

HEALTH ISSUES IMPACTING HEALTHY PEOPLE 2010 OBJECTIVES FOR THE BLACK AMERICAN POPULATION

Access to Quality Care

Emphasis in Healthy People Objectives stress primary prevention. However, this mechanism for health promotion may not conform with the Black American's model of health seeking behavior. As a group, Black Americans have been historically disenfranchised from mainstream medical and educational opportunities, often the origin of primary prevention messages. Therefore, the adoption of the Healthy People Objectives emphasis on primary prevention as universal should be accompanied by alterations in development of primary prevention messages, and delivery systems that will facilitate access and quality care to those who are disenfranchised and not likely to access mainstream systems of health care delivery.

- ◆ *Greater attention should be paid to involving primary prevention methods into community based programs, schools, churches, clubs, neighborhoods, etc. to accommodate multiple health seeking modalities and behaviors.*
- ◆ *Schools should have an integrative curriculum that teaches children on several levels the positive benefits of primary prevention of diseases.*
- ◆ *Communities should be involved in collaborative processes that provide access to healthy behavior, e.g., proper nutrition and safe environments for physical activity. Collaboration on the development of policies that ensure comprehensive prevention modalities, such as advertising, alcohol and tobacco in neighborhoods should be implemented.*

Data Issues

Systems for data collection and reporting with respect to minorities are uneven and sometimes outdated. The sample sizes are often inadequate to give reliable estimates of progress toward objectives for the different racial/ethnic groups and subgroups of the population in each state, e.g, prenatal care, immunizations, dental care. In other cases existing data may be collected but is not analyzed for racial/ethnic groups (or subgroups) for individual states and/or rural vs. urban areas within states.

- ◆ *Federal agencies, state and other agencies/programs should be required to ensure that health-related data are collected by race and ethnicity, in order to document eligibility, enrollment, participation, utilization and health outcomes.*
- ◆ *Where data exists with identification for racial/ethnic groups for individual states and urban and rural areas, the data should, jointly with representatives of the respective communities of color, be analyzed, interpreted and disseminated to states, local governments and communities of color.*
- ◆ *Funding should be increased to permit larger sample sizes for racial/ethnic groups within states, e.g., in measuring immunization levels, access to dental care for children and adults, screening for breast and prostate cancer, etc.*
- ◆ *Develop a plan for new and/or improved racial and ethnic data collection for states for different health conditions, disabilities, hospitalization, access to health care, access to dental care, health insurance, occupational and environmental exposures and related health outcomes, etc. Determine and evaluate different options for collecting this data, e.g, targeting states with larger proportions of minorities, over-sampling, add-ons, etc., and type of collection (census, sample*

survey, institutional surveys, administration records), costs, etc.

- ◆ *Develop systems to measure the well-being, health, medical and dental care, nutritional intake, etc., of the disenfranchised, the homeless (both rural and urban), farm and migrant workers and their children, persons in jails and prisons, mental institutions and nursing homes.*
- ◆ *The HP 2010 planning group must clearly define what data is available, what additional data should be collected to measure progress toward reaching the year 2010 goals, including who will provide data and to what year data are age-adjusted to, who will collect the data and measure progress toward the goal, and what actions are to be taken if no progress is made. Data agencies and statisticians must be included in all planning and progress reviews.*
- ◆ *Monitoring disease prevention and health promotion for Black Americans during the next decade will encounter several challenges: (1) New Federal standards for racial and ethnic data, (2) New age-adjustment standard policy, (3) Developmental objectives, and (4) Census sampling.*
 - *New Federal standards for racial and ethnic data were revised in October, 1997. Three changes may affect data for Blacks: the new option to indicate more than one race, use of the term “Black/African-American” instead of “Black” and stronger recommendation that race and Hispanic ethnicity data be collected separately. Since Federal agencies have until January of 2003 to implement the new standards, a crosswalk of the old and new standards will be needed for Healthy People 2010 objectives to ensure that baseline data collected in the late 1990's and subsequent*

monitoring data are comparable.

