SOCIO-POLITICAL IMPLICATIONS IN PHYSICIAN CULTURAL COMPETENCE AND LATINO CROSS-BORDER HEALTH CARE UTILIZATION: A REVIEW OF THE CURRENT LITERATURE

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Abstract

This paper examines the manner in which socio-political climate, primarily the stigmatization of immigrants, impacts health outcomes and the prevalence of cross-border healthcare utilization for Latinos in the United States. Stigma stemming from public support for immigration reform has implications in Latino health at the structural, interpersonal, and individual level. The harmful attitudes lead to overt discrimination and implicit personal biases that affect the ability of physicians to provide culturally and linguistically appropriate services (CLAS)[1]. Previous studies on Latino health experiences indicate that a multitude of interrelated factors influence the decision to receive healthcare in Mexico, including dissatisfaction of care[2] and language proficiency[3], but no direct connection has been made to interpersonal discrimination or cultural incompetence. Cultural competence education for physicians that involves political awareness is one positive step towards improving disparities in the U.S. healthcare system (Tervalon and Murray-García 1998; Evans 1992).

[1] See, U.S. Department of Health and Human Services National Standards for Culturally and Linguistically Appropriate Services in Health Care, 2001
[2] See, for example, Bergmark et al 2010
[3] See, for example, Su et al 2011, De Jesus and Xiao 2013

Introduction

A rise in anti-immigrant policies and attitudes observed in recent years has implications in the social, political, and health outcomes of Latino Americans (Philbin et al 2017), the largest ethnic minority in the United States, representing 18% of the population in 2019 (U.S. Census Bureau). Stigmatization[4], perpetuated by anti-immigrant policies[5], extends to all Latinos regardless of nativity status, as the concepts of being an immigrant and being Latino are often falsely conflated (Hatzenbuehler et al 2013; Morey 2018). Stigma and racial bias are known social determinants of poor health outcomes by negatively affecting mental and physical health, preventing access to health resources, and facilitating the reproduction of health inequities (Hatzenbuehler et al 2013). As stress placed on Latinos due to discrimination and stigmatization can increase risk of mental or physical illness, immigration policy becomes intertwined with health policy (Morey 2018).

Despite the ethical standards in place, health care professionals are not exempt from carrying personal biases influenced by the current political climate (Nelson 2002), and may incorporate them into their practice either deliberately or subconsciously (van Ryn 2002). In 2001, the U.S. Department of Health and Human Services issued guidelines on Culturally and Linguistically Appropriate Services (CLAS) in Health Care with the intention of improving quality of care for an increasingly diverse U.S. population. While these standards have served as a preliminary policy effort to address health disparities stemming from culturally incompetent

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[4] Stigma is defined by Link and Phelan as negative stereotyping, status loss, discrimination, and labeling due to perceived differences about a group of individuals, and is reproduced due to societal power differences (2001).

[5] See, for example, Immigration and Nationality Act; ICE Secure Communities Program; Personal and Work Opportunity Reconciliation Act

care, they understate the relevance of 1) CLAS education for physicians and other health providers and 2) the importance of political and social awareness in medical training. Discrimination fueled by racial stigmatization manifests in a clinical setting as misinterpetation of symptoms, negative expectations concerning treatment adherence, and disrespectful or culturally insensititve attitudes based on a negative assumption of the patients' personality, intelligence, or education level (van Ryn 2002). Discrimination may influence some Latinos to seek care in another context, such as crossing the border into Mexico to receive health services[6]; cost difference and ease of access are known factors in influencing 'medical tourism'[7], but cultural factors also may play a significant role (Connell 2012). If physician attitudes and cultural incompetence are found to be factors compelling Latino individuals to seek an alternate context of care, this would have meaningful implications in health policy. The relationship between patient and physician is critical to effective care (Flores 2000), and language barriers (Fernandez et al 2004), cultural misunderstandings (Flores 2000), and outright prejudice (Hausmann 2011) directly affect the mental and physical well-being of the patient (Paradies 2006). This relationship becomes increasingly relevant in border states such as Arizona, California, and Texas, and areas with a higher Latino population. Furthermore, this phenomenon would highlight the unjust provision of care for minorities and immigrants in the United States, and serve as a basis for future policy action and improvement in health professional education programs.

