
UNITED STATES OF AMERICA

GENERAL SITUATION AND TRENDS

Socioeconomic, Political, and Demographic Overview

The health situation of United States residents has improved in the last 10 years. Between 1990 and 1995, overall life expectancy at birth increased from 75.4 years to 75.8 years. By 1995, a person who had reached the age of 60 years could expect to live an average of 21.1 more years, for a total of 81.1 years. A person reaching the age of 65 could expect to live an average of 17.4 more years, to 82.4 years. Life expectancy at birth was much higher for white males (73.4) than for African-American males (65.4); the gap is shrinking, however. Increases in life expectancy in the 1990s were 0.7 years for white males and 0.9 years for African-American males. The difference in life expectancy at birth for white and African-American females was 5.6 years. The 1990–1994 data are final, but 1995 data are preliminary and therefore subject to change. Preliminary data are available for whites, African-Americans, and Hispanic populations, but are not available for other racial and ethnic groups.

An estimated 36 million people were living in poverty in 1995. The national poverty rate was 13.8% in 1995, compared with 15.1% in 1993. The poverty rate among African-Americans, the largest minority group, was 29.3%—nearly triple the rate among the white population.

The poverty rate for female-headed households with children declined sharply, from 47.1% in 1991 to 41.5% in 1995, and the poverty rate among children decreased from 21.8% to 20.8%. In 1995, the percentage of African-American children living in poverty (42%) was about 2.5 times that of white children (16%). Poverty levels among Hispanic children (40%) were similar to the levels seen among African-American children.

The resident population of the United States totaled 263 million in 1995, a 6% increase over the 1990 population. Be-

tween 1990 and 1995, the population 75–84 years of age grew by 11% to 11 million, and the population 85 years and older grew by 20% to 3.6 million. The African-American population increased by 8%, to 33 million, and the Hispanic population increased by 20%, to 27 million. The Asian and Pacific Islander population grew by 24%, reaching 9 million persons.

Mortality Profile

In 1995, an estimated 2,312,180 deaths were registered in the United States, a rate of 880.0 deaths per 100,000 population. This was 0.5% above the rate of 875.4 per 100,000 in 1994 and the same as the rate in 1993. The age-adjusted death rate, which eliminates the effects of aging of the population, was at a record low of 503.7 per 100,000 population, 0.7% below the 1994 rate of 507.4, and 1.9% below the 1993 rate of 513.3. For most of the 10-year age groups for females and all of the age groups for males, death rates declined between 1994 and 1995 for all races combined. However, death rates increased for females 85 years and older. The most important contributing factor in lower death rates for the white population and African-Americans in the 15–24-year age group was the decrease in homicides.

The age-adjusted death rate in 1995 for all causes combined was about 70% higher for males than for females. For each of the 15 leading causes of death, male mortality was also higher. The greatest differential between genders was seen for HIV infection, where the age-adjusted rate for males was 5.1 times that for females. The smallest sex differential was for diabetes mellitus, with a male-to-female ratio of 1:1.

During the 1990s there were major declines in rates for three of the leading causes of death: heart disease, stroke, and unintentional injuries. Much of the decrease can be attributed to the reduction in risk factors that cause illness. Accompanying these trends are increased public awareness of the risks

posed by such activities as tobacco use and driving while under the influence of alcohol.

Between 1990 and 1995, the age-adjusted death rate for heart disease, the leading cause of death, declined 9.1%. This dramatic reduction reflects increased high blood pressure screening and control, a decline in cigarette smoking, and increased awareness of the role of dietary fat in production of cholesterol. The decline in heart disease mortality since 1990 was 10.8% for white men, 7.5% for white women, and 9.7% for African-American men and women. In 1995, heart disease mortality for white men was almost double that for white women; it was more than 64% higher among African-American men than African-American women. In 1993, the age-adjusted death rate for heart disease among males of Asian descent aged 45 years and over (107.6 deaths per 100,000 population) was about 17% lower than the rate for Hispanics, 3.8% lower than the rate for American Indians, 77% lower than for whites, and 149% lower than the rate for African-Americans.

Deaths among white women due to lung cancer showed a 5.8% increase between 1990 and 1995. Death rates from this disease decreased for African-American men by 14.5% and for white men by 8.7%. In 1995, age-adjusted lung cancer death rates for African-American men and white men (73.7 and 51.7 deaths per 100,000, respectively) were two to three times those for African-American women and white women (26.1 and 27.4, respectively).

In 1993, the age-adjusted death rates for all cancers for American Indians, Asians, and Hispanic males aged 45 years and older were similar (92.9, 99.9, and 97.4 deaths per 100,000, respectively); these rates were considerably lower than the rates for whites or African-Americans (156.4 and 238.9 deaths per 100,000, respectively). The most recent available data are from 1993 for certain race groups, including Asians and American Indians.

The age-adjusted death rate from stroke, the third leading cause of death, declined by 3.6% between 1990 and 1995, continuing the downward trend of the 1980s. Declines in stroke mortality since 1980 ranged from 34.1% for African-American men to 36.8% for white men. In 1995, age-adjusted death rates due to stroke were almost twice as high for African-American men as for white men, and 69.4% higher for African-American women than for white women.

Cancer has surpassed heart disease as the leading cause of death for people 45–64 years of age since 1984. In 1995, cancer resulted in 252.5 deaths per 100,000 persons in this age group. Breast cancer rates remain high despite the attention paid to early detection and treatment. Cancer accounts for about one of every four deaths in the United States each year, and, in 1995 it claimed the lives of 537,969 people. Overall, cancer mortality rates have changed little since 1950.

SPECIFIC HEALTH PROBLEMS

Analysis by Population Group

Health of Infants

The infant mortality rate in 1995 was 7.5 deaths per 1,000 live births. Between 1990 and 1995, the infant mortality rate for white infants declined by 17.1%, from 7.6 to 6.3 deaths per 1,000 live births; for African-American infants, it declined by 17.2%, from 18.0 to 14.8. These declines resulted in record low infant mortality rates in the U.S.

