comprise only 3.5 percent of all master's students in the U.S. in 1990, and Hispanic-Americans received 7,905 master's degrees in 1989, which was 2.5 percent of all such degrees.

Now, it's important for us to rid ourselves of the belief that Hispanic students go on to professional schools. Hispanic first professional school enrollments increased only from 2 percent in 1980, to 3.5 percent in 1990. Now, in actual enrollments, the number went from 7,000 to 10,000 students. Hispanic students are not being diverted from graduate school by professional school enticements; they are not necessarily going into professional degree programs. GMAT data show that only 1.1 percent of all the GMAT test-takers in 1989 were Chicanos, and only 0.7 percent were Puerto Ricans. And in terms of law school, to quote a colleague of mine, Law Professor Michael Olivas, "Hispanics are not flocking to law school." There were approximately 5,000 Hispanics enrolled in law schools in 1990 for only 3.8 percent of the total, and the situation is equally dismal in other professional fields.

I suspect you've had an opportunity to talk about what the Hispanic representation is in the schools of medicine and allied health fields. In 1989, the number of Hispanic college graduates with science degrees was 1,682. Of those, a good part of them—1,338—applied to medical school. In 1990, Hispanic Americans constituted only 5.6 percent of all first year students enrolled in U.S. medical schools. The total enrollment, or the enrollment of Hispanic-American students in medical schools in 1990, was also 5.4 percent, and I suspect that Hispanic-American representation in the other health professions—nursing, dentistry, pharmacy, physical therapy, research in bioscience areas, public health, health administration, health policy—is equally low as it has been documented for these others.

One particular concern is the alarmingly small number of Hispanic U.S. citizens that are earning doctorate degrees. We argue strenuously that those small numbers are a critical stumbling block in our ability to change the face of U.S. higher education. In 1989–1990, the total number of doctorates awarded in the United States was 37,980. Of that number, only 783 doctorates, or 2.1 percent, were awarded to Hispanics. These degrees represent 2.6 percent of the doctorates awarded to U.S. citizens that year. Hispanic Ph.D.s represent approximately 1.7 percent of all doctorate degree recipients in the sciences and mathematics. Now, while there have been fluctuations in the number of doctoral degrees awarded to Hispanics over the last 10 years, the overall share has not increased substantially, with the actual numbers remaining minuscule. Clearly, the dearth of Hispanic Ph.D. recipients has reached a critical level in terms of participation in academia and in research and development. One obvious outcome of such poor postbaccalaureate attainment rates is that Hispanics constitute approximately 2 percent of university faculty and about 2.3 percent of full-time postsecondary education administrators.

Your conference provides a golden opportunity to address the national resource needs for Hispanic representation in the medical profession and allied health fields. Given the already noted dismal participation levels of Hispanics in graduate education and in the postsecondary education teaching and administrative ranks overall, much remains to be done.

HACU shares the belief that the soundest method for increasing the number of Hispanics with doctorates and professional degrees is to enhance the awareness of college research and teaching careers among Hispanic students at earlier stages in the collegiate experience. We just cannot continue to cream the cream. We have to work strenuously to expand that pool. Hispanics need to be informed of opportunities for doctoral study and the career advantages that can be afforded to them from pursuit of a career in medicine and health. Only by

such targeted interventions can we create a larger pool at the undergraduate level of potential medical and related health professionals.

In addition, HACU strongly believes that increased Federal support for such study is an essential element for correcting the current shortfall of Latino health professionals. It is critical that these considerations be addressed. HACU seeks to bring attention to the particular human resource needs of HSIs. Increasing the number of Latino faculty will have a broad-reaching and sustained effect of providing appropriate role models for undergraduate students moving through the educational stream. At every level from grade school to graduate school, Latinos lag in academic achievement.

There is progress, and I don't mean to paint such a dismal picture. As I noted earlier, our numbers have increased. We just don't think that they have increased significantly enough to make a difference because, if every student that you have in your medical programs now graduated tomorrow, it would still be a drop in the bucket.

Although the gap between Hispanics and other groups has widened in terms of education, there are some preliminary data from both programs that HACU runs at the precollege level as well as work done by colleagues of ours working with Hispanic community-based education efforts that suggest that community-based programs can lead to significant measurable improvements in student performance as well as significant increases in parent and community involvement in the educational process. I underscore the latter because it's only by working at those early levels that we can ensure ourselves of a better stream, a fuller stream, more representative of the numbers involved, subsequently coming through programs later on. I will encourage us not to look for just piecemeal, quick fixes. I think those would not be sufficient for our country's needs.

It's my sense that many of us have come to the conclusion that we are all interdependent and that our strategies will succeed if we have viable partnerships and lots of friends. We all recognize that Hispanic students face monumental challenges. If they are to achieve and attain beyond the isolated and piecemeal types of successes we find here and there, institutions such as the Department of Health and Human Services, PHS, and community-based organizations must enter into new and even more creative collaborative relationships.

HACU is in the position to serve as a conduit in this respect. You have out in the field some of the best programs targeted at providing the early career awareness and support for students within the pipeline. We just don't have enough of them. A case in point is the Health Careers Opportunities Program: I counted about seven such programs funded in our 118 HSIs. That tells you that there's not enough connection to Hispanics. The Minority Biomedical Research Support Program (MBRS Program), the MART programs, the minority high school student research apprenticeships, the Health Service Corps—how much are these entities really targeting our students? We must do a better job of somehow bringing them into a better focus with our institutions, both our community-based institutions and our institutions at the postsecondary level. I suggest that you consider how you can expand and maybe even consider other reauthorizations and legislative vehicles to bring attention to the Latino dimension of our minority equation.

There are 38 HSIs that offer health science degrees at the 2-year college level. At the 4-year college level, among our HSIs, we have 31 schools that offer a variety of baccalaureate and master's degrees, etc., in health science. In terms of allied health, at the community college level, 38 HSIs offer degree programs. Twenty-three 4-year HSIs offer bachelor's or higher degree programs in allied health. In terms of life sciences, 21 2-year HSIs offer degree programs and 39 4-year HSIs offer a

variety of baccalaureate degrees or higher. Twenty-one 2-year HSIs and 31 4-year HSIs offer degrees in mathematics. Seventeen undergraduate HSIs, 17 community college HSIs, and 33 4-year HSIs offer a variety of degrees in psychology. What we don't have is a lot of medical schools. We do have our programs in Puerto Rico, and I think a lot of us on the mainland often give short shrift to the benefits of our institutional systems on the island. It behooves us to consider how we can better tie both the programs and the flow of students, faculty, and resources of our schools on the island to the needs here on the mainland.

