

DEPARTMENT OF HEALTH AND HUMAN SERVICES
STATEMENT OF
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SURGEON GENERAL OF THE UNITED STATES
AND
ASSISTANT SECRETARY FOR HEALTH
BEFORE THE COMMITTEE ON INDIAN AFFAIRS
U.S. SENATE

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Mr. Chairman and Members of the Committee:

Good afternoon. I am Dr. David Satcher, Assistant Secretary for Health and Surgeon General in the Department of Health and Human Services.

I am pleased to be here this afternoon to testify before the Senate Indian Affairs Committee about two important efforts in the department to help us address the health care needs in Indian Country.

You have requested that I speak to the President's Initiative on Race, particularly the Department's Initiative on Disparities in Health and also to the Healthy People 2010 Objectives, as each relates to specific goals being established for the American Indian and Alaska Native population. I would also like to take this opportunity to share with you my priorities for my tenure as Surgeon General. However, first let me set the stage somewhat and develop a snapshot of our American Indian/Alaska Native citizens.

Of the nearly two million American Indians and Alaska Natives in the United States, 38 percent reside on tribal trust lands. When compared to the overall U.S. population, the American Indian and Alaska Native population is more likely to live in poverty and have fewer years of education. Approximately 30 percent of the American Indian and Alaska Native population live below the poverty level compared to 13 percent of the total population. American Indians and Alaska Natives have a median income that is two-thirds of the U.S. median income and are more than twice as likely to be unemployed. The mean age of the American Indian and Alaska Native population is 23 compared to 32 for the general population, largely due to several factors, including a high proportion of deaths that occur at relatively young ages, as well as a relative young population, with a high birth rate.

Historically, the American Indian/Alaska Native population has benefited from many of the same improvements in health care that the general population has enjoyed during recent times. For example, infant mortality rates for American Indians/Alaska Natives decreased over 60 percent, down to 8.8 in 1991-93 from 22.2 infant deaths in 1972-74, a decrease quite comparable to the rate for all races in the U.S. Also, comparing current data to 1973, we see significant drops in mortality rates for tuberculosis (80%), gastrointestinal diseases (76%), and death due to unintentional injuries (56%). A comparison of the 1970 maternal mortality rate to that of 1990 shows a drop of 75%. These are successes which all can celebrate. However, this progress fades when examined in the context of the current health status of this population and compared to that of the general population.

The following numbers are illustrative of significant health disparities among American Indians and Alaska Natives:

- American Indians and Alaska Natives have the second largest infant mortality rate in the U.S. at 9.0 per 1,000 live births in 1995 and the highest death rate from SIDS at 207 per 100,000 live-born infants in 1995. 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.
- SIDS accounts for approximately 10 percent of all infant deaths in the first year of life. The rates are three to four times as high for some American Indian and Alaska Native populations than for the total population.
- The teen pregnancy rate for American Indians and Alaska Natives is twice that of their white counterparts, and second only to blacks in the United States.
- American Indians and Alaska Natives have the lowest rate of prenatal care beginning in the first trimester of all members of the U.S. population.
- For breast and cervical cancer screening and treatment, American Indian and Alaska Native women still have lower rates due to limited access to health facilities and physicians, as well as barriers related to language and culture.
- Cardiovascular disease is the leading cause of death for all racial and ethnic groups in the United States, including American Indians and Alaska Natives.
- 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. Rates for diabetes-related complications such as ESRD and amputations are higher among

American Indians compared to the total population.

- In 1994, 40% of American Indian and Alaska Natives over the age of 18 used tobacco, the highest rate of use among all groups in the U.S.

The chart attached to my written statement shows the disparities that currently exist in mortality from the ten leading causes of death for American Indians and Alaska Natives. Once again, you should keep in mind that these numbers can be misleading because they do not reflect the diversity among Indian communities.

It is because American Indians and Alaska Natives suffer from health problems which, in many ways, are similar to those of all U.S. citizens that I have set forth the following priorities for my tenure as Surgeon General.

The first priority is making sure that every child has an opportunity for a healthy start in life. It relates to the health of the mother and the parents and it relates to the problem of teenage pregnancy. It relates to what kind of access to prenatal care a mother has in this country. It relates to counseling a mother concerning the risks associated with tobacco use and substance abuse during her pregnancy. It relates to what kind of access the mother has to drug treatment programs. It also relates to the early environment of the newborn and whether that is positive or negative. All of these things impact upon whether a child has a healthy start.

My second priority is helping the American people to take personal responsibility for their health. This relates to nutrition, physical activity, sexual behavior and the avoidance of toxins--including tobacco. We must ask ourselves: How do we convince teenagers to resist tobacco or delay sexual activity? How do we convince people of every age to become more physically active? Sometimes people think we are only talking about children when we talk about prevention. But the science shows that we have the ability to significantly improve the quality of life for older people, not just children, through more physical activity and better nutrition. We've found that adults who are more physically active are able to remain independent longer and are less likely to be socially isolated. So at every age, we have the opportunity to improve the health status of the American people through their personal behavior.