In 1994, almost 32,000 infants—about 0.75% of those born—died before reaching 1 year of age. The five leading causes of death in 1995 were congenital anomalies, disorders relating to short gestation and unspecified low birthweight, sudden infant death syndrome, respiratory distress syndrome, and maternal complications of pregnancy.

The overall percentage of live-born infants weighing less than 2,500 g was 7.3% in 1994, up from 7.2% in 1993. The proportion of infants weighing less than 1,500 g at birth (those at greatest risk of death and disability) was stable at 1.3%. In 1994, the percentage of African-American infants weighing less than 1,500 g was three times that of white infants (3.0% as compared with 1.0%). Maternal cigarette smoking has been identified as a risk factor for low birthweight babies in the United States. Other major problems associated with low birthweight include lack of prenatal care, young age of the mother, and alcohol and drug use.

The spread of HIV/AIDS among women and heterosexual men has resulted in increasing numbers of seropositive newborns. Infants born with HIV infection require more intensive health care services throughout their lives. Through June 1996, AIDS was reported in more than 6,900 children under 13 years old.

Health of Children and Adolescents

The coverage rates for DPT, polio, and measles immunizations given between 19 months and 35 months of age were 90%, 79%, and 90%, respectively, in 1994. This represents some improvement over 1992, when the coverage rates were 83% for DPT, 72% for polio, and 83% for measles. Nonetheless, the 1994 level of immunization coverage is lower than in many other countries, including many developing countries.

Outbreaks of communicable diseases still occur throughout the United States, indicating that vaccination programs have not adequately reached many children, especially in rural and inner city areas. Nevertheless, other than an increase in the number of measles cases between 1989 and 1990, especially among preschoolers, there have been no

major outbreaks or epidemics of vaccine-preventable diseases in recent years.

Over 42% of all childhood deaths are due to unintentional injuries, and about 30% of these occur as a result of motor vehicle accidents. The number of deaths due to automobile accidents has declined as a result of increased compliance with laws in all 50 states that require the use of car safety restraints for young children.

Among teenagers, the three leading causes of death are unintentional injuries, homicide, and suicide. While motor vehicle deaths involving alcohol are the greatest risk to white males in the 15–24-year age group, homicide is the leading killer among African-American males in the same age group. The death rate from motor vehicle accidents for young white men was 42.4 per 100,000 in 1995.

The suicide rate for American Indian males 15–24 years of age (31.6 deaths per 100,000 population in 1993) was one-third higher than the rate for white youths, 57% higher than the rate for African-American youth, 74% higher than for Hispanic youth, and 150% higher than the rate for Asian youth.

Studies indicate that in the United States, the average age at first sexual intercourse is 16 years, putting high school students at risk for acquiring HIV infection. Through June 1996, there were 2,463 reported cases of AIDS among adolescents (13–19 years of age); and 94,414 among 20–29 year olds. Because the time from infection with HIV to development of AIDS can be 10 years or more, many people with AIDS who are in their twenties were infected as teenagers. The proportion of adolescent AIDS cases diagnosed among females peaked in 1994 (43%) and declined to 40% in 1995.

Mental retardation, learning disabilities, and emotional and behavioral problems are other threats to child health. These conditions seem to be more prevalent among children living in poverty than among children in higher socioeconomic situations.

Health of Adults

In 1994, the fertility rate was 66.7 live births per 1,000 women 15–44 years of age, 1% lower than the rate of 67.6 in 1993, and 6% lower than in 1990 (70.9). There were 3,952,767 babies born in 1994, 1% fewer than in 1993. Preliminary data for 1995 indicate births continued to decline by about 1%.

Between 1993 and 1994, birth rates by age of mother fell 1% for women 15–29 years old. Rates for women in their 30s rose 1% to 2%, while the rate for women aged 40–44 years increased 5%. Rates for the youngest teenagers, 10–14 years, and for women aged 45–49 years were unchanged. The birth rate for 15–17-year-olds dropped to 37.6, and the rate for 18–19-year-olds to 91.5 per 1,000 births, both declines of 1%.

Preliminary data for 1995 suggest that teen birth rates continued to decline.

Fertility rates for women of Hispanic origin declined 1% in 1994 to 105.6 per 1,000. Preliminary data indicate that the 1995 rate (103.7) is the lowest since national data on Hispanic fertility became available in 1989. Despite the decline, Hispanic women in 1994 continued to have much higher fertility than non-Hispanic white women at all ages. For example, the birth rate for Hispanic teenagers was 107.7, compared with 40.4 for non-Hispanic white teenagers. Among Hispanic groups, the fertility of Mexican American women was highest (115.4 in 1994), followed by Puerto Rican women (81.9) and Cuban women (55.9). For Hispanic women not belonging to those three groups the fertility rate was 97.7.

AIDS is the third leading cause of death among women aged 2–44 years. The number of AIDS cases due to heterosexual transmission of the virus to women increased by 165% between 1992 and 1993, partly because of the inclusion of gynecological conditions as markers in the AIDS case definition in 1993; from 1993 to 1995 the number of cases due to heterosexual transmission declined by 14%. Although African-American and Hispanic women make up only 22% of the female population, 74% of the women diagnosed with AIDS since 1981 belong to these ethnic groups.

In 1995, 64.2% of women between 15 and 44 years of age were using some form of contraceptive. New contraceptive choices such as the Norplant implant and the “female condom” are currently available; however, the implant is costly and the extent to which it will be available to low-income women is uncertain. While the female condom has the potential to greatly reduce the incidence of STDs among women who use it, its acceptability in populations at greatest risk for these infections and unwanted pregnancies from its use are still unknown. Data for 1994 show that the abortion rate was 321 abortions per 1,000 live births, down from 345 in 1990. The abortion rate is 21 per 1,000 women in the age group 15–44. This rate remained stable from 1980–1991, and has recorded moderate but consistent annual declines since 1991.

Health of the Elderly

The aging of the population is one of the greatest challenges facing the health care system in the United States. By the year 2000, it is projected that the number of people 65 years and over will rise to 35 million, accounting for 13% of the population. That proportion is expected to climb as high as 23% by the year 2040. Most significant, however, is the rapid growth of the population 85 years of age and over, whose numbers are expected to rise 52%, to 4.6 million by the year 2000. As a result, a considerable increase will be seen in such disabling conditions as hip fractures and Alzheimer’s disease.

