

Healthy People 2000 Progress Review for Black Americans

Overview

Process

In preparation for this progress review, the Office of Minority Health convened a workgroup consisting of representatives from the Office of Minority Health, Administration on Aging, Administration on Children and Families, Agency for Health Care Policy and Research, Centers for Disease Control and Prevention, Health Care Financing Administration, Food and Drug Administration, Health Resources and Services Administration, National Institutes of Health, Office for Civil Rights, Office of Disease Prevention and Health Promotion, Substance Abuse and Mental Health Services Administration, South Carolina and California Public Health Departments, academic institutions, and health related organizations within the private sector.

The charge of the workgroup was to shape the context of the progress review. This translated into choosing a theme for the progress review; recommending participants for the October meeting; examining the impact of cross-cutting issues (socioeconomic status, race, service availability and accessibility, and emerging populations of African extraction) on the movement toward the elimination of racial and ethnic disparities in health status; integrating the President's six priority areas into the review process; and providing feedback on the proposed 2010 objectives.

Data collected by the National Center for Health Statistics, the Centers for Disease Control

and Prevention, the Office of Minority Health, and the U.S. Bureau of Census was considered for review. Analysts from these agencies presented their findings at several of the workgroup meetings. The workgroup interpreted the data collectively with meaningful participation from all workgroup members. Most decisions were made by consensus.

Highlights of Workgroup Discussions

The workgroup had twelve meetings over a period of seven months. The following three issues emerged from these discussions that will frame the formal progress review on Oct. 26, 1998:

- 1) Contributing factors to health status of Black American population
- 2) Health systems measures required to eliminate health disparities
- 3) Role of communities, individuals and others in eliminating health disparities

The workgroup examined the 91 Healthy People 2000 objectives or indicators targeted for African Americans and classified them in terms of the number of objectives achieved; the number for which there exists little data; the number approaching their targets and at what rate; the number of objectives showing no change; and the number of objectives moving away from their targets. The results are summarized below in Table 1.

Table 1

Progress	Number	Percentage
Met or surpassed targets	14	15
Moving towards targets	52	53
Moving away from targets	18	20
Showing no change	4	4
No data to determine progress	7	8
Total	95	100

Data obtained from National Center for Health Statistics, 1998

The workgroup chose to feature 20 (of the 95) indicators that revealed the most dramatic trends in the 1998 Progress Review Book. In light of the health indicators that are moving away from their respective targets and the indicators that are moving too slowly to reach their targets by 2000, the workgroup members proposed that public health agencies (community, state, and national) forge linkages with organizations outside of the health arena, such as sororities, fraternities, HBCUs, the prison community, and religious and civic groups. The rationale was that this combination might deliver the “healthy” message and implement the Healthy People 2000 goals more effectively because of the relationships that these "new partners" have with their communities.

The interval of study for this progress review was 1987 through 1996. Mathematical, statistical and political reasoning were used to set the Healthy People 2000 targets. The Healthy People 2000 targets (in the majority of cases) do not address the total elimination of disparities in key health areas. Instead, they were designed to narrow the gap between

African Americans and the overall population. The elimination of disparities in key areas is a bold goal for the new millennium.

State Profiles

The workgroup took a closer look at the health status of African Americans in five states/districts which have the largest numbers of African Americans (District of Columbia, Georgia, Louisiana, Mississippi, and South Carolina) and in five states representing each geographical region in the U.S. (California, Florida, Illinois, New York, and Texas). Specifically, they looked at health status with respect to the President's six priority areas as well as one additional health area – homicide.

Parameters

In summary, the Healthy People 2000 process has revealed a potential for celebration in the African American community if current trends persist, particularly in the areas of breast cancer screening, deaths from unintentional injuries, and neonatology. The review has also signaled areas of "red alert," public health challenges that require immediate attention and resources.

Demographics

The 1996 Current Population Survey counted approximately 33.4 million African Americans; this number represents 12.7% of the U.S. population, making African Americans the largest of any minority group. This figure also reflects an increase of 3.4 million African Americans over the past six years (U.S. Bureau of the Census, Current

Population Survey 1996).

While African Americans are located throughout the U.S., they are in greater concentrations in urban areas and in the southeastern section of the country, particularly in the Mississippi Delta region. In some Mississippi counties, African Americans constitute 50% or more of the population. Coincidentally, higher rates of poverty tended to be found in the southern and southwestern states in 1996 as has been characteristic of those regions in the past (Health, US 1998).