One of the things that I learned about this past year is the development of the new Hispanic Centers of Excellence in the United States. The numbers of the Latino students in the Centers of Excellence are not what they should be, so I would encourage that those Centers of Excellence receive a lot more funding. The funding that was divided among those institutions was paltry. Such a situation is intolerable. There are more than 400,000 students in those institutions. It's a fact that has been taken up with some notice by our friends in the Federal bureaucracies. As bad as things are for us obviously in health, they're not much better in the other professional fields, and so we have had other agencies who have had that light bulb come on and say, "Ah, can we work with you guys to get these students thinking about careers in agricultural science and various other technology and math fields?"

HACU is not a panacea to the larger issue of gross underrepresentation of Hispanics. We have to work at building strong partnerships. That's why I emphasize strengthening the precollege as well as the postsecondary linkages so that the students that come in don't fall out, so that you can be guaranteed that you're going to have students being tracked through these institutional linkages, and so that you're going to have students prepared to go into your advanced programs.

Approximately 138,000 students are enrolled in Puerto Rican institutions. You have another 222,000 in California alone. The California system of higher education is structured in such a way that 68 percent of those students are in community colleges. If we want to have a significant impact on pulling many of these students into health professions, we have to be creative at finding ways to bring health career opportunities to community colleges. Not that we start there; I'm suggesting we start much earlier. We have to find ways to engage all the segments in implementing additional ways to bring Hispanic students into health professions, hold them, and carry them through the process.

Eleanor Chelimsky

Assistant Comptroller General
U.S. General Accounting Office

It's a great pleasure to be here. Today what I thought I'd do is talk about the GAO report that I see most of you have received and our work generally on Hispanic Americans and especially their access to health care. Let me begin by presenting a short profile of the Latino population living in the United States and then move on to a discussion of five specific barriers to health care that they currently face.

Latinos make up the second largest and also the fastest growing minority group in the United States. We tend to have only a one-sided picture of the issues. We hear a lot more about machismo, for example, than about the strength and cohesiveness of Latino families, more about high rates of diabetes than about low rates of infant mortality, more about school dropouts than about the achievements of Latinos in all areas of American life. Is this because we're a problem-oriented society with a strong belief in the idea "if it ain't broke, don't fix it"? Is it because we get our information mostly from whatever data the media may choose to report? Or is it because we simply haven't come around yet to a very balanced

understanding of the diverse Hispanic population rooted and growing in our midst?

The fact is that, since 1980, the Hispanic population has experienced phenomenal growth, up from 9 million people in 1970 to 21 million people today. This is largely a result of two factors—a high birth rate and massive immigration—both of which lead, in turn, to a relatively youthful Latino population having a median age of 26, compared with 34 for non-Hispanics. In a nutshell, about 1 of every 12 persons in the United States today is Hispanic, and by the turn of the century Latinos will be our largest single ethnic group. So we've seen dramatic increases in size for the Hispanic population but much slower progress in socio-economic standing.

About one in four Latinos lived in poverty in 1989. That's about the same as it was in 1980. And that compares to only one in nine for non-Hispanics. Two of every five Latino children are born into poor families, and this includes the children growing up in single, female-headed households, about half of which fall below the poverty level. Now, the importance of sizeable numbers of poor, single, female-headed households in any population subgroup is that, for the single mother and her children, the pathways for breaking out of poverty, and especially the pathways of education and economic opportunity, are severely limited. In 1991, Latino families maintained by a female householder with no husband present amounted to 24 percent of all Latino families compared to 16 percent for non-Hispanic families. Of course, the diversity that I mentioned earlier is reflected here. You find only 19 percent of Mexican American households headed by single mothers, compared to 43 percent of Puerto Ricans. Still, the 24 percent average rate for Hispanic families as a whole is nearly twice the 13 percent average rate for white families. Suffice it to say that poverty and education are intimately linked.

Now, let me turn to health status. Here again, the Hispanic profile differs notably from that of non-Hispanics. Data on mortality indicate that, while Hispanics live about as long as non-Hispanic whites on average, they tend to die from different causes: accidents, diabetes, and cirrhosis of the liver kill proportionately more Latinos than non-Latinos, and the top 10 killers include homicide and AIDS, whereas neither of these is among the major killers for the white population. On the other hand, Mexican American infant mortality rates have been at or below white rates and much below black rates since data have been collected on this group. With regard to morbidity, Hispanics are more likely than non-Hispanics to suffer from hypertension, cardio-pulmonary problems, strokes, cirrhosis of the liver, and cancer of the cervix. AIDS also represents a serious increasing concern, not only for those Latinos who are addicted to intravenous drug use but also for larger numbers of people, especially teenagers, who may not have received sufficient health education to understand the risks of AIDS and especially how it is transmitted. Hispanics are two to three times more likely than non-Hispanics to have both diabetes and its complications, like blindness or amputation, which often occur without treatment. A study of Texas border counties that we looked at, for example, showed that, among all the cases followed in the study, 60 percent of diabetes-caused blindness, 51 percent of kidney failures, and 67 percent of diabetes-related amputations of feet and legs could have been prevented with timely and proper treatment.

Given these data on the high rates of Hispanic mortality and morbidity with respect to so many diseases that are preventable, or at least treatable, access to the health care system emerges as a critical issue for Latinos. Unfortunately, I would say that the situation here is far from encouraging. In 1989, as all of you know, more than 14 percent of the American population as a whole had no health insurance, public or private. But for Hispanics, that

figure was more than twice as high—33 percent had no health insurance versus about 19 percent for blacks, 12 percent for whites. Yet in the United States, the lack of health insurance erects a primary barrier to the receipt of adequate and timely health care. People who are uninsured are less likely to have a regular source of health care or to have an ambulatory visit during the year. They are more likely to use an emergency room as their usual source of care, and they are less likely to use preventive service, such as pap smears, blood pressure checks, and breast examinations. Even if they have a chronic and serious illness, they'll make fewer visits to the physician than if they were insured. And when they finally do receive care, their physical complications are likely to be more advanced and, hence, also more difficult and costly to treat.

