Latino Health Issues in National Health Reform Debates

Alliance for Health Reform and Robert Wood Johnson Foundation

August 13, 2008

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ED HOWARD, J.D.: I hope I have this down right, thanks to my technical advisor. [Speaking in Spanish] Welcome to everybody. On behalf of the Alliance for Health Reform, our congressional leadership, Senators Rockefeller and Collins and the rest of our board of directors.

My name is Ed Howard, I am with the Alliance and we are very pleased to have you join us at this forum on concerns about the health of Hispanics in America, which we think is the sleeper issue in what many believe will be the most important health care debate in a generation and how we are going to reform, if you will, the health care system in 2009 and beyond.

The partner that we have in our program is Robert Wood Johnson Foundation, America's largest philanthropy dealing with and working to improve health and health care in America. You are going to be hearing from Debra Perez in a moment. We are also pleased to have Adam Coin with us from the Foundation.

In a couple of weeks, the U.S. Census Bureau is going to release its findings on the number of uninsured Americans in 2007. And unless there is some miraculous improvement from previous years, you are going to find that Hispanics will have been uninsured at a rate three quarters again higher than the rates for African-Americans and three times as high as the rate for non-Hispanic Whites.

Couple that with one other figure from something that is in your packets. It is the U.S. population projections that Pew Research Center has done and that shows in one of the graphs, that by 2050, the share of the population that will be Hispanic, compared to what it was in 2005, is going to double to 29-percent and the number of Hispanics over that period is actually going to triple in the United States.

Now, you put those facts and trends together and I think they raise serious questions about the impact of Hispanics on the health care system and vice versa. As the health care reform debate intensifies over these next few months, any thoughtful reform that gets proposed is going to have to take into account the Hispanic factor, if you will, in a variety of ways.

And rather than to labor that point, I think I would like now to introduce my co-moderator for this discussion, Debra Perez, who is a Senior Program Officer at the Robert Wood Johnson Foundation and a nationally known expert on health care disparities in her own right. Debra thanks for being with us.

DEBRA JOY PEREZ: Thank you so much and I am very delighted to be here and thank you all for joining us. This is, in fact, one of the most important topics facing the nation today, the increase in the number of Latinos, the variation in diversity within the Latino population and what we are going to do to prepare ourselves for the next wave.

I just want to say a few words about a collaboration that we have been engaged in with Pew Hispanic Center and that this is the first time that we have been able to do a study that has such a vast number of Latinos and covers a number of much of the diversity that we are talking about and you will hear from Susan's presentation in a little bit, some of that diversity.

But, I think it is important to understand that whatever solution we come up with at the Foundation, obviously we are concerned with a number of issues related to chronic disease management, diabetes, obesity and the uninsured, that we need to start thinking about tailoring those interventions to the specific subgroups within different populations and that includes understanding the differences among Latinos who speak art of language spoken at home, English verses Spanish, immigrants verses non-immigrants, arrival in the U.S. at a young age verses arriving here as an adult and differences between Cubans verses Mexicans and Puerto Ricans.

I think that what we need to accept finally is that there is no one size fits all solution for all the problems that Latinos face in this country. So, I am going to turn now to introduce Susan, who is going to give you a brief update on what we found and I just want to introduce her and you have a full bio in your packet.

But, a couple of very important things is that she is the Deputy Director of the Pew Hispanic Center whose mission is to improve the understanding of the U.S. Hispanic population. And the Pew Hispanic Center is a non-partisan research organization supported by the Pew Charitable Trust and takes no advocacy or policy positions. You will hear just the facts from Susan I think.

On a personal note, Susan and I have been working together for the past few months. This report is a very significant report for us. This is the first time that we have entered into this type of collaboration. She has her PhD from Columbia in Political Science and specialized in Latin America. So, Susan?

SUSAN MINUSHKIN: Hi. Thank you for having me here today. Today, I am going to briefly present some of the survey findings. Your packets should all have the presentation so I will not labor some of the data and I will let my co-panelists take over the discussion from there.

So, the survey explores Hispanics for access to health care, where they get health care information, and some questions about their knowledge about an important chronic disease.

Well, let us start up. Hispanics in the United States, there is about 45 million of them, Hispanic adults, roughly 30 million, Hispanic adults. Well, it is a young population and

it is generally a healthy population. That said, they do have a higher prevalence of overweight and obesity and they have a greater predisposition to diabetes than the non-Hispanic White population. Here is some data from the CDC that shows the age adjusted prevalence and risk factors for Hispanics compared with Whites and Blacks.

So, one of the first questions that we looked at in the study is, who has a place for medical care because when you are thinking about chronic disease or when you are thinking about a population that is today healthy, and young, but will be getting older and has a predisposition to a serious chronic disease, you want to think about how they get their medical care, where they get their medical care.

So, we asked a series of questions if people had a usual place where they could seek medical care or ask questions of a medical professional and if they said yes, we asked them where that was, what doctor's office, a clinic, a hospital outpatient center or an emergency room. They volunteered the kind of place and some people said no, they do not have any of those places.

Well, what we did is we defined in line with the existing research in health care, having a usual provider for health care, being anyone that says yes, they have a usual place to go for care other than the emergency room. So, if

they went to a clinic, if they went to a doctor's office, if they went to an outpatient center, all of those counted.

So, the first thing here is I want to talk about who is it that lacks a usual health care provider that they can go to when they are sick or to ask questions to.

Overall, 27-percent of Hispanic adults say that they lack a usual health care provider; they do not have a place to go other than those that said that they have the emergency room. How many is that? Well, if there is roughly 30 million Hispanic adults, there is someone between 7 and 8 million Hispanic adults, a large city-sized who do not have a usual provider for their health care.

Well, that is interesting but who are these people? Because a Pew Hispanic Center, one of the things we want to do is look within the Hispanic population, of the diversity within that population so, here is some data. Who lacks a usual provider? Men are more likely to lack a health care provider than women. Young people more likely than older people, those with less then a high school degree, more likely with those with more education, the uninsured, much more likely than the insured.

But, interestingly, 20-percent of the people who do not have a usual health care provider actually have health insurance. So, if we do a quick calculation, if we say okay, there is roughly 8 million Hispanics without a usual place for

care and there is roughly 20-percent of these people have insurance, we have got a significant number of people with insurance who do not have a place for care.

We also pay great attention in the survey to the national origins or the ancestry of Hispanics because we believe that it is important to know if there are differences between a recently arrived immigrant from Mexico and someone that is Puerto Rican ancestry living in the United States. Well, in fact, we do find differences based on national origin or ancestry and we see that Mexicans and Central Americans are much more likely to lack a usual health care provider than have Puerto Ricans.

