

Overcoming Barriers to Access Health Care

The Challenges Facing Minorities and Immigrants in Washington State

Layla G. Booshehri, PhD, Jerome Dugan, PhD



Key Points

- Washington state's Black, Indigenous, and People of Color (BIPOC) and immigrant communities face worse health outcomes and a lower standard of care compared to their white counterparts.
- Barriers to access, both at the individual and system levels, are the primary drivers for inadequate care and unmet needs.
- As a purchaser and regulator, the state and its agencies can exercise their authority to finance, implement, and oversee interventions to help reduce and/or eliminate systemic barriers that disproportionately affect minority and immigrant households.

Health status is determined by many factors, one of which is access to health care. What can Washington state do to reduce disparities in access experienced by BIPOC and immigrant communities?

The Center for Health Innovation & Policy Science (CHIPS) is an interdisciplinary research center that works to improve health across communities and the lifespan through innovation, evaluation, and training in health policy and health systems science, with a focus on health equity.

Director
David Grembowski, PhD

Associate Director
Layla G. Booshehri, PhD

Summary of Issues

Black, Indigenous, and People of Color (BIPOC) and immigrant communities in Washington state and the nation not only seek and receive health care services at lower rates than whites but also receive care of lesser quality compared to whites. Researchers have documented that the delay, avoidance, and receipt of low-quality care can lead to poorer health outcomes as measured by morbidity and mortality. It is no surprise, therefore, that BIPOC and immigrant communities across Washington state, and the nation as a whole, report worse health than their white counterparts.

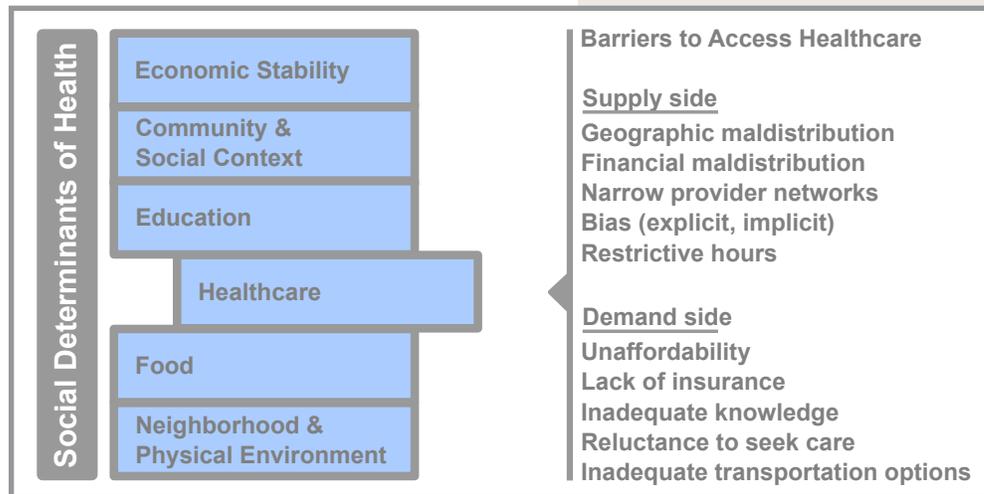
The reasons behind these disparities are more complex than previously documented. They are attributable not only to an individual's personal and social obstacles but also to the policies, practices, or attitudes of institutions that impede BIPOC and immigrant populations from enjoying low-barrier access to health- and welfare-promoting services. Figure 1 summarizes

the social determinants of health status and common barriers to access health care. Barriers to health care access include both supply- and demand-side factors that primarily originate from constraints at the institutional and policy levels.

Reducing disparities in health and health care has been a priority for Washington state's executive and legislative branches for the last four decades. Although Washington state has a strong track record in narrowing health disparities, those between white and BIPOC and immigrant communities continue to persist. This is due, in part, to the fact that barriers can vary substantially across individuals, communities, and geographies, necessitating a systematic plan of action to address their root causes.