Another priority is mental health. As a nation, we still tend to blame the victims of mental illness. We stigmatize those who get help. That only discourages others who need help. Untreated, mental health problems often lead to other serious health problems we face in this country --- substance abuse, both illicit drugs and alcohol, and violence.

We know that alcohol abuse is a major contributor to increased mortality among American Indians and Alaska Natives. An estimated 75 percent of unintentional injury deaths to American

Indians and Alaska Natives are alcohol-related. Alcohol is also a factor associated with domestic violence, homicide, and suicide. The science is undisputed. If we focus increased attention on the need for mental health prevention and treatment programs, we can not only address existing illnesses, we can also practice a form of prevention in these other areas. We are in the early phases of preparing a Surgeon General's report on mental health, and I look forward to seeing this completed in due course.

The Racial and Ethnic Health Disparities Initiative in the Department is yet another important priority for me as Surgeon General. 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.

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 American Indians and Alaska Natives 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.

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*; 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, with the goal of elimination by 2010.

This Health Disparities Initiative will have a significant impact on the lives of American Indians and Alaska Natives if we are successful in the six areas. In addition, the information gained from our selected focus will be useful in improving the health of all American Indian and Alaska Natives in other areas. The challenge to the Department -- and to all who are concerned with the nation's health -- is to identify and act upon the steps that are necessary to address these gaps in health. Conversations with external experts, and our internal deliberations, have identified a number of the important areas for early action:

- 1) improved data to correctly identify high risk populations and monitor the effectiveness of interventions in reaching these groups;
- 2) research dedicated to a better understanding of the relationships between health status and different racial and ethnic minority backgrounds;
- 3) improved access to quality health care; and
- 4) disease prevention/health promotion efforts that are designed in collaboration with communities.

The Department has assembled workgroups in all six areas, in addition to a work group focusing on data issues. The work group activities are overseen by a departmental steering committee co chaired by Dr. Margaret Hamburg, the Assistant Secretary for Planning and Evaluation and myself as the Assistant Secretary for Health and Surgeon General. The Steering Committee consists of the agency heads from each of the HAS Operating Divisions, as well as Staff Divisions.

Each of the work groups are developing strategic plans which include outreach to the communities most affected by these health problems. We intend to engage fully with tribal governments and community representatives as we develop and evaluate interventions. We also plan to involve representatives from the impacted communities in identifying and implementing

actions to achieve the six goals. These consultations will give us important community perspectives on how to improve our current programs.

The President's FY 99 Budget contains a proposal for \$30 million annual or \$150 million over ly five years for a new demonstration program to test preventive or clinical interventions that show promise of being effective at the community level. Our intent is to identify preventive and clinical interventions that research suggests will be effective in achieving one or more of the six disparity reduction goals, and then to invite diverse communities to compete to test those models at the community level. The grant will support the core activities, and our Departmental Steering Committee will identify opportunities to augment the basic grant with other discretionary resources.

Again, we intend to consult widely with individuals and organizations who have expertise about how these six health disparity areas affect specific racial and ethnic minority communities, and to ask their assistance in helping us design and monitor the demonstration grants. We expect to learn a great deal from these demonstrations that will enable us to reduce and eventually eliminate disparities in these six areas. We expect to gain knowledge that will be applicable to our broader undertaking for meeting our Year 2010 goals, and to the redesign and improvement of the Department's current programs.

In addition to the community grants, the President's budget contains a proposed investment of \$250 million over five years for existing public health programs targeted on the six Year 2000 goals. Of this amount, IHS will receive \$45 million or \$9 million a year for alcohol prevention and treatment activities, and the breast and cervical cancer project. These investments, however, are only the expenditures specifically identified with the race initiative. A far larger set of ' investments and efforts are being made in the ongoing programs of the Department that are critical to developing the knowledge needed to eliminate disparities,

Eliminating disparities in these six areas will be a major challenge, and we will try to mobilize and strengthen the Department's resources to maximize our effectiveness in addressing these disparities. The key to success, however, will be to base these efforts on increased collaboration with tribal, State, and local governments, communities and their leaders, foundations, the corporate sector, and national and regional organizations, including those focused on minority health and other minority issues. We intend to broaden and strengthen our current partnerships with all of these entities.

Paralleling the Health Disparities Initiative, is the Department's effort to establish health objectives for the nation in Healthy People 2010.

Healthy People began over two decades ago. The first set of national objectives to improve the health of the American people was published in 1979 in a Surgeon General's Report on Health Promotion and Disease Prevention. This report set 1990 targets for health improvement for various age groups. Many of these were achieved through the combined efforts of the Nation's public health agencies. Then, through an unprecedented collaboration among government, voluntary and professional organizations; business and individuals, Healthy People 2000 objectives were developed and published.

In addition to targeting reductions of the causes of higher mortality among American Indians and Alaska Natives, forty of the Healthy People 2000 objectives specifically target improved health and improved data reporting for American Indians and Alaska Natives. These include reductions in fetal alcohol syndrome, anemia in children, overweight, cigarette smoking, smokeless tobacco use among youth, dental caries, gingivitis, baby bottle tooth decay, limitation of activity due to chronic conditions, diabetes-related complications, diabetes incidence and prevalence, viral - hepatitis, tuberculosis, and bacterial meningitis. They also target improvements in breast feeding, prenatal care, and in receipt of basic preventive services.

The year 2000 objectives also focus on greater representation of American Indians and Alaska Natives in the health professions and a greater proportion of community health promotion programs that are culturally and linguistically appropriate. Healthy People 2000 also targets improvement of data collection efforts for American Indians and Alaska Natives.

The Department has conducted two Healthy People Progress Reviews specifically on American Indians and Alaska Natives. These reviews enable the Department to look broadly across health domains and to engage our partners in discussions about both the barriers and challenges to making health improvements in Native American communities. In the last review, representatives of the Cherokee Nation demonstrated how they use the Healthy People objectives in planning and delivering health promotion and disease prevention programs. This is an excellent example of how Healthy People will assist the Department's efforts working with communities for the race initiative.

There is progress to report. The 1995-96 Healthy People 2000 reviews published by the CDC's NCHS showed that of the 40 objectives targeted for American Indians and Alaska Natives, 55 percent had been met or were moving in the right direction. Unfortunately, 30 percent were moving away from the target, another 7.5 percent showed no change over the decade, and 7.5 percent lacked sufficient data to make an assessment.

Healthy People also serves as the metric for reporting to Congress under the Indian Health Care Improvement Act, P.L. 102-573. In the 1992 re authorization of this Act, Congress explicitly required that selected objectives in Healthy People 2000 be addressed annually by the IHS.

As the year 2000 approaches, the Department is engaging people from across the nation in developing a robust set of national health objectives that will unify the efforts of public and private health care providers, schools, and work sites to create "Healthy People in Healthy Communities", the motto of the Healthy People effort. This vision statement for Healthy People 2010 can be a rallying cry for tribal leaders to join other public health leaders in renewing the call for Health for ALL.

Healthy People 2010 will extend the effort begun by Healthy People 2000. In the draft objectives that will be circulated for public comment in September of this year, we will propose that the nation set a goal of eliminating health disparities by the year 2010. Previously, we were merely striving to reduce these disparities. Committing the nation to the goal of eliminating disparities will be an important motivating force to improving the health of the nation as a whole.

We have a lot of work to do. How will we get this work done? The first step is to start a dialogue with the American people. That brings me to another of my still evolving priorities as Surgeon General.

I feel one of the major responsibilities of the Surgeon General is to communicate with the American people about the health care system in this country and how to best access it. I want to help Americans make some sense out of our health care system and help people understand how they can best utilize it for themselves and for their families. At the same time, it is also important to communicate with the Administration and Congress about what we need to do to provide access for all people. I take that responsibility very seriously.

That priority also includes the need for a dialogue with tribal, State and local governments and communities to identify barriers and develop strategies to improve the effectiveness of the Department's programs, therefore improving the health of the American people. But, communication means listening as well as talking. I would like to be known as the Surgeon General who listened. In a commencement address I gave on Monday to 140 medical school graduates at my alma mater, Case Western Reserve University, I wrote them a very important prescription. I told them that listening to the patient is the most important thing they could do. I believe we all could use a good dose of listening.

As we move forward to develop the Healthy People 2010 Objectives for the nation, we need to listen. As we ask tribal, State, and local governments to join us in our efforts to eliminate racial and ethnic disparities in health status, we also need to listen. As we work with national and regional organizations, foundations, and private businesses to join in this effort--to sharpen their attention to racial and ethnic disparities in health status, and to make whatever contributions they can to eliminating these disparities, we need to listen and learn.

In summary, increasing personal responsibility for one's own health, focusing resources and effort on the elimination of disparities in health status, working to assure that every child born in America gets a healthy start in life, increasing awareness of the need for more mental health prevention and treatment programs and how such programs serve to prevent other health related problems, and communicating with the American people about health care --- I believe all these will advance us into the next millennium with improved health for all Americans.

I appreciate the role this Committee will play in that effort and look forward to working with you.

I will be happy to respond to any questions that the Committee may have"