GOOD INTENTIONS ARE NOT ENOUGH!

Latino Health Disparities and Barriers to Health Care Access

This report is in draft form and is intended for discussion purposes only at the planned Latino Health Advocates Founders Summit. The views herein represent only the opinions of the initial Working Group and the author of the report. Please do not circulate this document prior to the Summit as it may change after the receipt of comments

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Acknowledgements and Preface

How did this report come into existence? It all basically started with informal discussions among a number of community leaders on the lack of a voice for Latinos on critical health care decisions and issues. Many of us had seen the impact of AIDS advocacy and education on making structural changes in the health system and in building a community response to address that disease. We were frustrated that the same energy was not in place for the range of structural and disease specific health issues that impact seriously on the Latino community.

The people that had been talking came together informally as a Working Group to bring some structure to the conversation. We discussed the concept of an education and advocacy voice that would provide an independent Latino perspective on some of the major health issues affecting our communities and to organize Latino communities in effective responses to these issues. While such an effort would be unique to New York, there are similar such organizations in California and Texas.The Working Group together did not simply want to create a group of "experts" that produce policy papers on health concerns but to form an action oriented presence in the City, State and elsewhere based on solid information to address the issues that affect the health interests of the diverse segments of our communities.

The members of the Working Group were chaired by Dennis deLeon, President of the Latino Commission on AIDS and included Silvana Bonil (Asociación Tepeyac), Jose "Pepe" Morales (formerly with St. Barnabas Hospital), Roy Cosme (Arcos Communications), Ivan Cortes (Promesa, Inc.), George Falus (Hispano American Biomedical Association), Dr. Miguel Sanchez (New York University/Belleview Hospital), Angelo Falcon and Myra Estepa (Institute for Puerto Rican Policy at the Puerto Rican Defense and

Education Fund), Manuel A. Rosa (Hunt's Point Multi-Service Center), Elsa Rios (National Latina Institute for Reproductive Rights), George Zeppenfeldt Cestero (Association of Hispanic Health Care Executives), and Reverend Rosa Caraballo (Bruised Reed Ministry), Salonia Ramos (Betances Health Center), Cheraine Ease (Urban Health Plan), and Joe Semidei and Maritza Rodríquez (Coalition for Hispanic Children and Families).

To start the organizational process, the Working Group asked Elsa Rios to prepare a general overview of health disparities structural health obstacles in the Latino community and to analyze the kind of community and organizational response that was needed. The Group was very lucky to recruit Elsa Rios to research and prepare the report that follows. She has been a responsible critical analyst and a long time community leader on health and social justice issues affecting Latinos. Elsa brought insight and shape to the vague ideas of the Working Group. The report was paid for by the Latino Commission on AIDS. Dennis deLeon offered edits and some additions to the final product.

Special thanks must go to Dr. Hector Balcazar, University of North Texas and Chair of the National Latino Health Collaborative and Mr. Tony Vera, Director of Planning, Betances Health Center for their insightful contributions to the report.

This report must be seen as the beginning of a process leading to the creation of coalition for change. In the future we must develop a coherent statement of needs and priorities and the ability to educate, organize and advocate on the key health policy and community concerns of the Latino community. The voice of Latinos must be heard clearly on the major structural and disease specific concerns that have resulted in the severe health challenges facing Latinos.

Executive Summary

The Latino Health Crisis

Latinos constitute 27% of New York City and 15% of the State. This number is an increase of almost 20% over 1990. Latinos play a critical role in the economic and social progress in the entire New York region. Despite this central place of Hispanics one of the most dynamic economies in the country, the health and well being of Latino New Yorkers is in serious jeopardy. The reality is that Latinos are facing a health care crisis. More than 36% of Latino adults do not have health insurance and the consequences are often devastating. Uninsured Latinos are two-three times more likely to go without needed health care resulting in higher rates of preventable disease and premature death.

Moreover, serious health disparities persist between Latinos and the general population. Latinos are twice as likely to be diagnosed with diabetes and are at dramatically higher risk for asthma, hepatitis C, cervical cancer and HV/AIDS, among other health problems. Oftentimes, poor health among multiple family members creates high levels of stress for Latino family caregivers and often thrusts Latino families into an economic tailspin, especially when illness leads to loss of employment and/or costly medical bills. Even in some areas where Latinos may have lower disease incidence rates, their medical outcomes are worse than for other groups.

Failure to address the health crisis facing the Latino community will have serious consequences for all New Yorkers. Increased incidence of illness and disease amongst Latinos will lead to lower labor force participation rates resulting in lower productivity, costly public financing for treatment of preventable diseases and over-utilization of already understaffed and financially distressed public health institutions.

The U.S. Department of Health and Human Services (DHHS), in its principal health promotion and disease prevention planning document, Healthy People 2010, has set two overarching and ambitious goals for the nation: 1) to increase quality and years of healthy life, and; 2) to eliminate health disparities by the year 2010 (2000).

To achieve the goals set out in Healthy People 2010 that are directed to the Latino community will require substantial investments at the national, state and local levels.

These resources have yet to materialize in 2002 and are unlikely to present in the future unless the Latino community mobilizes to demand sustainable solutions to the health problems they face. This concept paper seeks to serve as one of several vehicles by which to generate discussion among diverse sectors of the Latino community about health disparities and access problems faced by Latino New Yorkers and strategies to effectively address these problems.

Creating an Organizational Engine for Health Care Reform: The Latino Health Advocacy Coalition

The Latino community can no longer afford to wait for poorly conceived and insubstantial "band-aid" health care reform initiatives to "trickle down" in the hopes of staving off the urgent and pervasive health care crisis affecting Latino New Yorkers.

In order to address the complex health problems faced by Latino New Yorkers, it is imperative to wage a well organized Latino Health Advocacy Campaign capable of articulating sustainable health care solutions and successfully advocating for their adoption. A six-part strategy must be implemented to achieve this goal:

1. Building Capacity: Creating the Latino Health Advocacy Coalition of New York

Efforts to address Latino health problems will require that we galvanize our best thinkers, community leaders, heath care providers and strategists under a single, unified and powerful advocacy umbrella consisting of a state-wide Latino Health Advocacy Coalition (LHAC). By bringing together health experts, health providers, researchers, advocates, civic leaders, consumers and health policy makers, LHAC can garner the necessary expertise and strategic insight necessary to articulate sustainable health care solutions for the Latino community. An investment in the development of a permanent infrastructure will enable LHAC to regularly pool the advocacy resources of its organizational partners,establish early credibility and enhance its negotiating position and leveraging power in support of its goals.

