organizations to develop culturally competent means of outreach, particularly for immigrant populations and populations with limited English proficiency. This would include development of program-specific information and educational materials.

Strategy: The Department of Health should collaborate with the Departments of Aging, Insurance, and Public Welfare, and the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) to develop culturally competent information about CHIP, Medicare, and other public programs, including application materials for limited English proficient populations.

Strategy: The Department should collaborate with ethnic/racial community groups, community health improvement partnerships, and health care provider organizations to address the need for more culturally competent health care providers, especially primary care providers, in low-income and other medically underserved areas, including populations with limited English proficiency. This would include identifying potential incentives for providers in such areas.

Strategy: The Department should collaborate with ethnic/racial community groups and health care provider organizations to develop resource materials related to the culture, language, beliefs, and practices of various ethnic/racial groups in order to enable health care providers to better provide culturally competent care to individual members of these groups.

Strategy: The Department of Health should consider continuing its outreach to the minority population of the state through ethnic community forums and other means, including encouraging minority group participation in community health improvement partnerships or the creation of minority community health improvement partnerships.

Strategy: The Department of Health and community health improvement partnerships should encourage ethnic and racial community organizations to participate in the health improvement planning process as a means of ensuring that the need of their constituents are met.

Recommendation: The Department of Health should develop and disseminate culturally competent information on health care access issues to the elderly.

Strategy: The Department of Health should collaborate with the Department of Aging to develop and disseminate culturally competent information on the PACE drug program and how to apply for enrollment, including application materials for limited English proficient populations.

Strategy: The Department of Health should collaborate with the Departments of Aging and Public Welfare to develop culturally competent information about Medicare and other public programs for the elderly, including application materials for limited English proficient populations.

Strategy: The Department of Health should collaborate with the Departments of Aging, Public Welfare, and Insurance and the U.S. Centers for Medicare and Medicaid Services to develop culturally competent material related to HMOs, including both enrollment information and information of how to deal with the pullout of HMOs from Pennsylvania. This material should include provisions for persons with limited English proficiency.

Strategy: The Department of Health should identify and use cultural brokers within the various ethnic/racial communities, including faith-based institutions, to address issues of service awareness, linguistic barriers, data collection, the health problems of new immigrants, and cultural perceptions of the role of women. These brokers should also be asked to participate in the training of community members to provide these services and information.

Recommendation: **The Department of Health should develop means for increasing the awareness of, and of enforcing, the Title VI of the Civil Rights Act of 1964 requirements related to limited English proficiency.**

Strategy: The Department of Health should partner with the Department of State and ethnic and racial community groups to develop certification requirements and a Code of Ethics for medical interpreters in both medical and mental health fields.

Strategy: The Department of Health should develop standard language for inclusion in all regulations, contracts, and grants requiring adherence to the Title VI requirements related to linguistically isolated populations.

Strategy: The Department of Health should develop standards and practices for adherence to the requirements of Title VI for all state health centers and clinics.

Strategy: The Departments of Aging, Health, and Public Welfare should collaborate with the various medical, allied health, and public health professional societies (Pennsylvania Medical Society, Pennsylvania Osteopathic Medical Association, Pennsylvania Dental Society, Pennsylvania State Nurses Association, Pennsylvania Public Health Association, etc.) and medical trade organizations (Hospital and Healthsystem Association of Pennsylvania, Pennsylvania Association of Rehabilitation Facilities, Pennsylvania Health Care Association, Association of Home Health Agencies, etc.) and ethnic/racial minority groups to develop and promote standards and guidelines for adherence to the requirements of Title VI by all hospitals and providers of primary health care.

Strategy: The Department of Health should include training in the requirements of Title VI and standards and guidelines for meeting these requirements in its public health institutes, as well as encourage and participate in such educational programs by other organizations.

Strategy: The Department of Health should create a standing Work Group within the Minority Health Task Force to advise it on issues related to cultural and linguistic competence of health care providers. Community facilities should be encouraged to develop minority-based community advisory committees to provide advice on culturally competent services.

Strategy: The Department of Health should encourage the Department of State to consider the issues of bilingual proficiency and cultural competence in licensing reciprocity programs.

Strategy: The Department of Health should encourage community health improvement partnerships and other local health organizations to consider the requirements of Title VI and the issues of cultural competence in developing and implementing local programs.

