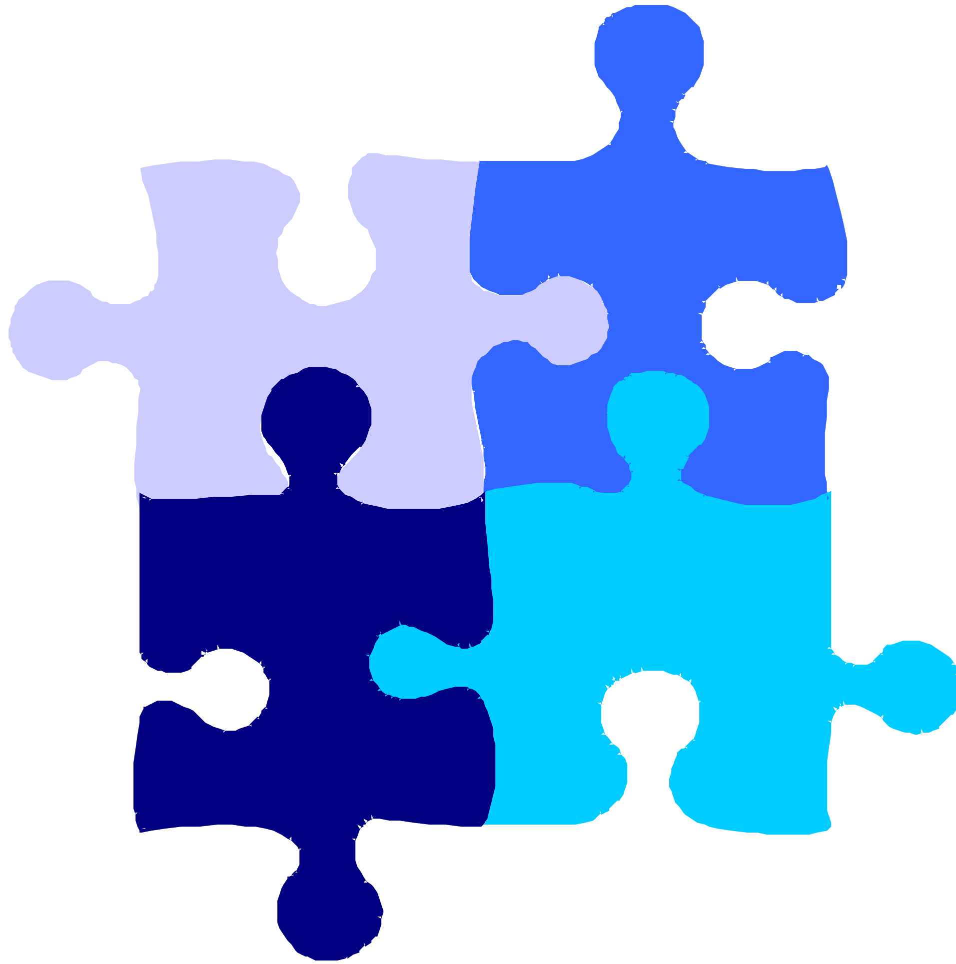

How Inequality Makes Us Sick: The Growing Disparities in Health and Health Care

Onondaga Citizens League 2007 Study Report Report No. 28

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PREFACE

For 30 years, the Onondaga Citizens League has represented an outstanding example of citizen participation in public affairs. Founded in 1978, OCL is an independent and not-for-profit organization that encourages citizen education and involvement in public issues. OCL's annual study, on a topic of community-wide relevance, culminates in a report designed to help citizens comprehend the issue and its implications, and give decision makers recommendations for action.

"*How Inequality Makes Us Sick: The Growing Disparities in Health and Health Care*" was one of OCL's most challenging study topics, but was also very timely. As the study report was readied for release in early 2008, the Robert Wood Johnson Foundation issued a report describing, in bleak detail, the extent of health disparities in this country, illustrating, as have previous studies, that a person's health is determined by more than medical care and heredity. With the issuance of the report, the Foundation also created the *Commission to Build a Healthier America* to find creative programs that lower the burden of ill health among the poor and middle class, who are generally much less healthy than those who are wealthier and better educated. At the same time, the Corporation for Public Broadcasting began broadcast of *Unnatural Causes*, a documentary series that makes it clear that a person's risk of becoming sick and dying prematurely are very much related to social factors such as income, education, and job and neighborhood environments.

While Onondaga County is plagued by many of the same disparities experienced around the country, our community also holds a number of exemplary, practical programs run by government agencies, community organizations and educational institutions. The study committee spoke with representatives of many, though by no means all, of the excellent groups trying to improve factors affecting health, and was inspired by their efforts. The results of the OCL study reflect the complexity of the issue, and the coordination of effort necessary to address it.

Recognition and appreciation are due to OCL Board member Betty DeFazio, who as study chair encouraged the study committee to persevere in understanding the complex, and sometimes overwhelming, topic of health disparities. Special thanks are extended, as always, to the individual and corporate members of OCL who support the work of the League through their membership dues and financial contributions, and to University College of Syracuse University, which provides the administrative and organizational support without which the Citizens League could not function.

Sandra Barrett
Executive Vice President

ACKNOWLEDGEMENTS

Health is something you usually don't think about when you have it. Yet, as this year's OCL study shows, far too often there are members of our community whose health is compromised by the disparities that exist in medical service access, the cultural competence of providers and in the availability of healthy food and exercise options. While racial and cultural biases account for some of the disparities, poverty is the factor that links almost all disparities.

To say this year's topic was huge is a "huge" understatement. The interconnectedness of issues is stunning to me. So is the effort that many government and non-profit healthcare and social service agencies are putting into trying to get people the care and services they need. Yet, much remains unsolved.

As our group pondered difficult questions, I got to know the resource and committee members better and appreciated the diverse perspectives they brought to the discussions. While many people served as resources, some served as steering committee members. I have great admiration and appreciation for Liz Crockett, Mary Jensen, Martha Ryan, Peter Sarver, Cynthia Stevenson, and Amanda Torre-Norton. Each of these individuals participated in steering the study, difficult though it was at times! This report is richer for their contributions.

We also appreciate the input of the contributors to the study, and our many panelists and expert presenters, and acknowledge the organizations that hosted our study sessions: Home Aides of Central New York, Inc.; Dunbar Association, Inc.; Syracuse Community Health Center, Inc.; SALUD, Inc.; and University College of Syracuse University.

Special appreciation goes to Sandra Barrett for helping guide us when we were overwhelmed by the enormity of the study topic. Her steady direction helped us stay on track and OCL is fortunate to have her leadership. Lastly, thank you to Cheryl Abrams, our study writer.

Acknowledgements would be incomplete, though, without pointing out that it was Mayra Urrutia who had recommended this topic to the OCL Board. Although she could not participate as she had planned, Mayra continued to push me to explore the impact of poor health and health inequalities on the minority members of our community. Her insights are woven into the final product.

We lose when our community members are not healthy. Kids cannot learn when they are too hungry to think clearly. Mothers cannot care for children if they are choosing between paying the rent or buying fresh vegetables. People cannot follow the doctor's "orders" if there is no doctor to see them or, even worse, if the doctor cannot give understandable directions. People cannot take advantage of helpful programs if they don't know about them.

In times like these, when economic factors drive many changes, it is important to remember that in order to have a vibrant, educated workforce, people must be healthy. That is why fixing health inequalities and disparities is crucial to citizens in Onondaga County, in New York State and in America. In fact, I believe our future depends upon it.

Betty DeFazio, Study Chair

EXECUTIVE SUMMARY

How Inequality Makes Us Sick: The Growing Disparities in Health and Health Care

SUMMARY

"The health of our people affects the overall health of our economy and our nation. While we must make health care delivery more efficient and broaden access to care, the medical system addresses only some of the factors influencing health. … There is more to health than health care."
Alice Rivlin, Ph.D., senior economist at the Brookings Institution and co-chair, Robert Wood Johnson Foundation Commission to Build a Healthier America.

Life expectancy and overall health have improved in recent years for most Americans, thanks in part to a focus on preventive medicine and dynamic new advances in technology. Not all Americans are benefiting equally, however, as compelling evidence shows that those in minority racial and ethnic groups experience many health problems at higher rates compared with the population as a whole.

In spite of the fact that the U.S. spends twice per person on medical care than other industrialized nations, we have worse health outcomes, lower life expectancy, and greater health inequalities. And the fact that our entire health care system is, by many standards, in crisis mode, exacerbates the problems of the poor, minorities and the middle classes, who are being squeezed by health care costs and who suffer from health disparities compared with their more affluent countrymen.

The public debate on health care focuses primarily on access and affordability. A growing number of studies, however, tell us that the economic, social, and physical environments in which we live are far greater determinants of health than whether or not we see a doctor. Society must tackle the interrelated issues of jobs and incomes, education levels, and quality neighborhoods to get at the root causes of disparities in health. At the same time, however, more must be done to ensure good medical care and health outcomes for all Americans, and while some of the solutions require state or national action, many begin here at home.

The Onondaga Citizens League dedicated its 2007 study toward examining the issue of health inequalities in health status, health outcomes and health care in Onondaga County in order to shed light on the issue, increase awareness locally, and spur additional dialogue and action to address health disparities.

CONCLUSIONS AND RECOMMENDATIONS

"Despite improvements in the overall health status of Americans, minorities continue to lag behind whites in health status and access to health care. Since the 2002 release of the Institute of Medicine report,* Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, a significant amount of analytic work has enhanced our understanding of the scope and causes of disparities in health and health care. It is now time to move beyond documenting disparities and to focus our efforts on actionable steps to eliminate them."
—Center for Health Care Strategies, Inc. Issue Brief, August 2007

The challenges surrounding health and health care disparities in Onondaga County are the same as those that many communities nationwide face. But the depth and complexity of the problems mean that rather than waiting for the "silver bullet" solution, we should be attacking the problem, forcefully, now, on many fronts.

Why Should We Care? Social disparities in health compromise the quality of life of individuals, and also jeopardize the economic health of the community, which depends on the health of all of its members. While the human and social consequences alone should drive the search for elimination of disparities, their economic costs and the potential savings from improved health outcomes are compelling reasons for political action and systematic changes at the federal, state and local levels.

What Can We Do and How Can We Do It? While there are still some gaps in the data used to measure disparities in health and healthcare and in our understanding of the causes of the disparities, many studies have enhanced our awareness of strategies necessary to address the documented gaps in care.