As one would expect, those who are Spanish dominant are also more likely to lack a usual provider and those who are foreign born but not a legal permanent resident. We have four categories, we ask people if they are citizens, if they are native born citizens, naturalized citizens. If they are not citizens, we ask them if they are legal permanent residents. The remainder are foreign born, not legal permanent residents.

We do not know that all of these people are undocumented immigrants but we feel quite sure that many, most, the largest share of this group are undocumented immigrants and they are much less likely to have a usual place for care, as are those who arrived in the United States within the past five years.

Well, why should we care? Well, preventative care, I think I will venture an opinion, even though I am from Pew Research Center, and say preventative care is probably a good thing. So, we looked at who is getting certain kinds of preventative care or monitoring of their health? And we compared between those who have a usual health care provider and do not.

And those who do not have a provider are much less likely to have had their blood pressure checked, much less likely to have their cholesterol checked, much less likely to have their blood sugar tested. And even among Hispanics who told us they have been diagnosed with diabetes, those who do not have a usual place for care, are much less likely to have had a blood sugar test in the past two years.

So, why do these people not have a usual place for health care? One might imagine it is because they do not necessarily have insurance or whatever. Well, that is true. But, the largest number say that they do not have a place because they are seldom or never sick. And additional number added to that say that they take care of themselves, they treat themselves.

Well, as a mentioned this is a young population that on many measures is healthier than the population as a whole. So, it may be that they do not get sick. However, as I mentioned, there is the prevalence of overweight and obesity in the

community, adjusted for age. So, even though they are young, they are heavier than other people the same age.

And we see also the financial reasons are important. Roughly 28-percent cite no health insurance and the cost of medical care. So, where are Hispanics getting information if they are not asking doctors, and most do get most of their medical information from doctors? Roughly 70-percent are getting information from doctors.

But the media, we can see, is playing a very important role. More Hispanics are getting information from the media than from doctors. Although, I do want to emphasize 71-percent, 7 in 10 are getting their information from doctors.

So, as we see within the media, television is the most important. So, almost as many Hispanics are getting information just from television as are getting information from doctors and other medical professionals. I cannot comment on whether the information they are getting is good or bad. But, what I can say is that those that do receive information from the media make changes in their behavior.

Forty-one percent who get health information from the media say that it has affected their decisions about how to treat an illness or a medical condition, 57-percent say that it has led them to ask doctors new questions and 64-percent say that the information they learned from the media has changed the way they think about diet and exercise.

I think there I will conclude. There is a lot more in the survey, there is a lot more in the packet I provided but I want to leave lots of space on the panel for the rest of them to discuss some of what they believe are the implications and policies that come out of this survey. Thank you very much.

The survey is available on website of both the Robert Wood Johnson Foundation and the Pew Hispanic Center. And just as a last note, the Pew Hispanic Center, we are non-partisan, non-advocacy and take no policy positions on the issues. Thank you.

ED HOWARD, J.D.: Thank you Susan. Now that you have the Joe Friday version of this issue, just the facts, nothing but the facts, we are going to turn to some people who can help you put it in context. Before I introduce them, let me just handle a couple of housekeeping chores.

In a few days you are going to be able to get a transcript of this briefing on our website. The Alliance's website is allhealth.org. It will also be available on kaisernetwork.org along with digital versions of the material in your packets and I want to call attention to a couple things that are in your packets.

One of them is a list of further resources that we did not reprint but you have links to. If you go to the website, you will not have to type the 28 character URL. You can just click on it and get the material.

The other thing that is in there that I want to make sure you see is what we call our Find an Expert service. We have assembled 400 or 500 of the country's top experts on different topics in health care that you as a reporter can access if you register with us and there is a way to do that in your packets. You can sort by geography, you can sort by the subtopics of expertise you want to find, you can sort by the ability to do an interview in Spanish and you will be able to find a number of people who can fit your needs.

If you have any questions, Bill Erwin, our Communications Director is the person who can answer those questions. He is also the person who did all the heavy lifting in arranging today's briefing. So, we want to try to be responsive to that.

And as I say, we have, that is to say, Bill with some substantial help, have assembled I think a terrific panel to help you sort out and place in context, the facts and the trends that Susan has delineated for you. As Debra did, we are not going to give these folks the introductions that they deserve because there is information in the packets about their biographical background. But, let me just sketch, in the merest terms, who you are going to be hearing from.

First up is Bill Vega. Bill is a Professor of Medicine at UCLA Medical School where he has done a ton of research on Latin adolescents and adults, work that has made him literally

one of the world's most quoted social scientists. And he was also deeply involved in this Pew Hispanic Center survey.

Next to me is Dr. Elena Rios who is President and CEO of The National Hispanic Medical Association, one of the most visible and forceful spokespersons in the country on Hispanic health issues. She was directly involved in the health reform efforts in the early '90s and has been thinking through these reform issues for the coming discussion as they affect Hispanics.

At my far left is Sumi Sousa. She is a health care advisor to California Assembly Speaker, Karen Bass, served in the same position for the previous Speaker, Fabian Nunez during the negotiations with Governor Arnold Schwarzenegger that almost yielded a sweeping reform bill.

And that bill had in it, important provisions affecting Hispanics and we want to hear from her about how those came about and what they were. So, if we can get started with William Vega, let us give you some context for this issue's framing. Bill?

WILLIAM VEGA: Thank you and good afternoon. I am actually going to bypass the slide presentation because of the few minutes that I have available. It would take me the entire time to explain the slides and I think they are redundant with what has been presented and what is in your packets already. I just want to be very concise and cover what I consider to be

cardinal points of what the report is implying or actually saying.

I think the critical thing to remember, as we said at the opening of the entire program here today, is that the Latino population today is growing rapidly and the composition is somewhat unique because three-quarters of the Latino population of the current 45 million in the United States are composed of immigrants or children of immigrants.

The impact of that is that you have a population that is going through a very intense process of assimilation and culture change which includes learning how to use the health care system and its exposures to the health care system.

Now, those health care exposures are obviously very unsystematic because of the high levels of un-insurance, especially in the immigrant group where we tend to see the real differences compared to the U.S. born Latinos, differences in use of having a usual care provider, a differences in quality of care we see, differences in complaints about languages not being compatible and having problems in that arena, differences in knowledge about chronic disease.

All of these are differences that really tend to disproportionately affect the immigrants and most especially those that have less time in the country, five years or less for example, I think only half of them did not have a usual source of care.

So, you can see that obviously people are going through the transaction of learning in this society about everything including the health care system. And I think it is critical that we take that into account as we confront the possibility of health care reform in the future, that the real issues of understanding of how to use the system affectively.