- *New age-adjustment standard policy - Effective September 1, 1998, for deaths occurring in 1999 and beyond, all HHS agencies and programs using age-adjusted death rates must change the population standard used from 1940 to the year 2000 population (based on Bureau of the Census's projections). Use of the new standard will produce mortality data that are uniform throughout the Department, and that are more consistent with the current population structure (older) than the 1940 population standard (younger) that it replaces. In addition, it will reduce the statistical burden on State and local health agencies, and result in more effective communication with the public. This will affect the size of the mortality disparity between Blacks and Whites. Using the 1940 standard, Blacks have an age-adjusted death rate 60 percent higher than that for the White population, under the new standard Blacks will have an age-adjusted death rate 40 percent higher than that for Whites. The widening or narrowing of the race gap in mortality will be approximately the same when the same standard is used even if the magnitude of the gap itself is different.*
- *Developmental objectives - Healthy People 2010 proposed objectives include "developmental objectives" for which baseline data are not currently available. Monitoring of these objectives will require that baseline and monitoring data will need to be collected.*
- *Census sampling -- The Bureau of the Census plans to count all persons*

in the U.S. in the decennial Census in year 2000. Following up the census with sampling would improve the accuracy of the count especially for young men. For young Black/African American men especially, this under-count in the last Census was significant and can impact on the accuracy of corresponding health data and statistics. For example, an undercount of young Black American men, could result in an over-estimation of death rates for homicide and other causes for young Black American men. The decennial Census serves multiple purposes, including redistricting.

- ◆ *Occupational hazards are known to be distributed differentially, and workers with specific biologic, social, and/or economic characteristics are more likely to have increased risks of work-related diseases and injuries. Research is needed to define the nature and magnitude of risks experienced and to develop appropriate intervention and communication strategies. These research needs can be addressed by:*
 - *Identifying the interaction between psychosocial stressors (such as low pay and racial conflict.*
 - *Identifying where African Americans are working, the conditions of work, and the extent and severity of disease and injury among these workers.*
 - *Identifying chemical, physical, and biological agents which may place African American workers at excess risk for occupational morbidity and mortality.*

- ◆ *Augmenting current surveillance systems to identify and follow-up the*

occupational problems associated with these traditionally underserved minority populations. For example, special emphasis could be placed on obtaining records from health care providers serving primarily African American populations.

Research

Historically, African Americans and other minorities have been under represented in all phases of the biomedical research process. Systems for data collection and reporting with respect to minorities are uneven and sometimes outdated. Researchers have rarely examined the connection between race, poverty, occupational exposures, health disparities, as well as treatment outcomes. Blacks have traditionally been excluded both in planning and implementing biomedical and health related research, including epidemiological, behavioral and community based research and clinical trials, nor have they been included in adequate numbers to provide statistically valid estimates of health outcomes and differences if they exist. Greater participation by and for African Americans in all biomedical research is needed and this will require:

- ◆ *Development and implementation of a process to shift and increase funding to programs designed for and by the communities and minority institutions/researchers.*
- ◆ *Resources/funding that are targeted toward the minority groups that show the greatest disparities for each particular disease or other health outcome.*
- ◆ *Programs and activities that especially address primary prevention, e.g., preventing injury or the transmission of infection vs. treating injury or infection*

after it occurs.

- ◆ *Emphasis on: a) working with the communities to find out what the communities believe their problems are and support them both with funding and technical support to solve these problems and b) with the community develop, evaluate, and implement prevention and intervention strategies that are appropriate for their community.*

Cultural Competency

As we move beyond simplistic, blame-oriented social programs, more focus should be placed on incorporating community prevention that honors culture, and recognizes that no one methodology or strategy is considered right. Community prevention efforts should recognize the inherent value of multiple approaches, and ultimately multiculturalism. The Western paradigm is not always the most effective approach for communities of color.

- ◆ *Health care providers and public health professionals need to have an understanding of cultural issues relevant to minority populations and be able to provide services in a culturally competent manner if we are to get beyond the “one-size” fits all mentality of program development and implementation. Preparing public health professionals to understand the complex issues of culture and health is critical to eliminating disparities.*
- ◆ *There is a need for the development of a culturally appropriate paradigm for health promotion in African American, and other racial and ethnic communities that is not based.*

- ◆ *Cultural competency should be incorporated into all health care curriculum and health facilities.*

Infrastructure and Capacity Building

- ◆ *The development of infrastructure and capacity in communities of color to engage and participate in the health promotion and disease prevention process is imperative. This includes making resources available for the fostering of community leadership and provisions for meaningful community input into the development of programs as the norm, and an environment where health care stakeholders are fully aware of the perceptions, and needs of communities.*
- ◆ *To enhance the use of media, assuring the inclusion of multiple, concurrent strategies of ongoing communication - based on the culture of the targeted minority populations in all outreach and education efforts.*

Expanded Partnerships

Meeting Healthy People 2000 targets is challenging enough. Targets in most instances do not yet project the elimination of gaps, but rather the reduction of the huge disparities that existed in 1987 between African Americans and the society as a whole.

- ◆ *New traditional and non-traditional partners will be need to enhance those already committed. Reaching out to new partners outside the traditional health arena will be essential. These include but not limited to institutions representing the faiths community, community-based organizations, state and local*

government and the business community.

