

S. HRG. 107-701

**HISPANIC HEALTH: PROBLEMS WITH COVERAGE,  
ACCESS, AND HEALTH DISPARITIES**

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**HEARING**  
BEFORE THE  
SUBCOMMITTEE ON PUBLIC HEALTH  
OF THE  
COMMITTEE ON HEALTH, EDUCATION,  
LABOR, AND PENSIONS  
UNITED STATES SENATE  
ONE HUNDRED SEVENTH CONGRESS  
SECOND SESSION  
ON  
EXAMINING HISPANIC HEALTH PROBLEMS, FOCUSING ON COVERAGE,  
ACCESS, AND HEALTH DISPARITIES

SEPTEMBER 23, 2002

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# C O N T E N T S

## STATEMENTS

MONDAY, SEPTEMBER 23, 2002

	Page
Bingaman, Hon. Jeff, a U.S. Senator from the State of New Mexico .....	1
Rodriguez, Hon. Ciro, a U.S. Representative from the State of Texas .....	3
Beato, Cristina, M.D., Deputy Assistant Secretary For Health, U.S. Department of Health and Human Services, Washington, DC; Francisco Cigarroa, M.D., President, University of Texas Health Science Center at San Antonio, TX; Glenn Flores, M.D., Chair, Latino Consortium of the American Academy of Pediatrics Center For Child Health Research; Director, Community Outcomes, and Associate Director, Center For the Advancement of Urban Children, Department of Pediatrics, Medical College of Wisconsin, Milwaukee, WI; Dan Reyna, Director, Border Health Office, New Mexico Department of Health, Las Cruces, NM; and Elena Rios, M.D., President, National Hispanic Medical Association, Washington, DC .....	9

## ADDITIONAL MATERIAL

Statements, articles, publications, letters, etc.:	
Francisco G. Cigarroa, M.D. ....	33
Glenn Flores, M.D. ....	36
Ciro D. Rodriguez ....	41
Cristina Beato, M.D. ....	48
Dan Reyna ....	59
Elena Rios, M.D. ....	74



## **HISPANIC HEALTH: PROBLEMS WITH COVERAGE, ACCESS, AND HEALTH DISPARITIES**

MONDAY, SEPTEMBER 23, 2002

U. S. SENATE,  
SUBCOMMITTEE ON PUBLIC HEALTH,  
OF THE COMMITTEE ON HEALTH, EDUCATION, LABOR, AND  
PENSIONS,  
*Washington, DC.*

The subcommittee met, pursuant to notice, at 2:00 p.m., in room SD-430, Dirksen Senate Office Building, Senator Bingaman (chairman of the subcommittee) presiding.

Present: Senator Bingaman.

### OPENING STATEMENT OF SENATOR BINGAMAN

Senator BINGAMAN. We will go ahead and start the hearing. Thank you all for coming today. Our hearing today is focussed on the health of the Hispanic population in the United States. The figures that all of us are generally aware of are shocking. Over a third or 35 percent of Hispanic adults lack health insurance. Despite the passage of the Children's Health Insurance Program, 27 percent of Latino children remain uninsured. That compares to 9 percent of white children, 18 percent of black children, 17 percent of Asian-Pacific Islander children.

In the case of poor children who are largely eligible for Medicaid and SCHIP, 1.1 million poor Latino children are uninsured, compared again with 806,000 white, 704,000 black and 95,000 Asian poor uninsured children.

The Centers for Disease Control and Prevention keeps figures on morbidity and mortality rates and again those are very adverse to the Hispanic community. For example, age-adjusted mortality rates for diabetes are over 50 percent higher among Hispanic persons than with non-Hispanics. HIV infection rates are over three times those for non-Hispanics. Tuberculosis rates among Latin children are 13 times as high as in the white population.

This hearing will raise particular attention to the problems that we face along the U.S.-Mexico border where we have 11 million people, five of the seven poorest metropolitan statistical areas in the country. If the region were a State the border would rank number one in the number of uninsured, it would rank last in terms of per capital income, and first in the number of diseases.

The purpose of today's hearing is to get an updated assessment of the status of Hispanic health in the country, begin to put forth an agenda that can take the next steps in addressing these pro-

found disparities in health that should be viewed as unacceptable in our society.

Representative Rodriguez, who is the new chair of the Congressional Hispanic Caucus, he and I have worked together in an effort to respond to the challenges before us with regard to coverage and access and health disparities and as a result, we've put together a legislative initiative we are introducing today entitled "The Hispanic Health Improvement Act of 2002." While that legislation puts forth several initiatives to address what are disproportionately Hispanic problems, it needs to be noted that each section of the bill, including those to reduce the number of uninsured and to improve access to care, would substantially improve the overall health of our entire Nation, regardless of their race or ethnicity.

Let me just begin by introducing Representative Rodriguez. He is our first witness to testify about the legislation and the issues that he believes call on us to pass this legislation. It is a pleasure for me to work with him jointly on this effort and we appreciate him coming over for this testimony today. Why do you not go right ahead, Congressman?

Before we begin I have a statement from Senator Clinton.

[The prepared statement of Senator Clinton follows:]

#### PREPARED STATEMENT OF SENATOR CLINTON

I am pleased that my colleague on this committee, Senator Bingaman, and Representative Ciro Rodriguez have worked to bring a much-needed spotlight to the important issue of healthcare disparities among our nation's Hispanic population. In fact, I believe that this issue deserves floodlights, given that minority health barriers are a significant burden for millions of Americans of color today.

In New York, the healthcare hurdles are truly disappointing and the lack of access to healthcare must be addressed. For example, nearly 30 percent of Latinos in New York were uninsured from 1999-2000, and nationwide, there are currently 1.1 million uninsured Hispanic children in the U.S., compared to 806,000 uninsured white children or 703,000 uninsured black children.

The prevalence of health disparities speaks to a complex, multi-layered problem with many causes, including a need for education on part of healthcare providers, a need for greater awareness among patients, discriminatory actions, and inaccessible or unaffordable healthcare options. The public health risks that result from unchecked illnesses are far costlier and more troubling than education programs, outreach initiatives, or cultural training in healthcare facilities or universities. Perhaps the costliest, most intolerable expense is an expanding number of unhealthy, Hispanic families and children.

In my home state of New York, Latino constituents face multiple challenges on a daily basis. We have heard often from community health workers who stress the importance of recognizing the unique health struggles that the heterogeneous Latino population experiences from neighborhood to neighborhood, community to community, whether Puerto Rican, Mexican, Dominican, or Columbian. While some communities may battle asthma, another may battle diabetes. In Buffalo for example, Hispanics are likely to stiffer from

asthma because of the region's extreme weather and the prevalence of older homes, whereas in New York City, though Hispanics make up 24 percent of the city's population, Hispanics also account for 31 percent of all the city's reported AIDS cases.

However, if we look closely enough, common barriers emerge as well. Many Hispanics experience language barriers, which can compromise the quality of their care. Cultural barriers in certain communities have engendered mistrust of healthcare providers. Worse still, some may feel a lack of entitlement to visit a physician in their time of need. Even if these obstacles were removed, without health insurance coverage, families will never access high-quality, affordable, accessible health care. Currently, Hispanics represent a disproportionate percentage, one-quarter, of the 44 million Americans who are uninsured. If these conditions continue, a growing number of Hispanics will continue to be without medications or professional assistance.

While the numbers may project a grim outlook, Senator Bingaman and Representative Rodriguez have certainly taken a strong step toward a creating brighter, more productive future for the Hispanic population in this nation by meeting their healthcare needs. It is certainly time for steps to improve bilingual services, educational and outreach field programs, and training the next, truly diverse generation of physicians and nurses.

I firmly believe that this gap in care must be addressed immediately. I am committed to addressing this disparity as well as educating patients and healthcare professionals about this injustice in our healthcare system.

**STATEMENT OF HON. CIRO RODRIGUEZ, A REPRESENTATIVE  
IN CONGRESS FROM THE STATE OF TEXAS, AND CHAIRMAN,  
CONGRESSIONAL HISPANIC CAUCUS**

Mr. RODRIGUEZ. Thank you, Mr. Chairman. Let me first of all take this opportunity to thank you for the invitation for this historic hearing on Hispanic health. I am currently serving as the first vice chair of the Congressional Hispanic Caucus and chairman of the Task Force on Health and looking forward to becoming the chairman of the caucus. So I want to thank you personally for allowing us to come before you and I do feel that this is a historical hearing in terms of the fact that we have an opportunity to talk about health care as it impacts Latinos throughout this country.

In my own district, which stretches from San Antonio to the Mexican border, over 60 percent of my constituency is Hispanic. One of my border counties, which is Starr County, is about 98 percent Hispanic and Starr County unfortunately is also the poorest county in the Nation. It has over 44 percent that live in poverty.

It is truly an honor to be here with you, Senator, and I have enjoyed working with you and look forward to continuing to work with you. I would like to extend special thanks to also Senator Kennedy and yourself and your staff for their hard work that has brought us to this day.

In addition, I would like to recognize the witnesses in the next panel, especially of our own hometown, Dr. Francisco Cigarroa of the University of Texas Health Science Center at San Antonio. I have worked with Dr. Cigarroa on a variety of issues and consider

him a leader in health care at both the local and national levels. Dr. Cigarroa is the first Hispanic to ever be president of an institution regarding health, so we are real pleased to have him there in San Antonio.

As you also know, September 15 marks the beginning of Hispanic Heritage Month. The many events of this month mean little if we cannot have some positive change, and that is with regard to policies, so I want to thank you for bringing up the legislation as it deals with health during this particular month.

Today's hearing represents an important part of that whole equation and our celebrations of Hispanic Heritage Month but I commend the subcommittee for the desire to learn more about what I consider to be a national emergency, the status of Hispanic health.

I will focus on what I believe are the three most critical and comprehensive areas of need. First, we need to dramatically expand health care coverage for the growing Hispanic population. Second, we need to improve access to services for Hispanics in areas of particular need, such as diabetes, AIDS and border health, including mental health. Third, we need to build a health profession system that will reduce health disparities in the long run through improving training opportunities, as well as educational opportunities.

On improving coverage, the 2000 Census revealed what many of us already knew, and that is that the Hispanic community has grown by leaps and bounds over the past decades. Hispanics are now the fastest growing community in the United States, making 13 percent of the U.S. population, yet Hispanics make up 23 percent of the uninsured population. Nearly 37 percent of Hispanics under the age of 64 are uninsured. Sadly enough, 31 percent of the Hispanic children are uninsured.

Research shows that about 87 percent of the uninsured Hispanics come from working families. These are families that are working hard trying to make ends meet and yet find themselves uninsured. Additionally, only 43 percent have employer-based coverage compared to 73 percent of Anglos. Close to 60 percent of Hispanic families have annual incomes less than 200 percent of the Federal poverty rate. Access to affordable, quality health care is challenging. This includes economic challenges, language barriers, cultural differences, citizenship status. Even location plays a key role and we know that it is a direct relationship to health disparities.

A recent report of the National Institutes of Medicine outlined four areas that contribute to the health disparities. One of these areas is the language barrier. The second is the inadequate health coverage; the third, health care provider biases, as well as the fourth, which is the lack of minority physicians. In addition, the report showed that even when controlling for factors such as access to care, racial and ethnic health disparities still exist.

This report documents what health care advocates have been talking about for years. There is a level of unequal treatment for racial and ethnic minorities in health care systems. We need to target public health changes to reverse these trends in both the short term and the long-term. I believe we can do so by greatly expanding insurance and other coverages, by also addressing specific diseases that disproportionately impact Hispanic communities, and also by making institutional changes in our health professions and



training so that more doctors become sensitive to the particular needs of the Hispanic community.

The Hispanic population encounters many of the diseases at rates that are far beyond their numbers in the population. We need to improve access to affordable treatment in these specific areas if we are serious about addressing the needs of Hispanic health. I have included greater detail in the written testimony but I would like to be able to mention a few of the items that disproportionately hit and these diseases, such as diabetes, HIV/AIDS, and along the border with Mexico, Hispanics also encounter unusual high levels of infectious diseases, such as tuberculosis and hepatitis.

About approximately 10.2 percent of all Hispanic Americans have diabetes. For those that are 50 and over, about 30 percent have diabetes. Worse yet, Type 2 diabetes is spreading among Hispanic youth. According to the Centers for Disease Control, Hispanics account for 18 percent of the cumulative AIDS cases and 20 percent of the total AIDS cases among women and 23 percent of the total AIDS cases among children. In 1999, Senator, approximately 19 percent of the new AIDS cases were among Hispanics.

Hepatitis A also, which is mainly spread through unclean food and water migration, is two or three times more prevalent along the border than in the U.S. as a whole. We still have the need for infrastructure development when it comes to potable water. We still have people we call the water haulers that are hauling water in buckets and they still need those services. And I am not talking about the other side of the border; I am talking about on the U.S. side.

One-third of the new TB cases also in this country are in the border States. While the challenge seems daunting, I am confident that we have resources and the passion to change those outcomes.

This past August we helped organize the first National Hispanic Health Leadership Summit in San Antonio, TX. Dr. Richard Carmona, the new U.S. Surgeon General, delivered a striking keynote address on the need for ensuring that all sectors of society have access to health care services. We were joined also by a selected group of over 150 health experts nominated from across the country by partners that also helped to participate in this conference. Participants navigated through a series of facilitated workshops to build consensus on program and policies that can be delivered and enhanced to improve the quality of health care delivery to Hispanics in the United States for the next 5 years.

This leadership summit was sponsored by the National Hispanic Medical Association with the Congressional Hispanic Caucus serving as an honorary chair. Dr. Elena Rios, president of the National Hispanic Medical Association, should be commended for her leadership and her hard work in making the summit a success. I am sure she will share some of her thoughts on the leadership summit during her testimony.

However, I want to highlight some of the recommendations that came from the eight workshops that were done. The recommendations included increasing outreach and enrollment in Federal programs by creating State initiatives for community-based outreach programs, not only for AIDS but also in the area of SCHIP and Medicaid enrollment and high uninsured populations. Second, in-

fusing cultural competencies into medical literacy and medical error debate. Third, building workforce capacity to deliver quality health services, including interpreters and promotoras. Third, creating a Federal clearinghouse for health information and a regular report on the status of Hispanic health in this country. And finally, building community-based Hispanic research, just to name a few.

A report is going to be put together and the recommendations are going to be laid out and we look forward to continuing to work with you but I am pleased that the Hispanic Health Improvement Act, of which you are the main author and I want to thank you, Senator, incorporates a lot of the concerns that were raised during that summit, and that is why I have taken the time to mention that summit, because it took people from throughout the country to address those issues.

Congressional action is needed to address the needs of the Hispanic community so Senator, I want to thank you for introducing the legislation entitled "The Hispanic Health Improvement Act of 2002." I will also introduce the companion bill tomorrow in the House, since it turns out that we are not in session today. This landmark legislation, as you well know, is based on the previous Hispanic Health Care Act that we had introduced in the 106th Congress and on existing legislation that you yourself have had and you have championed in the Senate.

In addition, we have taken some of the Federal recommendations from the Hispanic Health Leadership Summit and incorporated them into what I consider to be one of the most comprehensive bills aimed at improving Hispanic health in the United States. The legislation offers a variety of different strategies for expanding health care coverage. It helps to improve access and affordability and helps to reduce health disparities. While I consider each provision in our bill to be important, I am just going to highlight some of the important things that I think are urgent ones.

In order to address the lack of health care and coverage, the legislation provides \$33 billion between fiscal year 2003 and 2010 for the expansion of the successful State Children's Health Insurance Program or SCHIP, to cover the uninsured low income pregnant women and parents.

In addition, it provides States the option to enroll legal immigrant pregnant women and children in Medicaid and SCHIP. The Congressional Hispanic Caucus considers the expansion of Medicaid and SCHIP eligibility to those that are here legally critical legislation as a priority, so we want to thank you in those efforts.

Second, the title also deals with access and affordability. Our bill requires an annual report to Congress on how Federal programs are responding to improving the health status of Hispanic individuals with respect to diabetes, cancer, asthma, HIV infection, AIDS, substance abuse, and mental health. The legislation provides \$100 million targeted to diabetes prevention, education, and school-based programs and screening activities in the Hispanic community.

Similarly, the bill also provides for targeted funding for programs aimed at prevention of suicide among Hispanic young ladies. We found some alarming data and research that shows that Latina young ladies are committing suicide at alarming rates and so I want to thank you for including that in your legislation.

Targeted grants also will be available for funds also to provide support for promotoras, improving the health of women and families in medically underserved areas, such as the border.

The third title focuses on the reduction of health care disparities by addressing the lack of providers who provide for the culturally competent and linguistically appropriate care. The bill also provides for increasing funding for the HRSA's health professions diversity programs. And, as you well know, the president's 2003 budget proposal eliminates virtually all the funding for these important programs that are drastically needed in our community and throughout our country.

In addition to promoting diversity, these programs support the training of health professionals in the fields experiencing shortages, such as pharmacy, dentistry, allied health, as well as nursing, and promoting access to health care services in medically underserved communities. The Hispanic Caucus considered increased funding for these programs a high priority. As the Hispanic community continues to grow, the implementation of these provisions will take on an even greater importance.

Mr. Chairman and members of the subcommittee, I ask for your support of the Hispanic Health Improvement Act and I want to thank you for your leadership in this area.

And I just want to close by indicating the importance of the cultural relevancy. When I first heard testimony and we allowed individuals to come before us in the year 2000, we had a lady who basically testified that she had been told, and she testified in Spanish and indicated to us that she had been told that she was positive, positiva, when it came to AIDS and she understood that as being positive, that everything was okay. And when she had a baby, her baby contracted AIDS, not knowing full well that she had AIDS. She had misunderstood her doctor when she was told that she did have it. So by indicating that she was positive, positiva, for AIDS, that was interpreted as being positive, so everything was okay, versus the other.

So when we hear stories like that of what continues to occur, it only emphasizes the need for us to continue to reach out, the need for us to continue to provide the education that is needed and the interpretation that is required and especially when we are dealing in cases of mental health and psychiatric help where those interpretations even become more critical.

Mr. Chairman, thank you for your leadership. I look forward to continue working with you and I really do appreciate your hard work in this area. Your staff has done a tremendous job and I want to thank you for being there for us and for all Americans. Thank you.

Senator BINGAMAN. Well, thank you very much, Congressman Rodriguez. I think your leadership is absolutely essential for us to succeed with this legislation, so we very much appreciate it.

Let me also just acknowledge Bruce Leslie, who used to be in the House, on the staff there, and has been working here with me in the Senate now for some time. He, of course, is from the border, as well, and understands these issues very well, as well as understanding the way the Congress functions.

So we are anxious to move ahead and I will not pose a series of questions to you at this point. I think it is clear to both you and me what the real questions are here. We have five very distinguished witnesses on the next panel and I am looking forward to hearing what they can contribute to this effort.

But again thank you very much and we will continue to work with you in the remaining weeks of this session and then into the next Congress, as well.

Mr. RODRIGUEZ. Looking forward to working with you, Senator. Thank you very much.

[The prepared statement of Mr. Rodriguez may be found in additional material.]