1. **We can guarantee access to preventive and primary medical care.** All Americans still don't have what citizens of every other industrialized nation in the world have: guaranteed access to basic services. With more than 45 million uninsured nationally, as individuals and organizations, we should press our governmental, professional and business leaders for a system of health insurance coverage that will reduce the financial gap in access to health care.

2. **We can collect and use specific and reliable data** on health and health care indicators by race, ethnicity, language, and neighborhood so that disparities can be better understood by the professional community, the lay public and those suffering these deprivations.

3. **Engage the broader community in these discussions** by promoting public dialogues on the inequities in health status, health outcomes and access to care.

4. **We can encourage all eligible recipients to take advantage of available health insurance programs and we can advocate for expanded eligibility**.

5. **We can forge new connections—**both formal and informal**—**between the individuals and agencies that serve populations affected by disparities. We can create incentives for these collaborations that will strengthen the new relationships.

6. **We can help consumers become partners in their own health care and teach consumers to be savvier** about their own health, about access to health care, and about what quality healthcare "looks like." We can improve our health literacy by enhancing "the user friendliness" of provider communications in verbal exchanges as well as in printed materials and other mediums.

7. **We can help providers to be more sensitive** to cultural differences and potential biases against patients from minority groups.

8. **We can be engaged in critical public health issues** such as improvements in nutrition, increased reductions in lead poisoning of children, eliminating tobacco use, HIV/AIDS prevention and expansion of recreational opportunities, especially for safe walking.

FINAL THOUGHTS

Good health comes from healthy lifestyles, good choices and a supporting environment. Good health care comes by delivering the right care at the right time in the right way. Neither will occur without deep, long-lasting transformational change in our systems, in our behaviors and in ourselves.
Robert Wood Johnson Foundation

The reduction of disparities in health and healthcare in our community will require the involvement of more than just healthcare providers. We all have a critical stake in making dramatic improvements in the inequalities that inhibit the full realization of wellness by so many in our midst. Only when we move beyond talk into concerted action will we see the benefits for everyone.

INTRODUCTION

"The success or failure of any government in the final analysis must be measured by the well-being of its citizens. Nothing can be more important to a state than its public health; the state's paramount concern should be the health of its people."
—Franklin Delano Roosevelt

Life expectancy and overall health have improved in recent years for most Americans, thanks in part to a focus on preventive medicine and dynamic new advances in technology. Not all Americans are benefiting equally, however, as compelling evidence shows that those in minority racial and ethnic groups experience many health problems at higher rates than the population as a whole.

Health disparities, or inequalities in health status, health outcomes and access to health care, have probably always existed, but it is difficult to comprehend why many of these same disparities continue to manifest themselves in the 21st century. In January 2008, the Department of Health and Human Services reported that national health spending, which has nearly doubled in the last 10 years, topped $2 trillion in 2006, an average of $7,200 a person. Yet, in spite of the fact that the U.S. spends double the amount per person on medical care compared to other industrialized nations, we have poorer health outcomes, lower life expectancy, and greater health inequalities. The fact that our health care system is, by many standards, in crisis mode, exacerbates the problems of the poor, minorities, and even the middle classes, who are being squeezed by health care costs and suffer from health disparities more than their affluent countrymen.

The Onondaga Citizens League dedicated its 2007 study toward examining the issue of health inequalities in health status, health outcomes and health care in Onondaga County[1] in

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[1] **Definition of Terms**

During the course of the 2007 study of health inequalities by the Onondaga Citizens League, certain definitions have guided the discussion.

Health Status
Health status is the current state of one's health. It includes the status of wellness, fitness, and any underlying diseases or injuries. Health status also includes such influencing factors as weight, nutrition, agility and flexibility or ability to move, smoking, alcohol consumption, or caffeine consumption. Compliance with prescribed medications, treatments, activity, diet, etc. affects one's health status.

Health Outcomes
An outcome is the result or consequence of an event, a disease, a drug, a treatment, etc., based on the diagnosis or problems presented. A health care team (which includes the patient) derives goals to treat an illness or injury, to prevent an illness or injury, or to promote wellness. The outcome is the result of the efforts put forth by all.

Health care
Health care refers to the delivery of assessment and/or treatment.

Health Inequalities

order to shed light on the issue, increase awareness locally, and spur additional dialogue and action to address health disparities that do, indeed, exist in our community.

The 2007 Study Committee was comprised of professionals who work in health care, social service and academic settings across Onondaga County. Their first-hand knowledge served significantly to inform the report and to identify those who could provide statistical data, cogent insight and personal testimony about heath inequalities in Onondaga County.

Six public sessions were organized with the purpose of gaining information about health inequalities from experts in their respective fields and, additionally, to gain perspective from caregivers and the general public. Further investigation occurred during committee meetings over the course of the year, when guest speakers were invited to focus on specific topics related to the study. Supplemental research was conducted by accessing various published reports and data accessible through the Internet.

National Perspective

"Reducing infant mortality rates and health disparities for our most vulnerable populations is a priority for any committed community."
—Rep. James Walsh (NY-25), May 13, 2005
(http://www.ongov.net/Press/articles/872.shtml)

National studies on health inequalities have led to several federal initiatives over the past three decades.

In 1979, the first set of national health targets was published in *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*. This agenda put forth as its primary goals to decrease mortality among infants, children, adolescents and young adults, and to increase independence among older adults.

In 1985 the Office of Minority Health (now called the Office of Minority Health and Health Disparities) was established within the United States Department of Health and Human Services as a result of the *Report of the Secretary's Task Force on Black and Minority Health,* which revealed large and persistent gaps in health status among Americans of different racial and ethnic groups. The Centers for Disease Control and Prevention (CDC) created its own Office of Minority Health (OMH) in 1988 in response to the same report. Congress passed the "Disadvantaged Minority Health Act of 1990" in order to improve the health status of underserved populations, including racial and ethnic minorities.

"A population is a health disparity population if there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality or survival rates in the population as compared to the health status of the general population."
Minority Health and Health Disparities Research and Education Act
United States Public Law 106-525 (2000), p. 2498

In 1990, *Healthy People 2000* was released, putting forth a comprehensive agenda with three overarching goals for the nation: 1) to increase the years of healthy life for Americans; 2) to reduce health disparities among Americans; and 3) to achieve access to preventive services for all Americans.

A nationwide health promotion and disease prevention agenda, *Healthy People 2010*, was launched by the Department of Health and Human Services in January 2000. The initiative builds upon prior programs with the primary goals of increasing the quality and years of healthy life and eliminating health disparities, or inequalities. These goals recognize that we are growing older as a nation and that our population is growing more diverse.

The second goal of *Healthy People 2010* is to eliminate health disparities among different segments of the population that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation. Compelling evidence indicates that race and ethnicity correlate with persistent, and often increasing, health disparities among U.S. populations in all these categories. This demands national attention. The Healthy People initiative is dedicated to the principle that, regardless of differences among populations, every person in every community across the nation deserves equal access to comprehensive, culturally competent, community-based health care systems that are committed to serving the needs of the individual and promoting community health.

Racial and Ethnic Approaches to Community Health (REACH) 2010 is a cornerstone of the CDC's efforts to eliminate racial and ethnic disparities in health. Launched in 1999, REACH 2010 is designed to eliminate disparities in six priority areas in which racial and ethnic minorities experience serious disparities in health access and outcomes: 1) infant mortality; 2) deficits in breast and cervical cancer screening and management; 3) cardiovascular disease; 4) diabetes; 5) HIV infections/AIDS; and 6) child and adult immunizations.

New York State Perspective

"Ensuring all children have health insurance is one of the Governor's highest priorities. Insurance coverage increases a child's ability to grow up healthy and learn in school."
- NYS Council on Children and Families Children's Cabinet

New York State is ranked first in the nation in Medicaid spending per capita − more than twice the national average. New York's Medicaid budget costs taxpayers more than $45 billion each year, with more money going to hospitals and nursing homes than any state in the country. In spite of a generous range of benefits that comprises Medicaid expenditures, New York has a higher percentage of deaths due to chronic disease than any other state in the nation. New York's nursing homes rank among the nation's worst in citations for placing their residents at immediate risk for serious injury or death. Statewide, one in every twelve of our children is afflicted with asthma, and more than one in five is obese.

With a range of benefits offered to New York State residents who use Medicaid, one must ask why those covered by the program still experience disparities in health status. A Minority Health Surveillance Report released in September 2007 by the NYS Department of Health shows progress in reducing minority health disparities for certain diseases and access to care.

But minorities continue to experience lower health status when measured against other groups and the population as a whole. "Although some gains have been made, racial and ethnic minorities continue to experience a disproportionate burden of disease," said New York State Health Commissioner Richard F. Daines, M.D, at a meeting in the fall of 2007 with the New York State Minority Health Council in New York City. "People of color continue to have dramatically higher rates of HIV infection, Hispanics have a higher incidence of diabetes deaths, and African-Americans have higher rates of death from cancer."

To assist the Health Department in helping to reduce disparities, Dr. Daines asked the Council for assistance in three primary areas: getting more minorities who are eligible for public health insurance programs to enroll; examining how health care reimbursement formulas can be changed to encourage and reward greater delivery of primary and preventive care; and developing incentives for more minorities to become physicians in order to increase minority access to culturally and linguistically appropriate health care.

In New York State, 2.6 million residents, including 400,000 children, are uninsured. In July 2007, the health commissioner and insurance superintendent were directed to develop "a comprehensive strategy for universal health insurance for New York State…that ensures access to affordable, high-quality medical care for every single New Yorker." The initiative is called "Partnership for Coverage." Hearings on the subject were held across the state in 2007.

Local Perspective

"People of faith are tired of waiting for things to change."
—Linda Ervin, program coordinator for the Alliance of Communities Transforming Syracuse Community rally, Sunday, November 18, 2007

Onondaga County, located in the heart of New York State, has a land area of 793.5 square miles and approximately 35 miles in length and 30 miles in width. The 2000 U.S. Census showed a population of 458,336 for Onondaga County, which included a population of 147,306 for the city of Syracuse, situated in the approximate center of the county. Included in these population figures, 15.3 percent are members of a minority in the county overall, with a 35.7 percent minority population within the city.

In Onondaga County, selected socioeconomic indicators by race reveal significant inequities between white and black citizens.

According to statistics provided by Cynthia Morrow, M.D., commissioner of health for Onondaga County, 36.4 percent of blacks lived in poverty in Onondaga County in 1999, compared with just 8.5 percent of whites. For that same year, 9.5 percent of white females and 37.7 percent of black females lived in poverty. Similarly, those under age 17 living in poverty in 1999 totaled 9.5 percent, while 43.5 percent of black children lived in poverty.

