



STRATEGIES FOR IMPROVING LATINO HEALTHCARE IN AMERICA

Report of The Latino Healthcare Taskforce

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September 2006



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LETTER FROM THE CHAIRMAN

Dear Friends and Colleagues:

Thank you for your interest in “Strategies for Improving Latino Healthcare in America.” The report is the culmination of the hard work and dedication of a fantastic group of individuals, and I am extremely proud of what the Latino Healthcare Taskforce has accomplished. The document identifies pressing health issues confronting Latinos and offers strategies and recommendations for each. It is structured around four key initiatives: **reducing the uninsured population, empowering Latinos to be better healthcare consumers, partnering with the Latino community, and getting more Latinos into healthcare fields.** All of the Taskforce members have generously donated their time to this initiative and the results of their hard work and collaboration lie within.

I would like to extend my deepest gratitude to Taskforce member Dr. Glenn Melnick and to Ms. Lois Green, Clinical Associate Professor of Health Management and Policy, both from the University of Southern California, as well as to Dr. Lawrence Stiffman from Applied Statistics Laboratory in Ann Arbor, Michigan for their perseverance in researching and writing the report. Their commitment and expertise are invaluable and very much appreciated.

I am also very grateful for the contributions from Wellpoint Inc. and Verizon Foundation to this project and to each of the Taskforce members who so generously offered their time and resources in-kind. Most importantly, each of them contributed a wealth of knowledge and insights that provided the platform on which our four key initiatives are based. Their dedication and ideas have been essential to the success of the recommendations within this report and I know that many of those ideas will come to fruition. I would also like to extend my thanks to Deborah Lachman whose unique expertise in health insurance helped guide the initiative to reduce the number of uninsured. Ms. Lachman’s career has been devoted to finding ways to make healthcare insurance more affordable to all.

In closing, I want you to know how important this report is to me. My lifetime work has been devoted to helping others improve their quality of life through increased access to healthcare. This is a subject that is near and dear to my heart, and to the hearts of my Taskforce colleagues. This truly is transformational work, and working together, we are making a difference.

Sincerely,

A handwritten signature in black ink that reads "Josh Valdez".

Josh Valdez, DBA
Senior Vice President
Health Care Management, West Region
WellPoint, Inc.

PREFACE

Healthcare is among the most expensive commitments of government, business and individuals. Approximately 46 million Americans are currently without health insurance, and addressing this issue is one of the nation's most urgent challenges. This tremendous challenge can and must be met with a focused commitment of will, resources and cooperation to institute change. While there is no single solution to the issue of the uninsured, there are many ways we can work together to formulate realistic solutions and put them into action.

Uninsurance, while a compelling issue, is not a singular challenge to be addressed. Concurrently, it is imperative that we pursue avenues to encourage healthier behaviors, improve health literacy, and ensure access to culturally appropriate healthcare services and a competent, diverse healthcare workforce. These interrelated issues will require thoughtful and concerted attention.

The Latino Healthcare Taskforce ("Taskforce") was formulated in July 2005 for this purpose. A nationwide search was conducted for Taskforce members who would represent both public and private sectors with expertise on healthcare and related issues. This 18-member Taskforce is a collaboration of a diverse group of professionals including small business owners, physicians, researchers and health care industry leaders.

Taskforce members include:

Chair: Josh Valdez, DBA

Senior Vice President, Health Care Management, WellPoint, Inc.

Co-chair: Robert G. de Posada

President, The Latino Coalition

Dr. Sergio Aguilar-Gaxiola

Professor of Internal Medicine and Director of the Center for Reducing Health Disparities University of California, Davis

Mike Barrera

President and CEO, U.S. Hispanic Chamber of Commerce

Catherine Benavidez Clayton, RN, MS, NP

President, National Association of Hispanic Nurses, Colorado Chapter

Dr. Rodolfo Burquez

General Dentist Private Practice, Whittier, CA

Dr. Joxel Garcia

Deputy Director, Pan American Health Org.

Emilio X. Gonzalez

Exec. Director for Policy, Public Affairs & Communications, Verizon Communications

Deborah Lachman

President, Individual and Small Group, WellPoint, Inc.

Dr. Rosalio Lopez

Medical Director, White Memorial Medical Center, Adventist Health

Dr. Vinicio Madrigal

General Practice and Family Medicine Physician

Dr. Glenn Melnick

Professor, School of Policy, Planning and Development, University of Southern California

Pam Mokler

Gerontologist and Consultant

Eva M. Moya, LMSW

Health and Human Services Consultant

Jose Nino

President, El Nino Group, Ltd.

Honorio Padron

President, Hispanic Business Roundtable

Dr. Rene Rodriguez

President and Founder, Interamerican College of Physicians and Surgeons

Dr. Pejman Salimpour

President and CEO, CareNex Collaborative

EXECUTIVE SUMMARY

Charge

The Latino Healthcare Taskforce's charge was to analyze key challenges facing Latino healthcare and offer recommendations on how best to meet them.

The Taskforce sought to:

- **Identify barriers** that could impact strategies and action plans, primarily at the federal level,
- **Propose alternative solutions** to issues at all levels, and
- **Provide action recommendations** to President Bush, as well as to community, governmental agency and congressional leaders.

The Taskforce concluded that lasting solutions for Latino healthcare require the collaborative efforts of elected and agency officials, foundations, school districts, civic organizations, health care and human services providers, researchers, other advocates and individuals.

Areas of Focus

Four priority areas were emphasized:

- **Reduce the uninsured Latino population**
- **Inform and empower Latinos to be better healthcare consumers** through the accurate production and culturally appropriate diffusion of useful and usable information
- **Partner with Latino communities** to enhance the planning, production and cost-effective delivery of health promotion, preventive and curative health services
- **Increase the numbers and skill levels of Latinos in all healthcare fields** through a variety of public and private programs with both "supply side" and "demand side" incentives

Latino Trends

In 2003, Latinos became the largest ethnic minority group in America, surpassing African-Americans and numbering nearly 40 million, according to the U.S. Census Bureau. By 2004, there were more than 41 million Latinos in the U.S., representing 14.1 percent of the total population. Given current trends, Latinos will make up 28.6 percent of the U.S. population by 2070.

Less than fifteen years from now, by 2020, the majority of children entering high school, the majority of workers entering the work force, and the majority of newly-eligible voters will be Latino.

Latino purchasing power in America has surged to nearly \$700 billion and is projected to reach as much as \$1 trillion by 2007, nearly three times the overall national rate over the past decade, according to HipanTelligence®. Yet, even as their numbers and influence grow, Latinos face intractable challenges in health and prosperity. If these challenges remain unaddressed and unresolved, the long-term impact of a decline in the nation's health and economic welfare appears inevitable.

Issues

The financing of healthcare plays an important role in the ability of Latinos to access care. Despite their strong presence in the workforce, Latinos are mainly concentrated in low-wage, service-industry jobs where employers are less likely to offer health insurance and other employee benefits. Presently just one in four Latino workers has the benefit of employer-sponsored insurance. The Latino Coalition notes that since most Latinos have to purchase their own health insurance, they must first overcome obstacles to finding an affordable plan.

Latinos, in fact, have the highest rates of uninsurance of any racial or ethnic group in the United States and are three times more likely to be uninsured than whites. The U.S. Agency for Healthcare Research and Quality estimates that in 2004, more than one-third of Latino Americans lacked health insurance coverage, compared with less than 19 percent of whites. The percentages of uninsured Latinos are particularly high in Texas, Arizona, California, Florida, New York and New Jersey.

Latinos are disproportionately affected by some of the most serious health problems facing our country. Health conditions such as tuberculosis, depression, asthma, HIV, and certain cancers disproportionately affect Latinos and will require targeted, culturally appropriate interventions at the individual, institutional and community levels.

Education and prevention, lifestyle and health behaviors impact health status. However, a lack of health insurance impedes the ability of many Latinos to attain benefits of preventive care services. As a result, Latinos often suffer from complications due to their chronic disease states.

Latinos—whether or not they are insured—face the challenge of receiving care in a manner culturally and linguistically appropriate for the growing numbers of patients with limited English proficiency, as well as low levels of general and health literacy.

More than half of foreign-born Latinos have not completed a high school education. More than 70 percent of foreign-born Latinos speak Spanish as their dominant language, while about one-quarter are bilingual. Among native-born Latinos, 60 percent speak English as their dominant language.

Not surprisingly, the Commonwealth Fund has found that one-third of Latinos have difficulty communicating with their physicians. Many have trouble reading and understanding written information in their doctors' offices, omit medications, miss office appointments and rely on hospital emergency departments for their general healthcare. By contrast, Spanish-dominant patients served by Spanish-speaking physicians tend to ask more questions about their health, have higher levels of satisfaction and have better recall of their physician's recommendations.

Research shows that changing patient behavior will have the greatest impact on overall health. However, effective health communication is highly dependent upon the social and cultural milieu that shapes individuals, families and communities—a challenge in a culturally diverse society. Many studies link poverty, low literacy rates, access problems and uninsurance to poor health, all of which are indeed challenges in Latino communities.

Although the nation is becoming more diverse, this trend has not carried over to the health workforce. While the number of Latinos in the U.S. grew 58 percent in the 1990s and now represents more than 14 percent of the population, they comprise only three percent of nurses, four percent of physicians, five percent of healthcare managers, and nine percent of nursing aides and orderlies, according to the U.S. Health Services and Resources Administration (HSRA). The under-representation of minorities in health professions is a growing crisis.

Solutions

Many Latinos are unfamiliar with how to most effectively access the healthcare system and the various options for funding care. More such options are needed, including the creation of innovative and affordable healthcare products, tax incentives for small employers and individuals to purchase health coverage and consumer-directed health savings accounts (HSAs).

Latinos also will benefit from an increased enrollment of eligible children in federally funded health programs and an expanded capacity of community clinics offering free or low-cost healthcare in strategically placed areas with high Latino and other uninsured minority populations. Tax incentives to reduce malpractice insurance costs will make it more feasible for physicians and other healthcare professionals to work or volunteer in medically underserved communities.

A variety of multimedia communications can help reach Latinos with desperately needed healthcare education. Spanish-language television targets more than 10 million Spanish-speaking households in the U.S. The news media and interactive technologies also hold great potential. Coordinated outreach through faith- and community-based organizations, healthcare professionals and Latino social networks can also greatly help Latinos become more informed healthcare consumers.

Reducing the long-term costs and consequences of health disparities, cultural myopia and under- and un-insurance among ethnic groups must become a national priority. In order to achieve success, government at all levels, together with funders, communities, and institutions must be aligned and committed to common goals. The strategies in this Report lay the foundation for that success.

Summary of Recommended Strategies

The Latino Healthcare Taskforce's Report is comprised of a number of recommended healthcare strategies. Nine Principal Strategies are presented below, including recommended actions that may produce the most significant results within the Latino population. Chapter three provides more detailed information on the strategies and actions recommended here.

Complementing the nine Principal Strategies, the Taskforce also offers supplemental recommendations, for which further consideration and action is strongly encouraged. These may also be found in Chapter three. The nine Principal Strategies are:

1 **CREATE A NATIONAL STRATEGIC ACTION PLAN FOR LATINO HEALTH IMPROVEMENT (P.21)**

The Task Force calls on the President to create a National Strategic Action Plan for Latino Health Improvement. The plan would span all critical federal agencies within the U.S. Department of Health & Human Services (e.g., National Institutes of Health, Agency for Healthcare Research and Quality, Health Resources and Services Administration, Centers for Disease Control and Prevention, Bureau of Health Professions, Centers for Medicare and Medicaid Services, Administration on Aging) as well as external to DHHS (such as the U.S. Census Bureau, Departments of Labor, Commerce, Immigration), and would include key policymakers, private foundations, and advocacy organizations.

The purpose of this plan, which could be budget-*neutral*, is to analyze and review all current federal healthcare programs serving Latino communities and restructure priorities and redirect funds to optimize program productivity, coordination and effectiveness.

2 EXPAND MARKET-BASED OPTIONS TO REDUCE UNINSURANCE (P. 23)

Multiple strategies are necessary to reduce the unacceptably high levels of uninsurance among Latinos. The Taskforce recommends that state and federal governments work aggressively with health plans and employers to stimulate a range of market-based solutions.

These would include:

- **Tax credits for small employers**, particularly micro-businesses with ten or fewer employees, to induce them to offer coverage for their employees.
- **Tax credits for individuals who do not have access to employer-sponsored coverage** or who cannot afford their share of an employer-sponsored plan. Such credits should be assignable, fully refundable and advanceable.
- **Stimulation of health savings accounts** (HSAs) to help individuals and small business employees afford the insurance coverage they need.
- **Pilot and demonstration projects** to document the effectiveness of innovative market reforms for increasing access, improving affordability, and expanding awareness of insurance options, which includes:
 - **“One-stop shopping center” for healthcare**, e.g., an 800 phone number and companion Website that provides basic healthcare information, a menu of available programs Latinos may qualify for, and other local options for healthcare coverage. The program would provide basic health care information consumers qualify for, available rates and data for health insurance available, location of local community health centers, qualification for federally funded programs, and other information. This pilot program could be modeled after the Medicare Part D outreach program, where an individual or employer could provide or input basic data such as age, zip code, income, and family status (e.g., marriage status, number of children).

3 SEED-FUND FIVE LATINO HEALTH EMPOWERMENT CENTERS (P. 25)

Targeting geographic areas with large Latino populations, the federally seed-funded regional, national or university-based Latino Health Empowerment Centers would stimulate public-private partnerships among communities, universities, businesses and faith-based organizations, among others, to provide technical assistance and to identify, evaluate and disseminate best practices and approaches for improving Latino health and healthcare.

4 IMPLEMENT COMMUNITY-BASED INITIATIVES TO BOOST ENROLLMENT IN FEDERAL HEALTH PROGRAMS FOR CHILDREN (P. 27)

To improve child healthcare coverage and access, we must expand culturally proficient, community-based programs that optimize youth enrollment in federally-sponsored programs for which they are eligible and eliminate barriers that prevent people from enrolling for coverage.

This includes:

- **A Centers for Medicare and Medicaid Services (CMS) outreach initiative** to deliver counseling and outreach services to increase enrollment and utilization of uninsured children Medicaid and S-CHIP (similar to the President’s “Cover the Kids” campaign).
- **A Latino Program Enrollment Working Group** at DHHS, NIH Office of Minority Health and others to acquire and document best practices on increasing awareness, desirability, enrollment and appropriate use of heretofore inaccessible programs and services beneficial to various segments of the Latino community.
- **Best practice primers** that include culturally appropriate marketing communication, outreach and enrollment strategies as researched, evaluated and developed in many channels, including TV infomercials, novellas, pharmacy and other point of contact information sharing, faith-based initiatives and others.

5 ESTABLISH A NATIONAL MULTIMEDIA LATINO HEALTH LITERACY INITIATIVE (P. 29)

To help educate the Latino population about basic health literacy, appropriate health behavior and effective navigation of the healthcare system, the Taskforce recommends the creation and funding of three to five national or university-based centers for the research, development and implementation of multimedia strategies and programs targeting Latino populations.

Such centers should include:

- **Entertainment industry outreach**, e.g. Spanish-language and English-language broadcast media that utilizes entertainment education and integrated marketing communications approaches to reduce risk behavior and increase prevention behavior among audience members.
- **News media outreach**, such as fact-based reporting in broadcast and print media that uses journalistic approaches to influence information-seeking and utilization of healthcare services to increase community-based screening and immunization for disease prevention, and to reduce incidence of disease progression among audience members.
- **New technologies**, including Web-based media that employ entertainment and gaming approaches targeted to adult and youth audiences for health promotion and disease prevention.
- **Convening of key leaders** in media (television, film, radio, and print), healthcare communications and the Latino community for the purpose of identifying innovative and effective strategies to improve health literacy and empower consumers.
- **National dissemination of innovations**: technical information, case studies, and summaries of model programs and approaches for culturally appropriate, consumer-driven health information.

6 EXPAND INITIATIVES TO ENSURE A DIVERSE HEALTHCARE WORKFORCE (P. 32)

National attention should be focused on the importance of the widening gap between the racial and ethnic composition of the U.S. population and the composition of the healthcare workforce. This effort could be spearheaded jointly by DHHS and the Department of Education (DOE) and guided by a national working group on healthcare workforce diversity. This group should include senior staff of government agencies (e.g. Bureau of Health Professions, National Institutes of Health, and DOE), the media, private foundations, K-12 schools and associations of health professions schools.

