A Latino Health Report
Identifying Barriers and Solutions to Reduce Health Care Disparities
The Chicano Latino Affairs Council was established in 1978 by the Minnesota Legislature to advise the governor and legislature on issues of concern to the state’s Latino community and the unique problems encountered by Latino migrant agricultural workers.

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A Latino Health Report

Identifying Barriers and Solutions to Reduce Health Care Disparities

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January 2009
# Table of Contents

Executive Summary ........................................................................................................ 7  
Introduction ................................................................................................................... 11  
Health Research Review............................................................................................... 12  
Health Focus Groups ................................................................................................. 13  
  Methodology ............................................................................................................. 13  
  Focus Group Demographic Breakdown .................................................................... 13  
Findings....................................................................................................................... .. 14  
  Accessing and Navigating the System .................................................................... 14  
  Lack of Language Access ....................................................................................... 15  
  Transportation ......................................................................................................... 17  
  Increasing and High Costs for Health Care ............................................................... 17  
  Communication and Awareness of Health Information ............................................. 18  
  Quality of Health Services and Programs ................................................................. 20  
    Lack of social services geared at Latinos in suburban Minnesota ...................... 20  
    Access to health insurance and quality in the services provided ......................... 20  
    Beliefs of discrimination in the use of services..................................................... 21  
  Immigration Status .................................................................................................... 22  
Recommendations ........................................................................................................ 23  
CLAC Health Access Survey......................................................................................... 25  
  Research Purpose.................................................................................................... 25  
  Health Status of Minnesota ..................................................................................... 25  
  Health Survey Demographics .................................................................................. 26  
  Survey Methodology............................................................................................... 26  
  Survey Results ....................................................................................................... 27  
  Summary & Conclusion ......................................................................................... 29
Executive Summary

This report presents the findings of eight health focus groups with Latino community members organized by the Chicano Latino Affairs Council and facilitated by the Hispanic Advocacy and Community Empowerment through Research (HACER) during the months of May and August 2008. Six focus groups were conducted in the Twin Cities metro area and two in Greater Minnesota. Focus groups conducted in the Greater Minnesota communities of Willmar and Rochester were partly funded the Office Minority and Multicultural Health at the Minnesota Department of Health.

The Chicano Latino Affairs Council (hereinafter CLAC) worked with already established community organizations (e.g. adult groups, Latino-serving organizations, and churches) to recruit Latino residents in several metropolitan area neighborhoods, as well as Willmar and Rochester. Participants recruited for these focus groups were Spanish-speakers who use different programs or services offered by some of the sponsoring organizations. Nearly all of the study participants were either recent or settled immigrants in Minnesota.

Seventy Latinos and Latinas, mostly immigrants from different Latin American countries, met with HACER and CLAC staff to talk about their experiences with the U.S. health system in Minnesota. From the discussions, four main recurrent barriers were identified:

1. Accessing and Navigating the Health System. The majority of the study participants pointed out the lack of affordable health insurance and transportation to have appropriate health care. Many were not informed about how to access health insurance and what services were available for uninsured individuals. Others indicated the excessive high cost of screenings and medical services in general. In greater Minnesota this is also a main concern as clinic options were less and driving far distances often created logistical difficulties for Latino clients.

2. Communication and Awareness of Health Care Information. A significant number of the participants indicated limited access to preventive health information and few culturally competent and bilingual services outside the metropolitan area, particularly in suburban areas. Many of the participants were also unaware of clinics that offer services on a reduced fee basis for primary care. Other focus groups pointed to gaps in preventative, nutritional, and sexual health education.

3. Quality of Health Services and Programs. A significant number of participants believed that the quality of services depends on the type of health insurance. Some explained that the lack of health insurance also entails some form of discrimination. Some of them were concerned about limited, inefficient, and expensive dental care, to the extent that some prefer to go back to their countries of origin to have dental treatments. In addition to diabetes, dental care and severe family mental health situations were two issues frequently mentioned in all focus groups. In rural areas, the problems were related to health insurance costs, competent language access, migrant status definitions, and logistical needs or challenges such as transportation or driving times.
4. **Immigration Status.** Many participants who might be eligible for services are unaware of the requirements needed to qualify for certain federal or state funded programs. Their main concern is affordability and the use of services for families without documentation. Some shared that they perceive anti-immigrant sentiments or are afraid of using health care services because of their immigration status.

When asked what policy recommendations they would offer to lawmakers in Minnesota, health study participants referred and addressed to the following:

- **Support Universal Health Coverage.** To provide universal health care coverage to all residents in the state regardless of immigration status. Universal health coverage must also include dental services. Lastly, the majority of all study participants stressed the need for state leadership to consider health a basic human right, not a privilege.

- **Provide Affordable and Differentiated Health Plans.** To provide affordable health care and meet the medical needs of families in the state. Health plans in the state should be accessible for low-income families whether through employer-based health coverage or state programs, and immigration status should not deter access for those in medical need.

- **Increase Community Health Outreach.** To provide additional resources for community-based programs to conduct health promotion activities and outreach in the Latino community. Health outreach activities should address health illnesses that affect Latinos, such as diabetes, heart disease, and cancer through multimedia prevention campaigns. Further, increase awareness of nutrition, health, and wellness.

- **Increase Funding for Health Clinics.** To sustain and expand current levels of funding for community health clinics that assist low-income individuals and families with health care and medical needs. Community health clinics must be given adequate resources and funding to continue their work with low-income families and immigrants seeking health care in the metro area and in Greater Minnesota. Also, provide support for programs like “promotoras de salud” (lay health workers) that help ensure access to health prevention and education.

