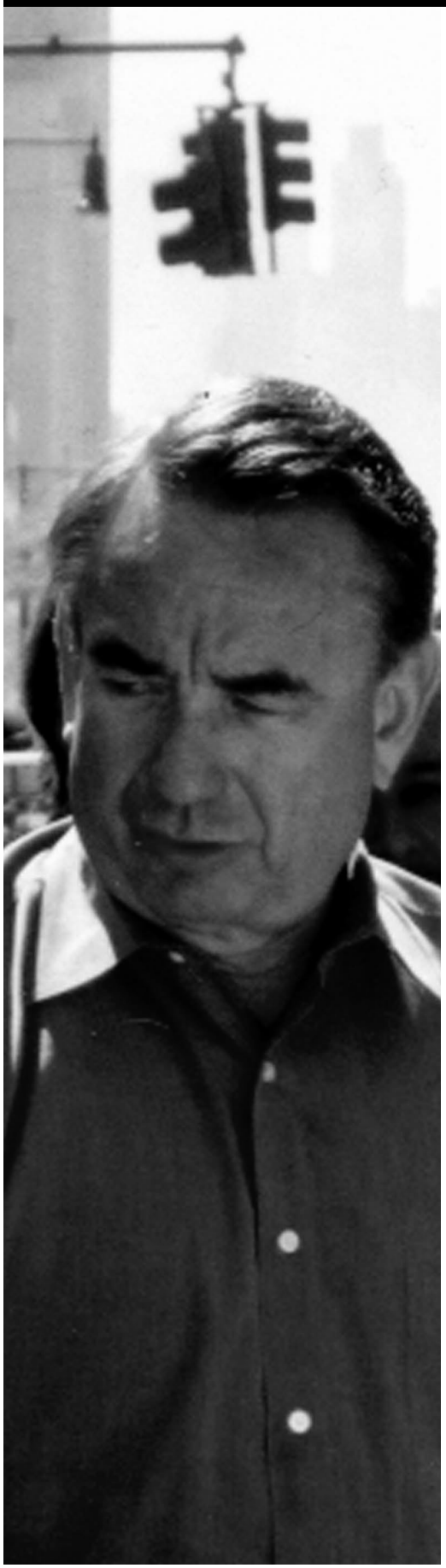
Responded to Other Health Threats to Our Nation and Communities



In addition to dealing with terrorist attacks, HHS and its components have continued to address on-going health threats to Americans that affect our daily lives. HHS continues to take a lead role in advancing the overall health of the nation through initiatives to prevent disease, ensure proper nutrition, as well as prevent and treat substance abuse and mental health problems.

As Americans continue with their daily lives, there is good news that life expectancy for Americans reached a record high of 76.9 years in 2000, according to the most recent preliminary figures from CDC. Mortality declined for several of the leading causes of death, namely for heart disease and cancer.

The leading causes of death and disability—heart disease and stroke, cancer, diabetes, and arthritis—are chronic diseases and are among the most prevalent, costly, and preventable of all health problems. More than 90 million Americans live each day with chronic diseases and seven out of ten Americans die of these diseases. The problems are caused in large part, by behaviors established during youth—tobacco use, high-fat diets, inadequate physical activity, drug and alcohol use, and risky sexual behaviors.

Although chronic diseases account for the majority of all United States deaths, infectious diseases remain a leading cause of death worldwide. Earlier predictions of the elimination of infectious disease did not take into account changes in demographics and human behaviors and the extraordinary ability of microbes to adapt, evolve, and develop resistance to drugs. Because of the advances and accessibility of modern transportation, epidemics can jump from city to city and from continent to continent within just hours. HIV/AIDS and the West Nile Virus are just two of the infectious diseases that currently threaten the American population. There is also a continuing need for immunization of children from various infectious diseases and adults from influenza, pneumonia, and Hepatitis B.

Over the past several decades the nation's capability to determine and address potential environmental health threats has eroded. Such threats also continue to pose risks to our health and pose significant challenges to public health and environmental policy makers.

HHS, its components, and many partners continued to direct resources and effort in FY 2001 to address these concerns.

"Americans on average are living longer than ever before, and much of this is due to the progress we've made in fighting diseases that account for a majority of deaths in the country. But we can do more by eating right, exercising regularly, and taking other simple steps to promote good health and prevent serious illness and disease."

-Tommy G. Thompson.

HHS and its components are working with their partners to provide Americans the protection and information necessary to prevent and treat these chronic and infectious diseases, as well as environmental diseases such as asthma.

