



"Christopher Edley, Jr." <edley @ law.harvard.edu>

02/23/99 10:46:09 AM

Record Type: Record

To: Paul J. Weinstein Jr./OPD/EOP

cc:

Subject: Help!!

I need help filling in a big gap identified by POTUS in the jobs/econ development chapter. He wants something focused on single men BIG -- comparable to welfare-to-work, or whatever. Please page me at 888-710-4964, or call at 5-1039, as soon as you get a chance. I thought Maria was going to handle this for me with Bruce, but apparently nothing has happened.

Gracias.

Andrea Kane

02/23/99 12:11:29 PM

Record Type: Record

To: edley @ law.harvard.edu @ inet

cc: Paul J. Weinstein Jr./OPD/EOP, Cynthia A. Rice/OPD/EOP

Subject: Men

Your note to Paul mentioned single men, but I'm assuming this would also include non-custodial fathers. So, here's info about the President's proposal in the Welfare-to-Work reauthorization to dedicate at least 20% of the state formula funds (about \$150 M) to helping low income non-custodial parents (primarily fathers) increase their employment and earnings so they can better meet their responsibilities to their children and become more involved with their children. I think Paul is getting back to you on some other issues, but in the meantime, I'd be glad to discuss any of these with you (6-5573)

Paper from 1/25 event where POTUS highlighted the initiative (he also made brief mention in State of the Union)



wtw0125c.wpd

POTUS remarks from 1/25 (see bold sections)



speecha.wpd

Bio and remarks from Carlos Rosas, the father who introduced the President on 1/25



carlos.wpd



carlossp.wpd

Two pager on the WtW reauthorization



dolwtw4.wpd

PRESIDENT CLINTON WILL ANNOUNCE NEW STEPS TO HELP FATHERS SUPPORT THEIR CHILDREN AND FAMILIES MOVE FROM WELFARE TO WORK

January 25, 1999

With welfare caseloads down by nearly half since 1993 and over 10,000 companies committed to welfare-to-work, President Clinton will announce today a new package of initiatives designed to ensure that those remaining on the welfare rolls make a successful transition from welfare to work, with a new focus on increasing the employment of low-income fathers so they can support their children. The President's \$1 billion Welfare-to-Work initiative will help 200,000 more people go to work. At least \$150 million will go toward helping fathers fulfill their responsibilities to their children by working and paying child support. Remaining funds will focus on long-term welfare recipients with the greatest obstacles to employment. The President also will announce today that his budget will contain new welfare-to-work housing vouchers, transportation funds, and tax credits to help those on welfare get to work and stay employed. Taken together, these initiatives will provide parents the tools they need to support their children and succeed in the workforce.

Welfare-to-Work Funds with a Focus on Fathers

The President's \$1 billion Welfare-to-Work initiative will help 200,000 long-term welfare recipients in high-poverty areas move into lasting unsubsidized employment. It is an extension of the two-year \$3 billion Welfare-to-Work program the President secured in the Balanced Budget Act. The initiative, as reauthorized, will provide at least \$150 million to ensure that every state helps fathers fulfill their responsibilities by working, paying child support, and playing a responsible part in their children's lives. Under this proposal, states and communities will use a minimum of 20 percent of their formula funds to provide job placement and job retention assistance to low-income fathers who sign personal responsibility contracts committing them to work and pay child support. This effort will further increase child support collections, which have risen 80 percent since the President took office, from \$8 billion in 1992 to \$14.4 billion in 1998. Remaining funds will go toward assisting long-term welfare recipients with the greatest barriers to employment to move into lasting jobs. The reauthorized program also will double the welfare-to-work funding available for tribes.

The Department of Labor will announce today the availability of \$240 million in competitive grants from the current \$3 billion Welfare-to-Work program. These funds will support innovative local welfare-to-work strategies for individuals with limited English proficiency, disabilities, substance abuse problems, or a history of domestic violence.

Transportation and Housing for Families Moving From Welfare to Work

The President also will announce today that his budget will contain \$580 million for welfare to work housing vouchers and transportation assistance to help those on welfare get to work and stay employed. The President's budget will provide \$430 million for 75,000 welfare-to-work housing vouchers, including \$144 million in new funds

for 25,000 additional vouchers. This is a 50 percent increase over the 50,000 vouchers the President secured last year. The vouchers will help families move closer to a new job, reduce a long commute, or secure more stable housing so they can perform better on the job. The President's budget will also increase Access to Jobs transportation funding from \$75 million to \$150 million, doubling the number of individuals and communities that can receive transportation assistance. This competitive grant program supports innovative state and local transportation solutions such as shuttles, van pools, new bus routes, and connector services to mass transit to help welfare recipients and other low income workers get to work.

Private Sector Hiring from the Welfare Rolls

The President will announce that his budget will include \$530 million to extend for one year the Welfare to Work and Work Opportunity Tax Credits to encourage more employers to hire welfare recipients and other disadvantaged individuals. Already, in response to the President's challenge two years ago in the State of the Union, 10,000 companies have joined the Welfare to Work Partnership and hired, retained, and promoted hundreds of thousands of former welfare recipients. Forty-two percent of these companies are very small businesses (25 or fewer employees), while four percent are very large businesses (3,000 or more employees).

Welfare Rolls Decline as More Recipients go to Work

The President will release state-by-state data showing that welfare caseloads are at their lowest level in 30 years and that the welfare rolls have fallen by nearly half since he took office. Since January 1993, 36 states have had caseload declines of more than 40 percent and nationwide the rolls have fallen by 44 percent, from 14.1 million to just below 8 million. Recent information released by the Department of Health and Human Services also shows that the percentage of welfare recipients working has tripled since 1992, that an estimated 1.5 million people who were on welfare in 1997 were working in 1998, and that all states met the first overall work participation rates required under the welfare reform law.

**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 Native Americans. African-American 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 by the year 2010: infant mortality; cancer screening and management; cardiovascular disease; diabetes; HIV/AIDS rates; and child and adult immunization levels. The President's plan:

- **Initiates Sweeping New Outreach Campaign Led by the Newly-Confirmed Surgeon General and Assistant Secretary for Health, Dr. David Satcher.** The President is announcing that the Department of Health and Human Services will initiate a major outreach campaign led by Surgeon General Satcher that will send critical treatment and prevention messages to all Americans, with a special focus on reaching racial and ethnic minorities. This campaign will reach out to local communities, churches, nurses, physicians, and other community-based programs and experts in minority health. It will improve education and outreach efforts and develop innovative strategies to address racial and ethnic health disparities.
- **Includes Over \$400 Million to Develop New Approaches and to Build on Existing Successes to Address Racial and Ethnic Health Disparities.**
 - **Spurs New, Local, Innovative Strategies to Address Disparities.** Seriously addressing racial and ethnic disparities in health will require not

only the focused application of existing knowledge and best practices, but the development of new approaches. The President's budget proposes a total of \$150 million over five years for grants to up to 30 communities, chosen through a competitive grant process. These grants will be used to conduct research to devise innovative new strategies to improve minority health status. Successful approaches learned in these communities will be applied to all health programs across the Department of Health and Human Services.

- **Builds on Approaches That Have Proven 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. The plan 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 to Develop Ways to Target Racial and Ethnic Health Disparities.** The President issued a challenge to employers, churches, schools, community-based clinics, nurses, and 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 new 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.

ELIMINATING DISPARITIES IN INFANT MORTALITY

Thanks to an intensified national commitment to give babies a healthy start in life, the U.S. infant mortality rate (the rate at which babies die before their first birthday) reached an historic low of 7.2 deaths per 1,000 live births in 1996. While infant deaths have also declined significantly among racial and ethnic minority groups, the rate of decline has lagged behind the overall national trend. Infant death rates among blacks, American Indians, Alaska Natives, and Puerto Ricans are above the national average. Blacks have the highest infant mortality rate of any group (14.2 per 1,000 in 1996) -- nearly 2.5 times that of white infants (6.0 per 1,000 in 1996). The overall American Indian rate (9.0 per 1,000 live births in 1995) does not reflect the diversity among Indian communities, some of which have infant mortality rates approaching twice the national rate. Similarly, the overall Hispanic rate (7.6 per 1,000 live births in 1995) does not reflect the diversity among this group. Puerto Ricans, for example, had a rate of 8.9 per 1,000 live births in 1995.

Among the leading causes of death in infants, the racial and ethnic disparities are greatest in: disorders related to short gestation (preterm birth) and unspecified low birthweight, respiratory distress syndrome, perinatal infections and newborns affected by maternal complications of pregnancy, and sudden infant death syndrome (SIDS). For example, a much higher incidence of preterm births occurs among black mothers than among white mothers (17.7 compared with 9.7 percent). Underlying factors, such as chronic hypertension, which has a higher incidence among blacks, play a role in preterm births. In addition, SIDS -- which accounts for about 10 percent of all infant deaths -- affects minorities disproportionately. American Indian and Alaska Natives babies are three to four times more likely to die of SIDS than white infants, and black infants are 2.5 times more likely to die of SIDS than white infants.

YEAR 2000 GOALS. To eliminate these disparities, the President's initiative sets goals for immediate progress, setting the nation on course to eliminate disparities in infant mortality rates by 2010. By 2000, the President's initiative will aim to reduce infant mortality among blacks -- the group with the highest infant death rates -- by at least 20 percent from the 1996 rate. The initiative will also work to reduce infant mortality among American Indians, Alaska Natives, and Puerto Ricans, whose infant mortality rates are also above the national average. In addition, we will continue to monitor progress in reducing SIDS rates for all racial and ethnic groups as an indicator of our progress toward reducing the national infant mortality rate.

FUNDING. The President's FY 1999 budget includes an additional \$30 million for CDC for a community-based demonstration program in up to 30 communities that will focus on eliminating racial and ethnic health disparities. The President's budget also includes an additional \$15 million for Community Health Centers to enhance services targeted on reducing health disparities.

ADDITIONAL ACTIVITIES. To bolster ongoing efforts, HHS is launching targeted initiatives, including:

Mississippi Delta Project. Infant mortality rates in the 10-county Mississippi Delta region are among the highest in the nation. The HHS Health Resources and Services Administration will join forces with community leaders in the Delta region to develop a comprehensive strategy to improve child and infant health and reduce the overall burden of disease. HRSA will award up to \$100,000 for community planning. Based on the findings of the planning process, HRSA will make a substantial increased investment in its programs and will encourage other federal agencies and foundations to support this underserved area.

SIDS Outreach. The National Institutes of Health is launching a new outreach effort targeted to racial and ethnic communities. This project will include new media efforts to reach non-English-speaking parents, outreach to health professionals who serve primarily ethnic and racial communities, and better use of ethnic radio stations to raise parental awareness of what we know about SIDS.

ELIMINATING DISPARITIES IN BREAST AND CERVICAL CANCER SCREENING AND MANAGEMENT

Breast and cervical cancer kill more than 50,000 American women each year, but early detection and screening can reduce the risk of death from breast cancer by 30 percent and can nearly eliminate of the risk of death from cervical cancer. However, disparities persist among racial and ethnic groups not only in the incidence and death rates due to breast and cervical cancer, but also in the percentage of women who receive screening for breast and cervical cancers.

Despite considerable gains in screening in the black community, the mortality rate from breast cancer for black women continues to be higher than that for white women. Some of the reasons for this disparity include the fact that many women have not had a mammogram or Pap smear, and many more are not screened regularly. Others are screened, but have limited follow-up and treatment options available to them. Hispanic, American Indian, Alaska Native, and Asian and Pacific Islander women also have low rates of screening and treatment, limited access to health facilities and physicians, and barriers related to language, and culture. In addition, Vietnamese women in the United States have a cervical cancer incidence rate more than five times greater than white women (47.3 vs. 8.7 per 100,000). Black and Hispanic women also have higher cervical cancer death rates than the overall U.S. rate.

YEAR 2000 GOALS. By the year 2000, the President's initiative will increase to at least 60 percent the proportion of women from all racial and ethnic groups aged 50 and older who have received a clinical breast exam and a mammogram within the previous two years, and increase to at least 85 percent the proportion of all women aged 18 and older who have had a pap test within the past three years.

FUNDING. To build on the Department of Health and Human Services' ongoing investments in these areas, the President's FY 1999 budget includes an additional \$5 million for the Indian Health Service's Breast and Cervical Cancer Project, allowing service for an additional 250,000 American Indian women. In addition, the President's budget provides an additional \$30 million to CDC for a community-based demonstration project in up to 30 communities that will focus on reducing racial and ethnic health disparities, and would increase funding for Community Health Centers by \$15 million to enhance services targeted toward reducing disparities.

ADDITIONAL ACTION STEPS. To build on these efforts, HHS will also launch:

Increased Female, Ethnic and Racial Group Recruitment for Cancer Care and Clinical Trials. In FY 1998, the National Cancer Institute will add a screening center targeted toward Hispanic-Americans to its Community Oncology Program. This program provides enhanced support for expanding clinical research in racial and ethnic community settings by bringing state-of-the-art treatment, cancer prevention, and control research to racial and ethnic groups in their own communities. NCI also recently added a racially- and ethnically-enriched screening center with an African-American focus to the Prostate, Lung, Colorectal and Ovarian Trial.

Mammography Pilot Project. The HHS Health Care Financing Administration will lead a 3-year project which will identify effective interventions to increase utilization of Medicare screening benefits among black and Hispanic beneficiaries in six cities. Funding for this activity will be approximately \$1 million per year for the next three years.

ELIMINATING DISPARITIES IN CARDIOVASCULAR DISEASE

Cardiovascular disease -- particularly heart disease and stroke -- kills nearly as many Americans as all other diseases combined, and is one of the major causes of disability in the United States. Major disparities also exist among population groups, with a disproportionate burden of death and disability from cardiovascular disease in minority and low-income populations. The age-adjusted death rate in 1995 for blacks attributable to heart disease was 147 deaths per 100,000 people, compared to 105 per 100,000 for whites and 108 per 100,000 overall. And while the overall death rate for coronary heart disease declined by 20 percent from 1987 to 1995, the decrease for blacks was only 13 percent. For strokes, the 1995 death rate for blacks was 45.0 per 100,000, compared to 24.7 per 100,000 whites and 26.7 per 100,000 Americans overall. Although age-adjusted death rates for cardiovascular disease among other racial and ethnic groups are lower than the national average, there are subgroups within these populations that have high death rates from heart disease and stroke.

Disparities also exist in the prevalence of risk factors for cardiovascular disease. Racial and ethnic minorities have higher rates of hypertension, tend to develop hypertension at an earlier age, and are less likely to undergo treatment to control their high blood pressure. For example, from 1988 to 1994, 35 percent of black males ages 20 to 74 had hypertension, compared to 25 percent of all men. When age differences are taken into account, Mexican-American men and women are also disproportionately prone to elevated blood pressure rates. In addition, minorities are less likely to seek regular cholesterol screening. Only 50 percent of American Indians/Alaska Natives, 44 percent of Asian Americans, and 38 percent of Mexican-Americans have had their cholesterol checked within the past two years.

YEAR 2000 GOALS. By the year 2000, the President's plan seeks to reduce the death rate for heart disease among blacks by 25 percent and the death rate for strokes among blacks by 40 percent from their 1995 level. In addition, the plan will work to identify and develop strategies to reduce high mortality rates from heart disease and stroke among racial and ethnic subgroups.

FUNDING. The President's FY 1999 budget includes an additional \$5 million for existing CDC programs devoted to reducing cardiovascular disease to allow more targeted interventions for minority populations. The President's budget also includes an additional \$30 million for CDC for a community-based demonstration program in up to 30 communities that will focus on eliminating racial and ethnic health disparities, and an additional \$15 million for Community Health Centers to enhance services targeted on reducing health disparities.

ADDITIONAL ACTION STEPS. In addition, HHS will launch efforts to:

Increase State-based Programs. In FY 1998, the CDC will initiate state-based cardiovascular disease prevention programs in states with high rates of cardiovascular disease. The funded states will reflect the disparities in cardiovascular disease rates and will have large ethnic or racial populations. These state programs will determine which groups are the most at-risk and will direct specific program interventions to reduce risk factors in these populations to levels at or below the general population. This program will result in a national strategy for cardiovascular disease prevention through state-based programs. Funding for the program is estimated to be between \$2.7 million and 8 million.

NIH Partnership on Cardiovascular Disease. NIH is working with Univision on the new Salud para su Corazon (Health for Your Heart) program, a comprehensive community education and outreach program that encourages Latinos to make the lifestyle changes necessary to reduce their risks of cardiovascular disease. Salud para su Corazon blends the Spanish language with Latino traditions to provide science-based health messages, bilingual education materials, and strategies for community, family and personal action.

ELIMINATING DISPARITIES IN DIABETES

Diabetes, the seventh leading cause of death in the United States, is a serious public health problem affecting nearly 16 million Americans with estimated total direct and indirect costs of \$98 billion per year. The prevalence of diabetes in blacks is approximately 70 percent higher than whites and the prevalence in Hispanics is nearly double that of whites. The prevalence rate of diabetes among American Indians and Alaska Natives is more than twice that for the total population and at least one tribe, the Pimas of Arizona, have the highest known prevalence of diabetes of any population in the world. Cardiovascular disease is the leading cause of death among people with diabetes, accounting for over one-half of all deaths.

YEAR 2000 GOALS. The President has set two goals for the year 2000 to reduce racial disparities in this area: (1) reducing the rate of kidney disease from diabetes among blacks and American Indians/Alaska Natives by 65 percent from their 1995 levels by the year 2000, and (2) reducing lower extremity amputation rates from diabetes among blacks by 40 percent from their 1995 levels.

FUNDING. The President's FY 1999 budget provides an increase of \$5 million to the CDC for targeted, community-based diabetes education and intervention. The President's budget also provides an additional \$30 million to CDC for a community-based demonstration project in up to 30 communities that will focus on reducing racial and ethnic health disparities. The President's budget also would increase funding for Community Health Centers by \$15 million to enhance services targeted toward reducing disparities.

IMMEDIATE ACTION STEPS. HHS is also initiating additional initiatives, including:

National Diabetes Education Program (NDEP) Public Awareness Campaign The NIH National Institute of Diabetes and Digestive and Kidney Diseases and CDC's Division of Diabetes Translation (DDT) will launch a public awareness campaign in 1998, which will focus heavily on minority populations. The annual budget for this activity will be approximately \$1.5 to \$2.5 million.

Diabetes Control Programs. The goal of CDC's State-based Diabetes Control Programs (DCP's) is to improve access to high-quality diabetes care for persons with diabetes. In FY 1998, CDC will increase the number of State comprehensive diabetes programs by seven to nine States. The expanded funding will allow the additional States to develop statewide, comprehensive diabetes program activities that target populations that have a disproportionately high risk of diabetes, including blacks, Hispanics, American Indians and Alaska Natives, Asians and Pacific Islanders, and the elderly.

ELIMINATING DISPARITIES IN HIV/AIDS INFECTION RATES

While racial and ethnic groups account only for about 25 percent of the U.S. population, they account for more than 50 percent of all AIDS cases. While the epidemic is decreasing in some populations, the number of new AIDS cases among blacks is now greater than the number of new AIDS cases among whites. For example, although the number of AIDS diagnoses among gay and bisexual men has decreased dramatically among white men since 1989, the number of AIDS diagnoses among gay and bisexual black men has increased. In addition, about 75 percent of AIDS cases and new infections related to injecting drug use are among minority populations (56 percent black and 20 percent Hispanic). Of cases reported among women and children, more than 75 percent occur among racial and ethnic minorities.

From 1995 to 1996, AIDS death rates declined 23 percent for the overall U.S. population, but only declined by 13 percent for blacks and 20 percent for Hispanics. Contributing factors to these disparities include late identification of the disease, the cost of effective treatment, lack of health insurance to pay for drug therapies, differences in access to HIV primary care, and inconsistent education and experience among physicians who treat under served populations.

YEAR 2000 GOALS. By the year 2000, the President's initiative will work to assure early and equal access to health care and appropriate drug therapies for at least 75 percent of low-income persons living with HIV/AIDS, many of whom are minorities. The initiative will also seek to establish educational outreach to all major medical providers of medical care to assure that the current standard of clinical care is achieved for all persons living with HIV/AIDS, including Medicaid-eligible women and children.

FUNDING. The President's FY 1999 budget proposes an additional \$10 million for CDC HIV/STD demonstration projects. The President's FY 1999 budget also includes an additional \$30 million to CDC for a community-based demonstration program in up to 30 communities that will focus on reducing racial and ethnic health disparities. The budget also proposes an increase of \$15 million for Community Health Centers to enhance services targeted on reducing health disparities.

ADDITIONAL ACTION STEPS. In addition, HHS will launch several new initiatives including:

HIV Community Planning. In FY 1998, the CDC will invest \$14 million to strengthen the capacity of health departments to provide targeted prevention services to those at highest risk, including racial and ethnic groups. The CDC will strengthen and refine the HIV prevention community planning process to help develop priorities that specifically address unique community needs, including those of racial and ethnic populations.

Communities of Color Initiative. The CDC will develop an initiative in FY 1998 that will focus on black, Hispanic, American Indian, Alaska Native and Asian/Pacific Islander communities. This initiative will identify barriers to successful HIV prevention and ways to remove those barriers.

ELIMINATING DISPARITIES IN IMMUNIZATION RATES

Since 1993, childhood immunization rates have reached all-time highs, with 90 percent or more of America's toddlers receiving the most critical doses of most of the routinely recommended vaccines for children by age 2. In addition, reported levels of disease were at or near record lows in 1996. For the most critical childhood vaccines, vaccination levels are nearly the same for preschool children of all racial and ethnic groups, narrowing a gap that was estimated to be as wide as 26 percentage points a generation ago. However, minority children still lag behind white children when overall vaccination rates are compared. While 79 percent of white children have received the full series of vaccinations by age 2, only 74 percent of African-American children and 71 percent of Hispanic children are fully vaccinated against childhood disease.