Strategy: The Department of Health should collaborate with providers of home health services to provide culturally competent materials and information on home safety, fall prevention, and poisoning.

Strategy: In keeping with the requirement of Title VI that it work to better understand the language proficiency problems of its client population, the Department of Health should consider the issue of limited English proficiency in surveys and other data collection activities.

Recommendation: The Department of Health should collaborate with various other groups to encourage minority individuals to enter and remain in the health care professions.

Strategy: The Departments of Aging, Health, and Public Welfare should collaborate with the various medical, allied health, and public health professional societies (Pennsylvania Medical Society, Pennsylvania Osteopathic Medical Association, Pennsylvania Dental Society, Pennsylvania State Nurses Association, Pennsylvania Public Health Association, etc.) and medical trade organizations (Hospital and Healthsystem Association of Pennsylvania, Pennsylvania Association of Rehabilitation Facilities, Pennsylvania Health Care Association, Association of Home Health Agencies, etc.), schools of public health, and ethnic/racial minority groups to develop and promote programs to eliminate discriminatory behavior towards minority health professionals and encourage hiring of racial and linguistic minority personnel in administrative, professional, paraprofessional, technical and personnel positions to address equity.

Strategy: Health employers should be encouraged to aggressively recruit minority and bilingual professionals from universities throughout the United States.

Strategy: The Departments of Aging, Health, and Public Welfare should collaborate with the various medical, allied health, and public health professional societies, medical trade organizations, and ethnic/racial minority groups to develop and promote job ladders and mentoring programs for minority health and associated health professionals.

- Strategy: The Department of Health should work with the Department of Education and the various medical, allied health, and public health professional societies and schools of public health to develop ways to encourage minority students, especially those in grade school and middle school to consider careers in medicine, the allied health professions or public health.
- Strategy: The Department of Health should work with the Governor's School for Health Care to develop creative ways of recruiting minority students to participate in that program.
- Strategy: The Department of Health should meet with the Department of Education to assess the degree to which allied health career training programs are incorporated into vocational-technical training programs and to explore the expansion of these programs and the number of minority students enrolled.
- Strategy: Any Work Group convened by the Department of Health to investigate health care personnel shortages within the State should consider strategies for increasing the number of minorities in those professions.

Summary

There are great disparities in access to all manner of health care services among racial and ethnic minorities, including health insurance coverage, lack of a source of primary care (particularly for prenatal care) and transportation. Cultural and linguistic differences may make persons less likely to seek care and to accurately communicate with health care providers, so that the provider understands the problem and the patient understands and follows the prescribed treatment. There are also disparities in the healthcare workforce with Blacks and Hispanics being very underrepresented. These issues impact on all the other healthcare categories and must be addressed to best improve the health of all citizens of the Commonwealth.

Access to Care

- ¹ M.J. Friedrich, “Medically Underserved Children Need More Than Insurance Card,” *Journal of the American Medical Association* 283:23, 3056. The definition is attributed in the article to Irwin Redlener, M.D., President of the Children’s Health Fund.

