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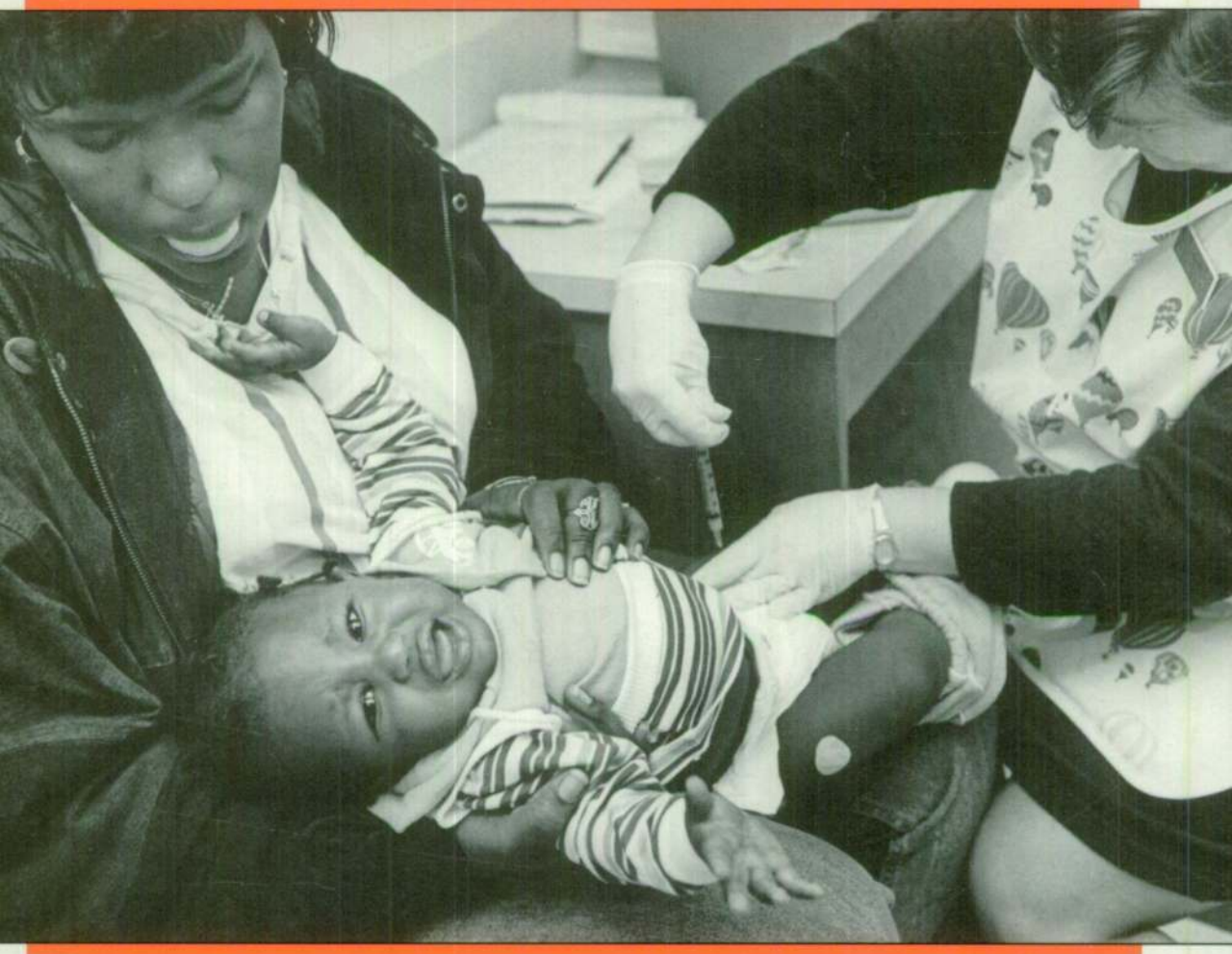

The Health of Minority Citizens in North Carolina

N.C. Center for Public Policy Research

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The Center was formed in 1977 by a diverse group of private citizens "for the purpose of gathering, analyzing, and disseminating information concerning North Carolina's institutions of government." It is a nonpartisan organization guided by a self-elected Board of Directors and has individual and corporate members across the state.

Center projects include the issuance of special reports on major policy questions; the publication of a quarterly magazine called *North Carolina Insight;* joint productions of public affairs television programs with the University of North Carolina Center for Public Television; and the regular participation of members of the staff and the Board in public affairs programs around the state. An attempt is made in the various projects undertaken by the Center to synthesize the thoroughness of scholarly research with the readability of good journalism. Each Center publication represents an effort to amplify conflicting ideas on the subject under study and to reach conclusions based on sound rationalization of these competing ideas.

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Cover: Eight-month-old Carl Thorpe, held by his mother Val Thorpe, gets an immunization shot from Wake County Health Department nurse Cindy Burchette. (Photo by Karen Tam.)

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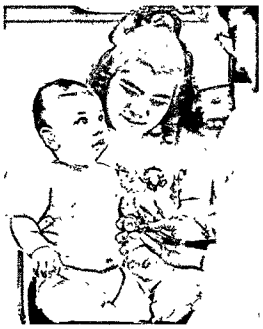

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The Center's study of minority health in North Carolina was supported by a grant from Glaxo Inc., a pharmaceutical research company with U.S. headquarters at Research Triangle Park, N.C. The N.C. Center for Public Policy Research extends its sincere thanks for Glaxo's generous support of this project.

Karen Tam

Toni Danisha Thomas, age 10 months, gets a checkup at the Wake County Health Department.

The Health of Minority Citizens in North Carolina

by Mike McLaughlin

This study of minority health in North Carolina was supported by a grant from Glaxo Inc., a pharmaceutical research company with U.S. headquarters at Research Triangle Park, N.C. The N.C. Center for Public Policy Research extends its sincere thanks for Glaxo's generous support of this project.

Summary

North Carolina minorities—particularly African Americans—are less healthy than the white majority. They are more likely to suffer disease and less likely to have health insurance to pay for care. Thus, they have less access to care and are more likely to wait until they are sicker to seek care. For these and other reasons, they die younger. Their mortality rates are higher for such diseases as diabetes and stroke, and the rates are higher for heart disease and cancer when adjusted to account for age differences in the population. These are among the Center's findings in a year-long study of minority health in North Carolina.

The state has only begun to make minorities a special focus for some local health programs. Most health programs still are aimed at the general population, and there is some resistance to targeting services to population subgroups such as African Americans, Native Americans, Hispanics, and Asian Americans. Yet these populations have special health needs that are reflected in their overall health status. What is the health gap between minorities and whites in North Carolina? What steps are being taken to help close the gap, and what chance do they have for success?

The Center took a four-pronged approach in seeking answers to these questions. This involved: (1) analyzing state-level and county-by-county data produced by the State Center for Health and Environmental Statistics on morbidity and mortality of whites compared to minorities; (2) conducting field audits of immunization efforts at local health departments as one measure of how well preventive health services are reaching their intended targets; (3) surveying all local health directors for further insights into what obstacles may exist in serving minorities at the local level; and (4) examining existing programs addressing minority health issues for clues to what works.

The Center's year-long study found access to health services to be a problem for minorities. Part of this may be attributed to socioeconomic factors, but there also may be other factors at work. It may be that minorities feel less welcome in a health-care system run predominantly by whites. It may be that those who can't pay their way choose to stay away until a medical emergency forces them to seek care for a crisis that could have been prevented.

The Center concludes that the state must be more aggressive in assuring that services are available and in convincing minorities that they should avail themselves of those services. To help narrow the gap in health status between whites and minorities, the Center makes six recommendations to deal with specific health problems and to increase the state's efforts in health promotion and disease prevention.

To find the faces behind the numbers that show a health gap between minorities and whites, one doesn't have to look beyond the front-line troops. Take, for example, Barbara Pullen-Smith, director of the Office of Minority Health. She attributes the early death of her father and her mother's chronic hypertension to a lack of access to health care.

"I've always believed that if my father had had access to better care, he probably would have lived longer," says Pullen-Smith, an African American who was raised in rural Warren County. "He had a blood clot on the brain. He died when I was six weeks old. . . . The nearest hospital was 16 miles, and in 1959, 16 miles was very far away. My mother has had hypertension for as long as I can remember. . . . She calls it 'high blood.'"

Other health care workers share similar stories. Vanessa Davis is a college-educated professional who formerly worked for the Governor's Commission on the Reduction of Infant Mortality. She testified at a public hearing on minority health issues about the loss of her two infants.[1] She wanted people to know it isn't just the poor and uneducated whose tragedies are recorded in infant mortality statistics that show African Americans are twice as likely to die in their first year of life as whites.

Quinton Baker, director of the Community Based Public Health Initiative in Chatham County, suffers from diabetes and partial blockage of the arteries. Baker tries to control these maladies through diet and exercise, and he's seeking ways to help other African-American males who suffer similar fates.

In some way, all of these warriors in the battle to narrow the health gap between minorities and whites are touched by the very conditions and illnesses they are fighting against. Indeed, it would be difficult to be a minority citizen in North Carolina and *not* be affected in some way by the statistics.

The problem is particularly acute for African Americans, who face a long list of illnesses from which they are more likely than whites to get sick or die.[2] Consider these stark statistics, which represent the average number of deaths per 100,000 residents attributed to a given disease each year from 1988 through 1992:[3]

Stroke. Average mortality rate 79.9 for African Americans. White mortality rate 67.3. African American rate 19 percent higher.

Mike McLaughlin is editor of North Carolina Insight. *Center interns Myron Dowell and Emily Coleman contributed to this report.*

"My mother has had hypertension for as long as I can remember. . . . She calls it 'high blood.'"

— BARBARA PULLEN-SMITH, DIRECTOR OF THE N.C. OFFICE OF MINORITY HEALTH

Chronic Liver Disease and Cirrhosis. Average African-American mortality rate 13.9. Average white mortality rate 9.9. African-American mortality rate 40 percent higher.

Diabetes. Average mortality rate 33.0 for African Americans. White mortality rate 17.3. African-American rate 91 percent higher.

Kidney Disease. Average African-American mortality rate 13.7. Average white mortality rate 6.8. African-American mortality rate 101 percent higher.

Acquired Immune Deficiency Syndrome. Average African-American mortality rate 16.8. Average white mortality rate 3.5. African-American rate 380 percent higher.

Unadjusted white death rates from 1988–1992 were higher than those of African Americans for the leading causes of death in North Carolina, heart disease and cancer. But this is explained by the fact that African Americans are a younger population than whites, and cancer and heart disease predominantly strike older people. Approximately half of African-American deaths are attributed to heart disease and cancer. And when death rates are adjusted for age differences in the population, African Americans are more likely than whites to die of these diseases as well.

The 1991 age-adjusted heart disease mortality rate for North Carolina minority males, for example, was 275.1 deaths per 100,000 population. That's 34.3 percent higher than the white rate of 204.8 per 100,000. For minority females, the gap after age adjusting was even greater, at 54.0 percent. For cancer, the minority male age-adjusted death rate (241.0 per 100,000) was 51.2 percent higher than the white age-adjusted rate (159.4 per 100,000). The gap narrows when comparing minority females to white females, although it still exists. Age-adjusting also illustrates the impact of stroke on minorities. For males, the rate was more than twice

that of whites. (See Table 1 below for 1991 age-adjusted figures on heart disease, cancer, and stroke.)

Researchers attribute higher death rates for the three leading causes of death among African Americans—heart disease, stroke, and cancer—to smoking, hypertension, and obesity, as well as socioeconomic factors.[4] And in the case of cancer, the overall numbers hide relatively high death rates for particular *types* of cancer—such as breast cancer, for which early detection and treatment represents the best hope for a cure, and lung cancer, which is preventable.

Aside from *mortality* data, the state also keeps track of *morbidity*—or illness—for a broad range of communicable diseases and for cancer. For almost every type of communicable disease the state tracks, African-American infection rates far exceed those of whites.[5] Consider these examples:

- African Americans are more than five times more likely to be infected with **AIDS** than whites.
- African Americans are more than twice as likely as whites to be infected with **hepatitis B**.

Rates are also a much higher among African Americans for the food and water-borne illnesses salmonellosis and shigellosis, and for bacterial meningitis (caused by a bacteria called *H. influenza*).

Rates of **sexually transmitted diseases** among African Americans dwarf those of whites. For example, the gonorrhea rate for African Americans is 1,897.6 cases per 100,000 North Carolina residents, compared to 62.9 cases per 100,000 residents for whites. Syphilis infects African Americans at a rate of 208.4 times per 100,000 residents, compared to 7.1 per 100,000 residents for whites. Native Americans and Asians also have higher rates of sexually transmitted disease than whites, although not as high as African Americans.

These statistics underscore the magnitude of the problem of differences in health between whites and minorities. And they raise a number of questions for state policymakers. Why do disease and death strike African Americans disproportionately? What about other minority subgroups such as Hispanics and Native Americans? How does their health stack up against that of the white majority? Is it the role of the state to try to address the health gap between whites and minorities in North Carolina? If so, what can be done that is both effective and economical?

The N.C. Center for Public Policy Research took a four-step approach in addressing these questions. The approach involved: *(1)* analyzing state-level and county-by-county data produced by the State Center for Health and Environmental Statistics (CHES) on morbidity and mortality of whites

Table 1. U.S. and N.C. Age-Adjusted Mortality Rates for Heart Disease and Cancer, by Race, 1991*

Mortality Rates per 100,000	White Male		White Female		Minority Male		Minority Female	
	U.S.	N.C.	U.S.	N.C.	U.S.	N.C.	U.S.	N.C.
Heart Disease	196.1	204.8	100.7	99.5	234.0	275.1	143.1	153.2
Cancer	159.5	159.4	111.2	104.2	207.4	241.0	121.2	114.9
Stroke	26.9	32.7	22.8	26.8	48.2	65.9	36.9	47.3

* Deaths per 100,000 population using 10-year age groups and U.S. 1940 population as standard for direct age adjustment.

Source: "North Carolina Center for Health Statistics Pocket Guide—1993," State Center for Health and Environmental Statistics, N.C. Department of Environment, Health, and Natural Resources, December 1994, Table 5.

compared to minorities; *(2)* conducting field audits of immunization efforts at local health departments as one measure of how well preventive health services are reaching their intended targets; *(3)* surveying all local health directors for further insights into what obstacles may exist in serving minorities at the local level; and *(4)* examining existing programs addressing minority health issues for clues as to what works.

At the request of the N.C. Center for Public Policy Research, CHES produced reams of data on the health of North Carolina residents. The Center asked for statewide and county-level mortality data by race on 13 leading causes of death, plus data on illness for major communicable diseases and cancer. (See Table 2, pp. 8–9, for a breakdown of the leading causes of death in North Carolina, overall and by race.) By analyzing these data, the Center was able to paint a portrait of the state's health, by race. In many areas, the picture isn't pretty for minorities, particularly African Americans.

African-American Health Issues

A total of 62 percent of all African-American deaths are due to four leading causes: heart disease (28.8 percent), cancer (20.8 percent); stroke (8.5 percent), and diabetes mellitus (3.5 percent). African Americans were more likely than whites to suffer death from these diseases, which in some cases could be controlled or influenced by diet. (See Table 3, pp. 10–11, for a county-by-county look at mortality rates for stroke, by race, and Table 4, pp. 12–13, for a similar county-level look at diabetes mellitus mortality by race.) African Americans were slightly more likely to have an accident that

Patients check in for services at Reynolds Health Center, a county-subsidized facility in Winston-Salem.

Mike McLaughlin

▼

Now the sons
he never fathered learn
his lesson well:
You are black and male
in america
You are never
too young to die

—MICHELLE PARKERSON
"STATISTIC"

would lead to death, and about four-and-a-half times more likely to be murdered or die at the hands of a law officer. For minority youth ages 15–19, the discrepancy is even greater. They are more than 12 times more likely to be murdered or killed by authorities than white youths.[6] (See Table 2, pp. 8–9.) But the biggest discriminator in black-white death rates was Acquired Immune Deficiency Syndrome (AIDS): the death rate for African Americans was nearly five times the rate for whites.

Even areas for which the overall numbers look good, such as cancer mortality, are misleading. When African-American death rates are adjusted for the fact that the population is younger, cancer death rates exceed those of whites. "Cancer is largely a disease of older people," says Dale Herman, a statistician with the N.C. Cancer Registry, which tracks all deaths by cancer in the state. "Since there are more older whites than minorities, there will be more cases of cancer among whites. However, the rates for minorities are higher than for whites for each age group."

Some types of cancer, such as prostate and cervical cancer, are much more common among African Americans than whites, and the survival rate for African Americans generally is lower. After adjusting for age, African-American males are more than twice as likely to die of prostate cancer as white males, according to N.C. Cancer Registry data provided by Herman. These data show an age-adjusted mortality rate of 60.3 per 100,000 African-American males, compared to 24.5 annual prostate cancer deaths per 100,000 whites.[7] Indeed, the mortality rate of African-American males suffering prostate cancer in North Carolina is among the highest of any state in the nation.[8]

African-American males also have higher age-adjusted mortality rates for lung cancer than do white males. The disease kills 103 African-American males per 100,000 population, compared to 83.3 white males.[9]

A program called Project ASSIST in the Adult Health Promotion Division of the Department of Environment, Health, and Natural Resources is attempting to increase its focus on African Americans in order to prevent lung cancer, heart disease, and other smoking-related illnesses. Sandra Headen, a faculty member with the Tobacco Education and Training Center at the University of North Carolina School of Public Health, says differences in smoking habits may account for higher lung cancer mortality rates among African Americans.

African Americans, she says, are more likely to use mentholated brands that encourage them to inhale more deeply. They also are more likely to have a relapse if they quit, Headen says. She adds that tobacco is ingrained in the African-American culture. Tobacco companies advertise heavily in African-American oriented magazines, Headen says, and on billboards in African-American neighborhoods. They also underwrite cultural and athletic events important to African Americans, she says. Headen is helping Project ASSIST use culturally appropriate materials to combat these messages and to help African-American smokers quit.

Part of the national American Stop Smoking Intervention Study, Project ASSIST works in partnership with the American Cancer Society and statewide and local coalitions. The project's aim is to reduce the percentage of North Carolinians who smoke from the current 29 percent of the population to 15 percent by 2000. To achieve this, the program relies on community-level campaigns that provide encouragement and support for people who want to kick the habit, says Sally Malek, state-level project manager in the Division of Adult Health Promotion. More effective targeting of minorities is one of the keys to reaching this 15 percent goal, Malek says.

African-American females are three times more likely to die of cervical cancer than white females, with a rate of 7.2 deaths per 100,000 population compared to a death rate of 2.3 per 100,000 for whites.[10] African-American females also are somewhat more likely to die of breast cancer than white females,[11] even though the disease is more common among whites. (See "These Graduates Spread the Message of Breast Cancer Prevention," pp. 17–19, for more on an innovative program to encourage African-American women above age 50 to seek breast cancer screening.)

—continues on page 14

Table 2. Leading Causes of Death in North Carolina, 1988–1992, Overall and by Race, with Rankings by Race

Cause	Total Deaths	Rate per 100,000	Overall Rank	Native American Deaths	Rate per 100,000	Rank	Asian/ Other Deaths	Rate per 100,000	Rank
DISEASES OF THE HEART	94,793	284.8	1	666	164.0	1	73	27.4	2
CANCER	66,147	198.8	2	396	97.5	2	112	42.0	1
CEREBRO-VASCULAR DISEASES (STROKE)	23,005	69.1	3	121	29.8	4	26	9.7	4
CHRONIC OBSTRUCTIVE PULMONARY DISEASES (LUNG DISEASE)	10,737	32.3	4	66	16.2	8	4	—	11
PNEUMONIA AND INFLUENZA	9,596	28.8	5	59	14.5	9	6	—	9*
OTHER ACCIDENTS AND ADVERSE EFFECTS	7,425	22.3	6	88	21.7	6	20	7.5	6
MOTOR VEHICLE ACCIDENTS	7,343	22.1	7	164	40.4	3	29	10.9	3
DIABETES MELLITUS	6,901	20.7	8	101	24.9	5	11	—	7
SUICIDE	4,275	12.8	9	38	9.4	10	9	—	8
HOMICIDE/LEGAL INTERVENTION	3,748	11.3	10	74	18.2	7	22	8.2	5
CHRONIC LIVER DISEASE AND CIRRHOSIS	3,570	10.7	11	36	8.9	11	6	—	9*
NEPHRITIS NEPHROSIS (KIDNEY DISEASE)	2,740	8.2	12	25	6.2	12	1	—	13
ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)	2,134	6.4	13	14	—	13	2	—	12
ALL CAUSES	290,582	873.2		2,230	549.0		402	150.7	

* Indicates tie in rankings

Source: Data produced by the State Center for Health and Environmental Statistics, Department of Environment, Health, and Natural Resources. Rates are average number of annual deaths per 100,000 persons, based on a five-year period, 1988–92. Rates based on fewer than 20 deaths may be misleading and were not computed.

Table 2, *continued*

Cause	African-American Deaths	Rate per 100,000	Rank	White Deaths	Rate per 100,000	Rank
Diseases of the Heart	19,728	268.8	1	74,326	294.2	1
Cancer	14,265	194.4	2	51,374	203.3	2
Cerebrovascular Diseases (Stroke)	5,846	79.7	3	17,012	67.3	3
Chronic Obstructive Pulmonary Diseases (Lung Disease)	1,253	17.1	9	9,414	37.3	4
Pneumonia and Influenza	1,863	25.4	7	7,668	30.3	5
Other Accidents and Adverse Effects	2,159	29.4	5	5,158	20.4	7
Motor Vehicle Accidents	1,763	24.0	8	5,387	21.3	6
Diabetes Mellitus	2,419	33.0	4	4,370	17.3	8
Suicide	485	6.6	13	3,743	14.8	9
Homicide/Legal Intervention	2,067	28.2	6	1,585	6.3	12
Chronic Liver Disease and Cirrhosis	1,019	13.9	11	2,509	9.9	10
Nephritis/Nephrosis (Kidney Disease)	1,007	13.7	12	1,707	6.8	11
Aquired Immune Deficiency Syndrome (AIDS)	1,236	16.8	10	882	3.5	13
All Causes	68,542	933.9		219,408	868.4	

Source: Data produced by the State Center for Health and Environmental Statistics, Department of Environment, Health, and Natural Resources. Rates are average number of annual deaths per 100,000 persons, based on a five-year period, 1988–92. Rates based on fewer than 20 deaths may be misleading and were not computed.

Table 3. Rates of Death by Stroke in North Carolina, 1988–1992, by Race and by County*

County	White Deaths	Rate per 100,000	African-American Deaths	Rate per 100,000
ALAMANCE	323	74.6	84	80.5
ALEXANDER	67	51.7	5	—
ALLEGHANY	42	88.7	1	—
ANSON	65	105.6	67	119.8
ASHE	97	87.6	2	—
AVERY	29	39.5	1	—
BEAUFORT	110	75.7	64	96.6
BERTIE	46	118.0	69	109.9
BLADEN	65	76.1	66	116.8
BRUNSWICK	123	58.6	32	68.5
BUNCOMBE	644	80.7	78	108.2
BURKE	161	46.0	15	—
CABARRUS	261	60.8	39	60.3
CALDWELL	207	61.9	13	—
CAMDEN	19	—	9	—
CARTERET	157	65.6	26	117.4
CASWELL	50	81.1	46	107.9
CATAWBA	293	54.8	37	68.7
CHATHAM	108	72.4	36	80.8
CHEROKEE	69	70.5	—	—
CHOWAN	59	139.6	21	81.5
CLAY	23	64.7	—	—
CLEVELAND	239	71.9	77	86.4
COLUMBUS	157	94.6	98	127.7
CRAVEN	154	51.7	97	91.0
CUMBERLAND	303	34.6	172	38.6
CURRITUCK	34	55.9	10	—
DARE	52	48.3	4	—
DAVIDSON	345	60.3	47	75.3
DAVIE	59	46.5	12	—
DUPLIN	148	110.8	94	139.6
DURHAM	343	62.0	201	59.2
EDGECOMBE	156	124.7	140	87.0
FORSYTH	774	78.3	271	81.5
FRANKLIN	103	86.7	61	93.7
GASTON	490	64.7	84	73.6
GATES	21	81.5	18	—
GRAHAM	26	77.2	—	—
GRANVILLE	97	82.6	82	108.9
GREENE	31	69.5	13	—
GUILFORD	1,050	83.9	265	57.7
HALIFAX	155	118.7	156	112.2
HARNETT	141	54.3	52	67.1
HAYWOOD	179	76.9	8	—
HENDERSON	337	100.7	15	—
HERTFORD	52	112.7	72	110.7
HOKE	38	78.2	38	76.5
HYDE	18	—	16	—
IREDELL	294	75.2	61	81.2
JACKSON	75	63.0	3	—
JOHNSTON	241	71.8	58	78.9
JONES	17	—	21	114.3

—continues

Table 3, *continued*

County	White Deaths	Rate per 100,000	African-American Deaths	Rate per 100,000
LEE	81	51.2	32	67.3
LENOIR	150	86.6	124	109.1
LINCOLN	178	77.7	20	97.5
MACON	92	79.5	1	—
MADISON	108	128.4	1	—
MARTIN	48	68.8	47	82.8
MCDOWELL	131	77.1	11	—
MECKLENBURG	878	47.9	410	60.7
MITCHELL	57	79.5	1	—
MONTGOMERY	69	81.0	25	82.7
MOORE	241	100.7	75	137.1
NASH	224	86.4	101	83.8
NEW HANOVER	365	76.1	120	98.4
NORTHAMPTON	44	104.3	81	130.7
ONSLOW	104	18.3	39	25.9
ORANGE	143	37.1	43	57.5
PAMLICO	37	88.5	19	—
PASQUOTANK	91	93.8	40	69.0
PENDER	63	62.7	44	99.7
PERQUIMANS	40	114.9	22	128.9
PERSON	94	89.8	26	56.8
PITT	191	53.6	182	100.7
POLK	68	101.3	9	—
RANDOLPH	297	59.8	30	93.8
RICHMOND	119	76.6	64	98.5
ROBESON	190	99.5	135	102.3
ROCKINGHAM	323	94.9	78	88.7
ROWAN	402	87.3	97	108.7
RUTHERFORD	213	84.8	20	61.2
SAMPSON	174	112.7	85	106.8
SCOTLAND	55	57.5	62	101.1
STANLY	214	94.0	25	82.7
STOKES	124	70.6	13	—
SURRY	231	78.4	14	—
SWAIN	48	121.9	1	—
TRANSYLVANIA	88	72.1	1	—
TYRRELL	10	—	8	—
UNION	179	50.7	39	57.7
VANCE	67	63.2	80	91.2
WAKE	713	43.2	260	58.1
WARREN	37	111.4	73	148.0
WASHINGTON	30	79.1	14	—
WATAUGA	73	40.6	1	—
WAYNE	189	54.1	136	80.1
WILKES	217	76.3	17	—
WILSON	182	89.1	160	127.6
YADKIN	109	74.2	3	—
YANCEY	84	109.4	—	—
NORTH CAROLINA	**17,012**	**67.3**	**5,846**	**79.7**

* *Source:* State Center for Health and Environmental Statistics, Department of Environment, Health, and Natural Resources. Rates are average annual number of deaths per 100,000 persons, based on a five-year period, 1988–92. The Native-American and Asians/Others categories are omitted from this table because the number of deaths at the county level is too small to produce meaningful statistics. Rates based on fewer than 20 deaths may be misleading and are not computed.

Table 4. Rates of Death from Diabetes in North Carolina, 1988–1992, by Race and by County*

County	White Deaths	Rate per 100,000	African-American Deaths	Rate per 100,000
ALAMANCE	139	32.1	49	46.9
ALEXANDER	12	—	3	—
ALLEGHANY	5	—	—	—
ANSON	10	—	17	—
ASHE	19	—	2	—
AVERY	10	—	—	—
BEAUFORT	43	29.6	47	70.9
BERTIE	16	—	23	36.6
BLADEN	15	—	33	58.4
BRUNSWICK	30	14.3	16	—
BUNCOMBE	134	16.8	33	45.8
BURKE	83	23.7	9	—
CABARRUS	69	16.1	16	—
CALDWELL	87	26.0	12	—
CAMDEN	6	—	1	—
CARTERET	44	18.4	11	—
CASWELL	14	—	18	—
CATAWBA	94	17.6	20	37.1
CHATHAM	42	28.1	13	—
CHEROKEE	20	20.4	—	—
CHOWAN	3	—	11	—
CLAY	3	—	—	—
CLEVELAND	78	23.4	31	34.8
COLUMBUS	33	19.9	33	43.0
CRAVEN	20	6.7	31	29.1
CUMBERLAND	110	12.5	84	18.9
CURRITUCK	12	—	4	—
DARE	15	—	—	—
DAVIDSON	87	15.2	19	—
DAVIE	23	18.1	4	—
DUPLIN	22	16.5	36	53.4
DURHAM	80	14.5	101	29.8
EDGECOMBE	32	25.6	40	24.8
FORSYTH	180	18.2	147	44.2
FRANKLIN	23	19.4	29	44.6
GASTON	129	17.0	33	28.9
GATES	2	—	5	—
GRAHAM	6	—	—	—
GRANVILLE	12	—	32	42.5
GREENE	9	—	6	—
GUILFORD	214	17.1	108	23.5
HALIFAX	38	29.1	42	30.2
HARNETT	52	20.0	26	33.6
HAYWOOD	57	24.5	3	—
HENDERSON	36	10.8	5	—
HERTFORD	13	—	15	—
HOKE	5	—	15	—
HYDE	3	—	7	—
IREDELL	51	13.0	26	34.6
JACKSON	22	18.5	—	—
JOHNSTON	63	18.8	23	31.3
JONES	3	—	10	—

—continues

Table 4, *continued*

County	White Deaths	Rate per 100,000	African-American Deaths	Rate per 100,000
LEE	32	20.2	23	48.4
LENOIR	40	23.1	41	36.1
LINCOLN	30	13.1	6	—
MACON	34	29.4	—	—
MADISON	24	28.5	—	—
MARTIN	23	32.9	29	51.1
MCDOWELL	36	21.2	3	—
MECKLENBURG	273	14.9	189	28.0
MITCHELL	18	—	—	—
MONTGOMERY	19	—	8	—
MOORE	27	11.3	17	—
NASH	51	19.7	39	32.4
NEW HANOVER	84	17.5	50	41.0
NORTHAMPTON	7	—	27	43.6
ONSLOW	30	5.3	15	—
ORANGE	45	11.7	23	30.8
PAMLICO	5	—	5	—
PASQUOTANK	25	25.8	11	—
PENDER	14	—	16	—
PERQUIMANS	6	—	4	—
PERSON	15	—	10	—
PITT	59	16.5	86	47.6
POLK	22	32.8	5	—
RANDOLPH	79	15.9	16	—
RICHMOND	45	29.0	28	43.1
ROBESON	67	35.1	37	28.1
ROCKINGHAM	74	21.7	34	38.7
ROWAN	85	18.5	31	34.7
RUTHERFORD	52	20.7	14	—
SAMPSON	34	22.0	30	37.7
SCOTLAND	16	—	25	40.8
STANLY	71	31.2	12	—
STOKES	24	13.7	2	—
SURRY	56	19.0	6	—
SWAIN	8	—	—	—
TRANSYLVANIA	20	16.4	3	—
TYRRELL	3	—	4	—
UNION	59	16.7	22	32.5
VANCE	33	31.1	20	22.8
WAKE	167	10.1	142	31.7
WARREN	4	—	11	—
WASHINGTON	5	—	5	—
WATAUGA	15	—	—	—
WAYNE	63	18.0	53	31.2
WILKES	48	16.9	4	—
WILSON	49	24.0	63	50.3
YADKIN	21	14.3	1	—
YANCEY	25	32.6	—	—
NORTH CAROLINA	**4,370**	**17.3**	**2,419**	**33.0**

* *Source:* State Center for Health and Environmental Statistics, Department of Environment, Health, and Natural Resources. Rates are average annual number of deaths per 100,000 persons, based on a five-year period, 1988–92. The Native-American and Asians/Others categories are omitted from this table because the number of deaths at the county level is too small to produce meaningful statistics. Rates based on fewer than 20 deaths may be misleading and were not computed.

Karen Tam

Darrell Geoffroy, 11, waits to be seen by a doctor at the Open Door Clinic, which offers free care in Raleigh.

—continued from page 7

Herman says one reason for these higher death rates is that African Americans are not having their cancers detected early enough through preventive screenings. "People should not be dying of cervical cancer," says Herman. "If [cervical] cancer is detected early enough, it's treatable."

Diabetes is another disease for which early detection is important. The disease to a large degree can be controlled by some combination of medicine, diet, and physical activity—yet many African Americans with diabetes have not even been diagnosed. The result: diabetes is nearly twice as likely to kill African Americans as whites. African Americans also suffer disproportionately from diabetes-related illnesses such as kidney disease and blindness.

Through a five-year grant from the federal Centers for Disease Control in Atlanta, Ga., the state is coordinating a major initiative targeting African Americans in Wake County. Peter Andersen, chief of the Chronic Disease Section in DEHNR's Division of Adult Health Promotion, says the initiative grew out of a pilot study in Wake County in which 900 persons were interviewed and 250 people were selected for comprehensive physical exams to provide baseline data. "That study found diabetes to be high in prevalence, plus there was a high prevalence of undiagnosed diabetes," says Andersen.

Project DIRECT (Diabetes Interventions Reaching and Educating Communities Together) was proposed to deal with this finding, and in October 1994, CDC funded it to the tune of $650,000—a major grant for this type of program. "It's the only such program in the country," says Andersen. "It's a community demonstration project with a high research focus to it."

The program, to be operated largely through the Wake County Health Department, has a three-part focus. It will: *(1)* work with health providers to develop and implement new and innovative approaches to diabetes care; *(2)* provide increased community outreach to identify and serve people who have not been diagnosed and those previously diagnosed who are dropouts from care programs; and *(3)* conduct a health promotion campaign that encourages proper diet and exercise to contain diabetes and possibly prevent its onset.

Wake County residents will play key roles in the community-based project as members of the Project DIRECT advisory board and work groups. At the end of the study period, the intervention will be evaluated to see if community changes have fostered improvements in health. Andersen says the results may provide a model for better serving minorities with diabetes in other North Carolina counties. "Oftentimes, the lessons learned could be and should be replicated elsewhere," Andersen says,

"perhaps not at this level, but the concept is valuable and can be applied."

The large gap in sexually transmitted disease rates between whites and African Americans may be explained in part by the fact that more African Americans than whites use local health departments for diagnosis and treatment. Local health departments are thought to be more likely than private providers to report such cases to the state. (See Table 5, p. 16, for a breakdown of communicable disease rates for North Carolina by race.)

"Most of the disease reports we get come from the public clinics, and African Americans are more likely to go to the public clinics," says Rebecca Meriwether, deputy chief of the Communicable Disease Control Section in the N.C. Department of Environment, Health, and Natural Resources. "That doesn't explain the entire difference, however."

Meriwether says newborn screening for AIDS and congenital syphilis reveals that African-American mothers are much more likely to pass these diseases to their infants. For AIDS, she says, the rate of infection is 10 times greater for African Americans than for whites. "Some of it is reporting bias, but it's also true that sexually transmitted diseases are more common in African-American communities," says Meriwether. "A lot of it is probably due to socioeconomic factors."

Jane Leserman, author of an N.C. Equity report on the status of women's health in North Carolina, also cites the reporting bias in her report. But she too concludes that most of the racial gap can be attributed to socioeconomic factors. "Socioeconomic factors that are likely to increase the risk of getting an STD [sexually transmitted disease] are lack of access to health services resulting in delayed treatment and wider spread of disease, exchanging sex for drugs or money, and cultural or sexual norms," Leserman writes.[12]

Of all of the sexually transmitted diseases, AIDS is the most deadly. The blood-borne virus that causes AIDS is passed most frequently through anal intercourse and by sharing dirty needles. Thus, male homosexuals and intravenous drug users are the most likely to be infected. Increasingly, however, the ailment is being spread to women through unprotected intercourse with an infected male.

At a Charlotte conference sponsored by the Office of Minority Health, former Mayor and U.S. Senate candidate Harvey Gantt gave a fiery speech on the impact of AIDS in the African-American community. "Why is AIDS growing exponentially in our community? I think there's something there we need to examine," said Gantt.

Gantt said African Americans are more likely to keep homosexuality in the closet than whites and have generally dealt with AIDS by trying to ignore the problem and hoping it would go away. "I want us to create a crisis atmosphere among young people early on to inform them of the dangers that await them," Gantt said. "We're not talking to our young people about casual sexual behavior. They go on thinking it can't possibly happen to them. It's a victim mentality. There's no transmission of values."

The fact that AIDS takes such a heavy toll on African Americans and prompts so little action from society as a whole speaks volumes, Gantt said. "We need to start talking about the impact of race in North Carolina and quit sweeping that under the rug as well," he said.

To fight AIDS, the Minority Health Advisory Council has pressed for increased funding to *(1)* support prevention and education programs and *(2)* provide additional support services for people already living with AIDS. The General Assembly increased AIDS funding by $500,000 in the 1994 short session, far less than the $6 million the council had sought. DEHNR included $2 million in increased funding for AIDS prevention and services in its 1995 budget request to Governor Hunt, but Hunt left it out of his final budget proposal.

Tuberculosis is another disease striking harder at African Americans, and again, socioeconomic factors may be to blame. "TB has for a long time been more prevalent in the African-American community than for whites, and that's pretty much true

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No sooner had I told him
Than I awoke.
The doctor said, Madam,
Your fever's broke—

Nurse, put her on a diet,
And buy her some chicken.
I said, Better buy two—
Cause I'm still here kickin'!

—FROM "MADAM AND THE WRONG VISITOR"
SELECTED POEMS OF LANGSTON HUGHES

all over the nation," says Meriwether. "It's more prevalent among people who live in poverty. It's more prevalent among people who live in crowded conditions." (See Table 5 below for a breakdown of AIDS and Tuberculosis disease rates, by race.)

Meriwether says improvements in living standards have contributed to a long-term decline in the prevalence of tuberculosis, but the rate of decrease has slowed. One reason for this, she says, is the rise in the number of people infected with HIV. TB is relatively difficult to catch, Meriwether says, and people with compromised immune systems are more susceptible. Between 1988 and 1992, 2,013 tuberculosis cases were reported among N.C. African Americans compared to 1,034 cases among whites.

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Table 5. Communicable Disease Cases and Rates in N.C., By Race, 1988–92*

White Cases	Rate per 100,000	African-American Cases	Rate per 100,000	Native-American Cases	Rate per 100,000	Asian/Other	Rate per 100,000	Total in N.C.	Rate per 100,000
ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)									
988	3.9	1488	20.3	1	—	6	—	2483	7.5
HEPATITIS A									
1377	5.4	390	5.3	12	—	15	—	1794	5.4
ACUTE HEPATITIS B									
2200	8.7	1540	21.0	121	29.8	112	42.0	3973	11.9
SALMONELLOSIS									
3746	14.8	1587	21.6	66	16.2	32	12.0	5431	16.3
SHIGELLOSIS									
1690	6.7	1170	15.9	62	15.3	16	—	2938	8.8
BACTERIAL MENINGITIS AND H FLU									
1019	4.0	489	6.7	31	7.6	6	—	1545	4.6
SYPHILIS									
1790	7.1	15295	208.4	95	23.4	47	17.6	17227	51.8
GONORRHEA									
15893	62.9	139275	1897.6	1070	263.4	458	171.7	156696	470.9
CHLAMYDIA AND NON-GONOCOCCAL URETHRITIS									
33808	133.8	76717	1045.3	791	194.7	703	263.5	112019	336.6
TUBERCULOSIS									
1034	4.1	2013	27.4	35	8.6	97	36.4	3179	9.6

* *Source:* Data produced by the State Center for Health and Environmental Statistics, Department of Environment, Health, and Natural Resources. Rates are average number of annual cases per 100,000 persons, based on a five-year period, 1988–92. Rates based on fewer than 20 cases may be misleading and were not computed.

These Graduates Spread the Message of Breast Cancer Prevention

It was graduation day in Beaufort County, replete with diplomas, flashing cameras, and finger food. Yet the students—all African Americans over 50—had taken only one class that lasted three Saturdays. That class was in the prevention of breast cancer, a disease more prevalent among white women but more frequently fatal among African-Americans.

