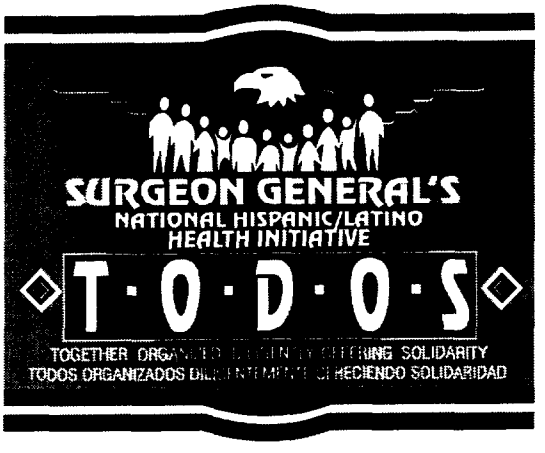

Artist:
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Original Concept:
TODOS Hispanic Student Organization
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Design Contributions:
Executive Planning Committee
Surgeon General's National Hispanic/Latino Health Initiative

The symbolic elements of this logo reflect the mission of the Surgeon General's National Hispanic/Latino Health Initiative. The colors of the United States of America represent the effort to unite all Hispanics/Latinos, regardless of their diverse backgrounds and roots, under our flag. The Bald Eagle, the traditional symbol of "supreme power and authority," uses its great wingspan, keen eyesight, and ability to soar over great distances to protect and embrace its territory. The eagle embodies the Office of the Surgeon General, whose "wings" protect those in need. The people represent all Hispanics/Latinos: the individuals and families, the young and the elderly, all those who need that protection. The circle was used in many ancient civilizations as a symbol representing the Sun, life itself, and the aim to achieve perfection, to do everything right, to live in good health, and to prolong our existence. As a graphic symbol for health, the circle represents the well-being of the body and the freedom from physical disease or pain, not only for the individual or for a people, but for the Nation. The powerful words "organized" and "solidarity" are designed to stir positive reactions beyond the borders of this Nation, bringing together all Hispanics/Latinos. Finally, the small squares and the borders show the artistic traditions of the Hispanic/Latino Heritage.

Message from the Surgeon General

In this melting pot called America, we Hispanics/Latinos—soon to become the largest and youngest of its ethnic minorities—have merely remained on the outside of the pot looking in. Following the path of least resistance, we have let the status quo sustain us for the last 500 years. Branded as one amorphous group, we have persevered, but we have never really been accounted for or counted in collectively as one . . . until now. Speaking with one loud voice, we can begin to make America listen to us as never before. Only then can we Hispanics/Latinos finally begin to come into our own.

Today, Hispanics/Latinos make up 22 million hardworking members of the American family, and by the year 2000, there will be 31 million of us. Poverty, underemployment, absence of true data, low educational attainment, cultural dislocation, and limited access to health care and insurance have set many of us apart from mainstream America and jeopardized our health.

To begin to confront the challenges that Hispanics/Latinos face in this country, and to develop a plan to address our complex barriers to quality health care and services, the Surgeon General's landmark Hispanic/Latino Health Initiative was born. This far-reaching Initiative, designed to unite the efforts of diverse Hispanic/Latino groups nationwide through the Office of the Surgeon General, was characterized by three main goals:

- To gather information on the health needs, concerns, and priorities of Hispanic/Latino Americans.
- To propose effective and realistic recommendations for addressing these needs.
- To provide a clear focus for coordinating the activities of the Department of Health and Human Services with those of the Hispanic/Latino community.

Antonia Coello Novello, M.D., M.P.H.
Surgeon General
U.S. Public Health Service

This report documents the activities and findings of the Initiative. As an unprecedented compendium of information, the report describes the status of Hispanic/Latino health in five regions of the United States, defines the challenges and priority issues encompassing our greatest disparities and barriers, and lists the recommendations related to Hispanic/Latino health priorities.

The Initiative and this report were made possible through the support of the U.S. Department of Health and Human Services, Public Health Service, Office of Minority Health. The Initiative was guided by an Executive Planning Committee made up of 48 Hispanic/Latino leaders from throughout the country.

In September 1992, in Washington, D.C., we held the first event of the Initiative—the Surgeon General's National Workshop on Hispanic/Latino Health. More than 200 Hispanic/Latino leaders

concerned with the health and well-being of the Hispanic/Latino community came together to speak at this landmark Workshop.

They shared their experience and expertise in developing recommendations for addressing five health concerns critical to Hispanic/Latino Americans. These issues remained as the central focus of our Initiative efforts:

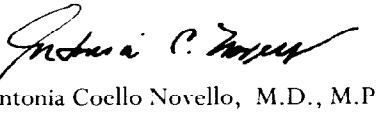
- Improved access to health care.
- Improved data collection strategies.
- Increased representation in the science and health professions.
- Development of a relevant and comprehensive research agenda.
- Health promotion and disease prevention efforts.

Subsequently, in March and April 1993, we held five Regional Health Meetings in U.S. cities with large Hispanic/Latino populations—New York, Miami, Chicago, San Antonio, and Los Angeles. At these intensive 2-day meetings, hundreds of Hispanic/Latino leaders and health professionals pooled their expertise to identify Hispanic/Latino health issues specific to each region, to formulate partnerships for action at the State and local levels, and to develop appropriate, community-based recommendations.

Following the regional meetings, the Executive Planning Committee members met in Washington, D.C., for a comprehensive, 2-day followup session at the end of April. At that time, we reviewed all the recommendations proposed at the National Workshop and the five Regional Health Meetings for possible implementation. This report summarizes the most pertinent recommendations developed by the group in addressing the five critical issues in improving the health and well-being of the Hispanic/Latino community.

The recommendations come at a time when the Nation is examining health care for all Americans. It was the hope of the group that these recommendations could be used by Federal, State, and community leaders as they plan for the health and well-being of Hispanics/Latinos. When these recommendations were made to the Surgeon General, it was the group's consensus that they could be used to empower communities and close the gaps between the "haves" and the "have-nots."

As a result of working together and speaking with one voice, I am confident that we are on the right track and are beginning to make a real difference in dealing with these complex issues. Our collective efforts in carrying forth the aims of this Initiative are critical to the health of every Hispanic/Latino American. For only with a new, more cohesive, in-depth, and realistic profile of this Nation's Hispanics/Latinos can we truly begin to plan for the future as true equals in this land of opportunity. As we proceed to work together for good health, let us make TODOS (all of us) our watchword for years to come.



Antonia Coello Novello, M.D., M.P.H.
Surgeon General

Chapter 1: Introduction

Background

Hispanics/Latinos constitute one of the fastest growing ethnic minorities in the United States. Today, there are 22 million Americans of Hispanic/Latino descent in this country, making up about 9 percent of the Nation's population. By the year 2000, Hispanics/Latinos will become the largest—and one of the youngest—of America's ethnic minority groups, with an estimated 31 million members. By 2050, the Hispanic/Latino population is projected to be 81 million people or about one-fifth of the predicted American population.

