



# Closing the Gap

A newsletter of the Office of Minority Health, U.S. Department of Health and Human Services

Special Issue — March 1998

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OFFICE OF PUBLIC HEALTH  
AND SCIENCE  
U.S. DEPARTMENT OF HEALTH  
AND HUMAN SERVICES

## The U.S. and U.K. Collaborate on Minority Health

Dear Colleagues:

U.S. and U.K. officials sign joint statement of intent to collaborate on minority health.

In this special issue of *Closing the Gap* newsletter, we are pleased to share excerpts of speeches and papers prepared for "Health Gain for Black and Minority Ethnic Communities," a conference between the United States and the United Kingdom (U.K.) that took place on September 16-18, 1997 in London, England.

At the request of Veena Bahl, the U.K. Department of Health's ethnic health advisor, the Office of Minority Health (OMH) helped organize the conference to provide a forum for the U.S. and U.K. to exchange information on minority health needs in each country, and to develop an agenda for long-term collaboration. We assembled people who are among our top consultants to share their knowledge and perspective on minority health.

About 150 people attended the conference. Workshop topics included: ensuring access and quality of services for minority groups; developing primary care; and involving minority consumers in the delivery of services. Conference participants identified the following areas as priorities: improving access to services; improving research on minority health; empowering minority consumers; improving data collection; and enhancing leadership and organization in minority health.

The highlight of the conference was the signing of a joint statement of intent between the U.S. Department of Health and Human Services and the Department of Health of the United Kingdom to collaborate on improving minority health. Following the conference, U.S. and U.K. workgroups identified areas for collaboration and developed action steps. The core areas for initial collaboration are improving access to culturally competent health services and developing the voice of our communities and grassroots sectors. Each country has organized a steering committee and workgroups on these health areas.

Our goal is to develop a cooperative process for improving the health of racial and ethnic minorities in the U.S. and the U.K. To achieve this end, we will seek the involvement of federal, state, and local government agencies, as well as the involvement of private sector organizations. To date, we have shared information on OMH's authorizing legislation, mission, and the guidelines for racial and ethnic minority data collection in the U.S. Additionally, U.K. conference participants have been added to our database at the OMH Resource Center, and we are exploring other ways to further improve the exchange of minority health information.

A follow-up meeting to report on progress of this collaboration is planned for September 1998, in Washington, D.C. If you would like more information on U.S./U.K. activities, contact Ms. Georgia Buggs at OMH, 301-443-5084.

*Clay E. Simpson, Jr., MSPH, PhD*

# Race, Ethnicity, Class, and Culture

*By Marcia Bayne Smith, DSW, Assistant Professor-Urban Studies Department  
Queens College-City University of New York*

Several studies have shown that the highest rates of poverty are concentrated among the same U.S. subgroups of non-White people who are also those with disproportionately worse health status. This health status of racial and ethnic minorities in the U.S. is a function of the very structure of the U.S. society. In this structure, racism and economic inequality are institutionalized.

The result of this stratification is that greater deprivations accrue to those who are poor and non-White. This is true in every arena—material, emotional, psychological, and of every commodity: health, education, and political and economic power.

The health care delivery system is no different than all other components of the U.S. social structure in terms of its reaction to race and class. In fact, health care in the U.S. is a multi-billion dollar industry that, in and of itself, is reflective of race and class divisions within society.

In each component of the industry, there are very powerful interest groups, each with their own paid lobbyists, who are constantly at work to protect the industry's dominance in the health care marketplace.

Within this context, access to regular, ongoing primary health care in the U.S. is contingent upon the possession of health insurance, whether public or private, which is directly connected to one's employment or lack thereof. This is a problem for significant numbers of minorities who tend to have higher rates of unemployment. Eligibility for Medicaid, the public insurance available to the poor, is based on stringent guidelines for means testing, which have now become even more rigorous as a result of welfare reform.

The situation leaves large numbers without health insurance.

