EXECUTIVE SUMMARY

Information tools, such as the personal computer and the Internet, are increasingly critical to economic success and personal advancement. *Falling Through the Net: Defining the Digital Divide* finds that more Americans than ever have access to telephones, computers, and the Internet. At the same time, however, NTIA has found that there is still a significant "digital divide" separating American information "haves" and "have nots." Indeed, in many instances, the digital divide has *widened* in the last year.

This report, NTIA's third in the *Falling Through the Net* series, relies on December 1998 U.S. Department of Commerce Census Bureau data to provide an updated snapshot of the digital divide. The good news is that Americans are more connected than ever before. Access to computers and the Internet has soared for people in all demographic groups and geographic locations. At the end of 1998, over 40 percent of American households owned computers, and one-quarter of all households had Internet access. Additionally, those who were less likely to have telephones (chiefly, young and minority households in rural areas) are now more likely to have phones at home. (Chart I-1)

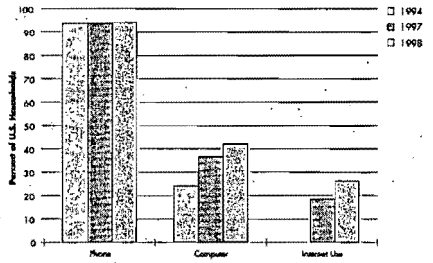


Chart I-1

Accompanying this good news, however, is the persistence of the digital divide between the information rich (such as Whites, Asians/Pacific Islanders, those with higher incomes, those more educated, and dual-parent households) and the information poor (such as those who are younger, those with lower incomes and education levels, certain minorities, and those in rural areas or central cities). The 1998 data reveal significant disparities, including the following:

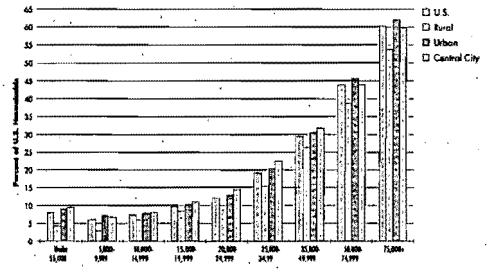


Chart I-21

- Urban households with incomes of $75,000 and higher are more than *twenty times* more likely to have access to the Internet than rural households at the lowest income levels, and more than *nine times* as likely to have a computer at home. (Chart I-21)
- Whites are more likely to have access to the Internet from home than Blacks or Hispanics have from *any* location.
- Black and Hispanic households are approximately *one-third* as likely to have home Internet access as households of Asian/Pacific Islander descent, and roughly *two-fifths* as likely as White households. (Chart I-22)

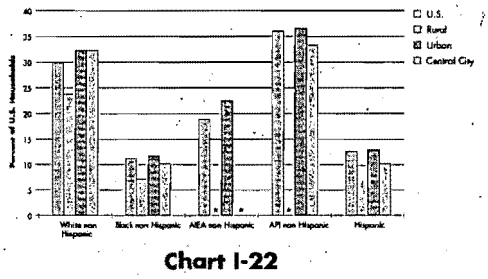


Chart I-22

- Regardless of income level, Americans living in rural areas are lagging behind in Internet access. Indeed, at the lowest income levels, those in urban areas are more than twice as likely to have Internet access than those earning the same income in rural areas.

For many groups, the digital divide has *widened* as the information "haves" outpace the "have nots" in gaining access to electronic resources. The following gaps with regard to home Internet access are representative:

- The gaps between White and Hispanic households, and between White and Black households, are now approximately five percentage points larger than they were in 1997. (Chart I-23)
- The digital divides based on education and income level have also increased in the last year alone. Between 1997 and 1998, the divide between those at the highest and lowest education levels increased 25 percent, and the divide between those at the highest and lowest income levels grew 29 percent.

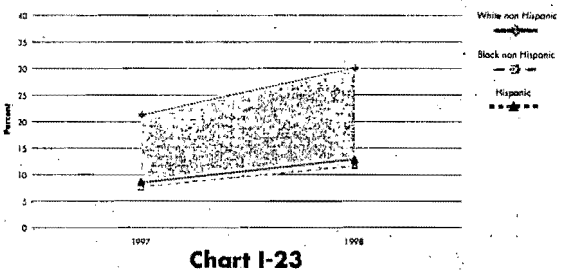


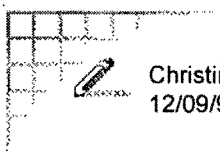
Chart I-23

Nevertheless, the news is not all bleak. For Americans with incomes of $75,000 and higher, the divide between Whites and Blacks has actually narrowed considerably in the last year. This finding suggests that the most affluent American families, irrespective of race, are connecting to the Net. If prices of computers and the Internet decline further, the divide between the information "haves" and "have nots" may continue to narrow.

Until every home can afford access to information resources, however, we will need public policies and private initiatives to expand affordable access to those resources. The Clinton Administration is committed to connecting all Americans to the National Information Infrastructure. Pro-competition policies, to reduce the prices of basic phone and information services, and universal service policies will continue to be important parts of the solution.

Community access centers (CACs) — such as schools, libraries, and other public access points — will play an important role. The 1998 data demonstrate that community access centers are particularly well used by those groups who lack access at home or at work. These same groups (such as those with lower incomes and education levels, certain minorities, and the unemployed) are also using the Internet at higher rates to search for jobs or take courses. Providing public access to the Internet will help these groups advance economically, as well as provide them the technical skills to compete professionally in today's digital economy.

Establishing and supporting community access centers, among other steps, will help ensure that all Americans can access new technologies. As we enter the Information Age, access to computers and the Internet is becoming increasingly vital. It is in everyone's interest to ensure that no American is left behind.



Christine L. Anderson
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Subject: Fact Sheet: The Clinton-Gore Administration: Working to Bridge the Digital Divide

THE CLINTON-GORE ADMINISTRATION: WORKING TO BRIDGE THE DIGITAL DIVIDE

December 9, 1999

Today, President Clinton announced that he intends to lead a New Markets tour in the Spring of 2000 to focus national attention on the digital divide -- the growing division in the United States between information "haves" and "have-nots." This issue has also been a top priority for Vice President Gore, who has worked to bridge the digital divide by ensuring that all of our children have access to educational technology. To support this effort, President Clinton issued a Directive to members of his Cabinet to take specific actions to close the digital divide, such as expanding Community Technology Centers in low-income urban and rural neighborhoods, continuing to measure the extent of the digital divide, and helping low-income workers gain the skills they need to compete for high-paying information technology jobs. He also announced several commitments from the private sector and non-profit organizations that will help address the problem, including a commitment of the Congress of National Black Churches to make this issue a top priority, a comprehensive clearinghouse of state and local efforts to bridge the digital divide, and a partnership between the private sector and the Leadership Conference on Civil Rights that will help bring civil rights organizations into the 21st century.

The President was joined today by Duane Ackerman, Chairman and CEO, BellSouth Corporation; Michael Armstrong, Chairman and CEO, AT&T; Zoe Baird, President, Markle Foundation; Richard Brown, Chairman and CEO, EDS; Stephen Case, Chairman and CEO, America Online; Darien Dash, CEO, DME Interactive Holdings; Tessie Guillermo, Exec. Dir., Asian and Pacific Islander American Health Forum; Wade Henderson, Exec. Dir., Leadership Conference on Civil Rights; Roberta Katz, CEO, Technology Network; Susan Masten, President, National Congress of American Indians; Jorge Schement, Board Member, Benton Foundation; and Irma Zardoya, Superintendent, District 10, New York Public Schools.

Today's announcement came as Secretary of Commerce William Daley convened a summit on

the digital divide with these and other prominent high-tech CEOs and leaders in the civil rights, educational, and non-profit communities.

I. FROM DIGITAL DIVIDE TO DIGITAL OPPORTUNITY

President Clinton made several announcements that will help bridge the digital divide and create digital opportunity for more Americans.

A New Markets trip to disadvantaged urban and rural communities to focus national attention on the digital divide: The President will lead a tour next spring to highlight communities that are using information technology to enhance our children's education, expand access to life-long learning, and create economic growth and high-tech, high-wage jobs. Previous New Markets trips -- to communities such as Appalachia, the Mississippi Delta, Newark, and Chicago -- have served as a catalyst for new public-private partnerships to expand opportunity in those regions of the country that have not yet reaped the benefits of America's economic expansion.

A directive to members of the Cabinet to take specific actions to address the digital divide: President Clinton is directing members of his Cabinet (Secretaries of Commerce, Education, Health and Human Services, Housing and Urban Development, and Labor) to take specific steps to close the digital divide, including:

Continuing to measure the nature and extent of the digital divide by examining the importance of income, education, race, gender, geography and age to Americans' access to Information Age tools;

Expanding the network of Community Technology Centers to provide access to technology for those American who can't afford it;

Promoting applications of the Internet that will empower low-income families, such as the ability to start their own business; and

Upgrading the IT skills of workers in low-income communities.

3. **Digital Divide Network**: Companies from across the computing, telecommunications, software, and Internet industries -- as well as the Urban League and several of the nation's largest private foundations-- are coming together to launch the Digital Divide Network. The network is an Internet-based clearinghouse for information on public and private efforts to bring technology to underserved communities. For the first time, America will have a one-stop shop for tracking our progress and for learning exactly what has worked and what has not.

Digital Opportunity Partnership The Leadership Conference on Civil Rights is working with many nonprofit organizations and private-sector companies to launch a new Digital Opportunity Partnership. This initiative will empower the entire civil and human rights communities through an expanded Web site (civilrights.org), leadership forums, and even "freedom riders" who will bring high-technology to the doorstep of nonprofit organizations.

Congress of National Black Churches: The Congress of National Black Churches, representing 65,000 churches and 20 million members, is sending a letter to the President acknowledging the importance of the digital divide as a key civil rights issue for the 21st century, and committing to work with the President and with industry to help close the digital divide.

II. THE IMPORTANCE OF BRIDGING THE DIGITAL DIVIDE

Access to computers and the Internet and the ability to effectively use this technology are becoming increasingly important for full participation in America's economic, political and social life. People are using the Internet to find lower prices for goods and services, work from home or start their own business, acquire new skills using distance learning, make better informed decisions about their healthcare needs, and get more involved in the education of their children by communicating more frequently with teachers.

Access to computers and the Internet has exploded during the Clinton-Gore Administration. Unfortunately, there is strong evidence of a "digital divide" -- a gap between those individuals and communities that have access to these Information Age tools and those who don't. In some instances, this divide is actually widening. A July 1999 report from the Department of Commerce, based on December 1998 Census Department data, revealed that:

Better educated Americans more likely to be connected. Between 1997 and 1998, the technology divide between those at the highest and lowest education levels increased 25%. In 1998, those with a college degree are more than *eight times* likely to have a computer at home and nearly *sixteen times* as likely to have home Internet access as those with an elementary school education.

The gap between high- and low-income Americans is increasing. In the last year, the divide between those at the highest and lowest income levels grew 29%. Households with incomes of $75,000 or higher are more than *twenty times* more likely to have access to the Internet than those at the lowest income levels, and more than *nine times* as likely to have a computer at home.

Whites more likely to be connected than African-Americans or Hispanics. The digital divide is also persistent and growing along racial and ethnic lines. Whites are more likely to have access to the Internet from home than African-Americans or Hispanics have from *any* location. African-American and Hispanic households are roughly *two-fifths* as likely to have home Internet access as White households. The gaps between White and Hispanic households, and between White and African-American households, are now more than six percentage points larger than they were in 1994. However, for incomes of $75,000 and higher, the divide between Whites and African-Americans has narrowed considerably in the last year.

Rural areas less likely to be connected than urban users. Regardless of income level, those

living in rural areas are lagging behind in computer ownership and Internet access. At some income levels, those in urban areas are 50% more likely to have Internet access than those earning the same income in rural areas. Low income households in rural areas are the least connected, with connectivity rates in the singles digits for both computers and Internet access.

III. A STRONG RECORD OF ACCOMPLISHMENT

President Clinton and Vice President Gore have worked hard to close the digital divide, and to help create opportunity for more Americans in the Information Age. They have worked to:

Ensure that every child is technologically literate: The President and Vice President have set a goal of connecting every classroom and library to the Internet by the year 2000 -- a goal that we are on track to meet. They also have fought for investments in technology training for teachers, modern computers in the classroom, and high-quality education software. Technology in the classroom can make it easier for parents and teachers to communicate, prepare our children for the high-tech workplace of the 21st century, and help improve student performance in all academic subjects. Major Administration initiatives in educational technology include the Technology Literacy Challenge Fund, and the "e-rate." The "e-rate" is helping to connect our children to the future by providing discounted Internet access to libraries and 1 million classrooms, with the deepest discounts going to the poorest schools and libraries that need it most.

Expand the network of Community Technology Centers: The final budget deal included a tripling of support for Community Technology Centers, which provide access to technology for those who can not afford it.

Encourage the development of applications of information technology for low-income Americans: Administration grant programs have supported innovative pilot projects -- such as the use of telemedicine for prenatal care, telementoring for at-risk youth, a national computer network for local food banks, and distance learning for people who have lost their jobs.

Expand access to technology for people with disabilities: President Clinton and Vice President Gore have been strong supporters of efforts to make technology more accessible for people with disabilities. Recent actions by the Federal Communications Commission will help ensure that telecommunications equipment, such as cellular phones, is designed to be accessible for people with disabilities.

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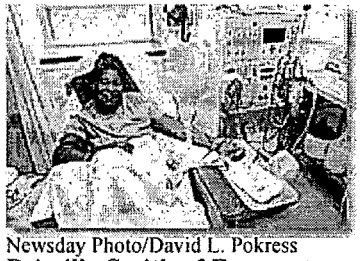

Newsday Photo/David L. Pokress
Priscilla Smith of Freeport gets dialysis at Nassau County Medical Center.

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THE HEALTH DIVIDE

A Difference of Life and Death

For blacks, medical care and state of health trail whites

By Ford Fessenden
Staff Writer

DECADES AFTER legal segregation ended, blacks and whites in America are largely treated under two different medical systems -- not separate, but still unequal.

The consequences are stark:

African-Americans are less likely to get the high-tech, advanced medical care that can mean the difference between life and death, a Newsday computer analysis has found.

They are less likely to use a medical system that for generations has engendered a deep mistrust, born of unethical medical experiments and segregated hospitals.

Blacks on Long Island and in Queens get bypass operations at a rate less than one-quarter that of whites, Newsday found. They get angioplasties, the operation that clears blockages from coronary arteries, at one-third the rate.

African-Americans wait longer in local hospitals for kidney transplants. They get hip and knee replacements at a rate that's lower than whites. Black women get more of the scarring kind of hysterectomy operation than white women, and fewer of the less-invasive type than white women. Blacks with diabetes and circulatory problems get more leg amputations, but fewer leg-saving operations than whites.

At bottom, the health care gap in this region and in the nation adds up to a stunningly shorter life expectancy for African-Americans: on average, they die six years younger than whites.

The faces of the health gap are people such as Dedri Brown, a school safety officer from Far Rockaway, a diabetic who lost a leg to amputation, a fate suffered more frequently by blacks with the disease than whites. They include Gerald Adams, of Jamaica, who's been waiting five years for a kidney transplant - almost twice as long as the average white person in New York. And Andrea Cherry of Baldwin, who got prenatal care, took vitamins and did all the right things, but still lost her baby at birth, the kind of tragic event that happens 2 1/2 times more frequently to African-American mothers. And Toya Davis, a Hempstead woman who said she had to intervene with her homeless mother's doctors to make sure she got the angioplasty she needed.

Black infants die at higher rates, and violence and infectious diseases are a significantly greater threat to blacks than whites. At the same time, blacks suffer just as much from "diseases of affluence" - colorectal and breast cancer and heart disease - that afflict people in high-income, high-stress areas. But they get their first heart attacks in their early 60s, on average, instead of their late 60s, as whites do, Newsday found in reviewing hospital data.

The reasons behind the racial health gap are many, they are incompletely understood, and the issue is highly charged. Blacks often have poorer access to care and to health insurance, and as a result may put off attending to problems until they are more severe. The longer a patient waits to take care of a health problem, the greater the likelihood the disease will involve complications that can make it more difficult to cure with advanced medical techniques. They may live in more stressful and unhealthy environments that compound health problems as well.

But researchers long ago dismissed as improbable notions that the gap is due to biological differences that some assumed rendered blacks more susceptible to common diseases than whites.

"The public thinks race is biological, but it's not. That's misleading mythology," said Dr. Robert Hahn, an epidemiologist at the federal Centers for Disease Control and Prevention in Atlanta who studies disease clusters and race. "Race has only a minimum connection with biology."

While the health gap affects other racial and ethnic groups in different ways, the differences are most pronounced for African-Americans.

Having money and good insurance increases the chance of getting the most intensive medical care, regardless of race. But even when the type of insurance was the same, black residents of Queens and Long Island aren't treated as intensively as whites. And the disparity persists at high income levels. Blacks making from $50,000 to $75,000 were only half as likely as whites to get angioplasty or bypass surgery after they had been admitted to the hospital for a heart attack or clogged arteries, Newsday found.

"It's all about being perceived as worthy," said Davis, whose mother got an operation to save her heart after Davis lobbied her doctors. "I think that because I let them know that I was concerned and that I was educated, they took better care of her. She got the angioplasty she needed because I was there, and I don't know if she would have gotten it if I wasn't."

These treatment differences also help explain why the health of African-Americans compared with whites is persistently worse in Queens and Long Island - and in the rest of the nation as well.

"You get treated by what you look like," said Kathleen Gaffney, the Nassau County health commissioner. "If you're black . . . the physician is less likely to take your symptoms as seriously, so you may not get the same response. There continue to be health care stereotypes in terms of minority patients being less compliant, they `don't take their

drugs,' and there is also a perception that they are less motivated and less educated. It becomes a self-fulfilling prophecy because they're treated differently by health professionals."

Doctors and hospitals say much of the disparity they can do little or nothing about - black patients often come in with disease more advanced, health more compromised. If just infant mortality were the same as whites, the life expectancy rate would go up nine months for blacks. And black patients and doctors say, yes, indeed, many blacks avoid doctors, but out of fear and mistrust as well as economic issues. For generations, blacks in America were shut out of top-flight medical care and, in some infamous cases, used as unwitting subjects of dangerous medical experiments.

Whatever the reasons for the disparity, President Bill Clinton has charged a federal government task force with the job of eliminating it.

"I don't think there's any way that we can tolerate an environment in which a lot of people who are minorities are not receiving quality health care," said U.S. Surgeon General David Satcher, "or suffering disproportionately from infant mortality, or not receiving immunizations, or unnecessarily getting cardiovascular disease and hypertension." Satcher, who is leading the effort to narrow the racial health gap, told Newsday in an interview: "If you just look at it from a humanitarian point of view, you say: As a nation we cannot tolerate the disparities."

And black leaders have begun to stake out the issue as a new front in civil rights. "It does not matter how much social, political, and economic progress we make, it means nothing if you are not alive," said the Rev. Al Sharpton. "This is the new civil rights battle of the 21st Century."

For the past year, a team of Newsday reporters has been examining the health of people in this region. The newspaper conducted a behavioral-risk study of more than 2,000 residents on Long Island and in Queens to parallel surveys done at the federal level. Newsday extensively analyzed databases covering every hospital admission in New York State over the past seven years. To get precise information about doctors and insurance companies, Newsday sued New York State under the Freedom of Information Act, and won.

Here's what Newsday's examination found:

Whites get more intensive treatment. Even though they die of coronary heart disease at lower rates than blacks, whites are much more likely to get advanced heart procedures. Last year, there were 138 cardiac bypass operations per 100,000 people among whites, just 31 per 100,000 among blacks in Queens and Long Island. Newsday found whites also get hip replacements at a rate twice as high as blacks, knee replacements at a rate 23 percent greater, and gall bladder operations at a rate 53 percent higher. All figures are adjusted for differences in age between the races.

Blacks often get more radical surgery when less severe alternatives are an option. For instance, among those with diabetes, blacks are more likely to lose feet or legs to amputation, while whites are more likely to

get surgery to restore blood flow and save their legs. Among 1,907 whites and 385 blacks from Nassau, Suffolk and Queens who got surgery for atherosclerosis or diabetes-related circulatory problems in 1995, 61 percent of whites got surgery to restore blood flow, but only 43 percent of blacks got leg-saving surgery. The rest had amputations. And black women are more likely to get the more invasive kind of hysterectomy treatment, and less likely to get the less drastic vaginal hysterectomy, which doesn't require a large incision. The vaginal operation is more expensive and harder, and studies have shown it is used more on women higher on the socioeconomic scale.

Blacks with serious kidney problems wait longer for transplants, and are less likely to receive a kidney than whites. For every 1,000 blacks in the hospital with kidney failure, there were 8.2 transplants; for every 1,000 whites with kidney failure, there were 13.3 transplants. Some of this is due to biological factors involved in matching, but there are aspects of the transplant system that could be modified to make more organs available to blacks.

A chasm of culture and color separates African-American patients from mostly white doctors. Barely 40 percent of blacks say they trust other people not to take advantage of them if given the chance, compared to 71 percent of whites. And that distrust extends to the medical system, where a history of unequal treatment has poisoned the relationship between many black patients and doctors. "I think you have to approach doctors under the premise that they're all liars," said Hempstead mortgage consultant Virginia Covington, 56. Blacks are more likely to seek alternatives to traditional medicine, and they delay going to doctors. Even blacks with good insurance are sicker when they arrive at the doors of medical practitioners. Black cancer sufferers are more likely to die of their disease, a strong indicator they aren't getting care early enough.

African-Americans in Queens and Long Island have a mixed picture on lifestyle risks for disease. They're more likely to be overweight and to get less exercise, Newsday's poll showed. They're also more likely to live in more dangerous places, and experience a lot more stress. All that could contribute to worse health. But in key ways, they also should be more healthy: They're much less likely than whites to smoke or to drink excessively, Newsday's poll shows.

While blacks have lower life expectancy in general, something occurs around age 80 that turns the debate about race and health upside down. The number of years remaining for blacks and whites becomes equal. Then, after age 84, life expectancy becomes higher for blacks than for whites. In fact, while African-Americans are 13 percent of the general population they are up to 19 percent of the nation's centenarians. While debates have raged for years about this crossover, it adds to the notion that poorer health outcomes for minorities are not a matter of biology, but one of social circumstance and access to care.

A "silent curriculum" of purported racial differences perpetuates medical stereotypes about blacks and other minorities. These include perceptions about the treatment of disease and what is normal for certain ethnic groups. For example, Laurence Thomas, a Syracuse University professor, was told by his doctor that he had high blood pressure, but that it was OK because he is African-American. It turned

out that Thomas didn't have the illness at all. But even if he did, the notion that it was something he should just live with because of his race is mistaken, according to experts. Commonly held beliefs like this one affect judgments about what drugs are prescribed and what kinds of procedures will work. "There are lots of little stories that physicians believe that are neither scientifically based nor proven. That's the problem," said Dr. Judith Gwathmey, a professor of medicine and physiology at Boston University.

Treatment disparities have been the dirty little secret of medicine: There has been a growing and mostly unrefuted body of literature in medical journals since the 1980s that shows black patients don't get the same treatment as whites. Yet little has been done to change the situation.

"What is striking is that the findings are not subtle and that we as a country have done nothing about it," said Dr. Arnold Epstein, chairman of the department of health policy of the Harvard University School of Public Health.

Indeed, Newsday's study of hospital data showed that in 1991, whites on Long Island and in Queens got five times as many bypass operations as blacks. In the next several years, numerous studies would emerge across the country pointing out the problem. By 1997, though, Newsday found, local doctors were still performing bypasses on whites at 4 1/2 times the rate for blacks.

"I think it's a reality that if you have money, if you have political influence, there is going to be a different level of care," said Bob Gumbs, former executive director of the New York City Health Systems Agency. Now president of Strategic Resources Associates, a New Jersey consulting firm, Gumbs said, "It's the equivalent of the school system. Should schools be different? Maybe not. Is the reality that they are different? Yes."

To be sure, there are some procedures in which Newsday found little or no difference between the races. For instance, rates of breast-saving cancer surgery were similar between blacks and whites. Prostate removal rates also were nearly equivalent between whites and blacks. So were heart and liver transplant rates.

And there may be some technical issues that cloud the picture. For instance, Newsday could not determine from the hospital data whether blacks with circulation problems in their legs had more advanced disease, or those with arthritis of the hip or knee had less advanced disease.

But overall, researchers say, there are enough discrepancies to show a pattern - a gap that is "pervasive and widespread," said Jose Escarce, a researcher at the RAND Corp. in Santa Monica, Calif., who found big gaps between black and white Medicare patients in most of 23 common hospital procedures in a 1993 study.

"Let's face it," said Mary Hibberd, the former Suffolk County health director, now senior medical director at IPRO, a medical consulting firm in Valley Stream. "There's still a lot of racism, and classism, on Long Island."

Newsday found evidence that segments of the minority population are absent from the standard routines of care. Many are uninsured. But even many African-Americans who are insured are still not getting the kind of routine preventive care that improves and saves lives. At health fairs in minority communities this year sponsored by a community group associated with Dr. Aubrey Lewis, a cardiologist from Merrick, almost everyone who showed up for free screenings had some kind of abnormal test.

A third were anemic, more than half had high cholesterol. A patient who showed up at a fair in Uniondale Sept. 26 had blood glucose levels at walking-time-bomb levels. She recently had lost her health insurance, and lost control of her diabetes.

Newsday's investigation found that blacks weren't getting medical care in time. They end up seeing doctors - but they're sicker when they finally do. African-Americans, in fact, actually are more likely than whites to have a hospital stay in any given year.

"I couldn't take the time to be sick," said Ethel Mae Payton of Hempstead. Her husband had just lost his leg to complications from diabetes when doctors told her she had to start dialysis because her kidneys were failing. "My husband was already ill and I had to take care of my husband."

"Access to early care is critical," said Hibberd. "Prevention is really where it's at. Once you come in with your first heart attack, there's a lot of damage already been done."

That's not just talk: Lack of access to primary and preventive care clearly means that many blacks on Long Island and in Queens die needlessly.

An example: More black cancer patients die of their disease. Cancer survival is largely dependent on how early the disease is caught and how aggressively it is treated, and state cancer statistics show blacks are not surviving at the same rate as whites. The ratio of death to incidence - a rough measure of how many people don't survive cancer - is 50 percent for black women, just 42 percent for white women. And there's a similar gap for black and white men. The cancers are no different - but the delays mean that hundreds of blacks die.

Seventeen percent of blacks on Long Island say they have not gone to a doctor when they needed to because they couldn't afford it, according to Newsday's survey, compared with just 7 percent of whites. One in four black households on Long Island has at least one person with no insurance, nearly twice the rate of whites, according to the survey. In Queens, more than a quarter of black households had an adult with no insurance versus one in five for whites.

A Newsday study of hospital admissions in 1997 shows that even blacks with good insurance may be less likely to get good primary care.

Hospitalization of children for earache is considered a barometer of primary care - it rarely happens when the kids are seeing a doctor regularly because the problem gets taken care of before it becomes

critical.

On Long Island and Queens, such hospitalizations are more likely for black children than for white, but not just because black children are more likely to be uninsured. Even among those covered by commercial insurance, black children are twice as likely as white children to be hospitalized for severe ear infections.

Beyond insurance coverage, there's something else keeping blacks from getting to doctors. "There's a basic distrust, a feeling that when you do go for care you're treated poorly," said Marion Terry of the African American Health Education and Development Foundation in Hempstead. "That's one of the reasons that, even if you do have access, you don't access the medical system until you're much sicker."

"Blacks have a tremendous fear of institutional everything," Lewis said. "Remember Tuskegee," he said, referring to the decades-long government project that used African-American men as unwitting subjects in a syphillis experiment.

Virginia Covington says she insists her doctors respond to her questions, but thinks many blacks may not. "I pick my hospitals and I pick my doctors very carefully," Covington said. "I come with a list of questions, and instead of the five minutes he wants to spend on me, he spends 15. I think any minority person who doesn't articulate, for any reason, or feels intimidated, doesn't get the help and the care they need."

Surgeon General Satcher said: "I think there are cases in which racism plays a role. It has a lot to do with the sensitivity and commitment of the health professional. It has to do with people's relationship with health care providers . . . It has to do sometimes with the information that's available to the patient . . . How we pay for health care in this country comes into play. And in some cases racism."

But health professionals say if that happens, it's not intentional. Mita Giacomini, assistant professor of clinical epidemiology and biostatics at McMaster University in Hamilton, Ontario, said, "Most physicians would say, `We're not a bunch of racist people.' But there certainly are things going on in the system that have that effect."

Getting in the door to the medical system isn't the only problem. After they enter, Newsday found, African-Americans get a different reception.

Among Medicare patients, 17.1 percent of whites who entered the hospital with heart attack or atherosclerosis got a bypass or angioplasty - an operation to open up clogged blood vessels - but just 8.6 percent of black patients with the same diagnosis and the same insurer got such surgery. Twenty-two percent of white patients with commercial insurance got the surgery, but just 17 percent of black patients with the same kind of insurance.

And there is little evidence that the gaps are narrowing - Newsday's review of local practices shows remarkable consistency in the racial disparity over the last six years. National studies also have been consistent year after year.

"It is distressing - one would have thought some of the differentials in care would have narrowed, and they really haven't," said Wayne Giles, medical epidemiologist with the Centers for Disease Control and Prevention.

Recent studies have tried to determine whether black patients don't want the operations that whites are getting - that they, rather than their doctors, opt for fewer bypass operations and angioplasties. Steven P. Sedlis at the Veterans Adminstration Medical Center in Manhattan found that blacks were twice as likely to refuse a bypass, and concluded that "reluctance by African-American patients to undergo invasive cardiac procedures may help explain observed disparities in race-related cardiac care."