2. Development of a Latino Health Agenda and Advocacy Campaign

One of LHAC's initial steps must be to build broad based consensus concerning the top priorities for strategic action that will most effectively address the access problems and health disparities faced by Latino New Yorkers. Towards that aim, a Latino Health Advocacy Coalition Founders Summit (the "Summit") is proposed for September 2002. The Summit will serve to galvanize and facilitate dialogue among diverse sectors of the Latino community in order to work cooperatively to establish a preliminary agenda for action and map out a statewide Latino Health Advocacy Campaign with measurable goals and objectives.

3. Public Education and Strategic Communications

For the most part, Latinos and non-Latinos alike remain unaware of the serious health disparities affecting Latinos making it easier for elected and appointed officials to ignore Latino health care needs. To address this problem, LHAC must launch and maintain an ongoing public education and strategic media campaign capable of educating the general public about the health care needs of Latinos and the impact Latino health problems have on the overall economic well being of the City and State and its health care institutions.

Moreover, since many laudable advocacy campaigns have been lost not on the merits but based on public perceptions it is imperative that LHAC develop the capacity to continually assess and influence public opinion. Conducting periodic assessments is an important step in developing a program of communication and action that promotes the public's understanding of the issues and generates appropriate levels of support.

4. Legislative and Regulatory Advocacy and Monitoring

The federal and state legislatures and administrative agencies are critical actors in health care funding and reform. LHAC must develop the capacity to regularly brief legislators and public officials on Latino health issues, track legislation, create effective mechanisms to counter adverse legislative initiatives and most importantly develop its own proactive legislative program in tandem with other progressive groups. Most immediately, in the aftermath of the September 11th tragedy and the deepening impact of welfare and immigration reform that has severely impacted the Latino community, it is imperative that LHAC assume an aggressive watchdog role to ensure that the limited resources available to the Latino community for health care are not reduced further.

5. Community Organizing and Leadership Development

LHAC must also be able to build a vocal, sophisticated and diverse constituency base with the capacity to mobilize quickly and efficiently and to continually inform LHAC's policy positions through regular dialogue and active participation in a wide range of advocacy activities. This effort could entail the development of local community health advocacy networks, sponsorship of community meetings and health advocacy "teach-ins", as well as, providing technical assistance to local groups engaged in health policy and advocacy activities.

6. Building the Future: Developing a Pipeline of Health Professionals and Researchers.

The under-representation of Latinos in the health professions and in the areas of biomedical and behavioral research hinders our ability as a community to influence key areas in health and science including the health and academic institutions that generate new research and innovative approaches to health care. Coalition members can play a pivotal role in demanding corrective action to address the under-representation of Latinos in health and research. LHAC's role would include advocating funding for scholarships and mentoring programs that would contribute to the development of a cadre of professionals more likely to dedicate themselves to providing care in underserved Latino communities and/or lending their expertise to advance solutions to Latino health problems.

In conclusion, this concept paper seeks to serve as one of several vehicles by which to generate discussion among diverse sectors of the Latino community concerning the health disparities and access problems faced by Latinos and the process for developing effective, sustainable solutions to these problems.

I. HEALTH TRENDS IN THE LATINO COMMUNITY

Access to quality health care remains elusive for a majority of Hispanics. Lack of insurance coverage, poor quality of care at public facilities, language barriers, and under-representation in research programs threaten the health and well being of many Hispanics. The result is a larger population predisposed to life-threatening diseases.

Congressional Hispanic Caucus Institute
Year 2000 Conference Report

While it is beyond the scope of this paper to provide a comprehensive survey of the health problems faced by the Latinos, certain disease patterns shed light on the disease and mortality trends and the disproportionate burden of disease experienced by the Latino community. These trends illustrate the need for Latino health education, prevention and early diagnosis and treatment initiatives.

Moreover, when viewed in its totality, these health trends provide irrefutable evidence that the Latino community faces a serious health crisis. This is a crisis that will only worsen unless leaders from diverse sectors of the Latino community are galvanized and work together to advocate for increased access to quality health care and the elimination of Latino health disparities.

Health disparities are defined as “differences in the incidence, prevalence, mortality and burden of disease and other adverse health conditions that exist among specific population groups" (National Institutes of Health, 2001).

The first section of this paper highlights some of the major health problems and health disparities faced by the Latino community.

Coronary Heart Disease and Stroke

Depending on age group, the major leading causes of death for Latinos are coronary heart disease, cerebrovascular disease, cancer, diabetes and AIDS (Collins, Hall, & Neuhaus, 1999 and Latinos and AIDS, report of the Kaiser Family Foundation 2002). Diseases of the heart and stroke account for 27.9% of deaths among Latino males and 34.3% of the deaths among Latinas (American Heart Association, 2001).

New York State ranks number one among all the states in deaths due to coronary heart disease (National Heart, Lung and Blood Institute, 1996) and New

York City has the highest rate of heart disease deaths among Latinas across the nation (Centers for Disease Control, 2001).

Risk factors for coronary heart disease include high blood pressure, elevated blood cholesterol, tobacco use, insufficient physical activity, among others and many of these risk factors are prevalent among Latinos. For example, more than 40% of Latinos have elevated cholesterol levels, almost 19% of Latino adults have been diagnosed with high blood pressure, and a quarter of Latino males smoke (National Heart, Lung and Blood Institute, 1996). Additionally, 18% of Latinos suffer from obesity and 34% are physically inactive which is defined as having no leisure physical activity in the last thirty days (American Heart Association, 2001).

Despite the higher prevalence of risks factors for heart disease Latinos remain generally unaware of behavioral changes that could prevent the onset or progression of heart disease and stroke.

Similar to heart disease, the risk factors for stroke include tobacco use and uncontrolled hypertension. Latinos between the ages of 35-64 have a 1.3 times higher risk of stroke (American Heart Association, 2001). In urban areas such as New York City the risk appears to be higher. For example, the Northern Manhattan Stroke Study (1993-1996) found that Latinos had a twofold increase in stroke prevalence compared to all age groups older than fifty-five years of age (Pérez-Stable, Jurabe, & Moreno-John, 2001).

It is important to note that the prevalence of heart disease and stroke and their related risk factors increases with age. As the relatively young Latino population matures over the next two decades, it is expected that heart disease and stroke will significantly increase unless funding is provided to increase Latino prevention and risk reduction health initiatives (National Council of La Raza, 2001a).

Cancer

Cancer is the third leading cause of death in the United States accounting for approximately 544,000 deaths each year. Among Latinos cancer is the leading cause of death for Latinas ages 25-54 and among Latino males, age 45 and over (Collins, Hall, & Neuhaus, 1999). While Latinos have a lower overall cancer rate than non-Latinos, they do experience higher rates of certain cancers including cervical cancer and stomach cancer and have disproportionately high cancer mortality rates (Ramirez & Suarez, 2001).