More than two-thirds of Hispanics/Latinos now living in the United States are native citizens; however, they do not share in America's bounty. Their per-capita income is disproportionately lower than that of African Americans or non-Hispanic/Latino whites, and more than one-third of them do not have health insurance even though Hispanics/Latinos are the most highly employed minority. The disparity in health status between the Hispanic/Latino and non-Hispanic/Latino populations in the United States is a recognized problem, and research has been conducted to determine the magnitude and causes of this disparity. However, the problem defies any generic approaches for solutions because of the diversity of the Hispanic/Latino population in national origin and cultural heritage, economic status, geographical distribution, and demographic characteristics.

Numerous groups within the Hispanic/Latino community have attempted to address the diverse and complex problems of Hispanic/Latino health status. Recognizing the need to address this problem in a united and unified effort, the Congressional Hispanic Caucus, national Hispanic/Latino leaders, and several Hispanic organizations recommended that the Public Health Service (PHS) launch an initiative to develop solutions; they also recommended that Surgeon General Antonia Coello Novello lead the initiative. Thus, the Surgeon General's National Hispanic/Latino Health Initiative was formed. This report documents the activities of the Initiative.

The Initiative is designed to meet three critical goals in support of the Department of Health and Human Services' (DHHS) commitment to health for all Americans: to reduce the health disparities of all people in this country, to improve delivery of health services to those in need and those at risk, and to ensure access to health care for all. More specifically, the Initiative addresses five crucial health objectives pertinent to the Hispanic/Latino population:

- To improve access to health care for all.
- To improve the collection of health data for Hispanics/Latinos across the board.
- To develop a relevant and comprehensive research agenda.
- To increase Hispanic/Latino representation in the science and health professions.
- To expand community-based health promotion and disease prevention outreach activities.

To assist her in planning the activities of the Initiative, the Surgeon General enlisted Hispanic/Latino leaders from across the Nation who have expertise in Hispanic/Latino health issues. The members of the Executive Planning Committee are listed in the front of this report.

Events of the Initiative

National Workshop on Hispanic/Latino Health: Implementation Strategies

This Workshop was the critical first step in meeting the goals of the Initiative. Held September 28–30, 1992, at the ANA Westin Hotel in Washington, D.C., the Workshop was hosted by Dr. Novello and was sponsored by the Office of the Assistant Secretary for Health (OASH), Office of Minority Health, and co-sponsored by the National Institutes of Health, the Centers for Disease Control and Prevention, and the Substance Abuse and Mental Health Services Administration.

The Workshop brought together more than 200 Hispanic/Latino leaders from diverse backgrounds and organizations in a unique forum that pooled their strengths and leadership abilities to promote the health and well-being of the Nation's Hispanic/Latino population. The purpose of the Workshop was to document the status of Hispanic/Latino health and to begin developing strategies to meet the identified needs. Its specific goals were

- To gather information about the health needs, concerns, and priorities of Hispanic/Latino Americans.
- To propose effective and realistic recommendations for meeting those needs.
- To provide a clear focus for coordinating the Department's efforts with the efforts of the Hispanic/Latino community.

To prepare the Workshop participants to address the issues in each of these areas, the Surgeon General commissioned a set of Background Summary Papers. These Background Summary Papers outline the problems in each area, summarize proposed solutions from existing literature, and offer suggestions for implementation strategies. They were sent to the participants before the Workshop and were presented at the Workshop by the Hispanic/Latino Health Issues Panel, composed of the five corresponding authors. The papers laid the groundwork for and served as a prelude to the important work that occurred at the Workshop. The Background Summary Papers are to be published in Public Health Reports, the journal of PHS.

During the Workshop, the participants were assigned to Work Groups, which were charged with developing implementation strategies for improving the health and well-being of the Nation's Hispanic/Latino population. Each Work Group was tasked with meeting three objectives:

- To identify between 5 and 10 priority problems or issues for the assigned topic (access to health care, data collection, research agenda, representation in the health professions, and health promotion and disease prevention efforts) and to rank them according to their priority.
- For each problem or issue, to identify at least one aim or desired end.
- To develop a list of implementation strategies for reaching each aim. As strategies were developed, some groups also identified at what level—Federal, State, or local—and by which sector—public, private, or public-private partnerships—these implementation strategies should be undertaken.

On the final day of the Workshop, a spokesperson for each Work Group presented the Work Group's findings to Workshop participants; to a Responder Panel composed of key leaders of Federal agencies; and to local, State, and Federal policymakers.

Regional Health Meetings

The findings of the National Workshop provided the basis for the second phase of the Initiative, the Regional Health Meetings, held in the spring of 1993 in cities across the country—New York, Miami, Chicago, San Antonio, and Los Angeles. The Regional Health Meetings drew approximately 1,000 participants from diverse Hispanic/Latino populations to address health problems within their communities.

The objective of each Regional Health Meeting was to identify and focus on the specific needs of the regions and to develop strategies for creating partnerships for action at the local and State levels, where lacking, and for strengthening the linkages that already exist to promote Hispanic/Latino health and well-being. Following a format similar to the National Workshop, groups of participants developed strategies for each critical area of concern and presented the findings to the entire gathering.

This report contains a chapter summarizing the Regional Health Meetings. The full proceedings for each meeting are to be published in separate reports.

Executive Planning Committee Meeting

On April 22 and 23, 1993, just days after the last of the Regional Health Meetings took place, the Executive Planning Committee for the Initiative met in Washington, D.C., to review the findings of the National Workshop and the Regional Health Meetings and to draft a national plan of action for improving the health and well-being of Hispanic/Latino Americans. This national plan synthesizes and prioritizes the strategies developed at all of the other workshops; its purpose is to address the diverse health needs of the Hispanic/Latino community.

About This Report

This report is published in two versions. The first version, entitled *Recommendations to the Surgeon General To Improve Hispanic/Latino Health*, contains a summary of the Executive Planning Committee meeting held on April 22 and 23, 1993, and the implementation strategies identified at the meeting as crucial for prompt action. Because this report is a synthesis of the findings from all of the activities of the National Hispanic/Latino Health Initiative and prioritizes the recommendations developed, it serves as an action plan for the Nation to begin addressing the critical issues related to the health status of the Hispanic/Latino population.

The second version of the report, entitled *One Voice, One Vision—Recommendations to the Surgeon General To Improve Hispanic/Latino Health*, documents all events of the Initiative with emphasis on the National Workshop held in September 1992. Chapter 2 contains Dr. Novello's charge to the participants at the National Workshop. Chapter 3 is the presentation of the Background Summary Papers. Chapter 4 lists the implementation strategies developed at the National Workshop, and Chapter 5 is the presentation of those implementation strategies. Chapter 6 contains Dr. Novello's closing remarks from the National Workshop. Chapter 7 provides a summary of the Regional Health Meetings, with highlights of the implementation strategies developed at the meetings. Chapter 8 contains the priority recommendations developed at the April 22–23, 1993, Executive Planning Committee Meeting.