- **Review Certification and Licensure Standards for Immigrant Professionals.** To review state certification and licensure standards for professionally trained immigrants, especially in the fields of medicine and education. Currently, there are a growing number of many medically trained professionals from Latin America who are bilingual, but cannot practice in the state. In an effort to address the need for bilingual and culturally competent staff, state policy makers must explore ways to validate immigrants’ medical training and credentials.

- **Health Issues in Greater Minnesota.** To address the needs of the Latinos in Greater Minnesota, especially the state’s migrant worker population. Due to limited access to health services, there is a significant need to further educate Latinos of available health programs and services. Migrant health information and preventative health measures must also be readily available for Latino seasonal workers in rural areas.
The report is also inclusive of quantitative data and findings from the CLAC Health Access Survey. The primary purpose of the survey was created to gather input on the main issues that Latinos face in accessing quality health care services from the perspective of health access providers. A secondary aim of the health survey was to identify the root causes that contribute to Latino health disparities in Minnesota, the effect of immigration status on health care access, policy change suggestions, and health care models which could improve health care access for Latinos in Minnesota.

The CLAC Health Access Survey is comprised of five sections that detail the background documents, research design, and survey results which guided the survey instrument. A selected pool of 175 participants were identified and selected for the survey. Approximately, 96 respondents completed the survey, 77.8 percent from the Twin Cities metro area and 19.2 percent from Greater Minnesota. The majority of the respondents were community health workers (34.5%), followed by nurses (14.5%), case workers (12.7%), health officials (9%) and researchers (5.5%).

The top three root causes for Latino health disparities in Minnesota were listed as follows:

- Lack of coverage or access to health insurance.
- Language, cultural or communication barriers.
- The affordability of health care.

Policy input from survey participants yielded the following recommendations:

- The expansion of health care access to all Minnesota residents through appropriate legislation.
- A comprehensive reform of existing health access legislation.
- Investment in community based health prevention and education solutions.
INTRODUCTION

This report presents the findings of eight health focus groups with Latino community members organized by the Chicano Latino Affairs Council (hereinafter CLAC or the council) and facilitated by the Hispanic Advocacy and Community Empowerment through Research (HACER) during the months of May and August 2008. Six focus groups were conducted in the Twin Cities metro area and two in Greater Minnesota. Focus groups conducted in the Greater Minnesota communities of Willmar and Rochester were partly funded by the Office of Minority and Multicultural Health at the Minnesota Department of Health. The purpose of the focus groups was to explore the causes behind barriers preventing urban and rural Latinos from gaining access to the health care system and to gather current information based on personal accounts to advise the governor and the Minnesota Legislature and present health care policy recommendations. As part of Chicano Latino Affairs Council’s legislative agenda, the ultimate goal of this report is to advise state legislators and policy makers and educate the broader public around the issues that impact a growing segment of Minnesota’s population.

The council worked with already established community organizations such as adult groups, Latino-serving organizations, and churches to recruit Latino residents in several metropolitan area neighborhoods, as well as Willmar and Rochester. In contrast to the summer 2007 community forums, when all Latino participants in CLAC’s community forums were English-speakers and the visits focused on informing the community about the work of the council, participants recruited for these focus groups were Spanish-speakers who use different programs or services offered by some of the sponsoring organizations. Nearly all of the attendants were either settled or recent immigrants in Minnesota.

Seventy Latinos and Latinas, mostly immigrants from different Latin American countries, met with HACER and CLAC staff to talk about their experiences with the U.S. health system. From the discussions, four main recurrent barriers were identified: 1. accessing and navigating the health system; 2. communication, educational material, and awareness of health care information; 3. quality of health services and programs; and 4. immigration status.

CLAC wants to contribute to the current national and local debate on health reform and health disparities by including the voices of Latinos, both settled and newcomers, as well as health care experts in the state. Many of CLAC’s findings are not new for health care practitioners and advocacy members in the areas of public health and culturally competent health care providers. Yet, while the Latino population continues to grow in Minnesota and nationwide, the persistence of many of these barriers in health care are cause for concern, proving the need to continue fostering a broader understanding of the multi-causal issues faced by many Latino residents when it pertains to accessing health care and improving their quality of life.
There are lengthy and educational studies that have been conducted in Minnesota regarding health issues or disparities among the Latino community in the state. Comunidades Latinas Unidas en Servicio (CLUES) produced one of these reports in 2004 entitled *Health Disparities Affecting Chicano/Latino Communities in Minnesota*. The aim of the study was to define health disparity indicators with the community and understand Latinos' approach to health. Among the main findings, the study also revealed that health disparities affecting Chicano/Latinos were described “as the consequences of multiple factors combined in different ways to different individuals, families, and communities.” As such, the study pointed that health disparities were seen as a complex set of parameters as a result of multiple variables, including lack of awareness, poverty, education, health insurance, job conditions, culture and language, immigration status, health promotion and disease prevention.1

Regarding migrant Latinos, specifically migrant students, HACER, in its study *Let Us Meet You Where You Are: Securing the Educational Accomplishments of Migrant Students (SEAMS)*, issued in 2006, found that migrant students were susceptible to health problems related to traveling, living conditions, and farm work such as sleep deprivation, common colds, dehydration, diarrhea and vomiting which ultimately affected their education. In addition, study participants mentioned other health concerns that included dental problems, poor vision, pregnancy, poor nutrition, mental health issues, and social problems.2

The Public Health Perspective to Eliminate Health Disparities

At the national level, in 2000 the U.S. Department of Health and Human Services identified health objectives and priorities for the country in the document *Healthy People 2010*. The overarching goals were to increase quality and years of healthy life and eliminate health disparities.3 An article by Holly Avey referring to how policies impact health disparities, explains that this initiative contains 467 specific objectives, organized into twenty-eight focus areas.4 Avey indicates that *People 2010* mentions the need to take a multidisciplinary approach in achieving health equity, including improving education, housing, labor, justice, transportation, agriculture, and the environment. One of its primary focuses is on improving access to health care and using health communication and health education techniques to improve individual health behaviors and reduce the incidence and prevalence of specific diseases.

