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ACHIEVING EQUITABLE HEALTH CARE
ACCESS FOR LATINOS WITH LIMITED
PROFICIENCY IN ENGLISH

A FOCUS GROUP STUDY

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“Sometimes I’ve used my daughters as interpreters. For me it’s uncomfortable that my daughters find out about my condition before I do. Sometimes I’ve used other interpreters, but I’ve noticed that I’ll be saying one thing and they’re saying something else . . . I have noticed several times that what I say is not interpreted fully.”

“Language is important, because if we don’t speak English fluently, we can’t explain what we feel. Medical terms are very different from the terms we use daily. Sometimes the doctors start asking questions and we don’t understand what they’re asking. For me, language is a barrier.”

“Once I went to a hospital in the San Fernando area. I had an emergency with my son, who had a fever . . . After I had waited a long time, I said in English, ‘I’m leaving. Just because you see my Latina face and I didn’t speak English—but I do, and I also have insurance.’ . . . So the doctor came right away to help me . . . I thought, ‘Too bad that when [these people] see patients who don’t speak English, who look different, of a different color, they value them less.’”

— Focus group participants

Americans spend vast sums on health care every year, far outstripping expenditures in other industrialized nations.¹ Yet the United States lags well behind other industrial countries in health metrics such as life expectancy, infant mortality, and access to insurance coverage, indicating that too many Americans do not have adequate access to health care.² Thus, despite increased health spending and signals from the American people that out-of-pocket cost remains the largest single barrier to equitable health, the global health standing of the United States has actually slipped in recent decades.³ Given that US residents with a limited

proficiency in English are more likely to be poor—over one in three have family income below the federal poverty level, compared to about one in five people who are English proficient—these persons and their communities are at particular risk when it comes to the high price of health in America.⁴

Although there is growing evidence that language influences both health insurance coverage and the quality of health services received, and despite the fact that the number of US residents who are limited English proficient (LEP) has increased substantially in recent decades, language proficiency is still too often overlooked in research on health care access.⁵ This report focuses on language proficiency as a potential barrier to equitable health care, presenting consumer data collected from two focus groups organized by the UCLA Chicano Studies Research Center at Mission Community Hospital in the San Fernando Valley in 2011.

Findings from the study are considered in the light of the legal history of Title VI of the 1964 Civil Rights Act, which mandates that institutions that receive federal funds must provide equitable access to their programs and services regardless of “race, color, or national origin,” a stipulation that directly affects people with limited English.⁶ The US Justice Department, responsible for enforcing the Civil Rights Act, has stated that Title VI prohibits both intentional discrimination and “practices that have the effect of discrimination.”⁷

The meaning of “effect” has been of central concern in legal cases and executive orders concerning Title VI.⁸ Partly because of this ambiguity, the Justice Department indicates that “separate analyses should be undertaken with respect to each different language group” within a given beneficiary class.⁹ Executive Order 13166, signed into law by President Bill Clinton in 2000, stipulates that in the effort to improve access to services for LEP people, “stakeholders, such as LEP persons and their representative organizations, recipients, and other appropriate individuals or

entities, [must] have an adequate opportunity to provide input.”¹⁰

The findings of our study provide a nuanced understanding of published research that indicates that limited English proficiency is a barrier to access in institutions and programs that receive federal funds. Our hope is that by presenting stakeholders’ input we can aid future efforts to close the equity gap.

BACKGROUND: LEP LATINOS AS A VULNERABLE POPULATION

Almost 52 million Latinos lived in the United States in 2011 (a 48 percent increase over 2000), meaning that roughly 17 percent of the US population is now Latino.¹¹ However, a disproportionate three in ten of the nation’s poor are Latino, and a greater share of Latinos live in poverty than any other racially defined group.¹² Latinos and African Americans also continue to lag well behind in home ownership, the largest single source of wealth for middle-class Americans: only 44 percent of black Americans and 46 percent of Latinos own homes, compared to 58 percent of Asian Americans and 72 percent of white Americans.¹³ The connection between wealth and health is well established and is exemplified by the positive correlation between income and insurance coverage.¹⁴

In 1986, the landmark Heckler Report attempted for the first time to produce a federally funded, synthesized analysis of minority health in America.¹⁵ The Office of Minority Health within the US Department of Health and Human Services (HHS) was established as an outcome of that study. Since then, evidence has accumulated to indicate that although Latino immigrants tend to arrive in the United States in better-than-average health their health deteriorates with time and increased acculturation (though the gap between the health of “new immigrants” and “settled residents” is closing).¹⁶ Research shows, for example, that the longer immigrants from Mexico spend in the United States, the greater their odds of becoming obese, and foreign-born Latinos have lower rates of obesity

than their US-born offspring (suggesting that the US environment may be distinctively “obesogenic”).¹⁷ Foreign-born Latino immigrants actually tend to live longer than their US-born Latino counterparts.¹⁸

Language fluency and usage varies greatly both across generations of Latinos and among Latino subgroups. However, the 2010 census indicated that 76 percent of US Latinos speak a language other than English at home, and 35 percent are not fluent in English.¹⁹ Among Latinos who are legal permanent residents, just 30 percent say they speak English “very well” or “pretty well.”²⁰

Spanish speakers accounted for 66 percent of the total US LEP population in 2010, dwarfing the next-largest linguistic group, Chinese speakers at 6 percent.²¹ California has more than twice the LEP population of any other state (including Texas, the state with the second-highest share) and over a quarter of the total LEP population of the United States.²² The Los Angeles–Long Beach metropolitan area is home to the nation’s largest Latino population, 5.7 million people, largely of Mexican origin, and accounts for 11 percent of Latinos nationwide (fig. 1).²³

A 2009 study by the School of Public Health at the University of California, Berkeley, indicated that 6 to 7 million Californians—one in five—are LEP, meaning they speak English less than very well. In Los Angeles, San Francisco, Monterey, and Imperial counties, one-quarter to one-third of the population is LEP.²⁴ In Los Angeles County, where we conducted our focus groups, Spanish was the primary language spoken in over a quarter (26.5 percent) of households in 2007, more than three times the rate of the next non-English language. To put that number in perspective, there are almost five primarily Spanish-speaking households for every ten primarily English-speaking households in Los Angeles County.²⁵

Fortunately, language proficiency as a barrier to health is now gaining increasing attention and clarity due to its widespread implications. The Berkeley

report, for example, concludes that “language barriers contribute to inadequate patient evaluation and diagnosis, lack of appropriate and/or timely treatment, and other medical errors that compromise the safety of LEP patients and result in increased medical costs.”²⁶ Indeed, public health data continue to show that LEP individuals face significant barriers to accessing health coverage and care compared to those who report speaking English very well.²⁷

LEP individuals are more likely to have lower levels of education and are significantly more likely to be uninsured. They are also less likely to seek medical care, including preventive services, even when they are insured. Perhaps most tellingly, LEP individuals are more likely to report negative health care experiences.²⁸

It is important to remember that language is one in a broader web of barriers to equitable health care and that it should not be considered in isolation. The Kaiser Commission on Medicaid and the Uninsured notes, “The cumulative effects of race/ethnicity, citizenship status, low education, and poverty that frequently characterize the LEP population often result in additional barriers.”²⁹ These barriers affect every aspect of health, from the most basic preventive health measures—such as access to a clean, healthy environment for exercise and to high-quality fruits and vegetables—through care and treatment all the way to health outcomes.

Our study comes at a time when two major developments are having a

significant impact on health access for Latinos in California, especially those with limited English skills. One is the Patient Protection and Affordable Care Act of 2010, also known as the Affordable Care Act (ACA), major provisions of which are set to take effect in 2014.³⁰ The other is the state budget of California. We wrote the bulk of this report during the 2012–13 fiscal year, when the budget included more than \$1 billion in cuts from health programs. The 2013–14 budget, which was signed into law by Governor Jerry Brown on June 27, 2013, is generally kinder to health and social services and includes Medi-Cal and education expansions (which include extra funding for English language learners and a halt to adult education cuts).³¹ Yet it also fails to bring most spending measures back to pre-recession levels, signaling the ongoing fragility of the state’s economic recovery.³² As a result of these decisions, which are discussed in more detail near the end of this report, Californians and all Americans face critical new challenges and opportunities in the effort to achieve equitable access to affordable, high-quality health care.

FOCUS GROUP METHODOLOGY

In light of these trends, and with the generous support of the California Endowment, the UCLA Chicano Studies Research Center (CSRC) organized a summit at UCLA in fall 2010 on the issue of health care access for local LEP Latinos. It focused on the integrated goals of increasing access (e.g.,

Figure 1. Latino Population of the Los Angeles–Long Beach Metropolitan Area



LOS ANGELES - LONG BEACH, CA

LATINO POPULATION
5,724,000

**AMONG LATINOS,
SHARE FOREIGN BORN**
42.5%

**SHARE LATINO AMONG
TOTAL POPULATION**
44.5%

**AMONG UNDER 18,
SHARE LATINO**
58.5%

Source: Data from 2010 American Community Survey, US Bureau of the Census.

insurance coverage), efficiency (i.e., the effectiveness of actual care), and health outcomes.³³

One of the participants' recommendations was to organize focus groups in Los Angeles with the goal of gathering information from Latino community members regarding access to health care for primary Spanish speakers. Accordingly, the CSRC organized and conducted two focus groups at Mission Community Hospital's San Fernando Community Campus for Health and Education on November 30 and December 7, 2011.³⁴ This study is intended as a local, Latino-centric stakeholder evaluation of whether discrimination, intentional or unintentional, affects access to health care programs that receive federal funds—specifically, insurance programs and physical care settings such as hospitals and clinics—and, if so, whether affordable and focused public policy measures could help correct such discrimination.

FOCUS GROUP COMPOSITION

The two focus groups conducted by CSRC had thirteen and nine participants, for a total of twenty-two people. The first group was entirely female, while the second included two men. Each group responded to a brief written questionnaire and then engaged in guided discussions in Spanish, with the same questions asked of both groups. The sessions lasted two and a half hours and were tape-recorded. Afterward, the recordings were transcribed and translated into English for analysis.

Focus group participants were selected on the basis of language proficiency (primary Spanish speakers) among people from the city of San Fernando and adjacent areas. One of the authors of this report, Roberto Belloso, was in charge of conducting the focus groups. He has experience conducting focus groups as part of other collaborative research projects between different academic institutions (including UCLA) and the Latino community in the San Fernando area. Of the twenty-two participants, a significant majority, fifteen participants, or 68 percent, identified Spanish as their primary

language (figure 2). An even larger majority, eighteen participants, or 82 percent, reported that they prefer to speak Spanish at home (figure 3). The same number reported that they speak less than excellent English (figure 4), which, for our purposes, is synonymous with the federal government's self-rated guideline for being considered LEP.³⁵ Thus, a large majority of our focus group participants could be considered to have limited English proficiency.

Of the twenty-two participants, twelve (55 percent) had some form of health insurance coverage and ten (45 percent) were uninsured (figure 5).

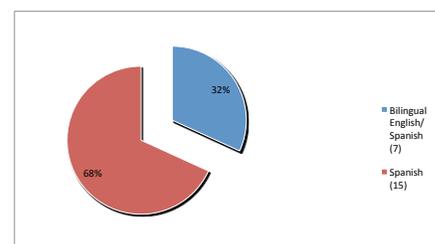
QUALITATIVE CONTENT ANALYSIS

To analyze our focus group data, we employed conventional qualitative content analysis, also known as inductive category development, in which we derived coding categories directly from the transcripts.³⁶ One key aspect of this approach was the use of established methodologies that allowed us to generate inferences from transcripts, freeing us from inflexible quantification.

Conventional qualitative content analysis follows an iterative process, beginning with the repeated reading of the data and the development of the coding process. Category development involves the derivation of criteria from the data, based on background considerations and research objectives.³⁷ This underscores why substantial background research on health care developments and trends is indispensable for any project concerning equitable health care access for local LEP Latinos.

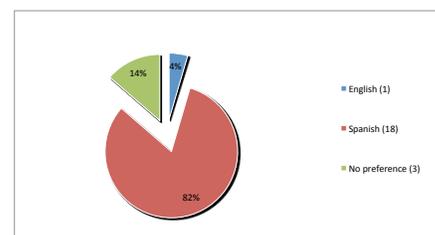
As the iterative process progressed, transcripts were analyzed for patterns and descriptive codes were developed. We then looked at the patterns to identify the presence of larger themes, and categories were revised or removed based on their frequency and reliability. For our purposes, this involved identifying barriers to equitable health care that were repeatedly mentioned in our focus groups (sometimes in response to a direct question).

Figure 2. Primary Language(s) Spoken



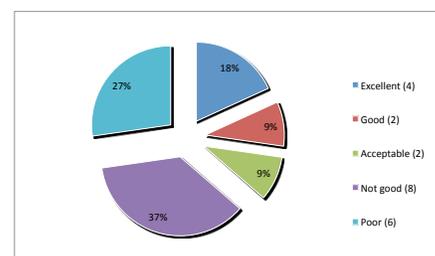
Source: Focus Groups 1 and 2.

Figure 3. At-Home Language Preference



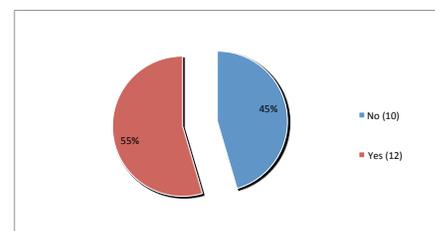
Source: Focus Groups 1 and 2.

Figure 4. Self-Rated English Skills



Source: Focus Groups 1 and 2.

Figure 5. Health Insurance Coverage



Source: Focus Groups 1 and 2.

After the inductive process of category development, we moved on to a deductive process of category application.³⁸ In this step we defined how texts should be coded after a category was established. For example, after inferring from repeated comments about interpreter qualifications that there is a need for a federal language certification program, we returned to the comments to delineate the participant's statement (e.g., whether language services are

more urgent for nursing staff or for primary care physicians; whether phone and/or TV services are more, or less, or just as appropriate as in-person interpreter services).

These findings were then compared to pertinent published research and, as relevant, to common experience, which refers to the concerns, knowledge, and aspirations that form the public domain.³⁹ As it relates to health care in America, common experience involves, among other things, discussions in the public domain about the relationship between income and/or wealth and insurance coverage, the weighing of cost against the necessity of care, and the debate over health care as a government (public) responsibility. Common experience is therefore reflected in widespread public and private debate in, for example, the media, the political arena, and academia.

Our methodology yielded results that proved largely compatible with the existing academic research literature on health care access for LEP Latinos, which, although increasingly substantial, is still rather young.

ANALYTIC CATEGORIES

Working in conjunction with the lead investigator, a co-author (not the focus group moderator) examined the transcripts for each focus group. Initial emphasis was placed on identifying responses concerning the relationship between limited English skills and equitable health care access in three areas: (a) participants' access to care (e.g., insurance coverage); (b) the efficiency of the care they receive (i.e., affordability and quality); and (c) their health outcomes, determined from their comments regarding common negative health indicators and specific health conditions that disproportionately affect the Latino community.⁴⁰

The research team then identified three key barriers to equitable health care access among the focus group participants: (a) lack of coordinated interpreter qualification and training across health services at both state and federal levels; (b) the challenge of improving English skills within LEP households

and communities; and (c) the integrated system of socioeconomic factors and ethnoracial discrimination. Socioeconomic factors (including income and wealth inequalities, as well as social mobility) and ethnoracial discrimination together constitute, in our view, by far the most significant threat to equitable health care for LEP Latinos because it is an integrated system that overarches all other barriers to access. In other words, it is the root cause of most inequities in health.

After identifying these areas, the research team used consensus methodology to develop coding categories that were then applied to the transcripts. Development of these categories was guided by existing public health research on the barriers to health faced by vulnerable populations. These studies increasingly recognize that socioeconomic factors disproportionately affect lifespan and health and that education, in particular, is an influential determinant of health.⁴¹ Our study encompasses the hypotheses that support this research and presents additional, largely qualitative evidence that limited English skills also contribute to disparities in health.⁴²

Our findings resonate with the National Health Law Program's "Language Access in Health Care Statement of Principles" and with the *National Healthcare Disparities Report, 2012*, of the US Department of Health and Human Services.⁴³ Both describe the goal of a world in which language barriers do not affect health outcomes, contrasting this ideal picture with the current system in which appropriate health care is distributed both inefficiently and unevenly across populations. Notwithstanding the small population sample and limited geographic range of our focus groups, our research offers an up-close, in-depth view of barriers to health care from the perspective of people who experience them on a daily basis. We hope that the findings will provoke further discussion of the barriers to care, both in LEP Latino communities and in all communities facing disparities in access to health.

FOCUS GROUP FINDINGS: HOW LANGUAGE FUNCTIONS AS A BARRIER TO EQUITABLE HEALTH CARE ACCESS

The following sections present results of our qualitative focus group analysis on the three main hurdles to health access faced by LEP Latinos: (a) the lack of coordinated interpreter qualification and training, (b) the challenge of improving English skills, and (c) the effects of an integrated system of socioeconomic factors and ethnoracial discrimination. We identify some general findings based on survey questions administered to the focus groups in writing or orally (participants were asked to respond by raising their hands). In addition, we include selected quotes from the participants that present their experiences, opinions, and analysis in their own words.⁴⁴ There is some redundancy in the inclusion of quotes because we consider interpreter services, improving English skills, and socioeconomic factors and ethnoracial discrimination to be interconnected and overlapping concerns and have integrated this thinking into our data analysis.

LACK OF COORDINATED INTERPRETER QUALIFICATION AND TRAINING

Our focus groups relayed numerous experiences with absent or unsatisfactory interpreter services, highlighting the need for a more coordinated, strategic process of interpreter training and qualification. Interpreter services can be provided in person, over the phone, through video interface, or using some combination of those options. It is worth noting that California has the most comprehensive legislation on language services of any state, and it continues to lead the nation in this aspect of health care.⁴⁵ We can therefore infer an even greater need for interpreter services in states with less-robust policies on language access. They include some with substantial Latino populations, particularly Texas, which has the second-largest Latino population after California.

Participants repeatedly pointed to a lack of specifically trained (i.e.,

certified) interpreters at every step along the health care path, from reception to diagnosis to treatment to discharge and home care (for chronic conditions). They emphasized that this issue was of major importance to them and their health.

Participants testified to the significant improvement in language services for LEP Latinos in recent years, which stems in large measure from California's policy efforts in this regard. Yet our data also point to the ongoing problems caused by a lack of stringent state and federal guidelines and regulations for the provision of qualified, trained interpreters and translators.

