



Racial and Ethnic Disparities in Health

Response to the President's Initiative on Race
by
The United States Department of Health and Human Services

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Eliminating Racial and Ethnic Disparities in Health

OVERVIEW

The President has 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:

- ◆ Infant Mortality
- ◆ Cancer Screening and Management
- ◆ Cardiovascular Disease
- ◆ Diabetes
- ◆ HIV Infection/AIDS
- ◆ 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 were implemented in fiscal year 1999. These projects were designed to test models for reducing disparities in specific minority communities.

- The Department's programs to improve the economic security of low-income families and communities will be 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.

- The President's fiscal year 1999 budget proposes the beginning of a new five-year, \$400 million set of activities addressing health disparities.
 - Included in this request is an additional \$30 million for CDC to award up to 30 large community-based demonstration projects testing science-based approaches to achieve the six health disparity reduction goals. Results from these demonstrations will be important in shaping strategies to eliminate disparities, and for improving the focus and effectiveness of the Department's current programs.
 - An increase of \$50 million in funding also is requested for FY 1999 for 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.

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.



GOAL 1

Eliminate disparities in infant mortality rates.

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

Infant mortality rates (IMR's) vary substantially among and within racial and ethnic groups. Infant death rates among blacks, American Indians and Alaska Natives, and Hispanics in 1995 or 1996 were all above the national average of 7.2 deaths per 1,000 live births. The greatest disparity exists for blacks, whose infant death rate (14.2 per 1,000 in 1996) is nearly 2½ times that of white infants (6.0 per 1,000 in 1996). The overall American Indian rate (9.0 per 1,000 live births in 1995) does not reflect the diversity among Indian communities, some of which have infant mortality rates approaching twice the national rate. Similarly, the overall Hispanic rate (7.6 per 1,000 live births in 1995) does not reflect the diversity among this group which had a rate of 8.9 per 1,000 live births among Puerto Ricans in 1995.

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

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

In 1996, the proportion of pregnant women across the Nation receiving prenatal care in the first trimester reached 81.8 percent—a consistent improvement for the seventh consecutive year and up from 75.5 percent in 1989. Yet, one in five pregnant women, or three-quarters of a million women, still did *not* receive timely prenatal care; almost 47,000 women received *no* prenatal care at all. In addition, there are substantial racial disparities in the timely receipt of prenatal care. In 1996, 84 percent of white pregnant women, compared with approximately 71 percent of black and Hispanic

pregnant women, received early prenatal care. Eliminating these disparities requires the removal of financial, educational, social, and logistical barriers to care.

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

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

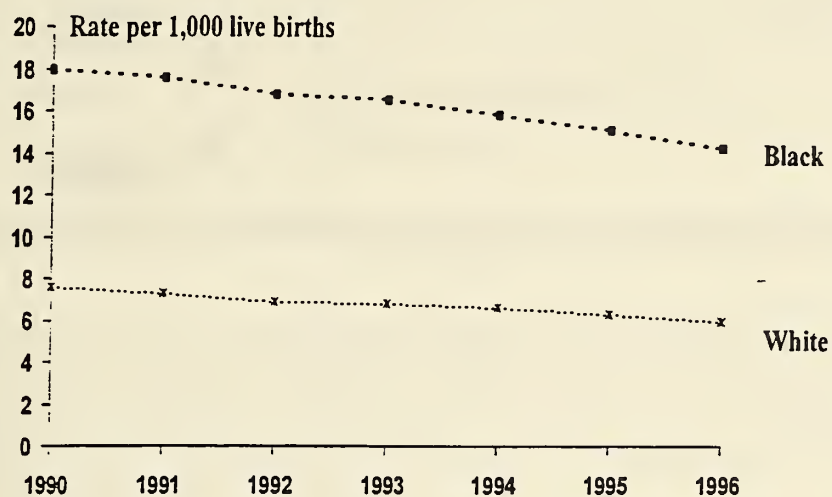
We will have a significant impact on infant mortality by increasing our efforts to address the racial disparities that exist in both PTB and SIDS rates. Racial and ethnic differences in PTB's and SIDS most likely reflect variations in the prevalence of risk factors, including socioeconomic and demographic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

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

Near-Term Goal

Reduce infant mortality among blacks by at least 22 percent.

Infant Mortality Rates for the United States, 1990-1996

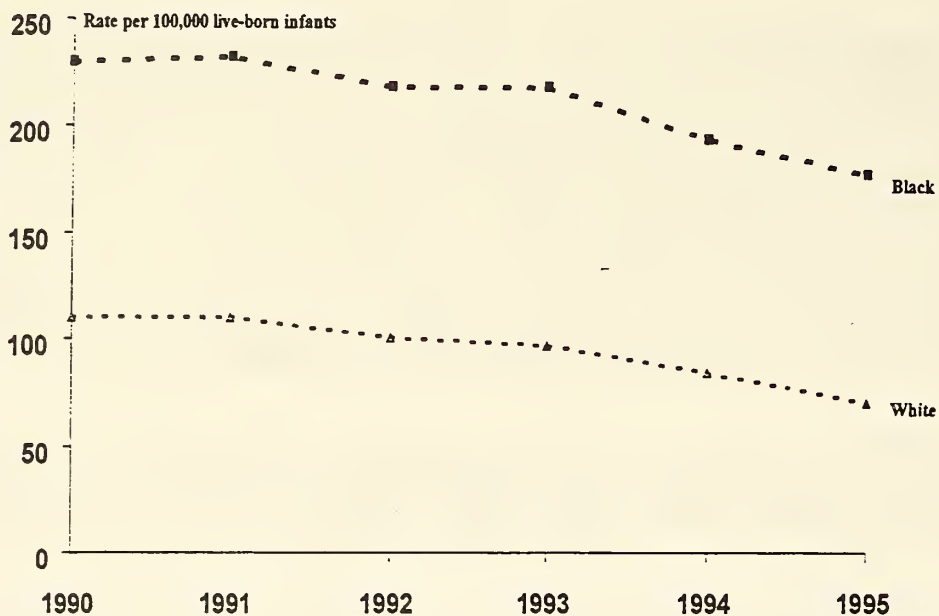


Infant Mortality Rate Baselines:

- Total: 7.2 per 1,000 live births (1996 preliminary data)
- White: 6.0 per 1,000 live births (1996 preliminary data)
- Black: 14.2 per 1,000 live births (1996 preliminary data)
- American Indian/Alaska Native: 9.0 per 1,000 live births (1995 linked data)
- Native Hawaiian: 6.5 per 1,000 live births (1995 linked data)
- Puerto Rican: 8.9 per 1,000 live births (1995 linked data)

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

Sudden Infant Death Syndrome (SIDS) Rates for the United States by Race, 1990-1995



Race for infants who died from SIDS was determined by the race of each infant, and race for all live-born infants was determined by the race of the mother.

Sudden Infant Death Syndrome Rate Baselines:

Total: 74.2 per 100,000 live-born infants (1996 preliminary data)

White: 71.0 per 100,000 live-born infants (1995)

Black: 178.6 per 100,000 live-born infants (1995)

American Indian/Alaska Native: 206.6 per 100,000 live-born infants (1995 linked data)

Asian/Pacific Islander: 49.9 per 100,000 live-born infants (1995 linked data)

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



Eliminate disparities in cancer screening and management.

CANCER is the second leading cause of death in the United States, accounting for more than 544,000 deaths each year. About 1.4 million new cases of cancer are expected to be diagnosed in 1997, and approximately 7.4 million Americans have or have had cancer. The chances of developing cancer in a lifetime are nearly 50 percent for men and nearly 40 percent for women. About half of those who develop the disease will die from it.

Many minority groups suffer disproportionately from cancer. Disparities exist in both mortality and incidence rates. For men and women combined, blacks have a cancer death rate about 35 percent higher than that for whites (171.6 vs. 127.0 per 100,000). The death rate for cancer for black men is about 50 percent higher than it is for white men (226.8 vs. 151.8 per 100,000). The death rate for lung cancer is about 27 percent higher for blacks than for whites (49.9 vs. 39.3 per 100,000). The prostate cancer mortality rate for black men is more than twice that of white men (55.5 vs 23.8 per 100,000).

Paralleling the death rate, the incidence rate for lung cancer in black men is about 50 percent higher than in white men (110.7 vs. 72.6 per 100,000). Native Hawaiian men also have elevated rates of lung cancer compared with white men. Alaska Native men and women suffer disproportionately higher rates of cancers of the colon and rectum than do whites. Vietnamese women in the United States have a cervical cancer incidence rate more than five times greater than white women (47.3 vs. 8.7 per 100,000). Hispanic women also suffer elevated rates of cervical cancer.

Much can be done to reduce the burden of cancer in the United States through prevention. Lifestyles can be modified to greatly reduce an individual's risk for cancer. Tobacco use is responsible for nearly one-third of all cancer deaths. Evidence suggests that diet and nutrition may be related to 30 to 40 percent of cancer deaths. Additionally, many of the estimated 900,000 skin cancer cases diagnosed each year could be prevented by reducing sun exposure.

For some cancers that we do not yet know how to prevent, early detection can dramatically reduce the risk of death. Regular mammography screening and appropriate follow-up can reduce deaths from breast cancer by about 30 percent for women 50 years of age and older. Screening by Pap test for cervical cancer along with appropriate follow-up care can virtually eliminate the risk of developing this disease.

The purpose of goal 2 is to improve screening and management of cancer. Although colorectal cancer screening is now recommended, few data on screening rates exist. Screening for prostate cancer remains controversial, and for this cancer as well, few data on screening rates exist. Indeed, there is a significant need for public education about what is known, what is not known, and what is believed about prostate cancer screening and treatment. Breast and cervical cancers, however, have proven screening modalities for which screening data, both baseline and continuing, are available. For this reason, the strategy for achieving goal 2 focuses on breast and cervical cancers.

Despite the considerable gains in screening in the black community, the mortality rate from breast cancer for black women is greater than for white women. Some of the reasons for this disparity include the fact that many women have not yet had a mammogram or a Pap smear, many more are not screened regularly, and still others are screened but have limited follow-up and treatment services available to them. Hispanic, American Indian and Alaska Native, and Asian and Pacific Islander women also have low rates of screening and treatment, limited access to health facilities and physicians, and barriers related to language, culture, and negative provider attitudes, which negatively affect their health status. Eliminating these differences is critical and will be the focus of attention for the HHS initiative to help identify and understand approaches that have proven successful in some communities. Our focus on tracking breast and cervical cancer will serve as an indicator for assessing our overall efforts to reduce and eventually eliminate disparities in the prevention and management of all cancers.

