

PRESIDENT CLINTON ANNOUNCES NEW RACIAL AND ETHNIC HEALTH DISPARITIES INITIATIVE

February 21, 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 1½ 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 coordinated by the Centers for Disease Control. 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.

Native American Statistics

The Native American population is one of the most disadvantaged and disenfranchised in American society. On virtually every indicator available, they rank at or near the bottom compared to other ethnic/racial groups.

Native Americans have the highest unemployment rates (80% on some reservations), the lowest family incomes and highest percentages of people living below the poverty level. Almost half of young Native American children live in poverty.

Indian women do not receive adequate screening for breast cancer. They have the worst survival statistics than any ethnic group because of late detection and difficulties in obtaining adequate care. In addition, Indian women die of cervical cancer at twice the rate of non-Indian women.

Up to 85 cents of every dollar generated on-reservation is spent off-reservation. In spite of recent growth in Native American-owned businesses, one quarter of all jobs on reservations are staffed by non-Natives, and up to half of full-time reservation jobs are federally funded.

Key Facts Concerning the Status of American Indians and Alaska Natives

- 31% of Indians live below the poverty level, compared to 13% of the total population.
- Oglala Sioux men of the Pine Ridge Reservation live an average of 56.5 years, the shortest life expectancy of any group in the country, similar to ones seen in sub-Saharan Africa.
- On the Pine Ridge Reservation, fatal car crashes are four more times more likely than anywhere else. Infants are twice as likely to die from sickness or injury.
- Diabetes is virtually an epidemic in Indian Country and is the sixth leading cause of death for Native Americans.
- Car accidents are the third leading cause of death on Indian reservations.
- On the Pine Ridge Reservation, nearly half the population has a problem with alcohol, fueling the reservation's soaring rates of Sudden Infant Death Syndrome, suicides, and accidents. Alcoholism is the 5th leading cause of death among Native Americans.
- According to the 1990 Census, only 65.3 percent of Indians age 25 and older residing in the current Reservation States are high school graduates or higher. For bachelor's degree or higher, this percentage is 8.9.

- In 1990, 16.2 percent of Indian males age 16 and older residing in the current Reservation States were unemployed, compared with 6.4 percent for the U.S. All Races male population. For females, these percentages were 13.4 and 6.2, respectively.
- According to the 1990 Census, the median household income in 1989 for Indians residing in the current Reservation States was \$19,897, compared with \$30,056 for the U.S. All Races population.
- The American Indian and Alaska Native birth rate for 1991 - 1993 of 26.6 births per 1,000 population was 67 percent greater than the U.S. All Races birth rate for 1992 of 15.9, and 77 percent greater than the rate for the U.S. White population (15.0).
- The two leading causes of death for American Indians and Alaska Natives (1991-1994) and the U.S. All Races and White populations (1992) were diseases of the heart and malignant neoplasms. This is a change for the Indian population; accidents had been the second leading cause of death.
- Of all American Indian and Alaska Native people who died during 1992-1994, 30 percent were under 45 years of age. This compared to 11 percent for the U.S. All Races population (1992).
- The age-adjusted death rate for American Indians and Alaska Natives dropped from 188.0 in 1972-1974 to 83.4 in 1992-1994, a decrease of 56 percent. However, the rate is nearly triple the U.S. All Races of 29.4 for 1992.
- The age-adjusted suicide death rate for American Indians and Alaska Natives for 1992-1994 was 16.2 deaths per 100,000 population compared with the U.S. All Races rate of 11.1 for 1992, a ratio of 1.5 to 1.
- The age-adjusted homicide death rate for American Indians and Alaska Natives in 1992-1994, was 14.6 deaths per 100,000 population compared with 10.5 for the U.S. All Races population in 1992, a ratio of 1.4 to 1.
- The age-adjusted alcoholism death rate for American Indians and Alaska Natives in 1992-1994, was 38.4 deaths per 100,000 population or 5.6 times the U.S. All Races rate of 6.8 in 1992.
- The age-adjusted diabetes mellitus death rate for American Indians and Alaska Natives in 1992-1994 of 31.7 was 2.7 times the U.S. All Races rate of 11.9 in 1992.
- The age-adjusted tuberculosis death rate for American Indians and Alaska Natives is 2.1 deaths per 100,000 population in 1992-1994. The Indian rate is still 5.3 times the U.S. All Races rate of 0.4 for 1992.

Key Facts Concerning the Health Status of American Indians and Alaska Native Youth

- Of the 1.43 million Indians living on or near reservations, nearly 500,000 (29 percent) are under the age of 15.
- Native American students have the highest dropout rate of any racial/ethnic group (36%) and lowest high school completion and college attendance rates of any minority group.
- Indian infants die from sudden infant death syndrome (SIDS) at a rate 1.8 times the rate for U.S. All Races infants, 2.1 compared to 1.2.
- 13% of Indian deaths pertain to ages under 25 compared to 4% for U.S. All Races.
- 45 percent of Indian mothers having their first child are under age 20, compared to 24 percent for U.S. All Races mothers.
- 33 percent of the Indian population is younger than 15 years in contrast to 22 percent for the U.S. All Races population.
- 38 percent of Indians aged 6 to 11 years live below the poverty level, more than twice the number for the U.S. All Races age group (18 percent).
- 61 percent of juvenile delinquents confined by the Federal Bureau of Prisons in 1994 were Indians.
- The death rate for Native American youth (142.0/100,000) was 59% higher than the rate for white youth.
- The alcoholism death rate for Indians 15 to 24 years of age is over 17 times the comparable rate for U.S. All Races, i.e., 5.2 versus 0.3.
- The accident death rate for Indians aged 5 to 14 years is nearly double the corresponding U.S. All Races rate, 17.1 to 9.3.
- The suicide death rate for 15 to 24 year old Indians is 2.4 times the corresponding rate for U.S. All Races, 31.7 to 13.0.
- Homicide is the second leading cause of death among Indians from 1-14 years of age and third for 15-24 year-olds.
- More than 180 gangs have been identified in Indian Country.

*Health Care Statistics for
The Tribes of the Great Sioux Nation
(Aberdeen Area)*

(RATES SHOWN ARE %
HIGHER THAN THE
NATIONAL AVERAGE)

● DEATHS FROM TUBERCULOSIS	1,300%
● DEATHS FROM DIABETES	400%
● SUDDEN INFANT DEATH SYNDROME	328%
● POST NEONATAL MORTALITY RATE	200%
● DEATH FROM CERVICAL CANCER	251%
● DEATHS FROM ALCOHOLISM	1200%
● DEATHS FROM SUICIDE	147%
● LIFE EXPECTANCY	60 YEARS (vs. 74.9 for U.S. population)

*1993 Indian Health Service Report entitled "Regional Differences in Indian Health"

DISPARITIES IN RACE AND HEALTH AND POSSIBLE OPTIONS

Secretary Shalala has identified six areas to improve disparities in race and health: Infant mortality, cardiovascular disease, diabetes, breast and cervical cancer (although we would like to expand to all cancers), immunizations, and AIDS. These are not the only areas where there are disparities, however, they were selected because there are disparities in more than one minority group.

Cardiovascular Diseases. Heart disease is the leading cause of death in the United States.

- 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.

Cancer. Minorities suffer from a number of different cancers at a higher rate than , including prostate cancer, breast cancer, cervical cancer.

- African-American men have a higher rate of cancer than other Americans -- particularly prostate cancer where it is 75 percent higher.
- African-American women die of cervical cancer at twice the rate of white women.
- 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.
- Only half of Hispanic women over the age of forty have had a mammogram in the last two years and nearly two-thirds of whites and African-Americans have.

Cost: \$25-\$30 million. (CDC current program is \$22 million for breast and cervical cancer).

Infant Mortality

- African-American infants dies 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.

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.

Preliminary Possible Options

Cardiovascular Disease Outreach/Education Program (CDC program): While cardiovascular disease is the leading cause of death, there is currently no nation-wide public health or outreach program to educate health providers, communities, and the public how to identify those at risk and take precautions against this disease. This program could have a focus on minority communities. This unprecedented national program would expand health communication and public health education efforts, including

- A national program building on current state and community-based programs for state-based and community-based programs for cardiovascular disease prevention;
- A national education program (e.g. educating providers to identify and counsel people at risk);
- Improving research, e.g. the impact of diet.

Costs: \$100 to \$200 million per year

Cancer Outreach Program (CDC program). This program would build on existing programs which provide free or low-cost screening for breast and cervical cancer. It would provide screenings for other cancers where that minorities suffer at higher rates, including prostate and colon cancer. This program could also provide outreach, education on prevention and early treatment, particularly in minority communities. Concerns In HHS initial presentation, they only identified breast and cervical cancer.

Diabetes (CDC program). While NIH believes that 16 million Americans have diabetes, only 8 million have been diagnosed. Those who go undiagnosed are far more likely to suffer the serious consequences of this disease, including blindness and kidney failure. CDC has proposed expanding their diabetes education program nationwide to provide prevention, identification, and diabetes management education to millions of Americans who suffer from this disease. It would also offer health care providers more education as to how to identify and counsel those at risk for this disease.

Costs: \$30 million

Infant Mortality (HRSA?/CDC programs). *Home Visiting Program for pregnant women.* Improves prenatal care and recent studies suggest that home visiting may lessen the likelihood of outcomes like child abuse and neglect. *Back to sleep campaign.* While the HHS campaign to reduce sudden infant death syndrome has been effective, there are still disparities in minority communities. This program could be expanded and targeted specifically to minority communities.

Costs of both initiatives: \$20 million

DRAFT

To: Race Initiative Contacts in Federal Agencies
From: Judith Winston

Thank you for agreeing to be the President's Initiative on Race's contact in your agency and for all the work you have done already in that capacity. We are currently trying to gather data on race in the United States. We believe that the federal agencies already have the information we are seeking, so we are requesting your help in compiling the data.

We have identified key demographic data, as well as eight broad categories that require researching. Data elements for each of these categories are outlined on the attached sheets. These elements are only suggested, so please feel free to substitute statistics you feel are better measurements for the information we are seeking. For each of these categories, we would like to identify the following information:

1. Key indicators of progress- the best ways of measuring success in each category
2. Trends in disparities among races
 - where have positive changes occurred (especially those where government intervention has made a difference)
 - where are disparities growing
 - where are disparities due to race and where are they due to class
 - what are the effects of urban/rural location
3. Costs of discrimination
4. Data sources, upcoming studies, other sources of information

I have asked Michele Cavataio of my staff, Jose Cerda of the Domestic Policy Council, and Sandy Korenman of the Council of Economic Advisors to pull together a meeting with you and the appropriate statistician/researcher in your agency to discuss what data your agency has available. This meeting will take place on Wednesday, August 20, from 2-3 PM in the Old Executive Office Building, room _____. We would appreciate it if you would come prepared to discuss the information on the attached sheets. In addition, we suggest that you share this information with and obtain input from your civil rights division. Please call Michele Cavataio at 395-1013 to confirm your attendance or if you have any questions.

Thank you very much. We look forward to meeting with you soon.