Latinas have significantly higher rates of cervical cancer (15.8 per 100,000 cases) as compared to white women (7.1 per 100,000 cases) (National Alliance for Hispanic Health, 2001). Despite the fact that the cervical cancer rate for Latinas is more than twice that of white women, 33% of Latinas reported not having obtained a pap smear in the preceding three years. Lower pap smear rates among Latinas results in Latinas being diagnosed at a more advanced stage of disease when fewer treatment options are available resulting in poorer health outcomes and higher rates or mortality.

Although Latinas have a lower rate of breast cancer (69.8 per 100,000) as compared to white women (111.8 per 100, 000), breast cancer remains the leading cause of cancer deaths among Latinas.The five-year survival rate for Latinas with breast cancer is only 76% as compared to 85% for white women (Intercultural Cancer Council, 2001).

The high rate of mortality can be attributed in part to lack of breast cancer screening. Only 38% of Latinas aged 40 and older have regular mammograms that could detect cancer at its earliest stage before clinical symptoms develop (Intercultural Cancer Council, 2001).

Hispanic men suffer higher incidences of liver and stomach cancers. The rate of stomach cancer among Latino males is 30 to 90 percent higher than those of whites and the rate of liver cancer among Latino males is twice the rate for whites (Ramirez & Suarez, 2001). In general, uninsured Latinos are two to three times more likely to have cancer diagnosed at a later stage leading to poorer health outcomes and higher rates of mortality (Intercultural Cancer Council, 2001). Specifically, uninsured Latinas with breast cancer are 2.3 times more likely to be diagnosed at a later stage while uninsured Latino males with prostate cancer are 3.75 times more likely to be diagnosed at later stages of cancer (Intercultural Cancer Council, 2001).

Diabetes

The prevalence of diabetes among Latinos is almost twice the rate of whites and is likely to increase in the future as four out of every ten Latinos are at risk for developing diabetes (Luchsinger, 2001).

Diabetes presents a serious challenge for the Latino community because of the increased prevalence of diabetes and associated risk factors among Latinos, as well as a greater incidence of diabetes complications such as kidney disease and heart disease (National Institute of Diabetes and Digestive and Kidney Diseases, 2001). Moreover, Latinos are twice as likely to die from diabetes as whites (United States Department of Health and Human Services, 2000).

Diabetes is particularly common among middle aged and elderly Latinos. Between 25 and 30 percent of Latinos 50 years of age and older have diabetes (National Institute of Diabetes and Digestive and Kidney Diseases, 2001). Between 90 and 95 percent of Latinos with diabetes have type 2 diabetes, which can be treated with diet, exercise, oral medications and injected insulin. Physical inactivity and obesity are risk factors for diabetes and as mentioned earlier both are prevalent within the Latino community.

As of 1998, 1.2 million Latinos had been diagnosed with diabetes. Moreover an alarming 675,000 Latinos have diabetes but their diabetes has gone undiagnosed and therefore untreated (National Institute of Diabetes and Digestive and Kidney Diseases, 2001). The fact that one third of all Latinos with diabetes are unaware of their condition illustrates the urgent need for early detection and treatment initiatives specifically targeted to the Latino community.

HIV/AIDS and Hepatitis C

Although Latinos in New York represent 9% of the U.S. Latino population, they account for 30% of all U.S. Latino AIDS cases (Latino Commission on AIDS, 2001). Overall, Latinos are shouldering an increasingly larger portion of the HIV/AIDS epidemic than ever before, representing almost 20% of the new AIDS cases in the U.S. reported through 1999.The rate per 100,000 of Latino AIDS cases is almost 4 times that of White Non-Hispanics. HIV is a leading cause of death for Latinos between ages of 25 and 44. For Latino Men, AIDS ranks 6th for ages 20 to 24, 4th for 25 to 34 and 2nd for 35 to 44. For Latinas, AIDS ranks 8th for ages 20 to 24, 4th for 25-34 and 3rd for 35 – 44. 18% of total AIDS deaths in 1999 were among Latinos (Kaiser Family Foundation 2002). For New York State, AIDS as a cause of death among Latino is much higher than the national figures indicate.

HIV transmission by intravenous drug use represents 56% of the AIDS cases among Latino New Yorkers. Latino youth comprise 40% of the AIDS cases in New York between the ages of 13 and 24 and Latino men who have sex with men (MSM) account for 21% of all the AIDS cases among MSMs in New York City. Latinas comprise a third of all the female AIDS cases in New York City - well in excess of their presence in the total population (13%). Finally, Latinos in New York State prisons are disproportionately impacted. Although Latinos make up 30% of the more than 70,000 individuals incarcerated in the State they comprise 47% of the AIDS cases among this population (Latino AIDS Commission, 2001).

Despite the life threatening nature of this disease, HIV prevention and education initiatives remain woefully inadequate. For example, a recent survey among sexually active teenagers

indicated that Latinos continued to have the lowest rate of condom use (48%) as compared to blacks (64%) and whites (56%) (Giachello, 2001). Another survey indicated that only 33% of Latinas reported ever talking to a health provider about HIV/AIDS and even fewer had specifically discussed the risks of being infected with HIV (23%) or getting tested for HIV (22%) with any provider during their lifetime (Kaiser Family Foundation, 2001).

The rise of Hepatitis C (HCV) virus has become an important public health problem for Latinos. Approximately 1 out of every 50 Latinos nationwide is

infected with Hepatitis C (Latino Organization for Liver Awareness, 2001). Hepatitis C is a major risk factor for primary liver cancer and cervical cancer, which are already disproportionately high among Latinos.

Moreover, not only are Latinos twice as likely to become infected with Hepatitis C than whites but also, Latinos are being diagnosed at later stages of HCV disease oftentimes when the only treatment alternative remaining is a liver transplant (Latino Organization for Liver Awareness, 2001). Additionally, HCV impacts some of the most vulnerable sectors of the Latino community such as drug users who are less likely to seek out preventive and routine health care. In New York City, for example seroprevalence studies estimate that as many as 80% of New York current and former drug users are already infected with HCV (Latino Commission on AIDS, 2001).

Sexually Transmitted Disease (STDs)

Latinos also encounter higher prevalence rates for sexually transmitted diseases. The rate of primary and secondary syphilis among Latinas is twice the rate as that of non-Latino women and congenital syphilis is nine times greater for Latino infants as compared to white infants (Giachello, 2001). Among Latino men, the rate of syphilis is 2.1 cases per 100,000 as compared to 0.6 cases per 100,000 for whites (Centers for Disease Control, 1998).

Latino males have higher rates of gonorrhea (67 per 100,000) than white males (20 per 100,000) and the rate of gonorrhea for Latinas is three times higher (69.4 per 100,000) than for white women (26.0 per 100,000). Moreover, among Latina teens (15-19) the rate of gonorrhea has reached staggering proportions (251.6 per 100,000) (Carter-Pokras & Zambrana, 2001).