And also having equitable access is a problem that affects the entire U.S. population that especially affects the U.S. Latino population and we need to give these issues inclusion in the discussion about any health care reform, both at the national, regional and of course ultimately at the local levels.

I think this study was very, very useful because we rarely have studies that give us a lot of information about those that we know least about, for example, differences in Latino nationality groups such as Central Americans which turned out to have a level of twice as high of not having the usual care providers compared to say Puerto Ricans who are more likely to have public insurance for example.

So, this is a population, especially these new immigrants, that is low education, low health literacy, a population that speaks predominantly Spanish. Therefore, how do they enter the health care system and get regular care? How do they come into the scope of public health services and get regular screenings for example?

These are really difficult issues that we need to cross in very practical terms. It seems to me the study really points out where the jagged edges are, where the deficits are occurring.

Beyond that, I think it is very interesting also to note from the information provided here that people who have a usual source of care benefit on several levels. One of them is that for one thing, they are more likely to guideline based care from a physician if they have a usual source of care.

That is reflected in the data in this report. That is they are more likely to have the usual signals checked of blood sugar, for example, blood pressure et cetera, the things that we automatically assume a doctor is going to do for us when we go see him on a regular basis if we are adults.

Now, that will occur much more frequently if you have a usual source of care. It will also be more likely that you are going to get favorable reports about the quality of care that was received when you visited a physician or other health care provider. So, those two things go together and are very important, it seems to me in the ongoing dialogue of health care reform in this country.

Since I am free to offer insights and opinions because I do not work for Pew and I can say to you that from the standpoint of understanding the big issues in health care reform, one of the outstanding issues in the United States

today is the fact that more and more we are going towards specialty care at a very time when populations such as Latinos clearly require greater access to primary care.

This is undeniable when we look at the facts that come forward from this report that they need primary care access regularly; they need people that they will be able to count on with flexible schedules to come in a present their health care problems.

This is a population that is a heavily worker population that works many hours, has family members that have different levels of coverage with health insurance and many with no coverage at all. And of course, the likelihood of any particular person in these families being not covered by health insurance over the course of the year is high in the immigrant population.

So, the confusion about what they actually can access in terms of health care resources and especially specialty care because of the fact that many of them are safety net users. They are using the safety net providers in the United States and thus, as a result of that, do not necessarily have access to any type of specialty care easily without paying out of pocket. And in point of fact, the Latino immigrant population does pay a high percentage of health care cost out of pocket.

So, it is not to say that they do not get care at all, they are getting care. Obviously, it is limited by the lack of

health care coverage and insurance, but there is a lot of out of pocket payment for health care.

Nevertheless, the big picture adds up to a definite conclusion that the usual source of care, which is, as far as I am concerned, the cornerstone is extremely weak on the Latino immigrant side.

And even among those who are U.S. born, if you look at the residual group of those who do not have a usual source of care of the entire Latino population, almost 50-percent of that is among U.S. born, English-speaking Latinos. So, and these are high school graduates, these are not people with minimal education. They at least have a high school education.

So, even in the group that is reporting not having usual source of care, the reality is that half of that group is composed of U.S. born. However, disproportionately, the U.S. born are more likely overall to have health insurance, they are disproportionately more likely to have a usual source of care.

So, it is these issues, it seems to me, of how we get and improve access to care for Latinos that we really have to think about in terms of the arrangements that we develop in any future health care system because it will ultimately affect whether they get a high quality of care, whether they get a quality of care that they are satisfied with as individual consumers and all of us are consumed with that because we all consume health care services. Thank you.

ED HOWARD, J.D.: Now let us turn to Dr. Elena Rios.

ELENA RIOS: Thank you Ed. It is a pleasure to be here. I wanted to focus on solutions and strategies. Let me just mention who National Hispanic Association is. We were established in 1994 here in D.C. We are a non-profit organization that represents over 36,000 Hispanic physicians in the country. Our mission is to improve the health of Hispanics and other underserved.

We are led by a board of directors and our Chairman is Dr. Ciro Sumaya, Dean of the Rural Public Health School at Texas A&M, former Administrator for PRSA, the Health Resources and Services Administration, and we also have established a foundation that does research in other educational activities affiliated with NYU's Wagner School of Public Service.

In terms of the American Latinos and health care, the largest ethic group now and will be in the new America by 2050. I am calling a new America that will be a nation where over 50-percent of the population will be bi-cultural. I do not believe the word minority is in order but I do not know what we are going to call ourselves. This includes African-Americans, Native-Americans, Asians and Hispanics.

For the Hispanics, we are the most uninsured of all the groups, over one-third of all Hispanics. Most problems with disparities in health care, according to the U.S. Department of Health and Human Services disparities reports, and there is a

very critical need for cultural language and educational services in our health care system and the system lacks Hispanics everywhere, whether it is researchers, providers, and especially leaders and decision makers in all our public and private agencies that impact health care.

In terms of the Pew survey, these are two takeaways, one, the 2009 health care reform debate needs information, health communication channels to be targeted to the community less than 30 years old whether that is low literate information, bilingual information, bicultural information, but there has got to be a new media approach for health communication in this country.

I believe, knowing my nephews and nieces, it needs to go through the internet and cable, there is lots of bilingual cable T.V. that everybody is looking at in the younger generations and I would call the social marketing through media in terms of health communications.

The second takeaway is for 2009's usual health care provider, I think that that needs to be defined as a health team with community linkages who can change behavior with low educated communities and I am not saying medical team because I believe it is a health team. We need the nutritionists and the educators and the midlevel to be a part of the team, not just doctors and nurses.

In order to have a health team like this, we need to recruit Latino health care workforce now, at all levels. And why? Because it is the Latinos who come from our communities, who best understand how to communicate and treat appropriately our communities and we need a national prevention curriculum that focuses on diabetes and obesity and all our nursing education programs.

So, in terms of the NHMA and some of our strategies and solutions, we partnered with the HHS's Office of Minority Health and did three summits this year to develop consensus recommendations to improve the health of Hispanic community targeted to federal programs over the next five years. Three regional summits with three hundred participants were held in New York, Sacramento, California, and Austin, Texas.

The recommendations were announced at our national conference this last spring to the health policy advisors of Obama, Clinton and McCain. The stake holder participants were from private and public sector. We were very careful to have nominations to have a balanced approach.

There were consensus and facilitators to give us the recommendations; these are everybody that was at the— participants from Pharma and insurance companies to government to K through 12 teacher's et cetera.

Our three areas of focus were access to health care, prevention of diabetes and obesity, and increase in Hispanics

in the health professions. I am only going to give you the access recommendations. These were ranked and done by consensus.