But another study in a VA hospital in Pittsburgh, which also found blacks more likely to say they would refuse an invasive heart procedure, found they probably refused because they didn't understand. The people refusing were those who thought they were going to die from the procedure or thought they couldn't trust their doctors, and those people were largely black.

"There's a profound mistrust coming through," said Dr. Jeff Whittle, the author of the Pittsburgh study. "If you look at the people who refuse a procedure, they're not the ones who have a long-standing relationship with a doctor."

And another study by researchers in Albany, which is to appear in January in the journal Medical Care, provides evidence that, in fact, doctors don't recommend cardiac surgery as often for black patients as whites.

"One of the things alleged by those who say that there are truly not racial differences is that blacks tend to turn down procedures that have been offered to them," said Ed Hannan, professor and chairman of the Department of Health Policy, Management and Behavior at the School of Public Health at the State University at Albany. "But what we found, essentially, is that the physician did not recommend the surgery."

Edward McFadden, 58, of Uniondale, sees a cardiologist for a heart murmur. "He kept saying that everything was fine, but I wanted him to explain to me more about why everything was fine. I don't know if he thinks that I'm stupid or simply because he doesn't have the time, but he should have been more interested."

Doctors, with limited time to get to know a patient, make a lot of judgments about who's a good candidate for a therapy such as bypass or angioplasty.

"We're not talking about people who are overtly racist," said Michelle van Ryn, a researcher at SUNY-Albany, and lead author of the study. "Physicians have very busy worlds. The encounters [with patients] are quick. These are things that increase stereotyping."

Under such circumstances, "the doctor might decide this patient can't perform the rehabilitation necessary, or he's going to live just another five years," said David Carlisle, a researcher at the University of

California at Los Angeles. "There are all sorts of potential biases."

Those judgments can result in a racial effect when the patient is black and the doctor is white, researchers say.

"It's the person you see as suffering that you empathize with," Whittle said. "If you have more empathy with one person, you're more prone to talk that person into a procedure."

But local cardiologists say they try to treat everyone properly.

"Once we put someone on a treadmill and find something wrong, there's no way we're not going to treat them," said Dr. Vellore Padmanabhan of North Shore University Hospital, Manhasset, and Jamaica Medical Center.

Dr. Stephen Green, the assistant chief of cardiology at North Shore University Hospital in Manhasset, said sometimes the problem occurs long before he sees the patient. "What might be occurring is that these patients are not reaching our attention until later in life, when they're not as good candidates" for surgery, said Green.

Part of the issue may be that doctors develop standard guidelines on how best to treat patients, but they are dependent on subjective judgments. "If you look at practice guidelines, they will mention things like, `The patient has to have a stable family environment, the ability to pay for drugs,'" said McMaster University's Giacomini. Such things can have a racial effect, not only if fewer blacks than whites meet the guidelines, but also if doctors think so.

"Those ideas that the client has to be loyal to treatment regimens probably play on physician preferences," Giacomini said. "Whose lifestyle appeals to them in a way they can trust?"

"There are a lot of subtle factors at work: Can they participate in rehab? Do they have a high-risk lifestyle?" van Ryn said. "I've become pretty convinced that it's a series of encounters in which subtle judgments are made. But I believe doctors are no more or no less racist than anyone else in our society."

Some researchers have argued that, in fact, the less intensive treatment blacks receive may be more appropriate. Research has pointed out that many operations - from hysterectomy to cardiac bypass - are performed unnecessarily. But van Ryn's study found that wasn't the case: Among patients for whom detailed review showed that a cardiac bypass was not only appropriate, but downright necessary, blacks were more likely than whites to end up without it.

At a time when advances in health care continue to be made, but the will to pay for them is not as strong, chances are that inequities in health care, especially those between races, will get worse, experts say. The rich tend to get richer, but they also tend to get healthier, relatively speaking.

"Things can get better for everyone, while the disparities can grow," said Dr. Paul Wise, director of social and health policy research at Boston Medical Center. "Where cost containment is colliding with

technical innovation, that's where you have the greatest potential for differences in treatment."

An example: Survival of premature infants has greatly increased since 1990, when the federal Food and Drug Administration approved use of drugs to aid development of the lungs of premature infants. But researchers have found that the drugs get used more for white than for black mothers and babies.

Indeed, on Long Island and Queens, Newsday found that the drugs seem to have made a great difference in survival of the lowest birth-weight babies. While it is impossible to say from the data whether the drugs are being used more for white than black preemies, this much is clear: The number of in-hospital deaths of white preemies on Long Island and in Queens has dropped 32 percent since 1991, compared to just 11 percent for blacks, Newsday found in reviewing hospital data. The gap between whites and blacks in infant health, already large, thus got larger.

"It's critical that all children have the rights to the fruits of medical progress," Wise said. "At a time of revolution in medicine, it's critical to keep an eye on questions of equity and justice."

Toya Davis wasn't looking for a revolution in medicine to save her mother, just some dignity as she faced serious medical problems a few years ago.

"I had lost touch with my mother for many years, and it turned out she was homeless and . . . living on public assistance," Davis said. "I told them not to do anything to her until I got there. I really wanted those doctors to know that this poor, homeless, black woman did have family and did have people that cared about her and that they couldn't simply brush off her medical conditions."

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Race, Gender, and Partnership in the Patient-Physician Relationship

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Context Many studies have documented race and gender differences in health care received by patients. However, few studies have related differences in the quality of interpersonal care to patient and physician race and gender.

Objective To describe how the race/ethnicity and gender of patients and physicians are associated with physicians' participatory decision-making (PDM) styles.

Design, Setting, and Participants Telephone survey conducted between November 1996 and June 1998 of 1816 adults aged 18 to 65 years (mean age, 41 years) who had recently attended 1 of 32 primary care practices associated with a large mixed-model managed care organization in an urban setting. Sixty-six percent of patients surveyed were female, 43% were white, and 45% were African American. The physician sample (n = 64) was 63% male, with 56% white, and 25% African American.

Main Outcome Measure Patients' ratings of their physicians' PDM style on a 100-point scale.

Results African American patients rated their visits as significantly less participatory than whites in models adjusting for patient age, gender, education, marital status, health status, and length of the patient-physician relationship (mean [SE] PDM score, 58.0 [1.2] vs 60.6 [3.3]; $P = .03$). Ratings of minority and white physicians did not differ with respect to PDM style (adjusted mean [SE] PDM score for African Americans, 59.2 [1.7] vs whites, 61.7 [3.1]; $P = .13$). Patients in race-concordant relationships with their physicians rated their visits as significantly more participatory than patients in race-discordant relationships (difference [SE], 2.6 [1.1]; $P = .02$). Patients of female physicians had more participatory visits (adjusted mean [SE] PDM score for female, 62.4 [1.3] vs male, 59.5 [3.1]; $P = .03$), but gender concordance between physicians and patients was not significantly related to PDM score (unadjusted mean [SE] PDM score, 76.0 [1.0] for concordant vs 74.5 [0.9] for discordant; $P = .12$). Patient satisfaction was highly associated with PDM score within all race/ethnicity groups.

Conclusions Our data suggest that African American patients rate their visits with physicians as less participatory than whites. However, patients seeing physicians of their own race rate their physicians' decision-making styles as more participatory. Improving cross-cultural communication between primary care physicians and patients and providing patients with access to a diverse group of physicians may lead to more patient involvement in care, higher levels of patient satisfaction, and better health outcomes.

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STUDIES HAVE SHOWN THAT African Americans and other minority patients often receive differential and less optimal technical health care than white Americans.[1-16] It is uncertain how much of these racial differences in health care and outcomes can be explained by patient cultural factors, health care professional biases, or health care system biases. Differences in socioeconomic status and health insurance coverage between patients only partially explain the observed racial differences in health care.[7,17,18]

Race and ethnicity have been cited as important cultural barriers in patient-physician communication.[19-22] However, cross-cultural factors in patient-physician communication are largely unexplored. Problems in communication due to cultural differences between patients and physicians often contribute to a disparity in the understanding that patients and physicians have regarding the cause of disease and the effectiveness of available treatments.[23,24] One study showed some enhancement of communication when physicians and patients belonged to the same ethnic group; however, the match between the physician and patient with respect to the explanatory model of illness and expectations for the visit were equally important in determining outcome.[25]

Few studies have related differences in the quality of interpersonal health care to patients' and physicians' ethnicity or to ethnic concordance or discordance in the patient-physician relationship. These studies have found that racial and ethnic differences between physicians and pa-

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tients do influence physicians' communication and decision making.[8,26-29] In the Medical Outcomes Study, minority patients rated their physicians' decision-making styles as less participatory than nonminority patients did.[30]

Studies investigating the influence of patient gender on communication in the medical visit show that female patients generally receive more information, ask more questions, and have more partnership-building with physicians than male patients.[28,31-33] Less is known about the communication style of female physicians. A few recent studies have shown that female physicians exhibit more empathy and engage in more positive talk, partnership-building, question-asking, and information-giving compared with their male counterparts.[30,34-36]

The quality of interpersonal care is important to patients. Studies have shown that increasing patient involvement in care via negotiation and consensus-seeking improves patient satisfaction and outcomes.[37-39] Specifically, visits in which the physician uses a participatory decision-making (PDM) style are associated with higher levels of patient satisfaction.[40] Recent studies of patient-physician communication in primary care show the highest levels of patient satisfaction and the lowest level of malpractice claims with the psychosocial pattern, which is characterized by psychosocial exchange and an almost equal distribution of patient and physician talk.[41-43]

Our study questions were as follows: (1) Do minority patients rate their physicians' decision-making styles as less participatory than white patients? (2) Do the patients of minority physicians rate their physicians' decision-making styles as less participatory than the patients of white physicians? and (3) What is the association between race and gender concordance or discordance in the patient-physician relationship and PDM style?

METHODS

Study Design and Population

The data for this analysis were collected in the baseline survey for a randomized clinical trial evaluating an intervention to improve care of primary care patients with depression. We identified all primary care practices with more than 200 enrollees from a large mixed-model independent practice association and network-style managed care organization (NYLCare) with primary care capitation in the Washington, DC, metropolitan area for our sample target. Washington, DC, and its Maryland suburbs have a large percentage of minorities compared with the national average. Additionally, this managed care organization has historically served geographic areas that have high African American patient and physician populations. Two thirds of the practices agreed to participate, and 85% of those actually provided data. Patients from a total of 32 practices, representing general internal medicine and family practice, were interviewed. Most practices had fewer than 5 physicians. For larger practices, a maximum of 5 physicians were included. The physician sample included 64 primary care physicians. There were 36 white physicians (56%), 16 African American physicians (25%), 10 Asian physicians (15%), and 2 Latino physicians (3%). The physician sample included 40 men (63%) and 24 women (37%).

The original sampling procedure for patients was for the office receptionist to identify all consecutive NYLCare patients who came to see the physician on recruitment days. Race and other patient demographics were not included in the sampling scheme. The mean and median number of patients contributed per physician was 28.

The study procedures were reviewed and approved by the Johns Hopkins Medical Institutions Joint Committee on Clinical Investigation. After giving informed consent, 2481 patients (87% of those eligible) who were insured by the managed care organization, aged 18 years or older, and had visited their primary care physician within the preceding 2 weeks were interviewed on the telephone between November 1996 and June 1998. No Medicare or Medicaid patients were enrolled in this managed care organization at the time of this study. Patients had to respond to the question about self-defined race/ethnicity and all 3 questions regarding PDM style to be included in this analysis. Of the 2481 patients, 665 patients did not answer all 3 of the questions regarding PDM style or did not self-identify into a racial group. Therefore, there were 1816 patients in our main analyses. Individuals with incomplete responses were slightly younger than the study respondents, more educated, less likely to have known their physician for at least 1 year, and had higher self-rated overall health status. Additionally, incomplete response rates were lower for African Americans (21%) than for whites (26%) and other races (26%) (χ^2, $P<.01$). There were no gender differences between the study respondents and those responding to fewer than 3 questions. More than 400 of the incomplete responders answered "I don't know" or "I am not sure" to at least 1 of the 3 questions. None of the characteristics of incomplete responders suggest these individuals did not understand the questions. Since our incomplete responders were more healthy and less likely to have known their physician for at least 1 year, it is likely that these patients do not have enough experiences with medical decisions upon which to base an evaluation of their physicians' partnership style. Fewer than 10 patients refused to answer all 3 questions.

Study Variables

Our main independent variables included patient race/ethnicity, physician race/ethnicity, physician gender, and race and gender concordance or discordance in the patient-physician relationship. Covariates for the analyses included factors related to race and to PDM style in previous studies. Patient factors included age, gender, education, marital status, self-rated perceived health (5-point scale from poor to excellent), and length of the patient-physician relationship.

Because patient satisfaction and PDM style have been highly associated in previous studies, we wanted to see if the association would be similarly strong within each racial group. The mea-

sure of patient satisfaction included questions about the patients' level of satisfaction with the following: (1) overall health care; (2) their physicians' technical skills, such as thoroughness, carefulness, and competence; (3) their physician's explanation of their problem and its treatment; and (4) their physicians' personal manner, such as courtesy, respect, sensitivity, and friendliness. Each question was scored on a scale from 0 to 4, from "not at all satisfied" to "extremely satisfied." The scores were added together, divided by 16, and multiplied by 100 to arrive at the satisfaction score.

Our main dependent variable was PDM style, originally described in 1995 by Kaplan and colleagues.[10] The PDM style is defined as the propensity of physicians to involve patients in treatment decisions and is measured as the aggregate of 3 items, each rated on a 5-point scale from 0 (never) to 4 (very often), as follows: (1) If there were a choice between treatments, how often would this doctor ask you to help make the decision? (2) How often does this doctor give you some control over your treatment? and (3) How often does this doctor ask you to take some of the responsibility for your treatment? The highest possible score is 12. By convention, the raw score is divided by 12 and multiplied by 100 to arrive at a 0- to 100-point scale. A higher score means the visit was more participatory.

Analyses

Generalized estimating equations (GEEs) were used to analyze the relationship between PDM style and patient race/ethnicity, physician race/ethnicity, race and gender concordance or discordance in the patient-physician relationship, and all other covariates. The GEE method was preferred over linear regression because of its ability to account for the clustering effects of any existing within-physician correlation and the different number of patients per physician, while producing valid and robust results.[11,12] In the multivariate model, we adjusted for patient age, gender, education, marital status, health status, and length of the patient-physician relationship. In subsequent models, we also included physician gender and race.

We also used GEEs to study the relationship between patient satisfaction and PDM style for the overall sample and by patient race/ethnicity. We explored unadjusted and adjusted models.

RESULTS

Characteristics of Study Sample

Characteristics of the patient sample are shown in TABLE 1. About half the patients had been seeing their physician for more than 3 years. The mean overall health status was 77.2 on a 0- to 100-point scale, with approximately 60% reporting that they felt their health was very good or excellent. Approximately 60% of the patients were seeing a male physician and 40% were seeing a female physician. Almost half the patients were seeing white physicians, 27% were seeing African American physicians, and 26% were seeing physicians of other races. There were statistically significant differences among patient race/ethnic groups in several variables. African American patients were slightly older,

Table 1. Characteristics of Patient Sample*

		Race/Ethnic Group		
	Total (N = 1816)	White (n = 784)	African American (n = 814)	Other (n = 218)
Age, y				
18-29	15	19	12	16†
30-39	28	25	29	31
40-49	32	30	33	31
50-65	25	26	25	22
Gender				
Male	34	39	28	41‡
Female	66	61	72	59
Education				
High school or less	36	27	45	35‡
Some college	24	22	27	22
College graduate	21	26	15	26
Graduate school	19	25	13	17
Marital status				
Married	55	60	47	68‡
Separated/divorced/widowed	19	15	24	12
Never married	26	24	29	20
Self-rated health status				
Poor/fair	11	7	14	8‡
Good	28	26	31	30
Very good	40	43	37	39
Excellent	21	24	18	23
Length of relationship with primary care physician, y				
<1	20	18	20	25‡
1-3	28	26	28	37
>3	52	55	52	38
Race of physician seen				
White	47	67	30	39‡
African American	27	13	43	16
Other	26	19	26	46
Gender of physician seen				
Male	61	66	56	61
Female	39	34	44	39

*All data are percentages.
†Differences among racial/ethnic groups, χ^2, $P \leq .01$.
‡Differences among racial/ethnic groups, χ^2, $P \leq .001$.

more likely to be women, less likely to be married, less educated, had poorer perceived health, and were more likely to see African American physicians than white patients (Table 1).

Relationship of Patient Characteristics to PDM Style

Several patient factors were associated with PDM style in unadjusted analyses. Patients aged 40 to 65 years rated their visits as more participatory than patients younger than 30 years. Patients with a graduate school education had more participatory visits than those with a high school education or less. Patients with better ratings of their own health status had more participatory visits with physicians. Patients who knew their physician for 3 years or longer rated their visits as more participatory than patients who knew their physician for less than 1 year. In this sample, there were no differences in PDM style ratings by patient gender or marital status (TABLE 2).

Relationship of Patient Race to PDM Style

There were significant differences in PDM scores among patient racial groups in unadjusted analyses. African Americans and other minority patients rated their physicians as having lower PDM scores than did white patients. In models adjusting for patient age, gender, education, marital status, health status, and length of the patient-physician relationship, African Americans had significantly less participatory visits than whites. Asian, Latino, and other minority patients also rated their physicians as less participatory, but the results did not achieve statistical significance. Adding physician gender and physician race to the model attenuated the relationship between PDM style and patient race; however, African American patients still rated their visits as less participatory than white patients (TABLE 3).

Relationship of Physician Race and Gender to PDM Style

There were no significant differences between minority and white physicians with respect to patient ratings of PDM style in unadjusted analyses. Similarly, in analyses adjusting for patients' age, education, health status, and length of the patient-physician relationship, there were no

Table 2. Relationship of Patient Characteristics to Participatory Decision-Making (PDM) Style*

	No. of Patients	PDM Style Score, Mean (SE)	P†
Age, y			
18-29	278	72.7 (1.3)	Reference
30-39	514	73.5 (1.6)	.61
40-49	577	76.8 (1.5)	.008
50-65	433	77.5 (1.6)	003
Gender			
Male	626	75.2 (1.0)	Reference
Female	1190	75.4 (1.0)	84
Education			
High school or less	653	74.2 (1.0)	Reference
Some college	438	74.8 (1.3)	.63
College graduate	381	75.8 (1.4)	.25
Graduate school	338	77.9 (1.4)	.008
Marital status			
Married	1003	75.6 (0.8)	Reference
Separated/divorced/widowed	338	76.5 (1.2)	.51
Never married	469	73.8 (1.3)	.13
Self-rated health status			
Poor/fair	194	71.4 (1.6)	Reference
Good	517	73.8 (1.8)	.004
Very good	720	78.2 (1.7)	001
Excellent	379	77.9 (1.9)	.001
Length of relationship with primary care physician, y			
<1	360	73.9 (1.2)	Reference
1-3	516	74.0 (1.5)	.95
>3	923	76.8 (1.4)	.04

*The PDM style score is based on 3 questions and ranked on a 0- to 100-point scale. Higher scores mean the physician is more participatory.
†P values are from generalized estimating equations.

Table 3. Relationship of Patient Race to Participatory Decision-Making (PDM) Style*

		Model 1†		Model 2‡		Model 3§		Model 4‖	
Patient Race	No. of Patients	Unadjusted Score, Mean (SE)	P	Adjusted Score, Mean (SE)	P	Adjusted Score, Mean (SE)	P	Adjusted Score, Mean (SE)	P
White	784	77.1 (0.9)	Reference	60.6 (3.3)	Reference	59.3 (3.3)	Reference	59.8 (3.4)	Reference
African American	614	73.9 (1.2)	.007	58.0 (1.2)	.03	56.6 (1.2)	.02	57.5 (1.2)	.07
Other minority	218	73.8 (1.7)	.05	58.3 (1.7)	.17	56.9 (1.7)	.17	57.9 (1.7)	.26

*The PDM style score is based on 3 questions and ranked on a 0- to 100-point scale. Higher scores mean the physician is more participatory. P values are from generalized estimating equations.
†PDM score by patient race (unadjusted).
‡Adjusted for patients' age, gender, education, marital status, and length of the patient-physician relationship.
§Adjusted for patients' age, gender, education, marital status, health status, length of the patient-physician relationship, and physician gender.
‖Adjusted for patients' age, gender, education, marital status, health status, length of the patient-physician relationship, physician gender, and physician race.

significant differences between minority and white physicians with respect to PDM style. However, physician gender was related to PDM style. Female physicians had more participatory visits with their patients than male physicians in adjusted analyses (TABLE 4).

Relationship of Race and Gender Concordance or Discordance to PDM Style

To study the potential influence of race concordance or discordance between physicians and patients on PDM style, we stratified patients according to the race/ethnicity of their physicians and measured the relationship between PDM style and patient race within each physician race group, adjusting for patient age, gender, education, marital status, health status, and length of the relationship. African American patients had significantly less participatory visits with white physicians than white patients (β = −4.3, SE = 1.7, $P<.02$, adjusted). Asian and Latino patients had less participatory visits with African American physicians than African American patients; however, these results were based on very small sample sizes. There were no significant racial differences in PDM scores among patients seeing Asian or Latino physicians. However, there were only 2 Latino physicians in the study sample; therefore, reliable conclusions regarding the PDM style of Latino physicians cannot be drawn (data not shown).

To explore the overall significance of racial and ethnic concordance in the patient-physician relationship, we conducted an analysis to assess the relationship between race/ethnic concordance between physicians and patients and PDM style. Because of previously described relationships between physician gender and PDM style, we looked at the effect of both race and gender concordance or discordance. Patients in race-concordant relationships with their physicians rated their physicians as significantly more participatory than patients in race-discordant relationships (β = +2.6, SE = 1.1, $P<.02$, adjusted). Gender concordance between physicians and patients was not significantly related to PDM style (TABLE 5). Participatory decision-making style was highest in relationships that were race and gender concordant (β = +4.3, SE = 1.5, $P<.01$, adjusted) compared with relationships that were race and gender discordant (data not shown).

Patient Satisfaction and PDM Style

Patient satisfaction with technical and interpersonal aspects of care was highly associated with PDM score (β = +0.5, SE = 0.02, $P<.001$, adjusted). The relationship between patient satisfaction ratings and PDM style was similar for all racial groups. Asian and Latino patients, but not African American patients, were significantly less satisfied than whites. Patient gender was not related to satisfaction. Both race concordance and gender concordance were significantly and positively associated with patient satisfaction.

COMMENT

In this study, African American patients had significantly less participatory visits with their physicians than white patients. This finding persisted after adjusting for potential confounders in the relationship between patient race and physician decision-making style. There were no significant differences between minority and white physicians with respect to patient ratings of PDM style. Female physicians had more participatory visits with patients than male physicians. Patients in race-concordant relationships with their physicians rated their physicians as significantly more participatory than pa-

Table 4. Relationship of Physician Characteristics to Participatory Decision-Making (PDM) Style*

Characteristic	No. of Patients	Model 1† Unadjusted Score, Mean (SE)	Model 1† P	Model 2‡ Adjusted Score, Mean (SE)	Model 2‡ P
Physician race					
White	850	76.3 (1.0)	Reference	61.7 (3.1)	Reference
African American	489	74.2 (1.7)	.23	59.2 (1.7)	.13
Other minority	467	74.3 (1.8)	.28	59.9 (1.7)	.30
Physician gender					
Female	707	76.9 (1.4)	.09	62.4 (1.3)	.03
Male	1109	74.5 (0.8)	Reference	59.5 (3.1)	Reference

*The PDM style score is based on 3 questions and ranked on a 0- to 100-point scale. Higher scores mean the physician is more participatory. P values are from generalized estimating equations.
†PDM score by physician race or physician gender (unadjusted).
‡Adjusted for patients' age, gender, education, marital status, health status, and length of the patient-physician relationship.

Table 5. Relationship of Race and Gender Concordance in the Patient-Physician Relationship to Participatory Decision-Making (PDM) Style*

Concordant Status	No. of Patients	Model 1† Unadjusted Score, Mean (SE)	Model 1† P	Model 2‡ Adjusted Score, Mean (SE)	Model 2‡ P	Model 3§ Adjusted Score, Mean (SE)	Model 3§ P
Race concordant	958	76.6 (1.1)	.02	62.8 (1.1)	.05	61.1 (1.1)	.02
Race discordant	858	74.0 (0.9)	Reference	60.4 (2.9)	Reference	58.5 (3.0)	Reference
Gender concordant	949	76.0 (1.0)	.12	62.2 (1.0)	.12	63.3 (1.0)	.11
Gender discordant	867	74.5 (0.9)	Reference	60.7 (3.2)	Reference	61.7 (3.0)	Reference

*The PDM style score is based on 3 questions and ranked on a 0- to 100-point scale. Higher scores mean the physician is more participatory. P values are from generalized estimating equations.
†PDM score by race- or gender-concordant status (unadjusted).
‡Adjusted for patients' age, gender, education, marital status, health status, and length of the patient-physician relationship.
§Adjusted for patients' age, gender, education, marital status, health status, length of the patient-physician relationship, and physician gender (race-concordant analysis) or physician race (gender-concordant analysis).

tients in race-discordant relationships. Gender concordance was not significantly related to PDM style. The data suggest that all patients prefer participatory visits, as patient satisfaction was highly associated with PDM score for patients in all ethnic groups.

This study adds to a growing body of research indicating that ethnic differences between physicians and patients are often barriers to partnership and effective communication.[19-22,30] A number of physician factors may account for these problems. First, physicians may unintentionally incorporate racial biases, such as racial and ethnic stereotypes, into their interpretation of patients' symptoms, predictions of patients' behaviors, and medical decision making.[4,6] Second, physicians may lack understanding of patients' ethnic and cultural disease models or attributions of symptoms. A third possibility is that physicians are often not aware of or have expectations of the visit that differ from patients' expectations. There are also patient factors that might contribute to less participatory visits. Factors such as language barriers, low health literacy and educational status, and lack of self-efficacy regarding managing one's health may be more prevalent among ethnic minority patients.

Why do patients seeing physicians of the same ethnic background as themselves rate their physicians as more participatory? Physicians and patients belonging to the same race or ethnic group are more likely to share cultural beliefs, values, and experiences in the society, allowing them to communicate more effectively and to feel more comfortable with one another. Previous research has suggested that socioeconomic differences, rather than racial or ethnic differences, might serve as more important communication barriers between physicians and patients.[31,36] Our study does not support this finding, since African American and other minority patients had less participatory visits with white physicians, regardless of educational level. It is possible that shared cultural experiences and values between patients and physicians offset the effects of differences in socioeconomic status on communication. The physicians in race-concordant visits may have actually used more partnership-building communication in their encounters with patients, or the patients may have simply perceived the communication that way. Regardless of the objective findings, patient perceptions are still important and do influence patient behavior. Since communication is both verbal and nonverbal, analyzing audiotapes and videotapes of racially concordant and discordant visits might help to further clarify this issue.

In our study, patients of female physicians had more participatory visits than patients of male physicians; however, gender concordance between physicians and patients was not significantly related to PDM style. It is unclear whether these findings are the results of patient selection or socialization of women physicians. Previous work has shown that both physician and patient gender may be important determinants of PDM style, other aspects of interpersonal care, and medical decision making.[30-31,34,35,46-48]

Small numeric differences in adjusted style scores of the magnitude presented in this study are likely to be meaningful with respect to patient care. Previous studies have shown that small differences in patient ratings of care can have an important impact on patient behavior. In the Medical Outcomes Study, differences of 2 points in the PDM style score were related to a 10-percentage point difference in the likelihood that patients would leave a physician's practice in the next 12 months.[30] Our study showed differences in PDM score between minority and white patients, patients of female and male physicians, and race-concordant and race-discordant relationships, of between 2 and 4 points. Based on results from previous studies, it is likely that these differences would be related to important differences in patient behavior.

This study has several strengths. First, the percentage of middle-class African American patients and physicians is larger than in previous studies. Second, the same managed care insurance coverage of all the study subjects minimizes the possibility of confounding due to racial and ethnic differences in socioeconomic status. Third, we had good measures of potential confounders between PDM style and patient race, such as patient age, gender, education, health status, and length of the patient-physician relationship.

There are also limitations. First, this was an observational study, and patients are not assigned to physicians in a randomized fashion. For example, patients who favor a more participatory decision-making style might be more likely to choose female physicians or physicians of their own ethnicity. Second, PDM style relies on patient self-report, and a high percentage of patients do not respond to all 3 questions. However, in a recent study, physician conversation styles measured by audiotape corresponded with patient measures of PDM style.[49] In separate analyses that included individuals who answered at least 2 questions (giving them a PDM score based on 8 points), our results were not changed. Third, it would have been useful to have other physician or practice measures known to affect physician communication, such as the practice volume. Unfortunately, this information was not available for most of the physicians in our sample.

What are the implications of this study for clinical practice, medical education, and health policy? One strategy to improve access to care for ethnic minority patients is to increase their participation in care. A multifaceted approach should include patient and physician interventions to improve cross-cultural communication in primary care settings. Interventions that empower ethnic minority patients to become more informed and active consumers of health care should be developed and evaluated. Additionally, since minority physicians are more likely to practice in areas with a high concentration of poor and minority patients, this study supports the argument for increasing the numbers of minority physi-

cians in the workforce.[30-32] Furthermore, communication training programs for medical students, residents, practicing physicians, and health professionals of all ethnic backgrounds should include an emphasis on understanding and addressing the needs of a patient population that is becoming more culturally diverse. Cultural competence is described as the demonstrated awareness, inclusion, and integration of 3 population-specific issues in the delivery of health care: (1) health-related beliefs and cultural values, (2) disease incidence and prevalence, and (3) treatment efficacy.[33] Health care organizations interested in fostering cultural competence should incorporate evidence-based medicine as well as the viewpoints of ethnic minority patients, patients with low levels of education and literacy, poor health status, and other vulnerable populations. Improving cross-cultural communication in health care settings may lead to more patient involvement in care, adherence to recommended treatment, higher quality of care, and better health outcomes.

