



One Voice, One Vision – Recommendations to the Surgeon General To Improve Hispanic/Latino Health

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June 1993



Executive Planning Committee

To each of the Executive Planning Committee members of the National Hispanic/Latino Health Initiative, I applaud your tireless efforts and commend you from the heart. By speaking and acting as one to address our most critical issues, you have fostered the health and well-being of Hispanics/Latinos in communities across America. For all of this, I thank you.

A cada miembro del Comité Ejecutivo de Planificación de la Iniciativa Nacional de Salud Hispana/Latina, les felicito de todo corazón por sus incansables esfuerzos con respecto al bienestar de nuestra comunidad. Al hablar y actuar como representantes de nuestra sociedad, han fomentado la salud y el bienestar de los Hispanos/Latinos en comunidades en todos los Estados Unidos. Y por todo esto les extiendo mi sincero agradecimiento.

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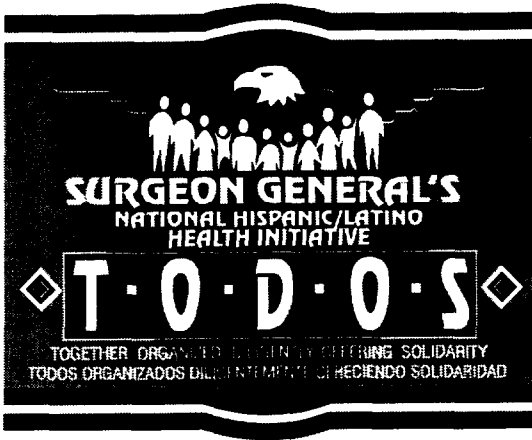
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The symbolic elements of this logo reflect the mission of the Surgeon General's National Hispanic/Latino Health Initiative. The colors of the United States of America represent the effort to unite all Hispanics/Latinos, regardless of their diverse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

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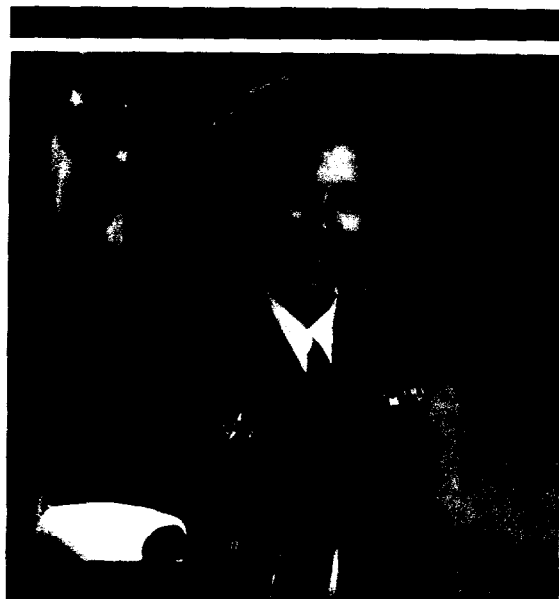
Message from the Surgeon General

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

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

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

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



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

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

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

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

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

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

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

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

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

The recommendations come at a time when the Nation is examining health care for all Americans. It was the hope of the group that these recommendations

could be used by Federal, State, and community leaders as they plan for the health and well-being of Hispanics/Latinos. When these recommendations were made to the Surgeon General, it was the group's consensus that they could be used to empower communities and close the gaps between the “haves” and the “have-nots.”

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

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

Chapter 1: Introduction

Background

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

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

Numerous groups within the Hispanic/Latino community have attempted to address the diverse and complex problems of Hispanic/Latino health status. Recognizing the need to address this problem in a united and unified effort, the

Congressional Hispanic Caucus, national Hispanic/Latino leaders, and several Hispanic organizations recommended that the Public Health Service (PHS) launch an initiative to develop solutions; they also recommended that Surgeon General Antonia Coello Novello lead the initiative. Thus, the Surgeon General's National Hispanic/Latino Health Initiative was formed. This report documents the activities of the Initiative.

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

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

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

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Events of the Initiative

National Workshop on Hispanic/Latino Health: Implementation Strategies

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

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

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

To prepare the Workshop participants to address the issues in each of these areas, the Surgeon General commissioned a set of Background Summary Papers. These Background Summary Papers outline the problems in each area, summarize proposed solutions from existing literature, and offer suggestions for implementation strategies. They were sent to the participants before the Workshop and were presented at the Workshop by the Hispanic/Latino Health Issues Panel, composed

of the five corresponding authors. The papers laid the groundwork for and served as a prelude to the important work that occurred at the Workshop. The Background Summary Papers are to be published in *Public Health Reports*, the journal of PHS.

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

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

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

Regional Health Meetings

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

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

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

Executive Planning Committee Meeting

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

About This Report

This report is published in two versions. The first version, entitled *Recommendations to the Surgeon General To Improve Hispanic/Latino Health*, contains a summary of the Executive Planning Committee meeting held on April 22 and 23, 1993, and the implementation strategies identified at the meeting as crucial for prompt action. Because this report is

a synthesis of the findings from all of the activities of the National Hispanic/Latino Health Initiative and prioritizes the recommendations developed, it serves as an action plan for the Nation to begin addressing the critical issues related to the health status of the Hispanic/Latino population.

The second version of the report, entitled *One Voice, One Vision—Recommendations to the Surgeon General To Improve Hispanic/Latino Health*, documents all events of the Initiative with emphasis on the National Workshop held in September 1992. Chapter 2 contains Dr. Novello's charge to the participants at the National Workshop. Chapter 3 is the presentation of the Background Summary Papers. Chapter 4 lists the implementation strategies developed at the National Workshop, and Chapter 5 is the presentation of those implementation strategies. Chapter 6 contains Dr. Novello's closing remarks from the National Workshop. Chapter 7 provides a summary of the Regional Health Meetings, with highlights of the implementation strategies developed at the meetings. Chapter 8 contains the priority recommendations developed at the April 22–23, 1993, Executive Planning Committee Meeting. Appendix A lists the participants of the National Workshop. (Participants of the Regional Health Meetings are listed in separate proceedings documents for each meeting.) Appendix B contains the agenda for the National Workshop. Appendix C provides the Executive Planning Committee members and the agenda for each Regional Health Meeting. Appendix D lists the regional sponsors and co-sponsors for each Regional Health Meeting. Appendix E contains the remarks of government and community leaders who took part in the National Workshop.

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Chapter 2: Charge to Participants

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

Surgeon General

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

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

This Workshop will bring to the forefront—

- The links between having good health and having a good life.

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

For example, during our Workshop—

- In our discussion of improving access to health care, it means removing cultural barriers that perpetuate fear, mistrust, and misunderstanding. It means access that is culturally sensitive and culturally responsible. It means bridging the language gap—or should I say the inability to communicate between those who speak English and those who do not. It means encouraging women who seek out medical care last because of family obligations to put themselves first for once. It means access that is community-based, family-centered, and under one roof.
- Increasing representation in the health professions means becoming more involved in

our education, eliminating illiteracy, increasing the number of college graduates, and reducing the time it takes to get a degree. It also means getting on in the world of biotechnology and science and aspiring to be the best, whether young or old. It means education for everyone. It means encouraging not only our young people but also our adults to get in school and continue to learn. It means aspiring to and preparing for careers in professions that we did not feel were open to us in the past. It means empowering our youth to have a say in their futures. It means having the power to set the educational agenda that fits our needs and not walking around blindfolded to opportunities.

- When we talk about improving data collection strategies, it means responsiveness to all ethnic groups and subgroups and accountability to the truth. It means that our population of 22 million people needs to be accounted for and counted in. It means getting comprehensive data, identifying what is and is not appropriate, and making accurate assessments and reasonable predictions about the real status of Hispanic/Latino health.
- Developing a comprehensive research agenda goes hand in hand with collecting better data. We cannot expect to understand where we are headed and where we ought to be in terms of health until we understand, first, where we are today. It means finding a way by which we benefit from what science has to offer by tailoring its benefits to our needs. It means focusing on the diseases that kill us and putting priorities on research aimed at Hispanics/Latinos and other minorities—in the areas of HIV/AIDS and sexually transmitted diseases; alcoholism and other drug abuse; infant mortality and perinatal addiction; child abuse; cancer, tuberculosis, diabetes, and

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

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

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

- We must secure a place for our children in the explosive new century. And while securing their place, let’s not forget to include them in the planning process. Being young is no reason for exclusion.
- We must also get involved. I would like to hear less of “I want, I need, and I deserve,” and more of “What can I do? How can I help? When do we start?”

- We must foster acceptance of our population and promote our incorporation into a true multicultural society. I would like to see us help mainstream America understand and accept our Hispanic/Latino culture with its centuries of knowledge; encourage our contributions; and value our diversity. It is time we put an end to cultural stereotypes once and for all.
- We must learn to develop partnerships, not only among ourselves but also among States, local community groups, and businesses. Such partnerships will extend our resources, combine our skills and specialties, and ensure more comprehensive services.
- We must also seek help when help is needed. We need help to overcome the difficulties and stress of cultural dislocation and assimilation into American life. These problems can leave wounds that can last a lifetime.
- We also must not overlook the silent cries of our children, who are watching us and emulating our behavior. They do what we do, not what we tell them to do. We must set the example of a healthy lifestyle and help them see through the mixed messages about false glamour, affluence, popularity, and the so-called “good life.” For how can we expect to raise our children to value our traditions and customs, to respect the cultural traits that shape our individuality, when we ourselves lose our identity and self respect?

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

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

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

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

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

I believe the time to act is upon us, for we have precious little time to rehearse. A generation

is waiting in the wings, and how well the 31 million are received in the next 8 years depends on how well we perform our roles during the next 3 days.

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

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

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

Gracias. Adelante TODOS!

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

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

Improving Access to Health Care in Hispanic/Latino Communities

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

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

mentation strategies by highlighting some of the issues that I think we need to keep in the forefront of our thinking if we are to improve access to health care for Latinos.

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

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



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

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

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

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

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

ment opportunities. These are at the heart of the barriers that we see affecting Latinos.

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

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

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

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

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

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

Improving Data Collection Strategies

Jane Delgado, Ph.D.

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

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



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

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

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

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

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

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

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

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

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

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

In terms of data analysis, it is critical to support the Hispanic health research infrastructure to analyze Hispanic-specific information. We should provide technical assistance to CBOs

[community-based organizations] and Hispanic researchers for research grants for data analysis award, include Hispanic researchers in development of RFAs and RFPs, and also submit an annual report on progress made toward improving Hispanic health data collection and percentage data analysis dollars granted to Hispanic focus programs.

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

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

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

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

Increasing the Representation of Hispanics/Latinos in the Health Professions

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

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

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

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

Our parents do everything they can to support us, but all too many of them have very limited experience with educational systems and can offer only limited help to us. So we need to look to the teachers and the administrators and others to guide us along. Yet, unfortunately, when you look at this, you find that fewer than 3 percent of all the teachers in the United States are Hispanic. The

result is that too many of our students (approximately 75 percent) who do stay in school are focusing on nonacademic tracks that will not prepare them for the health professions.

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



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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

Ray Marshall, former Secretary of Labor, has estimated that 90 percent of the growth in the work force that is going to occur in the United States from 1990 to the year 2000 will be composed of women and minorities. We have large numbers of

people who are not going to be well prepared to find a suitable and productive career. We think the health profession, if you look at it, is one of the professions that's growing, and there's going to be continued demand. This could produce some productive contributing citizens for us.

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

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

Gerardo Marin, Ph.D.

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

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

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

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

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

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

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

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

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

In terms of increasing the research infrastructure, as I mentioned before, there's a very significant need to increase the representation of Hispanics in health-related research. I'd like to suggest that those who make decisions about RFAs and RFPs and about funding take into consideration the kind of research that's being carried out in the

States that have high Hispanic representation and demand that Hispanics be included in those samples. I'd like to suggest that oversampling of Hispanics/Latinos be required of proposals in critical areas of health concern for Hispanics. There is a need to educate members of IRGs, and this needs to be done by DHHS. There is a need to prepare IRGs, again, to be competent in making appropriate decisions about funding.

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

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

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

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

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

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

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

Health Promotion and Disease Prevention

Marilyn Aguirre-Molina, Ed.D.

All of the presentations that have preceded mine provide a framework for understanding why Latinos face so many problems in the area of health promotion and access to preventive services. I think it's probably safe to assume two things. The first is that the reduction of one or two risk factors for the leading causes of morbidity and mortality can add years to a person's life and reduce medical costs. The second assumption is that the most effective

way to reduce risk factors is through health promotion and disease prevention strategies. It's generally accepted that, for many sectors of U.S. society, these two assumptions are true. People are accessing preventive services, and we are beginning to see the results—i.e., changes in morbidity and mortality patterns in the United States.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Workshop Recommendations

Access to
Health
Care

Problem/Issue #2:

Inadequate coverage by Medicaid for Hispanics/Latinos.

Desired Aim

To provide full coverage by Medicaid for comprehensive services for Hispanics/Latinos.

Implementation Strategies

- ◆ Reduce (or eliminate) categorical and other eligibility restrictions for Medicaid coverage, eliminate asset tests, enforce presumptive eligibility for pregnant women and children.
- ◆ Require Medicaid and Medicare reform to address the unique needs of the Hispanic/Latino population; programs should support primary care and shift from an emergency hospital care approach to a comprehensive community-based care approach (that includes preventive services).

Problem/Issue #3:

Government and institutional policies are unresponsive to the health needs of Hispanics/Latinos.

Desired Aims

- To establish an integrated and coordinated service-delivery system that links public health, private providers, and community/migrant health centers; foster collaboration.
- To establish policies that provide for linguistically and culturally competent programs.
- To support health professions education for Hispanics/Latinos in order to increase the number of culturally competent health care providers.
- To accurately define the health needs of Hispanic/Latino communities and provide resource allocations necessary to meet those needs.

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Implementation Strategies

- ◆ Convene all stakeholders to explore ways to collaborate and interface. (Federal, State, local—public and private)
- ◆ Recognize that categorically funded programs do not always meet the needs of the intended populations; review criteria for categorically funded programs that support health centers; influence the decision-making process for placement of health centers and their modes of operations so that they better serve the unique needs of the Hispanic/Latino community. (Federal, State, local—public and private)
- ◆ Ensure that more Hispanics/Latinos are in key policy decision-making positions. (Federal, State, local—public and private)
- ◆ Define the “minority” label. Programs and policies should include all minority groups, including Hispanics/Latinos. (Federal, State, local—public and private)
- ◆ Develop standards for cultural competency.

Problem/Issue #4:

Lack of health care facilities in Hispanic/Latino communities.

Desired Aim

To develop an infrastructure in Hispanic/Latino communities that ensures accessibility to health care providers.

Implementation Strategies

- ◆ Enhance the health care infrastructure and provide funds for construction of health facilities in Hispanic/Latino communities (legislation).
- ◆ Reformulate the criteria for appointing physicians and other health providers to medically underserved areas.
- ◆ Offer economic incentives to practitioners for locating practices in Hispanic/Latino communities.

- ◆ Create community-based health training centers that provide training and job opportunities in the health professions (legislation).

Problem/Issue #5:

Exclusion of important subsegments of the Hispanic/Latino population from health programs.

Desired Aim

To establish a health care system that meets the needs of all Hispanics/Latinos, including undocumented residents, migrant and seasonal workers, rural residents and other subsegments of the Hispanic/Latino population.

Implementation Strategies

- ◆ Include intervention activities in the public health arena to meet the needs of special subsegments of the Hispanic/Latino population (i.e., migrant and seasonal farmworkers, children, homeless people, people in rural areas, immigrants, and undocumented residents).
- ◆ Require that health-care institutions, programs, and initiatives ensure health-care delivery that meets the needs of special populations (i.e., migrant and seasonal farmworkers, children, homeless people, people in rural areas, immigrants, and undocumented residents).

Problem/Issue #6:

Lack of health objectives for the Hispanic/Latino population.

Desired Aim

To include a Hispanic/Latino agenda in *Healthy People 2000*; to develop detailed health objectives that are specific to the Hispanic/Latino population.

Implementation Strategies

- ◆ Review the *Healthy People 2000* plan to identify gaps and develop objectives and implementation

strategies to address the health needs of the Hispanic/Latino community. (Federal)

Problem/Issue #7:

A public health system and an infrastructure that are inadequate and unresponsive to Hispanic/Latino health needs.

Desired Aim

To create a strong Federal, State, and local public health system that has the ability to monitor and influence the planning and policy development of health initiatives and interventions.

Implementation Strategies

- ◆ Allocate 6 percent of health expenditures to fund public health programs and infrastructure.
- ◆ Make the public health system accountable for meeting the health needs of the Hispanic/Latino population; establish health goals (indicators) for all public health interventions.
- ◆ Promote Hispanic/Latino participation at all levels of public health decisionmaking.

Problem/Issue #8:

Omission of health care as an integral part of economic and regional development planning.

Desired Aim

To include Hispanic/Latino health issues in regional development strategies.

Implementation Strategies

- ◆ Include Hispanic/Latino health issues in all social and economic development programs.

Problem/Issue #9:

Lack of Hispanic/Latino participation in the development and review of publicly funded proposals to ensure that programs meet the health needs of the Hispanic/Latino population.

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Care

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Workshop Recommendations

Access to
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Desired Aim

To achieve equitable representation of Hispanics/Latinos in the development and review of Requests for Proposals throughout PHS.

Implementation Strategy

- ◆ Use legislative mechanisms and the regulation process to increase Hispanic/Latino representation in the proposal process.

Problem/Issue #10:

Lack of proven models for alternative primary care financing responsive to Hispanic/Latino community needs.

Desired Aim

To explore innovative primary care financing and delivery systems.

Implementation Strategies

- ◆ Fund pilot projects that explore alternative primary health care financing and delivery systems (analogous to Health Care Financing Administration's SHMO demonstrations).
- ◆ Include Hispanic/Latino-specific initiatives in the Request for Proposal process to foster models of primary/managed care that meet the health needs of the Hispanic/Latino population.

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Problem/Issue #11:

Lack of well-planned, coordinated lobbying efforts on Hispanic/Latino health issues.

Desired Aim

To create a strategically planned and coordinated lobbying structure that advocates the advancement of a Hispanic/Latino health agenda.

Implementation Strategies

- ◆ Enlist the interest and support of health organizations around the country to participate in a unified effort.

- ◆ Create a national coalition that lobbies on behalf of Hispanic/Latino health issues (e.g., National Hispanic/Latino Coalition for a Healthy USA).

Problem/Issue #12:

Lack of Hispanic/Latino access to DHHS policy decision makers.

Desired Aim

To develop rapport and fluid channels of communication with DHHS policy decision makers.

Implementation Strategies

- ◆ Meet regularly with the Secretary (or a representative) regarding Hispanic/Latino health issues.
- ◆ Establish an Advisory Committee to the Secretary of Health and Human Services to advise the Department on policies affecting Hispanic/Latino populations.
- ◆ Provide advocacy for Hispanic/Latino participation in the decision-making process. The number of Latinos in decision-making positions should be proportional to the size of the population they represent.
- ◆ Foster policies that encourage Hispanic/Latino representation on boards, commissions, and advisory committees.

Problem/Issue #13:

Underrepresentation of Hispanics/Latinos in the Office of Minority Health and other top-level positions of DHHS.

Desired Aim

To achieve an equitable representation of Hispanic/Latino representation in top-level positions of DHHS.

Implementation Strategy

- ◆ Increase representation of Hispanics/Latinos in the Office of Minority Health and all departments of DHHS, to include top-level representation. To the

extent possible, Hispanic/Latino issues should be addressed by Hispanic/Latino representatives.

Problem/Issue #14:

Lack of participation by Hispanics/Latinos in leadership appointments in DHHS.

Desired Aim

To involve Hispanics/Latinos in the leadership search process within in DHHS.

Implementation Strategy

- ◆ Involve Hispanics/Latinos in the expert talent search process and selection for leadership positions in DHHS.

Data Collection

There are 22.4 million Hispanics/Latinos living in the 50 States and the District of Columbia and 3.5 million persons who reside in Puerto Rico—a total of 25.9 million people. More than two-thirds of all Hispanic/Latino Americans were born in the United States, yet it was not until 1989 that the model birth and death certificates included a Hispanic/Latino identifier.

Too often, organizational priorities and funding decisions are established without taking into account Hispanic/Latino data. Adequate planning is not available without the appropriate availability, utilization, and interpretation of Hispanic/Latino data. Therefore, resources from government (Federal, State, and local) foundations, nonprofit and for-profit corporations, and education institutions are not allocated consistently with the needs of the Hispanic/Latino community. As we approach the year 2000 and beyond, the need for Hispanic/Latino data will only increase. Given the imperative to effectively target resources to maximize benefit and efficiency, the six areas described below are the minimal set of issues that must be addressed to serve the health needs of the Nation.

Problem/Issue #1:

Inclusion: the need for inclusion of Hispanics/Latinos in data systems.

Desired Aim

To include data on Hispanics/Latinos in all data systems.

Implementation Strategies

- ◆ Include Hispanic/Latino and Hispanic/Latino subgroup identifiers in all surveys and forms.
- ◆ Determine sample sizes for Hispanics/Latinos that are adequate for analysis.
- ◆ Enforce OMB Directive 15 and Public Law 94-311. Educate agencies about the use of OMB directives for inclusion of Hispanics/Latinos (and Hispanic/Latino subgroups) in data systems and in federally funded intramural and extramural research programs.
- ◆ Develop and maintain an advisory board to the Office of the Surgeon General to oversee Federal, State, and local Hispanic/Latino data issues.

Problem/Issue #2:

Local and regional data: lack of data on specific Hispanic/Latino health issues at the local and regional levels.

Desired Aim

To reduce gaps in Hispanic health data and improve the overall availability of data at the local and regional levels.

Implementation Strategies

- ◆ Develop guidelines and standard procedures within all agencies and provide technical assistance on data collection for Hispanic/Latino population groups at the local, State, and regional levels.
- ◆ Focus on Hispanic/Latino-specific issues. For example, data that just enumerate the number of gunshot wounds is not useful unless information is also available on the community support programs.
- ◆ Use a series of local pilot studies that identify patterns and trends to justify future activities.
- ◆ Establish *Healthy People 2000* and baseline data for those objectives at the State and local levels.

Data Collection

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Data
Collection

Problem/Issue #3:

Quality: lack of quality, accurate, timely, and culturally sensitive data system design, data collection, and analysis.

Desired Aim

To develop a foundation of high-quality, valid, and timely information on Hispanic/Latino data, equivalent to that of other ethnic/racial groups.

Implementation Strategies

- ◆ Include Hispanics/Latinos in the design, implementation, analysis, and dissemination of health assessment and health monitoring data systems and in funding decisions affecting these systems.

- ◆ Assess data collection and research designs to include considerations of the heterogeneity of the Hispanic/Latino population. Oversampling has been identified as a feasible method for highly concentrated Hispanic/Latino subgroups; other methods need to be developed to sample geographically dispersed Hispanic/Latino subgroups.

- ◆ Test and validate data collection and research instruments for cultural competence and linguistic appropriateness.

- ◆ Foster collaboration between the Census Bureau and the National Center for Health Statistics (NCHS) to identify existing and emerging research issues; address problems such as procedures for assigning race, use of surname as a proxy, adequateness of "Other Race" and "Other Hispanic" categories, etc. Involve Hispanic/Latino researchers in seeking resolution to these issues.

- ◆ Study the problems associated with changes in ethnic self-identification.

- ◆ Establish guidelines for the coding and keying of data on birthplace, work history, generation status, socioeconomic status, language use, family relationship, etc., all of which may be powerful indicators of the health status of Hispanics/Latinos.

- ◆ Develop data release plans that meet priorities and the needs of users for timeliness.

Problem/Issue #4:

Analysis: the need to identify (inventory) and analyze existing data. Available data can be instrumental in understanding Hispanic/Latino health concerns.

Desired Aim

To increase the analyses of Hispanic/Latino health data at the Federal and State levels and by academia and to increase the number of Hispanic/Latino researchers involved in this process.

Implementation Strategies

- ◆ Include Hispanics/Latinos and researchers with specific knowledge of the health status, living conditions, and culture of Hispanic/Latino populations in the development of health theses and conceptual frameworks.

- ◆ Identify existing data sets and determine their accessibility to researchers.

- ◆ Develop a network of Federal/State, university, and community-based analysts with a primary focus in health data analysis.

- ◆ Provide funding for technical assistance to researchers who are involved in Hispanic/Latino health issues.

- ◆ Increase the technological capacity of researchers to conduct more advanced analysis (i.e., Geographic Information Systems).

- ◆ Encourage collaborative, interdisciplinary research that bridges quantitative and qualitative methods.

- ◆ Identify a person in each agency/organization to serve as the principal point of contact for Hispanic/Latino data analysis.

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Workshop Recommendations

Research Agenda

- ◆ Target and intensify efforts to recruit Hispanics/Latinos into PHS's existing research and training programs.
- ◆ Develop and fund distinguished research career programs within PHS to allow Hispanic/Latino researchers to concentrate on research, writing, and mentoring and to free them from the multiple requirements and responsibilities commonly faced by minority academicians.
- ◆ Conduct grantsmanship workshops such as those developed by the Hispanic Cancer Control Program at the National Cancer Institute (NCI), where Hispanic/Latino researchers have the opportunity to improve proposal-writing skills and have their pre-proposals reviewed by agency program review staff. These programs must be made available at the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), and other Federal agencies concerned with health issues.
- ◆ Expand and evaluate specific initiatives within the Department of Education and the National Science Foundation to ensure that Hispanic/Latino middle and high school students take courses essential for pursuing science careers.
- ◆ Assess the results of programs such as the Minority Behavioral Research Supplement, Minority Access to Research Careers, Health Careers Opportunity Programs, and the Minority High School Apprenticeship Program with respect to Hispanic/Latino students.
- ◆ Encourage professional associations to stimulate the involvement of Hispanic/Latino students in research careers.
- ◆ Develop special initiatives to fund research proposals submitted by new and established Hispanic/Latino investigators.
- ◆ Increase and enhance the capacity for institutionalized Hispanic/Latino health research through the establishment of Hispanic/Latino health research

centers and through support of individual Hispanic/Latino investigators.

- ◆ Orient PHS program staff to Hispanic/Latino health and related methodological issues.

Desired Aim B

To improve cultural competence and sensitivity of Hispanic/Latino and non-Hispanic/Latino scientists.

Implementation Strategies

- ◆ Develop requirements by regional and professional accreditation agencies that Hispanic/Latino health research issues be incorporated into curricula.
- ◆ Develop and institute courses, seminars, and conferences by educational, institutional, professional associations, and PHS on methods for conducting research on Hispanic/Latino populations.
- ◆ Orient members of IRGs on the procedures required for culturally competent research that targets Hispanics/Latinos and on the evaluation of proposals with respect to appropriate sampling, instrumentation, methodology, and cultural sensitivity in the development of research protocols.
- ◆ Provide appropriate training and guidelines to reviewers of proposals so that IRGs will be competent in the evaluation of Hispanic/Latino research. This initiative is consistent with and enhances the recent NIH guidelines for including women and minorities in study populations.

Desired Aim C

To improve communication and interaction among Hispanic/Latino scientists.

Implementation Strategies

- ◆ Centralize and expand the existing PHS databank on Hispanic/Latino researchers and on non-Hispanics/Latinos conducting research on Hispanic/Latino populations.
- ◆ Encourage professional associations to facilitate networking among Hispanic/Latino researchers.

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Problem/Issue #2:

Dearth of research relevant to the health of Hispanics/Latinos.

Desired Aim A

To develop a health research agenda that is relevant to and focused on Hispanics/Latinos.

Implementation Strategies

- ◆ Commission a number of research efforts within the Office of Minority Health that critically analyze the literature on Hispanic/Latino health in each of the areas identified by previous reports as deserving attention (e.g., child and adolescent health, women's health, diabetes, HIV, cancer, substance abuse, depression, violence, accidents, and unintentional injury). These reports will present a review of the current knowledge base on each of the areas covered by *Healthy People 2000*, clarify objectives, and identify research needs.
- ◆ Appoint a high-level committee within the Office of Minority Health with appropriate Hispanic/Latino health expert involvement to review the outcome of the activities of the first year of the Hispanic/Latino Health Initiative and the information obtained from the state-of-the-art reviews cited above. This panel must be charged with developing an outline of priorities for research with Hispanics/Latinos.
- ◆ Develop special funding programs or initiatives at the Federal level to fund research on the role of factors such as acculturation, national origin or background, socioeconomic status, and migrational history on the health status of Hispanics/Latinos.
- ◆ Require large-scale, cross-sectional, and longitudinal research with Hispanics/Latinos funded by Federal and State initiatives to include the effects of acculturation, national origin or background, socioeconomic status, and migrational history on the health status of Hispanics/Latinos as possible moderators of the findings.

- ◆ Develop special program initiatives at the Federal level to analyze the health status of Hispanics/Latinos working in high-risk environments such as migrant agriculture, assembly plants (including border *maquiladoras*), service professions, and other industrial environments.

- ◆ Conduct health services research to identify the characteristics of health care delivery, including the characteristics of personnel and structure of services that facilitate access, utilization, and effectiveness of health services among Hispanics/Latinos. At least 25 percent of the funds allocated for evaluation at the Substance Abuse and Mental Health Services Administration (SAMASA) and Health Resources and Services Administration (HRSA) should be targeted for services research to investigate questions pertaining to Hispanics/Latinos. The Office of Health Planning and Evaluation should also direct funds for research on health services utilization by Hispanics/Latinos.

- ◆ Create an Office of Hispanic/Latino Health within the Office of Minority Health, Office of the Assistant Secretary for Health, to coordinate Hispanic/Latino health-related initiatives and to oversee their implementation within the Federal Government. The Office must be properly funded and must include an advisory board on Hispanic/Latino health research to review its activities on a quarterly basis. In addition, the Office of Minority Health should issue a biannual report to Congress detailing progress on the Hispanic/Latino health agenda and the progress within PHS in meeting the mandates in the Disadvantaged Minority Health Act as they relate to Hispanics/Latinos.

- ◆ Fund research within PHS that is specifically targeted at providing baseline data to enable formulation of Hispanic/Latino-specific objectives for *Healthy People 2000*.

- ◆ Develop mechanisms to obtain and incorporate community input into the formulation of a research agenda.

Research
Agenda

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Health Professions

Problem/Issue #3:

Lack of culturally appropriate research theories and methods.

Desired Aim A

To increase the number and improve the availability and validity of research instruments and measurement tools used in investigations on Hispanic/Latino health.

Implementation Strategies

- ◆ Develop Federal programs to fund research that tests the usefulness of current instruments and to develop new, culturally appropriate instruments that meet applicable standards of validity and reliability.
- ◆ Fund a repository of Hispanic/Latino health-related instruments within PHS. This repository must be managed by Hispanic/Latino organizations or researchers who can properly serve as the caretakers of these files and report on the issues dealing with Hispanics/Latinos.

Desired Aim B

To study the applicability of existing constructs and theories to Hispanic/Latino populations.

Implementation Strategy

- ◆ Fund research within PHS to develop new behavioral models and theories and to test the validity of existing ones.

Problem/Issue #4:

Underrepresentation of Hispanics/Latinos in PHS.

Desired Aim A

To ensure proportional representation of Hispanic/Latino researchers on scientific advisory boards, national advisory councils, and IRGs and technical evaluation groups.

Implementation Strategies

- ◆ Survey national agencies concerned with Hispanic/Latino health issues, as well as researchers, universities, or research institutes, on a yearly basis to identify qualified individuals who may be willing to serve in this capacity. Results of those surveys should be published in a yearly updated directory and made available to Federal and State agencies funding health-related research.
- ◆ Include Hispanic/Latino representation on IRGs within technical evaluation groups, national advisory councils, and scientific advisory boards.

Desired Aim B

To ensure proportional representation of Hispanics/Latinos on the staff of PHS.

Implementation Strategies

- ◆ Expand short-term service initiatives that allow Hispanic/Latino researchers and academicians to serve within PHS without severing ties with their home institutions.
- ◆ Implement special efforts to recruit, retain, and promote Hispanics/Latinos at all levels of PHS scientific and administrative staff.

Health Professions

Problem/Issue #1:

Insufficient numbers and inadequate preparation of Hispanic/Latino students by the educational system (kindergarten to undergraduate) for pursuit of health professions education.

Desired Aim

To increase the number of Hispanics/Latinos in the education pathway toward health professions education so that, by the year 2000, the number of Hispanics/Latinos admitted to health professional schools reflects the size of the Hispanic/Latino population by State.

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Implementation Strategies

- ◆ Increase parental involvement in their children’s education through family counseling, dissemination of information, and enhancement of established programs sponsored by the school, community-based organizations, the private sector, and the media.
- ◆ Assist low-income families in planning their children’s education.
- ◆ Ensure that Hispanic/Latino children gain English-language competency at an early age; early childhood programs can play an important role.
- ◆ Stimulate private-sector investment in inner city schools, colleges, and universities with high Hispanic/Latino student bodies.
- ◆ Stimulate private sector and government investment in scholarships and awards to Hispanic/Latino students in inner city schools, colleges, and universities with large Hispanic/Latino student bodies.
- ◆ Expand the scope and funding of Health Careers Opportunity Programs.
- ◆ Encourage Hispanic/Latino health professional organizations to develop and participate in mentoring programs at all levels.

Problem/Issue #2:

Poor infrastructure and lack of funding to promote greater participation of Hispanic/Latino students in the health professions.

Desired Aim A

To increase the number of Hispanic/Latino full-time equivalent faculty and students in universities and health professions schools to reflect the percentage of Hispanics/Latinos in the population of the area.

Implementation Strategy

Provide additional Federal funds, student loans, and assistance to schools that have significant full-time equivalent Hispanic/Latino faculty and students.

Desired Aim B

To improve the coordination of organizations and to build a better infrastructure that will augment the pool of Hispanic/Latino students eligible to pursue the health professions.

Implementation Strategies

- ◆ Expand health professional clinical training at community-based sites.
- ◆ Bridge health professions training of two- and four-year colleges, including training of administrative managers because they make day-to-day decisions on service delivery to populations.
- ◆ Develop formal linkages between Federal, State, and private organizations serving Hispanics/Latinos.

Problem/Issue #3:

Obstacles to entry, retention, and graduation from professional health education programs faced by Hispanic/Latino students.

Desired Aim A

To increase the number of Hispanics/Latinos entering health professions schools by a minimum of 10 annually for the next 10 years; the ultimate minimum goal is a doubling of the number of students currently enrolled.

Implementation Strategies

- ◆ Establish a consistent definition of Hispanics/Latinos in the criteria for admission to the health professions.
- ◆ Set standards at the Federal and State levels for increased Hispanic/Latino student enrollments; these standards must be tied to funding.
- ◆ Incorporate qualitative measures in school admissions criteria.
- ◆ Increase Hispanic/Latino participation in the admissions process.
- ◆ Train admissions personnel in cultural diversity and the health needs of the Hispanic/Latino community.

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- ◆ Credit students for diverse personal and educational experiences.

Desired Aim B

To increase the number of Hispanic/Latino students who graduate from professional health programs.

Implementation Strategies

- ◆ Develop, expand, and fund retention programs that would enable Hispanic/Latino students to graduate from professional education programs (i.e., health career opportunity programs, peer support groups, financial assistance programs, National Service Corps activities, and other educational initiatives targeting retention).
- ◆ Foster mentorship activities at health professions schools.
- ◆ Assess standardized testing procedures; address any biases that may affect the performance of Hispanic/Latino candidates.

Desired Aim C

To make health professions education financially accessible for Hispanics/Latinos.

Implementation Strategies

- ◆ Expand scholarships, low interest loans, and loan repayment programs available to Hispanics/Latinos.
- ◆ Increase the proportion of grant monies (versus loans) in financial aid programs targeted at Hispanics/Latinos pursuing health professions education.
- ◆ Expand financial assistance programs to incorporate the support of hospitals, communities, and other private or public organizations.
- ◆ Ensure thorough dissemination of financial assistance information to Hispanic/Latino students; ensure that the format and delivery of this information are appropriate to the target audience.

Desired Aim D

To expand the funding and scope of Hispanic/Latino Centers of Excellence to include all health professions.

