Rural Hispanic Health Care Utilization

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Abstract

Background and Research Objective: Minority populations living in rural areas are often disadvantaged in their abilities to access healthcare in their community. To further understand the scope of this problem a sample of adult Hispanics residing in three north central Texas rural counties was studied.

Sample and Method: A convenience sample of 386 adult Hispanic residents of three rural counties in north central Texas completed surveys about their utilization of health care services in their communities.

Results and Conclusions: 74.4 % were uninsured, 72.3% did not have a primary care physician and 63.6% reported they needed access to more health care. Over the past year 23.3 % reported 1-3 visits to the hospital emergency room for health care. Over half (51.3%) reported the need for a translator when going to the doctor. My conclusion is, rural Hispanics are disadvantaged to health care utilization by a lack of health insurance, language barriers and access to a primary care physician.

Keywords*:* Rural, Access to Health Care, Hispanic

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There is a well-documented problem with health care access for rural minorities (United States Department of Health and Human Services [USDHHS], 2010). Without proper access to primary, secondary and tertiary levels of care poor minority populations are medically vulnerable (Perez-Escamilla, 2010). Rural Hispanics are at risk of suffering from chronic health conditions that could be medically managed with an early diagnosis. Hispanics suffer from diabetes at a much higher rate than other ethnicities (Center for Disease Control and Prevention [CDC], 2011). Between five and seven and a half million Hispanics may have adult onset diabetes, but less than half of these cases are diagnosed (Idrogo & Mazze, 2004). Key barriers for health care access are lack of medical insurance and not having a usual source of care (Durden & Hummer, 2006).

Lack of health insurance coverage is an important indicator of healthcare access. In 2007 health insurance access for Hispanics was lower (68.2% compared with 87.4%) for non-Hispanic whites (USDHHS, 2008). Between 2008 and 2009 the percentage of uninsured Hispanics increased from 30.7 percent to 32.4 percent (DeNavas-Walt, Proctor & Smith, 2010). According to the National Health Interview Survey, Hispanics under age 65 years were about twice as likely as non-Hispanic persons under age 65 years to be uninsured (CDC, 2010). In a study of racial differences in access to health insurance, 45 percent of rural adult Hispanics were uninsured compared to 18 percent of rural adult whites (Glover, Moore, Probst & Samuels, 2004). Another study of Texas Latino immigrant's access to healthcare insurance reveals that only 26 percent of

the total study population reported having some form of health insurance (Rojas, Marshal, Trevino, Lurie & Bayona, 2006).

The gap in health care access for minorities is expected to broaden with projected increases in the Hispanic population. There were 9.1 million Hispanics residing in Texas in 2009 and the median age was 27.4 years. (United States Census Bureau, 2010). In 2000, racial/ethnic minorities accounted for one of every four United States (U.S.) residents (CDC, 2000). In 2009 the Hispanic population was the largest minority population in the U.S. and accounted for 16 % of the total population (United States Census Bureau, 2010).

Further, geographical location complicates access to healthcare. Rural minorities have a more difficult time accessing healthcare as compared to urban minorities (Berdahl, Kirby& Stone, 2007). Common barriers to healthcare access, are low wages, fewer work opportunities that provide healthcare insurance and less discretionary income. Rural Hispanic minorities earn less income and are three times more likely to live in poverty compared to whites. (Ziller, Coburn, Loux, Hoffman & McBride, 2003). In addition to lack of healthcare insurance, language barriers compound the problem. English speaking Hispanics are more likely to have health insurance and access to a doctor when needed for a medical condition (Dubard & Gizlice, 2008).

Design and Methods

The purpose of this study was to explore the healthcare access and utilization among rural adult Hispanics. A descriptive design was used to explore healthcare utilization and identify barriers to healthcare access among three rural Texas counties with a growing Hispanic population. The instrument used to gather information was a modified version of a proven instrument obtained from a questionnaire developed by Duke University in collaboration with the U.S. Department of Health, Education and Welfare. Eric Pfeiffer was the originator in 1975 of the Multidimensional Functional Assessment Scale that measured multiple areas at the same time to provide a profile of an individual (Pfeiffer, 1976). This instrument has been used multiple times with noted reliability and validity.

The study data were collected among adult Hispanics residing in three rural counties (counties with fewer than 50,000 persons) of North Central Texas. Participants were recruited from local Hispanic churches. With the help of a translator I explained the purpose of the study and gained permission from the clergy to recruit participants from their churches. Spanish speaking surveyors were recruited and received training on use of the survey tool.

Prior to data collection the purpose of the survey was explained to the participants. Those who agreed to participate were enrolled in the study after completing an informed consent form. The participants were given the option of answering the survey questions in the language of their choice. Most of the participants responded to the interview in Spanish. Questionnaires were administered through a face- to- face interview. In order to maintain confidentiality no names or identifiers were included in the interview. The questionnaire consisted of 34 structured questions in English and Spanish. The questions assessed participants' demographic characteristics, health status, access to health insurance, access to health care, health problems or conditions. Questions used to indicate healthcare barriers include; Do you have health insurance? Do you have a primary care physician? Do you need someone to translate for you when you visit the doctor?

