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ASSESSING BARRIERS TO HEALTH CARE SERVICES FOR HISPANIC RESIDENTS IN RURAL GEORGIA*

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ABSTRACT

Since the 1990s, many Hispanics have been relocating to the rural South and their permanency (although beneficial to the economy) poses new challenges at the institutional level. One area of major concern is the adequate provision of health care. Our article evaluates the socioeconomic, cultural, and geographic/transportation barriers that Hispanic residents face when seeking primary health care services in Toombs County, Georgia. Data were acquired through personal interviews with Hispanic residents, local health professionals, and key community informants by using a combination of opportunity sampling and a snowball approach. Results indicate that the local health system and the county as a whole have not yet fully adapted to the health needs of Hispanic migrants. There was a consensus among all respondents that language and communication issues were the primary barriers to accessing health care.

Hispanics are the largest minority group in the United States, in 2010 numbering more than 50 million people and accounting for 16.3 percent of the total population (U.S. Census Bureau 2010). Before the 1980s the major Hispanic settlement areas were Texas, California, and New York. During the 1980s, Hispanic settlement patterns moved from Texas to the Midwest and in the 1990s migration and settlement patterns shifted away from the traditional areas to the Southeast (Saenz et al. 2003). Indeed, many Hispanics are relocating in the rural South, especially in Alabama, North Carolina, South Carolina, and Georgia, where a combination of rural industrialization and employment opportunities on farms and in forests have provided ample work and economic opportunities (McDaniel and Casanova 2003; Torres 2000). Hispanic immigration is no longer a temporary borderlands issue, with many Hispanic immigrants coming to the United States to stay and seek permanent rather than seasonal employment. Once established, the Hispanic population significantly influences local socioeconomic well-being by

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contributing workers to, and expanding the consumer base for, local businesses. On the other hand, a rapidly increased Hispanic population poses new challenges and financial costs at the institutional level, notably in schools and in health care (Erwin 2003; Torres 2000).

In this paper, we focus attention on health care. The primary purpose of this study was to examine barriers to access to primary health care services faced by Hispanic residents (including migrant workers) in the rural South. We report on a qualitative case study based on interviews with Hispanic residents and medical professionals in Toombs County, Georgia. We examine issues of access to primary health care using the five dimensions of access identified by Penchansky and Thomas (1981), which are:

1. Availability – the relationship between the volume and type of existing services compared with client needs
2. Accessibility – the relationship between the location of supply and the location of clients, taking account of client transportation resources and travel time, distance, and cost
3. Affordability – the relationship between the cost of health services and the clients' income, ability to pay, and existing health insurance
4. Accommodation – the relationship between the manner in which health services are provided and both clients' ability to accommodate those factors and the clients' perception of their cultural appropriateness
5. Acceptability – the relationship between clients' attitudes about personal and practice characteristics of providers and the actual characteristics of existing providers, as well as provider attitudes about acceptable personal characteristics of clients.

Hartley (2004) argued that the traditional approach to understanding rural health disparities, which focuses on questions of access, needs to be expanded to include cultural dimensions of health. In this paper we examine questions of both access and cultural factors that affect the broad definition of access adopted here. The limited existing research on rural health among Hispanic populations in the United States has identified both structural and cultural obstacles affecting access to primary health care. These include low rates of health insurance coverage, limited income levels, linguistic and cultural differences, and a lack of private means of transportation (Casey, Blewett, and Call 2004). Primary care physicians, in particular, are scarce in rural counties. As the point of entry into the health care

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system, primary care physicians can reduce health disparities among the poorest and most underserved populations by addressing most personal basic health needs and by coordinating patients' specialist care (Blumenthal, Mort, and Edwards 1995). Provision of primary care services could be a central means of improving Hispanics' overall health status and enhancing their constructive participation in the local communities.

We first describe Toombs County, Georgia, the economy of which is based on farming and forestry. We then describe our research methodology. Our research findings are organized along the five dimensions of health care access described above. We conclude by discussing political and policy debates surrounding immigration and health care and the prospects for improving access to health care by Hispanic residents of the rural South.

THE STUDY REGION

Toombs County is located 185 miles from Atlanta, in the heart of southeast Georgia, and has been chosen as the study area because its Hispanic immigration pattern well resembles the relocating process of Hispanics in the southern states, which principally concentrates around agricultural and forestry jobs, as well as meat processing plants. In particular, Toombs County well represents the small, agricultural counties found in the rural south of Georgia, where an almost constant demand for seasonal and permanent agricultural workers in the last 10–15 years has fueled a remarkable increase in Hispanic residents. Initially attracted by farmers growing the regionally-famous Vidalia onion and other row crops, Hispanic workers have branched out to work in pine straw raking and other forest-based enterprises (Casanova 2007). In 1990, the total Hispanic population of Toombs County numbered 824, representing 3 percent of the county total (U.S. Census Bureau 1990). By 2000, the Hispanic population had grown to 2,310, 8.9 percent of the total (U.S. Census Bureau 2000). The growth continued over the next decade to 3,055, representing more than 11 percent of the total county population by 2010 (U.S. Census Bureau 2010). Most (89 percent) of the Hispanic population of Toombs County in 2010 were of Mexican origin. Between 1990 and 2010, Toombs County grew a total of 13 percent and Hispanics accounted for more than 70% of that figure.

The non-Hispanic population of Toombs County includes whites (two-thirds of the total population) and African Americans (one quarter of the population; U.S. Census Bureau 2010). Among the many demographic characteristics that distinguish Hispanics from other residents of Toombs County is median age. The

median age of male Hispanic residents in 2010 was 26.6 years, compared with 30.7 and 40.8 for African American and white men, respectively. Among women, median ages of Hispanics, African Americans, and whites were 14.3, 34.2, and 43.7 years, respectively. These median ages reflect a population of recent migrants dominated by younger male workers and relatively few adult women.

The growth in the Hispanic population reflects high demand for their abilities as workers, but they are still struggling to fit into the local social system. Key informants underlined how Hispanics' living conditions are made complicated by many economic impediments and socio-cultural barriers that undermine their full participation within the community. Mostly employed in minimum wage jobs with no insurance benefits, lacking in English proficiency, and often facing undocumented immigration status, the Hispanic population are often socially isolated, and unable to appropriately take advantage of local educational, social, and economic opportunities. This isolation contributes to inadequate access to social services and, more significantly, limits the Hispanics' access to health care services. Health professionals in Toombs County reported that cardiovascular diseases, diabetes, hypertension, tuberculosis, and cancer are the primary health problems affecting Hispanics. Alcoholism and domestic violence are other major health-related concerns among this population. Hispanics are also likely to experience health problems related to the hazardous and unhealthy working conditions of their agricultural jobs, such as physical injuries, allergies, respiratory diseases, skin rashes, and exposure to toxic chemicals. Finally, since many migrant workers have decided to settle in the area, living in trailers and sharing the location with several other persons, residential overcrowding is one of the major risk factors for the spread of numerous contagious diseases (principally tuberculosis) among the local Hispanic community. Data on health insurance coverage for Hispanic residents of Toombs County are not available, but for Georgia as a whole, nearly half (48.7 percent) are reported to be without health insurance (U.S. Census Bureau 2009).

