

# Race-Health Disparities File

## STATEMENT BY THE PRESIDENT

Today I am pleased to sign into law S. 1880, the "Minority Health and Health Disparities Research and Education Act of 2000." This Act will enhance biomedical and behavioral research on minority health and health disparities, support medical training for minorities and others, and improve the study and collection of data regarding minorities and other populations.

This important legislation builds on the work of my Administration, particularly the efforts of the Secretary of Health and Human Services (HHS), Donna Shalala, to develop a truly national commitment to end disparities in health through research, training, and data gathering. Under Secretary Shalala, HHS committed to eliminate disparities in health by race and ethnicity by the year 2010. This commitment will require additional research and new approaches, but in the process of addressing the health needs of our most vulnerable populations, we will improve the Nation's health care system for everyone. This Act was made possible through the bipartisan efforts of the Congress, a multiracial coalition of leaders in public health, business, education, and charitable foundations, and my Administration.

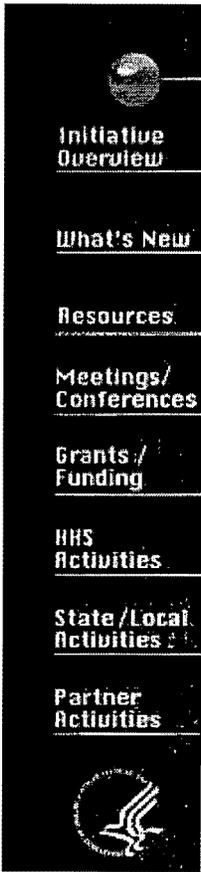
The Act creates a National Center on Minority Health and Health Disparities at the National Institutes of Health (NIH). This Center will fund research programs on health disparities and minority health; support training of members of health disparity populations as researchers; and provide education loan relief for health professionals who commit themselves to perform health disparities research. The Center will also coordinate all NIH research efforts in this area. The Center promises to help all Americans who bear the burden of health disparities regardless of their race, ethnicity, gender, socioeconomic status, or geographic location.

This legislation also authorizes the Agency for Healthcare Research and Quality to conduct and support activities and research to measure health disparities and identify causes and remedies. In addition, it authorizes the Health Resources and Services Administration to support research and demonstration projects to train health professionals on reducing health care disparities.

I would like to thank many individuals who helped develop and pass this landmark law, particularly Senators Kennedy, Frist, Jeffords, and Hatch, as well as Representatives Thompson, Lewis, Jackson, Jr., Watts, Norwood, Strickland, Brown, Bilirakis, Christensen, Towns, Rodriguez, Underwood, and Roybal-Allard. I also would like to acknowledge the diligent efforts of Secretary Shalala, David Satcher, the Surgeon General, Ruth Kirschstein, Principal Deputy Director of NIH, and the many others who worked tirelessly to bring this legislation forward.

The elimination of health disparities will require a comprehensive effort, involving both the Federal Government and the private sector. The Federal Government must continue to make measurable progress against diseases and conditions that are major contributors to health disparities, and our commitment to health disparities research must ensure that new knowledge generated benefits all of our citizens. We must also ensure that there is a diverse health care and research workforce in the future by making efforts to attract and train a generation of scientists and health care professionals who are prepared to dedicate themselves to helping eliminate health disparities.

## How Do We Reach The Goal?


 Initiative Overview

What's New

Resources

Meetings/  
ConferencesGrants /  
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ActivitiesState /Local  
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Activities

## GOAL 1 - Eliminate disparities in infant mortality rates.

Infant mortality is an important measure of a nation's health and a worldwide indicator of health status. Although infant mortality in the United States has declined steadily over the past several decades and is at a record low of 7.2 per 1,000 live births (1996 data), the United States still ranks 24th in infant mortality compared with other industrialized nations.

Infant mortality rates (IMR's) vary substantially among and within racial and ethnic groups. Infant death rates among blacks, American Indians and Alaska Natives, and Hispanics in 1995 or 1996 were all above the national average of 7.2 deaths per 1,000 live births. The greatest disparity exists for blacks, whose infant death rate (14.2 per 1,000 in 1996) is nearly  $2\frac{1}{2}$  times that of white infants (6.0 per 1,000 in 1996). The overall American Indian rate (9.0 per 1,000 live births in 1995) does not reflect the diversity among Indian communities, some of which have infant mortality rates approaching twice the national rate. Similarly, the overall Hispanic rate (7.6 per 1,000 live births in 1995) does not reflect the diversity among this group which had a rate of 8.9 per 1,000 live births among Puerto Ricans in 1995.

To achieve further reductions in infant mortality and morbidity, the public health community, health care providers, and individuals must focus on modifying the behaviors, lifestyles, and conditions that affect birth outcomes, such as smoking, substance abuse, poor nutrition, other psychosocial problems (e.g., stress, domestic violence), lack of prenatal care, medical problems, and chronic illness.

Women who receive prenatal care in the first trimester have better pregnancy outcomes than women who receive little or no prenatal care. For example, the likelihood of delivering a very low birthweight (VLBW) infant (less than 1,500 grams or 3 lb. 4 oz.) is 40 percent higher among women who receive late or no prenatal care compared with women entering prenatal care in the first trimester. Approximately 95 percent of VLBW infants are born preterm (less than 37 weeks gestation). The risk of early death for VLBW infants is about 65 times that of infants who weigh at least 1,500 grams.

In 1996, the proportion of pregnant women across the Nation receiving prenatal care in the first trimester reached 81.8 percent--a consistent improvement for the seventh consecutive year and up from 75.5 percent in 1989. Yet, one in five pregnant women, or three-quarters of a million women, still did *not* receive timely prenatal care; almost 47,000 women received *no* prenatal care at all. In addition, there are substantial racial disparities in the timely receipt of prenatal care. In 1996, 84

percent of white pregnant women, compared with approximately 71 percent of black and Hispanic pregnant women, received early prenatal care. Eliminating these disparities requires the removal of financial, educational, social, and logistical barriers to care.

Among the leading causes of death in infants, the racial and ethnic disparity (expressed as the ratio of the infant mortality rate for black infants to that for white infants, representing the greatest disparity) is greatest in the following: disorders relating to short gestation (preterm birth [PTB]) and unspecified low birthweight (4.1), respiratory distress syndrome (2.8), infections specific to the perinatal period and newborns affected by maternal complications of pregnancy (2.7), and sudden infant death syndrome (SIDS) (2.6). Overall, 13 percent of infants die from disorders relating to short gestation. A much higher incidence of PTB's occurs among black mothers than among white mothers (17.7 compared with 9.7 percent). Underlying factors, such as chronic hypertension and bacterial vaginosis, which have higher incidences among blacks, play a role in PTB's.

SIDS accounts for approximately 10 percent of all infant deaths in the first year of life. Minority populations are at greater risk for SIDS. In addition to the greater risk among blacks, the rates are three to four times as high for some American Indian and Alaska Native populations.

We will have a significant impact on infant mortality by increasing our efforts to address the racial disparities that exist in both PTB and SIDS rates. Racial and ethnic differences in PTB's and SIDS most likely reflect variations in the prevalence of risk factors, including socioeconomic and demographic factors, certain medical conditions, quality of and access to health care, and practices such as placing babies on their backs to sleep to prevent SIDS. We can work toward addressing all of these issues and measure their impact on reducing the rates of infant deaths due to PTB and SIDS.

### **Near-Term Goal**

Reduce infant mortality among blacks by at least 22 percent.

Our goal is to continue progress in reducing overall infant mortality rates and to eventually eliminate disparities among groups. As a major step toward that end, we have set a near-term goal to reduce infant mortality among blacks (the group with the greatest disparity in terms of infant death rates) by at least 22 percent from the 1996 rate by the year 2000--or from 14.2 per 1,000 to 11.0 per 1,000 live births. We also will work to reduce infant mortality rates among American Indian and Alaska Natives, and Puerto Ricans, whose rates also are above the national average. In addition, we will continue to monitor progress in reducing the SIDS rates for all



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## Diabetes Among Latinos

### What Is Diabetes?

Diabetes is a disease that affects the body's ability to produce or respond to insulin, a hormone that allows blood glucose (blood sugar) to enter the cells of the body and be used for energy. Diabetes falls into two main categories: type 1, which usually occurs during childhood or adolescence, and type 2, the most common form of the disease, usually occurring after age 45.