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In Minnesota, the Office of Minority and Multicultural Health at the Department of Health, leads the Eliminating Health Disparities Initiative (EHDI). The EHDI was funded by the Minnesota Legislature in 2001 with the goal of strengthening and improving the health status of American Indians, African Americans, Asian Americans, and Latinos/Hispanics in Minnesota. The purpose of the EHDI is to close the gap in the health status of African Americans/Africans, American Indians, Asian Americans, and Hispanic/Latinos in Minnesota compared with whites in the following priority health areas: breast and cervical cancer, cardiovascular disease, diabetes, HIV/AIDS and sexually transmitted infections, healthy youth development, and violence and unintentional injuries; and by 2010, decrease by 50 percent the disparities in infant mortality rates and adult and child immunization.

In addition, the Minnesota Commissioner’s Task Force on Immigrant Health on its report entitled Immigrant Health: A Call to Action sponsored by the Minnesota Department of Health and the Minnesota Department of Human Services in 2005, acknowledged that despite their contributions to the state, immigrants to Minnesota are the least served by the health and social services system. Factors such as income, wealth and legal status hinder equal opportunities to access the system, discouraging them to seek for timely care and resulting in poorer health and expenses to the health system.5

Health Focus Groups

Methodology

After a series of community visits in the summer 2007, conversations with experts in the field of health care and the revision of existing literature on health disparities, CLAC commissioned HACER, a recognized Latino participatory research organization working with Latinos in the state, to conduct eight focus groups in the Twin Cities and Greater Minnesota. The Office of Minority and Multicultural Health expressed an interest to investigate the issue about the challenges and barriers Latinos face when accessing health care in rural Minnesota and contrast them with residents in the Twin Cities metro area. CLAC worked with Latino and diverse coalition organizations in Saint Paul, Minneapolis, Burnsville, Lakeville, Willmar and Rochester to recruit participants and use their facilities to host these focus groups. HACER facilitated each of the focus groups in Spanish, lead by a facilitator with a note taker. The focus group discussions were recorded and transcribed by HACER and CLAC analyzed and summarized the data and notes based on the transcription recordings.

Focus Groups Demographic Breakdown

A total of seventy people participated in the focus groups, nearly all of them immigrants from different Latin American countries. A significant proportion of the focus groups population was from Mexico (66 percent), followed by other Latinos from Central America, the Caribbean, and South America. A small percentage was native-born (7 percent). Respectively, nearly all of

them were Spanish-speaking residents: a significant percentage has lived in Minnesota for more than ten years (45 percent). In terms of gender, six in ten participants were female. Nearly all participants had children under the age of 18, an average of two children per family. The majority of participants were adults between 26 and 45 years old. Half of the participants were uninsured, mostly with an income below $30,000 a year. Those with health coverage or insurance were either earning more than $40,000 per year, or they were in the $20,000-29,000 and $30,000-39,000 income brackets. Further, the majority of participants earned on average between the aforementioned income brackets. Finally, in terms of educational attainment, most focus group participants did not complete a high school diploma.

Findings

Many issues were presented by the participants during the discussions. Each session started by showing the participant some pictures they could relate to their experiences when they look for help if they are sick. Eleven questions were then asked to explore where the attendees would look for health services, their experiences with the health system, difficulties related to access health providers and information, positive outcomes, and what would be easier for them to increase accessibility. At the end, participants were asked for ideas and recommendations they wished to present to their state representatives or leaders in the community, given the opportunity to talk with them and influence public policy.

Accessing and Navigating the System

A significant theme in the focus groups’ input involved identifying obstacles to health access and navigating the health system in Minnesota. These obstacles referred mostly to qualification requirements, understanding benefits, processing paperwork and comprehending billing statements. While participants overwhelming desired to collaborate with the health system, many of the participants’ experiences left them with feeling that the system barred them from accessing the health system except under emergency conditions.

Participants with private health insurance reported burdensome insurance restrictions. These restrictions included obligations to use specific clinics or health providers. This was especially the case with dental needs. New insurance policy holders were subject to a six month waiting period between the purchasing of insurance and obtaining the health benefits. One participant from Burnsville, Minnesota contrasted this requirement with his previous experience, saying that in Mexico he was granted health access from the very first day of work.

On the contrary, other participants reported several county and city public health programs facilitating and ensuring health access. One Minneapolis participant noted Hennepin County Medical Center’s discount card for qualifying low income residents. Women participants repeatedly shared their access with medical pregnancy insurance and infant care. Many participants reported that Minnesota has exceptional access to the system for child health care services. No cases were reported of an infant in Minnesota going without medical services, vaccinations or medical follow-up. However, one participant in Burnsville noted how the lack of
health access hinders older school age children from extracurricular activities, since the children cannot present valid certificates of health.

Without insurance, participants reported numerous challenges in accessing the health system, from long waiting periods, to minimal service and in some cases refusal of service. One participant in Minneapolis shared her experience of returning to the same health provider for a thyroid problem. One the second occasion, after obtaining health insurance she was surprised of the sequence of exams and tests she underwent in contrast to the treatment she received earlier for the same conditions without insurance. Many participants validated her observation that health access in the United States was perceived as a privilege for those who could afford it rather than a basic human right for all people.

In addressing these challenges, participants reported several strategies in meeting their health access needs. Many participants appealed to the sliding fee community health clinics for non-life threatening medical conditions. Other participants reported the use of home remedies learned from their parents or brought from their native country. Another strategy involved the solicitation of potentially unsafe medicines bought from Latino stores in Minnesota and even in extreme cases the solicitation of medicines imported into the United States from Mexico. One participant summed up this strategy and stated, “[f]irst we try the home remedies, then later we self-prescribe, and in the end if it is really urgent and the home remedy did not heal the condition, then we run to the doctor.”