Senator BINGAMAN. Why do we not go ahead with the second panel and let me ask all five witnesses to come forward. Dr. Cristina Beato, Dr. Francisco Cigarroa, Dr. Glenn Flores, Dan Reyna, and Dr. Elena Rios.

Let me give a little more complete introduction for each of these witnesses before they begin their testimony. First let me welcome Dr. Cristina Beato, who is the Deputy Assistant Secretary for Health. I am happy to add that she comes from my home State of New Mexico, which we are very proud of, and served as the chief medical officer at the University of New Mexico Health Sciences Center.

Next to her, Dr. Cigarroa, Dr. Francisco Cigarroa, who is the president of the University of Texas Health Sciences Center at San Antonio. Congressman Rodriguez referred to Dr. Cigarroa. He is the Nation's first Hispanic president of a medical school and a renowned pediatrician and transplant surgeon. We very much appreciate you being here.

Dr. Glenn Flores has recently published an outstanding report as lead author of the Latino Consortium of the American Academy of Pediatrics Center for Child Health Research in the Journal of the American Medical Association or JAMA entitled "The Health of Latino Children," so we very much appreciate you being here.

Dan Reyna, who is the head of the Border Health Office for the New Mexico Department of Health and has initiated a number of outstanding and successful projects in the southern part of our State with far too few resources, I would point out, but has done a wonderful job in spite of that. He is also past president of the U.S.-Mexico Border Health Association.

And our final witness is Dr. Elena Rios. She is the president of the National Hispanic Medical Association and chief executive officer of the Hispanic-Serving Health Professionals Schools, Inc. Thank you very much for being here.

Why do we not just go right across and we will hear from all of you? If you could summarize your testimony, that would be most appreciated. We will include the complete statement that you have submitted in the record but if you could make the main points that you think we should be aware of and then I will have a few questions.

Dr. Beato, go ahead.

**STATEMENTS OF DR. CRISTINA BEATO, DEPUTY ASSISTANT SECRETARY FOR HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC.; DR. FRANCISCO CIGARROA, PRESIDENT, UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT SAN ANTONIO, TX; DR. GLENN FLORES, CHAIR, LATINO CONSORTIUM OF THE AMERICAN ACADEMY OF PEDIATRICS CENTER FOR CHILD HEALTH RESEARCH; DIRECTOR, COMMUNITY OUTCOMES, AND ASSOCIATE DIRECTOR, CENTER FOR THE ADVANCEMENT OF URBAN CHILDREN, DEPARTMENT OF PEDIATRICS, MEDICAL COLLEGE OF WISCONSIN, MILWAUKEE, WI; DAN REYNA, DIRECTOR, BORDER HEALTH OFFICE, NEW MEXICO DEPARTMENT OF HEALTH, LAS CRUCES, NM; AND DR. ELENA RIOS, PRESIDENT, NATIONAL HISPANIC MEDICAL ASSOCIATION, WASHINGTON, DC.**

Dr. BEATO. Thank you, Senator. Good afternoon. I am Cristina Beato. I am Deputy Assistant Secretary for Health and I want to thank you, Senator Bingaman and the other members of the Subcommittee on Public Health, for the invitation to testify at this important hearing on the health care needs of our Hispanic population. In my testimony today I will primarily focus on the efforts of President George Bush and Secretary Tommy Thompson to eliminate those health disparities that disproportionately affect Hispanic Americans.

The department recognizes that Hispanics are disproportionately affected by certain health conditions, such as heart diseases, breast cancer, unintentional injuries, diabetes, and HIV/AIDS. Additionally, Health and Human Services notes that Hispanics are also the largest group without any health insurance coverage.

Under the leadership of Secretary Thompson, the department has made elimination of racial and ethnic disparities a health priority. Departmental efforts focus on six major areas where minorities, including Hispanic Americans, experience serious disparities in health access and outcomes: diabetes, heart disease, stroke, cancer, infant mortality, child and adult immunizations, and HIV/AIDS.

Health and Human Services continues to support a vigorous, broad-based public health response to HIV/AIDS that include extensive research, prevention initiatives, and efforts to expand access to quality health care and services for those who need them. We are also working to address disproportionate impact of HIV/AIDS on racial and ethnic minorities. African-Americans and Hispanics account for more than half of our Nation's AIDS cases although they only represent 25 percent of our population. Department funds will continue to be used for expanded treatment, services, and community-based prevention activities HRSA Ryan White Care and Treatment Programs, minority HIV/AIDS and Office of Minority Health RC expanded technical assistance program for HIV.

Prevention of diabetes is primary in our department. The National Diabetes Education Program, a joint program sponsored by CDC and NIH, has reached 3.6 million Hispanics to date, with public service ads, media broadcasts, print media, including the Hispanic/Latino Campaign called "Mas que Comida es Vida," meaning

“More than Food; It’s Life.” It focuses on Hispanics who have diabetes or who are at high risk to develop that disease and this effort is slated to continue for the fiscal year 2003.

Health and Human Services also started “Take Time to Care About Diabetes,” another bilingual campaign to make more women aware of the dangers of diabetes. “Cuide Su Corazon” is one more campaign aimed at Hispanic Americans to help them understand the need to control all aspects of diabetes and to help prevent heart disease.

Through the Racial and Ethnic Adult Disparities in Immunization Initiative, known as READII, HHS will continue the two-year demonstration projects in five sites to improve influenza and pneumococcal vaccination rates both in African-American and Hispanic communities. San Antonio, TX, a predominantly Mexican-American community, is one of the selected sites and the efforts in Chicago, IL also target a significant Hispanic population. We know that immunization rates for adult Hispanics are at least 43 percent lower than those of their non-Hispanic white counterparts. Over the 2 years, the READII project sites will collaborate with stakeholders to develop and implement a community-based plan utilizing existing and innovative approaches.

Our department has developed a bilingual booklet to provide information to Spanish-speaking parents whose children may be eligible for health insurance benefits through the State Children’s Health Insurance Program or SCHIP program and Medicaid. The State agencies and others involved in SCHIP and Medicaid programs are encouraged to use the booklet to assist our Spanish-speaking residents to learn about the availability of free and low-cost health insurance programs for children in low-income families through their State’s SCHIP program.

Secretary Thompson recently launched Healthfinder Espanol, a Spanish-language Web site that helps consumers track down reliable health information quickly and easily on the Internet on our Web site. By providing essential resources in Spanish, Health and Human Services is creating a gateway for Spanish-speaking people to learn about preventing and treating illness and developing a healthy lifestyle.

Healthfinder Espanol brings together in one easy-to-use site Spanish language health information on over 300 topics from 70 government agencies and nonprofit organizations, including the health issues of the greatest concern to those of Hispanic heritage. The site offers both a Spanish text search and a list of topics in Spanish that can be browsed.

MEDLINEplus, the National Library of Medicine’s consumer-friendly health Web site, is also now in Spanish. The department is using tools at its disposal to increase health education and awareness to Americans across the country. MEDLINEplus en Espanol is one more step to ensuring that Hispanic Americans have real-time access to the important health information that they need.

Vital to us are Community Health Centers. Health and Human Services continues to support increased funding for the Community Health Centers, which play a vital role in treating and serving the health care of Hispanics. Last month Secretary Thompson an-

nounced \$30 million in grants to create 70 new and expanded health centers. This is a vehicle to extend health care service for people without health insurance. For fiscal year 2003 our department proposes to increase its funding of Community Health Centers to a level of \$1.5 billion, a \$114 million increase above the current year's appropriation and \$290 million above the funding level of the last 2 years. This funding will add 1,200 new and expanded health center sites over a five-year period and increase the number of patients treated from 11 million to 16 million.

In terms of bilingual and bicultural services, Health and Human Services continues to support principal demonstration grants through the Office of Minority Health's Bilingual/Bicultural Service programs in communities to improve Minority Health Grant Programs. Both of these programs support the development of strategies geared at eliminating health care access barriers, improving the coordination of integrated community-based screening, outreach, and other enabling services of the Spanish-speaking individuals.

The U.S.-Border Health Commission, created in July of 2000 by joint action of the United States and the Mexican governments, exemplifies our department's commitment to a binational framework. The goals for the Commission are as follows: to create "Healthy Borders 2010" objectives and health indicators pertinent to the region; to provide international leadership; and to optimize the health and quality of life along the U.S.-Mexico border. Secretary Thompson, who co-chairs the commission with the Mexican Minister of Health, has made border health a priority for our department.

A Healthy Border 2010 program was recently launched by the BCH to promote and improve the health of people living on the United States-Mexico border region. The two major objectives of this program are to increase and improve the quality and the years of healthy life and to eliminate health disparities. A Border Commission office now operates out of El Paso, TX and funding is provided to support the BCH objectives.

Recently, Secretary Thompson and the Mexican Minister of Health signed a cooperative agreement to enhance the safety of food supplies in both of our countries and to reduce the incidence of food-borne illnesses on both sides of the border through improved inspections. Other projects that address health issues along the U.S.-Mexico border include HRSA's HIV Border Health Initiative and the HRSA and NIH Salud para su Corazon, a project to reduce heart disease, and HRSA's Workforce Diversity Border Initiative, "Building a Workforce for a Health Border."

Like Congressman Rodriguez said, Health and Human Services Centers for Medicare and Medicaid Services funds researchers, including Hispanic researchers, to conduct research on access, utilization, quality of service, and activities related to health screening, prevention, and education of Hispanic Medicare and Medicaid beneficiaries.

The National Center on Minority Health and Health Disparities at NIH is authorized to promote minority health and to lead, coordinate, support and assess the NIH effort to reduce and elimi-

nate health disparities. Addressing the health research needs of Hispanics is a key activity of this center.

Promoting NIH minority health disparities research and health disparity career opportunities for minorities is a major goal of NCMDH. Since fiscal year 2001, NCMDH has operated two loan repayment programs—the Loan Repayment Program for Health Disparities Research and the Extramural Clinical Research Loan Repayment Program for individuals from disadvantaged backgrounds. There is outreach to Hispanic health professionals and researchers for participation in these two pipeline programs.

Grants administered by the Centers of Excellence in HHS's Health Resources and Services Administration assist health professions schools to support programs of excellence in health profession education of minority individuals in allopathic and osteopathic medicine, dentistry and pharmacy, graduate programs in behavioral or mental health, including clinical counseling psychology, clinical social work, marriage and family therapy. The Centers of Excellence strengthen the national capacity to train students from minority groups that are underrepresented in these health professions and build a more diverse health care force. HRSA currently supports 11 Hispanic Centers of Excellence.

In August of 2001 Secretary Thompson launched the Health Insurance Flexibility and Accountability waiver initiative to encourage States to expand access to health care coverage for low-income individuals through Medicaid and State Children's or the SCHIP demonstrations. This initiative gives the governors more tools and flexibility to coordinate State Medicaid and SCHIP programs and offers a simpler application for States that commit to reducing the number of people without health insurance. Thousands of Hispanic Americans living now in California, New Mexico and Arizona, among other States, now enjoy the ability to expand health insurance benefits as a result of waivers granted to their States under the secretary's initiative.

President Bush also has health insurance tax credits because the absence of health insurance coverage for some 40 million Americans, including many that are Hispanic Americans, is a problem calling for an immediate solution. The president in his 2003 budget sets forth a package of solutions including, most importantly, a proposal for the use of tax credits to offset the cost of obtaining health insurance. This proposal has received broad bipartisan support. If enacted, it can lead to a significant reduction in the uninsured population and, at the same time, lead to improvements in the market for individually purchased health insurance, greater choice and flexibility for individuals for determining the coverage that best fits their needs, and improving quality and price of health care provided not just to Hispanic Americans but to all Americans.

In closing, I have provided a snapshot of some of the president's and the secretary's activities that focus on eliminating health disparities that disproportionately affect Hispanic Americans. Our department is making progress but we know that more can be done and we will continue to do more in order to lessen the social and economic burden of not improving the health status of Hispanic Americans.



Again, Senator, I thank you for the opportunity to testify before you today. Thank you.

Senator BINGAMAN. Thank you very much.

[The prepared statement of Dr. Beato may be found in additional material.]

Senator BINGAMAN. Dr. Cigarroa, why do you not go right ahead?

Dr. CIGARROA. Senator Bingaman, I thank you very much for inviting me to speak and testify before this important subcommittee but I would also like to give my appreciation to Congressman Ciro Rodriguez, who has really been a tremendous leader in addressing health disparities and health challenges in South Texas.

Senator BINGAMAN. Congressman Rodriguez, why do you not move up here beside me? There is no reason to be clear down at the end. I did not even see you sitting there. Please come over here. We have plenty of room right up here at the front.

Go right ahead, Doctor.

Dr. CIGARROA. Sorry, Ciro.

Well, what I would like to do is discuss this testimony the subject of Hispanics and the health professions. I have given written testimony so I would like to just summarize this in about five minutes.

The University of Texas Health Science Center is the academic health center responsible for the vast South Texas border region, which comprises more than 4 million people, almost 25 percent of the land mass of the State of Texas. Our Health Science Center has five schools but in addition to that, it has a regional academic health center which resides right on the U.S.-Mexico border region.

We have been responsible for educating more than 15,000 health professionals since the inception of the Health Science Center in San Antonio and many of those health professionals have chosen to practice in communities which are largely Hispanic. There is no doubt that our role is extremely important to South Texas because many of these regions in South Texas are among the most medically underserved. And Congressman Rodriguez actually cited Starr County, which is probably the most medically underserved region in this Nation.

We also have clinicians and scientists whose great interest is really addressing diseases that affect the border population, predominantly diabetes and infectious diseases.

I would like to touch upon some of the challenges we face in South Texas as we address the issues of Hispanic health. One of the greatest challenges, and I do not believe anybody here will disagree on this, is that the shortage of Hispanics in the health professions is among our greatest challenges. If we want to improve the health care of the Hispanic population, then it is essential that we educate more Hispanic health care professionals. And if we want to educate more Hispanic health care professionals, then we must provide more role models for the Hispanic population in South Texas and along the U.S.-Mexico border region.

So it is important that we provide these mentors and send these young students encouraging messages at an early age. I have been truly fortunate because my father, my grandfather and my uncle were practicing physicians in South Texas and I remember very clearly just about 25 years ago traveling with my uncle around the surrounding communities of South Texas because he was the only

general surgeon in these communities. That was only 25 years ago and we have done a lot to improve that but it is still extremely medically underserved.

Also firsthand I realized the importance of being sensitive to cultural competencies and also the importance of being able to be bilingual in such an area.

So really it was these topics that I was actually addressed with at home, growing up in this environment, that really set the stage for myself. It set the stage to develop high goals, to leave Laredo, among one of the poorest public school systems in the United States, but to have the courage to become educated and among one of the greatest educational centers in our Nation and among some of the greatest residencies in our Nation. And it was these experiences that gave me the great desire to return to South Texas and contribute to the education of health care professionals along the U.S.-Mexico border region.

There is no doubt in my mind that if it was not for these important mentors that I had growing up in South Texas, I would not have become a pediatric surgeon; I would not have become a transplant surgeon; I would not have returned to South Texas. But it was these global experiences that I had that also gave me the courage to become the president of an academic health center.

I know firsthand that there are many young, bright, capable students that have not had the privilege that I have had to be able to discuss health and the health professions around their dinner table. So I personally recognize the importance of stimulating the scientific interests of students long before they reach undergraduate or graduate school.

So at the Health Science Center we place a great emphasis on these pipeline issues. One of our most successful programs is the Med/Ed program, which I believe should be replicated in cities around this Nation. This is a program which introduces young students from South Texas to the health professions by introducing them at a very early age to physicians, to clinics, to our own Health Science Center in San Antonio, and through that means hopefully providing that stimulating experience that inspires youngsters to enter the health professions and also to build big dreams.

As the students who have participated in the Med/Ed program begin to graduate from college and enter the health professional training, we are seeing successes. Since 1997 more than 750 high school students have been a part of this program and now the first class is beginning to graduate and more than 75 of these students are entering the health professions and many of these students will again practice in South Texas.

We are also very proud that through Med/Ed we have actually established three Hispanic Centers of Excellence at the Health Science Center—one in the medical school, one in the dental school, and one in the school of nursing. There is no doubt that we have a commitment to providing role models and that commitment was demonstrated this past June when we established the Regional Academic Health Center in Harlingen, TX. That opening ceremony of the Regional Academic Health Center, at which 48 of our medical students are educated right along the U.S.-Mexico border region, in that 1 day we nearly doubled the number of Mexican-

American physicians who serve as faculty at academic health centers in this Nation. Again the importance of establishing mentors and individuals which the younger generation can aspire to become.

We are proud of these interventions we provide at the Health Science Center but we also know that the number of Hispanics who graduate from college is unacceptably low and this statistic is worse the closer you get along the U.S.-Mexico border region.

As the demographics change in our Nation, if we do not change, these two divergent trends—a rising Hispanic population and a small number of Hispanic college and postcollege graduates—then we are on a collision course. Unless we reverse the college and postcollege success rate of underrepresented minorities, the future and the health of our Nation are in jeopardy.

Our major challenge in reversing these statistics, of course, is funding. Our past funding has allowed us to implement many of these wonderful programs which I have commented upon but in fiscal year 2003 we face the possibility not only of a funding shortfall but possibly even a virtual elimination of the current level of funding for Title VII health professional training programs. Now to discontinue this funding now would be to discontinue our progress now, which would take us a step away from the goal that we want to achieve.

Now there exist many more issues that are critical to Hispanic health. Those are paucities of nursing and allied health professionals along this border region. There is also a severe shortage of these professionals in our Nation, but it certainly worse in Hispanic areas. And there also exist diseases, as Congressman Rodriguez has stated, such as diabetes, multidrug-resistant tuberculosis, that affect this border region so significantly. So we also not only need to encourage students to enter the health professions but we also need to encourage students to enter the field of biomedical science.

I, too, Congressman Rodriguez, agree with the report issued by the Institutes of Medicine that calls for the government to recognize and reward academic health centers that actively recruit and support well trained faculty and students who are from underrepresented minority populations. If we fail to take steps to address the gap between the health of the majority population and the health of the Nation's rapidly growing minority population, then we are on a course leading to an unhealthier Nation. The bill, Senator Bingaman, that you are considering contains much that would be of great assistance as we continue to progress toward many of the goals that the Health Science Center and many other academic health centers are making.

In Texas we know all too clearly that diseases care nothing about borders. Just as there are rivers of commerce, there are rivers of infectious diseases and though they may start at the border, they are eventually seen all the way to our northern border which we share with Canada.

I personally applaud you, sir, for the concern that you have for the situations that we face along the U.S.-Mexico border, situations which if left unchecked, will have a major impact on the State of Texas and on our Nation. So I thank you, sir, for the opportunity

to present this testimony to this important and distinguished subcommittee and certainly a more formal statement is made in my formal testimony.

Senator BINGAMAN. Thank you very much for that excellent testimony.

[The prepared statement of Dr. Cigarroa may be found in additional material.]

Senator BINGAMAN. Dr. Flores, we are glad to have you here.

Dr. FLORES. Thank you very much, Senator. I chair the Latino Consortium of the American Academy of Pediatrics Center for Child Health Research. I am a pediatrician who has cared for disadvantaged children for over 10 years, a researcher who studies how to improve the health of America's children, and a faculty member at the Medical College of Wisconsin. I am pleased and honored to be here today.