Diabetes is a chronic disease that **has no cure**.

### How Does It Affect Latinos?

#### Prevalence

- The prevalence of type 2 diabetes is **2 times higher** in Latinos than non-Latino whites.
- 1.2 million or 10.6% of all Mexican Americans have diabetes.
- Approximately **24%** of Mexican Americans in the United States and **25%** of Puerto Ricans between the ages of 45-74 have diabetes.
- Nearly **16%** of Cuban Americans in the United States between the ages of 45-74 have diabetes.

### Latinos and Diabetic Complications

- **Diabetic retinopathy is a term used for all abnormalities of the small blood vessels of the retina caused by diabetes, such as weakening of blood vessel walls or leakage from blood vessels. The prevalence of diabetic retinopathy in Mexican Americans is 32-40%.**
- Ten to twenty-one percent of all people with diabetes develop **kidney disease**. In 1995, 27,900 people initiated treatment for end stage renal disease (**kidney failure**) because of

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1 (800) 342-2383  
or e-mail us.

for **end stage renal disease (kidney failure)** because of diabetes. Among people with diabetes, Mexican Americans are **4.5 to 6.6 times more likely** to suffer from end stage renal disease.

**What Is Needed?**

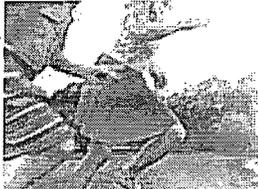
In ideal circumstances, Latinos with diabetes will have their disease under good control and be monitored frequently by a health care team knowledgeable in the care of diabetes.

- **Patient education is critical.** People with diabetes can reduce their risk for complications if they are educated about their disease, learn and practice the skills necessary to better control their blood glucose levels, and receive regular checkups from their health care team.
- People with diabetes, with the help of their health care providers, should **set goals for better control of blood glucose levels, as close to the normal range as is possible for them.**
- **Health care team education is vital.** Because people with diabetes have a multi-system chronic disease, they are best monitored and managed by highly skilled health care professionals trained with the latest information on diabetes to help ensure early detection and appropriate treatment of the serious complications of the disease. A team approach to treating and monitoring this disease serves the best interests of the patient.

For more information, contact the  
American Diabetes Association

at 1-800-DIABETES

or visit our website at [www.diabetes.org](http://www.diabetes.org)



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 or by E-mail

## African Americans

**The Population:** The US census refers to African Americans as blacks and defines them as "persons whose lineage includes ancestors who originated from any of the black racial groups of Africa." The majority of African Americans are descendants of slaves who were transported from Africa to the US and the Caribbean during the 17th through the 19th centuries. However, an increasing proportion of this population is comprised of either new immigrants or their first or second generation descendants. African Americans comprise the second largest racial group in the US. According to the 1990 census, there are approximately 30 million African Americans in the US, accounting for about 12% of the population.

**Cancer Incidence:** The leading cancer sites for African-American men during 1988-1992 were prostate, lung, colon and rectum, oral cavity, and stomach. African-American men have a higher overall cancer incidence rate than any other racial or ethnic group in the US. They also have higher incidence rates for cancers of the prostate, lung, and oral cavity than those for other groups.

The leading cancer sites for African-American women include breast, colon and rectum, lung, corpus uteri, and cervix uteri. Rates for cancers of the lung, and colon and rectum are higher among African-American women than among women of any racial or ethnic group other than Alaska Natives.

**Risk Factors, Screening, and Access to Health Care:** Obesity is a major health problem for African-American men and women. According to data from the Behavioral Risk Factor Surveillance System, 37.7% of African-American women and 28.4% of African-American men are overweight. African-American women are more likely to be overweight than women of other races or ethnicities.

High smoking rates and low participation in breast screening exams are also major contributing factors to health problems among African Americans. According to the most recent data, 33.9% of African-American men and 21.8% of African-American women report that they currently smoke. Only 54.9% of African-American women over 50 report having had a mammogram and a clinical breast exam within the previous two years.

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**Minority Health and Health Disparities Research and Education Act of 2000 (S1880)**

\$ in millions

<b>Agency</b>	<b>Program</b>	<b>2001 Budget</b>	<b>2001 Conference</b>	<b>Explanation</b>
NIH	Center for Minority Health & Health Disparities	\$31	\$36	Budget & Conference provide funding for Office of Research on Minority Health – forerunner to new Center
	Centers of Excellence for Research Education & Training	0	0	New activity
	Extramural Loan Repayment for Minority Health Researchers	0	0	New activity; NIH has similar repayment programs on Intramural side (\$4M in '00)
AHRQ	Health Disparities Research	42.5	42.5	Funded within existing AHRQ activities. Conference level not available; AHRQ's total funding above Budget, suggesting funding for minority health research will likely be close to Budget
OS	National Academy Study on HHS' Minority Data Collections	0	0	New activity
	Education Campaign on Minority Health & Health Disparities	0	0	New activity
HRSA	Health Professions Education Grants	0	0	New activity

NOTE: The lack of funding in the Labor/HHS Conference bill for some of the new activities authorized in S1880 is due, in part, to the fact that S1880 was passed late in the session after much of the deliberations on L/HHS funding had concluded.

## **PARTICIPANTS IN HEALTH CARE FAIRNESS ACT SIGNING**

### **HHS: 3 [CABINET AFFAIRS WILL HAVE A FINAL LIST IN THE AM]**

1. Dr. David Satcher, Surgeon General (T)
2. Helen Mathis, Deputy Assistant Secretary for Legislation (T)
3. Dr. Ruth Kirschstein, NIH (T) or John Ruffin, Assoc. Dir., Office on Minority Health (T)

### **Members of Congress: 2**

4. Rep. Robert Underwood (D-GU)
5. Rep. Bennie Thompson (D-MS)

### **OPL: 13**

6. Ronny B. Lancaster, MBA, JD, President, Association of Minority Health Professions Schools
7. Louis W. Sullivan, MD, President, Morehouse School of Medicine
8. John E. Maupin, DDS, MBA, Board Member, Minority Health Professions Foundation
9. Frank Royal, MD, Chair, Meharry Medical College
10. Louis Stokes, former Member of Congress, Ohio
11. Rodney Hood, MD, President, National Medical Association
12. Susan Shinagawa, Chair, Intercultural Cancer Council
13. Elena Rios, MD, MSPH, President, National Hispanic Medical Association
14. Laura Williams, MD, Board Member, Association of American Indian Physicians
15. Beny Primm, MD, Executive Director, National Minority AIDS Council
16. Ruth Perot, Executive Director, Summit Health Institute
17. Raymond Fowler, MD, CEO, American Psychological Association
18. Fredette D. West, President, Network Associates

## HEALTH CARE FAIRNESS ACT OF 1999

### TITLE I: IMPROVING MINORITY HEALTH THROUGH THE NATIONAL INSTITUTES OF HEALTH

**New center on Minority Health and Health Disparities.** The Health Care Fairness Act authorizes \$100 million to create the Center for Research on Minority Health and Health Disparities. This center will develop a comprehensive plan for minority health research that should be conducted or supported by NIH; establish a minority health research information system to track minority-related research, training, and construction; and fund innovative projects that address high priority areas of minority health research.

**Expanding biomedical research education for minorities.** This legislation authorizes grants to designated biomedical research institutions and other public and nonprofit health or educational entities to support programs of excellence in biomedical research education for under-represented minority individuals.

**Creates a new loan repayment program for minority health researchers.** This legislation allows HHS to contract with qualified health professionals who, in return for an annual payment of up to \$35,000 towards their educational loans, agree to engage in minority health research or research into the nature of health disparities that affect racial, ethnic, and indigenous populations.

### TITLE II: MEDICAL EDUCATION

**Developing courses of study designed to reduce health care disparities.** Authorizes the Secretary to fund a maximum of 20 public and private nonprofit research and demonstration projects developing curricula to reduce disparity in health care outcomes and improve cultural competency in graduate and undergraduate health professions education.

**Conference on continuing medical education as a tool to reduce health care disparities.** This legislation instructs HHS to convene a national conference on continuing health professions education as a method for reducing health care disparity, including continuing medical education on cultural competency.

