EQUAL ACCESS TO HEALTH CARE

FOR ALL MISSOURIANS

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Introduction

Consider first the demographical evidence: (A) Latinos, at 32 million, make the United States the fifth largest country of Spanish origin. By 2030, with a projected 96.3 million, the United States will be second, after Mexico. (B) California is already a state where the majority consists of minorities. (C) Hispanics now outnumber blacks in six of America's ten largest cities, (and in three of these they surpass non-Hispanic whites). By 2003, they will outnumber blacks in 18 of the 25 most populous U.S. counties. (D) Hispanics have grown in the last decades at 10 times the rate of non-Hispanic whites, and they are overwhelmingly an urban population. (E) Latinos represent 50 percent of the population growth in 10 central states, (they now make up 27 percent of the population of Chicago), which has led to "the browning of the Midwest." (F) Latinos have contributed 71 percent of the U.S. Catholic growth since 1960, but they also feed into Evangelical and Protestant expansion, (Hispanics are now over 15 percent Protestant). (G) Two-thirds of all U.S. Hispanics are of Mexican origin, (roughly half of these born in Mexico). Besides Cubans and Puerto Ricans, recent immigration has added significant numbers of Dominicans, (who now outnumber Puerto Ricans in New York), and Salvadorans, (There are more Salvadorans in Los Angeles than there are in San Salvador.). (H) Intermarriage across Hispanic categories, (e.g., Ecuadorians with Puerto Ricans, etc.), is on the rise. We are getting a generation of more generic "Hispanics". (I) The Hispanic retail market is huge, generating $28.9 billion annual sales in Los Angeles, $17.6 billion in New York, $9 billion in Miami, and $6 billion each in San Francisco and Chicago.

The Latino potential for social and political change in our cities is restricted because so many recent immigrants have been trapped into traditional urban manufacturing jobs that are being massively automated, suburbanized or exported overseas.

The best evidence is that new immigrants replace rather than displace American workers. Inner-city schools fail the new immigrants; returns on education for Hispanics are less than for non-Hispanic whites. Inter-ethnic differentials in college attendance have widened, not decreased, in the last decade.

U.S. Latinos seem trapped on the wrong side of the "digital divide". Aging white voters consistently vote down schools. Nationwide, 70 percent of black students and 75 percent of Latinos attend schools that are predominantly Afro-American and Latino. "The principle of a "common education" has become a bad joke."

Many Hispanics fail to vote, but the potential is there and growing. Hispanics hold a strategic concentration in New York and Florida. One in five voters in Texas and one in seven in California is Hispanic.

In response to anti-immigrant backlash, 255,000 Mexican became citizens in 1997, the largest single nation naturalization record in American history. Hispanics are reshaping the American labor movement in social mobilization, such as Los Angeles's Justice for Janitors and in the food, health care and construction industries.

Aside from jobs … the vital public resources for the working poor are education, health care and transit.

DEMOGRAPHICS

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Spanish speaking (both immigrant and non-documented) are estimated at over 35,000+ in St. Louis. There has been an increase of Missouri Hispanics of 92.2 percent since 1990.

Vietnamese refugees are estimated at 16,000+.

Presently there are 37,000 refugees from former Yugoslavia, including American-born children, making St. Louis the top Bosnian resettlement site in the country.

Approximately 5,000 Jewish and Evangelical Christian refugees from the former Soviet Union are in the greater Metropolitan area.

There also are small, but significant groups, of Africans from Somalia, Ethiopia, Eritrea, Nigeria, Republic of Congo, Sierra Leone, Sudan, Burundi, and Liberia.

Other small but significant groups are from: Afghanistan, Iran and Iraq (Arabic & Kurdish).

There are significant numbers of non-documented immigrants of Asian, Canadian, European and Hispanic origin in the region.

Some St. Louis neighborhoods are comprised of 20% refugee/immigrant families.

17% of Saint Louis City families use a primary language other than English at home.

*Statistical estimates from: The International Institute, Refugee Reports, Census Data, St. Louis Post-Dispatch

ACCESS TO PHYSICIAN CARE

175,000 people in St. Louis City and County have no health insurance. 70% of those individuals reside in Saint Louis County.

Most of the uninsured have low-income jobs and work for companies that do not offer health care benefits.

1 in every 7 Missouri residents (>860,000 individuals) is insured by the Medicaid Program.

60 low-income Missouri counties have critical shortages in the number of health care professionals.

Specialty care appointment wait times commonly average 3-4 months for patients referred from community health centers.

20% of Missouri's 9,100 doctors do not participate as Medicaid providers.

2/3 of the physicians participating in Medicaid see less than 50 Medicaid patients per year.

Only 347 providers in Missouri have a significant Medicaid practice. These doctors account for >50% of all outpatient care received by Medicaid patients.