Overall, the rate of chlamydia among Latinas has risen to 599 per 100,000 as compared to 161.9 per 100,000 among white women (NARAL Foundation, 2000). Left untreated chlamydia and gonorrhea can lead to infertility and life threatening ectopic pregnancies. Additionally, chlamydia and gonorrhea increases the risk of becoming HIV infected upon exposure to HIV, leaving Latino teens that are less likely to receive care for sexually transmitted diseases, at higher risk for HIV infection.

Maternal and Child Health

Latinas have the highest fertility and birth rates of any group and account for 18.6% of U.S. births with more than 70% of these occurring to Mexican American women. Despite the high number of Latino births, Latinas are less likely to secure prenatal care during the first trimester. In fact, only 74.3% of Latinas in comparison to 87.9% of white women secured prenatal care within their first trimester (Giachello, 2001).

Latinas have the second highest teen pregnancy rate (17%), a rate that is also almost twice as high as white teens (Collins, Hall & Neuhaus, 1999). Factors leading to higher teen pregnancy rates among Latinas include; lower rates of contraception use and lower levels of knowledge concerning sexuality issues and birth control methods (Giachello, 2001). The consequences of teen pregnancy for young Latinas can be substantial setting in motion a chain of events leading to lower educational attainment and persistent poverty.

For many Latinos, health disparities begin during childhood. For example; only 71% of Latino children are fully vaccinated by two years of age as compared to 80% of white children and 78% of African American children. Latinos also account for 39% of all reported childhood cases of tuberculosis, a rate thirteen times higher than for whites (Flores & Zambrana, 2001).

Oftentimes, the overall quality of care received by Latino children is sub-optimal predisposing Latino children to chronic disease, long-term disability and premature death. For example, although 500,000 Latino children have asthma (two thirds of Latino children with asthma are Puerto Rican) the care received by Latino children is often inadequate. In a study of preschool children hospitalized for asthma, Latino children were found to be seventeen times less likely to receive a nebulizer at the time of discharge as compared to white children (Flores & Zambrana, 2001).

Unintentional injuries are also a major health issue affecting Latino children. The leading causes of morbidity and mortality for Latino children are: pedestrian injury, motor vehicle accidents, drowning and poisoning. Latino children are five times more likely to experience unintentional injury and in the case of motor vehicle accidents. Latino children had a death rate 72% higher than white children (Flores & Zambrana, 2001).

Mental Health

From adolescence to adulthood, Latinos experience higher rates of stress and mental health problems but tend to underutilize mental health services. While Latino youth are less likely to receive mental health services they are more likely to become involved with the juvenile justice and/or child welfare systems (Vega & Alegría, 2001). Yet, Latino youth "in care" still receive fewer therapeutic services and remain "in care" for longer periods than other groups. Another alarming trend is that Latino youth have the highest rate of suicidal attempts reaching 10.7% as compared to 6.3% for white youth and 7.3% for African American youth demonstrating the need to increase access to mental health services especially crisis intervention services for Latino youth (Vega & Alegría, 2001).

Among Latino adolescents and adults, depression has become a particularly serious problem. A study among high school students indicated that 25% of

Latino students meet the criteria for clinical depression and the rate of depression was even higher among Latina teens reaching 31%,the highest rate of any group (Flores & Zambrana, 2001).

Unfortunately the situation does not improve with age. A survey reported by the Commonwealth Fund revealed that Latino adults had the highest rate of depressive symptoms of any group with 53% of Latinas and 36% of Latino males reporting moderate to severe depressive symptoms a week prior to the survey interviews (Collins, Hall & Neuhaus, 1999).

Alcohol and Drugs

According to the Youth Risk Behavior Survey of 1997, Latino students were significantly more likely to have consumed alcohol in their lifetime, report current alcohol use, and to report episodic heavy drinking than African Americans (Caetano & Galvan, 2001). During the period of 1984 to 1995, Latinos showed an increase in number of persons abstaining from alcohol consumption. Among Latino males the rate of abstention has increased from 22% to 35% and among Latinas the rate of abstention has increased from 47% to 57%.

However, the percentage of Latino males reporting frequent heavy drinking has increased slightly from 17% in 1984 to 18%. Not surprisingly, Latino death rates linked to cirrhosis and other chronic liver disease ranked as the eighth leading cause of death for Latinos but did not appear as one of the ten leading causes of death for either African Americans or whites (Caetano & Galvan, 2001).

In New York State, the rate of drug-induced deaths among Latinos is higher (8.6 per 100,000) than the national average for Latinos (6.2 per 100,000) (United States Department of Health and Human Services, 2000). Between 1991 and 1998, Latino emergency room admissions for drug use increased by 80%. The use of heroin within the Latino community is particularly serious. In 1997, Latinos accounted for 32% of treatment admissions for heroin and 32% of all Latino drug use related deaths resulted from heroin use (Caetano & Galvan, 2001). These figures do not even include the tens of thousands of deaths among Latino men and women from the sharing of HIV contaminated syringes.

II. BARRIERS TO HEALTH CARE ACCESS

Latinos have the highest uninsured rates of all racial/ethnic groups in the United States, and have to navigate a health care system that is often unfamiliar with- and sometimes hostile to - their culture, language and beliefs.

Raul Yzaguirre, President
National Council of La Raza

The health disparities described in the previous section presents only one facet of the health challenges faced by Latinos. Oftentimes, accessing quality health care requires Latinos to maneuver a daunting obstacle course in order to secure even the most basic health care services.

The health care access barriers faced by Latinos include:

- lack of health insurance;
- poverty and lower socioeconomic status;
- dependence on a financially distressed public health system;
- discrimination in health care delivery and public health policies;
- insufficient health research on Latino populations;
- lack of Latino healthcare personnel;
- lack of linguistically appropriate and culturally competent health care services;
- immigration law restrictions on access health care; and
- excessively punitive drug use policies.

The Latino Uninsured

One of the major contributing factors to poor health outcomes for Latinos is lack of health insurance. Widespread lack of health insurance is arguably the most urgent health problem facing Latinos today. The overall national poverty rate among Latinos is 21.2% contrasted with the national average of 11.3% and the rate of poverty is even higher for Latino New Yorkers (28.8%), Latino children (28%) and female-headed households (34.3%) (Bureau of Census. Community Service Society and National Council of La Raza, 2001b).

Furthermore, Latinos have the lowest income levels of any racial or ethnic group. The median weekly earnings for Latino males is only $445.00 per week as compared to $687.00 for white males and for Latinas the median weekly earnings are even lower amounting to $383.00 per week as compared to $522.00 for white women (Bureau of Labor Statistics, 2001).