Sample

Approval for this study was obtained from the Human Subjects Research Review Board at Tarleton State University. A convenience sample of 110 men and 276 women aged 18 years and

older constituted the subjects of this study. The participants were recruited from Hispanic churches in 3 rural counties in north central Texas.

Analysis

Statistical analysis was computed using SPSS version 17 (Chicago, IL.). Descriptive statistics of frequencies, means and standard deviation were computed using ANALYZE DESCRIPTIVE. Surveys with missing data about race, age, gender, primary care physician and access to health insurance were excluded from analysis.

Findings

A total of 386 surveys were included in the data processing and analysis. The mean age of respondents was 34.1 years with a range of 18-78 yrs. Average monthly income was $1261.00 with a range of $100.00 - $6000.00 monthly. The majority of the participants in this study are living in poverty or near poverty depending on the size of their family.

Table 1 lists the findings related to demographic variables including age, gender, marital status, ethnicity, country of origin and education. The sample was predominately (n = 276) female. All respondents were of Hispanic ethnicity (n = 386). The education level was predominately (n = 250) high school and below A small number (n = 20) had a college education. Small percentages (15%) were born in the United States. Many of the respondents (n = 309) did not answer the question about origin of birth. Most (n = 308) responded to the interview in Spanish**.**

Table 1

Demographic Finding

	N	%		N	%
Marital Status			Gender		
Single	87	24.8	Male	110	28.5
Married	264	75.2	Female	276	71.5
Ethnicity			Education		
Hispanic	386	100	Not HS Graduate	132	37.9
Born in the United States			HS Graduate	118	33.3
Yes	59	15	College Graduate	20	5.7
No	18	4.6	Post Graduate	6	1.7
Missing Data	309	78.6	Technical Certificate	10	2.9

Table 2 lists the findings related to health care access. Findings show that the majority of respondents are disadvantaged in their ability to access healthcare. A large number (n= 287) did not have medical insurance. Over seventy percent (72.8%) did not have access to a primary care physician. When seeking medical care (n= 193) needed help with translation. The majority (n=319) did not have enough money for their health needs. A small percent (26.2%) used the emergency room for health care.

Table 2

Barriers to Healthcare Access

	N	%		N	%
Medical Insurance			Trips to ED in Past Year		
Public Assistance	23	6.2	None	276	73.8
Employer Insurance	49	13.2	1-3	87	23.3
No Medical Insurance	287	74.4	4-6	9	2.4
Primary Care Physician			7-9	2	.5
Yes	107	27.7	Enough Money for Health Needs		
No	29	72.3	Yes	19	4.9
Need More Health Care			No	319	81.9
Yes	229	63.6	Don't Know	51	13.3
No	131	36.4	Need Transportation		
			Yes	193	51.3
			No	183	48.7

Diabetes (n = 29) and hypertension (n = 45) were the most common reported chronic illnesses. Table 3 lists reported chronic health problems.

Table 3

Self-reported Chronic Health Problems

	N	%		N	%
Diabetes			High Blood Pressure		
Yes	29	8.8	Yes	45	13.6
No	285	86.4	No	285	86.4
Cancer			Stroke		
Yes	3	0.8	Yes	1	0.3
No	327	83.2	No	329	83.7
Arthritis					
Yes	27	6.0			
No	319	81.2			

Discussion

These results support what is documented in the research literature regarding lack of health insurance among poor rural minorities. This study shows that rural Hispanics are disadvantaged

in their abilities to access healthcare by a lack of income, health insurance and access to a primary care physician. Self-report of emergency room usage in this sample was lower than has been previously portrayed in the literature. Tracking of Hispanic emergency room use in this three county area could assist in developing healthcare policy.

As for chronic conditions, the participants did not have a high incidence of diabetes and hypertension. This could be related to the young age of the respondents or lack of access to health screenings to identify chronic diseases. In the early stages of chronic diseases such as diabetes and hypertension it is not uncommon to be asymptomatic.

This study is limited in its ability to show direct causation or relationship. However, it is important to provide descriptive data on this population to help rural nurses have a better understanding on the scope of the problem. Several questions arise from this study. How do poor, uninsured rural Hispanics access healthcare? Since the participants in this study were predominately female, do rural male Hispanics access healthcare differently than females? How do rural communities provide healthcare for poor minority residents? Many respondents reported they needed translation when seeking healthcare. If no translation is available how are healthcare needs conveyed to the healthcare provider? More research is needed to answer these questions.

Recommendations

Even though this was about Hispanics, the health of the whole community is affected. Minorities in rural communities are working in restaurants, farming, construction and child care. The rural economy is heavily dependent upon their wellbeing. Rural nurses face the challenges of caring for this population and understand the associated issues of poverty and lack of health care. The rural nurse, like all nurses have a responsibility to serve as an advocate for the whole community. To improve the health of minorities such as those in this study, the whole community will need to be involved. Rural nurses will need to work collaboratively with county and city leaders, health care providers, community employers, clergy and others to improve health outcomes for this population.

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