Appendix A lists the participants of the National Workshop. (Participants of the Regional Health Meetings are listed in separate proceedings documents for each meeting.) Appendix B contains the agenda for the National Workshop. Appendix C provides the Executive Planning Committee members and the agenda for each Regional Health Meeting. Appendix D lists the regional sponsors and co-sponsors for each Regional Health Meeting. Appendix E contains the remarks of government and community leaders who took part in the National Workshop.

Chapter 2: Charge to Participants

Antonia Coello Novello, M.D., M.P.H.

Surgeon General

Buenas tardes y bienvenidos. It is my great pleasure to welcome you all to this landmark National Workshop on Hispanic/Latino Health: Implementation Strategies. As you know, our motto for this important event is TODOS, and it has been precisely in the spirit of togetherness and unity, of solidarity and a vision for a healthier future, that we have been working so hard in the past months to make this Workshop a reality. A heartfelt thank you to everyone on the Executive Planning Committee—and especially to the original five individuals (Rudy Sanchez, Raul Yzaguirre, Jane Delgado, Helen Rodriguez-Trias, and Castulo de la Rocha). Without the Committee's tireless and diligent efforts, there would be no workshop today.

This group meeting here today for the first time is very similar in composition to the Hispanic/Latino population as a whole—multicultural and multidisciplinary. We come from throughout the United States, we can trace our heritage back centuries, and we come from multiple Hispanic/Latino groups. We come from the public and private sectors: we consist of national, State, and local officials; community leaders; and health professionals—clinicians, physicians, researchers, and educators. Whether participant or observer, we are all in this together and have come to mark a great new beginning for Hispanic/Latino health.

This Workshop will bring to the forefront—

- The links between having good health and having a good life.
- The reality of family ties that not only bind our immediate households and relatives but that go back five centuries.
- The true meaning of love of country, love of heritage, and love of learning.
- The application of knowledge to move forward—con respeto, confianza, y honor.

Above all, the Workshop will strengthen the conviction that, in the words of Pablo Neruda, "All paths lead to the same goal: to convey to others what we are." Basically, we plan to get to the heart of what it means to be a Hispanic/Latino man, woman, or child in this country. That is why we are here.

In this historic meeting, it is my hope that we will filter out the noise of our separate realities and make our many voices heard in one choir—a choir of voices that will make America listen as never before. TODOS, together, with one voice, we Hispanics/Latinos will live up to the single most important goal positioned for the future: *that people from every cultural and ethnic group shall be empowered to contribute, not only to themselves but to the common good of all Americans.*

In that spirit of empowerment, we shall meet here for the next 3 days. These 3 days may bring moderate success for some and laurels for a few on which to rest in the coming months, or they may bring unprecedented achievements that will resonate for years to come and well into the next century.

As the Surgeon General for all Americans, I ask you to rise to the challenge and aim for the unprecedented achievements that will make it feasible for each one of us to have a future. In doing

so, make it happen not only for yourselves but for each member of the Hispanic/Latino community.

In these critical days, I ask you to use not only your experience and intellect, but your feelings. Bring not only your care and concern but, if necessary, your anger and frustration, your sense of empathy, justice, and fair play. Adding feeling to intellect will temper our data and theories with a healthy dose of reality. At the same time, I am asking you not to let your emotions and feelings overpower you to the extent that we become splintered and lose sight of our overriding goal in this spirit of empowerment: to develop implementation strategies that *can cut through talk and result in action*. We want to "get real," but in doing so, we must address our pressing concerns with realistic, feasible solutions. I am asking you to bring your honest perceptions of what can help our families and children to be healthier and better prepared for the new age upon us, while allowing us to face our many barriers objectively.

We have all heard a great deal about Hispanics/Latinos; we have been inundated with statistics that paint a complex and often gloomy picture of what it is to be Hispanic/Latino in America. Let me share some of those with you today.

- We know that, by the year 2000, the 22 million Hispanics/Latinos of today will become almost 31 million, yielding the single largest and youngest ethnic minority in the United States.
- The majority of Hispanics/Latinos—67 percent—were born in the United States.
- Hispanics/Latinos live in virtually every part of the Nation but are heavily concentrated in the four States of California, Texas, New York, and Florida. Most of our population live in urban areas.
- The Hispanic/Latino population includes many different nationality groups. The

majority (63 percent) identify themselves as Mexican Americans; 11 percent are Puerto Rican; 5 percent are Cuban; 14 percent are Central or South American; and 8 percent are from other Hispanic/Latino subgroups.

- Although Hispanics/Latinos comprise the fastest growing segment of the elderly population, as a group they are younger than other Americans. They have the highest birth rates in the country and have larger families than non-Hispanics/Latinos; 20 percent of these families are headed by a single female.
- Hispanics/Latinos have the lowest levels of educational attainment of any major population group. Only about one-half of adults are high school graduates, and fewer than 1 in 10 has completed college.
- The per-capita income for Hispanics/Latinos is disproportionately lower than for African Americans or whites. In fact, Hispanics/Latinos are less likely to be homeowners than

other Americans, and more than one-fourth live in poverty.

- Hispanics/Latinos die from various causes. Among the major ones are accidents, diabetes, cirrhosis of the liver, homicide, AIDS, and perinatal conditions.
- Thirty-three percent of Hispanics/Latinos lack health insurance, despite the fact that there may well be an adult worker in the family.

These facts portray our sociodemographic and economic realities and show who we are *today*. I believe that many of the problems we face as Hispanics/Latinos reflect the educational and economic disparities we all know. Yes, we have problems, but they are not insurmountable. Because we also have great resources and strength—not the least of which is our strong work ethic and our sense of justice.

Your commitment and that of the organizations and institutions you represent is critical to our success in this Workshop. With that kind of mutual commitment, we can bring the very best knowledge and resources to bear for each of the five critical issues we will discuss—this time with eyes toward the future.

For example, during our Workshop—

- In our discussion of improving access to health care, it means removing cultural barriers that perpetuate fear, mistrust, and misunderstanding. It means access that is culturally sensitive and culturally responsible. It means bridging the language gap—or should I say the inability to communicate between those who speak English and those who do not. It means encouraging women who seek out medical care last because of family obligations to put themselves first for once. It means access that is community-based, family-centered, and under one roof.
- Increasing representation in the health professions means becoming more involved in our education, eliminating illiteracy, increasing the number of college graduates, and reducing the time it takes to get a degree. It also means getting on in the world of biotechnology and science and aspiring to be the best, whether young or old. It means education for everyone. It means encouraging not only our young people but also our adults to get in school and continue to learn. It means aspiring to and preparing for careers in professions that we did not feel were open to us in the past. It means empowering our youth to have a say in their futures. It means having the power to set the educational agenda that fits our needs and not walking around blindfolded to opportunities.
- When we talk about improving data collection strategies, it means responsiveness to all ethnic groups and subgroups and accountability to the truth. It means that our population of 22 million people needs to be accounted for and counted in. It means getting comprehensive data, identifying what is and is not appropriate, and making accurate assessments and reasonable predictions about the real status of Hispanic/Latino health.
- Developing a comprehensive research agenda goes hand in hand with collecting better data. We cannot expect to understand where we are headed and where we ought to be in terms of health until we understand, first, where we are today. It means finding a way by which we benefit from what science has to offer by tailoring its benefits to our needs. It means focusing on the diseases that kill us and putting priorities on research aimed at Hispanics/Latinos and other minorities—in the areas of HIV/AIDS and sexually transmitted diseases; alcoholism and other drug abuse; infant mortality and perinatal addiction; child abuse; cancer, tuberculosis, diabetes, and

heart disease; homicides, suicides, accidental injury; and the links between these diseases and the "disease" of poverty.

