A Cultural View on Healthcare Access: Considering the Hispanic Perspective

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ABSTRACT
This research provides a cultural perspective on healthcare access with a specific focus on Hispanic consumers. The research question of how Hispanics experience healthcare access is addressed with 24 phenomenological interviews. The findings are presented as emergent themes: affordability, access and resistance, and consequences of a lack of healthcare access.

Keywords: Healthcare, Hispanic consumer, consumer culture, phenomenology

INTRODUCTION
This research addresses the question of how Hispanics experience healthcare access. Access to healthcare was proposed by the United Nations (UN) in 1948 and again in 2012 as a human right (UN 2012), which is a policy position supported by the United States of America (USA). Similarly, a key policy objective in the Organization for Economic Co-operation and Development (OECD) is to reduce health inequalities and to achieve adequate and equitable healthcare access (Devaux 2015). Accordingly, most OECD nations provide universal healthcare coverage (Pearson et al. 2016), with the exception of the USA (Davis et al. 2014). Ranked as the most expensive healthcare system globally (Lorenzoni, Belloni, and Sass 2014; Mahon and Fox 2014), the USA ranks last on measures of quality of care, access, and equity (Brubaker et al. 2011; Davis et al. 2014; Mossialos et al. 2016).

Rather than universal coverage, USA employer-sponsored private insurance arrangements spread widely during 1940-1950 (Oberlander 2012), linking insurance to employment (Schembri and Ghaddar 2017). The 1965 establishment of Medicare and Medicaid was designed to accommodate the healthcare needs of the elderly and low-income households (Iglehart and Sommers 2015). More recently, the enactment of the Patient Protection and Affordable Care Act in 2010 enabled a significant decrease in the number of uninsured Americans with some 20 million adults gaining insurance and the greatest impact evident in African American and Hispanic minority groups (Office of the Assistant Secretary for Planning and Evaluation (ASPE) 2016). Yet, despite this progress, millions of American consumers remain uninsured with low-income (Milligan 2015) and minority consumers overly represented (Mitchell 2015). More specifically, across the USA and also in Texas, Hispanics show the highest rate of uninsurance (Marks, Ho, and Balbi 2015). Indeed, the negative social and economic impact of health inequalities is well documented (Brummer et al. 2016; LaVeist, Gaskin, and Richard 2011; Magge et al. 2013) and especially so amongst ethnic and racial minorities (Hunt and Whitman 2014; VanderWilen et al. 2015). Therefore, investigating the perspective of lower-income, minority, specifically Hispanic, consumers in terms of healthcare access is a timely and worthy question. To that end, this phenomenological investigation focuses on Hispanics and their experience of healthcare access.

CONSIDERING THE HISPANIC CONSUMER PERSPECTIVE
As the largest and fastest growing ethnic/racial minority in the USA (Ennis 2010) and representing 17% of the US population (US Census 2014), the Hispanic segment purchasing power is reported between $1.2 and 1.5 trillion (Gonzalez and Monistere 2014; Nielsen 2012, 2015). However, rather than an identifiably homogenous group, there is much diversity within the 54 million Hispanic demographic (US Census 2014) with, for example, 63% of Mexican origin (63%), 9.6% from Puerto Rico, and 5.3% from Cuba (US Census 2010). As a predominantly collectivist culture, cultural values include familial relationships with primary reference groups including friends and family (Alvarez, Dickson, and Hunter 2014). Accordingly, overcompensation to children is high with documented higher spending in baby goods, hair care, and toiletries (Nielsen 2012). Hispanic brand loyalty is also reported as high because Hispanics are fear driven and risk-averse consumers (Korzenny and Korzenny 2012).

The challenge in engaging the Hispanic consumer with regards to healthcare is related to the documented disparities (Bleich et al. 2012; Ramirez, Thompson, and Vela 2013). Hispanics have significantly higher rates of diabetes (Brunk et al. 2015), obesity (Isasi et al. 2015), cancer (Shoemaker and White 2016), HIV and AIDS (Bonacci and Holtsgrave 2016), and myriad other conditions (Martinez, Ward, and Adams 2015). Yet, the healthcare system is not necessarily designed to accommodate Hispanic needs. Compounding evident health disparities, proactive patient activation is low for Hispanics relative to non-Hispanics (Cunningham, Hibbard, and Gibbons 2011). As well, those without health insurance are less likely to seek health services and when they eventually do seek help, their health conditions tend to be more advanced (Cawley, Mortiya, and Simon 2015). Little or no access to healthcare adversely affects health outcomes, increases morbidity and mortality, and increases healthcare costs, especially for minority groups (Reininger et al. 2012). While lack of health insurance and finances constitute formidable barriers for Hispanics to access healthcare, individual, interpersonal, and systemic influences are also substantial barriers (Reininger et al. 2012); personal influences include fear, denial, embarrassment, and unaffordability; interpersonal influences include culturally interpreted concepts of respect and effective communication, and systematic influences including medical care access considered easier in Mexico than USA. Therefore, Hispanics are reluctant to access, likely choosing to delay care and prefer to access healthcare in Mexico (Su et al. 2011). Accordingly, there is a double jeopardy situation for Hispanics, where being uninsured as well as in poorer health means being at higher risk of needing medical care (Bruhn 2014).