Proud family members and teachers crowded the room to mark the occasion. Lela King served as informal valedictorian.

She glanced at her notes, remarked on all the men in the room, then plowed ahead with her story. "It was December 1, 1983," she says. "I went to the doctor. He said I had a small lump on my left breast and told me, 'I'm going to let you go talk to the surgeon.'"

The lump the size of the tip of her little finger was malignant. Lela King had breast cancer. The surgeon recommended a mastectomy and King quietly complied. But breast cancer wasn't talked about much in this rural coastal county. King tells her classmates that she kept her surgery and her suffering largely to herself. She didn't even tell her close friends at church.

"Somehow after the operation I felt neglected and rejected," says King. "I thought that God had dealt me a bad blow. I was not even going to church anymore. I felt I was the only one in the world going through something like that, and thought, 'Why did it have to happen to me?'"

Still, the surgery was a success. King did not have to go through chemotherapy or radiation treatment. "By starting in time and catching it in time, he [the surgeon] was able to get everything done." At the 10-year mark, King's doctor found her cancer-free and pronounced her cured. "We hollered and shouted about that," she says.

King's jubilation about her own cure and her sorrow about another breast cancer case that wasn't caught in time helped her come to a conclusion. She isn't keeping quiet anymore. "I would like to advise all women to please, keep your breasts checked," she says.

King and her fellow graduates have been charged to do exactly that. After three Saturdays of training, they are certified lay health advisers. Their job is to go out in the community and encourage African-American women to come in to local health facilities for breast cancer screening. The training came via the North Carolina Breast Cancer Screening Program—a five-county intervention to improve the inclination of African-American women to practice preventive health.

The program relies on community leaders like Lela King to get the word out among African-American women about the need for breast cancer screening. It also works with local health departments and clinics to assure that they have access to these services at a cost they can afford. Ultimately, the results in five counties—Bertie, Beaufort, Martin, Tyrrell, and Washington—will be compared with five control counties to see if the intervention has had an impact.

The N.C. Breast Cancer Screening Program is modeled on a Wilmington, N.C., program called Save Our Sisters. That program was successful in getting more African-American women to seek breast cancer screening where traditional outreach efforts had failed. These traditional efforts included a publicity campaign and free clinical breast exams at African-American churches and referrals for mammograms.

Part of the reason breast cancer is so deadly for African-American women is that they are less likely than whites to seek breast cancer screening that could lead to early detection and a cure. Indeed, researchers found a gap of 11 percent when they compared how many African-American and white women got breast cancer screening in New Hanover County in 1990.

A resulting public education campaign and series of free clinics had an unintended consequence. The gap grew to 17 percent. Even at the African-American churches, white women out-

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Prevention

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numbered blacks in seeking breast cancer screening.

That's when Geni Eng, a professor of health behavior and health education at the University of North Carolina School of Public Health, decided to apply some of the lessons she learned while working with another professor at the school, John Hatch. Hatch, she says, had worked with black churches in "defining and capturing that natural helping that goes on in congregations" and applying it to health issues.

Eng decided the same approach would work with breast cancer awareness. Her idea was to recruit and train natural leaders within the African-American community to spread the word among their peers about the need for breast cancer screening.

Part of the task of designing a lay-health-adviser intervention program was to figure out why black women were reluctant to seek breast cancer screening in the first place. For this, Eng turned to focus groups. The results were eye-opening.

Among the barriers teased out in focus group interviews were concerns about costs, fear of the mammogram procedure, and a pervasive attitude that preventive health care is a luxury. "They might need the money to feed their kids and clothe them and some other things," one New Hanover County focus group participant observed. Another said an African-American woman might not come in for screening, even when she feels a lump, "because she is so used to bumps and knocks and hurts until she ignores it."

Eng believes that memories of a previously segregated health care system may also have made black women reluctant to seek preventive care. "There's a history out there of a health care system during segregation," says Eng. "It wasn't the most pleasant, sincere kind of interaction during segregation, so you would only go when you were hurting. We're telling them now to go when they don't have a problem and to go and look for a problem."

To dispel these kinds of doubts and fears, Eng felt that African-American women needed role models in the community. She advertised in the local newspaper and wound up hiring Jackie Smith as the Save Our Sisters coordinator. Through the efforts of Smith and others, 95 lay health advisers were trained to spread the preventive care message in New Hanover County and get African-American women in for screening.

So far, more than 200 women have received breast cancer screening as a direct result of SOS efforts, and countless others may have been encouraged to do so through contact with lay health advisers. The program is being evaluated to determine if older black women in New Hanover County were more prone to get breast cancer screening than those in a control county that did not have a program like Save Our Sisters.

Although the jury is still out, Smith is confident Save Our Sisters has made a difference. "You know what I think? I think the key to our success is getting lay people out into the community, and they get the word out to other people," says Smith. "I try to recruit ladies, and we coordinate the training and go around and speak to people."

But the job involves more than public speaking and sharing information about breast cancer around the kitchen table. If necessary, lay health advisers are encouraged to bring people in for services at clinics or to shepherd women to mobile mammography units deployed at housing projects and black churches.

Smith says the barriers to screening can be anything from fear of losing a breast or hair through chemotherapy or radiation treatment to inability to read and write well enough to fill out the required paperwork. Some might require a gentle nudge, such as, "Can I help you fill out that form?" says Smith. Otherwise, they might leave a clinic in frustration. "You have to be very sensitive to people," Smith says.

And sensitivity involves dealing directly with these women's fears and helping them overcome them. "I think it's the fear of finding breast cancer and the fear of losing hair or breasts, more than pain from radiation or a mastectomy," says Smith. "They're in the habit of going to the doctor for a specific problem instead of going to the doctor to look for one."

Ric Carter

Breast cancer survivor Lela King displays her diploma indicating she is a lay health adviser promoting breast cancer screening in Beaufort County.

The goal of SOS, says Smith, is to build the confidence of older African-American women to the point that they demand the health services they need. Smith chuckles when she speaks of one previously soft-spoken woman who went to the doctor for screening and scolded him when he failed to feel for lumps. "She told him, 'You come back here. You didn't examine my breasts,'" Smith says. "We're telling women to take control of their bodies, and if they don't get the answers from one doctor, to go talk to another one."

The N.C. Breast Cancer Screening Program hopes to replicate the success of SOS in motivating lay volunteers in a different setting—five rural, medically underserved counties. It also will try to build on SOS by breaking down barriers such as cost and lack of capacity to serve clients. The goal is to improve by 20 percent the number of African-American women who get regular breast cancer screening and mammograms.

Unlike Smith, the coordinators of the programs for the five counties are health department employees. This strengthens the link to service providers, although Eng worries that the increased institutionalization may erode trust in the community. "Right now, the beauty of SOS is that we're all equal," says Eng.

But even with heightened professionalism, the success of the other programs will depend upon lay volunteers like Lela King, who must spread the word that the key to curing breast cancer is early detection. If they fail, it won't be for lack of enthusiasm for the mission. That's because for many of these volunteers, the problem of breast cancer awareness hits painfully close to home.

"I had a bad experience with my daughter," says King in closing her graduation remarks. "She had it a couple of years ago, and she didn't get it in time, and she passed. I'm telling my granddaughter now."

—Mike McLaughlin

—*continued from page 16*
(See Table 5, p. 16.) By population, African Americans were nearly seven times more likely to suffer from the disease than whites.

Native-American Health Issues

For Native Americans in North Carolina, motor vehicle accidents are a major killer, claiming lives at nearly twice the rate of whites. (See Table 2, pp. 8–9.) Homicide rates also were double the rate of whites, and deaths by diabetes mellitus were somewhat higher.

Russell Childers is district health director for Swain and Graham counties in the mountainous far west. Swain's population is approximately 20 percent Cherokee Indian, and Childers says these Cherokee are in relatively good health. "For some things, such as diabetes and cholesterol, because of their diet, they do have a little higher problem," says Childers. "But chronic and communicable disease rates are no higher. Comparatively speaking, they are a well-blessed tribe."

The Swain County Health Department sits on a hilltop just outside Bryson City in the Smoky Mountains. It is a spartan, but tidy facility, and Childers apparently runs a tidy operation. His county's on-time immunization rate for children under age 2, at 79.1 percent, was the best of any of the nine counties the Center examined. (See pp. 32–43.) For Native Americans, the rate was somewhat lower, at 68.4 percent. But Childers says most Swain County Indians get their shots at Indian Health Services on the Cherokee reservation, where services are free for anyone listed on the Cherokee tribal roles.

On one wall of Childers' office is a plaque that reads, "As you go through life, two rules will never bend. Never whittle toward yourself or pee against the wind." But Childers' department violates these rules through its efforts to change the way people eat. Fried and high-fat foods are the primary culprits in the Indians' diet, Childers says, adding that Swain County whites also indulge in high-fat diets. The health department continues to try and change dietary habits among the Indians and other Swain County citizens by providing nutrition education and participating in a control program aimed at diabetes. "It's almost an impossible challenge," Childers says.

One reason, he says, is that the Native American foods taste good. "Fry bread, bean bread—made out of baked pinto beans, pigs' feet, souse meat,"[13] says Childers, ticking off a menu of high-fat foods. These are some of the Cherokees' dietary staples that make controlling diabetes difficult. Alcoholism, Childers says, is a problem for Indians. This may be reflected in high rates of deaths in car crashes in Swain County.

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I always like summer
best
you can eat fresh corn
from daddy's garden
and okra
and greens
and cabbage
and lots of
barbecue
and buttermilk
and homemade ice-cream
at the church picnic . . .

—NIKKI GIOVANNI
"KNOXVILLE, TENNESSEE"

Another major concentration of Native Americans resides at the opposite end of the state, in Scotland, Robeson, and Hoke counties. The largest component of Robeson County's population is, in fact, Native American, according to health director William Smith. More than 40,000 Lumbee Indians call Robeson home, the largest concentration of Native Americans east of the Mississippi.

The Lumbee are not a federally recognized tribe, says Smith, but they do have recognized health problems. "The Indian population here has the same characteristic high diabetes and heart disease rates, which don't differ a great deal from the African-American population," Smith says. They also have the same characteristic high rate of deaths in automobile accidents suffered by the Cherokees.

Smith adds, though, that white death rates from diabetes and heart disease aren't much different than those of Native Americans and African Americans in Robeson County. "If it's truly diet, that would make sense," says Smith. He says Robesonians, regardless of race or ethnic origin, love their high-fat foods. "It's more your everyday fatback in the green beans, sliced fatback for breakfast," Smith says.

To attack the problem, the health department is participating in a Diabetes Today project to train lay

people about the high level of diabetes and the impact it is having on the community. These volunteers will be expected to spread the word to their peers. Smith says he has had success in the past with beauticians in a program aimed at spreading the message about the need for breast cancer screenings. For diabetes, he is adding barbers to the list.

"We're going to try that route, rather than a doctor or nurse preaching to people," says Smith. Smith adds that too many minorities get their primary care from emergency rooms, where they get no advice at all about preventive health. "You don't get any education in the emergency room. You wait around forever for a service, and then you're gone." The diabetes control program was started by a $10,000 state grant.

The health department also belongs to a consortium of local agencies called Partnership for Community Health. The consortium includes representatives from Pembroke State University, the public schools, social services, and private industry. A committee of this group is focusing on diabetes and heart disease and plans to work on prevention for all age groups. One vehicle will be the schools, but the group hopes to reach parents as well. "If you can't get the parents to change a little bit, it doesn't do any good to tell the children what they ought to be eating," says Smith. "When they go home, they don't have any choice."

Native Americans also have higher rates of sexually transmitted diseases and tuberculosis than whites, although not as high as African Americans. (See Table 5, p. 16.) For example, Native Americans are about three times as likely to be infected with syphilis as whites. And Native Americans, with 35 cases of tuberculosis over the five-year period, were about twice as likely to suffer the disease as whites.

Karen Tam

Tiffany Montalvo, age 9 months, pictured here with her mother Elsanava, gets a well-child checkup at the Wake County Health Department.

Hispanic Health Issues

The Center for Health and Environmental Statistics did not produce death rates for Hispanics because their numbers were too small to produce meaningful statistics at the county level. They also are defined by the U.S. Census Bureau as an ethnic, rather than a racial group. Most Hispanics categorize themselves as either white or African American. They are thought to have been undercounted in the 1990 Census and are underreported on death certificates, according to the State Center for Health and Environmental

Karen Tam

In some counties, health departments offer van service for patients like this Chatham County mom, Irma Pacheco. In many other counties, transportation remains a major access barrier.

Statistics.[14] Many health reporting systems and surveys do not collect information on Hispanic origin, so data on the state of Hispanic health are hard to come by.

CHES, however, used birth certificates to identify Hispanics and examine maternal and child health indicators from 1988 through 1992. These indicators are largely positive for Hispanics, despite some complicating factors. For instance, Hispanic mothers of Mexican origin are less likely to receive prenatal care in the first trimester of pregnancy than virtually any subgroup of the population. Hispanics of Puerto Rican origin are particularly prone to anemia and diabetes during pregnancy. Yet Hispanic mothers are no more likely than non-Hispanic whites to have a low birthweight baby, thought to be the leading direct cause of infant mortality. Hispanic infant death rates are about the same as non-Hispanic whites.[15]

Hispanics represent only 1.2 percent of the state's population according to the 1990 Census. Yet they place a heavy burden on some local health departments. Migrant workers and their families may as much as double the state's Hispanic population during harvest season,[16] and many communities have experienced significant growth in their Hispanic populations since the 1990 Census.

At a Chatham County Health Department clinic in Siler City, for example, Hispanics represent 35 percent of the clientele. That compares to a county-wide Hispanic population of 1.5 percent, according to the 1990 Census. Yet Hispanics are flocking to the Siler City area of the county, drawn by low-wage jobs in area chicken-processing plants.

In 1991, when Siler City lost its only obstetrician and the local hospital shut down its birthing center, the health department expanded its role to provide prenatal care. Among the services the department added was a transportation network to get patients to its maternal and child health clinic. It also coordinates support groups for both African-American and Hispanic mothers, some of whom speak no English. These groups provide training in both prenatal care and parenting skills. Hispanics also get lessons in English as a second language.

The county has seen a drop in its infant mortality rate since instituting these new services, although some of it may be random fluctuation in rates. In 1990, for example, the rate was 8.4 infant deaths per 1,000 live births, according to Robert Meyer, head of perinatal epidemiology at the State Center for Health and Environmental Statistics. The rate increased to 11.2 per 1,000 births in 1991, plummeted to 1.8 in 1992, then

rose again to 7.7 in 1993.

But Meyer says citing infant mortality rates for a single year can be misleading, particularly in a small county. Because the number of live births is so small, one infant death can have a relatively large impact on the rates. For instance, in Chatham County there were five infant deaths in 1990. This produced an infant mortality rate of 8.4 per 1,000 live births. In 1991, six infant deaths produced the 11.2 rate, and in 1992, two deaths out of 571 births produced the 1.8 rate. The better statistic to use, Meyer says, is the average number of deaths over a five-year period. For the years 1988–92, Meyer says, Chatham's rate was 7.7.

Nationally, studies have found Hispanics to be the racial or ethnic group *least* likely to have health insurance. They see a doctor less than whites or African Americans, and are more likely to report fair or poor health status than whites. They suffer higher rates of accidents or injuries than whites and are three times more likely to have AIDS. Diabetes mellitus is also a problem among Hispanics, although hypertension, serum cholesterol levels, and rates of heart disease are lower than those of the population as a whole.[17]

Asian-American Health Issues

Asians and any other racial groups were lumped together in the CHES data produced for the North Carolina Center for Public Policy Research, but the number of deaths was too low to provide reliable death rates for most categories of illness. (See Table 2, p. 8–9.)

For categories for which death rates could be calculated, the rates often were far lower than those of the general population. Deaths from heart disease, for example, totaled 27.4 per 100,000 population, compared to an overall death rate of 284.8. Cancer death rates also were much lower than those of the population as a whole, at 42 per 100,000 compared to an overall death rate of 198.8.[18]

Paul Buescher, chief of CHES health statistics section, surmises that Asian death rates are lower for two primary reasons: *(1)* they are a fast growing immigrant population and thus younger; and *(2)* Asians in the United States, while a diverse population, generally are healthy, with fewer risk factors that affect longevity.

As for disease data, Asians and others did suffer disproportionately in some areas, such as sexually transmitted diseases and tuberculosis. (See Table 5, p. 16) Asians and others, with 97 tuberculosis cases over a five-year period, were about nine times more likely to be infected than whites.[19] Their rate was the highest of any racial group or ethnic group for which data were available.

Meriwether says tuberculosis is relatively difficult to catch and tends to circulate in minority communities where there is more exposure to the germs that spread the disease. The fact that minorities are more likely to contract tuberculosis may also present an access barrier. Once infected, treatments are available that will decrease markedly the likelihood of developing TB, but first one must seek treatment.

Access to Care

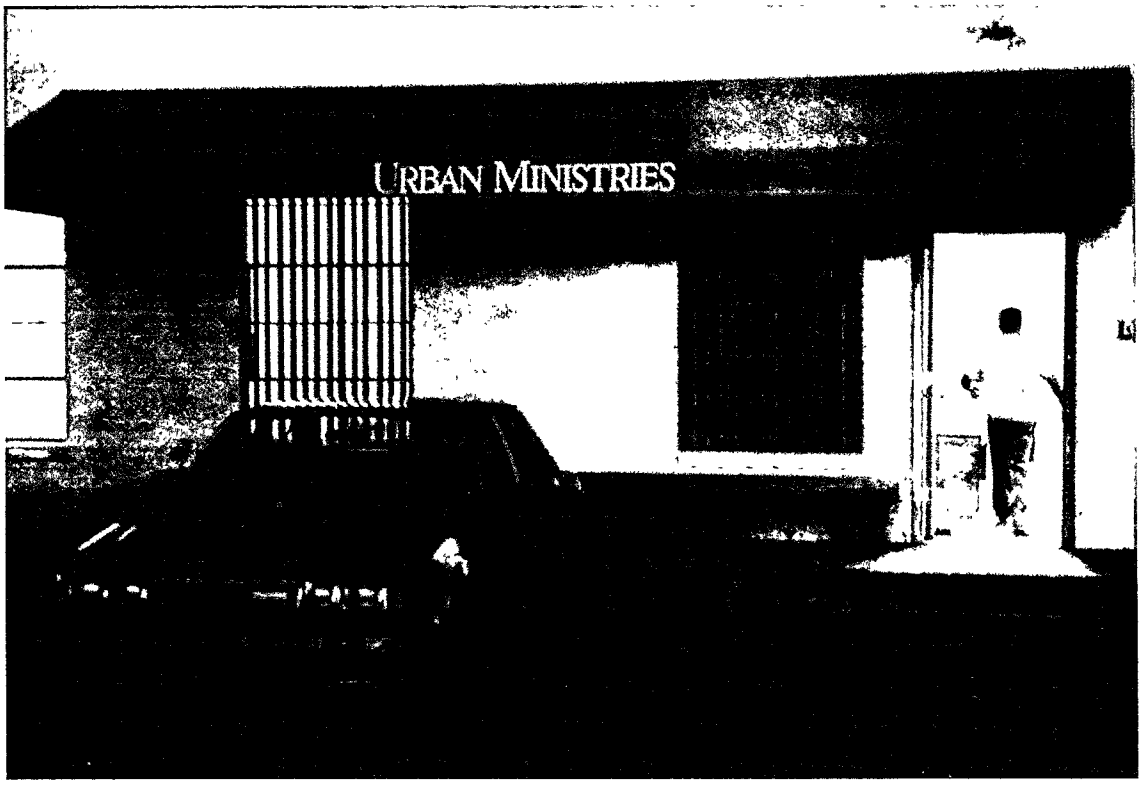
Indeed, access to care is cited repeatedly by service providers and others as a major barrier to improved health for minorities. Access can be broken down into at least two components—availability and affordability. In North Carolina, many minorities have a hard time getting to health services due to rural isolation. Once they get to the doctor, they often can't afford to pay for the service. The counties with the highest percentage of African-American population, for example, are among the poorest, most rural, and most isolated. These include: Warren County, the state's poorest, 57 percent African American; Bertie, third poorest, 61 percent African American; Halifax, fourth poorest, 50 percent African American; and Hertford, tied for fifth poorest with Tyrrell, 58 percent African American.[20]

These counties are also among the most unlikely to be able to attract and retain doctors and other highly paid health care providers. "One county I represent has no general practitioner whatsoever," says Rep. Howard Hunter (D-Northampton), who represents Gates, Northampton, and parts of Bertie and Hertford in the rural northeast. "Two counties have no hospital. The older people [health care providers] are getting old, and no new physicians

▼

The left side of her world is gone—
the rest sustained by memory
and a realization: There are still the
children.

—WILLIAM STAFFORD
"STROKES"



Karen Tam

Free clinics such as the Open Door Clinic in Raleigh offer one source of health care for minorities.

are moving back in. . . . We need more physician assistants to deliver services."

But Hunter says even with more health care facilities and services, citizens would have trouble gaining access to them, both because they don't have a way to pay for services and because they don't have a way to get there. "Transportation is a problem in my district. They ain't got a house, much less a car."

African Americans also are about twice as likely not to have health care coverage as whites. One in five African Americans are without health care coverage in North Carolina, compared to only one out of every nine whites. That's despite the fact that African Americans are four times more likely than whites to qualify for Medicaid, the government health care program for the categorically eligible poor.[21]

Yet another possible indicator of an access barrier is the infant mortality rate for African Americans. North Carolina almost hit bottom in 1988, when its overall rate was 12.6 per 1,000 live births—49th in the nation, above only Georgia.[22] Since then, the state's overall standing has improved.

In 1992, North Carolina's infant mortality rate stood at 9.9 per 1,000 live births—the lowest in the state's history. Yet the state still trailed much of the nation, primarily because its infant mortality rate for African Americans, at 15.7, was more than twice the white rate of 7.2. The rate crept up to 10.6 in 1993, with increases in rates for whites, at 7.9, and African Americans, at 16.4.

The racial gap has confounded the experts because socioeconomic factors such as age and education do not seem to have a big effect. Meyer, the perinatal epidemiologist in the State Center for Health and Environmental Statistics, says much of the recent improvement is due to "better survival of low-birthweight infants. It's usually ascribed to high-tech medical care."[23]

Adds Tom Vitaglione, chief of the Children and Youth Section in the Division of Maternal and Child Health, "The most intractable problem to us in terms of minorities is infant mortality."

The state has attacked the infant mortality problem through a broad category of services under the Medicaid-funded Baby Love program. Through this program, Medicaid eligibility and services have been expanded greatly for pregnant women, with maternity care coordinators assigned to assure that

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Doctors Care in Winston-Salem

All of North Carolina's urban communities make some effort to provide health services to those without the means to pay—both by writing off unpaid care at clinics and hospitals and by providing free clinics for the poor. But Winston-Salem and Forsyth County have woven an extra strand into the health care safety net—a health care program for the working poor called Doctors Care.

"It's great," says Vaughn Thomas, who screens applicants for the program through Consumer Credit Counseling in Winston-Salem. "It's a very generous program. Care is provided at no charge except for a co-payment at the doctor or dentist's office. We've had some people on the program who got mega-services, who needed it, obviously."

Doctors Care is for working people with no health insurance who earn too much money to qualify for a discount of more than 50 percent on health services at Reynolds Health Center, a county-subsidized primary care clinic in Winston-Salem. There also is an income ceiling of 150 percent of the federal poverty level, or $21,505 a year for a family of four.

Dr. Thomas Hinson, the Forsyth County physician who designed Doctors Care, says it is part of a multi-tiered system that attempts to provide indigent health services in Winston-Salem. None of these programs specifically targets minorities, but they all serve a disproportionate number of minority patients because they serve the city's poor.

At the first level are free clinics called Samaritan Clinic and Sunnyside Ministry. Next is the Reynolds Health Center, which bases its fee schedule on ability to pay. Finally, there is Doctors Care. All of these facilities refer qualifying patients to a free pharmacy operated by Crisis Control Ministries, and all have a strong role to play in providing access to care in Winston-Salem.

Doctors Care

Hinson established the Samaritan Clinic, and his success landed him the assignment to develop Doctors Care. Dr. Tom Koontz, a surgeon and president of the local medical society, asked him to come up with a program to serve the thousands of working poor with no health insurance who reside in Forsyth County.

For people who meet the income requirements and are accepted into Doctors Care, the program provides everything from checkups to hospitalization at minimal cost. Hinson says Doctors Care provides health care for people who can't afford it. For doctors, it provides a way of dealing with non-paying patients.

"Our particular practice writes off about 15 percent of its billing," says Hinson. "We take all comers, as most doctors do. This organizes all of that. Doctors know that people are truly needy, so they don't try to pursue the bill. There is no collection agency. You can feel truly good about what you're doing. . . . It's good for the doctors and the patients. It's just a good system."

Doctors Care enrollees are assigned a managing physician. Each visit to the doctor's office requires a co-payment of $5, $15, or $20. A trip to the emergency room cost $25 if approved by the managing physician. The higher charge is intended to discourage overuse of the emergency room for primary care.

Except for extraordinary treatments such as organ transplants, which are not guaranteed, the program provides blanket care. "They can be seen by a doctor, seen by a dentist, seen by a specialist if referred by the managing physician. They get free medicine at Crisis Control. They get hospitalization free and free surgery."

All of the Doctors Care participants work, many of them in low-paying service sector jobs such as busing tables at restaurants, cleaning hotel rooms, or doing dry cleaning and laundry.

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Doctors Care

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But Hinson's personal interest extends beyond low-income workers. He also provides countless hours of volunteer service providing free medical care for those who don't have a job or even a permanent address.

Samaritan Clinic

Hinson founded Samaritan Medical Clinic in 1986 in the vacant rooms above a soup kitchen. "For me, I'm a Christian," says Hinson. "I sort of see this as an extension of my faith. A friend of mine invited me to come down and work at the soup kitchen. I did that for about a year, and, being a doctor, I saw a lot of people with medical needs."

Bearded, suspendered, and tieless, Hinson sits slumped at a folding table in the oblong room that serves as the waiting room of a clinic that has just seen 22 walk-in patients. Forsyth County Public Health Nurse Eddie Grubbs tidies up the paperwork while Hinson talks about the clinic and the maladies of patients he is likely to meet on any given Thursday.

"Basically, it's primary care," says Hinson. "We see a lot of hypertension, trauma, diabetes, sprains and strains, acute infections, various abdominal complaints . . . but a higher dose of trauma than you see in suburban North Carolina."

Hinson describes two types of trauma: accidents, and intentional and seemingly random violence. "We see people who've been cut, beaten, who've staggered out in front of a car and been hit. . . . A lot of times it's violence. You might have somebody sleeping under a bridge, and somebody would come up and beat them with a bottle. They don't have anything anybody would want to rob them for. Or somebody has gotten drunk and fallen down an embankment."

Mike McLaughlin

Dr. Thomas Hinson outside the Samaritan Clinic in Winston-Salem

Hinson says he also sees more hypertension cases than one would expect in a standard medical practice, as well as more complications due to diabetes, and more cardiopulmonary problems. In the winter, influenza becomes a problem. "What we hope we are doing is picking these things up early," says Hinson, "diabetes before it reaches renal failure, cardiopulmonary problems before they trigger a heart attack. Prevention is the major theme here."

Yet Hinson says any treatment plan is complicated by lack of follow-through on the part of the patient, particularly for problems like hypertension. "It's hard to get people to take medicine for something that shows no symptoms," says Hinson, "and follow-up is a big problem here. People seem to disappear. We may not see them for six months, and then they come back. But a significant minority do come back. They get their blood pressure checked. They get their medicine filled on a regular basis. They participate in their care. For those patients, treating them is very gratifying."

The clinic—though still Spartan—has come a long way since its founding. Twelve doctors volunteer on a regular basis, and three dentists provide basic services such as pulling teeth. It is equipped with an X-ray machine, an electrocardiogram machine, and a few medicines—"everything we need to take care of patients," says Hinson.

Sunnyside Ministry

A second indigent-care clinic in Winston-Salem, Sunnyside Ministry, also provides free medical services but serves a different kind of clientele—families and children rather than street people. On a recent Thursday, director Linda Yokely was more concerned about being overwhelmed with children needing immunizations to start school than with festering knife wounds and trauma. A fall clinic would feature nothing but flu shots. Yokely says the clinic, which operates out of the basement of Trinity Moravian Church in one of Winston-Salem's older subdivisions, is an example of taking health care to the neighborhoods.

Yokely's office is in a frame house painted bright yellow. A chain-link fence crowned with strands of barbed-wire surrounds the property—evidence the neighborhood, known as the Washington Park area, is more vulnerable to theft and vandalism than it once was. The neighborhood grew up around Arista Mills in the late 1930s and early 1940s. "Part of it was a very well-to-do area," says Yokely. "There were smaller homes for the millworkers too. It's a neighborhood in transition. Less than half the people who live here own their own homes. It's mixed racially."

The clinic's clientele reflects the composition of the neighborhood, although it also draws from rural Davidson County. Fliers for the twice-monthly clinic are printed in both English and Spanish. The clinic is staffed by four doctors—two for adults and two for children, plus a Forsyth County Health Department nurse. The nurse interviews clients for its Women, Infants, and Children nutritional program at the same time doctors are seeing patients.

Clinic patients get such services as physicals, immunizations, and basic lab work. "We're seeing about 65 people a clinic," says Yokely. "We've really increased the numbers of infants we're seeing. Maybe they are infants who would not have been seen earlier."

The clinic is a basement operation, with an assembly hall used as a waiting room and Sunday school rooms used for examinations. But Yokely says it has a sort of permanence for people who use its services regularly. They have physicians they see regularly, and if their physician isn't volunteering on a particular night, they stay home. "They have their own doctor, they've been coming so long," says Yokely.

Sunnyside Ministry is the social outreach arm of the Moravian Church. The agency provides a range of services for the poor. Yokely says the medical clinic is the most gratifying. "I would rather work at the clinic than do my job every day," Yokely says. "We don't ask any questions. We don't qualify people. The door is opened, and it's first-come, first-served. . . . We'll probably turn away people tonight."

Reynolds Health Center

Free clinics like Samaritan and Sunnyside offer patients access to basic care. At least 20 such clinics operate in North Carolina. At the

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Doctors Care

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next level stands Reynolds Health Center, which dispenses $10 million worth of primary care out of a building originally intended to be a hospital for African Americans in Winston-Salem. These services produce about $5 million a year in revenue. The county also contributes some $5 million annually to the Center's operating budget.

"It's like a large, multi-specialty group practice," says Dennis MacGovern, Reynolds Health Center executive director. "We do diagnosis, treatment, and referral. We can see anyone. You don't have to be indigent. You don't have to reside in the county. Some of our patients are fairly affluent. They choose to come here. They don't get a discount."

At Reynolds Health Center, 60 percent of the patients are African American. The center also is seeing increasing numbers of Hispanic patients—drawn by low-cost, no-questions service and the fact that the center has several bilingual staff members.

A Free Pharmacy and a Strong Volunteer Spirit

Forsyth's network of free and sliding scale clinics, plus its innovative managed care program for the working poor, is bolstered by a spirited annual fund-raiser that features a celebrity basketball game. The event pumps about $250,000 a year into the free pharmacy at Crisis Control.

But as Hinson has learned, making a program available and even publicizing it heavily and seeking referrals does not mean the service will be used. Doctors Care can serve up to 676 participants. Hinson figures more than 20,000 people in the Winston-Salem/Forsyth County area are eligible. Yet as of Dec. 31, 1994, only 376 had signed up.

"We're glad it's moving along slowly and cautiously," says Hinson. "It's proceeding at a pace that is comfortable and appropriate for us. But it is surprising.... Apparently, health care is not a priority to the poor unless they get sick. They have too many other things to worry about."

—Mike McLaughlin

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pregnant women get the services they need to improve the chances they will have a healthy child. One study found that for each dollar spent on maternity care coordination, there was a savings of $2.02 in medical care costs for newborns during the first two months of life.[24]

A recently added service under the Baby Love program is special home visits using culturally paired workers. Called maternal outreach workers, these workers take a personal role in supporting low-income pregnant women deemed at high-risk of having poor pregnancy and parenting outcomes, says Marcia Roth, policy and program development assistant in the Division of Maternal and Child Health.

Through home visits and peer counseling, maternal outreach workers encourage at-risk expectant mothers to get appropriate prenatal care and to get care for themselves and the child for a full year after the birth. "We see maternal outreach workers as being ambassadors acting as cultural translators between health agencies and communities," says Roth.

Funded by Medicaid and the Kate B. Reynolds Charitable Trust, the maternal outreach program already is available in 24 local health agencies and should be available statewide by January 1996. DEHNR has proposed expanding the program so that maternal outreach workers stay with at-risk mothers until their children reach age 3. The cost would be $550,000 for the 1995–96 fiscal year.

Roth says part of the justification for this is that the maternal outreach worker may be able to encourage longer intervals between subsequent pregnancies and thus prevent low birthweights. A second reason is that these workers may be able to promote a safer atmosphere for children (accidents and injury are a leading cause of death in this age group) and encourage better use of preventive health services for both mother and child.

A study by Family Health International pinpointed low birthweight due to prematurity as the primary contributor to the infant mortality rate in North Carolina. The study eliminated such potential causes as a higher rate of teenage pregnancy among African Americans. In fact, the study found that for African Americans, older mothers had worse birth outcomes than teens.[25]

"It's not strictly an issue of poverty," says Hugh Young, executive director of the Governor's Commission on Infant Mortality. "There's something else that's there. The problem is low birthweight. It's twice that of whites, and this accounts predominantly for the difference in the infant mortality rate." To attack the racial gap in the state's infant mortality rate, the legislature in 1994 awarded funding for 15 pilot projects at $50,000 each, to be administered through the Division of Maternal and Child Health. "The idea is to see if the communities themselves can come up with something that researchers and professionals had missed," says Young. "The challenge is to see if anything can be done through some type of community support so that these women can have higher birthweights."

Immunization Rates: An Indicator of Preventive Care

Rep. Howard Hunter's concerns about health care in his home district are underscored by immunization field audits conducted by the N.C. Center for Public Policy Research in the spring and summer of 1994. The audits took a detailed look at nine local health departments and their ability to deliver required shots on time to children ages 2 and under. (For more on this study, see "Center Study Finds Minorities Lagging in On-Time Immunizations," pp. 32–43.) In Hertford County, part of which lies in Hunter's district, the Center found only 42 percent of children who got their shots at the local health department were up to date on their immunizations. That compares to an average for the nine counties of 60.6 percent and a statewide average of 58.8 percent.[26]

Hertford was among the poorest and most isolated of the nine counties studied. With a population that is 58 percent African American, Hertford also was among the counties with the highest proportion of minorities.

Overall, the Center found that minorities using health departments in the nine counties were less likely to be up to date on their immunization shots than their white counterparts, but this was not the case in Hertford County. African Americans in Hertford were slightly *more* likely to be up-to-date than whites.

District Health Director Jim Boehm says part of the problem with children being behind on their immunizations is the county's low socioeconomic standing.[27] Poor people, he says, are more interested in short-term survival than long-term preventive health. Neighboring Gates County, also in Boehm's district, offers a sharp contrast. The per capita income is much higher, and so is the propensity of health department users to follow through on things like getting their immunization shots on time. Boehm doesn't think this is a coincidence.

Ann Meyers, nursing supervisor in the Hertford County Health Department, sees apathy on the part of parents in general. "People say, 'Well, I'll get it when they start to school.' They don't care if they get whooping cough or influenza in the meantime." Meyers is old enough to remember polio epidemics and iron lungs. Such memories can be a strong motivator to seek immunizations, and contemporary parents haven't had these experiences. "They're not scared into thinking, 'My child will get crippled or die,' like I have seen in my lifetime," says Meyers.

To improve performance in delivering immunization shots on time, the staff of the Hertford County Health Department has tried everything from extended hours to special shot days. They have prescreened the records of children with scheduled

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4 1/2 Months: Halfway Song

(Hey, Baby! What you know good?)

Cuddled in the dark,
we place our hands
on the sturdy brown bulb
to feel
the life thumps
of what we've made
with our love.
I tell her
it's a message;
my African son
drumming on the wall.
She tells me
it's my African daughter
dancing to the rhythm
of her own fetal heartbeat.
We agree that
love is a black baby
growing in our hearts.

—GEORGE BARLOW

"It's absolutely defensible to spend our energies and resources on addressing the health gap. You do that not by bringing the health status of others down, but by bringing the status of minorities up."

— RON LEVINE,
STATE HEALTH DIRECTOR

clinic appointments to make sure they don't miss an opportunity to get shots to a child who is behind. They've even tried dividing up the names and telephone numbers of parents with children who are not up to date and handing them over to local Kiwanis Club members for follow-up. Boehm is troubled that these efforts have produced no better results. "If we can't give shots [on time], we might as well close it up," he says.

Why is the ability to deliver immunizations on a timely basis of such importance? Because immunization shots represent basic preventive care that is required by law. "These diseases are much more dangerous when children are infants, not when they are 4–5 years old," says Norma Allred, immunization epidemiologist in the N.C. Department of Environment, Health, and Natural Resources. "It's not just immunizations. It's also looking at well-child care." If parents won't get their child immunized, what *will* they do in the way of well-child care? And if they won't provide preventive care for their children, will they secure it for themselves?

The Center's study examined the immunization records of 4,194 children in nine county health departments—Buncombe, Halifax, Hertford, Johnston, Mecklenburg, New Hanover, Pender, Robeson, and Swain. Of these, 2,543, or 60.6 percent, were up to date on their immunizations. In selecting local health departments to examine, the Center sought a cross-section of rural and urban counties with a significant minority population. The Center also wanted some geographic balance.

Among white health department users included in the study, 66.4 percent (1,478 of 2,227 children) were up-to-date. Hispanics had an on-time immunization rate of 58.8 percent (47 of 80 children). Native American children, at 54.5 percent (159 of 292), were less likely to be up to date on their immunizations than Hispanics. Among African-American children, 53.9 percent (only 801 of 1,485 children) had received their shots on time, the lowest percentage among racial and ethnic groups examined by the Center.

That minorities are less likely to obtain free immunization shots suggests a problem that goes deeper than just cost or availability of a health service. Service providers and minority recipients may fail to connect for any number of reasons, including lack of transportation, inconvenient hours, lack of information about the need for and importance of immunizations, and lack of motivation on the part of parents.

The problem of minorities getting too little preventive health care is by no means confined to immunizations. The long list of illnesses and causes of death from which minorities suffer disproportionate to their numbers in the population suggests that minorities are not receiving a broad range of services they need to lead a long and healthy life.

Delton Atkinson, director of the State Center for Health and Environmental Statistics, notes that many of the health outcome disparities between whites and minorities flow out of behavioral and lifestyle differences. A major campaign targeting preventive health and lifestyle changes, he notes, could have an impact on these numbers. "If you look at what's driving some of those rates, it seems to be more lifestyle factors," says Atkinson. "If you could significantly change some of those things, you might see a difference in health outcomes."

But should the state mount a special effort to close the health gap between whites and minorities? Ron Levine, the state health director, believes the answer clearly is yes. "I believe the state has a role in trying to close the gap and address the disparities in health status and outcomes," says Levine, who labels the health gap "morally unacceptable."

The gap prevents some citizens from reaching their full potential, Levine says, and thus retards the progress of the entire state. "It's absolutely defensible to spend our energies and resources on addressing the health gap. You do that not by bringing the health status of others down, but by bringing the status of minorities up."

Levine says the prime movers in calling attention to the gap in North Carolina have been the Office of Minority Health and the Minority Health Advisory Council, both created in 1992.[28] Yet despite all the statistics, not everyone agrees that focusing exclusively on the health problems of minorities is appropriate.

A case in point is a call-in television show on minority health aired in November 1994 by the N.C. Agency for Public Telecommunications. Laureen Lopez of the Office of Minority Health was asked to respond to a question from a caller that really was more of a lecture on the wrongheadedness of efforts to single out minorities for special focus.

"I'm wondering, why do you have an issue called minority health issues?" mused the vitriolic caller from Carrboro. "If I understand the human body as I do, I don't really see that much difference in our anatomy and physiology. I wouldn't like to have to separate and exclude groups from attention and public services because of race. It's not working, I don't like it, it's not fair, and it's biased."

