

Chicago Report Profiles

Big City Health



Cities are often ranked as the “most livable,” “most expensive,” or “best for the elderly.” The Chicago Department of Public Health report, *The Big Cities Health Inventory 1997: The Health of Urban U.S.A.*, offers the public health version of these rankings.

City-level comparisons of important measures of morbidity and mortality are essential in placing a city's health in perspective. Yet there is no national system in place for compiling city-level data. In recent years, the Chicago Department of Public Health, in collaboration with health departments across the country, has taken on the task of collecting and disseminating information on major health indicators. Such efforts have resulted in three reports presenting comparative health data.

The most recent report presents 1994 data on 20 important health indicators for the 46 cities in the United States with populations greater than 350,000. Statistics on AIDS, cancer, tuberculosis, sexually transmitted diseases, homicide, heart disease, infant mortality, low birth weight, and other conditions are included.

The indicators of morbidity were gathered from participating local health departments, and indicators of mortality and maternal and child health were obtained from vital records files provided by the National Center for Health Statistics.

The report has two basic compo-

nents. The first consists of a series of tables presenting overall rates, gender- and ethnicity-specific rates, and city rankings according to these measures.

The second component presents sample analyses that illustrate the possible uses of this information. For example, one analysis focuses on three central public health issues—AIDS mortality, homicide, and infant mortality. A comparison of these causes of death among the 46 cities shows that during 1994:

- AIDS killed more people than homicides or infant mortality in 27 cities;
- infant mortality killed more people than AIDS or homicides in 10 cities; and
- homicides killed more people than infant mortality or AIDS in 9 cities.

For the 46 cities combined, AIDS killed more people (19,723)

than homicides (9694) and infant mortality (7720). Comparing large-city mortality from these three causes with figures for the United States as a whole provides an interesting perspective. Although the 46 large cities represent only 16% of the nation's population, they experienced 47% of the nation's AIDS deaths and 41% of all homicides in 1994.

As illustrated by this analysis, the report can be an important tool for health professionals, researchers, policy makers, and community advocates interested in promoting healthier cities.

The *Big Cities Health Inventory 1997: The Health of Urban U.S.A.* is available for \$20 from the Chicago Department of Public Health, Epidemiology Program, Rm. 2136, 333 S. State St., Chicago IL 60604-3972; tel. 312-747-9620. ■

WHO Decides: Food Irradiation Safe at Any Level

Following years of controversy among consumer groups, participants in a week-long World Health Organization (WHO) meeting on high-dose food irradiation concluded that strictly from the scientific point of view, no ceiling should be set for doses greater than the upper level currently recommended by the Codex Alimentarius Commission.

The recommended upper level is 10 kiloGray (kGy, the amount of radiation energy absorbed per unit mass of the material irradiated).

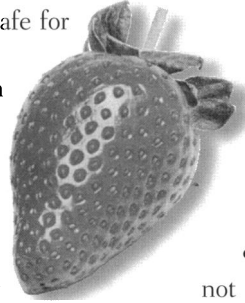
The week-long meeting, organized jointly by WHO, the United Nations Food and Agriculture Organization, and the International Atomic Energy Agency, was held in the fall of 1997.

Participants reviewed all relevant data related to the toxicological, microbiological, nutritional, radiation chemical, and physical aspects of food exposed to doses greater than 10 kGy and came to the unanimous conclu-

sion that such food is safe for consumption.

The presence in food of harmful microorganisms such as *Salmonella* species, *Escherichia coli* O157:H7, *Listeria monocytogenes*, or *Yersinia enterocolitica* is a problem of growing concern to public health authorities all over the world. In an attempt to reduce or eliminate the resulting risks, national regulations on food safety are being tightened up in many countries.

In the United States, for example, the Department of Agriculture issued new regulations for meat and poultry requiring testing for *E. coli* beginning in January 1997 and requiring that raw meat and poultry processed by large firms be virtually free of *Salmonella* beginning in January 1998. For some products, food irradiation has



been suggested as the best method to ensure the absence of these microorganisms.