Estimated to be anywhere from 40 to 75 million, the uninsured are actually two groups: the never insured and the sometimes insured. The latter group are the working poor whose low-income jobs customarily do not provide health benefits nor pay enough to purchase private insurance.

U.S. health care delivery and policy targeting minorities has historically employed two opposing but similar approaches in terms of outcome. In one approach, the importance of race is downplayed or negated in health analysis. In the other approach, the claim is made that minorities experience poor health and premature death because of pathological behavior that includes a choice to smoke, drink heavily, consume the wrong foods, engage in unprotected sex and violent behavior, and lead sedentary lifestyles.

This latter approach, known as "blaming the victim," is reminiscent of earlier justifications used to defend health care policies that denied health care to Blacks during a time when racism was sanctioned by law throughout a majority of states in the Union. People thought that minorities were dying, so a commitment to care for them would be wasted. Unfortunately, variations of this argument continue to undergird minority health policy today. There are assumptions that individuals alone can control their health destiny without consideration of their economic capacity to do so, or the availability, cultural compatibility, or accessibility of health care services.

It is important to note that this connection between health status, race and ethnicity, and socioeconomic status is not unique to the United States. This is a global condition that is well documented in the international health literature. The National Health Service (NHS) in the U.K. was

designed largely to serve a homogeneous White population. So though the U.K. has a system of universal health access, minorities there—as is the case for minorities in the U.S.—do not always receive culturally and linguistically appropriate care.

Both the U.S. and the U.K. are aware that any improvement in the health status of racial and ethnic minorities must flow from a strong research agenda. To deliver effective primary care services to the entire population of both countries, we must first acknowledge some critical factors. One is that given what we now know about the progressive nature of health deterioration over time and how this is influenced by behavior change, we must recognize that medicine has failed us in terms of its ability to help us change behavior. This is not to detract from the amazing life-saving technological advancements over the last 50 years. But the challenge of both countries is how to best bring about behavioral change, considering the extent to which health behavior and practices are influenced by culture.

In many ways, the development of primary care as a national health services delivery strategy that meets the needs of everyone demands a new kind of research—one that is population driven. Research and needs assessments of minority communities must be conducted using totally new paradigms. The community must be involved in planning the research. Community members must be trained to serve as point persons in data collection, as they are much more likely to obtain data that is accurate than the outside researcher. And as data is analyzed, minority groups being studied must help interpret data. This type of research is beneficial because health education flows in two directions rather than one. ❖

# Minority Health Perspective

## Learning from Each Other: Joining Forces

Clay E. Simpson, Jr., MSPH, PhD  
Deputy Assistant Secretary for Minority Health

**W**e are here today from different countries, but we are united by what we have in common. Although the demographics of our populations are very different, we both have racial and ethnic minority populations who have poorer health than the general population. We are both working to reverse this trend. It is this commitment to improving minority health status that brings us here. We share common problems, and now we are here to share solutions. This is an opportunity for us to learn from each other and join forces.

The Office of Minority Health was created by the U.S. Department of Health and Human Services (HHS) in 1985 as a result of the Report of the Secretary's Task Force on Black and Minority Health. We believe in disease prevention and health promotion. But we don't just focus on diseases because so many other factors contribute to our health status. We also address cross-cutting issues, such as the ability to pay for care and culturally competent delivery.

Over the last few years, we have seen increasing signs of support for minority health issues in HHS. We have been able to support the establishment of HHS-wide initiatives for each of our target populations. This means that every health agency within HHS is responsible for making commitments to address the health of African Americans, Hispanics/Latinos, American Indians/Alaska Natives, Asians, and Native Hawaiians and other Pacific Islanders.

Through these initiatives, we are making and shaping policies that affect the health outcomes of our people. Our department-wide efforts not only increase minority representation in HHS, but help put minorities in decision-making positions.