Focus Group Data

Tables 1 and 2 present focus group data and selected quotes from participants. The interpreter-related issues highlighted by the groups included a sometimes inappropriate reliance on family members, including minors, as health interpreters; the general dangers of using untrained interpreters in health settings; the need for interpreting services to be available 24/7; and the often dependent role that English skills play in determining health access and outcomes.

Discussion

Health care in the United States relies on a lexicon and knowledge system that is esoteric for the average citizen. Even for fluent English speakers, understanding the complexities of medical diagnoses and treatment recommendations can be as difficult as understanding the intricacies of private equity firms or collateralized debt obligations for non-economists. These difficulties are compounded for people with limited proficiency in English. As one of our participants commented, "Medical terms are very different from the terms we use daily." Not only is interpretation necessary, therefore, but interpreters benefit from standardized training that enables them to accurately and effectively translate the specialized medical terminology used by health care providers. This points to an urgent need for a coordinated and

enforceable system of interpreter training and qualification, potentially at the federal level.

Participants in our focus groups called for more regularized, streamlined interpreter services that are culturally sensitive. They pointed out that interpretation was often provided informally, if at all: "If the doctor doesn't speak Spanish, there's a nurse who interprets for me. If there is no nurse, then I try to make myself understood, in my own way." Participants highlighted the unreliability of noncertified interpreters, particularly in terms of not providing full interpretation: "They do not interpret everything we say." Many had relied on friends or family members, including children, for interpretation, leading to embarrassing and sometimes potentially dangerous situations. "Sometimes I have used my daughters [as interpreters]. For me it's uncomfortable that my daughters find out [about my condition] before I do."

Taken together, the responses spoke to recent trends in language service provision in California. These include the observation that California's language services have improved dramatically: participants indicated that there were significantly fewer doctors who spoke Spanish years ago. However, there is an evident need for more educational outreach to dispel fundamental misconceptions about language services, reflected in one participant's comment that "hospitals are not obligated to have staff who speak Spanish." Moreover, all participants said they worry about the quality of health services they receive because of their difficulties in communicating effectively. Many participants reported having experienced discrimination in health care settings, and language was a part of this.

In the public discourse on health care, a common response to the assertion of a need for improved interpreter services is that it would be too costly. However, research suggests that the long-term savings associated with appropriate interpreter services would outweigh the short-term cost. A recent

study found that when a group of California hospitals banded together to offer interpreter services via phone and video, the cost per patient was only \$25 per event.⁴⁶ With respect to national costs, a 2002 report from the White House Office of Management and Budget (OMB) estimated that it would cost the United States \$268 million per year to offer interpreter services in inpatient hospital, outpatient physician, emergency department, and dental visits.⁴⁷ The OMB's estimate, however, "does not discount for the costs of language services already being provided or for reductions in other health costs that might occur if there is better patient-provider communication." As a result of these additional savings, which include reduced hospitalization and better handling of home-based chronic conditions, the net costs of expanding language services in the near term are almost certainly eclipsed by the associated long-term savings.⁴⁸

Another way that better interpretation saves money is by reducing medical malpractice costs. A 2010 study conducted by the University of California, Berkeley, School of Public Health and the National Health Law Program found that health care providers, insurers, and patients bear many direct and indirect costs that "could be avoided with effective communication. Those costs include damages paid to patients, legal fees, the time lost when defending a lawsuit, the loss of reputation and patients, the fear of possible monetary loss, and the stress and distraction of litigation." The ultimate and unacceptable medical cost is, of course, patient harm. Thus, the study concluded, "The investment in language services is far less than the direct and indirect costs of not providing language services."⁴⁹

The overhauling of the language services system could involve a federally instituted or enforced interpreter certification program, as well as the creation of further incentives for existing health practitioners to become certified bilingual interpreters. Such a system must ultimately reflect the varied needs of LEP stakeholders, many of

Table 1. Findings and Statements Regarding Interpreter Services, Focus Group 1

GROUP FINDINGS
When asked whether they personally had experienced discrimination when seeking medical care, 10 of 13 participants raised their hands.
All participants said that they had received services from people who speak Spanish to some extent.
The majority of participants said that the issue of not fully interpreting everything a patient says remains a major concern. However, a majority said that the provision of basic Spanish language services has improved significantly in recent years.
The majority of participants said that they have used a family member or friend to interpret for them. Sometimes the person doing the interpreting was a child.
All participants said that the quality of services is related to the ability to speak English. This opinion has not changed in recent years even though language services have improved significantly.
All participants indicated that language plays an important role in their health outcomes.
Nine participants said that they did not receive services in Spanish when they first arrived in the United States but that services have improved since then. Given the age of most of our participants, this is a testament to the improvement in language services over the years, particularly in California.
SELECTED QUOTES
"Discrimination comes from the Latino doctors and staff themselves. When Americans hear us speaking English, they say, 'I understand, I understand.' On the contrary, Latinos say, 'I don't understand. What are you saying?' . . . Then, we feel bad."
"Once I had a doctor who was trying to speak Spanish, and I asked her, 'Do you want my daughter to help you?' And the doctor said, 'No, no, no. I want to continue practicing Spanish.'"
"I asked my doctor, 'Why did you learn Spanish?' The doctor replied, 'Because I knew that I would provide services to people like you.' In some cases doctors learn the languages that are spoken in the area they work. That is very important."
"One time, I waited more than an hour, not understanding that they were calling me by my first name. Then, my doctor didn't speak Spanish. I didn't understand instructions like 'don't walk,' 'rest,' or 'lie down.' My nephew explained to me the meaning of those phrases."
"During pregnancy, for example, my doctor—I can't remember if he spoke Chinese or Japanese—did not speak Spanish or English. He only spoke his language. I don't know how I was able to understand him, but I did. We used body language."
"They don't interpret everything we say. There are very few interpreters [who are excellent in relation to interpreting everything we say]."
"It is uncomfortable [to use a relative as an interpreter] because we can't express ourselves in a direct manner. We have to tell [our situation] to another person."
"Those who speak English get services first."
"I believe that if we speak Spanish, they don't give us information. They don't want to waste their time."
"At the clinics, we don't receive this type of information [about services available]. We receive this type of information from 'outside'—at schools or health fairs."

Table 2. Findings and Statements Regarding Interpreter Services, Focus Group 2

GROUP FINDINGS
Only 4 of the 9 participants said their doctors speak Spanish. The rest said their doctors speak only English.
Half of the participants said that they are offered services in Spanish before they need to request them.
All participants agreed that when they need Spanish services they always get help.
Participants said that they appreciate a doctor who tries to speak Spanish.
Participants recalled that there were significantly fewer doctors who spoke Spanish years ago.
All participants indicated that they worry about the quality of health services they receive because of their ability to communicate effectively.
All participants indicated that language plays an important role in their health.
All participants agreed that non-English-speaking people are not made aware of all the health services available to them, while the availability of services is made known to those who speak English.
SELECTED QUOTES
"I don't think about the language. That's because if the doctor doesn't speak Spanish, there's a nurse who interprets for me. If there is no nurse, then I try to make myself understood, in my own way."
"Language is important, because if we don't speak English fluently, we can't explain what we feel. Medical terms are very different from the terms we use daily. Sometimes the doctors start asking questions and we don't understand what they're asking. For me, language is a barrier."
"If there is no interpreter available right away, I have to wait."
"We feel 'safe' [when a doctor or nurse speaks Spanish]. It feels good to know that the doctor understands what we are saying. It helps to give the correct diagnosis. Can you imagine if the doctor doesn't understand us? Or [worse], if the doctor says that he/she understands but in reality doesn't understand what disease or symptoms we're talking about? He/she may give us the wrong prescription."
"One day, there was a lady interpreting for me but I asked her not to do it. I said about 20 words and she just interpreted three words. Also, she was going back and forth [in and out of the room] because she needed to interpret for another person as well."
"Sometimes I've used my daughters [as interpreters]. For me it's uncomfortable that my daughters find out [about my condition] before I do. Sometimes I've used other interpreters, but I've noticed that I'll be saying one thing and they're saying something else . . . I have noticed several times that what I say is not interpreted fully."
"Now that they have more staff who speak Spanish, they offer better services."
"My son has private insurance and the same doctor [who I see at UCLA] takes care of him. My son [who speaks English] receives a totally different type of care than I receive."
"If we speak with somebody who speaks Spanish, we will keep asking [follow-up questions], depending on the answers we get. However, if [a provider] speaks English and there is an interpreter, the interpreter doesn't look at you. He/she just turns to you and says, '[The doctor] says this and that.' We don't have a chance to ask questions or express any doubt we may have."
"I know that hospitals are not obligated to have staff who speak Spanish* . . . However, it would be easier for hospitals to do that than for people to learn English because [learning English] is a very long process."
*Note: This is not true for hospitals that receive federal funds and is particularly untrue in California, given its more stringent language service laws. The participant's statement thus reflects the importance of targeted knowledge outreach.

whom do not see a primary care physician consistently. Meeting the needs for interpretation will be an uphill battle, but it is one that our participants pointed to as essential to their health.

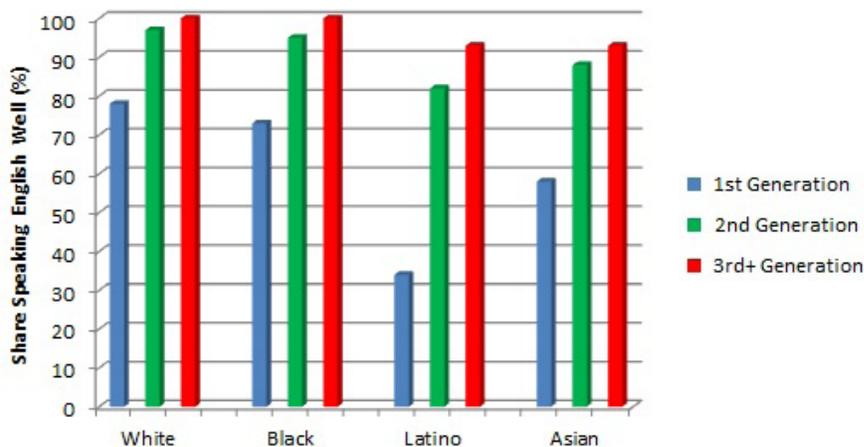
THE CHALLENGE OF IMPROVING ENGLISH SKILLS

Americans view English skills as a key component of national identity. A 2007 survey conducted by Tufts University showed that 94 percent of US residents believe that being able to speak English is “somewhat” or “very” important in determining if someone is considered a “true” American.⁵⁰ A May 2011 study conducted by the Migration Policy Institute affirmed that English proficiency is a “virtual requirement for full participation in U.S. society.”⁵¹ When the Pew Hispanic Center asked Latino permanent residents why they had not naturalized, 26 percent, the largest percentage for any single response, identified personal barriers such as a lack of English proficiency.⁵²

A common nativist charge against non-European immigrants—and Latino immigrants in particular, since they are the most numerous group of foreign-born—is that they make little or no effort to acculturate into American society. Language proficiency is commonly argued to be a key baseline measurement of such effort.⁵³ Because of this lack of personal initiative, the argument goes, today’s immigrants are not following the path of acculturation and success trod by the primarily European immigrants that preceded them.⁵⁴

Immigrants from Spanish-speaking nations make up the bulk of the US migrant population, and given their numbers, they have ample opportunity to speak Spanish while in America. So it is not a great surprise that Latin Americans have higher LEP rates than other immigrant groups. However, multiple studies indicate that the Latino population is indeed acquiring English proficiency and acculturating over time. Perhaps the most notable irony of the nativist argument is that new Latino immigrants unavoidably internalize American acculturation in

Figure 6. Proportion of Individuals Age 5 and Over Who Speak Only English or English Very Well, by Ethnoracial Group and Generation, 2004



Source: Tomás R. Jiménez, *Immigrants in the United States: How Well Are They Integrating into Society?* Washington, DC: Migration Policy Institute, 2011. Based on data from the March 2004 Current Population Survey of the US Census Bureau.

their bodies, often in ways that are detrimental to their physical and mental well-being.⁵⁵

The shift to English among contemporary immigrants and their descendants is particularly striking when one looks at language use across generations. Analyzing Census Bureau data, the Migration Policy Institute found that in all ethnoracial groups, the proportion of immigrants who “speak English well” jumps to over 80 percent by the second generation (the US-born children of immigrants) (figure 6). The improvement in English skills between the first and second generations is most dramatic among Latinos, despite common misconceptions. The study states, “By the third and higher generations, close to everyone, regardless of ethnoracial group, reports speaking only English or English very well.”⁵⁶

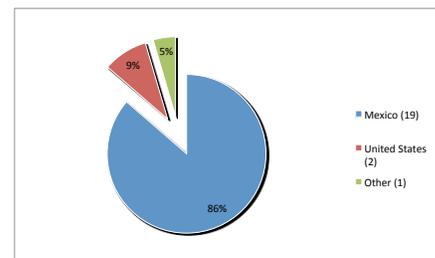
These patterns hold among Mexican immigrants, currently the largest US immigrant group and the group most often criticized in nativist discussions of immigrants’ purported reluctance to assimilate. This is pertinent to our study, as Mexican Americans are by far the largest LEP Latino community in Los Angeles and constituted nearly all of our volunteer participants. A study published in 2006 showed that among immigrants of Mexican ancestry in Los Angeles who are twenty-five

years of age and older, only about 25 percent of the second generation preferred to speak Spanish at home, while 4 percent of the third generation and 3 percent of the fourth generation expressed the same preference.⁵⁷

Focus Group Data

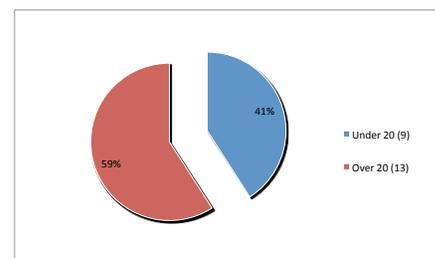
Of our twenty-two focus group participants, a large majority, nineteen people, were born in Mexico (figure 7). In addition, a majority of the twenty-two participants immigrated when they were over twenty years of age (figure 8). This is notable because studies

Figure 7. Place of Birth



Source: Focus Groups 1 and 2.

Figure 8. Age at Emigration



Source: Focus Groups 1 and 2.

demonstrate that younger immigrants become fluent in English more quickly than older immigrants.⁵⁸

Of the six participants who rated their English skills as good or excellent, two grew up in the United States and the remaining four immigrated at age seventeen or younger. Furthermore, of these six, only one received less than a secondary (i.e., high school) education; this person was also the only one of the six who listed her primary language as Spanish rather than “bilingual.” These limited data confirm research indicating that English acculturation within Latino immigrant communities occurs at higher rates among immigrants who entered the country at a young age and/or received more extensive education.⁵⁹

Tables 3 and 4 present focus group data and selected quotes on improving English skills. Themes include the importance of learning English in general and the specific importance of language proficiency in health care settings.

Discussion

Contrary to nativist stereotypes, our focus groups suggest that LEP Latinos are highly aware of the importance of learning English and are constantly striving to do so, sometimes at the expense of their cultural heritage. “Of course it’s a good thing we have our language, but we live in this country,” one person noted. Our participants made clear that they want to improve their English skills and are well aware of the social benefits of doing so. For

many, however, learning English has been and remains a challenge. “I have four children, so I dedicated myself to work and taking care of my children,” one woman said. “I would have loved to go to school [to learn English], but I didn’t have that opportunity.” Another emphasized that learning English “is a very long process.” All participants expressed an appreciation of efforts to provide low-cost or free language services and called for more access to affordable English classes.

Participants suggested that learning English would give them more power over their health care, particularly in terms of responding to treatment perceived to be unjust. One person commented, “Language is very important. I remember one of the Anglo nurses who

Table 3. Findings and Statements Regarding English Skills, Focus Group 1

GROUP FINDINGS
All participants agreed that the quality of health services they receive is related to their ability to speak English.
All participants said they were concerned about the quality of health care they receive because of their ability to communicate properly.
All participants agreed that language plays an important role in their health outcomes.
SELECTED QUOTES
“What about the doctor telling us, ‘Oh good, you are speaking English’? I think that we also must do our part [by learning English].”
“Of course it’s a good thing that we have our language, but we live in this country. Sometimes our community doesn’t make an effort to learn English. This is not fair.”
“Well, for me [the language issue] is different. That’s because I am learning English. I can now communicate a little better. I don’t use an interpreter.”
“I try to encourage families to learn English. This is good not just for them but for their children. English is useful to help our children do homework, to be able to obtain other things. The best thing we can do is to prepare ourselves to be able to help our children. This is the only way to prosper and get a good job. We must learn English . . . We must learn to be able to defend ourselves.”

Table 4. Findings and Statements Regarding English Skills, Focus Group 2

GROUP FINDINGS
There were mixed feelings among the participants as to whether the quality of services is related to the ability to speak English.
However, all participants said they were concerned about the quality of health care they receive because of their ability to communicate properly.
All participants agreed that language plays an important role in their health outcomes.
SELECTED QUOTES
“Language is important, because if we don’t speak English fluently, we can’t explain what we feel. Medical terms are very different from the terms we use daily. Sometimes the doctors start asking questions and we don’t understand what they’re asking. For me, language is a barrier.”
“I thought that if I knew how to speak English, the doctor would have to pay attention to me [listen to what I have to say].”
“Now that there are more Latinos, they want us to speak ‘English only.’ That is what they want.”
“Language is very important. I remember one of the Anglo nurses who did not treat me right. If I knew how to speak English, I would have defended myself.”
“I know that hospitals are not obligated to have staff who speak Spanish* . . . However, it would be easier for hospitals to do that than for people to learn English because [learning English] is a very long process.”
*Note: This is not true for hospitals that receive federal funds and is particularly untrue in California, given its more stringent language service laws. The participant’s statement thus reflects the importance of targeted knowledge outreach.
“I have four children, so I dedicated myself to work and taking care of my children. I would have loved to go to school [to learn English], but I didn’t have that opportunity.”
“I just want to say that, as others have said, I agree that English is important for facing our needs.”
“[Not knowing English] is a barrier for many of us.”
“I also agree that language [English] is the barrier that does not allow us to obtain information about available services.”

did not treat me right. If I knew how to speak English, I would have defended myself.” Another noted, “If we don’t speak English fluently, we can’t explain what we feel. Sometimes the doctors start asking questions and we don’t understand what they’re asking. For me, language is a barrier.”

All participants agreed that language plays an important role in their health outcomes. However, there was some divergence between the two focus groups. In the first, made up of women, all participants expressed concern that the quality of health care they receive may be negatively affected by their difficulties with English communication. In the second, which contained two men, there were mixed feelings as to whether the quality of services received is related to the ability to speak English. We do not have enough data to say whether gender or other demographic factors played a role in this divergence of opinion, but it is worth noting.