**Creates information clearinghouse on racial health care disparities curricula.** This legislation requires the Director of the Office of Minority Health within HHS to establish of, an information clearinghouse for curricula to reduce racial and ethnic health care disparity.

TITLE III: MINORITY HEALTH RESEARCH BY THE AGENCY FOR HEALTH CARE POLICY AND RESEARCH

**New research on eliminating racial health care disparities.** This legislation directs the Administrator of the Agency for Health Care Policy and Research to: (1) conduct and support research for improving the quality and outcomes of health care services for minority populations and the causes of such health care disparities; (2) identify, test, and evaluate strategies for eliminating such disparities; and (3) increase the number of minority health care researchers and health services research capacity of institutions that train minority health care researchers.

TITLE IV: DATA COLLECTION RELATING TO RACE OR ETHNICITY

**New NAS database on race and health.** This legislation directs HHS to contract with the National Academy of Sciences to conduct a comprehensive study of HHS data collection systems and practices relating to the collection of data on race or ethnicity, including other Federal data collection systems with which HHS interacts.

TITLE V: PUBLIC AWARENESS

**New national media campaign.** This legislation directs the Secretary to conduct a national media campaign for informing the public about racial and ethnic health care disparities.

**PRESIDENT CLINTON DECLARES HIV/AIDS IN RACIAL AND ETHNIC MINORITY COMMUNITIES TO BE A "SEVERE AND ONGOING HEALTH CARE CRISIS" AND UNVEILS NEW INITIATIVE TO ADDRESS THIS PROBLEM**

*October 28, 1998*

Today, the President will declare HIV/AIDS in racial and ethnic minority communities to be a "severe and ongoing health care crisis" and will unveil a series of initiatives that invest \$156 million to address this urgent problem. Citing the chronic and overwhelmingly disproportionate burden of HIV/AIDS on minorities, the President will outline a new comprehensive initiative that includes unprecedented efforts to improve the nation's effectiveness in preventing and treating HIV/AIDS in the African-American and Hispanic communities. The President will also highlight other important increases to fight HIV/AIDS in the budget as well as new funding for his initiative to address racial health disparities for a range of diseases, including HIV/AIDS.

**HIV/AIDS in the minority community is a "severe and ongoing health care crisis."** While overall AIDS deaths have declined for two years in a row, AIDS remains the leading killer of African American men age 25-44 and the second leading killer of African American women in the same age group. African Americans comprise more than 40 percent of all new HIV/AIDS cases, and African-American women make up 60 percent of female cases. Hispanics represent over 20 percent of new HIV/AIDS cases and only about 10 percent of the population. This is also a critical concern in Asian American communities, as well as Native American communities, where many are high risk and hard to reach.

**Historic initiatives invest \$156 million for HIV/AIDS prevention and treatment in the minority community.** During the recent budget negotiations, the Clinton Administration and the Congressional Black Caucus fought successfully to secure a major commitment of funds to address the urgent problem of HIV/AIDS among minorities through new prevention efforts, improved access to HIV/AIDS drug treatments, and training for health professionals who treat this disease. Over two-thirds of this funding is from new resources appropriated through the Omnibus Appropriations Act. The rest will be dedicated from the Department of Health and Human Services' budget.

-- **Crisis response teams.** HHS will make available Crisis Response Teams to a number of highly affected areas. These teams of public health and HIV prevention and treatment experts, doctors, nurses, and epidemiologists -- from a range of agencies including the Substance Abuse and Mental Health Services Administration, the Health Resources and Services Administration, the Centers for Disease Control and Prevention -- will help assess existing prevention and treatment services for racial and ethnic minorities and develop innovative, effective strategies that best meet the needs of these communities. This effort will take place within a period of several weeks after a request for a crisis response team is received.

-- **Enhanced HIV/AIDS prevention efforts in racial and ethnic minority communities.** These funds will be used for HIV prevention purposes at the Centers for Disease Control such as grants for minority, community-based organizations to work with local health clinics, make testing and counseling available, conduct community workshops, and develop HIV and substance abuse prevention programs on the campuses of Historically Black Colleges and Universities and in institutions of higher learning that predominantly serve Hispanics. The funding also will help provide comprehensive substance abuse treatment programs for African American and Hispanic women with or at risk for HIV/AIDS and their children.

- **Reducing disparities in treatment and health outcomes for minorities with HIV/AIDS.** Studies show that African Americans and Hispanics are much less likely to receive treatments that meet federally recommended treatment guidelines. This new funding, which supplements the already large increase in the Ryan White program, will help minorities get access to cutting-edge HIV/AIDS drug treatments as well as the range of primary health services needed to treat this disease. Funds also will be used to educate health care providers who treat largely minority populations on treatment guidelines for HIV/AIDS.

**Unprecedented Increases in Effective HIV/AIDS Treatment, Prevention, and Research Programs.** Substantial and critical funding increases in a wide range of effective HIV/AIDS programs, include:

- **An historic \$262 million increase in the Ryan White Care Act,** which provides primary HIV health care services, treatments, and training for health care professionals on HIV treatment guidelines. The treatment funding in this investment includes a more than 60 percent increase for the AIDS drug assistance program that provides protease inhibitors and other life-saving HIV/AIDS treatments to those who cannot afford the cost, which can run as high as \$20,000 a year.
- **A 12 percent increase for HIV/AIDS research at NIH.** In FY 1999, research on HIV/AIDS at the National Institutes of Health (NIH) will total \$1.8 billion, a 12 percent increase. This increase will enhance both basic research to further our understanding of the HIV virus as well as applied research that includes clinical testing of new HIV/AIDS pharmacological therapies.

**A Commitment to Eliminate Racial Health Disparities.** Minorities suffer from a number of critical diseases, including HIV/AIDS, at higher rates than white Americans. Hispanics are more than four times as likely to get HIV/AIDS than whites, while African Americans are more than eight times as likely. The Congress has taken a first step in investing in the President's proposal to address racial health disparities by funding \$65 million of this initiative. Congress partially funded the proposed grants for communities to develop new strategies to address these disparities and for increases in other critical public health programs, such as heart disease and diabetes prevention at CDC, that have shown promise in attacking these disparities.

**Calling on Congress to Pass an Unfinished Agenda for People With HIV/AIDS.**

- **A Patients' Bill of Rights.** The President and Vice President have repeatedly urged the Congress to pass a strong, enforceable Patients' Bill of Rights that contains critical protections for people with HIV/AIDS, including access to specialists and continuity of care to prevent abrupt changes in critical treatment when an employer changes health plans.
- **A Work Incentives Bill for People with Disabilities.** Congress also failed to pass the bipartisan Jeffords-Kennedy bill that would have enabled people with disabilities and other disabling conditions, such as HIV/AIDS, to return or to remain at work by expanding options to buy into Medicaid and Medicare and by offering other pro-work initiatives. This bill was on the list of top Administration priorities in the final budget negotiations.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

*Race & Health File*

Date: *4/29/98*

**FACSIMILE**

**PLEASE NOTIFY OR HAND-CARRY THIS TRANSMISSION TO THE FOLLOWING PERSON AS SOON AS POSSIBLE:**

Name(s): *CHRIS JENNINGS*

Department: \_\_\_\_\_

Phone#: \_\_\_\_\_

Fax#: \_\_\_\_\_

FROM: *Tom Hertz for Gary Clayton*

*Assistant Secretary for Planning & Evaluation*

FAX NUMBER (202) 401-7321

Number of pages being transmitted (including fax sheet): *8*

COMMENTS: *This is the list of names Gary told you about - approx. 30 names. Also 9 names of foundation people suggested by Grantmakers in Health. We were planning on shortening the lists to a total of approx. 20 people in addition to the Federal and Grantmakers staff. Grantmakers is handling the logistics for the meeting and will arrange for the invitations, the meeting site, etc. The meeting is scheduled for May 28, from 10:00 am - 3:00 pm.*

[RWJ]

Suggested advisory panel members from the grantmaking community:

- Karen Scott Collins, Commonwealth Fund →
- Calvin Freeman, California Endowment →
- Sandra Hernandez, San Francisco Foundation →
- Stewart Kwoh, California Wellness Foundation (trustee) →
- Terri Langston, Public Welfare Foundation →
- Len McNally, New York Community Trust →
- Ann Pauli, Paso del Norte Health Foundation →
- Diane Rowland, Kaiser Family Foundation →
- Gloria Smith, Kellogg Foundation →

RW

Leni - Steans

\*-Recommended by OMH (15)  
WH-Invited to White House for Initiative Roll-out.

