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MEMORANDUM TO ALEXIS HERMAN
MIKE LUX
MELANNE VERVEER
CHRIS JENNINGS

DATE: **August 25, 1993**

FROM: **Charlotte Hayes**

SUBJECT: **Health Care Reform--Strategy for African-Americans and Hispanics groups**

STRATEGY-ONE IDEA

We should build an outreach/surrogate/supporter activity network and schedule of forums based on the coalition of African-American and Hispanic groups with whom we have already met in particular the meetings held for two days in June with the National Medical Association and other African-American and Hispanic provider groups. With some of the minority working group members as speakers, we should work with these groups and the Congressional Black Caucus and Hispanic Caucus to set a schedule of regional community forums on health care reform. Perhaps starting with 4 or 5, in Los Angeles, New York, and Florida, MidWest, Southern state locales matching to our congressional strategy.

In any event, those on the attached list should be contacted at the time of roll out, receive the initial plan documents, and have a briefing on its contents.

BACKGROUND

We have been working with the NMA and some of the other groups (see attached lists.) We have a great opportunity to have them bought in early if we play it right and can build on the meetings (like the 2-day one in June) they have already had with us. As you know, the essential is the direct communication to allay fears and shortcut rumors as well as get **our** plan out. We can affirmatively show that we have included much of what they offered as comments on the plan as then conceived. In addition, we can and must address one of the most important concerns: minority providers will be discriminated against by a new system that relies on large managed care organizations that have historically excluded African-American and Hispanic providers and shunned their communities.

These groups are different. They are very distrustful of policy-makers who say they will safeguard their concerns. The NMA is the oldest and most influential of the minority health professional organizations. Like the AMA, it exists to serve its membership and has traditionally done so by providing vehicles (social gatherings, newsletters, a journal and scientific meetings) for exchanging information. Like the other minority groups, the NMA lacks anywhere near the financial and personnel resources of the majority medical associations; however, NMA has appointed their outgoing President (Dr. Richard Butcher) as the leader of their health care reform effort for the next three years. I have established a good relationship with him and his lobbyist.

SOME SIGNIFICANT CONTACTS TO DATE

In the last few years, the NMA has attempted to become more of a player in the policy arena with mixed results. The NMA organized a Summit on May 2-3, 1993 to explore issues related to health care reform among African-American health care professional and civil rights leaders. **Ira spoke to the group and was met with some hostility and many sharp questions. As a result, we solicited them for follow up meetings.**

NMA was one of many African-American and Hispanic interest groups (see attached list), which spent 2 days, June 4 and 5, assessing the plan as then conceived, meeting with working group leaders and **talking with Ira for more than 2 hours.** They offered detailed comments on anti-discrimination provisions they believe are essential to ensure that the overhaul is fair to all Americans and does not produce what they believe are worse situations for health care of African-Americans. After the meeting, NMA and some of the groups sent a set of 11 guidelines for health care reform that are consistent with our plan as conceived. (see attached document.)

The First Lady spoke by telephone to the NMA 98th Annual Convention Council of Delegates meeting held in San Antonio, TX on August 10. Reports are that she was well received, though some wished they could have had her there in person with an opportunity to ask questions and have her address the discrimination against provider issue. (Talking points attached.)

SOME STATISTICS

African-American and Hispanic physicians are a very small group nationally. Though minorities (African-American, Hispanic and Native-American) constitute 22% of total U.S. population, only 7% of practicing physicians are minorities (or approximately 35,000.) African Americans comprise 12.1% of the population and 3% (or approximately 16,000) of the practicing physicians. Minorities will make up 25% of U.S. population by 2000, and yet the number of minorities matriculating in U.S. medical schools has not increment proportionately. [Source: Council on Graduate Medical Education/HHS/PHS/HRSA October 19, 1992.]

THE BIG ISSUES

The big issues, among others, are:

1. Discrimination against and exclusion of minorities from plans;
2. Discrimination against and exclusion of minority providers (apparently some states, most recently Arkansas, have included provisions in managed care programs that operate to exclude minority physicians--I am doing some research into this issue);
3. Universal coverage;
4. Access to health care;
5. Undocumented persons;
6. Disproportionate illness among African-Americans;
7. Primary and preventive care;
8. Minority medical schools; and
9. National Health Service Corps.