Priorities for action should include:

- **Greater public and private coordination in developing a national strategy** for working from early education through health professions training in order to prioritize—and optimize—funding along educational pipelines.
- **Continued funding of existing programs that target upstream, early educational stages** (e.g., academic health centers/K-12 school partnerships) as demonstration projects with rigorous evaluations.
- **Greater targeted resources for interventions** (e.g. enrichment programs, RN-to-BSN programs) to increase opportunities for and the number of underrepresented minority students in nursing, health management and allied health professional programs.
- **Expanded opportunities for student financial aid:** grants, loan forgiveness programs, tuition reimbursement, and paid, on-campus opportunities for minority and disadvantaged students, as opposed to student loans.

7 MEDICAL MALPRACTICE REFORM (P. 35)

The high cost of medical malpractice insurance hinders many physicians and healthcare workers from practicing in underserved areas. There is a demonstrated need for medical malpractice reform, including specifically:

- **Medical malpractice relief through tax incentives** that reduce financial obstacles for healthcare practitioners working or volunteering in underserved communities.

8 HEALTHCARE INFORMATION TECHNOLOGY (P.36)

In a 2005 report on healthcare interoperability from the National Institutes of Health and the U.S. Department of Health and Human Services, the case was made for the importance of incorporating an information technology system to make health care more accessible, safer and more cost effective. The study, “Ending the Document Game,” stated: “Although your airline ticket confirmation number, your rental car record, and even your cellular phone bills and calling history are available 24/7 on-line, your medical records are locked away in filing cabinets somewhere, partially handwritten and partially typed, stored in paper folders, and stacked alphabetically.”

Given the critical importance of health information technology, the Taskforce recommends:

- **Create of financial and other incentives** for individuals and healthcare-related organizations to participate in and implement electronic healthcare support systems. These incentives should also include revision or elimination of regulations that create unnecessary barriers to healthcare IT.
- **Establishment of interoperable medical record standards** with universal acceptance. The federal government should pursue the completion of such standards now under study by groups such as the American Health Information Community (AHIC) and the National Committee for Vital and Health Statistics (NCVHS). Standards should also reflect requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), or the designers of standards should work with lawmakers to seek adjustments to HIPAA.
- **Establishment of privacy rules and identity authentication protocol** to ensure that a patient seeking access to records can prove identity, and that a caregiver or organization seeking access has secured appropriate permission. The government also should require system designers to satisfy ethical and legal requirements of privacy rights.
- **Promotion of the vital benefits and immediate need for healthcare IT** to help save lives. The potential to improve healthcare and save money is so great that if the public knew about it, they would demand action. Therefore the federal government should authorize a significant, high-profile campaign to educate the public on the many personal and social benefits of large-scale healthcare IT.

9 BENCHMARK PROGRESS IN LATINO HEALTH (P. 38)

The ability to measure and monitor our progress in improving Latino health is critical to the long-term health and vitality, not only of Latinos, but of our nation.

The Taskforce recommends:

- **A Latino Healthy People 2010 midcourse review** to report baseline data and identify a tracking system for each *Healthy People 2010* objective.
- **Improvements in Latino health data collection, analysis, and reporting under DHHS data systems** in order to achieve baseline and tracking data for 100 percent of *Healthy People 2010* objectives in compliance with Office of Management and Budget guidelines on the collection of racial and ethnic data.
- **Latino Health Fact Sheets**, published periodically, to identify and monitor trends. These Fact Sheets can serve as a definitive source of information for Latino health advocates, multimedia communications, policymakers and others.
- **Standard electronic recording of race and ethnicity information** as part of the expansion of electronic medical records (EMR) nationwide, that allows healthcare providers to use standardized categories stored in standard formats.

STRATEGIES FOR IMPROVING LATINO HEALTHCARE IN AMERICA

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CHAPTER ONE: THE LATINO HEALTHCARE TASKFORCE

Recognizing the critical importance of Latinos to the future of our nation, the Latino Healthcare Taskforce was convened to review, determine and recommend whether, and where, problems faced by Latinos are adequately identified and systematically addressed in ways that are culturally proficient, appropriate and cost-effective.

Taskforce Charge

There is general consensus that improving health and eliminating or reducing racial and ethnic disparities in both health status and health service delivery requires the collaborative efforts of elected and agency officials, foundations, schools districts, civic organizations, healthcare and human services providers, researchers, other advocates, and individuals.

The Taskforce charge thus includes the following:

- **Share data and information** to identify key Latino health issues,
- **Identify legislative, resource, and other barriers** that could impact strategies and action plans,
- **Develop strategies** for significant improvement of key issues,
- **Propose solutions** to potential barriers and provide recommendations, and
- **Provide a final report of strategic recommendations** to President George W. Bush and Congressional leaders

Taskforce Areas of Focus

During its deliberations, the Taskforce identified four priority areas of focus for purposes of framing its recommendations. These are:

- **Reduce the uninsured Latino population.**
- **Inform and empower Latinos to be better healthcare consumers** through the accurate production and culturally appropriate diffusion of useful and usable information.
- **Partner with Latino communities** to enhance the planning, production and cost-effective delivery of health promotion, preventive and curative health services.
- **Increase the numbers and skill levels of Latinos in all healthcare fields** through a variety of public and private programs with both “supply side” and “demand side” incentives.

Underlying the recommendations presented in this report is a philosophical commitment to:

- Improve existing public sector planning and programming; including greater clarity in goal setting, information collection and analysis, and performance measurement with emphases on community liaison and empowerment-building at the community, family and individual levels.
- Aid in the identification, promotion and diffusion of private sector “best practices” of individuals, groups, organizations, networks, forums and communities.
- Promote enhanced access to healthcare and improve health literacy levels through culturally appropriate education, outreach, prevention and access to healthcare.
- Encourage cultural proficiency in healthcare, which holds each culture in high esteem.

Report Outline

Chapter one of this report provides background regarding the Latino Healthcare Taskforce, its charge and focus.

Chapter two describes the issues and trends in Latino health that were important in shaping the recommendations and priorities of the Taskforce, and in helping others to appreciate the current situation of Latinos in the United States. This chapter is intended to provide a profile and overview of critical issues in Latino health.

Chapter three contains the Taskforce’s nine Principal Strategies. Each of these strategic recommendations includes further information and analysis to illuminate context and intent. Following the Principal Strategies are supplemental recommendations for each of the four Taskforce areas of focus. These recommendations complement the nine strategies and further discussion and consideration of them is highly encouraged.

Chapter four is a compilation of statistics and additional information, some of which is embedded in other areas of the report. This chapter consolidates from numerous public and private sources, facts and trend data regarding Latinos and Latino health and insurance status, health literacy, work force diversity, and other initiatives. The information may be helpful to communities, agencies and organizations interested in gaining a better overall appreciation of Latino health issues. Its broad range and variety also underscores the importance of bringing disparate elements together to gain a more complete picture of Latino health.

Source Information Used in Preparation of this Report

Consolidation of historic and extant analyses and recommendations is a stepping stone to help generate an action agenda or blueprint for the nation, relying on the vast partnership potentials of the public and private sectors to impact health challenges faced by all minority groups, including Latinos.

This report draws information from many organizations that document general and discrete health status-related problems and issues. Generally, information provided isolates impacts on Latino populations and subpopulations¹.

Some governmental or foundation-driven programs routinely survey or collect statistics on an ad-hoc basis with or without commentary or analysis of the information obtained. Some documents represent consolidation of information from disparate data sources, while others report on evidence gathered from a particular survey or data compilation.

In addition, there are numerous state and local government agencies and non-governmental organizations (NGOs) in high proportion Latino-populated states, think tanks, foundations and advocacy organizations that define and describe disparities and other health issues among minority groups, including Latinos.

¹ Racial and ethnic categories are based on OMB recommendations, Directive 15, adopted in 1977; Data for Hispanic subcategories based on the country of origin – Cuban, Mexican, and Puerto Rican, - are included where data are available in documents. When used, the category “Other Hispanic” includes those not from specified countries or the specific country of origin is unknown.

CHAPTER TWO: OVERVIEW OF LATINOS IN AMERICA

Latinos: A Diverse and Growing Influence

Today, one in four Americans is a member of a racial or ethnic minority group; by 2070, one in two Americans will be. The nation is becoming increasingly diverse. In 2003, Latinos became the largest ethnic minority group, surpassing African-Americans and numbering nearly 40 million, according to the U.S. Census Bureau. They are the fastest growing group, as well. By 2004, there were more than 41 million Latinos in the U.S., representing 14.1 percent of the total population; by 2005, nearly 43 million. Given current trends, Latinos will make up 28.6 percent of the U.S. population by 2070.

Historically the greatest concentration of Latinos has been in the West, Southwest, and Southeastern states. However, significant numbers of Latinos are settling in such states as Illinois, New Jersey, and New York. These migration patterns are creating new population dynamics across the nation.

Approximately 60 percent of the 1.3 million new Latinos in 2005 are citizens born here, according to Census Bureau estimates released in May 2006. While the Center for Immigration Studies estimates that about one-third of newborn Latinos were born to mothers of undocumented resident status, even if immigration came to a standstill, the Latino population boom would not end for at least another generation.

Latinos in the U.S. are, in fact, primarily first-generation immigrants; however, they are setting down firm roots. Nearly 20 percent are second-generation citizens and 17 percent have lived in the U.S. for multiple generations.

While hailing from many nations, Latinos share common cultural strengths and values that resonate among Americans: a strong emphasis on family and religion, strong social networks and sense of community, strong traditions and great ethnic pride, and a variety of healthy behaviors, particularly among those who have recently immigrated.

The unprecedented growth and strength of Latinos in the United States is having a profound impact on our society. Less than fifteen years from now, by 2020, a majority of children entering high school, workers entering the work force and newly-eligible voters will be Latino.

Latino participation in and contributions to our economy and culture cannot be understated. U.S. Latino purchasing power has surged to nearly \$700 billion and is projected to reach as much as \$1 trillion by 2007, nearly three times the overall national rate over the past decade, according to HipanTelligence®.

Yet, even as their numbers and influence grow, Latinos face intractable challenges in health and prosperity. If these challenges remain unaddressed and unresolved, the long-term impact of a decline in the nation's health and economic welfare appears inevitable.

Access and Coverage

Accessing and receiving healthcare is a particularly significant challenge, and the availability of healthcare remains divided along socioeconomic and ethnic lines. Despite the fact that 80 percent of Latinos are working, slightly more than one-fifth live in poverty and half earn less than \$30,000 annually. Moreover the lowest rates of employer-provided health coverage occur in families with the lowest incomes — a double “whammy” for the working poor.

The financing of healthcare plays an important role in the ability of Latinos to access care. Despite their strong presence in the workforce, Latinos are mainly concentrated in low-wage, service-industry jobs where employers are less likely to offer health insurance and other employee benefits. Presently just one in four Latino workers has employer-sponsored health insurance. The Latino Coalition notes that since most Latinos have to purchase their own health insurance, they must first overcome obstacles to finding an affordable plan.

Latinos, in fact, have the highest rates of uninsurance of any racial or ethnic group in the United States and are three times more likely to be uninsured than whites. The U.S. Agency for Healthcare Research and Quality estimates that in 2004, more than one-third of Latino Americans lacked health insurance coverage, compared with less than 19 percent of whites. The percentages of uninsured Latinos are particularly high in Texas, Arizona, California, Florida, New York and New Jersey.

Staying Healthy, Overcoming Disparities

Many studies link poor health to poverty, access problems and uninsurance, all of which are difficult issues in many Latino communities. Latinos are disproportionately affected by some of the most serious health problems facing our country. Young Latinos, in particular, are confronting high rates of unintended pregnancy and sexually transmitted diseases (STDs). Latinos have also been hit hard by the AIDS epidemic, and worry about its impact on their families and communities.

Of major concern is the growing diabetes “epidemic.” Diabetes risk is almost twice that for Latinos than for other ethnic groups and diabetes appears at an earlier age. Latinos also are more likely to suffer from a combination of diabetes risk factors known as “metabolic syndrome,” marked by insulin resistance, together with high lipid levels, mildly elevated blood pressure, and obesity. The prevalence of obesity among Latinos has doubled in the past ten years. For instance, about one-third of Mexican women are clinically obese. Among Latino youth, 22 percent are obese.

Other health conditions such as tuberculosis, depression, asthma, and certain cancers disproportionately affect Latinos and will require targeted, culturally appropriate interventions at the individual, institutional and community levels. Among poignant examples:

- The HIV infection rate among Latinas is seven times higher than for white women.
- Among Mexican-American and Puerto Rican women, the cervical cancer incidence is two to three times higher than for white women.
- Latinos have the highest rates of depression among ethnic groups.
- They face the highest risk of exposure to pollution and toxic substances due to their strong presence in agriculture and highly polluted urban areas. Latino children also have higher rates of asthma than non-Latinos.
- Finally, the risk of contracting tuberculosis is six times higher for Latinos than for whites, with the rate of new infection at 13.6 per 100,000 populations for Latinos versus 6.8 for the nation as a whole.

Many of these difficult health issues are positively impacted by education and preventive care, lifestyle and health behaviors, such as diet and exercise. Yet lack of health insurance may significantly impede the ability of many Latinos to attain benefits of preventive care services, such as cancer screenings, diabetes and HIV education and nutritional counseling. As a result, Latinos often suffer from complications due to their chronic disease states. Because Latinos tend to live longer than non-Hispanic whites, issues of morbidity, not mortality, must be viewed with the greatest of concern in the nation's attempts to control healthcare costs and improve the quality of life of Latinos.

Latinos, Language and Health Literacy

As with the lack of health insurance, lack of accurate health information, limited access to a regular source of care, and a reliance on traditional *clínicas*, community clinics or hospital emergency departments are related, critical issues for Latinos. Presently 22 percent of Latinos rely on their local community or public clinics for care. A Commonwealth Fund study shows that among Spanish-speaking Latinos, that percentage increases to 34 percent. In fact, nearly one-quarter of Spanish-speaking Latinos report having no regular source of care and use hospital emergency departments for services. Among all Latinos, this percentage drops to 14 percent, compared with eight percent of all patients ages 18-64.

Latinos—whether or not they are insured—face the challenge of receiving care in a manner culturally and linguistically appropriate for the growing numbers of patients with limited English proficiency, as well as low levels of general and health literacy.

Health literacy, according to the Institute of Medicine, is the degree to which individuals can obtain, process and understand the basic health information and services they need to make appropriate health decisions. In *Health Literacy: A Prescription to End Confusion*, the IOM estimates that nearly half of all American adults have difficulty understanding and acting on health information. Consequently, U.S. Surgeon General Richard Carmona's healthcare priorities specifically include a goal to improve health literacy.

General literacy and educational level is a major factor affecting Latino health literacy, as more than half of foreign-born Latinos have not completed a high school education. Among native-born Latinos, one-fourth failed to complete high school and educational achievement is significantly higher overall.

Language is the other major factor influencing health literacy. More than 70 percent of foreign-born Latinos are Spanish dominant; about one-quarter are bilingual, compared with native-born Latinos, 60 percent of whom are English dominant, according to the Pew Hispanic Center and Kaiser Family Foundation. Translated into care-seeking behaviors, the National Latina Institute estimates that 26 percent of Spanish language dominant Latinos need an interpreter when obtaining healthcare services.

According to the Commonwealth Fund, one-third of Latinos also have difficulty communicating with their physicians, compared with 19 percent of the population nationwide. Many have difficulty reading and understanding written information in their doctors' offices; more than 60 percent have trouble understanding instructions on a prescription bottle. Those without Spanish-speaking providers also tend to omit medications, miss office appointments and rely on hospital emergency departments for their general healthcare. By contrast, Spanish-dominant patients served by Spanish-speaking physicians tend to ask more questions about their health, have higher levels of satisfaction and have better recall of their physician's recommendations.