Implementation Strategies

- ◆ Influence the legislative process.
- ◆ Ensure equitable distribution of funds to Hispanic/Latino Centers of Excellence relative to the total funding allocated to such initiatives.
- ◆ Evaluate the performance (outcomes) of Hispanic/Latino Centers of Excellence.

Problem/Issue #4:

Need for greater coordination between the private, local, State, and Federal sectors to improve the support to Hispanic/Latino health professionals.

Desired Aim

To ensure provision of technical assistance and financial resources to Hispanic/Latino health professionals.

Implementation Strategies

- ◆ Enhance programs and improve coordination of initiatives within DHHS.
- ◆ Review Department annual fiscal reporting mechanisms; delineate funding for activities targeting Hispanic/Latino health professionals; specify DHHS funding going to Hispanic/Latino researchers; increase the number of Hispanic/Latino researchers.
- ◆ Increase postgraduate training opportunities in the health professions through private- and public-sector funding.
- ◆ Increase the participation of Hispanic/Latino health professionals in program and policy evaluation committees, task forces, and oversight entities.

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◆ Workshop Recommendations

Problem/Issue #5:

Need for an increased number of Hispanic/Latino health professionals in faculty, advanced career positions, and decision-making bodies.

Desired Aim A

To increase the number of Hispanic/Latino health professionals in management, policy, and research positions in DHHS/PHS and other Federal and State agencies.

Implementation Strategies

- ◆ Develop a substantive plan to develop and promote Hispanics/Latinos in management, policy, and research positions.
- ◆ Hold government institutions and programs accountable for promoting Hispanic/Latino health professionals' development.
- ◆ Enact legislation that requires all directors to be evaluated on an annual basis on the following criteria, among others:
 - a. Recruitment and retention of Hispanic/Latino staff.
 - b. Representation of Hispanics/Latinos on review committees.
 - c. Grants awarded and programs established with a Hispanic/Latino health focus.
 - d. Grants awarded to Hispanic/Latino principal investigators.
 - e. Grants awarded to universities with significant Hispanic/Latino graduation rates.
- ◆ Implement a reporting and review system of the implementation and outcomes of the above plan.

Desired Aim B

To increase the number of Hispanic/Latino faculty in health professions schools.

Implementation Strategies

- ◆ Develop effective methods for addressing deficiencies in hiring and promotion policies affecting Hispanic/Latino faculty in health professions schools.
- ◆ Develop legislation that would add funding to the Disadvantaged Minority Health Improvement Act for Hispanic/Latino faculty positions in health professions schools.
- ◆ Reconsider the balance between research, training, and community and clinical service needs; implement promotion mechanisms accordingly.
- ◆ Earmark funding of New Investigator Awards to Hispanic/Latino researchers.
- ◆ Track the number of grants/contracts by Hispanic/Latino researchers that have been submitted, approved, and funded by DHHS.
- ◆ Provide technical assistance to support Hispanic/Latino researchers as needed.

Desired Aim C

To encourage mentoring of junior Hispanic/Latino faculty.

Implementation Strategy

- ◆ Provide opportunities to establish mentoring relationships with senior faculty.

Desired Aim D

To increase Hispanic/Latino representation on local, State, and Federal grant review groups, panels, task forces, and advisory committees.

Implementation Strategy

- ◆ Develop and maintain a centralized information bank of talented Hispanic/Latino health professionals.

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Problem/Issue #6:

Lack of culturally relevant (Hispanic/Latino) input in the licensing/certification process and the accreditation of health professions schools.

Desired Aim A

To encourage accrediting bodies to use cultural diversity standards relevant to Hispanics/Latinos.

Implementation Strategies

- ◆ Communicate the need for use of cultural diversity standards in the accreditation criteria of health professional education programs.
- ◆ Provide awareness training on cultural diversity issues to students and faculty at colleges/universities and other educational programs.

Desired Aim B

To increase the number of Hispanics/Latinos participating in the development of licensing and certification tests and procedures.

Implementation Strategies

- ◆ Promote Hispanic/Latino health professionals within accrediting agencies to ensure Hispanic/Latino representation.
- ◆ Work with the individual health professions examination boards to determine the appropriateness of tests, and to address cultural biases.

Desired Aim C

To enhance the entry of foreign-trained Hispanic/Latino health professionals into the health service delivery system.

Implementation Strategy

- ◆ Develop innovative programs and funding mechanisms to assist/(re)train foreign-trained Hispanic/Latino health professionals so that they can practice in the United States.

Problem/Issue #7:

Lack of data on practice characteristics of Hispanic/Latino health professionals for planning purposes.

Desired Aim

To obtain data on practice characteristics of all Hispanic/Latino health professionals.

Implementation Strategy

- ◆ Request that health professionals organizations gather and analyze data on the practice characteristics of Hispanic/Latino professionals.

Health Promotion and Disease Prevention

Underlying all of the issues listed below are policy, communication, cultural behaviors, resource development, and community intervention factors.

Problem/Issue #1:

Insufficient data and research on Hispanic/Latino health issues:

- Lack of research on health promotion and disease prevention (HPDP) efforts that target subgroups of the Hispanic/Latino population.
- Lack of data on awareness, attitudes, behaviors, and use of screening services by Hispanic/Latino subgroups
- Lack of baseline data on morbidity and mortality; lack of Hispanic/Latino-specific HPDP year 2000 health objectives.

Desired Aims

- To gather and maintain adequate data on Hispanic/Latino health issues.
- To initiate, enhance, and/or expand research programs for the various Hispanic/Latino subgroups. This research should be initiated, used, and disseminated at the community level.

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- To facilitate the development of appropriate Hispanic/Latino-specific year 2000 objectives.

Implementation Strategies

- ◆ Establish and maintain a comprehensive and uniform database on HPDP efforts (comparable to non-Hispanic/Latino databases) that accommodates different Hispanic/Latino subpopulations. (Federal, State, local)
- ◆ Establish a body that will monitor the implementation of Hispanic/Latino HPDP initiatives and advocate on behalf of community-based organizations and funding for HPDP programs. (Federal, State, local)
- ◆ Monitor public agencies responsible for data collection and hold them accountable.
- ◆ Include Hispanics/Latinos on review panels, study sections, PHS advisory councils and working groups. (Federal, State, local)
- ◆ Establish culturally appropriate methods and standards for data collection.
- ◆ Foster initiatives that will target and fund Hispanic/Latino-specific HPDP activities (new funding and reallocation of existing funds). (Federal, State, local)
- ◆ Establish, implement, and monitor Hispanic/Latino-specific objectives in all *Healthy People 2000* prevention priority areas with a specific focus on those affecting Hispanic/Latino youth. (Federal, State)
- ◆ Establish culturally sensitive and appropriate methods for Hispanic/Latino data collection methods and processes. (Federal, State, local)
- ◆ Establish, expand, and share data networks that assist all research activities and community-based organizations. (Federal, State, local)

Problem/Issue #2:

Lack of Hispanic/Latino health professionals in HPDP decisionmaking and leadership positions and in the field.

Desired Aim

To increase the recruitment, training, and retention of Hispanic/Latino health and other related professionals in the administration and management of HPDP programs in the private and public sectors.

Implementation Strategies

- ◆ Establish a comprehensive Hispanic/Latino-specific HPDP mentorship program for research, teaching, and community interventions. (Federal, State, local)
- ◆ Secure scholarships for training Hispanic/Latino leaders in HPDP. (Federal, State, local)
- ◆ Increase funding for Centers of Excellence for Hispanic/Latino health professions with emphasis in HPDP and increase the number of Centers. (Federal)
- ◆ Enforce existing Federal and State mandates to ensure Hispanic/Latino opportunities in higher education (faculty and boards), decision-making positions (boards), and the workplace (management). (Federal, State, local)
- ◆ Encourage PHS to develop incentives for primary care providers serving hardship and underserved areas. (Federal)

Problem/Issue #3:

Weak organizational development of prevention providers and lack of organizational development, education, and training programs:

- Lack of HPDP curriculum in schools.
- Lack of multidisciplinary approaches to HPDP curriculum development.
- Lack of formal HPDP training for Hispanic/Latino leaders.
- Institutionalized and individual racism as a barrier to service delivery and professional development.

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Desired Aims

- To develop a Hispanic/Latino-specific cross-cultural and multidisciplinary curriculum to address the HPDP needs of the Hispanic/Latino population.
- To expand the pool of qualified Hispanic/Latino HPDP providers; to conduct aggressive recruitment and retention programs of Hispanic/Latino HPDP professionals.
- To enhance the capabilities of non-Hispanic/Latino HPDP professionals to better serve Hispanic/Latino communities.
- To increase the capacity of Hispanic/Latino community-based organizations to provide prevention/service programs.

Implementation Strategies

- ◆ Develop partnerships among training institutions, community-based organizations, and national Hispanic/Latino agencies to better provide HPDP services.
- ◆ Mandate all public organizations and institutions receiving Federal, State, and local HPDP funding to (1) develop a cross-cultural, multidisciplinary HPDP curriculum and (2) recruit, train, and retain Hispanic/Latino HPDP professionals to practice in underserved communities.
- ◆ Provide incentives (tuition, loan forgiveness programs, financial benefits) to providers for serving Hispanic/Latino and underserved communities.
- ◆ Develop training and other sensitivity initiatives to address issues of cultural diversity and racism.
- ◆ Develop attractive HPDP continuing education programs for health professionals in the delivery of preventive health services to Hispanics/Latinos.

Problem/Issue #4:

Lack of culturally sensitive and population-specific primary prevention programs.

Desired Aims

- To develop and evaluate Hispanic/Latino-specific models and approaches (e.g., clinics on wheels, bilingual outreach programs) to prevention programs.
- To develop grass-roots community-based programs.
- To develop a short- and long-term prevention strategy for communities at risk of environmental hazards, communicable and chronic diseases, etc.

Implementation Strategies

- ◆ Build on nontraditional methods of access to care (i.e., nurse practitioners, dental hygienists, etc.). (Federal, State, local)
- ◆ Establish linkages among community-based organizations, universities, the private sector, and lay people in the community. (Federal, State, local)
- ◆ Leverage public health initiatives with support of community-based organizations and community coalitions. (State, local)
- ◆ Emphasize the importance of awareness, education, early identification, and intervention through HPDP programs via community coalitions.
- ◆ Ensure that organizations serving Hispanics/Latinos have at least 12 months of experience in working with the Hispanic/Latino community, and that at least 50 percent of their board is Hispanic/Latino with Hispanics/Latinos in key administrative and program staff positions. (Federal, State, local)

Problem/Issue #5:

Lack of comprehensive and systematic approaches to clinical and preventive services; lack of appropriate screening and diagnostic procedures for Hispanics/Latinos.

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Desired Aim

To develop, implement, and, where appropriate, reinstitute culturally relevant and comprehensive preventive services.

Implementation Strategies

- ◆ Increase the use of community settings for the delivery of primary care/preventive services (i.e., churches, community centers, schools, community clinics). (Federal, State, local)
- ◆ Train staff in cross-cultural issues (i.e., involvement of family members, use of culturally relevant screening, and diagnostic procedures, etc.) in the delivery of services. (Federal, State, local)
- ◆ Recruit and use community leaders and “Promotores de Salud” effectively to conduct outreach and deliver services. (State, local)
- ◆ Require that evaluation be built into service delivery programs to ensure adequacy of services. (Federal, State, local)

Problem/Issue #6:

Lack of public-private partnerships in support of HPDP goals for Hispanics/Latinos.

Desired Aim

To increase collaboration between private and public organizations in the development of HPDP initiatives.

Implementation Strategies

- ◆ Create a solid Hispanic/Latino HPDP information network and clearinghouse via a public-private partnership. (Federal, State)
- ◆ Develop regulations that require private and nonprofit institutions (including universities) serving Hispanics/Latinos to include adequate Hispanic/Latino representation at decision-making and program levels. (Federal, State, local)
- ◆ Encourage the creation of a national Hispanic/Latino philanthropic federation that includes representation of grass-roots organizations. (Federal)

- ◆ Establish guidelines for Hispanic/Latino community-based organizations and national organizations for accepting corporate contributions; corporations’ products and services must be compatible with HPDP goals.

- ◆ Obtain corporate sponsorship and funding of HPDP programs for Hispanics/Latinos from industries that do not promote disease.

Problem/Issue #7:

Lack of cooperation among nations in addressing health issues.

Desired Aim

To develop, expand, and maintain cooperative efforts in environmental and HPDP areas among countries in the Americas (the United States, Mexico, Central/South America, Caribbean).

Implementation Strategies

- ◆ Foster close collaboration between Latin American countries and the United States regarding HPDP issues. (Federal, State, local)
- ◆ Make health and prevention (including environmental issues) critical elements in the regulations and implementation of the free-trade agreement. (Federal, State)

Problem/Issue #8:

Lack of a constituency for Hispanic/Latino political advocacy.

Desired Aim

To build a political constituency for HPDP.

Implementation Strategies

- ◆ Build rapport and working relationships with Hispanic/Latino, other appointed/elected officials, and national organizations. (Federal, State, local)
- ◆ Develop a Hispanic/Latino constituency to counter disease-promoting industries. (Federal, State, local)

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- ◆ Develop a consensus within the Hispanic/Latino community for acceptable universal standards of primary care.

Problem/Issue #9:

Lack of diffusion of culturally appropriate HPDP models:

- Lack of consistency in defining community-based HPDP interventions.
- Lack of community resources for the replication of successful Hispanic/Latino HPDP models.

Desired Aims

- To identify, showcase, and disseminate successful Hispanic/Latino HPDP models.
- To develop strategies to fund successful HPDP models.

Implementation Strategies

- ◆ Establish mechanisms and procedures by which all prevention RFPs have Hispanic/Latino community input. (Federal, State)
- ◆ Appoint Hispanics/Latinos to the proposal review process for research, training, and services.

Problem/Issue #10:

Lack of media involvement and sensitivity to Hispanic/Latino health and HPDP issues.

Desired Aim

To increase media's awareness of Hispanic/Latino health issues and the media's role in disseminating information on HPDP.

Implementation Strategies

- ◆ Develop an agenda/workshops/training for media representatives to participate in HPDP programs. (Federal, State, local)
- ◆ Develop community-based training programs in media advocacy.
- ◆ Use paid media to complement other HPDP efforts.

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Chapter 5: Presentation of National Workshop Recommendations

A representative from each Work Group at the National Workshop was chosen to present the recommendations developed by the Work Group. This chapter contains the presentation of the recommendations, which are listed in Chapter 5.

Access to Health Care

Castulo de la Rocha, J.D.

President and Chief Executive Officer
AltaMed Health Services Corporation

Access to health care is probably the most important issue facing Latino communities today, and I am certain it will be the most important issue facing this community for the remainder of this decade. Nearly one-third of all Latinos are uninsured or underinsured. We're the poorest, the youngest, and the least educated of major ethnic groups. We depend less on the welfare system, and we have a strong work ethic and strong family values. Our population is increasing rapidly. We have high visibility. But at the same time, the needs of our community also continue to expand very rapidly. The current focus of public debate regarding health care reform has focused on issues such as cost containment, the impact of business, governance, financing, and the role of the private sector in health care reform.

What has been missing in this debate are the financial, structural, and institutional barriers and obstacles that we have to face as Latinos. What we are attempting to do is to outline these barriers. We will focus on the lack of health care financing; Government policies that have been unresponsive to

needs; the structure of the health care system, which inhibits opportunities and the appropriate use of health services; and institutions and their inability to care for our population.

The specific recommendations are the following: First, health care reform must eliminate disincentives that work to cause the linkages of lack of public health coverage and unemployment, specifically focusing on the Medicaid system. Second, require Medicaid and Medicare reform to specifically address the needs of the Latino community by supporting primary health care services and shifting from the emergency hospital care to comprehensive community-based care, including preventive services. Third, develop demonstration models within HCFA [Health Care Financing Administration] that look toward alternative health care systems that are responsive to Latino community needs. This includes managed care systems. Fourth, even if we had adequate health care financing, there is no assurance that our population, based on historical practices, would be able to access those institutions.



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Thus, we strongly recommend the improvement of the infrastructure and access to working capital for the construction of health care facilities in Latino communities and the development of economic incentives to provide and to place medical practices within Latino populations.

We should also reformulate the administrative rules for designating physicians and other health manpower in shortage areas and medically underserved areas. The present indicators and determinants for medically underserved areas are, in fact, discriminatory and prejudicial to the Latino population. I strongly urge that we move aggressively in the direction of redefining those indicators.

We strongly support the funding of public health programs and infrastructure by the provision of at least 6 percent of health expenditures that must be accountable to the needs of the Latino community. What has happened over the years is that the attention has been moved away from public health services. We view this as an integral part of having an effective system of health care in the delivery of services to Latino populations.

We should require Latino participation in proportion to the total population in the decisionmaking process and in positions that affect policies in DHHS [Department of Health and Human Services], specifically in boards, commissions, and advisory committees, and in the RFP [request for proposal] process, development, and review. It is equally important that Latinos be involved in the search and selection of leadership within DHHS. An advisory committee to the Secretary of Health and Human Services should be established to advise the Department on policies affecting Latino populations. It's critically important that we have some way of monitoring and holding people accountable for the recommendations that we have developed.

Finally, we strongly recommend the formation and the development of a national effort aimed at lobbying for legislative issues that are important

to the Latino community. This is particularly important in light of the recommendations that we will receive today. We also recommend the development of a national Latino coalition for a healthy U.S.A.

Aida L. Giachello, Ph.D.

Assistant Professor
Jane Addams College of Social Work
University of Illinois—Chicago

The main problems/issues identified by our group have to do with the fact that we feel that there is no universal health coverage that would facilitate entry into the health care system. And there were all kinds of discussion in terms of what the ideal system is. Portability and affordability are essential. The people, regardless of where they are in the United States, should be able to have entry into the system. There should be a basic package of services where prevention would be emphasized. The consumer should have a choice of providers and comprehensive coverage allowing for continuing of care. It should be an integrated system of care where you would have a public sector, community health services, and the private provider that, in most instances, will usually be included in any kind of meaningful discussion. The system should provide progressive health care financing that spreads the burden across all sectors of society based on level of personal wealth. Eligibility would not be based on residency status, or employment status for that matter, or on any preexisting condition. It should be easy in terms of enrollment and participation; it should have measures of cost containment, quality assurance, improved efficiency, and accountability to recipient; and it should allow the recipient and the consumer to be active agents in the process of planning any implementation of services.

Another element that was discussed is that the system should reward providers who develop services for the underserved and unserved

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populations. It should provide incentives for coverage for prevention services and have a uniform procedure for reimbursement that recognized regional differences.

In terms of the strategy, we felt very strongly that there should be some kind of advocacy coalition, involving the public and the private sectors, in every State with a significant Latino population. There should be some kind of methodology of assessing the cost of universal coverage that factors in preventive measurements. We felt that Government and institutional policy right now have been unresponsive to Hispanic/Latino health needs. Therefore, there should be policy that would integrate service delivery systems and coordinate referral mechanisms linking the different sectors—the public, the private provider, the community, the migrant health centers, and the mental health centers. There should also be policy that would consider linguistic and cultural issues. The system should foster collaboration among all parties and target health profession education funding to increase a number of primary care providers. It should determine the unique health needs of Hispanic/Latino communities and provide resource allocation necessary to meet those needs.

In terms of implementing strategy for this particular issue, we need to bring together all parties to explore areas of collaboration and partnership. We also need to recognize that the

categorically funded programs as they stand now do not meet the needs of the different populations that they're supposed to serve; all kinds of examples were given of how the many assistance programs do not address the basic needs in our community. We also need to establish guidelines to review those categorically funded programs such as HIV programs and maternal and child health programs, to figure out a way of supporting Centers of Excellence, which would best meet the needs of the Hispanic/Latino community at all levels. And then we need to ensure that greater numbers of the Hispanics/Latinos are in key policymaking positions. Allocation of resources and the relevance of services to our community are better handled when you have people in key positions who would be able to advocate and bring the concerns to the discussion table.

The third area has to do with the fact that right now, the Latino community does not have access to the full array of health services. Examples were given in services such as primary care and preventive services, acute hospitalization, emergency services, dental services, drug and alcohol abuse prevention and rehabilitation, occupational health and rehabilitation, mental health services, social service, nutrition and health education, prescription drug, and visual and hearing services. These are some of the many areas of priorities that any comprehensive package should include and make available to our community.

We also acknowledged the fact that Latinos are not linked to a regular source of care. According to a recent report by the Robert Wood Johnson Foundation, one-third of our Latino population do not have a point of entry. One of the biggest barriers is that if you do not have that point of entry, you end up going to the hospital emergency room because you just do not know where to go when you become ill. Therefore, we feel that we need to address this issue.

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We also feel that, in terms of an ideal system, we want to eliminate language and cultural barriers. We want a system that can provide service to mobile populations like seasonal migrant farm workers, the homeless, refugees, and border and other transient populations. We want to reduce fragmentation and poor communication and coordination among services providers—linking the private provider with other local public and private sectors and community and mental health facilities.

We want reimbursement for services, for public information and public education and transportation, as well as provision for child care and social services. We believe that to be able to begin linking consumers to the available sources of care, we need to engage, particularly at a local level, in a series of outreach and marketing strategies that would increase consumer knowledge about what is available and how to enter a system. We also discussed the whole issue of interpreters, and we were concerned about the fact that the role of the interpreter may affect the quality of care. We were concerned also about the issue of confidentiality. There are ethical issues involved when you use interpreters and so the lack of guidance, the lack of training, the lack of really establishing protocols to serve providers was a clear concern of the group.

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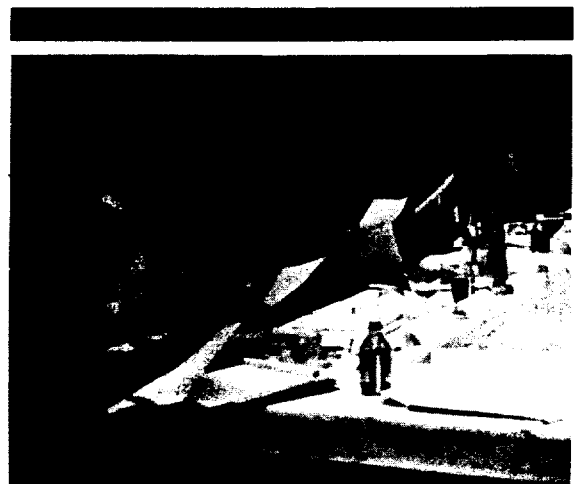
We also felt that we need to introduce legislation. There should be policy and guidance to promote bilingual and culturally competent, relevant services. We need to develop standards for those services; we need to revise criteria of eligibility for funding for community and other health programs to ensure responsiveness to Hispanic/Latino health needs; and we need to assess service delivery. There were discussions about the fact that the clinics available, public or private, don't have flexibility of hours or services. The services are organized to the convenience of the provider, not to the convenience of the

consumer. And the only way that we would be able to change this is by assessing the policy that every clinic follows, by seeing how we can make it more responsive to the specific needs of a given community.

People expressed concern that if you are under Medicaid and you move to another State, what you have is not portable. You cannot really access another system from another State. There has to be a guideline or policy; we need to explore how can we make programs more helpful, more useful, in addition to decreasing the number of Latinos who are left out because of the existing criteria.

I also want to mention the need to address and assess the needs of Hispanic women. Somehow the discussion of meaningful policy planning in general left out the health needs of Hispanic women, and please keep that in mind.

The final issue I want to address concerns the labeling of minority. There was concern among members of the Work Group that sometimes when the label "minority population" is used in allocation of funding, the term is not identified specifically with Asian American, Native American, or Hispanic/Latino American. Perhaps we should be more specific when we are stating policies in the allocation of resources.



Data Collection

Manuel R. Modiano, M.D.

Director, Arizona Cancer Center
Minority Cancer Control

We must not underemphasize the importance of data; without them, access to care, health professions, health promotion, etc., will never happen. There are 22.4 million Hispanics living in the 50 States and D.C., and 3.5 million people living in Puerto Rico, for a total of 25.9 million Hispanics in the United States. More than two-thirds of all Hispanics were born in the United States, yet it was not until 1989 that the model birth and death certificates included a Hispanic identifier.

Too often, organizational priorities and funding decisions are established without taking into account Hispanic data. Adequate planning is not available without the appropriate availability, utilization, and interpretation of Hispanic data. Therefore, resources from governments (Federal, State, and local), foundations, nonprofit and for-profit corporations, as well as educational institutions, are not allocated consistently with the needs of the Hispanic community.

As we approach the year 2000 and beyond, the need for the Hispanic data will only increase. Given the imperative to effectively target resources to maximize benefit and efficiency, the six areas that I am going to describe are the minimal set of issues that must be addressed to serve the health needs of the Nation.

The first issue is inclusion. There is a need for inclusion of Hispanics in all data systems. Our aim is to increase the mainstream inclusion of Hispanics in all systems, and the strategies for implementation are the following: First, all surveys and forms must include Hispanic and Hispanic population subgroups identifiers. Second, there must be sufficient numbers of Hispanics and Latinos included for analysis. Third, enforce OMB [Office of Management and Budget] Directive 15 and

Public Law 94-311. Educate the agencies about the use of the OMB Directive for inclusion of Hispanic and Hispanic/Latino subpopulation groups and data systems. Similar policies should be set for State, regional, and substate levels as well as for non-Federal purposes. And fourth, all agencies must report progress on inclusion of Hispanics and Latinos and their subgroups in data systems as well as in federally funded, intramural, and extramural research programs.

The second issue is local and regional data. There is a need for data relevant to the identified Hispanic health issues at the local and regional levels for specific subpopulations. We hope to be able to do this by improving the availability and reducing the gaps in local and regional Hispanic health data through the following implementation strategies. First, all agencies need to develop guidelines and technical assistance to be used by State or regional groups to collect data for Hispanic population groups at the local or local-regional level, including emerging Hispanic populations. Second, focus on Hispanic-specific generated issues. For example, collected data that only enumerate a number of gunshot wounds in a specific community would be useful only if they are made available to the community and if they are integrated with other data that already exist in that community. Third, develop a new series of local pilot studies to identify patterns and strengths that will justify the use of further activities in the same community and outside. And fourth, establish new objectives for the year 2000 and baseline data for those objectives at the Federal, State, and local levels.

There is a need for quality, precise, timely, and culturally sensitive data design, collection, and analysis. We hope to do this through the development of a foundation of high quality, valid, and timely information on Hispanics equivalent to or better than that existing in other ethnic or racial groups. The strategies for implementation are the following: First, include Hispanics in the design,

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implementation, analysis, funding, decisions, and dissemination of health assessment and health monitoring data systems. Second, assess the data collection research designs to include considerations of the heterogeneity of the Hispanic population. Third, oversampling has been identified as a feasible method of inclusion, but other methods need to be developed to efficiently locate less concentrated and dispersed Hispanic subgroups. Fourth, validate data collection and research instruments for cultural competency and linguistic appropriateness for use within Hispanic population and subpopulation groups. Fifth, bring the Census Bureau and NCHS together to identify the existing and emerging research issues with denominator and numerator problems, such as the rules for assigning race, using surname as a proxy, and the usefulness of other races and, quote, "other Hispanic categories." It is imperative that we involve Hispanic researchers in seeking the resolution to these issues. Sixth, study the problems associated with changes in ethnic self-identification. Seventh, establish guidelines for the coding and keying of data on birthplace, work history, generation status, socioeconomic status, language usage, family relationship, etc., which have been shown to be predictive of Hispanic health status. And finally, develop data release plans that meet priorities and the timeliness needs of users.

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On the issue of analysis, there is a need to identify and inventory the large amount of available data. These data need to be analyzed for use in understanding the Hispanic health concerns. To do this, we need to increase the analysis and production of Hispanic health data at Federal, State, and academic levels, and to increase the number of Hispanic researchers involved in these processes.

The strategies for implementation include the following: First, research on the health status, living conditions, and culture of the Hispanic/Latino populations should be included, in the development of hypotheses and conceptual frameworks. Second, identify existing data sets and

determine their access to the researchers. Third, support a network of Federal, State, university, and community-based analysis and analysts with a primary focus on health data analysis. Fourth, provide support for technical assistance to researchers who are involved in the urgent health issues for Hispanics. Fifth, increase the technological capacity of researchers to conduct more advanced analysis—for example, the geographic information system. And finally, encourage collaborative interdisciplinary research, which bridges quantitative and qualitative investigation.

In the area of dissemination, there are data that are unavailable or inaccessible, but are in critical demand. Our goal is to maximize the availability of Hispanic data to Hispanic and non-Hispanic policymakers, funding sources, practitioners, community-based organizations, and researchers. The data must be made accessible by training community-based organizations to access the data in training others in data cultural competency. The data produced by public agencies through public funds need to be made available to the community by providing information packets that include audiovisuals, slides, and other materials for community-based organizations.

We need to provide assistance on how to analyze data so that people can draw their own conclusions. The data should be balanced to include not only the negatives but also the important strengths of the Hispanic/Latino community and other issues. Federal regional offices should fund statewide clearinghouses on Hispanic health in high-impact States. There is a need to provide information to a broad range of groups, Hispanic civic advocacy groups and non-Hispanic white groups, and we need to identify in each agency and organization a person or people to serve as principal point of contact on Hispanic health data.

There is a need for coordination between and among Federal and State agencies in Hispanic health data collection and analysis. The aim is to

enhance and expand the development of Hispanic data by public agencies. We hope to do this by using the existing Federal data systems to establish cooperative agreements with States for developing standard State and local health status profiles for Hispanic communities. Second, establish an inventory of existing Federal, State, and local data resources to identify gaps and areas of improvement. Third, provide government support for a network of community-based health data collection efforts to serve as an early warning system for setting of health policy priorities. Fourth, maintain an advisory board to the Office of the Surgeon General to help oversee Federal, State, and local Hispanic health issues. And finally, establish a Federal interagency task force on Hispanic health-related data with input from appropriate, non-governmental Hispanic advisors.

Research Agenda

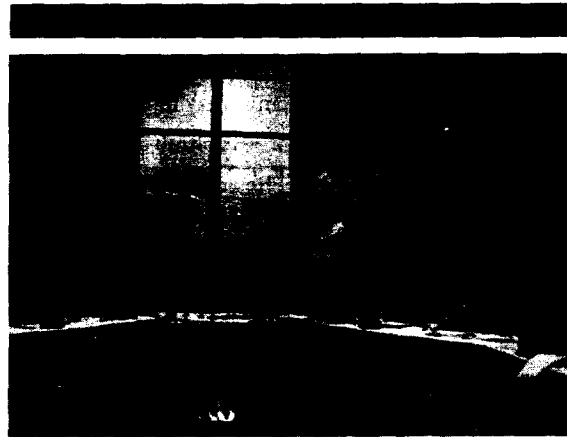
Hortensia Amaro, Ph.D.

Associate Professor
Boston University School of Public Health

Research data provides the knowledge base for forming policy and developing programs. We identified four major problems in the development of a Hispanic health research agenda and developed aims and implementation strategies targeted to specific Federal and private sector institutions.

The first major problem that we identified was the lack of an appropriate infrastructure and human and physical resources or capacity to conduct research. We developed three aims in this area. The first aim is to increase the number of behavioral and biomedical Hispanic scientists. We developed 11 recommendations for implementation strategies related to this aim.

First, to accomplish this aim, PHS [Public Health Service] should develop specific support programs for pre- and postdoctoral training for Hispanics in behavioral and biomedical research to



eliminate their underrepresentation in health-related research. Second, PHS and other Federal agencies must develop programs directed at Hispanic researchers to improve methodological expertise in health-related research. Third, PHS should target and intensify efforts to recruit Hispanics into its existing research and training programs. It was recognized that PHS has excellent research and training programs currently, and we need to actively recruit Hispanics to these programs. Fourth, PHS should develop and fund distinguished research career programs to allow Hispanic researchers to concentrate on research, writing, and mentoring to free them from the multiple requirements and expectations commonly faced by minority academicians. Fifth, NIH [National Institutes of Health], CDC [Centers for Disease Control and Prevention], and other Federal agencies should conduct grantsmanship workshops where Hispanic researchers have the opportunity to learn proposal writing strategies and have their preproposals reviewed by ad hoc IRGs. Sixth, expand and evaluate specific initiatives to ensure that Hispanic middle and high school students take courses essential for entering science careers. We think the Department of Education, and especially the National Science Foundation, should play a leading role in this effort. Seventh, as was noted this morning, there is a need to improve and to assess the effectiveness of existing programs, such as

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the Minority Biomedical Research Support Program, the MARC [Minority Access to Research Careers] program, and the minority high school apprenticeship program, for recruiting and assisting Hispanic students to complete research and training careers. Eighth, we need to encourage professional associations to stimulate the involvement of Hispanic students in research careers. Ninth, PHS and other Federal agencies should develop special initiatives to fund grants submitted by new and established Hispanic investigators. We need to engage Hispanic researchers and encourage them to take advantage of these opportunities. Tenth, increase and enhance institutional capacity for Hispanic health research through the establishment of Hispanic health research centers and through support for individual Hispanic investigators. While it is clear that research centers are needed, it was also recognized that many Hispanic researchers make invaluable contributions as individual researchers, and they must be supported. Finally, PHS should provide orientation to public health program staff on Hispanic health and related methodological issues, so that they can better guide program initiatives and review group scientists in these areas. The goal here is to increase the commitment and knowledge of Hispanic health issues on the part of program staff who can be so influential in funding decisions.

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A second aim related to the lack of a research infrastructure is to improve cultural competence and sensitivity of Hispanic and non-Hispanic/Latino scientists. The recommendations for implementation strategies are, first, that regional and professional accreditation agencies should require that Hispanic health research issues be incorporated into existing curriculum. Second, educational, institutional, and professional associations and PHS should develop and institute courses, seminars, and conferences on methods for conducting research on Hispanic populations. Third, members of internal review groups must be instructed on the procedures

required for culturally competent research that targets Hispanics. The evaluation of proposals should include specific points assigned for culturally appropriate research methods. And fourth, staff should provide appropriate training and guidelines to reviewers in order to improve the ability of IRGs [Internal Review Groups] to evaluate research on Hispanic health. We see this as being consistent with the NIH [National Institutes of Health] guidelines for including women and minorities in study populations.

A third aim related to the lack of a research infrastructure is to improve communication and interaction among Hispanic scientists. The first implementation strategy is to centralize and expand the existing data bank on Hispanic researchers at PHS and to add non-Hispanic researchers conducting research on Hispanic health. The data bank now focuses primarily on individuals who have received grant awards, and we think that this needs to be expanded to other researchers as well. Second, we need to encourage professional associations to facilitate networking among Hispanic researchers.

The second major problem area we identified is the dearth of research relevant to the health of Hispanics. The first aim here is to develop health research that is relevant to the Hispanic population. The first recommended implementation strategy is that the Office of Minority Health commission a number of state-of-the-art papers that critically analyze the literature on Hispanic health in each of the areas identified by previous reports and assess gaps in knowledge. These papers would present a review of current knowledge in each of the areas covered by Healthy People 2000. The papers should be used as guides for funding by PHS agencies. Second, a high-level committee with the appropriate Hispanic health expert involvement must be appointed by the Office of Minority Health to review the outcome of the activities of the first year of the Hispanic/Latino Health Initiative and the information obtained from the state-of-the-art papers. This panel must be charged with developing an outline

of priorities and initiatives for research with Hispanics. Third, special funding programs or initiatives must be developed by the Federal Government to fund research on the role of factors such as acculturation, migration, national origin, socioeconomic status, and their impact on the health status of Hispanics. As part of this, large-scale, cross-sectional, longitudinal studies with Hispanics funded by Federal and State initiatives must be required to include these factors as possible moderators of health status. Fourth, special program initiatives must be developed by the Federal Government to analyze the health status of Hispanics working in high-risk environments, such as migrant agricultural environments, assembly plants, service professions, and other industrial environments, to better understand environmental health risks. Fifth, health services research must be conducted to identify the characteristics of health care delivery, including personnel and facilities that facilitate access, utilization, and effectiveness of health services among Hispanics and Latinos. A meaningful proportion of services research set-aside funds, especially those related to mental health, alcohol, and substance abuse, should be targeted to investigate questions pertaining to Hispanics. Sixth, create an Office of Hispanic Health within the Office of Minority Health in the Office of the Assistant Secretary for Health, to coordinate Hispanic health-related initiatives and to oversee their implementation within the Federal Government. It is critical that this office be properly funded and that it include an advisory board that would review its activities on a quarterly basis. The Office of Minority Health should issue a biannual report to Congress detailing the progress on the Hispanic health agenda and the progress within PHS in meeting the mandates of the Disadvantaged Minority Health Act as they relate to Hispanics. Seventh, PHS should fund research targeted at providing baseline data to enable formulation of Hispanic-specific objectives for the next *Healthy*

People report. Eighth, PHS should develop mechanisms to obtain meaningful community input into the formulation of a research agenda.