In addition to the very young, older adults are at increased risk for many vaccine-preventable diseases. Approximately 90 percent of all influenza-associated deaths in the United States occur in people aged 65 and older -- the fastest growing population group in America. Reduction of deaths in this age group has been hindered in part by relatively low vaccine utilization. Each year, an estimated 45,000 adults die of infections related to influenza, pneumococcal infections, and hepatitis B despite the availability of safe and effective vaccines to prevent these conditions and their complications. There is a disproportionate burden of these diseases in minority and underserved populations. 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 well below the general population.

YEAR 2000 GOALS. By the year 2000, the President's initiative will work to double the 1994 influenza immunization rates and quadruple the 1994 pneumococcal immunization rates among minorities ages 65 and older; as well as achieve and maintain childhood immunization rates of 90 percent for all population groups.

FUNDING. The President's FY 1999 budget includes an additional \$30 million for CDC for a community-based demonstration program in up to 30 communities that will focus on eliminating racial and ethnic health disparities. The President's budget also includes an additional \$15 million for Community Health Centers to enhance services targeted on reducing health disparities.

ADDITIONAL ACTION STEPS. To bolster ongoing efforts, HHS will launch new initiatives, including:

Enhanced CDC Intervention Strategies. The CDC will spend about \$100,000 in FY 1998 to conduct immunization training courses to providers of immunization care services for racial and ethnic children and to develop a distance-based immunization training program for health care professionals in major urban areas.

Adult Flu and Pneumonia Vaccination Campaign. HCFA will expand efforts to reach medically underserved groups at the community level, through outreach to Historically Black Colleges and Universities, clergy, family physicians, pharmacies and home health agencies serving black beneficiaries.

GENERAL QUESTIONS AND ANSWERS

Q. What is HHS' role in the President's Initiative on Race and what exactly is the HHS Race and Health Initiative?

A. Our role is to help the President achieve his aim of One America for the 21st century by knocking down barriers that keep minorities from enjoying good health. Our budget includes \$400 million over five years for the HHS Race and Health Initiative. But this initiative goes far beyond dollars. It's also a treatment and prevention message outreach campaign led by our new Surgeon General, Dr. David Satcher; a new task force that brings together the brightest minds at the National Institutes of Health and the Centers for Disease Control and Prevention, the Public Health Service and other agencies of the Department; and better coordination of the existing medical, scientific and public health resources of all our agencies throughout the Department.

The goal is to reduce health disparities among minorities and non-minorities in six key areas. They are: infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS infection rates, and child and adult immunization. This is a cross-cutting initiative that addresses health disparities experienced by Hispanics, African-Americans, Native Americans and Asian Americans.

Of the \$400 million, \$250 million would go to existing HHS public health programs in CDC, HRSA and IHS to better reach minority populations and address their needs in each of the six areas. Another \$150 million would be aimed at funding innovative and effective programs that target health disparities, and create successful models for future efforts.

Q. Whether it's \$80 million for one year or \$400 million for five years, the fact is that this is a drop in the bucket, at best, for serious health problems whose underlying root causes have been building over decades. How do you tell people that you're really serious about an undertaking like this when you're devoting so few resources?

A. If someone asked, "How much money do you need to eliminate these problems today," you couldn't put a price tag on it. There is no right amount of dollars – billions, millions or otherwise – that would totally eliminate these disparities immediately. The smartest strategy is the one we're pursuing – through using this money and this initiative to sharpen our efforts within the Department and with our partners on the outside.

The Race and Health Initiative is a first step – a very strong first step. When attacking a challenge as awesome as eliminating the racial health disparities we face in this country, the first thing to do is more precisely target the resources we have. Then we must better coordinate all our ongoing activities and mesh those with the new efforts we undertake, and coordinate state and local efforts. We're doing all of that. The \$400 million is really a catalyst to help us bring more fight and more focus to this effort – more than we've ever had.

This is really a mobilization effort. We're mobilizing the resources of the agency to attack these public health problems through education, outreach, research and all the tools we have. We're taking the knowledge and all the resources that we already have throughout the Department and in our public and private partnerships to battle these disparities and energize this initiative.

Q. It just seems impossible to turn around tough, nearly intractable problems without a massive infusion of new resources over an extended period of time. What makes you confident?

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

We can learn from partnerships like the one involving the Association of Black Psychologists and the Congress of National Black Churches, who are targeting African American women at risk for diabetes through church-based nutrition and physical activity intervention programs.

We can also learn from the partnership between CDC and the University of Illinois at Chicago's Midwest Latino Health Research, Training, and Policy Center to promote diabetes management and control among Latino populations through a culturally specific education program.

Q. HHS has been accused of picking and choosing which health programs it wants to emphasize, essentially playing favorites with different diseases. Isn't this just another case?

A. We are not playing favorites. We aren't picking and choosing. We pursue all of our education and prevention efforts with great vigor. But these are all America's leading

killers, and closing the gaps that separate minorities from non-minorities is important to our collective health and our future as a nation. It's important to the President, and it's important to the nation.

Q. It was just last year that the President offered a formal apology for the Tuskegee experiment. Isn't the HIV/AIDS component of this reminiscent of Tuskegee?

A. Absolutely not. This initiative is about education, prevention and treatment. The tragedy of Tuskegee was that people were intentionally deceived and denied treatment that was readily available. Here, we are targeting our education and prevention efforts to help people who are at risk. We're trying to prevent the spread of AIDS and provide effective treatment to those who need it. There is no comparison between our Race and Health Initiative and Tuskegee.

Q. So how are you going to close these gaps ?

A. The strategy that the President laid out today is comprehensive and lays the groundwork for a solid, coordinated effort. But these answers will be different for each of the six disparities. For some of these goals, the answers are relatively easy. For example, we've had some success with immunization programs, and so we know what can work in this area. In other areas, like infant mortality, the picture is more complex, and that's where the \$400 million -- particularly the community-based demonstrations -- will move us toward answers. And for a disease like diabetes, the challenge is how to address disparities through basic research -- like looking at NIH for opportunities where we can shed light on racial health disparities through clinical trials and other research tools.

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

A. No single strategy can solve all our problems. But with the initiative we're unveiling today and the help of our partners in the private and nonprofit sectors, we can close these gaps. It's also important to remember that we already have a strong track record of addressing the challenges of access and poverty. We passed Kassebaum-Kennedy legislation to improve the availability of health insurance for working families and their children; we expanded the Earned Income Tax Credit; and we just raised the minimum wage. We're also improving access to high quality, subsidized child care; and education and training programs. The new CHIP child health program, improved Medicaid outreach efforts and expansions in the community health center program all increase access -- as will our Medicare outreach efforts for mammograms and adult immunizations.

Further, the booming economy this Administration has presided over has helped people move up from poverty, with low interest rates, 15 million new jobs, an unemployment rate that is below 5 % and the lowest inflation in 30 years.

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

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

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

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

A. We did not go into this process saying we had to have a five-, six- or 10-point plan. We weren't looking at a “package” with any specific number attached to it. What we aimed for was an initiative that allowed us to maintain our broad focus on minority health issues, and emphasize a few key areas that are representative of the larger minority health picture. That number just happens to be six. The six priority areas represent health issues that account for a significant burden of disease but are also amenable to targeted improvement. Enough data exists in each of these areas to allow progress to be measured.

Q. What exactly are your goals for the year 2010?

A. Those goals are going to be set in the year 2000 using our already established Healthy People process. Healthy People, first introduced in 1979, is a national partnership effort among government, business, voluntary and professional organizations, and individuals to improve the public's health through health promotion and disease prevention. We are already working with all of our partners in the next year also as part of that process, to determine how best to proceed toward eliminating these disparities. President Clinton will release these new national health goals to the country in January 2000, but we are committing ourselves today to goals that will be the same for minorities and white Americans for the first time since goals were set in 1980.

Q. What happens if, in the year 2000, at the end of the Clinton Administration, there is no progress toward any or all of these goals, and the gaps widen. What

does that mean for this overall initiative?

We fully expect to succeed, but we also acknowledge the risks. In fact, throughout our nation's history we've been presented with challenges that seemed insurmountable, but we took those challenges on nonetheless. When President Kennedy said we would put a man on the moon and return him safely to Earth, we didn't know how we'd do it. But we focused the resources of a great nation to accomplish the task, and succeeded in the greatest scientific achievement of this century. We can eliminate health disparities if we put the nation's will to work.

As we progress, we may see over time that a particular gap is widening. If so, we will be able to respond more quickly and aggressively to turn it around because of the attention that will be focused on these areas. We hope and expect to meet our interim goals by the year 2000.

These are not easy goals. However, we believe that with the efforts that the public health and medical communities at the federal, state, and tribal levels bring to this effort, and strong, active partnerships with communities, we will meet the year 2000 goals. And, we will set our feet on the right path to eliminate racial health disparities by 2010.

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

A. Once something like this is set in motion and partnerships are formed, we believe future Administrations and the American people will make sure this remains a health priority. This is not political. This is about good health, about improving health, and we think future administrations will continue these priorities. "Healthy People" has been around since 1980 – through four Presidents – and it will always be there. We are already working with the states, and more than 350 national organizations on developing the framework for Healthy People 2010.

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

A. The president announced a five-step plan today, which:

· Sets Interim Goals for Immediate Progress. The President's plan sets interim targets for the nation to reach by the year 2000, which will set the nation on course to eliminate health disparities by 2010. These interim goals include: (1) reducing black infant mortality by 22 percent; (2) increasing to at least 60 percent the number of women 50 and older who have received a clinical breast exam and mammogram within the preceeding two years; and (3) reducing cardiovascular disease mortality among African-Americans by 25 percent.

- **Expands Outreach.** The Department of Health and Human Services will initiate a sweeping outreach campaign led by Surgeon General David Satcher that will send critical treatment and prevention messages to all Americans, with a special focus on reaching racial and ethnic minorities.
- **Spurs Local Innovation.** The President's budget for next year includes \$30 million for grants to 30 communities, which will conduct research and test interventions to devise innovative new strategies to improve minority health status.
- **Targets Federal Health Resources.** The Secretary of Health and Human Services will convene a new taskforce which will bring together the best minds at the National Institutes of Health and the Centers for Disease Control and all parts of the Department to develop a comprehensive strategy to better target the resources and energy of the Federal government to continue to increase gains in minority health status.
- **Builds on Proven Programs.** The President's FY 1999 budget dedicates \$250 million to building community partnerships to strengthen public health programs with a proven record of reaching minorities. minority communities to learn what they think will be most effective in assuring that we reach these goals, and to use the process as a testing ground for the strategies that will support the President's bold commitment for the Year 2010.

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

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

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

It is important to stress that the elimination of health disparities will require a national effort -- public and private sector, individuals and communities. HHS, in collaboration with states, private sector organizations and the health community will establish a framework for action to eliminate disparities through *Healthy People 2010* -- the nation's health action agenda for the next century. The two over-arching goals for 2010 are to increase years of healthy life for the entire population and to eliminate health disparities.

The Healthy People process will articulate data needs, research investments, and the action strategies that can be employed by the nation to reach the goal of eliminating disparities by 2010. In our consultations we have received near unanimous support for committing to this goal.

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

A. This is about raising the health status of all Americans, and we will continue to press ahead on all fronts. Sharpening the focus in these six areas will give us new tools and methods for addressing health disparities wherever they exist.

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

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

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

A. This will help Americans to talk about health and how we should be concerned with the health of all people, not just with our own, or with people like ourselves. This initiative will get people to realize that their health is intertwined with the health of others as well as the future of our country. We believe that this initiative will help promote racial harmony because it will generate dialogue on race on another level. For example, top researchers will talk to minority community advocates. Community advocates will talk to citizens. Policymakers will talk to health professionals. In the course of that dialogue, racial and ethnic groups will build an understanding that will mesh with other race initiative strategies throughout government to build the One America President Clinton has challenged us to achieve.

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

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

health arena.

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

For months, these groups have been discussing strategies to improve health as well as Departmental customer service to Hispanic, Native American, African-American and Asian-American and Pacific Islander communities. All of these working groups are coordinated under one body called the Minority Initiatives Coordinating Committee, which serves as an umbrella to them, and a central point for us to measure what we are doing to improve minority health.

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

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

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

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

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

in order to support good health.

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

Q. What makes this different from Healthy People 2000?

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

This fits in with the President's broader goal to address some of the toughest challenges we face as we move to the new millennium. As the 21st century dawns and our demographics change to make us a more diverse country than we ever have been, it will become increasingly critical for us to address these pressing health challenges faced by minorities if we are to enter the new millennium as one America, fully prepared to take advantage of the strengths of that diversity.

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

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

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

Q. How will this effort be coordinated? Will any kind of special commission or panel be formed to follow progress on these six goals?

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

charge to that committee is:

- To review the status of the six health disparity reduction goals for the Year 2000 and assure that the Department's research, health services and prevention programs give priority to attention to them.
- To conduct a process of consultation with minority community representatives and with the scientific and health services communities to improve our understanding of how to achieve both the near term disparity reduction goals and the 2010 disparity elimination goal.
- To examine the Department's research, data, service and prevention programs and recommend to the Secretary necessary changes in these programs to support the President's goal of eliminating health disparities in the next century.

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

Q. Where exactly are the disparities?

- A.** Disparities in health status vary widely among racial groups in the United States. It's a complex picture. A myriad of factors, including culture, lifestyle, socioeconomic status, and access to health care, all contribute to the health status of all Americans.

The disparities the President has chosen to highlight reflect that complexity. Not every racial group is experiencing a disparity in every area. However, in each of the six targeted areas, at least one minority racial group is faring more poorly than white Americans.

Here is a snapshot of the health status of each minority group under the six target areas:

Infant Mortality

- The national average is 7.2 deaths per 100,000 live births and the white rate is 6.0.
- Blacks (14.2), American Indian (9.) and Hispanics (7.6) were higher in 1995 or 1996.
- Near-term goals for the year 2000: To reduce the black rate by 22 percent (to 11.2) from the 1996 rate.

Cancer Screening and Management

- The white cancer death rate is 127 per 100,000
- Blacks (171.6) fare worst, and have higher death rates than whites in terms of men, lung cancer, and prostate cancer. Also, Native Hawaiian men have higher lung cancer rates than white men; Alaska Natives have higher colon cancer rates than whites; Vietnamese women in the U.S. have a cervical cancer incidence rate five times greater than white women (47.3 vs. 8.7 per 100,000) and Hispanic women have higher cervical cancer rates.
- Near-term goals for the year 2000: To increase the percentage of 50 and older women of all racial and ethnic groups who get clinical breast exams and mammograms within the preceding two years to 60 percent; to increase the proportion of women 18 and over who receive a Pap test within three years to at least 85 percent.

Cardiovascular Disease

Coronary Heart Disease

- Age-adjusted death rate for coronary heart disease for the total population declined by 20% from 1987-95.
- Black rate of decrease (13%) for coronary heart disease was worse 1987-95, and black coronary disease death rate was higher (40%) than for whites in 1995.
- Coronary heart disease mortality was 40% lower for Asian Americans in 1995, but Asian-American males had a higher stroke mortality rate than white males.

Hypertension

From 1988 to 1994, for all men age 20-74, from 1988 to 1994, 25 percent had hypertension.

Blacks had a higher rate of hypertension (35 percent) among black males age 20-74 and Mexican-American men and women have higher blood pressure rates than whites when age differences are accounted for.

Near-term goals: To reduce the heart disease and stroke death rates among blacks by 25% and 40% respectively, from their 1995 levels

Diabetes

- Blacks (70 percent) and Hispanics (nearly double) have higher prevalence rates than whites, and American Indians and Alaska Natives (more than twice) have higher prevalence rates than the total population.
- Near-term goals: To reduce the rate of end-stage renal disease from diabetes among blacks and American Indians/Alaska Natives by 65% from their 1995 levels; and reduce lower extremity amputation rates from diabetes among blacks by 40% from their 1995 levels.

HIV/AIDS Infection Rates

- AIDS death rates declined 23% for the whole population in 1995 and 1996.
- Blacks (13%) and Hispanics (20%) have declined at a slower rate.
- Near-term goal: To provide through Medicaid, Medicare, and Ryan White equal

access to life-enhancing health care and appropriate drug therapies for at least 75 % of low-income persons living with HIV/AIDS.

Child and Adult Immunization Rates

- While childhood immunization is at an all-time high, minority rates have been lower than whites, yet minority rates are rising faster than whites.
- While vaccination levels against pneumococcal infections and influenza have increased slightly for 65 and over blacks and Hispanics, the coverage in these groups remains substantially below the general population and year 2000 targets.
- Near-term goals: To achieve a 90% coverage for all recommended vaccines in all populations and to eliminate remaining disparities among groups, and to increase pneumococcal and influenza immunization rates among all adults 65 and over to 60%.

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In radio address, Clinton proposes equalizing black and white

health care

Eds: SUBS final item on HIV/AIDS to add statistics showing racial disparity; SUBS 4th graf, His health, to CLARIFY that \$400 million is new money sted total federal cost

By SANDRA SOBIERAJ=

Associated Press Writer=

WASHINGTON (AP) President Clinton broadened his initiative for racial harmony on Saturday, asking for \$400 million and an aggressive public awareness campaign to wipe out health disparities between minority and white Americans.

Though AIDS death rates are down and childhood immunization levels are at an all-time high, ``we must not be blind to the alarming fact that too many Americans still do not share in the fruits of our progress,'' Clinton said in his weekly radio address. ``Nowhere are the divisions of race and ethnicity more sharply drawn than in the health of our people.''

Among the gaps that Clinton called ``unacceptable in a country that values equality'': black children are twice as likely to die in infancy as white children, and American Indians suffer from diabetes at three times the national average.

His health initiative would specifically target for elimination by 2010 disparities in six areas where differences between white and minority Americans are most stark. The administration's budget request asks for \$400 million in new money over five years. It would be combined with existing federal programs and private-sector help.

Clinton linked the campaign to this month's celebration of Black History month. As part of it, a coalition of 136 philanthropic foundations would convene a national conference on minority health this spring, the president said.

Representatives of the NAACP and other minority interest groups joined Clinton in the Oval Office for his broadcast. Health and Human Services Secretary Donna Shalala cast the proposal as the latest installment of Clinton's drive for racial understanding.

While that ongoing dialogue has been widely criticized as unfocused and abstract, Shalala emphasized the health goals would be measurable and the administration would annually report on progress.

Surgeon General David Satcher and former New York City Health Commissioner Peggy Hamburg were put in charge of the overall project. Congress would have to approve the \$400 million in funding, with some \$30 million per year slated for 30 communities that would each focus on one or two health problems in order to develop model strategies.

The administration would also be seeking private-sector help, Shalala said.

She cited past projects where McDonald's printed childhood immunization information on their restaurant tray liners, where Pampers diapers helped get the word out on children's health insurance and where Gerber baby foods did outreach about preventing Sudden Infant Death Syndrome.

``We can't wait for everybody in this country to get good health insurance,'' Shalala said. ``When you really want to close a health care gap and you do not have a single health care system, you go to

every part of the country and have everybody pull in the same direction."

Satcher said the effort to speed up improvements in minority health would not come at the expense of others.

"We're going to improve it for everybody," he said. "This project will not succeed unless the white community is supportive. The American Indian, the African American and Asian, all of these groups have to work together in communities in order for this to be successful."

Aside from the money that would be put aside for 30 communities yet to be designated, the balance of the federal funds would be directed to the Centers for Disease Control and Prevention for enhanced prevention programs in the six targeted areas:

Infant mortality. Black children die in infancy at a rate 2 1/2 times higher than whites; American Indian infants 1 1/2 times higher.

Cancer screening and management. Black men under 65 are diagnosed with prostate cancer at nearly twice the rate of white men; Vietnamese women get cervical cancer at nearly five times the rate of white women; and Latinos have two to three times the rate of stomach cancer.

Cardiovascular disease. Black men suffer heart disease at twice the rate of whites.

Diabetes. The disease afflicts three times as many American Indians, and black people at a 70 percent higher rates than white people.

Child and adult immunizations. Just 20 percent of black adults get the vaccine for pneumonia, compared with 35 percent of white adults.

HIV/AIDS. Seventy-five percent of all AIDS cases among women and children are minority cases. And from 1995 to 1996, overall death rates declined 23 percent, but among blacks, the death rate fell only 13 percent.

APWR-02-21-98 1800EST

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^Clinton sets health goal to end racial imbalance@

(recasts, updates throughout)

By Laurence McQuillan

WASHINGTON (Reuters) - President Clinton, decrying a racial and ethnic gap when it comes to the health of Americans, Saturday outlined a \$400 million plan to eliminate the disparity in six key areas by 2010.

``No matter what the reason, racial and ethnic disparities in health are unacceptable in a country that values equality and equal opportunity for all,'' Clinton said in his weekly radio address to the nation.

``This is our national goal,'' Clinton declared. ``By the year 2010 we must eliminate racial and ethnic disparities in infant mortality, diabetes, cancer screening and management, heart disease, AIDS and immunization,'' he said.

He cited statistics showing that infant mortality rates are twice as high for African Americans compared with whites, that black men suffer from heart disease at nearly twice the rate of white males and that overall cancer deaths are disproportionately high among both Latinos and blacks.

Additionally, Vietnamese women are five times as likely to have cervical cancer, Chinese Americans are four to five times as likely to have liver cancer, and Hepatitis B is more prominent among Asian Americans than the rest of the U.S. population.

Native Americans suffer higher rates of infant mortality and heart disease, while diabetes among Hispanic are twice the national average and three times above the national average for Native Americans.

Clinton said the budget proposal he submitted to Congress earlier this month ``devotes an unprecedented \$400 million to spur promising prevention and outreach programs to help us meet this challenge.''

The money, to be spent over five years, would be used to assess current programs, improve data collection and work with localities.

Under the plan, newly-installed Surgeon General David Satcher will lead an outreach campaign aimed at mobilizing local communities, churches, physicians and nurses and other community-based program to join the federal effort.

