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Health inequalities among Latinos: what do we know and what can we do?

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WHAT DO WE KNOW?

Numbering over 40 million, Latinos constitute 12.5 percent of the U.S. population, and that number is projected to grow to 103 million, with Latinos representing 24 percent of the population by 2050 (U.S. Census Bureau, 2003). Contrary to the public perception that Latinos are "one culture," the demographic profile is diverse. Comprising a youthful age structure, one-third of Latinos are younger than 18 years of age, and the median age of Latinos in the United States is 27 years, which is considerably lower than 40, the median age for white people (Pew Hispanic Center, 2006). Latinos have multiple origins (63.9 percent are Mexican, 9.1 percent are Puerto Rican, 3.5 percent are Cuban, 10.2 percent are Central American, 5.4 percent are South American, and 8.1 percent are other). Languages spoken among Latinos vary; 80 percent of those younger than 18 years of age reported that they speak English very well, whereas 53 percent of those older than 18 claimed a similar level of English fluency. Among the immigrant population older than 18, nearly three out of four said they speak English less than very well (Pew Hispanic Center, 2006). The geographic location of Latinos is varied, with some residing in traditional urban hubs (that is, Los Angeles, Miami, New York, and Chicago) and with others residing in new growth communities. From 2000 to 2005, the percentage change of the Latino population more than doubled in states like North Dakota (62.1 percent), Arkansas (58.6 percent), South Carolina (51.4 percent), and Tennessee (51.3 percent) (Pew Hispanic Center, 2007). In addition, their family compositions include a rich generational mix of foreign-born and U.S.-born members. For example, three in 10 Latinos are native-born children of foreign-born parents (Pew Hispanic Center, 2006). From 2000 to 2020, the second generation will contribute to 47 percent of the growth of the Latino population, whereas the first generation will contribute only 28 percent (Suro & Passel, 2003).

Planning for the future requires measuring these demographic trends against what is happening within the current U.S. health care context. The increasing federal and state budget deficits, the rising number of uninsured people, and the escalating health care costs present new challenges for policymakers and health practitioners. Consumer needs for health services such as preventive and specialty care, prescription drugs, technological innovations in treatment, and end-of-life care are far exceeding our nation's system capacity to provide affordable, quality, and accessible coverage to a diverse citizenry. Furthermore, a historical pattern of existing health-related inequalities among racial and ethnic minorities and the lack of political will to address them accelerate this health crisis. Given the growth of a heterogeneous Latino population and the emerging challenges facing the nation, what should policymakers, health care providers, and social workers consider in planning for the future?

On the one hand, we should be cautiously optimistic because research has demonstrated that Latinos have favorable health outcomes despite having low levels of education, income, and health insurance coverage (Escarce, Morales, & Rumbaut, 2006; Franzini, Kibble, & Keddie, 2001; Vega & Amaro, 1994; Wei, et al., 1996). This apparent health advantage seems to be particularly evident among immigrants compared with their U.S.-born counterparts with regard to infant mortality, low-birth weight, and all-cause mortality (Acevedo-Garcia, Soobader, & Berkman, 2005; Frisbie & Song, 2003; Hummer, Rogers, Amir, Forbes, & Frisbie, 2000; Singh & Siahpush, 2001).

On the other hand, research on the positive health profile of Latinos suggests a pattern of worsening health outcomes for Latino immigrants with longer durations of stay in the United States and for later generations (Cacari Stone, Acevedo-Garcia, & Viruell-Fuentes, 2007). Thus, we should be overly concerned by evidence that documents growing inequalities in access to health care. For example, the National Healthcare Disparities Report (Agency for Healthcare Research and Quality, 2005) found that although health care disparities between U.S. minority groups and white people are narrowing, Latinos are falling farther behind. By examining the 2002 and 2003 data from 46 different health measures and along six categories of access to care, the researchers found that 59 percent of the disparity access measures were widening for Latinos, whereas 41 percent were decreasing for other minority groups. According to the data from the access measures, Latinos were less likely than were white non-Latinos to receive treatment for diabetes, mental illness, and tuberculosis and were less likely to receive dental and preventive care (Agency for Healthcare Research and Quality, 2005). Both a deteriorating health advantage with greater length of stay in the United States and the widening inequalities with regard to health care access might be the results of structural vulnerabilities within and outside the health care system that require immediate action.