OMH knows that no matter how optimistic we are, we cannot solve all of our nation's minority health problems. This is why our approach centers on building partnerships to strengthen our resources. Our OMH Resource Center has served as a national resource and referral service on minority health for 10 years. We encourage increased awareness of minority health through free services such as database searches, publications, and mailing lists.

OMH has also helped establish other offices of minority health in more than half of our states, and in our federal agencies. This is a network we are building. It involves not only government, but promotes community, family, and individual action as a way to improve minority health.

What I propose today is that we pay close attention to the lessons we've learned. We have come here to sign a joint agreement between the U.S. and the U.K. to take what we learn at this conference to the next level—a level of ongoing international collaboration that produces results, benefits both countries, and improves the quality of life for our people. *This editorial was part of Dr. Simpson's speech at the U.S./U.K. Conference.* ❖

## British Government Efforts on Ethnic Minority Health

**T**here are an estimated three million people of minority ethnic origin living in England and Wales. They make up six percent of the population. Indians are the largest ethnic group, followed by Black Caribbean, Pakistani, Black African, Bangladeshi, and Chinese.

Health care is provided mainly by the public sector in the form of the National Health Service (NHS). The need for appropriate policies for health care of Black and ethnic minority communities was not apparent until the 1980s, according to Veena Bahl, the British government's ethnic health advisor.

Early efforts included a national "Stop the Rickets Campaign," which set out to increase awareness about rickets and Vitamin K deficiency in the Asian community. That campaign highlighted the need to overcome language and cultural barriers at the point of service delivery.

The British health department improves access to health services, and has provided funding for nearly 100 projects over the last four years. Projects produce videos in ethnic minority languages on women's health issues such as menopause and breast screening. Additionally, information about nutritional needs of children has been developed in several languages.

Recent NHS reforms provide an opportunity for minority health to be part of mainstream health delivery. Health authorities are required to assess the health needs of the local population in order to purchase appropriate health services locally. In support of these efforts, NHS has funded the development of a compendium of good practices in minority health, and has issued guidance on meeting the spiritual needs of patients. ❖

# The Quality of Racial Data

By David Williams, PhD, MPH, Associate Research Scientist, University of Michigan

Race is routinely used in an uncritical manner with little attention given to the underlying problems of measurement that exist for the current racial categories. These problems have a significant effect on the quality of U.S. health data.

## Measurement Error: Observer Bias

The numerator for the officially reported death rates in the U.S. come from death certificates. There are reliability problems with the assessment of race that suggests there is an acute problem of undercounting racial and ethnic status for American Indians/Alaska Natives, Asian Americans and Pacific Islanders (AAPI), and Hispanics.

A major source of this undercount is the discrepancy between race as observed by an interviewer and self-reporting by respondents. Between 1957 and 1977, race was determined by interviewer observation in the Health Interview Survey. In 1978, the year in which the measurement of race was changed in that survey, racial information was collected both by interviewer and self-report.

Analyses of the discrepancy between these two measurement strategies revealed that 6 percent of persons who reported themselves as Black, 29 percent who reported themselves as Asian, 62 percent of self-identified American Indians, and 80 percent of those who identified themselves as "other", were classified by the interviewer as White.

Respondent self-report is not an option on the death certificate; it appears that officials who complete these forms make a decision based on their own judgment instead of obtaining the race of the deceased from the next of kin. A national survey of vital registrars found that only 63 percent of

medical examiners, 50 percent of coroners, and 47 percent of funeral home directors use the recommended method of relying on family members for racial information. The survey also indicated that funeral directors consider requesting racial information as an imposition on the family.

## Reliability: Change in Racial Identity

A study of a large national population found that one-third of the U.S. population reported a different racial or ethnic status one year after their initial interview. The most dramatic evidence of change in self-identification comes from analyses of trends in the American Indian population over time. Between 1960 and 1990 there was a six-fold increase in the Indian population. This dramatic growth cannot be explained by biological growth or international migration. It also appears to reflect a change in self-definition, with more adults of mixed ancestry identifying themselves as American Indian. This shift in self-identification into the American Indian population is more common at younger ages.

The degree of identification as Indian may not be very strong for many of these "new Indians." Most persons reporting American Indian ancestry did not report American Indian race. American Indian identification for this group may be optional and contextual, depending on the form of the race question, economic incentives for being Indian in some states, and increased willingness to self-identify as American Indians.

Given current rates of intermarriage of Indians with persons of other races, there is likely to be continued rapid growth in the pool of persons who will be of some Indian ancestry, but for whom this ethnic identification may not be consequential.

## Definition of Racial Groups

The discussion of establishing the racial status of American Indians raises the more general problem of establishing the race of an individual whose parents are of different races.

Birth certificates in the United States have never listed the race of the child, but they include the race of both parents. Prior to 1989, the National Center for Health Statistics (NCHS) used this method to determine the race of children whose parents belong to different races: If the father was White, the child would be given the race of the mother. But if the father was non-White, the child would be assigned the race of the father. If one parent was Hawaiian, then the child was Hawaiian. Thus, unlike the assignment of race for all other racial groups, the child would be White only if both parents were White.

NCHS no longer reports vital statistics by the race of the child, but reports all birth data by the mother's race. However, the Indian Health Service continues to consider a child as Indian if either the mother or father is American Indian, and there is considerable discrepancy in the publication of infant mortality rates by race of the child or by race of the mother. For example, in 1989 there were 39,478 American Indian births calculated by the race of the mother, but 46,267 as calculated by race of the child.

The question of how to classify persons whose parents are of different races continues to be a hotly debated policy issue in the U.S., with some groups pushing for further changes in the Office of Management and Budget's racial standards, which were revised in 1997. Current trends of interracial marriage suggest that this classification question will apply to an ever-increasing proportion of the population. Twenty-five percent to 44 percent of Hispanics marry non-Hispanics. And from 25 to 50 percent of AAPI subgroups marry persons of other races. Rates of Black/White intermarriage increased from two percent in 1970 to six percent in 1990.❖

# Minority Health in the U.S.: An Overview

## Problems

Racial and ethnic minorities are less likely to have health insurance and may experience a lower quality of health care. Minorities have higher rates of disability, disease, and death for a wide range of health conditions. For example, African Americans have a higher death rate than Whites for 12 of the 15 leading causes of death. Heart disease is the number one cause of death for all groups in the U.S., followed by cancer. But rates are often higher for racial and ethnic minorities.

Minority women are less likely to receive prenatal care within the first three months than Whites. The gap in infant mortality for Blacks has grown to twice that for Whites. Infant mortality continues to be a major problem for American Indians, Puerto Ricans, and Native Hawaiians.

Infant deaths and deaths due to unintentional injuries, homicide, and HIV/AIDS take our young people too soon. Diabetes and high blood pressure, major chronic diseases among adults, are a greater burden for racial and ethnic minorities, as their higher rates of amputations and kidney disease show. The increase in AIDS cases during the past five years has been greater for minorities than Whites. Now, three-fourths of AIDS cases among women and children are among minorities.

Asthma, the leading chronic disease among children, is also more common among racial and ethnic minorities. Infectious diseases such as tuberculosis and hepatitis are more common among immigrant populations. Tuberculosis has increased during the past 10 years for Asians, Pacific Islanders, and Hispanics, but has decreased for Whites. Hepatitis increased for American Indians during 1988-1994, while decreasing for the total U.S. population.