The WHO group came to the following overall conclusions:

- Doses greater than 10 kGy will not lead to changes in the composition of food that, from a toxicological point of view, would have an adverse effect on human health;
- These higher doses will greatly reduce potential microbiological risk to the consumer;
- Higher doses will not lead to nutrient losses to an extent that would have an adverse effect on the nutritional status of individuals or populations.

Some 30 countries are currently using food irradiation technology in processing a variety of food products. ■

UN Agencies Join Against FGM/FC

The World Health Organization (WHO), the United Nations Children's Fund, and the United Nations Population Fund have issued an unqualified call for the elimination of female genital mutilation, or female circumcision (FGM/FC), in all of its forms.

While noting that FGM/FC continues as a deeply rooted traditional practice in some countries, the joint statement maintains that culture is in constant flux, capable of adapting and reforming.

The three agencies say that their joint position is presented in the hope that this harmful practice will end when people understand the severe health consequences and indignity it inevitably causes.

The 20-page statement has six sections. The first cites arguments, based on universally recognized human rights, supporting the conclusion that FGM/FC is an infringement on the physical and psychosexual integrity of women and girls, is a form of violence against them, and is therefore universally unacceptable.

The second section defines four types of mutilation according to the procedure followed, noting that all procedures are irreversible, with effects lasting a lifetime.

Section three documents the many associated health risks, including immediate severe pain, hemorrhage, shock, and infection and later cysts and abscesses, damage to the urethra, urinary incontinence, sexual dysfunction, and complications during childbirth.

The remaining sections cite a number of international agreements that support the elimination of this practice and identify 18 precise areas for immediate community, national, and international action to end this form of violence against girls and women.

A brief presentation of statistics on prevalence and distribution includes the estimate that at least two million girls are at risk of FGM/FC every year.

An English version of the statement is available for \$9 from the WHO Publications Center, 49 Sheridan Ave., Albany NY 12210; tel. 518-436-9686; fax 518-436-7433. ■

GENETIC SAMPLING: Big Brother or Big Science?

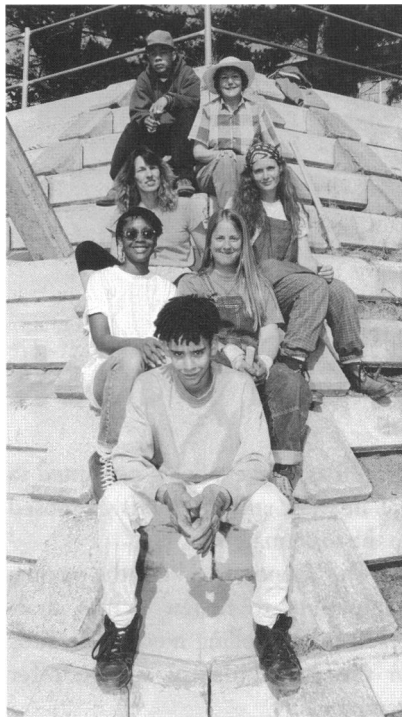
Following an exhaustive examination, a National Research Council committee found that a consensus proposal for a worldwide survey of genetic variation developed by an international group of geneticists and molecular biologists does not clearly explain the purpose of the project or provide the necessary safeguards for protecting participants.

Known as the Human Genome Diversity Project, the survey would serve as a central database for researchers. The project would involve collecting and storing DNA samples from hundreds of population groups.

"A collection of DNA samples that represents the whole of human genetic diversity could provide insight into human evolution and origins and serve as a springboard for important medical research," said committee chair William J. Schull, Director of the Human Genetics Center, School of Public Health, University of Texas-Houston. "But this research," he continued, "must not be used as a means for discriminating against individuals or groups in any way. Scientists must be aware of potential abuses and inform participants of possible risks before any samples are taken."