For the years 2001 through 2005, education and employment among whites and blacks further reflected disparities among the county's population. Among those 25 and over, not having a high school diploma, the rate among blacks was two and a half times that of whites,

31 percent versus 12.4 percent. Unemployment statistics also showed a three-times-higher rate for black men and women: 16.5 percent of the black male population was unemployed, compared to just 5 percent of white males. Just 4 percent of white females were unemployed, while 12.2 percent of black women did not have jobs.

The area seems well poised to deliver high-quality care to its citizens, through five major hospitals in Onondaga County: Upstate Medical University, part of the State University of New York system; Crouse Hospital; St. Joseph's Hospital Health Center; Community General Hospital; and the Veterans Administration Hospital. A county nursing home, Van Duyn Home and Hospital, and a number of private long-term care facilities are also located in the area.
Yet many members of the local health care and social services fields, along with various citizen coalitions, assert that the same health inequities that exist in the United States also plague our local health care system.

The 2007 OCL Study Committee assembled a number of health care stakeholders from across the area to gain a perspective on health inequalities in Onondaga County, with the findings comprising this report.

FINDINGS

"In health there is freedom. Health is the first of all liberties."
—Henri Frederic Amiel, Swiss author

Barriers to Health Care

Health inequalities exist for many complex reasons, including barriers to health care due to financial, cultural, and other issues of access to services.

Financial Barriers

For the majority of citizens in the middle and upper classes, a medical insurance card is wedged comfortably in wallets between charge cards and driver's licenses. This sliver of plastic offers not just a *sense* of protection, but *real access*—ideally, easy and affordable—to doctors, nurses, specialists, tests, procedures, treatments and cures.

There are two other main segments of the population, however, for which medical access based on finances is not so effortless: those who rely on the Medicaid system and those considered "working poor"— those who are employed but do not receive employer-provided health benefits but make too much in wages to qualify for Medicaid assistance.

The segment of the county's population living in poverty increased steadily from 2001 through 2005, according to Onondaga County health indicator profile statistics from the New York State Department of Health. In 2001, 10.9 percent of county residents lived in poverty. The percentage rose to 11 percent in 2002; 12.1 percent in 2003; 12 percent in 2004; and 13.4 percent—59,463 people—in 2005.

Insurance status often determines whether people receive the preventive care, early diagnosis and treatment that mean the difference between wellness and disease, survival and death. Indeed, the American Cancer Society, in an unprecedented move, is using a portion of its advertising budget this year to advocate for increased access to care.

Medicaid and Other Social Security Insurance Programs

Medicaid is the country's primary health insurance program for low-income individuals and people with disabilities. Medicaid is funded jointly by the federal, state and county governments. Eligibility is determined by income. According to Michael Wasylenko, professor of economics and senior associate dean at Syracuse University's Maxwell School, 57 million Americans are enrolled in the Medicaid system. Children from low-income households and their parents comprise 75 percent of the enrollees and account for 30 percent of Medicaid costs. The other 70 percent of Medicaid costs are attributed to care for those who are disabled or elderly.

Steve Morgan, executive deputy director of Social Services for Onondaga County, describes Medicaid as an array of "approximately 15 different programs" for which people may be eligible. According to figures Morgan provided, Onondaga County incurred close to $565 million in Medicaid expenses in 2006, of which $90 million was paid for locally.

Most Medicaid recipients are in managed care, and for those in the SSI program, a mandatory enrollment process in managed care was recently started. Morgan says that managed care for any population will increase the coordination of their care, resulting in better health outcomes at a potentially reduced cost to those who pay for it.

As part of New York State's "Partnership for Coverage" initiatives, a concerted effort to enroll individuals in the Medicaid program is being conducted state wide. Facilitated enrollers are working closely with local agencies to make certain those eligible for benefits receive them and gain access to health care services. According to the Onondaga County Department of Health, 7,700 children in the county are enrolled in Child Health Plus, while another 7,500 children in the county are eligible but not enrolled.

Enrolling those who are eligible for Medicaid and children's health insurance programs is a good first step, but questions loom regarding county and state medical infrastructure for providing care. Fewer and fewer physicians accept those with Medicaid coverage and few health care providers in the county provide chemotherapy for Medicaid patients. Providers are under no legal obligation to accept Medicaid patients, and low reimbursement rates and excess paperwork, give them little incentive to do so.

A study released by the American Cancer Society in the March 2008 issue of *The Lancet Oncology* found a consistent relationship between insurance coverage and the stage at which cancer was diagnosed. According to researchers from the American

Cancer Society, people who have no health insurance, or rely on Medicaid, are more likely to be diagnosed with advanced cancers than people who have private health insurance. The study used the National Cancer Database, which includes data from 1,430 medical facilities and information on 73 percent of cancer patients in the U.S. who were diagnosed with any of 12 cancers between 1998 and 2004.

The Working Poor and Middle Class Squeeze

Tucked into the north side of Syracuse is the Poverello Clinic, which, since opening in March 2000, provides free health care services to the uninsured. The Poverello Clinic, a part of the Franciscan Collective Ministry, is staffed by Sister James Peter, Sister Dolores Bush, 18 physicians, four nurse practitioners and about 20 nurses from the community who provide volunteer coverage on an alternating basis. Dr. Suzanne LaManna is to be recognized for her role in the inception of the clinic. Until recently, Poverello was the only free general medicine clinic in Central New York; the nearest other free clinic was in Rochester. A second clinic, the Amaus Clinic, opened in late 2007 at the Cathedral of the Immaculate Conception in downtown Syracuse. A third free clinic, the Salt City Hope Clinic, specifically for homeless individuals, is open in the John H. Mulroy Civic Center on Wednesday evenings. The Salt City Clinic is staffed by physicians and medical students from Upstate Medical University, also on a volunteer basis.

Along with the health care providers at Poverello, social work counselors volunteer to see patients during the clinic hours, Mondays for a two-hour shift, and Wednesdays for the majority of the day, depending on the availability of the volunteers. Medications are donated by physicians and drug companies and by the Dames and Knights of Malta, a Catholic organization that purchases generic drugs for Poverello.

According to Sister James Peter, Poverello's client base has steadily increased since it was founded. In years one to four, it served about 600 people; in years five to present, it has grown to between 1,400 and 1,600 clients. Considering the initial volume in the first two months of 2008, it is anticipated that the volume will exceed 2,400 clients this year.

Clients include people who work, but who are not covered by an employer-offered health insurance plan. Typically these clients work for minimum wage and, while they make too much to qualify for Medicaid, cannot afford to purchase health insurance on their own.

According to Sr. James Peter, the clinic sees clients primarily for acute health concerns, for complications of chronic disease, employment and school physicals. Whenever a child presents to the clinic, the support staff attempt to enroll the child in Child Health Plus, if they do not qualify for Medicaid. Many of those who come to Poverello have social, mental and or emotional issues and are frequently referred to Dorothy Day House and/or Vera House for additional services, as well as to CPEP (Comprehensive Psychiatric Emergency Program), a licensed psychiatric emergency room at St. Joseph's Hospital.

The continuity of care in their patient base is "very frustrating," says Sister James Peter. Many of those who seek care at Poverello suffer from chronic diseases − primarily diabetes, hypertension and obstructive pulmonary disease, which are not being managed properly because of the financial barriers to care. Referrals to internists and specialists are difficult because most clients have no insurance and cannot pay for services. Staff always encourages those they see to re-apply for Medicaid in the hope they will qualify for assistance. Additionally, because prescription drug costs are so high, people who are uninsured or underinsured cannot access medications they may need to appropriately manage or treat their conditions.

Such problems once existed only for those unemployed or those holding low-income, minimum wage positions. Today people who would be considered middle class are feeling the pinch as much as ever, particularly single-parent families. With wages that often do not keep up with the rising cost of living and health insurance premiums, particularly for family coverage, many people opt out of employee plans because the cost is prohibitive.

Of the 47 million uninsured people in the United States, 7.3 million come from families with incomes of $75,000 or more, and an additional 6.9 million earn between $50,000 and $75,000, according to 2006 U.S. census estimates.

Cultural, Language and Literacy Barriers

As people from other countries and cultures comprise more of the Unites States' population, there has been an increased awareness and real need in the medical community for "cultural competency," that is, incorporating a patient's language, culture of origin, religious traditions, literacy, and comprehension levels when providing care.

SALUD: Syracuse Area Latinos United Against Disparities

SALUD means health in Spanish. Locally, SALUD, or Syracuse Area Latinos United against Disparities, is serving a special niche in our community. After completing a community needs assessment in 2004, Mayra Urrutia found her suspicions about disparities in health care for communities of color and those living in poverty were well founded. Using the Healthy People 2010 initiative, in August 2007, she opened SALUD to address those disparities.

SALUD's focus is on prevention, education, outreach, case management and referrals in order to secure better health outcomes. Although the small agency finds itself serving many Latinos, a diverse population is using the organization.

Today, SALUD is available to help people navigate a difficult health care system. According to Mrs. Urrutia, President and CEO of SALUD, more than 200 cases are open already. SALUD is helping individuals with preparing for a medical appointment and formulating questions to ask during the visit; completing applications for public insurance programs, especially for those living in poverty; serving as a language interpreter during the medical visit; acting as a patient advocate; learning why treatment compliance for a range of chronic illnesses such as diabetes, hypertension, etc. is important; seeking out services like dental care; and ultimately, advocating for systems change to eliminate health care disparities.

While disparities in health care and health outcomes are a significant problem for African-Americans, Mayra notes the impact on Latinos is even greater. Latinos living in poverty frequently encounter language barriers in accessing health care which adds a burden not usually shared by African-Americans. Further, she cites statistics that indicate higher rates of HIV infection in Latinos coupled with poor HIV testing rates, which creates a vicious cycle. Plus, even higher school drop-out rates among Latino youth add to frustrating literacy issues which, in turn, impact an individual's compliance with treatment.

Although SALUD is doing what it can to address health care disparities locally, it has just begun to scratch the surface of what remains to be done.

A landmark study published by the Institute of Medicine in 2002, *Unequal Treatment: What Health Care Providers Need to Know About Racial and Ethnic Disparities in Heathcare*, uncovered behavioral differences among racial groups when seeking health care, as well as instances of varying treatment on the part of providers who were not aware of their own racial and cultural biases. This same study concluded that all current and future health professionals can benefit from cross-cultural education.

