February 18, 2011

Nicole Patterson,
Office of Shortage Designation
Bureau of Health Professions
Health Resources and Services Administration
Room 9A–18
Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857

Re: Medically Underserved Populations: Race, Culture and Language as the Largest Barriers to Access

Dear Ms. Patterson:

The National Asian Pacific American Women’s Forum (NAPAWF) and the National Latina Institute for Reproductive Health (NLIRH) are pleased to submit these joint comments to you on the Negotiated Rulemaking process for medically underserved populations. NAPAWF is the only national, multi-issue Asian/Pacific Islander (API) women's organization in the country. Our mission is to build a movement to advance social justice and human rights for API women and girls. NLIRH works to ensure the fundamental human right to reproductive health for Latinas, their families and their communities. Our organizations represent communities that have a shared need for access to quality health care.

Successfully reforming health care requires putting patients first and improving how their care is delivered. This is particularly important for low health literacy, immigrant and limited English proficient populations such as API and Latina women.

We applaud and strongly support your initiative to create a comprehensive methodology and criteria for the (MUP/PSA), using a Negotiated Rulemaking (NR) process. As organizations that represent drastically underserved populations, we strongly recommend that solutions for addressing race, culture and language as barriers to access be central to each deliberation the committee undertakes.

It is critically important that the methodology that is used to identify a community as being a medically underserved population consider the disproportionate barriers that some communities experience. For the API and Latina community, immigration status, cultural, racial and linguistic
barriers, and lack of health insurance have severely impacted health outcomes and led to significant health disparities of preventable diseases. Thus, when the Negotiated Rulemaking Committee considers the methodology and criteria for Designation of Medically Underserved Populations and Primary Care Health Professional Shortage areas, we ask that the Committee consider the following:

1. **Include limited English-proficiency (LEP) and immigration status variables** in the development of the next iteration of the Index of Medical Underservice (Index)

   Immigrant status and Limited-English Proficiency (LEP) factors are highly correlated with higher rates of poverty, lack of insurance and unmet health needs.

   Asian Americans, Native Hawaiians and Pacific Islanders speak more than 100 different languages. Data from the Census Bureau’s American Community Survey reveal that more than 8 million people in the United States speak Asian and Pacific Island languages at home and more than 4 million of them are considered “limited English proficient,” meaning they speak English less than “very well” or not at all. Struggles with English can cause significant communication difficulties in health care settings.

   These struggles with linguistic access are mirrored in the Latina community where language and immigration status is a continual barrier to quality health care, which contributes significantly to health disparities in our communities. These difficulties result in patients who are unable to fully communicate the extent of their health issues and must rely on family members and friends who must often interpret confidential and private health information on behalf of an LEP patient. It also results in unnecessary follow up visits due to misunderstanding a health provider’s original instructions, and medical errors that sometimes lead to fatalities. Immigration status and language barriers greatly affect API and Latina women’s ability to seek health care, often resulting in delayed care, inability to seek preventive services, or inadequate care.

2. **Include an uninsured status variable** in the Index. Other variables, such as low-income status and employment, are valid indicators of need but are not accurate proxies for insurance status because a large proportion of the uninsured are employed. Furthermore, many low-income people have insurance coverage through Medicaid.

   Many API and Latina women work in small business and industries where health insurance is unaffordable but they are not able to participate in the Medicaid program. The Korean American community has the highest rate of uninsured individuals of any racial or ethnic group and 37% of Latinas are uninsured, compared to 16% of non-Hispanic white women. This lack of health insurance creates barriers to access to health services that would otherwise allow API and Latina women to obtain necessary medical care. For example, API women experience disproportionately high rates of Hepatitis B virus while Latinos had the highest incidence of Hepatitis A among all ethnic groups in

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2007. Many of these individuals are unaware of their health status or increased risks for these diseases and are left untreated due to lack of insurance.

3. **Include a wider range of health status variables** in order to address disparities in health status and other preventable health conditions.

APIs and Latinas are significantly less likely than non-Hispanic whites to receive recommended levels of screening, counseling, or care and face additional barriers that reduce accessibility of important health programs and services. As a result, APIs and Latinas are at increased risk for diseases that are preventable. Studies have found that diabetes is the fourth leading cause of death for API females. In addition, although less likely to have heart disease, Latinos are more likely to die of it than non-Hispanic whites due to late detection and inadequate treatment. Latinos are also 1.6 times more likely to die of diabetes as whites. While many factors contribute to the high rates of preventable diseases among these individuals, including lack of culturally and linguistically appropriate services, the lack of health insurance and knowledge about preventive care within API and Latina communities push available services out of reach.

4. **Support the development of a process to recognize racial minority communities as Medically Underserved Populations.** Our understanding is that the current methodology for identifying Medically Underserved Populations fails to fully capture the needs of racial and ethnic minorities. This may result from the fact that although these communities are clearly medically underserved, they are disadvantaged by data availability, data quality issues, or the methodology used to calculate a needs score. We strongly urge the Health Resources and Services Administration to re-evaluate and revise its methodology to enable it to properly identify racial and ethnic minority communities as medically underserved populations.

Lack of disaggregated scientific data on API and Latina subgroups continues to result in adverse health outcomes for our communities. The little research that does exist on API and Latino communities demonstrate unacceptably high health disparities that are often the result of the failure of medical communities to provide linguistically and culturally competent services, recognize the need to test and treat for certain preventable diseases, or otherwise make their services affordable and accessible for low-income and LEP individuals. For example, although cervical cancer rates have fallen for all major racial groups, rates for API women continue to rise, with Vietnamese American women seeing cervical cancer rates that are five times higher than that of non-Hispanic white women.

Elsewhere within the implementation of PPACA, we are advocating that data collection practices must disaggregate by ethnicity and subpopulations and include appropriate standardized measures, indicators, and methods for collecting and reporting data to learn

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3 Office of Minority Health Hepatitis http://minorityhealth.hhs.gov
4 National Center for Health Statistics, 1999
more about health care access, quality and outcomes by patient demographic factors, including race and ethnicity, age, gender, primary language, socio-economic position, geographic location, and health literacy. This data is crucial for API and Latino populations in order to monitor, prevent, treat and support the recovery and wellness of these groups in terms of substance abuse and mental health issues. However, recognizing the difficulties and delays that exist in implementing such data acquisition, methods should account for these flaws and a systemic approach to utilizing information that demonstrates these disparities should be used to timely address these concerns. These methods should be flexible to recognize status indicators that are based on national priorities, such as those outlined in Healthy People 2020.

5. **Ensure That Any Proposed Designation Method is Transparent, Easily Understandable, and uses Easily Available Data**

The PPACA states that “the degree of ease or difficulty that will face potential applicants for such designations in securing the necessary data” should be taken into account. Communities that are truly medically underserved must be able to demonstrate their status without significant burdens. Any method must have a scientific-basis, but be easily understandable and use easily available data to avoid already strapped communities from being forced to rely heavily on expensive consultants and “experts” to demonstrate their underserved status.

In conclusion, NAPAWF and NLIRH appreciate the opportunity to comment on the development of methodology and criteria for the Designation of Medically Underserved Populations and Primary Care Health Professional Shortage Areas.

Thank you for your consideration of these comments.

Sincerely,

Miriam W. Yeung  
Executive Director  
National Asian Pacific American Women’s Forum

Silvia Henriquez  
Executive Director  
National Latina Institute for Reproductive Health