Oftentimes Latinos have no other recourse but to either delay or forgo needed health care services because they simply cannot afford it. Forgoing health care services is especially disconcerting considering that 24% of Latinos reported being in fair to poor health as compared to 18% of whites.

In New York State where Latinos account for 15% of the total population, 34% of Latinos do not have health insurance and the consequences are often devastating (Quinn, 2000). Uninsured Latinos are two-three times more likely to go with out needed health care resulting in higher rates of preventable disease and premature death.

Even Latinos who are employed full-time are still less likely to secure health insurance from their employer as compared to other groups. In 1996, thirty-seven percent of full-time Latino workers were uninsured as compared to 20% of African American workers and 12% of white full-time workers.

Not surprisingly, a survey conducted by the Commonwealth Fund indicated that 45% of Latino adults reported difficulty paying for medical care as compared to 26% of white adults (Collins, Hall, & Neuhaus, 1999). Moreover, 38% of Latinos in New York City reported difficulty obtaining needed health (Sandman, Schoen, Des Roches, & Mckonnen, 1998).

Uninsured adults receive health care services that are less adequate and appropriate than those received by patients who have either public or private health insurance, and they have poorer clinical outcomes and poorer overall health than do adults with private health insurance. Uninsured persons with diabetes, cardiovascular disease, cancer, endstage renal disease, diabetes, HIV infection and mental illness have worse clinical outcomes than insured patients. Uninsured adults are less likely than adults with any kind of health insurance to receive preventive screening and preventive services. Although health insurance by itself will not eliminate ethnic and socioeconomic disparities and improve health-related outcomes, it would reduce such disparities and improve health-related outcomes for minority and economically disadvantaged groups (Institute of Medicine, Care Without Coverage 2002).

Lack of health insurance also impacts on continuity of care; 49% of Latino adults as compared to 25% for whites report that they do not have a regular doctor and 31% of Latinos reported not visiting the doctor in the past year as compared to 16% for whites (Quinn, 2000). A recent report from the Institute of Medicine

The Health Care Delivery System

Latinos rely heavily on public hospitals and public funded health centers for their care. For the most part, these institutions are located in medically underserved communities with larger poor and immigrant populations and provide

health care to an increasingly disproportionate share of the uninsured (Cantor, Haslanger, Tassi, Weiss, Finnerman & Kaplan, 1998). For example, according to the Bureau of Primary Health Care, from 1990 to 1997, the number of uninsured patients at community health centers increased by 49 percent (Davis, Collins & Hall, 1999). Not surprisingly, with high increases in the number of uninsured patients who are unable to pay for care, these institutions oftentimes operate under a climate of financial distress posing serious challenges to the provision of quality health care.

These same institutions have also been impacted by recent health and social policy changes. According to a report issued by the Urban Institute the implementation of managed care and changes in public benefits programs have had a substantial impact on public hospitals and publicly funded health centers. Federal welfare reform and changes in immigration laws have contributed to the growth in the ranks of the uninsured by decreasing the number of persons receiving Medicaid (Cantor, Haslanger, Tassi, Weiss, Finnerman & Kaplan, 1998). In fact, between 1995 and 1999, New York City witnessed a 12% decline in the Medicaid rolls resulting in the loss of Medicaid for 200,000 persons including 105,00 children (Carillo, Treviño, Betancourt & Coustasse, 2001).

It is estimated that half of all insured New Yorkers now participate in a managed care plan (Sandman, Schoen, Des Roches, & Makonnen). Medicaid managed care has forced public hospitals and health centers into competition for patients. Private hospitals and for profit managed care organizations are in a better position financially to recruit doctors and specialists, make building improvements and develop sophisticated marketing plans to recruit new patients. Therefore, it is not surprising that these private institutions are siphoning off patients with health insurance from public hospitals and health centers, (Carrillo, Treviño, Betancourt, & Coustasse, 2001).

Diminishing revenue streams due to competition from private hospitals and commercial managed care organizations, the increased number of uninsured and the decline in the number of patients receiving Medicaid threatens the very survival of public hospitals and publicly funded health centers.

For many Latinos, these institutions are their only source of care making their survival an important objective for Latino health advocates. However, their survival is far from being assured. Public hospitals and publicly funded health centers serve a disproportionate share of the uninsured that tend to delay seeking treatment until later states of disease. These same institutions are the least able to afford yet more likely to carry the burden of providing costlier treatment services to an ailing uninsured population. In contrast, commercial managed care organizations seek to maximize their cost savings by recruiting an insured, healthier patient base that regularly seeks preventive and primary care.

Research and Data Collection

Behavioral and biomedical research plays a powerful role in shaping health care delivery and public health policies.The National Institutes of Health recognizes that research provides the scientific basis and legitimacy necessary to support efforts aimed at improving standards of care, formulating better public health policy, changing the individuals' health related behaviors, improving health care delivery systems and creating strategies for overcoming cultural and economic barriers to health care (National Institutes of Health, 2001). In addition to research, health data collection allows for the identification of health trends in a given population so that more targeted health interventions can be utilized to ameliorate health problems.

Despite the importance of research and health data collection in addressing the health needs of a population, the first comprehensive Hispanic health survey known as the Hispanic Health and Nutrition Survey (HHANES) was not implemented until 1982-1984 and the leading causes of death for all Latinos were not published by the Department of Health and Human Services in its annual report to Congress until 1993 (Giachello, 1996).

A review of Healthy People 2010 illustrates that there are still substantial research gaps for Latinos in many health areas as demonstrated by the lack of availability of baseline data on Latinos by which to establish sound benchmarks for the year 2010 (Latino Health Institute & Mauricio Gaston Institute, 2001). Additionally, according to the National Alliance for Hispanic Health large gaps in Latino health data remain, especially in the areas of occupational safety and health, immunization, infectious disease, chronic kidney disease, respiratory disease, injury and violence prevention, mental health, nutrition, cardiovascular and oral health (2001). Despite these glaring omissions, it is estimated that only 1% of the National Institutes of Health research funding has been allocated to conduct research on Latinos (Giachello, 1996).

Moreover, data collection and surveillance systems are not keeping up with the rapidly changing demographics and characteristics of the Latino population (Latino Health Institute & Mauricio Gastón Institute, 2001). Most national data sets do not have significant sample sizes by which to analyze Latino health needs by sub group populations (Lillie-Blanton, Martinez, Taylor & Robinson (1993). Without subgroup specific data, health problems experienced by various sub-groups are often overlooked in the development of policies and programs intended to serve Latinos or the trends in a leading subgroup are incorrectly generalized to other subgroups. For example, further research by subgroup population could shed light on whether acculturation or other factors are the reasons why Puerto Ricans with low socioeconomic status (SES) appear to have significantly poorer health status than low SES Mexicans (National Center for Health Statistics, 2000).

