Disparities in Healthcare Access Among the Scranton Latino Community

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BACKGROUND

Scranton is the sixth-largest city in Pennsylvania and the largest in the northeastern region of PA. It is a metropolitan city (Norcross, 2016). It once flourished due to the success of the coal and garment industries. Now, tourist attractions such as the Steam Town National Historic Site are hallmarks of the city. In the 20th century, Scranton saw a large influx of immigration, especially European immigration. Italian and Irish were the biggest ethnic groups that immigrated to the area in the 20th century (Parsons, 2007). Up until the late 1980s, the Hispanic immigrant population was relatively small; however, that began to change as increasing numbers of Spanish-speaking immigrants created a second wave of immigration throughout the area (Parsons, 2007).

Yet Scranton, as well as other cities in Pennsylvania such as Hazleton and Wilkes Barre, has been apprehensive about the second wave of immigrants migrating into the city over the last 40 years (Parsons, 2007). For example, in 2006 Hazleton passed a law declaring English as the city's official language, provided strict guidelines for the deportation of undocumented immigrants, and promised harsh punishments for those who hired them (Parsons, 2007). Scranton, on the other hand, seems to have (at least at a governmental level) distanced itself from such overt divisiveness; yet it does not take much effort to discover that similar prejudicial sentiments prevail in the city as well (Parsons, 2007).

In a study looking at racial/ethnic segregation and spatial isolation, Scranton ranked among the top five most racist metropolitan areas out of 287 studied (Rugh, 2014). The term "spatial isolation" refers not simply to the racial composition of communities and neighborhoods; but also to the spatial proximity of such communities (Reardon, 2004). One study conducted an analysis of Google trends measuring the volume of pejorative terms regarding Hispanics and Non-Hispanic Blacks used in the area of Scranton as well as other metropolitan areas (Rugh, 2014). Scranton had one of the highest volumes of pejorative terms toward these minority groups and ranked among the top five. The Google trend method was previously proven effective by its ability to predict voter turnout for President Obama across market areas in the 2008 presidential election (Rugh, 2014). Hispanic segregation, and especially Hispanic spatial isolation, have risen over the last three decades (Rugh, 2014). Anti-Hispanic sentiment also materializes in many forms, including restrictions on density zoning.

For example, limiting the density of residential construction in predominantly non-Hispanic White communities, which raises the costs of housing and creates both income and racial segregation, is consequential in slowing down or stopping integration (Rugh, 2014).

Given that racial prejudice has been documented in Scranton, it is reasonable to presume that density zoning and other activities that slow or stop racial integration have also taken place.

The issue of healthcare access within the context of racial discrimination is also important and has been illustrated by numerous studies. For example, Greer's study on metropolitan racial segregation and deaths due to cardiovascular disease found that among non-Hispanic Blacks in metropolitan areas, segregation (as well as other factors) was positively associated with heart disease mortality (Greer, 2014). Haas' study (2004) also demonstrates that among a national sample, non-Hispanic Blacks who reside in segregated metropolitan areas have significantly higher rates of death from heart disease. These findings suggest that spatial isolation and residential segregation could be factors negatively contributing to a multitude of health determinants, including access to quality healthcare (Haas, 2004). Moreover, Hispanics residing in Pennsylvania are more likely than non-Hispanic Blacks and Whites to report no usual source of care, as well as to report having no doctor visits in the past two years (KFF, 2016). About a quarter of Hispanics in Pennsylvania report being in fair or poor health generally. Furthermore, non-Hispanic Blacks and Hispanics are approximately three times as likely to be poor than Non-Hispanic Whites (KFF, 2016).

The effect that socioeconomic status has on healthcare access is impossible to overlook. Low socioeconomic status (SES) is a contributor to an array of factors that adversely affect healthcare outcomes, including access to healthcare and the quality of care that is received. Individuals with lower SES have more chronic conditions, self-report worse health, and have lower life expectancy than higher SES individuals (Arpey, 2017). In addition to having fewer access to healthcare due to high expenses and coverage, lower SES individuals receive fewer medications and diagnostics for their chronic diseases than higher SES individuals (Arpey, 2017). Furthermore, because lower SES individuals are more likely to lack health insurance, they often receive late treatment for their conditions. Lack of health insurance can cause individuals to forego primary care, which can result in preventive issues turning into severe medical problems due to inconsistent care (Morrisey, 2008).

