

COMMENTARY

Our Commitment to Eliminate Racial and Ethnic Health Disparities

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Both the life expectancy and the overall health of Americans have improved greatly over the last century, but not all Americans are benefiting equally from advances in health prevention and technology. There is compelling evidence that race and ethnicity correlate with persistent health disparities in the burden of illness and death. For example, compared with their white counterparts, black babies are twice as likely to die during their first year of life, and American Indian babies are 1.5 times as likely. The rate of diabetes among Native Americans is three to five times higher than the rest of the American population, and among Hispanics it is twice as high as in the majority population. Although constituting only 11% of the total population in 1996, Hispanics accounted for 20% of new tuberculosis cases. Also, women of Vietnamese origin suffer from cervical cancer at nearly five times the rate for white women.

Current information about the biologic and genetic characteristics of these populations does not solely explain these health disparities. These disparities result from complex interactions among genetic variations, environmental factors, specific health behaviors, and differences in health care access and quality. While the diversity of the American population may be one of our nation's greatest assets, it also represents a range of health improvement challenges—challenges that must be addressed by individuals, communities, and the nation. The demographic changes that are anticipated during 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 depends substantially on our success in improving the health of racial and ethnic minorities. A national focus on disparities in health status is also particularly important

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as major changes unfold in how health care is delivered and financed.

In a February 1998 radio address, then-President Clinton committed the nation to an ambitious goal by the year 2010: to eliminate the disparities experienced by racial and ethnic minority populations in six health-related areas, including cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS, immunization rates, and infant mortality. 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. Clinton's goal parallels the focus of *Healthy People 2010*—the nation's health objectives for the twenty-first century—which Donna Shalala, former Secretary of the Department of Health and Human Services (DHHS), and I released in January 2000.

Achieving this vision will require a major national commitment to identify and address the underlying causes of higher disease and disability levels in racial and ethnic minority communities. These causes include poverty, lack of access to quality health services, environmental hazards in homes and neighborhoods, and the scarcity of effective prevention programs tailored to the needs of specific communities. The effort will require improved collection and use of standardized data to correctly identify all high-risk populations, and to monitor the effectiveness of health interventions targeting these groups. Research dedicated to a better understanding of the relationships between health status, race, ethnicity, and socioeconomic background will help us acquire new ways to eliminate disparities and to apply our existing knowledge.

I. THE ROLE OF THE COMMUNITY

While leaders in the federal government have both the opportunity and the obligation to set the direction for the nation, our responsibility does not end here. To reduce health care disparities in our nation, we must reach out to communities. Creating real and meaningful partnerships is essential to achieving a balanced community health system. This system needs to make access to quality care available to all, and balance early detection of disease with health promotion and disease prevention. Drawing on community involvement, from schools, faith-based organizations, and civic and local groups, this project is realizable. Health and quality of life rely on many community systems and factors, not simply on a well-functioning health and medical care system. Making changes within existing systems can effectively and efficiently improve the health of a large segment of the community. Also, environmental and policy approaches, such as better street lighting and policies to fortify foods, tend to have a greater impact on the whole community than do

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individual-oriented approaches.

Communities experiencing the greatest success in addressing health and quality-of-life issues have drawn upon public health, health care, businesses, local governments, schools, civic organizations, voluntary health organizations, faith-based organizations, park and recreation departments, and other interested groups and private citizens. Communities that are eager to improve the health of specific at-risk groups have found that they are more likely to be successful if they work collaboratively within their communities, and if the social and physical environments are conducive to supporting healthy changes.

As noted in the Conference Edition of *Healthy People 2010*, community health promotion programs should include community participation from at least three of the following sectors: government, education, business, faith-based organizations, health care, media, voluntary agencies, and the public. Programs should also include community assessments to determine community health problems, resources, and perceptions and priorities for action, as well as measurable objectives that address at least one of the following: health outcomes, risk factors, public awareness, or services and protection. Monitoring and evaluation processes are other key components. Finally, comprehensive, multifaceted, and culturally relevant interventions with multiple targets for change are critical.

