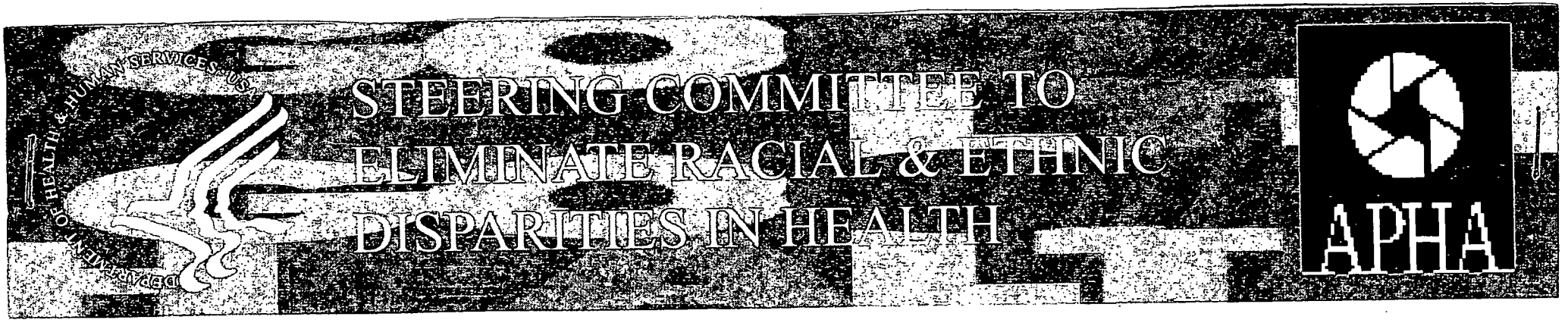
STEERING COMMITTEE TO ELIMINATE RACIAL & ETHNIC DISPARITIES IN HEALTH

October 6, 2000
White House/Eisenhower Executive Office Building


DEPARTMENT OF HEALTH & HUMAN SERVICES USA
STEERING COMMITTEE TO
ELIMINATE RACIAL & ETHNIC
DISPARITIES IN HEALTH
APHA

American Public Health Association

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Influential and Diverse Leaders Join Steering Committee of APHA/HHS Campaign to Eliminate Racial and Ethnic Health Disparities

In a Pledge to the Campaign and to Their Nation, Leaders Sign Historic Document

Washington, DC – Today the American Public Health Association (APHA), the U.S. Department of Health and Human Services (HHS) and a diverse group of national leaders representing government agencies, major health care organizations, philanthropic foundations, corporations, public service, racial and ethnic organizations, faith-based groups and the labor community will commit themselves to eliminating the racial and ethnic health disparities which exist in the United States.

In an intensive morning meeting participants discussed the way racial and ethnic health disparities affect their represented communities. After the meeting, the Steering Committee members signed a "Call to the Nation" showing their commitment and opening up the Campaign to the Nation.

> **"[A]t the beginning of a new millennium, we are issuing this Call to the Nation to Eliminate Racial and Ethnic Health Disparities in Health with the hope that organizations and individuals throughout the country will endorse and commit to achieving this historic goal...Now is the time to ensure that current and future generations of all Americans are healthier, happier, and more productive."**
> -- Excerpt from "Call to the Nation: to Eliminate Racial and Ethnic Disparities in Health."

"When APHA and HHS announced this initiative last April, we knew we could not succeed without the help of national leaders from all sectors of our society," said Mohammad N. Akhter, MD, MPH, executive director of the American Public Health Association. "Racial and ethnic health disparities are a critical problem for the future strength of our nation. Today we have national leaders here with us who will start the process for eliminating disparities and creating good health for all Americans in the coming decades."

"Through this creative partnership, we can do things that we never before had the advantage to do, because we never before had the involvement of such a wide group of change agents," said David Satcher, MD, PhD, Surgeon General and Assistant Secretary for Health at DHHS. "This partnership will put an end to the looming burden of disease and it will go a long way toward assuring that by the time we reach 2010, America's health system, our labor force, and our citizenry at large will be in a solid position to face the future."

Racial and ethnic minorities in the United States have significantly higher rates of death and disability. Consider the following statistics from the Health Resources and Service Administration Office of Minority Health Report *"Health Care Rx: Access for All"* and the Healthy People 2010 Report:

- **Infant Mortality** – Infant mortality rates are 2 ½ times higher for African Americans and 1 ½ times higher for American Indians than whites.
- **Cancer** – African American men under 65 have prostate cancer at nearly twice the rate of whites and women of Vietnamese origin have cervical cancer at nearly five times the rate of white women.

- **Heart Disease** – The age-adjusted death rate in 1995 for African Americans 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.
- **HIV/AIDS Infections** – The number of new AIDS cases among African Americans is now greater than the number of new AIDS cases among whites. AIDS is the third leading cause of death for Hispanic men aged 25-44. In the last year, 19% of new AIDS cases were among Hispanic adults and adolescents.
- **Diabetes** – The prevalence of diabetes in Hispanics, American Indians and Alaska Natives is nearly double that of whites.

Last April, the U.S. Department of Health and Human Services (DHHS) and the American Public Health Association (APHA) announced their partnership to eliminate racial and ethnic health disparities. The Campaign has three phases or milestones. The first major milestone, achieved today, is the completion and signing of the "Call to the Nation" by the Steering Committee.

A larger coalition of some 300 people – from national, state and local organizations – will be selected by January 2001 and they will use the Call to reach the second milestone, the development of a detailed plan of action (completed by November 2001).

Finally, the third milestone, made possible by public-private partnerships, will be the implementation of the action plan at the national, state and local level. The evaluation of the Campaign's success in eliminating racial and ethnic disparities in health by the year 2010 will be presented in annual reports from APHA and HHS.

APHA Executive Director, Mohammad N. Akhter, MD, MPH and U.S. Surgeon General and Assistant Secretary DHHS will provide joint leadership during all phases of this public-private endeavor.

The Federal Steering Committee Members are: **Gwendolyn Brown**, Dep Assistant Secretary of Defense, U.S. Dept of Defense; **Romy Diaz**, Assistant Administrator for Administration and Resources Management, U.S. Environmental Protection Agency; **Willie Hensley**, Director Center for Minority Veterans, U.S. Dept of Veterans Affairs; **Richard Jerome**, Dep Associate Attorney General, U.S. Dept of Justice; **Eileen Kennedy**, PhD, Dep Undersecretary for Research, Education and Economics, U.S. Dept of Agriculture; **Leslie Kramerich**, Acting Assistant Secretary for the Pension and Welfare Benefits Administration, U.S. Dept of Labor; **Eva Plaza**, Asst Secretary for Fair Housing and Equal Opportunity, U.S. Dept of Housing and Urban Development; **Oliver McGee III**, PhD, Dep Assistant Secretary for Transportation, U.S. Dept of Transportation; and **Judy Winston**, Acting Undersecretary & General Counsel, U.S. Dept of Education.

The non-Federal Steering Committee Members are: **Linda Chavez**, President, Center for Equal Opportunity; **Mary Chung**, Executive Director, National Asian Women's Health Organization; **Karen Davis**, PhD, President, The Commonwealth Fund; **Thomas Donahue**, President, U.S. Chamber of Commerce; **Reverend Robert Franklin**, President, Interdenominational Theological Center; **David Gipp**, President, United Tribes Technical College; **Val Halamandaris**, President, National Association of Home Care; **Scott Harshbarger**, President and CEO, Common Cause; **Rodney Hood**, MD, President, National Medical Association; **Senator Daniel Inouye**, Hawaii State Senator; **Robert Johnson**, CEO, Black Entertainment Television, Inc.; **David Lawrence**, MD, Chairman and CEO, Kaiser Foundation Health Plan, Inc.; **Norma Lopez**, Vice President, National Council of La Raza; **Floyd Malveaux**, MD, Dean, Howard University College of Medicine; **Reuben Mark**, Chairman and CEO, Colgate-Palmolive; **Thomas Menino**, Mayor of Boston; **Elena Rios**, MD, MSPH, President, National Hispanic Medical Association; **Ciro D. Rodriguez**, Congressman, Texas; **Rabbi David Saperstein**, Director and Counsel, Religious Action Center of Reform Judaism; **Steven Schroeder**, MD, President, The Robert Wood Johnson Foundation; **Randolph Smoak**, Jr., MD, President, American Medical Association; **Andrew Stern**, International, President Service Employees International Union (Affiliate of AFL-CIO); **Linda Stierle**, Executive Director, American Nurses Association; **Jesse Ventura**, Governor of Minnesota; and **Ambassador Andrew Young**, President, National Council of Churches.

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The American Public Health Association (APHA) is the oldest and largest organization of public health professionals and represents more than 50,000 members from over 50 public health occupations. Based on the values of health, equity, diversity, empowerment, integrity, dignity and knowledge for individuals and communities, APHA is the leading professional association that promotes and protects the health of the people. APHA has dedicated both its 2000 Annual Meeting (Boston, Nov 12-16) and November 2000 issue of the American Journal of Public Health to the issue of Racial and Ethnic Health Disparities.

Agenda

INAUGURAL MEETING OF THE STEERING COMMITTEE TO ELIMINATE RACIAL & ETHNIC DISPARITIES IN HEALTH

AGENDA

OCTOBER 6, 2000

7:00 - 8:00 a.m.	Breakfast for all Steering Committee members & core staff (Westin Fairfax Hotel, 2100 Massachusetts Avenue, N.W.)
8:00 a.m.	Committee members not at Breakfast meet rest of group at the Hotel for transport to White House/Eisenhower Executive Office Bldg.
8:15 a.m.	Committee members depart Hotel for WH/EEOB
8:30 a.m.	All Committee members meet at WH/EEOB (1700 Pennsylvania Avenue entrance) to be checked in as a group
9:00 a.m. - 11:30 a.m.	**INAUGURAL MEETING OF THE STEERING COMMITTEE: Building a National Coalition to Eliminate Racial & Ethnic Disparities in Health** (WH/EEOB - Indian Treaty Room) ***Opening Remarks*** (15 minutes) - Mohammad N. Akhter, MD, MPH Executive Director, APHA - David Satcher, MD, PhD Assistant Secretary for Health and Surgeon General, DHHS ***Facilitated Discussion with Committee Members*** (2 hours) Facilitator: W. David Helms, Ph.D., President & CEO, Academy for Health Services Research and Health Policy ***Next Steps/Closing Remarks*** (15 minutes) - Dr. Akhter & Dr. Satcher
11:30 a.m. - 12:30 p.m.	**PRESS EVENT: Issuing a *Call to the Nation to Eliminate Racial and Ethnic Disparities in Health*** (WH/EEOB/Room 450) (To Be Recorded) - Welcome by Dr. Akhter - Introduction of Committee Members by Dr. Satcher - Issuance of the *Call to the Nation* on behalf of the Committee by Karen Davis, President, The Commonwealth Fund - Questions from the Press - Signing Ceremony by all Committee Members & Photos
12:30 p.m. - 1:30 p.m.	Lunch (WH/EEOB - Indian Treaty Room)
1:45 p.m.	Depart for the Westin Fairfax Hotel

Meeting Participants

Steering Committee to Eliminate Racial and Ethnic Disparities in Health
(As of 10/5/00)

Co-Chairs

Mohammad N. Akhter, MD, MPH
Executive Director
American Public Health Association

David Satcher, MD, PhD
Assistant Secretary for Health
and Surgeon General
U.S. Department of Health & Human
Services

Committee Members

Gwendolyn A. Brown
Deputy Assistant Secretary of Defense
(Health Budgets and Financial Policy)
U.S. Department of Defense

Mary K. Chung
Executive Director
National Asian Women's Health
Organization

Karen Davis, PhD
President
The Commonwealth Fund

Romulo L. Diaz, Jr.
Assistant Administrator for Administration
and Resources Management
Environmental Protection Agency

Steve Fogarty
Worldwide Vice President, Oral Care and
Global Business Development
Colgate-Palmolive Corporation

David M. Gipp
President
American Indian Higher Education
Consortium

Val Halamandaris
President
National Association of Home Care

Scott Harshbarger
President and CEO
Common Cause

Willie L. Hensley
Director, Center for Minority Veterans
U.S. Department of Veterans Affairs

Rodney G. Hood, MD
President
National Medical Association

Richard B. Jerome
Deputy Associate Attorney General
U.S. Department of Justice

Robert L. Johnson
Chief Executive Officer
Black Entertainment Television, Inc.

Eileen Kennedy, DSc
Deputy Undersecretary for Research,
Education, and Economics
U.S. Department of Agriculture

Leslie B. Kramerich
Acting Asst Secretary for the Pension and
Welfare Benefits Administration
U.S. Department of Labor

David M. Lawrence, MD
Chairman & CEO
Kaiser Foundation Health Plan, Inc.

Norma Y. Lopez
Vice President
National Council of La Raza

Floyd J. Malveaux, MD, PhD
Interim Vice President for Health Affairs &
Dean, College of Medicine
Howard University Hospital

Oliver G. McGee III, PhD
Deputy Assistant Secretary for
Transportation Technology Policy
U.S. Department of Transportation

The Honorable Thomas M. Menino
Mayor of Boston

Eva M. Plaza
Asst Secretary for Fair Housing and
Equal Opportunity
U.S. Department of Housing and
Urban Development

Joseph A. Riggs, MD
Board of Trustees
American Medical Association

Elena V. Rios, MD, MSPH
President
National Hispanic Medical Association

The Honorable Ciro D. Rodriguez
U.S. House of Representatives
28th District of Texas

Rabbi David Saperstein
Director and Counsel
Religious Action Center of Reform Judaism

Steven A. Schroeder, M.D.
President
The Robert Wood Johnson Foundation

Andrew L. Stern
Service Employees International Union
(Affiliate of AFL-CIO)

Linda J. Stierle
Executive Director
American Nurses Association

The Honorable Jesse Ventura
Governor of Minnesota

Judith A. Winston
Acting Undersecretary & General Counsel
U.S. Department of Education

APHA & HHS ATTENDEES
(As of 10/4/00)

American Public Health Association

Mohammed N. Ahkter, MD, MPH
Executive Director

Kitty Hsu Dana, MM
Chief Operating Officer

David Fouse
Director of Marketing

Richard A. Levinson, MD, DPA
Associate Executive Director

Michele Late
Editor, "The Nation's Health"

Henry Montes, MPH
Special Assistant for Health Manpower

Sandra Nolte
Executive Assistant for Governance

Ponnuswamy Swamidoss, PhD
Director, Educational Services

Ray Thomas, MS
Executive Assistant to the Associate Executive Director

Karin Wallestad, BA
Director, Media Relations

Carole Zimmerman, MA, APR
Director of Communications and Marketing

HHS

David Satcher, MD, PhD
Assistant Secretary for Health (ASH)
and Surgeon General (SG)
Office of Public Health and Science (OPHS)

Mirtha Beadle
Office of the Executive Secretary, OS, DHHS

Cynthia Bennett
Deputy Director of Public Affairs, OPHS

Mary Beth Donahue
Chief of Staff, Office of the Secretary, DHHS

Tuei Doong
Deputy Director
Office of Minority Health, OPHS

Kathryn A. Ellis
Principal Deputy Director
Office for Civil Rights, DHHS

Matthew Guidry, PhD
Director, Healthy Communities, Work Place,
& Schools Team
Office of Disease Prevention & Health
Promotion, OPHS

Kaye Hayes
Executive Assistant to the ASH/SG, OPHS

Nicole Lurie, MD, MSPH
Principal Deputy Assistant Secretary for
Health OPHS

Beverly Malone, PhD, RN, FAAN
Deputy Assistant Secretary for Health, OPHS

Amandeep Matharu, MPP
Health Policy Advisor, OPHS

Helen Mathis
Office of the Assistant Secretary for Legislation
OS, DHHS

Omar T. Passons
Public Health Analyst
Office of Disease Prevention and Health
Promotion, OPHS

Anita Frye-Smith
Policy Specialist
Office of the Executive Secretary, OPHS

Jimmie Smith, Jr., MD
Special Assistant to the ASH/SG, OPHS

Nathan Stinson, MD, PhD, MPH
Deputy Assistant Secretary for Minority
Health
OPHS

Damon Thompson
Communications Director, OPHS

Valerie A. Welsh
Senior Health Policy Analyst
Office of Minority Health, OPHS

Bertha N. Williams
Presidential Management Intern, OPHS

Randolph F. Wykoff, MD, MPH, TM
Deputy Assistant Secretary for Health
(Disease Prevention and Health Promotion)
OPHS

OTHER INVITED GUESTS
(As of 10/4/00)

Gloria Brown
National Association of Home Care

Lorraine T. Cole, PhD
National Medical Association

Karen Scott Collins, MD, MPH
The Commonwealth Fund

Barbara Ferrer, PhD
Deputy Director
Boston Public Health Commission
Boston, Massachusetts

Alfred F. Fisher
Office of the Vice President for Health Affairs
Howard University

Rose I. Gonzalez, Pamela C. Hagan, or Cornelia P. Porter?
American Nurses Association

Matt Keller
Common Cause

Jeremy Laducer
United Tribes Technical College

Commissioner Jan Malcolm
State of Minnesota

Laura Marquez
Legislative Fellow
Office of Congressman Ciro Rodriguez

Emilio Morante
National Hispanic Medical Association

Eugene Z. Oddone
Director of the Center for Health Services Research in Primary Care
U.S. Department of Veterans Affairs

Rachel Orkand
Religious Action Center of Reform Judaism

Carol J. Regan
Services Employees International Union

Kelli J. Richardson
Black Entertainment Television, Inc.

H. Michelle Yang
National Asian Women's Health Organization

ABOUT OUR FACILITATOR

W. David Helms, Ph.D.

Dr. W. David Helms, Ph.D., is President and CEO of the Academy for Health Services Research and Health Policy. The Academy was formed on June 19, 2000, from the merger of the Alpha Center and the Association for Health Services Research (AHSR). The purpose of this Academy is to improve health and health care by generating new knowledge and moving knowledge into action. The Academy and its programs are dedicated to stimulating the development, understanding, and use of the best available health services research and health policy information by public and private decision makers.

In addition to leading the development of this new Academy, Dr. Helms serves as the program director for the Robert Wood Johnson Foundation's State Coverage Initiatives, a national demonstration program to support state efforts to expand health insurance coverage. He also serves as project director for the Academy's contract with the Agency for Healthcare Research and Quality to conduct workshops and prepare research reviews for state and local government officials.

Dr. Helms founded and directed the Alpha Center from 1976-2000. Through these 25 years Alpha was known as a non-partisan, non-profit health policy center that provided expert technical assistance, objective analysis and research, and comprehensive education and facilitation services. Dr. Helms received his doctorate in public administration and economics in 1979 from the Maxwell School of Citizenship and Public Affairs, Syracuse University.

STEERING COMMITTEE TO ELIMINATE RACIAL AND ETHNIC DISPARITIES IN HEALTH

BIOGRAPHICAL SKETCHES

(As of 10/4/00)

Mohammad N. Akhter, MD, MPH, is Executive Director of the American Public Health Association, the oldest and largest organization of public health professionals in the world. Prior to joining APHA, Dr. Akhter was a senior advisor at the U.S. Department of Health and Human Services. Dr. Akhter is a physician with Board Certification in Preventive Medicine and is a clinical professor in the Department of Family and Community Medicine at Georgetown University Medical School in Washington, D.C. Dr. Akhter has served in many public health leadership positions, including Director of the Missouri State Department of Health and as Health Commissioner in the Nation's Capital. His current priorities in guiding the APHA include strengthening its science base and enhancing its advocacy role to protect the health of the American people in the 21st century.

Ms. Gwendolyn A. Brown was appointed by President Clinton in February 1995 to serve as the Deputy Assistant Secretary of Defense (Health Budgets and Financial Policy), Office of the Assistant Secretary of Defense for Health Affairs, U.S. Department of Defense (DOD). She is the principal DOD official responsible for overseeing the Defense Health Program, which includes the $15 billion budget for the Military Departments and Defense components. Ms. Brown is responsible for submitting a balanced and comprehensive Department Health Budget and for congressional coordination of the submission. She works closely with the Military Services and components to promote cost-effective medical resource management policies and quality health care for more than 8.2 million beneficiaries of the Military Health System (MHS).

Prior to her appointment, Ms. Brown was the chief of staff and legislative director to Congressman Julian C. Dixon, of California. Ms. Brown directed the Congressman's legislative agenda, managed his leadership activities, and was responsible for defense appropriations and foreign policy matters. Before her tenure on Capitol Hill, Ms. Brown served as an international trade specialist at the U.S. Department of Commerce. She advised administration officials and company executives on the economic conditions and investment opportunities in the Middle East region and nontraditional markets.

Ms. Brown has received numerous professional and civic awards. She was awarded the bronze medal--at that time, the highest medal of distinction awarded by the Department of Commerce for superior federal service.

Ms. Brown received her Bachelor of Arts Degree from the University of California at Santa Barbara, a Master's degree from the University of California at Los Angeles, and completed advanced graduate studies at the Fletcher School of Law and Diplomacy at Tufts University in Massachusetts.

Mary K. Chung is Founder, President, and Chief Executive Officer of the National Asian Women's Health Organization based in San Francisco, California. She has over a decade of

experience working for social justice in the nonprofit sector. Ms. Chung has received nationwide media coverage of her work in publications such as *Newsweek*, *USA Today*, and the *Los Angeles Times*. Ms. Chung lends her expertise in several national forums as a Board Member for the Alan Guttmacher Institute, the National Breast Cancer Coalition, and the Reproductive Health Technologies Project. Ms. Chung received a Bachelor of Science degree in Applied Economics from the University of San Francisco.

Karen Davis is president of The Commonwealth Fund, a national philanthropy engaged in independent research on health and social policy issues. Dr. Davis assumed the presidency of the fourth oldest private foundation in the country on January 1, 1995. Established by Anna M. Harkness in 1918 with the broad charge to enhance the common good, the Fund seeks ways to help Americans live healthy and productive lives, giving special attention to those groups with serious and neglected problems.

Dr. Davis is a nationally recognized economist, with a distinguished career in public policy and research. Before joining the Fund, she served as Chairman of the Department of Health Policy and Management at The Johns Hopkins School of Hygiene and Public Health, where she also held an appointment as professor of economics. She served as Deputy Assistant Secretary for Health Policy in the Department of Health and Human Services from 1977-1980, and was the first woman to head a U.S. Public Health Service agency. Prior to her government career, Ms. Davis was a senior fellow Brookings Institution in Washington, D.C., a Visiting Lecturer at Harvard University, and an assistant professor of economics at Rice University. A native of Oklahoma, she received her doctoral degree in economics from Rice University, which recognized her achievements with a Distinguished Alumna award in 1991.

Dr. Davis has published a number of significant books, monographs, and articles on health and social policy issues, including the landmark books *Health Care Cost Containment*; *Medicare Policy*; *National Health Insurance: Benefits, Costs, and Consequences*; and *Health and the War on Poverty*. She is a past president of the Association for Health Services Research (AHSR), and an AHSR Distinguished Fellow, a member of the Council of the Institute of Medicine, a member of the Kaiser Commission on Medicaid and the Uninsured, and a member of the National Advisory Council of the Agency for Healthcare Research and Quality. She serves on the Board of Directors of Mount Sinai-NYU Health and the Mount Sinai School of Medicine. Dr. Davis is the recipient of the 2000 Baxter-Allegiance Foundation Prize for Health Services Research.

Romulo (Romy) L. Diaz, Jr. was appointed by President Clinton as Assistant Administrator for Administration and Resources Management (OARM) at the Environmental Protection Agency (EPA) in October 1998. He provides direction for the Agency's human resources, contracts and grants, employee health and safety, and the management of facilities located in 38 states. He administers a budget of $6 billion and oversees a staff of nearly 1,400 employees at EPA headquarters and the regions.

Under his leadership, OARM has developed strategic alliances with public and private laboratories, educational institutions, and community groups to broaden the Agency's programs to protect the environment and enhance public health. He has championed efforts to create a

more diverse workforce, such as outreach to Hispanic communities nationwide, and to ensure that the Agency has the scientific and technical skills it will need in the years ahead. In addition, he has promoted initiatives to reduce air and water pollution from Agency facilities and make them more energy efficient. He has implemented OARM's first management plan, a results-oriented strategy designed to stimulate innovation and customer service, while ensuring financial integrity.

Mr. Diaz has more than 25 years of experience in public service. He served as Deputy Chief of Staff and Counselor to former Department of Energy (DOE) Secretary Hazel R. O'Leary, and as DOE's Deputy Assistant Secretary for International Affairs. He was the first Director of DOE's regulatory coordination office. He also served as Chairman of the North Atlantic Treaty Organization's Petroleum Planning Committee.

His past accomplishments include negotiating the international continency response to the 1990-91 Gulf Crisis, which resulted in the first emergency drawdown of the U.S. Strategic Petroleum Reserve. He received the Secretary of Energy's Gold Award for coordination DOE's regulatory reform efforts that resulted in the elimination and streamlining of the Department's regulations, internal directives, and paperwork burden, saving more than $100 million.

A native of Texas, Mr. Diaz received a bachelor's degree from the University of Texas at Austin, and a J.D. from the University of Texas School of Law. He is a member of the State Bar of Texas, the Federal Bar Association, and the National Hispanic Bar Association.

Steve Fogarty (bio not yet available)

David M. Gipp has served as President and Chief Executive Officer of United Tribes Technical College (UTTC) since May 2, 1977. President Gipp serves under the UTTC Board of Directors, comprised of the tribal chairperson and tribal council delegates from the United Tribes of North Dakota.

Dr. Gipp has long been an advocate for the economic and cultural development of Indian people through education and self-determination, and has held posts at the local and national levels. He served on the board of the National Indian Education Association from 1977-1980, chaired the Education Committee of the National Congress of American Indians from 1982-1984, and was a delegate to the White House Conference on Indian Education. He is the past executive director and president of the American Indian Higher Education Consortium (1978-1980, 1991-1993, 1999-2000).

Among his numerous awards, Dr. Gipp has received the Martin Luther King, Jr. Federal Commission National Service Award of Excellence, and was honored as the founder and first president of the Indian Association at the University of North Dakota. He was named Indian Educator of the Year by the National Indian Education Association, and was the recipient of the North Dakota Multicultural Educator of the Year award.

Dr. Gipp received a Bachelor of Science in Political Science from the University of North Dakota in 1969, and obtained a certificate in military journalism in 1973 from Ft. Benjamin Harrison, Indianapolis, Indiana. In 1991, he received a Doctorate in Laws, Honoris Causa, from North Dakota State University for his contributions in developing tribal higher education.

Dr. Gipp was born in Fort Yates, North Dakota, and is an enrolled member (Hunkpapa Lakota) of the Standing Rock Sioux Tribe. His Indian name is Lone Star (also known as Alone Star).

Val J. Halamandaris was named President of the National Association of Home Care effective July 1, 1982. During his tenure, membership, revenues, and staff have grown dramatically. He came to this position from the staff of the house of Representatives Select Committee on Aging, where he was senior counsel and director of oversight. The Honorable Claude Pepper was chairman of the committee. Mr. Halamandaris was associate counsel to the U.S. Senate Committee on Aging between 1969 and 1978. From 1962 to 1969, he worked with U.S. Senator Frank E. Moss, who was instrumental in the founding of the Senate Aging Committee.