Provision of linguistically and literacy appropriate healthcare services thus appear to positively influence health quality and outcomes. Studies show that changing patient behavior will have the greatest impact on overall health. However, effective health communication is highly dependent upon the social and cultural milieu that shapes individuals, families and communities—a challenge in a culturally diverse society.

Immigration, Health & the Latino Paradox

Many studies link poverty, low literacy rates, access problems and uninsurance to poor health, all of which are indeed challenges in Latino communities. Yet surprisingly, Latinos are at lower risk than the general population in several health measures, such as mortality overall and for cancer and heart disease, as well as for infant mortality. This is known as the “Latino paradox.” Theories of its roots are healthy immigration, strong social/family networks, low tobacco and drug use, religiosity and traditional healing practices.

Across a broad range of health status indicators, foreign-born Latinos are in better health than their native-born counterparts. As immigrants acculturate to American society, they frequently adopt the diet and behavior patterns of mainstream culture, including decreased fiber consumption and increased use of alcohol and cigarettes. A growing portion of U.S.-born Latinos are forsaking the protective health behaviors of the immigrant generation. This pattern of unhealthy acculturation suggests that the health status of the Latino population may decline in the future. However, health gains may be realized by preserving the positive health behaviors of immigrants.

Toward a Diverse Workforce

Although the nation is becoming more diverse, this trend has not carried over to the health workforce. While the number of Latinos in the U.S. grew 58 percent in the 1990s and now represent more than 14 percent of the population, they comprise only three percent of nurses, four percent of physicians, five percent of healthcare managers, and nine percent of nursing aides and orderlies, according to the Health Resources and Service Administration.

The under-representation of minorities in health professions is a growing healthcare, business and economic crisis given the increasing racial and ethnic diversity of our nation. Lack of educational opportunities and achievement for many minority groups is a fundamental problem. This situation begins “downstream” in grades K-12 and continues “upstream” comparatively low rates of Latino high school and college graduation, through health professions training.

Many interventions have been established to improve minority academic performance, from Head Start programs affecting thousands to enrichment programs for college students. There is considerable opportunity for better coordination among agencies that fund and implement programs designed to improve the educational success of underrepresented minority students and to increase their participation in the health professions.

Moving Forward

Many Latinos are unfamiliar with how to most effectively access the healthcare system and the various options for funding care. Integral to improving the current and future healthcare outcomes of Latinos, there is enormous potential to affect change in the way Latinos finance their healthcare. Among worthwhile approaches that will contribute to a reduction in under- and uninsurance are the creation of innovative and affordable healthcare products, tax incentives for small employers and individuals to purchase health coverage and consumer-directed health savings accounts (HSAs).

Increasing enrollment of eligible children in federally-funded health programs, such as Medicaid and State Health Insurance Programs (S-CHIP), offers a significant opportunity to reduce the number of youth who lack healthcare coverage through stepped-up community-based outreach and streamlined enrollment processes. Latinos also will benefit from expansion in the numbers and capacity of community clinics offering free or low-cost healthcare in strategically placed areas with high Latino and other uninsured minority populations. Tax incentives to reduce malpractice insurance costs will make it more feasible for physicians and other healthcare professionals to work or volunteer in medically underserved communities.

Further, if provided language- and literacy-appropriate health information through trusted communication channels, Latinos will be able to directly impact their quality of life. Therefore, multimedia efforts to reach Latinos, particularly through Spanish-language television targeted to more than ten million Spanish-speaking households in the U.S., news media and interactive Web-base and game technologies hold great potential. The goals of such programming are to increase audience knowledge, create favorable attitudes, shift social norms, and change overt behavior. Communication and outreach through faith- and community-based organizations, healthcare professionals and Latino social networks also are important strategies to inform and empower Latinos to be better healthcare consumers.

Delivery of quality healthcare also requires that providers and delivery systems become more culturally competent. As the nation's diversity grows, so will the need to ensure diversity among those who are providing healthcare services. Redoubled and more coordinated efforts of government, educators, families and communities are necessary to ensure that Latinos develop the skills and knowledge necessary to be attracted to—and succeed in—the health professions.

Reducing the long-term costs and consequences of health disparities, cultural myopia and under- and un-insurance among ethnic groups must become a national priority. According to the Institute of Medicine, expanding healthcare access and coverage is a good investment for America and would likely lead to substantial gains in the nation's health and productivity. Although comprehensive coverage is estimated to increase health spending \$48 billion annually, resultant health and productivity improvements are estimated at \$103 billion. Given the growing size, impact and influence of Latinos, prudent and strategic investments to improve Latino health can yield significant benefits for the nation.

In this report, the Latino Coalition Taskforce recommends a range of strategic initiatives intended to advance our progress in Latino health. To achieve the gains necessary to overcome the economic and health disparities of Latinos, government at all levels, together with *funders*, communities, and institutions must be aligned and committed to common goals. While much work has been done, much more remains, requiring a coordinated plan for strategic action, and the commitment to monitor our progress together.

CHAPTER THREE: STRATEGIES AND RECOMMENDATIONS

Principal Strategies

The Latino Healthcare Taskforce developed a number of recommendations in its four areas of focus. However, the Taskforce has identified nine priority recommendations, or Principal Strategies. Following these strategic priorities are supplemental recommendations, which are an outgrowth of the Taskforce's work and discussions, and complement the strategic recommendations presented below.

1 CREATE A NATIONAL STRATEGIC ACTION PLAN FOR LATINO HEALTH IMPROVEMENT

The Taskforce recommends the coordinated, inter-agency and inter-organizational development of a National Strategic Action Plan for Latino Health Improvement. The plan would span all critical federal agencies within the U.S. Department of Health and Human Services (e.g., the National Institutes of Health, Agency for Healthcare Research and Quality, Health Resources and Services Administration, Centers for Disease Control and Prevention, Bureau of Health Professions, Centers for Medicare and Medicaid Services, Administration on Aging) as well as external to DHHS (such as the U.S. Census Bureau, Department of Labor, Department of Commerce), and would include key policymakers, private foundations, and advocacy organizations.

The action plan could be budget-*neutral*. Its purpose is to analyze and review all current federal healthcare programs serving Latino communities, restructure priorities, and appropriately redirect funds to optimize program productivity, coordination and effectiveness.

While there has been serious agenda and goal setting at the federal level, *there is no central repository of policy goals, linked with actionable recommendations supportable by sufficient information to measure their attainment, and none specific to Latino health.*

A compelling reason to consider how the Taskforce's recommendations—and progress in Latino health -- will be implemented and monitored is the recognition that myriad agencies and organizations are involved in advancing the four foci addressed. Most of these entities are well-intentioned; however, overlapping mandates, limited coordination, and lack of follow-up monitoring, funding vagaries and other factors may impede real progress.

For example, legislation in 2000 created the National Center on Minority Health and Health Disparities (NCMHD), which was intended to serve as a focal point for planning and coordinating of minority health and other health disparities research. This legislation also mandated that the NCMHD, working in coordination with the Institutes and Centers (ICs) of the National Institutes of Health (NIH) develop a strategic plan for the reduction and ultimate elimination of health disparities. The NCMHD plan is intended to represent the major priorities and range of activities that NIH will undertake to address health disparities, and reflect a guiding vision of how NIH will develop research priorities and expend resources to improve the health status of minorities and other health disparity populations.

The NCMHD strategic plan identifies three major goals (research, research infrastructure, and public information and community outreach), as well as specific objectives within each goal. The Institutes of Medicine (IOM) is assessing the adequacy of the NIH health disparities strategic plan. It also will assess the adequacy of coordination across NIH institutes and centers; how to avoid duplication of administrative resources among Institutes, Centers, and Divisions; and identify means, including potential legislative modifications, to help NIH achieve its minority health and health disparities strategic plan objectives.

The Taskforce believes it is essential to work with NCHMD to create a mechanism to track the final review of the plan and to comment on its relevance in addressing the specific concerns of Latinos. Moreover, the NCHMD plan can serve as a valuable input in the development of a National Strategic Action Plan for Latino Health.

A National Strategic Action Plan for Latino Health can bring together, draw from and expand upon other excellent work produced thus far. For example, the National Institute of Child Health Development (NICHD) in NIH developed a strategic plan to deal with health disparities² based on a lifespan approach, across generations. The plan was the work of 30 scientific, planning and policy staff and drew upon ongoing planning efforts, recent forums, workshops, conferences, and research findings as well as external researchers and a panel of national experts. The NICHD Health Disparities Strategic Plan found at <http://www.nichd.nih.gov/strategicplan/disparities/disparities.pdf> offers depth of coverage, resource commitments towards production, and a broad series of recommendations.

Although much planning activity has been accomplished to date and more is yet in progress, the need for the disparate plans, goals and initiatives affecting Latinos and Latino health must be brought together as a fulcrum for strategic action. The Taskforce therefore believes it is essential that we build on the foundation established thus far, but that we move forward purposefully to create a measurable, action-oriented strategic plan to address the healthcare and lifespan needs of the growing Latino population in the United States.

² <http://www.nichd.nih.gov/strategicplan/disparities/disparities.pdf>

2 EXPAND MARKET-BASED OPTIONS TO REDUCE UNINSURANCE

Multiple strategies are necessary to reduce the unacceptably high levels of uninsurance among Latinos. The Taskforce recommends that state and federal governments work aggressively with health plans and employers to stimulate a range of market-based solutions. This would include:

- **Tax credits for small employers**, particularly micro-businesses with ten or fewer employees, to induce them to offer coverage for their employees.
- **Tax credits for individuals who do not have access to employer-sponsored coverage** or who cannot afford their share of an employer-sponsored plan. Such credits should be assignable, fully refundable and advanceable.
- **Stimulation of health savings accounts** (HSAs) to help individuals and small business employees afford the insurance coverage they need.
- **Pilot and demonstration projects** to document the effectiveness of innovative market reforms for increasing access, improving affordability, and expanding awareness of insurance options, which includes:
 - **“One-stop shopping center” for healthcare**, e.g., an 800 phone number and companion Website that provides basic healthcare information, a menu of available programs Latinos may qualify for, and other local options for healthcare coverage. This program could be modeled after the Medicare Part D outreach program, where an individual or employer could provide or input basic data such as age, zip code, income, and family status (e.g., marriage status, number of children). The program would provide basic healthcare information consumers qualify for, available rates and data for health insurance available, location of local community health centers, qualification for federally funded programs and other information.

Access to affordable private health insurance is a problem that disproportionately affects the U.S. Latino community. Latinos have lower levels of income and live in higher rates of poverty than the population as a whole, and more than 36 percent lack health coverage—the highest rate of uninsurance among all ethnic groups.

The current situation is both unacceptable and unsustainable given the continued growth of the Latino population and the cultural diversity of our nation. Continued disparities in access to health insurance and healthcare among Latinos and other minorities, especially vulnerable populations such as the youth and elderly, erodes the health of families and the future vitality of communities and the nation.

While there are a variety of reasons for high levels of Latino uninsurance, the major reason is their job situation. The vast majority of uninsured Latinos are working—68 percent are employed full-time and 11 percent work part-time, according to the Institutes of Medicine and others. However, oftentimes they are working poor, concentrated in low-wage, service-industry jobs where employers do not offer health insurance. In fact, in 2004, 65.7 percent of whites had employer-provided coverage, as compared to 49.9 percent of African Americans and just 41.1 percent of Latinos, regardless of income level. When benefits are offered, 82 percent of Latinos eligible to participate in their employer-sponsored plan do so, a high take-up rate, based on Commonwealth Fund research.

The continuing decline in employer-sponsored health insurance coverage can be addressed, at least in part, through the development of innovative products and strategies, including well-regulated medical discount programs for micro-businesses, tax relief and a range of federal coverage options.

Health savings accounts (HSAs), for example, allow people to save money tax-free to pay for their out-of-pocket healthcare costs and are coupled with a high-deductible health policy to cover catastrophic expenses. According to the New York Times, enrollment in these accounts has grown rapidly since their 2003 introduction, to more than three million individuals. For small employers who may not otherwise be able to offer health coverage, policies linked with HSAs may be a viable option.

However, steps also need to be taken to simplify the health insurance system to make it easier for consumers to secure coverage. For example, there are currently more than 1,800 individual mandates for health insurance coverage in different states. The Council for Affordable Health Insurance (CAHI) estimates that state mandates can increase insurance prices 20 to 45 percent. These mandates also may be restricting choice, keeping some people out of the health insurance market altogether. U.S. Congressman John Shadegg's recently introduced legislation, H.R. 2355 or the Health Care Choice Act, proposes a number of options that could lower health insurance costs, and increase coverage, by creating a nationwide market for health insurance competition. Estimates are that the cost of health insurance could be decreased as much as 12 percent, on average, by letting people compare insurance plans across the country and pick the one that is right for them.

The Latino Coalition advocates that people who are working should not be discriminated against by the federal tax code in their purchase of health insurance simply because they must buy a policy outside of their place of employment. Moreover, products for working individuals must be designed to cost effectively meet their needs and preserve choice—whether young people who must be persuaded to recognize the value of health insurance, or the middle-aged who are not yet Medicare-eligible.

There is no “one-size-fits-all” solution to the uninsured. Even minorities who are insured can have access problems due to language, literacy, provider availability, and other factors. As consumer-driven healthcare becomes more common, difficulties in navigating the system are likely to be compounded, further hampering a reduction in health disparities and frustrating Latinos in their efforts to secure quality, culturally competent healthcare services. Information about insurance products also needs to be appropriate for different populations, and information about how to use insurance should be readily available.

3 SEED-FUND FIVE LATINO HEALTH EMPOWERMENT CENTERS

The Taskforce recommends a national initiative to establish five Latino Health Empowerment Centers (LHEC) in geographic areas with large Latino populations. These federally seed-funded centers would stimulate public-private partnerships among communities, universities, businesses and faith-based organizations, among others, to provide technical assistance and to identify, evaluate and disseminate best practices and approaches for improving Latino health and healthcare.

Major geographic areas across the nation are witnessing the growth of the Latino population through immigration and migration. Although they are heavily concentrated in the West and Southwest, Latinos are settling in key population centers such as Miami and Chicago, the latter of which is home to the nation's second largest concentration of Mexican-Americans.

The impact of a more diversified population on communities and states across the nation needs to be understood and that knowledge disseminated. Effective strategies for community-based outreach and education, methods for ensuring healthcare access and culturally appropriate service delivery, avenues to expand workforce diversity, and research into Latino health disparities intervention and reduction are needed.

Moreover, Latino cultures are themselves diverse. While the vast majority of Latinos (60 percent) are of Mexican decent, almost 10 percent are Puerto Rican; 3.5 percent are Cuban. These three groups represent the largest, traditional segments of the Latino population. Yet there are several newer, growing groups, such as Dominicans, Salvadorians, and Columbians. Although all share many aspects of a common heritage such as language and emphasis on extended family, Hispanic cultures vary significantly by country of origin. Therefore, innovative approaches for meeting the unique health and cultural needs of various ethnic sub-groups also must be documented and the knowledge shared to enrich and energize our communities.

It is expected that each Latino Health Empowerment Center (LHEC) function as an independent center for innovation. Yet they must be linked and able to facilitate the transfer and application of knowledge. LHECs, while seed-funded using federal funds, would also pursue government and private sources of funding to advance their strategic objectives.

The types of activities in which LHECs may become engaged include:

- **Targeted approaches for community based planning and interventions** that address specific health problems that affect Latinos such as diabetes, HIV infection, mental health, cervical cancer among Latinas, and access to dental and preventive healthcare,
- **Research, documentation and dissemination** of interventions aimed at increasing healthcare access and reducing disparities,
- **Demonstration projects** to reduce the high rates of uninsurance among Latinos,
- **Use of multi-media campaigns** and information sources to expand health literacy, encourage healthy behaviors, and improve health system navigation skills,

- **Programs to expand opportunities and preparedness of Latino youth to enter the health professions,**
- **Community capacity building** for advocacy and program development in multicultural health also would be an essential role for LHECs, given the success of culturally proficient model programs and policy developed by or in collaboration with community based organizations, and
- **Development of funding and grants to support programs and services,** which may include working with providers, coalition building, outreach and advocacy.
- **Community based interpreter banks** hold promise in cost effectively making available to health providers and organizations a wide variety of language skills that are culturally appropriate for even small language groups and can improve access to care for Latinos and other minorities. LHECs can be a central resource and organizing entity for such ventures.