Study Aim

Oftentimes, however, studies lack direct and open input from individuals who are experiencing the impacts of issues such as low SES, spatial isolation, and geographic segregation. Although many studies have established the link between those factors and negative health outcomes due to access or other health disparities, not many have gone out of their way to solicit community members' perspectives on their situations, which are important to collect to benefit the community. For example, organizations may want to help the community, but without direct insight from the people living in those communities, they may cause unforeseen damage or use resources ineffectively. Through the use of both quantitative data (analyzing health care access outcomes) and qualitative data (analyzing self-assessment of community needs), this study will gain insight into perceptions of need among residents living in the southside of Scranton. The confluence of both structural inequalities and individual disparities may result in this community experiencing unequal access to health care. It is imperative, therefore, to better understand the effect of segregation and isolation among Scranton's Hispanic and low-SES community. The Southside of Scranton, whether purposely segregated or isolated, is a majority

Hispanic and low-SES community that is likely to suffer from low levels of healthcare access and utility.

The primary goal of this study is to examine the factors that are significantly related to healthcare access among Scranton's Hispanic population. Specifically, the study examines the following three research questions. First, we ask: To what extent do Hispanics in the Southside of Scranton report difficulties accessing healthcare, including access to physicians, specialists, and medications? Second, we ask: To what extent does access to healthcare difficulties vary by gender? It is likely that Hispanic women have lower access to healthcare than Hispanic men, due to a variety of social factors. Social status, gender norms, and low-skilled work opportunities are some contributors to women accounting for the biggest proportion of those living in poverty (Puentes-Markides, 1992). Low-paying jobs may render many women unable to afford quality healthcare, as well as cause stressors that may influence health-seeking behavior (Puentes-Markides ,1992).

Finally, we ask what perspectives do Hispanics residing in the southside of Scranton have regarding their community's health care needs? The study will examine patterns and themes that emerge from the perception of need of Hispanics in the southside of Scranton.

Study Implications

The study aims to show the results of the survey as they relate to the broader healthcare, historic, and socioeconomic environment of Scranton PA. This research can be the foundation for future research in the area. If inequity is shown to be a pattern, other studies can be carried out to understand the causalities behind those inequalities. Policy shifts, although driven by a variety of influences, can happen because of research. Academic literature often focuses on ways in which rigorous research was unable to make such changes, but there are examples of the opposite (Philpott, 2002). The Mwanza trial I is a prime example of this, the results of this study were proven to be incredibly effective in changing policy (Philpott, 2002). Treatment services with regard to sexually transmitted infections (STIs) improved significantly in Tanzania. Management of STIs in rural areas saw improvements, and the rate of incidence of HIV dropped around 40% (Philpott, 2002). The incredible changes that happened as a result of this study, were due to of various reasons, as stated in the Philpott case study: "The policy environment was favorable, researchers and policymakers formed strategic alliances for policy shift and it was possible to present the data in an easily understandable form" (Philpott, 2002). It is not always possible for this to happen, nor is it likely that will be the case for Scranton, given its history. Nonetheless, as we see recent social movements produce significant change throughout the country (e.g., racial justice advocacy), this may be the most favorable environment for health access policy changes in Scranton. In consequence, it is extremely important to share the results of this study with community leaders, local organizations, and citizens of the area.

METHODOLOGY

Data Source

The study will conduct secondary data analysis of survey data collected by the Geisinger Commonwealth Medical School's Center of Excellence program. The data was collected from July 6th until the 14th of 2018. Respondents were recruited from two locations in the southside of Scranton: a Farmer's Market and a United Neighborhood Center Language Class. Individuals age 18 and older were eligible to participate in the study. The survey was delivered via electronic and paper surveys and were available in both English and Spanish. A total of 119 respondents participated in the survey.

The anonymity of the respondent was reassured before delivering each survey. The respondents were also reminded that they could skip any questions that they did not want to answer. The survey received exempt IRB approval.

Measures

The study's first primary outcome includes a set of binary responses to the following six questions measuring health care access difficulties: 1) *Do you have access to a primary care doctor or primary care services?* 2) *Was there a time in the past 12 months when you or anyone in your household needed to see a doctor but could not?* 3) *Was there a time in the past 12 months when you or anyone in your household needed to see a medical specialist but could not?* 4) *Was there a time in the past 12 months when you or anyone in your household needed to see a dentist but could not?* 5) *Was there a time in the past 12 months when you or anyone in your household needed prescription medication(s) but could not get them?* and 6) *Was there a time in the past 12 months when you or anyone in your household wanted or needed counseling or therapy but could not get it?* The respondents answered "yes" or "no" to each of the questions.

To account for the number of health care access difficulties a respondent reported experiencing, a numerical scale was created ranging from 0 to 6 based on the number of positive responses reported to each of the six questions above. Moreover, respondents with missing data on two or more questions were excluded from the analysis (n=10).

The study's secondary outcome is the respondents' perceptions of needs. To measure the populations' perspectives regarding ongoing needs, the survey included an open-ended response item that asked the following question: *"Please provide any comments that you have regarding the needs of Hispanics and Latino(a)s who live in the area."* Thematic content analysis was conducted to identify common themes and patterns that emerged within respondents' perceptions of need for their community. Emerging themes were captured and categorized. These dominant themes were then analyzed for relevance and data representation and contextualized to the study. Analysis also included identifying any differences in themes appearing within different genders.