Mr. Halamandaris is a lawyer who has built an impressive 20-year record working with Congress. He is an acknowledged expert in health, aging, and long-term care. He has received nationwide recognition for his role as a congressional investigator and his efforts to expose fraud against the elderly, including insurance fraud, medical quackery, real estate fraud, nursing home abuse, and other scams victimizing the elderly.

His legislative achievements include assisting in enactment of legislation requiring federal minimum standards for nursing homes and authorizing federal funds to help schools of nursing and medicine provide training in geriatrics.

Mr. Halamandaris is serving as a member of the board of the Rosalynn Carter Institute, and has served as a member of the board of Give Kids the World, a nonprofit organization which sends terminally ill children and their families to Walt Disney World in Orlando, Florida. He was also appointed by President Clinton to serve as a Commissioner on the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry from 1996-1998.

Mr. Halamandaris received his B.A. from George Washington University and his law degree from the Catholic University School of Law, both in the Nation's Capital. He is a member of the District of Columbia Bar, the U.S. District Court of Appeals, and a member of the Bar of the Supreme Court of the United States.

Scott Harshbarger is President and Chief Executive Officer of Common Cause, a nonpartisan citizens' lobby founded in 1970 by John Gardner to make government more open, honest, and accountable at the federal, state, and local levels. The organization's current national priorities include enacting effective campaign finance reform, serving as a campaign finance watchdog to identify abuses in the presidential election, improving enforcement of campaign finance laws, fighting to eliminate corporate welfare, and upholding government ethics. He is also the Hadley Professor of Criminal Justice and Law at Northeastern University in Boston, Massachusetts.

Prior to his election to his current position at Common Cause, Mr. Harshbarger was the Attorney General of Massachusetts, an office to which he was first elected in 1990 and reelected in 1994. As Massachusetts' top law enforcement officer, Mr. Harshbarger won national recognition for his work in crime prevention, civil rights and hate crimes enforcement, and prosecution of white-collar crime and public corruption. In 1996, Mr. Harshbarger was elected president of the National Association of Attorneys General, and was one of the nation's first Attorneys General to sue the tobacco industry to help recover smoking-related health care costs. Ms. Harshbarger was the Democratic nominee for Governor of Massachusetts in 1998.

Before being elected Attorney General in 1990, Mr. Harshbarger served as District Attorney for Middlesex County, was an attorney in private practice, and served as the first General Counsel of the Massachusetts State Ethics Commission. Born in Pennsylvania in 1941, Mr. Harshbarger is a 1964 graduate of Harvard University and a 1968 graduate of Harvard Law School.

Willie L. Hensley is the Director, Center for Minority Veterans at the U.S. Department of Veterans Affairs. As such, he is the principal advisor to the Secretary of Veterans Affairs on policies and programs affecting minority veterans. He also makes recommendations for the establishment of programs to meet the specific needs of minorities, and is responsible for ensuring that veteran programs are used by minorities.

Prior to his VA appointment, Mr. Hensley was Deputy Chief of Staff for Personnel with the U.S. Army Operational Test and Evaluation Command, where he directed personnel management for more than 2,000 military and civilian employees. He was the principal advisor to the commanding general on all personnel matters for the headquarters and the subordinate units at 15 locations throughout the U.S. He has also served two 2-year terms as vice president of ROCKS, Inc., a nonprofit organization of 1,200 active duty members and veterans, and chaired its task force on equal opportunity and sexual harassment.

Mr. Hensley was a 22-year active duty Army officer (now retired), rising to the rank of lieutenant colonel in September 1990. He began his career in the military as the chief of the separation transition facility at Fort Carson, Colorado. Other duty assignments included work with the Office of the Chairman, Joint Chiefs of Staff, and the Office of the Adjutant General at the U.S. Total Army Personnel Command in Alexandria, Virginia. He has also been the Commander of an adjutant general postal detachment in Korea and a personnel service company in Germany.

Mr. Hensley's military awards include the Army Achievement Medal, the Army Commendation Medal (three), the Meritorious Service Medal (three), the Defense Meritorious Service Award, and the Legion of Merit.

Mr. Hensley was born in Shreveport, Louisiana and lived in northern Louisiana until he attended Southern University in Baton Rouge, where he earned a B.S. in social studies, with emphasis in history. Later, he earned a master of arts in education from the University of Northern Colorado in Greeley. He is a member of the American Legion, the Retired Officers Association, and the American GI Forum.

Rodney G. Hood, MD, is the 101th president of the National Medical Association (NMA), a 25,000-member African-American physicians' organization. In this capacity, he serves as national spokesperson on behalf of the NMA membership and as health advocate for improving health care access and the health status of African Americans. Dr. Hood has been in private medical practice for over 20 years and is currently managing partner for CareView Medical Group, cofounder and President of a 300-member independent physician's group called MultiCultural Primary, and founder of CompCare Health Plan.

Dr. Hood attended Northeastern University in Boston, Massachusetts, and graduated with honors from the School of Pharmacy. After matriculating at the University of California, San Francisco Graduate School of Pharmacology and Toxicology, he became interned in pursuing medicine. In 1973, was among the first African Americans to graduate from University of California, San Diego medical school. He went on to complete his postgraduate medical training and become Board Certified in Internal Medicine. Dr. Hood has received numerous honors in recognition of his distinguished career and dedication to the community such as his establishing the San Diego NMA Chapter's Mickey Leland Scholarship Fund which has donated over $40,000 to minority medical students. He is also recipient of the NAACP/SanDiego Distinguished Medical Service Award.

Richard B. Jerome serves as Deputy Associate Attorney General at the U.S. Department of Justice. He assists and advises the Associate Attorney General and other senior Department officials on a wide range of legal and policy issues, with particular emphasis on oversight of the Civil Rights Division and the Community Relations Service within the Department of Justice. Included in his responsibilities are the Department of Justice's efforts to promote police integrity and address police misconduct.

Prior to his current position, in 1996, Mr. Jerome was Counsel to Deval Patrick, Assistant Attorney General for Civil Rights, and assisted Mr. Patrick in coordinating the National Church Arson Task Force, formed to respond to the sharp rise in reported arson at houses of worship, especially black churches in the southeastern United States. From 1989 to 1996, Mr. Jerome was a senior trial lawyer for the Voting Section of the Civil Rights Division, where he was lead counsel in several congressional and statewide legislative redistricting cases, and cases enforcing the bilingual election provisions of the Voting Rights Act. Mr. Jerome served as Legislative Assistant for Senator Brock Adams (Washington State) from 1987 to1989, and was an associate at Verner, Liipfert, Bernhard, McPherson and Hand, a Washington D.C. law firm, from 1984 to 1987. Mr. Jerome is a 1980 graduate of Brown University and a 1984 graduate of Harvard Law School.

Robert L. Johnson is founder, Chairman, and Chief Executive Officer of BET Holdings, Inc., one of the leading black-owned and operated media-entertainment companies in the United States. With the mission of establishing BET as the most-valued consumer brand within the Black marketplace, BET has enjoyed prominent success since its inception in 1980. For two consecutive years, BET Holdings, Inc. has been recognized by *Forbes* magazine as one of the "Best Small Companies in America."

From 1976 to 1979, Mr. Johnson served as vice president of Government Relations National Cable Television Association (NCTA), a trade association representing more than 1,500 cable television companies. Prior to joining the NCTA, Mr. Johnson was on the staff of the Honorable Walter E. Fauntroy, Congressional Delegate from the District of Columbia. Mr. Johnson previous held positions at the Washington Urban League and the Corporation for Public Broadcasting.

Mr. Johnson serves on numerous corporate boards including, U.S. Airways, the Hilton Hotels Corporation and General Mills. His service to the nonprofit sector include board membership on the United Negro College Fund and the American Film Institute. He is also a member of the Board of Governors for the Rock and Roll Hall of Fame in Cleveland, Ohio.

Major awards received by Mr. Johnson include: 1997 Broadcasting & Cable Magazine's Hall of Fame Award; CTAM's Grand Tam Award; Cablevision Magazine's 2020 Award which lists him as one of the twenty most influential people in the cable industry; and, the NAACP Image Award. He is a graduate of the University of Illinois and holds a Master's degree in International Affairs from the Woodrow Wilson School of Public and International Affairs at Princeton University, from which he received the Distinguished Alumni Award.

Eileen Kennedy, DSc is currently Deputy Under Secretary of the U.S. Department of Agriculture (USDA). In this position, she provides leadership in shaping and managing the USDA's broad research, education, and extension programs in production agriculture, food safety, nutrition, conservation and the environment. She was previously the first Executive Director of the USDA's Center for Nutrition Policy and Promotion. The Center serves as the focal point within USDA, linking scientific research to the nutritional needs of the American consumer as well as policy advice and analysis for USDA's domestic and international agenda. Dr. Kennedy has been deeply involved in social policy research relative to health , nutrition, food security, and poverty alleviation, nationally and internationally. She has represented the U.S. on international policy committees and is currently a member of the Advisory Group on Nutrition for the United Nations (U.N.). She serves on a number of boards an committees of the U.N., the National Academy of Sciences and other professionally related organizations. Her research has been reported extensively in national and international scientific journals.

Dr. Kennedy holds a Bachelor's degree in biology from Hunter College in New York City, and a a Master's in Science degree in foods and nutrition from Pennsylvania State University, a Master's in Science degree in nutrition from Harvard University in Cambridge, Massachusetts, and a Doctor of Science degree in nutrition, also from Harvard University.

Leslie B. Kramerich became Acting Assistant Secretary of the Labor Department's Pension and Welfare Benefits Administration (PWBA) on December 6, 1999. Previously, she was PWBA's Deputy Assistant Secretary for Policy, a position she continues to hold. Ms. Kramerich directs a staff of more than 700 in carrying out administrative, policy, and enforcement functions under the Employee Retirement Income Security Act (ERISA). The agency oversees more than 6.7 million private pension and welfare plans, with pension assets alone totaling nearly $4 trillion.

Before joining the Department of Labor, Ms. Kramerich had experience in pension, securities, and bankruptcy law. She came to the Department after five years of working with the Pension Benefit Guaranty Corporation (PBGC) as an attorney-advisor to the chief negotiator. While at PBGC, she participated in several landmark agreements between the government and private companies. From May 1989 to November 1993, she was an attorney with Verner, Liipfert, Bernhard, McPherson & Hand, a Washington, D.C. law firm, where she advised clients on issues dealing with employee benefits, disability, tax, and bankruptcy. Her legislative experience includes serving as advisor to minority members of the committee with oversight of federal government programs, and as a staff member to the Chairman of the Senate Finance Subcommittee on Health (Senator David Durenberger) and to the Chairman of the Senate Aging Committee (Senator John Heinz).

Ms. Kramerich's professional affiliations include membership in the Ohio State Bar, District of Columbia Bar, and the American Bar Association. She has a Bachelor of Science degree from Case Western Reserve University and earned a Juris Doctor from Ohio State University College of Law in 1984.

David M. Lawrence, MD, MPH, is Chief Executive Officer and Chairman of the Boards of Kaiser Family Health Plan, Inc. and Kaiser Foundation Hospitals. During his tenure with the organization, he has served as Area Medical Director and Vice President of Operations for the Northwest Permanente Medical Group and as Regional Manager of the Colorado and Northern California Regions. Dr. Lawrence previously served as Health Officer and Director of Human Services for Multnomah County, Oregon, on the faculty of the School of Public Health and Community Medicine and the School of Medicine at the University of Washington, as an adviser to the Minister of Health in Chile under the aegis of Johns Hopkins University, and as a Peace Corps physician in the Dominican Republic and in Washington, D.C.

Dr. Lawrence received his medical degree from the University of Kentucky, his Masters of Public Health from the University of Washington, and his bachelors degree from Amherst College. He completed his residency at Johns Hopkins and the University of Washington, and is board certified in General Preventive Medicine.

Norma Y. Lopez has been a trial attorney since graduating from Northeastern University School of Law, in Boston, Massachusetts, in 1988. Ms Lopez, who is fluent in Spanish, began her career as an assistant district attorney from Bronx county, New York, prosecuting misdemeanor and felony cases. In 1994, she began practicing personal injury law. In 1999, she joined Troman, Glaser & Lictman as a plaintiff's trial attorney. She is responsible for the litigation of a wide variety of accident cases. In 1989, Ms. Lopez was admitted to the State Bar of New York and has been admitted to the federal bars of the Southern and Eastern districts of New York as well as the Bar of the United States Supreme Court.

She serves as a board member for the Association of Arbitrators for the Small Claims Arbitrator. She is also a member of the New York County Lawyers Association, the Dominican Bar Association, the Puerto Rican Bar Association, the New York State Trial Lawyers Association, and the Bronx Women's Bar Association.

Floyd J. Malveaux, MD, PhD, has served as the Interim Vice President for Health Affairs in the Howard University College of Medicine since July 1996. He has also served as Dean of the college since 1995. Dr. Malveaux began his academic career at Howard University in 1968 as an assistant professor of microbiology where he was instrumental in establishing the graduate program in microbiology. Following graduation from medical school, he returned in 1978 to the Department of Medicine at Howard University and established the Conjoint Training Program in Allergy and Immunology which was fully accredited. In 1984, he joined the faculty of Johns Hopkins University where, as a member of the Division of Clinical Immunology, he initiated studies on asthma mortality and morbidity. Dr. Malveaux returned to Howard University in 1989 as Chair of the Department of Microbiology and associate professor of microbiology and medicine.

Dr. Malveaux is a nationally recognized expert on asthma and allergic diseases and has published and lectured extensively in these areas. His research has been supported by grants from the National Institute of Allergy and Infectious Diseases, the National Heart, Lung, and Blood Institute (NHLBI), the Hasbro Children's Foundation, and the Robert Wood Johnson Foundation, among others. Dr. Malveaux was also founder and president of the Urban Asthma and Allergy Center in Baltimore, Maryland from 1986 to 1989.

Dr. Malveaux is active in numerous professional organizations and is or has served as a member of the Advisory Council of the American Lung Association; Chair of the Committee of Under-represented Minorities, American Academy of Allergy and Immunology; a member of the Board of Trustees of the Education Commission for Foreign Medical Graduates; a member of the Board of Trustees of the Asthma and Allergy Foundation of America; and a member of NHLBI's National Asthma Education and Prevention Program. He has served as a member of the Board of Directors of the Maryland Thoracic Society and the Maryland Chapter of the Asthma and Allergy Foundation of America, and as Chair of the Minority Outreach Initiative for the American Lung Association of Maryland. He has also held a number of positions with the National Medical Association, including member of the Board of Trustees.

Dr. Malveaux is the recipient of numerous awards, among which are the National Research Service Award from the National Institutes of Health, the Vivian B. Allen Foundation Fellowship, the Clemens von Pirquet Research Award from the Georgetown University School of Medicine, and the Outstanding Faculty Research Award from Howard University.

Dr. Malveaux received a B.S. degree from Creighton University, Omaha, Nebraska (1961), an M.S. degree from Loyola University, New Orleans, Louisiana (1964), and a Ph.D. degree in Microbiology and Public Health from Michigan State University (1968). He received his M.D., with honors, from Howard University College of Medicine in 1974 and was elected to the Alpha Omega Alpha Honor Medical Society. He received specialty training in Internal Medicine at the Washington Hospital Center in the District of Columbia (1974-76), and sub-specialty training in Allergy and Clinical Immunology at the Johns Hopkins University in Baltimore, Maryland (1976-78).

Thomas M. Menino was first elected Mayor of Boston on November 2, 1993, winning 64% of the vote and 18 of the city's 22 wards. He was reelected to a second term without opposition in November 1997. Prior to the first election, Mayor Menino served four months as Acting Mayor, after Mayor Raymond L. Flynn left his post to serve as the U.S. Ambassador to the Vatican in July of 1993. Mayor Menino served nine years as a District City Councilor from Boston's Hyde Park neighborhood. He founded and chaired the City Council Ways and Means Committee and was Vice-Chair of the Committee on Housing.

Mayor Menino chairs the Task Force on Mayors and Public Schools and the Subcommittee on Enterprise Zones for the U.S. Conference of Mayors. In the National League of Cities, he chairs the Task Force on Youth, Education, and Families, serves on the Advisory Council, and has served on the Board of Directors. He also has been an advisor to the National Trust for Historic Preservation since 1989.

Mayor Menino is a graduate of St. Thomas Aquinas High School. He earned a degree in community planning from the University of Massachusetts in 1988.

Eva M. Plaza currently serves as the Assistant Secretary for Fair Housing and Equal Opportunity (FHEO) at the U.S. Department of Housing and Urban Development (HUD). The Office of Fair Housing and Equal Opportunity serves to protect the housing rights of all Americans granted under the Federal Fair Housing Act of 1968. Since her arrival at HUD, Ms. Plaza has vigorously enforced this vital law and its amendments, while waging aggressive education/outreach efforts in communities across the country. In addition to doubling the rate of enforcement actions within her first year, Ms. Plaza's accomplishments include: brokering groundbreaking civil rights settlements with two leading financial institutions that resulted in more than $3 billion in loans for minority and low-income home buyers, conducting a joint training program on Title VI and Environmental Justice Act investigations with the Department of Justice (DOJ) in FY 2000 that trained 120 HUD investigators and significantly increased the Department's ability to conduct Title VI compliance reviews and Environmental Justice Act investigations; charging one of the first Fair Housing Act complaints involving the Internet, and its use to incite acts of hate; commissioning the Urban Institute study entitled, "What We Know About Lending Discrimination," which details the discrimination that minorities encounter throughout the lending process; establishing HUD's first National Fair Housing Testing Conference, an event that brought together more than 300 civil rights advocates from the Department, DOJ, and private sector groups; and redesigning FHEO's housing discrimination complaint process, earning her a Hammer award from Vice President Al Gore.

Prior to her appointment as Assistant Secretary, Ms. Plaza served as Deputy Assistant Attorney General over the Torts Branch at the Department of Justice. Ms. Plaza also gained considerable experience as a trial lawyer with the Washington, DC law firms of Seyfarth, Shaw, Fairweather & Geraldson April 1989-July 1993) and Arent, Fox, Kinter, Plotkin & Kahn (September 1986-March 1989).

Ms. Plaza has received awards for her outstanding achievements, such as the Albert Arent Pro Bono Award, 1989; the U.S. Department of Justice Hispanic Employment Program Award,

1996; and the National Conference for College Women Leaders, Women of Distinction Award, 1998. Ms. Plaza graduated cum laude from Harvard University in 1980, and went on to study law at the University of California at Berkeley, Boalt Hall School of Law. There, she served as Associate Editor of the California Law Review, and, after graduating in 1984, was selected to the highly acclaimed Attorney General's Honors Program of the Department of Justice - Commercial Litigation Branch.

Joseph A. Riggs (bio not yet available)

Elena V. Rios, MD, MSPH, currently serves as President of the National Hispanic Medical Association (NHMA), representing Hispanic physicians in the United States and Director of the Hispanic-Serving Health Professions Schools, Inc., representing 21 medical schools with 9% Hispanic student enrollment. The mission of both organizations is to improve the health care of Hispanics across the Nation. Dr. Rios also serves on the American Medical Association's (AMA's) Minority Affairs Consortium Steering Committee, the National Hispanic Leadership Agenda Board of Directors, is co-chair for the Hispanic Health Coalition, and was recently appointed by Secretary Shalala to the Advisory Panel for Medicare Education. Dr. Rios has lectured and published widely and has received numerous awards on health policy.

Before joining the NHMA, Dr. Rios served as the Advisor for Regional and Minority Women's Health for the U.S. Department of Health and Human Services Office on Women's Health. In 1992, Dr. Rios worked for the State of California Office of Statewide Health Planning and Development where she developed the database for residency programs in the state and participated in state and Federal activities to enhance the health professions recruitment programs for minority students.

Dr. Rios graduated from Stanford University in 1977 and obtained a B.A. in human biology and public administration from University of California Los Angeles (UCLA) School of Public Health in 1980 and obtained an M.S. in health planning and policy analysis. She attained her MD degree from UCLA, Los Angeles School of Medicine in 1987.

Ciro D. Rodriguez is the United States Representative from the 28th District of Texas. After his swearing-in on April 17, 1997, Congressman Rodriguez joined the National Security (now Armed Services) Committee to support our military and the special place they have in his hometown of San Antonio. He joined the Veterans' Affairs Committee to promote the rights and benefits of the more than 50,000 veterans in his district who answered the call to serve. Congressman Rodriguez works closely with local community leaders and actively fights in Congress for area military bases and for business development for large and small companies. He also advocates for strengthening public education, improving benefits for veterans and military retirees, and protecting Texas farmers and ranchers. He supports protecting Social Security and Medicare, expanding access to health care, and promoting economic development and small businesses throughout South Texas. Congressman Rodriguez has also successfully obtained additional resources for regional technical assistance centers used by educators and for area transportation needs, and helped spearhead a successful effort to bring new health care access points for veterans in South Texas.

In the Texas House of Representatives, then-Representative Rodriguez held the chairmanship of the important Local and Consent Calendar Committee. He served on the Public Health and the Higher Education Committees, and presided as a vice-chairman of the Legislative Study Group, a coalition of progressive Texas House members. From 1975 to 1987, Mr. Rodriguez served as a board member of the Harlandale Independent School District, worked as an educational consultant for the Intercultural Development Research Association, and served as a caseworker with the Department of Mental Health & Mental Retardation. From 1987 to 1996, he taught at Our Lady of the Lake University's Worden School of Social Work.

Congressman Rodriguez attended San Antonio College and later received his B.A. in Political Science from St. Mary's University in San Antonio. He received his Masters of Social Work from Our Lady of the Lake University.

Rabbi David Saperstein is the Director of the Religious Action Center (RAC) of Reform Judaism. Described in recent profiles in both *The Washington Post* and *Mother Jones* as the "premier religious lobbyist on Capital Hill," he represents the National Reform Jewish Movement to Congress and the Administration. During his 25-year tenure, Rabbi Saperstein has served on numerous Boards, including Common Cause, the NAACP, and People for the American Way.

The RAC not only advocates on a broad range of social justice issues, but provides extensive legislative and programmatic materials used by synagogues, federations, and JCRCs ?? nationwide.

Also an attorney, Rabbi Saperstein teaches seminars in both First Amendment church-state law and in Jewish Law at Georgetown University Law School. A prolific writer and speaker, Rabbi Saperstein is author of six books, including: *Tough Choices: Jewish Perspectives on Social Justice*, co-authored with Al Vorspan.

David Satcher, MD, PhD, is the 16th Surgeon General of the United States. Sworn in on February 13, 1998, he is only the second person in history to simultaneously hold the positions of Surgeon General and Assistant Secretary for Health. In these roles, he serves as the Secretary's senior advisor on public health matters and as director of the Office of Public Health and Science. Prior to nominating Dr. Satcher to serve in his present post, President Clinton had appointed him as Director of the Centers for Disease Control and Prevention and Administrator of the Agency for Toxic Substances and Disease Registry, where he served from 1993 to 1998. Before joining the Administration, he was President of Meharry Medical College in Nashville, Tennessee, from 1982 to 1993.

Dr. Satcher served as professor and Chairman of the Department of Community Medicine and Family Practice at Morehouse School of Medicine from 1979 to 1982. He is a former faculty member of the University of California at Los Angeles (UCLA) School of Medicine and Public Health and the King-Drew Medical Center in Los Angeles, where he developed and chaired the King-Drew Department of Family Medicine. From 1977 to 1979, he served as the Interim Dean of the Charles R. Drew Postgraduate Medical School, during which time he negotiated the

agreement with UCLA School of Medicine and the Board of Regents that led to a medical education program at King-Drew. He also directed the King-Drew Sickle Cell Research Center for six years.

Dr. Satcher is a former Robert Wood Johnson Clinical Scholar and Macy Faculty Fellow. He is the recipient of 18 honorary degrees and numerous distinguished honors, including top awards from the American Medical Association, the American College of Physicians, the American Academy of Family Physicians, and *Ebony* magazine. In 1995, he received the Breslow Award in Public Health and in 1997 the New York Academy of Medicine Lifetime Achievement Award. Last year, he received the Bennie Mays Trailblazer Award and the Jimmy and Roslyn Carter Award for Humanitarian Contributions to the Health of Humankind from the National Foundation for Infectious Diseases.

Dr. Satcher graduated from Morehouse College in Atlanta in 1963 and was elected to Phi Beta Kappa. He received his M.D. and Ph.D. from Case Western Reserve University in 1970 with election to Alpha Omega Alpha Honor Society. He did residency/fellowship training at Strong Memorial Hospital, University of Rochester, UCLA, and King-Drew. He is a fellow of the American Academy of Family Physicians, the American College of Preventive Medicine, and the American College of Physicians.

Dr. Satcher would most like to be known as the Surgeon General who listens to the American people and who responds with effective programs. His mission is to make public health work for all groups in this Nation.

Steven A. Schroeder, MD, became president of the Robert Wood Johnson Foundation in Princeton, New Jersey, in 1990. Nine years later, on July 1, 1999, he assumed the dual role of president and CEO. The Foundation–the nation's largest health philanthropy–concentrates its grant making in three major areas; assuring access to health care for all Americans; improving the care of persons with chronic illness; and reducing harm from substance abuse.

Dr. Schroeder graduated with honors from Stanford University and Harvard Medical School. He trained in internal medicine at the Boston City Hospital, and in epidemiology as a member of the Epidemic Intelligence Service of the Centers for Disease Control, and in public health at the Harvard Center for Community Health and Medical Care. He has held faculty appointments at three academic health centers, serving as Instructor at Harvard, George Washington University (GWU), and University of California at San Francisco (UCSF). At both GWU and UCSF, he was founding medical director of a university-sponsored health maintenance organization. He has published extensively in the fields of clinical medicine, health care organization and financing, workforce, quality of care, health policy, prevention, and philanthropy. Dr. Schroeder has received many honors including four honorary doctorates.

Andrew L. Stern is international president of the Service Employees International Union (SEIU), the largest and fastest-growing union in the AFL-CIO and the nation's largest health care union. Stern is the architect of SEIU's ground-breaking efforts to help janitors, home care workers, nursing home employees, and other low-wage workers to close the growing wealth gap

and to bridge the digital divide. A leader in increasing labor's voice in pension fund investments, Mr. Stern is co-chair of the Council of Institutional Invertors and a member of the boards of the National Coordinating Committee for Multi-Employer Plans and the AFL-CIO Housing Investment Trust.

Before his election as president of the international union, Mr. Stern held a number of elected positions in SEIU Local 668 in Pennsylvania, representing state employee social service workers. Mr. Stern received a Bachelor's of Arts degree in urban studies from the University of Pennsylvania in 1972.

Linda J. Stierle, MSN, RN, CNAA, a nurse leader with more than 30 years diverse management experience in health care operations, is the Chief Operating Officer of the American Nurses Association (ANA). ANA is the oldest and largest professional organization for registered nurses (RNs), a federation of 53 constituent nurses organizations representing the interests of the nation's 2.6 million RNs.