In Willmar and Rochester, the challenges of health cost, access, and quality exhibited a distinctive rural context. Focus group participants emphasized that health insurance premiums provided by agricultural companies were simply too cost-prohibitive to purchase, given monthly earnings between $800-$1,000 per household. A Rochester participant spoke about the challenges in balancing medical assistance income requirements for the family and his frustrated hopes for financial growth through better economic opportunities. Another participant who had purchased her company’s health policy expressed her desire for assistance in understanding the documents, restrictions and benefits of her health insurance plan. Many participants identified their lack of knowledge in educating themselves between the privatized American and socialized Latin American models of health care. Some participants expressed their frustration at perceptions that insurance companies have driving motives for economic gains. According to one participant in a Twin Cities metro area focus group, the system is built that way. The participant stated, “[t]his is part of the system; that they provide insurance if you don’t have diseases or illnesses because the insurance is left with the money to invest. If you have a disease they won’t cover you because the insurance is to make money.”

Lack of Language Access

Adequate communication and language challenges were ubiquitously identified as a key factor hindering health access throughout all eight focus groups. These challenges manifested themselves, primarily in inpatient interviews, doctor/nurse communication, health education, prescription directions, hospital applications, and benefit explanations.
A participant in St. Paul mentioned, “Latinos are always inclined to go to clinics where they speak Spanish.” For both newly arrived Latinos as well as long time residents, having a reliable, ready interpreter was identified as essential for proper health access. Interpreters facilitate communication in all aspects of health access. One Minneapolis participant stated, “[t]ranslators should be professionals, because the medical staff can change medicine based on their interpretation of the translator.” One Lakeville participant mentioned her discomfort at learning that her health insurance obliged her to attend a clinic with few interpretive resources.

Some participants urged that a qualified interpreter should command some level of cultural competence in navigating through the distinct Latino Spanish dialects and idioms. In this sense, interpreter error, especially if the Latino patient has some English language proficiency, was perceived as disempowering and sometimes resulted in gross medical or surgical errors. A Lakeville participant commented on her frustration when her interpreter confused gonorrhea with gangrene. In addition, a Minneapolis participant rightly pointed out a language dialect confusion when the translator knew traditional Spanish (Spain dialect) perfectly, and they did not know the language or regional terminology of the person from Honduras and further committed a big error.

In order to address communication needs, many participants reported turning to their American born children. This strategy exhibits major weaknesses in the system as it disempowers parents and places children in awkward positions of authority without fluent command of medical terminology. Other participants candidly noted that the need is so great that you have to look for other options. According to a Minneapolis participant, “[y]ou have to make an effort, find a friend, pay a translator, or learn English.”

Language access is not only needed in direct oral translation, but also in understanding written medical documents, such as bills, prescriptions, and educational health material. Finally, participants noted that language access sometimes turned into communication vacuums as doctors sometimes have no way to communicate effectively with patients.

In essence, qualified interpreters are necessary for understanding intake interviews, medical and surgical procedures, medical dosages, billing and exit interviews. In the absence of interpreters, participants reported feeling helpless, lost and unmotivated to engage their health practitioner. One participant who was also a medical doctor noted that appropriate medical interpretation was not simply a matter of literal word for word translation, but one of concept transfers through competent means. He suggested that Latino culture stresses oral over written communication, therefore, pictorial or interactive conversation is more effective over simple narrative in facilitating understanding.

Several focus group participants noted the presence of Latino doctors, nurses and other medically trained Latinos working within the service sector. Repeated focus groups revealed that participants sought these experts as linguistic and cultural experts regarding medical advice. Many participants strongly expressed desire for public recognition and sanction of these competent medical staff in providing better health access to Latinos.
In Willmar and Rochester, competent language and communication access remained an important need in facilitating health access. For these Greater Minnesota participants who lacked community clinics or other agencies for community support present in the Twin Cities, communication access with health providers was even more crucial for educational, preventative, and diagnostic purposes.

Transportation

A number of focus group participants noted that transportation logistics proved a significant barrier in accessing health services. Transportation obstacles included clinic hours after work, access to available transportation, vehicle accessibility, and geriatric transportation for those Latinos who were too elderly to drive. Other Latinos who did not qualify for driver’s licenses, especially if they lived in a suburb and sought health access in the Twin Cities, noted both the distances and time commitment required to receive medical services. Participants also expressed a lack of awareness of ambulance and other transportation services, and generally relied upon taxis or family members with vehicles to provide transportation.

Nonetheless, this need seemed to be offset by medical programs which included transportation. Several Minneapolis participants noted an awareness of a non-emergency taxi voucher program which could be extended to both pregnant, geriatric, and other non-emergency cases. Communication of this program was reportedly poor by other focus group participants.

Adequate transportation for greater Minnesota participants was regarded as a critical issue. The most often mentioned challenges included lengthy commutes to accessible clinics and dentists.

Increasing and High Costs for Health Care

The increasing and high cost for health care was another ubiquitous barrier identified in all of the focus groups. Even if other helping factors were present, such as language, transportation, and insurance, continued perceptions of prohibitively high cost deeply influenced Latinos preferences for not seeking health care.

One participant from Lakeville, Minnesota complained that there are few options for doctor appointments that cost less than $300 for a consultation. Another participant who is also a community service provider in Lakeville noted that when her clients become sick, they defer to seek medical help due to economic limitations. High costs affect the effective treatment of chronic illness. A diabetic participant in Minneapolis noted that the high cost of needles and insulin prevented her from regular treatment, further making her more susceptible to high risk.