I am going to talk about kids. I will discuss the demographic surge in our Nation's Latino children, highlight urgent priorities and unanswered questions in Latino children's health, and show why the Hispanic Health Improvement Act or HHIA would improve the lives of millions of American children. For extensive details and 113 references on what I will discuss today, I refer you to my written testimony and an article of ours published in the Journal of American Medical Association in July 2002.

Latinos are now the largest minority group of children in the United States, numbering 12 million and comprising 17 percent of the population under 18 years of age. In California Latinos surpassed whites as the largest racial and ethnic group of children in 2000 and by 2010 half of California's children will be Latino. Latinos are one of the youngest and fastest growing groups in our Nation. Despite this dramatic population growth, Latino children continue to experience a disproportionate burden of illness, injuries, impaired access to health care, and health disparities.

Here is a true story. Maria was a three-year-old Latino girl brought to the emergency room because of severe stomach pain. Maria's mother spoke no English and no medical interpreter was available. A pediatrician examined Maria and discharged her with a diagnosis of colic. An hour later Maria's parents brought her back to the emergency room because her pain had worsened. The same pediatrician examined her and Maria's mother found the physician to be quite angry. Maria's father was upset because no interpreter was available and he felt Maria was treated poorly because his family was Latino. The pediatrician sent Maria home again.

Several hours later Maria and her family returned to the emergency room. Maria's condition had deteriorated and was not quite serious. The pediatrician hospitalized Maria immediately. In the operating room Maria was found to have a perforated appendix and peritonitis. Maria was hospitalized for 30 days because of complications, including two infections of her surgical incisions. Maria had no health insurance.

The issues faced by Maria and her family typify those confronting millions of U.S. Latino children and their families. Maria's family spoke no English. 44 million Americans speak a language other than English at home and 19 million are limited in English proficiency, or LEP. Latino parents cite language barriers as the single

greatest obstacle to health care access for their children but medical interpreters frequently are not called when needed, inadequately trained, or simply not available at all. Only a few States provide third-party reimbursement for medical interpreters and only one-fourth of hospitals actually train their interpreters.

The HHIA would provide Medicare and Medicaid reimbursement for hospital interpreters and fund identification and training of bilingual health professionals. All third-party payers should reimburse for medical interpreters because we can either pay a little now for high quality medical care for all children or pay a lot more later when preventable medical errors, hospitalizations, lawsuits and deaths result because no interpreters were available.

The Office of Management and Budget estimates that providing adequate language services to all LEP Americans would cost \$4.04 per visit, a 0.5 percent annual increase in national health care expenditures. Medical Spanish classes should be mandatory in medical schools in States with large Latino populations and health care institutions should require that all medical interpreters undergo fluency testing and proper training.

Maria had no health insurance coverage for her 30-day hospital stay. Latinos are far more likely to be uninsured at 25 percent than any other group of U.S. children. In comparison, 7 percent of white and 14 percent of African-American children are uninsured. SCHIP efforts to enroll Latino children have largely been unsuccessful. Only 26 percent of parents of uninsured children ever obtain information about Medicaid enrollment and 46 percent of Spanish-speaking parents are unsuccessful at enrolling their uninsured children in Medicaid because materials are unavailable in Spanish. Additional research is needed on effective interventions for insuring uninsured Latino children and the HHIA would be a giant step forward because it would provide grants to promote innovative outreach and enrollment.

Maria's story emphasizes the importance of culturally competent health care. Failure to consider cultural issues in health care can result in dissatisfaction, medical errors, inadequate pain management, fewer prescriptions, and use of harmful remedies, but cultural competency training is still not an integral part of educating health professionals, with only 8 percent of U.S. medical schools offering separate courses on cultural issues and only 26 percent teaching about Latino cultural issues. Cultural competency training should be mandatory in health profession schools and continuing professional education. The HHIA would enhance provision of culturally competent health care by creating a national center for cultural competency responsible for providing educational materials and programmatic assistance.

The physician that cared for Maria was not Latino. Latinos are underrepresented in all health professions. Although 17 percent of children are Latino, only 3 percent of medical school faculty, 5 percent of pediatricians, 3 percent of dentists and 2 percent of nurses are Latino. To match future population growth, our Nation would need twice as many Latino physicians but minority medical school enrollment recently fell. These trends are alarming because Latino communities are more likely to have physician shortages and

Latino physicians significantly more often care for Latino and uninsured patients.

We need programs targeting minority students interested in the health professions at an early age. The HHIA's Health Career Opportunity Program and Hispanic-Serving Health Professions Schools Grants are excellent examples.

Latino children like Maria frequently receive a lower quality of health care. In children hospitalized for surgical correction of serious limb fractures, whites receive significantly higher doses of narcotic pain medications than Latinos. Other noteworthy health disparities for Latino children include the highest rates in U.S. children of tuberculosis, cavities, unintentional injuries, suicide in adolescent girls, obesity in boys, and asthma in Puerto Rican children. More research is needed on why health professionals treat minority children differently and effective interventions for eliminating health disparities. Mandatory medical school cultural competency courses examining health disparities are a critical first step.

Because Latino children are frequently not included in medical research, we need mechanisms to ensure better recruitment. Federally funded research should always include methods to recruit and appropriately study diverse populations, including educating minorities about clinical trials, recruiting non-English speakers and immigrants, and collecting and analyzing data by race and ethnicity. The HHIA includes several important mechanisms for reducing health disparities for Latino children.

In conclusion, one out of every six American children is Latino. It's time for our health policies, services, and research to address this dramatic demographic change, which can be accomplished by one, ensuring all children and families with limited English proficiency have access to trained medical interpreters reimbursed by third-party payers or bilingual health professionals; two, providing all children with health and dental insurance; three, requiring cultural competency training for health professionals; four, increasing the number of Latinos in health care professions; five, including more Latino children in medical research; and six, eliminating health disparities for Latino children.

The Hispanic Health Improvement Act would address all of these issues and result in significant improvements in the health and well-being of the 12 million Latino children in America. Thank you.

Senator BINGAMAN. Thank you very much for the excellent testimony.

[The prepared statement of Dr. Flores may be found in additional material.]

Senator BINGAMAN. Next is Dan Reyna, who, as I indicated before, is director of the Border Health Office for the New Mexico Department of Health in Las Cruces. Dan, please go right ahead.

Mr. REYNA. Thank you, Senator Bingaman, Congressman Rodriguez. I appreciate the invitation to be with you today. I appreciate also the opportunity to share some thoughts with you today on the issues of Hispanic health as they affect this Nation and the Hispanic heartland of the Southwest, the U.S.-Mexico border.

The U.S.-Mexico border is my neighborhood. It is a complex binational, bilingual, multistate, multicultural, multieconomic 10-State region that stretches nearly 2,000 miles horizontally with no less

than five distinct vertical border regions that are more directly defined by those communities 100 kilometers on either side of the international border. The border is an area with multiple public health systems among the 10 States, local county jurisdictions and two Federal Governments. Today it is, as Congressman Rodriguez mentioned, most appropriate that the discussion of a new strategy for the improvement of the Nation's Hispanic health occurs during our celebration of Hispanic Heritage Month.

The U.S.-Mexico border factors significantly in the overall Hispanic demographic picture, as is evident by the following and as mentioned by some of the presenters. Half of all Hispanics live in just two States—California and Texas. New Mexico has the highest percentage of Hispanics of any State, at 42 percent, followed by California and Texas at 32. New Mexico led all States in the percentage of people aged five and up who spoke Spanish at home, followed by Texas at 27 and California at 26 percent.

Targeting the health status improvement of the growing Hispanic population is both a public policy challenge and opportunity. It is a true opportunity to engage in a systems approach that can target long-term improvements in health status.

As to health care coverage, the New Mexico Border Health Office has been a State partner with the Rural Health Office at the University of Arizona in Tucson since 1996 and the Health Resources and Services Administration's "Border Vision Fronteriza" Project. Although the project began as an initiative to develop model outreach projects, the focussed shifted in 1999 toward outreach and enrollment of children into Medicaid and SCHIP. The project for the current funding cycle referred to as BVF II was funded for 1 year from October 2001 to September 2002.

The BVF II project is unique in New Mexico such that I refer to it as an integrated program approach model. HRSA provided funds taken from at least three internal program sources, since there was no specific line item, to the University of Arizona who thereafter subcontracted to a community nonprofit organization in Las Cruces, NM to support the project in Dona Ana County, a border county just north of El Paso County, Texas. The role of the Border Health Office is to operate as the coordinating entity directing the activities of the 13 partner agencies.

The BVF II project provides at least a half-time community health advisor or promotora, Spanish for promoter of health, to the primary partners, which includes a hospital outreach clinic, two community health centers, a State public health clinic, a behavioral health center, a juvenile criminal detention facility, and partial support to a primary school. A key ingredient to our partnership list is the active involvement of the local staff of the Income Support Division of the State Department of Human Services, the State Medicaid agency and the leadership of the local, surprisingly so, Immigration and Naturalization Service, INS, district office. The New Mexico project was to receive nearly \$79,000 for this fiscal year but program cuts will limit us to only \$60,000. It is probable that funding may not be provided after the end of this month, although we remain hopeful.

The effectiveness of this model approach for outreach and enrollment of children is evident in the results. For the project period of

January 1, 2000 to August 15, 2001, BVF I phase, the project in Dona Ana County achieved 549 percent of its target. This amounted to direct processing of no less than 12 percent of all Medicaid and SCHIP enrollments in the county. For the project BVF II from October 2001 to September 2002, the project has to date, through August of this year, achieved 190 percent of the target enrollments. The legislation as proposed will provide \$50 million to improve outreach and enrollment of children into Medicaid/SCHIP.

We are confident that the replication of the BVF-type programs throughout the county will ensure that no child misses an opportunity to access the appropriate health care services. Using promotoras as in the BVP model is cost-effective and appropriate in targeting the Hispanic populations in need. It is a model they recognize and accept. It has performed as advertised.

As to access, an example of a similar integrated program approach is that of the development of the Healthy Gente initiative for the U.S.-Mexico border region. Healthy Gente—Gente is the Spanish word for people—is a risk-population-targeted and outcome-based health planning initiative established by the U.S. State Border Health Offices specifically designed to be compatible with the United States Healthy People 2010 program. The Healthy Gente program includes 25 Healthy Gente objectives that relate directly to the 46 national Mexican health indicators on the Mexican side.

Progress in achieving the Healthy Gente objectives for the U.S. border region is a significant challenge when you consider that if the U.S. border region were a separate State it would rank last in access to health care, first in the highest rates of uninsured, second in deaths related to hepatitis, third in deaths related to diabetes, first in the number of cases of tuberculosis with 34 percent of all U.S. cases found in the four border States, first in children living in poverty and last in per capital income. Additionally, the average percent of uninsured for Hispanics in the four States of the border exceeds 34 percent, as mentioned earlier, slightly higher than the national uninsured rate for Hispanics at 32.

Diabetes, Senator, is a major chronic disease confronting the Hispanic population. It is one of the leading causes of death on both sides of the U.S.-Mexico border.

The Las Cruces Sun News editorial of September 17 described diabetes as the “darkest cloud” upon the review of the recently released report on the Status of U.S. Health by the Department of Health and Human Services. Diabetes, I contend, is essentially the center of gravity for the Hispanic population in the U.S. Prevention and control efforts require the maximum support at all levels. All available means and approaches focussed on early screening and diagnosis, including at the primary school age, require immediate attention.

The U.S. Mexico border region is the unavoidable front line to many of the growing and emerging public health challenges. The funding of the border health initiatives at \$200 million for fiscal year 2003 will allow the stakeholders to address the problems in their totality. Effective solutions require resources for prioritization and coordination and strengthening of joint efforts and sustainability.



Adequate funding to the Border Health Commission—\$10 million for fiscal year 2003—will ensure strengthening its capacity to serve as a platform from which public health problems can be assessed, collective policy development coordinated and assurance of actions adequately evaluated. The U.S.-Mexico Border Health Commission is an appropriate venue to undertake these significant impact issues of Hispanic health for the border region, developing and supporting bold interventions by local and State partners in areas such as diabetes, substance abuse, and infectious diseases.

The utility and appropriateness of the promotora model has been proven effective for the range of outreach and community support activities. The approach is compatible with all Hispanic populations. It is, as I have referred to it at times, the “Mary Kay” approach to community health. It has worked throughout the country and I ask that you support the requested funding of \$5 million for fiscal year 2003 through 2005.

As to health disparities, the emerging national demographics will bring additional challenges in meeting the health manpower capacities needed by the increasing minority populations. Latinos, African-Americans and Native Americans account for about 25 percent of the U.S. population yet they represent only about 6 percent of practicing physicians in the United States, according to the report, “The Color of Medicine: Strategies for Increasing Diversity in the U.S. Physician Workforce.”

A quick look at the data on the availability of Hispanic faculty in the health professions schools is no less than disturbing, as may be seen by the following institutional self-reporting statistics on the percentage of Hispanic faculty. As to medical colleges, Hispanic faculty make up 3.33 percent of all faculty, as to colleges of nursing, 1.3 percent, as to social work, 4 percent, dental, 3 percent. We cannot engage in a systems approach to addressing the health problems of the Hispanic population if we cannot open the doors to the future and widen the hallways of opportunity for aspiring and qualified health professions students and faculty.

It is no less a crisis for the next generation, considering the gestation time from high school graduation to medical practice, and surely much more to reach for a medical or dental school faculty position. It could take a half-century to reach 10 percent in any one professional category, or possibly more. We should hope not.

Senator, Congressman, I thank you for the opportunity to be with you today.

Senator BINGAMAN. Thank you very much, Dan, for that excellent testimony.

[The prepared statement of Mr. Reyna may be found in additional material.]

Senator BINGAMAN. Dr. Rios, you are the final witness today. We are very pleased to have you here. Please go right ahead.

Dr. RIOS. Thank you very much, Senator and Congressman Rodriguez. I am very honored to be here.

I just wanted to start out by saying I just flew in this morning from California where I was with the California Latino Medical Association, which is a group that I was actually president of before I came to Washington in 1993. And on Friday I was in San Diego with a sponsored conference, along with our partner national

groups, the National Medical Association representing African-American doctors and the American Association of Indian Physicians representing Native American doctors. And in both meetings I think there is a lot of enthusiasm among the medical community for the support of activities such as this bill that really show potential for how the health system can improve American health for all Americans. And I just want to say that we are actively seeking support for this bill.

The National Hispanic Medical Association represents licensed Hispanic physicians in the United States. The mission of NHMA is to improve the health of Hispanics. The Health-Serving Health Professions Schools, Inc. represents 22 medical schools and three public health schools and the mission of this organization is also to develop Hispanic student and faculty and research capacity to improve Hispanic health.

We all know Hispanics are now 14 percent of the U.S. population and by the year 2050 one out of every four Americans will be of Hispanic origin. In the case of Hispanic patients, as we have heard, we are challenged by the language needs, literacy levels, lower levels of poverty and education, citizenship status, strong cultural beliefs and attitudes, family group decision-making, poor awareness of public health programs or how to follow instructions that come with complex treatment regimens, prescription drug labels, referrals for specialty care or elaborate x-ray preps and exams.

Our health system is the best in the world but in order to be proud of that system the Hispanic Health Improvement Act of 2002 challenges the U.S. Senate to develop new strategies to improve the quality of health care delivery that responds to the needs of Hispanics.

In August, as Congressman Rodriguez mentioned, NHMA was proud to co-sponsor, with the Congressional Hispanic Caucus and the Department of Health and Human Services, the National Hispanic Health Leadership Summit. Also partners included the EPA, the National Highway Traffic Safety Administration, the Robert Wood Johnson Foundation, California Endowment, Amgen, Aventis, PhRMA, GlaxoSmithKline, and several national Hispanic organizations. One hundred and fifty health providers from Hispanic communities around the country and our partner representatives put forward several recommendations to improve programs both at the Federal and State level and at the community level for our private sector community-based organizations and many of those recommendations overlap with issues addressed by this bill. We will have a report on those recommendations this fall and I am not going to address that here, just to say that we are very proud to see people on the same page.

I would like to address proposed strategies that this bill addresses for the Department of Health and Human Services to continue to improve health programs and activities targeted to Hispanics.

First of all, on access to care, I think we do know the major barrier to access is that two out of five Hispanics do not have insurance and this legislation addresses this barrier by creating grants for outreach and enrollment and increasing eligibility for both SCHIP and the Medicaid program and we applaud these efforts. However, we also believe that employers need incentives that in-

crease their ability to provide insurance, since smaller employers who employ Hispanics cannot afford insurance benefits.

We also applaud the special programs that would be targeted at families with limited English proficiency and we recommend that there be reimbursement for interpreters added to this legislation. Moreover, the U.S. Department of Health and Human Services, currently reviewing its guidance to the Nation on LEP services under Title VI and supported by the administration, should have a clear and firm guidance to direct to our health providers. It is critical that communication be enhanced between providers and patients and we are supportive of the Federal Government, representing the largest insurance programs in the Nation, taking the lead in this area. We recognize the importance of this bill in moving this area along.

We recognize the vision for the development of the reimbursement policy for LEP services for Medicaid program and SCHIP in this bill and also recognize that the bill for the reauthorization of community clinics introduced earlier this Congress also provides a provision for reimbursement. We hope that there could be a strategy, perhaps starting with a Congressional task force, linked to the future of Medicare, Medicaid and SCHIP on LEP services reimbursement and the evaluation of interventions to guide further policy-making.

In terms of the U.S.-Mexico border, it has already been addressed. The U.S.-Mexico Border Health Commission is very key and has great potential to serve as a conduit for advancing many, many health programs if properly supported and funded. It is also critical that we investigate further research along the U.S.-Mexico border.

In terms of disparities in health, it has already been mentioned, all of the different areas—diabetes, HIV/AIDS, cancer, mental health. I think we are especially aware of these new programs supported in this bill and would hope that it would include also the patient navigator system, the community health workers, and the Special Population Networks, such as Redes en Accion, that are models right now for targeting chronic disease interventions in the Hispanic communities.

In terms of diversity in the health professions, the U.S. Federal Government has supported the national policy to recruit disadvantaged and minority students into the health professions since the 1960s. The literature has proven over and over again that the Federal Health Careers Opportunity Program has resulted in two to three times the number of graduates practicing in medically underserved areas and Hispanic and black physicians provide more care to their communities and to Medicaid and uninsured patients than nonminority doctors. Surely we can recognize these programs as successful.

In addition, in this era of increasing health care costs, we must also consider that minority patients, who tend to be uninsured, will eventually create more costs in the system as they demonstrate chronic illnesses. Thus it is more effective for the health system to finance recruitment programs for future minority doctors who can provide targeted services. The consequences of not supporting mi-

minority health workforce development will be greater cost to the taxpayers of America, who would bear the brunt of shifting costs.