HEALTH CARE REVIEW GROUP

James Acevedo	American HealthCare Management
Jesse Barber	National Medical Assn
Phillip Brooks	National Hospital Assn
Richard Butcher	National Medical Assn
Michael Byrd	Harvard School of Public Health
Pamela Cashaw	Riverside General Hospital, Houston, TX
Linda Clayton	Harvard School of Public Health
Rosemary Davis	National Medical Assn
Susan Drake	National Immigration Law Center
Adolph Falcon	National Coalition of Hispanic Health & Human Services Orgs.
Hector Flores	Chicano/Latino Medical Assn
Maria Elena Flood	Texas Tech Health Science Service Center
Joyce Essien	Emory U. School of Public Health
Luis Estevez	New York City Health and Hospitals Corp.
Thurman Evans	National Medical Assn
Earnest Gibson	Riverside General Health Care System
Tessie Guillermo	Asian-American Health Forum
Hazel Harper	National Dental Assn
Joseph Henry	Harvard School of Dental Medicine
Anne Hill	National Urban League
Sadako Holmes	National Black Nurses Assn
Charles Kamasaki	National Council of La Raza
Gertrude Elizabeth King	Queens Village Comm. for Mental Health
Daphne John	Riverside General Hospital, Houston, TX
B. Waine Kong	Assn Black Cardiologists
Osvaldo Lopez	InterAmerican College of Physicians & Surgeons
Randall Maxey	National Medical Assn
Ramona McCarthy	National Pharmaceutical Assn
Lauren Mayeno	Assn Asian Pacific Coomunity Health Orgs
Vernellia Randall	University of Dayton School of Law
Elena Rios	Chicano/Latino Medical Assn of California
Rene Rodrigues	InterAmerican College of Physicians & Surgeons
Diane Sanchez	National Hispanic Coalition for Health Reform
Frank Sessoms	NAACP
Westley Sholes	National Assn Black County Officials
Samuel Simmons	Center on Black Aging
Paul Simms	National Black Caucus of Health Workers
Terri Smith-Moore	National Pharmaceutical Assn
Sara Torres	National Assn Hispanic Nurses
David Valdez	Chief Resident, Corpus Christi, TX
Herbert Weldon	National Black Hospital Assn

CO-CONVENERS

National Medical Association
Congressional Black Caucus Foundation, Inc.

PLANNING COALITION

Association of Black Cardiologists, Inc.
Black Congress on Health, Law and Economics
Joint Center for Political and Economic Studies
National Association for the Advancement of Colored People
National Association of Black County Officials
The Black Caucus of Health Workers
National Black Nurses Association
National Dental Association
National Pharmaceutical Association
National Urban League

COALITION PARTNERS

Alpha Kappa Alpha, Inc.
Alpha Phi Alpha, Inc.
Auxiliary to the National Medical Association
American Black Chiropractor Association
Black Leadership Commision on AIDS
Black Psychiatrists of America
Black Women's Agenda, Inc.
Charles R. Drew University of Medicine and Science
Chi Delta Mu Fraternity, Inc.
Chi Eta Phi Sorority, Inc.
Children's Defense Fund
Congress of National Black Churches
Congressional Black Associates
Delta Sigma Theta Sorority, Inc.
Howard University College of Medicine
Jack and Jill of America, Inc.
Kappa Alpha Psi, Inc.
The Links, Inc.
Meharry Medical College
Morehouse School of Medicine
National Association for Sickle Cell Disease, Inc.
National Bar Association
National Black Caucus of State Legislators
National Black Media Coalition
National Black Women's Health Project
National Caucus and Center on Black Aged, Inc.
National Coalition of 100 Black Women
National Conference of Black Mayors, Inc.
National Council of Negro Women
National Forum for Black Public Administrators
National Minority AIDS Council
National Newspaper Publishers
National Podiatric Medical Association
National Society of Allied Health
National Tots and Teens, Inc.
Omega Psi Phi, Inc.
Phi Beta Sigma, Inc.
Quality Education for Minorities Network
Sigma Gama Rho, Inc.
Student National Dental Association
Student National Medical Association
United States Senate Black Legislative Staff Caucus

SPONSORS

Robert Wood Johnson Foundation
Henry J. Kaiser Family Foundation
Kellogg Foundation
Downstate Medical Center, New York
Kennedy King Community College, Illinois
NMA, Region VI
Prairie State Medical Society, Illinois
United Hospital Medical Center, New Jersey

*GUIDING PRINCIPLES FOR HEALTH CARE REFORM**

1

Universal coverage for all residents
- Every American is entitled to basic health service coverage.
- Every American is entitled to access to a benefit package of basic health care services.
- Every American is entitled to the highest quality of health care services, delivered by culturally-sensitive health care providers.