Health promotion programs need to be sensitive to the diverse cultural norms and beliefs of the people for whom the programs are intended. Achieving such sensitivity continues to be a challenge, as the nation's population becomes increasingly diverse. To ensure that interventions are culturally sensitive, linguistically competent, and appropriate for people of all races, ethnicities, genders, sexual orientations, ages, and disability statuses, members of the populations served, and their gatekeepers, must be involved in the community assessment and planning process.

Community assessment helps to identify the cultural traditions and beliefs of the community, and the education, literacy level, and language preferences necessary for the development of appropriate materials and programs. In addition, community assessments can help identify levels of social capital and community capacity, as well as the skills, resources, and abilities needed to manage health improvement programs in communities.

Educational and community-based programs must be supported by accurate, appropriate, and accessible information derived from a scientific base. Increasing evidence supports the effectiveness of health education and health promotion in schools, workplaces, and health care facilities. Examples of gaps in research include the dissemination and diffusion of

effective programs, new technologies, and approaches to disadvantaged and special populations.

Communities also need to be involved as partners in conducting research to ensure that the content of prevention efforts is tailored to meet their needs. Their research should also enhance the appropriateness and sustainability of science-based interventions and prevention programs, as well as ensure that the lessons of research are transferred back to the community. Sustainability is necessary for successful research to be translated into programs of lasting benefit to communities.

II. STRATEGIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

In launching *Healthy People 2010*, DHHS's first step was 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 were identified, and research agendas were developed to address them. New programs or modifications of existing programs were recommended when appropriate. In addition, the Department provided a national framework for public and private sector collaboration to eliminate health disparities in the six areas first highlighted by former President Clinton.

A. 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. The lifetime chance of developing cancer is nearly 50% for men and nearly 40% for women in the United States. About half of those who develop cancer will die from it. Minority groups suffer disproportionately, with disparities in both cancer mortality and incidence rates. For men and women combined, blacks have a cancer death rate about 35% higher than that for whites (171.6 *vs.* 127 per 100,000). The death rate for cancer among black men is about 50% higher than it is for white men (226.8 *vs.* 151.8 per 100,000). Mortality from prostate cancer for black men is more than twice that of white men (55.5 *vs.* 23.8 per 100,000). The death rate for lung cancer is about 27% higher for blacks than for whites (49.9 *vs.* 39.3 per 100,000).

Paralleling the death rate, the incidence of lung cancer in black men is about 50% 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. Native Alaskans suffer disproportionately higher rates of cancers of the colon and rectum than do whites. Vietnamese women in the United

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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. White, non-Hispanic males are nine times more likely to contract invasive melanoma of the skin than their black counterparts (3.7 *vs.* 0.4 per 100,000), and more than nine times more likely to die from it (2.9 *vs.* 0.3 per 100,000).

For some cancers, early detection can dramatically reduce the risk of death. Regular mammography screening and appropriate follow-up care can reduce deaths from breast cancer by about 30% for women fifty years of age and older. Screening by Pap smear for cervical cancer, along with appropriate follow-up care, can virtually eliminate the risk of developing this disease. Colorectal cancer screening is recommended for people forty-five to eighty years old, but data on screening rates is scarce. Screening for prostate cancer remains controversial, and 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 are available. 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 black women have not had a mammogram, 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 face barriers related to language, culture, and negative provider attitudes, all of which negatively affect their health status. Eliminating these differences is critical, and will be the focus of attention for the DHHS initiative to help identify and understand approaches that have proven successful in some communities. The tracking of 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.

During Breast Cancer Awareness Month in October 1998, DHHS announced new efforts to encourage mammography screening among special populations, including 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 (NCI) co-sponsored an educational campaign about the new annual Medicare mammography benefit and the importance of regularly scheduled screening mammograms. In addition, HCFA offered

mammograms to older African-American and Hispanic-American women in Atlanta, Chicago, Cleveland, Los Angeles, Philadelphia, Washington, D.C., and San Antonio. HCFA is also working with the NCI to develop and disseminate culturally appropriate breast cancer materials geared toward Asian-American and Pacific-Islander women. The Centers for Disease Control and Prevention (CDC) offers the National Breast and Cervical Cancer Early Detection Program, which provides free or low-cost mammograms to uninsured, low-income, elderly, minority, and Native-American women throughout the country. One million mammograms have been conducted through this program.