The National Research Council committee therefore offered its own assessment of the scientific value and merit of research on human genetic differences—including a global survey—and the ethical, organizational, and policy issues surrounding such research.

The committee report suggests types of genetic groups to include, such as those that share a common



geographic boundary, ethnicity, language, or culture. It does not identify which particular population groups to include in the survey.

Concerns have arisen about how research findings could be used against the participants. For example,

health insurance might be denied to members of a group that is found to be genetically predisposed to a disease, or gene sequences could be patented for profit without any proceeds going to the group or individual donors from whom the genetic material was taken.

The report recommends that the U.S. government should limit its initial funding for genetic diversity research to projects that originate in the United States, where an infrastructure of experienced investigators and well-equipped laboratories exists.

The committee also writes that before international research can begin, governments and researchers should have a clear understanding of their responsibilities.

Evaluating Human Genetic Diversity is available from the National Academy Press, 2101 Constitution Ave. NW, Washington DC 20418; tel. 202-334-3313 or 800-624-6242; at a cost of \$35 plus shipping charges of \$4 for the first copy and 50 cents for each additional copy. ■

UPCOMING CONFERENCES

The 19th Annual International Disaster Management Conference: Disaster '98—Assessing the Threat to Your Community will be held on February 19–22, 1998, in Orlando, FL. Contact: Florida Emergency Medicine Foundation, 407-281-7396.

PREVENTION '98, the 15th annual national meeting of the American College of Preventive Medicine and the Association of Teachers of Preventive Medicine, will be held on April 2–5, 1998, in San Francisco. Contact meeting staff, 202-466-2569.

The 8th International Congress on Infectious Diseases will be held on May 15–18, 1998, in Boston. Contact: Norman R. Stein, 617-277-0551. ■



Federal Mine Agency Warns of Mercury Risk

According to the Department of Labor's Mine Safety and Health Administration (MSHA), many of the 19,000 miners at work in the nation's 191 gold mines and 15 silver mines are at risk for mercury contamination.

The children of these workers can also be affected either by the reproductive damage mercury can cause in their parents or by exposure when their parents bring home mercury-contaminated clothing and other items.

Odorless and invisible, mercury vapor is absorbed through the lungs, the skin, or the digestive tract, leading workers to often underestimate the hazard. Cumulative poisoning can affect the brain, the central nervous system, the kidneys, and the reproductive system. While mercury can be naturally present in ore, it is also a by-product of gold and silver mining.

In the past six years, MSHA found 86 mercury overexposures in more than 690 samples taken from people at 72 gold and silver mines. Of the 86 overexposures, half were more than twice the exposure limit. Exposures ranged as high as 50 times the allowable limit. MSHA has also found lunchrooms contaminated by mercury

as well as workers being permitted to eat in work areas previously exposed to the toxic material.

The agency is asking the mining community to review a new draft guide to controlling mercury hazards in the gold industry and to offer comments.

Twelve states have gold or silver mines: Alaska, Arizona, California, Colorado, Idaho, Montana, Nevada, New Mexico, South Carolina, South Dakota, Utah, and Washington. Nevada has 30% of the total operations and employs 65% of the miners. California is second with 19% of the operations and 10% of the miners.

Gold production in the United States has increased approximately tenfold since 1980, with reported gold mine employment increasing from 6000 in 1980 to more than 17,000 in 1996.

MSHA's draft Best Practices Toolbox on controlling mercury hazards in gold mining is available on the World Wide Web at www.msha.gov or from MSHA's Division of Technical Support, Attn.: Mercury Report, 4015 Wilson Blvd., Arlington VA 22203; tel. 703-235-1580. ■

Nurses to Recommend Provider Mix in Shortage Areas

The Health Resources and Services Administration (HRSA) of the U.S. Public Health Service has contracted with the American Association of Colleges of Nursing (AACN) to recommend a formula for determining how three groups of primary care providers—nurse practitioners, certified nurse-midwives, and physician assistants—should be used to meet health care needs in underserved areas. (See related article in this issue on page 75.)