The third major problem area we identified is lack of culturally appropriate research theories and methods. The first aim is to increase the number, availability, and validity of research instruments used in investigations on Hispanic health. To achieve this aim, the Work Group recommended that Federal programs fund research to test the usefulness of current instruments and to develop new culturally appropriate instruments that meet applicable standards of validity and reliability. Second, PHS must fund a repository of Hispanic health-related instruments to facilitate the use of these instruments by scientists.

A second aim related to the lack of culturally appropriate theories and methods is to study the applicability of existing health constructs and theories that currently guide research and assess their appropriateness to Hispanic populations. PHS should fund research to develop new behavioral models and theories and to test the validity of existing models.

A fourth major problem area that was identified is the underrepresentation of Hispanics in PHS. The first aim is to ensure proportional representation of Hispanic researchers on scientific advisory boards, national advisory councils, and IRGs as well as technical evaluation groups that review contracts. The recommended implementation strategy is that a yearly survey be conducted to identify qualified individuals willing to serve in these bodies. Results of those surveys should be published yearly, and an updated directory should be made available to Federal and State agencies that fund health-related research. It is recommended that the internal review groups, technical evaluation groups for contracts, national advisory councils, and scientific advisory boards within PHS and other Federal agencies, should include Hispanic representation.

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The second aim related to the underrepresentation of Hispanics in PHS is to ensure proportional representation of Hispanics on the staff of PHS. One implementation strategy is to expand the short-term service initiatives that allow Hispanic researchers and academicians to serve within PHS without severing ties with their home institutions. Finally, PHS should develop and target efforts to recruit, retain, and promote Hispanics at all levels of the scientific and program staff at PHS.

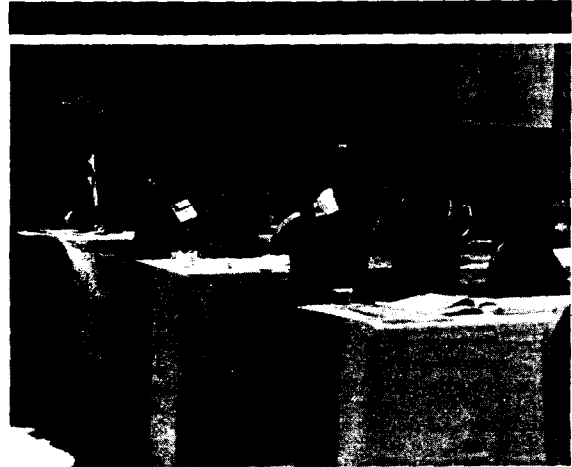
Health Professions

Rene F. Rodriguez, M.D.

President
Inter-American College of Physicians and Surgeons

In our area, we identified four problems. The first problem was inadequate education of Hispanics to move toward the health profession. Our desired aim is to increase the numbers of Hispanics in the education pathways toward the health profession so that, by the year 2000, the number of Hispanics admitted to health professional schools reflects the percentage of Hispanic population by State. The implementation strategies are (1) to increase parental involvement in children's education through family counseling, dissemination of information, programs like ASPIRAS established by the school's community-based organizations, private sector media campaign, and assisting and monitoring low-income families in planning earlier for later schooling of their children; and (2) to move children into English language competency as soon as possible through early childhood programs.

The second problem is lack of accountability. Our desired aim is that all PHS agency directors should be evaluated annually based, in part, of the following: (1) recruitment and retention of Hispanic staff; (2) representation of Hispanics in review committees; (3) grants, awards, and programs with a Hispanic health focus; (4) grants awarded to Hispanic principal investigators; and



(5) grants award to universities with significant Hispanic graduation rates.

Our implementation strategies will be to enact legislation that will require all PHS directors to be evaluated annually based on the criteria mentioned above, or to secure an Executive Order that will achieve the same goals and objectives.

The second desired aim is to significantly increase, by the year 2000, the number of Hispanic full-time equivalent faculty and students in universities and health professional schools to reflect the percentage of Hispanic population in the area. The implementation strategy will be that the schools showing significant increases in full-time equivalent Hispanic faculty and students will receive additional Federal funds, student loans, and assistance.

Our third desired aim is to address the lack of adequate resources for success in preparation of Hispanic students for health professions. Our desired aim is to significantly increase, by the year 2000, the resources assigned to inner city schools, colleges, and universities with large Hispanic student bodies. The implementation strategies will be (1) to stimulate the private sector to invest in supporting inner city schools, colleges, and universities with large Hispanic student bodies; (2) to stimulate the private sector and Government to invest in scholarships to Hispanic students in inner city schools, colleges, and universities with large

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Hispanic student bodies; (3) to increase funding and the scope of the health career opportunity programs; and (4) to stimulate Hispanic health professional organizations to develop and participate in mentoring programs on all levels.

The fourth desired aim is to address the lack of data on the practice characteristics of Hispanic health professionals necessary for planning purposes. Our desired aim is to have updated, analyzed data on the practice and characteristics of all Hispanic health professionals to be disseminated for planning purposes. The implementation strategy will be to request that health professional organizations gather and analyze data on the practice characteristics of Hispanic professionals.

Ciro V. Sumaya, M.D., M.P.H.T.M.

Associate Dean for Affiliated Programs and Continuing Medical Education
The University of Texas Health Science Center at San Antonio

Why do we need more Hispanic health professionals? First, let us look at the moral issue. There is talent in the community that, if better tapped, could be an effective resource for addressing health needs of the country and its large Hispanic community. If one looks at the economic side, it is clear that an increase in the number of Hispanic/Latino health professionals would enlarge the proportion of people that are educated and economically sound. And if we look at the cost containment issue, there is evidence indicating that Hispanic/Latino health professionals are more likely to provide care for Hispanics/Latinos and other minorities in the community, addressing health problems in these underserved populations that, if ill treated, would lead to more costly treatments and increased human suffering.

Yet significant barriers exist in the educational system that impede an increase in the number of Hispanic/Latino health professionals, i.e., barriers that are economic in nature or deal with academic

preparation, cultural differences, the admissions/retention process in health professional schools, etc. This presentation will cover some of the more important issues, aims, and implementation strategies proposed by our Work Group. A complete listing of these findings will appear in the written proceedings of the Workshop.

Our initial aim is to increase by a minimum of 10 percent per year the number of Hispanics entering health professions schools over the next 10 years. One of the principal implementation strategies to accomplish this aim is to bring more qualitative evaluations and measures into the admissions process. Individuals should be evaluated as a whole, not merely looking at their aptitude tests and grade point averages. What obstacles has the individual had to surmount to reach the application stage? What values can the individual bring to society? What are society's needs? It is most important and relevant that students be credited for their personal and diverse educational pathways. Additional needs include increasing Hispanic/Latino participation in the admissions process. Also, cultural diversity should be brought to the attention of the admissions committee, and establishing more consistent definitions or identification of Hispanics/Latinos as part of the admission criteria for health professions schools.

The second aim proposed by the Work Group was the graduation of all Hispanic/Latino students enrolled in health professions schools. In other words, students that are admitted need to complete their education. A number of effective retention and support programs that address this aim do exist, but there is a major need to expand the existing ones and to develop them in schools in which they are weakly structured or lacking.

The Work Group also stipulated that the Federal Government and the States should set standards for increased representation of Hispanics/Latinos in the health professions and that these standards be tied to funding/appropriation levels.

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More research is needed in analyzing standardized test bias and lack of predictability of these tests in determining future medical performance of medical school graduates. In plain words, how well do these test predict future performance of these individuals in the community and in the provision of needed health care, particularly for the more vulnerable populations?

The Hispanic Centers of Excellence, as recently legislated, are a most important concept in the entry and advancement of health professional students and faculty. These Centers need our strong support and appropriate Federal funding. It was specifically noted that there should be an equitable distribution of monies to Hispanic Centers of Excellence in relation to the total amount allocated for such initiatives through the Minority Disadvantaged Health Improvement Act. These Centers should also be broader in scope, covering not only the disciplines of medicine, dentistry, and pharmacy, as applicable currently, but also nursing and allied health. Moreover, there should be a critical evaluation of the Centers in terms of outcomes and products that can enhance their success.

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Measures to make health professions education affordable are imperative. Yet there currently exists insufficient financial support for Hispanic/Latino students pursuing health professions and sciences. This situation overly affects Hispanic/Latino students because they are more likely than non-Hispanics/Latinos to come from lower economic circumstances. There are immediate needs for more or expanded scholarship programs, low-interest loans, and effective loan repayment programs. Scholarships, in particular, have a greater impact for low-income Hispanics/Latinos, because they require no payback. The availability and accessibility of these measures or programs should be readily disseminated to individuals, their families, and their teachers. Further, this information needs to be given in a format that is

easily understood by the target audience—unfortunately an audience that is likely to be overly familiar with a low-income lifestyle and, as a corollary, whose family heads have lower levels of education.

Coordinated efforts among the private sector and local, State, and Federal groups to improve the academic preparation of Hispanic/Latino students can have a profound effect on the number of Hispanic/Latino students entering and successfully completing health professional training and education. Examples of these efforts include kindergarten through 12th grade (K-12) science education taught in part by health professionals, sessions between health professionals and students along with their parents and teachers/counselors, site trips by K-undergraduate students to health centers or clinics, student-faculty/private practitioner mentorships, medical research laboratory training programs, articulation between 2- and 4-year colleges with health professional schools, and on and on.

Another aim proposed by this Work Group was the equitable allocation of technical assistance and financial resources to Hispanic/Latino health professionals within DHHS, and, by extension, to the State health agencies. Implementation strategies considered for this aim include a mechanism for reviewing and revising DHHS fiscal reporting to enable a clearer picture of Hispanic/Latino health professional employment practices and monies targeting Hispanic/Latino health issues and Hispanic/Latino researchers. There must be increased participation of Hispanics/Latinos in study groups, advisory boards, councils, and task forces within DHHS.

Our next important issue was career development and faculty advancement. The aim proposed here is an increased representation of Hispanics/Latinos in advanced career and faculty level positions in health professional schools and other health-related organizations. To this end, a well-defined plan to promote Hispanics/Latinos in upper

management, policy, and research positions, with an accompanying reporting and review system, should be implemented.

Effective methods for addressing deficiencies in the hiring and promotion policies affecting Hispanics/Latinos in schools for the health professions are needed. The Disadvantaged Minority Health Improvement Act should incorporate funded programs that assist in increasing the currently very low numbers of Hispanic/Latino faculty in health professions schools. These programs can include preparation enhancement as well as incentives to the schools. With a changing focus of faculty responsibilities in the 1990s, there also is a need to rectify the balance among research, training, and service in relation to the tenure and promotion process for faculties. Community and clinical service should carry with it valid credit towards faculty tenure and promotion. Equitable research funding should target Hispanic/Latino health issues and Hispanic/Latino researchers, i.e., New Investigator Awards to Hispanic/Latino researchers. The latter will require the tracking of the number of grants and contracts by Hispanic/Latino researchers that have been submitted, approved, and funded by DHHS, along with the amount of technical assistance provided by the granting agencies. An effective mentoring system for junior Hispanic/Latino faculty members should be routinely available and accessible.

In addition, there is a major need for increased Hispanic/Latino representation across the board in local, State, and national policy and decision making groups such as panels, task forces, councils, and advisory committees. This aim can be implemented more effectively by the development of a current, centralized information bank of talented Hispanic/Latino health professionals that could serve on the above groups.

The final issue to highlight deals with licensure and institutional accreditation. It is readily apparent that there is a lack of culturally relevant input in the

licensing/certification process and in the accreditation of health professions schools. One of the aims targeting this issue argues for the incorporation of cultural diversity standards relevant to Hispanics/Latinos in the accreditation process. The implementation of this aim is in three steps: communication of these needs to the accrediting body; placement of culturally diverse issues in the curriculum and before faculty forums; and a monitoring of implementation strategies in terms of action and outcomes. Another aim is to increase the representation of Hispanics/Latinos in the test development processes that are used for licensing and certification of the various health professions. This aim can be implemented by having listings of Hispanic/Latino health professionals that can be selected by accrediting and licensure committees, working constructively with the health professions examination boards to determine culturally biased and inappropriate test questions. The last aim for this issue points to the enhancement of entry of foreign-educated Hispanic health professionals into the health service delivery system. Implementation of this aim can be generated from innovative programs and funding mechanisms to assist, train, and retrain foreign-educated Hispanic/Latino health professionals to practice in the United States.

Health Promotion and Disease Prevention

Elsa M. Garcia, R.N., M.H.A.

Humana Michael Reese Health Plan

Problem/issue one is that there is a lack of data on knowledge, attitudes, practices, and utilization of screening services by the Hispanic subgroups, and a lack of research on new HPDP [Health Promotion and Disease Prevention] strategies targeting Hispanic subgroups. So we need some information on mortality and morbidity, and that must be implemented keeping in mind two aims. One, we want policies that would establish and maintain a comprehensive and uniform Federal, State, and local

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database on HPDP, comparable to non-Hispanic/Latino databases, by various Hispanic/Latino populations. Two, research programs that are initiated, utilized, and disseminated at the community level for various Hispanic populations must be established and expanded. The strategies are (1) establish a body that will monitor and implement the goals of HPDP and advocate community-based organizations and funding for such programs; (2) monitor agencies that are responsible for data collection and hold them accountable by including Hispanics on review panels, study sections, public health services, advisory councils, and work groups; (3) specifically target Hispanic/Latino funding initiatives, and that may mean new funds and reallocation of present funds; (4) establish, implement, and monitor Hispanic-specific component objectives in all *Healthy People 2000* prevention priority areas with a specific focus on those affecting Hispanic youth—they are our future; (5) establish culturally sensitive and appropriate methods for surveillance and for other data collection processes; and (6) establish, expand, and share the data networks that assist all research and community-based organizations.

Problem/issue two is the lack of organizational development, education, and training programs; lack of HPDP curriculum in local schools; lack of multidisciplinary approaches to HPDP curriculum development; lack of leadership training in HPDP; and institutionalized and individual racism, which is a barrier to delivery of services and professional development.

The desired aims are to (1) increase the capacity of Hispanic CBOs [community-based organizations] to provide prevention service programs; (2) develop Hispanic-specific educational curricula and role models in prevention and primary care and in teaching and research, and recruit and retain an emerging majority in the HPDP field; (3) develop a Hispanic cross-cultural and multi-disciplinary curriculum in HPDP; (4) increase the

pool of Hispanic preventionists and increase the capacity of non-Hispanics to better serve Hispanics.

The strategies to meet those aims are (1) develop partnerships among training institutions, CBOs, and national Hispanic agencies to empower communities in the area of HPDP and service programs; (2) mandate all public organizations and institutions receiving Federal, State, and local funding to develop cross-cultural, multi-disciplinary HPDP curricula to recruit, train, and retain Hispanics and other appropriate role models who will teach and conduct research in HPDP and return to provide HPDP services in their communities; (3) provide incentives such as tuition and loan forgiveness programs, and financial benefits for Hispanics in underserved communities; (4) develop training and sensitization work groups to deal with the “isms” (e.g., racism) on individual and institutional levels; and (5) develop continuing education programs for health professionals delivering preventive health services to Hispanics.

Problem/issue three is the lack of culturally sensitive and population-specific primary prevention programs. Our aims are (1) to develop and evaluate Hispanic models and approaches: clinics on wheels, bilingual outreach programs, prevention programs focused at traditional and nontraditional families and targeted populations; (2) to develop community-based programs; and (3) to develop a short- and long-term prevention strategy for communities at



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risk of environmental hazards and/or communicable and chronic diseases. The strategies are (1) to build on nontraditional methods to access care—nurse practitioners in the field, dental hygienists—and tap into those resources; (2) to establish linkages of CBOs with universities and the private sector and lay people in the community; and (3) to identify, educate about, and intervene in public health issues early through community coalitions.

Problem/issue four is the lack of systematic response to the full range of preventive services to Hispanics. The aim is to develop, implement, and, where appropriate, reinstitute culturally relevant and comprehensive preventive services. The implementation strategies are, first, to increase the use of community settings, such as churches, community centers, and schools, for delivery of primary care and preventive services; second, train bilingual and other staff to be culturally sensitive and competent in the delivery of services, and this involves the family; third, recruit and use community leaders, including HIV-infected individuals who want to go back and talk to their communities about what they've gone through; and fourth, require evaluation to be built into the service delivery programs and ensure that evaluation is conducted by Hispanic professionals.

Frank Beadle de Palomo, M.A.

Director, NCLR Center for Health Promotion
National Council of La Raza

Continuing with that, we have the fifth problem/issue statement, which is a lack of public and private partnerships in HPDP programs for Hispanics/Latinos. We're constantly hearing about the shortage of money in the public sector, that there is a scarcity, and that there is not enough funds allotted for us to do the kinds of programs we want, so we need to encourage and get private industry to become more involved.

Our implementation strategies for this aim would be (1) to establish guidelines for Hispanic/Latino CBOs and national organizations for accepting corporate contributions that are compatible with HPDP programs; (2) to obtain corporate, non-disease-promoting industry sponsorship and funding of HPDP programs for Hispanics/Latinos, who represent a significant sector of their market; (3) to create and enhance a strong Hispanic/Latino HPDP information network and clearinghouse via public and private partnerships; (4) to develop regulations that mandate private and nonprofit institutions, including universities serving Hispanics/Latinos, to ensure participation in decision and policymaking and service implementation; and (5) to encourage the creation of a national Hispanic/Latino philanthropic federation with representation of the grassroots level of the Hispanic/Latino community.

The sixth problem/issue statement deals with the lack of Hispanic/Latino health professionals in decisionmaking and leadership positions and in the fields. We cannot affect policies and we cannot change the current system unless we're able to make those decisions. Our aim is to increase the recruitment, training, and retention of Hispanic/Latino health professionals in the administration and management of HPDP programs in the private and public sectors. Our strategies are (1) to establish a creative, comprehensive Hispanic/Latino-specific HPDP mentorship program for research, teaching, and community interventions and for training mentors; (2) to procure scholarships for training the Hispanic/Latino leaders in HPDP programs; (3) to increase the number of and funding for Centers of Excellence for Hispanic/Latino health professions with an increasing emphasis in HPDP; and (4) to enforce existing Federal and State mandates to ensure Hispanic/Latino opportunities in higher education, such as faculties, boards, and management. To do this, we would encourage PHS to develop incentives for primary care providers

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serving hardship areas and to ensure that organizations serving Hispanics and Latinos have at least 12 months' experience in working with the Hispanic/Latino community and that at least 50 percent of their board members are Hispanic/Latino, with Hispanics/Latinos in key administrative and program staff positions.

The seventh problem/issue statement deals with a lack of binational United States-Mexico health cooperation. Our desired aim is to develop, expand, and maintain cooperative efforts in environmental and HPDP areas among countries in the Americas: Mexico, Central and South America, and the Caribbean.

Implementation strategies are (1) to target all HPDP strategies that apply to Hispanic/Latino prevention efforts to the aim of this issue and (2) if the North American Free Trade Agreement becomes policy, make health, including environmental issues, a critical element in the regulation and implementation of such policy.

The eighth problem/issue statement—there's a lack of constituency for Hispanic/Latino political advocacy in the health arena. We need to build a political constituency for HPDP programs to exist. Our strategies would be (1) to build community and working relationships with Hispanic/Latino and other appointed elected officials and national organizations, (2) to develop and build a Hispanic/

Latino constituency to counter disease-promoting industries, and (3) to develop a consensus with the Hispanic/Latino community for acceptable universal standards of primary care.

The ninth problem/issue statement—there's a lack of diffusion of culturally relevant HPDP programs. There might be some fantastic programs that exist in one State or in one community, but other places don't know about those. Or, it's difficult to replicate these programs. Therefore, our aims are to identify, showcase, and disseminate successful Hispanic/Latino HPDP models, and to develop strategies to fund these successful models. Our strategy is to establish mechanisms and procedures by which all prevention-related RFPs have Hispanic/Latino community input and to appoint Hispanics/Latinos to review proposals.

And our last issue is the lack of media awareness and sensitivity to Hispanic/Latino health and HPDP issues. Our desired aim is to increase media's awareness of the Hispanic/Latino health issues and the media's role in disseminating information on HPDP. Our strategies are, first, to develop an agenda for workshops and training for media representatives to become actively involved in health promotion and disease prevention; second, to develop community-based training programs in media advocacy; and third, to capitalize on marketing media and health promotion.

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Chapter 6: Closing Remarks

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

Surgeon General
Public Health Service
U.S. Department of Health and Human Services

Buenas tardes. Here we are, finally, after 3 days of intensive participation at this landmark National Workshop on Hispanic/Latino Health: Implementation Strategies. To say that it has been quite a Workshop is an understatement. It has been for me, and I hope equally for you, 3 of the most memorable and productive days of my term as Surgeon General—

- Three days in which all of us have discussed and debated, analyzed and strategized, synthesized and prioritized.
- Three days in which you have risen to the challenge I gave you on Monday, that is, not to “let the laurels rest with a few” but to strive for unprecedented achievements for us all.
- Three days in which we have been TODOS UNIDOS, as one, for the very first time, and it is my hope that it will be for always.
- Three days in which, to “cut through talk and get us action,” you brought your feelings and anger where they were needed, left your egos at the door, made use of the best we all have to offer, and spoke with one voice.

In these 3 days, we have also been informed and enlightened as never before. Our invited speakers have responded to both our collective identity and our badges of individuality. We have heard from the top experts in this country on everything from who we Hispanics/Latinos are,

where we come from and where we live, to how much we have grown, how old we are, who goes to school, what we do and what we earn, and how many of us fall into the “haves” and how many fall into the “have nots.” And we have listened with the urgency of those who, knowing our realities for so long, must *act now* to secure a place for ourselves, our communities, and especially for our children.

For the longest time, we have been told that—

- We Hispanics/Latinos number 22 million (10 percent of the U.S. population), and by the year 2000, there will be 31 million of us—the single largest and youngest ethnic minority in the United States. Yet amazingly, it was not until 1989 that the model birth and death certificates included a Hispanic/Latino identifier.
- Sixty-seven percent of us were born in the United States, and we represent many nationalities. We live in virtually every part of this country (primarily in urban areas) but are concentrated in seven States. In California and Texas, one in four people are Hispanic/Latino.
- We also compose 5 percent of the elderly population, have the highest fertility rates in the country, and have larger families than non-Hispanics/Latinos. Many of these families are headed by a single female.
- We have the lowest educational attainment in the country, we are among the country’s poorest people, and we are less likely to be homeowners than others.

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- We suffer disproportionately from many diseases and medical conditions, and about one-third of us lack health insurance, even in the presence of an employed adult in the family.

As I have said, these facts portrayed our sociodemographic and economic realities and showed who we were only yesterday. These facts underscored the point that many of the problems we face as Hispanics/Latinos reflect the educational and economic disparities that we have heard about throughout this Workshop, and throughout our lives.

Now, you might say, "What's new?" I can tell you that the latest data we have learned in just these past 3 days have done more than corroborate what we knew only yesterday. Aside from being clearer, broader, varied, and more precise, they have also added a sense of urgency in that we have very little time left to rehearse—an urgency to remind the American people that Hispanics/Latinos are 22 million voices who need to be accounted for and counted in!

- For example, by the year 2050 the Census Bureau predicts that the Hispanic/Latino population will increase to between 74 and 96 million people, which means that almost one-fourth of the people in this country will be of Hispanic/Latino descent.

- Next, as a group, we are becoming the youngest minority: 35 percent of Hispanics/Latinos in this country are under 18. In contrast, only 26 percent of non-Hispanics/Latinos are under 18.
- In 1992, 11.3 percent of Hispanics/Latinos were unemployed (as opposed to 7.5 percent of non-Hispanics/Latinos and 6.5 percent of whites), with Puerto Ricans, Mexicans, and those of Central and South American descent having the highest unemployment rates among Hispanics/Latinos.
- Hispanics/Latinos are more likely to be employed in lower paying, less stable, and more hazardous occupations than non-Hispanics/Latinos.
- Among Hispanic/Latino men, a large number (28 percent) are operators of equipment and machinery, and only 11 percent are in the managerial/professional fields. Among non-Hispanic/Latino men, only 19 percent are equipment operators and 27 percent are in the managerial/professional fields.
- Among Hispanic/Latino women, the majority (40 percent) fall into the technical/sales fields, which is not far behind the 45 percent of non-Hispanic/Latino women in those fields. However, only 16 percent of Hispanic/Latino women hold managerial/professional positions, in contrast to 28 percent of non-Hispanic/Latino women.
- Sadly, too many of our families and our children live in poverty. The median family income for Hispanics/Latinos is \$23,000, compared with \$37,000 for non-Hispanics/Latinos in general and \$39,000 for non-Hispanic/Latino whites.
- In 1991, 26.5 percent of Hispanics/Latinos in this country were living in poverty, compared with only 10 percent of non-Hispanics/Latinos and 7 percent of non-Hispanic/Latino

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whites. Puerto Ricans were found to be the poorest, with 35.5 percent living below the poverty line, and Cubans are the least poor.

- Close to 41 percent of Hispanics/Latinos under 18 years of age live in poverty, in marked contrast to only 13 percent of non-Hispanic/Latino youth. And 21 percent of Hispanic/Latino adults, including the elderly, also live in poverty.
- Our school dropout rates are cause for concern: only 53 percent of Hispanics/Latinos have completed 4 years of high school, in contrast to 82 percent of non-Hispanics. And only 9 percent of Hispanics/Latinos have attended 4 or more years of college, as opposed to 22 percent of non-Hispanics/Latinos.
- Currently, only 850,000 Hispanics/Latinos are enrolled in colleges and universities. About half are enrolled in Hispanic-serving institutions of higher education. Of the total number of Hispanic/Latino college students, 223,000 are enrolled in California; 148,000 in Texas; and 150,000 in Puerto Rico. This means we actually have only 229,000 enrolled in the remaining States.

We also learned that, because of limited resources, the forthcoming National Health and Nutrition Examination Survey (NHANES III) will report only on non-Hispanic/Latino blacks, non-Hispanic/Latino whites, and Mexican Americans. In other words, we have made progress—now there is *some* Hispanic/Latino representation in the National Survey, but two categories covered in the previous HANES, Cuban American and Puerto Rican, will not be covered.

In the same vein, the lack of Hispanic/Latino identifiers in 20 States, uncertain reporting in 30 others, samples too small to use for analysis, and a 10-year gap between data collection worsen the picture. Moreover, we have learned that, ironically, those of us under the poverty line who happen

to be staying together as a family put ourselves at risk for Medicaid coverage. And sadly, many of us still use the entrances of emergency rooms rather than the doorways of primary care providers.

My friends and colleagues, these are the grim facts as we know them today; they provide an urgent reminder that we can't wait until tomorrow to take action. During this Workshop, we have strived to address these realities and to find the best solutions to secure our futures. In the presence of so many negatives, let us not forget that all is not bad—regardless of the stereotypes that so many have used as artificial barriers to keep us from what is rightfully ours. For, contrary to what others may say—

- We are not found “sleeping under a palm tree or dancing the night away.” In the last 7 years, the number of Hispanic/Latino elected officials has increased by 30 percent. They are represented in States nationwide—on school boards, in city councils, in State legislatures, and in Congress, where 13 members are Hispanic/Latino. And contrary to the perceived “machismo,” 22 percent of our elected officials are Latinos.
- We come from many countries, but America is our home. Patriotism is one of our strongest traits, along with a strong work ethic, loyalty to family, and religious faith—values that are identified as typically American. I remind you that Mexican Americans have the highest proportion of Congressional Medal of Honor winners of any identifiable ethnic group.
- We are much more than Chiquita Banana and Juan Valdez, I assure you. If anyone has any doubt, just tell them to take a good look around at the faces, the credentials, and the achievements of the men and women in this room!

Colegas, let us now get to the heart of why we have worked so earnestly in these past 3 days:

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to develop the blueprint of our national Hispanic/Latino health agenda for years to come. What have we concluded? Which of these concerns are our greatest priorities? What are our aims? How do we overcome some of these disparities? What implementation strategies will have repercussions for decades to come? Where do we start?

We came to this Workshop to discuss five key issues: access, data collection, representation, research, and health promotion and disease prevention.

Let me now highlight for you some of your key findings regarding these issues.

- With respect to access, we should aim to develop more comprehensive health insurance coverage that promotes an integrated system of care and service delivery—coverage that is affordable, accessible, open to choice, secure, with easy enrollment, nonbiased to preexisting conditions, with broad coverage eligibility, and most important, culturally responsive and culturally responsible. In addition, health care centers and primary care services must be linked to consumer and community needs.
- With regard to data, you attested to the fact that data for Hispanics/Latinos are either unavailable or inaccessible, but data are in critical demand. You expressed the need to include all subgroups of Hispanics/Latinos in all pertinent Hispanic/Latino data. These data should be high-quality, precise, timely, and culturally sensitive in their design, collection, and analysis. They must be analyzed and standardized for use in understanding Hispanic/Latino health concerns, and they must be coordinated appropriately among Federal and State agencies.

Regarding representation, you agreed that there were insufficient numbers of people, programs, and finances for the entry, retention, and graduation of Hispanic/Latino

health professionals. You also expressed the need to increase the participation of Hispanic/Latino professionals in the admissions process, train such personnel in cultural diversity, and employ consistent definitions of Hispanics/Latinos for admission criteria to health professions. Moreover, we must increase, where appropriate (or include, where lacking), the number of Hispanic/Latino health professionals in faculties, at advanced level career positions, on decision-making bodies, in the licensing certification process, and in health professional school accreditations. Likewise, all PHS programs should be evaluated on the basis of recruitment, retention, and representation of Hispanics/Latinos in independent research grants. We must also increase the number of Hispanic/Latino Centers of Excellence to broaden their base, and we must evaluate them accordingly. We must provide greater support early in the process to our families, teachers, and students and offer more in the way of mentorships.

- In addressing research, you agreed that research relevant to the health of Hispanics/Latinos is extremely scarce. We must develop the appropriate infrastructure and capacity to conduct such research, as well as culturally appropriate research theories and methodologies. We need greater numbers of Hispanics/Latinos in all fields of research, and we must recruit, train, and retain Hispanic/Latino scientists throughout PHS.
- With regard to prevention, you agreed that we lack a systematic response to the full range of preventive services for Hispanics/Latinos and that we must have more Hispanic/Latino professionals in decision-making and leadership positions in the prevention field. We also lack data on knowledge, attitudes,

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practices, and utilization of screening services by Hispanic/Latino subgroups. In addition, the *Healthy People 2000* objectives have neglected to address multiple health issues that are relevant to Hispanics/Latinos. You agreed that our efforts in health promotion and disease prevention must be culturally relevant. Also, we need to awaken the media to increased awareness and sensitivity to Hispanic/Latino health and prevention issues.

Although these are only highlights of what you have produced, TODOS, together, our many voices are already speaking in one choir to amplify our single most important goal: that people from every cultural and ethnic group shall be empowered to contribute, not only to themselves but to the common good of all Americans. More important, our mutual efforts speak to the fact that government *alone* cannot be responsible for our future. We must chart our own destiny. And today, proceeding as one body, we have taken the first steps to secure a place for the next generation.

In 3 days, we have communicated, reached out, spoken out, and learned to pool our collective wisdom and skills in a proactive, unified effort. As a group, we have contributed to making this country even stronger, and we have enriched the lives of those who may not even know of our existence.

When we leave here later today and disperse across this country, let us remember this day, not as the end of a Workshop but as the beginning of a new solidarity, a new tradition of caring for all, a new opportunity to involve leaders at all levels of government, a renewed sense of empowerment to let us claim our most basic needs, and an overriding goal for all Hispanics/Latinos: to convey to America who and what we are.

My friends, the time to act truly is now. A generation is watching and waiting. We must act while we have the support of those at the top, the support of our colleagues in all professions and disciplines, and the support of our communities, our families, and our friends. And come what may, *mis queridos colegas*, you will always have the support of your Surgeon General.

As we work together in the coming months and years, let knowledge, imagination, dignity, and fairness chart our path for the future. But let us also remember that, without our health and without our education, we will have very little to offer to this country in the years to come.

Lideres del futuro: Let us move forward, toward a future brimming with health. In the end, I can tell you, we shall also overcome. May God bless you all.

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Chapter 7: Regional Health Meetings

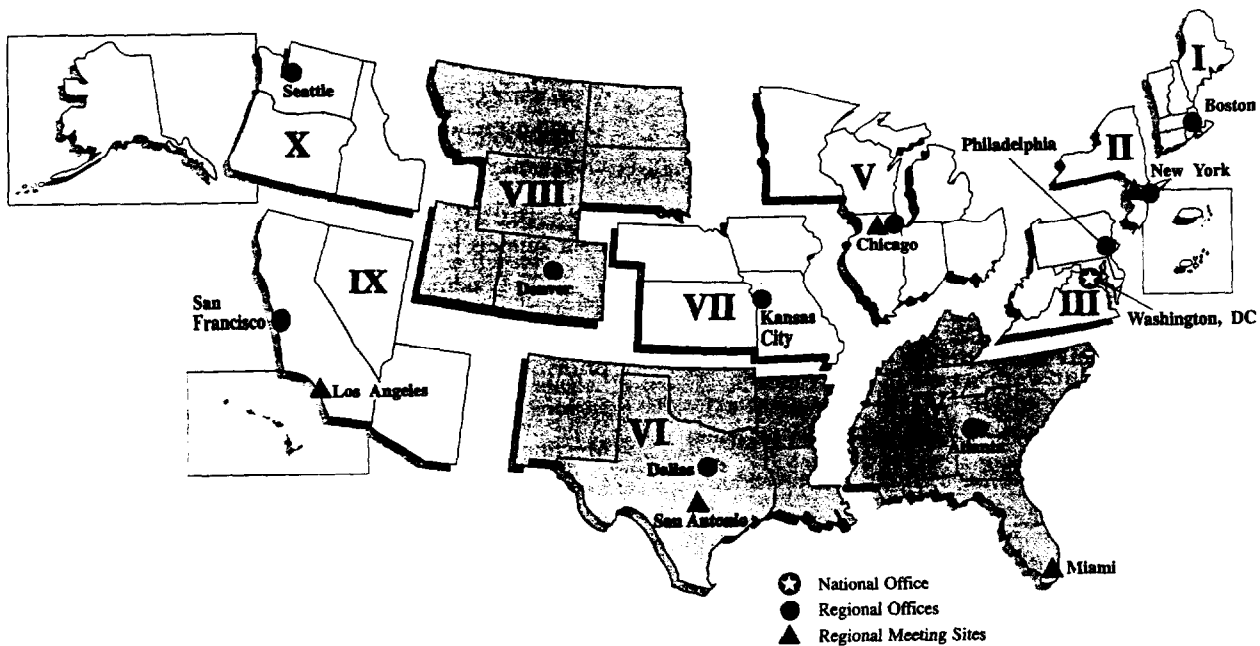
Introduction

The Regional Health Meetings, conducted as the second phase of the Surgeon General's National Hispanic/Latino Health Initiative, were planned with the recognition that, if the Initiative is to achieve its goals, action must be taken at the regional, State, and local levels as well as at the national level. Thus, the Surgeon General selected five geographically dispersed sites in cities that have high concentrations of Hispanic/Latino populations—Miami, Chicago, San Antonio, New York/Newark, and Los Angeles—to hold the meetings. These sites were chosen to focus on the specific needs of Hispanics/Latinos in all 10 Public Health Service (PHS) regions of the country (see map), to reach the largest possible number of Hispanics/Latinos within various regions, and to target specific subpopulations within the Hispanic/

Latino community—those of Cuban and South American descent in Miami; multiple groups, including migrants, in Chicago; Mexican-Americans and those from Central America in San Antonio; Puerto Ricans in New York/Newark; and Mexican-Americans and migrant groups in Los Angeles. The five meetings were held on the following dates:

- Miami: March 3–4, 1993
- Chicago: March 11–12, 1993
- San Antonio: March 22–23, 1993
- New York/Newark: April 14–16, 1993
- Los Angeles: April 19–20, 1993

In keeping with the goal of creating and strengthening State and local partnerships for addressing the health needs of Hispanics/Latinos, Dr. Novello sought the assistance of the PHS Regional Health Offices and numerous other groups in planning and conducting the meetings.