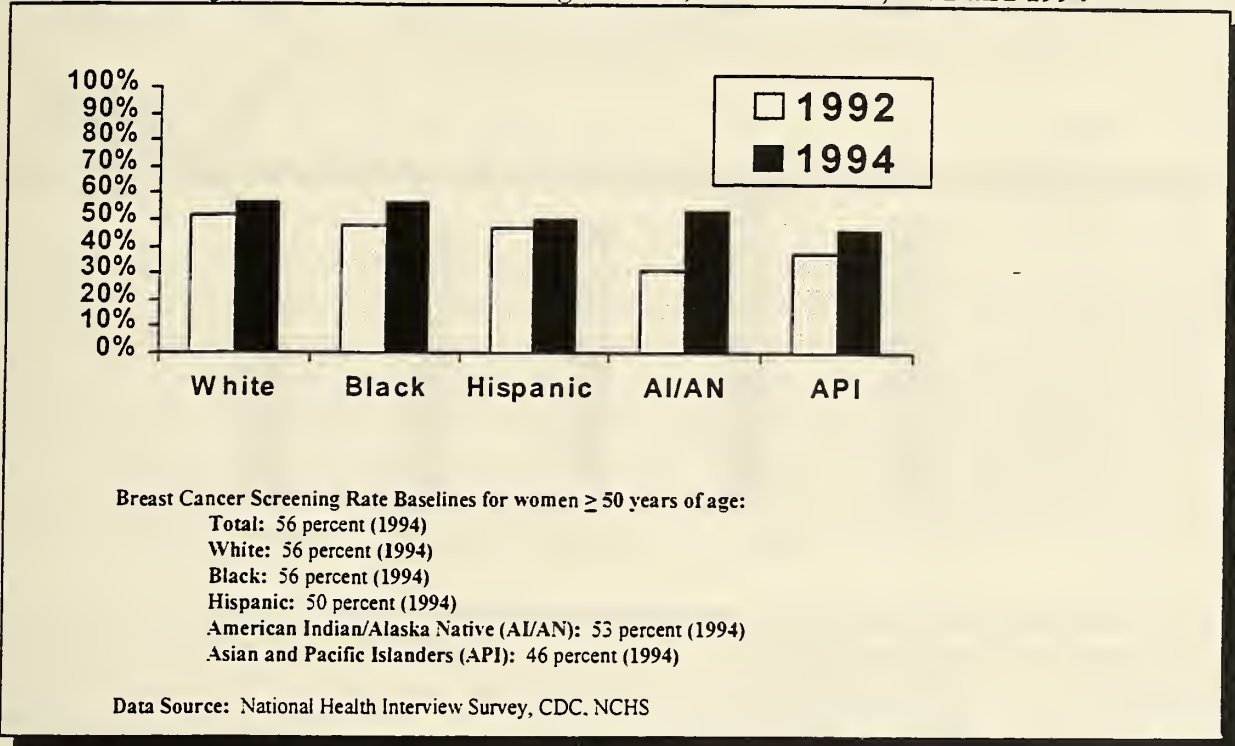
Breast Cancer

Our goal for the year 2000 for breast cancer screening is to increase to at least 60 percent those women of all racial or ethnic groups, aged 50 and older, who have received a clinical breast exam and a mammogram within the preceding 2 years.

Near-Term Goal

Increase to at least 60 percent those women of all racial or ethnic groups, aged 50 and older, who have received a clinical breast exam and a mammogram within the preceding 2 years.

Proportion of Women Aged 50 and Older Who Have Received a Clinical Breast Examination and a Mammogram Within the Preceding 2 Years, United States, 1992 and 1994



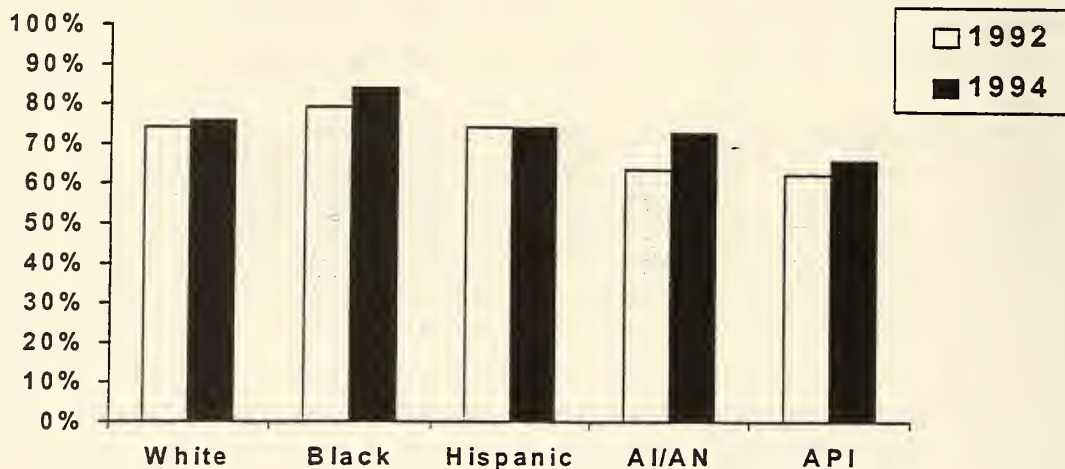
Cervical Cancer

Our goal for the year 2000 for cervical cancer is to increase to at least 85 percent the proportion of all women aged 18 and older who have received a Pap test within the preceding 3 years.

Near-Term Goal

Increase to at least 85 percent the proportion of all women aged 18 and older who have received a Pap test within the preceding 3 years.

Proportion of Women Aged 18 and Older Who Have Received a Pap Test Within the Past 3 Years, United States, 1992 and 1994



Cervical Cancer Screening Rate Baselines for Women Age \geq 18 Years:

Total: 77 percent (1994)
 White: 76 percent (1994)
 Black: 84 percent (1994)
 Hispanic: 74 percent (1994)
 American Indian/Alaska Native (AI/AN): 73 percent (1994)
 Asian and Pacific Islander (API): 66 percent (1994)

Data Source: National Health Interview Survey, CDC, NCHS



GOAL 3

Eliminate disparities in cardiovascular disease.

CARDIOVASCULAR DISEASE, primarily coronary heart disease and stroke, kills nearly as many Americans as all other diseases combined and is among the leading causes of disability in the United States. Cardiovascular disease is the leading cause of death for all racial and ethnic groups. The impact of premature morbidity from cardiovascular disease on the ability of affected individuals to function independently or to participate fully in everyday life is devastating in terms of personal loss, pain, suffering, and effects on families and loved ones. The annual national economic impact of cardiovascular disease is estimated at \$259 billion as measured in health care expenditures, medications, and lost productivity due to disability and death.