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Eliminating Discrimination in Health Care: Problems and Challenges

A. The Persistence of Racial Disparities[1]

Despite recent improvement in the health of Americans, racial minorities still confront a myriad of health care challenges. The racial disparities between racial and ethnic groups are well documented. For instance,

- African-American men suffer from heart disease at nearly twice the rate of whites.
- A baby born to an African-American mother has twice the risk of dying in the first year than a white baby. An American Indian baby is 1.5 times more likely to die.
- Cervical cancer is nearly five times more likely among Vietnamese American women than white women. Liver cancer among Vietnamese Americans is more than 11 times higher than whites.
- The prevalence of diabetes in blacks is approximately 70 percent higher than whites and the prevalence in Hispanics is nearly double that of whites.
- Hispanic children are five times more likely to be without a usual source of health care than white children.
- Hispanics of all ages are the most likely to be uninsured. Nearly 3 in 10 Hispanic children have no insurance coverage.

B. The Role of Discrimination

Before these and other disparities can be eliminated, it is important to identify the underlying causes. These include poverty, lack of access to quality health services, environmental hazards in homes and neighborhoods, and the need for effective prevention programs tailored to specific community needs.

The disparities are also a function of discrimination. Unfortunately, there is frequently a reluctance to discuss racial disparities in health care in terms of discrimination. As David Barton Smith, Director of the Healthcare Management Program at Temple University and author of "Health Care Divided: Race and Healing a Nation"[2] correctly noted, "the solution [to the health

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[1]Healthy People 2000", http://raceandhealth.hhs.gov/pres.htm

[2]Smith, David Barton, Health Care Divided: Race and Healing a Nation, The University of Michigan Press, Ann Arbor, 1999

care divide] that we seem to have drifted into is not to talk about race." Yet, all too frequently, discrimination either prevents minorities from getting access to health care altogether, or forces them to accept health care delivery systems that, while not separate, are entirely unequal.

Discrimination in health care delivery has been well documented, both in research and through the enforcement activities of the Office for Civil Rights (OCR) at the Department of Health and Human Services.

Research - Studies[3] have shown that even when factors such as education, insurance, income, and access to quality health service are held constant, there are still disparities in the outcomes between whites and minorities. A recent Georgetown University study[4] highlighted the problem of discrimination vividly, as the research demonstrated that the race and sex of the hypothetical patients had a significant effect on the treatment decisions of the physician. Georgetown University researchers documented that physicians would refer African American women for heart catheterization significantly less often than they would refer identically situated white men. This study suggests that race and gender independently influence how physicians manage chest pain.

Enforcement - Investigations conducted by OCR have demonstrated that discrimination in the health care context remains a persistent problem. Discrimination occurs in many venues and many forms as illustrated by recent OCR settlements.

- **Medical Redlining** - OCR negotiated a settlement agreement with a national home health agency that had instructed employees that they were not required to provide service to persons residing in predominately minority areas of New Haven, Connecticut, because these areas were designated as "unsafe".[5]

- **Segregation** - OCR negotiated corrective action in a New York City hospital which had

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[3] "Racial and Ethnic Differences in Health, 1996, Kass, B., Weinick, R., and Monheit, A., MEPS Chartbook, No. 2, Publication No. 99-0001; http://www.meps.ahcr.gov/publication.htm

[4] "The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization", Kevin A. Shulman M. D., Jesse A. Berlin, ScD., William Harless, PhD., Jon F. Kerner, Ph.D., Shyrl Sistrunk, M.D., Bernard J. Gersh, M.B., Ch.B., D.Phil., Ross Dube, Christopher K. Taleghani, M.D., Jennifer E. Burke, M.A., M.S., Sankey Williams, M.D., John Eisenberg, M.D., and Jose J. Escarce, M.D, Ph.D., The New England Journal of Medicine, Volume 340, Number 8, February 25, 1999

[5] U.S. Department of Health and Human Services, Office for Civil Rights. Staff Builders Services, Inc., v. Department of Social Services, 01943050

segregated maternity wards, with one floor serving predominantly minority patients, and the other, non-minority patients.[6]

- **Limited English Proficient Patients** - OCR negotiated an agreement with a University hospital in Philadelphia, Pennsylvania whose inadequate language assistance practices had resulted in serious problems for an Hispanic woman who came to the Emergency Room with vaginal bleeding and lower abdominal pain due to her high risk pregnancy.[7]

- **Ensuring Access** - OCR negotiated an agreement with a hospital in a Texas border town which provided its security personnel with uniforms similar to the uniforms worn by the U.S. Border Patrol. In the settlement, the hospital agreed to discontinue the use of the uniform, which had the effect of discouraging the local Hispanic population from using the facility.[8]

The OCR enforcement experience, coupled with the compelling research documenting the prevalence of racial bias, demonstrate that bridging the health divide is both a public health and civil rights challenge. Unless the role of discrimination is understood, it will be impossible to eliminate the disparities.

C. Policy Initiatives

The President has committed the nation to an ambitious goal by the year 2010: eliminate the racial and ethnic disparities in six areas of health status (infant mortality, cancer screening and

management, cardiovascular disease, diabetes, HIV/AIDS and immunizations) while improving the overall health of the American people.[9]

Eliminating the disparities will require a comprehensive strategy that focuses on a variety of areas, and involves the mobilization of public health and civil rights groups, other community leaders, medical professionals, and the private sector.

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[6] U.S. Department of Health and Human Services, Office for Civil Rights. In Re: Matter of the Mount Sinai Hospital, 02947801

[7] U.S. Department of Health and Human Services, Office for Civil Rights. Acosta v. Temple University Hospital, 03983030

[8] U.S. Department of Health and Human Services. Texas Legal Aid v. McAllen Medical Center, 06913841

[9] "Healthy People 2000", http://odphp.osophs.dhhs.gov/pubs/hp2000 and htp://web.health,gov/healthypeople

The U.S. Surgeon General is leading the effort on the public health front. Under his leadership, HHS has initiated a major public health campaign focused on disease prevention, additional research, and improving access to health care. It is imperative to augment this public health campaign with an equally aggressive civil rights initiative to eliminate discrimination.

The civil rights strategy should include the following elements:

- **Aggressive Enforcement of Anti-Discrimination Laws** - In fiscal 1999, for the first time in seven years, OCR received a budget increase that was greater than a basic inflationary adjustment. Despite this $1 million budget increase, the current funding level for OCR is actually less than the funding level in FY 1980, when the HHS office was first established. A substantial increase in OCR funding is necessary to enable the office to carry out its enforcement efforts effectively.

- **Public Education and Outreach** - All too frequently, victims of discrimination in the health care context do not even realize that they have been victimized. Such discrimination is quite subtle. As a result, it is necessary to engage in a widespread public education campaign so the recipients and providers of health care fully understand their rights and responsibilities.

- **Civil Rights Protections in Patients' Bill of Rights** - Any legislation establishing a Patients' Bill of Rights should include civil rights protections that safeguard against discrimination that contributes to health disparities.

- **Training of Health Care Professionals** - Hospitals, HMOs, medical schools and other institutions that train health care professionals should establish formal training programs that will foster cultural sensitivity. The University of Wisconsin Medical School offers one such course to medical students, in which sensitive issues of race are discussed openly. Other institutions should follow suit.

- **Continued Commitment to Diversity** -- The discrimination documented by OCR and in the medical literature reinforces the compelling need to ensure that the health care profession reflects the ever increasing diversity of the population. HHS is partnering with the Association of American Medical Colleges to ensure the enrollment of 3000 minority students in medical schools by the year 2000 (Project 3000 by 2000). Additional programs are needed throughout the health sciences.

- **Development of Civil Rights Best Practice Guide for Managed Care** - The exponential proliferation of managed care raises distinct civil rights concerns, especially in connection with Medicaid managed care programs that involve populations who are disproportionately minority, and frequently have limited English proficiency. Developing a civil rights best practices guide for managed care providers would assist providers in complying with their civil rights obligations.

D. Conclusion

Eliminating discriminatory barriers to health care access for minorities is a legal requirement and a moral imperative. It is possible to bridge this health care divide, but only if there is a clear understanding of the nature of the problem.

The New York Times

November 28, 1999, Sunday, Late Edition - Final

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An Integrated Army Doesn't Think Alike

BYLINE: By STEVEN A. HOLMES

DATELINE: WASHINGTON

BODY:

AT first, the survey results seemed depressingly familiar: Nearly two-thirds of those who responded said they had had a racially offensive encounter with a colleague during the 12 previous months, and there was a wide disparity in how blacks and whites saw the state of race relations.

What is startling is the setting in which the answers occurred. This was not Simi Valley, Calif., or Decatur, Ill., or even a typical college campus. This was the military, which has been held up as the paragon of racial integration, tolerance and equal opportunity.

The findings are contained in a 265-page report issued last week on how the nearly 1.4 million men and women in the armed forces view the racial climate there. More than 40,000 enlisted men and women and officers responded.

Nearly 20 percent of black members of the military -- a rate five times higher than among whites -- said they believed they had received a worse evaluation than they deserved because of their race.

And while only 17 percent of whites said the military was paying "too little attention" to racism and discrimination in its ranks, 38 percent of Hispanic military personnel and 62 percent of blacks felt that way.

This racial Rashomon is nothing new in the civilian world. From the O. J. Simpson trial to opinions about the police to the need for affirmative action, whites and minorities, especially blacks and Hispanics, have seen things through such different lenses as to make one wonder if they are on the same planet.

"If this is going on and those incidents are being experienced in an environment that we think is doing pretty well on race, it gives you pause to wonder what might be happening on the factory floor or in offices around the country," said Edwin Dorn, a former under secretary of defense for personnel and readiness.

Indeed, the report's findings raise the question of whether any institution can ever do enough to bridge racially divided perceptions, or whether racial attitudes are so deep-seated that nothing can root them out.

"Lesson number one is that blacks will always see race relations in a more pessimistic way than whites," said Charles Moskos, a Northwestern University sociologist who has studied the military. "This cuts across gender and rank and is not likely to change in the foreseeable future. But it also shows that blacks and white do not have to hold identical views of the racial situation in order to succeed together. That's why we don't care about attitudes. We care about behavior."

SUCH a notion would, no doubt, cause jitters among liberals since many of their favored ideas, like producing minority role models and diversity training, focus on influencing racial attitudes rather than discriminatory behavior.

There is little question that the military, especially the Army, is far and away the most racially integrated institution in American society. Black, Hispanic, Asian and Native American men and women make up 32 percent of the armed forces, although as in civilian society they are more heavily clustered at the bottom ranks than at the top.

In the Army, the military's largest branch, blacks make up nearly one-quarter of the staff sergeants, master sergeants and first sergeants. More than 15 percent of all military officers are members of a minority group.

As Mr. Moskos and John Sibley Butler, co-authors of "All That We Can Be: Black Leadership and Racial Integration the Army Way," (Twentieth Century Fund) point out, at some point in virtually every white soldier's career, his or her boss will be black; this is something that few, if any, other institutions in the country can claim.

The high level of racial integration has flowed into other areas. Studies indicate that the most racially integrated cities in the country -- places like Fayetteville, N.C., Lawton, Okla., and Jacksonville, N.C. -- are military towns. The armed forces also devote a tremendous amount of time and effort to promoting good race relations and equal opportunity. Incoming military personnel undergo intensive training in race relations. Military units have a race relations adviser to make sure things are going well.

Yet widely different perceptions remain about the state of race relations and the military's efforts to improve things. Such a finding leads to questions over whether whites understate the problem to shield themselves from guilt or the charge of racism and minorities overstate it out of pressure not to be out of step with peers.

LAST March, Cooper & Seacrest, an Alexandria, Va., polling company, inquired into racial attitudes in Fayetteville, N.C. In their survey, 53 percent of black respondents who were interviewed individually by black questioners and told that their answers would be confidential agreed with the statement that "as a country we focus too much on issues of race." When African-Americans were asked the same question in a focus group, nearly everyone disagreed.

But before Pentagon officials take comfort in a notion that the study merely reflects the grousing that normally goes on in the ranks they should contemplate one other finding. About 85 percent of white, Hispanic and Asian respondents, and 79 percent of blacks, said they did not officially report a bothersome racial incident in the previous 12 months. The leading cause was that they didn't think anything would be done.

Looking at such a finding, Pentagon officials might well recall the words of the former chairman of the Joint Chiefs of Staff, Colin L. Powell, the most successful African-American ever in the military. "The day soldiers stop bringing you their problems is the day you have stopped leading them," Mr. Powell wrote. "They have either lost confidence that you can help them or concluded you do not care. Either case is a failure of leadership."

http://www.nytimes.com

GRAPHIC: Photo: Diverging racial perceptions persist in the military. Saluting the Tomb of the Unknowns. (Stephen Crowley/The New York Times)

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NEWS

For Immediate Release

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All That We Can Be

Black Leadership and Racial Integration the Army Way

The U.S. Army has made itself into a model for developing black leadership in a racially integrated setting. And it didn't just happen. Beset with racial difficulties in the 1970s, the Army made a commitment to devote the resources and do what it would take to insure there would be a large pool of qualified blacks from which to promote the next generation of leaders. With no lowering of standards, the Army embarked on a course where equal opportunity became a reality instead of the rhetoric that often substitutes for it in civilian life. In a groundbreaking study, Charles C. Moskos and John Sibley Butler, detail the journey the Army has taken, and how the lessons it learned might be applied to other areas of society.

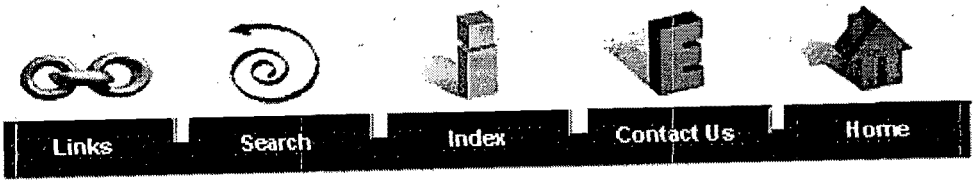
"Every American -- white or black, military or civilian -- who cares about building healthy race relations in our country ought to read All That We Can Be," writes General Colin L. Powell.

Moskos--professor of sociology at Northwestern University--and Butler--professor of sociology and business at the University of Texas--show how an emphasis on education, training, and leadership skills created an environment in the Army where people can flourish. Among the reasons cited by Moskos and Butler for the Army's success:

- Promotion strictly by talent
- Assuring a large pool of blacks from which to find leaders
- Strong remedial education programs instead of lowered standards
- A cadre of black sergeants who serve as a repository of positive values

Moskos and Butler make clear their understanding that there are aspects of the armed forces that cannot be duplicated elsewhere. People in the military are trained to follow orders; their careers — even their lives — depend on it. Programs designed to promote integration in the private sector lack the force of a military order. Still, they make a strong case for replicating the essence of what has made the Army's experience so successful. Their call for an extensive non-military national service program summons a sense of duty and concern for the common good. "This need not be taken to military extremes in civilian national service," say Moskos and Butler, "but it does correspond with ascendant communitarian thought that citizens have responsibilities as well as rights."

About TCF



REPORT BY COALITION OF AFRICAN-AMERICAN TV WRITE + NAAC

AS WE HEAD INTO THE NEXT MILLENNIUM, SHAMEFU

In recent weeks, the media has focused its attention on the lack of racial diversity in the casting of network television primetime shows. The major networks have responded by belatedly adding 17 minority characters to a few of their new and returning series. This same lack of diversity also exists behind the scenes; however, there has been no mention of diversifying the writing staffs of any of these series.

The lack of diversity in writers' rooms throughout television is even more startling than the lack of diversity on the air. Whereas shows such as Spin City, Touched By An Angel and Veronica's Closet feature African American characters as series regulars, there are no African American writers or writer/producers working on these shows. In fact, only 18 of the 95 network sitcoms and dramas on the fall line-up employ African American writers. Of the 839 total writers employed on primetime shows, only 55 are African American. And an overwhelming 83 percent of these 55 writers are segregated on black-themed shows.

When a pattern such as this is so blatantly pervasive, is it a matter of happenstance? Oversight? Or is it racial discrimination? We'll let the numbers speak for themselves.

THE FACTS

Fall 1999 Primetime Schedule

There are 95 sitcoms and dramas on the six networks' fall schedules.

On ABC, only 9 of the 171 writing positions are held by African Americans. (5.3 %)
On CBS, only 2 of the 144 writing positions are held by African Americans. (1.4%)
On NBC, only 1 of the 189 writing positions is held by an African American. (0.5%)
On FOX, only 3 of the 160 writing positions are held by African Americans. (1.9%)

Of the 839 writers employed on the 95 shows, only 55 are African Americans. (6.6%)
Only 1 white-themed show currently employs more than 1 African American writer.
45 of the 55 African American writers work on black-themed shows. (83%)

Only 5 of the 9 black-themed shows have African American show runners. (56%)
Zero white-themed shows have African American show runners. (0%)
Only 8 of the 55 African American writers are employed on the 39 dramas. (14.5%)
Only 8 African American writers out of 838 total writers are employed on dramas. (.95%)

33% of all African American writing positions are on Moesha and The Parkers on UPN.
77% of all African American writing positions are on black-themed shows on UPN and The WB.

Only 11 Latino writers are employed on series on the fall schedule. (1.3%)
Only 3 Asian American writers are employed on series on the fall schedule. (0.3%)
Zero Native Americans writers are employed on series on the fall schedule. (0.0%)

African Americans, Latinos, Asian Americans, Native Americans and other minorities make up over 30 percent of the U.S. population. Yet, together, these groups account for only 7 percent of primetime network writing positions.

…LY, HOLLYWOOD STILL LOOKS LIKE PLEASANTVILLE

	Total Writers	African American Writers
ABC		
Boy Meets World/Disney	11	1
Dharma & Greg/20th TV	13	0
The Drew Carey Show/Warner Bros.	17	0
The Hughleys/Greenblatt-Janollari	11	6
It's Like You Know/Dreamworks	10	0
The Norm Show/Warner Bros.	10	0
NYPD Blue/20th TV	8	0
Odd Man Out/Warner Bros.	9	0
Oh, Grow Up/Greenblatt-Janollari	10	0
Once & Again/Disney	8	0
The Practice/20th TV	6	2
Sabrina the Teenage Witch/Viacom	9	0
Snoops/20th TV	6	0
Spin City/Dreamworks	14	0
Sports Night/Imagine	8	0
Two Guys and a Girl/20th TV	13	0
Wasteland/Miramax	6	1
CBS		
Becker/Paramount	7	0
Chicago Hope/20th TV	8	0
Cosby/Carsey-Werner	9	2
Diagnosis Murder/Viacom	5	0
Early Edition/Columbia-Tristar	10	0
Everybody Loves Raymond/HBO-IP	10	0
Family Law/Columbia-Tristar	4	0
Jag/Paramount	6	0
Judging Amy/CBSP	8	0
King of Queens/Columbia-Tristar	12	0
The Ladies Man/Columbia-Tristar	10	0
Love or Money/Paramount	10	0
Martial Law/CBSP	12	0
Nash Bridges/Rysher	8	0
Now & Again/Paramount	6	0
Touched by an Angel/CBSP	10	0
Walker, Texas Ranger/CBSP	4	0
Work With Me/CBSP	11	0
NBC		
Cold Feet/Warner Bros.	8	0
ER/Warner Bros.	8	0
Frasier/Paramount	14	0
Freaks & Geeks/Dreamworks	7	0
Friends/Warner Bros.	12	0
Jesse/Warner Bros.	11	0
Just Shoot Me/Brillstein-Grey	16	0
Law & Order/Studios USA TV	6	0
Law & Order SVU/Studios USA TV	5	0
The Mike O'Malley Show/NBCS	16	0
The Pretender/20th TV	9	0
Profiler/NBCS	4	0
Providence/NBCS	8	0

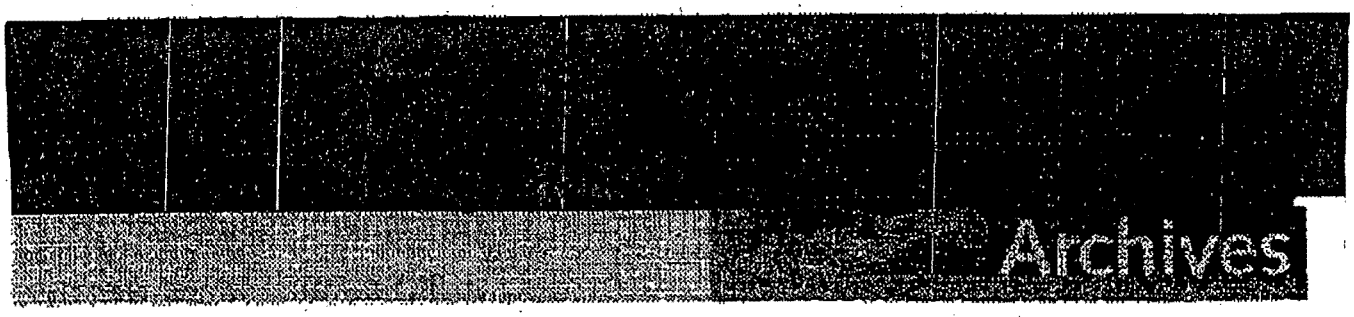
	Total Writers	African American Writers
Stark Raving Mad/20th TV	9	0
Suddenly Susan/Warner Bros.	16	0
3rd Rock/Carsey-Werner	8	0
Veronica's Closet/Warner Bros.	11	0
Third Watch/Warner Bros.	6	1
Will & Grace/NBCS	10	0
The West Wing/Warner Bros.	10	0
FOX		
Action/Columbia-Tristar	6	0
Ally/20th TV	1	0
Ally McBeal/20th TV	1	0
The Badlands/Regency	8	1
Beverly Hills 90210/ Spelling	8	0
Family Guy/20th TV	18	0
Futurama/20th TV	12	0
Get Real/20th TV	11	1
Harsh Realm/20th TV	8	0
King of the Hill/20th TV	19	0
Malcolm in the Middle/Regency	10	0
Manchester Prep/Columbia-Tristar	4	0
Party of Five/Columbia-Tristar	8	0
The Simpsons/20th TV	29	0
That 70's Show/Carsey-Werner	6	0
Time of Your Life/Columbia-Tristar	8	1
The X-Files/20th TV	6	0
The WB		
Angel/20th TV	5	0
Buffy the Vampire Slayer/20th TV	6	0
Charmed/Spelling	14	0
Dawson's Creek/Columbia-Tristar	8	0
The Downtowners/Castle Rock	6	0
Felicity/Imagine	9	0
For Your Love/Warner Bros.	13	5
Jack & Jill/Warner Bros.	8	0
The Jamie Foxx Show/Warner Bros.	7	7
Popular/Disney	7	0
Roswell/20th TV	8	0
Safe Harbor/Spelling	4	0
7th Heaven/Spelling	5	0
The Steve Harvey Show/Brillstein-Grey	10	6
UPN		
Dilbert/Columbia-Tristar	3	0
Grown Ups/Columbia-Tristar	12	1
Malcolm & Eddie/Columbia-Tristar	6	8
Moesha/Big Ticket TV	9	8
The Parkers/Big Ticket TV	11	10
7 Days/Paramount	10	0
The Strip/Warner Bros.	6	1
Shasta McNasty/Columbia-Tristar	8	0
Star Trek/Voyager/Paramount	5	0

WRITERS BY TELEVISION PRODUCTION COMPANY

Production Company	Writers	African American Writers
BIG TICKET TV	20	18 (all on UPN)
BRILLSTEIN-GREY	26	6 (6 on Steve Harvey)
CASTLE ROCK	6	0
CARSEY-WERNER	27	2 (2 on Cosby)
CBS PRODUCTIONS	42	0
COLUMBIA/TRISTAR	101	6 (4 on black shows on UPN)
DISNEY	26	1
DREAMWORKS	31	0
GREENBLATT-JAN.	21	6 (6 on The Hughleys)
HBO-IP	10	0
IMAGINE	14	0
MIRAMAX TV	6	1

Production Company	Writers	African American Writers
NBC STUDIOS	42	0
PARAMOUNT	52	0
REGENCY TV	18	0
RYSHER	8	0
SPELLING TV	23	0
STUDIOS USA TV	11	0
20TH TELEVISION	167	3
VIACOM TV	14	0
WARNER BROS. TV	142	14 (12 on black shows on The WB)

Numbers were obtained through a telephone survey conducted by the Beverly Hills/Hollywood NAACP and the Coalition of African American Television Writers (CAATW).
The Beverly Hills/Hollywood NAACP can be reached at [illegible].
CAATW is an organization made up of professional writers who are members of the WGA.



Saturday, October 9, 1999
Home Edition
Section: Calendar
Page: F-2

Survey Cites Low Number of Minority Writers on Series;
Television * NAACP says lack of diversity on staffs is more blatant than among the casts of new fall series.;

By: GREG BRAXTON
TIMES STAFF WRITER

TV executives on Friday were mostly unavailable or slow to react to a newly released survey conducted by the Beverly Hills/Hollywood branch of the NAACP and a group of African American writers that detailed a disproportionately low number of minority writers on network comedies and dramas.
ABC, CBS and Fox reacted to the survey, as they have since the issue of the near absence of minority actors on the season's new prime-time shows first emerged in May during network upfront presentations to advertisers: repeating a broad-stroke commitment to diversity in front of and behind the camera. Other networks and most television studios, which produce shows and thus are on the front-line of hiring writers as well as actors, were unavailable for comment.
Billie Green, president of the local NAACP branch, said the survey, which was conducted over a two-month period by the branch and the Coalition of African American Television Writers, revealed what she called "discriminatory writing practices" by studios and networks in the hiring of writers.
She said the lack of diversity on TV writing staffs was more blatant than the dearth of minorities that were cast in new shows premiering this fall on the four major networks.

The survey concluded that of the 839 writers currently employed on prime-time network shows, only 55 are African American. Additionally, 83% of those 55 black writers are employed on black-themed shows.

The survey also stated that shows such as "Spin City," "Touched by an Angel," and "Veronica's Closet" feature black characters, but have no black writers or producers working on those shows.

Also, only 11 Latino and three Asian American writers are working on prime-time series this fall, the survey said. There are no Native American writers employed on

a prime-time series, according to the survey.

"We wanted to do this survey to basically embarrass the industry," said Green. "Now they can really see where the shortcomings are. Hopefully they can start to make corrections by employing writers of color."

For example, according to the survey, CBS has a total of 144 writers on their series, but only two of them are African American. Both work on "Cosby," starring Bill Cosby. NBC has a total of 198 writers, but only one black writer, who works on "Third Watch."

Said Green: "African Americans, Latinos, Asian Americans, Native Americans and other minorities make up over 30% of the population of this country. But combined, these groups account for only 7% of prime time network writing positions."

A few network executives privately said that while they were taking note of the survey, they pointed fingers at studios who do the actual hiring of writers for series. The lack of diversity in writing staffs is a critical battleground for Green and the NAACP since that is the track to eventually becoming a producer, who in turn develop the shows themselves, like Steven Bochco and David E. Kelley.

Green accused the industry of "blatant racism," saying that writers of color, particularly African Americans, had been told repeatedly that they were not wanted for series featuring predominantly or all-white casts, but that white writers were routinely hired on black-themed shows.

Many shows with staffs of 10 or more writers, such as "The Simpsons," "The West Wing," "Just Shoot Me," "Frasier," "Two Guys and a Girl," and "Dharma & Greg," have no black writers, the survey said.

In the survey, several studios were also singled out as not hiring African Americans including NBC Studios, Paramount, Spelling TV, Studios USA TV, DreamWorks, Castle Rock and Imagine. Big Ticket Television had the most black writers--18--but all of them were on shows broadcast on UPN, which has several series targeted for urban audiences. Of the 14 black writers working at Warner Bros. TV, 12 were working on black shows shown on the WB network, the survey said.

Green said she would wait for reaction from the various TV entities before determining the next step in what will be an ongoing effort to increase minority participation within the TV industry.

Type of Material: Poll or Survey
Descriptors: TELEVISION INDUSTRY -- BLACKS; WRITERS; NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE; MINORITIES; POLLS; TELEVISION PROGRAMS;

page 14

Boxoffice Preview

THE Hollywood REPORTER®
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70th year | October 8-10, 1999 | $1.85 (California) $2.25 (Elsewhere)

Zeta-Jones, Costner eye Stone's next

By Zorianna Kit and Stephen Galloway

Catherine Zeta-Jones is in negotiations to star in Oliver Stone's "Beyond Borders" for Mandalay Pictures. She could cuddle up with Kevin Costner, who's talked about reteaming with his "JFK" director.

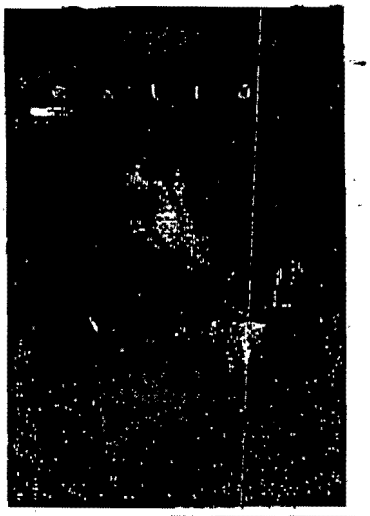
Zeta-Jones

Costner

Shooting is expected to begin early next year.

"Borders," written by Stone and British scribe Caspian Tredwell-Owen, is a love story that takes place over the course of many years and is set against the backdrop of humanitarian efforts around the

See "BORDERS" on page 54



Film Roman's emperor falls

Board at ani firm ousts Pritchard

By Cynthia Littleton

David Pritchard has exited as president and CEO of Film Roman after the animation company's board of directors opted not to renew his employment contract.

In a statement, Film Roman said that chief operating officer Bill Shpall and senior vp Jon Vein would take on Pritchard's responsibilities until a successor is named. Film Roman executives would not elaborate on the matter.