## Improvements

Since the release in 1985 of the Secretary's Task Force on Black and Minority Health, there have been some improvements. More racial and ethnic minorities are being trained as health care professionals, which improves access to culturally competent care. More racial and ethnic minorities are being screened for cervical cancer and receiving immunizations. And more minorities with diabetes or high blood pressure have been diagnosed, and are being treated for these health problems. Other examples:

- In 1996, infant mortality reached its lowest rate for the nation (7.2 deaths per 1,000 live births.) Rates for Blacks declined 6 percent (from 15.1 to 14.2), while rates for Whites declined 5 percent (from 6.3 to 6.0)—reducing the gap in infant mortality between Blacks and Whites for the first time in several years.
- High blood pressure, an important risk factor for heart disease, has dropped significantly for Black Americans and Mexican Americans.
- Life expectancy reached an all-time high of 76.1 years for the nation in 1996. Record life expectancies were reached for White and Black males (73.8 and 66.1 years, respectively), and for Black females (74.2 years). The gap in life expectancy between Blacks and Whites has narrowed from 6.9 years to 6.5 years after several years of increasing.
- Mammography rates are now similar for Whites, Blacks, and Hispanics, though survival rates are still lower for minority women who are diagnosed with breast cancer. ❖

# Racial Data in the United Kingdom

*By David Williams*

The 1991 Census of England and Wales was the first to utilize the question on ethnicity. Seven preassigned codes were used in the census. These were: White, Black Caribbeans, Black Africans, Indians, Pakistanis, Bangladeshis, and Chinese. An additional 28 categories were developed in the census based on write-in responses under the "Black other" and "any other" ethnic group categories.

Several recent health surveys in the U.K. have also included measures of ethnic group membership. The Health Survey of England, which began in 1991 and focuses heavily on cardiovascular disease, has included racial and ethnic data. Similarly, the General Household Survey of about 15,000 households per year has included data on ethnicity and country of birth in recent years. The survey includes measures of self-reported illness, both chronic and acute, as well as of risk factors and socioeconomic status.

Data on patient care in the U.K. is available through the Hospital Episode Statistics system, which collects data on all inpatient and outpatient hospital visits. In 1995, ethnic categories were included in this data system. It will thus become possible to examine rates of particular diseases, surgical interventions, severity, etc., by ethnic group status. Ethnic status is not collected on death certificates, and it would require an Act of Parliament for the inclusion.

But country of birth has been collected on death certificates since 1969 so that it is easy to examine mortality rates for first generation immigrants. Similar to the U.S., there is a linked infant birth and death file in the U.K. But unlike in the U.S., ethnicity is not collected at the time of registration of birth. ❖

# Cultural Competency

*By Moon Chen, Jr., PhD, MPH, Chair, Division of Health Behavior and Health Promotion, College of Medicine and Public Health, Ohio State University*

Cultural competence has three components: purpose, attitude, and skills. The purpose of cultural competence is to achieve improved health outcomes. Attitude is the willingness to adapt oneself to others' needs. And skills are those competencies or behaviors that exemplify correctness of technique in interactions between the professional and the patient.

Minority health professionals are individuals most likely to be the impetus to empower their own communities for health improvement. Hence, increasing the number of trained minority health professionals is one strategy that must be pursued. They are the ones most like the racial and ethnic communities who need to be targeted because of their disparate health status.

In analyzing the empowerment of ethnic minorities in human service organizations, L.M. Gutierrez discusses appreciating and understanding diversity of minority clients, rather than just considering their human service needs. She outlined the

following steps for ethnic sensitive services: 1) Developing access to services such as hiring bilingual and bicultural staff members; 2) Tailoring interventions through learning another culture; 3) Modifying services such as integrating traditional medicine with Western medicine; 4) Initiating an appropriate organization development model and a specialized program model such as initiating a Native Hawaiian health care system. Another model by Arthur Himmelman discusses empowerment in a continuum of collaboration strategies. He indicates that this continuum is differentiated by the degree to which time, trust, and turf can be overcome.

Networking, the first stage, is defined as exchanging information for mutual benefit. While networking reflects initial trust, commitments of time and turf are limited. The next stage is coordinating, and results in exchanging information and altering activities to achieve a common purpose. Mutual investments of time, trust, and turf sharing are increased.