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Regional Health Meetings

First, from the national Executive Planning Committee, she selected regional Co-Chairpersons for each meeting:

Ramon Rodriguez-Torres, M.D., F.A.A.P., F.A.C.C.

Chief of Staff
Miami Children's Hospital

Sara Torres, R.N., Ph.D.

President
National Association of Hispanic Nurses

Aida L. Giachello, Ph.D.

Assistant Professor
University of Illinois-Chicago

Steven Uranga McKane, D.M.D., M.P.H.

Program Director
W.K. Kellogg Foundation

Ciro V. Sumaya, M.D.

Associate Dean, Affiliated Programs and Continuing Education
Director, South Texas Health Research Center

Paula S. Gomez

Executive Director
Brownsville (Texas) Community Health Center

Marilyn Aguirre-Molina, Ed.D.

Assistant Professor
Robert Wood Johnson Medical School

Carlos Perez, M.P.A.

Area Administrator
Office of Health Systems Management
New York State Department of Health

Castulo de la Rocha, J. D.

President and CEO
AltaMed Health Services, Inc.

Helen Rodriguez-Trias

President
American Public Health Association

To support the regional Chairpersons,

Dr. Novello organized regional Executive Planning Committees of approximately 25 members each, with representation from the national sponsors and co-sponsors and from leaders of local Hispanic/Latino communities. The Executive Planning Committee members recommended participants, attended regional planning sessions, and provided ongoing advice to the Chairpersons, their Vice Chairs, and the Department of Health and Human Services (DHHS) Regional Project Officer about

the planning and development of the meetings. The regional Executive Planning Committee members are listed in Appendix C.

In addition, more than 100 diverse public- and private-sector organizations co-sponsored or provided support at the local level to the five Regional Health Meetings. These organizations represent departments of health, academia, the media, the insurance industry, research institutions, community services providers, and other business and industry groups. These organizations are listed in Appendix D.

More than 975 participants—including health care decisionmakers in Federal, State, and local governments; religious leaders; experts in data collection systems; leaders in the fields of education and service; and advocacy groups—attended the five meetings. As in the National Workshop, participants were divided into Work Groups to address the five areas crucial to Hispanic/Latino health: improved access to health care, improved data collection, development of a relevant and comprehensive research agenda, increased representation in the health professions, and health promotion and disease prevention efforts. The Work Groups were charged with (1) identifying priority problems/issues for each area of concern and (2) developing aims and accompanying implementation strategies to address each problem/issue. At each meeting, a spokesperson for each Work Group presented the Work Group's findings in a closing plenary session. Key government officials and experts in Hispanic/Latino health expressed their support by speaking in plenary sessions.

The findings of the Work Groups in the Regional Health Meetings reveal a similarity of priorities and implementation strategies across regions. The participants of all Regional Health Meetings unanimously concluded that, despite many innovative activities currently under way within each region, much remains to be accomplished within the five key areas of concern in promoting Hispanic/Latino health care.

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Although Work Group priorities and suggested implementation strategies were categorized by the five key areas, many cross-cutting issues were identified, including the need for funding; Hispanic/Latino subgroup data, definitions, and culturally sensitive identifiers; an infrastructure for research on Hispanic/Latino health needs; training; and information dissemination. These cross-cutting issues reflect the interrelationships among the five areas. Like the members of the national Executive Planning Committee, the participants agreed that no one area can be addressed in isolation; progress in one area cannot be achieved without progress in the other areas.

The identification of number one priorities in each area and the development of related implementation strategies resulted in consensus in most areas. Listed below are the number one priorities identified at the Regional Health Meetings.

- **Access**—Hispanics/Latinos across America must have greater access to health care coverage and services. Participants of all the meetings identified the need for a universal system of health care services and delivery as the first priority strategy for improving access to health care.
- **Data**—Data on Hispanics/Latinos are now either unavailable or inaccessible, but data are in critical demand. All five cities called for Hispanic/Latino subgroup identifiers as a first priority strategy for improving data collection.
- **Research**—Because research relevant to the health of Hispanics/Latinos is extremely scarce, Hispanic/Latinos must be the subjects of and the participants in more research. There was no unanimity across cities for a number one priority. Participants in three of the five cities identified the need for an infrastructure for Hispanic/Latino research and Hispanic/Latino leadership as the first priority to advance the research agenda. Other cities called for a Hispanic/Latino

infrastructure and power base; development of appropriate Hispanic/Latino methodology, theories, and models; and legislatively earmarked funds as key strategies for intensifying Hispanic/Latino research efforts.

- **Representation**—Hispanics/Latinos need greater representation in the health professions. There are insufficient finances and numbers of people and programs for the entry, retention, and graduation of Hispanic/Latino health professionals. There was no unanimity across cities for a number one priority. Participants suggested a variety of activities, including educational financing and preparation; Hispanic/Latino empowerment; reduction of credentialing obstacles for foreign-educated professionals; and Hispanic/Latino representation in certification and accreditation policies as key strategies for improving representation.
- **Health Promotion and Disease Prevention**—Hispanics/Latinos must become involved in health promotion and disease prevention efforts. There is a lack of a systematic response to the full range of preventive services for Hispanics/Latinos. There was no unanimity across cities for a number one priority. Participants recommended a variety of activities, including Hispanic/Latino data collection and research; establishment of more community programs and capacity-building among existing programs; establishment of advocacy networks; establishment of public-private partnerships; and assessment of available resources as key strategies for health promotion and disease prevention.

The remainder of this chapter provides summaries of each of the five Regional Health Meetings.

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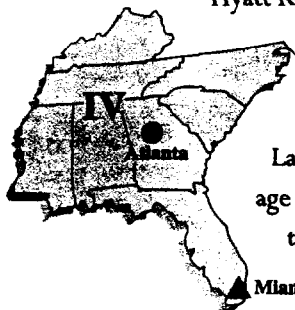
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The Miami Hispanic/Latino Regional Health Meeting

Region IV



The first Regional Health Meeting was held at the Hyatt Regency Miami Hotel in Miami, Florida, on March 3 and 4, 1993. Approximately 225 participants attended.

More than 2 million Hispanics/Latinos live in Region IV, the largest percentage of whom are concentrated in Florida. Of these 2 million people, more than 350,000 live below the poverty level. Many Hispanics/Latinos in Florida are

typically unemployed, poor, and uninsured. In addition, Hispanic/Latino migrant farmworkers in the region are at risk for high infant mortality rates.

Five Work Groups identified priority Hispanic/Latino health issues and developed implementation strategies for each issue. Following is a discussion of top priority issues and strategies by Work Group.

Access to Health Care

Priority Issue: Lack of an organized system of health care access and delivery for all Hispanic/Latinos at the local, State, and Federal levels.

Implementation Strategies:

- ◆ Implement a cost-effective universal health care plan that includes undocumented persons.

- ◆ Implement a program producing public-private partnerships to improve coordination and linkages of health care services.
- ◆ Finance community-based health and social services.

Data Collection

Priority Issue: No uniform Hispanic/Latino identifier to capture ethnic heritage.

Implementation Strategies:

- ◆ Involve community leaders to develop an inclusive, global Hispanic/Latino definition for the U.S. Census Bureau and other agencies; share this definition to ensure standardized criteria, data accessibility, and utilization.
- ◆ Establish linkages with government leaders to ensure Hispanic/Latino participation in criteria development and data collection.
- ◆ Provide data collection form instructions that ensure accuracy in the data collection process and cultural sensitivity.

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Surgeon General
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Matthew Murguia

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Office of Minority Health

Ramon Rodriguez-Torres, M.D.

Co-Chairperson and Chief of Staff,
Miami Children's Hospital

Sara Torres, R.N., Ph.D.

Co-Chairperson and President,
National Association of Hispanic Nurses

Beaumont Hagebak

Vice Chairperson and Regional Health Administrator for Region IV
U.S. Public Health Service

Yvonne Johns

Minority Health Coordinator for Region IV

Robert Ribera
Planning Liaison

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Research Agenda

Priority Issue: Lack of infrastructure relating to educational institutions to promote relevant research initiatives on Hispanic/Latino health issues.

Implementation Strategies:

- ◆ Conduct research using priority funding to support Hispanic/Latino candidates from elementary through post-graduate levels, thereby ensuring a pool of potential Hispanic/Latino health researchers and scientists.
- ◆ Establish a national clearinghouse network to collect and disseminate Hispanic/Latino health research and funding opportunities.
- ◆ Create a multidisciplinary, national/regional task force to institutionalize the process of establishing Hispanic/Latino research priorities.
- ◆ Establish a Hispanic/Latino professional health journal.

Health Professions

Priority Issue: Lack of financing for education in health and science professions.

Implementation Strategies:

- ◆ Finance Hispanic/Latino employee retraining through private sector flexibility.
- ◆ Endow a chair for Hispanic/Latino faculty members at colleges and universities.

◆ Establish service repayment programs, loans, and scholarships at the Federal, State, and local level specifically targeted for Hispanics/Latinos.

◆ Establish an adopt-a-student program sponsored by individual professionals.

◆ Develop Hispanic/Latino role models in corporate-sponsored health and science professions.

◆ Examine the Hispanic/Latino-modified Minority Access to Research Careers (MARC) model for health careers.

◆ Reduce Hispanic/Latino qualifying criteria for workstudy programs.

◆ Financially support student expenses other than tuition, including childcare, stipends, etc.

◆ Involve Hispanic/Latino leaders at State and local levels.

Health Promotion and Disease Prevention

Priority Issue: Lack of health issues education and awareness programs within the Hispanic community.

Implementation Strategy:

◆ Request Federal and State funding for school health education and prevention programs, health care professionals' education for children, media programs, and Hispanic/Latino role model programs.

Region IV

- Alabama
- Georgia
- Florida
- Kentucky
- Mississippi
- North Carolina
- South Carolina
- Tennessee

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- ◆ Establish more uniform Federal forms and uniform Medicaid eligibility criteria across State borders.

Data Collection

Priority Issue : Exclusion of Hispanics/Latinos in data collection systems.

Implementation Strategies:

- ◆ Implement standardized data collection systems at local and regional levels.
- ◆ Establish a data bank for the Midwest region.

Research Agenda

Priority Issue : Lack of cultural appropriateness of research methodology.

Implementation Strategies:

- ◆ Validate research instruments and sampling methods for the Midwest and for different subpopulations.
- ◆ Take into consideration economic status of Hispanics/Latinos in sampling.

Health Professions

Priority Issue: Insufficient number and inadequate preparation of Hispanic/Latino students in the educational system to pursue an education in health and sciences.

Implementation Strategies:

- ◆ Encourage parental involvement by creating models that are appropriate for individual locations.
- ◆ Control environmental factors that adversely affect education such as violence, lack of safety, gangs, and substance abuse.

- ◆ Identify high-risk students who are in danger of dropping out of school at an early age.

- ◆ Establish appropriate intervention to keep students in school and to encourage them to graduate.

- ◆ Educate parents about and involve them in the required academic preparation.

- ◆ Create partnerships between school, faculty, health professionals, and health professions students to provide role modeling, mentoring, teaching, and health career exploration.

Health Promotion and Disease Prevention

Priority Issue: Inconsistent definition of Hispanic/Latino ethnic groups and subgroups.

Implementation Strategy:

Establish a health data collection system characterized by a uniform and consistent racial and ethnic identifier. In particular:

- ◆ Develop Hispanic/Latino community actions to request the establishment of procedures at the local, State, and Federal levels.

- ◆ Advocate Federal legislation that mandates the implementation of health promotion and disease prevention (HPDP) in a standardized form.

- ◆ Establish advocacy groups that will make community leaders and policymakers accountable for implementing HPDP data collection.

- ◆ Train and educate providers as well as Hispanic/Latino consumers on appropriate identification procedures for data collection.

Regions V & VII

Illinois

Indiana

Iowa

Kansas

Michigan

Minnesota

Missouri

Nebraska

Ohio

Wisconsin

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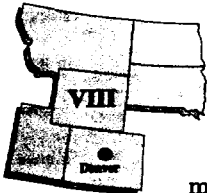
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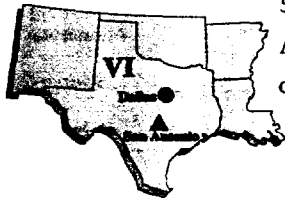
The San Antonio Hispanic/ Latino Regional Health Meeting

Regions VI & VIII

The third Regional Health Meeting was held at the Sheraton Fiesta Hotel in San Antonio, Texas, on March 22 and 23, 1993. Approximately 160 participants attended.



More than 5 million Hispanics/Latinos live in Region VI—4 million in Texas alone and one-half million in New Mexico. Indeed, minorities constitute 54 percent of the population in Region VI.



Access to health care for the underserved is an ongoing problem in this region, especially along the Texas-Mexico border. Outbreaks of tuberculosis and cholera and a high rate of anencephalic births are the most prominent health risks affecting Hispanics/Latinos of this area. In addition, San Antonio ranks second in low educational attainment of the 15 largest U.S. cities.

In Region VIII, there are more than one-half million Hispanics/Latinos—most of them living in Colorado. Approximately 43,000 migrant and seasonal agricultural workers and their families live in Colorado. These migrant farmworkers are among the most deprived in the Nation, facing pervasive poverty, unemployment, isolation, and alienation. Their transience and inability to speak English severely hamper their access to health care. Health risks faced in this region include diabetes, smoking, alcoholism, and a high infant mortality rate.

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Following is a discussion of top priority issues and strategies identified by the Work Groups.

Access to Health Care

Priority Issue: Lack of universal health coverage.

Implementation Strategies:

- ◆ Conduct needs assessment of health coverage on local level, where needed.
- ◆ Increase Hispanic/Latino participation in decision-making processes regarding health care service delivery.
- ◆ Standardize and streamline administrative forms to decrease expenditures of human and fiscal resources better allocated to service delivery.

Data Collection

Priority Issue: Need for Hispanic/Latino identifiers at the national, State, and local levels for ethnic subgroups, foreign-born, and migrant populations.

Implementation Strategies:

- ◆ Require all agencies authorized to collect health-related data to include identifiers of ethnic subgroups.
- ◆ Require all agencies working with survey data to draw adequate random sample sizes for statistical accuracy.

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Vice Chairperson and Acting
Regional Health Administrator
for Region VIII
U.S. Public Health Service

Sue Hammett, R.N., M.S., C.N.S.
HIV/AIDS Coordinator for
Region IV

Jane Wilson, M.S.
Minority Health Coordinator for
Region VIII

- ◆ Earmark adequate funding for agencies to incorporate identifiers of Hispanic/Latino groups into data gathering procedures.

Research Agenda

Priority Issue: Lack of a Hispanic/Latino research infrastructure.

Implementation Strategies:

- ◆ Develop specific PHS support programs for Hispanic/Latino predoctoral and postdoctoral training in behavioral and biomedical research to eliminate underrepresentation.
- ◆ Develop programs directed to Hispanic/Latino researchers to allow them to become better equipped and to improve methodological expertise in health-related research.
- ◆ Develop and fund PHS distinguished research career programs to allow Hispanic/Latino researchers to concentrate on research, writing, and mentoring and to free them from the multiple requirements and expectations commonly faced by minority academicians.
- ◆ Assess the results of existing minority-focused programs with respect to Hispanic/Latino students.
- ◆ Encourage professional associations to stimulate Hispanic/Latino student involvement in research careers.

Health Professions

Priority Issue: Lack of empowerment and political influence in developing biomedical/health education and delivery system.

Implementation Strategies:

- ◆ Increase Hispanic/Latino legislative and academic representation and political system involvement through Hispanic/Latino voter registration and political candidate evaluations and recommendations.
- ◆ Increase academic involvement at the national level through inclusion of Hispanics/Latinos in

national review boards of grant funding agencies and in professional journal editorial boards.

- ◆ Increase involvement at the academic university level by expanding the Hispanic/Latino presence and involving Hispanic/Latino faculty in decision-making processes.
- ◆ Educate appointed and elected officials by educating the Congressional Hispanic Caucus and the Boards of Regents members and by developing a national lobby to promote the Hispanic/Latino education agenda.
- ◆ Educate the public/community sector on issues involving Hispanic/Latino education by utilizing mass media resources to market storytelling to them, mobilizing community outreach, and promoting inclusion by and use of institutional news and information facilities.

Health Promotion and Disease Prevention

Priority Issue: Lack of culturally sensitive and population-specific comprehensive and systematic approaches to clinical, community, and preventive health programs, and lack of appropriate screening and diagnostic procedures for Hispanics/Latinos.

Implementation Strategies:

- ◆ Obtain interim strategy consensus from entire Regional Health Meeting attendees.
- ◆ Request a Federal mandate for community representation in regional health plans.
- ◆ Recommend immediate interim preventive ambulatory care benefits package.
- ◆ Fund the creation of a national Hispanic/Latino multidisciplinary commission to monitor policy, create a sounding board, create a resource pool, create a clearinghouse to disseminate information, and conduct outreach using community resources.

Regions VI & VIII

- Arkansas
- Colorado
- Louisiana
- Montana
- New Mexico
- North Dakota
- Oklahoma
- South Dakota
- Texas
- Utah
- Wyoming

One

Voice

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Vision



- ◆ Tie Federal funding to data collection and reporting, including undocumented Hispanics/Latinos.
- ◆ Encourage State Hispanic/Latino data collection legislation.
- ◆ Share data collection, analysis, and dissemination expenses between data users, including government.
- ◆ Define data collection purposes and establish timelines.
- ◆ Include Hispanic/Latino data collection in strategic plans such as *Healthy People 2000*, Minority Health Activities, and Primary Care Access Plans.
- ◆ Expand the third National Health and Nutrition Examination Survey sample to include findings from the 1994 survey in New York.
- ◆ Enforce OMB Directive 15 and Public Law 94-311 among Federal agencies.
- ◆ Establish northeast regional Hispanic/Latino health coalitions to monitor implementation of the Surgeon General's National Hispanic/Latino Health Initiative strategies.

Research Agenda

Priority Issue: Lack of a Hispanic/Latino research infrastructure and lack of appropriate data collection instruments, research findings dissemination, and Hispanic/Latino-focused conceptual models and methodology.

Implementation Strategies:

- ◆ Provide Federal funding for practice-based research networks and research capability at community/migrant centers, mental health facilities, and related facilities to generate community- and patient-based health data.
- ◆ Expand programs and demonstration research relevant to the Hispanic/Latino community in the Northeast.

- ◆ Change Federal requirements to ensure more inclusive definitions representative of the diverse Hispanic/Latino communities in the Northeast.

Health Professions

Priority Issue: Insufficient numbers and inadequate preparation of Hispanic/Latino students by the educational system, kindergarten through undergraduate, for pursuit of health professions education.

Implementation Strategies:

- ◆ Increase parental involvement through family counseling, information dissemination, and enhancement of current programming.
- ◆ Assist low-income families in their children's educational planning.
- ◆ Ensure English language competency at early ages.
- ◆ Stimulate private-sector investment in educational institutions with high Hispanic/Latino populations, and promote investment in scholarships and awards.
- ◆ Encourage Hispanic/Latino health professional organizations to develop and provide mentor programs.
- ◆ Increase student awareness of health career opportunities.

Health Promotion and Disease Prevention

Priority Issue: Increase and improve data collection and research on Hispanic/Latino health care issues.

Implementation Strategy:

- ◆ Develop effective and individualized marketing strategies to promote health and prevent disease in the Hispanic/Latino community.
- ◆ Increase the use of mass media and hotlines to gather desired information on knowledge, attitudes, and behaviors in the Hispanic/Latino community.
- ◆ Increase funding levels for data collection.

Regions I, II, & III

Connecticut
 Delaware
 Maine
 Maryland
 Massachusetts
 New Hampshire
 New Jersey
 New York
 Pennsylvania
 Puerto Rico
 Rhode Island
 Vermont
 Virginia
 Virgin Islands
 Washington, DC
 West Virginia

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Access to Health Care

Priority Issue: Lack of universal, affordable health insurance coverage and comprehensive benefits for everyone.

Implementation Strategies:

- ◆ Ensure that special populations are covered under Medicaid.
- ◆ Create new infrastructures at various levels in educational and governmental institutions that are directed toward and sensitive to Hispanic/Latino issues.
- ◆ Create a “seamless” health delivery system in which all providers of primary care dealing with special populations are included and supported.
- ◆ Encourage the incorporation of alternative health care delivery systems that can effectively deal with the needs of special populations.
- ◆ Recommend that service providers have consumer representatives on their policymaking boards.
- ◆ Ensure that traditional providers are placed on an equal footing with other providers so they may compete fairly in any new health care contracting system.
- ◆ Give health purchasing governing boards the flexibility to develop systems of care that reflect local needs and priorities.
- ◆ Ensure that quality of services is measured in terms of bicultural, bilingual competency of provider staff.
- ◆ Use different health settings as effective places of health care and services.

Data Collection

Priority Issue: Lack of a universal ethnic identifier.

Implementation Strategies:

- ◆ Develop community-based epidemiological data that can complement and be compared with hospital data.
- ◆ Improve collection of and access to current data, and provide guidelines to users.
- ◆ Develop a centralized regional body that can collect, analyze, and disseminate Hispanic/Latino data.
- ◆ Include research data for health promotion and disease prevention within the managed care system.
- ◆ Provide feedback to the Hispanic/Latino communities being analyzed.

Research Agenda

Priority Issue: Poor communication among researchers and poor dissemination of findings.

Implementation Strategies:

- ◆ Develop the capacity for Hispanic/Latino research.
- ◆ Centralize and expand existing data banks.
- ◆ Develop a liaison with the Hispanic/Latino caucus to link research issues with immigration issues.
- ◆ Encourage bi-national collaboration.
- ◆ Promote collaboration among community-based organizations, community clinics, and university researchers in the design and execution of research projects.
- ◆ Identify current data collection efforts and demand that Hispanic/Latino ethnic identifiers be incorporated.

Regions IX and X

Alaska
 American Samoa
 Arizona
 California
 Guam
 Hawaii
 Idaho
 Nevada
 Oregon
 Trust Territory of the Pacific Islands
 Washington

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Voice

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Vision



Regions IX and X

- Alaska
- American Samoa
- Arizona
- California
- Guam
- Hawaii
- Idaho
- Nevada
- Oregon
- Trust Territory of the Pacific Islands
- Washington

Health Professions

Priority Issue: Lack of school counselors, funding, programs, grants, and training to ensure increased representation.

Implementation Strategies:

- ◆ Increase the number of school counselors to help decrease the dropout rate and ensure thorough dissemination of financial aid to all Hispanic/Latino students through identified counselors at each institution.
- ◆ Hire elementary and secondary teachers who better reflect the diverse ethnic population.
- ◆ Establish summer work program internships and expand scholarship and loan programs.
- ◆ Provide awareness training on cultural diversity issues to students, faculty, and staff at educational facilities.
- ◆ Obtain data on trends and profiles of health professionals to assist in health personnel planning.
- ◆ Enhance the entry of foreign-trained Hispanic/Latino health professionals into the health delivery system.
- ◆ Ensure the availability of residencies and call for national licensing standards with unrestricted reciprocity.

Health Promotion and Disease Prevention

Priority Issue: Need to build on the nontraditional methods of access to care and need to emphasize the importance of awareness, education, early identification, and intervention through health promotion and disease prevention programs.

Implementation Strategies:

- ◆ Provide home-based health education through television and radio.
- ◆ Restrict negative promotional advertising.
- ◆ Create a Hispanic/Latino HPDP information network and clearinghouse via a public-private partnership.
- ◆ Increase the awareness of HPDP issues and concepts among policymakers, community leaders, and politicians.
- ◆ Enhance community capabilities in developing targeted HPDP programs.
- ◆ Incorporate community workers into HPDP models; recruit allied health professionals and provide incentives to them.
- ◆ Use recent immigrants with skills in health promotion in the workforce.

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Chapter 8: Priority Recommendations

On April 22 and 23, 1993, the Executive Planning Committee of the Surgeon General's National Hispanic/Latino Health Initiative met at the Madison Hotel in Washington, D.C., to review the findings from the Surgeon General's National Workshop on Hispanic/Latino Health and the five Regional Health Meetings. During the past year, the Committee had met three times to help guide the activities of the Initiative and, thus, to help create a unified Hispanic/Latino voice, *TODOS*, to alert the Nation's leaders to the barriers that Hispanics/Latinos face in receiving adequate health care. Members of the Executive Planning Committee also served as Work Group chairpersons at the National Workshop and as chairpersons to plan and coordinate the Regional Health Meetings. At each of the previous meetings, the Executive Planning Committee members worked with hundreds of other Hispanic/Latino leaders to identify, analyze, and prioritize the issues and concerns with the greatest implications for the health and welfare of Hispanics/Latinos throughout the country.

At this meeting, the Committee members were charged with their final task—to determine which of the recommended implementation strategies will have the greatest impact for improving Hispanic/Latino health and to develop a summary report of the critical recommendations in each of the key areas:

- Access to health care.
- Data collection strategies.
- Development of a relevant and comprehensive research agenda.
- Representation in the health professions.

- Health promotion and disease prevention.

The Surgeon General, Dr. Antonia Novello, challenged them to put their “collective reality” into words that can be “bureaucratically understood.” She directed the Committee members to examine the needs expressed in the recommended strategies, looking for similarities across the board, and to determine the strategies that are most feasible and can best meet those broad-based needs. To guide their deliberations, the Committee members were asked to consider opportunities for action in developing the report and to determine the strategies that represent the best opportunities for action in the following areas: representation of Hispanics/Latinos and communication of their health needs, development of policy to improve access to health care, provision of resources to improve Hispanic/Latino health status, public-private partnerships to improve health care delivery, advocacy for Hispanic/Latino health needs, and legislation that mandates improved access and delivery.

During their deliberations, Committee members from different regions related the special health concerns that participants expressed at the Regional Health Meetings. For example, a special workshop on the health needs of migrant workers was provided at the Chicago meeting. In San Antonio, participants expressed concern about the health implications of environmental conditions along the U.S.-Mexican border. However, despite these unique concerns, the issues raised contained several recurring themes, for example—

- Universal access to health care for all persons residing in the United States is imperative if this Nation is to thrive. Without universal access,

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many people delay getting proper care until conditions become serious and costly to treat.

- Adequate infrastructure for providing health care must be developed in underserved areas to ensure universal access.
- Resources and mechanisms must be developed for enlarging the pool of Hispanic/Latino health professionals to provide culturally competent care, particularly in underserved areas. Repeatedly, Committee members echoed the urging of their colleagues in the regions that funding for Hispanic Centers of Excellence and the number of such centers be increased.

Working in small groups to address each area of concern (access, data collection, research, representation in the health professions, and health promotion and disease prevention efforts), the Committee members selected specific strategies that address these common themes and, when combined together, create a feasible and achievable plan of action. The final step in the preparation of the recommendations was to choose approximately five strategies in each area that the Committee members consider to be of highest priority for implementation.

In the development of the report, several issues emerged that cut across the areas of concern that the Initiative addresses. Because a number of the recommended strategies have implications for all the areas of concern, the group categorized them separately as “cross-cutting issues.” These cross-cutting issues indicate that no one area of concern can be addressed in isolation; rather, progress in one area is dependent upon progress in the other areas. For example, health promotion and disease prevention cannot be adequately addressed in the Hispanic/Latino population without culturally sensitive research and data collection. Similarly, access to appropriate health care services cannot be achieved without Hispanic/Latino representation in the science and health professions and in decision-making positions.

The remaining sections of this chapter contain the recommendations developed at the Executive Committee Meeting. Presented first are the cross-cutting issues. Next are the implementation strategies for each of the five critical areas of concern. These sections begin with a statement of the problems related to the area, then present the implementation strategies deemed of highest priority (listed as the summary of key strategies), and conclude with specific implementation strategies grouped by areas of opportunities for action.

This report is intended to guide the Hispanic/Latino national health agenda for years to come. Progress will not occur overnight. However, Hispanic/Latino leaders will continue to work together to tailor these strategies to solve key problems within their communities and to ensure that this plan of action for Hispanics/Latinos becomes a vital part of a national universal system of health coverage for all Americans.

Cross-Cutting Issues

- ◆ Establish an advisory body to monitor the implementation of the National Hispanic/Latino Health Initiative and to ensure accountability within all offices of DHHS.
- ◆ Ensure that all racial/ethnic minority populations be given equal access to all relevant resources of the Office of Minority Health of the Office of the Assistant Secretary for Health.
- ◆ Establish offices of minority health in all public health agencies, and, for those already established, provide adequate resources and staffing to ensure access to health care for all Americans.
- ◆ Develop national, uniform standards for quality of care.
- ◆ Provide appropriate resources to strengthen public health assessment, policy development, and surveillance activities pertaining to Hispanic/Latino health issues.

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- ◆ Ensure that organizations serving Hispanics/Latinos are culturally competent and represent their needs.
- ◆ Increase resources to maintain adequate data on Hispanic/Latino health issues.
- ◆ Disseminate Hispanic/Latino research, data, and health information via centralized clearinghouses to researchers, health care providers, and others who require such data.
- ◆ Appoint Hispanics/Latinos to review panels, study sections, PHS advisory councils, and working groups at the Federal, State and local levels.
- ◆ Ensure that at least 50 percent of the boards of organizations serving Hispanics/Latinos are Hispanics/Latinos, with Hispanics/Latinos in key administrative and program staff positions.
- ◆ Develop regulations that require private and nonprofit institutions (including universities) that serve Hispanics/Latinos to include adequate Hispanic/Latino representation at decision-making levels.
- ◆ Secure scholarships for training Hispanic/Latino leaders in all health professions (clinical and nonclinical).
- ◆ Enforce existing Federal and State mandates to ensure opportunities for Hispanics/Latinos in higher education (faculty and boards), decision-making positions, and the workplace.
- ◆ Base health promotion and disease prevention efforts on the needs of the community being served.
- ◆ Promote the participation of health care providers and the community in health promotion and disease prevention outreach activities.
- ◆ Coordinate the administration of intervention to ensure effective and efficient management.

Access to Health Care

Preamble

The Hispanic/Latino population is composed of individuals and families of multiple national origins, some of which date back to the 1600's. The vast majority of Hispanics/Latinos live in large urban centers; however, included in this population are rural residents and migrant and seasonal workers, as well as those who are undocumented. Despite having the highest rate of labor force participation of all U.S. population groups, Hispanics/Latinos are the poorest minority group living in the United States today, and more than one-third of the population is uninsured. Not only do they lack accessible, affordable, available, affable, and portable health care, but they also are severely underrepresented in ownership of health-related enterprises.

Because of the great diversity of Hispanic/Latino populations, to address the needs of this group, national health reform must allow States to meet the national goals and standards of universal coverage and quality health care in creative and different ways. The Federal Government should facilitate any processes that allow States to select and craft their own administrative and insurance entities.

Problems

1. Lack of comprehensive and portable health care coverage for Hispanics/Latinos.
2. Underrepresentation of Hispanics/Latinos in leadership positions during critical phases of local, State, and national budgetary and programmatic planning activities.
3. Lack of adequate and available health care service delivery systems and infrastructure to address primary, secondary, and tertiary health care needs of the diverse Hispanic/Latino population groups.

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4. Lack of accessible and adequate health care facilities because of financial and nonfinancial barriers in Hispanic/Latino communities.

Summary of Key Strategies

1. Provide for Hispanic/Latino participation in the development and implementation of a national health care system that ensures universal access to all persons living in the United States, the Commonwealth of Puerto Rico, and U.S. territories.
2. Increase Hispanic/Latino representation at all levels of the public health and health policy leadership pool and workforce.
3. Ensure Hispanic/Latino participation in the planning, design, staffing, evaluation, and ownership of public health and health care infrastructure to ensure that it serves community needs.
4. Eliminate all financial, cultural, language, age, belief, or gender barriers to health care.

Specific Strategies

Key audiences: Local, State, and Federal administrators and officials; Hispanic/Latino communities; and the media.

A. Provide Universal Health Care for All Americans

- ◆ Develop a universal health care system that—
 - Is affordable, accessible, available, acceptable, affable, and portable.
 - Offers a basic package of services that includes health promotion and disease prevention.
 - Gives a choice of providers.
 - Allows for a regular source of such care and facilitates continuity of care.
 - Integrates systems of care: combines public health, community health, and private providers.

- Strives for innovative health care financing that spreads the burden across all sectors of society.
- Ensures coverage eligibility regardless of U.S. residency and employment status (does not exclude undocumented persons).
- Offers easy enrollment and service procedures that facilitate participation.
- Provides measures of cost containment, quality assurance, improved efficiency, and accountability to service recipients.
- Allows service recipients and all providers, including “safety net providers,” to participate in the governance of plans.
- Offers rewards for providing services to underserved and unserved populations.
- Provides incentives for coverage of preventive services.
- Enforces uniform procedures for reimbursement while recognizing differences by region and geography.
- Provides outreach activities to increase awareness and use of available programs.
- Is culturally competent and linguistically appropriate.
- Addresses other needs specific to the Hispanic/Latino population (e.g., respite care, long-term care, transportation, child care, and other support services).
- Does not exclude persons with preexisting illness and conditions.
- Establishes health advocacy coalitions of public and private providers and consumers in Puerto Rico and in each State with significant Hispanic/Latino populations to review programs and develop recommendations annually.
- Establishes a methodology for accurately estimating the cost of universal coverage.

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Representation and Communication

- ◆ Develop a mass media marketing plan that informs the public about how to gain access to and properly utilize health and related services. This plan should target Spanish-speaking and bilingual Hispanics, especially in areas where little or no information is available. (State and local)
- ◆ Include Hispanic/Latino representation in the development of outreach and public information campaigns, including television, radio, and the print media.

Policy

- ◆ Allow for cultural and regional differences in clinical and administrative measurements. What may be appropriate for one ethnic community or region may not be appropriate for others.
- ◆ Make client surveys, chart pulls, and nonmedical content of care components of quality measurement.
- ◆ Measure quality of care in terms of the bicultural and bilingual competency of staff. Capacity to serve in a culturally competent manner must be demonstrated. This competency should be addressed as part of any contracting process.
- ◆ Emphasize preventive and primary services in quality measurement. Standardization of tracking and data systems is needed and should be oriented toward periodic and preventive care that is age-appropriate.
- ◆ Include a cultural index of accessibility to care as part of quality measurements and requirements. Financial resources must be made available to those entities that need infrastructure development to meet this requirement.
- ◆ Strengthen the public health capacity for surveillance, assurance, and policy and planning.
- ◆ Develop plan coverage information in the language of the population and adapt it culturally as necessary. Member services should also have

language-proficient representatives to serve individuals. Representatives should be required to provide outreach to job sites, social service centers, and other locations where these populations congregate.

- ◆ Require health care plans to provide physicians and other providers who have a minimum of 24 hours of training in cultural competency.
- ◆ Require States to develop certification components for interpreters to serve underserved populations.
- ◆ Provide a health benefit package that includes the following:
 - Primary care and preventive services, including mental health services, immunizations, periodic screening, health education, a full range of reproductive health services, comprehensive perinatal care, and outpatient medical care. (Local)
 - In-patient hospital care and alternatives to hospitalization, including skilled home health services. (State and local)
 - Emergency services, including emergency transportation. (Local)
 - Social services.
 - Dental services. (Local)
 - In-patient and out-patient drug and alcohol abuse prevention, treatment, and rehabilitation. (State and local)
 - In-patient and out-patient rehabilitation services (physical, occupational, and vocational therapy).
 - In-patient and out-patient mental health services.
 - Case management, including psychosocial support services.
 - Nutrition counseling.
 - Prescription drugs.