It is envisioned that each LHEC may develop depth and expertise in one or more areas (e.g., health literacy, multimedia outreach, community-based health interventions, or health workforce development). This will facilitate creation of resource and consultative centers of excellence among the Latino Health Empowerment Centers.

4 IMPLEMENT COMMUNITY-BASED INITIATIVE TO BOOST ENROLLMENT IN FEDERAL HEALTH PROGRAMS FOR CHILDREN

To improve child healthcare coverage and access, we must expand culturally proficient, community-based programs that optimize youth enrollment in federally-sponsored programs for which they are eligible and eliminate barriers that prevent people from enrolling.

This includes:

- **A Centers for Medicare and Medicaid Services (CMS) outreach initiative** to deliver counseling and outreach services to increase enrollment and utilization of uninsured children Medicaid and S-CHIP (similar to the President's "Cover the Kids" campaign).
- **A Latino Program Enrollment Working Group** at DHHS, NIH Office of Minority Health and others to acquire and document best practices on increasing awareness, desirability, enrollment and appropriate use of heretofore inaccessible programs and services beneficial to various segments of the Latino community.
- **Best practice primers** that include culturally appropriate marketing communication, outreach and enrollment strategies as researched, evaluated and developed in many channels, including TV infomercials, novellas, pharmacy and other point of contact information sharing, faith-based initiatives, and others.

Latino children represent more than one-third of all uninsured children nationwide yet comprise just 18 percent of all children under 18 years of age. Twenty percent of Latino children, nearly three million youth, lack health insurance coverage, compared with nine percent of African American and six percent of white children. This is the highest rate of uninsurance among all ethnic groups, based on U.S. Census Bureau population estimates and an Urban Institute analysis.

Although more than seven in ten Latino uninsured children are eligible for coverage through Medicaid or State Children's Health Insurance Programs (S-CHIP), they are not enrolled. Despite recent public program enrollment improvements, overall efforts to enroll eligible children in government and private programs have been insufficient to address the coverage gap. Most parents have heard about Medicaid, S-CHIP or both; however there is a disconnect between awareness and action. An Urban Institute study reports that a majority of parents say that they would enroll their children if they knew they were eligible.

Sadly, more than 40 percent of uninsured Latino children receive no medical care, says the State Health Access Data Assistance Center. However, HIV infection for Latinos aged 1-4 is the ninth leading cause of death. Latino children are increasingly obese and at risk for diabetes. Studies indicate that Puerto Rican children greater than three times more likely to suffer from active asthma than non-Hispanic whites. These are just examples of the health challenges facing Latino children, regardless of insurance status.

Income and uninsurance disparities are exacerbated for foreign-born immigrants. Federal funding for immigrant health coverage is restricted by complicated rules, creating confusion among Latino families about who can get Medicaid or S-CHIP and who cannot. Immigrants, and especially refugees, may be hesitant to seek healthcare, even for their children. Limited literacy levels necessitates well targeted, easy to understand information.

Frequent address changes, lack of phone service and other lifestyle challenges underscore the critical need for establishment of relationships through outreach, as well as simplified enrollment and eligibility renewal for Latino children. Much of this work can be done through community organizations, schools, pharmacies, and other access points. Training of knowledgeable outreach workers and healthcare providers who are trusted in the Latino community is pivotal to overcoming parental concerns and improving access to Medicaid and S-CHIP for uninsured Latino children.

5 ESTABLISH A NATIONAL MULTIMEDIA LATINO HEALTH LITERACY INITIATIVE

Increased and effective use of multimedia forms of communication is essential in educating and empowering large segments of the Latino population regarding basic health literacy, appropriate health behavior and more effective navigation of the healthcare system. As such, the Taskforce recommends the creation and funding of three to five regional, national, or university-based centers for the research, development and implementation of multimedia strategies and programs targeting Latino populations.

Such centers should include:

- **Entertainment industry outreach**; e.g. Spanish-language and English-language broadcast media that utilizes entertainment education and integrated marketing communications approaches to reduce risk behavior and increase prevention behavior among audience members.
- **News media outreach**, such as fact-based reporting in broadcast and print media that uses journalistic approaches to influence information-seeking and utilization of healthcare services to increase community-based screening and immunization for disease prevention, and to reduce incidence of disease progression among audience members.
- **New technologies**, including Web-based media that employ entertainment and gaming approaches targeted to adult and youth audiences for health promotion and disease prevention.
- **Convening of key leaders** in media (television, film, radio, and print), healthcare communications and the Latino community for the purpose of identifying innovative and effective strategies to improve health literacy and empower consumers.
- **National dissemination of innovations**: technical information, case studies, and summaries of model programs and approaches for culturally appropriate, consumer-driven health information.

Increasingly, health decision making is being delegated to patients and healthcare consumers. Too often people with the greatest health burdens have limited access to health information, according to a recent National Institutes of Health funding announcement. The move toward consumer-driven healthcare will place greater demands on consumers' general literacy and health literacy levels, and will require greater knowledge of the healthcare system and its costs and benefits. To effectively reach large segments of the Latino population who are highly dependent on mass media, a multi-faceted, multimedia approach to improving health literacy is needed, coupled with methods to enhance culturally proficient healthcare delivery.

More than ten million Latino households in the United States rely on Spanish-language and other Latino-oriented media for information, particularly about health issues. Latino-oriented media in this country have grown dramatically in numbers and in influence, making them a powerful ally in the fight to educate consumers and promote healthier behaviors in order to reduce disparities and improve health.

Numerous studies shed light on the popularity and credibility of Spanish-language media in the lives of viewers, and particularly the very broad appeal of *telenovelas* as a source of learning about health issues. For example, a study of four Los Angeles communities that consist predominantly of first- and second-generation immigrants from Mexico and Central America, reported that interpersonal networks and Spanish-language television are the top two ways that they learn about health information (Cheong, Wilkin, & Ball-Rokeach, 2003).

The application of combined media and interpersonal communications, as well as behavioral journalism, community networking skills, and cultural tailoring are useful tools for social marketing and consumer empowerment. Many federally funded campaigns target a wide array of preventable illnesses. A number have proven effectiveness in their preventive capacity and can and should be modified for the Latino populations and subpopulations. Translating efforts and cultural modifications can be applied to pre-existing programs using fewer resources than designing completely new programs.

One successful model of multimedia health communication is the University of Southern California Annenberg School for Communication Hollywood, Health and Society (HH&S) project. Established in 2001 by a cooperative agreement grant from the Centers for Disease Control and Prevention (CDC), HH&S currently is funded by CDC and the National Cancer Institute (NCI) to develop, maintain and evaluate an entertainment education program for public health and cancer. Special projects are funded by the Health Services Resources Administration's Division of Transplantation and the Agency for Healthcare Research and Quality. Technical assistance is provided by funding agencies and their partner organizations, including other agencies of the National Institutes of Health, academic medical schools, schools of public health, national, state and local health departments, and nonprofit health agencies.

As an integral part of this activity, HH&S conducts outreach to the U.S. entertainment industry and conducts formative and summative research with the participation of faculty and students at USC and other universities throughout the United States, such as the University of Georgia. HH&S monitors health content of English-language prime time TV shows and evaluates effects of TV health storylines on multicultural audiences, including Latino audiences at greatest risk for preventable diseases in the United States. HH&S works with Spanish-language television to develop and support network campaigns based on health storylines in *telenovelas*. Two such projects are currently focused on worker safety topics with support from the CDC's National Institute of Occupational Safety and Health.

This model provides a unique entertainment education approach that utilizes popular entertainment media as the basis for an integrated marketing communications campaign, including journalistic and Web-based media channels. As the model expands to reach the growing Latino population, through the burgeoning marketplace of Spanish-language entertainment channels, additional centers of expertise are needed to support journalistic and Web-based outreach, both in support and independent of the entertainment channels.

Web-based entertainment and gaming approaches can be targeted, for example, to reducing youth risk behaviors described in the CDC's Youth Risk Behavior Surveillance System described at <http://www.cdc.gov/HealthyYouth/yrbs/index.htm>, and to promote healthy lifestyle habits as described in the CDC's VERB campaign at <http://www.cdc.gov/youthcampaign/>.

Complementing mass media strategies to improve health literacy and health behaviors, healthcare practitioners must be encouraged to employ evidence-based, multi-component programs that integrate culturally-appropriate communication with access to services.

Culturally appropriate communications require both linguistic competence (language, accurate translation for sub-populations, literacy and health literacy levels) and cultural competence (including accuracy of messaging and information, relevance, and understanding of and sensitivity to the population's values, customs and traditions, and other factors). Publications such as the National Alliance for Hispanic Health's *A Primer for Cultural Proficiency* are instrumental in providing information and materials to educate and assist healthcare providers in serving the diverse Latino population.

Yet more research is needed to improve our understanding of culturally appropriate communications strategies, as few studies assessing culturally appropriate communications models have been conducted.

Nevertheless, provider-driven programs, such as health promotion outreach teams, bilingual staff and interpreter services continue to be important among the range of efforts to improve access to and satisfaction with healthcare services, as well as to enhance the ability of consumers to successfully navigate the healthcare system. It is critical to expand consumer-driven efforts to empower consumers through health knowledge that can positively impact both health access and healthy behaviors.

6 EXPAND INITIATIVES TO ENSURE A DIVERSE HEALTHCARE WORKFORCE

The Taskforce recommends focusing national attention on the widening gap between the racial and ethnic composition of the U.S. population and the composition of the healthcare workforce, as well as its long-term implications for the healthcare delivery system. Such an initiative should be jointly spearheaded by DHHS and the Department of Education (DOE) and be guided by a national working group on health workforce diversity that meets regularly to coordinate activities among the various sponsors. This group should include senior staff of government agencies (e.g. Bureau of Health Professions, National Institutes of Health, and DOE), the media, private foundations, K-12 schools and associations of health professions schools.

Priorities for action should include:

- **Greater public and private coordination in developing a national strategy** for working from early education through health professions training in order to prioritize—and optimize—funding along educational pipelines.
- **Continued funding of existing programs that target upstream, early educational stages** (e.g., academic health centers/K-12 school partnerships) as demonstration projects with rigorous evaluations.
- **Greater targeted resources for interventions** (e.g. enrichment programs, RN-to-BSN programs) to increase opportunities for and the number of underrepresented minority students in nursing, health management and allied health professional programs.
- **Expanded opportunities for student financial aid:** grants, loan forgiveness programs, tuition reimbursement, and paid, on-campus opportunities for minority and disadvantaged students, as opposed to student loans.

The U.S. faces a long-term labor shortage of skilled workers. By their sheer numbers, minorities and immigrants represent a major source of the potential future business and healthcare workforce, yet the top ranks of clinical and management health professionals are far less diverse than the patient population. The under-representation of minorities in health professions is a growing healthcare, business and economic crisis given the increasing racial and ethnic diversity of our nation.

Disparities in the number and distribution of minority and other healthcare professionals increase healthcare costs and impede access, efficiency, and the quality of the healthcare experience and of care itself. The nation requires a healthcare workforce with the skills and diversity to maintain the nation's position as a world leader in healthcare.

According to a comprehensive California Endowment study, the source of the minority health professions problem is seen “upstream,” at the beginning of the pipeline, where primary and secondary schools are failing too many students. Lack of educational opportunities and early under-achievement for many minority groups are fundamental obstacles and lead to under-representation in health professions. By 2030, Latino children will comprise one-fourth of the nation's total school population; however young Latinos lag behind white children in early school-related skills. They are more likely to enter kindergarten early and without the benefit of preschool.

There are thousands of early intervention programs aimed at low-income and minority youth. And although extremely broad in its focus, efforts to increase Latino participation in the health professions must begin at the K-12 levels. Latino children are less likely than non-Hispanic whites to participate in gifted and talented K-12 classes, access to which is an important predictor of math and science achievement. Studies have shown that low-income and minority children begin to disengage from school at an early age, starting a downward trend in academic achievement from which they do not recover. The failure to place more minority children in gifted programs is a lost opportunity to increase their likelihood of future success.

Efforts to expand the number of Latino high school and college students who are adequately prepared to enter the health professions also must be continued. According to the U.S. Department of Education's National Center for Education Statistics (NCES) data, nearly 30 percent of 16-24 year old students who drop out of high school are Latino compared with about eight percent of whites and 14 percent of non-Latino blacks. Those who graduate are often ill-prepared in math, science and English, according to 2000 NCES statistics. Low income and minority students, particularly those with limited English proficiency, also have been shown to be more likely to have teachers without adequate training (Shields et al., 1999).

Latinos also are less likely than either whites or African Americans to enroll in college (Wilds 2000). Community colleges are pivotal in the pipeline for underrepresented minorities (URMs); however, these colleges can divert students off the path to a four-year degree. According to the California Endowment, minority students often fail to receive the educational validation and support they need to proceed in their academic education. Despite improvements in recent years, whites are five times more likely to earn a four-year degree than Latinos. This creates an enormous leak in the health professions pipeline.

For many Latino students, educational financing remains a barrier to entry into the health professions. Minority students are more likely than non-minorities to come from low-income families, and are therefore disproportionately affected by the rising costs of higher education and adverse trends in the availability of financial aid.

Despite considerable federal, state and private investment in diversity programs, academic achievement and entry into the health professions by underrepresented minorities have not increased significantly. Nevertheless, although evaluation research is limited, studies show that targeted, culturally appropriate intervention strategies can be effective in increasing the enrollment of URMs in health professions.

Major intervention strategies include:

Strategy	Definition
<i>Mentoring</i>	Pairing of students with professionals, faculty, or more advanced students for social support and possibly academic and career guidance
<i>Financial Support</i>	Scholarships, loans or loan repayment programs
<i>Psychosocial Support</i>	Counseling, motivational programs, or peer groups to assist student in social adjustment
<i>Academic Support</i>	<i>K-12</i> academic enrichment, tutorials, or admissions preparations to assist students who need additional academic support or to provide more rigorous academic preparation
<i>Professional Opportunities</i>	Internships, apprenticeships, or information dissemination meant to expose students to health professions careers

Source: "Strategies for Improving the Diversity of the Health Professions," The California Endowment, 2003.

There is considerable opportunity for better coordination among agencies and organizations that fund and implement programs designed to improve the educational success of URM students and to increase their participation in the health professions. Within the federal government these include the Bureau of Health Professions, Office of Minority Health in the Health Resources and Services Administration, National Institutes of Health, National Science Foundation and Centers for Disease Control and Prevention, among others. Private organizations that have focused on health workforce diversity include the Robert Wood Johnson Foundation, the W.K. Kellogg Foundation, Josiah Macy Jr. Foundation, Howard Hughes Medical Institute, the Commonwealth Fund, Pew Charitable Trusts, and the National Medical Fellowships. Multiple state and community foundations, notably The California Endowment and The California Wellness Foundation, also have tackled various initiatives in workforce diversity.

There also is opportunity to help young people identify and explore the broad range of health professional options, some of which (e.g. nursing) do not require a bachelor's degree for entry. Many health professions (e.g., health management) tend to be discovered by "word of mouth," through a relative or acquaintance's experience. As a nation, we can do better to expose tomorrow's leaders to promising educational opportunities in healthcare, and to more adequately prepare them to take on the challenges of caring for a diverse population.

7 MEDICAL MALPRACTICE REFORM

The high cost of medical malpractice insurance hinders many physicians and healthcare workers from practicing in underserved areas. There is a demonstrated need for medical malpractice reform, including specifically:

- **Medical malpractice relief through tax incentives** that reduce financial obstacles for healthcare practitioners working or volunteering in underserved communities.

The nation faces challenges in ensuring that all communities and populations have access to a sufficient number of primary medical care professionals. The HRSA Bureau of Health Professions National Center for Health Workforce Analysis estimates that 20 percent of the U.S. population currently resides in primary medical care Health Professional Shortage Areas (HPSAs), which include minorities living in both urban and rural settings.

Exacerbating an existing shortage of minority healthcare professionals, other dedicated physicians and healthcare providers may be dissuaded from working or volunteering in underserved areas. Among the critical drivers, the high cost of malpractice insurance is a major disincentive. For example, the average obstetrician/gynecologist in Florida paid a 2002 premium of \$173,000 for medical liability insurance, according to Medical Liability Monitor. Higher risk patients and high levels of uninsurance, coupled with litigation potential, also contribute to providers' hesitancy to reach out to underserved communities.

