

Reducing Health Disparities Among Low Socioeconomic Status Hispanics in the United States

By

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Abstract

Hispanics comprise a large proportion of the U. S. population. However, most Hispanic workers are employed in low-wage jobs that lack occupational benefits including health care. As a result of an adverse labor-centered life, the health of many underserved Hispanics is poor; they suffer inequities both in their access to, and the quality of, medical care available to them. These disparities exist on many different levels ranging from the individual level to the level of government policies. This paper reviews and analyzes the barriers and risk factors that affect the health disparities of large portions of the U. S. Hispanic population. These barriers include personal beliefs, affordability of health care, cost of living, low education, limited access to transportation, living in hazardous environments, and nearly inescapable poverty. Realizing that healthcare disparities are a multifaceted issue, the author uses the Social Ecological Model (SEM) of health to understand risk factors to good health and bring attention toward mitigating them. The author also discusses interventions consistent with the components of the Social Ecological Model - individual, interpersonal, organizational, community, and policy level, that aim to reduce and ultimately eliminate the inequity in access to quality of health care for underprivileged and underserved Hispanic communities across the United States.

Introduction

Health is well known to be one of the greatest contributors to quality of life, and although not mentioned in the Constitution, according to the World Health Organization (WHO), good health should be regarded as a fundamental human right (Ghebreyesus 2017). However, the reality is that there exists an immense disparity in health and health care among various segments of the U. S. population, especially minority groups. Health inequity is defined as an individual's unequal or complete lack of access to essential health services based on certain discriminatory factors including race, ethnicity, socioeconomic status (SES), education level, and more. Health disparities have resulted in increased numbers of preventable deaths.

This paper investigates the presence and effects of health disparities among the Hispanic populations of the United States and examines current solutions for

these inequities that have been effective and ineffective in addressing the health care needs of this population. The author uses The Social Ecological Model of Health (SEM) to understand these health disparities because this model is arguably one of the most effective approaches for tackling health issues on a large scale.

The U. S. Hispanic population is an important group to investigate because they are the largest minority group in the nation with projections that they will make up 29% of the country's population by 2060. Hispanics are also the nation's youngest minority group with 32% of them younger than 18 years old and 26% between 18 and 33 years old (Raymond, 2017). Furthermore, Hispanics often face some of the highest rates of obesity and the lowest rates of reproduction. They also suffer from immense health inequity, health outcomes, and undesirable living conditions (Raymond 2017). Thus, it is necessary to explore and solve the issues that the low SES Hispanic population faces, and in understanding how to reduce disparities in such a large population,

perhaps it will be easier to branch off and expand our interventions, using previous success as a benchmark.

The U. S. Census Bureau defines the term Hispanic as referring to the “region, not the race, of any person whose origins are of Mexico, Puerto Rico, Cuba, Central or South America—or in some other Hispanic origin country. Areas conquered by the Spaniards were considered part of a region originally called Hispania, which is where the term Hispanic likely derived” (Wolfe 2019). It is important to note that the entire Hispanic population should **not** be viewed as disadvantaged, although it is critical to understand that there are large numbers of disadvantaged Hispanics in the U. S. For example, 33% of Hispanic youth live in poverty (APA, 2016).

Literature Review

Health disparities among Hispanic communities are rooted in risk factors that make many individuals more likely to face health inequality. Important risk factors include income/SES, educational level, environment, occupation, and personal beliefs. These multi-dimensional risk factors reinforce the use of the SEM to observe and analyze health disparities and the need to approach solutions from different angles.

Individual-Level Risk Factors

Some of the health disparities that exist for Hispanic populations are consistent with their cultural attitudes, beliefs, and a fear of health care. Non-Hispanic physicians are often confused or skeptical when they hear their Hispanic patients explain their use of “folk healing” with a native healer/shaman, through a ritual called “curanderismo” instead of seeking treatment from a western doctor (Juckett 2013). Other types of folk healing include herbalists called “yerberas” and physical therapists called “sobradores.” All illnesses are viewed in religious terms as a “sickness of the soul” or tainted by an evil spirit (Juckett 2013).

