WORK FORCE ISSUES AND OPTIONS IN THE BORDER STATES *

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Work Force Issues and Options in the Border States

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* An issue paper prepared for the U.S. Health Resources and Services Administration (HRSA) Border Vision Fronteriza Project (U.S.-Mexico Border Health Collaborative Outreach Demonstration) under a subcontract with the Migrant Clinicians Network, Inc., April 1996.

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INTRODUCTION

The border region provides a glimpse into the health care situation of the United States by the mid 21st century. The issues and opportunities facing the health care work force in the border states today, the result of unprecedented demographic and cultural change, will be the issues and opportunities facing the rest of country by 2050. This paper will provide an overview of the changes, their importance for health care services provision, and the combination of challenges and opportunities facing the health care work force of the future.

ECONOMIC DEVELOPMENT

United States

The health of the border counties, and the every-day working conditions of health care providers, takes place in an economic environment that is also rapidly changing. While in the past it was not uncommon to think of the border counties (perhaps with the exception of San Diego County) as consisting of economic "sleepy border town" backwaters, this is no longer the case. Economic growth in the four border states have been part of the "sunbelt" development phenomenon which has seen a gradual redistribution of economic initiative from a nearly exclusive focus on the Midwest and Northeast states to one concentrated in the so-called "Sun Belt."

The economies of the states have diversified (e.g., California away from aerospace and Texas away from petroleum) at a time of industrial restructuring with a greater reliance in manufacturing outside of classic capital-intensive factories and more onto sub-contractual relationships. While on the one hand this leads to greater overall economic growth and stimulation, it also creates a demand for "sweatshop" labor and conditions (i.e., low wage, low benefit, non-unionized), into which an immigrant population can fit all too well.

Mexico

Much of the "magnet" drawing internal migration to the Mexico side of the border region is the lure of better working conditions at the border area -- more jobs, higher wages, better conditions -- and the always present possibility of the "trampoline" effect into the US for even higher wages. The *maquiladora* industry has provided hundreds of thousands of jobs, and does not appear to be abating. This job creation has been a two-edged sword, both providing employment and economic development, and the hope of technology transfer, while at the same *time* stimulating population growth that threatens to overburden the infrastructure.

NAFTA

For the first year, NAFTA provided a stimulus for investment and development, especially in the Dallas-Monterrey corridor. The peso devaluation and subsequent economic crisis have slowed down that pace, but have not eliminated the fact of greater international interdependence. The nature of industrial restructuring would have meant some NAFTA-like effects, even if NAFTA had not been approved. And, belligerent presidential primaries to the contrary, market forces are large than any single piece of legislation, and should NAFTA be rescinded or blocked in the courts, the process of industrial and trade re-alignment will continue. The major question is whether or not that restructuring will be done to the mutual benefit of the US and Mexico, or whether other regions will benefit.

DEMOGRAPHIC OVERVIEW

Latino Population

The US-Mexico border is a dynamic area whose component states contain 52 million residents, over one out of every five Americans. These border states also contain a large Latino component: 13.3 million Latinos, or nearly 60% of all Latinos in the country. The Latino population is distributed into (See Figure 1)

- 7,687,938 million in California,
- 688,330 million in Arizona,
- 79,224 million in New Mexico and
- 4,339,905 million in Texas.

The health profiles of these states are very much affected by the health profile of the Latino population within them.

Concentration

Latinos comprise around one-fourth of the population of the border states (See Figure 2)

- 25.8% of California's population is Latino,
- 18.8% of Arizona's,38.2% of New Mexico's and
- 25.5% of Texas'.

Border Counties Latino Representation

The counties contiguous with the Mexican border have a total of 2,128,058 Latinos residents. To put this in perspective, the Latino population of the border counties is equivalent in size to the entire state of Arkansas or Kansas. The Latino border county population of each states is (See Figure 3).

- 582,716 in California
- 258,250 in Arizona
- 88,060 in New Mexico
- 1,199,032 in Texas

Because of this large number of Latino residents in a relatively small area, the border counties have a higher concentration of Latinos than the rest of the state. San Diego county is the only county in which a smaller percent of the total population is Latino (20.4%) than the state concentration (25.8%). In all other border counties, the representation of Latinos is higher than the state figure, ranging from 24.5% Latino in Pima County, Arizona (state norm: 18.8% Latino) to a high of 93.9% in Webb County, Texas (state figure is 25.5%).

Border Counties as Percent of Total Latino

The size relationship between the Latino population in the border counties and the rest of the Latino population varies considerably by state. While over half a million Latinos reside in California's border counties, they represent only 7.5% of the state's total of 7.7 million Latinos. Arizona's much smaller border county Latino population is a much larger percent, 37.5%, of the state's total Latino population. In New Mexico, 15.2% of the state's Latino population is in the border counties, and in Texas, 27.6% (See Figure 4).

IMMIGRATION/MIGRATION

The facts of international immigration from Mexico to the US, and of internal migration from the interior of Mexico to the *Frontera* (border) have created a new border cultural situation.

International Immigration

While the immediately bordering US counties have historically been the recipient of on-going immigration, changes in the immigration flow to the north of those counties have created a now socio-demographic/epidemiological situation. The number of Latin American immigrants in the four border states is 5,090,500 in 1990. California received the most immigrants (3,636,000), followed by Texas (1,134,000), Arizona (239,000) then New Mexico (81,500) (See Figure 5).

The large absolute number of immigrants in California has greatly influenced the overall Latino population. Overall, nearly half the Latino population (47.3%) are immigrants (See Figure 6). Most of those immigrants, however, are adults. In the adult population (25+ years) 59.6% are immigrant. Because of this large immigrant population, Spanish language television and radio stations are the #1 stations in the Los Angeles ADI (Area of Demographic Influence), eclipsing the English language stations in listenership and viewership. In southern California, Spanish has become a common medium of communication. Market sensitive institutions, including health care organizations, have learned to become sensitive to the Latino market, and have marshaled increasing forces to serving that market.

Immigrants in California tend to have higher labor force participation, lower welfare utilization and stronger family formation than US born Latinos. However, they also tend to have much lower levels of education and greater levels of poverty.

That same growth has generated a political backlash, culminating in efforts such as Proposition 187 and current debates about limiting access of non-citizen legal permanent residents to services and curtailing citizenship of children born in the US of undocumented parents. While the perception is that there are millions of undocumented Mexican immigrants in the state, most data based research indicate that the actual number of undocumented would account for 7% to 10% of the total Latino population.

In Arizona, 34.7% of the state's Latino population is immigrant, while in Texas 26.4% are immigrant. New Mexico's Latino population is an outlier, with only 14.1% of it composed of immigrants (See Figure 6).

The direct influence of immigrants has been less in the other states. However, the communication and market responses to the total immigrant population (in large part driven by immigrant presence in California and Florida) have created a linguistic/cultural shell that was lacking just twenty years ago.

Language Patterns

The Latino populations of the border states present interesting variants of language patterns. New Mexico Latinos are the most English dominant, the least Spanish dominant, and the most bilingual of any state. Texas Latinos are the least English dominant, with a high rate of Spanish dominance. California Latinos are the most Spanish dominant (See Figure 7).

CULTURE OF THE BORDER

For decades, there has been an apprehension in Mexico that the constant penetration of North American cultural mores and artifacts would lead to a weakening, and perhaps loss, of Mexican culture. Now that Latinos are closing in an population parity with the While non-Hispanic

population, there is concern expressed about the possible "Mexicanization" of North American culture. The border region perhaps offers the best clues as to what might happen.

A cultures is the largely unconscious construction aggregated up out of the daily experiences, hopes, fears, aspirations and desires of millions of common, everyday people going about their seemingly mundane business. So unthinking is its construction that most people building a culture would deny that they are creating anything--as far as they can tell they are simply trying to earn a living, raise children, get along with their family and friends, and find a little joy in life. However, by what they do, and what they do not do, by what they think is desirable and beautiful or undesirable and not beautiful, they are laying the commonly shared unconscious foundations of a culture. When Latinos are the vast majority of a population, Latino hopes, fears and desires form the basic collective unconscious that drives a culture forward.

A living culture is not legislated into existence: it is created by daily interactions. In spite of political speeches, people will construct their daily lives in accordance with what they know how to de, and not to please politicians. As Latinos become the social matrix of most of the border states region (except for northern California and northern Texas), the following are likely to be seen: bilingualism the norm. For Latinos, the norm after three generations in the US is a functional bilingualism. Given the market driven forces behind language use, it is clear that Spanish will not disappear', neither, for that matter, will English. Indeed, Latino immigrants have shown great effort and interest in the acquisition of English by themselves, and particularly, by their children. The Spanish language communications shell will make retention of Spanish easier to accomplish alongside a rapid acquisition of English.

Biculturalism

In spite of Mexican fears of loss of culture, Latino communities of the border region show that Latino culture is alive, vibrant and well, which also means that it continues its 500 year history of rapid and dynamic change. For over five centuries the Latino-Catholic civilization has incorporated new tongues, foods, governments and gods from around the world (Europe, Africa, Asia) onto a wildly heterogeneous Amerindian base.

The basic elements of Anglo-Protestant culture, offspring of the Reformation, are no strangers to this syncretic culture, and will no doubt be also incorporated. In reciprocity, there are populations of the Anglo-Protestant culture that are not afraid to adopt Latino cultural elements in a manner similar to Latino cultural syncretism. However, there are other Anglo-Protestant populations that would believe themselves the guardians of some monolithic, hopefully immutable culture that can tolerate no sharing or change. It is not clear that current monoculturalists will be successful in their attempt to legislate a civilizational purity. In the end, cultures and civilizations live and die on their own merits, not by the whims of governors, kings or assemblies.

HEALTH OF THE BORDER REGION

The health profile of the border counties is largely driven by the health profile of the Latino populations within those counties (San Diego County is the lone exception). In many ways, the Latino health profile is the "norm" for these counties.

In general, the Latino health profile can be summarized as:

- low mortality, both crude and age adjusted, for most causes of death
- long life expectancy
- high morbidity
- healthy birth outcomes
- low services utilization
- low rates of insurance coverage.

We shall look at these profiles by comparing three levels of population:

- the rates for all races for each state
- the rates for all Latinos in each state
- the rates for Latinos in the border counties.

In this way, we can appreciate the extent to which Latinos in border counties resemble the Latino state norms, and to what extent they differ.

Life Expectancy at Birth

Latinos in the border states have a longer life expectancy at birth than other populations in the states, and the border states have a longer life expectancy at birth than the national figure. In California, the statewide life expectancy at birth is 76.9 years, and for Latino it is 80.2 years. This longer life expectancy holds for all age groups, including 65 and older. In Texas, the state life expectancy is 76.3 years, while for Latino it is 77.5 years. New Mexico was the only exception, where Latinos had a shorter life expectancy (76.0 years) than the state figure of 76.1 years. Data for Arizona were not available, nor were data specific to the border counties. The national life expectancy figure is 75.5 years (See Figure 8).