The major modifiable risk factors for cardiovascular disease are high blood pressure, high blood cholesterol, cigarette smoking, excessive body weight, and physical inactivity. The greatest potential for reducing coronary heart disease morbidity, disability, and mortality appears to be in prevention, by addressing these risk factors.

- Some people with *high blood pressure* have three to four times the risk of developing coronary heart disease and may have as much as seven times the risk of a stroke as do those with normal blood pressure. Clinical trials show that blood pressure reduction significantly reduces stroke mortality and can help to reduce deaths from coronary heart disease.
- Each 1 percent reduction in serum *cholesterol* level has been associated with a greater than 1 percent reduction in risk of coronary heart disease death.
- Prospective epidemiologic studies have documented a rapid and substantial reduction in coronary heart disease rates following *smoking* cessation. Reducing the proportion of youth who start to smoke and encouraging smoking cessation among current smokers are important preventive measures for reducing coronary heart disease incidence and mortality.
- A reduction in the proportion of Americans who are *overweight* and *physically inactive* can help lower coronary heart disease incidence and mortality. Risks of nonfatal myocardial infarction and coronary heart disease death increase with increasing levels of body mass index (BMI) (weight in kg divided by height in meter²) and with weight gain. Risks are lowest in men and women with BMI's of 22 or less and increase with modest elevations of BMI. Persons who are physically active have one-half the risk of both coronary heart disease incidence and mortality compared to persons who are sedentary.

Major disparities exist among population groups, with a disproportionate burden of death and disability from cardiovascular disease in minority and low-income populations. The age-adjusted death rate for coronary heart disease for the total population declined by 20 percent from 1987 to 1995; for blacks, the overall decrease was only 13 percent. Compared with rates for whites, coronary heart disease mortality was 40 percent lower for Asian Americans but 40 percent higher for blacks in 1995. Stroke is the only leading cause of death for which mortality is higher for Asian-American males than for white males.

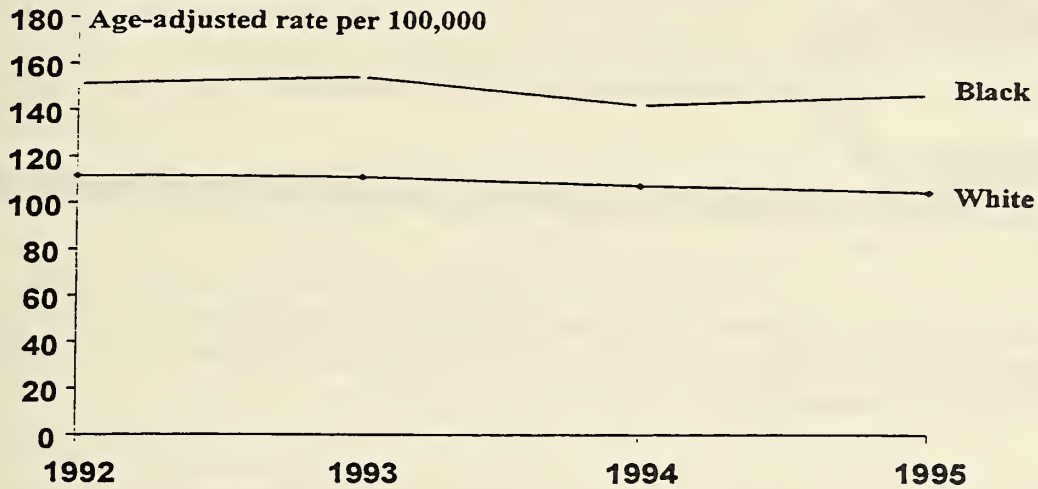
Disparities also exist in the prevalence of risk factors for cardiovascular disease. Racial and ethnic minorities have higher rates of hypertension, tend to develop hypertension at an earlier age, and are less likely to undergo treatment to control their high blood pressure. For example, from 1988 to 1994, 35 percent of black males ages 20 to 74 had hypertension compared with 25 percent of all men. When age differences are taken into account, Mexican-American men and women also have elevated blood pressure rates. Among adult women, the age-adjusted prevalence of overweight continues to be higher for black women (53 percent) and Mexican-American women (52 percent) than for white women (34 percent). Furthermore, the rates for regular screening for cholesterol show disparities for certain racial and ethnic minorities—only 50 percent of American Indians/Alaska Natives, 44 percent of Asian Americans, and 38 percent of Mexican-Americans have had their cholesterol checked within the past 2 years.

Our goal is to continue progress in reducing the overall death rates from heart disease and stroke and eventually to eliminate disparities among all racial and ethnic groups. To have the greatest impact toward that end, we have set near-term goals of reducing the heart disease and stroke mortality rates among blacks by 25 and 40 percent, respectively, from their 1995 level by the year 2000. Although age-adjusted death rates for cardiovascular disease among other minority groups are lower than the national average, there are subgroups within these populations that have high mortality rates from heart disease and stroke. We will develop strategies to reduce these mortality rates as well.