Lopez, a consultant to the office who has produced a number of reports on the health status of minorities and services available to them, offered this response: "The reason we focused on minority health and created this office is really the tremendous difference in health status of the minority and non-minority populations. Minority people get sicker more often, they die sooner, and they generally have less access to health care. There needs to be a special effort to reach these people in order to bring them up to the level of the rest of the population."

Her reply prompted an angry retort from the Carrboro caller. "My family has Indian blood. Does that mean I get half a service? It's not an issue of race. It's an issue of economics . . . what people can afford. When it's couched as an issue of race, it really turns people like me off and makes me mad. I wish you people could just get it straight."

But under the leadership of Barbara Pullen-Smith, the office has spent countless hours over the last two years trying to convince people like the caller from Carrboro that the issue of minority health needs special attention. The office has spun out reports outlining the health status of minorities and barriers to receiving services at the local level. Its staff has trooped across North Carolina conducting public hearings with the Minority Health Advisory Council, which advises the governor and the secretary of the Department of Environment, Health, and Natural Resources on minority health matters.

The regional hearings were conducted in Asheville to the west, Durham in the Piedmont, Winton in the northeast, and Pembroke in the southeast. Staff members published transcripts of the hearings and a summary of major issues raised at the hearings. While the testimony varied from region to region, office staff found consistent themes in the comments.

"I wouldn't like to have to separate and exclude groups from attention and public services because of race. It's not working, I don't like it, it's not fair, and it's biased."

—ANONYMOUS CALLER TO TALK SHOW ON MINORITY HEALTH

They divided the issues that surfaced at the hearings into two broad categories: *(1) access issues* such as ability to pay, a lack of providers, and cultural differences between service providers and recipients; and *(2) health issues* such as drug dependency, teen pregnancy, infant mortality, and AIDS and other sexually transmitted diseases. Heart disease and cancer also frequently were mentioned as health issues.[29]

Among the recommendations for change offered by people who testified at the hearings were: health insurance reform aimed at expanding coverage to the uninsured, more health education programs, more community-based health programs and services, increased recruiting and retention of minorities in health careers, more school health programs, and more money for local services.

Levine says the council decided AIDS was the public health issue having the most devastating impact on minority communities and made attacking the disease its top priority. "They made a quick move on AIDS," says Levine. "For a long time, African Americans did not realize the strength of the penetration of AIDS into the African-American community and the suffering it was engendering," he says . As a result of the council's focus, says Levine, the 1994 General Assembly "made the first sizable appropriation to combat the AIDS epidemic." That appropriation totaled $500,000 for the 1993–94 fiscal year.

Still, the work of these two groups only has begun to bring resources to bear on the broad range of health issues affecting minority communities. "It's a process accomplishment," says Levine of the light the two groups have begun to shine on minority health issues. "It's got to be backed up by improved programs and services and eventually by changes in the numbers [for minority health status]." *—continues on page 44*

Center Study Finds Minorities Lagging in On-Time Immunizations

by Steve Adams

North Carolina—armed with free vaccines and a forthcoming computerized tracking system—aims to greatly improve its performance in immunizing preschool children when the shots are due. But how good a job are health departments doing now in immunizing minorities at the local level? And how can the state improve its chances of reaching its Year 2000 goal of having 90 percent of children ages two-and-under age-appropriately immunized?

To address these questions, the Center analyzed immunization records at nine North Carolina health departments—all with significant minority populations. Its findings? Only 60.6 percent of the children being served had received immunizations on time. And for minorities, the problem appears even worse—an indication that minority children may not be receiving the well-child care they need to get a healthy start in life. Only 54.1 percent of minorities were up to date, compared with 66.4 percent of whites.

These findings reflect a state and national problem. North Carolina and the rest of the country do an excellent job of making sure school children are fully vaccinated for common childhood diseases. More than 95 percent of North Carolina children are fully immunized by the time they reach school. This is not surprising; state law requires parents to provide immunization records when children enroll.[1] Nationally, the percentage of school-age children immunized is a point or two higher.[2]

Among younger children, the numbers aren't so encouraging. A retrospective, school-based immunization survey, conducted by the department of epidemiology in the University of North Carolina at Chapel Hill School of Public Health, examined records of 990 first-grade children enrolled during the 1993–94 school year. Of these children, only 58.8 percent (581) were up-to-date with all recommended vaccines by age 2.[3]

That figure approximates the national average of 57 percent. But the United States lags behind even many less developed countries, according to Gary Freed of the Cecil G. Sheps Center for Health Research at the University of North Carolina at Chapel Hill. Indeed, the United States ranked 17th in immunization rates in 1988–89, trailing Bulgaria, Hungary, Greece, Brazil, China, Mexico, North Korea, Chile and Romania, among others. Even during the civil war in El Salvador, the warring factions called cease-fires to allow childhood immunization teams safe passage.[4]

In North Carolina and the United States as a whole, the most expensive health-care system in the world simply isn't doing its job in delivering immunizations. And minorities bear a disproportionate share of the problem.

The Health Departments' Role

In the fall of 1992, the state initiated an ambitious "Immunization Action Plan" to raise the proportion of children ages 2 and under who got their shots on time to 90 percent by the year 2000. The plan was updated in November 1993 to satisfy legislative mandates and add a universal distribution program using vaccines purchased with state and federal tax dollars. The action plan's tactics include expanding the state's program of distributing vaccines free to all providers and establishing a statewide computer data base to monitor all children's immunizations from birth.[5]

About 45 percent of North Carolina preschool children rely on health departments for their immunizations.[6] Although the departments continue efforts to increase the number of immunizations they give and to keep their young patients on schedule, the action plan may require them to play a greater role in keeping track of

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immunizations for all children, including those who get their vaccinations privately. "Local health departments will immunize less children [proportionately], but will need to accept the quality assurance role for vaccines administered in physicians' offices," Annette Byrd, head of the Immunization Section, wrote to local health directors in May 1994.[7]

How well prepared are health departments to handle this expanded role? They have a long way to go.

In the spring and summer of 1994, the Center examined the immunization records of 4,866 children, ages 1.5 months to slightly over 2 years, at nine health departments, urban and rural, east and west. The counties surveyed were Buncombe, Halifax, Hertford, Johnston, Mecklenburg, New Hanover, Pender, Robeson, and Swain.

While these counties are not intended to be representative of the state as a whole, the survey's findings generally track earlier state and national surveys. And, indeed, they support the key elements of the action plan.

The survey found:

- Overall, 60.6 percent of the children surveyed were "on time." Immunizations are scheduled at 2, 4, 6, and 12 to 15 months. Children were counted as *on time* if they were no more than a month overdue for the latest appropriate round. (See "How the Immunization Survey Worked," pp. 42–43.)
- Minorities rely on health departments for immunizations more heavily than whites, but they are less likely to be on schedule. The 1990 census reported that minorities make up 29.9 percent of the population in the counties surveyed, but 49.1 percent of the children in the Center's survey were nonwhite. The compliance rate was 66.4 percent for whites, compared with 54.1 percent for others.
- Success rates vary considerably among departments. The proportion of children who were on schedule ranged from 42.7 percent in Hertford to 79.1 percent in Swain.
- The health departments and other government agencies often don't screen children for immunizations when they visit for another purpose. There were no immunization records for nearly 14 percent of the children, even though they had received some other service. The survey excludes these children in calculating compliance rates. But with no records, health departments have no way of knowing whether these children are receiving their immunizations or not.
- Record-keeping methods are inconsistent from county to county, even though most use standardized paper cards. Some counties were able to summarize their records from computer data bases, while others were not.

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- Although all of the departments surveyed had some system of tracking children who are due or overdue for immunizations, the systems varied widely in scope.

A picture emerges of a system in transition. At the time of the Center's survey, the Immunization Action Plan had been in place for only a few months, and its effects were only beginning to appear. Many of the issues raised by the survey are addressed by the plan, but at this point, there is much opportunity for improvement.

The Immunization Action Plan

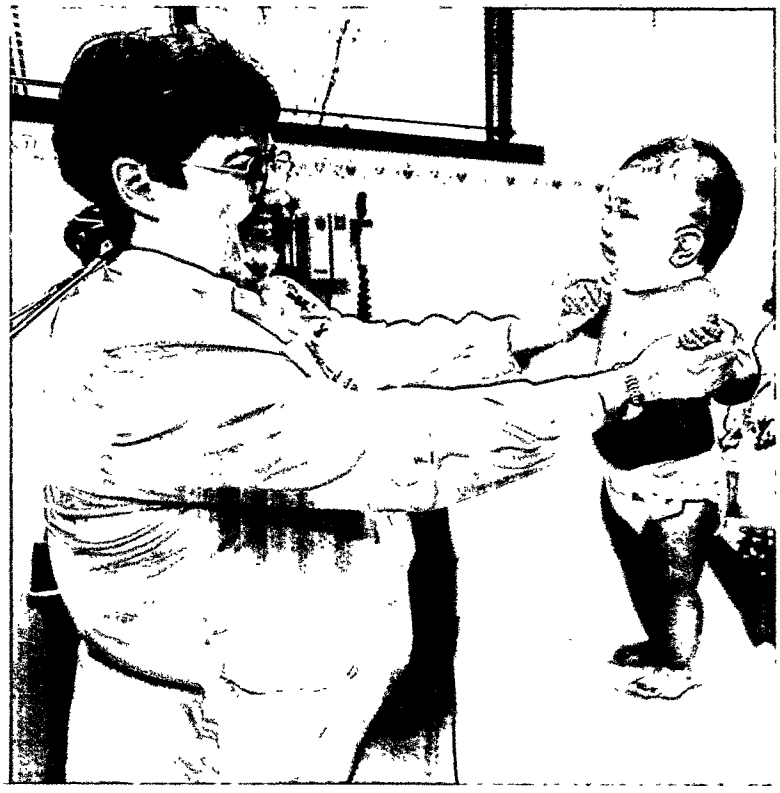
The Immunization Action Plan is designed to build a more structured system for making sure that preschoolers receive vaccinations on time. For the first time, there will be a central system for distributing vaccines and maintaining records for private providers, health departments, and other agencies with an interest in maintaining child health.

The relationship between the N.C. Department of Environment, Health, and Natural Resources and local health departments is similar to that of the public school system. Local departments are responsible to boards of health, which in return report to county commissioners. The departments get "direction and quality assurance from the state, but for the most part they structure programs to meet the needs of their vastly different populations," as DEHNR put it in the action plan.[8]

Now health departments will be responsible for monitoring immunizations for all children born in their counties. Private providers, who traditionally have been left on their own to monitor vaccinations, will be required to participate in the statewide immunization registry if they accept vaccines from the state.

The action plan—begun in earnest in 1993 with increased funding to local health departments to expand capacity to deliver services—contains several important components. It proposes to:

- Establish a statewide immunization registry, a computer data base with a goal of 90 percent participation from all immunization providers by 1996. Data for all children born in the state will be automatically loaded into the system electronically using birth certificate data.
- Expand the state program of providing state-purchased vaccine for private, as well as public providers, as it has for health de-



Tiffany Montalvo, 9 months, with nurse Shirley Moser at the Wake County Health Department

Karen Tam

partments since the 1950s. The program, begun in 1994, is a key to the success of the registry, because all providers who receive vaccines will be required to participate. The plan calls for increasing purchases of vaccines from 1 million doses in 1993–94 to 2 million in 1994–95. These figures include vaccines for both the departments and for private providers.

- Extend clinic hours to make them more convenient for working parents.
- Coordinate tracking and follow-up with other agencies, such as Medicaid and the Supplemental Food Program for Women, Infants, and Children (WIC).
- Increase educational efforts to emphasize the importance of immunizations.

The plan will increase the cost of administering the immunization program by nearly a third in a single year. The state provides a little over half the funds. Most of the rest is federally funded. The budget for DEHNR's Immunization Section increased from $15.5 million in 1993–94 to $20.3 million in 1994–95. Most of the increase is attributable to purchasing vaccines ($9.4 million to $14.2 million).

The cost of setting up the registry is comparatively small—$600,000 in the first year and $1.2 million in the second. However, in the fall of 1994, the registry, originally scheduled for "roll out" to all health departments by July, was months behind schedule, as the Immunization Section was still working to get the first departments on line on a pilot basis.[9]

Race and Immunization

In deciding which local health departments to include in its study, the Center sought a mix of rural and urban counties with significant minority populations. The Center also wanted some geographic balance. The result is a good cross-section of North Carolina counties, although not a representative sample. Success

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Table 6. Percentage of Children 2 and Under Age-Appropriately Immunized in Nine North Carolina Counties

County	Number of Children with Immunization Records	Number Up-to-date on Shots*	Percent Up-to-date
BUNCOMBE	598	385	64.4
HALIFAX	615	373	60.7
HERTFORD	316	135	42.7
JOHNSTON	306	190	62.1
MECKLENBURG	446	246	55.2
NEW HANOVER	493	361	73.2
PENDER	609	377	61.9
ROBESON	624	328	52.6
SWAIN	187	148	79.1
Total	4,194	2,543	60.6

* Children were counted up to date if they had received immunization shots on the following schedule: Age 1.5–5 months, first diptheria, pertussis, tetanus (DPT1), first oral polio (OPV1); age 5–7 months, DPT2, OPV2; age 7–16 months, DPT3, OPV2; over 16 months, DPT4, OPV3, measles, mumps, rubella (MMR1).

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rates vary significantly by county, as shown in Table 6 on page 35. At 79.1 percent, Swain County's compliance rate was nearly double Hertford's rate of 42.7 percent.

Local administration and resources may account for part of this discrepancy. However, preschool immunization patterns in North Carolina resemble national trends. In the United States, 97 percent to 98 percent of children are fully immunized when they enter school, yet only 60 percent are fully immunized by age 2. [10]

Particularly at risk are children in rural areas and inner cities, poor children, children whose parents have little education, and children of young, single mothers. Immunization rates for minority children are some 30 percent lower than for whites, according to the Centers for Disease Control in Atlanta, Ga. There are also indications that children who receive vaccinations at health departments are less likely to be on schedule than those who receive immunizations privately. Success rates may be even lower for children who switch back and forth.[11]

In the Center's survey, race was the only one of these risk factors that could be identified consistently. Minority parents tend to rely more heavily than whites on health departments for their children's immunizations, but they are less likely than whites to be on schedule for immunizations, according to the health department records.

According to the 1990 Census, 70.1% of the people in the nine counties surveyed were white, yet the sample of children with health department immunization records was almost evenly divided (53.1 percent vs. 46.9 percent). Only in Swain, where many Cherokee Indians use the federal Indian Health Service for their immunizations, did minorities account for a smaller percentage of health department patients than they do in the overall population. In Buncombe County, the two figures were the same. (See Table 7, p. 37.)

A large majority of minority patients are African American—1,485 of 1,967 minority children in the survey (75 percent). Another 292 are Native American (15 percent of minority children in the survey); most of these—264—were in Robeson County. No county had more than a handful of Hispanic patients. The remaining children are members of other minorities or classified in health department records as "Other."

In Swain, more than a quarter of the population is Native American, but Native Americans there are more likely to use the Indian Health Service on the Cherokee Qualla Boundary Reservation than the health department, says health director R.D. Childers, Jr. There is no federal health service in Robeson, where the Lumbees have long sought federal recognition as a tribe.

As shown in Table 8, p. 38, the overall success rate for the nine counties was 60.6 percent—66.4 percent for whites and 54.1 percent for minorities. Success rates among minority groups varied little—from a low of 52.7 percent (58 of 110) among Asians and others to a high of 58.8 percent (47 of 80) among Hispanics. Table 9, p. 39, shows that the pattern of lower success

Immunization Index

Percentage of U.S. children fully immunized on entering school in 1991: 97 to 98 percent.

Percentage of N.C. children fully immunized on entering school in 1991: 95 percent.

Percentage of U.S. children not fully immunized at age 2 in 1991: up to 40 percent.

Percentage of N.C. children not fully immunized at age 2 in 1991: 41.3 percent.

Number of countries with higher immunization rates than the U.S. for children under 1 year in 1988–89: 16, including Brazil, Bulgaria, Chile, China, Greece, Hungary, Mexico, North Korea, and Romania.

Number of measles cases in the U.S. in 1983: 1,497.

Number of measles cases in the U.S. in 1990: 27,672.

Source: Gary L. Freed, W. Clayton Bordley and Gordon H. DeFriese, "Childhood Immunization Programs," The Milbank Quarterly, Vol. 71, No. 1, 1993, pp. 65 ff.

rates for minorities occurs in seven of the nine counties. In Buncombe, minorities actually had a higher success rate than whites. However, minorities make up less than 10 percent of the children surveyed there.

Missed Opportunities

Too often, health departments fail to screen children for immunizations when they visit for some other reason. Public health workers call these "missed opportunities." In three of the counties surveyed, the Center detected this problem for children in the Special Supplemental Food Program for Women, Infants and Children (WIC).

Overall, there were no immunization records for 13.8 percent of the children who had visited health departments. Again, the percentage was higher for minorities than for whites—17.7 percent vs. 10 percent.

Six departments had at least some immunization records for more than 97 percent of their patients. But Hertford and Johnston had vaccination records for only slightly over half of their patients. New Hanover had records for 86.9 percent of its patients. The majority of the children without immunization records in those counties had visited the health department for WIC reviews.

WIC is a federal nutrition program administered by DEHNR. The program requires semiannual eligibility reviews. Children are tested for anemia, but "there's nothing you would call a regular checkup," says Alice Lenihan, head of the department's WIC section. As for immunization screening, "They haven't been asked to do that," she says.

Nevertheless, health departments in Hertford, Johnston, and New Hanover routinely set up an immunization master card when a child

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Table 7. Percentage of Minorities in Nine North Carolina Counties and Percentage of Children Ages 2 and Under Who Get Immunization Shots at Health Department

County	Percentage of Minorities in County	Percent Minorities 2 and Under Immunized at Health Dept.
BUNCOMBE	9.6%	9.7%
HALIFAX	53.3	61.8
HERTFORD	59.3	72.8
JOHNSTON	19.6	38.2
MECKLENBURG	29.5	56.1
NEW HANOVER	21.6	33.5
PENDER	31.6	43.5
ROBESON	64.0	77.2
SWAIN	31.8	10.7*
Total	29.9	46.9

* Swain County has a large population of Native Americans who get immunizations at the Indian Health Service on the Cherokee reservation.

Sources: 1990 U.S. Census and N.C. Center for Public Policy Research field audits of immunization records in nine North Carolina counties.

Table 8. Number and Percentage of Whites and Minorities Up-To-Date on Immunizations

Racial or Ethnic Group	Number of Records Examined	Number Up-To-Date on Shots	Percent Up-To-Date on Shots
WHITE	2,227	1,478	66.4%
AFRICAN AMERICAN	1,485	801	53.9
NATIVE AMERICAN	292	159	54.5
HISPANIC	80	47	58.8
OTHER	110	58	52.7
Total Minority	1,967	1,065	54.1
Overall Total	4,194	2,543	60.6

* Children were counted up-to-date if they had received immunization shots on the following schedule: Age 1.5–5 months, first diptheria, pertussis, tetanus (DPT1), first oral polio (OPV1); age 5–7 months, DPT2, OPV2; age 7–16 months, DPT3, OPV2; over 16 months, DPT4, OPV3, measles, mumps, rubella (MMR1).

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visits for a WIC review. They do not, however, systematically check immunizations. In Johnston and New Hanover, children in WIC made up exactly half of the sample, but accounted for more than three-quarters of the children with no immunization records. WIC children also accounted for a majority of those with no vaccination records in Hertford. It was not possible to identify WIC children from the records available in the other six counties.

A large proportion of children in the WIC program are also on Medicaid, which will pay for immunizations from a private provider. Thus, many of these children may be receiving vaccinations elsewhere. Nevertheless, the health departments see these children periodically, and it is clear that at least the three departments for which WIC records were available had not consistently screened for vaccinations during WIC visits.

To address this problem, DEHNR has launched demonstration projects in five North Carolina counties to provide immunization nurses at WIC sites. The aim is to see if this approach will have an impact on raising on-time immunization rates. Their duties will be to screen children enrolled in WIC for their immunization status; immunize children as needed or counsel parents to obtain immunizations from private providers; follow up with children who are behind or who are at risk of falling behind in their immunization status; and work with private providers who immunize WIC enrollees to ensure that these children are getting their shots on time. If these pilots are successful, they could be replicated in other counties.

A new Medicaid program called Health Check also may ultimately help with assuring that children receiving Medicaid benefits get their immunizations on time. It requires that young children have regular health checkups that include immunization shots. Health Check outreach workers follow up when children are not brought in for appointments.

WIC visits are merely one example of missed opportunities to screen for immunizations and lack of coordination among child services. In 1992, the Immunization Section held a series of focus groups involving health department officials, private doctors, and others. Participants listed "fragmentation" of efforts as one of the key barriers to raising immunization levels for preschoolers.[12]

The Immunization Registry should help make immunization information available, but it may not answer the question of who is responsible for making sure children keep on schedule. Meanwhile, health departments are supposed to be responsible for keeping track of their patients and private doctors for theirs. Many children get health care only when they are sick, often at emergency rooms or urgent care centers.

Local health departments are the logical choice for monitoring immunizations at the county level. But they don't have the resources to do it.

Following Through

Lack of staff and facilities was another barrier to immunizations identified in the Immunization Section's 1992 focus groups. Health officials called for extended clinic hours, additional clinic locations, and more staff to administer vaccinations and to follow up with the parents of children who were due or late.

That was before the idea of universal immunization fully took hold. Of the nine departments the Center surveyed, three—Buncombe, Mecklenburg, and Robeson—maintain fairly sophisticated computer data bases. That alone does not solve the problem. Those counties' rates of on-time immunization ranged from 52.6 percent to 64.4 percent.

Particularly in poorer counties, health departments continue to struggle with cramped facilities and limited numbers of staff to follow up on children who are late or disappear from the record-keeping system.

In Pender County, Sandra Rivenbark brought her own typewriter to work in mid-1994 when the health department hired her part-time to track down children due for immunizations. Even though the department's records are stored

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Table 9. Percentage of Minority Children Up-To-Date on Their Immunizations Compared to Whites in the Nine Counties Surveyed

County	Percent of White Children Up-To-Date*	Percent of Minority Children Up-To-Date	Overall Total
BUNCOMBE	64.3%	65.5%	64.4%
HALIFAX	70.6	54.5	60.7
HERTFORD	41.9	43.0	42.7
JOHNSTON	65.6	56.4	62.1
MECKLENBURG	54.6	55.6	55.2
NEW HANOVER	77.4	64.8	73.2
PENDER	65.4	57.4	61.9
ROBESON	59.9	50.4	52.6
SWAIN	80.2	70.2	79.1
Total	66.4	54.1	60.6

* Children were counted up-to-date if they had received immunization shots on the following schedule: Age 1.5–5 months, first diptheria, pertussis, tetanus (DPT1), first oral polio (OPV1); age 5–7 months, DPT2, OPV2; age 7–16 months, DPT3, OPV2; over 16 months, DPT4, OPV3, measles, mumps, rubella (MMR1).

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on computer, she had to go to another office to use one. By October, she had transferred to a receptionist's position at the department because she needed a full-time job. "The county doesn't pay anything," says health director Irma Simpson. "That's why we have a hard time getting anybody."

In New Hanover, Kim Sykes makes 60 to 80 calls a week to track down children who are overdue for immunizations. She also visits pediatricians' offices and clinics to collect immunization records. Although she has access to computer records at her desk, she uses a paper-card "tickler" system to keep track of which children she needs to contact. She was hired in November 1993 with a $35,000-a-year grant from the Immunization Section. A year later, she was still working her way through the department's card file.

Sykes' job requires the skills of a record researcher and the tactics of a bill collector. "There are still people due in January who still haven't come in," she said in October. "They're the ones that are really delinquent.... We'd have to hire three more people to do it thoroughly."

Sykes' efforts provide some indication of the scale of the problem. In her first six months on the job, she single-handedly cut the number of blank immunization records in New Hanover by more than 50 percent. By searching the records of local pediatricians and other providers, she located records for 80 children included in the Center's survey, 63 of whom were in the WIC program.

Since the survey in New Hanover randomly selected one record in five, it appears that she had located records for about 400 children, about three-quarters of whom were in the WIC program. After this effort, the health department still had no records for 13.1 percent of all children surveyed and for 24.3 percent of those in the WIC program. Without Sykes' research, however, the figures would have been 27.3 percent and 47.8 percent, respectively.

Ironically, Sykes' research actually lowered the survey's estimate of New Hanover's compliance rate. The Center's survey, like state compliance surveys, doesn't count children who have no immunization records in determining the percentage who are on schedule. Of the records she located, 65 percent were up to date, compared with 73.2 percent for the county sample as a whole.

However, Sykes also actively recruits parents to have their children immunized. From the records available, there was no way to determine how effective that effort had been because someone in the clinic enters the records when the children actually get their vaccinations.

Nevertheless, it seems reasonable to conclude that personal contact is more effective than less direct outreach efforts, such as post-cards, community education programs, and recruiting civic groups to promote immunizations. "To be honest with you, people [parents] just don't care," says Hertford's Jim Boehm. "They're just not concerned."

Conclusion

There is fairly general agreement on the obstacles to increasing immunization rates in North Carolina:

- lack of a centralized record system;
- parents—and even some doctors—who don't know the required immunization schedule;
- long waits at clinics;
- cost at private clinics, although the cost of vaccine is free to patients and the administration fee has been greatly reduced (health department vaccinations are free);
- transient families;
- health departments that don't provide convenient enough clinic schedules;
- difficulty getting off work, particularly for parents with more than one child;
- lack of transportation; and
- lack of coordination between programs such as WIC, Medicaid, and health departments.[13]

Health departments have tried various promotional tactics to encourage immunizations. They give away T-shirts when children come in. They have shot days at shopping centers. They enlist civic groups, such as the Kiwanis Clubs. They provide brochures and pamphlets. In some counties, such as Swain, a staff nurse makes

home visits. Some hire people like Kim Sykes in New Hanover to pester the parents of children who are late. There has been some success with auto-dialed reminders and sending post-cards to parents. Some have set up their own computer databases.

But these tactics alone will inevitably leave a significant number of children unserved, and minorities will continue to suffer a disproportionate share of the problem. The backbone of the Immunization Action Plan is clearly the vaccine distribution program and the immunization registry.

Public and private schools are effective in enforcing immunization laws because they have access to nearly all school-age children and they have the means to enforce the law. There is no such central authority for preschoolers. Instead, there is a hodgepodge of programs that monitor preschoolers' health. Although the action plan calls for more coordination (words like "cooperate" and "collaborate" appear frequently), no one is clearly accountable for making sure that all children receive vaccinations. Buncombe County Health Director James Tenney puts it bluntly: "It's not our responsibility to look after the ones who attended private practices. . . . The responsibility for administering vaccine rests with the provider of care." There should be a centralized monitoring system for tracking immunizations, he says, but the information should come from providers. Those two ideas, he admits, "may be incompatible."

The action plan addresses this problem in several ways. The immunization registry may provide a commonly accessible data base for government agencies and private providers. The plan suggests that free vaccine provided by the state may reduce private referrals to health departments by as much as 30 percent, thereby freeing health department workers to take a stronger role in compliance. The Immunization Section has set a goal of increasing immunizations, *in raw numbers*, by 5 percent per year.

Education campaigns may increase compliance rates. The plan also calls on health departments to increase their emphasis on immunizations—but proposes funding of only $1.6 million a year for that purpose. That's an average of $16,000 per county for 100 counties.

But who *is* responsible? The state can maintain a central data base, but it can't track down children who need shots from Raleigh. Programs such as WIC can try to coordinate their efforts, but it doesn't make sense to duplicate efforts. And it doesn't make sense to deny a child nutritional supplements because its parent does not comply with the immunization law. Most private doctors are responsible individuals, but who will check up on them?

That leaves the health departments, and they clearly don't have the resources to take on a much greater responsibility for tracking immunizations. The action plan calls for $11.1 million in state funding for 1994–95, more than 90 percent of which is for buying vaccines. Still, it's clear that health departments must take a stronger role if the state is to have a hope of meeting its goal of having 90 percent of children ages two-and-under age-appropriately immunized by the year 2000.

FOOTNOTES

[1] G.S. 130A-155(a), which reads in part, "No child shall attend a school (K–12), whether public, private, or religious, or a day-care facility as defined in G.S. 110-86(3), unless a certificate of immunization indicating that the child has received the immunizations required by G.S. 130A-152 is presented to the school or facility."

[2] Gary L. Freed, *et al.*, "Childhood Immunization Programs: An Analysis of Policy Issues," *The Milbank Quarterly*, Vol. 71, No. 1, 1993, p. 66.

[3] *Immunization Action Plan*, Immunization Section, Department of Environment, Health, and Natural Resources, Raleigh, N.C., November 1993, p. 1.

[4] Freed, *et al.*, pp. 67–68.

[5] *Immunization Action Plan*, p. 2.

[6] Telephone interview with Norma Allred, immunization epidemiologist, Immunization Section, Division of Health Services, N.C. Dept. of Environment, Health, and Natural Resources, Sept. 2, 1994.

[7] Letter from Annette Byrd, head of Immunization Section, to local health directors, May 16, 1994.

[8] "The State of North Carolina Presents the Infant Immunization Initiative Action Plan: Get the Ticket to Board a Healthy Year 2000," DEHNR proposal to the federal government for funding of the state's immunization action plan, June 23, 1992, p. 6.

[9] *Immunization Action Plan*, pp. 2–3, 34, and 51–52.

[10] Freed, *et al.*, p. 66.

[11] "The State of North Carolina Presents the Infant Immunization Action Plan: Get the Ticket to Board a Healthy Year 2000," Appendix 3.

[12] *Ibid.*, unnumbered appendix.

[13] *Ibid.* and Freed, *et al.*, pp. 80–90.

How the Immunization Survey Worked

From April 1994 through July 1994, the N.C. Center for Public Policy Research surveyed nine local health departments to determine what percentage of children ages 2 and under were age-appropriately immunized. The Center's survey selected a sample of 4,866 children. The sample excluded 672 children for whom there was no record of immunizations, even though the departments had their names and other data entered on immunization mastercards. That left a total sample of 4,194.

Of those with immunization records, 60.6 percent (2,542) were on schedule or "up to date" on their immunizations. What does that mean?

The definition makes a considerable difference. Using standards based on criteria provided by the Immunization Branch of the N.C. Department of Environment, Health, and Natural Resources, for example, the Center found that 73.2 percent of the New Hanover children included in the survey were "up to date." At about the same time, using the same records, the health department indicated a compliance rate of 95 percent in its monthly "No Name Tracking System" report to the Immunization Section.[1]

These results are not necessarily contradictory; the criteria are simply different. The New Hanover criteria allow four months beyond the recommended date for a child to receive vaccinations. The Center's criteria allow as little as one month, depending on the child's age. Also, the county checks only children in their fourth month past a vaccination date. For example, the county checks for vaccinations due at 2 months when children are 6 months, for vaccinations due at 4 months when children are 8 months, and so on. Thus, the Center's method counts any child over 3 months old without records for 2-month vaccinations as overdue, while New Hanover County's method does not include children until they are 6 months old.

In short, the Center's method excludes fewer children from the calculation and uses broader age groups for determining compliance. While any child counted as late in the tracking report would also count as late under the Center's criteria, the reverse is not the case. In New Hanover County, children can be behind schedule, and thus not age-appropriately immunized, without being counted as delinquent (or behind) for the next dose of vaccine. This has to do with the process of catching up. Appropriate spacing between shots must be maintained in order for vaccines to be effective.

State law requires all children to be vaccinated against nine diseases by age 2: diphtheria; tetanus (lock-jaw); pertussis (whooping cough); polio; type b hemophilus influenza (Hib); measles, mumps, rubella (red measles); and hepatitis.[2] The state's recommended immunization schedule calls for 15 shots in order for a child to be fully immunized against these nine diseases.

Immunizations for the first two years are scheduled at ages 2 months, 4 months, 6 months and 12 to 15 months. Based on Immunization Branch guidelines, the Center survey counts children as "up to date" if they have received vaccinations on the schedule below.[3]

Age	Required Immunizations
1.5–5 months	First diphtheria, pertussis, tetanus (DPT1); first oral polio (OPV1)
5–7 months	DPT2, OPV2
7–16 months	DPT3, OPV2
Over 16 months	DPT4; OPV3; measles, mumps, rubella (MMR1)

Only children for whom there were some immunization records were included in calculating compliance rates. The survey excludes hepatitis B because the vaccine was not routinely given until after the beginning of the survey period. It also excludes Hib, the shot inoculating children against type b hemophilus influenza, as Hib has not been routinely included for providing data to the federal Centers for Disease Con-

trol. However, it is extremely rare for a child to receive a DPT shot without also receiving Hib. (In most exceptions, the record notes a legitimate reason.)

Except for children under three months, this schedule allows at least a month for a child to receive appropriate vaccinations. The younger children are included because they are eligible for the first round of vaccinations and have had at least some immunizations. Only 96 of the 4,194 children surveyed who had some immunization records were under 3 months, and their compliance rate was 57.3 percent. Most of the rest had received only hepatitis vaccinations, which can be given at birth.

In departments serving fewer than 700 children—Halifax, Hertford, Pender, and Swain—all records were included in the survey. For these counties, there was no sampling error. In larger counties, the Center took random samples of about 600 records. In Johnston County, for example, this involved examining every third record. Center staff drew samples from Johnston, New Hanover, and Robeson counties. Health directors in Buncombe and Mecklenburg generated their own samples from computerized immunization records.[4]

Since the children surveyed do not represent a random statewide sample, statewide generalizations cannot be assumed from the results. The results do, however, parallel other statewide and national surveys.

Because the Center's project focuses on minority health, the departments were deliberately selected to include relatively large minority populations. However, the Center also sought geographic balance and a mix of urban and rural counties. For geographic balance, Buncombe County to the west was chosen. The county is 90.9 percent white, but contains the largest population of African Americans residing in Western North Carolina. One urban county (New Hanover) also has a white population that exceeds the state average, as does rural Johnston—added because the health department serves a relatively large number of Hispanics.

Overall, the proportion of whites in the counties surveyed—70 percent—is slightly lower than the statewide figure of 75.6 percent, according to the 1990 census. However, the census population is less than 50 percent white in Halifax (46.8 percent), Hertford (40.9 percent) and Robeson (36.1 percent). There are large Native American populations in Swain (27.3 percent) and Robeson (38.5 percent).

Children with no immunization records were included in calculating the racial makeup of health department patients and in assessing "missed opportunities" to track or provide vaccinations, but excluded in calculating compliance.

The result was a sample of 4,862 children ranging in age from 1.5 months to slightly over 29 months; 4,194 had some immunization records.[5] The racial designations used by the health departments were used, except that several groups were lumped into the "Other" category. In addition to children designated as "Other" in the records, these include any children not designated as white, African American, Native American, or Hispanic. Asians are included in this group because there were not enough records on Asian children to analyze.[6] In this analysis, whites are considered to be "majority," and all others are considered "minority." Only 2.9 percent of the records fall into the "Other" category.

—Steve Adams

FOOTNOTES

[1] New Hanover County Health Department "Tracking File Assessment," June 1994.

[2] G.S. 130A-152.

[3] Immunization Section, DEHNR: "Immunization Fact Sheet," undated; "Immunization Status Calculations," undated.

[4] For the counties in which random samples were drawn, the margin of error varied by sample size, as follows: Buncombe, plus or minus 4 percent; Johnston, plus or minus 5.6 percent; Mecklenburg, plus or minus 4.6 percent; New Hanover, plus or minus 4.4 percent; and Robeson, plus or minus 3.9 percent. Blank records were excluded from the Center's analysis, which accounts for most of the difference in sample size.

[5] Children younger than 1.5 months (46 days) at the time the sample was taken were eliminated from the group. Records containing obvious clerical errors were also excluded. Occasionally, for example, records contained immunization dates later than the date the sample was taken. In a few case in which the correct data could be deduced with reasonable certainty, records were corrected. Otherwise, inconsistent records were deleted.

[6] Others in the "Other" group include records with no racial designation, a few records indicating mixed race, records in which race is designated as "Unknown," and a few records in which race was not clearly designated.

—continued from page 31

Local Health Directors: Thoughts from the Front Line

Local health directors are required to diagnose the health of their community and either provide certain services or certify that they are available in the community.[30] Thus, they are in a good position to know both the health needs of their communities and the services available to meet those needs. (For more on local health departments, see "Health Services at North Carolina's Local Health Departments, pp. 46–48.) With this in mind, the Center decided to survey all 86 local health directors on several key questions. These questions ranged from the racial breakdown of local health department clientele to whether health directors thought access to health care was a problem for minorities in their communities.

Of 86 local health directors, 72 responded—an overall response rate of 84 percent.[31] The results represent the opinions and information offered by 72 local health directors or their designees, spread across North Carolina.[32]

Among the survey's highlights:

- Minorities use local health services more than whites. While whites make up 75.6 percent of the North Carolina population, they comprise only 57.9 percent of health department clientele. African Americans, on the other hand, are heavy users of health department services. They represent 35.9 percent of health department clientele, but only 22 percent of the state's population. Hispanics also use health departments in numbers disproportionate to their share of the population, representing 4.6 percent of health department users and only 1.2 percent of the population as a whole.
- Asked to select from 13 possible health issues, health directors labeled access to health care the most pressing health issue facing minorities in their communities. Adolescent pregnancy ranked second, and heart disease ranked third. (For more on the adolescent pregnancy problem, see "Cycle Busters Aims to Put Teen Moms Back on Track," pp. 57–59.)
- Lack of transportation is by far the biggest barrier to obtaining health services at local health departments, according to local health directors. Transportation also is an issue in the private sector, they say, but the larger issue is lack of health insurance or other means to pay for services.
- A number of health departments have employed translators to ease the language barrier between health department staff and burgeoning Hispanic clientele. A total of 51 health directors said they use translators. Of these, 29 said the translator was on staff rather than a volunteer or contract employee, although these translators also typically had other duties. As for the transportation barrier, 40 health directors said their departments offer home visits, and eight indicated that they offer some type of transportation service.[33]
- A solid majority of local health directors—44 of the 71 who responded to this question—believe it *is* the role of local health departments to make minorities a special focus to assure that they have access to a full range of health services in their communities.
- Fully 70 percent of respondents did not think that public and private health services are adequate to meet the needs of minorities in their communities, yet 77.9 percent thought services for minorities were about the same as those for whites.
- Asked to choose from among four options, local health directors most often picked lifestyle or behavioral changes as the most important key to improving minority health. Increased access to existing health services was the second most popular choice, followed by improvement in the local economy to provide jobs and alleviate poverty. Only 10 respondents thought simply adding more services was most important.
- Despite heavy use of health departments by minorities, 37.5 percent of the local health directors said their departments did not include minorities or minority groups in their community diagnosis planning processes. Local health departments are required to conduct this diagnosis biennially to identify health needs and plan a strategy for meeting those needs. Community involvement in developing the plan is recommended but not required.
- Respondents overwhelmingly agreed that access to health care is a problem for minorities (90 percent said yes), yet they were less inclined to define the problem as inadequate services. And in a separate question, they indicated that services available were about the same as those available to whites. They did, however, identify a clear problem with barriers minorities face in using services.

Karen Tam

Health departments are seeing a more diverse clientele. Here Allyson Swelam, her son Haithim, and daughters Amira and Dania (in stroller) await services at the Wake County Health Department.

These barriers included: convenience factors such as lack of transportation and operating hours of local health department; communications problems such as lack of information about available resources; and cost problems such as lack of health insurance or other means to pay for services.

"Both white and minority populations have access to health care if they have insurance or other funding," commented one respondent from an urban coastal county. It is the indigent, she says, who are without care. Another commented, "The single greatest factor affecting healthy outcomes for minorities is economic stability. In spite of Medicaid and AFDC, many people are still unable to pay for health care, especially those who are in poverty."

Rep. Howard Hunter of Northampton County says would-be clientele cannot use health department services if the doors open at 8 a.m. and close at 5 p.m. "Most of them work. How can they afford to get off work to get a shot or a check-up? Health departments are not making the service available at a time they can access it."

The Center survey indicates health departments *are* making some effort to make their departments more user-friendly, although more could be done. State regulations require that health departments provide a night or weekend clinic to deliver immunization shots at least once a month.[34] About half the respondents indicated they go beyond this minimal requirement by conducting clinics more than one night a month. In addition, 12 respondents indicated they conduct more than one weekend clinic per month.