Crude Death Rates

The general trend for Latino death rates in the border states is to be lower than the state death rate. In all four states, the crude death rate for all races combined is 714.3 per 100,000, while for Latino it is 342.4. This general pattern holds in all border states except for New Mexico: There, the Latino crude death rate, while lower than the state rate, is much closer to the state norm than the Latino death rate in the other states (See Figure 9).

Generally, the Latino death rate is slightly less than half the state rate, ranging from 47.9% of the state rate in California to 40.2% in Arizona. The New Mexico Latino death rate is 76.5% of the state rate (See Figure 10).

On the one hand, this crude rate is important, for it is an indicator of potential hospital utilization: in California, the crude death rate translate almost directly into hospital utilization patterns.

Age-Adjusted Rates.

On the other hand, a good part of this differential is due to the younger age structure of the Latino population compared to stEven when adjusted for age, the Latino death rates in California and Arizona are lower than state rates. The state age adjusted death rate in California is 471.3 while the Latino age-adjusted rate is 363.7 (See Figure 11).

In Arizona, the state age-adjusted death rate is 539.1 while the Latino rate is 472.5. Age adjusted rates were not available for New Mexico or Texas, but there is every reason to expect that the general trends observed in California and Arizona will hold for Texas and, to a lesser extent, for New Mexico.

Border County Death Rates

The Latino crude death rates for the border counties follow the general Latino norm in being substantially below the state figure. However, there is an interesting pattern: border counties crude death rates in California, Arizona and Texas are around 10% higher than the Latino norm for each state, while in New Mexico, the border counties death rate is lower than the Latino state norm (See Figure 12).

Causes of Death

The Latino mortality rates in the border states is lower than the state norms for the major causes of death, including:

Diseases of the heart
Cancer
Stroke
Chronic obstructive pulmonary
AIDS
Accidents
Pneumonia and influenza
Suicide

These are major causes of death, whose treatment absorbs a good portion of health dollars. These are "style of life" diseases. For whatever the reason, Latinos in the border states have significantly lower death rates.

There are some causes of death for which Latino rates are higher than the state norms. These include:

- Diabetes
- Chronic liver disease and cirrhosis
- Homicide

While county-specific Latino death rates were not available, there is every reason to believe that they will follow this trends of the state Latino norms, with only minor variations.

Infant Mortality

The Latino epidemiological paradox was first noticed in the area of birth outcomes. Detailed longitudinal data from California (1980-1994) show that Latinos have the lowest rate of first trimester prenatal care seeking, and the highest rate of delivery without prenatal care. Latinos also have the lowest income, lowest educational level and least access to care. Yet, Latinos have a lower percentage of low birth weight babies and lower infant mortality than the state norms.

This general pattern holds in the border states. In California, Arizona and Texas, Latino infant mortality in the state is lower than the all-races state figure. New Mexico is the only exception, wherein Latino infant mortality is higher than the state rate.

The Latino epidemiological paradox continues in the border counties, with even lower infant mortality in border county Latinos than the statewide Latino infant mortality figure. Given the proximity to the border, there may be a slight underreporting of deaths, yet the border county figures are consistent with Latino figures for counties hundreds of miles from the border.

Morbidity

Reportable disease data with Latino identifiers are available only for California and Arizona. In California, Latinos had higher than state incidence rates of:

- Hepatitis
- Tuberculosis

Compared to the California state norm, Latinos had lower rates of sexually transmitted diseases, including:

- Syphilis

- Gonorrhea
- HIV (Human Immunodeficiency Virus)

While Arizona data were not as complete, they appear to follow the California profile.

Hospital Utilization

Data are only available for California. Given the youth of the Latino population, it generates fewer bed-days per 1,000 than the state norm. In 1993, 1,000 Latinos generated 400.4 bed days, while the state norm was 614.0. Those few days generated are largely for birth-related DRGs Diagnostic Related Group), as opposed to the more expensive heart, cancer, stroke and related DRGs (See Figure 14).

Latinos also generate far fewer hospital charges. The average Latino generated $854 in hospital charges in 1993, compared to the state norm of $1,295 (See Figure 15).

These effects of lower use and charges holds for all age structures, becoming most pronounced in the 65+ age group. Yet, for using hospital services far less, the overall Latino health profile does not appear to suffer greatly.

Hospital utilization is heavily conditioned by the structures of access to coverage and organization of services, hence it is not clear how far the California findings can be generalized to the other border states.

EXPANDING DEFINITION OF HEALTH

New Demographics of Health

While it has become customary to think of "minority health" only in terms of problems and obstacles, a longer, epidemiological look might lead to an alternative view: as the Latino population grows, its overall effect on the health profile of the region will be to reduce mortality for the major, expensive causes of death. There will be, however, an increase in morbidity.

In California, Arizona, Texas, and, to a lesser extent in New Mexico, Latinos are the population closest to meeting more of the goals for Healthy People 2000 than any other population group. In essence, as the Latino population grows, the border states come closer to Health People 2000 goals in the major causes of death due to the compositional effects.

Movement to Managed Care

The states in the border region were among the first to rely on managed care for significant delivery efforts in both the public and private sectors. The California Department of Health Services has announced its timeline to enroll all Medi-cal (Medicaid) recipients in managed care; Arizona's AHCCCS program is a form of managed care for those who would be Medicaid enrolled in other states. Federal level policy discussion indicates that the elderly enrolled in Medicare will soon be encouraged to enroll in managed care plans. And, in the private sector, managed care is rapidly becoming the major mode of coverage in California and Arizona.

Whether in the private or public sector, a successful managed care program is one in which the enrollees make less use of services than under fee-for-service. This lesser utilization may be achieved in two ways:

- by denying care and services to populations that have come to expect them
- enroll younger, healthier populations who will have less need for services

In the border states, an opportunity exists to use the paradoxically healthy profile of the Latino population to generate greater enrollment in Medicaid, Medicare and similar programs without causing a concomitant demand for expensive tertiary care services.

However, such an enrollment strategy will require a much better understanding and preparation in the management of the health status of a largely Latino enrollee base. This management will require special knowledge, motivations and skills.

HEALTH WORKER ISSUES AND OPPORTUNITIES

Health of the Border Population

With the exception of San Diego County, the majority population of the combined border counties is Mexican origin Latino. The ability of managed care organizations to maintain financial solvency depends upon their ability to manage the health of a largely Latino patient base. It has become customary characterize Latinos as a minority population, and to infer from generally low levels of Latino income and education a generic "minority health" profile, i.e. Short life expectancy, high mortality, poor birth outcomes, and high services utilization. However, this model is inappropriate for the border region.

The predominantly Latino border region population should best be thought of as an extension of any state's Latino population, rather than as an isolated population. To a certain extent, border county Latino populations resemble most the rest of each state's Latino population, and should best be approached analytically as variants of each state's Latino norms. Thus, the general social processes that affect Latino health in any given region can be seen in operation at the border, with the special modification of the specific border situation.

The health care workforce needs to be developed, educated and prepared to function in this type of environment.

Latino Provider Preparation

Prior to 1970, Texas was the only state to educate significant numbers of Latino providers on a consistent basis. California, Arizona and New Mexico began doing so in the mid 1970s. However, there is a tremendous "doctor gap" between Latino providers and Latino population. As a proxy measure, medical school graduates provide one view of the situation.

In 1980, in the border states combined, for every medical school graduate, there were 22,573 residents. However, for every Latino medical school graduate, there were 63,519 Latino residents. This number varied by state, with Arizona having no Latino medical school graduates that year.

By 1990, the overall figure had improved slightly, to one medical graduate per 22,259 in the general population, and one Latino medical graduate for 59,410 Latino population. There was still a significant Latino shortfall. The apparent progress by 1990, however, was more apparent than real: three important factors impinge upon this apparent improvement:

- Arizona went from no graduates in 1980 to 10 in 1990, a huge percentage increase;
- Texas greatly increased the number of Latino medical graduates from 54 to 85, a 57% increase;
- California's ratio actually regressed. The number of medical graduates did increase modestly from 69 in 1980 to 94 in 1990, a 36% increase. However, the state's Latino population grew by 62% in that same period: while in 1980 for every Latino medical graduate there were 65,860 Latinos, by 1990 that had gotten worse, to 81,787 Latinos for every graduate.

It is not clear how the University of California's retreat from affirmative action admissions policies will affect these ratios: they were bad enough to begin with, and may well become even worse (See Figure 1 6).

Generic Provider Preparation

Probably not until 2050 will "natural" increases in medical and other health professional graduates bring Latino provider:population ratios to parity with the rest of the border states population. Hence, for at least our lifetimes, it behooves us to ensure that all health care providers, irrespective of race/ethnic background, be trained in managing the health of an increasing Latino patient base. The major areas for provider preparation include:

Language

While public sector institutions are debating the feasibility of mandating English-only policies, private sector institutions have taken a "market-driven" approach to the Latino market. This has meant a tremendous expansion in Spanish language preparation, education, advertising and marketing.

Patient Education

Drinking, smoking, drug use, diet and physical activity are the major determinants of post-industrial America's mortality profile. While Latinos have lower rates of mortality due to heart, cancer and stroke, it is clear that as Latinos assimilate, their levels of smoking, drinking, drug use, poor diet and other harmful behaviors increase. Patient education is the key to developing and supporting lifestyle behaviors that affect health. From the knowledge of smoking campaigns, the "messages" that appeal-to Latinos are very different form the messages that work with non-Latino populations. The whole range of health education needs to be re-normed, so that their messages are consistent with Latino values, norms and mores.

In-Class preparation

At the very least, a portion of each health professional student's preparation (medical, dental, nursing, pharmaceutical, etc.) should include the basic knowledge elements of Latino health:

- sociodemographics
- mortality profile
- morbidity
- services utilization patterns
- mental health
- cultural history and dynamics

POLITICS AND LEADERSHIP

Increased Voter Power

Historically, low levels of Latino political participation was depressed by the virtually non-existent levels of naturalization of immigrant Latinos. Proposition 187 and its sequelae, specially the proposals to strip legal permanent resident immigrants of Social Security and medicare benefits, have changed that in the heavily immigrant states. Record numbers of Latino immigrants are taking out citizenship. In California alone an estimated 1,000,000 Latinos will become naturalized by the years 2000. Proportionally similar numbers are likely to be seen in Arizona and Texas. Motivation for participation is high, given the high profile of Proposition 187 and related discussions.

Growing Latino Representation

This is most pronounced at the state and local levels. The national trend to term limits has increased the turn-over of elected officials, and is occurring at a time of increased Latino political participation.

This is occurring at a time of federal devolution of responsibilities to state and local levels. In essence, Latino local leadership will be enhanced just as decision-making responsibilities are being increased.

Elected Leadership

There is a gap in Latino political leadership, most noticeable in California and Arizona. Elected Latino officials are almost exclusively US born Latinos, who tend to be Democratic in party affiliation and generally supportive of the Democratic Civil rights era mind-set. However, the newer voters coming on line are immigrants, who do not necessarily see the Democratic civil rights agenda as reflecting their interests.