Pritchard

Pritchard signed a two-year contract when he was named president and CEO of Film Roman in September 1997. He had worked as an indie animation producer and as vp corporate

See FILM ROMAN on page 6

NAACP: Lack of black TV writers is 'startling'

Just 6.6% of primetime scribes this fall

By David Robb

Of the 839 writers employed on the primetime dramas and sitcoms that comprise the fall lineup, only 55 — or 6.6% — are black, according to a survey conducted by the Beverly Hills/Hollywood branch of the NAACP and the Coalition of African American Television Writers.

Forty of those 55 black writers are employed on UPN and the WB shows, while only 15 are employed on shows that air on NBC, CBS, ABC and Fox, according to the survey. The NAACP branch and the CAATW conducted the survey during a two-month period by calling the production companies and asking how many minority writers were on staff for each show.

See WRITERS on page 54

After 5 months, 5 more years for Disney duo

By Chris Gardner

Todd Garner and Nina Jacobson, on the job as co-presidents of the Buena Vista Motion Picture Group for only five months, have quickly reupped for an additional five years.

Jacobson

Garner

Garner and Jacobson took over immediately after David Vogel exited in May (HR 5/4). They report to studio chairman Joe Roth, Disney Studios

See DISNEY on page 53

Whose .com is it anyway?

By Paul Bond

Log onto the Internet and type *www.BradPitt.com* and you'll be met with a Web page containing just two sentences: "This domain is for sale. Contact domain@netmaster.com and state your offer!"

Try *www.SlyStallone.com* and you're taken to a multilingual site under construction. It, too, is for sale. Asking price: $5,000.

Welcome to the world of cybersquatting.

It's big business, registering an Internet domain name for $70 and reselling that name on the open market. And cybersquatters have been buying up every celebrity-named Web address imaginable.

Want to own the rights to your own name in cyberspace? John Flock, a new media attorney at Kenyon & Kenyon in New York, says you have three options:

See CYBERSQUATTING on page 53

It's another tall 'Order' for NBC

By Lynette Rice

Another powerful performance by "Law & Order" helped NBC squeak past ABC in adults 18-49 on Wednesday, while the debut of "Roswell" gave the WB its second highest-rated series premiere ever in adults 18-34.

"Order" (7.1 rating/20 share) attracted the highest 18-49 ratings

See TV RATINGS on page 8

Writers

Continued from page 1—

The survey found that:

- on NBC shows, only one of the 189 staff writing positions is held by a black writer (0.5%);
- on CBS shows, only two of the 144 staff writing positions are held by blacks (1.4%);
- on Fox shows, only three of the 160 staff writing positions are held by blacks (1.9%);
- and on ABC shows, only nine of the 171 staff writing positions are held by blacks (5.3%).

The survey also found that on the six networks' fall shows, only 11 Latino writers (1.3%), three Asian-American writers (0.3%) and no Native Americans are employed on the shows.

"The lack of diversity in writers' rooms throughout television is even more startling than the lack of diversity on the air," said Billie Green, president of the NAACP Beverly Hills/Hollywood branch. "Whereas shows such as 'Spin City,' 'Touched By an Angel' and 'Veronica's Closet' feature African-American characters as series regulars, there are no African-American writers or writer-producers working on these shows."

The survey found that of the 55 black TV writers employed on the fall lineup of sitcoms and dramas, 83% were employed on "black-themed" shows. Indeed, 33% of the 55 black writers were employed on just two shows — UPN's "Moesha" and "The Parkers."

According to the survey, the only NBC show that employs a black writer is "Third Watch," while the only CBS show with a black writer is "Cosby," which has two.

At Fox, "The Badlands," "Get Real" and "Time of Your Life" each employ one black writer.

At ABC, five black writers are employed on "The Hughleys," two on "The Practice" and one on "Boy Meets World" and "Wasteland."

The WB employs 17 black writers, but they are clustered on three shows: "The Jamie Foxx Show" with seven and "The Steve Harvey Show" and "For Your Love," each of which employs five.

UPN has five shows with black writers. "The Parkers" has 10 and "Moesha" has eight, while "Malcolm & Eddie" has three. "Grown Ups" and "The Strip" each employ one black writer.

Altogether, NBC has 19 shows without any black writers, CBS has 17, Fox has 14, ABC has 13, the WB has 11 and UPN four.

The survey also found that the vast majority of the 55 black writers employed on the fall shows were employed in comedies. According to the survey, only 15% of the 55 were employed on dramas, with the other 85% on sitcoms.

Among the production companies, the survey found that no black TV writers were employed by Paramount, NBC Studios, DreamWorks, Castle Rock, CBS Prods., Imagine, Regency TV, Rysher, Spelling TV, Viacom TV and Studios USA TV.

"When a pattern such as this is so blatantly pervasive, is it a matter of happenstance or oversight?" Green asked. "Or is it racial discrimination? We'll let the numbers speak for themselves."

Mike Mahern, the secretary-treasurer of the Writers Guild of America West, said he has not seen the survey but noted that the guild's board held a special meeting in August to explore the problem of "segregation" in half-hour shows.

"Guild statistics show that in half-hour shows, there are no African-American writers employed on shows that do not have predominantly black casts," Mahern said. "The board and officers find the degree of segregation among writers in half-hour comedies very troubling, and we are acting to try to correct the situation."

Spokespersons for ABC, CBS, NBS and Fox declined comment, saying that they had not seen the survey and could not verify its accuracy. Several also noted that writers are generally hired by the shows' production companies, not by the networks.

UPN and the WB spokespersons had not returned phone calls by press time. □

'Borders'

Continued from page 1—

world.

Stone's former partner, Dan Halsted, produces with him. Doug Claybourne executive produces.

Stone is completing his football-themed "Any Given Sunday" for Warner Bros.

Costner most recently starred in Universal's "For Love of the Game" and is shooting "13 Days." Zeta-Jones, repped by ICM's George Freeman, starred this year in "The Haunting" and "Entrapment." □

McCain tries to revive minority-sale tax break

By Brooks Boliek

WASHINGTON — Media companies will get a tax break if they sell properties to minorities under legislation Sen. John McCain, R-Ariz., plans to introduce today.

By resurrecting a minority tax-certificate program similar to one the FCC was forced to discontinue, McCain and some other lawmakers hope to widen diversity in the ownership of television, telephone and cable companies.

"All Americans have a stake in advanced telecommunications technology, and all Americans should have a chance to enjoy its benefits, not only as users, but as owners," McCain said when he first announced this year that he supported the tax-certificate idea.

McCain has been pressing for legislation that would permit the deferral of the capital-gains tax if media properties are sold to purchasers that have been historically underrepresented in the telecommunications business. The tax could also be deferred if a company invested its profits from the sale in a telecommunications business that was owned by a minority individual or a woman.

There are strings attached to the deferral claim, including limits on the size of a qualifying company and restrictions on the resale of the company by the new owner.

Introduction of the McCain bill comes as minorities criticize the broadcast TV networks for not including the proper proportion of black or brown faces in programming. Minority leaders, led by the Rev. Jesse Jackson, argue that more minority owners will foster a greater minority presence on TV and in the movies. □

Pavarotti

Continued from page 7—

could not attend the performance in Helsinki are now able to participate in the concert through MCY.com," Pavarotti said. "It is wonderful that the Internet is being used for cultural purposes."

In addition to the Sept. 25 performance, camera teams from MCY filmed Pavarotti during his entire stay in the capital of Finland, and have archived exclusive backstage interviews, rehearsals and press conferences. These, too, will be featured in the download.

"We are very proud to welcome Luciano Pavarotti in(to) our family," CEO and president of MCY Bernhard Fritsch said. "What can one say about Pavarotti that hasn't already been said? The range, the purity of tone — he is a living legend."

Pavarotti

Pavarotti's Helsinki concert, attended by 12,000 people, was the last stop in his recent European tour. This fall, he continues his schedule with performances of "Tosca" at the Metropolitan Opera House in New York, a tour of Australia in November and a Three Tenors performance in San Jose, Calif., Dec. 29. □

Earnings

Continued from page 13—

Ireland that is 30% owned by Canada's CanWest, said first-half pretax profit for the year to June 30 was down by more than half at £2 million ($3.3 million) on revenue up 2.4% at £18.5 million ($30.5 million).

Telescene Film Group, a Montreal-based film production company, said second-quarter net earnings decreased 28% to $721,000 in the three months ended Aug. 31. Gross revenue increased 28% to $12.1 million.

Audiofina SA, a Luxembourg media holding company, reported that after-tax profit on ordinary activities increased 228% to 49.2 million euros ($52.5 million) in the six months ending June 30, excluding activity from European broadcasting group CLT-UFA. Audiofina jointly owns CLT-UFA with German media group Bertelsmann AG.

Media 100 Inc., a Marlboro, Mass., maker of digital video systems, reported a third-quarter net loss of $172,000 and a net sales increase of 30% to $13.1 million for the three months ending Aug. 31.

VCL Film, Germany's largest independent video and DVD distributor, saw sales leap 110% in the first nine months of 1999 to DM45 million ($24.6 million). Profit for the period was up 383% to DM5 million ($2.7 million) compared with the same three quarters last year.

Groupe AB, the leading supplier of thematic channels in France, posted first-half net income of 25.8 million francs ($4.2 million), compared with a loss of 151 million francs ($25 million) in the same period last year. Revenue increased nearly 15% to 382 million francs ($64 million).

Advanced Medien, a Munich, Germany-based theatrical distributor, saw turnover soar 720% to DM33.3 million ($19.2 million) in the first nine months of 1999. Pretax profits were up 808% compared with the same period in 1998 to DM4.9 million ($2.7 million).

Mail Call

New York Times
Monday, September 20, 1999

Stung by Criticism of Fall Shows, TV Networks Add Minority Roles

[illegible]

... Although minority actors and [illegible] reactions were [illegible] positive, they still made it clear that suddenly hiring a handful of black actors and writers hardly changes the mind-set of network executives, producers and advertisers.

"People running television live on the mean streets of Malibu, and minorities just don't exist in their world," said James McDaniel, a former New York stage actor who has [illegible] Arthur Fancy since [illegible] started in 1993 and [illegible] black actors in [illegible] series.

[illegible] president of the [illegible]

Continued on Page A14

NEWS SUMMARY	A2
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Updated news: www.nytimes.com

New York Times, Monday September 20, 1999

Stung by Criticism of the New Fall Shows, TV Networks Rush to Add Minority Roles

Continued From Page A1

National Association for the Advancement of Colored People, called the fall shows a "virtual whitewash," and Latino and Asian-American groups joined in the protests. Mr. Mfume met top executives at CBS, NBC, ABC and Fox over the last six weeks, and his organization bought 100 shares in each of the companies that own these networks "so we can go to board meetings and raise the kind of hell and the issues that we think are necessary," Mr. Mfume said.

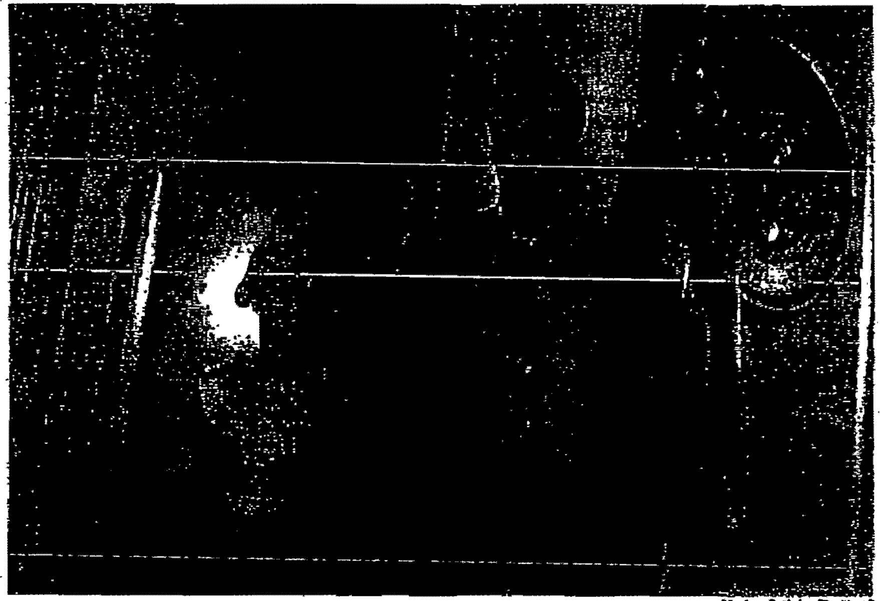
In some cases television executives and producers seem to have responded to the protest with alarm and embarrassment.

"We're certainly glad that some of the networks have seen fit to add minorities to their programs," said John C. White, the N.A.A.C.P.'s director of communications. "But we still think it's even more important that minorities are hired in decision-making positions — and when we say minorities we're not just talking African-Americans. We think there's an insufficient number of Latinos, Asian-Americans and Native Americans on television."

The evidence is clear that the protests over the all-white new shows have stung executives and producers now that there is a rush to add minority roles. "There were hardly any African-American roles in the pilot season and the shows that got picked up," said Karen Goldberg, a talent agent at the Don Buchwald agency. "Now, suddenly, they're definitely adding ethnic characters."

Ming-Na Wen, an Asian actress who appeared in the first season of NBC's hospital drama "E.R.," is returning in its sixth year as a medical student, and a black woman has been added as a doctor. CBS's new series "Judging Amy," about a single mother from New York who becomes a judge in Hartford, has added a black bailiff as a top role. Another CBS show, "Family Law," about a struggling law firm, has added black and Hispanic law-school trainees. The NBC comedy "Suddenly Susan" has added a black woman as an assistant to the actor Eric Idle, who plays the new boss of a men's magazine.

The pilot for the Kevin Williamson series on ABC, "Wasteland," about six people in their 20's exploring life in Manhattan after college, was reshot to incorporate a black character. The actor, Jeffrey Sams, who was scheduled to appear in later episodes, is now a significant figure on the show, playing an Assistant District Attorney in the middle of a divorce who has an affair with a Southern debutante who works for him.



Marissa Roth for The New Y

Aaron Sorkin, creator of "The West Wing," a new dramatic series about the White House. The show, pilot episode was criticized for the absence of minority roles, has recently added many ethnic charac

"ABC asked us, as a result of the controversy, to speed the story up," said Mr. Williamson, who wrote the screenplay for "Scream" and created the hit television show "Dawson's Creek." He added: "I said, 'Absolutely, with pleasure.' The N.A.A.C.P. was very right. Now Jeffrey has a pivotal role on the show."

Not only are these and other shows adding minority characters and quickly shifting plot lines, but networks are also looking ahead to next year, partly to avoid the problems of this year. Last week CBS said it was developing a series about several generations of a Mexican-American family in New York with the Latino filmmaker Gregory Nava, who directed the film "Selena."

At the same time ABC ordered the development of a one-hour series based on the black detective character Easy Rawlins, created by the novelist Walter Mosley. Mr. Mosley's novel "Devil in a Blue Dress" was adapted into a 1995 film in which Denzel Washington played the detective.

Suddenly, a number of ethnic characters in several new and familiar series.

The new series is being created by David Mills, who has written for "N.Y.P.D. Blue" and "E.R.," and Thomas Carter, a director. Both men are black.

"I'm mindful of the fact that the public complaints about the industry made this a good time to pitch such a project and contributed to the hospitality with which it was received," said Mr. Mills, a former Washington Post reporter. "We all knew the time was right now. This is not to diminish the value of Walter Mosley's franchise and the great characters he created."

The urgency with which the networks are seeking to add minority characters was underlined by the fact that Marcia Shulman, senior vice president for talent and casting at 20th Century Fox Television, which produces 13 shows, more than any other company, flew to New York last week to interview actors "of every ethnicity" for next year.

Ms. Shulman said, "I'm anticipating us putting together for next season casts that are multiethnic and ensembles that feature the kind of diversity that we have in real life."

Top network executives and minority actors and writers seem united on one issue: that the failure to reach beyond all-white casts is not the result of overt racism but more indifference and insensitivity on the part of networks.

Several hit NBC comedies like "Friends" and "Will and Grace," which take place in New York, and "Frasier," which is set in Seattle, are especially noticeable for their lack of racially and ethnically diverse characters, just as "Seinfeld" and "Cheers" were.

Scott Sassa, president of NBC, West Coast, said: "We want to have more minorities on the schedule. And the N.A.A.C.P.'s efforts have had some impact on the process."

Leslie Moonves, president and chief executive of CBS Television, observed: "This is something we're constantly conscious of. This is something that everyone recognizes in the industry." But CBS executives made it clear that some shows did not lend themselves to casting a minority character in a top role, such as a new romantic comedy, "Love and Money," an upstairs-downstairs series set in New York about a handyman and a shy heiress.

And Pat Fili-Krushel, president of the ABC Television network, said: "We have obviously realized that the casts of some of our shows were mainly white, and some of our additional casting has been in response to that. We've realized we didn't have enough ethnic characters on the canvas. We've realized we've got to look a little deeper and a little further."

Such comments hardly assuage the resentments and anger of actors and creators, some members of minorities and some not.

Steve Harvey, whose program on the WB network, "The Steve Harvey Show," is the No. 1 show in African-American households, said the huge success of what he termed all-white shows like "Friends" had simply led advertisers and networks to follow suit. "They know they can make money without black faces on television," he said.

Similarly, Nancy Miller, executive producer of "Any Day Now," a highly acclaimed if little-known series on Lifetime about the friendship between a black woman and a white woman (Lorraine Toussaint and Annie Potts) in Birmingham, Ala., said that the "incredible arrogance" of the networks in casting mostly white faces would not soon fade. "It cracks me up that all these networks are scrambling to throw black and minority faces on these shows," said Ms. Miller, who is white. "That's not how you do it. It's got to come from the creators and the writers. And they don't seem to want stories about anyone but white people. How dare they! How incredibly arrogant!"

But Yvette Lee Bowser, who created Fox's "Living Single," a mostly black show, and is preparing a quasi-biographical one-hour series for WB, was optimistic about the show, tentatively called "The Miseducation of Piper Fein." The series is about a biracial girl in Los Angeles and her multicultural friends. Ms. Bowser said that WB was most enthusiastic about her show. "This is the network that will give it probably the best chance to survive," she said.

But Ms. Bowser said her previous experience with television had sometimes been frustrating because executives often wanted her to churn out stereotypical black women. "They wanted to make things more ethnic, they wanted to make women more sassy and in your face, less progressive and less upwardly mobile," she said. "They seemed comfortable wanting to recreate images that they've seen before."

'The N.A.A.C.P.'s efforts have had some impact on the process.'

Some of television's most successful writer-producers, like David E. Kelley ("The Practice," "Ally McBeal") and Steven Bochco ("N.Y.P.D. Blue,"), have successfully used minority characters, and sometimes focused on story lines dealing with racial issues. Mr. Bochco's newest series, "City of Angels," to be shown early next year on CBS, is populated almost entirely by black, Hispanic and other minority actors, with only a handful of white faces. The show is set in an inner-city hospital in Los Angeles.

Mr. Bochco discounted the notion that because of his success, he could write his own ticket while other writers would meet resistance to a virtually all-minority show. "I don't think there's a conscious prejudice on television, I don't think anyone can make that leap," Mr. Bochco said. "It's unthinking. It tends to be an unmindful reflection of self on the part of writers and developers and networks in general."

As to the current last-minute spate of hiring of minority members, Mr. Bochco said he disagreed with anyone who called the step cynical. "It doesn't matter to me if you hire as an afterthought," he said. "It doesn't matter if you hire me for the wrong reasons. At least you've done it. You've hired me."

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
Wednesday, Oct. 20, 1999

Contact: NCI Press Office
(301) 496-6641
HCFA Press Office
(202) 690-6145
CDC Press Office
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DESPITE INCREASES IN MAMMOGRAPHY AMONG OLDER WOMEN, MISPERCEPTIONS PERSIST
PSAs Featuring Whitney Houston Launched To Continue Education Efforts

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Despite increases in mammography rates among older women, misperceptions about the procedure still persist, HHS Secretary Donna E. Shalala announced today, releasing a new study conducted by the National **Cancer** Institute (NCI) and the Health Care Financing Administration (HCFA) to mark National **Breast Cancer** Awareness Month.

To spread the word about the importance of mammography in early detection of **breast cancer**, especially in the minority community, Secretary Shalala also released two public service announcements featuring singer and actress Whitney Houston and First Lady Hillary Rodham Clinton. Since 1995, both the President and the First Lady have appeared in television public service announcements encouraging older women to get mammography screening and promoting the use of Medicare coverage for mammography.

According to the study released today, the vast majority (88 percent) of women ages 65 and older have had at least one mammogram in their lifetime, representing a 25 percent increase from a similar survey conducted by the American Association of Retired Persons (AARP) in 1992. The majority of women over age 65 (70 percent) have received a mammogram within the last two years - again a substantial increase from 35 percent in 1992.

Although **breast cancer** risk increases with age, data from the survey also show that more than one-third of women ages 65 and older are not as concerned about getting **breast cancer** as they were when they were younger. Additionally, only 57 percent of the nationally representative sample of 814 women ages 65 and older know they should have a screening mammogram every one or two years.

"Since 1993, we have made great strides in our battle against **breast cancer**," Secretary Shalala said. "We've increased women's access to screening, early detection and treatment, improved the quality of care, and launched the largest **breast cancer** clinical trial ever. Yet these findings remind us that we must do more to address the need for regular **breast cancer** screening, especially among older women," she said.

Other key findings from the NCI/HCFA survey include:

- Minority women were nearly twice as likely as white women to say that they "didn't know" at what age to start getting mammograms (20 percent vs. 11 percent).
- Half of the women who have had mammograms received them as part of routine medical care. One-third (34 percent) also indicated that a doctor or other health professional had recommended it to them. Those who never had a mammogram were most likely to report that they didn't feel

they needed it and/or that a doctor had not recommended it.

- More than three-quarters of women (77 percent) were aware that Medicare will cover the cost of mammograms, but only slightly more than half (58 percent) had actually used Medicare for this purpose. Minority women are nearly twice as likely as white women to be unaware that Medicare covers mammograms (29 percent vs. 17 percent).

HHS also provides screening services for low-income and medically underserved women in all 50 states, six U.S. territories, the District of Columbia, and 12 American Indian/Alaska Native organizations through CDC's National **Breast** and Cervical **Cancer** Early Detection Program. New data released today show that the program has provided more than 2.2 million screenings since 1991, including over one million mammograms, with minority women making up nearly half of those screened.

In December 1993, the Clinton Administration launched the National Action Plan on **Breast Cancer**, which has guided HHS efforts to increase research, prevention, and treatment. For **breast cancer** research alone, NIH spending has increased from $237 million in fiscal year 1993 to $478 million in fiscal year 1999. President Clinton's fiscal year 2000 budget included $501 million for **breast cancer** research at NIH. NCI and HCFA formed a partnership in 1998 to raise awareness of the importance of regular mammography screening among women ages 65 and older, and of the expanded mammography screening benefit for Medicare beneficiaries. NCI has also launched the Study of Tamoxifen and Raloxifene (STAR) clinical trial, to compare the drugs for their effectiveness in reducing the risk of **breast cancer** in postmenopausal women who are at increased risk for the disease.

Full copies of the NCI/HCFA research study "Knowledge, Attitudes, and Behavior of Women Ages 65 and Older on Mammography Screening and Medicare" (POS# T162) and other **breast cancer** and mammography screening information are available through NCI's **Cancer** Information Service (CIS) at 1-800-4-**CANCER** and NCI's web site at http://www.nci.nih.gov/ by clicking on "press releases."

More information on CDC's National **Breast** and Cervical **Cancer** Early Detection Program can be found at http://www.cdc.gov/**cancer**/nbccedp/spot.htm.

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Note: For other HHS Press Releases and Fact Sheets pertaining to the subject of this announcement, please visit our Press Release and Fact Sheet search engine at: http://www.os.dhhs.gov/news/press/.

HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

May 25, 1999

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HHS: Advancing the Science, Improving the Treatments for Breast Cancer

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*Overview: **Breast cancer** is the most commonly diagnosed **cancer** and the second leading cause of **cancer** deaths among American women. Early detection through mammography and clinical **breast** exams are essential for effective **breast cancer** screening.*

*For women age 50-69, having regular mammograms can reduce the chance of death from **breast cancer** by approximately 30 percent. Despite these numbers, 33 percent of women ages 50-64, and 45 percent of women age 65 and older reported not receiving a mammogram during the past two years.*

*The Clinton Administration has responded to the significant threat posed by **breast cancer** with increased efforts in research, prevention and treatment. HHS Secretary Donna E. Shalala convened a conference in December 1993 to establish a National Action Plan on **Breast Cancer**. The national plan, which is being carried out today by the public, private and volunteer sectors, is a key element of the Administration's commitment to fighting **breast cancer**.*

*At the same time, spending on **breast cancer** research at National Institutes of Health has increased from $237 million in FY 1993 to $478 million in FY 1999. President Clinton's FY 2000 budget includes $501 million for **breast cancer** research at NIH.*

In 1995, First Lady Hillary Rodham Clinton launched a campaign urging older women to obtain mammograms, and, in particular, to promote use of Medicare coverage for mammography. Both the President and the First Lady have appeared in TV public service announcements encouraging older women to get mammography screening.

As of January 1998, Medicare coverage expanded to help pay for annual mammograms for all Medicare beneficiaries age 40 and over.

Background: More Women Can Survive Breast Cancer

- A woman's chances of getting **breast cancer** change with age: by age 40, one of 217 women will face **breast cancer**; by age 70, one of 14 will be diagnosed with the disease. Although death rates from **breast cancer** have declined in recent years, **breast cancer** accounts for 30 percent of all cancers among women.
- Approximately 175,000 new cases of **breast cancer** are estimated for 1999, and about 43,300 women are expected to die from **breast cancer**. Epidemiologic studies estimate that **breast cancer** will be diagnosed in 1.5 million American women in this decade and that **breast cancer** will claim nearly half a million lives.
- Death rates from the disease are highest among older, black and low-income women. With proper screening and treatment, however, the chances of surviving **breast cancer** are improving. **Breast**

cancer mortality trends among both black and white women have improved markedly in the United States since the 1980s. During the 1980s, **breast cancer** incidence for women increased, but in the 1990s, it has leveled off.

- The death rate for women with **breast cancer** has declined on average 1.7 percent per year since 1989. Between 1992 and 1996, for example, the greatest reductions in death rates were among younger women (5.7 percent) and white women (5.5 percent), with more modest reductions among African Americans (0.4 percent) and women age 65 and older (3.9 percent).

- During the most recent 5-year period, 1992-1996, death rates among white women declined for all decades of age from 30 to 79 years. Among black women, rates were down for all decades of age from 30 to 79 years. Among both groups, the greatest improvements in mortality were seen in the younger age groups. For women aged 30 to 39 years, rates dropped about 4.24 percent among whites and 2.8 percent among blacks. For women aged 40 to 49 years, rates dropped 8.78 percent among whites and 0.97 percent among blacks.

HHS Spending On Breast Cancer

HHS discretionary funding for **breast cancer** research, prevention and treatment has increased from approximately $283 million in FY 1993 to $599 million in FY 1999. President Clinton's FY 2000 budget includes $501 million for these activities. As the Centers for Disease Control and Prevention (CDC) have worked to increase access for all women to mammography screening and follow up services, the resources devoted to **breast cancer** services have increased from an estimated $43 million in FY 1993, to $93 million in FY 1999. **Cancer** research is vital to our understanding of how to prevent, detect and treat **breast cancer**. The Clinton Administration has invested in **breast cancer** research at the National Institutes of Health by increasing funding from $237 million in FY 1993, to $478 million in FY 1999. HHS also helps provide treatment for **breast cancer** through the Medicare and Medicaid programs and through the Indian Health Service.

HHS Action To Combat Breast Cancer

Under President Clinton, HHS has directed a wide array of activities and new initiatives:

New Mammography Benefit

Since January 1998, Medicare coverage has expanded to help pay for annual mammograms for all Medicare beneficiaries age 40 and over. Under this new benefit, Medicare waives the Part B deductible for screening mammograms. NCI, following advice from its National **Cancer** Advisory Board, recommends women in their 40s who are at average risk of **breast cancer** be screened every one to two years with mammography. In April, the Food and Drug Administration determined a new imaging device safe and effective to help radiologists determine whether a woman warrants further evaluation if mammogram results are ambiguous. T-Scan 2000 should help identify women who should be referred for early biopsies.

Mammography Quality Standards

The Mammography Quality Standards Act (MQSA) of 1992 went into effect April 28, 1999, ensuring universal access to high quality mammography services in this country. Under the final rules of MQSA, FDA sets high standards for mammography facilities and certifies those which meet the standards. The roughly 10,000 mammography facilities nationwide accredited by the FDA must meet quality standards for equipment and personnel, and are inspected annually.

These regulations spell out the details for requiring facilities to hire capable technologists, use quality dedicated equipment that produces clear images, and employ skilled interpreting physicians to interpret the results both accurately and efficiently. The rules also require that doctors be fully and quickly informed of results so that any follow-up testing or treatment can begin immediately. In fact, the Mammography Quality Standards Reauthorization Act of 1998 required every U.S. mammography facility to notify patients of their mammogram results promptly and in easy-to-understand language.

The names and locations of FDA-certified mammography facilities are available by calling the **Cancer**

Information Service at 1-800-4-**CANCER**. In addition, the FDA has included a list of all FDA-certified mammography facilities in the United States on its Internet home page. The address is http://www.fda.gov/cdrh/faclist.html.

National Action Plan on **Breast Cancer**

HHS' Office on Women's Health coordinates the National Action Plan on **Breast Cancer**. This first-ever national plan was developed in 1993 under Secretary Shalala's leadership. The Plan has awarded over $9 million in grants for 99 innovative research and outreach projects, with a special emphasis on the development of public-private partnerships targeted in the six priority areas:

The Information Action Council Working Group is working to improve access to information about **breast cancer** for consumers, scientists and practitioners via the Internet and other information technologies.

