Understanding the Barriers to Healthcare that Exist for Hispanics in the United States: A Review

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INTRODUCTION

Health equity is defined as the "state in which everyone has a fair and just opportunity to attain their highest level of health" (Centers of Disease Control and Prevention, 2022), a concept that has not been consistent within the United States. This can be seen through the apparent health disparities that exist as a byproduct of the lack of health equity in this country and is simply defined as the differences or gaps in quality of health/healthcare between different groups of people (Riley, 2012). Unfortunately, many minority groups are the primary demographic facing the consequences of this lack of care and it is shown in their health outcomes (Radley et al., 2021). There are many factors that play a key role in perpetuating health disparities within the US among minorities, varying from interpersonal to systemic (Diamond, 2022).

Lack of proper access to healthcare persists as one of the main contributing factors to health disparities, consequently as well as negative health outcomes, and is also manipulated by interpersonal and systemic issues of discrimination (CDC, 2021). The literature shows that racism, both implicit and explicit, has led to an increased negative effect on the physical and mental health of those targeted, often with those already living in areas at greater risk for poorer health outcomes (CDC, 2021). Additionally, due to continued effects of segregation, Black and Latino individuals are among the most likely to live in medically underserved communities that will often lead to increased usage of emergency rooms over primary care physicians (Diamond, 2022).

Current displays of discrimination and stereotypes also greatly impact these communities with national data showcasing how 56% of white people in the US believe that Black people prefer to live off welfare (Williams & Rucker, 2000). These racial stereotypes and existing implicit biases reside in healthcare professionals as well and have led to a plethora of health

complications for marginalized communities (Riley, 2012). One of the first studies showcasing health disparities among ethnicities found that nearly 45% of death within the Black population under age 70 would have been avoidable if disease was better detected and treated at earlier stages (Riley, 2012). A continuation of health outcome disparities exists in infant mortality as well since it is nearly 2.5 times higher than that for White babies, and life expectancy is nearly a decade less than that of the White population (Riley, 2012).

While the Black community currently faces the greatest amount of negative health outcomes among minorities in the US, the Latinx/Hispanic population has proven to be the highest in barriers to care (Radley et al., 2021). Even though they have lower preventable mortality rates despite their poor access to healthcare, research has shown that mortality and prevalence of chronic conditions for the Latinx populations has been on the rise (Radley et al., 2021). An example of this can be seen with the prevalence of diabetes among the Latino population, who have a 66% higher likelihood of developing disease compared to non-Hispanic Whites (Diamond, 2022). This is primarily due to the unique variety of barriers that Latinos face, which often are characterized by an undocumented immigrant status, language barrier, low income, and lack of insurance (Valdez et al., 1993).

35 to 37 million Americans are uninsured, and the Hispanic population makes up 7 million of those, which is proportionally 39% of the Latino population, establishing them as the highest demographic of those uninsured outside of Native Americans (Valdez et al., 1993). This can be greatly attributed to the immigration-based barriers that exist preventing access to care through public systems like Medicaid or within the ACA marketplace (Radley et al., 2021). This has been a large issue for immigrants as they are not only more likely to have not access to care in the states, but data has shown that immigrants enter the US with better health than US natives,

and health declines the longer they reside in the states (Damle et al., 2022). Yet exclusive legislation continues to harm the Hispanic population within the US. For example, Proclamation 9945 of October 4, 2019, barred immigrants from entering the US unless they had health insurance within 30 days of arriving in the US (Damle et al., 2022). Additionally, legislation passed to aid those in a lower SES class such as that of the expansion of Medicaid through the Affordable Care Act kept undocumented immigrants out of the expanded aid (Damle et al., 2022). Due to this, it is estimated that 60% of undocumented immigrants in the United States do not have any health insurance (Damle et al., 2022)..

Yet it is not only undocumented immigrants that face these hardships with healthcare coverage, as those who have obtained citizenship still face financial hardship, discrimination, and cultural barriers that limit their access to healthcare (Valdez et al., 1993). Due to many Latinos working essential jobs in the labor force, many see low wages with little benefits towards healthcare coverage (Valdez et al., 1993)**.** For those that can access health insurance through work, many will opt out simply due to it being too expensive to justify (Valdez et al., 1993). Finally, due to their association with low-income jobs, language barrier, and immigration status many Latinos report discrimination in the healthcare system (Andrade et al., 2020).

One in four Latino older adults report facing some form of racial discrimination (Funk & Lopez, 2022). While different variables affect why discrimination occurs, it is often seen due to language differences, cultural differences, class discrimination, and stereotyping (Andrade et al., 2020). Discrimination from providers drives Latinos away from the doctor's office and leads to more negative health outcomes. A final issue that many face is the cultural and language barrier that exists between patient and provider, which research has shown can lead to excessive medical

testing, increased use of emergency as opposed to primary care, and misunderstanding of provider instructions (Escarce & Kapur, 2019).