Civil Leadership

There is been a tremendous growth of the Latino middle class, reflected in increasing numbers of business, professional and community leadership. These are more likely to immigrant leaders than political leaders, and provide an important outlet of opinion.

Non Latino Leadership

There is a division in non-Latino leadership over the meaning of the recent demographic change. California, and to a lesser extent, Arizona, seem to harbor a substantial non-latino leadership which is not comfortable with the recent changes, and whose political agenda appears to consist of developing obstacles for full Latino participation in daily life. In those states, an opposition to such views is noticeable by its absence: there is no major figure proposing an alternative vision of society. Such alternative views seem to be emanating from New Mexico and Texas, where the demographic changes have been greeted more positively.

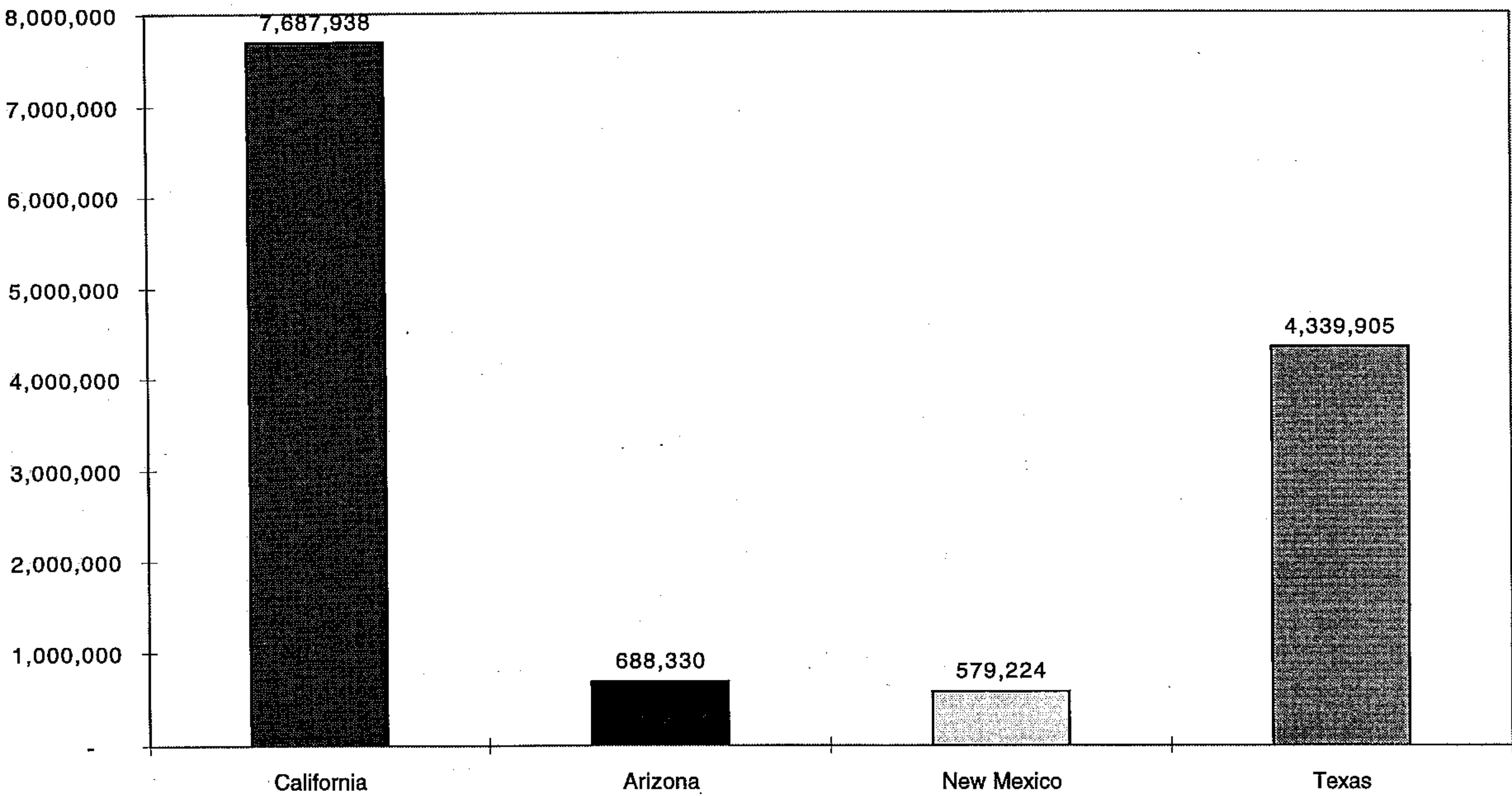
CONCLUSION

The border region offers, perhaps, a glimpse into American culture, identity and health profiles of the mid 21st century. The opportunity currently for the health care work force is to understand the processes and dynamics of change, and use them to both community and professional benefit during a period of rapid and fundamental change. The challenges for health care workforce may be summarized as follows:

- To develop a vision of a truly bicultural, bilingual society;
- To foster the emergence of a political and civil leadership that shares that vision;
- To encourage the emergence of organizations which are built along the lines of that vision;
- To create health care services structures that are consistent with the health profile of the border population;
- To create health education "messages" that resonate with the population's social reality;
- To ensure that health care providers are educated and prepared to manage the health of a border population.