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[6] Health services is defined as medical care, dental care, or the purchase of medications (Wallace et al 2010)

[7] "Medical tourism" is commonly known as the act of traveling to another country for health care, and is a growing issue in health policy. The formal definition varies as to whether or not non-invasive procedures or travel to nearby destinations constitute medical tourism. Availability and quality of care and cultural ties are known to be related to this phenomenon (Connell 2012).

Anti-Immigrant Stigma and Health Disparities

Stigma is defined as negative stereotyping and loss of status based on distinguishable and easily-labeled human differences that exist with imbalance of power in social, economic and political contexts (Link and Phelan 2001). This conceptualization of stigma includes race and immigration status, but intersects with other demographic factors such as economic status disability, HIV status, gender, and sexual orientation– a culmination of perceived differences that motivate discrimination (Link and Phelan 2001). The fundamental cause theory proposes that social conditions, primarily socioeconomic status, perpetuate health inequality by governing access to resources and determining the effect of existing individual risk factors on disease outcomes (Link and Phelan 1995). Stigma similarly meets the criteria as a fundamental cause, reproducing health disparities over time (Hatzenbuehler et al 2013). Furthermore, the social isolation and exclusion of stigmatized groups can lead to internalization of negative stereotypes, thus damaging self-image and increasing stress levels, affecting both the mental and physical health of a stigmatized population (Hatzenbuehler et al 2013). Negative stereotypes about undocumented immigrants (as illegal, criminals, an economic burden, etc.) also result in anti-immigration policies that indirectly exacerbate health disparities. Harmful rhetoric has spread throughout the United States that labels immigrants as outsiders and wrongly conflates undocumented individuals, immigrants, and racial minorities who may be immigrants (Morey 2018). Self-reported racism has been associated with negative health outcomes across a number of studies[8]. This poses health risks for all Latinos, regardless of citizenship status or country of origin, and racism and racial stigmatization affects public health on the individual, interpersonal,

[8] See, for example, Paradies 2006.

and structural level (Morey 2018; Jones 2000). At the individual level, the stress of living with the threat of violence, or possibly deptoration, negatively affects mental and physical well-being (Gee and Ford 2011). At the interpersonal level, discrimination from others in the community, including health providers, affects the quality of care received (Gee and Ford 2011). I argue that this may dissuade Latinos from receiving health care in the United States and encourage the seeking of care in an alternate context. At the structural level, many policies, including those related to health, are disadvantageous to racial minorities and limit access to 1) material resources 2) political power (Jones 2000). The pervasiveniss of structural racism is observed in policies aiming to discourage immigration by deliberately excluding undocumented immigrants and limiting access to health resources for documented immigrants (Gee and Ford 2011). For example, the 1996 Personal and Work Opportunity Reconciliation Act prevented most immigrants from receiving care under Medicaid during the first 5 years of residency (De Jesus and Xiao 2013).

Immigration Policy and Health Outcomes

In the mid-2000s, public support for immigration reform led to an increase in state-level legislation aiming to reduce employment opportunities, access to health care, and other public resources and social institutions for undocumented immigrants, but with the stereotypes pereptuated through these laws, also fed into stigma and structural racism. In this manner, laws that do not directly address health care can play a role in Latino health through a number of proposed pathways involving structural racism[9] (Philbin et al 2017). An interview-based study in North Carolina suggests that enforcement of federal immigration policies such as the

[9] Structural racism, also known as institutional racism, is defined as macro-level systems and mechanisms that reproduce racial and ethnic inequities (Gee and Ford 2011).

Immigration and Nationality Act and the Immigration and Customs Enforcement (ICE) Secure Communities Program serve as a barrier of access to health services for documented and undocumented immigrant Latinos due to the fear of deportation and/or dentention they cause, and may influence some patients to utilize other types of health care (Rhodes et al 2014). Section 287(g) of the Immigration and Nationality Act allows local law enforcement agencies to enforce federal immigration laws under the supervision of ICE, and is currently in effect in 24 U.S. states ("Immigration and Nationality Act"). Analysis of the North Carolina Vital Statistics System showed that Latina mothers were more likely to have late or inadequate prenatal care than non-Latina mothers, with a greater difference following implementation of Section 287 (g) (Rhodes et al 2014).