But even three decades of Federal funding of HCOP have not resulted in enough Hispanics in the health workforce. We are only 5 percent of the total physicians, 3 percent of the total dentists, 2 percent of the total nurses, and there are many, many reasons why this is so. I think a major reason though is the limited support from the health system for academic skills-building and admissions preparation services available in minority community schools in the grammar schools and in the high schools and the colleges. The Federal Government and, I believe, the private industry and private businesses need to get involved in supporting HCOP at the \$40 million level that has been recommended in this bill.

So, too, the Congress should support the Center of Excellence at the \$40 million level, which is the HRSA program that not only continues the HCOP's recruitment, but adds curriculum development and research and minority faculty development that is so much needed for role models in our health professions.

Last in terms of health professions, I have to say that the concept of having special grants to those schools that are designated as Hispanic-Serving Health Profession Schools is a unique opportunity for this country to recognize the importance of those schools with important track records of having Hispanic students and having Hispanic faculty, that have the potential to promote much more curriculum that is needed for the whole country to understand Hispanics.

In terms of data collection and research, we strongly support this area and we need to have racial and ethnic identifiers and data collection and research in order to demonstrate trends and new knowledge for our program development and a more effective policy analysis and policy debate on what is needed to improve Hispanic health. And we have to recognize all of our Hispanic subgroups—Mexican, Puerto Rican, Cuban, Central and South American and other Hispanics.

Data collection through community-based research is most important, as is being done by the Federal agencies now, as was mentioned earlier, CMS, also NIH, AHRQ, and CDC. We strongly support expanding the opportunities for research in these agencies and, for example, specific projects—the NIH has a new Export Program; NIH and HRSA have Centers of Excellence Programs; the AHRQ agency has the Exceed Program, which is the Excellence Center to Eliminate Racial Disparities in Health; CDC has REACH programs and I know that CMS has a special Hispanic Health Services Research Program.

But really what is critically needed is that we start putting more funding into the development of more research and more researchers that are from the Hispanic community and that we link the academic centers with the communities and have real community-based research. That is something that this Nation really has not done in terms of Hispanic health. And not only that, but we need research institutes, publications, journals and clearinghouses so that we can have better use of the research that we should develop.

Then the last area really is about cultural competence. It has already been mentioned, the important needs, so I am not going to

go over that. I just think that what is critical now is that we start developing a sense of where to go and having clearinghouses on cultural competence, and that is really one of the major roles of the Office of Minority Health and why I think the Office of Minority Health was included in this bill. The Office of Minority Health at HHS and all of the agency's Offices of Minority Health would continue to coordinate the outstanding internal programs of the development, as well as linking to the constituents through all of their HHS regional offices.

But I think that what is most important in this bill is the Center for Cultural Competence and Language is a new center that needs to be funded at the highest levels—I believe it is mentioned at \$5 million in this bill—so that demonstration projects can be not only started and enhanced but that we can publish the results of those demonstration programs, evaluate the outcomes, and learn from the demonstration programs. And we recognize the opportunity here for the Office of Minority Health to promote leadership in this whole area of cultural competence.

And last, I might add that leadership development is something that we sorely need in the Hispanic health care community. We believe that Hispanic leaders need to be promoted within Hispanic health programs. The Federal Government and the private sector need to have leaders who are from the Hispanic health care community to better educate others about the important needs that we discuss here today. Thank you very much.

Senator BINGAMAN. Thank you very much. Thank you for the excellent testimony.

[The prepared statement of Dr. Rios may be found in additional material.]

Senator BINGAMAN. I think all of this testimony has been very good. Let me ask a few questions and then defer to Congressman Rodriguez for his questions.

Dr. Beato, let me ask you a couple of questions first. We have a bill, S. 724, which we passed out of the Senate Finance Committee. This is a bill involving prenatal care for women and babies, to add pregnant women, to expand the SCHIP to cover pregnant women, and we passed that out in July.

In April, April 12, Secretary Thompson wrote a letter to me in which he said the following. He said, "Prenatal care for women and their babies is a crucial part of medical care. These services can be a vital life-long determinant of health. We should do everything we can to make sure this care is available for all pregnant women. It is one of the most important investments we can make for the long-term good health of our Nation."

"As I testified recently at a hearing of the Health Subcommittee of the House Energy and Commerce Committee, I also support legislation to expand SCHIP to cover pregnant women."

We got that legislation passed out of our committee and we have been anxious to get a letter of support from the administration for the bill, S. 724. Could you get that done for us?

Dr. BEATO. Yes, sir, we will.

Senator BINGAMAN. Thank you very much. That would be a big help.

Border health. Secretary Thompson in October of 2001 visited El Paso and Ciudad Juarez and committed at a meeting of the U.S. Border Health Commission that he would work to come up with an additional \$25 million for health projects along the border. A week later Dr. Frank Cantu of the Health Services and Resources Administration reiterated that commitment at the University of Texas Health Sciences Center at San Antonio.

Do you know the status of the effort to get that \$25 million?

Dr. BEATO. I do not, Senator, but we will check on that and follow up with your office.

Senator BINGAMAN. If you could get back to us on that, that would be appreciated. I think that funding is certainly needed.

Dr. BEATO. Yes, sir.

Senator BINGAMAN. Let me ask on the health professions, Dr. Cigarroa and various others have asked or have emphasized the importance of training more health professionals who are bilingual and who are from the Hispanic community.

The administration's budget to us this year proposed major cuts—I think a 72 percent cut—in health professions funding. Also it proposed zeroing out funds for a number of the programs that we have discussed here today.

Do you know what the administration's position is now on that? Have they changed their views on that? Would they support a higher level of funding than was asked for in the budget?

Dr. BEATO. What the administration proposed was indeed eliminating some of those HRSA diversity programs and shifting those funds to the National Health Services Corps program. What we found is that individuals that went to the National Health Service program in the Public Health Service tended to stay in those communities longer than individuals who went to the HRSA program.

So what the administration did was sort of refocus from the HRSA to the National Health Service Corps. The funds were re-shifted to National Health Service Corps. That is what we proposed, I think in April, when the president put forth that.

Senator BINGAMAN. Obviously in my own view, I support the National Health Service Corps but I had not thought that the two were really trying to target the same need. My impression was that the funding which had been substantially cut was really for training of people in the health care professions and that that would be needed even if there were increased funding for the National Health Service Corps.

Dr. BEATO. What the administration proposed was increasing the scholarships in the National Health Service, so it would be also for training health care professionals, including allied health and dentistry.

Senator BINGAMAN. I see. So you basically stand by the position that you took in the budget proposal as to where the funds ought to be put?

Dr. BEATO. That is correct.

Senator BINGAMAN. Dr. Cigarroa, let me ask you about some of the figures that you cited and that several others have cited here about the need for training of health care professionals. All of the statistics for the number of Hispanics in these professions are dismal. I am particularly concerned when I see the figure on nursing

because it would seem to me that the barriers to entry to that profession should be substantially less or are, just as a de facto matter; they are substantially less than the barriers to becoming a doctor. I mean you can become a nurse more easily, with less years of education than you are required to put in to become a doctor. It would seem that there would be a chance to do much better than the 1.3 percent was the figure that Dan Reyna said; 1.3 percent of the nurses in our country are Hispanic.

Do you have some insights you could give us as to how to solve that problem? Also, if you have any comments as to the importance of funding for training in this area.

Dr. CIGARROA. There is no doubt about it that this is a significant problem. In fact, when I became president 2 years ago of the University of Texas Health Science Center, I was also equally as alarmed as you are in regards to the very low percentage of students enrolling into the nursing profession.

What has happened, at least over the past 5 years, is that a significant number of faculty who serve as educators in our nursing schools have retired, so we had to actually put a lot of energy in recruiting and retaining faculty members in order to increase enrollment. We are making headway on that but I do believe that just like in the medical school professions, the individuals in the Hispanic population need more role models not only in medical school but also in the nursing schools. We have increased enrollment by about 33 percent in the past 3 years but we just have a significant way to go.

Now why is there such a discrepancy between—why do we have more Hispanics becoming physicians than nurses? I still have not put my finger on that but it requires a lot of significant effort on all our parts to try to solve that problem.

Senator BINGAMAN. Dr. Flores, I do not know if any of the work you have done gets at this question of why we are doing so poorly at bringing Hispanics into these professions and with particular emphasis on nursing. Is that something you have looked at or not?

Dr. FLORES. I think the first place you have to start is with the fact that Latinos by far have the highest school drop-out rate of any group—29 percent. Compare that to 13 percent for African-Americans and 7 percent for whites. So the first thing we have to do is keep Latinos in school.

The next thing is if they are interested in health care, we need to encourage that. We need to have pipeline programs like HCOP and I share your concern in looking at the 2003 budget and the fact that we are going to completely zero out that program, and also that we are going to completely zero out another important program called the Minority Medical Program for faculty who are minority and want to stay in medicine.

On top of that, we are going to have all the minority student scholarships. Then finally, the ultimate blow, as well, is we are going to cut AHRQ funding and, as Dr. Rios mentioned, HRQ supports these Exceed grants, the Excellence Centers to Eliminate Ethnic and Racial Disparities, and I sat on the study section for those projects and I was so impressed with how creative those were. I thought those were some of the first programs we were

looking at that actually made a difference and now with the budget cut, those will probably be the first programs to go.

So I would say we have to restart that pipeline, not cut it off, and begin early on, as early as the Head Start programs, where we know that Latino kids, despite the fact that they have high rates of poverty, are less likely than African-American kids to enroll in Head Start and we also know that Latino kids are more likely to be left back as early as elementary school grades.

So from early age on, we need to encourage bright, talented, enthusiastic Latino students to stay with school and to go on into health care professions, like several of the doctors here.

Senator BINGAMAN. Let me ask Dan Reyna on the promotora program that you have talked about, how extensive is that? Do we have a lot of people who are employed in that capacity and doing that throughout our State or is it just in a few locales or how extensive is that program today?

Mr. REYNA. Senator Bingaman, we are fortunate in New Mexico. We have a citizen legislature and they are very much involved in the community. One of the charges that we received in 1994 with some State funding was replicate the promotora programs in Southern New Mexico, in our border region.

So we have done so. We have all our six border counties with a promotora program. There are a number of similar programs in Northern New Mexico but we have the southern portion completely covered. For instance, we have I would say FTE equivalent, we have only 10 in the south that we fund through the Border Health Office but the Department of Health also funds promotora programs from other sources. And because of the success of this community-based program, our last review of one county, Dona Ana, there were 98 promotoras, outreach workers, in that one county provided by different sources of funds and projects.

We think that we can do much with little. They are people from the community, people that know their neighbors. One of the key elements of community outreach is trust. If you do not trust the person that is trying to help you, you are not going to listen; you are not going to be educated. That is the success that we have had.

The success with the BVF project cannot be discounted. When you exceed your target that HRSA has set by 549 percent and we are wondering 2 weeks before the end of the month whether we are going to have any funding next month, I am curious as to how we look at those kinds of things.

Senator BINGAMAN. I would agree. Of course, around here we do not know if anything is going to be funded next, is the reality of things.

Dr. Rios, did you have any experience with the promotora program in the work you have been doing? Is that something that is a useful expenditure of Federal funds or is that need being met? What is your thought on that?

Dr. RIOS. I have had experience dealing with leaders who have started promotora programs. In fact, in Arizona along the border, one of the clinics there, they had the beginning of a large program.

I used to be in the Office on Women's Health and we actually worked with quite a few different women's health groups and promotoras were used back in the early 1990s. I think it was just



starting to gain awareness by the Federal Government and I think that it is very crucial in our communities to have community workers who can relate to the communities and, like Dan said, the issue of trust in our health system needs to be overcome in terms of the Latino patients for several different reasons that I will not go into.

But I think the promotora program is a model that has been used successfully in other countries and has been successful in this country and I think the Federal Government would be wise to support it.

Senator BINGAMAN. Thank you very much.

Let me call on Congressman Rodriguez for any questions that he has.

Mr. RODRIGUEZ. Thank you, Senator.

I want to hit on a couple of items on the area of AIDS. It seems like we have been making a great deal of inroads, yet when it comes to the Hispanic community, we are losing ground there. There is a great disparity between the 13 percent population that we have and the almost 18 percent of the cases that are out there. And I know that one of the issues that is brought up by the community is the fact that in other communities, such as the African-American, they have community-based organizations and that ours, we have very few of them and there is a large number of communities that do not have any.

I was wondering as to what ways would be some of the ways, not only in terms of community-based organizations, but other things that we could reach out or some of the programs that you might already be familiar with that we could look at providing resources. I just wanted to throw that out to the panel as a whole.

Dr. RIOS. I can answer from East Los Angeles, where I grew up. There is a large community health center, Federal community health center, the Ultimate Health Services Corporation that has their own AIDS clinic in the middle of East L.A. and I know that they have had speakers to testify here for the Congress in the past as a model community program. And I think that, you know, there are so many people in the whole Los Angeles County and this is only one major clinic and it is community-based and a lot of people know about it but you do not have clinics in every city, in every suburb in Los Angeles, for public awareness about the HIV/AIDS services.

In New York and other cities I know that there are very, very targeted HIV/AIDS services for Latinos. They are culturally competent and very good services but there are very, very few. That is the major problem. And I think that some of the strategies to get at that would be the Ryan White funding out of HRSA and the programs at CDC that the leadership within the agencies and the leadership on the review committees and the actual community boards that help to disseminate the awareness of the needs for these programs, that they be in tune with the needs.

And I know that the Latino—I was on as task force for CDC on the implementation of their five-year strategic plan and the Latino rates are rising tremendously and we are in for a big disaster in HIV/AIDS.

Mr. RODRIGUEZ. We are hearing also in that area that the community-based groups, as the grants go out, have a great deal of dif-

ficulty of competing, at least in our communities, and competing with the other communities in those resources. I do not know if you want to add to that.

Dr. BEATO. There are two things I would like to add. Two months ago we had the first—with the Office of HIV/AIDS, faith-based Initiatives, just for Latino faith-based leaders around the country, we had 27 of them, Puerto Rico included, and it is the first time that the department sat down with faith-based Latino leaders to bring up the issue of HIV/AIDS, to try to engage at the community level leaders in the Latino communities to make education, prevention and treatment options available to them through issues like the Ryan White Act.

Also, the Office of Women's Health, the fastest rising percentage is now in Latinas in HIV/AIDS. It is a large concern for Latinas. Tailoring programs to go reach out with the women in women's groups through education, again in prevention and treatment options, especially in anything that has to do with prenatal. As the example that you brought up, there is no need if we have an HIV-positive woman that we do not start taking steps to ensure that that baby does not get treatment before it is born.

So there are several programs but including faith-based communities and forming partnerships with existing State health departments and sort of expanding that, CDC is looking at some of those programs, as Dr. Rios has said, and expanding, tailoring more to Latino women right now.

Mr. REYNA. Congressman, I can add a point. For a number of years now the New Mexico Border Epidemiology Center at New Mexico State University, a component office of the Border Health Office, has had a unique project on the Mexican side funded with initial moneys provided by the U.S. Mexico Border Health Association about four or 5 years ago. We call that project Espejo. One of the ways to work on the AIDS issue is to try to prevent it and we have focussed on the Mexican side with the sex workers, the prostitutes in Palomas, Chihuahua. It is a community of less than 20,000 and it has almost a three-digit number of sex workers every weeks.

So we are working with the health system on the Mexican side as they work with their sex workers every weekend because the customers come from the U.S. And in the years that we have worked that project, we have had only one AIDS confirmed case of a sex worker on the Mexican side but we work on that side and because of that, there are no sources for funding for us to help the Mexican public health system that although prostitution is illegal in Mexico, the public health system still works to try to prevent issues and health problems with the sex workers.

I was in Matamoros, Mexico this past summer and visiting one of the hospitals in Matamoros across from Brownsville, TX. We spoke about the Espejo project in New Mexico, Chihuahua and they were trying to begin a similar project in Matamoros with about 1,000 sex workers. Unfortunately, we heard the news that in 1 week they had five confirmed AIDS cases of sex workers. Those clients—clients that they use come from the U.S. because they are paid in dollars. We have to find ways where we can work with Federal funding on the Mexican side to work with our colleagues in

Mexico to help them help themselves so that eventually it ends up helping us.

Mr. RODRIGUEZ. Let me ask you one other question. I think when we talk about health, one of the areas that is almost an afterthought is the area of mental health and esp with children. I know that the piece of legislation talks about looking at the suicide rates among Latinas but I was wondering if you want to make any comments in the area of mental health services because I know it is one of the areas that is lacking.

A recent report also talked about the great number of disparities among children, Latino children, in terms of access even after they have been diagnosed, of not getting access to health. I just wanted to throw that out to the panel if there are any comments.

Dr. FLORES. There is actually now an accumulating body of research on exactly what you are talking about, where there is some disturbing disparities. For example, we know that Latino children are substantially less likely to be hospitalized for mental health conditions across the board, whether you talk about all of them or individual diagnoses, despite the fact that they are more likely to have these diagnoses, even compared to African-Americans, and we do not understand why that is.

And for some reason, Puerto Rican children lead the pack in all U.S. ethnic and racial groups as far as chronic developmental disorders, which I also would put under that general grouping.

I think it is a good example, as well, when we are talking about HIV. I think there is an intriguing cultural phenomenon going on that we do not have enough research on and it is something called the healthy immigrant effect. Basically there is now a larger body of research that grows each year that shows that first generation U.S. Latino children have several excellent health outcomes and indicators and that deteriorates with greater acculturation in each successive generation. This has been found to be true for adults, as well.

So we always talk about cultural competency as a deficit issue in many events, like avoiding harmful folk remedies—

Mr. RODRIGUEZ. Can I get a clarification? You said that as they assimilate they get worse in terms of their health?

Dr. FLORES. Yes. Let me give you an example. First generation Latino kids are more likely to have—sorry. The less acculturation you have, in other words, the less American you are, the better your health outcomes, whether you are talking about rates of low birth weight. Your rates are lower and once you have been in the U.S. for one or more generations, they go up.

We also know that there are higher immunization rates when you first come to the U.S. Those go right downhill the longer you have been in the country and the more generations.

We also know that when you have less acculturation you have less depression, less suicidal ideation, less cigarette smoking, less illicit drug use and an older age of first sexual intercourse. Once you have been in the U.S., all those outcomes become adverse outcomes, and this is called the healthy immigrant effect where the epidemiologic paradox—we do not understand what that is but is fascinating because there is something protective that Latinos

bring to this country and then it gets destroyed by generations, probably of poverty, in the U.S.

So if we could do some more research and find out what it is that is protective and maybe use our own community resources and our values and whatever it is that is healthy to then promote good behaviors and avoid AIDS and avoid mental health problems, I think we could make some fantastic strides, but we need to understand that better and we need to do more research on this.

Mr. RODRIGUEZ. Finally I just wanted to make a comment and I would hope a message to the administration, as well as to all of us. That is that in the area of the importance of resources and opportunities in training for health careers, I know that last year, the previous year, we had brought in about 190,000 people through those H1 visas. A lot of them were in health professions. I know that in Texas, I will quote you a figure, not necessarily the exact numbers but we certify about 1,200 doctors who graduate and then certify 4,500. So we basically import them from other States and other countries.