All participants ultimately assumed personal and collective responsibility for improving their English skills. “What about the doctor telling us, ‘Oh good, you are speaking English?’ I think that we also must do our part [by learning English],” one person said. They stressed the importance of language acculturation as a means to secure a better life for their children. For families to prosper, “we must learn English,” one person emphasized.

Unfortunately, access to affordable English language instruction has been increasingly restricted in the wake of the economic crash that began in 2007. Public disinvestment in the California educational system left the state near the bottom in national rankings of education spending as a share of a state’s economy, and this has had direct consequences for English language instruction. In an October 2011 report, the California Budget Project wrote,

California schools with large numbers of English language learners and students from low-income families face significant challenges. Yet, despite research

that shows English language learners and students from low-income families are more costly to educate, California spends less than other states that have fewer of these students. Moreover, most spending measures do not account for the additional resources required to educate students from low-income families and English language learners. As a result, the spending gap between California schools and the rest of the US does not reflect the resources required to adequately educate California’s diversity of students.⁶⁰

Adult education, perhaps the single most important source of affordable English as a second language (ESL) classes, also experienced unprecedented budget cuts in California. Spending declined well over 50 percent following the economic crash, though the demand for classes continued to outpace supply.⁶¹ High school completion, ESL, and career preparatory programs serve over 140,000 adult students in Los Angeles alone.⁶² EdSource, an education nonprofit, reported in 2012 that twenty-two of the state’s thirty largest school districts had made major cuts to adult programs in the preceding year; one district had eliminated adult education completely.⁶³

California’s 2013–14 budget offers additional resources for educating English learners and students from low-income families. It also promises to protect adult education from cuts for the next two years and includes \$25 million in planning grants.⁶⁴ Despite these positive aspects, the new budget does not restore the funding that was available before the crash, seriously hampering the efforts of low-income LEP adults who are trying to improve their English proficiency.

If ESL classes are not available or are price-prohibitive (particularly given Latinos’ general economic standing), then access to language education, especially for recent immigrants, is essentially cut off. Because this may effectively lock in a key aspect of inequality in health access for LEP

Latinos, the limited availability of ESL classes may itself constitute a barrier to health care.

Despite the obstacles, Latinos, including our focus group participants, are making strides in their English language education both within single lifetimes and, most significantly, across generations.⁶⁵ We would argue that, as is the case with interpreter services, policy efforts to provide for affordable and accessible English classes would lead to the improvement of all aspects of health care, from access to affordability to outcomes.⁶⁶ Curtailing access to English instruction is a prime example of public policy that prioritizes short-term savings at the expense of long-term benefits for individuals and the broader society.⁶⁷

THE EFFECTS OF SOCIOECONOMIC FACTORS AND ETHNORACIAL DISCRIMINATION

Our focus group sessions reflected the reality that language proficiency cannot be considered within a public policy vacuum. As we have seen, the issue of language as a barrier to health is closely connected to specific policy concerns, such as the need for a federally certified interpreter certification program and the availability of low-cost English classes. Even more significant, however, are the structural factors, both political and economic, that shape one’s experience with the health care system. Chief among these is what we refer to as the integrated system of socioeconomic factors and ethnoracial discrimination.

Our participants’ comments affirm what public health research is increasingly finding: socioeconomic factors influence many key measures of health and lifespan, and nonwhites are hampered in their pursuit of equitable health care by racism, affecting their mental as well as physical health.⁶⁸ Nearly every aspect of health is shaped by income and wealth, and education is a particularly powerful determinant: higher levels of education are associated with better health and longer life, in part because of the impact of education on future earnings and wealth.⁶⁹

Unfortunately for Americans, particularly vulnerable Americans, the nation is now about as unequal in terms of wealth and income as it was during the Great Depression, though we benefit from a higher standard of living and a stronger social safety net.⁷⁰ The United States also ranks near the bottom of OECD nations in terms of social mobility across generations.⁷¹ Wealthy Americans rarely struggle with exorbitant health costs in the same ways that poor Americans do, in part because they are more likely to be covered by top-tier private health insurance. When integrated with related indicators such as education, geographic location, and race/ethnicity, affluence itself significantly improves the chances of positive health outcomes.⁷²

Important new scholarship has focused on the strong correlation between affluence and political influence. Princeton professor Martin Gilens, for example, compared the policy preferences of earners in the top, middle, and bottom income brackets with subsequent policy outcomes, based on thousands of survey questions conducted between 1964 and 2006. He concludes that American citizens are vastly unequal in their influence over policy making: “In most circumstances, affluent Americans exert substantial influence over the policies adopted by the federal government, and less well off Americans exert virtually none.” Gilens also found that inequality in policy influence is growing.⁷³

Our focus group participants repeatedly referred to their lack of influence and the difficulty of making their voices heard, both directly and indirectly. For example, our participants repeatedly noted the difficulty of filing health care–related complaints in English.

The impact of socioeconomic factors on health care is particularly worrisome because of the spread of poverty in the United States. A September 2012 report from the Pew Research Center indicated that the percentage of Americans who self-identify as being in the lower-middle or lower class has risen from a quarter of the adult population

to about a third in the previous four years. Latinos led the march into the lower brackets, with 40 percent self-identifying as in the lower-middle or lower class in 2012 compared to 30 percent in 2008, a remarkable 10 percent difference.⁷⁴

Perhaps most relevant here, the self-identified lower classes report being less happy and less healthy than their more affluent counterparts, and the stress levels they report are higher than those of adults who are not poor. Pew found that people in low socioeconomic brackets are four times as likely to report being in subpar health as affluent people, three times as likely to be unhappy, and twice as likely to be frequently stressed. “By significant margins, those in the self-identified lower classes say they are less satisfied than others with their family life, housing, education, and finances. On many responses, the gap between the lower and middle classes is much larger than that between the middle and upper classes.” When it comes to health care, 45 percent of those who identified themselves as being in the lower-middle or lower class had difficulty paying for medical care for themselves or their families, while just 18 percent of middle-class adults and 11 percent of upper-class adults faced a similar problem.⁷⁵

Our focus group participants indicated that language proficiency represents a serious barrier to equitable health care access. Because of the correlations between limited English proficiency, poverty, and ethnoracial difference, the language barrier must be seen as thoroughly integrated within a larger system of socioeconomics and race/ethnicity. Discrimination based on language proficiency does not simply constitute a violation of the intent of Title VI of the 1964 Civil Rights Act, it also interacts with other socioeconomic and ethnoracial factors to contribute to inequalities in health.

Focus Group Data

Of the twenty-two focus group participants, over half (twelve) had less than a secondary education (figure 9).⁷⁶ All of those participants were born

abroad, with eleven of the twelve born in Mexico. Although we did not ask participants for income or wealth information, studies show that educational attainment is a key barometer of future socioeconomic status. As a result, we used education data as a (loose) proxy for socioeconomic status.

Of the twelve respondents with less than a secondary education, seven relied on low-income, state-sponsored health insurance (often for emergency care), while the other five were without any insurance coverage (figure 10).

As noted earlier, twelve of the twenty-two participants had some form of health insurance coverage and 10 had none. The majority of those who were insured reported that they relied on Medi-Cal, California’s version of Medicaid (figure 11). One participant, shown in the figure as covered by “other insurer,” listed a public hospital in the San Fernando Valley as her provider, and the focus group facilitator surmised that this patient is also likely covered by Medi-Cal. Only two participants were enrolled in a major, private insurance plan (Kaiser); both of these individuals had at least some college education.

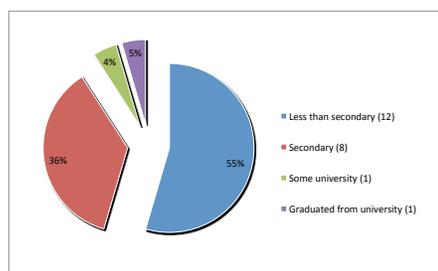
When asked to self-rate their health, over three-quarters of our participants (seventeen people) rated their health as either acceptable, not good, or poor. Only five people rated their health as good, and none reported excellent health (figure 12).

Of the ten people who relied on (or was surmised to rely on) Medi-Cal, three ranked their health as not good and five as acceptable. The remaining two ranked their health as good.

Among the ten people without any insurance coverage, the breakdown was similar, but it skewed slightly toward worse health. One participant reported poor health, and three reported that their health was not good. Five reported acceptable health, and one reported good health (figure 13).

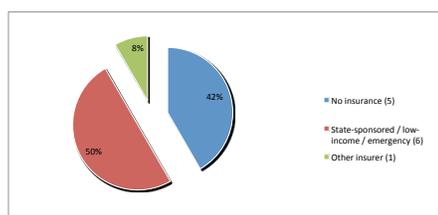
By contrast, the two participants covered by a major private insurance plan reported their health as good. As noted, they were also the only

Figure 9. Educational Attainment



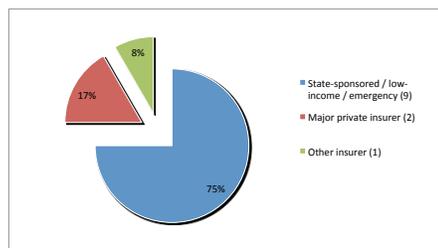
Source: Focus Groups 1 and 2.

Figure 10. Health Insurance Coverage, Respondents with Less than Secondary Education



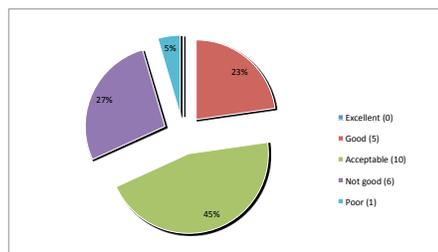
Source: Focus Groups 1 and 2.

Figure 11. Type of Health Insurance (If Covered)



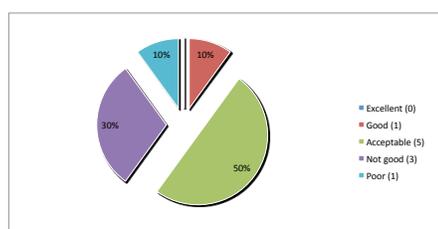
Source: Focus Groups 1 and 2.

Figure 12. Self-Rated Health



Source: Focus Groups 1 and 2.

Figure 13. Self-Rated Health, Respondents with No Health Insurance Coverage



Source: Focus Groups 1 and 2.

participants in our focus groups who had attended college. Thus, our findings likely align with those in the PEW study.⁷⁷

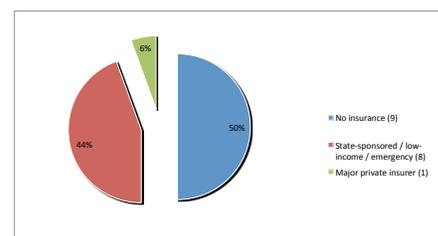
With respect to English proficiency, only four participants identified their English skills as excellent. We consider this rating to be comparable to HHS’s self-rated language proficiency of speaking English “very well,” the level below which HHS considers an individual to be LEP (figure 4).⁷⁸ Of those four participants, two were covered by Medi-Cal, one had private insurance, and one was uninsured. Of the eighteen remaining participants, who indicated that they speak less than excellent English, nine lacked insurance coverage altogether and eight relied on Medi-Cal (figure 14). Only one of the eighteen participants who qualified as LEP was covered by a major private insurer, though it should be noted that she self-rated her English as “good,” considered herself bilingual, and had a college education.

Delving deeper, we compared English proficiency with education and found similar trends. Three out of the twenty-two participants spoke excellent English (self-rated) and had attained at least a secondary education. Two of these three were born in the United States, while the third immigrated from Mexico at the age of four and thus had the opportunity to acclimate to US culture during early childhood. Of these three participants, one had private insurance, one had state-sponsored insurance, and one was uninsured (figure 15).

By contrast, of the eleven participants who attained less than secondary education and spoke less than excellent English, six relied on state-sponsored, low-income insurance, and the remaining five were uninsured (figure 16).⁷⁹ Furthermore, of these eleven participants, all were born abroad and all but one in Mexico.

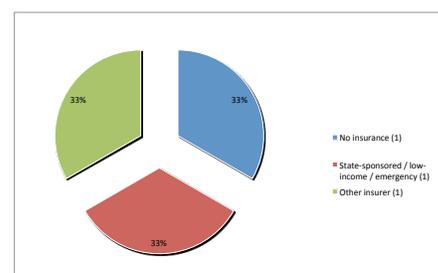
When we equate our language proficiency standards to those of the federal government, a significant majority of our participants (82 percent) is classified as LEP. Of that group, all but

Figure 14. Health Insurance Coverage, Respondents with Less than Excellent English Skills



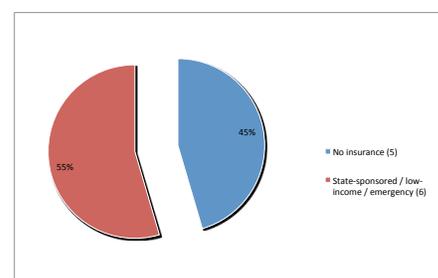
Source: Focus Groups 1 and 2.

Figure 15. Health Insurance Coverage, Respondents with Secondary Education or Above and Excellent English Skills



Source: Focus Groups 1 and 2.

Figure 16. Health Insurance Coverage, Respondents with Less than Secondary Education and Less than Excellent English Skills



Source: Focus Groups 1 and 2.

one were either uninsured or relied on Medi-Cal. This makes the increase in health access under the Affordable Care Act, and a strengthening of state-level Medicaid plans such as Medi-Cal, all the more meaningful. It also highlights the ongoing need for strong health care cost controls in the American health care system.

Tables 5 and 6 present findings and selected participants’ comments related to socioeconomic factors and ethnoracial discrimination. Given that this barrier to health encompasses many interrelated factors, many of the quotes and trends are broader in scope than those discussed in the previous sections.

Table 5. Findings and Statements Regarding Socioeconomic Factors and Race, Focus Group 1

GROUP FINDINGS
At least half the participants reported that they use urgent care clinics.
10 of 13 participants raised their hands when asked, "Have you personally experienced some kind of discrimination when you seek medical services?"
At least 8 participants agreed that some providers have a negative attitude toward Medi-Cal.
At least 4 participants reported having chosen an urgent care clinic over the emergency room because of cost and, moreover, selecting a specific clinic based on its copayment cost.
All participants agreed that the quality of the services they receive is related to the ability to speak English.
All participants agreed that they were concerned about the quality of health care they receive because of their ability to communicate properly.
At least 3 participants said they had taken the time to submit a complaint about the quality of their health services.
At least 10 participants had a complaint but never expressed or filed it.
SELECTED QUOTES
"In general the clinics are expensive . . . If I get a cold, I just deal with it. I don't go to the clinic. I simply go to Target and get Tylenol or something that can help."
"I speak English, so I haven't had any issues with communication. Once I went to a hospital in the San Fernando area. I had an emergency with my son, who had a fever of 103 degrees. After I had waited a long time, I said in English, 'I'm leaving. Just because you see my Latina face and I didn't speak English—but I do and I also have insurance.' . . . So the doctor came right away to help me . . . I thought, 'Too bad that when [these people] see patients who don't speak English, who look different, of a different color, they value them less.'"
"They discriminate against us when they ask, 'What insurance do you have?' and we answer, 'Medi-Cal.' Many times when I take my children to the clinics and I mention Medi-Cal, they don't provide my children with the care that they should . . . I took my daughter in July for a checkup; then, by the end of the year, she started showing diabetes symptoms. So I took her back to the clinic and they didn't want to do any tests because they had already done the physical exam. They said that Medi-Cal would not cover [those tests]."
"The copayment [influences my decision of where to go for medical care]. Like she said, I prefer to go to urgent care and pay \$20 than to the emergency room where I would have to pay \$100."
"One day my neighbor took my husband to the hospital. They found my husband on the street, so it was an emergency . . . When I arrived at the hospital they still had not taken care of him. I told the staff that he had Emergency Medi-Cal. The lady that was checking in the computer said, 'This Medi-Cal coverage is not good for you because he works. He must have his own insurance.' . . . She then told us, 'You know what? You come to this country to steal. You have no right to have Medi-Cal.' I was shaking and very mad. She turned to her coworker and said, 'These Latinos come here to create a nuisance.' . . . [A secretary at Human Resources later] confirmed that we had Medi-Cal."
"As far as insurance, I believe there must be some reforms. My father-in-law has a truck business. He had an accident in downtown LA and one of his arms was completely destroyed. They took him to a hospital. He couldn't talk due to his pain. They didn't give him any painkillers. They wanted to see his insurance first. They had him sitting in a wheelchair and did nothing. He was bleeding and they were ready to cut his hand because it was the less expensive thing to do. They didn't know that he had good insurance, Blue Cross . . . The reason why they didn't help him in the first place was because they saw he was Latino. He looked so dirty due to his work . . . they discriminated due to his appearance. They didn't look in his pockets . . . There should be a reform so that everybody has the same opportunity."
"Years ago, [we received] excellent services because my children had private insurance. Unfortunately, my husband changed his job and we couldn't pay the private insurance. It was too expensive. My children then got Medi-Cal. My oldest son was moved to Kaiser. Each of them goes to a different clinic. The service is not so satisfactory."
When asked whether available services are made known at urgent care clinics: "At the clinics, we don't receive this type of information. We receive this type of information from 'outside'—at schools or health fairs."
"[Communication is the] problem with our community. It's not that they don't listen to us. We have to write letters, but some people don't want to take the time to do that. Yes, they listen. Yes, they implement the changes. We must insist and not back down . . . They listen because it is not to their advantage to have a bad record." Another participant: "Yes, but again [the ability to write a complaint] is influenced by language."
"They should provide services—not free, because we don't value them—but low-cost, to prevent diseases. If we can't afford medical care, we don't go to checkups. Then we go and find out that we already have diabetes and it's too late. They should make it possible for those who have no resources to get services . . . Medi-Cal is cutting benefits. Before, Medi-Cal used to cover Tylenol; now I have to pay for it. For the health of our children we buy it, no matter how hard it is. But for us [adults] we always say, 'Later, later.' Then, we realize it's too late. I hope they will offer insurance programs at low cost. We need opportunities for adults. My children have Medi-Cal but I don't. I only have Medi-Cal for emergencies. So, I wonder, 'Should I throw myself under a truck so that they take care of me?'"