Brainstorming Meeting Notes: President's Race Initiative August 9, 1997

Getting started

1. 5 goals:
 - a. Articulate the President's vision of a just, unified America
 - b. Educate all Americans about the facts of race
 - c. Promote a constructive dialogue
 - d. Encourage leadership
 - e. Identify and disseminate solutions
2. study-dialogue-action
3. Need a common language to build one America / can we agree on shared values?
 - a. common ground
 - b. opportunity
 - c. family
 - d. race has impeded building of one America

Measures of success

1. Nation is better educated
 - a. Number of blacks in the US is not 50 percent
 - b. Percentage of minorities in America is changing so that there will be no majority race in a few decades
 - c. Discrimination exists
2. Judicial system
 - a. Vigorously enforce civil rights' laws/ commit adequate resources
 - b. Tie federal funds to training
3. Education system
 - a. Broad support for testing
 - b. What kind of public education system do we want? Consider resources, access.
 - c. Admission's criteria -- how to help schools measure all characteristics of a candidate and value diversity
 - d. Quality education at lower levels ensures qualified students in the pipeline

Dialogue

1. Don't let debate focus only on affirmative action
 - a. We need to treat the symptoms until we cure the disease, but we also need to focus on the disease.
2. Debate should move us to acknowledge racial tensions in our history
3. Debate should move from English only to English plus

4. Difference between prejudice which is a belief and racism which is acting on prejudice
5. America needs to agree on common values / aspirations
6. We need to educate Americans on the facts e.g. why are there haves and have nots? What are impediments to equal opportunity?
7. Recognize that not everyone will be starting in the same place
8. Should group membership include people from different races in proportion to population?
 - a. What adjustments do we need to bring about this result?
9. Helpful to understand what majority thinks.
 - a. Whites don't recognize their own privilege
 - b. Where do poor whites fit in the discussion?

Outcomes

1. Is the nation better educated about racism?
2. Do they care?
3. Are they willing to do something about it?

Strategies for realizing outcomes

1. Convince folks that diversity is important. Why?
 - a. Enlightened self interest, globalization of the economy
 - b. We don't have a person to waste
 - c. Reality: whites aren't majority in the future
 - d. Cost of discrimination (need to measure)
2. Use the bully pulpit (President, Cabinet)
3. Bring together CEOs from majority and minority communities
4. Get kids to talk to each other
5. Sponsor a Race for the Races - footrace before town meetings
6. Identify what works and share this information broadly
7. Involve public officials e.g. U.S. Conference of Mayors
8. Involve the media
 - a. Challenge networks to hold their own town meetings
 - b. Create PSAs/ Network sponsorship of primetime PSAs
 - c. Encourage commercials rather than lengthy specials
 - d. Need to educate media, too
9. Sponsor unity concerts

Audience

1. White soccer moms
2. Internet users
 - a. Email (85% has been very positive)
 - b. Capture best practices on website
 - c. Sponsor interactive dialogues
3. Folks who aren't invested

4. People who don't believe that racism exists
 - a. Mystery shopper testing is a good way to demonstrate existence of racism
5. Whites and other races - need to measure changes in attitudes
6. Policy makers
7. Corporate America -- believes in traditional meritocracy, need to broaden vision of what merit is
8. Federal Government must model behavior
 - a. E.g. military believes every person can achieve with adequate support/training
 - b. How to respond to the culture of entitlement, especially for non-performers

Concluding remarks

1. Year long initiative needs to lay foundation for continued progress
2. Need to narrow focus of initiative to concrete goals

COPY ALL DDC STAFF "file Race"

RACE INITIATIVE Qs & As

THE INITIATIVE

Q: Is systemic racism and bigotry still a crucial problem for the United States? Is race still an impediment to opportunity and progress in America?

A: America is moving closer to fulfilling its fundamental promise of equality and the opportunity of advancement for all. President Clinton has worked to restore the American dream by expanding the economy, investing in education and making our communities safer. However, more needs to be done. We face new challenges and a very different America in the next century.

For instance, there are four school systems in the country right now, including one across the river (in Virginia) where the school children represent over 150 nations and speak over 100 different languages all in a single district. We should embrace such diversity.

Unfortunately, there are some disturbing examples of going backward: the lack of economic progress among Hispanic Americans; the greatly reduced number of African-American and Hispanic students in California and Texas universities; and the young, African-American boy in Chicago who was dragged from his bicycle and beaten just because of his color.

Q: How was this initiative developed? Who did the President call on among the White House staff?

A: The President charged Erksine Bowles and Sylvia Mathews with developing the parameters of an initiative that would move to fulfill America's promise of opportunity and fairness for all Americans, and that would promote unity while preserving cultural differences.

Sylvia convened an internal working group of approximately 25 individuals from different offices within the White House and from different races. The group met regularly starting in March, and daily for the past few weeks. Erskine and other members of the senior staff participated periodically in the working group meetings. The President received regular updates on the group's direction and progress.

Q: How can the President ask others to "get their houses in order" on this subject, when the White House itself lacks diversity, especially in its upper ranks?

A: President Clinton is proud of the record diversity of his Administration. He has appointed more African Americans, Hispanics and Asian Americans than any other President.

Cabinet: 15% African American [Alexis Herman (Labor), Rodney Slater (Transportation), Jesse Brown (Veterans Affairs) and Frank Raines (OMB)]; 12% Hispanic [Bill Richardson (UN), Aida Alvarez (SBA), Federico Pena (Energy)].

Presidential Appointments: 13% African American (twice as many as any previous Administration); 8% Hispanic; 3% Asian American; 1% Native American.

Q: Isn't this just the President's reactionary position after the Administration has neglected to take stronger stances on behalf of minorities?

A: The President wants *this issue* to get more media attention. The President has consistently said he had three goals in running for the office: to keep the American Dream alive for everyone who wanted to work for it; to keep America a force in the world for peace and democracy; and to keep us "One America," a nation coming together instead of coming apart.

The Administration has made real progress on issues of economic opportunity, strengthening families, reducing crime rates, and foreign policy (the first two goals).

Economic policies that have helped the entire country have also helped minorities.

- The unemployment rate for Hispanic Americans in May was about 7 percent, down from 11 percent when President Clinton took office.
- The African-American poverty rate dropped to 29 percent in 1995 -- its lowest level since data was collected.
- The Administration has approved more than \$2 billion in Small Business Administration loans to Asian Americans.

The time is right to move forward more aggressively on the President's third goal. Already the President has taken action in this area with his apology, on behalf of the federal government, to the victims of the Tuskegee experiment and his commitment to a White House conference on hate crimes. In addition, an interagency group is exploring how to address the problem of declining diversity in student bodies.

PRESIDENT'S COMMITMENT

Q: The President seems to waiver in his commitment to this issue. One day he asks the Supreme Court not to hear an affirmative action case and the next day he announces an initiative on improving race relations. How serious is he about this initiative?

A: The President is very serious about this initiative. He has been steadfast throughout his life and professional career in his pursuit of equality and opportunity for all.

- The President's experiences with discrimination are rooted in the South's legacy of slavery.

- As a candidate, the President has consistently said one of his main goals in running for the office was to keep the American Dream alive for everyone who wanted to work for it and to keep us "one America," a nation coming together instead of coming apart.
- As President, he has been a constant voice in pressing racial healing and unity. For instance: speeches in Memphis, Tennessee, in 1993 and Austin, Texas, in 1995; inaugural and State of the Union addresses this year; and remarks at the Jackie Robinson anniversary commemoration.

President Clinton's personal history and conviction to lead this country in finding strength in our diversity make him well-suited to help forge alliances and reconcile differences among us. The President will be actively involved in the initiative and will help provide its intellectual leadership.

Q: Does the President really expect this initiative to make a difference or is it just a way for him to get more media attention?

A: This initiative will attempt to identify and create solutions for improving race relations and the circumstances of Americans of all races. Those solutions will be designed for individuals, communities, religious congregations, educational and non-profit organizations, businesses, state and local governments, and other groups to implement. The Administration will develop wholly new policy and refocus existing policy. Some policies will respond to information arising as the initiative moves forward. Other policies will attempt to address longstanding problems in new and creative ways.

EXPECTATIONS

Q: Will this initiative address the serious imbalances in opportunity that can be attributed to race?

A: This initiative will study the imbalances in opportunity that can be attributed to race, open channels for discussion about those imbalances and create or refocus policy to address those imbalances.

We will strive to identify and create solutions for improving race relations and the circumstances of Americans of all races. Those solutions will be designed for individuals, communities, religious congregations, educational and non-profit organizations, businesses, state and local governments, and other groups to implement.

Q: How can the President hope to improve race relations and the lot of minorities without dedicating significant funds to the problems that arise from racism?

A: Different times call for different solutions. The choice is not between massive programs and nothing. Much can be done within the confines of tighter federal spending that we face today and going forward. Funds can be reallocated, as they were, in the balanced

budget agreement, to provide health coverage to five million uninsured children. And we can seek creative ways to generate new funds, not just from federal and state spending.

Q: What can we expect to see change as a result of this initiative?

A: We will promote a better understanding of and a greater respect for both the similarities and differences between people of different races.

We will challenge leaders and “doers” will step forward, in communities throughout the nation, to find and put into practice ideas to improve race relations and stimulate opportunity for all.

We will identify and disseminate proven practices for promoting racial harmony.

We will analyze critical issues affecting race relations in this country and propose government actions and policies to address these issues.

Q: How does the President intend to keep this from becoming just a big talk fest?

A: The effort will be a balance of study, dialogue and action -- including fact finding and policy.

We will seek to promote honest dialogue on the issues of race and to develop real solutions that can be implemented by individuals, communities, religious congregations, educational and non-profit organizations, businesses, state and local governments, and other groups. We will undertake fact finding (e.g.: what are the stereotypes and what are the facts), dialogue and policy/action (e.g.: best practices, positions on minority enrollment in higher education) concurrently and through an iterative process.

Q: Civil rights groups have expressed dissatisfaction that they have not been consulted and dismay at the lack of substance to the initiative. How do you respond?

A: In the process of defining this initiative, we sought comments and ideas from numerous individuals and organizations. More importantly, we have created plenty of opportunities for future consultation. This is only the beginning of an initiative that will be a uniquely inclusive and broad-ranging year-long effort. We encourage those willing to engage in tough, honest dialogue to join us.

The President is prepared to design wholly new policy and to refocus existing policy. We will look for and implement solutions in areas such as economic opportunity, housing, health care, crime and the administration of justice. We have said all along that we will not outline a full set of proposals and recommendations at the outset. The Administration will unfold policy changes and developments over the course of the year.

LOGISTICS

Q: When will the advisory board hold its first meeting? When will it conclude its work?

A: The advisory board will meet for the first time in the next six weeks or so. An exact date has not yet been determined. At this point, the board will likely disband after the President submits his report to the American people.

Q: When can we expect to see the first action or policy recommendations from the advisory board?

A: As a result of this initiative, we expect the President to implement wholly new policies as well as to reshape existing policies. The Administration's actions and policy changes will take place over the course of the year-long initiative. We cannot say when the first announcement will be. It will be several weeks before the advisory board, the initiative staff and Administration representatives start working.

ADVISORY BOARD

Q: Why did the President appoint an advisory board rather than an independent commission?

A: This initiative is designed to use presidential leadership to prepare the American people for the next century. President Clinton's personal history and conviction to lead this country in recognizing the strength in our diversity make him well-suited to help forge new alliances among citizens. The President will be actively involved in the initiative and will help provide its intellectual leadership. He will also involve the American people in an unprecedented way.

The board members will serve as partners in the initiative by reaching out to various communities, amplifying the President's efforts and recruiting more leaders on this issue. The advisory board members were selected based on the concept that they would excel in these responsibilities and be respected, if not well known, in what is a Presidentially-led effort.

Q: Wouldn't you have been better off with individuals with name recognition?

A: In identifying an advisory board, the working group sought individuals who could reach out on behalf of the President to various communities, provide guidance and analysis on topics concerning race and recruit more leaders to implement solutions that will improve race relations.

We also looked for a group of individuals who would provide diversity on a number of fronts, be respected in their fields and work well together exemplifying the relationships we hope the whole initiative will engender.

Many of the advisory board's members are familiar ones, especially in their communities or areas of expertise.

Q: How much is this initiative going to cost?

A: We are working with the appropriators on a Justice Department reprogramming of funds for the initiative. The approximate cost of the initiative is \$2.9 million.

Q: What is the \$2.9 million for?

A: The funding will enable us to bring the advisory board to the American people and for providing staff who will study the issues and reach out to the American people.