Heart disease, cancer, stroke, pneumonia/influenza, chronic obstructive pulmonary disease, and diabetes are the major causes of death among persons aged 65 and older. Because pneumococcal disease is three times more prevalent among those older than 65, immunization for older adults is considered a priority preventive service.

Problems such as arthritis, visual and hearing impairments, osteoporosis, incontinence, and dementia also have significant impact on the lives of seniors. Health promotion offers major benefits toward maintaining the health of the elderly. Physical activity and proper diet can increase bone mineral content, reduce the risk for osteoporotic fractures, and help maintain appropriate body weight.

Health of Special Populations

Growth has been much faster among racial/ethnic minority populations than the majority white population over the past two decades, a trend that is expected to continue for at least the next 30 years. It is projected that the African-American population will increase 35% from 1990 to the year 2020, while the population of other minority groups (mostly Asians and Pacific Islanders, but also American Indian/Alaska Natives) will more than double. The Hispanic population is expected to rise by 84%. The projected increase in the white population during this period is only 11%.

While chronic disease conditions are the leading causes of death for both minority and nonminority persons over 45 years of age, minority populations (African-Americans, Hispanics, Native Americans, and Asian American/Pacific Islanders) incur a disproportionate share of death, illness, disability, and adverse health conditions. Commonly used health indicators such as life expectancy at birth and infant mortality rates show continued widening of the health gap between minority and majority populations. Poverty is a major contributing factor to the disparities in health status.

African-Americans. African-Americans are the largest minority group, comprising 12% of the nation's population. Although African-Americans live in all parts of the country and occupy every socioeconomic level, one-half of their population lives in urban areas that are typified by poverty, poor schools, and inadequate housing, and one-third of the population lives in poverty—a rate three times that of whites.

Death rates among African-Americans exceed those of the white population by 58.8%. Rates are also higher for most of the leading causes of death. Homicide continues to be responsible for the greatest rate differential between the races. The age-adjusted death rate due to homicide in the African-American population in 1995 was about six times higher than in the white population, and it was the leading cause of death in

1995 among African-Americans 15–24 years of age. Age-adjusted death rates for chronic diseases are one-third to nearly three times higher in the African-American population than in the white population. The death rates for colorectal, respiratory, and breast cancer among the African-American population have decreased in the 1990s, as they have among the white population. The three leading causes of death for which rates were lower among African-Americans than among whites were chronic obstructive pulmonary diseases and allied conditions, suicide, and Alzheimer's disease.

Hispanics. The Hispanic population is the second largest and fastest growing minority group. Hispanic subgroups, including Mexican Americans, Puerto Ricans, Cuban Americans, and Central and South American immigrants, comprised about 10% of the total population in 1995. The birth rate among Hispanics was 25.5 births per 1,000 population in 1994, while that of the total population was 15.2 births per 1,000.

Tobacco use poses a substantial risk to the health of Hispanics, since 43% of Hispanic men currently smoke and teenagers of both sexes smoke more than African-American or white teenagers. Hispanic teenagers also report more frequent use of alcohol than African-Americans and whites.

Asians and Pacific Islanders. Speaking more than 30 different languages and representing many cultural groups, Asians and Pacific Islanders are the nation's third largest minority. Asians who have been established in the United States for generations are virtually indistinguishable socioeconomically from the majority population, and their median income is higher than that of the overall population.

Local studies have identified certain diseases that pose special health risks for Asian Americans and Pacific Islanders. The lung cancer rate is 18% greater for Southeast Asian men than for white men. Higher rates of high blood pressure have been documented among Filipino men ages 50 and older living in California than among the total California population. Tuberculosis and hepatitis B are of particular concern in immigrant communities. Rates for these conditions among Southeast Asian immigrants are 40 times higher than those in the total population.

Native Americans. The Native American Indian and Alaska Natives form the smallest minority group, numbering 2.1 million. About 50% live in urban areas, while many of the rest live on reservations. Health care for this native population is provided by the federal government through the Indian Health Service.

This population is relatively youthful, because large proportions of Native Americans die before 45 years of age and because of a relatively high level of fertility. Age-adjusted

death rates for diabetes, liver disease, and tuberculosis are two to three times higher among Native Americans than comparable rates for the total U.S. population.

The major cause of death among Native Americans under the age of 45 is unintentional injuries, which most often follow alcohol use (75%). The injury death rate for American Indians 15–24 years of age is two to three times higher than the rate for any other group. More than half (54%) of the motor vehicle accidents in this population have been attributed to the effects of alcohol.

Alcoholism is the leading health and social problem of the American Indian and Alaska Native people. The 1992 age-adjusted death rate for alcohol-induced causes among American Indians and Alaska Natives was 38.4 deaths per 100,000 population—5.6 times the rate for the total population (6.8 deaths per 100,000). Smoking and other tobacco use are also significant health problems.

Refugees. In 1995, approximately 131,300 refugees were admitted to the United States. Of these, 34% came from Eastern Europe and the former Soviet Union, 28% from East Asia, 3% from the Near East, 30% from Latin America and the Caribbean, and 3% from Africa. The number of refugees entering the United States in fiscal year 1995 represents a decrease of 9% from the number who entered the country in 1992. The number of refugees and entrants from Latin America and the Caribbean increased by 131% in the same period.

Upon arrival in this country, refugee reception and initial placement is the responsibility of 12 nonprofit organizations that operate through federally funded cooperative agreements with the Department of State. Thereafter, the refugees receive assistance from state programs funded by the Department of Health and Human Services.

Because refugees often have health problems that stem from the conditions in their countries of origin, health care services are offered in first-asylum camps located in refugee processing centers. At ports of entry, refugees and their medical records are inspected by quarantine officers who also notify the appropriate state and local health departments of their arrival. Health services are provided by the Refugee Resettlement Program for all refugees who meet a means test.

The Government provided close to US\$ 412 million in 1995 to support refugee activities both overseas and domestically. Grant program funds are awarded to state and local health offices for post-arrival health assessments to help identify health problems that might impair effective resettlement, employability, and self-sufficiency of newly arriving refugees.