Health departments are addressing the transportation issue by providing home visits, opening remote sites closer to

▼

The mind may not mind death.
It means at last letting go, the inevitable
capitulation. After all, it's tired,
very tired. But the body fights
right to the end . . . .

—STEPHEN DOBYNS
"THE BODY'S STRENGTH"

minority communities, and, in some instances, actually giving clients a lift to the clinic. They also are bringing interpreters on staff to ease the language barrier, although Laureen Lopez of the Office of Minority Health cautions that local health departments are not meeting the current need.[35]

Lopez notes that though many local health departments have translators on staff, they usually have other job responsibilities and are not always available to translate. "They may not be fluent in both languages, skilled in the interpretation process, or have knowledge of health issues," says Lopez.

In a 1993 survey of 35 local health directors in counties with high-density Hispanic populations, Lopez found that only four departments "almost always" had a translator on duty for health care. An additional 27 of the 31 local health directors who responded to the question indicated that they had translators available at least occasionally.[36] In a separate question that drew 33 responses, only six departments indicated they were "doing all right" with translation for health care, while 26 said they still needed more help.[37]

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Health Services at North Carolina's Local Health Departments

The state requires every local health department to provide mandatory services for each county's population.[1] Any person who lives within the jurisdiction of the local health department can receive health care at the department, although certain populations are specifically targeted as "needy" because of economic status or lack of access to health care.

State regulations do not specify that any health department programs should be targeted explicitly to minority populations. Instead, certain programs are structured to assist segments of the population with limited resources, says Thornton B. Haynes, chief of the Office of Local Health Services in the Division of Health Services, Department of Environment, Health, and Natural Resources. These programs are costly, Haynes says, and health departments charge fees for some services. State statutes say that required immunizations must be provided free at local health departments.[2] Diagnosis and treatment for sexually transmitted diseases also is provided free at local health departments.

Medicaid covers some health care services, but not all. For services not covered by Medicaid, Haynes says county commissioners work with the local boards of health and health directors to create a fee schedule for the local health departments. The income from these fees is applied to the cost of providing services. With the help of the state, Haynes says, local health departments attempt to make health care affordable for all residents of North Carolina, regardless of income level or race.

Mandatory services are outlined under 13 categories in the North Carolina Administrative Code. These categories are: *(1)* adult health; *(2)* home health; *(3)* dental public health; *(4)* food, lodging, and institutional sanitation; *(5)* individual on-site water supply; *(6)* sanitary sewage collection, treatment, and disposal; *(7)* grade A milk sanitation, *(8)* communicable disease control; *(9)* vital records registration; *(10)* maternal health; *(11)* child health; *(12)* family planning; and *(13)* public health laboratory support.[3]

While local health departments must make sure the mandated services are available, health departments may or may not offer them in house. Offering extensive mandatory services is costly, Haynes says, often beyond what the local health departments can cover with their resources alone. If a health department does not have the staffing, funding, or space to support a necessary service, it can contract with the private sector to ensure that the county will have access to the required range of services. The county also can pool its resources with another county by forming a dis-

—continues

Emily Coleman, a recent Davidson College graduate, was a Center intern in the fall of 1994.

Table 10. Selected Health Services Available at Local Health Departments

Service	# of counties offering service
Maternal Health:	
Maternity Care Coordination	98
WIC Services[1]	95
SIDS Counseling [2]	94
Prenatal and Postpartum Care	91
Family Planning:	
Contraceptive Care	96
Pregancy Prevention-Adolescent	90
Child Health:	
Child Services Coordination	98
Well-Child Services	97
WIC Services - Children	95
School Health Services	93
Lead Poisoning Prevention	91
Adolescent Health Service	81
Services to Developmentally Disabled Children	74
Genetic Services	42
Chronic Disease Control:	
Early Detection and Referral—	
Hypertension	88
Diabetes	87
Cholesterol	87
Cancer	86
Glaucoma	42
Arthritis	28
Kidney Disease	24
Epilepsy	22
Patient Education—	
Cholesterol	94
Hypertension	92
Cancer	89
Diabetes	89
Chronic Disease Control:	
Patient Education— (continued)	
Glaucoma	57
Arthritis	47
Epilepsy	40
Kidney Disease	34
Home Health Services	65
Chronic Disease Monitoring and Treatment	50
Health Promotion and Risk Reduction:	
Nutrition Counseling	93
Lifestyle Behavior Modification	91
Injury Control	68
Communicable Disease Control:	
Tuberculosis Control	98
Immunization	97
AIDS/HIV Screening	97
Acute Comm. Disease Control	95
STD Control—[3]	
Drugs	93
Training/Education	92
Case Management	84
Epidemic Investigations—	
Risk Assessment	70
Pesticide Poisoning	31
Dental Health:	
Dental Health Education	83
Dental Screening and Referral	82
Dental Treatment	39
Other Personal Health:	
Migrant Health	64
Refugee Health	40

[1] WIC = Women, Infants, and Children nutrition program

[2] SIDS = sudden infant death syndrome

[3] STD = sexually transmitted diseases

Source: Local Health Department Facilities, Staffing, and Services Summary for Fiscal Year 1993, State Center for Health and Environmental Statistics, August 1993, pp. 52–122.

Health Services

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trict health department, such as North Carolina's Toe River District Health Department, which includes the small mountain counties of Avery, Mitchell, and Yancey.

Once the state mandates a program, the local health departments are monitored to assure that this service is provided for each county. Haynes says administrative rules outline how each program is monitored and require each county to submit objectives and anticipated outcomes.

Each division of DEHNR monitors the programs under its jurisdiction. For example, the Division of Maternal and Child Health picks a small number of health departments each year to check for efficiency, effectiveness, and use of funds. These factors, combined with outcomes and health statistics, help the division decide if the local health department is adequately providing services for women and children.

Only as a last resort will the state threaten to take away funds from the local health department. Haynes says he recalls only once when the state has initiated this action. In June 1992, an administrative law judge signed an order allowing the withholding of funds because the local health director in Hyde County did not meet minimum hiring criteria, Haynes says. The issue was resolved when the Hyde County Board of Health and the Department of Environment, Health, and Natural Resources agreed on a course of study to be completed by the acting health director. Officials on the state level do not want to see funds taken from the local departments' budgets, he says, so they work closely with local officials to create efficient and accessible health departments.

Periodically, the Department of Environment, Health, and Natural Resources and the State Center for Health and Environmental Statistics publish a databook on North Carolina's local health departments. The report contains both statewide and county-by-county information about the health departments, including facilities, staffing, and the various health services that are currently available. Although the state mandates certain broad categories of services, counties maintain varied programs which cover the requirements of the Commission for Health Services.[4] (See Table 10, p. 47, for Selected Health Services Available at Local Health Departments.)

The Center for Health and Environmental Statistics surveys each of North Carolina's 100 counties, asking the local health department officials if their department provides specific services. Frank Matthews, a state official who compiled the fiscal year 1993 report, says that in each response, the counties were not asked to specify if the programs in question were contracted out or provided at the health department. If a service was available in some form for the county's needy population, the county was counted as providing the service.

The selected data listed in Table 10 are a mix of mandatory services and supplementary programs, covering categories such as dental public health, communicable disease control, maternal health, child health, and family planning. For example, under the communicable disease control section of the North Carolina Administrative Code, each department must offer tuberculosis diagnostic and follow-up services and treatment services.[5] The study indicates tuberculosis control is offered by 98 counties, a total matched by only maternity care coordination and child services coordination.

With regard to chronic disease, the code mandates prevention and detection services for cancer, diabetes, and hypertension. Early detection and referral services for cancers were available in 86 counties, while similar programs were available for diabetes in 87 counties, and for hypertension in 88 counties.[6]

Matthews says that the fact that no single service is reported as available in all 100 counties does not necessarily mean that local health departments are falling short of mandated requirements. North Carolina has 86 local health departments, and some services may be available within a district that are not available in each county that comprises the district.

—Emily Coleman

FOOTNOTES

[1] 15A N.C. Administrative Code 25.0201.

[2] G.S. 130A-153.

[3] 15A NCAC 25.0201.

[4] N.C.G.S. 130A-1.1 *(b)*. The Commission for Health Services is the rulemaking body that determines which services local health departments must provide to satisfy the requirements of the General Statutes.

[5] 15A NCAC 25.0214.

[6] 15A NCAC 25.209.

Karen Tam

Marie Watson gets her teeth examined by Dr. George Walker at the Open Door Clinic in Raleigh.

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Many local health departments also indicated they have developed special programs to reach minorities through African-American churches and other avenues. Person County offers a breast and cervical cancer program called "Project Sister to Sister" that targets low-income African-American women over 50 for breast and cervical cancer screening. Pitt County offers "street education" on AIDS prevention in a minority community. Wake County has its own minority programs manager to oversee programs in such areas as adolescent pregnancy prevention, AIDS prevention, and breast cancer awareness.

Five Eastern North Carolina counties—Bertie, Halifax, Hertford, Northampton, and Pasquotank—are participating in a program called "Five a Day Black Churches United for Better Health." The project uses African-American churches as the vehicle for encouraging rural African Americans to incorporate five servings of fruits and vegetables in their diets each day for cancer prevention. Churches are given a small cash incentive to participate, plus dollars for their campaigns to promote better diet.

Yet respondents almost universally agree that access is still a problem. At a training session for lay health advisers in a breast cancer screening program in Washington, N.C., Beaufort County Health Director Tamara Hower asked how many women had used health department services. One or two hands went up out of the dozen women in the room. Most said they didn't even know that adult services were available. "Maybe it's our responsibility at the Beaufort County Health Department to make the community more aware of what we do offer," Hower told the group.

Should Minorities Be a Special Focus of State Action?

Respondents to the Center's survey were divided on whether local health departments should make minorities a special focus for health programs. Most said there should be some targeting of services. "Their needs are unique, and their health problems are disproportionate to the rest of the population," said one local health director. Added another, "The minorities' negative [health] indicators are about double the white rates."

Nearly a third of the respondents, however, argued that there should be no special focus. "Health department services should focus on a broad spectrum of populations," commented one respondent. Another respondent said health departments should not have the responsibility of assuring access to services they do not provide. "Minorities' principal

—continues on page 54

Table 11. Summary of Responses to Survey of Local Health Directors on Minority Health Issues by the N.C. Center for Public Policy Research*

1. Please tell us the approximate percentage of persons using your health department who belong to each of the following population groups:

(out of 66 responses)

Population Groups	Average percentage	1990 Makeup of N.C. pop.
White	57.9%	75.6%
African American	35.9%	22.0%
Native American	1.0%	1.2%
Hispanic	4.6%	1.2%
Asian or Pacific Islander	0.3%	0.8%
Other	0.3%	NA

2. What are the three most significant health issues, in priority order, affecting minorities in your county? *(Score: top choice received 3 points, second received 2, and first received 1 point.)*

(out of 70 responses)

Response	Score	(Rank)
Access to health care	86	(1)
Adolescent pregnancy	60	(2)
Heart disease	56	(3)
Health insurance	45	(4)
Sexually transmitted diseases	30	(5)
Drug/alcohol abuse	26	(6)
Diabetes	25	(7)
Prenatal care	22	(8)
Cancer	20	(9)
Other	16	(10)
Violence	14	(11)
Nutrition	5	(12)
Stroke	4	(13)
Immunization	2	(14)tie
Vaccine-preventable diseases	2	(14)tie

Table 11, *continued*

3. Do you think access to health care is a problem for minorities in your community?

(out of 72 responses)

Response	Percent	Number
yes	90.3%	65
no	9.7%	7

If yes, please tell us in priority order which of the following are the biggest barriers to obtaining health care for minorities in your community. *(Score: top choice received 3 points, second received 2, and first received 1 point.)*

(out of 70 responses)

	Top Barriers at:			
Response	Health Department	(Rank)	Private Clinics	(Rank)
Lack of transportation	121	(1)	87	(2)
Health department has too few resources to meet community needs	75	(2)	3	(10)
Lack of information about services available	53	(3)	18	(7)
Lack of health insurance or other means to pay for services	28	(4)	157	(1)
Health department or private clinic is open too few hours	25	(5)	11	(8)
Language barrier between health services provider and minority community	24	(6)	29	(3)tie
Inadequate services	22	(7)	10	(9)
Stigma attached to receiving services at the public health department	18	(8)	0	(11)
Too great a distance between health services provider and minority community	17	(9)	21	(5)
Other	8	(10)	19	(6)
Past experiences at office of the provider	4	(11)	29	(3)tie

Table 11, *continued*

4. Do you think it is the role of the local health departments to make minorities a special focus to assure that they have access to a full range of health services in your community?

	(out of 72 responses)	
Response	**Percent**	**Number**
yes	61.1%	44
no	30.6%	22
no answer	8.3%	6

5. What steps has your local health department taken to reduce health-care access barriers for minorities? (could choose more than one answer)

	(out of 68 responses)
Response	**Number**
1) Use translator to ease language barrier.	51
If so, is translator:	
on staff?	29
volunteer?	12
contracted as needed?	10
2) Home visits for people without transportation	40
3) Open clinic on weeknights more than one night per month	36
4) Offer services at remote sites closer to minority community	35
5) Other, e.g., transportation services	22
6) Clinic open on weekends more than one night per month	12

6. Considering both the public and private sector, are services adequate to meet the health needs of minorities in the community?

	(out of 72 responses)	
Response	**Percent**	**Number**
yes	27.8%	20
no	69.4%	50
no answer	2.8%	2

Table 11, *continued*

7. In your opinion, how do health services for minorities in your community compare to those available to whites?

	(out of 70 responses)	
Response	**Percent**	**Number**
much better	0%	0
better	1.4%	1
about the same	77.1%	54
worse	21.4%	15
much worse	0%	0

8. In your opinion, which of the following is most important to improving health outcomes for minorities? (some people checked more than one choice)

	(out of 76 responses)	
Response	**Percent**	**Number**
1) Lifestyle or behavioral change	42.1%	32
2) Increased access to existing health services	23.7%	18
3) Improvement in local economy to provide jobs and alleviate poverty	21.0%	16
4) More health services	13.2%	10
5) Other	2.6%	2

9. Did your local health department involve minorities or minority groups in its 1993–1994 community diagnostic process?**

	(out of 72 responses)	
Response	**Percent**	**Score**
yes	55.6%	40
no	37.5%	27
no answer	6.9%	5

* While the Center addressed its survey to local health directors, some chose to delegate the task of responding to another staff member such as a nurse supervisor or health educator.

** The community diagnostic process is a biennial process the state requires local health departments to undertake to plan services.

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need is primary care, and most health departments do not provide primary care."

State regulations governing local health departments do not specify that minorities should be a focus of state programs, and there is widespread thinking that all health services should be for all people.

"It's understandable and, under different circumstances, it would be reasonable, but the reality is, health differences between whites and minorities are not getting any better," says Pullen-Smith. "That's why the Office of Minority Health and the Minority Health Advisory Council were formed—to look at changes that might be needed in the system to make it more responsive to the health needs of minorities."

Levine, the state health director, believes it is appropriate "to target and focus on the needs of minorities who demonstrate worse health status and outcomes." His reasoning? Programs must be tailored to meet the needs of the populations they serve. One size does not fit all in health services. In addition, by targeting services to minorities, it is easier to highlight these programs within minority communities and win the support that will help them achieve their objectives. In other words, they are less apt to be viewed as white people's programs.

Levine credits the Office of Minority Health and the Minority Health Advisory Council with fostering a mind set that increasingly looks to the community to deliver services. Examples are HIV prevention programs, the Five-A-Day program using African-American churches as partners to encourage better nutrition and prevent chronic disease, and new programs for the prevention of infant mortality.

"They have sensitized the public health officials and program managers and legislators and people responsible for policies and programs to look outside the bureaucracy, and I think it's penetrated throughout the agency," says Levine. "People are changing their mind set about how to fashion services to really be successful in the various subcultures we already have all over the state."

A Broad Proposal to Address Issues in Children's Health

Although not aimed at minorities, DEHNR, the Department of Human Resources, and the Department of Public Instruction individually have proposed to the governor mutually supportive programs that could have an impact on minority health. These children's health initiatives call for $64.25 million in new appropriations for the 1995–97 biennium.

Together the new programs would add 200 school nurses, expand Medicaid to reach more children above the poverty line, and fund an array of public health services such as pregnancy prevention, peer counseling for at-risk pregnant women, child health awareness, nutrition counseling, and a major campaign to improve overall community health. "While the programs do not specifically target minorities, minorities will benefit from them because of the disparity in incomes," says Janet Ramstack, a health policy adviser in the State Health Director's Office.

Among the more innovative of these proposals is DEHNR's community-based campaign to improve public health. Similar in scope and design to a five-year experimental program in North Karelia, Finland, the $1.2 million program would focus community resources on trying to raise the overall health status of a community—especially in children.

Dale Simmons, director of the Division of Adult

▼

Strangers Like Us: Pittsburgh, Raleigh, 1945–1985

The sound our parents heard echoing over
housetops while listening to evening radios
were the uninterrupted cries running and cycling
we sent through the streets and yards, where
spring summer
fall we were entrusted to the night, boys and
girls together, to send us home for bath and
bed after the dark had drifted down and eased
contests between pitcher and batter, hider and
seeker.

Our own children live imprisoned in light.
They are cycloned into our yards and hearts,
whose gates flutter shut on unfamiliar smiles.
At the rumor of a moon, we call them in
before the monsters who hunt, who hurt, who
haunt
us, rise up from our own dim streets.

—GERALD BARRAX

Health Promotion in the Department of Environment, Health, and Natural Resources, says the Finnish program achieved sustained reductions in hypertension and cholesterol levels over a 20-year period. He says the program has become a model for how an entire community's health behavior can be altered to provide for better health.

In North Carolina, the program would work through preschool, public schools, and work places to involve children, parents, teachers, and employers. Plus, there would be broader public messages delivered through local media. The result would be a community-wide campaign to promote fitness, nutrition, and healthy choices such as forgoing drugs and smoking. With only four pilot programs funded statewide, these campaigns would have considerable resources to focus on their mission.

"Looking at preventive programs promoting good health may be a wise course for us to take. I think it's cost effective."

— SEN. BETSY COCHRANE (R-DAVIE) AND SENATE MINORITY LEADER

Sukhmani Singh, 2, held by her mom, Claudine, at the Open Door Clinic in Raleigh.

Karen Tam

Ramstack says that while North Carolina community-based initiatives would be funded on a request-for-proposals basis, communities with larger minority populations could have an edge. "We'll probably look for diversity," Ramstack says.

Need vs. Political Reality

Most of the Children's Health Initiative got left out of Democratic Gov. Jim Hunt's proposed 1995–97 biennial budget. Hunt's proposal for $486 million in tax cuts precluded major expansion, even for children's health. Republican legislative candidates campaigned on a Tar Heel version of the Contract with America, calling for at least $200 million in tax cuts of their own. Republicans captured control of the House (68 of 120 seats) and 23 of 50 seats in the Senate. (The 15th District Senate race was left unresolved pending a March 28, 1995, special election.)

For the immediate future, the outlook is parsimonious. But the health problems of minorities are real. Democratic and Republican legislators alike realize that in the long run, prevention is cheaper than cure. "I hope that the health departments can be bigger players in preventive medicine," says Rep. Dub Dickson (R-Gaston). "We need to go back and fund them so they can really do the core public health things they are set up to do. If you can prevent horrible diseases like heart disease, cancer, and diabetes, it's cost effective. If you can prevent somebody from going to the emergency room for non-emergency care, it's cost effective."

Sen. Betsy Cochrane (R-Davie), the Senate minority leader, agrees that prevention is key, but says she isn't sure more dollars are needed. "Looking at preventive programs promoting good health may be a wise course for us to take," says Cochrane.

Table 12. The Cost of Prevention Versus the Cost of Cure

Each Dollar Spent for These Preventive Measures	Equals These Dollars Saved in Treatment Costs
For measles, mumps, rubella vaccine	$16.30
For diphtheria, tetanus, pertussis vaccine	6.20
For oral polio vaccine	3.40
For maternal care coordination to prevent low birthweight infants	2.02

Sources: Paul A. Buescher, *et al.*, "an Evaluation of Maternity Care Coordination on Medicaid Birth Outcomes in North Carolina," *American Journal of Public Health*, Vol. 81, No. 12, (December 1991), pp. 1626–1627; for immunizations, Centers for Disease Control, Atlanta, Ga.

"I think it's cost effective." Possible channels for public education include health departments, social services agencies, community groups such as churches and civic organizations, and health professionals in private practice, she says.

"There are a lot of things out there that give us the opportunity to disseminate some information" Cochrane says, adding, "We need to call on people in [the minority] community to help a little bit more. We need to expect a little more involvement in that community in helping us solve the problem. I don't see that more resources will help us solve the problem."

Senate Majority Whip Frank Ballance (D-Warren), a five-term African-American lawmaker from North Carolina's poorest county, offers a different perspective. "In 1982, the infant mortality rate and various poverty issues were endemic in African-American community and in rural North Carolina areas where I live and work," he says. "They still seem to be very strong and prevalent as indicators of the state of health in the African-American community. I'd propose that we move forward . . . to provide assistance, resources, and money. When you look at the big picture, I think the sin on my part would be not to address the issue."

Rep. Jim Black (D-Mecklenburg), House minority leader, adds that while a tax cut may be nice in theory, the amount of extra money remaining in each taxpayer's pocket may not be worth the cost to society as a whole. "We can cut a little bit and spend smarter, but there's not just a whole lot of fat out there," says Black. "I don't think it's going to amount to enough to excite me about taking it out of education and indigent health."

"When you look at the big picture, I think the sin on my part would be not to address the issue."

— SEN. FRANK BALLANCE (D-WARREN) AND SENATE MAJORITY WHIP

Conclusion and Recommendations

If any single theme stands out in the Center's research as key to improving minority health, it's access to care. And access to *preventive* care may be the most cost effective means of closing the health gap between whites and minorities. (See Table 12 above.) Without neglecting treatment for those who have nowhere else to turn, the state *must* step up its efforts in health promotion and prevention.

In virtually every category of disease for which the State Center for Health and Environmental Statistics provided data, proper preventive health can have a major impact. Take, for example, the top four killers of African Americans in North Carolina—heart disease, cancer, stroke, and diabetes. All are potentially devastating. Yet preventive

—continues on page 60

Cycle Busters Aims to Put Teen Moms Back on Track

Cassandra Tucker dreamed of going to college one day in hopes of breaking the cycle of poverty that her family has experienced for generations. Adolescent pregnancy interrupted that dream. But thanks to her own determination and a program called Cycle Busters, she is back on track toward her goal.

"I had always wanted to go to college, but when I had Latrisa I didn't think I would finish high school," says Cassandra, who at age 17 gave birth to her child. Cassandra, now 19, is a sophomore at North Carolina State University. She maintained a 3.1 grade point average throughout her freshman year.

The accomplishment is all the more impressive because of Cassandra's background. She grew up in Raleigh housing projects—shuffled from grandparents to mother to aunt and back to mother again. And she never met her father until she was 6 years old. His address was a state prison.

Cassandra learned she was pregnant in August of 1991. She enrolled for her junior year at high school in September. Still living with her mother, Cassandra began to receive AFDC (Aid to Families with Dependent Children) payments, while she prepared for the birth of her child. Meanwhile, the father of the child attempted to talk Cassandra into having an abortion.

"When I first told him I was pregnant, he tried to get me to get an abortion. I told him no, and he disappeared until the day my daughter was born. Then he started to come around and buy her things like clothes and toys."

Cassandra stayed out of school six weeks following the birth of her child, receiving tutoring so she would not fall too

—continues

Cassandra Tucker with daughter Latrisa

Myron Dowell

Cycle Busters

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far behind in her class work. Then she returned to school, but stayed only three days because she couldn't find anyone to care for her child. She had no luck with the local department of social services. They would pay for day care for someone returning to work, but not to school. She checked into day care, but it cost more than her $236 a month welfare check. "I considered dropping out," Cassandra says. "I felt hopeless when I found out how much day care was going to cost."

After being out of school for two weeks, Cassandra's spirits—and her prospects—got a lift. Her high school guidance counselor referred her to the local Jobs Opportunities and Basic Skills program, and the program agreed to pay for her child care. Still, going to school *and* raising a child proved almost more than she could handle. Cassandra found it harder to study. Her grades began to suffer, and she had to repeat English during summer school and two more courses—chemistry and computer science—during her senior year.

"It was hard because my schedule was centered around hers [Latrisa's]," says Cassandra. "I would get two to three hours sleep. My social life was reduced to a minimum." Realizing the juggling act Cassandra was trying to pull off, a JOBS employee finally referred Cassandra to Cycle Busters.

The Cycle Busters program is administered through the Wake County Department of Social Services. It is one of 35 programs across North Carolina funded by the Adolescent Pregnancy Prevention Program in the Division of Maternal and Child Health Services, Department of Environment, Health, and Natural Resources. The program works with first-time adolescent mothers who are on AFDC and live in Wake County, have a family history of adolescent pregnancy, and have dropped out of high school since becoming pregnant. The goals of the program are to prevent teen mothers from having a second pregnancy, to increase graduation from high school, and to reduce welfare dependency.

Through enrichment activities that include contracts with teens, needs assessment, psychological testing, and weekly group meetings, Cycle Busters hopes to increase employability and economic independence for teen moms and produce welfare savings for the government. Each of the 12 participants are assigned to a mentor. Teen mothers stay in the program until they graduate from high school or become pregnant for the second time.

In September of 1992, Cassandra was approached by Nancy Godwin, the program's director, about joining. "They called me one day and asked me three questions, and I qualified by answering [yes to] two of them," says Cassandra, 'Was I on AFDC?' and 'Did I ever drop out of school?'

"I was skeptical at first about joining the program, but when I found out that one of my friends was in the program I was more at ease. They made me feel right at home because the people in the program were in the same situation that I was in." Cassandra says she became close friends with her mentor, and talked with her about anything from Latrisa's father, to her new boyfriend, to going to college.

In the Cycle Busters program, Cassandra says she had the opportunity to form new friendships, learn new and helpful parenting skills, and raise her self-esteem to become more motivated to go to college and better herself. Cassandra still keeps in touch with Nancy Godwin, the program director.

Godwin, who has worked with the Cycle Busters program since its inception in 1990, says she got involved because she wanted to help prevent adolescent mothers like Cassandra from dropping out of school. She attributes increases in adolescent pregnancy to low self-esteem and factors such as lack of resources, feelings of hopelessness, and alienation from the mainstream. Having a child can provide a source of immediate gratification and attention, although teens rarely weigh the long-term consequences.

Godwin says the Cycle Busters program's success has been its ability to create a bond of trust between group members. "I think our results are really, really good," she says. "These kids need this opportunity." According to Philliber Research Associates, an organization from New York that compiles annual reports on all Adolescent Pregnancy Prevention programs, Cycle Busters "seems to be having a positive effect on those students that participate in it."

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Nature has a way
Of not caring much
About marriage
Licenses and such.

But the neighbors
and her mother
Cared very much!

— FROM "S-SSS-SS-SH!"
SELECTED POEMS OF LANGSTON HUGHES

The agency noted that only 23 percent of the program's students dropped out of school, compared to 86 percent in a control group. There also seemed to be a general increase in appreciation for the value of an education among Cycle Busters participants.

Godwin says she is particularly proud of Cassandra Tucker's progress. "I feel wonderful about that. She would never had gone to State without our help," says Godwin.

Godwin says she hopes to increase awareness of the program because it is helpful to teen mothers who otherwise get lost in the cycle of poverty that many adolescent mothers face. And Cycle Busters participants serve as a resource for even younger adolescents. Recently, for example, members of Cycle Busters participated in a dialogue with members of another APP program, New Horizons. The meeting gave members of New Horizons, who are between the ages of 9 and 14, the chance to ask Cycle Busters members intimate questions about being a teen mother.

Some of those questions included, "How did it feel when your water broke?," asked by a 12-year-old, and, "What was it like to have something growing inside of you?," asked by a 9-year-old. An emotional moment came when a Cycle Busters teen asked how many of the younger children were sexually active. "She is," blurted a 9-year-old, pointing to a 12-year-old New Horizons member. "She's done it twice." As everyone looked at her, the 12-year-old burst into tears.

The Cycle Busters program is funded by the Adolescent Pregnancy Prevention Program. Each program gets between $12,000 and $60,000 in start-up money, depending on needs. The funding is spread over a five-year period and decreases during each year of funding. Godwin's program is in its final year.

Godwin says that Wake County Social Services plans to continue to pay for her salary but won't fund the other components of the program, such as excursions, weekly meetings, seminars, and newsletters. She says it costs approximately $62,000 annually to run Cycle Busters. She plans to approach local foundations for support and hopes that ultimately the General Assembly will pick up some of the funding.

Cycle Busters is intended to help AFDC moms throughout Wake County, but presently it only assists African Americans in Raleigh. One of the program's drawbacks is that its requirements are so rigid. For each member in the program there must be a matching member in the control group participating in the program. The control group consists of all AFDC teen mothers in Wake County who don't participate in Cycle Busters. They are, however, tracked in order to compare their outcomes with members of Cycle Busters. Twelve members of the control group are matched with Cycle Busters participants with similar backgrounds. These outcomes measured include high school graduation rates and second pregnancy rates. Godwin says it is difficult to recruit white or Hispanic teen moms to participate, because it is hard to find a match for the control group. Most of the white teen mothers live in the county, which presents a transportation problem because most activities take place in the city of Raleigh.

Still, participants like Cassandra say the program has been successful for the people it serves. "I want to make it known that this is a great program," she says. "It helped me psychologically, emotionally, and academically. When I had problems with school work, they would find tutors to help. Without the Cycle Busters program, I don't think I would have made it this far."

—Myron Dowell

Myron Dowell was a Center intern in the summer of 1994. He is a graduate student at the University of Pittsburgh.

▼

How To Stay Young

Avoid fried foods, which angry up the blood.

If your stomach disputes you, lie down and pacify it with cool thoughts.

Keep the juices flowing by jangling around gently as you move.

Go very lightly on the vices such as carrying on in society.

Avoid running at all times.

Don't look back. Something might be gaining on you.

—SATCHEL PAIGE
HALL OF FAME BASEBALL PITCHER

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health measures such as proper diet, exercise, and giving up smoking can improve the chances of avoiding or controlling these diseases.

Local health directors point to the need to improve access to existing services such as disease-preventing immunization programs and well-child screenings. Speakers at public hearings across North Carolina told the Minority Health Advisory Council of the need for increased involvement of community-based agencies in spreading the message of public health. And Republican and Democratic legislators alike agree that preventive health strategies are cost-effective in the long-run.

Actions to improve access to preventive health services for minorities are justified by the tremendous health gap between whites and minorities. With an eye toward closing this gap, the Center proposes the following six-point plan:

1 The Legislature should appropriate $750,000 for the 1996–97 fiscal year for a new grant program to develop local community-based preventive health programs to attack the health gap that exists between whites and minorities in North Carolina. Minorities in North Carolina die younger and carry a greater burden of illness throughout their lives. This is a fact painted in black and white by the stark health statistics. The state continues to gather evidence on approaches that show promise in improving the overall health of minorities through strengthening preventive health programs.

These include: the National Institutes of Health Five-A-Day Program in the area of cancer prevention through better diet; the National Cancer Institute's Project ASSIST with its effort to urge people to quit smoking for the prevention of cancer and heart and lung disease; and Project DIRECT, the Wake County campaign to better contain and control diabetes among African Americans, which is funded by the federal Centers for Disease Control and Prevention.

The evidence is strong that effective health promotion campaigns can be mounted to address the health gap. The legislature should appropriate funds for five-year grants to local health departments to attack the health gap in such areas as heart disease, cancer, stroke, and diabetes.

The Division of Adult Health Promotion in the Department of Environment, Health, and Natural Resources, should administer these grants, with consideration of at least the following four criteria: *(1)* the size of the minority population; *(2)* the discrepancy in health between whites and minorities in the target area; *(3)* available local resources, including the strength of the local health department and the strength of the local economy; and *(4)* the likelihood of success of the proposed program. Each proposal should include a strong evaluation component and a long-range goal of improving minority health and narrowing the gap in health status between whites and minorities by a given percentage.

If successful, the community health promotion projects could provide a model for better preventive health across North Carolina. That would be an investment well worth the return. The gauge of success, however, should be a tough one: Did the campaign actually affect behaviors that would improve the health of minorities in the targeted community? Did minorities seek more preventive care? Did they eat fewer fatty foods? Did they exercise more? Did these behavioral changes ultimately lead to better health?

The legislature should require an interim report on the success of these programs by 1999, and a final report by the year 2002, with an eye toward expanding successful programs and terminating the failed ones.

2 To aid in the fight against infant mortality, the legislature should support the expansion of the maternal outreach workers program

to all 100 counties and appropriate $550,000 annually to allow maternal outreach workers to work with families until children reach age 3. Maternal outreach workers should make a special effort to target minority families. Of all of the health gaps the Center noted in its research on minority health, the difference in infant mortality rates is perhaps most tragic. The minority rate is more than double the death rate for white infants. The Division of Maternal and Child Health already plans the expansion of maternal outreach workers to all 100 counties, and, due to higher infant death rates and generally poorer economic standing, minorities will be the prime beneficiaries. These maternal outreach workers make home visits to at-risk expectant mothers to assure they get the care and services they need and work closely with these women until their children reach age 1.

Expansion is based on evidence that these workers can have an impact on the infant mortality rate. This is accomplished by encouraging low-income expectant mothers to get prenatal care and attend to their own health and that of their infant after the child's birth. The program as currently structured is fundable through Medicaid and existing resources, and taking the current program statewide will not require an additional appropriation.

The division also has recommended, through the Children's Health Initiative, further expansion to allow these workers to aid families until age 3, rather than the current age 1. This is desirable for several reasons. Inadequate birth spacing is one contributor to the higher infant death rate among minorities. Maternal outreach workers can provide counseling on this issue, and, if there is a subsequent pregnancy, they can help to assure that expectant mothers get adequate prenatal care.

In addition, abuse, neglect, and accidents are primary causes of death among low-income children. Maternal outreach workers could provide support to lower the death rate among children ages 1–3. And they could assure that children get the well-child services they need to get a healthy start in life, including on-time immunizations, proper nutrition, and checkups.

3 The legislature should appropriate $500,000 annually to fund immunization outreach workers in 20 high-minority, low-wealth counties across North Carolina. The legislature or the Health Services Commission should clarify that local health departments will be responsible for seeing that children ages 2 and under are age-appropriately immunized. The Center's research in nine North Carolina counties uncovered a clear problem with assuring that children ages 2 and under are up to date on their immunizations. This is particularly a problem with minorities. In a review of 4,194 immunization records, the Center found that only 54.1 percent of minorities who use local health departments for services were up to date on their immunizations, compared to 66.4 percent of whites.

The Center found promise in a New Hanover County program in which an outreach worker takes responsibility for assuring that *all* children are up to date. Yet many high-minority, low-wealth counties do not have the resources to implement such a program. The Center recommends that a pool of $500,000 be established to fund immunization outreach workers in 20 high-minority, low-wealth counties. In exchange, the legislature or the Health Services Commission should clarify that local health departments *will* be responsible for assuring that children who reside in their counties are up to date.

With the implementation of a statewide immunization registry and state-supplied vaccines, monitoring children should be easier, and the state's goal of having 90 percent of its 2-year-olds age-appropriately immunized by the year 2000 may be attainable. Besides preventing childhood diseases, this campaign should have the effect of boosting well-child care in general. This will benefit minorities and all North Carolina citizens.

4 The legislature should appropriate $500,000 annually for AIDS *prevention* and $500,000 annually for AIDS *treatment* for the benefit of

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To Satch

Sometimes I feel I will never stop
Just go on forever
Till one fine mornin
I'm gonna reach up and grab me a
handfulla stars
Swing out my long lean leg
And whip three hot strikes burnin
down the heavens
And look over at God and say
How about that!

—SAMUEL ALLEN

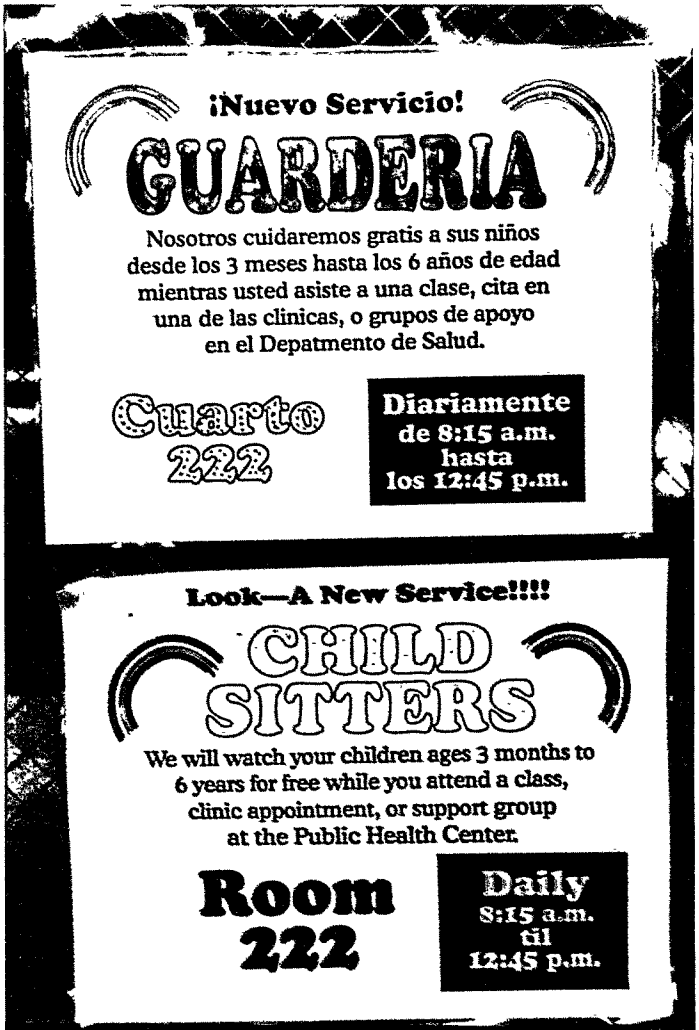
minority communities across North Carolina. The $500,000 the state has appropriated so far for the AIDS fight is only a start. AIDS is having a disproportionate impact on minorities. The mortality rate for AIDS among African Americans is 16.8 per 100,000 residents, nearly five times the white death rate of 3.5 per 100,000 residents. And African Americans are five times more likely to contract AIDS than whites. The state must respond aggressively to such discrepancies in health status. The $2 million biennial budget requested by DEHNR—$1 million for prevention and $1 million for treatment—would have given a much-needed boost to community-based programs addressing the AIDS epidemic. Governor Hunt left this out of his budget.

5 Local health departments should take further steps to include both minority staff and minority-community members in planning for health services. A major goal should be to make services more accessible to minority populations. The clientele of local health departments is heavily weighted toward minorities. Yet well over a third of the respondents to the Center's survey (37.5 percent) say they do not involve minorities or minority groups in their community diagnostic planning process used to identify health needs and plan a strategy for meeting those needs. Many others do not go outside the local health department for minority input and advice. This kind of insular planning neglects a local resource that could be applied to local problem-solving.

Some local health officials need to develop their listening skills. How can they tailor services and programs to the communities they serve when there is no dialogue? Those who listen likely will find that health department clientele need more convenient hours. Often, people who use health department services are the working poor who may not get paid time off to go to the doctor or take their child in for an immunization shot or other services.

Currently, the N.C. Administrative Code requires only that clinics offering immunization shots be offered at a time convenient to working parents at least once a month. At least 36 of the 86 local health departments already exceed this minimal requirement, according to the Center's survey of local health directors. All local health directors should examine whether they can offer a full range of health services at convenient hours.

6 Local health departments, in partnership with the state, should provide interpreter services in counties where the combined resident and migrant Hispanic population exceeds 2 percent of the total population or 5 percent of health department clientele. The legislature should appropriate $250,000 annually in matching funds for local health departments who meet these criteria and wish to hire additional bilingual staff. Health departments increasingly are serving Hispanic clientele with English language skills so limited they can't even tell health department personnel what sort of service they need. The problem has health directors scrambling for help with translation



Karen Tam

services. Hispanics represent only 4.6 percent of overall health department clientele, according to the Center's survey. Yet in areas where the language barrier looms, a small percentage of clientele are creating a major problem.