Q: Why are there no Native Americans on the advisory board?

A: The advisory board is small in number. These individuals represent diversity in race, age, gender, background and political perspective. There will be many, many opportunities (for example: staff appointments, Presidential town hall meetings, advisory board outreach) over the course of the initiative for the President and the advisory board to work with and hear from individuals whose diversity is not reflected on the board.

File

Race +

Health

NTB

Sarah + Chris,
Here are
impacts
of selected
diseases on
minorities
Mary

MEMORANDUM

TO: TOM FREEDMAN, MARY L. SMITH
FROM: DREW HANSEN
RE: IMPACTS OF SELECTED CAUSES OF DEATH ON MINORITIES
DATE: JULY 29, 1997

SUMMARY

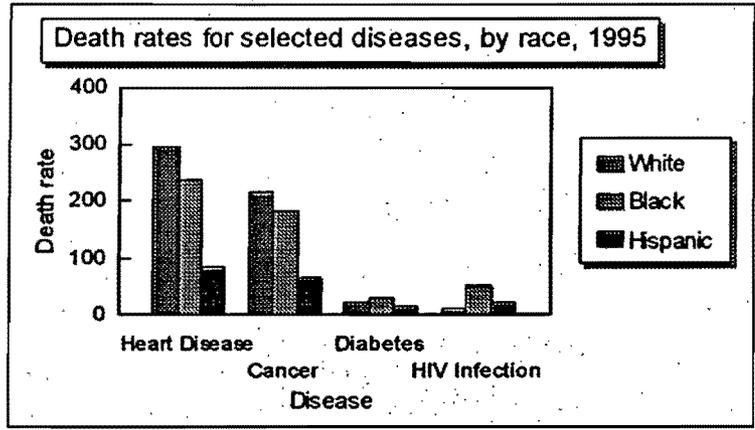
The following data summarizes the impact of selected causes of death (AIDS, cancer, diabetes, heart disease, hypertension, and infant mortality) on members of minority groups.

1. TOTALS, SELECTED DISEASES

Deaths and death rates for selected diseases, by race, 1995

Cause of death	White		Black		Hispanic Origin	
	Number	Rate	Number	Rate	Number	Rate
Cancer	468897	215	60603	182.9	17419	64.7
Diabetes	47475	21.8	10402	31.4	4194	15.6
Heart Disease	649089	297.6	78643	237.3	22403	83.3
HIV Infection	25509	11.7	17139	51.7	6110	22.7

Source: CDC, Monthly Vital Statistics Report, Vol. 45, No. 11(S) 2, June 12, 1997



2. AIDS

AIDS cases and annual rates per 100,000 population, by race/ethnicity and age group, reported in 1996, United States

Race/Ethnicity	Adults/Adolescents		Children <13		Total	
	No.	Rate	No.	Rate	No.	Rate
White, notHispanic	26229	16.2	98	0.3	26327	13.5
Black, notHispanic	28346	115.3	429	5.7	28775	89.7
Hispanic	12966	55.8	145	1.7	13111	41.3
Asian/Pacific Islander	561	7.5	1	0	562	5.9
Amer. Indian/Alaska Native	207	14.1	3	0.6	210	10.7

Source: U.S. Dept of Health and Human Services, "HIV/AIDS Surveillance Report," Vol. 8 No. 2, 1996.

3. CANCER

5 Year Relative Cancer Survival Rates, by Site: White and Black Patients 1986 to 1992

Site	White	Black
Thyroid	95.5	90.3
Testis	95.4	85.8
Prostate	88.6	73.2
Melanomas of Skin	87.6	72.2
Corpus and Uterus, NOS	85.5	55.9
Breast	85	69.8
Bladder	82.4	59.5
Hodgkin's Disease	81.5	71.9
Cervix	71.4	56.4
Larynx	68.3	52.3
Colon	62.9	53.4
Rectum and Rectosigmoid Junction	60.5	52.8
Kidney and Renal Pelvis	59.6	54.6
Oral Cavity and Pharynx	55.2	33.4
Non-Hodgkins Lymphomas	52.1	43.8
Ovary	45.6	40
Leukemias	42.6	34
Brain and CNS	28.8	31.8
Multiple Myeloma	28.4	29.8
Stomach	19.3	20.3
Lung and Bronchus	14	11.2
Esophagus	11.7	7.9
Liver and IBD	6.5	5.3
Pancreas	3.5	5.1

Source: National Cancer Institute, Data from SEER program, 1986-1991.

4. DIABETES

Diabetes Prevalence and Death Rate, by Race (1993)

Race/Ethnicity	Prevalence	Death Rate	Death Rate/Whites
<i>White</i>	6.2%		
<i>Black</i>	9.0%		
*men	4.1%	26.3	115.6%
*women	4.9%	26.9	169.0%
<i>Amer. Indian/Alaska natives</i>	9.2%		
*men	4.2%		
*women	5.0%		
<i>Asian/Pac. Islander</i>	5.8%		
*men	3.4%		
*women	2.4%		
<i>Hispanic</i>	7.2%		
*men	3.7%		
*women	3.5%		

Source: American Heart Association. "White" rate is from U.S. General Accounting Office, Diabetes: Status of the Disease Among American Indians, Blacks, and Hispanics," 1992.

5. HYPERTENSION

Persons Reporting High Blood Pressure, 1990

Race/Ethnicity	Percent, 18yrs +
White	15.9%
Black	21.3%
Hispanic	10.1%
Non-Hispanic	16.8%

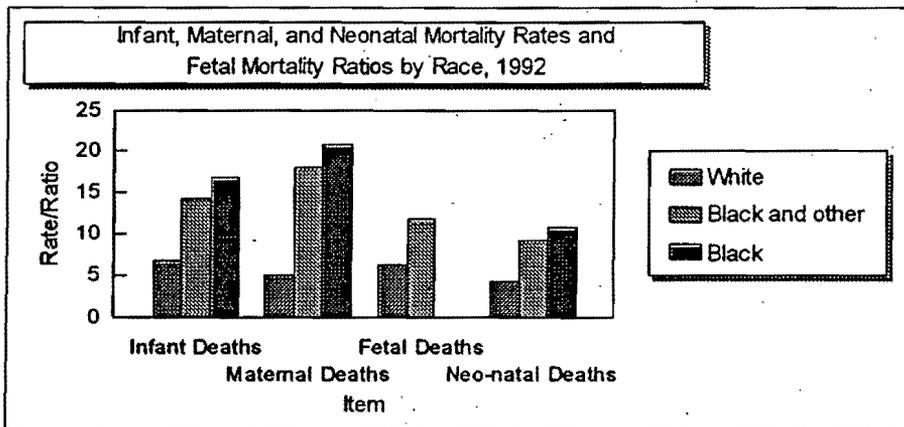
Source: Statistical Record of Health and Medicine, 1995

6. INFANT MORTALITY

Infant, Maternal, and Neonatal Mortality Rates and Fetal Mortality Ratios by Race, 1992

Item	Total	White	Black and other	Black
Infant Deaths	8.5	6.9	14.4	16.8
Maternal Deaths	7.8	5	18.2	20.8
Fetal Deaths	7.4	6.3	11.7	NA
Neo-natal Deaths	5.4	4.3	9.2	10.8

Source: Statistical Abstract of the United States, 1996.



Eliminating Disparities in Health

In support of the President's Initiative on Race, the Department of Health and Human Services has identified six areas in which racial and ethnic minorities experience serious disparities in access to health services and in health status. The leadership and resources of the Department will be committed to achieving significant reductions in these disparities by the Year 2000, with the ultimate goal of eliminating these disparities. Through this effort, we will contribute to meeting three of the five central goals of the President's Initiative on Race:

- educate the nation about the facts surrounding the issue of race
- promote a constructive dialogue to confront and work through the difficult and controversial issues surrounding race
- find, develop and implement solutions in critical areas such as health care for individuals, communities, corporations and government at all levels.

A national focus on health disparities is needed given the compelling evidence that race and ethnicity correlate with persistent, and often increasing, health disparities between populations in the United States. Indeed, despite significant progress in the overall health of the nation, as documented in *Health, United States*, the annual report card on the health status of the American people, there are continuing disparities in the burden of death and illness experienced by Blacks, Hispanics, American Indians and Alaska Natives and Asians and Pacific Islanders as compared to the U.S. population as a whole. The demographic changes that will unfold over the next several decades heighten the importance of addressing the issue of disparities in health status: Groups that currently experience poorer health status will increase as a proportion of the total population. Therefore, the future health of the American people will be substantially influenced by our success in improving the health of racial and ethnic minorities.

It is particularly important that the Department and the nation focus on the issue of disparities in access to services and health status as major changes unfold in the systems through which care is financed and delivered. Indeed, one of the Department's strategic goals for the next six years is to improve the quality of health care, with particular attention given to the problem of disparities in access to quality services. However, it is important to note that improvements in prevention and clinical services can only partially address the difficult, complex and often controversial issues surrounding racial and ethnic disparities in health status. Education, income and other socioeconomic factors play a large role in influencing health outcomes. The Department's programs to improve the economic security of low-income families and communities will be important contributors to improving the health status of low-income populations—populations that are disproportionately composed of racial and ethnic minorities. We look forward to collaborations with other federal departments, states and the private sector to address the broader determinants of health.

The Department has selected six health problem areas to address as part of the President's Initiative on Race: infant mortality, breast and cervical cancer, heart disease and stroke, diabetes, AIDS case rates, and child and adult immunizations. These focus areas are drawn from the health objectives for the nation, *Healthy People 2000*. The targets to reduce these disparities have been established in collaboration with the major national organizations that are active in addressing health concerns for the affected populations. The six focus areas will receive priority attention because achieving these goals will make an important contribution to improving the health of racial and ethnic minorities. In the process we will also learn how to more effectively target strategies and resources to address other problem areas. This exercise will contribute materially to our longer term objective of substantially eliminating disparities in health status by the year 2010.

To achieve the goals of the President's Initiative on Race will require a reexamination and re-energizing of existing efforts within the Department. The Department must redouble its efforts to assure that the needs of its customers are identified and addressed, and that Departmental efforts are communicated as effectively as possible. The Department must broaden and strengthen its partnerships with state and local governments, with national and regional minority health and other minority-focused organizations, and with minority community-based organizations--those who have the greatest access to and knowledge of the community. Finally, the Department must ensure that adequate monitoring efforts are carried out, and that local and national data necessary for determining priorities, and designing programs are available.

The Department has set forth an action plan for the next twelve months aimed at achieving progress towards the six goals. In addition, the Secretary and the Assistant Secretary for Health will conduct strategic assessments for each of the six goals over the next year to assess whether the Department and the nation are doing the right things to assure that the goals are met, and to begin a broad national dialogue to identify the most effective actions to achieve progress in these six areas, and by extension the other areas of disparity that must be addressed in the long term.