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- Vision and hearing services.
- Long-term care and alternatives to long-term care, including case management, in-home support services, hospice, and adult day health care.
- Transportation for health care visits.

Structure a financing package that distributes cost equitably according to ability to pay, stressing progressive financing schemes, cost-effective delivery systems, and infrastructure development for special populations:

- Shared payment responsibility between employers and employees.
- Government subsidies for small businesses.
- Information safeguards for undocumented workers in an employment-based system.
- Simultaneous reform of medical malpractice, the tort system, and workers' compensation.
- Incorporation of Medicaid, CHAMPUS, and private and public employer-based health care payment systems, as needed.
- Focus on progressive taxes with strong consideration of alcohol and tobacco taxes and with recognition that additional funds will be needed.
- Consideration of equalization of reimbursement regardless of the individual.
- Maintenance and equalization of efforts in terms of State government financial commitments.
- Recognition of special financing needs of special populations.
- Systemic incentives for cost-effective health care system approaches.

◆ Conduct needs assessment of health coverage at the local level, where needed.

◆ Increase the participation of representatives of diverse segments of the Hispanic/Latino population, including grassroots leaders, in decision-making processes regarding health care service delivery.

◆ Standardize and streamline administrative forms required to be completed by patients and providers. Reallocate the saved human and fiscal resources to service delivery.

◆ Enhance the health care infrastructure that services Hispanic/Latino populations. Funds should be earmarked specifically to develop local community-based primary care facilities and service network associations. The financial authority should fund community-based infrastructure development projects operated and managed by minority-owned and/or managed corporations and organizations.

◆ Include "safety net" providers—primary care clinics, traditional providers, and public health providers—in the health care system. The system must have representative governance and community involvement.

Public-Private Partnerships

◆ Direct the agencies within PHS to implement programs to foster establishment of public-private partnerships that improve and increase delivery of health care services for Hispanics/Latinos in all regions.

Advocacy

◆ Support the development of community advisory boards to evaluate community grievances, provide feedback, address quality issues, and influence community empowerment.

◆ Secure funding to provide health leadership training at the grassroots level to ensure community empowerment.

Legislation

◆ Enact Federal legislation to include coverage for the uninsured and the undocumented as part of health care reform.

◆ Provide a benefits package that is universal, whether the recipient gains access to care through employer-based coverage or is unemployed, undocumented, or a Medicaid recipient.

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- ◆ Enhance the health care infrastructure and provide funds for the construction of health facilities in Hispanic/Latino communities.
- ◆ Reformulate the criteria for appointing physicians and other health providers to health professional shortage areas (HPSAs).
- ◆ Create community-based health training centers that provide both training and job opportunities.
- ◆ Reformulate the criteria for Federal designation of medically underserved areas to accurately reflect the ethnic, demographic, and cultural characteristics of the communities served.
- ◆ Fund pilot projects that explore alternative primary health care financing and delivery systems (analogous to Health Care Financing Administration's SIIMO demonstrations).

B. Provide Accessible Health Care and Workmen's Compensation for the Farmworker Population

Farmworkers are the most underserved of all groups. Because 3 to 5 million of them are Hispanic/Latino, a special emphasis is required to address their health needs.

Policy

- ◆ Foster and reward networking through technical assistance and remove bureaucratic barriers, such as categorical funding that limits care for patients with multiple needs because of separate tracking of services by fund source. All existing efforts to integrate and coordinate health, education, and social services should be mandated. (Federal)
- ◆ Guarantee the participation of Medicaid-eligible farmworkers in the PHS329 program and identify alternate funding resources for others not eligible. Include case management as a mandatory reimbursable service for farmworkers. (State)
- ◆ Require companies that hire migrant workers to provide access to health care facilities. (Federal)

- ◆ Recognize that environmental factors—such as nonexistent or inadequate housing, lack of alcohol and drug abuse programs and mental health services, and the failure of implementation of occupational and environmental regulations—play a significant role in the health of the migrant farmworker, the family, and the community as a whole.

Resources

- ◆ Provide funding for standardized data collection procedures and continuous analysis and reporting to provide a base for advocacy for future funding.

Advocacy

- ◆ Provide funding for standardized data collection procedures and continuous analysis and reporting to provide a base for advocacy for future funding.

Legislation

- ◆ Federalize the Medicaid Program, eliminating the conflicting State eligibility criteria and varying reimbursement rates. Establish a national set-aside of funds to cover farmworkers. (Federal)
- ◆ Under the PHS329 services, expand farmworker eligibility for Medicaid to all farmworkers. (State)
- ◆ Establish national guidelines for farmworkers' coverage under the States' worker's compensation laws, thereby guaranteeing full and unrestricted access to rehabilitating and financial compensating services by those suffering accidents and diseases contracted in the performance of their jobs.
- ◆ Include the following features in the demonstration projects:
 - Simplification of all farmworker eligibility processes.
 - Recertification of farmworkers on the basis of annual or semiannual income, not month-to-month earnings.
 - Recognition of all farmworkers' eligibility.

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- Clarification of payor reimbursement rates and eligibility standards, regardless of the origin of eligibility or site of service delivery.
- Assurance of access to all primary care services on a timely basis.
- Provision of funding for primary care research, including psychosocial and mental health services.

5. Duplication and lack of coordination of efforts in health data collection by State and Federal agencies.

Data Collection

Preamble

It was not until 1989 that Hispanic/Latino identifiers were included on the standard registration certificates for vital events recommended for use by the States. Although the ability to assess mortality among Hispanics/Latinos has greatly improved, significant gaps in knowledge still exist regarding morbidity, quality of life, and disability in Hispanic/Latino communities. This lack of data has prevented the establishment of adequate baselines and subobjectives for the *Healthy People 2000* objectives that target Hispanics/Latinos. Because funding decisions at the Federal, State, and local levels have often been based on the *Healthy People 2000* objectives, this lack of data has hindered progress to improving health status of Hispanics/Latinos.

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Problems

1. Inadequate inclusion of Hispanics/Latinos in data systems.
2. Lack of data on specific Hispanic/Latino health issues.
3. Limited awareness of and access to local, State, and Federal Hispanic/Latino health databases.
4. Lack of quality, accurate, timely, and culturally sensitive data system design, data collection, and analysis.

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Summary of Key Strategies

1. Include Hispanic/Latino and Hispanic/Latino subgroup identifiers in all surveys and forms, and provide for adequate sample sizes for detailed analysis to establish new baselines and subobjectives for *Healthy People 2000*.
2. Increase Hispanic/Latino representation in the design, implementation, analysis, and dissemination of health assessment and health monitoring data systems, and in funding decisions affecting these systems, including the identification of health indicators specific for Hispanics/Latinos.
3. During current Federal and State budget appropriations hearings, request additional funds to take advantage of the resources already developed for the third National Health and Nutrition Examination Survey. These funds should be used to (1) update the data collected on Puerto Ricans and Cubans during the Hispanic Health and Nutrition Examination Survey and (2) collect, for the first time, detailed health data on other Caribbean and Central and South American subgroups in areas where they are geographically focused.
4. Establish Federal, State, and local laws to ensure confidentiality of respondents and to provide absolute protection of respondents from use of the identifying information by law enforcement and immigration authorities.
5. Ensure that sociocultural data be collected, so that analysis and interpretation of Hispanic/Latino health data can be placed in the context of larger social issues.

Specific Strategies

Key Audiences: Local, State, and Federal administrators and officials.

Representation and Communication

- ◆ Develop methodologies and programs for educating public and private entities regarding the need for scientifically valid Hispanic/Latino health data.
- ◆ Increase Hispanic/Latino representation in the design, implementation, analysis, and dissemination of health assessment and health monitoring data systems and in funding decisions affecting these systems. This increased representation is needed in Federal, State, and local departments and agencies, community-based organizations, colleges and universities, and other private research entities.
- ◆ Increase Hispanic/Latino membership in committees, councils, and commissions appointed by county, State, and Federal health departments; agency administrators; State and Federal legislators; and Governors to monitor data collection, analysis, interpretation, and dissemination.
- ◆ Provide regular Hispanic/Latino health data updates in publicly funded electronic newsletters, bulletin boards, and other communication activities.
- ◆ Increase the use of Hispanic/Latino newsletters, radio, and other effective media mechanisms as tools for disseminating data information.
- ◆ Facilitate public access to Hispanic/Latino health data reports and systems. Federal, State, and local health departments should identify existing data sets that can be used to assess the health status of Hispanics/Latinos and should determine the accessibility of these data sets to researchers.
- ◆ Identify a person in each agency or organization that collects and disseminates data to serve as the principal point of contact for Hispanic/Latino data analysis.
- ◆ Encourage researchers to report back to Hispanic/Latino communities regarding their research findings

before public dissemination of results, including publication and presentation at scientific meetings.

Policy

- ◆ Include Hispanic/Latino and Hispanic/Latino subgroup identifiers in all surveys and forms (e.g., birth and death certificates, patient discharge forms, and forms from primary and ambulatory care clinics). Analysis and dissemination should be subgroup specific for State and local communities with a significant (5 percent or greater) Hispanic/Latino population.
- ◆ Tie the release of Federal funds to States to the collection and reporting of Hispanic/Latino ethnicity. Data collection and reporting should include both documented and undocumented Hispanics/Latinos.
- ◆ Allocate funds in Federal, State, and local health programs to pay for data collection, analysis, and dissemination of Hispanic/Latino health data so that progress in improving Hispanic/Latino health status, and ultimately the health status of the Nation, can be tracked. Government agencies that use these data, but do not produce data, should share in the expenses of data collection, analysis, and dissemination.
- ◆ Set timelines for improving data collection for Hispanics/Latinos.
- ◆ Include the improvement of Hispanic/Latino data collection, analysis, and dissemination in Federal, State, and local strategic plans, such as *Healthy People 2000*, *Minority Health Activities*, and *Primary Care Access Plans*.
- ◆ Include consideration of the heterogeneity of the Hispanic/Latino population in all county, State, and Federal health department data collection and research designs. Oversampling has been identified as a feasible method for highly concentrated Hispanic/Latino subgroups; develop other survey methodologies to collect data for geographically dispersed Hispanic/Latino subgroups.

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- ◆ Employ culturally and linguistically appropriate interviewing techniques at all times when conducting surveys on Hispanic/Latino health issues. For example, dependence on telephone interviews is not appropriate for Hispanic/Latino communities with high rates of telephone noncoverage.

- ◆ Develop incentives to increase the quality and quantity of Hispanic/Latino health databases. Review data sets continuously for inconsistencies; errors in reporting, coding, and keying; and other issues that affect quality. Development plans for databases should include financial, technical, and training resources for establishment and maintenance of quality control programs.

- ◆ Create a Hispanic/Latino advisory board to the Secretary of Health and Human Services, State departments of health, and philanthropic foundations to oversee the implementation of the recommendations from the National Workshop and Regional Health Meetings of the Surgeon General's Hispanic/Latino Health Initiative.

- ◆ Establish local, State, regional, and national Hispanic/Latino health data clearinghouses.

- ◆ Starting immediately, review existing *Healthy People 2000* objectives and establish subobjectives to target Hispanics/Latinos. Provide baseline data for Hispanics/Latinos for those subobjectives at the Federal, State, and local levels.

- ◆ Develop publicly accessible computerized systems for retrieval of Hispanic/Latino health data.

- ◆ Promote needs assessment at the local level to empower communities to prioritize their health needs and seek funding accordingly.

- ◆ Identify and develop funding mechanisms for survey methodologies to study Hispanic/Latino subgroups. Additional funds should be allocated to the National Center for Health Statistics' Minority Health Statistics Grant program and Census survey research programs to support targeted research to

develop appropriate, culturally competent, and linguistically sensitive survey methodology to study subgroups of Hispanics/Latinos. Consideration should be given to the undocumented and recent immigrants.

- ◆ Enforce OMB Directive 15 and Public Law 94-311 among Federal agencies. Educate Federal agencies about the use of OMB Directive 15 for inclusion of Hispanics/Latinos (and Hispanic/Latino subgroups) in data systems and in federally funded intramural and extramural research programs.

- ◆ Develop a clear definition of the term "Hispanic/Latino," incorporating the concept of subgroup populations, to be uniformly implemented in county, State, and Federal health department and agency data collection and analysis activities.

- ◆ Ensure that sociocultural data are collected and that appropriate statistical methodologies and interpretation of these data are used. Analysis and interpretation of Hispanic/Latino health data should be placed in the context of larger social issues to ensure that "blaming the victim" is avoided and to allow identification of social factors that contribute directly and indirectly to the production and treatment of disease.

- ◆ Develop and disseminate written guidelines for confidentiality. Such guidelines should include a requirement for a detailed rationale for collecting and using data items. In addition, the guidelines should include a procedure for true informed consent in obtaining data from Hispanics/Latinos.

- ◆ Use existing data systems (e.g., Census Bureau and the National Center for Health Statistics (NCHS)) to establish cooperative agreements with States to develop standard State and local health status profiles for Hispanic/Latino communities.

- ◆ Conduct a national conference—cosponsored by the NCHS, other parts of the Centers for Disease Control and Prevention, the Commerce

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Department, the Department of Education, the Department of Justice, the Environmental Protection Agency, and other Federal agencies—to improve the coordination of data collection, analysis, and dissemination, with the goal being to reduce the burden of voluntary and mandatory reporting by the States and to improve the consistency of reporting of race/ethnic origin. Recommendations based on the findings from the 1993 PHS Task Force on State and Community Data should be used to help develop the agenda for the conference. Among the products of this conference should be guidelines for comparability and plans for providing, on a continuous basis, technical assistance and resources to State and local agencies responsible for data collection. This conference should take place by 1995 at the latest to ensure that tracking of *Healthy People 2000* objectives can be based on consistent and accurate data.

Resources

- ◆ Increase funding by county, State, and Federal health departments and agencies to provide technical assistance and training for data collection and analysis of Hispanic/Latino health data.
- ◆ Fund county, State, and Federal Hispanic/Latino health research and data analysis training centers.
- ◆ Provide support for local, State, regional, and national Hispanic/Latino health data forums, conferences, and workshops.
- ◆ Develop standardized forms for data collection on Hispanics/Latinos.
- ◆ Increase quantitative skills of Hispanic/Latino undergraduates to expand the pool of Latino researchers with the skills necessary to conduct research on Hispanic/Latino health issues.
- ◆ Require statistical agencies of the Federal Government to provide technical assistance to State and local agencies for development of data collection instruments and completion of instruments according to high

standards of quality. Additionally, software to assist in this process should be developed and provided.

- ◆ Develop programs for Hispanic/Latino community-based organizations to enhance their skills in Hispanic/Latino health data collection, analysis, and interpretation.

Public-Private Partnerships

- ◆ Establish cooperative agreement mechanisms to develop easily accessible Hispanic/Latino health data retrieval computer programs.
- ◆ Develop funding incentives to increase the use of Hispanic/Latino health databases by public and private entities.
- ◆ Include Hispanics/Latinos in interdisciplinary work groups, which should plan for research and data collection, evaluate data collection instruments, ensure that collected data are inclusive and usable, and assist in the interpretation and dissemination of these data. These work groups should include multiethnic individuals from the community to be studied, community-based organizations, health care professionals, advocates, and researchers.
- ◆ Establish a balance between the data needs for research and policy-making and the burden on the health care provider to collect information in addition to providing services.
- ◆ Establish regional Hispanic/Latino health coalitions to monitor implementation of the strategies developed during the national and regional workshops of the Surgeon General's Hispanic/Latino Health Initiative.

Advocacy

- ◆ Prepare user-friendly summary reports regarding Hispanic/Latino health on a regular basis and distribute them to local elected officials and community leaders.
- ◆ Collaborate with church groups, media sources, public figures, and leaders of multidisciplinary

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professional associations to inform the American public regarding Hispanic/Latino health data issues.

- ◆ Develop summary reports on Hispanic/Latino health for dissemination to policy analysts, program planners, elected officials, and community and political leaders.

Legislation

- ◆ Pass State laws requiring the collection of data on Hispanics/Latinos, especially in States with large Hispanic/Latino populations. The California legislation can be used as a model.

- ◆ During Federal and State budget appropriations hearings, request additional funds to take advantage of the resources already developed for the third National Health and Nutrition Examination survey. These funds should be used to (1) update the data collected on the Puerto Rican community in the New York City metropolitan area during 1984, and (2) collect, for the first time, detailed health data on Caribbean and Central and South American subgroups. Appropriation of funds should not wait for the fourth National Health and Nutrition Examination Survey. Taking advantage of already trained staff and existing questionnaire and other survey materials from the current survey (to be completed in 1994) should result in an economy of scale.

- ◆ Establish Federal, State, and local laws to ensure confidentiality of respondents and to provide absolute protection of respondents from use of the identifying information by law enforcement and immigration authorities. Such laws should not restrict the linkage of data sets for the purposes of aggregate epidemiologic analyses and program development.

Research Agenda

Preamble

Health research provides the foundation for understanding health. However, Hispanics/Latinos

are disproportionately underrepresented in research activities. Without adequate and targeted research, Hispanics/Latinos are disadvantaged in policy-making, resource allocation, program planning, and program implementation activities.

Currently, our body of knowledge about Hispanic/Latino health is limited at best. There are few culturally appropriate theoretical frameworks, and many research methodologies (instruments, data collection, and data analysis) are inadequate for addressing the unique health services research and delivery needs of the diverse Hispanic/Latino population groups.

Problems

1. Underfunding of Hispanic/Latino health research initiatives and agendas.
2. Lack of culturally appropriate theories, models, and methodologies.
3. Underrepresentation of Hispanics/Latinos at all levels of research activities, including students, research faculty, and administrators of research programs.
4. Lack of U.S. and international multidisciplinary Hispanic/Latino health research and lack of coordination of efforts among diverse areas of investigation.

Summary of Key Strategies

1. Increase funding to (1) determine high-priority health problems that affect morbidity and mortality of Hispanic/Latino groups (such as cardiovascular disease, cancer, diabetes, HIV/AIDS, substance abuse, violence, accidents, environmental and occupational hazards, and tuberculosis); (2) assess the impact of gender, ethnicity, and physical ability on the health status of urban and rural Hispanics/Latinos across their lifespan; and (3) assess the role of factors such as assimilation, country of origin, and migratory status.

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2. Increase Hispanic/Latino representation on multidisciplinary grant review bodies, advisory groups, and task forces to identify and implement Hispanic/Latino research priorities at local, State, and Federal levels.
3. Create and update directories of multidisciplinary Hispanic/Latino researchers for use by publicly or privately funded health departments, agencies, organizations, and/or institutions.
4. Reform the curricula of multidisciplinary health professional institutions and continuing education programs to include Hispanic/Latino health research theories, methodologies, and models.
5. Ensure the recruitment, training, and retention of Hispanic/Latino investigators and administrators.

Specific Strategies

Key Audiences: Local, State, and Federal administrators and officials.

Policy

Local and State

- ◆ Create Hispanic/Latino representation on multidisciplinary grant review bodies, advisory groups, and task forces to identify and implement Hispanic/Latino research priorities at local, county, and State levels.
- ◆ Create linkages to local educational, philanthropic, corporate, and research organizations.
- ◆ Utilize community-based organizations and neighborhood opinion leaders as distribution channels for information and service delivery. These groups and opinion leaders should also be used as a way of providing feedback to the scientific community on the effectiveness of research in addressing the needs of the communities and population groups.
- ◆ Create registries and update directories of multidisciplinary Hispanic/Latino scientists and

researchers for use by publicly or privately funded health departments, agencies, organizations and/or institutions.

- ◆ Reform curricula of multidisciplinary health professional institutions and continuing education programs to include Hispanic/Latino health research theories, methodologies, and models.
- ◆ Assess the results of programs such as the Minority Behavioral Research Supplement, Minority Access to Research Careers, and Health Careers and Opportunity Programs with respect to recruitment and retention of Hispanic/Latino students and researchers.
- ◆ Develop innovative research internship and fellowship programs for Hispanic/Latino students and scientists at the Federal and State levels.
- ◆ At the local levels, develop and enhance publicly and privately funded training and mentorship programs at various sites, such as the Minority High School Mentorship Program.
- ◆ Develop programs and initiatives to fund research on the role of assimilation, acculturation, country of origin or background, and socioeconomic status and migratory history on the health status of Hispanics/Latinos.
- ◆ Develop programs and initiatives to fund research on the impact of age, gender, geographic location, and functional ability on the health status of Hispanics/Latinos.

Federal

- ◆ Enhance Hispanic/Latino representation on multidisciplinary grant review bodies, advisory groups, and task forces to identify and implement Hispanic/Latino research priorities at Federal health departments and agencies.
- ◆ Enhance opportunities for and appointment of Hispanics/Latinos in key administrative and policy-making jobs in Federal agencies.
- ◆ Create and/or enhance Hispanic/Latino research agendas and health training in PHS and other

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agencies of DHHS. These programs should incorporate and emphasize the cultural, linguistic, and socioeconomic aspects and needs of the subpopulations.

- ◆ Create and/or enhance linkages within and across Federal agencies to replicate “best practices” and augment research and training resources.
- ◆ Establish county, State, and national clearing-houses to collect and disseminate information on Hispanic/Latino health research and funding opportunities.

Resources

- ◆ Increase funding to determine high-priority health problems (such as cardiovascular disease, cancer, diabetes, HIV/AIDS, tuberculosis, and substance abuse) that affect morbidity and mortality of Hispanic/Latino groups.
- ◆ Increase funding for enhanced recruitment, training, retention, and promotion of Hispanics/Latinos into health research leadership positions.
- ◆ Allocate funding for increased recruitment, training, retention, and promotion of Hispanic/Latino researchers employed by county, State, and Federal health departments and agencies.
- ◆ Examine and reapportion institutional funding, with special emphasis on discretionary funds, spent on Hispanic/Latino health research, particularly in the inner cities and rural areas.
- ◆ Develop and fund Distinguished Scholars programs to enhance career development for Hispanic/Latino researchers at the undergraduate, graduate, and postgraduate levels.
- ◆ Allocate funds, including set-aside funds, to ensure that research on Hispanics/Latinos is responsive to their subgroup needs and priorities.
- ◆ Fund a repository of Hispanic/Latino survey instruments, research methodologies, and data within PHS, with special emphasis on making the

information accessible and affordable to Hispanic/Latino institutions or researchers.

- ◆ Establish a directory of Hispanic/Latino researchers to disseminate for use by county, State, and Federal health departments and agencies.
- ◆ Fund activities and programs that will promote linkages between community-based health delivery systems serving Hispanics/Latinos and academic institutions.

Public-Private Partnerships

- ◆ Establish collaborative partnerships between academic and health institutions.
- ◆ Collaborate with public officials, corporate leaders, and foundation administrators in establishing multidisciplinary mechanisms for determining Hispanic/Latino research priorities and funding sources.
- ◆ Establish and support ongoing U.S.-Latin American health conferences and research collaborations.

Advocacy

- ◆ Collaborate with editorial boards of established professional journals to focus on Hispanic/Latino health issues.
- ◆ Establish new information dissemination strategies to meet the needs of Hispanic/Latino researchers and health service providers. (For example, include specific columns in the *Journal of the American Medical Association* and local newsletters of professional organizations.)
- ◆ Establish new health information dissemination strategies to meet the needs of the general Hispanic/Latino community.
- ◆ Continue and expand interaction with legislative bodies (city council members, mayors, county commissioners, State and Federal legislators, Hispanic Congressional Caucuses, and committee staff).

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Legislation

- ◆ Consider alternatives that could allow U.S.-trained, foreign medical graduates to maximally participate in research activities, particularly those related to Hispanic/Latino issues.
- ◆ Ensure reauthorization of the Disadvantaged Minority Health Act and appropriations of related Federal agencies.
- ◆ Amend the Disadvantaged Minority Health Act to specifically address the health needs of the Hispanic/Latino populations.
- ◆ Enhance tax incentives and programs for businesses that provide funding for Hispanic/Latino research and training.

Representation in Health Professions

Preamble

Hispanics/Latinos are severely underrepresented in the health professions. Accordingly the delivery of health care services to the Hispanic/Latino community suffers. In addition, communities need culturally competent, and culturally sensitive professionals in all disciplines to address their needs with appropriate programs and services.

Problems

1. Underrepresentation of Hispanics/Latinos at all levels of the health professions, including practitioner, faculty, advanced career positions, and decision-making bodies.
2. Underrepresentation of Hispanics/Latinos in the educational pipeline of the health professions.
3. Lack of adequate mechanisms for identifying, recruiting, retaining, and promoting Hispanics/Latinos in health and science professions.

4. Underfunding for Hispanics/Latinos in health and science education programs.
5. Underutilization of linguistically and culturally competent foreign-educated Hispanic/Latino health professionals to provide care in Hispanic/Latino communities.

Summary of Key Strategies

1. Promote the recruitment, retention, and advancement of Hispanic/Latino health professions faculty, including an increase of tenured and tenured track faculty. (Local)
2. Ensure the entry and retention of Hispanics/Latinos through funding incentives (such as institutional development) in undergraduate and graduate programs at Hispanic/Latino-serving institutions and Hispanic Centers of Excellence.
3. Establish guidelines for the recruitment and retention of Hispanic/Latino students in all health professions and make universities accountable by tying the requirements to levels of funding.
4. Ensure the broad dissemination of information on financial assistance and educational initiatives—such as college work-study programs, grants, scholarships, fellowships, and national service.
5. Develop and support awareness, educational enrichment, and student guidance and mentoring programs to encourage Hispanic/Latino students to pursue careers in the health professions.
6. Develop licensure preparation courses, alternate competency examinations, and tracking mechanisms to increase retraining opportunities and promote the greatest use of Hispanic/Latino foreign-trained health professionals.

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Specific Strategies

Key Audiences: Local, State, and Federal administrators and officials.

Communication and Representation

- ◆ Increase the use of media resources to promote positive images and advancements of Hispanics/Latinos of both genders in health and science careers. (Local, State, and Federal)
- ◆ Increase the participation of Hispanics/Latinos in commissions, task forces, advisory committees, boards, and conferences sponsored by county, State, and Federal health departments or agencies. (Local, State, and Federal)

Policy

- ◆ Develop information programs on Hispanic/Latino education data for members of school boards, university regents, foundation boards of trustees, and county, State, and Federal education and health administrators. (Local, State, and Federal)
- ◆ Develop electronic and computer-accessible Hispanic/Latino bulletin boards to provide access to Hispanic/Latino databases via 800 lines for “networking” information regarding available resources and career development programs. (State, Federal)
- ◆ Require the NIH Office of Minority Health Research to establish a Hispanic/Latino health division. (Federal)
- ◆ Increase access for Hispanics/Latinos in biomedical research and health professional educational systems. (Local, State, and Federal)
- ◆ Increase the involvement of Hispanic/Latino families, teachers, principals, and faculty in decision-making processes regarding all levels of Hispanic/Latino education issues.
- ◆ Increase the involvement of Hispanic/Latino faculty in planning, funding, admission, and curriculum activities. (Local)

- ◆ Encourage education administrators to provide Hispanic/Latino bilingual tutors for students in primary and secondary levels and to increase the number of Hispanic/Latino faculty to be consistent with the Hispanic/Latino population.
- ◆ Promote the retention, advancement, and increase of tenured and tenured track faculty. (Local)
- ◆ Develop leadership training programs, such as the Cuban-American National Council Leadership Board Training Model, that enhance the career development of Hispanic/Latino health professionals. (Local, State, and Federal)
- ◆ Support and expand programs targeting Hispanic/Latino student participation (such as Minority Biomedical Research Support Programs and Minority Access to Research Careers (MBRS/MARC)) at biomedical research and health professional schools and Hispanic Centers of Excellence. (Federal)
- ◆ Establish funding incentives targeting the entry and retention of Hispanics/Latinos in undergraduate and graduate institutions serving Hispanic/Latino populations to reverse the extremely low rates of Hispanics/Latinos with a college education.
- ◆ Expand support for culturally competent education and science enrichment programs and models that promote the success of Hispanic/Latino health and science students, clinicians, and academicians. (State, Federal)
- ◆ Provide funding to health professional schools that recruit Hispanic/Latino clinicians from low income areas. (State, Federal)
- ◆ Develop additional loan forgiveness, college work-study, and scholarship/fellowship programs specifically targeted for Hispanic/Latino students and practitioners, particularly in extremely rural and urban communities.
- ◆ Establish mechanisms to disseminate information on how to obtain student financial assistance, grants, scholarships, and fellowships.

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- ◆ Promote the use of nonbiased cultural measures and assessments for admission and licensing exams and accountability and performance standards. (State, Federal)

- ◆ Develop tracking mechanisms for foreign medical graduates to determine sites where retraining opportunities are available, health care positions and vacancies are posted, and license requirements are disseminated.

- ◆ Develop licensure preparation courses and alternate competency examinations for Hispanic/Latino foreign-trained health professionals. (State, Federal)

Resources

- ◆ Develop and fund adopt-a-student programs to encourage recruitment and retention of Hispanics/Latinos into health and science professions. (State, Federal)

- ◆ Increase the number of Hispanic/Latino health professionals by eliminating barriers that prevent, deter, or delay licensure. (Local, State, and Federal)

- ◆ Develop and increase support for programs that employ foreign-trained Hispanic/Latino health professionals. (State, Federal)

Public-Private Partnership

- ◆ Develop and support early awareness, dropout prevention, and other education enrichment programs such as “Padres A la Escuela” (Washington, D.C.) and the Hispanic Mother-Daughter Program at Arizona State University. (Local, State, Federal)

- ◆ Support Hispanic/Latino corporate-sponsored mentoring programs in the health science professions. (Local, State, and Federal)

- ◆ Develop cooperative agreements between private and public institutions for support of research by Hispanic/Latino scientists. (Local, State, and Federal)

- ◆ Solicit funding for endowed Chairs for Hispanic/Latino faculty members at educational institutions. (Local, State, and Federal)

- ◆ Collaborate with State licensing boards, university presidents, State legislators, and professional associations to expand career opportunities for Hispanic/Latino educators and health professionals. (Local, State)

Advocacy

- ◆ Develop and support education enrichment and student guidance programs that address special needs of Hispanic/Latino students contemplating health or science careers. (Local, State, and Federal)

- ◆ Promote awareness among elected officials (city council members, mayors, county commissioners, etc.) of health education issues affecting Hispanics/Latinos. (Local, State, and Federal)

- ◆ Support the development of licensure examinations for foreign-trained Hispanic/Latino health professionals. (State)

- ◆ Collaborate with leaders of educational and health professional associations to increase Hispanic/Latino involvement and leadership. (Local, State, and Federal)

- ◆ Promote inclusion and participation of Hispanic/Latinos in editorial boards of professional health and science journals and publications. (Local, State, and Federal)

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Health Promotion and Disease Prevention

Preamble

The overall health profile of Hispanics/Latinos presents a striking socioeconomic disparity when compared with the health status of the rest of the American population. Nevertheless, much can be done to improve the health of this population by implementing health promotion and disease prevention (HPDP) interventions. The challenge is to develop and implement efficacious HPDP

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Priority Recommendations

strategies for improving the health of Hispanics/Latinos across the country. HPDP interventions targeted to Hispanics/Latinos are essential for achieving the Hispanic/Latino-specific health care objectives for the Nation by the year 2000.

Problems

1. Weak infrastructure for training in HPDP:
 - Lack of multidisciplinary approaches to HPDP curriculum development.
 - Lack of HPDP curriculum in schools.
 - Lack of formal HPDP training for Hispanic/Latino leaders.
 - Institutionalized and individual racism as a barrier to service delivery and professional development.
2. Lack of proven models for comprehensive, culturally competent, and community-specific primary prevention programs.
3. Lack of public-private partnerships in support of HPDP goals for Hispanics/Latinos.
4. Lack of diffusion of culturally appropriate HPDP models and lack of community resources for the replication of successful Hispanic/Latino HPDP models.
5. Lack of media awareness of Hispanic/Latino HPDP issues.
6. Lack of cooperation in addressing environmental hazards and HPDP issues among countries in the Americas (the U.S.–Mexican border, Central and South America, and the Caribbean).

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Summary of Key Strategies

1. Encourage and endorse authorizing legislation at the Federal level to direct Federal funds for the development and evaluation of HPDP programs directed toward Hispanic/Latino groups.

2. Integrate paraprofessionals, informal community leaders, ethnic/folk healers, “Promotores de Salud,” and other community health workers in HPDP programming for the Hispanic/Latino community, and provide appropriate recognition and incentives for their participation.
3. Use appropriate media resources and community networks at local, State, and Federal levels to educate Hispanic/Latino communities regarding HPDP issues.
4. Establish guidelines for Hispanic/Latino national and community-based organizations for accepting corporate contributions; corporations’ products and services must be compatible with HPDP goals.
5. Make HPDP issues (including environmental issues) critical elements in the regulations and implementation of the North American Free Trade Agreement (NAFTA).
6. Develop a mass media marketing plan that informs the public on how to gain access to and properly utilize health and related services. This plan should target Spanish-speaking and bilingual Hispanics, especially in areas where little or no information is available. (State and local)

Specific Strategies

Representation and Communication

- ◆ Include culturally sensitive and competent Spanish-language components in all public health education campaigns currently being funded by DHHS.
- ◆ Include Hispanic/Latino representation in the development of outreach and public information campaigns, including television, radio, and the print media.
- ◆ Integrate paraprofessionals, informal community leaders, ethnic/folk healers, “Promotores de Salud,” and other community health workers in HPDP

programming for the Hispanic/Latino community, and provide appropriate recognition/incentives for their participation.

- ◆ Establish a comprehensive Hispanic/Latino-specific HPDP mentorship program for research, teaching, and community interventions.
- ◆ Develop agendas, workshops, and training for media representatives to promote Hispanic/Latino HPDP programs.
- ◆ Develop a mass media marketing plan that informs the public on how to gain access to and properly utilize health and related services. This plan should target Spanish-speaking and bilingual Hispanics, especially in areas where little or no information is available. (State and local)
- ◆ Develop multilingual, multimedia public health education campaigns that address lifespan, gender-based, and cultural needs of the diverse Hispanic/Latino population groups.
- ◆ Use appropriate media resources and community networks at local, State, and Federal levels to educate Hispanic/Latino communities regarding HPDP issues.
- ◆ Increase the media's awareness of Hispanic/Latino health and HPDP issues and clarify their role in HPDP information dissemination.
- ◆ Develop training programs in media advocacy for community residents and organizations.
- ◆ Use paid media to complement other HPDP efforts targeting Hispanics/Latinos.

Policy

- ◆ Establish policies and procedures by which all requests for proposals (RFPs) for prevention activities at the Federal and State levels have Hispanic/Latino community input.
- ◆ Make HPDP issues (including environmental issues) critical elements in the regulations and implementation of the NAFTA.

Resources

- ◆ Provide incentives, such as tuition, loan forgiveness programs, and financial benefits, to HPDP program providers for serving Hispanics/Latinos in underserved communities.
- ◆ Increase funding for and the number of Centers of Excellence for Hispanic/Latino health professions with emphasis in HPDP.
- ◆ Recommend that all levels of government (Federal, State, and local) increase the use of toll-free hot lines in a culturally appropriate fashion and that they be properly advertised in the communities they serve.
- ◆ Foster initiatives that will target and fund Hispanic/Latino-specific HPDP activities (new funding and reallocation of existing funds).
- ◆ Expand, establish, and fund Hispanic/Latino health education information clearinghouses at the Federal, State, and county levels.
- ◆ Establish guidelines for Hispanic/Latino national and community-based organizations for accepting corporate contributions; corporations' products and services must be compatible with HPDP goals.

Public-Private Partnerships

- ◆ Establish linkages for HPDP programs and services among community-based organizations, universities, the private sector, and lay people in the community.
- ◆ Develop partnerships among training institutions, community-based organizations, and national Hispanic/Latino agencies to collaborate in the design of more appropriate HPDP programs.
- ◆ Create a Hispanic/Latino HPDP information network and clearinghouse via a public-private partnership.
- ◆ Foster close collaboration between Latin American countries and the United States regarding HPDP issues.

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Priority Recommendations



Advocacy

- ◆ Promote the importance of wellness, education, early identification of health problems, and appropriate intervention in HPDP via community coalitions.
- ◆ Develop national and local Hispanic/Latino constituencies to counter disease-promoting industries.