Ms. Stierle recently retired as a Brigadier General of the Air Force. She began her military career in 1970 as a staff nurse in intensive care. During her career she held various clinical and management positions including chief nursing officer at Lackland Air Force Base in San Antonio, Texas, and at the 48th Tactical Fighter Wing Hospital, Royal Air Force in Lackenheath, England. In addition, she has both regional and headquarters corporate experience. From 1995 until her retirement, she was director, medical readiness and nursing services at Bolling Air Force Base, Washington, D.C.

Ms. Stierle, a member of the Texas Nurses Association, was also instrumental in the creation of ANA's newest constituency for nurses in the uniformed services, FedNA. Her military awards include Legion of Merit with one oak leaf cluster, Meritorious Service Medal with three oak leaf clusters, Air Force Commendation Medal, Air Force Achievement Medal, and National Defense Service Medal. Ms. Stierle earned a Masters of Science in Nursing from the University of California, San Francisco, a Bachelors of Science in Nursing from Incarnate World College, San Antonio, Texas, and a diploma in nursing from Spartanburg General Hospital in Spartanburg, South Carolina.

Ronald A. Stroman is Director of the Office of Civil Rights for the U.S. Department of Transportation. Before his appointment to this position in 1997, Mr. Stroman was the deputy minority staff director and procurement counsel for the House Committee on Government Reform and Oversight. During 1993 and 1994, he was the staff director and chief counsel for the Subcommittee on Human Resources and Intergovernmental Relations, and for six years before that, he was general counsel for the Committee on Government Operations. In the latter role, he drafted and reviewed legislation that included minority business development, procurement reform, urban aid, and budget reform.

As the attorney advisor in the Office of the General Counsel at the U.S. Department of Housing and Urban Development from 1978-1984, Mr. Stroman was responsible for cases involving

discrimination in the sale or management of housing, as well as matters involving utilization of minority business enterprises.

Mr. Stroman has a law degree from the Rutgers University Law Center, Neward, and majored in government for his bachelor's degree from Manhattan College. He is a member of the Pennsylvania State Bar.

Jesse Ventura was elected the 38th Governor of Minnesota on November 3, 1998. As the only Reform Party candidate to ever win statewide office, Governor Ventura's upset victory over the Republican and Democratic candidates drew National attention, and was notable for the new voters who participated in the election as well as the low-budget campaign, spending less than $400,000.

As Governor, Mr. Ventura's stated priority is to keep new voters engaged in the political process by promoting efficient, common sense policies that reduce reliance on government and promote self-sufficiency. As a strong proponent of public education, the Ventura Administration is also working to reduce class sizes and improve Minnesota's public schools.

Governor Ventura grew up in the south Minneapolis Longfellow neighborhood, attended Cooper Elementary School, and graduated from Roosevelt Senior High School in 1969. Immediately after high school, Mr. Ventura joined the Navy and was trained as a SEAL. He served in the Navy for six years, four on active duty, two in the Reserves, and served in Vietnam. After his honorable discharge from the Navy in 1973, Mr. Ventura attended Community College on the GI bill.

For 11 years, Mr. Ventura enjoyed a successful career as a professional wrestler. In 1984, Mr. Ventura retired from wrestling and became an actor, starring in several films and later became a radio talk show host. In 1990, Mr. Ventura was prompted to run for Mayor of Brooklyn Park, Minnesota's sixth largest city, due to the imminent destruction of a treasured wetland. He served as Mayor until 1995, championing crime reduction. Governor Ventura is a member of the *Make a Wish of Minnesota* Board of Advisors and has been a volunteer football coach at Champlin Park High School for three years. He has been a member of the Screen Actors Guild for 11 years, and the American Federation of Television and Radio Artists for about 10 years.

Judith A. Winston was sworn in as General Counsel to the U.S. Department of Education in June 1993. She manages a staff of more than 100, including more than 80 attorneys. The Office of General Counsel interprets laws affecting Department operations, drafts and reviews regulations and legislation, represents the Department in litigation, and advises the Secretary on policy issues. The Office also manages the Department's ethics and regulations programs.

In 1997, President Clinton asked Ms. Winston to head the President's Initiative on Race, where she served as Executive Director until September 1998. The Race Initiative engaged many diverse groups, communities, regions, and various industries in a search for understanding the causes of racial tension in our country. Through thoughtful study, constructive dialogue, and positive action, the Race Initiative addressed the continuing challenge of how Americans can live

and work together more productively. In January 1998, Ms. Winston resumed her leadership as General Counsel to the Department of Education.

In March 2000, the President named Ms. Winston the Acting Under Secretary for the Department of Education. As such, Ms. Winston works with the Secretary and Deputy Secretary on management policy and operations, and represents the Department on the President's Management Council.

Previously, Ms. Winston served as an Associate Professor of Law at American University in Washington, D.C. where she taught civil procedure and civil rights courses. She also worked as a lawyer on a variety of civil rights, race, and gender equity issues. Formerly, she was the Deputy Director for Public Policy at the Women's Legal Defense Fund in Washington, Deputy Director of the Lawyers' Committee for Civil Rights Under Law, and Assistant General Counsel for Educational Equity at the U.S. Department of Education. She was Executive Assistant and Legal Counsel to the Chair of the Equal Employment Opportunity Commission and Special Assistant to the Director of the Office for Civil Rights in the former U.S. Department of Health, Education, and Welfare.

Ms. Winston has received a number of honors and citations, including the prestigious Thurgood Marshall Award, recognizing her lifetime commitment to the cause of civil rights. She has served on numerous boards and committees and has authored many articles on civil rights, employment discrimination, and women of color in the workplace. Ms. Winston is a graduate of the Georgetown University Law Center and Howard University.

October 2000

Meeting Format

INAUGURAL MEETING OF THE STEERING COMMITTEE TO ELIMINATE RACIAL AND ETHNIC DISPARITIES IN HEALTH

TO: Steering Committee Members

SUBJECT: Preparing for October 6 Steering Committee Meeting

We are looking forward to our October 6th meeting and the opportunity it affords us to shape a common vision to eliminate racial and ethnic health disparities in the U.S. This memo is intended to help you prepare for the day's activities. The day will consist of a meeting that will center around a facilitated discussion (9am-11:30 am), which will be followed by a press event (11:30am-12:30p.m.) and then lunch (12:30pm-1:30pm).

In the first session, we anticipate a lively and engaging discussion. After opening remarks, members will be asked to introduce themselves and briefly address the following questions (approximately 2 minutes per member):

- ***How do you view your own sector's role with regard to the elimination of racial and ethnic health disparities? What is your sector already doing to address this major national concern?***

After all members have introduced themselves, we anticipate the rest of the discussion to be more free-flowing and to address the following questions:

- ***How can we get your sector and other members and segments of society more involved in helping us to eliminate racial and ethnic health disparities so that we can really make a difference?***

- ***How should we go about building, supporting, and strengthening an effective coalition to eliminate racial and ethnic health disparities? What role should APHA, DHHS, other Federal entities, and the Steering Committee play?***

Following the meeting, we will be holding a press event and signing ceremony at which we anticipate all Steering Committee members signing the Call to the Nation to Eliminate Racial and Ethnic Disparities in Health. The media will have an opportunity to ask questions of Committee members during the press event/signing ceremony and will also be free to follow up with members on an individual basis after the ceremony.

Lunch will be served at the conclusion of the signing ceremony.

If you have any questions, please feel free to contact Dr. Richard Levinson at the American Public Health Association at (202) 777-2443 (richard.levinson@apha.org) or Ms. Amandeep K. Matharu at the U.S. Department of Health and Human Services at (202) 401-7945 (amatharu@osophs.dhhs.gov).

Call to the Nation

to Eliminate Racial and Ethnic Disparities in Health

The twentieth century witnessed unprecedented improvements in the health and longevity of millions of people in the United States. Dramatic advances in medicine, public health, and the overall standard of living have led to many important health gains. Yet, despite decades of progress in these areas and significant achievements in civil rights protections, health disparities have persisted and, in many cases, have worsened. Racial and ethnic minorities - many of whom are economically disadvantaged - have not shared fully in this progress.

Statistics amply demonstrate the disproportionately greater burden of disease, disability, and death experienced by racial and ethnic minorities in this country. As employers face a tight labor market and changing demographics in the labor force, this country's ability to effectively address health disparities also becomes critical to the continued health of the economy. Invisible in the numbers is the suffering of those who experience a disproportionate burden of health problems.

Previous efforts to address the tragic legacy of these health inequities have not fully engaged the entire country. Given the broad roots of this problem, it is only with the combined efforts of all sectors and disciplines of society - the public and private sectors, business and labor, non-profit and community-based organizations, educational institutions, the faith community, and others - that we can hope to eliminate racial and ethnic health disparities. Major institutions, all levels of government, communities, and individuals - both within and outside of the health care arena - must come together to amplify our knowledge, talent, and resources to reach this goal. Unless we focus our collective attention *as a nation* on racial and ethnic disparities in health, we can never hope to eliminate them

Thus, at the beginning of a new millennium, we are issuing this Call to the Nation to Eliminate Racial and Ethnic Disparities in Health with the hope that organizations and individuals throughout the country will endorse and commit to achieving this historic goal. We are calling for the creation of a national coalition with an inclusive, diverse membership to lead this charge. And, we are calling upon this new national coalition to develop and implement a national strategy to eliminate racial and ethnic health disparities in the United States.

As we experience the longest economic expansion in U.S. history, we believe the elimination of racial and ethnic disparities in health is a worthy, ground-breaking, and achievable goal for our prosperous and energetic nation. Now is the time to ensure that current and future generations of *all* Americans are healthier, happier, and more productive. With much enthusiasm, we urge others to join with us as we embark on this momentous undertaking.

[Signatures of Steering Committee members]

We support the Call to the Nation to Eliminate Racial and Ethnic Disparities in Health and sign on as members of the National Coalition.

[Signatures of new Coalition members]

HEALTHY PEOPLE 2010 PUBLICATIONS

Healthy People Information Line
1-800-367-4725

Healthy People 2010: Understanding and Improving Health

Explains the context, goals, background, and Leading Health Indicators for Healthy People 2010. 70 pages (Stock Number 017-001-00543-6). For sale by the U.S. Government Printing Office, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954; (202) 512-1800. $9
This publication is also available on the Internet at www.health.gov/healthypeople.

Healthy People 2010: Conference Edition, Volumes I and II

Includes *Understanding and Improving Health*, *Objectives for Improving Health*, and *Tracking Healthy People 2010*. Explains the context, goals, background, and Leading Health Indicators for Healthy People 2010. Sets national objectives for the decade to increase the length and quality of healthy life and eliminate health disparities for all Americans. 1244 pages. Limited number of copies available from ODPHP Communication Support Center, P.O. Box 37366, Washington, DC 20013-7366; (301) 468-5960. $22 (B0074).
This publication is also available on the Internet at www.health.gov/healthypeople.

Healthy People 2010: Individual Chapters

Available from ODPHP Communication Support Center, P.O. Box 37366, Washington, DC 20013-7366
(301) 468-5960. $2 per chapter.

1. Access tp Quality Health Services (B0073a)
2. Arthritis, Osteoporosis, and Chronic Back Conditions (B0073b)
3. Cancer (B0073c)
4. Chronic Kidney Disease (B0073d)
5. Diabetes (B0073e)
6. Disability and Secondary Conditions (B0073f)
7. Educational and Community-Based Programs (B0073g)
8. Environmental Health (B0073h)
9. Family Planning (B0073i)
10. Food Safety (B0073j)
11. Health Communication (B0073k)
12. Heart Disease and Stroke (B0073l)
13. HIV (B0073m)
14. Immunization and Infectious Diseases (B0073n)
15. Injury and Violence Prevention (B0073o)
16. Maternal, Infant, and Child Health (B0073p)
17. Medical Product Safety (B0073q)
18. Mental Health and Mental Disorders (B0073r)
19. Nutrition and Overweight (B0073s)
20. Occupational Safety and Health (B0073t)
21. Oral Health (B0073u)
22. Physical Activity and Fitness (B0073v)
23. Public Health Infrastructure (B0073w)
24. Respiratory Diseases (B0073x)
25. Sexually Transmitted Diseases (B0073y)
26. Substance Abuse (B0073z)
27. Tobacco Use (B0073aa)
28. Vision and Hearing (B0073bb)

Healthy People 2010 CD-ROM

This CD-ROM contains *Healthy People 2010: Understanding and Improving Health* and *Healthy People 2010: Conference Edition, Volumes I and II.*
Available from ODPHP Communication Support Center, P.O. Box 37366, Washington, DC 20013-7366
(301) 468-5960. $5 (B0071).

Healthy People 2010 Fact Sheet (1999)

Summarizes the development of the Healthy People 2010 objectives. 2 pages.
Available from ODPHP Communication Support Center, P.O. Box 37366, Washington, DC 20013-7366
(301) 468-5960. (B0059A) No charge.

For express mail information or questions regarding orders from the ODPHP Communication Support Center, please call (301) 468-1273, ext 243 or 5058.

rev 2/25/00

NEW HEALTHY PEOPLE 2010 PUBLICATIONS

(Available from GPO in print and on the Web mid-November 2000)

Understanding & Improving Health (second edition) - This short volume explains the history of Healthy People 2010 and the overall Healthy People initiative, the model on which Healthy People is based, how to use Healthy People as a systematic approach to health improvement, and the Leading Health Indicators. The text of this publication is also included in the second edition of *Healthy People 2010.* This publication will be available for sale from the Government Printing Office (GPO) (202) 512-1800. Stock number 017-001-00-550-9, cost $10. Available on the Web at www.health.gov/healthypeople.

Healthy People 2010 (second edition, in two volumes) - This edition of Healthy People 2010 supercedes the January 2000 conference edition. Most objectives are unchanged, but some have been reworded. Editorial changes and new data have been added to certain objectives. Updates to baselines and population group data tables may have resulted in revisions to the targets. Additionally, a few developmental objectives are now measurable. This two-volume set will be available for sale from the Government Printing Office (202) 512-1800. Stock number 017-001-00547-9, cost $70/set. Available on the Web at www.health.gov/healthypeople.

Tracking Healthy People 2010 - This statistical compendium provides information on measuring the objectives, technical notes, and operational definitions. This publication will be available for sale from the Government Printing Office. Stock number 017-001-00548-7, cost $66/copy. Available on the Web at www.cdc.gov/nchs/hphome.htm.

Healthy People 2010 CD-ROM - This CD-ROM will contain electronic files (Microsoft Word, HTML, PDF, and RTF) of the second edition of *Understanding & Improving Health*, *Healthy People 2010* (second edition, in two volumes), and *Tracking Healthy People 2010.* This CD-ROM will be available for sale from the Government Printing Office (202) 512-1800. Stock number 017-001-00549-5, cost $19 each.

Please call or email Gloria Barnes at (202) 401-0745 (gbarnes@osophs.dhhs.gov) if you have any questions or need additional information.

Since 1871, the Surgeon General of the United States has been the nation's leading spokesperson on matters of public health, serving as a principal advisor to the President and Congress and communicating directly to the American people about the best available science. As the 16th Surgeon General in our nation's history, Dr. David Satcher also oversees the 6,000-plus person Commissioned Corps of the U.S. Public Health Service, a uniformed cadre of health professionals on call 24 hours a day, 7 days a week, in the event of a public health emergency. He is only the second person in history to simultaneously hold the position of Assistant Secretary for Health.

For more information please visit the Office of the Surgeon General webpage at:

www.surgeongeneral.gov

Resources

National Health Information Center
800-336-4797
nhic-nt.health.org

The National Health Information Center (NHIC) is a health information referral service that puts health professionals and consumers who have health questions in touch with organizations that are best able to provide answers.

healthfinder
www.healthfinder.gov

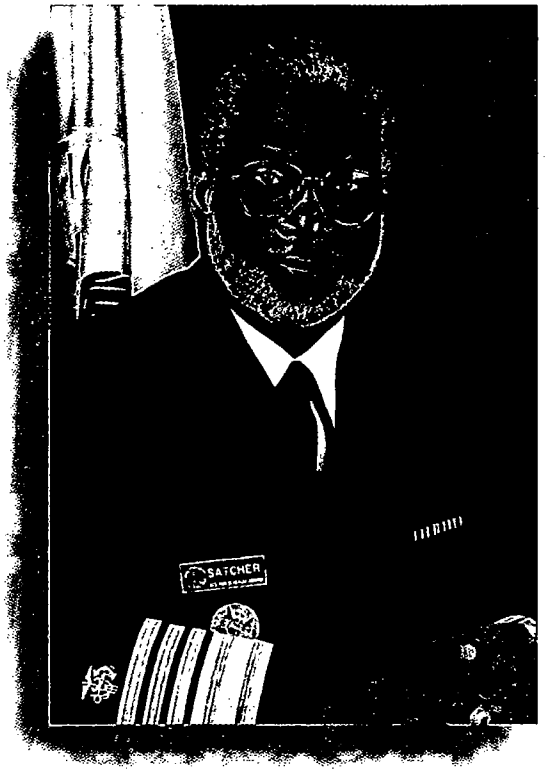
healthfinder® is a free gateway to reliable consumer health and human services information developed by the U.S. Department of Health and Human Services. **healthfinder®** can lead you to select online publications, clearinghouses, databases, websites, and support and self-help groups, as well as the government agencies and not-for-profit organizations that produce reliable information for the public.

Healthy People 2010
www.health.gov/healthypeople

Healthy People 2010 is the nation's health plan for the first decade of the 21st century and provides the nation with a wide range of public health opportunities.

U.S. Department of Health and Human Services
Office of Public Health and Science
Washington, DC 20201
April 2000

The Surgeon General's Priorities



"I would most like to be remembered as the Surgeon General who listened to the American people and responded with effective programs."

David Satcher, M.D., Ph.D.

A Balanced Community Health System

Our nation must move toward a balanced community health system that balances health promotion, disease prevention, early detection, and universal access to quality care. That system must be grounded at the community level, calling on the serious involvement of civic and other local groups, the criminal justice system, community schools, and faith-based organizations. It must support a partnership between public health and medicine. And, finally, it must be supported by a balanced research agenda.

We must address the persistent problems of access, cost, and quality that plague this nation and that have become major barriers to health. When people are left out of the system—for whatever reason—we miss crucial opportunities to put prevention into practice.

Our system must:

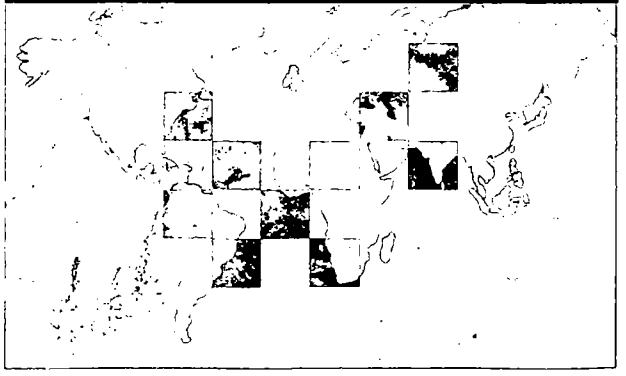
- Provide equitable access to quality health care services
- Ensure that every child has an opportunity for a healthy start in life
- Promote healthy lifestyles
- Offer new approaches to mental health

A Global Approach to Public Health

Our public health perspective calls for new and innovative global partnerships. Because we live in a global village, we must work together with other nations as global partners to improve world health overall. Thanks to phenomenal advances in transportation, international trade, and technology, we are living in an age where two million people, innumerable products, and countless ideas cross international borders every day.

Several areas of global health concern:

- Polio eradication
- Emerging and re-emerging infectious diseases
- Bioterrorism
- Food and blood safety
- Violence and injury prevention
- Tobacco control



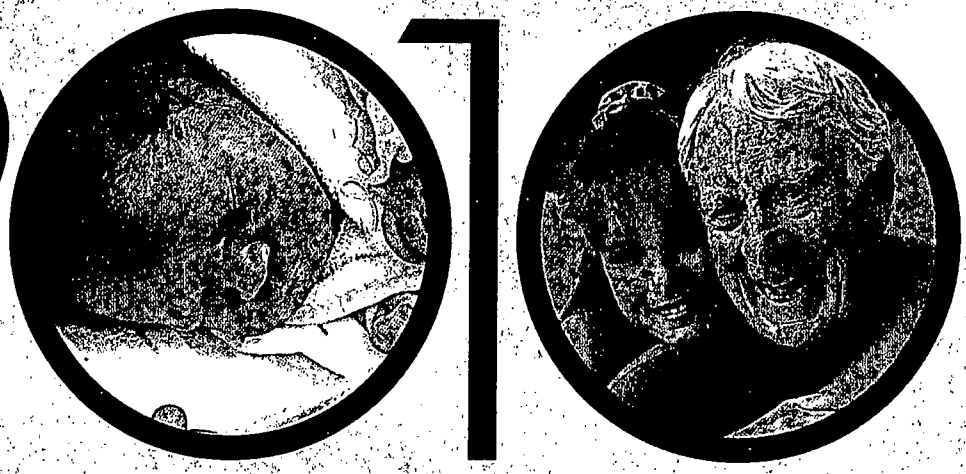
Elimination of Racial & Ethnic Disparities in Health

This priority to eliminate racial and ethnic disparities in health by 2010 is an outgrowth of the President's Race Initiative and parallels one of the two goals of "Healthy People," the Department's Initiative that sets the nation's health agenda every 10 years. What we have done through this initiative is to make the first-ever commitment in the history of our government to eliminate, not just reduce, the health disparities between majority and minority populations. We operate on the principle that to the extent we care for the health needs of the most vulnerable among us, we do the most to protect the health of the nation.

Our six areas of initial focus:

- Infant mortality
- Child and adult immunizations
- HIV/AIDS
- Cardiovascular disease
- Breast and cervical cancer screening and management
- Diabetes complications

HEALTHY PEOPLE 2010



Understanding and Improving Health

Partnerships for Health in the New Millennium
January 24-28, 2000

Clinton Presidential Records
Digital Records Marker

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Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

DHHS Initiative to Eliminate Racial and Ethnic Disparities in Health
Overview

In February 1998, as part of his Initiative on Race, the purpose of which was to build One America for the 21st century, President Clinton committed the Nation to an ambitious goal: by the year 2010, eliminate racial and ethnic disparities in health outcomes in six health focus areas, while continuing the progress we have made in improving the overall health of the Nation.

When the President announced this Initiative, he noted that there was much good news for celebration. 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 this epidemic. However, the President also noted that, while our Nation has made tremendous improvements in improving the health status of Americans in general, racial and ethnic minorities have not shared in the fruits of our progress. For example, infant mortality rates are twice as high for African American as Whites. Cancer fatalities are disproportionately high among Latinos and Blacks. Vietnamese women are five times more likely to have cervical cancer than White women. Native Americans suffer higher rates of diabetes and heart disease. Overall, minorities are less likely to be immunized, less likely to be routinely tested for cancer, less likely to have regular check-ups.

One study, published by Georgetown University in the *New England Journal of Medicine* and which received widespread attention, concluded that physicians refer Blacks and women to heart specialists for cardiac catheterization tests only 60% as often as they would prescribe the procedure for white male patients. The study suggested that the differences were the consequences of race and sex bias. The study was based on a survey sample of 720 primary care physicians. Because the survey sample was so large, it represented one of the best attempts so far to document racial attitudes of physicians as a factor in the poorer health of African Americans.

It was reports and studies like this one that caused the President to charge HHS, under the leadership of Secretary Donna Shalala, to lead a national effort to close these gaps in health status. He called upon us, by the year 2010, to **eliminate racial and ethnic disparities in the following six health issue areas**:

1. **infant mortality**
2. **cancer screening and management**
3. **cardiovascular diseases**
4. **diabetes**
5. **HIV infection/AIDS**
6. **child and adult immunization**

These six health focus areas were selected because they reflect areas of disparity that are known to affect multiple racial and ethnic populations. These six areas were also selected because they are relevant and important to all minority communities across the board and because they affect

both adults and children. Furthermore, we believe that these health areas are amenable to interventions which can be influenced by HHS.

Additionally, the six health focus areas were also drawn from the *Healthy People* process. *Healthy People* is our national strategy for significantly improving the health of all Americans by establishing national health objectives across multiple health focus areas, and measuring our progress in achieving those objectives. The *DHHS Initiative to Eliminate Racial and Ethnic Health Disparities* complements *Healthy People* by developing more focused and intensified strategies aimed at closing the gap for minority groups. The lessons that we learn from this Initiative can be applied across other health focus areas and other select populations in *Healthy People 2010.*

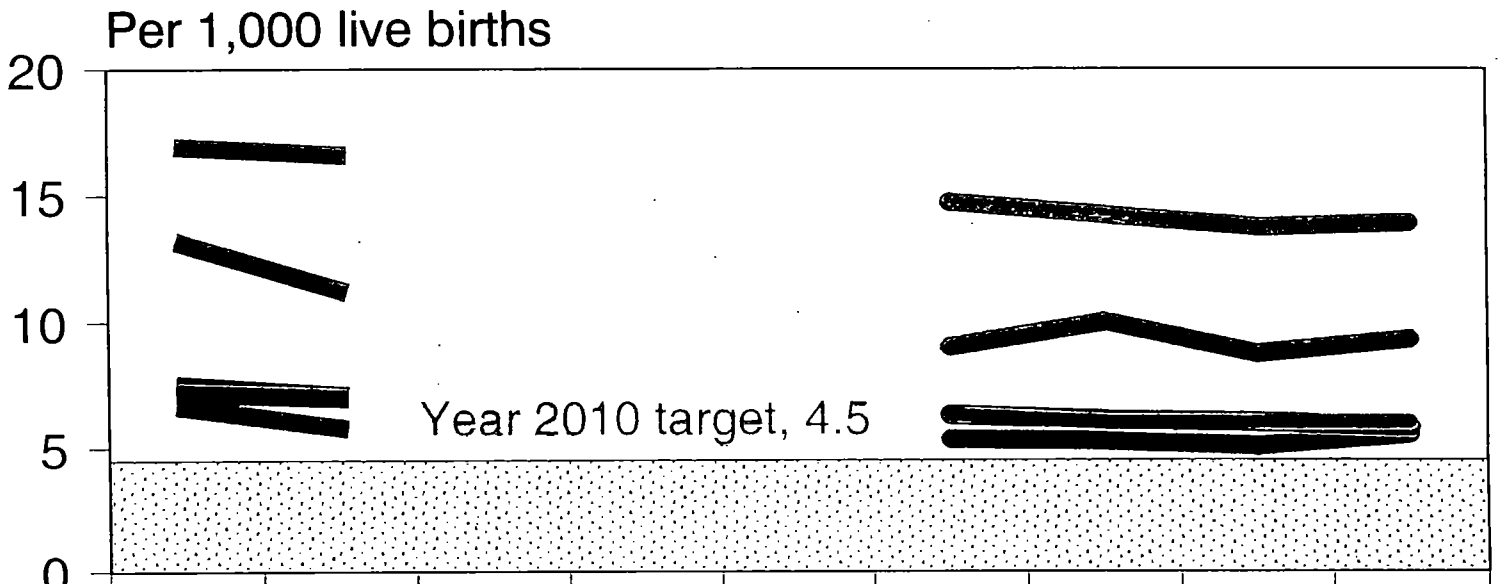
We know at HHS that eliminating health disparities is an audacious goal. A commitment to meeting this goal means that we will have to make conscious, deliberate, and sustained efforts to focus program and policy priorities on those who have the greatest need. It will also require us to take on the tough challenges posed by poverty, inadequate access to services, inequities in health care delivery, language and cultural barriers, behavioral risks, and discrimination.