Another interesting risk factor in the health disparities among male Hispanics is “machismo.” Machismo refers to Hispanic men’s culturally-defined sense of masculinity that puts pressure on men to avoid seeking preventative medical care because seeking care may be viewed as a sign of weakness (Bryner 2009). The influence of personal beliefs on health is evident in studies by the American Sociological Association. These studies reveal that Hispanic men, on average, lose five years of life expectancy. Hispanic women, on the other hand, are

reported by physicians to have difficulty approaching providers due to immense stress and hardships related to childcare, work, and lack of social support (Valdez et al., 2011).

Interpersonal-Level Risk Factors

A study done by the University of Wisconsin reveals that a language barrier often exists between Hispanic patients and their health care providers, since not all physicians speak Spanish, and communication is critical when providing health care (Valdez et al. 2011). Hispanic patients tend to seek providers who are also of the same ethnicity because they find it difficult to relate and be comfortable with non-Hispanic providers. However, only five percent of the physicians in the U. S. are of Hispanic origins (Valdez et al. 2011).

There is also a certain level of provider incompetence regarding Hispanic culture(s). Some patients find it difficult to relate to, and be comfortable with, providers who perceive them in stereotypic terms (Valdez et al. 2011). In addition to a less patient-centered quality of care, many Hispanics also face long wait times or miss their doctor’s calling hours due to the patient working multiple jobs. With financial burdens in the way, it becomes increasingly difficult to take action on individual health or even take time off to schedule a doctor’s appointment (Valdez et al. 2011).

Organizational-Level Risk Factors

Despite the rates of employment being in favor of immigrants with less education (Waters 2015:4), education itself is also an important social factor that greatly affects health and health care disparities because lower education contributes both to lower income and a decrease in health literacy. Health literacy is important. Research shows that 34% of Hispanics lack accurate health information and access and rely on their local clinics for critical information, including accurate translation of health information into Spanish (Valdez & Posada 2006: 18). In general, Hispanics are the least educated segment of the U. S. population (Joint Center 2004:4). The Behavioral Risk Factor Surveillance System shows that 14% of the adults do not have a high school diploma. Hispanics without a high school education are statistically three times more likely to die before they reach age 65, compared to Hispanics who have completed a college education (Woolf & Braveman 2011:2; Joint Center 2004: 4). Hispanic adults with less than 12 years of education are expected to live

approximately seven years less than those with sixteen or more years of education (Woolf & Braveman 2011:2). Every additional year of education Hispanics achieve, on average, results in their having approximately three more years added to their life expectancy (Woolf & Braveman 2011:2).

Many Hispanic immigrants arrive in the U. S. with skills that make them favorable for certain occupations, thus forcing them to choose between a steady work-centered life or pursuing more education, with the former being the option taken by the majority (Waters 2015:3). However, those who do pursue education tend to excel in academics and become meaningful contributors to the U. S. workforce and, consequently, to the health of the Hispanic community (Waters 2015: 3). In the end, education is important for health because it provides the information and skills needed to solve problems. However, educational institutions in impoverished areas may not provide either the necessary or the best education.

Community-Level Risk Factors

In analyzing health disparities, it is critical to also consider the living conditions and the circumstances set by the environment, particularly among low-income communities. One common misconception is that unhealthy behaviors are a product of personal decisions. However, further evidence points towards stronger influences that are seen in the areas in which people live and work (Woolf & Braveman 2011:3). For example, choosing a healthy diet is quite difficult for low-income households because healthy foods and supermarkets are often too far away. In contrast, fast food is both locally available and cheap.

The environment plays another crucial role in health disparity because access to transportation is a variable dictated by location. Many essential health services, clinics, and hospitals are out of reach for disadvantaged communities where they are perhaps needed the most (Woolf & Braveman 2011:3). Additionally, low-income communities heavily discourage physical exercise. This is especially true in Hispanic neighborhoods where residents feel less safe due to high crime rates or to a lack of crosswalks, signs, and traffic safety. Therefore, they may not choose the option of walking or biking to work, clinics, parks, and supermarkets (Woolf & Braveman, 2011:3). Hispanic immigrants new to the U. S. tend to live in the same residential areas as previous waves of Hispanics, despite the living conditions these impoverished communities impose, the reduced access

to healthy food options, and weaker educational systems for their children (Waters 2015:5).