Near-Term Goals

- **Reduce the heart disease mortality rate among blacks by 25 percent.**
- **Reduce the stroke mortality rate among blacks by 40 percent.**

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

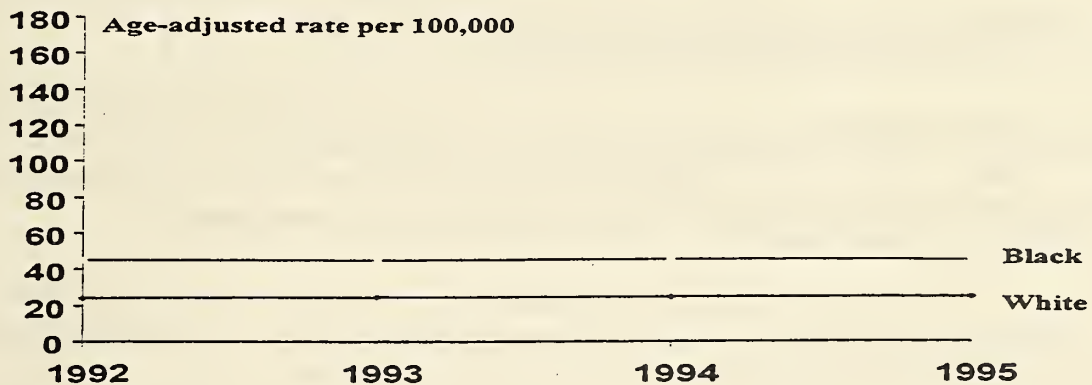


Coronary Heart Disease Mortality Rate Baselines:

- Total: 108 per 100,000 persons (age-adjusted) (1995)
- White: 105 per 100,000 persons (age-adjusted) (1995)
- Black: 147 per 100,000 persons (age-adjusted) (1995)
- American Indian/Alaska Native: 76 per 100,000 persons (age-adjusted) (1995)
- Asian and /Pacific Islander: 65 per 100,000 persons (age-adjusted) (1995)

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

Rates of Stroke Death, United States, 1992-1995



Stroke Mortality Rate Baselines:

- Total: 26.7 per 100,000 persons (age-adjusted) (1995)
- White: 24.7 per 100,000 persons (age-adjusted) (1995)
- Black: 45.0 per 100,000 persons (age-adjusted) (1995)
- American Indian/Alaska Native: 21.6 per 100,000 persons (age-adjusted) (1995)
- Asian and Pacific Islander: 25.8 per 100,000 persons (age-adjusted) (1995)

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



GOAL 4

Eliminate disparities in diabetes.

DIABETES, the seventh leading cause of death in the United States, is a serious public health problem affecting nearly 16 million Americans. The estimated total direct and indirect costs of diabetes for the United States in 1993 was \$98 billion.

The prevalence of diabetes in blacks is approximately 70 percent higher than whites and the prevalence in Hispanics is nearly double that of whites. The prevalence rate of diabetes among American Indians and Alaska Natives is more than twice that for the total population and at least one tribe, the Pimas of Arizona, have the highest known prevalence of diabetes of any population in the world.

Cardiovascular disease is the leading cause of death among people with diabetes, accounting for over one-half of all deaths. Achieving mortality reduction among high-risk populations will require targeted efforts to reduce cardiovascular risk factors among these groups, which is a focus of our goal on eliminating disparities in cardiovascular disease. Individuals with diabetes, however, face not only a shortened life span, but also the probability of multiple acute and chronic complications, including end-stage renal disease (ESRD), blindness, and lower extremity amputations. All of these complications have the potential to be prevented.

- If uncontrolled hypertension among people with diabetes were reduced by half, about one-quarter of *ESRD* due to diabetes could be prevented.
- *Diabetic retinopathy* is the leading cause of new cases of blindness among people 20 to 44 years of age. Clinical trials have demonstrated that approximately 60 percent of diabetes-related blindness can be prevented with good blood glucose control or by early detection and laser photocoagulation treatment, which is widely available but underused.
- One half of all *lower extremity amputations* can be prevented through proper foot care and by reducing risk factors such as hyperglycemia (abnormally high blood sugar), cigarette smoking, and high blood pressure.

Preventive interventions should target high-risk groups. Rates for diabetes-related complications such as ESRD and amputations are higher among blacks and American Indians compared to the total population. Even among similarly insured populations, such as Medicare recipients, blacks are more likely than

whites to be hospitalized for septicemia, debridement, and amputations — signs of poor diabetic control. Scientists are concerned that a number of people in these minority groups develop type 2 (non-insulin-dependent) diabetes in adolescence, and therefore face a lifetime of diabetes and its potential complications. Undiagnosed and poorly controlled diabetes increases the likelihood of serious complications; for every two persons who are aware of their illness, there is one person who remains undiagnosed.

Although the increasing burden of diabetes is alarming, the good news is that much of this major public health problem can be prevented with early detection, improved care, and diabetes self-management education. Diabetes presents both a challenge and an opportunity for public policy makers, health care providers, community leaders, and individuals with diabetes to apply prevention strategies known to make a significant impact. Recent studies in diabetes have confirmed that careful control of blood glucose levels is a strategy that works for preventing the complications of diabetes. The challenge is to make proper diabetes management part of daily clinical and public health practice.

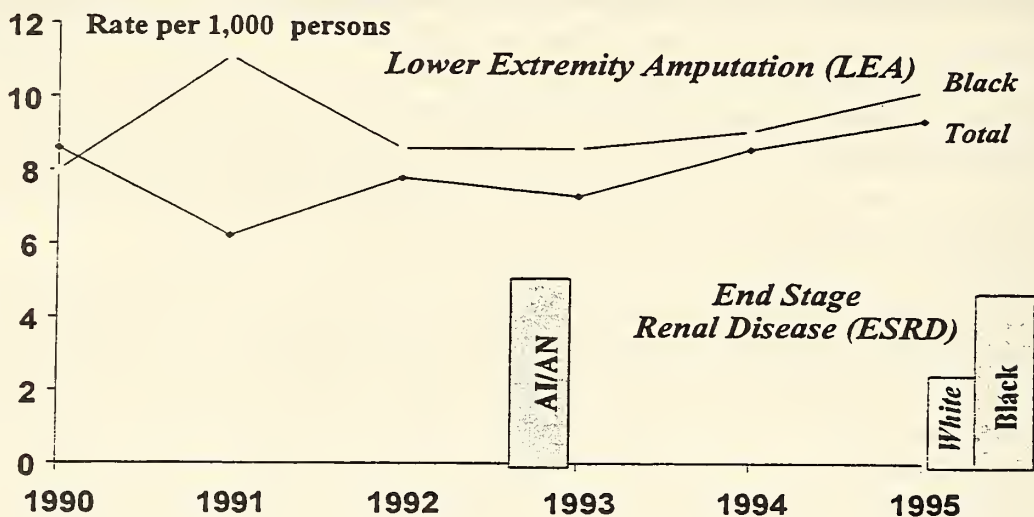
Therefore, our goal is to monitor progress in reducing diabetes by reducing the overall rate of diabetic complications among all individuals with diabetes and eventually to eliminate disparities among groups. As a major step toward that end, we have set two near-term goals: (1) reducing the rate of ESRD from diabetes among blacks and American Indians/Alaska Natives by 65 percent from their 1995 levels by the year 2000, and (2) reducing lower extremity amputation rates from diabetes among blacks by 40 percent from their 1995 levels. Rates of diabetic complications among Hispanics are also high; however, current data do not permit us to monitor diabetic complications among this group. We will develop strategies to reduce diabetes-related complications among all minority groups and to improve data collection.