Despite these challenges, we believe that the time is <u>now</u> for our Nation to commit to this audacious goal. For years, the approach to minority health in this country was to seek incremental improvements, that is, reducing rather than eliminating health disparities. But, if we are truly going to "close the gap", we must set the bar higher so that we can have meaningful impact. We must dramatically accelerate our efforts to find solutions to complex and multiple barriers to good health. We can improve the health of our Nation only if we improve the health of those who are in greatest need.

We know that HHS and the federal government cannot achieve this goal by ourselves. Since the President announced the Initiative, we have been reaching out to minority communities, public health and health professional groups, State, local and tribal governments, and many others to get their ideas for reaching this goal.

This Initiative, together with *Healthy People 2010,* are some of the most important things we can do to assure that the health of the public – that means everyone – is the best it can be. By doing so, we will be meeting one of the basic premises on which the Public Health Service was created: *by caring for the most vulnerable among us, we improve the health of all Americans.*

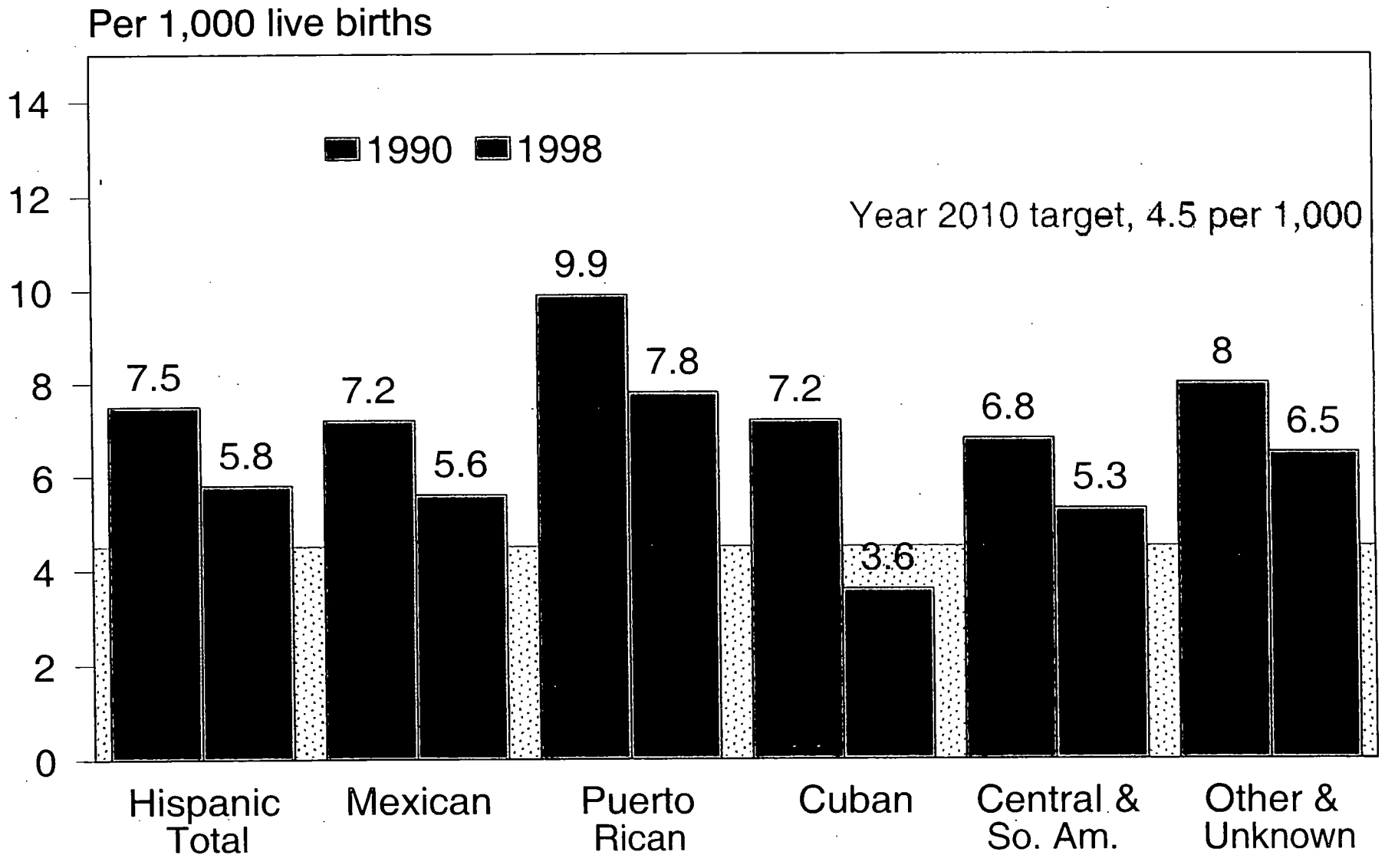
Infant Mortality Rates by race and Hispanic origin of mother



	1990	91	92	93	94	95	96	97	98
White non-Hispanic	7.2	7				6.3	6	6	6
Black non-Hispanic	16.9	16.6				14.7	14.2	13.7	13.9
Hispanic	7.5	7.1				6.3	6.1	6	5.8
Am. Indian/Alaska Native	13.1	11.3				9	10	8.7	9.3
Asian/Pacific Islander	6.6	5.8				5.3	5.2	5	5.5

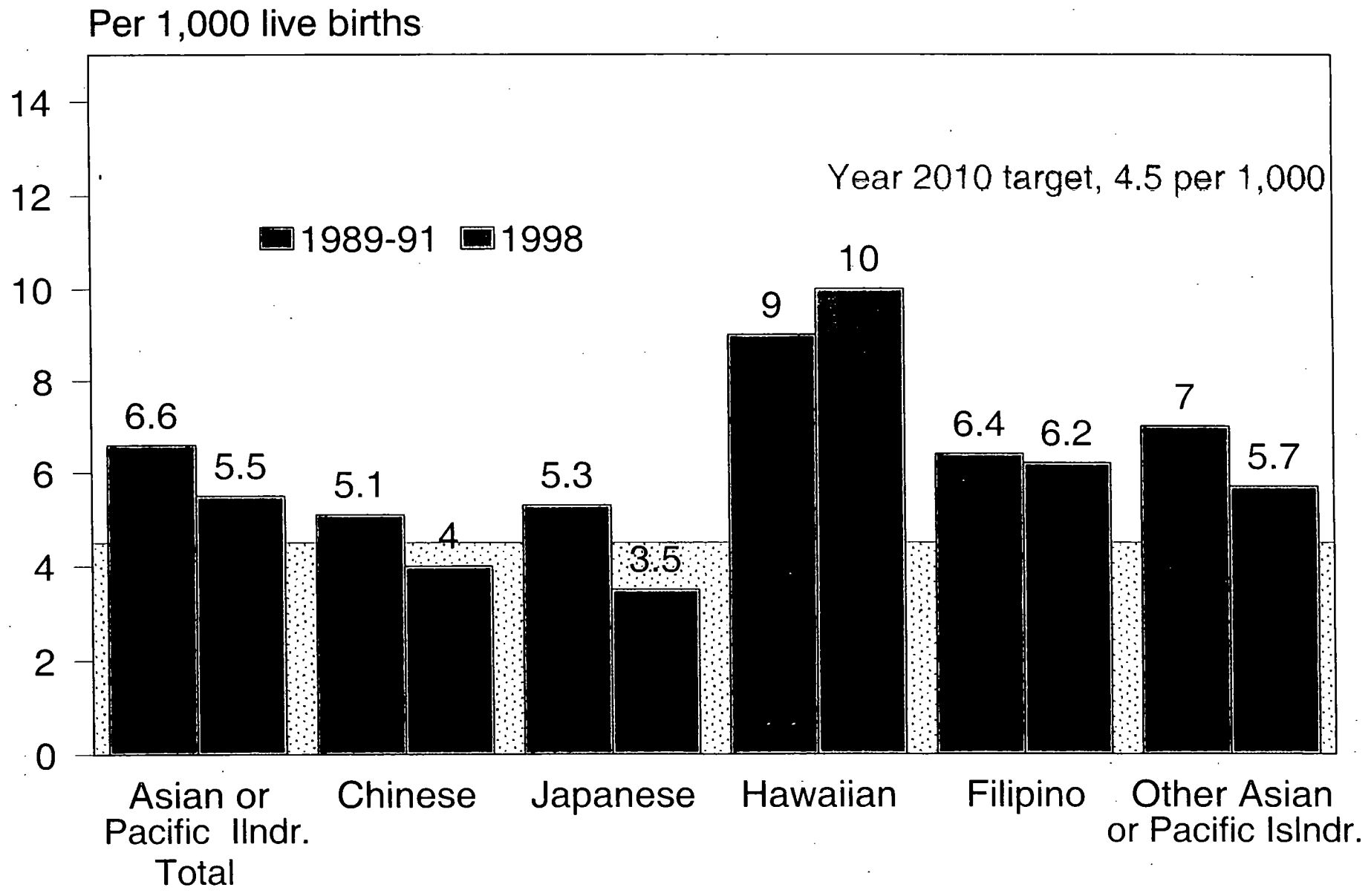
SOURCE: CDC/NCHS, National Vital Statistics System, Linked Birth-Infant Death data set

Infant Mortality Rates by Hispanic Origin of Mother



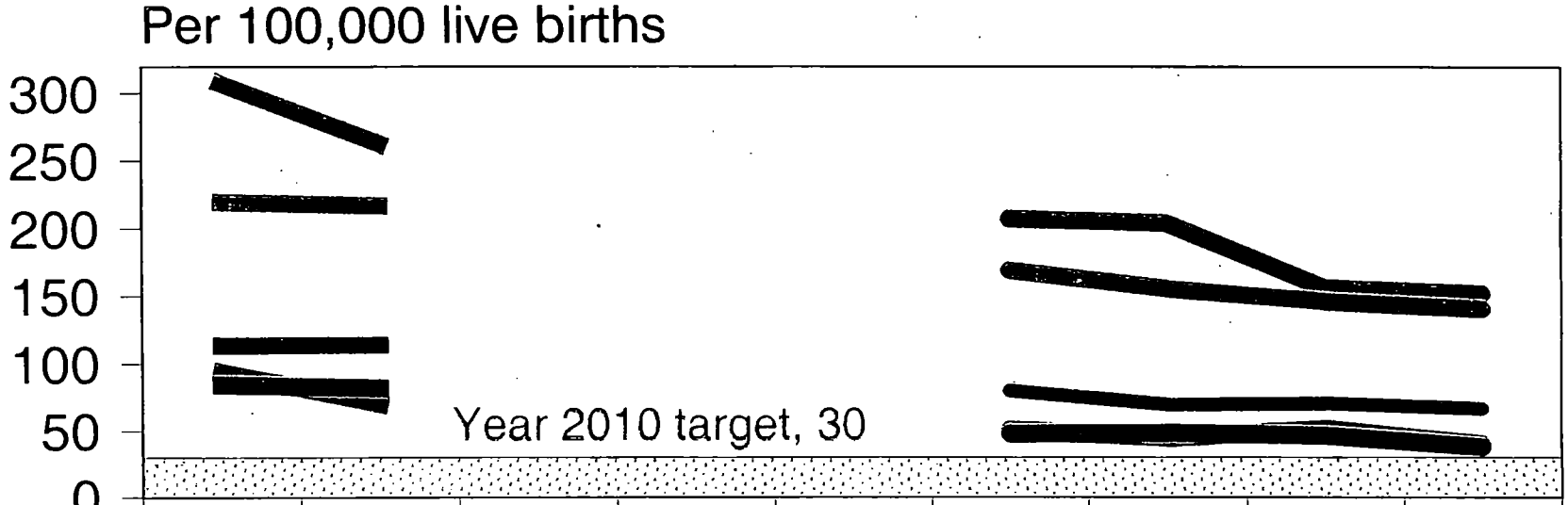
SOURCE: CDC/NCHS, National Health Interview Survey

Infant Mortality Rates by Origin of Mother



SOURCE: CDC/NCHS, National Health Interview Survey

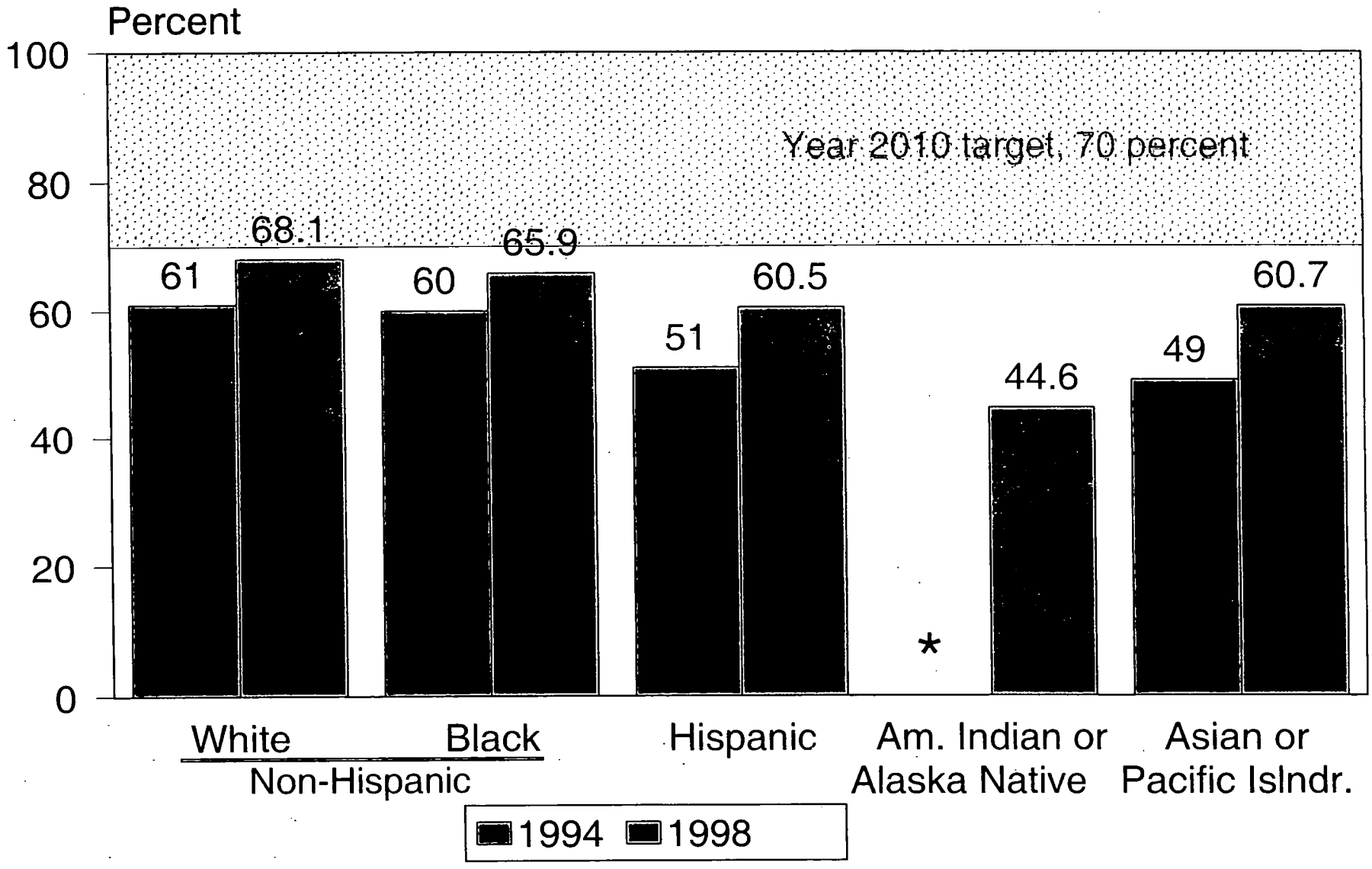
SIDS mortality rates by race and Hispanic origin of mother



	1990	91	92	93	94	95	96	97	98
White non-Hispanic	113.7	113.9				79.8	69.5	70.7	66.4
Black non-Hispanic	219.3	216.7				168.8	155.3	145.7	140
Hispanic	84.2	82				47.7	48.5	46.5	37.4
Indian/Alaska Native	307.3	262.6				206.6	203.3	155.6	151.5
Asian/Pacific Islander	93.2	69.5				49.9	44	51.2	39.4

SOURCE: CDC/NCHS, National Vital Statistics System, Linked Birth-Infant Death data set

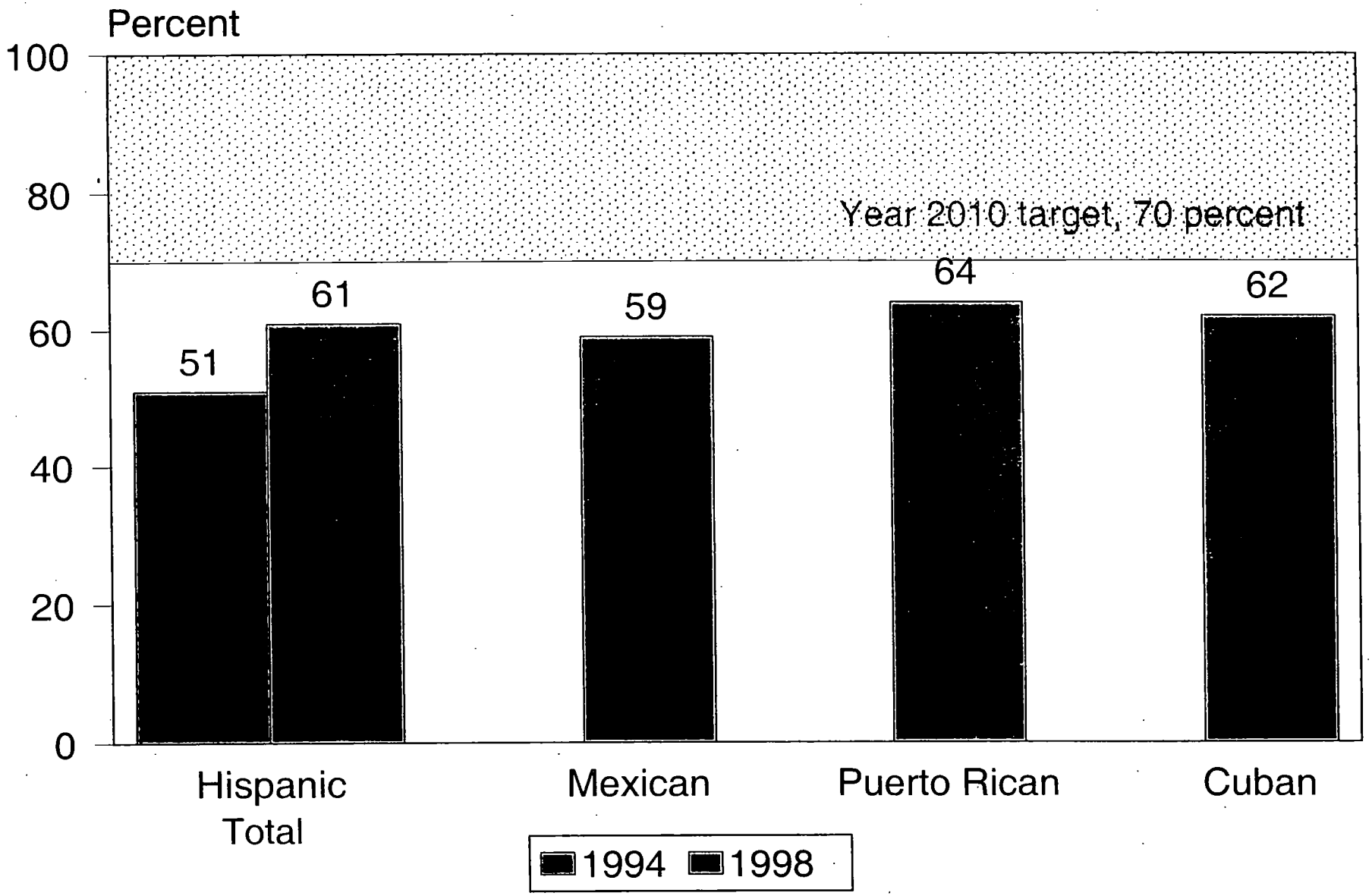
Mammogram in last two years among women ages 40 years and over (age-adjusted, 2000)



* Data are statistically unreliable

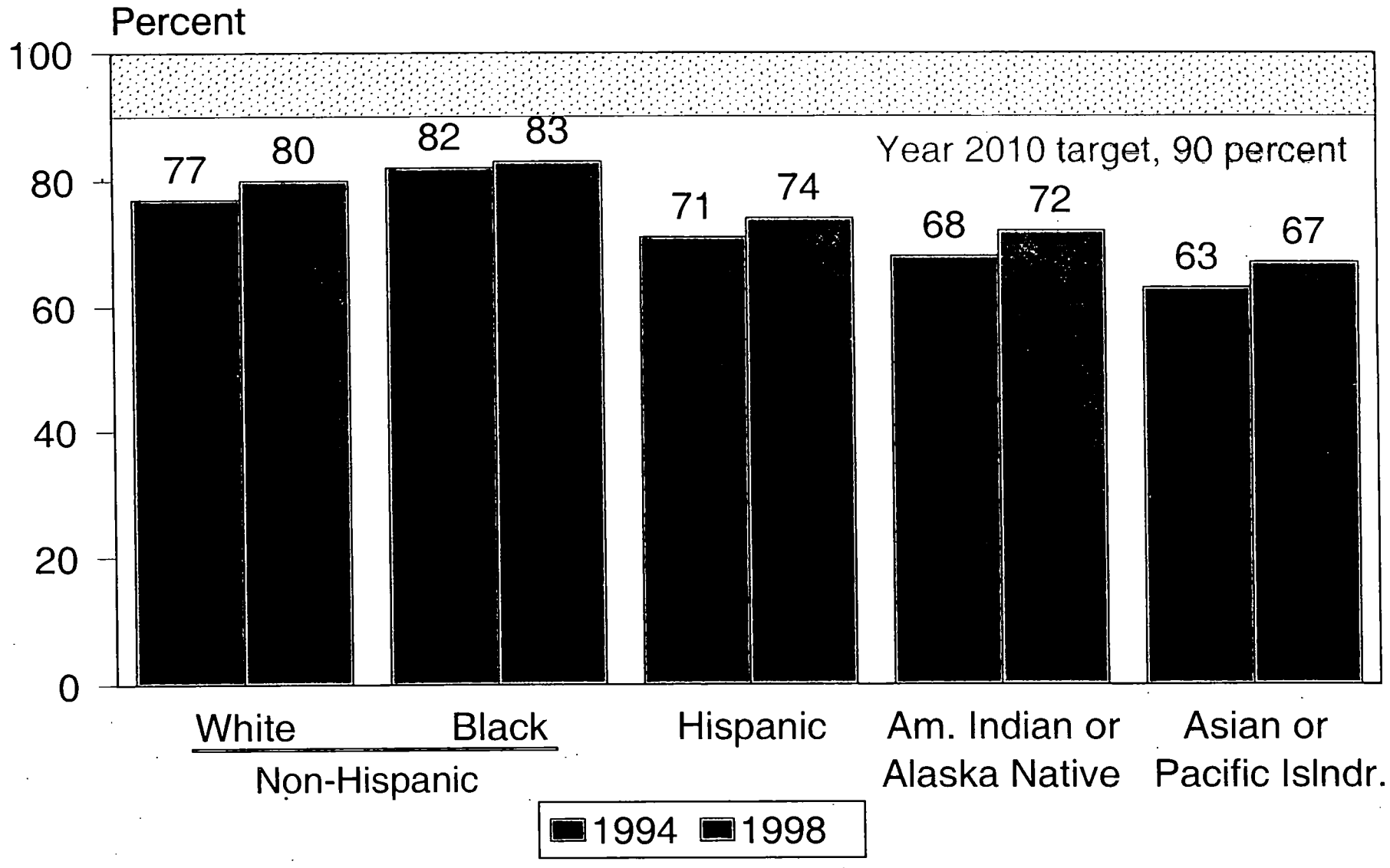
SOURCE: CDC/NCHS, National Health Interview Survey

Mammogram in last two years among women ages 40 years and over (age-adjusted, 2000)



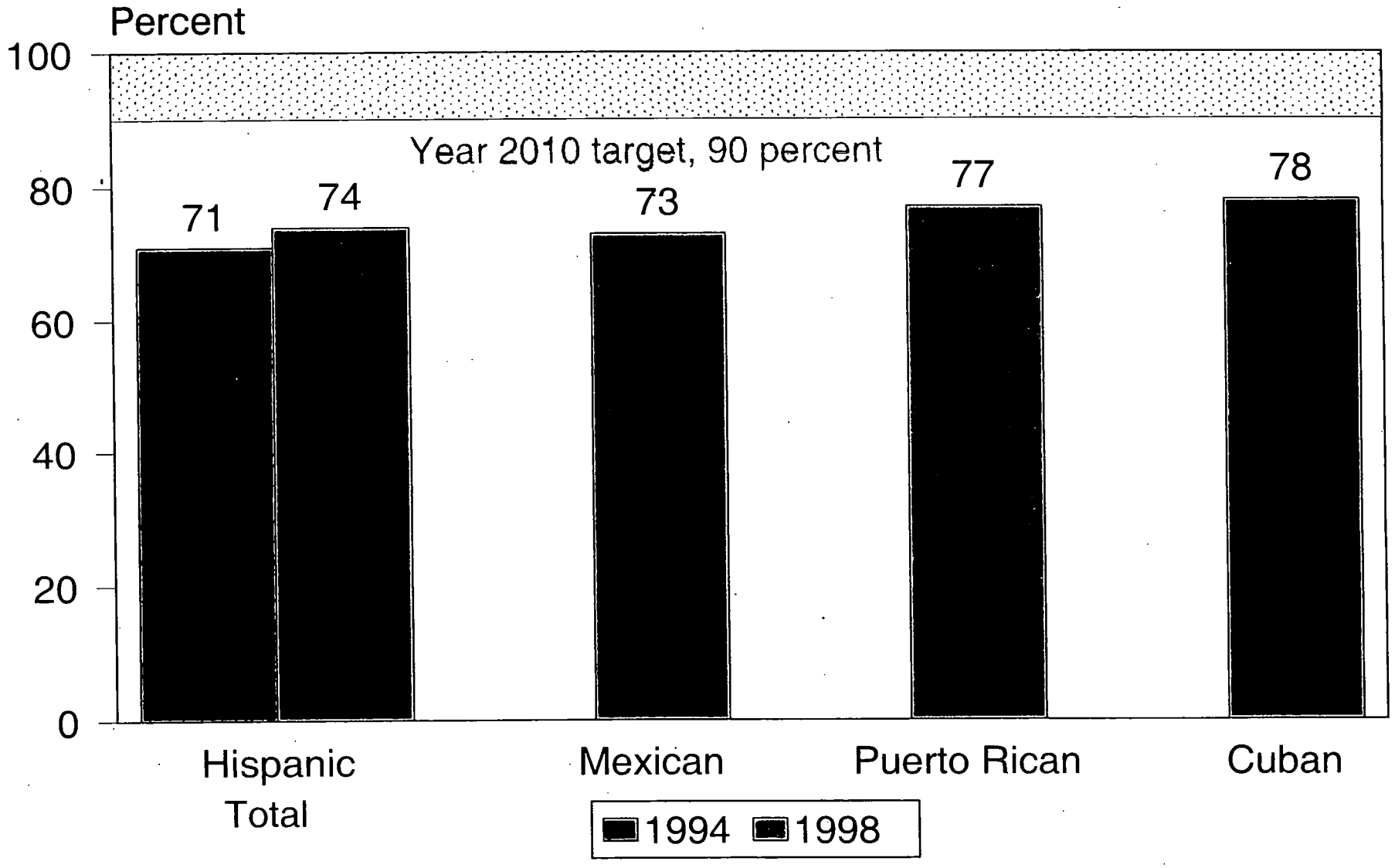
SOURCE: CDC/NCHS, National Health Interview Survey