Many Hispanic people in the United States don't seek care when they need to, not necessarily because of their own choice, but due to a variety of external factors that exist in limiting their options. Ranging from income to transportation, there is a multitude of reasons for restricted healthcare among the Hispanic population. This review will work to find the barriers that currently exist for Hispanic adults when accessing healthcare in the United States.

METHODS

A search was conducted through PubMed for peer-reviewed journals with free full-text from 2002 to the present day to address the research question. The study selection criteria were primarily founded by looking for articles on the barriers that Hispanic adults face when accessing healthcare in the United States. The main barriers include cultural barriers, discrimination, and formal healthcare challenges (such as transportation and financial barriers). Six unique searches were performed before the final desired number of articles was achieved at 191 results. The search used was as follows: ((hispanic[tiab] OR latin*[tiab]) AND (access[tiab] OR barrier*[tiab])) AND (healthcare[tiab] OR "health care"[tiab] OR "medical care"[tiab]) AND transportation.

Out of the yielded 191 results, 10 were chosen for the results section of this literature review. To filter through the high number of results for the 10 needed for the results, I looked through all the titles to see which ones sounded like they might answer my research question and then I utilized the abstract to see if it matched with what I was looking for. If the abstract looked good I then did a final check by skimming the results and discussion section to ensure that the data and findings presented in the articles was pertinent to what the research question asked for.

A second database, PsycINFO, was utilized to find more articles to answer the research question. Data was collected after performing a few different searches on the database and establishing some limiting and inclusion factors. The first strategy looked at articles published only from the years 2002 to 2023, included a free full text link, and included the exact keywords included in the search. The search was as follows: “healthcare or health care or hospital or health services AND latinos or Hispanics AND America or united states or us or usa AND access to health care AND barriers AND discrimination.” The search yielded 26 results and 2 articles were chosen based off the criteria on whether or not the article focused on specifically discrimination against Latinos and the different reasons for their interactions with discrimination in healthcare. The same strategy of looking through titles, abstracts, and skimming the results and discussion section was used.

The second search that was used on this database followed the exact format except the keyword discrimination was replaced with culture, with these 27 articles were found and 3 were used for the results based on the same criteria as before. The final search was on PsycINFO again and followed the exact same format for searching as before but this time instead of culture or discrimination, insurance coverage was used as the final keyword. This search yielded 26 results and 2 were picked to use for the results. Once again, the same strategy of skimming titles, abstracts, etc. was utilized and articles containing information regarding insurance coverage were used.

RESULTS

After further reviewing the selected articles, a variety of challenges to accessing healthcare were discovered. The primary identified barriers include formal healthcare challenges, cultural barriers, and discrimination.

Formal Healthcare Barriers

Hispanics are more likely to have lower education and median household income, which greatly impacts their ability to afford quality health insurance (Luque et al., 2018). The median household income for Latinos in 2021 was $59,000 existing below the overall median in the US of $67,800. However, this statistic does not accurately represent the expansive low income shared among many undocumented immigrants (Oduro et al., 2012)**.** While newer provisions from the Patient Protection and Affordable Care Act were put into place in 2010 to aid more uninsured individuals, undocumented immigrant households still face their own set of challenges as they were excluded from this legislation's expanded health coverage (Luque et al., 2018). This has greatly limited the options present for undocumented immigrants, as out of pocket costs are often too high to justify paying outside of urgent health conditions (Peak et al., 2008).

Yet even for those who are legally documented, they still may not be able to receive the benefits of health insurance as many low-income Hispanics are still not eligible for public health programs, such as Medicaid (Cristancho et al., 2008). To access a public program like Medicaid, individuals must have incomes equal to or less than 133.33% of the Federal Poverty Line (Oduro et al., 2012)**.** Though an inclusive piece of legislation, there is a significant number of Latinos who exist just outside those regulations and consequently face more economic hardship due to lack of governmental support (Oduro et al., 2012). Additionally, most cannot afford private insurance, and even if offered through an employer, many Latinos don't have the financial means to pay for it (Peak et al., 2008). This lack of medical insurance acts as a massive barrier to care for a majority of those who are under/uninsured and can lead to a complication of health outcomes when treatment is not attempted (Cristancho et al., 2008).

Due to this lack of insurance, the literature has shown many lack a facility for usual care (Mojica et al., 2017). This means that there is not a set location and care provider for Latinos to access for routine checkups or procedures, which creates a greater disconnect between the patient and provider by not allowing a relationship between the two to develop (Saluja et al., 2022). Approximately 27% of Latinos in the United States report not having a usual source of care, compared to 16% of non-Hispanic Whites (Mojica et al., 2017). The prevalence of this disparity is greatest among the youngest and oldest Latino populations, with there being a significant relationship with elevated income security and extended residence in the United States (Montealegre & Selwyn, 2012). However, for those who exist in the extremes of age within this demographic, usual formal sources of care occur much more seldom (Montealegre & Selwyn, 2012). This will often lead to more negative health outcomes and a greater distrust for the medical system as there is no relationship built or consistency in quality of care being brought to the patient (Montealegre & Selwyn, 2012).