Medical malpractice insurance covers doctors and other professionals in the medical field for liability claims arising from their treatment of patients. The lack of affordable insurance also is leading doctors to retire prematurely, relocate their practices to non-litigious areas, practice without insurance or drop risky procedures. According to the American Medical Association (AMA), the medical liability situation has reached a crisis point in at least 18 states and a crisis is looming in many others.

President Bush reiterated a call for Congressional action on medical liability reform in his 2006 State of the Union address. While the issues surrounding liability reform may be complex and varied, tax incentives to increase the affordability of malpractice insurance offer a straight-forward approach to encourage and enable healthcare professionals to extend their services into communities in need.

8 HEALTHCARE INFORMATION TECHNOLOGY

In a 2005 report on healthcare interoperability from the National Institutes of Health and the U.S. Department of Health and Human Services, the case was made for the importance of incorporating an information technology system to make health care more accessible, safer and cost effective. The study, “Ending the Document Game,” stated: “Although your airline ticket confirmation number, your rental car record, and even your cellular phone bills and calling history are available 24/7 on-line, your medical records are locked away in filing cabinets somewhere, partially handwritten and partially typed, stored in paper folders, and stacked alphabetically.”

Given the critical importance of health information technology, the Taskforce recommends:

- **Create incentives for adoption.** The federal government should create financial and other incentives for individuals and healthcare-related organizations to participate in and implement electronic healthcare support systems. These incentives should also include revision or elimination of regulations that create unnecessary barriers to healthcare IT.
- **Establish standards.** Since a nationwide system of medical records and related information must be interoperable, the project must begin with a set of standards that enjoys universal acceptance. The federal government should pursue the completion of such standards now under study by groups such as the American Health Information Community (AHIC) and the National Committee for Vital and Health Statistics (NCVHS). Standards should also reflect requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), or the designers or standards should work with lawmakers to seek adjustments to HIPAA.
- **Establish privacy rules and identity authentication protocol.** Given the importance of privacy and the cost of care, the government should establish a system to ensure that a patient seeking access to records can prove identity, and that a caregiver or organization seeking access has secured appropriate permission. The government also should require system designers to satisfy ethical and legal requirements of privacy rights.
- **Promote to the public the vital benefits of and immediate need for healthcare IT.** The potential to save lives, improve healthcare and save money is so great that the public about it, they would demand action. Therefore the federal government should authorize a significant, high-profile campaign to educate the public on the many personal and social benefits of large-scale healthcare IT.

Background

The problems of the current U.S. healthcare system are myriad. They cause human suffering, loss of life, wasted money, and wasted time and resources of caregivers. These challenges include:

Loss of life from medical errors. According to the Institute of Medicine, as many as 98,000 Americans die each year from preventable medical errors. Other studies indicate twice that number. More Americans die from medical errors each year than from breast cancer, AIDS, or motor vehicle accidents. Many and perhaps most of these errors could be avoided through the use of interoperable healthcare information technology (IT).

Diminished quality of care due to missing medical information. Each time a patient sees a new caregiver, that patient must provide a complete medical history, usually from memory. Typically, this history already exists in the files of other physicians, but as medical records are not interoperable or immediately accessible—they are usually on paper or stored away on a personal hard drive—caregiver and patient can only hope the ad hoc history is accurate and complete. The operative elements are luck and memory. Given technological solutions similarly implemented in banking and other industries, this deadly shortcoming cannot be allowed to continue.

Skyrocketing costs. According to recent studies, total U.S. spending on healthcare in 2004 reached \$1.9 billion—equal to about two-thirds of the entire federal budget, and almost \$6300 per person.³ That spending is expected to double by 2015, when it will reach 20 percent of GDP—which means that one of every five dollars worth of work in the U.S. will go to paying for healthcare.⁴ Healthcare IT will lessen administrative spending that drives up these costs.

Benefits Healthcare IT Can Provide

Interoperable healthcare IT is one of the great missed opportunities for better quality of life, the saving of lives and cost savings for everyone. Benefits include:

Convenience. When medical information, test results and treatment records are available to any doctor or lab (with the permission of the patient), the problems of delays, inaccurate information and missing data will be virtually eliminated. Care providers will be able to “pull up” whatever they need on a patient whenever they need it, without waiting for transmission or mailing of information. Electronic systems will be easily backed up, so medical records will no longer be subject to loss from fire or storm damage. Adult children of aging parents will be able to track care from their home instead of having to travel across the country. And patients will be able to more easily monitor personal progress and interact with healthcare providers.

Dramatic time savings. With interoperable healthcare IT in place, patients will no longer have to fill out a complete medical history for every new healthcare provider they see. Healthcare professionals will save time because they will no longer have to gather information from multiple other providers.

Medical history accessible anywhere. If an individual needs to see a new doctor or a healthcare provider far from home, interoperable healthcare IT will make medical history, test results, prescription records and more available immediately from any location. For example, ambulance workers will not have to ask basic questions of a victim who may not be in a condition to answer.

End of prescription errors and confusion. By moving from paper-based prescriptions to electronic entry, the risks of errors caused by illegible handwriting are eliminated. Duplicate filling of prescriptions can be prevented, as well. Caregivers also can readily check to see if prescriptions are being filled, improving medication compliance by patients.

Reduced fraud. Secure access ensures the person receiving treatment is the person he or she claims to be. Fraudulent insurance claims will be reduced, false self-identification of patients to receive free treatment could be nearly ended, and prescription drug fraud will be harder to achieve and easier to detect.

³ Smith, C., C. Cowan, A. Sensenig and A. Catlin. "Health Spending Growth Slows in 2004." *Health Affairs* 25:1 (2006): 186-196; cited in "Health Insurance Cost" from National Coalition on Healthcare at <http://www.nchc.org/facts/cost.shtml>, last accessed 7/29/06, 352pm.

⁴ Borger, C., et al., "Health Spending Projections Through 2015: Changes on the Horizon," *Health Affairs* Web Exclusive W61: 22 February 2006; cited in "Health Insurance Cost" from National Coalition on Healthcare at <http://www.nchc.org/facts/cost.shtml>, last accessed 7/29/06, 352pm.

9 BENCHMARK PROGRESS IN LATINO HEALTH

Accurate, usable information on race and ethnicity is essential to benchmark our progress, monitor quality of care and address persistent healthcare disparities. The ability to measure and monitor our progress in improving Latino health is critical to the long-term health and vitality, not only of Latinos, but of our nation.

The Taskforce recommends:

- **A Latino Healthy People 2010 midcourse review** to report baseline data and identify a tracking system for each *Healthy People 2010* objective.
- **Improvements in Latino health data collection, analysis, and reporting under DHHS data systems** in order to achieve baseline and tracking data for 100 percent of *Healthy People 2010* objectives in compliance with Office of Management and Budget guidelines on the collection of racial and ethnic data.
- **Latino Health Fact Sheets**, published periodically, to identify and monitor trends. These Fact Sheets can serve as a definitive source of information for Latino health advocates, multimedia communications, policymakers and others.
- **Standard electronic recording of race and ethnicity information** as part of the expansion of electronic medical records (EMR) nationwide, that allows healthcare providers to use standardized categories stored in standard formats.

With approximately a decade of Latino-specific information at least partially available, it is vital that we establish mechanisms for building accountability and monitoring of our national, state and regional progress in Latino health. These mechanisms may take the form of benchmarks, metrics, and ongoing mechanisms to collect and analyze timely and relevant information.

The Taskforce's principal and work group specific recommendations were drawn from data, reports and issue briefs produced by a variety of agencies, groups and organizations interested in Latino health and, more broadly, health disparities. Many focused on closing or reducing "disparities."⁵ These disparities are considered (a) gaps or differences in health status, (b) biologic and cultural influences/"determinants" that influence health promotion/lifestyle and healthcare servicing provisions, as well as (c) other important factors such as barriers to access to healthcare services and insufficiencies in the supply of a culturally sensitive workforce.

Annual changes in disparities tend to be small. Even when improvement in quality or access is observed, disparities often persist because all groups typically change proportionately. To reduce disparities, groups with poorer quality of care or access to care need to experience more rapid improvements in care than other groups. This is rarely observed. Small sample sizes often lead to pooling of minorities which mask variations of subpopulations within larger racial and ethnic groups.

⁵ *Healthy People 2010* and the NHDR define *disparities* as any difference among population. Disparities are generally stratified by race, ethnicity and socioeconomic status (primarily income and educational level attained).

In the *National Healthcare Disparities Report* (NHDR) released in early 2005, several themes were highlighted for policymakers, clinicians, health system administrators, and community leaders seeking to use information in the report to improve healthcare services for all Americans. Data regarding the health status of minorities for six areas targeted by the federal government show disparities affect individuals across the life span and how profound disparities have become. These include HIV/AIDS, cancer screening and management, coronary heart disease, diabetes, immunization levels, and infant mortality. A majority of these issues also are health concerns of Latinos.

The most recent National Healthcare Disparities Report was the third in an annual series. Thirty-eight measures of healthcare effectiveness and 31 measures of access to health care were documented. *Latinos received lower quality of care than non-Latino whites for half of quality measures and had worse access to care than non-Latino whites for about 90% of access measures.*

For example, the quality of diabetes care declined among Latino adults as it improved among white adults. In addition, the quality of patient-provider communication (as reported by patients themselves) declined among Latino adults as it improved among white adults. Access to a usual source of care increased more slowly among Latinos than among whites.

The National Alliance for Hispanic Health has highlighted the fact that our ability to track and benchmark status and progress of Latino health also is lacking. According to the Alliance, 40 percent of *Healthy People 2010* population-based objectives and sub-objectives do not have Latino baseline data. Further, 86% of Latino community leadership recommendations were not fully incorporated into the final objectives under *Healthy People 2010*.

Scorecards and fact sheets may provide excellent tools to support tracking and benchmarking of Latino health progress. One example of a scorecard approach is the Greater Los Angeles United Way research document that tracks numerous social indicators, including some health status measures, against 2003 baseline values. Funding to develop a National Latino Health Scorecard could be pursued and fulfilled through a research consortium using a meta-analysis approach. Derived information would become the baseline for performance monitoring and progress reporting to the Administration and the American people.

The University of California, Los Angeles (UCLA) A Center for Health Policy Research, together with the Government of Mexico and the University of California-Mexico Health Initiative, published in October, 2005 a comprehensive summary of health issues and *Fact Sheets* which capsule key demographic and health status/health access issues. Similarly, The Latina Issues Forum in San Francisco publishes *Latina Health Fact Sheets*, The California Office of Multicultural Health publishes *Facts and Survey Findings: California Hispanic/Latino Population* and The National Latina Institute for Reproductive Health produces *Facts/Hechos*. Examples of scorecards abound and can be useful in creating a nationwide approach to Latino health benchmarking.

The value of technology as a powerful tool in the nation's efforts to improve health and healthcare delivery also must be leveraged. The Administration has taken a leading role and is committed to moving the nation and its healthcare providers towards electronic medical record (EMR) systems. This initiative presents an opportunity to standardize and improve the collection of racial and ethnic data for healthcare planning.

Supplemental Recommendations by Area of Focus

Complementing the Latino Healthcare Taskforce Principal Strategies, the group's four areas of focus led to the development of specific, supplemental recommendations for which further consideration and action is urged.

Reducing the Uninsured Latino Population

- 1.1** Based on the President's 2006 State of the Union address, targeted programs and services that are Latino culturally proficient should be undertaken to increase access and use of new Part D Medicare programming, including prescription drug plan selection, health savings account (HSA) enrollment and increasing health literacy regarding appropriate utilization.
- 1.2** The Taskforce supports the current Food and Drug Administration policy opposing the re-importation of pharmaceuticals from other nations due to quality and safety concerns; however, it recognizes the cost of drugs as a major issue for many Americans and urges continued efforts to ensure the availability of quality, affordable pharmaceuticals.
- 1.3** Profile, document and disseminate information on current un- and under-insurance status of Latinos at the federal, state and selected local areas on a *comparative annual basis* to denote trends. This can be accomplished through the creation of a Latino Health Insurance Working Group at the Department of Health & Human Services (e.g., CMS, Assistant Secretary of Planning and Evaluation) with the Census Bureau, high Latino-proportion state insurance offices, and others.
- 1.4** Major advocacy groups should be urged to acquire and publish comparative statistics on Latino populations, as post-1989 databases have now matured to allow such comparisons. Trend analyses should be undertaken, as well as forecasts and projections based on the growing sub-population groups entering *mid-life* and *senior* status. Issues related to *undocumented immigrants* and their impact on healthcare facilities as loci of last resort also should be considered.
- 1.5** Fund an ongoing series of national research studies to document the economic impact of uninsurance and health disparities on healthcare costs, business productivity, and the national economy. Utilize the results to spur identification and development of specific initiatives aimed at reducing uninsurance levels, with emphasis on minorities and underrepresented populations.
- 1.6** Federal and state initiatives should be undertaken to clearly define and communicate eligibility criteria for immigrants.

- 1.7** Issue a report on the costs and authorities required to expand eligibility under the Children's Health Insurance Program to the parents of eligible children up to 150% of the Federal Poverty Level, as also recommended by the National Alliance for Hispanic Health.
- 1.8** Work with federal and state agencies and private health plans to increase the availability of population-specific, low cost health plan options through flexible and innovative plan design.
- 1.9** Support subsidized coverage through reinsurance and high-risk pools for the uninsurable.
- 1.10** Support expansion of efforts such as the Cover the Uninsured Week's Small Business Working Group to educate and encourage employers to provide health insurance through employer tax credits for employer-sponsored coverage, health savings accounts (HSAs), and employee assistance in finding coverage solutions.

Informing and Empowering Latinos to be Better Healthcare Consumers

- 2.1** Federal agencies and organization should strive to become role models in cultural proficiency through internal and external knowledge development, communications, and research. Evaluations of federal entities should include criteria related to workforce diversity and cultural proficiency.
- 2.2** As recommended by the IOM Committee on Communication for Behavior Change in the 21st Century: Improving the Health of Diverse Populations panel, an intervention analysis comparing the effectiveness of existing communication programs, new and ongoing programs, and potential alternative strategies targeting diverse communities must be undertaken. As a starting point, focus should be placed on the Latino population segment in recognition of its size, diversity, rapid growth and national impact.
- 2.3** Government and private funders should require of all relevant contractors that communication theory and health behaviors be considered in a more consistent and aggressive way during the development and implementation of communications programs, including media, for Spanish-speaking populations.

In addition, health outreach, promotion and communications programs should be able to quantitatively, as well as qualitatively, demonstrate competency in the specific community or Latino sub-group being served.

2.4 Investments are needed in research, training, and delivery of technology-savvy communications and interventions to improve the health of diverse populations. Research methods are needed to estimate the untapped potential and costs of communications technology used to improve healthcare for diverse populations.

For example, the IOM proposes that new measures, such as life experiences and cultural processes, are needed to understand health behavior variations. Greater support should be provided for ethnographic research that examines historical, social and cultural contexts of diverse communities' health behaviors.

2.5 Funders should encourage the use of interdisciplinary teams in the design and implementation of communication strategies.

2.6 As recommended by the National Alliance for Hispanic Health, the National Institutes of Health (NIH) should release data on the number of supported Latino principal investigators (PIs), the budget for Latino community education programs, and a plan for doubling the budget for Latino community education by the next fiscal year in each Institute and Center.

Partner with Latino Communities to Enhance Planning, Production and Delivery of Health Services

3.1 The Taskforce commends President Bush for his initiative to double the number of community clinics serving America and recommends these clinics be strategically placed in areas with high uninsured populations, specifically to help Latinos and other uninsured minority groups.

Further, the Taskforce recommends a progress report be developed on The President's Community Health Center Initiative. The Initiative was designed to create new and expanded health center access points to impact 1200 communities over five years (starting FY 2002). Progress reporting should include success against projected new centers and expanded points of access; expansion of oral health, mental health, substance abuse, and disease collaborative at sites currently supported under Section 330; and an assessment of the Initiative's goal of reaching an additional six million people.