Table 6. Findings and Statements Regarding Socioeconomic Factors and Race, Focus Group 2

GROUP FINDINGS
At least 6 participants indicated that they use public clinics run by Los Angeles County.
Only 1 participant reported having a primary care physician.
All participants agreed that doctors often allow too little time for visits.
All participants agreed that they were concerned about the quality of health care they receive because of their ability to communicate properly.
All participants indicated that language plays an important role in their health.
All participants agreed that non-English-speakers are not made aware of all the services that are available to them, while the availability of services is made known to those who speak English.
SELECTED QUOTES
"I go to private clinics . . . I won't be able to continue because I have been unemployed for about six months."
"I also couldn't continue with an eye surgery I needed because I couldn't afford to pay."
"I have always paid for my care and for my medicine. But my husband had a stroke. Neither of us has a job, so it's not possible for us to go to a hospital. It would be too expensive."
"I go to places [where] I have to wait eight hours. It's an emergency! But they still make me wait eight hours. I ask them, 'Why do I have to wait eight hours?' It's the system . . . I don't want to have emergencies."
"I believe the way they treat us and the services we receive determine where to go. If we receive bad service [and] have to wait 8, 10, 12 hours at the emergency room, feeling bad, [this is not a good thing]."
"Besides the problem with the language, we have another problem: they don't care about us. I believe that those who answer the telephone should receive a course in human relations. Also, the people who are at the front desk, they think that we go to the clinics or hospitals to beg. They treat us as if we are objects."
"I have had bad experiences with the county. Since I started using county services, those people have made me feel like I'm begging for those services. Many times, I left [county facilities] crying. They don't understand that their salaries come out of the same funds that the government uses to provide us health assistance. They underestimate us. They look down on us."
"I believe the reason why we don't [file complaints] is because we don't use this system in the countries that we come from . . . We don't exercise our right because of lack of information, not knowing, or choosing not to argue."
"[Not knowing English] is a barrier for many of us. However, I have seen some changes. Those changes are due to the fact that there are many Latinos in this country. There are more than 50 million Latinos, approximately—30 million who are Mexican and more from other countries. Let us hope that Spanish continues 'growing' for the well-being of all of us."
"I also agree that the language [English] is the barrier that does not allow us to obtain information about available services . . . I think that there are politicians in control of resources that they don't want to share. They just want to advance in their political careers. Some people are selfish. There are people [in the community] with different needs."

Discussion

Our focus group data are consistent with the findings of many recent public health studies concerning LEP communities and, more specifically, LEP Latino communities. Chief among them is the disproportionate impact that socioeconomic factors have on equitable health care access, with language proficiency serving as a key mediator and barrier. Our participants confirm that English proficiency, ethnoracial factors, income, and type of insurance coverage affect Latinos' ability to receive health services, especially services that are affordable, efficient, and oriented to prevention.

At least four people mentioned that they selected a care location based on copayment cost, and sometimes not seeking care at all: "In general the clinics are expensive . . . If I get a cold, I just deal with it. I don't go to the clinic. I simply go to Target and get Tylenol or something that can help." This decision may not cause harm when the illness is really a cold, but the practice of foregoing care can have negative consequences when a health problem is more serious. A vicious cycle can result when health care is cost prohibitive: untreated conditions worsen, leading to a reliance on costly emergency care: "I go to places [where] I have to wait eight hours. It's an emergency! But they still make me wait eight hours. I ask them, 'Why do I have to wait eight hours?' It's the system . . . I don't want to have emergencies." In turn, overreliance on emergency care drives up provider costs.

Participants noted the stresses that result from the stigma of poverty and/or poor English skills and demonstrated a nuanced awareness of how socioeconomic and ethnoracial factors affect their access to health care. When asked if they personally had experienced discrimination when seeking medical care, ten of the thirteen participants in one focus group raised their hands. One person's story was telling: "My father-in-law has a truck business. He had an accident in downtown LA and one of his arms was completely

destroyed. They took him to a hospital. He couldn't talk due to his pain. They didn't give him any painkillers. They wanted to see his insurance first. They had him sitting in a wheelchair and did nothing. He was bleeding and they were ready to cut his hand because it was the less expensive thing to do. They didn't know that he had good insurance, Blue Cross. . . . The reason why they didn't help him in the first place was because they saw he was Latino. He looked so dirty due to his work . . . they discriminated due to his appearance. They didn't look in his pockets. . . . There should be a reform so that everybody has the same opportunity."

Our participants spoke about direct experiences with racism, even when language proficiency was not at issue. "I speak English, so I haven't had any issues with communication. Once I went to a hospital in the San Fernando area. I had an emergency with my son, who had a fever of 103 degrees. After I had waited a long time, I said in English, 'I am leaving. Just because you see my Latina face and I didn't speak English—but I do and I also have insurance.' . . . So the doctor came right away to help me . . . I thought, 'Too bad that when [these people] see patients who don't speak English, who look different, of a different color, they value them less.'" Notably, concerns about discrimination existed independent of the race and ethnicity of health personnel. In fact, multiple focus group participants said they perceived discrimination by Latino health staff in particular.

Another theme was the stigma of public health insurance. At least eight participants agreed that some providers have a negative attitude toward Medi-Cal. "They discriminate against us when they ask, 'What insurance do you have?' and we answer, 'Medi-Cal.' Many times when I take my children to the clinics and I mention Medi-Cal, they don't provide my children with the care that they should."

Participants seemed to lack access to care that focuses on prevention and lifestyle, in part for language reasons.

All participants agreed that non-English speakers are not made aware of all the services that are available to them, while the availability of services is communicated more clearly to those who speak English. When asked whether available services are publicized at urgent care clinics, one person said they are not: "At the clinics, we don't receive this type of information. We receive this type of information from 'outside'—at schools or health fairs."

Language proficiency was also cited as a barrier to seeking remedies for poor treatment and inefficient health delivery: "[Communication is the] problem with our community. It's not that they don't listen to us. We have to write letters, but some people don't want to take the time to do that. Yes, they listen. Yes, they implement the changes. We must insist and not back down. . . . They listen because it is not to their advantage to have a bad record."

Participants' responses supported a now widely accepted public health hypothesis: that people with less education and lower English proficiency tend to have poorer-than-average health (figure 14).

The Los Angeles County Department of Public Health divides Los Angeles County into eight Service Planning Areas (SPAs). Our focus groups were conducted in SPA 2, the San Fernando Valley. Data from the 2010 census show that 39.1 percent of residents in SPA 2 were Latino. In addition, 45 percent of adults were not born in the United States, and 23.8 percent of adults spoke mostly Spanish at home.⁸⁰ However, pockets of wealth within SPA 2 give the area a lower poverty rate than Los Angeles County as a whole and skew many of the socioeconomic and ethnoracial metrics we might use to evaluate the link between socioeconomic/ethnoracial status and health.

A more striking example of this link is found in the data for SPA 6, South Los Angeles, which includes the communities of Athens, Compton, Crenshaw, Florence, Hyde Park, Lynwood,

Paramount, and Watts. Within Los Angeles County SPA 6 contains the highest percentage of residents who speak mostly Spanish at home (51.7 percent), ranks second in terms of overall Latino population (67.7 percent), and ranks third in terms of adults who are foreign-born (50.2 percent). Black Angelinos make up 28.5 percent of SPA 6 residents, the highest concentration of blacks in the eight SPAs and well above the county average of 8.5 percent. Together, Latinos and blacks make up a remarkable 96.2 percent of the population of SPA 6.

SPA 6 has the highest rate of poverty in Los Angeles County, 31.1 percent, which is 13.1 percentage points higher than the county average. For comparison, in 2011 the national Latino population had a poverty rate of 23.2 percent (about 9 percentage points higher than the overall US rate) and black Americans had a poverty rate at 25.8 percent (about 11 percent higher than the overall rate). Only Native Americans and Alaskan Natives had a higher poverty rate, a testament to the ongoing struggles these communities face.⁸¹

Tellingly, SPA 6 leads, or is close to leading, Los Angeles County in most causes of preventable death. It ranks a close second, for example, in coronary heart disease deaths, the number one cause of preventable death in the county and nationwide. SPA 6 also leads or places a close second in many negative aspects of general health, including the percentage of adults and children who report their health as fair or poor, the average number of days per month in which adults limited their daily activities due to poor physical or mental health, and the average number of unhealthy days experienced per month (table 7).

As we saw in our focus groups, socioeconomic and ethnorracial factors appear to be strongly correlated with self-reported health in South Los Angeles. In addition to having the highest levels of poverty in Los Angeles County, SPA 6 was also home to the highest percentage of uninsured adults and

children and the highest percentage of adults who reported experiencing difficulty in accessing health care. With respect to education, SPA 6 led the county in the percentage of the population with less than a high school education and was last in terms of the percentage with a college degree or higher. It also had the second-highest unemployment rate, at 15.5 percent.

SPA 6 also lags behind county averages in measures of the “built environment,” which evaluate the presence and use of infrastructure, which in turn has a major impact on preventive health and lifestyle factors. In addition, SPA 6 contains the lowest percentage of residents who feel that their neighborhood is safe (64.4 percent, nearly 20 percentage points below the county

average), the lowest percentage who report that children have a safe place to play (68 percent), and the lowest percentage who report that it is easy to get fresh fruits and vegetables (77.9 percent). Access to healthy, fresh produce is particularly important for preventive health as research continues to indicate that eating fewer than five servings of fruit and vegetables each day is linked with a higher chance of dying early.⁸²

This also has a significant impact on children, whose bodies are still developing and who thus are more susceptible to the ill effects of their environment. The US Environmental Protection Agency has documented that Latino children are almost twice as likely to be hospitalized for asthma

Table 7. Profile of South Los Angeles: SPA 6 Rankings among All Eight SPAs in Los Angeles County*

DEMOGRAPHICS
#1 — Percentage of adults who mostly speak Spanish at home ^b
#1 — Percentage of population in poverty ^c
#1 — Percentage of adults with less than a high school education ^b
#2 — Percentage of adults who are unemployed and looking for work ^b
#2 — Percentage of population that is Latino ^d
#3 — Percentage of adults who are foreign-born ^b
GENERAL HEALTH
#1 — Percentage of adults whose health is fair or poor ^b
#1 — Percentage of children with no regular source of health care ^b
#1 — Average number of poor mental health days in the past month reported by adults ^b
#1 — Percentage of adults who are uninsured ^b
#1 — Percentage of children who are uninsured ^b
#1 — Percentage of adults who experience difficulty in accessing health care ^b
#8 — Percentage of adults who think their neighborhood is safe ^b
#8 — Percentage of adults who report it is easy to get fresh produce (fruits and vegetables) ^b
PREVENTABLE DEATH
#1 — Deaths related to homicide (ages 15–34) ^e
#1 — Deaths related to stroke ^e
#2 — Deaths related to coronary heart disease ^e
#2 — Deaths related to diabetes ^e

^a Los Angeles County is divided into eight Service Planning Areas (SPAs). SPA 6, South, includes the communities of Athens, Compton, Crenshaw, Florence, Hyde Park, Lynwood, Paramount, and Watts.

^b Self-reported data collected in 2011 from adults and parents or guardians by the Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology.

^c Data collected in 2011, prepared for Urban Research, LA County Internal Services Department. “Poverty” is defined as having a household income of less than 100 percent of the federal poverty level.

^d Data estimate of the April 1, 2010, resident population of the United States, by county, by the US Bureau of the Census.

^e Data collected in 2009 by the Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology. Two SPAs did not report homicide data.

Source: Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology, *Key Indicators of Health by Service Planning Area* (Los Angeles: County Department of Public Health, 2013).

as white children. The agency noted that asthma is a complex disease with a number of causes, including heredity, but that “racial and ethnic differences in the burden of asthma may be related to social and economic status, access to health care, and exposure to environmental triggers.”⁸³

The barriers to equitable health care experienced by our focus groups, particularly the LEP participants, can be placed in perspective by looking at SPA 6. This area, which has the highest percentage of Spanish speakers in Los Angeles County, is also home to some of the worst socioeconomic conditions, including those related to health care access, poverty, educational achievement, and access to preventive health resources such as healthy food and a safe neighborhood. Just as our focus groups indicated that LEP Latinos tend to self-rate their health as poorer than non-LEP Latinos, and that education and English proficiency correlate with wealth and health, data from SPA 6 show that socioeconomic and ethnoracial discrimination have substantial influence over access to equitable health care. Both data sets mirror national trends, which show that Latino Americans (like African Americans and Native Americans) remain disproportionately likely to experience both poverty and lower health standards. It seems fair to conclude that in Los Angeles County, just as in the nation as a whole, one’s ability to speak English “very well” has a concrete and nuanced impact on access to equitable health care.

UPDATE: RECENT POLICY INITIATIVES AND THEIR IMPACT ON HEALTH ACCESS FOR LEP LATINOS

Major health policy developments took place after our focus groups were conducted and this report went to press that will affect LEP Latinos both statewide and nationally. These include the US Supreme Court’s decision to uphold the constitutionality of President Barack Obama’s landmark Affordable Care Act and the

California legislature’s approval of Governor Jerry Brown’s 2012–13 and 2013–14 budgets. As a result of these developments, LEP Latinos, as well as all Californians, face new challenges and opportunities on the path toward accessibility, affordability, and quality in health care.

FEDERAL LEVEL

Prior to the Supreme Court’s landmark ruling on June 28, 2012, which upheld the constitutionality of the ACA, the US Department of Health and Human Services stated that the health care overhaul law had already extended health insurance to a substantial number of racial and ethnic minorities by allowing young adults to stay on their parents’ insurance plans through age twenty-six. The agency indicated that approximately 1.3 million young minority adults, 736,000 of them Latino, had been able to obtain health insurance as a result of the plan since 2010. At that time HHS Secretary Kathleen Sebelius stated, “We are making strides in giving every American regardless of race or ethnicity a fair shot at quality, affordable health care coverage. Because of the law, more and more young adults can breathe a little easier knowing they have health coverage.”⁸⁴

When the Supreme Court upheld the ACA, many advocates for low-income and minority people applauded the effort to make health care more accessible and affordable. Latinos and African Americans are expected to see further substantial gains in insurance coverage as the ACA’s central provisions are implemented in 2014. According to a report by the Urban Institute, the ACA’s coverage expansions will significantly reduce discrepancies in baseline insurance coverage, offering the greatest assistance to those with low and moderate incomes, despite ongoing concern from community service providers that a lack of information and resources is already erecting obstacles as providers prepare Latinos to enroll in public or subsidized health insurance.⁸⁵ Yet given the close correlations between income, race, and ethnicity, just over 48 percent of

the nearly 24 million people likely to gain health insurance will be people of color.⁸⁶ As a substantial number of LEP Latinos have low or moderate incomes, this is an important development for this population.

As part of the ACA, all states, including California, have the option to expand their Medicaid programs, with 100 percent of funds for the initial expansion and no less than 90 percent after that coming from the federal government.⁸⁷ California is one of the states that have chosen to accept this federal help and expand its Medicaid program. According to the California Health and Human Services Agency, at least 1.6 to 1.9 million Californians are expected to join Medi-Cal as a result.⁸⁸

However, while the bill’s passage is widely regarded in the public health community as an improvement over the status quo, it falls short in significant respects. For one, the individual mandate, which requires individuals to purchase still-costly private health insurance beginning in 2014, provides a federal subsidy to some but not all purchasers. There is no guarantee that the private plans offered will be affordable. Given the socioeconomic trends for Latinos, especially LEP Latinos, this is a significant concern for this population. Moreover, even after 2014, as many as 29 million Americans are expected to remain without any insurance coverage; in addition to undocumented immigrants, they include people who are eligible for, but not enrolled in, Medicaid.⁸⁹

Advocacy groups also argue that the federal poverty level, to which the new health care subsidies are pegged, is too low, given the national and regional cost of living. Under the ACA, families that earn up to 138 percent of the federal poverty level (\$26,951 for a family of three in 2013) will be eligible for Medicaid.⁹⁰ For households that earn from that threshold up to 400 percent of the federal poverty level, subsidies will be available. If the poverty line is set unrealistically low when these changes to Medicaid take effect

on January 1, 2014, many needy families will be excluded from the program, and the subsidies offered them may not be sufficient to make coverage affordable. This constitutes an additional barrier to health that results in a serious underreporting of inequities in health access, particularly in states that refuse to expand Medicaid.

It is important to note that the ACA offers no benefits—whether in the form of a federal subsidy or Medicaid eligibility—to undocumented immigrants. Millions of Latinos in the United States live in mixed immigration status families in which some members are US citizens and others are not. As a result, states with high ethnic minority populations will have to make strong efforts to clarify that taking advantage of subsidies for those who are eligible will not lead to negative contact with immigration authorities.⁹¹

Just as important for the Latino LEP community, the law does not directly address the root causes of minority health disparities, including high health care costs, a problem that the ACA mostly likely will not solve. The Massachusetts health reforms, on which the ACA was modeled, dramatically increased health insurance coverage in that state (Massachusetts had a 6 percent uninsured rate in 2010 compared to an 18 percent national average). But they did little to address the structural causes, and consequences, of high health costs. Massachusetts has the highest individual market premiums in the country, and per capita health spending there remains 15 percent higher than the national average.⁹² While the individual mandate is predicted to lower premium rates in the short term as insurers sign up millions of young and healthy residents who previously went uninsured, higher premiums could well return once insurers have a better handle on the new market.⁹³

Nor does the ACA address the many barriers to quality health care, highlighted by our focus group participants, that are rooted in inequality

and discrimination in the society at large. These include discrimination by health care providers based on language, appearance, or type of insurance coverage; scarcity of providers that will accept public insurance and provide adequate time for health interactions; lack of qualified interpreters to bridge the language gap; overcrowding and long wait times; low-quality care and lack of preventive care, and so forth.

Still, advocates like Lisa Clemans-Cope, a health economist at the Urban Institute's Health Policy Center, say the ACA is a step in the right direction: "There are a lot of numbers here so it may be hard to process. But we're talking about at least 25 percent of uninsured Latinos and 59 percent of uninsured African Americans becoming insured. That's huge."⁹⁴

Ultimately, the impact of the ACA on the nation's LEP Latino population will be decided in large measure in California. Clemans-Cope notes that the impact of the ACA on Latinos depends how the law is implemented in two states: "That's Texas and California, because over half of all Latinos live there."⁹⁵ In 2009, both states had lower than average enrollment among those eligible for the children's version of Medicaid, indicating that both states have issues with outreach and education.⁹⁶ As of late July, Texas had still refused to expand its version of Medicaid.

STATE LEVEL

On June 27, 2012, one day prior to the Supreme Court's decision to uphold the ACA, California's Democratic governor, Jerry Brown, signed the state's 2012–13 budget bill into law. That budget reflected the fragility of the California economy as well as the momentum toward balanced budgets and cautious austerity among policy makers. "This budget reflects tough choices that will help get California back on track," Brown said in a statement following the signing.⁹⁷

Governor Brown's 2012–13 budget aimed to close a projected \$15.7 billion shortfall in the state budget by means of \$16.6 billion in budget "solutions."