Sociodemographic Characteristics

Respondents were stratified by gender to note whether one gender reports better or worse access to healthcare than the other. This was done by looking at the total distribution of responses to the survey questions. The study also examined other sociodemographic factors such as age, income, and employment status to obtain a better picture of the social determinants that may affect respondents' ability to access healthcare, information that may help us make inferences about the populations' access outcomes.

Analysis

The study applied descriptive statistical methods to analyze the data. A p-value of 0.05 was used to measure whether significant associations between gender and access difficulty existed. GraphPad prism (version 7.04, GraphPad software, San Diego, CA) was used to perform the described procedures. Results from these procedures demonstrate the different levels of access to care in the sample and provide a window into the significance of gender as it pertains to the levels of care.

RESULTS

Quantitative Results

Table 1 describes sociodemographic characteristics of the sample population. Respondents were majority female and comprised 56% percent of the population. Nineteen percent of the respondents described themselves as unemployed, while 14% were part-time workers. The category "Other", which makes up 21% of the respondents, includes students and stay-at-home respondents. Most of the sample population falls under the income bracket of $10,000 to $24,999 per year. In addition, 14% of the participant's income is less than $10,000 a year. Moreover, almost half of our participants said they had difficulties accessing a dentist when needed, and more than one-third of the participants had difficulties accessing a doctor when needed.

Table 2 demonstrates the type of healthcare access difficulties by gender. For example, the number of respondents who indicated that they lack access to a primary care provider is marked as n, a percentage, and a p-value For each of the healthcare access issues examined, the p-value suggests there were no significant differences in the type of healthcare access issue experienced by males or females.

Table 3 illustrates the number of access difficulties experienced by gender. If we zoom in to healthcare issues experienced by the respondents, we can see that there are some differences in the number of issues that affect each gender. In general, we can see that a higher percentage of females experienced more than 2 access issues compared to male respondents, although this difference is not statistically significant.

Qualitative Results

The survey included one open-ended question that provided the respondents with an opportunity to comment on their perception of the community needs: "Please provide any comments that you have regarding the needs of Hispanics and Latino(a)s who live in the area." Thirty-one respondents, or 26% of the sample, provided commentary. Sixty-one percent of the answers were written in Spanish. Comments were reviewed by the first author and a second coder, two themes emerged from the responses. Following a grounded theory approach, a total of two dominant themes emerged from the data including, "Health Access" and "Social Determinants of Health". Twenty-six comments or 84% of the comments expressed needs while 5 comments (16%) were unrelated to needs such as "I'm not sure" or "Loves Geisinger".

The first theme, Health Access, relates to comments that expressed the need for improvement in areas of acquisition of health or health delivery. For example, one respondent stated, "Necesitamos más personal para que atiendan la comunidad hispana y puedan atender mejor y allá una mejor comunicación y mejor trato la que muchas de las beses (sic) el idioma es un gran obstáculo". The comment explains the need for more personnel that can tend to the Hispanic community. In addition, it expresses the need for better treatment and communication with the community, pointing out that sometimes language can be a big obstacle for Hispanic individuals residing in the area. In healthcare, it is essential to address those barriers. Situations such as misunderstandings due to language can have fatal consequences.

There were a few subthemes that emerged within the dominant theme of "Health Access". For instance, translation was quoted a few times as a barrier for access to care in the comments. One respondent wrote via a translator, "She would like more translators in areas that are offering health services. For example, when she goes to the dentist there is no one to translate." Important decisions about a patient's health can be compromised when they are

unable to communicate their needs to the provider. Difficulty obtaining insurance was a second subtheme that is important to note. When asked about the needs of the community, one respondent noted "Problems getting insurance" as an issue affecting Hispanics in the area. Lack of insurance creates access issues that then lead to, in some cases, severe medical illness (Morrisey, 2008). Improving access to healthcare was the issue that participants mentioned the most (n=16), with comments such as "Mas programas con acceso a salud a bajo costo" and "Más seguridad Y médicos a nuestro alcance", which translate to "More programs for accessing healthcare at low cost" and " (More safety/security/insurance) and more (available/accessible) doctors" respectively. The volume of comments related to healthcare access may be an indicator of prevalence for access issues within the community.

The second dominant theme, the Social Determinants of Health, include views related to education, job security, and housing. For this theme, the topics addressed by participants were more diverse. Some respondents (n= 4) talked about job opportunities and housing. For example, one respondent wrote, "Escasos empleos, apartamentos o casas para rentar". Other respondents (n=5) discussed the need for educational programs such as English classes and programs for children. For example, one respondent expressed, "I feel that we have the need of more schooling for people to learn English and be able to FEND FOR THEMSELVES". Another participant wrote, "Hispanic needs better housing". Although these issues may seem to not be directly related to healthcare, they are factors that could affect health outcomes. For example, a misunderstanding due to language barriers can cause a patient to misuse medication or not understand her condition correctly. Lack of adequate living conditions can produce illness. In addition, scarce work opportunities can affect people's ability to access healthcare, as well as healthy foods.

DISCUSSION

This study investigated healthcare access in the Hispanic population residing in the southside of Scranton, PA. Several areas within the study need to be further researched to provide conclusive statements about the issues discussed. One of those areas is the difference in difficulties experienced by gender. Further research on other sociodemographic characteristics of the population may be insightful in understanding health access in the community.

Conversely, much of the information obtained suggests access difficulty within the population. In 4 of the 6 access issues examined in this study, more than 30% of the population described access difficulties. Female participants seemed to experience a greater amount of issues simultaneously. Fifty percent of female participants experienced more than 2 access issues, while 42% of males experienced more than two access issues. Nineteen percent of the population was unemployed, 14% worked part-time, comprising 33% of the population that did not have a full-time job. In addition, much of the sample population falls under the income bracket of $10,000 to $24,999 a year. Fourteen percent makes under $10,000, which may suggest low levels of access to healthy foods, and even a high rate of uninsured people within the population.

Health care access was the number one theme throughout the responses to the open-ended question (16 comments were about health access). This finding, as well as the socioeconomic data, suggest that lack of health access may be an essential factor affecting health outcomes of the population. Lack of insurance emerged as an important subtheme of health access. In addition to difficulty obtaining insurance, the lack of resources to help with the process was also raised by participants. Lower socioeconomic status individuals are more likely to lack insurance coverage, and 56% of the sample population makes under $25,000 a year.

Behavioral determinants of health can be affected negatively when individuals lack financial stability. They may not be able to afford healthy foods, doctor visits, or even necessary medical procedures.

Further research may need to be conducted with regard to discrimination and tension. Comments addressing tension and discrimination were not sufficient to consider them a theme. On the other hand, the lack of Hispanic personnel, translation, and mistreatment of Hispanics in the area could be influenced by racial tensions within the city. Healthcare organizations may benefit from patient-centered approaches in order to better meet the needs of the population. Other social determinants of health that could be influenced by racial tension are security, jobs, and housing opportunities. This is particularly germane given that ten out of the twenty-six respondents who wrote about concerns expressed a need regarding housing, job security, and education.

In conclusion, further investigation into these issues with a larger sample is needed to draw conclusive statements from the data. Even so, both qualitative and quantitative data seem to indicate that many individuals are having difficulty accessing healthcare. Sociodemographic characteristics, as well as racial tensions, could be negatively impacting health outcomes for Hispanics in the Southside of Scranton. In addition, there are indications that Hispanic women may be experiencing a larger spectrum of access difficulties than Hispanic men within the community.

Table 1. Descriptive Statistics of the Study Sample

	N = 119	Percentage
Gender		
Male	47	44%
Female	60	56%
Age		
18-30	34	31%
31-55	49	45%
55+	8	7%
Employment Status		
Employed- full time	46	43%
Employed – Part time	15	14%
Unemployed	20	19%
Other	23	21%
Income		
Less than 10k per year	15	14%
10k to 24,999k per year	45	42%
25k to 50k per year	21	19%
50k to 75k per year	9	8%
75k+	1	0.9%
Healthcare Access		
Primary care access	37	34%
Access to doctor when needed	38	35%
Access to medical specialist when needed	35	32%
Access to dentist when needed	49	45%
Access to counseling/therapist when needed	28	26%
Access to medication when needed	26	24%

Table 2. Types of Healthcare Access Difficulties by Gender

Healthcare Access Issue	**Male**		**Female**		***P*-value**
	n	Pct.	n	Pct.	
Primary care access	19	40%	18	30%	0.2057
Access to Doctor when needed	14	30%	24	40%	0.2057
Access to Medical specialist when needed	14	30%	21	55%	0.3181
Access to Dentists when needed	25	53%	24	40%	0.3181
Access to Medication when needed	13	28%	15	25%	0.7607
Access to Counseling/Therapy when needed	11	23%	15	25%	0.7607

Table 3. Number of Healthcare Access Difficulties Experienced by Gender

Number healthcare access issues	**Male**		**Female**		***P*-value**
	n	Pct.	n	Pct.	
0	15	31%	16	27%	0.5228
1	5	10%	9	15%	0.5965
2	4	8%	13	22%	0.1099
3	5	10%	6	10%	0.8549
4	5	10%	3	5%	0.2588
5	5	10%	5	8%	0.6548
6	2	4%	3	5%	0.8993

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