Satcher, who spoke with reporters, said he soon will announce 30 communities that will be targeted for participation.

**STATEMENT OF REPRESENTATIVE HENRY A. WAXMAN
FEBRUARY 23, 1998**

Lead poisoning is a widespread and serious environmental health threat to children. Children exposed to lead through paint, gasoline, or other leaded products can have severe health problems such as brain damage, seizures, coma and death. Even at low levels of exposure, lead can impair a child's learning ability and motor development and cause behavioral problems such as hyperactivity.

Lead poisoning is also entirely preventable. Although we have made great strides in reducing sources of lead exposure, close to one million children continue to have dangerous blood lead levels. Poor children living in older housing stock remain the most at-risk.

In order to identify the extent of the problem of lead poisoning, I requested that the General Accounting Office analyze the prevalence of dangerous lead levels in Medicaid children, and the extent to which these children are being screened for lead toxicity. The new GAO report we are releasing today finds that Medicaid populations are still severely threatened by the disease, and even the most basic preventative step -- blood lead screening -- is being neglected.

According to today's report, half a million Medicaid children, or roughly one in twelve Medicaid children between the ages of one to five, have harmful levels of lead in their blood -- a rate three times that of non-Medicaid children. Although Medicaid children comprise one third of the U.S. population of children aged 1 to 5, they represent 60% of the 890,000 children with elevated blood lead levels. Over 80% of children with the most severe cases of lead poisoning are covered by Medicaid.

To address the problem of lead poisoning among Medicaid children, Congress passed a law in 1989 requiring lead screening as part of Medicaid's special preventive health program for children. In 1991, the CDC issued revised screening recommendations, calling for universal screening and the use of the blood lead screening test.

The GAO report I am releasing today demonstrates that these requirements simply are not being implemented. Despite mandatory screening requirements, 81% of Medicaid children were not screened at all for lead toxicity. Of the 535,000 Medicaid children identified with elevated blood lead levels, 65% -- or roughly 352,000 -- had not been properly screened.

The Health Care Financing Administration is currently considering modifying its screening requirement for Medicaid children, giving states the responsibility of deciding whether mandatory screening is necessary. I think we need to be very cautious in this area. By so dramatically confirming that lead toxicity is predominantly concentrated in Medicaid children, the data revealed in today's GAO report underscores the critical importance of ensuring that we do a better job screening children in Medicaid populations. HCFA and other agencies need to do more screening -- not relax their screening requirements.

The data being released today shows that there is a lead poisoning epidemic among Medicaid children and that we are doing very little to help these children. I hope that the Administration and Congress will be able to use this information as they develop new strategies for combating this preventable environmental threat to children's health.

Donna Shalala, secretary of health and human services, also will lead a federal task force charged with examining existing federal health program to root out policies and procedures that permit racial and ethnic disparities.

``But to truly eliminate these disparities and ensure better health for all Americans, all Americans must do their part,'' Clinton said.

The announcement drew a broad cross-section of support from groups representing minorities, including the NAACP and several Hispanic organizations.

Clinton announced that Grantmakers in Health, a coalition of more than 136 philanthropic foundations across the country, will join the effort.

He said that the White House and the coalition jointly will host a conference this spring ``to help solve this national problem community by community.''

``America has the best health care system in the world, but we can't take full pride in that system until we know that every American has the best health care in the world,'' Clinton said.

Shalala said that ``what's happened in the past is that when we set health goals we had one set of goals for the racial and ethnic communities in the United States and another set of goals for the rest of the country.''

``We're going to end those disparities and, in fact, set one set of goals,'' Shalala said.

Satcher acknowledged that ``it's not going to be easy. It's a real challenge to do this ... some of the factors are not in the health care system, they're in individual behavior.'' He said, ``all of these things have to work together in order for us to be successful.''

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Reut16:54 02-21-98

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FDCH Political Transcripts

February 21, 1998, Saturday

TYPE: NEWS BRIEFING

LENGTH: 3804 words

HEADLINE: HOLDS NEWS BRIEFING ON HEALTH CARE COVERAGE;
WASHINGTON, D.C.

SPEAKER:

DONNA SHALALA, U.S. SECRETARY OF HEALTH AND HUMAN SERVICES

BODY:

U.S. SECRETARY OF HEALTH AND HUMAN SERVICES AND U.S. SURGEON

GENERAL HOLDS NEWS BRIEFING ON THE PRESIDENT INITIATIVE ON

HEALTH CARE COVERAGE

FEBRUARY 21, 1998

(EMBARGOED UNTIL 10:06 A.M. 2/21/98)

SPEAKERS: DONNA SHALALA, U.S. SECRETARY OF HEALTH AND HUMAN

SERVICES

DR. DAVID SATCHER, U.S. SURGEON GENERAL

SHALALA: Tomorrow morning, the president will announce his administration's intention to eliminate racial and ethnic disparities in six critical health areas by the year 2010.

This means that for the first time in its history, the federal government will set universal national health goals, ending the practice of setting separate, lower goals for minority communities. What's happened in the past is that when we set health goals, we had one set of goals for the racial and ethnic communities in the United States, and another set of goals for the whole -- for the rest of the country. And we're going to end those disparities, and in fact set one set of goals.

Since taking office, we've had some very important public-health accomplishments. Infant mortality is down. HIV and AIDS rates are falling, for the first time since the beginning of the epidemic. Cancer rates may actually be starting to decline in this country.

But these accomplishments are tempered by the fact that there are persistent disparities in health outcomes -- Thank you very much...

(LAUGHTER)

... there are persistent disparities in health outcomes for white Americans and for minorities. And I'm defining "minorities" as including American Indians, African Americans, Hispanics, and Asian Americans.

But simply bringing down the numbers is not enough. We want to close disparities for the major killers in this country. Heart disease, cancer, stroke, diabetes, and HIV-AIDS.

And he'll set a goal tomorrow of ending health disparities in these six -- in six critical areas by the year 2010.

And we've actually selected out six specific areas. Infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV-AIDS infection rates, and child and adult immunizations.

We're also going to expand outreach with a sweeping campaign led by the surgeon general of the United States, Dr. David Satcher, and Dr. Satcher will be spreading the word and helping to organize the country to reduce the disparities in all of these health areas.

In addition to Dr. Satcher, an internal task force will be led by Dr. Peggy Hamburg, the assistant secretary for planning and evaluation. Dr. Hamburg was the New York City health commissioner before she joined the administration, and is widely credited for reducing the incidence of tuberculosis in New York City. She actually will be putting the mobilization campaign in place, and has had wide experience in public health, and actually changing and reducing health disparities.

SHALALA: The task force -- the Internal Task Force is going to monitor progress in all these six areas. All of these six areas are areas in which we will actually have statistics. We'll know what our baseline is and, as we close the gaps, we'll be able to report yearly on how we're doing in raising immunization rates, for example, or reducing the incidence of particular diseases or getting better management of diseases like hepatitis.

Finally, the president will be asking Congress for \$400 million over the next five years to both assess our current programs and improve data collection and work with communities. Remember, the important point here is this is an historic breakthrough in public health. We will now have the same standard for the major killers that we have for the wider community.

What we intend to do is to close the gaps in health disparities between minority communities and the rest of the country. And it will be a major breakthrough. It will take a huge mobilization effort in this country to bring health care to the communities, to get communities to use the health care system.

Let me now ask Dr. Satcher whether he has anything to add.

SATCHER: Thank you. I'd just like to stress, as the Secretary pointed out, that this is a mobilization initiative. It's going to be very important that this is a public and private initiative. It's not limited to the government. We are depending upon organizations in communities throughout this country to join us in making this initiative work.

We will be communicating with communities throughout this country, listening to communities, trying to identify successful models that can be applied more broadly. But it is a public/private venture. Grant-Makers of America will be joining us in trying to identify strategies that will work that can help us to demonstrate the efficacy of these efforts to narrow and close the gaps that exist in areas like infant mortality, immunizations, HIV/AIDS, cardiovascular disease, diabetes and cancer.

SATCHER: So we're looking forward to working with people throughout this country in this next...

SHALALA: The context for this is obviously the president's race initiative. This is the health piece of the president's race initiative. It is a measurable set of goals.

So we actually will be able to report each year on our progress, and the president will expect us to report each year on the country's progress to actually improve the health by reducing the differences.

Questions?

QUESTION: What do you mean by -- I'm sorry. Go ahead.

QUESTION: Are you saying that all along we've accepted, in targeting funds, that the infant mortality rate is going to be higher in minority communities than in white communities?

SHALALA: When we set the goals, the process of setting the nation's goals over the years, we actually had different goals for the minority communities, because they were further back, in terms of how far we were going to move, and what we're saying now is, we no longer will have separate goals.

We want to bring up and eliminate disparities between the two communities, access to mammography, adult immunization, cardiovascular disease -- we're actually going to try to move faster in the minority communities, to close these gaps.

QUESTION: Those goals have been tied to funding decisions?

SHALALA: Well, no.

Actually, they have not been tied to funding decisions. Those goals were set lower because those communities were further behind, and so we're now saying, is we're going to put additional resources into this effort, so that we can leverage and mobilize the country to close the gaps in all of these major areas, and the areas we've chosen are areas that are specifically -- of specific concern to these communities, because there is higher incidence in these communities of these particular diseases or these particular gaps.

QUESTION: What additional resources?

SHALALA: We're talking about \$400 million over the next five years, but that's glue money to pull our public health resources ~~and our research resources~~ together for a specific focus.

QUESTION: The rationale that has existed is based on the idea that because there was so much more that needed to be done for minorities -- I mean, so by changing the goal,...?

SHALALA: We give ourselves a big...

QUESTION: (OFF-MIKE) I mean in that realistic? I mean, doesn't...?

SHALALA: Well...

QUESTION: I mean, presumably, the old rationale wasn't meant, you know, in a negative way. It was meant to deal with a realistic approach to the problem.

SHALALA: I think what we're saying is that we're going to make an extraordinary effort to actually close those gaps.

Let me give you a specific example. In 1993, the immunization rates for American kids, up to two years old, were 55 percent, 55 percent. And there were big gaps between white kids and African-American and Hispanic kids in particular.

QUESTION: (OFF-MIKE)

SHALALA: There was a difference of 20 percent?

SATCHER: You know, there are some specific examples throughout the country, but in a place like Detroit, where the difference was as high as 30 percent.

SHALALA: Between whites and African-American kids?

SATCHER: That's right.

SHALALA: We mobilized the country to get kids below two years old immunized, and we now have childhood-immunization rates for most of the vaccines for minority kids at precisely the same rate as white kids. We've brought up minorities actually faster, because we had further to come.

And we have 90 percent of all the kids in the country now immunized.

That took a tremendous targeted mobilization effort, to get the resources and the organization to the places where we had the biggest gaps.

What we're saying, for these other disparities, that we're going to do -- which in some ways will be a more complicated campaign, because it involves getting people to care as not just shots. We're going to do that for these other major disease areas, in somewhat the same way, but it's a huge effort. We're simply going to raise the standards, not lower them.

QUESTION: Is the trust factor in the minority communities some of the reason for the disparities in health output, ethnic versus mainstream?

SATCHER: I think there are a lot of reasons, and I think we -- we've assumed that trust is one of the factors, and our strategy for dealing with that is to try to be more effective in involving the communities, as we did with the immunizations.

SATCHER: We identified organizations like the Congress of National Black Churches or a Hispanic organization in Chicago that works out of the church system there, and we work through those organizations to get people immunized in those communities.

So we have learned some things in areas like immunization about how to deal with issues related to trust. Those are not going to go away easily. But I think we're just going to have to recognize them and work with people who live and work in those communities and who are trusted by people in those communities.

SHALALA: Socioeconomics also plays a large part as well.

SATCHER: Oh, no question about it. There are a lot of factors like the American Indians -- one of the major concerns is diabetes where the risk of diabetes in American Indians in this country is over twice as great as it is for whites in this country. And there are a lot of factors in terms of life style and other factors that we can not even define.

But in working with those populations and in groups that are familiar with those populations and trusted by them, we believe we can make progress.

QUESTION: Dr. Satcher, can you describe that mobilization process in a little bit more detail? Does it mean that more money goes to hospitals that cater to these communities? Is it more outreach? Can you tell us?

SATCHER: Well, one of the strategies that I'm really quite involved in would be the outreach program to 30 communities. We're going to identify at least 30 communities in the country, and each of those communities will have at least one of these areas -- infant mortality, immunizations, HIV/AIDS, et cetera. And we will work with those communities in developing strategies for closing the gaps. And they will have to define what are the unique challenges in their community that we need to focus on.

But what we want to do is to demonstrate success in these various communities in different areas. Some of them will be African American. Some of them will be Asian. Some of them will be Hispanic. Some of them will be American Indians, reservations, et cetera. But we want to demonstrate in these various communities that we can be successful in closing the gaps.

And once we've done that, we can bring the full force of our department to bear on those problems with all of our resources.

SHALALA: The earlier announcement this week by the president and the first

lady for an outreach program for children's health insurance will obviously dovetail into this.

SHALALA: But what we've clearly done here is put our institutions, both public and private, as well as our own reputations, on line to say that it's time we closed these huge health gaps, that we can't wait for everybody in this country to get good health insurance, that we have to mobilize what health-insurance system we have in this country, make it fit together in a way so that we really do close the gaps, and make a difference in people's lives.

QUESTION: What is the source of the funding? Is it from the tobacco tax, or is it -- are there offsets or...?

SHALALA: No, actually, I think this is a -- I'm sure we identified offsets, but I -- this is part of our regular budget. This is not on our list of -- where we clearly identified the tobacco money for it. It's 80 million for the first year, and then it -- over the five years, it becomes 400 million.

But we will be spending a lot more than \$400 million, because what we're going to do is leverage NIH resources, CDC resources, public-health resources, the Health Care Financing Administration, plus the private sector. Remember, when we did immunizations, we did -- McDonald's gave us their tray liners, and Pampers is giving us, for the children's health-insurance outreach. So we'll be going to the private sector, to the churches, to the public health system in the United States.

When you really want to close a health care gap, and you do not have a single health-care system, you go to every part of the country, and have everybody pull in the same direction.

QUESTION: Do you think, when you say "leverage," though, about the -- what percentage -- how much would the 400 million leverage, approximately? What are you contemplating?

SHALALA: My assumption is that we'll be well over a billion dollars, by the time we're finished, in what the private foundations will give us, in what other public health -- parts of the public health system will give us, in what private health insurance itself will commit to as it puts special efforts on closing some of this gaps.

We'll be working with the HMOs around the country. They were terrific on the immunization campaigns.

QUESTION: What's a realistic ratio for closing this gap that's gone on for

many, many years?

SHALALA: Well, what we're saying is, we're going to close it.

SHALALA: We're actually saying by 2010 our goal is not to be competitive here, but it's to close the gap. We're not saying we want to cut this gap in half. We're saying we actually want to close the gap by 2010.

SATCHER: Let me just add one thing to that. I think it's not going to be easy. It's a real challenge to do this. And I think what we're saying is that we have to work together.

Some of the factors are not in the health care system they're in individual behavior, physical activity, diet, you know, smoking, toxins of various kinds. So we've got to work with communities to help people change their life styles.

We have some successful models throughout the country already that we've developed. We've got to expand those. But all of these things have to work together in order for us to be successful.

QUESTION: To what extent do you think the disparity is due to lack of insurance? And if it's an uninsured population, how do you address that?

SHALALA: Well, if you go to the analyst in the system, the people who look at this, they'll say both a combination of poverty and a lack of health insurance lead to this. But we've put in place before special programs.

If we had believed that, we would have never gotten the kids in this country immunized. What we learned out of the immunization campaign was that you've got a public and private system, you've got community health centers, you have hospitals that provide special programs. You can put special money out.

CDC has most recently had a special campaign focused on African- American women for mammograms that has begun to actually make a percentage difference. We -- at the NIH, they've been under Mrs. Gore's leadership in running a campaign to reduce infant mortality from Sudden Infant Death Syndrome by running the "Back to Sleep" campaign. Gerbers has been part of that campaign.

We now have almost 70 percent of the kids in this country, when they're born, their first couple of years are put on their backs. We have a large -- a significant problem with the American Indian population who tend to put their babies on their stomachs. This campaign to close the gap will focus on that population, getting the message out that if you put your baby on its back, it will reduce its chances of dying as an infant.

SHALALA: That'll be an integral of this overall campaign.

I don't want to sound too enthusiastic or anything.

SATCHER: Let me...

(LAUGHTER)

SHALALA: But it's fun not to just say we're going to have a 10 percent goal, but we're really going to go after the whole thing.

And we're not going to be discouraged by the fact that we don't have a single health care system. We're going to take every piece of this health care system, public and private, plus every person, every church, every community leader, to get people to the health program that will -- that will make a difference for them.

QUESTION: You know, I'm sorry, but I'm not sure if I quite understand how to explain where the \$400 million would be spent.

SHALALA: Oh, I...

QUESTION: I mean,...

SHALALA: ... actually tell you specifically.

David, do you want to describe the 30...

SATCHER: Yes.

SHALALA: Go through the...

SATCHER: Of the 80 million, 30 million will be used in these 30 communities that I mentioned, that we're going to select throughout the country, and have each one of them adopt at least one of these areas for closing the gaps.

The others are...

SHALALA: 150 over five years.

SATCHER: Right. 30 times five. So over five years, 150.

The other 50 million are ongoing programs, HIV/AIDS, diabetes, programs that we have in place, and we're committing so much funds to enhance those programs.

Sexually transmitted diseases. To make sure that, over the next few years, we enhance our strategies in these minority communities.

SHALALA: What the...

QUESTION: Is that a grant then? I mean, are you talking about giving a million dollars to a community?

SHALALA: Well...

SATCHER: In some cases.

SHALALA: In some cases.

What we're talking about is taking the rest of the money, some of it taking existing programs and retargeting them, specifically to communities where we see the gaps. That's why we use terms like "mobilization."

It's not -- you can't take a billion dollars and go buy this, and close the gaps. You have to mobilize every part of the system.

And I realize it doesn't -- it's not as easy as saying we're going to do this program, we're going to hand out the money, it's going to get done.

In -- because the American health care system is fragmented, if you want to actually improve people's health, you have to almost Scotch tape it together for a huge campaign to close those gaps, and get it to work together. And that's the way it gets done.

It's a leadership-mobilization, huge management effort.

SHALALA: And what we've done is picked two people, first the Surgeon General, David Satcher, and second, Peggy Hamburg, who ran the New York City Health Department, the two leading public health people in the country who have actually done this kind of thing and said let's go out and not take an incremental step. Let's take a giant step to improve the health of minorities in this country.

QUESTION: Of those 30 communities, can you identify a handful for us now?

SATCHER: No, I won't. That wouldn't be appropriate for me. I think we're going to work to identify the best communities. And in order to do that, we need to do some listening and at what people are doing now, what they propose to do, the extent to which people can work together in communities across racial lines.

This project will not succeed unless the white community is supportive, the American Indian, African American, Asian -- all of these groups have to work together in communities in order for this to be successful.

We're looking for communities that are willing to make that kind of commitment. I was just thinking of another example, somewhere that we're really struggling now, and that's adult immunization. If you take the pneumococcal vaccine, for example, that could save many thousands of lives in this country every year.

SHALALA: Pneumonia.

SATCHER: That's right. Very few African American adults, probably less than 20 percent, are getting that vaccine, and only about 35 percent of white adults. So we need to close the gap. But as we close it, we're going to improve it for everybody.

So we're not talking about taking anything away from anybody. We're talking about developing strategies and showing that they can work, and then applying them broadly. But obviously those who are at the bottom are going to go much faster just like they did with the immunizations -- the childhood immunizations.

SHALALA: Thank you. One more question? Yeah.

QUESTION: Which gap and which disease area is the largest?

SHALALA: Gee, this is disease.

SATCHER: Oh, disease areas.

SHALALA: Yeah, disease areas.

SATCHER: I would probably say diabetes because what we see and people like Senator Domenici and others in Congress have a major concern. What we see, for example, in the American Indian population in this country, sometimes it's five times as great as in the white population in certain groups of American

Indians.

Like the Penobscot population, for example, it tends to be higher.

SATCHER: Same thing with Hispanic populations. There are some groups where

the gap in diabetes is really great.

And we see the difference in terms of complications, like the need for amputations, end-stage renal disease, blindness from diabetes.

We see some major gaps in these areas that we believe that we can begin to close.

And I also want to point out, it's going to benefit our entire health care system, because the way we spend our money now, we spend too much of it on treatment, because we have to, because we're not preventing things as early as we would like, and part of this initiative will be to significantly enhance prevention.

SHALALA: OK. Thank you.



THE WHITE HOUSE
Office of the Press Secretary

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RADIO ADDRESS BY THE PRESIDENT TO THE NATION

The Oval Office

THE PRESIDENT: Good morning. February is Black History Month, the time when we celebrate the rich heritage of the African American community and rededicate ourselves to the value of equal opportunity for all Americans that is at the heart of the American ideal. Today I want to talk about an important step we're taking to make sure all Americans, no matter what their background, have a better opportunity to live healthier lives.

In the last six years we've worked hard to make quality health care more accessible and affordable and to place more emphasis on prevention. And this approach is working. Since 1993, our nation's health has greatly improved. Infant mortality has reached an all-time low, childhood immunization levels are at an all-time high and AIDS death rates are falling, for the first time in the history of the epidemic. Americans are living longer and are in better health than ever before.

This is good news we should all celebrate. But we must not be blind to the alarming fact that too many Americans do not share in the fruits of our progress, and nowhere are the divisions of race and ethnicity more sharply drawn than in the health of our people.

