Appendix E: National Workshop Speakers

Keynote Speakers

Louis W. Sullivan, M.D.

Secretary
U.S. Department of Health and Human Services

Dr. Novello has been an outstanding Surgeon General, and I want to thank her here in front of all of you for the very outstanding job that she is doing and continues to do, not only for the Hispanic/Latino community, but really for all of our citizens. I'm very pleased and honored to have her as a member of the President's team in PHS.

This is an historic conference that is under way today. It's historic because it marks the first time that health professionals from the Federal Government have joined with Hispanic/Latino health experts and community leaders to address the health concerns of the Hispanic/Latino community.

America is justly noted for its culturally and ethnically diverse populations. Our Nation's strength comes, I believe, from the very national and ethnic ties that make up the rich American mosaic. As our national motto so aptly puts it, *e pluribus unum,* out of many, one. The Hispanic contribution to this Nation's history from the very beginning has been enormous. One might say that Hispanics laid some of the cornerstones of the American mosaic. Of course, as we all know, there is a great deal of diversity within the Hispanic community itself, and this Workshop recognizes and takes into account that diversity.

History has shown us time and time again that with diversity sometimes comes inequity. This inequity frequently gives rise to economic and social disparities. We are here today to address the health care disparities that affect the Hispanic/Latino population. America is a culturally diverse Nation, but one thing all Americans have in common is the need and the desire for good health and good health care. This Department and this administration will not rest until we have raised the level of health care for all Americans. We can, and we will, close the gap in health disparities. I do not have to remind you here today that the situation is indeed critical. Recent reports indicate that, from a health perspective, the Hispanic population is significantly more at risk than the non-Hispanic white population.

Hispanics face many barriers to decent, equitable health care. They also suffer disproportionately from such diseases as cancer, diabetes, HIV and AIDS, and other conditions. Additionally, Hispanics have a high incidence of substance abuse, homicide, and accidents. To address these problems, we have identified five areas that we need to focus on if we are going to improve the health care and the health status of the Hispanic/Latino community.

First, we need to enhance access to health care. Second, we need to improve data collection on the Hispanic/Latino population. Third, it is imperative that we increase Hispanic representation in the sciences and the health professions. The fourth area of emphasis calls for a comprehensive and relevant research agenda for the Hispanic/Latino populations. Finally, we need to focus greater attention and resources on health promotion and disease prevention.

Hispanics encounter numerous barriers to health care, but one of the major barriers is lack of health insurance. In fact, of the approximately 35

to 37 million Americans without health insurance, approximately 7 million are Hispanics. This means that, while only 8 percent of the general population, Hispanics constitute about 20 percent of the uninsured.

The Administration's health care reform agenda would go a long way toward remedying this situation, but there are also financial, structural, and institutional barriers that impede Hispanic/Latino communities from safeguarding their health. Many Hispanics reside in areas where clean water is not a given, where transportation is inadequate, where violence is depressingly routine, and where working conditions are unhealthy. Before we can begin to address health care reform in these communities, we must first ensure that the Hispanic/Latino community can expect a basic level of health care access that all Americans deserve.

Since 1970, the Federal Government has been engaged in a continuing effort to upgrade data collection on Hispanic/Latino communities. As a result of a DHHS task force established in 1984, we now have Hispanic/Latino birth and mortality data available for 44 States and the District of Columbia. This represents coverage of 97 percent of our Nation's Hispanic/Latino population. Also in 1984, the National Center for Health Statistics conducted the first comprehensive Hispanic/Latino health survey ever to be carried out in the United States. These and other positive measures that we have undertaken are encouraging, but they are not enough. In response to the need for more Hispanic/Latino health data, Congress called on the National Center for Health Statistics to "collect and analyze adequate health data that is specific to particular ethnic and racial populations, including data collected under national surveys."

It is often said that knowledge is power. The knowledge that we gain from improving our data collection will be a powerful tool in our efforts to improve the health of the Hispanic/Latino community.

One area, I believe, that is especially crucial to achieving this goal is increasing the representation of Hispanics in the health professions. The paucity of minorities across the spectrum studying for and working in these fields is of crisis proportions. We simply have to have more minorities involved in the health professions if we are to provide our underserved communities with adequate health care.

Why is this so essential to improving health care in Hispanic communities? Well, first, minority health professionals typically show greater than average interest in and willingness to serve and establish their practices in medically underserved areas. Additionally, they are able to bridge cultural differences that often create obstacles to effective patient care. In recognition of the critical need for more minority participation in the health care professions, I've developed a five-point plan to reduce minority health disparities. A major component of the plan is a 20 percent increase in funding for the National Health Service Corps. This includes training, recruitment, placement, and retention of providers, with a particular emphasis on minority providers.

We are taking steps to improve our data collection on Hispanic/Latino communities. To make maximum use of that data, we will need to design a relevant and comprehensive research agenda to improve Hispanic/Latino health. This will require action in three areas: First, the development of an appropriate research infrastructure; second, increasing the availability of needed research instrumentation; and third, identifying and assigning priorities. In conjunction with my previous point, this research agenda must identify mechanisms for increasing the number of trained Hispanic/Latino researchers and health professionals. The data we collect will tell us what we need to know. This research agenda will tell us what we need to do.

The final priority to be addressed at this Workshop is health promotion and disease prevention. The Hispanic/Latino population is growing rapidly. It will soon constitute the largest ethnic racial group in America. It will also be the youngest minority population in the Nation. This poses a special challenge for those of us charged with promoting the health and well-being of the population. The challenge is to develop and maintain thoroughgoing strategies for improving the health of the various and diverse Hispanic/Latino populations across the Nation. Implementing health promotion and disease prevention is critical. Health promotion/disease prevention interventions targeted to Hispanic/Latinos are essential if we are to achieve Hispanic-specific health care objectives for the year 2000.

It is almost impossible to overstate the importance of the task ahead of us. The Nation as a whole has a tremendous stake in improving the health of the Hispanic/Latino population. The national costs of bearing the burden of untreated health problems—frequently, the uninsured who eventually become more and more expensive, who eventually require more and more expensive hospital and specialty care—are prohibitive. Our society incurs additional costs when people are unable to work or unable to contribute to society because of illness. The tragedy is compounded when one considers that these illnesses are often preventable, or with early, primary medical intervention or treatment, they are frequently controllable.

As you can see, there is much work ahead and many things to be done. This Workshop is only the beginning. We'll be following up with five regional meetings, in New York, Chicago, San Antonio, Los Angeles, and Miami. This takes into account the fact that the Hispanic/Latino community is itself a diverse, multiracial, multiethnic group. The culmination of this program will be a national conference on Hispanic/Latino health to be held in 1993.

Achieving our goal, which is improved health for the Hispanic/Latino community, is a daunting task. This requires a broad range of approaches and strategies, but I'm reminded once again of our national motto, *e pluribus unum.* From the many bright, committed, and talented minds assembled here today will come a single comprehensive strategy to advance the worthy cause of improved Hispanic/Latino health. The diverse gifts that you bring to this mission convince me that we will succeed. So I look forward to working with all of you toward achieving these goals in the months and years to come. Thank you.

The Honorable Lynn Martin

Secretary
U.S. Department of Labor

We are only 8 years away from the 21st century. Those who say that tomorrow never comes are wrong. It does, and it seems to come even faster than it ever did before. We're also living in a world that's not just different from 100 years ago. It's different than it was a decade ago. That means the people of this great Nation—the people who work or who want to work, the American workforce—are at a crossroads, and we have to make sure that we go in the right direction. To do so, we really just have to start asking ourselves questions. What do we need? To answer that from the position of the Department of Labor, we can figure out pretty easily the two major challenges that we face.

One is to recognize that the jobs of tomorrow are more complex. They will require higher skills and more education. I don't have to tell you that many of the young people in America, therefore, are headed in exactly the wrong direction. One million students drop out of high school each year, and 50 percent of those who do graduate from high school never go to college or have any additional education. Only 24 percent of our young people who go to college get a degree, and that means,

bluntly and nonpolitically, that too many young people are entering the workforce absolutely unprepared to meet the future. Twenty million 16- to 24-year-olds are in that category, and these kids are being left behind. You can talk all you want. I can talk all I want. Without change, those young people will be left behind. Although minorities do constitute a disproportionate share of that number, these aren't just poor inner city youth. They're from all over. Too many of our young people aren't motivated.

Before, in a less globally dominated economy, there was less required of an employee. Our grandfathers could work at a low-skill job, raise a family, save, perhaps get a house. That is not true now, and it will not change.

Young people are still in demand in the labor market. There are jobs for them, but they have to have more skills and specialized skills. Today young people have to hit the ground running. They need updated skills. They need a path that will connect their schooling with careers, and that's where you and I come in.

