

Managed Care and Asian Pacific Island Women

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Managed care organizations clearly have the potential to affect the health status of a defined population and the ability to account for their efforts through measures of quality and desired outcomes.¹ However, the need for linguistically appropriate and culturally competent care by an increasingly diverse American population presents a major challenge to this assumption.

According to the US Census, the Asian Pacific Island (API) population has experienced the greatest percentage increase among all minority groups in the United States.² Much of this growth is the result of immigration, even though most Pacific Islanders in the United States were born here.³ The API population is very heterogeneous and includes people from more than 50 Asian countries and Pacific Islander groups. Any examination of API health issues must also recognize the limitations inherent in currently available data, which pool information on these diverse subgroups, each of which has distinct language(s), culture, and history. API census data also indicate that more than a third (35%) are linguistically isolated and living in households where no one over the age of 14 speaks English very well.²

Current assessments of health system preparedness for diverse populations indicate that there is much work to be done. The National Public Health and Hospital Institute (NPHHI) has conducted a survey of interpreter services in public and private teaching hospitals around the United States. Survey results reflect the impact of increased diversity in the American population. One-third of respondents reported the need for interpreter services for an average of 27% of their patients. However, only 11% had a policy for recruiting bilingual staff, and less than one-quarter had any staff

training programs for interpretation services. The survey also found institutional variability in organization of interpretation services, and only 36% of respondents conducted any evaluation of their quality.⁴

Providers of health services for non-English speaking clients are well aware of the impact that linguistic barriers can have on care. A growing body of evidence in the medical literature supports the pivotal role of bilingual services in achieving desired outcomes.⁵ Findings from several reports on use of preventive health services by Asian women highlight linguistic and cultural barriers to care. Chen and colleagues conducted a home survey using a modified version of the Centers for Disease Control Behavioral Risk Factor Surveillance System among women in the Chinese community in Oakland, California. Their findings indicate that women who do not speak English fluently are less likely to have had mammograms.⁶ The Korean Health Survey in Los Angeles found that only 29% of women over age 18 had had breast exams within the previous year as compared to 50% of all American women, and only 35% had ever had Pap smears, as compared with half of all women in the United States.⁷ Jenkins and colleagues found that only 17% of Vietnamese refugee women in San Francisco over age 40 had ever had mammograms.⁸

Potential mechanisms to address linguistic and cultural barriers in health care services are provided in the protections of Title VI of the Civil Rights Act of 1964, which apply to programs that receive federal funding. However, a survey of state Medicaid managed care requirements for linguistically appropriate care conducted by the Association of Asian Pacific Community Health Organizations (AAPCHO) found variability in enforcement. The survey also found an absence of uniform guidelines, limited availability of accurate information on the number of enrollees who do not speak English, and lack of data on the

actual costs incurred in providing bilingual services.⁹

Linguistic requirements for Medicaid managed care would be expected to have limited direct impact for API women, since AAPCHO surveys of payer status among women using federally funded community health centers in Asian and Pacific Island communities in New York, California, and Hawaii have found lower use of Medicaid and Medicare than would be expected based on age and income.¹⁰ Nevertheless, policy initiatives are needed to guide industrywide efforts to address access to care for minority populations. Experiences in a health care system with limited capacity for linguistically appropriate and culturally competent care are no doubt the basis for the 1995 Commonwealth Fund national survey findings indicating that Asians were the least likely to be satisfied with the quality of their health care services.¹¹ Further evidence of the need for standards is found in studies that demonstrate the important role of bilingual services in promoting patient satisfaction and achievement of favorable outcomes (H. Burstin, MD, unpublished data, 1996).

Realizing the potential of managed care for API women will require a commitment to linguistically appropriate and culturally competent health care. Cross and colleagues have described culturally competent systems of care as those that value diversity, have the capacity for cultural self-assessment, recognize the dynamics inherent when cultures interact, have an institutionalized cultural knowledge, and develop adaptations to diversity.¹² Many models exist for these efforts, most notably the federally funded community health centers serving API and other communities nationwide. Service delivery in these facilities is based on community participation in needs assessment and program planning as well as in implementation and evaluation. Those providing services to women in API communities would be well advised to seek out these community-based facilities for guidance and partnership

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in their endeavors. Outcome measures must be based on indicators and methodology reflecting needs specific to the population,¹³ as do current efforts by NPHHI to assess cultural competence of health care institutions (D. Andrulis, PhD, written communication, 1996). Enhanced knowledge of factors influencing health-seeking behaviors of API women, currently under investigation by AAPCHO in conjunction with the Robert Wood Johnson and Henry J. Kaiser Family Foundations, will improve our ability to provide services that meet their special needs and increase the utility of assessments for quality and outcome (S. Jiang, MSW, written communication, 1996). ■

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