Legislation

- ◆ Encourage and endorse authorizing legislation at the Federal level to direct Federal funds for the development and evaluation of HPDP programs directed toward Hispanic/Latino groups.



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Acting Director
 Program Evaluation and Data Analysis Branch
 Office of Minority Health
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 Rockville, MD 20852

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President
 National Hispanic Council on Aging
 2713 Ontario Road, NW
 Washington, DC 20009

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Director
 Maternal and Child Health Division
 COSSMHO
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 Washington, DC 20036

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Deputy Chief of Staff
 California State Senator Charles Calderon
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 Office of Research on Women's Health
 National Institutes of Health
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 University of South Florida
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 Los Angeles, CA 90031

Antonia M. Villarruel, M.S.N., R.N.

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Deputy Assistant Secretary
 Office of Policy External Affairs
 Administration for Children and Families
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 Washington, DC 20447

Christina Wypijewski, M.P.H.

Prevention Policy Advisor
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 330 C Street, SW
 Washington, DC 20201

Frank Beadle de Palomo, M.A.

Director
 Center for Health Promotion
 National Council of La Raza
 810 First Street, NE, Suite 300
 Washington, DC 20002

Adela de la Torre, Ph.D.

Chair
 Chicano and Latino Studies
 California State University
 1250 Bellflower Blvd.
 Long Beach, CA 90840

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Appendix B: National Workshop Agenda

Surgeon General's National Workshop on Hispanic/Latino Health, Washington, DC

September 28, 1992

12:00 pm–1:00 pm

Registration

ANA Westin Hotel Main Lobby

1:00 pm–2:00 pm

Opening of Plenary Session

Welcome

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

Surgeon General

Public Health Service

U.S. Department of Health and Human Services

Keynote Speaker

The Honorable Louis W. Sullivan, M.D.

Secretary

U.S. Department of Health and Human Services

Charge to Workshop Participants

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

2:00 pm–2:30 pm

Break

2:30 pm–4:00 pm

Hispanic/Latino Health

Issues Panel—Background

Summary Papers

Chair

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

Panelists

Improving Access to Health Care in Hispanic/Latino Communities

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

Improving Data Collection Strategies

Jane Delgado, Ph.D.

Increasing the Representation of Hispanics/Latinos in the Health Professions

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

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

Gerardo Marin, Ph.D.

Health Promotion and Disease Prevention

Marilyn Aguirre-Molina, Ed.D.

4:00 pm–5:30 pm

Work Group Session I

Identification and Prioritization of the Key Problems/Issues

6:00 pm–8:00 pm

Reception

Organization of American States Building

Welcome

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

Introduction of Speakers

Samuel Lin, M.D., M.P.H.

Acting Deputy Assistant Secretary for

Minority Health

Office of Minority Health

Public Health Service

U.S. Department of Health and Human Services

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Speakers

The Honorable Solomon P. Ortiz
 Representative
 State of Texas
 Chairman, Congressional Hispanic Caucus
 U.S. House of Representatives

The Honorable Nancy L. Kassebaum
 Senator
 State of Kansas
 U.S. Senate

September 29, 1992

7:00 am–8:30 am
Buffet Breakfast

ANA Westin Hotel Colonnade Restaurant

Speakers

Gail R. Wilensky, Ph.D.
 Deputy Assistant to the President for
 Policy Development
 The White House

Barbara Everitt Bryant, Ph.D.
 Director
 Census Bureau
 U.S. Department of Commerce

Robert S. Murphy, M.S.P.H.
 Director
 Division of Health Examination Statistics
 National Center for Health Statistics
 Centers for Disease Control and Prevention

8:30 am–10:00 am
Work Group Session II

Implementation Strategies

10:00 am–10:30 am
Break

10:30 am–12:00 pm
Work Group Session III

Implementation Strategies (cont'd)

12:00 pm–1:30 pm
Lunch (free time)

1:30 pm–2:00 pm
Keynote Speaker

The Honorable Lynn Martin
 Secretary
 U.S. Department of Labor

2:00 pm–3:30 pm
Work Group Session IV

Implementation Strategies (cont'd)

3:30 pm–4:00 pm
Break

4:00 pm–6:00 pm
Work Group Session V

Finalize Implementation Strategies

6:00 pm–7:00 pm
**Chairpersons, Vice Chairpersons,
 and Staff Meeting**

7:00 pm–8:00 pm
Work Group Session VI

Finalize Presentation
 (Chairpersons, Vice-chairpersons, Rapporteurs, and
 Presenters only)

September 30, 1992

7:00 am–8:00 am
Continental Breakfast

ANA Westin Hotel Court

8:00 am–9:00 am
Remarks

Rafael J. Magallan
 Director, Washington Office
 Hispanic Association of Colleges and Universities
 Hispanic Access to Health Care/GAO Report

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Eleanor Chelimsky
 Assistant Comptroller General
 U.S. General Accounting Office

9:00 am–10:15 am

**Work Group Reports to Workshop
 Participants**

Chair

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

10:15 am–10:30 am

Break

10:30 am–11:00 am

**Work Group Reports to Workshop
 Participants (cont'd)**

11:00 am–12:30 pm

Responder Panel

Chair

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

Guest Panelists

James O. Mason, M.D., Dr.P.H.
 Assistant Secretary for Health
 U.S. Department of Health and Human Services

John T. MacDonald, Ph.D.
 Assistant Secretary for Elementary and
 Secondary Education
 U.S. Department of Education

Thomas Komarek, M.B.A.
 Assistant Secretary for Administration
 and Management
 U.S. Department of Labor

Karen R. Keesling, J.D.
 Acting Administrator
 Wage and Hour Division
 U.S. Department of Labor

Louis D. Enoff
 Acting Commissioner
 Social Security Administration
 U.S. Department of Health and Human Services

William Toby, M.S.W.
 Acting Administrator
 Health Care Financing Administration
 U.S. Department of Health and Human Services

Michael McGinnis, M.D.
 Director
 Office of Disease Prevention and Health Promotion
 U.S. Department of Health and Human Services

Robert S. Murphy, M.S.P.H.
 Director, Health Examination Statistics
 National Center for Health Statistics
 Centers for Disease Control and Prevention
 Public Health Service
 U.S. Department of Health and Human Services

Rafael J. Magallan
 Director
 Hispanic Association of Colleges and Universities

Kenneth Shine, M.D.
 President
 Institute of Medicine

12:30 pm–12:45 pm

**Charge for the Future: Where Do
 We Go from Here?**

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

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Appendix C: Regional Health Meetings—Executive Planning Committees and Agendas



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

Antonia C. Novello, M.D., M.P.H.
Surgeon General U.S.P.H.S.
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Novello:

Please convey my best wishes for a successful meeting to the participants in the New York Regional Meeting on Hispanic/Latino Health.

As an integral part of the National Hispanic/Latino Health Initiative, the Regional Meetings are an historic milestone in our public health activities. The Regional Meetings are the first, regionally focused effort to address the special health needs of the Hispanic and Latino community.

The findings of the Regional Meetings will be used to inform Department and key regional and national health policy leaders of the health needs of the Hispanic/Latino people in five critical areas: access to health care, representation of Hispanic/Latinos in science and health professions; improved data collection strategies; a relevant and comprehensive research agenda; and health promotion and disease prevention issues. I am confident that the Regional Meetings will result in strong and lasting partnerships committed to implementing effective health care and access strategies.

I applaud your efforts and I commend your dedication to improving the health of the Hispanic and Latino members of our American family.

Sincerely,

Donna E. Shalala

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This letter is a sample of the letters sent by Secretary Shalala for all the Regional Health Meetings.

Region IV Executive Planning Committee

Alabama

Florida

Georgia

Kentucky

Mississippi

North Carolina

South Carolina

Tennessee

Co-Chairpersons

Ramon Rodriguez-Torres, M.D.

Chief of Staff

Miami Children's Hospital

Sara Torres, Ph.D., R.N.

Associate Professor, College of Nursing

University of South Florida

Vice-Chairperson

Beaumont R. Hagebak, Ed.D.

Health Administrator, Region IV

Coordinators

Robert C. Ribera

Special Projects Office

Miami Children's Hospital

Peggy Smith Maddox

Special Projects Office

Miami Children's Hospital

Members

Myriam B. Ares, M.D., M.P.H.

Chief, Office of Disease Prevention

Dade County Public Health Unit

Salvador Bou, M.D.

Office of Clinical Management

Public Health Service, Region IV

Jean Malecki, M.D., M.P.H.

Medical Director

Palm County Health Unit

Pedro Castillo

Minority Health Advisory Council

North Carolina Department of Health

and Natural Resources

Orlando Dominguez, M.D., F.A.A.P.

President

Cuban Pediatric Society

Jose Szapocnic, Ph.D.

Professor of Psychiatry and Deputy Director

Center for Biopsychosocial Studies and AIDS

Caroline A. Macera, Ph.D.

Assoc. Prof. of Epidemiology

University of South Carolina School of Public Health

Josefina Carbonnell

President

Little Havana Activities and Nutrition Centers

Estela Niella-Brown

Public Affairs Specialist

Food and Drug Administration

Linda S. Quick

Executive Director

Health Council of South Florida, Inc.

Ariela Rodriguez, M.D.

Director of Health and Social Services

Little Havana Activities and Nutrition Centers

Eleni D. Sfikianaki, M.D.

Medical Executive Director

Dade County Public Health Unit

Yvonne Jons

Associate Regional Health Administrator for

Minority Health

Public Health Service, Region IV

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Region IV Regional Health Meeting Agenda

Miami, Florida

Region IV

Alabama

Florida

Georgia

Kentucky

Mississippi

North Carolina

South Carolina

Tennessee

March 4, 1993

8:00 am–9:00 am

Registration

9:00 am–10:30 am

Opening Plenary Session

Welcome

Ramon Rodriquez-Torres, M.D.

Co-Chairperson

Miami Children's Hospital

Sara Torres, Ph.D., R.N.

Co-Chairperson

University of South Florida

Beaumont Hagebak, Ed.D.

Vice-Chairperson

Acting Regional Health Administrator

U.S. Public Health Service, Region IV

Donna E. Shalala (invited)

Secretary of Health and Human Services

Claudia R. Baquet, M.D., M.P.H. (invited)

Deputy Assistant Secretary for Minority Health

U.S. Public Health Service

Lydia E. Soto-Torres, M.D., M.P.H.

National Coordinator

Surgeon General's National Hispanic/Latino

Health Initiative

Office of the Surgeon General

U.S. Public Health Service

Keynote Address and Charge to Participants

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

Surgeon General

U.S. Public Health Service

10:30 am–11:00 am

Break

11:00 am–12:30 pm

Work Group Session I

Access to Health Care

Co-Facilitators:

Rosebud L. Foster, Ed.D.

Professor of Health Services Administration

Florida International University

Ariela C. Rodriguez, Ph.D., A.C.S.W.

Director of Health and Social Services

Little Havana Activities and Nutrition Centers of

Dade County, Inc.

Data Collection

Co-Facilitators:

Linda Jacobs

Project Administrator

Office of Vital Records and Public Health Statistics

South Carolina Department of Health and

Environmental Control

Teresa Fernandez, R.N., M.H.M.

Ambulatory Care Director

University of Florida Medical Center

Research

Co-Facilitators:

Donna Richter, Ed.D.

Assistant Dean

University of South Carolina

Susannah Young, R.D., M.P.H.

Director

North Carolina Migrant Health Program

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Region IV

Alabama

Florida

Georgia

Kentucky

Mississippi

North Carolina

South Carolina

Tennessee

Health Professions

Co-Facilitators:

Robert Fernandez, D.O., M.P.H.

Deputy Dean

Southeastern College of Osteopathic Medicine

Hilda Brito, R.N., B.S.N.

Career Counselor

Jackson Memorial Hospital

Health Promotion and Disease Prevention

Co-Facilitators:

Pedro Castillo

Director, Casa Guadalupe

Member, North Carolina Mental Health Advisory Council

Gustavo Saldias, M.P.H.

Director for Safety and Health

Farmworkers Legal Services of North Carolina

12:30 pm–2:00 pm**Luncheon****Speaker***A. Frederick Schild, M.D., F.A.C.S.*

President

Florida Medical Association

2:00 pm–3:30 pm**Work Group Session II**3:30 pm–4:00 pm**Break**4:00 pm–5:30 pm**Work Group Session III**5:30 pm–6:00 pm**Facilitators Meeting**6:00 pm–7:30 pm**Reception**

Sponsored by CAC-Ramsay Health Plans

March 5, 1993

9:00 am–10:00 am**Work Group Session IV**10:00 am–10:30 am**Break**10:30 am–12:00 pm**Plenary Session****Work Group Reports****Access to Health Care***Rosebud Foster, Ph.D.***Data Collection Strategies***Linda Jacobs***Science and Health Professions***Robert A. J. Fernandez, D.O.M., M.P.H.,**F.A.C.G.P.***Comprehensive Research Agenda***Donna Richter, Ed.D.***Health Promotion and Disease****Prevention***Gustavo Saldias, M.P.H.***Responder Panel**

Moderator

Marisa Azaret, Psy.D.

Faculty Member

Miami Children's Hospital

Jose Szapocznik, Ph.D.

Professor of Psychiatry

University of Miami

Burton Dunlop, Ph.D.

Director of Research

Southeast Florida Center on Aging

North Miami, Florida

Sister Barbara Harrington, G.N.S.H.

St. Joseph's Hospital

Atlanta, Georgia

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Gema Hernandez, D.P.A.

Associate Professor
NOVA University
Ft. Lauderdale, Florida

Madelin Escagedo Menacho, M.S.

Regional Coordinator for the National Hispanic
Education and Communication Project
Miami, Florida

12:00 pm–1:30 pm

Luncheon

Speaker

The Honorable Lincoln Diaz-Balart
U.S. Congressman

Closing Remarks

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

Region IV

Alabama

Florida

Georgia

Kentucky

Mississippi

North Carolina

South Carolina

Tennessee

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Regions V and VII Executive Planning Committee

Illinois

Indiana

Iowa

Kansas

Michigan

Minnesota

Missouri

Nebraska

Ohio

Wisconsin

Co-Chairpersons*Aida L. Giachello, Ph.D.*

Assistant Professor

Jane Addams College of Social Work

University of Illinois at Chicago

Steven Uranga McKane, D.M.D., M.P.H.

Program Coordinator

Kellogg Foundation

Members*Connie Alfaro*

Public Health Consultant

Office of Minority Health

Michigan Department of Public Health

Nohema Astaburuaga

Program Specialist

Ohio Commission on Minority Health

*Jose Avila, R.N.**Lisa Bartra*

Case Manager

Good Samaritan

Ira Bey

District Manager

Marion-Merrell Dow Pharmaceuticals, Inc.

Tony E. Caceres, M.D., M.P.H.

Medical Director

Sinai Samaritan Medical Center

Gerardo Colon

Hispanic Liaison

Community Relations Board

City of Cleveland

Elsa Garcia, R.N., M.H.A.

Manager, Medical Benefits and Vendor

Quality Assurance

Humana Health Plan

Jorge Girotti, Ph.D.

Assistant Dean, Urban Health

Director, Hispanic Center of Excellence

University of Illinois at Chicago

Romeo Guerra

Administrator

Office of Minority Health

Nebraska Department of Health

Monica Medina

Executive Director

Centro Hispano

Theitypanic Center

Augustine Paz

Effort for AIDS

Ila Plascencia

L.U.L.A.C. Midwest Education

Betsy Reyes

Assistant Director for Community Affairs and

Minority Business

Arturo Robles

Office of Local and Rural Health

Kansas Department of Health and Environment

Socorro Roman, R.N.

Indiana University Northwest

Adriana Ruiz

AIDS Coordinator

C.L.U.E.S.

Esther Sciammarella

Special Assistant to the Health Commissioner

Director, Chicago Hispanic Health Coalition

Chicago Department of Health

Sylvia Tijerina

Administrator

Commission on Latino Affairs

Kathy Wederspahn

Health Program Representative

Minnesota Department of Health

Federal Representatives

National Coordinator

Lydia Soto-Torres, M.D., M.P.H.

National Coordinator

Surgeon General's National
Hispanic/Latino Health Initiative

Office of the Surgeon General
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Rockville, Maryland 20857
(301) 443-4000/3574 fax

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Acting Regional Public Health

Administrator, Region V

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E. Frank Ellis, M.D.

Regional Health Administrator, Region VII

U.S. Public Health Service

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Hazel Farrar

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U.S. Public Health Service

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Regions V & VII

- Illinois
- Indiana
- Iowa
- Kansas
- Michigan
- Minnesota
- Missouri
- Nebraska
- Ohio
- Wisconsin

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Regions V & VII

Regions V and VII Regional Health Meeting Agenda

Illinois
Indiana
Iowa
Kansas
Michigan
Minnesota
Missouri
Nebraska
Ohio
Wisconsin

Chicago, Illinois

March 10, 1993

10:00 am–1:00 pm
Work Group Chair and Co-Chair Orientation

1:00 pm–2:00 pm
Lunch

2:00 pm–3:30 pm
Midwest Regional Executive Planning Committee Meeting

3:30 pm–4:00 pm
Break

4:00 pm–8:00 pm
Regional Meeting Registration

6:00 pm–8:00 pm
Reception

Sponsored by the Chicago Department of Health and the Chicago Hispanic Health Coalition

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

March 11, 1993

7:30 am–9:00 am
Continental Breakfast

Westin Hotel

7:30 am–3:00 pm
Registration

8:30 am–9:00 am
Opening Plenary Session

Welcome Remarks
Aida L. Giachello, Ph.D.
University of Illinois at Chicago
Regional Health Meeting Co-Chairperson

Julia Attwood
Acting Regional Public Health Administrator
U.S. Public Health Service, Region V
Regional Health Meeting Vice-Chairperson

Steven Uranga McKane, D.M.D., M.P.H.
Program Coordinator, Kellogg Foundation
Regional Health Meeting Co-Chairperson

Donna E. Shalala (invited)
Secretary of Health and Human Services

Claudia R. Baquet, M.D., M.P.H. (invited)
Deputy Assistant Secretary for Minority Health
Office of Minority Health

Mayor Richard M. Daley (invited)
City of Chicago

9:00 am–9:20 am
Public Health Issues

E. Frank Ellis, M.D., M.P.H.
Regional Public Health Administrator
U.S. Public Health Service, Region VII
Regional Health Meeting Vice-Chairperson

9:20 am–9:35 am
The Surgeon General's National Hispanic/Latino Health Initiative Overview

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Lydia E. Soto-Torres, M.D., M.P.H.
National Coordinator
Surgeon General's National Hispanic/Latino
Health Initiative
Office of the Surgeon General
U.S. Public Health Service

9:35 am–10:15 am

**Overview of Hispanics/Latinos
in the Midwest**

Sylvia Puerte, M.A.
Director of Research and Documentation
Latino Institute, Chicago, IL

10:15 am–10:30 am

Break

(Sponsored by Blue Cross and Blue Shield of Illinois)

10:30 am–12:00 pm

**Hispanic/Latino Health Issues
in the Midwest**

Summary of Background Papers
Moderator

Steve Uranga McKane, D.M.D., M.P.H.
Regional Co-Chairperson

Access to Health Care

Aida L. Giachello, Ph.D.
Jane Addams College of Social Work
University of Illinois at Chicago

Data and Research

Jose O. Arrom, M.A.
Midwest Hispanic AIDS Coalition

Health Professions

Jorge Girotti, Ph.D.
Hispanic Center of Excellence
College of Medicine
University of Illinois at Chicago

**Health Promotion and Disease
Prevention**

Cristina Jose-Kampfner, Ph.D.
Eastern Michigan University

Migrant and Rural Health Issues

Manny Gonzalez

12:00 pm–2:00 pm

Working Luncheon

Luncheon Moderator

E. Frank Ellis, M.D., Ph.D.
Regional Meeting Co-Chairperson

Invocation

The Reverend Thomas A. Baima
Director, Office of Ecumenical and
Interreligious Affairs
Archdiocese of Chicago

Partners in Health

Karen Timmons
Chief Operating Officer
Joint Commission on Accreditation of
Health Care Organizations

Beau Stubblefield, M.B.A.
Program Director, Division of Medical Affairs
American Medical Association

Linda Bresolin, Ph.D.
Director of Women's and Minority Health
American Medical Association

2:00 pm–2:30 pm

Break/Networking

Sponsored by the Norwegian American Hospital

2:30 pm–3:30 pm

**Keynote Address/Charge to
Workshop Participants**

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

3:30 pm–6:00 pm

Concurrent Workshops

Workshop A—Access to Health Care

Chairperson
Elsa Garcia, R.N.
Humana Health Plan
Chicago, Illinois

Regions V & VII

Illinois

Indiana

Iowa

Kansas

Michigan

Minnesota

Missouri

Nebraska

Ohio

Wisconsin

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Regions V & VII

Illinois
 Indiana
 Iowa
 Kansas
 Michigan
 Minnesota
 Missouri
 Nebraska
 Ohio
 Wisconsin

Co-Chairperson
Monica Medina, M.P.A.
 Hispanic Center
 Indianapolis, Indiana
 Reporter
Ivan de la Rosa
 University of Michigan

Workshop B—Data and Research

Chairperson
Flavio Marsiglia, Ph.D.
 Board of Education
 Cleveland, Ohio
 Co-Chairperson
Victoria Amaris
 St. Paul, Minnesota

Reporter
Mercedes Rubio
 University of Michigan

Workshop C—Health Professions

Chairperson
Socorro Roman, R.N., Ph.D.
 Indiana University Northwest

Co-Chairperson
Jorge Girotti, Ph.D.
 University of Illinois at Chicago

Reporter
Carman Abriego
 University of Illinois at Chicago

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Workshop D (1)—Health Promotion and Disease Prevention

Chairperson
Migdalia Rivera
 Executive Director, Latino Institute

Co-Chairperson
Connie Alfaro
 Michigan Department of Public Health

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Reporter
Virginia Lopez
 Clinica Sta. Maria
 Grand Rapids, Michigan

Workshop D (2)—Health Promotion and Disease Prevention

Chairperson
Steve Guerra
 Illinois Prevention Resource Center
 Chicago

Co-Chairperson
Cristina Jose, Ph.D.
 Eastern Michigan University

Reporter
Jose Avila
 Cudahy, Wisconsin

**6:00 pm–7:00 pm
 Chairs/Co-Chairs/Reporters Meeting**

**6:30 pm–7:30 pm
 Reception**

Mariachis Band
 Sponsored by Marion-Merrell Dow
 Pharmaceuticals, Inc.
 Hacienda Los Gutierrez Mexican Restaurant

**7:30 pm–10:00 pm
 Regional Award/Recognition Dinner**

Sponsored by Marion-Merrell Dow
 Pharmaceuticals, Inc.
 Entertainment by “Las Cuerdas Clasica”

Master of Ceremonies

Rod Sierra
 WGN Radio
 Chicago, Illinois

Invocation

The Reverend Ruben Cruz

Welcome Remarks

Steve Uranga McKane, M.D.M., M.P.H.
 Regional Co-Chairperson

Aida L. Giachello, Ph.D.
 Regional Co-Chairperson

Ira Bey
 District Manager
 Marion-Merrell Dow Pharmaceuticals, Inc.



Remarks

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

Awards Recognition Ceremony

Regional Awards

Main Awards

Special Awards

Regions V & VII

- Illinois
- Indiana
- Iowa
- Kansas
- Michigan
- Minnesota
- Missouri
- Nebraska
- Ohio
- Wisconsin

One

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Regions VI and VIII Executive Planning Committee

Arkansas

Colorado

Louisiana

Montana

New Mexico

North Dakota

Oklahoma

South Dakota

Texas

Utah

Wyoming

Chairpersons*Ciro V. Sumaya, M.D., M.P.H.T.M.*Associate Dean for Affiliated Programs and
Continuing Medical EducationUniversity of Texas Health Science Center at
San Antonio*Paula S. Gomez*

Executive Director

Brownsville Community Health Center

Associate Chairpersons*Amelie G. Ramirez, Dr. P.H.*Assistant Director for Administration
and Health PromotionSouth Texas Health Research Center
University of Texas Health Science Center
at San Antonio*Antonio Furino, Ph.D.*Professor of Economics and Director
Center for Health Economics and Policy
University of Texas Health Science Center
at San Antonio**Conference Coordinators***Virginia Seguin*Social Science Research Associate
South Texas Health Research Center
University of Texas Health Science Center
San Antonio, Texas*Ileana Fonseca*Research Assistant
Center for Health Economics and Policy
University of Texas Health Science Center
San Antonio, Texas**Members***Mary Bowers*Program Liaison Specialist (Minority Health)
U.S. Public Health Service, Region VI
Dallas, Texas*James A. Doss*Acting Regional Health Administrator
U.S. Public Health Service, Region VI
Dallas, Texas*Estevan Flores, Ph.D.*Coordinator of Research
Center for Studies in Ethnicity and
Race in America
University of Colorado at Boulder*Adela Gonzalez*Director
Department of Health and Human Resources
Dallas, Texas*Sue Hammett*Program Liaison Specialist (AIDS)
U.S. Public Health Service, Region VI
Dallas, Texas*Alberto Mata, Ph.D.*Associate Professor
Department of Human Relations
University of Oklahoma
Norman, Oklahoma*Oscar L. Medrano*Chief of Environmental Health
New Orleans Health Department
New Orleans, Louisiana*Hector Mena, M.D.*Representative for Nuevo Mexicanos for Health
Instructor, University of New Mexico at
Albuquerque*Virginia Ramirez*Co-Chair
Communities Organized for Public Service
San Antonio, Texas*Reymundo Rodriguez*Executive Associate
Hogg Foundation
University of Texas at Austin

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Hugh Sloan, D.S.W.

Acting Regional Health Administrator
U.S. Public Health Service, Region VIII
Denver, Colorado

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

Dean
Southwest Texas School of Health Professions
San Marcos, Texas

Chris Urbina, M.D.

Department of Family and Community Medicine
University of New Mexico

Pauline Valdez

Director, Hispanic Affairs
Salt Lake City, Utah

Jane Wilson

AIDS/Minority Health Coordinator
U.S. Public Health Service, Region VIII
Denver, Colorado

Regions VIII VIII

Arkansas

Colorado

Louisiana

Montana

New Mexico

North Dakota

Oklahoma

South Dakota

Texas

Utah

Wyoming

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Voice

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Regions VI and VIII Regional Health Meeting Agenda

- Arkansas
- Colorado
- Louisiana
- Montana
- New Mexico
- North Dakota
- Oklahoma
- South Dakota
- Texas
- Utah
- Wyoming

San Antonio, Texas

March 21, 1993

3:00 pm–5:00 pm
**Training Session for Chairs,
 Co-Chairs, and Recorders**

5:30 pm–7:30 pm
Registration

6:00 pm–8:00 pm
Reception

Introduction of Executive Planning Committee
 Guest Speaker
John P. Howe III, M.D.
 President
 University of Texas Health Science Center
 at San Antonio

March 22, 1993

7:30 am–8:30 am
**Registration and Continental
 Breakfast**

8:30 am–9:00 am
Invocation

Monsignor Balthasar Janacek
 Christ the King Parish
 San Antonio, Texas

Welcome
Ciro V. Sumaya, M.D., M.P.H.T.M.
 Associate Dean for Affiliated Programs and
 Continuing Medical Education
 University of Texas Health Science Center
 at San Antonio

Paula S. Gomez
 Executive Director
 Brownsville Community Health Center

Claudia R. Baquet, M.D., M.P.H.
 Deputy Assistant Secretary for Minority Health
 U.S. Public Health Service

**Overview of the Surgeon General's
 National Hispanic/Latino Health
 Initiative**

Lydia E. Soto-Torres, M.D., M.P.H.
 National Coordinator
 Surgeon General's National Hispanic/Latino
 Health Initiative
 Office of the Surgeon General

9:00 am–9:15 am
Keynote Address

The Honorable Donna E. Shalala, Ph.D.
(invited)
 Secretary
 U.S. Department of Health and Human Services

9:15 am–9:45 am
Charge to the Participants

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

9:45 am–9:55 am
**Regions VI and VIII Health
 Perspective**

Amelie G. Ramirez, Dr.P.H.
 Assistant Director for Administration and
 Community Health Promotion
 South Texas Health Research Center

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9:55 am–10:00 am**Introduction and Guidelines for the Work Groups***Antonio, Furino, Ph.D.*

Director

Center for Health Economics and Policy
University of Texas Health Science
Center at San Antonio**10:00 am–10:15 am****Break****10:15 am–12:00 pm****Work Group Session I**

(Review National and Regional Issues)

Access to Health Care

Chairperson

Estevan Flores, Ph.D.

Coordinator of Research

Center for Studies in Ethnicity and Race in America
University of Colorado at Boulder

Vice Chairperson

Oscar Medrano, M.P.H.

Chief of Environmental Health

New Orleans Health Department

Data

Chairperson

Adela Gonzales, M.P.A.

Director

Department of Health and Human Services
Dallas, Texas

Vice Chairperson

*Renato Espinoze, Ph.D.***Research Agenda**

Chairperson

*Christopher Urbina, M.D., M.P.H.*Department of Family and Community Medicine
University of New Mexico

Vice Chairperson

*Robert Trevino, M.D.***Health Professions**

Chairperson

Hector Mena, M.D.

Instructor

University of New Mexico at Albuquerque

Vice Chairpersons

*Janie Menchaca-Wilson, Ph.D., R.N.**John Alderete, M.A.***Health Promotion and Disease Prevention**

Chairperson

Pauline Voldez

Director of Hispanic Affairs

Salt Lake City, Utah

Vice Chairperson

*Louise Villejo, M.P.H., C.H.E.S.***12:00 pm–1:30 pm****Lunch****Guest Speaker***Patricia Montoya*

Executive Director

New Mexico Health Resources
Albuquerque, NM**1:30 pm–3:30 pm****Work Group Session II**

(Prioritize and Develop Issues)

3:30 pm–3:45 pm**Break****3:45 pm–6:00 pm****Work Group Session III**(Define Implementation Strategies and
Funding Sources)**6:30 pm–8:00 pm****Dinner**

Sponsored by Marion-Merrell Dow

Pharmaceuticals, Inc., Levi Strauss, Inc., and
Abbott Laboratories

Regions VI & VIII

Arkansas

Colorado

Louisiana

Montana

New Mexico

North Dakota

Oklahoma

South Dakota

Texas

Utah

Wyoming

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Vision

Regions VI & VIII

Arkansas

Colorado

Louisiana

Montana

New Mexico

North Dakota

Oklahoma

South Dakota

Texas

Utah

Wyoming

Speakers

James Doss, M.B.A.

Acting Regional Health Administrator
U.S. Public Health Service, Region VI

Hugh Sloan, D.S.W.

Acting Regional Health Administrator
U.S. Public Health Service, Region VIII

8:00 pm–9:00 pm

**Work Group Leaders and
Recorders Meeting**

March 23, 1993

7:30 am–8:00 am

Continental Breakfast

8:00 am–8:30 am

Guest Speakers

Maria Guajardo

Executive Director
Latin American Research and Service Agency
Denver, CO

Christopher E. Urbina, M.D., M.P.H.

University of New Mexico
Department of Family and Community Medicine
Albuquerque, NM

Joseph D. Diaz, M.D.

President
Mexican American Physician's Association

8:30 am–10:30 am

Work Group Reports

Moderator

Paula S. Gomez

Access to Health Care

Estevan Flores, Ph.D.

Research

Christopher Urbina, M.D., M.P.H.

Data

Adela Gonzalez, M.P.A.

Representation

Hector Mena, M.D.

Health Promotion and Disease Prevention

Pauline Valdez

10:30 am–10:45 am

Break

10:45 am–12:00 pm

Responder Panel

Moderator

Ciro V. Sumaya, M.D., M.P.H.T.M.

Ledy Garcia-Eckstein

Policy Advisor
Office of the Governor
Denver, CO

Reymundo Rodriguez, M.Ed., M.P.A.

Executive Associate
Hogg Foundation
University of Texas at Austin
Austin, TX

Mario Griffin

Manager of Contributions
Levi Strauss Foundation
El Paso, TX

Bryan Sperry

Deputy Commissioner
Health and Human Services Commission
Austin, TX

Charles B. Mullins, M.D.

Executive Vice Chancellor for Health Affairs
The Office of University of Texas System
Austin, TX

12:00 pm–1:30 pm

Luncheon

Featured Speaker

Senator Don Mares

Denver, CO

Closing Remarks

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

Surgeon General



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Regions I, II, and III Executive Planning Committee

Regions I, II, & III

Chairperson

Dr. Marilyn Aguirre-Molina

Robert Wood Johnson Medical School
University of Medicine and Dentistry of New Jersey
Piscataway, NJ

Co-Chairpersons

Carlos Perez

Department of Health
New York State
New York, NY

Raymond Porfilio

U.S. Public Health Service
Region II
New York, NY

Members

Hortensia Amaro, Ph.D.

Boston University School of Public Health
Boston, MA

Mercedes Barnet

Office of Minority Health
Commonwealth of Massachusetts
Boston, MA

Aixa Beauchamp

New York Community Trust
New York, NY

Mercedes Benitez-McCraday

University of Medicine and Dentistry of New Jersey
Newark, NJ

Leslie Boden

Office of Bronx Borough President
Bronx, NY

Oscar Camacho, Jr.

Governor's Office of Hispanic Affairs
New York State
New York, NY

Emilio Carrillo, M.D., M.P.H.

William Ryan Community Health Center
New York, NY

Gilberto Cardonas, M.D.

U.S. Public Health Service
New York, NY

Lorraine Cortes-Vazquez

Aspira of New York, Inc.
New York, NY

Christina Cuevas

The Ford Foundation
New York, NY

Carola Eisenberg, M.D.

Harvard University
Cambridge, MA

Sandra Estepa

Latino Commission on AIDS
New York, NY

Rafael Lantigua, M.D.

College of Physicians and Surgeons
Columbia University
New York, NY

Ana M. Lopez Fontana, M.S.

National Conference of Puerto Rican Women
New York, NY

Father Vidal Martinez

La Asuncion Church
Perth Amboy, NJ

Hermann Mendez, M.D.

Brooklyn Pediatric AIDS Network
Brooklyn, NY

Carlos Molina, Ed.D.

York College
City University of New York
Jamaica, NY

Hildamar Ortiz, Esq.

New York City Health and Hospital Corp.
New York, NY

Carmen I. Paris

Philadelphia Department of Health
Philadelphia, PA

Connecticut

Delaware

Maine

Maryland

Massachusetts

New Hampshire

New Jersey

New York

Pennsylvania

Puerto Rico

Rhode Island

Vermont

Virginia

Virgin Islands

Washington, DC

West Virginia

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Regions I, II, & III

Connecticut	Belkis Pimentel-Mateo Boricua Health Organization Piscataway, NJ
Delaware	Annette Ramirez de Arellano National Hispanic Council on Aging New York, NY
Maine	
Maryland	
Massachusetts	Nancy Reyes-Svarcbergs, R.N., M.S.N New Jersey State Department of Health Trenton, NJ
New Hampshire	
New Jersey	Jenny Romero Boricua Health Organization Piscataway, NJ
New York	
Pennsylvania	
Puerto Rico	John Sepulveda Connecticut State Department of Health Hartford, CT
Rhode Island	
Vermont	Stephanie Siefken New York City Department of Health New York, NY
Virginia	
Virgin Islands	
Washington, DC	Hector Velazquez National Puerto Rican Forum New York, NY
West Virginia	

Technical Advisory Group

Regional Health Administrators
Andrew G. Johnston U.S. Public Health Service, Region I Boston, MA
Norman C. Dittman U.S. Public Health Service, Region II Philadelphia, PA
Regional Program Liaison to the Executive Planning Committee
Sunchita F. Tyson Public Health Service, Region II New York, NY
Regional Representation on the Executive Planning Committee
Janet Scott-Harris U.S. Public Health Service, Region I Boston, MA
Emory Johnson U.S. Public Health Service, Region III Philadelphia, PA

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Host Committee

Moises Perez
Executive Director
Alianza Dominicana

Lorraine Cortes-Vaquez
Executive Director
Aspira of New York, Inc.