African Americans continue to lag behind the overall U.S. population in material wealth. The median income for African American households in 1996 was \$23,482, \$12,000 less than the average median income for the nation (*Health, US 1998*). The percentage of African Americans living below the poverty level in 1996 was twice that of the overall population. Close to half of the African American population was classified as poor or near poor; and over two-thirds of black children were living in or near poverty during that same year (*Health, US 1998*).

Fewer African Americans advance to the same educational levels as the overall population, and this pattern is reflected in the workplace. In 1996, 20% of the African American population between the ages of 25 and 64 had less than a high school education and 15% had completed at least a baccalaureate degree. In comparison, 15% of the overall population had less than a high school education, and 25% had

completed at least a baccalaureate degree. While 39% of men of all races held blue-collar positions in 1996, nearly one-half of all black men in the workforce held blue-collar positions (*Health, US 1998, p. 45*). Nearly two-thirds of the remaining 50% of the black male workforce held white-collar positions, and almost all of the remainder were employed in the service sector of the economy (*Health, US 1998, p. 45*).

The occupational breakout was slightly different for African American women. Approximately 60% of all African American women in the workforce held white-collar positions; 25% occupied positions in the service industry; and 15% held blue-collar positions (*Health, US 1998, p. 45*).

Employment is a critical component contributing to economic, physical, and emotional well being. In 1996, among the civilian non-institutional population 16 years of age and older, the African American population represented the lowest annual average employment rate of any population group in the United States. Only 57.4 percent of African Americans are in the labor force, as contrasted with 64.1 percent of whites and 60.6 percent of people of Hispanic origin. As a corollary, the annual average unemployment rate for African Americans in 1996 was 11.2 percent, while the annual average unemployment rate for whites was 4.6 percent and for people of Hispanic origin 8.9 percent (U.S. Bureau of the Census, Current Population Survey, 1997).

Those African Americans who advance to the highest levels of the educational system

earn less than their white colleagues. In 1996 African American men who held at least a baccalaureate degree or more earned approximately \$12,000 less than white men with similar educational backgrounds; African American females with baccalaureate degrees or more earned \$4,000 less than white females with similar educational backgrounds (U.S. Bureau of the Census, 1998).

A single parent heads increasing numbers of African American households. In 1990 a single parent headed 50% of all African American households; in 1996 that percentage had risen to 54% with 47% headed by women and 7% headed by men. The median income of families headed by single African American females suggests that this group has not fared well economically. In 1996, the median income was \$15,530 for African American female headed households compared to \$22,370, the median income for white households headed by women (U.S. Bureau of the Census, 1998).

Health Status

According to *Health, US 1998*, "In 1996, life expectancy at birth for black males increased for the third consecutive year to a record high of 66.1 years, following a period of year-to-year declines in life expectancy from 1984-1993." Although black men are living longer, their life expectancies are 7 years less than that for all men. Black women born in 1996 can expect to live to the age of 74 which is five years less than the life expectancy figure for all women.

The leading causes of death for African Americans in 1996 included heart disease, lung cancer, cerebrovascular disease, HIV/AIDS, unintentional injuries, prostate cancer, homicide, diabetic complications, breast cancer, pneumonia, influenza, chronic obstructive pulmonary disease, and perinatal conditions. African Americans died from several of these diseases at dramatically greater rates than the overall population. For example, in 1996 African Americans died at twice the rate from prostate cancer and diabetic complications than the overall population, and the age-adjusted mortality rate for stroke for the black population was two-thirds higher than that for the overall population (*Health, US 1998*).

Two of the ten leading causes of death for the African American population, HIV/AIDS and homicide, did not rank among the top ten leading causes of death for the overall population. To illustrate this point, HIV/AIDS mortality rates for the African American population were 41 per 100,000 compared to 11 per 100,000 for the overall population. Similarly, homicide rates for African Americans were 31 per 100,000 compared to 9 per 100,000 for the overall population in 1996 (*Health, US 1998*).

These numbers just tell part of the story. The other part of the picture is revealed in the patterns that key health indicators (or objectives) have followed since 1987. Twenty health indicators that capture the most dramatic trends and for which significant data exists were selected for review. They are discussed below in the context of the Healthy People 2000 goals. (See charts for reference.)