Two contradictory hypotheses have emerged as to whether a strong ethnic identity improves or worsens perceived discrimination and the resulting stress; the first suggests that a strong racial/ethnic identity has a protective effect in counteracting discrimination (Mossakowski et al 2003), while the other asserts that it exacerbates the effects of discrimination due to its threat to self-identity (Yip et al 2008). A survey study of Miami-Dade County found that discrimination was associated with higher levels of depression, and that U.S.-born Latinos reported more discrimination than foreign-born Latinos (Mossakowski et al 2018). As noted by the authors, these findings contribute to a growing discussion on the role of identity in the effects of discrimination, but depend largely on mental health disparities in certain areas. The racial and ethnic composition of a community may also be associated with the level of cultural competence and minority representation in the health care professions in that area, ideally decreasing discrimination and improving the patient experience (Mossakowski et al 2018).

The Role of Cultural Competence in Addressing Racial Disparities in Health Care

While structural implications of racial and immigrant stigmatization on health, such as limited resource access and insurance coverage (Link and Phelan 1995), and the individual impacts, such as the harm to mental health (Gee and Ford 2011; Hatzenbuehler et al 2013), have been widely studied and accepted in the literature, the interpersonal effects are often understated, especially in the context of provider-patient relationships.[10] Stigma and xenophobia perpetuated by political rhetoric and anti-immigration policy is expected to affect the ability of health professionals to provide CLAS, as the field of medicine is not exempt from racial biases and stereotyping (Nelson 2002 and van Ryn 2002). Cultural competence education[11] functions to reduce these effects by improving the provider-patient relationship (Flores 2000).

The conversation surrounding cultural competence began in the mid-to-late 1900s with the observation of negative health outcomes for historically marginalized populations, highlighting the need for culture-specific practices that require a patient-centered approach to help abate health disparities (Borne 2015). Evidence strongly suggests that physician behaviors fueled by stereotypes and racial/ethnic bias play a role in health disparities (Nelson 2002). Physician assumptions about a patient, such as their personality, intelligence, or education level, may influence the interpretation of symptoms and other clinical decision-making during the encounter, affecting quality of treatment, as well as determine interpersonal behavior, which can lead to patient discomfort (van Ryn 2002). Dissatisfaction with care and mistrust of the physician

[10] See, for example, van Ryn 2002, Sherrill 2016, While 2018

[11] Cultural competence education involves the training of medical professionals to be able to provide CLAS by acquiring Spanish-language proficiency (Fernandez et al 2004), an understanding of normative cultural values and folk illnesses (Flores 2000), and a patient-centered approach to care (Tervalon and Murray-Garcia 1998).

decreases the likelihood of patient self-disclosure, adherence to treatment, and question-asking in future medical encounters (van Ryn 2002). In addition to cultural competence improving patient response, Spanish-speaking patients have been found to be more satisfied with their care when interacting with a Spanish-speaking physician, supporting that direct communication between the doctor and patient is more effective for the understanding of patient concerns than the use of a certified interpreter (Fernandez et al 2004). Patients who have experienced discrimination in a healthcare setting are less likely to access necessary health services and more likely to present a negative affect in doctors' visits (Hausmann 2011; Paradies 2006). Socioeconomic status, along with other identifiers such as disability, sexual orientation, religion, and gender, are modifiers that exacerbate the effect of racial discrimination (Hausmann 2011; Paradies 2006). As a result, cultural competence has been mandated as a standard of care in most medical accreditation programs, including the Accreditation Council on Graduate Medical Education (ACGME), the American Public Health Association (APHA), the Liaison Committee on Medical Education (LCME), and the American Psychological Association (APA). Cultural competence requires an understanding of normative cultural values, foreign language skills, knowledge of folk illnesses, and a nonjudgmental awareness of non-traditional health remedies; in a clinical context, it addresses the use of noverbal communication, language interpretation, and respectful attitudes (Flores 2000).