But why are Hispanics so disadvantaged with respect to health insurance? We uncovered in our work a number of reasons, some applying to private health insurance, some to public programs. Beginning with a lack of private coverage, we found that two factors are principal contributors to the problem: jobs that fail to provide health insurance and incomes that don't reach the poverty level.

The fact that Hispanic families are more likely to be uninsured than either white or black families is, of course, well-known. What is less well-known is that this holds true regardless of whether there is an adult worker in the family. Whites are likely to be uninsured mostly when there's no adult worker in the family. But having a job is no guarantee for Latinos. In families with adult workers, only 57 percent of Hispanics, compared with 84 percent of whites, have private insurance coverage. Said another way, this means that if Hispanic families with adult workers had the same rate of insurance coverage that whites have, the overall rate of non-insurance for Hispanic families would have been 18 percent, not 33 percent. The issue here is that some jobs in some industries don't provide health insurance benefits to employees. The problem for Hispanics is that, in comparison with both whites and blacks, they are more likely to work in industries that don't provide health insurance coverage—for example, personal services or agriculture—and less likely to work in industries that routinely provide such coverage—for example, manufacturing, professional services, and public administration.

With regard to income as a contributor to non-insurance, this relates to the potential for buying health insurance when a job doesn't offer it. We found that employed Hispanic men with incomes above the poverty level had much higher rates of private insurance than those with incomes below that level, with 67 percent versus 31 percent. Higher income meant not only a greater likelihood of insurance coverage through employers but also the ability to afford private health insurance when coverage through a job was not available. Higher incomes are also relevant when workers receive job-related health benefits for themselves but not for their families. Low incomes simply preclude the additional coverage needed, and the problem gets worse because, on average, Hispanics have larger families than non-Hispanics and, therefore, more persons for whom to purchase extended coverage. So the outlook for Hispanic health insurance, at least in the private sector, is not currently very encouraging.

But what about public insurance? Are Hispanics better off with Medicare and Medicaid than they are with private insurance? Well, certainly with Medicare they are. The Medicare program covers only the elderly, but it has the rare virtue in the United States of being nearly universal with 96 percent of people 65 or over having coverage. Ninety-six percent of whites, 95 percent of blacks, and 91 percent of Hispanics are covered by Medicare, and the reason coverage is so widespread is that Medicare eligibility is relatively straightforward. Anyone over the age of 65 who is

eligible to receive Social Security is automatically eligible to receive Medicare. But even though coverage is nearly universal, I would still point out to you that 4 percent of elderly Hispanics, about 42,000 people, are covered neither by Medicare nor by any other health insurance at all.

The situation is very different with Medicaid, where stringent eligibility criteria greatly restrict access to the program in a number of States with high concentrations of Hispanics. Because each State determines its own eligibility criteria for Medicaid, even though the criteria must fall within Federal guidelines, the criteria obviously vary dramatically across the States. Two of the most restrictive States are Texas and Florida, in which about 3 of every 10 Hispanics reside. In California to qualify for Medicaid a family of three must earn less than 79 percent of the Federal poverty line income. But to qualify in Texas, a family of three must earn less than 22 percent of the poverty line income. So in 1989, when the poverty level was about $12,000, a family of three earning $6,500 a year would have qualified for Medicaid in California but not in Texas.

Now, there are major differences in Medicaid coverage across Hispanic subgroups, which are largely explained by these differences in eligibility criteria. For instance, Mexican Americans and Puerto Ricans both have high rates of poverty and low median incomes. But Puerto Ricans, who are concentrated in New York and New Jersey, are much more likely than Mexican Americans, with a substantial population in Texas, to meet Medicaid eligibility criteria. As a result, a higher proportion of Puerto Ricans than Mexican Americans receives Medicaid. It's true that the greatest numbers of Mexican Americans, about 42 percent, do reside in California, and California has the least stringent eligibility criteria for Medicaid in the Nation. Still, with more than 30 percent of Mexican Americans residing in Texas, Texas Medicaid policies do play a role in restricting health care coverage for the group. Further, and very important, despite California's less restrictive criteria, 23 percent of California's non-elderly population—that's 6 million people—were uninsured in 1989. This reflects once again the effect of employment in low wage jobs that don't provide health insurance.

The situation in California illustrates very well the complexity of the policy difficulties that are involved here. Just raising the Medicaid thresholds closer to the poverty line would still leave uninsured many working people who earn more than poverty level income but not enough to afford health insurance.

Now, let me turn to three other kinds of barriers that I wanted to talk about with you today that also affect Hispanic access to health care. The first of these is the extraordinary complexity of the Medicaid program. Let me just point out that, in addition to the problem of variable and sometimes restrictive income eligibility criteria that I noted earlier, the Medicaid program is itself a barrier to access because of the impenetrable maze it presents to potential applicants.

In Texas, for example, there are nearly 10 different programs for Medicaid enrollment, each with its own criteria for eligibility. For example, pregnant women with incomes up to 133 percent of the poverty line; children born before January 2, 1982, who are eligible for AFDC [Aid to Families with Dependent Children]; children born before October 1, 1983, with incomes between the AFDC and medically needed criteria; and so on. Medicaid case workers in Texas engage in 4 weeks of training just to learn the eligibility criteria and how to communicate them to potential recipients. Medicaid officials are well aware of the formidable barrier the program's complexity represents. They note that it's difficult to explain to people that they may not be eligible for Medicaid now but could be so in the future and that the process of enrolling people is excruciatingly burdensome, and they realize that standing in line

for a full day at the Medicaid office does not compete favorably with the practical alternative of receiving free care in an emergency room or a community health center. But recognition is not resolution. Medicaid needs either to find a cord with which to lead applicants through its maze or destroy the maze.

On the other hand, making health insurance available and simplifying bureaucratic procedures, no matter how important those actions might be, are still not enough to resolve the problem of Hispanic access to health care. The second noninsurance barrier I wanted to mention is the fundamental impediment constituted by the shortage of physicians serving Hispanic communities. This is a truly critical problem, but it's more severe in some places than it is in others. It's acute in El Paso. Only 30 of the city's 800 physicians, 4 percent, maintain practices in the poorest part of the city that houses 32 percent of the El Paso population. Twenty years ago, some of you may remember, the American Medical Association used to estimate that a ratio of 1 general practitioner for a population of 750 was reasonable. Today, we have fewer general practitioners, and ratios of 1 physician to 5,000 or 6,000 people are not uncommon in the center cities where many Latinos reside. Now, this shortage of physicians is naturally accompanied by a dearth of primary care facilities available to the Hispanic community. It's hard to overestimate the importance of this problem. Taken together, these two supply problems involving physicians and facilities are at least as important as noninsurance in impeding effective access of Latinos to health care.