Part of the barriers of high costs stem from participants’ challenges in understanding the medical billing system through prescriptions, doctor consults, and administrative fees. Other challenges included negative interaction with collection agencies, anecdotes from other Latinos and poor communication with the hospital billing staff. Still other participants had negative interactions with hospital collections departments or had their credit ruined as a result of
nonpayment, such as one participant from Minneapolis who was asked to pay $250 upfront for a check-up and subsequently being turned away.

Furthermore, anecdotes stemming from extraordinarily high costs have encouraged participants of Mexican origin to wait to return to Mexico for health care treatments. This is especially true in regard to oral health access. Access to dentists was a common theme in all focus groups and requires significant attention in health care reform. One Minneapolis participant compared her yearly trip to see both her family and dentist in Mexico with the price of a single dental visit in the Minnesota.

Unlike the Twin Cities where low-income dental care is accessible through Medicaid affiliated dental clinics, a participant in Greater Minnesota noted the significant logistical challenges in accessing affordable dental care by describing two hour commutes. Rochester participants also emphasized affordable dental care. One female participant commented on the challenges of finding dentists who accept insurance; others require the obligation to pay half of the visit or dental operation in cash before any services are rendered.

Willmar participants shared some root causes for unaffordable health insurance. These included the Greater Minnesota Latino economic demographic and migrant status definitions. For those Willmar participants who did not have health insurance, the strongest factor influencing health access was the perception of cost. One participant summed up her thoughts in comparing her company wage against insurance costs. She stated, “[i]f you are working for a company and earn a minimum or low wage, it’s very hard to pay $350 of health insurance every month for the family.” Another participant could not afford health insurance even though he had worked for four years at an agricultural plant. He stated, “[u]ltimately, the moment arrives in which you have to decide whether my children will eat, or I will pay the rent, or I can buy health insurance.” Other participants who are settled migrants noted challenges in purchasing health insurance once their resident status changed from migrant worker -defined as residing in the state for less than one year. Migrant workers in Minnesota qualify for migrant health care and insurance. Settled migrants –defined as residing for more than one year in Minnesota- no longer qualify and must depend on their own resources to buy health care insurance.

Communication and Awareness of Health Information

The third largest theme present in all focus groups touched upon Latino health access through the communication of health information. This information included a range between basic preventative education, such as nutritional, work injury, sexual health to health insurance education such as service providers, qualification requirements, claims, and billing. Many participants agreed that this information would help to dispel myths and fears Latinos might have about the health system.

In deepening the focus group conversation about specific lack of informational resources, participants identified several root causes: accessibility, language barriers, cultural competency, preventative information (especially obesity, diabetes and cardiovascular disease), Latino lifestyle matrices (poor nutrition, physical burn-out from over work, cramped quarters) and lack of education regarding accessible hospitals and clinics. Other factors mentioned included
educational level attained and over reliance on home remedies or home country resources and ignorance in addressing chronic illnesses, such as diabetes, heart disease, or cancer.

Additionally, a sense of fear and lack of education in health topics has led many to unduly delay seeking health access. One participant echoed this thought; he stated, “Latinos are sick for such a long time, they may arrive at the hospital eventually, but it maybe could have been remedied earlier.” Numerous participants suggested that health information and prevention strategies were the most urgently needed interventions in order to communicate health information.

Willmar and Rochester participants also urged significant attention to public health education. The focus group participants in Willmar specified diabetes, alcoholism, heart disease, and mental health education as most urgent. In Rochester, a common theme identified in accessing health services was the necessity for effective preventative and nutritional education. The main factors mentioned by participants included diabetes, obesity, heart disease, depression, and alcoholism. One participant indicated that diabetes care was especially urgent as her experience with care for the chronic illness was poor due to language and communication challenges. On a positive note, a Rochester participant highlighted the effectiveness of school health education against his own and expressed optimism for the next generation of Minnesota Latinos.

Several women participants voiced concern for women’s reproductive health issues. One participant noted the urgency of prevention and education for pap smears, mammograms, and prostate exams. One mother also commented on the increasing trend of teenage pregnancy and poverty for Latinas in Minnesota. According to the Rochester participant, “[y]oung women get pregnant too young; they leave their studies and the cycle repeats itself becoming a trend.” Many participants agreed that the diffusion of health access knowledge was needed in the Latino community.

Furthermore, many participants raised awareness of the need for appropriate mental health education. Various participants shared feelings of depression and other mental health symptoms as a result of the stresses of working and living in the United States. Other participants noted the grave absence of qualified psychiatrists, therapists and social workers who could effectively address mental health needs. One participant noted the benefits of alcohol recovery support groups, yet felt the intervention was limited due to his obligation to communicate through a translator. After considering external factors that influence Latino health access, participants spoke of internal and community factors negatively influencing effective health access. These included a cultural illiteracy or suspicion toward mental health. The theme was echoed by a participant in Lakeville who stated, “[i]n the Latino community we are not conscious of psychological problems or mental disturbances.”

Additionally, many participants mentioned an urgent need for effective sexually transmitted diseases and HIV education. Women participants in Minneapolis were also sensitive to sexual and gynecological check-ups. One participant in Minneapolis mentioned that some women only have access to these services during their pregnancies. Another participant in Minneapolis
mentioned how a free mammogram in a health clinic detected a lump in her breast which ultimately saved her life.

Quality of Health Services and Programs

Lack of social services geared at Latinos in suburban Minnesota

Two focus groups focused on the health access needs of Latinos in suburban communities. The participants from these communities offered several insights into their experience. All participants agreed that interaction and care received from doctors was exceptional. Participants in Lakeville and Burnsville expressed a desire for Latino specific health initiatives to be created in the suburbs or to be provided through private insurance agencies. Other suburban participants reported experiences of lengthy delays, minimal health care supervision due to lack of insurance, and other indirect forms of discrimination. In some cases, participants were solicited for resident documentation before treatment was offered. In other cases, participants were obliged to pay either half or the full amount of treatment before they were admitted. This pre-condition sent some suburban participants to seek loans or other means from which to pay their medical debts.