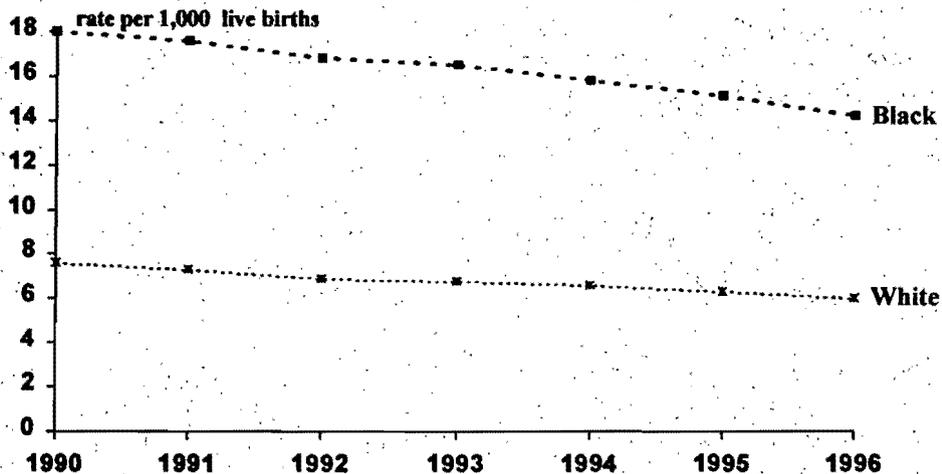


GOAL 1

**Eliminate disparities in infant mortality rates,
including death from Sudden Infant Death Syndrome (SIDS)**

There are substantial racial and ethnic disparities in infant morbidity and mortality rates in the United States. Our goal is to continue progress in reducing overall morbidity and mortality rates, and to eventually eliminate disparities among groups. As a major step towards that end, we have set a near term goal of reducing the greatest disparity in infant mortality, which is among blacks whose rate is nearly 2 ½ times as great as whites, by at least 20% from their 1996 rate by the Year 2000. We will also work to reduce infant mortality rates among American Indians and Alaska Natives, Puerto Ricans, and Native Hawaiians whose rates are also above the national average. These are our goals under *Healthy People*--the nation's health objectives.

Infant Mortality Rates for the United States by Race, 1990-1996.



Infant Mortality Rate Baselines:

Total: 7.2 per 1,000 live births (1996 preliminary data)

Black: 14.2 per 1,000 live births (1996 preliminary data)

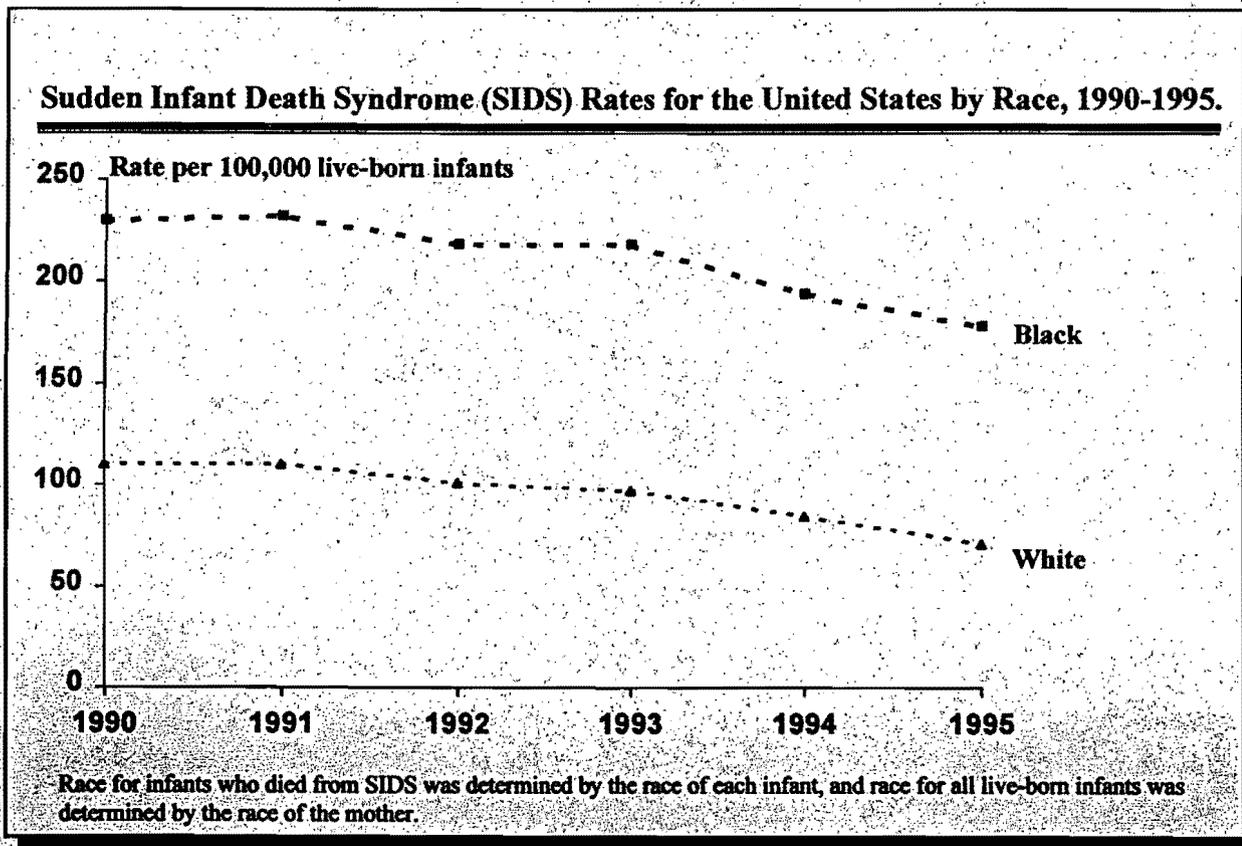
White: 6.0 per 1,000 live births (1996 preliminary data)

Data Source: National Vital Statistics System natality/mortality files, CDC, NCHS

Periodicity of data source: Annual. Preliminary data for the total population, and for white and black subgroups are available nine months after the close of the data year; final data are available 16 months after the close of the data year. Data for other subgroups come from linked data sources and are not available until 21 months after the close of the year (due to inconsistencies in

reporting ethnic origin, birth and death files for Hispanic and other minorities that must be linked before accurate statistics can be reported). Linked infant birth and death file data for 1995 will be available this fall for American Indians and Alaska Natives, Puerto Ricans, and Native Hawaiians.

Background: Although overall infant mortality rates have been declining, the decline in rates for a number of racial and ethnic groups significantly lags behind the national experience. A major factor in these varied rates is the substantial racial disparity in low birth weight and preterm birth. Much of the decline in overall rates can be traced to research advances, better understanding and treatment of respiratory distress syndrome as well as reductions in deaths due to Sudden Infant Death Syndrome (SIDS). Despite improvements in recent years, SIDS still accounts for approximately 10% of all infant deaths in the first year of life. Minority populations are at greater risk for SIDS, with rates among blacks being two and one half times that of whites, and among some American Indian and Alaska Native populations being three to four times greater. Among blacks the SIDS rate has declined 18 percent between 1993 and 1995, the largest decline ever observed. However, the disparity *between* blacks and whites for SIDS remains large.



Sudden Infant Death Syndrome Rate Baselines:

- Total:** 74.2 per 100,000 live-born infants (1996 preliminary data)
- Black:** 178.6 per 100,000 live-born infants (1995)
- White:** 71.0 per 100,000 live-born infants (1995)

Data Source: National Vital Statistics System mortality data, CDC, NCHS

Periodicity of data source: Annual. Preliminary data for the total population are available nine months after the close of the data year; final data that include racial subgroups are available 16 months after the close of the data year.

Strategy for Achieving the Goal

- Provide enhanced prenatal services to low-income pregnant women by building community-based outreach and family-centered infrastructures in communities with high rates of infant mortality, morbidity, and poverty.
- Support a range of biological and behavioral research to better identify the specific factors contributing to the racial and ethnic disparities associated with infant death, preterm delivery, low birth weight, SIDS, and related adverse outcomes.
- Form linkages among public agencies and academic, professional, business and other private entities to address and promote coordinated research and health and social services.
- Promote the recruitment and training of minority researchers and the support of minority institutions that have immediate access and can contribute to the care of high-risk populations.

Action Steps for the Next 12 Months

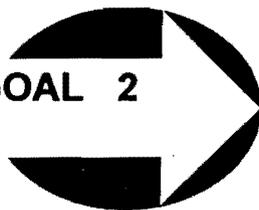
- ◊ Increase to 100% the number of States with a plan that addresses infant mortality reduction and the associated racial/ethnic disparities. Emphasis will be placed on increasing the percentage of minority pregnant women receiving prenatal care in the first trimester.
- ◊ All 50 States will have active "Back to Sleep" or SIDS risk reduction campaigns
- ◊ Increase to 60 the number of high-risk communities addressing infant mortality reduction, and especially the elimination of disparities in infant mortality rates.

Examples of Programs that Support this Strategy

- **"Back-to-Sleep" Campaign:** Much of the recent decline in the incidence of SIDS is credited to this campaign which recommends that healthy babies be placed on their backs to sleep to help reduce the incidence of SIDS. The campaign will expand efforts to reach minority and ethnic populations. (NIH, HRSA, CDC)
- **Cultural Competence in SIDS Service-Delivery Systems:** Complete a Task Force Report by Fall 1997 with recommendations for culturally competent strategies to improve public

health campaigns and bereavement services for under served racial and ethnic populations. (HRSA)

- **SIDS-Related Research:** Support research to 1) better understand the physiologic causes of SIDS and why SIDS infants die, 2) develop effective screening tests that can identify infants at risk for SIDS, 3) develop effective pharmacologic therapies for high risk infants; and 4) define specific patterns of risk in racial populations. (NIH)
- **Healthy Start Initiative:** Fund approximately 40 new high-risk communities to implement one or more of the community-based strategies to reduce infant mortality determined to best address the needs of the individual community. (HRSA)
- **State Mortality/Morbidity Review Support Programs:** Support up to five States in their efforts to promote, coordinate, and sustain mortality and morbidity review programs at state and community levels. This will allow States to expand their focus to morbidities and additional population groups. Emphasis will be placed on developing community and state partnerships that utilize the community-based review findings pertaining to service barriers and proposed systems changes to improve racial disparities and other problems associated with poor pregnancy or child health outcomes. (HRSA)
- **Perinatal Research:** Increase identification of risk factors and biological markers for adverse pregnancy outcomes, (e.g., LBW and preterm births), as well as SIDS, among minorities, with the expectation of developing appropriate and effective interventions and treatments for clinical conditions. (NIH, HRSA, CDC)



GOAL 2

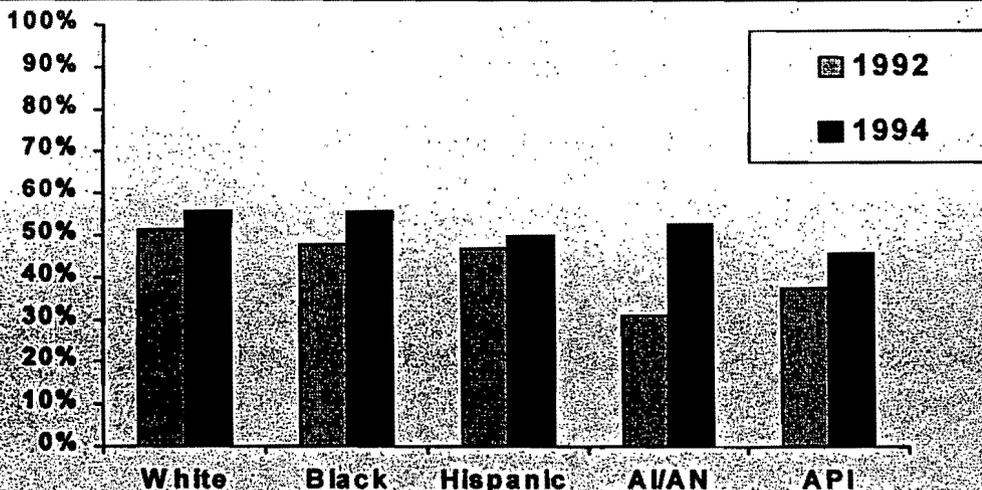
Eliminate disparities in breast and cervical cancer screening and management.

Cancer is the second leading cause of death for all women. Disparities in breast and cervical cancer incidence and death rates occur among various racial and ethnic groups. Screening to detect early disease is critical in the management of these two cancers. Even small changes in the percentage of women screened by mammography and Pap tests can have significant impact on the overall burden of suffering from these cancers. Our goal is to continue progress in getting more women screened for these two cancers at the appropriate age and time intervals, and to eventually eliminate disparities among all racial and ethnic groups in regards to screening and management.