People with Disabilities. In the United States, more than 49 million people have physical and mental disabilities. For these individuals, disability affects all aspects of their well-being, and has emotional, social, and financial consequences.

In 1994–1995, the National Center for Health Statistics conducted the first-ever comprehensive national disability survey in this country. The survey found that the prevalence of disabilities is disproportionately higher among minority, elderly, poor, and rural populations.

In fiscal year 1997, the Department of Health and Human Services devoted over US\$ 62 billion to programs for people with disabilities. Not only do disabilities entail high costs for individuals, but also for states and for the nation as a whole. In 1997, estimated economic losses due to disability, including the increased cost of health care and reduced productivity, was over US\$ 350 billion.

Health care is an essential component to helping people with disabilities lead independent lives, and the Department of Health and Human Services is helping to ensure that people with disabilities have access to quality health care throughout their lives. Medicare and Medicaid, the Government's largest public financing programs, in 1997 provided health insurance to about 12 million individuals considered to be disabled based on federal criteria. Spending during fiscal year 1997 is estimated at US\$ 21 billion for health care and services under Medicare, and the Government is expected to make US\$ 33 billion in Medicaid payments. The budget for FY 1998 includes proposals to help people with disabilities lead more independent lives.

As the Health Care Financing Administration (HCFA), a division of the Department of Health and Human Services, implements the Health Insurance Portability and Accountability Act of 1996, special care is being taken to protect the insurability of individuals with preexisting conditions. The HCFA also continues to support community-based, long-term care for the elderly and people with developmental or physical disabilities.

The Department of Health and Human Services supports and conducts a wide array of research activities on service organization and delivery, quality, and financing of health and long-term care for people with disabilities. In particular, the Agency for Health Care Policy Research helps policymakers plan for meeting the health needs of people with disabilities by examining their access to and use of health services, as well as their views of how the health care system works.

The lack of knowledge about the health needs of women with disabilities resulting from chronic physical impairments prompted the National Institutes of Health Office of Research on Women's Health to sponsor development of health promotion activities. These programs are identifying barriers to health promotion and are developing effective, well-defined interventions that will lead to improved health for women with disabilities.

Other Special Groups. A government-sponsored program known as Health Care for the Homeless (HCH) intends to im-

prove access by homeless individuals to primary health care services and substance abuse treatment. In 1997, 123 HCH programs were supported in 48 states, the District of Columbia, and Puerto Rico. Fiscal year 1997 funding for the HCH program totals US\$ 69 million.

Residents of public housing projects have also been targeted for assistance with federal funds to help overcome barriers to health services such as lack of transportation, language difficulties, and lack of financial resources. In 1997, a total of US\$ 9 million was awarded to 21 grantees to improve access to health care for people who reside in public housing.

Analysis by Type of Disease or Health Impairment

Communicable Diseases

Vaccine-Preventable Diseases. Among vaccine-preventable diseases, diphtheria, tetanus, pertussis, and polio either decreased or remained at a constant low level between 1988 and 1995. However, a major measles outbreak occurred in 1989–1990, after almost 10 years of relatively few reported cases. The number of measles cases in 1989 was higher than the median number reported annually during the preceding eight years, and in 1990, 27,786 cases were reported. In 1995, only 281 cases of measles were reported.

While the measles outbreak affected all age groups, the most notable increases in incidence occurred in preschool-aged children and adults over 20 years old. In several cities, data indicated that measles vaccination coverage was only 40%–65% in kindergarten children, and low coverage significantly contributed to the spread of the disease. Measles outbreaks also occurred among school-aged children with high coverage rates, prompting 21 states to require that students receive a second measles vaccination upon entering kindergarten, first grade, or middle school.

AIDS and Other STDs. The number of persons infected with HIV in the United States was estimated at between 635,000 and 900,000 in 1992. As of June 1996, 530,397 AIDS cases in adults, adolescents, and children had been reported. The number of AIDS cases more than doubled between 1992 and 1993, partly because of the expansion of the AIDS surveillance case definition in 1993, as mentioned previously. Between 1993 and 1995, the annual number of cases declined by 30%, to 71,300 in 1995.

HIV infection continues to be a major health problem, with racial/ethnic minorities bearing a disproportionate share of the burden. However, annual numbers of AIDS cases among African-Americans and Hispanics decreased 23% and 25%, respectively, between 1993 and 1995, to rates of 91 per

100,000 population in African-Americans and 42 per 100,000 in Hispanics, compared to 15 per 100,000 in whites.

In the 1993–1995 period, there was a larger proportionate decrease in reported cases among men (33%) than among women (18%). For women, 1995 rates were higher among African-Americans and Hispanics (46 and 17 per 100,000 population, respectively) than among whites (3 per 100,000). In 1995, African-American children accounted for 66% of all reported pediatric AIDS cases.

The primary exposure categories for reported AIDS cases in the United States are homosexual males (44%) and injecting drug users (26%). A growing number of people have been infected through heterosexual contact (11%). In 1995, the number of women infected with HIV through heterosexual contact exceeded the number infected through injection drug use.

Prevention programs, directed toward changing behaviors, continue to be the main strategy in the control of HIV/AIDS. Massive education and prevention programs have been undertaken to reduce injection drug use, decrease high-risk sexual behaviors, and increase the use of condoms. Efforts to develop creative preventive programs, improve care of AIDS patients, and conduct research on care have been initiated throughout the country.

Because many AIDS patients do not have medical insurance and others have depleted their private insurance and personal resources to pay for costly treatment, much of the cost for treating HIV/AIDS is borne by local and state programs as well as by Medicaid, a public health financing program.

Women in the United States are at substantial risk for sexually transmitted diseases (STDs). In 1995, rates for syphilis and gonorrhea among women were 6 and 140 per 100,000, respectively; both rates have declined during the 1990s. Once infected, women are less likely than men to have symptoms, less likely to seek care, and less likely to be diagnosed correctly after seeking care. Since STDs in women pose far more serious complications than in men (including infertility, ectopic pregnancy, and cervical cancer), it is important for women to be knowledgeable about the prevention, diagnosis, and implications of STDs.