Finally, let me turn to a third barrier that needs to be mentioned, and that's patient health education. Two factors are particularly salient in the demographic health profiles of Latino populations that I spoke to you about earlier—comparatively lower levels of educational achievement and comparatively higher levels of preventable or treatable disease. There is a need for special efforts to educate Latinos about effective health practices and generally the special health problems they face and to educate them in their language, taking account of the cultural factors particular to the different Hispanic communities. It's probably unnecessary to make the case to this audience of the importance of early detection in the outcomes of diseases like cancer or diabetes. Yet, early detection depends largely on the patient's knowledge, which triggers a visit to the doctor in the first place.

It seems clear that all of these five problems—noninsurance, bureaucratic complexity, a shortage of physicians, a shortage of primary care facilities, and very uncertain patient awareness of important health issues—are major barriers to health care facing Latinos today. I think these problems are at the heart of improving not only access but also health status, and especially the preventable or treatable diseases afflicting this population. I think the shortage of physicians, facilities, and health information contribute heavily to a situation in which patients go to community health centers or hospital emergency rooms in advanced stages of illness.

This situation makes prevention academic. It causes treatment to be more difficult and more expensive, and it renders outcomes much more uncertain. This is especially the case for diabetes among Hispanics where severe complications arise because of delayed treatment and lack of patient awareness. But of greatest concern are the failures of prevention, the inadequacy of prenatal care that could reduce high rates of pregnancy or childbirth complications for women and children, the unavailability of pap smears that allow early detection of cervical cancer, the lack of health counseling to deter obesity or alcoholism, or the transmission of HIV.

In conclusion, the five barriers I've discussed are not the only ones facing Hispanics in their quest for better health care. But it certainly seems clear

that improvement is not going to occur if we don't address them. Initial steps should include more adequate health insurance coverage, both private and public; simplification of eligibility determination in the Medicaid program; stronger community provision of primary care; and greater Federal and State efforts to educate Latino populations with regard to both the prevention and the treatment of those diseases most likely to affect them.

Finally, I would also make a plea for better data. Our current information is plagued by lack of Hispanic identifiers in 20 States, by uncertain reporting in the other 30 States, by Hispanic samples too small to use for analysis or estimation, and by 10-year gaps between data collections for a population that is growing with this speed. The truth is that no existing database currently provides accurate, complete, and timely data on the entire Hispanic population, including the often very different subgroups. Perhaps this conference might also consider data improvement. I realize you have a difficult and a complex task in front of you, and some of you may be thinking right now of Alfonso the Learned's remark as he considered Spain's problems in the 13th century: "If God, in His wisdom, had thought to consult me before embarking on the creation of the world, I would have suggested something simpler."

Responder Panel

James O. Mason, M.D., Dr.P.H.

Assistant Secretary for Health
U.S. Department of Health and Human Services

The first step in solving a problem is to identify and to define it. You've done a masterful job of that during this Workshop. I want you to know that those of us who are responding are here not just to learn and to listen, but we've come to act as a result of the work that you've done. Represented here are men and women who report directly to Secretary Sullivan, to Secretary Alexander, and to Secretary Martin. These three individuals report directly to President Bush. So your recommendations, your identification of issues and problems, have the President's ear.

You should also know that the President already has a comprehensive health care reform initiative on the table. His plan will provide access, security, choice, and affordability for all Americans. It is a plan that can work.

You've discussed community and migrant health centers. HRSA has just awarded 71 new sites, either through expansion or new grants. In addition, we are putting more money into community and migrant health centers in high-risk areas with the "weed-and-seed" program. For years, there haven't been new programs in community health centers. Through this administration's support of these programs, we're moving ahead again. And if we can get Congress to act on the President's budget for fiscal year 1993, there will be more expansions and more increases during the next fiscal year.

We're also revitalizing the National Health Service Corps. It almost disappeared. Now it's on its way up. We promise you in accordance with the recommendations that you've made that we will target minorities. Among those minorities, our Hispanic/Latino community will be specifically targeted.

In the area of research, we've had funding increases over the last few years. However, we're afraid that Congress is not going to give us the President's budget for NIH or for SAMHSA. At NIH, we've recently created an Office of Minority Health Research. And SAMHSA is our new organization that will come into being tomorrow morning. Its mission is to ensure knowledge is used effectively and comprehensively for the prevention and treatment of addictive and mental disorders.

So the structure is there to begin to address the issues that you have identified. We will work with you.

Michael McGinnis, M.D.

Director
Office of Disease Prevention and Health Promotion
U.S. Department of Health and Human Services

I'd like to begin today by emphasizing that the process of setting and implementing national health promotion and disease prevention objectives highlights that serious and intolerable gaps exist in our national effort to improve the health of the Hispanic/Latino community, but it also demonstrates that we can and will close those gaps.

I'd like to applaud the focus that the Surgeon General has given here to the issues in disease prevention and health promotion and commend each of the members of the work group for identifying some of the key issues in succinct fashion. Let me take a few minutes to revisit some of the issues by looking at three categories of targets in *Healthy People 2000*—the Nation's health promotion and disease prevention objectives: (1) the first category includes those objectives that have specific Hispanic targets, (2) the second category includes those objectives that do not have specific Hispanic targets and for which Hispanics are actually doing better than the general population, and (3) the third category includes those objectives that do not have specific Hispanic targets and for which the Hispanic population is at higher risk than the general population.

In the first category, targets were set for those issues that I know are viewed as of greatest importance to each of you, as they are to me. These include increasing the regular source of primary care specifically for Hispanics, increasing receipt of clinical preventive services by Hispanics, reducing tuberculosis among Hispanics, confining the incidence of AIDS among Hispanics, reducing diabetes among Hispanics, reducing adolescent pregnancy among Hispanics, reducing growth retardation, increasing access to prenatal care, reducing infant mortality, increasing access to mammography and Pap tests, reducing untreated dental caries, increasing the years of healthy life among Hispanics, reducing homicides among Hispanics, reducing cigarette smoking and overweight among Hispanics, reducing infertility among Hispanic couples, increasing Hispanic representation in the health professions, and reducing data gaps by specifically improving the availability of Hispanic data. Those are the key targets among the 25 that were set specifically for the Hispanic population.