A plan has been developed within DEHNR that would provide $500,000 in the 1995 fiscal year to add interpreters in the 20 counties with the highest density of Hispanic population. In 1996–97, the plan would add the next 40 highest-density counties at a cost of $1 million.

The Center recommends a more modest approach. Local health departments should provide interpreter services in counties where the combined resident and migrant Hispanic population exceeds 2 percent of the total population or 5 percent of health department clientele. The legislature should appropriate $250,000 in renewable matching funds as a challenge grant for local health departments who meet the population density criteria and wish to hire additional bilingual staff.

The Center has two reasons for recommending this more modest approach: *(1)* fierce competition for health funding in the current political climate (health directors in the Center's survey rated translation services as only their sixth most pressing need in promoting health access); *(2)* many local health departments are addressing this issue and perhaps could do more with a little encouragement from the state. By appropriating matching funds for new personnel only, the legislature leverages limited funds and assures that it is getting increased effort, rather than merely substituting state dollars for local ones. The appropriation could be increased in future years if necessary to meet demand.

Of the 72 local health directors who responded to the Center's survey, 51 said they use a translator to ease the language barrier, and 29 said this individual was on staff. An additional 10 said they contract for translation services, and 12 said they use volunteers.

Still, there is evidence that the current efforts are not enough. Of the 18 health departments in counties with Hispanic populations exceeding 1 percent, three—Harnett, Henderson, and Onslow—indicated in the Center's survey that they do not provide translation services. Health directors in two other counties with significant Hispanic populations—Henderson and Orange—did not respond.

And the 1990 Census provides only a floor estimate of the state's Hispanic population. Migrant workers more than double the Hispanic population in some counties during harvest season and the number of Hispanics taking up permanent residence in the state increases every year. The language barrier clearly is a problem, and it is one that many local health departments are struggling to solve. Some departments clearly could work harder to address this problem. The state should encourage them to do so and provide the carrot of additional funding for counties that are willing to meet the state halfway.

* * *

These modest proposals alone will not cure the health gap. As Sen. Cochrane suggests, it's going to take the efforts of government and the private sector, churches and charities, and it's going to take a stronger North Carolina economy that lifts people out of poverty. The Center's recommendations represent only the first steps, and there are many steps to take to close the health gap between whites and minorities in North Carolina.

The trend toward addressing the health needs of minorities must continue and intensify. What is called for is greater inclusiveness that broadens health programming to reach out to minority communities that traditionally have faced access barriers to health care. The ultimate goal should be better health for all North Carolinians. But as the data make clear, minorities are a great deal further from that goal than the white majority.

FOOTNOTES

[1] Rachele Kanigel, "Racial disparity in infant deaths targeted," *The News & Observer*, Raleigh, N.C., Nov. 14, 1992, p. 1B.

[2] The health status of the North Carolina population is discussed in Ken Otterbourg, "How Healthy is North Carolina's Population?," *North Carolina Insight*, Vol. 14, No. 1 (May 1992), pp. 2–19. This was the second of two special theme issues of *North Carolina Insight* devoted to health care in North Carolina. The discrepancy in health outcomes between whites and minorities was a recurring theme in these two issues of *Insight*, leading the Center to launch a major research project on this topic alone.

[3] Mortality data were produced by the State Center for Health and Environmental Statistics in the Department of Environment, Health, and Natural Resources. With the exception of infant mortality, rates cited are averages per 100,000 citizens of a given race, based on five years of data collected between 1988 and 1992.

[4] *Chronic Disease in Minority Populations*, Centers for Disease Control and Prevention, Atlanta, Ga., 1992, pp. 2–16.

[5] Data on communicable disease rates were compiled by the State Center for Health and Environmental Statistics in the N.C. Department of Environment, Health, and Natural Resources. Rates were based on the average number of annual cases per 100,000 residents over a five-year period, 1988–92.

[6] Kathryn B. Surles, *Adolescent Health in North Carolina: The Last 15 Years*, State Center for Health and Environmental

—continues on page 69

Letting the Community Decide What's Good for It: A New Approach in Public Health

A consortium of educators, community agencies, and citizens are turning the traditional public health model on its ear with a new approach: Letting the people decide what's good for them.

Called the Community-Based Public Health Initiative, the idea is to ask people in minority communities what is really bothering them, listen to their answers, and work with the community to try to solve the problems they identify.

So far, the process has produced some interesting results:

- In Orange County, one community wanted relief from drug trafficking.
- Residents of a Lee County housing project wanted the local housing authority to repair natural gas leaks in their apartments.
- A rural Chatham County community wanted improved water and sewer services.
- In Siler City, a neighborhood wanted a healthy place for community play instead of a weed-infested vacant lot where drug users congregated.

These sorts of concerns are being addressed through a $2.5 million, four-year grant from the W.K. Kellogg Foundation and an innovative leadership structure that brings local resources to bear on community problems. Along the way, communities in four North Carolina counties—Chatham, Lee, Orange, and Wake—are stretching the definition of public health.

"It's health related, but we're looking at more the environmental factors that affect health—economics, the environment, housing, poverty, health care, access to health," says Lechelle Wilson, Community-Based Public Health project manager. "It's a broader approach to public health. That's not to say we're leaving out the health specific things."

Indeed, lay health advisers in three of the four counties are receiving training on everything from adolescent sexuality to preventing prostate cancer in older males. Through their training, they are exposed to sound preventive health practices. In Wake County, there are regular blood pressure checks, cholesterol screenings, and other traditional health services provided in a clinic staffed by a nurse and a physician's assistant.

A four-county steering committee provides an umbrella organization that links the four counties in a common mission. On that committee are state health officials, educators from the University of North Carolina schools of public health and medicine, representatives of local health agencies, and members of community organizations. Each county has its own local governing coalition as well. These boards are structured to include people who bring concerns to the table, plus people with the resources and expertise to address them.

A Platform for Community Interests

Lee County's 10-member coalition, for example, includes representatives from the Wake Area Health Education Center (affiliated with the UNC School of Medicine), the Sanford Housing Authority, the University of North Carolina School of Public Health, the Orange-Chatham Comprehensive Health centers, a local church called Christian Provision Ministries, and four representatives from local housing projects.

"The coalition serves as a platform," says the Rev. Charles Mellette, a Lee County Coalition board member. "It gets people who haven't had an interest in minority or high-risk communities to get involved. The community people have a chance to interact with people who have a big effect on their lives—people with health agencies, the educational system, and people with the business community. . . . From our perspective, it's healthy. It forces organizations to deal with issues that have been suppressed for a long time."

Mellette's church stands adjacent to the Garden Street Housing Project—one of two

communities in Sanford participating in the Kellogg Foundation project. He ministers to a congregation with needs that extend well beyond the spiritual. Mellette believes the Community-Based Public Health Initiative has an important role to play in helping to meet those broader needs.

"At least you're hearing what other parties have to say," says Mellette. "It's a challenge just to sit at the table and let other people say what they're interested in, and you don't say anything about what you're interested in. You may have differences of opinion, but if people are talking, then improvement is taking place. You have to deal with the fact that, OK, everything is not perfect. . . but you're seeing improvement. . . . People get a chance to have a voice. That means more than anything right away."

Certain goals are common to every county. One of these goals is encouraging more minorities to pursue health careers. But the local communities also develop their own goals. Most counties have two or three target communities. Lee is the only county in which public housing projects are the target communities.

"One of the first things they wanted to do was improve living conditions," says Fiorella Horna-Guerra, a health educator who co-directs the Kellogg Foundation project in Lee County with social worker Johnnette Henderson. "We helped them learn how to take up issues with the public housing authority."

More Attention to Good Health

Because the resident council members sat on a committee with a housing authority member and other community leaders, it was easier to call attention to their concerns. "The first year was devoted to housing cleanup and renovation, getting gas leaks repaired and so on," says Henderson. "Now, after the first year, they're willing to listen to health concerns."

And Henderson and Horna-Guerra are giving them an earful. They offer a 10-week curriculum that covers everything from adolescent sexuality to maternal and child health. Graduates of the course are called natural helpers and asked to share what they learn with their peers in public housing.

Most of the curriculum is devoted to maternal and child health issues because of the demographics of the two communities. "The communities are 99 percent female," says Henderson. "The male role models are very fleeting. The typical resident is an 18- to 35-year-old mother with three to four kids."

Henderson also devotes some time in the training sessions to health promotion programs and health resources available to the communities. "Some of the older adults, they don't even know the resources they can access in Lee County," she says. The Lee County Health Department also has taken its Health Wise preventive screenings for heart disease, cancer, and diabetes to the housing projects.

Resident councils have been activated to provide a forum for people's concerns. At Garden Street, Daisy Adams serves as president. A 64-year-old mother of 10, Adams is one of the matriarchs of Garden Street. "I call them my people," she says of the residents. Adams is humble about her role as resident council president. "Somebody's got to come out," she says. "No way I'd go to all these meetings if I didn't care about all these people."

The vice president is Clyde McLeod. He is more outspoken. McLeod complains of gas leaks in the Garden Street apartments, peeling paint, and a long-standing failure to install a promised fence to keep drug dealers from slipping back and forth between the housing project and a wooded area. "We've got to get the housing doing a little better than they're doing," McLeod says. "If they say something, they have got to mean what they say."

Mobilizing the Community

Drug trafficking was the chief concern in the Orange County community of Perry Hills. "The neighborhood at 2 in the morning was like rush hour in Raleigh," says Quinton Baker, who works both Chatham and Orange counties for the Kellogg Foundation project. "There were people racing up and down the street, going in houses, looking for drugs."

Baker borrowed the idea of drug patrols from a Charlotte minister, and community members launched a largely successful campaign to rid their neighborhood of the unwanted activity.

—continues

Community

—continued from page 65

"We had a clean-up day in which we sort of symbolically took back the neighborhood," says Baker, who is project director in Chatham and a community advocate in Orange. "We had a march, and a rally, and that night we started patrols."

Equipped with walkie-talkies, Perry Hills community members regularly walk the streets and record the license plate numbers of people who can't be identified as residents. The plate numbers are turned over to the Orange County Sheriff's Department, which runs down the addresses of the owners.

The owners then receive a post-card bearing the following message: "Please be informed that your vehicle was in a known drug area." The card has a space for indicating the date and time of the sighting and notes that the vehicle's license plate number has been turned over to the sheriff's department. The card elaborates on the drug problem in Perry Hills, states that community members hope the owner of the vehicle is not contributing to the problem, and notes that while not everyone entering the neighborhood does so to buy drugs, many do.

Then comes the clincher. "It would be a shame for your license plate to show up on our list again. You should know, however, that if this does happen, your vehicle registration information, including the owner's name, may be published in your local newspaper and turned over to drug enforcement agencies."

Baker says the effect has been startling. "There were five identified homes," says Baker. "Now there is one, maybe one-

Mike McLaughlin

Daisy Adams, president of the Garden Street Resident Council, a group formed by the Lee County Community-Based Public Health Initiative

and-a-half, where drug activity is taking place." How has this improved the community? "It's just basically the quiet that you get. Traffic is far less. People are able to sleep at night. People are not afraid to go out."

The key to success, Baker says, has been the community's involvement in the solution. "Residents can't just stand around and let the police do their jobs," he says. "It has to be a public-private partnership. Drugs exist in communities because people allow them to exist there."

The Cedar Grove community, with the help of the Kellogg Foundation project, has landed a Family Resource Center. The Center will offer health classes like prenatal care, along with parenting courses and practical resources like books, reading hours for children, and a toy lending room. "It will have all kinds of training for the whole family," says Iris Fuller, Orange County project director.

Leaders for the Future

Fuller says the Orange County efforts have been guided by two subgroups—United Voices of Cedar Grove, and United Voices of Efland-Cheeks, which includes the Perry Hills community. The group names derive from the initial leadership sessions in the communities. Called Community Voices, the training sessions are based on a model developed at North Carolina A&T State University in Greensboro. Community groups in all four counties participated in these leadership development programs.

"It's a shared leadership model," says Fuller. Participants are asked to "develop a vision of what the community looks like now

—continues

Clyde McLeod, vice president of the Garden Street Resident Council

Mike McLaughlin

Community

—continued from page 67

and what they want it to look like 10 years from now—in all kinds of areas, from housing to jobs to health care to education and human services and housing."

Out of this process come goals for the communities. In Efland-Cheeks, those goals included more activities for teens. Participants agreed that teens needed exposure to health promotional topics such as sexually transmitted disease prevention, family planning, and conflict resolution, plus attention to their recreational needs.

As in the other counties, Fuller is fostering public health activities in the communities. Again, a primary vehicle is the training of natural helpers on topics ranging from nutrition to hypertension to diabetes. But Fuller says these efforts bear fruit because the communities are getting their broader needs addressed at the same time.

"The future of public health is in community-based programs," Fuller says. "We've been doing traditional public health programming for so long, but it's not working. We're not improving the health of the community. It's not changing health behaviors."

The Wake County program serving southeast Raleigh is the most urban of the four Kellogg Foundation initiatives. Called the Southeast Raleigh Center for Community Health and Development, it focuses on four broad areas: health care; economic development; leadership development; and career development. With a receptionist, a nurse, and a physician assistant on site, the center's public health focus is apparent.

Besides basic health screenings, center staff train lay health advisers in breast and cervical cancer prevention, prostate cancer prevention, and healthy lifestyles. The Center also has conducted leadership development training, and, like the other initiatives, has set about identifying young people interested in pursuing health careers. A fall workshop at a local housing project focused on preventing violence among teens. The center has worked to spread the message about health through churches and local talk radio.

And What About Results?

The outcome of all this activity will be hard to measure, says Preston McClain, Wake County project director. But then, the same is true of efforts in all four counties.

A formal evaluation will examine whether the program has made a difference at three levels: *(1)* the community; *(2)* the agencies that serve the community; and *(3)* the university through the UNC School of Medicine and the School of Public Health, says Edith Parker, a doctoral student in the School of Public Health. Parker is evaluating the project under the direction of Professor Alan Cross in the school's Center for Health Promotion and Disease Prevention. She says the evaluation will attempt to gauge whether the problem-solving capacity of communities has improved and whether local agencies are collaborating more and becoming more responsive to community needs.

At the institutional level, the evaluation will look at such issues as whether faculty in the School of Public Health are getting more involved in community-based public health programs and how medical students are interacting with minority communities. Data will be gathered to track junior high students who participated in activities intended to encourage them to seek health careers. Parker says the evaluation will not look at hard health data because the project lasts only four years and the communities are too small to extract reliable data.

The ultimate aim of the Community-Based Public Health Initiative is to strengthen the communities and equip citizens to look out for their own interests. Says Fuller, "We want to leave them with the skills and leadership ability to get the resource people coming out to their communities and get the community leadership identifying needs and seeking resources to meet those needs."

Baker, for one, is skeptical that this can occur over the course of a four-year grant. "The length of the program is unrealistic," says Baker. "We will not know anything in four years—not if the community is to take the lead role. We will know we are succeeding if people in the community are helping the health departments and health agencies know what needs to be done in their communities. . . ."

—Mike McLaughlin

—continued from page 63

Statistics, Department of Environment, Health, and Natural Resources, Raleigh, N.C., CHES Studies No. 89, January 1995, p. 4, table 6.

[7] N.C. Cancer Registry, 1988–1992 race and sex specific, age-adjusted mortality rates per 100,000 population. Standard = 1970 U.S. Census total.

[8] Cary Robertson, *et al.*, "Prostate Cancer in North Carolina," *North Carolina Medical Journal*, Vol. 53, No. 9 (September 1992), p. 447.

[9] N.C. Cancer Registry. See note 7 above.

[10] *Ibid.*

[11] *Ibid.*

[12] Jane Leserman, *In Sickness and In Health—The Status of Women's Health in North Carolina*, N.C. Equity, Raleigh, N.C., 1993, p. 84. Regarding cultural norms, in Eilene Z. Bizgrove, *et al.*, "Racial Differences in North Carolina Infant Mortality: An Analysis for the Identification of Prevention Strategies," Family Health International, Research Triangle Park, N.C., September 1994, the authors note that "while black women are usually sexually active earlier than white women, there is no evidence that black women have, on average, more sexual partners than white women." See p. 13 for this discussion.

[13] Souse is a pickled loaf made of pork trimmings.

[14] For more on this issue, see, "North Carolina Minority Health Facts: Hispanics/Latinos," State Center for Health and Environmental Statistics, N.C. Department of Environment, Health, and Natural Resources, November 1993, p. 1.

[15] *Ibid.*, pp. 2–3.

[16] For an estimate of the state's Hispanic migrant population and discussion of the need for interpreter services, see Laureen Lopez, "Interpreter Services for Hispanic/Latino Clients: Report and Recommendations," Office of Minority Health, Department of Environment, Health, and Natural Resources, Raleigh, N.C., September 1994, pp. 1 ff.

[17] National data on Hispanic health are taken from *The State of Hispanic Health*, National Coalition of Hispanic Health and Human Services Organizations, Washington, D.C., pp. 21–57.

[18] CHES data, 1988–1992.

[19] *Ibid.*

[20] Poverty rankings and population figures are based on the 1990 U.S. Census. Among the six counties with the highest poverty rates, only Swain in the far west and Tyrrell to the northeast were less than 50 percent black. Swain has a Native American population of 27 percent, and much of its land is owned by the federal government. Tyrrell has a black population of 40 percent.

[21] For a thorough discussion of the problem of the uninsured and underinsured, see Chris Conover and Mike McLaughlin, "Spreading the Risk and Beating the Spread: The Role of Insurance in Assuring Adequate Health Care," *North Carolina Insight*, Vol. 13, Nos. 3–4 (November 1991), pp. 21–47. See especially p. 30.

[22] Preliminary results placed North Carolina last in 1988, but the final tally had Georgia lower than North Carolina, says Robert Meyer, head of the Perinatal Epidemiology Branch, State Center for Health and Environmental Statistics, Department of Environment, Health, and Natural Resources.

[23] For more on this issue, see Robert E. Meyer, *et al.*, "Trends in Cause and Birthweight-Specific Infant Mortality in North Carolina, 1987–88 to 1991–92," State Center for Health and Environmental Statistics, N.C. Department of Environment, Health, and Natural Resources, Report No. 88, November 1994.

[24] Paul A. Buescher, *et al.*, "An Evaluation of the Impact of Maternity Care Coordination on Medicaid Birth Outcomes in North Carolina," *American Journal of Public Health*, Vol. 81, No. 12 (December 1991), pp. 1626–1627.

[25] For more on this topic, see Eilene Z. Bisgrove, *et al.*, "Racial Differences in North Carolina Infant Mortality: An Analysis for the Identification of Prevention Strategies," Family Health International, Research Triangle Park, N.C., Sept. 8, 1994, 44 pp. plus addenda.

[26] The statewide figure is based on a retrospective study of children who entered school in 1991. While the methodology was different, it is cited here for rough comparison purposes.

[27] By any of several measures, Hertford stands near the bottom among North Carolina counties. Its per capita income, at $9,016, ranked 90th among the state's 100 counties, according to the 1990 U.S. Census. The county's poverty rate, at 25 percent, was fifth highest in the state. For more on demographics and poverty, see Ken Otterbourg and Mike McLaughlin, "North Carolina's Demographic Destiny: The Policy Implications of the 1990 Census," *North Carolina Insight*, Vol. 14, No. 4 (August 1993), pp. 2–49. County-by-county rankings appear on pp. 17–20.

[28] Chapter 900 (H.B. 1340), sections 165 and 166 of the 1992 Session Laws.

[29] Office of Minority Health summary of comments offered at public hearings conducted in 1993 by the Minority Health Advisory Council.

[30] 15A N.C. Administrative Code 25.0201.

[31] While the survey was directed to local health directors, some delegated the responsibility of filling it out to nurse supervisors or health educators.

[32] For some questions, the response rate was lower because some local health directors left some questions blank.

[33] Transportation was not offered as an option. The eight health directors volunteered this information through the "other" category. Thus, the actual number of health departments offering transportation services may be higher.

[34] 15A NCAC 25.0214(3)(B)

[35] See Lopez, note 16 above, p. 4.

[36] Laureen M. Lopez, "An Assessment of Health Service Needs for the Hispanic/Latino Community in North Carolina," Office of Minority Health, N.C. Department of Environment, Health, and Natural Resources, Raleigh, N.C., October 1993, p. 10.

[37] *Ibid.*, p. 11.

CREDITS

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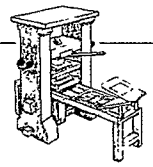


Civic Journalism: Strengthening the Media's Ties With the Public

by Tom Mather

A growing number of newspapers and television stations—in North Carolina and across the country—are trying a different approach to covering the news. The new approach, called civic or public journalism, seeks to stem growing disillusionment with politics and the news media by focusing coverage on the issues that concern people the most. Practitioners hope to present news in more appealing ways, attract more readers and viewers, and better involve the public in the political process. But some critics warn that civic journalism may be pandering to the public's sometimes conflicting and short-sighted desires.

The *Charlotte Observer* turned to an unlikely source—the public—when seeking advice on how to cover the 1992 election campaign. In a groundbreaking media experiment, the paper polled 1,000 Charlotte-area residents about what issues they considered most important for political leaders to address. The *Observer* then used those survey findings to guide its coverage of candidates running for the Governor's Office, the U.S. Senate, and the Presidency.

For example, the paper used its findings to identify key concerns of local residents and to develop questions for its reporters to pose to candidates. Since then, the *Observer* has used a similar approach to guide its coverage of the N.C. General Assembly, local crime issues, and the 1994 elections.

"Our coverage has dramatically changed," says Rick Thames, the *Observer*'s assistant managing editor. "More than anything, this is a change in the way we think about election coverage. It's really voter-driven election coverage, rather than candidate-driven coverage."

The *Observer*'s experiment seemingly flies in the face of typical journalistic practice. Traditionally, newspaper editors and television producers have called the shots when deciding what news is fit to print or broadcast. That has led to a perception, among some readers, that an elite group of editors is telling the public, "You WILL read this!"

In reality, public opinion has always been a factor in news coverage. After all, editors and reporters are people too, and they have friends, relatives, and neighbors among the general public. Ignoring public opinion also can be bad for business. Many people won't buy newspapers or watch TV shows that don't cover the news they consider important or that dwell too much on events they don't care about.

Nevertheless, a growing number of journalists are concluding that they need to do a better job of listening to public concerns about news coverage. Many journalists also feel that they need to find new ways of attracting readers and viewers, presenting news in appealing ways, and involving the public in the political process. Practitioners of this emerging style of news coverage, labeled "civic" or "public" journalism, make use of several methods to better engage the public:

- Identifying what issues people consider most important through opinion polls, interviews, and focus groups;
- Placing more attention on the potential solutions and remedies for problems discussed in news coverage;

Tom Mather is Associate Editor of North Carolina Insight.

■ Clearly noting, when possible, how elected officials stand on the issues most important to voters;

■ Regularly informing readers and viewers how to contact their elected officials, vote in elections, attend public meetings, and otherwise participate in the political process;

■ Organizing public meetings, televised forums, and other ways for people to discuss public policies and the solutions to problems.

By themselves, these techniques are not revolutionary changes in news coverage. What's new about civic journalism is the *systematic use* of such methods in order to involve the public more in news coverage and politics.

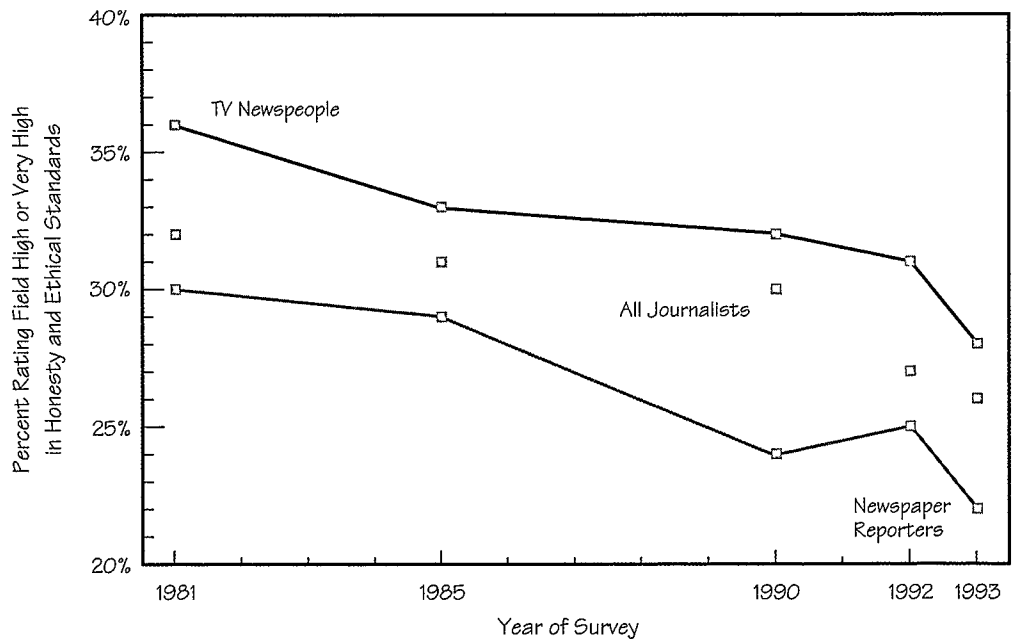
"Civic journalism is a revulsion against the usual election campaign coverage rituals of 'horse race' polling, 'sound-bite' reportage and television attack ads," writes Neal R. Peirce, a nationally syndicated columnist.[1] "One could say the papers' and stations' primary interest in civic journalism is to attract readers and viewers. . . . But civic journalism is arguably more: an opening wedge of papers and broadcasters to 're-engineer' their operations and reinforce the focus they should always have—the needs and concerns of all of us, not just as consumers but as participating citizens."[2]

Reasons for Changing Media Coverage

News media have been re-examining their coverage of issues for several reasons. One of the key concerns is the public's increasing disillusionment with the political process. As Jay Rosen, a professor at New York University and one of the leading proponents of civic journalism, says: "Citizens are frustrated with the political system. Public life is in an advanced state of decay and journalism must do something about it. And because public life is in trouble, journalism is in trouble."[3]

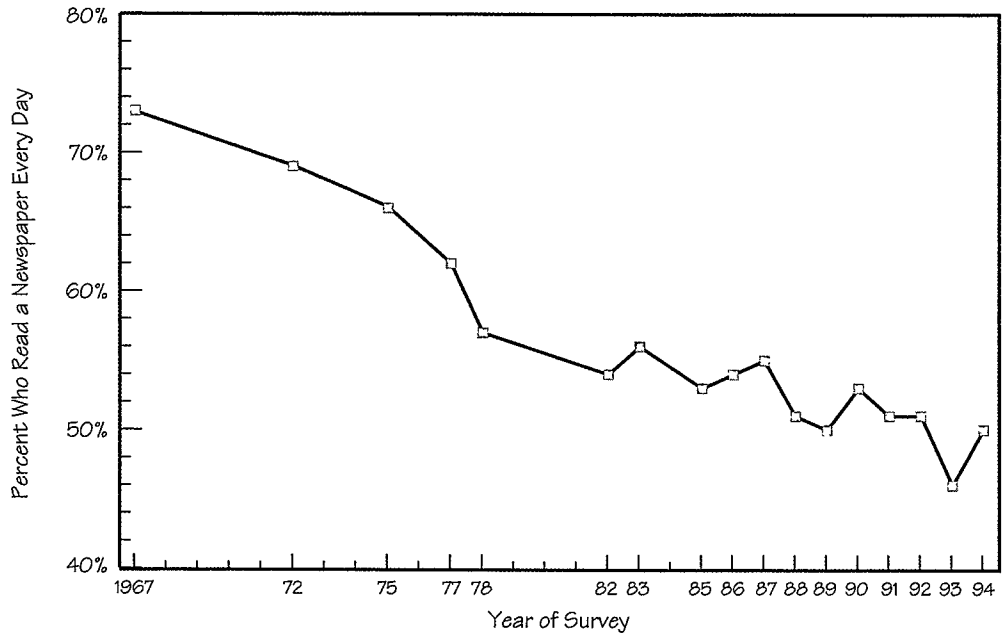
Rosen's contention is supported by growing public skepticism about the accuracy and veracity of the news media. That trend is illustrated by polls showing that the public's regard for journalists has declined steadily over the past decade. (See Figure 1 below.) For example, 30 percent of the respondents to a 1981 Gallup poll rated newspaper reporters as having high or very high honesty and ethical standards. By 1993, that number had declined to 22 percent. Similar declines have occurred in public ratings of all journalists and television reporters. (The silver lining in the Gallup findings is that journalists have consistently ranked higher than many other groups, including lawyers, business executives, senators, congressmen, local and state

Figure 1.
Public Ratings of Journalists' Honesty and Ethics



Source: Gallup Poll

Figure 2.
Newspaper Readership



Source: National Opinion Research Center

office-holders, and the perennial also-rans—car salesmen.)

Perhaps related to the declining esteem of journalists is a long-term decline in newspaper readership. The proportion of adults who read newspapers every day dropped from 73 percent in 1967 to 50 percent in 1994, according to surveys conducted by the National Opinion Research Center at the University of Chicago. (See Figure 2 above.) A similar, although less dramatic, decline in newspaper readership has occurred in North Carolina since 1979, according to The Carolina Poll conducted by the University of North Carolina at Chapel Hill.[4] The Carolina Poll also found that the percentage of people watching television news shows has declined moderately among younger residents (those less than 30 years old) but has increased among older residents (those more than 30 years old).

"U.S. newspapers are not dying; they are committing suicide," says Gene Cryer, editor of the *Sun-Sentinel* in Fort Lauderdale, Fla. "They are produced by journalists for other journalists and/or their sources. They are, for the most part, irrelevant to most reader groups."[5]

"Newspapers are keenly aware of a younger generation of non-readers that does not care whether it sees a newspaper in the morning or not, and newspapers are trying to appeal to this generation by writing down to it."

— GARRISON KEILLOR
HUMORIST AND AUTHOR

Such trends have convinced Cryer and other journalists that the news media need to change the way they cover politics and public policy. Instead of focusing on the latest political scandal or squabble, such critics contend that the media need to pay closer attention to what the public wants from news

coverage. "All the editors have to do is listen to their readers," Cryer says. "Not talk. Listen. And keep listening."[6]

Another journalist, Arthur Charity, expressed a similar view in *Columbia Journalism Review*: "[O]rdinary Americans, far from needing lessons from us in serious journalism, understand what it can and ought to be much better than most reporters and editors do. I'm convinced that people have steadily retreated from newspapers and networks until now because what they found there was shrill and shallow. We will not survive if they continue to feel unsatisfied. Our ideals and our bottom lines both point to the same fact—that we stand to gain quite a lot from a little reckless faith in the American people."[7]

"Our coverage has dramatically changed. More than anything, this is a change in the way we think about election coverage. It's really voter-driven election coverage, rather than candidate-driven coverage."

— RICK THAMES
ASSISTANT MANAGING EDITOR
THE CHARLOTTE OBSERVER

Such concerns prompted the *American Journalism Review* in 1993 to organize a conference in which a cross-section of citizens shared their views of news coverage with a panel of journalists. The magazine summarized the citizens' concerns in the following statements:[8]

- "We don't understand how you operate, especially how you make decisions on story selection and what news to cover."
- "We don't think the news media are held accountable for what they do."
- "We've lost a certain level of trust and confidence in the press. Above all, we question your accuracy."
- "It seems that 'anything goes' to sell newspapers or to compete in today's TV market. News and entertainment have become blurred; sensationalism has replaced substance."
- "Why can't the press be more responsive to the needs of the communities? You're elite and out of touch with the concerns of most people."
- "We are bombarded by so many choices today in obtaining news and are having a hard time sorting through everything."
- "You do a poor job of covering politicians, focusing on their personal lives instead of their jobs."

Civic Journalism Not Without Its Critics

There are drawbacks, however, with some of the techniques central to civic journalism—particularly if taken to an extreme. Critics are most vocal about journalists guiding their coverage of news with opinion polls, focus groups, and other ways of gauging public attitudes. The problem is the fickle nature of public opinion. Surveys show that the public can be notoriously inconsistent in its assessment of the importance of issues. For example, a January 1993 poll identified the economy as the most important issue facing the American public, followed by unemployment, the federal budget deficit, health care, and crime. By January 1994, a similar poll showed almost a complete reversal—with the public ranking the top issues as crime, health care, unemployment, the economy, and the deficit.[9]

The wording of questions in such polls also can have dramatic effects on the results. For example, in a July 1994 poll that asked what was the *single* most important issue for the federal government to address, the top three choices—in rank order—were: crime, the economy, and health care.[10] That was a reversal from a May 1994 poll that asked what were the *two* most important issues for the government to address. In the earlier poll, the top choices by rank were: health care, crime, and employment.[11]

Another problem with polls is a variation of the old riddle: Which came first, the chicken or the egg? That is, do the news media cover an issue because that's what the public is concerned about? Or, does an issue become important to the public because that's what the news media are covering?

"Polls can be a mirror or a window," says Richard Morin, director of polling for *The Washington Post*.[12] "On many issues, survey results merely reflect back what people have superficially absorbed from the media. Instead of peering into the minds of voters, reporters sometimes merely are seeing them-

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Ad-Watches: Seeking Truth in TV Political Advertising

The growing use of negative advertising has been blamed for much of the current public disillusionment with politics and news coverage. Such "mudslinging" always has been a part of politics—one could argue that modern campaigns are relatively tame compared to those in the 18th and 19th centuries. But, negative advertising at least *seems* to be much worse now because of the power and pervasiveness of television attack ads.

"Television has capacities that stump speakers, print barrages, and radio appeals lacked," writes media analyst Kathleen Hall Jamieson, dean of the Annenberg School for Communication at the University of Pennsylvania. "When skillfully used, television's multiple modes of communication and powerful ability to orient attention can invite strong, unthinking negative responses in low-involvement viewers."[1]

The problem with negative advertising is that it works, despite the public's professed revulsion to mudslinging. As a result, during election years, negative TV ads have become as widespread as pumpkins in October. "Year by year, it seems, the resistance to attack campaigning diminishes, and the impulse 'to go negative' intensifies," writes Ferrel Guillory, associate editor for *The News & Observer* of Raleigh.[2] "As a result, American politics spins downward another spiral: Attack-the-opponent commercials breed more disillusionment and surliness in the electorate. Conditioned to believe the worst, voters bemoan and yet respond to negative ads. Because these ads work, candidates use them."

The news media also shoulder some of the blame for the increase in negative advertising, by publicizing the charges contained in ads. Nevertheless, some newspapers and television news shows are trying to counter the trend. They're doing that through rigorous analyses of political advertisements—primarily TV ads—for truth and accuracy. Such "ad-watches" have become a regular staple of political news coverage during election campaigns in North Carolina and across the nation.

A Different Approach to Covering Political Advertising

Although the news media have reported on political advertising for years, ad-watches are a more systematic approach to analyzing such commercials. A typical ad-watch includes information on the ad's sponsor and target, descriptions of the ad's language and video images, and analyses of the ad's accuracy and fairness. (For an example, see p. 75.) Jamieson, the University of Pennsylvania media analyst, says she began promoting the ad-watch concept because of widespread dissatisfaction with news coverage during the 1988 election campaign.

"Throughout the 1988 Presidential campaign—the one that gave us misleading advertisements featuring Willie Horton and Boston Harbor—I expressed concern that reporters were focusing more on the political strategy behind the ads than on the accuracy of the claims presented," Jamieson writes.[3] "... At the same time, I suggested that reporters themselves evaluate the fairness and accuracy of political advertisements."

Jamieson credits syndicated columnist David Broder with popularizing the ad-watch concept through his columns and speeches following the 1988 election. As a result, ad-watches were in widespread use across the nation by the 1992 election campaign. In North Carolina, ad-watches have been embraced by several large newspapers—including *The Charlotte Observer*, the *News & Record* of Greensboro, and *The News & Observer* of Raleigh.

The Charlotte Observer began using ad-watches as far back as the 1984 campaign, focusing on the Senate race between incumbent Sen. Jesse Helms and Gov. Jim Hunt. Since then, ad-watches have become a regular part of the *Observer*'s campaign coverage, says Jim Morrill, who covers state politics for the paper. For example, an ad-watch that ran before the primary election in April 1994 examined an ad for Don Reid, one of three Republican candidates vying

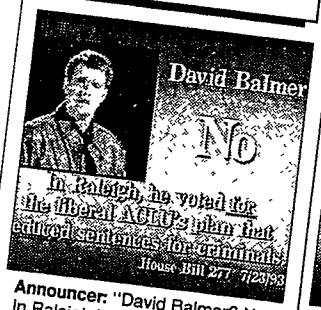
■ 9TH DISTRICT U.S. HOUSE RACE

Reid ad targets Balmer, Myrick on crime issue

In the new commercial for Republican Don Reid, he targets two candidates he believes stand in the way of his nomination in the district that includes most of Mecklenburg and Gaston counties and eastern Cleveland County.

Ad: Fighting crime
Time: 30 seconds
Creator: Jefferson Marketing

THE AD

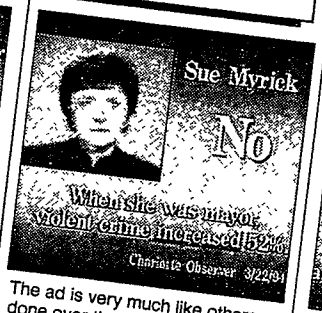


Announcer: "David Balmer? No. In Raleigh he voted for the liberal ACLU's (American Civil Liberties Union's) plan that reduced sentences for criminals.

"Sue Myrick? No. When she was mayor, violent crime increased 52%.

"Don Reid? Good idea. Don Reid fought for community policing and put more police on the streets. That makes sense. Don Reid. Businessman. Conservative Republican for Congress."

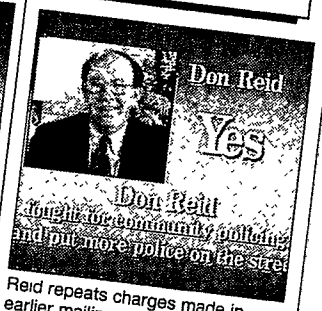
KEY IMAGES



The ad is very much like others done over the years by Jefferson Marketing, a company allied with the National Conservative Club.

The text is printed on the screen, next to less-than-flattering pictures of Balmer and Myrick pulled from their TV ads. Reid's own photo is a new campaign shot.

ANALYSIS



Reid repeats charges made in earlier mailings and in radio ads. Balmer voted for a 1993 law that will reduce sentences on the books but, by eliminating parole, effectively keep inmates in prison longer. It passed with bipartisan support.

With Balmer's support, the legislature also took action this spring to make room to keep 3,000 more people behind bars. Reid wants even more prisons.

Violent crime did rise during the four years Myrick was Charlotte mayor, just as it did across the country.

Reid *has* helped put more police on the streets. Bipartisan council majorities have rejected his proposals to hire even more.

— Jim Morrill

The Charlotte Observer
has been using ad-watches, such as this example from the 1994 primary elections, for 10 years.

for the 9th District U.S. House of Representatives seat. (See reprint above.) The article includes a verbatim transcript of the commercial, shows images of Reid and his opponents, and points out claims that could be misleading to viewers.

The News & Observer has run similar ad-watches focusing on key statewide political races since the 1992 campaign. "We use this mainly on ads that we view as negative," says Van Denton, an editor at the paper. "But we might look at an ad and say, 'We checked this out and it's all true.'" What makes ad-watches effective, he says, is their graphic presentation—which makes the analyses stand out on the news pages and catch the attention of readers.

"This is a continuation of a long tradition in journalism to hold people accountable," Denton says. "It's just being presented in a different format than it used to be. The [political] junkies would read the story. By doing it in a graphic format, we're hoping it will attract more readers who don't follow politics as closely."

—continues

—*continued from p. 73*

selves in these survey results. And too often, what's been written or broadcast about an important issue and then partially digested by the public is either wrong or misleading."

With some issues, Morin says, media coverage has had a substantial—and misleading—influence on public perceptions. "Consider the current spotlight on crime, which ranks as the top concern of many voters," he says.[13] "But that finding doesn't quite square with reality: that the overall crime rate actually is going down and that the violent crime rate—including the murder rate—is lower now than it was a decade ago.[14] There is strong evidence to suspect that the media have created the current undifferentiated fears about crime by their often careless coverage of the issue."