Healthy People 2000 Priority Targets

The good news is that the Healthy People 2000 target for **cancer deaths** for African Americans has been met, and age-adjusted death rates for this disease continue to decrease. Since 1993, the incidence of **hepatitis B** has been on the decline as well, and in 1996 the target for this indicator was met. Deaths from **lung cancer** and from **unintentional injuries** have been steadily decreasing, also. The target for **lung cancer** has been met, and the African American population is rapidly approaching the target for **unintentional injuries**. However, the rate of decrease for these two indicators must be greater in order for the numbers of African Americans who die from **lung cancer** or **unintentional injuries** to approach the numbers for the overall population.

More encouraging news indicates that increasing numbers of African American women have had **breast exams and mammograms** in the past 2 years. In fact, in 1994 the percentage of black females 50 years and over that had received these services echoed the national norm. If the rate of increase continues at the present pace, the objective will be met by the year 2000. The real challenge rests in increasing the percentage of women who receive mammograms and breast examinations *on a regular basis*.

The area of neonatology offers even more positive indicators of African American health. The percentage of **low birthweight** among black infants decreased from 13.6 to 13.0 % between 1991-96. A related health indicator, **infant mortality**, has been steadily declining from 1990-96 as well. The percentage of **very low birthweight** babies, however, has

remained the same at 3.0 percent. Once again, the rates of decrease for these indicators will have to decrease *further* in order for the African American population to achieve parity with the overall population.

Coronary heart disease deaths have been declining at a steady rate since 1987, more good news. If the age-adjusted death rate continues to decline at this pace, this indicator will reach its Healthy People 2000 target.

Although homicide is one of the leading killers of African American males, the **homicide death rate** for African American males ages 15 through 34 has begun a slow decline since 1991. If the decrease in the number of homicides continues at this rate, the target will be achieved. As noted above, however, the disparity in homicidal death rates between African American males and the overall population is still alarming.

Now for the bad news. Even though several indicators (**breast cancer deaths, incidence of tuberculosis, early prenatal care, hospitalizations for pelvic inflammatory disease, incidence of primary and secondary syphilis, and pneumococcal and influenza vaccinations**) are moving in the right direction, the rate of change is too slow to meet the Healthy People 2000 target.

Finally, the shocking news. HIV incidence has been skyrocketing explosively from 1990-1995 in the following subpopulations of the African American community: heterosexual

females, female intravenous drug users, and homosexual males, all born between 1965 and 1974 (*JAMA*, June 17, 1998). The rise in AIDS incidence has been less dramatic for the entire African American community but nonetheless steadily increasing since 1989. On the other hand, AIDS incidence has remained fairly constant for the overall population over the same time period. In other words, at this rate, by the year 2000 the gap between blacks and others will be wider than ever before.

The age-adjusted **death rate from asthma** in the African American community has been climbing at a rate greater than that of the overall population (National Vital Statistics), and the number of **asthma hospitalizations** has increased since 1987, again moving away from the Year 2000 target. As with AIDS, the trend has been relatively flat for the overall population with respect to asthma hospitalizations.

This pattern of widening disparity, with the burdens of illness and early death increasing in African American population and remaining stable in the overall population, is repeated for **maternal mortality** and **diabetes-related deaths**. In fact, the age-adjusted maternal mortality rates for African American women were five times that for non-Hispanic white women in 1996.

Two indicators related to diabetes-related deaths that are complications of diabetes, **end-stage renal disease (ESRD)** and **lower extremity amputation (LEA)**, are affecting greater numbers of African Americans each year. Unlike the other “shocking” indicators (AIDS, maternal mortality, asthma hospitalizations, and diabetes-related deaths), the trends for ESRD and LEA in the overall population mirror those of the African American

community, but the diseases affect the overall population to a lesser degree.

Health Issues Impacting on Healthy People 2000 and 2010 Goals

As government policymakers, public health professionals and providers, and business and community leaders develop strategies responding to these trends by the years 2000 and 2010, they must confront new challenges and overcome old barriers. These new challenges and old barriers are discussed in the following section in the context of the cross cutting issues defined by the 1985 Report of the Secretary's Task Force on Black and Minority Health.

Health Care Access, Financing, and Seeking Patterns

Health Care Financing

In 1996, Black persons were more likely to be uninsured than were white persons (19.0 and 15.4 percent, respectively). Black persons were also more likely to receive Medicaid than were white persons (24.5 and 9.3 percent, respectively) (*Health, US 1998*, p. 362).