FIGURE 1

LATINO POPULATION IN BORDER STATES, 1990

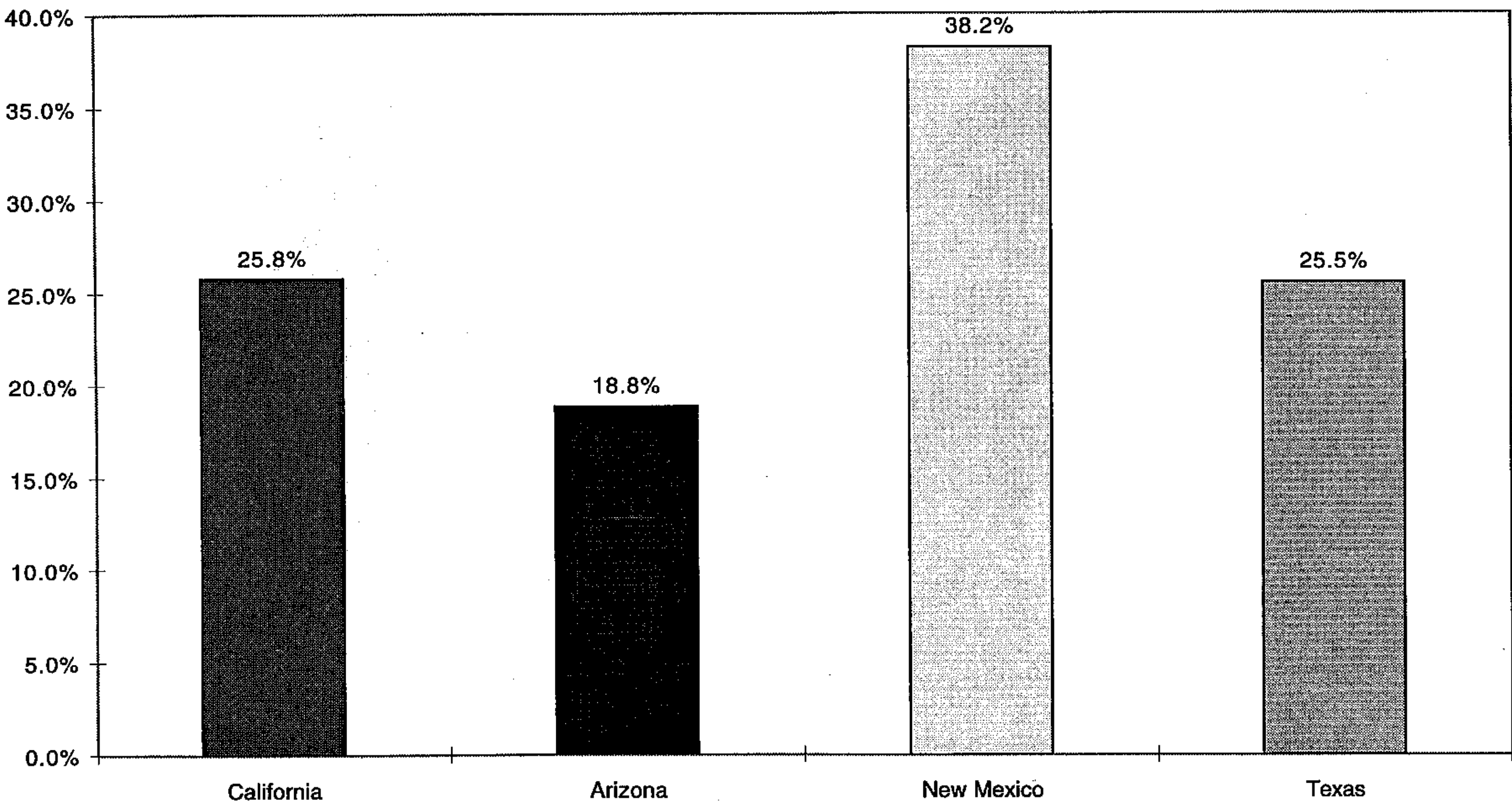


SOURCE: 1990 CENSUS STF 3

CENTER FOR THE STUDY OF LATINO HEALTH, UCLA

FIGURE 2

LATINO AS PERCENT OF BORDER STATES POPULATION, 1990

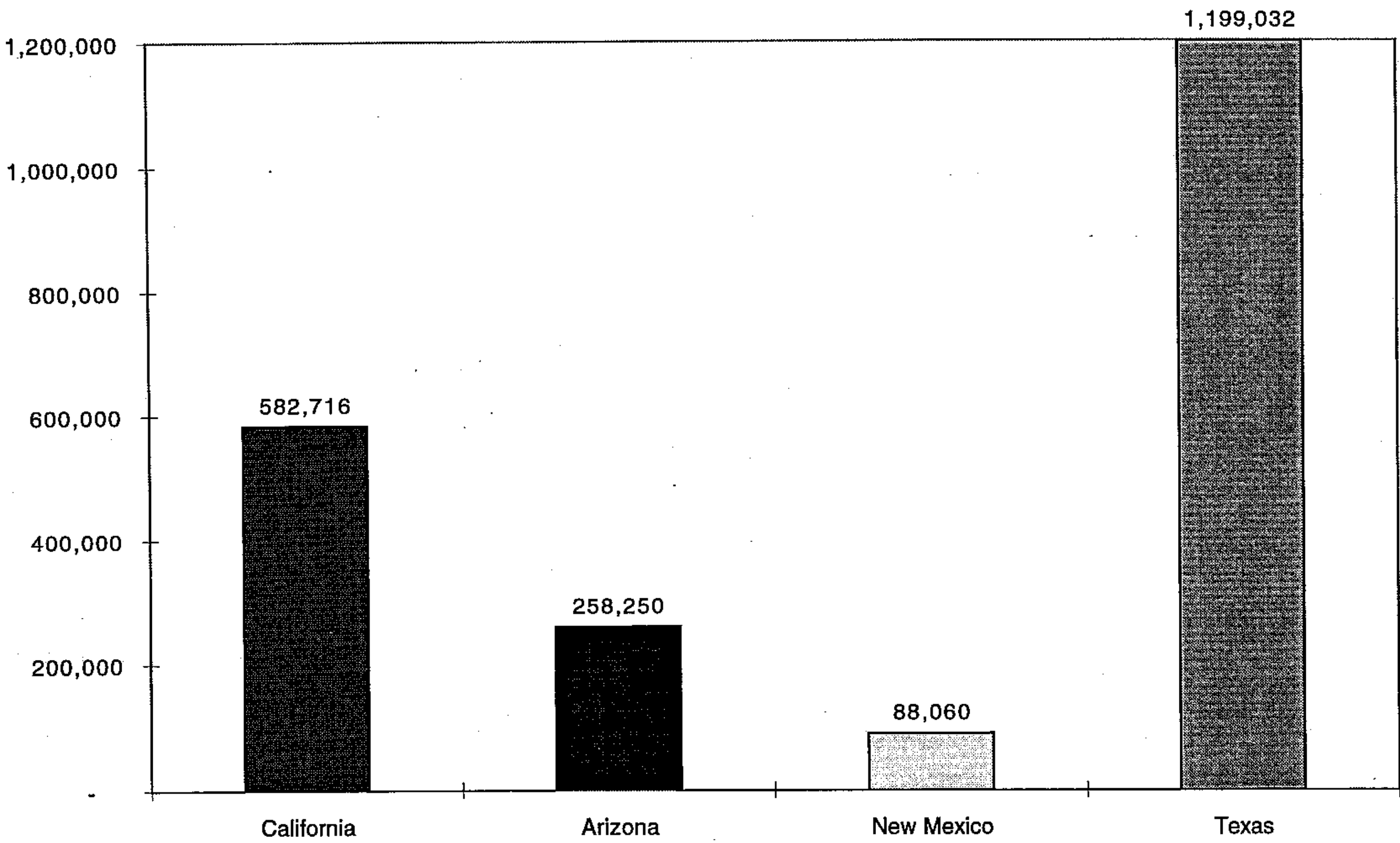


SOURCE: 1990 CENSUS STF 3

CENTER FOR THE STUDY OF LATINO HEALTH, UCLA

FIGURE 3

LATINO BORDER COUNTY POPULATION, 1990



SOURCE: 1990 CENSUS STF 3

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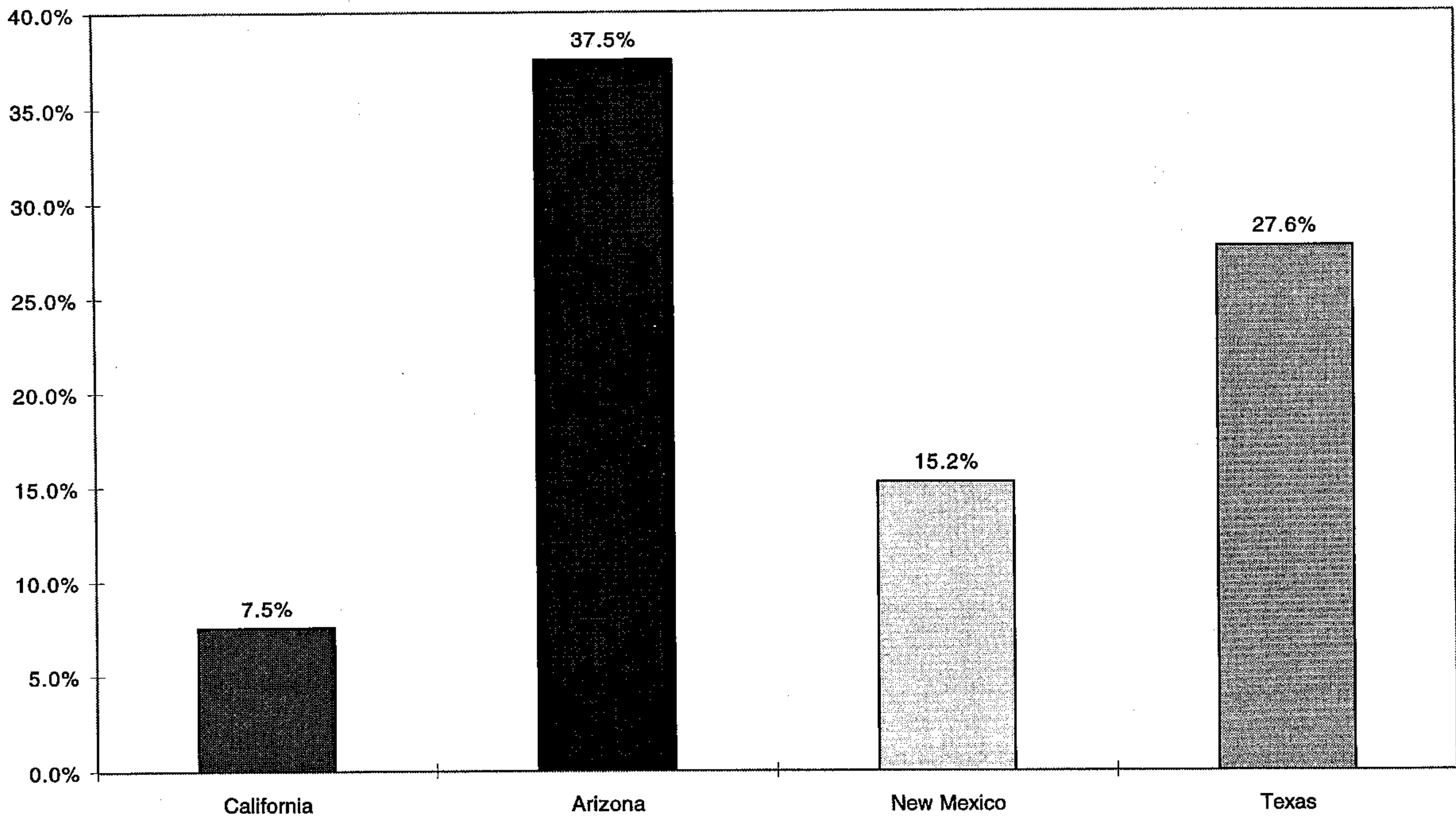
FIGURE 4