And nationally the figures are also that we are not producing the number of doctors that we should. My understanding is that we graduate between 12,000 and 15,000 and then bring in 3,000 to 5,000 from abroad. And with the problems after 9/11, a lot of that is going to stop. And at a point in time, you know, we are a brain drain on the rest of the world so that we need to begin to prepare and educate our own so that it is a real need for us to put some real resources in that area.

And I would hope the administration looks at those numbers and the fact that we complain, Senator, we complain about the Mexican that comes over but we forget that we have been a brain drain on them in terms of bringing a lot of their doctors over. After they pay for their education on the other side, they come over here and become doctors and they have been a great asset to us but at some point we also need to begin to prepare our own.

Thank you, Senator.

Senator BINGAMAN. Thank you very much, all of you. I think it has been very useful testimony. I appreciate it and I think this will help us in our efforts to persuade our colleagues, both in the House and the Senate, to move ahead with this legislation. Thank you very much.

[Additional material follows.]

## ADDITIONAL MATERIAL

PREPARED STATEMENT OF FRANCISCO G. CIGARROA, M.D.

Good afternoon. Mr. Chairman, members of the Committee, I am Dr. Francisco Cigarroa, President of The University of Texas Health Science Center at San Antonio.

I want to give you a brief overview of are region and the university I lead, so that as I discuss the importance of this issue, you will understand that it is not just a theoretical issue with me. It is at the very core of what we do every day.

The UT Health Science Center at San Antonio is the medical center responsible for the vast South Texas/Border Region, which comprises more than 4 million people, and is one of the most rapidly growing areas of the nation. The Health Science Center has five schools, (Medical, Dental, Nursing, Allied Health Sciences and Graduate School of Biomedical Sciences.) We have educated more than 15,000 health professionals and are the center of the biosciences in San Antonio, the city's largest economic generator and one that has an annual impact of more than \$8 billion on the area. We are also the source of internationally-recognized medical breakthroughs, major medical research, and extensive patient care. Each year, we also give more than \$80 million in uncompensated health care to the medically indigent in our region.

We also have extensions campuses throughout the region. Much of our focus is on the Hispanic population. In San Antonio, the Hispanic population is more than 50% and as you go further toward the Border, it is more than 90%. This is the most rapidly growing segment of our nation, and it is a true statement that we cannot have a healthy America unless we take the steps necessary to ensure a healthy Hispanic population. And we do just that. We are the only post-graduate institution in the nation to have earned the distinction of being the site of three Hispanic Centers of Excellence—in our Medical, Nursing and Dental schools. We are also the lead center for the United States/Mexico Center of Excellence Consortium, an entity that includes major universities from California, Arizona, Texas, and, Senator Bingaman, your own state of New Mexico.

I am also a pediatric transplant surgeon who is still doing surgery so that, even as Health Science Center President, I am never very far away from the front lines of medicine. It is an honor to be with you today and I am so pleased to have so many Congressional leaders gathered in support of this common cause today. Thank you all for being here and for the leadership you are providing on this most important issue.

### HISpanics AND THE HEALTH PROFESSIONS: FOCUS ON THE FUTURE.

As president of the Health Science Center, I would like to talk to you about some of the challenges we face in South Texas as we address the issue of Hispanics and health, particularly Hispanics and the health professions. Increasing the number of Hispanics who enter the health professions is a critical element to improving the overall health care of the Hispanic population. And if we want to educate more Hispanic health care professionals, then we must begin by providing young Hispanics with encouraging role models and mentors in the health professions.

It is so important that we provide these role models and send these positive encouraging messages at an early age. I am fortunate, because my father and grandfather were both physicians. I didn't have to seek out role models; they sat around my dinner table. That made it easy for me to set high goals for myself, and to go from the Laredo public schools to Yale, Harvard and Hopkins. My mentors were always available to me and it made all the difference in the world in my own career . . . from an early age, all the way to when I assumed the role as the first Hispanic in the nation to become the President of a major health and research university.

But I am all too aware that so many young, bright, capable students do not have the privilege of discussing health careers around the dinner table. Far too many of our young people, who are just as bright as others, never even have the opportunity to consider a career in the biosciences. And that severe lack of professionals is taking a major toll on the health, the wellbeing, and, ultimately, even the economy of this vast region which is so reflective of the America of tomorrow. At the Health Science Center, we recognize the importance of stimulating the scientific interests of students long before they reach undergraduate or graduate school. We place a great deal of emphasis—and resources—on the 'pipeline'.

I would like to describe a couple of our most successful programs, because they are easily replicable and because they have been so successful.

One of our most successful programs—our Med/Ed program—should be replicated in cities around the country. This year-round program introduces young students from the Rio Grande Valley in Texas to the health professions by allowing them—at an early age—to visit labs, doctors' offices, and hospitals, and our Health Science Center, years before they will start their future careers. These young students, in high school and even in middle school, see our doctors, dentists, and nurses—and our students-in action. They get help with difficult science course work. They talk to students and see that many of our students are not that different from themselves. And they begin to build big dreams—many for the first time in their lives.

As the students who participated in the Med/Ed program begin to graduate from college and enter health professions training, we are seeing success in the results of this program. Since 1997, a total of 750 students have participated in our Med/Ed Program. Of the 1997 and 1998 high school graduates who participated, we have a total of 78 students who are entering the health professions. And because many of the other participants are still in college, we know that the number of students who enter the health professions will continue to grow.

We are very proud of our Med/Ed program, and we are proud to be the only Health Science Center in the nation with three Hispanic Centers of Excellence on campus to support the needs and goals of our Hispanic students. As I mentioned, we hold this distinction in our Medical, Dental, and Nursing Schools. Through these Centers of Excellence, we provide support for our students through faculty mentors, pre-matriculation programs, and tutoring opportunities. In addition, through the Hispanic Centers of Excellence, we are able to provide additional outreach programs to high school and college students. Through our partnership with a local undergraduate university, St. Mary's University, and the Health Careers Opportunity Program, we offer a six-week intensive summer academic enrichment and career preparation program. This program, like many others offered through the Centers of Excellence, immerses young students in the clinical setting and provides them with the unique and inspiring opportunity to shadow health professionals.

Our Health Science Center's commitment to providing role models was shown again this past June when we opened the Medical Education Division of our Regional Academic Health Center in Harlingen. In that one day, we nearly doubled the entire national number of Mexican-American physicians who serve as faculty physicians—and therefore as mentors—for medical students and the younger students of the community.

We are very proud of the early intervention programs that we offer at the Health Science Center.

But we also know that the number of Hispanics who graduate from college is unacceptably low. As the demographics in our nation change, if we don't change these two divergent trends—rising Hispanic population and small number of Hispanic college and post-college graduates, physicians and other health professionals—then we are on a collision course with disaster. Unless we reverse the college and post-college success rate of under-represented minorities, the future and the health of our nation are in serious jeopardy.

Our major challenge in reversing these statistics will be funding. Our past funding has allowed us to implement so many wonderful and successful programs. But now, for the Fiscal Year 2003, we face the possibility not only of a funding shortfall, but possibly even a virtual elimination of the current level of funding for all Title VII health professions training programs. To discontinue this funding now, to discontinue our progress now, would be to take a large step away from, rather than toward, our goal.

As a nation, we must continue to provide positive role models and early intervention opportunities for our young people who are underrepresented in the health professions. We must continue to provide the resources to support these important programs. We must commit ourselves to improving the college and post-college success rate of under-represented minorities in order to provide a healthier, more prosperous future for all people.

I have had some of my colleagues ask why we place such an emphasis on these early intervention programs when, after all, we are a post-graduate institution. The answer is easy. Our vision for our region, our state and our country is a seamless transition of success: from elementary school, through high school, college and medical school.

These pipeline programs are an integral part of the success and the future of our country, and I would be pleased to send additional information to anyone who would like to know more about these initiatives.

## OTHER CHALLENGES

But there are many more issues that are critical to Hispanic health. We have a desperate shortage of nurses in this country, and the shortage is even more severe in the largely Hispanic areas. Even as President in my own medical school in San Antonio, I was called to do a transplant and was then told that we could not proceed with the operation because the hospital could not find sufficient nurses. As President, I had the authority to do whatever it took to save a life that day. How many surgeons have heard that same message: “We don’t have enough nurses for you to operate today” and been unable to do anything about it.

Our nursing school turned away more than 300 qualified students, a great many of them Hispanic, because we couldn’t find enough faculty to keep the required one-to-eight ratio. Through some creative financial steps, I was able to increase our faculty and add many new students . . . but we need more resources, so that we can hire more faculty, so that we can educate more students. This is a high priority for the entire country.

## RESEARCH BREAKTHROUGHS: THE KEY TO A HEALTHIER FUTURE

We are focusing our basic research on conditions most prevalent in this region, diseases that take a tremendous financial toll on our country. Diabetes: diseases related to aging, infectious diseases, multi-drug resistant tuberculosis, which is undergoing a terrible resurgence. We need programs that encourage students, and particularly Hispanic students, to enter the research field and complete their PhDs. An alarming twenty percent of our Mexican American population will develop adult-onset diabetes. That is a rate substantially higher than the non-Hispanic population. What follows are an array of diseases of the heart, eyes, circulatory system, neuropathy of all kinds. What this does to the quality of life is hard for us to imagine. What this does to our state and national budget is also hard to imagine. We have scientists who already have identified genes that are involved in diabetes. We believe we are close to the critical “next steps” that lead toward prevention. What an overwhelming difference that will make on this country, once we are successful in that search.

## STEPS TO ENSURE SUCCESS

I agree with the report issued by the Institute of Medicine that calls for the government to recognize and reward medical schools that actively recruit and support well-trained faculty and students who are from under-represented minority populations.

We should do this because it is the smart thing to do. If we fail to take steps to address the gap between the health of the majority population and the health of the nation’s rapidly growing minority populations, we are on a course leading to a collision. We are far too great a nation to allow this to happen.

We know that it is futile to continue to do the same things, but expect different results. Well, as a nation, if we continue to treat issues of Hispanic health as we are doing now, we will indeed see the same results: lack of coverage, access and care. And those results are not sufficient to ensure a healthy America in the future.

At The University of Texas Health Science Center at San Antonio, we are doing all that we can, and with great success, to ensure a healthier region. I am proud of our record of success, which also includes leveraging government resources with private philanthropy and we have also been very successful in that arena as well. We look forward to continuing our partnership with the government—federal as well as state—as we work together in this most worthy common cause of a healthier America, achieved by ensuring a healthier Hispanic population.

The bill you are considering contains much that would be of such great assistance to us as we continue the progress we have already made. It addresses topics that we address every day: diabetes, addiction, issues of early care for pregnant women and children, pipeline issues, and funding for Border and Hispanic health concerns. In Texas, we know all too clearly that diseases care nothing about green cards. Germs respect no INS regulations. We truly must work with our neighbors to the South if we are to avoid a major influx of new conditions and diseases. It can be seen so clearly on a map. Just as there are ‘rivers of commerce’ there are ‘rivers of infectious disease’ and though they may start at the Border, they are eventually seen all the way to the northern Border that we share with Canada. We can and do work with Mexico on these, and other environmental-related diseases. I applaud all of you for the concern you have for the situations we face along the Border, situations which, if left unchecked, will have a major impact on every state in the nation.

Thank you for the opportunity to present this testimony to this important and distinguished Senate Committee.

PREPARED STATEMENT OF GLENN FLORES, M.D.

The views presented are those of the author, and do not necessarily represent those of the American Academy of Pediatrics or Medical College of Wisconsin.

Good afternoon, Mr. Chairman, and distinguished Members of the Committee. I appear before you as Chairman of the Latino Consortium of the American Academy of Pediatrics Center for Child Health Research. I am a pediatrician who has cared for disadvantaged children for over 10 years, and Associate Professor of Pediatrics, Epidemiology and Health Policy at the Medical College of Wisconsin, where I am Director of Community Outcomes, and Associate Director of the Center for the Advancement of Urban Children in the Department of Pediatrics. I am a researcher with expertise on Latino children's health issues, access to health care, children's health disparities, and cultural and linguistic issues in health. Prior to coming to the Medical College of Wisconsin, I founded and was Co-Director of the Pediatric Latino Clinic at Boston Medical Center.

I am pleased and honored to be here today to discuss with you the important issue of the health of Latino children. I will talk about the dramatic demographic surge in our nation's Latino children, highlight the urgent priorities and unanswered questions in Latino children's health, and show why the Hispanic Health Improvement Act would substantially improve the lives of millions of American children. For further details and 113 references on these issues, I refer you to the article of ours published in the *Journal of the American Medical Association* (Flores G, et al. The health of Latino children: Urgent priorities, unanswered questions, and a research agenda).

Latinos are now the largest minority group of children in the United States, numbering 12.3 million, and comprising 17% of the population less than 18 years of age. In California, Latinos surpassed whites as the state's largest racial/ethnic group of children in 2000, and by 2010, half of all California children will be Latino, outnumbering white children in the state by 1.9 million. The 2000 Census documents that Latinos are one of the youngest and fastest growing groups in our nation. But despite this dramatic population growth, Latino children continue to experience a disproportionate burden of health risk factors, illness, injuries, impaired access to health care, and health disparities.

I would like to share with you two stories about children that we recently cared for at the Pediatric Latino Clinic at Boston Medical Center (the names have been changed to protect confidentiality):

Maria Fuentes was a 3-year-old Latino girl brought to the emergency room by her parents at midnight because of complaints of severe stomach pain. No medical interpreter was available in the emergency room, and because Maria's mother spoke no English, she was unable to adequately describe her daughter's condition. The emergency room pediatrician examined Maria, and discharged her with what Maria's mother understood to be a diagnosis of "colic." One hour later, both parents brought Maria back to the emergency room, because her pain had worsened. The same pediatrician examined her, and Maria's mother found the physician to be quite angry. Maria's father was extremely upset because no interpreter was available, and he felt that Maria was treated poorly because his family was Latino. The pediatrician sent Maria home again, this time with a medication, the name of which the Maria's mother did not recall.

Several hours later, Maria and her family returned to the emergency room. Maria's condition had deteriorated, and was now quite serious. The pediatrician hospitalized Maria immediately.

In the operating room, Maria was found to have a perforated appendix and peritonitis, a serious infection of the lining of her abdomen due to her appendix bursting. Maria was hospitalized for 30 days, because of complications including two infections of her surgical incisions. Maria had no health insurance.

My second story is about a two-year-old Latino girl named Rosa Morales, whose parents brought her to the emergency room for right shoulder pain. X-rays revealed that Rosa had fractured her right collarbone. Rosa's mother spoke Spanish almost exclusively. When Rosa's mother was asked what happened, she responded, "Se pego, se pego." The resident physician interpreted this to mean, "She was hit." Rosa's mother then showed the nurse a discharge summary from a previous emergency room visit to another hospital two months prior to the first visit, when Rosa also was diagnosed with a right collarbone fracture after a fall from her bed.

Child abuse was suspected by the emergency room staff, and the state Department of Social Services was contacted. A Department of Social Services caseworker



came to evaluate Rosa and her 4-year-old brother, Jose. Without a Spanish interpreter, the caseworker spoke with Rosa's mother, and then asked her to sign over voluntary custody of Rosa and Jose. Rosa and Jose immediately were taken from their mother and placed in Department of Social Services custody.

When the Spanish interpreter arrived, Rosa's mother was interviewed again, and she reported that Rosa had fallen from her tricycle and struck ("se pego") her right shoulder. The primary care physician was contacted, and denied any history of abuse or neglect in the family, or having concerns. Rosa's mother regained custody of Rosa and Jose after 48 hours.

The issues faced by Rosa, Maria and their families typify those confronting millions of Latino children and their families in the United States. For example, neither Rosa nor Maria's family spoke English. About 45 million people in the US speak a language other than English at home, and about 19 million are limited in English proficiency, or LEP. Spanish is the language spoken by 26.7 million, or 60%, of those who speak a language other than English at home, and 12.5 million, or 64% of LEP Americans. Five percent of school aged US children (or about 2.4 million) are LEP, an 85% increase since 1979. Multiple studies demonstrate a wide range of adverse effects that LEP can have on health and use of health services, including impaired health status, a lower likelihood of having a usual source of medical care, lower rates of mammograms, pap smears, and other preventive services, non-adherence with medications, a greater likelihood of a diagnosis of more severe psychopathology and leaving the hospital against medical advice among psychiatric patients, a lower likelihood of being given a follow-up appointment after an emergency department visit, an increased risk of intubation among children with asthma, a greater risk of hospital admissions among adults, an increased risk of drug complications, longer medical visits, higher resource utilization for diagnostic testing, lower patient satisfaction, and impaired patient understanding of diagnoses, medications, and follow-up.

Latino parents cite language barriers as the single greatest barrier to health care access for their children. But research documents that medical interpreters are frequently not called when needed, are inadequately trained, or are simply not available at all. In Maria's case, if an interpreter had been present when she initially presented to the emergency room, the nature and severity of the symptoms might have been recognized immediately. The outcome with an interpreter, indeed, could potentially have been prompt diagnosis of appendicitis, a routine short hospital stay for an appendectomy, and a satisfied family, in stark contrast with the costly, complicated 30-day hospital stay that actually occurred and left the family dissatisfied and embittered. A recent study of ours underscores that lack of adequately trained medical interpreters can result in increased medical errors. We found that an average of 19 interpreter errors of clinical consequence are made per pediatric encounter, with untrained interpreters, such as family members, making significantly more such errors than trained interpreters. In a case where a child was visiting his physician for an ear infection, an untrained interpreter incorrectly told a mother that an oral antibiotic should be placed in the child's ear, and in another case, a hospital interpreter told a mother to rub a steroid cream prescribed for an infant's facial rash over the infant's entire body.

But only five states in the US currently provide third-party reimbursement for medical interpreter services, and less than one-quarter of hospitals nationwide provide any training for medical interpreters. The HHIA would ensure many children and families with limited English proficiency would have access to health care without language barriers by providing for use of Medicare and Medicaid funds to pay for hospital interpreters. I would also suggest that all third-party payers should reimburse for medical interpreters, because we can either pay a little now to provide high quality medical care to all children, or pay a lot more later when preventable medical errors, hospitalizations, lawsuits, and even deaths result in LEP patients because no interpreters were available. Indeed, a 2002 report to Congress by the Office of Management and Budget estimated that providing adequate language services to all LEP persons in our nation's healthcare system would cost about \$4.04 per visit, equivalent to about a 0.5% annual increase in national healthcare expenditures.

There are other feasible solutions to eliminating language barriers in our nation's healthcare system. First, we must increase the number of current and future health care providers who speak Spanish and other second languages commonly spoken by Americans. This can be achieved by making medical Spanish and other language classes mandatory in medical schools in states with large Latino populations, and offering ongoing Spanish and other language courses for current healthcare professionals. Section 321 of the HHIA would also be helpful in that it would identify bilingual health professionals and train them with respect to minority health condi-

tions. Second, health care institutions need to ensure that all LEP patients have access to trained medical interpreters. Fewer than one-fourth of hospitals nationwide provide any training for medical interpreters, and only 14% of US hospitals provide training for volunteer interpreters, and in half of these hospitals, the training programs are not mandatory. It is time for our healthcare institutions to require that all medical interpreters undergo fluency testing and proper training.