The federal battle against minority cancer received a boost when the NCI announced a \$60 million program to address the unequal cancer burden within certain populations in the United States over the next five years. Eighteen grants at seventeen institutions will create or implement cancer control, prevention, and research and training programs in minority and underserved populations. The cooperative relationships established by the networks will be used to foster cancer awareness activities, support minority enrollment in clinical trials, and encourage and promote the development of minority junior biomedical researchers.

B. Cardiovascular Disease

Cardiovascular disease, primarily in the form of coronary artery disease (CAD) and stroke, kills nearly as many Americans as all other diseases combined, and is among the leading causes of disability in the United States. It is the leading cause of death for all racial and ethnic groups. 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. Prevention through modification of these risk factors seems to provide the most potential for reducing morbidity, disability, and mortality due to cardiovascular disease. Minorities suffer disproportionately from cardiovascular disease. For instance, while the age-adjusted death rate from CAD in the population as a whole declined 20% from 1987 to 1995, the decrease in the black population during the same period was only 13%. Compared with rates for whites, CAD mortality was 40% lower for Asian Americans, but 40% higher in blacks.

People with high blood pressure, also known as hypertension, are three to four times more likely to develop CAD when compared to controls with normal blood pressure, and may have as much as seven times the risk

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of suffering a stroke. Reduction in blood pressure significantly reduces stroke mortality and can also help to reduce deaths from CAD. Racial and ethnic minorities tend to have higher rates of hypertension, 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% of black males, aged twenty to seventy-four, had hypertension, while the rate in the general population was 25%. When age differences are taken into account, Mexican-American men and women also have elevated blood pressures when compared to the population at large. The prevalence of hypertension in minorities may be a direct cause of their higher overall risk of cardiovascular disease.

Being overweight is also a risk factor for cardiovascular disease that disproportionately affects minorities. Risk of heart attack and CAD increases with increasing body mass index (BMI) and with weight gain. Among adult women, the age-adjusted prevalence of being overweight continues to be higher for black women (53%) and Mexican-American women (52%) than for white women (34%), which may contribute to a heightened cardiovascular morbidity risk in these minority groups.

High cholesterol is another risk factor for cardiovascular disease that is more common in certain ethnic and racial minorities, many of whom do not check their cholesterol levels as often as do whites. It has been shown that each 1% reduction in serum cholesterol level has been associated with a greater than 1% reduction in risk of death from CAD. However, the current rates for regular screening for cholesterol show that only 50% of American Indians and Alaska Natives, 44% of Asian Americans, and 38% of Mexican Americans have had their cholesterol checked within the past two years, as compared to a rate of 67% for all U.S. adults.

Tobacco use, a leading cause of cardiovascular disease, also varies in ethnic and racial minority groups, and is at an overall rate of about 25% for adults in the United States. American Indians and Alaska Natives have the highest prevalence of tobacco use at 39%, while African Americans have a rate of about 26% among adults.

Finally, physical activity helps prevent heart disease, and the overall number of adults who report no participation in physical activity is 29%. However, the rates of African Americans and Hispanics who report no participation in physical activity are higher than the average, at 39% and 35%, respectively.

The National Institutes of Health (NIH) has many programs designed to address heart health in minorities. For example, one pilot program in Washington, D.C., called “Salud Para su Corazon (For the Health of Your Heart),” works through the Latino community using Latino traditions to

provide science-based health messages, educational materials, and action strategies to improve heart health in Latinos. Because of the program's success in changing behaviors and increasing awareness, the National Heart, Lung and Blood Institute at the NIH is encouraging the use of this model in other Latino communities nationwide.

C. Diabetes

Diabetes, the seventh leading cause of death in the United States, is a serious public health problem affecting nearly sixteen million Americans. The estimated total cost of diabetes for the United States in 1993 was \$98 billion. The rate of diabetes for blacks is approximately 70% higher than for whites, and the rate in Hispanics is double that of whites. The prevalence of diabetes among American Indians and Alaska Natives is nearly three times that for the total population, and the Pima Indians of Arizona have the highest known prevalence of diabetes in the world.