Those who are lucky enough to find health insurance still may face more barriers in their access to healthcare due to the confines of bureaucracy within the healthcare system (Caraballo et al., 2022). There has been a high number of cases reported, specifically from ethnic minorities, of longer wait times and overall delayed care among various healthcare providers (Caraballo et al., 2022). Discrimination may play a large part in this, but especially regarding lower income status or less insurance coverage, many Hispanic individuals will find themselves among a delay of care significantly more often than White individuals (Caraballo et al., 2022). Following long wait times, (Oduro et al., 2012) found that many individuals who rely on public healthcare feel they have too limited of time with the physician and has led to an increased distaste for the medical system. Additionally, those who have limited care with public programs haven’t been

able to develop a trusting relationship with their physicians as many individuals' doctors rotate every six months (Oduro et al., 2012). This showcases another barrier that exists outside of income that continues to deter this demographic from seeking medical help when needed.

A final formal healthcare barrier that has been identified is transportation (Akinlotan et al., 2023). Transportation persists as a barrier to care that is based upon a multitude of factors, ranging from simple geographic location to lack of proper infrastructure, to lack of monetary needs (Akinlotan et al., 2023). For Hispanics living in the United States, travel time is significantly higher, especially among the rural Hispanic demographic, when compared to other ethnicities, specifically White individuals (Akinlotan et al., 2023). Income has much to do with the outcome of transportation to access healthcare, and it was found that those living below the poverty threshold or those enrolled in Medicaid have much greater odds of facing transportation barriers than other demographics (Wolfe et al., 2020). When compared to non-White individuals, Hispanic people had 1.5 times the odds of facing some form of transportation barrier (Wolfe et al., 2020). As previously discussed, these types of barriers are only amplified by low financial status as they determine the area in which one may reside, oftentimes in a poorer community with less infrastructure (Topmiller et al., 2016). Without enough capital to purchase and maintain a car, or with limited access to one, people in these communities are reliant on public transportation, which is not always reliable and potentially not available at all (Topmiller et al., 2016).

Cultural Barriers

Outside of the financial and institutional issues that exist for access to healthcare, culture barriers play a large role in access to care and help-seeking behaviors. Historically, many Hispanics take on jobs that are extremely hands-on and labor-intensive, and while this may not

be the case for all Hispanics in America, it is known to be a cultural factor for increased health risk (Smith et al., 2009). While not all Latinos think this way, among many Hispanic cultures it is common for men to take on more physically intensive and traditionally masculine roles (Smith et al., 2009). As previously stated, this can oftentimes lead to future health complications as when working in the career field with physical labor, many start out young to help support their families (Smith et al., 2009). (Oduro et al., 2012) found that due to an average low socioeconomic status, many Latino men will prioritize return to work directly following treatment over allowing sufficient recovery. In some Latino cultures, this can be heavily attributed to the cultural belief of *machismo*, which is to avoid dealing with health issues until there is no other option (Peak et al., 2008). This cultural bias can and has led to a negative association with seeking care and has served as both a barrier to care and increased negative health outcomes (Peak et al., 2008).

Additionally, while not all Hispanics treat medicine this way, some do question the effectiveness of the practice and will supplement herbal or other more culturally sound methods to remedy illness (Smith et al., 2009). The presence of more traditional healing is found in the highest quantity among Latino farm workers, primarily with those of Mexican and Guatemalan heritage (Arcury et al., 2016). Due to Latino farmworkers often sustaining high rates of injury, low access to conventional healthcare, and limited opportunities for health insurance, many utilize more traditional forms of care (Arcury et al., 2016). The primary types of healers include *curanderos* and *espiritualistas* (spiritual healing), *hueseros* (bonesetters), *sobardores* (massages), and *yerberos* (herbalists) (Arcury et al., 2016). In a study looking at Mexican American women in Washington State, it was revealed that 21% of the participants received treatment from *curanderos*, *espiritualistas*, or *sobadores* at some point over the past five years. The usage of

these forms of care are often seen more commonly with farmworkers as many, particularly from Mexico, will travel back to their country every year as it is more common and culturally significant for many (Arcury et al., 2016).

While physical health is impacted by culture, mental health is the sector that is most highly impacted by culture and the cultural differences between the patient and provider. One of the largest issues that emit from the difference in culture and its effect on mental health for Hispanics is the way in which mental health distress is displayed (Jimenez et al., 2022). Among White individuals, mental health is often displayed in the forms of sadness, loss of interest, or other various means which are more psychological (Jimenez et al., 2022). However, since most Hispanics have culturally learned to repress their mental illness or not focus on it at all, the symptoms of mental illness reveal themselves as physiological symptoms such as pain, fatigue, headaches, and even gastrointestinal disease (Jimenez et al., 2022). Many health professionals aren't used to looking out for these types of symptoms to be associated with mental health disorders so there is a much higher percentage of people who are less likely to be screened or diagnosed properly, often missing proper treatment altogether (Cook et al., 2017).