Pap test in last three years among women ages 18 years and over (age-adjusted, 2000)



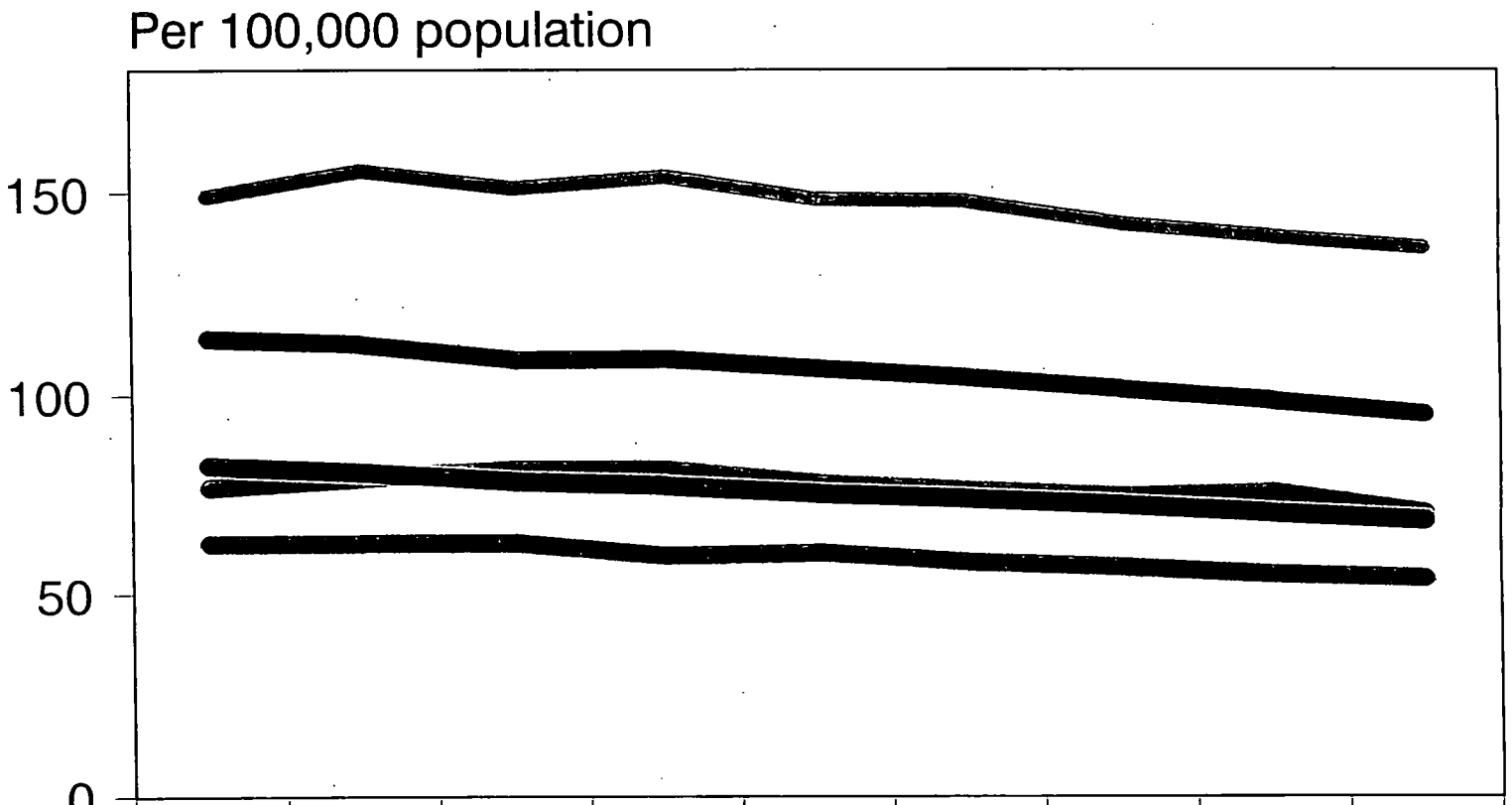
SOURCE: CDC/NCHS, National Health Interview Survey

Pap test in last three years among women ages 18 years and over (age-adjusted, 2000)



SOURCE: CDC/NCHS, National Health Interview Survey

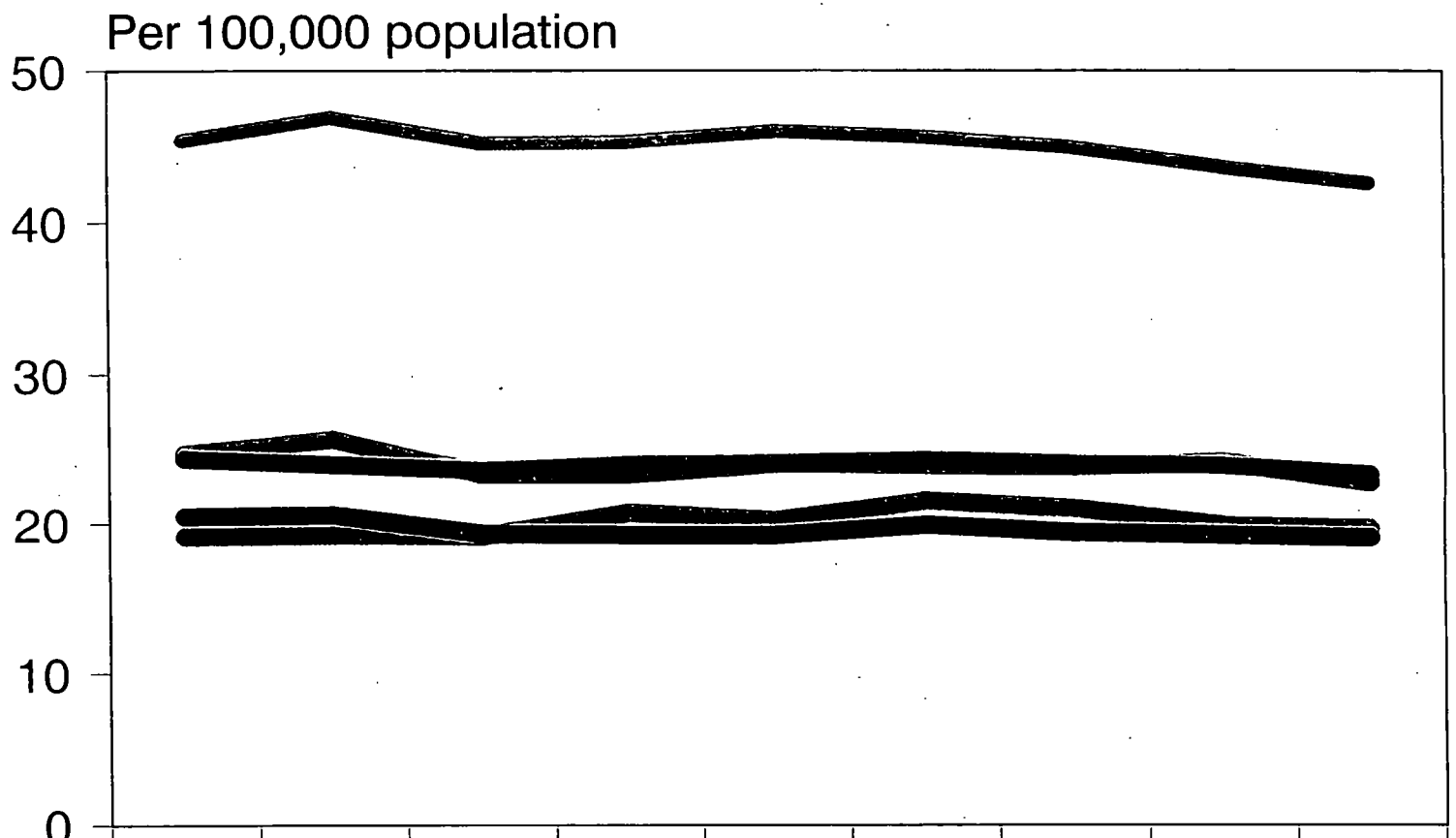
Coronary heart disease death rates (age-adjusted,1940) by race and Hispanic origin



	1990	91	92	93	94	95	96	97	98
White non-Hispanic	114	112.6	108.8	109	106.6	104.2	101.3	98.4	95.1
Black non-Hispanic	149	155.3	151	153.9	148.3	147.7	142.2	139	136.3
Hispanic	82.3	80.7	78.2	77.1	75	73.7	72.1	70.1	68.3
Am. Indian/Alaska Native	76.7	79	81.3	81.2	77.7	75.9	74.3	75.4	70.1
Asian/Pacific Islander	62.5	62.6	62.7	59.4	60.2	57.8	56.4	54.6	53.6

SOURCE: CDC/NCHS, National Vital Statistics System

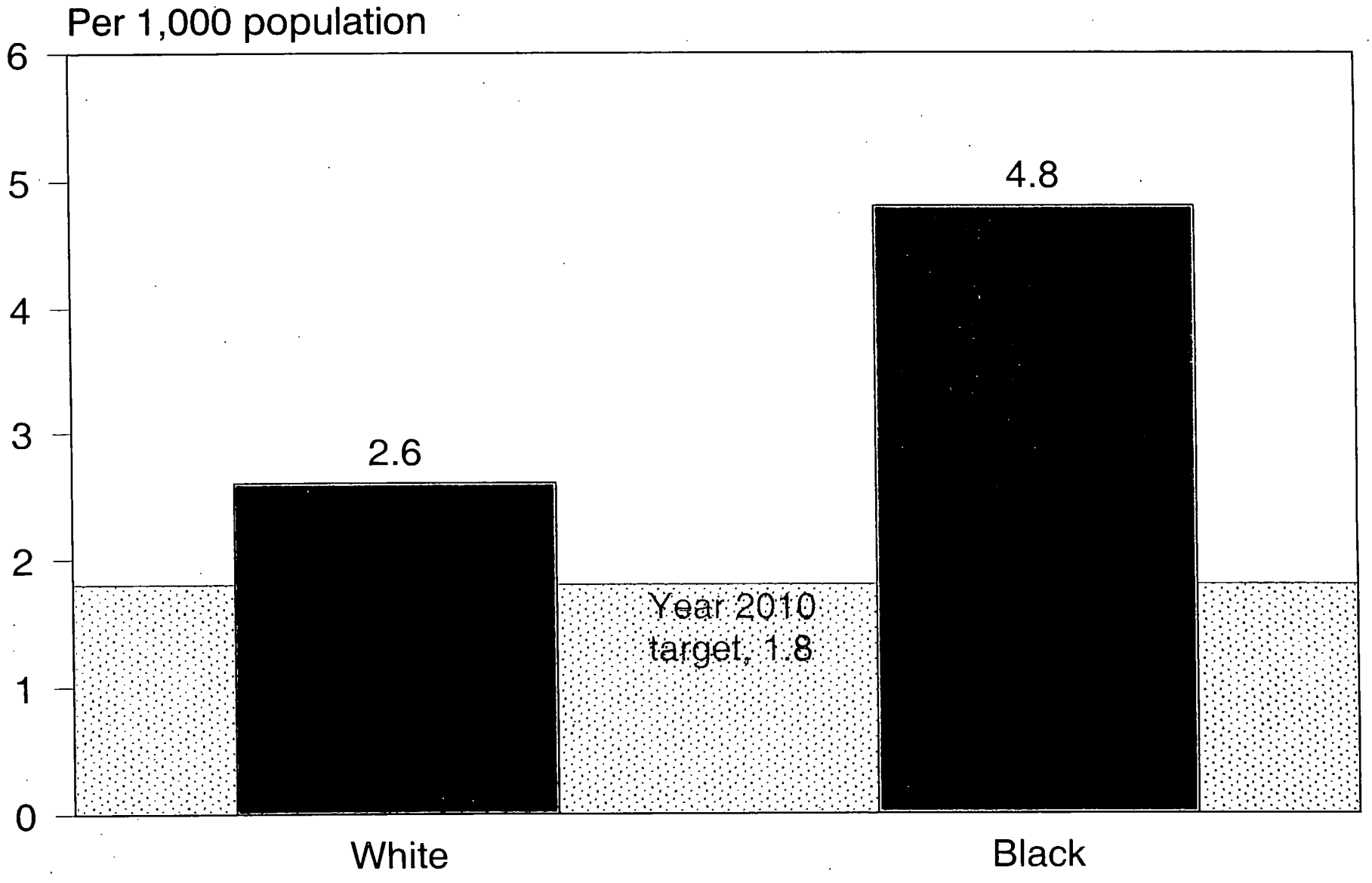
Stroke death rates (age-adjusted,1940) by race and Hispanic origin



	1990	91	92	93	94	95	96	97	98
White non-Hispanic	24.4	24	23.6	24	24.1	24.3	24	23.9	23.3
Black non-Hispanic	45.4	46.9	45.2	45.3	46	45.6	44.9	43.6	42.5
Hispanic	20.5	20.6	19.3	19.2	19.2	19.9	19.4	19.2	19
Am. Indian/Alaska Native	24.7	25.7	23.3	23.3	24	23.9	23.8	24.1	22.7
Asian/Pacific Islander	19.1	19.2	19.1	20.7	20.2	21.5	21	19.8	19.6

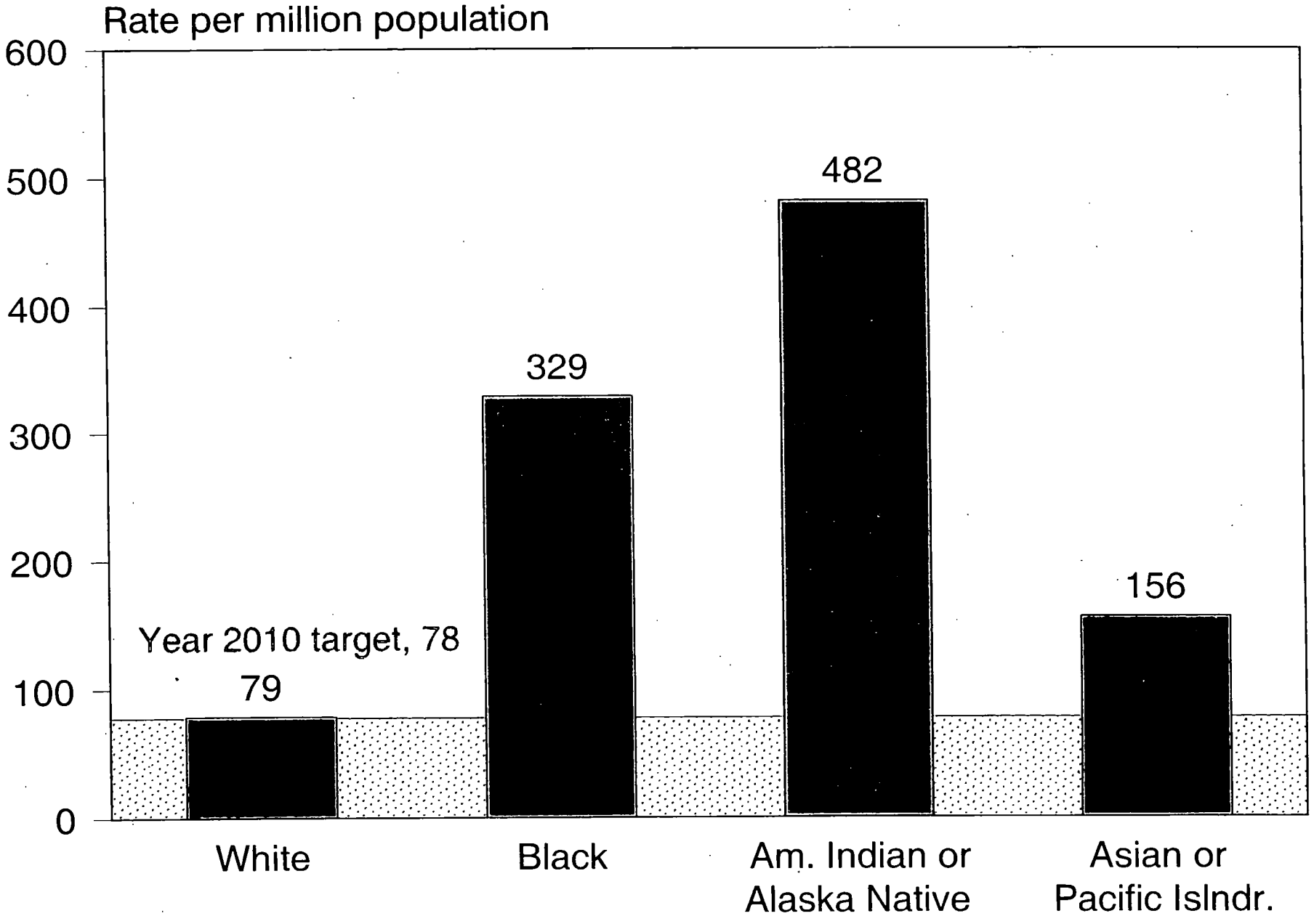
SOURCE: CDC/NCHS, National Vital Statistics System

Lower extremity amputations in persons with diabetes (age-adjusted, 2000), 1997



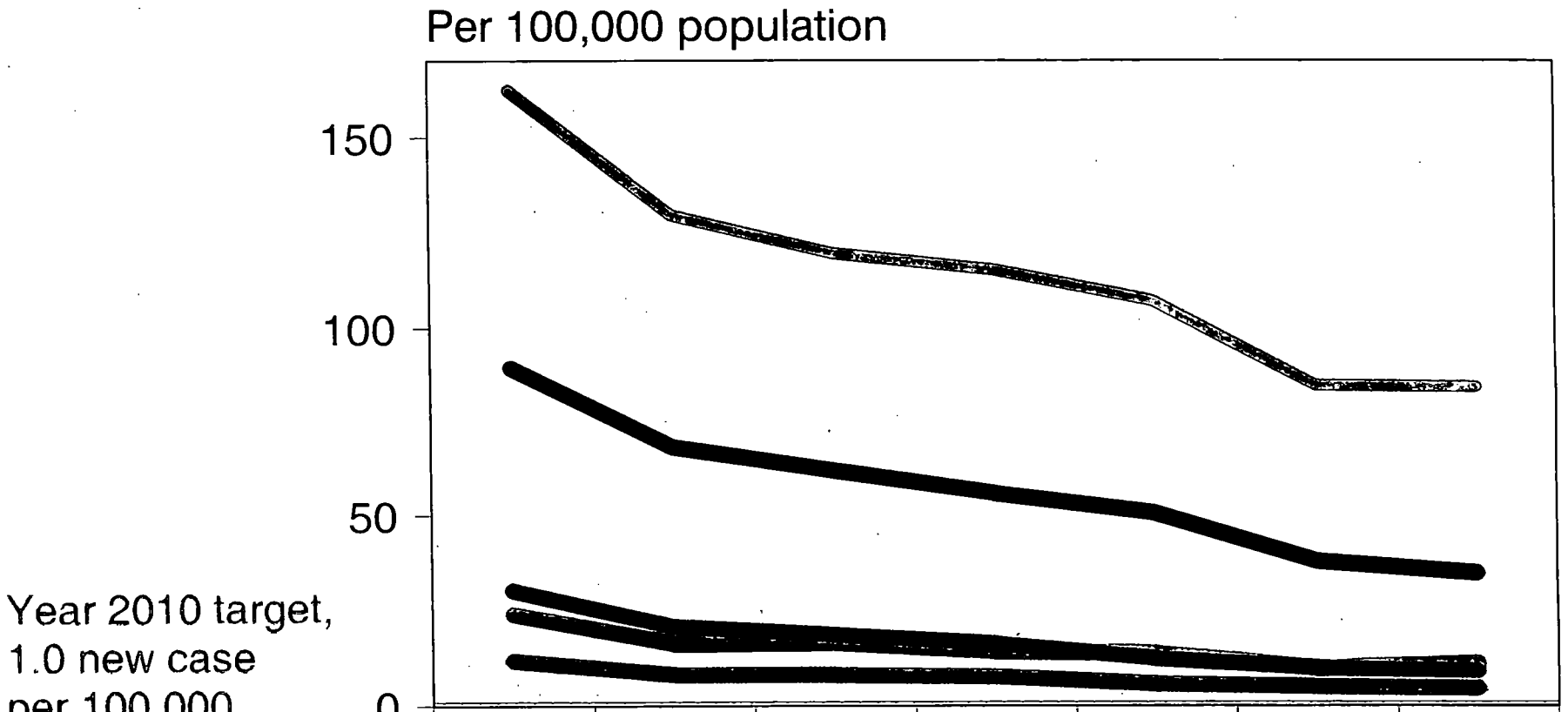
SOURCE: CDC/NCHS, National Health Interview Survey and National Hospital Discharge Survey

Diabetic persons with End-Stage Renal Disease (ESRD), 1996



SOURCE: NIH/NIDDK, U.S. Renal Data System (USRDS)

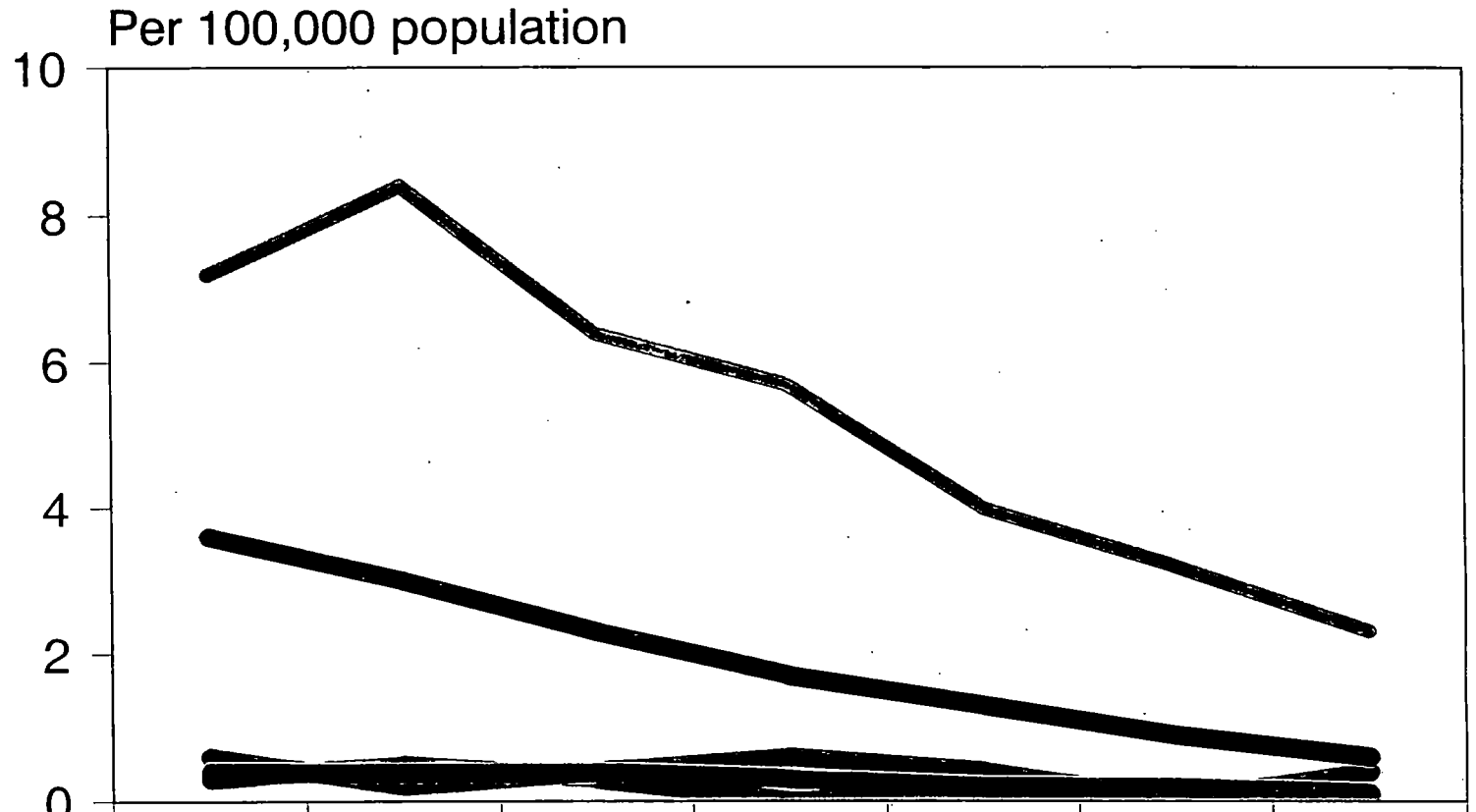
AIDS case rates among persons ages 13 years and over by race and Hispanic origin



	1993	94	95	96	97	98	99
White non-Hispanic	30.2	20.8	18.5	16.2	12.4	9.9	9
Black non-Hispanic	162.2	129.8	119.7	115.3	107.2	84.7	84.2
Hispanic	89.5	68.2	61.9	55.8	50.6	37.8	34.6
Am. Indian/Alaska Native	24	16.1	16.5	14.1	13.6	9.7	11.3
Asian or Pacific Islander	11.7	8	7.8	7.5	5.6	4.8	4.3