This was done largely through reductions in state spending (\$8.1 billion), additional revenues (\$6.0 billion, nearly all tied to a temporary tax increase approved by California voters in November 2012), and loan repayment extensions (\$2.5 billion).⁹⁸ That state budget bill, and the \$8.1 billion in spending cuts in particular, were not fully reversed by the more generous 2013–14 budget and will thus continue to have a significant and most likely negative impact on the prospect of equitable health care access for LEP Latino communities in the state.

In particular, the finalized 2012–13 budget included more than \$1 billion in cuts from health programs, including Medi-Cal—the very program into which many low-income LEP Latinos will be channeled by the ACA.⁹⁹ "In one of the most controversial moves," the *Los Angeles Times* reported, "lawmakers are eliminating the Healthy Families program, shifting the nearly 900,000 poor children it covers into Medi-Cal over the course of a year. The decision is expected to save \$13 million in the new fiscal year, with savings increasing to \$73 million two years from now."¹⁰⁰

Eliminating new enrollment for Healthy Families is having a noticeable impact on Latino residents and LEP Latino communities in particular. Chad Silva, policy director at the Latino Coalition for a Healthy California, noted that Latinos constituted 46 percent of Healthy Families beneficiaries statewide and 82 percent of beneficiaries in Los Angeles (or around 165,000 children).¹⁰¹ Healthy Families was unique because it provided health access for young people whose families earned too much to qualify for Medi-Cal but who could not otherwise afford private insurance. Finally, Healthy Families was supported by a two-to-one federal matching program, and thus the savings that came from its elimination were doubly offset by lost federal aid.¹⁰²

The 2013–14 budget, signed into law by Governor Brown on June 27, 2013, is generally kinder to health

and social services. As the California Budget Project points out, the budget “marks a significant turning point in California’s fiscal outlook, thanks to additional revenues approved by voters last November as well as gradually improving economic conditions in the state,” noting, however, that “poverty and long-term unemployment are still high in the wake of the Great Recession, while the social safety net and critical employment services remain weakened by recent years’ spending cuts.”¹⁰³ In particular, the current budget offers expanded Medi-Cal eligibility and increased spending for K-12 schools, community colleges, the California State University, and the University of California. It also offers some modest improvements to public services that were severely cut in the 2012–13 budget and that directly impact the LEP Latino community. These services include child care and preschool as well as CalWORKS, which provides cash assistance to low-income families while parents try to find work.

While an increasing number of Californians recognize that the state economy is beginning to rebound, more than seven in ten continue to describe the economy as being “in bad times” and only 38 percent say that the state is going in the right direction.¹⁰⁴ The massive cuts made in the 2012–13 budget shortened the time that poor Californians (who are disproportionately Latino) could remain in the workfare program and reduced payments for child care, preschool, and college. The 2012–13 budget reorganized Medi-Cal to cut costs and integrated the Healthy Families program into Medi-Cal. Whether these cuts can be offset in 2013–14 and beyond will rely primarily on how widely the state’s economic recovery is shared.

ADDITIONAL FOCUS: THE ACA AND CALIFORNIA’S LEP LATINOS

A timely joint study from the University of California, Berkeley, and UCLA focuses attention on the ACA’s probable impact on California’s LEP Latino communities. The report confirms that

millions of previously uninsured Californians will gain coverage by 2019, primarily as a result of the predicted expansion of Medi-Cal and the availability of federally subsidized private coverage through Covered California, California’s version of the state health exchanges, created under the ACA, that are designed to provide consumers with easy access to competitive health insurance plans.¹⁰⁵

According to the UC Berkeley-UCLA study, the number of uninsured Californians under 65 will decrease by an estimated 1.8 to 2.7 million by 2019, depending on outreach efforts.¹⁰⁶ Of those expected to gain coverage, similar numbers will be funneled into Medi-Cal and private plans. As a result of these coverage expansions, between 89 and 91 percent of nonelderly Californians are predicted to have health care under the ACA, compared to 84 percent without the law.¹⁰⁷

However, 3 million to 4 million Californians under the age of 65 could remain uninsured even after the ACA is fully implemented. Of the Californians expected to remain uninsured, almost three-quarters will be US citizens or lawfully present immigrants, a staggering two-thirds (66 percent) will be Latino, and nearly three in five adults will be LEP.¹⁰⁸ To place those figures in perspective, adults who speak English very well are expected to see a 44 percent reduction in uninsured rates, while LEP adults are expected to see a reduction of only 25 percent. Thus, while baseline insurance coverage among California’s LEP communities (which are predominantly Latino) is set to improve by an impressive 25 percent, the share of uninsured people who are LEP is actually expected to increase, from 47 percent pre-ACA to 51 percent post-ACA.¹⁰⁹ Thus, LEP Latinos may be disproportionately left behind when it comes to insurance gains under the ACA, just as they are currently disadvantaged in equitable access to insurance coverage.

It is also important to note that almost all of those expected to remain ineligible for coverage under the ACA

due to immigration status will be Latino (95 percent) as well as LEP (80 percent). The Berkeley-UCLA model further predicts that a majority of uninsured Californians who will be eligible for no-cost or subsidized private coverage but fail to enroll will be Latino (64 percent) and LEP (54 percent). Of this group, 62 percent will be residents of Los Angeles and other Southern California counties, which is particularly relevant to our study. Likewise, 57 percent will have household incomes at or below 200 percent of the federal poverty level, a socioeconomic bracket that, as reported earlier, Latinos occupy at disproportionate levels both statewide and nationally.¹¹⁰

To conclude, under the baseline ACA the number of uninsured Californians is expected to fall from almost 6 million to barely over 4 million, an impressive improvement; with effective outreach and enrollment measures, that number can drop further to around 3 million. LEP adults, who are overwhelmingly Latino, are expected to see a 25 percent reduction in lack of insurance coverage. However, two-thirds of Californians who remain uninsured will be Latino, and nearly three in five uninsured adults will be LEP. And regardless of language proficiency and ethnicity/race, the predicted 2.3 million Californians at or below 200 percent of the federal poverty level who will remain uninsured will continue to need a strong health safety net.¹¹¹

As a reform, the Affordable Care Act is a meaningful improvement for ethnic minorities as measured in baseline access to health care. However, it appears to do less to actively reverse the cost trends that keep the United States spending around twice as much per capita as other wealthy countries, and it leaves many people—especially LEP people—behind. In addition, the 2013–14 state budget, while more generous to social and health spending than previously, does not promise an equitable recovery in income and wealth in California.

CONCLUSIONS AND RECOMMENDATIONS

“All Americans should have equal access to high-quality care.”
— *National Healthcare Disparities Report, 2012*¹¹²

Health care remains a fiscal albatross for many Americans. Over 60 percent of all personal bankruptcies in America involve medical bills, and a strong majority of those individuals are insured at the onset of their health crisis.¹¹³ Unfortunately, despite predicted gains in basic health access under the ACA, the price of health care in America is projected to remain extremely high. According to the Centers for Medicare and Medicaid Services, health spending will continue to climb to \$4.6 trillion by 2020, far outpacing the growth of the US economy. If that happens, health spending will account for nearly 20 percent of US gross domestic product (GDP), far and away the highest such percentage among OECD nations.¹¹⁴ It is no coincidence that the Bureau of Labor Statistics notes that ten of the twenty fastest-growing occupations are related to health care,¹¹⁵ or that the pharmaceutical and health care products industries, combined with organizations representing doctors, hospitals, nursing homes, health services, and health maintenance organizations, have spent over \$5.3 billion since 1998 on federal lobbying efforts, a figure that dwarfs the \$1.5 billion spent by the defense and aerospace industries.¹¹⁶

The high cost of health care has an especially severe impact on people in vulnerable, low-income communities, who are disproportionately likely to be Latino, and LEP Latino in particular. An analysis of census data by the Robert Wood Johnson Foundation found that “families in the lowest income quintile contributed more than 20 percent of their income to health care expenditures. All other families, regardless of their income group, contributed only 15–16 percent.”¹¹⁷ This burden of cost often results in lower rates of insurance and increased reliance on state health

plans. Of our twenty-two focus group participants, of whom only four self-rated as having excellent English, ten were uninsured. Another ten relied on low-income, state-sponsored insurance plans. Major private insurers covered only two of our participants. One of the latter was born in the United States and the other arrived as a child; both had at least some college education and good or excellent English skills. The three barriers we focused on here—interpreter services, English language instruction, and the integrated system of socioeconomic and race—were chosen both for their redundancy within our focus groups and for their relevance in contemporary public health research. In telling their stories, our participants returned repeatedly to the question of cost, which research finds to be a key gatekeeper of the health care system (and a symptom indicating the need for major health service restructuring). Recent research has documented the high cost associated with hospitalization of LEP patients and neonatal care for LEP mothers and the costly and potentially dangerous realities of miscommunication in the emergency room, particularly for children.¹¹⁸ Providing context for our focus group findings, public health research therefore demonstrates the numerous ways in which we as a society already bear the consequences of denying equitable health care to LEP populations.

The long-term economic benefits of providing such care have already been noted, though more research on the cost-benefit relationship is needed. The OMB’s 2002 Report to Congress assessed the benefits and costs of Executive Order 13166, which sought to improve access to institutions for people with limited English proficiency. The OMB states, “Almost all individuals, LEP and non-LEP, need to access the health care system at multiple points in their lives. Making these interactions more effective and more accessible for LEP persons may result in a multitude of benefits, including: increased patient satisfaction, decreased medical costs, improved health, sufficient

patient confidentiality in medical procedures, and true informed consent.” The report concluded, “The benefits of language-assistance services for particular LEP individuals, while not readily quantifiable in dollar units, can be significant.”¹¹⁹ Additional research indicates that provision of enhanced interpreter services does not significantly increase hospital operating costs, while it does reduce ER visits and costs and improves overall patient satisfaction.¹²⁰

Ultimately, longitudinal health outcomes remain the most meaningful measure of a health system. We asked our participants to self-rate their health, and our data support existing research on the correlation between self-reported health and socioeconomic/ethnoracial discrimination. Of the twenty participants who relied on state-sponsored coverage or who had no insurance at all, seven reported their health as not good or poor, only three reported being in good health, and none reported excellent health. The human and economic cost of poor health affects not only these individuals and their families, but also their communities and the society at large.

Our focus group participants repeatedly stressed the importance of competent interpreter services and the potentially frightening consequences of inappropriate interpretation, not to mention the detrimental impact of long waits for such services. All participants indicated that language plays an important role in their health outcomes, and a majority of participants in one group specifically cited the issue of inaccurate interpretation as a major concern.

Participants also stressed their desire to improve their English skills, especially for the sake of their children, but they also noted the challenges of working toward that goal. Unfortunately, cutbacks in the provision of affordable English classes are making this even more difficult for participants and other LEP Latinos.

As we analyzed our focus group data, the significance of socioeconomic factors and ethnoracial discrimination surfaced again and again. A majority

of participants indicated that they were discriminated against when receiving medical services or had experienced a negative attitude on the part of health care providers toward Medi-Cal. This barrier was also evident in the participants' overreliance on ER care and in their widespread fear or reluctance to file complaints related to health care. Perhaps the simplest indicators of the importance of socioeconomic and ethnoracial discrimination was the universal declaration by our focus group members that language plays an important role in their health, and the near-universal belief that non-English speakers are not made aware of the services available.

Since inequality and discrimination are at the root of disparities in health, a complete and lasting solution must involve widespread efforts to close the growing income, wealth, and mobility gap and to erase discrimination based not only on race but also on ethnicity, language, and gender. This is of course a long-term proposition, touching on many facets of public policy. Meanwhile, several specific and more easily implemented steps can make a difference in the short term. They are:

- Establish state and federal mandates for stringent training and qualification of medical interpreters.
- Establish federal mandates for the appropriate provision of interpreter services.¹²¹
- Expand access to English as a second language classes at low or no cost, particularly for adults.

The National Health Law Program's statement of principles on language access in health care, endorsed by numerous national health organizations, includes the following principles that overlap closely with our own findings:

- "Mechanisms should be developed to establish the competency of those providing language services, including interpreters, translators, and bilingual staff/clinicians."¹²²
- "Access to English as a second language instruction is an additional mechanism for eliminating the

language barriers that impede access to health care."¹²³

- "The responsibility to fund language services for LEP individuals in health care settings is a societal one that cannot fairly be visited upon any one segment of the public health or health care community."¹²⁴

We see tremendous opportunity in a future project that would create an innovative methodology to gauge Title VI compliance at the local level, and we are currently seeking grant funding for such a proposal. The project would develop a set of replicable indicators or metrics (akin to the health code letter grade system for California food establishments) that could help determine whether institutions such as health care providers are in compliance with the mandates of Title VI. Our proposed model borrows from the National Committee for Quality Assurance's Multicultural Health Care Distinction program, an evaluation program designed to help health care organizations monitor and reduce health care disparities among racial and ethnic minorities. The program highlights the activities of health plans that provide culturally and linguistically appropriate services aimed at reducing disparities in care. Our project would offer a "toolkit for compliance" that would place the implementation of the evaluative program into the hands of consumers. It could be used by nonprofit community groups and individuals to evaluate their local health providers based on standardized criteria. In the case of noncompliant providers, such a system would produce constructive negative publicity and a prompt to action; a failing grade could, for example, help constitute grounds for government-led discovery, that is, for legal action to induce appropriate compliance with Title VI. All hospitals and health centers receiving federal funds are supposed to be accountable to the public; this project could prove a useful tool for further improved accountability.

The development of such a scorecard system would require an intensive meta-analysis of available public health

research as well as programs and standards like those in the Multicultural Health Care Distinction program. It would be based on previous federal mandates from Democratic and Republican presidents as well as guidelines issued by the US Department of Justice, which outline four "reasonable measures" when it comes to addressing LEP concerns under Title VI: "the number or proportion of LEP persons in the eligible service population, the frequency with which LEP individuals come in contact with the program, the importance of the service provided by the program, and the resources available to the recipient."¹²⁵ These policies, which resulted from community-led demands for equal access to health, voting, and education, reflect the United States' historic leadership in designing norms and standards for the recognition and protection of human rights.¹²⁶ The United States was instrumental in the adoption of the Universal Declaration of Human Rights by the UN General Assembly in 1948. This document states that every person has "the right to a standard of living adequate for the health and well being of himself and of his family, including food, clothing, housing and *medical care* and necessary social services."¹²⁷ Denial of equitable access to health care violates our core values as a nation, particularly in the context of America's rich immigrant past, and future Title VI enforcement guidelines—such as the scorecard system we propose—should explicitly incorporate support for universal human rights, particularly considering the transnational character of the United States' LEP population.¹²⁸ In short, efforts in this arena should guarantee equal access to an inclusive and responsive democracy.

The National Health Law Program, like Executive Order 13166, specifically calls for stakeholder input in assessing and improving LEP services within the context of health care. It is our sincere hope that our focus group data and analysis provides such input and that it helps us move closer to the goal of equitable access to high-quality health care for all.

APPENDIX

Appendix Table 1. Findings and Statements Regarding Interpreter Services, Focus Group 1

SELECTED QUOTES	
“When I take my 10-year-old with me, she interprets for me. When I don’t take her with me, I ask for an interpreter.”	“Discrimination comes from the Latino doctors and staff themselves. When Americans hear us speaking English, they say, ‘I understand, I understand.’ On the contrary, Latinos say, ‘I don’t understand. What are you saying?’ . . . Then, we feel bad.”
“Once I had a doctor who was trying to speak Spanish, and I asked her, ‘Do you want my daughter to help you?’ And the doctor said, ‘No, no, no. I want to continue practicing Spanish.’”	“I speak Spanish and English. I took my girl to the [hospital] and waited an hour. The doctor was talking and laughing with the nurse. Then, he came to see my daughter and he was mad like never before. He asked me, ‘Do you speak Spanish or English?’ I replied, ‘Both.’ Then he rolled his eyes and asked my why I had brought my daughter.”
“About eight years ago, my mother died. I fainted. I had diabetes at that time. I was taken to a hospital. They asked me if I spoke English. I didn’t answer. I could hear what they were saying. They said: ‘[She came] just because her mother died.’ I told them that I spoke English . . . They didn’t check my glucose. They didn’t take my blood pressure . . . I was going to sue the hospital because they didn’t do anything. When I got the bill, they were charging for checking my glucose and ‘everything.’ I went back to the hospital and gave them a document showing that I was going to sue them. I told them I was the one that checked my glucose with my own machine. I had a level of 570. I was seven months and three weeks of pregnancy. Now my daughter was born with a pulmonary problem. I could say that it was your fault. I told them I recorded when they were laughing. That was not true but I told them I recorded it. Like I said in this country when they think that we don’t speak English—I mean—when I spoke English at that time, they wanted to transfer me to another hospital in helicopter. I told them ‘No, thank you. I will go driving.’”	“In general, thank God, in the places where I go the doctors speak Spanish. There was only one time when my husband got sick, nobody spoke Spanish, and I didn’t understand.”
“When I came to the U.S. they didn’t provide me with services in Spanish.” (9 people indicated that they did not receive services in Spanish when they first arrived in the United States.)	“I asked my doctor, ‘Why did you learn Spanish?’ The doctor replied, ‘Because I knew that I would provide services to people like you.’ In some cases doctors learn the language that is spoken in the area they work. That is very important.”
“Approximately 20 years ago, one of the first things I experienced was that they changed my name. In Mexico I am known by my middle name. When I came to the US, they called me by my first name. One time, I waited more than an hour, not understanding that they were calling me by my first name. Then, my doctor didn’t speak Spanish. I didn’t understand instructions like ‘don’t walk,’ ‘rest,’ or ‘lie down.’ My nephew explained to me the meaning of those phrases.”	“In my case, thank God, I didn’t have any problem because my sister-in-law would go with me and serve as my interpreter.”
“One day a doctor told me that my daughter had ‘roseola y chibolitas.’ I told him that I didn’t know the meaning of roseola or chibolitas. The doctor said, screaming, ‘I am talking to you in Spanish.’”	“During pregnancy, for example, my doctor—I can’t remember if he spoke Chinese or Japanese—didn’t speak Spanish or English. He only spoke his language. I don’t know how I was able to understand him, but I did. We used body language.”
“They thought I didn’t understand what they were telling me. They told me that my barrier was the language. They also said there was nothing else they could do for my daughter. My point is that they thought I didn’t understand. They thought I had a problem with the language.”	“The first time I went to Holy Cross they sent me a nurse that spoke Spanish when I told them that I didn’t speak English. The second time I went they didn’t send anybody.”
“The first time I went to Holy Cross they sent me a nurse that spoke Spanish when I told them that I didn’t speak English. The second time I went they didn’t send anybody.”	“It is very common that [medical staff] say they don’t speak Spanish even when they do. The receptionists do that more than anybody else . . . One day we went to a clinic with my sister-in-law . . . [The staff member] looked at me and said, ‘Uhh, these little Mexicans’ and left. She covered her badge so that we couldn’t see her name.”
“One problem is that the interpreter interprets whatever he or she wants.”	“They don’t interpret everything we say. There are very few interpreters [who are excellent in relation to interpreting everything we say].”
“Every single time, I need a relative.”	“Sometimes I need an interpreter via telephone. I have called the Healthy Families Program. I made many calls. The problem is that they told me to leave a message. They offered to call back in Spanish but they didn’t.”
“It is uncomfortable [to use a relative as an interpreter] because we can’t express ourselves in a direct manner. We have to tell [our situation] to another person.”	“The fact that there is another person present means there is no confidentiality.”
“For me it’s bad. They don’t give me an interpreter. When I take my son [for medical care], they don’t do anything. I have to say ‘bad’ because my son continues the same [no improvement], but they always send the bill.”	“Those who speak English get services first.”
“Yes, language plays an important role in our health outcomes.” (All participants shared this opinion.)	“Yes, they let us know” (about availability of language services).
“At the clinics, we don’t receive this type of information [about services available]. We receive this type of information from ‘outside’—at schools or health fairs.”	“I believe that if we speak Spanish, they don’t give us information. They don’t want to waste their time.”
“[The ability to write a complaint] is influenced by the language.”	“When they call me to pay the premium for Healthy Families, they have an interpreter. However, when I need an interpreter at the clinic, they don’t find anyone to help me.”