Such concerns have led political analyst Susan Rasky to describe civic journalism as a "perhaps well intentioned, but ultimately harebrained notion."[15] Using opinion polls to guide reporting, she says, would result in news coverage that "amounts to an expanded version of letters to the editor."

"It is neither fashionable nor polite—let alone politically correct—to suggest that the *vox populi* may not be all it's cracked up to be," Rasky writes. "But the dirty little truth that emerges in voters' 'voices' is well known to political reporters, political scientists and above all to the politicians themselves: Citizens generally want very contradictory things from those who govern."[16]

By focusing news coverage on popular perceptions, Rasky says, journalists are abandoning a key responsibility—to guide public discourse. One of the ways journalists exercise that responsibility, she says, is by gathering and analyzing the views of academics, leaders, experts, and informed sources.

Indeed, surveys and other studies have shown that public opinion often can differ widely from expert opinion.[17] Such differences could support arguments against the wisdom of basing news coverage on popular opinions. Some critics already accuse the media of pandering to popular public interests by de-emphasizing political coverage at the expense of news about celebrities, sports, sensational crimes, and life styles.

Ad-Watch, *continued*

But Do Ad-Watches Work?

The question on many journalists' minds, however, is: Do such ad-watches result in more accurate political ads? The jury is still out on that question. After the 1992 election, many campaign consultants said that ad-watches had affected their advertising strategies. "I think these reality checks made our commercials less effective," says Harold Kaplan, a consultant for the 1992 Bush-Quayle campaign.[4]

Nevertheless, follow-up studies have shown that some television ad-watches have produced effects opposite their intended goals. That is, many viewers of TV ad-watches remember the ads' negative messages, but not the critical analyses. "The implication for my proposal was clear: Ad-watches could amplify, rather than undercut, the influence of deceptive advertising," Jamieson says. To prevent such misconceptions, Jamieson recommends that TV ad-watches run reduced-size images of the ads in question and clearly indicate mistakes or corrections.[5]

Despite such findings, journalists say that ad-watches are here to stay because they add a needed dimension to political news coverage. "I don't think we harbor any illusions that we are countering the effect of the negative ads being analyzed," Denton says. "But, if nothing else, this puts the politicians on notice that they're going to be held accountable for what they say in their ads. Hopefully, the end result will be that politicians and their consultants are more responsible about what they say about their opponents."

—Tom Mather

FOOTNOTES

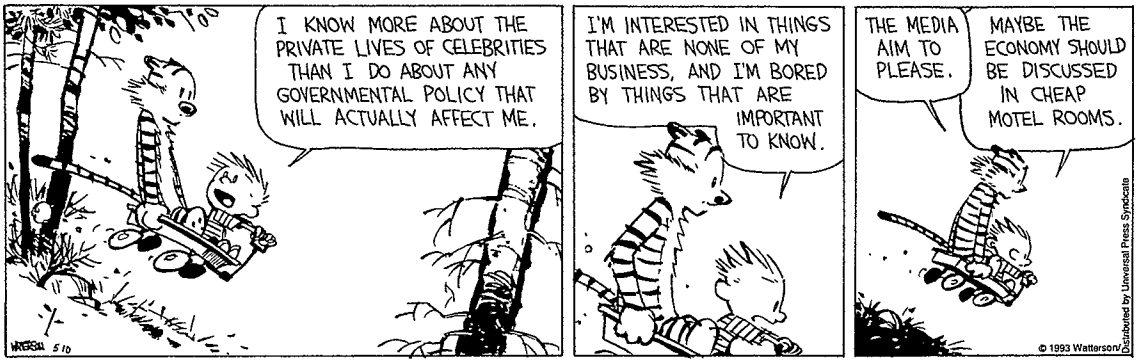
[1] See Kathleen Hall Jamieson, *Dirty Politics: Distraction, Deception, and Democracy*, Oxford University Press: New York, 1992, p. 50.

[2] See Ferrel Guillory, "Candidates can't resist the pull 'to go negative,'" *The News & Observer*, Raleigh, N.C., Oct. 6, 1994, p. 16A.

[3] See Kathleen Hall Jamieson, "Political Ads, the Press, and Lessons in Psychology," *The Chronicle of Higher Education*, Sept. 28, 1994, p. A56.

[4] *Ibid.*

[5] *Ibid.*



CALVIN AND HOBBES ©1993 Watterson. Reprinted with permission of UNIVERSAL PRESS SYNDICATE. All rights reserved.

Humorist and author Garrison Keillor is among those who have criticized newspapers for "dumbing down" their news coverage. "Newspapers are keenly aware of a younger generation of non-readers that does not care whether it sees a newspaper in the morning or not, and newspapers are trying to appeal to this generation by writing down to it," Keillor says. "In the mind of a not very bright 14-year-old, the entire adult world consists of dolts and jerks and meanies, and that is how reporters tend to write about government these days."[18]

Other critics of civic journalism worry about crossing the line between civic responsibility and boosterism. Such critics say that reporters and editors could lose their objectivity by actively urging the public to vote, contact politicians, and become more involved in the political process. "I know newspapers will tell you they are only going out to develop a civic culture, to get people involved," says Howard Schneider, managing editor of *Newsday* in New York. "But inevitably, once a newspaper gets identified as a particular advocate for a position, the dangers are self-evident. Once you lose your credibility and your ability to speak with authoritativeness, you're losing everything."[19]

More Newspapers and TV Stations Trying Civic Journalism

Despite such concerns, some media observers cite civic journalism as the kind of approach that newspapers and television news shows must try in order to attract more readers and viewers. Phil Meyer, a journalism professor at the University of North Carolina at Chapel Hill, says civic journalism could stimulate citizens to become more involved in their communities and in the political process—thus boosting newspaper circulation in the long-run. "There's some risk to it, but that's not a reason not to do it," Meyer says. "I think it's a risk that newspapers ought to take because the loss of community is such a frightening thing."

Jay Rosen, the New York University professor, says critics of civic journalism have exaggerated its reliance on opinion polls. Polls, he says, are just part of a broader effort to involve citizens more in news coverage and public policy. "A lot of places where public journalism is done best, polling isn't being done at all," Rosen says. "The point is for journalists to think about the ways they isolate themselves from citizens—and then try to overcome that. . . . The real thrust of public journalism is how to help make public life work."

Rosen and other proponents of civic journalism appear to be gaining converts, particularly among newspapers. In 1992, only a handful of newspapers were using the civic journalism approach. By 1994, dozens of newspapers across the country were doing so. *Editor & Publisher*, a magazine that covers the news industry, analyzed the civic journalism trend in a recent editorial: "It is an idea that

". . . [T]he dirty little truth that emerges in voters' 'voices' is well known to political reporters, political scientists and above all to the politicians themselves: Citizens generally want very contradictory things from those who govern."

— SUSAN RASKY
POLITICAL ANALYST

is catching on and developing in many ways. It may become a groundswell and sweep the country, in spite of the opposition of some traditionalists who believe trained journalists know better what a newspaper should contain than does the reading public."[20]

Here are some examples of newspapers and television stations that have adopted civic journalism techniques:

■ In Kansas, *The Wichita Eagle* used surveys and extensive interviews to identify problems that local governments seemed unable to solve, including faltering schools, crime, family tensions, and health care. The paper analyzed the problems in special reports, sponsored community forums in which citizens could work on solutions, and used its findings to guide coverage of local elections in 1991.[21]

■ In Ohio, the *Akron Beacon-Journal* examined racial inequities in its community and then sponsored a public forum on racism. The paper even published a pledge card urging readers to vow to fight racism, drawing more than 22,000 responses.[22]

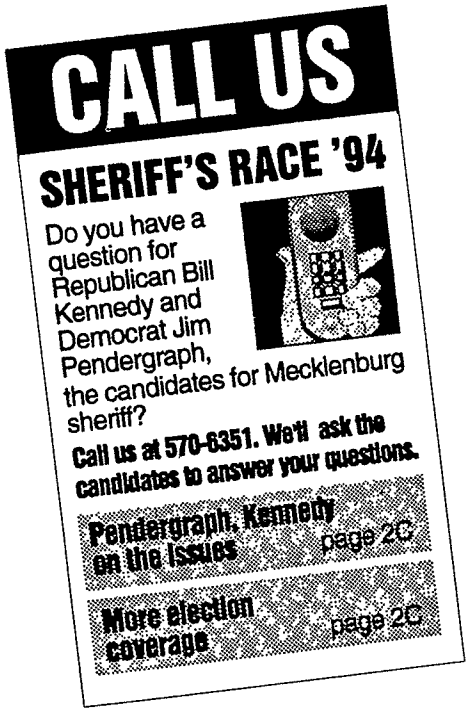
■ In Florida, the Fort Lauderdale *Sun-Sentinel* conducted 130 group discussions with more than 1,400 readers on how to cover the news better. The paper also assigned a senior editor whose full-time job is to talk with readers and "give them a voice in what the paper does."[23]

■ In Washington, the Spokane *Spokesman-Review* encouraged public involvement in community issues by sponsoring "Pizza Papers" meetings. The paper donated $15 worth of pizza to readers who volunteered to host neighborhood discussion groups on issues such as crime, traffic congestion, and city-county consolidation.[24]

■ In Georgia, *The Atlanta Journal-Constitution* published a special voter's guide on the governor's race that included a score sheet for ranking the candidates on major issues. The paper printed candidates' responses to voters' key concerns as identified in a statewide poll; it also co-sponsored with WSB-TV a town meeting in which voters, not reporters, questioned the candidates.[25]

■ Nationally, the CNN cable television network broadcast a series called "The People's Agenda" that examined issues facing American voters at the outset of the 1992 campaign season. The reports, aired over two weeks in February 1992, sought "to present issues as voters see them, not as candidates perceive them."[26]

As part of its civic journalism project, The Charlotte Observer regularly prints graphics such as this showing readers how to contact or direct questions to candidates and public officials.



North Carolina: A Laboratory for Civic Journalism

In 1992, *The Charlotte Observer* became one of the first newspapers—in North Carolina as well as the nation—to embrace civic journalism techniques. The paper's conversion is partly due to its affiliation with the Knight-Ridder newspaper chain, which has actively encouraged efforts to make news coverage more relevant to readers. "People with a sense of connection to the places they live are almost twice as likely to be regular readers of our newspapers," says Knight-Ridder Chairman James Batten, a former executive editor of the *Observer*.[27]

Another catalyst for the change was the Poynter Institute for Media Studies, a think tank in St. Petersburg, Fla. In 1991, the institute was seeking a daily newspaper to participate in an experimental civic journalism project, patterned after *The Wichita Eagle*'s groundbreaking coverage of its local elections that year. *Observer* editors heard about the

The Charlotte Observer

Metro Final (4)

Sunday, January 19, 1992

E

FEAR FOR THE FUTURE

Insurance woes: Diane Spargo, a Gastonia widow with twins, Greg (top) and Brian, faces $800 monthly fees if her late husband's firm changes insurance carriers. "Everybody should be entitled to health care. It should not cost them the entire money that they get . . ."

GARY O'BRIEN/Staff

People demand politicians hear them

By DAVID PERLMUTT
And JIM MORRILL
Staff Writers

Listen, candidates, your neighbors are worried

Worried about losing their jobs, their health insurance and even the moral values that glue their communities together.

Worried that taxes — and the cost of a decent life — will go up so much they won't be able to afford a home or send their children to college.

And, as more are touched by the scourge of drug-related crime, they worry about simply going outside their home — or about someone breaking in.

As a new election year unfolds, a Charlotte Observer/WSOC-TV poll of 1,003 Carolinians found people are deeply troubled about the future And nine out of 10 in the 14-county Charlotte region doubt their elected leaders are in touch with the powerful forces tearing at their personal lives.

They want their worries heard. They want them to become the priorities of politicians.

Listen to Carol Horn of Chester, S C., on the faltering economy.

> **"It's a sense of things being out of control . . . people are adjusting their lifestyle to the fact that they may not have a job next week or down the road"**
>
> **— Rev. John Giuliani,** pastor of Divine Saviour Church in York, S.C.

"People don't know around here from one day to the next whether they have a job," Horn said.

Or Mae Rose McMiller of Gastonia about crime.

"I'm afraid to walk out the door," she said "You just don't know what's going to happen with people outside who are using drugs We live in a dangerous and critical situation."

And Bob Mauldin Jr. of Lake Wylie, S.C., about mounting medical bills.

"I don't think anybody should have to go into financial ruination as a result of having to go to the hospital," said Mauldin, who suffered a heart attack and had triple bypass surgery. "I think we have to attack some way to bring the medical costs down and provide equal health care to all . . . "

It's a chain reaction of fears.

If people lose jobs, they lose health insurance. They fear losing their homes and their children not living a prosperous life. Perhaps, mostly, they fear losing their independence — and dreams It's what Tom Smith of Rock Hill calls a fear of "backward mobility."

The fears are unavoidably intermingled

"Our whole economy system and cultural value system are so thoroughly addicted to squandering any kind of resource," said Dave Payne of Charlotte. "Whether it's the environment or the economy, the whole thing moves by using resources as quickly as possible."

For many, optimism has given way to uneasiness.

"It's a sense of things being out of control," said the Rev. John Giuliani, pastor of Divine Saviour Church in York, S.C. "People are adjusting their lifestyle to the fact that they may not have a job next week or down the road. People are very cautious about making commitments "

The top worries

YOUR VOTE IN '92

According to 1,003 Carolinians interviewed in an Observer/ WSOC-TV poll:

The Economy/Taxes
32% are very worried they or someone in their family will lose a job

Crime/Drugs
67% strongly agree handguns are too easy to get

Health Care
60% strongly agree that government should guarantee medical coverage

Education
73% want more taxes spent to improve education

The Environment
62% want more tax money spent to clean the environment

Family/Community
48% strongly agree elected officials are not concerned enough with children's needs

Full report on the poll
Pages 8-9A

NOTE: Citizens were polled Dec. 13-Jan. 6 in Anson, Cabarrus, Catawba, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly and Union counties in North Carolina; and Chester, Lancaster and York counties in South Carolina.

INSIDE

The Charlotte Observer ***kicked off its ground-breaking civic journalism project by publishing the results of its poll showing local residents' key concerns in the 1992 election campaign.***

Poynter plan and offered to participate.

"Rich Oppel, our [former] editor, was very unhappy with the way news coverage had gone during the 1988 elections," says Thames, the *Observer*'s assistant managing editor. "It seemed to focus on a lot of inconsequential issues, such as flag-burning or who could be the most macho." *Observer* editors also were disenchanted with the media's focus on horse-race polling during the 1990 election, in which Republican Sen. Jesse Helms had defeated Democratic challenger Harvey Gantt—even though polls had shown Gantt ahead during the entire campaign.[28]

The *Observer* and the Poynter Institute agreed on several goals for their joint project:[29]

- To let the voters, not the candidates, establish the key issues in the 1992 election campaign.
- To focus news coverage on issues and the solutions to problems, while forcing candidates to deal with voters' concerns.
- To de-emphasize coverage of horse-race polling, inside politics, and political posturing.
- To forge a partnership with a broadcast competitor, WSOC-TV, in order to reach a broader audience.
- To expand the use of innovative graphics in order to make news coverage more accessible and appealing to readers.

The first step in the project was to survey 1,003 residents in the *Observer*'s core readership area, encompassing 14 counties in the Charlotte region. "We began with a baseline poll, in which we tried to establish what the voters thought this election was about," Thames says. "We wanted to test the waters before they were disturbed." That poll identified six core issues of concern to local citizens: the economy and taxes, crime and drugs, health care, education, the environment, and family and community concerns. (See excerpt on p. 79.)

"This was not exactly a surprising agenda; a lot of things you would expect were there," Thames says. "What did surprise us is that we didn't realize to what an extent the economy would be an issue. The poll helped us realize early on that the economy would probably dominate the election—if voters had their way. . . . We did three polls during the campaign. So, we did retest it. Interestingly enough, in this campaign, the key issues were fairly stable."

The *Observer*'s involvement with citizens didn't end with its surveys. It sought public input on issues by regularly publishing phone numbers that readers could call to voice their opinions with newspaper reporters and editors. It published columns written by local citizens or based on interviews with them. It invited readers to submit questions to be used by *Observer* reporters when interviewing candidates. It organized focus groups to evaluate readers' reactions to its news coverage. It ran articles and graphics showing candidates' stands on issues the voters had identified as most important. It printed phone numbers and addresses where citizens could contact candidates and elected officials. It prominently featured information on how and where citizens could register to vote. It sponsored forums where citizens, experts, and politicians could talk about issues and solutions to problems.

Along with its efforts to involve the public, the *Observer* also changed the way its reporters and editors covered the election campaign. It focused its news articles on issues, rather than on campaign strategies and political spats. It downplayed its coverage of campaign polls. It published regular "ad-watches" that examined the accuracy of political advertisements. (See the related article, "Ad-Watches: Seeking Truth in TV Political Advertising," on pp. 74–76.) "We didn't ignore the horse-race polls and inside politics," Thames says. "We just reserved most of our space on page 1A for in-depth reporting on the issues. Other papers were stripping stories on page 1A that ended up as briefs inside our paper."

Does Civic Journalism Make a Difference?

Ferrel Guillory, associate editor of *The News & Observer* in Raleigh, compliments the Charlotte newspaper for its coverage of the 1992 election. But Guillory says that many elements of civic journalism—such as paying close attention to public concerns, reporting candidates' stances on issues, and informing readers how to participate in the political process—are techniques that always have been considered good journalism. "One of the things I do like about civic journalism is that it's more focused on solutions," he says. "Newspapers do need to become more focused on solutions, not just on problems and criticisms."

Nevertheless, Guillory questions whether the *Observer* covered the 1992 campaign better than other newspapers in the state that used more conventional reporting techniques. "The bottom line is, 'Were the readers of *The Charlotte Observer* any better served?'" he asks. "Did the people learn any more about the politics of the state or the candidates they covered? . . . Did they learn more than the readers of other newspapers learned?"

Taking back our neighborhoods

Seversville needs your help

If our city is to curb violence, we must confront it neighborhood by neighborhood. Here are specific needs, big and small, that residents believe could make a significant difference in Seversville's struggle. If you, your business, church, civic organization or neighborhood want to help with any of the items listed below, call this number:

335-1697

HOUSING

Seversville has some of the city's most dilapidated housing. Later this year the Charlotte-Mecklenburg Housing Partnership will begin renovating 20 houses in the neighborhood. The Partnership purchased the properties in 1993 and hopes to help stabilize the community by selling the houses to homeowners. Habitat for Humanity plans to construct three houses in Seversville. The organization uses volunteer labor and donated supplies to help low-income families build their own homes.

DONATIONS NEEDED

- The Housing Partnership needs materials to renovate houses, including vinyl siding and flooring, paint, drywall, kitchen cabinets, carpet, appliances, carpentry materials, windows and doors, bricks and bathroom accessories.
- Habitat for Humanity needs businesses and organizations to sponsor houses planned for Seversville

Workers from the Charlotte-Mecklenburg Housing Partnership board up homes to protect against vandalism on Katonah Avenue

VOLUNTEERS NEEDED

- The Housing Partnership needs volunteers to handle landscaping, demolition and other work tied to its renovation of houses.
- The agency also needs volunteers to host workshops on gardening, home improvements and decorating for the new homeowners.
- Habitat will need volunteers to help build the three houses. Plumbing, heating, masonry and electrical work is needed.

JOBS

Seversville residents say better-paying jobs would help discourage young people from turning to the drug trade. City and county officials say they have a wide range of job-training programs, but it's hard for residents living on the edge of poverty to stick with the programs, some of which take up to three years to complete.

VOLUNTEERS NEEDED

- The Rev. Ratoy Gaston is seeking volunteers to help him organize and operate a jobs bank for the community at Clinton Chapel AME Zion Church.
- Central Piedmont Community College needs volunteer tutors for a program designed to help Seversville area residents learn basic education and job skills. Classes are taught at Johnson C. Smith University and the ABLE Center at 3607 Beatties Ford Rd.

OTHER HELP NEEDED

- Local banks can help by contributing loans and/or lines of credit to the Northwest Corridor Community Development Corp., an organization that seeks to boost economic development in the west Charlotte area that includes Seversville. The corporation also wants new, expanding or relocating businesses to consider coming to the West Trade Street/Beatties Ford Road corridor

CHILDREN

Photos by T. ORTEGA GAINES-Staff

Seversville has no public parks, no recreation center and almost no organized activities for children like 2-year-old Ronald Martin (above). So far, local government has done little to help. The Mecklenburg County Park and Recreation Department hasn't yet offered recreational activities in the neighborhood. With little to do, some neighborhood kids turn to drugs, guns and other trouble, residents say. The community is trying to find ways to entertain and educate its children. But it needs help.

DONATIONS NEEDED

- A building and sponsoring agency to help revive an after-school program offering tutoring and organized activities. (A similar church-run program disbanded earlier this year. Nearby Bruns Avenue Elementary School has agreed to accept Seversville children into its after-school program, but it does not offer tutoring.) Also needed for the program: tutors, school supplies and books on black history and other subjects.

VOLUNTEERS NEEDED

- Drivers and vehicles to transport children on field trips and to recreation centers outside the neighborhood.
- At least four adult volunteers to help lead a Girl Scout troop now being organized in Seversville. The troop will meet in the Seversville Apartments community room.
- At least five adult leaders to help start a Boy Scout troop in Seversville. Meetings will be at the Seversville Apartments community room.
- Six men to volunteer as Big Brothers to six boys, ages 7 to 15. African-American men are especially needed
- Ten African-American men to mentor Seversville youngsters on behalf of Save the Seed, a nonprofit group that provides role models for black male youths. The group also needs more churches to join their effort.
- Volunteers to help the Mecklenburg County Park and Recreation Department begin operating programs for Seversville children.

GOODS and SERVICES NEEDED

- Uniforms for the "Seversville Steppers," a group of Seversville girls – ages 4 through 12 – who recently began a drill team.
- Transportation and housing to provide several Seversville children a weekend beach trip this summer
- Scholarships for summer camps.
- Complimentary tickets to movies, the zoo and other attractions.
- A mobile basketball goal for use throughout the neighborhood.

COMMUNITY NEEDS

Seversville residents are working together to meet their neighborhood's needs. They're organizing a neighborhood crime watch. And they're trying to recruit new members to the neighborhood community association.

HELP NEEDED

- The neighborhood needs land and money for a community center where people could meet and children could play. The nonprofit Northwest Corridor Community Development Corp. has agreed to oversee a fund for donations and is willing to help build a center
- Focus on Leadership, a nonprofit program to enhance leadership skills for neighborhood leaders, will reserve space for up to three Seversville residents at its next series of seminars. Donations are needed to cover the $50-per-person cost.
- Two programs that provide meals to the elderly and shut-ins have Seversville residents on their waiting lists. Volunteers with their own transportation are needed to deliver meals at lunch and on weekends. The Mecklenburg County Senior Nutrition Program operates out of Gethsemane AME Zion Church. Friendship Trays is based at St. Martin's Episcopal Church
- There is nothing now to mark Seversville for visitors and passersby. To install community pride, residents would like to obtain signs and place them at entrances to the neighborhood.

In its "Taking Back Our Neighborhoods" project,
The Charlotte Observer ***has gone beyond reporting the news by showing readers how to get involved in solving community problems, such as crime and violence.***

ISSUES '94

How to fight poverty

This is the latest in a series of questions on issues in the 2nd and 4th congressional district races. Answers are based on interviews with the candidates in the Nov. 8 election.

Q • There are millions of North Carolinians who live in poverty. What should be the federal government's role in helping people climb out of poverty?

2ND CONGRESSIONAL DISTRICT

REPUBLICAN

David Funderburk

"I think it's government's role to try to provide opportunities for people to educate themselves and be trained so they are better equipped to get a job and to be employed. A lot of this is being offered by the government in terms of job training programs and in terms of community college education and so forth. I don't think it's the government's job to simply extend grants of money to everybody who presently is in poverty to move them into what is not categorized as poverty.

"It's not the government's duty to solve all domestic problems in this country."

DEMOCRAT

Richard Moore

"One of the biggest things the federal government can do is making sure the working poor pays as few taxes as possible. As someone who lives in a very poor part of North Carolina, I see my friends and neighbors who the husband and wife work extremely hard, long hours, and they are just barely making ends meet. They should be rewarded by the federal government for their work instead of comparing themselves to another neighbor who may not work at all and has roughly the same lifestyle.

"I think that is something the federal government has got to focus on — from an earned income tax credit to expanding it even more.than it was expanded last year."

4TH CONGRESSIONAL DISTRICT

REPUBLICAN

Fred Heineman

"I think the federal government, as well as state government, or government itself, should make a target of cutting costs by cutting fraud.

"I think we should raise the dropout age to 18. I'd want to keep people in school until 18, hold the family responsible and the kid responsible. At 16, we should give them an option of going to trade school. The federal government would probably have to assist in funding these trade schools.

"We have rules that keep fathers out of housing developments. We need them back there, with the families, being responsible. I don't think we're going to save much money in welfare, and I don't think that should really be our aim."

DEMOCRAT

David Price

"The best poverty program is an expanding economy, the kind of economic growth and development we've seen in the last year, since the five-year budget plan was put in place."

"In my opinion the problem with welfare is not just that we're spending a lot of money without really moving people forward, but we're also spending it, probably, in the wrong ways. We ought to be investing more in education and training programs and job placement efforts.

"We ought to be making a greater effort at child-support enforcement."

— Compiled by staff writers ROB CHRISTENSEN and MARY E. MILLER

The answer to those questions is 'Yes,' according to two separate studies. After the 1992 election, the Poynter Institute commissioned a content analysis which showed that *The Charlotte Observer* substantially changed its news coverage. Compared to the 1988 campaign, the *Observer* published 58 percent more news coverage about the 1992 election. That coverage included nearly three times more text about issues, 25 times more text about voter information, and only one-fifth as much text about candidate polling.[30]

The Charlotte Observer also covered the issues more thoroughly during the 1992 campaign than other major newspapers in North Carolina, according to an independent content analysis by Phil Meyer, the UNC-CH journalism professor.[31] In a study of 13 daily newspapers, Meyer found that the *Observer* devoted the most space on its front page to coverage of policy issues (25 percent)—nearly double the average (13 percent). The *Observer* also devoted the least amount of space to coverage of horse-race polls (2 percent)—less than half the average (5 percent).

"In sum, the editors in Charlotte were right to abandon journalistic passivity to the extent that they resolved to follow through on their reporting, including polling on policy issues, and convene citizens' groups and promote action," Meyer says. "But their rejection of traditional horse race polling may work against them by depriving the audience of one sure-fire generator of excitement and interest."[32]

Poynter researchers also assert that the *Observer*'s coverage stimulated more voters to participate in the 1992 election, but that result is debatable. "We're convinced it did,"

Other newspapers, such as* The News & Observer *of Raleigh, also are using civic journalism techniques, such as this graphic analyzing the views of Congressional candidates in the 1994 election.

says Edward Miller of the Poynter Institute. "Voter turnout in Mecklenburg County (metro Charlotte) was spectacular—up 32 percent (59,000 voters) over the previous record."[33]

Miller's claim isn't fully supported by records from the State Board of Elections. Total turnout in Mecklenburg County in the 1992 presidential election was up 27.7 percent (49,567 voters) from the 1988 election, according to state records. That was better than the statewide voter turnout, which was up 22.4 percent from 1988 to 1992. But Mecklenburg's turnout did not increase as much as some other counties. For instance, voter turnout in Wake County was up 44.6 percent from 1988 to 1992. Looked at another way, 70.0 percent of Mecklenburg County's registered voters participated in 1992 election, compared with 68.4 percent of the registered voters statewide and 74.6 percent of the registered voters in Wake County.

An unexpected result of the *Observer*'s civic journalism project, Thames says, is that the paper got a lot fewer criticisms from readers about its coverage during the 1992 campaign than it did in the 1990 race. "In 1992, the criticisms dropped practically to zero," he says. "We got a lot of calls and letters saying, 'We do appreciate your emphasis on the issues.'"

But aren't newspapers supposed to rile people up? "Sometimes you need to do that," Thames says. "On the other hand, you can't afford to hide behind that. Maybe we ought to do a better job of listening and determining how we might better do our jobs."

Meanwhile, the *Observer*'s editors were so pleased with their 1992 election coverage that they have expanded their use of civic journalism techniques. In 1993, they used surveys and focus groups to identify the public's key concerns among the issues facing the N.C. General Assembly. And in 1994, the paper began a series of reports focusing on crime—one of the key concerns identified in their polls and interviews—while trying to organize local solutions to the problem.[34] (See p. 81.)

Civic journalism also is catching on at other North Carolina newspapers—even at papers like *The News & Observer*, that are wary of using opinion polls to dictate coverage. The Raleigh paper has run regular ad-watches examining candidates' TV

—continues on page 86

Newspapers Track Campaign Contributions

Negative advertising and the news media aren't the only culprits blamed for increasing public disillusionment with the political process. Many observers say the current cynicism and apathy dates back to the Watergate scandal that tumbled the presidency of Richard M. Nixon in 1974.

Now, some North Carolina newspapers are using one of the key Watergate-inspired reforms—federal and state laws requiring the disclosure of campaign contributions—to improve their political coverage.[1] *The Charlotte Observer* has used campaign finance reports to compile 10 years of data on contributions collected by state legislators. In Raleigh, *The News & Observer* has used such information to track campaign contributions to candidates for all statewide political offices, including the Governor's office, legislative leadership posts, Council of State positions, and Congressional seats.

Such analyses have been made possible by two factors: (1) the existence of public records showing the amount and sources of campaign contributions; and (2) the increasing availability of computers to compile, sort, and analyze those records.

"Before we had the campaign finance laws, we weren't likely to ever find out who the contributors were to political campaigns," says Van Denton, an editor for *The News & Observer*. "Now, with the computer, we've got a tool that allows us to analyze contributions. We finally have a way to look at the role of money in politics. It can be done now, whereas before it was almost an impossible job."

The Role of Campaign Finance Laws

Current federal and state campaign finance laws are an outgrowth of the Watergate scandal. Investigations by Congress and the news media revealed that wealthy donors had contributed millions of dollars under questionable circum-

—continues

stances to President Nixon's 1972 re-election campaign. Such problems helped prompt Congress to enact the Federal Elections Campaign Act of 1971 and to amend the law in 1974.[2] The act had four main goals: (1) to monitor the flow of money into and out of national campaigns; (2) to limit individual contributions to candidates; (3) to provide federal financing to presidential candidates; and (4) to limit spending by candidates who accept federal funding for their campaigns.[3]

In North Carolina, the Watergate scandal helped spur legislators to enact the state Campaign Reporting Act in April 1974.[4] The law sets limits on the amount of money that contributors can give to political campaigns and requires candidates to file reports summarizing their campaign contributions. These reports must include the amounts and sources of all campaign contributions totaling more than $100.

Candidates for public offices in North Carolina must file reports on four occasions: (1) no later than 10 days preceding the primary election; (2) no later than 10 days after the primary election; (3) no later than 10 days preceding the general election; and (4) an annual report by the last Friday in January following any year in which a candidate receives or spends campaign contributions.[5]

Compiling Campaign Finance Data a Laborious Process

State and federal campaign finance reports have provided a wealth of information for political reporters. But analyzing that information is no simple task. In order to make sense out of the data, newspaper reporters first have to compile the names and amounts of contributions from centralized records kept at the State Board of Elections. Then, the records must be entered into computer data bases. "If you totaled all the money we've punched in, it would be more than $55 million from more than 250,000 contributors," says Denton of *The News & Observer.*

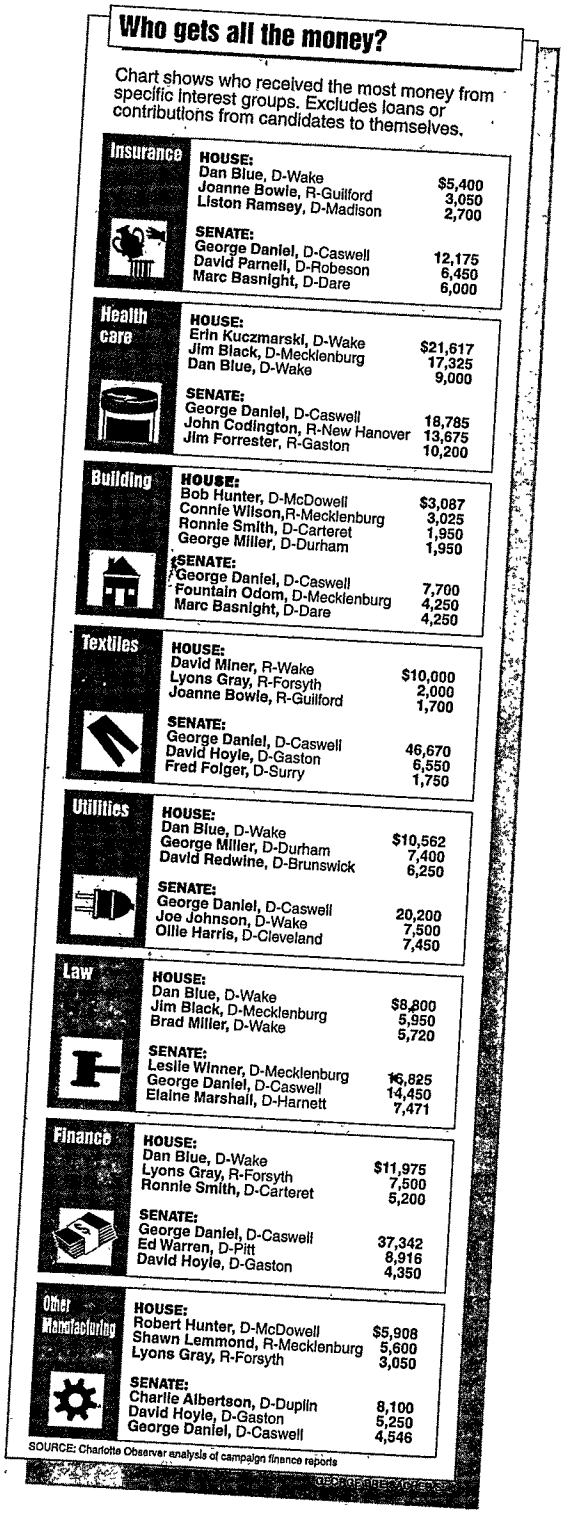
But that information in itself means little. "Ten years ago, when we first started this, reporting who was giving money to the legislature was news in itself—because no one had ever done that before," says Jim Morrill, a staff writer for *The Charlotte Observer.* "Now, that isn't enough. . . . The hard thing to show is what difference that money makes. That's where the reporting comes into play."

One of newspapers' primary goals in analyzing campaign finance reports is to determine whether contributions influence politicians' votes on issues. To do that, reporters must identify contributors' occupations—which are not included on campaign finance reports.[6] Reporters consult a number of sources to determine the occupations of contributors, including public libraries, professional directories, chambers of commerce, and candidates and contributors themselves. After all that information is compiled and sorted by computers, reporters then analyze that information for trends.

The Charlotte Observer has used its data on campaign contributions to reveal a number of important findings about the N.C. General Assembly since 1984, when it first began compiling campaign finance reports.[7] For example, the newspaper reported in 1989 that the cost of running for the state legislator had nearly doubled from 1984 to 1988, with political action committees (PACs) accounting for an increasingly larger share of the costs.[8] The *Observer* also has used its data bases to publish special reports every two years showing:

- Each legislator's total campaign contributions and expenditures, as well as the amounts collected from PACs and selected interest groups.
- The leading PACs in legislative contributions as well as the leading legislators in PAC money collected. (See example on p. 85.)
- Total legislative contributions by selected interest groups, such as banks, builders, health care firms, insurance companies, lawyers, manufacturers, and utilities.

While the *Observer* has focused its attention on the state legislature, *The News & Observer* has used its data base to look at statewide political campaigns, such as races for the Governor's office and the U.S. Senate. For example, the Raleigh paper reported in 1991 that U.S. Sen. Jesse Helms had raised $17 million in the 1990 campaign, with more than two-thirds of that money coming from out-of-state contributors. In 1992, *The News & Observer* reported that



The Charlotte Observer
has used its computer analyses of campaign contributions to show which legislators have received the most contributions from selected interest groups.

Republican Gov. James G. Martin had received more than $500,000 in campaign contributions from developers, builders, and real estate agents or their spouses since 1987.

"This isn't just a tool for the big stories," Denton says. "We can do that, but we try to use this [information] every day in our reporting."

Limitations in Campaign Finance Analyses

Despite the increased media attention on campaign finances, some problems limit the usefulness of the available information. One of these problems, as noted, is that campaign finance laws do not require candidates to list the occupations of contributors. The practical result of that omission is that it can be laborious, time-consuming, and expensive to compile and analyze the records. "It's a pretty painstaking process," says Morrill of *The Charlotte Observer*.

The omission of contributors' occupations also can cause gaps or inaccuracies in newspapers' analyses of campaign finance records. For example, the *Observer* typically is unable to determine the occupations of about 5 percent of the contributors listed in campaign reports. "One year, we identified everybody," Morrill says. "But usually we end up with a few stragglers." A related problem is that contributors can change jobs, thereby affecting the accuracy of analyses that relate campaign spending to various interest groups. To avoid such errors, the Charlotte and Raleigh newspapers periodically purge their databases and recheck the backgrounds of contributors.

Another problem is that reporters cannot analyze all of the campaign finance reports when the information would be most useful to voters. That's because candidates aren't required to file all of their campaign finance reports until *after* the elections. "You never have time to do this before the election," Morrill says. "We try to get cranked up right after the elections. It's a very labor-intensive effort."

But perhaps the most serious drawback is a loophole called "bundling," which can prevent the news media from identifying the sources of campaign contributions. With bundling, interest groups or corporations can avoid reporting re-

—continues

Newspapers, *continued*

quirements by gathering together large numbers of individual contributions—each of which is less than $100 and thus not required to be reported. "There are ways to get around the law," Morrill says. "If they don't put down names, you just don't know."

—Tom Mather

FOOTNOTES

[1] See Kim Kebschull, Marianne Kersey, and Ran Coble, *Campaign Disclosure Laws: An Analysis of Campaign Finance Disclosure in North Carolina and a Comparison of 50 State Campaign Reporting Laws*, North Carolina Center for Public Policy Research, 1990, pp. 3–13. Also see Ann McColl and Lori Ann Harris, *Public Financing of State Political Campaigns: How Well Does It Work?*, North Carolina Center for Public Policy Research, 1990, 79 pp.

[2] 2 U.S.C. 431 (1982 and 1988).

[3] See John Aldrich, *et al.*, *American Government*, Houghton Mifflin Co., Boston, Mass., pp. 241–243.

[4] N.C.G.S. 163-278.6 to 163-278.40E.

[5] N.C.G.S. 163-278.9A.

[6] In 1990, the N.C. Center for Public Policy Research recommended that the occupations of donors to candidates be included in the state's campaign disclosure requirements. See Kebschull, *et al.*, note 1 above, pp. 46–49. The state Senate passed a bill (S.B. 1563) in 1994 that would have required candidates to list each contributor's occupation, place of employment, and business mailing address on campaign finance reports, but the House did not pass the legislation.

[7] *The Charlotte Observer* has published special reports on campaign finances every two years since 1985. The authors, titles, and dates of lead articles are: Ken Eudy, "In N.C. Legislative Campaigns, Money Speaks With Authority," June 16–20, 1985, p. 1A; Jim Morrill and Tim Funk, "Interest Groups Cast Big Money Shadow," April 5, 1987, p. 1A; Jim Morrill, "Lobbyists Escalate Arms Race," April 9, 1989, p. 1A; Jim Morrill, "Contributions Pave Way for Access to Legislators," May 5, 1991, p. 1A; and Jim Morrill and Ted Mellnik, "Price of Power," June 13, 1993, p. 1A.

[8] Also see Kim Kebschull Otten and Tom Mather, *The Cost of Running for the North Carolina Legislature*, North Carolina Center for Public Policy Research, 1993, 84 pp.

—continued from page 83

ads. It has published a number of graphics focusing on candidates' stances on particular issues. (See example on p. 82.) And, in special reports, it often tells readers how to contact reporters, editors, and public officials—by telephone and computer networks.

"You can call that civic journalism or not," Guillory says. "We just call it good journalism. Civic journalism has some strengths, but it is not some magic potion. Traditional journalism has its strengths, but periodically it needs to be re-assessed."