Maria had no health insurance to cover her expensive 30-day hospital stay. Latinos are far more likely to be uninsured, at 25%, than any other racial or ethnic group of US children. In comparison, 7% of white and 14% of African-American children are uninsured. About 3 million Latino children lack health insurance, and approximately one-third of all poor Latino children are uninsured, despite eligibility of the vast majority for Medicaid and the State Children's Health Insurance Program (SCHIP). Among uninsured poor children in the US, Latinos outnumber all other racial/ethnic groups, including whites: there are 1 million poor, uninsured Latino children, compared with 766,000 white, and 533,000 African-American poor, uninsured children. Congress enacted SCHIP in 1997 with a 10-year investment of about \$40 billion. Although 1999 marked the first time in many years that the proportion of uninsured Latino children actually decreased (from 30% to 27%), recent national data suggest that outreach efforts to enroll Latino children have largely been unsuccessful. A Kaiser Commission report found that only 26% of parents of eligible uninsured children said that they had ever talked to someone or received information about Medicaid enrollment, and 46% of Spanish-speaking parents were unsuccessful at enrolling their uninsured children in Medicaid because materials were unavailable in Spanish. Additional research is needed on identifying the most effective interventions for outreach and enrollment of uninsured Latino children, and the Hispanic Health Improvement Act, or HHIA, would be a giant step forward in this area. The HHIA would provide grants to promote innovative outreach and enrollment efforts, and would target the most vulnerable populations, including children living in rural areas and in families for whom English is not their primary language.

Rosa's and Maria's stories also emphasize the importance of providing culturally competent health care. Cultural issues can have a profound impact on Latino children's health and their quality of care. Failure to consider these issues in clinical encounters can have a variety of adverse consequences, including difficulties with informed consent, miscommunication, inadequate understanding of diagnoses and treatment by families, dissatisfaction with care, medical errors, preventable morbidity and mortality, unnecessary child abuse evaluations, a lower quality of care, clinician bias, and ethnic disparities in prescriptions, analgesia, test ordering, and diagnostic evaluations. Unfortunately, cultural competency training still is not an integral part of the education of physicians, nurses, and other healthcare professionals. For example, a recent published study by my research team revealed that only 8% of all US medical schools have separate courses addressing cultural issues. We also found that only 26% of US medical schools teach about Latino cultural issues, and only 35% of the schools address the cultural issues of the largest minority groups in their particular states. More research is needed on the most effective course content and structure for teaching cultural issues, along with formal evaluation of the effectiveness of various curricula. In the meantime, given the substantial evidence that lack of culturally-competent care can have a major impact on Latino children's health and healthcare, cultural competency training should be a mandatory educational component in health professions schools, residency programs, and continuing professional education. The HHIA would ensure that all US children receive culturally-competent health care by creating a Center for Linguistic and Cultural Competence in Health Care within the Office of Minority Health, which would be responsible for developing education materials and providing technical assistance in carrying out programs.

Much could be learned from Latino culture about improving the health of all American children. A growing body of research documents that first-generation US Latino children have several excellent health outcomes and indicators that deteriorate with greater acculturation and each successive generation. For example, less acculturation is associated with significantly lower rates of low birth weight, higher immunization rates, less depression, less suicidal ideation, less cigarette smoking, less illicit drug use, and older age at first sexual intercourse. These findings are particularly striking in light of data indicating that first-generation immigrant children have significantly decreased health care access and utilization. Yet we have little understanding about what factors are responsible for this "healthy immigrant" effect. Such compelling findings require that we abandon the traditional "deficit" view of Latino culture and its impact on health, and adopt a more balanced perspective that emphasizes appreciation and understanding of the salutary components of

Latino culture. It is clear that more research needs to be conducted in this intriguing area.

Neither of the physicians that cared for Maria and Rosa was Latino. Latinos are underrepresented at every level of the health care professions. Although 17% of children <18 years old are Latino, only 3% of medical school faculty, 5% of pediatricians, 2.8% of dentists and 2% of nurses are Latino. The Latino pediatrician-to-child population ratio is expected to fall from 17 Latino pediatricians per 100,000 Latino children in 1996 to 9 per 100,000 by 2025. Analyses indicate that to achieve parity with future ethnic changes in the US population, our nation would need twice as many Latino physicians, but there has been a recent decrease in minority medical school enrollment, especially in states with large Latino populations that have banned affirmative action policies, such as California and Texas. These trends are particularly alarming because studies document that Latino communities are substantially more likely to have physician shortages, Latino physicians are significantly more likely to care for Latino and uninsured patients,<sup>31</sup> and Latino patients are more likely to be satisfied with health care from Latino vs. non-Latino physicians.

Additional research is needed on the most effective ways of increasing the numbers of Latino health professionals and faculty at health professions schools. But we also need to fund programs that early on identify, recruit and retain talented minority students with an interest in the health professions. The expanded Health Career Opportunity Program described in the HHIA is an excellent example. This program would identify and recruit disadvantaged students with an interest in healthcare starting in elementary school, and provide counseling, additional educational opportunities and stipends. Not only would this program address the Latino workforce deficiency, but it would also increase the number of bilingual physicians, while at the same time addressing the staggering school dropout rate for Latino children, which, at 29% (compared with 13% for African-Americans and 7% for whites) is by far the highest for any group of American children. Another excellent program in the HHIA would provide grants to the Hispanic-Serving Health Professions Schools.

Latino children like Maria and Rosa face formidable barriers to health care access. A comprehensive literature review revealed 22 access barriers to health care frequently encountered by Latino children, including lack of health insurance, poverty, low parental educational attainment, lack of a regular source of care, transportation problems, excessive waiting times in clinics, decreased preventive screening, receipt of proportionally fewer prescriptions, language problems, and cultural differences. For example, 30% of Latino children live in families with annual incomes below the federal poverty level (second only to African-American children, at 33%), and 37% of Puerto Rican children live in poverty, making them the most impoverished racial/ethnic group in the U.S. Important unanswered questions include what are effective interventions to reduce or eliminate such formidable barriers, and what are the health trajectories of Latino children with impaired access to care?

Maria is Puerto Rican and Rosa is Mexican-American. These subgroup distinctions are important, as several studies have demonstrated that substantial differences in health and use of health services exist among Latino subgroups (such as Mexican-Americans, Puerto Ricans, and Cuban-Americans) that would otherwise be overlooked, and that can exceed that magnitude of differences among major ethnic and racial groups. For example, major Latino subgroup differences have been documented for rates of prematurity and low birth weight, asthma prevalence, illicit drug use, vaccination coverage, the prevalence of chronic conditions, and several indicators of health status and use of services. Latino child health data, however, are rarely collected and analyzed by pertinent subgroups. Failure to perform subgroup analyses can result in missing critical findings that can have a major impact on child health, policy, and advocacy.

Latino children like Maria and Rosa also frequently receive a lower quality of health care. For example, among children with gastroenteritis, Latinos are significantly less likely than whites and African-Americans to have diagnostic laboratory tests and X-rays. Among preschool children being discharged from the hospital for asthma, Latino children are 17 times less likely to be prescribed a key piece of equipment for asthma treatment at home, called a nebulizer. In children hospitalized for surgical correction of serious limb fractures, researchers found that whites receive significantly higher doses of narcotic pain medications, at 22 mg/day, compared with blacks at 16 mg/day and Latinos at 13 mg/day. There also is a long list of serious health disparities for Latino children.<sup>2</sup> Some of the most noteworthy include: Latino children are 13 times more likely than white children to be infected with tuberculosis; Latina adolescent girls have the highest suicide rate in the US, at 19%, compared with 9% for white and 8% for African-American adolescent girls; Latino children have the highest numbers of cavities and untreated dental condi-

tions among American children; Latino boys are the most overweight and Latina girls the second most overweight racial/ethnic groups of US children; Latino children have one of the highest risks of being hospitalized for or dying from unintentional injuries; and Puerto Rican children have the highest prevalence of asthma in the US.

More research is needed on why health professionals treat children from different racial and ethnic groups differently, and what interventions are most effective in eliminating racial/ethnic disparities. Mandatory medical school cultural competency courses examining these health disparities would be an important first step. In addition, because Latino children frequently are not included in medical research, we need to develop mechanisms to ensure better recruitment of Latino children into studies. For example, federally-funded research should always include methods to recruit and appropriately study diverse participants, including efforts to educate minorities about clinical trials, to recruit non-English-speaking and immigrant populations, and to collect and analyze data by appropriate racial/ethnic groups and subgroups. The HHIA includes several important mechanisms for reducing health disparities for Latino children, including grants to improve the provision of dental health services through schools, community health centers and public health departments; coverage of immunizations and dental care under SCHIP; establishing a program for the prevention of Latina adolescent suicides; research requirements for collecting data on race and ethnicity; expanding programs in the Office of Minority Health; establishing individual offices of minority health within agencies of the Public Health Service; and establishing an Assistant Secretary of Health and Human Services for Civil Rights.

The two stories I shared with you are about urban Latino children, and we too often disregard the health of rural Latino children, especially migrant children. Children of migrant Latino farm workers are particularly at risk for sub-optimal health and use of services, and face additional unique health challenges due to their migratory status. Of the more than one million children that travel with their parents annually in pursuit of farm labor, 94% are Latino. These children have been shown to receive inadequate preventive care; experience high rates of infectious diseases including tuberculosis, parasites, and sexually transmitted diseases; have inadequate preparation for school entry and low rates of school completion; have impaired access to appropriate day care, forcing parents to bring them to the fields where they have increased risks of pesticide exposures and injuries; work as farm laborers often in unsafe working conditions; and to be at risk for nutritional disorders such as anemia, diabetes, failure to thrive, and obesity. In addition, migrant Latino children's eligibility for Medicaid and SCHIP is hindered by high interstate mobility and difficulties with residency and citizenship status. The HHIA will substantially improve the plight of migrant Latino children by 1) giving states the ability to enroll legal immigrant pregnant women and children in Medicaid or SCHIP, and the ability to provide important preventative and public health services to immigrants with state resources; and 2) calling for a study by the Institute of Medicine of binational health insurance efforts.

In conclusion, the 2000 Census definitively documents that Latinos are the predominant racial/ethnic minority group of US children, representing one out of every six children in America. It is time for our health policies, services and research to address this dramatic demographic change, which can be accomplished by 1) ensuring that all children and families with limited English proficiency have access to either trained medical interpreter services reimbursed by third-party payers, or bilingual health professionals; 2) providing all children with health and dental insurance through innovative outreach and enrollment strategies; 3) requiring cultural competency training for health care professionals; 4) increasing the number of Latinos in health care professions; 5) including more Latino children in medical research; and 6) eliminating health disparities for all Latino children. The Hispanic Health Improvement Act would address all of these issues, and result in significant improvements in the health and well-being of the 12 million Latino children in America. Thank you.

**Testimony of Congressman Ciro D. Rodriguez  
28<sup>th</sup> District of Texas**

**Before the  
Health, Education, Labor, and Pensions Committee  
Subcommittee on Public Health  
United States Senate**

**Hearing on Hispanic Health: Problems with Coverage, Access and Health  
Disparities  
September 23, 2002 - 2:00 p.m.**

Good afternoon, Mr. Chairman, and members of the Subcommittee. Thank you for the invitation to address you at this historic hearing on Hispanic health. I currently serve as the First Vice-Chair of the Congressional Hispanic Caucus and Chair of the Hispanic Caucus Health Task Force. In my own district, which stretches from San Antonio to the Mexican border, over 60% of my constituency is Hispanic. One of my border counties, Starr County, is about 98% Hispanic. Starr County unfortunately is also the poorest one in the nation with close to 44% living in poverty.

It is truly an honor to be here. I would like to extend a special thanks to Senator Bingaman and his staff for their hard work to make today happen. In addition, I would like to recognize a witness from the next panel from my hometown, Dr. Francisco Cigarroa of the University of Texas Health Science Center at San Antonio. I have worked with Dr. Cigarroa on a variety of issues and consider him a leader in health care at both the local and national level.

As you know, September 15<sup>th</sup> marked the beginning of Hispanic Heritage Month. The days have been filled with numerous events to celebrate the history, the culture and the contributions of Hispanics in the United States. Our community has come out in full force with educational workshops and conferences, award ceremonies, galas and the like. However, these events mean little if we cannot effect positive change at all policy levels to improve the quality of life for Hispanics and all Americans.

**Overview**

Today's hearing represents an important part of the equation. I commend the Subcommittee for their desire to learn more about what I consider to be a national emergency, the status of Hispanic health.

I will focus on what I believe are the three most critical and comprehensive areas of need. First, we need to dramatically expand health care coverage for the growing Hispanic population.

Second, we need to improve access to services for Hispanics in areas of particular need, such as diabetes, AIDS, and border health. Third, we need to build a health professions system that will reduce health disparities in the long run through improved training and opportunity.

### Improving Coverage

The 2000 Census revealed what many of us could already see back home -- the Hispanic community has grown by leaps and bounds over the past decade. Hispanics are now the fastest growing community in the United States making up close to 13% of the U.S. population with \$450 billion dollars in purchasing power.

Yet, Hispanics make up 23% of the uninsured population. According to a report by the Kaiser Commission on Medicaid and the Uninsured, nearly 37% of Hispanics under the age of 64 are uninsured. Sadly, 31% of Hispanic children are uninsured.

The profile of the uninsured Hispanic population may surprise some of you. Research shows that about 87% of uninsured Hispanics come from working families.<sup>1</sup> Additionally, only 43% have employer-based coverage, compared to 73% of Anglos. Close to 60% of Hispanic families have annual incomes less than 200% of the federal poverty level.<sup>2</sup>

Access to affordable, quality health care is a challenge -- this includes economic challenges, language barriers, cultural differences, citizenship status, even location plays a key role. And we know that it has a direct relation to health disparities.

A recent report by the National Institute of Medicine entitled: "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" outlined four areas that contribute to health disparities: (1) language barriers; (2) inadequate health coverage; (3) health care provider bias; and (4) lack of minority physicians. In addition, the report showed that even when controlling for factors such as access to care, racial and ethnic health disparities still exist.

The release of this report received nation-wide attention. Why did it get so much attention? It documented what health care advocates have been talking about for years -- there is a level of unequal treatment for racial and ethnic minorities in the health care system. We need targeted public policy changes to reverse these trends in both the short-term and the long-term. I believe we can do so by greatly expanding insurance and other coverage, by addressing specific diseases that disproportionately impact the Hispanic community (and other communities of color), and by

<sup>1</sup>Kaiser Commission on Medicaid and the Uninsured, 2000.

<sup>2</sup>Families USA, 2001.

making institutional changes in our health professions and training so that more doctors are sensitive to the particular needs of the Hispanic community.

#### Access to Affordable Care

The Hispanic population encounters many diseases at rates that are far beyond their numbers in the population. We need to improve access to affordable treatment in each of these areas if we are serious about addressing the needs of Hispanic health. For purposes of today's hearings I will highlight three such areas, but these are merely representative of a larger problem faced by Hispanics across the country. The three are diabetes, HIV/AIDS and border health.

#### Diabetes

Diabetes strikes Hispanics, especially Mexican-Americans and Puerto Ricans, at disproportionate rates. In 2000, an estimated 2 million Hispanic Americans had been diagnosed with diabetes and another 1 million are estimated to have undiagnosed diabetes. Approximately 10.2% of all Hispanic Americans have diabetes. For those 50 and older, about 30% have diabetes.

Hispanics, on average, are almost 2 times more likely to have diabetes than non-Hispanic whites. In addition, they experience higher rates of diabetes complications -- including nephropathy, retinopathy, eye disease, and amputations-- than do non-Hispanic whites.

There is evidence that Type 2 diabetes --once limited primarily to adults-- is being increasingly diagnosed among Latino youth. Some studies estimate that 30% of diabetes diagnoses among children are now Type 2 cases. This is fueled in large part by the increase in obesity among children, due largely to poor nutrition and lack of physical activity. However, the increased rate of Type 2 diabetes children is a relatively new phenomenon and additional research is desperately needed.

#### HIV/AIDS

Last year marked the 20<sup>th</sup> year of HIV/AIDS. As the nation took a moment to reflect how HIV/AIDS has changed the world, many struggled to understand recent reports showing increased infection rates in LGBT (lesbian, gay, bisexual and transgender) communities of color at a time when the national rate of infection declined.

According to the CDC, Hispanics account for 18% of the cumulative AIDS cases, 20% of total AIDS cases among women, and 23% of total AIDS cases among children. In 1999, approximately 19% of the new AIDS cases were among Hispanics. HIV/AIDS was the third leading cause of death for Hispanic men aged 25 - 44 in 1998. For that same age group, HIV/AIDS was the fourth leading cause of death for Hispanic women in 1998.

There is an urgent need for increased funding to address HIV/AIDS in racial and ethnic minority

communities. In addition, we should work to increase technical assistance and infrastructure support for community based organizations and increase access to prevention and care.

#### **Border Health**

As a representative of a border region, I want to mention the unique obstacles facing border residents. They face not only the problems encountered by other Hispanics, but also problems unique to the international border itself. As you know, what happens on one side of the border directly impacts the other.

On the US side of the border, one-fourth of border residents are in need of wastewater facilities, some 175,000 colonia residents lack safe drinking water, 14 border cities exceed federal air quality limits, and hazardous waste disposal is virtually non-existent. This poor infrastructure has led to real health problems in the US, including the spread of infectious diseases like hepatitis, diabetes, and even tuberculosis.

Hepatitis A which is mainly spread through unclean food and water and migration is two to three times more prevalent along the border than the US as a whole. One-third of new TB cases in the US come from the four border states. It is estimated that 15 million people in the US alone are currently infected with TB. Mexico has equally high TB rates due in large part to lack of diagnoses and or treatment.

We need a comprehensive and multi-disciplinary approach to border health issues. We must build infrastructure, solve environmental hazards, and improve bi-national problem-solving.

#### **National Hispanic Health Leadership Summit**

While the challenges seem daunting, I am confident that we have the resources and the passion to change the outcomes. This past August, I helped organize and lead the National Hispanic Health Leadership Summit in San Antonio, Texas. Dr. Richard Carmona, U.S. Surgeon General, delivered a striking keynote address on the need to ensure all sectors of society have access to health care services.

We were joined by a select group of 150 health experts nominated from across the country by partners of the NHMA, the CHC and members of Congress with Hispanic constituencies. Participants navigated through a series of facilitated workshops to build consensus on programs and policies that can be developed or enhanced to improve the quality of health care delivery to Hispanics in the United States over the next five years.

The Leadership Summit was sponsored by the National Hispanic Medical Association with the Congressional Hispanic Caucus serving as the Honorary Chair. Dr. Elena Rios, president of the



National Hispanic Medical Association, should be commended for her leadership and hard work in making the Summit a success. I am sure she will share some of her thoughts on the Leadership Summit during her testimony. However, I want to highlight some of the recommendations that came of the eight workgroups.

The Health Access Workgroup focused on four areas: (1) outreach and enrollment, (2) insurance programs, (3) immigrant and migrant health, and (4) Puerto Rico and the territories. Recommendations included increasing outreach and enrollment in federal programs by creating state incentives for community based outreach and automatic SCHIP/Medicaid re-enrollment in high uninsured populations.