Additionally, as noted by the Midwest Latino Health, Research, Training and Policy Center, there is a real need to re-frame the Latino research agenda:

> Research on Latinos and other minorities traditionally has included methods of observation and criteria for validating facts and theories that intentionally or unintentionally justify stereotypes about these populations… This often has resulted in a number of biases that reinforce the social, economic and political disadvantages of these groups in society (2001).

Crucial to the effort to eliminate bias in research is the recruitment and training of bilingual/bicultural Latino researchers who can help to deconstruct some of the biases contained in present day research paradigms and develop new frameworks.

Linguistically and Culturally Appropriate Services

Recognizing that the provision of culturally competent health services is an essential strategy towards the elimination of racial/ethnic health disparities, the DHHS Office of Minority Health has developed Recommended Standards for Culturally and Linguistically Appropriate Health Care Services (CLAS) to provide health care institutions and providers with guidance for achieving cultural competence.

Cultural competence in health care delivery requires providers to have an understanding of the beliefs, values, traditions and practices of a cultural group including cultural based beliefs about the etiology of illness and disease, concepts of health and healing practices (National Center for Cultural Competence, 2001). The provision of culturally competent health care can improve health outcomes for individuals and communities; including increasing levels of patient satisfaction and improving cost efficiency. According to the Health Resources and Services Administration (HRSA), culturally competent practices enable providers to: 1) obtain more specific and complete information to make a diagnosis; 2) facilitates the development of treatment plans that are more likely to be adhered to by the patient and supported by the family; and 3) enhances overall communication and interaction between patient and provider (2001).

Providing linguistically appropriate services is also an essential strategy for eliminating Latino health disparities. Patients who experience language barriers are a growing population.The Census reports that 26.7 million Latinos in the U.S. over the age of five speak Spanish at home and estimates that 12.4 million Latinos speak English less than "very well."

A recent survey sponsored by the Robert Wood Johnson Foundation (December 2001) found that ninety-four percent of providers say communication is a top priority in delivering quality care, and they cite language barriers as a major challenge to delivering that care. Seventy-three percent of providers say the aspect of care most compromised by language barriers is a patient's understanding of treatment advice and of their disease; 72 percent say that barriers can increase the risk of complications when the provider is unaware of other treatments being used; and 71 percent say barriers make it harder for patients to explain their symptoms and concerns.

The Robert Wood Johnson study also found that when translation help is offered, it is often makeshift. Fifty-one percent of the providers surveyed say that when they need interpretive services, they often enlist help from staff who speak Spanish, including clerical and maintenance staff. Another 29 percent say they rely on patients to bring in family members or friends who can translate for them. Patients say makeshift translation practices, like using family members or untrained staff, often leave them feeling embarrassed, that their privacy has been compromised and that the translators have omitted information.They also say these concerns cause them not to talk about personal issues when interpreters are present.

A study on access barriers to health care for Latino children indicated that 25% of parents surveyed indicated that language discordance was the single largest barrier to getting health care for their child (Flores, Abreu, Olivar, & Katsner, 1998). Latino patients with language discordant doctors are more likely to omit medication, miss office appointments and rely on the emergency room for care that can lead to poor health outcomes (Carrillo, Treviño, Betancourt & Coustasse, 2001).

By contrast, language concordance between physician and patient has a positive impact on health behaviors. A study conducted at the General Medical Practice of the University of California – San Francisco, found Spanish monolingual patients whose physicians spoke Spanish had better recall of their physician's recommendations and asked more questions during their visit than their counterparts seen by non-Spanish speaking clinicians (Pérez- Stable, Nápoles-Springer & Miramontes, 1997).

Discrimination

Discrimination in health care delivery settings can take many forms from outright racial/ethnic slurs by health care personnel to subtle forms of differential treatment by providers such as, when providers spend less time taking a patient history, order fewer diagnostic tests or take less time to explain a diagnosis and treatment plan to patients.

There has been relatively little research on the discrimination faced by Latinos in health care settings. One study conducted in Kings County, Washington indicated that 21% of Latinos reported experiencing at least one incident of discrimination in a health care setting that can result thereafter in reluctance to

seek out needed health care. For example, a second study conducted in Kings County, Washington showed that 70% of Latinos who had experienced prior discrimination in the health care setting reported they subsequently delayed seeking needed health care as contrasted to 48% of Latinos without prior discriminatory experiences.

Other indicators of discrimination include disparities in health care spending, for example, in 1996, $1,428 was spent on the average Latino Medicaid recipient compared to $4,074 for the average white recipient (Health Care Financing Administration, 1998). In other cases, institutional discrimination is less blatant taking on different shades and contours, such as when hospitals separate their privately insured postpartum patients on different floors or wards from their uninsured and Medicaid patients who are primarily people of color (Vera, 2001).

Moreover, the adoption of coercive public health policies that disproportionately impact Latinos and other people of color also serve as impediments to accessing health care. For example, in the 1950's public hospitals in New York City sterilized thousands of Latinas, primarily Puerto Rican women, without proper counseling and safeguards to insure informed consent (Lopez, 2001) fostering a deep sense of distrust within the Latino community.

A recent example of a coercive, public health policy disproportionately impacting people of color was the participation of a public hospital operated by the Medical University of South Carolina which collected evidence used to criminally prosecute pregnant addicted mothers.The majority of women taken into custody as a result of the hospital's actions were African American women.

Health Care Personnel

The number of Latino health providers is “abysmally low”, according to Mr. Tony Vera, Director of Planning and Development at the Betances Health Center in lower Manhattan (2001).

This is especially disconcerting considering that several studies have indicated that patient satisfaction is highest when the patient and doctor are of the same race or ethnicity and that minority physicians tend to care for minority patients in greater numbers and to work in medically underserved areas (United States Department of Health and Human Services, 2000).

Although Latinos account for almost 13% of the total U.S. population, they comprise only 4.6% of physician and 4.7% of dentists in the United States.

Latino representation in the field of nursing is even lower reaching only 2.4% and Latinos account for only 2.8% of pharmacists (United States Department of Health and Human Services, 2000).

Although more people of color applied to medical school in 2000 fewer were accepted than in 1998 and 1999. Of the 37,137 minority applications to medical school in that year, 17, 546 were accepted but of those minority applicants that were accepted only 545 were identified as either Mexican American (415) or Puerto Rican (130) (Ernst, 2000).

The recruitment of Latino health personnel is considered to be an important vehicle by which to increase access and quality of care for Latinos. Latino health personnel are more likely to be able to bridge the language gap that often deters Latinos from seeking prompt care or that interferes with the patients' ability to comprehend and follow through on health care instructions such as taking medications properly.