Consider: Infant mortality rates are twice as high for African Americans as for white Americans. African American men suffer from heart disease at nearly twice the rate of whites. African Americans are more likely to die from breast cancer and prostate cancer. Overall, cancer fatalities are disproportionately high among both Latinos and blacks. Vietnamese women are five times as likely to have cervical cancer; Chinese Americans four to five times as likely to have liver cancer. Hepatitis B is much more prominent among Asian Americans than the rest of the populations. Native Americans suffer higher rates of infant mortality and heart disease. And for diabetes, Hispanic rates are twice the national average, and Native American rates three times the national average.

Research shows that overall, all these groups are less likely to be immunized against disease, less likely to be routinely tested for cancer, less likely to get regular check-ups.

We do not know all the reasons for these disturbing gaps. Perhaps inadequate education, disproportionate poverty, discrimination in the delivery of health services, cultural differences are all contributing factors. But we do know this: No matter what the reason, racial and ethnic disparities in health are unacceptable in a country that values equality and equal opportunity for all. And that is why we must act now with a comprehensive initiative that focuses on health care and prevention for racial and ethnic minorities.

This is our national goal: By the year 2010, we must eliminate racial and ethnic disparities in infant mortality, diabetes, cancer screening and management, heart disease, AIDS, and

immunization.

My balanced budget plan devotes an unprecedented \$400 million to spur promising prevention and outreach programs to help us meet this challenge. I'm asking our top public health officials, led by Secretary Donna Shalala, to convene a task force to find new ways of targeting existing federal programs to reduce racial and ethnic disparities. Our new Surgeon General, Dr. David Satcher, will launch a comprehensive campaign to educate the public and work with community leaders and health professionals to reach more Americans.

These steps, along with our drive to give 5 million more children, many of them minorities, health insurance, and our huge increase in overall medical research, will bring us closer to our goal. But to truly eliminate these disparities and ensure better health for all Americans, all Americans must do their part.

I'm pleased to announce that Grant-Makers in Health, a major coalition of over 136 philanthropic foundations across the country, is joining our efforts. Together we'll host a national conference this spring to help solve this national problem, community by community.

Above all, Americans must take more responsibility for our own health and the health of our children, for good health is the greatest gift God can bestow and it is each of our duty to protect it.

America has the best health care system in the world. But we can't take full pride in that system until we know that every American has the best health care in the world. With these steps, I'm confident that we can meet the challenge and go forward as one America into the 21st century -- stronger and healthier than ever before.

Thanks for listening.

**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 Native Americans. African-American 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 by the year 2010: infant mortality; cancer screening and management; cardiovascular disease; diabetes; HIV/AIDS rates; and child and adult immunization levels. The President's plan:

- **Initiates Sweeping New Outreach Campaign Led by the Newly-Confirmed Surgeon General and Assistant Secretary for Health, Dr. David Satcher.** The President is announcing that the Department of Health and Human Services will initiate a major outreach campaign led by Surgeon General Satcher that will send critical treatment and prevention messages to all Americans, with a special focus on reaching racial and ethnic minorities. This campaign will reach out to local communities, churches, nurses, physicians, and other community-based programs and experts in minority health. It will improve education and outreach efforts and develop innovative strategies to address racial and ethnic health disparities.
- **Includes Over \$400 Million to Develop New Approaches and to Build on Existing Successes to Address Racial and Ethnic Health Disparities.**
 - **Spurs New, Local, Innovative Strategies to Address Disparities.** Seriously addressing racial and ethnic disparities in health will require not

only the focused application of existing knowledge and best practices, but the development of new approaches. The President's budget proposes a total of \$150 million over five years for grants to up to 30 communities, chosen through a competitive grant process. These grants will be used to conduct research to devise innovative new strategies to improve minority health status. Successful approaches learned in these communities will be applied to all health programs across the Department of Health and Human Services.

- **Builds on Approaches That Have Proven 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. The plan 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 to Develop Ways to Target Racial and Ethnic Health Disparities.** The President issued a challenge to employers, churches, schools, community-based clinics, nurses, and 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 new 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.

ELIMINATING DISPARITIES IN INFANT MORTALITY

Thanks to an intensified national commitment to give babies a healthy start in life, the U.S. infant mortality rate (the rate at which babies die before their first birthday) reached an historic low of 7.2 deaths per 1,000 live births in 1996. While infant deaths have also declined significantly among racial and ethnic minority groups, the rate of decline has lagged behind the overall national trend. Infant death rates among blacks, American Indians, Alaska Natives, and Puerto Ricans are above the national average. Blacks have the highest infant mortality rate of any group (14.2 per 1,000 in 1996) -- nearly 2.5 times that of white infants (6.0 per 1,000 in 1996). The overall American Indian rate (9.0 per 1,000 live births in 1995) does not reflect the diversity among Indian communities, some of which have infant mortality rates approaching twice the national rate. Similarly, the overall Hispanic rate (7.6 per 1,000 live births in 1995) does not reflect the diversity among this group. Puerto Ricans, for example, had a rate of 8.9 per 1,000 live births in 1995.

Among the leading causes of death in infants, the racial and ethnic disparities are greatest in: disorders related to short gestation (preterm birth) and unspecified low birthweight, respiratory distress syndrome, perinatal infections and newborns affected by maternal complications of pregnancy, and sudden infant death syndrome (SIDS). For example, a much higher incidence of preterm births occurs among black mothers than among white mothers (17.7 compared with 9.7 percent). Underlying factors, such as chronic hypertension, which has a higher incidence among blacks, play a role in preterm births. In addition, SIDS -- which accounts for about 10 percent of all infant deaths -- affects minorities disproportionately. American Indian and Alaska Natives babies are three to four times more likely to die of SIDS than white infants, and black infants are 2.5 times more likely to die of SIDS than white infants.

YEAR 2000 GOALS. To eliminate these disparities, the President's initiative sets goals for immediate progress, setting the nation on course to eliminate disparities in infant mortality rates by 2010. By 2000, the President's initiative will aim to reduce infant mortality among blacks -- the group with the highest infant death rates -- by at least 20 percent from the 1996 rate. The initiative will also work to reduce infant mortality among American Indians, Alaska Natives, and Puerto Ricans, whose infant mortality rates are also above the national average. In addition, we will continue to monitor progress in reducing SIDS rates for all racial and ethnic groups as an indicator of our progress toward reducing the national infant mortality rate.

FUNDING. The President's FY 1999 budget includes an additional \$30 million for CDC for a community-based demonstration program in up to 30 communities that will focus on eliminating racial and ethnic health disparities. The President's budget also includes an additional \$15 million for Community Health Centers to enhance services targeted on reducing health disparities.

ADDITIONAL ACTIVITIES. To bolster ongoing efforts, HHS is launching targeted initiatives, including:

Mississippi Delta Project. Infant mortality rates in the 10-county Mississippi Delta region are among the highest in the nation. The HHS Health Resources and Services Administration will join forces with community leaders in the Delta region to develop a comprehensive strategy to improve child and infant health and reduce the overall burden of disease. HRSA will award up to \$100,000 for community planning. Based on the findings of the planning process, HRSA will make a substantial increased investment in its programs and will encourage other federal agencies and foundations to support this underserved area.

SIDS Outreach. The National Institutes of Health is launching a new outreach effort targeted to racial and ethnic communities. This project will include new media efforts to reach non-English-speaking parents, outreach to health professionals who serve primarily ethnic and racial communities, and better use of ethnic radio stations to raise parental awareness of what we know about SIDS.

ELIMINATING DISPARITIES IN BREAST AND CERVICAL CANCER SCREENING AND MANAGEMENT

Breast and cervical cancer kill more than 50,000 American women each year, but early detection and screening can reduce the risk of death from breast cancer by 30 percent and can nearly eliminate the risk of death from cervical cancer. However, disparities persist among racial and ethnic groups not only in the incidence and death rates due to breast and cervical cancer, but also in the percentage of women who receive screening for breast and cervical cancers.

Despite considerable gains in screening in the black community, the mortality rate from breast cancer for black women continues to be higher than that for white women. Some of the reasons for this disparity include the fact that many women have not had a mammogram or Pap smear, and many more are not screened regularly. Others are screened, but have limited follow-up and treatment options available to them. Hispanic, American Indian, Alaska Native, and Asian and Pacific Islander women also have low rates of screening and treatment, limited access to health facilities and physicians, and barriers related to language, and culture. In addition, Vietnamese women in the United States have a cervical cancer incidence rate more than five times greater than white women (47.3 vs. 8.7 per 100,000). Black and Hispanic women also have higher cervical cancer death rates than the overall U.S. rate.

YEAR 2000 GOALS. By the year 2000, the President's initiative will increase to at least 60 percent the proportion of women from all racial and ethnic groups aged 50 and older who have received a clinical breast exam and a mammogram within the previous two years, and increase to at least 85 percent the proportion of all women aged 18 and older who have had a pap test within the past three years.

FUNDING. To build on the Department of Health and Human Services' ongoing investments in these areas, the President's FY 1999 budget includes an additional \$5 million for the Indian Health Service's Breast and Cervical Cancer Project, allowing service for an additional 250,000 American Indian women. In addition, the President's budget provides an additional \$30 million to CDC for a community-based demonstration project in up to 30 communities that will focus on reducing racial and ethnic health disparities, and would increase funding for Community Health Centers by \$15 million to enhance services targeted toward reducing disparities.

ADDITIONAL ACTION STEPS. To build on these efforts, HHS will also launch:

Increased Female, Ethnic and Racial Group Recruitment for Cancer Care and Clinical Trials. In FY 1998, the National Cancer Institute will add a screening center targeted toward Hispanic-Americans to its Community Oncology Program. This program provides enhanced support for expanding clinical research in racial and ethnic community settings by bringing state-of-the-art treatment, cancer prevention, and control research to racial and ethnic groups in their own communities. NCI also recently added a racially- and ethnically-enriched screening center with an African-American focus to the Prostate, Lung, Colorectal and Ovarian Trial.

Mammography Pilot Project. The HHS Health Care Financing Administration will lead a 3-year project which will identify effective interventions to increase utilization of Medicare screening benefits among black and Hispanic beneficiaries in six cities. Funding for this activity will be approximately \$1 million per year for the next three years.

ELIMINATING DISPARITIES IN CARDIOVASCULAR DISEASE

Cardiovascular disease -- particularly heart disease and stroke -- kills nearly as many Americans as all other diseases combined, and is one of the major causes of disability in the United States. Major disparities also exist among population groups, with a disproportionate burden of death and disability from cardiovascular disease in minority and low-income populations. The age-adjusted death rate in 1995 for blacks attributable to heart disease was 147 deaths per 100,000 people, compared to 105 per 100,000 for whites and 108 per 100,000 overall. And while the overall death rate for coronary heart disease declined by 20 percent from 1987 to 1995, the decrease for blacks was only 13 percent. For strokes, the 1995 death rate for blacks was 45.0 per 100,000, compared to 24.7 per 100,000 whites and 26.7 per 100,000 Americans overall. Although age-adjusted death rates for cardiovascular disease among other racial and ethnic groups are lower than the national average, there are subgroups within these populations that have high death rates from heart disease and stroke.

Disparities also exist in the prevalence of risk factors for cardiovascular disease. Racial and ethnic minorities have higher rates of hypertension, tend to develop hypertension at an earlier age, and are less likely to undergo treatment to control their high blood pressure. For example, from 1988 to 1994, 35 percent of black males ages 20 to 74 had hypertension, compared to 25 percent of all men. When age differences are taken into account, Mexican-American men and women are also disproportionately prone to elevated blood pressure rates. In addition, minorities are less likely to seek regular cholesterol screening. Only 50 percent of American Indians/Alaska Natives, 44 percent of Asian Americans, and 38 percent of Mexican-Americans have had their cholesterol checked within the past two years.

YEAR 2000 GOALS. By the year 2000, the President's plan seeks to reduce the death rate for heart disease among blacks by 25 percent and the death rate for strokes among blacks by 40 percent from their 1995 level. In addition, the plan will work to identify and develop strategies to reduce high mortality rates from heart disease and stroke among racial and ethnic subgroups.

FUNDING. The President's FY 1999 budget includes an additional \$5 million for existing CDC programs devoted to reducing cardiovascular disease to allow more targeted interventions for minority populations. The President's budget also includes an additional \$30 million for CDC for a community-based demonstration program in up to 30 communities that will focus on eliminating racial and ethnic health disparities, and an additional \$15 million for Community Health Centers to enhance services targeted on reducing health disparities.

ADDITIONAL ACTION STEPS. In addition, HHS will launch efforts to:

Increase State-based Programs. In FY 1998, the CDC will initiate state-based cardiovascular disease prevention programs in states with high rates of cardiovascular disease. The funded states will reflect the disparities in cardiovascular disease rates and will have large ethnic or racial populations. These state programs will determine which groups are the most at-risk and will direct specific program interventions to reduce risk factors in these populations to levels at or below the general population. This program will result in a national strategy for cardiovascular disease prevention through state-based programs. Funding for the program is estimated to be between \$2.7 million and 8 million.

NIH Partnership on Cardiovascular Disease. NIH is working with Univision on the new Salud para su Corazon (Health for Your Heart) program, a comprehensive community education and outreach program that encourages Latinos to make the lifestyle changes necessary to reduce their risks of cardiovascular disease. Salud para su Corazon blends the Spanish language with Latino traditions to provide science-based health messages, bilingual education materials, and strategies for community, family and personal action.

ELIMINATING DISPARITIES IN DIABETES

Diabetes, the seventh leading cause of death in the United States, is a serious public health problem affecting nearly 16 million Americans with estimated total direct and indirect costs of \$98 billion per year. The prevalence of diabetes in blacks is approximately 70 percent higher than whites and the prevalence in Hispanics is nearly double that of whites. The prevalence rate of diabetes among American Indians and Alaska Natives is more than twice that for the total population and at least one tribe, the Pimas of Arizona, have the highest known prevalence of diabetes of any population in the world. Cardiovascular disease is the leading cause of death among people with diabetes, accounting for over one-half of all deaths.

YEAR 2000 GOALS. The President has set two goals for the year 2000 to reduce racial disparities in this area: (1) reducing the rate of kidney disease from diabetes among blacks and American Indians/Alaska Natives by 65 percent from their 1995 levels by the year 2000, and (2) reducing lower extremity amputation rates from diabetes among blacks by 40 percent from their 1995 levels.

FUNDING. The President's FY 1999 budget provides an increase of \$5 million to the CDC for targeted, community-based diabetes education and intervention. The President's budget also provides an additional \$30 million to CDC for a community-based demonstration project in up to 30 communities that will focus on reducing racial and ethnic health disparities. The President's budget also would increase funding for Community Health Centers by \$15 million to enhance services targeted toward reducing disparities.

IMMEDIATE ACTION STEPS. HHS is also initiating additional initiatives, including:

National Diabetes Education Program (NDEP) Public Awareness Campaign The NIH National Institute of Diabetes and Digestive and Kidney Diseases and CDC's Division of Diabetes Translation (DDT) will launch a public awareness campaign in 1998, which will focus heavily on minority populations. The annual budget for this activity will be approximately \$1.5 to \$2.5 million.

Diabetes Control Programs. The goal of CDC's State-based Diabetes Control Programs (DCP's) is to improve access to high-quality diabetes care for persons with diabetes. In FY 1998, CDC will increase the number of State comprehensive diabetes programs by seven to nine States. The expanded funding will allow the additional States to develop statewide, comprehensive diabetes program activities that target populations that have a disproportionately high risk of diabetes, including blacks, Hispanics, American Indians and Alaska Natives, Asians and Pacific Islanders, and the elderly.

ELIMINATING DISPARITIES IN HIV/AIDS INFECTION RATES

While racial and ethnic groups account only for about 25 percent of the U.S. population, they account for more than 50 percent of all AIDS cases. While the epidemic is decreasing in some populations, the number of new AIDS cases among blacks is now greater than the number of new AIDS cases among whites. For example, although the number of AIDS diagnoses among gay and bisexual men has decreased dramatically among white men since 1989, the number of AIDS diagnoses among gay and bisexual black men has increased. In addition, about 75 percent of AIDS cases and new infections related to injecting drug use are among minority populations (56 percent black and 20 percent Hispanic). Of cases reported among women and children, more than 75 percent occur among racial and ethnic minorities.

From 1995 to 1996, AIDS death rates declined 23 percent for the overall U.S. population, but only declined by 13 percent for blacks and 20 percent for Hispanics. Contributing factors to these disparities include late identification of the disease, the cost of effective treatment, lack of health insurance to pay for drug therapies, differences in access to HIV primary care, and inconsistent education and experience among physicians who treat under served populations.

YEAR 2000 GOALS. By the year 2000, the President's initiative will work to assure early and equal access to health care and appropriate drug therapies for at least 75 percent of low-income persons living with HIV/AIDS, many of whom are minorities. The initiative will also seek to establish educational outreach to all major medical providers of medical care to assure that the current standard of clinical care is achieved for all persons living with HIV/AIDS, including Medicaid-eligible women and children.

FUNDING. The President's FY 1999 budget proposes an additional \$10 million for CDC HIV/STD demonstration projects. The President's FY 1999 budget also includes an additional \$30 million to CDC for a community-based demonstration program in up to 30 communities that will focus on reducing racial and ethnic health disparities. The budget also proposes an increase of \$15 million for Community Health Centers to enhance services targeted on reducing health disparities.

ADDITIONAL ACTION STEPS. In addition, HHS will launch several new initiatives including:

HIV Community Planning. In FY 1998, the CDC will invest \$14 million to strengthen the capacity of health departments to provide targeted prevention services to those at highest risk, including racial and ethnic groups. The CDC will strengthen and refine the HIV prevention community planning process to help develop priorities that specifically address unique community needs, including those of racial and ethnic populations.

Communities of Color Initiative. The CDC will develop an initiative in FY 1998 that will focus on black, Hispanic, American Indian, Alaska Native and Asian/Pacific Islander communities. This initiative will identify barriers to successful HIV prevention and ways to remove those barriers.

ELIMINATING DISPARITIES IN IMMUNIZATION RATES

Since 1993, childhood immunization rates have reached all-time highs, with 90 percent or more of America's toddlers receiving the most critical doses of most of the routinely recommended vaccines for children by age 2. In addition, reported levels of disease were at or near record lows in 1996. For the most critical childhood vaccines, vaccination levels are nearly the same for preschool children of all racial and ethnic groups, narrowing a gap that was estimated to be as wide as 26 percentage points a generation ago. However, minority children still lag behind white children when overall vaccination rates are compared. While 79 percent of white children have received the full series of vaccinations by age 2, only 74 percent of African-American children and 71 percent of Hispanic children are fully vaccinated against childhood disease.

In addition to the very young, older adults are at increased risk for many vaccine-preventable diseases. Approximately 90 percent of all influenza-associated deaths in the United States occur in people aged 65 and older -- the fastest growing population group in America. Reduction of deaths in this age group has been hindered in part by relatively low vaccine utilization. Each year, an estimated 45,000 adults die of infections related to influenza, pneumococcal infections, and hepatitis B despite the availability of safe and effective vaccines to prevent these conditions and their complications. There is a disproportionate burden of these diseases in minority and underserved populations. 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 well below the general population.

YEAR 2000 GOALS. By the year 2000, the President's initiative will work to double the 1994 influenza immunization rates and quadruple the 1994 pneumococcal immunization rates among minorities ages 65 and older; as well as achieve and maintain childhood immunization rates of 90 percent for all population groups.

FUNDING. The President's FY 1999 budget includes an additional \$30 million for CDC for a community-based demonstration program in up to 30 communities that will focus on eliminating racial and ethnic health disparities. The President's budget also includes an additional \$15 million for Community Health Centers to enhance services targeted on reducing health disparities.

ADDITIONAL ACTION STEPS. To bolster ongoing efforts, HHS will launch new initiatives, including:

Enhanced CDC Intervention Strategies. The CDC will spend about \$100,000 in FY 1998 to conduct immunization training courses to providers of immunization care services for racial and ethnic children and to develop a distance-based immunization training program for health care professionals in major urban areas.

Adult Flu and Pneumonia Vaccination Campaign. HCFA will expand efforts to reach medically underserved groups at the community level, through outreach to Historically Black Colleges and Universities, clergy, family physicians, pharmacies and home health agencies serving black beneficiaries.

GENERAL QUESTIONS AND ANSWERS

Q. What is HHS' role in the President's Initiative on Race and what exactly is the HHS Race and Health Initiative?

A. Our role is to help the President achieve his aim of One America for the 21st century by knocking down barriers that keep minorities from enjoying good health. Our budget includes \$400 million over five years for the HHS Race and Health Initiative. But this initiative goes far beyond dollars. It's also a treatment and prevention message outreach campaign led by our new Surgeon General, Dr. David Satcher; a new task force that brings together the brightest minds at the National Institutes of Health and the Centers for Disease Control and Prevention, the Public Health Service and other agencies of the Department; and better coordination of the existing medical, scientific and public health resources of all our agencies throughout the Department.

The goal is to reduce health disparities among minorities and non-minorities in six key areas. They are: infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS infection rates, and child and adult immunization. This is a cross-cutting initiative that addresses health disparities experienced by Hispanics, African-Americans, Native Americans and Asian Americans.

Of the \$400 million, \$250 million would go to existing HHS public health programs in CDC, HRSA and IHS to better reach minority populations and address their needs in each of the six areas. Another \$150 million would be aimed at funding innovative and effective programs that target health disparities, and create successful models for future efforts.

Q. Whether it's \$80 million for one year or \$400 million for five years, the fact is that this is a drop in the bucket, at best, for serious health problems whose underlying root causes have been building over decades. How do you tell people that you're really serious about an undertaking like this when you're devoting so few resources?

A. If someone asked, "How much money do you need to eliminate these problems today," you couldn't put a price tag on it. There is no right amount of dollars – billions, millions or otherwise – that would totally eliminate these disparities immediately. The smartest strategy is the one we're pursuing – through using this money and this initiative to sharpen our efforts within the Department and with our partners on the outside.