Belkis Pimental-Mateo
National President
Boricua Health Organization

Jane Delgado, Ph.D.
President
COSSMHO

Christina Cuevas
Program Officer
Ford Foundation

Aixa Beauchamp
Program Officer
Hispanics in Philanthropy

Walter Alicea
President
Hispanic Society - N.Y.C. Police Department

Isaura Santiago, Ph.D.
President
Eugenio Maria de Hostos Community College
City University of New York

Angelo Falcon
President and Founder
Institute for Puerto Rican Policy, Inc.

Ricardo Fernandez, Ph.D.
President
Lehman College
City University of New York

Dennis Rivera
President
Local 1199
Union of Health Workers

Margaret Hamburg, M.D.
Commissioner
New York City Department of Health

The Honorable Fernando Ferrer
President
Office of the Bronx Borough President

Congressman Jose Serrano
The Bronx, New York

Congresswoman Nydia Velazquez
Brooklyn-Queens-New York, New York

Felix Cruz
Director, Office of Minority Affairs
Office of the Governor
State of New Jersey

Marlene Cintron de Frias
Director, Office of Hispanic Affairs
Office of the Mayor
City of New York

Raymond Porfilio
Office of the Regional Administrator
U.S. Public Health Service, Region II

Jaime Rivera-Dueno, M.D.
Executive Director
San Juan AIDS Institute, Puerto Rico

Susan S. Addiss, M.P.H., Mu.R.S.
Commissioner, Administration
Department of Health Services
State of Connecticut

Bruce Siegel, M.D., M.P.H.
Office of Minority Health
Department of Health
State of New Jersey

Mark Chassin, M.D., M.P.H.
Commissioner
Department of Health
State of New York

Ana Lopez Fontana
President
National Conference
of Puerto Rican Women

Regions I, II, & III

Connecticut

Delaware

Maine

Maryland

Massachusetts

New Hampshire

New Jersey

New York

Pennsylvania

Puerto Rico

Rhode Island

Vermont

Virginia

Virgin Islands

Washington, DC

West Virginia

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Regions I, II, & III

Connecticut
Delaware
Maine
Maryland
Massachusetts
New Hampshire
New Jersey
New York
Pennsylvania
Puerto Rico
Rhode Island
Vermont
Virginia
Virgin Islands
Washington, DC
West Virginia

Raul Yzaguirre
President
National Council of La Raza

Hector Velazquez
President
National Puerto Rican Forum

Stanley H. Bergen, M.D.
University of Medicine and
Dentistry of New Jersey

Norman Edelmann, M.D.
Dean
University of Medicine and
Dentistry of New Jersey
Robert Wood Johnson
School of Medicine

Jose M. Saldana, D.M.D., M.P.H.
President
University of Puerto Rico

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Voice



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Regions I, II, and III Regional Health Meeting Agenda

Newark, New Jersey/New York, New York

Regions I, II, & III

Connecticut
 Delaware
 Maine
 Maryland
 Massachusetts
 New Hampshire
 New Jersey
 New York
 Pennsylvania
 Puerto Rico
 Rhode Island
 Vermont
 Virginia
 Virgin Islands
 Washington, DC
 West Virginia

April 14, 1993

4:00 pm–5:30 pm

Executive Planning Committee Meeting with the Surgeon General

4:00 pm–8:00 pm

Registration

6:00 pm–7:30 pm

Reception

Hosted by the University of Medicine and Dentistry of New Jersey

8:00 pm–9:30 pm

Meeting of Speakers, Facilitators, and Recorders

April 15, 1993

7:30 am–3:00 pm

Registration

7:30 am–8:30 am

Continental Breakfast

8:30 am–10:00 am

Plenary Session I

Call to Order and Welcome

Marilyn Aguirre-Molina, D.Ed.

Chair, Regional Executive Planning Committee

Greetings

Representative

Office of Minority Health

U.S. Public Health Service

Raymond Porfilio

Acting Regional Health Administrator
 U.S. Public Health Service, Region II, and on behalf of Regions I and III

The Honorable Enrique Vazquez Quintana, M.D.

Secretary of Health
 Commonwealth of Puerto Rico
 On behalf of the Governor of Puerto Rico

Bruce Siegel, M.D., M.P.H.

Commissioner
 New Jersey State Department of Health

Oscar Camacho, Jr.

Deputy Director
 New York State Governor's Office of Hispanic Affairs

Yvette Melendez Thiesfield

Deputy Commissioner
 Connecticut State Department of Health Services

Overview of the Surgeon General's National Hispanic/Latino Health Initiative

Lydia E. Soto-Torres, M.D., M.P.H.

National Coordinator
 Surgeon General's National Hispanic/Latino Health Initiative

Introduction of Keynote Speaker

Hector Velazquez

President
 National Puerto Rican Forum

Keynote Address

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

Surgeon General
 U.S. Public Health Service

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Regions I, II, & III

Connecticut

Delaware

Maine

Maryland

Massachusetts

New Hampshire

New Jersey

New York

Pennsylvania

Puerto Rico

Rhode Island

Vermont

Virginia

Virgin Islands

Washington, DC

West Virginia

10:00 am–11:15 am**Regional Health Issues****Access to Health Care***J. Emilio Carillo, M.D., M.P.H.*

Medical Director

William F. Ryan Community Health Center

New York, NY

Data Collection*Olivia Carter-Pokras, M.S.*

Public Health Analyst

Office of Minority Health

U.S. Public Health Service

Representation in the Health Professions*Stanley S. Bergen, Jr., M.D.*

President and Professor of Medicine

University of Medicine and Dentistry of New Jersey

Research Agenda*Ruth E. Zambrana, Ph.D.*

Center for Medical Effectiveness Research

National Institutes of Health

U.S. Public Health Service

Health Promotion and Disease Prevention*Annette Ramirez de Arellano, Dr.P.H.*

Chairperson

National Hispanic Council on Aging

New York Chapter

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11:15 am–11:30 am**Break****11:30 am–12:30 pm****Work Group Session A**

Problem Identification

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Vision

Access to Health Care

Facilitator

Edwin Mendez-Santiago

Executive Director

Raices, Inc.

New York, New York

Recorder

Nancy Reyes-Svarcbergs, R.N., M.S.W.

Outreach Coordinator

Office of Minority Health

New Jersey State Department of Health

Data Collection

Facilitator

Olivia Carter-Pokras, M.S.

Public Health Analyst

Office of Minority Health

U.S. Public Health Service

Recorder

John Sepulveda

Manager Analyst

Office of Health Policy Development

Connecticut Department of Health Services

Health Professions

Facilitator

Rene Rodriguez, M.D.

President

Inter-American College of Physicians and Surgeons

Recorder

Maria Soto-Green, M.D.

Physician

University of Medicine and

Dentistry of New Jersey

Research Agenda

Facilitator

Barbara S. Menendez, Ph.D.

Assistant Professor

Lehman College

City University of New York

Recorder

To Be Announced

Health Promotion and Disease Prevention

Facilitator

Carlos Molina, Ed.D.

Vice President for Academic Affairs

York College

City University of New York

Recorder
Leslie Boden, M.S.
 Associate Director of Health and
 Human Services
 Bronx Borough President's Office

12:30 pm–2:00 pm

Luncheon

Invocation

Father Vidal Martinez, O.S.M.

Introduction of Guest Speaker

Rafael Lantigua, M.D.
 Associate Clinical Professor of Medicine
 College of Physicians and Surgeons
 Columbia University

Guest Speaker

*The Honorable Enrique Vazquez
 Quintana, M.D.*
 Secretary of Health
 Commonwealth of Puerto Rico

2:00 pm–5:00 pm

Work Group Session B

Development of Recommendations
 and Strategic Action Plans

6:30 pm–8:30 pm

Awards Dinner and Cultural Event

Performance by Grupo Folklorico de la Alianza
 Dominicana

8:45 pm–9:45 pm

**Meeting of Facilitators and
 Recorders**

April 16, 1993

7:30 am–8:30 am

Continental Breakfast

8:30 am–10:00 am

Work Group Session C

Final Review of Recommended Strategies and
 Preparation for Presentation

10:00 am–10:15 am

Nutrition Break

10:15 am–12:00 pm

Plenary Session II

Work Group Presentations

Presiding
Marilyn Aguirre-Molina, D.Ed.
 Chairperson, Regional Executive Planning
 Committee

Carlos Perez, M.P.A.
 Co-Chairperson, Regional Executive Planning
 Committee

12:30 pm–1:30 pm

Luncheon

Invocation

Father Vidal Martinez, O.S.M.

Introduction of Guest Speaker

Lorraine Cortes-Vazquez, M.P.A.
 Executive Director
 Aspira of New York

Guest Speaker

The Honorable Nydia Velazquez
 U.S. Congresswoman

1:30 pm–2:00 pm

Closing Remarks

Where Do We Go From Here?

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

Regions I, II, & III
 Connecticut
 Delaware
 Maine
 Maryland
 Massachusetts
 New Hampshire
 New Jersey
 New York
 Pennsylvania
 Puerto Rico
 Rhode Island
 Vermont
 Virginia
 Virgin Islands
 Washington, DC
 West Virginia

One
 Voice

One
 Vision

Regions IX and X Executive Planning Committee

Alaska

American Samoa

Arizona

California

Guam

Hawaii

Idaho

Nevada

Oregon

Trust Territory of
the Pacific Islands

Washington

Co-Chairpersons*Castulo de la Rocha, J.D.*President and Chief Executive Officer
AltaMed Health Services Corporation
Los Angeles, California*Helen Rodriguez-Trias, M.D.*President
American Public Health Association
Brookdale, California**Vice-Chairpersons***John Whitney*Regional Health Administrator
U.S. Public Health Service, Region IX
San Francisco, California*Dorothy Mann, M.P.H.*Regional Health Administrator
U.S. Public Health Service, Region X
Seattle, Washington**Coordinators***Jose Fuentes*Department of Health Services
San Francisco, California*J. O'Neal-Adams*Minority Health Coordinator
U.S. Public Health Service, Region X
Seattle, Washington**Members***Gabriel Arce*Chief Executive Officer
San Ysidro Health Center/Community
Health Group
Chula Vista, California*Maria Becerra-Cruz, M.P.H.*Program Assistant
California Area Health Education Center
Fresno, California*Diana M. Bonta, Dr.P.H.*Director
Department of Health and Human Services
City of Long Beach
Long Beach, California*Luis Caraballo*Attorney at Law
Office of Immigration Coordination Chair
Governor's Immigration Coordination Committee
Portland, Oregon*Tina Castanares, M.D.*La Clinica del Carino
Hood River, Oregon*Francisco Castillon, J.D.*Executive Director
California Health Federation, Inc.
Sacramento, California*Adela de la Torre, Ph.D.*Chair, Chicano and Latino Studies
California State University
Long Beach, California*Eunice Diaz, Ph.D., M.P.H.*Commissioner
National Aids Commission
Infant Mortality Commission
Santa Barbara, California*Steven Escoboza*Director
Santa Barbara County Health Care Services
Santa Barbara, California

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Jose Fernandez

Director, Medical Services
State Department of Health Services
Sacramento, California

George R. Flores, M.D., M.P.H.

Public Health Officer
Sonoma County Public Health Department
Santa Rosa, California

Robert Gomez

President
National Associations of Community Health Centers
Tucson, Arizona

Priscilla Gonzalez, R.N.

Chief
Health Careers Opportunity Program
Sacramento, California

David Hayes-Bautista, Ph.D.

Director
UCLA Center for the Study of Latino Health
Los Angeles, California

Dan R. Jimenez, Ph.D.

Director of Urban Affairs
Kaiser Permanente Health Plan
Pasadena, California

Rosalio Lopez, M.D.

General Practitioner
Artesia, California

Lia Margolis

Director, Planning Division
Public Health Program and Services
County Health Services
Los Angeles, California

Makota Nakayama

President and Chief Executive Officer
San Gabriel Valley Medical Center
San Gabriel, California

Gilbert M. Ojeda

Latino Health Affairs Council
Berkeley, California

J. Carlos Olivares

Executive Director
Yakima Valley Farmworker Clinic
Toppenish, Washington

Stan Pallida

Medical Director
Qual-Med Health Plan
San Francisco, California

Roberto Reyes Colon

SLIAG Program Coordinator
Governor's Immigration Coordinating Committee
Salem, Oregon

Rogelio Riojas

Executive Director
Sea Mar Community Health
Seattle, Washington

Elena V. Rios, M.D., M.S.P.H.

President
Chicano/Latino Medical Association
of California
Sacramento, California

Roberta Salazar

Monterey Park, California

Chris Sandoval

Section Manager and Director of AIDS Services
Men's and Women's Health Department
San Jose, California

Wayne Sausada

Director, Office of AIDS/SIDA
California Department of Health Services
Sacramento, California

Regions IX and X

- Alaska
- American Samoa
- Arizona
- California
- Guam
- Hawaii
- Idaho
- Nevada
- Oregon
- Trust Territory of the Pacific Islands
- Washington

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Voice

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Regions IX and X Regional Health Meeting Agenda

Alaska
 American Samoa
 Arizona
 California
 Guam
 Hawaii
 Idaho
 Nevada
 Oregon
 Trust Territory of
 the Pacific Islands
 Washington

Los Angeles, California

April 19, 1993

8:00 am–8:30 am

Registration

8:30 am–10:00 am

Opening/Welcoming Session

Moderator

Castulo de la Rocha, J.D.

Lydia E. Soto-Torres, M.D., M.P.H.

National Coordinator

Surgeon General's National Hispanic/Latino
 Health Initiative

Donna E. Shalala (invited)

Secretary of Health and Human Services

Claudia R. Baquet, M.D., M.P.H. (invited)

Deputy Assistant

Secretary for Minority Health

U.S. Public Health Service

Charge to Conference Participants

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

Surgeon General

10:00 am–10:15 am

Break

10:15 am–12:15 pm

**Plenary Session: Regional Health
 Issues**

Moderators

Diana Bonta, R.N., Dr.P.H.

Carlos Olivares

Panelists

Access to Health Care I and II

Carmela Castellano, Esq.

Richard Figueroa

Carlos Olivarez

Gladys Sandlin

Data Collection

David Hayes-Bautista, Ph.D.

Jane Delgado, Ph.D.

Health Professions

Robert Montoya, M.D., M.P.H.

Priscilla Gonzalez-Leiva, R.N.

Research Agenda

Adela de la Torre, Ph.D.

Miguel Tirado, Ph.D.

Health Promotion and Disease Prevention I and II

Diana Bonta, Dr.Ph.

George Flores, M.D., M.P.H.

Chris Sandoval

Lia Margolis

12:15 pm–1:45 pm

Luncheon

Master of Ceremonies

George Flores, M.D., M.P.H.

Welcome

Robert Gates

Director

Los Angeles County Health Services Agency

Empowering State and Local Actions

Art Torres

California State Senator

Chairman, Committee on Insurance

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Vision

1:45 pm–3:15 pm

**Work Group Sessions (5 areas,
7 sub-groups)**

Experts in Issue Areas

**Access I—Impact of Health Reform
Proposals on Latinos**

Carmela Castellano, Esq.

Richard Figueroa

Bob Valdez, Ph.D.

Richard Valdez, Ph.D.

Richard Veloz, J.D., M.P.H.

Jose Fernandez

Helen Rodriguez-Trias, M.D.

Antonio Sanchez

**Access II—Health Care for Latinos
in Underserved Areas: Emphasis on
Needs of Special Populations**

Carlos Olivares

Gladys Sandlin

Francisco Castillon, M.P.A.

Barbara Garcia

Jane Garcia, M.P.H.

Sylvia Villarreal, M.D.

Hector Flores, M.D.

**Data Collection—State and Local
Actions: Promoting Federal Linkages**

David Hayes-Bautista, Ph.D.

Jane Delgado, Ph.D.

Ed Mendoza, M.P.H.

Fernando Mendoza, M.D., M.P.H.

Leo Estrada, Ph.D.

Adolfo Falcon, Ph.D.

**Health Professions—Reforms in
Health Professional Development**

Robert Montoya, M.D., M.P.H.

Priscilla Gonzalez-Leiva, R.N.

Elena V. Rios, M.D., M.P.H.

Margie Beltran

Ed Martinez, M.H.A.

Carmen Vasquez

**Research Agenda—Creating Public,
Private, and Community
Partnerships**

Adela De La Torre, Ph.D.

Miguel Tirado, Ph.D.

Carmen Portillo, Ph.D.

Eliseo Perez Stable, M.D.

**Health Promotion and Disease
Prevention I—Latino Public Health
Issues and Policies**

Diana Bonta, Dr.Ph.

George Flores, M.D.

Carmen Navarez, M.D.

Eunice Diaz, Ph.D.

Steve Escoboza

Guadalupe Olivas, M.D.

**Health Promotion and Disease
Prevention II—Healthy Latinos:
Successful Programs and Strategies**

Chris Sandoval

Lia Margolis

Henry Montes

Sylvia De Trinidad

Tony Najera

Maria Becerra-Cruz

Wayne Sauseda

Note: Emphasis on prioritizing national findings and interpreting their relevance in various States and regions; invitees will receive outlines and questions that will facilitate their participation.

3:15 pm–3:30 pm

Break

3:30 pm–5:00 pm

Work Group Sessions II

Note: During this second set of sessions, the groups will focus on specifying doable actions at the local and State level to implement priority findings.

5:00 pm–6:30 pm

**Work Group Session Followup:
Meetings of Issue Coordinators and
Facilitators**

State Breakout Sessions

Regions IX and X

Alaska

American Samoa

Arizona

California

Guam

Hawaii

Idaho

Nevada

Oregon

Trust Territory of
the Pacific Islands

Washington

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Regions IX and X

- Alaska
- American Samoa
- Arizona
- California
- Guam
- Hawaii
- Idaho
- Nevada
- Oregon
- Trust Territory of the Pacific Islands
- Washington

6:00 pm–7:00 pm

Reception

7:00 pm–9:30 pm

Reception and Dinner

Speakers

Richard Veloz, J.D., M.P.H.

National Health Care Reform Task Force

Liaison to the Congressional Hispanic Caucus

Bob Valdez, Ph.D.

Professor

UCLA School of Public Health

National Health Care Reform Task Force Member

April 20, 1996

9:00 am–10:15 am

Work Group Sessions III

Note: During this third set of sessions, the groups will focus on how to forge effective coalitions among Latinos and with other communities of color, the private sector, and government.

10:15 am–10:30 am

Break

10:30 am–11:45 am

Closing Plenary Session

Moderators

Gilbert M. Ojeda

Sandra Hendricks

Work Group Reports

State-by-State Summary Statements

Reaction Panel

Note: Persons would be designated by State to prepare statements on the expected impact in their State for actions and policies endorsed by Work Groups.

12:45 pm–2:00 pm

Luncheon

Master of Ceremonies

Castulo de la Rocha, J.D.

Keynote Speaker

Jose Fernandez

Director of Medical Services

California Department of Health Services

Closing Remarks

**Where Do We Go From Here:
Latino Health Initiative Projected
Outcomes**

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

Surgeon General

Appendix D: Regional Sponsors and Co-Sponsors

Miami:

Co-Sponsors:

Public Health Service, Region IV
Office of Minority Health, Region IV
Food and Drug Administration, Southeast Region
Miami Children's Hospital
Little Havana Activities and Nutrition Centers
of Dade County

Additional Co-Sponsors:

CAC-Ramsay Health Plans
Delta Business Systems
IBM
U.S. Printers & Lithographers, Inc.

Chicago:

Co-Sponsors:

Health Resources & Services Administration
Bureau of Maternal and Child Health
Public Health Service Office, Region V
Public Health Service Office, Region VII

Sponsoring Corporations:

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W.K. Kellogg Foundation
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Blue Cross & Blue Shield of Illinois
Chicago HMO

Additional Co-Sponsors:

American Medical Association
Chartwell Midwest
Chicago Department of Health
Chicago Hispanic Health Coalition
Chicanos/Latinos Unidos En Servicio (CLUES)
City of Cleveland

Commission on Latino Affairs
Eastern Michigan University
Effort for AIDS, St. Louis
El Centro Hispano, Indianapolis
Good Samaritan, Kansas City
Health & Medicine Policy Research Group
Home Visits Plus
Humana Health Care Plans
Illinois Department of Children & Family Services
Illinois Department of Public Health
Indiana University Northwest, Gary
Iowa Health Department, Des Moines
Kansas Department of Health and Environment,
Kansas City
La Hacienda de Los Gutierrez Restaurant
La Raza Newspaper
L.U.L.A.C. Midwest Education
Michigan Department of Public Health
Midwest Farmworker Employment and
Training, St. Paul
Midwest Hispanic AIDS Coalition
Minnesota Department of Health, Minneapolis
Missouri Department of Health
Nebraska Department of Health, Lincoln
Norwegian American Hospital
Ohio Commission on Minority Health, Columbus
Ohio Department of Health, Columbus
Presbyterian St. Luke's Hospital
Sinai Samaritan Medical Center, Milwaukee
Smith Barney, Harris Upham & Co., Inc.
Staff Builders
University of Illinois at Chicago, Jane Addams
College of Social Work
University of Illinois at Chicago,
Chancellor's Office
University of Illinois at Chicago, College of
Medicine's Hispanic Center for Excellence

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Valet Parking Services
Walgreens Corporation
West Side Health Center, St. Paul
Wisconsin Department of Health, Madison
Witchita State University
WSNS, Telemundo Channel 44

San Antonio:

Sponsors:

U.S. Department of Health and Human Services
The University of Texas Health Science Center
at San Antonio

Co-Sponsors:

The Bureau of Health Professions, Health
Resources and Services Administration
Brownsville Community Health Center
Center for Health Economics and Policy
National Hispanic Leadership Initiative on Cancer
Public Health Service Office, Region VI
Public Health Service Office, Region VIII

Supporters:

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Area Health Education Center of South Texas
Levi Strauss, Inc.
Mexican American Physicians' Association
Mesilla Valley Psychiatric Hospital
Southwestern Bell Telephone Company
The University of Texas Health Science Center
Austin Minor Emergency Clinic

New York:

Co-Sponsors:

Public Health Service, Regions I, II, and III

Contributors:

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W.K. Kellogg Foundation
Brooklyn Union Gas
Marion-Merrell Dow Pharmaceuticals, Inc.

Los Angeles:

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California State Office of AIDS
CareAmerica
FPH
Intergroup Health Corporation
James Irvine Foundations
Kaiser Permanente Southern California
Marion-Merrell Dow Pharmaceuticals, Inc.
National Council of La Raza
National Health Service Corps
PacifiCare Health System
Sisters of Providence
Southern California Edison

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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

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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.

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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,

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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

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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*

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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

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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.

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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?*

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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

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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

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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

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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

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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

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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

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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

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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.

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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

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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

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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

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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.

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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

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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

comprise only 3.5 percent of all master's students in the U.S. in 1990, and Hispanic-Americans received 7,905 master's degrees in 1989, which was 2.5 percent of all such degrees.

Now, it's important for us to rid ourselves of the belief that Hispanic students go on to professional schools. Hispanic first professional school enrollments increased only from 2 percent in 1980, to 3.5 percent in 1990. Now, in actual enrollments, the number went from 7,000 to 10,000 students. Hispanic students are not being diverted from graduate school by professional school enticements; they are not necessarily going into professional degree programs. GMAT data show that only 1.1 percent of all the GMAT test-takers in 1989 were Chicanos, and only 0.7 percent were Puerto Ricans. And in terms of law school, to quote a colleague of mine, Law Professor Michael Olivas, "Hispanics are not flocking to law school." There were approximately 5,000 Hispanics enrolled in law schools in 1990 for only 3.8 percent of the total, and the situation is equally dismal in other professional fields.

I suspect you've had an opportunity to talk about what the Hispanic representation is in the schools of medicine and allied health fields. In 1989, the number of Hispanic college graduates with science degrees was 1,682. Of those, a good part of them—1,338—applied to medical school. In 1990, Hispanic Americans constituted only 5.6 percent of all first year students enrolled in U.S. medical schools. The total enrollment, or the enrollment of Hispanic-American students in medical schools in 1990, was also 5.4 percent, and I suspect that Hispanic-American representation in the other health professions—nursing, dentistry, pharmacy, physical therapy, research in bioscience areas, public health, health administration, health policy—is equally low as it has been documented for these others.

One particular concern is the alarmingly small number of Hispanic U.S. citizens that are earning

doctorate degrees. We argue strenuously that those small numbers are a critical stumbling block in our ability to change the face of U.S. higher education. In 1989–1990, the total number of doctorates awarded in the United States was 37,980. Of that number, only 783 doctorates, or 2.1 percent, were awarded to Hispanics. These degrees represent 2.6 percent of the doctorates awarded to U.S. citizens that year. Hispanic Ph.D.s represent approximately 1.7 percent of all doctorate degree recipients in the sciences and mathematics. Now, while there have been fluctuations in the number of doctoral degrees awarded to Hispanics over the last 10 years, the overall share has not increased substantially, with the actual numbers remaining minuscule. Clearly, the dearth of Hispanic Ph.D. recipients has reached a critical level in terms of participation in academia and in research and development. One obvious outcome of such poor postbaccalaureate attainment rates is that Hispanics constitute approximately 2 percent of university faculty and about 2.3 percent of full-time postsecondary education administrators.

Your conference provides a golden opportunity to address the national resource needs for Hispanic representation in the medical profession and allied health fields. Given the already noted dismal participation levels of Hispanics in graduate education and in the postsecondary education teaching and administrative ranks overall, much remains to be done.

HACU shares the belief that the soundest method for increasing the number of Hispanics with doctorates and professional degrees is to enhance the awareness of college research and teaching careers among Hispanic students at earlier stages in the collegiate experience. We just cannot continue to cream the cream. We have to work strenuously to expand that pool. Hispanics need to be informed of opportunities for doctoral study and the career advantages that can be afforded to them from pursuit of a career in medicine and health. Only by

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such targeted interventions can we create a larger pool at the undergraduate level of potential medical and related health professionals.

In addition, HACU strongly believes that increased Federal support for such study is an essential element for correcting the current shortfall of Latino health professionals. It is critical that these considerations be addressed. HACU seeks to bring attention to the particular human resource needs of HSIs. Increasing the number of Latino faculty will have a broad-reaching and sustained effect of providing appropriate role models for undergraduate students moving through the educational stream. At every level from grade school to graduate school, Latinos lag in academic achievement.

There is progress, and I don't mean to paint such a dismal picture. As I noted earlier, our numbers have increased. We just don't think that they have increased significantly enough to make a difference because, if every student that you have in your medical programs now graduated tomorrow, it would still be a drop in the bucket.

Although the gap between Hispanics and other groups has widened in terms of education, there are some preliminary data from both programs that HACU runs at the precollege level as well as work done by colleagues of ours working with Hispanic community-based education efforts that suggest that community-based programs can lead to significant measurable improvements in student performance as well as significant increases in parent and community involvement in the educational process. I underscore the latter because it's only by working at those early levels that we can ensure ourselves of a better stream, a fuller stream, more representative of the numbers involved, subsequently coming through programs later on. I will encourage us not to look for just piecemeal, quick fixes. I think those would not be sufficient for our country's needs.

It's my sense that many of us have come to the conclusion that we are all interdependent and that our strategies will succeed if we have viable partnerships and lots of friends. We all recognize that Hispanic students face monumental challenges. If they are to achieve and attain beyond the isolated and piecemeal types of successes we find here and there, institutions such as the Department of Health and Human Services, PHS, and community-based organizations must enter into new and even more creative collaborative relationships.

HACU is in the position to serve as a conduit in this respect. You have out in the field some of the best programs targeted at providing the early career awareness and support for students within the pipeline. We just don't have enough of them. A case in point is the Health Careers Opportunities Program: I counted about seven such programs funded in our 118 HSIs. That tells you that there's not enough connection to Hispanics. The Minority Biomedical Research Support Program (MBRS Program), the MART programs, the minority high school student research apprenticeships, the Health Service Corps—how much are these entities really targeting our students? We must do a better job of somehow bringing them into a better focus with our institutions, both our community-based institutions and our institutions at the postsecondary level. I suggest that you consider how you can expand and maybe even consider other reauthorizations and legislative vehicles to bring attention to the Latino dimension of our minority equation.

There are 38 HSIs that offer health science degrees at the 2-year college level. At the 4-year college level, among our HSIs, we have 31 schools that offer a variety of baccalaureate and master's degrees, etc., in health science. In terms of allied health, at the community college level, 38 HSIs offer degree programs. Twenty-three 4-year HSIs offer bachelor's or higher degree programs in allied health. In terms of life sciences, 21 2-year HSIs offer degree programs and 39 4-year HSIs offer a

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variety of baccalaureate degrees or higher. Twenty-one 2-year HSIs and 31 4-year HSIs offer degrees in mathematics. Seventeen undergraduate HSIs, 17 community college HSIs, and 33 4-year HSIs offer a variety of degrees in psychology. What we don't have is a lot of medical schools. We do have our programs in Puerto Rico, and I think a lot of us on the mainland often give short shrift to the benefits of our institutional systems on the island. It behooves us to consider how we can better tie both the programs and the flow of students, faculty, and resources of our schools on the island to the needs here on the mainland.

One of the things that I learned about this past year is the development of the new Hispanic Centers of Excellence in the United States. The numbers of the Latino students in the Centers of Excellence are not what they should be, so I would encourage that those Centers of Excellence receive a lot more funding. The funding that was divided among those institutions was paltry. Such a situation is intolerable. There are more than 400,000 students in those institutions. It's a fact that has been taken up with some notice by our friends in the Federal bureaucracies. As bad as things are for us obviously in health, they're not much better in the other professional fields, and so we have had other agencies who have had that light bulb come on and say, "Ah, can we work with you guys to get these students thinking about careers in agricultural science and various other technology and math fields?"

HACU is not a panacea to the larger issue of gross underrepresentation of Hispanics. We have to work at building strong partnerships. That's why I emphasize strengthening the precollege as well as the postsecondary linkages so that the students that come in don't fall out, so that you can be guaranteed that you're going to have students being tracked through these institutional linkages, and so that you're going to have students prepared to go into your advanced programs.

Approximately 138,000 students are enrolled in Puerto Rican institutions. You have another 222,000 in California alone. The California system of higher education is structured in such a way that 68 percent of those students are in community colleges. If we want to have a significant impact on pulling many of these students into health professions, we have to be creative at finding ways to bring health career opportunities to community colleges. Not that we start there; I'm suggesting we start much earlier. We have to find ways to engage all the segments in implementing additional ways to bring Hispanic students into health professions, hold them, and carry them through the process.

Eleanor Chelimsky

Assistant Comptroller General
U.S. General Accounting Office

It's a great pleasure to be here. Today what I thought I'd do is talk about the GAO report that I see most of you have received and our work generally on Hispanic Americans and especially their access to health care. Let me begin by presenting a short profile of the Latino population living in the United States and then move on to a discussion of five specific barriers to health care that they currently face.

Latinos make up the second largest and also the fastest growing minority group in the United States. We tend to have only a one-sided picture of the issues. We hear a lot more about machismo, for example, than about the strength and cohesiveness of Latino families, more about high rates of diabetes than about low rates of infant mortality, more about school dropouts than about the achievements of Latinos in all areas of American life. Is this because we're a problem-oriented society with a strong belief in the idea "if it ain't broke, don't fix it"? Is it because we get our information mostly from whatever data the media may choose to report? Or is it because we simply haven't come around yet to a very balanced

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understanding of the diverse Hispanic population rooted and growing in our midst?

The fact is that, since 1980, the Hispanic population has experienced phenomenal growth, up from 9 million people in 1970 to 21 million people today. This is largely a result of two factors—a high birth rate and massive immigration—both of which lead, in turn, to a relatively youthful Latino population having a median age of 26, compared with 34 for non-Hispanics. In a nutshell, about 1 of every 12 persons in the United States today is Hispanic, and by the turn of the century Latinos will be our largest single ethnic group. So we've seen dramatic increases in size for the Hispanic population but much slower progress in socio-economic standing.

About one in four Latinos lived in poverty in 1989. That's about the same as it was in 1980. And that compares to only one in nine for non-Hispanics. Two of every five Latino children are born into poor families, and this includes the children growing up in single, female-headed households, about half of which fall below the poverty level. Now, the importance of sizeable numbers of poor, single, female-headed households in any population subgroup is that, for the single mother and her children, the pathways for breaking out of poverty, and especially the pathways of education and economic opportunity, are severely limited. In 1991, Latino families maintained by a female householder with no husband present amounted to 24 percent of all Latino families compared to 16 percent for non-Hispanic families. Of course, the diversity that I mentioned earlier is reflected here. You find only 19 percent of Mexican American households headed by single mothers, compared to 43 percent of Puerto Ricans. Still, the 24 percent average rate for Hispanic families as a whole is nearly twice the 13 percent average rate for white families. Suffice it to say that poverty and education are intimately linked.

Now, let me turn to health status. Here again, the Hispanic profile differs notably from that of non-Hispanics. Data on mortality indicate that, while Hispanics live about as long as non-Hispanic whites on average, they tend to die from different causes: accidents, diabetes, and cirrhosis of the liver kill proportionately more Latinos than non-Latinos, and the top 10 killers include homicide and AIDS, whereas neither of these is among the major killers for the white population. On the other hand, Mexican American infant mortality rates have been at or below white rates and much below black rates since data have been collected on this group. With regard to morbidity, Hispanics are more likely than non-Hispanics to suffer from hypertension, cardio-pulmonary problems, strokes, cirrhosis of the liver, and cancer of the cervix. AIDS also represents a serious increasing concern, not only for those Latinos who are addicted to intravenous drug use but also for larger numbers of people, especially teenagers, who may not have received sufficient health education to understand the risks of AIDS and especially how it is transmitted. Hispanics are two to three times more likely than non-Hispanics to have both diabetes and its complications, like blindness or amputation, which often occur without treatment. A study of Texas border counties that we looked at, for example, showed that, among all the cases followed in the study, 60 percent of diabetes-caused blindness, 51 percent of kidney failures, and 67 percent of diabetes-related amputations of feet and legs could have been prevented with timely and proper treatment.

Given these data on the high rates of Hispanic mortality and morbidity with respect to so many diseases that are preventable, or at least treatable, access to the health care system emerges as a critical issue for Latinos. Unfortunately, I would say that the situation here is far from encouraging. In 1989, as all of you know, more than 14 percent of the American population as a whole had no health insurance, public or private. But for Hispanics, that

figure was more than twice as high—33 percent had no health insurance versus about 19 percent for blacks, 12 percent for whites. Yet in the United States, the lack of health insurance erects a primary barrier to the receipt of adequate and timely health care. People who are uninsured are less likely to have a regular source of health care or to have an ambulatory visit during the year. They are more likely to use an emergency room as their usual source of care, and they are less likely to use preventive service, such as pap smears, blood pressure checks, and breast examinations. Even if they have a chronic and serious illness, they'll make fewer visits to the physician than if they were insured. And when they finally do receive care, their physical complications are likely to be more advanced and, hence, also more difficult and costly to treat.

But why are Hispanics so disadvantaged with respect to health insurance? We uncovered in our work a number of reasons, some applying to private health insurance, some to public programs. Beginning with a lack of private coverage, we found that two factors are principal contributors to the problem: jobs that fail to provide health insurance and incomes that don't reach the poverty level.

The fact that Hispanic families are more likely to be uninsured than either white or black families is, of course, well-known. What is less well-known is that this holds true regardless of whether there is an adult worker in the family. Whites are likely to be uninsured mostly when there's no adult worker in the family. But having a job is no guarantee for Latinos. In families with adult workers, only 57 percent of Hispanics, compared with 84 percent of whites, have private insurance coverage. Said another way, this means that if Hispanic families with adult workers had the same rate of insurance coverage that whites have, the overall rate of non-insurance for Hispanic families would have been 18 percent, not 33 percent. The issue here is that some jobs in some industries don't provide health

insurance benefits to employees. The problem for Hispanics is that, in comparison with both whites and blacks, they are more likely to work in industries that don't provide health insurance coverage—for example, personal services or agriculture—and less likely to work in industries that routinely provide such coverage—for example, manufacturing, professional services, and public administration.

With regard to income as a contributor to non-insurance, this relates to the potential for buying health insurance when a job doesn't offer it. We found that employed Hispanic men with incomes above the poverty level had much higher rates of private insurance than those with incomes below that level, with 67 percent versus 31 percent. Higher income meant not only a greater likelihood of insurance coverage through employers but also the ability to afford private health insurance when coverage through a job was not available. Higher incomes are also relevant when workers receive job-related health benefits for themselves but not for their families. Low incomes simply preclude the additional coverage needed, and the problem gets worse because, on average, Hispanics have larger families than non-Hispanics and, therefore, more persons for whom to purchase extended coverage. So the outlook for Hispanic health insurance, at least in the private sector, is not currently very encouraging.

But what about public insurance? Are Hispanics better off with Medicare and Medicaid than they are with private insurance? Well, certainly with Medicare they are. The Medicare program covers only the elderly, but it has the rare virtue in the United States of being nearly universal with 96 percent of people 65 or over having coverage. Ninety-six percent of whites, 95 percent of blacks, and 91 percent of Hispanics are covered by Medicare, and the reason coverage is so widespread is that Medicare eligibility is relatively straightforward. Anyone over the age of 65 who is

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eligible to receive Social Security is automatically eligible to receive Medicare. But even though coverage is nearly universal, I would still point out to you that 4 percent of elderly Hispanics, about 42,000 people, are covered neither by Medicare nor by any other health insurance at all.

The situation is very different with Medicaid, where stringent eligibility criteria greatly restrict access to the program in a number of States with high concentrations of Hispanics. Because each State determines its own eligibility criteria for Medicaid, even though the criteria must fall within Federal guidelines, the criteria obviously vary dramatically across the States. Two of the most restrictive States are Texas and Florida, in which about 3 of every 10 Hispanics reside. In California to qualify for Medicaid a family of three must earn less than 79 percent of the Federal poverty line income. But to qualify in Texas, a family of three must earn less than 22 percent of the poverty line income. So in 1989, when the poverty level was about \$12,000, a family of three earning \$6,500 a year would have qualified for Medicaid in California but not in Texas.

Now, there are major differences in Medicaid coverage across Hispanic subgroups, which are largely explained by these differences in eligibility criteria. For instance, Mexican Americans and Puerto Ricans both have high rates of poverty and low median incomes. But Puerto Ricans, who are concentrated in New York and New Jersey, are much more likely than Mexican Americans, with a substantial population in Texas, to meet Medicaid eligibility criteria. As a result, a higher proportion of Puerto Ricans than Mexican Americans receives Medicaid. It's true that the greatest numbers of Mexican Americans, about 42 percent, do reside in California, and California has the least stringent eligibility criteria for Medicaid in the Nation. Still, with more than 30 percent of Mexican Americans residing in Texas, Texas Medicaid policies do play a role in restricting health care coverage for the

group. Further, and very important, despite California's less restrictive criteria, 23 percent of California's non-elderly population—that's 6 million people—were uninsured in 1989. This reflects once again the effect of employment in low wage jobs that don't provide health insurance.

The situation in California illustrates very well the complexity of the policy difficulties that are involved here. Just raising the Medicaid thresholds closer to the poverty line would still leave uninsured many working people who earn more than poverty level income but not enough to afford health insurance.

Now, let me turn to three other kinds of barriers that I wanted to talk about with you today that also affect Hispanic access to health care. The first of these is the extraordinary complexity of the Medicaid program. Let me just point out that, in addition to the problem of variable and sometimes restrictive income eligibility criteria that I noted earlier, the Medicaid program is itself a barrier to access because of the impenetrable maze it presents to potential applicants.

In Texas, for example, there are nearly 10 different programs for Medicaid enrollment, each with its own criteria for eligibility. For example, pregnant women with incomes up to 133 percent of the poverty line; children born before January 2, 1982, who are eligible for AFDC [Aid to Families with Dependent Children]; children born before October 1, 1983, with incomes between the AFDC and medically needed criteria; and so on. Medicaid case workers in Texas engage in 4 weeks of training just to learn the eligibility criteria and how to communicate them to potential recipients. Medicaid officials are well aware of the formidable barrier the program's complexity represents. They note that it's difficult to explain to people that they may not be eligible for Medicaid now but could be so in the future and that the process of enrolling people is excruciatingly burdensome, and they realize that standing in line

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for a full day at the Medicaid office does not compete favorably with the practical alternative of receiving free care in an emergency room or a community health center. But recognition is not resolution. Medicaid needs either to find a cord with which to lead applicants through its maze or destroy the maze.

On the other hand, making health insurance available and simplifying bureaucratic procedures, no matter how important those actions might be, are still not enough to resolve the problem of Hispanic access to health care. The second noninsurance barrier I wanted to mention is the fundamental impediment constituted by the shortage of physicians serving Hispanic communities. This is a truly critical problem, but it's more severe in some places than it is in others. It's acute in El Paso. Only 30 of the city's 800 physicians, 4 percent, maintain practices in the poorest part of the city that houses 32 percent of the El Paso population. Twenty years ago, some of you may remember, the American Medical Association used to estimate that a ratio of 1 general practitioner for a population of 750 was reasonable. Today, we have fewer general practitioners, and ratios of 1 physician to 5,000 or 6,000 people are not uncommon in the center cities where many Latinos reside. Now, this shortage of physicians is naturally accompanied by a dearth of primary care facilities available to the Hispanic community. It's hard to overestimate the importance of this problem. Taken together, these two supply problems involving physicians and facilities are at least as important as noninsurance in impeding effective access of Latinos to health care.

Finally, let me turn to a third barrier that needs to be mentioned, and that's patient health education. Two factors are particularly salient in the demographic health profiles of Latino populations that I spoke to you about earlier—comparatively lower levels of educational achievement and comparatively higher levels of preventable or

treatable disease. There is a need for special efforts to educate Latinos about effective health practices and generally the special health problems they face and to educate them in their language, taking account of the cultural factors particular to the different Hispanic communities. It's probably unnecessary to make the case to this audience of the importance of early detection in the outcomes of diseases like cancer or diabetes. Yet, early detection depends largely on the patient's knowledge, which triggers a visit to the doctor in the first place.

It seems clear that all of these five problems—noninsurance, bureaucratic complexity, a shortage of physicians, a shortage of primary care facilities, and very uncertain patient awareness of important health issues—are major barriers to health care facing Latinos today. I think these problems are at the heart of improving not only access but also health status, and especially the preventable or treatable diseases afflicting this population. I think the shortage of physicians, facilities, and health information contribute heavily to a situation in which patients go to community health centers or hospital emergency rooms in advanced stages of illness.

This situation makes prevention academic. It causes treatment to be more difficult and more expensive, and it renders outcomes much more uncertain. This is especially the case for diabetes among Hispanics where severe complications arise because of delayed treatment and lack of patient awareness. But of greatest concern are the failures of prevention, the inadequacy of prenatal care that could reduce high rates of pregnancy or childbirth complications for women and children, the unavailability of pap smears that allow early detection of cervical cancer, the lack of health counseling to deter obesity or alcoholism, or the transmission of HIV.

In conclusion, the five barriers I've discussed are not the only ones facing Hispanics in their quest for better health care. But it certainly seems clear

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that improvement is not going to occur if we don't address them. Initial steps should include more adequate health insurance coverage, both private and public; simplification of eligibility determination in the Medicaid program; stronger community provision of primary care; and greater Federal and State efforts to educate Latino populations with regard to both the prevention and the treatment of those diseases most likely to affect them.

Finally, I would also make a plea for better data. Our current information is plagued by lack of Hispanic identifiers in 20 States, by uncertain reporting in the other 30 States, by Hispanic samples too small to use for analysis or estimation, and by 10-year gaps between data collections for a population that is growing with this speed. The truth is that no existing database currently provides accurate, complete, and timely data on the entire Hispanic population, including the often very different subgroups. Perhaps this conference might also consider data improvement. I realize you have a difficult and a complex task in front of you, and some of you may be thinking right now of Alfonso the Learned's remark as he considered Spain's problems in the 13th century: "If God, in His wisdom, had thought to consult me before embarking on the creation of the world, I would have suggested something simpler."

Responder Panel

James O. Mason, M.D., Dr.P.H.

Assistant Secretary for Health
U.S. Department of Health and Human Services

The first step in solving a problem is to identify and to define it. You've done a masterful job of that during this Workshop. I want you to know that those of us who are responding are here not just to learn and to listen, but we've come to act as a result of the work that you've done. Represented here are men and women who report directly to Secre-

tary Sullivan, to Secretary Alexander, and to Secretary Martin. These three individuals report directly to President Bush. So your recommendations, your identification of issues and problems, have the President's ear.

You should also know that the President already has a comprehensive health care reform initiative on the table. His plan will provide access, security, choice, and affordability for all Americans. It is a plan that can work.

You've discussed community and migrant health centers. HRSA has just awarded 71 new sites, either through expansion or new grants. In addition, we are putting more money into community and migrant health centers in high-risk areas with the "weed-and-see" program. For years, there haven't been new programs in community health centers. Through this administration's support of these programs, we're moving ahead again. And if we can get Congress to act on the President's budget for fiscal year 1993, there will be more expansions and more increases during the next fiscal year.

We're also revitalizing the National Health Service Corps. It almost disappeared. Now it's on its way up. We promise you in accordance with the recommendations that you've made that we will target minorities. Among those minorities, our Hispanic/Latino community will be specifically targeted.

In the area of research, we've had funding increases over the last few years. However, we're afraid that Congress is not going to give us the President's budget for NIH or for SAMHSA. At NIH, we've recently created an Office of Minority Health Research. And SAMHSA is our new organization that will come into being tomorrow morning. Its mission is to ensure knowledge is used effectively and comprehensively for the prevention and treatment of addictive and mental disorders.

So the structure is there to begin to address the issues that you have identified. We will work with you.

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Michael McGinnis, M.D.

Director
Office of Disease Prevention and Health Promotion
U.S. Department of Health and Human Services

I'd like to begin today by emphasizing that the process of setting and implementing national health promotion and disease prevention objectives highlights that serious and intolerable gaps exist in our national effort to improve the health of the Hispanic/Latino community, but it also demonstrates that we can and will close those gaps.

I'd like to applaud the focus that the Surgeon General has given here to the issues in disease prevention and health promotion and commend each of the members of the work group for identifying some of the key issues in succinct fashion. Let me take a few minutes to revisit some of the issues by looking at three categories of targets in *Healthy People 2000*—the Nation's health promotion and disease prevention objectives: (1) the first category includes those objectives that have specific Hispanic targets, (2) the second category includes those objectives that do not have specific Hispanic targets and for which Hispanics are actually doing better than the general population, and (3) the third category includes those objectives that do not have specific Hispanic targets and for which the Hispanic population is at higher risk than the general population.

In the first category, targets were set for those issues that I know are viewed as of greatest importance to each of you, as they are to me. These include increasing the regular source of primary care specifically for Hispanics, increasing receipt of clinical preventive services by Hispanics, reducing tuberculosis among Hispanics, confining the incidence of AIDS among Hispanics, reducing diabetes among Hispanics, reducing adolescent pregnancy among Hispanics, reducing growth retardation, increasing access to prenatal care, reducing infant mortality, increasing access to mammography and Pap tests, reducing untreated

dental caries, increasing the years of healthy life among Hispanics, reducing homicides among Hispanics, reducing cigarette smoking and overweight among Hispanics, reducing infertility among Hispanic couples, increasing Hispanic representation in the health professions, and reducing data gaps by specifically improving the availability of Hispanic data. Those are the key targets among the 25 that were set specifically for the Hispanic population.

Let's take a look at the second category, the area in which available data tell us that the Hispanic population is doing better than the general population. From this COSSHMO publication, *The State of Hispanic Health*, we know that the Hispanic population is doing better with respect to coronary heart disease, stroke, cholesterol levels, high blood pressure, cigarette smoking among adolescents, and suicide. Because the *Healthy People 2000* special population targets were set only for those areas in which the population was at higher risk than the general population, there are no targets specific to the Hispanic population in these particular areas. However, as a Nation, we clearly must be vigilant in preserving that relative advantage in these areas.

Let me now focus on the third category—in which there are several priority areas with no Hispanic-specific objectives but in which we know that Hispanics may be at higher risk than the general population. These priority areas include alcohol and other drugs, unintentional injuries, occupational safety and health, environmental health, food and drug safety, and sexually transmitted diseases. It is quite clear that the reason that there are no Hispanic-specific objectives is not because the Hispanics are doing better, but because we just don't have adequate data in these critical areas. This was pointed out time and time again by the presenters. We could have arbitrarily set targets without data, but that would have obscured the fact that we don't have the data that we need. We need to find the data and use it as we establish objectives

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for the future. But, most importantly, we cannot let the absence of data get in the way of progress. The issue should not only be the presence or absence of Hispanic or Latino objectives. We also need to ensure that we close the gaps and that we have a plan in hand for reaching the Hispanic/Latino community with implementation efforts. The priority must be improving Hispanic health, and I can pledge that this issue will be an ongoing commitment of *Healthy People 2000* and all PHS efforts.

Louis D. Enoff

Acting Commissioner
Social Security Administration
U.S. Department of Health and Human Services

I would like to address the issue of access. Although we're already doing a good job, we know that we need to do better in terms of access to services that we provide at the Social Security Administration. Among our 1,300 offices, more than 65 percent have Spanish-speaking employees. About 3,300, or one-tenth, of our employees in the field offices speak Spanish. However, in a survey of all of the offices that we did earlier this year, we found that 300 of those offices have a need for additional services, and that may include additional technical personnel.

You can't always rely solely on a translator to provide access. You have to have someone who understands the program and who understands some of the cultural issues that may be involved in revealing some very personal data that help determine eligibility for Supplemental Security Income (SSI).

Now, in addition to our field offices, we have the busiest 800-number in the world. Last year we had some 76 million calls. In that 800-number service, which is available nationwide 12 hours a day, we have more than 300 Spanish-speaking teleservice representatives. Now, I understand that some folks do not like to use the telephone to take care of that business. We are not saying you must use the telephone. We're saying you have access

either through the telephone or through the personal visit to our office, but we want to provide that availability to everyone.

Our notices are well-known throughout the newspaper world as being some of the most technical notices that go to anyone, not only in Spanish—we have a problem communicating in English some of these technical kinds of decisions that are made. But all of our pamphlets and forms are in Spanish as well as English. Thanks to new computer innovations, we now send Spanish language notices automatically to people who request them and to residents of Puerto Rico. We are constantly improving our capabilities in this area, and I believe we will have our computers geared to offer all of our communications in Spanish in about a year and a half.

We now provide our very popular personalized earnings and benefits estimate in Spanish. This service provides your wage record and your benefit estimate upon request and regardless of your age, it tells what you can expect to receive in Social Security benefits. It's very good for retirement planning. It's also good in the area of wage reporting, a particular area of interest in some of your communities, particularly for migrant workers. Next month we will be distributing some 75,000 publications to migrant farm workers in four States, California, Arizona, Florida, and Texas, to remind them of the need to check their wage records. And, working with our colleagues in the Labor Department and IRS, we will be reminding the employers of their need to report wages. We are working toward better compliance in that area.

Two other areas may be of interest. We know that there are areas of the community where we have not been able to reach all of the people who may be eligible for SSI. Estimates run from two-thirds to three-quarters of eligible persons who may be receiving SSI benefits. Along that line, Commissioner King launched an aggressive outreach program about 3 years ago. We've awarded more

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than 83 grants, working with private-sector organizations as well as some State and local entities to reach out into the community to find persons who may be eligible for SSI but who have not come in contact with our office or may not be aware of it. And, I would tell you that one-fourth to one-third of those grants have been given to organizations that are Hispanic or that are reaching out into Hispanic communities.

Finally, as the Commissioner of Social Security, I do have the Hispanic Affairs Advisory Council. I meet with them on a regular basis. These are employees from throughout our organization who bring to our attention particular needs of the Hispanic community, and I can tell you that they are very aggressive, very open, and forthright about some of the things that we need to continue to do. So we'll take your report, we'll look at it, and we'll get back to you and we promise that we will improve, too.

John T. MacDonald, Ph.D.

Assistant Secretary for Elementary and Secondary Education
U.S. Department of Education

Your work is so important to the work that we're trying to accomplish, particularly when one views that, by the year 2000, 34 percent of our school population will be Hispanic/Latino. And in terms of that population right now, as Dr. Novello has said, we're not doing so well, as indicated by a headline like "Schools Still Fail Hispanics" in *The Miami Herald*.

We're losing about 35 percent of the youngsters who attend school. About 63 percent of those youngsters are immigrants. I believe that through the multitude of services that we have in the Office of Elementary and Secondary Education—Compensatory and Chapter 1 programs, programs for the homeless, follow-through programs, the Even Start program, the dropout prevention program, magnet programs, and Chapter 2 programs—coupled with

services provided by the Office of Migrant Education and the Office of Indian Education—we must be able to affect what is happening to our Hispanic/Latino youngsters. In my opinion, and in the opinion of my colleagues, we have to take an entirely different direction with public education and the way we operate schools.

We have been working with folks, including Jim Mason and others from DHHS, on some of these concepts. I am going to touch on something that I think needs to be addressed in this country: schools that operate on extended-day or extended-year schedules, schools that address the multitude of diverse issues related to children and families and the need for services. This concept is formally called "integrated services" or "school-linked services." What I heard in the five forums conducted by Secretary Cavazos around the country 2 years ago was that people were not aware of what services they could access and how to access them. They were not aware of how they could be represented and how they could seek representation. The conclusion was that our schools had to be redesigned and reconfigured so that they served the population that needed those particular kinds of services.

We are proposing to develop, through our Even Start model, the first Federal integrated family service literacy program for children ages zero through seven and their parents. This program will be a partnership with DHHS as a formula program that ties in with more than Even Start grantees that we have today and provides an ability to have these youngsters served by Medicaid. The Department of Agriculture is presently working with us to have these youngsters served by the Women, Infants, and Children's Supplemental Food Program. What we are saying is that we have to have varieties of services that reach each and every child in a way that is appropriate not just to their schooling and language acquisition needs but also to their allied health and nutrition needs. This effort is

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currently under way and it is being prepared for secretarial review.

In the meantime, there is nothing to stop us from encouraging local grantees today to pursue these ends and develop these kinds of programs. For example, Jim Mason and I cochair an interagency program on school-related health issues. You might want to think of it as an ad hoc committee to that agency to advise and consult on allied health issues, because schools are the common thing in our communities that people go to. Schools are not only the largest real property investment we have but also the one with which people are familiar. It is possible to use them as a location to coordinate the services that children and families need through the establishment of family service centers. Between the programs in Jim Mason's office and in mine, there are ways of pulling public health and education programs together to facilitate this, and it is time that we did it. We are running out of time with these youngsters and we are making no inroads in terms of the dropout rate for the Hispanic children.

One program that we are going to be watching carefully is through our heavy involvement with Hurricane Andrew, particularly in Dade County. (Tomorrow I will be in Louisiana working with parish superintendents there that have been affected by the hurricane.) In Dade County, they have proposed to start a new Phoenix Project, which will be operating in 26 schools. The Department will be funding that. It will cost us about \$12 million to establish a new model like the one I described. It will provide not only for the educational needs of children but also for their multidiverse needs in terms of allied health, nutrition, acculturation, and recreation. Both children and families will be served on an extended-day and extended-year schedule.

We should operate our schools to accommodate the diverse needs of today's society. Our society is not the same society that our schools were originally designed to serve. Schools have to change

to meet today's needs and meet them wherever they are located, if we are to succeed, interagency collaboration at the Federal, State, and local levels.

In terms of representation, we should be working together with our Eisenhower program, directed by Alicia Coro, among the school improvement programs to identify the 5 percent set-aside that serves specifically underrepresented groups in the science areas. We should be working with DHHS and the National Science Foundation to see if we can design new programs to reach out and serve more people than we are serving now in the areas that are being neglected. This is going to take interagency collaboration.

In terms of the free trade agreement, for the past 2½ years, we have had under way a Memorandum of Understanding with the Mexican government and the Mexican Secretary for Education. (I visited with Mexican education officials last month to discuss the changes that have taken place with their change of administration.) We are very hopeful to complete our Credit Accrual Project, which can give youngsters moving back and forth across the border some hope of finishing high school. Hopefully, this can be phased into our College Assistance Migrant Program (CAMP), so that we can increase the numbers of attendance in higher education. We are getting excellent cooperation from States like California, Arizona, and New Mexico, but we have a long way to go in terms of this population.

There are 375,000 youngsters who need these kinds of services. With your effort and your support, and with your recommendations in terms of issues related to access and representation, we'll get there.

Thomas Komarek, M.B.A.

Assistant Secretary for Administration and Management
U.S. Department of Labor

The primary policy issue at the Department of Labor is jobs for American people, and, as we all

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know, one of the primary ways to provide health care to people is associated with employer-provided health care. Unfortunately, at this point in time, we do not have enough jobs. The unemployment rate for all Americans and for Hispanics/Latinos, which make up about 9 percent of the overall labor force, is unacceptably high. The President, Secretary Martin, and everybody at the Department of Labor is working today on that very serious problem.

I learned something during this visit that I sort of intuitively knew; I was reading the GAO report on Hispanic health care and noted the numbers in there that indicated that even when Hispanics and Latinos had jobs, often those jobs did not provide employer-assisted health care to the same degree that others in our society received, and that's a problem. One of the problems as we move forward toward the year 2000 is the need for education and skills to get the good jobs, the jobs that do provide the health care assistance from employers.

The most important impression I take away from this conference is the overwhelming complexity of all these issues that you have raised. When you think about it, education leads to jobs, which lead to health care. Each of those areas requires much work, many resources, and devoted attention. There is one thought, however, that I heard in many of the presentations this morning that is also very dear to the heart of my boss, the Secretary of Labor, Lynn Martin. At least half of the presenters spoke about the importance of Hispanic/Latino representation in the policymaking levels of the Federal Government and in other decision-making areas. Secretary Martin has been pushing very hard with her glass ceiling effort in the Department of Labor and throughout the Federal Government. I think we all need to realize that, in the years ahead, we're going to have some very difficult budget times, and we will not be able to do all the things we would like to do. One of the keys to making sure that the best decisions are made in these very

difficult times is to have a diverse group of key policymakers in the Federal Government who will make decisions on grants and on job and health policies. Key to that is getting Hispanics/Latinos and a diverse corps of policymakers.

You can have the assurance of the Department of Labor that we will continue to push this effort as hard as we can. As long as the people at the top in our decision-making processes do not appreciate diversity, then we will have some problems. Once we get a diverse group—women, minorities, Hispanics/Latinos—in those top jobs, I think the problems will go away gradually. The best program that we have to work on to achieve this objective is the glass ceiling program.

Karen R. Keesling, J.D.

Acting Administrator, Wage and Hour Division
U.S. Department of Labor

I'm here as a representative of a law enforcement agency. You might ask: What is the Acting Administrator of the Wage and Hour Division doing here? But as you have heard, we've been working with the Social Security Administration, and we've been working with the Department of Education.

We enforce two very important statutes that should be of major concern to you. One is the Fair Labor Standards Act, which is what we were created for, minimum wage and overtime, and child labor provisions. In the child labor area, as Assistant Secretary MacDonald mentioned, we have also been very active in an MOU between our Department of Labor and the Mexican Department of Labor, and I have also been down to Mexico working on a joint report with my colleagues there on child labor. So there's a lot of activity going on, and I know that was a recommendation, and I would encourage you to continue to work in the health field with our Mexican counterparts.

The other most important statute is the Migrant and Seasonal Agricultural Worker Protec-

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tion Act, or MSPA, which we enforce. Although we don't enforce health standards ourselves, one of the things we do enforce is the housing for migrant workers. We're there to make sure that health hazards are eliminated, working with the State agencies. A lot of times when we go into these areas we're there with the State departments of labor and health to look at these conditions. We also work with our sister agency, the Occupational Health and Safety Administration, as far as field sanitation is concerned. So when we find violations, we work with the State agencies to try to correct the health and safety areas.

We also have an annual meeting with the farm employers, with the farm and migrant workers, and with the State and local agencies. I happened to attend a meeting last month in Portland, and I was very impressed with the representation from all of the local agencies. One of the things we talked about was access to health care, and I think it's something that the representatives were continuing to try to address and to get the right parties together to continue to work on those areas. So those are the things that we're doing on the enforcement side, working with the various agencies and trying to assist in getting the migrant workers the adequate health care that they need.

William Toby, M.S.W.

Acting Administrator,
Health Care Financing Administration
U.S. Department of Health and Human Services

The first thing I want to say is that as I looked at your paper, it reminded me of the mistakes that were made in 1965 when Medicare and Medicaid were first envisioned and implemented. If we were implementing the Medicaid and Medicare programs today, I can assure you that issues such as access and need for prevention would not even be discussed. We'd probably be talking about something else because one of the main mistakes I think we made in the beginning of this program was to focus almost

primarily on the fee-for-service system at the expense of other modalities of delivering services, and we've been paying for that ever since. So one of the things that I have inherited is to try to straddle the structural problems that create some of the issues you have mentioned.

You talked about the need to improve data, the need to have trained personnel, the need to have targeted research programs, and I must tell you that HCFA really can make significant improvements in all of these areas because HCFA is perhaps the largest financing agency in this Nation and has the 12th largest budget in the entire world. But there are some things we can't fix.

Let me talk about data for a minute. When I was getting ready for this conference, I asked for Hispanic data in terms of Medicaid, and they gave me the numbers—5.6 million. I asked for the data in terms of Medicare. There are no data. Medicare does collect data by race but not by ethnicity. Consequently, I don't have any data. So yesterday I fired off a very nasty memorandum to my staff suggesting that we look at that issue because the next time I have this kind of meeting, I'd like to have some information on Hispanics on Medicare.

The second thing you mentioned is the need for trained personnel. I walked into HCFA 6 months ago, and I have some sense and some sensitivity. So the first thing I noticed was that there was nobody really of my color at the senior level in HCFA, and I raised that question about improving it. The next thing I noticed, and I've known for a long time, is that you can forget about Hispanics in HCFA. So I have a few opportunities. I was given an opportunity when I was there about a month. The Director of Personnel came in to see me and said, "Look, Bill, we're getting ready to hire 12 scholars. We have a program which allows us to get around all the bureaucracy. If you are smart, truly smart, if you're at the top of your class, then we can basically hire you almost on the spot." So they gave me a list of 12 individuals to be hired. I

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looked at the list. There was not one minority on the list. I asked them to try again. I asked them to come back with seven minorities and five others. We had more than 100 people who had been interviewed, but not one minority on the list. We have the final list, and Dr. Sullivan entertained the 12 scholars I presented to him just 1 month ago. We have 12 scholars, 7 of whom were minority—4 are black and 3 are Hispanic. And I got lucky—the three Hispanics are all beautiful women. One graduated from Smith, and the other two went to incredible colleges, and I just learned that we have another Hispanic in the agency I didn't know about, a daughter of one of the participants here today. So I'll find out about her tomorrow, and I'll make sure that my staff understands that we're going to target Hispanics, going to target minorities to be on the fast track for promotions in my agency.

The third thing on personnel—I am the only head of an agency in DHHS who is not a physician. You all know about Dr. Mason, who has been a dear friend to me, seriously, since I've been on board. Dr. Novello, Dr. Bob Harmon, everybody is a doctor. I am not a doctor. I have a master's degree in social work and a master's degree in public management. So I'm in discussions with a brilliant physician who happens to be Hispanic and who has agreed to become my physician advisor. So I hope in the near future, at the next meeting of this type, to be accompanied by a physician who is of Hispanic background.

The other thing I want to mention is that we as an agency have enormous clout in terms of reimbursement policies to try to do something about primary care. That's something else you care about deeply. And we have been trying to do something under current law. We have basically been working with States to increase reimbursement for obstetrical services. We are also trying to make other changes in primary care by using the leverage of HCFA.

We pay for about 60 percent of graduate

medical education, and we have decided to see how we can take the leverage of Medicare, in particular, to change the minds of the medical schools, which are putting out so many specialists. We will use the clout of the Medicare reimbursement and use the clout of PHS as a team to send a message to medical schools that if they don't produce more primary care physicians, they are not going to get our money.

Dr. Mason and I are going on the road. We are working with the National Governor's Association and with private foundations to send a message to increase the supply of primary care providers, and we're going to have the first symposium, I believe, in Burlington, Vermont, next March. Basically, we are going to have a public affairs strategy to get the words out that this administration cares deeply about the need for primary care doctors. And because most minorities live in urban areas, we are going to particularly focus on the need in those areas. We are also working very hard to expand eligibility for pregnant women, infants, and children, and adolescents under Medicaid, and we are closely in touch with States to make sure that they do what they are supposed to do. And my hope is that that's going to help.

One of the things I did when I came in was to ask the question of our public affairs people, how are we communicating with the Hispanic population? I was not happy with the answers. We have hired more consultants to translate our documents into Spanish throughout. We have also decided that we are going to talk to our Medicare contractors about the need to have more Hispanics around the country. We have 28,000 people who work for Medicare through our contractors. We want to have Hispanic people working in those Medicare contractors, to be able to talk to Hispanic providers, to talk to Hispanic beneficiaries.

Two years ago when I was living in New York, I found out that even though we had a Spanish translator in Washington working on the Medicare handbook, the people in Puerto Rico did not understand

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the handbook. So we made sure this year that we sent that handbook to our Puerto Rico office, and my staff in Puerto Rico has done a herculean task of reviewing that document, translating it to make sure that local idioms in Puerto Rico are understood, and that it will be understood in Texas, Colorado, Kansas, and everywhere in this country where there are Hispanics.

I also would like to say that as we talk about the fact that most Hispanics lack access to the health care system, the best hope for the Hispanic population, the best hope for all minorities, will be health care reform, and the President's health care reform plan is the major strategy that we have. I know Dr. Wilensky met with all of you. I know you understand probably the various strategies we have, the concepts in that plan, and I won't bore you with that. But I will tell you that if you're interested in access, and most Hispanics are working for small employers, the President's health care plan at least provides tax credits, tax certificates, tax deductions, and will allow them to buy insurance. So it's one way, not the only way, but it's one way to gain access. It is the best hope for the future.

I had been asked a question by Tony about "whenever we are united as a family, some of the benefits?" It is true that the Medicaid program is not devoted to paying for services based on needs. The Medicaid program is a medical program that is a component of the cash assistance program, so it's an entitlement program. So you can't just get Medicaid services because you have a need. You have to have some linkage to the cash assistance program or you have to be pregnant or a child and meet a certain income test. My sense is that you have to work with Congress if you want to change the program in terms of meeting needs and break the linkage to the cash program. We're already doing that. Congress has made the reforms that it has because you have been active. You must have been complaining about Medicaid and how it operates, otherwise Congress would not have been

moving under the current trend that it is. And the current trend is to try to break the linkage to the cash programs, and the low-income pregnant women and poor children benefit is one example because before we got that, changing it would have been impossible. So basically, until we change the entitlement aspects of the Medicaid program, there will continue to be a great deal of tension and lack of access because it is a means-tested program based on income resources and category of relationship.

Six weeks ago, I testified before the Senate Finance Committee, the Committee on Long-Term Care and Medicare, and one of the things I talked about was the fact that in the future, in terms of the new direction of Medicare reimbursement for graduate medical education, we will be tying our reimbursement to medical schools that go beyond the hospital setting to other kinds of settings. In other words, we are thinking about community health centers as being a site for training. We are thinking about increasing the reimbursement for those kinds of settings. We want to weigh the reimbursement to the medical schools that look for alternate settings, such as community centers, and that is basically the direction we will be going. And we are preparing a legislative package to go before Congress to do just that.

Kenneth Shine, M.D.

President
Institute of Medicine

I'm sort of the odd person out in this. For one thing, I'm the only one on the podium who doesn't work for the Government. The Institute of Medicine, the National Academy of Sciences, is an independent, not-for-profit corporation chartered by Congress to advise Government with regard to health, health policy, and other aspects of science. But we're not a governmental institution. In that regard, we have the capacity to do a number of things that can be helpful in confronting the issues

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that you describe and with which you are concerned, including the capacity to convene around issues of health and health policy.

I'm an odd person on the podium also in that, until the end of June, I served as dean of an American medical school—UCLA in Los Angeles. And there's both good news and bad news. The good news is that I had the privilege not long ago of conferring the medical degrees on 31 Hispanic physicians in a class of 150, the largest number of Hispanic physicians ever awarded medical degrees in a single medical school at a single time. I'm also pleased that, this November, a member of the UCLA graduating class of 1993 will receive the McLean Award as the outstanding minority medical student in the United States. A UCLA student has won that award in 9 of the last 14 years, and 7 of them have been Hispanics. So, the good news is that we're making some significant progress with regard to at least one medical school in Los Angeles in educating Hispanics as physicians, that they are doing extremely well.

The bad news, of course, is that I also played a role in creating a task force on access in the county of Los Angeles and had the opportunity to address that task force on the morning of its first meeting and to remind them that two out of three preschool Hispanic youngsters in Los Angeles were not immunized. I have had the personal experience in our teaching hospitals of attending to several cases of measles occurring in youngsters who had seizures associated with that illness, cases which should never have happened, and I've had the experience of taking care of tetanus in a migrant Hispanic farm worker because of lack of immunization. So in coming to this meeting, I have a personal sense of the intensity of the concerns and the issues that are confronting the Hispanic/Latino community in terms of dealing with health and health care.

The Institute of Medicine in the Academy does several kinds of things. It is best known perhaps for the reports that it issues based on analysis of data that are used to influence public policy, and we've issued

reports on access, on primary care. In 1978, we issued a report strongly urging that 50 percent of American medical school graduates be in primary care specialties. We're still fighting that battle.

We have issued reports on nutrition, child care, maternal and child health, and I can also tell you that I have had the personal experience of tending to two of the first six AIDS cases that were reported. They were also at UCLA, and I watched AIDS develop in our community and also recognized that until the Institute of Medicine published its famous report on AIDS in 1986, the response was not very outstanding in terms of either research or patient care.

So we will continue to work on those kinds of reports. There are several that will be of great interest to you. The first is a report on recruiting minorities to the health professions, an activity that will go on over the next year, which will include a series of workshops in which we will invite public comment to the committee responsible for making those recommendations. The second is a report on employer-based health insurance, which is likely to be directly responsive to some of the issues that you've raised with regard to health in small companies and in segments of the workforce in which many of the Hispanic and Latino workers work.

I think that the other main function that we serve is a convening function. We run a variety of forums to guide public policy and private activity from this point of view. And we intend to continue to focus on the importance of AIDS in minority communities as part of that forum activity. We have just initiated a forum on health statistics, and we remain concerned about many of the issues that you've addressed. Part of our goal in creating this forum is not so much to issue a report as to bring together Federal and local Governments to understand how to better collect health statistics and health data.

We have a major and abiding interest in the issue of the pipeline for health professionals,

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particularly as it relates to minorities in both research and education, and I want to point out a couple of aspects that I think are important to you. First, math and science education is a major issue. We believe that there is a major role in the United States for academic health centers and scientists to become involved in education, particularly in minority communities in math and science in kindergarten through grade 12. You ought to be aware of those activities, and you ought to try to participate in those activities wherever they take place because for them to succeed there has to be a community linkage. Second, we will continue to evaluate ways in which we can encourage more Hispanics to choose health careers, particularly in medicine. And, as you know, we are working closely with the Association of American Medical Colleges on the 3,000 by 2000 project, which tries to get proportionality with the population.

In terms of public and private activities, it's very clear that we need more faculty members in medical schools and in other health professional schools who are of minority backgrounds. We need role models. And in that regard, I would point out

to you that I continue to be disappointed that the Robert Wood Johnson minority faculty program has relatively few applicants from Hispanic faculty members. You need to encourage young Hispanics to apply for that program because it is a preeminent program for faculty development.

I'm very much involved with another program in identifying generalist physicians and faculty development in collaboration with Robert Wood Johnson. And again, we need to be sure that there are adequate nominees for those kinds of activities.

Finally, I would point out to you that we have recently established a formal relationship with the Mexican National Academy of Medicine. We have established a foundation that will be funded by both the American and Mexican Governments. The amount of money is not great in the initial stages, but it will allow funding of research activities, particularly in the areas of border health. And I anticipate that we will again use our capacity to bring together governments, academies, and the public and private sectors in a way that will try to address a number of the issues that you've raised.