WHAT CAN WE DO?

When planning for the future, we must work within the mainstream health care policy venues and address the social determinants of health, including income, work, education, and housing. This two-pronged approach involves the following four actions: (1) increase awareness of the causes and consequences of inequalities, (2) strengthen the health care system and build capacity, (3) improve living and social conditions, and (4) engage communities in strategies to eliminate health inequalities.

Increase Awareness of Health Inequalities

Research has demonstrated that there is no single cause of health inequalities but that at any given time multiple factors interact to moderate health and well-being within a particular political, economic, environmental, cultural, ideological, ethnic, and racial context (Berkman & Kawachi, 2000; Institute of Medicine, 2003; Smedley, Stith, & Nelsen, 2003; Syme, 2001). First, individual factors such as income, education, employment, race and ethnicity, gender, and age are critical components in explaining health differences and outcomes. Latinos are more likely to experience low socioeconomic status than are other racial and ethnic groups: For example, more Latinos (22.6 percent) live below the poverty line than do white non-Latinos (9.1 percent), and more Latinos (24 percent) have less than a ninth-grade education than do white non-Latinos (3.2 percent), African Americans (5.6 percent), and Asian Americans/Pacific Islanders (8.1 percent) (Pew Hispanic Center, 2007). Personal behavior also plays a role in mediating risks and protective factors such as exercise, diet, and substance use. Other individual factors that affect health include insurance status, primary language spoken, and generational status in the United States. For instance, of the 46 million uninsured people younger than age 65, Latinos comprise 34 percent, whereas white non-Latinos and African Americans comprise 13 percent and 21 percent, respectively (Kaiser Family Foundation, 2007). The consequences of being uninsured include not having a regular source of care, lacking preventive care and screening, and delaying care until health problems are severe and more costly.

Equally important are the medical and public health services that train and educate health professionals and that deliver care. Access to preventive services, availability of primary and specialty health providers, affordable health care and products, and culturally and linguistically appropriate services are critical determinants of health and well-being. Living and working conditions such as geographic location (rural versus urban) and neighborhood living (community cohesion versus violence) affect health. Environmental conditions such as accessible roads, clean air, and safe drinking water are critical to protecting the physical health and safety of entire communities. In addition, social and economic opportunities such as the cumulative advantages of educational status and the availability of jobs that provide a living wage and employer-sponsored health insurance are critical to health and well-being. Finally, local, state, and national policies are instrumental in either tackling or exacerbating health disparities. For example, a child's state of residence influences his or her likelihood of having public or private health insurance coverage because of that state's labor market and the types of employers offering coverage, Medicaid eligibility levels, and availability and distribution of health care services.

Evidence that a combination of individual factors, health system barriers, and social conditions affect health has become more visible to the general public (Smedley, Stith, & Nelsen, 2003; World Health Organization, Commission on the Social Determinants in Health, 2007). Although ongoing research and public education are needed to increase the understanding of the complex issues surrounding Latino health and the sub-cultural variations in health status and access, it is imperative to use existing evidence to inform immediate actions toward health system change and social equity.

Strengthen the Health Care System and Build Capacity

Recent state-level efforts to implement health insurance reforms have fueled optimism around the idea that individual states can lead the way to improve the plight of the uninsured population. States that have both large Latino population hubs and new growth communities are poised to merge reform efforts on insurance coverage with efforts to address health inequalities. For example, states could build principles of equity into legislation, ensuring that premiums, co-payments, deductibles, and other out-of-pocket costs are affordable. Given the high rate of uninsured Latinos, states must require employers to either provide insurance for their employees or pay into a health care purchasing pool. States also have the option to expand Medicaid eligibility and benefits for children and families up to 300 percent of the federal poverty level. More rigorous and innovative outreach and enrollment strategies could be built into the design of health care reform initiatives such as express-lane eligibility and the use of community health workers or case managers to enroll hard-to-reach and linguistically isolated Latino communities in the state's health coverage plan.

