Human Rights Group Calls NIH Plan to Address Racial and Ethnic Health Disparities Inadequate, Urges Revision

At the center of the strategic plan developed by the National Institutes of Health (NIH) to eliminate racial and ethnic disparities in health is a blind spot that will prevent the plan from achieving its goals, according to a critique of the plan by Physicians for Human Rights (PHR). Because the plan focuses solely on disparities in health status and ignores the quality of care received by minority groups, it fails to incorporate steps to understand factors that contribute to unequal treatment, PHR says. Without such an understanding, inequities in the quality, intensity, and comprehensiveness of diagnostic procedures and in treatment choices afforded minority patients will continue to result in minority populations' "living sicker and dying younger."

The NIH Strategic Research Plan and Budget to Reduce and Ultimately Eliminate Health Disparities was posted for public comment in October 2003. PHR, a national nonprofit human rights organization, released a 22-page critique of the plan in January. The critique is based on PHR's analysis of hundreds of peer-reviewed studies of racial and ethnic disparities in health care. Many of these studies were cited by the Institute of Medicine (IOM) in its landmark 2002 report *Unequal Treatment: Documenting Racial and Ethnic Disparities in Healthcare.* This research shows that the quality of health care received by patients from ethnic minority groups is poorer than that received by white patients across the full spectrum of disease categories and medical and surgical procedures, even when analyses control for status-related factors, such as health insurance, sex, age, income, hospital type and resources, severity of disease, and comorbidity.

In its critique, PHR commends NIH for its commitment to eliminating racial and ethnic disparities in health and notes that the NIH plan recognizes that such disparities are the result of many factors. The plan includes quality of care and racial discrimination in a list of contributing factors—and even acknowledges that discrimination may not be overt but can result from insensitivity or a lack of cultural competence. However, it is the plan's failure to include research on the causes of unequal treatment that is of most concern to PHR. Such studies would explore such areas as the nature and impact of stereotyping, patients' mistrust of providers, the effectiveness of various interventions in eliminating disparities in the quality of care, and the role of socioeconomic status and racial bias. These and other research recommendations were outlined by PHR in *The Right to Equal Treatment,* a report published shortly before the NIH plan was released.

In a January 27 op-ed piece for *The Washington Post,* H. Jack Geiger, M.D., past-president of PHR, attributed the plan's gaps to a broad effort to "paper over" systematic deficiencies in health care for minorities. He described how the Department of Health and Human Services recently rewrote a report card on health care in America that had been drafted by the Agency for Healthcare Research and Quality. The revised version played down references to racial and ethnic disparities, describing them as problems that existed "in the past," and concluding that "there is no implication that these differences result in adverse health outcomes."

Although the PHR critique calls the overall NIH plan inadequate, it also notes that three of NIH's 27 centers and institutes offer plans that can serve as models to other NIH groups in revising their research strategies. The exemplary plan presented by the National Institute of Mental Health (NIMH) proposes research to address quality-of-care issues, including studies to examine whether providers use different interventions for different minority groups; to identify behaviors and principles of providers that affect the quality of care and treatment outcomes for minority groups; and to explore factors that overcome disparities in service delivery to and use by ethnic populations. The PHR critique notes that NIMH is particularly cognizant of treatment inequities since the publication in 2001 of the U.S. Surgeon General's report, which noted racial and ethnic disparities in service availability and access are more of a problem in mental health than in other areas of medicine.

PHR also singles out the plan of the National Institute of Neurological Disorders and Stroke, citing the institute's major research initiative on social, behavioral, and clinical issues in the use of analgesics, which have been found to be underprescribed for minority patients. In addition, NIH's Office of Behavioral and Social Sciences Research is commended for proposing to investigate socioeconomic status, health systems issues, and racial bias.

The NIH strategic plan is available on the Web site of the National Center on Minority Health and Health Disparities at www.ncmhd.nih.gov. The critique can be found on the Physicians for Human Rights site at www.phrusa.org.

Warnings About the Dangers of Ecstasy Appear Effective as Rates of Teen Drug Use Continue an Overall Decline

The number of U.S. teenagers reporting use of any illicit drug in the past 12 months has declined for the third year in a row, according to the 2003 Monitoring the Future Survey. Use of ecstasy decreased significantly among all teens, in particular among tenth- and 12th-grade students, whose reported past-year use has fallen by half since 2001.