Those from one race or culture may view health care providers of other races or cultures as "outsiders." Anything that interferes with building trust and goodwill may also prevent care at any level from occurring. As an example, on a national level, Gregory Threatte, M.D., from Upstate Medical University, points to the "Tuskagee Incident" as a major basis for a lack of trust in the American health care system among blacks. In 1972, a journalist uncovered that the U.S. Public Health Service continued to conduct a study, begun in 1932, in Tuskegee, Alabama, on the course of syphilis in untreated African-American men and chose not to provide penicillin to study participants. A more racially and culturally diverse population of health care providers may help to build trust and confidence among minority patients.

On the local level, Luis Castro, M.D., medical director of St. Joseph Hospital's Westside Family Health Center, points to cultural competent care as a cornerstone of the success the center has had in reducing the number of infant deaths and difficult deliveries. In Le Moyne College's physician assistant program, cultural competencies and disparities are addressed, with the goal of developing professionals who are aware of these issues. Recently, Crouse Hospital School of Nursing offered a cultural competency training forum with nationally-known expert Larry Purnell, Ph.D., R.N., F.A.A.N., as its keynote speaker.

Onondaga County Department of Social Services Commissioner David Sutkowy says the social services department continually assesses whether they are able to reach all the populations in the county. To communicate with those for whom the department has no translator, they use the Verizon Translator Program that covers about 200 world languages. To reach out to those with physical disabilities, they use videoconferencing when necessary.

Access to Health Care

One prevalent obstacle to care for those using Medicaid is that fewer and fewer physicians accept those on this health assistance plan. Commissioner David Sutkowy believes moving into managed care and issuing cards that do not identify someone as a Medicaid recipient may help level the playing field and reduce disparities. While there are no statistics to prove this, Commissioner Sutkowy observes that access has improved locally and that there is better access to care now than nine or ten years ago. In some instances, particularly certain specialties, improved access is not necessarily the case. According to Martha Ryan from the American Cancer Society, there are few health care providers in the county who accept chemotherapy patients on Medicaid, and access to primary care physicians and dentists is challenging.

It's Time to Curb Medical Arrogance

Beyond cultural and racial awareness is the need for the medical profession to take into account patients' literacy levels and abilities for comprehension in written and verbal communications. In an October 28, 2007 op-ed piece in The Post-Standard*, Crouse Hospital President and CEO Paul Kronenberg, M.D., wrote, "There is a term I have used in my years of practicing medicine, and in particular, since I became CEO of Crouse, and that is "medical arrogance." As clinicians, we know what is best for you. Listen to what we say. And don't ask too many questions. This has been a prevailing attitude for years in health care. It needs to change."*

Providers are under no legal obligation to accept Medicaid patients. Local experts agree that reasons include the inordinate amount of paperwork that needs to be completed; high no-show rates for Medicaid patients (although due to legitimate reasons); and the fact that physicians are not reimbursed at what is considered an acceptable rate. Doctors report they continue to lose money by caring for Medicaid patients.
Another barrier to care is the shortage of primary care providers in our region—particularly in rural communities. According to Tom Dennison, of the Maxwell School at Syracuse University, one of the major impacts of quality, managed care has been the shift from primary care practices to high-tech specialties. He says that there has been a huge drop in the number of residents opting into primary care, which weakens the system's ability to provide care at a basic level. A recent *New York Times* article (July 23, 2007, "Few Young Doctors Step in as Upstate Population Ages") highlighted the problem.

Last spring, Senator Charles Schumer introduced bipartisan legislation aimed at directing $200 million in federal funds toward physician recruitment efforts, citing the aging of upstate physicians, the loss of graduating doctors to others areas of the state and country and the increasing population of the elderly, who use the most in health care consumption. The Physician Shortage Elimination Act of 2007 was introduced; it has not been voted on as of late 2007.

In January 2008, the "Doctors Across New York" program, in recognition of this critical issue, was announced. More than one-quarter of the state's population lives in areas designated as "underserved" by proper health care providers; more than 300 physicians are needed just to meet their primary care needs. The Executive Budget proposes programs to provide grants and enhanced reimbursement rates to physicians and clinics with the goal of encouraging new primary care and specialist physicians to practice in rural and inner-city underserved communities.

Upstate Medical University's Rural Medical Education Program pairs medical students with physicians in rural communities to help ease the provider burden in these areas across New York State. Statistics show that 50 percent of resident physicians leave New York after completing their training. To help stem that flow, specifically in Syracuse, the Onondaga County Medical Society and SUNY Upstate's Medical Alumni Association announced in late February 2008 a scholarship for graduates of Onondaga County high schools who will begin medical school at Upstate in the fall 2008. The scholar award could increase if its recipient promises to practice medicine in the Syracuse area.

Another barrier significant to health care access is the issue of transportation. Health care and social service providers reference the high no-show appointment rate of those using Medicaid. When one relies solely on public transportation or on others for rides, life can be tenuous in terms of timeframes. What can be a short 20-minute drive from home to a doctor for one person can be a two-hour ordeal involving multiple bus connections for another. Liz Crockett, Ph.D., director of REACH CNY (formerly know as Family Ties Network), suggests that physicians and clinics need to be understanding and use flexible appointment scheduling to accommodate patients who have transportation issues.

Maternal and Child Health

"Unforgivable."
—Richard Aubry, M.D., describing the public response to the historical and current health inequalities in Onondaga County in the area of maternal and child health.

After 45 years of working in our region toward the improvement of pregnancy outcomes, Dr. Aubry should know. He currently serves as a professor in the Department of Obstetrics and Gynecology at Upstate Medical University, as the director of the Central New York Regional Perinatal Program and Data System and as the medical director of the Center for Maternal and Child Health at Upstate.

In 1987, Aubry left his practice in Central New York to pursue a master's degree in public health at Harvard University, concentrating his studies on maternal and child health. While he possessed a great deal of medical knowledge and skills, he wanted to acquire additional educational, sociological, and statistical tools that would equip him to make a difference in an area that lays important groundwork for a newborn's life.

Today, in spite of his enduring passion and tireless efforts, the work of his colleagues, the well-intentioned initiatives of private and public agencies, many academic and statistical studies and public education endeavors, Aubry is somber when he reflects upon the actual progress achieved in pregnancy outcomes.

Citing statistics that likewise reflect those from across the nation, Aubry states that here in Onondaga County, serious disparities still exist between white mothers and non-white mothers and their newborns.

Data for early prenatal care, a major determinant in the future health of a child, shows that 87.8 percent of white mothers to be receive such care, while only 68.2 percent of black mothers do. A low birth weight outcome is often the result of a mother's poor health habits while she is pregnant. In Onondaga County, there are twice as many low birth weight (less than 2,500 grams) black infants born than white babies—7.0 percent versus 13.2 percent.

What can be done about such inequalities? According to Aubry, overall improvement in women's health care. Not just when a woman becomes pregnant, but improved preconception care. He also says that all local OB/GYN physicians should adhere to recommendations put forth by the American College of Obstetricians and Gynecologists (ACOG) to end women's health care inequalities. Among their eight suggestions are advocating for increased public awareness of preventive care and screenings and intervention; recruiting minorities to the health professions; improving cultural competency in the physician-patient relationship; and using best practice guidelines for care to reduce unintended variations in outcomes by gender, race and ethnicity. Finally, Aubry agrees with the ACOG that the most significant step in reducing health care inequalities is universal health insurance for all Americans.

Successful Programs

Syracuse Healthy Start, a program of the Onondaga County Health Department, celebrated its 10th anniversary in 2007. According to program director Kathleen Coughlin, M.P.A., Syracuse Healthy Start was established to reduce the disparity in infant mortality rates between black and white infants in Syracuse. Since 1987, the overall infant mortality rate in the city has been cut in half. (In 2006-2007 the overall infant mortality rate in the city was 8.1 per 1,000). The disparity between black and white infant mortality rates has decreased, but has not yet been eliminated. Syracuse Healthy Start promotes healthy pregnancies and healthy babies through community partnerships, community referrals, health education, and case management. The program also offers professional education to health care and human service providers in best practices for caring for pregnant women and infants, and targets the public with key messages to promote healthy pregnancy and parenting.

For the past nine years, St. Joseph's Hospital's Westside Family Health Center, at 216 Seymour Street, has been trying to educate its patients and improve health outcomes. The center's medical director is Luis Castro, M.D., who describes himself as a family physician whose practice includes obstetrics and gynecological health. The center's patient base is 60 to 70 percent Latino.

Castro and his staff started a "Pregnancy Club," which meets each Monday at the center. The members have a group visit with Castro, as well as a nutritionist, lactation consultant, and social worker. Equally important, says the doctor, is the knowledge sharing and empathizing that occurs among the women each week.

According to Castro, the Westside Family Health Center has shown, according to Dr. Castro, a decrease in low birth weight babies and fetal deaths and an increase in healthy deliveries. He credits this success to the Pregnancy Club and the fact that women receive care at an earlier stage of pregnancy. He also cites the culturally-competent care his patients receive at the center, which increases patient trust in the caregivers and, therefore, increases participation in receiving treatment and investing in their own care.

LANGUAGE BARRIERS

Luis Castro, M.D., medical director of St. Joseph's Hospital's Westside Family Health Center, tells a true story that illustrates the degree of trust that can exist between health care providers and patients when both are of the same culture.

The mother of a child having a severe asthma attack passed two hospitals on the way to Castro's center. The reason: She thought it would take too long to explain her child's problem because she didn't speak English.

Nutrition

Medication or Food

No dessert until you're done with dinner. Clean your plate. Eat your veggies. These incantations can be heard in the homes of many across Onondaga County each evening. We may have even invoked them ourselves at the supper table just last night.

Yet for many others in our area, there are no after-meal treats (or dessert-type foods *are* the meal),

cupboards are empty and, because local convenience stores in urban neighborhoods often do not stock fresh fruit and vegetables, they are not readily accessible.

The fact that hunger exists in our community is probably not a surprise to most. We see Food Bank commercials on TV, drop canned goods in collection barrels at work or church and see the appeals for cash donations at registers in major grocery stores to benefit agencies serving the needy.

Beyond the simplistic equation that people are hungry because they are poor is a complicated set of issues relating to health inequalities that arise from the lack of access to a nutritionally balanced diet on a regular basis.

In Central New York, 21 percent of the population is faced with the decision of whether to purchase food or purchase medication, according to Liz Campbell of the Food Bank of Central New York. She and her colleagues help the people who are faced with making these choices daily, and Campbell wonders if the hunger statistics might be lowered by a more proactive community-wide initiative in this area.