The purpose of this policy brief is to (1) summarize the health and health care disparities facing BIPOC and immigrant communities in Washington state, (2) describe the major barriers to health care access these groups face, (3) discuss current state efforts to reduce disparities, and (4) provide guidance for ongoing and planned interventions.

Figure 1



Health Disparities in Washington State

Washington is a diverse state, home to over 7.7 million residents and 29 federally recognized tribes spread across 39 counties. BIPOC residents currently represent 20% of Washington state's population and, according to the state's Office of Financial Management, will grow to nearly 30% by 2040.¹ A report from the American Immigration Council notes that immigrants make up 15% of Washington state residents.² Mirroring national trends, BIPOC populations will constitute a majority of the state's population over the next few decades. The disparities BIPOC and immigrant populations face in access to care will persist in the future in the absence of more aggressive policy action.

Rates of communicable and noncommunicable diseases are one example of disparities in morbidity and mortality in Washington state. For example, the COVID-19 communicable disease pandemic has resulted in high rates of infections and death, with Hispanic households being disproportionately affected. While Hispanics account for 13% of Washington's population, this community had 31% of all COVID-19 cases and 23% of all COVID-19-related hospitalizations as of March 2021.³ Across a broad range of noncommunicable disease categories, data from the Behavioral Risk Factor Surveillance System (BRFSS) show that BIPOC populations have a higher prevalence of arthritis, asthma, cardiovascular disease, COPD, depression, diabetes, and renal disease than whites.⁴

All-cause mortality is also substantially higher for some BIPOC communities compared to whites: 692.2 per 100,000 persons for whites versus 771.1 for Blacks and 893.6 for American Indians and Alaska Natives.⁵ A study led by researchers at Washington State University documented that between 2011 and 2017, opioid-only mortality increased among American Indians, Alaska Natives, and Hispanics.⁶ Furthermore, American Indians and Alaska Natives reported the highest alcohol-only, opioid-only, and co-use mortality across all racial/ethnic groups.

These findings demonstrate that BIPOC and immigrant communities face significant individual and collective burden of disease attributable to disparities.

In Washington state, all-cause mortality is substantially higher for some BIPOC communities compared to whites.

Barriers to Access Care

In addition to significant disparities across diseases, BIPOC and immigrant communities systematically report lower health insurance coverage rates and use and availability of services as well as higher costs of health care services than their white counterparts. Although access barriers are numerous and interrelated, which can be present on both the demand- and supply-sides of the health care marketplace, researchers have identified several notable barriers as important in explaining health and health care disparities among BIPOC and immigrant communities.

- **Geographic maldistribution.** Although shortages in the health care workforce will be a significant challenge over the next decade, it is the geographic maldistribution of medical facilities and physician workforce that presents an immediate barrier for patients. The concentration of medical facilities and physician workforce in urban, suburban, or affluent areas can leave socioeconomically vulnerable populations with inadequate access to health care services. In addition to a well-documented divide in health care professionals between urban and rural areas, significant disparities exist across federally designated health professional shortage areas (HPSA), medically underserved areas/populations (MUA/P), and rural areas.
- **Financial maldistribution.** A higher proportion of BIPOC and immigrant communities rely on public programs such as Medicaid, which commonly pay providers less than private insurers. As a result, many providers limit how many beneficiaries of these programs they will see, sometimes leading to severe barriers to access services, notably for mental health, dental, and other specialty care. Low payment rates may lead some care providers to relocate to communities where the dominant form of coverage reimburses at a higher rate, and this can further exacerbate geographic maldistribution.^{7,8}
- **Restricted provider networks.** In an effort to design more affordable health insurance plans, insurers have designed offerings with limited networks of providers. Insurers are often able to negotiate better reimbursement terms by directing patients to narrower and less costly provider networks. This strategy, however, has two unintended consequences. First, if a health plan includes too few providers, beneficiaries may have to travel excessive distances to receive care. Second, when networks are too narrow, beneficiaries may be forced to use out-of-network care, which can lead to unaffordable or unavailable care.⁹
- **Racial bias.** Both explicit bias (overt discrimination, racism) and implicit bias (unconscious prejudice) among providers have been shown to harm health and further exacerbate health disparities among socioeconomically vulnerable populations. These biases degrade trust in the patient-provider relationship, which in turn contributes to poor clinical outcomes.¹⁰⁻¹³
- **Limited appointment availability.** Providers who restrict hours or do not offer after-hours care impede individuals' ability to seek timely care.¹⁴ In a recent Washington Health Care Authority (HCA) report, patients identified a lack of clinics with extended hours, long wait times for child visits, and lack of appointment time slots for families with multiple children as major access challenges.¹⁵ Many patients reported that standard hours of operation do not easily accommodate parents' work and children's school schedules. BIPOC and immigrant communities are particularly affected by these factors.