GROUP FINDINGS

When asked if they personally had experienced discrimination when seeking medical care, 10 of 13 participants raised their hands.
All participants said that they had received services from people who speak Spanish to some extent.
Most members of the focus group indicated that the issue of not interpreting everything a patient says has remained the same, even though provision of basic Spanish language services has improved significantly.
Most participants said that they use a friend or family member to interpret for them.
Some participants indicated that they have used a child under age 18 to interpret for them.
All participants agreed that the quality of services is related to the ability to speak English, and that this has not changed over the years even though language services have improved.

Appendix Table 2. Findings and Statements Regarding Interpreter Services, Focus Group 2

SELECTED QUOTES	
"I don't think about the language. That's because if the doctor doesn't speak Spanish, there's a nurse who interprets for me. If there is no nurse, then I try to make myself understood, in my own way."	"Language is important, because if we don't speak English fluently, we can't explain what we feel. Medical terms are very different from the terms we use daily. Sometimes the doctors start asking questions and we don't understand what they're asking. For me, language is a barrier."
"The clinic I go to always has an interpreter. But I had an experience that I didn't like . . . I thought that if I knew how to speak English, the doctor would have to pay attention to me [listen to what I have to say]."	"Not all places offer interpreting services."
"There are cases in which the nurse does not interpret to the doctor all the exact words we want them to say."	"Here in San Fernando, I exercise my rights. I speak up. I don't know if I speak good English but I do the best I can to defend myself."
"If there is no interpreter available right away, I have to wait."	"[Years ago] there were fewer doctors who spoke Spanish. Now there are more doctors who speak Spanish."
"Now that there are more Latinos, they want us to speak 'English only.' That is what they want."	"First of all, when they answer the telephone, they don't speak Spanish."
"When they tell us to call to make an appointment, I call and get an answering machine (and always in English)."	"In general, it is not very common to find doctors who speak Spanish."
"We feel 'safe' [when a doctor or nurse speaks Spanish]. It feels good to know that the doctor understands what we are saying. It helps to give the correct diagnosis. Can you imagine if the doctor doesn't understand us? Or [worse], if the doctor says that he/she understands and in reality doesn't understand what disease or symptoms we're talking about. He/she may give us the wrong prescription."	"About three weeks ago, I had to get some test done. I was seen by a nurse from the Philippines who spoke English but I couldn't understand anything. I asked for help."
"I feel more comfortable with an interpreter [knowing that the doctor understands my medical condition better] . . . I told [the doctor] about [the need for an interpreter] when he tried to explain about the A1C test [for diabetes]."	"One day, there was a lady interpreting for me but I asked her not to do it. I said about 20 words and she just interpreted three words. Also, she was going back and forth [in and out of the room] because she needed to interpret for another person as well."
"I used an interpreter when I had health insurance. It was a good experience."	"Now that they have more staff who speak Spanish, they offer better services."
"Sometimes I've used my daughters [as interpreters]. For me it's uncomfortable that my daughters find out [about my condition] before I do. Sometimes I've used other interpreters, but I've noticed that I'll be saying one thing and they're saying something else . . . I have noticed several times that what I say is not interpreted fully."	"When the nurse comes in to interpret (supposedly), I don't like the way she interprets, so I try to make myself understood."
"The services have improved [over the years]."	"The quality is the same. Physicians don't care whether patients speak English or not. They are professionals. At least, I haven't witnessed a difference."
"In my case, the doctor who takes care of me at UCLA has a private office too. My son has private insurance and the same doctor takes care of him. My son [who speaks English] receives a totally different type of care than what I receive."	"Since I started using county services, those people have made me feel like I'm begging for those services. Many times, I left [county facilities] crying . . . They look down on us."
"Even if the person speaks English, he or she may not understand the medical terminology that the doctors use. Doctors should consider using simple terms."	"If we speak with somebody who speaks Spanish, we will keep asking [follow-up questions], depending on the answers we get. However, if [a provider] speaks English and there is an interpreter, the interpreter doesn't look at you. He/she just turns at you and says, '[The doctor] says this and that.' We don't have a chance to ask questions or express any doubt we may have."
"Language is important and it can have an effect on our health and everything."	"Language is very important. I remember one of the Anglo nurses who didn't treat me right. If I knew how to speak English, I would have defended myself."
"I know that hospitals are not obligated to have staff who speak Spanish . . . However, it would be easier for hospitals to do that than for people to learn English because [learning English] is a very long process."	

GROUP FINDINGS
Only 1 participant reported having a primary care physician.
4 of the 9 participants said their doctors speak Spanish. The rest said their doctors speak only English.
Half of the participants said that they are offered services in Spanish.
All the participants who need Spanish services said that they always get help.
1 participant stated that she had to wait for language assistance.
Participants said that they appreciate a doctor who tries to speak Spanish.
The participants believe that one of the differences is that years ago, there were many fewer doctors who spoke Spanish.
All participants indicated that they worry about the quality of health services they receive because of their ability to communicate effectively.
All participants agreed that language (knowing how to communicate in English) has always played an important role in health.
All participants agreed that non-English-speakers are not made aware of all the health services available to them.
All participants said that the availability of services is made known to those who speak English, however.

Appendix Table 3. Findings and Statements Regarding English Skills, Focus Group 1

SELECTED QUOTES	
"What about the doctor telling us, 'Oh good, you are speaking English'? I think that we also must do our part [by learning English]."	"Of course it's a good thing that we have our language, but we live in this country. Sometimes our community doesn't make an effort to learn English. This is not fair."
"Well, for me [the language issue] is different. That's because I am learning English. I can now communicate a little better. I don't use an interpreter."	"I try to encourage families to learn English. This is good not just for them but for their children. English is useful to help our children do homework, to be able to obtain other things. The best thing we can do is to prepare ourselves to be able to help our children. This is the only way to prosper and get a good job. We must learn English . . . We must learn to be able to defend ourselves."
GROUP FINDINGS	
All participants agreed that the quality of services is related to the ability to speak English.	
All participants said they were concerned about the quality of health care they receive because of their ability to communicate properly.	
All participants agreed that language plays an important role in their health outcomes.	

Appendix Table 4. Findings and Statements Regarding English Skills, Focus Group 2

SELECTED QUOTES	
"Language is important, because if we don't speak English fluently, we can't explain what we feel. Medical terms are very different from the terms we use daily. Sometimes the doctors start asking questions and we don't understand what they're asking. For me, language is a barrier."	"I thought that if I knew how to speak English, the doctor would have to pay attention to me [listen to what I have to say]."
"Now that there are more Latinos, they want us to speak 'English only.' That is what they want."	"The language is very important. I remember one of the Anglo nurses who didn't treat me right. If I knew how to speak English, I would have defended myself."
"I know that hospitals are not obligated to have staff who speak Spanish. We have an obligation to speak English. However, it would be easier for hospitals to do that than for people to learn English because [learning English] is a very long process."	"I have four children, so I dedicated myself to work and taking care of my children. I would have loved to go to school, but I didn't have that opportunity."
"I just want to say that, as others have said, I agree that English is important for facing our needs."	"[Not knowing English] is a barrier for many of us."
"I also agree that language [English] is the barrier that does not allow us to obtain information about available services."	
GROUP FINDINGS	
There were mixed feelings among the participants as to whether the quality of services is related to the ability to speak English.	
All participants said they were concerned about the quality of health care they receive because of their ability to communicate properly.	
All participants agreed that language plays an important role in their health outcomes.	

Appendix Table 5. Findings and Statements Regarding Socioeconomic Factors and Race, Focus Group 1

SELECTED QUOTES	
"If it is an emergency, I go to the emergency room, but they ask me, "Do you have insurance?" So sometimes I end up not going. I take Tylenol or something because I don't want to go to the emergency room."	"I have not used urgent care clinics. I have noticed that children or adults who don't have insurance tend to 'prescribe for themselves."
"In general the clinics are expensive . . . If I get a cold, I just deal with it. I don't go to the clinic. I simply go to Target and get Tylenol or something that can help."	"I have many friends who visit a <i>curandero</i> because they don't have money to pay [a medical doctor]. Or they go to a <i>sobador</i> , because going to a chiropractor costs them \$200 instead of \$10–\$20 with the <i>sobador</i> ." [A <i>curandero</i> is a traditional healer, and a <i>sobador</i> is a kind of lay chiropractor.]
"They should provide services—not free, because we don't value them—but low-cost, to prevent diseases. If we can't afford medical care, we don't go to checkups. Then we go and find out that we already have diabetes and it's too late. They should make it possible for those who have no resources to get services . . . Medi-Cal is cutting benefits. Before, Medi-Cal used to cover Tylenol; now I have to pay for it. For the health of our children we buy it, no matter how hard it is. But for us [adults] we always say, 'Later, later.' Then, we realize it's too late. I hope they will offer insurance programs at low cost. We need opportunities for adults. My children have Medi-Cal but I don't. I only have Medi-Cal for emergencies. So, I wonder, 'Should I throw myself under a truck so that they take care of me?'"	"I speak English, so I haven't had any issues with communication. Once I went to a hospital in the San Fernando area. I had an emergency with my son, who had a fever of 103 degrees. After I had waited a long time, I said in English, 'I'm leaving. Just because you see my Latina face and I didn't speak English—but I do, and I also have insurance.' . . . So the doctor came right away to help me . . . I thought, 'Too bad that when [these people] see patients who don't speak English, who look different, of a different color, they value them less."
"Discrimination comes from the Latino doctors and staff themselves. When Americans hear us speaking English, they say, 'I understand, I understand.' On the contrary, Latinos say, 'I don't understand. What are you saying?' . . . Then, we feel bad."	"They discriminate against us when they ask, 'What insurance do you have?' and we answer, 'Medi-Cal.' Many times when I take my children to the clinics and I mention Medi-Cal, they don't provide my children with the care that they should . . . I took my daughter in July for a checkup; then, by the end of the year, she started showing diabetes symptoms. So I took her back to the clinic and they didn't want to do any tests because they had already done the physical exam. They said that Medi-Cal would not cover [those tests]."
"The copayment [influences my decision of where to go for medical care]. Like she said, I prefer to go to urgent care and pay \$20 than to the emergency room where I would have to pay \$100."	"I speak Spanish and English. I took my girl to the [hospital] and waited an hour. The doctor was talking and laughing with the nurse. Then he came to see my daughter and he was mad like never before. He asked me, 'Do you speak Spanish or English?' I replied, 'Both.' Then he rolled his eyes and asked me why I had brought my daughter."
"One day my neighbor took my husband to the hospital. They found my husband on the street, so it was an emergency . . . When I arrived at the hospital they still had not taken care of him. I told the staff that he had Emergency Medi-Cal. The lady that was checking in the computer said, 'This Medi-Cal coverage is not good for you because he works. He must have his own insurance.' . . . She then told us, 'You know what? You come to this country to steal. You have no right to have Medi-Cal.' I was shaking and very mad. She turned to her coworker and said, 'These Latinos come here to create a nuisance.' . . . [Later the secretary at Human Resources] confirmed that we had Medi-Cal."	"About eight years ago, my mother died. I fainted. I had diabetes at that time. I was taken to a hospital. They asked me if I spoke English. I didn't answer. I could hear what they were saying. They said: '[She came] just because her mother died.' I told them that I spoke English . . . They didn't check my glucose. They didn't take my blood pressure . . . I was going to sue the hospital because they didn't do anything. When I got the bill, they were charging for checking my glucose and 'everything.' I went back to the hospital and gave them a document showing that I was going to sue them. I told them I was the one that checked my glucose with my own machine. I had a level of 570. I was seven months and three weeks of pregnancy. Now my daughter was born with a pulmonary problem. I could say that it was your fault. I told them I recorded when they were laughing. That was not true but I told them I recorded it. Like I said in this country when they think that we don't speak English—I mean—when I spoke English at that time, they wanted to transfer me to another hospital in helicopter. I told them 'No, thank you. I will go driving.'"
"In general, thank God, in the places where I go the doctor speaks Spanish. There was only one time when my husband got sick, nobody spoke Spanish, and I didn't understand."	"When I came to the US, my son was seven months old. I then got pregnant. They [medical personnel] wanted me to abort the second baby. I was feeling tired. I wasn't feeling really bad, I was just tired. I was four months pregnant. They gave me a paper and told me to go to a clinic. When I arrived, they told me to lie down. I asked why? And they told me that I needed to lie down because they needed to perform an abortion. I told them they were crazy and left."
"I take my son to Kaiser. They take excellent care of him. But I take my other four children to another place [where I have] to make an appointment in person. In this place, the staff are busy, answering the telephone and so forth. If I call on the telephone, I end up waiting an hour and I have to hang up."	"One time I was feeling very sad. I guess I was depressed. Everything hurt me. I went to the doctor and checked my glucose, my liver, the pap smear, and everything. They told me that I had to pay for certain tests because Medi-Cal didn't cover everything. So I paid, and the doctor told me, 'You are sick in the head.' Why couldn't the doctor say that I had a problem with my nerves, that I was stressed? . . . Sometimes we go to the doctor as a preventive measure and they interpret that as an exaggeration on our part . . . This clinic is one block from my house but I don't want to go there. I'd rather go to another clinic that is farther but provides me better service."
"Two years ago, my husband was diagnosed with cancer. He started going to clinics. He has insurance from his job but he had to cover part of the total cost . . . When he went to his appointments, he would be told, 'The doctor did not come to work today' or 'The machine broke down.' . . . Time passed. The cancer advanced . . . When they decided to do the biopsy, it was too late. The cancer had spread in his body. There was nothing they could do. If they had treated him when he started to feel bad, maybe they could have done something. But they didn't take care of him because of his insurance. When he was hospitalized, nobody made an effort to communicate with me . . . So I think there is still negligence because of language and because of insurance."	"I think that it is prohibited for the medical staff to provide information about the availability of programs. They say, 'Go to this place or that place but don't say I told you.' Then, we find out and receive help from other places. Doctors don't talk about the different types of assistance. That's why bad things can happen to us, because we don't have money."

Appendix Table 5. (cont.)

SELECTED QUOTES	
<p>“As far as insurance, I believe there must be some reforms. My father-in-law has a truck business. He had an accident in downtown LA and one of his arms was completely destroyed. They took him to a hospital. He couldn’t talk due to his pain. They didn’t give him any painkillers. They wanted to see his insurance first. They had him sitting in a wheelchair and did nothing. He was bleeding and they were ready to cut his hand because it was the less expensive thing to do. They didn’t know that he had good insurance, Blue Cross . . . The reason why they didn’t help him in the first place was because they saw he was Latino. He looked so dirty due to his work . . . they discriminated due to his appearance. They didn’t look in his pockets. There should be a reform so that everybody has the same opportunity.”</p>	<p>“Now we hear that doctors can see you even if you don’t have insurance. That is a lie. They tell us to sign attesting that we have insurance. For example, if I didn’t sign stating that we had insurance, they wouldn’t take care of my husband.”</p>
<p>“My father had an experience with a doctor from Asia. Before saying anything to my father, just by looking at him, the doctor said, ‘Can we get an interpreter?’”</p>	<p>“It is very common that [medical staff] say they don’t speak Spanish even when they do. The receptionists do that more than anybody else . . . One day we went to a clinic with my sister-in-law. I knew that this [staff member] spoke Spanish but she denied it. I heard her talking in Spanish with another person. I told her to give me her name to report her. She looked at me and said, ‘Uhh, these little Mexicans’ and left. She covered her badge so that we couldn’t see her name.”</p>
<p>“I try to encourage some families to learn English . . . We must learn to be able to defend ourselves.”</p>	<p>“Years ago, [we received] excellent services because my children had private insurance. Unfortunately, my husband changed his job and we couldn’t pay the private insurance. It was too expensive. My children then got Medi-Cal. My oldest son was moved to Kaiser. Each of them goes to a different clinic. The service is not so satisfactory.”</p>
<p>“[The quality of services is related not only to] the language but to our appearance.”</p>	<p>When asked about whether services are made known: “At the clinics, we don’t receive this type of information. We receive this type of information from ‘outside’—at schools or health fairs.”</p>
<p>“I believe that if we speak Spanish, they don’t give us information. They don’t want to waste their time.”</p>	<p>“We are aware [of available services] through other places or our relatives, but not through the clinics.”</p>
<p>“I haven’t really had issues with the services . . . However, one time I had an appointment for my son and we needed to register. There was a very long line to sign in . . . I told the supervisor that we had been waiting for 15 minutes and the line was long. I told her that two of her staff had gone to lunch. I also said that we pay enough money through the insurance for them to take care of us. Very quickly, four people came to assist us.”</p>	<p>“[Communication is the] problem with our community. It’s not that they don’t listen to us. We have to write letters, but some people don’t want to take the time to do that. Yes, they listen. Yes, they implement the changes. We must insist and not back down . . . They listen because it is not to their advantage to have a bad record.” Another participant: “Yes, but again [the ability to write a complaint] is influenced by language.”</p>
<p>“The reason I filed a complaint is because I need to show them that just because I don’t speak English, this doesn’t mean I don’t know as much as they do. They think they know too much.”</p>	<p>“We should not stop with one opinion from one provider. We should look for different opinions. We should not let the language stop us.”</p>
<p>“I haven’t had much of a problem with the language. My problem has always been that I don’t have a lot of time . . . I would rather prescribe for myself than go to the clinic where I will waste three hours.”</p>	<p>“[We would like to have] a telephone line where we can complain.”</p>
<p>“Providers should not be good to us just to bill us. They should be able to provide good services, to help us in an emergency. I notice that when they call me to pay the premium for Healthy Families, they have an interpreter. However, when I need an interpreter at the clinic, they don’t find anyone to help me.”</p>	<p>“There are many children without insurance. If they go to the doctor, they are denied services. They should help those people who live on the street [the indigent/homeless].”</p>

GROUP FINDINGS

At least half the participants reported that they use urgent care clinics.
10 of 13 participants raised their hands when asked, “Have you personally experienced some kind of discrimination when you seek medical services?”
At least 8 participants agreed that some providers have a negative attitude toward Medi-Cal.
At least 4 participants reported having chosen an urgent care clinic over the emergency room because of cost and, moreover, selecting a specific clinic based on its copayment cost.
All participants agreed that the quality of the services is related to the ability to speak English.
All participants agreed they were concerned about the quality of health care they receive because of their ability to communicate properly.
At least 3 participants said that they had taken the time to submit a complaint about the quality of their health services.
At least 10 participants had a complaint but never expressed or filed it.