METHODOLOGY

Toombs County was selected not only because it represents many rural southern counties with a growing Hispanic population, but also because of an existing working relationship with leaders and staff of the Southeast Georgia Communities Project (SEGCP), a non-governmental organization that works with Hispanic residents in Toombs County. The leaders and staff of the organization served as key informants, providing valuable insights and contacts within the county.

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Primary data were collected during the spring of 2006 through personal semi-structured interviews with permanent Hispanic residents as well as migrant workers. Local health professionals in Toombs County were also interviewed. These interviews were conducted using interview guides framed around broad questions focusing on social, cultural, and organizational barriers to primary health care services, as well as data regarding utilization of primary services and preventive care. A total of 40 face-to-face semi-structured interviews (comprising both open and closed-ended questions) were conducted with local Hispanic residents using a combination of opportunity sampling and a snowball approach. Respondents also had the opportunity to expand on subjects of particular interest to them. Because many respondents were migrants whose legal status was a matter of concern, we decided to carry out anonymous interviews. Guaranteeing confidentiality considerably eased the interviewing process and avoided making Hispanics feel threatened and less predisposed to participate. For the same reasons, we chose not to use recording devices during the interviews. Even so, several potential respondents refused to be approached and sometimes the answers provided, especially those ones concerning delicate topics (such as medical debts and reported mistreatment while seeking health care) might have been influenced by distrust and apprehension.

Most interviews took place in local commercial establishments, such as the local Wal-Mart in Vidalia or in one of several Hispanic grocery stores in downtown Lyon. These places are the few public places that Hispanics frequent, other than the Catholic Church and local laundries. These interviews in turn led to other interviews, which took place in a trailer park in Lyons, where most of the county Hispanic population resides. After being properly instructed, SEGCP's staff directly interviewed 16 of the 40 total Hispanic respondents (by using an interview guide developed by both authors), either when they were waiting in medical professionals' offices or when they were in the SEGCP's facility. The remaining 24 interviews were conducted by the lead author. Most interviews were conducted in Spanish. Interviewing local Hispanics in Spanish was absolutely necessary due to their limited English proficiency. Communicating in Spanish served to make respondents more comfortable. The fact that the lead author is not an American citizen significantly contributed to the willingness of respondents to be interviewed and share their experiences.

Local key informants and five medical professionals employed at local public health facilities were the second source of primary information. These individuals were interviewed by the lead author through semi-structured interviews to acquire

their professional opinions concerning the most relevant access barriers to health services and the most appropriate solutions that the local health system could adopt. The professionals interviewed are employed at the Vidalia Hospital emergency room, the county health department in Lyons, and the Community Health Center in Reidsville, Tattnall County.

No specialized software was used in recording data. Typically, at the end of each day, more detailed notes were developed based on field notes taken during the day (notes were written in Microsoft Word). Data were organized around the previously-mentioned five themes related to health care access. The relatively small sample size allowed for simple counting of responses. Quotations were written verbatim at the time and were retrieved from the data file by searching under the relevant theme.

Sample Characteristics

Consistent with census statistics, Mexico was the country of origin of 82.5 percent of the respondents, while the residual 17.5 percent of the participants reported having been born in United States, (generally in Texas or Florida). The Hispanics we interviewed correctly reflected the young age of this population as well. The largest respondent age group was in fact constituted by those Hispanics who are between the ages of 25 and 29 (25 percent), and the two adjacent age groups (18-24, 20 percent; 30-34, 20 percent) were the next two largest groups. Together, these three age groups comprised 65 percent of all participants, while only 2.5 percent of the sample was older than 50 years old. However, the participants did not reflect the gender composition of the local Hispanic community, which was predominantly male. Most of the Hispanic respondents were women, representing 67.5 percent of the total sample (Table 1). This imbalance was partly the consequence of the greater mistrust demonstrated by Hispanic men, who were often more reluctant than women to be approached. One logical explanation might relate to their common undocumented status, and the consequent fear of males to jeopardize their traditional role as the main financial providers of their families.

In addition, due to their expected homemaking role and more frequent unemployed status, during the fieldwork stage it was more common to find women at home and interview them. As a result, women were the largest and the most valuable source of information. They normally showed a greater openness and propensity to discuss their economic conditions and personal health concerns, even more so when asked about the health of their children. Most of the

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TABLE 1. SAMPLE CHARACTERISTICS

AGE GROUP	MALE	FEMALE	TOTAL	PERCENT
18–24.	2	6	8	20.0
25–29.	2	8	10	25.0
30–34.	1	7	8	20.0
35–39.	4	3	7	17.5
40–44.	3	1	4	10.0
45–49.	1	1	2	5.0
>50.	0	1	1	2.5
TOTAL.	13	27	40	100.0
MARITAL STATUS				
Married.	11	20	31	77.5
Cohabiting.	0	6	6	15.0
Single.	2	0	2	5.0
Divorced.	0	1	1	2.5
TOTAL.	13	27	40	100.0

respondents were farm workers, mostly crop harvesters (40 percent), while other 10 percent of them reported being employed as poultry plant workers and carpenters. Other occupations were clothing factory workers, mechanics, cooks, waiters, crew-leaders, and truck-drivers (Table 2). An additional 20 percent of the participants reported being unemployed (all of them were women). Since answers regarding their immigration status have been intentionally avoided, establishing the number of respondents who were legal residents is not possible. However, it is likely that a significant number were undocumented.

Primary data were collected in 2006, before what has become known as the Great Recession, a time of economic downturn that news media report led to a decline in Hispanic migration. Nonetheless, data from the 2010 Census Bureau shows that the Hispanic population in Toombs County continued to grow during this period. Based on follow-up conversations with leaders of the SEGCP, we are confident that findings of our research remain relevant to conditions found in Toombs County, and many other rural southern counties.

TABLE 2. HISPANIC RESPONDENTS BY EMPLOYMENT

JOB/OCCUPATION	MEN	WOMEN	TOTAL	PERCENT
Pine-straw harvester.	4	4	8	20.0
Onion harvester.	1	7	8	20.0
Unemployed.	0	8	8	20.0
Poultry plant worker.	0	2	2	5.0
Carpenter.	2	0	2	5.0
Cook.	1	0	1	2.5
Air conditioner installer.	1	0	1	2.5
Mechanic.	1	0	1	2.5
Food server.	0	1	1	2.5
Construction.	1	0	1	2.5
Data entry.	0	1	1	2.5
Crew leader.	1	0	1	2.5
Clothing factory worker.	0	1	1	2.5
Truck driver.	1	0	1	2.5
Other.	0	3	3	7.5
TOTAL.	13	27	40	100.0

RESULTS

In this section we examine barriers faced by Hispanics residing and working in Toombs County when seeking primary health care services. We use the framework of five dimensions that define access to health care established by Penchansky and Thomas (1981), namely: availability, accessibility, affordability, accommodation, and acceptability.