The Etiology Working Group is focusing on efforts to expand the scope and breadth of biomedical, epidemiological and behavioral research on **breast cancer**. The group has identified four priority areas: chemicals and hormones, viruses, radiation and electromagnetic fields, and lifestyle factors.

The National Biological Resources Banks Working Group (NAPBC) has focused on the development of a national mechanism and standard for obtaining and storing tissue for multiple areas of **breast cancer** research. The NAPBC has awarded funds to establish a national biological resources bank and is now conducting a survey of tissue banks throughout the country to identify and determine the accessibility of all available biological resources.

The Working Group to Ensure Consumer Involvement has defined several specific activities to help ensure consumer involvement at all levels in the development of national research, education and service delivery programs related to **breast cancer**.

The Clinical Trial Accessibility Working Group has identified a series of initiatives to address four types of barriers to participation in clinical trials, including barriers associated with the informed consent process, patient and physician misperceptions about clinical trials, lack of information about the availability of trials, and cost.

The Working Group on Heredity Susceptibility is evaluating the ethical, legal and policy issues of individuals carrying **breast cancer** susceptibility genes.

Developed by a public/private partnership and coordinated by the Department of Health and Human Services Office on Women's Health, a National Action Plan on **Breast Cancer** (NAPBC) web site serves as a gateway to information on **breast cancer** research, treatment, and prevention. Since October 1996, the web site has been providing answers on frequently asked questions about **breast cancer**, as well as information on the NAPBC, **breast cancer** clinical trials and research, **breast cancer** organizations and advocacy groups, educational conferences, publications, and government and private resources. The web site address is http://www.napbc.org.

Discovery of BRCA1 and BRCA2 Genes for **Breast Cancer**

Breast cancer research has been expanded at the National Institutes of Health. Promising news came late in 1994 when a team of investigators at the University of Utah, Myriad Genetics and the National Institute of Environmental Health Sciences (NIEHS) identified a **breast cancer** susceptibility gene (BRCA1) that may account for 5-10 percent of the **breast** cancers diagnosed each year. The discovery of a second, entirely different **breast cancer** susceptibility gene, BRCA2, has helped us understand even more about the genetics of **breast cancer**. Researchers more recently discovered a particular variant of the BRCA1 susceptibility gene in Jewish women of eastern European descent (Ashkenazi Jews). While only 5-10 percent of all **breast** cancers are the result of an inherited anomaly, these findings hold promise for the development of new prevention and treatment strategies.

Other **breast cancer** research includes psychosocial research, which looks at how to enhance the quality of life in women with **breast cancer**, and the **Breast Cancer** Prevention Trial.

On October 27, 1996, President Clinton announced $30 million in new funding for research into the genetic basis of **breast cancer** through a collaborative initiative between the Department of Defense and the National Institutes of Health.

Breast Cancer Prevention Trial
As part of a large North American study conducted by the National Surgical Adjuvant **Breast** and Bowel Project (NSABP) with support from the National **Cancer** Institute (NCI), more than 13,000 women volunteered to take tamoxifen or an inactive pill to see if the drug would help prevent new cases of **breast cancer**. In 1998, the trial showed 49 percent fewer cases of **breast cancer** reported in the high-risk women in the trial who took the drug versus those on the inactive pill. The study highlighted the fact that while a reduction in new cases is significant, there are risks associated with tamoxifen that must be carefully weighed against the benefits of **breast cancer** reduction. NSABP and NCI are developing information for individual decision making that will help women at increased risk of **breast cancer** consult with their health care providers about whether or not to begin tamoxifen therapy.

In October 1998, HHS Secretary Shalala announced the largest-ever **breast cancer** prevention clinical trial involving an estimated 400 sites across the United States and Canada. The study of tamoxifen and raloxifene, (STAR), includes 22,000 postmenopausal women at increased risk of **breast cancer**. STAR will build on the success of the **Breast Cancer** Prevention Trial by determining whether raloxifene, a drug similar to tamoxifen, is also effective in preventing **breast cancer** but with fewer side effects than tamoxifen.

Privacy of Genetic Information and **Breast Cancer**
President Clinton has supported bipartisan legislation to prohibit health plans from inappropriately using genetic screening information to deny coverage, set premiums or to distribute confidential information. In many diseases, such as **breast cancer**, we are beginning to identify genetic alterations that may place a woman at increased risk. Women who test positive may increase **cancer** detection efforts, may choose to have preventive surgery or may join a **cancer** prevention research study. However, insurance companies and others also can misuse genetic testing to discriminate and stigmatize individuals and groups of people. In fact, studies show that women often do not get genetic testing for **breast cancer** because they fear the information will be used to discriminate against them.

National **Breast** and Cervical **Cancer** Early Detection Program
CDC's National **Breast** and Cervical **Cancer** Early Detection Program offers free or low-cost mammography screening to uninsured, low-income, elderly, minority and Native American women nationwide. Resources devoted to **breast cancer** screening services have grown from an estimated $43 million in FY 1993 to $93 million in FY 1999. The program, which has been operating in an increasing number of states over the past six years, has provided more than 1.3 million screening tests to medically underserved women. Currently, the program provides funding for all 50 states, five territories, the District of Columbia, and 15 American Indian/Alaska Native organizations.

Breast Cancer Among the Elderly
The Agency for Health Care Policy and Research (AHCPR) is currently funding a five-year Patient Outcomes Research Team study on the care, costs and outcomes of early stage **breast cancer**. The study is examining three alternative treatments for early-stage **breast cancer** in the elderly: modified radical mastectomy, **breast**-conserving surgery with radiotherapy and **breast**-conserving surgery without radiotherapy. The project is studying quality and cost-effectiveness in these projects and will develop clear recommendations for treating early-stage **breast cancer** in the elderly. A supplemental project with additional funding from the Federal Coordinating Committee on **Breast Cancer** is addressing these same issues but with a specific focus on African-American Medicare beneficiaries.

New Frontiers In **Breast Cancer** Early Detection
The Department of Health and Human Services has been working with the Department of Defense, the CIA, NASA, and other public and private entities to explore ways in which imaging technologies from other fields may be applied to the early detection of **breast cancer**. In particular, the computer technologies that have been used to improve spy satellites may help improve **breast cancer** detection as

well. In October 1996, HHS awarded $1.98 million to the University of Pennsylvania to conduct a series of clinical trials of imaging technology from the intelligence community -- originally used for missile guidance and target recognition -- to improve the early detection of **breast cancer**.

Centers of Excellence
On October 1, 1996, the Department of Health and Human Services established six National Centers of Excellence in Women's Health to serve as national models for improving the health care of American women. The new Centers of Excellence program, with facilities located at academic institutions in different areas of the country, will integrate health care services, research programs, public education and health care professional training. HHS? Office of Women's Health now supports18 centers of excellence.

Mammography Clinical Practice Guidelines
Recognizing the importance of the quality of screening mammograms in the early detection of **breast cancer**, AHCPR in October 1994 developed a Clinical Practice Guideline--Quality Determinants of Mammography--with separate versions for mammography providers, health care professionals and consumers. The guidelines detail the roles and responsibilities of each health care professional involved in mammography services, and include information and recommendations for women.

Mammography for Women with Addictive and Mental Disorders
Women who are in need or who receive substance abuse or mental health services often lack appropriate primary health care, including **breast cancer** education, detection and treatment. Women-focused substance abuse and mental health programs funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) are designed to be comprehensive, delivering primary health care services to women who often are medically underserved. These services include education on **breast** self-examination and mammography services and counseling on risks for **breast cancer**.

Environmental Factors and **Breast Cancer**
HHS' Office on Women's Health has established a Federal Interagency Coordinating Committee on the Environment and Women's Health that focuses on how home, work, atmospheric pollutants, exogenous hormones, drugs, and other environmental factors may contribute to the risk of **breast cancer** and other disorders.

Office of **Cancer** Survivorship
On October 27, 1996, President Clinton unveiled the new Office of **Cancer** Survivorship at the National **Cancer** Institute. Recent success of **cancer** prevention, early detection and treatment efforts has created a new need: research into the physical, psychological and economic well-being of the growing number of **cancer** survivors. The Office of **Cancer** Survivorship supports research covering the range of issues facing survivors of **cancer**, including: long-term medical and psychological effects; factors that predispose survivors to second malignancies; reproductive problems following **cancer** treatment; and their unique insurance and employment issues.

Last year, NCI began including consumer advocates as full voting members of the peer review groups evaluating grant applications. This is much like the two dozen **cancer** patients and/or advocates who have assisted in **cancer** drug approval decisions since 1996 as voting members of FDA advisory committees.

NCI also formed, last year, a Director's Consumer Liaison Group, a formal committee of 15 **cancer** survivors who directly advise the NCI director and bring the patient's perspective to bear on the full range of NCI activities. This year, NCI will fully integrate patients and advocates into activities such as reviewing grant proposals and planning policy.

In September 1998, NCI earmarked $15 million over five years for new research into the physical and emotional well-being of **cancer** survivors who are alive five or more years after diagnosis. This is in addition to $20 million already earmarked by NCI for survivorship-related studies.

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Note: HHS fact sheets releases are available on the World Wide Web at: http://www.hhs.gov.

PRESS RELEASES

NAACP INVESTIGATES DENIAL OF OPPORTUNITY IN NETWORK TELEVISION INDUSTRY

CONVENES PUBLIC HEARING IN LOS ANGELES

November 29, 1999

Karen Narasaki. Exec. Dir., Nat'l Asian Pacific Legal Consortium; Dennis Hayes, NAACP General Counsel; Esteban Torres; Kweisi Mfume

Baltimore – The National Association for the Advancement of Colored People (NAACP), under the leadership of Kweisi Mfume, President and CEO, convened a public hearing today to examine the pattern of discriminatory treatment by the television industry against African Americans, Asian Americans, Latinos, Native Americans and other minorities.

Mfume said, "The hearings today are designed, not so much to determine whether or not there continues to be a severe problem with respect to equal opportunity in network television, but rather to develop a public record on why the denial of opportunity for people of color continues to go virtually unabated."

The probe is a part of the NAACP's ongoing investigation of diversity at the major TV networks, ABC, CBS, NBC and FOX. It was highlighted by testimony from CBS Television CEO Leslie Moonves, the only network president to attend the hearing.

Actors Blair Underwood (City Of Angels, L.A. Law), Apesanahkwat (Northern Exposure), actresses Ann Marie Johnson

(JAG, In The Heat of the Night), Erika Alexander (Cosby, Living Single), and producer/director Yvette Lee Bowser (Living Single) presented their personal testimony.

Former Congressman Esteban Torres of the National Hispanic Media Coalition, Sonny Skyhawk, Executive Director of American Indians in Film and Television and Karen Narasaki, Executive Director of the National Asian Pacific American Legal Consortium joined Mfume and the NAACP's General Counsel Dennis Hayes, and Assistant General Counsel Debbie Liu as the panel officers who queried the guest witnesses about experiences and/or perceptions of the industry.

The seven-hour public hearing drew a capacity crowd in the Westside Room of the Century Plaza Hotel & Tower in Los Angeles, California.

Also on hand to testify were industry insiders representing management and talent agencies, network executives, civil rights, advocacy, actor and writer guilds and trade unions.

Unable to testify at the originally scheduled time, representatives from ABC, NBC and FOX left the hearing without testifying. Mfume said, "We tried to rearrange the schedule to hear from the network representatives, but time did not allow. They can't treat this like a drive-by hearing, stop two or three hours and then move on.

"We have made every attempt to meet the four major networks more than halfway on this issue of diversity, but there is a limit to even the NAACP's patience. This issue will not disappear and this movement will not go away," said Mfume who brought this problem to the forefront last summer after lambasting the fall prime-time lineups for excluding people of color from starring or leading roles in the 26 new shows.

Mfume said, "In the absence of any real, measurable effort on the part of the networks to try to develop a way out of this problem, they run the risk of a sustained, focused and continuous consumer action in the form of repetitive boycotts, picketing, and large scale demonstrations in front of their network headquarters, the offices of network owned affiliates nationwide and the headquarters of their major advertisers."

The NAACP has monitored the portrayal and employment opportunities of African Americans in the television industry since 1951.

Founded in 1909, The National Association for the Advancement of Colored People (NAACP) is the nation's oldest and largest civil rights organization. Its half-million adult and youth members throughout the United States and the world are the premier advocates for civil rights in their communities, conducting voter registration drives and monitoring equal opportunity in the public and private sectors.

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THE WHITE HOUSE

WASHINGTON

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OCTOBER 29, 1999

MEMORANDUM FOR THE PRESIDENT AND VICE PRESIDENT

FROM: KATHLEEN AHN FOR BEN JOHNSON

SUBJECT: OFFICE ON THE PRESIDENT'S INITIATIVE FOR ONE AMERICA WEEKLY REPORT

ACTIONS

Civil Rights Commission Cites Failure in Enforcement of Health Care Civil Rights Laws: The US. Commission on Civil Rights released a report sharply critical of the federal government's continuing failure to enforce civil rights laws regarding health care for minorities and women. The main focus of the report was the alleged inadequate efforts of the Department of Health and Human Services (HHS) and particularly its Office of Civil Rights to enforce civil rights laws in the health care arena. I talked to Mary Berry before the report was released and got her to agree not to do a press conference on it. She complained that she has talked to Secretary Shalala about the matter but nothing has resulted from their conversations.

Seventh Day Adventist: Ben kicked off a four day leadership summit, "Racial Harmony in the New Millennium: Making It Happen," with greetings and a message from you to the 300 top leaders of the Seventh Day Adventist Church from across North America. This summit was coordinated as a direct response to your call for Americans, including the faith community, to engage in a dialogue to improve race relations. The summit sought not only to discuss the issues, but also, to formulate solutions that individuals can implement in their congregations to bring about positive change in race relations.

The Seventh Day Adventist Church has a worldwide membership of 10.5 million in 205 countries, with about 1 million members in North America. The Church also runs 15 Colleges and Universities in the U.S. as well as several hospitals in the DC area.

Montgomery College: Ben gave the keynote address at the campus and community dialogue with a focus on the College's role in achieving the goal of "One America in the 21st Century: Forging A New Future." The dialogue sought to identify strategic direction and institutional priorities to meet the educational needs of the diverse learning community as we enter the next century. This forum was organized as part of the second annual "Campus Days of Dialogue" co-sponsored by our office and Sec. Riley.

AMERICAN HEALTH LINE
National Journal's Daily Briefing

1 of 51 results | Next Story | Back to Results List

12-10-1999

OPINIONMAKERS - SURGEON GENERAL: SATCHER OUTLINES GOALS FOR 21ST CENTURY

Surgeon General David Satcher said that ending the racial disparities in health care "should be the goal of medicine" as we enter the 21st century. Speaking at the national "Bioethics in the Urban Context" symposium this week at the New York Academy of Medicine, Satcher called for "one standard of health ... for all Americans." He noted racial differences in infant mortality, immunization, HIV, cancer, diabetes and cardiovascular disease, and outlined six areas in need of a "greater 'balance' in the public health system:"

- Greater emphasis on disease prevention rather than "high-tech medical interventions;"
- A national research agenda focused on community-based disease prevention research and epidemiological research;
- A "bottom up" approach to public health that increases community involvement;
- Including mental health in the national health care agenda --particularly focusing on suicide;
- Balancing treatment with maintaining a healthy lifestyle;
- Devotion to the "uns," including the uninsured, the underinsured, the underrepresented, the underserved, the uninformed, and the uninspired.Satcher also emphasized the need to improve the quality of life for America's elderly (Reuters Health, 12/8).

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Eliminating Racial and Ethnic Disparities in Health

OVERVIEW

In his radio address on February 21st, 1998, President Clinton committed the Nation to an ambitious goal by the year 2010: eliminate the disparities in six areas of health status experienced by racial and ethnic minority populations while continuing the progress we have made in improving the overall health of the American people. This goal will be a major legacy of the President's Initiative on Race and will be the cornerstone of the Department of Health and Human Services' contribution to this initiative. In addition, this goal will parallel the focus of *Healthy People 2010*, the Nation's health objectives for the 21st century, to be released by the President in the year 2000.

Achieving the President's vision will require a major national commitment to identify and address the underlying causes of higher levels of disease and disability in racial and ethnic minority communities. These include poverty, lack of access to quality health services, environmental hazards in homes and neighborhoods, and the need for effective prevention programs tailored to specific community needs.

Compelling evidence that race and ethnicity correlate with persistent, and often increasing, health disparities among U.S. populations demands national attention. Indeed, despite notable progress in the overall health of the Nation, there are continuing disparities in the burden of illness and death experienced by blacks, Hispanics, American Indians and Alaska Natives, and Pacific Islanders, compared to the U.S. population as a whole. The demographic changes that are anticipated over the next decade magnify the importance of addressing disparities in health status. Groups currently experiencing poorer health status are expected to grow as a proportion of the total U.S. population; therefore, the future health of America as a whole will be influenced substantially by our success in improving the health of these racial and ethnic minorities. A national focus on disparities in health status is particularly important as major changes unfold in the way in which health care is delivered and financed.

Eliminating racial and ethnic disparities in health will require enhanced efforts at preventing disease, promoting health and delivering appropriate care. This will necessitate improved collection and use of standardized data to correctly identify all high risk populations and monitor the effectiveness of health interventions targeting these groups. Research dedicated to a better understanding of the relationships between health status and different racial and ethnic minority backgrounds will help us acquire new insights into eliminating the disparities and developing new ways to apply our existing knowledge toward this goal. Improving access to quality health care and the delivery of preventive and treatment services will require working more closely with communities to identify culturally-sensitive implementation strategies.

The Department's Strategy

The Department has selected six focus areas in which racial and ethnic minorities experience serious disparities in health access and outcomes:

1. Infant Mortality
2. Cancer Screening and Management
3. Cardiovascular Disease
4. Diabetes
5. HIV Infection/AIDS
6. Immunizations

These six health areas were selected for emphasis because they reflect areas of disparity that are known to affect multiple racial and ethnic minority groups at all life stages. The representative near-term goals within these six areas are drawn from *Healthy People 2000*, the Nation's prevention agenda; targets for reducing disparities have been developed in consultation with representatives from target communities and experts in Public Health. Reliable national data is also available to track our progress on these near-term goals in a timely fashion. The leadership and resources of the Department will be committed to achieving significant reductions in these disparities by the year 2000.

In attempting to eliminate disparities among different subpopulations, the goals of each of these six health areas present very different challenges. In some areas, such as immunizations, we are cognizant of what will help to eliminate the disparities. In others, where knowledge about how to reduce these disparities is less developed, there is a need to understand the causes and to find more effective methods to reach individuals and communities that have not benefitted from established interventions. Advances in medicine and increased access to care can only partially address the difficult, complex, and often controversial issues surrounding racial and ethnic disparities in health status. Education, environment, income and other socioeconomic factors contribute substantially to health outcomes.

The Department's Action Plan

HHS will provide leadership through research, expanding and improving programs to purchase or deliver quality health services, programs to reduce poverty and provide children with safe and healthy environments, and expanded prevention efforts. The Department's first step will be to examine its current programs to assure that they focus on opportunities to reduce health disparities and fully maximize the best scientific and community derived knowledge about how to deliver effective clinical and preventive services. Gaps in knowledge will be identified and research agendas developed to address them. New programs or modifications of existing programs will be recommended where appropriate. In addition, the Department will provide a national framework for public and private sector collaboration to eliminate health disparities through Healthy People 2010 -- the nation's health action agenda for the 21st century.

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

- To review the status of the six health disparity reduction goals for the Year 2000 and assure that the Department's research, health services and prevention programs give priority to them.

- To conduct a process of consultation with minority community representatives and with the scientific and health services communities to improve our understanding of how to achieve both the near-term disparity reduction goals and the 2010 disparity elimination goal.

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

The Steering Committee will oversee efforts to examine how effectively the Department's current programs are using their resources to support the elimination of health disparities and to recommend changes that would enhance their impact. It also will consider ways in which the FY-2000 budget can be designed to effectively support the President's goals. Under the general guidance of the Steering Committee, working groups of Departmental experts will be convened for the six goal areas, to help shape strategy for achieving the goals and to monitor our progress.

Consonant with the approach developed to guide the President's Initiative on Race, the Department of Health and Human Services' efforts in the current year will include *dialogue, research and action.*

Dialogue:

As part of its efforts, the Department of Health and Human Services will broaden and strengthen its partnerships with State and local governments, with national and regional minority health and other minority-focused organizations, and with minority community-based organizations -- those who have the greatest access to and knowledge of the communities.

- We will collaborate with other Federal departments, State, local, and tribal governments, and communities and professional groups to address broader determinants of health such as education, environment, income and other socioeconomic factors which contribute substantially to health outcomes.

- A series of structured planning and strategy sessions will be conducted with health experts and community representatives to review what we know about how to address each of the six health conditions and how well that knowledge is being applied at the community level. Barriers will be identified and strategies developed or refined to improve the effectiveness of the Department's programs.

- In addition, our nationwide consultation to develop *Healthy People 2010* involves organizations and individuals reflecting the views of minority communities.

Research:

The Department will direct attention to improvements in monitoring and developing the local and national data necessary for determining priorities and designing programs.

- As a first step in improving baseline data about the effectiveness of HHS programs in reaching minority

populations, the Department has adopted a policy that requires all HHS-sponsored data collection and reporting systems to include standard racial and ethnic categories. This inclusion policy will help monitor HHS programs to determine that Federal funds are being used in a nondiscriminatory manner and to promote the availability of standard racial and ethnic data across various agencies. This policy will enable us to make a coordinated response to major health conditions of minority populations, monitor progress in meeting their needs, and help to ensure nondiscrimination in access to and provision of appropriate HHS services for various racial and ethnic groups.

- Research focused on how to improve our interactions and interventions in minority communities will test approaches tailored to the specific cultural and social norms of these communities. Results from small-scale studies will be incorporated into the design and management of the Department's programs. In addition, HHS will develop and disseminate strategies to assist researchers in their outreach to minority communities to foster partnerships and enhance the involvement of minorities in research studies.

Action:

In addition to ongoing research and program investments that are committed to improving the health of minority communities, a number of new projects will be implemented in fiscal year 1999. These projects are designed to test models for reducing disparities in specific minority communities. The Centers for Disease Control and Prevention will administer a $10 million demonstration program that will enable multiple communities to design and test community-tailored interventions. The FY 1999 budget also includes additional new funding to support existing successful public health programs that, in partnership with community, advocacy, and tribal organizations, would expand and adapt proven public health strategies to better reach minority populations.

The Department's programs to improve the economic security of low-income families and communities will continue to make important contributions to improved health status of low-income populations--populations disproportionately composed of racial and ethnic minorities. The recently enacted State Child Health Insurance Program (CHIP), (Title XXI of the Social Security Act), which will be administered by the Health Care Financing Administration, will distribute $24 billion over the next 5 years among the States and territories. CHIP will be supplemented by an increased emphasis in the Medicaid program to identify and enroll eligible children. Taken together, these two approaches will seek to provide health insurance for at least half of the 10 million uninsured children in this country. Through a combination of education, outreach, and increased access to health care for the uninsured, a major step to eliminating racial and ethnic disparities in children's health will be achieved.

Summary

The Department of Health and Human Services recognizes that eliminating racial and ethnic disparities in these six areas will require new knowledge about the determinants of disease and effective interventions for prevention and treatment. This goal will also require improved access for all to the resources that influence health. However, focused improvement in these six health conditions will make an important contribution to

improving the health of racial and ethnic minorities as well as advance the knowledge needed to achieve the President's commitment to eliminate all disparities in the next century.

We will do so by furthering development of existing data systems, conducting research and improving the focus and effectiveness of our health service delivery and insurance programs to better meet the needs of racial and ethnic minorities. Success in this effort will accomplish two important results:

- A meaningful improvement in the lives of minorities who now suffer disproportionately from the burden of disease and disability
- Development of the tools and strategies that will enable the Nation to meet the far more challenging goal of eliminating these disparities by the year 2010

This is a long-term undertaking that will extend into the next century and requires an enduring commitment from this and future administrations.

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CDC Awards Funding to Community Coalition for Projects to Help Eliminate Racial and Ethnic Health Disparities

Surgeon General David Satcher today announced that the Centers for Diseas Control and Prevention (CDC) will award $9.4 million to community coaliti in 18 states to help address racial and ethnic disparities in the United States.

"The President has committed the nation to an ambitious goal by the year 20 eliminate the disparities in health status experienced by racial and ethnic minority populations, while continuing the progress we have made in improv the overall health of the American people," said Dr. Satcher. "These awards part of the Administration's initiative to support community-based programs that are effective in reaching and serving these affected communities."

The awards are a component of CDC's new initiative, "Racial and Ethnic Approaches to Community Health (REACH 2010)," a demonstration project that targets six health priority areas: infant mortality, improving breast and cervical cancer screening and management, cardiovascular disease, diabetes, improving child and/or adult immunization levels and HIV/AIDS. President Clinton has set a national goal of eliminating, by the year 2010, longstanding disparities in health status that affect racial and ethnic minorities, and the Department of Health and Human Services is guiding this initiative.

"These awards will put funds into the hands of frontline leaders and minority health organizations without delay to build on the progress we've already ma in reducing racial and ethnic health disparities," HHS Secretary Donna E. Shalala said. "With this money, we are helping local communities marshal th resources and fund the programs they need to close the health disparities gap the benefit of all."

A total of 32 community coalitions will receive funding, and three additiona community coalitions will be funded by the California Endowment to participate in REACH 2010. Grantees will spend the first year planning and developing activities to reduce the level of disparity in one or more of the priority areas. The following year, all of these organizations will compete fo funding to implement these plans utilizing clearly defined interventions in a geographically defined minority population. The populations include African American, American Indian, Alaska Native, Hispanic American, Asian American, and Pacific Islander.

"CDC works to end racial and ethnic health disparities by partnering with diverse communities in research and intervention programs," said Jeffrey P. Koplan, M.D., M.P.H., Director, CDC. "REACH 2010 makes an important contribution to our commitment to eliminate all disparities in the next centur

The elimination of health disparities will require a national effort--public and

private sector, individuals, and communities. A better understanding of the relationships between health status and different racial and ethnic minority backgrounds will require working more closely with communities to identify culturally-sensitive implementation strategies.

REACH 2010 FUNDED PROJECTS

GRANTEE NAME	CITY	STATE	HEALTH PRIORITY	*RAC ETH
Boston Public Health Commission	Boston	MA	Breast & Cervical Cancer	AfA
Cancer Consortium of El Paso	El Paso	TX	Cardiovascular Disease	HA
Carolinas Health Care System	Charlotte	NC	Cardiovascular Disease /Diabetes	AfA
Center for Community Health Education	Dorchester	MA	HIV/AIDS	AfA
Chicago Department of Health	Chicago	IL	Cardiovascular Disease /Diabetes	AfA,
Community Health Centers, Inc.	Salt Lake City	UT	Immunization/Infant Mortality	HA, A
Community Health Councils of LA	Los Angeles	CA	Cardiovascular Disease /Diabetes	AfA
Community Health & Social Services	Detroit	MI	Cardiovascular Disease /Diabetes	AfA,
Eastern Band of Cherokee Indians	Cherokee	NC	Diabetes	AI
First Choice Community Health Centers	Albuquerque	NM	Diabetes	HA
Florida Department of Health	Tallahassee	FL	Infant Mortality	AfA
Florida International	Miami	FL	HIV/AIDS	AfA,

University				
Fulton County Department of Health and Wellness	Atlanta	GA	Cardiovascular Disease	AfA
Genessee County Health Department	Flint	MI	Infant Mortality	AfA
Greater Lawrence Family Health	Lawrence	MA	Cardiovascular Disease /Diabetes	HA
Harbor-UCLA Research and Education Institute	Torrance	CA	Immunization	AfA,
Institute for Urban Family Health	New York	NY	Cardiovascular Disease /Diabetes	AfA,
Lowell Community Health Center	Lowell	MA	Cardiovascular Disease /Diabetes	AsA
Matthew Walker Comprehensive	Nashville	TN	Cardiovascular Disease /Diabetes	AfA
Medical University of South Carolina	Charleston	SC	Diabetes	AfA
Migrant Health Promotion	Lower Rio Grande	TX	All Six	HA
Minnesota Department of Health	St. Paul	MN	Infant Mortality	AfA,
National Black Women's Health Project	Washington	DC	Cardiovascular Disease	AfA
Oklahoma State Department of Health	Oklahoma City	OK	Cardiovascular Disease /Diabetes	AI
San Francisco Department of Public Health	San Francisco	CA	Infant Mortality	AfA
Seattle-King Department of Public Health	Seattle	WA	Diabetes	AfA, AsA,
Sinai Family	Chicago	IL	Breast & Cervical	AfA,

Health Center			Cancer	
Trustees of Columbia University	New York	NY	Immunization	AfA,
UMDNJ-New Jersey Medical School	Newark	NJ	Breast & Cervical Cancer	AfA,
University of Alabama, Birmingham	Birmingham	AL	Breast & Cervical Cancer	AfA
University of California, San Francisco	San Francisco	CA	Breast & Cervical Cancer	AsA
University of Illinois, Chicago	Chicago	IL	Diabetes/ Immunization	AfA,

* AfA(African-American), AI(American Indian), AsA(Asian American), HA(Hispanic American), Islander)

HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

December 20, 1999

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HHS STRATEGIES FOR IMPROVING MINORITY HEALTH

***Overview**: Life expectancy and overall health has improved in recent years for a large number of Americans, thanks to an increased focus on preventive medicine and dynamic new advances in medical technology.*

However, not all Americans are benefiting equally from the medical advances and disease prevention. For too many racial and ethnic minorities in our country, good health is elusive as limited access and available appropriate health care are often associated with an individual's economic status, race and gender. These health gaps - or disparities - raise health care costs for all Americans. And while Americans as a group are healthier and living longer, the nation's health status will never be as good as it can be as long as there are segments of the population with poor health status.