Appendix Table 6. Findings and Statements Regarding Socioeconomic Factors and Race, Focus Group 2

SELECTED QUOTES	
"I have several conditions: high blood pressure, high cholesterol, and my heart. I already had open heart surgery. It has been very difficult for me to obtain assistance from the government."	"I go to private clinics. I pay . . . I won't be able to continue because I have been unemployed for about six months."
"I also couldn't continue with an eye surgery I needed because I couldn't afford to pay."	"I have always paid for my care and for my medicine. But my husband had a stroke. Neither of us has a job, so it's not possible for us to go to a hospital. It would be too expensive."
"I have a son with depression . . . He is 23 and can't get help. I can't help him because I am not working."	"I go to places [where] I have to wait eight hours. It's an emergency! But they still make me wait eight hours. I ask them, 'Why do I have to wait eight hours?' It's the system . . . I don't want to have emergencies."
"I believe the way they treat us and the services we receive determine where to go. If we receive bad service [and] have to wait 8, 10, 12 hours at the emergency room, feeling bad [this is not a good thing]."	"I exercise my rights. I speak up. I don't know if I speak good English but I do the best I can to defend myself."
"My brother had insurance with Kaiser. He got really sick, so I took him to Kaiser. He had lost his job and there were only 21 more days left on his insurance coverage. They said that my brother didn't qualify because he needed a long treatment. I told them he still had 21 days, so they could still see him. They said, 'No, this is not the county. We don't have [social] programs. This is a private place.'"	"I have always suffered from sinusitis. A private doctor told me, 'You have a serious problem; you need surgery; you have cysts inside your nose.' She told me this in less than three minutes. She told me she needed to perform the surgery immediately. I asked her how much the surgery would cost and she said \$6,000. I said, 'No, I'll be back.' I left and went for a second opinion. They [the second provider] told me nothing."
"Now that there are more Latinos, they want us to speak 'English only.' That is what they want."	"When they answer the telephone [when one calls to set up an appointment] they don't speak Spanish. Second, to get an appointment, it takes at least three months."
"Besides the problem with the language, we have another problem: they don't care about us. I believe that those who answer the telephone should receive a course in human relations. Also, the people who are at the front desk, they think that we go to the clinics or hospitals to beg. They treat us as if we are objects."	"When they tell us to call to make an appointment, I call and get an answering machine (and always in English). I am having a problem right now. My husband needs a doctor who speaks Spanish. He has Blue Cross. I called and a young lady helped me. She tried to find a doctor who speaks Spanish and could not find any. How is that possible?"
"I had insurance. I called and they gave me an appointment but I had to wait 30 days. [I decided] to go to the emergency room. They were upset with me. They told me not to do that again."	"I was waiting to pick up my medicine at Olive View [county hospital]. Usually there is a long wait. We have to wait a couple of hours . . . I was in pain. I told them I couldn't wait . . . I sat down but I felt bad, bad. Finally, I fainted. I lost consciousness . . . I had not eaten anything. So they took me to the emergency room. My son and I were so disappointed to see that the staff from the pharmacy didn't move at all."
"I have had bad experiences with the county. Since I started using county services, those people have made me feel like I'm begging for those services. Many times, I left [county facilities] crying. They don't understand that their salaries come out of the same funds that the government uses to provide us health assistance. They underestimate us. They look down on us."	"I have had a complaint about a health program. As I mentioned before, I have received medical bills. I sent the application for the program and I am still waiting. I got a call from a social worker. She told me to go to the office to do this and that . . . I told her that I knew about the bill and that I have already applied . . . The social worker replied in a rude manner . . . I actually went to the office to let them know that a person had called me . . . They confirmed that I had to wait . . . So, this is a case of very bad communication. I was upset with the person who called me."
"I believe the reason why we don't [file complaints] is because we don't use this system in the countries that we come from . . . We don't exercise our right because of lack of information, not knowing, or choosing not to argue."	"When I had my first baby, 11 years ago, they treated me very badly. I complained but it didn't go beyond that . . . I felt that I was ignored."
"[Not knowing English] is a barrier for many of us. However, I have seen some changes. Those changes are due to the fact that there are many Latinos in this country. There are more than 50 million Latinos, approximately—30 million who are Mexican and more from other countries. Let us hope that Spanish continues 'growing' for the well-being of all of us."	"I also agree that the language [English] is the barrier that does not allow us to obtain information about available services . . . I think that there are politicians in control of resources that they don't want to share. They just want to advance in their political careers. Some people are selfish. There are people [in the community] with different needs."
"Sometimes, we feel bad and they tell us to call [to set up an appointment] at 7:30 a.m., but nobody answers. So it's better to go to the emergency room."	

GROUP FINDINGS

At least 6 participants indicated that they use public clinics run by Los Angeles County.
Only 1 participant reported having a primary care physician.
All participants agreed that doctors often allow too little time for visits.
All participants agreed they were concerned about the quality of health care they receive because of their ability to communicate.
All participants agreed that language (knowing how to communicate in English) has always played an important role in their health.
All participants said they thought that non-English-speakers are not made aware of all the services that are available to them, while the availability of services is made known to those who speak English.

NOTES

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1. See, for example, Organisation for Economic Co-operation and Development, *OECD Health Data 2012: How Does the United States Compare?* (Paris: OECD, 2012), 1; and Centers for Medicare and Medicaid Services, "National Health Expenditure Fact Sheet," January 9, 2013.
2. According to a December 2008 report from the McKinsey Global Institute, the United States overspends on health care by \$650 billion per year. Roughly two-thirds of the excess spending is a result of outpatient care (e.g., visits to physicians, same-day hospital care, emergency room care, and expensive diagnostic tests like MRIs and CT scans), as well as unnecessary "more is better" care. Another 15 percent is due to high pharmaceutical costs, 14 percent is due to high health administration and insurance costs, and nearly 10 percent is due to overspending on the salaries of medical professionals, who tend to be paid less in other industrial nations. Diana Farrell et al., *Accounting for the Cost of US Health Care: A New Look at Why Americans Spend More* (New York: McKinsey & Company, 2008). United Nations statistician and health economist Howard Steven Friedman further shows that the United States receives a comparatively low return on its investment in terms of health expenditure per capita versus life expectancy. Howard Steven Friedman, *The Measure of a Nation: How to Regain America's Competitive Edge and Boost Our Global Standing* (New York: Prometheus Books, 2012). See also Organisation for Economic Co-operation and Development, *Health at a Glance 2011: OECD Indicators* (Paris: OECD, 2011).
3. When one major health poll recently asked, "If the federal government could do one thing to improve the nation's health care system in the next few years, what do you think it should be?" the public's leading suggestion was "make health care more affordable and lower costs." Kaiser Family Foundation, Robert Wood Johnson Foundation, and Harvard School of Public Health, *The Public's Health Care Agenda for the 113th Congress* (Washington, DC: Henry J. Kaiser Family Foundation, 2013), 9. For the status of health in the United States, see Christopher J. L. Murray, "The State of US Health, 1990–2010: Burden of Diseases, Injuries, and Risk Factors," *JAMA*, July 10, 2013.
4. Kaiser Commission on Medicaid and the Uninsured, *Overview of Health Coverage for Individuals with Limited English Proficiency* (Washington, DC: Henry J. Kaiser Family Foundation, 2012).
5. For the influence of language, see: C. A. Dubard and Z. Gizlice, "Languages Spoken and Differences in Health Status, Access to Care, and Receipt of Preventive Services among US Hispanics," *American Journal of Public Health* 98, no. 11 (2008): 2021–28; Glenn Flores, "Language Barriers to Health Care in the United States," *New England Journal of Medicine* 355 (2006): 229–31; Ninez Ponce, Ron Hays, and William Cunningham, "Linguistic Disparities in Health Care Access and Health Status Among Older Adults," *Journal of General Internal Medicine* 21, no. 7 (2006): 786–91. For the LEP population, see: Migration Policy Institute, National Center on Immigrant Integration Policy, *Limited English Proficient Individuals in the United States: Number, Share, Growth, and Linguistic Diversity*, LEP Data Brief (Washington, DC: Migration Policy Institute, December 2011).
6. In 1963 President John F. Kennedy called for the bill in a landmark speech on civil rights, stating, "Simple justice requires that public funds, to which all taxpayers of all races contribute, not be spent in any fashion which encourages, entrenches, subsidizes or results in racial discrimination." Title VI expanded Kennedy's formulation of "racial" discrimination to include color and national origin: "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." Title VI of the 1964 Civil Rights Act, 42 U.S.C., sec. 2000d.
7. US Department of Justice, "Overview of Title VI of the Civil Rights Act of 1964," May 14, 2013.
8. The "universal regulatory language" of Title VI has been challenged repeatedly in the courts. In *Lau v. Nichols*, 414 U.S. 563 (1974), the Supreme Court faced a challenge by Chinese-speaking students to a school district's policy of offering instruction only in English. Siding with the students, the Court ruled that a failure to provide information and services in languages other than English could result in discrimination on the basis of national origin in cases where this failure resulted in a significant number of LEP beneficiaries from the same language minority being unable to fully realize the intended benefits of a federally assisted program or activity. According to the Justice Department, "The core holding in *Lau*—that the failure to address limited English proficiency among beneficiary classes could constitute national origin discrimination—has equal vitality with respect to any federally assisted program or activity providing services to the public." US Department of Justice, Civil Rights Division, *Title VI Legal Manual* (Washington, DC: US Department of Justice, 2001).
9. In August 2000, an order by President Bill Clinton reaffirmed and clarified the obligation to eliminate limited English proficiency as an artificial barrier to full and meaningful participation in all federally assisted programs and activities (Executive Order 13166, 65 Fed. Reg. 50121). Although the Supreme Court's 2001 decision in *Alexander v. Sandoval*, 532 U.S. 275, held that there is no private right of action to enforce Title VI's disparate impact regulations (that is, only the funding agency issuing the disparate impact regulation has the authority to challenge a recipient's actions), the assistant attorney general for the Justice Department's Civil Rights Division established that *Sandoval* did not undermine the validity of those regulations or otherwise limit the authority and responsibility of federal grant agencies to enforce their own implementing regulations. Thus, recipients of federal funds are still reasonably required to address, consistent with the core objectives of the federally assisted programs or activities, the specific language needs of their LEP beneficiaries that operate as artificial barriers to full and meaningful participation. US Department of Justice, *Title VI Legal Manual*.
9. *Ibid.*
10. US Department of Justice, "Executive Order 13166: Improving Access to Services for Persons with Limited English Proficiency," news release, August 11, 2000.
11. Seth Motel and Eileen Patten, *Statistical Portrait of Hispanics in the United States, 2011* (Washington, DC: Pew Research Hispanic Center, 2013).
12. Mark Hugo Lopez and D'Vera Cohn, *Hispanic Poverty Rate Highest in New Supplemental Census Measure* (Washington, DC: Pew Research Hispanic Center, 2011).
13. Motel and Patten, *Statistical Portrait of Hispanics in the United States, 2011*.
14. Josep Figueras and Martin McKee, eds., *Health Systems, Health, Wealth and Societal Well-Being: Assessing the Case for Investing in Health Systems*, European Observatory on Health Systems and Policies (Berkshire, UK: Open University Press, 2012); US Bureau of the Census, "Income, Poverty, and Health Insurance Coverage in the United States: 2011," September 2012.
15. Centers for Disease Control and Prevention, "Perspectives in Disease Prevention and Health Promotion: Report of the Secretary's Task Force on Black and Minority Health," *Morbidity and*

Mortality Weekly Report 35, no. 8 (February 28, 1986): 109–12.

16. Guillermina Jasso et al., "Immigrant Health: Selectivity and Acculturation," in *Critical Perspectives on Racial and Ethnic Differences in Health in Late Life*, ed. N. B. Anderson, R. Bulatao, and B. Cohen (Washington DC: National Research Council of the National Academies, 2004), 227–66; Kathryn Pitkin Derose, José J. Escarce, and Nicole Lurie, "Immigrants and Health Care: Sources of Vulnerability," *Health Affairs* 26, no. 5 (2007): 1258–68.
17. Karen R. Flórez et al., "Mexico–United States Migration and the Prevalence of Obesity: A Transnational Perspective," *Archive of Internal Medicine* 172, no. 22 (2012): 1760–62. Latinos born abroad have also been found to have a significantly lower risk of stroke than US-born Latinos. J. Robin Moon et al., "Stroke Incidence in Older US Hispanics: Is Foreign Birth Protective?" *Stroke* 43, no. 5 (2012): 1224–29. Public health researchers have hypothesized a web of factors to explain these Latino immigrant health trends, including the food environment in US society, the stress that accompanies acculturation, and the loss of support networks available in an immigrant's native country.
18. Gopal K. Singh and Barry A. Miller, "Health, Life Expectancy, and Mortality Patterns among Immigrant Populations in the United States," *Canadian Journal of Public Health* 95, no. 3 (2004): 14–21. Latino immigrant men and women had, respectively, 7.8 and 3.0 years' longer life expectancy than their US-born counterparts.
19. Office of Minority Health, US Department of Health and Human Services, "Hispanic/Latino Profile," September 7, 2012.
20. Ana Gonzalez-Barrera et al., *The Path Not Taken: Two-thirds of Legal Mexican Immigrants Are Not US Citizens* (Washington, DC: Pew Research Hispanic Center, 2013).
21. Migration Policy Institute, National Center on Immigrant Integration Policy, *Limited English Proficient Individuals in the United States*.
22. Ibid. Fifty percent of US Latinos lived in California and Texas in 2000; by 2010, that share had fallen to 46.5 percent. Jeffrey Passel, D'Vera Cohn and Mark Hugo Lopez, *Hispanics Account for More than Half of Nation's Growth in Past Decade* (Washington, DC: Pew Research Hispanic Center, 2011).
23. Seth Motel and Eileen Patten, *Characteristics of the 60 Largest Metropolitan Areas by Hispanic Population* (Washington, DC: Pew Research Hispanic Center, 2012).
24. Mary Masland and Lonnie Snowden, *California's Limited English Proficient Population (LEP) and Strategies to Promote Health Care Access* (Berkeley, CA: California Program on Access to Care, University of California at Berkeley School of Public Health, August 2009).
25. Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology, *Key Indicators of Health by Service Planning Area* (Los Angeles: County Department of Public Health, March 2013). The County Department of Public Health publishes its *Key Indicators of Health* report based on the Los Angeles County Health Survey.
26. Masland and Snowden, *California's Limited English Proficient Population*.
27. Emily Feinberg et al., "Language Proficiency and the Enrollment of Medicaid-Eligible Children in Publicly Funded Health Insurance Programs," *Maternal and Child Health Journal* 6, no. 1 (2002): 5–18.
28. Kaiser Commission on Medicaid and the Uninsured, *Overview of Health Coverage for Individuals with Limited English Proficiency*.
29. Ibid.
30. On July 2, 2013, it was announced that there would be a one-year delay in the implementation of the so-called "employer mandate" component of the ACA, which penalizes employers with more than fifty employees if they fail to provide a minimum standard of affordable health insurance for employees who work more than thirty hours per week. However, research indicates that the employer mandate has far less effect on both health care coverage and cost than the individual mandate component of the ACA. Linda J. Blumberg, John Holahan, and Matthew Buettgens, *It's No Contest: The ACA's Employer Mandate Has Far Less Effect on Coverage and Costs Than the Individual Mandate* (Washington, DC: Urban Institute, 2013), 1.
31. California Budget Project, *Final 2013–14 Budget Agreement Signals a New Chapter for California, With More Work to Be Done* (Sacramento: California Budget Project, 2013).
32. Because the 2013–14 budget has not had time to fully take effect, and because the 2012–13 budget reflects the ongoing fragility of California (and the nation's) economic recovery, we focus on last year's budget in this report.
33. The health summit, "Achieving Equitable Health Care Access for Latinos with Limited Proficiency in the English Language," convened experts, including a number of UCLA faculty, representing different areas relevant to this issue: law, direct service delivery, academic research, and public policy.
34. Mission Community Hospital is the recipient of a California Endowment grant, "Community Engagement for Sustainable Healthier City Environments." Focus groups were conducted through the research infrastructure facilitated by that earlier grant. This arrangement was made possible by the existing partnership between the CSRC and Mission Community Hospital, as well as by the involvement of UCLA faculty also involved with community health projects in San Fernando.
35. Agency for Healthcare Research and Quality, US Department of Health and Human Services, "Defining Language Need and Categories for Collection," chap. 4 of *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*, Institute of Medicine Report (Rockville, MD: AHRQ, 2010).
36. Philipp Mayring, "Qualitative Content Analysis," *Forum: Qualitative Social Research* 1, no. 2 (June 2000).
37. J. R. Barrett, "The Researcher as Instrument: Learning to Conduct Qualitative Research through Analyzing and Interpreting a Choral Rehearsal," *Music Education Research* 9, no. 3 (2007): 417–33.
38. Mayring, "Qualitative Content Analysis."
39. Barrett, "The Researcher as Instrument."
40. Agency for Healthcare Research and Quality, US Department of Health and Human Services, "Living in Hispanic or Black Communities Increases Risk for Obesity," December 2012; Office of Minority Health, US Department of Health and Human Services, "Diabetes and Hispanic Americans," March 12, 2013.
41. For lifespan and health see Michelle Brandt, "Social Factors Better Indicators of Early Death Risk than Skin Color, Geography, Study Shows," Stanford School of Medicine, April 17, 2012. For education see Centers for Disease Control and Prevention, "Higher Education and Income Levels Keys to Better Health, According to Annual Report on Nation's Health," news release, May 16, 2012.
42. For a practitioner-based perspective on how language barriers contribute to health disparities, see Lisa C. Diamond and Elizabeth A. Jacobs, "Let's Not Contribute to Disparities: The Best Methods for Teaching Clinicians How to Overcome Language Barriers to Health Care," *Journal of General Internal Medicine* 25, suppl. 2 (2010): 189–93.
43. National Health Law Program, *Language Access in Health Care: Statement of Principles* (Washington, DC: National Health Law Program, 2010); Agency for Healthcare Research and Quality, US Department of Health and Human Services, *National Healthcare Disparities Report, 2012* (Rockville, MD: AHRQ, 2013).