Heart Disease Prevention

Cardiovascular disease (CVD)—primarily heart disease and stroke—is the nation's number-one killer of men and women across all racial and ethnic groups. More than 40% of deaths in the United States—900,000 each year—are directly attributable to heart disease and stroke, and CVD is the leading cause of death in all states, with associated annual costs exceeding $286 billion.

In FY 2001, state-based cardiovascular health programs were expanded to include 27 states and the District of Columbia. The number of states with five of the seven core prevention capacities that support healthy behavior and appropriate health care also increased. The seven core prevention capacities include partnership development, scientific capacity, policy and environmental strategies, state cardiovascular health plan, training and technical assistance, population-based strategies, and strategies for priority populations.

The performance target for FY 2001 was to have 15 states that have five of the seven core prevention capacities. Although data are not available for FY 2001 until the summer of 2002, the GPRA targets have been exceeded for the prior two years. The FY 1999 and FY 2000 targets of 8 and 11 respectively, were in actual performance, accomplished by 11 and 15 states, respectively. This is a continuing positive trend, which started from a low of 7 states in FY 1998.

In FY 2001 CDC also developed a first-ever, comprehensive resource to assist states' programs in focusing their prevention strategies for men. CDC released a report on "Men and Heart Disease: An Atlas of Racial and Ethnic Disparities in Mortality." The atlas shows disparities of heart disease death rates among U.S. men aged 35 years and older.

Diabetes Prevention

Nearly 16 million Americans suffer from diabetes, and the number of new cases is increasing steadily by approximately 800,000 per year. Diabetes is the primary cause of new cases of blindness, non-traumatic amputations, and kidney failure in adults. According to the American Diabetes Association, in 1997, the medical expenditures incurred by people with diabetes were $10,071 per capita, compared with $2,669 per capita for people without diabetes.

AN OUNCE OF PREVENTION IS WORTH....

As many as 50,000 U.S. adults die annually of vaccine preventable diseases of influenza, pneumococcal infections, and Hepatitis B, the cost to society exceeds $10 billion each year.

For every $1 spent, childhood vaccines for

Diptheria, Tetanus, and Pertussis save $27.00,

Measles, Mumps, and Rubella save $13.50, and

Chickenpox (Varicella) saves $5.40.

Every 1 to 3 percent reduction in fat intake would reduce the overall incidence of coronary heart disease by 32,000 to 92,700 cases, saving $4.1 billion to $12.7 billion in medical costs and productivity losses over 10 years (US$1993).

A regular exercise regimen would cost only $3,433 per life-year gained (US$1985).

Early detection through screening and timely intervention can reduce the incidence of severe vision loss in diabetic mellitus sufferers by 50 percent to 90 percent. The cost of providing currently suggested screening and treatment of diabetic retinopathy is $1757 per person-year of sight saved.

In addition to the high costs of morbidity and mortality, HIV has high economic costs. The estimated lifetime cost in the U.S. of treating just one person infected with HIV is $155,000. Multiplied by 40,000 persons infected each year, this means additional annualized costs of more than $6 billion every year.

Drug prevention investments and decreases in the prevalence of drug abuse have a direct correlation. Cost benefit ratios range from 8:1 to 15:1 on reduced costs in crime, school and work absenteeism, as well as reduced need for and costs of substance abuse treatment.

Sources: "An Ounce of Prevention...What are the Returns?," 2nd Edition, October 1999, CDC, CDC FY 2003 GPRA plan, and the Office of National Drug Control Policy.

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— Tommy G. Thompson

In FY 2001, a landmark study on diabetes was concluded. On August 8, 2001, Secretary Thompson and NIH's National Institute of Diabetes and Digestive and Kidney Diseases announced results of the Diabetes Prevention Program, a major clinical trial comparing diet and exercise to treatment with the diabetes drug metformin in more than 3,200 people with impaired glucose tolerance, a condition that often precedes diabetes. The study showed that people at high risk for type 2 diabetes could sharply lower their chances of getting the disease with diet and exercise. The study proves that diet and exercise-as little as 30 minutes a day-can surpass drug treatment efforts.

Also, on May 4, 2001, the National Diabetes Education Program,(NDEP), a joint federal program run by NIH and CDC, joined forces with CMS to help older adults understand that routine self-monitoring of blood sugar levels can help delay or prevent the complications of diabetes.

There are some populations that are more likely to have diabetes than the rest of the U.S. general population. A recent Harvard/CDC study found that the lowest life expectancies in the country for both men and women exist in American Indian communities. Further, the more current National Center for Health Statistics mortality data (1996-1998) found that the diabetes health disparity is worsening for American Indian/Alaska Native (AI/AN) people. The diabetes death rate for AI/AN people is now 291 percent higher than the general population; an increase over the 249 percent cited in last year's *Accountability Report*.