The Clinton Administration has developed and implemented a number of strategies to improve minority health and help close these unacceptable health gaps. These strategies include a coordinated effort to eliminate racial and ethnic health gaps in six areas by the year 2010, enhanced resources for fighting HIV/AIDS in racial and ethnic minority communities, and the formation of a number of special work groups to review health status, determine research needs, and develop strategies that help improve minority health.

The elimination of health disparities will require a national effort - public and private sector, individuals, and communities. A better understanding of the relationships between health status and different racial and ethnic minority backgrounds will require working more closely with communities to identify culturally-sensitive implementation strategies.

In September, Surgeon General David Satcher announced that the centers for Disease Control and Prevention (CDC) awarded $9.4 million to community coalitions in 18 states to help address racial and ethnic disparities in the United States. A total of 32 community coalitions received funding, and will spend the first year planning and developing activities to reduce the level of disparity in one or more of the priority areas. The following year, all of these organizations will compete for funding to implement these plans utilizing clearly defined interventions in a geographically defined minority population.

Addressing Minority Health Needs - 1999-2000

The Fiscal Year 2000 Budget Requests for Minority Health Needs. In the first budget of the new millennium, President Clinton has requested $4.2 billion at HHS for improving minority health in Fiscal Year 2000. These funds would be targeted to minority Americans for health education and disease prevention and treatment, and would continue work already underway that addresses racial and ethnic health needs.

Included in this request:

- $2.8 billion for health care services delivery through the Indian Health Service;
- $92.5 million for health professions diversity training through the Health Resources and Services Administration (HRSA);

- $4 million for nursing workforce diversity, also through HRSA;
- $169.7 million for the Centers for Disease Control and Prevention (CDC) to address such health areas as HIV/AIDS, heart disease, diabetes, prostate cancer, as well as to fund STD/HIV prevention activities;
- and $928 million for minority health research at the National Institutes of Health (NIH).

Highlights of Minority Components of the Fiscal Year 2000 Request

$145 million to continue activities under the Initiative to Eliminate Racial and Ethnic Disparities in Health, which the President, Secretary Donna E. Shalala, Surgeon General David Satcher and Assistant Secretary for Planning and Evaluation Margaret Hamburg unveiled in February 1998. These funds would be used to support a variety of prevention, education and outreach activities by various agencies within HHS to attack racial and ethnic health disparities. This request is $80 million more than what Congress appropriated for these activities in fiscal year 1999.

An additional $170 million to boost the budget of the Indian Health Service (IHS) to $2.8 billion, an increase of about 8 percent over FY 1999. If enacted, this increase would mean more comprehensive clinical, preventive and environmental health activities, stronger injury prevention programs, increased mental health services, and more opportunities to visit doctors and dentists.

Medicaid Reimbursement for American Indian Facilities. Earlier this year, states were authorized to increase rates for IHS and IHS-funded tribal facilities. The rate increase could provide an additional $82 million in reimbursements under Medicaid for services provided from 1998-2000.

Included in the authorized reimbursement rate increase are $29 million in retroactive payments for services those facilities provided in 1998. The additional money could result in more staff, improved training, the purchase of additional medical equipment and supplies, and improved facilities for IHS and tribally owned facilities.

Enhancements to Fight HIV/AIDS in Communities of Color. While racial and ethnic groups account only for about 25 percent of the U.S. population, they account for more than 50 percent of all AIDS cases. While overall AIDS deaths are down, AIDS remains the leading killer of African-Americans age 25-44. In early 1998, the President revealed a major, new Federal initiative to eliminate racial and ethnic disparities in HIV/AIDS and five other key areas of health. The President is asking for $400 million over five years to fund this initiative and eliminate these health disparities by 2010. Congress has provided $65 million to begin this initiative in fiscal year 1999 and a total of $145 million is included in the fiscal year 2000 President's budget request.

On October 28, 1998, President Clinton declared HIV/AIDS to be a severe and ongoing health crisis in racial and ethnic minority communities and announced a comprehensive new initiative that invests an unprecedented $156 million to improve the nation's effectiveness in preventing and treating HIV/AIDS in African-American, Hispanic and other minority communities.

On June 16, 1999, the Administration announced that Detroit, Philadelphia and Miami would be the first of 11 U.S. metropolitan areas to receive special technical assistance from federal Crisis Response Teams to help combat the spread of HIV/AIDS among racial and ethnic minority populations. The Crisis Response Teams will meet with local officials, public health personnel and community-based organizations that work with racial and ethnic minority persons living with HIV/AIDS and help them develop targeted strategies to curb the rapid spread of HIV/AIDS among minority populations in their communities.

Several of HHS' largest agencies are contributing resources and staff to this initiative: the Health Resources and Services Administration (HRSA), the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institutes of

Health (NIH) and the Office of Minority Health (OMH).

Other components of the HIV/AIDS initiative for communities of color include:

- Funding for community-based organizations to provide new services, technical assistance and faith-based HIV prevention programs will be made available through CDC and SAMHSA;
- Supplemental funding under HRSA's Ryan White CARE Act is expanding service for some of the hardest hit minority communities and establishing AIDS Education and Training Centers at Historically Black Colleges and Universities to provide ongoing AIDS education to health care providers serving African-American communities;
- Through SAMHSA, HHS is providing funding for comprehensive mental health and substance abuse prevention and treatment programs for African-Americans and Hispanics with HIV/AIDS or at-risk for it; for community-based outreach to minority populations at risk for HIV; and for expanding HIV/AIDS and substance abuse prevention and treatment options for minority populations, through SAMHSA; and
- Resources for increasing the number of African-American principal investigators conducting HIV/AIDS research, and broadened research on HIV/AIDS and minorities, including an increased emphasis on behavioral research linking substance abuse and HIV infection rates in African-Americans are being made available through NIH.

The department has requested $171 million in fiscal year 2000 to continue these expanded activities to combat HIV/AIDS in minority communities.

Ongoing Activities to Improve Minority Health

Initiative to Eliminate Racial and Ethnic Disparities in Health. The department is one year into its plan to help the President eliminate racial and ethnic physical and mental health disparities in six key areas of health by the year 2010: *infant mortality, diabetes, cardiovascular disease, breast and cervical cancer screening and management, HIV/AIDS infection rates, and childhood and adult immunizations.*

CDC has launched the Racial and Ethnic Approaches to Community Health (REACH 2010) Demonstration project which awarded approximately $9.4 million to community coalitions to help address racial health disparities in the U.S. The awards that are being made target the six priority health areas described earlier. The populations include: African-American, American Indian and Alaska Natives, Hispanic and Asian American and Pacific Islanders. A total of 32 community coalitions will receive REACH 2010 funding.

Within HHS, Secretary Shalala has assigned the task of coordinating the Racial and Ethnic Disparities health initiative to the Public Health Council. The Assistant Secretary for Health/Surgeon General and the Assistant Secretary for Planning and Evaluation are co-directing efforts in this area, including reviewing the status of the department's elimination goals, consulting with minority communities and the scientific and research communities, and reviewing and making recommendations about the department's resources and programs to attack racial and ethnic health disparities.

HHS has taken several step to advance the racial and ethnic health disparities initiative, including:

- Collaborated with Grantmakers In Health last year on a national leadership conference of about 250 people to generate ideas and identify action steps for the racial and ethnic health disparities initiative;
- Developed an informational World Wide Web site for the Initiative to be used by interested media and communities [http://www.raceandhealth.omhra.gov];
- Organized internal workgroups in each of the six areas that are looking at HHS' existing programs

and making recommendations;

- Hosted a town hall meeting in Boston in July 1998 with members of the President's Initiative on Race to discuss the barriers that racial and ethnic minorities face in obtaining health care;

- Distributed from the Office of Public Health and Science (OPHS) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) an informational resource booklet on racial disparities for members of the Association of State and Territorial Health Officers (ASTHO);

- and solicited public input about the Racial and Ethnic Disparities Initiative from a series of regional meetings regarding Healthy People 2010, a set of overarching disease prevention and health promotion goals being pursued by the department;

Already, HHS has made notable progress in the following six health areas that are goals of the Initiative to Eliminate Racial and Ethnic Disparities in Health:

- ***Diabetes***. In 1998, the IHS awarded 286 grants to Indian communities on or near reservations and in urban areas for programs focused on primary prevention of diabetes and promoting healthy lifestyle choices, including substance abuse prevention and treatment and mental health services. The programs will reach more than 100,000 American Indians and Alaska Natives suffering with diabetes as well as another 30,000-50,000 who are at risk or have undiagnosed cases. In addition, HRSA launched an intensive effort to help its community health centers prevent, diagnose and treat diabetes. The centers are the health care provider of choice for 10 million people, 65 percent who are racial and ethnic minorities.

  Also, the Health Care Financing Administration (HCFA) announced in November that the Medicare program would be taking steps to ensure that all patients with renal failure, regardless of race or ethnicity, are being evaluated for transplantation. The purpose is to ensure equal opportunity for transplantation as part of the patient's long-term care plan.

- ***HIV/AIDS***. In response to the severe and ongoing crisis regarding HIV/AIDS in racial and ethnic minority communities, the department joined President Clinton and the Congressional Black Caucus in announcing a special package of initiatives in fiscal year 1999 aimed at reducing the disproportionate burden of HIV/AIDS, especially African-Americans and Hispanics. This initiative will address physical and mental health needs, as well as issues related to substance abuse prevention and treatment, and mental health services.

  In addition, HHS marked World AIDS Day 1999 by announcing an $11 million grant program, beginning in May 2000, to support four five-year demonstration projects and one evaluation center to provide innovative health care and support services for people with HIV/AIDS living in the U.S.-Mexico border region. The grants will go to organizations in the border states of Arizona, California, New Mexico and Texas.

- ***Infant Mortality***. The overall infant mortality rate reached a new low of 7.1 deaths per 1,000 live births. Mortality from Sudden Infant Death Syndrome (SIDS) continued to decline, and more Americans learned the importance of placing infants on their backs to sleep, to prevent SIDS. Timely prenatal care also reached record levels in 1997 as an estimated 82.5 percent of women received care in their first trimester of pregnancy. Low-birth-weight babies accounted for 7.5 percent of all births, compared to 7.4 percent in 1996. This increase was confined to non-Hispanic white and Hispanic women. Low birth weights remained unchanged for births to black women.

  Timely prenatal care reached record levels in 1998 as an estimated 82.8 percent of women received care in their first trimester of pregnancy. The teen birth rate also fell two percent in 1998, continuing a seven-year trend. The birth rate for teenagers 15-17 years dropped five percent for 1998 to a record low of 30.4 per 1,000. From 1991-98, birth rates for non-Hispanic white and black teens 15-19 years dropped steeply; 19 percent and 26 percent, respectively.

Yet, there was no change in the preliminary infant mortality rate in 1998: the overall infant mortality rate was 7.2 infant deaths per 1,000 live births, the same as the record low reported in 1997. It is the first time there has been no improvement in this masure in nearly four decades, and the rate for black infants is still twice the rate for white infants.

As HHS continues its efforts to reduce infant mortality and increase prenatal care, he National Institute of Child Health and Human Development (NICHD) has also broadened its efforts to reduce the incidence of Sudden Infant Death Syndrome (SIDS).

As part of the "Back To Sleep" campaign that encourages parents and caregivers to place children on their backs or sides to sleep to prevent SIDS, NICHD distributed packages of "Back To Sleep" educational materials to all licensed daycare centers in the U.S., including centers that serve African-American and Hispanic communities.

In conjunction with "SIDS Awareness Month" in October, Secretary Shalala and Mrs. Tipper Gore announced a new component to the successful "Back To Sleep" campaign that will focus on reducing the incidence of Sudden Infant Death Syndrome (SIDS) among African-Americans. The goal of the new initiative is to develop and implement a community-based approach to eliminate the disparity in SIDS rates impacting African-American babies. The new campaign will be led by the department's National Institute of Child Health and Human Development (NICHD) and will be carried out by a newly created partnership with the National Black Child Development Institute, HRSA, the American Academy of Pediatrics, the SIDS Alliance and the Association of SIDS and Infant Mortality Programs.

- ***Immunizations.*** Immunization rates for the complete series of childhood immunizations has reached a record high of 79 percent, and the gap between children of all racial and ethnic groups for the most critical vaccines is much narrower than it was a generation ago - when it was as wide as 26 points. While 82 percent of non-Hispanic white children (19-to-35-month-old) have received the complete series by age two, only 73 percent of black children and 75 percent of Hispanic children are fully vaccinated. American Indians and Alaskan Native children, however, continue to be immunized at a rate of 79 percent, one of the best in the world.

  In April, Secretary Shalala announced a new Spanish-language childhood immunization public awareness campaign to create and distribute culturally relevant and language appropriate educational materials to help raise Hispanic immunization rates to the national average. The Spanish-language theme, "Vacunelo A Tiempe ... Todo el Tiempo," ("Vaccinate Your Children On Time, every Time"), encourages parents and caregivers to talk with their child health care provider to make sure their child is up to date by age two. The Spanish-language PSA is narrated by popular Cuban-American musician Jon Secada.

  As for adults, only 65 percent of the elderly received their annual flu shot during the preceding year, and only 45 percent ever received a pneumococcal vaccine. Significant progress is still needed among certain populations with substantially lower coverage, including African-American and Hispanic persons. Among persons aged 65 years or more, influenza and pneumonia were the fifth leading cause of death for African-Americans, Hispanics and non-Hispanic whites.

  As part of pandemic influenza preparedness, HHS, through CDC's National Immunization Program, is studying factors influencing the use of vaccines by African American physicians and using feedback and assessment from immunization providers to improve vaccination levels among older African American women.

  Gospel star CeCe Winans joined HHS' flu shot public education campaign in November 1999 by recording a 60-second radio segment encouraging African-American seniors to get their flu and pneumonia shots this winter. The spots were heard on the 300-station American Urban Radio Network in November, including on "The Bev Smith Show," which is also broadcast on the network.

- ***Cancer Screening and Management.*** During 1990-95, cancer incidence rates declined for most age groups, for both men and women, and for most racial and ethnic groups. During Breast Cancer Awareness Month in October 1998, Secretary Shalala announced new efforts to encourage mammography screening among special populations, especially to older, low income, and minority women, who tend to have the highest breast cancer mortality rates. The Health Care Financing Administration (HCFA) and the National Cancer Institute co-sponsored education campaign about the new annual Medicare mammography benefit and the importance of regularly scheduled screening mammograms. The new efforts focus on high concentration areas of older women. In addition, HCFA offered mammogram screenings to older African-American and Hispanic-American women in Atlanta, Chicago, Cleveland, Los Angeles, Philadelphia, San Antonio, and Washington, D.C.

- ***Cardiovascular Disease.*** In December 1998, HHS released a landmark study showing that total cholesterol levels for Americans decreased in men and women in several racial groups. However, the study showed that black adolescents experienced a smaller decline compared to non-Hispanic whites and Mexican Americans within the same age range. Of all the groups, black females continued to have the highest total cholesterol and experienced the smallest decrease over time. The finding of higher total cholesterol levels in black adolescents differs from the pattern in adults, in whom blacks have lower total cholesterol than whites. This will be an area of continued research at NIH.

Racial and Ethnic Data Workgroup. This workgroup will identify and assess the available racial/health data to determine gaps and trends. The workgroup will provide recommendations to improve data collection about racial and ethnic minorities.

Departmental Committees on Minority Health. HHS has relied on a series of in-house committees representing a cross-section of agencies to look at health and customer service concerns that impact minority populations. In 1999, these committees were restructured to coordinate efforts better across agency lines and within each operating unit of the department. They are staffed by the Office of Minority Health and meet quarterly at the department.

Departmental Minority Initiatives Steering Committee. This broad, new committee has been designed to provide policy direction and guidance for key minority health initiatives: The Asian American and Pacific Islander Action Agenda , the Hispanic Agenda for Action, the Historically Black Colleges and Universities Initiative, and the Tribal Colleges and Universities Initiative. This steering committee is chaired by HHS Deputy Secretary Kevin Thurm and includes the Assistant Secretary for Health/Surgeon General, the Assistant Secretary for Management and Budget, and the heads or deputies of HHS divisions.

Departmental Minority Initiatives Coordinating Committee. This committee is comprised of senior agency staff who report directly to agency heads or their deputies. While the steering committee helps set department minority-related policy, this group helps draw together the actual work of all four minority initiatives to avoid duplication and foster interagency cooperation on strategies to improve the health status of minorities.

Following are the Minority Initiatives overseen by the Steering Committee and Coordinating Committee. These committees will issue an annual report to identify the accomplishments of the minority initiatives, as well as areas for further development:

- **Hispanic Agenda For Action (HAA)** - This initiative was put into action at HHS as a formal way to involve the Hispanic community in program planning, implementation and evaluation, and to increase Hispanic representation throughout HHS' employment ranks. The Agenda for Action was developed out of a senior-level working group on Hispanic issues that was formed in spring of 1995 and features a nine-point agenda for change, including the Executive Order on Educational Excellence (1994) for Hispanic Americans and strategies to enhance the department's ability to serve its Hispanic customers.

- **Historically Black Colleges and Universities (HBCU) Initiative** - In keeping with a 1993 Executive Order issued by President Clinton, the department is working at closer partnering relationships with HBCUs. Through this initiative, the department is formally working to strengthen the ability of these schools to participate in and gain from federal health programs. This includes programs that aim to strengthen the capacity of HBCUs to compete for and benefit from federal grants as well as participate in research.

- **Tribal Colleges and Universities (TCU) Initiative** - In response to President Clinton's 1996 Executive Order, this initiative to ensure that HHS meets Clinton administration goals, so that tribal higher education institutions are not impeded from funding opportunities and from participating in federal health programs like other colleges and universities. In January, the department sponsored a conference and exposition in Phoenix for tribal colleges and universities.

- **Asian American/Pacific Islander (AAPI) Action Agenda** - As an outgrowth of its consultation with representatives of the AAPI community, HHS launched this initiative in June 1997 to improve health services, research, data and customer service for this population group. Coordinated by HHS' Departmental Minority Initiatives Coordinating Committee, the AAPI initiative is designed to address health issues unique to Asian American and Pacific Islanders as well as those shared by other racial and ethnic minority groups. In June 1999, President Clinton issued an Executive Order creating a White House Initiative on Asian Americans and Pacific Islanders, pledging a partnership among federal agencies to address health and quality of life issues for Asian American and Pacific Islander peoples throughout the United States and its jurisdictions, especially those living in underserved areas. HHS has been chosen to lead this effort because of the momentum from work it has already begun in researching and responding to the challenges faced by these diverse communities.

Other Agency Projects:

- SAMHSA, in collaboration with HRSA and the Office of Minority Health has produced a series of monographs that address issues related to cultural competence, which is the practice of being culturally aware and culturally relevant in delivering health and medical services to minority communities. Nine published or soon-to-be-published volumes address these issues from a variety of approaches, including guidelines for health professionals in community health settings dealing with various racial or ethnic communities on matters related to both general health care and substance abuse. HRSA has established an agency- wide steering committee to incorporate cultural competency into HRSA programs.

- SAMHSA's Center for Mental Health Services (CMHS) in partnership with the National Institute on Mental Health, is developing the Surgeon General's Report on Mental Health. A major goal of the report is to raise public awareness to the importance of adequately addressing mental illness. The report will discuss the similarities between mental health and physical health, the value of prompt and appropriate treatment intervention, and the growing consumer involvement in the recovery process.

- SAMHSA's Center for Substance Abuse Treatment developed a four-page insert for six issues of the national Spanish language health magazine, *Pro Salud*, on mental health and substance abuse treatment and prevention issues.

- SAMHSA's Center for Substance Abuse Treatment has issued a grant to enhance Systems of Services for Persons with Co-Occurring Substance Abuse and Mental Health Disorders in Alaska. The project targets the Alaska Native population.

- HRSA administers grants to each of its Centers of Excellence, which are academic medical centers, to fund the development of curricula on cultural competence, training and recruitment of minority faculty and research on minority health issues. These activities are designed to make Centers of Excellence more responsive to the needs of the local populations served.

- On April 22, FDA met with minority health professional organizations to discuss how the agency can improve its relationship with organizations that address minority health issues, for example, by improving minority representation on FDA's advisory committees and increasing minority participation in clinical trials both as a participants and as investigators.
- FDA parthered with several minority health professional organizations and community groups to do outreach on FDA's tobacco regulation, for example, through presentations at minority health professional meetings and collaboration with community-based groups targeted to minority communities.

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Note: For other HHS Press Releases and Fact Sheets pertaining to the subject of this announcement, please click here for our Press Release and Fact Sheet search engine at: http://www.hhs.gov/news/press/.

HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

December 31, 1999

Contact: HHS Press Office
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A YEAR OF ACHIEVEMENTS, A CENTURY OF PROGRESS

In 1999, the Department of Health and Human Services (HHS) continued to make important progress in improving the health and welfare of all Americans. We made major investments in the health of our nation's children, increased life expectancy and prenatal care, continued our efforts to reduce health care disparities, increased the expansion of health care coverage to Americans and took significant steps in the battle against disease--including AIDS and cancer.

*Providing a safe and **healthy** childhood for our children has always been a high priority of HHS, and in 1999 we awarded the first adoption bonuses to 35 states that had increased the number of children adopted from foster care. The teen birth rate fell again, continuing a seven-year trend; the overall immunization rate for preschool children increased to a record 80 percent; and tobacco and illicit drug use among teenagers declined.*

This past year brought significant new gains in research and in our efforts to prevent disease and promote health. AIDS dropped out of the top 15 causes of death and HHS-supported researchers unraveled the DNA code of an entire human chromosome, a discovery that holds tremendous promise for enhancing our understanding of genetics and disease. The National Institutes of Health (NIH) budget increased to approximately $17.9 billion, a 31.5 percent increase in the last two years. We also proposed historic new medical privacy regulations to ensure that Americans confidential health records are protected even as we search for new cures and new drug therapies. The Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC) continued to take important actions to improve food safety. And we increased our coordination with other agencies to improve our preparedness for a pandemic or a bioterrorist attack.

This year, we also took a number of steps to increase Americans' access to health care. We worked with states to increase the availability of Medicaid, particularly to young adults leaving the foster care system; made it possible for disabled Americans to keep federally funded health insurance when they return to work; obtained initial funding for a new program to improve health care access for the uninsured; and made it easier for children to get health insurance through their non-custodial parents after a separation or divorce. And, in September, we completed the approval of all 56 states and territorial plans under the State Child Health Insurance Program (SCHIP), which will provide health insurance for nearly 2.6 million children in low-income families by September 2000.

During 1999, HHS made Year 2000 (Y2K) computer preparedness its highest management priority. The department worked to ensure that its own computer systems functioned correctly and helped its partners in the health and human services sectors in preparing for the millenium roll-over.

*As we enter the new millenium, we hope to build on our successes. We will continue to move **people** from welfare to work, expand and improve health care and, with the budget increase we secured for NIH in fiscal year 2000, we will work diligently to unlock the mysteries of cancer, AIDS and other diseases that threaten mankind. And we will work to build on the successes of 1999--by improving our knowledge to combat diseases through efforts such as the human genome project, passing a Patients' Bill of Rights, and reducing the risk of errors in medical treatment.*

Donna E. Shalala

THE PROMISE OF A SAFE AND HEALTHY CHILDHOOD

*As we stood at the threshold of the new millennium, providing a safe and **healthy** childhood for our children remained a top priority for the Clinton administration in 1999. After years of effort, immunization rates against childhood diseases reached record highs, and vaccine-preventable disease incidence reached record lows. Head Start received the largest single year budget increase in its history. Fewer young **people** smoked cigarettes, used illegal drugs, or had children of their own. More children in the foster care system were adopted than ever before, with states on track to reach the President's goal of doubling the number of adoptions by 2002. More children of divorced and separated parents received child support payments, even as we made it easier for them to receive health insurance from their non-custodial parents as well. The Supreme Court took up the issue of FDA jurisdiction over tobacco, even as we pursued other strategies to reduce youth smoking. And expansions in the Medicaid and SCHIP programs improved the health care available to millions of children.*

Adoption and Foster Care. In 1999, the Administration for Children and Families (ACF) awarded $20 million in the first adoption bonuses to 35 states that had increased the number of children adopted from foster care. Thirty-six thousand foster care children were adopted in fiscal year 1998, an increase from 31,000 in 1997 and 28,000 in 1996. These numbers indicate that we are on the way to meeting the President's goal of doubling the number of children adopted from foster care by the year 2002.

On December 14, President Clinton signed into law the Foster Care Independence Act of 1999. This legislation will help ensure that young **people** who leave foster care get the tools they need to make the most of their lives. HHS will provide $270 million over the next five years to increase funding for the Independent Living Program, which provides assistance for the nearly 20,000 young **people** leaving foster care each year at the age of 18 without an adoptive family or permanent home. HHS also announced that national child abuse and neglect statistics continued a four-year decline, and approved eight more child welfare demonstrations.

Child Support Enforcement. Since taking office, the Clinton administration has made child support enforcement a critical priority. The National Directory of New Hires, which matches child support orders to employment records, found more than 2.8 million delinquent parents in its two years of operation. Paternity establishment rose to 1.45 million in 1998, a more than three-fold increase from 516,000 in 1992. The Passport Denial Program collected more than $2.25 million in lump sum child support payments and is currently denying 30 to 40 passports to delinquent parents per day. And under the federal tax offset program, the federal government collected a new record amount of $1.3 billion in overdue child support from federal income tax refunds for tax year 1998. Nearly 1.4 million families benefited from these collections, which represented an 18 percent increase over the previous year and a 99 percent increase since 1992.

Head Start Program. Head Start is the nation's premier early childhood development program for low-income children and families. The program has an unprecedented track record of preparing children to start school ready to learn. Since 1995, Early Head Start has served infants and toddlers in recognition of the clear evidence that the earliest years are the most important to children's growth and development. The President proposed and Congress enacted $5.3 billion for Head Start program in fiscal year 2000, $607 million more than fiscal year 1999 and the largest single year budget increase it has ever received. Under the Clinton administration, Head Start has grown from 714,000 children in 1993 to 877,000 children with the budget agreement. Early Head Start will expand to support nearly 45,000 children aged 0 to 3 and their families. This increase keeps Head Start on track to reach the President's goal of enrolling 1 million children by 2002. In addition to expansion, funds will be used for raising the quality of programs, including improving school readiness, enhancing staff training, obtaining safer and better equipment, and reducing class size and staff turnover.

Teen Pregnancy. In October 1999, HHS announced that the teen birth rate fell for the seventh straight year and reached its lowest level since 1987. We also released a new guide to help local communities and non-profit organizations establish successful teen pregnancy prevention programs. The guide, "Get Organized: A Guide to Preventing Teen Pregnancy," stresses a localized approach, a long-term

commitment and careful evaluation. This three-volume publication also includes strategies for collecting basic data, reaching out to religious leaders and conducting program evaluation.

Rise in Childhood Immunizations. On September 23, CDC announced that the nation's overall immunization rate for preschool children increased to a record 80 percent in 1998, the highest rate ever recorded. Because childhood vaccination levels in the United States are at an all-time high, disease and death from diphtheria, pertussis, tetanus, measles, mumps, rubella and Hib are at or near record lows. There was only one reported case of diphtheria, 100 reported cases of measles, and no reported cases of wild poliovirus for 1998.

Children's Hospitals Graduate Medical Education (GME) Program. In December 1999, President Clinton signed the Healthcare Research and Quality Act of 1999 establishing HHS' Children's Hospitals GME program to be managed by the Health Resources and Services Administration's (HRSA) Bureau of Health Professions. In fiscal year 2000, HRSA will provide $40 million to nearly 60 freestanding children's teaching hospitals serving low-income or uninsured children for training resident pediatricians.

Youth Smoking. Every day, 3,000 children become smokers and 1,000 have their lives shortened because of it. According to the 1999 Monitoring the Future Study, past month use of cigarettes decreased from 19.1 percent to 17.5 percent among 8th graders, but overall cigarette smoking among teenagers did not change during 1999, which emphasizes the importance of continuing our efforts on reducing youth tobacco use.

In April 1999, the Clinton administration took an important step in preventing and reducing tobacco use, as more than 3,000 tobacco industry billboards across the country were removed and replaced with an array of new messages discouraging tobacco use and promoting good health. Three HHS agencies--CDC, FDA and the National Cancer Institute (NCI)--collaborated with the National Association of Attorneys General and 37 individual states and the District of Columbia that had replacement billboards to organize this nationwide effort.

HHS also worked to encourage states to use their funds from the 1998 settlement with the tobacco industry to reduce youth smoking and promote public health. CDC released two state-specific reports on tobacco use in August, one highlighting the severity of the public health problem and the other presenting a science-based blueprint for solving it. And in September, CDC began funding the tobacco control programs in all 50 states, the District of Columbia, and U.S. territories. This effort provides funds and technical support to states and serves as a building block for coordinated national tobacco control efforts today and into the next millennium.

By the end of fiscal year 1999, the FDA had arranged for tobacco retailer inspections under the agency's final rule in all 50 states and three territories. FDA has also conducted more than 150,000 inspections through the end of fiscal year 1999. FDA's effort to reduce youth access to tobacco products is already having an impact. According to the announcement of the most recent Monitoring the Future study, "[R]eported accessibility has been falling since 1996, particularly among the eighth-graders...This suggests that the efforts by federal and state governments are starting to have an effect...The U.S. Food and Drug Administration has been assisting states in monitoring retailer behavior and levying penalties on retailers who sell to underage buyers."

In October, the Substance Abuse and Mental Health Services Administration (SAMHSA) announced that average retailer sales rates of tobacco products to minors dropped by nearly half, from 40 percent in 1997 to 24 percent in 1998. This new data reflects not only a substantial decline in retailers' sales of tobacco to children, but also the growth of effective state tobacco enforcement programs that have been established as a result of the Synar program, which requires states to reduce youth access to tobacco by enforcing their laws prohibiting the sale of tobacco products to anyone under age 18.