The Race and Health Initiative is a first step – a very strong first step. When attacking a challenge as awesome as eliminating the racial health disparities we face in this country, the first thing to do is more precisely target the resources we have. Then we must better coordinate all our ongoing activities and mesh those with the new efforts we undertake, and coordinate state and local efforts. We're doing all of that. The \$400 million is really a catalyst to help us bring more fight and more focus to this effort – more than we've ever had.

This is really a mobilization effort. We're mobilizing the resources of the agency to attack these public health problems through education, outreach, research and all the tools we have. We're taking the knowledge and all the resources that we already have throughout the Department and in our public and private partnerships to battle these disparities and energize this initiative.

Q. It just seems impossible to turn around tough, nearly intractable problems without a massive infusion of new resources over an extended period of time. What makes you confident?

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

We can learn from partnerships like the one involving the Association of Black Psychologists and the Congress of National Black Churches, who are targeting African American women at risk for diabetes through church-based nutrition and physical activity intervention programs.

We can also learn from the partnership between CDC and the University of Illinois at Chicago's Midwest Latino Health Research, Training, and Policy Center to promote diabetes management and control among Latino populations through a culturally specific education program.

Q. HHS has been accused of picking and choosing which health programs it wants to emphasize, essentially playing favorites with different diseases. Isn't this just another case?

A. We are not playing favorites. We aren't picking and choosing. We pursue all of our education and prevention efforts with great vigor. But these are all America's leading

killers, and closing the gaps that separate minorities from non-minorities is important to our collective health and our future as a nation. It's important to the President, and it's important to the nation.

Q. It was just last year that the President offered a formal apology for the Tuskegee experiment. Isn't the HIV/AIDS component of this reminiscent of Tuskegee?

A. Absolutely not. This initiative is about education, prevention and treatment. The tragedy of Tuskegee was that people were intentionally deceived and denied treatment that was readily available. Here, we are targeting our education and prevention efforts to help people who are at risk. We're trying to prevent the spread of AIDS and provide effective treatment to those who need it. There is no comparison between our Race and Health Initiative and Tuskegee.

Q. So how are you going to close these gaps ?

A. The strategy that the President laid out today is comprehensive and lays the groundwork for a solid, coordinated effort. But these answers will be different for each of the six disparities. For some of these goals, the answers are relatively easy. For example, we've had some success with immunization programs, and so we know what can work in this area. In other areas, like infant mortality, the picture is more complex, and that's where the \$400 million -- particularly the community-based demonstrations -- will move us toward answers. And for a disease like diabetes, the challenge is how to address disparities through basic research -- like looking at NIH for opportunities where we can shed light on racial health disparities through clinical trials and other research tools.

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

A. No single strategy can solve all our problems. But with the initiative we're unveiling today and the help of our partners in the private and nonprofit sectors, we can close these gaps. It's also important to remember that we already have a strong track record of addressing the challenges of access and poverty. We passed Kassebaum-Kennedy legislation to improve the availability of health insurance for working families and their children; we expanded the Earned Income Tax Credit; and we just raised the minimum wage. We're also improving access to high quality, subsidized child care; and education and training programs. The new CHIP child health program, improved Medicaid outreach efforts and expansions in the community health center program all increase access -- as will our Medicare outreach efforts for mammograms and adult immunizations.

Further, the booming economy this Administration has presided over has helped people move up from poverty, with low interest rates, 15 million new jobs, an unemployment rate that is below 5 % and the lowest inflation in 30 years.

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

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

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

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

A. We did not go into this process saying we had to have a five-, six- or 10-point plan. We weren't looking at a “package” with any specific number attached to it. What we aimed for was an initiative that allowed us to maintain our broad focus on minority health issues, and emphasize a few key areas that are representative of the larger minority health picture. That number just happens to be six. The six priority areas represent health issues that account for a significant burden of disease but are also amenable to targeted improvement. Enough data exists in each of these areas to allow progress to be measured.

Q. What exactly are your goals for the year 2010?

A. Those goals are going to be set in the year 2000 using our already established Healthy People process. Healthy People, first introduced in 1979, is a national partnership effort among government, business, voluntary and professional organizations, and individuals to improve the public's health through health promotion and disease prevention. We are already working with all of our partners in the next year also as part of that process, to determine how best to proceed toward eliminating these disparities. President Clinton will release these new national health goals to the country in January 2000, but we are committing ourselves today to goals that will be the same for minorities and white Americans for the first time since goals were set in 1980.

Q. What happens if, in the year 2000, at the end of the Clinton Administration, there is no progress toward any or all of these goals, and the gaps widen. What

does that mean for this overall initiative?

We fully expect to succeed, but we also acknowledge the risks. In fact, throughout our nation's history we've been presented with challenges that seemed insurmountable, but we took those challenges on nonetheless. When President Kennedy said we would put a man on the moon and return him safely to Earth, we didn't know how we'd do it. But we focused the resources of a great nation to accomplish the task, and succeeded in the greatest scientific achievement of this century. We can eliminate health disparities if we put the nation's will to work.

As we progress, we may see over time that a particular gap is widening. If so, we will be able to respond more quickly and aggressively to turn it around because of the attention that will be focused on these areas. We hope and expect to meet our interim goals by the year 2000.

These are not easy goals. However, we believe that with the efforts that the public health and medical communities at the federal, state, and tribal levels bring to this effort, and strong, active partnerships with communities, we will meet the year 2000 goals. And, we will set our feet on the right path to eliminate racial health disparities by 2010.

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

A. Once something like this is set in motion and partnerships are formed, we believe future Administrations and the American people will make sure this remains a health priority. This is not political. This is about good health, about improving health, and we think future administrations will continue these priorities. "Healthy People" has been around since 1980 – through four Presidents – and it will always be there. We are already working with the states, and more than 350 national organizations on developing the framework for Healthy People 2010.

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

A. The president announced a five-step plan today, which:

· Sets Interim Goals for Immediate Progress. The President's plan sets interim targets for the nation to reach by the year 2000, which will set the nation on course to eliminate health disparities by 2010. These interim goals include: (1) reducing black infant mortality by 22 percent; (2) increasing to at least 60 percent the number of women 50 and older who have received a clinical breast exam and mammogram within the preceeding two years; and (3) reducing cardiovascular disease mortality among African-Americans by 25 percent.

- **Expands Outreach.** The Department of Health and Human Services will initiate a sweeping outreach campaign led by Surgeon General David Satcher that will send critical treatment and prevention messages to all Americans, with a special focus on reaching racial and ethnic minorities.
- **Spurs Local Innovation.** The President's budget for next year includes \$30 million for grants to 30 communities, which will conduct research and test interventions to devise innovative new strategies to improve minority health status.
- **Targets Federal Health Resources.** The Secretary of Health and Human Services will convene a new taskforce which will bring together the best minds at the National Institutes of Health and the Centers for Disease Control and all parts of the Department to develop a comprehensive strategy to better target the resources and energy of the Federal government to continue to increase gains in minority health status.
- **Builds on Proven Programs.** The President's FY 1999 budget dedicates \$250 million to building community partnerships to strengthen public health programs with a proven record of reaching minorities. minority communities to learn what they think will be most effective in assuring that we reach these goals, and to use the process as a testing ground for the strategies that will support the President's bold commitment for the Year 2010.

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

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

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

It is important to stress that the elimination of health disparities will require a national effort -- public and private sector, individuals and communities. HHS, in collaboration with states, private sector organizations and the health community will establish a framework for action to eliminate disparities through *Healthy People 2010* -- the nation's health action agenda for the next century. The two over-arching goals for 2010 are to increase years of healthy life for the entire population and to eliminate health disparities.

The Healthy People process will articulate data needs, research investments, and the action strategies that can be employed by the nation to reach the goal of eliminating disparities by 2010. In our consultations we have received near unanimous support for committing to this goal.

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

A. This is about raising the health status of all Americans, and we will continue to press ahead on all fronts. Sharpening the focus in these six areas will give us new tools and methods for addressing health disparities wherever they exist.

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

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

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

A. This will help Americans to talk about health and how we should be concerned with the health of all people, not just with our own, or with people like ourselves. This initiative will get people to realize that their health is intertwined with the health of others as well as the future of our country. We believe that this initiative will help promote racial harmony because it will generate dialogue on race on another level. For example, top researchers will talk to minority community advocates. Community advocates will talk to citizens. Policymakers will talk to health professionals. In the course of that dialogue, racial and ethnic groups will build an understanding that will mesh with other race initiative strategies throughout government to build the One America President Clinton has challenged us to achieve.

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

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

health arena.

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

For months, these groups have been discussing strategies to improve health as well as Departmental customer service to Hispanic, Native American, African-American and Asian-American and Pacific Islander communities. All of these working groups are coordinated under one body called the Minority Initiatives Coordinating Committee, which serves as an umbrella to them, and a central point for us to measure what we are doing to improve minority health.

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

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

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

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

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

in order to support good health.

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

Q. What makes this different from Healthy People 2000?

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

This fits in with the President's broader goal to address some of the toughest challenges we face as we move to the new millennium. As the 21st century dawns and our demographics change to make us a more diverse country than we ever have been, it will become increasingly critical for us to address these pressing health challenges faced by minorities if we are to enter the new millennium as one America, fully prepared to take advantage of the strengths of that diversity.

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

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

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

Q. How will this effort be coordinated? Will any kind of special commission or panel be formed to follow progress on these six goals?

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

charge to that committee is:

- To review the status of the six health disparity reduction goals for the Year 2000 and assure that the Department's research, health services and prevention programs give priority to attention to them.
- To conduct a process of consultation with minority community representatives and with the scientific and health services communities to improve our understanding of how to achieve both the near term disparity reduction goals and the 2010 disparity elimination goal.
- To examine the Department's research, data, service and prevention programs and recommend to the Secretary necessary changes in these programs to support the President's goal of eliminating health disparities in the next century.

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

Q. Where exactly are the disparities?

- A.** Disparities in health status vary widely among racial groups in the United States. It's a complex picture. A myriad of factors, including culture, lifestyle, socioeconomic status, and access to health care, all contribute to the health status of all Americans.

The disparities the President has chosen to highlight reflect that complexity. Not every racial group is experiencing a disparity in every area. However, in each of the six targeted areas, at least one minority racial group is faring more poorly than white Americans.

Here is a snapshot of the health status of each minority group under the six target areas:

Infant Mortality

- The national average is 7.2 deaths per 100,000 live births and the white rate is 6.0.
- Blacks (14.2), American Indian (9.) and Hispanics (7.6) were higher in 1995 or 1996.
- Near-term goals for the year 2000: To reduce the black rate by 22 percent (to 11.2) from the 1996 rate.

Cancer Screening and Management

- The white cancer death rate is 127 per 100,000
- Blacks (171.6) fare worst, and have higher death rates than whites in terms of men, lung cancer, and prostate cancer. Also, Native Hawaiian men have higher lung cancer rates than white men; Alaska Natives have higher colon cancer rates than whites; Vietnamese women in the U.S. have a cervical cancer incidence rate five times greater than white women (47.3 vs. 8.7 per 100,000) and Hispanic women have higher cervical cancer rates.
- Near-term goals for the year 2000: To increase the percentage of 50 and older women of all racial and ethnic groups who get clinical breast exams and mammograms within the preceding two years to 60 percent; to increase the proportion of women 18 and over who receive a Pap test within three years to at least 85 percent.

Cardiovascular Disease

Coronary Heart Disease

- Age-adjusted death rate for coronary heart disease for the total population declined by 20% from 1987-95.
- Black rate of decrease (13%) for coronary heart disease was worse 1987-95, and black coronary disease death rate was higher (40%) than for whites in 1995.
- Coronary heart disease mortality was 40% lower for Asian Americans in 1995, but Asian-American males had a higher stroke mortality rate than white males.

Hypertension

From 1988 to 1994, for all men age 20-74, from 1988 to 1994, 25 percent had hypertension.

Blacks had a higher rate of hypertension (35 percent) among black males age 20-74 and Mexican-American men and women have higher blood pressure rates than whites when age differences are accounted for.

Near-term goals: To reduce the heart disease and stroke death rates among blacks by 25% and 40% respectively, from their 1995 levels

Diabetes

- Blacks (70 percent) and Hispanics (nearly double) have higher prevalence rates than whites, and American Indians and Alaska Natives (more than twice) have higher prevalence rates than the total population.
- Near-term goals: To reduce the rate of end-stage renal disease from diabetes among blacks and American Indians/Alaska Natives by 65% from their 1995 levels; and reduce lower extremity amputation rates from diabetes among blacks by 40% from their 1995 levels.

HIV/AIDS Infection Rates

- AIDS death rates declined 23% for the whole population in 1995 and 1996.
- Blacks (13%) and Hispanics (20%) have declined at a slower rate.
- Near-term goal: To provide through Medicaid, Medicare, and Ryan White equal

access to life-enhancing health care and appropriate drug therapies for at least 75 % of low-income persons living with HIV/AIDS.

Child and Adult Immunization Rates

- While childhood immunization is at an all-time high, minority rates have been lower than whites, yet minority rates are rising faster than whites.
- While vaccination levels against pneumococcal infections and influenza have increased slightly for 65 and over blacks and Hispanics, the coverage in these groups remains substantially below the general population and year 2000 targets.
- Near-term goals: To achieve a 90% coverage for all recommended vaccines in all populations and to eliminate remaining disparities among groups, and to increase pneumococcal and influenza immunization rates among all adults 65 and over to 60%.

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In radio address, Clinton proposes equalizing black and white

health care

Eds: SUBS final item on HIV/AIDS to add statistics showing racial disparity; SUBS 4th graf, His health, to CLARIFY that \$400 million is new money sted total federal cost

By SANDRA SOBIERAJ=

Associated Press Writer=

WASHINGTON (AP) President Clinton broadened his initiative for racial harmony on Saturday, asking for \$400 million and an aggressive public awareness campaign to wipe out health disparities between minority and white Americans.

Though AIDS death rates are down and childhood immunization levels are at an all-time high, ``we must not be blind to the alarming fact that too many Americans still do not share in the fruits of our progress,'' Clinton said in his weekly radio address. ``Nowhere are the divisions of race and ethnicity more sharply drawn than in the health of our people.''

Among the gaps that Clinton called ``unacceptable in a country that values equality': black children are twice as likely to die in infancy as white children, and American Indians suffer from diabetes at three times the national average.

His health initiative would specifically target for elimination by 2010 disparities in six areas where differences between white and minority Americans are most stark. The administration's budget request asks for \$400 million in new money over five years. It would be combined with existing federal programs and private-sector help.

Clinton linked the campaign to this month's celebration of Black History month. As part of it, a coalition of 136 philanthropic foundations would convene a national conference on minority health this spring, the president said.

Representatives of the NAACP and other minority interest groups joined Clinton in the Oval Office for his broadcast. Health and Human Services Secretary Donna Shalala cast the proposal as the latest installment of Clinton's drive for racial understanding.

While that ongoing dialogue has been widely criticized as unfocused and abstract, Shalala emphasized the health goals would be measurable and the administration would annually report on progress.

Surgeon General David Satcher and former New York City Health Commissioner Peggy Hamburg were put in charge of the overall project. Congress would have to approve the \$400 million in funding, with some \$30 million per year slated for 30 communities that would each focus on one or two health problems in order to develop model strategies.

The administration would also be seeking private-sector help, Shalala said.

She cited past projects where McDonald's printed childhood immunization information on their restaurant tray liners, where Pampers diapers helped get the word out on children's health insurance and where Gerber baby foods did outreach about preventing Sudden Infant Death Syndrome.

``We can't wait for everybody in this country to get good health insurance,'' Shalala said. ``When you really want to close a health care gap and you do not have a single health care system, you go to

every part of the country and have everybody pull in the same direction.''

Satcher said the effort to speed up improvements in minority health would not come at the expense of others.

''We're going to improve it for everybody,'' he said. ''This project will not succeed unless the white community is supportive. The American Indian, the African American and Asian, all of these groups have to work together in communities in order for this to be successful.''

Aside from the money that would be put aside for 30 communities yet to be designated, the balance of the federal funds would be directed to the Centers for Disease Control and Prevention for enhanced prevention programs in the six targeted areas:

Infant mortality. Black children die in infancy at a rate 2 1/2 times higher than whites; American Indian infants 1 1/2 times higher.

Cancer screening and management. Black men under 65 are diagnosed with prostate cancer at nearly twice the rate of white men; Vietnamese women get cervical cancer at nearly five times the rate of white women; and Latinos have two to three times the rate of stomach cancer.

Cardiovascular disease. Black men suffer heart disease at twice the rate of whites.

Diabetes. The disease afflicts three times as many American Indians, and black people at a 70 percent higher rates than white people.

Child and adult immunizations. Just 20 percent of black adults get the vaccine for pneumonia, compared with 35 percent of white adults.

HIV/AIDS. Seventy-five percent of all AIDS cases among women and children are minority cases. And from 1995 to 1996, overall death rates declined 23 percent, but among blacks, the death rate fell only 13 percent.

APWR-02-21-98 1800EST

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^BC-CLINTON-HEALTH 1STLD@

^Clinton sets health goal to end racial imbalance@

(recasts, updates throughout)

By Laurence McQuillan

WASHINGTON (Reuters) - President Clinton, decrying a racial and ethnic gap when it comes to the health of Americans, Saturday outlined a \$400 million plan to eliminate the disparity in six key areas by 2010.

"No matter what the reason, racial and ethnic disparities in health are unacceptable in a country that values equality and equal opportunity for all," Clinton said in his weekly radio address to the nation.

"This is our national goal," Clinton declared. "By the year 2010 we must eliminate racial and ethnic disparities in infant mortality, diabetes, cancer screening and management, heart disease, AIDS and immunization," he said.

He cited statistics showing that infant mortality rates are twice as high for African Americans compared with whites, that black men suffer from heart disease at nearly twice the rate of white males and that overall cancer deaths are disproportionately high among both Latinos and blacks.

Additionally, Vietnamese women are five times as likely to have cervical cancer, Chinese Americans are four to five times as likely to have liver cancer, and Hepatitis B is more prominent among Asian Americans than the rest of the U.S. population.

Native Americans suffer higher rates of infant mortality and heart disease, while diabetes among Hispanic are twice the national average and three times above the national average for Native Americans.

Clinton said the budget proposal he submitted to Congress earlier this month "devotes an unprecedented \$400 million to spur promising prevention and outreach programs to help us meet this challenge."

The money, to be spent over five years, would be used to assess current programs, improve data collection and work with localities.

Under the plan, newly-installed Surgeon General David Satcher will lead an outreach campaign aimed at mobilizing local communities, churches, physicians and nurses and other community-based program to join the federal effort.

Satcher, who spoke with reporters, said he soon will announce 30 communities that will be targeted for participation.

**STATEMENT OF REPRESENTATIVE HENRY A. WAXMAN
FEBRUARY 23, 1998**

Lead poisoning is a widespread and serious environmental health threat to children. Children exposed to lead through paint, gasoline, or other leaded products can have severe health problems such as brain damage, seizures, coma and death. Even at low levels of exposure, lead can impair a child's learning ability and motor development and cause behavioral problems such as hyperactivity.

Lead poisoning is also entirely preventable. Although we have made great strides in reducing sources of lead exposure, close to one million children continue to have dangerous blood lead levels. Poor children living in older housing stock remain the most at-risk.

In order to identify the extent of the problem of lead poisoning, I requested that the General Accounting Office analyze the prevalence of dangerous lead levels in Medicaid children, and the extent to which these children are being screened for lead toxicity. The new GAO report we are releasing today finds that Medicaid populations are still severely threatened by the disease, and even the most basic preventative step -- blood lead screening -- is being neglected.

According to today's report, half a million Medicaid children, or roughly one in twelve Medicaid children between the ages of one to five, have harmful levels of lead in their blood -- a rate three times that of non-Medicaid children. Although Medicaid children comprise one third of the U.S. population of children aged 1 to 5, they represent 60% of the 890,000 children with elevated blood lead levels. Over 80% of children with the most severe cases of lead poisoning are covered by Medicaid.

To address the problem of lead poisoning among Medicaid children, Congress passed a law in 1989 requiring lead screening as part of Medicaid's special preventive health program for children. In 1991, the CDC issued revised screening recommendations, calling for universal screening and the use of the blood lead screening test.

The GAO report I am releasing today demonstrates that these requirements simply are not being implemented. Despite mandatory screening requirements, 81% of Medicaid children were not screened at all for lead toxicity. Of the 535,000 Medicaid children identified with elevated blood lead levels, 65% -- or roughly 352,000 -- had not been properly screened.

The Health Care Financing Administration is currently considering modifying its screening requirement for Medicaid children, giving states the responsibility of deciding whether mandatory screening is necessary. I think we need to be very cautious in this area. By so dramatically confirming that lead toxicity is predominantly concentrated in Medicaid children, the data revealed in today's GAO report underscores the critical importance of ensuring that we do a better job screening children in Medicaid populations. HCFA and other agencies need to do more screening -- not relax their screening requirements.

The data being released today shows that there is a lead poisoning epidemic among Medicaid children and that we are doing very little to help these children. I hope that the Administration and Congress will be able to use this information as they develop new strategies for combating this preventable environmental threat to children's health.

Donna Shalala, secretary of health and human services, also will lead a federal task force charged with examining existing federal health program to root out policies and procedures that permit rācial and ethnic disparities.

``But to truly eliminate these disparities and ensure better health for all Americans, all Americans must do their part,'' Clinton said.

The announcement drew a broad cross-section of support from groups representing minorities, including the NAACP and several Hispanic organizations.

Clinton announced that Grantmakers in Health, a coalition of more than 136 philanthropic foundations across the country, will join the effort.

He said that the White House and the coalition jointly will host a conference this spring ``to help solve this national problem community by community.''

``America has the best health care system in the world, but we can't take full pride in that system until we know that every American has the best health care in the world,'' Clinton said.

Shalala said that ``what's happened in the past is that when we set health goals we had one set of goals for the rācial and ethnic communities in the United States and another set of goals for the rest of the country.''

``We're going to end those disparities and, in fact, set one set of goals,'' Shalala said.