Health care authorities such as the Commonwealth Health Insurance Connector Authority implemented in Massachusetts could serve as a single point of accountability over the training, educating, and licensing of health professionals. A well-trained workforce that is linguistically and culturally competent is needed to improve health access and quality for Latinos. The Office of Minority Health of the U.S. Department of Health and Human Services (HHS) issued the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care (HHS, 2001). State health reform legislation could mandate minimal service standards for the delivery of health care following these guidelines and could adapt the CLAS standards as guidelines for the use of on-site interpreters.

Health coverage authorities that span state agencies, programs, and commissions also could set minimal performance standards for reducing disparities in access and health status for populations served by public funds. Public and private health plans, hospitals, and providers should collect demographic information (for example, race and ethnicity, language preference) to analyze utilization patterns, track health outcomes, and develop solutions to eliminate disparities (Having Our Say Coalition, 2007). Improved performance through focused management practices and common reporting requirements and data collection by race and ethnicity are needed to measure where access disparities exist, what the magnitude of need is, and how these compare with the current system capacity and supply of services. Two health system reform goals for significantly reducing or eliminating disparities should be to provide both comparable access to and results from medical and behavioral health care. Achievement of comparable access and results requires the development and implementation of sound management practices that intervene effectively and that involve the following: data collection and comparative analysis of service utilization rates (access) and service outcomes (health status, hospital readmissions, disease management measures) by types of service users. Both access and outcomes data should be compared with the demographic composition of the community and with the existing service capacity. Accurate data collection, analysis, and monitoring can be used to establish where health status and access disparities reside and also can be used to develop targeted short- and long-term interventions for eliminating them across the entire health care system. These basic benchmarks are essential to moving to a "pay for performance"

environment in which provider and hospital rate increases are based on improving access, quality, and costs and reducing racial and ethnic health disparities.

Given the lack of a national health reform plan, unique opportunities exist for states to act as laboratories for eliminating inequalities in health by moving toward universal health coverage, expanding eligibility policies, providing innovative enrollment and outreach strategies, fostering a culturally and linguistically competent workforce, and affecting system-wide change by setting and monitoring performance standards.

Improve Living and Social Conditions

Social policies and programs that focus on improving the social conditions of Latinos are the cornerstone to promoting and protecting intergenerational health and well-being. Because education is a vehicle for securing employment and attaining economic security, programs that prepare children early in life for school success and that continue to support academic engagement are critical for future health (Mechanic, 2005). Public and private sector investments are necessary for revitalizing low-income neighborhoods, improving the quality of schools, and linking Latino families to economic opportunities (Joint Center for Political and Economic Studies and Policy Link, 2004). As a society, we must invest not only in improving housing conditions and neighborhood environments where Latinos reside, but also in providing incentives for mobility to communities of their choice. The protection of rights for equal participation in the labor market through monitoring and compliance with federal equal employment opportunity laws, the guarantee of minimum living wages, and the provision of employer-sponsored health insurance are the bases for self-determination and health for Latino communities (Cacari Stone et al., 2007).

Foster Community Engagement and Leadership

Public policies to address health inequalities are more likely to be effective if they include leaders in communities of color whose knowledge and values are consistent with community needs and concerns (Marsh, Milly-Hawk, & Putnam, 2003). In addition, system change must be guided by the community. Establishing effective communication with formal and informal community leaders within the local Latino community is a necessary strategy for building service capacity that is meaningful and accepted by the community. Strong consideration should be given to conducting performance measurement in partnership with allied partners such as social services, child welfare, and corrections providers to maximize the sharing of resources and mutual problem solving.

IMPLICATIONS FOR SOCIAL WORKERS

An ethical principle driving the practice of social work is a commitment to social justice. With a focus on social context and living conditions as determinants of health and well-being, the field is well-positioned to lead the nation in eliminating health inequalities (NASW, 2000). Social work extends across distinct institutional structures, including education, employment, housing, and the health care system. All are intersecting avenues to life opportunities that affect health and well-being. Thus, irrespective of whether social workers may be administrators or direct service staff working in the health care system or in other sectors, they must be involved in

eliminating health inequalities. Active strategies are needed to raise awareness of the causes and consequences of inequalities, to strengthen the health care system, to improve living and social conditions, and to partner with communities to eliminate health inequalities.

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