- When we talk about health promotion and disease prevention, it means that promoting health for Americans must be planned to encompass the views, needs, and feelings of the people who require it. Health promoters and policy makers must step, as it were, into the shoes of the unfamiliar if they are to develop programs that are responsive to the needs of those entrusted in their care. It means bilingual, culturally sensitive, and culturally competent programs, materials, and training that address the diverse needs of our pluralistic high-tech society. It means promoting the involvement of everyone to empower their own health and the health of their families. It means, in a sense, making us a part of getting better—by empowering us to understand why getting better is important, not by patronizing us but by enlightening us and enticing us.

If we are to succeed in this coming century, we must work to bridge our differences, uniting in a common bond and speaking with a common voice. We must learn not only to get a piece of the pie but to have a say in how it is baked. Most importantly, we must earn the trust but not arouse the fear of other minorities like us who seek a piece of the same pie. In doing so, we must strive for the following:

- We must secure a place for our children in the explosive new century. And while securing their place, let's not forget to include them in the planning process. Being young is no reason for exclusion.
- We must also get involved. I would like to hear less of "I want, I need, and I deserve," and more of "What can I do? How can I help? When do we start?"
- We must foster acceptance of our population and promote our incorporation into a true multicultural society. I would like to see us help mainstream America understand and accept our Hispanic/Latino culture with its centuries of knowledge; encourage our contributions; and value our diversity. It is time we put an end to cultural stereotypes once and for all.
- We must learn to develop partnerships, not only among ourselves but also among States, local community groups, and businesses. Such partnerships will extend our resources, combine our skills and specialties, and ensure more comprehensive services.
- We must also seek help when help is needed. We need help to overcome the difficulties and stress of cultural dislocation and assimilation into American life. These problems can leave wounds that can last a lifetime.
- We also must not overlook the silent cries of our children, who are watching us and emulating our behavior. They do what we do, not what we tell them to do. We must set the example of a healthy lifestyle and help them see through the mixed messages about false glamour, affluence, popularity, and the so-called "good life." For how can we expect to raise our children to value our traditions and customs, to respect the cultural traits that shape our individuality, when we ourselves lose our identity and self respect?

Now, let me return to remind you of what we all can do together at this Workshop. As health practitioners and advocates, you have a chance to become the leading architects and designers of our agenda for the future. It will be up to you to make these Work Group sessions meaningful and constructive. It will be up to you to develop sound objectives and implementation strategies by relying

on the shared expertise and collective wisdom of your colleagues in so many fields. I am relying on you all to work hard, pull together, and develop a truly workable, useable plan of action—a plan that will be the blueprint of our national Hispanic/Latino health agenda for years to come.

In closing, let me stress that our challenges are far from easy. We must retain our pride without lingering at the altar of personal ambition. We must transform without transgressing, share without imposing, and integrate without interrupting. We must also remember that it is not solely the responsibility of the Government to sustain us and find a place for us in the next century. Ultimately, no government, no community organization alone, is responsible for our future. We must take command in shaping our destiny.

As we work together to solve some of our most pressing problems, let us rely on our strong values and traditions for guidance. Let's rebuild where it is needed, maintain what is essential, learn new skills and strategies, and seek help—if help is what is needed most.

Accordingly, do not refrain from speaking out to our leaders—communicate, reach out, be proactive. Let us not fail out of fear of displeasing a few. After all, we empowered our leaders by our votes; it is our rightful place to seek empowerment in return.

I believe the time to act is upon us, for we have precious little time to rehearse. A generation is waiting in the wings, and how well the 31 million are received in the next 8 years depends on how well we perform our roles during the next 3 days.

Let me close by reminding you that the Hispanic/Latino community is diverse, very family oriented, very strong, yet, at times, vulnerable. Hispanics/Latinos have succeeded against tremendous odds time and again. As a group, we have contributed to making this country strong and diverse, and we have enriched the lives of young and old alike through our many talents in every field. America, it is time you do not forget us!

Together, as Hispanics/Latinos and as Americans, we can make a difference, starting today. For, in the words of the great sage, Hillel, who lived in the 2nd century, "If we are not for ourselves, who are we? If we are only for ourselves, what are we?" As part of this glorious mosaic that is our Hispanic/Latino family, I urge us all to make our minds and hearts converge on one important goal: to remember who we are, and to show America what we are.. As we navigate the uncharted paths ahead, let us remember that intellect alone cannot be our compass; without knowledge, there can be no change, but without heart, there can be no dignity.

Lideres del futuro: I urge you to think clearly, act decisively, and care tenderly.

Gracias. Adelante TODOS!

Chapter 3: Hispanic/Latino Health Issues Panel—Background Summary Papers

The Background Summary Papers were commissioned to prepare participants for the National Workshop by summarizing the existing literature on the Hispanic/Latino health status—the problems identified and solutions recommended. Participants received the papers before the Workshop took place so that they could arrive at the Workshop ready for the task of developing implementation strategies. This chapter contains the presentation of the Background Summary Papers at the Workshop by the corresponding authors.

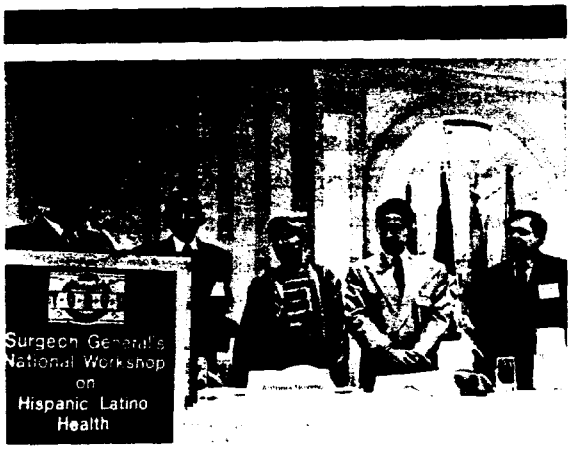
Improving Access to Health Care in Hispanic/Latino Communities

Robert Valdez, Ph.D., M.H.S.A.