2

Affordable health services without financial barriers
- Access to the health care system should not be limited by a person's ability to pay for services which may be long-term and expensive.
- Access to the health care system should not be determined by whether a person is employed, unemployed, or under-employed.
- Access to the health care system should begin with an extensive program of health promotion and disease prevention.
- Access to the health care system is enhanced when patients are made active participants in the promotion of good health and the prevention of disease.

3

A national health program that includes a basic benefits package for all medical conditions
- A national health care program should provide basic benefits, incorporating diagnostic, therapeutic, and reasonable services for every medically necessary condition, including dental care, mental health, long-term care, and pharmaceutical products and services.
- A national health care program should be based on health promotion and disease prevention.

4

A national health care program that is accountable to the public
- A national health care program should be monitored by all levels of government to insure quality, access, and standards for cost.
- A national health care system should be accountable to the public by involving the public to insure that the system responds to community needs.
- A national health care system should clearly define the roles and relationships of public hospitals in the broad health care system.

5

Consumer and provider empowerment
- Health care consumers and health care providers must be involved in the design of any reformed health care system.
- Health care consumers and health care providers must be involved in the implementation of any reformed health care system.
- Health care consumers and health care providers must be involved in the decision-making and evaluation of a reformed health care system that promotes family-oriented, community-based care.

* Adopted by the Planning Coalition for Summit '93: African American Prescription for Health/Intercultural Health Coalition.

6 **Assurance of high quality and efficiency, as well as availability, adaptability, and acceptability of the national health care program**

- Availability must include full and equal access to and participation in health care plans for all Americans, with the inclusion of health care providers who are culturally-sensitive.
- Adaptability of the national health care program must focus on the diverse and serious health care concerns of the nations' underserved population and the delivery of high quality health services to that population.
- Acceptability of the national health care program must be based on meeting the health care needs of all Americans.

7 **A payment mechanisms to insure desired health outcomes**

- A payment mechanism for health care services should be efficient and provide incentives for prevention, primary care, and the continuity of care and service to the underserved.
- A payment mechanism for health care should place emphasis on health promotion and disease prevention.

8 **A national health care program that supports education and training**

- A national health care system should provide incentives for the training of African American health professionals and other persons committed to serving underserved populations.
- A national health care system should provide additional incentives to historically black colleges and universities.

9 **A national health care program that encompasses the principle of affirmative action**

- A national health care program must provide for full and equal access by all health care workers, consumers, and trainees.
- A national health care program must include the establishment of African American-owned and operated networks that provide health-related services.

10 **Expansion of consumer education**

- Consumer education must focus on the individual, family, and community institutions.
- Consumer education must focus on health promotion and disease prevention.
- Consumer education must be responsive to cultural diversity in the American population.

11 **Reform of malpractice insurance, tort procedures, and anti-trust laws**

- The delivery of affordable health care services should not be limited by the high cost of malpractice insurance.
- The delivery of affordable health care services should be enhanced by the reform of legal procedures which produces a system which is responsive both to the needs of the patient and the health care provider.

Please share this message with family friends, colleagues, neighbors, church members, public officials , and others!

History of NMA and/or Coalition Interaction with the White House

December 16, 1992.....Meeting with Judith Feder, included Drs. Richard Butcher and Jesse Barber; Singleton McAllister, Esq. and Mrs. Rosemary Davis

January 22, 1993.....Mrs. Davis and Pontheolla Mack-Abernathy attended the White House signing of medical legislation on the use experimential use of fetal tissue and abortion rights

February 19, 1993.....Mrs. Davis met with one of the Task Force workgroups

March 29, 1993.....Dr. Butcher testified before Vice President Albert Gore and other Task Force leaders

March 30, 1993.....Dr. Butcher met with White House Senior Advisor for Policy Development, Ira Magaziner

April 30, 1993.....Drs. Butcher, Davidson and Lawrence along with Mrs. Davis met with Donna Shalala of Health and Human Services

May 2-3, 1993.....Coalition hosted "Summit '93: African American Prescription for Health" Ira Magaziner was the keynote speaker

May 17, 1993.....Members of the Coalition met with Ira Magaziner to discuss concerns over involvement in policy making process

June 4-5, 1993.....Members of the Coalition met with Task Force group leaders, reviewed proposed health care reform package and offered reccomendations

NATIONAL MEDICAL ASSOCIATION, AFRICAN-AMERICANS AND HEALTH CARE REFORM

TALKING POINTS

I want to thank your President, Dr. Richard Butcher and President-Elect Leonard Lawrence for their hard work and participation in a series of meetings on health care reform held at the OEOB with Ira Magaziner and members of the working groups. Dr. Butcher worked with a number of other minority interest groups to make suggestions for improving the health plan as then conceived.