Mental health among Hispanics also faces another consequence that is simply a product of cultural values and views on mental health specifically from older generations (Jimenez et al., 2022). Older Latinos have expressed the belief that mental illness is caused by a variety of issues including the loss of family and friends, issues within the family, and moving to a different place (Jimenez et al., 2022). Additionally, the disruption of one's social support network due to immigration is highly associated with negative health outcomes and an increase in perceived and experienced trauma (Jimenez et al., 2022). Yet, despite the acknowledgment of these issues potentially leading to more negative mental health, many older Hispanics still don't see it as the

big issue that many others might classify as (Sorkin et al., 2016). This demographic often equates poor mental health with having a weak character, being a punishment from God, or simply considering it a part of normal aging (Jimenez et al., 2022). Once again, this belief is most firmly rooted in the cultural idea of *fatalismo*, which in essence is the belief that if you go to the doctor when nothing is wrong, they will find something wrong (Peak et al., 2008). The previously discussed cultural belief of *machismo* also influences the older generation's idea of how care should be handled (Peak et al., 2008)**.** However, these beliefs have significant consequences on the younger generations and instill the idea that mental health is essentially a weakness and not to be prioritized as a true health issue (Peak et al., 2008). These cultural beliefs can act as a strong barrier to receiving adequate help for mental health and serves as a barrier for many to even consider accessing mental healthcare resources in the first place.

Discrimination

A final main factor that acts as a barrier to healthcare access for Hispanics in the United States is discrimination. Many Hispanic Americans face discrimination in healthcare, with one study showcasing how in a cross-sectional survey of 166 Latina immigrants, 42% of them had encounters with at least one act of discrimination in healthcare (Sheppard et al., 2014). There are a variety of factors that cause discrimination for this demographic in healthcare settings, with some already discussed and more to be elaborated on. One of the largest reasons for discrimination in the healthcare system stems from thoughts, or policies put in place, on immigration status (Sheppard et al., 2014). Most United States law offers very little if any financial assistance for healthcare to undocumented immigrants, and this leads to most undocumented immigrants forgoing care altogether due to the extremely high costs and concerns of deportation (Sheppard et al., 2014). Additionally, even if their undocumented immigrants can

find aid in seeking care, the rising anti-immigrant climate has significantly limited the number of immigrants seeking care (Sheppard et al., 2014). This increasingly negative attitude towards immigrants has led to many more cases of discrimination from healthcare providers and has led many Hispanic people to feel more marginalized and grow a significant distrust of the medical system (Sheppard et al., 2014).

The repercussions of this discrimination can be seen in many ways, one of which was discussed in the case of quality and timely care. A significant number of Hispanics in the United States, among other ethnic groups, still report some form of lack of timely care (Caraballo et al., 2022). This is often seen in extended wait times, deferred calls, difficult scheduling, and many other ways in which care for this demographic is cut short (Caraballo et al., 2022). The constant deferring of calls or extended wait times for seemingly no reason have had great impacts on the way that Hispanics go about receiving their healthcare, often deterring many from getting any in the first place (Caraballo et al., 2022). Even for those who can afford healthcare, this form of discrimination is extremely demoralizing and a main contributor to people not seeking care, especially primary care (Caraballo et al., 2022).

Language also serves as a primary barrier for many non-native English speakers and can create difficulty in communication between the patient and physician (Sheppard et al., 2014). In 2020, 26% of Hispanics reported not speaking English well or at all and are considered to have limited comfortability speaking English (Hall et al., 2022). This can lead to further discrimination from the care provider by establishing a power dynamic between the physician and patient (Cristancho et al., 2008). There have been many cases of physicians not explaining things clearly enough to the patient and rather than ensuring they understand, they simply continue and can charge more or assign unnecessary procedures, screenings, or medication

(Cristancho et al., 2008). While not incredibly common, this form of discrimination still happens in the healthcare system and is often seen in the form of the physician's own bias, even if they are not necessarily aware of it (Cristancho et al., 2008). The use of some medical information regarding Hispanics is also not always culturally sensitive and can lead to further issues and negative thoughts about the provider whether intentional or not (Sheppard et al., 2014).

According to a study that utilized the medical expenditure panel survey from 2013-2016, when compared to non-Hispanic Whites (NHW), Hispanics that were comfortable speaking in English (CE) were less likely to have a usual source of care (78% vs 84%) (Hall et al., 2022). Hispanic adults who had limited comfort speaking English (LCE) were less likely than Hispanics with CE to have a usual source of care (69% vs. 78%). This pattern of disparity between language capability among Latinos continued in the study for lack of ambulatory visits, emergency department visits, and dental visits. Mental health care service use is also significantly lower among those with LCE (Kim et al., 2011). In a study performed among 372 Latino and Asian immigrants with psychiatric disorders, only 19.4% had accessed mental health services (Kim et al., 2011). Additionally, the ability for Hispanics to trust their healthcare provider, culturally impacted by the ideas of *personalismo* and *confianza*, increases greatly when presented with a provider who speaks Spanish (Peak et al., 2008).

Finally, while not as common anymore, blatant racism still plays a role in the discrimination of Hispanics seeking care (Cristancho et al., 2008). An important reason for many Hispanics not seeking care is how uncomfortable they feel with a provider due to their implicit or explicit bias against them (Cristancho et al., 2008). This has been seen more commonly as anti-immigrant sentiments have risen since 2016 and perpetuated the explicit nature of racial discrimination (Peak et al., 2008). All these forms of discrimination have only led to more

distrust among the Latinx community in the United States and continue to be a major deterrent to care and a barrier to comfortable and safe access.

DISCUSSION

After selecting the articles and analyzing the results, many conclusions may be drawn from the research, but one common factor stands out among the various barriers, all identified factors are interlinked. The results show that a variety of barriers exist, each impacting access to health care in their own way, with their effect only compounded by the existence of other barriers. Although some issues have a greater impact on the rest of the barriers, many of these barriers have established relationships with certain outcomes.

To explain the observed interactions, one of the first disparities seen among the Latino community was how undocumented immigration status limited the ability for many Latinos to purchase health insurance (Escarce & Kapur, 2019b). While this barrier directly affects one's ability to access care in lack of purchasing insurance, its effect is compounded by the relationship immigration shares with discrimination (Garcini et al., 2022). For nearly 66% of the US population, healthcare is shown to be a primary stressor, and this angst is exacerbated for the Hispanic population within the US (Garcini et al., 2022). There is a consistent common fear among undocumented immigrants about being deported and due to their immigration status, many feel highly discriminated against (Garcini et al., 2022). This is directly seen in delay in care or lack of quality care seen by the few that can make it into the doctor's office (Oh et al., 2020). Although, delay in care is not a barrier propagated by simply immigration status or socioeconomic status, but rather amplified by existing language barriers (Oh et al., 2020).

The literature has shown that Spanish-speaking Latinos were 3.26 times more likely to not have a primary care provider and 1.27 times more likely to not have had a checkup in the

past year when compared to English-speaking Latinos (Oh et al., 2020). While income is also considered a motivating factor for these outcomes, limited English proficiency (LEP) has shown to be a primary reason that many struggle to access proper healthcare, regardless of documentation status (Oh et al., 2020). Those with LEP typically report higher cases of low-quality interactions between patient and provider, as many in this subgroup already find it increasingly difficult to understand the complex medical terminology, also struggling to ask and convey the right questions, often leading to more negative health outcomes (Oh et al., 2020). Due to this lack in effective communication, many Latinos that have the ability to access care still limit their interaction with it as there is little trust between the two parties, which can be seen in cultural beliefs like *fatalism*o (Fleming et al., 2016). Consequently, if a patient wants to seek care from a Spanish-speaking care provider, they may not have one in their local area and can be outside the bounds of their desired travel area, establishing another connection to the transportation barrier to care (Oh et al., 2020).

From issues with transportation, to insurance, to discrimination and cultural barriers, all these barriers share some form of commonality with one another. However, the literature has found two that work interchangeably with one another to affect the outcomes of nearly all other barriers, immigration status and socioeconomic status (Bailey et al., 2014). As previously mentioned, each works independently to affect another barrier, such as transportation or discrimination, but the true impact of this association lies in how these two influence each other. When looking at socioeconomic status, this factor alone can contribute to an increase in inaccessibility with transportation, higher likelihood of being under/uninsured, and a larger percentage of those facing discrimination in healthcare settings (Bailey et al., 2017). Additionally, looking solely at immigration status, its effect on insurance, quality/timely care,

and amount of people seeking care is negatively significant (Garcini et al., 2022). However, it is important to note that each of these factors can be a significant cause for the prevalence of the other. For Latinos that come into the United States as undocumented immigrants, they immediately are barred from accessing many healthcare benefits that documented immigrants have (Bailey et al., 2014). Yet an undocumented status is also greatly associated with lower income (Escarce & Kapur, 2019b). This is often because many undocumented Hispanic immigrants turn to more physically demanding and lower income jobs which have also been known to have unsteady unemployment (Fleming et al., 2016). Aside from this being the primary option for undocumented immigrants due to limited options, many properly documented immigrants have a lower health education attainment overall, even when compared to other minority groups, which leads many to this field of work (Fleming et al., 2016). Whether born in the states or immigrated, low socioeconomic status is a factor that affects all Latinos and is a primary driver for all other foreseen barriers (Fleming et al., 2016).

The underlying reason for undocumented immigrant status and low income being extreme barriers to accessing healthcare is due to the systematic issues embedded within the United States (Fleming et al., 2016). The literature shows that legislation has been put in place to keep undocumented immigrants out of public health benefits and the repercussions of this are even felt by those who are now properly documented (Garcini et al., 2022). For example, the COVID-19 stimulus bill provided financial relief to many essential workers, but undocumented immigrants still were not able to access the aid through direct payment or Medicaid as it still had not been expanded to them, even though most Hispanics in the US continued to put themselves at risk by continuing their essential jobs (Shiro & Reeves, 2020). Additionally, even those who are now US citizens can face extreme economic hardship due to the generational debt and

social/physical environment in which they reside (Fleming et al., 2016). Many within this group aren't able access public aid, such as Medicaid, which requires enrollees to be within 133.33% of the poverty line, although a majority of low-class Latinos live just outside of these margins (Fleming et al., 2016). Therefore, national bias against undocumented immigrants and its subsequent affect on socioeconomic status has led to Latinos in the United States facing the greatest number of barriers when it comes to accessing healthcare.

Some possible limitations of this review may come from the types of studies used to obtain the data for the completion of this literature review. Most of the articles used for the results section were cross-sectional and had little room for bias or confounding, there were a select few that may not have been as thorough as the cross-sectional studies and may have run into some bias or less accurate information along the way. Additionally, the methods to obtain the data may be flawed in how all resulting articles came from one source rather than multiple. It is possible that better and more pertinent data exists outside of the confounds of the one database used, therefore potentially leading to a less comprehensive review. This study also does not focus on proposing solutions for these barriers but rather simply identifying them instead of explaining potential ways to help break down these barriers. Finally, more concise results could potentially be yielded if the study was not as expansive. For example, rather than focusing on Hispanic adults in the United States a potentially more beneficial research question might have been restricted to looking at only Hispanics in urban or rural populations to get more specific data.

Implications of Research

With the various barriers to access to healthcare and the way they interact now identified, the next step would be to find the best solutions to these various issues. Dealing with every issue at once may prove to be unfeasible but tackling one problem at a time would be optimal to

reduce the number of barriers present to this demographic. Community-based interventions may yield some of the greatest success, yet more research may be needed to ensure its true effectiveness (Bailey et al., 2017). Additionally, this research shows that there is a large issue at hand with how the Hispanic population is treated in healthcare. While the issue is extremely multifaceted, it could be optimal to work towards change by altering the biases established within healthcare services and providing more resources to aid non-native speakers and address issues with a greater level of cultural understanding and sensitivity (Garcini et al., 2022). However, further research must be done into the different ways that policy might be able to aid in the financial and transportation/infrastructure-based barriers present in this community.

REFERENCES

1. Sorkin, D. H., Murphy, M., Nguyen, H., & Biegler, K. A. (2016). Barriers to Mental Health Care for an Ethnically and Racially Diverse Sample of Older Adults. *Journal of the American Geriatrics Society*, *64*(10), 2138–2143. https://doi.org/10.1111/jgs.14420
2. Jimenez, D. E., Park, M., Rosen, D., Joo, J. hui, Garza, D. M., Weinstein, E. R., Conner, K., Silva, C., & Okereke, O. (2022). Centering Culture in Mental Health: Differences in Diagnosis, Treatment, and Access to Care Among Older People of Color. *The American Journal of Geriatric Psychiatry*, *30*(11).
3. Saluja, S., Hochman, M., Dokko, R., Morrison, J. L., Valdez, C., Baldwin, S., Tandel, M. D., & Cousineau, M. (2022). Community-Based Health Care Navigation's Impact on Access to Primary Care for Low-Income Latinos. *The Journal of the American Board of Family Medicine*, *35*(1), 44–54. https://doi.org/10.3122/jabfm.2022.01.210253
4. Luque, J. S., Soulen, G., Davila, C. B., & Cartmell, K. (2018). Access to health care for uninsured Latina immigrants in South Carolina. *BMC Health Services Research*, *18*(1). https://doi.org/10.1186/s12913-018-3138-2
5. Caraballo, C., Ndumele, C. D., Roy, B., Lu, Y., Riley, C., Herrin, J., & Krumholz, H. M. (2022). Trends in Racial and Ethnic Disparities in Barriers to Timely Medical Care Among Adults in the US, 1999 to 2018. *JAMA Health Forum*, *3*(10), e223856. https://doi.org/10.1001/jamahealthforum.2022.3856
6. Akinlotan, M. A., Nima Khodakarami, Primm, K., Bolin, J. N., & Ferdinand, A. O. (2023). Travel for medical or dental care by race/ethnicity and rurality in the U.S.: Findings from the 2001, 2009 and 2017 National Household Travel Surveys. *Preventive Medicine Reports*, *35*, 102297–102297. https://doi.org/10.1016/j.pmedr.2023.102297

7. Smith, A. K., Sudore, R. L., & Pérez-Stable, E. J. (2009). Palliative Care for Latino Patients and Their Families. *JAMA*, *301*(10), 1047. https://doi.org/10.1001/jama.2009.308
8. Topmiller, M., Zhen-Duan, J., Jacquez, F. J., & Vaughn, L. M. (2016). Place Matters in Non-Traditional Migration Areas: Exploring Barriers to Healthcare for Latino Immigrants by Region, Neighborhood, and Community Health Center. *Journal of Racial and Ethnic Health Disparities*, *4*(6), 1214–1223. https://doi.org/10.1007/s40615-016-0329-6
9. Cristancho, S., Garces, D. M., Peters, K. E., & Mueller, B. C. (2008). Listening to Rural Hispanic Immigrants in the Midwest: A Community-Based Participatory Assessment of Major Barriers to Health Care Access and Use. *Qualitative Health Research*, *18*(5), 633–646. https://doi.org/10.1177/1049732308316669
10. Wolfe, M. K., McDonald, N. C., & Holmes, G. M. (2020). Transportation Barriers to Health Care in the United States: Findings From the National Health Interview Survey, 1997–2017. *American Journal of Public Health*, *110*(6), 815–822. https://doi.org/10.2105/ajph.2020.305579
11. Canedo, J. R., Miller, S. T., Schlundt, D., Fadden, M. K., & Sanderson, M. (2017). Racial/Ethnic Disparities in Diabetes Quality of Care: the Role of Healthcare Access and Socioeconomic Status. *Journal of Racial and Ethnic Health Disparities*, *5*(1), 7–14. https://doi.org/10.1007/s40615-016-0335-8
12. Maxwell, A. E., Young, S., Crespi, C. M., Vega, R. R., Cayetano, R. T., & Bastani, R. (2015). Social determinants of health in the Mixtec and Zapotec community in Ventura County, California. *International Journal for Equity in Health*, *14*(1). https://doi.org/10.1186/s12939-015-0148-0
13. Sheppard, V. B., Williams, K. P., Wang, J., Shavers, V., & Mandelblatt, J. S. (2014). An Examination of Factors Associated with Healthcare Discrimination in Latina Immigrants: The Role of Healthcare Relationships and Language. *Journal of the National Medical Association*, *106*(1), 15–22. https://doi.org/10.1016/S0027-9684(15)30066-3
14. Dulin, M. F., Tapp, H., Smith, H. A., de Hernandez, B. U., Coffman, M. J., Ludden, T., Sorensen, J., & Furuseth, O. J. (2012). A trans-disciplinary approach to the evaluation of social determinants of health in a hispanic population. *BMC Public Health*, *12*(1). https://doi.org/10.1186/1471-2458-12-769
15. Cook, B. L., Trinh, N.-H., Li, Z., Hou, S. S.-Y., & Progovac, A. M. (2017). Trends in Racial-Ethnic Disparities in Access to Mental Health Care, 2004–2012. *Psychiatric Services*, *68*(1), 9–16. https://doi.org/10.1176/appi.ps.201500453
16. Bailey, Z. D., Krieger, N., Agénor, M., Graves, J., Linos, N., & Bassett, M. T. (2017). Structural Racism and Health Inequities in the USA: Evidence and Interventions. *The Lancet*, *389*(10077), 1453–1463. https://doi.org/10.1016/s0140-6736(17)30569-x
17. Bailey, R. K., Jaquez-Gutierrez, M. C., & Madhoo, M. (2014). Sociocultural Issues in African American and Hispanic Minorities Seeking Care for Attention-Deficit/Hyperactivity Disorder. *The Primary Care Companion for CNS Disorders*, *16*(4). https://doi.org/10.4088/pcc.14r01627
18. Garcini, L. M., Venta, A., Mercado, A., Galvan, T., Compean, C. L., Guerrero, G., & Domenech Rodríguez, M. M. (2022). One more wall to cross: The role of psychologists in addressing integrated health among undocumented Latinx immigrants in inpatient medical settings. *Psychotherapy*. https://doi.org/10.1037/pst0000381

19. Funk, C., & Lopez, M. H. (2022, June 14). *Hispanic Americans' experiences with health care*. Pew Research Center Science & Society. https://www.pewresearch.org/science/2022/06/14/hispanic-americans-experiences-with-health-care/
20. CDC. (2022, June 27). Unfair and Unjust Practices and Conditions Harm Hispanic and Latino People and Drive Health Disparities. *Centers for Disease Control & Prevention*. https://www.cdc.gov/tobacco/health-equity/hispanic-latino/unfair-and-unjust.html
21. Radley, D., Baumgartner, J., Collins, S., Zephyrin, L., & Schneider, E. (2021, November 18). *Achieving Racial and Ethnic Equity in U.S. Health Care*. Www.commonwealthfund.org. https://www.commonwealthfund.org/publications/scorecard/2021/nov/achieving-racial-ethnic-equity-us-health-care-state-performance
22. Centers of Disease Control and Prevention. (2022, July 1). *What is health Equity?* Centers for Disease Control and Prevention. https://www.cdc.gov/healthequity/whatis/index.html
23. Diamond, F. (2022, November 2). *Study: Racial, ethnic minorities experienced more barriers to healthcare over a nearly 20-year span*. Fierce Healthcare. https://www.fiercehealthcare.com/providers/study-racial-ethnic-minorities-experienced-more-barriers-healthcare-over-nearly-20-year
24. CDC. (2021, November 24). *Racism and Health*. Centers for Disease Control and Prevention; Centers for Disease Control and Prevention. https://www.cdc.gov/minorityhealth/racism-disparities/index.html
25. Riley, W. J. (2012). Health Disparities: Gaps in Access, Quality and Affordability of Medical Care. *Transactions of the American Clinical and Climatological Association*, *123*, 167–174. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3540621/#:~:text=A%20few%20examples%20are%20illustrative
26. Williams, D. R., & Rucker, T. D. (2000). Understanding and addressing racial disparities in health care. *Health Care Financing Review*, *21*(4), 75–90. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194634/
27. Valdez, R. B., Giachello, A., Rodriguez-Trias, H., Gomez, P., & de la Rocha, C. (1993). Improving access to health care in Latino communities. *Public Health Reports (Washington, D.C. : 1974)*, *108*(5), 534–539. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1403427/#:~:text=Access%20to%20appropriate%20medical%20care
28. Damle, M., Wurtz, H., & Samari, G. (2022). Racism and health care: Experiences of Latinx immigrant women in NYC during COVID-19. *SSM - Qualitative Research in Health*, *2*, 100094. https://doi.org/10.1016/j.ssmqr.2022.100094
29. Andrade, N., Ford, A. D., & Alvarez, C. (2020). Discrimination and Latino health: A systematic review of risk and resilience. *Hispanic Health Care International*, *19*(1), 154041532092148. https://doi.org/10.1177/1540415320921489
30. Escarce, J. J., & Kapur, K. (2019). *Access to and Quality of Health Care*. Nih.gov; National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK19910/
31. Peak, T., Gast, J., & Ahlstrom, D. (2008). A Needs Assessment of Latino Men's Health Concerns. *American Journal of Men's Health*, *4*(1), 22–32. https://doi.org/10.1177/1557988308327051

