This chapter presents an overview of key issues in Latino health. It is not intended to be an exhaustive review of the state of the literature on Latino health. Rather, significant areas are highlighted for further research on the health of Latinos in the United States. We begin by describing the Latino population, and present a brief profile of the health of Latinos. Next, key issues on acculturation are discussed, focusing on health behavior and other norms, especially familism and fatalism. We then describe features of social environments that may shape health, specifically, the neighborhoods in which Latinos reside. The chapter then proceeds to discuss broader macro-level influences on health; specifically, policies that affect access to health care and immigration. We conclude that the study of Latino health requires expansive models that consider interactions between national origin, acculturation, and broad determinants of health that include cultural, social, and political contexts.

There are currently 50.5 million Latinos in the United States, comprising 16% of the U.S. population (U.S. Census Bureau, 2011). The “Latino” category, however, combines very diverse populations. Mexican Americans (who constitute 63.0% of Latinos) are the largest group, followed by (mainland) Puerto Ricans (9.2%), and Cubans (3.5%). Salvadorans, representing 3.3% of all Latinos, typically are combined within the “Central and South American” category. Latinos from the Dominican Republic, typically categorized as “Other Hispanic”, comprise 2.8% of all Latinos (U.S. Census Bureau, 2011).

The various Latino groups also differ in nativity status (Motel & Patten, 2012). One-third (36%) of Mexicans are foreign-born. This compares to over half of Cubans (59%) and Dominicans (57%), and almost two-thirds of Salvadorans (62%). One-third (31%) of Puerto Ricans living state-side were born on the island (Brown & Patten, 2013).

Latino populations also vary greatly in terms of immigration history, patterns, and trajectories. Moreover, due to shifting economic conditions, labor shortages, and the political climate in the US, the context of reception differed for the various groups and at different historical periods (Tienda & Sanchez, 2013).
Latino Health

Health Profiles

Despite the heterogeneity of the Latino population, research tends to focus on the health of Latinos as a monolithic group. Overall, Latinos present a mixed profile of health. For example, despite significant socioeconomic disadvantages relative to non-Latino Whites, Latinos have a lower all-cause mortality rate and lower death rates from most leading causes (Dominguez et al., 2015). This observation, known as the Latino mortality paradox, contradicts a large body of literature documenting an inverse relationship between socioeconomic status and poor health. Reasons underlying the paradox remain unknown (Ruiz, Hamann, Mehl, & O’Connor, 2016).

In spite of the overall better health profile assessed as mortality from all causes, relative to non-Latino Whites, Latinos experience significant health burdens and disparities in access to health care (Dominguez et al., 2015). For both Latinos and Whites, cancer is the leading cause of death, and cardiovascular disease (CVD) constitutes the second most common cause of death. However, diabetes prevalence is more than two times greater (6% versus 14%) and mortality is 51% higher (18.7% versus 28.3%) among Latinos compared with Whites (Dominguez et al., 2015).

Despite their large and growing numbers, few large-scale, national studies exist on the health of Latinos. To date, the Hispanic Community Health Study/Study of Latinos (HCHS/SOL), supported by the National Institutes of Health, is one of the most comprehensive studies. However, its focus is limited to cardiovascular and respiratory health. The study examined 16,415 Latinos who self-identified as Central American, Cuban, Dominican, Mexican, Puerto Rican and South American and sampled respondents living in four areas: Bronx, New York; Chicago, Illinois; Miami, Florida; and San Diego, California (Daviglus et al., 2012).