BORDER LATINO AS PERCENT OF STATE LATINO POPULATION, 1990

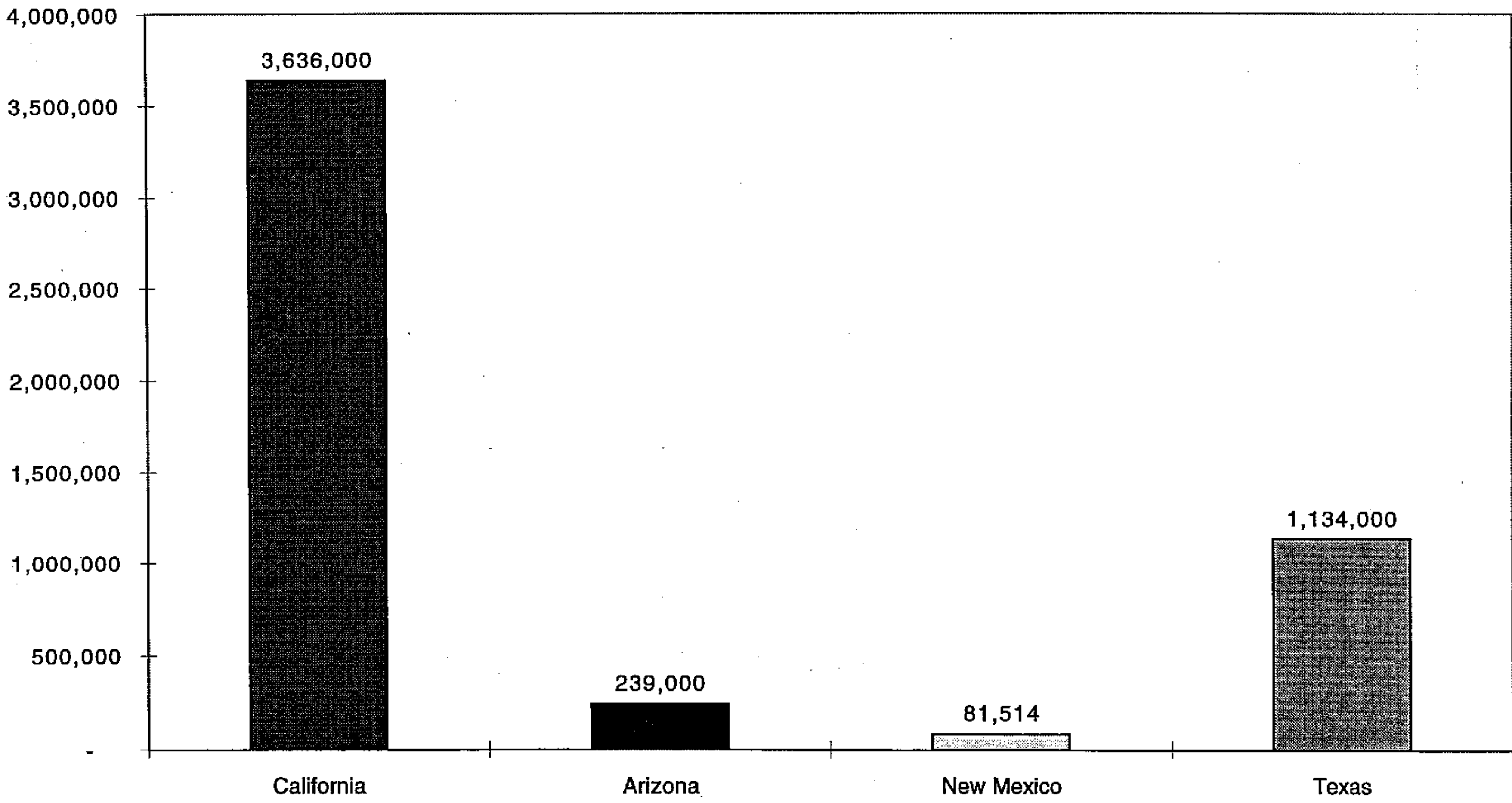


SOURCE: 1990 CENSUS STF 3A

CENTER FOR THE STUDY OF LATINO HEALTH, UCLA

FIGURE 5

LATINO IMMIGRANTS IN BORDER STATES, 1990

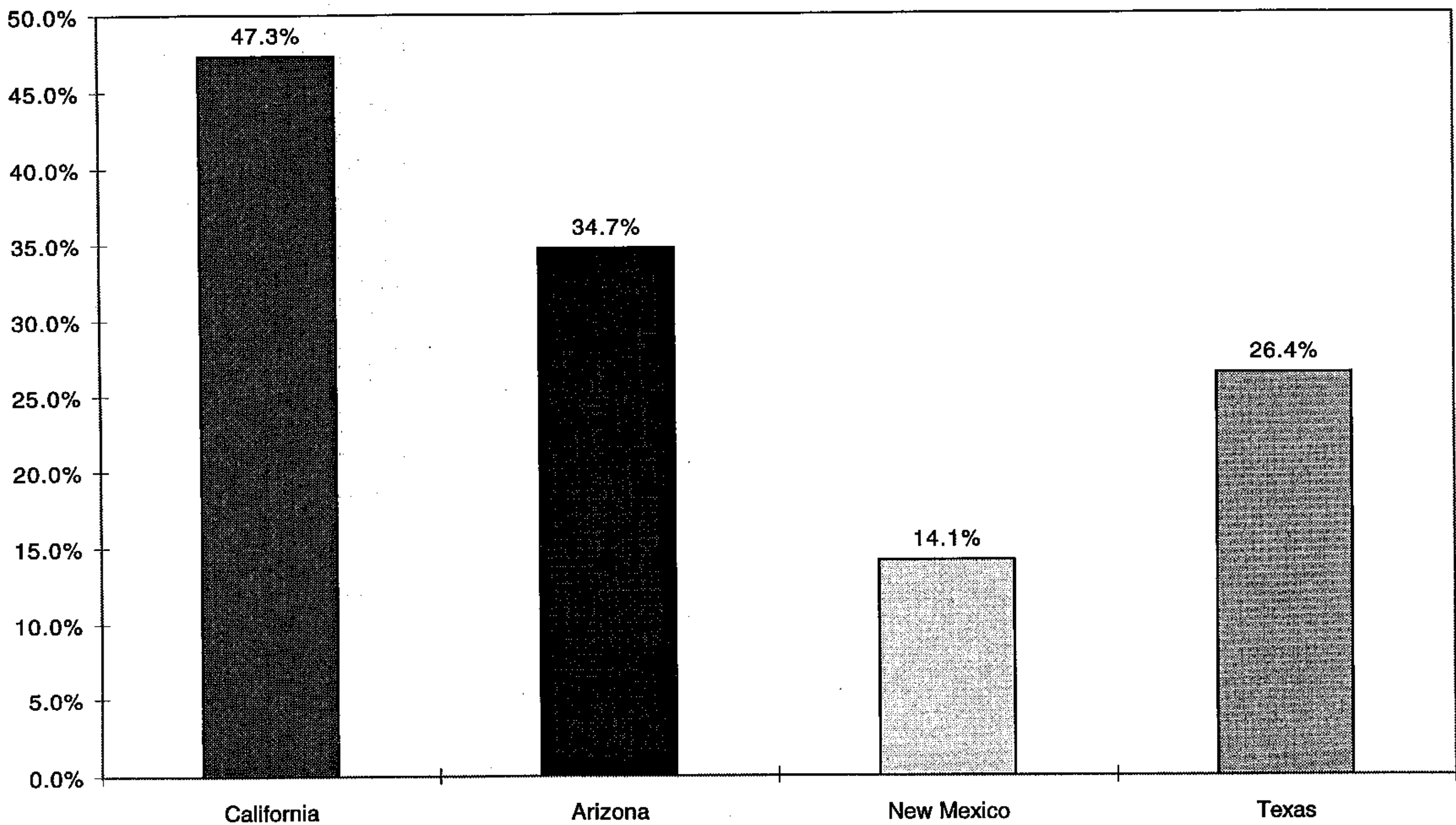


SOURCE: 1994 CURRENT POPULATION SURVEY

CENTER FOR THE STUDY OF LATINO HEALTH, UCLA

FIGURE 6

IMMIGRANTS AS PERCENT OF STATE LATINO POPULATION, 1990



SOURCE: 1994 CURRENT POPULATION SURVEY

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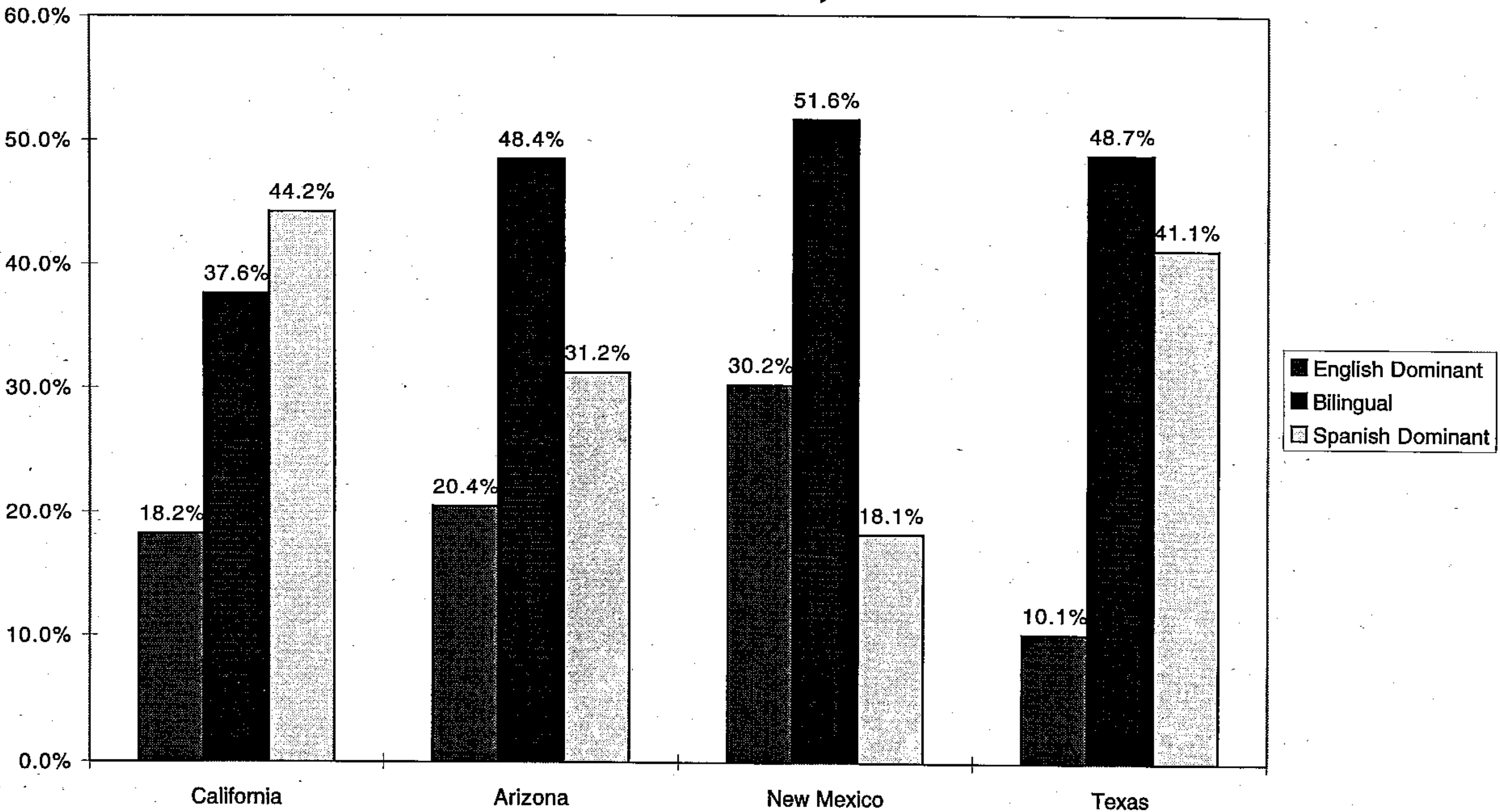
FIGURE 7

LATINO BORDER STATE LANGUAGE PATTERNS, 1990



SOURCE: 1990 CENSUS STF 3A

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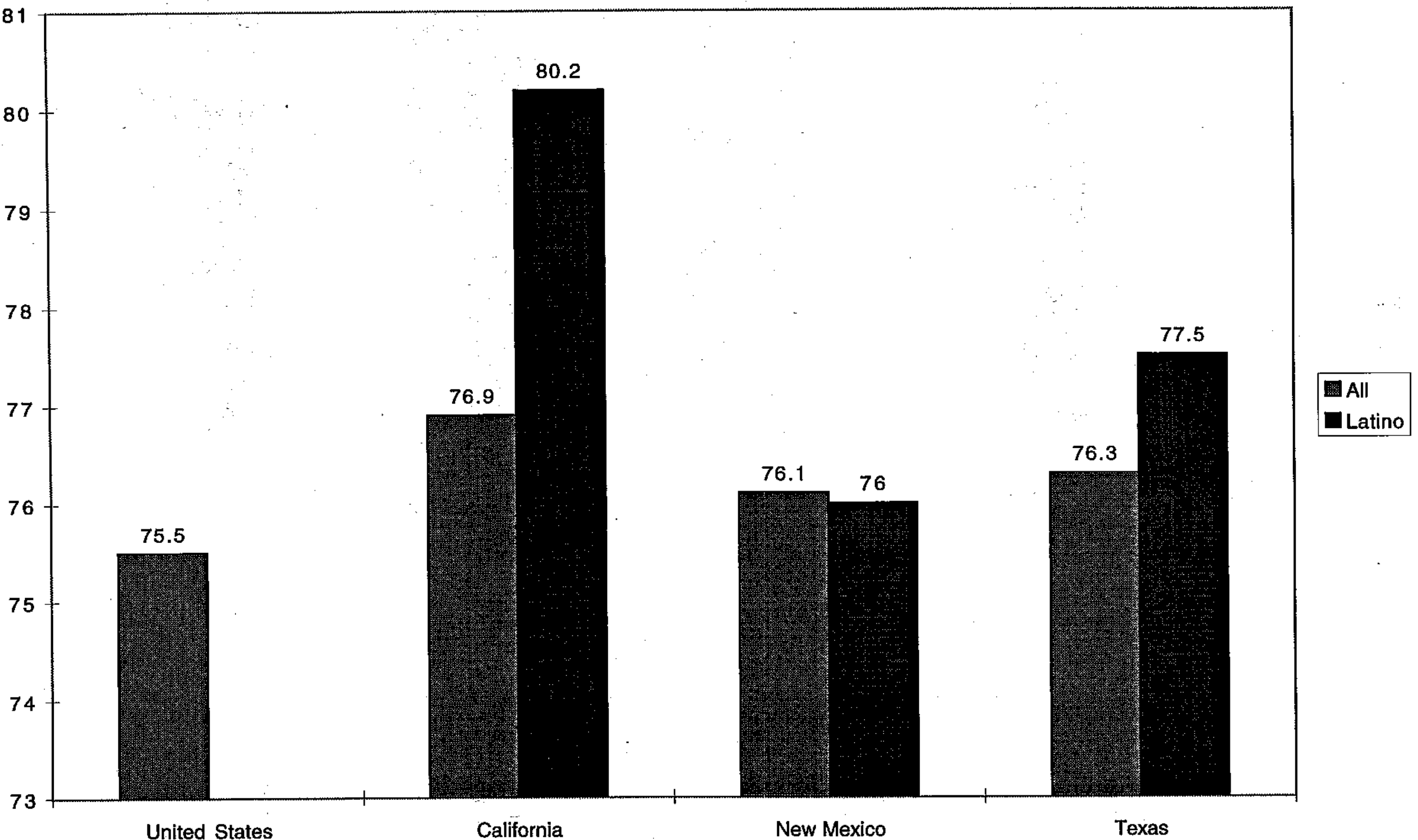
FIGURE 8