From the beginning of the process to make recommendations to the President on health care reform, we have ensured that we addressed the problems of underserved populations, particularly access to health care, lack of health insurance coverage and the need for primary and preventive care.

We have met with Rep. Stokes, who heads the Congressional Black Caucus Health Brain Trust and will continue meeting with him and members of the Brain Trust.

Our working groups included hands-on health care providers, as well as health policy experts, from all the minority communities, including African-Americans, Hispanics and Native Americans.

Just some of the notable African-American providers are:

Dr. Claudia Baquet (BACK-QUAY), who is the director of the Office for Minority Health at the Department of Health and Human Service;

Dr. Risa Lavisso-Mourey, Deputy Administrator Agency for Health Care Policy and Research at HHS and a geriatrician from Philadelphia, who is in San Antonio with you today;

Dr. Mark Smith, of the Kaiser Foundation in San Francisco and an expert on AIDS;

Dr. Aaron Shirley, from Jackson, Mississippi and the clinic he founded (I am also proud to note that he just received a MacArthur Foundation Genius Grant for and to continue his work in his community;

Dr. Marian Gray Secundy, a noted medical ethicist at Howard University School of Medicine;

Dr. David Satcher, the President of Meharry Medical School, which educates the majority of African-American physicians in America. (I am proud to say that Dr. Satcher is the President's choice to be the new Director of the Centers for Disease Control in Atlanta); and

Dr. Reed Tuckson, President of Drew Medical School in Los Angeles.

We met and consulted, multiple times, with many minority health interest groups, including groups like the National Medical Association and the National Black Nurses Association.

You and I know that minority Americans suffer disproportionately more from diseases such as cancer, hypertension, diabetes, AIDS, infant mortality, and chemical dependency than white Americans.

That is why we are emphasizing that primary and preventive care are key for all Americans, especially minorities, who have lacked access to care because of who they are, where they live, and because they do not have insurance coverage.

We know that we must increase the number of minority providers; and, therefore historically black medical schools and schools like Drew are key because they educate most of the African-American physicians who have tended to practice in low-income areas and serve minorities.

We support an expanded National Health Service Corps to increase the number of primary care physicians in areas with a shortage of health care professionals.

We have worked to craft a proposal that is sensitive to preserving the important role of minority health care providers in their communities as we create a new system that relies on health plans serving large geographic areas with diverse populations.

In addition there are many other elements of the new system we have talked about to ensure that the most vulnerable populations are receive quality care.

The Health Security Plan

LATINO/HISPANIC HEALTH CARE

As America's fastest growing minority group, with a unique set of cultural and linguistic needs -- Latinos are the single group most at risk of going without care and coverage today. single group most at risk of going without care and coverage today. Even though Latinos have high workforce participation, they are often employed in low-skill, low-wage industries which normally provide little or no coverage. In addition, Latinos face a number of tremendous health care challenges which require special interventions. the include:

- *A lack of access to primary and preventive care.*
- *Rates for tuberculosis and other infectious diseases more than double those of the population at large.*
- *Inadequate prenatal care during the first trimester of pregnancy.*
- *Diabetes rates almost double those of the population at large.*

Latino and Hispanic Americans deserve health care that responds to their specific needs and guarantees comprehensive benefits that can never be taken away.

Guaranteed Comprehensive Benefits:

- The Health Security plan will guarantee all American citizens and legal residents comprehensive health benefits they can never lose. Health alliances and plans are prohibited from discriminating on the basis of race, ethnicity, gender, religion, or country of origin.
- Medicaid recipients will be eligible for the same comprehensive benefits and choice of health plans offered to the rest of the population.
- Alliances will be prevented from creating two-tier systems of care, and a system for redressing grievances quickly is required of all plans and alliances.

Investments in Community-Based Care

- Community-based plans that can best address the needs of a particular community will be encouraged through special incentives, capital development programs, and public health initiatives.
- New initiatives designed to expand access to care and encourage primary care will bring high quality medicine to millions of Latino/Hispanic Americans who are now medically underserved.
- The Health Security plan's health care workforce initiatives will increase funds for medical schools that train primary care doctors and expand the National Health Service Corps and this will increase the number of Latino/Hispanic physicians, nurses, and other health professionals.
- Under the Health Security plan, providers will receive higher payments to reflect the cost of inner city care.