We've got to get businessmen and women to increase their presence in schools. In the schools, we have to increase the desire to have business there. We have to show students what skills are required to succeed, and schools have to be held more accountable. They've got to make sure that their students are able to perform. There's something very wrong with a system that can allow our young people to graduate from high school when they still don't have the basic skills needed to perform on a job.

I'm not placing blame. Blame is easy enough. Job demands are changing so rapidly that I'd have a tough time right now telling a child what career to choose that would be absolutely relevant in tomorrow's workplace. I'd have a tough time knowing as a parent if my school was training my own children correctly for future employment. But, that doesn't mean that we shouldn't address the problem.

To deal with this, we've moved toward something called America 2000. It's a bold, comprehensive, long-range plan—not a 1-year solution but a 20-year plan—that offers a very different vision for schools. We must restructure and revitalize the educational system. That goal means making every school in America free of the drugs and violence that a small minority use but a large majority are finding now an impossibly difficult part of their lives. We should be increasing our high school graduate rate to at least 90 percent, and we've got to make sure that every adult in America is literate and exercises the rights and responsibilities of citizenship.

We also saw in my own Department that Federal job training programs were too difficult to find and that many overlapped. Therefore, the President gave me a mandate to make these programs more accessible, more efficient, and more responsible to real jobs and job training. Not too originally, we called it Job Training 2000. We think it is the right way to go. It will help young people who haven't completed their education. It will help adults with minimal skills to get better training, and it will help discipline workers to expand their skills.

We had, within the Department, a commission with outstanding people from unions, from business, from education. It's called SCANS, the Secretary's Commission on Achieving Necessary Skills. It has, for the first time, provided concrete guidelines on what particular skills young people will need to succeed in the workplace. We went to business and said, "Hey, enough telling me what's wrong; be part of the solution. Tell us what you need today and tomorrow." The commission's guidelines are now being, little by little, worked into the curricula of schools all through this country. In conjunction with that workforce strategy, we've initiated a youth apprenticeship program to develop a better school-to-work system for the 50 percent of our young people who don't

go to college. It combines academic training with on the-job training. Students who complete the course get a diploma and a job. We cannot have 50 percent of our young people, the ones who don't go on to school, ignored. We can't keep calling them "the forgotten half." Someone has to remember them, and that's what we're trying to do.

Last month, the President announced the New Century Workforce, a $3 billion per year training proposal to help working men and women who see their jobs changing or who see job loss. This program would give adult workers up to $3,000 in vouchers for a training program of their choice. It triples the money currently now allowed.

In addition to this commitment to worker adjustment, we're talking about a youth program that has four major parts: a youth training corps for those disadvantaged youth; a comprehensive drug treatment plan that provides job training as well as rehabilitation so that, while you're going through rehabilitation, you can also be looking to a future with a job; an expanded apprenticeship program; and an ROTC [Reserve Officers' Training Corps] program that is double the current size, because, in many schools, this is one of the avenues out for young people who desperately need it.

I said there were two big challenges. One is to have the state-of-the-art workforce. The second is to make sure that all Americans have a chance to get and then to use these skills. We must continue to remove all obstacles that might prevent qualified minorities, qualified women, anyone, from achieving the benefits that they earn. In the United States, we've always held that democracy is not complete until the rights and opportunities are extended to all. Democracy means freedom, but it also means fairness. We cannot say one thing and do another. Our actions must match the message. We must confront the new century and this new economy with the same spirit we've had over the last 200 years, but renew it so it includes more Americans.

Who better than all of us understand what a free society is? That, if I may state the obvious, is what drew many Hispanics to America, the same need that drew Coronado to Mexico when he risked everything on a new venture. The first ship brought Columbus from Spain—some wanted that ship to turn back, you know, but the ship came—and the world was given a new land and, eventually together, our fathers and grandfathers and great-grandmothers and grandmothers all will come together as we look for a better place for our children and grandchildren.

The waters of this brand new sea have often been turbulent, but then again nothing good ever comes easy. The challenge now is to expand the good. The President and I have committed to shattering, for instance, the glass ceiling. It may seem a daunting task. After all, it is still too easy to find reasons why one shouldn't be promoted, why one shouldn't be given the advancement; but it will be done. Those who have been outside looking in, those who have been at the end of the line, the minorities, disadvantaged, disabled, women, will have new opportunities for success.

Those are our challenges. The work is difficult. It is not over, but we can and we will make a difference. We must open the doors of opportunity, and we must help all Americans walk through these doors with their heads held high. We can see the American dream endure. We can see the dream become a reality, because after all, what is America but the chance to reach for a better life and a better future, and part of that life and future includes the chance for a job, for a career, to grow, and to prosper.

Thank you for letting me be with you. I'll be happy to answer any of your questions.

Q. *Dr. Martin, as you stated, a disproportionate number of people who are Latino or Hispanic participate in the lower paying workforce. I would like to know from you, what is your perspective on the issue of these*

workers who provide the person power for the agriculture industry and the service industries if our technology tomorrow and the education required for tomorrow's jobs are actually increased? Who will take the place of those workers in the future, and what assurances are there that people who continue to take those jobs will have adequate insurance for health needs and adequate incomes to provide for their families, and this is in spite of whether they're legal or not? They're participating as taxpayers in our labor force to drive the American economy.

A. First of all, do not mix reality with the idea that somehow, someday a migrant worker is going to make $50,000 a year. It's not going to happen. There can be a minimum wage, but $4.75 an hour isn't what you want your kids to grow up to do. Most migrant workers don't want that for their children, and we shouldn't confuse the two issues. It is the job and appropriate role of the Department of Labor to make sure that migrants are safe, that there's not peonage, that there is responsible pay, that there is the minimum wage, that there are ways to live. But, don't ever let anybody kid you that, boy, are those great jobs. They're hard, and they're tough, and their very nature is they're never going to pay a lot of money.

Don't worry, then, about who the planter is going to hire 10 years down the line. Worry about what our kids are going to do. Worry about how, in city after city, we have growing numbers of kids dropping out of high school. They're not going to be migrant workers; it isn't even part of their camp. But, they're not going to be able to be part of this society. No matter how many speeches or programs are given, it is now so directly tied to education.

I'm going to tell you something from the Secretary of Labor. If our young people, a young girl, drops out of high school, is unmarried, has a child, and doesn't complete her education, she's going to be poor all of her life–period. Take the young man, the 15-year-old, the cool guy, and he drops out of school. Guess what? If you're talking about anything legal, he's poor all his life.

My grandfather could work a job in the steel mills. The job in the steel mills today is so complex, it requires skills and ability and education. It's not that there aren't going to be some low pay jobs. There always are, but not as many, and they're not going to be good.

So I am absolutely convinced, the reason we're talking about job apprenticeship training, the reason we're talking about the fact that jobs and careers are important is we've diminished labor over the last 20 or 30 years.

We're trying to get that connection again in high school. I have been blessed in my life with children and step-children. Therefore, I see them all of the time. Now I'm just going to tell you, 15-year-olds don't have judgment. The idea that we have these systems where we let them make up their minds strikes me as so silly it takes your breath away. We owe them more than that. You can't tell a 15-year-old, "Listen, stay at this boring thing that has no relevance in your life, and you'll see someday." I mean, an hour ahead is forward thinking for them. So we have to have stuff for the connector.

For that 50 percent who aren't going to go right on to college, there has to be something that keeps them there. But, we have a responsibility not to lie to them and not to tell them that somehow the rest of the world is going to be wonderful for them, if they choose to make some of these other choices and get off the line. The fact is, it won't and it can't happen. We spend in Job Corps about $23,000 a year for kids who need a second or third chance. It's one of our good programs that the President wants to make bigger, but it won't hit everybody. We've got to do better in schools. Every company, every union tells me the kids aren't ready. We've got to do it.

Just for a moment, I'm going to speak about Hispanic Americans. I'm not Hispanic American. I can't think of anything more aggravating than

someone telling you what it would be like to be Hispanic American who's not. I'm a woman. I look at the numbers of young girls who aren't going on in math and science when there are now openings in every engineering firm and when, with the glass ceiling on the push, there's a chance to work. I want to find out why the same young girl, the same young minority boy, the same Hispanic boy or girl who was doing just fine, thank you, to fifth grade suddenly start going down the tubes. You and I know what part of it is; but then let's start looking at why sixth and seventh and eighth grade just aren't working. Let's not lose our children.

Compared to 50 years ago, there's finally opportunity for people, and what a waste if our youngsters aren't ready to just grab that opportunity and push it forward. So I just think we've got a ton to do here. I think we can do it, but I think we have to be very clear that, if we accept lesser standards, if we try to homogenize the world for our children and say, "Oh, it will be fine, whatever you do is going to be fine," that isn't going to work either. We have to be very clear what's going to be needed. It's going to be tougher. The jobs are going to be safer, cleaner, pay more. They'll have more satisfaction. That's the good part. You must get the skills to get there.