44. A more complete summary of the findings and more extensive quotes are included in the appendix. Tables 1 through 6 in the main text highlight a few selected quotes, no more than 10 for each thematic area.
45. Jane Perkins and Mara Youdelman, *Addressing Language Needs in Health Care: Summary of State Law Requirements* (National Health Law Program, January 2008), 4.
46. Glenn Flores et al., "Errors of Medical Interpretation and Their Potential Clinical Consequences: A Comparison of Professional Versus Ad Hoc Versus No Interpreters," *Annals of Emergency Medicine* 60, no. 5 (2012): 545–53.
47. This figure is based on an estimate of 66.1 million health care interactions. The OMB assumed that 20 percent of interpreting encounters would be provided by volunteers, including family and friends, and further assumed that 95 percent of total encounters would be face-to-face, with the remaining 5 percent provided via commercial telephonic contracted interpreter services (at a more expensive rate). Office of Management and Budget, *Report to Congress: Assessment of the Total Benefits and Costs of Implementing Executive Order No. 13166: Improving Access to Services for Persons with Limited English Proficiency* (Washington, DC: OMB, 2002).
48. Leighton Ku and Glenn Flores, "Pay Now or Pay Later: Interpreter Services in Health Care," *Health Affairs* 24, no. 2: 435–44 (2005).
49. Kelvin Quan and Jessica Lynch, *The High Costs of Language Barriers in Medical Malpractice* (Berkeley: University of California, Berkeley, School of Public Health; Washington, DC: National Health Law Program, 2010), 40.
50. Deborah J. Schildkraut, "Defining American Identity in the Twenty-First Century: How Much 'There' Is There?" *Journal of Politics* 69, no. 3 (2007): 597–615.
51. Jiménez, Tomás R., *Immigrants in the United States: How Well Are They Integrating into Society?* (Washington, DC: Migration Policy Institute, 2011).
52. Gonzalez-Barrera et al., "The Path Not Taken."
53. Lucy Tse, *Why Don't They Learn English? Separating Fact from Fallacy in the U.S. Language Debate* (New York: Teachers College Press, 2001).
54. The notion that earlier immigrants groups all learned English quickly is to some extent myth. German immigrants, who represented the biggest immigration wave to the Midwest during the mid-nineteenth century, continued for decades speaking mainly or exclusively German. German remained the primary language of commerce, education, and religion in their communities well into the twentieth century, and some members of the US-born second and third generations still spoke only German as adults. Miranda Wilkerson and Joseph Salmons, "'Good Old Immigrants of Yesteryear' Who Didn't Learn English: Germans in Wisconsin," *American Speech* 83, no. 3 (2008): 259–83.
55. Public health literature points to the detrimental effects of racism on both physical and mental health. See Kathryn Freeman Anderson, "Diagnosing Discrimination: Stress from Perceived Racism and the Mental and Physical Health Effects," *Sociological Inquiry* 83, no. 1 (2013): 55–81; Pamela J. Sawyer et al., "Discrimination and the Stress Response: Psychological and Physiological Consequences of Anticipating Prejudice in Interethnic Interactions," *American Journal of Public Health* 102, no. 5 (2012): 1020–26. A 2010 Pew survey found that 61 percent of Latinos felt that discrimination is a "major problem" that prevents Latinos in general from succeeding in America (up 7 percentage points from 2007). Mark Hugo Lopez, Rich Morin, and Paul Taylor, *Illegal Immigration Backlash Worries, Divides Latinos* (Washington, DC: Pew Research Hispanic Center, 2010). Studies have further shown that immigrants with psychiatric disorders may be at particular risk, given that mental health treatment relies on direct verbal communication. Tetine Sentele, Martha Shumway, and Lonnie Snowden, "Access to Mental Health Treatment by English Language Proficiency and Race/Ethnicity," *Journal of General Internal Medicine* 22, suppl. 2 (2007): 289–93. Being LEP significantly decreases the odds that Latino immigrants will use mental health services, and limited English skills thus constitute a substantial barrier to mental health service use among Latino immigrants with psychiatric disorders. Giyeon Kim et al., "Limited English Proficiency as a Barrier to Mental Health Service Use: A Study of Latino and Asian Immigrants with Psychiatric Disorders." *Journal of Psychiatric Research* 45, no. 1 (2011): 104–10.
56. Jiménez, *Immigrants in the United States*, 5. "Third and higher generations" include individuals who are born in the United States to US-born parents.
57. Rubén G. Rumbaut, Douglas S. Massey, and Frank D. Bean, "Linguistic Life Expectancies: Immigrant Language Retention in Southern California," *Population and Development Review* 32, no. 3 (2006): 447–60.
58. Hoyt Bleakley and Aimee Chin, "Age at Arrival, English Proficiency, and Social Assimilation among U.S. Immigrants," *American Economics Journal: Applied Economics* 2, no. 1 (2010): 165–92.
59. A February 2013 Pew report noted that a greater percentage of Latino adults hold a high school degree today than in 2000. According to census data, 52 percent of Latino adults had at least a high school or equivalent degree in 2000, while 63 percent did in 2011. Furthermore, while 20 percent of Latinos aged 18–24 were enrolled in some level of higher education in 2000, that age-specific percentage had increased to 33 percent in 2011. Motel and Patten, *Statistical Portrait of Hispanics in the United States*.
60. California Budget Project, "A Decade of Disinvestment: California Education Spending Nears the Bottom," *School Finance Facts*, October 2011.
61. California Budget Project, *Final 2013–14 Budget Agreement*, 4.
62. Michael Romero, "Division of Adult and Career Education: Academic Achievement for All Students," presentation to the Board of Education, Los Angeles Unified School District, February 12, 2013.
63. EdSource, *At Risk: Adult Schools in California* (Mountain View, CA: EdSource, Inc., 2012).
64. California Budget Project, *Final 2013–14 Budget Agreement*, 4.
65. Migration Policy Institute, *Limited English Proficient Individuals in the United States*.
66. According to HHS, "LEP Hispanic adults were more likely to report worse general physical health (fair or poor) than that of English-proficient Hispanic adults." Agency for Healthcare Research and Quality, US Department of Health and Human Services, *Research Findings #28: Demographics and Health Care Access and Utilization of Limited-English-Proficient and English-Proficient Hispanics* (Rockville, MD: AHRQ, 2008), 3.
67. Such classes may be cost-saving measures in the long run, as education increases earning potential and lowers the chances of unemployment. Bureau of Labor Statistics, US Department of Labor, "Earnings and Unemployment Rate by Educational Attainment," May 22, 2013.
68. For the effect of socioeconomic factors, see Brandt, "Social Factors Better Indicators." A growing literature shows that racial/ethnic discrimination raises the risk of many mental and physical problems. Indeed, two journals dedicated entire issues to the subject in recent years. See the *American Journal of Public Health* 102, no. 5 (2012) and the *Du Bois Review: Social Science Research on Race* 8, no. 1 (2011).
69. Centers for Disease Control and Prevention, "Higher Education and Income Levels Keys to Better Health."

70. Thomas Piketty and Emmanuel Saez, "Top Incomes and the Great Recession: Recent Evolutions and Policy Implications," paper presented at the 13th Jacques Polak Annual Research Conference, International Monetary Fund, Washington, DC, November 8–9, 2012.
71. Orsetta Causa and Åsa Johansson, "Intergenerational Social Mobility in OECD Countries," *OECD Journal: Economic Studies*, vol. 2010: 9.
72. S. V. Subramanian and Ichiro Kawachi, "Income Inequality and Health: What Have We Learned So Far?" *Epidemiologic Reviews* 26, no. 1 (2004): 78–91; Susan L. Ettner, "New Evidence on the Relationship between Income and Health," *Journal of Health Economics* 15, no. 1 (1996): 67–85; Anne Case, "Health, Income and Economic Development," paper prepared for the ABCDE Conference, World Bank, Washington, DC, May 1–2, 2000.
73. Martin Gilens, "Under the Influence," *Boston Review*, July-August 2012. It should be noted that, as Gilens demonstrates, affluent Americans tend to favor the protection or expansion of government support in the case of health care. Health may thus be a situation in which existing institutional structures, such as the private insurance and pharmaceutical industries, are able to overcome individual attitudes, even of the affluent. Wendell Potter, a healthcare whistleblower and former executive at CIGNA and Humana, points to this possibility in his book *Deadly Spin: An Insurance Company Insider Speaks Out on How Corporate PR Is Killing Health Care and Deceiving Americans* (New York: Bloomsbury Press, 2011).
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75. Ibid.
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77. One of these participants was female and the other was male. Future focus groups would benefit from having more gender diversity in order to better reveal gender trends in education and health.
78. Agency for Healthcare Research and Quality, US Department of Health and Human Services, "Defining Language Need and Categories for Collection."
79. Only one participant attained a less-than-secondary education but spoke excellent English. This participant emigrated to the United States before turning eighteen.
80. Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology, *Key Indicators of Health by Service Planning Area*, 6. Demographic and health figures on the San Fernando Valley and South LA in this section are drawn from this report.
81. US Bureau of the Census, "Poverty Rates for Selected Detailed Race and Hispanic Groups by State and Place: 2007–2011," February 2013.
82. Andrea Bellavia et al., "Fruit And Vegetable Consumption and All-Cause Mortality: A Dose-Response Analysis," *The American Journal of Clinical Nutrition* 98, no. 2 (2013): 454–59.
83. US Environmental Protection Agency, *Children's Environmental Health Disparities: Hispanic and Latino American Children and Asthma*, fact sheet, April 2008.
84. US Department of Health and Human Services, "Health Care Reform Law Helps 1.3 Million Minority Young Adults Obtain Health Insurance," news release, March 7, 2012.
85. National Council of La Raza, "Community Service Providers Cite a Complex Process and Lack of Information and Resources as Obstacles to Prepare Latinos to Enroll in January 2014," news release, July 18, 2013.
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91. Jeffrey Passel and Paul Taylor, *Unauthorized Immigrants and Their U.S.-Born Children* (Washington, DC: Pew Research Hispanic Center, 2010), 4.
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97. Chris Megerian, "Jerry Brown Signs Budget that Relies on Voter-Backed Tax Hikes," *Los Angeles Times*, June 28, 2012.
98. California Budget Project, *Governor Signs 2012–13 Spending Plan* (Sacramento: California Budget Project, 2012), 1.
99. Approximately two-thirds of this \$1 billion in savings stems from a plan to move 1.4 million seniors and people with disabilities who receive benefits from both Medicare and Medi-Cal into less costly (for the state) managed care plans.
100. Megerian, "Jerry Brown Signs Budget."
101. Jonah Most, "Latino Care at Risk with End to Healthy Families," *New America Media*, June 27, 2012.
102. Most, "Latino Care at Risk."
103. California Budget Project, *Final 2013–14 Budget Agreement*, 1.
104. Mark DiCamillo and Mervin Field, "Greater than Seven in Ten Continue to Describe California's Economy as Being in Bad Times," *The Field Poll*, no. 2477, March 1, 2013; Greenberg Quinlan Rosner Research, "New University of Southern California Dornsife College of Letters, Arts and Sciences/Los Angeles Times Poll," June 5, 2013.
105. Laura Lucia et al., *After Millions of Californians Gain Health Coverage Under the Affordable Care Act, Who Will Remain Uninsured?* (Berkeley, CA: UC Berkeley Center for Labor Research and Education; Los Angeles: UCLA Center for Health Policy Research, September 2012), 4.
106. Ibid. National surveys show that a lack of language-appropriate materials hinders Medicaid enrollment among Spanish-speaking parents. Kaiser Commission on Medicaid and the Uninsured, *Medicaid and Children: Overcoming Barriers to Enrollment* (Washington, DC: Kaiser

Commission on Medicaid and the Uninsured, 2000).

107. Lucia et al., *After Millions of Californians Gain Health Coverage*, 8.

108. *Ibid.*, 5. By comparison, Latinos are projected to account for approximately 45 percent of the nonelderly population of California in 2020.

109. *Ibid.*, 11. As the Berkeley/UCLA study shows, this disproportionate outcome can be significantly reduced with massive, coordinated outreach efforts to target communities.

110. *Ibid.*, 13.

111. *Ibid.*

112. Agency for Healthcare Research and Quality, US Department of Health and Human Services, *National Healthcare Disparities Report, 2012*, H2.

113. David Himmelstein et al., "Medical Bankruptcy in the United States, 2007: Results of a National Study," *American Journal of Medicine* 122, no. 8 (2009): 741–46.

114. Centers for Medicare and Medicaid Services, "National Health Expenditure Projections 2011–2021." According to the World Bank, health expenditures accounted for 17.9 percent of the United States GDP in 2011. By comparison, our nearest industrial competitors, the Netherlands and France, spent 12.0 and 11.6 percent, respectively. World Bank, "Health Expenditure, Total (% of GDP)," accessed June 10, 2013.

115. C. Brett Lockard and Michael Wolf, "Occupational Employment Projections to 2020," *Monthly Labor Review* (Bureau of Labor Statistics) 135, no. 1 (January 2012): 84–108.

116. Center for Responsive Politics, "Lobbying: Top Industries," OpenSecrets.org, 2013.

117. Changes in Health Care Financing and Organization, *Findings Brief: In Health Care Spending, Americans Who Make the Least Contribute the Greatest Share of Income* (Robert Wood Johnson Foundation, October 2012).

118. For hospitalization and neonatal care, see Mary Lindholm et al., "Professional Language Interpretation and Inpatient Length of Stay and Readmission Rates," *Journal of General Internal Medicine* 27, no. 10 (2012): 1294–99; Francesca Miquel-Verges, Pamela K. Donohue, and Renee D. Boss, "Discharge of Infants from NICU to Latino Families with Limited English Proficiency," *Journal of Immigrant and Minority Health* 13, no. 2 (2011): 309–14. For emergency room miscommunication, see Flores et al., "Errors of Medical Interpretation and Their Potential Clinical Consequences." Language barriers extend to homecare treatment as well. A 2012 report in the *Annals of Allergy, Asthma and Immunology*

describes how older people with asthma in the United States have a "tougher time controlling the condition if they have poor English skills." Juan P. Wisnivesky et al., "The Association Between Language Proficiency and Outcomes of Elderly Patients with Asthma," *Annals of Allergy, Asthma and Immunology* 193, no. 3 (2012): 179–84. Another study on the effects of the LEP on hospital length-of-stay and home healthcare referral for children with infections concluded that "among pediatric inpatients with infections requiring long-term antibiotics, a primary caregiver with limited English proficiency was identified as an important independent risk factor for both increased LOS [length of stay] and decreased number of home health care referrals." Michael N. Levas, John D. Cowden, and M. Denise Dowd, "Effects of the Limited English Proficiency of Parents on Hospital Length of Stay and Home Health Care Referral for Their Home Health Care–Eligible Children with Infections," *Archives of Pediatrics and Adolescent Medicine* 165, no. 9 (2011): 831–36.

119. Office of Management and Budget, *Report to Congress*, 3.

120. Elizabeth A. Jacobs, Laura S. Sadowski, and Paul J. Rathouz, "The Impact of an Enhanced Interpreter Service Intervention on Hospital Costs and Patient Satisfaction," *Journal of General Internal Medicine* 22, suppl. 2 (2007): 306–11.

121. The US Department of Justice, in *Title VI Legal Manual*, outlines four factors to be considered when determining what are "reasonable steps" to ensure LEP access to federally assisted programs. "Title VI and its regulations require recipients to take reasonable steps to ensure 'meaningful' access to the information and services they provide. What constitutes reasonable steps to ensure meaningful access will be contingent on a number of factors. Among the factors to be considered are the number or proportion of LEP persons in the eligible service population, the frequency with which LEP individuals come in contact with the program, the importance of the service provided by the program, and the resources available to the recipient."

122. National Health Law Program, *Language Access in Health Care: Statement of Principles*, 23.

123. *Ibid.*

124. *Ibid.*, 2.

125. U.S. Department of Justice, *Title VI Legal Manual*.

126. Phillip M. Guerty, "Human Rights," *Organization of American Historians Magazine of History* 22, no. 2 (2008): 3.

127. Universal Declaration of Human Rights, Article 25(1), emphasis added. Eleanor Roosevelt was the US representative on the drafting committee and the driving force for the document's adoption, as noted on the UN's website (www.un.org). The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (preamble to the Constitution of the World Health Organization, 1948). The WHO also measures health as the "extent to which an individual or group is able . . . to realise aspirations and satisfy needs [and] to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living; it is a positive concept emphasising social and personal resources as well as physical capacities." World Health Organization, *Milestones in Health Promotion: Statements from Global Conferences* (Geneva: WHO, 2009). The US Global Health Initiative defines health as "the heart of human progress," indicating that health "determines whether parents can work to support their families, children can attend school, women can survive childbirth, and infants can grow and thrive. Where health services are strong and accessible, families and communities flourish. Where health services are inaccessible, weak, or nonexistent, families suffer, adults die prematurely, and communities unravel." US Global Health Initiative, *United States Government Global Health Initiative Strategy* (Washington, DC: US Global Health Initiative, 2009).

128. Adelaida Castillo's theory of "social citizenship" is also relevant. Castillo and other internationally minded human rights advocates directly challenge the belief that legal citizenship, or nationhood, is vital to the practice of full rights. They instead suggest a prioritization of "social" citizenship in which basic social entitlements, including health care, are deemed legal birthrights. Adelaida Castillo, "Illegal Status and Social Citizenship: Thoughts on Mexican Immigrants in a Postnational World," *Aztlan: A Journal of Chicano Studies* 27, no. 2 (2002): 9–32.

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