The number one issue of course was financing and of course, with health care reform on the horizon, our group thinks that universal and affordable health insurance coverage is the most critical policy needed for our communities but we need to expand eligibility, not just have health insurance, but expand eligibility for the public programs that now exist and target families, target the undocumented, target the legal documented, target the federal poverty level, look at comprehensive benefits that not only include prevention, but mental health, dental health, and educational services, target individual mandates, make it automatic for everybody, portable, quality, accountable.

Second issue in financing was to create low cost care delivery with public private partnerships. I think what is important about this is that you take what we have now in the safety net and expand it. So, we have community health centers everywhere in our communities, we need mobile clinics to reach the harder-to-reach.

In terms of the health care system, our access recommendations were to enforce standards for culturally and linguistically appropriate services through JAYCO, which is the accreditation body for hospitals and nursing homes, and promote

culturally competency provider training because we know that there are not enough Hispanic doctors and nurses, et cetera.

There needs to be incentives, performance payments, federal clearing houses. There needs to language services, not only interpreters, but pooling of resources and federal laws to have access to these services and we need to support providers in underserved communities including strengthening the dish programs and national service corps programs.

Lastly, the health care system needs to invest in a diverse workforce, fully fund our health careers opportunity programs and centers of excellence, which have been decimated over the last three years, and have a medical home that is the primary care home. We think it should be community health centers for all with an increase in referral systems to tertiary care, which they do not have, and a patient centered care approach.

Then, the last point, which was brought up by the survey, was to have more access policy in the area of education and marketing and to start promotion awareness at K through 12 through a standard health education curriculum in the K through 12 and to use [Speaking in Spanish] community health workers from our own communities for community education, have national media campaigns, and lastly, we need reimbursements and incentives for patient education within the health care system. Thank you.

ED HOWARD, J.D.: Terrific. Thanks very much Dr. Rios. We did not get a chance to run off hard copies of Dr. Rios's slides, did we? So, we have them at the front table. You can pick up a copy on your way out or you can sneak out there when you finish your sandwich. Now, let us turn to Sumi Sousa from the California Assembly Speaker Office.

SUMI SOUSA: Great. Well, thanks for letting me come here. It was a long trip out from California and I am flying right back after this. [Laughter] So, I actually switched my slides around too so I cheated a little bit so you probably look up here instead of at the slides in your packet.

I think kind of building upon what all the previous speakers had said, to take it in a little bit of a more micro level on a state, but definitely a big state like California. Basically, what is happening in the Latino population is just really intense in California.

So, really what is going on there drives policy in California and whether that be in education, whether it regard to our health care, basically, it is a very, very important and large and growing population in our state.

Right now, 35-percent of the population in three more years, they are going to be the largest racial or ethnic group in the state. And in 2042, so we will do it faster than the national level, 52-percent of California's population will be Latino. So, why does that matter?

Well, California has the most uninsured of all the states and boy, 60-percent of them are Latino. So, it is very, very important that health care reform recognize the demographics of this population. The other kind of obvious thing is 1 in 3 Latinos in California is uninsured.

So, California, last year, actually took a little bit longer than last year, but like a lot of other states, embarked on a serious attempt at health care reform and it is something in the area of comprehensive health care reform, not a small reform.

And it was really trying to address the big problems that all the other states are experiencing, we just happen to experience a lot of them and that be the unsustainable growth and the cost of health care, the huge numbers of uninsured that we have in the state, the dysfunctional individual market that we have, the need for a prevention agenda if we are going to do anything about containing costs over the long run and then lastly, trying to change the delivery system as we have it, which is not particularly rational or smooth.

We had a very short window of opportunity. There is a certain Republican Governor in California, you might know of him. In 2006 he said well, 2007 is going to be the year of health care reform and for Democrats that is like magic to us.

It does not happen very often and he was serious about it and so you had an unprecedented effort on the part of both

leader in the Senate and my boss, the Speaker of the Assembly at that time, Fabian Nunez, to really drive some kind of a deal towards getting comprehensive health care reform in California.

And that being said, within the context of a year, Massachusetts took three years, lots of other states were taking more than three years, we basically had a little bit over a year.

That was largely because we have a two-thirds vote requirement meaning it is very difficult to raise any money without Republicans and Republicans have all taken pledge of no new taxes. We had 2008 elections coming up which we knew would be a big turnout year and that would be important for financing. So, that meant that we had to have a deal struck pretty much by the end of the year.

Significant constraints, I am only going to list the really, really, really big ones because we had a lot of them. As I said before, two-thirds vote requirement on taxes, we had ERISA. We also had some really significant political constraints, a children’s health initiative had just been defeated a couple of months before.

A previous kind of more modest attempt had been referenda'd and had failed. So you had a very organized lobby of folks, largely a business community, who were opposed to something that was what they viewed as burdensome on employers. Two-thirds vote requirement meant the Governor had no Republic

votes. And then the politics of immigration, which are very difficult in California like they are everywhere else.

Okay, so, let me go quickly over 81X which was there were many versions of things that were in play but 81X was really the one thing that ended up being what we would consider the compromise bill. It established a system of near universal coverage, it was not total coverage, we will talk a little more about that, particularly in the context of Latinos.

It was employer and individual responsibility, a version of payer play with an individual mandate, establish a purchasing pool for workers in firms that were not offering coverage and had a system of tax credits, which were largely subsidies for low income workers, many individual market reforms including guaranteed issue and 8515 MLR and then some very, very large public program expansions in the state's Medicaid program, which is called Medi-Cal and in the state's SCHIP program, which is called Healthy Families in California, as well as something for an expansion program childless adults. I am not hitting the center here.

There was a pretty significant rate increase of the quality improvement fee assessed on hospitals, public health and prevention programs, particularly targeted towards obesity, diabetes and tobacco, a very hefty tobacco tax increase. It is about $0.87 right now, we were going to raise it $1.75

additionally. And some scope of practice changes to increase supply and availability of health care providers.

Okay. So, what does that have to do with the Latino population in California? You are all smart people here, you know it is pretty obvious but I am going to talk about it in terms of coverage, affordability, access, the prevention agenda and then some work force things. I think it kind of marries a lot of what the discussion was earlier with regards to Pew and sort of how we approached it although we were much less scientific than the Pew folks. [Laughter]

As we talked about 1 in 3 Latinos uninsured, we knew we wanted to do something about coverage and the uninsured in California are largely low income workers. 84-percent of the uninsured are workers and their family members but Latinos work in firms that have one of the lowest offer rates amongst all firms in California, which is about 70-percent.

For White population, they have an offer rate of about 90-percent so you see the significant disparity. They also have one of the lowest take-up rates in California of 80-percent for those who are offered.

So, the structure of the payer play component was very important for Latinos because many of them, while they are working, they work in firms that do not offer and do not spend so the minimum spending requirement that was proposed in 1X was important because it offered something for them and a place for

them to go. There was a pool where they and their families could get comprehensive coverage at a fairly low cost.