**Recommended Organizations to Invite to "Grantmakers" Planning Sessions**

Black/African American

Ronnie Lancaster, President or Dale Dirks  
Association of Minority Health Professions Schools  
507 Capitol Court, NE Ste 200  
Washington, DC  
202-544-7499

*Organization that represents 11 minority health professionals schools in the US*

\* Rev. Sullivan Robinson, Interim Executive Director  
Congress of National Black Churches, Inc.  
1225 I Street, NW Ste 750  
Washington, DC  
202-371-1092

*Voluntary nonprofit Christian coalition of 6 major historically Black denominations*

WH

Millicent Gorham (Executive Director) or Anna McClain  
National Black Nurses Association  
1511 K St., Ste 415  
Washington, D.C.  
202-393-6870

*National nursing body regarding issues that affects Blacks*

Ethyl Bothwell, Executive Director  
The Links Inc.  
1200 Massachusetts Ave.  
Washington, D.C. 20005  
202-842-8686

*African American women's service organization with more than 10,000 members in the US, Caribbean and Europe*

WH

Dr. Harold Freeman  
Chair, President's Cancer panel  
Harlem Hospital Center  
506 Lenox Ave., Rm 11-103  
New York, NY 10037  
212-939-3533

*Three member Presidentially appointed advisory committee charged with examining barriers and making recommendations to the President on issues affecting the national cancer program.*

WH Dr. Lorraine Cole, Ph.D., Executive Director  
National Medical Association  
1012 10th St., N.W.  
Washington, D.C. 20001  
202-347-1895  
*Founded in 1895, professional organization representing 16,000 Black physicians in the US and territories*

WH Tyle Herrell, Executive Director  
National Black Women's Health Project  
1111 14th St., NW Ste 1001  
Washington, D.C. 20005  
202-898-16  
*Health advocacy organization committed to improving health status of Black women*

Henry Ponder, Ph.D., CEO and President  
National Association for Equal Opportunity in Higher Education (NAFEO)  
8701 Georgia Ave., Ste 200  
Silver Spring, MD 20910  
301-650-2440  
*Voluntary, independent organization of HBCUs*

WH Hugh Price (Executive Director) or Lisa Bland-Malone  
National Urban League  
1111 14th St., N.W. Ste 10001  
Washington, D.C. 20005  
202-898-1604  
*National service and civil rights organization advocating equal opportunities for Blacks and other minorities*

WH \* Ruth Perot, Executive Director  
Summit Health Coalition  
1424 K. Street NW, Suite 500  
Washington DC 20005  
202-371-0277  
*Largest network of primary African-American organizations focusing on health policy issues*

\* Dr. Bailus Walker, Health Director  
Joint Center for Political and Economic Studies  
1090 Vermont Ave., N.W. Ste 1100  
Washington, D.C. 20005-4961  
202-806-2697  
*National nonpartisan research and policy institution*

WH \* Kweisi Mfume (Executive Director) or Caya Lewis (Health Coordinator)  
 NAACP  
 4805 Mt. Hope Drive  
 Baltimore, MD 21215  
 410-358-8900  
*National organization that advocates for the civil rights of Blacks*

American Indian/Alaska Native

\* Joann Chase, Executive Director  
 National Congress of American Indians  
 2010 Massachusetts Ave., NW 2nd Floor  
 Washington, D.C. 20036  
 202-466-7767  
*Oldest, largest and most representative Native American organization*

WH Lorraine Edmo, Executive Director  
 National Indian Education Association  
 121 Oronoco St.  
 Alexandria, VA 22314  
 703-838-2870  
*National voice for the improvement of education for American Indians and Alaska Natives*

WH \* Buford Rolin, Chairman  
 National Indian Health Board  
 1385 S. Colorado Blvd., Ste A-707  
 Denver, CO 80222  
 303-759-3075  
*Leading nonprofit organization addressing Tribal Health Issues*

\* Margaret Knight, Executive Director  
 Association of American Indian Physicians, Inc.  
 1235 Sovereign Row, Ste. C-9  
 Oklahoma City, OK 73108  
 405-946-7072  
*National Network of American Indian MDs*

Hispanic/Latino

\* Ronald Blackburn-Moreno (National Executive Director) or Hilda Crespo  
 ASPIRA  
 1444 Eye St., NW Ste 800  
 Washington, DC 20005

202-835-3600

*National nonprofit organization serving Puerto Rican and other Latino youth*

Dr. Antonia Villarruel (Executive Director) or Rose Gonzalez

National Association of Hispanic Nurses

1501 16th St., NW

Washington, DC 20036

202-387-2477

*Association serving nursing related needs of Hispanics and professional needs of Hispanic nurses*

Dr. Antonio Flores (President), Roger Campos

Hispanic Association of Colleges and Universities

1 Dupont Circle, NW Ste 230

Washington, D.C. 20036

202-833-8361

*National organization representing accredited colleges and universities with 25% or more Hispanic enrollment*

Jeannette Noltenius, Ph.D.

Executive Director

Latino Council on Alcohol and Tobacco

1015 15th Street NW, Suite 409

Washington DC 20005

202-371-1186

202-371-0243 (FAX)

*National nonprofit organization dedicated to prevention efforts that will reducing the harm caused by alcohol and tobacco in the Latino community*

Rebecca Barrera (President) or Josephine F. Garza

National Latino Children's Institute

1412 West 6th St.

Austin, TX 78703-5139

512-472-9971

*National nonprofit organization that serves as the voice for Latino children's issues (e.g., education, housing, health care, child care, environment).*

\* Dr. Jane Delgado (Executive Director) or Caroline Quijada (Senior Policy Advisor)

COSSMHO

1501 16th St., NW

Washington, D.C. 20036

202-797-4343

*National organization focusing on health and human service needs of Hispanics in the US*

WH

\* Raul Yzaguirre, President  
 National Council of La Raza (NCLR)  
 1111 19th St., NW Ste 1000  
 Washington, D.C. 20036  
 202-785-1670  
*National advocacy organization for Hispanic Americans*

WH

\* Asian/Pacific Islander  
 Stephen Jiang (Executive Director) or Jean Lau Chin  
 Association of Asian Pacific Community Health Organizations  
 1440 Broadway, Ste 510  
 Oakland, CA 94612  
 510-272-9536  
*National network of community health centers serving Asian Americans and Pacific Islanders*

\* Ford Kuramoto DSW (Executive Director) or Emile Gaborne-Dearing  
 National Asian Pacific American Families Against Substance Abuse (NAPAFASA)  
 300 West Seizer Chales Ave. Ste B  
 Los Angeles, CA 90012-2818  
 213-625-5795  
*Organization committed to eliminating alcohol and drug abuse amongst Asian Americans and Pacific Islanders*

WH

\* Tessie Guillermo (Executive Director) or Dong Suh  
 Asian and Pacific Islander American Health Forum, Inc.  
 942 Market St., 2nd Floor  
 San Francisco, CA 94102  
 415-954-9988; 703-841-9128 (Dong Suh)  
*National coalition of health professionals and groups seeking to promote improved health status for Asian Americans and Pacific Islanders*

Cross-Cutting Organization

\* Paul Akió Kawata, Executive Director  
 National Minority AIDS Council  
 1931 13<sup>th</sup> Street, NW  
 Washington, DC 20009-4432  
 202-483-6622, 202-483-135 fax  
*Works to provide organizations offering AIDS-related services to people of color with the*

*information, resources and technical assistance necessary for a more coordinated and effective response.*

Lovell A. Jones, Ph.D. or Armin D. Weinberg, Ph.D.

Co-Chairs

Intercultural Cancer Council

1720 Dryden Court, Suite C

Houston, TX 77030

*Organization that develops and promotes policies and programs to redress the imbalance of cancer incidence and survival rates among racial and ethnic minorities.*

Society for Advancement of Chicanos and Native Americans in Science (SACNAS)

[No name of individual as yet.]