Breast Cancer:

Our goal for the year 2000 for breast cancer screening is to increase to at least 60% those women of all racial or ethnic groups aged 50 and older who have received a clinical breast exam and a mammogram within the preceding two years. This means we will have to increase the screening rate among white and black women by 7% from their 1994 level, American Indian and Alaska Natives by 13 %, Hispanic women by 20%, and Asian and Pacific Islanders by 30% in order to reach our goal under *Healthy People*--the nation's health objectives.

Proportion of Women Aged 50 and Older Who Have Received a Clinical Breast Examination and a Mammogram Within the Preceding Two Years, United States, 1992 and 1994.



Breast Cancer Screening Rate Baselines for women \geq 50 years of age:

Total: 56 % (1994)

White: 56% (1994)

Black: 56% (1994)

Hispanic: 50 % (1994)

American Indian/Alaska Native (AI/AN): 53% (1994)

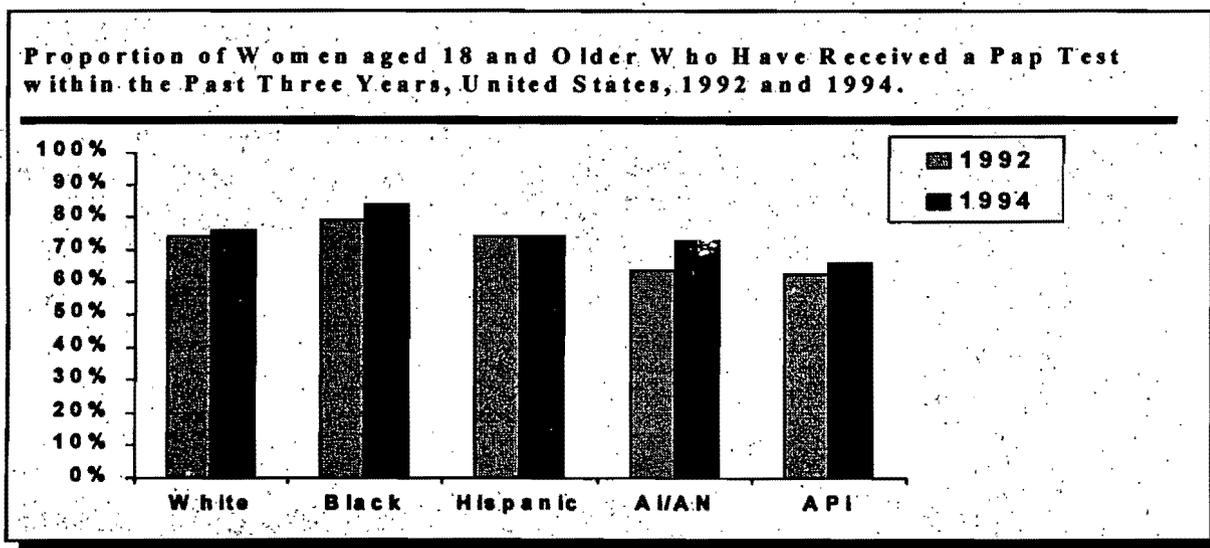
Asian and Pacific Islanders (API): 46% (1994)

Data Source: National Health Interview Survey, CDC, NCHS

Periodicity of Data Source: Data are available once every three years, six months after the close of the data year.

Cervical Cancer:

Our goal for the year 2000 for cervical cancer is to increase to at least 85% the proportion of all women aged 18 and older who have received a Pap test within the preceding three years. This is our goal under *Healthy People*--the nation's health objectives.



Cervical Cancer Screening Rate Baselines for women age \geq 18 years :

Total: 77 % (1994)

White: 76% (1994)

Black: 84% (1994)

Hispanic: 74 % (1994)

American Indian/Alaska Native (AI/AN): 73% (1994)

Asian and Pacific Islanders (API): 66% (1994)

Data Source: National Health Interview Survey, CDC, NCHS

Periodicity of Data Source: Data are available once every three years, six months after the close of the data year.

Discussion: Black women have a 30% greater risk of dying from breast cancer than white women, despite an overall lower risk of acquiring breast cancer in the first place. This higher death rate among blacks is most likely due to later diagnosis and treatment, hence the need for better cancer screening and management among minority populations. Furthermore, the breast cancer death rate *decreased* 10 percent for white women during 1980-1995, while it *increased* 18 percent for black women. These disparities hold true for cervical cancer as well, where the death rates are higher for black (5.2 per 100,000 in 1995) and Hispanic women (3.1 per 100,000) than for the total population (2.5 per 100,000).

Strategy for Achieving the Goal

- Increase public education campaigns to address the benefits of mammography, thereby increasing the proportions of women aged 50-70 who have had a screening mammogram in the prior two years.
- Provide access to optimal care for minority women.
- Establish the Healthy People goal as performance measures in HRSA Primary Care Programs and as program expectations for community and migrant health centers across the nation.

Action Steps for the Next 12 months

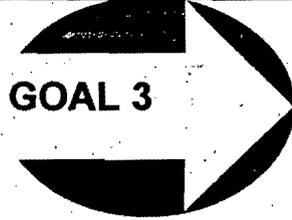
- Increase in the proportion of minority women 50 to 70 years of age who have had a mammogram and clinical breast exam in the past two years as measured by the 1998 National Health Interview Survey.
- Increase the proportion of minority women aged 18 and above who have had a Pap test in the prior three years as measured by the 1998 National Health Interview Survey.
- Expand access to screening and treatment to underserved women through the Breast and Cervical Cancer Early Detection Program.

Examples of Programs that Support this Strategy

- **CDC's National Breast and Cervical Cancer Early Detection Program** builds the public health infrastructure for breast and cervical cancer early detection in States through public and provider education, quality assurance, surveillance and partnership development. This program offers free or low-cost mammography and Pap tests to medically under served women, many of whom are minorities. Nearly 1 million screening tests have been performed since the program's inception.

- **The National Cancer Institute (NCI)** is funding twelve regional conferences in FY 1997 on the recruitment and retention of minorities in clinical trials.
- **The Minority Based Community Clinical Oncology Program** which is one of the programs responsible for the proportional representation of blacks and Hispanics in NCI sponsored treatment trials.
- **The National Black Leadership Initiative on Cancer and The National Hispanic Leadership Initiative on Cancer** are important public education programs working in concert with the NCI's Office of Cancer Communication.
- **The National Program of Cancer Registries (NPCR)**, which supports comprehensive, timely, accurate cancer registries in 42 States and the District of Columbia. The NPCR enables reporting of cancer data by age, ethnicity and geographic regions and provides critical feedback to States for tracking cancer trends, targeting and evaluating cancer control interventions, and health resource planning.
- **The Information Action Council of the National Action Plan on Breast Cancer** has developed a **Bridge to Underserved Populations initiative**. This initiative is exploring a variety of strategies for providing hard-to-reach populations with breast cancer information using the Internet. The IAC convened a series of regional meetings across the country to investigate and develop strategies for bridging the gap between the underserved women and the Information Superhighway. The meetings brought together community based organizations, private organizations, and women from underserved communities. The IAC plans to build partnerships with community based organizations in model pilot projects, that will ensure that underserved women have access to the wealth of information about breast cancer available on the Information Superhighway.
- **The Health Care Financing Administration Medicare Mammography Campaign**, which was launched in conjunction with First Lady Hillary Rodham Clinton and the U.S. Public Health Service's Office on Women's Health, encourages older women to use Medicare's mammography screening benefit.
- **Coverage of Mammography and Pap Smears Under Medicare and Medicaid** - Under H.R. 2015, enacted in August 1997, mammography coverage under Medicare will be expanded to include annual screening mammograms for women over 39, with the cost-sharing waived. Pelvic exams, clinical breast exams, and Pap smears will be covered under Medicare every three years, with annual Pap smears for women at risk of developing cervical cancer and those who have not had negative Pap smear in the past three years. Cost-sharing would also be waived. The Health Care Financing Administration has also sent letters to state Medicaid Directors urging them to provide coverage for annual screening mammograms for women aged 40 and older under Medicaid.
- **HCFA** will continue projects with medical peer review organizations to measure quality of medical practice and assure that all Americans receive the same high quality health care.

- **The Minority Women's Health Initiative** of the PHS Office on Women's Health (OWH) was developed in response to recommendations made during the PHS OWH Minority Women's Health Conference in January 1997. This initiative will target breast cancer in minority women as a top priority.
- **The Federal Coordinating Committee on Breast Cancer** will be awarding up to \$3 million in fiscal year 1997 to supplement existing programs as well as to support approved but unfunded projects that are targeted towards reducing breast cancer in underserved populations. These funds will be distributed to all agencies of the federal government that carry out breast cancer activities.

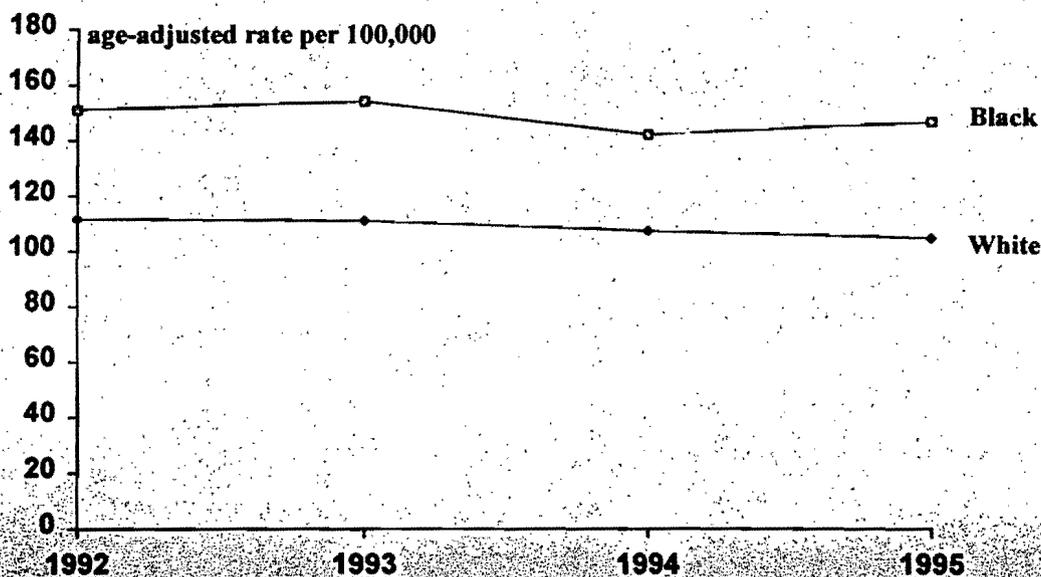


GOAL 3

Eliminate disparities in heart disease and stroke

Cardiovascular disease, particularly heart disease and stroke, kills nearly as many Americans as all other diseases combined and is also one of the major causes of disability in the United States. Our goal is to continue progress in reducing the overall death rates from heart disease and stroke, and to eventually eliminate disparities among all racial and ethnic groups. In order to have the greatest impact towards that end, we have set near term goals of reducing the heart disease and stroke mortality rates among blacks by 25% from their 1995 level by the year 2000; these are our goals under *Healthy People*--the nation's health objectives. Although age-adjusted death rates for cardiovascular disease among other minority groups are lower than the national average, there are subgroups within these populations that have high mortality rates from heart disease and stroke. We will develop strategies to reduce these mortality rates as well.

Rates of Coronary Heart Disease (CHD) Deaths, United States, 1992-1995.