Availability: Shortage of Primary Care Services

As is true in many other southern rural areas, local health facilities and personnel in Toombs County face a persistent shortage of primary care services and physicians. Since 1978, Toombs County has been designated as both a Medically Underserved Area and a Health Professional Shortage Area due to the shortage of

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primary care and mental health providers as determined by the U.S. Department of Health and Human Services (HRSA 2012). Presently, Toombs County's IMU (Index of Medical Under-service) score is 50.7, where 0 represents completely underserved and 100 represents best served or least underserved. Under the established criteria, each service area found to have an IMU of 62.0 or less is considered medically underserved. For Health Professional Shortage Areas (HPSA), scores range from 1 to 25; and the higher the score, the greater the shortage. Toombs County's current score is 15 (HRSA 2011).

During interviews, both Hispanic residents and health professionals reported that lack of qualified medical interpreters, bilingual staff, and Hispanic nurses or other health professionals were among the most significant health access barriers for the local Hispanic community. Additional primary health care facilities (especially patient clinics) were also identified as a need because they would reduce the great number of visits to the emergency room at the Vidalia Hospital, which many Hispanic residents have used because they had no primary health care provider. Other identified needs included mental health professionals and additional dialysis and detoxification centers to better serve patients affected by diabetes or in need of blood filtering to treat drug and alcohol abuse. The local hospital could stabilize alcohol abusers' conditions, but was unable to provide specific treatments, and patients were sent for treatment to health facilities in the surrounding counties. All medical professionals and informants interviewed considered diabetes, alcoholism, and domestic violence to have been the Hispanic health-related concerns that were least-adequately addressed. Since the local health system already faced persistent physician shortages, an overloaded hospital, many uninsured residents, and limited availability of financial resources, it was only partially able to meet the special needs brought by Hispanic patients and was often unable to deal with their primary health issues. Frequently uninsured and undocumented, Hispanic diabetic patients were in fact more seriously affected by the scarcity of dialysis centers, and encountered greater difficulties than the rest of the population in obtaining proper and rapid treatment in the area. This problem was made worse by the absence of bilingual mental health professionals. In the same way, the scarcity of adequate family services able to serve women who were victims of domestic abuse was an important issue for Hispanic women whose undocumented status did not allow them to sue their husbands/partners, and whose lack of English proficiency did not permit them to obtain professional help. Key informants indicated the existence in the local area of just one safe shelter for abused women called 'The Refuge – El Refugio'.

Accessibility: Geographic and Transportation Barriers

When lack of transportation and poverty are compounded by geographic distances and longer travel-time, obtaining health care becomes an even more critical problem. Spatial accessibility affects the likelihood that people in need can access the healthcare system (Guagliardo 2004); and geographical barriers to health care often interact with barriers based on income, race, and ethnicity and lead to complex patterns of disadvantage (McLafferty 2003; Wang and Luo 2005).

Physical access to health care services was seen as a serious constraint to Hispanic residents of Toombs County, where there was no public transportation system. As a result, Hispanic and other residents relied on private transportation to reach hospitals, clinics, or doctors' offices. The 2008-2010 American Community Survey 3-Year Estimates for Toombs County show that 8.7 percent of all households had no available vehicle (U.S. Census Bureau 2008-2010). In 2000 this figure was 10.3 percent, but was nearly double (19 percent) for Hispanics (U.S. Census Bureau 2000). Among our respondents, however, almost one-third (32.5 percent) reported that they did not have their own vehicle. Limited access to private transportation was related in part to low incomes, but may sometimes have been due to the undocumented immigration status of some Hispanic residents.

Many Hispanic residents live in the rural southern census blocks of the county, far from the town of Vidalia, in the northern part of the county (Figure 1). Since both the hospital and most of the local private physicians are in Vidalia, Hispanics are at a geographic disadvantage in seeking health care. Besides the health care facilities in Vidalia, the county health department has an office in Lyons, also in the northern half of the county. Beyond Vidalia and Lyons, Hispanic residents of Toombs County also reported having traveled to towns in three surrounding counties (Treutlen, Emanuel, and Tattnall) to receive health care (Figure 2). On average, Hispanic residents living in the south of Toombs County reported having to travel 22 miles to get to a health center.

As defined by the Institute of Medicine, a primary health care facility in a rural area must be within close physical proximity, such as a 30-minute drive, to be considered geographically accessible (NCPC 2003). However, 45 percent of our Hispanic respondents reported having to drive more than 30 minutes to get to their usual source of care, and 50 percent considered it 'very difficult' or 'difficult' to reach those local health facilities.

When compared with all Hispanics living in Toombs County, those who live in the southernmost census tract represented the lowest median family and per capita