1156 High Street

Santa Cruz, CA 95064

*SACNAS encourages Chicano/Latino and Native American students to pursue graduate education and obtain the advanced degrees necessary for research careers and science teaching professions at all levels.*

Wade Henderson

Executive Director

Leadership Conference on Civil Rights

1629 K Street NW, Suite 1010

Washington, DC 20006

202-466-3311

Embargoed Until 10am February 22, 1998

*Ron & Norma Felt*

**PRESIDENT CLINTON ANNOUNCES NEW RACIAL AND ETHNIC HEALTH  
DISPARITIES INITIATIVE**

February 22, 1998

Today, President Clinton announced a new initiative that sets a national goal of eliminating by the year 2010 longstanding disparities in health status that affect racial and ethnic minority groups. The President announced that the Federal government will, for the first time, set high national health goals for all Americans, ending a practice of separate, lower goals for racial and ethnic minorities. To help reach these ambitious targets, the President also announced a five-step plan to mobilize the resources and expertise of the Federal government, the private sector, and local communities to eliminate disparities that for too long have been treated as intractable.

**BUILDING ON THE RECORD OF IMPROVEMENTS IN HEALTH STATUS FOR ALL AMERICANS.** Since 1993, key indicators show that our nation's health has greatly improved. The President highlighted the fact that infant mortality has reached an all-time low, childhood immunization levels are at record highs, and HIV and AIDS rates are falling for the first time in the history of the epidemic.

**RECOGNIZING AND CONDEMNING UNACCEPTABLE RACIAL AND ETHNIC HEALTH DISPARITIES THAT EXIST TODAY.** Despite some encouraging news, the President condemned the fact that minorities suffer from certain diseases at up to five times the rate of white Americans. For example, infant mortality rates are 2 ½ times higher for African-Americans and 1 ½ times higher for American Indians. African-Americans men under 65 suffer from prostate cancer at nearly twice the rate of whites; Vietnamese women suffer from cervical cancer at nearly five times the rate of whites; and Latinos have two to three times the rate of stomach cancer. African-American men also suffer from heart disease at nearly twice the rate of whites. Native Americans suffer from diabetes at nearly three times the average rate, while African-Americans suffer 70 percent higher rates than white Americans.

**MOBILIZING ALL AMERICANS TO CLOSE GAPS IN HEALTH STATUS.** To close these gaps, the President today announced a five-step plan that sets a national goal of eliminating health disparities in six areas with great disparities by the year 2010: infant mortality; cancer screening and management; cardiovascular disease; diabetes; HIV/AIDS rates; and child and adult immunization levels. The President's plan:

- **Initiates Sweeping New Outreach Campaign Led By the Newly-Confirmed Surgeon General and Assistant Secretary for Health Dr. David Satcher.** The President is announcing that the Department of Health and Human Services will initiate a major outreach campaign led by Surgeon General Satcher that will send critical treatment and prevention messages to all Americans, with a special focus on reaching racial and ethnic minorities. This campaign will reach out to local communities, churches, nurses, physicians; and other community-based programs and experts in minority health. It will improve education and outreach efforts and develop innovative strategies to address racial and ethnic health disparities.

- **Includes Over \$400 Million to Develop New Approaches and to Build on Existing Successes to Address Racial and Ethnic Health Disparities.**
  - **Spurs New Local Innovative Strategies to Address Disparities.** Seriously addressing racial and ethnic disparities in health will require not only the focused application of existing knowledge and best practices, but the development of new approaches. The President's budget proposes a total of \$150 million over five years for grants to up to 30 communities, chosen through a competitive grant process. These grants will be used to conduct research to devise innovative new strategies to improve minority health status. Successful approaches learned in these communities will be applied to all health programs across the Department of Health and Human Services.
  - **Builds on Approaches That Have Proved Successful At Addressing Racial and Health Disparities.** The President's balanced budget proposes a new \$250 million investment over five years that would strengthen public health programs that have a proven record of effectively targeting these problems. These proposals include new investments in prostate cancer screening education, diabetes outreach and education, breast and cervical cancer screening for Native Americans, heart disease awareness programs, and HIV prevention. It also includes new funding for community health centers that serve historically underserved populations to make special efforts to target them.
- **Announces a Major New Foundation/Public Sector Collaboration to Address Disparities.** Addressing these serious disparities will take a nationwide effort involving the public and private sectors. The President is announcing today that Grantmakers in Health, an association of over 136 national, regional, and local foundations with over \$42 billion in assets, will team up with the Department of Health and Human Services to co-host a national conference this Spring. This conference will be dedicated to help coordinate public and private research, demonstrations and evaluations on racial disparities in health.
- **Develops More Effective Ways To Target Existing Federal Programs to Address Health Disparities.** The Secretary of Health and Human Services will convene a new taskforce which will bring together the best minds at the Centers for Disease Control and Prevention, the National Institutes of Health, and other public health and science agencies, to develop a comprehensive plan -- in consultation with experts and minority communities -- that will ensure, for example, that the latest scientific discoveries about AIDS are transmitted to State Medicaid and Children's Health Programs, and that research, treatment, and education programs for diabetes and heart disease are interconnected and that successful demonstrations are converted to nationwide programs.

- **Issues National Challenge to Involve Communities, Foundations, Advocacy Organizations, and Businesses Develop Ways To Target Racial and Ethnic Health Disparities.** The President issued a challenge to employers, churches, schools, community-based clinics, nurses, doctors to make a new commitment to address these racial and ethnic disparities in health. This includes developing new ways to target families to ensure their children are immunized and developing strategies to make individuals feel more comfortable getting the preventive care they need.

**Historic National Health Goals.** Using the expertise gained from all of these activities, HHS will join forces with public health groups, medical professionals, minority organizations, and the private sector to develop the first-ever across-the-board national health goals. These new goals will be included in *Healthy People 2010* -- a program that sets the nation's health goals to be accomplished by 2010 -- which will be released in the year 2000.



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*The California Wellness Foundation*

February 20, 1998

Chris Jennings  
White House Policy Advisor on Health  
Old Executive Office Building  
Washington, D.C. 20501

Dear Chris:

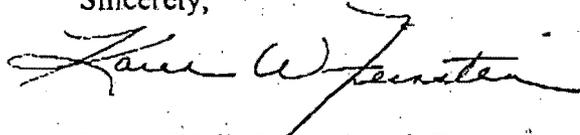
Grantmakers In Health (GIH) is excited about a potential partnership with the Administration in advancing a national initiative on race and health. A national nonprofit organization serving private-sector foundations and corporate giving programs in health and related human services, GIH is comprised of 136 formal funding partner members representing over \$42 billion in assets, and a communication network of over 700 grantmaking organizations. With an annual pay-out of \$2.1 billion, we estimate that we are already spending approximately \$500 million on these issues. More specifically, because so many of our foundations have funded and evaluated worthy demonstration and community education efforts to narrow racial disparities in childhood immunization, the treatment of AIDS, sudden infant death syndrome and infant mortality, and mortality resulting from heart disease, cancer, and stroke, we can be of assistance to the proposed national initiative.

In support of this partnership, GIH is prepared to organize a Spring conference on racial disparities in health to share best practices and develop local partnership agendas involving public health, foundations, government and nonprofit organizations. In short, GIH is committed to working with the President, his Administration, and the Department of Health and Human Services to make this important program a success.

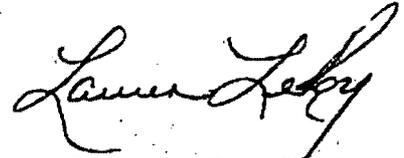
Grantmakers In Health will be holding its annual meeting on health and human services philanthropy next week, February 26-27th, in Los Angeles, California. With over 230 grantmaking representatives thus far registered to attend, we would very much welcome putting you on the agenda Thursday or Friday to brief our constituency.

Thank you. We look forward to further discussing the partnership with you. Should you have any questions or require either of us in attendance for the announcement this Saturday, please do not hesitate to call (Karen Feinstein's contact information: (W) 412/594-2555, (H) 412/682-1670, (Fax) 412/394-5464).

Sincerely,



Karen Wolk Feinstein, Ph.D.  
Chair, Grantmakers In Health



Lauren LeRoy, Ph.D.  
President and CEO



Recent Health FY

## MEMORANDUM

TO: Jeanne Lambrew, Ph.D.