A more modern approach to cultural competence emphasizes the need for cultural *humility*, conceptualized by Tervalon and Murray-García, which addresses culture as fluid and dynamic, and encourages individuals to engage in ongoing self-reflection on the role of structural inequalities in provider-patient interactions (1998). In physician education, cultural humility

promotes training in diverse communities and engagement with community leaders– with this goal in mind, medical training is integrated with political advocacy (Tervalon and Murray-García 1998). This idea is consistent with Evans' argument that physician trainees who are well-informed in policy and social determinants of health– beyond what is taught in the traditional medical school curriculum– are better equipped to address the health needs of a community (Evans 1992). While cultural competence is regarded as a skill-set to be mastered, cultural humility requires lifelong learning and accountability. This approach challenges health disparities from their foundation, requiring individuals to consider the pervasiveness of socio-political power differentials (Borne 2015).

Efforts to reduce racial bias in health care have incorporated the addition of cultural competence and humility training to medical curriculum, with some success. After completing a course created to inform medical students about personal biases by drawing on historical and political context, participants reported an increased awareness of their own bias blind spots (White et al 2017). Another study points out clinical training during medical school is insufficient for teaching cultural awareness, finding that experiences prior to medical school matriculation, such as immersion in a Latino-dominant community or living in a Spanish-speaking country, are significant contributors to level of cultural competence, while clinical experience with Latino patients during medical school is not associated with knowledge of Latino cultural norms, cultural competence, or comfort with Latino patients (Sherrill 2016). Since the addition of coursework to the curriculum is unrealistic, professional programs are seeking alternatives to ensure culturally competent physicians, including recruiting students with relevant previous experiences (Sherrill 2016).

Cross Border Utilization of Health Care

The literature thus far clearly demonstrates the impacts of physician discrimination and lack of cultural humility on Latino health outcomes, but fewer studies examine the alternative decisions patients make based on these impacts, such as going to Mexico for health services where possible.

Evidence suggests that an effective provider-patient relationship is most critical in regions closest to the U.S.-Mexico Border, given that the option to cross the border for care is more feasible (Su et al 2011). The 2008 Cross-border Health Care Utilization Survey examined the use of health services in Mexico by residents of border counties in Texas, as well as social factors that predict the use of cross-border care. Survey analysis indicates a positive correlation between crossing the border for care and proximity to the border, lack of insurance, and poor perceived health status (Su et al 2011). In addition, survey results suggest that the interpersonal capabilities of providers, such as language proficiency and cultural competence, may impact the perceived quality of care and preference to seek care in a different context (Su et al 2011). Further analysis highlights that insufficient insurance coverage, such as high copayments and deductibles found often in self-purchased health plans, also increases the likelihood of seeking care in Mexico (Su et al 2014). Foreign-born respondents were more likely to be uninsured or underinsured than native-born respondents, which is expected due to typical barriers to access for immigrants (Su et al 2014).

A study utilizing the 2007 Pew Hispanic Healthcare Survey categorized explanatory factors for cross-border care utilization into 1) predisposing characteristics, 2) enabling resources, and 3) need/ health status. The study found that individuals who reported receiving

"poor" or "fair" quality of care in the U.S. or lacked consistent health insurance, were more likely to seek care in another country, but perceived health status was not a significant predictor. Individuals who were U.S. citizens were more likely to cross the border, likely due to the risks of deportation or detention imposed on non-citizens at the US-Mexico border. Responses also largely depended on region of residence, with more individuals from the southern U.S. crossing the border for care. With regard to poor or fair quality of care, the authors noted language barriers and cultural incompetence among U.S. physicians as possible explanatory factors (De Jesus and Xiao 2013).

A 2009 study by Wallace, Mendez-Luck, and Castañeda using data from the 2001 California Health Interview Survey found similar common predictors of California residents to receive medical care, dental care, and the purchase of medicines in Mexico to include: proximity to the border, lack of insurance or underinsurance, and language barriers. Poor self-reported health, however, was found to be negatively correlated with seeking care in Mexico. The authors noted no association to gender, highlighting California's Medicaid policy that provides maternity care coverage to all residents regardless of immigration or nativity status. The authors offer a multitude of explanations for the decision to cross the border for health services, emphasizing that many interrelated factors exist affecting individual patient decision-making (2009).