- **Lack of affordability.** According to the Peterson-Kaiser Family Foundation Health System Tracker, 10.5% of adults report delaying or not getting care because of health care costs. When broken down by race, 15.5% of Hispanics, 13% of non-Hispanic Blacks, and 9.4% of non-Hispanic whites report delaying/avoiding care due to costs.¹⁶ Moreover, patients with a lower health status (19.4%) reported costs as a barrier at a higher rate than healthier respondents (8.9%). The uninsured reported cost as a barrier at a much higher rate (36.5%) compared to the insured (5.2%).
- **Inadequate insurance coverage.** Health insurance coverage is the primary mechanism to finance health care services in the U.S. Therefore, missing or inadequate health insurance coverage makes people more likely to avoid using services for disease prevention, treatment or recovery, or appropriate treatment for managing chronic conditions. A recent study from the Washington State Office of Financial Management reports that the uninsured rate for whites sits at 5.1% but is 9.3% for Blacks, 14.8% for Native Americans and Alaska Natives, and 23% for all other races. When broken down by Hispanic origin, persons of Hispanic origin report a 17.7% uninsured rate, while non-Hispanics report a 4.5% uninsured rate.¹⁷
- **Inadequate knowledge.** The health care system is complex, making it difficult for people to understand and exercise their options to access care. This challenge is exacerbated if the patient is an immigrant whose primary language is not English. Researchers have documented that Washington state households whose primary language is not English reported lower rates of preventive care, fewer checkups, and greater inability to manage medical conditions than households where English is the primary language.¹⁸
- **Lack of trust.** Mistrust of the health care system is a major challenge among BIPOC communities. In the African American community, historical injustices have fueled distrust that has lasted more than a century, contributing to low participation in clinical trials and beliefs that physicians expose them to unnecessary risks.¹⁹ Hispanics have also indicated that anti-immigrant messaging erodes trust, regardless of citizenship status.²⁰
- **Inadequate transportation.** In a recent HCA report, a lack of resources to facilitate transportation to and from appointments was cited as a major factor impeding access to care.¹⁵ It was also documented that patients who were unable to secure transportation often delayed or avoided care altogether. A 2017 study reported that 5.8 million patients in the U.S. delayed medical care because they could not access transportation, with Hispanics, persons living under the poverty level, and Medicaid recipients disproportionately harmed.²¹ Other studies have highlighted that Blacks and Native Americans were more likely to cite transportation inadequacy as a barrier to access medical care compared to whites.^{22,23}



Strategies to Reduce Barriers to Access Health Care Services

Several efforts in various stages of development are focused on overcoming access barriers that contribute to health and health care disparities that disproportionately affect BIPOC and immigrant communities.