FROM: Karen Scott Collins, M.D., M.P.H. *KSC*

SUBJECT: The Commonwealth Fund's Programs on Minority Health

DATE: February 18, 1998

---

Jeanne, attached is a memo summarizing the Fund's current work in minority health. I'd be happy to elaborate further on anything you need. If I had to give you a couple of sentences on the Fund and minority health, perhaps this:

*The Commonwealth Fund, a national health foundation based in New York, supports research on access to quality health care for minority populations, through its program on "Managed Care and Minority Communities". The foundation also supports the training of minority health professionals through the Commonwealth Fund/Harvard University Fellowship in Minority Health Policy.*

Karen Scott Collins, M.D., M.P.H.  
THE COMMONWEALTH FUND  
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[http:// www.cmwf.org](http://www.cmwf.org)



# MEMORANDUM

TO: Jeanne Lambrew, Ph.D.

FROM: Karen Scott Collins, M.D., M.P.H. *KSC*

SUBJECT: The Commonwealth Fund's Programs on Minority Health

DATE: February 18, 1998

---

Thank you for inquiring about The Commonwealth Fund's work in the area of minority health. As you know, the Fund is a national foundation with a strong focus on issues of insurance coverage and access to quality health care for all Americans. The Fund has had a long standing program area devoted to health care issues for minority Americans. I am pleased to summarize our current work in this area for you.

In April 1995, two programs were approved for development over a five year period. These are "Managed Care and Minority Communities" and "The Commonwealth Fund/Harvard University Fellowship in Minority Health Policy". The managed care program supports health services research related to the impact of current changes in the health care system on minority populations. The fellowship supports minority physicians pursuing careers in health policy, and includes support for completing a Masters in Public Health at Harvard School of Public Health. The Fund budgets approximately \$650,000 per year for each of these programs.

## Managed Care and Minority Communities

Programmatic work is examining the impact of managed care on access and quality of care in minority communities. This includes a focus on Medicaid managed care, and on the safety net providers who have traditionally served low income minority populations. Key projects include:

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E-MAIL [KSC@cmwf.org](mailto:KSC@cmwf.org)  
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- **Managed Care and Safety-Net Providers.** A project at George Washington University Center for Health Policy Research is conducting case studies and analysis of how safety net providers are responding to managed care, including restructuring or aligning with new partners. The project will also help suggest the implications of these changes for delivering care to uninsured and minority populations. (P.I.-Ann Zuvekas, 202/296-6972)
- **Minority Physicians and Managed Care.** Risa Lavizzo-Mourey, M.D. at University of Pennsylvania has conducted survey analysis and focus groups with physicians on experiences with managed care. A key overall finding of the work is that while minority physicians do not appear to experience managed care differently in terms of their practice, there were differences in their perceived ability to provide quality care to their patients. Hispanic and African American physicians - who care for a greater portion of patients from those ethnic groups- expressed the highest concern regarding managed care limiting their ability to provide quality care. (P.I.-Risa Lavizzo-Mourey, 215/898-1537)
- **Educating Medicaid Managed Care Beneficiaries on Managed Care.** The Community Service Society of New York has a major initiative to develop, implement and evaluate an education program to help Medicaid beneficiaries understand and use managed care effectively. The Fund supported an evaluation of the pilot phase in New York City, which showed this educational intervention to be a promising model for improving Medicaid beneficiaries understanding of managed care. The Fund is currently considering further support to extend the evaluation. This project has several co-funders, including the Henry J. Kaiser Foundation and Robert Wood Johnson. These two foundations have supported the extension of the program to Los Angeles and Philadelphia. (P.I.-Christine Molnar, 212/614-5401)
- **Urban Safety Net Hospitals.** Darrell Gaskin of Georgetown University is conducting analysis of the impact of managed care and market forces on the ability of urban safety net hospitals to provide essential services (such as trauma) and indigent care. Some of his analysis has shown that increased managed care penetration has resulted in reduced patient volumes in hospitals located in minority neighborhoods, with a corresponding increase in patient volumes in non-minority neighborhoods, raising concerns about the continued availability of health providers in some minority communities. (P.I.-Darrell Gaskin, 202/687-0880)
- **Educating Minority Leaders About Managed Care.** The Fund is working collaboratively with the Joint Center for Political and Economic Studies to support policy discussions on the effect of health system changes on minority communities, and to disseminate findings from our program's work. The activities under this grant to date have included a Capitol Hill briefing on public hospitals, moderated by Congressman Louis Stokes and a related workshop in Detroit for state and local leaders. (P.I.-Bailus Walker, 202/789-3525)

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 E-MAIL [KSC@cmwf.org](mailto:KSC@cmwf.org)  
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- **Analysis of the Commonwealth Fund 1994 National Comparative Survey of Minority Health Care.** In order to conduct in-depth analysis of our survey, 14 papers have been commissioned on topics including financial barriers, satisfaction with care, Hispanic health and Asian American health. The manuscript is being prepared for publication later this year. Carol Hogue, Ph.D. at Emory University has the grant overseeing this project. (P.I.-Carol Hogue, 404/727-8736)
- **Managed Care and Cultural Competence.** A small grant to Molly Joel Coye, M.D. at the Lewin Group was just approved to explore issues related to cultural competence, and whether, or how, managed care and quality assurance activities should include consideration of cultural competence. (P.I.-Molly Coye, 415/538-2816)

#### **Anticipated Program Work Over the Next Year**

(This summarizes projects we are preparing to present to our board in April)

The Fund will continue a focus on managed care issues under this program. As I mentioned in our conversation this morning, we are considering supporting some work on reporting health plan quality performance measures for minority populations. An important focus there would be in identifying measures which can reflect health care for populations at higher risk for some conditions, for complications of illnesses, or for not receiving appropriate, quality health care. We are also considering continued work on educating Medicaid beneficiaries on managed care.

In addition, the program office here at the Fund will be increasing activities with respect to generating information related to minority populations, health and access to care, based on survey analysis. This will include a chart book, fact sheets and articles or reports. The other major product anticipated in 1998 is a volume based on analysis of the Fund's minority health survey.

#### **The Commonwealth Fund/Harvard University Fellowship in Minority Health Policy**

In an effort to address major national health issues, it is essential to include the perspectives and concerns of all racial and ethnic groups. The fellowship is a one-year, full-time program designed to create physician-leaders, particularly minority physician-leaders, who will pursue careers in minority health and public policy. Directed by Joan Reede, M.D., assistant dean for faculty development and diversity, the fellowship combines an intensive year of training with special program activities. The program supports five fellows per year.

At the end of the program's five-year course, it is anticipated that twenty-five physicians will receive awards, marking the Fund's long commitment to supporting minority health issues and physicians. Commencing in the 1940's, a series of grants was awarded to the National Medical Fellowships, Inc., a source of scholarships for minority medical education.

(P.I.-Joan Reede, 617/432-2413)

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Overall, our work in the minority health area reflects the Fund's overall concerns with insurance coverage, managed care and access to care. I think this work provides an opportunity to examine some of the long standing differences in access to care across racial and ethnic groups, but certainly issues of race and equity in health care are significant and broad. Racial differences in mortality, morbidity from chronic diseases, and access to highly specialized medical services continue to exist and require attention from the medical and public health as well as health services research communities.

Jeanne, I hope this is helpful in considering how you might include the Fund in your work. Please call me at (212) 606-3854 to discuss any of the Fund's work further.

Karen Scott Collins, M.D., M.P.H.  
**THE COMMONWEALTH FUND**  
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E-MAIL [KSC@cmwf.org](mailto:KSC@cmwf.org)  
<http://www.cmwf.org>

## INFANT MORTALITY

**Total:** 7.2 per 1,000 live births (1996 preliminary data)<sup>1</sup>  
**White:** 6.0 per 1,000 live births (1996 preliminary data)  
**Black:** 14.2 live births (1996 preliminary data)

- African-American infants die at more than twice the rate of white infants.
- About one-third of African-American, Native American, and Asian American women do not receive prenatal care until the third trimester.

## SIDS

**Total:** 74.2 per 100,000 live births (1996 preliminary data)  
**White:** 71.0 per 100,000 live births (1996 preliminary data)  
**Black:** 178.6 per 100,000 live births

- African-Americans are also 2 ½ times more likely to die of SIDS. Some American Indians and Alaska Natives die from SIDS at 3 to 4 times the rate.