Latino heath professionals are also more likely to understand cultural belief systems and to work within this context to support health promotion, disease prevention and early medical intervention when needed.

Challenges to the Safety of Immigrants and Migrants

While access to health care for Latinos has always been difficult, the availability such services for Latino immigrants has even been more limited. In 1996 the United States Congress and President William Jefferson Clinton passed sweeping immigration and welfare law changes that severely eliminated all but emergency forms of health for low-income immigrants. The reforms prohibited legal immigrants from accessing Medicaid and Medicare and Food Stamps during their first five years of residence. For those that did use public services including health care during this period, the immigrant could be targeted as being a “public charge” and deemed ineligible for citizenship without sponsors reimbursing the government for costs incurred. Further, for undocumented immigrants with serious health conditions the only avenues for health care were community clinics with limited healthcare options and hospital emergency rooms.

The result of these changes in the law was to make it even more likely that Latino and other immigrants (already struggling with the above described language and cultural discrimination by many health providers) would be forced to forgo necessary health care. This deferral of health care has resulted in health emergencies that have ended up greatly increasing the ultimate cost to the public health system. The inability of immigrants to obtain assistance for laboratory tests or such common procedures as x-rays has caused debilitation and pain.

Health care for migrant labor in the New York region has remained difficult. Often living in the isolation of labor camps, migrant laborers (many of who are Latino) are rarely connected to health care services unless an emergency is presented. Underfunding of migrant health programs and the ability of such

health efforts to provide more complete services, has shortened the life span of many hard working Latino migrants legally in this country. Failure by State and Federal government agencies to monitor the occupational safety, basic sanitation rules or the adequacy of housing services has only contributed to the poor health conditions in this population.

Punitive Drug Policies

For some sectors of the New York Latino community, governmental policies toward injecting and non-injecting drug use has been the source of much disease. The reluctance to initiate syringe exchange programs and poor funding for effective drug treatment has ensured that HIV and HCV infection have traveled an easy road into the extended Latino family. Thousands of deaths and the physical degradation among drug users has created generations of health problems that could have been prevented. Punitive drug laws and the refusal to acknowledge the importance of harm reduction as a health care strategy only contribute to the declining health of large segments of the Latino community.

III. COALITION BUILDING AND PUBLIC POLICY ADVOCACY

Coalitions and collaborations allow groups to pursue bigger targets on a larger scale, address power inequities, shape public ideology, and build solutions to complex problems together.

Beth Rosenthal & Terry Mizrahi,
Strategic Partnerships: How to Create and Maintain Interorganizational Collaborations and Coalitions

Despite the growing number of uninsured Latinos and the significant health disparities Latinos face, health policy makers have paid little attention to Latino health needs. On those limited occasions when Latino health care needs have been recognized insufficient resources have been assigned to address the problem leading to a sense of frustration and limited progress. For example, according to Dr. Balcazar of the National Latino Health Collaborative, an evaluation conducted in 1995 concerning the objectives set forth in Healthy People 2000 showed that there had not been any progress made in 46% of the declared objectives that included Latinos and in many cases health outcomes had worsened rather than improved (Latino Health Institute and Mauricio Gastón Institute, 2001).

The health and well being of Latinos is in jeopardy – an overburdened and financially distressed public health system, increasing numbers of uninsured, stricter Medicaid eligibility rules and managed care – threaten to unravel the already tattered safety net which many Latinos rely upon for their health care.

Against this backdrop, Latino New Yorkers stand alone without a strong, unified Latino health advocacy organization to lead efforts to address the serious health disparities and access barriers faced by Latinos. To ameliorate this problem, a small ad-hoc planning group comprised of health advocates, community based organizations and health professionals have been meeting to plan a Latino Health Advocates Founders Summit.

The objectives of the Latino Health Advocates Founders Summit include:

1. To galvanize and facilitate dialogue among diverse sectors of the Latino community including health advocates and consumers, health providers, researchers, community based organizations, civic and religious leaders in order to work cooperatively to effectively address the health disparities and access barriers faced by Latinos;

2. To formalize the creation of a New York Latino Health Advocacy Coalition and;

3. To discuss and develop a preliminary strategic health advocacy plan to guide the Coalition's work during its initial phase of development.

A. GUIDING PRINCIPLES AND STRATEGIC ACTION STEPS

As mentioned at the beginning, this paper is intended to serve as one of several vehicles by which to generate discussion among diverse sectors of the Latino community about the health disparities and access problems faced by Latino New Yorkers. The principles and strategic action steps presented below are only a starting point for discussion and hopefully will serve as building blocks for consensus decision-making at the Founders Summit scheduled for the September 2002.

Recognizing and Utilizing Community Strengths. As the 21st century unfolds, it is becoming increasingly clear to all Americans that Latinos have and will continue to play a critical role in the economic and social progress of this nation. There are now 35 million Latinos living in the U.S. representing a 58% population increase in only ten years (1990-2000) and Latinos now account for almost 13% of the total U.S. population and 15% of the population in New York State. Bureau of the Census (2001)

Latino contributions to the economic prosperity of this nation are impressive. Currently, Latino males have the highest labor force participation rate of any group; in fact, two out of every five new workers hired in 1999 were Latino. Latino purchasing power in 2000 reached $452.4 billion, an increase of 118% since 1990. Moreover, by 2050, it is estimated that Latinos will account for 25% of the total U.S. population. As the Latino population grows and more of its members reach adulthood, they will play an increasingly influential role in shaping the future of this nation.

For several decades Latino discourse has been "deficit driven." Latino leaders and advocates must now seize the opportunity to reframe the discourse highlighting the important role Latinos play in the social and economic progress of this nation and demanding increased consultation with, and representation of the Latino community in decision making bodies that allocate resources and set policy.

Understanding Health as More than the Absence of Disease. In order to improve the health of Latinos in the New York State, it will also be necessary to move past a restrictive or limited concept of health defined only by the absence of disease.The World Health Organization (WHO) offers a more comprehensive definition of health, namely, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (2001).

In light of the socio-economic stressors faced by large segments of the Latino community and their detrimental impact on Latino health, it is critically important to define health broadly so that interventions are designed to address the full spectrum of issues impacting health including the socioeconomic stressors that influence Latino health outcomes.

Defining Health as a Social Justice Issue. Poverty and lack of health insurance are powerful predictors of health outcomes. In 1999, almost half of uninsured Latinos had not seen a doctor when sick, could not afford to fill a prescription for needed medications or went without recommended medical tests or treatments (Carrillo, Treviño, Betancourt & Coustasse, 2001) resulting in later stage diagnosis and poorer health outcomes. Unless we locate the issue of health within a broader social justice context we will not be able to create the types of systemic changes necessary to address many of the health problems faced by Latinos.