In addition, not withstanding that the population is working, there was a very large public program expansion. The important thing about that within the context with Latinos was that we increased the eligibility limits for kids but we also had no documentation requirements with regards to Medi-Cal and Healthy Families. That was very important because as you know, a number of children, it is basically close to 20-percent of the uninsured children in California are undocumented.

There was also a coverage program importantly for the remaining uninsured adults which is, as we all know, it is the undocumented and that was via the state's non-profit community clinics which is essentially where they tend to go, would create a medical home, kind of give them a card, all of those good things.

Basically, let me zoom through the slides here because I am already out of time. Basically, what you have is about a quarter of the population in California as undocumented so it is important that you have some type of a coverage program or a place for them to go because they are not going to be able to go into the purchasing pool and they are not going to be able to get into the public programs except for their kids.

So, the coverage program was very important. We used John Gruber in terms of our estimates and basically he had kind

of said, in terms of the estimates, about 71-percent of the uninsured would have been covered.

Okay. Let me go quickly over affordability, provisions, I think the key thing is it is a low income population. There were significant subsidies that were proposed in the bill that would have allowed folks who were working to be able to afford coverage through the purchasing pool or through a very low cost means with regards to the public program expansion.

Essentially, those refundable advanceable tax credits would have been available at 250-percent to 400-eprcent of federal poverty, very large population of Latinos in that population.

Essentially, 61-percent of Latinos have incomes actually below 250 so they would have been eligible for the public program expansion. Then, the remaining that were under 400-percent of federal poverty would have been eligible for the tax credits.

I want to talk a little bit about one of the key things and kind of different in California is that we have a lot of folks who are eligible for public programs but remain un-enrolled and 68-percent of those are Latinos, it is Latino children. We have a real problem with that, we need to do more outreach.

But, part of it is also the fact that the Medicaid program is very difficult to get through. There were a number of enrollment simplifications with regards to the Medicaid program and that would have, we think, made a pretty significant difference in terms of trying to cover the 800,000 kids in California that are uninsured.

Let me talk just lastly on sort of the prevention issues that we dealt with and I would just sort of say at the outset, we did not do enough because it was hard enough to try and deal with the financing and the coverage and the access issues that we were dealing with.

But, there were some very important pieces with regards to obesity, diabetes, and smoking cessation, community makeover grants, which would have gone directly to the local entities and would have been able to target folks particularly in terms of the language and cultural barriers that we have right now, getting fresh foods into communities, trying to educate folks with regards to the obesity crisis.

Nearly 7 out of 10 Latinos in California is overweight or obese. And with regards to diabetes we have the same problem. Well, Latinos are, as folks talk about, largely a healthier population although overweight and obesity is a real problem.

In diabetes, it is a growing problem and I think the one that is important to note is that last bullet which is 8-

percent of Latinos in California are diabetic. 21-percent of Latinos, age 50 to 64 are diabetic. So, it is a growing problem particularly in our aging population. So, let me stop there and we will go with the rest of the panel here and take questions.

ED HOWARD, J.D.: I cannot imagine anybody has any questions after all that presentation. But, if you would, identify yourself and direct the question to one or another of the panelists if that is your want. And you had your first hand up.

AMANDA GWAKER: Amanda Gwaker [misspelled?] reporter of Men Page Today [misspelled?]. My first question is if the Latino population is generally younger and healthier than the rest of the population then I guess I am not exactly sure why it is such a huge problem that a quarter of them do not have a usual health care provider.

And my second question is, I guess this is for Elena Rios, I think the stat here was that of those without a usual source of health care, 45-percent do have health insurance? So, how would having universal health insurance for these people affect having a usual health care provider if almost half already do have insurance and do not have a provider?

ELENA RIOS: You noted the importance, we just cannot have insurance, you have to have education to the population that the population understands. And I will give you an

example. In our communities, babies are born fat and that is healthy and lots of mothers have gestational diabetes and then we have even more abundance of fatter babies.

Not only that, in our communities, to have a child grow up through their adolescence and be skinny means they are not eating enough, they must be sick. So, for a provider not to understand that, providers then will not be able to bring it up or there would be tendency not to bring it up.

So, there is an importance in culturally education of our providers and understanding in our communities, what being sick means. So, what is obesity? What is overweight? All those things have never really been discussed in the community outside of a doctor's office or a clinic.

DEBRA JOY PEREZ: Can I highlight, in your first question you asked why not having a usual provider is a problem if Hispanics are generally younger and healthier. There is this phenomenon called the Hispanic paradox that immigrants come over healthier, they have lower socioeconomic status, lower income and education, yet have much better health outcomes.

What we know is that the longer they are in this country, the worse their health becomes and I think that habits formed at a earlier age persist so I want to emphasize and I might punt this over to Bill, we cannot overemphasize the importance of having coverage with regard to access to a usual

source of care. It was twice as many Latinos without insurance said they had no usual source of care than those who had insurance.

So, saying that while we recognize that it is a younger population, we need to prepare now for the long term when this population gets older and sicker. Bill, do you want to add to that?

WILLIAM VEGA: Yes, I think it is a part of the process of becoming an American over multiple generations that you begin to have the same health profile as Americans do and that includes everything from substance abuse, mental health, as well as diabetes and obesity so that obesity increases directly with the amount of time you have been in this country if you are an immigrant and it is even higher if you are born in this country because you developed the same eating habits. Obviously, you learn the behaviors and in terms of the differences.

I think it is very interesting that what Elena was just talking about because when you go to third world countries, including Mexico, it is the wealthy that are obese. And now, in Mexico, because you are getting changes in the society itself, you are seeing more and more people in the middle class becoming obese still. And in rural areas, you see it is rarely seen.

So, the image in third world developing countries is obese is to be well off, that you are doing well and to be thin is because you do not have enough to eat. It is actually scarcity. So, clearly when people come to this society, the opportunity to have whatever you want to eat and to have it in great quantities for example, especially fast food and processed food et cetera, becomes available and that becomes a direct risk factor then.

I think the issue of preventive care is very important too that obviously, all of us would think it would be pretty odd not to go to the doctor for years and not have just the usual checkups on blood pressure and blood sugar and heart and all the rest of this that goes along with just being taken care of and it is not expensive, but it is certainly an early signal that there is trouble ahead. And things like that, they just take a long time to develop.

We have to be very careful about this because if we can catch it early we can perhaps prevent it as opposed to allowing it to develop and most diabetes type 2 really onsets in the 50's so if you wait that long, it is too late. You have diabetes and then you have a big burden for the family, for the person, for the society and you have a big cost burden.