Let's take a look at the second category, the area in which available data tell us that the Hispanic population is doing better than the general population. From this COSSHMO publication, ***The State of Hispanic Health***, we know that the Hispanic population is doing better with respect to coronary heart disease, stroke, cholesterol levels, high blood pressure, cigarette smoking among adolescents, and suicide. Because the *Healthy People 2000* special population targets were set only for those areas in which the population was at higher risk than the general population, there are no targets specific to the Hispanic population in these particular areas. However, as a Nation, we clearly must be vigilant in preserving that relative advantage in these areas.

Let me now focus on the third category—in which there are several priority areas with no Hispanic-specific objectives but in which we know that Hispanics may be at higher risk than the general population. These priority areas include alcohol and other drugs, unintentional injuries, occupational safety and health, environmental health, food and drug safety, and sexually transmitted diseases. It is quite clear that the reason that there are no Hispanic-specific objectives is not because the Hispanics are doing better, but because we just don't have adequate data in these critical areas. This was pointed out time and time again by the presenters. We could have arbitrarily set targets without data, but that would have obscured the fact that we don't have the data that we need. We need to find the data and use it as we establish objectives

for the future. But, most importantly, we cannot let the absence of data get in the way of progress. The issue should not only be the presence or absence of Hispanic or Latino objectives. We also need to ensure that we close the gaps and that we have a plan in hand for reaching the Hispanic/Latino community with implementation efforts. The priority must be improving Hispanic health, and I can pledge that this issue will be an ongoing commitment of *Healthy People 2000* and all PHS efforts.

Louis D. Enoff

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

I would like to address the issue of access. Although we're already doing a good job, we know that we need to do better in terms of access to services that we provide at the Social Security Administration. Among our 1,300 offices, more than 65 percent have Spanish-speaking employees. About 3,300, or one-tenth, of our employees in the field offices speak Spanish. However, in a survey of all of the offices that we did earlier this year, we found that 300 of those offices have a need for additional services, and that may include additional technical personnel.

You can't always rely solely on a translator to provide access. You have to have someone who understands the program and who understands some of the cultural issues that may be involved in revealing some very personal data that help determine eligibility for Supplemental Security Income (SSI).

Now, in addition to our field offices, we have the busiest 800-number in the world. Last year we had some 76 million calls. In that 800-number service, which is available nationwide 12 hours a day, we have more than 300 Spanish-speaking teleservice representatives. Now, I understand that some folks do not like to use the telephone to take care of that business. We are not saying you must use the telephone. We're saying you have access either through the telephone or through the personal visit to our office, but we want to provide that availability to everyone.

Our notices are well-known throughout the newspaper world as being some of the most technical notices that go to anyone, not only in Spanish—we have a problem communicating in English some of these technical kinds of decisions that are made. But all of our pamphlets and forms are in Spanish as well as English. Thanks to new computer innovations, we now send Spanish language notices automatically to people who request them and to residents of Puerto Rico. We are constantly improving our capabilities in this area, and I believe we will have our computers geared to offer all of our communications in Spanish in about a year and a half.

We now provide our very popular personalized earnings and benefits estimate in Spanish. This service provides your wage record and your benefit estimate upon request and regardless of your age, it tells what you can expect to receive in Social Security benefits. It's very good for retirement planning. It's also good in the area of wage reporting, a particular area of interest in some of your communities, particularly for migrant workers. Next month we will be distributing some 75,000 publications to migrant farm workers in four States, California, Arizona, Florida, and Texas, to remind them of the need to check their wage records. And, working with our colleagues in the Labor Department and IRS, we will be reminding the employers of their need to report wages. We are working toward better compliance in that area.

Two other areas may be of interest. We know that there are areas of the community where we have not been able to reach all of the people who may be eligible for SSI. Estimates run from two-thirds to three-quarters of eligible persons who may be receiving SSI benefits. Along that line, Commissioner King launched an aggressive outreach program about 3 years ago. We've awarded more

than 83 grants, working with private-sector organizations as well as some State and local entities to reach out into the community to find persons who may be eligible for SSI but who have not come in contact with our office or may not be aware of it. And, I would tell you that one-fourth to one-third of those grants have been given to organizations that are Hispanic or that are reaching out into Hispanic communities.

Finally, as the Commissioner of Social Security, I do have the Hispanic Affairs Advisory Council. I meet with them on a regular basis. These are employees from throughout our organization who bring to our attention particular needs of the Hispanic community, and I can tell you that they are very aggressive, very open, and forthright about some of the things that we need to continue to do. So we'll take your report, we'll look at it, and we'll get back to you and we promise that we will improve, too.

John T. MacDonald, Ph.D.

Assistant Secretary for Elementary and Secondary Education
U.S. Department of Education

Your work is so important to the work that we're trying to accomplish, particularly when one views that, by the year 2000, 34 percent of our school population will be Hispanic/Latino. And in terms of that population right now, as Dr. Novello has said, we're not doing so well, as indicated by a headline like "Schools Still Fail Hispanics" in *The Miami Herald.*

We're losing about 35 percent of the youngsters who attend school. About 63 percent of those youngsters are immigrants. I believe that through the multitude of services that we have in the Office of Elementary and Secondary Education—Compensatory and Chapter 1 programs, programs for the homeless, follow-through programs, the Even Start program, the dropout prevention program, magnet programs, and Chapter 2 programs—coupled with services provided by the Office of Migrant Education and the Office of Indian Education—we must be able to affect what is happening to our Hispanic/ Latino youngsters. In my opinion, and in the opinion of my colleagues, we have to take an entirely different direction with public education and the way we operate schools.

We have been working with folks, including Jim Mason and others from DHHS, on some of these concepts. I am going to touch on something that I think needs to be addressed in this country: schools that operate on extended-day or extended-year schedules, schools that address the multitude of diverse issues related to children and families and the need for services. This concept is formally called "integrated services" or "school-linked services." What I heard in the five forums conducted by Secretary Cavazos around the country 2 years ago was that people were not aware of what services they could access and how to access them. They were not aware of how they could be represented and how they could seek representation. The conclusion was that our schools had to be redesigned and reconfigured so that they served the population that needed those particular kinds of services.