The goal of America's "Second Harvest" is to "feed people well." The Food Bank of Central New York is a part of the Second Harvest national network, and is also committed to not just providing access to food, but to sound, nutritional foods.

Hunger-Obesity-Disease Cycle

Good nutrition has been shown to have a profound effect on positive health outcomes. Closely related is the dramatic increase in the United States of obesity, directly linked to many chronic conditions including type 2 diabetes. Roberto Izquierdo, M.D., is the associate medical director of Upstate Medical University's Joslin Diabetes Center in Syracuse. He states that projections show diabetes may increase in this country from 18 million cases in 2000 to 30 million by 2030. Izquierdo and his colleagues are observing 'epidemic' increases in rates of type 2 diabetes mellitus diagnosed in children under 18 years of age—across the country and right here in our community.

Hunger and obesity are closely intertwined due to three main reasons, according to Campbell. About 11 percent of Americans, according to a recent National Health and Nutrition Exam Survey, are "food insecure," meaning that they literally do not know where their next meal is coming from. A "feast or famine" phenomenon often occurs when food insecure individuals finally have access to food and then over-consume calories.

Food insecure and/or economically disadvantaged households often find that the most accessible foods are high calorie, low-nutrient foods. Mapping studies conducted by Community geographer Jonnell Allen of Syracuse University, show that few stores within low-income neighborhoods in Syracuse stock fresh fruits and vegetables. On the other hand, access to candy, soda and fast foods in the neighborhoods is high. Lack of exercise also contributes to obesity. In Onondaga County, economically disadvantaged families, including many minority families, live in higher-crime neighborhoods where it is less safe for children and adults to walk or play outside.

Robert Izquierdo, M.D., summarizes the problem of poor nutrition by saying that there are many barriers to proper prevention and care, including lack of availability to facilities for exercise and unsafe streets for walking; lack of access to healthy food in lower-income neighborhoods; lack of family support; and lack of education about making better food choices.

Central New York Nutrition Programs

Dunbar Center Food Pantry
One community resource is the Food Pantry at the Dunbar Association, located on South State Street. Dwight Rhodes, director for Family and Community Services at the center, says the pantry serves an urban area with a high poverty index, a high rate of unemployment and a high rate of violence. Lack of education and literacy are major issues, says Rhodes, stating that a high percentage of those in the surrounding neighborhood are food insecure. The Dunbar pantry provides non-perishable items five days a week from 9:30 a.m. to 12:30 p.m. On the second Tuesday of each month, fresh foods, including vegetables, salads, fruits, dairy products and bread, are available. Dunbar would offer fresh foods more often if they had adequate storage.
Each month, more than 240 people rely on the Dunbar pantry for food supplies that come from FEMA, the Interreligious Food Consortium and the Food Bank. Rhodes says it feels good to help, but in this pocket of the community where people have so little, so much more could be done.

Food Bank of CNY’s Self-Sufficiency Efforts
According to Liz Campbell, the Food Bank has initiated a number of programs that do more than just feed people, but help people gain greater access to fresh, unprocessed foods. For example, they do not accept candy and soda as donations. They have created the Garden in a Bucket program, which teaches people how to grow their own food and allows food stamps to be used to purchase plants and seeds. The Food Bank distributes 450 cases of produce a month to emergency food programs, and community gardens have been established at three local sites. In addition, farmer’s markets are being placed outside WIC facilities in the county.

Kids Win
Starting them early is the philosophy of a new program of Catholic Charities called Kids Win. The premise is to educate children ages 5 through 18 about healthy eating. The program serves 250 to 280 children, with more in the summer, and helps them make meals with foods most readily available to them. Kids Win also has ten community gardens throughout the city, where they teach children how to grow vegetables and preserve them for later use.

Good News about Vitamin D
Susan Brown, Ph.D., is a medical anthropologist and certified nutritionist who leads the Osteoporosis Education Project. Citing national studies, Brown advocates for the distribution of Vitamin D, which studies show helps decrease the incidence of osteoporosis, cancer and other chronic diseases, particularly among dark-skinned individuals and those who live in northern climates.

Chronic Disease

According to the Centers for Disease Control and Prevention (CDC), seven of every 10 Americans who die each year, or more than 1.7 million people, die of a chronic disease. Today, chronic diseases—such as cardiovascular disease (primarily heart disease and stroke), cancer, and diabetes—are among the most prevalent, costly and preventable of all health problems.

The 2007 OCL Study Committee invited several key local health providers to a public session to examine health inequalities in Onondaga County among those with chronic diseases. Panelists during the May 3, 2007 session were Cynthia Morrow, M.D., M.P.H., Commissioner of the Onondaga County Health Department; Sherry Tomasky, regional advocacy director for the American Cancer Society; and Roberto Izquierdo, M.D., associate professor of Medicine and Pediatrics and section chief, Pediatric Endocrine and Diabetes at SUNY Upstate Medical University and Associate Medical director of the Joslin Diabetes Center in Syracuse.

Predictors of Chronic Diseases

Cynthia Morrow, M.D., referenced a 2004 report that showed that socio-economic status—lower levels of education, employment, and income, as well as living in unsafe neighborhoods—are associated with poorer health outcomes and shorter life expectancy. In the U.S., she pointed out, poverty and minority status are intertwined.

Although socioeconomic status is a bigger predictor of low health outcomes than are racial determinants, according to Morrow, there is more health data available based on race/ethnicity than on education and income. Morrow stated that hundreds of studies focus on racial/ethnic disparities in health outcomes, with a fewer number focusing on social disparities in health outcomes.

Morrow referred to evidence that the health care delivery system in the U.S. contributes to health inequalities, based on the "Unequal Treatment" study by the Institute of Medicine in 2002 (referenced on page 9). That study concluded minorities are less likely to receive needed services, including procedures and pharmaceuticals. Cultural and attitudinal differences in acceptance of interventions cannot fully explain the differences in health care received.

Infant Mortality

Often considered a key indictor of health status, infant mortality rates in Onondaga County are above the state and national averages. From 2003 to 2005, infant deaths per 1,000 live births were 5.6 for whites, while the rate reached 15.9 for black infants. Data presented from 1985 through 2005 show that for the past 20 years, infant mortality rates for blacks have been consistently higher than for whites. The highest disparity was during the 1994-1996 time period, when more than 25 in 1,000 black infants did not survive, versus about 6 in 1,000 white infants.

From 2003 to 2005 in Onondaga County, the rates for both races have decreased, though the black infant mortality rate remains higher than that of whites. These statistics mirror those of the CDC, whose national figures from 1980 to 2000 show that although infant mortality has decreased among all races during the past two decades, the overall black-white gap for infant mortality has widened. One of the *Healthy People 2010* national objectives for maternal and infant health is to reduce deaths among infants aged less than one year to less than 4.5 per 1,000 live births among all racial/ethnic groups.

Adult Mortality

Residents of Onondaga County can expect to live, on average, slightly longer than their fellow citizens across the United States. Still, data reveals significant inequalities among the life expectancy rates of white and black males and females in our region and in the U.S.

Statistics presented by Morrow, Health Commission, from 2000 to 2002 for Life Expectancy at Birth by Sex for Selected Races compares Onondaga County rates to national rates, as follows:

	Onondaga County	Unites States
White Females	81.1 years	80.0 years
Black Females	75.0 years	74.9 years
White Males	76.5 years	74.8 years
Black Males	69.0 years	68.2 years

In the U.S. 2002 Mortality Data report, the three out of 10 leading causes of death are the same for whites and blacks: heart disease, cancer and stroke. Among the top 10 causes, HIV and homicide are attributed to black mortality and not that of whites, while influenza/pneumonia, Alzheimer's disease and suicide are among the top 10 causes for whites, but not blacks.

Cancer in Onondaga County

Cancer Statistics

The leading cause of death among all races, male and female, in the United States is heart disease, followed closely by cancer. The leading cause of death in Onondaga County, according to county data for the years 2001-2005, is cancer.

Disparities between blacks and whites who have incidences of cancer and those who die from the disease can be gleaned through data from the New York State Department of Health's Cancer Registry, 2000 through 2004. The greatest disparity has to do with statistics for prostate cancer: The incidence rate for black males is 59.1 percent higher than for white males, while the mortality rate for black males is 231 percent higher than for white males. Breast cancer is, again, more problematic for blacks: The incidence rate for black females is 31.73 percent lower than the incidence rate for white females, yet the mortality rate for black females is 18 percent higher than for white females.

Colorectal cancer statistics also shows a disparity: The incidence rate for black males is 6.89 percent greater than the incidence for white males, while the mortality for black males is 18.78 percent higher than that of white males. The incidence rate for black and white females is virtually identical, but the mortality rate for black females is 16.86 percent higher than for white females.

Lung and bronchus cancers affect black men as follows: The incidence rate among black males is 16.31 percent higher than those of white males, while the mortality rate among black males is 24.01 percent higher than for white males.

The only area in which blacks fare better than whites is in the stats for lung and bronchus cancers for women: The incidence rate for black females is 22.71 percent less than for white females, and the mortality rate among black females is 15.06 percent less than for white females.

Tobacco: The Leading Cause of Preventable Death

Tobacco remains the leading preventable cause of death and disease in the United States, responsible for more than 400,000 premature deaths each year. In 2000 alone, about 4.8 million smoking-related premature deaths occurred worldwide. Half of all Americans who continue to smoke will die from smoking-related diseases. In the U.S., tobacco use is responsible for nearly one in five deaths. In addition, an estimated 8.6 million people suffer from smoking-related chronic conditions, bronchitis, emphysema and other cardiovascular diseases.

- *Smoking accounts for at least 30 percent of all cancer deaths and 87 percent of lung cancer deaths.*
- *The risk of developing lung cancer is about 23 times higher in male smokers and 13 times higher in female smokers compared to lifelong non-smokers.*
- *Smoking is associated with increased risk of at least 15 types of cancer.*
- *Smoking is a major cause of heart disease, cerebro-vascular disease, chronic bronchitis and emphysema, and is associated with gastric ulcers.*

(American Cancer Society, Cancer Facts & Figures, 2007)

Onondaga County Tobacco Facts 2006

- *85,197 estimated cigarette smokers in Onondaga County*
- *$35,886/day or $13.1 million/year is the estimated Medicaid burden attributable to cigarette smoking in Onondaga County*
- *$901/household in NYS is the estimated tax burden from smoking-caused expenditures*
- *Onondaga County exceeds the New York State average for lung cancer mortality with the 2004 rate per 100,000 at 65.9 as compared to the NYS rate of 48.7 (NYSDOH 2006)*
- *Incidence of lung and bronchus cancers in Onondaga County from 1999 to 2003 is 172.2 compared to the NYS incidence of 137.*

(NYS CR 2006)

Poverty and Insurance: Barrier to Early Detection

According to Sherry Tomasky, regional advocacy director for the American Cancer Society, mortality rates among those with cancer have decreased eight percent since the 1989-1993 period. Tomasky cites early detection and improved treatment options as the reason for the eight percent decrease in deaths, and underscores one of the most repeated phrases regarding cancer: early detection saves lives. For instance, statistics show that the survival rate improves 83 percent when breast cancer is detected early and that timely mammography screening could prevent 15-30 percent of all deaths from breast cancer among woman over forty. Early detection is based on screenings for cancer at recommended intervals. According to Tomasky, one of the major reasons for not having screenings is poverty and lack of education about the importance of screenings, and the rate of those under- or non-insured.