FEMALE SPEAKER: [Inaudible]

ED HOWARD, J.D.: Yes, you want to wait for the microphone?

FEMALE SPEAKER: My question is for the panel generally and that is what if health care reform does not come? What if 2009 comes and there is no meaningful reform? You have set out a really excellent set of things that are needed to improve the health of the community. What will you do if the reform you are planning on or hoping for does not come?

DEBRA JOY PEREZ: I will start by saying we have not had major reform in 40 years and that has not stopped our progress in terms of providing continuous, as best we can, access and more importantly, the quality of the access to care. I do want to overlook the fact that even with insurance, the quality of care is less than desirable and these disparities exist.

I think there are other ways to address the problem of health access and health care though coverage is extremely important. We will continue at the Foundation and other advocates for access to quality health and health care to work in this area whether there is reform or not.

ED HOWARD, J.D.: Maybe I would ask Sumi to respond to that too. What are you going to do now that there was not the reform?

SUMI SOUSA: Well, let me answer in the very short term. The Governor has come up with his health care light version which is pieces that do not cost very much that he is

trying to move forward. But, I think the real answer is look, health care reform is incredibly hard to do.

In California we failed, we had a very short amount of time, we got pretty close but it means is that the problems that we all identify with the system do not go away. Health care costs too much. Everybody feels it, even the middle class feels it and the rate of growth is unsustainable.

We will continue to pay more for health outcomes that are worse than the rest of the industrial world. So, it just seems to me like yes, is it odds on favor that it happens? No. It is really, really, really hard and I think it is going to be a tough challenge but the problems only get worse and that makes the need for reform even greater.

DEBRA JOY PEREZ: Can I just add that there are things we can do now. We know, for example, that racial and ethnic disparities exist in the quality of care and so activating consumers and doing more with public reporting of the quality so the consumers can be informed to make decisions based on quality and performance improvement measures.

Those things help improve the quality of the care that is delivered and at the Foundation we are embarked upon a nationwide 14-site regional quality strategy called the Lining Forces for Quality that does precisely that, brings together the community including the insurance companies, the business

sector, the health provider sector, and consumers themselves to advocate for higher quality care.

ELENA RIOS: Yes, coming from the federal level, looking at policies across the board right now, health disparities I think needs to have a more primary care approach and the health disparities legislation that the trichocyst in this Congress has introduced over the last eight years as well Senator Kennedy and Senator First and now Senator Cochran on the Senate side, those are all very targeted bills that are very important.

Unfortunately, they have not passed and I think perhaps we need to take a look at the pieces of those legislations to be able to incorporate them in a way that allows it to pass. But, I do think that the health disparities legislation mirrors a lot of the solutions that we have talked about and they have already been introduced and there is lots of support from Republican and Democrat.

I just think in the era of budget problems right now, domestic budget issues, we have to look at a more feasible approach to passing the Congressional legislation.

WILLIAM VEGA: I would just say that it is clear that we have a real problem emerging in the adequacy of the health care professional resource pool, the human resource pool. We need people in all areas of alive health as well as the physicians and nurses.

As a result of that, this seems to be a very opportune time to increase the opportunities here for the pipeline to produce more Latinos who can come into those areas who can speak Spanish and who can supply more culturally appropriate services to this population.

This issue of language ability being available, the capacity being available in clinics and health care providers is a critical one because all kinds of mistakes can occur in those situations and we know that it affects satisfaction of care and the likelihood that people will go back to a particular provider.

And as a result of that, it is very important to have availability of translators that are appropriately trained and people who are actually operating the providers the offering processes of care from secretaries all the way through to surgeons that speak Spanish and can communicate with their patients.

This is a very big challenge because it goes to the core of the educational system itself and our ability to produce adequate numbers. But it is certainly one that we need to undertake in a multilevel way right now.

JOE HUMBLE: Hi, I am Joe Humble [misspelled?], I am leading the University of California Journalism Program here. I had a couple of questions, one, when you talked about Latinos getting a lot of health information from the media. I do not

know if you looked into what kind of medias, the advertisements on T.V. for diet pills or is it shows where qualified doctors are talking with [inaudible] greater reliability, that is question number one.

Question number two, if there is a big problem with Latinos disproportionately not having primary health providers, how can you project out what impact this might have on long-term health costs in terms of if you let things slip at the primary level, what kind of implications that has for burdening the system further down the line especially with a larger number of people suffering from diabetes and obesity.

SUSAN MINUSHKIN: In terms of the question about sources of health information from the media, the question wording was very generic. How much information did you get about health and health care over the past year from and then we asked about the source, doctor or other medical professional, family or friends, the radio, the internet, television.

So, we do not delve into it if it is from news programs or health programs or commercials. We do not evaluate the quality of the information either.

SUMI SOUSA: Can I just add something on that? The one thing that was really interesting to me during the whole health care reform debate in California was how closely it was followed, not just by the general media, but by the Latino and

Spanish-speaking press essentially. We had probably the greatest participation amongst the Spanish-speaking press. There was a full time reporter covering it both in print and on T.V. and on radio.

It was amazing and when you look at some of those numbers of how many people in California that are uninsured that are Latino, it is no wonder. So, I included a few in the packet of just some of the articles that had come out, I think just a couple.

But, I think it would be interesting for some of your students to look back and just do a search of [Speaking in Spanish] in California and you will be surprised at how many articles actually pop up from [Speaking in Spanish].

WILLIAM VEGA: I just want to say one thing which is in relationship to who is using those sources. It tends to be the immigrants and the Spanish-speaking so they are using Spanish-speaking media, they are using Spanish-speaking television, Spanish-speaking radio for that information.

I just want to hearken back to the opening presentation because it noted that the report clearly shows that they actually get information that they claim to be acting on.

We did not observe how much they acted on this information but they claimed to be more likely to go to physicians to get clarifying information about health issues,

they claimed to be thinking more about how to change diet and exercise.

Whether they change that behavior, we do not know but at least it is prompting, it is prompting them to look into these issues and give them the alternative sources available to them which are negligible from the health care public health community, especially in Spanish.

I think it shows how important it is that the media is playing some important role in this area and I think Spanish-speaking media is giving more and more attention to obesity and diabetes.

DEBRA JOY PEREZ: I just thought the question that you asked about the cost long term. Everyone has heard the phrase an ounce of prevention is worth a pound of cure. There are people looking at the actual cost of the lack of primary care. I do not have those figures in front of me but I can direct you to for example, the Trust for America's Health which looks at the low amount of resources invested in public health.

Only about 1-percent of all NIH funding goes to public health and their estimation is somewhere in the $30 million mark of underfunding in the public health agency where a lot of this population, the vulnerable, the undocumented population rely on public health system to get the care they need.