Tuberculosis. The incidence of tuberculosis rose in the United States in the early 1990s after decades of decline. A total of 26,673 new cases were reported in 1992, a 20% increase over 1985. Since 1992, the annual number of new cases of tuberculosis has declined to about the level of 1985 (22,860 cases reported in 1995). The increase in the early 1990s was due to many factors, including the HIV epidemic, deterioration in the local public health care infrastructure, and increases in the number of cases among immigrants.

The occurrence of resistant and multi-drug-resistant tuberculosis has caused great concern regarding recent out-

breaks. A national task force, created to expand the 1989 Strategic Plan for the Elimination of Tuberculosis, developed a national action plan to control multi-drug-resistant tuberculosis. The plan defines steps that must be taken to bring current outbreaks under control, prevent new ones, and work toward the ultimate elimination of the disease.

Foodborne Illnesses. Foodborne illnesses remain a major health problem in the U.S. It is estimated that as many as 9,000 deaths and from 6.5 to 33 million illnesses are food-related. Hospitalization costs alone for these illnesses are estimated at over US\$ 3 billion a year and costs for lost productivity for seven specific pathogens have been estimated to range between US\$ 6 billion and US\$ 9 billion.

Between 1988 and 1992, 2,423 foodborne outbreaks were reported in the United States. Bacterial pathogens were responsible for causing 79% of the 1,001 outbreaks and 90% of the cases for which an etiology was determined. Outbreaks caused by *Salmonella enteritidis* continued to cause significant morbidity and mortality, but decreased by 35% between 1989 (77 outbreaks) and 1996 (50 outbreaks). In addition to bacteria such as *Campylobacter jejuni*, *Escherichia coli* O157:H7, and *Listeria monocytogenes*, parasites (including *Cryptosporidium parvum* and *Cyclospora cayentanensis*) are emerging as important foodborne pathogens. Multi-state outbreaks of foodborne illness caused by contaminated produce are of epidemiological importance.

While about 400 outbreaks are reported each year in the U.S., most foodborne diseases occur as sporadic, individual cases. In the past, passive surveillance for specific infections was conducted by local, state, and national health authorities to provide a sketch of those diseases. Beginning in 1996, an active surveillance program in five sentinel sites (FoodNet) was initiated to provide more detailed data on sporadic cases of diagnosed infections.

Noncommunicable Diseases and Other Health-Related Problems

Malignant Tumors. It is estimated that 180,200 new cases of breast cancer will be diagnosed in women in 1997, making it the second leading cause of cancer deaths among women. One in 10 women is projected to develop breast cancer in their lifetime. Although African-American women have an 18% lower incidence of breast cancer than white women, their survival rates are significantly lower, probably a result of earlier diagnosis of the disease in white women. The incidence rate of lung cancer in men began to decline in 1984, but the rate among women continues to rise.

Although incidence rates for colorectal cancer have increased since 1973, they seem to have peaked among white

males and females. In recent years there have been significant declines in incidence in both sexes in the white population, a modest decline in African-American females, and stability in African-American males. Mortality rates for colorectal cancer have risen somewhat among African-American males; however, for African-American females the mortality rate has been stable in recent years.

Accidents and Violence. In 1995, nearly 151,000 Americans died from injuries sustained from motor vehicle accidents, falls, burns, drowning, poisoning, homicide, and suicide. This translates into more than 400 people who die from injuries each day; at least 58 of these are children. Costs due to injury including direct medical care and rehabilitation as well as lost income and productivity in 1995 are estimated at more than US\$ 224 billion. This represents an increase of 42% over the last decade. Accidental injuries kill more people between the ages of 1 and 34 in the United States than any other cause. Many measures for preventing unintentional injury are available, such as safety belts and child safety seats to prevent traffic fatalities, smoke detectors to warn residents of fire, and fencing around swimming pools to prevent drowning, but people do not use them consistently.

Traffic fatalities have decreased remarkably over the past 30 years. Even so, more than 1.2 million people died on the roads during that period, and traffic accidents remain the leading cause of death from unintentional injury. At present, motor vehicle crashes account for nearly one-third of all injury fatalities, and they are the leading cause of death for persons 5–24 years of age. Alcohol is involved in over 40% of all traffic deaths, and is a factor in about 1.2 million crash-related injuries each year. In 1993 alone, there were over 1.5 million arrests for driving while under the influence of alcohol or narcotics. It is estimated that about two in every five persons in the U.S. will be in a traffic accident involving alcohol at some time in their lives.

Every year, nearly 900 people die from injuries sustained while cycling. Another 550,000 injured bicyclists are treated in emergency departments, 33% of these for head injuries. Head injuries are involved in 62% of bicycle-related deaths. Studies have shown that bicycle helmets reduce the risk of head injury by 80%.

The United States currently has the highest overall fire death rate of all industrialized countries. Residential fires are the major cause of overall fire-related mortality. In 1995, 414,000 residential fires claimed the lives of 3,640 individuals and injured another 18,650 people. Direct property damage exceeded US\$ 4.2 billion; fire death and injury costs totaled US\$ 16 billion. Persons living in residences equipped with functional smoke detectors are half as likely to die in a house fire. About one-quarter of U.S. households lack a working smoke detector.

On an average day, 70 people die from homicide in the United States, 87 people commit suicide, as many as 3,000 attempt suicide, and a minimum of 18,000 survive assaults. Between 1990 and 1995, the age-adjusted homicide rate decreased by 8.9% to 9.2 deaths per 100,000 population, and among males aged 25–44, the rate decreased by 20.4%. However, there were large disparities in homicide rates in 1995 among males aged 15–24. African-American males had rates 18 times higher, and Hispanic males had rates 8.7 times higher than white males. Homicide is the second leading cause of death for young people aged 15–24 and the leading cause for African-Americans in that age group.

In 1994, almost 5,000 women in the United States were murdered. In those cases in which it was known whether or not the perpetrator and the victim knew each other, only 13% were killed by a stranger. Of the women murdered by someone they knew, approximately half were murdered by a spouse or someone with whom they had been intimate. The great majority of assaults on women do not result in death, but in physical injury and severe emotional distress. In 1985, the most recent year for which there are data, an estimated 1.8 million women were physically assaulted by male partners.

From 1980 to 1995, the suicide rate for the U.S. population rose only slightly. Still, suicide was the ninth leading cause of death in 1995. Each year, suicide claims more than 30,000 lives; about 80% of those who die are males. Mortality data compiled for the 1990–1995 period show that the rate of suicide among children under 15 years of age in the United States was double the average suicide rate among that age group in other highly industrialized countries. From 1952 through 1995, suicide rates among adolescents and young adults more than tripled. From 1980 to 1995, the rate of suicide among people aged 15–19 increased by 23%, and among those aged 10–14, the increase was 118%. For African-American males aged 15–19, the rate increased by 146% in this period.

Suicide rates continue to be highest among people aged 65 and older. The 1980–1990 period was the first decade since the 1940s in which the suicide rate for older people rose instead of declined. In 1995, persons aged 65 and older accounted for 13% of the population but almost one-fifth of all suicides. Because this is the fastest growing age group in the United States, it is likely that the number of suicides in this age group will continue to increase.

Behavioral Disorders. In 1994, there were 5,932 mental health facilities in operation in the United States. Nearly 60% (3,216) were operated and/or funded in whole or in part by a state mental health agency. State and county mental hospitals numbered 260 (5%); private psychiatric hospitals, 430 (8%); residential treatment centers for emotionally disturbed children, 459 (9%); general hospitals with separate psychiatric services, 1,612 (30%); Veterans Administration psychiatric

organizations, 161 (3%); and all other mental health organizations, 2,470 (46%).

Mental health facilities received US\$ 37.4 billion in funding in 1994. Of this amount, facilities funded in whole or part by state mental health agencies received US\$ 23.2 billion, and US\$ 7.4 billion of these funds went to state and county mental hospitals. The Medicaid program provided 20.4% (US\$ 7.7 billion) of total funds received by all mental health facilities in 1994, and 21.9% (US\$ 5.1 billion) of funds received by mental health facilities operated and/or funded by state mental health agencies. Managed care organizations provided funds to 2,662 (46%) of all mental health facilities.

In 1992 (the latest year for which data are available), the one-year prevalence of mental disorders other than substance abuse was 16% among non-institutionalized, non-rural adults between the ages of 18 and 54. Of these adults, 11.1% had a depressive (affective) disorder, and 34.2% obtained treatment. The prevalence of depressive disorders was higher among women (34.2%) than among men (13.1%).

Substance Abuse. Approximately 11% of preventable deaths in the United States are related to alcohol and illicit drug use. Alcohol is associated with motor vehicle crashes and fatal intentional injuries such as suicides and homicides: in 1994, 19,470 deaths were attributed to alcohol-induced causes. Heavy alcohol use, defined as five or more drinks in a row at least once in the prior two-week period, has increased in the past several years. In 1995, the rate of heavy use among high school seniors was reported as 28%; among college students, the rate was 41%.

In 1992, the prevalence of marijuana use among high school seniors began to increase. Of related concern is the continued decline in the proportion of high school seniors who perceive social disapproval of occasional use of marijuana and physical and psychological harm from regular marijuana use. The rate of use among young adults (18–25 years) remained about the same in 1994 and 1995.

The Secretary of Health and Human Services has named the Youth Substance Abuse Prevention Initiative as one of the Department's six key initiatives. Consistent with the objectives of the Office of National Drug Abuse Policy, the initiative aims to educate the country's youth and enable them to reject illegal drugs, as well as alcohol and tobacco. Its primary goal is to reverse the upward trend in marijuana use and to reduce by 25% the rate of use among youth aged 12–17.

Oral Health. Dental and oral diseases, including dental caries and periodontal diseases, may be the most prevalent and preventable conditions in the United States, especially among lower socioeconomic groups. Although oral health status has been improving on average, especially among children, expenditures for dental services totaled US\$ 45.8 billion

in 1995, about 5.2% of all expenditures for personal health care. Of that total, 95.6% was paid either “out-of-pocket” by consumers or through private dental insurance. It is important to note, however, that less than one-half the U.S. population has such insurance.

A nationwide survey conducted between 1988 and 1994 found that more than 60% of children under the age of 10 had a caries-free primary dentition, as had 55% of children and adolescents aged 5–17. While caries in permanent teeth continue to decline among school-aged children, 45% of them still suffer from this preventable disease. Tooth decay is nearly universal among American adults. The survey found that 94% of people aged 18 and older had either untreated decay or fillings in the crowns of their teeth. Women had more caries than men, but they also had slightly less untreated decay. Whites had approximately twice as many coronal caries as African-Americans and Mexican Americans, but these two groups had more tooth surfaces in need of treatment than did whites. Women had better periodontal health than did men, and whites had fewer periodontal problems than did African-Americans or Mexican Americans.

Oral cancer primarily affects adults over age 60 and results in over 8,000 deaths annually. Treatment of oral cancer is costly and frequently results in significant disfigurement and loss of function. The most common risk factors for oral cancers are tobacco and alcohol use and excessive exposure to sun. Early detection and treatment can reduce both morbidity and costs. Workplace or community-based strategies to eliminate use of tobacco could prevent many of the 30,000 new cases of oral cancer that occur each year.

RESPONSE OF THE HEALTH SYSTEM

National Health Plans and Policies

The most comprehensive U.S. policy to improve health and prevent adverse health conditions is called Healthy People 2000. The central goal is to increase the number of people who live long, healthy, and disability-free lives. The second goal of the plan calls for the elimination of disparities in health among population groups. The third goal of the strategy is to achieve access to clinical preventive services for all people.

As overall coordinator of Healthy People 2000, the Office of Disease Prevention and Health Promotion, a program office in the Department of Health and Human Services, works with Public Health Service agencies, other federal agencies and departments, and members of the Healthy People Consortium. The Consortium consists of 345 national membership organizations representing professional, voluntary, and corporate interests and 271 state agencies that collaborate to support

the prevention agenda and achieve the year 2000 goals. The Consortium members have worked on revising and adding to the year 2000 objectives and many have participated in periodic progress reviews chaired by the Assistant Secretary for Health.