Focuses on Prevention and Research

- The comprehensive benefits package covers a wide range of preventive services including prenatal care, well-baby care and nutritional counseling to reduce infant mortality and get children off to a healthy start.
- The Health Security plan will increase funding for research into diabetes, heart disease, and stroke.

Seamless Coverage

- Portability of coverage will be ensured under the Health Security plan. This provision guarantees that migrant laborers and their families will maintain full coverage even when they move from state to state.
- Undocumented persons will continue to have access to emergency and public health services as they do today.

Community Input

- Alliances will have a board of directors composed of equal numbers of consumers and employers who purchase care in that area. Each alliance will reflect the communities it serves.

- To ensure that health plans are responsive to community needs, they will conduct annual consumer surveys and must seek out those in communities that have historically been denied access to high quality care.

October 8, 1993

The Health Security Plan

AMERICANS WITH DISABILITIES

Americans with disabilities are a large and diverse population. Of the estimated 35 to 43 million people with physical or mental impairments, a significant portion are of working age. For many, their disability status -- compounded by the lack of available and affordable assistance -- renders them unable to get health insurance, and hurts their job prospects. All this despite the protections of the landmark Americans With Disabilities Act.

In a health insurance industry that competes by insuring only the healthiest people, Americans with disabilities are often discriminated against, dubbed "high risk" applicants because they may have higher health care costs. Those who <u>are</u> able to obtain insurance are often forced to pay the highest rates in the market, and are still faced with a lifetime limit on benefits. After that, they're on their own.

Guaranteed Comprehensive Benefits

- Under health reform, all Americans -- including those with disabilities -- are guaranteed a comprehensive package of benefits at the agreed-upon community rate. Like all other Americans, persons with disabilities will be able to choose their doctor and health plan.

- There will be no lifetime limits on care -- a change that will free many Americans with disabilities to go to work without fear of losing the health benefits they now get through Medicaid or through private coverage.

- Benefits will include not only acute-care services, but also certain rehabilitative services in both inpatient and outpatient settings.

- The guaranteed benefits package, protections from discrimination in health care, and new services will substantially improve access to health services for Americans with disabilities.

Community-Based Long Term-Care

- A new community-based long-term care benefit will aid Americans of all ages with severe physical or mental disabilities, regardless of income. This will benefit 840,000 Americans.

- Children under the age of six with severe disabilities or chronic medical conditions who would otherwise require hospital or institutional care will be able to receive home and community-based assistance.

- Through the new home and community-based program, a broad range of personal assistance services will be available to children and working age adults with severe disabilities.

- States will have the flexibility to design their own approaches to community-based care. States may expand their programs beyond personal assistance to include case management, homemaker and chore services, home modifications, respite services, assertive technology, adult day care, and rehabilitation services.

- For low-income persons with lesser levels of disability, states will be able to continue their home and community-based programs under Medicaid.

New Tax Credit

- Under the Health Security plan, employees with disabilities who require personal assistance with daily tasks will be eligible for new tax credits covering 50 percent of their personal care service costs -- up to a maximum of $15,000 each year.

October 8, 1993

The Health Security Plan

ASIAN/PACIFIC AMERICANS

Asian/Pacific Americans are diverse and dynamic populations with unique health care needs. They are among the biggest owners of small businesses, primarily family-owned sole proprietorships. As such, Asian/Pacific Americans face tremendous obstacles to finding affordable, stable coverage for their families and employees.

Many other Asian/Pacific Americans work in low-paying service jobs which provide little or no coverage and limit their access to care. Recent immigrants also confront cultural and language barriers that can prevent them from seeking or receiving needed care. A lack of familiarity with prevention and primary care services leads to outbreaks of preventable illnesses that eventually require more costly treatments.

To compound these unique problems health information sources often undercount Asian/Pacific Americans and do not collect separate information on different Asian American communities. The Health Security plan will respond to the unique cultural needs of these communities and guarantee comprehensive benefits to all.

Guaranteed Comprehensive Benefits

- The Health Security plan will guarantee all Americans citizens and legal residents comprehensive health care benefits that can never be taken away. Health alliances and plans will be prohibited from discriminating on the basis of race, ethnicity, gender, religion, or country of origin.

- States will provide financial incentives to ensure that health plans enroll disadvantaged groups and provide appropriate services such as outreach, education and interpreting services that remove cultural and linguistic barriers to care.