The Cultural Competence and LEP Services Workgroup recommended cultural competence be infused into medical literacy and the medical error debate. In addition, they stressed the need to build a workforce capacity to deliver quality health services, including interpreters and promotoras.

The Heart, Cancer, Diabetes, Hypertension, and Asthma Workgroup recommended a federal clearing house for health information and a regular report on the status of Hispanic health.

Other workgroups focused on building community based Hispanic research, women's health, and children's health to name a few. Their recommendations are divided for the federal, state, and local level as well as for public and private organizations. A report on these recommendations will be released in a couple of months, and I would be happy to share these findings with the Subcommittee at that time.

#### **Hispanic Health Improvement Act**

Congressional action is needed to address the needs of the Hispanic community. Today, Senator Bingaman will be introducing legislation entitled the Hispanic Health Improvement Act of 2002. I will introduce a companion bill tomorrow in the House since we are not in session today.

This landmark legislation is based on a previous Hispanic Health Act I introduced in the 106<sup>th</sup> Congress, and on existing legislation that Senator Bingaman has championed in the Senate. In addition, we have taken some of the federal recommendations from the Hispanic Health Leadership Summit and incorporated them into what I consider to be one of the most comprehensive bills aimed at improving Hispanic health in the United States. The legislation offers a variety of different strategies for expanding health care coverage, improving access and affordability, and reducing health disparities. While I consider each provision in our bill to be important, I am just going to highlight some of the more urgent ones.

In order to address the lack of health care coverage, we examined ways to expand existing programs like SCHIP and Medicaid. While this is not a new idea, it will have an enormous impact on the Hispanic population. The legislation provides \$33 billion between fiscal years

2003 and 2010 for the expansion of the successful State Children's Health Insurance Program (SCHIP) to cover uninsured low-income pregnant women and parents. In addition, it provides states the option to enroll legal immigrant pregnant women and children in Medicaid or SCHIP.

The Congressional Hispanic Caucus considers the expansion of Medicaid and SCHIP eligibility to be a critical legislative priority for improving Hispanic health. Between 1995 and 1999, the proportion of citizen children in immigrant families who were uninsured grew from 28 percent to 31 percent. During that same time period, the percentage of low-income immigrant children insured by Medicaid or SCHIP fell from 36 percent to 28 percent. These trends can be attributed to fear and confusion of eligibility requirements by mixed-status and immigrant families. I cannot overstate the importance of expanding these two programs. As you can see, the ones who are hurt the most are our children.

As the health care system struggles with how to meet the needs of an increasingly diverse patient population, culturally competent and linguistically appropriate health care services should be a priority. All sectors of society should have access to care where they will be treated with dignity and where they have the opportunity to participate in making their own health care decisions. Our bill provides for an enhanced 90% federal matching rate to states through Medicaid and SCHIP for the provision of language services. This includes oral interpretation, translation of written materials, and other language services for individuals with limited English proficiency.

In the area of access and affordability, our bill requires first and foremost an annual report to Congress on how federal programs are responding to improve the health status of Hispanic individuals with respect to diabetes, cancer, asthma, HIV infection, AIDS, substance abuse, and mental health. The legislation provides \$100 million for targeted diabetes prevention, education, school-based programs, and screening activities in the Hispanic community. Similarly, the bill provides for targeted funding for programs aimed at the prevention of suicides among Hispanic girls. Targeted grant funds are also provided to support promotoras in improving the health of women and families in medically underserved areas.

Our last section focuses on the reduction of health care disparities by addressing the lack of providers who can provide culturally competent and linguistically appropriate care. The bill provides for increased funding for HRSA's health professions diversity programs. As you know, the President's FY03 budget proposal eliminates virtually all funding for these important programs. Earlier this year I initiated a letter supporting increased funding for health professions diversity programs. The letter received widespread support with 45 House members signing on.

In addition to promoting diversity, these programs support the training of health professionals in fields experiencing shortages (i.e., pharmacy, dentistry, and allied health) and promote access to health care services in medically underserved communities. The Hispanic Caucus considers increased funding for these programs a high priority.

Once again, these are just some of the highlights of the bill. As the Hispanic community

continues to grow, the implementation of these provisions will take on an even greater importance.

Mr. Chairman, and members of the Subcommittee – I ask for your support of the Hispanic Health Improvement Act.

**Conclusion**

I would like to close today with a story that some of you may have heard me tell before. In October of 2000, the Hispanic Caucus held a Hispanic Health Awareness Week. During the forum on HIV/AIDS, I remember a doctor telling the story of women diagnosed with HIV. Yet, what was most troubling was that she did not realize being "Positivo" is a bad thing. In Spanish, "positivo" means that you're okay and she thought she was okay. When she became pregnant and was not fully aware that she had the virus, she passed it onto her baby.

The transmission of the virus from mother to child is something that can be prevented in most cases - if the mother is aware of the she is infected, and if she is aware of the services available to her. It was not the case for this particular woman, and her story haunts me to this day.

For me, this story speaks to the need to ensure cultural competency in the education of our health professionals. This story speaks to the need for creating a higher public awareness. This story speaks to the need that there is still much work to be done in the area of prevention and education in communities of color. Mr. Chairman, thank you for the opportunity to testify before you today. I would be happy to answer any questions at this time.



Testimony  
Before the Subcommittee on Public Health  
Committee on Health, Education, Labor,  
and Pensions  
United States Senate

**The Health Care Needs of  
the Hispanic Population**

*Statement of*  
**Cristina Beato, M.D.**  
*Deputy Assistant Secretary for Health  
Office of Public Health and Science  
U.S. Department of Health and Human  
Services*



For Release on Delivery  
Expected at 2:00pm  
on Monday, September 23, 2002

**Introduction**

Good afternoon, I am Cristina V. Beato, M.D. Deputy Assistant Secretary for Health. I want to thank Senator Jeff Bingaman and the other members of the Subcommittee on Public Health for the invitation to testify at this important hearing on the health care needs of the Hispanic population. In my testimony today, I will primarily focus on the efforts of President George Bush and Secretary Tommy Thompson to eliminate those health disparities that disproportionately affect Hispanic Americans.

**Demographic Profile of Hispanics in the United States**

The Hispanic population is the largest minority group in the United States, based on the latest U.S. Census Bureau data. According to the Census Bureau, the nation's Hispanic population grew 57.9 percent from 1990 to 2000—from 22.3 million to 35.3 million. Hispanics now constitute 13.0 percent of the total U.S. population and are projected to comprise 25% of the total population by the year 2050. The dramatic growth of the Hispanic population is attributed to two factors, high birth rates and immigration.

The states with the highest concentration of Hispanics are California, Texas, New York, Florida, Illinois, Arizona, and New Jersey. The Hispanic population is also relatively young, with a median age of 25.9 years (the median age for the U.S. population overall is 35 years).

The Hispanic population represents a diverse array of ancestry and cultures. According to the 2000 census, 58 percent of the nation's Hispanics are of Mexican

origin, 10 percent are from Puerto Rico, 3.5 percent are of Cuban origin, and the remaining 28.5 percent are Central and South American, Dominican, and other Hispanic origins.

A large percentage of Hispanic Americans speak Spanish as their predominant language. The census reports that 26.7 million Hispanics in the U.S. over the age of five speak Spanish at home and estimates that 12.4 million Hispanics speak English less than "very well."

#### **HHS Efforts to Eliminate Health Disparities Affecting Hispanic Americans**

The Department recognizes that Hispanics are disproportionately affected by certain health conditions such as heart disease, breast cancer, unintentional injuries, diabetes, and HIV/AIDS. Additionally, HHS notes that Hispanics are also the largest group without any health insurance coverage.

Under the leadership of Secretary Thompson, the Department has made elimination of racial and ethnic disparities in health a priority. Departmental efforts focus on six major areas where minorities experience serious disparities in health access and outcomes -- diabetes, heart disease, stroke, cancer, infant mortality, child and adult immunizations and HIV/AIDS. So with this effort, the Department strategically uses and applies its resources to effectively target those health disparities that also disproportionately affect Hispanics.

Specifically, the Department has aggressively undertaken the following activities to address Hispanic health disparities.

### Preventing the Spread of HIV/AIDS

HHS continues to support a vigorous, broad-based public health response to HIV/AIDS that includes extensive research, prevention initiatives, and efforts to expand access to quality health care and services for those who need them. HHS is also working to address disproportionate impact of HIV/AIDS on racial and ethnic minorities. African-Americans and Hispanics account for more than half of the nation's AIDS cases, although they represent only about 25 percent of the population. Department funds will continue to be used for expanded treatment, services, and community-based prevention activities (HRSA's Ryan White Care and Treatment Programs, Minority HIV/AIDS activities, OMH-RC expanded technical assistance program for HIV/AIDS).

### Prevention of Diabetes

HHS's National Diabetes Education Program, a joint program sponsored by CDC and the National Institutes of Health, has reached 3.6 million Hispanics to date with PSAs, media broadcasts and print media, including the Hispanic/Latino Campaign called "**Mas que Comida es Vida**" (It's More than Food, It's Life) that focuses on Hispanics who have diabetes or who are at high-risk to develop the disease. This effort is slated to continue in FY 2003.

HHS's "Take Time to Care about Diabetes" is another bilingual campaign to make women more aware of the dangers of diabetes. "**Cuide Su Corazon**" is one more campaign aimed at Hispanic Americans, to help them understand the need to control all aspects of their diabetes to help prevent heart disease.

**Initiative to Reduce Racial and Ethnic Disparities in Adult Immunization**

Through the Racial and Ethnic Adult Disparities in Immunization Initiative (READII), HHS will conduct two-year demonstration projects in five sites to improve influenza and pneumococcal vaccination rates in African-American and Hispanic communities. San Antonio, Texas, a predominately Mexican-American community, is one of the selected sites, and the efforts in Chicago, Illinois, also target a significant Hispanic population. Immunization rates for adult Hispanics are at least 43% lower than those of their non-Hispanic white counterparts. Over two years, the READII project sites will collaborate with stakeholders to develop and implement a community-based plan utilizing existing and innovative approaches.

**Bilingual Outreach Efforts**

HHS developed a bilingual booklet to provide information to Spanish-speaking parents whose children may be eligible for health insurance benefits through the State Children's Health Insurance Program (SCHIP) and Medicaid. State agencies and others involved in SCHIP and Medicaid programs are encouraged to use the booklet to assist Spanish-speaking residents learn about the availability of free and low-cost health insurance for children in low-income families through their state's SCHIP program. Increasing the awareness and utilization of this program by the Hispanic community is the goal.

HHS uses the Internet technology to provide health information to consumers. Recently, Secretary Thompson launched **Healthfinder® Español**, a Spanish-language Web site that helps consumers track down reliable health information quickly and easily



on the Internet. (<http://www.healthfinder.gov/ospanol/>)

By providing this essential resource in Spanish, HHS is creating a gateway for Spanish-speaking people to learn about preventing and treating illness and developing a healthy lifestyle.

Furthermore, Healthfinder<sup>®</sup> Español brings together in one easy-to-use site Spanish-language health information on over 300 topics from 70 government agencies and nonprofit organizations, including the health issues of greatest concern to those of Hispanic heritage. The site offers both a Spanish text search and a list of topics in Spanish that can be browsed.

HHS's **MEDLINEplus**, the National Library of Medicine's consumer-friendly health Web site, is also now in Spanish. The Department is using tools at its disposal to increase health education and awareness to Americans across the country. MEDLINEplus, en Español is one more step to ensuring that Hispanic Americans have real-time access to the important health information that they need.

#### **Community Health Centers**

HHS continues to support increased funding for Community Health Centers, which play a vital role in treating and serving the health care needs of Hispanics. Last month, Secretary Thompson announced \$30 million in grants to create 70 new and expanded health centers, a vehicle to extend health care services for people without health insurance. For FY 2003, HHS proposes to increase its funding of Community Health Centers to a level of \$1.5 billion – a \$114 million increase above the current year's

appropriation and \$290 million above the funding level of the last two years. This funding will add 1,200 new and expanded health center sites over a five-year period and increase the number of patients treated annually from 11 million to 16 million. Again, Community Health Centers act as safety-net providers for the provision of primary health care and preventive health services to the medically uninsured and under-insured, including Hispanic Americans residing in rural and inner-city areas.

#### **Bilingual/Bicultural Service Demonstration Program**

HHS continues to support its principal demonstration grant programs such as the Office of Minority Health's Bilingual/Bicultural Service Demonstration and its Community Programs to Improve Minority Health Grant programs. Both of these grant programs support the development of strategies geared at eliminating health care access barriers, improving coordination of integrated community-based screening, outreach, and other enabling services of Spanish-speaking individuals.

#### **The US-Mexico Border Health Commission**

The US-Mexico Border Health Commission (BHC), created in July 2000 by joint action of the U.S. and Mexican Governments, exemplifies HHS's commitment to a binational framework. The goals for the Commission are to:

- Create "Healthy Borders 2010" objectives and health indicators pertinent to the region;
- Provide international leadership; and
- Optimize health and quality of life along the U.S./Mexico border.

Secretary Thompson, who co-chairs the Commission with the Mexican Minister of Health, has made border health a priority for the Department.

A **Healthy Border 2010** program was recently launched by the BCH to promote and improve the health of people living on the United States-Mexico border region. The two major objectives of the program are to increase and improve the quality and years of healthy life and to eliminate health disparities. A border commission office now operates out of El Paso, Texas, and funding is provided to support the BCH objectives. Recently, Secretary Thompson and the Mexican Minister of Health signed a cooperative agreement to enhance the safety of food supplies in both countries, and reduce the incidence of food-borne illnesses on both sides of the border through improved inspections. Other projects that address health issues along the U.S.-Mexico border include HRSA's HIV/AIDS Border Health Initiative, the HRSA and NIH **Salud para su Corazon** project to reduce heart disease, and HRSA's Workforce Diversity Border Initiative, "Building a Workforce for a Health Border."

#### Diversification of Health Workforce/Researchers

HHS's Centers for Medicare and Medicaid Services funds researchers, including Hispanic researchers, to conduct research on access, utilization, quality of services, and activities related to health screening, prevention, and education of Hispanic Medicare and Medicaid beneficiaries.

The National Center on Minority Health and Health Disparities (NCMHD), at HHS's National Institutes of Health, is authorized to promote minority health and to lead, coordinate, support and assess the NIH effort to reduce and eliminate health

disparities. Addressing the health research needs of Hispanics is a key activity of the Center.

Promoting NIH minority health disparities research and health disparity career opportunities for minorities is also a major goal of the NCMHD. Since FY 2001, NCMHD has operated two loan repayment programs--the Loan Repayment Program for Health Disparities Research and the Extramural Clinical Research Loan Repayment Program for individuals from disadvantaged backgrounds. There is outreach to Hispanic health professionals and researchers for participation on these two pipeline programs.

Grants administered by Centers of Excellence (COE), in HHS's Health Resources and Services Administration, assist health professions schools to support programs of excellence in health professions education of minority individuals in allopathic and osteopathic medicine, dentistry and pharmacy, and graduate programs in behavioral or mental health (clinical and counseling psychology, clinical social work, marriage and family therapy). COE strengthen the national capacity to train students from minority groups that are under-represented in these health professions and build a more diverse health care workforce. HRSA currently supports eleven Hispanic Centers of Excellence.

#### **Efforts to Expand Health Insurance Coverage**

In August 2001, Secretary Thompson launched the Health Insurance Flexibility and Accountability (HIFA) waiver initiative to encourage states to expand access to health care coverage for low-income individuals through Medicaid and State Children's Health

Insurance Program (SCHIP) demonstrations. This initiative gives Governors more tools and flexibility to coordinate state Medicaid and SCHIP programs and offers a simpler application for states that commit to reducing the number of people without health insurance. Thousands of Hispanic Americans, living in California, New Mexico, and Arizona, among other states, now enjoy health insurance benefits as a result of waivers granted to their states under the HIFA initiative.

#### **President Bush's Health Insurance Tax Credits**

Finally, the absence of health insurance coverage for some 40 million Americans, including many Hispanic Americans, is a problem calling for an immediate solution. President Bush's FY 2003 budget sets forth a package of solutions, including, most importantly, a proposal for the use of tax credits to offset the cost of obtaining health insurance. This proposal has received broad bipartisan support. If enacted, it can lead to a significant reduction in the uninsured population and at the same time lead to improvements in the market for individually purchased health insurance, greater choice and flexibility for individuals in determining the coverage that best fits their needs, and improvements in quality and price of health care provided not just to Hispanic Americans, but to all Americans.

#### **Conclusion**

In closing, I have provided a snapshot of some of the President's and the Secretary's activities that focus on eliminating health disparities that disproportionately affect Hispanic Americans. The Department is making progress, but we know that more can be done. And we will continue to do more in order to lessen the social and economic

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burden of not improving the health status of Hispanic Americans.

Again, thank you for the opportunity to testify before you today. At this time, I would be happy to answer any questions.

59

TESTIMONY

BEFORE THE

**UNITED STATES SENATE**

**HEALTH, EDUCATION, LABOR AND PENSIONS  
COMMITTEE**

**“HISPANIC HEALTH: PROBLEMS WITH COVERAGE,  
ACCESS, AND HEALTH DISPARITIES”**

PRESENTED BY:

DAN REYNA  
DIRECTOR,  
NEW MEXICO BORDER HEALTH OFFICE  
PUBLIC HEALTH DIVISION, DEPARTMENT OF HEALTH  
LAS CRUCES, NEW MEXICO

September 23, 2002  
2:00 p.m.

Mr. Chairman, members of the Committee, good afternoon. I am Dan Reyna, a public health manager serving as the Director of the New Mexico Border Health Office, an office located in Las Cruces, New Mexico, in the Southern and border region of the state. I have had the privilege of working on public and border health issues for over 18 years in the United States – Mexico border area. I appreciate the opportunity to share some thoughts with you today on the issues of Hispanic health as they affect this nation and the Hispanic heartland of the Southwest, the U.S. Mexico border region.

The New Mexico Border Health Office began operations in 1993 after significant community advocacy through the New Mexico Border Health Council, a group of lay and professional community members seeking to improve health conditions in the region. The mission of the Border Health Office is “to improve health status and health services in the New Mexico border region and other border-impact areas of the state.” It has been to the credit of the collective border community that each of the border states of New Mexico, Texas, Arizona, and California have established offices in their health departments to address the multiplicity of border health issues as a joint effort among the four states and in concert with their binational partners on the Mexican side. The border health offices have served a



critical role in the initial and ongoing developmental work of the United States – Mexico Border Health Commission, established in 1994 (P.L. 103-400).

"...vision without strategy is of little use. Simply reciting the acceptable levels of mortality and morbidity is not enough - we need to articulate the strategies and systems that are required to reach these improved levels of health". (Coye, M.J., "Our own worst enemy: Obstacles to improving the health of the public", 1993). It is therefore necessary for us to take those steps that will identify for us the collective and integrated strategies essential in focusing on the complex health problems of the Hispanic population. To be successful, it will be necessary for those strategies to take a systems approach in the identification, intervention and solution of those problems. "The challenge to government officials, health care providers, and all citizens is to think and act as if life and health were part of the same system." (Bruhn, J., Border Health: Challenges for the United States and Mexico, 1997). It should be obvious to us that objectives and strategies are interdependent in a systems view of the problem.