To deal with this trend, HHS' Indian Health Service (IHS) and Indian tribes continued to deliver IHS-funded diabetes prevention and treatment services in FY 2001. The IHS Diabetes program conducts an annual medical record review of a random sample of charts to assess compliance with the standards of care for diabetes. For FY 2000, the most recent data available, key indicators directed at reducing complications of diabetes including blindness, remained the same or improved. Glycemic control continued to increase over the past three years, from 22 percent in FY 1998, to 24 percent in FY 1999, and 26 percent in FY 2000. The FY 2000 target for improvement over the FY 1999 target of 25 percent was met. The blood pressure control targets were not met in FY 1999 or FY 2000 and the actual performance has fluctuated from 27 percent in FY 1997, to 38 percent in FY 1998, while the 35 percent actual rate in FY 2000 is essentially the same as the 36 percent rate in FY 1999. The FY 2001 actual performance data will not be available until problems with aggregated data reporting in the automated patient records data system are corrected.

In FY 2001, funding and technical assistance were also provided by CDC to the national network of diabetes control programs. CDC documented that 100 percent of the programs have adopted, promoted, and implemented guidelines for improving the quality of care for persons with diabetes. Also, studies were conducted on translating research findings into clinical and public health practice, which were then published in peer-reviewed journals.

Increasing Immunization for Infectious Diseases

By all accounts, efforts to protect children in the U.S. from vaccine-preventable disease have been a success. CDC data shows that because of high levels of childhood vaccinations, diseases and deaths associated with chickenpox (varicella), diptheria, pertussis, tetanus, measles, mumps, rubella, and Hib (cause of bacterial meningitis) are at, or near, all time lows in the United States. Cases of most vaccine-preventable diseases of childhood are down by more than 97 percent from peak levels before vaccines were available. The FY 2001 incidence data is not available until the fall of 2002, however the FY 2000 data show that polio, rubella, measles, and tetanus cases decreased from FY 1999. The 90 percent vaccination rate for children aged 19 to 35 months was achieved for four of the six recommended vaccines, and there was significant improvement for the chickenpox vaccinations.

Progress also continued toward meeting the Healthy People 2010 goal for immunization coverage rates for influenza and pneumococcal disease among adults aged 65 years and older. These coverage rates have continually increased to 67 percent for influenza and 54 percent for pneumococcal vaccination in FY 1999. The target rate of 70 percent for influenza may not be met for FY 2000 because CDC has a preliminary estimate of 68 percent for influenza coverage in FY 2000. This was accomplished despite challenges in production and supply of the influenza vaccine for that year. The FY 2001 performance target was to have 72 percent of adults aged 65 years and older vacci-

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nated for influenza and 63 percent for pneumococcal disease. Data is expected by the summer of 2003.

In FY 2001, in response to delay and a possible vaccine shortage, CDC developed recommendations for use of influenza vaccine during the 2001–2002 influenza season. CDC, with the Advisory Committee on Immunization Practices and other partners, also prepared a media campaign, developed a Web site to facilitate purchase and possible redistribution of influenza vaccine, and provided technical assistance to state and local health departments dealing with vaccine delays.

Expanding HIV/AIDS Treatment

Of the infectious diseases, HIV remains a deadly infection for which there is no vaccine or cure and for which there are limited treatments. Recent advances in highly effective antiretroviral medications allow people to live longer with HIV. As people live longer with infection, the potential for spreading infection increases.

An estimated 800,000-900,000 persons are living with HIV infection in the United States. Although incidence has decreased substantially from the high of 150,000 cases per year in the late 1980s, CDC estimates that some 40,000 Americans become infected with HIV every year.

HHS' Health Resources and Services Administration (HRSA) is the focal point for the federal response to the needs of those who are living with the HIV disease. HRSA partners with states, heavily impacted metropolitan areas, and community-based providers to provide health care and support services to those with HIV/AIDS.

In FY 2000, an estimated 500,000 people received HIV medical care and related supportive services through HRSA's Ryan White Comprehensive AIDS Resources Emergency Act programs. Outpatient and ambulatory care services for women and racial/ethnic minorities (per CDC reports, groups for which the incidence of AIDS cases continue to increase, despite the reduction seen overall), increased from FY 1998 to FY 1999. The targets for serving a proportion of women and racial/ethnic minorities in Title I-funded programs that exceed their representation in national AIDS prevalence data, by a minimum of five percent for FY 2000 and FY 2001, are 64 percent and 69 percent, respectively. Actual performance data will be available for these years in January 2002 and January 2003. However, the FY 1999 target of 64 percent was exceeded when a 68.9 percent rate was achieved.