Satcher acknowledged that ``it's not going to be easy. It's a real challenge to do this ... some of the factors are not in the health care system, they're in individual behavior.'' He said, ``all of these things have to work together in order for us to be successful.''

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Reut16:54 02-21-98

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Received by NewsEDGE/LAN: 2/21/98 4:54 PM

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FDCH Political Transcripts

February 21, 1998, Saturday

TYPE: NEWS BRIEFING

LENGTH: 3804 words

HEADLINE: HOLDS NEWS BRIEFING ON HEALTH CARE COVERAGE;
WASHINGTON, D.C.

SPEAKER:

DONNA SHALALA, U.S. SECRETARY OF HEALTH AND HUMAN SERVICES

BODY:

U.S. SECRETARY OF HEALTH AND HUMAN SERVICES AND U.S. SURGEON

GENERAL HOLDS NEWS BRIEFING ON THE PRESIDENT INITIATIVE ON

HEALTH CARE COVERAGE

FEBRUARY 21, 1998

(EMBARGOED UNTIL 10:06 A.M. 2/21/98)

SPEAKERS: DONNA SHALALA, U.S. SECRETARY OF HEALTH AND HUMAN
SERVICES

DR. DAVID SATCHER, U.S. SURGEON GENERAL

SHALALA: Tomorrow morning, the president will announce his administration's intention to eliminate racial and ethnic disparities in six critical health areas by the year 2010.

This means that for the first time in its history, the federal government will set universal national health goals, ending the practice of setting separate, lower goals for minority communities. What's happened in the past is that when we set health goals, we had one set of goals for the racial and ethnic communities in the United States, and another set of goals for the whole -- for the rest of the country. And we're going to end those disparities, and in fact set one set of goals.

Since taking office, we've had some very important public-health accomplishments. Infant mortality is down. HIV and AIDS rates are falling, for the first time since the beginning of the epidemic. Cancer rates may actually be starting to decline in this country.

But these accomplishments are tempered by the fact that there are persistent disparities in health outcomes -- Thank you very much...

(LAUGHTER)

... there are persistent disparities in health outcomes for white Americans and for minorities. And I'm defining "minorities" as including American

Indians, African Americans, Hispanics, and Asian Americans.

But simply bringing down the numbers is not enough. We want to close disparities for the major killers in this country. Heart disease, cancer, stroke, diabetes, and HIV-AIDS.

And he'll set a goal tomorrow of ending health disparities in these six -- in six critical areas by the year 2010.

And we've actually selected out six specific areas. Infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV-AIDS infection rates, and child and adult immunizations.

We're also going to expand outreach with a sweeping campaign led by the surgeon general of the United States, Dr. David Satcher, and Dr. Satcher will be spreading the word and helping to organize the country to reduce the disparities in all of these health areas.

In addition to Dr. Satcher, an internal task force will be led by Dr. Peggy Hamburg, the assistant secretary for planning and evaluation. Dr. Hamburg was the New York City health commissioner before she joined the administration, and is widely credited for reducing the incidence of tuberculosis in New York City. She actually will be putting the mobilization campaign in place, and has had wide experience in public health, and actually changing and reducing health disparities.

SHALALA: The task force -- the Internal Task Force is going to monitor progress in all these six areas. All of these six areas are areas in which we will actually have statistics. We'll know what our baseline is and, as we close the gaps, we'll be able to report yearly on how we're doing in raising immunization rates, for example, or reducing the incidence of particular diseases or getting better management of diseases like hepatitis.

Finally, the president will be asking Congress for \$400 million over the next five years to both assess our current programs and improve data collection and work with communities. Remember, the important point here is this is an historic breakthrough in public health. We will now have the same standard for the major killers that we have for the wider community.

What we intend to do is to close the gaps in health disparities between minority communities and the rest of the country. And it will be a major breakthrough. It will take a huge mobilization effort in this country to bring health care to the communities, to get communities to use the health care system.

Let me now ask Dr. Satcher whether he has anything to add.

SATCHER: Thank you. I'd just like to stress, as the Secretary pointed out, that this is a mobilization initiative. It's going to be very important that this is a public and private initiative. It's not limited to the government. We are depending upon organizations in communities throughout this country to join us in making this initiative work.

We will be communicating with communities throughout this country, listening to communities, trying to identify successful models that can be applied more broadly. But it is a public/private venture. Grant-Makers of America will be joining us in trying to identify strategies that will work that can help us to demonstrate the efficacy of these efforts to narrow and close the gaps that exist in areas like infant mortality, immunizations, HIV/AIDS, cardiovascular disease, diabetes and cancer.

SATCHER: So we're looking forward to working with people throughout this country in this next...

SHALALA: The context for this is obviously the president's race initiative. This is the health piece of the president's race initiative. It is a measurable set of goals.

So we actually will be able to report each year on our progress, and the president will expect us to report each year on the country's progress to actually improve the health by reducing the differences.

Questions?

QUESTION: What do you mean by -- I'm sorry. Go ahead.

QUESTION: Are you saying that all along we've accepted, in targeting funds, that the infant mortality rate is going to be higher in minority communities than in white communities?

SHALALA: When we set the goals, the process of setting the nation's goals over the years, we actually had different goals for the minority communities, because they were further back, in terms of how far we were going to move, and what we're saying now is, we no longer will have separate goals.

We want to bring up and eliminate disparities between the two communities, access to mammography, adult immunization, cardiovascular disease -- we're actually going to try to move faster in the minority communities, to close these gaps.

QUESTION: Those goals have been tied to funding decisions?

SHALALA: Well, no.

Actually, they have not been tied to funding decisions. Those goals were set lower because those communities were further behind, and so we're now saying, is we're going to put additional resources into this effort, so that we can leverage and mobilize the country to close the gaps in all of these major areas, and the areas we've chosen are areas that are specifically -- of specific concern to these communities, because there is higher incidence in these communities of these particular diseases or these particular gaps.

QUESTION: What additional resources?

SHALALA: We're talking about \$400 million over the next five years, but that's glue money to pull our public health resources and our research resources together for a specific focus.

QUESTION: The rationale that has existed is based on the idea that because there was so much more that needed to be done for minorities -- I mean, so by changing the goal,...?

SHALALA: We give ourselves a big...

QUESTION: (OFF-MIKE) I mean in that realistic? I mean, doesn't...?

SHALALA: Well...

QUESTION: I mean, presumably, the old rationale wasn't meant, you know, in a negative way. It was meant to deal with a realistic approach to the problem.

SHALALA: I think what we're saying is that we're going to make an extraordinary effort to actually close those gaps.

Let me give you a specific example. In 1993, the immunization rates for American kids, up to two years old, were 55 percent, 55 percent. And there were big gaps between white kids and African-American and Hispanic kids in particular.

QUESTION: (OFF-MIKE)

SHALALA: There was a difference of 20 percent?

SATCHER: You know, there are some specific examples throughout the country, but in a place like Detroit, where the difference was as high as 30 percent.

SHALALA: Between whites and African-American kids?

SATCHER: That's right.

SHALALA: We mobilized the country to get kids below two years old immunized, and we now have childhood-immunization rates for most of the vaccines for minority kids at precisely the same rate as white kids. We've brought up minorities actually faster, because we had further to come.

And we have 90 percent of all the kids in the country now immunized.

That took a tremendous targeted mobilization effort, to get the resources and the organization to the places where we had the biggest gaps.

What we're saying, for these other disparities, that we're going to do -- which in some ways will be a more complicated campaign, because it involves getting people to care as not just shots. We're going to do that for these other major disease areas, in somewhat the same way, but it's a huge effort. We're simply going to raise the standards, not lower them.

QUESTION: Is the trust factor in the minority communities some of the reason for the disparities in health output, ethnic versus mainstream?

SATCHER: I think there are a lot of reasons, and I think we -- we've assumed that trust is one of the factors, and our strategy for dealing with that is to try to be more effective in involving the communities, as we did with the immunizations.

SATCHER: We identified organizations like the Congress of National Black Churches or a Hispanic organization in Chicago that works out of the church system there, and we work through those organizations to get people immunized in those communities.

So we have learned some things in areas like immunization about how to deal with issues related to trust. Those are not going to go away easily. But I think we're just going to have to recognize them and work with people who live and work in those communities and who are trusted by people in those communities.

SHALALA: Socioeconomics also plays a large part as well.

SATCHER: Oh, no question about it. There are a lot of factors like the American Indians -- one of the major concerns is diabetes where the risk of diabetes in American Indians in this country is over twice as great as it is for whites in this country. And there are a lot of factors in terms of life style and other factors that we can not even define.

But in working with those populations and in groups that are familiar with those populations and trusted by them, we believe we can make progress.

QUESTION: Dr. Satcher, can you describe that mobilization process in a little bit more detail? Does it mean that more money goes to hospitals that cater to these communities? Is it more outreach? Can you tell us?

SATCHER: Well, one of the strategies that I'm really quite involved in would be the outreach program to 30 communities. We're going to identify at least 30 communities in the country, and each of those communities will have at least one of these areas -- infant mortality, immunizations, HIV/AIDS, et cetera. And we will work with those communities in developing strategies for closing the gaps. And they will have to define what are the unique challenges in their community that we need to focus on.

But what we want to do is to demonstrate success in these various communities in different areas. Some of them will be African American. Some of them will be Asian. Some of them will be Hispanic. Some of them will be American Indians, reservations, et cetera. But we want to demonstrate in these various communities that we can be successful in closing the gaps.

And once we've done that, we can bring the full force of our department to bear on those problems with all of our resources.

SHALALA: The earlier announcement this week by the president and the first

lady for an outreach program for children's health insurance will obviously dovetail into this.

SHALALA: But what we've clearly done here is put our institutions, both public and private, as well as our own reputations, on line to say that it's time we closed these huge health gaps, that we can't wait for everybody in this country to get good health insurance, that we have to mobilize what health-insurance system we have in this country, make it fit together in a way so that we really do close the gaps, and make a difference in people's lives.

QUESTION: What is the source of the funding? Is it from the tobacco tax, or is it -- are there offsets or...?

SHALALA: No, actually, I think this is a -- I'm sure we identified offsets, but I -- this is part of our regular budget. This is not on our list of -- where we clearly identified the tobacco money for it. It's 80 million for the first year, and then it -- over the five years, it becomes 400 million.

But we will be spending a lot more than \$400 million, because what we're going to do is leverage NIH resources, CDC resources, public-health resources, the Health Care Financing Administration, plus the private sector. Remember, when we did immunizations, we did -- McDonald's gave us their tray liners, and Pampers is giving us, for the children's health-insurance outreach. So we'll be going to the private sector, to the churches, to the public health system in the United States.

When you really want to close a health care gap, and you do not have a single health-care system, you go to every part of the country, and have everybody pull in the same direction.

QUESTION: Do you think, when you say "leverage," though, about the -- what percentage -- how much would the 400 million leverage, approximately? What are you contemplating?

SHALALA: My assumption is that we'll be well over a billion dollars, by the time we're finished, in what the private foundations will give us, in what other public health -- parts of the public health system will give us, in what private health insurance itself will commit to as it puts special efforts on closing some of this gaps.

We'll be working with the HMOs around the country. They were terrific on the immunization campaigns.

QUESTION: What's a realistic ratio for closing this gap that's gone on for

many, many years?

SHALALA: Well, what we're saying is, we're going to close it.

SHALALA: We're actually saying by 2010 our goal is not to be competitive here, but it's to close the gap. We're not saying we want to cut this gap in half. We're saying we actually want to close the gap by 2010.

SATCHER: Let me just add one thing to that. I think it's not going to be easy. It's a real challenge to do this. And I think what we're saying is that we have to work together.

Some of the factors are not in the health care system they're in individual behavior, physical activity, diet, you know, smoking, toxins of various kinds. So we've got to work with communities to help people change their life styles.

We have some successful models throughout the country already that we've developed. We've got to expand those. But all of these things have to work together in order for us to be successful.

QUESTION: To what extent do you think the disparity is due to lack of insurance? And if it's an uninsured population, how do you address that?

SHALALA: Well, if you go to the analyst in the system, the people who look at this, they'll say both a combination of poverty and a lack of health insurance lead to this. But we've put in place before special programs.

If we had believed that, we would have never gotten the kids in this country immunized. What we learned out of the immunization campaign was that you've got a public and private system, you've got community health centers, you have hospitals that provide special programs. You can put special money out.

CDC has most recently had a special campaign focused on African- American women for mammograms that has begun to actually make a percentage difference. We -- at the NIH, they've been under Mrs. Gore's leadership in running a campaign to reduce infant mortality from Sudden Infant Death Syndrome by running the "Back to Sleep" campaign. Gerbers has been part of that campaign.

We now have almost 70 percent of the kids in this country, when they're born, their first couple of years are put on their backs. We have a large -- a significant problem with the American Indian population who tend to put their babies on their stomachs. This campaign to close the gap will focus on that population, getting the message out that if you put your baby on its back, it will reduce its chances of dying as an infant.

SHALALA: That'll be an integral of this overall campaign.

I don't want to sound too enthusiastic or anything.

SATCHER: Let me...

(LAUGHTER)

SHALALA: But it's fun not to just say we're going to have a 10 percent goal, but we're really going to go after the whole thing.

And we're not going to be discouraged by the fact that we don't have a single health care system. We're going to take every piece of this health care system, public and private, plus every person, every church, every community leader, to get people to the health program that will -- that will make a difference for them.

QUESTION: You know, I'm sorry, but I'm not sure if I quite understand how to explain where the \$400 million would be spent.

SHALALA: Oh, I...

QUESTION: I mean,...

SHALALA: ... actually tell you specifically.

David, do you want to describe the 30...

SATCHER: Yes.

SHALALA: Go through the...

SATCHER: Of the 80 million, 30 million will be used in these 30 communities that I mentioned, that we're going to select throughout the country, and have each one of them adopt at least one of these areas for closing the gaps.

The others are...

SHALALA: 150 over five years.

SATCHER: Right. 30 times five. So over five years, 150.

The other 50 million are ongoing programs, HIV/AIDS, diabetes, programs that we have in place, and we're committing so much funds to enhance those programs.

Sexually transmitted diseases. To make sure that, over the next few years, we enhance our strategies in these minority communities.

SHALALA: What the...

QUESTION: Is that a grant then? I mean, are you talking about giving a million dollars to a community?

SHALALA: Well...

SATCHER: In some cases.

SHALALA: In some cases.

What we're talking about is taking the rest of the money, some of it taking existing programs and retargeting them, specifically to communities where we see the gaps. That's why we use terms like "mobilization."

It's not -- you can't take a billion dollars and go buy this, and close the gaps. You have to mobilize every part of the system.

And I realize it doesn't -- it's not as easy as saying we're going to do this program, we're going to hand out the money, it's going to get done.

In -- because the American health care system is fragmented, if you want to actually improve people's health, you have to almost Scotch tape it together for a huge campaign to close those gaps, and get it to work together. And that's the way it gets done.

It's a leadership-mobilization, huge management effort.

SHALALA: And what we've done is picked two people, first the Surgeon General, David Satcher, and second, Peggy Hamburg, who ran the New York City Health Department, the two leading public health people in the country who have actually done this kind of thing and said let's go out and not take an incremental step. Let's take a giant step to improve the health of minorities in this country.

QUESTION: Of those 30 communities, can you identify a handful for us now?

SATCHER: No, I won't. That wouldn't be appropriate for me. I think we're going to work to identify the best communities. And in order to do that, we need to do some listening and at what people are doing now, what they propose to do, the extent to which people can work together in communities across racial lines.

This project will not succeed unless the white community is supportive, the American Indian, African American, Asian -- all of these groups have to work together in communities in order for this to be successful.

We're looking for communities that are willing to make that kind of commitment. I was just thinking of another example, somewhere that we're really struggling now, and that's adult immunization. If you take the pneumococcal vaccine, for example, that could save many thousands of lives in this country every year.

SHALALA: Pneumonia.

SATCHER: That's right. Very few African American adults, probably less than 20 percent, are getting that vaccine, and only about 35 percent of white adults. So we need to close the gap. But as we close it, we're going to improve it for everybody.

So we're not talking about taking anything away from anybody. We're talking about developing strategies and showing that they can work, and then applying them broadly. But obviously those who are at the bottom are going to go much faster just like they did with the immunizations -- the childhood immunizations.

SHALALA: Thank you. One more question? Yeah.

QUESTION: Which gap and which disease area is the largest?

SHALALA: Gee, this is disease.

SATCHER: Oh, disease areas.

SHALALA: Yeah, disease areas.

SATCHER: I would probably say diabetes because what we see and people like Senator Domenici and others in Congress have a major concern. What we see, for example, in the American Indian population in this country, sometimes it's five times as great as in the white population in certain groups of American

Indians.

Like the Peno (ph) population, for example, it tends to be higher.

SATCHER: Same thing with Hispanic populations. There are some groups where

the gap in diabetes is really great.

And we see the difference in terms of complications, like the need for amputations, end-stage renal disease, blindness from diabetes.

We see some major gaps in these areas that we believe that we can begin to close.

And I also want to point out, it's going to benefit our entire health care system, because the way we spend our money now, we spend too much of it on treatment, because we have to, because we're not preventing things as early as we would like, and part of this initiative will be to significantly enhance prevention.

SHALALA: OK. Thank you.

THE FRONT LINES

By THOMAS PETZINGER JR.

Wall St. Jnl., 2-27-98

Nurses Discover The Healing Power Of Customer Service

SALT LAKE CITY

HAD ANY OUTPATIENT surgery recently? Did you have to strip naked and put on one of those ridiculous, wide-open hospital gowns, even though it was a minor procedure? If so, you weren't being treated at LDS Hospital. At LDS, outpatients wear their underwear into surgery. What's more, they walk into the operating room instead of being rolled in.

Nothing is quite the same here since a group of nurses pushed through a major re-engineering effort a while back. Their official purpose was making outpatient surgery more competitive in the local market. But the initiative came to radical results because it proceeded from a starting point unusual in medicine: putting the customer first.

The principal facilitator was Diane Kelly, who spent 15 years as a neonatal intensive-care nurse. Early in her career she was perplexed by the priorities of some families. For instance, "I'm working like crazy to save a child, but the parents get upset because the grandparents can't see the baby." Clinical competence, she eventually saw, was only part of medicine. "We hold people's lives in our hands at a very vulnerable time," she realized. "Health care is about a personal encounter." (In quieter times, people called this "bedside manner.")

Ms. Kelly became convinced that medical and business people knew too little of each other's worlds to fix the problems in health care. So she studied for an M.B.A. and became a "whole systems" planner at LDS and its regional affiliates. "Innovation will come from people who have crossed boundaries," she says.

In helping to re-engineer outpatient surgery Ms. Kelly had a powerful ally in Joan Leis, who had just become chief of surgical services. A nurse herself, Ms. Leis had a combative streak and wasn't cowed by surgeons. Ms. Leis and Ms. Kelly, working with front-line nurses at LDS and its affiliates, moved to create a more efficient operation that looked at the whole patient — not just the procedure — as the customer.

A FEW REFORMS had more marketing than medical benefit, such as valet parking, hot blankets and a kitchen stocked with free refreshments for family members. Ms. Leis was incredulous that relatives had to roam the hospital to break a bill for a vending machine: "You're spending \$3,000 on a loved one, but you better bring correct change."

The real problem was delay. A few surgeons missing the 7:30 a.m. start time sometimes wrecked an entire day's worth of schedules. "It was absolute chaos," recalls Cathy Hughes, a top nursing manager. So the nurses began tracking chronically late surgeons, pointing out how their tardiness actually shrunk the surgical capacity of the clinic. Staff nurses also adopted a rallying cry: "7:30 means 7:30."

Nobody likes getting stuck with needles, so the nurses made it a routine to draw blood during the insertion of IVs; this eliminated the

need for a lab technician to draw a second sample, further reducing delay. The committee also championed cutting back on rote X-rays and other orders that weren't specifically indicated, a process they called "minimum labs." Their action cost the hospital revenue, but the increase in outpatient capacity vastly made up for the loss.

In talking to patients, the nurses discovered a subtext in the com-



Diane Kelly and Joan Leis

plaints about delays: resentment over the loss of personal control. So instead of requiring patients to fill their post-op prescriptions here, which held up their departure, the nurses asked doctors to write prescriptions that could be filled anywhere. This also eased congestion.

SOME PATIENTS were especially bothered to spend half the day without underwear — for shoulder surgery, say. Ms. Leis was convinced this longstanding practice was meaningless as a guard against infection, persisting only as the legacy of a culture that deprived patients of control. "If you're practically naked on a stretcher on your back," she says, "you're pretty subservient." The nurses persuaded an infection control committee to scrap the no-underwear policy unless the data exposed a problem, they have not.

They also turned to a design problem. Pre-op procedures and surgeries were conducted at opposite ends of the hospital, forcing patients to wait as long as 10 minutes for a wheelchair or gurney. To save time, the committee decided healthy patients could walk the distance instead of staring at ceiling tiles like characters in an episode of "Dr. Kildare."

As these changes took effect the nurses witnessed something amazing. Recovery times grew demonstrably shorter. People went under feeling better and woke up feeling better. They left for home sooner, freeing up still more capacity. Ms. Leis says these snowballing effects proved "if you're guided by only one phrase — do what is best for the patient — you will always come up with the right answer."

Today, peak capacity is up more than 50%, with zero increase in staff or square footage. Patient satisfaction is way up. Leaders like Joan and Diane have instigated controversial notions and caught the eyes of physicians, says Gary Hunter, a plastic surgeon here. "We've learned from them. And the result has trickled down to our patients."

Though it may be clearest with human health at stake, the lesson applies universally. When scarce resources create conflicting demands, the interests of the customer provide the largest space on which to seek common ground.