Access to health insurance and quality in the services provided

A significant segment of each focus group was dedicated to uncovering the root causes of Latino coverage in health insurance. Several themes emerged from the focus group data.

One answer related to the perceptions of the U.S. model of health care based on private insurance. One participant in Minneapolis reviewed the basic health strategy dilemma of many Latinos. The participant stated, “[i]f you do not have insurance, you will not be seen; you have to wait until it is an emergency. And when you go in for emergency treatment, the bill can be extremely large.”

Other participants shared their concerns of commercialized health care providers and the unequal treatment of Latinos. According to a participant in Greater Minnesota, “[m]edicine is so commercialized to the point that they [health care providers] do not treat people like human beings, but like numbers.” Another participant in Minneapolis highlighted a cultural distinction in saying that, “we expect to get equal and adequate treatment. When I get medical attention, it is not just that the body is functioning perfectly, but also that emotionally a person is not having problems.” This sense of powerlessness was exacerbated by the lack of recourse that many participants experienced in voicing their complaints or concern for care. One participant in St. Paul stated, “There is not a place to go and leave a complaint or to telephone and make a complaint.” This was echoed by another participant who attempted to call to voice her concern, but had no luck.

Another factor identified was inadequate quality of available insurance programs. Some participants with insurance policies noted that coverage was so poor that they naturally turned to other medical alternatives to find more feasible access. Within this theme a Burnsville participant noted, “Sometimes we sacrifice buying extremely expensive insurance. I prefer to
have medical insurance for the kids, because we do not have this kind of access to the medical insurance of the government.”

That question of quality elicited strong input from almost all participants in the focus groups in all parts of the state. Participants often wished to dispel the myth that Latinos desired free medical services in the United States. Repeatedly, participants’ voices called for affordable and accessible insurance, which could be accessed through a more equitable system. Some participants even suggested the creation of new taxes destined at funding public health insurance. Most significantly, participants stressed their desire to work and pay for accessible and affordable health care in contradiction to perceptions of system abuse or solicitation of free medical services.

Beliefs of discrimination in the use of services

Beliefs of discrimination were another significant theme present in a large portion of the focus groups. These perceptions were based on racial, language, and prejudicial assumptions. Many participants echoed the voice of a Minneapolis resident who identified racial bias as a contributing factor to hindering health access. The participant stated, “[t]hey treat us based on the color of our skin and are sometimes afraid of us.” Another Minneapolis participant noted, “[w]hen they took a look at me and saw that I was brown, they assumed that I had just crossed the border and that I could not speak English. Further, they put up a barrier around themselves in assuming that I could not communicate.” Additionally, other participants spoke of lengthy waits in emergency rooms, even while latter arrivals were treated first. Another participant perceived ridicule by nurses who were unaware the participant spoke English. Most significantly, many participants commented on the lack of avenues for complaints or for seeking resolution of conflict with hospital staff.

A significant sense of injustice was reported from numerous participants who were denied access to public services even though they contributed to paying taxes. Commenting on this fact, one participant noted that the health care system in the U.S. seemed to be a privilege for those who can afford it, rather than a basic human right. This was especially true in the case of dental access. For Latinos who qualified for Medicaid, finding a dentist who accepted Medicaid was extremely challenging especially in Greater Minnesota. One participant in Minneapolis who qualified for Medicaid noted, “I arrived here 11 years ago and immediately had dental health issues so I made an appointment. I was put on a wait list and to this day I am waiting for them to call me about my teeth, but now they have all fallen out.”

The exception to these experiences occurred in the case of both pregnancy and early child care, which many participants reported as excellent. In other cases, such as cancer or other chronic illnesses, participants noted that health care was almost inaccessible. While few Latino participants reported ever having been denied health access simply on racial bias alone, others reported a solicitation of questions, such as immigration status as a precursor to accessing health care services.
Immigration Status

A number of participants in the CLAC focus groups disclosed their experiences as undocumented residents seeking health access. While these residents do not qualify for Medicaid, Medicare or MNCare, their plight at accessing health services poses significant challenges. Although these participants contribute their fair share of tax revenue, nearly all reported difficulty in qualifying for either private or public health services in the absence of a social security identification number. One participant in Minneapolis voiced a common opinion and remarked, “[i]mmigration status has nothing to do with health access, and any person who is employed is serving the state; we pay taxes and we do not have services.”

Other participants shared their difficulty in obtaining health services for their U.S.-born children. One participant in St. Paul reported an incident in which a health worker solicited her resident documentation as a precondition for admitting her children. Due in part to these experiences, many undocumented participants experienced significant fear and apprehension in seeking health care, even if they were the subjects of work-related injury. One participant summed up his perceptions of fear and shared, “Latinos are scared to talk because if they have no documents, there is not much help.”