Concerns about the confidentiality of HIV surveillance data could hamper state-based initiatives to include HIV surveillance as part of their HIV prevention plans. Therefore, CDC issued technical guidance for HIV/AIDS surveillance that precludes the release of HIV/AIDS surveillance data for non-public health purposes. In FY 2001, 100 percent of the states had adopted and maintained recommended security and confidentiality standards.

HHS and CDC's HIV/AIDS activities are not limited to the United States. In June 2001, CDC expanded the Global Aids program to include and address the HIV/AIDS epidemic in the Caribbean and Latin America.

Although the incidence has not risen to the same level as the other diseases discussed, the spreading threat of West Nile virus and other arboviral diseases prompted CDC to provide more than $16 million in funding to 47 states, 5 cities, and the District of Columbia to bolster their epidemiologic and laboratory capacity for surveillance of and response to the West Nile Virus.

Preventing and Controlling Asthma

Environmental factors may be linked to existing health conditions that have worsened over the past few years. For example, an estimated 14.9 million Americans have asthma (including 4.8 million children). The number of people with asthma increased by 102 percent between 1980 and 1994. The financial burden of asthma was $6.2 billion in FY 1990 and approximately $11 billion in 1998.

In FY 1998, CDC established asthma contacts in all 50 states to act as focal points for initiation of asthma programs. The first step in developing a national program to address this epidemic is to enable all states and major cities that can document an asthma problem to implement core asthma programs that track incidence, ensure that interventions are science-based, and develop partnerships within the state.

CDC and the states exceeded the FY 2001 performance targets for improving state and local public health capacity to prevent and control asthma. Although the target was 18 states to have implemented core asthma programs, 22 states implemented core asthma programs. This trend has steadily increased from zero states in 1997, to four in FY 1999, and 12 in FY 2000.

Providing Food Nutrition

Poor nutrition and lack of physical activity contributes to at least four of the ten leading causes of death and disability. The costs associated with diet-and activity-related health conditions, including direct health care and lost productivity were estimated at $71 billion a year, according to a U.S. Department of Agriculture paper issued several years ago. Older Americans are particularly vulnerable to poor nutrition.

To combat this problem, in FY 2001 funds were provided to states, area agencies, and tribes which are part of the Administration on Aging's nationwide Aging Network for meals served in congregate (group or community) settings, and home-delivered meals and other community-based services. The Aging Network is comprised of 56 State Units on Aging, 655 Area Agencies on Aging, 233 Indian Tribal organizations, and two organizations serving Native Hawaiians.

The Network leverages funds received from AoA to provide meals and other community-based services. These meals provided 40 percent to 50 percent of a client's daily intake from one meal per day according to the 1996 program evaluation entitled "Serving Elders at Risk".

Based on an analysis of the most recent available information for FY 1999, the trend toward an increase in home-delivered meals continued up from 119 million meals served annually in FY 1995 to 134.9 million in FY 1999. AoA exceeded its FY 1999 target of 119 million for home-delivered meals. Congregate meals served decreased from 114.1 million in FY 1998 to 112.8 million in FY 1999. The target for FY 1999 had been 123.4 million so this target was not met. The FY 2001 targets are 176 million and 115.2 million for home-delivered and congregate meals, respectively. Actual data will be available in February 2003.

Preventing and Treating Mental Illness

An estimated 51 million Americans, including eight million children suffer from mental illness. The attacks of September 11th emphasize the traumatic effect tragic events have on mental health, for people both directly or indirectly involved. In FY 2001, HHS' Substance Abuse and Mental Health Administration (SAMHSA), funded $28 million in grants to provide immediate support to victims; SAMHSA also provided mental health support throughout the nation.

SAMHSA works in partnership with state and local governments, other federal agencies, non-profit treatment providers, consumers, clients, and a wide range of grantees to provide needed mental health services through the Community Mental Health Services Block Grant program. The program assists adults with serious mental illness and children with serious mental disturbances. The purpose of the program is to move the care for adults and children from costly and restrictive inpatient hospital care to the community where they can receive the necessary treatment and support to live more fulfilling and productive lives.

In 1999, 16 states began a pilot project to develop uniform data and unduplicated counts of people served in state hospitals, as part of the 32 performance indicators which will be used to assess performance under the block grants. The FY 2000 and FY 2001 targets for the 16 state project were to have 16 states participating and doing piloting of the 32 performance indicators. These targets were met. The pilot program was due to be completed by the end of FY 2001 and the pilot program results will be published in FY 2002. Concerns remain regarding the ability of states other than the 16 pilot states to adopt the indicators without assistance from SAMHSA.