Clinton seeks \$400m to wipe out health disparities between Whites and Blacks

President points to high death rate of Black infants, cancer sufferers and AIDS victims

By Sandra Sobieraj
Associated Press

WASHINGTON (AP-Feb. 21) — President Clinton broadened his initiative for racial harmony on Saturday, asking for \$400 million and an aggressive public awareness campaign to wipe out health disparities between minorities and White Americans.

Though AIDS death rates are down and childhood immunization levels are at an all-time high, "We must not be blind to the alarming fact that too many Americans still do not share in the fruits of our progress."

Among the gaps that Mr. Clinton called "unacceptable in a country that values equality": Black children are twice as likely to die in infancy as White children, and American Indians suffer from diabetes at three times the national average.

His health initiative would target for elimination by 2010 disparities in six areas where differences between White and minority Americans are most stark. The administration's budget request asks for \$400 million in new money over five years. It would be combined with existing federal programs and private-sector help.

Mr. Clinton linked the campaign to this month's celebration of Black History month. As part of it, a coalition of 136 philanthropic foundations would convene a national conference on minority health this spring, the president said.

Representatives of the NAACP and other minority interest groups joined President Clinton in the Oval Office for his broadcast. Health and Human Services Secretary Donna Shalala cast the proposal as the latest installment of Mr. Clinton's drive for racial understanding.

Surgeon General David Satcher and former New York City Health Commissioner Peggy Hamburg were put in charge of the overall project. Congress would have to approve the \$400 million in funding.

with some \$30 million per year slated for 30 communities that would each focus on one or two health problems in order to develop model strategies.

Mr. Satcher said the effort to speed up improvements in minority health would not come at the expense of others. "We're going to improve it for everybody," he said. "This project will not succeed unless the White community is supportive. The American Indian, the African American and Asian, all of these groups have to work together in communities in order for this to be successful."

Aside from the money that would be put aside for 30 communities yet to be designated, the balance of the federal funds would be directed to the Centers for Disease Control and Prevention for enhanced prevention programs in the six targeted areas:

—Infant mortality. Black children die in infancy at a rate 2 1/2 times higher than Whites; American Indian infants 1 1/2 times higher.

—Cancer screening and management. Black men under 65 are diagnosed with prostate cancer at nearly twice the rate of White men; Vietnamese women get cervical cancer at nearly five times the rate of White women; and Latinos have two to three times the rate of stomach cancer.

—Cardiovascular disease. Black men suffer from heart disease at twice the rate of Whites.

—Diabetes. The disease afflicts three times as many American Indians, and Black people at a 70 percent higher rate than White people.

—Child and adult immunizations. Just 20 percent of Black adults get the vaccine for pneumonia, compared with 35 percent of White adults.

—HIV/AIDS. Seventy-five percent of all AIDS cases among women and children are minority cases. And from 1995 to 1996, overall death rates declined 23 percent, but among Blacks, the death rate fell only 13 percent.

N.Y. Times; 2-21-98

Clinton Orders Rights Action In Health Care

By ROBERT PEAR

WASHINGTON, Feb. 20 — President Clinton took action today to improve the quality of health care provided to more than 85 million Americans who participate in Medicare, Medicaid and various health insurance programs for Federal employees, retirees and veterans.

Mr. Clinton ordered members of his Cabinet to enforce a "bill of rights" for patients who receive medical care through Government programs. Patients would be entitled to appeal denials of care or coverage by insurance companies, would get detailed information about the performance of their doctors and hospitals, and would generally have better access to medical specialists and emergency care.

The Labor Department regulates many health plans sponsored by private employers. But Chris Jennings, a White House aide who coordinates health policy for the President, said the department had concluded that it could not force private employers to comply with the standards decreed by Mr. Clinton for Federal health programs.

Mr. Clinton challenged Congress to rewrite the Federal law governing employee benefits to assure that all Americans have the protections being made available under Medicare and Medicaid.

The issue is already provoking a fight in Congress. Most Democrats and many Republicans favor stringent new Federal standards for health insurance and health maintenance organizations. But Republican leaders like Senator Trent Lott of Mississippi and Representative Dick Armey of Texas oppose such regulation, saying it will increase the cost of health care and health insurance.

President Clinton minimized such concerns and insisted that Americans could have higher-quality care with little increase in cost.

"With the authority of the Federal Government," Mr. Clinton said, "we will insure that a third of all Americans are protected by a patient's bill of rights. Now that's every person on Medicare; every person on Medicaid, including children and people with disabilities; all of our Federal employees and their families that are covered; all of our military personnel, and members of the biggest health system in America — all of our veterans and all their families."

Wash. Times; 2-22-98

Clinton to apply \$400 million to eliminate racial health gap

By Joyce Howard Price
THE WASHINGTON TIMES

President Clinton yesterday announced a new \$400 million effort to end long-standing health disparities between white and minority Americans by the year 2010.

"Nowhere are the divisions of race and ethnicity more sharply drawn than in the health of our people," Mr. Clinton said in his weekly radio address.

"No matter what the reason, racial and ethnic disparities in health are unacceptable in a country that values equality and equal opportunity for all. And that is why we must act now with a comprehensive initiative that focuses on health care and prevention for racial and ethnic minorities," the president declared.

In his address, Mr. Clinton detailed nearly a dozen fatal or potentially life-threatening disorders that disproportionately afflict blacks or other minorities, such as Latinos, Asian-Americans or American Indians.

The "elimination of racial and ethnic disparities in infant mortality, diabetes, cancer screening and management, heart disease, AIDS and immunization" by the year 2010 is a "national goal," Mr. Clinton said.

"My balanced-budget plan devotes an unprecedented \$400 million to spur promising prevention and outreach programs to help us



David Satcher and Donna Shalala confer outside the West Wing of the White House yesterday.

meet this challenge," he added. The money would be spent over five years.

Health and Human Services Secretary Donna E. Shalala and newly installed Surgeon General Dr. David Satcher will be heading up the effort to abolish the "disturbing gaps" between the health of white Americans and that of blacks and other minorities, Mr. Clinton said.

In his remarks, the president

dramatized some of the disparities. "Infant mortality rates are twice as high for African-Americans as for white Americans. African-American men suffer from heart disease at nearly twice the rates of whites. African-Americans are more likely to die from breast cancer and prostate cancer. Overall, cancer fatalities are disproportionately high among both Latinos and blacks," he said.

"Vietnamese women are five times as likely to have cervical cancer; Chinese-Americans four to five times as likely to have liver cancer. Hepatitis B is much more prominent among Asian-Americans than the rest of the populations. Native Americans suffer higher rates of infant mortality and heart disease. And for diabetes, Hispanic rates are twice the national average, and Native American rates three times the national average," Mr. Clinton said.

Federal officials "do not know all the reasons" for these disparities. "Inadequate education, disproportionate poverty, discrimination in the delivery of health services, cultural differences" may all be "contributing factors," he said.

At a press briefing Friday, Dr. Satcher said "it's not going to be easy" to achieve medical parity for all racial and ethnic groups in the next 12 years.

"It's a real challenge to do this" since "some of the factors [in-

Cont'd on next page



President Clinton, HHS Secretary Donna Shalala (left), Peggy Hamburg, an assistant HHS secretary, and Surgeon General David Satcher joke in the Oval Office after Mr. Clinton's weekly radio address yesterday.

Cont'd from previous page

involved in the disparity) are not in the health care system — they're in individual behavior: physical activity, diet, you know, smoking, toxins of various kinds," he said.

"So we've got to work with communities to help people change their lifestyles," the surgeon general said.

He said this will be a joint government-private sector effort. Miss Shalala predicts as much as \$1 billion will be allocated for the

program through combined federal and private support.

Mr. Clinton is the first president ever to set a deadline for eradicating racial and ethnic health disparities.

"What's happened in the past is that when we set health goals, we had one set of goals for the racial and ethnic communities in the United States and another set of goals for the rest of the country," said Miss Shalala, who shared the

podium with Dr. Satcher at Friday's news conference.

Health goals for minorities were "set lower," the HHS secretary said, "because communities were further behind."

But in this initiative, she said, "we're going to ... set one set of goals" and will be applying additional resources "so that we can leverage and mobilize the country to close the gaps in all of these major areas" of disparity.

THE GREEN SHEET

THE GREEN SHEET, a compilation of news that is of interest to the U.S. Department of Health and Human Services, is published by the Office of the Assistant Secretary for Public Affairs, on weekdays, except holidays.

Selected articles do not necessarily represent the Department's views.

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THE GREEN SHEET

News About the U.S. Department of Health and Human Services

Vol. 45 No. 35

Monday, February 23, 1998

Balt. Sun; 2-21-98

Clinton's 'bill of rights' for patients would refine federal health plans

Republicans are split on legislation for insurance providers

By JONATHAN WEISMAN
SUN NATIONAL STAFF

WASHINGTON — With the stroke of a pen yesterday, President Clinton helped widen a rift between rank-and-file Republicans who are eager to defy unpopular health insurers in an election year and GOP leaders who want to avoid alienating their corporate supporters.

The president's "bill of rights" for patients that was unveiled yesterday seeks to improve the care received by the nearly 90 million Americans enrolled in federal health programs. It might prod Congress to follow suit for patients covered by private health plans.

By the end of the year, the president's executive order will give to Medicaid beneficiaries, federal workers, military personnel, veterans and American Indians the same protections that Congress gave last year to those covered by Medicare. These protections include the right to seek emergency care, choose specialists, appeal coverage decisions to an independent panel, receive information on treatment options and maintain the confidentiality of medical histories.

Such standards apply to most federal health care beneficiaries. But Clinton has made clear he would like to see the protections extended to the 160 million Americans in the private sector covered by employer-provided health plans, especially those in managed care.

"We must not stop here," Clinton said yesterday at a senior citizen's center, insisting that his executive order "should be an example that the rest of America should follow."

To some in Congress, that means legislative action. At a time when Clinton might be weakened by scandal and foreign policy distractions, he continues to find ways to go around Republican leaders in Congress.

First, he neutralized Republican plans for a big election-year tax cut by declaring that any budget surplus must be dedicated to saving Social Security. Now he has seized a health care issue that appears to resonate with voters.

Rep. Harris W. Fawell, an Illinois Republican and leading opponent of government intervention in health care, conceded that pressure is building in Congress to pass some kind of legislation this year to regulate health insurers.

A House leadership aide, speaking on condition of anonymity, said: "This has been nipping at the heels of the leadership. It's time to think up what our response should be."

Two Republicans — Rep. Char-

lie Norwood of Georgia and Sen. Alfonse M. D'Amato of New York — have proposed legislation that goes further than Clinton's order. It not only sets minimum standards of care for health plans but also allows patients to sue insurers who fail to comply. Ninety-two Republicans and 128 Democrats have signed the House bill, more than enough to ensure passage if Republican leaders schedule a vote on the measure.

And Norwood, a conservative dentist usually allied with the leadership, has not shied away from highlighting the rift over the issue between Republican rank-and-file and the party leadership. While Norwood and his allies tap into public anger over cost-conscious insurers, Republican congressional leaders have echoed the argument of insurers and employers who say the bill would raise health care costs and swell the ranks of the uninsured.

"The worst thing we could do is come in here with some immense micromanagement scheme," Fawell said. "I am very fearful that these well-intentioned plans will do so much harm."

Even industry lobbyists are glum, acknowledging they are standing in the way of an issue with growing momentum. "I think the pressure's very great, and that legislation may well pass," said Bill Gradison, president of the Health Insurance Association of America. "But I ... don't think it's a slam dunk."

On Friday, a spokeswoman for R. J. Reynolds, a subsidiary of R.J.R. Nabisco Holdings Corporation, said that nicotine levels were not a "design characteristic" in developing cigarettes. "In fact, our research through the years has focused on reducing total 'tar' and nicotine yield," the spokeswoman said.

The company has also said that its scientists had mistakenly associated free nicotine levels with higher cigarette sales, and that there was no evidence to indicate that the nicotine availability of any of the company's brands had been purposely increased to improve sales.

Nicotine exists in two forms. One is its "bound" form that scientists believe is slowly absorbed by a smoker. In its other, or free, form, nicotine is more pharmacologically active and is more quickly absorbed, researchers believe.

Government tests measure total nicotine, but not the proportions of the bound and free forms. That ratio is controlled by the acidity or alkalinity of cigarette smoke, as measured by its pH, said James Pankow, a researcher at the Oregon Graduate Institute in Portland. W. com-

Wash. Post; 2-22-98

Clinton Seeks Improved Health For Minorities

Associated Press

Prostate cancer strikes twice as many blacks as whites and diabetes three times as many American Indians as whites. These are two of the health disparities that President Clinton says he wants to eliminate with \$400 million and a new public awareness campaign.

"No matter what the reason, racial and ethnic disparities in health are unacceptable in a country that values equality and equal opportunity for all," the president said yesterday in his weekly radio broadcast. He was joined in the Oval Office by representatives of the NAACP and other organizations of minorities.

While noting that childhood immunization levels have recently increased and Americans overall are living longer and healthier, Clinton added: "We must not be blind to the alarming fact that too many Americans still do not share in the fruits of our progress."

The president's initiative would cost \$400 million over five years, combined with private-sector help. By 2010, it hopes to eliminate disparities in six areas where differences between white and minority Americans are most stark.

As part of the campaign, which Clinton linked to this month's celebration of Black History month, 136 philanthropic organizations would convene a national conference on minority health this spring, the president said.

"For the first time in its history, the federal government will set universal national health goals, ending the practice of setting separate, lower goals for minority communities," Health and Human Services Secretary Donna E. Shalala said.

Some \$30 million per year would go to 30 communities to focus on one or two health problems and develop model strategies, said Surgeon General David Satcher, who is leading the campaign.

The balance of the federal funds, if approved by Congress, would be directed to the Centers for Disease Control and Prevention for enhanced prevention programs in the six targeted areas:

- Infant mortality. Black children die in infancy at a rate 2½ times higher than whites; American Indian infants, 1½ times higher.

- Cancer screening and management. Black men under 65 are diagnosed with prostate cancer at nearly twice the rate of white men; Vietnamese women get cervical cancer at nearly five times the rate of white women; and Latinos have two to three times the rate of stomach cancer.

- Cardiovascular disease. Black men

See HEALTH, p. 7

N.Y. Times; 2-23-98 p. 1

Cigarette Maker Manipulated Nicotine, Its Records Suggest

By BARRY MEIER

Tobacco industry documents, including some released in recent weeks, strongly suggest that one of the nation's largest cigarette producers, the R. J. Reynolds Tobacco Company, altered nicotine delivery to smokers, apparently believing that doing so would increase the "kick" of its popular Winston brand and make it more competitive.

All cigarette manufacturers, including R. J. Reynolds, have denied that they manipulate levels of nicotine, the substance in cigarettes that addicts smokers. And some of the techniques used by R. J. Reynolds, like the addition of ammonia compounds, have also been employed by producers like the Philip Morris Companies.

But the latest R. J. Reynolds records, when added to previously disclosed documents, offer the most vivid case study yet of how one producer apparently decided in the

1970's to enhance nicotine delivery in an effort to make a brand more competitive. The documents show that R. J. Reynolds researchers noticed that Philip Morris had a higher level of free nicotine in its popular Marlboro brand. Soon after, the R. J. Reynolds researchers set out with the apparent intention of matching that quality in the company's Winston product.

The question of whether cigarette makers deliberately manipulated nicotine is a central focus of the Justice Department's criminal investigation into possible fraud by tobacco producers. Of particular interest to Justice Department officials is whether producers used various techniques to alter nicotine availability even while nicotine levels as measured by Government cigarette tests were falling, said two people questioned by investigators.

See TOBACCO, p. 9

World-Wide

Wall St. Jnl.; 2-23-98 p. 1

THE U.N. CHIEF ANNOUNCED a deal with Iraq, but the U.S. reserved judgment.

Secretary-General Annan's spokesman said he expects the agreement, reached in Baghdad after talks with Saddam Hussein and other top officials, will be acceptable to the entire Security Council. The U.S. demands that Iraq, to avoid airstrikes, must guarantee unrestricted access to arms inspectors who are fully under U.N. control. If the accord is accepted, military planners say, keeping U.S. forces in the Persian Gulf on alert would be more costly than an attack. (Articles on Pages A3, A24 and A17)

Whatever the outcome, Washington's long-running efforts to contain Iraq and Iran must yield eventually to the global economics of oil, industry experts say.

The FBI again searched the home of a Nevada man released from jail Saturday after he and another man were arrested last week on suspicion of possessing anthrax, a biological-warfare agent. He was freed after tests showed that the substance was a harmless animal vaccine. The second man, still in custody, faces a hearing today.

Monica Lewinsky's attorney rejected in a TV interview allegations that Clinton confidant Vernon Jordan worked to find a job for the former White House intern in return for her denying she had an affair with the president. He also said Lewinsky needs a legal-defense fund similar to the Clintons', and hinted she may someday write a book.

Former Arkansas Gov. Tucker agreed to cooperate with the Whitewater prosecutor in a plea bargain Friday that spared him a potential prison sentence. Tucker, who resigned in 1996 after conviction in an unrelated case, pleaded guilty to conspiring to avoid taxes through a sham bankruptcy.

Affirmative-action programs face new challenges in Washington state, where a ban on racial or gender preferences will be on the November ballot, and Houston, where a judge appears set to gut the Texas city's contracting policy. A Washington poll released Friday found the initiative is favored to be passed easily. (Article on Page A3)

Tyson Foods was sued by a group of cattlemen claiming the poultry firm's \$12,000 in gifts to former Agriculture Secretary

Espy was part of a "pattern of racketeering activity" that won it preferential treatment from the federal government. They seek \$3 billion in damages. (Article on Page A24)

India held the second day of voting in national elections, which completed balloting in about 75% of the 543 districts at stake. Violence killed 12, mostly in the eastern state of Bihar. President Narayanan, meanwhile, held talks on the ouster of a Hindu nationalist government in Uttar Pradesh.

Sinn Fein asked for a meeting with Britain's Blair after the IRA-allied party was ejected from Northern Ireland peace talks Friday. Sinn Fein can return March 9 as long as the IRA isn't implicated in any violence. Hours after the expulsion, 11 people were injured by a bomb in the village of Moira.

Sri Lanka said Tamil rebels killed at least 45 soldiers and sailors in suicide attacks that sunk two of 12 ships traveling off the northern Jaffna peninsula. The ships were carrying reinforcements to the peninsula, where rebels have cut the main road.

The NAACP chose Julian Bond as chairman Saturday, succeeding Myrlie Evers-Williams, who chose not to seek a fourth one-year term. Bond, 58, a 1960s ally of the Rev. Martin Luther King, said he wants to broaden the civil-rights group's message.

Indonesia imposed a 25-day ban on street protests to quell rising discontent as the nation's economic crisis forces up prices. Human-rights groups say five people died and 13 were missing in rioting this month.

South Korea's president-elect named Kim Jong Pil prime minister, but the nomination faces opposition in the National Assembly over Kim's role in a 1961 coup. Kim Dae Jung becomes president Wednesday.

The 18th Winter Olympics ended with ceremonies in Nagano, Japan, and the flag was passed to Salt Lake City, the host for the 2002 Games. Germany won the most medals, 12 gold, nine silver and eight bronze. Norway placed second with 10, 10 and five, while Russia was third with nine, six and three.

Died: Abraham Ribicoff, 87, former senator, Connecticut governor and Kennedy's secretary of health, education and welfare, in New York, after battling Alzheimer's.

THE MYTH OF THE MELTING POT

America's Racial and Ethnic Divides

Wash. Post; 2-22-98 p. 1

One Nation, Indivisible: Is It History?

*Soon, No Single Group
Will Comprise Majority*

*First of a series
of occasional articles*

By William Booth
Washington Post Staff Writer

At the beginning of this century, as steamers poured into American ports, their steerages filled with European immigrants, a Jew from England named Israel Zangwill penned a play whose story line has long been forgotten, but whose central theme has not. His production was entitled "The Melting Pot" and its message still holds a tremendous power on the national imagination—the promise that all immigrants can be transformed into Americans, a new alloy forged in a crucible of



This century's second huge wave of immigrants is attracted to large metropolitan areas like Los Angeles, above.

democracy, freedom and civic responsibility.

In 1908, when the play opened in Washington, the United States was in the middle of absorbing the largest influx of immigrants in its history—Irish and Germans, followed by Italians and East Europeans, Catholics and Jews—some 18 million new citizens between 1890 and 1920.

Today, the United States is experiencing its second great wave of immigration, a movement of people that has profound implications for a society that by tradition pays homage to its immigrant roots at the same time it confronts complex and deeply ingrained ethnic and racial divisions.

The immigrants of today come not from Europe but overwhelm-

ingly from the still developing world of Asia and Latin America. They are driving a demographic shift so rapid that within the lifetimes of today's teenagers, no one ethnic group—including whites of European descent—will comprise a majority of the nation's population.

This shift, according to social historians, demographers and others studying the trends, will severely test the premise of the fabled melting pot, the idea, so central to national identity, that this country can transform people of every color and background into "one America."

Just as possible, they say, is that the nation will continue to fracture into many separate, disconnected communities with no shared sense of commonality or purpose. Or perhaps it will evolve into something in between, a pluralistic society that will hold on to some core ideas about citizenship and capitalism, but with little meaningful interaction among groups.

The demographic changes raise other questions about political and economic power. Will that power, now held disproportionately by whites, be shared in the new America? What will happen when Hispanics overtake blacks as the nation's single largest minority?

"I do not think that most Americans really understand the historic changes happening before their very eyes," said Peter Salins, an immigration scholar who is provost of the State Universities of New York. "What are we going to become? Who are we? How do the newcomers fit in—and how do the natives handle it—this is the great unknown."

This is the first of a series of articles examining the effects of the new demographics on American life. Over the next few months, other reports will focus on the impact on politics, jobs, and social institutions

Cont'd on next page

Cont'd from previous page

Bygone Consensus

Fear of strangers, of course, is nothing new in American history. The last great immigration wave produced a bitter backlash, epitomized by the Chinese Exclusion Act of 1882 and the return, in the 1920s, of the Ku Klux Klan, which not only targeted blacks but Catholics, Jews and immigrants as well.

