

Dr. Varmus introduced a panel discussion on health disparities by explaining that NIH is concerned by the question of why some individuals and groups have different health status and health outcomes than the general population. Much of this concern focuses on minority populations, but other disparities can be seen in rural, elderly, and low-income groups. To explore this question, NIH is pursuing several avenues of investigation—socioeconomic, behavioral, genetic, and educational—in order to identify the factors that influence these differences.

Dr. John Ruffin, Director of the NIH Office of Research on Minority Health, moderated the discussion. He asserted that health disparities are real and that health differences can be quantified, but that the influence of race in particular is filtered through biological, cultural, socioeconomic, and political perspectives. In fact, there is an emerging consensus that multiple factors influence the relationship between race and health status. To address these disparities, NIH has launched a major initiative to investigate international and domestic health disparities. In addition, NIH is collaborating in an HHS-wide initiative to eliminate, by the year 2010, all racial disparities in six specific areas: infant mortality, cancer, cardiovascular disease, diabetes, HIV-AIDS, and child health and adult immunization.

Dr. Ed Sondik of the National Center for Health Statistics, Centers for Disease Control and Prevention (CDC), described the available epidemiological data on health disparities. He explained that these statistics have two uses: (1) to demonstrate that the lower risk or better outcome is achievable; and (2) to help allocate resources for identifying and testing interventions that will achieve this lower risk or better outcome in all groups. A broad range of factors is at work, but the differences between groups are clear and common. For example, the overall death rates for black males in the United States is 1,000 per 100,000, but for white males it is 600; for Hispanic males, 500; and for Asian males, 373. The rate of new cancers is 10 percent higher among blacks than among whites, while the rate of mortality from cancer is 30 percent higher; this raises questions of access to health care. Similarly, the rate of heart disease is 40 percent higher in blacks than in whites, but much of this may be related to socioeconomic factors rather than race: men 25 to 54 with incomes below \$10,000 have 2.5 time the risk of men with higher incomes. Other disparities follow no particular pattern: hepatitis A is far more common among American Indians and Native Americans than among other groups; diabetes among blacks; obesity among blacks and Hispanics. Indeed, significant disparities can be documented in almost any health problem, but in almost every case it is income and education, rather than race, that appear to exert the most influence.

Dr. Norman Anderson, Director of the NIH Office of Behavioral and Social Sciences Research, described NIH's efforts to promote research on questions such as the relationship between socioeconomic status (SES) and health. Using measures such as income, education, and occupational status, researchers are investigating a number of mechanisms through which SES affects health status: access to health care, residential environment, health-promoting (or damaging) behaviors, stress and other psychological factors, and physiological mediators. At this time, however, all of these variables taken together cannot fully account for SES-based differences in health status. NIH is determined to solve this puzzle and is organizing a trans-NIH initiative to address these questions. In addition, Dr. Varmus has also designated health disparities as one of eight areas of emphasis for all of NIH. Finally, the National Institute of Environmental Health Sciences (NIEHS) is developing a research agenda on the environmental aspects of socioeconomic disparities. Both NIH and NIEHS need input and advice from the public, and from COPR, on how to shape these research initiatives.

Dr. Otis Brawley, Director of NCI's Office of Special Populations Research, distributed statistics on the incidence and mortality rates for six different cancers among different racial and ethnic groups. In almost every case, the rates for black men and women are higher than those for their white counterparts. He nevertheless insisted that "race" is a social, not a biological, construct. Consequently, although his office focuses on research directed to a special population, or research of

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