3.2 Government and private funders should support and encourage the formation of community coalitions to engage in advocacy activities around linguistically and culturally competent health services and policy.

3.3 The DHHS Office of Minority Health should conduct a follow up study of its early 1990s assessment of the capacity of state, county and local health departments to deliver linguistically and culturally appropriate services. Best practices and highly transferable models identified should be widely shared to encourage replication.

- 3.4** Working within the agreed funding set for the Centers for Disease Control and Prevention by Congress for the upcoming fiscal year, reconfigure funds to achieve *a doubling of the budget for Latino community-based services* with the majority of funds supporting an expansion of Latino services within the National Center for Chronic Disease Prevention and Health Promotion, as recommended by the Latino Health Alliance.
- 3.5** An interagency, multidisciplinary national diabetes prevention and control initiative should be created to target the growing diabetes and obesity epidemics, focusing on Latino communities and nationwide.
- 3.6** Policies and research initiatives that enhance health outcomes for underserved minority populations and directly address the design and delivery of healthcare systems that respond to the specific needs of racial/ethnic minorities should be considered for priority funding.

Increasing Latinos in the Healthcare Fields through a Variety of Public and Private Programs with “Supply Side” Incentives

- 4.1** Prioritize funding of rigorously conducted evaluation research in addition to funding interventions themselves.
- 4.2** Medical, nursing and health professions schools, including health management programs, receiving federal or state funding should be directed to develop strategic plans and offer curriculum that will assure all physicians, nurses and health professionals receive training in health disparities, culturally proficiency and the provision of sensitive, patient-focused care.
- 4.3** Increase emphasis on adequate support for federal programs that extend professional mentorship beyond residency training.
- 4.4** Consistent with the recommendation of the 2003 Sullivan Commission, ensure the provision of adequate federal support for faculty development programs that will expand and complement the development of minority students, health professionals and health leaders.
- 4.5** Academic medical centers must be encouraged to take proactive leadership roles to ensure the inclusion of Latino and minority health issues in all aspects of research and education.

- 4.6** Thorough and consistent with the scope and standards of the Medicare Conditions of Participation, JCAHO, state licensing boards and other accrediting bodies, hospitals, physicians and other healthcare providers should be directed to offer/receive and develop measurements for continuing education and training to enhance the provision of culturally-proficient care.
- 4.7** Medical, nursing and health professions schools, including health management programs, receiving federal or state funding should be directed to develop strategic plans and offer curriculum that will assure all physicians, nurse and health professionals receive training in health disparities, cultural proficiency and the provision of sensitive, patient-focused care.

CHAPTER FOUR: SUPPORTING INFORMATION

Latino Demographics and Economic Strength

A number of key demographic measures and trends serve to define and segment the nature of health issues in the Latino population. Latinos are not a homogeneous group, and strategies and tactics for health advancement must be based on the dynamic nature of people, communities and cultures.

Latinos (or Hispanics) are persons of Cuban, Mexican, Puerto Rican, South or Central-American, or other Spanish culture or origin, regardless of race. The federal government considers race and Latino origin to be two separate and distinct concepts; Latino Americans may be any race.

The Latino Population is Diverse, and Growing Rapidly

- *Latinos Are Nearly 15 Percent of the U.S.:* According to the 2000 U.S. Census, Latinos of all races represented 13.3 percent of the U.S. population, about 37.4 million individuals. Latinos accounted for 40 percent of the country's population growth between 1990 and 2000. This dynamic population is estimated to continue to grow--by more than 1.7 million a year (U.S. Census Bureau).
 - In 2003, Latinos became the nation's largest ethnic minority group, at nearly 40 million.
 - By 2004, there were 41 million Latinos in the U.S., representing 14.1 percent of the total population; by 2005, approximately 42.7 million.
 - By 2040 there will be 87.5 million Latino individuals, comprising 22.3 percent of the population.
 - By 2070, Latinos will make up 28.6 percent of the U.S. population.
- Among the 1.3 million new Latinos in 2005, 60 percent are citizens because they were born here. Estimates are that undocumented resident Latinas gave birth to one-third of babies born to Latinos that year. (U.S. Census Bureau 2006; Center for Immigration Studies)
- *Latino Cultures are Themselves Diverse:* More than one eighth of the people in the United States are of Latino origin, but they come from very diverse Spanish-speaking cultures. Among the Latino population in 2004, 59 percent were of Mexican decent, 9.6 percent were Puerto Rican, and 3.5 percent were Cuban. These three groups represent the largest, traditional segments of the Latino population. Among newer and growing groups are: Dominicans 2.2 percent, Salvadorians 1.9 percent and Columbians 1.3 percent. Though they share many aspects of a common heritage such as language and emphasis on extended family, Hispanic cultures vary significantly by country of origin. (U.S. Census Bureau)

- *Recent Immigrants Offer Health Improvement Opportunity:* The recent immigration status and relatively young average age of Latinos in the U.S. presents a unique opportunity for chronic disease prevention through health promotion and treatment of modifiable risk factors through behavioral changes prior to negative health acculturation.
 - First generation Latinos are those born outside the U.S., including those born in Puerto Rico. This is the largest group of Latinos, at 63 percent.
 - The second generation is comprised of those born in the U.S. to foreign-born parents (19%)
 - Third generation or higher includes anyone whose parents were born in the U.S. (17%). (U.S. Census Bureau)

- *Geographic Concentration:* In 2002, the ten states with the largest Latino markets by spending power were: California, Texas, Florida, New York, Illinois, New Jersey, Arizona, Colorado, Georgia and New Mexico. The states with the greatest concentration of Latinos are New Mexico, California, Texas, Arizona, Nevada, Colorado, and Florida. (Selig Center)

Many Latino Families Face Financial Challenges

- *High Rates of Poverty:* The poverty rate for Latinos is 22.2 percent, or approximately nine million people, compared with 12.6 percent for all U.S. residents. However, the poverty rate of Latinos is slightly lower than for Native Americans (24.4%) and African Americans (24.6%). (Census Bureau 2005)
 - In 2003, 29.4 percent of Latino families with children under age 18 lived below the federal poverty line. (U.S. Census Bureau, Current Population Survey, 2004).

- *Lower Household Incomes:* Latinos and African Americans report having similar household incomes, which tend to be lower than household incomes reported by whites.

Household Income by Race/Ethnicity

Household Income	Latinos All	Latinos Foreign-born	Latinos Native-born	Whites	African Americans
Less than \$30,000	50%	57%	37%	29%	44%
\$30,000 - < \$50,000	23	20	28	27	30
\$50,000+	17	11	27	42	22
Don't Know	11	12	8	3	4

Pew Hispanic Center/Kaiser Family Foundation 2002 National Survey of Latinos, Table 1.1, p. 12

- Foreign-born Latinos generally live in households with lower incomes than those who are native born. A majority (57%) of foreign-born Latinos report making less than \$30,000 a year, while a majority (53%) of native-born Latinos report making more than \$30,000 a year.
- Employed foreign-born Latinos are also more likely to report being in blue-collar jobs (65%) than those who are native-born (28%).

Despite Challenges, Latinos Have Considerable Economic and Political Strength

- *A Future Workforce and Voting Power.* By 2020, a majority of children entering high school, workers entering the workforce, and newly-eligible voters will be Latino.
- *Burgeoning Purchasing Power.* U.S. Latino purchasing power has surged to nearly \$700 billion and is projected to reach as much as \$1 trillion by 2007, nearly three times the overall national rate over the past decade. (HispanTelligence®)
- *Improving Prosperity.* The number of prosperous Latino households—those with incomes of at least \$100,000—rose 137 percent between 1990 and 2000. (U.S. Census Bureau)

Latinos and Health Insurance

- *Disproportionate Levels of Uninsurance.* Based on 2004 estimates 19 percent (48.1 million) of U.S. residents under 65 years of age were lacking health insurance coverage.
 - Among Latinos, 36.2 percent lacked insurance—the highest rate of uninsurance among all ethnic groups. This percentage represents an increase over 2003 (35.7%).
 - Latinos accounted for 28.8 percent of the uninsured, but 15.1 percent of the estimated population. (Center for Financing, Access and Cost Trends, AHRQ MEP Survey, 2003 and 2004.)
 - Latinos are three times more likely than whites to be uninsured. (IOM, 2003)
- Latinos are disproportionately uninsured, largely due to low employer-provided insurance: 43 percent compared with 76 percent for whites.
- Three quarters of uninsured Latinos are low income. (Commonwealth Fund, 2002.)
 - Forty-one percent of uninsured non-elderly Latinos earn less than \$15,000 annually.
- *Uninsurance Costs.* Despite limited resources, the low income uninsured pays up to 40 percent of medical care costs by themselves, including 88 percent of their drug costs and 47 percent of ambulatory care costs. (IOM, 2003)

- The Institute of Medicine estimates that uninsurance in the U.S. costs between \$65-130 billion annually in increased morbidity and mortality.
 - 18,000 deaths are estimated to result due to uninsurance—the 6th leading cause of death nationally for those 25-64. (IOM, 2003).

Latino Children Disproportionately Lack Health Care Coverage & Access

- *Many Children Uncovered.* There are 2.9 million uninsured Latino children in the U.S. Approximately one in 5 Latino children lacks coverage. (U.S. Census Bureau, Population estimates, 2004)
- One-third (34.7%) of all uninsured children under age 18 are Latino. Yet Latinos comprise just 18 percent of all children under 18. (U.S. Census Bureau, Population estimates, 2004.)
- Latino children are uninsured at more than twice the rate of African American children and nearly 3.5 times the rate of white children. (Urban Institute analysis of CDCP 2003 National Health Interview Survey.)
- Although uninsurance rates of Latino children fell from 26 percent in 1998 to 20 percent in 2003, the uninsurance rates of their parents rose three percent, to 1.5 million. (Urban Institute analysis of CDCP 2003 National Health Interview Survey.)
- *Medicaid & S-CHIP Eligible.* More than 7 in 10 Latino uninsured children are eligible for coverage through Medicaid or S-CHIP, but are not enrolled. (Urban Institute analysis of CDCP 2003 National Health Interview Survey.)
 - Approximately nine out of ten low-income Latino families with uninsured children have heard of Medicaid, S-CHIP, or both. The majority say they would enroll their children if they knew they were eligible. (Urban Institute 1999 and 2002 NSAF Surveys)
- *Limited Access.* More than 40 percent (41.4%) of uninsured Latino children did not receive any medical care during 2003, compared with just 17.5 percent of insured Latino children.
 - These uninsured children are 10 times more likely not to received needed care than their insured counterparts (6.1% vs. 0.6%) (State Health Access Data Assistance Center, 2003.)

Immigration Status Complicates Insurance Status

- Non-citizens are far more likely to be uninsured, irrespective of ethnic group.
 - Slightly more than forty-four percent of non-citizens lack insurance, compared with 13.3 percent of those native born, 17.2 percent of naturalized citizens, and 33.7 percent of those foreign-born. (U.S. Census Bureau, 2005)
- Latino immigrants and their U.S. born children make up two-thirds of the Latino population. Legal immigrants who lived in the U.S. before August 22, 1996 can get public coverage through Medicaid or S-CHIP; those who entered after that date are ineligible for five years, and then other restrictions apply.

- Undocumented immigrants are ineligible from Medicaid in most states. More than one fifth of all uninsured children live in “mixed-citizenship” families. Although the children are citizens and eligible for coverage, their parents are non-citizens and erroneously fear that enrolling their children will hurt their chances of becoming citizens. (IOM report, Families USA)
- Only 22 states have opted to use their own funds to provide health coverage to immigrants in the absence of federal funding. (Families USA)

Access & Uninsurance

- *Delayed Care.* Uninsured people are more likely to receive too little medical attention and to receive it too late, to be sicker and to die sooner, according to the Institute of Medicine (IOM, 2003).
 - One-fourth of those with diabetes go without a health checkup for two years, while uninsured women and their newborns receive less prenatal care and are more likely to have poor outcomes.
- Latinos have the highest percentage of adults with no regular doctor, at 41 percent vs. 23 percent of the overall population. (Commonwealth Fund, 2002)
- *Chronic Conditions.* More than one-third of non-elderly Latino adults who do not have health insurance report having one or more chronic health conditions.
 - More than one-quarter (27%) of uninsured Latino adults with chronic conditions reported no visits to health professionals in the last 12 months; 50% lack a usual source of healthcare other than an ER visit.

Declining Employer-provided Coverage

- *Working, but Uninsured.* The vast majority of uninsured Latinos are working; 68 percent are employed full-time and 11 percent work part-time. (IOM, 2003; Commonwealth Fund, 2002.)
- In 2004, 65.7 percent of whites had employer-provided coverage as compared to 49.9 percent of African Americans and just 41.1 percent of Latinos. (U.S. Current Population Survey 2001-2005)
 - 82% of Latinos eligible to participate in their employer-sponsored do so, a high take-up rate. (Commonwealth Fund, 2002)
- *Lost Coverage:* About 3.7 million people—including workers, their spouses, and their children—lost employer-provided health insurance between 2000 and 2004.
 - The percent with employer-provided health insurance fell from 63.6 percent in 2000 to 59.8 percent in 2004, a decline of 3.8 percentage points. Coverage declines occurred across age, sex, race, education, and family income level.

- Some people were more hurt than others. Those with only a high school education and those in the second-to-lowest family income quintile were hardest hit. High school graduates were less likely than college graduates to have employer-provided insurance (55.3% vs. 77.5%), and experienced greater declines. (U.S. Current Population Survey 2001-2005)
- *Income Impact:* The lowest rates of employer-provided coverage occurred in families with the lowest incomes.
 - Only about 1 in 5 individuals in families in the bottom 20 percent of earners had employer-provided health insurance.
 - More than four in five individuals in families at the highest 20 percent of earners had such coverage.
 - Individuals in families in the second quintile, those with approximately \$20,000-38,000 in yearly income, saw the largest declines in coverage. Their coverage rates fell seven percentage points, to 47.6 percent in 2004. While over half of the individuals in these families had coverage in 2000, fewer than half had coverage by 2004.
- *Declining Coverage for Workers:* The percent of workers with employer-provided health insurance coverage fell from 2003 to 2004, continuing the uninterrupted decline that began in 2000.
- More than half (55.9%) of workers who worked at least 20 hours per week and 26 weeks per year received employer-provided health insurance from their own employer, down from 56.4 percent the previous year. (U.S. Current Population Survey 2001-2005)
- *Children Hardest Hit:* Employer-provided coverage fell further for children than for any other age group. While overall employer coverage fell from 63.6 percent to 59.8 percent, the decline in employer-provided insurance that covered children fell from 65.6 percent to 60.8 percent, a drop of 4.8 percentage points.
- Only 18.2 percent of children in the lowest income quintile were found to have employer-provided health insurance, compared with 87.4 percent of the children in the highest income quintile.
 - In other words, children whose family incomes were in the top 20 percent were nearly five times more likely to have employer-provided health insurance than children in the lowest 20 percent of family income. This disparity has only been exacerbated over the past four years: the drop in coverage for those in the lowest income quintile was over four times that for children in the highest quintile.
 - The group hurt the worst, however, was children in the second lowest quintile; their coverage rates declined by 8.5 percentage points, from 54.3 percent to 45.8 percent. (U.S. Current Population Survey 2001-2005)

Type of Insurance Coverage

- Health coverage among Latinos in 2002 and 2005 was:

	Commonwealth Fund, 2002	The Latino Coalition, 2005
○ Employer based	43.0	35.1
○ Public programs	18.0	17.9
○ Individual, military and other	4.0	7.4
○ Uninsured	35.0	39.6

- The percentage of the population covered by Medicaid, Medicare or the State Children's Health Insurance Program rose to 26.6 percent in 2004, up from 24.1 percent in 2000. (Commonwealth Fund, 2005).
- In 2001, 80 percent of Medicare beneficiaries were non-Latino white, nine percent were non-Latino black, and seven percent were Latino. One-fifth of Latino beneficiaries and one-quarter of non-Latino beneficiaries were persons under 65 years of age entitled to Medicare through disability, compared with 12 percent of non-Latino white beneficiaries.
- Although the majority of Medicaid beneficiaries are white, a disproportionate number are members of minority groups.
 - Ten percent are white, 26 percent are African-American, 22 percent are Latino, and 15 percent are Other.
 - Percentages of Latino Medicaid recipients vary by state, based on the size of the minority population and the state's Medicaid policies.
 - Massachusetts, 39%
 - California & Oklahoma, 23%
 - Florida, 17%
 - Illinois, 14%
 - Nevada, 9% (Kaiser Family Foundation/Statehealthfacts.org, 2005)

Latino Health Literacy and Consumer Empowerment

Language & Literacy

- Literacy is not a given; 10 million Americans cannot read in any language, and 40 million cannot read English at a 5th grade level. (Friedman, 2005)
- Among all Latinos in the U.S., about half (47%) are Spanish-dominant.
 - Sixty-three percent are first generation/new immigrants. Only four percent of first generation Latinos are English-dominant; 72 percent speak predominantly Spanish.
 - Between 25-35 percent of Latinos are bilingual.