Access and Seeking Patterns

Today, seven out of every ten African Americans receive care through some kind of managed care arrangement, slightly more than the population at large (The Kaiser/Commonwealth Fund 1997 National Survey of Health Insurance). Further, for many adults who are now required to take low-paying jobs that do not offer health insurance, welfare reform has disrupted the continuity of care that Medicaid used to provide.

At the same time, more than one of four African Americans has no insurance at all, compared to not quite two of ten whites. In addition, approximately four out of every ten African Americans reported that they had no regular physician in 1997; whereas one out of every four white persons claimed that they had no regular physician. Fifteen percent of Blacks could not afford prescription medications; ten percent of whites could not afford prescription medications (1997 Medical Expenditure Panel Survey, The Commonwealth Fund). What's more, the percentage of black children with no usual source of care is more than twice that of white children.

The State Children's Health Insurance Program (CHIP), created in 1997 as part of the Federal Balanced Budget Act, was designed to provide about 40 billion dollars over the next ten years for states to provide health insurance to uninsured children. Under this legislation, states may either expand their existing Medicaid programs or develop new health insurance options.

Of the estimated 8-11 million children who go without health insurance, approximately 4.3 million are currently eligible for existing Medicaid insurance, and many more will be eligible under CHIP and under private programs sponsored through Blue Cross/Blue Shield companies in 25 states.

Effective outreach programs to identify and enroll eligible children into these programs will be a challenge for both the state and community-based organizations. Medicaid outreach activities are allowable administrative expenses that are matched 50-50 by the federal government (Alliance for Health Reform, May 1998).

These facts have profound implications. First, far many African Americans have no access to health care. Second, there is growing evidence that with its emphasis on managing cost, managed care may be limiting access to care for the very populations who need it most (*JAMA*, 1996, 276: 1039-1047).

Prospect for Improvement

To improve access to health care, however, both non-financial and financial barriers must be overcome. The capacity to deliver health care services to underserved populations needs to be developed and sustained must include enabling services that assist minority populations to use the health care system effectively.

Continued attention to the following key issues is required to improve access and financing of services for minority populations: (1) availability of services (health personnel and facilities) for underserved populations; (2) appropriateness of these services, particularly the need to offer primary and preventive care; (3) affordability of health insurance coverage; (4) accessibility of services to populations in need; and (5) acceptability of services, particularly in terms of quality of care and the competence of service providers to deal with client populations with different languages and cultures.

Health Professions Development

African Americans continue to be significantly underrepresented in the health professions. While only 12.8 percent of the nation's population are African American, 7.8 percent are

pharmacists; 2.7 percent are optometrists; 5.7 percent are dentists; 5.1 percent are podiatrists; 3.5 percent are osteopathic physicians; 7.6 percent are allopathic physicians; and 9.0 percent are nurses (AAMC, 1995).

African American Underrepresentation in Health Professions

Both an adequate supply and distribution of African American health professionals are essential to efforts aimed at improving the health status of African Americans.

Need to Encourage African American Youth to Remain in the Health Professions

Pipeline

According to the American Association of Medical Colleges (AAMC), most of the minority students in this country with an interest and prerequisite preparation are already applying to medical school. This finding suggests that more intensive recruiting efforts must occur prior to college graduation in order to significantly increase the number of applicants to health professions schools.

- (1) The Quality Education for Minorities (QEM) Network is initiating a project for the Office of Minority Health, Department of Health and Human Services to strengthen the academic science research infrastructure at Spelman and Bennett Colleges. This is to be accomplished through inquiry-based science instruction, seminars, proposal development workshops, and greater opportunities for students to engage in independent research (unpublished report).

- (2) The AAMC launched “Project 3000 by 2000,” a national campaign whose goal is to enroll 3000 underrepresented minority students in medical school annually by the year 2000. This is to be accomplished by establishing linkages between local school systems, high schools, colleges, and medical schools.

African American Underrepresentation on Faculties of Health Professions

Schools

The Bureau of Health Professions reports a serious underrepresentation of African Americans in faculty positions at health professions schools. A cadre of African American health professionals/academicians is needed to provide leadership; to support and advance recruitment and retention of African American students; to develop curriculum at health professions schools; and to take a lead in the framing of clinical issues, research questions, and health policy.