The U.S. – Mexico border is my neighborhood. It is a complex binational, bilingual, multi-state, multi-cultural, multi-economic, ten-state region that

stretches nearly 2,000 miles horizontally with no less than five distinct vertical border regions that is more directly defined by those communities 100 kilometers on either side of the international boundary. The border is an area with multiple public health systems among the ten states, local county jurisdictions and two Federal governments. It has the largest binational land port in the United States (Laredo, Texas), the busiest open border in the free world (over 60 million legal north-bound crossings per year), and the busiest port of entry between San Diego, California and Tijuana, Baja California. The border is a region where the sister communities in each country may have stronger social, economic and cultural ties to their counterpart in the neighboring country than to other areas in their own state or country. I have referred to the border region on many occasions as our (Public Health) "Region 11". It has been quite helpful in my work on the border to have learned not merely to "think out of the box", but simply not to have one.

It is today most appropriate that the discussion of a new strategy for the improvement of the nation's Hispanic health occur during our celebration of "Hispanic Heritage Month." The impact of the growing Hispanic population is clear in the data compiled by the Population Resource Center, and is worth noting:

- In 2000, Hispanics were the largest minority group, comprising 12.5 percent of the U.S. population
- Hispanic Americans are the fastest growing demographic group in the U.S., increasing by 58% since 1990
- Hispanics accounted for 40 percent of the increase in the nation's total population from 1990 to 2000
- The Hispanic population will almost triple by 2050: one out of every four Americans will be Hispanic
- In 2000, Mexican Americans were a population of 20.6 million, which was 58.5 percent of the total Hispanic population
- Approximately 13 million of the U.S. Hispanic population is foreign-born
- After English, Spanish is the most common language in the United States
- By 1998, Hispanic school-aged children had become the largest group of minority school children in the United States

The U.S. – Mexico border factors significantly in the overall Hispanic demographic picture, as is evident by the following:

- Half of all Hispanics live in just two states: California (11.0 million) and Texas (6.7 million)
- New Mexico has the highest percentage of Hispanics of any state at 42 percent, followed by California and Texas at 32 %.
- New Mexico led all states in the percentage of people age 5 and up who spoke Spanish at home, followed by Texas (27%) and California (26%)

Targeting the health status improvement of the growing Hispanic population is both a public policy challenge and opportunity. It is a true opportunity to engage in a systems approach that can target long-term improvements in health status. The “Hispanic Health Improvement Act of 2002” translates into that essential step that integrates on a national scale those agencies, organizations and groups needed for a total-systems approach in addressing the problems of health coverage, access and health disparities.

Health Care Coverage

The New Mexico Border Health Office has been a state partner with the Rural Health Office at the University of Arizona in Tucson since 1996 in the Health Resources and Services Administration's (HRSA) "Border *Vision Fronteriza*" Project. Although the project began as an initiative to develop model outreach projects, the focus shifted in 1999 toward outreach and enrollment of children into Medicaid and SCHIP. The project for the current funding cycle, referred to as BVF II, was funded for one year from October 2001 to September 2002, with possible extensions from year-to-year.

The BVF II project is unique in New Mexico such that I refer to it as an integrated program approach model. HRSA provided funds taken from at least three internal program sources to the University of Arizona who thereafter sub-contracted to a community non-profit organization in Las Cruces, New Mexico to support the project in Doña Ana County, a border county just north of El Paso County, Texas. The role of the Border Health Office is to operate as the coordinating entity directing the activities of the thirteen partner agencies.

The BVF II project provides at least a half-time Community Health Advisor or *Promotora* (Spanish for promoter of health) to the primary partners which includes a hospital out-patient clinic, two community health centers, a state public health clinic, a behavioral health center, a juvenile criminal detention facility, and partial support to a primary school. A key ingredient to our partnership list is the active involvement of the local staff of the Income Support Division of the State Department of Human Services (the State Medicaid agency) and the leadership of the local Immigration & Naturalization Service (INS) District office. The New Mexico project was to receive nearly \$79,000 for this fiscal year but program cuts will limit us to only \$60,000. It is probable that funding may not be provided after the end of this month, although we remain hopeful.

The effectiveness of this model approach for outreach and enrollment of children is evident in the results. For the project period of January 1, 2000 to August 15, 2001 (BVF I), the project in Doña Ana County achieved 549% of the target enrollments set by HRSA. This amounted to direct processing of no less than 12 percent of all Medicaid SCHIP enrollments in the county for that period. For the project period of October 1, 2001 to September 30, 2002 (BVF II), the project has to-date (thru August 2002) achieved 190% of

the target enrollments. The legislation as proposed will provide \$50 million to improve outreach and enrollment of children into Medicaid SCHIP. We are confident that the replication of BVI-type programs throughout the country will insure that no child misses an opportunity to access the appropriate health care services. Using *promotoras* such as in the BVI model is cost-effective and appropriate in targeting the Hispanic population in need. It is a model they recognize and accept. It has performed as advertised.

#### Access

An example of a similar integrated program approach is that of the development of the Healthy *Gente* initiative for the U.S. border region. Healthy *Gente* (*Gente* is the Spanish word for people) is a risk-population targeted and outcome-based health planning initiative established by the U.S. State Border Health Offices specifically designed to be compatible with the United States Healthy People 2010 program. Healthy *Gente* essentially laid the groundwork for the development of the Healthy Border 2010 program of the United States – Mexico Border Health Commission. The Healthy Border program, on the other hand, is a binational initiative that

draws from the 25 Healthy *Gente* health objectives and the 46 national Mexican health indicators.

Progress in achieving the Healthy *Gente* objectives for the U.S. border region is a significant challenge when you consider that if the U.S. border region were a separate state, it would rank last in access to health care, first in the highest rates of uninsured, second in deaths related to hepatitis, third in deaths related to diabetes, first in the number of cases of tuberculosis (34 % of all U.S. cases are found in the four border states), first in children living in poverty and last in per capita income. Additionally, the average percent of uninsured for Hispanics in the four states of the border exceeds 34 percent, slightly higher than the national uninsured rate for Hispanics at 32 percent.

Diabetes is the major chronic disease confronting the Hispanic population. It is one of the leading causes of death on both sides of the U.S. - Mexico border. We recognize that because diabetes is not listed as a cause of death when the death is caused by the complications of diabetes underreporting is quite common. Death rates due to diabetes are two and one-half times higher among Texas Hispanics, than for White non-Hispanics. Gathering all



the estimated diabetics in New Mexico would establish the second largest city in the state behind only Albuquerque.

The *Las Cruces Sun News* Editorial of September 17 described diabetes as the "darkest cloud", upon their review of the recently released report on the Status of U.S. Health by the Department of Health & Human Services.

Diabetes is essentially the center of gravity for the Hispanic population in the United States. Prevention and control efforts require the maximum support at all levels. All available means and approaches focused on early screening and diagnosis, including at the primary school age, require immediate attention.

Neither the border State departments of health collectively, or the U.S. Section of the U. S. – Mexico Border Health Commission can muster the joint efforts necessary to affect the complexity and volume of public health, health services or health disparity problems along our border without the necessary resources. The U.S. – Mexico border region is the unavoidable front lines to many of the growing and emerging public health challenges. The funding of the border health initiatives at \$200 million for fiscal year 2003 will allow the stakeholders to address the problems in their totality.

Effective solutions require resources for prioritization and coordination, strengthening of joint efforts and sustainability.

Adequate funding to the Border Health Commission (\$10 million for fiscal year 2003) will insure strengthening its capacity to serve as a platform from which public health problems can be assessed, collective policy development coordinated and assurance of actions adequately evaluated. The U.S. - Mexico Border Health Commission is an appropriate venue to undertake those significant impact issues of Hispanic health for the border region, developing and supporting bold interventions by local and state partners in areas such as diabetes, substance abuse and infectious diseases.

The utility and appropriateness of the *promotora* model has been proven effective for the range of outreach and community support activities. The approach is compatible with all Hispanic populations. It is, as I have referred to it at times, the "Mary Kay" approach to community health. It has worked throughout the country. I ask that you support the requested funding of \$5 million for fiscal year 2003 through 2005.

### Health Disparities

The emerging national demographics will bring additional challenges in meeting the health manpower capacities needed by the increasing minority populations. “Latinos, African Americans, and Native Americans account for about 25 percent of the U.S. population, yet they represent only about 6 percent of practicing physicians in the United States”, according to the report, “The Color of Medicine: Strategies for Increasing Diversity in the U.S. Physician Workforce”, by Philip Gonzalez and Betsy Stoll, (April 2002).

The authors of further propose that the under representation of ethnic minorities among practicing physicians is both a problem of equity and of health care access and quality. Their research suggests that minority physicians tend to see more minority patients and are more likely to treat Medicaid patients.

A quick look at the data on the availability of Hispanic faculty in the health professions schools, is no less than disturbing, as may be seen by the following institutional self-reporting statistics on the percentage of Hispanic faculty:

- Association of American Medical Colleges (1998)  
**3.33%**
- American Association of Colleges of Nursing (1999-2000)  
**1.30 %**
- Council of Social Work Education – Graduate Faculty  
(1999)  
**4.00 %**
- American Dental Education Association (1998)  
**3.20 %**

We cannot engage in a systems approach to addressing the health problems of the Hispanic population if we cannot open the doors to the future and widen the hallways of opportunity for aspiring and qualified health professions students and faculty.

It is no less a crisis for the next generation, considering the gestation time from high school graduation to medical practice, and surely much more to reach for a medical or dental school faculty position. It could take a half-

century to reach ten percent in any one professional category, or possibly more. We should hope not.

I thank you for the opportunity to visit with you today.

74

Testimony

Submitted to the

U.S. Senate Subcommittee on Public Health

“Hispanic Health Improvement Act of 2002”

by

Elena Rios, M.D., M.S.P.H.

President & CEO

National Hispanic Medical Association

CEO, Hispanic-Serving Health Professions Schools, Inc.

September 23, 2002

Senator Kennedy, Senator Frist, Senate committee members, Senator Bingaman and Congressman Rodriguez, it is an honor to provide testimony to all of you today in support of the "Hispanic Health Improvement Act of 2002".

The National Hispanic Medical Association (NHMA) represents licensed Hispanic physicians in the United States. The mission of the NHMA is to improve the health of Hispanics. The Hispanic-Serving Health Professions Schools, Inc. represents 22 medical schools and 3 public health schools. The mission of this organization is to develop Hispanic student and faculty and research capacity to improve Hispanic health.

Hispanics are now 14% of the US population and by 2050, one out of every four Americans will be of Hispanic origin. In the case of Hispanic patients, we are challenged by the language needs, literacy levels, lower levels of poverty and education, citizenship status, strong cultural beliefs and attitudes, family group decision-making, poor awareness of public health programs or how to follow instructions that come with complex treatment regimens, prescription drug labels, referrals for specialty care or lab and xray preps and tests. Our health system is the best in the world; but in order to be proud of that system, the "Hispanic Health Improvement Act of 2002" challenges the U.S. Senate to develop new strategies to improve the quality of healthcare delivery that responds to the needs of Hispanics.

In August, NHMA and Honorary Co-chair, the Congressional Hispanic Caucus, along with the U.S. Department of Health and Human Services convened the National Hispanic Health Leadership Summit along with the EPA, NHTSA, the Robert Wood Johnson Foundation, the California Endowment, Amgen, Aventis, PhRMA, GlaxoSmithKline, and several national Hispanic organizations. 150 health providers from Hispanic communities and our partner representatives put forward many recommendations to improve programs at the Federal, State and community levels and there is much overlap with what we are addressing today. We will have a report this Fall from our meeting.

I would like to address proposed strategies for the Department of Health and Human Services to continue to improve health care programs and activities to improve the health of Hispanics.

#### **Access to health care**

The major barrier to access to health care is the fact that 2 out of 5 Hispanics under the age of 65 do not have health insurance. This legislation addresses this barrier by creating grants for outreach and enrollment and increasing eligibility for the SCHIP and Medicaid program and we applaud these efforts. We also believe that employers need incentives to increase their ability to provide insurance, especially small employers who employ Hispanics but cannot afford to offer insurance benefits.

We applaud also that a special focus for the new grant program would be families with limited English proficiency, and we recommend that there be reimbursement for interpreters added to this legislation. Moreover, the U.S. Department of Health and Human Services, currently reviewing its guidance to the nation on LEP services under Title VI and supported by the

Administration, should have a clear and firm guidance to direct to our health providers. It is critical that communication be enhanced between providers and patients and we are supportive of the Federal government, representing the largest insurance programs in the nation of taking the lead in this area. We recognize the vision for the development of the reimbursement policy for LEP services for the Medicaid programs and SCHIP in this bill and also recognize that the bill for the reauthorization of Community Clinics also provides provision to do so. We hope that there could be a strategy – perhaps starting with a Congressional task force linked to the future of Medicare, Medicaid and the SCHIP on LEP services reimbursement and evaluation of interventions to guide policy making.

Other major areas addressed in this bill that we support include expanding assistance for aliens who are lawfully residing in the United States who are pregnant women and children, simplifying the applications and determination of financial eligibility, and expanding wrap around benefits of SCHIP including dental health and pediatric vaccine distribution.

#### **US – Mexico Border Health**

This year, the Institute of Medicine published its first major report on Hispanic health. It is a critical need to further investigate with experts on a program that could enhance the insurance products for the Hispanic population, especially in this area of the nation, where so many Americans live without access to care. In addition, the US-Mexico Border Health Commission has great potential to serve as a conduit for advancing health programs if properly supported.

#### **Diabetes, HIV/AIDS, Cancer, and Mental Health**

President Bush and the U.S. Department of Health and Human Services and the Institute of Medicine Report “Unequal Treatment” have continued to focus the national health agenda on the Disparities in Health for Racial and Ethnic minorities in the United States. This bill calls for the increase of education and prevention as well as clinical treatment services in the area of diabetes, HIV/AIDS, cancer, and mental health. We need to emphasize that there is a critical need to increase prevention not only to better quality of life but to cut down on the tremendous costs to our society when Hispanics and others are constantly found in the end stages of chronic diseases without having had proper medical care. We as a nation can change this.

We are especially aware of the new programs being supported in this bill for a patient navigator system, community health workers and the Special Population Networks such as Redes en Accion and recognize these as models for chronic disease interventions in Hispanic communities.

#### **Diversity in the Health Professions**

The U.S. Federal government has supported the national policy to recruit disadvantaged and minority students into the health professions since the 1960s. The literature has proven over



and over again that the Federal Health Careers Opportunity Program has resulted in 2-3 times the number of graduates practicing in medically underserved areas and Hispanic and Black physicians provide more care to their own communities and to Medicaid and uninsured patients than the non-minority doctors. In addition, in this era of increasing health care costs, we must also consider that the minority patients, who tend to be uninsured, will eventually create more cost in the system, as they demonstrate chronic illnesses. Thus, it is more effective for the health system to finance recruitment programs for future minority doctors who can provide targeted services. The consequences of not supporting minority health workforce development will be greater costs to the taxpayers of America, who would bear the brunt of the shifting costs.

But even the 3 decades of Federal funding of HCOP has not resulted in enough Hispanic workforce. Hispanics are only 5% of the total physicians, 2% of the total nurses and lesser proportions in allied health professions. There are many factors to consider why the recruitment efforts over 3 decades have not resulted in greater numbers of Hispanic and other minority physicians and health professionals. A major reason is the limited support from the health system for academic skills building and admissions preparation services available in minority community schools and for universities. The Federal government and a small number of private programs have been in this business that needs to be expanded.

We believe that the Federal government should continue support of the recruitment program, the Health Careers Opportunity Program (HCOP) at a \$40 million dollar level; however, there should also be a new approach with a focus on outcomes in collaboration with the business community. The private sector, after all, has a greater proportion of physicians – in HMOs, in private practice, in hospitals, in academic health centers. So too, the Congress should continue to fund the HRSA Centers of Excellence program (COE) at a \$40 million dollar level in order to recruit faculty and develop activities – curriculum and research, mentorship, and faculty development.

Specific programs that have proven track records of increasing the disadvantaged student success rate in being admitted to medical schools include academy magnet high schools for math and science or health careers, admissions counseling, financial support and scholarships, post-baccalaureate programs for students who need enhanced skills building for the science curriculum and MCAT test preparation. We and other minority health professional organizations will continue to work with the Federal government on these efforts.

#### **Hispanic – Serving Health Professional Schools**

This bill supports the development of priority grants with health professions schools with a track record of enrolling Hispanic students and hiring Hispanic faculty, providing a resource of curriculum and academic activities. Health professions schools should be provided incentives to build the necessary curriculum, faculty and research for the 21<sup>st</sup> century health. We believe that medical schools and other health professional schools should be directed by Federal funds with incentives to promote health professional and research service to the medically underserved areas.

### **Data Collection and Research**

We strongly support data collection and research that contains racial and ethnic identifiers in order to demonstrate trends and new knowledge for our program development and a more effective policy analysis and policy debate on what is needed to improve Hispanic health. Hispanic identifier is critical, as is data collection on the Hispanic sub-groups – Mexican, Puerto Rican, Cuban, Central, South American.

Data collection through community-based research is most important, as is being done now by NIH, AHRQ, and CDC. We strongly support expanding these opportunities in this bill – for example, the NIH Project Export Program, NIH and HRSA Centers of Excellence, the Agency for Healthcare Research and Quality Exceed Program (Excellence Center to Eliminate Racial Disparities in Health), the CDC REACH program and community research efforts, and the NIH efforts led by the Center for Minority Health and Disparities in Health research activities. What is critically needed to improve Hispanic health, is the development of future research and researchers – so we need training of Hispanic researchers and others interested in Hispanic health services and policy research. We need research institutes, publications, and clearinghouses so that policy can be developed.

### **Cultural Competence Medical Education**

There is a critical need to provide curriculum for training of medical students and other health professional students in order to prepare for the workforce of the future. In addition, we recognize the importance of training of physicians, who never had information about minority patients. NIIMA is developing community led curriculum with evaluation and outcomes protocols, and publishing case studies that tell stories of different sub-group encounters with physicians and a new Website to serve as a resource for Hispanic cultural competence. HSHPS schools have been developing curriculum for their students and the HSHPS, Inc. collection of that information is in progress.

### **Office of Minority Health and HHS Agency OMHs**

Lastly, there is a critical need for leadership for the nation. Minority health is a complex endeavor, as we know. The OMH and the Agency OMHs are needed to coordinate the Minority Health Resource Center, and to coordinate its outstanding internal programs and linkages to constituents through the HHS Regional offices.

The Center for Cultural Competence and Language is a service that this bill addresses so that we can have more interventions in the health system – demonstration projects to learn from.

We recognize the opportunity for the OMH to promote leadership development and would encourage the bill to include this as an area of priority, for we cannot expect the health system to change and understand the needs of Hispanic health without first educating the leaders of the health system. Finally, we believe that Hispanic leaders need to be promoted in the Federal and private sectors in decision-making positions to advance a quality health system for all Americans.

[Whereupon, at 3:45 p.m., the subcommittee was adjourned.]

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