In the next few minutes I'm going to try to summarize some of the highlights of this working paper, "Improving Access to Health Care in Hispanic/Latino Communities," by reviewing the literature on the financial, structural, and institutional barriers that Latinos face in acquiring care. Many of these barriers, of course, are buttressed by low standards of living in our community, where basic public health and sanitation practices are not adequately maintained or provided. Next, I'm going to talk about some of the proposed recommendations, or summarize some of the proposed recommendations, that have been offered by health policy analysts from national Latino organizations, from academia, and from other community organizations. Last, we'll talk about some of the concerns or considerations as we begin to deliberate implementation strategies by highlighting some of the issues that I think we need to keep in the forefront of our thinking if we are to improve access to health care for Latinos.

Let me first focus on the financial issues. Most Americans finance their health care through health plans offered as a fringe benefit of their employment, but that link between employment and health insurance is much weaker for Latinos. Generally, employment reaps very low wages and few fringe benefits, as exemplified by the health insurance data. These data on health insurance coverage, or the lack of health insurance coverage—the uninsured—illustrates that Latinos are three times more likely to be uninsured than the Anglo population, and about 60 percent more likely to be uninsured than the black or Asian and other populations.

As you recall, about 7 million Latinos are uninsured, but that 7 million is spread out differentially among the various Latino ethnic groups. Mexican Americans and Central and South American populations appear to have a greater problem in this area.



Access to Health Care

Part of the problem arises from the fact that, despite very high employment participation, Latinos are very unlikely to receive fringe benefits, including health insurance, as compensation for their work.

Let me turn now to some of the structural issues. Some of the structural issues that I want to talk about are really those concerns about how the system in the United States is put together or not put together, as it were. Part of that system has to do with the public programs that are offered to provide financial coverage, and the major program is Medicaid, a poor program for some of the poor. Many of the structural problems with Medicaid revolve around payment fees and procedures that basically, reduce eligibility of the Latino population to participate.

The system as a whole—that is, the health care system as a whole—is generally characterized as culturally insensitive and fragmented, as many of you have tried to put together your own system, by choosing a physician who then chooses other referral physicians, who then choose hospitals to use on a haphazard basis. The quality of your health care system depends on the quality of your physician's ability to socialize with other colleagues.

Finally, we touch on the structural issues. The structural issues have to do with the fact that much of our concern focuses on medical care and ignores the issues of public health. Many of our communities lack clean, safe water and basic sanitation. And clearly, there isn't the kind of focus on reducing violence that is necessary to make headway in the morbidity and mortality in our communities.

Let me turn to some of the institutional issues, or institutional barriers. Many of them are the reflection of the stereotypes and racial problems that exist in our current system and that have led to the exclusion in some communities of Latinos from leadership roles. Many of the current reform proposals that focus primarily on the financial barriers close out Latino business opportunities and community development opportunities. These are at the heart of the barriers that we see affecting Latinos.

Let me summarize, or at least highlight, a few of the recommendations in the report. Clearly, they can be broken up into three areas: (1) modifying governmental (Federal, State, and local) policies; (2) expanding the supply of culturally competent providers, either through increasing the number of Latino providers or assisting non-Latino providers to become much more attuned to the concerns and the issues that affect our communities; and (3) creating incentives for public health and primary care.

As we begin to think about implementation strategies, there are a whole host of strategies that we could come up with. Some of them needn't be mutually exclusive. We could follow several different strategies at one time.

Some of the considerations that I think we're going to have to deal with have to do with the fact that our populations are highly concentrated locally and in particular States. One implementation strategy would suggest that we concentrate our efforts for change in the 12 States with the largest Latino populations; alternatively or in conjunction, we could focus on the 20 largest urban areas. We've seen a reflection of what it means to ignore the urban areas in Los Angeles with the recent "fire sale," or riots, that occurred there in May.

The other thing that we have to keep in mind is the development of advocacy among our national, State, and local leaders and our officials. It's our responsibility to educate the newly elected Latino officials who will be joining Congress, who will be joining the State Houses, and who will be joining city councils all across the country. Unless we take it upon ourselves to educate these officials, it's unlikely—given the kinds of community development issues that most of us have to deal with—that health care will be on the top of their agenda.

Last, we need to consider how we are going to portray ourselves to the national media, to the

national public. There appears to be a lack of Latino images, and this lack inhibits our ability to make changes and gain access to the power that's necessary for increasing access to medical care and health care for Latinos.

Improving Data Collection Strategies

Jane Delgado, Ph.D.

First, I want to thank my coauthor, Dr. Leo Estrada, and the COSSMHO [National Coalition of Hispanic Health and Human Services Organizations] staff, who were very important to this paper. I want to start off with a little bit of history, which is critical to give us a perspective on this subject.

In 1970, the Census first used Spanish origin as an identifier. In 1976 Public Law 94-311 was enacted, instructing Federal agencies to collect data on "Americans of Spanish origin or descent." In 1977, as everyone knows, the Hispanic Health and Nutrition Examination Survey was established.

Later, you'll see that data was not actually collected until 1981. In 1978, OMB [Office of Management and Budget] issued Directive 15, which set the standard for Federal agency data collection related to persons of Hispanic origin. As you can see, in the 1970s we had two things: We had legislation, and we had an OMB directive.

Moving on, we see that by 1980 the Census started to use Hispanic identifiers for the first time. In 1986, the Hispanic Health Research Consortium was established. In 1987, the National Medical Expenditure Survey began to oversample for Hispanics. In 1988, GAO [U.S. General Accounting Office] released a report on Hispanic health data collection; 1989 was a landmark year for us as a community, because that's the year the national model birth and death certificates began to include a Hispanic identifier with specificity for subpopulations.

One of the factors related to Hispanic health that this timetable reveals is that, until very recently, we didn't know how many Hispanics were dying. This explains why, for so long, infant mortality has driven all of our national health policy, when in fact that's not an issue affecting Hispanics.

Now, looking into the 1990s: Congress passed the Disadvantaged Minority Health Improvement Act. This Act is very important, because it is the first health legislation that focuses on the specific needs of Hispanic communities and instructs people to look at us as a unique community, rather than in a "minority community" model. In addition, DHHS released 300 *Healthy People 2000* objectives. There are only 25 Hispanic objectives because all of the objectives had to have a baseline. Because we did not have a baseline, there were not Hispanic component objectives in some areas which are important: alcohol abuse, substance abuse, mental health, sexually transmitted diseases, etc.

In 1991, *JAMA* [*Journal of the American Medical Association*] published an issue on Hispanics and DHHS released "Health United States 1990," which

Data Collection

includes Hispanic and Hispanic subpopulation health data. In 1992, the Hispanic Health Research Consortium awarded grants to establish five university-based research teams focused on Hispanic women's health.

These events are the significant ones in the history of our data collection. We have a very short history, and I think that's part of the problem. So, when we look at recommendations in the area of Hispanic health, I think that the first thing we have to look at is data collection.

What are the things that we need in data collection? First of all, we need to include a statistically valid sample for Hispanics and major Hispanic subpopulation groups in major national data collection systems. If you look at the Background Summary Paper, we have a listing of all the major data sources within DHHS, and it indicates which sources include samples for us. Most of them do not.