LIFE EXPECTANCY AT BIRTH, 1991

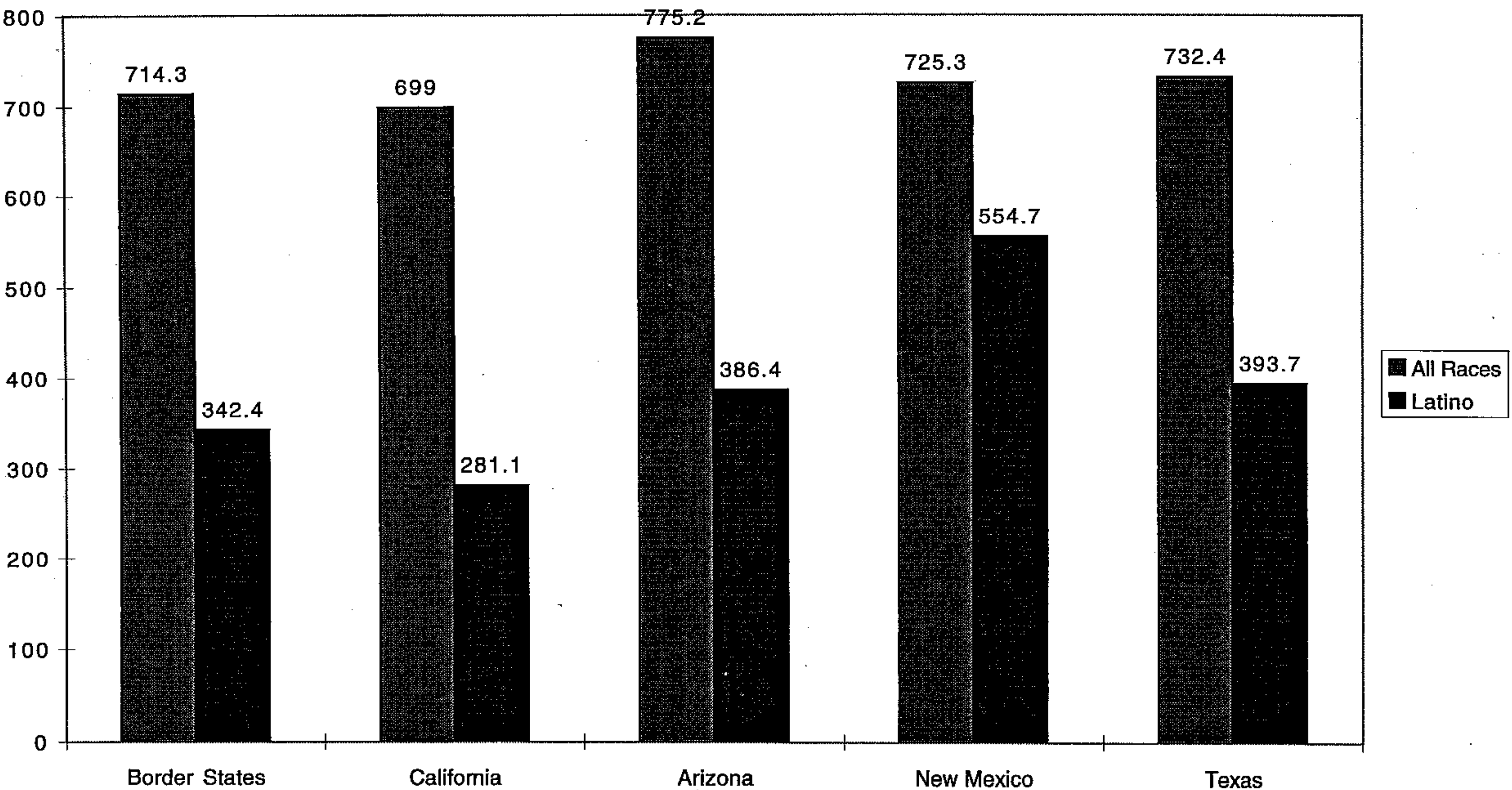


SOURCE: 1995 The Interamerica Institute for Border Health and Environment

CENTER FOR THE STUDY OF LATINO HEALTH, UCLA

FIGURE 9

STATE CRUDE DEATH RATES, ALL RACES AND LATINO, 1991

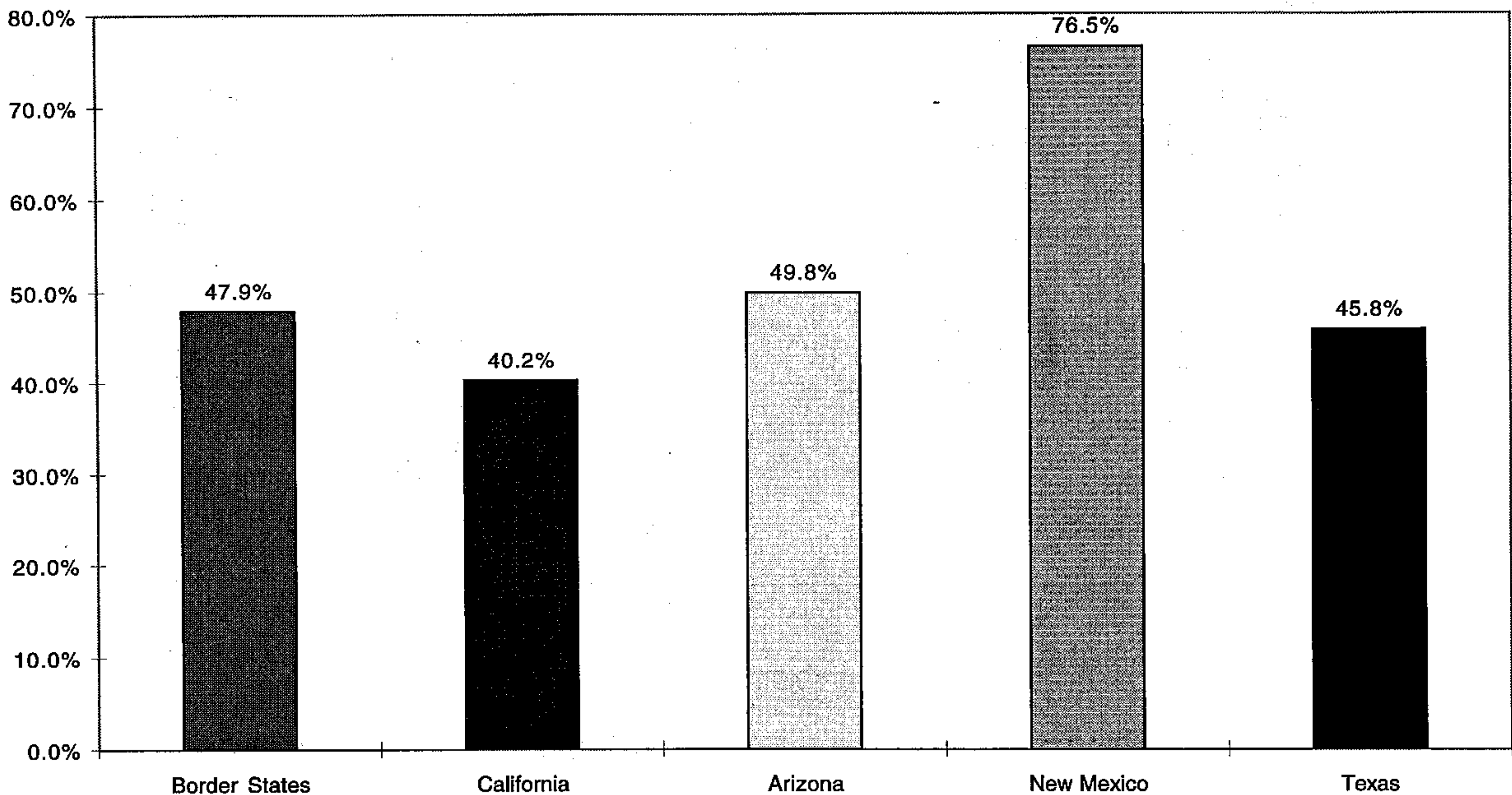


SOURCE: 1995 The Interamerica Institute for Border Health Environment

CENTER FOR THE STUDY OF LATINO HEALTH, UCLA

FIGURE 10

LATINO MORTALITY RATE AS PERCENT OF STATE ALL RACE MORTALITY RATE, 1991

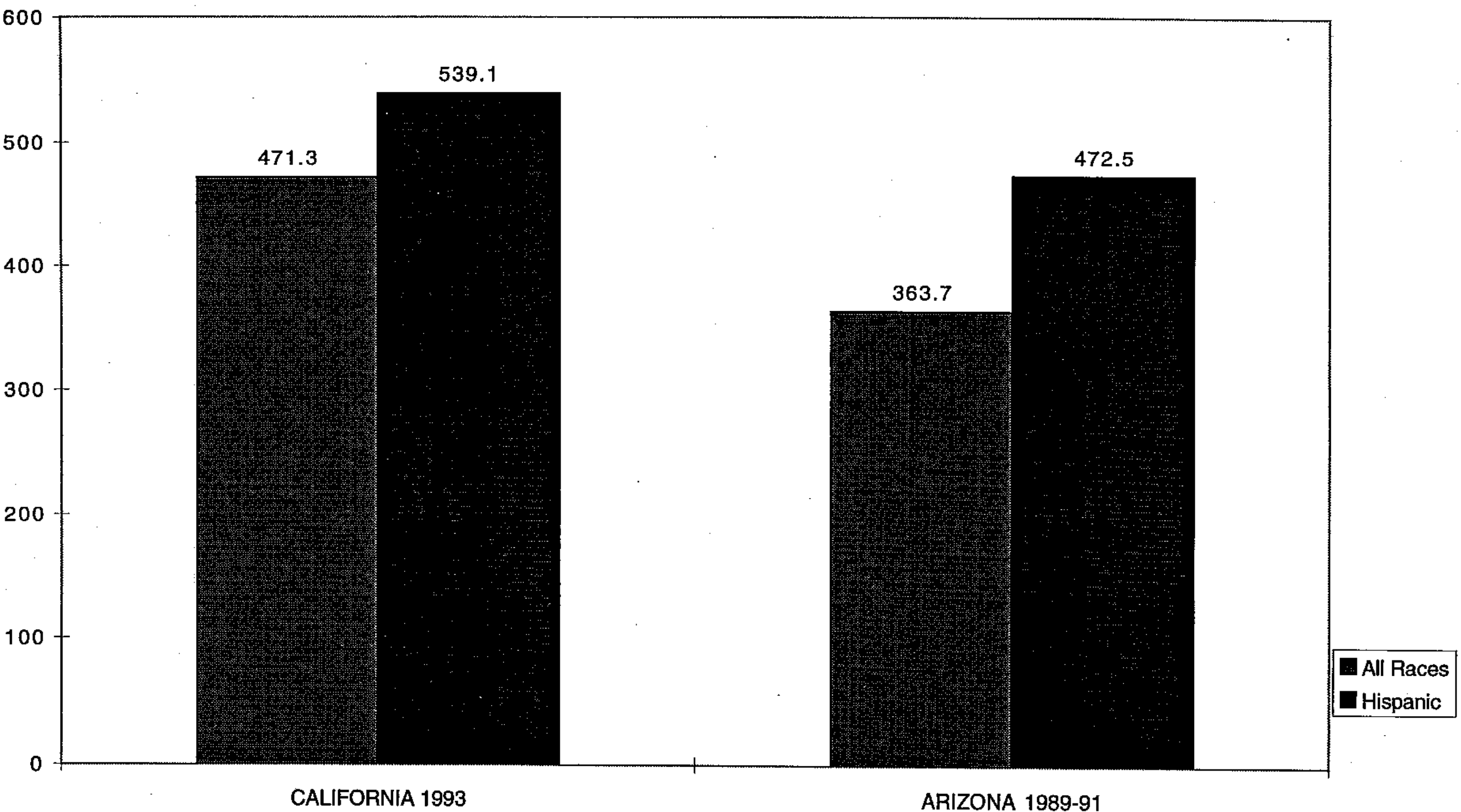