Policy-Level Risk Factors

Income is a significant social determinant of health and health care disparities. Among Hispanics, income is a powerful indicator of a household's ability to afford health care and other important health services. Despite having the highest rates of labor workforce participation, Hispanic families have the highest rates of poverty in the U. S. (Joint Center 2004:4; Valdez & Posada 2006:16).

Hispanic adults between the ages of 18-35 are five times more likely to report poor levels of health compared to households that are above the poverty line (Woolf & Braveman 2011:2). The National Longitudinal Mortality Study reveals that low-income Hispanic individuals around the age of 25 have an average life expectancy between 50-55 years of age (Woolf & Braveman 2011:2).

Earnings for Hispanic immigrants are heavily stratified by race and ethnicity and are also the lowest of all immigrants with this disparity in income (Waters 2015:4). Hispanics in general have the lowest rates of insurance in the U. S. and are working low-wage jobs that don't offer health insurance or employee benefits (Valdez & Posada 2009:16). The U. S. Agency for Healthcare Research and Quality estimated that a third of Hispanic Americans lack health insurance coverage (Valdez & Posada 2006:17). Lack of access to health care and health literacy may eventually lead to self-medication as the cheaper alternative, which may lead to risks of antibiotic resistance or overdose.

Interventions

Again, the Social Ecological Model is fitting for analyzing health disparities among Hispanic populations because it reveals and underlines the fact that health disparity is a multifaceted issue that requires a multitude of interventions in order to effectively reduce health inequality in the many dimensions where it is prevalent. The SEM consists of the *individual level* concerning personal beliefs and attitudes, the *interpersonal level* focusing of relationships with others, the *organizational level* relating to the effects of institutions and organizations on an individual, the *community level* introducing the entire network of organizations and resources of an individual's environment, and the *political level* revolving around governments and policymaking.

Individual-Level Interventions

As stated previously, individual-level risk factors result from personal beliefs and attitudes concerning individual health care and the personal barriers that discourage or are completely out of people's control. Individual-level barriers and risk factors can hinder the quality of, or access to, health care; these factors include resources such as transportation, health care affordability, and costs of living, as well as behavioral individual-barriers such as fear, lack of confidence, commitment, and religion. Lower SES Hispanics do not have the financial capability to afford and maintain a car along with its many bills and often must rely on public transportation as their means of reaching their health institution.

Research shows a significant difference in access to transportation among Hispanics in rural areas compared to any other minority group. Sixty percent of Hispanic patients fear that transportation could be a leading cause of missing their treatment/appointments (Syed et al. 2013).

An impactful intervention addressing this individual-level barrier can focus on providing free or reduced-fee transportation funded by health care institutions for their patients. Alternatively, if transportation to health facilities is still beyond patients' reach, providers could travel to patients for examination or drug delivery. A mobile clinic could also be organized in rural areas where health facilities are sparse.

Success with these interventions has been seen with Denver Health Medical Center, which has recently partnered with the transportation company Lyft to aid in transportation between homes and hospitals, showing significant improvement in patient health (Situ 2017). For difficult places to reach via transportation, the hospital provides mobile health and medication delivery as well; these mobile clinics are 40-foot, state-of-the-art trucks that can travel to disadvantaged neighborhoods and provide care to those who need it the most (Situ 2017). Additionally, Calvert Health CARE clinics now offer home consultation and visits from providers to patients unable to pick up medication, arrive at their appointments, and need information about their health and medications (Situ 2017). The main limitations observed in current interventions are the sparsity of such programs and the need for further integration into the most rural areas where they are needed most.

Information about available transportation programs can be sent to patients by health care institutions either via letter or electronically. A blanket mailing or email

runs the risk of offering a transportation service to patients who do not necessarily need it. This concern can be addressed by analyzing patients' addresses from those who have submitted a request for transportation and prioritizing patients who are located the farthest distance from the hospital. Eligibility can be based on the amount of safe walking distance and the level of neighborhood safety regarding violence and traffic; patients in the poorest and most dangerous situations would be the most eligible.