Federally designated Health Professional Shortage Areas are critical to determining which clinics are eligible for certain types of Federal funding and for providing scholarships and educational loan programs to attract nursing and other health professions students to the National Health Service Corps (NHSC)—the only source of health care for many Americans in rural and other underserved communities. The Corps' health care providers agree to serve in shortage areas in exchange for student financial assistance through NHSC.

Under the four-month, \$28,109 contract, AACN will evaluate the completeness of available data that list the numbers, locations, and practice specialties of these providers nationwide. Following that review, AACN will recommend whether and how a combined database on these groups can be created and how the three types of providers should be included in formulas that determine the percentage of primary care workers needed to meet the demand in shortage areas.

"HRSA has provided powerful testimony of the essential and central role of [nurse practitioners and certified nurse-midwives] in delivering high-quality primary care to the nation's underserved," said AACN President Carole A. Anderson, RN PhD. ■

Chronic Fatigue Syndrome

Continuing Education Credits Online



The Department of Health and Human Services (DHHS) is using the Internet to provide a free continuing education course on chronic fatigue syndrome (CFS) to health professionals.

The program consists of a replay of a September 18, 1997, live interactive Public Health Training Network satellite broadcast that covered the epidemiology of CFS, CFS research, and the diagnosis and management of the syndrome. A panel of experts also answered questions posed by health care professionals in the viewing audience.

Continuing education credits include 2 CME for physicians, 2.4 CNE for nurses, and 2 CEU for other professions.

The program will be available without cost through March 22, 1998, at www.tstradio.com/cfids 24 hours a day. To watch it on a home computer, it is necessary first to install Realplayer software, which can be downloaded free of charge from the same site.

Speakers on the broadcast included Dedra Buchwald, MD, Associate Professor, Department of Medicine, University of Washington School of Medicine, Seattle; Mark A. Demitrack, MD, Clinical Research Physi-

cian, Eli Lilly Research Laboratories, Indianapolis; Anthony Komaroff, MD, Professor of Medicine, Harvard Medical School, Editor-in-Chief of Harvard Medical Publications, and Senior Physician, Brigham and Women's Hospital, Boston; Philip R. Lee, MD, Former Assistant Secretary for Health, Office of Public Health and Science, DHHS, and currently Professor Emeritus, University of California, San Francisco; William C. Reeves, MD, Chief, Viral Exanthems and Herpesvirus Branch, Division of Viral and Rickettsial Diseases, Centers for Disease Control and Prevention, Atlanta; and Alexis Shelokov, MD, Director of Medical Affairs, Government Services Division, The Salk Institute, San Antonio, and Adjunct Professor of International Health, Johns Hopkins University.

Program materials that accompanied this broadcast may be viewed and printed as follows:

Guidelines to the Management and Treatment of Chronic Fatigue Syndrome (Centers for Disease Control and Prevention and Public Health Training Network) may be downloaded in Word-Perfect format;

Chronic Fatigue Syndrome: Information for Physicians (National Institute

of Allergy and Infectious Diseases, National Institutes of Health) is available at www.niaid.nih.gov/publications/cfs/contents.htm;

The Facts About Chronic Fatigue Syndrome (National Center for Infectious Diseases, Centers for Disease Control and Prevention) is available at www.cdc.gov/ncidod/diseases/cfs/facts.htm;

The Chronic Fatigue Syndrome: A Comprehensive Approach to Its Definition and Study (Fukuda K, Straus SE, Hickie I, Sharpe MC, Dobbins JG, Komaroff A, and the International Chronic Fatigue Syndrome Study Group) is available at www.cdc.gov/ncidod/diseases/cfs/defined3.htm.