- ◆ *Assure the survival and expansion of those educational and research institutions that educate and train substantial numbers of minority health professionals, including HBCUs and HSIs, so that they can serve their respective communities.*
- ◆ *Research new methods on how best to reach underserved populations.*

EMERGING SUBPOPULATIONS

Demographics

"Diversity" is becoming a descriptor of the U.S. black population as it is of the population as a whole. Of the 33.4 million persons of African descent in the United States in 1996, two million were immigrants of African extraction (U.S. Bureau of Census, Current Population Survey, 1996.)

In 1996, approximately 6 percent of blacks in this country were foreign born; blacks comprised 8 percent of all foreign born individuals in the United States. A recent study concludes that children in immigrant families are the fastest growing component of the U.S. child population, particularly children of color (From Generation to Generation - The Health and Well-Being of Children in Immigrant Families, National Research Council and the Institute of Medicine, September 1998).

From FY 1983 to FY 1995 the United States admitted 1,264,258 refugees, entrants and Amerasians to this country. From FY 1983 to FY 1996 71,576 refugees were admitted from African countries and from Haiti. As of 1996, the U.S. Bureau of Census reports the following states and the District of Columbia as having significant numbers of black refugees: California, Florida, Georgia, Illinois, Iowa, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New York, New Jersey, Pennsylvania, South Dakota, Texas, Virginia and Washington.

Implications for Research and Health Care Delivery

The emergence of these subpopulations has important implications for research and health care delivery in the year 2000 and beyond. Policy-makers and health care providers must be prepared to revamp current practices to meet these newcomers' needs.

First, it is important to use existing systems, such as the U.S. Census, and to establish other methods to track and document the health status of these emerging subpopulations.

Just as significant health status differences have been found among Asians (e.g., Japanese as compared with Vietnamese), evidence is mounting that there are similar distinctions among immigrants and between foreign- and native-born persons of African descent. Yet, at present, data on black subpopulations are nearly non-existent.

Second, health providers must acquire a far better understanding of health-related practices, customs and traditions, and language differences among these populations.

Further, they must be able to identify potential and actual barriers to health care access and coverage which may relate to immigrant status as well as cultural differences.

Addressing Health from a Wholistic Perspective

There are several barriers to adequate health care associated with immigrant or refugee status. For example, since passage of the Balanced Budget Act by the U.S. Congress in 1997, some immigrants, particularly undocumented individuals, no longer have health care coverage or are reluctant to seek care for fear of being reported.

Black immigrants, like all immigrants, also must also deal with challenges associated with

finding gainful employment, inadequate housing conditions, language barriers, drastically different mores and values, as well as societal influences that can undermine the family structure. It is important therefore to recognize their special needs in the development of comprehensive programs and support services which will contribute to health and well-being.

Health Impacts of Imported Cultural Practices

The practice of female genital mutilation is an example of a custom that poses significant health challenges. Despite growing opposition on the African continent and around the world, this is a convention still observed by many Africans, particularly in Muslim societies.

The World Health Organization (WHO) estimated in 1993 that between 85 and 114 million girls and young women worldwide have undergone these procedures (World Health Forum 1993:15:416). A recent survey in Sudan revealed that 89 percent of all women and girls in the northern region of that country undergo some sort of genital mutilation (Obstetrical and Gynecological Survey, vol.52, no. 19, 1997).

This ritualistic practice is associated with serious medical complications, long-term health risks and mental health consequences. Women subjected to mutilation may fear exposure to American health care professionals, who in turn may be unprepared to deal with the condition. There are also possible legal consequences which must be considered when seeking and providing care.

As immigrants from Africa and the Middle East have become part of the American tapestry,

their cultural practices and traditions come with them. It is imperative therefore that they have access to medical, educational and support services that are culturally and linguistically appropriate. They have every right to expect that health providers who serve them are culturally competent and respectful of their experiences and traditions.

Lessons to be Learned

Studies of the health of immigrants in comparison to that of African Americans can be instructive in another respect. They can shed light on the relative impact and interaction of genetics, culture and environment. Lessons can be learned from research such as the referenced work by the National Research Council. Investigators examined the physical and mental health of immigrant children and their adaptation to life in the United States.

The authors were surprised to find that, although children in immigrant families (all races) in 1990 experienced a somewhat higher rate of poverty, these immigrant children tended to be as healthy or healthier than children of U.S. born parents. This health advantage deteriorated over time and by the third generation, had disappeared.

Yet another surprise was the finding that there are fewer low birth weight babies and infant deaths in immigrant families. The lower rates persisted for blacks and other ethnic groups even though U.S. born mothers have greater access to prenatal care.