For other individual-level barriers such as *machismo*, media can be used to dispel these social norms. For example, advertisements can show the significant benefits for Hispanic men who seek treatment compared to those who do not. Advertisements can show Hispanic male patients with a hospital gown being happy or doing masculine activities such as fixing a car (Bryner 2009). To successfully target Hispanic patients' trust and attitudes towards health and medical care, interventions need to be culturally tailored for them and show empathy for their values, beliefs, and histories that relate to and can potentially affect their health. A sense of mutual respect reinforces better patient attitudes and trust in the care that they are provided as well as boost their self-efficacy (Mitrani 2009; Juckett 2013).

Interpersonal-Level Interventions

Interpersonal-level interventions are where a lack of empathy and cultural sensitivity to Hispanic patients' beliefs and attitudes usually occur. An intervention addressing these issues can approach them from two directions, one centered around patients and the other focusing on the providers. For patients, integration of a peer-mentor program that reinforces confidence and exercises certain skills in communications and physician expectations may help Hispanic patients increase their self-efficacy and feel more autonomous about their ability to take their health into their own hands. For providers, additional training mandated by medical boards or even self-assertion emphasizing on practicing patient feedback and reducing ethnic biases would be a valuable intervention for reducing and eliminating health inequity that exists on the patient-provider level (Valdez et al. 2011).

Studies indicate that mindfulness training for providers has been showed to reduce their levels of stress and negative emotions. Reducing both is important because physical and emotional burdens often attribute to unequal or missing treatment of patients (Burgess 2009:6). These same studies, however, have shown

promising improvements in the quality of care of peer-mentored participants, showing higher levels of patient engagement and the number of questions asked during physician visits, coupled with provider-feedback. A study by Chin (2007:12) revealed that when exercising these interventions, patients exhibited very similar levels of controlled diabetes as patients who are admitted into specialty clinics.

When finding patient-participants for the intervention program, participants can be recruited based on physician data that shows which patients have the lowest frequency of health check-ups, indicating potential patient-provider conflicts or barriers. Provider-participants can be identified with similar methods, with the focus centered around areas with non-Hispanic providers and a high number of Hispanic patients with poor health, which anticipates potential cultural or linguistic barriers.

Other interpersonal-level interventions include having bilingual Spanish speaking staff, allowing longer visits for those without English proficiency, setting up evening office hours to accommodate those who have unfavorable work shifts, and offering patients medical and dietary literature with Spanish translations (Juckett 2013).

Organization-Level Interventions

Since nearly 30% of the workforce will be Hispanic in origin by 2050, and that many of the jobs at which Hispanics will likely work will be low-wage, it is crucial for organizational-level interventions to address work institutions and the need for employee benefits and health insurance (Rook 2016).

Fast-acting and reasonably high-level health coverage is both needed and important. Even if employees have health insurance however, lack of effective coverage will still result in some Hispanic workers choosing to pay bills rather than pay attention to their own health (Rook 2016).

Another important employee benefit is paid leave. Paid leave is particularly important because low-income Hispanic workers prioritize financial needs and tend to choose work over health, if their financial burdens depend on it. Thus, by having paid work leave, they will be better able to focus on their health rather than having to choose between the stress of work and their health. Doing this is important because stress itself also contributes to poor health (Rook 2013). Therefore, having an organizational-level intervention committed to workplace and employee benefits, such as health insurance and paid leave, would greatly reduce

health disparities for many low SES Hispanic workers. Participants for this intervention could be assembled relatively easily considering it will provide the crucial benefit of employer-paid or employer-supported health insurance.

Community-Level Interventions

The community must be addressed to reduce health care inequality. The community includes the totality of the institutions, geography, networks, and resources that contribute to health. Transitioning from employee benefits and institutional-level interventions, occupational health and safety are necessary priorities for community-level interventions.

Hispanic workers are exposed to greater risks of work injuries than any other group, including the risk of injury from transportation to work, workplace violence, and physical hazards (Gany et al. 2014). Furthermore, workers are less likely to report work injuries due to the lack of employee benefits and the fear of losing work (Gany et al. 2014).