The broadcast and its availability on the Web is a collaborative project of several DHHS agencies (including the Centers for Disease Control and Prevention, the Food and Drug Administration, the Health Resources and Services Administration, the National Institutes of Health, and the Office of Public Health and Science), the Social Security Administration, and the Public Health Training Network. ■

PHS Ellis Island Exhibit Shown in Washington

As part of the Public Health Service Bicentennial Commemoration in 1998, the exhibit *Doctors at the Gate: The U. S. Public Health Service at Ellis Island* will be on display at the National Museum of Health and Medicine, Armed Forces Institute of Pathology, in Washington DC from February 5, 1998, through June 21, 1998.

The exhibit focuses on the role played by the Public Health Service (PHS) in the medical inspection of immigrants arriving at Ellis Island from the time the facility on the Island opened



A female PHS physician examines a woman immigrant on Ellis Island, about 1915.

MEDIA ARTS BRANCH, PROGRAM SUPPORT CENTER

in 1892 until more restrictive laws greatly slowed the flow of immigrants to the United States in 1924.

It will also show the care provided on the Island to those immigrants who required hospitalization.

The Office of the PHS Historian and the Media Arts Branch of the Program Support Center, Department of Health and Human Services, collaborated with the Museum in the preparation of the exhibit. Professor Alan Kraut of American University, an expert on immigration history, served as a consultant. A number of individuals and institutions provided artifacts, photographs, and information for use in the exhibit.

For further information on the activities of PHS at Ellis Island, see "PHS Chronicles" in this issue (page 83).

The National Museum of Health and Medicine is located in the Walter Reed Army Medical Center at

Georgia Avenue and Elder Street NW in Washington. Museum hours and directions can be obtained at 202-782-2200.

HEALTH ONLINE

AMA, Nemours Launch KidsHealth

The American Medical Association (AMA) and the Nemours Foundation have established KidsHealth at the AMA, a website for children's health information.

The new site (www.ama-assn.org/kidshealth) is the first release of a three-year collaborative effort to produce the most comprehensive children's health site on the World Wide Web. A team of nationally known health writers, medical editors, physicians, and children's health experts was assembled to contribute to the new site.

KidsHealth at the AMA provides parents with reliable children's health information on a range of topics, including childhood infections, emergencies and first aid, safety and accident prevention, and child development. ■



APHA Launches Innovative Health Projects Network

The American Public Health Association (APHA) has joined the Centers for Disease Control and Prevention in launching the Public Health Innovations Project to help public health practitioners develop their skills and encourage them to share information about advances in the field.

Descriptions of innovative projects from state and local health practitioners, policy makers, and others in the public health arena are being gathered to create a Public Health Innovation Exchange.

The project descriptions will be collected and disseminated in print and electronically on an ongoing basis through an online searchable database. This information will help establish models for replication and for tailoring existing projects to local needs.

The first eight projects listed are:

Prevention through Privatization. The Tacoma-Pierce County Health Department, Tacoma, WA, has contracts with private medical providers to deliver the entire system of public health primary care clinical services to the community. The range of services covers all aspects of care for tuberculosis, sexually transmitted diseases, immunizations, refugee health, family planning, and HIV counseling and testing.

Close to Home Training—A New Methodology for Outreach. The Association of North Carolina Boards of Health, Raleigh, NC, orients members of the state's 86 Boards of Health through local training conducted during regular Board meetings.

Public Health Expert-in-Residence Program. The New Jersey Public Health Association-

Washington Information Network for Public Health. The Northwest Center for Public Health Practice at the University of Washington, Seattle, will form a national public health information-sharing network on the Internet as one of 12 states chosen by the Centers for Disease Control and Prevention.

Priorities '95. The Columbus Health Department, Columbus, OH, has brought together an all-volunteer effort to identify specific local environmental risk issues and to develop risk-reduction policy recommendations for city-wide implementation.

Lake County Community Health Partnership. The Lake County Health Department, Waukegan, IL, has launched a community health partnership to develop a network of community organizations to measure and improve the health status of county residents.

East Side Healthcare Coalition. The East Side Health District, East St. Louis, IL, has developed a partnership among the Health District, the Southern Illinois Health Care Foundation, and the township hospital to deliver integrated health care services to the community.

tion in Linden, NJ, created a website for public health professionals and members of the general public to network with experts on various public health issues.