SOURCE: CDC/NCHSTP, Adult/Adolescent AIDS Reporting System

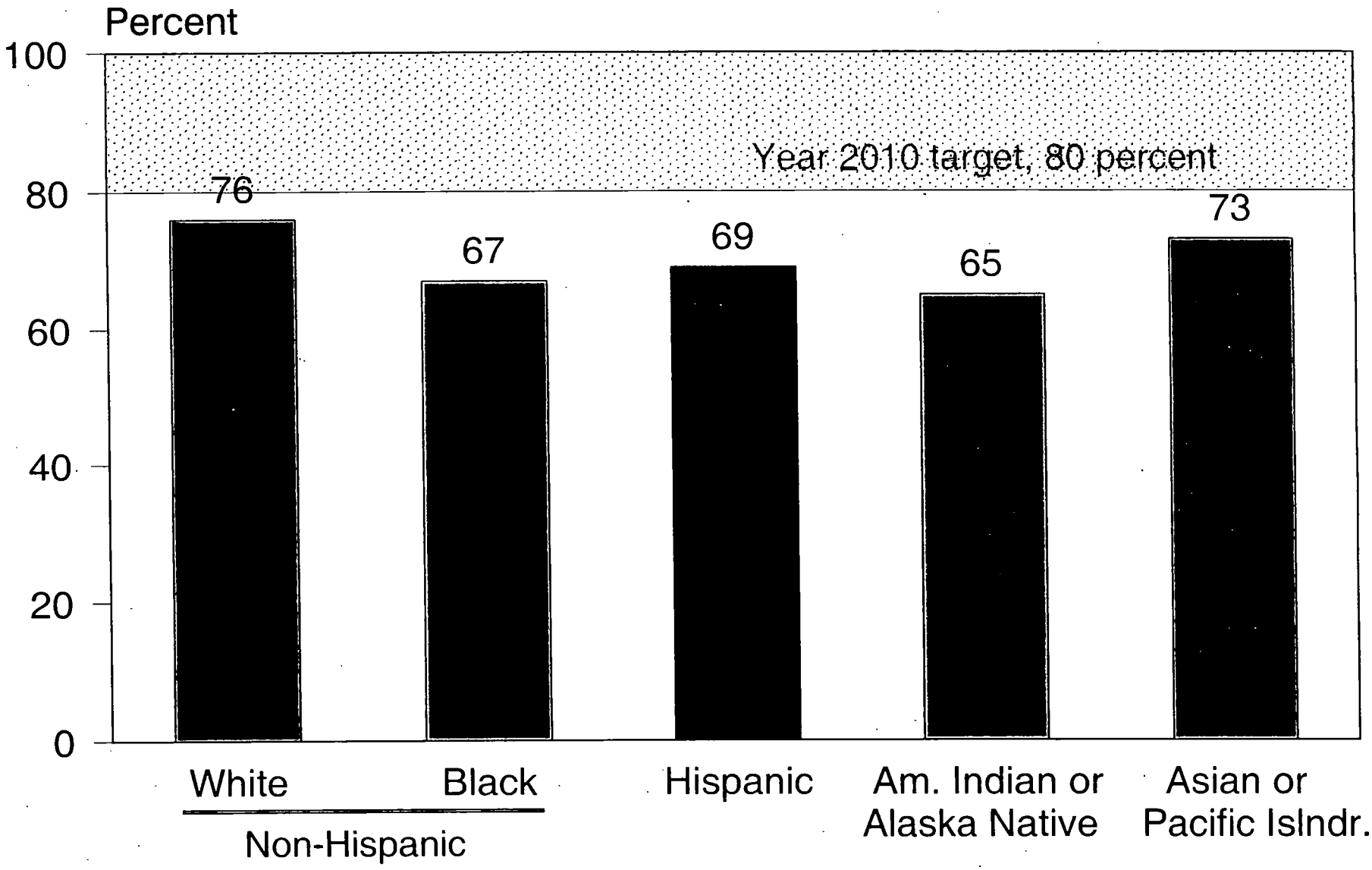
AIDS case rates among persons under age 13 years by race and Hispanic origin



	1993	94	95	96	97	98	99
White non-Hispanic	0.4	0.4	0.4	0.3	0.2	0.2	0.1
Black non-Hispanic	7.2	8.4	6.4	5.7	4	3.2	2.3
Hispanic	3.6	3	2.3	1.7	1.3	0.9	0.6
Am. Indian/Alaska Native	0.6	0.2	0.4	0.6	0.4	0	0.4
Asian/Pacific Islander	0.3	0.5	0.3	0	0.1	0.1	0.1

SOURCE: CDC/NCHSTP, Adult/Adolescent AIDS Reporting System

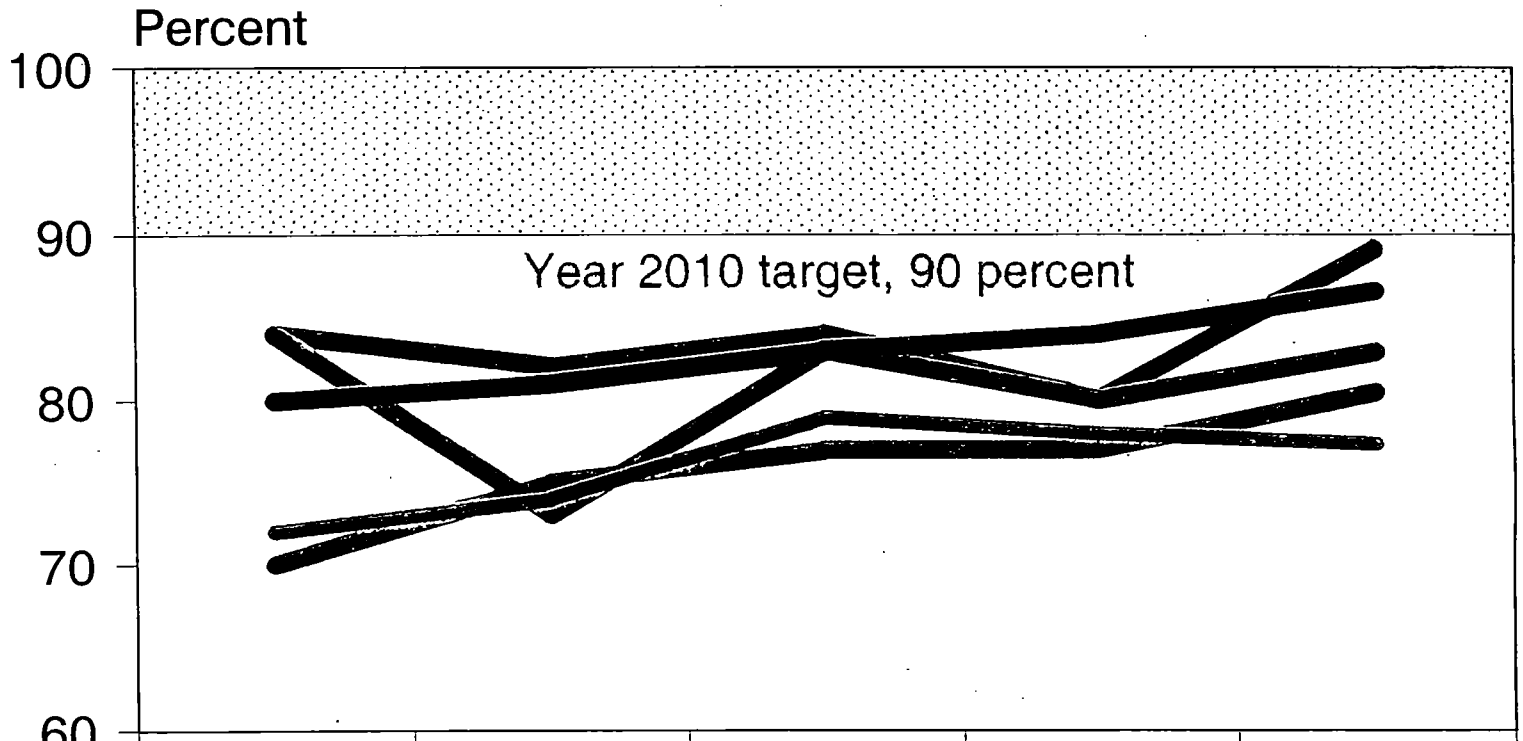
Complete childhood immunization, 1998 (4:3:1:3:3 for children 19-35 months)*



* Immunization rates are for children ages 19-35 months who have received 4 doses of DTP (diptheria, tetanus, pertussis), 3 polio, 1 MMR (measles, mumps, rubella), 3 Hep B (hepatitis B), and 3 hib (Haemophilus influenza type b).

SOURCE: CDC/NIP and NCHS, National Immunization Survey

Childhood immunization with 4 DTP/DT doses* by race and Hispanic origin

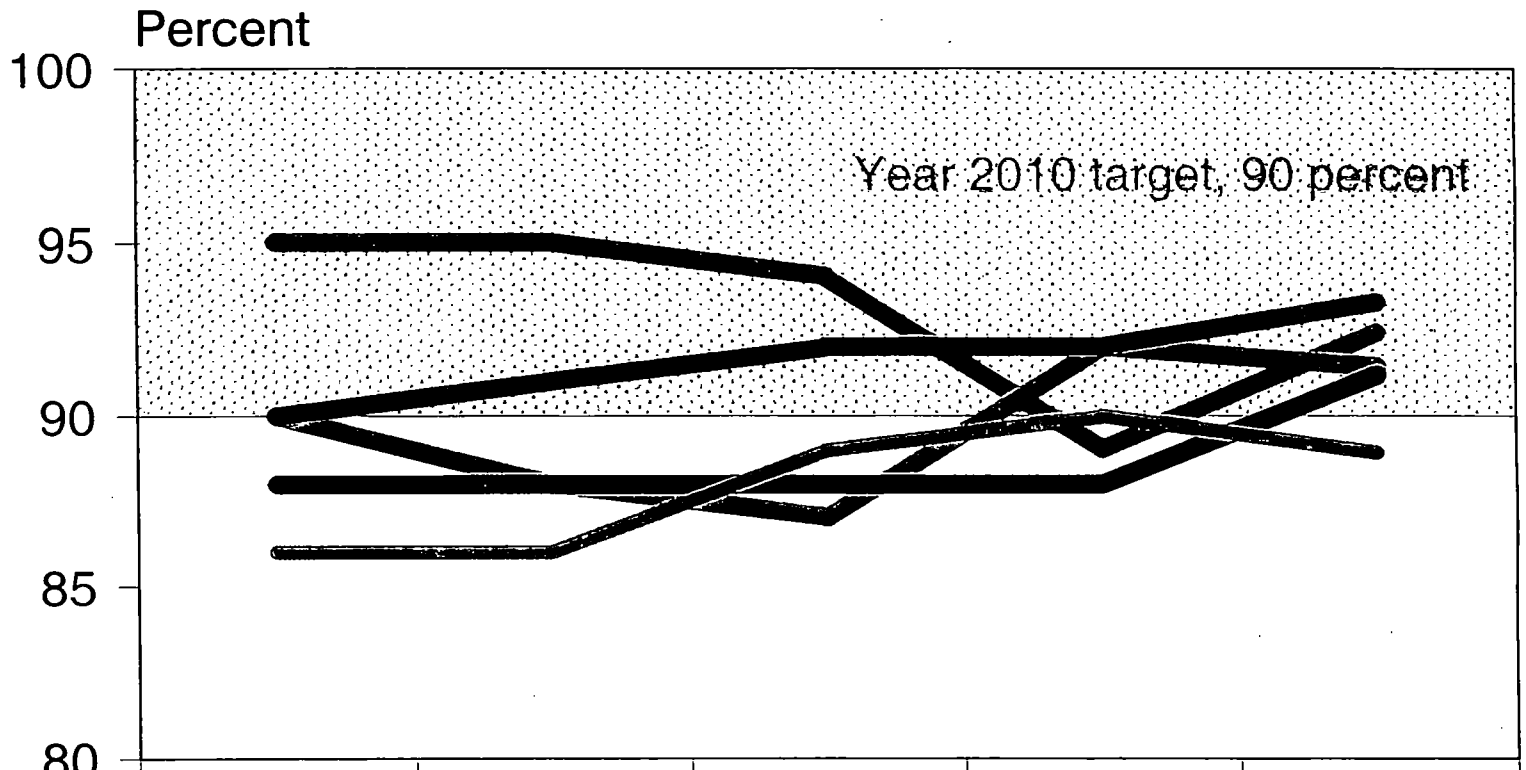


	1994	95	96	97	98
White non-Hispanic	80	81	83	84.	86.6
Black non-Hispanic	72	74	79	78	77.3
Hispanic	70	75	77	77	80.5
Am. Indian/Alaska Native	84	73	83	80	82.9
Asian/Pacific Islander	84	82	84	80	89.1

* Immunization rates are for children ages 19-35 months who have received 4 doses of DTP vaccine (diptheria, tetanus, pertussis).

SOURCE: CDC/NIP and NCHS, National Immunization Survey

Childhood immunization for measles* by race and Hispanic origin

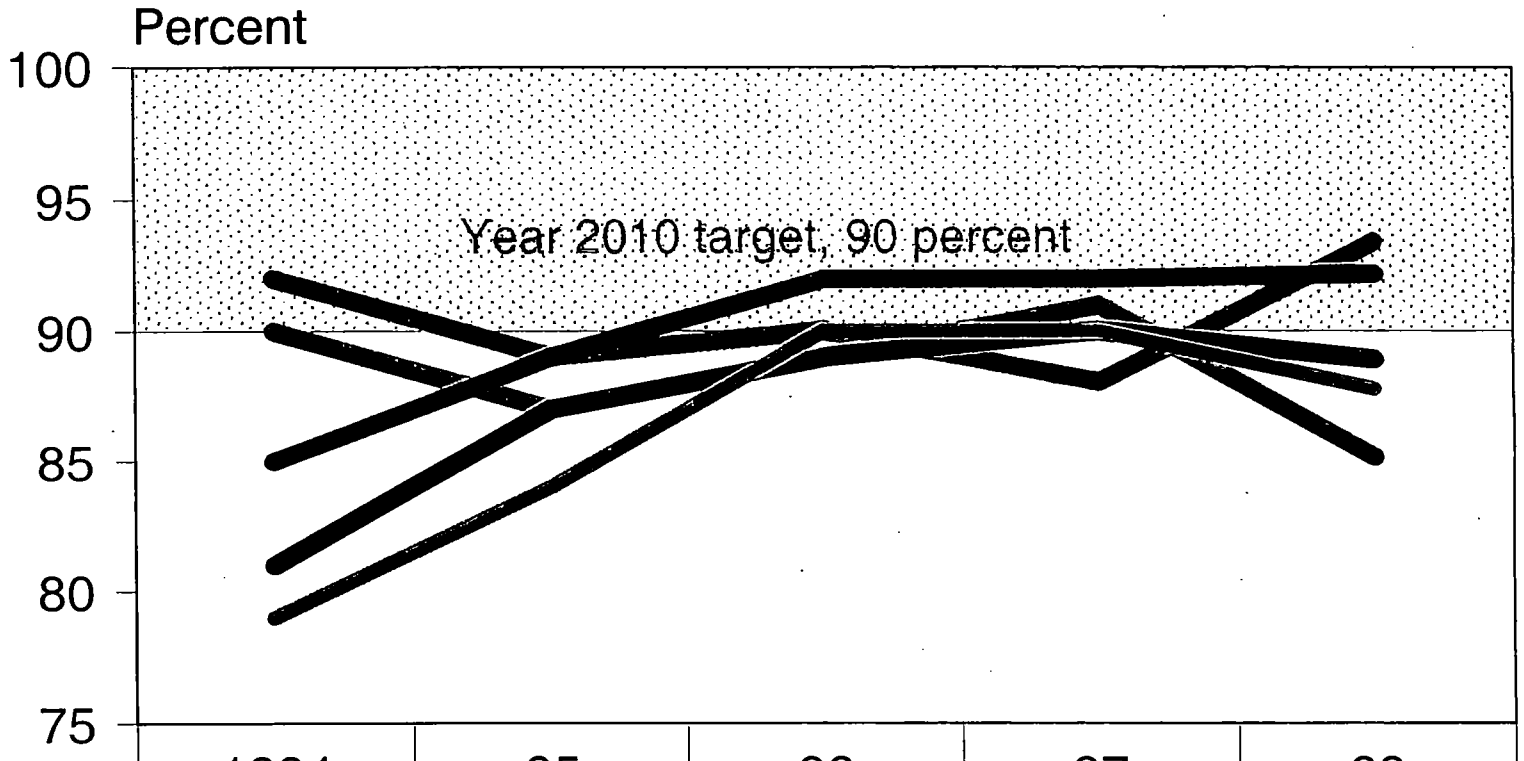


	1994	95	96	97	98
White non-Hispanic	90	91	92	92	93.3
Black non-Hispanic	86	86	89	90	88.9
Hispanic	88	88	88	88	91.2
Am. Indian/Alaska Native	90	88	87	92	91.4
Asian/Pacific Islander	95	95	94	89	92.4

* Immunization rates are for children ages 19-35 months who have received 1 dose MMR vaccine (measles, mumps, rubella).

SOURCE: CDC/NIP and NCHS, National Immunization Survey

Childhood immunization with 3 or more polio doses* by race and Hispanic origin

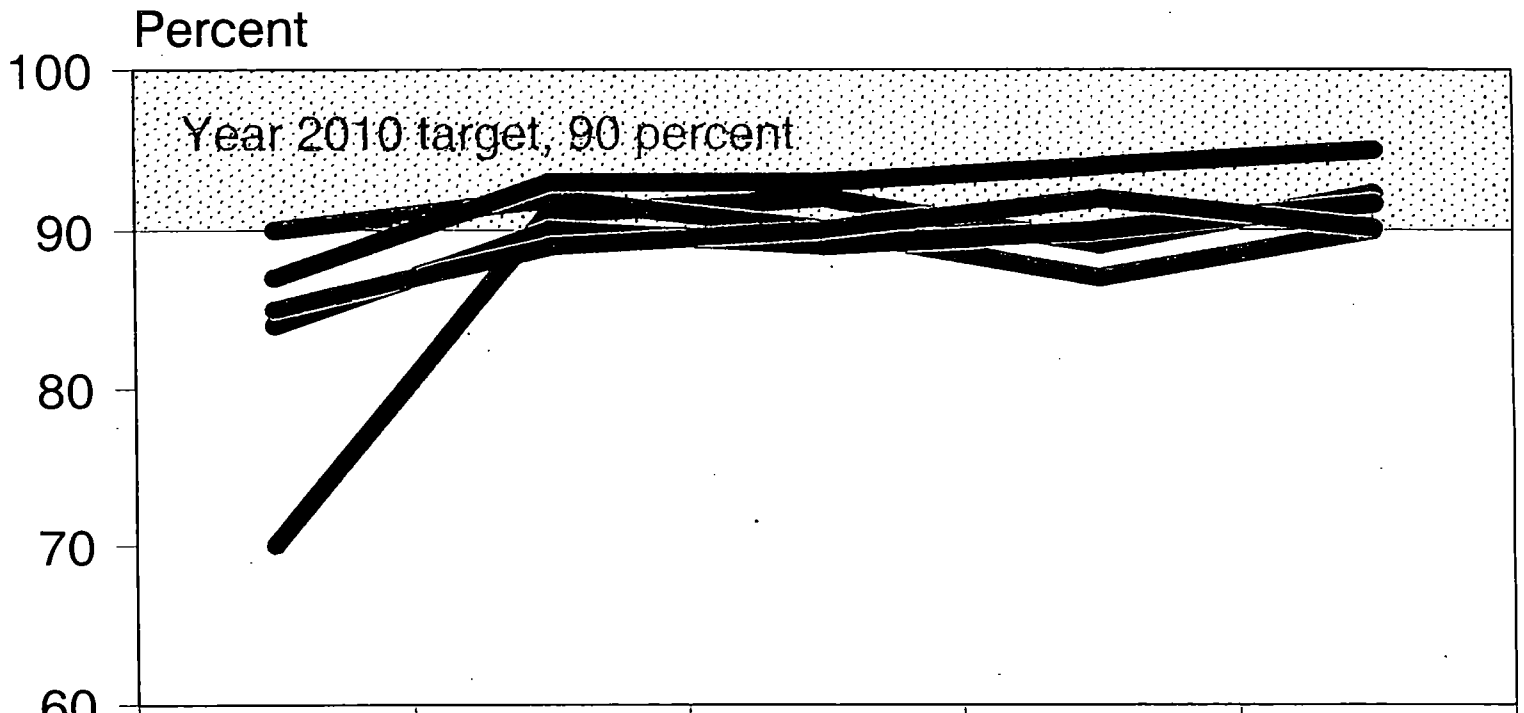


	1994	95	96	97	98
White non-Hispanic	85	89	92	92	92.2
Black non-Hispanic	79	84	90	90	87.8
Hispanic	81	87	89	90	88.9
Am. Indian/Alaska Native	90	87	89	91	85.1
Asian/Pacific Islander	92	89	90	88	93.4

* Immunization rates are for children ages 19-35 months who have received 3 or more doses of polio vaccine.

SOURCE: CDC/NIP and NCHS, National Immunization Survey

Childhood immunization with 3 or more Hib doses* by race and Hispanic origin

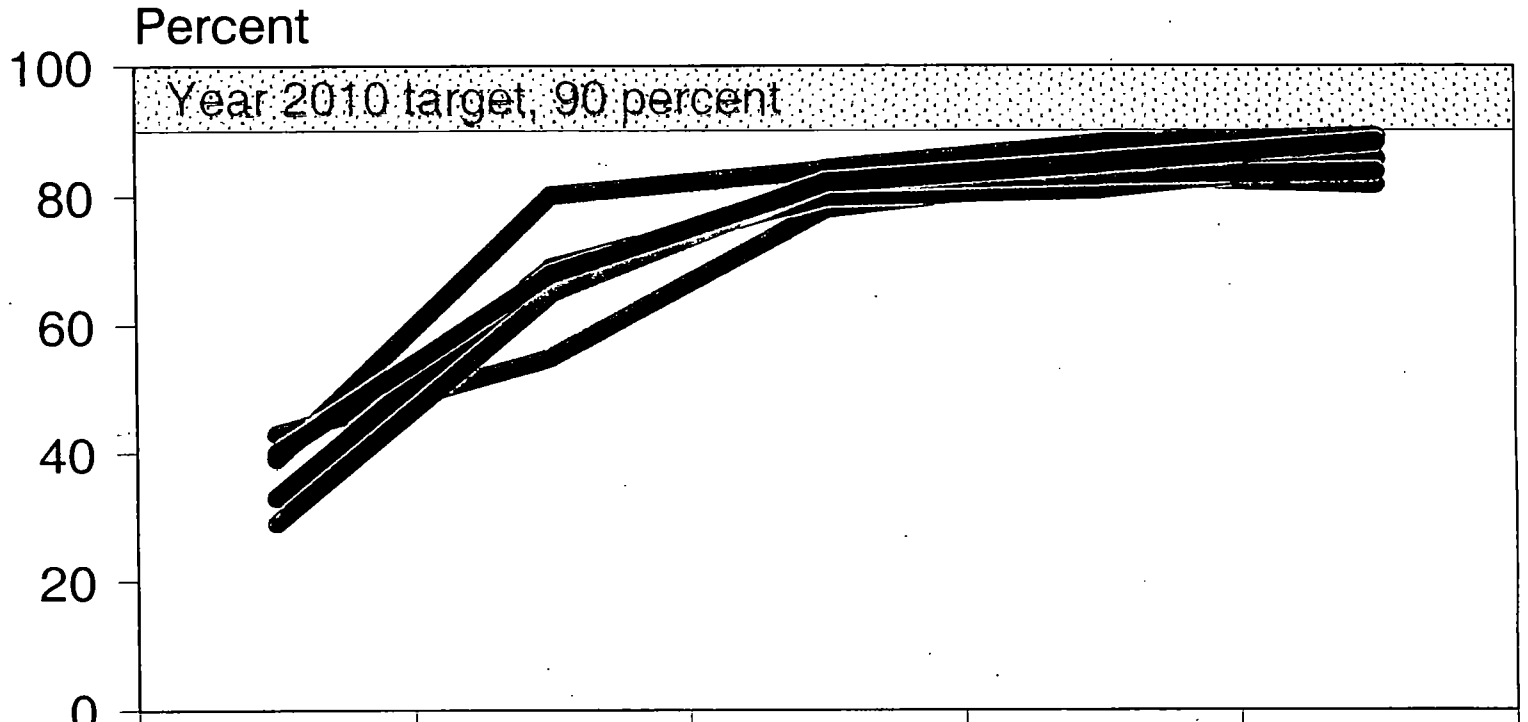


	1994	95	96	97	98
White non-Hispanic	87	93	93	94	95
Black non-Hispanic	85	89	90	92	90.1
Hispanic	84	90	89	90	91.7
Am. Indian/Alaska Native	90	92	90	87	90
Asian/Pacific Islander	70	91	92	89	92.3

* Immunization rates are for children ages 19-35 months who have received 3 or more doses of Hib vaccine (Haemophilus influenza type b).

SOURCE: CDC/NIP and NCHS, National Immunization Survey

Childhood immunization with 3 or more Hep B doses* by race and Hispanic origin

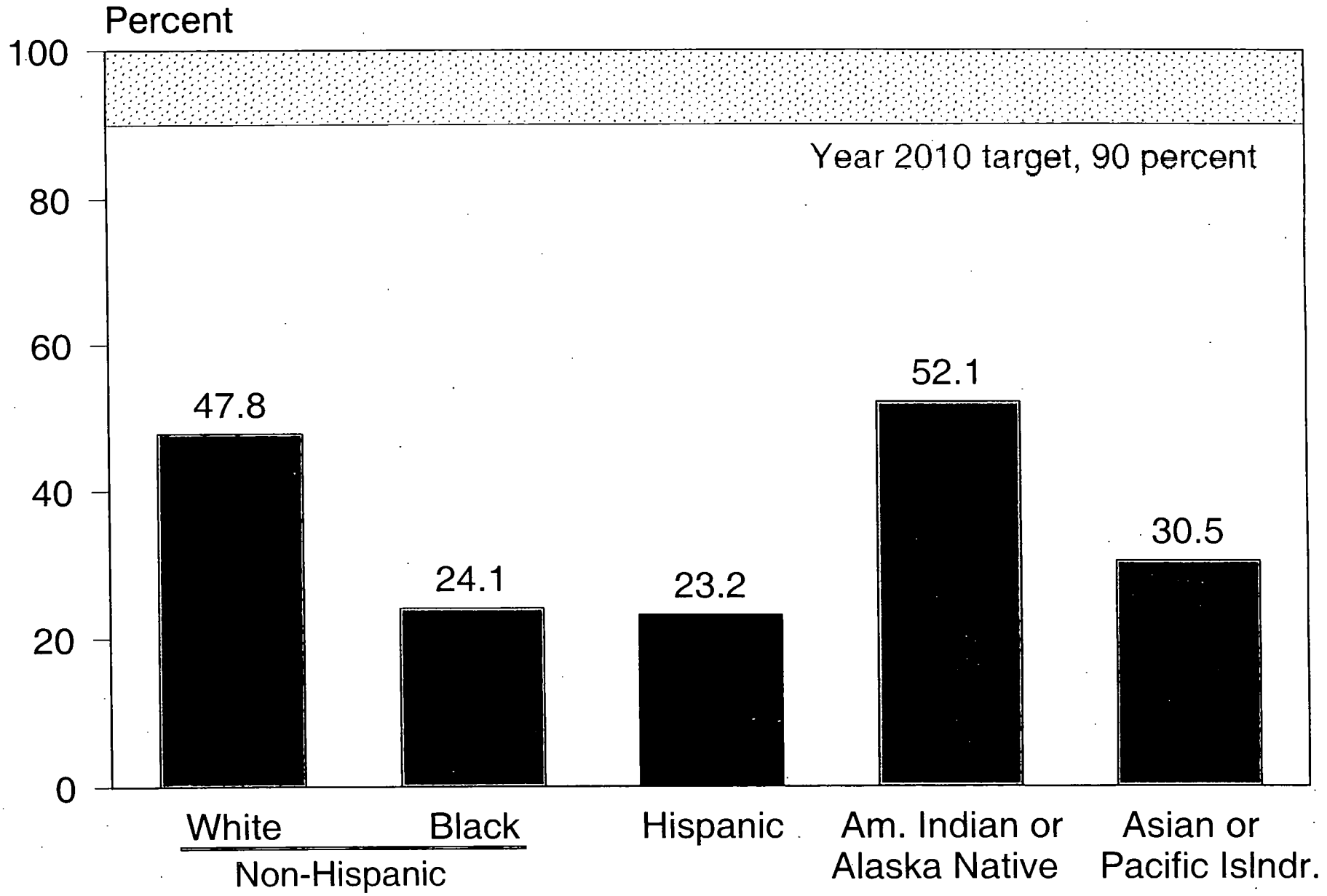


	1994	95	96	97	98
White non-Hispanic	40	68	82	85	88.3
Black non-Hispanic	29	65	82	83	83.7
Hispanic	33	69	80	81	85.7
Am. Indian/Alaska Native	43	55	78	83	81.6
Asian/Pacific Islander	39	80	84	88	89

* Immunization rates are for children ages 19-35 months who have received 3 or more doses Hep B vaccine (Hepatitis B).