ED HOWARD, J.D.: Any other questions? Yes?

LAURA DENAMA: Laura Denama from [inaudible]. And I am wondering about the –

ED HOWARD, J.D.: Want to use the microphone there?

LAURA DENAMA: When, in California, when you were looking at the cost for this, what are the overall health care costs for the uninsured because I would assume because they are uninsured, they are delaying going in to get treatment until it is at a more drastic stage. And then similarly, how much of the health care costs are also for the undocumented who also would be fearful probably in going in to the system and probably also delay any health care treatment.

SUMI SOUSA: Well, that is a loaded question. [Laughter] Let me answer it in this way. The cost of the proposal as it was outlined, which would have covered a lot of people, was roughly in the $15 to $16 billion categories in terms of a full year implementation. Clearly, we could not get the votes for that and that was going to have to be on a ballot initiative.

In terms of trying to pencil in and pencil out what the cost of prevention is verses the cost of coverage and verses the cost of access, we did not do that and the reason why is because I think that probably would have been a useful exercise to have afterwards.

You know the reality is when we are working within a budget constraint and we are working within a current year and

the next year's budget and we generally had to look at— when you are talking about prevention, those costs over time, you will probably see some decline in terms of cost and I think you can look at some of the research there.

But, in terms of overall budgeting, you are going to have to budget for the upfront cost and prevention cost up front and we just kind of swallowed it and did it and that is the tough thing and that is why prevention and public health.

And all of these areas of which we talked a little about, they often get short shrift compared to coverage because coverage is the first thing that you need to do, it is not the only thing that you need to do but it is one of the first things that you need to do and it is the most expensive thing to do and so everything else tends to kind of get crowded out.

So, the amount that we were spending on public health and prevention was probably much smaller compared to what the overall cost of coverage is although I think the idea that we were going to have a medical home for people who would not have— number one, we were going to provide some access to preventive care obviously for people who do not have any right now.

And then secondly, and try to rationalize it so they were going to primary care as opposed to acute care. And then lastly, to provide some type of a coverage product which we did for people who would be the people who are left behind, the

undocumented people who just simply will not sign up for Medicaid.

So, in terms of what it would have cost in terms of the undocumented, I am not going to go there because we just did not look at those dollars and they tended to get bogged down in the politics of it.

ED HOWARD, J.D.: Let me offer the second-hand observations of a poor country lawyer in the midst of a bunch of professionals on this. But, the generally accepted health policy estimate is that someone who is uninsured incurs expenses of about $0.60 on the dollar compared to somebody with insurance.

So, the idea that you can save money by putting more people in may be true in some long term but you cannot get the congressional budget office to score it and most of the analysts will tell you that if you give people coverage, it is going to cost more than not having coverage. That is why 18,000 people, the Institute of Medicine says, die every year because they do not have insurance and they do not get the services they need.

DEBRA JOY PEREZ: Can I?

ED HOWARD, J.D.: Yes.

DEBRA JOY PEREZ: There is one other way to look at prevention and cost of care and that is to change the paradigm that is a community approach that we really need, not just a

health care system overhaul and the community approach would mean that the federal agencies that impact health care and you might not realize that it is not just the department of health and human services, but it is the Veteran's Administration, it is the department of defense, it is the department of housing because we have to have safer housing and cleaner housing and no lead, et cetera.

The Department of Commerce, because of our roads and the traffic and all the air pollution, Department of Transportation, Department of Commerce, the Department of Labor because labor sets the health care benefits to the workers of the country and to department of education because of our education programs within K through 12 and colleges. And to really get your hands around health prevention, it is not health care reform, it is health care reform plus.

Plus, and I think the term that is being used is transformation, that we have to transform the way we think in terms of health and it is not about disease which has been the approach of people talking about the U.S. Department of Health and Human Services programs are directed to diseases, NIH, et cetera.

But, if you look at a health approach and how to have health communities, we need to engage all of our different federal agencies. The money is there, it I just redirecting it

and transforming the way our leadership can understand how to redirect it.

ED HOWARD, J.D.: Bill?

WILLIAM VEGA: I would just make a very quick point which is most studies I have seen indicate that insured Latinos actually have a much lower cost to the insurance companies than do people of other ethnic backgrounds. That is a per-capita cost in terms of services utilized in considerably lower than it is for other populations, especially among the immigrant groups.

So, it is possible actually to cover this population and the per capita cost is considerable lower and still be able to make a reasonable profit from it for these insurance companies. So, it is not a bad investment to cover this population if we can find a financial platform to finance it.

ED HOWARD, J.D.: Yes, go right ahead sir.

DOUG TRAP: Hi. Doug Trap [misspelled?], American Medical News. I have got a question on a follow up actually. I am just wondering, you have touched on this a little bit, the panelists touched on this just a little bit, but how important are programs like Medicaid and SCHIP to getting coverage for Latinos, Hispanics of any type, documents or otherwise? Or is it more complicated than that?

DEBRA JOY PEREZ: Well, it is a complex issue. I will touch a little bit on that. But, it is SCHIP programs and

state programs that provide coverage are extremely important because one of the things that we know about Latinos in this country is that there are many, many eligible children who are not currently enrolled in SCHIP programs.

There is a lot of reasons for that. Some of them might be they have undocumented parents or mixed parents, one is documented, one is not and there is kind of a fear to enroll their children.

There is a ban in this country if you immigrate and you are applying for citizenship, you have to wait five years before receiving public benefit and that does not apply to the U.S. citizen child. Parents think it does apply. So, SCHIP programs, state programs that provide health insurance to children expanding that coverage to include low income families, raising the cap, those are important interventions.

ED HOWARD, J.D.: You say you had a—

SUMI SOUSA: Totally critical, for a state like California cannot do without it, absolutely impossible and it is for the same reasons that Debra was talking about but clearly, it is just states cannot do it alone and this is a low income working population.

And so it is trying to make some necessary adjustments with regards to eligibility enrollment in order to get folks actually on these programs. Fifty-three percent of the

population of our entire Medi-Cal population which is roughly 6.5 million is Latino.

ED HOWARD, J.D.: Sumi, can I just ask you to follow up. I noticed that one of the features of your reform plan was a significant boost in reimbursement rates.

SUMI SOUSA: Yes, that is a good point Bill. Two fold value, number one, California is a terrible partner. We are probably the worse partner amongst all the states in terms of the Medicaid program. Our average is in the 50's but for some providers we are in the 40-percent kind of category so we are not a terrific provider which is a real problem.

So, we had to do something about our Medi-Cal rates, number one, because we need to sustain those safety net institutions that are seeing our low income population. So, what are community clinics, how are they are going to keep their door open without continuing the bake sales that they are having on the side and the hospitals that essentially that folks are going to? So, we needed to do a pretty hefty Medi-Cal rate increase to sort of kind of prop up our current safety net providers.