SOURCE: 1995 The Interamerica Institute for Border Health and Environment

CENTER FOR THE STUDY OF LATINO HEALTH, UCLA

FIGURE 11

AGE ADJUSTED DEATH RATES, ALL RACE AND HISPANIC, CALIFORNIA AND ARIZONA



SOURCE: California Department of Health Services;
Arizona Department of Health Services

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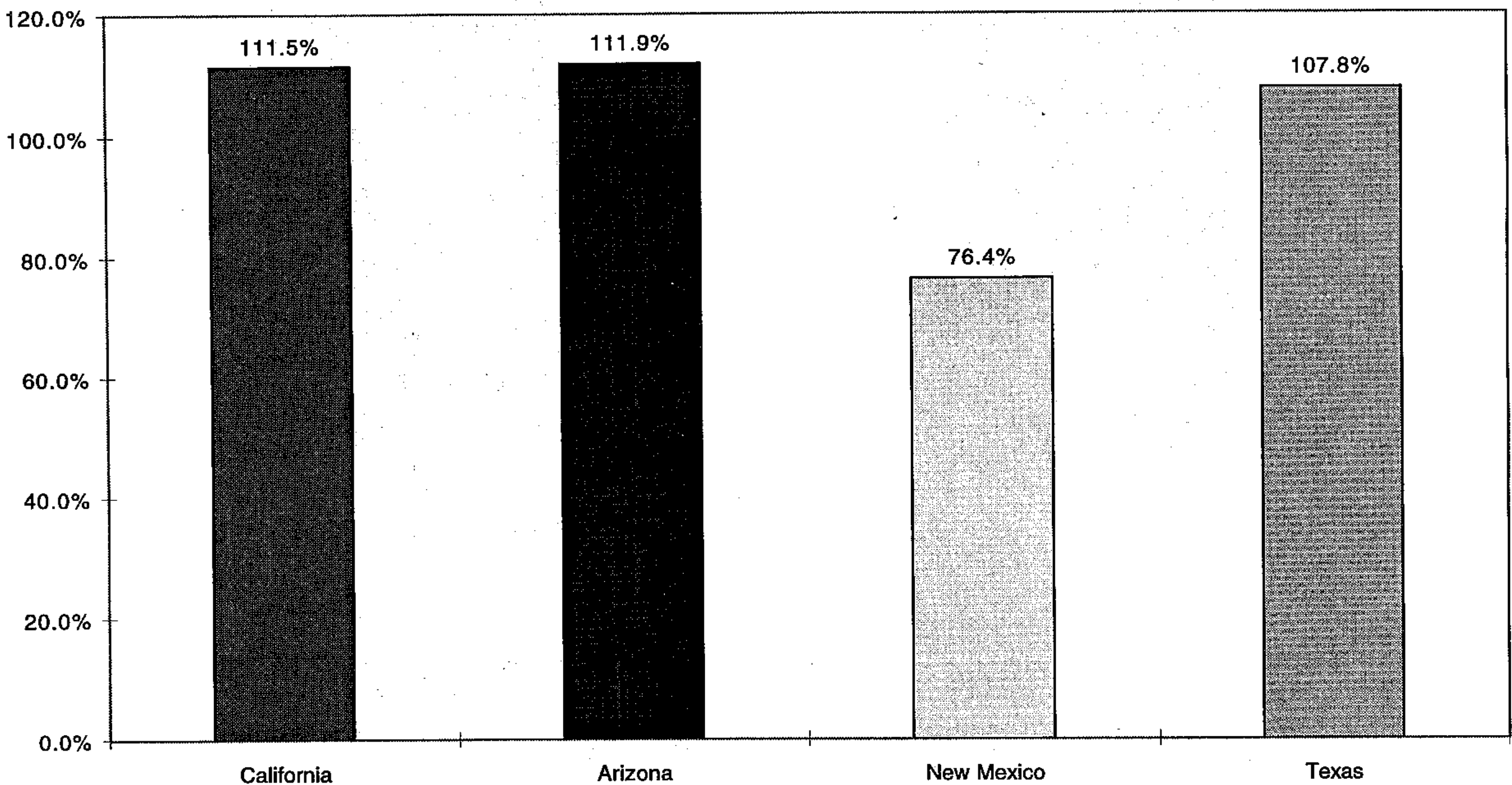
FIGURE 12

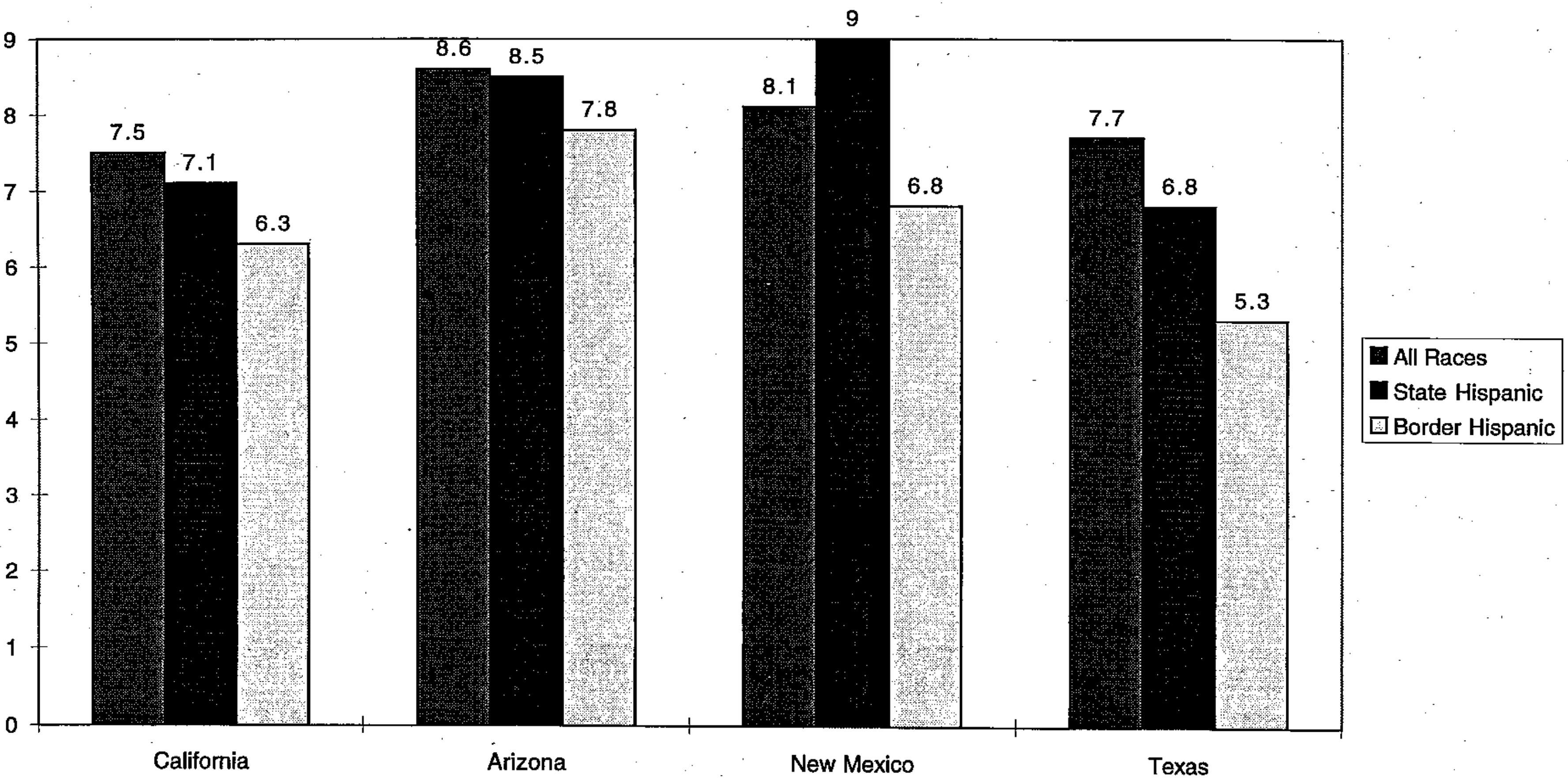
HISPANIC BORDER COUNTY MORTALITY RATE AS PERCENT OF STATE HISPANIC MORTALITY RATE, 1991