In 1994, the Public Health Service undertook a midcourse review of the Healthy People 2000 objectives. The resulting review document showed that of the 300 objectives, 50% were moving toward the target, 18% were moving away from the target, 3% showed no change, and 29% had insufficient data to measure progress. As of 1997, 44 states, the District of Columbia, and Guam had published Healthy People 2000 plans of their own. By 1993, 70% of local health departments were using Healthy People objectives.

At the 1996 meeting of the Healthy People Consortium, at which WHO and PAHO were represented, the foundation was laid for the third generation of these objectives, Healthy People 2010, which will be released in January 2000. Consortium members and federal, state, and local agencies are collaborating to develop a set of objectives that will reflect current prevention science and the most important health promotion and disease prevention issues. Healthy People 2010 is the United States response to the World Health Organization's *Renewing the Health for All* strategy.

Health Services and Resources

Organization of Services for Care of the Population

Food and Nutrition. Diet plays a critical role in the prevention of diseases such as coronary heart disease, cancers, strokes, and diabetes mellitus, which are leading causes of death and disability in the United States. Improvement of maternal and child nutrition is especially critical to improving national health.

Objectives in improving nutrition nationwide relate to obesity, relationships between diet and disease, the application of the “Dietary Guidelines for Americans” to food service operations, dietary counseling, food labeling, nutrition education in schools, maternal and infant nutrition, and feeding of older people. Strategies to achieve these objectives focus on the following: labeling foods in a way that facilitates consumers’ application of the dietary guidelines; ensuring that the dietary guidelines are followed in institutional meal preparation, such as in schools and day-care centers; and nutrition education, particularly for school-aged children, low-income populations, and medical professionals.

The strategy for food safety involves four components: regulatory measures to increase food safety; technical support for states and territories for regulation of food operations; surveillance systems to track the incidence of foodborne

pathogens; and communication with consumers about safe food-handling practices.

Environmental Health. Addressing environmental health concerns requires the participation of federal agencies including the Department of Health and Human Services, the Environmental Protection Agency, the Department of Agriculture, and the Department of Transportation, as well as state and local agencies, the private sector and community groups. The wide range of priority areas reflects the broad nature of the problems. Some of the priorities include environmental health education, risk assessment programs for state health agencies, emergency response programs, and water/sanitation projects among migrant and rural people.

In its ongoing efforts in disease prevention, the U.S. Public Health Service recognizes that environmental risks are underlying factors contributing to the disease process. Among the numerous diseases and dysfunctions that have a known or suspected environmental component are cancer, reproductive disorders such as infertility and low birthweight, neurological and immune system impairments, and respiratory conditions such as asthma. Exposure to environmental hazards covers a broad range of factors such as pesticides, toxic chemicals, and radiation. The environmental component of a particular disease or health outcome is frequently the result of repeated and cumulative exposures.

The magnitude of the threat posed by environmental hazards on the health of the nation is evident in the following examples. In 1995, one-third of the United States population lived in an area where the air was too polluted to meet health standards. One in four United States residents lived within four miles of a so-called "Superfund site," which denotes areas assigned highest priority by the Environmental Protection Area for accelerated clean-up of hazardous wastes. Aquifers from which much of the country draws its drinking water are shrinking faster than they can be replenished, and as this happens, they become increasingly vulnerable to toxic contamination.

Family Planning Services. Public funds to provide family planning services come from several programs. The largest source of funds is the federal-state Medicaid program, which focuses on low-income women. In fiscal year 1997, Medicaid reimbursed health care providers an estimated US\$ 475 million for their provision of family planning services.

The only federal program dedicated solely to funding family planning services is Title X of the Public Health Service Act, "Population Research and Voluntary Family Planning Programs." Funded agencies provide a variety of contraceptive options, along with education and counseling to low-income women, especially those who do not qualify for Medicaid and lack private insurance. With a fiscal year 1997 budget

of US\$ 198 million, the Title X program serves 5 million women through a network of 5,000 clinics nationwide. Family planning services are also partially supported in most states with federal funds from the Maternal and Child Health Block Grant and the Social Services Block grant program. In addition, some family planning clinics receive support from state and local sources.

The Adolescent Family Life Program has a fiscal year 1997 budget of US\$ 14.2 million for programs to control the number of teen pregnancies. With these funds, it supports community-based demonstration projects focusing on issues of adolescent sexuality, pregnancy, and parenting. Prevention projects encourage adolescents to abstain from early sexual activity. Parental consent is required for receipt of these services.

Research and Technology

Research. Biomedical and behavioral research and training are conducted through a vast network of extramural programs involving the country's major universities, medical schools, and research centers. The federal government supports nearly 40% of all biomedical research and development in the country through the National Institutes of Health (NIH). The highest funding priority at NIH is basic research. This research investment has led to many achievements: new knowledge about the body, from the level of the gene to organ systems; research and clinical technologies; new diagnostic techniques; new drugs to fight illnesses; and new vaccines to prevent disease. Through its training programs, NIH ensures a steady flow of young researchers into the biomedical research community.

The total NIH budget for fiscal year 1998 is approximately US\$ 13.6 billion, which includes US\$ 1.6 billion for AIDS research. Approximately 79% of the budget supports extramural research and training in the United States and abroad and about 11% of the budget supports intramural research conducted at NIH's own laboratories. Although international cooperation accounts for only about 1.5% of the total NIH budget, it is an important component of the NIH research portfolio. Interaction on a global scale among biomedical and behavioral researchers, technicians, and laboratories increases the opportunity to capitalize on scientific opportunities and new technologies for the diagnosis, prevention, and treatment of disease.

Technology Transfer. Technology transfer has gained increased importance in the United States. It involves the dissemination of research results; collaboration between public, academic, and industrial organizations on research and development projects; licensing of intellectual property rights; and introduction to the marketplace of new devices, vaccines,

diagnostic and therapeutic drugs, etc. Effective partnerships between these entities increase the capacity to conduct laboratory and clinical research, facilitate the movement of scientific discoveries into public health advances, and contribute to economic growth. NIH is considered the preeminent government technology transfer entity in the United States, since it accounts for over 80% of the royalty income generated by the entire Government.