(Mrs. Gore is the spokesperson for this campaign at HHS. Her office has told me they are interested in seeing if we could do something in this area).

## CARDIOVASCULAR DISEASE

**White:** 105 per 100,000  
**Black:** 147 per 100,000  
**American Indian/  
Alaska Native:** 76 per 100,000  
**Asian and Pacific  
Islanders:** 63 per 100,000

- Death rates caused by heart disease for African-American males is over 40 percent higher than for whites.
- Death rates are two-thirds higher for African American women.
- Nearly half of African-American women have hypertension -- the leading cause of heart attacks and strokes by age fifty.

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<sup>1</sup>Most data in this memo is from the National Vital Statistics System natality/mortality files CDC/NIH, with the exception of the bullet points which comes from other HHS sources.

## STROKES

<b>White:</b>	24.7 per 100,000
<b>Black:</b>	45 per 100,000
<b>American Indians/ Alaska Native:</b>	21.6 per 100,000
<b>Asian and Pacific Islanders:</b>	25.8 per 100,000

## BREAST CANCER

### Breast Cancer Mortality Rates

<b>White:</b>	26.0 per 100,000 live births
<b>Black:</b>	31.2 per 100,000 live births
<b>American Indians: Native Alaskan:</b>	21.7 per 100,000 live births 44.2 per 100,000 live births
<b>Korean</b>	7 per 100,000 live births
<b>Japanese &amp; Filipino</b>	14 per 100,000 live births

### Screening Rates

<b>White:</b>	56 %
<b>Black:</b>	56%
<b>Hispanic:</b>	50%
<b>American Indians</b>	53%
<b>Asian and Pacific Islanders</b>	46%

(From 1973 to 1988, breast cancer mortality rates increased 1.1% among white women and 19.4% among African-American women).

## OTHER CANCER STATISTICS

### Five year cancer survival rates (National Cancer Institute)

	<b>White</b>	<b>Black</b>
<b>Prostate</b>	88.6	73.2
<b>Breast</b>	85	69.8
<b>Bladder</b>	82.5	59.5
<b>Cervix</b>	71.4	56.4
<b>Colon</b>	62.9	53.4
<b>Oral Cavity/ Pharynx</b>	55.2	33.4
<b>Hodgkins</b>	81.5	71.9

- Latinos have two to three times the rate of stomach cancer and higher rates for prostate cancer and cancer of the esophagus.
- Lung cancer is nearly double the rate for some Native American groups.

## **DIABETES**

- Native Americans have diabetes at nearly three times the rate of whites and are also much more likely to the severe consequences, such as blindness of this disease at a higher rate.
- African Americans suffer from this disease at double the rate.
- End stage renal disease is twice as high for blacks as for whites.

## **AIDS**

### **AIDS Case Rate Baseline**

**White:** 16.2 per 100,000

**Black:** 115.3 per 100,000

**Hispanic:** 55.8 per 100,000

**American Indian/Alaska Native:** 14.1 per 100,000

**Asian and Pacific Islanders:** 7.5 per 100,000

### **Pediatric AIDS Case Rate Baseline**

**White:** 0.3 per 100,000

**Black:** 5.7 per 100,000

**Hispanic:** 1.7 per 100,000

**American Indian/Alaska Native:** .6 per 100,000

**Asian and Pacific Islanders:** 0.0 per 100,000

## **IMMUNIZATION RATES**

### **Childhood Immunization Rate Baseline**

**White:** 78%

**Black:** 76%

**Hispanic:** 73%

**American Indian/Alaska Native:** 81%

**Asian and Pacific Islanders:** 81%

## **Immunization Rate Baseline for Adults 65 years and older**

### **Influenza:**

**White:** 55% (1994)  
**Black:** 57% (1994)  
**Hispanic:** 38% (1994)  
**Asian and Pacific Islanders:** 43% (1994)

### **Pneumococcal:**

**White:** 30% (1994)  
**Black:** 31% (1994)  
**Hispanic:** 14% (1994)  
**Asian and Pacific Islanders:** 14% (1994)

[revised 2/12/98 pm]

## **GENERAL QUESTIONS AND ANSWERS**

**Q. What will be the tangible gains of closing these health gaps? How will minorities actually “feel” these successes if the gaps close?**

A. As these gaps begin to close, we believe minorities will live longer and healthier lives. While we certainly will look at data and hope to see a narrowing of the gaps in that sense, the results must go beyond the cold facts of science, and translate into a better quality of life for racial and ethnic minorities in terms of their health.

This is about more babies surviving past their first year; more families keeping their mothers, grandmothers, sisters and wives around longer because of early detection and treatment for breast cancer; fewer minorities having to undergo limb amputations from diabetes; and fewer persons of color suffering from debilitating strokes and heart attacks.

**Q. Why select six priority areas to focus on as opposed to five, 10, or some other number? Is there anything magical about having six?**

A. We did not go into this process saying we had to have a five-, six- or 10-point plan. We weren't looking at a “package” with any specific number attached to it. What we aimed for was an initiative that allowed us to maintain our broad focus on minority health issues, and emphasize a few key areas that are representative of the larger minority health picture. That number just happens to be six. There's nothing magical about that number at all. The six priority areas represent health issues that account for a significant burden of disease but are also amenable to targeted improvement. Enough data exists in each of these areas to allow progress to be measured.

**Q. How did you arrive at these goals?**

A. The goals are drawn from our Healthy People process, which represents a scientific consensus in the Department and among many outside experts. The target for each goal was set in a process that involved consultations with organizations concerned with minority health issues.

**Q. How will you monitor progress toward these goals?**

A. We have selected goals for which we have national data reported on an annual basis-- so every year we will know whether we are making the progress we expect. In addition, we plan to work with communities to gauge more accurately how much progress is being made at the grass-roots level.

**Q. What happens if, in the year 2000, at the end of the Clinton Administration, there is no progress toward one or all of these goals and the gaps widen from what they are now. What does that mean for this overall initiative?**

A. Any time you pursue ambitious goals, there is always the risk of not achieving those goals. And certainly there is a possibility -- as always -- that a situation will worsen, for whatever reasons, over time. The fact is that we believe it is far better to track these problems and work to solve them rather than fail to act.

I think if we see as we go along that a particular gap is widening, we will be in position to respond quickly and aggressively to turn it around so that by the year 2000, because of the attention that will be focused on these areas, we expect to meet our interim goals.

These are not easy goals, however, we believe that with the efforts that the public health and medical communities at the federal, state, and tribal levels bring to this effort, and through active partnerships with communities, we will meet the year 2000 goals.

**Q. How can you be sure that a new Administration -- regardless of party -- will follow through and maintain this minority health initiative as a priority?**

A. Once something like this is set in motion and partnerships are formed and expectations are created, we believe the American people will make sure this remains a health priority, regardless of who is in the White House. This is not political. This is about good health, about improving health, and we think any future administration will see this as a priority. It would be a tragedy if a future Administration identified this initiative solely as a matter of party, ideology or personality.

**Q: What is HHS planning to do to support the President's Commitment for 2010?**

A. Our first step will be to focus on the six health disparity reduction goals for the Year 2000. We intend to consult closely with representatives of the minority communities to learn what they think will be most effective in assuring that we reach these goals, and to

use the process as a testing ground for the strategies that will support the President's bold commitment for the Year 2010.

In addition, we will work with Congress to gain approval of the proposed community grant program that will enable us to test in a community setting the interventions that show greatest promise of achieving the six health disparity reduction targets. The knowledge that we gain through these demonstrations will be used to improve the Department's current programs and to help us design the strategies necessary to reach the President's goal for the Year 2010.

**Q. Is it realistic to expect that the nation can eliminate health disparities by the Year 2010?**

A. This is without question a major challenge -- and one that we do not yet have the knowledge necessary to accomplish in *all* areas. However, we do know a great deal about how to improve health outcomes in disadvantaged communities and over the coming decade we will expand our knowledge about the causes of specific disparities will gain experience in how to work more effectively with communities to improve health.