The second critical factor is the need to redesign samples to collect data with more population specificity in the Central and South American and other Hispanic subpopulations. Computer technology has made coding pretty straightforward. It is also important to assess the validity of current data collection instruments and procedures for data collection in Hispanic communities.

A third key issue is to establish Hispanic component objectives for *Healthy People 2000*. Many of our communities at the State and local level know States are using *Healthy People 2000* to drive their local agendas. Because we didn't have baseline data, we are left out of a lot of *Healthy People 2000* objectives. We need to have better data collection so States can track our health status and incorporate Hispanic/Latino communities into *Healthy People 2000* objectives at the State and local levels.

In terms of data analysis, it is critical to support the Hispanic health research infrastructure to analyze Hispanic-specific information. We should provide technical assistance to CBOs [community-based organizations] and Hispanic researchers for research grants for data analysis award, include Hispanic researchers in development of RFAs and RFPs, and also submit an annual report on progress made toward improving Hispanic health data collection and percentage data analysis dollars granted to Hispanic focus programs.

In addition, it is critical that we include rating criteria that would give people points on being able to demonstrate they can work in our community. It should not be controversial that, if you are dealing with a bilingual/bicultural community, somebody on your team should be able to do that, too. Considering that we are the group with the least amount of information about us, we should be getting not only our proportionate share but more, so we can catch up for all the lost time we've had. I think that's one of the things that we have to be much more aggressive about. We are way behind in data collection research. We don't know what our community is dying of. We know it's not infant mortality. We know that we tend to live longer than non-Hispanic whites. There are other things we are dying of, though. We need to be able to document that and make sure people are getting research monies for that.

The final issue, which is also crucial, is the whole idea of data dissemination. We need to educate people about who we are as a community. It's good to do research, but make sure that the data we get and the data we collect are then disseminated.

We need to be included in every issue of *Health U.S.*, which is a document that non-Hispanic health communities use as their data bible. The categories should not be "White/Other." They should not read, "White, Black, Other." We need to have a category that holds our information, because our communities are different. We have different issues, and it's a disservice to health planners across the country not to provide that information. Also, we have to make the data more accessible to people. If people want to know us, we

have to give them the information. Those are the recommendations that we started off with in the area of data collection.

Increasing the Representation of Hispanics/Latinos in the Health Professions

Fernando Trevino, Ph.D., M.P.H.

I would like to thank my coauthors, Dr. Ciro Sumaya, Magdalena Miranda, Laudelina Martinez, and Jose Manuel Saldana, without whom we would not have been able to put this paper together.

The issue we want to talk about is health professions. Very few career choices exist for students that are more competitive and more demanding than the health professions. In addition, they require a very long educational period. You have to study and successfully complete anywhere from 12 to 16 years of an education before you even begin to study health.

For us, this is a problem, because the sad thing is that, at the present time, somewhere between 60 and 75 percent of our young students never go to college at all and, of those that do go to college, fewer than 10 percent will graduate. The problem is that 90 percent of our students are in urban schools, which suffer from a limited tax base and have to deal with all the additional problems of society that we're all too familiar with. Although school segregation has decreased for blacks and whites, it has actually increased for the Hispanic population.

Our parents do everything they can to support us, but all too many of them have very limited experience with educational systems and can offer only limited help to us. So we need to look to the teachers and the administrators and others to guide us along. Yet, unfortunately, when you look at this, you find that fewer than 3 percent of all the teachers in the United States are Hispanic. The result is that too many of our students (approximately 75 percent) who do stay in school are focusing on nonacademic tracks that will not prepare them for the health professions.

Only 51 percent of Hispanics older than the age of 25 have completed high school, compared with 81 percent of non-Hispanics. Between 1975 and 1990, high school graduation rates increased by 12 percent for black students and 2 percent for white students. Yet they actually decreased 3 percent for Hispanic students. As of 1989, Hispanics were approximately twice as likely as black students to drop out of school, and almost three times as likely as Anglo students.

At the current time, about 9.7 percent of Hispanics older than the age of 25 have a college degree. If you look at it by national origin, you see that Cuban Americans have the best experience. Approximately 18.5 percent of Cuban Americans older than 25 have a college degree. Now this is the best that any of our people have been able to do. That's still below the rate for non-Hispanics. It drops all the way down to 6.2 percent of Mexican Americans. Not only is the situation bad; it's getting worse. In 1976, 36 percent of Hispanic high school graduates went on to college. Ten years later, in 1986, we had lost 7 percent. We

went to 29 percent of our students who are going to college.

Our group looked at the work force that we currently have, and we found that there is not a single field where we have achieved expected representation, based on our population. We come close in things like radiologic technology and in one that won't surprise you—health aides. We come close to what we should be at that point, but we drop considerably as the educational level increases for a given profession.

We've had some successes, though. I think it was in 1968 when the effort to educate minority professionals really kicked in, and it was needed. At that time —1968—minority students composed only 3.6 percent of all U.S. medical students. Now, three-fourths of these minority students were black, and three-fourths of them were enrolled at two predominantly African American schools, Meharry and Howard Medical Schools. There were practically no minority students in any of our other medical schools. So the Federal government really kicked in and developed some programs and, as you can tell, they've had some success.

Of interest to me is the fact that, in 1968, nursing had the best representation for Hispanics, and yet that's the one field that didn't really do much. It sort of plateaued out there. The others increased dramatically, as you can tell. In 1968, there were only 23 Hispanic first-year medical students in allopathic medical schools. In 1988, 20 years later, we had 949. So we've made great increases. Unfortunately, they still represent only 5.6 percent of all first-year medical students.

In dentistry, in 1971 we had 40 Hispanic first-year dental students. In 1988, we had 316, constituting 7.6 percent of the total in that field.

Data aren't available on first-year enrollments in the field of optometry, but in 1971 total Hispanic students constituted 1 percent of all optometry students in the Nation; 20 years later, they constituted 3.1 percent. In fact, there are only two

schools of optometry in the entire United States that have more than 5 percent Hispanic enrollment. One is in California, and the other is in Texas.

By the way, I should mention that all these figures exclude the island of Puerto Rico and all their schools because, obviously, that is a different situation.

I can go on and on. Pharmacy: 3.4 percent of our first-year students are Hispanic. Podiatry: 3.6 percent. Veterinary medicine: 2.8 percent. And again, nursing: Regrettably, in 1971, 2.5 percent of all students admitted to any RN program at whatever level were Hispanic. In 1985, that increased 0.2 percent, going to 2.7 percent of our nursing students.

In public health we've talked a lot about the need to address prevention efforts and really focus on developing delivery systems, and I'm a little concerned. If you exclude the island of Puerto Rico's School of Public Health (and you need to, because the University of Puerto Rico School of Public Health employs one-half of all Hispanic public health faculty in the country and it's graduating two-thirds of all Hispanic public health graduates), you will find that all the other schools of public health put together have a student body of only 3.2 percent that is Hispanic.