METHOD
This research was conducted across two counties in South Texas, along the US-Mexico border. The population exceeds one million, is predominantly Hispanic (91%), with a median income less than $35,000, 31% living in poverty (US Census 2015), 39% uninsured (Smith and Medalia 2015), and with a high prevalence of obesity, diabetes, cancer, and heart disease (Ramirez et al. 2013). Existing at the periphery of the USA economy, the US-Mexico border community is distinct geographically, economically, culturally, and socially, and is subject to systematic economic, social, and health injustices (Lusk et al. 2012). As such, there is much need for access to healthcare and a phenomenological research design has been used to investigate the question of how Hispanics experience healthcare access.

For phenomenologists (Heidegger, 1962/1927; Husserl 1970/1900-1; Merleau-Ponty 1962/1945), the world is considered an experiential world where reality is assumed to be socially construct-
ed and meaning is based on the context. Generalizability therefore is not the goal but rather a depth of understanding (Hudson and Ozanne 1988; Schembri and Sandberg, 2002, 2011; Thompson, Locander, and Polio 1989, 1990). In this study, the research focus was to provide a contextually dependent depth of insight as to how Hispanic consumers access healthcare, which has been documented with 24 phenomenological interviews. Treating the interview transcripts as legitimate accounts of how Hispanics experience healthcare access, interpretation proceeded as a part to whole analysis of participant experience, as per Thompson et al. (1989, 1990). This analytical process began with repeatedly reading each of the transcripts in full to gain an initial understanding of the situation for each participant. From there, the set of interviews were considered more broadly and holistically and then segments and fragments were identified and contextually considered in relation to the whole. This part of whole analytical process continued to the point where recurrent meaningful themes began to emerge and stabilized. Then, significant statements were specifically identified as illustrative quotes of emergent themes. Note, the English grammar has not been corrected in the illustrative quotes presented to demonstrate the Hispanic linguistic context of these participants. As summarized in table 1, the emergent themes reported here are affordability, access and resistance, and the experiential consequences of the lack of healthcare access.

**FINDINGS**

This research addresses the question of how Hispanics experience healthcare access. From a series of phenomenological interviews and an interpretative analytical process, the emergent themes identified are affordability, access and resistance, and consequences of a lack of healthcare access. These findings are summarized in table 1.

**Affordability**

Given this research was conducted in one of the poorest areas of America, with almost a third of families living below the poverty level and nearly 40% uninsured (US Census Bureau 2015), cost constraints and affordability were a primary concern with regards healthcare access. Giving context to the financial consideration, Catalina (22 years) explains how very expensive her $40 co-pay is. But Catalina is lucky because she has health insurance. Unlike Catalina, Matias (26 years) and his family do not and he explains how his mom was in hospital for nine days and will be paying that bill for the rest of her life. Like Matias, Ivanna (21 years) does not have insurance and neither does her younger sister. So when Ivanna’s sister had a kidney stone, they had to go to Mexico to fix it! “We can’t really go to the hospital here [USA] because we know is really expensive.” (Ivanna, 21 years)

<table>
<thead>
<tr>
<th>Theme</th>
<th>Summary</th>
<th>Illustrative quote</th>
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<td>Affordability</td>
<td>In this low-income Hispanic context, affordability is given meaning with Catalina’s “very expensive” $40 co-pay; without health insurance, Matias’ mother will be paying the bill for her 9-day hospital stay for the rest of her life; Ivanna’s younger sister went to Mexico to treat a kidney stone.</td>
<td>“I just have colds and stuff it’s not a big deal.” (Mateo, 24 years)</td>
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**Access and Resistance**

Beyond the lack of financial resources and health insurance, another constraint on healthcare access for Hispanics is the cultural orientation. Karen is 36 years old and works as an administrative assistant in a dental office. She explains how the context of the Hispanic culture is a barrier to healthcare.

“I mean because anyone and everyone knows that whenever something is broken we [Hispanics] go to Mexico to fix it!”

Karen goes on to explain the Hispanic inclination to exit the USA in order to access healthcare.

“…in the Hispanic community if we don’t have to go to the doctor we don’t go unless it is an absolute emergency. We are talking about bleeding and severe pain that you can’t control with a pill, [otherwise] we are not going to utilize …I mean because anyone and everyone knows that whenever something is broken we [Hispanics] go to Mexico to fix it!”