Importantly, HCHS/SOL revealed significant differences in CV health profiles between the Latino groups (Daviglus et al., 2012). Puerto Ricans, in particular, had high rates of many CVD risk factors compared with others groups. For hypertension, overall, one-quarter of men (25%) and women (24%) had hypertension; however, among men, prevalence of hypertension was highest among Dominicans, and for women, hypertension was highest among Puerto Ricans (29%). Diabetes prevalence was similar among men and women (17%). Among men, prevalence of diabetes was highest among Mexicans (19%) and Dominicans (18%). For women, Puerto Ricans and Mexicans (both 19%) showed the highest diabetes prevalence (Daviglus et al., 2012). With regard to health behaviors related to CVD, HCHS/SOL revealed that one-quarter (26%) of men but only 15% of women were current smokers. For both men and women, Puerto Ricans (35% of men, 32% of women) and Cubans (31% of men and 21% of women) had the highest prevalence of smoking. Finally, when considering CVD risk factor profiles, the prevalence of three or more CVD risk factors (hypercholesterolemia, hypertension, obesity, diabetes mellitus, and smoking) was highest among Puerto Rican men followed closely by Cuban men. A similar pattern held for women (Daviglus et al., 2012).

Obesity presents a significant risk factor for Latinos. Rates of obesity are greater among Latinos compared to Whites (Dominguez et al., 2015). Moreover, the HCHS/SOL found differences by gender and group. Approximately one-third of Latino men (37%) were obese. Obesity prevalence was lowest among South American men (27% of whom were obese) and highest (41%) among Puerto Rican men. Overall prevalence of obesity among Latina women was 43%, with the highest prevalence (51%) among Puerto Rican women (Daviglus et al., 2012).

The major factors contributing to obesity are diet and lack of physical activity. Regular physical activity (PA) is crucial to preventing obesity and reducing the risk of cardiovascular and other diseases. The majority of Latinos, however, do not meet recommended levels of PA. Only 15.3% of Latinos meet full guidelines for aerobic and muscle-strengthening activities. Lack of PA is particularly severe among women—especially Latinas, only 11.5% of whom meet PA recommendations (National Health Interview Survey, 2014).
In summary, relative to non-Latino Whites, Latinos exhibit better health on some indicators, such as all-cause mortality, but poorer health attributable to various chronic and other conditions, including diabetes and obesity. With regard to health behaviors, Latinos also present a mixed profile, with relatively low rates of smoking and PA, especially among women. These mixed profiles suggest that behavioral, cultural, and broad social factors, including community contexts and policies that affect health and health care, may account for the health of Latinos. We next turn to a discussion of these issues.

**Acculturation, Norms, and Cultural Belief Systems**

A growing literature documents the importance of acculturation on the health of Latino populations in the United States (Abraído-Lanza, Echeverría, & Flórrez, 2016). Although definitions vary, we define acculturation broadly as the process by which groups and individuals adapt to a new environment and potentially adopt the norms, values, and practices of their new society (Abraído-Lanza et al., 2016). Although numerous risky health behaviors increase with acculturation, including smoking, alcohol use, high body mass index, and decreased consumption of low-fat foods, acculturation also is associated with healthy behaviors, such as physical activity (Abraído-Lanza et al., 2016).

Much of the literature on acculturation and health behaviors assumes that beliefs or norms concerning particular behaviors change with greater acculturation. Little progress has been made, however, in identifying or testing potential cultural norms or belief systems that may help explain why acculturation has differential effects on various health behaviors (Abraído-Lanza et al., 2016). Moreover, despite the growing literature on acculturation and health among Latinos, to date, there is almost no research testing the *mechanisms* by which acculturation may affect various health behaviors (Abraído-Lanza et al., 2016). Greater acculturation may lead to changes in health-related and other beliefs, or in other factors unrelated to health beliefs, or to changes in norms or values that may directly or indirectly impact health behaviors. In general, additional research is needed to further explore whether differences in norms or other explanatory mechanisms account for these findings.

Familism, a general orientation towards family, is a core feature of Latino value systems (Perez & Cruess, 2011). Strong family ties and reciprocal family support systems are prominent in Latino culture, rooted in the value placed on family relationships, and the view of the family as a source of support, strength, and inspiration. Familism may have different associations with various health behaviors. Whether this cultural value system—and its associated effects on particular health behaviors—declines with greater acculturation remains a question for further research.