The Latino Health Advocacy Coalition can play an important role in educating and mobilizing consumers to assert their health rights and advocating for the adoption of equitable resource allocation policies. Equitable resource allocation practices would allow for greater investments in Latino communities characterized by limited infrastructures and higher levels of stress associated with substandard housing, homelessness, discrimination, environmental degradation, poverty, and higher levels of crime, violence and drug use.

Non-Discrimination. The Latino community is no different than other ethnic or racial groups in having discrimination and exclusion within its own community. Latino lesbian/gay/bisexual and transgendered persons suffer from frequent oversight by community leaders. Latinas are only becoming to come leadership positions in significant institutions. Current and former drug users are often treated like pariahs by members of the extended Latino family. Any health care advocacy movement must operate with these internalized and unarticulated prejudices in mind.

Sustainability. Coalition members must make a long-term commitment to building and sustaining the coalition effort understanding that efforts to effect systemic change and improve health outcomes for Latino New Yorkers will require ongoing vigilance and problem solving over an extended period of time. Coalition members must also be committed to building the Coalition's organizational infrastructure to ensure efficacy and long-term organizational viability.

Inclusion of All Ethnic Groups. The Latino community in the New York region has become very diverse. In addition, to the predominance of Puerto Rican migrants and immigrants from the Dominican Republic, there are sub-

stantial waves of new immigrant populations (Mexican, Colombian, Ecuadorian, Salvadoran and more) that must have a voice in shaping health care priorities and formulating strategies.

B. CREATING AN ORGANIZATIONAL ENGINE FOR HEALTH CARE REFORM

1.Building Capacity: Creating the Latino Health Advocacy Coalition of New York

Efforts to effect systemic change are most successful when a common vision can be forged and broad based support is cultivated through the development of collaborations or the formation of coalitions. Coalitions are characterized by "an organized grouping of independent organizations that share a common social change goal, and join forces to influence external institutions, while maintaining their own autonomy" (Rosenthal & Mizrahi, 1994). Coalition building efforts have proven to be highly effective in addressing complex problems by pooling the resources and expertise of diverse groups, fostering synergy and employing creative problem solving approaches to the issues encountered by their constituencies.

Efforts to address Latino health problems will require that we galvanize our best thinkers, heath care providers and strategists under a single, unified and powerful advocacy umbrella consisting of a statewide Latino Health Advocacy Coalition (LHAC). By bringing together health experts, health providers, researchers, advocates, civic leaders, consumers and health policy makers, LHAC can garner the necessary expertise and strategic insight necessary to the problem solving process and the articulation of sustainable health care solutions for the Latino community.

An investment in the development of a permanent infrastructure will enable LHAC to regularly pool the advocacy resources of its organizational partners, establish early credibility and enhance its negotiating position and leveraging power in support of its goals.

2.Development of a Latino Health Agenda and Advocacy Campaign

One of LHAC's initial steps must be to build broad based consensus concerning the top priorities for strategic action that will most effectively address the access problems and health disparities faced by Latino New Yorkers. Towards that aim, a Latino Health Advocates Founders Summit (the “Summit”) is proposed for September 2002. The Summit will serve to galvanize and facilitate dialogue among diverse sectors of the Latino community in order to work cooperatively to establish a preliminary agenda for action and map out a statewide Latino Health Advocacy Campaign with measurable goals and objectives.

LHAC can play a critical advocacy role holding health care institutions, health related governmental agencies, elected officials and policy makers accountable for creating and implementing programs and policies intended to reduce health disparities and increase health care access at the local and state levels. Effective advocacy activities may include: sponsoring town meetings, disseminating policy briefs, providing testimony at hearings, organizing civil actions and issuing "report cards" assessing health institutions and governmental agencies' efforts to reduce health disparities and improve health care access

For the most part, Latinos and non-Latinos alike remain unaware of the serious health disparities affecting Latinos making it easier for elected and appointed officials to ignore Latino health care needs. To address this problem, LHAC must launch and maintain an ongoing public education and strategic media campaign capable of educating the general public about the health care needs of Latinos and the impact Latino health problems have on the economic well being of the City and State and its health care institutions.

Moreover, since many laudable advocacy campaigns have been lost not on the merits but based on public perceptions it is imperative that LHAC develop the capacity to continually assess and influence public opinion. Conducting periodic assessments is an important step in developing a program of communication and action that promotes the public's understanding of the issues and generates appropriate levels of support through the use of persuasive communication techniques.

A strategic communications plan would entail aggressive outreach to the mainstream Spanish and English language media including cultivating relationships with key reporters, targeting alternative media outlets and developing issue oriented press kits in addition to publishing a variety of bilingual public education materials.

3. Legislative and Regulatory Advocacy and Monitoring

The federal and state legislatures and administrative agencies are critical actors in health care funding and reform. LHAC must develop the capacity to regularly brief legislators and agency heads on Latino health issues,track legislation, create effective mechanisms to counter adverse legislative initiatives and most importantly develop its own proactive, legislative program in tandem with other progressive groups.

Most immediately, in the aftermath of the September 11th tragedy and with the deepening impact of welfare and immigration reform that has severely impacted the Latino community, it is imperative that LHAC assume an aggressive watchdog role to ensure that the limited resources available to the Latino community for health care are not reduced further.

4.Community Organizing and Leadership Development

LHAC must also be able to build a vocal, sophisticated and diverse constituency base with the capacity to mobilize quickly and efficiently and to continually inform LHAC's policy positions through regular dialogue and active participation in a wide range of advocacy activities. This effort should entail the development of local community health advocacy networks, sponsorship of community meetings and health advocacy "teach-ins", as well as, providing technical assistance to local groups engaged in health policy and advocacy activities.

5.Building the Future: Developing a Pipeline of Health Professionals and Researchers

The under-representation of Latinos in the health professions and in the areas of biomedical and behavioral research hinders our ability as a community to influence key areas of health and science and the health and academic institutions that generate new research and approaches to heath care problems.

Coalition members can play a pivotal role in demanding corrective action, including advocating funding for scholarships and mentoring programs that will contribute to the development of a cadre of professionals more likely to dedicate themselves to providing care in underserved Latino communities and/or lending their expertise to advance solutions to Latino health problems.

IV. CONCLUSION

The Latino community can no longer afford to wait for poorly conceived and insubstantial "band-aid" health care initiatives to "trickle down" in the hopes of staving off the urgent and pervasive health care crisis affecting Latino New Yorkers. Utilizing the guiding principles and strategic action steps described earlier, LHAC has the potential to become an important voice and powerful advocacy engine for Latinos, with the ability to influence the health policymaking process and ensure the adoption of strategies that will eliminate health disparities and improve health outcomes for Latino New Yorkers.

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