Cooperating is the third stage, and requires greater organizational commitments than either networking or coordinating. The final stage is collaborating.

Dr. Pui-Ling Li, a U.K. workshop presenter, illustrated how she had empowered the Chinese community in London. First, she compiled demographic data on the Chinese population in the U.K. From an analyses of that data, she discovered that the largest group was age 20-44 and that nearly 30 percent of that group is born in the U.K. She also discovered that nearly all older people born outside of the U.K. don't speak English and that 25 percent of the older group had an education beyond the primary school level.

The majority of Chinese people in the U.K. work in the food catering trade. Dr. Li documented that access to health care meant taking into account work schedules of 12 or more hours per week each day. She founded the London Chinese Health Resource Center in London's Chinatown as a means of empowering the Chinese community to meet its needs. The center not only provides linguistically and culturally competent health services, but also English lessons. The center has become an identifiable organization and creates a focus for coordinating Chinese health care. It is rooted in community and is forming an infrastructure to influence district and national levels of health policy.

Both the U.S. and the U.K. are nations of immigrants and are increasingly becoming more demographically diverse. Based upon the 1990 Census, the only original inhabitants of the U.S., American Indians and Alaska Natives, made up approximately one percent of the population. It is clear that at the individual and social levels in both the U.S. and the U.K., overcoming linguistic and cultural barriers is fundamental. As the population becomes increasingly diverse, these issue of empowerment will become even more complex. ❖



Photo #2

*From left to right: Dr. Clay E. Simpson, Jr., Deputy Assistant Secretary for Minority Health; Paul Boateng, Parliamentary Under Secretary of State for Health; Frank Dobson, Secretary of Health, U.K.; Kevin Thurm, Deputy Secretary of Health and Human Services; Tessa Jowell, U.K. Minister of State for Public Health.*

# A Look at Medicaid and Managed Care

*By Fernando Trevino, PhD, MPH, Professor and Chairman, Department of Public Health and Preventive Medicine, University of North Texas Health Science Center*

**M**edicaid is the publicly-funded health insurance program designed to care for the poor populations in the U.S. It is funded through state and federal funds and managed at the state level.

Each state designates a single agency that is responsible for Medicaid program operations. The states determine eligibility of Medicaid applicants, determine provider qualifications, payment methods and levels, as well as negotiate contracts with managed care plans and other providers. The state also processes and pays medical claims, communicates with beneficiaries and oversees quality of care in facilities funded by Medicaid.

For each state, the federal medical assistance percentage (FMAP) is calculated using a formula that relates state per capita income to national per capita income. Thus it is one measure of relative individual state poverty. The FMAP pays for medical services in Medicaid.

The state share is the difference between FMAP and the total costs for Medicaid. Medicaid programs, poverty lines, and FMAP's vary considerably from state to state. The percentage of Medicaid costs borne by the federal government varies from 50 percent in more affluent states to 79 percent in the poorest states, and averages 57 percent nationwide. A state's Medicaid plan must be in effect throughout the entire state. And the amount, duration, and scope of services must be equal among eligible groups.

The U.S. Department of Health and Human Services may grant a waiver of these requirements under two broad categories: research and demonstration (1115 waivers) and freedom of choice (1915 waivers).

Medicaid operates as a vendor payment program, with payments made directly to providers by states.

Payment levels are subject to conditions that all state Medicaid plans and agencies must satisfy. Payments must be sufficient to enlist enough providers to participate in the plan and ensure comparable services statewide. Participating providers must accept the Medicaid reimbursement as payment in full, and payments to providers must be consistent with efficiency, economy, and quality of care standards.

## Medicaid Managed Care

Managed health care organizations integrate the delivery and financing of health care for their members. This integration changes the historical supply side (provider) incentives. The change in incentives forces the provider to bear part of the financial risk, and the organization has a strong incentive to cut costs, and reduce excessive care and inefficiencies. At the same time, the goal is to improve quality.