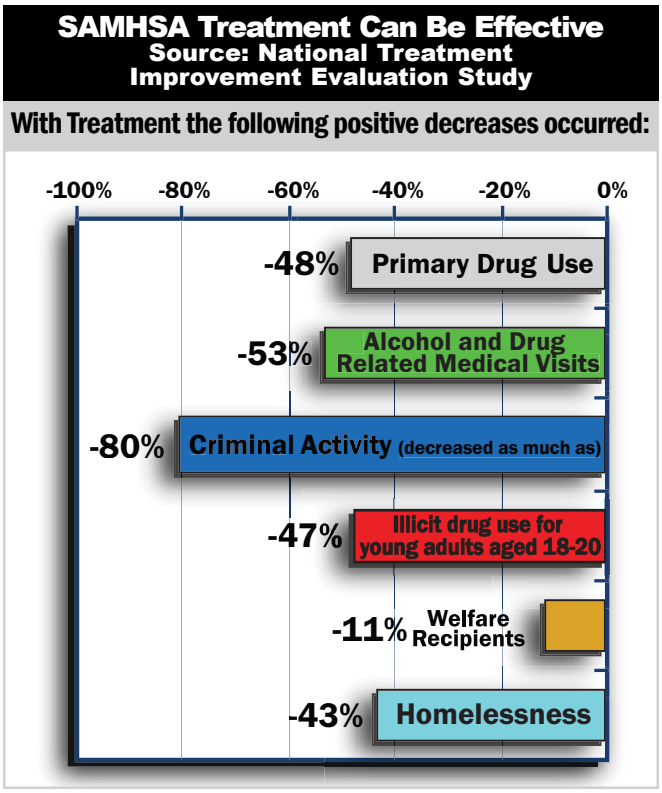
The Comprehensive Community Mental Health Services for Children and their Families Program also provided 67 grants in 43 states to develop comprehensive community-based systems of care. Improvement in children's outcomes such as school attendance (which has a positive relationship with school performance) and absence of contacts with law enforcement can be used to demonstrate the extent to which a system of care makes a difference in a child's life.

In FY 2001, the target for the first indicator of percent of children attending school 75 percent or more of the time was not exceeded; the target was to increase the percent of children by 18 percent over the FY 1997 baseline of 70 percent of children. Although the target was not met, actual data did show though that 80 percent (a 14.2 percent increase) of the children included in the study, did attend school 75 percent or more of the time after 12 months of care. It may be that the children for whom outcomes were reported during FY 2001 entered systems of care with greater mental health needs than children for whom outcomes had been reported in previous years, e.g., in FY 1999 when 88.9 percent of children studied achieved this goal.

The second indicator, the percent of children with law enforcement contacts at entry who had no law enforcement contacts after 12 months of care, remained at the same level in FY 2001, compared with FY 2000 (44 percent). The FY 2001 target was 43 percent. This indicator appears to have stabilized.

In FY 2001, the HHS Surgeon General issued an updated report on mental health that focused on the disparities in mental health incidence and treatment.

Continued to Fight Substance Abuse and Address Gaps in Its Treatment

Based on SAMHSA's FY 2000 National Household Survey on Drug Abuse, overall rates of current use of illicit drugs were relatively unchanged, although drug use did decline among early teenagers. Leading indicators for drug use—including rates of use among the youngest age group and the number of new users—suggest possible future declines. Among youths aged 12 and 13, a key target audience of the National Youth Anti-Drug Media Campaign, the rate of past month illicit drug use declined from 3.9 percent in FY 1999 to 3.0 percent in FY 2000. The estimated number of new marijuana users has declined from a recent peak of 2.6 million in FY 1996 to 2 million in FY 1999. Illicit drug use includes marijuana, cocaine, heroin, hallucinogens and inhalants.

Where illicit drug use occurs, research such as the National Treatment Improvement Evaluation Study, has consistently shown that drug abuse treatment can be effective in reducing drug use and the consequences of addiction. Yet many people are not being treated. The Office of National Drug Control Policy estimates that as many as 5 million Americans are in need of drug abuse treatment services. However, fewer than half of those who need treatment actually receive services. SAMHSA provides its partners funding and assistance to address this need through the Substance Abuse Prevention and Treatment Block grant. For substance abuse treatment, one measure of performance is the number of clients served. Actual performance data for FY 2001 with the target of 1,635,422 clients served, will not be available until 2003. In the meantime, the most recent actual performance data available for FY 1998 show that 1,564,156 clients were served.