Cardiovascular disease is the leading cause of death among people with diabetes; it accounts for over one-half of all diabetes-related deaths. Achieving mortality reduction among high-risk populations will require targeted efforts to reduce cardiovascular risk factors among these groups. Diabetics also face the probability of multiple acute and chronic complications, other than cardiovascular disease, including end-stage renal disease (ESRD), blindness, infections, and peripheral neuropathies, which may lead to lower extremity amputations. All of these complications, which have the potential to be delayed and possibly prevented, are more pronounced in minority populations. 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 rates in the total population. Even among similarly insured populations, such as Medicare recipients, blacks are more likely than whites to be hospitalized for septicemia, debridement, amputations, and other complications of poor diabetic control. There is concern that some people in minority populations are developing type II (non-insulin-dependent) diabetes in adolescence, and therefore are more likely to face a lifetime of diabetes and its potential complications. Undiagnosed and poorly controlled diabetes increases the likelihood of serious complications; for every two people 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 many major public health problems can be prevented with early detection, improved care, and diabetes self-management education. For

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public policy makers, health care providers, community leaders, and individuals with diabetes, the disease presents an opportunity 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 every day clinical and public health practice.

Toward the goal of reducing the public health burden of diabetes, the Indian Health Service awarded 286 grants in 1998 to Indian communities for programs focused on primary prevention of diabetes and promotion of healthy lifestyle choices, including mental health services and substance abuse prevention and treatment programs. These 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. Comparing the 1994-96 Indian adjusted death rates with the overall U.S. population, the American-Indian and Alaska-Native populations have diabetes death rates that are 3.5 times greater than the overall population.

In addition, the Health Resources and Services Administration (HRSA) launched an intensive effort to help its community health centers diagnose and treat diabetes. These centers are the health care provider of choice for ten million people, 65% of whom are racial and ethnic minorities. Also, 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 evaluated for transplantation. The purpose is to ensure equal opportunity for transplantation as part of the patient's long-term care plan.

D. HIV/AIDS

HIV infection and AIDS are major problems for the American people and our health care system. There are an estimated 650,000 to 900,000 Americans living with HIV infection. Racial and ethnic minorities are disproportionately affected by this problem. These minorities constitute approximately 25% of the total U.S. population, yet they account for nearly 54% 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. In fact, in 2000, 70% of new AIDS cases were in blacks (48%) and Hispanics (22%).

There are several different HIV epidemics occurring simultaneously in the United States, each affecting specific populations. For example, although the number of AIDS diagnoses among gay and bisexual white

men has decreased dramatically since 1989, the number of AIDS diagnoses among gay and bisexual black men has increased. Similarly, AIDS cases and new HIV infections related to intravenous drug use appear to be increasingly concentrated in minorities; of these cases, about 75% were among minority populations (56% black and 20% Hispanic). Of HIV/AIDS cases reported among women and children, more than 75% are among racial and ethnic minorities.

Statistics show that during 1995 and 1996, AIDS death rates declined 23% for the total U.S. population, while declining only 13% for blacks and 20% for Hispanics. Contributing factors for these mortality disparities include late identification of disease and lack of health insurance to pay for drug therapies. Inadequate recognition of risk, detection of infection, and referral to follow-up care are major issues for some high-risk populations. About one-third of persons who are at risk of HIV/AIDS have never been tested.

HIV-counseling and testing programs must better facilitate the early diagnosis of HIV infection and ensure that HIV-infected persons have access to care and treatment services that will enable them to benefit from treatment advances. A continued emphasis on behavioral risk reduction and other prevention strategies targeted to at-risk populations is still the most effective way to reduce HIV infections. Efforts should include risk-reduction counseling, street and community outreach, preventative case management services, and help for at-risk individuals in gaining access to HIV testing, treatment, and related services.