According to the American Cancer Society, nationwide, 11 percent of cancer patients under age 65 are uninsured. Lack of insurance is cited as a significant barrier to accessing health care services, decreases screening rates and causes poorer health outcomes upon diagnosis, and leaves millions of Americans without access to health care services and lacking the financial resources to fight serious illnesses such as cancer.

Additional figures show the uninsured are more likely than the insured to have skipped medical treatments (39 versus 13 percent) or not have filled prescriptions (30 versus 12 percent) because of the cost. Uninsured women are 49 percent more likely to die than insured women during the 4 to 7 year period following an initial breast cancer diagnosis.

According to Tomasky, lack of insurance is the single most significant driving factor in screening rates and accessing health care services, followed by education and race. Hispanics bear the highest burden, with 40 percent under age 65 are uninsured. Uninsured and under-insured people undergo fewer cancer screening tests, including pap smears, mammograms, prostate exams and colon cancer screenings. This population segment has an increased risk of late-stage cancer diagnosis.

Diabetes on the Rise

Roberto Izquierdo, M.D., associate professor of Medicine and Pediatrics and section chief, Pediatric Endocrine and Diabetes at SUNY Upstate Medical University and associate medical director of the Joslin Diabetes Center in Syracuse, discussed the growing epidemic of diabetes, particularly among young people.

Diabetes is a disease state in which the blood sugar level is elevated; the best way to diagnose it is through a simple blood test. Type 1 diabetes, previously known as juvenile diabetes, is usually diagnosed in children and young adults.

Type 2 diabetes is the most common form of diabetes. In type 2 diabetes, either the body does not produce enough insulin or the cells ignore the insulin. Insulin is necessary for the body to be able to use glucose for energy. When you eat food, the body breaks down all of

the sugars and starches into glucose, which is the basic fuel for the cells in the body. Insulin takes the sugar from the blood into the cells. When glucose builds up in the blood instead of going into cells, it can cause two problems: cells may be immediately starved for energy or, over time, high blood glucose levels may damage eyes, kidneys, nerves or the heart.

While diabetes occurs in people of all ages and races, some groups have a higher risk for developing type 2 diabetes than others. According to the American Diabetes Association, the disease is more common in African-Americans, Latinos, Native Americans and Asian Americans/Pacific Islanders, as well as the aged population.

In the U.S., 8.7 percent of non-Hispanic whites have diabetes, while 13.3 percent of non-Hispanic African-Americans, and 9.5 percent of Hispanic/Latino Americans, have been diagnosed with the disease.

Roberto Izquierdo, M.D. states that 14.6 million in the U.S. have been diagnosed with type 2 diabetes and 1 million with type 1 diabetes. It is believed that another 6.2 million have a "pre-diabetes" condition that could be controlled if these people took the appropriate steps to reduce their risk of developing type 2 diabetes. Obesity is one of the primary risk factors for developing the disease, and a major cause of the epidemic increase in the disease.

Diabetes is an increasingly growing problem, according to Izquierdo, with projections stating that diabetes may increase from 18 million cases in 2000 to 30 million by 2030 in the U.S. His colleagues are observing epidemic increases in rates of type 2 diabetes mellitus diagnosed in children under 18 years of age. In Syracuse during 2004, he observed an 8 percent increase in type 2 in this age group.

In summary, Izquierdo says that type 2 diabetes can be difficult to treat and that there are many barriers to proper care, including lack of availability to facilities for exercise; unsafe streets for walking; lack of access to healthy food; and lack of family support. Lifestyle changes, along with proper screening, could decrease the prevalence of this chronic disease in our county.

HIV/AIDS

"Although the disease is no longer a death sentence, the epidemic is still here and it is not going away."
— Steve Waldron, Ph.D., Director of CNY HIV Care Network

Because medical care now enables people to live longer with HIV/AIDS, and the number of persons dying from AIDS is decreasing, many people think "AIDS is over." However, statistics in the HIV/AIDS Annual Surveillance Report, produced by the Department of Epidemiology of the New York State Department of Health (NYSDOH) and released in October 2007, reveal otherwise.

The 11-county NY State Ryan White Region of Syracuse includes Cayuga, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence and

Tompkins counties. As of December 2005, there were 604 people in this region living with HIV (not AIDS) and 997 people living with AIDS, for a combined total of 1,601 cases. These figures do not include prisoners. In Onondaga County alone, excluding prisoners, there were 299 individuals with HIV, and 523 with AIDS, for a combined total of 822 cases. Including the prison population in the county brings the combined total to 858 cases. Of the 1,601 HIV/AIDS patients in the region, race/ethnicity breaks down as follows: 838 white; 551 black, 147 Hispanic, 12 Asian, 7 Native American, 44 multi-racial and 2 unknown.

Health inequalities are the result of many factors - among them poverty, low educational attainment and language and cultural barriers. One's residence or geographic location and social networks can also affect behavior, and in the case of risky behaviors (drug use, crime, unprotected sex, for example), can lead to outcomes that are the product of, or result in, health disparities.

According to Rosemary Arroyo-Perez, a founding member of the community organization SALUD, barriers to testing include language and culture, and the attitude that "it's not going to happen to me."

Steve Waldron, Ph.D., director of the Central New York HIV Care Network, a health care planning agency and consortium for providing services, concurs. "AIDS," says Waldron, "is often just the latest thing to happen to someone," explaining that prior risky behaviors or being in the third generation of abuse have contributed to the fact people are marginalized by a lack of education and employment.

Waldron also states that there is a decreased awareness about HIV/AIDS in the communities most affected. Those who acquired the disease early on are gone. Those who witnessed the disease are older now, and the younger generation has not seen the high number of deaths and devastation that the disease once produced in this country.

Sandy Lane, chair of the Department of Health and Wellness and Professor of Social Work and Anthropology at Syracuse University says that incarceration is a key risk factor. African-American men are two times more likely to be in prison than white men and rape is prevalent in the prison environment, contributing to the spread of HIV/AIDS. Studies also show that men are having "concurrent partnerships," meaning that they are having more than one sexual partner at a time. When men are "scarce," including for reasons of incarceration, women seem to tolerate this situation to keep relationships going, which contributes to the high spread of HIV/AIDS among African-American women.

Melody Holmes, director of the Jail Ministry, agrees. She shared the scenarios of three inmates: "Mr. Douglas," who is HIV-positive and is concerned about treatment. He is European-American and has health insurance. "Mr. Dennis" is also HIV-positive and is having difficulty in prison getting medications and treatment. If he "plays crazy," he may get treatment for mental health issues. "Mr. Ruiz," also HIV-positive, has no trust in a Spanish interpreter and writes questions in Spanish for Melody to have translated. The Jail Ministry asks, "How can we help these people?"

According Moustafa Awayda, M.D., HIV Specialist at the Syracuse Community Health Center (SCHC), education and access is the best way to combat the spread of the disease, especially in underserved populations. The SCHC has developed a comprehensive HIV/AIDS program to provide more access to testing and treatment.

The World Health Organization says that the state of health is the ability for one to live a social and productive life. "The U.S. is not the best model in the world for helping its citizens to achieve this definition of health," observes Awayda. "The future health of our nation as a whole depends on how we work with communities to eliminate health disparities."

Long-Term Care

Long-term care is more than just nursing home care for the elderly. According to the U.S. Department of Health and Human Services (2008), long-term care is defined as the "range of medical and/or social services designed to help people who have disabilities or chronic care needs. Services may be short or long-term and may be provided in a person's home, in the community, or in residential facilities (e.g., nursing homes or assisted living facilities)." It is important to remember that these services are available for all individuals above the age of 18.

A recent issue of *Medicaid Facts* published by the Kaiser Commission on Medicaid and the Uninsured (2007), states that more than 10 million Americans require long-term care services. Although the majority (55%) of those utilizing long-term care services are above the age of 65, 42% are below the age of 65. There is a large spectrum of individuals who require the need of long-term care services, including children with developmental disabilities, and young adults with spinal and brain injuries or serious mental health conditions. In addition "those with severely disabling chronic diseases such as diabetes and pulmonary disease need more extensive acute and long-term services as they age".

In discussing the health inequalities associated with long-term care, it is important to note that there is not much data related to disparities that may exist in this area, particularly here in Onondaga County. While addressing issues of inequalities in long-term care, the Study Committee concluded it is impossible to exclude all previously discussed findings. It is the existence of these inequalities over one's lifespan that have affected the increased need for long-term care in our society. Long-term care in many ways should be viewed by policy makers and practitioners alike as the outcomes associated with existing inequalities. It is impossible to ignore the impact of poor nutrition in early life on one's chances of developing diabetes in later life, or the impact of poor medical literacy on one's ability to manage his or her own health over time. These serve as a few examples of how the continuation of health inequalities in our society is interconnected across the lifespan. None of us is immune to the presence of health inequalities, nor can we expect to live a life that is untouched by this topic.

CONCLUSIONS AND RECOMMENDATIONS

"Despite improvements in the overall health status of Americans, minorities continue to lag behind whites in health status and access to health care. Since the 2002 release of the Institute of Medicine report,* Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, a significant amount of analytic work has enhanced our understanding of the scope and causes of disparities in health and health care. It is now time to move beyond documenting disparities and to focus our efforts on actionable steps to eliminate them."
—Center for Health Care Strategies, Inc. Issue Brief, August 2007

While a year of studying the issue of health disparities has enhanced our understanding of the causes and ramifications of inequalities in health status and access to health care, in many ways the OCL study has raised more questions than answers in what is a very broad and complex topic. It was a difficult task to separate the issue of health disparities from the larger issues of a fragmented health care system, lack of basic health insurance coverage and persistent poverty and social injustice in our community and country.