Survey investigators attributed the decline in ecstasy use to a growing perception among youths of its dangers, which have been described in national advertising campaigns and in other public education efforts since early 2002. The rate of ecstasy use reported by 12th-grade students in 2003 was 4.5 percent, down from 9.2

percent in 2001. Three percent of tenth-graders reported use in 2003, compared with 6.2 percent in 2001. Among eight-graders use has fallen from 3.5 percent in 2001 to 2.1 percent in 2003.

The Monitoring the Future survey has been conducted since 1975 among high school seniors and since 1991 among students in the eighth and tenth grades. In the latest survey, nearly 50,000 students from 392 U.S. public and private secondary schools were interviewed. The survey, which is funded by the National Institute on Drug Abuse, was designed and conducted by the University of Michigan Institute for Social Research

The survey found that in 2003 overall use of illicit drugs fell significantly among eighth- and tenth-grade respondents—16 percent of eighth-graders and 32 percent of tenth-graders reported using an illicit drug in the past 12 months. Rates in 2001 were 19.5 percent among eighth-graders and 37 percent among tenth-graders. In 2003, the rate of illicit drug use among high school seniors was 39.3 percent, compared with a 2001 rate of 41.4 percent. Use of illicit drugs reached its most recent peak among teens in 1996 and 1997. Since then only eighth-graders have exhibited a gradual but significant ongoing decline. Use in the upper grades held fairly constant until 2002, when rates in all three grades began to decline.

Because marijuana is by far the most widely used illicit drug, trends in its use tend to drive the index of any use of illicit drugs. In 2003 rates in the upper grades declined for the second year, and the rate among eight-graders declined for the seventh consecutive year. Rates of marijuana use in 2003 were 35 percent for seniors, 28 percent for tenth-graders, and 13 percent for eighth-graders, down from 2001 rates of 37, 33, and 15.4 percent, respectively. For the first time in several years students in all three grades reported an increased perceived risk of marijuana use, which may be attributable to a national advertising campaign that began to air in October 2002.

Use of cigarettes in all three grades, which has declined steadily for several years, fell significantly among high school seniors in 2003—24.4 percent reported use in the past 30 days compared with a rate of 26.7 percent in 2002. Past-month use of cigarettes was 10.2 percent among eighth-graders and 16.7 percent among tenth-graders in 2003.

Alcohol use changed little in 2003. Reported use in the past 30 days was 20 percent for eighth-graders, 35 percent for tenth-graders, and 48 percent for 12th-graders. Occasions of heavy drinking (having five or more drinks in a row sometime in the past two weeks) continued to decline slightly in all three grades.

Survey findings of increased use of some substances—especially inhalants and the synthetic narcotics oxycodone and hydrocodone—have raised concerns. Inhalant use has consistently been highest among eighth-grade students, most likely because inhalant products are cheap and easy to obtain. After several years of substantial decreases in all three grades, use of inhalants by eighth-graders increased significantly this year—from 7.7 percent in 2002 to 8.7 percent in 2003, whereas use by tenth- and 12th-grade students declined slightly to 5.4 and 3.9 percent, respectively.

Illicit use of oxycodone and hydrocodone among teenagers has been monitored only since 2002. Rates have increased in all three grades, though none significantly. The 2003 rates for oxycodone use were 1.7 percent for eighth-graders, 3.6 percent for tenth-graders, and 4.5 percent for 12th-graders. Corresponding use of hydrocodone was 2.8, 7.2, and 10.5 percent.

This year survey investigators expressed particular concerns about findings for eighth-grade students, who have been harbingers of change for the upper grades. Eighth-grade respondents are no longer reporting declines in use of several drugs—including hallucinogens other than LSD, amphetamines and methamphetamine, and tranquilizers—and in past-month alcohol use. The decline in their use of cigarettes is also decelerating. Investigators suggest that "generational forgetting," which was apparent in the early 1990s and which appears to have contributed to significant upswings in illicit drug use by 1996 and 1997, is about to take place again.

Results of the survey are available at www.monitoringthefuture.org.

NEWS BRIEF

SAMHSA guide for clergy: The Substance Abuse and Mental Health Services Administration (SAMHSA) has developed a guide designed to help clergy members obtain the basic information and skills needed to help addicted individuals and their families. *Core Competencies for Clergy and Other Pastoral Ministers in Addressing Alcohol and Drug Dependence and the Impact on Family Members* summarizes the discussions and conclusions of an expert consensus panel held a year ago in Washington, D.C., to find ways of engaging faith communities in prevention and treatment of substance abuse and dependence. Twelve core competencies are described, and steps are outlined for developing curricula and integrating substance abuse training into seminary programs. The guide is available on the SAMHSA Web site at www.samhsa.gov.