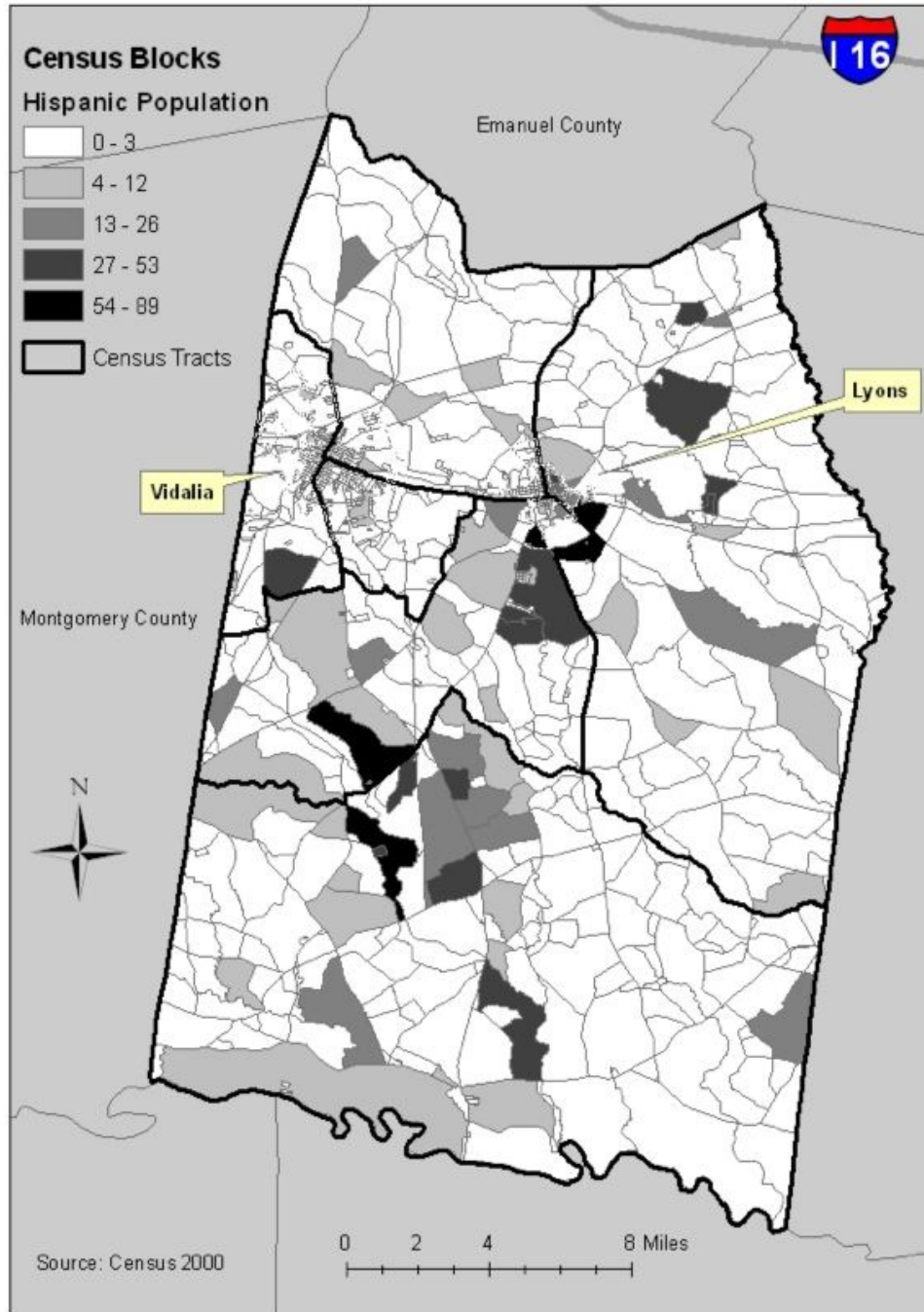


FIGURE 1. HISPANIC POPULATION IN TOOMBS COUNTY, GA BY CENSUS BLOCKS

incomes (U.S. Census Bureau 2000). They were also the families with the highest number of children less than five years old, a particularly vulnerable population that typically requires frequent and special health support. Therefore, Hispanics in the southern rural areas of Toombs County are simultaneously those who most need

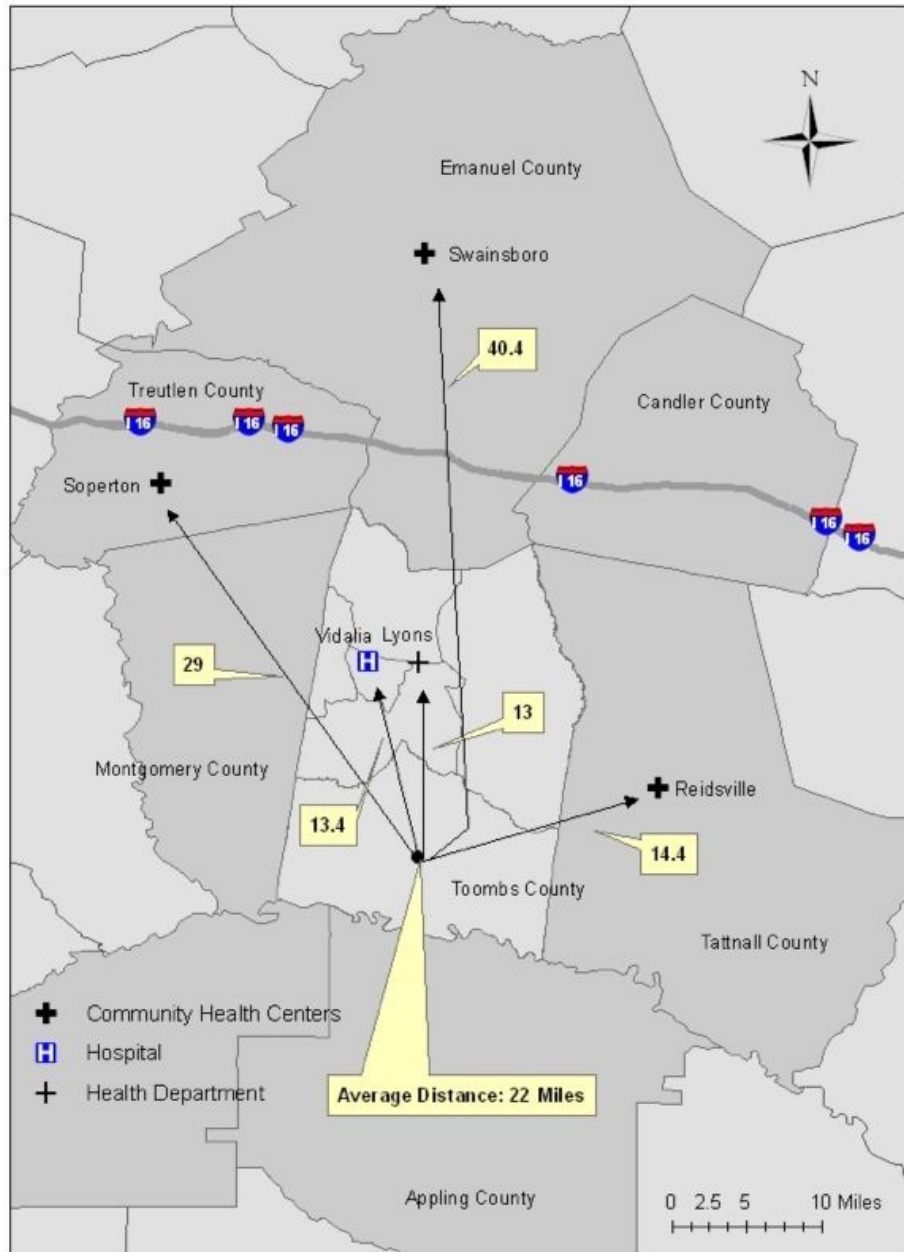


FIGURE 2. DISTANCE TO HEALTH FACILITIES FORM THE SOUTHERNMOST TRACT (TOOMBS COUNTY, GA)

primary health assistance and those who resided furthest from their usual sources of care.

Hispanics without access to their own vehicles were forced to rely on taxi services; rides provided by relatives, friends, and neighbors; car sharing, and employer-provided busing. One in eight (12.5 percent) indicated that they used a

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taxi as their common means of reaching a health care facility. Sometimes, this might represent an unaffordable and prohibitive cost. As one Hispanic mother said: “I pay \$40 just for a one-way trip... [Therefore] sometimes, I do not go to visit the doctor because I do not have enough money for the taxi.”

Asking for a ride from family members and friends might also be complicated because many Hispanics reported being afraid to drive into town where the doctors’ offices, clinics, and hospitals were located, especially if they were undocumented and did not have a valid driver’s license. Local informants reported that being taken into custody and having to pay fines up to \$800 for driving without valid documentation is common for local Hispanics. One Hispanic resident said: “People are afraid of helping each other...since they are illegal and do not have valid driver’s licenses.”

Current licensing regulations in Georgia make it almost impossible for Hispanic immigrants without documentation to obtain a driver’s license. Licensing might be complex even for documented Hispanics, who might find it difficult to provide proof of identification as many came from rural or poor backgrounds and never had their births recorded. In addition, proof of local residency is difficult to establish since many Hispanics live with friends or relatives and do not have utility bills or leases in their name. As a result, many Hispanics drive without licenses (Atiles and Bohon 2002). Key informants indicated that, in Toombs County, local law enforcement officials were becoming increasingly sensitive to the problems of local Hispanic residents and that Hispanic police officers were helping minimize problems for legal residents, but that the problems faced by undocumented Hispanic residents remain.