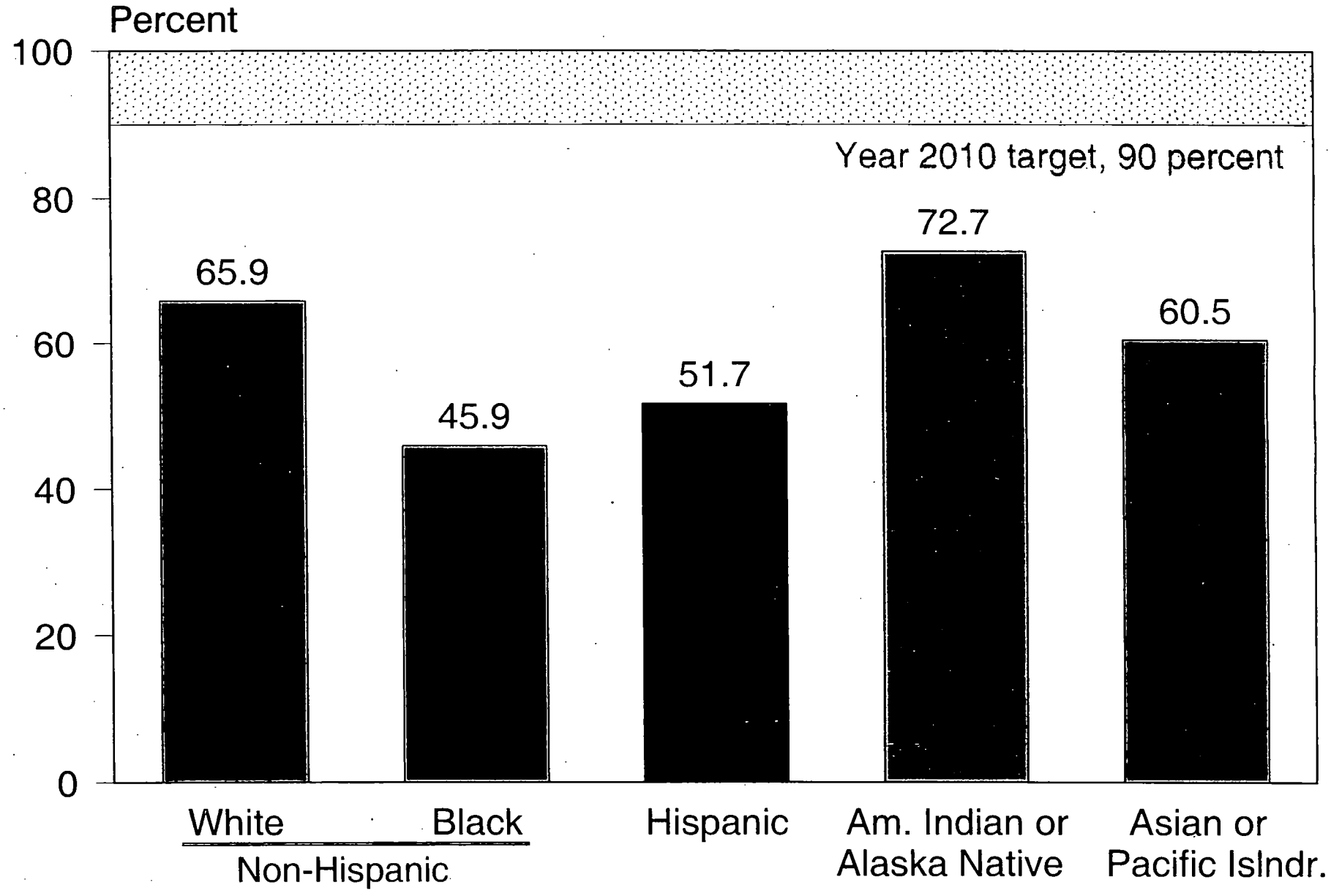
SOURCE: CDC/NIP and NCHS, National Immunization Survey

Pneumococcal immunization rates among persons ages 65 years and over, 1997-98 (age-adjusted, 2000)



SOURCE: CDC/NCHS, National Health Interview Survey

Influenza immunization rates among persons ages 65 years and over, 1997-98 (age-adjusted, 2000)



SOURCE: CDC/NCHS, National Health Interview Survey

HHS INITIATIVE TO ELIMINATE RACIAL AND ETHNIC DISPARITIES IN HEALTH

Budget Theme Paper

The Problem

Racial and Ethnic Disparities in Health

As has been pointed out in annual issues of *Health, United States* and *Healthy People 2000*, the overall health picture of the Nation continues to steadily and significantly improve over time. These reports also indicate that racial and ethnic minorities have not benefitted equally in the fruits of such progress. The sad fact remains that disparities in the burden of death and illness experienced by Blacks, Hispanics, American Indians/Alaska Natives (AIs/ANs), and Asians/Pacific Islanders (APIs)--as compared with the U.S. population as a whole--have existed ever since accurate Federal record keeping began. These disparities persist, and, in many areas, are growing. For example:

- According to *Health, U.S., 1998*, infant mortality rates are more than twice as high for Black Americans than for Whites[1].

- Cerebrovascular disease death rates for Black American men 45-54 years of age are four times that of their White counterparts; death rates for HIV infection are more than five times higher for Black than White men[2].

- Cervical cancer fatalities are disproportionately high among Latino and Black women[3,4], and its incidence is five times higher among Vietnamese than White women[5].

- Hispanics and AIs/ANs suffer much higher rates of diabetes and its complications than do non-Hispanic Whites of similar age, with Hispanics almost twice as likely to have the disease and with prevalence among some AI/AN tribes as high as 50%[6,7].

- Overall, from a health services perspective, racial and ethnic minorities are less likely to be insured[8] and, if insured, are less likely to have a usual source of health care, less likely to receive check-ups, less likely to be immunized or routinely screened for cancer[9], and less likely to receive treatment for HIV infection and other diseases and conditions[10,11].

Disparities Likely to Increase with Shortcomings of Health Care System and Increasing Diversity

Addressing these disparities is even more challenging, given major changes currently underway in the U.S. health care system to rein in costs while maintaining the quality of health care, and the ever-increasing racial, ethnic, cultural, and linguistic diversity of the U.S. population. There

are many people whom the American health care system does not serve well, and they are disproportionately found among racial and ethnic minorities and other already underserved populations, with access, cost barriers, and quality as recurring issues. Recent declines in managed care plan participation in government-sponsored health care programs, particularly for Medicaid beneficiaries, raise serious concerns about the future role of health plans in addressing the health care needs of some of the Nation's most vulnerable populations[12] [13]. Other examples include:

- Thirty-eight percent of Hispanics, 24% of Blacks, and 24% of Asian Americans (compared to 14% of Whites) were uninsured in 1996[14].

- Of those adults who are able to get health care, a substantial and increasing proportion are reporting difficulties in paying for health care. For example, 35% of Blacks, 45% of Hispanics, and 41% of Asian Americans–compared to 26% of Whites–report having a "major problem" in paying for medical care[15].

- Blacks and Hispanics are less likely than Whites to have a regular doctor (and, thus, are more likely to have poorer access to care than those with regular doctors)[16].

- Sixteen percent of Black adults have a "major problem" with access to specialty care compared to 22% of Hispanics, 26% of Asian Americans (41% of Chinese Americans), and 8% of Whites[17].

These issues show that the current health care system does not ensure equal access to quality health care for racial and ethnic minorities. This raises a question regarding the impact of changing demographics on the health of the Nation. By 2030, 40% of the population will be non-White[18].

Need to Better Understand Nature and Extent of Disparities and Their Underlying Causes

The challenge of addressing racial and ethnic disparities in health is further compounded by **a lack of supportive infrastructure for data collection** to better identify and monitor the nature and extent of racial and ethnic disparities in health. As documented by reports from the six focus area work groups of the eliminating disparities initiative, the challenge is magnified by a corresponding **lack of scientific knowledge and understanding about the underlying causes of such disparities and about how to *substantively and effectively* address such disparities**. This lack of knowledge and understanding may, itself, be reflective of forces that perpetuate the status quo (e.g., inertia, denial, complacency, apathy). The dearth of appropriate data and information to address racial and ethnic health disparities may also result in the undue attention to certain possible "causes" at the expense of other more significant causes.

Racial and Ethnic Data Needs. Of the 270 population-based objectives in *Healthy People 2000*, 55 percent do not include at least one specific racial/ethnic group to permit examination of racial and ethnic disparities for the particular issue in question[19] [20]. Also, in the current draft of *Healthy*

People 2010, two-thirds of the measurable objectives proposed have incomplete racial/ethnic breakouts to enable monitoring of progress in achieving the elimination of racial/ethnic health disparities[21]. Furthermore, although there is evidence that disparities in health care exist and that violations of Title VI of the 1964 Civil Rights Act may be occurring, consensus is yet to be achieved regarding how best to collect and use information to assess discrimination in health care.

Knowledge Acquisition Needs about Underlying Causes.--Not only do we lack information about the nature and extent of health disparities across the various racial and ethnic groups and among subgroups within each racial and ethnic group, we also lack knowledge and understanding of **the underlying causes of these disparities** in health status and health care, **the nature and extent of their influence on such disparities**, and **the interrelationship of the causes or factors with one another**. What is critically needed, then, is more research to strengthen the science base and promote a more balanced, complete, and comprehensive understanding of these issues.

Such a balanced, complete, and comprehensive understanding means, first, multi-disciplinary research that includes, but is not limited to, the role of socioeconomic status (SES), risk-promoting behaviors, and biological factors on health. Clearly, behavioral and biomedical research have yielded results that have informed decisions concerning strategies, approaches, and interventions to prevent disease, disability, and premature death as well as to minimize or treat health problems and conditions once they occur. However, research in these areas can only shed light on part of the bigger picture and, thus, interventions based on such research findings can only address part of the problem. Efforts that focus only on high-risk behaviors may overlook the need to also address the context of these behaviors in people's lives, including their interactions with others, their economic circumstances, and their physical and cultural environments.

Increased awareness of these issues has been evident in the past year. For example, *Health, United States, 1998 with Socioeconomic Status and Health Chartbook*[22] is illustrative of the relatively recent recognition of the role of lower SES (especially income and education) in the production of ill health. Similarly, in April 1999, the New York Academy of Science, in collaboration with NIH's Office on Behavioral and Social Science, held a conference on the role of SES in health. Also, the White House Council of Economic Advisers published its report and chartbook on racial and ethnic disparities as part of the President's Race Initiative. Lastly, the relatively high degree of media attention given to the publication this past February of the study by Dr. Kevin Schulman of Georgetown University[23] on physician bias in clinical decision making is indicative of a greater acknowledgment of race and gender bias as a possible factor in decisions made by physicians concerning the care of their patients.

Increased, concerted, and systematic research attention–on par with that provided to biological, genetic, and behavioral factors–must be paid to the impact on health by SES, discrimination, and lack of cultural sensitivity, as well as physical, cultural and social environment, gender and other factors. Without more comprehensive knowledge and understanding, strategies, approaches, and

interventions will continue to be piecemeal, limited, and insufficient to adequately address these highly complex problems. Current approaches typically focus primarily on designing and testing interventions. Since they have been based on limited information about what works, and the underlying causes of the problem, these interventions may not effectively address the problem or root causes at hand. It is important to strengthen the Department's research portfolio to include evaluation of intervention effectiveness, including identifying appropriate points of intervention.

The Opportunity

As the Nation enters a new millennium, an unprecedented opportunity exists to influence and effect health in a way that is fundamentally fairer for, and more inclusive of, all Americans. The Department is ready to "step up to the plate" and eliminate health disparities. For example, the re-framing of one of the *Healthy People* goals to *eliminate* rather than only to reduce health disparities and to use the same target for all racial/ethnic groups, and the co-leadership of Drs. Margaret Hamburg and David Satcher on the Department's Initiative to Eliminate Racial and Ethnic Disparities in Health reflect a commitment at the highest level. HHS also has engaged new partners through the Grantmakers in Health Conference, consultation with representatives from the managed care industry, and enhanced attention to collaboration with other cabinet-level departments. Of particular consequence is NIH's increased awareness of the need for behavioral and social science research and its adoption of racial and ethnic health disparities as a trans-NIH priority.

Other influential players are also "stepping up to the plate." For example, the California Endowment has initiated a Program in Multicultural Health aimed at eliminating health disparities. The Robert Wood Johnson Foundation's Investigators Award in Health Policy Research Programs is seeking to improve understanding of the social determinants of health. State and local governments are also intensifying their prevention and service programs to address racial and ethnic health disparities.

We can consider the lack of racial and ethnic data and of research on underlying causes of racial and ethnic disparities in health as two sides of the same coin: either a major obstacle or a road map to guide HHS action. Proposals for the 21st Century must be analyzed and evaluated in light of the lack of knowledge and understanding about the nature, extent, and causes of disparities. A critical examination of all proposals must be made to ensure that proposed activities are targeted, build on progress already made, and hold the promise of advancing our understanding of how to effectively address the problem.

Given the confluence of interests in eliminating health disparities from divergent sectors, the time is NOW for HHS to exercise bold and vigorous leadership.

The FY 2001 Budget Proposals

For FY 1999, the President proposed $400 million over five years to eliminate racial and ethnic disparities in six health focus areas: infant mortality, breast and cervical cancer screening and management, cardiovascular disease, prevention of diabetes complications, access to state-of-the-art therapy for HIV/AIDS, and child and adult immunizations. The FY 1999 budget allocation was much less than anticipated, with only $10 million provided--of the $30 million in new monies requested--to support a two-phased demonstration project (the REACH--Racial and Ethnic Approaches to Community Health–program) focusing on community-based collaborative approaches to eliminating health disparities in one or more of these six health issue areas.

For FY 2001, HHS is proposing a broad range of new and expanded activities to strategically target both the six health focus areas of the Departmental Initiative to Eliminate Racial and Ethnic Disparities in Health and the eliminating health disparities goal for *Healthy People 2010*. Examples of proposed activities are outlined below and organized under five major categories which reflect our analysis of the problem and the impediments to progress:

- Strengthening Racial/Ethnic Data,
- Addressing Underlying Causes Through Research and Civil Rights Enforcement,
- Testing Interventions,
- Strengthening the Infrastructure, and
- Provision of Direct Services in Under-served Areas.

Strengthening Racial/Ethnic Data

- AHCPR is requesting $3.85 million to: (1) develop a National Healthcare Quality Report to provide a picture of the quality of care delivered by the American health care system, and (2) a multi-year, phased investment in data development for targeted, high priority conditions and issues (HIV in FY2001) to build capacity for monitoring the Nation's progress in assuring access to care, especially for priority populations. Some of the measures in the National Healthcare Quality Report are issues relating to disparities in quality of care for racial and ethnic minority populations, thereby providing national benchmarks against which States, health plans, and providers may compare quality for priority populations. Funds will be used to support a public-use database which will collect clinical, utilization and financial information from provider's records for a large and diverse sample of HIV-infected patients. The data-base will enable State-specific analyses of care provided to HIV-infected patients by race and ethnicity.

- CDC is requesting $10 million for "Improving the Health of American Indians and Alaska Natives" to support the Department's efforts to improve American Indian/Alaska Native access to federal programs to prevent disease, promote health and assure appropriate care. Grants will be given to AI/AN tribes and/or tribal organizations to address their own health priorities including:

- ✓ improved collection of standardized data to correctly identify AI/AN populations and tribes and monitor the effectiveness of health interventions targeting these groups;
- ✓ research to improve understanding of the relationships among health status, different AI/AN tribes, tribal-specific health risks, and effective preventive and clinical services; and
- ✓ community-based prevention and service delivery interventions that show promise in eliminating health disparities.

- NIH is requesting funds to expand the Surveillance, Epidemiology and End Results (SEER) national cancer registry program to collect data on a wider range of population subgroups (e.g., American Indian and Hispanic), and factors, such as SES, that underlie cancer trends. As many as four new state registries will be added to SEER, and up to ten additional states will receive supplementary funding to upgrade their registries. NIH is partnering with CDC on this effort.

Addressing Underlying Causes Through Research and Civil Rights Enforcement

- AHCPR is requesting $10.6 million in FY 2001 to sponsor new research on the determinants of quality of care, including quality of life, with a focus on minority populations. AHCPR will build on its prior investments to translate research into practice through projects to improve care for high priority conditions, including cardiac disease in minority women, and demonstration projects that enhance the capacity to improve quality for vulnerable populations. Research results will be applied broadly through partnerships with professional organizations, Federal partners, and consumer organizations. A national strategy will be undertaken to translate research on the causes of health disparities, which can help reveal persistent racial discrimination, into effective strategies to overcome the contribution of provider and system bias in medical decision-making to the observed health disparities.

- HCFA is requesting $750,000 to assist Peer Review Organization's (PROs) in developing effective interventions to reduce disparities as they implement the 6th scope of work. The research agenda developed during a joint AHCPR-Kaiser Family Foundation-HCFA conference on racial and ethnic disparities in health care will be used to set funding priorities. In addition, HCFA plans to continue the PROs' demonstration link to eliminating disparities–for example, some PROs are addressing diabetes while others are addressing immunizations.

- HCFA is requesting $300,000 to conduct studies related to racial/ethnic differences in health status and utilization of health care services among women with chronic diseases.

- NIH is requesting funds to initiate a Special Populations Network for Cancer Awareness Research and Training to improve cancer prevention and control in underserved

communities. Other research enhancements are aimed at understanding the relationship of cancer incidence/mortality disparities to health care accessibility, to any differences in treatment, and to differences in genetic and environmental risks. Funds are also requested to support a large biomarker program to identify breast cancer susceptibility genes and other susceptibility genes, and translate biomarkers into routine public health practice.

- NIH is requesting funds to expand research on drug use and AIDS risk in women, risk factors for oral complications of HIV/AIDS, the impact of maternal substance use in minority populations and its effect on infant development, and social factors that characterize pregnant adolescents who are also drug users.

- NIH is requesting funds to increase research efforts into the genetic, environmental, and social causes of infant mortality, low birthweight, birth defects, impaired respiratory function, and other endpoints of concern.

- NIH is requesting funds to (1) support studies of the effects of poverty and environmental exposures of poverty on learning and behavior, and (2) convene a conference to evaluate evidence that gestational events can lead to many of the adulthood diseases most prominent in disadvantaged communities (e.g, hypertension, diabetes, obesity) and to suggest research strategies.

- NIH is requesting funds to examine the role of nutrition in environmental health, diabetes and cancer. For example, studies have shown that calcium supplementation reduces uptake of lead in the environment. Lead is a common pollutant in impoverished communities and is associated with low birthweight babies, adult hypertension, and renal disorders. All of these endpoints are also health disparity conditions.

- NIH is requesting funds to provide an extensive exposure assessment of the body burden of environmental contaminants in the U.S., with particular attention to members of disadvantaged communities.

- The Office for Civil Rights is requesting $6.7 million for a Discrimination and Racial Disparities Initiative. These funds would be used to engage fully the issue of the effect of discrimination, whether intentional or unintentional, conscious or unconscious, on the disparities in health status among minority groups. This includes $3.7 million to expand the quality/access improvement review and partnership initiative currently underway in New York, by undertaking investigations and establishing regional racial disparities consortia in strategic locations throughout the nation; $400,000 to support geo-coding and mapping systems to increase the effectiveness of OCR's redlining investigations; $900,000 to determine through outreach and investigations the specific civil rights compliance issues and barriers facing individuals who are both minority and disabled; $900,000 to establish field offices in Los Angeles, Miami and Houston to focus on ensuring that the Hispanic community is provided equal access to health and human

services and that issues relating to immigration status and language proficiency not inappropriately become barriers to receipt of needed services; $800,000 to implement a testing program as part of OCR's overall civil rights enforcement effort, and $850,000 to improve measurement and tracking of race discrimination in several key sectors of the economy, including health care.

Testing Interventions Through Demonstrations to Understand What Works

- AHCPR is requesting $1 million to solicit grants to develop knowledge on how to improve access in particular for priority populations (e.g., rural populations, persons with HIV and other high-cost conditions, women, children) and for priority services (e.g., emergency department care, preventive and mental health services).

- AoA is requesting $6 million for Health Disparities Intervention Grants, a $2 million increase over the FY2000 President's Budget. Increased funds will help to further eliminate cardiovascular disease (CVD) and diabetes and to increase the number of immunized minority elders. These grants will allow states, in partnership with communities and national organizations, to design culturally competent service models for minority elders. The initiative, "Keepers of the Culture," contributes to the depart-mental Initiative, and uses an inter-generational approach and existing culturally trusted social structures to promote the adoption of healthy behaviors by minority groups.

- CDC is requesting an increase of $52 million above the FY2000 President's Budget ($35 million) for the Racial and Ethnic Approaches to Community Health (REACH) 2010 Demonstration, providing a total of $87 million project to expand and intensity CDC's effort to eliminate disparities in six priority health areas (diabetes, breast and cervical cancer screening and management, child and adult immunization, cardiovascular disease, infant mortality and HIV). Anticipated activities in the expansion of the REACH 2010 program include:
  - ✓ Funding 60 additional communities for Phase I planning grants,
  - ✓ Funding 20-25 competitive continuation communities for Phase II comprehensive grants,
  - ✓ Funding 10 national and regional minority organizations to provide support and training to communities to aid in sustainability
  - ✓ Expanding evaluation components of the program, technical assistance, and training,
  - ✓ Supporting prevention research in social and behavioral determinants of health disparities,
  - ✓ Supporting prevention research in efficacy and cost-effectiveness of interventions for racial/ethnic populations
  - ✓ Supporting extramural research to strengthen immunization communication strategies directed at the general public, providers and others.

- (Prevention Initiative) OMH is requesting a $6.7 million increase to continue support to organizations which will be funded under two FY1999 grant programs focusing on HIV/AIDS. This includes projects funded through the FY 1999 supplemental appropriation which were not included in the FY 2000 President's Budget. These programs will support activities aimed at reducing the risk of acquiring or transmitting HIV/AIDS, and at increasing access to services and treatment.

- (Prevention Initiative) OWH is requesting $2.2 million for Community Centers of Excellence: Promoting Community Linkages to support community-based organizations to link local resources in women's health services delivery, health education, community-based research, leadership development, and health sciences training for underserved women; and to enable those model programs to provide sustained technical assistance to other programs around the country interested in emulating these models of excellence.

- NIH plans to enhance minority participation in its Diabetes Prevention Program to test lifestyle and pharmacologic intervention strategies in individuals at risk of diabetes. In partnership with CDC, NIH proposes to continue to increase its minority representation in the National Diabetes Education Program to help individuals manage their diabetes.

- NIH is requesting funds to support studies on the nature, extent and origins of drug abuse among disadvantaged groups that are not adequately represented in national data sets, particularly APIs and AIs/ANs. An initiative will also be started to evaluate intervention programs targeted to alcohol abuse among minority youth.

- (Prevention Initiative) OMH is requesting $1 million to replicate the concept of family life centers developed under an existing cooperative agreement with Central State University to include Tribal Colleges and Universities. These family life centers would offer and support health promotion programs aimed at reducing critical health problems such as use of tobacco, alcohol and drugs, diabetes, hypertension, violence, and unintentional injury among college-aged youth, their younger siblings and other family members.

- (Prevention Initiative) SAMHSA is requesting $15 million to support a new Preventing Youth Alcohol and Tobacco Use Initiative. This initiative will employ both studies and dissemination/application strategies to reduce young people's use of these illegal substances (Hispanic component).

- (Prevention Initiative) SAMHSA is requesting $25 million more than the President's FY 2000 budget ($27 million) for the HIV/AIDS in Minority Communities initiative, a targeted program to provide substance abuse and HIV/AIDS prevention and treatment services to racial and ethnic minorities in need of them, with a particular emphasis on building capacity, through training and technical assistance in those communities with the highest incidence rates.

Developing and Strengthening the Infrastructure

Workforce Development, Education, & Training

- AHCPR is requesting $3.125 million for FY 2001 to fund grants to develop and/or expand research infrastructure and the capabilities of minority and minority-serving institutions and their faculties to train health services researchers and to conduct rigorous health services research.

- NIH is proposing to augment its research efforts with training programs that will serve to encourage students from those segments of society most adversely affected by health disparities to pursue biomedical research careers.

- NIH is requesting funds to support the Advanced Research Cooperation in Environmental Health (ARCH) program which partners minority-based colleges and universities with more traditional research-based colleges, and if successful, will serve as a prototype for the rest of NIH. This program will provide minority students with the physical infrastructure and support necessary to foster biomedical research interests. NIH is proposing to expand the Continuing Umbrella of Research Experiences, to encourage students from disadvantaged communities to pursue careers in biomedical research and to increase the research and training capacity of minority-based institutions.

- Prevention Initiative) OMH is requesting $1 million to (1) publish the June 1999 meeting summary on "Performance Measurement in Managed Care and its Role in Eliminating Racial and Ethnic Disparities in Health", (2) support efforts of 2-3 health professions schools to demonstrate how their curricula better prepare graduates of their programs to more effectively and equitably address the health needs of America's increasingly racially and ethnically diverse population, and (3) conduct workshops aimed at physicians and health care professionals of the nature and extent of racial and ethnic disparities in health care/health status and contributing factors (including biases), issues that increasing diversity brings to bear in the context of health care delivery, and the new knowledge, attitudes and skills they will need to more effectively and equitably address the needs of the changing populations they serve.

Capacity Building

- CDC is requesting $25 million to provide community outreach, support an expansion of clinical and laboratory services in the 31 counties that account for 50 percent of syphilis morbidity in 1998, fund outbreak response teams in each of the high morbidity areas, and conduct program-relevant operational research projects (e.g., develop noninvasive tests for syphilis).

- CDC is proposing an increase of $7.1 million for the Immunization program, providing a total of $533.3 million. The base Immunization program supports state and local capacity to raise vaccination coverage levels and reduce morbidity and mortality from vaccine-preventable diseases.