Health Insurance

- ² Both studies are cited in the Kaiser Commission on Medicaid and the Uninsured, *Uninsured in America: A Chart Book*, 2nd ed. (Menlo Park, CA: Kaiser Commission on Medicaid and the Uninsured, March 2000).
- ³ Pennsylvania Partnership for Children, “Covering Kids PA” (Harrisburg, PA, 2000). Discussion of focus groups and their results is available on-line at www.papartnerships.org/1200coverkids.html; Internet.
- ⁴ J.P. Stuber, K.A. Maloy, S. Rosenbaum, and K.C. Jones, *Beyond Stigmata: What Barriers Actually Affect the Decisions of Low-Income Families to Enroll in Medicaid* (Washington, D.C.: George Washington University, July 2000) and M. Perry, S. Kannel, and E. Castillo, *Barriers to Health Coverage for Hispanic Workers: Focus Group Findings* (New York: Commonwealth Fund, December 2000), cited in Peter J. Cunningham, “Targeting Communities With High Rates of Uninsured Children: Despite Improved Eligibility, Enrollment Outreach Remains the Key to Getting Children Insured.” *Health Affairs*, a web exclusive, July 25, 2001 at www.healthaffairs.org; Internet.
- ⁵ Kaiser Commission, “Health Insurance Coverage and Access to Care Among Asian Americans and Pacific Islanders” (Menlo Park, CA: Kaiser Commission, June 2000). This Fact Sheet is available on-line at www.kff.org/content/2000/1525/Asian%20Americans.pdf; Internet.
- ⁶ U.S. Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau, *Child Health U.S.A. 2000*. (Washington, D.C.: Health Resources and Services Administration, 2000), 66.
- ⁷ Pennsylvania Department of Health (PA DoH), Bureau of Health Statistics, *2000 Behavioral Health Risks* (Harrisburg, PA: Pennsylvania Department of Health, 2001), 7.
- ⁸ The material given here is from various tables in U.S. Census Bureau, *Health Insurance Coverage 2000*, available on-line at www.census.gov/hhes/www/hlthin00.html; Internet.
- ⁹ PA DoH, *2000 Behavioral Health Risks*, 7.
- ¹⁰ Kaiser Commission, *Uninsured in America*. The overall rate was 37%, the same as in 1999.
- ¹¹ Ibid.
- ¹² C.L. Schur, and J. Feldman, *Running in Place: How Job Characteristics, Immigrant Status, and Family Structure Keep Hispanics Uninsured* (New York City: The Commonwealth Fund, The Project HOPE Center for Health Affairs, May 2000).
- ¹³ Kaiser Commission, “Health Insurance Coverage and Access Among Asians and Pacific Islanders.”
- ¹⁴ Pennsylvania Department of Public Welfare, Office of Medical Assistance Programs, *Statistical Report 1998-99*. (Harrisburg, PA: Pennsylvania Department of Public Welfare, December 2000).

- 15 Kaiser Commission, “Health Insurance Coverage and Access to Care Among Latinos” (Menlo Park, CA: Kaiser Commission, June 2000). This Fact Sheet is available on-line at www.kff.org/content/2000/1525/-Latinos.pdf; Internet.
- 16 Kaiser Commission, “Health Insurance Coverage and Access Among Asians and Pacific Islanders.”
- 17 Pennsylvania Department of Insurance, “CHIP Enrollment by County” (Harrisburg, PA: Pennsylvania Department of Insurance, 2001). CHIP enrollment statistics for the most recent six months are available on-line at www.insurance.state.pa.us/html/enrlcnty.html; Internet.
- 18 Pennsylvania Department of Insurance, unpublished CHIP enrollment data (Harrisburg, PA, 2001).
- 19 PA DoH, *2000 Behavioral Health Risks*, 7.

On-Going Source of Care

- 20 E. Moy, B.A. Bartman, and M.R. Weir, “Access to Hypertensive Care: Effects of Income, Insurance, and Source,” *Archives of Internal Medicine* 155(14): 1497-1502, 1995 and S.L. Ettner, “The Timing of Preventive Services for Women and Children,” *American Journal of Public Health* 86:1748-1754, 1996. Both are cited in U.S. DHHS, *Healthy People 2010: Understanding and Improving Health*, 2nd ed., vol. 1, (Washington, D.C., November 2000), 1-18.
- 21 U.S. DHHS, National Centers for Health Statistics, *Health, United States, 2001 With Urban and Rural Chartbook* (Hyattsville, MD.: National Center for Health Statistics, 2000), Tables 75 and, 76.
- 22 Ibid.
- 23 U.S. DHHS, HRSA, National Center for Health Workforce Information & Analysis, Bureau of Health Professions, *HRSA State Health Workforce Profile: Pennsylvania*. (Washington, D.C.: Health Resources and Services Administration, December 2000).
- 24 DHHS, *Healthy People 2010*, vol. 1, 1-19.
- 25 PA DoH, *2000 Behavioral Health Risks*, 7.
- 26 Ibid.
- 27 Ibid., Table 83.
- 28 United Health Foundation, *State Health Ranking – 2001 Edition, Appendix C: Health Disparities Within States*. (Minnetonka, MN, 2001). The discussion and the description of the Modified Kessner Criteria is available on-line at www.unitedhealthfoundation.org/rankings2001/appendixc.html; Internet.
- 29 Ibid.
- 30 S.M. Yu, Greg R. Alexander, R. Schwalberg, and M.D. Kogan, “Prenatal Care Use Among Selected Asian Populations.” *American Journal of Public Health*. 2001; 91:1865-68.
- 31 U.S. DHHS, U.S. Public Health Service, “Health Professional Shortage Areas: Primary Care.” (Rockville, MD: U.S. Public Health Service, 18 July, 2001).