As a community intervention, workplaces can provide better safety measures for manufactures and industries where there is hazardous machinery. These are types of occupations common amongst Hispanic workers. Also, using community-based programs that educate laborers would also contribute greatly to health disparity. A few such programs have already been successfully implemented in cities such as Chicago where an Interfaith Workers' Rights Program educates Hispanic workers on workers' rights, occupational health and safety, and worker compensation (Gany et al. 2014).

Another community-level intervention can focus on youth of Hispanic backgrounds in the community. Outside of the environment itself, its people can also make a difference for their collective health if they work collaboratively. It is important to understand that simply educating the community is not enough and that educational programs tend to be effective only as a one-time reform. Renewal of these programs and their educational benefits will work best if their importance is stressed throughout each generation; thus, a community focused around educating and nurturing proactive Hispanic youth would ensure better community health.

Studies published in the *Journal of Adolescent Health* explain how youth engagement alongside familial support and advocacy, had a positive impact on their health status (Raymond 2017). Keeping in mind that Hispanic youth form the largest component of this population than in other ethnic groups in the U. S., their

collective efforts and engagement as community leaders and educators would make a dramatic improvement in the health outcomes of their communities (Raymond 2017). Moreover, it is important to educate and mentor Hispanic youth about health education as they have the chance to improve upon the health disparities that their parents face as the youth themselves approach adulthood.

Policy-Level Interventions

When considering policy-level interventions, it makes sense to use the Affordable Care Act (ACA) as a benchmark for those in the future. With the advent of the ACA, the number of uninsured Hispanics dropped from 41.8% to 30.3%, providing nearly 4 million people with health insurance (Raymond 2017).

Future interventions can strive to improve where the ACA lacked -- to provide health insurance coverage for new and undocumented immigrants. Some states, such as California and New York, have already begun this initiation by waiving the five-year waiting period for new immigrants and provides them with health insurance using local funds (Raymond 2017).

Suggestions for other policy-level interventions include policies offering tax credits or health savings accounts (HSA) for small employers so that they may have the means to offer health insurance coverage to their employees. An alternative is to have policies directly provide tax credits to individuals who are not sponsored by their employers (Valdez & Posada 2006:9).

Another possible, although ambitious, intervention is to form a task force of members of the Hispanic community at the national level to propose a strategic *action* plan that would be budget neutral and focused on reviewing and analyzing all current healthcare programs available to Hispanics and restructuring, redirecting, and reallocating funds where health disparities are most prominent in order to reduce inequities (Valdez & Posada 2006:8).

Suggested Indicators to Evaluate the Effectiveness of Specific Interventions

Individual-Level Indicators: Physician data on the health outcomes of Hispanic patients, including the number of new and return visits to health facilities, can be analyzed.

Interpersonal-Level Indicators: Provider feedback results can be analyzed along with survey data collected from patients asking them about their provider experiences.

Data from reports on patient interactions can also be used.

Organizational-Level Indicator: Health of workers can be observed after they have received and used employee benefits for a specific length of time; for example, at least 18 months.

Community-Level Indicators: The fatality rates of Hispanic workers can be observed to see if occupational education and safety have improved. Health outcomes of individuals in the Hispanic community, based on provider reports, can also be used to see if youth engagement has had any effect on the community's health and education.

Policy-Level Indicators: National studies of Hispanic health can reveal if health outcomes and disparities have improved after certain health reforms take place. Similar to the studies identified in this article, a well-designed survey of a national-level, random sample of the Hispanic population would be an effective technique for measuring the differences in the quality of health and health care. Furthermore, increases in the number of medical diagnoses and hospital admissions in Hispanic communities could show a reduction in health disparities over time.

However, it is necessary to consider that increases in diagnoses and hospital admissions do not necessarily imply that people are becoming more ill and, as a result, have poorer health outcomes than before. With deeper analysis, increases may mean that Hispanic patients who represent prevalent, undocumented diseases and injuries are finally reporting, admitting, and acquiring the medical care and attention that they need.

Illustration of One Community Level Intervention

Because I wanted to engage in, and better understand, real-life applications of the proposed community-level intervention focusing on Hispanic youth, I became engaged as a youth mentor and health educator in the projects of a local community organization called Sociedad Latina. Founded in 1968, the goal of this organization is to nurture the next generation of Hispanic youth leaders, work to eliminate the destructive cycle of poverty, improve access to health services, and increase educational and career opportunities for communities of all cultures (Sociedad Latina 2019).