- CDC is requesting $10 million more than the FY 2000 President's Budget ($49.3 million) for the diabetes portion of the Chronic Disease Prevention and Health Promotion Program, providing a total of $59.3 million; $30 million more than the FY 2000 President's Budget ($100.9 million) for the tobacco portion of the Chronic Disease Prevention and Health Promotion Program, providing a total of $130.9 million; and, $25 million more than the FY 2000 President's Budget ($15.5 million) for the cardiovascular (CVD) portion of the Chronic Disease Prevention and Health Promotion Program, providing a total of $40.5 million. This increase will fund an additional 15 states for CVD prevention programs (including those states which received FY1999 funding to focus on racial and ethnic disparities), an additional 9 states for comprehensive diabetes control programs, and an additional 10 states for cancer activities.

- The Office of HIV/AIDS Policy (OHAP) is requesting $1,454,000 (an increase of $547,000 over the FY2000 President's Budget) to (1) provide staff support to the Department's HHS Coordinating Group on HIV/AIDS, (2) increase its capacity to provide models and an information base to the OPDIVs using lessons learned from the Congressional Black Caucus/HHS Initiative to Eliminate Racial and Ethnic Disparities in health and the Baltimore Services Integration Project, and (3) design a departmental system to disseminate period updates of HIV Treatment Information to physicians and patients, and (4) establish and make available to select localities Crisis Response Teams (CRT) for an additional twelve cities beyond the three funded in FY 1999.

- OMH is requesting an increase of $1 million over the President's Budget request for FY2000 ($500,000) to continue activities under the Center for Linguistic and Cultural Competency in Health (CLCCHC). Activities under the CLCCHC will address the provision of quality health services to culturally and linguistically diverse populations. OMH will collaborate with HCFA to develop provider education programs to recruit providers that are culturally competence, develop proposed contract requirements for Medicaid contract providers which incorporate culturally competent service provisions, and develop culturally competent evaluation protocols to measure health outcomes of diverse populations. Funds will also be used to continue to support of research and assessment of effectiveness of culturally competent programs on racially and ethnically diverse patients. In addition, OMH will initiate a communication program directed at developing culturally appropriate health promotion and health prevention materials for limited English speaking communities.

- (Prevention Initiative) OMH is requesting an increase of $1.9 million over the FY2000 President's budget request ($500,000) to strengthen the capacity of local, state, tribal and regional organizations to plan and carry out programs aimed at eliminating racial and

ethnic disparities in health. Currently, 34 states maintain offices, commissions, advisory committees or programs on minority health. In FY 2001, OMH will expand its efforts to assist State public health agencies, based on findings from the FY 1999 assessment of state infrastructures for addressing health disparity issues and assist the remaining 16 states, 2 territories and the US Associated Pacific Island jurisdiction to develop or expand existing infrastructure to address the public health needs of racial and ethnic minorities. Through its Regional Minority Health Consultants, OMH will enhance outreach to minority community-based organizations to include them in the Department's efforts to eliminate health disparities. In addition, OMH will undertake a special project in response to Executive Order 13084 to assist states with significant American Indian/Alaska Native populations to engage Tribes and urban Indian health programs in planning for state health activities and projects that will eliminate disparities in health for American Indian/Alaska Native populations.

- (Prevention Initiative) OMH is requesting an increase of $1.3 million over the FY2000 President's Budget request ($1.4 million) to expand the Office of Minority Health Resource Center's ability to conduct information and education campaigns for minority communities on prevention and state-of-the-art therapy for HIV/AIDS and other diseases under the HHS Initiative to Eliminate Racial and Ethnic Disparities in Health. The increase would provide funds to enhance OMHRC's capacity to perform community outreach and technical assistance, use community media outlets to deliver educational messages, and disseminate more health related information products via Web pages and print publications.

Provision of Direct Services in Under-served Areas

- (Prevention Initiative) HRSA is requesting $11 million to support diabetes management activities. A recognized chronic disease management model for the Diabetes Improvement Project will be expanded to also address hypertension and asthma. The model consists of: (a) teaching patient self-management, (b) training providers and redesigning practices, (c) establishing clinical information systems, and (d) developing community partnerships to support patient care and health system planning. This also involves health education and support for drug therapies that can be prohibitively expensive.

- (Prevention Initiative) HRSA is requesting $18.8 million to increase activity in the Early Intervention Community-Based HIV/AIDS program particularly targeted to racial minorities. Planning grant support will be given to 60 new programs targeted to African American communities so as to increase by 10,000 the number of people living with HIV/AIDS receiving state-of-the-art clinical care.

- IHS is requesting an increase of $25.2 million for diabetes activities, $13.4 million for heart disease activities, $7 million to address HIV, tuberculosis and sexually transmitted

diseases (STDS), and $12.9 million for cancer activities. Recommended funding increases will support expanded prevention and treatment activities aimed at reducing onset and complications of these diseases. The specific types of services provided with these funds will be determined by the local priorities and needs at the service delivery sites. A total of $254 million is being requested to reduce the gap in health disparities.

Notes

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2.Ibid.

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4.Racial/Ethnic Patterns of Cancer in the United States, 1988-1992. Surveillance, Epidemiology, and End Results (SEER) Program, National Cancer Institute.

5.American Cancer Society, Cancer Facts and Figures for Minority Americans, 1991.

6.CDC National Diabetes Fact Sheet, November 1, 1997.

7.American Diabetes Association, 1995.

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9.*Healthy People* 2000, U.S. Department of Health and Human Services, DHHS Publication No. (PHS) 91-50212.

10.HIV Cost and Services Utilization Study, Agency for Health Care Policy and Research, 1999.

11.Hall, A.G., et.al., *Employer-Sponsored Health Insurance: Implications for Minority Workers.* New York, NY: The Commonwealth Fund: 1999.

12.Felt-Lisk, S., "The Changing Medicaid Managed Care Market: Trends in Commercial Plans' Participation," for the Kaiser Commission on Medicaid and the Uninsured, May 1999.

13."Managed Care Medicaid Experiment Fails in Ohio," *Washington Post*, August 14, 1999.

14.Op. Cit. Collins, *et.al.*

15.Ibid.

16.Ibid.

17.Ibid.

18.Ibid.

19.Presentation by Colleen Ryan & Elizabeth Jackson, National Center for Health Statistics, on "An Examination of Data Used to Track Objectives in *Healthy People 2000* and *Healthy People 2010*," American Public Health Association Annual Meeting, Washington, D.C., November 1998.

20.It must be noted, however, that *Healthy People 2000*'s framework and goals did not require–as does *Healthy People 2010*–examination of population-based issues across all racial and ethnic groups.

21.Analysis by staff of the National Center for Health Statistics working on finalizing the draft of *Healthy People 2010*, August 1999.

22.Op.Cit. *Health, United States, 1998.*

23.Schulman, K., et.al., "The Effects of Race and Sex on Physicians' Recommendations for Cardiac Catheterization," *The New England Journal of Medicine*, February 25, 1999, pp. 618-626.

American Public Health Association

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APHA Facts

The American Public Health Association (APHA) is an association of individuals and organizations working to improve the public's health. Founded as a result of the public health movement to combat yellow fever and other diseases in the 1870s, APHA is the world's largest, oldest and most diverse public health association and celebrates more than 128 years of leadership.

APHA promotes the scientific and professional foundation of public health practice and policy, advocates the conditions for a healthy society, emphasizes prevention and enhances the ability of members to promote and protect environmental and community health. Based on the values of health, equity, diversity, empowerment, integrity, dignity and knowledge for individuals and communities, APHA is the leading professional association that promotes and protects the health of the people.

Comprised of over 30,000 individual members and 20,000 additional state and local affiliate members, APHA represents more than 75 disciplines in public health and related fields. Members represent the many specialties that make up the community health team – administrators, physicians, nurses, educators, environmentalists, laboratory scientists, nutritionists, dentists, engineers, planners, civic leaders and others working both within and for private, governmental and industrial organizations serving public health.

The association influences policies and sets priorities on a broad set of issues, including children's health, environment and health, managed care, public health infrastructure, disease control, international health activities, tobacco control, food safety, state and federal funding for health programs and professional education in public health.

Among APHA's many national and international standard-bearer publications is the *American Journal of Public Health,* the prestigious, peer-reviewed monthly of original research, program evaluation and special reports that place it among the forefront of public health study.

APHA's Annual Meeting is the largest public health forum in the world, drawing 10,000 to 15,000 participants and serving as the focal point for professional dialogue on public health. The meeting provides public health professionals the opportunity to attend more than a thousand scientific sessions, workshops and panel presentations for peer discussion of current research, issues, practice and policies in public health. Upcoming Annual Meetings will be held in Boston, November 12-16, 2000 and Atlanta, October 21-25, 2001.

APHA's Public Health MILESTONES

Public health protects us all. Preventing illness and injury, promoting good health practices and keeping the environment clean, healthy and safe ensures our health and the health of our communities.

Milestones in public health mirror the rich heritage and enduring contributions of the American Public Health Association. APHA was formed in 1872 when Stephen Smith convened the top health specialists of the era in Long Branch, NJ, to discuss forming a national sanitary association. There, delegates forged a powerful, dynamic association that changed the face of public health for the entire world.

Since its beginning, the American Public Health Association has participated in some of the most extraordinary achievements in modern times: Gains in public health since the turn of the century have helped raise life expectancy from 45 to more than 75 years. In recent years, fresh policy initiatives, combined with APHA's bedrock values and long-standing expertise and experience, have made the Association a leader in advancing public health as one of the wisest investments of a dollar. This fusion of innovation and traditional strength prepares the American Public Health Association to meet the public health challenges ahead.

Each milestone on this poster symbolizes a contribution APHA has made with its leadership and influence on the quality of public health we enjoy today.

OVER A CENTURY OF ACHIEVEMENTS

1872 — APHA founded

1890s — APHA focuses on water pollution, milk sanitation, hygiene education, bacteriology, infectious diseases

1893 — PROCLAMATION

1894 — APHA publishes Standard Methods for the Examination of Water and Sewage

1900s — APHA addresses infectious diseases, municipal health, water, standardization of health data

1900 — APHA supports [illegible] Mosquitoes Cause Yellow Fever

1905 — APHA publishes Standard Methods for the Examination of Milk

1906 — Federal Food and Drug Act is passed; APHA publishes the American Journal of Public Hygiene

1908 — APHA's standards for death certificates adopted by US Census

1909 — APHA publishes Standard Methods for the Examination of Air

1911 — Control of Communicable Diseases in Man first published by APHA

1916

1920s — APHA focuses on local health departments, water, milk, training standards, personal hygiene, infectious disease

1925 — APHA creates Appraisal Form for Local Health Work

1930s — APHA addresses issues related to [illegible]

1938 — President Hoover speaks at APHA's Annual Meeting

1940s — APHA deals with professional standards, evaluations of schools of public health, infectious diseases, functions of local health departments

1943 — APHA sets qualification standards for health educators

1948 — APHA celebrates its 75th anniversary with 11,530 members

United Nations establishes the World Health Organization; Fluoridation of community water supplies begins

1950s — APHA pushes for federal agency solely focused on health and federal health funds for states, increases role in influencing health legislation and advocacy, accredits schools of public health

1950 — Introduction of Salk vaccine for polio by APHA member Jonas Salk

1956 — National Library of Medicine established

Late 1950s — Surgeon General's Report on Smoking and Health Published; President Johnson signs the Medicare/Medicaid Act

1960s — APHA addresses equality within the public health workforce, integration, the War on Poverty, "the Pill," public health training, environmental issues, consumer protection, human rights, peace

1964 — Congress establishes the Environmental Protection Agency (EPA), the Occupational Safety and Health Administration (OSHA); and the National Institute for Occupational Safety and Health (NIOSH)

1965 — APHA publishes the first Public Health Law Manual

1972 — APHA celebrates its 100th anniversary with 25,100 members

1973 — APHA cited in Supreme Court decision striking down most state anti-abortion laws

1974

1978 — Development of initial Healthy People health promotion and disease prevention objectives; APHA publishes guidelines for correctional facilities

1979

1980 — APHA supports Women's Right to Abortion

1982 — APHA testifies first Congressional hearings on AIDS

1986

1990s — APHA deals with the Clinton Health Reform Plan, Gulf War impacts, tobacco, and managed care

1992 — APHA develops guidelines on universal healthcare

1994 — Medicine and Public Health Initiative established by APHA and the American Medical Association

1996 — APHA develops a set of principles on managed care

1997 — APHA celebrates its 125th anniversary with 32,000 members; Presidential Citation presented to Nelson Mandela; Greater motor vehicle safety due to stricter regulation

1998 — Tobacco use declines among high school students

1999 — APHA builds [illegible]

Advancing and Building Support for Public Health

Racial and ethnic minorities in the United States have significantly higher rates of death and disability than the white majority. Consider the following statistics:

- Infant Mortality — Infant mortality rates are 2½ times higher for African Americans and 1½ times higher for American Indians than whites

- Cancer — African American men under 65 have prostate cancer at nearly twice the rate of whites and women of Vietnamese origin have cervical cancer at nearly five times the rate of white women

- Heart Disease — The age-adjusted death rate in 1995 for African Americans 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

- HIV/AIDS Infections — The number of new AIDS cases among African Americans is now greater than the number of new AIDS cases among whites

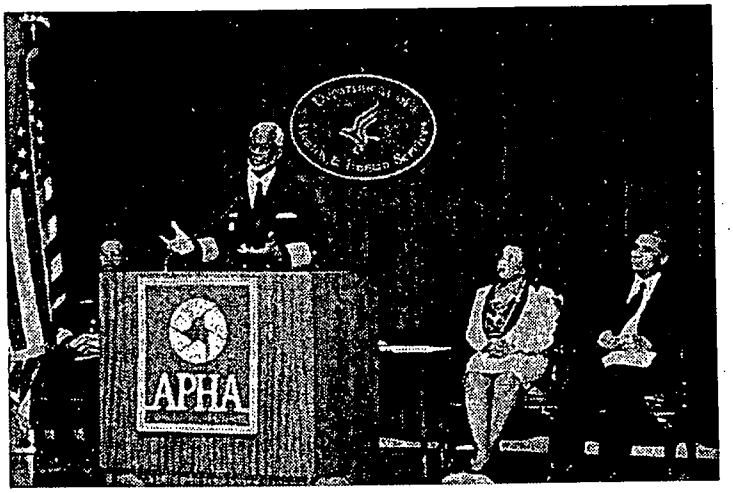
- Diabetes — The prevalence of diabetes in Hispanics, American Indians and Alaska Natives is nearly double that of whites

In addition to addressing issues related to limitations in access to health care among racial and ethnic minorities, the Initiative will also include other aspects of life that contribute to good health, such as housing, education, faith, workplace conditions and social welfare.

The Initiative has three phases or milestones. The first major milestone, completed in October 2000, was the development of a charge. This charge — or blueprint of guidelines and end goals for the Initiative — was developed by a Steering Committee of 25 leaders representing public and private sector organizations dedicated to improving the health of the public. The Steering Committee is comprised of leaders from business, labor, social welfare, housing, education, government, faith and ethnic organizations.

A larger coalition of around 300 people — from similar national, regional and local organizations — will use the charge to reach the second milestone, the development of a detailed, comprehensive plan. The plan will be completed by November 2001.

The third milestone, made possible by public-private partnerships, will be the implementation of the comprehensive plan, the redirection of resources where necessary and the evaluation of the Initiative's success in eliminating racial and ethnic disparities in health by the year 2010. APHA and HHS will provide joint leadership during all phases of this endeavor.



From left, U.S. Surgeon General David Satcher, MD, PhD, joins APHA President Carol Easley Allen, PhD, RN, and APHA Executive Director Mohammad N. Akhter, MD, MPH, in announcing the new partnership to address racial and ethnic health disparities.

National Initiative to Eliminate Racial and Ethnic Health Disparities

At an April news conference, APHA and the U.S. Department of Health and Human Services announced a historic partnership to eliminate racial and ethnic disparities. The partnership, which will ultimately include a large number of organizations concerned with improving the health of the U.S. population, represents a combined effort of both the public and private sectors.

NEWS

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HHS and APHA Announce National Campaign to Eliminate Racial and Ethnic Health Disparities

Historic Endeavor To Address Massive Health Inequities Represents First Public-Private Partnership of Its Kind

Washington, D.C. (April 24, 2000) – The U.S. Department of Health and Human Services (DHHS) and the American Public Health Association (APHA) today announced an historic partnership to eliminate racial and ethnic health disparities. The partnership, which will ultimately include a large number of organizations concerned with improving the health of the U.S. population, represents a combined effort of both the public and private sectors.

"The elimination of racial and ethnic health disparities, so that all people achieve the same level of good health, is one of the top goals of the Healthy People 2010 initiative," said David Satcher, MD, PhD, Surgeon General and Assistant Secretary for Health at DHHS. "The Campaign we are announcing today will help our country realize this goal."

"The time is up, we can no longer accept such massive health inequities for the next generation of Americans. Prior efforts to reduce disparities have been admirable but piecemeal. With this Campaign we announce a broad initiative including all aspects of public health," said Mohammad N. Akhter, MD, MPH, Executive Director of APHA. "We are pleased to be a part of this strategic national campaign to address the problem head-on."

Racial and ethnic minorities in the United States have significantly higher rates of death and disability than the white majority. Consider the following statistics from the Health Resources and Service Administration Office of Minority Health Report *"Health Care Rx: Access for All"* and the Healthy People 2010 Report:

- **Infant Mortality** – Infant mortality rates are 2 ½ times higher for African Americans and 1 ½ times higher for American Indians than whites.
- **Cancer** – African American men under 65 have prostate cancer at nearly twice the rate of whites and women of Vietnamese origin have cervical cancer at nearly five times the rate of white women.

-more-

- **Heart Disease** – The age-adjusted death rate in 1995 for African Americans 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.
- **HIV/AIDS Infections** – The number of new AIDS cases among African Americans is now greater than the number of new AIDS cases among whites.
- **Diabetes** – The prevalence of diabetes in Hispanics, American Indians and Alaska Natives is nearly double that of whites.

In addition to addressing issues related to limitations in access to health care among racial and ethnic minorities, the Campaign will also include other aspects of life that contribute to good health, such as housing, education, faith, workplace conditions and social welfare.

The Campaign has three phases or milestones. The first major milestone, to be completed by October of this year, is the development of a charge. This charge – which is basically a "blue print" of guidelines and end goals for the Campaign – will be developed by a Steering Committee of 25 leaders representing public and private sector organizations dedicated to improving the health of the public. The Steering Committee will be comprised of leaders from business, labor, social welfare, housing, education, government, faith and ethnic organizations.

A larger coalition of some 300 people – from similar national, regional and local organizations – will use the charge to reach the second milestone, the development of a detailed, comprehensive plan. This plan will be completed by November 2001.

Finally, the third milestone, made possible by public-private partnerships, will be the implementation of the comprehensive plan, the redirection of resources where necessary and the evaluation of the Campaign's success in eliminating racial and ethnic disparities in health by the year 2010. APHA and HHS will provide joint leadership during all phases of this endeavor.

"This effort is truly an historic one. Our success in this complex undertaking will not only be of enormous benefit to the United States in terms of productivity and quality of life, but it will also serve as a role model for countries throughout the world," said Carol Easley Allen, PhD, RN, President of APHA.

Healthy People is the national prevention initiative through which public and private partners set health goals for the country each decade. Healthy People 2010 is the United States' contribution to the World Health Organization's (WHO) "Health for All" strategy. The U.S. effort will be characterized by intersectoral collaboration and community participation.

The American Public Health Association (APHA) is the oldest and largest organization of public health professionals and represents more than 50,000 members from over 50 public health occupations. Based on the values of health, equity, diversity, empowerment, integrity, dignity and knowledge for individuals and communities, APHA is the leading professional association that promotes and protects the health of the people.

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THE NATION'S NEWSPAPER

USA TODAY

NO. 1 IN THE USA

Tuesday, September 5, 2000

Familiar faces close medical gap

Caring about culture helps minorities

By [illegible]anning
U[illegible]

Nobody looks forward to a visit with a doctor, especially one who is going to poke and prod you. That's why Timothy Woodward, a gastroenterologist at the Mayo Clinic in Jacksonville, Fla., recalls with special pleasure a patient who came to see him recently.

"He looked at me and said, 'It's so good to see you.' " Woodward says. That was all, but those six words conveyed volumes of unspoken thoughts.

Both patient and doctor are black. And while that shouldn't make a big difference in a doctor's office, Woodward knows that, especially for minorities, having a physician who understands your culture is important.

"There's a security. You can relax," Woodward says. When black patients enter his office, "there's a certain relief in their eyes that you can see. I don't know how to translate how that feels — to see another person of color."

Medical anthropologist Eric Bailey calls it a "subtle cultural connection. Many times you can just look a[illegible]rson, and you make that [illegible] and you feel assured t[illegible] in hands that will provide quality care and have a better understanding of your beliefs."

Bailey, author of *Medical Anthropology and African American Health* (Bergin & Garvey, $65), says culture — "shared heritage, beliefs, mores and traditions" — plays a

By Kelly LaDuke for USA TODAY

Woodward: "The little black woman who comes in complaining of chest pain, she kind of reminds me of my grandmother."

strong role in health and in a patient's approach to the medical establishment. If those cultural patterns are not understood by physicians or public health agencies trying to reach minority communities, they are doomed to fail, he says.

He recalls a prenatal care program in an inner-city neighborhood in Indianapolis some years ago. The strategy wasn't working; women were not taking part in great numbers. Health officials didn't know what was wrong, Bailey says, because they didn't understand the women's attitudes about prenatal care.

"They'd listen to their mother or grandmother. Many times they were not aware of the daily nutrition a mother would need," Bailey says.

"They would not know that moderate exercise would be needed. They did not know they would need childbirth classes. ... They just assumed that, since their mothers didn't have trouble, they didn't have to take part in this public health campaign."

The barrier, he says, was "the perception, the mistrust of going to the local health care facility because it didn't have a rapport with the African-American community."

Such barriers help incorrect beliefs persist. In one group of black and Hispanic mothers Bailey studied, the perception was that spicy food could harm a baby's eyes and that sitting a certain way could wrap the umbilical cord around a baby's neck.

Mistrust of the medical establishment by people of color has long been noted and explained. Part of the blame lies in historical lessons such as the Tuskegee medical experiments that began in the '30s, in which black men with syphilis went untreated for decades so doctors could observe the course of the disease.

But, Bailey says, his research suggests there's more than such blatant examples to the sense of mistrust. As he spoke to people in neighborhoods in several American cities, he found "many times they weren't aware of Tuskegee, but they were aware of the disconnection the African-American community had with the local health care community."

An October survey of 4,000 people by the Kaiser Family Foundation in Menlo Park, Calif., found that 51% of blacks feel they are treated fairly most or all of the time by health professionals, compared with 71% of whites. And nearly twice as many blacks as whites say they think the health care system often treats people unfairly based on race.

> "There's a certain relief in their eyes that you can see. I don't know how to translate how that feels — to see another person of color."
>
> — Timothy Woodward, gastroenterologist

Much of the disconnection between blacks and the medical community was founded in the personal experiences of friends and relatives, one person telling another of a bad experience at a clinic or hospital.

"We share information within our extended family network," Bailey says.

Sometimes that can cause a person to delay seeking tests or treatment for an illness, he says. It also can affect a parent's willingness to seek preventive medical care for a child.

Rudolph Jackson, professor of pediatrics at Morehouse University in Atlanta, spoke last month at a meeting of the National Medical Association, an association of minority physicians, about low vaccination rates in some minority communities.

"Poverty levels, accessibility, understanding the health issues, there are all kinds of factors that go into play when it comes to minorities," he says. Some people, he says, don't understand the value of vaccines, viewing them with deep suspicion.

There are those in the minority community who fear that doctors are giving them HIV, the AIDS virus, in vaccines and "what they're doing under the guise of being helpful is to give us something harmful," Jackson says.

Such mistrust is rooted in history, he says. "You take incidents like the Tuskegee incident, and when you come into a community with this great vaccine, immediately there's the thinking, 'Oh, look out, here it comes again.' "

That mistrust translates into lower vaccination rates for minorities, and that's one reason such diseases as Haemophilus influenza Type B, also know as Hib disease, are more common among blacks and Hispanics than in other racial and ethnic group, Jackson says.

Doctors and nurses who are white can help bridge the cultural gap when treating non-white patients by showing their "sincerity in understanding and connecting with them," Bailey says. By fostering a dialogue not only with the patient, but also with his or her family members during the office visit, then following up with a phone call at home, health care professionals can fully explain the diagnosis and treatment, enlist family support and clear up any misconceptions, he says. Other strategies include seeking the advice of a minority health care professional to help understand cultural issues and volunteering in community health care programs.

Whenever possible, Jackson says, minority health care professionals should be included in public health programs from the outset. "If there were more minorities in decision-making positions," he says, "at least we could be pointed to, and it can be said we are going to look out for the minority kids and not allow things that are detrimental to occur."

By H. Darr Beiser, USA TODAY

Bailey: Medical anthropologist has written a book on the importance of cultural influences.

Reaching out to find a cure

Culture is only one of several factors — along with lack of health insurance, access to health care, poverty and environment — that can account for disparities in health between racial and ethnic minorities and whites, health experts say.

The numbers tell the results:

- The infant mortality rate for black infants is more than twice that of whites. In 1997, there were six deaths per 1,000 live births among white infants, compared with 13.7 for blacks.
- The prevalence of diabetes in blacks is about 70% higher than it is in whites.
- Black men have an 85% greater risk than white men of developing prostate cancer.
- The death rate from heart disease is 147 per 100,000 people for blacks, compared with 105 for whites.

Federal officials are well aware of the problem. The president's Healthy People 2010 initiative, which calls for an end to health disparities by the end of the decade, has prompted action:

- A five-year project led by the Centers for Disease Control and Prevention in Atlanta has provided $9.4 million for coalitions in 32 U.S. communities aimed at addressing high disease rates among minorities.

The project, called Racial and Ethnic Approaches to Community Health (REACH) 2010, targets six health problems: infant mortality, breast and cervical cancer, cardiovascular disease, diabetes, immunization and HIV/AIDS.

REACH 2010 director Imani Ma'at-Shambhala says the local programs aim to identify weaknesses in health services and create plans for them. "We're hoping to get a lot of answers ... what the problems are at the local level, ... we're hoping they'll come up with answers to strengthen the infrastructure."

- A partnership between the American Public Health Association and the U.S. Department of Health and Human Services wants to "translate the 2010 objectives into a plan," says Richard Levinson, associate executive director of the public health association.

Starting next month, the program's steering committee will appoint a working group of representatives of government, community organizations, labor, churches, businesses and health care professionals. It won't be easy, Levinson says. "It's no small order to overcome all these years in which disparities have existed." The plan is to be finished by the end of next year, "and at that point, we hope also to have lined up sources of funds to make that a reality."

Woodward agrees. "For me and a lot of my African-American colleagues, the key point is identification," he says. "People don't realize how unconsciously identification comes into how you interact with patients. For me, the little black woman who comes in complaining of chest pain, she kind of reminds me of my grandmother. That has a lot to do with how you approach patients."

Selected Background Material