Ambulatory Care-Sensitive Conditions

- ³² Pennsylvania Health Care Cost Containment Council, Special Request RQ 1032 (Harrisburg, PA, July 2001).

Transportation

- ³³ U.S. Census Bureau, 1990 Census Summary Tape File 3C – Part 1. Table Look-up of Vehicle Availability by Household by Race/Ethnicity; Geographic Area: Pennsylvania. This is part of a data file available on-line at venus.census.gov/cdrom/lookup; Internet.
- ³⁴ The Children’s Health Fund, *Getting There: Getting Care: Transportation and Workforce Barriers to Child Health Care in America* (New York City: The Children’s Health Fund, 2001), 27.

Dental Care

- ³⁵ U.S. DHHS, National Institute of Dental and Craniofacial Research, *Oral Health in America: A Report of the Surgeon General* (Rockville, MD: National Institute of Dental and Craniofacial Research, 2000).
- ³⁶ Pennsylvania Department of Public Welfare, Office of Medical Assistance Programs, *Dental Summit 1999* (Harrisburg, PA: Pennsylvania Department of Public Welfare, 1999), work group descriptions.
- ³⁷ PA DoH, *1999 Behavioral Health Risks*, 9.
- ³⁸ U.S. DHHS, U.S. Public Health Service, “Health Professional Shortage Areas: Dental” (Rockville, MD: U.S. Public Health Service, 18 July 2001).

Mental Health Care

- ³⁹ U.S. DHHS, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General*. (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2001), 67-69. The statistics on religion are on page 54 of the report; available on-line at www.surgeongeneral.gov/library/mentalhealth/cre/sma-01-3613.pdf; Internet.
- ⁴⁰ Ibid., 146-147.
- ⁴¹ Ibid., 120-122.
- ⁴² U.S. DHHS, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, *Mental Health: A Report of the Surgeon General* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2001), 181-182.
- ⁴³ U.S. DHHS, U.S. Public Health Service, “Health Professional Shortage Areas: Mental Health” (Rockville, MD.: U.S. Public Health Service, 18 July 2001).

Access to Secondary/Tertiary Care

- ⁴⁴ The Commonwealth Fund, K.S. Collins, A. Hall, and C. Neuhaus, *U.S. Minority Health: A Chartbook* (New York City: The Commonwealth Fund, May 1999), Chart 4-17.
- ⁴⁵ Ibid.
- ⁴⁶ Ibid., Chart 4-15.

- ⁴⁷ Pennsylvania Health Care Cost Containment Council, Special Request 01-033 (Harrisburg, PA, 2001).
- ⁴⁸ J.L. Hargraves, J.J. Stodard, and S. Trude, “Minority Physicians’ Experience Obtaining Referrals to Specialists and Hospital Admissions”, Medscape, Inc. August 9, 2001. The article is available on-line at www.medscape.com/Medscape/GeneralMedicine/journal/2001/v03.n04/mgm0809.02.harg/-mgm0801.html; Internet. The study controlled for physicians’ personal, practice, environmental (Medicaid and HMOs), and patient payment characteristics. The differences between Hispanic and White rates for inability to obtain referrals and the Black and White rates for inability to obtain admissions are both statistically significant at $P < 0.05$.

Lack of Cultural Competence

- ⁴⁹ Elena Cohen, consultant, and Tawara D. Goode, *Rationale for Cultural Competence in Primary Health Care* (Washington, D.C.: National Center for Cultural Competence, Winter 1999). The report is available on-line at bphc.hrsa.gov/OMWH/default.htm; Internet.
- ⁵⁰ U.S. Census Bureau, 2000 Census Data Supplementary Survey Summary Table P035.
- ⁵¹ Discussion of these issues may be found at bphc.hrsa.gov/OMWH/default.htm; Internet.
- ⁵² U.S. DHHS, *Policy Guidance: Title VI Prohibition against National Origin Discrimination As It Affects Persons With Limited English Proficiency* (Washington, D.C.: U.S. DHHS, August 2000).
- ⁵³ Collins, Hall, and Neuhaus, *U.S. Minority Health*, Chart 4-17.

Lack of Diversity in the Workforce

- ⁵⁴ HRSA, *State Health Workforce Profile: Pennsylvania* (Washington, D.C.: HRSA, December 2000).