It is important to stress that the elimination of health disparities will require a national effort -- public and private sector, individuals and communities. HHS in collaboration with states, private sector organizations and the health community will establish a framework for action to eliminate disparities through *Healthy People 2010* -- the nation's health action agenda for the next century. We are already working with the states, and more than 350 national organizations on developing the framework for Healthy People 2010. The two over-arching goals for 2010 are to increase years of healthy life for the entire population and to eliminate health disparities. The Healthy People process will articulate data needs, research investments, and the action strategies that can be employed by the nation to reach the goal of eliminating disparities by 2010. In our consultations we have received near unanimous support for committing to this goal.

**Q. What about other areas of concern related to minority health that are not covered by these priorities? Do they get lower priority as a result of emphasis on these six areas?**

A. Certainly not. We will continue to press ahead on all fronts where there are minority health challenges, from sickle cell to lupus to other diseases that take a disproportionate toll on minority populations. We feel that, ultimately, the entire minority health picture will improve if we narrow these six important gaps. It would make no sense -- and we

would not achieve true progress – if we advanced in these six areas and slipped in other areas.

**Q. What about whites who suffer from these same medical conditions? Are you saying through this initiative that there is a shift in priorities to the health concerns of minorities at the expense of the total population?**

A. Absolutely not. We have said all along, and the American people understand it, that improving the health of all Americans means improving the health of minority Americans. In all of these areas our prevention programs and service delivery systems seek improved health outcomes for all races. This initiative, however, will give special emphasis to reaching populations that have been left behind.

**Q. The gaps that exist in these areas involve several longstanding challenges that have plagued minority health for years – such as access and poverty. In what way do you plan to address these concerns as part of the six priorities?**

A. The Administration is working on a number of fronts to reduce poverty -- through welfare reform, improving access to high quality, subsidized child care, and education and training initiatives. The new child health program, improved Medicaid outreach efforts and expansions in the community health center program all increase access -- as will our Medicare outreach efforts for mammograms and adult immunizations.

**Q. How can you turn around tough, nearly intractable problems without a massive infusion of new resources over an extended period of time?**

A. You cannot always match dollars to results. We are going to look carefully at how our current programs are working and how they can be more effective in reaching these communities. For example, the remarkable success we have seen in reducing SIDS has not been fully shared in the African American community. We need better methods of getting information such as “Back to Sleep” to minority practitioners and through them to parents. This does not require large sums of money -- but we do need better partnerships with minority physicians, nurses, and other health care providers.

**Q. The President’s Race Initiative is about bringing racial harmony to America by getting races to talk about their differences. How will this initiative do that?**

A. This will help Americans to talk about health and how we should be concerned with the health of all people, not just with our own, or with people like ourselves. This

initiative will get people to realize that their health is intertwined with the health of others as well as the future of our country. We believe that this initiative will help promote racial harmony because it will generate dialogue on race on another level, much of it for the first time ever. For example, top researchers will be talking to minority community advocates. Community advocates will be talking to citizens. Policymakers will be talking to health professionals, and in the course of that dialogue, racial and ethnic groups will build an understanding that will mesh with other race initiative strategies throughout government to build the One America President Clinton has challenged us to achieve.

**Q. The President has been criticized for preaching to the choir by giving speeches on the Race Initiative only to minority groups. Given the fact that this initiative refers only to minority health, in what way does it go beyond just preaching to the choir and involve the broader community?**

A. The President is talking to all Americans and so are we. We're making today's announcement before the whole country, not just to minority groups. This initiative will be featured in speeches and other communications from the Department from the Secretary on down. And this will be in a variety of venues, not just those venues that involve or impact particular minority groups. In addition to consulting minority health groups and community organizations, we will work with organizations that are concerned with these 6 areas such as the American Heart Association and the American Cancer Society. We will work with the entire medical profession and public health community to achieve these goals.

**Q. Is this the foundation of something larger that you're doing on race, or is this considered HHS' full and total effort on race?**

A. This initiative is indeed new and in support of the President's Race Initiative. But it is not all that we are doing at HHS to help close health gaps and bridge the racial divide in the health arena.

Earlier this year we organized, under the Deputy Secretary's leadership, several working groups to look at various aspects of minority health and those groups are now at work. These groups are comprised of staff members from all our agencies and operating divisions.

For months, these groups have been discussing strategies to improve health as well as Departmental customer service to Hispanic, Native American, African-American and Asian-American and Pacific Islander communities. All of these working groups are coordinated under one body called the Minority Initiatives Coordinating Committee,

which serves as an umbrella to them, and a central point for us to measure what we are doing to improve minority health.

The Assistant Secretary for Health has conducted progress reviews on the health status of Asian Americans/Pacific Islanders and Hispanic Americans. The information gained from these reviews will shape our planning for data collection and improved management of the Department's progress. A progress review on the health of African Americans is scheduled for later this year.

**Q. Where did the idea for this health initiative originate – in the White House or the Department?**

A. Secretary Shalala and the President have had several conversations about how HHS could contribute to the Race Initiative since the President announced it in June. This particular approach seemed to be the best and most comprehensive way to respond to real needs while meeting the President's call to action at the same time. This approach also seemed to be the best one for making a real difference in real people's lives. The President shares the Secretary's passionate concern for meeting the health needs of underserved and special populations, and this minority health initiative is really a logical extension of that mutual concern.

**Q. What is Healthy People 2000 and what role does it play in this endeavor?**

A. Healthy People 2000, the national prevention initiative to improve the health of all Americans, is the product of unprecedented cooperation among government, voluntary and professional organizations, business, and individuals. The cornerstone of this effort is a set of national health promotion and disease prevention objectives for the year 2000, which were developed in 1990. Measurable targets were set for improvements in health status, risk reduction, and service delivery. Organized under the broad approaches of health promotion, health protection, and preventive services, the national objectives provide direction for the 10-year drive to improve health. Individuals, organization, and communities are challenged to change personal behaviors and the environments in order to support good health.

Healthy People 2000 plays an important role in the Department's response to the President's Initiative on Race. The goals for each of the six health areas are based on the targets set for related areas in Healthy People 2000. In other words, our near term goals for reducing disparities by the year 2000 are the same as the Healthy People 2000 goals.

**Q. What makes this different from Healthy People 2000?**

A. While there are many parallels to the Healthy People 2000 process, this initiative goes the "next step," by developing action steps for achieving the goals which are based on the work of Healthy People. Healthy People 2010, the goals of the nation for the next decade, will be announced in 2000 and will parallel the goals of the President in this initiative.

**Q. You can make the argument that if these six areas should be a priority now, they should have been a priority some time ago. Why did it take until now to shed light on these areas and minority health in general?**

A. We have been focusing on minority health a great deal in the past four years. I mentioned the working groups that began early this year in advance of the President announcing the Race Initiative. Also, we have an Office of Minority Health that tracks these issues department wide. We've done a number of things in the past five years to address minority health. For example, about a year and a half ago, we formed a new office at our renowned National Cancer Institute -- the Office of Special Populations -- to address cancer in minorities. So this is a logical extension of everything we've been doing.

In fact, some of the six areas of emphasis were chosen because of the work we had already done in those areas. That has given us something to build on.

**Q. Will any kind of special commission or panel be formed to follow progress on these six goals?**

A. To guide this effort, the Secretary has established a senior level steering committee in the Department, chaired by the Assistant Secretary for Planning and Evaluation. The charge to that committee is:

- To review the status of the six health disparity reduction goals for the Year 2000 and assure that the Department's research, health services and prevention programs give priority to attention to them.
- To conduct a process of consultation with minority community representatives and with the scientific and health services communities to improve our understanding of how to achieve both the near term disparity reduction goals and the 2010 disparity elimination goal.

- To examine the Department's research, data, service and prevention programs and recommend to the Secretary necessary changes in these programs to support the President's goal of eliminating health disparities in the next century.

The Steering Committee will make recommendations to the Secretary regarding development of the FY-2000 budget, and priority investments or program re-directions to support the President's goals. It will also examine how effectively the Department's current programs are using their resources to support the elimination of health disparities and recommend changes that would enhance their impact. In addition to the Steering Committee, a working group of Departmental experts will be convened for each of the six goal areas, to help shape strategy for achieving the goals and to monitor our progress.

**Q. How do you plan to keep the American people informed about the progress of this initiative?**

A. We will continue to communicate through the media. And we will depend on our relationships with community groups and advocates, as well as grantees and health providers, formally and informally, to help keep people informed throughout the country as to how we're doing and where they can help us achieve these goals. And the working groups will help contribute to this process as well.