While technology transfer activity has increased, there have been numerous issues and concerns regarding its administration, such as how academic and industrial collaborations and agreements affect NIH-funded activities. Another area of concern is how public investments in research are reflected in the price of health care products. NIH has addressed this issue by using careful selection procedures for its partners, constructive negotiation techniques, aggressive monitoring of licensee's timely achievement of established benchmarks, and ensuring that discoveries move as rapidly as possible into the marketplace to improve public health.

The management of intellectual property, such as human genome research discoveries, is a new area requiring careful consideration. At issue is whether intellectual property derived from government-funded research should be patented or made available to the public.

Health Services Research. Increased emphasis is being placed on research to improve delivery of health services, patient outcomes, and assessment of health care technology. The Agency for Health Care Policy and Research (AHCPR), a part of the Public Health Service, is the lead agency charged with supporting research designed to improve the quality of health care, reduce its cost, and broaden access to essential services. The fiscal year 1997 budget for AHCPR was US\$ 143.5 million. These funds support research to test assumptions on which current health policies and practices are based; to examine new ways to organize, finance, and deliver health services; and to improve health care technology assessment methods.

Surveillance and Data Systems

Health information is vital to understanding the health status of the population and the planning, implementation, description, and evaluation of public health programs designed to control and prevent adverse health events. Data must be accurate, timely, and available in a usable form to allow the successful tracking of the status of public health objectives. The foundation for planning and evaluating the Healthy People 2000 objectives for the nation is information and its analysis.

The Public Health Service has established national surveillance and data system objectives in order to improve the cov-

erage and effectiveness of public health data systems. Important activities at the national level include the direct collection and compilation of data collected by other agencies; analysis and dissemination of health information about progress toward achieving the Healthy People 2000 objectives by other federal, state, and local agencies; assistance to state and local agencies in conducting public health surveillance and evaluation of data; and coordination of a federal, state, and local surveillance network for diseases of public health importance.

Expenditures and Sectoral Financing

National health expenditures in 1995 were US\$ 988.5 billion, up from US\$ 937.1 billion in 1994. Growth in health spending in 1995 was slightly higher than the 5.1% increase registered in 1994, while spending rose by US\$ 156 per person from US\$ 3,465 in 1994. Growth in the nation's health care spending decelerated steadily from annual double-digit and near double-digit increases in the 1980s and early 1990s to 6.9% in 1993. The growth rates for 1994 and 1995 are the slowest in more than 30 years. National health expenditures represented 13.6% of the gross domestic product in 1995.

The health care system in the United States relies heavily on the provision of payment for medical care through private insurance. Private insurance provided by employers or purchased individually covers about three-quarters of the population; 14% of the population has no medical coverage at all.

Medicare and Medicaid funded about 36% of all spending for personal health care in 1995 and accounted for 80.9% of the public share of health care financing. These two programs financed 47% of hospital care and about 26.9% of physician services.

Medicare, created in 1965, was designed to protect people 65 and older from the high costs of medical care. In 1972, it was expanded to cover other populations such as disabled workers and people with end-stage renal disease. Unlike other federal health programs, Medicare is not financed solely from the general revenue. In 1995, 85.4% of the hospital insurance portion of the program came from a 1.45% payroll tax levied on both employers and employees. The Supplemental Medical Insurance portion of Medicare that covers physician services is financed through monthly premiums paid by the 35.7 million beneficiaries.

Spending has grown faster for Medicare than the private sector, primarily because the private sector has garnered greater savings from managed care. Medicare must base its managed care payments on a formula related to Medicare fee-for-service costs. Therefore, under current law, Medicare may not benefit from discounts and other factors that generate savings for the private sector. This is a primary reason why

private sector spending grew at a rate of 2.9% in 1995 while public sector spending grew by 8.7% in that year.

Managed care is characterized by its emphasis on preventive care, elimination of unnecessary services, negotiated price discounts, and smaller copayments and deductibles. More than half of the U.S. population was enrolled in managed care in 1995.

Medicaid, also initiated in 1965, is a combined state-federal program intended to provide services to the poor. The federal government determines broad eligibility guidelines and mandatory services. Individual states have the option of expanding the basic coverage package by offering additional services. In 1995, Medicaid provided services to 36.3 million people and had actual expenditures of US\$ 328.9 billion.

Medicaid expenditures are mostly institutional, with 39.1% spent on hospital care and 27.2% spent on nursing home care. It is the largest third-party payer of long-term care expenditures, and financed 46.5% of nursing home care in 1995. One-fourth of program benefits went to poor Medicaid recipients, while the blind and disabled, who account for only one-third of the Medicaid population, used three-fourths of the benefits.

External Technical and Financial Cooperation

The United States provides technical assistance in health to other countries primarily through the U.S. Agency for International Development (USAID). In fiscal year 1996, the Center for Population, Health, and Nutrition obligated approximately US\$ 916 million for such assistance. The Department

of Health and Human Services works with countries directly or in partnership with USAID on technical cooperation health activities of mutual benefit.

Global public health issues have an increasing effect on the health of the population of the United States. Trends such as emerging and reemerging infectious diseases, food and pharmaceutical harmonization, global disease surveillance mechanisms, and the increasing importance of chronic diseases all are serious concerns. The United States is an active participant in multilateral and bilateral efforts to address the growing importance of these issues.

There is ongoing international collaboration on several fronts. Programs under the supervision of the Office of International and Refugee Health, Department of Health and Human Services, include: the Health Committee of the Gore-Chernomyrdin Binational Commission; the promotion of enhanced cooperation with Mexico, with special emphasis on the border; the U.S./Mexico Binational Commission; the development of a new program with USAID in Egypt, focusing on health policy and decision-making; support for the Gore-Mbeki Commission, a bilateral agreement with South Africa; cooperation with Israel, the Netherlands, Japan, and China on health policy and related issues; provisions of departmental support for global programs with WHO, UNAIDS, UNICEF, and PAHO; and ongoing cooperation with the Office of Refugee Resettlement and USAID on refugee health issues and emergency response capacity.

The United States is using the lessons learned from Healthy People 2000 to develop Healthy People 2010. The country is seeking to share its own experience and learn from other countries to improve the next generation of health for all.