We are proposing to develop, through our Even Start model, the first Federal integrated family service literacy program for children ages zero through seven and their parents. This program will be a partnership with DHHS as a formula program that ties in with more than Even Start grantees that we have today and provides an ability to have these youngsters served by Medicaid. The Department of Agriculture is presently working with us to have these youngsters served by the Women, Infants, and Children's Supplemental Food Program. What we are saying is that we have to have varieties of services that reach each and every child in a way that is appropriate not just to their schooling and language acquisition needs but also to their allied health and nutrition needs. This effort is

currently under way and it is being prepared for secretarial review.

In the meantime, there is nothing to stop us from encouraging local grantees today to pursue these ends and develop these kinds of programs. For example, Jim Mason and I cochair an interagency program on school-related health issues. You might want to think of it as an ad hoc committee to that agency to advise and consult on allied health issues, because schools are the common thing in our communities that people go to. Schools are not only the largest real property investment we have but also the one with which people are familiar. It is possible to use them as a location to coordinate the services that children and families need through the establishment of family service centers. Between the programs in Jim Mason's office and in mine, there are ways of pulling public health and education programs together to facilitate this, and it is time that we did it. We are running out of time with these youngsters and we are making no inroads in terms of the dropout rate for the Hispanic children.

One program that we are going to be watching carefully is through our heavy involvement with Hurricane Andrew, particularly in Dade County. (Tomorrow I will be in Louisiana working with parish superintendents there that have been affected by the hurricane.) In Dade County, they have proposed to start a new Phoenix Project, which will be operating in 26 schools. The Department will be funding that. It will cost us about $12 million to establish a new model like the one I described. It will provide not only for the educational needs of children but also for their multidiverse needs in terms of allied health, nutrition, acculturation, and recreation. Both children and families will be served on an extended-day and extended-year schedule.

We should operate our schools to accommodate the diverse needs of today's society. Our society is not the same society that our schools were originally designed to serve. Schools have to change to meet today's needs and meet them wherever they are located, if we are to succeed, interagency collaboration at the Federal, State, and local levels.

In terms of representation, we should be working together with our Eisenhower program, directed by Alicia Coro, among the school improvement programs to identify the 5 percent set-aside that serves specifically underrepresented groups in the science areas. We should be working with DHHS and the National Science Foundation to see if we can design new programs to reach out and serve more people than we are serving now in the areas that are being neglected. This is going to take interagency collaboration.

In terms of the free trade agreement, for the past 2½ years, we have had under way a Memorandum of Understanding with the Mexican government and the Mexican Secretary for Education. (I visited with Mexican education officials last month to discuss the changes that have taken place with their change of administration.) We are very hopeful to complete our Credit Accrual Project, which can give youngsters moving back and forth across the border some hope of finishing high school. Hopefully, this can be phased into our College Assistance Migrant Program (CAMP), so that we can increase the numbers of attendance in higher education. We are getting excellent cooperation from States like California, Arizona, and New Mexico, but we have a long way to go in terms of this population.

There are 375,000 youngsters who need these kinds of services. With your effort and your support, and with your recommendations in terms of issues related to access and representation, we'll get there.

Thomas Komarek, M.B.A.

Assistant Secretary for Administration and Management
U.S. Department of Labor

The primary policy issue at the Department of Labor is jobs for American people, and, as we all

know, one of the primary ways to provide health care to people is associated with employer-provided health care. Unfortunately, at this point in time, we do not have enough jobs. The unemployment rate for all Americans and for Hispanics/ Latinos, which make up about 9 percent of the overall labor force, is unacceptably high. The President, Secretary Martin, and everybody at the Department of Labor is working today on that very serious problem.

I learned something during this visit that I sort of intuitively knew; I was reading the GAO report on Hispanic health care and noted the numbers in there that indicated that even when Hispanics and Latinos had jobs, often those jobs did not provide employer-assisted health care to the same degree that others in our society received, and that's a problem. One of the problems as we move forward toward the year 2000 is the need for education and skills to get the good jobs, the jobs that do provide the health care assistance from employers.

The most important impression I take away from this conference is the overwhelming complexity of all these issues that you have raised. When you think about it, education leads to jobs, which lead to health care. Each of those areas requires much work, many resources, and devoted attention. There is one thought, however, that I heard in many of the presentations this morning that is also very dear to the heart of my boss, the Secretary of Labor, Lynn Martin. At least half of the presenters spoke about the importance of Hispanic/Latino representation in the policymaking levels of the Federal Government and in other decision-making areas. Secretary Martin has been pushing very hard with her glass ceiling effort in the Department of Labor and throughout the Federal Government. I think we all need to realize that, in the years ahead, we're going to have some very difficult budget times, and we will not be able to do all the things we would like to do. One of the keys to making sure that the best decisions are made in these very difficult times is to have a diverse group of key policymakers in the Federal Government who will make decisions on grants and on job and health policies. Key to that is getting Hispanics/Latinos and a diverse corps of policymakers.

You can have the assurance of the Department of Labor that we will continue to push this effort as hard as we can. As long as the people at the top in our decision-making processes do not appreciate diversity, then we will have some problems. Once we get a diverse group—women, minorities, Hispanics/Latinos—in those top jobs, I think the problems will go away gradually. The best program that we have to work on to achieve this objective is the glass ceiling program.

Karen R. Keesling, J.D.

Acting Administrator, Wage and Hour Division
U.S. Department of Labor

I'm here as a representative of a law enforcement agency. You might ask: What is the Acting Administrator of the Wage and Hour Division doing here? But as you have heard, we've been working with the Social Security Administration, and we've been working with the Department of Education.

We enforce two very important statutes that should be of major concern to you. One is the Fair Labor Standards Act, which is what we were created for, minimum wage and overtime, and child labor provisions. In the child labor area, as Assistant Secretary MacDonald mentioned, we have also been very active in an MOU between our Department of Labor and the Mexican Department of Labor, and I have also been down to Mexico working on a joint report with my colleagues there on child labor. So there's a lot of activity going on, and I know that was a recommendation, and I would encourage you to continue to work in the health field with our Mexican counterparts.

The other most important statute is the Migrant and Seasonal Agricultural Worker Protec-

tion Act, or MSPA, which we enforce. Although we don't enforce health standards ourselves, one of the things we do enforce is the housing for migrant workers. We're there to make sure that health hazards are eliminated, working with the State agencies. A lot of times when we go into these areas we're there with the State departments of labor and health to look at these conditions. We also work with our sister agency, the Occupational Health and Safety Administration, as far as field sanitation is concerned. So when we find violations, we work with the State agencies to try to correct the health and safety areas.