Coronary Heart Disease Mortality Rate Baselines:

Total: 108 per 100,000 persons (age-adjusted) (1995)

White: 105 per 100,000 persons (age-adjusted) (1995)

Black: 147 per 100,000 persons (age-adjusted) (1995)

American Indian/Alaska Natives: 76 per 100,000 persons (age-adjusted) (1995)

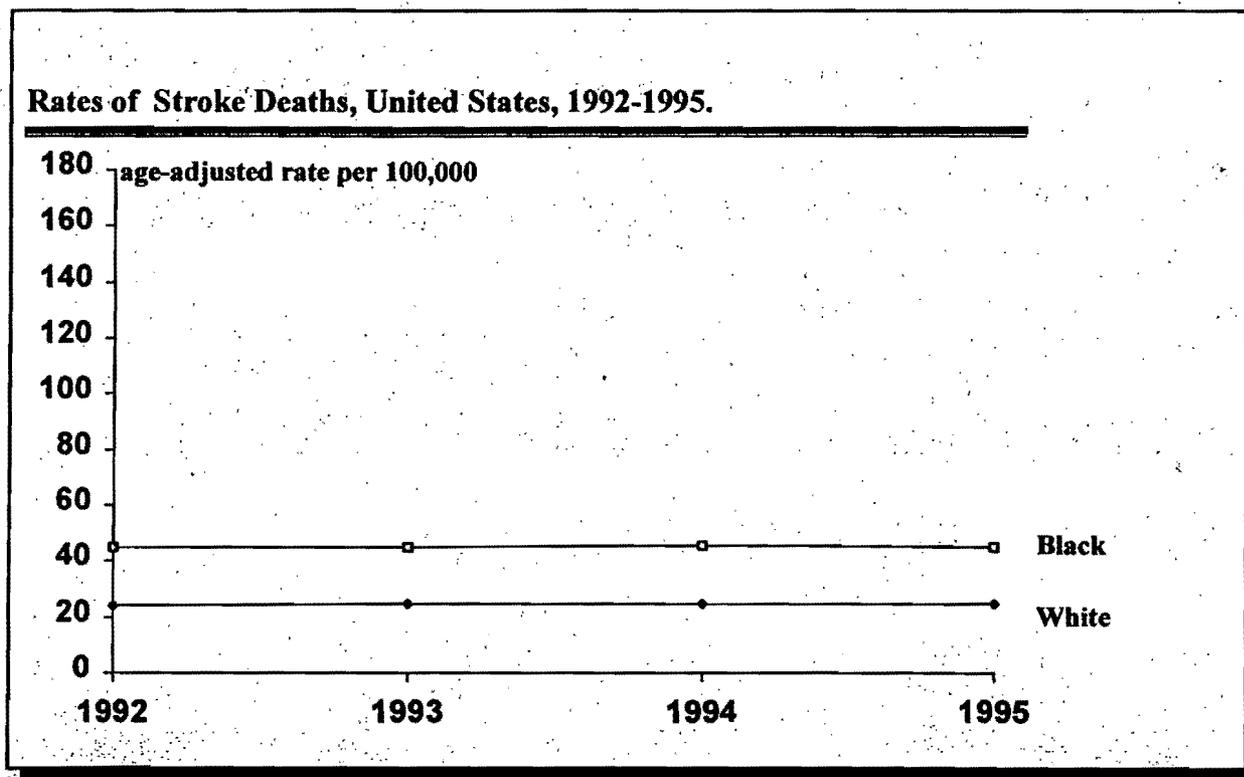
Asian/Pacific Islanders: 63 per 100,000 persons (age-adjusted) (1995)

Data Source: National Vital Statistics System mortality files, CDC, NCHS

Periodicity of Data Source: Data are currently available on an annual basis approximately 16 months after the close of the data year.

Mortality data are collected on minority subgroups; however, denominator data for total Hispanic population requires special data runs from Census to estimate the population sizes as of July 1 of the data year. These data are available approximately 28-30 months following the July 1 date. (1995 data will be available in fall 1997.)

Mortality data are collected on Asian/Pacific Islander subpopulations. However, the latest denominator data available from Census for these subpopulations is 1990.



Stroke Mortality Rate Baselines:

Total: 26.7 per 100,000 persons (age-adjusted) (1995)

White: 24.7 per 100,000 persons (age-adjusted) (1995)

Black: 45.0 per 100,000 persons (age-adjusted) (1995)

American Indian/Alaska Natives: 21.6 per 100,000 persons (age-adjusted) (1995)

Asian/Pacific Islanders: 25.8 per 100,000 persons (age-adjusted) (1995)

Data Source: National Vital Statistics System mortality files, CDC, NCHS

Periodicity of Data Source: Data are currently available on an annual basis approximately 16 months after the close of the data year.

Discussion: The age-adjusted death rate for coronary heart disease for the total population declined by 20% from 1987 to 1995; for blacks, the overall decrease was only 13 percent. Within similarly insured populations such as Medicare recipients, there are significant disparities between blacks and whites in the use of certain diagnostic procedures for heart disease that cannot be explained by differences in the severity of symptoms. Racial and ethnic minorities also have higher rates of hypertension, tend to develop hypertension at an earlier age, and are less likely to be undergoing treatment to control their high blood pressure. Furthermore, the rates for regular screening for cholesterol, another risk factor for heart disease, show disparities for certain racial and ethnic minorities--only 50% of American Indians/Alaska Natives, 44% of Asian Americans, and 38% of Hispanics have had their cholesterol checked within the past two years.

Strategy for Achieving the Goal

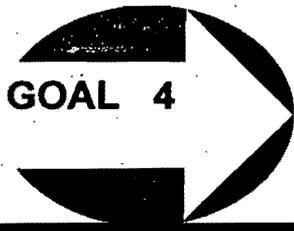
- Foster efforts by public and private health-related organizations to disseminate and implement current knowledge about prevention and treatment of cardiovascular disease
- Further explore issues of cardiovascular risk factors to define more clearly those populations that are at increased risk for cardiovascular disease.
- Conduct research to identify genetic determinants of elevated risk.
- Establish the Healthy People goals as performance measures in HRSA Primary Care Programs and as program expectations for community and migrant health centers across the nation.

Action Steps for the Next 12 Months

- ⊞ Evaluate results of the Latino Community Cardiovascular Disease Prevention and Outreach Initiative and use findings for planning a national strategy.
- ⊞ Implement selected program outreach strategies as reflected in the NHLBI Ad Hoc Committee on Minority Populations 5-Year Strategic Plan developed in FY 97.
- ⊞ Initiate a new Asian/Pacific Islander American Cardiovascular Disease Prevention Initiative.
- ⊞ Initiate a new coronary heart disease professional medical education Website for health professionals who provide care to black patients.
- ⊞ Disseminate widely the training materials on cultural competence so that health care providers have information that is relevant to greater patient compliance and better outcomes.

Examples of Programs that Support this Strategy

- **The African American Community Cardiovascular Disease Prevention and Outreach Initiative**, established by the **National Heart, Lung, and Blood Institute (NHLBI)** in 1992. As a part of this initiative, the NHLBI works with the National Medical Association, Association of Black Cardiologists, National Black Nurses' Association, and historically black medical colleges and universities' medical schools to develop and implement community-based cardiovascular disease prevention and education projects for inner-city blacks.
- **The Latino Community Cardiovascular Disease Prevention and Outreach Initiative**, established in 1995 by the NHLBI. This initiative is composed of local projects that involve community members in health promotion and disease prevention programs; develop culturally appropriate and language-specific materials; involve existing community organizations and services; use select influential media; and incorporate positive community lifestyles, values, and beliefs. Plans are underway to transition these local projects to a national effort.
- **Building Healthy Hearts for American Indians and Alaska Natives** was established in 1996 by the NHLBI. It seeks to increase awareness and knowledge of risk factors for cardiovascular diseases, which account for nearly a quarter of all American Indians and Alaska Native deaths. The initiative develops heart health promotion strategies that address needs and incorporate culture, tradition, lifestyles and values of Native Peoples.
- **The Smoking Cessation Strategies for Minorities Initiative** has been conducted by the NHLBI since 1989 to stimulate development of culturally specific smoking cessation and relapse prevention programs for under served minorities. The program developed data on smoking prevalence, acceptability of programs, and incentives that are effective in recruiting and retaining individuals in smoking cessation programs.
- **Improving Hypertensive Care for Inner City Minorities** is a research program initiated by the NHLBI in 1993 to develop and then evaluate the feasibility, acceptability, and effectiveness of various methods of maintaining therapy and control of hypertension in inner city minority groups.
- **The Centers for Disease Control and Prevention's Division of Nutrition and Physical Activity** oversees **WISEWOMAN**, which targets Hispanic women who are 50 years of age or older, do not qualify for Medicaid, and do not have medical insurance. This project, conducted in three states, aims to determine whether a comprehensive program to screen women for cardiovascular disease is feasible and effective, and whether a physical intervention activity is beneficial.

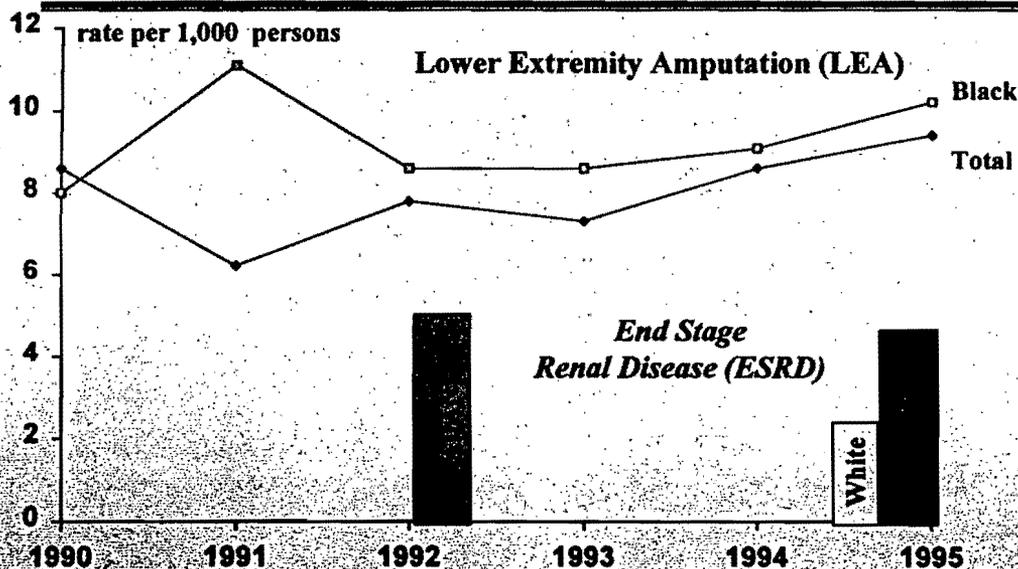


GOAL 4

Eliminate disparities in diabetes-related complications.

Diabetes, the seventh leading cause of death in the United States, is a serious public health problem affecting 16 million Americans, with disparities among racial and ethnic groups in the rate of diabetes-related complications. Our goal is to continue progress in reducing the overall rate of diabetic complications among all person with diabetes, and to eventually eliminate disparities among groups. As a major step towards that end, we have set a near term goal of reducing the rate of end stage renal disease from diabetes among blacks and American Indians/Alaska Natives with diabetes by 65% from their 1995 levels by the year 2000. In addition, by the year 2000, we will reduce lower extremity amputation rates from diabetes among blacks by 40% from their 1995 levels. These are our goals under *Healthy People*--the nation's health objectives. Rates of diabetes complications among Hispanics are also high; however, existing data do not permit us to monitor diabetes complications among this group. We will develop strategies to reduce diabetes-related complications among Hispanics, and to improve data collection.

Diabetes-related Complication Rates for End-Stage Renal Disease (ESRD) and Lower Extremity Amputation by Race and Ethnicity, United States, 1990-1995.