- **Geography.** The state legislature has enacted programs to reduce geographic barriers, especially since primary care professionals are disproportionately concentrated in urban and affluent areas. In recent years, the legislature altered regulations and provided funding to facilitate the creation of a new medical school in eastern Washington and additional residency slots to increase physician supply across the state.²⁴ The legislature has also allocated additional funds to expand both the state-funded Health Professional Loan Repayment Program, which facilitates the recruitment of providers to rural and underserved areas, and the Medical Home model, which enhances primary care access.
- **Health insurance and financial maldistribution.** Washington state has four decades of experience enacting state-initiated insurance expansions to address disparities in coverage and the burden of rising prices for medical services among socioeconomically vulnerable households.²⁵ With the passage of the most recent health legislation (Senate Bill 5526), the Washington Benefit Exchange, the HCA, and the Office of the Insurance Commissioner have been working together to introduce Cascade Care and public option plans into the health insurance exchange. This law intends to improve the quality and affordability of care by ensuring plans are available for every resident regardless of income, geography, age, gender, or disability. It also seeks to reduce financial maldistribution by raising the average reimbursement rates of public option plans to 160% of Medicare reimbursement rates. According to a report released by the HCA's Universal Health Care Work Group, of the three proposed models for moving toward universal insurance coverage, two explicitly describe approaches to cover immigrants presently ineligible to purchase insurance on health insurance exchanges, while the third examines the use of state-based subsidies to further improve affordability of insurance plans.²⁶
- **Affordability.** Follow-up health reform legislation passed in 2020 also led to the establishment of a health care cost transparency board whose purpose is to measure the state's total health care expenditures, identify cost drivers in the health care system, and create benchmarks for health care cost growth as a strategy to reduce cost growth in the state. The board convened its first meetings in February 2021 and will report annually to the state legislature with a set of recommendations on how to curb cost growth. The goal is to help control high and rising health care costs, which represent a significant access barrier for socioeconomically vulnerable households.



- **Racial bias and trust.** Since 2006, the Governor’s Interagency Council on Health Disparities (ICHHD) has worked to promote equity for all historically marginalized groups, with a focus on addressing racism. The Council actively advises both the Governor’s Office and state legislature on ways to create more equitable public systems. In recent years, the legislature authorized the establishment of the Office of Equity, whose goal is to address opportunity gaps and health disparities. The ICHHD and Office of Equity are dedicated to advancing an equity, diversity, inclusion, and anti-racism context for all executive and legislative decisions. Through the establishment of the Office of Equity, the state also hopes to rebuild trust among Washington state’s BIPOC and immigrant communities and ensure the delivery of culturally competent social services.
- **Unaddressed burdens.** Little has been done legislatively to address accessibility challenges when scheduling medical care; however, a recent *Purchaser Primary Care Support Letter* written to the Washington State Health Care Authority called on primary care providers to offer convenient and flexible care options using multiple modes of care (e.g., telephone, video, email, electronic messaging) and extended clinic hours.²⁷ The same letter also called on providers to offer team-based, continuous, and culturally sensitive care to ensure that equitable access and delivery of care is made available to all Washingtonians seeking care. No consensus yet exists in Washington state on how to reduce financial maldistribution (typically by increasing Medicaid fee-for-service reimbursement rates) or expand provider networks (past efforts sought to moderate through Any Willing Provider and Freedom of Choice laws). Furthermore, although some existing programs seek to improve patient knowledge and address transportation challenges when seeking medical care, such programs are not standardized or deployed universally across communities.

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The Path Forward

Over the coming months and years, state decision makers will make crucial choices about where to invest funds and which aspects of the health care marketplace to regulate as we transition from the pandemic to a post-pandemic recovery period. These decisions could benefit from academic-government partnerships that examine the equity and disparity impacts of current and proposed regulatory, fiscal, and program policies. Washington state has a history of collaboration with University of Washington researchers, and the researchers in the Center for Health Innovation & Policy Science (CHIPS)—a policy center focused on improving equitable health care access across the community and lifespan—are positioned to support state agencies and the newly established Office of Equity with evidence-based health policy research that will help advance the state’s mission of equitable and anti-racist access to health care services. This policy brief, the first of a new CHIPS policy brief series centered on equity as well as economic and health disparities, is a first step toward building such a partnership.

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