This sense of disenfranchisement was especially apparent in Greater Minnesota. In Willmar, one participant commented on the frustration of many Latinos. He stated, “[a]s taxpayers who work extraordinary hours, we receive few tangible public health services and that is not right.” The participants in Rochester also highlighted perceptions of immigration status barring needed health access. One participant noted his encounter with intake personnel. The participant recalled, “The receptionist basically said if you do not have a number, I cannot help you.” One Rochester participant expressed resentment at his wage deductions applied to public services which were inaccessible to him or his family, even after many years of work and contributions to a strong Minnesota economy.
Recommendations

The Latino community in Minnesota continues to grow and exercise its influence in many sectors across the state. While Minnesota has an established Latino demographic, many new Latinos have come to Minnesota, further diversifying the community in many ways. Even among these differences, Latino share many common health barriers. The barriers to health care faced by a significant number of Latinos in Minnesota presented in this report are not different in nature from all those experienced by low income families, or other minority groups with limited coverage or no coverage at all. Like many American families, the primary reason why many low-income immigrants are uninsured is the lack of employment based health care coverage. However, as shared by participants in the focus groups, in the case of new immigrants in the process of learning English and integrating to a new culture—particularly for those who lack proper documentation—the situation is more complex. In addition to the lack of health insurance and expensive health coverage for working Latinos to afford on their own, the health care system is limited with adequate preventive, cultural, and linguistic services.

After each health focus group was completed, CLAC and HACER staff engaged participants in an exit conference were they were given the opportunity to voice their recommendations in policy change for the health care system in Minnesota. When asked what recommendations they would engage in and offer to policy makers, most participants referred to the following:

a. **Support universal health coverage**
   To provide and expand universal health coverage to all residents in the state of Minnesota, regardless of immigration status in the U.S. Universal health coverage must include dental health services, as there is a high need for dental hygiene amongst Latinos in the state. According to many participants, health care in Minnesota and the U.S. should be treated as a basic human right and not a privilege.

b. **Provide differentiated health plans**
   To provide affordable health care and meet the medical needs of families in the state. Affordable and differentiated health plans must be made available to families based on family needs. Health plans in the state should be accessible for low-income families whether through employer-based health coverage or state programs. For many participants, immigration status should not be a barrier to deter health care safety-net programs.

c. **Increase community health outreach**
   To provide additional resources for community-based programs to conduct health promotion activities and outreach in the Latino community. Health outreach activities should address health illnesses that affect Latinos at alarming rates, such as diabetes, heart disease, and cancer through multimedia prevention campaigns. In addition, increase awareness of nutrition, health, and wellness programs should be implemented. Participants also confirmed studies that revealed a significant proportion of Latinos get health care information through TV and radio campaigns.

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d. *Increase funding for health clinics*
   To sustain and expand current levels of funding for community health clinics that assist low-income individuals and families with health care and medical needs. Given the economic crisis, both state and nationally, community health clinics must be given adequate resources and funding to continue their work with low-income families and immigrants seeking health care in the metro area and in Greater Minnesota. Additionally, provide support for programs like “promotoras de salud” (lay health workers) that help ensure access to health prevention and education.

e. *Review Certification and Licensure Standards for Immigrant Professionals*
   To review state certification and licensure standards for professionally trained immigrants, especially in the fields of medicine and education. According to many focus group participants, there are many medically trained professionals from Latin America who are bilingual, but cannot practice in the state. In an effort to address the need for bilingual and culturally competent staff, state policy makers must explore ways to validate immigrants’ medical training and credentials.

f. *Health Issues in Greater Minnesota*
   To address the needs of the Latino community in Greater Minnesota, especially the state’s migrant worker population. Due to limited access to health services, there is a significant need to further educate Latinos of available health programs and services. Additionally, migrant health information and preventative health measures must also be readily available for Latino seasonal workers in rural areas. Another important need in Greater Minnesota is communication and interpreter assistance.
CLAC HEALTH ACCESS SURVEY

The following section is submitted as a supplemental quantitative report to the qualitative data gathered and analyzed from the health focus groups. The CLAC Health Access Survey is comprised of five sections that detail the background documents, research design, and survey results which guided the work of the CLAC quantitative analysis. This section of the report represents the joint voices of experts from across the state in the area of Latino health access and services.

Research Purpose

The health survey report aimed to fulfill four objectives:

1. Acquire knowledge about health disparities in the state’s Latino community
2. Gather the voice of Latino/a health experts in the state
3. Create spaces of dialogue and civic engagement
4. Obtain input from the community and experts to provide policy recommendations

Each of these objectives was developed around CLAC’s central mandate to gather the voice of the Latino community and facilitate legislative recommendations to the Minnesota Legislature to improve Latino health access in the state.

Health Status of Minnesota

Health care indicators continue to show that Minnesota continues to be one of the healthiest states in the nation. According to the 2007 America’s Health Rankings report, the state of Vermont surpassed Minnesota as the healthiest. Some of Minnesota’s strengths and attributes include low premature death rate, low infant mortality rate, and low rate of uninsured population.\(^7\) Compared with the rest of the country, Minnesota has one of the highest percentages of employer based insurance. See Table 1 below.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer</td>
<td>61%</td>
<td>54%</td>
</tr>
<tr>
<td>Individual</td>
<td>7%</td>
<td>5%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>11%</td>
<td>13%</td>
</tr>
<tr>
<td>Medicare</td>
<td>12%</td>
<td>12%</td>
</tr>
<tr>
<td>Other Public</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>9%</td>
<td>16%</td>
</tr>
</tbody>
</table>


\(^7\) United Health Foundation et.al. (2007). America’s Health Rankings. A Call to Action for People & their Communities. Minnetonka, MN: United Health Foundation.
However, the same report revealed that the overall health of the country declined by a rate of 0.3 percent since 2006 despite progress in some areas. In regards to health disparities among different cultural groups, the study found that disparities have grown between Latino and non-Latino populations. According to the report, two trends were observed: Latinos received poorer quality health care than non-Latinos. Second, in terms of preventive health care, the Latino population had the lowest percentage of people accessing regular dental care and colon cancer screenings.\(^8\)

In Minnesota, it is estimated that about 374,000 people are uninsured, or 7.2 percent of the state’s populations, with Latinos accounting for 19 percent of that group.\(^9\) Regarding employer coverage by race and ethnicity, very few Latinos and blacks are covered by their employers when compared to the white population. See Table 2 below.

| Table 2. Distribution of the Nonelderly with Employer Coverage by Race/Ethnicity |
|-------------------|-------------------|-------------------|
| White             | 88%                | 73%        |
| Black             | 3%                 | 10%        |
| Hispanic          | 3%                 | 10%        |
| Other             | 6%                 | 7%         |


Health Survey Demographics

The health survey research initiative sought to build from an already established research base within the Latino community, individuals, and organizations that also work with Latinos in the area of health. The online survey was administered in the summer of 2008 to a specified group of Latino health experts, practitioners, and service providers statewide. The research population was defined and identified through their level of expertise and proximity to Latino health issues by way of profession or education.