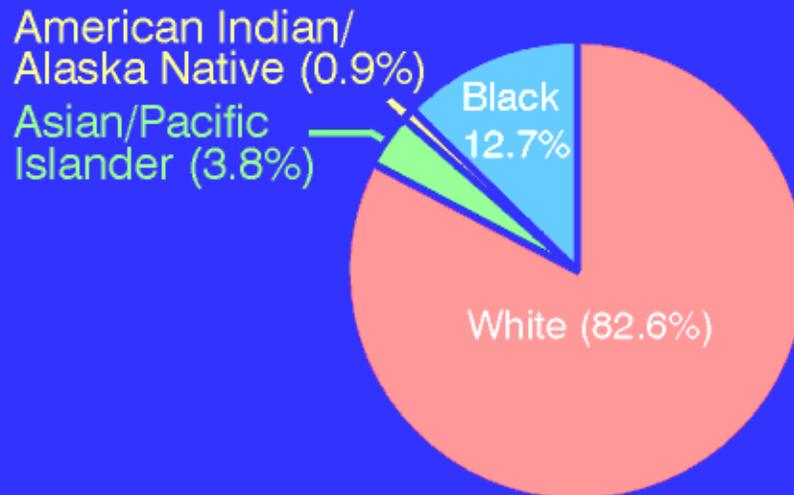
Data Collection and Analysis

Although there has been some improvement in the collection and reporting of data on the health status of African Americans, such is not the case for other underrepresented minority groups or for particular subpopulations within the African American community. In many instances, it is difficult to produce reliable data for African Americans in small geographic areas when drawing from national data sets.

Surveillance Systems

A process should be developed for identifying gaps in the Nation's disease prevention and health promotion data including gaps in the data for racial and ethnic minorities.

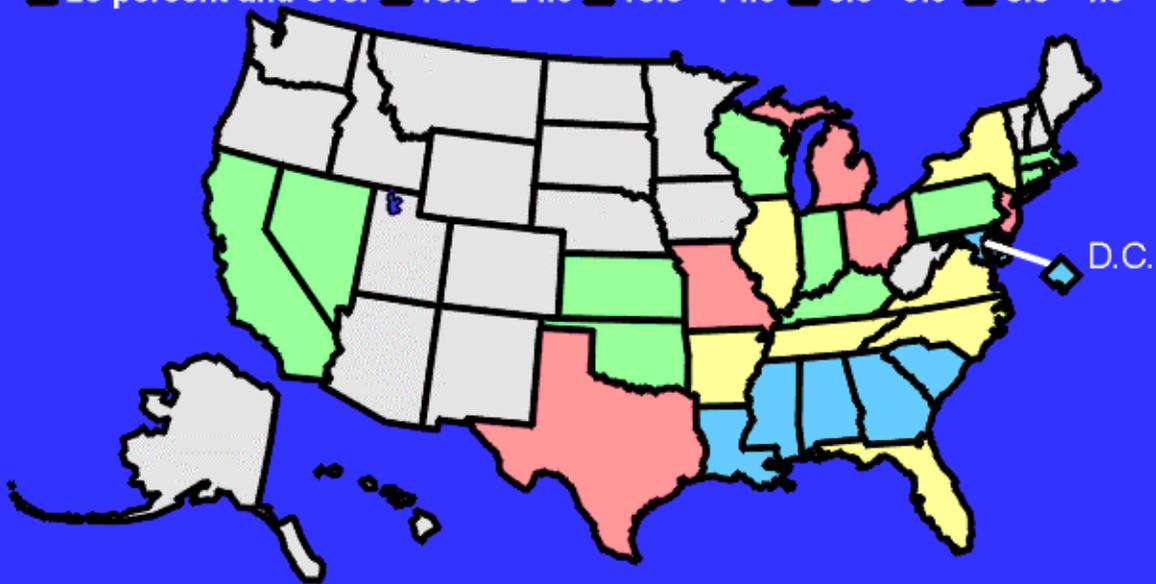
Resident population by race, July 1, 1998



NOTE: 11.3 percent of the population is of Hispanic origin, which may be of any race.
SOURCE: U.S. Bureau of the Census, Internet release date August 28, 1998.

Percent of black population in each state, 1997

■ 25 percent and over ■ 15.0 - 24.9 ■ 10.0 - 14.9 ■ 5.0 - 9.9 ■ 0.0 - 4.9



SOURCE: U.S. Bureau of the Census, Internet release date September 4, 1998