Interagency Water Quality Task Force. The City of Milwaukee, WI, has brought together a task force consisting of public health, water utility, regulatory, and waste water treatment personnel to improve communication and promote cooperative activities addressing the city's drinking water supply, with the goal of preventing waterborne illness.

Project descriptions may be submitted through the Innovations Project website at www.apha.org/science/innovations/phiipmain.html. ■

Ethnic Health Differences Persist

CAUSES ARE MULTIPLE

Although white Americans still live longer than black Americans, the gap in death rates has declined over the past 30 years. There is some evidence—though controversial—that black residents of the U.S. actually have lower death rates in their 80s and 90s than white residents.

Older Americans who identify themselves as Hispanic, Asian, or Pacific Islander have a lower death rate than those who identify as either white or black.

Black men have a 20% greater incidence of prostate cancer than white men, and white women have a 30% greater incidence of breast cancer than black women.

Beyond simply documenting these differences, the challenge facing researchers is to pinpoint the extent to which the differences can be explained by socioeconomic status, health-promoting behaviors, access to health care, and other factors, according to a new collection of papers from a workshop hosted by the National Research Council.

The papers examine the differing rates of mortality, disability, dementia, cardiovascular disease, and use of medical care among various ethnic groups. The papers say that although researchers have begun to piece together some of the explanations for these differences, research is limited by gaps in nationally representative data, by not having a full range of measures to compare life histories, and by ethical and legal obstacles

to linking survey data with genetic information.

Among the papers' conclusions:

- For the younger age groups, the death rate for black Americans exceeds that for white Americans by as much as 2:1, but the differences gradually narrow and may actually reverse as both groups get older. A lack of reliable information on older people leads some researchers to question this apparent reverse and ask whether the death rate for the white population remains lower throughout the lifespan.

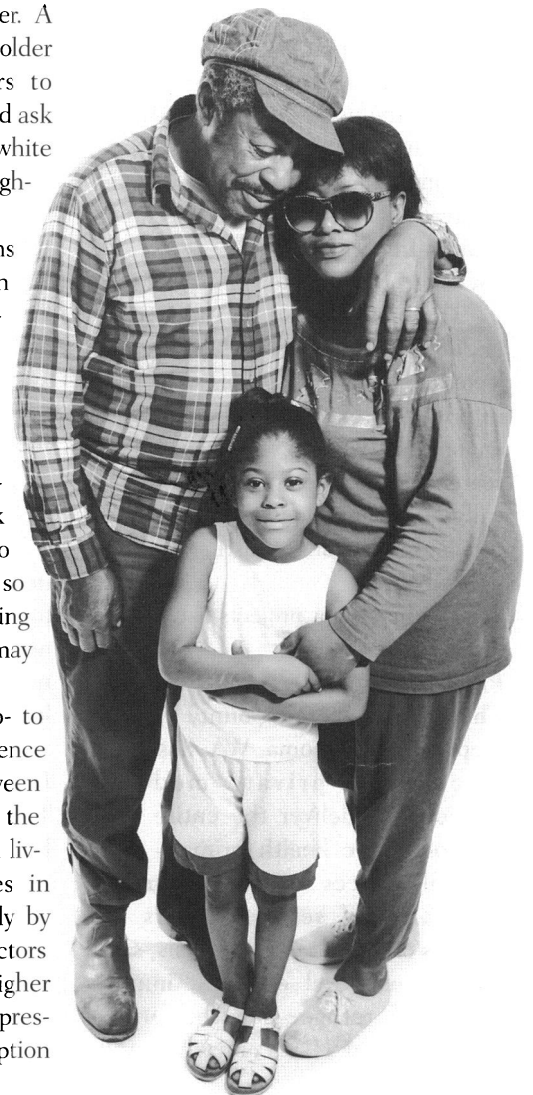
- Historically, black Americans have had less access to health care than their white counterparts. Black U.S. residents now spend as much per capita as white residents on medical care, as measured in physician visits and inpatient hospital stays. Surveys show, however, that black Americans are more likely to experience illness than whites, so they should actually be spending more, suggesting that there still may not be equal access to care.