Near-Term Goals

- **Reduce the rate of ESRD from diabetes among blacks and American Indians/Alaska Natives by 65 percent.**
- **Reduce lower extremity amputation rates from diabetes among blacks by 40 percent.**

The rates of diabetes-related complications used as outcome measures are crude indicators of progress in eliminating disparities; however, they are the only outcome measures available consistently on a national basis. We also will monitor behavioral practices and health care access issues as indicators of success. Examples of these indicators include diabetes-specific preventive care such as self-monitoring of blood glucose levels, clinic visits, diabetic foot care, and dilated-eye exams.

Diabetes-Related Complication Rates for ESRD and Lower Extremity Amputation by Race and Ethnicity, United States, 1990-1995



Lower Extremity Amputation Rate Baselines:

Total: 9.4 per 1,000 persons with diabetes (1995)
 Black: 10.2 per 1,000 person with diabetes (1995)

Data Source:

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

End-Stage Renal Disease Baselines:

Total: 3.0 per 1,000 persons with diabetes (1992-1995)
 White: 2.4 per 1,000 persons with diabetes (1992-1995)
 Black: 5.2 per 1,000 person with diabetes (1992-1995)
 American Indian/Alaska Native: 5.4 per 1,000 person with diabetes (1992)

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



GOAL 5

Eliminate disparities in HIV Infection/AIDS.

HIV INFECTION/AIDS is a leading cause of death for all persons 25 to 44 years of age. Between 650,000 and 900,000 Americans are estimated to be living with HIV infection. Approximately 62 percent (375,000) of the 604,200 adults and adolescents reported with AIDS in the United States have died from the disease.

AIDS has disproportionately affected minority populations. Racial and ethnic minorities constitute approximately 25 percent of the total U.S. population, yet they account for nearly 54 percent of all AIDS cases. While the epidemic is decreasing in some populations, the *number* of new AIDS cases among blacks is now greater than the number of new AIDS cases among whites.

There are several different HIV epidemics occurring simultaneously in the United States, each of which must address the specific population affected and their associated risk factors. For example, although the number of AIDS diagnoses among gay and bisexual men has decreased dramatically among white men since 1989, the number of AIDS diagnoses among black men who have sex with men have increased. In addition, AIDS cases and new infections related to injecting drug use appear to be increasingly concentrated in minorities; of these cases, almost 75 percent were among minority populations (56 percent black and 20 percent Hispanic). Of cases reported among women and children, more than 75 percent are among racial and ethnic minorities.

During 1995 and 1996, AIDS death rates declined 23 percent for the total U.S. population while declining only 13 percent for blacks and 20 percent for Hispanics. Contributing factors for these mortality disparities include late identification of disease and lack of health insurance to pay for drug therapies. The cost of efficacious treatment, between \$10,000 and \$12,000 per patient per year, is a major hurdle in the effort to ensure equitable access to available drug therapies.

Inadequate recognition of risk, detection of infection, and referral to follow-up care are major issues for high-risk populations. About one-third of persons who are at risk of HIV/AIDS have never been tested. Better prevention strategies are needed that are acceptable to the target community (i.e., they must be culturally and linguistically appropriate), and the capability of organizations serving at-risk populations to develop, implement, evaluate, and fund prevention and treatment programs must be improved. Efforts should include risk reduction counseling, street and community outreach, prevention case management services, and help for individuals at risk in gaining access to HIV testing, treatment, and related services.

At this moment, there are many causes for optimism in the fight against HIV/AIDS. HIV prevention efforts have contributed to slowing the spread of the disease. For the first 6 months of 1996, there was an overall decrease in deaths among persons with AIDS, attributed primarily to the effect of antiretroviral therapies on the survival of persons with HIV infection. The decrease in the growth of AIDS cases in minority populations, however, has not been so strong.

To enable HIV-infected persons to benefit from treatment advances, HIV counseling and testing programs in screening and health care settings must better facilitate early diagnosis of HIV infection and ensure that HIV-infected persons have access to care and treatment services. Continued emphasis on behavioral risk reduction and other prevention strategies targeted to these populations is still the most effective way to reduce HIV infections.

Although advances in prevention and treatment are improving the quality of life for individuals living with HIV/AIDS, not everyone is benefiting equally from this progress. Concerns regarding education about the benefits of knowing one's serostatus, access to counseling and testing, and referral and access to medical services, including efficacious therapies, will continue to guide the development and administration of Federal initiatives to prevent HIV transmission and improve access to care for individuals living with HIV/AIDS.