- The comprehensive benefits package covers a wide range of services to detect and prevent illness, including annual physicals, prenatal care, well-baby care, immunizations and cancer screenings.

Affordable Coverage

- The Health Security plan guarantees that no employer who participates in a regional alliance will pay more than 7.9% of payroll for health premiums. Depending on average wages, small businesses with fewer than 50 employees will be eligible for additional discounts that hold premiums to as low as 3.5% of payroll.

- Owners of low-wage small businesses, who today are only able to provide bare bones insurance and have trouble securing care for family members, will be able to provide comprehensive insurance to their employees at a reasonable price.

- Under the Health Security plan, the self-employed and independent contractors will be able to deduct 100% of their insurance costs, up from 25% today.

Community-Based Investments

- Community-based plans that can best address the needs of a particular community will be encouraged through special incentives, capital development programs, and public health initiatives.

- The Health Security plan will support community providers who speak the community language and understand the cultural differences of communities they serve. The plan will help these providers to establish networks that will enable them to compete equally in the new system.

Incentives for Providers

- New initiatives designed to expand access to care, encourage primary care, and develop more diverse health care professionals will bring high quality medicine to millions of Asian Americans who are now medically underserved.

- The plan's health care workforce initiatives will increase funds for medical schools that train primary care doctors and expand the National Health Service Corps. The plan will increase the number and diversity of Asian-American health care providers.

Community Input

- Alliances will have a Board of Directors composed of equal numbers of consumers and employers who purchase care in that area. Each alliance will reflect the community it serves.

- Health plans will conduct annual consumer surveys and seek out those in communities that have historically been denied access to high quality care and identify their access and health care needs. Other research studies will evaluate the impact of health reform on cultural and ethnic population groups not reached by current surveys.

October 8, 1993

The Health Security Plan

AMERICAN INDIANS AND ALASKA NATIVES

Health reform initiatives that affect Native American people will proceed within the framework of government-to-government relationships with the more than 500 sovereign Native American nations. Under the Health Security plan, the federal government will continue to expand funding for health care services for these underserved groups. Tribal governments will have autonomy and flexibility in devising health care which works for them.

The Health Security plan will not limit options currently available to tribes to control and operate their own health facilities.

Guaranteed Comprehensive Benefits

- The Health Security plan will guarantee all Americans comprehensive health care benefits they can never lose. Health alliances and plans are prohibited from discriminating on the basis of race, ethnicity, gender, religion, or country of origin.

- American Indians and Alaska Natives will be able to enroll in health plans offered through the regional alliances in their area, and are eligible for financial subsidies on the same basis as all other Americans.

Preserves and Strengthens the Indian Health Service

- Indian Health Service clinics and hospitals, tribal health centers and urban Indian programs will continue to operate outside regional health alliances.

- The Indian Health Service will be granted new authority to expand public health and prevention activities, and to cover Indian and non-Indian residents living on and around reservations.

- Under the Health Security plan, Indian Health Service centers will be able to contract services to non-Indian residents enrolled in health plans in their area.

Investments in Public Health Initiatives

- Public health service programs for American Indians and Alaska Natives will be expanded to improve access to available services in remote areas, and to provide health care that is sensitive to the diverse languages and cultures of these communities.

- The plan will provide incentives to increase the number of medical professionals including community health representatives, public health nurses, nutrition counselors and mental health and substance abuse professionals in order to provide more and better prevention and treatment services.

Recruits Health Professionals

- To recruit and train American Indian and Alaska Native health professionals, the plan will increase funding for Indian Health Scholarship Programs.

Community Input

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The Health Security Plan

HEALTH CARE COVERAGE FOR AFRICAN-AMERICANS

African-Americans face a health care system stacked against them -- they are among those Americans most at risk of going without care and coverage today. Losing or changing jobs often means losing health insurance, and African-Americans have one of the highest unemployment rates in the country. The health of African-Americans is also aggravated by:

- *Homicide and legal intervention rates which are seven times higher among African-American males (61.5%) than white males (8.1%).*
- *African-American infant mortality rates are double (18.5%) those in white communities (8.1%).*
- *High mortality rates from preventable diseases -- including heart disease, cancer, and stroke .*

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- Medicaid recipients will be eligible for the same comprehensive benefits and the same choice of health plans offered to the rest of the population.
- Alliances will be prevented from creating two-tier systems of care, and a system for redressing grievances quickly will be required of all plans and alliances.

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