Sociedad Latina has a well-organized approach to Hispanic social issues. They break their approach into

four main components. The first is civic engagement, in which youth develop leadership abilities to help move themselves and others in their communities towards improving racial inequities, health, and education. Second is the educational program at Sociedad Latina. Hispanic youth are guided throughout their educational career from middle school to college, creating a first generation of more highly educated students. Third, Sociedad's workforce development program helps prepare Hispanic youth for careers in which Hispanics are underrepresented -- health services, STEM, and entrepreneurship. Fourth, in the arts program, Hispanic youth engage in a wide variety of arts through which they learn, embrace, and promote Hispanic culture and traditions (Sociedad Latina 2019).

Over the years, impact reports demonstrated that Sociedad Latina had powerful social influences over Boston's Hispanic community. Their civic engagement program reports that 89% of its youth become peer and community educators who work to address social challenges and disparities. Over 4,500 community participants were involved in the community actively pressing for change (Sociedad Latina 2019). The health education program (a part of the civic engagement branch), helped increase health literacy for over 1000 youth and parents who reported better knowledge of nutrition, sexual education, tobacco use, and alcohol consumption as a result (Sociedad Latina 2019). The education and workforce development branches helped 97% of their youth graduate from high school and 84% of these youth admitted either into college or into full-time, well-waged jobs (Sociedad Latina 2019).

Current progress and future projects with Sociedad continue this tradition. Through surveying students from over 500 public schools and partnering with Boston Public Schools, Sociedad Larina aspires to encourage more educational reform. With Massachusetts spending one third of the state's budget on education, Sociedad Latina, along with Boston superintendents, have worked together to formulate a better public-school system. Since data revealed that distance was a significant factor in poor attendance and, consequently poor grades, Sociedad Latina (2019) addressed key aspects including safety of location (avoiding heavy traffic areas) and convenience of location (where students are not too far from school) to create new schools. Progress in the health education program includes program plans for a bilingual nutritional education program for adults in the local community (Sociedad Latina 2019). Finally, plans for the workforce program include hospital internships in the Longwood Medical Area, entrepreneurship

training with business colleges, and continuing to help students get into college.

Sociedad Latina is a great example of a community-level intervention against health disparity. They address not only community-level risk factors but also all levels of the SEM. The civic engagement program reduces health disparity by improving health literacy, removing personal barriers, and pressing for action at the policy level. The workforce development program helps fight against health disparity by tackling the variable of income by preparing Hispanics for higher-paying jobs in which they are currently underrepresented. The education program helps to improve the other mentioned social determinant of health by helping students become more competitive for college. Research shows that higher life expectancy and better jobs (and thus higher income) are affected by one's educational level. Lastly, the art program promotes Hispanic culture and heritage. This program serves as a reminder to celebrate Latin American cultures and to showcase the importance of Hispanic youth in bringing attention to health inequities in communities where health disparities exist.

CONCLUSION

The Hispanic population reflects a great disparity in health and health care. The need for change is especially crucial for three reasons. First, the gap in socioeconomic status is increasing and is difficult to reduce, especially in a capitalist country. Thus, there will be increased disease burden, greater medical spending, and widened disparities (Woolf & Braveman 2011:6). Second, today's youth are the future's adults. They will grow up in a world of overly expensive health care, making them potentially the first generation in history to live shorter lives than their parents (Woolf & Bravema 2011:4). Third, the budgets and finances for these interventions that promote education and deliver opportunities for better employment are either facing budget cuts or vulnerable to complete elimination (Woolf & Braveman 2011:4).

In sum, disparities in the health of the Hispanic population are a multifaceted issue that requires considerable effort and strategic approaches like the SEM. The true limitation of both health and health care disparity interventions is not having the resources to address them at all. Nevertheless, this does not necessarily mean that society should abandon working toward positive changes. If anything, it is a sign that we need to work even harder, be more proactive about the health and health care opportunities of disadvantaged

and neglected minority groups. As a society the U. S. needs to strive to provide and improve both the access to, and the quality of, medical care for all its residents.

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