Affordability: Economic and Insurance Barriers

The most potent economic determinant of health is individual income, which limits physical access to health care as well as the affordability of the services themselves. Five-year estimates (2006-2010) from the American Community Survey indicate that 44 percent of the Hispanic population of Toombs County had incomes below the poverty level compared with 20 percent and 38 percent for whites and African Americans, respectively (U.S. Census Bureau 2006-2010). Except for Native Americans, Hispanics are the poorest ethnic group in Toombs County. As is true with many other Hispanics who have relocated in the South, Hispanic residents of Toombs County are employed predominantly in the rural secondary labor market and often hold low-wage jobs that do not provide health insurance or survivor benefits. Migrant farm workers who have decided to temporarily reside in Toombs County have faced hard economic conditions. Unable to apply for government insurance plans because of their undocumented status, and mostly employed in low-

waged occupations that do not provide job-based health insurance, Hispanic migrants in Toombs County can rarely afford the weekly or monthly premium payments required to become and remain insured, and tend not to have insurance coverage. Nearly all (87.5 percent) of the Hispanic participants in this study reported that they were uninsured, and those respondents who were insured more commonly reported having an employment-based plan (7.5 percent) than having government health insurance, such as Medicaid (2.5 percent).

Lack of familiarity with the American health care system might be considered another major barrier, since Hispanics are often not used to dealing with a private health care system, and seem not to be culturally predisposed to acquire private health insurance. Local informants pointed out that even those Hispanics who have acquired higher incomes tend not to invest in health insurance, preferring instead to save their money for future unforeseen circumstances. In Latin American countries, the government normally subsidizes the health care system. Therefore, many Hispanic residents do not understand the concept of health insurance, and are reluctant to take advantage of this benefit, even in those circumstances in which their employers offer them an insurance plan (Arroyo and Hernandez 2005).

Without insurance benefits and with low income levels, Hispanics regularly struggle to pay for doctor visits, medicines, and other medical bills. Most of our respondents (82.5 percent) reported that it was 'very difficult' or 'difficult' to pay for basic needs such as shelter, food, and medications. Conditions might be even more difficult when women are unable to work, and therefore cannot contribute to the overall family income. Around 30 percent of the Hispanic women interviewed reported being unemployed, mostly because they were pregnant or had to take care of young children.

Our Hispanic respondents reported that they were generally unable to afford the high cost of health services that they sometimes require. Forty percent of our respondents reported having overdue medical bills. One respondent reported having paid \$500 to clear a debt incurred due to buying medicines. Usually, our respondents said they tried to pay their medical bills in monthly installments, but others reported that they simply do not try to repay medical expenses. One respondent admitted "Many times we [my husband and I] had bills to pay at the Hospital emergency room...they sent us the bills...but we never paid." In such situations, tracing Hispanic patients who are undocumented and do not have a valid Social Security number is nearly impossible. Local public health facilities and hospitals must recoup the cost of unpaid charges in other ways.

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To avoid paying for expensive medications, using drugs that family members or friends brought with them from their original countries, where medications such as antibiotics are easily available, was common for Hispanics. Although the practice is illegal, local informants estimated that at least 15 percent of the Hispanic population regularly purchases medicines coming from Mexico in local stores catering to the Hispanic population. Medical professionals expressed concern that this might complicate medical care, since doctors and nurses may not be able to fully understand what medications or dosages are being used by their patients. Sometimes, Hispanic residents prefer to return to their home-countries to obtain the required services for a significantly lower cost. However, the resulting absence from work might cause the loss of their jobs. As a 25-year-old Hispanic man said: "Once I was really sick...I went to Mexico for curing myself...but when I came back here, I lost my job." In total, 7.5 percent of our Hispanic respondents reported they had lost their jobs due to illness or injury and the consequent absence from work.

Accommodation: Organizational Barriers

Accommodation reflects the extent to which the health care providers organize their medical practices in ways that meet ("accommodate") the clients' constraints and preferences. Of greatest concern are convenient hours of operation, walk-in facilities, telephone services, and appropriate appointment systems (Penchansky and Thomas 1981). In addition, given their specific cultural and linguistic background, accommodations for Hispanic patients require additional arrangements, such as the provision of medical interpreter services, Spanish-speaking health professionals, and Hispanic physicians and nurses. By law, any recipient of federal funds must offer and provide adequate language services to patients with limited English proficiency (Arroyo 2004). Many health care providers in Toombs County are not in compliance because medical interpreters are costly. Usually the role of interpreter was performed by a relative, friend, or at best a staff person in the health care facility, and not by a trained medical interpreter. Similar problems have been reported by Kapur and Escarce (2006). Language barriers compound the difficulties of cultural differences between patients and physicians.

During the fieldwork stage of research, Hispanic participants were asked to describe what accommodation arrangements private by physicians and local public health facilities were most needed. The shortage of medical interpreters was by far the barrier most often mentioned.

Two-thirds of all respondents (67.5 percent) considered the doctors' inability to speak Spanish as their greatest difficulty in obtaining health services. Language

and communication problems seriously limit Hispanic patients' ability to communicate with health care personnel and obtain appropriate care. Few of our respondents spoke any English and many had limited educational backgrounds; only 30 percent completed elementary school and only 15 percent had 12 years of education. Hispanic respondents not only felt unable to communicate with doctors and nurses, but were even afraid for their own children's health because of this. One 37-year-old Mexican woman said: "I am afraid of talking with doctors...it is dangerous...because I do not speak English...and they [the doctors] might misunderstand what illnesses my children have." Hispanic patients reported that they usually brought family members, friends, and neighbors to interpret, or referred to the Southeast Communities Projects that provided free interpretation services. The only alternative was to limit themselves to those few local public health facilities (such as the health department) that during recent years had trained and hired qualified medical interpreters.

Both key informants and local medical professionals agreed that the overall situation has improved, and recognized the existence of a growing understanding of the need for either qualified interpreters or Hispanic doctors. However, they had also underlined the still significant lack of qualified interpreter services and bilingual staff able to appropriately work with physicians and nurses, and reported that the shortage was particularly considerable among local private physicians. Talking about the most significant accommodation barriers to health care for Hispanics, the clinical coordinator of the Southeast Health Community Center in Reidsville, stated:

For Hispanics, the main access barrier is the lack of interpreters...the situation has improved only in the health departments, which deliberately chose to use their funding to get new interpreters...[However], Hospitals do not have full-time certified interpreters and private physicians claim [they] do not have the required resources to hire them...we need more certified medical interpreters and trained bilingual staff for the safety of our patients.

The long waiting time required for getting an appointment was the second most common organizational barrier mentioned by Hispanic respondents. Twenty percent of our participants noted that obtaining a medical appointment is not easy, especially with a private physician. The Institute of Medicine indicates that in a primary health care facility, there must be sufficient capacity to care for acutely ill patients within 1-2 weekdays (NCPC 2003). However, only 37.5 percent of our Hispanic respondents indicated '1 to 3 days' as their usual waiting time to get an appointment, and 27.5 percent of them reported a waiting time longer than one

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week, or in some circumstances even longer than two weeks. Waiting this amount of time until the next available appointment was a special problem for Hispanics because they often sought health care only when it was strictly necessary. When health treatments cannot be delayed any longer, even a one-day waiting time might represent a risk, and in these situations Hispanic patients often turn to the local hospital emergency room.