Despite the concentration of research efforts in the Southwestern United States, some studies suggest that individuals further from the border also commonly utilize care in Mexico. A study conducted in 2008 by Bergmark, Barr, and Garcia interviewed Mexican immigrants living in Northern California and individuals who had previously lived in the United States but returned to Mexico. Participants who reported returning to Mexico for health care claimed that treatment

in the U.S. was unsuccessful, care was too costly, or they preferred Mexican care. Others reported receiving care in Mexico while visiting family, rather than traveling for health services alone. Participants also noted their preference for Mexican care due to discrimination in the United States (2010). While anecdotal responses provide some indication of discrimination influencing the decision to obtain care in Mexico, the variance in perspectives obtained further demonstrates that there are other interrelated variables at play.

Primary studies on cross-border health care utilization have focused on Mexican immigrants; fewer studies exist that assess the likelihood of U.S.-born individuals seeking health care in Mexico– and those that do mainly attribute it to lower cost as opposed to social factors (Wallace et al 2009). With some indication that actual and perceived health status are significant factors in the likelihood of cross-border care utilization (De Jesus and Xiao 2013), the healthy immigrant effect, also known as the Latino Health Paradox, becomes a topic of interest. This phenomenon demonstrates that Latino immigrants are less likely to have chronic health problems than their U.S-counterparts, despite existing disparities for immigrants that are expected to predict poorer health outcomes (Stone et al 2007). One explanation is that individuals must undergo health screening before applying for entry into the United States, denying entry of some with health conditions and deterring others from migration (Gee and Ford 2011). This explanation, however, does not account for undocumented immigrants, or a long-standing history of structural racism in immigration policy (Gee and Ford 2011). Alternatively, this phenomenon could be influenced by the decision of immigrants with social and cultural ties to their country of origin to seek care in that country (Wallace et al 2010).

Conclusion

Evidence in the literature suggests that Latino Americans have a multitude of motives for receiving healthcare in Mexico, but all of them share a commonality– they highlight pervasive flaws in the U.S. healthcare system that contribute to health disparities. Insufficient research has been conducted on the relationship between physician discrimination or cultural incompetence and cross-border health care utilization; while some studies suggest that crossing the border for care could be based on perceived discrimination from a provider, the majority of the evidence is anecdotal or based on indirect assumptions. Future research should expand upon the 2001 California Health Interview Survey and the 2007 Pew Hispanic Healthcare Survey and utilize direct questioning that clarifies these associations. A larger set of data describing motives for cross-border health care utilization would more strongly highlight the need for policy action that makes non-discriminatory U.S. healthcare more accessible for Latinos. This would also strengthen the association between political climate and bias in health care. In addition, future studies may want to investigate the variance in cross-border health care utilization among states, as it relates to state-level immigration policy enforcement, the breadth of cultural competency education in local health professional programs, and the political and social attitudes of the population.

There is a strong indication that implicit racial bias and immigrant stigmatization influence provider behavior and contribute to health disparities for Latinos. Furthermore, racial stereotypes are still largely present in modern America, including in health care, leading to overt interpersonal discrimination, with clear implications in Latino mental and physical well-being. With these relationships in mind, substantial effort has been made to establish cultural

competence and Spanish-language proficiency as educational standards in medical professional programs to improve the provider-patient relationship. These intervention efforts, while productive, often understate the implications of political climate on racial bias–awareness in political and social justice ought to be an area of concern as equally important as clinical competencies for health educators. Providers should also be educated on the potential impact of patients' past experiences on their verbal and nonverbal communication style, and be able to respond accordingly (Hausmann 2011). Though socio-political implications exist in all of health care, special consideration should be taken for particularly sensitive fields with stronger ties to social justice, such as reproductive health and behavioral health. Future studies in cultural competence education may undertake a more comprehensive approach that goes beyond direct patient-provider interactions, and instead implements historical and political context that may not be present in a pre-professional undergraduate education. Such measures would increase physician capacity for cultural humility– a necessary step towards the mitigation of existing health disparities for Latinos in the United States.

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