- Native-born Latinos are much more likely (61%) than foreign-born Latinos to speak English as their primary language.

Primary Language, by Foreign/Native-Born Latinos

	Foreign-Born Latinos	Native Born Latinos
English Dominant	4%	61%
Bilingual	24	35
Spanish-Dominant	72	4

Pew Hispanic Center/Kaiser Family Foundation 2002 National Survey of Latinos, Table 1.2, p. 13.

Media and the Message

- *Latino Media Trends.* Nielsen media research estimates that there were more than ten million Latino-American television audiences in 2003, half classified as Spanish-dominant.
 - 57 percent watch *telenovelas*
 - Spanish-television viewers reach all age and income levels. Approximately 44 percent earn \$40,000 or more annually, 31 percent have professional positions, and 30 percent have four or more years of college.
- First- and second-generation immigrants in Los Angeles report that interpersonal (social support) networks and Spanish-language television are the top two ways that they learn about health information (Cheong, Wilkin, & Ball-Rokeach, 2003).
- Findings from the 2002 Porter Novelli HealthStyles survey indicate that 61 percent of those who view *telenovelas* at least two times a week (regular viewers) learned something new about a health topic from a *telenovela* storyline and nearly half took one or more actions, such as telling someone about the health topic, doing something about it, visiting or calling a healthcare place (Beck, Huang, Pollard, Johnson, 2003).
- Results from a national Telemundo survey of *telenovela* viewers found 64 percent who felt that characters/storylines in Spanish-language TV related to their own life situations, compared to 44 percent who felt this way about English-language TV. More than half of the respondents indicated a strong interest in learning about topics such as screenings, cancer, healthy eating, diabetes, heart disease, vaccinations/child immunizations, exercise, HIV/AIDS, health insurance/access to care, STDs, worker health and safety, drug or alcohol addiction, eating disorders and mental illness.
- *Coverage of Health Issues in Spanish-language and Latino-oriented Media:*
 - Latinos want more information about a broad range of health issues, including health policy changes (59%); Medicare (54%) and Medicaid (50%); illnesses that most affect them (58%), and testing, treatment and prevention of HIV (46%).

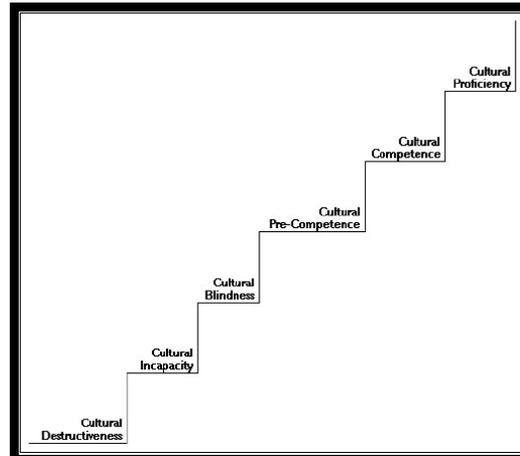
- A majority of Latinos say that within a year's period they received at least some health information from television, newspapers, magazines, or radio.
- Most Latinos say they prefer to turn to the general market media for health news (58%), but Latino-oriented publications and broadcast programs also play a significant role (38%), especially for those who primarily speak Spanish (68%).
- When it comes to what is covered in Latino-oriented media, health is high on the news agenda. Diseases and medical conditions dominate Latino-oriented health coverage. Nearly nine in ten stories (87%) about health focus on a "disease or medical condition," such as cancer (9%) or HIV/AIDS (8%). Three out of every five health stories (60%) contain some consumer information, though background on policy rarely provided (6%).
- The main focus of a health story in one out of every eight (13%) cases was presented as "Latino relevant." Often the Latino connection was made by highlighting the impact of a particular health or medical condition on the population (12% of health coverage overall). (Pew, 2002)
- *Latinas, Media and Health:* The growing market of magazines aimed at Latinas plays an important role in providing reproductive and sexual health information. Roughly one percent of all editorial content in these magazines were articles with a main focus on sexual health issues. Planned pregnancy was the most common sexual health topic covered in Latina magazines (Pew, 2002.)

Numerous Paths to Cultural Competency in Healthcare

- There is general consensus that if improvement of health status, access, empowerment and educational goals and objectives are to be actualized, culturally appropriate programs, policies and services are both the essential and cost-effective pathway.
- A multicultural framework is defined broadly to include populations that differ from the dominant North American culture in terms of race, ethnicity, language, sexual orientation and disability status. A *culturally appropriate* strategy is by nature flexible, adaptable, sustainable, non-stigmatizing and current, responsive to cultural heritage and legacy.
- There currently is no single, evidence-based model for cultural proficiency, although a variety of conceptual approaches are useful.
 - As described by Cross et al, *cultural proficiency* denotes the most positive and progressive approach for organizations, communities and others to take in their interactions with individuals from myriad cultures. In this model, *cultural proficiency* is characterized by holding culture in high esteem.

Culturally proficient providers and systems seek to do more than provide unbiased care; they value the positive role culture can play in a person's health and well being.

Cultural proficiency, as applied to individuals and institutions, involves adding to our knowledge base through research, new approaches based on culture, and publishing and disseminating research and demonstration projects. Such entities become dynamic role models.



Cross, TL, BJ Bazron, KW Dennis and MR Isaccs, "The Cultural Competence Continuum."

- Experts such as Dr. Joseph Betancourt explain that cultural competence/proficiency involves an ability to understand and respect patients with diverse values, beliefs and behaviors, and then to tailor healthcare delivery to meet patients' social, cultural, and linguistic needs. Others, including Jennifer Miranda and Kay Welsh, offer well conceived approaches to attaining cultural competency.

Latino Health and Community Interventions/Partnerships

Population Trends Affect Current and Future Service Needs

- *Youthful...*: Latinos tend to be younger than the white non-Latino population (except for Cubans, who have a higher proportion of elderly than other Latino groups). The median age for Latinos is 25.8 years—10 years younger than the median age for the United States as a whole. Services for young families and reproductive healthcare services are in high demand among the younger age cohorts. (U.S. Census Bureau)
- *...But Aging*: The Latino population in the 55-64 years age cohort is growing rapidly (29 million persons in 2004 and projected to increase to 40 million by 2014).
 - In 2000, five percent of the over-65 population was Latino. By 2050, 16 percent will be 65+. The older population places the heaviest demand on the healthcare system and will be more diverse in their healthcare needs. (U.S. Census Bureau, 2001).

Mortality & Life Expectancy

- Latinos live longer than non-Latino whites, with an average life expectancy of 75.1 years for men and 92.6 years for women. This makes issues of morbidity, and not mortality, of primary concern. (U.S. Census Current Population Reports P25-1130, Feb. 1996)
- As overall death rates have declined, racial and ethnic disparities in mortality persist. The top two leading causes of death for Latinos are the same as for non-Latino whites and blacks: *heart disease* and *cancer*. These diseases accounted for 45 percent of Latino deaths, versus 55 percent of white mortality.
 - Both male and female Latinos have lower age-adjusted mortality rates than whites. Among the elderly, Mexicans, Puerto Ricans, Cubans and “all other Latinos” have a lower mortality than whites. However, among persons aged 25 to 44, all Latino origin groups have higher mortality rates than whites.
- The Latino population is relatively young (median age 26.6 years vs. 38.6 years for whites). Consequently, deaths due to young male violence are more prevalent. Homicide rates among young black males (15-24) and young Latino males were about 50 percent lower in 2002 than in 1992, when homicide rates peaked for these groups. Despite downward trends, homicide was still the second leading cause of death for young Latino males in 2002 and substantially higher than for young white males.

Overall Rank (Not Rate) of Cause of Death by Ethnic Group, 1992

Rank	Latinos	White non-Latinos	Blacks
1	Diseases of heart	Diseases of heart	Diseases of heart
2	Cancer	Cancer	Cancer
3	Accidents/Adverse effects	Cerebrovascular disease	Cerebrovascular disease
4	HIV infection	COPD	Homicide
5	Homicide	Accidents/Adverse effects	Accidents/Adverse effects
6	Cerebrovascular disease	Pneumonia & Influenza	HIV infection
7	Diabetes mellitus	Diabetes mellitus	Diabetes mellitus
8	Chronic liver disease and cirrhosis	Suicide	Pneumonia & Influenza
9	Pneumonia & Influenza	Chronic liver disease and cirrhosis	Perinatal Conditions
10	Perinatal Conditions	HIV infection	COPD

Monthly Vital Statistics Report Volume 43, No 6(s)

Morbidity Issues of Growing Health Concern

Health issues that have major impact on the Latino population and that are receiving greater attention among Latino health and human services groups include: HIV/AIDS; cancer, heart disease and stroke; hypertension; diabetes; environmental health; mental health; and tuberculosis.

HIV/AIDS

- The annual incidence of AIDS for Latino adult males is 3.2 times and for Latinas 6.1 times that of their white counterparts. Latinas are infected with HIV at a rate seven times higher than for white women. (CDC 2000).
 - By the end of 1998, 57 percent of women with AIDS were African American and 20 percent were Latina.

- Approximately one-third of reported AIDS cases among Latino adults were due to injected drug use; male-to-male sex accounted for 39 percent of cases. Women were most likely to become infected through heterosexual contact (53.1%).

Cancer

- Latinos have lower incidence and mortality for the four most prevalent cancers (prostate, female breast, lung and colon/rectum). However:
 - Rates of stomach cancer are higher.
 - Latinas are more than twice as likely to develop cervical cancer as white women.

Heart Disease and Stroke

- Heart disease is the leading cause and stroke is the fourth leading of death among Latinos, although death rates are lower for Latinos than for whites or blacks.
- Data from the American Heart Association indicate that Latinos are substantially less likely to engage in vigorous physical activities during leisure time compared to other groups (41% do not exercise versus 26.7% of non-Latino whites). (Comas-Diaz, NHHSO)
 - Although many Latinos work in positions requiring manual labor, many of these activities do not contribute to aerobic fitness.
- Approximately one-quarter of Latinos over 20 years old have elevated blood pressure. For adult Latinos, the prevalence of high blood pressure is 24 percent for men and 22 percent for women.
 - Hypertension is more likely to go undiagnosed, untreated and uncontrolled in Latino men.
- Linked to diet and nutrition, up to 65 percent of adult Latinos have excessively high cholesterol levels. Many Latinos are less aware of their situation than non-Latino white counterparts.

Diabetes

- The increase in obesity rates is fueling an epidemic of Type 2 (non-insulin dependent) diabetes and impaired glucose levels. The risk of diabetes among Latinos is almost twice that for other ethnic groups (5.7/1000 compared with 3/1,000 non-Hispanic whites).
 - Latinos are more likely to suffer from a combination of diabetes risk factors known as “metabolic syndrome,” marked by insulin resistance, together with high lipids, central obesity, and mild elevations in blood pressure. Diabetes appears at an earlier age in Latinos compared to other ethnic groups
- Diabetes prevalence: Whites: 12 percent, African Americans 19.3 percent, Mexicans 23.9 percent, Puerto Ricans 26.1 percent, and Cubans 15.8 percent (Luchsinger J. Diabetes in Health Issues in the Latino Community, 2001)

- About 2.5 million or 9.5 percent of Latinos aged 20 years or older have been diagnosed with diabetes.
- The prevalence of obesity (overweight status) in the Latino population has approximately doubled in the last 10 years.
 - About one-third of Mexican women are obese, compared with 20 percent of white women.
 - Twenty-two percent of Latino youth are now overweight compared to 12.7 percent of white youth.
 - The disparity in obesity is greatest among low-income teens, where the percentage of obese teens is twice that for middle/upper-income teens.

Mental Health

- Latinos have the highest rates of depression among ethnic groups and are at high risk for anxiety and stress, according to the Hispanic Health Alliance.
- Self-inflicted and unintentional injuries are a worrisome issue among Latino youth.
 - Nearly thirteen percent of Latino high school students have attempted suicide, compared with 7.3 percent of blacks and 6.7 percent of whites; 18.9 percent of Latina high schoolers attempted at least one suicide within a year's period. (CDC Youth Risk Behavior Surveillance, 2000).
 - Death from homicide is almost five times higher for Latino youth (28%) than their white peers (5.8%). Among Latino high schoolers, 22 percent report fear of physical and violent attacks going to and from school. (NCHS, 2000)

Environmental Health

- Latinos in the U.S. face the highest rates of exposure to pollution and toxic substances, according to a 1991 study.
 - Puerto Rican children are three times more likely than white children to suffer from active asthma.
 - Exposure to agrochemicals is associated with a variety of cancers. Approximately 80 percent of pesticides in the U.S. are used in agriculture; Latinos comprise 71 percent of all seasonal agricultural workers and 95 percent of migrant farm workers. (Wernette & Nieves 1991; Comas-Diaz, NHHSO, 1990)

Tuberculosis

- In 1998, the rate of new tuberculosis cases among all Latinos was 13.6/100,000, compared with 2.3/100,000 for whites and 6.8/100,000 for the U.S. population as a whole. Migrant workers and immigrants may be a contributing factor.
 - The risk of contracting TB is six times higher for Latinos than whites.

Women and Child Health

Infant Mortality and Low Birth Weight (LBW)

- In 2002, infant mortality rates for Latinos (5.6/1000) fell below the rates for whites (5.8) and were far better than for the overall population (7.0). (NCHS, 2005)
 - Latino sub-populations present varying pictures. Infant mortality rates were high for Puerto Rican mothers (8.2 per 1,000) and low for Cuban mothers (3.7/1000).
- Latino infant low birth weight (LBW) is essentially the same as for whites, but vary within sub-populations. Mothers of Puerto Rican origin were 57 percent more likely to have LBW infants than Mexican mothers.

Reproductive Health

Latinas account for 18 million, or 51 percent, of the total Latino population. By 2050, 25 percent of women in the U.S. will be Latina. Latinas are faring far worse in numerous areas of reproductive health:

- In 2003, the fertility rate for Latinas (96.9 births per 1,000 Latinas 15-44 years) was 66 percent higher than for non-Latina white women (58.5 per 1000) (NCHS report)
 - More than 25 percent of Latinas do not receive prenatal care during the first trimester.
 - The rate of maternal mortality among Latinas is 1.7 times higher than for white women.
 - The birth rate for unmarried women increased to almost 45 births/1000 women in 2003. The birthrate for unmarried African American women was 66.3, while the birth rate for unmarried Latinas increased to 92.2/1000.
 - Although unintended pregnancy rates have declined overall, rates remain high for minorities (10 % for African Americans and 7% for Latinas).
(National Latina Institute for Reproductive Health Findings)
- *Sexually Transmitted Diseases (STDs):*
 - In 1998, the rate of gonorrhea was three times greater for Latinos than for whites.
 - The rate of congenital syphilis was nine times higher among Latino infants than among white infants.
 - The rate of chlamydia among Latinas is more than 3.5 times higher than for white women.
(National Latina Institute for Reproductive Health Findings)
- Latinas have the highest uninsurance rate among women (42%), which creates a significant barrier of access to reproductive healthcare services.