The third most common accommodation barrier reported by Hispanic residents was the lack of convenient hours of operation. Ten percent of the Hispanic respondents reported that hours of practice were inconvenient, since they were normally limited to weekdays from 8:00 A.M. to 5:00 P.M.. Hispanic workers did not have spare time due to their long daily working-hours, and tended to delay medical treatment because they could not take time off work. They reported that no private doctors and no public health facilities other than hospital emergency rooms provided evening and/or weekend hours of operation.

To understand organizational barriers affecting Hispanics' access to health care, we must include the extent to which local private physicians were willing to recruit new Hispanic patients. Generally, and even more so in rural areas, where they already had many patients to deal with, private physicians were hesitant to accept those patients that required the kind of accommodations required (i.e., qualified interpreters and bilingual staff) by Hispanic patients (Casey et al. 2004). In Georgia, physicians working in private practice were often concerned about uninsured and underserved patients and, in some communities, organized coordinated approaches to providing charity care. However, especially because of the growing influence of managed care plans, private health professionals typically could not offer up-front discounted charges or sliding fees for the services provided (NCPC 2003). The medical professionals we interviewed reported that in Toombs County the overall number of physicians who provide charity care is decreasing. The cofounder and executive director of the Southeast Communities Project explained why private doctors have usually been hesitant to accept Hispanic clients: "Usually, private physicians accept to see Latino patients only if they [Hispanics] bring their own interpreters and pay in cash... otherwise, the doctors send the patients to the health department."

Although some physicians offered charitable care, private physicians generally often considered lack of insurance and communication problems as significant constraints. In fact, local doctors were uncertain that Hispanic patients could pay their medical bills, and usually agreed to see them only when they could prove their ability to pay their medical bills, and provide their own interpreters. Medical

professionals and other informants underlined how the common practice of asking Hispanics to provide their own interpreters might represent a dangerous misconduct able to seriously jeopardize the health of the patients, who might misunderstand their diagnoses and the medical treatments to follow.

Acceptability: Socio-cultural Barriers

Almost one-third (32.3 percent) of Hispanic respondents reported that they had experienced mistreatment in a local health facility. The most common form of mistreatment was ‘negative staff attitudes’ typically experienced in public health facilities. A Hispanic woman said: “It is like they [the doctors] were only serving me because they got paid to do it...and not because they wanted to work with people or even help someone.” Doctors and medical staff were reported to be frustrated by their inability to understand Hispanic patients, who in turn complained that physicians did not have enough patience with them. They stated that they would like to spend more time with doctors and nurses to better understand what illnesses they and their children have, how to correctly follow prescriptions, and which behaviors to avoid. One Hispanic woman said: “They [doctors and nurses] do not have patience...they do not explain us to why and what we have to do.”

The second most common mistreatment was ‘longer waits’ reported by almost 12 percent of our Hispanic participants. Sometimes the long waits at the physician’s office were caused by the need to arrange interpreter services. In a few cases (2.9 percent), Hispanic respondents reported that they were denied medical treatment. In some circumstances, the Hispanics we interviewed considered mistreatment to be discriminatory behavior explicitly related to their different national origin. One woman said: “They [the doctors] do not treat us [Hispanics] in a fair way...it seems that what concerns us is not important...they first take care of the whites, then of the blacks, and only eventually of us.” Another Mexican woman stated: “Many times doctors and nurses had negative attitudes...they do not like Hispanic people.” Another Hispanic mother affirmed: “At the hospital in Vidalia...they [the doctors] do not treat us [Hispanics] in a quick way...Americans and blacks do not like Hispanic people...that’s very clear to me.”

Local informants and medical professionals reported the existence of similar ethnic tensions in Toombs County, and explained that these tensions were mostly caused by the tendency to perceive Hispanics as a population that receives social and health services free. Key informants said that white residents complained that Hispanics do not pay taxes and do not contribute to the local economy, whereas

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African Americans, in their view, are principally afraid of competing with them for employment opportunities as well as the already limited supply of community services and public health programs. These concealed social tensions might assume a concrete discrimination form when Hispanics interact with doctors and nurses, making them more likely than the rest of the population to be treated differently from other patients when accessing health care.

Use of Existing Health Services

Reflecting national trends, in Toombs County, cost and lack of health insurance prevent Hispanics from seeking medical care in private practices. Hispanics are therefore more likely to rely on public health facilities and to use informal methods of care (such as home remedies and over-the-counter medicines), rather than visiting a private doctor. Only 10 percent of the Hispanic respondents considered a private doctor as their usual source of care, while 20 percent reported that they usually use home remedies as their first health treatment. Hispanics were more likely to use those health care facilities where obtaining low-cost health services is easier. Many Hispanic respondents (32.5 percent) indicated that the local emergency room is their usual source of care, while 27.5 percent of them normally go to the county health department or other public health care centers in surrounding counties. In all these facilities, services are provided despite ability to pay. At the Meadows Regional Medical Center Hospital in Vidalia, documented Hispanics are also able to apply for Indigent Care Trust Funds, a program aimed at expanding Medicaid eligibility and services to all uninsured and indigent Georgians. However, respondents reported that these programs do not cover the costs associated with health care for undocumented migrants. Hospitals that treat a 'disproportionate' number of Medicaid and other indigent patients qualify to receive federal Disproportionate Share Hospital (DSH) payments through the Medicaid program, based on the hospital's estimated uncompensated cost of care for the uninsured (NCPC 2003).

When asked about the last time they received any kind of health service, most of our Hispanic respondents (55 percent) said the situation was urgent due to a serious illness or injury. Only 15 percent received health care as part of a regular checkup. Primary services and preventive care are underutilized especially by the Hispanic male population. Pregnancy and motherhood normally push women to contact the health care system more frequently than men. Hispanic mothers are usually in charge of maintaining the home and caring for the education and health of their children, and this traditional role naturally implies a closer relationship

with doctors and other health professionals. One Mexican mother said: “I almost never go to the doctor for myself...If I go...it is only when my children are sick.” The prevalent female composition of the sample surveyed helps to explain why 42.5 percent of the Hispanic respondents received health care in the last six months, a result at least partially unexpected. Indeed, of those who sought health care in the past six months, only one was a male, and nearly one-third (30.7 percent) of the Hispanic male respondents had never received health care while they had resided in Toombs County, compared with only 7.4 percent of all the Hispanic women. More than half of all Hispanic men interviewed (53.8 percent) had never had a general physical checkup, compared with 14.8 percent of the women, and during the past year 84.6 percent of the male respondents had not contacted a private physician, compared with 51.8 percent of the female respondents.

Although gender differences are relevant, our interviews documented the overall tendency of Hispanic residents of Toombs County to employ their limited financial resources only for those circumstances where seeking health care was inevitable. This may partially have been the result of a cultural disinclination to use preventive health care and the lack of familiarity with the American health system, but was mostly related to Hispanics’ economic status. One Hispanic woman clearly described this behavior: “Since going to the doctor is so expensive...most of the times we [my husband and I] try to resist...and we take something...like pills.” Consequently, both medical professionals and key informants pointed out how health treatment procrastination and lack of preventive care significantly contribute to the prevalence of chronic health problems among the local Hispanic community, such as diabetes, obesity, and heart diseases.