Missouri Medicaid payments to physicians are among the lowest in the United States (ranking 40th out of 50 states).

Missouri Medicaid pays physicians about 50% of what other Midwestern states pay for providing outpatient care.

Missouri Medicaid payments to physicians do not even cover the overhead costs (office staff, rent and utilities, medical supplies, malpractice insurance, etc.). For example, overhead costs for a typical visit average $41 while Missouri Medicaid pays only $20 for a Level 1 new patient visit.

With rare exception, Missouri Medicaid payments to physicians have remained unchanged since 1995 while office overhead expenses have increased at a rate of 6.2% per year.

ACCESS TO TRAUMA CARE IN MISSOURI

In Missouri, more than 3,500 people die each year from trauma, exceeded only by death from heart disease and cancer.

Trauma is the leading cause of death in children and adults under age 45, claiming more lives than all other diseases combined.

Nearly 28,000 Missourians are hospitalized each year for severe trauma.

More than 10,000 Missourians suffer severe debilitating injuries from trauma each year.

The overall death rate from traumatic injury in Missouri is 20% higher than for U.S. residents as a whole.

Decreasing Missouri's death rate from trauma to the national average would mean:

? 700 fewer deaths each year.

? $2 billion in savings related to medical spending, disability and lost future earnings.

Each day that passes, 10 deaths occur that could have been prevented.

Trauma victims fortunate enough to receive care in a specialized Trauma Center have a 20 - 30% greater chance of surviving.

Trauma Center are costly to operate; stand-by costs, to be ready to care for trauma victims, average $4.3 million per year for each level 1 Trauma Center – this cost must be borne by each trauma center.

On a cost basis, facility and physician operating losses at Missouri's 33 trauma centers exceed $46 million per year.

4 of Missouri's Trauma Centers have closed in the past 2 years due to mounting financial losses - additional trauma centers are likely to close in the near future for the same reason.

ACCESS TO DENTAL CARE

80% of tooth decay in children occurs among Medicaid and uninsured populations.

Less than 30% of Medicaid eligible children have an annual dental visit.

Appointment wait times for Medicaid patients in need of dental care run as long as 6 months.

Medicaid families and children frequently must travel several hours to receive dental care.

There is a general shortage of dentists and dental hygienists in Missouri.

The number of Missouri dentists caring for Medicaid patients has declined from 866 in 1995 to 416 in 2001.

There is an even greater shortage in the number of dental specialists (pediatric dentists, oral surgeons, and endodontists).

Missouri Medicaid payments to dentists are far below the overhead costs for providing dental services.

Trends and Demographics

A century-plus ago, St. Louis was the nation's immigration capital. Recently, St. Louis again has become a favored destination for refugees and immigrants, representing more than 10% of St. Louis City's population.

St. Louis is perceived as a "refugee and immigrant-friendly" city because of available steady employment, affordable housing, relatively welcoming neighborhoods and established communities.

Refugee resettlement is facilitated by three strong resettlement agencies: Catholic Refugee Services, International Institute and Jewish Family and Children's Services. Due to their success in meeting Federal goals for resettlement, St. Louis is listed in the top ten free-case refugee resettlement sites in the U.S. The city of St. Louis has the second highest concentration of foreign – born to native-born city residents in the nation and is rated third nationally in terms of degree of diversity of resettled refugees.

Healthcare for New Arrivals

Access to health care varies widely among new arrivals and is heavily dependent upon their INS status as they enter the U.S.

Refugees are eligible for state health care upon arrival via the Medicaid program (MC+) and for eight months thereafter. In reality, due to system lags and lack of documentation, refugees are not recognized as Medicaid eligible for as much as two months after arrival.

It is generally unrecognized in the healthcare industry that newly arrived refugees who do not yet show in the state's Medicaid database can be billed retroactively (fee for service) under straight Medicaid. Thus, refugees who have not received their cards are often unable to make appointments in primary provider's offices and may be turned away from outpatient environments.

Non-documented immigrants, (both transitory and permanent), are limited in terms of access to health care, especially in primary care settings. They are often discouraged from seeking services by probing questions from staff members and actions such as requiring documentation of the social security numbers from all family members, (required only for the applicant on the CHIPS application form).

Access to Care for Limited English Proficient (LEP) Individuals

Under Title VI of the Civil Rights Act of 1964, recipients of Federal financial assistance are obligated to provide equal access to benefits and services to all persons regardless of race, color or national origin.

Language barriers, however, may effectively bar an individual from accessing care.

There remains significant confusion regarding at what level within the health care system, exists the responsibility for providing financial interpreter support. All MO MC+ Health Plan provide interpreter services at medical appointments upon request but this excludes Staright Medicaid.

State Medicaid officials argue that the provider is responsible for ensuring adequate communication. This is an impossible burden for many primary care sites and hardly realistic given the level of reimbursement for managed care.