Allied health (this is a big, broad field that we lump together and which constitutes 60 percent of all of our American health care workers) has no

database to speak of. We could not find any one unified database for the field of allied health. So all we were able to find was data from 26 disciplines that are accredited by CAHEA. In 1989, these 26 disciplines had a Hispanic participation rate of 5.7 percent.

Why should we be worried about educating Hispanic health professionals? Well, first, it's the right thing to do. But that hasn't gotten us very far. Second, and I credit my colleague, Bob Montoya, for this one—he has shown very clearly that this is a very cost-effective way of meeting the health needs of our country.

We hear all the time that maybe we have a surplus of physicians in other categories. We know well, and these figures show, that we don't have a surplus of Hispanic health professionals. A Federal survey found that fewer than 10 percent of Anglo medical students stated that they planned to practice in a critical manpower shortage area. Less than 10 percent were even thinking about it. By contrast, the research done by Bob Montoya and others has found that 75 percent of Hispanic medical students—in this case, it was Mexican American medical students—go back and provide care to minorities. They go back and provide care in critical shortage areas. They are more likely to accept Medicaid payment and all the kinds of things that we're talking about doing.

Bob Montoya has made a good argument. That is, should we as a Federal Government or State government invest $350,000 to $400,000 for the education of a single physician who's going to go in a surplus area, or should we be investing the same $400,000 to produce the kind of physician or other health provider who is going to go serve where we need them as a country?

Ray Marshall, former Secretary of Labor, has estimated that 90 percent of the growth in the work force that is going to occur in the United States from 1990 to the year 2000 will be composed of women and minorities. We have large numbers of people who are not going to be well prepared to find a suitable and productive career. We think the health profession, if you look at it, is one of the professions that's growing, and there's going to be continued demand. This could produce some productive contributing citizens for us.

Last, I do want to tell you there are some positives. The hope for us really is the fact that most surveys have repeatedly found that, of the Hispanic college students and Hispanic students who are planning to go to college, a health career is one of their top three professional choices.

The Development of a Relevant and Comprehensive Research Agenda To Improve Hispanic/Latino Health

Gerardo Marin, Ph.D.

This paper was developed with the collaboration of Hortensia Amaro, Carola Eisenberg, and Susan Opara-Stitzer.

The two words that are critical in developing a relevant and comprehensive research agenda are "relevant" and "comprehensive." The development of a relevant and comprehensive behavioral and biomedical research agenda must address at least three areas, and I was very pleased to hear Secretary Sullivan saying that earlier today.

First, there is the need for the research infrastructure that is central to the design, implementation, and support of research programs. Second is the need for appropriate research instrumentation that provides valid and reliable information about Hispanics. The third area is the definition of research priority areas that are based on the kind of data that we already have about our health status.

As the basis of this, there are three other important concerns: (1) that Hispanics, Hispanic researchers, must be involved in this process;

(2) that we need an increased representation of Hispanic and Latino professional staff within DHHS; and (3) that our research must include an analysis of the realities and needs of all Hispanics, including those living in Puerto Rico.

Let me mention some of the issues relevant to the three major areas that we feel should be addressed. In terms of a lack of appropriate research infrastructure, more than 6 years ago the Surgeon General's office produced a report on minority health, and yet now we find that very little funding goes to Hispanic issues. Less than 2 percent of DHHS research funding is spent on Hispanic health research issues or in support of Hispanic researchers. By the same token, very few Hispanics work for DHHS, and very few Hispanics are part of the process to make decisions about research.

Unofficial data provided to us by PHS show that this year only 83 of the 2,342 members of IRGs are Hispanics. That's about 3 percent. Given this, it's difficult to understand how an IRG can understand the cultural significance and appropriateness and relevance of the proposals being submitted.

The issue of appropriate research instrumentation was mentioned before, and we want to reinforce that very significant need, as we see research that is being carried out without attention to our cultural characteristics, to group-specific attitudes, perceptions, norms, and values, or even to the requirements of an appropriate translation.

Priority areas of needed research have been mentioned throughout the day. So in the interest of time, I won't mention them here, but rather I'm going to list some of the suggestions that we have made for dealing with some of these issues.

In terms of increasing the research infrastructure, as I mentioned before, there's a very significant need to increase the representation of Hispanics in health-related research. I'd like to suggest that those who make decisions about RFAs and RFPs and about funding take into consideration the kind of research that's being carried out in the States that have high Hispanic representation and demand that Hispanics be included in those samples. I'd like to suggest that oversampling of Hispanics/Latinos be required of proposals in critical areas of health concern for Hispanics. There is a need to educate members of IRGs, and this needs to be done by DHHS. There is a need to prepare IRGs, again, to be competent in making appropriate decisions about funding.

In order to increase the number of Hispanic/Latino researchers, there is a need to provide pre-infrastructural training for Hispanic researchers in behavioral and biomedical research. Programs directed at senior Hispanic/Latino researchers must be developed to allow them to become better equipped and to improve their methodological expertise. There is a need to educate the young researchers coming this way, to provide grantsmanship and workshops, to provide training that will help them be competitive.

We need to improve the training and cross-cultural competence of non-Hispanic researchers. It's very clear that we cannot do all the research that we need to do. We need help from other researchers, but they need to be educated about how to conduct culturally appropriate research with our populations.

To increase the number of Hispanics participating in the funding process, we suggest again that significant effort be made to identify Hispanics who can serve in IRGs, as ad hoc reviewers, at national advisory councils and scientific councils, and as program staff at PHS and, certainly, in the Centers for Disease Control and Prevention. We'd like to suggest that IRGs try to include at least one Hispanic member to properly assess the appropriateness of proposals, and that special recruiting efforts be developed in order to bring some of the expertise that is in the field to the Federal government.

The dearth of appropriate instruments is a very difficult issue to address, but it something that needs to be taken care of. Again, there's a need to create a kind of a repository where all of the data, as well as the

instruments, and the procedures that can be used to do appropriate research, can be found.

We also suggest that, to define a specific research agenda, at least five steps be taken:

- That we pay attention to a proper understanding of the issues related to the kind of health problems that we mentioned are critical to our population—diabetes, HIV, cancer, and so on.
- That a high-level committee be appointed to follow through on the results of the Surgeon General's Initiative.
- That special funding programs or initiatives be developed to fund research on factors such as acculturation, poverty, national origin or background, and migrational history, and the effects they have on Hispanic health.
- That special programs be developed to study the health status of Hispanics who work in particular environments such as migrant agriculture, assembly plants, service professionals, and other industrial concerns.
- That special health services research be addressed in order for them to file characteristics of the health care delivery, personnel, utilization, and effectiveness.

Health Promotion and Disease Prevention

Marilyn Aguirre-Molina, Ed.D.