Use of Alternative Health Services

Given the obstacles to health care access, it is not surprising that some Hispanic residents of Toombs County avail themselves of health care alternatives. During interviews with Hispanic respondents, key informants, and medical professionals, we learned that both home remedies and folk medicine practices are in common usage not only due to cultural beliefs but also because of the high costs of conventional medications and health services. Local informants and health professionals reported that Hispanics frequently self-medicated by using salt, oil, lemon, eggs, tomatoes, and natural and traditional folk herbs (*hierbas*), which could be easily found in several local Mexican stores. Usually, these methods were used to treat fever, cough, diarrhea, conjunctivitis, vomiting, and stomach pain. Hispanics tended also to believe that penicillin could cure any kind of ailment and there was

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a lucrative local market for obtaining penicillin as an over-the-counter medicine. Twenty percent of the Hispanic participants indicated that they use 'home remedies' as their usual source of care. After the local emergency room, and the health department, 'home remedies' represent the third most common source of health care among Hispanic participants. Where home remedies do not provide relief, local Hispanic residents may call upon a *curandero* (healer) who may use a combination of massage, herbal remedies, and/or spiritual mediation to resolve the health problem (Neff 2002). Three *curanderos* were said to live and work in Toombs County.

Solutions Proposed by Hispanics and Medical Professionals

There was a consensus among all who were interviewed for this study that language and communication issues were the primary barriers to accessing health care (Figures 3 and 4). One solution to this problem would be to hire doctors and other health professionals who are bilingual, including physicians and nurses who are Hispanic. One suggestion made was the creation of a 'Hispanic Health Clinic,' which would employ only Hispanic personnel and provide health services exclusively to Hispanic patients. There was also a consensus that the hospital in Vidalia and private physicians should hire more qualified medical interpreters and bilingual staffs, to improve the safety of Hispanic patients, facilitate their recruitment, and reduce language barriers. There are currently no specific programs aimed at training qualified medical interpreters in Toombs County. Medical professionals highlighted the need for training programs to be offered at the county level, which could prepare qualified medical interpreters to be hired by local physicians and public health facilities. In particular, hiring bilingual mental health providers was seen as representing a vital priority since there are currently no bilingual mental health doctors practicing in Toombs County. Psychiatrists and psychologists able to speak in Spanish are required to address mental health issues that affect the local Hispanic community, as well as alcohol and drug abuse, domestic violence, juvenile delinquency, stress, anxiety, and depression.

The high cost of health care was the second most important barrier to effective access affecting Hispanic residents of Toombs County. Suggestions to address this issue by Hispanic respondents included an easier process to obtain Medicaid or the availability of affordable private health insurance plans. Under current federal law, however, undocumented migrants are not eligible for Medicaid, except for defined medical emergencies (Edwards 2010). Because most Hispanic migrants are relatively young, the cost of health insurance should be lower than for the general

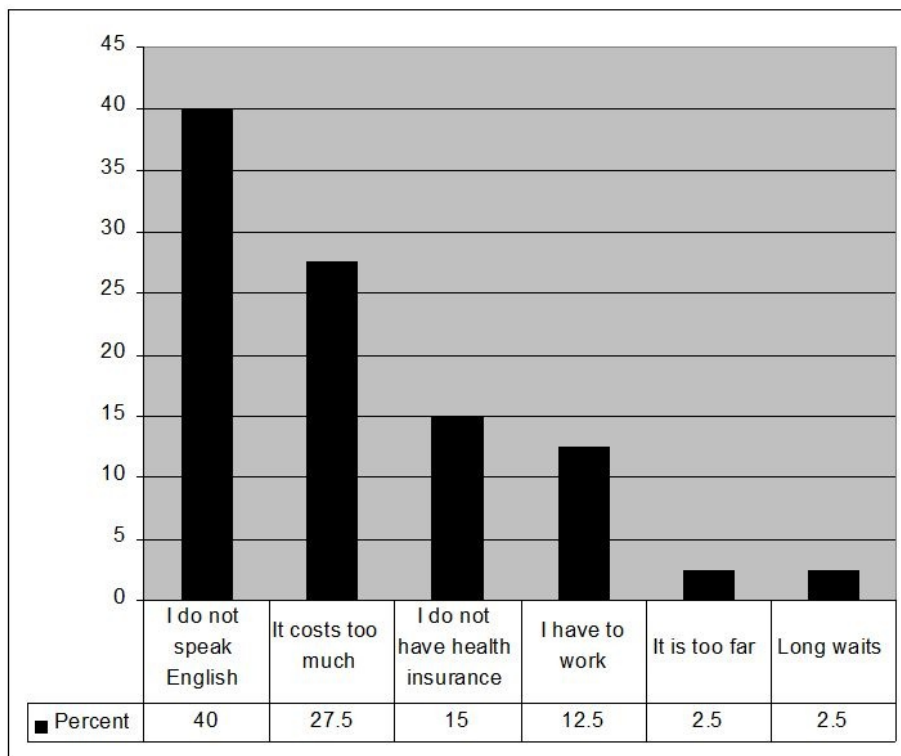


FIGURE 3. MAJOR DIFFICULTIES PERCEIVED BY HISPANIC RESPONDENTS IN OBTAINING HEALTH SERVICES

population. Either an expansion of Medicaid or the availability of health insurance would lower the cost of health care.

Medical professionals we interviewed recognized the need for affordable health care for a growing Hispanic population. There was a general recognition that most Hispanic patients were willing to pay for affordable health services, and that particular attention should be paid to the provision of low-cost services for prenatal care and chronic diseases. Prenatal care, preventive care related to women’s health (such as breast cancer examinations), and chronic disease care (such as for diabetes, heart diseases, cancer, and leukemia) are in fact the medical areas most in need of low-cost services despite the immigration status. To increase the supply of affordable basic care, health professionals also proposed to shift toward a county health department policy more focused on the provision of primary services.

DISCUSSION

The findings of our research demonstrate serious obstacles facing Hispanic residents in Toombs County, Georgia who need to access the existing medical

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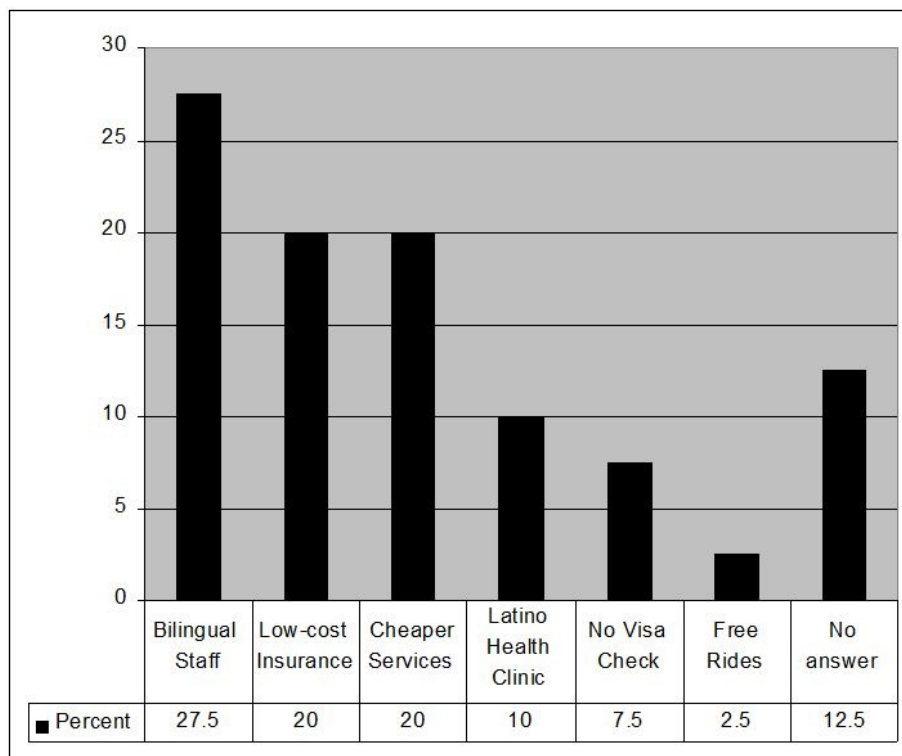