The challenges facing Onondaga County are the same as those that many communities face nationwide. But the depth and complexity of the problems mean that rather than waiting for the "silver bullet" solution, we should be attacking the problem, forcefully, now, on many fronts.

Why Should We Care? Disparities in health care affect the entire community. While we focus on the disparities suffered by minorities and persons of low income, they're not the only ones affected. At each step on the socioeconomic ladder, those with lower-paying jobs and less education have greater health risks. And the costs of care are staggering. The U.S. spends twice as much as other industrialized nations per person on medical care, and yet our life expectancy rate is ranked only 31 among other nations. Disparities contribute to health care costs. For instance, less access to adequate preventive and routine health care could be increasing costs for all due to delay in early diagnosis and treatment of illnesses, unnecessary use of emergency rooms for primary care and otherwise avoidable hospital stays. For example, a rough estimate of the cost to the U.S. health care system of racial disparities in health care for diabetes alone could be as high as $4 billion a year, according to an assessment by the Center for Health Care Strategies and the RAND Corporation. While the human and social consequences alone should drive the search for elimination of disparities, their economic costs and the potential savings from improved health outcomes are compelling reasons for political action and systematic changes at the federal, state and local levels.

What Can We Do and How Can We Do It? While there are still some gaps in the data used to measure disparities in health and health care and in our understanding of the causes of the disparities, many studies have enhanced our awareness of strategies necessary to address the documented gaps in care.

1. **We can guarantee access to preventive and primary medical care.** All Americans still don't have what citizens of every other industrialized nation in the world have:

guaranteed access to basic services. With more than 45 million uninsured nationally, as individuals and organizations, we should press our governmental, professional and business leaders for a system of health insurance coverage that will reduce the financial gap in access to health care.

How? Mobilize grassroots support through community groups such as ACTS (Alliance of Communities Transforming Syracuse) for local and state efforts to dramatically close the gap of the uninsured, particularly of children. Universal health care has been called for in New York State. Our residents must be involved in the debate as to how to achieve this goal in the near future.

2. **We can collect specific and reliable data** on health and health care indicators by race, ethnicity, language, and neighborhood so that disparities can be better understood by the professional community, the lay public and those suffering these deprivations. Better data should empower our citizens to pursue strategies to address inequalities for targeted populations. While we need new and improved data, we can make sure that the data that is already available is analyzed and utilized to maximize benefits for those disadvantaged.

How? Encourage our academic resources to expand their research on these topics. Scholars and students at Upstate Medical University, Syracuse University, and Le Moyne College could see health care disparities as a higher priority for their attention. We applaud the significant work of SU Professor Sandy Lane in uncovering data describing factors in our public health crisis. Other local health care stakeholders such as Excellus Blue Cross/Blue Shield, Health Advancement Collaborative of CNY, CNY Health Systems Agency, Community Health Foundation of Western and Central New York and Onondaga County Health Department offer a wealth of data that needs greater dissemination to all parties. We commend *The Post Standard* and other local media for their investigative reporting and informational advocacy, and encourage them to continue to expand their coverage of health care issues and disparities that exist in our community.

3. **We can encourage all eligible recipients to take advantage of available health insurance programs and we can advocate for expanded eligibility**.

How? Support the collaborative efforts of the community, including Onondaga County Health Department, ACTS, health insurers, and other stakeholders to identify and enroll eligible county residents in Medicaid, Family Health Plus, Child Health Plus and the New York State Cancer Service Program (formerly known in Onondaga County as the Healthy Living Partnership), which provides breast, lung and colon cancer screening for these uninsured. Determine and remedy barriers to effective and sustained enrollment in these programs through consultation with state and county officials. Promote an expansion of the federal/state partnership called SCHIP (State Children's Health Insurance Program) through Congressional action and Presidential approval. Our local Congressman James Walsh is to be commended for his efforts on this legislation in the House of Representatives.

4. **We can forge new connections—**both formal and informal—between the individuals and agencies that serve populations affected by disparities. We can create incentives for these collaborations that will strengthen the new relationships. For example,

through a grant from the March of Dimes, Upstate's Center for Maternal and Child Health opened an office in the Syracuse Community Treatment Court to offer health education and patient navigation services to women who are at high-risk for negative birth outcomes. The Community Health Foundation of Western and Central New York requires grantees in their Nuts & Bolts program to meet periodically to share their experiences. More inclusive networking opportunities, such as a monthly Health Roundtable open to all health care stakeholders, could lead to more connections and innovations.

How? Engage the broader community in these discussions by promoting public dialogues on the inequities in health status, health outcomes and access to care.

How? Create a continuing opportunity for health care and social service providers to come together on a regular basis to share timely updates about programs and opportunities that could better serve patients and clients. In addition to periodic meetings of such a forum, a web site should be developed to expand and reinforce cooperative enterprises. Through this year's OCL study, a number of providers have expressed that there is not a "clearinghouse" for information, and that frequently providers are not aware that new services even exist. This endeavor would also be used to encourage and facilitate more general communication among public and voluntary agencies. Creating such a medium will require the removal of territorial boundaries and the commitment to collaboration among key players. We especially see the need to **appoint a liaison between the medical community and the justice system** in Onondaga County to improve synergies among these constituencies.

5. **We can help consumers become partners in their own health care and teach consumers to be savvier** about their own health, about access to health care, and about what quality health care "looks like." We can improve our health literacy by enhancing "the user friendliness" of provider communications in verbal exchanges as well as in printed materials and other mediums.

How? Promote the Community Foundation's community-wide literacy campaign, including special efforts to develop health literacy to help to reduce disparities. Health Literacy is defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (*Healthy People 2010*). With some 24 percent of Syracuse (16 percent, Onondaga County) residents functionally illiterate, the enormous need to improve health literacy among the poorly educated (and even those with higher literacy skills), and to meet the challenge of this dilemma is critical to the problem of disparities. The Study Group also advocates making available a "Consumer's Checklist" on what constitutes a "good" health care visit at any age.

6. **We can help providers to be more sensitive** to cultural differences and potential biases against patients from minority groups.

How? Expand the integration of cultural competencies into basic training of health care professionals at area academic and training programs. Current practitioners should be encouraged through their professional associations to examine their practice patterns, seek additional education and adjust their clinical behaviors to enhance greater sensitivities to

cultural concerns. Bilingual candidates for health professions can be encouraged and current practitioners may seek to become bilingual as a means to improve communications with patients.

7. **We can be engaged in critical public health issues** such as improvements in nutrition, increased reduction in lead poisoning of children, elimination of tobacco use, HIV/AIDS prevention and expansion of recreational opportunities, especially for safe walking.

How? Support and expand community initiatives focused on improving basic nutrition and nutrition education, and on increasing availability of nutritional foods, especially fresh fruits and vegetables in schools and inner-city neighborhoods. We applaud the work of the Genesis Health Project, a Syracuse University outreach program working with black churches to empower members to eat better and exercise more. Headed by Professor Luvenia Cowart, among its accomplishments is eight African-American congregations having pledged to become "fry-free zone" churches. Likewise, new County Executive Joanne Mahoney is to be praised for her administration's recently announced pilot program for county employees to work with the Joslin Diabetes Center to enhance personal nutrition and exercise regimes.

How? Strongly support the Syracuse Lead Task Force and implement a comprehensive approach to decrease exposure to lead. Childhood lead poisoning is known to cause serious and irreversible developmental damage such as learning disabilities and behavioral problems. This is particularly true among children age six and younger, whose bodies are still developing. Most lead poisoning is attributed to lead in paint, dust and soil, and in Syracuse lead poisoning has been associated with high-risk housing—typically, older rental housing. It is essential to support existing city and county initiatives to decrease lead exposure and to identify promising ordinances and programs that could be implemented locally. For example, Rochester, adopted a Lead Based Paint Poisoning Prevention Law, which took effect in July 2006 and applies to rental properties built prior to 1978. It requires that all housing units inspected by the city undergo visual inspection for deteriorated paint. In addition, in the first year dust wipes were also required if the housing units were in any of 31 census tracts identified as having concentrated numbers of children with elevated blood levels. In December 2007, the Center for Governmental Research released findings from the first year of a two-year study assessing the impact of Rochester's law. The study found that nearly 1,400 housing units have been, or soon will be, made lead safe as a result of inspections conducted in the law's first year, and the cost to landlords for compliance was lower than anticipated. Community efforts to reduce lead exposure will pay off in better health and reduced health care costs.

A $1 million grant from the state Health Department was awarded to SUNY Upstate Medical University in March 2008 to expand its lead poisoning prevention program from 14 counties to 31 counties stretching east to Albany, north to the Canadian border and south to the Catskills. Formerly known as the Central New York Lead Poisoning Prevention Center, the new Central/Eastern Lead Poisoning Prevention Center will serve a population of more than 3.2 million people, up from 1.6 million. We applaud the state and Upstate for recognizing the growing need for lead prevention in our region.

How? Increase tobacco control initiatives in Onondaga County. Studies have shown that the more limits there are on tobacco use, tobacco use rates decline. Since tobacco is one of the leading causes of chronic disease and premature death, the more limitations, the greater the cessation rates. Community leaders need to encourage tobacco-free grounds on government property and employer worksites; support health care organizations' expansion of tobacco-free boundaries; and support increased taxation, one of the most effective methods of decreasing tobacco use.

How? Re-commit adequate resources to limit the spread of HIV and other infectious diseases. The threat of such preventable diseases continues to haunt the globe and our particular community. The "silent" spread of HIV through sexual contact and the sharing of needles among addicts have resulted in some 2,780 cases of persons living with the virus in our 11-county region (2006). Of these, 1,884 infected persons live in Syracuse. Public awareness is essential to thwart the continuing threat of HIV. The ongoing work of the CNY HIV Care Network funded through Ryan White federal dollars is to be commended. Its provider members and numerous institutions, such as public school districts that play a role in HIV education, need support of various kinds from the community. The use of teen peers and the witness of HIV+ persons as prevention communicators should be strongly affirmed. AIDS Community Resources, FACES (Southwest Community Center), Black AIDS Commission and other groups serving communities of color are especially critical as HIV infection is dramatically impacting African-American and Hispanic peoples disproportionately.

How? Make safe space for people to engage walking and other exercise into a community mandate. Exercise goes hand-in-hand with good nutrition to create optimal health. Unsafe streets and sidewalks in disrepair—or nonexistent—discourage regular exercise. Limited physical recreation facilities for children and adults alike are also an issue. Given the obesity levels of adults and the similar trend of children, creating more opportunities for safe, affordable exercise is tremendously important for the citizens of the entire county.