We also have an annual meeting with the farm employers, with the farm and migrant workers, and with the State and local agencies. I happened to attend a meeting last month in Portland, and I was very impressed with the representation from all of the local agencies. One of the things we talked about was access to health care, and I think it's something that the representatives were continuing to try to address and to get the right parties together to continue to work on those areas. So those are the things that we're doing on the enforcement side, working with the various agencies and trying to assist in getting the migrant workers the adequate health care that they need.

William Toby, M.S.W.

Acting Administrator,
Health Care Financing Administration
U.S. Department of Health and Human Services

The first thing I want to say is that as I looked at your paper, it reminded me of the mistakes that were made in 1965 when Medicare and Medicaid were first envisioned and implemented. If we were implementing the Medicaid and Medicare programs today, I can assure you that issues such as access and need for prevention would not even be discussed. We'd probably be talking about something else because one of the main mistakes I think we made in the beginning of this program was to focus almost primarily on the fee-for-service system at the expense of other modalities of delivering services, and we've been paying for that ever since. So one of the things that I have inherited is to try to straddle the structural problems that create some of the issues you have mentioned.

You talked about the need to improve data, the need to have trained personnel, the need to have targeted research programs, and I must tell you that HCFA really can make significant improvements in all of these areas because HCFA is perhaps the largest financing agency in this Nation and has the 12th largest budget in the entire world. But there are some things we can't fix.

Let me talk about data for a minute. When I was getting ready for this conference, I asked for Hispanic data in terms of Medicaid, and they gave me the numbers—5.6 million. I asked for the data in terms of Medicare. There are no data. Medicare does collect data by race but not by ethnicity. Consequently, I don't have any data. So yesterday I fired off a very nasty memorandum to my staff suggesting that we look at that issue because the next time I have this kind of meeting, I'd like to have some information on Hispanics on Medicare.

The second thing you mentioned is the need for trained personnel. I walked into HCFA 6 months ago, and I have some sense and some sensitivity. So the first thing I noticed was that there was nobody really of my color at the senior level in HCFA, and I raised that question about improving it. The next thing I noticed, and I've known for a long time, is that you can forget about Hispanics in HCFA. So I have a few opportunities. I was given an opportunity when I was there about a month. The Director of Personnel came in to see me and said, "Look, Bill, we're getting ready to hire 12 scholars. We have a program which allows us to get around all the bureaucracy. If you are smart, truly smart, if you're at the top of your class, then we can basically hire you almost on the spot." So they gave me a list of 12 individuals to be hired. I

looked at the list. There was not one minority on the list. I asked them to try again. I asked them to come back with seven minorities and five others. We had more than 100 people who had been interviewed, but not one minority on the list. We have the final list, and Dr. Sullivan entertained the 12 scholars I presented to him just 1 month ago. We have 12 scholars, 7 of whom were minority—4 are black and 3 are Hispanic. And I got lucky—the three Hispanics are all beautiful women. One graduated from Smith, and the other two went to incredible colleges, and I just learned that we have another Hispanic in the agency I didn't know about, a daughter of one of the participants here today. So I'll find out about her tomorrow, and I'll make sure that my staff understands that we're going to target Hispanics, going to target minorities to be on the fast track for promotions in my agency.

The third thing on personnel—I am the only head of an agency in DHHS who is not a physician. You all know about Dr. Mason, who has been a dear friend to me, seriously, since I've been on board. Dr. Novello, Dr. Bob Harmon, everybody is a doctor. I am not a doctor. I have a master's degree in social work and a master's degree in public management. So I'm in discussions with a brilliant physician who happens to be Hispanic and who has agreed to become my physician advisor. So I hope in the near future, at the next meeting of this type, to be accompanied by a physician who is of Hispanic background.

The other thing I want to mention is that we as an agency have enormous clout in terms of reimbursement policies to try to do something about primary care. That's something else you care about deeply. And we have been trying to do something under current law. We have basically been working with States to increase reimbursement for obstetrical services. We are also trying to make other changes in primary care by using the leverage of HCFA.

We pay for about 60 percent of graduate medical education, and we have decided to see how we can take the leverage of Medicare, in particular, to change the minds of the medical schools, which are putting out so many specialists. We will use the clout of the Medicare reimbursement and use the clout of PHS as a team to send a message to medical schools that if they don't produce more primary care physicians, they are not going to get our money.

Dr. Mason and I are going on the road. We are working with the National Governor's Association and with private foundations to send a message to increase the supply of primary care providers, and we're going to have the first symposium, I believe, in Burlington, Vermont, next March. Basically, we are going to have a public affairs strategy to get the words out that this administration cares deeply about the need for primary care doctors. And because most minorities live in urban areas, we are going to particularly focus on the need in those areas.

We are also working very hard to expand eligibility for pregnant women, infants, and children, and adolescents under Medicaid, and we are closely in touch with States to make sure that they do what they are supposed to do. And my hope is that that's going to help.

One of the things I did when I came in was to ask the question of our public affairs people, how are we communicating with the Hispanic population? I was not happy with the answers. We have hired more consultants to translate our documents into Spanish throughout. We have also decided that we are going to talk to our Medicare contractors about the need to have more Hispanics around the country. We have 28,000 people who work for Medicare through our contractors. We want to have Hispanic people working in those Medicare contractors, to be able to talk to Hispanic providers, to talk to Hispanic beneficiaries.

Two years ago when I was living in New York, I found out that even though we had a Spanish translator in Washington working on the Medicare handbook, the people in Puerto Rico did not understand

the handbook. So we made sure this year that we sent that handbook to our Puerto Rico office, and my staff in Puerto Rico has done a herculean task of reviewing that document, translating it to make sure that local idioms in Puerto Rico are understood, and that it will be understood in Texas, Colorado, Kansas, and everywhere in this country where there are Hispanics.

I also would like to say that as we talk about the fact that most Hispanics lack access to the health care system, the best hope for the Hispanic population, the best hope for all minorities, will be health care reform, and the President's health care reform plan is the major strategy that we have. I know Dr. Wilensky met with all of you. I know you understand probably the various strategies we have, the concepts in that plan, and I won't bore you with that. But I will tell you that if you're interested in access, and most Hispanics are working for small employers, the President's health care plan at least provides tax credits, tax certificates, tax deductions, and will allow them to buy insurance. So it's one way, not the only way, but it's one way to gain access. It is the best hope for the future.