DHHS has introduced many initiatives to combat the HIV/AIDS epidemic in America. In October 1998, DHHS joined the Congressional Black Caucus in announcing a special package of initiatives in response to the severe and ongoing problem of HIV/AIDS in racial and ethnic minority communities. The comprehensive new initiative invested an unprecedented \$156 million in fiscal year 1999 to improve the nation's effectiveness in preventing and treating HIV/AIDS in African-American, Hispanic, and other minority communities. DHHS received \$251 million from Congress in fiscal year 2000 to continue to combat HIV/AIDS in minority communities. Resources have also been broadened for research on HIV/AIDS and minorities, including an increased emphasis on behavioral research linking substance abuse and HIV-infection rates. Funding for community-based organizations to provide new services, technical assistance, and faith-based HIV-prevention programs has been made available through the CDC. There are many opportunities to address the racial and ethnic disparities in HIV/AIDS care and treatment, all of which will benefit America as a whole.

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E. Immunization Rates

The reduction in incidence of vaccine-preventable diseases is one of the most significant public health achievements of the past hundred years. One major factor in this success is the development and widespread use of vaccines, which are among the safest and most effective preventive measures available. Childhood immunization rates are at an all time high for all people in the United States. Immunization rates are lower for minority populations as compared with whites, but the gap is narrowing, and minority rates are increasing at a rapid rate. Preschool immunization is high in almost all states, but areas of need continue to exist.

In addition to the very young, older adults are at increased risk for many vaccine-preventable diseases. Approximately 90% of all influenza-associated deaths in the United States occur in people aged sixty-five and older, the fastest growing demographic group in the population. Each year an estimated 30,000 adults die from influenza and pneumococcal infections, despite the availability of safe and effective vaccines to prevent these conditions and their complications. There is a disproportionate burden of these diseases in minority and underserved populations. Although the levels of vaccination against pneumococcal infections and influenza among people sixty-five years and over have increased slightly for blacks and Hispanics, the coverage in these groups remains substantially below the general population.

DHHS has crafted several plans to achieve the goal of increasing minority immunization rates. For example, there is a Spanish-language childhood immunization public awareness campaign to create and distribute culturally relevant and language appropriate educational materials. The theme, “Vacunelo a Tiempo y Todo el Tiempo (Vaccinate Your Children On Time, Every Time),” encourages parents and caregivers to talk with their child’s health care provider to make sure their child is up to date on immunizations by age two.

In an effort to increase immunization rates among older adults, DHHS launched an initiative providing limited Medicare coverage for flu shots for the elderly in 1993. An aggressive outreach strategy by HCFA to inform minority seniors about immunizations includes the mailing of some eight million postcards in four languages to Medicare beneficiaries as reminders, as well as television and radio announcements in Spanish.

F. Infant Mortality

Infant mortality (IM) is an important measure of a nation’s health, as well as a worldwide indicator of health status. Although IM in the United

States has declined steadily over the past several decades, and is at a record low of 7.2 deaths per 1,000 live births (1996), the United States still ranks twenty-fourth in infant mortality among industrialized nations. Significant racial and ethnic disparities in our nation's infant mortality rate (IMR) may be the principal reason for our poor international showing. These disparities exist both between and within racial and ethnic groups. For instance, compared to a white baby, an American-Indian baby and a black baby are 1.5 and 2 times, respectively, more likely to die in their first year of life. Infant death rates among blacks, American Indians and Alaska Natives, and Hispanics were all above the national average in 1995 and 1996; black babies fared the worst at 14.2 deaths per 1,000 live births (1996), a rate nearly twice that of white infants, whose IMR was only 6 per 1,000 (1996).

IMRs also differ within certain ethnic and minority groups. For instance, while the overall American Indian IMR is 9 per 1,000 (1995), some Native-American communities have IMRs approaching twice the national rate. Similarly, the overall Hispanic IMR of 7.6 per 1,000 (1995) does not reflect the diversity within Hispanic communities; the IMR for Puerto Ricans, for example, was significantly higher than the Hispanic aggregate at 8.9 per 1,000 (1995).

The IMR of a nation is greatly affected by its ability to provide effective prenatal care to all pregnant women. Disparities among races and ethnic groups in quality and access to prenatal care is a major failure of our health care system, and a primary reason for our high IMR, relative to other industrialized nations. It is a known fact that women who receive prenatal care in the first trimester have better pregnancy outcomes than women who receive little or no prenatal care. The likelihood of delivering a very low birth weight (VLBW) infant (defined as less than 1,500 grams or 3 lbs. 4 ozs.) is 40% higher among women who receive late or no prenatal care, compared with women who begin receiving such care in the first trimester. VLBW infants are about sixty-five times as likely to suffer an early death than infants who weigh at least 1,500 grams. It is also a fact that while 84% of white women receive early prenatal care, only 71% of black and Hispanic women receive prenatal care in the first trimester.