There exists bipartisan support for the concept that states should have the flexibility to enroll Medicaid beneficiaries in managed care plans. This support stems from the belief that managed care is a way to stem the rapid growth of Medicaid expenditures and state funds, and as a way to expand coverage to more uninsured people with low incomes.

The health care system in the United States is thus moving from fee-for-service to capitation, where individual providers are merging into integrated delivery systems and managed care systems are vying for business in a newly-created price-sensitive market.

Historically, for-profit corporations shunned the Medicaid market, leaving the job to nonprofit HMOs organized by charity hospitals, community clinics, and physicians

working in poor neighborhoods. Now, with state Medicaid programs leaping into managed care, offering huge and potentially lucrative contracts, commercial plans are actively seeking this market.

Medicaid is now attractive to managed care companies because it delivers a ready-made pool of enrollees that otherwise would take years of costly and uncertain marketing efforts to develop. With the instant market share that a Medicaid contract can provide, such companies enjoy important advantages in the scramble to build provider networks and compete for the more lucrative business of private purchasers.

While it is clear that Medicaid is increasingly moving toward managed care, it is less clear how racial and ethnic minorities are being impacted. The limited research that has been conducted has found a positive impact on cost reduction, along with better access to care and higher levels of satisfaction when compared with conventional Medicaid beneficiaries. But what has not been researched is the quality and acceptability of care for minorities. Though the U.K. may have fewer financial access barriers for minority populations, this very issue—acceptability of services—must be addressed in both countries. ❖

## **Correction**

The correct phone number to call for the Faculty Loan Repayment Program is (301) 443-1700. Speak to Shirley Zimmerman at the Health Resources and Services Administration about loan repayment of up to \$20,000 per year for qualified health professionals in exchange for serving on a health professions or nursing school faculty for at least two years.

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Public Health Service  
Office of Minority Health Resource Center  
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## *Closing the Gap*

### Leaving No One Behind

*By Kevin Thurm, Deputy Secretary, U.S. Department of Health and Human Services*

The health gaps faced by people of color are not simply a minority problem. They are not simply a U.S. or U.K. problem. They are an international problem—a problem that will only be solved by working together, sharing knowledge and research, finding common ground, and setting common goals.

Under the leadership of President Clinton and Secretary Shalala, we have made great progress in strengthening the overall health of our nation. Childhood immunization rates are at an all-time high and infant-mortality is at an all-time low. Teen pregnancy rates are down. AIDS and overall cancer death rates have declined for the first time ever in the 1990s.

Great accomplishments? Yes. But not nearly enough. There's a saying in my country: When America catches a cold, the minority community gets pneumonia. While we've

made progress closing the gaps in some key health areas, far too often that saying still rings true. For example, many minority communities still suffer disproportionately from high infant mortality rates.

There are great disparities that can't be solved with a few programs or task forces. They can only be solved when everyone participates, when everyone is accountable, and when the changes we elicit are systematic and cultural. At HHS, that's what we've worked to create: A complete and total change in the way we do business. A total change in the very culture of the department. From the National Institutes of Health to the Centers for Disease Control and Prevention, we're looking at everything we do, everything we fund, and ensuring that we are creating an environment in which diversity and opportunity thrive.

If there's one thing we've learned over the last several years, it's that we can't achieve the health outcomes we want without simultaneously addressing other socioeconomic factors.

That's why the Administration fought to cut taxes for the working poor and raise the minimum wage. That's why President Clinton launched a Race Initiative that brings the nation his vision of a more united American community. An America that focuses on eliminating the hardships suffered by minority populations in education, housing, justice, and health.

When he announced the Race Initiative, President Clinton said, "We have to join hands with all of our children to walk into this era with excellence in education, with real economic opportunity, with unshakable commitment...that leaves no one behind." A commitment that leaves no one behind, like good health, is the kind of language anyone can understand.

*This editorial was taken from Mr. Thurm's speech at the U.S./U.K. Conference.❖*