I really went around on that, but I feel so strongly about it. Between migrant workers and what we have to do for our younger workers—especially, I think, Hispanic, African American, and young women—to lose some of that talent is just outrageous. We cannot afford to do it.

Q. *At the Department of Labor in 1985, they had the Youth 2000 program involving 50 major corporations and the Departments of Education, Health and Human Services, and Labor. It was concluded by the major corporations and the few Federal agencies that minority youth would be the major workforce in this country by the years 2000 to 2010. Unfortunately, that was 7 years ago, and I have yet not seen this. What happened in 7 years? It is in the best interest of our Nation to not be so guarded in saying we're going to put money into the Hispanic youth and the black. Unfortunately, both Democrat and Republican chose not to look at that issue and let America become a second power.*

A. Through the 1980s, the same time you're talking about, there were about 20 million new jobs. A majority of them were filled by African Americans, Hispanic Americans, new immigrants, and women. And just so you are quite clear on this, there are job programs. I just went through some of them briefly. I haven't been here for 7 years, but I would hope that most people would agree that in the last year and a half, we've made some enormous progress at the Department. But, the most compelling jobs are going to come from the private sector. Government jobs in the long run are paid for by people, by taxpayers. There's no advantage there. So you can have some for a short period of time.

In my view, every single thing should be judged in the light of how many new jobs it creates. Then we can move people to fill them, but unless we get that, I think we have real additional problems for minorities and for women and for immigrants.

Last year, immigration was three times what it was 5 years ago. So part of the growth of the Hispanic American community is certainly coming from recent immigrants. That's going to make America even better.

Gail R. Wilensky, Ph.D.

Deputy Assistant to the President for Policy Development

Good morning. It's a pleasure to join you here. I'm delighted to have a chance to begin this morning's session with a discussion of access to health care for the uninsured. Let me just try to give you some brief background. These are numbers concerning access to health care that now are recognized as features of the debate on access to health care. You probably have heard them on a number of occasions. Let me try to put our problems of access in perspective.

We have approximately 34 million people without insurance coverage in the United States. One-third of these people are poor officially—that is, their income level is below the poverty line. The other two-thirds are low and middle income families. There are some upper middle income families among the 34 million as well.

We really have two groups of populations that are without health insurance coverage and a very small third group. The first of the two groups includes those who are without health insurance coverage primarily because they're poor. This group consists of poor people who don't have the financial resources to buy insurance, yet fall through the cracks of Medicaid. They don't meet the Medicaid rules of eligibility. Medicaid primarily follows the receipt of welfare cash assistance. Pregnant women and young children also are eligible by virtue of being pregnant women and young children.

The other substantial group is formed primarily by those who work for small employers or are dependents of people who work for small employers and are not provided with health insurance benefits. They work and are not poor, but some have very low incomes and large families. The smaller the firm, the more likely it is that they will be without health insurance coverage. In general, we really have these two groups of people without health insurance coverage in the United States.

Another very small group is made up of people who are medically uninsurable. They present a problem because their profile indicates that they will incur significant medical expenses.

We know that lack of insurance is not the only problem we have with regard to access. However, the absence of insurance coverage makes health care more difficult to obtain and more expensive. People without health insurance coverage typically use about half of the health care that people with health insurance coverage do.

We also know that the problem is not only an issue of financial access. We know that many people on Medicaid, for example, still have enormous difficulty getting full access to health care because of the way their Medicaid program may be constructed. Similarly, there may be people who, although well insured, have difficulty getting health care because of where they live. There may be too few doctors, too few nurses, and/or a lack of health clinics and facilities. In the United States, however, we have rather an abundance in the aggregate of these human and professional resources.

I say that only because, as an economist, I typically focus on the problems of not having financial access—that is, health insurance. However, we do need to remember that, even for those with health insurance coverage, there may still be some problems in gaining access. This group is an easier group to deal with, but we can't assume that the problem has been solved once we have financial wherewithal.

Now we come to an issue that for many people who are activists in health may not seem like such a big deal. For me, however, this is a central issue. Both political parties and their official candidates have said that the poor are the Government's problem. The President's health care plan covers all people below the poverty line by a voucher of credit, with the notion being that such coverage will enable the economically disadvantaged to purchase health insurance. The Democrats have expanded on this approach and have proposed a public sector plan that would also cover people up to the poverty line. So our arguments these days are really not about the poor per se. We haven't done it, but we have at least proposed that poor people be covered by Government programs. There are some differences in terms of how they're constructed, but both assign a key role to the Government.

The big fight right now is Government obligation and responsibility and the best way of

resolving the problem for the nonpoor. There are basically three different approaches you can take and, in terms of presidential politics, two different strategies that are being proposed. It's important that we understand this, and it's particularly important that those of you who are interested in Latino health understand this, because you may be differentially affected in terms of how these choices work out.

One proposal requires employers to provide health insurance to their employees. Usually, that comes in the form of what's called "play or pay." "Play" means that an employer provides the health insurance coverage that the Government or some group appointed by the Government says he or she must provide. If not, the employer "pays" into a fund and somebody else provides the health insurance.

That has been the Democratic leadership plan. It is being adopted by Governor Clinton. He's saying that the "pay" part is not a payroll tax, which is what Senators Mitchell, Rockefeller, Reigel, and Kennedy have said. He's said, if you don't provide it, you have to pay a mandatory premium. In my view, that's a little silly; a mandatory premium is a tax for anybody who is trying to run a business. So, one idea is to say the way you get to the employed population—those two-thirds that are not poor but that may have low income—is to require employers to provide that coverage or to pay and then have it provided directly.

That may sound appealing, because it does get at a large part of the group that is uninsured. The difficulty is that, once you enforce this mandate on employers, you effectively make workers more expensive. This is particularly a problem for workers who are at or near the minimum wage. You have effectively raised the cost of hiring somebody. Somebody said to me that we really don't have any minimum wage workers in this country. Being a curious numerically oriented economist, I didn't quite believe that. So I talked to my colleagues at the Labor Department and asked about people that get a rate within fifty cents of the new minimum wage limit. The answer is not zero; it happens to be that 8 million people are within fifty cents of the minimum wage. Five million of them are women. The reason this is a worry to somebody like me is that, while I want to make sure that people have health insurance coverage, I also really want to make sure that, in the name of providing health insurance coverage for these people, we don't put them out of a job and kill off small businesses.

My reasons for being so concerned about this problem are twofold. First, small business has been the road to success in the United States. Second, small businesses happen to be the source of almost all economic growth in the United States.

The question is: How do we provide health insurance for people who are working in small firms? One option is to just say "thou must" or "thou shall or otherwise pay directly." That isn't the strategy that this administration has been taking, and our logic is the following.

Without the Government telling employers what they have to provide or how much money they have to put into the premium, almost all employers provide health insurance as a fringe benefit. This is not a mystery. The Tax Code strongly encourages people to take part of their compensation as a fringe benefit because you don't pay taxes on the part that your employer contributes. The problem has been that, while some small firms offer health insurance coverage, others do not. It's almost never a case where a firm offers health insurance coverage and an employee says, "No thanks." Therefore, our strategy has been to try to break down the barriers that have kept some small firms from offering health insurance coverage.

The problem is that health insurance for small firms has been too expensive and too unreliable. If somebody in your small firm of 10 or 20 employees becomes ill—I mean really ill, has cancer, has a

serious heart condition, has a serious case of diabetes—that makes health insurance either impossible for your firm or extraordinarily expensive.

What we have proposed is basically a restructuring of the rules that the insurance firms use when marketing to small firms. Under our proposal, insurance companies could vary their premiums only by a certain amount. They could increase premiums only by a certain amount over time.

We try to encourage small firms to band together by exempting them from some State mandates and taxes. That is, if you go into the marketplace representing 20 or 40 insured lives, with 15 employees, nobody is going to pay much attention when you ask for a good price. But, if you come in representing fifty thousand insured lives, you will command the same kind of attention that very large corporations do. Small firms coming together will represent a big block of business. Our approach, rather than mandating that employers provide insurance coverage, has been to try to break down the barriers that have kept some small firms out.

Now these are very different strategies to solve a commonly agreed upon problem. We all want to see people in this country protected by health insurance. It's a part of a larger fight because it involves different views of the classic role of Government in terms of solving problems. One involves using the force of Government to directly intervene and make the fix. The other requires the use of the force of Government to set up rules and enforce these rules to allow a fix to occur on its own. The problem with the direct alternative is that in attempting to provide health insurance, you kill off small firms and risk unemployment for many low-wage employees. This is central to the debate.

I think the positive news is that there is a clear and strong recognition of the problem that those of us who have been involved in health have felt plagued by for the last 15 years.

That is, a persistent number of people without health insurance coverage are at financial and medical risk to themselves and impose some real difficulties in their communities. The good news in the United States is that, for the most part, people who have a real need for health care will get health care, even when they don't have health insurance coverage. Nevertheless, we understand that they don't often get the right health care at the most appropriate time or from the best set of health care providers.