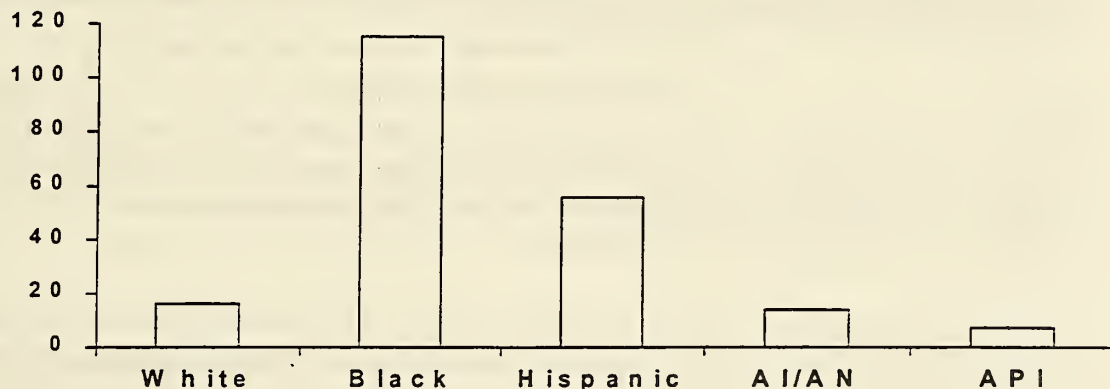
Our goal is to continue progress in increasing the overall availability of early diagnosis of HIV infection and ensuring access to appropriate health services for all and to eventually eliminate disparities among groups. By the year 2000, the combined efforts of Medicaid, Medicare, and HRSA's Ryan White CARE Act will ensure early and equal access to life-enhancing health care and appropriate drug therapies for at least 75 percent of low-income persons living with HIV/AIDS. We will establish educational outreach to all major medical providers to promote the current standard of clinical care for all persons living with HIV/AIDS, including Medicaid-eligible women and children with HIV infection.

Near-Term Goal

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

AIDS Case Rates in Persons ≥ 13 Years of Age by Race/Ethnicity, United States, 1996

Rate per 100,000 persons



Adult (≥ 13 years) AIDS Case Rate Baselines:

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

Data Source: Adult/Adolescent AIDS Reporting System. CDC

Pediatric (<13 years) AIDS Case Rate Baselines:

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

Data Source: Pediatric AIDS Case Reporting System. CDC



GOAL 6

Eliminate disparities in child and adult immunization rates.

THE REDUCTION in incidence of vaccine-preventable diseases is one of the most significant public health achievements of the past 100 years. This success is best illustrated by the global eradication of smallpox, achieved in 1977. The major factor in this success is the development and widespread use of vaccines, which are among the safest and most effective preventive measures. Billions of dollars are saved each year through the use of vaccines.

Childhood immunization rates are at an all-time high, with the most critical vaccine doses reflecting coverage rates of over 90 percent. The 1996 immunization coverage targets for all five vaccines (measles, mumps, and rubella [MMR]; polio; diphtheria, tetanus, and pertussis [DTP]; *Haemophilis influenza* type B [Hib]; and hepatitis b [Hep B]) were exceeded. Although immunization rates have been lower in minority populations compared with the white population, minority rates have been increasing at a more rapid rate, thus significantly narrowing the gap. For example, four of the five 1996 coverage targets were met for blacks. Current efforts must be sustained in order to achieve and maintain at least 90 percent coverage for all recommended vaccines in all populations.

Although coverage for preschool immunization is high in almost all States, pockets of need, or areas within each State and major city where substantial numbers of underimmunized children reside, continue to exist. These areas are of great concern because, particularly in large urban areas with traditionally underserved populations, there is a potential for outbreaks of vaccine-preventable diseases.

In addition to the very young, older adults are at increased risk for many vaccine-preventable diseases. Approximately 90 percent of all influenza-associated deaths in the United States occur in people aged 65 and older, the fastest growing age group of the population. Reduction of deaths in this age group has been hindered in part by relatively low vaccine utilization. Immunization is one of the most cost-effective strategies to prevent needless morbidity and mortality. Each year, however, an estimated 45,000 adults die of infections related to influenza, pneumococcal infections, and hepatitis B despite the availability of safe and effective vaccines to prevent these conditions and their complications. In addition, the overall cost to society for vaccine-preventable diseases exceeds \$10 billion each year.

There is a disproportionate burden of these diseases in minority and underserved populations. Although vaccination levels against pneumococcal infections and influenza among people 65 years and over have increased slightly for blacks and Hispanics, the coverage in these groups remains substantially below the general population and the year 2000 targets.