HHS also continues to work to provide the public with as much information as possible on the health dangers of tobacco. As a result of an Executive Memorandum issued by President Clinton, HHS announced a single federal source for Internet access to more than 27 million pages of tobacco industry

documents that illustrate the health dangers of tobacco. The new Web site http://www.cdc.gov/tobacco, hosted by CDC, allows users to conduct full-text searches of key documents made public as a result of state lawsuits, congressional subpoenas and the 1998 master settlement agreement between the states and tobacco companies.

Youth Substance Abuse Decreases. Results from the 1999 National Household Survey on Drug Abuse released in August and the 1999 Monitoring the Future Survey released in December showed that overall drug use among teenagers has declined or remained level for three consecutive years. Both surveys showed that among youths age 12-17, the disapproval of smoking marijuana once or twice a week increased between 1997 and 1998. This measure provides an important marker of drug use that can help explain the patterns and trends in substance use, particularly among youths. Teens alcohol use has decreased slightly since 1992 although daily use of alcohol remains unacceptably high.

In October, SAMHSA awarded State Incentive Grants for Community-Based Action in 20 states and the District of Columbia to support planning for coordinated substance abuse prevention services. SAMHSA also awarded Starting Early-Starting Smart Grants to examine the effectiveness of integrating substance abuse and mental health services into primary care settings and into early childhood service settings. SAMHSA also announced new Targeted Capacity Expansion Grants to assist local governments and American Indian and Alaska Native Tribal governments to address serious, emerging drug problems at the earliest possible stage.

HHS' efforts to reduce marijuana use among America's youth continue through its comprehensive Marijuana Initiative begun in 1995. As part of this initiative, HHS has funded new research on the effects of marijuana, and launched major prevention-oriented campaigns -- such as the anti-marijuana campaign "Reality Check" -- to help parents educate children about the dangers of drugs. As part of this effort, SAMHSA also provided free materials, such as "Marijuana: What Parents Need to Know," "Tips for Teens," and "Keeping Youth Drug Free." SAMHSA's Center for Substance Abuse Treatment is currently engaged in two multisite studies to determine the relative effectiveness and cost-effectiveness of several interventions aimed at eliminating marijuana use in both adolescents and adults.

As part of a national initiative to combat the increasing use of club drugs, the National Institute on Drug Abuse (NIDA) announced in December, that it will raise its funding for research about club drugs and what to do about them by 40 percent, bringing the total committed to this important effort to $54 million. In addition, NIDA and four national organizations launched a multimedia public education strategy to alert teens, young adults, parents, educators and others about the dangers of club drugs such as Ecstasy, GHB and Rohypnol, which are often used at all night "raves" or dance parties and have potentially life-threatening effects.

THE PROMISE TO MOBILIZE AMERICA'S SCIENTIFIC GENIUS TO MAKE OUR COUNTRY A HEALTHIER AND SAFER PLACE TO LIVE

This year marked a major milestone in our understanding of the basic blueprints of life, as scientists completed the first full map of a human chromosome. We also proposed new medical privacy regulations to ensure that American's confidential health records are protected even as we search for new cures and new drug therapies. FDA and CDC took new steps to improve food safety and make drug labels easier to read. The department's efforts to reduce research risks and scientific misconduct were improved. And we increased our coordination with other agencies to improve our preparedness for a pandemic or a bioterrorist attack.

Protecting Patients Personal Medical Records. On October 29, 1999, President Clinton and Secretary Shalala announced the first-ever set of national standards to protect the privacy of Americans' personal health records. The standards will apply to medical records created by health care providers, hospitals, health plans and health care clearinghouses that are either transmitted or maintained electronically, and the paper printouts created from these records. The proposal reflects the principles outlined by Secretary Shalala in September 1997 as part of her recommendations for protecting the confidentiality of individually identifiable health information. The proposed standards would enhance the protections afforded by many existing state laws. In circumstances where the federal rules and state laws are in

conflict, the stronger privacy protection would prevail. The proposed privacy standards would protect consumers whether they are privately insured, uninsured, or participants in public programs such as Medicare or Medicaid. At the same time, the Clinton administration called on Congress to enact comprehensive privacy legislation.

Increasing Funding for Biomedical Research. President Clinton's 1998 proposal for a 21st Century Research Fund has resulted in a dramatic increase in biomedical research funding for NIH over the past two years. The President's commitment to expanding the NIH budget has resulted in a $4.3 billion increase since 1998. These new resources will allow us to boost the number of funded research grants to an all-time high so that we can carry out essential biomedical research to prevent and combat diseases like Alzheimer's, AIDS, and cancer. President Clinton also proposed and Congress granted a 20 percent increase in funding for critical health services research at the Agency for Healthcare Research and Quality (AHRQ). NIH also announced new guidelines for stem cell research, which has the potential to find cures for many serious diseases.

Mapping the Human Genome. In December 1999, scientists in England, the United States and Japan, working under the umbrella of the ambitious international Human Genome Project, announced that they have unraveled the DNA code of an entire human chromosome. Their sequence of the 33 million DNA letters of chromosome 22 represents the longest continuous stretch of DNA code ever to be deciphered. This achievement is especially exciting because we can now see many future milestones that will occur with increasing speed and more chromosomes whose DNA code will be completely sequenced, unlocking the mysteries of many inherited and genetic disorders.

Protecting Research Subjects and Improving Research Integrity. In June, we announced our intent to further strengthen our resolve to ensure the safety and welfare of **people** who participate in HHS-sponsored research studies by moving the Office for Protection from Research Risks (OPRR) from NIH to the Office of the Secretary. The OPRR director will now report to the assistant secretary for health, and a new advisory committee on protection from research risks also will be created. These new initiatives complement the oversight roles of other HHS agencies in protecting research subjects already in place, including the FDA's responsibility in approving all clinical trials aimed at testing a new drug or medical device, and the NIH's important patient safety guidelines that must be followed in any research the agency funds. Additionally, NIH also has a special panel, the Recombinant DNA Advisory Committee (RAC) that provides oversight and public discussion of gene transfer clinical research.

On October 22, Secretary Shalala accepted the recommendations of a special review group on research misconduct and research integrity involving research funded by agencies of the U.S. Public Health Service. The recommendations include a more precise and useful definition of research misconduct, which is being adopted by agencies throughout the federal government. They are also aimed at improving the process for investigating allegations of misconduct, and at expanding educational efforts to prevent misconduct.

Protecting Against Bioterrorism. CDC awarded $40 million to states and major cities to expand and upgrade their ability to detect and respond to biological and chemical agents and bioterrorist acts in the U.S. These grants were part of a total of $124 million in fiscal year 1999 CDC funding to prepare against bioterrorism. In fiscal year 2000, departmental funding to prepare against bioterrorism totals $267 million. This includes $155 million for CDC to expand and upgrade state and local capacity to detect and respond to biological and chemical agents, and to provide a public health response to bioterrorism. Also included is $25 million for the Office of Emergency Preparedness (OEP) to continue development of the Metropolitan Medical Response System and training for Disaster Medical Assistance Teams and National Medical Response Teams. Finally, the department's budget for bioterrorism response includes $87 million for research and evaluations, of which $30 million is for research and development of new generation vaccines for smallpox and anthrax, two of the five critical agents identified as leading terrorist threats.

Food Safety. Continuing their joint efforts to combat foodborne illness, FDA, HHS and the U.S. Department of Agriculture's Food Safety and Inspection Service announced in July 1999, important new measures to prevent illnesses caused by contaminated eggs. The FDA has required safe handling

statements on labels of shell eggs to warn consumers about the risk of illness caused by Salmonella Enteritidis (SE). For the first time, there is a uniform federal requirement that all eggs and egg products packed for consumers be refrigerated at 45 degrees or below. In addition, the President's Council on Food Safety developed a strategic plan to further improve the safety of shell eggs and processed egg products. The fiscal year 2000 appropriation for HHS includes an increase of $40 million to carry out the President's Food Safety Initiative. This includes $30 million in FDA (for a total of $79 million) and $10 million in CDC (for a total of $29.5 million).

New, Easy to Understand Labels. To help consumers make informed decisions about the medications they use and give their families, the FDA announced a new regulation to provide new, easy-to-understand labeling on nonprescription drugs. The regulation calls for a standardized format that will improve the labeling on drugs Americans use most--nonprescription or over-the-counter (OTC) drugs. By clearly showing a drug's ingredients, dose and warnings, the new labeling will make it easier for consumers to understand information about a drug's benefits and risks as well as its proper use.

Delivering High Quality Health Care. The Agency for Healthcare Research and Quality (AHRQ)--formerly the Agency for Health Care Policy and Research (AHCPR), launched the National Guideline Clearinghouse (NGC), http://www.guideline.gov, an Internet-based source of information on clinical care that will help health professionals to improve the quality of care they provide to their patients. The NGC, a resource of evidence-based clinical practice guidelines, was developed by AHRQ in partnership with the American Medical Association (AMA) and the American Association of Health Plans (AAHP). The NGC has logged more than 640,000 visits in its first 10 months, an average of 3,000 to 4,000 per day.

THE PROMISE OF QUALITY, AFFORDABLE HEALTH CARE FOR EVERY WORKING FAMILY

*With new proposals to implement a Patients' Bill of Rights and reduce medical errors, 1999 was a milestone in the effort to improve health care quality. Life expectancy and prenatal care increased, while deaths from AIDS continued their remarkable decline. HHS took new steps to reduce health care disparities, by working to improve the programs and services that reach America's minority populations. And Dr. David Satcher released the first-ever Surgeon General's Report on Mental Health, which established conclusively that mental health is an essential component of a **healthy** life.*

Continuing the fight against HIV/AIDS. In October, CDC reported that AIDS fell from the top 15 causes of death in the U.S., declining an estimated 21 percent from 1997 to 1998, a rate of 4.6 deaths per 100,000, the lowest rate since 1987. HIV mortality has declined more than 70 percent since 1995.

The decline in AIDS deaths is in part due to the continuing impact of highly active antiretroviral therapy in helping **people** with HIV live longer and healthier lives, as well as to our continued efforts to prevent HIV infection in the first place. In 1999, the National Institutes of Health (NIH) conducted studies that found that pregnant women infected with HIV can reduce the risk of transmitting the virus to their infants by about 50 percent if they deliver by cesarean section before going into labor and before their membranes have ruptured.

In addition, a study sponsored by the National Institute of Allergy an Infectious Diseases (NIAID) at NIH, found that a single oral dose of the antiretroviral drug nevirapine (NVP) given to an HIV-infected woman in labor and another to her baby within three days of birth, reduced the transmission of the virus by half compared with a similar short course of AZT. If used and implemented widely in developing countries, this intervention potentially could prevent some 300,000 to 400,000 newborns per year from beginning life infected with HIV.

HRSA awarded $710 million in formula grants to 50 states, the District of Columbia and U.S. territories to improve access to HIV/AIDS primary care, support services and medications for **people** living with HIV/AIDS and their families. This amount includes $461 million earmarked for state AIDS Drug Assistance Programs (ADAP), which provide financial assistance to purchase HIV medications. HRSA also announced a new $11 million grant program beginning in May 2000 to support four five-year

demonstration projects and one evaluation center to provide innovative health care and support services for **people** with HIV/AIDS living in the U.S.-Mexico border region. The program will serve hard-to-reach, underserved individuals by funding innovative HIV/AIDS programs that help improve access to care.

SAMHSA's Center for Substance Abuse Treatment awarded grants totaling $16.8 million to enhance and expand substance abuse treatment and HIV/AIDS, sexually transmitted diseases, tuberculous, and hepatitis B and C services in 35 African-American and Latino and other ethnic/racial minority communities severely affected by the twin epidemics of substance abuse and HIV/AIDS. This program seeks to address gaps in treatment capacity and increase the accessibility and availability of substance abuse and HIV/AIDS treatment services. SAMHSA also funded an additional 25 community-based organizations for a total of $9.5 million to provide outreach services to substance abusers at risk of contracting HIV. Both of these grant programs were funded under the Congressional Black Caucus Initiative.

In December, NIAID announced renewed funding for the Adult AIDS Clinical Trials Group (AACTG), the largest clinical trials network in the world. Under the new award, the AACTG will receive $80 million in the first year of a five-year grant. The funding enables the network to continue conducting studies of antiviral interventions, methods to reconstitute the immune system damaged by HIV, and the treatment and prevention of opportunistic diseases and other HIV-related complications.

Closing the Gap in Health for Racial and Ethnic Minority Populations. Launched by President Clinton in February 1998, the racial disparities initiative sets a national goal of eliminating major health disparities in six key areas by the year **2010**. The administration won a huge victory in this regard in the fiscal year 2000 budget, obtaining an increase of 7 percent, to $2.4 billion in the Indian Health Service (IHS) budget. For fiscal year 2000, HHS has committed $30 million for the second year of CDC's Racial and Ethnic Approaches to Community Health (REACH **2010**). Fiscal year 2000 funds will enable communities that are ready to start implementing these plans. Several programs, which have a large effect on reducing racial and ethnic health disparities such as Community Health Centers and Ryan White HIV/AIDS activities, also received increases in fiscal year 2000.

HRSA's Bureau of Primary Health Care launched an ambitious campaign entitled "100 Percent Access/0 Health Disparities," by organizing community groups and key safety net providers in partnerships to address the health care needs of their communities. Local partnerships include public and private providers, hospitals, free clinics and universities. National partners include the Coalition for Healthier Cities and Communities, the American Academy of Pediatrics, and One Church, One Addict. The long-range goal is to build infrastructure to sustain and support communities in providing health care delivery and other social services for underserved residents.

- **HIV/AIDS**. In response to the severe and ongoing crisis regarding HIV/AIDS in racial and ethnic minority communities, CDC awarded $9.4 million in grants in September to 32 community coalitions in 18 states to help address racial and ethnic disparities. The awards are a component of CDC's new REACH **2010** initiative.

  On September 16, HHS awarded $3.9 million in planning grants to 79 public and private organizations to bolster HIV/AIDS care to African-Americans and individuals in rural and underserved areas. The 79 grants are funded under the Title III Planning Grant Program of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act administered by HHS' Health Resources and Services Administration (HRSA). Sixty of the grants, totaling $3 million, are being awarded as part of HHS' year-old partnership with the Congressional Black Caucus to battle HIV/AIDS in communities of color.

  In June, HHS announced that it would send special teams of experts known as Crisis Response Teams into those communities at their request to meet with local officials, public health personnel and community based organizations that work with racial and ethnic minority persons living with HIV/AIDS. The teams are designed to help communities develop targeted strategies to curb the rapid spread of HIV/AIDS among minority populations in their communities. To date, Crisis

Response Teams have been sent to Detroit, Miami and Philadelphia.

- **Diabetes**. Both the Indian Health Service and HRSA increased their efforts this year to reduce the incidence of diabetes among Native Americans and African-Americans. IHS funds will be used in part to fund grants to Indian communities for programs focused on primary prevention of diabetes and promoting **healthy** lifestyle choices.

- **Immunizations**. Immunization rates for the complete series of childhood immunizations has reached a record high of 80 percent, and rates for the most critical vaccines are nearly the same for children of all racial and ethnic groups--closing a gap that was as wide as 26 percentage points a generation ago. In April, Secretary Shalala announced a new Spanish-language childhood immunization public awareness campaign to create and distribute culturally relevant and language appropriate educational materials to help raise Hispanic immunization rates all the way up to the national average. The Spanish-language theme, 'Vacunelo A Tiempe, Todo el Tiempo,' ('Vaccinate Your Children On Time, Every Time'), encourages parents and caregivers to talk with their child health care provider to make sure their child is up to date by age 2. The Spanish-language PSA is narrated by popular Cuban-American musician Jon Secada.

  As for adults, progress is still needed among African-Americans and Hispanics. Among persons aged 65 years or more, influenza and pneumonia were the fifth leading cause of death for African-Americans and Hispanics as well as non-Hispanic whites. CDC's REACH grants provide funding for adult immunization activities aimed at eliminating disparities. Three additional REACH grants will be funded by the California Endowment.

  The Health Care Financing Administration (HCFA) also stepped up its efforts to increase the number of minorities receiving flu and pneumonia vaccinations this year, mailing nearly 8 million postcards in four languages to remind Medicare beneficiaries to get immunized and releasing television and radio announcements in English and Spanish for local outlets to use across the country, including a PSA with African-American gospel star CeCe Winans. HCFA also joined with Medicare's quality-review organizations and historically black colleges and universities to develop strategies for boosting immunization rates among African-American beneficiaries.

- **Infant Mortality**. On October 26, HHS announced the start of a new component of the successful "Back to Sleep" campaign that will focus on reducing the incidence of Sudden Infant Death Syndrome (SIDS) among African-Americans. The goal of the new initiative, led by the National Institute of Child Health and Human Development (NICHD) of the National Institutes of Health, is to develop and implement a community-based approach to eliminate the disparity in SIDS rates affecting African-American communities.

- **Prenatal Care**. Timely prenatal care improved steadily through the 1990s. In 1998, 82.8 percent of women began care in the first trimester of pregnancy, compared with 75.5 percent in 1989.

- **Cancer Screening and Management**. HCFA and the NCI co-sponsored a national education campaign about the new annual Medicare mammography benefit and the importance of regularly scheduled screening mammograms. The new efforts focus on areas where there is a high concentration of older women. In addition, Secretary Shalala also released two public service announcements featuring singer and actress Whitney Houston and First Lady Hillary Rodham Clinton. Since 1995, both the President and the First Lady have appeared in television public service announcements encouraging older women to get mammography screening and promoting the use of Medicare coverage for mammography.

  In March, a national campaign to educate Americans 50 and older about colorectal cancer --the nation's number two cancer killer--was launched by the CDC, HCFA and NCI. The "Screen for Life" campaign informs Americans 50 and older, the age group most at risk for colorectal cancer, about the importance of screening tests for early detection and prevention of the disease. It was expected that an estimated 129,400 men and women would be diagnosed with colorectal cancer in 1999, and more than 56,000 lives lost to this disease. Many colorectal cancer deaths could be

prevented with screening. In part, the campaign aims to encourage Medicare beneficiaries and others to take advantage of colorectal cancer screening, a preventive benefit now covered under Medicare.

CDC's initiative, REACH **2010**, also targets improving breast and cervical cancer screening and management as one of its six health priority areas. The other areas are infant mortality, cardiovascular disease, diabetes, improving child and/or adult immunization levels and HIV/AIDS.

- **Cardiovascular Disease**. In September 1999, the National Heart, Lung, and Blood Institute (NHLBI) and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) of NIH issued a statement to alert physicians, patients, and the public to the increasing importance of diabetes mellitus as a major risk factor for cardiovascular disease. The alert was prepared in collaboration with three leading private health organizations. Cardiovascular complications are now the leading causes of illness and death in the diabetic patient. The increasing prevalence of type 2 diabetes, the most common form of the disease, is related to a variety of factors including the rapid growth in the U.S. of populations that are particularly susceptible to the type 2 form: African-Americans, Hispanics, Native Americans, Pacific Islanders, and Asians. The statement emphasized that both cardiovascular disease and type 2 diabetes may be prevented by lifestyle changes that maintain normal weight and physical activity.

- Much of what we know about the cardiovascular complications of diabetes has come from studies supported by these two institutes. This year, they began two large clinical trials designed to identify ways to reduce these complications. One study will evaluate the benefits of intensified control of high blood sugar, cholesterol and hypertension. The other will focus on the benefits of weight loss in obese diabetics.

Health Care Worker Safety. The National Institute for Occupational Safety and Health (NIOSH) in CDC worked with diverse partners in industry, the health care community, labor, government, and public health to reduce job-related injuries and illnesses among the nation's eight million health care workers. By improving the quality of working conditions for this vital and growing workforce, these initiatives improve the quality of U.S. health care. For example, on November 22, NIOSH issued recommendations to prevent job-related needlestick injuries among health care employees. Six-hundred thousand to 800,000 such injuries are estimated to occur every year and can lead to serious or potentially fatal infections with bloodborne pathogens. NIOSH also continued to work with diverse partners on further research and risk communication for preventing allergic reactions due to job-related exposures to natural rubber latex in gloves and other products. Studies indicate that 8 to 12 percent of health care employees regularly exposed to latex are sensitized, compared with 1 percent to 6 percent of the general population.

Patients' Bill of Rights. On November 8, HHS announced a proposed regulation that will extend patient protections to all children enrolled in SCHIP. This proposed regulation is consistent with President Clinton's 1998 Executive Order that all federal health plans collectively covering over 85 million Americans should come into compliance with the Patients' Bill of Rights. The protections include access to health care specialists, access to emergency services when and where the need arises, an assurance that doctors and patients can openly discuss treatment options, and access to a fair, unbiased and timely appeals process.

In June, HCFA announced new patient protections in standards to protect the health and welfare of hospitalized patients. The patients' rights regulations strengthen existing protections for patient health and safety and will help assure that high quality care is provided to all patients in hospitals participating in the Medicare and Medicaid program. The six basic patient rights specified in the regulations include the right to confidentiality of patient records and communications, and the freedom from the inappropriate use of restraints and seclusion.

Reducing Medical Errors. On December 7, President Clinton issued an Executive Memorandum directing the Quality Interagency Coordination Task Force (QuIC) to develop new strategies to improve

health care quality and protect patient safety. The President also announced that each of the more than 300 private health plans participating in the Federal Employee Health Benefits Program will be required to institute quality improvement and patient safety initiatives. HHS and other federal agencies that administer health plans were asked by the President to evaluate, and where feasible, implement the latest error reduction techniques.

Improving the Safe Use of Pharmaceuticals. AHRQ launched the Centers for Education and Research on Therapeutics (CERT), a $7.7 million project to improve the quality of health care and help reduce risk of adverse drug events. The centers will conduct state-of-the-art clinical and laboratory research on new uses of drugs, biological products and devices; ways to improve their use; and the risks of new uses and risks of combinations of drugs and biological products. The CERT demonstration program was authorized by Section 409 of the FDA Modernization Act of 1997. AHRQ's reauthorization legislation made it a permanent initiative of the agency.

The Surgeon General's Report on Mental Health. On December 13, HHS released the first ever Surgeon General's Report on Mental Health, which emphasizes the importance of mental health as an essential component in leading a **healthy** life. Our understanding of mental health and illness has dramatically improved the way in which mental health care is provided. Safe and effective options are available to treat the mental disorders that affect one in five Americans per year. The report urges Americans to take advantage of this tremendous growth of scientific knowledge by seeking treatments for mental disorders, which affect one in five Americans. The report also emphasizes the importance of bringing this often hidden topic out into the open, and notes that disorders such as depression, schizophrenia, alcohol and drug addiction, and eating disorders are real illnesses that, if untreated, can be as disabling and serious as cancer and heart disease in terms of premature death and lost productivity.

EXPANDING HEALTH CARE COVERAGE

This year, we also took a number of steps to increase Americans' access to health care. We worked with states to increase the availability of Medicaid, particularly to young adults leaving the foster care system; and made it easier for children to get health insurance through their non-custodial parents after a separation or divorce. We obtained initial funding for a new initiative that complements these efforts by increasing health care access for uninsured workers. And we completed the approval of the State Children's Health Insurance Program (SCHIP) in all 56 states and territories in the country, extending health care coverage to millions of uninsured children.

Improving Health Care Access for the Uninsured. In fiscal year 2000, HHS will begin two new initiatives to improve health care access for the uninsured. The first initiative seeks to increase the capacity and effectiveness of the nation's health care safety net. Through a competitive grant program, communities will receive funds to support infrastructure and other improvements and to provide additional health care services. In fiscal year 2000, $25 million has been provided to fund 10-20 grants. In fiscal year 2000, $15 million has also been appropriated for a new initiative to support up to 10 grants to states to develop designs for providing access to health insurance coverage to all residents of the state.

SCHIP Expansion. In 1999, HHS worked diligently with the states to develop and implement plans to extend health care coverage to millions of uninsured children. On September 8, 1999, HHS announced that the State Children's Health Insurance Program (SCHIP) had been approved in all 56 states and territories in the country. Under the federal SCHIP program, the historic legislation signed into law by President Clinton in 1997, more than $24 billion has been appropriated for the first five years of the program to help expand health insurance to children whose families earn too much to qualify for traditional Medicaid, yet not enough to afford private health insurance.

Medicaid and SCHIP Outreach. In October, President Clinton announced new federal efforts to identify and enroll the millions of uninsured children who are eligible for Medicaid and SCHIP. These efforts included directing cabinet secretaries to develop strategies to integrate children's health insurance outreach into schools; sending new guidance to states and schools on funding options for school-based outreach; and dedicating more than $9 million over three years in research funds through a public-private partnership to identify effective children's health insurance strategies.

To help state and local outreach efforts, President Clinton and HHS, along with the National Governors' Association, launched the Insure Kids Now Hotline, 1-877-KIDS-NOW, and the Insure Kids Now Web site at http://www.insurekidsnow.gov. The Insure Kids Now Hotline is a national toll free number that parents or other interested persons can call for information about free or low-cost health insurance for their children. The Insure Kids Now Web site also offers information on children's health insurance coverage in each state or territory, information on how to apply for coverage, and guidelines for whether families might qualify for a plan.

HHS also proposed expanding the high performance bonuses authorized under the 1996 welfare reform law to reward states that meet increased enrollment of eligible children and families in Medicaid and SCHIP.

Expanding Children's Access to Private Insurance. On November 15, HHS announced a proposed rule to make it easier for children to get health insurance coverage through their non-custodial parents. The regulation creates a standard form to enforce child support agreements that require non-custodial parents to provide for their children's health care needs.

Improving the Quality of Care for Low-Income Children. AHRQ, the David and Lucile Packard Foundation, and HRSA joined to fund a set of research studies to help public health insurance programs and health care delivery systems improve the quality of, and access to, health care for low-income children. Overall funding will total $9.1 million over three years for nine research projects. President Clinton announced the award at a White House event in October.

SUPPORTING INDEPENDENT LIVES IN THE COMMUNITY FOR PEOPLE WITH DISABILITIES

The Department has continued its uncompromising support of health, long-term care, and social support programs and policies to ensure that the over 40 million Americans with disabilities are able to experience independent, high quality lives in the community.

The Ticket to Work and Work Incentives Improvement Act of 1999. On December 17, President Clinton signed landmark legislation making it possible for millions of Americans with disabilities to join the workforce without fear of losing their Medicaid and Medicare coverage. It also modernizes the employment services system for **people** with disabilities. This legislation creates new options for states to offer a Medicaid buy-in for workers with disabilities:

- Provides $150 million in grants to encourage states to take this option;
- Creates a new $250 million Medicaid buy-in demonstration to help **people** whose disability is not yet so severe that they cannot work;
- Extends Medicare coverage for an additional four-and-a-half years for **people** in the disability insurance system who return to work; and enhances employment-related services for individuals with disabilities through the new "Ticket to Work" program; and
- Creates a new $250 million demonstration program that tests whether early medical intervention, made possible through an affordable Medicaid benefit, will enable **people** with early symptoms of HIV, muscular dystrophy, Parkinson's Disease, or diabetes to stay healthier and keep working.

HHS has showed strong support for the Americans with Disabilities Act (ADA), most notably through rigorous enforcement by the HHS Office for Civil Rights. Secretary Shalala has also expressed her support for the Supreme Court's decision in the Olmstead v. L.C. case; the court found that the ADA requires states to administer their programs, including their Medicaid long-term care programs, in the most integrated setting possible. Secretary Shalala has expressed her interest in assisting state Medicaid programs in their efforts to comply with the ADA.

Multiple initiatives and programs have come about as a result of Secretary Shalala's strong commitment to partner with states to expand and promote home and community-based services.

- HHS provided funding for eight states to participate in the nursing home transition program. Through this grant program, states are assisting nursing home and other institutional residents to move into community-based settings, using grant funds to cover a range of expenses not typically covered by other programs.
- The "Cash and Counseling" demonstration continues, enabling **people** with disabilities to have more control over their personal assistance services, by hiring, training, and managing their own assistants.
- In 1999, HHS established a Home and Community-Based Resource Network, to support states and consumers in their collaborative efforts to plan and implement systems to increase home and community-based services options for **people** with long-term care needs.

THE PROMISE OF A RETIREMENT WITH DIGNITY FOR ALL AMERICANS

With the number of seniors doubling by the year 2030, providing proper care of our aging citizens will be one of the central challenges of the 21st century. We must ensure that living a long life also means enjoying a good life. That's why HCFA worked hard this year to improve customer service; joined with the Inspector General to fight waste, fraud and abuse; and toughen federal and state enforcement of nursing home standards. Marking the International Year of Older Persons, the Administration on Aging (AoA) organized new strategies to address the aging of our population and increased its investment in meals on wheels and consumer education. Of course, the cornerstone of our commitment to a retirement with dignity is Medicare. To ensure that the promise of Medicare is never broken, President Clinton has challenged this Congress to earmark one of every six surplus dollars for Medicare over the next 15 years, provide a much-needed prescription drug benefit, and enact competitive reforms in the program.

Improving Nursing Home Quality. AoA and HCFA joined forces to improve the quality of care in nursing homes by awarding $450,000 to four national aging organizations in the fall of 1999. The awards, part of the Clinton administration's initiative on nursing homes, will support the demonstration of approaches to educate and empower communities and families to improve nutrition, hydration and prevent abuse of nursing home residents.

On December 14, HCFA announced that nursing homes that fail to protect residents from harm will face immediate penalties and consumers will have access to more information about the quality of nursing-home care. HCFA instructed states to impose immediate sanctions, such as fines, against nursing homes in more situations, including any time that a nursing home is found to have caused harm to a resident on consecutive surveys. HCFA also:

- Increased states' flexibility to encourage speedier action to stop payments for new admissions and to impose other sanctions when nursing homes violate federal health and safety requirements.

- Enhanced Nursing Home Compare, its consumer Internet resource found at http://www.medicare.gov, to include information about the prevalence of bedsores, weight loss and other health conditions among residents in individual nursing homes.

- And updated its "Guide to Choosing a Nursing Home" to take families and friends step-by-step through the process of identifying an appropriate home for a loved one.