All of the presentations that have preceded mine provide a framework for understanding why Latinos face so many problems in the area of health promotion and access to preventive services. I think it's probably safe to assume two things. The first is that the reduction of one or two risk factors for the leading causes of morbidity and mortality can add years to a person's life and reduce medical costs. The second assumption is that the most effective way to reduce risk factors is through health promotion and disease prevention strategies. It's generally accepted that, for many sectors of U.S. society, these two assumptions are true. People are accessing preventive services, and we are beginning to see the results—i.e., changes in morbidity and mortality patterns in the United States.

When it comes to Latinos, it's a very different situation. Nevertheless, if you look at the leading causes of morbidity and mortality among Latinos, there's another thing we'll agree on, that indeed we can add years to people's lives or keep them alive through prevention, and the leading causes of morbidity and mortality can truly be influenced by health promotion and disease prevention programs.

The real question here is, why are Latinos not sharing the benefits of health promotion and disease prevention to improve their well-being? There are a number of factors. We don't want to ignore the fact that, nationally, prevention is probably a very low priority. That can be measured by the amount of resources allocated to prevention efforts. A recent CDC report indicates that in 1988, $32.8 billion were allocated to prevention. Although that may seem like a lot, it represents only 3 percent of the total health care expenditures, or only 0.7 percent of the gross national product. We don't know what percentage—how many of those dollars—are allocated to Latino programs, but again, it's safe to assume that they are not enough.

Other factors that prevent Latinos from accessing preventive care services include the following. Latinos have poor or low access to the health or medical care settings where these preventive services are likely to be offered. As indicated in other presentations, Latinos are just not approaching—much less fully utilizing—those systems. Shortage of primary care providers and, most importantly, the lack of Latino and cross-culturally competent care providers partially explains this phenomenon. Additionally, there's a

shortage of primary care facilities servicing Latinos. Therefore, if those services and those facilities are not available, those institutions that would be the most appropriate sources for providing preventive services are not available to the Latino community.

There are also financial barriers. My colleagues have already addressed financial barriers, and the impact they have on access to regular sources of care. Things like inadequate insurance and Medicaid coverage complicate and reduce access to settings where health promotion services are offered.

There's another important issue to address, and this is the participation of Latinos in the labor force. Latinos are overrepresented in secondary labor markets, for example, in agricultural and manufacturing industries. Unfortunately, these jobs provide the lowest rates of health insurance and fringe benefit packages, thus having an impact on access to health care and health promotion and disease prevention services. An added concern tied to these occupational settings is the high risk and rates of on-the-job injury. One must note that all those wonderful corporate health promotion programs that many of us have learned to enjoy and appreciate are just not available to a large majority of working people in the Latino community.

We also need to look at institutional or systemic barriers. A 1991 report by the Health Resources and Services Administration clearly describes the problem. Let me read a quote from this report to you: "The health care system in this country has been designed to serve the majority population and possesses limited flexibility in meeting the needs of populations that are poor or may have different illnesses, cultural practices, diets, or languages. Barriers faced by Latinos/Hispanics in receiving primary and preventive care are magnified due to their special linguistic and cultural differences." In other words, institutions are just not adequately geared up to serve the needs of our communities.

I think other presenters did an excellent job of demonstrating the glaring disparity and the lack of bilingual/bicultural and cross-culturally competent health care personnel who can effectively deliver health promotion and disease prevention services. I want to underscore the need: bilingual, bicultural, and cross-culturally competent professionals. They are in critical need.

Let me just mention other institutional barriers worthy of consideration. One of them is bureaucratic patient intake processes, many of which produce fear of deportation among people who are undocumented. Some of these institutions also have incredibly long waiting periods for appointments, and, when one actually gets an appointment, the waiting period to receive services is excessive. In many of these institutions, service hours do not respond to the needs of the communities they serve. Professionals may be able to afford to take a day off for a doctor's appointment, but the vast majority of our population cannot. They will not be able to receive services unless they are provided in the evenings or on Saturdays. All of these conditions constitute what can be described as non-user-friendly environments which discourage patient access. As a result, Latinos ignore early warning signs, and do not utilize screening services. Therefore, Latinos end up in emergency rooms.

The last two points that I want to make deal with the programs themselves. We've talked about financial considerations and institutional considerations. We also need to discuss programmatic issues.

In sum, culturally appropriate and competent programs are in short supply. Most health promotion and disease prevention programs of proven effectiveness are mainstream programs. An effective mainstream program, however, may not necessarily work in the Latino community. Sometimes we see programs that are translated into Spanish, which go on to become disasters in our communities, proving that translations are not enough. That's a central problem with many of the

prevention programs that are transported into Latino communities. Many programs are devoid of cultural competence. For example, there's a complete misperception of the role that family and the social support systems play or can play in promoting health and preventing disease among Latinos. Successful programs cannot ignore important cultural traits that are specific to Latinos.

Some existing programs are totally inadequate when it comes to outreach activities. They ignore, for example, that the church is a very important institution for Latinos. Additionally, programs often lack expertise on how to use the Hispanic media effectively for outreach purposes.

Often, those responsible for designing programs ignore important variables. One is the intergenerational variation that exists among Latinos. We really have to take intergenerational variations into account when designing programs. We also need to look at degrees of acculturation—that is, to what extent an individual is adapted to the U.S. culture. There seems to be a monolithic notion of a generic Latino individual, when in reality, we must acknowledge the intergroup diversity. As we all know, a Puerto Rican is not a Cuban. A Dominican is not a Central American. The result is that many of the existing programs are based on poor information and poor understanding of our community.

I will highlight only a few recommendations. First of all, as a nation, we have to reshift our priorities and start to think about prevention as a critical component of our community's health. It's less costly. It's easier. It's better. Of course, among other things, this will imply political advocacy to ensure this shift in priorities.

Data is another key element. We must be able to identify gaps in health promotion and disease prevention data, data for minority groups to determine health disparities, the use of alternate care systems, the extent of morbidity and mortality, and so forth.

We want to, of course, increase and improve access to primary and preventive care. This topic will be addressed by another work group.

Institutional barriers must be removed. That's where our advocacy capabilities must be directed. There are a lot of concrete things that can be discussed in our workshops to increase and enhance institutions and, in particular, community-based organizations' capacity to deliver effective preventive programs. I say community-based organizations, because CBOs play an important role in our communities. They started out as social clubs and moved on to become more comprehensive health and human services organizations that now have credibility and the ability to reach our communities. We have to upgrade their ability to deliver health promotion and prevention services and help them move away from funding by sectors of the disease-promoting corporate world. That's one of the big problems that we face in our communities: contradictions. Much can be done by Federal incentives in the way of financial incentives. We must also prepare individuals to be able to enter these institutions.

I'm hoping that the health professions group will help us define the direction and implementation strategies for increasing the pool of people who are going not just into medical care but into public health. We have to begin to make these lucrative and attractive career tracks.

I believe that much of what the different working groups will be exploring and discussing is going to overlap. Topics are interconnected; our ability to gain access to prevention is based on our ability to gain access to the systems where prevention services are provided and on having personnel in those systems who are prepared and cross-culturally competent to design the kinds of programs that will be effective and respond to our community's needs.