I had been asked a question by Tony about "whenever we are united as a family, some of the benefits?" It is true that the Medicaid program is not devoted to paying for services based on needs. The Medicaid program is a medical program that is a component of the cash assistance program, so it's an entitlement program. So you can't just get Medicaid services because you have a need. You have to have some linkage to the cash assistance program or you have to be pregnant or a child and meet a certain income test. My sense is that you have to work with Congress if you want to change the program in terms of meeting needs and break the linkage to the cash program. We're already doing that. Congress has made the reforms that it has because you have been active. You must have been complaining about Medicaid and how it operates, otherwise Congress would not have been moving under the current trend that it is. And the current trend is to try to break the linkage to the cash programs, and the low-income pregnant women and poor children benefit is one example because before we got that, changing it would have been impossible. So basically, until we change the entitlement aspects of the Medicaid program, there will continue to be a great deal of tension and lack of access because it is a means-tested program based on income resources and category of relationship.

Six weeks ago, I testified before the Senate Finance Committee, the Committee on Long-Term Care and Medicare, and one of the things I talked about was the fact that in the future, in terms of the new direction of Medicare reimbursement for graduate medical education, we will be tying our reimbursement to medical schools that go beyond the hospital setting to other kinds of settings. In other words, we are thinking about community health centers as being a site for training. We are thinking about increasing the reimbursement for those kinds of settings. We want to weigh the reimbursement to the medical schools that look for alternate settings, such as community centers, and that is basically the direction we will be going. And we are preparing a legislative package to go before Congress to do just that.

Kenneth Shine, M.D.

President
Institute of Medicine

I'm sort of the odd person out in this. For one thing, I'm the only one on the podium who doesn't work for the Government. The Institute of Medicine, the National Academy of Sciences, is an independent, not-for-profit corporation chartered by Congress to advise Government with regard to health, health policy, and other aspects of science. But we're not a governmental institution. In that regard, we have the capacity to do a number of things that can be helpful in confronting the issues

that you describe and with which you are concerned, including the capacity to convene around issues of health and health policy.

I'm an odd person on the podium also in that, until the end of June, I served as dean of an American medical school—UCLA in Los Angeles. And there's both good news and bad news. The good news is that I had the privilege not long ago of conferring the medical degrees on 31 Hispanic physicians in a class of 150, the largest number of Hispanic physicians ever awarded medical degrees in a single medical school at a single time. I'm also pleased that, this November, a member of the UCLA graduating class of 1993 will receive the McLean Award as the outstanding minority medical student in the United States. A UCLA student has won that award in 9 of the last 14 years, and 7 of them have been Hispanics. So, the good news is that we're making some significant progress with regard to at least one medical school in Los Angeles in educating Hispanics as physicians, that they are doing extremely well.

The bad news, of course, is that I also played a role in creating a task force on access in the county of Los Angeles and had the opportunity to address that task force on the morning of its first meeting and to remind them that two out of three preschool Hispanic youngsters in Los Angeles were not immunized. I have had the personal experience in our teaching hospitals of attending to several cases of measles occurring in youngsters who had seizures associated with that illness, cases which should never have happened, and I've had the experience of taking care of tetanus in a migrant Hispanic farm worker because of lack of immunization. So in coming to this meeting, I have a personal sense of the intensity of the concerns and the issues that are confronting the Hispanic/Latino community in terms of dealing with health and health care.

The Institute of Medicine in the Academy does several kinds of things. It is best known perhaps for the reports that it issues based on analysis of data that are used to influence public policy, and we've issued reports on access, on primary care. In 1978, we issued a report strongly urging that 50 percent of American medical school graduates be in primary care specialties. We're still fighting that battle.

We have issued reports on nutrition, child care, maternal and child health, and I can also tell you that I have had the personal experience of tending to two of the first six AIDS cases that were reported. They were also at UCLA, and I watched AIDS develop in our community and also recognized that until the Institute of Medicine published its famous report on AIDS in 1986, the response was not very outstanding in terms of either research or patient care.

So we will continue to work on those kinds of reports. There are several that will be of great interest to you. The first is a report on recruiting minorities to the health professions, an activity that will go on over the next year, which will include a series of workshops in which we will invite public comment to the committee responsible for making those recommendations. The second is a report on employer-based health insurance, which is likely to be directly responsive to some of the issues that you've raised with regard to health in small companies and in segments of the workforce in which many of the Hispanic and Latino workers work.

I think that the other main function that we serve is a convening function. We run a variety of forums to guide public policy and private activity from this point of view. And we intend to continue to focus on the importance of AIDS in minority communities as part of that forum activity. We have just initiated a forum on health statistics, and we remain concerned about many of the issues that you've addressed. Part of our goal in creating this forum is not so much to issue a report as to bring together Federal and local Governments to understand how to better collect health statistics and health data.

We have a major and abiding interest in the issue of the pipeline for health professionals,

particularly as it relates to minorities in both research and education, and I want to point out a couple of aspects that I think are important to you. First, math and science education is a major issue. We believe that there is a major role in the United States for academic health centers and scientists to become involved in education, particularly in minority communities in math and science in kindergarten through grade 12. You ought to be aware of those activities, and you ought to try to participate in those activities wherever they take place because for them to succeed there has to be a community linkage. Second, we will continue to evaluate ways in which we can encourage more Hispanics to choose health careers, particularly in medicine. And, as you know, we are working closely with the Association of American Medical Colleges on the 3,000 by 2000 project, which tries to get proportionality with the population.

In terms of public and private activities, it's very clear that we need more faculty members in medical schools and in other health professional schools who are of minority backgrounds. We need role models. And in that regard, I would point out to you that I continue to be disappointed that the Robert Wood Johnson minority faculty program has relatively few applicants from Hispanic faculty members. You need to encourage young Hispanics to apply for that program because it is a preeminent program for faculty development.

I'm very much involved with another program in identifying generalist physicians and faculty development in collaboration with Robert Wood Johnson. And again, we need to be sure that there are adequate nominees for those kinds of activities.

Finally, I would point out to you that we have recently established a formal relationship with the Mexican National Academy of Medicine. We have established a foundation that will be funded by both the American and Mexican Governments. The amount of money is not great in the initial stages, but it will allow funding of research activities, particularly in the areas of border health. And I anticipate that we will again use our capacity to bring together governments, academies, and the public and private sectors in a way that will try to address a number of the issues that you've raised.