The reduction of disparities in health and health care in our community will require the involvement of more than just health care providers. We all have a critical stake in making dramatic improvements in the inequalities that inhibit the full realization of wellness by so many disadvantaged persons in our midst. Only when we move beyond lip service and into real concerted action will we see the benefits of such essential efforts for everyone.

RESOURCES

For more information on the subject of health disparities, visit the following websites which contained supplemental information that helped to inform this report.

United States Department of Health and Human Service
Healthy People 2010
http://www.healthypeople.gov

United States Office of Minority Health
http://www.omhrc.gov/

Centers for Disease Control and Prevention (CDC) http://www.cdc.gov
Reach 2010
http://www.cdc.gov/reach.

CDC Office of Minority Health and Health Disparities
http://www.cdc.gov/omhd/About/about.htm

Institute of Medicine
Unequal Treatment: What Health care Providers Need to Know About Racial and Ethnic Disparities in Heathcare (2002)
http://www.iom.edu/CMS/3740/4475.aspx

World Health Organization (WHO)
http://www.who.int/en/

American Medical Association
Research Findings and Recommendation
http://www.ama-assn.org/ama/pub/category/10243.html

American Medical Association
AMA activities to eliminate health disparities
http://www.ama-assn.org/ama/pub/category/7983.html

American Medical Association
Commission to End Health Care Disparities
http://www.ama-assn.org/ama/pub/category/12809.html

American College of Obstetricians and Gynecologists (ACOG)
Note: Contains a listing of relevant Web sites relating to health disparities.
http://www.acog.org/departments/dept_notice.cfm?recno=20&bulletin=3342

New York State Department of Health
http://www.health.state.ny.us/diseases/aids/statistics/annual/2005/2005-12_annual_surveillance_report.pdf

http://www.nyhealth.gov/community/minority/docs/2007_minority_health_report.pdf

http://www.health.state.ny.us/statatics/chip/onondaga.htm

The Henry J. Kaiser Family Foundation
http://www.kff.org/minorityhealth/upload/7724.pdf
Legislation Introduced During the 110th Congress

The University of Hawaii System
http://www.hawaii.edu/hivandaids/Health_Disparities_in_HIVAIDS,_Viral_Hepatitis,_Sexually_Transmitted_Diseases_and_Tuberculosis_in_the_US__Issues,_Burden_and_Response.pdf

American Cancer Society http://www.cancer.org

American Diabetes Society http://www.diabetes.org

Public Broadcasting System's "Unnatural Causes"
http://www.unnaturalcauses.org

"Research Findings 28: Demographics and Health Care Access and Utilization of Limited-English-Proficient and English-Proficient Hispanics," Agency for Health care Research and Quality.
http://www.meps.ahrq.gov/mepsweb/data_stats/Pub_ProdResults_Details.jsp?pt=Research%20Findings&opt=2&id=851.

http://www.statehealthfacts.org/profileglance.jsp?rgn=34

http://www.health.state.ny.us/press/releases/2007/2007-09-28_minority_health_survey.htm

http://www.partnership4coverage.ny.gov/press/

APPENDICES

View study session and committee meeting notes at
http://onondagacitizensleague.org/ocl_studies/2007/

2007 STUDY SESSIONS

Study Session 1
April 10, 2007

Health Inequalities in Maternal and Child Health

Richard Aubry, MD, *Professor, Department of Obstetrics and Gynecology, Upstate Medical University; Director of the Central New York Regional Perinatal Program and Data System; and Medical Director of the Center for Maternal and Child Health at Upstate*
Luis Castro, MD, *Medical Director, St. Joseph Hospital's Westside Family Health Center*
Kathleen Coughlin, MPA, *Program Director, Syracuse Healthy Start, a program of the Onondaga County Health Department*
Mary Jensen, Moderator

Study Session 2
May 3, 2007

Chronic Disease

Cynthia Morrow, MD; MPH, *Commissioner, Onondaga County Health Department*
Roberto Izquierdo, MD, *Associate Professor of Medicine and Pediatrics and Section Chief, Pediatric Endocrine and Diabetes, SUNY Upstate Medical University and Associate Medical Director, Joslin Diabetes Center in Syracuse*
Sherry Tomasky, *Regional Advocacy Director, American Cancer Society*
Martha Ryan, Moderator

Study Session 3
May 9, 2007

Long-Term Care

Marilyn Barnes, *Community Health Nursing Supervisor, Onondaga County Long Term Care Resource Center*
Mary Hicks, *Executive Director, Enriched Resources for Independent Living (ERIE at Toomey Abbott Towers)*
Amanda Torre-Norton, Moderator

Study Session 4
May 23, 2007

HIV/AIDS

Steve Waldron, PhD, *Director, Central New York HIV Care Network*
Moustafa Awayda, MD; *HIV Specialist, Syracuse Community Health Center (SCHC)*
Rosemary Arroyo-Perez, *Founding Member, SALUD*
Melody Holmes, *Director, The Jail Ministry*
Peter Sarver, Moderator

Study Session 5 May 30, 2007	**Barriers to Healthcare** **Sister James Peter**, Poverello Clinic, Northside Franciscan Ministries
Study Session 6 June 11, 2007	**Nutrition and Health Inequalities** **Dwight Rhodes**, *Director, Family and Community Services, Dunbar Center* **Susan Brown, PhD**, *Anthropologist and Certified Nutritionist; directs The Osteoporosis Education Project* **Liz Campbell**, *Director, Internal Operations, Food Bank of Central New York* **Liz Coffey**, *Nutrition Coordinator, Kids Win!, Catholic Charities* **Betty DeFazio**, Moderator

COMMITTEE MEETING PRESENTATIONS

February 27, 2007	**Jonnell Allen**, *Community Geographer, Syracuse University*
June 7, 2007	**Steve Morgan**, *Executive Deputy Director, Onondaga County, Department of Social Services*
June 21, 2007	**Don Cibula**, *Director, Surveying and Statistics, Onondaga County Department of Health*
July 12, 2007	**Sandy Lane, PhD**, *Chair, Department of Health and Wellness; Professor of Social Work and Anthropology, Syracuse University*
September 28, 2007	**Tom Dennison, PhD**, *Professor of Practice; Public Administration; CPR Senior Research Associate; Director, Program in Health Services Management and Policy; Maxwell School, Syracuse University* **David Sutkowy**, *Commissioner, Onondaga County, Department of Social Services*
November 9, 2007	**James X. Kennedy**, Program Officer, Community Health Foundation of Western and Central New York
December 11, 2007	**Timothy Bobo**, *Executive Director, Central New York Health Systems Agency*

PREVIOUS OCL STUDIES

1979	*Equality and Fairness in Property Assessment* – Co-chairs: John Searles, Margaret Charters
1980	*Young People in Trouble: Can Our Services be Organized and Delivered More Effectively?* – Co-chairs: Jean Reeve, Roberta Schofield
1981	*The County Legislature: Its Function, Size and Structure – Co-chairs:* Helen Zych, Elma Boyko
1982	*Declining School Enrollments: Opportunities for Cooperative Adaptations* – Chair: Margaret Charters
1983	*Onondaga County Public Works Infrastructure: Status, Funding and Responsibilities* – Chair: Samuel P. Clemence
1984	*Police Services in Onondaga County: A Review and Recommendations* – Chair: John Kramer
1985	*The City and County Charters: Time for Revision?* – Chair: Thomas J. Maroney
1986-87	*Blueprints for the Future: Recommendations for the Year 2000* – Co-chair: Robert McAuliffe, Eleanor Shopiro, Helen Anderson
1988	*The Role of the Food Industry in the Economy of Onondaga County* – Chair: Kay Benedict
1989	*Poverty and its Social Costs: Are There Long-term Solutions?* – Co-chairs: Darlene D. Kerr, Marilyn Higgins
1990	*Syracuse Area Workforce of the Future: How Do We Prepare?* – Co-chairs: James J. Murphy, Anne L. Messenger, Patrick A. Mannion
1991	*Schools that Work: Models in Education that Can be Used in Onondaga County* – Co-chairs: Georgette Cowans, Gary Grossman, Gerald Grant
1992	*Town and Village Governments: Opportunities for Cost-effective Changes* – Co-chairs: Carol Dwyer, N. Thomas Letham, Helen Zych
1993	*The Criminal Justice System in Onondaga County: How Well is it Working?* – Co-chairs: M. Catherine Richardson, James E. Introne, N. Thomas Letham
1994	*The Delivery of Human Services: Opportunities for Improvement* – Co-chairs: Robert McAuliffe, Janet Starr, Phillip Trainor
1995	*Reinvesting in the Community: Opportunities for Economic Development* – Co-chairs: Marcene S. Sonneborn, Michael J. Atkins, Donald MacLaughlin
1996	*Building a Non-Violent Community: Successful Strategies for Youth* – Co-chairs: Paula Freedman, Carol Cowles, Jesse Dowdell
1997	*Security Check: Public Perceptions of Safety and Security* – Co-chairs: Michael Freedman, Corinthia Emanuel
1998	*Onondaga County School Systems: Challenges, Goals, and Visions for the Future* – Co-chairs: Patricia Schmidt, Bethaida Gonzalez
1999	*Economic Development: Models for Success* – Co-chairs: Shiu-Kai Chin, Susan Crossett, N. Thomas Letham
2000	*Housing and Neighborhoods: Tools for Change* – Co-chairs: John McCrea, Joanne Reddick, Russell Andrews
2001	*Civic Leadership for Community Transformation* – Co-chairs: Melissa Hall, Judith Mower
2002	*State of the Arts* – Chair: Fred Fiske
2003	*Mental Health Services: Access, Availability and Responsiveness* – Chair: Helen B. "Jinx" Crouch
2004	*Disappearing Democracy? A Report on Political Participation in Onondaga* County – Chair: Steven Kulick
2005	*Strategic Government Consolidation* – Chair: Laurence Bousquet
2006	*"Fixing the Hub: Leveraging Better Outcomes for Downtown"* – Co-chairs: Joseph Ash, Jr., Douglas Sutherland
2007	*"How Inequality Makes Us Sick: The Growing Disparities in Health and Health Care"* – Chair: Betty DeFazio

MISSION STATEMENT

Onondaga Citizens League

The Onondaga Citizens League fosters informed public discourse by identifying and studying critical community issues affecting Central New York, developing recommendation for action, and communicating study findings to interested and affected groups.

http://onondagacitizensleague.org/