There is also a great deal of disparity seen in the IMRs of blacks relative to whites when looking at many of the leading causes of infant death. For example, there is a black to white ratio of 2.8:1 for deaths from respiratory distress syndrome, a ratio of 2.7:1 for deaths from infections specific to the perinatal period and newborns affected by maternal complications of pregnancy, and a ratio of 2.6:1 when considering sudden infant death syndrome (SIDS). However, the greatest black-white disparity,

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at a ratio of 4.1:1, exists in pre-term births (PTBs) and unspecified low birth weight. Overall, PTBs occur in 17.7% of black mothers, but in only 9.7% of white mothers. Differences in various medical conditions and social practices may contribute to this racial disparity in PTBs, including higher rates of both chronic hypertension and bacterial vaginosis among black women. Minority infants are also far more likely than white infants to die of SIDS, with blacks and some American-Indian and Alaska-Native populations at greatest risk.

We can significantly reduce infant mortality by increasing our efforts to address the disparities that contribute to the higher IMRs seen in our ethnic and racial minority populations. In particular, PTB and SIDS rates seem responsive to variations in the prevalence of other identifiable risk factors that are more common in certain minority populations, such as socio-economic and demographic factors, certain medical conditions, quality of, and access to, health care, and practices like placing babies on their backs to sleep. 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.

To further reduce our nation's IMR, we must focus on modifying the behaviors, lifestyles, and conditions that affect birth outcomes. These include smoking, substance abuse, poor nutrition, and other psychosocial problems such as domestic violence and abuse, lack of prenatal care, medical problems, and chronic illness. We need to pay special attention to how these factors differentially impact racial and ethnic minorities.

As DHHS continues its efforts to reduce IM and increase prenatal care through HRSA programs, the National Institute of Child Health and Human Development (NICHD) has also broadened its efforts to reduce SIDS. As part of the "Back To Sleep" campaign that encourages parents and caregivers to place children on their backs to prevent SIDS, NICHD distributed packages of "Back To Sleep" educational materials to all licensed day care centers in the United States, including many that serve black and Hispanic communities.

In conjunction with "SIDS Awareness Month" in October 1999, DHHS announced a new initiative to develop and implement a community-based approach to eliminate the disparity in SIDS rates impacting black babies. The new campaign is being led by NICHD, and will be carried out by a 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.

CONCLUSION

In attempting to eliminate disparities among different sub-populations, 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 benefited 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 DHHS has developed a formal Racial and Ethnic Initiative. Steps to advance this Initiative include publishing a state-by-state look at risks for chronic diseases and injury for the five major racial and ethnic groups, completed in March 2000. This work identifies wide disparities, even among members of the same racial and ethnic group living in different states. DHHS has also developed an informational World Wide Web site for the Initiative to be used by interested media and communities (<http://www.raceandhealth.hhs.gov>), and has organized internal workgroups, for each of the six areas, that are looking at existing programs at DHHS and making recommendations. As part of this program, data collection systems are being reviewed and recommendations are being made on how to improve data collection for racial and ethnic minorities.

The goals of the initiative to eliminate racial and ethnic disparities are consistent with the principles upon which the U.S. Public Health Service was founded in 1798. At that time, the City of Philadelphia had, only a few years earlier, suffered an epidemic of yellow fever, which killed 10% of the city's population and sent half of the population fleeing the city altogether. When it was learned that the epidemic was spread from merchant ships coming to Philadelphia from the West Indies, our founding fathers saw the value of providing a national hospital system to care for merchant seamen. And so we learned that to the extent we care for the most vulnerable populations, we do the most to protect the overall health of the nation. The goal of eliminating disparities in health care by 2010 is ambitious. Yet in the twenty-first century, neither history nor humanity can settle for less. The pursuit of these goals will result in a stronger, improved public health system that better responds to the needs of everyone.