But, secondly, we have a terrible access problem. Nobody will take any new Medi-Cal patients. So, we are going to do this big expansion of Medi-Cal and essentially not have a place for them to go. So, we also needed to be able to get more providers to be in the program and so you are just not

going to be able to have any discussion in California about expanding that program and expanding real access quite honestly without Medicaid rate increase.

ED HOWARD, J.D.: Do you have a follow up?

DOUG TRAP: Yes, the follow up would be that there is a certain part of the population that believes that because people are undocumented, they deserve no help from government, tax payers, that sort of thing. What do you tell them knowing what your answer was before?

ELENA RIOS: You tell them that infectious diseases know no borders and HIV/AIDS, Tuberculosis, and other infectious diseases that are in the population of our restaurant workers, our hotel workers, our gardeners and everybody else that is the underground economy of this country are undocumented. So, people that are in our communities need to be healthy, whoever that is.

ED HOWARD, J.D.: See if there is a question down here. Yes?

JOCELYN FRANK: [Inaudible]

ED HOWARD, J.D.: You want to identify yourself?

JOCELYN FRANK: My name is Jocelyn Frank [misspelled?], I am a freelance journalist and I also work for National Public Radio.

I see that the study obviously focused on the rate of diabetes within the Latino and the community that identifies as

Latino origins and I am wondering if you can tell me if the rate of diabetes within that community is actually on the rise when you account obviously for the population that is growing very, very quickly. But, is that actual rate of diabetes within the community also increasing disproportionately?

ELENA RIOS: I will let Bill answer part of that. Let me just state that this was a cross-sectional study, one time prevalence rate so we are not talking about incidence, which is what you are asking about. We know that for example, 10-percent of Latinos are diabetic, that is higher than the general population which is at 6-percent. I will let Bill say if he has any other data on that.

WILLIAM VEGA: Well, as I mentioned earlier, clearly the U.S. born population has a higher prevalence of diabetes and the longer you stay in the country, if you are an immigrant, the more likely you are to become obese and then you will become diabetic-prone and then a higher likelihood of prevalence there as well.

So, it unfolds over time and this develops a curious irony that the more immigrants you have in the population, it actually artificially lowers the prevalence of diabetes in the population.

And if you close that window and you have fewer of them and then you have more and more people staying for longer periods of time in residence as immigrants or their children,

then the rates will eventually start climbing. They have already been climbing but I mean they are just going to continue to move up.

ED HOWARD, J.D.: We have time. Yes, back there. We have time for your question and your question and then we will have to wrap it up.

JOSHUA MASSETT: My name is Joshua Massett [misspelled?], I am a student of journalism at UCDC. My question is primarily for Elena Rios. I would like to ask about the new media connections that you are hoping to make to be able to spread this information. You talked about using the internet and about using cable. I was wondering to what degree it is going to be and what you are hoping to achieve by it exactly.

ELENA RIOS: Well, the National Hispanic Medical Association is working with CDC right now on developing heath communications projects and there are several national Hispanic-focused media right now that are interested including [Speaking in Spanish], which is a cable and radio and T.V., New America Media and the Hispanic Publications of America.

We have talked to them about being on an advisory committee and we have also talked to new cable T.V. that are in the realm of public T.V., Hispanic Telecommunications Network out of New York, for example. And they are cable T.V. with

satellite leasing that they do around the country and in Latin America.

There is lots of opportunity right now to think about communications to the community from a health perspective and we call it health communications and we are very much interested as physicians who take a real interest in being leaders for our community and also being responsive to our communities, understanding the Latino culture in how Latino physicians and other networks, we work the Hispanic nurses and Hispanic dentists and Hispanic health executives in the Latina Caucus of APHA and there is lots of interest in our professional communities to give back through this type of activity and be leaders involved in educating through media.

ED HOWARD, J.D.: Go ahead, there is your microphone.

EMILY: Emily from *A Page Today* [misspelled?]. This question is also for you. You mentioned some problems with legislation that has been introduced over the last six or seven years. Could you just briefly talk what you think legislation is going to need to include if it has any chance of getting passed and also maybe touch on if you think either of the two major Presidential candidates have adequately addressed health disparities in their health care plans?

ELENA RIOS: Yes, the legislation I talked about is known as Health Disparities Bills. This Congress's bills were called the Health Equity and Accountability act, that was HR

3014 introduced by the Tri-Caucus of the United States Congress.

Congresswoman Hilda Solis is the lead this year as the head of the Hispanic health care task force, Congressional Hispanic Caucus health care task force. And on the Senate side, the bill is Minority Health and Health Disparities Improvement Act, introduced by Senator Kennedy and Senator Cochran.

What is important to realize is the bills have been introduced in three Congresses and have been improving in terms of passage as far as we know, a bill can be passed because there is bi-partisan support and there is a lot more sponsors let us say. For both indicators, these bills have increased their bi-partisan support and the number of sponsors.

I think part of the problem has been the need for the leadership within the Senate to take it up as an important issue of the war and other things come up and keep coming up. And within the realm of health care, it was the Medicare Drug Act and then it was SCHIP and so, the importance of health disparities and prevention, which these bills really focus on, needs to be looked at.

And I think that because they are big bills, that perhaps taking them apart and putting them within other bills where they can ride the success of let us say if they had been part of the SCHIP reauthorization or these other big problems

that have to be reauthorized. I think that that would be the way to go.

And also with health care reform could include health disparities angles and issues such as diabetes and obesity and prevention that has been mentioned here. Both campaigns have looked at underserved populations but certainly the McCain agenda, which is more of pull yourself up by your boot straps and go out and have an ability to go to the market is a little less friendly towards the low income Latino population working at businesses that cannot afford health insurance.

So, the Obama platform does have specific health disparities initiatives within its health agenda, especially prevention, obesity, diabetes, health care workforce and lots of enrollment, cultural competence, language services, lots of things in Obama's platform.

ED HOWARD, J.D.: Okay. Well, we are just about out of time. Debra, do you have any final words you would like to share just to wrap it up?

DEBRA JOY PEREZ: Just that I would invite everyone to go to our website at rwjf.org. We have a number of programs addressing all the conditions that you heard spoken about today, diabetes, obesity and coverage. We are very interested in hearing back from you about how you will use the information that we partnered with Pew to collect. You can access the report on the website and on the Pew Hispanic Center.

ED HOWARD, J.D.: Terrific. Thanks to the Alliance staff. I want to thank the Foundation for its participation in and help with and support of this briefing. Thank you for coming and ask you to join me in thanking our panelists for an excellent presentation. [Applause]

[END RECORDING]