In general, the relative lack of research on cultural and other norms among Latino populations is surprising, given the prominence of norms in major health behavior theories (e.g., the Theory of Reasoned Action, among many others). To address this gap, Abraído-Lanza, Shelton, Martins, and Crookes (2017) examined whether occupational PA, acculturation, familism, and norms held by family and friends are associated with vigorous and moderate leisure-time physical activity (LTPA), and resistance training. Most women reported no vigorous LTPA or resistance training (74.5% and 73.1%, respectively); about half (52.1%) reported no moderate LTPA. Adjusting for sociodemographic factors, greater occupational PA was associated with greater LTPA. Acculturation was not associated with any outcome. Positive family norms about exercise were associated with increased LTPA and resistance training.

Another belief system—*fatalismo* (fatalism)—has attracted a great deal of research interest, especially in the area of cancer screening. Generally described as the perception that events are predetermined and that the course of one’s fate cannot be changed, fatalism frequently is cited as a barrier to screening (Pérez-Stable, Sabogal, Otero-Sabogal, Hiatt, & McPhee, 1992). The concept of fatalism sparked a debate as to whether it acts as a deterrent to cancer screening (Abraído-Lanza et al., 2007; Espinosa de los Monteros & Gallo, 2011). Although greater acculturation among Latinos is associated
with less fatalistic beliefs about cancer, evidence is inconclusive and mixed on the extent to which fatalism constitutes a barrier to cancer screening, especially after controlling for potential confounders, such as SES (Abraído-Lanza et al., 2007).

Moreover, almost no research examines whether acculturation is associated with fatalistic beliefs about breast cancer among Latinas, and whether these beliefs, in turn, prevent women from being screened. One study found that greater years lived in the United States was associated with less fatalism; however, acculturation assessed as language did not predict fatalism. A path analysis revealed that fatalism did not predict screening; instead, perceived barriers emerged as the strongest predictor of mammography screening (Abraído–Lanza, Martins, Shelton, & Flórez, 2015). Other work also indicates that such barriers as fear and pain are deterrents of screening (e.g., Martínez-Donate et al., 2013).

Several developmental and life course issues relevant to acculturation warrant mention, especially with regard to risky behaviors during adolescence. Among adolescents, for example, there is an association between greater acculturation and smoking (Echeverria et al., 2015; Kaplan et al., 2014). Moreover, Latino adolescents who report having co-ethnic Latino peers whose norms and attitudes are accepting of smoking are more likely to smoke compared with those whose peers are less accepting (Echeverria et al., 2014). These studies suggest that social factors such as peer influence and perceived norms about smoking may work in conjunction with acculturation to determine smoking behavior among Latino youth.

Acculturation—or the pressure to acculturate—could shift also over the life course and different developmental periods. For example, in early childhood, English fluency (and decreased Spanish fluency) can facilitate integration into school. During adolescence, however, lack of Spanish-language fluency could lead to limited ability to communicate with family members (Alegria, 2009). Indeed, greater English language use is associated with greater separation from parents, other family conflicts, and a decrease in traditional family values and norms (Bostean & Gillespie, 2018).

Overall, there is a paucity of research assessing the potential differential pathways and mechanisms by which acculturation affects various health behaviors. Also needed are more studies on whether particular cultural norms account for these differential effects. Finally, researchers should pay greater attention to life course and developmental processes. We next turn to a discussion of broader contexts that affect the health of Latinos: the communities in which they live.

**Neighborhoods and Latino Health**

A growing body of research links the social and physical features of neighborhoods to individuals’ health and behaviors, and an increasing number of studies focus on Latinos. Most of this literature, however, examines neighborhood risks. This work reveals, for example, that individuals living in socially and structurally disadvantaged neighborhoods report poorer health and dietary habits, and less physical activity relative to those who live in advantaged neighborhoods, and experienced increased incidence of cardiovascular disease and depression (Diez-Roux & Mair, 2010).

The focus on neighborhood risks overlooks potential resources inherent in living in predominantly Latino areas, or ethnic enclaves (Martins, Díaz, Valiño, Kwate, & Abraído–Lanza, 2014). Although many ethnic enclaves are socially disadvantaged in terms of income and wealth, residing in ethnic enclaves provides important mutual, supportive environments with a shared culture and other resources. Ethnic enclaves also may provide structural and other resources (Martins et al., 2014). Latinos living in neighborhoods with high concentrations of Latinos have greater social ties than do those residing in lower concentration areas (Viruell-Fuentes & Schulz, 2009). In addition, ethnic enclaves may support home country diets and other healthful lifestyle behaviors that reduce the risk of obesity (Suglia et al., 2016). Latinos in neighborhoods with a higher proportion of Latino immigrants (immigrant enclaves), relative to those in areas with fewer immigrants, are significantly less
likely to consume high fat and processed meats, even after adjusting for individual-level acculturation and other sociodemographic factors (Osypuk, Diez Roux, Hadley, & Kandula, 2009); however, they are significantly less likely to be physically active in a typical week. Although Latinos in areas with a higher concentration of Latino immigrants report more favorable healthy food environments, they also report worse built environment features (e.g., walkability, safety) and low neighborhood social cohesion (Osypuk et al., 2009).

It is important to note that immigration streams, economic, and sociopolitical factors affect the communities in which various Latino groups reside. Importantly, the degree of discrimination experienced by Latinos in particular communities may vary as a function of the number of co-ethnics living in particular areas. In this way, too, ethnic enclaves might confer benefits. For example, Puerto Ricans living in Chicago report greater discrimination compared with those in the Bronx, possibly because Puerto Ricans constitute a very small proportion (less than 5%) of the population in Chicago. In contrast, a large majority of the Bronx population is Latino, with Puerto Ricans constituting 21% of residents (Arellano-Morales et al., 2015).

The role of ethnic enclaves in promoting health and health-related behaviors has not been fully explored in research focusing on the neighborhood contexts in which Latinos live. There is a need for more research on the mechanisms by which neighborhood contexts, including resources found in ethnic enclaves, shape the health and health behaviors of Latinos.

We turn next to an in-depth discussion of broader, social and macro-level contexts that influence the health and well-being of Latinos. We focus, in particular, on the interplay of policies related to access to health care.

Access to Health Care

According to the latest data from the CDC, 41.5% of Latinos in the United States lack health insurance compared to 15.1% of Whites, and 15.5% of Latinos report delay or non-receipt of needed medical care due to cost concerns compared to 13.6% of Whites (Dominguez et al., 2015). While the instatement of the Affordable Care Act (ACA) in 2010 increased the rate of insurance and access to health care across all ethnic and racial groups, Latinos persistently experience the lowest rate of insurance coverage and also the highest rate of non-access to care of any other ethnic or racial group. Latinos of Mexican, Central American, or South American origin had the greatest rates of un-insurance, compared to Latinos of Puerto Rican and Cuban descent (Dominguez et al., 2015).

Certain subgroups of the Latino population face institutional and sociocultural barriers in accessing health care; some of these difficulties include residency status, sociocultural differences, institutional barriers, and lack of resources. In the following sections we examine unique impediments for Latinos in accessing health care and discuss evidence-based solutions to overcome or mitigate these obstacles.

Persistent Disparities Despite Affordable Care Act

Driven by high un-insurance rates, especially among Mexican Americans, South Americans, and Central Americans in the US, Latinos experience the highest rates of un-insurance, lack of a regular health care provider, and experience greater difficulties entering medical care services, despite the Affordable Care Act (ACA). Although a strong predictor, residence status in the US alone does not explain this disparity. The disparities between Latinos and other ethnic and racial communities may be largely due to unaddressed impediments among Latinos pertaining to difficulties navigating health institutions and terminology, socioeconomic barriers, language barriers, and immigration policies, or a combination of these factors.
Uninsured status strongly predicts lower rates of access and utilization of medical care services, especially prevention medicine and screening services. Recent analyses of national data from the Medical Expenditure Panel Survey from 2012 and 2013 corroborates previous findings that among Latinos, those with less education, more comorbid conditions, and those who were not insured experienced fewer colorectal cancer screenings than those with higher education, fewer comorbid conditions, and who were insured (Hong, Tauscher, & Cardel, 2017). Further, the most influential predictor of colorectal cancer screening is health insurance status (Hong et al., 2017). Similarly, uninsured Mexican American workers are less likely to receive cancer screening and are more likely to delay medical care, largely attributed to lower rates of employer-based insurance coverage (Talavera-Garza, Ghaddar, Valerio, & Garcia, 2013). Nevertheless, evidence suggests that being uninsured can lead to accessing free or reduced-cost clinics and may facilitate cancer screening access for poorer Latino populations (Mojica et al., 2017; Cowburn et al., 2013). For example, insured Latina women are less likely to have a history of cancer screening compared to Latino women who are uninsured (Mojica et al., 2017). These findings may reflect cost barriers—those who are insured may be responsible for co-pays or other fees not covered by health insurance, and uninsured women may have access to low- or no-cost clinics that offer free cancer screening (Mojica et al., 2017). This brings to light issues regarding under-insurance or red-tape associated with navigating health insurance or receiving care from intuitions such as Medicaid and Medicare. Greater health literacy and experiences interfacing with health care institutions may help to overcome these barriers. For example, there is a gap in preventive and screening behaviors among Mexican Americans due to patients’ lack of knowledge regarding these screenings, and lack of general health literacy (Talavera-Garza et al., 2013).

Health literacy moderates ease of interfacing with and navigating health care services and institutions. Gaps in health literacy among some Latinos may also contribute to the insurance enrollment rate disparities. Knowledge about navigating health services, financial terms related to insurance (premium, deductible, copayment, coinsurance, and maximum annual out-of-pocket spending), or non-financial terms (provider network, covered services, annual limits on services, and excluded services) strongly predicted insurance enrollment among a national Latino sample (Blavin, Zucker, Karpman, & Clemans-Cope, 2014). In that study, difficulty with these terms was highest among the Latino populations, compared to other race or ethnic groups (Blavin et al., 2014). Importantly, patients who receive assistance from a health care navigator report more confidence in their knowledge of the ACA and higher enrollment rates (Sommers & Gunja et al., 2015).

Knowledge gaps of health care provisions also include awareness of the ACA law, policies, and eligibility criteria (Garcia-Mosqueira, Hua, & Sommers, 2015; Sommers & Maylone et al., 2015). After the implementation of the ACA, the greatest decrease in enrollment disparities occurred among Puerto Ricans and non-Latino Whites (Alcalá, Alcalá, Chen, Langellier, Roby, & Ortega, 2017). Rigidity of state-level policies concerning the ACA and promotion of the ACA varied, and therefore awareness and enrollment also varied along these lines (Sommers & Maylone et al., 2015). Advertising of the ACA in certain southern states predicts knowledge and enrollment, but the application process itself is a barrier for monolingual and less educated Latinos, in particular. In the “Facilitating Insurance Enrollment and Access to Health Care” section later in the chapter, we discuss the importance of navigators in assisting in the insurance application and enrollment process.

The composition of the Latino population may shed light on the persistent disparities in insurance enrollment. Latinos are, on average, 15 years younger than the White population in the US (Dominguez et al., 2015). Those who are 26 and younger, under the ACA, may be enrolled onto a parent’s insurance plan, but this is, of course, contingent on parents’ insurance status. This intergenerational relationship may exacerbate the disadvantages for younger Latinos and may be a major driver for insurance enrollment disparities observed in this population (Terriquez & Joseph, 2016; Raymond-Flesch, 2014). For example, young immigrants who qualify for the Deferred Action for
Childhood Arrivals (DACA) program cite their parent’s lack of expertise and ease with the health care attainment process as a barrier to care and health care literacy (Raymond-Flesch, 2014, p. 326).

Overall, lack of health literacy may create hesitancy or under-utilization of health care services, even among insured Latinos. Safety-net services such as reduced cost or no-cost clinics targeting vulnerable Latino populations may increase access to prevention services. Gaps in health literacy, as well as under and un-insurance rates should be addressed. These barriers can be a source for low rates of having a long-term provider, which can be exacerbated by a delay in medical care or treatment, lack of health literacy, and intergenerational hesitancy with navigating health institutions. Access to employer-based insurance and education regarding the ACA and its provisions are critical in improving insurance enrollment for the Latino population as a whole. Insufficient experience with the health care system may in turn magnify the low rate of health care utilization and return to services. Access to care interventions must consider lower health literacy, education levels, and sociocultural factors that affect behaviors related to accessing health care and health insurance.

Immigration Policies and Access to Health Care

The 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) and the Illegal Immigration Reform and Immigrant Responsibility Act (“Welfare Reform”), had wide-ranging impacts on access to health care for both legal and unauthorized migrants. Some issues included limited eligibility for Supplemental Security Income (SSI), Medicaid (government-funded health care for those living under the poverty level) and the Supplemental Nutrition Assistance Program (SNAP), commonly known as “Food Stamps” (which helps individuals with limited income to purchase food) (Pollack & Reuter, 2006). This legislation was passed with the ostensible goal of reducing incentives to unauthorized migration, especially Mexican and Central American migration, due to a belief that these migrants exerted an unsustainable strain on local governments in California and in the Southwest. In 1994, California’s Proposition 187 proposed similar limits on unauthorized immigrants’ access to public services, and although the bill was declared unconstitutional, steps to “erase” it were not taken until 2014 (McGreevy, 2014). Combined, these policies reflected the anti-immigrant social climate, and continued to fuel the negative view of immigrants (especially Latinos) in public opinion.

Additional legislation established a “deeming” process, whereby the financial resources of a sponsor are considered available to the immigrant when determining financial eligibility for public programs (Lillie-Blanton & Hudman, 2001). Under the law, states decide whether to extend Medicaid services to newly arrived legal immigrants before the official eligibility date. Some states used this prerogative to provide public insurance coverage for immigrant children under Medicaid and the Children’s Health Insurance Program (CHIP), whereas others extended coverage further for prenatal care and to the elderly and disabled without regard for immigration status (Joyce, et al., 2001; Lillie-Blanton & Hudman, 2001). The states’ efforts to extend coverage to these populations contributed to reducing immigrant-specific health disparities (Graefe, Hasanali, DeJong, & Galvan, 2015) and blunted the predicted disastrous impact of the Reform on Latino immigrants. The size of the welfare recipient population and high adolescent pregnancy rates have been linked to states’ adopting more stringent requirements for Temporary Assistance for Needy Families (TANF), while economic stability contributed to implementing more leniency (Graefe, De Jong, Hall, Sturgeon, & VanEerden, 2008) on Latino immigrants.

Facilitating Insurance Enrollment and Access to Health Care

Despite larger-scale, political, and sociocultural barriers to insurance and access to health care, there are practical solutions to curbing these disparities. Before the ACA rollout, cost of health care was...
a substantial impediment for some Latinos seeking medical assistance (Martinez, Ward, & Adams, 2015). With the ACA expansion of Medicaid eligibility to adults with incomes under 138% of the federal poverty line, significantly fewer Latinos cite cost of access to care as a barrier to treatment (Martinez et al., 2015), therefore mitigating delay or non-receipt of needed health services due to cost issues.

Targeted outreach may also be appropriate to lessen enrollment and access disparities. States that offer ACA navigation assistance have better enrollment rates and knowledge regarding the ACA than those who do not (Garcia Mosqueira et al., 2015; Sommers & Gunja et al., 2015). The primary way in which assistance is offered is through navigators. Navigators provide unbiased information about health insurance plans that are best suited for an individual’s needs, assist with the application process, and provide their services free of charge (healthcare.gov). Further, general support in navigating the health care system is associated with higher enrollment rates for monolingual and less educated Latino subgroups. However, assistance in navigating medical institutions or programs need not be limited to official navigators. Help from social workers and/or lay health workers (“promotoras”) also increase rates of insurance enrollment (Dominguez et al., 2015; Garcia Mosqueira et al., 2015).

Other Key Issues in Health Care: Medical Mistrust and Satisfaction With Care

Health care institutions must be equipped to overcome barriers faced by Latinos and other underserved populations, and to increase their trust and satisfaction with. For example, among Latinos, medical mistrust increases as acculturation and English language skills increase. One explanation for this observation is that increased experiences with health care services may also increase negative experiences related to ethnicity or race in these settings (Hong et al., 2017).

Perceived quality of care and satisfaction with care are associated with medical trust. In a study of primarily Mexican American rural youth, medical mistrust and perceived discrimination by providers were associated with lesser satisfaction with care (Lopez-Cevallos, Harvey, & Warren, 2014). Furthermore, Latinos are more likely to report fear of being exploited as medical “guinea pigs” compared to Whites, and report higher mistrust and unwillingness to participate in cancer screening (Davis, Bynum, Katz, Buchanan, & Green, 2012). Perceived quality of care among Latinos mediates cancer-screening behaviors (Hong et al., 2017).

For stigmatized and sensitive health issues, such as care of sexually transmitted diseases, Latino ethnic status may magnify feelings of medical mistrust. In a study of HIV positive Latino men with low education levels and a high rate of undocumented status, Latino ethnicity discrimination compounded the effects of perceived sexual orientation discrimination (Galvan, Bogart, Klein, Wagner, & Chen, 2017). Similarly, a study on prostate cancer found that Latino men reported greater medical mistrust than Whites and this was associated with poorer physical health and emotional well-being (Bustillo et al., 2017). Medical mistrust is associated with lower rates of adherence to medical treatment as well as less satisfaction with care (LaVeist, Isaac, & Williams, 2009; LaVeist, Nickerson, & Bowie, 2000). Further, in areas of the US where punitive immigration policies exist, even Latinos who are residents or citizens are exposed to policies condoning racism and differential treatment towards all Latinos (Rhodes et al., 2015). Combined, these findings underscore the importance of building effective patient-physician communication and increasing quality of care to bolster satisfaction with care and medical trust.

Satisfaction with care is associated with language, gender, and ethnic concordance with the health care provider. For example, Spanish-speaking patients with limited English proficiency are more satisfied with care if their provider is fluent in Spanish (Eskes, Salisbury, Johannsson, & Chene, 2013).

Furthermore, satisfaction with care has implication for medical adherence and utilization of health care services. For example, patients with diabetes showed improvement in overall glycemic control.
after switching from a language dis-concordant to concordant provider (Parker et al., 2017). In addition, low English proficiency is correlated with poor glycemic control when care is provided by a language discordant compared to language concordant provider (Fernandez et al., 2010). In mental health care, due to the matching of intercultural communication styles, patient-provider ethnic concordance facilitates the process of building a therapeutic alliance and establishing continuation with care (Alegria et al., 2013). As further evidence, another study on pediatric surgery found that parents of patients with a language discordant provider were less likely to initiate questions regarding their child’s care compared to English and Spanish concordant client-provider pairings. In addition, language concordance increased parent satisfaction, and provider Spanish-language proficiency was a stronger predictor of satisfaction with care than medical mistrust and feelings of discrimination (Jamamillo et al., 2016). These findings suggest that language concordant care increases patient continuation with care, ability to follow guidelines, and may also be correlated with improvements in biometric health outcomes, and greater patient satisfaction.

However, there is some mixed evidence on the impact of patient-physician ethnic concordance. Findings from the Medical Expenditure Panel Survey indicate that Black and Hispanic patients with ethnic or racially concordant providers are not more satisfied with their providers relative to those with discordant physicians (Jerant, Bertakis, Fenton, Tancredi, & Franks, 2011; Sweeney, Zinner, Rust, & Fryer, 2016). This data source, however, has some limitations, as it relies on patients to identify provider ethnicity/race. In addition, other analyses of this data set find that language concordance for Hispanic patients increases satisfaction with care (Villani & Mortensen, 2014).