FIGURE 4. SOLUTIONS PROPOSED BY HISPANIC RESPONDENTS

system. Poverty, physical isolation, language barriers, and sometimes undocumented immigration status among some Hispanic residents do not fit well with the health system in a rural southern county with limited financial and human capital resources. The issue of health care access for 11 percent of the population poses practical, legal, and moral questions. Allowing a significant portion of the local population to live in conditions where disease is left untreated poses public health risks to the larger population (World Health Organization 2007). Employers who depend on Hispanic workers to be able-bodied will be affected, at least until they can replace one worker with another. Legally, health service providers that receive federal funding are required to meet certain obligations such as interpreter services, although these requirements do not affect private medical practices (Chen, Youdelman, and Brooks 2007). In moral terms, there are heated debates about whether public funds should be expended to care for recent migrants and in particular undocumented migrants who are here violating immigration laws (Glen 2012). On the other side of this debate are those who feel that health care is a human right and that migrant Hispanic workers (documented or otherwise) make important contributions to the local economy (Edwards 2010).

To face the needs brought up by Hispanic immigrants, new health delivery strategies are required, such as programs that explicitly target uninsured and underserved patients. In Toombs County, the development of community rural health networks based on an ongoing collaboration between public and private health providers could insure coordination of care and, above all, to increase the amount of affordable services by providing subsidized payments based on family income (NCPC 2003). More broadly, as indicated by the health professionals interviewed, policy makers should evaluate access to affordable health care, and reexamine existing health programs to make them more inclusive despite ethnicity or immigrant status (Atiles and Bohon 2002).

Perhaps the most direct way to address accessibility barriers would be to establish a mobile community health clinic run by the county health department with Hispanic or bilingual staff. This mobile clinic could establish a schedule of regular visits to communities where Hispanic populations are concentrated. Nurses and medical professionals could visit farm and plant workers directly in their workplaces (such as fields and poultry processing plants), providing them basic health services. Patients could pay for services and medications on a sliding scale. Employers who hire Hispanic residents but do not provide health care benefits could be assessed taxes to defray some or all the costs of running such clinics. As an alternative, emergency low-cost dial-a-ride services for those who do not have access to private means of transportation could be established.

Public health awareness and outreach programs directed toward Hispanic residents might be an effective way of communicating how best to navigate the U.S. health care system and providing information on a range of health issues including diabetes, obesity, prenatal care, pregnancy outcome, women's health, tuberculosis, HIV/AIDS, sexually transmitted diseases, cancer prevention and exams, high blood pressure, work safety, pesticide safety, domestic violence, family planning, drug and alcohol abuse, healthy life style, stress, anxiety, and depression. Educational programs for Hispanic parents (Parents' Information Centers) could help Hispanic parents interpret their children's behaviors in light of exposure to the dominant U.S. culture and prevent domestic child abuse, teenage pregnancy, obesity, juvenile delinquency, and juvenile drug and alcohol abuse. Informants and medical professionals also drew attention to the relevancy of domestic violence and alcoholism among the local Hispanic community. In their opinion, these two health issues need extra consideration and a more appropriate response by the local health system. In particular, it is necessary to establish an additional detoxification center able to better treat the large number of local patients affected by alcohol and drug

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abuse, and augment the number of social and family services able to serve abused Hispanic women.

Among the suggestions for addressing the high cost of health care made by Hispanic respondents was improving access to health insurance through either Medicaid or private health insurance policies. Whatever the merit of such suggestions, there is little likelihood that the federal or state governments will take an active role in subsidizing health care or insurance costs, especially for undocumented migrant workers. Employers of migrant workers might be required to provide health insurance. At present, employers are benefitting from the presence of these workers but are putting off costs of health care on the larger population through unpaid emergency room visits and costs to county health departments.

CONCLUSIONS

Until recently, Hispanic immigration has been mostly an urban phenomenon, but this population is no longer concentrated in 'traditional' destinations. The rural Hispanic population is rapidly increasing throughout many regions of the nation, mostly in states of the South and Midwest. As Hispanics relocate to the rural South, not only have they progressively changed rural areas and towns previously not having a significant Hispanic presence, but they have also challenged local institutions that had not planned to deal with many newcomers. The rural South will continue to attract Hispanics looking for economic opportunities, and these migrants will increasingly play a significant role in shaping the economic stability and development of this region. However, to actively contribute to the economic prosperity of the rural South, Hispanics must acquire additional social and human capital. One way to accomplish this is to deliver improved health care services, particularly primary health care services.

Toombs County represents the case of a southern rural area that was unprepared to deal with a culturally-different and fast-growing minority population. Although Hispanic immigration began about 20 years ago, the local health care system and the county as a whole have not yet fully adapted to the peculiar health and social needs brought by these newcomers. The Southeast Georgia Communities Project and other community organizations have contributed to building valuable social networks among Hispanic residents, service providers, and local citizens and institutions. There is also an overall better understanding of Hispanic cultural and health needs and local health facilities and medical professionals are beginning to provide bilingual staff and trained interpreters. Nevertheless, in Toombs County, Hispanics continue to experience social hostility,

critical economic circumstances, job insecurity, hazardous working conditions, a lack of health insurance, limited transportation, and uncertain immigration status. Structural deficiencies (such as the large number of uninsured residents, the shortage of primary physicians, and the limited availability of financial resources), constantly challenge the local health system, and much still needs to be done to ensure Hispanics an adequate level of bilingual professionals, affordable and accessible services, and preventive care. As a result, active involvement of Hispanics in the community and potential positive contributions to the local economy have been undermined. Health professionals have therefore emphasized the necessity to subsidize those physicians who are willing to provide sliding medical fees and hire qualified interpreters, to improve the overall local offering of affordable care, and to increase the safety of the Hispanic patients.

The massive Hispanic demographic influx will not only transform the country's ethnic composition and its national identity, but also challenge the ability of impacted regions to meet the need for and delivery of services for a fast-growing and complex community. The proper allocation of the human and financial resources required to facilitate integration of Hispanic migrants into the community, support their positive contributions to the economy, and improve their overall health status represents a major challenge that policy makers and institutions will face at the local, state, and national level.

AUTHOR BIOGRAPHIES

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