32. Arcury, T. A., Sandberg, J. C., Mora, D. C., Talton, J. W., & Quandt, S. A. (2016). North Carolina Latino Farmworkers' Use of Traditional Healers: A Pilot Study. *Journal of Agromedicine*, *21*(3), 253–258. https://doi.org/10.1080/1059924x.2016.1180272
33. Mojica, C. M., Flores, B., Ketchum, N. S., & Liang, Y. (2017). Health Care Access, Utilization, and Cancer Screening Among Low-Income Latina Women. *Hispanic Health Care International: The Official Journal of the National Association of Hispanic Nurses*, *15*(4), 160–165. https://doi.org/10.1177/1540415317735343
34. Kim, G., Aguado Loi, C. X., Chiriboga, D. A., Jang, Y., Parmelee, P., & Allen, R. S. (2011). Limited English proficiency as a barrier to mental health service use: A study of Latino and Asian immigrants with psychiatric disorders. *Journal of Psychiatric Research*, *45*(1), 104–110. https://doi.org/10.1016/j.jpsychires.2010.04.031
35. Montealegre, J. R., & Selwyn, B. J. (2012). Healthcare Coverage and Use Among Undocumented Central American Immigrant Women in Houston, Texas. *Journal of Immigrant and Minority Health*, *16*(2), 204–210. https://doi.org/10.1007/s10903-012-9754-8
36. Oduro, C., Connor, S. E., Litwin, M. S., & Maliski, S. L. (2012). Barriers to Prostate Cancer Care. *Qualitative Health Research*, *23*(3), 375–384. https://doi.org/10.1177/1049732312467852
37. Hall, I. J., Rim, S. H., & Dasari, S. (2022). Preventive care use among Hispanic adults with limited comfort speaking English: An analysis of the Medical Expenditure Panel Survey data. *Preventive Medicine*, *159*, 107042. https://doi.org/10.1016/j.ypmed.2022.107042
38. Garcini, L. M., Venta, A., Mercado, A., Galvan, T., Compean, C. L., Guerrero, G., & Domenech Rodríguez, M. M. (2022). One more wall to cross: The role of psychologists in addressing integrated health among undocumented Latinx immigrants in inpatient medical settings. *Psychotherapy*. https://doi.org/10.1037/pst0000381
39. Bailey, R. K., Jaquez-Gutierrez, M. C., & Madhoo, M. (2014). Sociocultural Issues in African American and Hispanic Minorities Seeking Care for Attention-Deficit/Hyperactivity Disorder. *The Primary Care Companion for CNS Disorders*, *16*(4). https://doi.org/10.4088/pcc.14r01627
40. Shiro, A. G., & Reeves, R. V. (2020, September 25). *Latinos often lack access to healthcare and have poor health outcomes. Here's how we can change that*. Brookings. https://www.brookings.edu/articles/latinos-often-lack-access-to-healthcare-and-have-poor-health-outcomes-heres-how-we-can-change-that/
41. Oh, H., Trinh, M. P., Vang, C., & Becerra, D. (2020). Addressing Barriers to Primary Care Access for Latinos in the U.S.: An Agent-Based Model. *Journal of the Society for Social Work and Research*, *11*(2), 165–184. https://doi.org/10.1086/708616
42. Escarce, J. J., & Kapur, K. (2019b). *Access to and Quality of Health Care*. Nih.gov; National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK19910/
43. Fleming, P. J., Villa-Torres, L., Taboada, A., Richards, C., & Barrington, C. (2016). Marginalisation, discrimination and the health of Latino immigrant day labourers in a central North Carolina community. *Health & Social Care in the Community*, *25*(2), 527–537. https://doi.org/10.1111/hsc.12338