The News & Observer also is trying to become more responsive to its readers. For example, prior to the legislature's special crime session in early 1994, the paper organized a focus group to find out citizens' primary concerns. The paper also has expanded its opinion polls to include more frequent and comprehensive assessments of the public's views on issues. But editors are quick to emphasize that *The News & Observer* is not using opinion polls to set the agenda for its news coverage.

"You've got to be in touch with your community," says Mike Yopp, the paper's deputy managing editor. "But you can't just let that dictate your coverage, because obviously there are some things going on that people don't always know about. We still have to use the traditional tools of journalists."

Editors at *The Charlotte Observer* agree that it would be a mistake to base news coverage solely on polls and other ways of gauging public opinion. They say they haven't abandoned traditional reporting techniques, such as interviewing experts, examining government records, and relying on gut instincts. But they say civic journalism techniques have helped them cover the news better, while involving their readers more in the political process.

"If this approach were taken to its extreme, it would be wrong," Thames says. "We didn't throw our instincts out. That would be foolish. . . . The problem is that journalists have done a bad job covering the minimal amount needed for voters to make decisions. I believe that the people who read our newspaper, when they went to the ballot box on election day, knew what they needed to know. That's what I'm most proud of."

FOOTNOTES

[1] See Neal R. Peirce, "Civic journalism's 'extra extra,'" *The News & Observer*, Raleigh, N.C., June 26, 1994, p. 16A.

[2] For further discussion of changing trends in news coverage, see Ferrel Guillory, "Customers or Citizens? The Redefining of Newspaper Readers," and related articles, *North Carolina In-*

sight, Vol. 12, No. 4 (September 1990), pp. 30–38. Also see Ellen Hume and John Ellis, "Campaign Lessons for '92," Conference Summary, Barone Center on the Press, Politics and Public Policy. Hume and Ellis list a number of suggestions for improving press coverage of politics, including: avoiding "manufactured news"; curtailing coverage of horse-race polls and inside campaign strategies; and reassigning senior reporters from covering day-to-day campaigning to doing more in-depth examinations of issues and fact-checking.

[3] As quoted in M.L. Stein, "A Catalyst For Public Awareness?" *Editor & Publisher*, Oct. 15, 1994, p. 11.

[4] See Thad Beyle, "'The Age of Indifference' and the Media in North Carolina," *North Carolina DataNet*, Issue No. 3 (December 1993), pp. 4–5. The Carolina Poll is conducted jointly by the UNC-CH School of Journalism and the Institute for Research in Social Science. The poll found that, between 1979 and 1990, the percentage of people who read newspapers at least 6 days a week declined from 35 percent to 30 percent among younger residents (those less than 30 years old) and from 60 percent to 56 percent among older residents (those more than 30 years old). During the same period, the poll found that the percentage of people who watch television news at least 6 days a week declined from 34 percent to 28 percent among younger residents but increased from 50 percent to 60 percent among older residents.

[5] As quoted in William B. Ketter, "Market-Driven Editorial Content—How Viable?" *Editor & Publisher*, Oct. 15, 1994, p. 13.

[6] *Ibid.*

[7] See Arthur Charity, "What Readers Want: A Vote for a Very Different Model," *Columbia Journalism Review*, November/December 1993, pp. 45–47.

[8] See Penny Pagano, "Public Perspectives on the Press," *American Journalism Review*, December 1993, pp. 39–46.

[9] From CBS News polls, as reported in "National Barometer," *The Polling Report*, Jan. 24, 1994, p. 8.

[10] From an ABC News/*Washington Post* survey as reported in "National Barometer," *The Polling Report*, July 18, 1994, p. 8.

[11] From a Harris Poll, as reported in "National Barometer," *The Polling Report*, June 13, 1994, p. 8.

[12] See Richard Morin, "Newspapers ask their readers what's important," *The Charlotte Observer*, Charlotte, N.C., June 16, 1994, p. 13A.

[13] *Ibid.*

[14] Federal crime statistics can be used to argue that crime rates have gone up *and* down; such discrepancies are largely due to differences in the way data are collected. For instance, the U.S. Bureau of Justice Statistics compiles its National Crime Survey based on incidents reported by citizens in polls. That survey shows that total crime has declined substantially over the past two decades, while violent crime has dropped slightly. For instance, the rate of total crime per 1,000 people declined from 124 in 1973 to 92 in 1991. During that same period, the rate of violent crime per 1,000 people dropped from 33 to 31. See U.S. Bureau of the Census, *Statistical Abstract of the United States* (113th edition), Washington, D.C., 1993, p. 196.

However, the Federal Bureau of Investigation has reached a different conclusion through its Uniform Crime Reporting Program, which is based on reports filed by law enforcement agencies. The FBI data show that total crime and violent crime have increased markedly over the past two decades. For example, the rate of total crime per 100,000 people increased from 4,154 in 1973 to 5,660 in 1992. During the same period, the rate of violent crime per 100,000 people increased from 417 to 758. See Federal Bureau of Investigation, *Uniform Crime Reports for the United States*, U.S. Department of Justice, Washington, D.C., 1992, p. 58.

[15] See Susan Rasky, "Voice of the Voter," *California Journal*, Vol. 25, No. 5 (May 1994), p. 15.

[16] *Ibid.*

[17] Consider the results of two separate surveys aimed at determining the most important public issues in July 1992, during the last presidential campaign. A poll by the Public Agenda Foundation asked some 500 leaders in government, academia, business, criminal justice, religion, and the media to rank 20 issues on their relative importance. By contrast, a Gallup poll asked 755 registered voters nationwide to rank 16 issues on their importance. Although both polls ranked education, the federal budget deficit, and crime in the top five, there were notable differences with regard to other issues. The experts' poll ranked health care as the third most important issue, while the voters' poll ranked it seventh. Likewise, the voters ranked the economy first and unemployment fifth, while experts ranked those issues eighth and tenth, respectively.

[18] See Garrison Keillor, "Shallow news, sorehead nation," *The News & Observer*, Raleigh, N.C., Oct. 25, 1994, p. 7A. (The article was reprinted from *The New York Times*.)

[19] See Alicia C. Shephard, "The Gospel of Public Journalism," *American Journalism Review*, September 1994, pp. 28–34.

[20] See "Public journalism," *Editor & Publisher*, Oct. 15, 1994, p. 6.

[21] See Peirce, note 1 above. Also see Michael Hoyt, "The Wichita Experiment," *Columbia Journalism Review*, July/August 1992, pp. 43–47.

[22] See David E. Brown, "Public journalism: Rebuilding communities through media," *Philanthropy Journal of North Carolina*, Vol. 1, Issue 11 (July–August 1994), pp. 1 and 11.

[23] See Ketter, note 5 above, p. 40.

[24] See Stein, note 3 above, p. 41.

[25] See Charles Walston, "Tell Us The Truth," *The Atlanta Journal-Constitution*, Oct. 16, 1994, pp. R1–7.

[26] From a CNN news release titled "The People's Agenda," (undated), Turner Broadcasting System, Atlanta, Ga.

[27] See Hoyt, note 21 above, p. 45.

[28] For a look at the accuracy of political polls, see Paul Luebke, "Newspaper Coverage of the 1986 Senate Race: Reporting the Issues or the Horse Race?" *North Carolina Insight*, Vol. 9, No. 3 (March 1987), pp. 92–95. Also see Adam Hochberg, "Polls Shed Light on Outcomes of Political Races in North Carolina's 1992 Elections," *North Carolina Insight*, Vol. 15, No. 1 (January 1994), pp. 48–61.

[29] For a description of *The Charlotte Observer*'s 1992 civic journalism project, see Edward D. Miller, "The Charlotte Project: Helping citizens take back democracy," Poynter Institute for Media Studies, St. Peterburg, Fla., 1994, 93 pp.

[30] *Ibid.*, pp. 65–66.

[31] See Philip Meyer, "The Media Reformation: Giving the Agenda Back to the People," pp. 89–108, in *The Elections of 1992*, edited by Michael Nelson, CQ Press: Washington, D.C., 1993.

[32] *Ibid.*, p. 105.

[33] See Miller, note 29 above, p. 72. For further discussion of issues related to voter turnout, see Jack Betts, "Voting in North Carolina: Can We Make It Easier?" and related articles, *North Carolina Insight*, Vol. 13, No. 2 (June 1991), pp. 20–53.

[34] See Liz Chandler, "Taking back our neighborhoods," *The Charlotte Observer*, Charlotte, N.C., July 17, 1994, p. 1A.

Lobbyists Bearing High-Tech Gadgets, and Other Tales from the Latest Lobbyist Rankings

by Mebane Rash Whitman

Lobbyists have long maintained that glad-handing, good jokes, and a hefty stash of campaign contribution cash are peripheral to winning one's way with the General Assembly. The real key to effective lobbying, they say, is getting good information into the hands of lawmakers. And the proliferation of innovative ways of communicating is having its effect on the trade.

This and other trends in the lobbying profession are apparent from the rankings in *The 50 Most Influential Lobbyists in the 1993 North Carolina General Assembly*, a report released by the North Carolina Center for Public Policy Research in August 1994. These trends include an increase in the number of new faces using high-tech gadgetry to work the halls of the General Assembly and the number of lobbyists forming teams to win their way with legislators. Hot public interest issues, like health care, also seem to fuel higher rankings for some lobbyists.

Patricia Pleasants, a lobbyist representing the National Federation of Independent Business, marvels at the trend toward high-tech lobbying. In 1993, for example, a group of business lobbyists hired a communications team to coordinate grassroots support for the proposed workers' compensation reform legislation.[1] Armed with a list of supporters for the bill and a sophisticated telephone system, communications firm employees would call people on the list and confirm support. Then, with the touch of a button, the citizens' telephone lines were directly linked to their legislators in Raleigh so they could express support for the bill.

"All they had to do was punch one button and the phone would automatically ring into that legislator's office," says Pleasants. "It was amazing." The ensuing barrage of calls to the legislative office building burned up the telephone lines. "The rumor was that one legislator got so many phone calls the phone broke," says Pleasants. "It's kind of a scary thought, that ability."

Ellis Hankins, a veteran lobbyist, has his own war stories. "I remember, during the 1990 session, that we got wind of a plan by the Senate appropriations leadership to cut the local reimbursements for the repealed inventory tax significantly, the next day. Out went a 'League LegisFAX' to 200 preprogrammed city hall numbers, and the next morning legislators' phones rang off the hook. By noon, that plan was dead, before the appropriations committees even met. Senator Bill Goldston asked me how in the world we got so many of our folks on the phone so fast with accurate information. It was music to my ears."

Welcome to the new age of lobbying. Beepers, cellular telephones, and laptop computers with modems are the essential tools of the trade, and technology is being used to provide quick and easy access to grassroots efforts, creating a powerful method of influencing legislators. As Terry Martin, capital correspondent for the *Winston-Salem Journal*, notes, "[T]he leading lobbyists regularly make use of such technology as facsimile machines, computers, videocameras, and telephone banks to ply their trade most effectively."[2]

Where does that leave Jane Doe, who has a concern about some particular issue but doesn't have access to a phone bank or a high-powered lobbyist? At least one commentator believes a well-timed call from a constituent still packs a punch.

Mebane Rash Whitman is the Center's policy analyst.

Karen Tam

Patricia Pleasants, a lobbyist for the National Federation of Independent Business, demonstrates some of the new tools of the lobbying trade.

"[L]egislators generally will pay more attention to one . . . genuinely concerned constituent than five lobbyists trying to win something for their clients," writes Danny Lineberry of *The Herald-Sun* of Durham, N.C.[3] The trouble is, notes Lineberry, "Not many people call their legislators, unless it's about a particularly hot issue. Lobbyists are in the Legislative Building every day."

So how does one keep up with who's influencing who? One way is through the Center's lobbyist rankings. Lobbyists list their rankings on resumes; clients use them to evaluate effectiveness, to determine if a raise is merited, or to decide which lobbyist to hire; citizens can use them too.

As an editorial in the Greensboro *News & Record* observes, "Just as voters, at election time, need to know the candidates vying for the privilege of representing them in the General Assembly, so also do they need to know who it is who has their elected officials' attention. . . . That's why surveys such as this one, which ranks the top 50 lobbyists, are useful."[4] This is the seventh time the Center has released its lobbyist rankings. The latest edition is based on results from a survey conducted during the fall of 1993 after adjournment of the regular session of the General Assembly.

Old and New Faces

Zeb Alley, who represents 18 clients with business and industry interests, received the top ranking for the fourth time in a row. Rounding out the top five spots were Allen Adams, representing 15 clients including the N.C. Retired Governmental Employees Association and Arts Advocates; Roger Bone, legislative liaison for the Department of Community Colleges and also representing 10 clients; Sam Johnson, representing 14 clients including IBM; and Bill Holman, representing the Sierra Club and other environmental groups. Although there was little movement among the top five spots, 30 percent of the 50 lobbyists ranked as most influential never had been ranked before.

The influx of newcomers and the shifts within the rankings make it apparent that a new generation of lobbyists is garnering the skills necessary to someday replace "the old guard." Fifteen of the 50 top lobbyists this legislative session have not been ranked previously among the most influential. Jim Phillips Jr. (11th), Governor Hunt's former legislative liaison, is the highest-ranked newcomer. Other newcomers to the rankings include: John McMillan (18th), representing 14 clients; D.G. Martin Jr.

(20th), legislative liaison for the UNC system; Harry Kaplan (21st), representing the Kaiser Foundation Health Plan of N.C.; Gene Upchurch (22nd), representing Southern Bell; John Niblock (23rd), representing the N.C. Child Advocacy Institute; Phil Kirk (26th), representing N.C. Citizens for Business and Industry; and Mike Carpenter (29th), representing the N.C. Home Builders Association.

Carpenter attributes the success of fellow newcomers to their "ability to take care of business in committee, winning their battles there instead of on the floor." Ran Coble, the Center's executive director, notes, "The committee system is the key part of the lawmaking process. The floor is for show, and the committees are for go. Influential lobbyists learn the committee system and use it to their client's advantage."

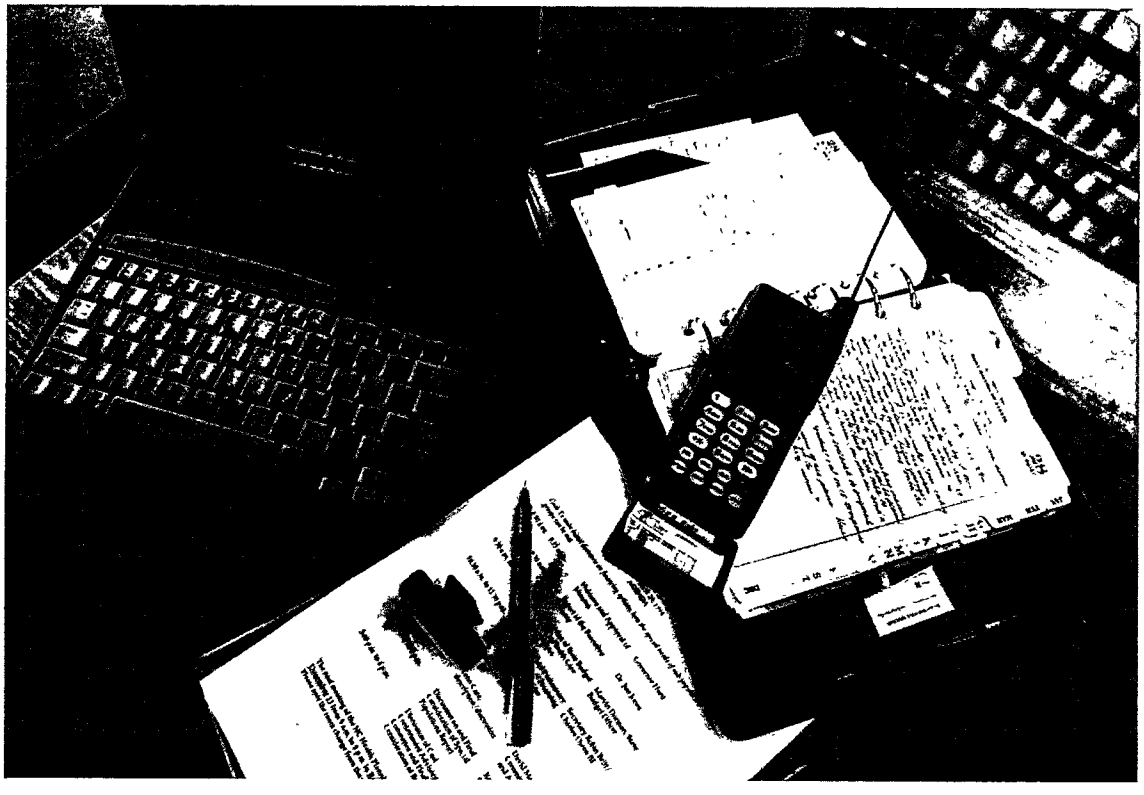
Richard Bostic, one of the General Assembly's fiscal research analysts, agrees. "Over the past two or three years, lobbyists have been very active in the appropriations committee process. In the transportation committee, for example, lobbyists attend the daily meetings during the session. And lobbyists who are employed year-round work to influence study committees in the interim. On the Transportation Oversight Committee, for example, lobbyists tried to influence the agenda and shape the recommendations made on some issues, such as overweight trucks."

Lobbying in Teams

Many of the traditional lobbying powerhouses in the legislature increased their clout by sending teams of lobbyists to Raleigh during the 1993 session. Six organizations and corporations—the American Petroleum Institute, Southern Bell, Carolina Power & Light Company, Citizens for Property Rights, the N.C. Retail Merchants Association, and the N.C. Association of County Commissioners—each were represented by three lobbyists ranked among the 50 most influential lobbyists. The American Petroleum Institute retained the three who collectively rank the highest, with Zeb Alley (1st), Marvin Musselwhite (8th), and Lawrence Bewley (16th) heading their lobbying team.

Ten other organizations and corporations—the Alliance of American Insurers, American Insurance Association, Amusement Machine Association, Blue Cross and Blue Shield of N.C., N.C. Citizens

Laptop computers, flip phones, and other high-tech devices are quickening the pace of lobbying the legislature.



Karen Tam

for Business and Industry, North Carolina Association of Educators, ElectriCities of N.C., N.C. Hospital Association, Kaiser Foundation Health Plan, and Microelectronics Center of N.C.—each were represented by two lobbyists ranked among the most influential.

Because power in the legislature is not as concentrated as it used to be, lobbyists have to lobby an increasing number of legislators if they want to be effective. This dispersion of power has increased team lobbying. Team lobbyists divide their responsibilities in numerous ways, says Coble, including "I'll take the House, you take the Senate," "I'll take the Republicans, you take the Democrats," and "I'll take this bill, you take that bill." Coalitions of lobbyists capitalize on the age-old adage that there is strength in numbers.

For example, Roger Bone subcontracts some of his work out to other lobbyists—one who specializes in legal issues, another who has contacts with Republicans, and another who works with African-American legislators. Farming work out in this manner allows Bone to take advantage of the different lobbyists' contacts.

Hot Issues, Hot Lobbyists

Each legislative session, some issue moves to the front burner of public attention, and lobbyists working on that issue tend to move up in the rankings. In 1993, the hot issue was health care, and many lobbyists representing clients with interests in health care ranked among the most influential. They include: Zeb Alley (1st) and Harry Kaplan (21st), representing Kaiser Foundation Health Plan; Allen Adams (2nd), representing Maxicare North Carolina; Roger Bone (3rd) and Brad Adcock (44th), representing Blue Cross and Blue Shield of N.C.; Marvin Musselwhite (8th), representing the N.C. Obstetrical and Gynecological Society; Bill Pully (9th) and John Bode (13th), representing the N.C. Hospital Association; and Janis Ramquist (14th), representing the N.C. State Optometric Society.

The high rankings of health care lobbyists were "no surprise given their big hand last year in writing—and watering down—legislation to overhaul what is a $20 billion-a-year industry in North Carolina," writes Foon Rhee, capital correspondent for *The Charlotte Observer*. "In the frenzy before state legislators adjourned, it was mainly lobbyists who cobbled together a health care bill approved at the last minute. They had copies of it before many lawmakers, and knew far more about it."[5]

The lobbyist who gained the most ground in the latest rankings, Pam Silberman, represented consumers in health care issues. Silberman, who has been a registered lobbyist since 1983, moved up from a tie for 35th in 1991–92 to 15th this year. From 1983 through July 1992, she lobbied exclusively for N.C. Legal Services Resource Center, representing low income families on health and public benefits issues. But, since the 1993 session, Silberman has lobbied extensively for comprehensive health care reform.

The N.C. Health Access Coalition, which she founded, is composed of 149 advocacy groups representing children, seniors, minorities, people with disabilities, labor, grassroots, and religious organizations. "The interest in health care reform expressed by citizens in the 1992 elections put health care on the legislative agenda," Coble says. "That, plus Silberman's individual skills, helped boost her influence." Silberman is now the deputy director of the N.C. Health Planning Commission.

Contract Lobbyists

The other lobbyist who jumped substantially in the rankings was Lawrence Bewley, who moved up from 30th in 1991–92 to 16th in the current rankings. Bewley is a contract lobbyist[6] representing 12 clients with business and industry interests, including American Express, R.J. Reynolds Tobacco, and Citizens for Property Rights. From 1978 to 1992, as senior director of the state government relations department at R.J. Reynolds, Bewley's major responsibility was the promotion and passage of a wide range of legislative initiatives by coordinating trade association and company resources. He is now president of his lobbying firm, Lawrence Bewley & Associates of Raleigh, which specializes in government relations and corporate affairs.

Ellis Hankins, ranked sixth this year, has also assumed the role of contract lobbyist. Hankins was the lead lobbyist for the League of Municipalities until February 1994. He is now with the law firm McNair & Sanford in Raleigh, representing seven clients including the Unisys Corporation, Phillips Petroleum, Lederle-Praxis Biologicals, Advantage Capital, Inc., as well as Brunswick, Sampson, and Richmond Counties.

"Lobbying for different clients, as a contract lobbyist or as part of a team, may lead to conflicts of interest in the future," says Coble. "Clients may begin to request that their lobbyists sign exclusivity agreements to ward off potential problems."

—continues on page 95

Table 1.
The 15 Most Influential Lobbyists in the 1993 General Assembly

Lobbyist and Clients	previous rankings where applicable								
	1993 **1994**	1991 1992	1989 1990	1987 1988	1985 1986	1983 1984	1981 1982	former legislator	lawyer
Zebulon D. Alley of the Raleigh law firm Zebulon D. Alley, PA, representing 18 clients with business/ industry interests including the American Petroleum Institute, Amusement Machine Association, NC Bankers Association, Carolina Power & Light Company, Citizens for Property Rights, Duke Power Company, Kaiser Foundation Health Plan of NC, Microelectronics Center of NC, Public Service Company of NC, Southern Bell, R.J. Reynolds Tobacco Company, and the NC Vending Association.	**1**	1	1	1	4	3	5	yes	yes
J. Allen Adams of the Raleigh office of the law firm Parker, Poe, Adams & Bernstein, representing 15 clients with business/industry, arts, and health care interests including Arts Advocates of NC, NC Citizens for Community Action, Digital Equipment Corporation, NC Headstart Association, Maxicare North Carolina, and the NC Retired Governmental Employees Association.	**2**	2	3	3	3	n/a	n/a	yes	yes
Roger W. Bone of the Raleigh lobbying firm Bone & Associates, representing 10 clients with business/ industry, health care, and education interests including Blue Cross and Blue Shield of NC, Chem-Nuclear Systems, NC Association of Long Term Care Facilities, NC Firemen's Association, NC Pork Producers Association, and the Tobacco Institute. Also representing the Department of Community Colleges as a legislative liaison.	**3**	4	10	14	n/a	n/a	n/a	yes	no

Table 1.
continued

Lobbyist and Clients	previous rankings where applicable								
	1993 **1994**	1991 1992	1989 1990	1987 1988	1985 1986	1983 1984	1981 1982	former legislator	lawyer
Samuel H. Johnson of the Raleigh law firm Johnson, Gamble, Mercer, Hearn & Vinegar, representing 14 clients with business/industry interests including Auto Insurance Agents of NC, Automobile Dealers Association of NC, NC Association of Certified Public Accountants, IBM Corporation, and NC Associated Industries.	**4**	3	2	2	1	2	2	yes	yes
William E. Holman representing the NC Chapter of the American Planning Association, Conservation Council of NC, NC Coalition for Public Transportation, NC Public Transportation Association, and the NC Chapter of the Sierra Club.	**5**	5	5	5	6	10(tie)	n/a	no	no
S. Ellis Hankins then representing the NC League of Municipalities, now with the Raleigh office of the law firm McNair & Sanford.	**6**	13	29	n/a	n/a	n/a	n/a	no	yes
William C. Rustin Jr. representing the NC Retail Merchants Association.	**7**	6	4	6	8	n/a	n/a	no	no
Marvin D. Musselwhite Jr. of the Raleigh office of the law firm Poyner & Spruill, representing 19 clients with business/industry and health care interests including the American Petroleum Institute, Browning-Ferris Industries of the South Atlantic, ElectriCities of NC, Hertz Corporation, Martin Marietta Aggregates, NC Obstetrical & Gynecological Society, PepsiCo. Inc., the Smokeless Tobacco Council, and the NC Association of Textile Services.	**8**	9	30	n/a	n/a	n/a	n/a	yes	yes

Table 1.
continued

Lobbyist and Clients	previous rankings where applicable								
	1993 **1994**	1991 1992	1989 1990	1987 1988	1985 1986	1983 1984	1981 1982	former legislator	lawyer
William A. Pully representing the NC Hospital Association.	**9**	15	15(tie)	30	n/a	n/a	n/a	no	yes
Jay M. Robinson representing the University of North Carolina system as a legislative liaison.	**10**	8	11	10	n/a	n/a	n/a	no	no
Jim W. Phillips Jr. representing the Office of the Governor as a legislative liaison.	**11**	n/a	n/a	n/a	n/a	n/a	n/a	no	yes
C. Ronald Aycock representing the NC Association of County Commissioners.	**12**	11	14	9	17	15	n/a	no	yes
John T. Bode of the Raleigh law firm Bode, Call & Green, representing 11 clients with health care and business/industry interests including the Bowman Gray School of Medicine, Carolina Power & Light Company, Managed Health Services, Inc., NC Hospital Association, NC Radiologists, and Southern Bell.	**13**	10	9	18	n/a	n/a	n/a	no	yes
Janis L. Ramquist representing nine clients with health care, education, and business interests including the Association of American Publishers, Learning Disabilities Association of NC, NC Association of Nurse Anesthetists, and NC State Optometric Society.	**14**	17(tie)	n/a	n/a	n/a	n/a	n/a	no	no
Pam C. Silberman then representing the NC Legal Services Resource Center, NC Primary Health Care Association, and the NC Health Access Coalition, now the deputy director of the NC Health Planning Commission.	**15**	35(tie)	37	n/a	n/a	n/a	n/a	no	yes

Karen Tam

Bill Pully of the N.C. Hospital Association (center) consults with fellow lobbyists outside a meeting of the Health Planning Commission. Health care was a hot issue in the 1993 General Assembly, fueling higher rankings for lobbyists working on health-related issues.

—*continued from p. 91*

Currently, 31 of the 50 top lobbyists—or 62 percent —represent a single client, corporation, or interest.

Clients with Clout

The Center notes that some lobbyists may benefit from the stature of their clients. For instance, there have been different individuals working as legislative liaisons for the Governor's Office and the UNC system in recent legislative sessions, yet each has consistently ranked highly. "This suggests a combination of the talent of the lobbyist and the clout of the client," says Coble. Jim Phillips Jr., former legislative liaison for Governor Jim Hunt, debuts at 11th this year. Ward Purrington, Governor Jim Martin's legislative liaison, ranked 32nd (of the 40 lobbyists ranked that year) in the 1989–90 rankings and Zeb Alley made his debut at fifth place as Governor Hunt's legislative liaison in the 1981–82 rankings.

During the 1993 session, the UNC system's legislative liaison, Jay M. Robinson, helped secure a statewide bond issue of $310 million in capital projects for 16 campuses. Robinson ranked 10th this year. D.G. Martin, Robinson's successor and a lawyer as well as a former Democratic nominee for Congress, debuts at 20th in the 1993–94 rankings. Their predecessor, R.D. McMillan, also consistently ranked among the most influential lobbyists.

Public Interest Lobbyists

Five public interest lobbyists[7] appear in this year's rankings: Bill Holman (5th), Pam Silberman (15th), Roslyn Savitt (17th), John Niblock (23rd), and Jo Ann Norris (30th). Niblock, who represents the N.C. Child Advocacy Institute, is the newcomer in this group. Governor Hunt proposed an early childhood development initiative called Smart Start in 1993, and Niblock's nonprofit institute supported Hunt's proposal. In 1993, Niblock also lobbied for the strengthening of child abuse laws and an improvement in child/staff ratios at child care centers.

Despite the appearance of several public interest lobbyists in the rankings, Lineberry, the capital correspondent for *The Herald-Sun*, is concerned that corporate lobbyists far outnumber public inter-

est lobbyists. "Obviously, business and industry lobbyists would work overtime to grease the skids for passage of a corporate tax cut, because millions could be at stake for their clients. Who would roam the halls of the Legislative Building, trying to shift a little more of the benefits of a tax cut to individuals and families? Who would argue that a cut in the sales tax—particularly the sales tax on food—might provide a more direct benefit to the state's citizens than a break for business? Not many lobbyists, that's for sure."[8]

Other Trends

- Several lobbyists ranked among those most influential in the 1993 session this time *will not return in 1995*, opening up the rankings for even more changes two years from now. Jay Robinson of the UNC System has retired; Jim Phillips has returned to his law practice in Greensboro; and, as previously mentioned, Pam Silberman has left the N.C. Health Access Coalition to become the deputy director of the N.C. Health Planning Commission.
- Janis Ramquist, who represents clients with health care, education, and business interests, is the *highest ranked woman* this year at 14th. Overall, women captured 11 of the 50 spots, or 22 percent. In the 1991–92 rankings, nine of the 37 (24 percent) lobbyists ranked were women.
- And, 21 of 50 ranked lobbyists (or 42 percent) are *lawyers*, but only nine of 50 (18 percent) are *former legislators*. Sixteen of the 37 lobbyists (43 percent) ranked in 1991–92 were lawyers, and ten were former legislators (27 percent).

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Janis Ramquist follows the action in an N.C. Health Planning Commission meeting. Ramquist, the top-ranked female lobbyist (14th), had several clients with health interests. Bill Rustin (7th) of the N.C. Retail Merchants Association also looks on.

The survey on which the rankings are based was sent to all state legislators, as well as legislative liaisons and registered lobbyists based in North Carolina, and 33 capital news correspondents. Respondents were asked to list the 10 most influential lobbyists and/or legislative liaisons of the 1993 General Assembly session. Eighty-six of the 120 House members (72 percent) responded to the Center's survey, as did 44 of the 50 Senators (88 percent), 168 of the 350 lobbyists and legislative liaisons (48 percent), and 17 of 33 capital news correspondents (52 percent). The overall response rate was a solid 57 percent.

During the 1993 session, 493 lobbyists were registered with the Secretary of State, representing 548 different companies or organizations. The Secretary of State says there are 1,141 lobbyists registered, but this figure counts the same lobbyist 10 times if she or he has 10 different clients. The Center's calculations count each lobbyist only once. There were also 205 legislative liaisons representing 25 different state government agencies and licensing boards.

The lobbyist rankings are available for $5.00 from the North Carolina Center for Public Policy Research, P.O. Box 430, Raleigh, NC 27602. They are a companion piece to *Article II: A Guide to the 1995–96 N.C. Legislature*, which is available for $22.50. *Article II* is a directory of legislators, including each legislator's educational background, occupation, list of bills introduced, committee assignments, voting records, and effectiveness rankings.

FOOTNOTES

[1] Senate Bill 906 proposed to rewrite substantially the workers' compensation laws of North Carolina. At the end of the 1993 session, the bill had passed the Senate but was pending in the House. The bill later passed the House and was ratified on July 5, 1994. The act is known as "The Workers' Compensation Reform Act of 1994" and is codified in Chapter 97 of the North Carolina General Statutes.

[2] Terry Martin, "Medical Industry Lobbyists Rank High," *Winston-Salem Journal*, Winston-Salem, N.C., Aug. 31, 1994, p. 17.

[3] Danny Lineberry, "Voice of the People Isn't Very Loud in 1994," *The Herald-Sun*, Durham, N.C., Sept. 4, 1994, p. A16.

[4] "Lobbyists Have Punch in the Halls of State," *News & Record*, Greensboro, N.C., Sept. 4, 1994, p. F2.

[5] Foon Rhee, "Medical Lobbyists Top List," *The Charlotte Observer*, Charlotte, N.C., Aug. 31, 1994, p. C1.

[6] Contract lobbyists are those who represent multiple clients on a contract basis.

[7] A public interest lobbyist is defined as someone who seeks a collective good, the achievement of which will not selectively and materially benefit the membership of the organization. This definition excludes groups which engage in some public interest lobbying but have as their primary purpose the benefit and protection of their membership.

[8] Lineberry, see note 3 above.

Center Presents Research to Legislative Study Commission on the Status of Education at the University of North Carolina

by Ran Coble

During the 1993 General Assembly, the Legislative Study Commission on the Status of Education at the University of North Carolina was set up to study, among other things, assessment and evaluation of faculty teaching, rewards and incentives for undergraduate teaching, the role evaluations should play in the rewards system, and the use of teaching assistants. On October 25, 1994, Ran Coble, executive director of the N.C. Center for Public Policy Research, was invited to speak before the commission. Coble's remarks summarize the findings of the Center's report How Do Universities in the UNC System Identify and Reward Excellent Teaching?, *published in February 1993. In his remarks, Coble commends the UNC Board of Governors, President C.D. Spangler Jr., and the General Assembly for their actions taken in the last year and a half, and identifies what remains to be done in increasing evaluation of teaching performance and rewards for excellent teaching. Below is Coble's presentation, edited for space.*

I am here today to share with you the findings of the Center's 429-page study which addresses the question *How Do Universities in the UNC System Identify and Reward Excellent Teaching?*[1] We tried to conduct our study in a spirit of cooperation and mutual respect with the University. One way of doing that is to describe the process we used for this study. The Center surveyed every department chair, dean, and vice-chancellor for academic affairs—492 people in all —at every university and got a 78 percent response rate. We also personally visited every campus. In 1990, we asked for input on what the questions should be, and then sent progress reports on the answers we were getting. And, we surveyed all 50 state legislatures and university governing bodies twice on their policies on teaching, research, and tenure. In February 1992, we sent our draft report for review to all the campuses and to UNC-General Administration. The purpose of the review process is to catch any factual errors, get suggestions for improvement,

and ensure that we have covered all sides of the issues. Finally, we briefed UNC System President C.D. Spangler Jr. and others in June 1992 and gave them the opportunity to comment on our draft findings and recommendations. Our final report was published in February 1993.

In our study, we asked two major questions: (a) How do the universities *evaluate* teaching? and (b) How do they *reward excellent teaching*?

Evaluating Teaching

In terms of evaluating teaching, we looked at the three most popular evaluation methods used in UNC system schools in 1990—(1) student course evaluations; (2) self-evaluations by faculty; and (3) peer review, or evaluations by fellow professors of a faculty member's knowledge, presentation, and organization of classes. We also looked at other evaluation methods used in UNC schools—reviews of a professor's syllabi, assignments, and tests; videotaping of faculty member's classes; exit interviews with senior departmental majors (which are used by UNC-Asheville's History department); and comparisons with national peers (which are used by UNC-Greensboro's Biology department).

Our first finding was that North Carolina's public universities lagged far behind their national counterparts in efforts to evaluate the quality of teaching. Now 99 percent of all departments in the UNC system already conducted student course evaluations, which is typical across the U.S. But only about 30 percent of all departments in the UNC system used peer review of faculty teaching, compared with 54 percent of all departments in four-year universities across the country. Furthermore, only 45 percent of all UNC system departments required faculty self-evaluation, as compared with 60 percent nationwide. Clearly, there was much room for improvement.

Therefore, we recommended that the Board of Governors require evaluations of teaching performance in all departments and that those evaluations consist of student evaluations of each section of every course, as well as at least one other objective method of evaluation, preferably some form of peer review. Almost everyone in America gets an annual review of their job performance. You as legislators probably get two evaluations—one back home in your regular jobs and then another evaluation from the voters every two years. This principle also should apply to faculty teaching in public universities.

Tenure and Promotion

Let's move to tenure and promotion because more than any other element, tenure and promotion guidelines show how universities and their divisions really view the overall work of faculty members. For example, when we conducted our research, the only regular method of evaluating teaching that was used in more than half the departments—student evaluations—was not systematically used in tenure and promotion

Almost everyone in America gets an annual review of their job performance. . . . This principle also should apply to faculty teaching in public universities.

—RAN COBLE

decisions. That is, student course evaluations were used in *merit pay* decisions but not usually in *tenure* decisions.

At your meeting in September, Dr. Roy Carroll [UNC Vice-President for Planning] gave the rationale for using student course evaluations very eloquently. He said, "If you want an opinion about the quality of the dinner, it's better to ask the diner than the chef." That too is a very good argument for student course evaluations being part of evaluating teaching performance.

> ***"If you want an opinion about the quality of the dinner, it's better to ask the diner than the chef."***
>
> — DR. ROY CARROLL, UNC VICE-PRESIDENT FOR PLANNING, ON THE RATIONALE FOR USING STUDENT COURSE EVALUATIONS IN RATING TEACHING PERFORMANCE

Overall, you had a situation a few years ago where the only method of evaluating teaching used in at least half of UNC departments was student course evaluations, and even that one method wasn't usually used in tenure and promotion decisions. That led to our second recommendation. *We recommended that the Board of Governors require that the results of teaching evaluations be linked to the three most important decisions in a professor's career—tenure and promotion decisions, course assignments, and hiring.* The reason for this recommendation was that you can require performance evaluation, but unless something is done with these evaluations, they will not be taken seriously. Our recommendation was designed not only to increase the amount of evaluation of teaching performance at public universities, but also to link these results of teaching evaluations to consequences—to the three key deci-

Table 1.
Members of the Legislative Study Commission on the Status of Education at the University of North Carolina*

Sen. David Hoyle, *Co-Chair* (D-Gaston)	Rep.Martin Nesbitt, *Co-Chair* (D-Buncombe)
Sen. Betsy Cochrane (R-Davie)	Rep. Anne Barnes (D-Orange)
Sen. Howard Lee (D-Orange)	Rep. James Black (D-Mecklenburg)
Sen. Beverly Perdue (D-Craven)	Rep. Toby Fitch (D-Wilson)
Sen. Marvin Ward (D-Forsyth)	Rep. Robert Grady (R-Onslow)
Sen. Dennis Winner (D-Buncombe)	Rep. Pete Oldham (D-Forsyth)

* At the commission's final meeting on Feb. 20, 1995, House Speaker Harold Brubaker (R-Randolph) replaced the five Democratic representatives with four Republicans and one Democrat: Rep. Frances Cummings (R-Robeson), Rep. Richard Morgan (R-Moore), Rep. William Owens Jr. (D-Pasquotank), Rep. Jean Preston (R-Carteret), and Rep. Steve Wood (R-Guilford). Brubaker also promoted Rep. Robert Grady (R-Onslow) to be the new House Co-Chair.

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UNC System President C.D. Spangler Jr.

sions in a professor's career: tenure and promotion, course assignments, and hiring.

And while we recognize that UNC system universities have different missions, *we further recommended that teaching ability and effectiveness count for at least one-third of the weight in a faculty member's overall performance evaluation. A normal performance evaluation in a public university includes looking at three areas—teaching, research, and service.* Naturally, the weight given to teaching will vary based on the individual needs and missions of universities and their departments. But the Board of Governors' policy says, and I quote: "[T]eaching or instruction is the primary responsibility of each of the UNC institutions. Thus while neither teaching nor service nor research is the sole measure of a faculty member's competence and contribution at any UNC institution, teaching should be the *first* consideration at all of the UNC institutions."[2] And if UNC says that teaching is primary among the three missions of teaching, research, and service, then teaching should count for at least a third of the weight in tenure and promotion decisions at all universities.