Lower Extremity Amputation Rate Baselines:

Total: 9.4 per 1,000 persons with diabetes (1995)

Black: 10.2 per 1,000 person with diabetes (1995)

Data Source: Numerator: National Hospital Discharge Survey, CDC, NCHS
Denominator: National Health Interview Survey, CDC, NCHS

Periodicity of data source: Data are currently available on an annual basis, 22 months after close of the data year.

End Stage Renal Disease Baselines:

Total: 3.0 per 1,000 persons with diabetes (1992-1995)

White: 2.4 per 1,000 persons with diabetes (1992-1995)

Black: 5.2 per 1,000 person with diabetes (1992-1995)

American Indian/Alaska Native: 5.4 per 1,000 person with diabetes (1992)

Data Source: Bureau of Data Management and Strategy; HCFA Program Statistics; PHS, IHS

Periodicity of Data Source: Data are available on an annual basis; data can be made available 12 months after the close of the data year.

Discussion: While remaining the same or decreasing for whites, prevalence and mortality rates for diabetes among American Indians/Alaska Natives and blacks have been increasing; the prevalence rate of diabetes among American Indian/Alaska Natives is more than twice that for the total populations (73 per 1,000 in 1994 compared to 30 per 1,000). Diabetes rates are also high for Puerto Ricans, Mexican-Americans, Cuban-Americans, Native Hawaiians and certain subgroups of Asian Americans. Rates for diabetes-related complications such as end-stage renal disease and amputations are also higher among blacks and American Indians as compared to the total population. Even with similarly insured populations such as Medicare recipients, blacks are more likely than whites to be hospitalized for amputations, septicemia and debridement--signs of poor diabetic control. Complication rates as outcome measures may not be sensitive indicators of progress regarding this initiative on eliminating racial disparities. We will continue to monitor behavioral practices and health care access issues as indicators of success in achieving a reduction in disparities. Examples of these indicators include diabetes-specific preventive care such as self-monitoring of glucose, clinic visits, diabetic foot care, dilated eye exams. These measures can be tracked by modifications of some currently available sources that will provide annual data.

Strategy for Achieving the Goal

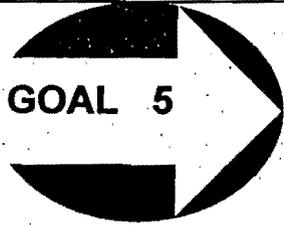
- Expand research efforts through the NIH that are inclusive of racial and ethnic minorities.
- Establish comprehensive community-directed and community-based efforts to reduce the incidence of Type II diabetes and its complications among American Indians and Alaska Natives.
- Enhance educational efforts for public and provider groups.
- Continue strong partnerships with national and local private sector interests.

Action Steps for the Next 12 Months

- ◇ Develop a major national outreach and consensus intervention initiative to reduce diabetes-associated disease and death, especially in racial and ethnic minorities.
- ◇ Establish cooperative agreements which focus on comprehensive community-directed and community-based efforts to reduce the incidence of type II diabetes, reduce its complications, and lower mortality among minority populations.
- ◇ Implement the Indian Health Service Diabetes Initiative.

Examples of Programs that Support this Strategy

- **National Diabetes Education Program:** Involves both public and private partners to design ways to improve treatment and outcomes for people with diabetes, to promote early diagnosis, and ultimately to prevent the onset of the disease.
- **The Diabetes Prevention Program Clinical Trial:** Designed to determine whether type 2 diabetes can be prevented or delayed in at-risk populations. Because type 2 diabetes disproportionately affects minority populations, approximately 50 percent of those enrolled in the DPP will be from those populations.
- **Diabetes Prevention Studies in Minority Populations:** The NIDDK continues to encourage increased research efforts on the disproportionate impact of diabetes in minority populations, including blacks, Hispanics, Asian and Pacific Islanders, Alaska Natives, and Native Americans and Hawaiians.
- **National Diabetes Data Group (NDDG):** The NDDG continues its collaboration with the National Center for Health Statistics in the diabetes component of the Third National Health and Nutrition Examination Survey. The NDDG also is continuing analyses of the diabetes component in the 1989 National Health Interview Survey of the NCHS. In addition, the NDDG recently published *Diabetes in America, 1995*. This important publication is a compilation of epidemiologic and public health data on diabetes, including data about the incidence, prevalence, and impact of diabetes and its complications on minorities.
- **The HRSA Lower Extremity Amputation Prevention (LEAP) program** will expand its partnerships with diabetes associations, pharmaceutical corporations, and community groups. Emphasis is on underserved populations, teaching patients to properly test and care for their feet to eliminate causes of amputation.
- **The Indian Health Service** has established 19 model diabetes centers to address the prevention and treatment of Type II diabetes. In 1998, the IHS will begin a 5 year effort to substantively increase its treatment and prevention capacity with funds (\$30 million per year) provided by the Budget Reconciliation Act.

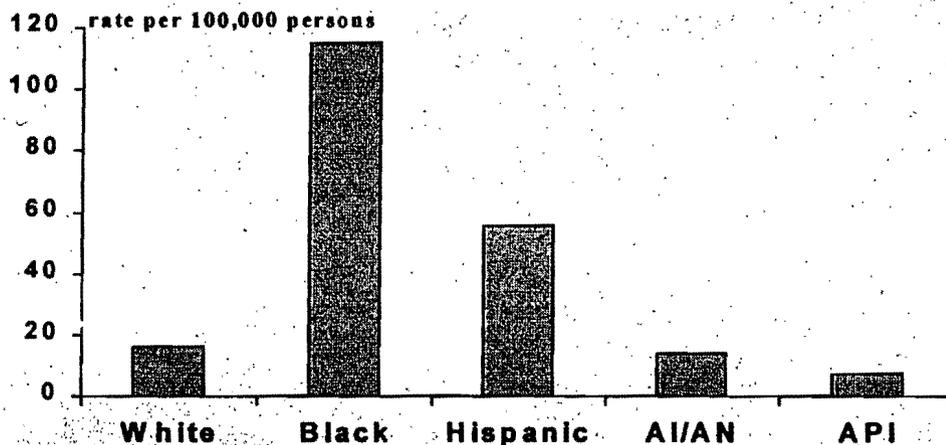


GOAL 5

Reduce disparities in AIDS case rates among racial/ethnic populations through increased knowledge of HIV serostatus and improved access to early medical treatment

HIV infection/AIDS has been a leading cause of death for all persons 25-44 years of age for several years regardless of race or ethnicity. Although racial and ethnic minorities constitute approximately 25 percent of the total U.S. population, they account for more than 50 percent of all AIDS cases. Our goal is to continue progress in increasing the overall availability of early diagnosis of HIV infection and assuring access to appropriate health services for all, and to eventually eliminate disparities among groups. By the year 2000, the combined efforts of Medicaid, Medicare, and HRSA's Ryan White CARE Act will assure early and equal access to life-enhancing health care and appropriate drug therapies for at least 75% of low income persons living with HIV/AIDS. We will establish educational outreach to all major medical providers to assure that the current standard of clinical care is achieved for all persons living with HIV/AIDS, including Medicaid-eligible women and children with HIV infection.

AIDS Case Rates in Persons \geq 13 years of age by Race/Ethnicity, United States, 1996



Adult (\geq 13 years) AIDS Case Rate Baselines:

Total: 31.4 per 100,000 1996
White: 16.2 per 100,000 1996
Black: 115.3 per 100,000 1996
Hispanic: 55.8 per 100,000 1996
American Indian/Alaska Native (AI/AN) 14.1 per 100,000
Asian and Pacific Islanders (API) 7.5 per 100,000

Data Source: Adult/Adolescent AIDS Reporting System, CDC

Periodicity of data source: Annual. Data are available three months after the close of the data year.

Pediatric (< 13 years) AIDS Case Rate Baselines:

Total: 1.3 per 100,000 **1996**
White: 0.3 per 100,000 **1996**
Black: 5.7 per 100,000 **1996**
Hispanic: 1.7 per 100,000 **1996**
American Indian/Alaska Native (AI/AN) 0.6 per 100,000
Asian and Pacific Islanders (API) 0.0 per 100,000

Data Source: Pediatric AIDS Case Reporting System, CDC

Periodicity of Data Source: Annual. Data are available three months after the close of the data year.

Discussion: Of cases reported among women and children, more than 75 percent are among racial and ethnic minorities. AIDS cases and new infections related to injecting drug use appear to be increasingly concentrated in minorities; of these cases, almost 3/4 were among minority populations (50% African American and 24% Hispanic). During 1995-96, AIDS death rates declined 19% for the total U.S. population, while declining only 10% for blacks and 16% for Hispanics. Contributing factors for these mortality disparities include late identification of disease, lack of health insurance to pay for drug therapies, differential access to HIV primary care, and inconsistency in the level of HIV education and experience among physicians treating historically disenfranchised groups. The cost of efficacious treatment, between \$10,000-\$12,000 per patient per year, is a major hurdle in the effort to assure equitable access to available drug therapies.

Strategy for Achieving the Goal

- Increase the percentage of minority populations that know their HIV serostatus and receive early access to primary care to prevent or delay progression of AIDS.
- Increase the number of racial/ethnic individuals, especially those with high risk factors, who receive counseling and treatment services in public settings.
- Increase access to counseling and testing and therapies that will prevent vertical transmission of HIV between mother and child, with a special emphasis on women of color and their children.

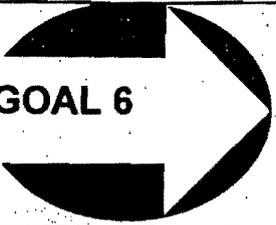
Action Steps for the Next 12 Months

- Continue to work with directly funded community based organizations to target individuals at high risk for HIV infection within racial/ethnic communities to increase counseling, referral services, and access to testing.
- Continue to work with state, city, and territorial health departments to support the HIV Prevention Community Planning process. Through this process, community planning groups work with health departments to develop a comprehensive prevention plan that reflects prioritized needs and is directly responsive to high risk racial/ethnic communities.
- Develop an initiative which creates an epidemiological profile of racial/ethnic communities throughout the country, examines current available programs serving these communities, identifies unmet needs, and develops strategies to address these needs.
- Increase access to prevention and supportive services, and efficacious medications, to assure that individuals from specific racial and ethnic groups receive services in proportion to their representation in the overall epidemic.
- Assure that the composition of the HIV prevention community planning groups reflect the epidemiologic profile of the jurisdiction and increase those groups with linkages to correction and drug treatment facilities.
- Implement the Office of Drug Pricing rebate program for the AIDS Drug Assistance Programs to increase the buying power of Federal, State, and local funds allotted to these programs.