But despite this strife, many historians argue that there was a greater consensus in the past on what it meant to be an American, a yearning for a common language and culture, and a desire—encouraged, if not coerced by members of the dominant white Protestant culture—to assimilate. Today, they say, there is more emphasis on preserving one's ethnic identity, of finding ways to highlight and defend one's cultural roots.

More often than not, the neighborhoods where Americans live, the politicians and propositions they vote for, the cultures they immerse themselves in, the friends and spouses they have, the churches and schools they attend, and the way they view themselves are defined by ethnicity. The question is whether, in the midst of such change, there is also enough glue to hold Americans together.

"As we become more and more diverse, there is all this potential to make that reality work for us," said Angela Oh, a Korean American activist who emerged as a powerful voice for Asian immigrants after the Los Angeles riots in 1992. "But yet, you witness this persistence of segregation, the fragmentation, all these fights over resources, this finger-pointing. You would have to be blind not to see it."

It is a phenomenon sometimes difficult to measure, but not observe. Houses of worship remain, as the Rev. Martin Luther King Jr. described it three decades ago, among

the most segregated institutions in America, not just by race but also ethnicity. At high school cafeterias, the second and third generation children of immigrants clump together in cliques defined by where their parents or grandparents were born. There are television sitcoms, talk shows and movies that are considered black or white, Latino or Asian. At a place like the law school of the University of California at Los Angeles, which has about 1,000 students, there are separate student associations for blacks, Latinos and Asians with their own law review journals.

It almost goes without saying that today's new arrivals are a source of vitality and energy, especially in the big cities to which many are attracted. Diversity, almost everyone agrees, is good; choice is good; exposure to different cultures and ideas is good.

But many scholars worry about the loss of community and shared sense of reality among Americans, what Todd Gitlin, a professor of culture and communications at New York University, calls "the twilight of common dreams." The concern is echoed by many on both the left and right, and of all ethnicities, but no one seems to know exactly what to do about it.

Academics who examine the census data and probe for meaning in the numbers already speak of a new "demographic balkanization," not only of residential segregation, forced or chosen but also a powerful preference to see ourselves through a racial prism, wary of others, and, in many instances, hostile.

At a recent school board meeting in East Palo Alto, Calif., police had to break up a fight between Latinos and blacks, who were arguing over the merits and expense of bilingual education in a school district that has shifted over the last few years from majority African American to majority Hispanic. One parent told report-



BY TODD BAGGLOW FOR THE WASHINGTON POST
In Los Angeles and other cities, demographers are seeing a new form of "white flight," way beyond the suburbs and deep into small towns and rural areas.

ers that if the Hispanics wanted to learn Spanish they should stay in Mexico.

The demographic shifts are smudging the old lines demarcating two historical, often distinct societies, one black and one white. Reshaped by three decades of rapidly rising immigration, the national story is now far more complicated.

Whites currently account for 74 percent of the population, blacks 12 percent, Hispanics 10 percent and Asians 3 percent. Yet according to data and predictions generated by the U.S. Census Bureau and social scientists poring over the numbers, Hispanics will likely surpass blacks early in the next century. And by the year 2050, demographers predict, Hispanics will account for 25 percent of the population, blacks 14 percent, Asians 8 percent, with whites hovering somewhere around 53 percent.

As early as next year, whites no longer will be the majority in California; in Hawaii and New Mexico this is already the case. Soon after, Neva-

da, Texas, Maryland and New Jersey are also predicted to become "majority minority" states, entities where no one ethnic group remains the majority.

Effects of 1965 Law

The overwhelming majority of immigrants come from Asia and Latin America—Mexico, the Central American countries, the Philippines, Korea, and Southeast Asia.

What triggered this great transformation was a change to immigration law in 1965, when Congress made family reunification the primary criteria for admittance. That new policy, a response to charges that the law favored white Europeans, allowed immigrants already in the United States to bring over their relatives, who in turn could bring over more relatives. As a result, America has been absorbing as many as 1 million newcomers a year, to the point that now almost 1 in every 10 residents is foreign born.

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These numbers, relative to the overall population, were slightly higher at the beginning of this century, but the current immigration wave is in many ways very different, and its context inexorably altered, from the last great wave.

This time around tensions are sharpened by the changing profile of those who are entering America's borders. Not only are their racial and ethnic backgrounds more varied than in decades past, their place in a modern postindustrial economy has also been recast.

The newly arrived today can be roughly divided into two camps: those with college degrees and highly specialized skills, and those with almost no education or job training. Some 12 percent of immigrants have graduate degrees, compared to 8 percent of native Americans. But more than one-third of the immigrants have no high school diploma, double the rate for those born in the United States.

Before 1970, immigrants were actually doing better than natives overall, as measured by education, rate of homeownership and average incomes. But those arriving after 1970 are younger, more likely to be underemployed and live below the poverty level. As a group, they are doing worse than natives.

About 6 percent of new arrivals receive some form of welfare, double the rate for U.S.-born citizens. Among some newcomers—Cambodians and Salvadorans, for example—the numbers are even higher.

With large numbers of immigrants arriving from Latin America, and segregating in barrios, there is also evidence of lingering language problems. Consider that in Miami, three-quarters of residents speak a language other than English at home and 67 percent of those say they are not fluent in English. In New York City, 4 of every 10 residents speak a language other than English at

home, and of these, half said they do not speak English well.

It is clear that not all of America is experiencing the impact of immigration equally. Although even small midwestern cities have seen sharp changes in their racial and ethnic mix in the past two decades, most immigrants continue to cluster into a handful of large, mostly coastal metropolitan areas: Los Angeles, New York, San Francisco, Chicago, Miami, Washington, D.C., and Houston. They are home to more than a quarter of the total U.S. population and more than 60 percent of all foreign-born residents.

But as the immigrants arrive, many American-born citizens pour out of these cities in search of new homes in more homogeneous locales. New York and Los Angeles each lost more than 1 million native-born residents between 1990 and 1995, even as their populations increased by roughly the same numbers with immigrants. To oversimplify, said University of Michigan demographer William Frey, "For every Mexican who comes to Los Angeles, a white native-born leaves."

Most of the people leaving the big cities are white and they tend to be working class. This is an entirely new kind of "white flight" whereby whites are not just fleeing the city centers for the suburbs but also are leaving the region, and often the state.

"The Ozzies and Harriets of the 1990s are skipping the suburbs of the big cities and moving to more homogeneous, mostly white, smaller towns and smaller cities and rural areas," Frey said.

They're headed to Atlanta, Las Vegas, Phoenix, Portland, Denver, Austin and Orlando, as well as smaller cities in Nevada, Idaho, Colorado and Washington. Frey and other demographers believe the domestic migrants—black and white—are being "pushed" out, at least in part, by competition with immigrants for jobs and neighborhoods, political clout and lifestyle.

Frey sees in this pattern the emergence of separate Americas, one white and middle-aged, less urban and another intensely urban, young, multicultural and multiethnic. One America will care deeply about English as the official lan-

guage and about preserving Social Security. The other will care about things like retaining affirmative action and bilingual education.

Ethnic Segregation

Even within gateway cities that give the outward appearance of being multicultural, there are sharp lines of ethnic segregation. When describing the ethnic diversity of a bellwether megacity such as Los Angeles, many residents speak tearfully of the great mosaic of many peoples. But the social scientists who look at the hard census numbers see something more complex.

James P. Allen, a cultural geographer at California State University Northridge, suggests that what Los Angeles, as seen from an airplane, is a tremendously mixed area, but on the ground, racial homogeneity and segregation are common.

This is not a new phenomenon; there have always been immigrant neighborhoods. Ben J. Stein, an early proponent of making English the "official language," worried about close-knit German communities. Sen. Daniel Patrick Moynihan (D-N.Y.) described the lingering clannishness of Irish and other immi-

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grant populations in New York in "Beyond the Melting Pot," a benchmark work from the 1960s that he wrote with Nathan Glazer.

But the persistence of ethnic enclaves and identification does not appear to be going away, and may not in a country that is now home to not a few distinct ethnic groups, but to dozens. Hispanics in Los Angeles, to take the dominant group in the nation's second largest city, were more segregated residentially in 1990 than they were 10 or 20 years ago, the census tracts show. Moreover, it is possible that what mixing of groups that does occur is only a temporary phenomenon as one ethnic group supplants another in the neighborhood.

If there is deep-seated ethnic segregation, it clearly extends to the American workplace. In many cities, researchers find sustained "ethnic niches" in the labor market. Because jobs are often a matter of whom one knows, the niches were enduring and remarkably resistant to outsiders.

In California, for example, Mexican immigrants are employed overwhelmingly as gardeners and domestics, in apparel and furniture manufacturing, and as cooks and food preparers. Koreans open small businesses. Filipinos become nurses and medical technicians. African Americans work in government jobs, an important niche that is increasingly being challenged by Hispanics who want in.

UCLA's Roger Waldinger and others have pointed to the creation, in cities of high immigration, of "dual economies."

For the affluent, which includes a disproportionate number of whites, the large labor pool provides them with a ready supply of gardeners, maids and nannies. For businesses in need of cheap manpower, the same is true. Yet there are fewer "transitional" jobs—the blue-collar work that helped Italian and Irish immigrants move up the economic ladder—to help newcomers or their children on their way to the jobs requiring advanced technical or professional skills that now dominate the upper tier of the economy.

A Rung at a Time

Traditionally, immigration scholars have seen the phenomenon of assimilation as a relentless economic progression. The hard-working new arrivals struggle along with a new language and at low-paying jobs in order for their sons and daughters to climb the economic ladder, each generation advancing a rung. There are many cases where this is true.

More recently, there is evidence to suggest that economic movement is erratic and that some groups—particularly in high immigration cities—can get "stuck."

Among African Americans, for instance, there emerge two distinct patterns. The black middle class is doing demonstrably better—in income, home ownership rates, education—than it was when the demographic transformation (and the



Korean American activist Angela Oh observes "this persistence of segregation, the fragmentation, all these fights over resources, this finger-pointing. You would have to be blind not to see it."

BY TODD BELLON FOR THE WASHINGTON POST

civil rights movement) began three decades ago.

But for African Americans at the bottom, research indicates that immigration, particularly of Latinos with limited education, has increased joblessness, and frustration.

In Miami, where Cuban immigrants dominate the political landscape, tensions are high between Hispanics and blacks, said Nathaniel J. Wilcox, a community activist there. "The perception in the black community, the reality, is that Hispanics don't want some of the power, they want all the power," Wilcox said. "At least when we were going through this with the whites during the Jim Crow era, at least they'd hire us. But Hispanics won't allow African Americans to even compete. They have this feeling that their community is the only community that counts."

Yet many Hispanics too find themselves in an economic "mobility trap." While the new immigrants are willing to work in low-end jobs, their sons and daughters, growing up in the barrios but exposed to the relentless consumerism of popular culture, have greater expectations, but are disadvantaged because of their impoverished settings, particularly the overwhelmed inner-city schools most immigrant children attend.

"One doubts that a truck-driving future will satisfy today's servants and assemblers. And this scenario gets a good deal more pessimistic if the region's economy fails to deliver or simply throws up more bad jobs," writes Waldinger, a professor of sociology and director of center for regional policy studies at the University of California-Los Angeles.

Though there are calls to revive efforts to encourage "Americanization" of the newcomers, many researchers now express doubt that the old assimilation model works. For one thing, there is less of a dominant mainstream to enter. Instead, there are a dozen streams, despite the best efforts by the dominant white society to lump groups together by ethnicity.

It is a particularly American phenomenon, many say, to label citizens by their ethnicity. When a person lived in El Salvador, for

example, he or she saw themselves as a nationality. When they arrive in the United States, they become Hispanic or Latino. So too with Asians. Koreans and Cambodians find little in common, but when they arrive here they become "Asian," and are counted and courted, encouraged or discriminated against as such.

"My family has had trouble understanding that we are now Asians, and not Koreans, or people from Korea or Korean Americans, or just plain Americans," said Arthur Lee, who owns a dry cleaning store in Los Angeles. "Sometimes, we laugh about it. Oh, the Asian students are so smart! The Asians have no interest in politics! Whatever. But we don't know what people are talking about. Who are the Asians?"

'Too American'

Many immigrant parents say that while they want their children to advance economically in their new country, they do not want them to become "too American." A common concern among Haitians in South Florida is that their children will adopt the attitudes of the inner city's underclass. Vietnamese parents in New Orleans often try to keep their children immersed in their ethnic enclave and try not to let them assimilate too fast.

One study of the children of immigrants, conducted six years ago among young Haitians, Cubans, West Indians, Mexican and Vietnamese in South Florida and Southern California, suggests the parents are not alone in their concerns.

Asked by researchers Alejandro Portes and Ruben Rumbaut how they identified themselves, most chose categories of hyphenated Americans. Few choose "American" as their identity.

Then there was this—asked if they believe the United States is the best country in the world, most of the youngsters answered: no.

FOR MORE INFORMATION

To review immigration statistics and read immigration laws, click on the above symbol on the front page of The Post's Web site at washingtonpost.com

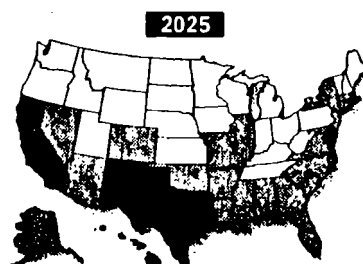
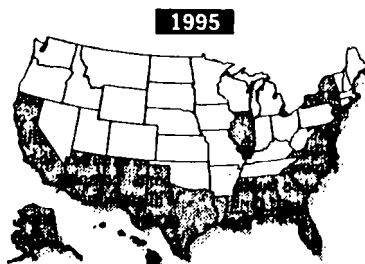
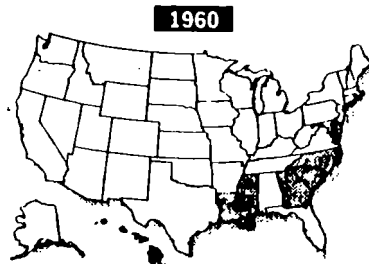
THE MYTH OF THE MELTING POT | America's Racial and Ethnic Divides

A POPULATION OF CHANGING DIMENSIONS

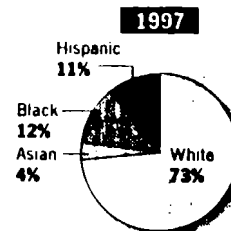
In 25 years, non-Hispanic whites will not be a majority in four states, including the two most populous ones, and in 50 years, they will make up barely half the U.S. population.

Non-Hispanic whites as percentage of state population

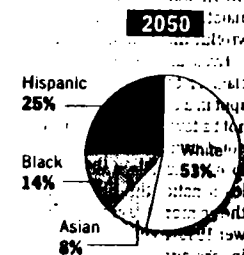
□ More than 75 percent ■ 50-75 percent ■ Less than 50 percent



U.S. population (projection)



Asian category includes Pacific islanders. Other races, including American Indians, make up less than 1 percent.
SOURCE: U.S. Census Bureau



ONE IN 10 U.S. RESIDENTS WAS BORN ABROAD

In 1960, foreign-born Americans were mostly from Europe. Now most come from Asia and Latin America.

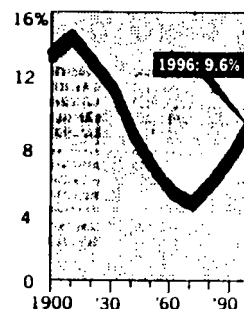
Foreign-born, by country of origin

1990	1996
Germany 990,000	Mexico 6,679,000
Canada 963,000	Philippines 1,164,000
Poland 748,000	China 801,000
Soviet Union 691,000	Cuba 772,000
Mexico 576,000	India 757,000
England 528,000	Vietnam 740,000
Ireland 339,000	El Salvador 701,000
Austria 305,000	Canada 660,000
Hungary 245,000	Korea 550,000
Czechoslovakia 228,000	Germany 523,000

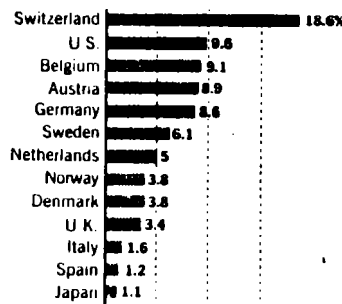
SOURCES: U.S. Census Bureau; World Bank. Foreign born data for other nations from 1994; other current data are for 1996.

Nearly 1 in 10 Americans was born outside the country, a high rate among industrialized nations.

Americans born abroad

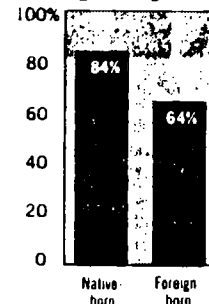


Percentage born abroad

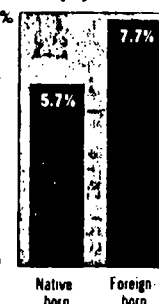


Foreign born Americans have less education and are more likely than native born to be poor and unemployed.

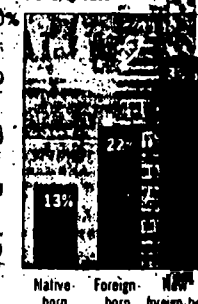
High school graduates



Unemployment rate



Poverty rate



* Arriving after 1990

Wash. Post; 2-23-98

New Union President Talks Tough On Pay Issues, Clinton Policies

By Stephen Barr
Washington Post Staff Writer

Bobby L. Harnage keeps a brass likeness of a Georgia bulldog on his desk at the American Federation of Government Employees headquarters. But he skips past an aide's observation that he can be as tenacious as a bulldog to instead invoke his enthusiasm for back-home football and Washington's Redskins.

While the new AFGE president may be uncomfortable talking about himself, he talks tough about representing the interests of federal workers. For instance, Harnage asserts that the Clinton administration has repeatedly violated a 1990 pay law and should not try to justify its pay decisions by pitting them against potential program or spending cuts.

"It is not a fair argument," Harnage declared. "It is one without a lot of morals, when you say because we want to balance the budget, let's work these people, let's make them fewer, require them to do more, be more efficient, do a better job, but we're not going to pay them what they're worth."

Harnage was also quite clear on his grading of the Clinton administration, as far as job cuts are concerned. He said that rank-and-file federal employees "took the hit on downsizing," and, even though the administration averted large-scale layoffs through the use of cash "buy-outs," it has not made progress on thinning management layers in the bureaucracy, as promised by Vice President Gore.

"They failed us miserably" on the management cuts, Harnage said.

His remarks, in an interview the week before the 200,000-member union meets March 1 for its annual legislative and political conference here, signaled that AFGE will no longer mute its criticisms of Clinton administration actions.

"I guess to sum it up, I'm getting a little short on patience in cooperating," Harnage said. "I think it's time to go back to the old ways and kick over a few chairs when you walk into the room and get some attention."

The union's growing frustration over pay issues is linked to the Federal Employees Pay Comparability Act, enacted in 1990 and put into effect four years later. The law's

PLAYERS

Bobby L. Harnage

Title: President, American Federation of Government Employees, AFL-CIO.

Age: 57.

Education: Attended Macon College, Ga., and the University of Georgia.

Family: Married, four children and six grandchildren.

Previous jobs: U.S. Air Force, 1959 to 1963; Warner Robins Air Force Base civilian employee, 1963 to 1968; appointed or elected to AFGE offices at district and national levels, 1968 to present.

Hobby: Woodworking.

On raises for federal workers:

"We're not asking to put the budget out of balance. If you're going to go around the country bragging about a surplus, what's the justification for not paying federal employees what they are entitled to under the law?"

THE WASHINGTON POST

basic goal was to close a perceived "pay gap" between federal workers and private sector employees.

The law provides for a uniform, nationwide raise in federal white-collar pay, based on a formula derived from a Labor Department survey. The law also provides for a second salary adjustment, called "locality pay," intended to reflect differences with non-federal salaries from one geographic area to another.

Next year, the law would provide federal employees with a 3.1 percent nationwide raise and locality pay increases of about 9 percent, for a total boost in annual pay of more than 12 percent.

But President Clinton's budget, as it has since he took office in 1993, rejected the law's formulas and, for 1999, proposed a total raise of 3.1 percent. His first budget described

the locality pay formulas as based on "flawed methodology."

Each 1 percent increase in federal civilian pay costs about \$800 million, budget estimates show. A 12 percent raise would cost about \$7 billion more than the proposed 3.1 percent raise.

Some administration critics of the pay law doubt that a pay gap between federal and private sector workers exists; others argue that the law may have led to some employees being overpaid and others underpaid.

But Harnage contends that if there are problems comparing federal pay against private sector salaries or if the 1990 law might lead to some federal workers being overpaid, then the blame rests with the Office of Management and Budget, the Office of Personnel Management and the Labor Department.

"We don't negotiate salaries and we don't negotiate grades. OMB and OPM created that problem," Harnage said. "So if people are a higher grade than what they should have been, the union didn't do that, because that is a non-bargaining issue. ... Management did that."

OPM Director Janice R. Lachance has signaled that the 3.1 percent pay proposal remains open to negotiation, saying, "It's important to remember that by law the president has until August to propose an alternative pay plan if he believes one is in order."

Federal union leaders plan to keep the pressure on, hoping to double the 3.1 percent raise proposed by Clinton. Harnage and Robert M. Tobias, president of the smaller National Treasury Employees Union, who opens his legislative conference today, plan to appear with Rep. Steny H. Hoyer (D-Md.) and other lawmakers at a news conference on pay issues Tuesday.

If Clinton and Congress would go along with a 5.8 percent raise, then AFGE would be willing to negotiate changes in the pay law, Harnage said. "Let's get a law everyone can live with. I'll take my chances at drafting a new law, as long as it is done fairly," he said. An aide, though, said the union has not ruled out filing a lawsuit over the administration's handling of locality pay issues.

Harnage also expressed disappointment that the White House has

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