Karen, 36 years

**Table 1: Summary of findings on how Hispanics experience healthcare access**
Multiple other participants discussed this cultural constraint and resistance to accessing healthcare even when it is available. In the following comment, Elisa highlights the quality of healthcare services she experiences in Mexico relative to the USA and the relational trust she experiences with her Mexican healthcare service provider.

“Here [USA] it’s a longer wait but there [Mexico] I just walk in and its empty so I just go in and sometimes I wait like thirty minutes if it’s busy. Here I use to go to the doctor and he [doctor] was like very busy, it was just a five minute thing [visit] and then he leave. I didn’t feel comfortable talking all my concerns and questions [but] over there like I guess since you trust a person [doctor] you know for a really long time you feel better over there in Mexico”

**Consequences to Lack of Access**

Given the financial, systemic, and cultural constraints on accessing healthcare, participants also brought to light consequences to a lack of healthcare access. Jose (33 years) for example is overweight with a history of thyroid problems and no health insurance. He explains that he does not need healthcare access because he does not get sick. This response from Jose mirrors the Hispanic cultural attitude towards healthcare access.

Manageable conditions left unattended may escalate unnecessarily, consequently requiring more resources when they are finally attended to. Other examples of this cultural orientation to healthcare access and the potential consequences are further demonstrated with Mateo’s situation. As a young child he suffered from cancer with healthcare access enabled through the Medicaid program. However, at 24 years of age, many years have passed since his last check up and he does not think he needs access. He says, "I just have colds and stuff it's not a big deal."

When there are complex medical needs, this non-attendance to manageable conditions is problematic not only for the individuals but also the immediate family in terms of worry and stress as well as the broader community in terms of financial burden. Andrea (20 years) highlights the stress of the situation when adequate healthcare access is not available.

“My mom is been I guess stressful and you know thinking ‘what about my kids get sick?’ ‘what about if they get in an accident?’ we have no way to be able pay the hospitals if we ever have to land at the hospital so it’s been very stressful, and then her work. It’s like work, us, the insurance. My grandma who is old and we have to take care of her I guess like is very stressful for my mom and you can tell by her face that she is stressed!”

Similarly, Vanessa (19 years) explains in the following comment the distress she feels in the face of not having health insurance and healthcare access. She explains that the fear of being unemployed, means working sick, possibly spreading the germs, and perpetuating the illness.

“If something happens to you or you feel sick you can’t go to the doctor and if you hate a job you can’t stop going to your job because you need the money and you’re just working sick and then people other people get sick ‘cause you’re sick and it’s like a little chain.”

At 23 years, Daniela explains that she has never seen a doctor and the consequence for her is that “I don’t know the process, what to do, or what they accept in order to get checkups.” Not knowing the process seems overwhelming for Daniela to visit the doctor for the very first time. Elisa brings the point home in stating that “my mom and dad, well my dad mostly, they’re like anti-doctor kind of thing.” If mom and dad are anti-doctor then the family will lack access too.

**CONTRIBUTION AND LIMITATIONS**

This research has investigated the question of how Hispanics experience healthcare access. As such, the contribution of this work is a depth of insight on Hispanic healthcare access where the emergent themes of affordability, access and resistance, and the consequences of a lack of healthcare access have been documented. In line with the findings of Cunningham et al. (2011), Hispanic proactive health management is not evident. The findings presented here also confirm the findings of Reiningher et al. (2012) that barriers to healthcare access for Hispanics include personal influences such as fear and unaffordability, interpersonal influences such as cultural interpretations, and systemic influences such as healthcare access considered easier in Mexico than USA. More than that, this work confirms the double jeopardy situation highlighted by Bruhn (2014), where uninsured Hispanics with complex healthcare needs are either delaying care or not accessing healthcare services. While this work confirms the work of Cunningham et al (2011), Reiningher et al. (2012) and Bruhn (2014) from health, minority health, and health disparities literature, the contribution of this work is focused on a consumer behavior perspective.

This contribution is useful to policy makers and social marketers in the design of future policy and communications seeking to achieve an improved outcome for minorities. Policy makers are informed in terms of the challenges and barriers that Hispanic healthcare consumers are facing. Social marketers are informed in terms of Hispanic consumer needs and considered alternatives with regards to healthcare service utilization.

Beyond this contribution, a limitation of this work is the focus on consumers alone. Consumers are only one of many stakeholder perspectives that might inform the question of how Hispanics experience healthcare access. Other stakeholder perspectives that might be investigated include the myriad healthcare service providers and para-professionals. Focusing specifically on the Hispanic consumer perspective, however, has enabled documentation of the consumer views of this increasingly significant segment. More than that, the phenomenological research design has achieved a depth of insight not achievable with other research methods.

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