anguish, emotional distress, and so forth) was reasonable if set at a generous level. Noneconomic damages are based on subjective judgment, and they have a significant effect on vaccine cost. By contrast, economic damages vary somewhat from State to State and case by case, but they generally fall within a broad range for particular types of injuries.

After examining several options, the Working Group recommended that the Administration seek the enactment of legislation to ban punitive damages in vaccine-related injury cases and to place a generous but reasonable cap on all noneconomic damages. This recommendation has been forwarded to the Congress, but corresponding legislation has not as yet been introduced. However, at least 2 proposals are presently being considered in the Congress (S5827 and HR1780) which address problems of vaccine compensation. One of the proposals (S5827), as introduced, does not appear to help the problem of liability exposure and consequently has been opposed by manufacturers. The other has features which would limit liability exposure but has other features which do not seem acceptable to parents or trial attorneys.

The problem is complex. Developing a reasonable solution will be difficult and will require close cooperation among all parties. It is imperative, however, that we have a continuing supply of life-saving vaccines.

James O. Mason, MD, DrPH
Director, Centers for Disease Control

References

1. Hinman, A. R.: DTP vaccine litigation. Am J Dis Child. In press.
2. Letter dated February 12, 1986, from Robert B. Johnson, president, of Lederle Laboratories Division, American Cyanimid Corporation, to Martin Smith, MD, president of the American Academy of Pediatrics.
3. Report of the Cabinet Council on Human Resources Working Group on Vaccine Supply and Liability. Issued July 1985.

Health Problems of Minority Groups: Public Health's Unfinished Agenda

The three excellent articles in this issue of *Public Health Reports* pertaining to the health status and access to care of Hispanics raise thought-provoking issues for any serious observer of minority health.

• One is struck by the limitations in the data and the resulting constraints on the number of questions we can answer. The Hispanic population is heterogeneous by country of origin, by income, by genetics, by length of residence in this country, and by conditions of entry (for example, immigrant, refugee, migrant agricultural laborer, undocumented worker). All of these factors (and others) correlate in various ways with health outcomes, yet to date we are primarily dependent on small sample or anecdotal reports to address questions which require this sort of fine-grained data. During the Task Force on Black and Minority Health (*1*), we also struggled with data limitations for Hispanics, Asian-Pacific Islanders, and the non-Indian Health Service Native American population. Because it is larger and has a long historical presence in the country, the black population is better characterized. Inconsistencies in ethnic identified data collection by the States, overaggregation of minority data, and insufficient representation of minorities in national surveys have all been problematic in the past.

• Andersen and colleagues raise many important points in their article on access and financing. Three points deserve amplification: (*a*) the serious problems among Hispanics and other minorities around the lack of health insurance, (*b*) the importance of culturally sensitive and culturally appropriate health care sources, and (*c*) the still highly disproportionate underrepresentation of Hispanics, blacks, and Native Americans among physicians and other health professionals after two decades of ameliorative efforts.

• A third important issue raised by these articles is the differentials in health status among the four major minority groups. It is often assumed that the health problems among minorities are overwhelmingly the result of poverty. Yet the data presented in these three articles as well as in the Task Force Report (*1*) indicate that the aggregate health status of Asian-Pacific Islanders, blacks, Hispanics, and Native Americans differ from one another. The Task Force data were recently summarized in the MMWR (see table, *2*). As compared with whites, overall black mortality rates are substantially worse, Hispanic and Native American rates are somewhat worse, and Asian-Pacific Islander rates are somewhat better. Within these

Average annual excess[1] and total deaths in minority populations up to age 70 years, by selected causes, by sex—United States, 1979-81

Cause of mortality	Males				Females			
	Black	Mexican-born[2]	Native American	Asian	Black	Mexican-born[2]	Native American	Asian
Cardiovascular disease	8,469	-362	-165	-1,059	9,712	-39	-21	-408
Cancer	5,782	-288	-243	-471	2,269	-145	-182	-450
Cirrhosis	1,362	-30	144	-117	782	-62	124	-65
Infant mortality	3,317	-76	49	-105	2,861	-26	53	-57
Diabetes	646	-2	31	-21	1,203	12	47	-22
Injuries	1,113	553	469	-523	134	-2	168	-119
Homicide	6,708	701	88	-39	1,381	20	31	1
Total	35,112	423	670	-2,901	23,545	-263	372	-1,373

[1] "Excess deaths" were defined as the difference between the number of deaths observed in the minority populations and the number that would have been expected if the minority population had the same age- and sex-specific death rates as the nonminority population. This method quantified the number of deaths that would not have occurred had mortality rates for minorities equaled those of nonminorities.

Excess mortality may be negative where observed mortality was less than that seen in whites. The numbers for Native Americans and Asian-Pacific Islanders, however, are based on much smaller denominators than the other populations and therefore are more subject to error.

[2] Figures represent only one subgroup within the Hispanic population for which mortality data were available. Comparable data on other Hispanic subgroups were not available or were incomplete.

SOURCE: reference 2.

aggregate trends, each group and subgroup show different patterns of disease and mortality. However, it is striking that, with the possible exception of Asian-Pacific Islanders, all of the other minority groups have substantially lower median family income than do whites. What this suggests is that, at least in the United States, poverty as represented by income data does not, for all minority groups, correlate with mortality rates.

Having said this, three caveats are in order:

1. Concealed within relatively better overall mortality rates for nonblack minority groups are some dreadful and often unquantified health problems. Following are some examples: (*a*) Recent Southeast Asian refugees have high rates of parasitic infections and tuberculosis. In addition, these populations have all the health and mental health sequelae of repression, exploitation, and once in the United States, cultural dislocation. (*b*) Migrant agricultural workers often have significant health problems combined with poor access to care. (*c*) Five of the 10 leading causes of death among Native Americans are related to alcohol: cirrhosis, accidents, suicide, homicide, and alcoholism. Moreover, as a result, 87 percent of Native American excess deaths occur prior to age 45 (*1*). (*d*) Hispanics, and to a lesser extent Native Americans, have homicide rates greater than those of the white population. (*e*) Obesity is a serious problem among blacks, Native Americans, and Hispanics.

2. Having said that poverty does not correlate clearly with minority health differentials is not to say that poverty is unimportant to health. Socioeconomic status remains a powerful predictor of morbidity and mortality, but it alone is insufficient to explain the relative mortality experience of various minorities.

3. In seeking noneconomic explanations for better or worse health status, such factors as family structure, community supports, and cultural values are often raised as possible contributors. Such questions must be asked, but matters of culture and behavior require subtlety and sensitivity; victim-blaming is a constant hazard.

CONCLUSION: What all of the above draws out for us is a challenging and imperative agenda for research and public health interventions. This is the challenge which spawned the Office of Minority Health and one which we seek to stimulate among the Federal and non-Federal public health communities.

Herbert Nickens, MD, MA
Director, Office on Minority Health
Office of the Assistant Secretary for Health

References

1. Report of the Secretary's Task Force on Black and Minority Health. Vol. 1. Executive summary. U.S. Department of Health and Human Services, August 1985.
2. Perspectives in disease prevention and health promotion. Report of the Secretary's Task Force on Black and Minority Health. MMWR 35:109-112, Feb. 28, 1986.