We also recommended that teaching should count for at least 40 percent of the weight at the Carnegie classified Comprehensive I universities, such as UNC-Wilmington, N.C. A&T, and Western Carolina, and that it should count for as much as 50 percent at the Carnegie classified Comprehensive II and Liberal Arts universities—such as Elizabeth City State, Pembroke State, and UNC-Asheville. This recommendation thus tried to respect the research emphasis of universities like Carolina, State, and UNC-G, and it tried to tier the weight so that it ascends in importance from one third at the Research universities, to 40 percent at Comprehensive I universities, to 50 percent at Comprehensive II and Liberal Arts Universities like Winston-Salem State in Sen. Marvin Ward's and

If UNC says that teaching is primary among the three missions of teaching, research, and service, then teaching should count for at least a third of the weight in tenure and promotion decisions at all universities.

Our study concluded that the public universities in North Carolina did not give enough emphasis to evaluating teaching performance. Because most institutions didn't do much to evaluate teaching, they had no basis for denying tenure to bad teachers. And perhaps most importantly, they did not systematically reward excellent teaching.

Rep. Pete Oldham's district.

At this point, I think it is important to emphasize that our report contained praise for a variety of efforts already underway. Specifically, the Center praised the efforts of UNC-Wilmington Chancellor James Leutze for his efforts to put undergraduate teaching "first in terms of time, commitment, focus, and value." The Center also had praise for three of the centers for teaching enhancement and faculty development (at Western Carolina University, UNC-Chapel Hill, and Appalachian State University). We were also impressed with specific departments, such as the English Department at UNC-Charlotte in Rep. Jim Black's district.

I think it is also very important to emphasize that this was not a study designed to attack the research function of the university. After all, we are a research organization; we value its role in public life. But every great university system has to be great at both research and teaching, and every public university system has to be great at public service also. However, our study concluded that the public universities in North Carolina did not give enough emphasis to evaluating teaching performance. Because most institutions didn't do much to evaluate teaching, they had no basis for denying tenure to bad teachers. And perhaps most importantly, they did not systematically reward excellent teaching.

Training Teaching Assistants

Now to our findings on the controversial issue of graduate students who are teaching classes. As you're probably aware, teaching assistants have come under a lot of fire for problems they're perceived to have—lack of training and preparedness, inability to speak English well enough for students to understand, and a host of other com-

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Comments on the Center's Testimony

Roy Carroll

Vice-President for Planning,
UNC General Administration

"... The Board of Governors undertook its study of *Tenure and Teaching within the University* to ensure that the quality of teaching continues to be a prime consideration in tenure decisions. The recommendations of that study have become policy. They are not options, they are requirements. Thus, now at every UNC campus: 100 percent of the departments conduct student evaluations of teaching of *all* faculty; 100 percent of the departments have adopted formal methods of peer review of faculty performance of *all* faculty; and 100 percent of the departments include, as *one method of peer review,* the direct observation of classroom teaching for all new faculty, non-tenured faculty, and graduate teaching assistants. Moreover, mission statements, tenure policies, and criteria for faculty personnel decisions give explicit recognition of the *primary* importance of teaching as mission and as a criteria for evaluating faculty performance.

"What this means is that the UNC system and its constituent institutions are ahead of their national counterparts. And if there is a need for clarification of these policies, the President and the Board of Governors of the University can do so without a statutory amendment. . . ."

—Comments continue on pages 108–109

plaints. Although not all departments in the UNC system use teaching assistants to teach undergraduate students, there are 2,918 teaching assistants in the 15 public universities that are part of the UNC system.[3] UNC-Chapel Hill alone has 1,277 graduate teaching assistants, and 56 percent of the lower division classes are taught by graduate teaching assistants.[4] The Commission on Colleges of the Southern Association of Colleges and Universities' Criteria for Accreditation contain standards for graduate teaching assistants. The Accreditation Commission's standard 4.4.4 states "An institution **must** avoid heavy dependence on graduate teaching assistants to conduct classroom instruction."[5] You might want to ask whether 56 percent qualifies as heavy dependence on teaching assistants.

We found that of the 147 departments in the UNC system that have teaching assistants, only about half—48 percent—reported having any form of training program. Therefore, we recommended that the Board of Governors and the individual universities ensure that no graduate student teaches an undergraduate course without extensive training, monitoring, and evaluation.

Let's turn to our findings on how frequently teaching excellence was rewarded.

Teaching Awards

Although tenure and promotion are perhaps the greatest (and the most lucrative) "awards" bestowed by universities, we also looked in our research at awards given specifically for outstand-

Endowed teaching chairs could help universities in the UNC system attract and build a national reputation for outstanding teaching, just as endowed chairs for research enable universities to attract and keep faculty members with excellent reputations as researchers.

ing teaching. We found that only 9 percent of all departments gave awards for excellent teaching. Only about half—55 percent—of all *schools or colleges within* universities gave teaching awards. And, where it really counted—at the *departmental* level—awards were usually only some sort of recognition—not tenure or job security, and not increased pay. Instead, the recipient's name was usually added to a plaque of departmental award winners. At the school or college level—which is several departments together—recognition for good teaching was more likely to be a monetary award. At the university-wide level, teaching awards were almost all monetary, but they were small amounts of money—ranging from about $500 to an infrequent $5,000. *But let me repeat the major finding here—only 9 percent of more than 400 departments in 15 universities gave any kind of award for excellent teaching.*

Therefore, we recommended that all departments, schools, and universities in the system consider establishing some method for recognizing excellent teaching. Although teaching awards, in and of themselves, may not cause faculty members to teach well, they do show that a university or department believes that teaching is important and worthy of reward, and they help establish a culture that's supportive of teaching.

We also recommended that universities seriously consider establishing endowed chairs for teaching. These would be lifetime positions recognizing outstanding achievement in teaching, similar to those recognizing research accomplishments. Currently, there are real differences in endowed chairs in the UNC system, with research chairs held for a much longer duration and with considerably more money attached. Endowed teaching chairs could help universities in the UNC system attract and build a national reputation for outstanding teaching, just as endowed chairs for research enable universities to attract and keep faculty mem-

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Table 2.
State Policies in Evaluation of Teaching Performance

Does your state have a policy of evaluating teaching performance in public colleges and universities?	yes	no
Alabama	■	
Alaska did not respond to this survey.		
Arizona	■	
Arkansas	■	
California did not respond to this survey.		
Colorado		■
Connecticut		■
Delaware		■
Florida	■	
Georgia	■	
Hawaii did not respond to this survey.		
Idaho	■	
Illinois did not respond to this question.		
Indiana		■
Iowa	■	
Kansas	■	
Kentucky		■
Louisiana		■
Maine		■
Maryland did not respond to this survey.		
Massachusetts		■
Michigan		■
Minnesota		■
Mississippi did not respond to this question.		
Missouri		■
Montana		■
Nebraska		■
Nevada		■
New Hampshire		■
New Jersey		■
New Mexico		■
New York		■
North Carolina	■	
North Dakota	■	
Ohio		■
Oklahoma		■
Oregon	■	
Pennsylvania		■
Rhode Island		■
South Carolina		■
South Dakota did not respond to this survey.		
Tennessee did not respond to this survey.		
Texas		■
Utah		■
Vermont		■
Virginia		■
Washington		■
West Virginia	■	
Wisconsin	■	
Wyoming		■
TOTAL	13	29

Source: N.C. Center for Public Policy Research survey..

Table 3. Which Faculty Members Are Required to Have Their Teaching Performance Evaluated?

State	all faculty	new faculty	nontenured faculty	tenured faculty	TA's
Alabama	■				
Arizona	■				
Arkansas	■				
Florida	■				
Georgia	■				
Idaho	■				
Iowa	■				
Kansas	■				
Mississippi	■				
New York	■				■
North Carolina		■	■	■*	■
North Dakota			■	■	
Oregon	■				
West Virginia	■				
Wisconsin	■				■
TOTAL	13	1	2	2	3

* See the Center's testimony, p. 111, on this point.

Source: N.C. Center for Public Policy Research survey.

Table 4. Uses of Faculty Evaluations, by State

Are the results of evaluations used as a factor in determining . . .

State	tenure decisions?	promotion decisions?	salary decisions?	merit pay decisions?	teaching awards?
Arizona	■	■	■	■	■
Arkansas		■	■	■	
Florida	■	■	■	■	■
Idaho	■	■	■	■	■
Iowa	■	■	■	■	■
Kansas	■	■	■	■	■
Mississippi	■	■	■	■	
New York	■	■	■	■	■
North Carolina*	?	?	■	?	■
North Dakota	■	■	■	■	■
Oregon	■	■			■
West Virginia	■	■			
Wisconsin	■	■	■	■	■
TOTAL	11	12	11	10	10

* See the Center's testimony, pp. 111 and 113, on this point.

Source: N.C. Center for Public Policy Research survey.

bers with excellent reputations as researchers. *Both* are needed for a great university system.

Progress and Praise: What's Been Accomplished by the UNC Board of Governors and the Legislature

Since the Center's report on teaching was released in February 1993, much progress has been made on re-emphasizing the role of teaching in public universities. I want to give credit and praise to UNC President C.D. Spangler Jr., Vice-President for Planning Roy Carroll, the UNC Board of Governors, and you as legislators.

Over the last year and a half, President Spangler and Board of Governors have adopted new policies on teaching and tenure which accomplished these six things:

1) The Chancellors were ordered to review mission statements, tenure policies, and the criteria for making faculty personnel decisions and revise them to explicitly recognize "the primary importance of teaching."

2) The Chancellors also were asked to review procedures for the evaluation of faculty performance to ensure (a) that student evaluations and formal methods of peer review are included in teaching evaluation procedures; (b) that student evaluations are conducted at least one semester each year; and (c) that peer review of faculty includes direct observation of the classroom teaching of new and non-tenured faculty and graduate teaching assistants.

3) The Chancellors of institutions without teaching awards were asked to establish awards at the institution-wide or college/school level.

4) With the legislature's help, the Board of Governors created annual systemwide teaching awards.

5) The Board of Governors said it expected all institutions without special teaching centers to create such centers as soon as possible.

6) And, in September this year, President Spangler sent out an excellent set of guidelines for training, monitoring, and evaluation of graduate teaching assistants who are assigned to teach undergraduate classes. Awards are also to be given for outstanding teaching by graduate students, and their proficiency in English is to be verified.[6]

Most of these new policies went into effect for this 1994–95 academic year. I want to publicly praise and recognize the University for the progress it has made at increasing evaluation of teaching performance, increasing teaching awards, increasing the number of teaching centers, and instituting

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better training, monitoring, and evaluation of graduate teaching assistants who are teaching undergraduates. So in large part today, I have come to praise Caesar, not to bury him.

The other progress that has been made has come from you, the members of the N.C. General Assembly, and you deserve equal praise for your efforts. As you know, during the 1993 session, this legislative commission was set up in the budget bill to study, among other things, the assessment and evaluation of faculty teaching, rewards and incentives for undergraduate teaching, the role evaluations should play in the rewards system, and the use of teaching assistants.[7] (Table 1 on p. 100 lists the members of the Legislative Study Commission on the Status of Education at the University of North Carolina.)

In that same budget bill, the legislature required the Board of Governors to allocate funds from the Reserve for University Operations to the

Comments on the Center's Testimony

(continued from page 103)

Joseph E. Johnson
Professor at the University of North Carolina at Greensboro

"I applaud the Center's interest in the quality of the student's experience at the universities.

"While I support the intent, I have major concerns with your proposals for legislation. I do not believe that it is desirable to enact statutory provisions with regard to the evaluation of teaching. Encouraging such specificity of legislative action invites meddling in all areas of academic life and in my opinion will result in efforts to control the content of the classroom and campus activities in teaching and in research. . . .

"Therefore, while I support the renewed focus on the quality of teaching and the primacy of teaching in our institutions, I believe that it is the wiser course to direct the Board of Governors to assure that teaching is the primary function at each of our institutions, and that the Board of Governors shall assure that student and peer evaluations for each faculty member are conducted annually and that such evaluations are used in conjunction with other appropriate information as the basis for personnel decisions.

"Consistent with the objective of emphasizing teaching as primary, I believe that it is desirable to direct the Board of Governors to establish policies requiring that peer review findings regarding teaching be given determinative weight in personnel decisions at each institution while allowing for exceptions for unique cases. . . .

"During my professional life, research has been the basis for the reward system and it continues to be. While I hear comments about the renewal of teaching focus, they are largely along the lines of what we have to do politically. In these times of tight budgets and enrollment pressures, administrators in particular see the issue as one of teaching loads—number of classes and hours—rather than the quality of teaching. . . .

"These thoughts may be provocative, perhaps incendiary and even helpful. On the other hand, I might have better spent my time working on my teaching."

Comments on the Center's Testimony

(continued from page 108)

Judith M. Stillion
Interim Vice-Chancellor of Academic Affairs at Western Carolina University

"[T]here are a few misperceptions in this testimony. . . . The first seems to be a confusion concerning peer review of teaching and an annual review of job performance. . . . At every college I have been associated with (six in all), faculty are evaluated annually as part of an Annual Faculty Evaluation (AFE) process. This involves a review of their teaching, research and service commitments for the year. Student evaluations are almost always a part of such reviews and most departments involve peer committees in the process, although some delegate the evaluation process solely to department heads, who are also peers. The results of the Annual Faculty Evaluation process are used for making merit pay and reappointment recommendations, form the foundation for developmental plans for the ensuing year, and lend their cumulative weight to decisions involving tenure and promotion. . . .

"The point made . . . regarding weighting teaching differently for different campuses is interesting. However, it assumes that all professors on any given campus have exactly the same assignments and skills. Professors are not cookie cutters. . . . To lay any kind of formula on constituent institutions would be to interfere with the most basic of necessary conditions for excellence: the ability of individual department heads to assign professional loads and hold faculty accountable for fulfilling them with distinction.

"In addition, different types of teaching require different types of evaluation. . . . Attempting to force a formula of any kind onto an institution that had very different styles of teaching would not be useful. . . . While I applaud the goal of your presentation, I believe that setting arbitrary percentages for teaching by type of school seriously underestimates the complexity of the multiple types of teaching and the variable professional loads necessary in every university. . . .

"One other area of concern that I have with your comments relates to the call for action represented in the proposed legislation. . . . This form of redundant micromanagement would not seem to serve the interests of the taxpayers.

"Finally, let me commend you and your organization for the work you are doing. Certainly, your report has been influential in helping to increase the visibility of teaching within the University of North Carolina, a position that we loudly applaud. Your suggestion of endowed chairs for excellence in teaching is a positive step and your understanding that teaching should explicitly count toward tenure and promotion helps to highlight its importance. While we may differ on some of the points you make, we certainly don't differ on the overall goal: to increase the quality of education for all North Carolinians attending our state's universities."

Overwhelmingly, if a state requires evaluation of teaching performance, it is required of all faculty members—including those with tenure.

Distinguished Professors Endowment Trust Fund—set up under Sen. Dennis Winner's leadership—for the establishment of endowed chairs that recognize excellence in undergraduate teaching.[8] You might want to ask the university for a progress report on how they're coming on creating endowed teaching chairs. And, in a third provision in the budget bill, the legislature required the Board of Governors to allocate $250,000 from overhead receipts each year to establish faculty awards for excellent teaching.[9]

As a result, the Board of Governors will divide that $250,000 into two equal pots—one for their new systemwide teaching awards, and one for teaching awards at each institution. The *systemwide award* winners will receive $7,500, and there will be one recipient from each of the 16 institutions. The *institutional award* winners will receive from $250 to $2,500. The seven institutions that did not already have teaching awards or had more limited resources got a total of $9,500 each (Elizabeth City State, Fayetteville State, N.C. Central, Pembroke State, UNC-Asheville, Winston-Salem State, and the School of the Arts). The other nine institutions got a total of $6,500 each to allocate. Both of these new award programs go into effect for the first time this academic year,[10] and your actions in the budget bill made this possible.

New Research on Actions by Other States

Let's turn now to what is happening in other states. Recently, we went back to all 50 states and sent a follow-up survey to state higher education governing boards or coordinating offices for higher education to determine state policies on evaluating and rewarding teaching performance in public colleges and universities. Forty-three states responded to the survey (88 percent). *Thirteen states indicated that they now have policies for evaluating teaching performance, compared to only two states a few years ago.* (See Table 2 on p. 105.) It was usually the system governing boards or the institutions themselves that initiated this requirement that teaching performance be evaluated. By contrast, in Arkansas, the governor and state legislature required the evaluation of teaching performance through a state statute that requires annual faculty evaluations. And, Florida's state legislature also crafted a state law that requires faculty evaluation.[11] *Overwhelmingly, if a state requires evaluation of teaching performance, it is required of all faculty members—including those with tenure (13 states)—and most evaluations are required at least once a year.* (See Table 3 on p. 106.) In two states, poor reviews can be used to challenge a professor's tenured status. The results of faculty evaluation are used for a variety of purposes, including tenure, promotion, salary, and merit pay decisions, as well as for determining recipients of teaching awards. (See Table 4 on p. 106.)

Only seven states indicated that their state has a system of rewards for teaching performance. Florida is the clear leader in terms of the amount of money available for teaching awards annually, with $5,300,000 in state appropriations alone. Three hundred thousand dollars ($300,000) is appropriated annually for one-time awards of $2,000 that recognize excellent undergraduate teaching and advising. Five million dollars ($5,000,000) is also appropriated annually for a Teaching Incentive Program. The Florida program provides $5,000 salary awards to faculty in recognition of excellent, productive teaching at the undergraduate level, and about 800 awards are given each year.

What Remains To Be Done

What remains to be done to ensure that teaching performance is properly evaluated and that excellent teaching is recognized and rewarded? I would suggest that this study commission recommend four needed actions to the 1995 General Assembly:

1 Make the Appropriation for Teaching Awards and Endowed Chairs a More Permanent Commitment in the State Budget

The first action needed is to make the appropriation for teaching awards and endowed chairs a more permanent commitment in the budget. Because the provisions for $250,000 for teaching awards and the use of the reserve for endowed chairs were in last year's budget bill, they will expire in June 1995 unless renewed in some way,

either in the 1995 budget bill or in separate legislation.

University officials told us that they have submitted a request to renew the $250,000 for teaching awards and an expansion request of $2 million for the Distinguished Professors Endowment Trust Fund. On the Trust Fund request, however, there is no mention of earmarking money for teaching chairs, and we think that should be added. The University's requests are included as part of Priorities #3 and #9 in the Board of Governors' budget.[12] We strongly endorse the parts of these requests that would go toward teaching awards and endowed chairs for teaching.

2 *Reinforce the University's Policy on Teaching Evaluation by Putting It in State Statutes*

The second action you should take is to put the policies enacted by the Board of Governors into the state statutes in order to affirm and reinforce the seriousness of this matter with both the public and the faculty within the institutions. Several states have done this. For example, the Arkansas legislature enacted a statute that says:

> "Each state-supported college and university shall conduct a rigorous, consistently applied, annual review of the performance of all full-time faculty members. This review shall include assessments by peers, students, and administrators and shall be utilized to insure a consistently high level of performance and serve in conjunction with other appropriate information as a basis for decisions on promotion, salary increases, and job retention. This review shall not be used to demote a tenured faculty member to a nontenured status."[13]

A recent national study of more than 4,000 faculty members across the country by James Fairweather, a researcher at Penn State, concluded that teaching simply is not valued in most universities. He found that 1) the greater the time spent on research, the higher the compensation; 2) the more time spent on teaching, the lower the compensation; and 3) the more hours in class per week, the lower the pay.

We recommend that the Board of Governors' current administrative policy be enacted into law. Such a statute would: first, restate the Board of Governors' position that teaching is the primary mission of the university system; second, restate the requirement that both student evaluations and peer reviews of teaching would be conducted at least once a year; third, make it clear that these evaluations would apply to *all* faculty—new, non-tenured and tenured faculty; and fourth, stipulate that direct observation of classroom teaching would be part of the peer review for new and non-tenured faculty and graduate teaching assistants.

3 *Clarify State Policy That Evaluation of Teaching Performance Includes Evaluating Tenured Faculty*

The third action we recommend relates to clarifying state policy in one respect. The area that needs clarification is whether the current Board of Governors' policy requiring student and peer evaluation of teaching performance applies to *tenured* faculty, as well as new faculty, non-tenured faculty, and graduate teaching assistants. The reason this is important is that more than 50 percent of the faculty in the UNC system already have tenure. Dr. Carroll has assured us that the Board's intent was to require evaluation of teaching performance of *all* faculty, including those with tenure, and we applaud him for that. Because we misunderstand the policy language passed by the Board, we wondered if others might too. So in the last few days, we called the offices of the Vice Chancellors for Academic Affairs on 12 campuses to see what their understanding was. We found that six campuses understood the evaluation policy correctly to apply to tenured faculty; five, however, said it did not apply to tenured faculty, and one said it didn't apply to tenured faculty but they were going to implement it that way anyway.[14] With that in mind, I think the Board could use your help in reinforcing in the statutes that evaluation of teaching performance applies to all faculty. That would clear up this misunderstanding.

4 *Plug Two Loopholes: Ensure That Teaching Is Given Adequate Weight, and Link Evaluation To Tenure, Course Assignments, and Hiring Decisions*

When the Fiscal Research Division was set up in 1971, I was one of the first researchers to work

Table 5.
Proposed Changes in the Statutes on Higher Education

Most statutes on higher education are located in Chapter 116 of the North Carolina General Statutes. Article 1, Part 1 contains general provisions. The only statute regarding the purpose of the University of North Carolina system is the following:

§116-1. *Purpose*

In order to foster the development of a well-planned and coordinated system of higher education, to improve the quality of education, to extend its benefits and to encourage an economical use of the State's resources, the University of North Carolina is hereby redefined in accordance with the provisions of this Article.

***

The N.C. Center for Public Policy Research proposes that the following statute be enacted to supplement § 116-1 above.

Section 1. Chapter 116 of the N.C. General Statutes would be amended by adding new sections to read as follows:

THIS SECTION WOULD ENACT CURRENT BOARD OF GOVERNORS' POLICY:

§116-11.3 *Missions of the University System*

(a) The primary missions of the University of North Carolina are teaching, research, and public service. Of these, teaching should be the first consideration at all of the UNC constituent institutions. Each institution must give explicit recognition to the primary importance of teaching in its mission statements, tenure policies, and criteria for making faculty personnel decisions.

(b) Each institution shall conduct a rigorous, consistently applied, annual evaluation of all full-time faculty members, including new, nontenured, and tenured faculty and graduate students who are teaching classes. This evaluation shall include evaluations by students at least one semester each year and evaluation by peer members of the faculty each year. Direct observation of classroom teaching shall be part of peer evaluation of teaching performance for new and nontenured faculty and for graduate students teaching classes.

THIS SECTION WOULD GO BEYOND CURRENT BOARD OF GOVERNORS' POLICY (MODELED AFTER ARKANSAS LAW):

§116-11.4 *Evaluations of Teaching Mission: Uses of Teaching Evaluations and Weight To Be Given in Overall Performance*

(a) All evaluations of teaching performance shall be utilized to ensure a consistently high level of performance and serve in conjunction with other appropriate information as a basis for decisions on tenure and promotion, salary increases, course assignments, hiring, and job retention.

(b) Each faculty member's performance should be evaluated in terms of furthering the University's missions of teaching, research, and public service. In such reviews, the evaluations of a faculty member's teaching performance shall count at least 33 percent of the weight in overall performance. The Board of Governors is authorized to adopt administrative regulations that require teaching to carry greater weight at various constituent institutions.

for you in those early years. One of the best lessons I ever got about public policy was from a representative from Asheville who told me to always write the best law you could for 90 percent of the situations and then try to anticipate the loopholes that the other 10 percent would use to try to get around the law.

There are two loopholes in the current Board of Governors' policy on evaluating teaching performance. The main loophole is that the Board of Governors' policy doesn't give guidance on the *weight* to be given to teaching in relation to the other two university missions—research and public service. And, the current policy also does not clearly require that these new evaluations of teaching performance are to be used in those three key decisions on tenure, course assignments, and hiring.

If you'll think about what's likely to happen in tenure and other decisions for the next few years, the university committees are going to be looking at file folders or portfolios full of information about a faculty member up for tenure or promotion or merit pay. In that folder are going to be a resume, all of their course syllabi, student evaluations, all of their research publications, and copies of any peer evaluations available. But for the next several years, there may be only one or two peer evaluations available, but there will be years worth of research publications. How is teaching performance going to fare in that scenario? This is one reason that we've recommended that teaching count for at least a third in all tenure decisions. Unless a weight is specified, there is a way for department chairs to beat this new process, and the Board of Governors has come too far to let that happen.

The second loophole you need to plug is to make it clear that evaluations of teaching performance are to be used in tenure and promotion decisions, course assignments, and hiring. The Board policy is very clear on requiring that student course evaluations and peer review are to be conducted as part of an overall program of evaluating faculty performance. And, though I think the Board is also clear in its intent to bring the student and peer evaluations into tenure decisions, we're not sure the policy language sent out to the constituent institutions actually says that. And, it is definitely silent on the need for teaching evaluations to be used in decisions on course assignments and hiring.

I have been a student in a system that encouraged evaluation of faculty performance but only as new information given to faculty—not as the primary tool for making policy decisions. You do not just want to create more paper that's not used. As a result of the Board of Governors' action, new evaluations of teaching performance will be on paper. What you want to ensure is that those evaluations of teaching performance are both used in key decisions and given adequate weight to fulfill the university's primary mission. And then you want the outstanding teachers to benefit from

THIS SECTION WOULD MAKE MORE PERMANENT THE PROGRAMS FOR TEACHING AWARDS AND ENDOWED CHAIRS FOR TEACHING:

§116-11.5 *Teaching Awards and Endowed Chairs for Teaching*

(a) In order to affirm that teaching is the primary mission at all constituent institutions of the University of North Carolina, each institution is to establish and administer awards to recognize and reward excellence in teaching performance. In addition, the Board of Governors is to establish and administer a systemwide program of teaching awards.

(b) In order to recognize and reward excellence in teaching and to foster a culture where teaching is the primary mission of the University of North Carolina, there is hereby established a program of Endowed Chairs for Excellence in Teaching.

Section 2. There is hereby appropriated from the General Fund to the University of North Carolina the sum of one million, two hundred fifty thousand dollars ($1,250,000) for each year of the 1995–97 biennium for making teaching awards and for establishing Endowed Chairs for Excellence in Teaching.

Karen Tam

your appropriations for teaching awards and endowed chairs.

The draft bill we propose would statutorily enact current Board policy on evaluation of teaching performance, clear up the murky area of whether tenured faculty are to be evaluated, plug those two loopholes I described, and make permanent the legislature's commitment to programs for teaching awards and endowed chairs for teaching. (See Table 5 on p. 112–113.) The draft statute is modeled after the Arkansas law I mentioned earlier, but adapted to fit the Board of Governors' current policy in North Carolina.

At your last meeting, one of your co-chairs, Rep. Martin Nesbitt, made a very astute observation. He said the only two ways the General Assembly affects policy are with money and the statutes, and that the legislature already had given the university system flexible budgeting, as well as all salary money in a block grant. If I remember correctly, he concluded, "We ate our carrot."

At the same meeting, one of your consultants, Peter Ewell, talked about the wisdom of setting aside some money for achieving legislative priorities. Your staff reinforced this by suggesting that you focus on what they called "change money" to help move forward on the legislature's priorities. Taking all this together, I think you and the University are now in agreement that teaching is the primary mission of all 16 institutions, but there is nothing in the statutes that says that. In fact, if you'll look at Chapter 116 of the North Carolina General Statutes [the chapter dealing with the University of North Carolina], there is little in the statutes at all on the University's missions.

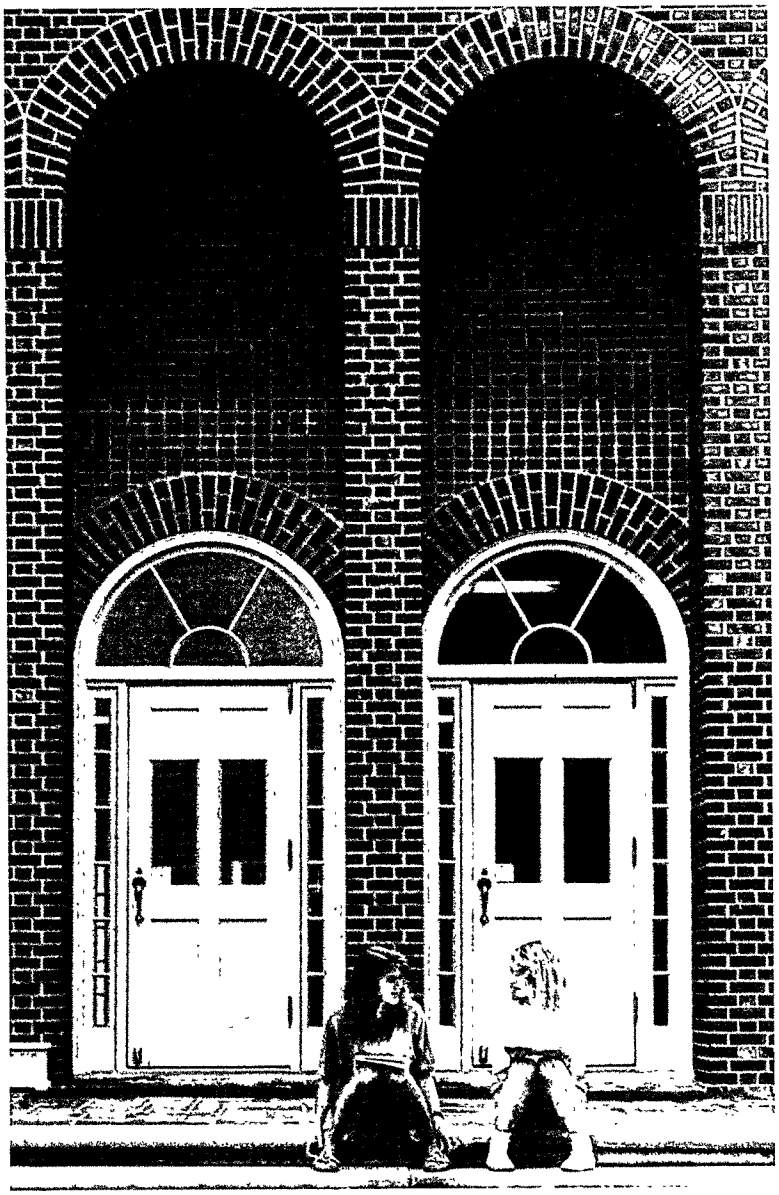
The Board of Governors has put a good new evaluation system into place. As with all state

Notwithstanding the improvements that may have taken place in the quality of undergraduate teaching in this country, the public has finally come to believe quite strongly that our institutions—particularly our leading universities—are not making the education of students a top priority.

— DEREK BOK
FORMER PRESIDENT,
HARVARD UNIVERSITY

agencies and employees, you want to ensure that performance in relation to the primary mission is evaluated. And, you've begun a pot of "change money"—the money for teaching awards and endowed chairs for teaching. The Center recommends that you reinforce the Board of Governors' policy on evaluating teaching performance by putting it into the statutes, plug the two loopholes we mentioned, and then link the policy of evaluating teaching with the carrot of increased appropriations for teaching awards and endowed chairs for teaching excellence. That would be a fine legacy for this study commission to leave.

A final word about the environment for higher education right now and the importance of what this study commission produces, because I think the public is very concerned about higher education. Both the public and the faculty seem to feel that the pendulum has swung too far toward incentives and rewards for research. If you talk to university students and their parents, you'll find concern about these issues runs very deep. Louis Harris, the national pollster, released a poll in 1993 that found that the percentage of the public that had great confidence in the people running institutions of higher education had dropped to an all-time low of 23 percent—a 59 percent decrease from the level in 1966. You see evidence of that in North Carolina in the 1993 vote on the bond package for the University system that passed by only 52 percent and which failed in 57 counties—including the home counties of Senators David Hoyle, Betsy Cochrane, and Beverly Perdue, and Representatives Toby Fitch and Robert Grady.



Karen Tam

You also might have read what the *Chronicle of Higher Education* found, as part of its Survey of Faculty Attitudes, when it asked faculty, "Do your interests lie primarily in teaching or research?" Among faculty in the United States, 37 percent indicated that their primary interest was in research, but 63 percent indicated that their primary interest was in teaching. So, almost two-thirds of the faculty *want* the priorities to lie with teaching.

Yet a recent national study of more than 4,000 faculty members across the country by James Fairweather, a researcher at Penn State, concluded that teaching simply is not valued in most universities. He found that 1) the greater the time spent on research, the higher the compensation; 2) the more time spent on teaching, the lower the compensation; and 3) the more hours in class per week, the lower the pay.

Former President of

Legislative Panel Endorses Center's Proposals on Evaluating and Rewarding Teaching in the UNC System

The Legislative Study Commission on the Status of Education at the University of North Carolina approved its findings and recommendations to the 1995 N.C. General Assembly in a final report adopted on Feb. 20, 1995. That report included five recommendations on Teaching and Learning that would carry out proposals in the North Carolina Center for Public Policy Research's report, *How Do Universities in the UNC System Identify and Reward Excellent Teaching?* Those recommendations are:

1a. The General Assembly should enact AN ACT TO IMPLEMENT THE RECOMMENDATION OF THE LEGISLATIVE STUDY COMMISSION ON THE STATUS OF EDUCATION AT THE UNIVERSITY OF NORTH CAROLINA TO CODIFY THE UNIVERSITY'S MISSION, WHICH EMPHASIZES THE PRIMARY IMPORTANCE OF TEACHING AND LEARNING.

1b. The General Assembly should enact legislation that would appropriate sufficient funds annually to establish a system of teaching awards to encourage good teaching throughout the University system.

1c. The General Assembly should enact legislation in support of the Board of Governors' policy that directs that teaching be given primary consideration in making faculty personnel decisions regarding tenure, hiring, and promotional decisions for those positions with teaching as the primary responsibility, and to assure that the personnel policies reflect the Board's directions.

1d. The Board of Governors should review its policies on peer evaluations of teaching performance to ensure that they apply to all teaching faculty, including those who are tenured.

2. The Board of Governors is encouraged to review the procedures used to screen and employ teaching assistants to ensure their ability to communicate effectively in the classroom. As part of this review, the Board may wish to consider the following issues:
   a. Whether all proposed teaching assistants and all new faculty should be required to attend teaching workshops before they teach their first classes.
   b. Whether there is a need to strengthen the role of faculty who supervise teaching assistants.
   c. Whether all faculty should attend periodic teacher training sessions.
   d. Whether teaching faculty should be required to have their teaching skills reviewed by established Centers for Teaching and Learning.
   e. Whether the English proficiency of all persons offering classroom instruction should be assessed prior to classroom contact with students.
   f. Whether undergraduate majors should take comprehensive exams to assess the degree of learning in the teaching/learning equation.
   g. If the use of contextual course evaluations would capture the unique aspects of differing disciplines and courses.

Harvard University Derek Bok summed this up by saying:

> "[R]ather than just react [to attacks on universities], we need to understand more deeply what is bothering the public. . . . Notwithstanding the improvements that may have taken place in the quality of undergraduate teaching in this country, the public has finally come to believe quite strongly that our institutions—particularly our leading universities—are not making the education of students a top priority. This is especially true for our undergraduates within the arts and sciences. . . . There are many everyday signs that betray these priorities. When we go to recruit a star professor, the bargaining chip is always a reduced teaching load—never a reduced research load. . . . They [the public] are often wrong about the facts—but they are right about our priorities, and they do not like what they see."[15]

The point that Bok makes about language is reinforced when you hear people on campuses in North Carolina speak of teaching *loads* and research *opportunities*. When we published our study, we dedicated it to some of our favorite teachers. Thanks to one of those teachers, I developed a lifelong love of history and literature. Therefore, I want to close with a quotation from one of this nation's most enduring autobiographies—*The Education of Henry Adams*. Adams was the grandson of President John Quincy Adams and great-grandson of President John Adams. He was also a history professor and the following passage underscores the importance of teaching and its long-lasting impact. Adams wrote:

> "A parent gives life, but as parent gives no more.
> A murderer takes life, but his deed stops there.
> A teacher affects eternity; he can never tell where his influence stops."[16]

We at the Center for Public Policy Research commend the members of this commission for what you have already done and what you are doing, we commend the University for what it has done, and we challenge you both to keep the momentum going. You will never know where your influence stops.

FOOTNOTES

[1] Kim Kebschull Otten, *How Do Universities in the UNC System Identify and Reward Excellent Teaching*?, North Carolina Center for Public Policy Research, 1993.

[2] The University of North Carolina Office of the President, Administrative Memorandum #338, UNC Board of Governors, "Tenure and Teaching in the University of North Carolina," Sept. 28, 1993, p. 1 (emphasis in the original).

[3] The N.C. School of the Arts was not surveyed.

[4] UNC Office of Institutional Research, *Who Teaches Undergraduates? University of North Carolina at Chapel Hill, Fall 1991*, released June 16, 1992, attachment II (The Percentage of Lower Division and Upper Division Undergraduate Courses/Sections Taught by Full Professors, Tenure Track Faculty and Teaching Assistants as the Primary Instructor).

[5] Commission on Colleges, Southern Association of Colleges and Schools, Criterion for Accreditation 4.4.4 (emphasis in the original).

[6] The University of North Carolina Office of the President, Administrative Memorandum #349, "Training, Monitoring, and Evaluation of Graduate Teaching Assistants," Sept. 22, 1994.

[7] Chapter 321 of the 1993 Session Laws, Senate Bill 27, § 101.5, pp. 78–80.

[8] Chapter 321 of the 1993 Session Laws, Senate Bill 27, § 89(d), p. 74.

[9] Chapter 321 of the 1993 Session Laws, Senate Bill 27, § 89(c), p. 74.

[10] The University of North Carolina Office of the President, Administrative Memorandum #343, "University Teaching Awards", April 29, 1994.

[11] Fla. Stat. Ch. 240.245 (1991).

[12] The University of North Carolina Board of Governors, 1995–97 Budget Request, Schedule of Priorities, pp. 124, 159, and 197–99.

[13] Ark. Code Ann. § 6-61-219 (Michie Supp. 1993).

[14] The actual language in Administrative Memorandum #338, see note 1, reads, "That the Board of Governors, through the President of the University, instruct the Chancellors of each constituent institution to do the following: . . . (c) Review procedures for the evaluation of faculty performance to ensure (1) that student evaluations and formal methods of peer review are included in teaching evaluation procedures, (2) that student evaluations are conducted at regular intervals (at least one semester each year) and on an ongoing basis, (3) that *peer review* of faculty includes *direct observation* of the classroom teaching of *new and nontenured faculty* and of graduate teaching assistants . . ." (emphasis added).

[15] Derek Bok, "Reclaiming the Public Trust," *Change*, American Association of Higher Education, July/August 1992, pp. 14–18.

[16] Henry Adams, *The Education of Henry Adams*, 1918, p. 300 (Houghton Miflin Company: Boston, 1961 edition). Adams probably underestimated the longlasting impacts of parents and murderers in his effort to emphasize the impact of teachers.

"A teacher affects eternity; he can never tell where his influence stops."

— HENRY ADAMS
FROM *THE EDUCATION OF HENRY ADAMS*

MEMORABLE MEMO

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Division Of Vocational Rehabilitation Services
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Director

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James B. Hunt, Jr.
Governor

C. Robin Britt, Sr.
Secretary

MEMORANDUM

TO: Interested Parties

FROM: Bob H. Philbeck

SUBJECT: FY 1993 Annual Report for Vocational Rehabilitation

DATE: June 24, 1994

The Agency has not published an Annual Report for distribution to the general public since FY 1972, and at least part of the slowness in getting this one out is attributed to that lack of experience. We do have it now and offer it to all our involved parties as a record of the Agency's work for that year.

We would appreciate any suggestions you might have on the Report or your views of the program. If you see ways to improve the format, it will not be long before FY 1994's edition will go to print.

BHP/ep

*Our nomination for the best impersonation of a 17-year locust: The "annual" report published by the N.C. Division of Vocational Rehabilitation Services. Actually, locusts appear with a bit more frequency than the division's not-so-annual report. But don't expect to wait two decades for the division's next report—it was at the printer in February, we hear.**

Meanwhile, the Center remains on the lookout for Memorable Memos. If you come across any that bug you, shoo them our way.

**Division Director Bob Philbeck has a simple explanation for the annual report's 21-year hiatus. In the early 1970s, the division began including its information in the annual report published by the N.C. Department of Human Resources. The division resurrected its annual report in 1994, after DHR ceased publishing a report.*

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