SOURCE, 1995 The Interamerica institute for Border Health and Environment

FIGURE 13

INFANT MORTALITY, STATE ALL RACES, STATE HISPANIC AND BORDER COUNTY HISPANIC, 1991



SOURCE: 1995 The Interamerica Institute for Border Health and Environment

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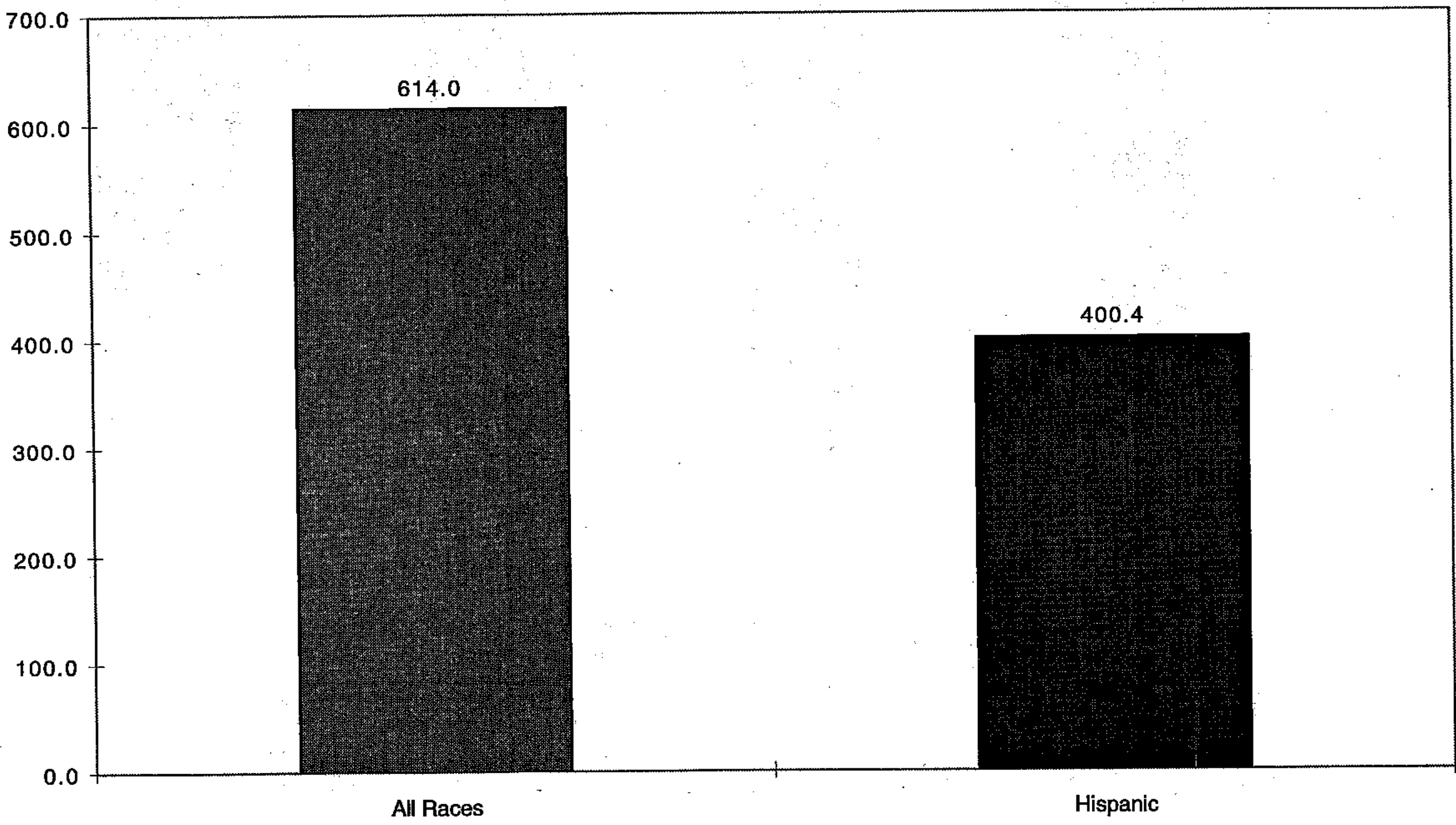
FIGURE 14

PATIENTS BED DAYS/1,000 PER YEAR, ALL RACES AND HISPANIC, CALIFORNIA 1993



SOURCE: HOSPITAL DISCHARGE MACHINE READABLE FILE

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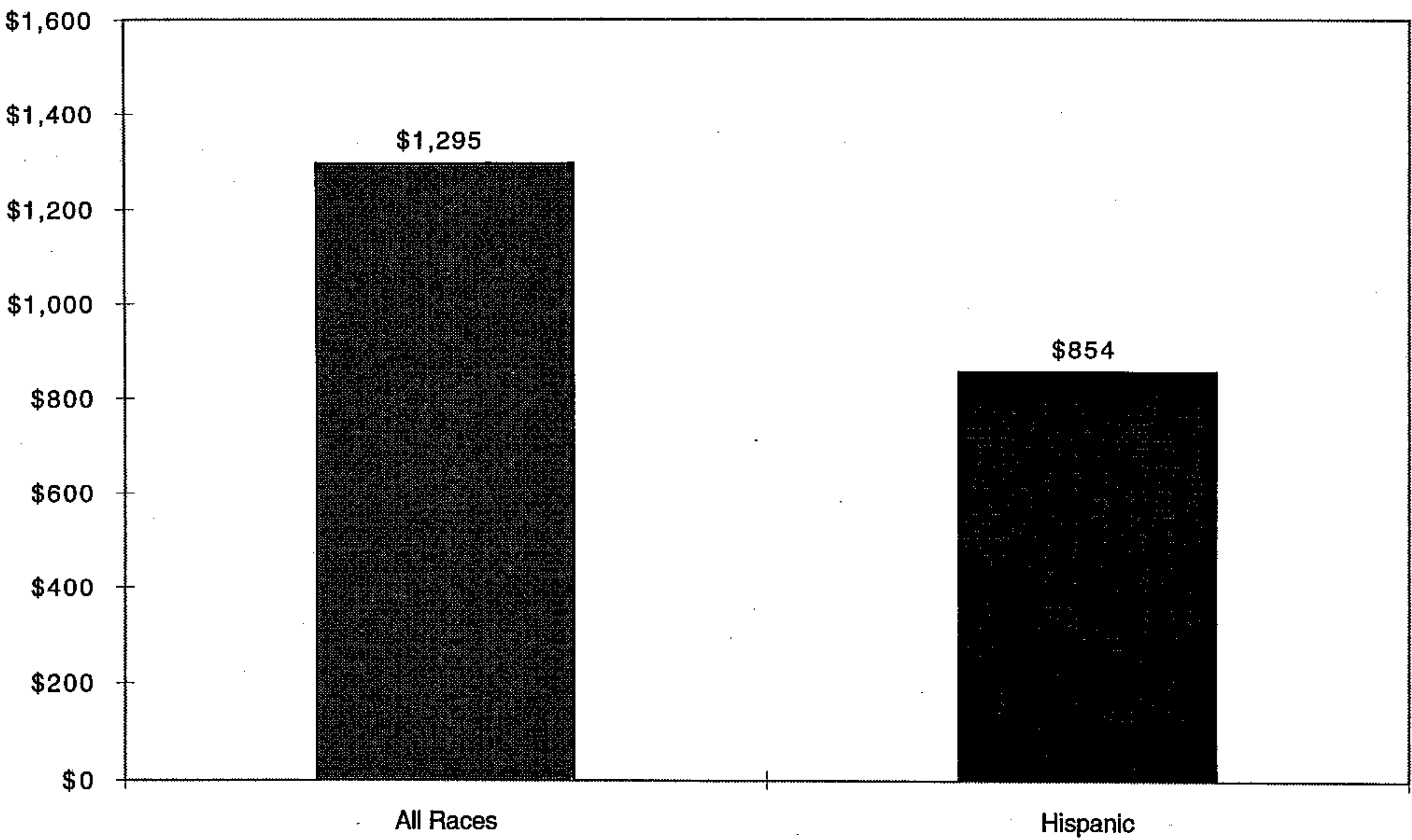
FIGURE 15

ANNUAL AVERAGE PER CAPITA HOSPITAL CHARGES, ALL RACES AND HISPANIC, CALIFORNIA 1993



SOURCE: HOSPITAL DISCHARGE MACHINE REDEABLE FILE

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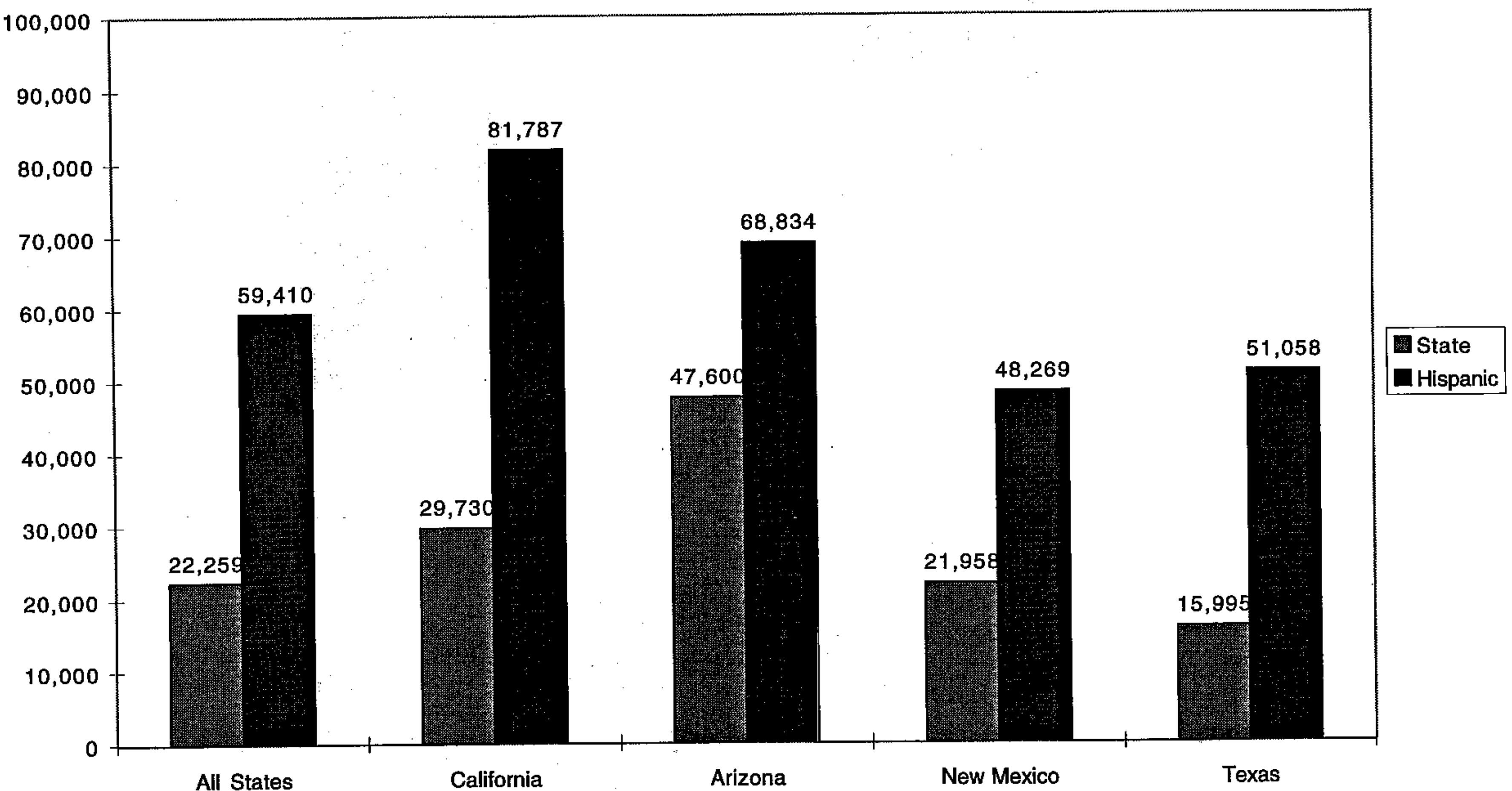
FIGURE 16

POPULATION PER MEDICAL SCHOOL GRADUATE, STATE AND HISPANIC, 1990



SOURCE: Association of American Medical Colleges

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