Survey Methodology

During the summer 2008, CLAC commissioned HACER (Hispanic Advocacy and Empowerment through Research) to assist with the creation of an effective survey instrument for CLAC to utilize in its effort to obtain quantitative data. The purpose of the CLAC Health Access Survey was to engage health experts in the following areas:

- Main health services provided by organizations
- Geographic location of health service providers

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\(^8\) Ibid.

• Main issues that Latinos face in accessing quality health care services*
• The top three root causes that contribute to Latino health disparities in the state*
• Policy change recommendation for health care in the state*
• The effect of immigration status on health care access
• Health care models aimed to improve health care access for Latinos

* Denotes survey feedback to these questions was obligatory

Approximately 175 individual on-line survey invitations were distributed to selected experts in health across the state. A total of 96 submissions (54.8 percent of total invitations) were returned. The survey respondents answered three obligatory survey questions. These questions solicited root cause identification for health disparities and policy recommendations. A slightly lower figure of 46 percent of the respondents offered input regarding health access models and personal feedback. The rate of return from survey respondents in the Twin Cities metro area who completed and submitted a survey had a rate of 77.8 percent, while 19.2 percent of the complete and submitted surveys originated from Greater Minnesota. The following table details the professional origins of survey respondents. See Table 3 below.

Table 3: Latino Health Access Survey Respondents (by percentage of total)

<table>
<thead>
<tr>
<th>Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comm. Health workers</td>
<td>34.5</td>
</tr>
<tr>
<td>Nurses</td>
<td>14.5</td>
</tr>
<tr>
<td>Case workers</td>
<td>12.7</td>
</tr>
<tr>
<td>Public health officials</td>
<td>9</td>
</tr>
<tr>
<td>Researchers</td>
<td>5.5</td>
</tr>
</tbody>
</table>

Survey Results

The tables below exhibit the results of the CLAC Health Access Survey. These tables represent expert feedback into Latino health access: Root Cause Identification (Table 4); State Policy Recommendations (Table 5); Health Care Best Practice Models aimed to close the Latino health disparity gap (Table 6).
Table 4: Root Cause Identification

<table>
<thead>
<tr>
<th>Lack of coverage and access to Health Insurance</th>
<th>Language and Cultural Barriers</th>
<th>The high cost of health care</th>
</tr>
</thead>
<tbody>
<tr>
<td>78%</td>
<td>59%</td>
<td>53%</td>
</tr>
</tbody>
</table>

The table above reports on the fundamental causes of Latino health disparities in Minnesota as reported on the CLAC Latino Health Access Survey. Most respondents reported that insurance coverage and access was the primary cause of Latino health disparities. This category included navigating the health system, understanding limits to insurance policies, and filing insurance claims. The second category was language and cultural barriers. This category was inclusive of communication challenges, such as language competent assistance and perceptions of uncertainty and fear. The third highest rated category identified was the high cost of health care. It was the third root cause for Latino health disparities in Minnesota.

Table 5: Policy Recommendations

<table>
<thead>
<tr>
<th>Promote legislation to expand health care to all residents of Minnesota, regardless of immigration status</th>
<th>Legislate a comprehensive health care access reform</th>
<th>Finance Community Based health prevention solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>83%</td>
<td>62%</td>
<td>59%</td>
</tr>
</tbody>
</table>
Table 5 reports on expert policy input solicited from the CLAC Latino Health Access Survey. The highest rated response (83 percent) sought policy changes which would redefine health care requirements for all residents in the state of Minnesota, regardless of immigration status. The next policy suggestion included reforming health care access policies for more accessibility to health services and language/cultural competent services. The response rate for this category was 64 percent, respectfully. The third policy recommendation provided by the respondents was to support grassroots community health prevention strategies, such as community health workers, preventative educators, and other community-based approaches.

Table 6: Best Practices Models

<table>
<thead>
<tr>
<th>Community Outreach and Education (CHW)</th>
<th>Funding of Culturally Competent Health Clinics</th>
<th>Redefine Low Income Requirements for State Health Plans</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>24</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>

The health survey also included a section for respondents to engage policy makers and provide further information by suggesting best practices to reduce Latino health disparities in Minnesota. The most often mentioned suggestion included the creation, expansion, and funding of culturally competent community health centers in high concentrations of Latinos in the Twin Cities and Greater Minnesota. The second highest input suggested reinforced preventative outreach and education models at the grassroots level. This model would ensure that health outreach in the community would provide greater access to health for families in need of medical attention. Other suggestions included re-examining the eligibility requirements for state health plans to allow for greater participation from Latino residents.

Summary & Conclusion

The voices compiled in this survey represent the expert opinions of professionals who work daily with Latino Minnesotans. CLAC’s role is to transmit this input to policy makers and other interested parties and to support public policy which strengthens the quality of life of the Latino community in Minnesota. The findings of the survey represent key perspectives gathered from primary care providers, health experts, and other health professional. For this reason, their voices carry significant weight and perspective for the greater good of the state to maintain a healthy population; to further contribute and advance a strong economic, cultural, and vibrant Minnesota.