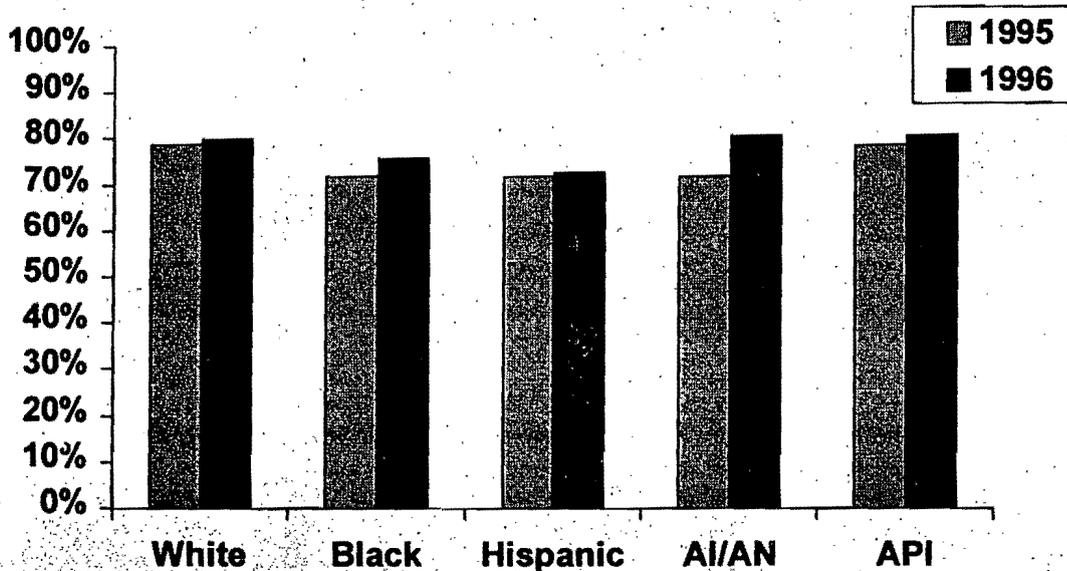
Examples of Programs that Support this Strategy

- The CDC HIV Counseling and Testing Data System began operating in 1985 to increase the availability of HIV counseling and testing services for persons who wanted to know their HIV status. Health departments in 65 States, cities, and territories collect information on the characteristics of persons seeking these services. In 1995, nearly 10,000 sites performed nearly 2.4 million HIV tests and reported results to CDC.
- CDC provides financial and technical assistance to community-based organizations working to prevent HIV infection, both directly and indirectly through health departments. This program primarily targets high-risk individuals within racial and ethnic communities. CDC also provides funds to National and Regional Minority organizations to identify the prevention needs of community-based organizations that work with racial and ethnic minorities.

- **The Young African-American Men's Study** is a CDC, 2-year formative study to prevent HIV/AIDS in young black men. Data are being collected in Chicago and Atlanta through interviews, observations and group discussions with community leaders, health care providers, and young men who have sex with men.
- **HRSA's AIDS Education and Training Center (AETC)** have a legislative mandate to provide training for minority providers and providers who treat minority populations in appropriate HIV therapeutics.
- The majority of **HRSA's Special Projects of National Significance (SPNS) Program** grants develop new models of HIV care for individuals from minority racial and ethnic populations. The SPNS Program currently is funding support service grants to increase access to HIV/AIDS care and related services for Hispanic populations living on the U.S./Mexico border, urban blacks dually diagnosed with HIV and substance abuse, Native Americans and Alaska Natives who were not accessing HIV services, and Asian and Pacific Islanders in New York City.
- **HRSA's Title III Early Intervention Services Program** provides grant support for outpatient HIV early intervention and primary care services for low-income, medically underserved individuals, primarily people of color in existing primary care systems. The objective of these programs is to maximize access to comprehensive and continuing clinical and supportive care for populations that have been disproportionately affected by the AIDS epidemic. Currently, approximately two-thirds of the clients who receive primary care services at Title III programs are members of racial and ethnic minority groups.
- **HRSA continues to publish "HIV Care Access Issues"** -- a technical assistance series of reports that identify barriers and strategies to overcome barriers to HIV care among specific population groups, e.g., black, Hispanics, Native Americans, and Asian Americans.
- **HRSA's AIDS Drug Assistance Programs (ADAP)** serve individuals from racial/ethnic minorities in approximate proportion to their cumulative representation in the epidemic to date.
- **HCFA estimates that in excess of 50% of people with AIDS, and over 90% of children with AIDS are served through Medicaid.**

**GOAL 6****Eliminate disparities in child and adult immunization rates**

Childhood immunization rates are at an all-time high, with the most critical vaccine doses reflecting coverage rates of over 90 percent. Although immunization rates have been lower in minority populations compared to the white population, minority rates have been increasing at a more rapid rate, thus significantly narrowing the gap. Our goal is to sustain current immunization efforts in order to achieve and maintain at least 90 percent coverage for all recommended vaccines in all populations, and to eventually eliminate disparities among groups. This is our goal under *Healthy People*--the nation's health objectives.

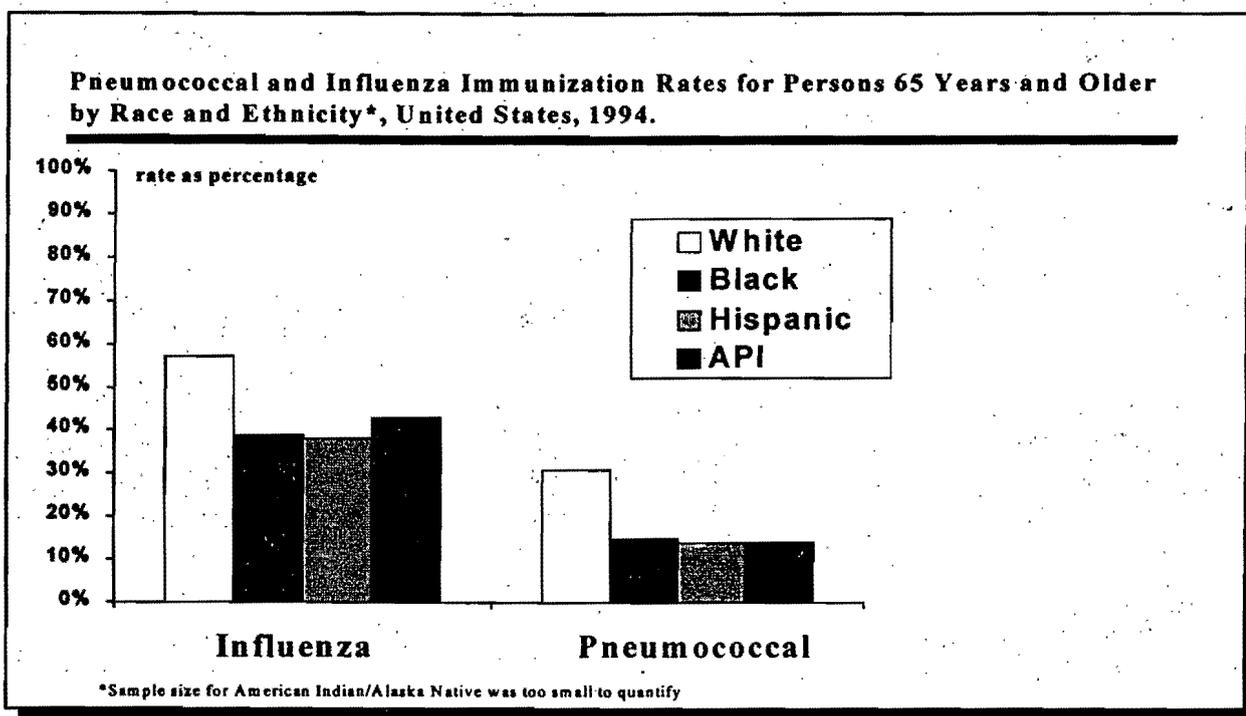
Childhood Immunization Rates* by Race and Ethnicity, United States, 1995-1996

*Immunization rates reflect those children ages 19-35 months of age who have received 4 doses of DTP (diphtheria, tetanus, pertussis), 3 Polio, and 1 MMR (measles, mumps, rubella).

Childhood Immunization Rate Baselines:**Total: 78 % (1996)****White: 80% (1996)****Black: 76% (1996)****Hispanic: 73 % (1996)****American Indian/Alaska Native (AI/AN): 81% (1996)****Asian/Pacific Islanders (API): 81% (1996)****Data Source: National Immunization Survey, CDC, NCHS**

Periodicity of Data Source: Data are reported semi-annually, eight months after the close of the respective data period.

Adult immunization is one of the most cost-effective strategies to prevent needless morbidity and mortality. There is a disproportionate burden of these vaccine-preventable diseases in minority and under served populations. Our goal is to increase pneumococcal and influenza immunizations among all adults aged 65 years and older to 60 percent, and to eventually eliminate disparities among groups. This is our goal under *Healthy People*--the nation's health objectives. In order to reach this goal, by the year 2000 we need to nearly *double* the 1994 influenza immunization rates among blacks, Hispanics, and Asian and Pacific Islanders and to *quadruple* the 1994 pneumococcal immunization rates among these groups.



Immunization Rate Baselines for Adults 65 years and older:

Influenza:

Total: 55% (1994)

White: 57% (1994)

Black: 39% (1994)

Hispanic: 38% (1994)

Asian/Pacific Islander: 43% (1994)

Pneumococcal:

Total: 30% (1994)

White: 31% (1994)

Black: 15% (1994)

Hispanic: 14% (1994)

Asian/Pacific Islander: 14% (1994)

Data Source: National Health Interview Survey (NHIS), CDC, NCHS

Periodicity of Data Source: Data will be available annually, approximately six months after the close of the data year. Data have previously been collected as part of supplements, but are currently in the adult core questionnaire. Data collected as part of the core using the new computer assisted personal interview procedure should be available approximately six months following the close of the data year. This system is currently being implemented.

Discussion: Though coverage for preschool immunization is high in almost all States, pockets of need, or areas within each State and major city where substantial numbers of under-immunized children reside, continue to exist. These areas are of great concern because, particularly in large urban areas within traditionally underserved populations, they have the potential to spawn outbreaks of vaccine-preventable diseases. Each year, an estimated 45,000 adults die of influenza, pneumococcal infections and liver cancer due to chronic hepatitis B infection despite the availability of safe and effective vaccines to prevent these conditions and their complications. Although vaccination levels against pneumococcal infections and influenza among people 65 years and over have increased slightly for blacks and Hispanics, the coverage in these groups remains substantially below the Healthy People Year 2000 targets.

Strategy for Achieving the Goal

Childhood

- The **Childhood Immunization Initiative (CII)** was launched to reduce most diseases preventable by childhood vaccination to zero and to establish a sustainable system to ensure that all 2-year olds receive required vaccines by the year 2000 and beyond. The CII is a comprehensive effort designed to marshal efforts of the public and private sectors, health care professionals and volunteer organizations.

Adult

- Increasing provider awareness of the need for timely immunizations in adults.
- Assuring effective vaccine delivery mechanisms for adults.
- Intensifying vaccine-preventable disease program evaluations, surveillance activities, and investigation of reported outbreaks or unusual occurrences of disease.
- Encouraging outreach to all seniors through Medicare beneficiary education efforts, with special efforts to target minorities.

Action Steps for the Next 12 Months

- Develop and promote use of software to assess vaccination practices and track vaccinations levels.

- ◇ Increase emphasis on immunizations by supporting collaborative activities to enhance influenza and pneumococcal vaccination levels among Medicare beneficiaries.
- ◇ Develop and test assessment tools for documenting adult immunization levels and practices in Community/Migrant Health Center sites.
- ◇ Continue to support the Department-wide Asian and Pacific Islander Americans (APIA) Action Agenda to ensure that susceptible APIA children and adolescents receive a hepatitis B vaccine series.
- ◇ As directed by the President, hold a national conference for the establishment of State and community immunization registries.

Examples of Programs that Support this Strategy

Childhood

CDC is working with its partners to:

- Develop and implement State and community immunization registries as a cornerstone to increase and sustain vaccination coverage rates to prevent outbreaks of disease.
- Target a range of interventions to address pockets of need in each State or major city.
- Continue implementing proven interventions, such as WIC/Immunization linkages and assessment of coverage levels in provider settings.

Adult

- The DHHS Action Plan for Adult Immunization identifies key steps for each agency to implement to increase adult immunization levels, including efforts targeted at populations with an increased burden of vaccine-preventable diseases.
- The National Coalition for Adult Immunization (NCAI), with about 100 members, cooperates in nationwide informational and educational programs to promote adult immunization activities.
- HCFA's Horizon's Pilot Project targets black Medicare beneficiaries in eight southern States by working with Historically Black Colleges and Universities and HCFA's Quality Improvement Organizations to improve influenza vaccination levels.
- CDC is collaborating with HRSA to conduct a quality improvement project in a limited number of Community/Migrant Health Center (C/MHC) sites targeting adults.