- Only 52 percent of Latinas reported feeling “comfortable” at the family planning clinic they visited and only 47 percent reported the staff “made an effort to find out their needs.” (National Latina Institute for Reproductive Health Findings)

Smoking, Alcohol & Drug Abuse

- Latinos have the lowest rate of smoking, at 18.9 percent in 1998, compared more than a quarter of African Americans and whites in the total population. (U.S. DHHS, 1998)
 - However, smoking is on the rise among youth. About half of Latino eighth graders reported smoking in the previous 30 days (U.S. NIDA, 1999)
 - Among first-generation Latinas, just 15 percent smoke, while 23 percent of second-generation Latinas reported smoking. (National Alliance for Hispanic Health, 1999)
- Nearly 60 percent of Latinos consumed alcohol within a year’s period. Heavy use is higher among Mexican Americans (6.9%) than whites (5.3%) or African Americans (4.7%). Alcohol consumption increases with acculturation of immigrants. (U.S. SAMHSA, 1998, 2000)

Access

Language & Access

- Twenty-six percent of Latino adults are Spanish language dominant and need an interpreter when obtaining healthcare services. The delivery of linguistically appropriate healthcare service can positively influence health outcomes. Spanish-dominant patients served by Spanish speaking physicians tend to ask more questions about their health and have better recall of their physician’s recommendations. Those without Spanish-speaking providers tend to omit medications, miss office appointments and rely on the ER for their healthcare. (National Latina Institute)
- One-third of Latinos report difficulty in communicating with their physicians, vs. 19 percent of the population nationwide.
 - 44 percent of Latinos have difficulty reading and understanding written information in their doctors’ offices; 63 percent have trouble understanding instructions on a prescription bottle. (Commonwealth Fund, 2002, 2003)

Sources of Care

- Latinos are more likely to rely on community or public clinics as their regular source of care. Twenty-two percent of all Latinos use community clinics, compared with 10% of the total population. Among Spanish-speaking Latinos, that percentage increases to 34 percent. (Commonwealth Fund, 2001, 2003; Doty, Hispanic Patients’ Double Burden: Lack of Insurance and Limited English, 2003.)
- Nearly one-quarter (23%) of Spanish-speaking Latinos report having no regular source of care or using the hospital emergency departments for services. Among all Latinos, this percentage drops to 14 percent, compared with eight percent of all patients ages 18-64. (Doty 2003)

Community Preventive Care Needs

- In many communities, members of minority groups—and some sub-groups—are in greater need of preventive services. (Commonwealth Fund, 2002)
 - *Colon cancer:* Just 18 percent of Latinos (adults ≥ 50) are screened for colon cancer, compared with 27 percent of the overall population.
 - *Pap test:* Slightly more than half (54%) of Latinas receive Pap tests annually; 82 percent have had a Pap test within a three-year period. This is slightly lower than for the nation as a whole (85%).
 - Puerto Rican (91%) and Cuban (89%) women are more likely than Mexican women (81%) to have the exam.
 - Fewer than three-quarters (72%) of uninsured Latinas get a Pap test, compared with 87 percent of those insured.
 - *Prostate cancer:* Only 40 percent of Latino males (≥ 40) have prostate cancer screening, compared with 48 percent in the U.S. overall.
 - Among uninsured Latino males, a mere 16 percent are screened.
 - *Dental care:* Rates of dental exams during the year are very low among Latinos, at 24 percent versus 41 percent nationwide.
 - Rates are slightly better for Cubans (31%) than for Puerto Ricans (26%) or Mexicans (22%).
 - Just 13 percent of uninsured Latinos get routine dental care, versus 32 percent of those insured.

Latinos and Diversity in the Health Professions

Wanted: Latinos in the Health Professions

- The health professions are far less diverse than the patient population. The number of Latinos grew 58 percent in the 1990s and now represent more than 14 percent of the U.S. population but in 2000 they were only:
 - 2.4% of dentists
 - 3.0% of RNs
 - 3.4% of pharmacists
 - 3.8% of physicians
 - 5.3% of healthcare managers
 - 6.7% of lab technicians
 - 9.3% of nursing aides & orderlies (US Census 2000; HRSA 2001; BHP 2001; NAPHHS Issue Brief)
- About 20 percent of the U.S. population resides in primary medical care Health Professional Shortage Areas, which include areas comprised of minority and other underrepresented populations.
- A total of 19 percent of minorities report difficulty in communicating with their physicians; among Latinos, this percentage is highest for all population groups, at 33 percent. (Commonwealth Fund, 2002)

Early Childhood Education of Latino Children Limited

- The percentage of Latino 3-5 year olds in center-based preschool and kindergarten programs in the U.S. lags all other ethnic groups at 88.6 percent vs. 92.9 percent of whites, 98.5 percent of African Americans, and 97.8 percent of other ethnic groups.
 - Latino children are more likely to go to kindergarten at an early age, which is associated with higher risk for less positive educational outcomes, especially if not preceded by preschool. (US Dept. of Education, NCES, Digest of Educational Statistics, 2000)
- According to 1999 data, Latino children represent only 8.6 percent of participants in gifted and talented K-12 classes, but are 14.3 percent of the school population. Access to gifted programs is important as a predictor of placement in high-level math courses in middle schools, which is a gateway to higher education. (US Dept. of Education, Office of Civil Rights, 1999)

Pre-baccalaureate Education and Enrichment Critical

- Approximately one-third (34%) of Latino high school graduates enroll in college, compared with 46 percent of white high school graduates. Most minorities enter two year colleges; if they attend four-year institutions, they are less likely to graduate than whites.
- Only ten percent of Latinos graduate from four-year colleges and universities. (White House Initiative on Educational Excellence for Hispanic Americans)

Baccalaureate Educational Achievement Lagging

- Latinos ages 20-25 have the nation's lowest rate of baccalaureate degrees, at 9.7 percent versus 53.9 percent of Asians, 34 percent of whites and 17.8 percent of African Americans. (US Census Bureau, 2000; American Council on Education 2000-01)
- In the period 1978-1998, the Latino college-aged population increased by 58.3 percent; the percentage in college enrollment was just 25.4 percent, compared with 45.3 percent for whites and 36.7 percent for African Americans. (U.S. Department of Education, 1998).

Enrollment in the Health Professions

- According to a study by the California Endowment, underrepresented minority trends in matriculants and enrollees over the past decade differ by health profession. All health professions fall short of "population parity."
 - Nursing, public health and pharmacy have seen a modest but steady rise.
 - Others, such as allopathic and osteopathic medicine, increased initially and then decreased in the late 1990s.
 - Dentistry has witnessed a steady decline. ("Strategies for Improving the Diversity of the Health Professions," The California Endowment, 2003.)

- *Medical Schools:* In 2004, African Americans constituted 7.8 percent and Latinos constituted 7.1 percent of all applicants to medical schools, while Asians were the largest minority group (19%).
 - African Americans, Latinos, Native Americans comprised 15 percent of the applicant pool. Women were over 50 percent of first-time applicants.
 - There is variation in the number of Latino applications by subgroup with Mexican American applicants increasing nine percent from 2002 to 2004, while Puerto Rican applicants declined by 20 percent. (American Association of Medical Colleges-AAMC)
- *Medical School Minority Faculty:* As of 2004 of a total of 115,000 faculty members, 7.2 percent were Latino, primarily concentrated at the rank of assistant professor, with about 80 percent males at the professor level and 60 percent at the assistant professor level. (American Academy of Medical Colleges)
- *Nursing:* Nursing is the only field that does not require a graduate degree for initial licensing. Of all clinically-oriented health professions, nursing has exhibited the most sustained increase in the proportion of underrepresented minority students and has the highest level of URM enrollees, at 16 percent (1999).

SELECTED BIBLIOGRAPHY

Among the reports from which information, implications and potential recommendations were drawn, the Taskforce particularly acknowledges the following:

- Betancourt, Joseph R. M.D., M.P.H., Alexander R. Green, M.D., J. Emilio Carrillo, M.D., and Elyse R. Park, Ph.D. *Cultural Competence and Health Care Disparities: Key Perspectives and Trends*, April 2005, , *Health Affairs* March/April 2005 24 (2): 499–505
- Briones-Jones M., et al. *Racial/Ethnic Diversity in Health Services Research: Pockets of Progress but a Long Way to Go*. Academy Health for the W. K. Kellogg Foundation. 2004.
- Comas-Dias, Lillian. *Delivering Preventive Health Care to Hispanics: A Manual for Providers*. National Coalition of Hispanic Health & Human Services Organizations, Washington, D.C., 1990.
- Commonwealth Fund, Creating a State Minority Health Policy Report Card, April 2005 (Also in March/April 2005 issue of *Health Affairs* which is a special issue on health disparities)
- Commonwealth Fund. *Healthcare Workforce Diversity: Developing Physician Leaders*. October 2003 for the Sullivan Commission
- *Compendium of Cultural Competence Initiatives in Health Care*, Henry J. Kaiser Family Foundation, January, 2003
- Cross, TL, BJ Bazron, KW Dennis and MR Isaccs, “The Cultural Competence Continuum.” *Toward a Cultural y Competent System of Care*. Center for Child Health and Mental Health Policy, Georgetown University Child Development Center, 1989.
- de Posada, Robert, *Uninsured Hispanic Americans*, The Latino Coalition, 2001. <http://www.thelatinocoalition.com/issues/articles/uninsuredhispanicamericans.htm>
- DiversityRx, *Models and Practices*. www.diversityrx.com
- Doty, MM, *Insurance, Access and Quality of Care Among Hispanic Populations*. 2003 Chartpack. The Commonwealth Fund. October 2003.
- Doty, MM, *Hispanic Patients’ Double Burden: Lack of Health Insurance and Limited English*. The Commonwealth Fund, February 2003.
- Friedman, Emily. *White Coats and Many Colors: Population Diversity and its Implications for Health Care*. American Hospital Association, Chicago, IL. 2005.
- Grumbach, K., Munoz C., Coffman J., Rosenoff E., Gandara P. and Sepulveda E. *Strategies for Improving Diversity in the Health Professions*, The California Endowment, Woodland Hills, CA. 2003. http://www.futurehealth.ucsf.edu/pdf_files/StrategiesforImprovingFINAL.pdf
- *Guide to Health Insurance Options for Small Businesses*, Cover the Uninsured Week Small Business Working Group, May 2004.
- Health Literacy: A Prescription to End Confusion. (2004). L. Nielsen-Bohlman, A. M. Panzer, and D. A. Kindig, Editors. Committee on Health Literacy, Board on Neuroscience and Behavioral Health, Institute of Medicine. <http://www.iom.edu/report.asp?id=19723>
- Institute of Medicine Committee on the Consequences of Uninsurance, 2003. *Hidden Costs, Value Lost: Uninsurance in America*. National Academy of Sciences, June 2003. www.iom.edu/CMS/3909/4460.aspx
- Institute of Medicine. *Health Insurance is a Family Matter*. National Academy of Sciences, Sept. 2002. www.iom.edu/CMS/3909/4460.aspx
- Institute of Medicine. *In the Nation’s Compelling Interest: Ensuring Diversity in the Healthcare Workforce*. National Academies of Science. February 2004. www.iom.edu/?id=18287&redirect=0

- Institute of Medicine. *Insuring America's Health: Principles and Recommendations*. National Academy of Sciences, January 2004. www.iom.edu/CMS/3909/4460.aspx
- Institute of Medicine. *Promoting Health: Intervention Strategies from Social and Behavioral Research*. National Academy Press, 2000.
- Institute of Medicine. *A Shared Destiny: Community Effects of Uninsurance*. National Academy of Sciences, March 2003. www.iom.edu/CMS/3909/4460.aspx
- Institute of Medicine. *Speaking of Health: Assessing Health Communication Strategies for Diverse Populations*. National Academy Press, July 2002. www.iom.edu/CMS/3775/4471.aspx
- Institute of Medicine, *Unequal Treatment*, National Academies of Science, 2002.
- National Alliance for Hispanic Health. *Five Point Plan to Reverse Widening Disparities for Hispanic Communities*. 2005.
- National Alliance for Hispanic Health, *A Primer for Cultural Proficiency, Towards Quality Health Services for Hispanics*.
- National Latina Institute for Reproductive Health: <http://www.latinainstitute.org/facts.html>
- *2002 National Survey of Latinos*, Pew Hispanic Center/Kaiser Family Foundation, 2002.
- *The Pipeline Report: The status of minority participation in business education*. Diversity Pipeline Alliance, McLean, VA. 2002.
- Strumpf and Cuban ski, *Options for Federal Coverage of the Uninsured in 2005*. The Commonwealth Fund, July 2005. www.cmf.org
- The Sullivan Commission. *Missing Persons: Minorities in the Health Professions. A Report of the Sullivan Commission on Diversity in the Healthcare Workforce*. 2004.
- *What's the Diagnosis? A Series of Three Reports on Latinos, Media & Health*, Summary of Key Findings, Kaiser Family Foundation, June 1998.

LIST OF ACRONYMS USED IN THIS REPORT

AHRQ	Agency for Healthcare Research and Quality
AOA	Administration on Aging
BHP	Bureau of Health Professions
BRFSS	Behavioral Risk Factor Surveillance System
BSN	Bachelors in Nursing
CAHI	Council for Affordable Health Insurance
CDC/CDCP	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicaid Services
DHHS	U.S. Department of Health and Human Services
DOC	Department of Commerce
DOE	Department of Education
DOL	Department of Labor
HP 2010	Healthy People 2010
HSA	Health Savings Account
HPSA	Health Professions Shortage Area
HSRA	Health Services and Resources Administration
IOM	Institutes of Medicine
JCAHO	Joint Commission for Accreditation of Healthcare Organizations
LHEC	Latino Health Empowerment Center
NAMCS	National Ambulatory Medical Care Survey
NCES	National Center for Education Studies
NCHS	National Center for Health Statistics
NCMHD	National Center for Minority Health and Disparities
NCQA	National Committee for Quality Assurance
NGO	Non-governmental Organization
NHDR	National Health Disparities Report
NICHD	National Institute for Child Health Development
NIH	National Institutes of Health
NSAF	National Survey of America's Families (Urban Institute)
NSF	National Science Foundation
OMB	Office of Management and Budget
OMH	Office of Minority Health
PI	Principal Investigator
URM	Underrepresented Minority

About The Latino Coalition

The Latino Coalition (TLC) is a non-profit, non-partisan organization based in Washington, D.C. TLC was established to address policy issues that directly affect the well-being of Hispanics in the United States. TLC's agenda is to develop and promote policies that will foster economic equivalency and enhance overall business, economic, and social development of Hispanics. For more detailed information on The Latino Coalition, please visit our website at www.TheLatinoCoalition.com.

The Latino Coalition (TLC) will research and develop policies that are relevant to Latinos' overall economic, cultural and social development while empowering individuals through the promotion of self-reliance and personal responsibility. As its primary mission, TLC will, on behalf of its members, closely monitor public policy at the federal, state and local levels to determine its impact on the Latino communities throughout the U.S., and engage in public education campaigns when warranted. TLC also will analyze and report to the public about the impact of Federal, State and local legislation, and government regulations, has on the Latino communities.

Within the Latino Community, Diversity is Key

The 2000 Census sent a shock wave across America. Corporate leaders, elected and appointed officials, and members of the media face the challenge of adapting to the new face of America. But before they can adapt, they will need to understand that Latinos are extremely diverse with different needs and concerns. For too long, Latinos have been viewed as a monolithic community in the U.S.

Nothing could be further from the truth. Hispanics living in the United States share many common traits. Most Latinos share their language, religious faith, and larger and close-knit families. However, they also have vast differences including unique cultural and colloquial idiomatic language variations; national and regional food tastes; educational and economic status, and different personal experiences leading to their migration to the U.S., to name but a few.

This diversity often times is dictated as much by current living conditions as it is by national origin or economic status. For instance, a Mexican-American family living in rural Fresno, California may have very different needs and concerns than a similar Mexican-American family living in urban Chicago, Illinois.

TLC: Promoting a Better Understanding of the Latino Communities

TLC will endeavor to promote a better understanding of the various Latino communities throughout the country. Through the use of ethnic research; public forums, and publications, TLC will educate American leaders on the sensitive balance - and differences - within these Latino communities.

TLC will serve as an archive and clearinghouse of behavioral and attitudinal research of Latinos in the U.S. TLC will research, analyze and report Hispanic trends based on in-house research and careful analysis of research conducted by other sources. As part of its in-house research, TLC will conduct regularly-scheduled policy-based public opinion studies including qualitative and quantitative research to promote a better understanding of the diverse U.S. Latino communities.

Special Thanks to:

