The 7th Conference on Health Care of the Chinese in North America

Viewpoint on Healthcare Reform: Asian Americans' Access to Healthcare

Tessie Guillermo, Executive Director, Asian and Pacific Islander American, Health Forum, San Francisco, California

---

Abstract

Introduction

In September of 1993, The Asian and Pacific Islander American Health Forum, a national, non-profit health advocacy organization based in San Francisco, announced its support for President Clinton's Health Security Act (HR3600). We believed that the plan outlines a system that provides for a major advancement in addressing inequalities in the U.S. health care delivery system. Our support, however, was qualified in that we identified a number of areas of concern to A/PI communities not adequately addressed in either the draft plan, nor the bill as introduced to congress. Chief among these areas are specific questions of universal access, health professionals development, long-term security for community based services, and quality management measures as they relate to underserved segments of the A/PI community.

Universal Access

Very little information exists to determine levels of disadvantage and underservice for the 7.4 million A/PI's that reside in the United States. However, national data indicate that A/PI's nationwide are 21% uninsured and have the lowest average physician utilization rates at 4.5 visits/person. While HR3600 does address the financial barriers that will close the uninsured and underinsured gap, many health care providers understand that there are other barriers which act to deny health care to Asian and Pacific Islanders, even for those who have insurance coverage. These non-financial barriers to care, such as education, geographic location, race, ethnicity and language and medical condition are recognized in the President´s plan, and language that prohibits discrimination based on some of the above factors is contained throughout the plan.

While we are pleased that the anti-discrimination language exist, HR3600 fails to include mention of Title VI of the Civil Rights Act, the most powerful mechanism that currently exist in law to assure that anti-discrimination protection for the individual enrollee are in place with regards to government subsidized services. It is essential that specific standards be implemented, pursuant to Title VI, for measuring and monitoring access of the underserved.

More than two thirds of A/PI Americans are immigrants to the U.S. and 1990 Census data indicate more than one-third do not speak English "very well." These characteristics act as

barriers in accessing the current health care delivery system because of the associated language, race/ethnicity and cultural differences with mainstream medicine.

However, only in subtitles E and F of title III, are specific authorizations made to address these barriers and then only by "qualified community health groups", who must compete annually for funding. We are concerned there may be a perception by other qualified health plans within an alliance that will not be subject to the same requirements to assure access to vulnerable, underserved populations, unless they wish to qualify for Title III funds. Further, there exist no financial incentives to guarantee access to such disadvantaged individuals outside of Title III, except with regard states' option to risk adjust premiums for disadvantaged populations, at their sole discretion, as stated in Section 1203 of Title 1.

The requirement to provide access to disadvantaged populations must not be perceived as a financing option as in Title I, nor should targeted resources be discretionary, as in title III. And subject to an annual appropriations process. There is real danger of funding levels being insufficient in either case to adequately provide assurances of universal access.

With regard specifically to native Hawaiians, we are troubled that HR3600 makes no mention of protecting or enhancing the native Hawaiian health care centers, established by the native Hawaiian Health Care Act. While these centers do not provide comprehensive primary care, they are often a major bridge to the larger health care delivery system, as well as to many other essential services, in Hawaii, where access is not available to small, rural and underserved Hawaiian communities. We would like to see that the United States recognizes its special obligation to the Hawaiian people by preserving and enhancing the role of the native Hawaiian centers.

Finally, health care reform should extend to all the U.S. Trust Territories, particularly those in the Pacific, for whose people the U.S. has a unique obligation to care for their well being and quality of life.

Health Professions Development

Although there is a perception that Asians are over represented in the health professions, the reality is that there is maldistribution both ethnically and geographically. Smaller and newer A/PI ethnic groups such as the Vietnamese, Koreans, Hawaiians and other Pacific Islanders are disproportionately underrepresented in the health fields, and the majority of A/PI physicians practice in the northeast and north central U.S., while 60% of A/PI reside in the west. While only 6.5% of Asia educated physicians in the U.S. are primary care practitioners, many of the remaining 93% specialty care physicians provide primary care services to Asian and Pacific Islander Americans because of their language skills and knowledge about cultural practices regarding health. These providers therefore bridge the gap for A/PI consumers in an unresponsive health care system.

Further, the majority of the supply of Asian nurses are hospital based, vocational and registered nurses, whose jobs are in danger in a reformed and more streamlined health environment. Unless they can be identified and re-trained as mid-level practitioners, or be otherwise placed to provide primary care services, the health care community will lose a

valuable resource available currently to address the language and cultural barriers faced by A/PI's, in maneuvering a health care system.

For both physicians and nurses, the aggregation of all A/PI's into a single ethnic category for purposes of determining representation of their respective professions, masks the disparity that exists within specific ethnic groups, and undermines the intent to provide an adequate supply of health professionals to all disadvantaged minorities. Title III programs for training and retraining of health professionals, which targets funding for "disadvantaged" persons and "underrepresented" minorities may not be available to A/PI health professionals if the conventional method of defining A/PI ethnic communities is in the aggregate.

Protection of Community Based Services

Community Health Centers and other traditional, community based providers of the underserved are in a strong and unique position to provide a ready point of access to A/PI vulnerable populations. The historical role and explicit mission of CHC´s in particular has been to serve the underserved. Further, their role in continuing to serve ineligible individuals is critical to maintaining control of costs to the overall health care system.

Section 1582 of Title I lists automatically certified classifications for "essential community providers," eligible for reimbursement for the cost of care associated with providing services for disadvantaged or underserved populations. Because language and cultural issues are among the most persistent access barriers nation-wide, the automatic certification of providers who provide linguistic help and are culturally competent, based on standards developed by the Secretary, should be included in this section.

Further, notwithstanding a mandate for all health plans to abide by anti-discrimination provisions as contained in Subtitle E, Title I, minority community based providers have little negotiating power with which to protect themselves and their practices in fully integrated environments. Methods for determining payment for the cost of care for underserved populations provided by essential community providers must be realistic, consistent and developed with full information about all costs.

Quality Management Measures and Data Development

As stated previously in my testimony, data on A/PI health professionals is aggregated, and thus meaningful analysis on specific ethnic representation is not done, making it difficult to develop policies and programs appropriate to underrepresented A/PI health professionals.

Health data is often aggregated in the same manner, but most often, Asians and the Pacific Islanders are coded within "non-white" or "other" categories. Given the emphasis on quality management with the Administration´s plan, measures such as patient satisfaction, performance and outcomes should include A/PI ethnic identification, consistent with U.S. Census ethnic categories, in data collection, analysis and reporting. The Asian and Pacific Islander American Health Forum was established largely because of the lack of adequate data with which to determine A/PI health status. We believe the key to framing coherent health policy, and thereby the delivery of health services for A/PI Americans as well as

other underserved groups, is to understand the problems specific to each population. Without making the distinction between and among groups, there is no basis for the development of that framework, and the establishment of an equitable health care delivery system which guarantees access for all cannot be achieved.

Testimony given by Ms. Guillermo before the United States House of Representatives Committee on Energy and Commerce, Subcommittee on Health and the Environment on January 24, 1994.

To use the same words is not a sufficient guarantee of understanding; one must use the same words for the same genus of inward experience; ultimately one must have one's experiences in common. - Friedrich Nietzsche