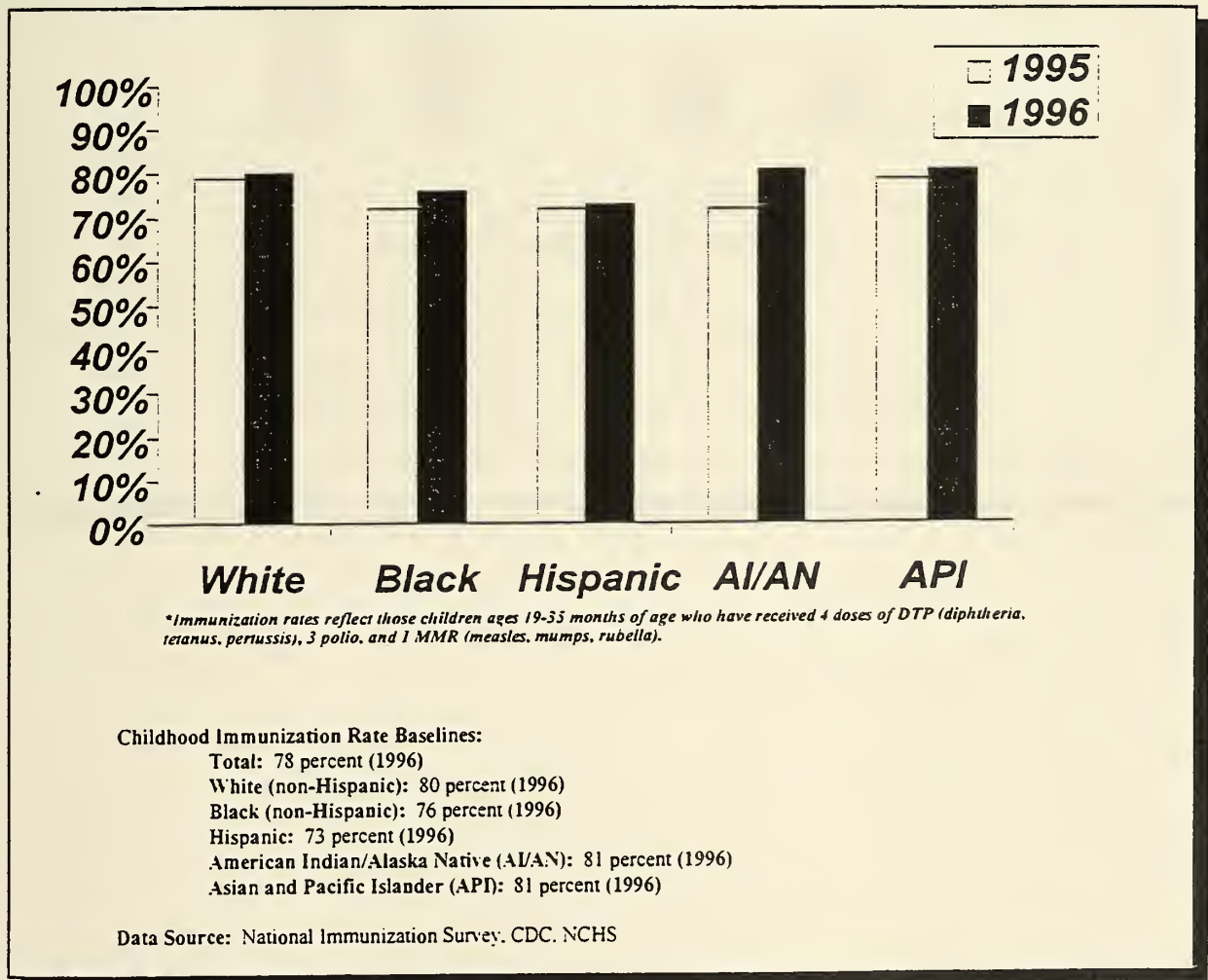
Childhood Immunization

Our goal is to enhance current immunization efforts in order to achieve and maintain at least 90 percent coverage for all recommended vaccines in all populations and to eliminate remaining disparities among groups.

Near-Term Goal

Achieve and maintain at least 90 percent coverage for all recommended childhood vaccines in all populations

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



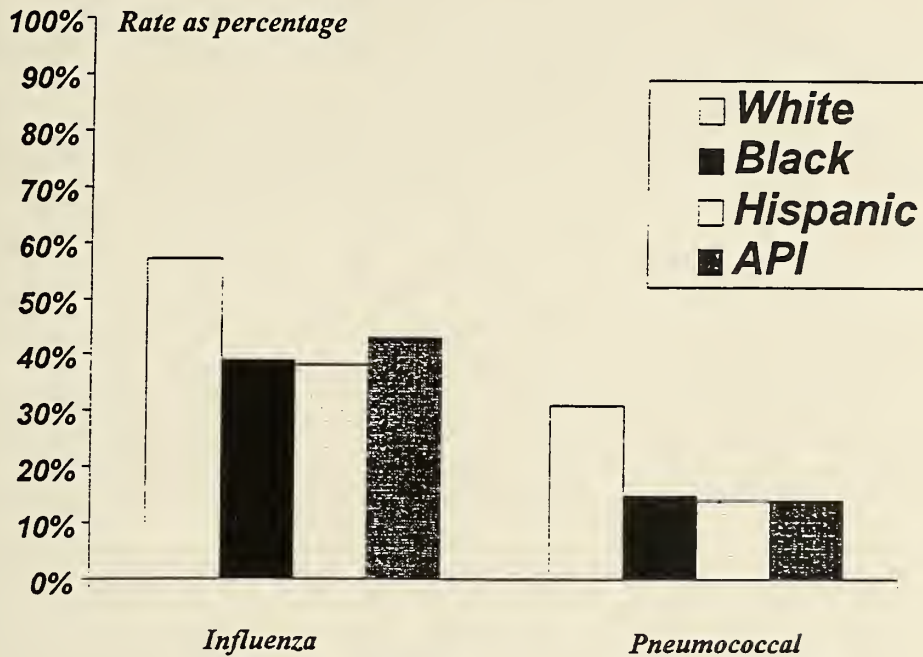
Adult Immunization

Our goal is to increase pneumococcal and influenza immunizations among all adults aged 65 years and older to 60 percent and eventually to eliminate disparities among groups. To reach this goal by the year 2000, we need to nearly *double* the 1994 influenza immunization rates among blacks, Hispanics, and Asians and Pacific Islanders and *quadruple* the 1994 pneumococcal immunization rates among these groups.

Near-Term Goal

Increase pneumococcal and influenza immunizations among all adults aged 65 years and older to 60 percent

Pneumococcal and Influenza Immunization Rates for Persons 65 Years and Older by Race and Ethnicity,* United States, 1994



Immunization Rate Baselines for Individuals Age ≥ 65 Years:

Influenza:

Total: 55 percent (1994)
 White: 57 percent (1994)
 Black: 39 percent (1994)
 Hispanic: 38 percent (1994)
 Asian/Pacific Islander: 43 percent (1994)

Pneumococcal:

Total: 30 percent (1994)
 White: 31 percent (1994)
 Black: 15 percent (1994)
 Hispanic: 14 percent (1994)
 Asian/Pacific Islander: 14 percent (1994)