- Studies have shown a two- to threefold difference in the incidence of coronary heart disease between men of Japanese origin living in the United States and Japanese men living in Japan. The higher rates in America can be explained largely by an increase in the major risk factors for heart disease, including higher cholesterol, glucose, and blood pressure levels and greater consumption of alcohol and tobacco.

The papers underscore that "race" and ethnicity are not biological definitions but fluid categories whose meanings vary according to the social and historical context.

This project was funded by the National Institute on Aging.

Copies of Racial and Ethnic Differences in the Health of Older Americans are available for \$42 prepaid plus shipping charges of \$4 for the first copy and 50 cents for each additional copy from the National Academy Press: tel. 202-334-3313 or 800-624-6242. ■



SAMHSA Studies Substance Use Among Women

Has women's use of alcohol, cigarettes, and illicit drugs changed over the last few decades? Is there a difference between men's and women's patterns of use?

The first major analysis of substance use in a nationally representative sample of women has been conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the Public Health Service.

Using data from SAMHSA's National Household Survey on Drug Abuse, this report showed trends in substance use and abuse among women and described the differences between males and females in substance use and abuse.

The report showed that in the early 1960s, about 7% of new alcohol users among girls were between the ages of 10 and 14. By the early 1990s, that percentage had increased to 31% of new alcohol users.

Likewise, among girls reporting their first use of marijuana in the early '60s only 5% were between the ages of 10 and 14; in the early '90s it had risen to 24% among this age group.

Other key findings included:

Alcohol

- Among adults, significantly fewer females than males reported use of alcohol, cigarettes, marijuana, cocaine, and any illicit drug. However, the gender difference in adults has narrowed in recent years.

- Among 12- to 17-year-olds, rates of female and male alcohol, cigarette,



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and illicit drug use were similar.

- During the periods 1961–1965 and 1986–1990, females generally initiated alcohol use at later ages than males. But in 1991–1995, the gender difference in age-specific rates of alcohol initiation became negligible.

Drugs

- Since the early 1970s, rates of marijuana initiation have consistently declined among females and males in every age group except 10- to 14-year-olds.

- Among 12- to 17-year-olds, a significantly higher percentage of females than males reported the non-medical use of psychotherapeutics such as painkillers, tranquilizers, sedatives and stimulants.

- An estimated 62,000, or 2.3%, of all pregnant women younger than age 44 reported using illicit drugs.

- Among adult women, the highest prevalence of illicit drug use was found among those ages 18 to 34, those who were unemployed, those who had never married, those who initiated substance use at an early age (at

age 15 or younger), and those with one or more of four mental syndromes addressed in the survey.

- About 30% of females who needed drug treatment in the year prior to the survey had received it, compared with 35% of males.

- Among adult women who needed but did not receive treatment, 40% were ages 18 to 25, 41% were alcohol-dependent, 28% had some college, 55% worked full- or part-

time, 32% lived with two or more children younger than age 18, and 71% had initiated alcohol or drug use before the age of 15.

Substance use during pregnancy

- About a fifth (21.5%) of pregnant women younger than age 44 said they smoked cigarettes, and more than a quarter of these pregnant smokers reported heavy smoking—one or more packs of cigarettes each day.

- About a fifth (21.2%) of pregnant women younger than age 44 reported alcohol use. Of this pregnant, alcohol-using group, nearly a third reported having three or more drinks on the days they drank.

- Women who were pregnant reported a significantly lower prevalence of use of alcohol, marijuana, and any illicit drugs than non-pregnant women with or without children.

Copies of the report are available on the Web at www.samhsa.gov or by calling the National Clearinghouse for Alcohol and Drug Information at 800-729-6686. ■