Fighting Health Care Fraud, Waste and Abuse. In June 1999, AoA awarded 41 grants totaling $7 million to expand a program that recruits and trains retired professionals to identify waste, fraud and abuse in the Medicare and Medicaid programs. The Senior Medicare Patrol Project grants, including 29 new and 12 renewed grants, were distributed among 36 states, the District of Columbia, and Puerto Rico. The grant funds will be used to teach volunteer retired professionals such as doctors, nurses, accountants, investigators, law enforcement personnel, attorneys, teachers and others how to work with Medicare and Medicaid beneficiaries. Volunteers work in their own communities and in local senior centers to help identify deceptive health care practices, such as overbilling, overcharging, or providing unnecessary or inappropriate services.

In February, the HHS Office of Inspector General reported that improper Medicare payments to

hospitals, doctors and other health care providers declined dramatically last year to the lowest error rate since the government initiated comprehensive audits three years ago. The error rate for fiscal year 1998 was an estimated 7.1 percent, nearly a 50 percent drop from the 14 percent error rate reported in fiscal year 1996.

Earlier this year, HCFA announced 12 new specialty contracts to investigate special aspects of waste, fraud and abuse including community mental health centers, specific fiscal intermediaries, and corporate integrity agreements. Further expanding the Clinton administration's campaign against waste, fraud and abuse, HCFA also announced a new contract to help Medicare increase the roughly $3 billion saved each year by ensuring that private insurance companies pay their share of Medicare beneficiaries' health care bills. By consolidating these efforts into a single contract, HCFA also expects to improve service to Medicare beneficiaries, health care providers, insurance companies and employers.

Improving Medicare Customer Service. On March 15, HCFA announced the new National Medicare+Choice toll-free telephone line, 1-800-MEDICARE (1-800-633-4227). This nationwide phone line gives Medicare beneficiaries--and those who help them make health care decisions--one more tool to get help with their questions about Medicare and their Medicare health plan options. HCFA also created and launched a new and much more user-friendly billing statement and award-winning Medicare-Compare Web site at http://www.medicare.gov. The statement was developed with input from focus groups and from senior organizations.

To ensure that Medicare beneficiaries have access to the latest effective, evidence-based treatments, HCFA announced in April that it has established a new process to make national coverage decisions more open, understandable and predictable. This new process outlines procedures on how the public may request national coverage decisions as well as timelines for reviewing requests and the roles of HCFA staff, the Medicare Coverage Advisory Committee and technology assessments in national coverage decisions.

In the fall of 1999, Medicare conducted the first national mailing of the "Medicare and You" 2000 handbook to more than 34 million beneficiary households. The handbook reflected improvements suggested by beneficiaries, advocates and members of Congress.

Home Delivered Meals Program. For fiscal year 2000, AoA received a 31 percent budget increase in the Older Americans home-delivered meals program, an increase to $147 million, which will provide 27 million additional meals to home bound elders.

International Year of Older Persons. The World Health Organization recognized HHS as the only national health department to have organized a collaborative cross-departmental response to the International Year of Older Persons. AoA, as head of the Federal Committee for the International Year for Older Persons, convened a symposium of nearly 300 senior administrators from across the executive branch of the federal government to address policy and program implications of our rapidly aging society. The federal committee will continue to meet to review symposium suggestions for interagency collaboration.

CONTINUING PROGRESS ON WELFARE REFORM

Since 1993, the Clinton administration has worked hard to help states reform the welfare system. This year, new findings were released showing that there have been real results in helping welfare recipients leave welfare, enter the workforce, and succeed on the job. New job retention rates and earnings increases, in particular, now demonstrate that there are promising strategies for helping low-income parents make the transition from dependence to self-sufficiency. And HHS took new steps to improve state performance by awarding the first high-performance bonuses, out-of-wedlock birth bonuses, and grants for Individual Development Accounts.

States Rewarded for Successfully Moving People from Welfare to Work. Twenty-seven states received high performance bonuses totaling $200 million in December for excellent performance in moving welfare recipients into jobs. The performance bonus program was authorized by the Personal

Responsibility and Work Opportunity Reconciliation Act of 1996, which made available a total of $1 billion over five years. The states placed 1.3 million welfare recipients into new jobs in 1998. Of these 80 percent retained their jobs three months after being hired. In addition, their earnings rose from $2,100 in the first quarter of employment to $2,650 in the second.

Record Results. On August 2, 1999, HHS reported that all 50 states and the District of Columbia met the overall work participation rates for all families in 1998, the first full year of the new welfare reform law. Welfare caseloads are at their lowest level since 1967 and the welfare rolls have fallen by nearly half since 1993. Nationwide, the rolls have fallen by 51 percent, from 14.1 million to 6.9 million.

States also reported a new record percentage of parents on welfare that are working. Data released in 1999 shows that 35 percent of all welfare recipients were working, looking for employment or enrolled in education and training in 1998. The percentage of employed recipients reached an all-time high at 23 percent, compared to less than 7 percent in 1992 and 13 percent in 1997. Similarly, the proportion of recipients who were working, including employment, work experience and community service, reached 27 percent, a nearly fourfold increase over the 7 percent recorded in 1992.

"Assets for Independence" Demonstration Grants. In September 1999, HHS announced the first award of $9.4 million for 40 demonstration grants under the Assets for Independence Demonstration Program. These new five-year projects will provide federal funds to match the amount of earnings that low-income working individuals and families put into savings for a first home; post-secondary education; or to start a new business. Since 1993, the Clinton administration has supported the creation of Individual Development Accounts (IDAs), which empower low income Americans to save and build assets for their futures. The 1996 welfare reform law encouraged states to use their federal welfare block grants to establish IDAs. Since then, 29 states have included IDAs as part of their welfare reform plans.

States Receive Bonuses in Reducing Out-of-Wedlock Births. HHS awarded $100 million in new bonuses to four states and the District of Columbia for achieving the nation's largest decreases in out-of-wedlock births between 1994 and 1997. This was the first award of the bonuses for reductions in out-of-wedlock births, as provided for in the welfare reform law of 1996. The awardees, Alabama, California, the District of Columbia, Massachusetts and Michigan, each received $20 million.

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HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
Thursday, Sept. 30, 1999

Contact: CDC Division of Media Relations
(404) 639-3286

CDC AWARDS FUNDING TO COMMUNITY COALITIONS FOR PROJECTS TO HELP ELIMINATE RACIAL AND ETHNIC HEALTH DISPARITIES

Surgeon General David Satcher today announced that the Centers for Disease Control and Prevention (CDC) will award $9.4 million to community coalitions in 18 states to help address racial and ethnic disparities in the United States.

"The President has committed the nation to an ambitious goal by the year **2010**: eliminate the disparities in health status experienced by racial and ethnic minority populations, while continuing the progress we have made in improving the overall health of the American **people**," said Dr. Satcher. "These awards are part of the Administration's initiative to support community-based programs that are effective in reaching and serving these affected communities."

The awards are a component of CDC's new initiative, "Racial and Ethnic Approaches to Community Health (REACH **2010**)," a demonstration project that targets six health priority areas: infant mortality, improving breast and cervical cancer screening and management, cardiovascular disease, diabetes, improving child and/or adult immunization levels and HIV/AIDS. President Clinton has set a national goal of eliminating, by the year **2010**, longstanding disparities in health status that affect racial and ethnic minorities, and the Department of Health and Human Services is guiding this initiative.

"These awards will put funds into the hands of frontline leaders and minority health organizations without delay to build on the progress we've already made in reducing racial and ethnic health disparities," HHS Secretary Donna E. Shalala said. "With this money, we are helping local communities marshal the resources and fund the programs they need to close the health disparities gap--to the benefit of all."

A total of 32 community coalitions will receive funding, and three additional community coalitions will be funded by the California Endowment to participate in REACH **2010**. Grantees will spend the first year planning and developing activities to reduce the level of disparity in one or more of the priority areas. The following year, all of these organizations will compete for funding to implement these plans utilizing clearly defined interventions in a geographically defined minority population. The populations include African American, American Indian, Alaska Native, Hispanic American, Asian American, and Pacific Islander.

"CDC works to end racial and ethnic health disparities by partnering with diverse communities in research and intervention programs," said Jeffrey P. Koplan, M.D., M.P.H., Director, CDC. "REACH **2010** makes an important contribution to our commitment to eliminate all disparities in the next century."

The elimination of health disparities will require a national effort-public and private sector, individuals, and communities. A better understanding of the relationships between health status and different racial and ethnic minority backgrounds will require working more closely with communities to identify culturally-sensitive implementation strategies.

A list of grantees is available upon request.

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Note: For other HHS Press Releases and Fact Sheets pertaining to the subject of this announcement, please click here for our Press Release and Fact Sheet search engine at: http://www.os.dhhs.gov/news/press/.

Media Relations
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FactSheet

Freddie Mac

Relationship Between Income and Credit Quality

NOTE: For purposes of the charts below, "bad" credit records are defined as those where consumers have been either 90-days late on a payment in the last two years, 30-days late on a payment more than once in the last two years, or have a record of delinquent liens, public records or a bankruptcy. "Good" credit records are defined as those where consumers have been 30-days late on a payment no more than once in the last two years and have no other derogatory credit marks, liens or bankruptcies.

Overall, 48% of African Americans had "bad" credit records, while 27% of whites had bad credit records.

Incomes Under $25,000

Race/Ethnic Group	Percent w/ "Bad" Credit	Percent w/ Indeterminate Credit	Percent w/ "Good" Credit
White	31.4	15.6	53.0
African American	47.7	18.0	34.3
Asian	22.2	10.8	67.0
Hispanic	39.1	16.8	44.1
Total	35.6	16.1	48.3

Incomes between $25,000 and $44,999

Race/Ethnic Group	Percent w/ "Bad" Credit	Percent w/ Indeterminate Credit	Percent w/ "Good" Credit
White	30.6	11.8	57.6
African American	50.3	14.9	34.8
Asian	20.3	12.6	67.1
Hispanic	34.7	14.3	51.0
Total	33.2	12.5	54.3

Incomes between $45,000 and $64,999

Race/Ethnic Group	Percent w/ "Bad" Credit	Percent w/ Indeterminate Credit	Percent w/ "Good" Credit
White	21.6	10.6	67.8
African American	48.4	12.0	39.6
Asian	15.7	13.1	71.2
Hispanic	28.2	12.9	58.9
Total	24.5	11.1	64.5

Incomes between $65,000 and $75,000

Race/Ethnic Group	*Percent w/ "Bad" Credit*	*Percent w/ Indeterminate Credit*	*Percent w/ "Good" Credit*
White	20.4	11.6	68.0
African American	34.5	13.6	52.0
Asian	12.5	13.2	74.3
Hispanic	26.8	14.3	58.9
Total	21.7	12.2	66.1

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FactSheet

FREDDIE MAC AND HBCU FOCUS GROUP SUMMARY

Freddie Mac

There are countless reasons for why people get into credit difficulties. The Freddie Mac Consumer Credit Education Initiative (CCEI) focus groups, however, suggest that many of these reasons fall into two categories: the inability to follow successful financial behaviors, like saving money and budgeting; or the existence of external circumstances that create financial burdens like sudden loss of work, high medical bills or divorce. Coupled with these reasons appear to be two additional factors: a lack of knowledge about financial and credit matters, and minimal financial resources.

Many of the focus group participants acknowledged that they do not follow many of the basics in financial planning – saving money, planning for the future, controlling spending habits – though many recognized that doing so would help to minimize their credit problems. Here are some of the anecdotes from the focus groups held:

BENEDICT COLLEGE

"Basically, your bills determine how you do things each month, whether you do a lot of activities as far as having your lights on a lot or having your heat higher or lower.

"My parents just bought things, brought it home, and that was it. You didn't know where the money was coming from, how they were spending it, what they had left over. And, I never had any information. In my case, my parents didn't help me."

CLARK ATLANTA UNIVERSITY

"I skimp on my utilities because they're never going to stop ... I will pay enough for them not to be turned off. If it is $100 ... I wouldn't even pay it ... because I didn't use $100 worth of electricity."

"The cell phone is the last bill on the list to be paid ... because I don't need that one. That's just a luxury thing."

HOWARD UNIVERSITY

"At one point, I had 23 credit cards. I was 23 years old. It was just a matter of having credit card after credit card," said one woman.

"Nobody's going to take you to jail if you don't pay your bills."

"Some people can learn [poor credit habits] through observation. I have a cousin who declared bankruptcy and one of his friends who, like him, didn't know anything, told him 'Well, once you declare bankruptcy, they can never take anything away from you again. You can never have anything repossessed.' So, after four years of declaring bankruptcy, he finally got a little credit built up, got a car and another car. After what his friend told him, he stopped paying his car payment – they repossessed his car."

"I put my credit card in the freezer so I won't use it!"

ST. AUGUSTINE COLLEGE

"I got a little bill thing, it says "bills" ... I used to fish them out ... they called me, if I didn't have it, I just didn't have to send it to you."

" I had a one [bill collector] to call me and said, 'is Ms. Wright home?' I said, 'this is her.' The bill collector said, "Miss Wright do you just make bills, just not to pay them?' I said, 'yeah, and I ain't paying yours!"

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FactSheet

Executive Summary
Freddie Mac National Consumer Credit Survey

Freddie Mac

OVERVIEW

The Freddie Mac Consumer Credit Survey was designed to provide insights into why some people get into credit difficulties, how these problems can be effectively remedied and if/how credit experiences differ for minority communities.

The survey was conducted by mail, and included a 12-page questionnaire containing approximately 200 questions that was sent to over 20,000 consumers from two separate mail panels. The respondents were between the ages of 20 to 40 years old, with income up to $75,000, the population for which obtaining and maintaining good credit is arguably most critical. We received approximately 12,000 completed surveys. The margin of error for the survey is 1.1%. In addition, Freddie Mac and the Historically Black Colleges & Universities conducted more than 50 focus groups.

For purposes of the survey, "bad" credit records are defined as those where consumers have been either 90-days late on a payment in the last 2 years, 30-days late on a payment more than once in the last 2 years, or have a record of delinquent liens, public records or bankruptcy. "Good" credit records are defined as those where consumers have been 30-days late on a payment no more than once in the last two years and have no other derogatory credit marks, liens or bankruptcies.

I. How many consumers have credit problems?

Having a poor credit record is a relatively common problem in today's society. Using the combined results from the CCS (i.e., African-Americans, Hispanics and Whites) we estimate that:

- 30% of these groups have "bad" credit records
- 13% of these groups have "indeterminate" credit records
- 57% of these groups have "good" credit records

Credit problems persist across income groups.
We estimate that:

- 36 % of consumers with incomes under $25,000 had "bad" credit records
- 33 % of consumers with incomes of $25,000 to $44,999 had "bad" credit records
- 25 % of consumers with incomes of $45,000 to $64,999 had "bad" credit records
- 22 % of consumers with incomes of $65,000 and $75,000 had "bad" credit records

Minority borrowers are more likely than white borrowers to experience credit problems.
For African-Americans we estimate that:

- 48% of African Americans have "bad" credit records
- 16% of African Americans have "indeterminate" credit records
- 36% of African Americans have "good" credit records

For Hispanics we estimate that:

- 34% of Hispanics have "bad" credit records
- 15% of Hispanics have "indeterminate" credit records
- 51% of Hispanics have "good" credit records

For Whites, in contrast, we estimate that:

- 27% of Whites have "bad" credit records
- 12% of Whites have "indeterminate" credit records
- 61% of Whites have "good" credit records.

II. How accurately do people assess their credit records?

The CCS shows that, in general, people have a reasonably accurate sense of their credit records.
For example:

- 69% of respondents with "good" credit records self-assess their own records as either "good" or "very good," only 13% of these same respondents self-assess their credit records as "bad" or "very bad."
- 50% of respondents with "bad" credit records self-assess their own records as either "bad" or "very bad," only 17% of these same respondents self-assess their credit records as "good" or "very good."

African-American borrowers with "good" credit, however, have a more pessimistic self-assessment than either Hispanic or White borrowers with similar credit records.

- Only 49% of African-American respondents with "good" credit records self-assess their own records as either "good" or "very good," as compared to 64% of Hispanic and 72% of White respondents.
- 22% of African-American respondents with "good" credit records self-assess their own records as either "bad" or "very bad," as compared to 14% of Hispanic and 11% of White respondents.

A similar dichotomy does not exist for African-American borrowers with "bad" credit records—their self-assessment of their credit records is in line with similarly situated Hispanics and Whites.

III. Why/how do people get into credit difficulties?

There are, of course, innumerable reasons for why people get into credit difficulties. Our focus groups, however, suggested that many of these reasons fall into 2 broad categories:
inability to follow "successful" financial behaviors (e.g., control spending, planning for future, saving money) external events that create financial stresses (e.g., unemployment, medical bills, divorce)

Compounding and interacting with these reasons are 2 other sets of factors:
lack of knowledge about financial and credit matters a poor economic "safety net" (e.g., low income, little savings, no friends or relatives to turn to in times of trouble)

1. Financial behaviors

Many participants facing credit difficulties in our focus groups expressed a seeming inability to follow a simple set of financial behaviors—controlling spending, planning for the future, saving money—even though they recognized/believed that doing so would help them mitigate or even avoid their credit problems.

The CCS results confirm this general finding:

People with "bad" credit records, for example, give themselves a low grade in the ability to control their spending: respondents with "bad" credit records are 70% more likely to say they do a "fair" or "poor" job of controlling their spending, as compared to respondents with "good" credit records (34% versus 20%.)

People with "bad" credit records also give themselves a low grade at planing for their financial future: respondents with "bad" credit records are 64% more likely to say they do a "fair" or "poor" job of planning for their financial future, as compared to respondents with "good" credit records (54% versus 33%.)

People with "bad" credit records also give themselves a low grade at saving money: respondents with "bad" credit records are 56% more likely to say they do a "fair" or "poor" job of planning for their financial future, as compared to respondents with "good" credit records (56% versus 36%).

Although minority respondents in the CCS generally express a somewhat worse ability to follow these financial behaviors, the differences across African-Americans, Hispanics and Whites are not large.

The relative inability of respondents with "bad" credit records to follow these financial behaviors holds across race and ethnicity (i.e., for African-Americans, Hispanics and Whites).

2. External events that create financial stresses

When asked to explain why they were facing their current credit difficulties, focus group participants consistently spoke about relatively rare external events—unemployment, loss of income, divorce—that, when they happen, create significant financial stresses and strains that then lead to credit difficulties. The CCS results confirm that people with "bad" credit records are more likely to have faced these stress-inducing external events.

Respondents with "bad" credit records are more likely to report the occurrence of external events that are likely to create financial stresses and strains.

Respondents with "bad" credit records are:

- 82% more likely to report that they have had a significant involuntary reduction in income over the past 2 years, compared to respondents with "good" credit records (31% versus 17%).
- 33% more likely to report that they have had a major medical expense over the past 2 years, compared to respondents with "good" credit records (32% versus 24%).
- 150% more likely to report that they have had a major legal or tax problem over the past 2 years, compared to respondents with "good" credit records (15% versus 6%).
- 125% more likely to report that they have been divorced, separated or widowed **over the past 5 years**, compared to respondents with "good" credit records (18% versus 8%).
- 78% more likely to report that they have had an extended period of unemployment where they couldn't find a job over the past 2 years, compared to respondents with "good" credit records (16% versus 9%).

The results also suggests that these financial stresses and strains disproportionately occur to minorities (African-Americans and Hispanics). In particular, with the exception of facing major medical expenses, African-American and Hispanic respondents report a higher occurrence of external events that are likely to create financial stress than do White respondents.

- 30% of African-American respondents and 24% of Hispanic respondents report an involuntary reduction in income over the past 2 years, while only 20% of White respondents do so.
- 24% of African-American respondents and 23% of Hispanic respondents report a major medical expense over the past 2 years, while 28% of White respondents do so.
- 12% of African-American respondents and 9% of Hispanic respondents report a major legal or tax problem over the past 2 years, while 8% of White respondents do so.
- 17% of African-American respondents and 14% of Hispanic respondents report they have been divorced, separated or widowed **over the past 5 years**, while only 11% of White respondents do so.
- 19% of African-American respondents and 14% of Hispanic respondents report an extended period of unemployment over the past 2 years, while only 10% of White respondents do so.

An intriguing result is that the occurrence of these external events is generally less closely associated with minority respondents' (African-Americans and Hispanics) "bad" credit records.

For example:

- African-American respondents with "bad" credit records are 27% more likely to report a significant reduction in income in the past 2 years, compared to respondents with "good" credit records (33% versus 26%). The equivalent number for Hispanic respondents is 63% (31% versus 19%), and for White respondents it is 93% (31% versus 16%).
- African-American respondents with "bad" credit records are 18% more likely to report a major medical expense in the past 2 years, compared to respondents with "good" credit records (26% versus 22%). The equivalent number for Hispanic respondents is 40% (28% versus 20%), and for White respondents it is also 40% (35% versus 25%).
- African-American respondents with "bad" credit records are 100% more likely to report a major legal or tax problem in the past 2 years, compared to respondents with "good" credit records (16% versus 8%). The equivalent number for Hispanic respondents is 71% (12% versus 7%), and for White respondents it is 200% (15% versus 5%).
- African-American respondents with "bad" credit records are 43% more likely to report having been divorced, separated or widowed **in the past 5 years,** compared to respondents with "good" credit records (20% versus 14%). The equivalent number for Hispanic respondents is 150% (20% versus 8%), and for White respondents it is 113% (17% versus 8%).
- African-American respondents with "bad" credit records are 18% more likely to report a major legal or tax problem in the past 2 years, compared to respondents with "good" credit records (20% versus 17%). The equivalent number for Hispanic respondents is 42% (17% versus 12%), and for White respondents it is 88% (15% versus 8%).

The generally diminished association between externally driven financial stresses and "bad" credit ratings among minority (African-American and Hispanic) respondents suggests that other factors may be differentially important in explaining credit problems in these communities.

3. Financial knowledge

Our focus group participants expressed somewhat conflicting views about the role that a lack of financial knowledge plays in explaining their credit difficulties. On the one hand, as noted above, many participants stated that they knew what to do, they just didn't do it. This suggests that the lack of knowledge itself may not be a problem, rather the key may be people's inability to implement what they know (i.e., change their financial behavior—control spending, engage in financial planning, save money). On the other hand, however, many focus group participants did express a desire to learn more about managing finances and a belief that such knowledge would improve their credit records/performance. There was also evidence of common misperceptions that could be corrected with education.

Given the above, it is not surprising that the CCS results on financial knowledge are somewhat mixed. In general respondents with "bad" credit records self-assess their knowledge of how to manage finances less favorably than do respondents with "good" credit records.

Minority (African-American and Hispanic) respondents also give a lower self-assessment of how much they know about managing their finances than do Whites. However, there is not much difference in how African-American respondents with "good" and "bad" credit self assess their knowledge of how to manage finances. And, interestingly, the primary source from which respondents with "bad" credit learned about managing money was not courses, parents or spouses/domestic partners, but rather from difficult financial experiences/the "school of hard knocks."

By their own assessment, respondents with "bad" credit records know less about managing finances than respondents with "good" credit records.

- Respondents with "good" credit records are 28% more likely to say they know "a fair amount" or "a lot" about managing finances, compared to respondents with "bad" credit records (51% versus 40%).
- Respondents with "bad" credit records are 50% more likely to say they know "very little" or "nothing" about managing finances, compared to respondents with "good" credit records (24% versus 16%).

Minority (African-American and Hispanic) respondents are also less likely to favorably view their knowledge of how to manage finances.

- 41% of African-American respondents say they know "a fair amount" or "a lot" about managing finances, compared to 40% of Hispanic respondents and 50% of White respondents.
- 27% of African-American respondents say they know "very little" or "nothing" about managing finances, compared to 28% of Hispanic respondents and 17% of White respondents.

Interestingly, the difference between respondents with "good" and "bad" credit is far more salient for Whites and Hispanics than it is for African-Americans. In particular, African-American respondents with "good" credit records are less likely than similarly situated Hispanic and White respondents to highly self-assess their financial knowledge. As a result, for African-Americans there is virtually no difference between respondents with "good" and "bad" credit records in their self-assessed knowledge about managing finances.

- African-Americans respondents with "good" credit records are 8% more likely to say they know "a fair amount" or "a lot" about managing finances, compared to respondents with "bad" credit records (42% versus 39%). The equivalent number for Hispanics is 23% (43% versus 35%), and for Whites the number is also 29% (54% versus 42%).
- An identical number of African-Americans respondents with "bad" and "good" credit records (26%) say they know "very little" or "nothing" about managing finances. The equivalent number for Hispanics is 7% (29% versus 27%), and for Whites the number is 64% (23% versus 14%).

Respondents with "good" and "bad" credit records also appear to have different sources of learning. Respondents with "good" credit records are more likely to learn about managing money from their parents and spouses.

- Respondents with "good" credit records are 14% more likely to say that they learned "a fair amount" or "a lot" from their parents, than respondents with "bad" credit records (49% versus 43%).
- Respondents with "good" credit records are 18% more likely to say that they learned "a fair amount" or "a lot" from their spouse/domestic partner, than respondents with "bad" credit records (40% versus 34%).

Respondents with "bad" credit records, however, are more likely to learn about managing money from difficult financial experiences/the "school of hard knocks".

Respondents with "bad" credit records are 60% more likely to say that they learned "a fair amount" or "a lot" from their difficult financial experiences/the "school of hard knocks," compared to respondents with "good" credit records (64% versus 40%).

We also asked about other sources of knowledge—high school and/or college courses, training courses and/or seminar taught outside school, friends and peers, work, and TV or radio. Respondents generally did not record that they learned as much from these sources, nor was there (self-assessed) differential learning between respondents with "good" and "bad" credit records.

African-Americans respondents report differentially important sources of learning than do Hispanic and White respondents. For example, African-American respondents with "good" and "bad" credit records do not report differential learning from either parents or spouse/domestic partner.

- 26% of African-American respondents with "good" credit records say that they learned "a fair amount" or "a lot" from their parents, and 27% of respondents with "bad" credit records respond similarly.
- 45% of African-American respondents with "good" credit records say that they learned "a fair amount" or "a lot" from their spouse/domestic partner, and 43% of respondents with "bad" credit records respond similarly.

As with Hispanic and White respondents, however, African-American respondents with "good" and "bad" credit records do report differential learning from difficult financial experiences/the "school of hard knocks.

And, although African-American respondents with "good" and "bad" credit records do not report differential learning from either training courses and/or seminars, or TV or radio, African-American respondents in general do report having learned more from these sources than do either Hispanic or White respondents.

- 13% of African-American respondents say that they learned "a fair amount" or "a lot" from training courses and/or seminars, and only 7% of Hispanic respondents and 6% of White respondents report similarly.
- 19% of African-American respondents say that they learned "a fair amount" or "a lot" from TV or radio, and only 9% of Hispanic respondents and 7% of White respondents report similarly.

4. Economic safety net

Although focus group participants did not explicitly cite lower income or savings as a cause for their credit problems, they were mentioned as contributors in many instances. The CCS results confirm this general view.

Respondents with "bad" credit records are less likely to have an effective economic safety net (e.g., lower income, lower savings/wealth, fewer alternatives to turn to in times of financial difficulty) than respondents with "good" credit records.

- Respondents with "bad" credit records are 33% more likely to report incomes of less than $35,000, compared to respondents with "good" credit records (56% versus 42%).
- Respondents with "bad" credit records are 67% more likely to report net wealth of less than $10,000, compared to respondents with "good" credit records (65% versus 39%).
- Respondents with "good" credit records are 70% more likely to report that they could "somewhat likely" or "very likely" pay their bills for 3 months without borrowing if they had an unexpected loss in income, compared to respondents with "bad" credit records (46% versus 27%).
- Respondents with "good" credit records are 28% more likely to report that they could "somewhat likely" or "very likely" get significant help from family or friends if they had an unexpected loss in income, compared to respondents with "bad" credit records (56% versus 46%).

With the exception of the ability to pay their bills for 3 months without borrowing, African-American respondents report a less effective economic safety net than Hispanic or White respondents.

- 63% of African-American respondents report incomes less than $35,000, while 52% of Hispanic respondents and 45% of White respondents do so.
- 64% of African-American respondents report net wealth of less than $10,000, while 62% of Hispanic respondents and 51% of White respondents do so.
- 38% of African-American respondents report that they could "somewhat likely" or "very likely" pay their bills for 3 months without borrowing if they had an unexpected loss in income, while 39% of Hispanic respondents and 40% of White respondents do so.
- 44% of African-American respondents report that they could "somewhat likely" or "very likely" get significant help from family or friends if they had an unexpected loss in income, while 48% of Hispanic respondents and 54% of White respondents do so.

Again, however, the economic safety net does not distinguish respondents with "good" and "bad" credit records as well for African-Americans as it does for Hispanic and White respondents.

- African-American respondents with "bad" credit are 10% more likely to report incomes less than $35,000, compared to respondents with "good" credit (65% versus 59%). The equivalent number for Hispanic respondents is 19% (57% versus 48%), and for White respondents it is 39% (53% versus 38%).

- African-American respondents with "bad" credit are 12% more likely to report net worth less than $10,000, compared to respondents with "good" credit (67% versus 60%). The equivalent number for Hispanic respondents is 24% (68% versus 55%), and for White respondents it is 43% (63% versus 44%).
- African-American respondents with "good" credit are 29% more likely to report they could "somewhat likely" or "very likely" pay their bills for 3 months without borrowing if they had an unexpected loss in income, compared to respondents with "bad" credit (44% versus 34%). The equivalent number for Hispanic respondents is 50% (45% versus 30%), and for White respondents it is 88% (47%versus 25%).
- African-American respondents with "good" credit are 2% **less** likely to report they could "somewhat likely" or "very likely" get significant financial help from family or friends if they had an unexpected loss in income, compared to respondents with "bad" credit (45% versus 46%). The equivalent number for Hispanic respondents is 21% **more** likely (51%versus 42%), and for White respondents it is 29% **more** likely (58% versus 45%).