Although evidence is not conclusive that racial and ethnic concordance leads to better health or clinical outcomes among Latinos, language concordance has great implications for health outcomes and patient satisfaction. Easing the patient-provider interaction with Spanish-language proficient providers offers ways to increase satisfaction with care and ease of communication for vulnerable Latino groups who may already be at a disadvantage due to medical knowledge gaps. Language proficient providers may help narrow this gap for Latino patients.

Access to Health Care: General Discussion

Institutional, sociocultural, psychosocial and political factors present substantial barriers to access to care among Latinos, especially for those of Mexican, South American, and Central American origin. Our findings suggest that medical care institutions and providers can adopt changes that may increase access to care for the especially vulnerable Latino groups. In the short term, free or reduced-cost clinics can provide screenings and health services for those who are uninsured or underinsured. Targeted efforts to increase access to health care navigators should also be supported, as multiple studies have demonstrated that health care navigators improve health insurance enrollment rates and health literacy among various Latino subgroups. As the Latino population grows in the US, efforts should be instated to meet the increasing and unique demands on health services. Bilingual health workers, and greater representation in medical school and public health may facilitate communication with care providers and ease the delivery of health care services. Additionally, increasing Spanish-language resources and availability of ethnic concordant care is correlated with higher insurance enrollment rates and adherence to treatment.

Given the overrepresentation of youth in the Latino community, early interventions may have a broader impact on this young population’s health as they age. By addressing health care enrollment, medical trust, and satisfaction barriers promptly, there is a potential to address and prevent higher disease burden in a matter of decades. Increasing the ease and knowledge of navigating health care institutions and insurance programs may in turn increase the younger populations’ comfort with these institutions. An important finding in the literature is that feelings of fear and anxiety contribute to the hesitancy in accessing medical treatment, even when necessary; building medical trust, and
increasing services tailored for bilingual populations, may help close the disparity between ethnic groups and vulnerable Latinos with the tools necessary for effectively navigating health services.

Conclusions

This chapter presents an overview of various significant issues in Latino health. Our intent was to provide information on key areas for further investigation. We summarize and conclude with the following key points:

- The Latino population is large and heterogeneous, spreading throughout the United States, with subgroups of different nationalities congregating in different geographic locations. These subgroups also have varying immigration histories and trajectories, and the differences persist in their health needs.
- Few national, comprehensive studies exist on the health of Latinos. The HCHS/SOL study is significantly addressing gaps in knowledge related to cardiovascular health, and is identifying the differences and similarities among Latino subgroups.
- Given the role of acculturation in Latino health, research should continue to explore the mechanisms of acculturation and their effect on health outcomes.
- Social ties and the protective effect of cohesive cultural enclaves should be further explored and promoted, given that they are not only correlated with better health outcomes, but that living in an ethnic enclave can facilitate general immigrant adaptation to new ways of living in the United States.
- Punitive immigration policies have psychosocial consequences for Latinos, whether individuals are undocumented or not.
- Anti-immigrant and anti-Latino sentiments impact the satisfaction with medical care, continuation with care, and trust in medical providers and services. Therefore, these policies have direct effects on Latino health.
- Medical providers and institutions have multiple venues through which they can target specific Latino health and psychological needs. These include efforts to increase patient satisfaction and communication at the interpersonal level, support community-based efforts to promote social support and mitigate negative health behaviors, and champion larger policy-based efforts to increase access to care and decrease discriminatory policies.

In summary, the study of Latino health requires expansive models that consider interactions between national origin, acculturation, and broad determinants of health that include cultural, social, and political factors that shape health and health care. The broader view provides an appropriate perspective from which to understand and develop programs and policies with significant, beneficial impact on the health of Latinos in the United States.

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