The issue is one that has been around for a long time. It's been one that we have now seen the Government focus on for the last couple of years, but we have yet to really solve this battle as to how to take care of the problem for the nonpoor. It is a question that we will have to deal with in acute care coverage. It is even going to be more difficult when we try to answer the same question for long-term care. That is, by the way, the question we're going to have to deal with, not who's going to take care of the poor. We know who's going to take care of the poor—the Government. Who else is going to take care of the poor? The real battle is going to be what obligation, if any, does the Government have to people who are not poor.

That question becomes even more complicated for us as a country as we move to combinations of medical and social service away from pure medical care, because we have a much less clear definition of what we think the proper role for Government is.

Let me stop here and see whether there are questions that I can answer before I turn you over to the rest of your program.

Q. *In earlier discussions it was said that 7 million of the uninsured are Hispanics and that many fall below the poverty line. My question is: How are we going to ensure access for these projected 7 million Hispanics? Also, can we help our families stay together when this effort may make many persons ineligible for Medicaid benefits?*

A. A strength of the Hispanic community is that families have tended to stay together. This is a real positive, but it does cause a problem with Medicaid coverage. This is a problem only because of our past of reliance on welfare as the main entrance into Medicaid coverage. The President is now proposing that anyone, by virtue of being below the poverty line, should be covered by a public program. This will address the problem you raise.

I think also the issue of what happens to small firms is of no small interest and consequence to the Hispanic community. Hispanics as a group have long been associated with small business and with the integrity and stability of family life. The challenge is to solve both problems while ensuring that we don't put small business at risk. These are concerns that have traditionally resonated in the Hispanic community.

Let me mention one other thing. We know that financial access is not the only problem. Physical availability is sometimes a problem. In Medicaid, we have had many programs that really have not been constructed in a way that enhances the ability of people to access physicians and nurses and obtain care outside of the emergency room. I know there is someone here from the Arizona Access Program. That's usually one of the programs I cite as an example of how we can, even spending at levels that we have traditionally associated with Medicaid, arrange health care in such a way that people are not pushed off to the emergency rooms to receive their health care. The Arizona Access Program enables people to receive care from health professionals outside of institutions and to use institutions only when and where needed.

We need to remind ourselves that financial access is the first step. We also have to be more creative in providing financial access, or we will spend a lot of money and end up not providing health care to some people who very much need it.

Q. *Two things are important in the Hispanic community. When we are insured, you pay for me, but you might not pay for my family. Do I lose my insurance if I change jobs? That's number one. The second one: If I have a small business, do I have a deduction bigger than 25 percent?*

A. The second question is the easiest. We are proposing a 100 percent deduction for all self-employed and unincorporated businesses. It is totally unreasonable to take our smallest, most vulnerable businesses and put them at the least tax advantaged position, that is, being able to deduct only 25 percent of the premium. We actually have legislation that has been up on Capitol Hill since May 8, with financing attached to it to increase the deductibility to 100 percent for self-employed. It has been enormously frustrating. Even with strong policy agreement, the bitterness of the political year has just kept things from being enacted.

With regard to the first issue, family coverage and changing jobs, we again are not proposing to people to provide coverage through their place of work. Our proposal seeks to ensure that, if you change jobs, you cannot be kept out of insurance coverage because of a preexisting condition. This would be true for large companies as well as small companies. No one, according to the insurance restructuring legislation that we have up on the Hill, would be able to be kept out of insurance because of a preexisting condition once they go through an initial 9-month waiting period, pregnancy not counting, as long as they are generally going through insurance coverage.

We have to make sure that insurance companies who cover many sick people don't go out of business. States will have to put up high risk pools to help insurance companies that happen to face an unusual number of sick people. This is the quid pro quo: Insurance companies must take all comers, but we will give a couple of different strategies that States can follow to make sure that those companies with disproportionate numbers of sick people have a way to get compensating payments. Without such support at the State level, insurance companies

would be put out of business or have a strong incentive to find a way to skirt whatever rule you put up, which is usually what happens.

Q. *Are taxes going to be raised to pay for this insurance?*

A. There are some substantial ways that we can fund health care without increasing taxes. Probably every one of us in this room at one time or another has said $800 billion really is enough—we're just not spending smartly. The first place that we would look is something that we call "disproportionate share spending." These are monies, mainly under Medicaid but a little under Medicare, that go to hospitals to cover payments for uninsured people. They are Medicaid and Medicare monies that don't go for Medicare and Medicaid people; rather, they are being used under these programs to finance care for the uninsured. But, we're doing it in the worst manner. That is, we're paying hospitals that treat people without health insurance in their emergency rooms and in the hospitals. We would like to divert a substantial amount of this money so that we can get people in the front door, not the back door, and keep them out of the emergency room.

Additionally, we know that some things use a lot of money in our system, such as malpractice, which causes institutions and physicians to do things not for their medical benefit but to protect themselves.

We know we can do some things to make the system more administratively efficient: using common billing forms, electronic billing, and common data elements for medical review, and getting some information out so that purchasers of health care know what it is they are purchasing, who charges what, and what they get for their money.

The base that we would start from is the $85 billion that we are going to be spending over the next 5 years for hospitals to provide health care to people without insurance coverage. Disproportionate share spending has got to be one of the worst ways to spend such a large block of money. Frankly, it reflects the financial maneuvering that States were doing in the last couple of years. The fact is, until 1990, disproportionate share spending under Medicaid was about $3 billion a year. It is now close to $16 billion a year.

Q. *Many of us who are adequately insured have seen really rip-roaring increasing costs with minimum benefit. That one issue has been of great concern to the middle class of the United States. Coverage for preventive service has been shrinking over time. How do you plan to address the issue of increasing costs in what is a highly unregulated society, a highly unregulated industry, including pharmaceuticals, possible billing equipment, etc.? How do you expect to deal with the costs that have to be paid for Medicaid or Medicare in this largely unregulated industry?*

A. Basically, you have two choices, and you have only two choices. One is to regulate the entire industry by price controls. The other is to treat the factors that contribute to rising expenses.

We have tried price controls in this country from time to time. We have not liked them. They haven't worked very well. They have typically led to very rigid systems. European countries that have tried to limit spending by directly controlling prices and setting global budgets have enjoyed some success in limiting spending. However, this control has typically been associated with rather long lines and with the unavailability of services during certain parts of the year.

Instead, we are trying to go after all of the forces that keep spending so high. Our approach features malpractice reform, coordinated care, managed care systems, repeal of anti-managed care laws that exist in a lot of the States, restructuring of the insurance market, assumption of managed risk, and requirements for States to put out consumer information (who charges what, what hospitals charge, which hospitals are good, what networks of physicians are doing, what you get for your money, what insurance companies are doing, how much of

the bills they pay in benefits versus how much premiums they collect). We are basically trying to attack the problems that have kept health care from responding to normal kinds of economic forces and incentives.

These really are your only two choices. You can try to control the industry by Government intervention across the board—hospitals, physicians, pharmaceuticals, medical supplies, wages, etc.—or you can try to make this area work the way other parts of the economy work.

I actually tried to set 7,000 prices under Medicare as part of the relative value scale. Having Government take over the function of setting the "right price"—not just in 1 year but over time—and making sure that prices really reflect both what the costs are of producing them and what people feel about them (so you don't end up with long lines because you miscalculate where it was people wanted to go) is a very daunting job.

I think the general concern that we feel in this country about having the Government try to regulate 13 percent of the GNP [gross national product] by direct Government regulation ought to make us pause. The worst thing we can probably do is go toward the middle in this choice. Either we're going to have to be serious about trying to unleash the forces that will allow for incentives and market forces to work or we're going to have to regulate like crazy; but you can't do a sloppy job in either approach. It's what we've been doing, and it doesn't work. We have found ourselves in the worst of both worlds.

Q. *I think the key word is prevention. Any family who is on the borderline in terms of affording medical coverage can be destroyed by acute care. Yet insurance companies have a notorious reputation of not providing adequate coverage for preventive medicine. I'm wondering if, in any of these programs involving insurance companies, they have been agreeable to increased coverage for preventive medicine.*

A. It depends on the setting in which it occurs. Preventive care, as part of a coordinated care/managed care setting, makes a lot of sense. In fact, when you look at who provides the most preventive care coverage, it's HMOs [Health Maintenance Organizations] and other groups that are financially responsible for all of the individual's health care.

Under our program, we have insisted that States must make a coordinated care plan available for everybody who is under the voucher. Although we're not going to force people to go into it, we would like to have coordinated care as the rule rather than the exception, because we think it offers the best amount of benefits for your money and encourages preventive health care. We also recognize that not everybody wants to be part of a group. Some people have rather strong feelings about not being part of a group, and we don't want to force them. The question of whether or not insurance either can or should insure a low-cost event, if it's outside of a managed care setting, is a much different question.

For people who are on the border of being poor and low income, you want to make sure that, if they are out of an HMO or a managed care setting, they have preventive health care available to them. That is why we have such a big push on community health centers, migrant health centers, and rural health centers. We have had an almost 50 percent increase in PHS funding over the last 3 or 4 years. But it's not always the right role for insurance coverage unless it's done within the coordinated care setting.

Q. *With the increase in access that the administration is working on and the plan to increase insurance availability, in what direction is the administration heading regarding health professionals' capacity to handle the increased health service deliveries that can come about from this?*

A. We have been worried about the numbers of people who are in specialty care in medicine versus

primary care and the number of people in urban areas versus rural areas. One of the reasons for making the relative value scale changes was to tip the balance of Medicare payments in favor of primary care medicine and away from specialty care. The 10 percent bonus payment for physicians that serve in underserved areas and the more liberal use of physician assistance reimbursement rules in rural and underserved areas were similar. Our proposal for several years, to reimburse hospitals' undergraduate medical education programs more for primary care residencies than secondary and tertiary care residencies and more for first residencies than secondary residencies, indicates a whole series of policies to tip this balance away from specialty care and into primary care.

There is also some real potential for more selective, targeted loan forgiveness programs to target individuals, minorities, and others who are underrepresented in providing access to special populations, and to get people out to areas that otherwise don't get enough health care professionals. We tried this approach during the late 1960s and early 1970s, and it was pretty much a failure. But tuition at the time, at least for medical school, was very low by comparison, say $2,000 or $2,500 in terms of the cost that most of the loan forgiveness programs were targeting. Medical school tuition is up to $22,000 a year. That gives you leverage on students, particularly when you add in living expenses; that really does allow you a lot of leverage if you care to use it. I think we're going to need to recognize it's going to take not one or two policies but a series of policies all moving in the same direction.

A concern has been that the minority physician is treating a disproportionate number of patients in those areas in need. Yet, I don't know if a 10 percent increase per patient is enough to motivate my colleagues to take these patients when they are already carrying a huge patient load. I don't see how we could continue to encourage medical personnel development in the minority areas for minority groups if this trend continues. We end up treating our own, but we don't get compensated for our own.

People have to understand that there's no single one policy that's going to do it. If all people who are poor have health insurance coverage, that will substantially change the whole dimension, particularly in urban areas, of who's been treating what, since large numbers of people who are in the urban areas don't have any financial wherewithal when they're coming in. The second thing is the change in the relative value scales tipping toward higher reimbursements for primary care and lower relative reimbursements for secondary care. In addition is the 10 percent bonus for people in underserved areas. If, in addition to that, there is greater use of selective loan forgiveness or other kind of targeting programs in working with medical schools, that's how you begin to change things. I know that the University of Minnesota at Duluth has reported a very successful venture in terms of recruiting people for rural areas and keeping them in rural areas. Dartmouth has a very intensified effort to produce primary care physicians. If we can get medical schools around the country to have a more aggressive role in recruiting minority students and other people who are likely to go into primary or rural practice, then you can begin to change this. Now there are some Federal possibilities for intervention, but these are largely outside of PHS: the military related program or public or private institutions with some Federal monies. Frankly, getting the medical schools to alter their attitudes and behaviors is really what's needed and not particularly amenable to legislation.

Barbara Everitt Bryant, Ph.D.

Director, Census Bureau
U.S. Department of Commerce

Buenos dias. Thank you for inviting me to share some of the information that the Census Bureau

produces that has relevance for the Hispanic/Latino Health Initiative. I'm going to present the census data on charts, because we always give you too many numbers to absorb, particularly after breakfast.

As you well know, the Hispanic/Latino population has been growing at a very rapid pace. Hispanic health, therefore, is of growing importance to the well-being of this Nation. Between 1980 and 1990, the Hispanic population grew by 53 percent or about 7 times as fast as non-Hispanics. This was one of the most dramatic findings of the 1990 Census. Numerically, this was an enormous growth, and it's showing up in all of our surveys now that we can do more detailed profiling of the Hispanic community.

The Mexican-American nationality, origin, or population grew at about the same rate, 54 percent, as the Hispanics overall. The slower growth of the Puerto Rican and Cuban populations—I'm talking about those in the 50 States and D.C.—of 35 and 30 percent reflect a slower level of immigration, but it's, nevertheless, very impressive compared to the white, non-Hispanic growth, which was only 4 percent. Now those we call "other Hispanics" are primarily of Central and South American origin. There are so many countries involved, we can't just disaggregate them by their nationality. But, you'll see that the 1980s was a time of enormous immigration and a growth of 67 percent. Not all of that growth was from immigration, but a great deal of it was immigration among what we call the "other Hispanics," which are those from the south of us. Our most recent projections which will be released later this year, perhaps even within the coming month, show that we expect this rapid growth to continue well into the next century.

Now here are some of the findings. First of all, in 1970 there were 9 million Hispanics in the United States. I point out that, though the Census has been around since 1790, we did not have a specific question on whether or not you were of Hispanic origin until the 1970 Census. You'll see that, between 1970 and 1990, you went from 9 to 22 million, and this does not include a separate count of Puerto Rico. There are 3.5 million persons there, most of whom would be called Hispanic.

In 1992, we already are estimating about 24 million Hispanics. According to our latest projections—and we do a sort of high, low, and middle series—the middle series shows that Hispanics may range from 29 to 31 million by the year 2000 and 37 to 54 million by 2020. Of course, as we get out further, there's more wobble in our projection; so we show a wider range of 74 to 96 million. At around 2010, we expect the Hispanic population to pass the African American population in this country.

In 1970, Hispanics in this country—and again I'm excluding Puerto Rico, though they are American citizens—were about 4.5 percent of our population; by 1990, this had doubled to 9 percent. We already know this growth is continuing, and by the year 2000, it's going to 10 to 11 percent. Then our numbers go on out again with a wider range when we get to 2050.

One advantage for you in doing a Hispanic/Latino initiative is that you can concentrate on a smaller number of States than 50 in terms of your numbers. Five States in the Southwest—California, Texas, Arizona, Colorado, and New Mexico—contain over 60 percent of the Nation's Hispanics. California has over one-third. Incidentally, California grew by about 6 million between 1980 and 1990; one-half of that growth, 3 million, was Hispanic, and about one-fourth of it was Asian. Thus, your Hispanic health initiative must focus disproportionately on these five southwestern States, plus Florida and the New York City area. You can include most Hispanics by concentrating on seven States; however, then the rest of the Hispanic population is very dispersed over the remaining 45 States and, therefore, much harder to focus that initiative on. In a number of States, the proportion

of Hispanics is higher than the national 9 percent average, and most notably, both California and Texas are now 26 percent Hispanic. So one out of every four citizens of those two States is Latino.

The Hispanic population is young and will continue to be comparatively young when you compare that to the non-Hispanic population. However, as time goes by, naturally, it will age. The median age of the Hispanic population is now 26 years, compared to 35 years for non-Hispanic whites. That is an enormous difference because, as all of you know, median means half are older and half are younger. It takes large numbers to move the median around, and that 9 percent difference there is really quite enormous.

Currently, this means that you've got a lot of children. About 35 percent of Hispanics are below age 18, and only 5 percent are age 65 and older. Thus, in the health field and in this initiative, you're going to need to concentrate more on pediatrics than gerontology. The 35 percent who are children or minors, i.e., below eighteen—teenagers would never let you call them children, of course—compares to 26 percent in the total U.S. population. The 5 percent of Hispanics who are senior citizens compares to 13 percent in the total United States.

This age mix will shift a few percent each decade. By 2020, between 31 to 34 percent, about one-third, will be below age 18, compared to the 35 percent today, and about 8 percent, compared to the 5 percent today, will be senior citizens. So you will still have, though with some change, a smaller percentage of elderly and a higher percent of children than in the population as a whole.

One of the real challenges for the Hispanic community is going to be to keep those children in school. Hispanics now have a lower educational attainment than other U.S. residents. Only about one-half or 53 percent of Hispanics who are age 25 or older—we start measuring education after age 25 to give most of us a chance to get it—have completed high school, compared to 82 percent of non-Hispanics. That is an enormous difference. Only 9 percent have graduated from college, compared to 22 percent of non-Hispanics. However, the good news is that there is progress. But, we need to be sure that progress continues because, obviously, deficits in education affect economic ability, and that in turn affects health care and access.

Hispanics are more likely to be unemployed than non-Hispanics. In March 1992 when we measured it, just a few months ago, 11.3 percent of Hispanics were unemployed, compared to 6.5 percent of non-Hispanic whites. There are clear variations among the Hispanic nationality groups, ranging from 9.5 percent among Cuban Americans to 12 percent among the Puerto Ricans in the 50 States. When employed, Hispanics are more likely to be employed in lower paying, less stable—and, as our previous speaker points out, less stable means less health insurance—and more hazardous occupations than non-Hispanics. Among males, Hispanics are more likely to be employed in services, farming, forestry, and precision production, and as operators in factories and other places. Non-Hispanics are more likely to be employed in managerial, professional, technical, and sales occupations. Interestingly, Hispanic women closely match non-Hispanics in the proportion of technical and sales jobs among women.

Hispanics tend to have lower incomes than do non-Hispanics, which has some correlation with the education levels that I showed you earlier. It also reflects the fact that proportionately more Hispanics are newcomers to the Nation. The median family income of Hispanics, at $23,400, was about $14,000 less than non-Hispanic white families. These are families with related people. There is variation among Hispanic groups, and there would be more variation if we had time this morning to go into details and look at groups according to whether they're first, second, or third generation within the country, whether they are recent immigrants, and

whether they've completed college or high school. Averages always, you know, mask diversity.

Based on cash income only, and that is the official definition by which Office of Management and Budget requires that we measure poverty, Hispanic families are more likely to be poor than non-Hispanic families. About one-fourth of Hispanic families, 26 percent, were below the poverty level for last year, 1991 (we measured it in March 1992, covering the previous year), compared to 10 percent of non-Hispanic white families. Again, there are some rather dramatic differences among groups by national origin. The Cubans reflect the fact that most of them have been in the country longer, having a much smaller proportion in poverty than other Hispanic groups. The Puerto Ricans have the highest levels there.

Poverty disproportionately affects children, and this is true whether you're white, non-Hispanic, African American, or Hispanic. But, it's rather dramatic among Hispanic children because proportionately the Hispanic population has more children. About 41 percent of Hispanic children live in poverty, compared with 13 percent of non-Hispanic children. This is why I am just so pleased about this Hispanic health initiative; because it is the children who are the future for us all. About 21 percent of Hispanic adults, including the elderly, also live in poverty.

How do these demographics affect health? Here, I really feel as though I am picking upon the subject of our earlier speaker, only showing it to you in a somewhat different way. We have a survey called "The Survey of Income and Program Participation" in which we interview families periodically over a period of 28 months, a little more than 2 years. Therefore, we can track things like health insurance, instead of doing what most surveys do, which is ask what were you doing yesterday or today when I interview you. This shows the pattern.

First of all, Hispanics are less likely than non-Hispanics to be covered by either private or governmental health insurance. Even among Hispanics with health coverage, they're less likely to be continuously covered than are non-Hispanics. Over this 28-month period that we measured, 11 percent of Hispanics had no health insurance during the entire 28 months. Thirty-six percent had coverage during some part of that time. These may be people who went in and out of the labor force; they may be children who became adults and lost family coverage—many reasons, some of them related to what our earlier speaker talked about. Only a little more than one-half or 54 percent had coverage the whole 28 months, the total health safety net.

So let me just summarize what I've covered this morning and take a few questions, if there's time. The Latino or Hispanic population has been growing at a very rapid rate. We fully expect the rapid growth to continue well into the next century, which is as far as we can see. Our crystal balls get very cloudy after that. Immigration has played, and will probably continue to play, an important role in this rapid growth. The Hispanic population is young, with a high proportion of children. Of course, the Hispanic population will age, but it will not have the proportions of elderly that exist in the total population until well after 2020. Compared to non-Hispanics, Hispanics have less education on average; are more likely to be unemployed; are more likely to be employed in lower paying, less stable, and more hazardous occupations; have lower income; are more likely to be poor, and this is particularly so for children; and have lower proportions covered or continuously covered by health insurance. These demographic differences are important to consider as you continue your planning of this Hispanic/Latino Health Initiative.

Q. *When discussing the issue of being accounted for, one must mention the undercounting of Latinos. What do you see being done by the year 2000?*

A. I see a lot of change coming for the year 2000. First of all, I would not say that 1990 was worse than 1980, even though the media said so. We now know that we have much better research on undercount in 1990 than we did in 1980. The two kinds of research we've done since the census do suggest an undercount of about 1.6 percent and about a 5 percent undercount among Hispanic. So, you know, there's possibly a million more than the 24 million we're saying there are in 1992.

What the undercount research has done has suggested some different ways of counting in 1990, plus probably incorporating some statistical estimation right into the counting process as we go along. For example, there's a much higher undercount among renters than among owners. Well this suggests that in the year 2000 we may do a very different, a more massive targeting of areas with a large number of rental homes, even perhaps before the major mail-out of questionnaires. I think we will also have more ways of being counted. We have, in the past, had to be very careful with how many questionnaires were out there so that nobody could vote early and often, as the old joke goes.

We certainly are going to be able to handle multiple languages much better in the year 2000. A lot of this will be computer-assisted telephone interviewing in which, if you want to be interviewed in Spanish rather than receiving a questionnaire in English in the mail, there will be an 800 number that you call. We actually used enumerators who spoke 52 languages finishing up the Census in New York City.

Q. *I notice in your data that you had "other Hispanics." How do you determine when you disaggregate the various groups? When do you disaggregate that particular designation to people from El Salvador or other places?*

A. It is disaggregated. When I say we can't disaggregate in detail, what I mean is that we can't keep disaggregating in too great a detail. What happens, when you get to different groups, you then can't start looking at things like, their health insurance by age or by poverty status.

We do know that the "other Hispanics" are mostly Central and South American. But, even a few from Spain itself come under Hispanic, and then we have a Philippine population that has come in as sort of Asian Hispanic. We get lots of variations.

Q. *A fairly significant proportion of Latinos along the border in California and Texas, in particular, migrate from Mexico legally and illegally at different times of the year. Did the Census account for people who are here temporarily on green cards, people who are here as laborers, both legal and not? And, where does it appear in the data? They do impact our services, and it is a significant burden to provide care for these.*

A. Everybody who is in the United States on April 1, 1990, is to be counted, and it doesn't matter whether he or she is documented, undocumented, citizen, or noncitizen. The exception would be if you were on a tourist visa. Even students that are here for the year are counted. Those who come across the border and just work for a week are counted. So the effort is to get everybody who's resident whether citizen or noncitizen, and that's the way our Constitution has been interpreted.

Q. *How do we encourage people to come forward to be counted without the traditional fears? How do we show that numbers will not be used against them, but for their benefit and the benefit of others? How is the census going to have a friendly face?*

A. We count on people like you to communicate that. The census does have the cleanest record in the world of never having revealed data on an individual—that is, not for 72 years. It is a particular problem to communicate that fact to an undocumented person. We do know from the

research on 1980 that we did count at least 2 million undocumented persons.

The census has a tremendous outreach program, working with community and national organizations. Some of these organizations put a great deal of their resources into trying to get their communities counted. Still, communication is a problem.

Robert S. Murphy, M.S.P.H.

Director, Division of Health Examination Statistics
National Center for Health Statistics
Center for Disease Control and Prevention

Buenos dias. I'm very pleased to be here on the 10th anniversary of the beginning of the Hispanic HANES [Health and Nutrition Examination Survey] Survey. Together, we made that work, and many Hispanic and Latino researchers that were involved in the definition and support for that study are here at this leadership conference. The tasks you have embarked upon involve very difficult issues, because what you are doing is trying to take the progress that has been made, sustain that progress, and go further. But, bureaucracies are feeling rather complacent after having made such progress.

We are now entering a time when resources are going to be rather scarce. There are going to be difficult decisions every day on what kind of programs can be supported. I think information is going to be crucial in allocating resources, both in the health field and all other fields. You are going to need to determine priority areas and push for them very hard. As a bureaucrat, at times I am going to be rather uncomfortable with the pushing, but it's necessary, and it's important because it will show what the priorities are in your communities.

I'm going to speak very briefly about the availability of data and somehow try to deal a little bit with what I see as the gaps. Some of the very important things that you're dealing with here in this conference involve how we position for the future, because clearly the way we're doing things now in trying to develop health studies that will satisfy the needs for data will need to change.

They will need to have different dimensions. It will no longer require oversampling of Hispanics when there are 50 million in the population or 60 million or even more. It will require having many different kinds of issues covered and different kinds of dimensions that researchers will find very difficult to deal with. And, we need to begin now; so one of the major purposes for my talk this morning is to try to define where we go from here and what I see as some of the issues that are involved.

In looking at the data availability over the decade, it's really impressive the progress that has been made, in vital statistics. Forty percent of the registration areas in 1980 reported Hispanic identifiers. In 1992, that percentage is up to 95 percent. We have a long way to go on the quality of the data. There are aspects of it that need to be improved dramatically, but it's no longer selling the need for the information in that area.

In the National Health Interview Survey we have made dramatic progress. It's very clear. Blacks will have been or have been oversampled in 1986 through 1994; Hispanics or Latinos in 1987, 1992, and 1993; and Asian groups in 1992. This basically means that we are going to be able to produce an awful lot of morbidity statistics, an awful lot of information about health characteristics and health actions and perceptions of health.

The redesign of the Health Interview Survey, begun a long time ago and instituted for 1995, will have, as part of its objective, the oversampling and the provision of information for Latinos, for blacks, for Asian and Pacific Islanders, and for special population studies. There's a big question, though, and I think it's important this group be aware. The design of the study calls for a huge increase in sample size of that study. Along with that, a lot of costs will be incurred, and the costs are going up.

What happens if the resources aren't available? How will that sample be allocated? Will you have the data that was basically built into the original proposal? It's an important question. I don't have an answer.

In the Health Examination Survey, in the 1960s up through the end of the 1970s, we produced information for the total population for blacks and for whites, and then we had the Hispanic Health and Nutrition Examination Survey, which was a landmark in its time. In HANES III, the current study being conducted from 1988 through 1994, we are oversampling some Hispanic people. In the Hispanic study we sampled Mexican Americans, Puerto Ricans, and Cuban Americans. In HANES III, we are oversampling only Mexican Americans.

What happened? We've made a lot of progress, but not enough. What we tried to do in planning for the HANES III study was to incorporate the gains of the previous study for the most important areas. The HANES study is a very expensive study, and the way we've approached it, it is very difficult to expand to small groups.

The original proposal for HANES III included a sample for the Puerto Rican population. The resources simply weren't available. Now I'm going to come back to this point a little bit later and try to say something about what this means, but it's the reason I raised the question about the Health Interview Survey. With the HANES study we are able to produce a lot of information on physiological variables, on physical characteristics, and on attaching this information to information about health care utilization, about perceptions, about assessing if our messages are getting through to people. We can ask both perceptions and get objective measures of certain types of characteristics. The important thing, I think, in looking at the HANES study is that one can say we made some progress, but we're not where we need to be.

The methodological and conceptual issues abound in trying to expand these national studies to cover more population groups. It's really an awesome task to try to see how to position the national studies to deal effectively with many different kinds of issues. I'd like to just raise a few, because I think we have to systematically address these kinds of issues, and having a group like this available and thinking about them and working with us to deal with them, I think, is vital. There are difficult issues, even for detailed research studies, no less the national population studies.

How does one separate out race and ethnicity issues from socioeconomic and demographic measures? We need efficient ways to sample minority populations. We need information, detailed information, for denominators in sampling frames if we are to reach minority populations in a cost-effective way. These denominators are very difficult to interpret, even when you gather information on ethnic and racial categories. There's a lot of disagreement on how to ask these questions, how they'll be interpreted. How do you define how the people feel their national origin should be reported, and what does it mean? Problems and limitations exist with current questionnaire design. Issues arise with cross-cultural validity and sensitivity. Interviewing techniques and conceptually equivalent approaches need to be developed if responses are to be standardized in their interpretation. This is a huge issue. This is not the kind of issue that is going to go away as your population gets bigger. This issue is going to remain constant. So this is an area in which we have to do research, and we have to do it now.

Numerous operational issues also exist. Methods and modes of operation need to be carefully examined. This is clear from what I think happened in HANES III. We tried to expand coverage to just one more population group, and the expense was too high. What's the implication? Something needs to change with the mechanism. I

mean, it needs to be examined again. Research will be necessary to develop simpler methods, and methods that can be employed under different, less expensive type of circumstances. It's not an easy thing to deal with, because you can't compromise the concept that you're trying to measure. You need to do it better and more efficiently. It's not going to be easy.

In addition, we need to look at issues of comparability over time and timeliness of the production of information. To address these issues with national samples and national studies is going to be very difficult. It could mean the need for major rethinking about how we go about our studies and design them. This is not good news to bureaucrats. This is uncomfortable, because it means change. It means reevaluation, and it means real thinking.

These are complex and multidimensional issues, and they are fundamental in trying to get you the kind of information you need about your communities. In the past, in designing statistical studies, in designing any kind of study, you set the objectives on what you wanted to be able to control for and how much precision you wanted your estimates to have. Typically, in the past this has been done by saying, for the total population, by age and sex group, we want this kind of information. Now if we are going to design studies that produce information for subgroups of the population with good precision and have the ability to do analysis in some detail to try to effect change or look at underlying relationships, this concept needs to change. The total is the sum of the parts rather than the other way around; i.e., find the total and then we'll get the parts that we can. The totals are very important for this country, and we are a country. On the other hand, we have to balance that with the need for detailed information on health care, health utilization and access, and the health characteristics of the population. Are the differentials disappearing? Are our actions or the money we're spending on health education and nutrition programs being effective? We need the information, and the only way we're going to get it is by looking at more detail in the subpopulation groups.

What mechanisms are available to support and promote this kind of effort? Well, I think there are several, and I'll only speak for NCHS and CDC a little bit. I think there is a recognized need that this is an important area and that we have to make progress in it. I think that's number one. I think you have to know that there's a problem before you can start dealing with it, and I think that is in place.

I think it's important that the issues and the urgency of the need for information be raised to the highest level people you can find. In this case, you've got a workshop here in which you have the Surgeon General of the United States, and I think that this is a vital way of approaching this problem. When the top recognizes the problem, it's amazing how the bottom follows along and does something about it. But, I think there's another important thing; it can't be a one-time occurrence. I think it needs to have periodic progress reviews, and I think they need to be visible. There are programs in place for doing intramural and extramural research. These kinds of mechanisms need to be employed to help change the systems that are currently in place for gathering health information.

We need to be able to develop cross-cultural questionnaires and sampling strategies that permit complementary and supplementary studies to the targeted populations, studies closely related to the national studies or incorporated into them. Otherwise, the analysis of the data is confounded by differences in time, comparability of methods, and a number of other issues that can be raised. Perhaps even the grant mechanism that NCHS has could be used to do some kind of special studies. I think it's also important in these grant mechanisms that the minority communities, researchers, and others involved be strengthened so that we can continue to have those that are informed, that

know the issues, and that can raise them effectively in agenda setting meetings.

I think it's important that we support the research of the Census Bureau. It's basically the Census Bureau that gives us the population denominators and the information on how to go about sampling strategies and to effectively and efficiently deal with changing our mechanisms for getting minority populations.

I think there is also a need for better analysis of the data that is available. This is difficult, because there is a shortage of money, and lots of times the research dollars go to basic research that is looking at new data collection. I would like to see more analysis of the data that is available. I think that this would help us in a number of ways in my program. It would help me get into the data in such a way that I could see what we have addressed adequately, and people that are doing the analysis could raise what we couldn't address adequately. Then we can change to address those most important issues.

I commend you for your support of the efforts of this workshop, and I look forward to your recommendations and any questions you have.

Q. *One of the major problems, we know, is the availability of Hispanic researchers in putting national data to good use. What mechanisms do you think need to be developed that could expand training and promotion of Hispanic researchers in working on those national data sets?*

A. With the institution of the minority health program in NCHS and the subsequent grants for the program, the recognition for the need for technical workshops and support, as part of the grant mechanisms for the development of Hispanic researchers is recognized and, to the extent possible, will be pursued. I can't tell you how much, other than that. I think, as the center becomes more knowledgeable and obtains more funds for the minority grant program, that it's necessary.

Q. *Why is there so little baseline information in the year 2000 objectives? There are 300 objectives; 25 of them are Hispanic specific. The reasoning is that there's not enough baseline. So for 275 objectives, they're saying that we don't have information on Hispanics. I thought that Hispanic HANES was going to be a good resource to get at that issue. What happened? What happened to the baseline on those 275?*

A. I guess you know that HANES addresses maybe 25 or 30 research areas, and of those, only a subset are in the year 2000 objectives. On the other hand, I think the information from the health interview surveys will begin providing baseline information for a wide variety of those objectives.

I really think that this group should discuss this issue surrounding Puerto Ricans, because it has lots of implications. One option is, obviously, to continue to pit one group against the other. I think it's important that, several years ago when the analysis of Hispanic HANES data occurred, it was really the action of lots of concerned individuals, many of you sitting in this room right now, that moved the appropriate political forces to suddenly get money to get the analysis done. So my sense of it, based on history, is that we can do this again. In order not to lose the opportunity to collect data, we must really mobilize and address the appropriate forces. We need to do something about HANES IV.

I am a witness that the Hispanic community basically mobilized the resources not only for the data analysis but also to conduct the study, the definition of the study and, further, the analysis of the data. It was mobilized at a time of very tough competition for resources. It was mobilized because the Hispanic leadership at that time went to the White House and said, "This is most important to us." Can it be done again? I would think so, but I think the point of my remarks was that what we know now and what we knew then is somewhat different. We know that we can't really expand HANES the way it's run or some of the other studies the way they're run to cover these groups

and lots of other groups, too, adequately. Can you mobilize? Yes. I think that this type of initiative that the Surgeon General has sponsored here is a first step in future development.

I'm just wondering what we can do to help you, and I'd like to make three points. I'm still not delighted to be part of the oversampling group, because this oversampling means I'm still not part of the big picture. So I'm not comfortable with that, and as part of a larger Hispanic group I think that doesn't serve me among my peers. Second, I think that it affects majority health care when we produce numbers that pertain to one group, and several things can happen. One, they can try to spread that knowledge among other Hispanic groups where it doesn't fit or, worse, they can say, this knowledge, we know, is only pertinent to this group. Therefore, we're just going to throw it all out and not use it at all. So that does not serve us. Third, I don't think the responsibility of leaning on people to get us funds for our group should be our responsibility. The majority of the country is included in this study, just as a fait accompli, as a natural course of events. I don't know what we can do, but I'm asking you to help us. How do we become part of this national course of events?

I agree with all your comments. What we have tried to do in the past in terms of looking at minority health populations, regardless of which minorities, has been to somehow add them to the national sample and keep everything else constant. That has to change, if we are going to do a better job on these areas. It has to change the way we sample, or it has to change the depth to which we can go in different types of studies, or it has to change in terms of accommodating special concurrent studies so that the data is comparable and of as high quality as the national studies are. It's very difficult for a national survey mechanism to address local types of population groups and issues. We've got to adapt those mechanisms differently and better.

We tried to build in, at a reasonable cost, two of the major Hispanic populations and to institutionalize the approach to understanding the health of these groups better, and it didn't work. What it means is that we now have to do something else. There's going to be a lot of competition for how we cover different population groups trying to gather information. It's going to be: Do you want this information or do you want more funds for Medicare? Do you want more funds for WIC [Supplemental Food Program for Women, Infants, and Children]? There's going to be a lot of competition for Federal funds. So it's going to be necessary for people who want information to make sure that the importance of that information is recognized by the people making the policy decisions, by the people that have the resources to allocate. By the time it comes down to me as a program manager, I may have so few options that I may not be able to do things in different kinds of ways.

I think that's crucial to this group to understand that the competition for funds is going to be at times very ugly. Do you want more services or do you want to study the problem? That's a hard question to deal with when you see how important those services are to people, to individuals. Information is important to make things happen, not just for the individual. So we'll try to be responsive.

Rafael J. Magallan

Director, Washington Office
Hispanic Association of Colleges and Universities

Buenos dias. I plan to touch on three topics in my brief presentation: first, to share some information regarding the Hispanic Association of Colleges and Universities, HACU; second, to make a few observations regarding the condition of Latinos in higher education; and third, to explore with you some possible opportunities for action and collaboration.

First, I think you should know a little bit about HACU. It's a very young organization. It's been around for only 6 years. But as young as it is, it has grown very rapidly. It comprises a network of 118 colleges and universities, all of which have at least 25 percent Hispanic/Latino enrollments. A good number of these schools have Latino majorities. It was felt that 25 percent represented a significant measure not so much of distribution, but of a sufficient enrollment to constitute a critical mass.

When we look at HACU member institutions designated as Hispanic-serving institutions (HSIs), those 118 colleges and universities represent one-half of all Latino students enrolled in U.S. higher education; that includes all our institutions in Puerto Rico as well. It's not insignificant. Our kids, our students are extraordinarily concentrated in a handful of those colleges and universities here in the country. We have 3,400 colleges and universities, and half of all Latino students are concentrated in 118. Such a concentration obviously portends well when we want to target serving those students better, taking opportunities to those students, providing interventions that might make the difference in terms of getting them into particular careers, particular academic tracks.

In addition to those 118 institutions, there are another 44 colleges and universities that belong to HACU as associate members. Associate membership status does not require a 25 percent Hispanic enrollment. Such a school says, "We have Latino students. We might have 2,000 of them (or 5,000), but not 25 percent. Yet, we feel committed to do something above and beyond the norm with our institution's efforts to better serve these students."

HACU is growing rapidly. It is helpful to understand that the definition of an HSI is not a static definition. The best parallel is with the historically black colleges and universities, created by legislative fiat after the Civil War in 1862 and in 1898. Those are schools that were deemed then to be historically black colleges. A few were added a little bit later on. But in essence, there has been no change. Those are HBCUs by definition, and those will always be HBCUs.

In contrast, HACU institutions, or HSIs, become HSIs because their populations change. Some might be schools that were not initially founded to serve Latinos. We have only two accredited institutions in the country in existence today that were founded with a charter to serve Latinos. One is St. Augustine College, a small 2-year college in Chicago. Another one is Boricua College, which is a small 4-year institution in New York. HOSTOS Community College, which is part of the CUNY [City University of New York] system in New York, also came aboard later primarily to serve Latinos. I mean, that's what their constituency is. HOSTOS is a 2-year college. We have another institution—the National Hispanic University—in the Bay area in California that is going through accreditation. It's not yet a member of HACU because to be a member of HACU you have to be a fully accredited institution.

By and large, all those 118 colleges have been working hard to train Hispanic students, as part of their mission of being Latino serving institutions. That dynamic—one that's driven by demographics—means that there will be more HSIs tomorrow. There will be more members of HACU next year because, as our population continues to grow, we are going to have more Latinos in higher education. This is a demographic reality, even if we did nothing to improve the very sorry state of precollege education. These institutions do share another important pattern, and it's a historical pattern of being seriously undersupported and underfunded. Our schools, by and large, are low-wealth institutions. Of these 118 HSIs, 59 of them are 2-year colleges, and the other 59 today are 4-year colleges. Eighty-four of these institutions are found on the mainland, and 34 of them are found in Puerto Rico. The nice thing about our schools in

Puerto Rico is that they have never had any problem about their mission of serving Latino students.

HACU has three main goals: to strengthen the capacity of our colleges and universities to provide a quality education for their students; to raise the educational attainment of our students in these institutions; and to be of service to the community and our schools by providing linkages with the corporate and Federal sectors, and with anyone else who wants to work in improving the education of HSIs' institutions and our students.

It is significant to point out that the HACU network stretches across the country more than 3,000 miles from Puerto Rico to California. It's even more significant to note that, like a bridge, the network rests, figuratively at least, on strong vertical pillars. These pillars are its member institutions. We draw from all sectors of higher education. HACU schools are a microcosm of the diversity of American higher education. We have some schools with research capabilities, we have a lot of comprehensive colleges and universities, and then we have a lot of junior colleges. Likewise, about two-thirds of our schools are public and the other one-third are private institutions.

HACU also has a rather innovative precollege program, known as the Hispanic Student Success Program (HSSP). The program involves a set of interventions that were put in place to help precollege students—starting with junior high and working through high school—better prepare themselves to move into postsecondary education, with an eye to moving them into academic careers such as research, which might lead hopefully to positions in the professorate.

The importance of these early outreach and intervention efforts becomes clear for all families with educational attainment rates. Hispanics are being underserved by the educational systems. Latino students at all levels lag behind their Anglo and other minority peers. Hispanic students, including virtually every subgroup, do poorly in grade school, middle school, and high school, particularly in the transition from one level to the next.

The key indicator of high school completion has worsened. High school graduation rates for Latinos have dropped from 62.9 percent in 1985 to 54.5 percent in 1990. Comparable white rates were 83 percent in 1985 and 82 percent in 1990, and black rates were 75 percent and 77 percent during the same period. Only 44 percent of Mexican-Americans, 56 percent of Puerto Ricans, and 64 percent of Cubans have completed 4 years of high school, while the figures for whites showed 80 percent with at least 4 years of high school. The corollary data are bleak.

Now, the bleakness of this precollege data takes a predictable toll on the Latino college-going population. In 1990, 29.1 percent of Latino high school graduates went to college. This was an increase over the 1985 level of 26 percent. However, 39.4 percent of the white graduates attended college, up from 34 percent in 1985, and black high school graduate figures showed a similar increase. Although Latino college enrollments in the 50 States and Washington, D.C., increased from 472,000 to 758,000 in the years between 1980 and 1990, their percentile of the total only went from 3.7 to 5.5. In addition, Hispanics are disproportionately enrolled in 2-year colleges, with 56 percent of all enrollments in this sector versus 38 percent for all other students. Those students are concentrated in just a handful of colleges.

In terms of undergraduate outcomes, Hispanics received 22,000 associate degrees in 1989–1990 for 4.9 percent of all such degrees awarded that year. Also, in the same year, Hispanics earned 32,686 bachelor degrees for 3.1 percent of the total conferred in the 50 States and D.C. In terms of graduate education, in 1990, 56,000 Hispanics were enrolled in postbaccalaureate programs, with 46,000 found in graduate school and another 10,000 in professional programs. Hispanics