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In 1985, a federal report entitled "Black and Minority Health" documented the wide disparity in health status between the white population and the four minority groups—the African-Americans, Hispanic Americans, Asian Pacific Islanders, and Native Americans. In response to the devastating statistics published in this report (1), the federal Office of Minority Health (OMH) was established.

After a careful review of the statistics, it was noted that Michigan was also experiencing higher death rates and levels of illness within its minority communities. In response to this marked mortality and morbidity, former state health director Dr. Gloria Smith convened a group of scientists, health professionals, and public policy leaders to examine the nature and causes of the discrepancy in health status between minorities and whites and to recommend potential solutions to close this gap.

Paralleling the national statistics, the most prominent mortality and morbidity for minorities in Michigan exist in the seven disease categories (now categorized as priority areas) of heart disease/stroke, cancer, diabetes, chemical dependency/liver disease, infant mortality, homicide/suicide/unintentional injury, and the acquired immunodeficiency syndrome. The Michigan task force report (2) also identified five prominent racial/ethnic groups in Michigan: African-American, Hispanic American, Native American, Arab/Chaldean, and Asian Pacific Islander.

Under the leadership of state health director Raj Wiener, the comprehensive and committed work of the task force was realized by the establishment of the OMH by executive order of Governor James Blanchard in 1988.

Impact of Minority Mortality Rates

In 1985, it was established that the minority population in Michigan totaled almost 1.8 million. One in five Michigan residents is a minority. The wide discrepancy in mortality rates between the white population and the minority population of African-Americans, Hispanic Americans, Arab Americans, Asian Pacific Islanders, and Native Americans is growing.

This mortality can be translated in terms of excess deaths—deaths caused by a particular disease which exceed the projected mortality rate. In 1985, Michigan death rates were higher for minorities than for whites for the four leading causes of death and for seven of the ten leading causes of death. Death rates for minorities are 27% higher both for diseases of the heart and for cancer. Overall, the death rate, which is age-adjusted for a population of per 100,000, was 48% higher for minorities than for whites.

We must consider this grave situation as more than just the reporting of statistics. We must look at how many minorities are dying who need not have died if our health care system and health programs were more accessible to address their needs. If there were no disparities in death rates, a total of 3,241 people in minority America would not have died in 1985. In ranking order, for heart disease there were 658 excess deaths for the aggregate of the minority population; for homicide there were 653 excess deaths; for cancer there were 473 excess deaths; for infant mortality there were 289 excess deaths; for chemical dependency as it relates to liver disease there were 209 excess deaths; for stroke there were 206 excess deaths; for diabetes there were 91 excess deaths; and for accidents there were 32 excess deaths.

How does this disparity in the mortality rates of minorities impact Michigan? What nation or state can long survive if one-fifth of its population fails to reach its full potential and contribute its unique gifts to society?

OMH's Mission and Objectives

The OMH is striving to work diligently to serve as a catalyst for coalition building within our state and within our nation. A total of six states have established Offices of Minority Health, including Michigan, Ohio, Indiana, Missouri, South Carolina, and New Jersey.

Expanding the collaboration among national, state, local, private, and community organizations is the key strategy of the OMH to strengthen the impact of programs targeting Michigan's minority communities. Coalition building is critical for several reasons. First, there will always be strength in numbers. Additionally, the OMH is based on the premise that people with disadvantaged lifestyles *will not* prioritize preventive health if survival needs such as food, shelter, and employment are not met. Therefore, costly acute care is often the outcome for the minority population. The OMH is committed to the holistic ap-

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proach to health to enable minorities to prioritize their health by facilitating their access to a myriad of "life-supporting" resources. It is hoped that when these other survival needs are met, people will then be able to view health as a priority in their lives.

The task at hand is for us as human and health service providers to understand and know better the resources which are available so that we can ensure smooth and timely access of these services by the community. Knowing about these resources has also been a prime mission of the OMH. The OMH formed what can be termed a Michigan model for an interstate departmental consortium. Formed in 1989, this consortium consists of many state departments such as Social Services, Mental Health, Labor, Commerce, Corrections, Agriculture, Department of State, Natural Resources, Office of Substance Abuse, and Education. The OMH convenes this consortium bimonthly to discuss strategies for facilitating access of these multiple resources by our minority communities. A similar consortium (the Intra-Departmental Consortium) was also formed within the state Health Department by the OMH in 1989.

Development of Culturally-Specific Programs

The establishment of the OMH, however, did not herald the beginning of action and concern. There are many well-designed programs currently in progress in Michigan. The OMH does not seek to duplicate current programs within the state or local public health departments, but to expand initiatives directed toward minorities.

The OMH has awarded approximately $1.3 million for demonstration or seed funding. These funded projects must specifically relate to either implementation (hands-on) or training and education for minorities. The funded programs target minorities spanning from birth to the elderly. Examples of types of programs funded include outreach and home-care; needs assessments, screening, and referrals; nonviolence community interventions; workshops, student internships, consumer education, and conferences/seminars. Additionally, the OMH administers and provides over $250,000 for Native American Community Health Representatives serving our Native American population.

The design, marketing, and implementation of state and local programs for our minority communities are concerted initiatives in which the state health department and local public health agencies are engaged. The OMH serves as a focused channel through which our communities can access and utilize these state and local program services.

Racial Identification

We as human and health service providers must know the exact number of people within our communities who are in need of services. It is impossible to count the number of people if we have no consistent mechanism up-front, for instance, during the intake process to identify to what racial/ethnic group an individual belongs. Data on racial identification of minorities have been gathered inconsistently and in some groups is virtually nonexistent. It is not against federal civil-rights laws of discrimination to inquire to what racial/ethnic group an individual belongs.

The OMH plans to convene a task force in 1990 to examine and design practical strategies which will work to maximize the data collection of racial/ethnic identification among the wide spectrum of service providers.

Legislative Initiatives

In the legislative area there are two bills which are significant. One of these is Senate Bill 393. SB393 is considered to be a loan forgiveness bill; that is, it will provide an incentive to expand the ranks of health professionals to work, upon graduation, in underserved areas. We hope that through this bill and other programs the need to preserve our most valuable asset—human resources—will be further promoted. Committed, qualified, and compassionate people of color are critically needed in health care systems, both in the public health sector and in the tertiary care sector. Culturally-specific programs and personnel are essential in bridging the gap for at-risk minorities.

Another bill, House Bill 4671, would establish the OMH in the Public Health Code, thus allowing continued focus and visibility on the critical problems before us.

First National Regional Conference on Minority Health

The Michigan OMH presented the first National Regional Conference on Minority Health in September 1990. This historic conference was cosponsored, among others, by Federal Region V, state universities, and the Region V states of Ohio, Indiana, and Minnesota. The conference entitled "Minority Health in the Nineties: Issues, Resources, Strategies and Interventions" was designed to bring people together to discuss current *positive* intervention strategies and to become more energized collectively to meet head-on the challenges and responsibilities of state and national health objectives. We all need to work together to halt the widening gap, elevate the quality of health, and expand the bridges of access to close the gap.

References

1. Black and minority health. Washington, DC: US Health Department, 1985.
2. Report of the Michigan Task Force on Minority Health. Lansing, MI: Department of Public Health, 1988.