The researchers called this finding an "epidemiological paradox". They suggested that immigrant mothers are less likely to smoke or use drugs or alcohol, may eat healthier

foods and may have stronger family bonds than women who have lived in the U.S. longer.

This study's authors called for new research, emphasizing the value of making comparisons between today's children in immigrant families and U.S. born black children.

They underscored the critical importance of achieving the goals of Healthy People 2000, Healthy People 2010 and the President's Race Initiative by concluding:

African American children, in particular, whose historical legacy arises from one of this nation's earliest immigration policies and from the abiding significance of race in American culture, face life chances that are often characterized by the same risks and foreclosed opportunities that are thought to apply to many immigrant children.

Additional research on the health and living conditions of emerging black subpopulations is urgently needed. It is clear that understanding and addressing their issues can result in new insights for the achievement of health equity within and among all populations in America.

"CUTTING EDGE" EMERGING RESEARCH ISSUES

Data presented for this progress review reveal often alarming disparities in health status between African Americans and the overall population. What is the driving force behind these persistent gaps is the subject of active debate in recent public health literature. Much of that literature is devoted to issues concerning socioeconomic variables, access, racism, life-style, environment and genetic predispositions to certain diseases, conditions and addictions.

The Role of Socioeconomics

Many analysts attribute racial disparities in health status to socioeconomic factors. Their premise is that advanced education brings greater awareness of health issues and preventive practices, while material resources buys access to health services. It follows then that African Americans who, on average, earn less and attain lower educational levels bear a greater burden of illness. Some researchers even maintain that there is no evidence for the hypothesis that genetic or biologic factors might explain differences in risk factors for diseases ("Health News", The Washington Post, July 28, 1998).

Racial Differences in Treatment - A Contributor to Health Inequity

Recent studies suggest on the other hand that socioeconomics alone does not adequately explain health disparities between African Americans and other racial/ethnic groups in this nation. Here are some examples:

- o In 1996, Gornick et al. found that although income had effects, there were still striking differences between even the most affluent blacks and whites

concerning treatment they received in hospitals for heart disease. Rates for angioplasty and coronary artery bypass graft (CABG) surgery were dramatically lower (N. Engl. J. Med. 1996;335:791-799).

- o In the same year, Allison et al. concluded that there were racial differences in the medical treatment of elderly African American Medicare patients who had suffered a heart attack. Twice as many whites as blacks (17% vs. 9%) were given clot-busting (thrombolytic) medications. Racial differences in treatment preference were ruled out as an explanation for these results (Journal of General Internal Medicine 11, pp. 736-743).

- o In 1997, Peterson et al. reported that blacks with severe heart disease are 32% less likely to undergo bypass surgery and 13% less likely to undergo angioplasty. These treatment differences correlate to poor survival among blacks, who are 18% more likely to die than are whites within 5 years (N. Engl. J. Med. 1997; 336:480-486).

Evidence of patterns of disparity in treatment based on race and ethnicity is mounting, even when incomes are comparable and health insurance is equally available. Whatever is at work to explain these differences, clearly institutional racism, the disproportionate, inequitable and predictable allocation of health services based on race, must be addressed as a factor. Such findings cry out for systematic data collection and examination of racial disparities in the use of services, as well as preventive, diagnostic

and therapeutic interventions at every level, particularly in federally-funded programs and systems of care.

The Role of Genetics in Explaining Racial Disparities

A second body of "cutting-edge" research deals with data of a different sort. These findings point to either 1) genetic differences between African Americans and the overall population; 2) the biologic effects of racism; or 3) a combination of the two, as explanations of racial disparities in health.

Perhaps the best known and researched example of a genetic predisposition among persons of African descent is sickle cell disease. An example of recent research that suggests a genetic predisposition comprises results from the Advanced Glaucoma Intervention Study, which indicate that blacks with advanced glaucoma benefit more from a regimen that begins with laser surgery, while whites benefit more from one that begins with an operation called a trabeculectomy (Ophthalmology 1998: 105, pp. 1146 -1164).

Similarly, two studies in a July 1998 edition of the Journal of the American Medical Association offered new evidence on the effects of tobacco on African American smokers.

One group of researchers found that there were higher serum cotinine levels among blacks as compared with white or Mexican American smokers. The other authors concluded that higher levels of cotinine per cigarette (related to slower clearance of the substance) could be related to higher intake of nicotine (JAMA 1998; 280:152-156).

These results could explain why African Americans suffer from such smoking-related illnesses as coronary artery disease, lung cancer and low birth weight at greater rates than the overall population. However, these findings do not take into account important data showing that more than three times as many blacks smoke menthol cigarettes as whites a pattern which could result in additional physiological complications. These findings also do not explain the lower incidence of chronic obstructive pulmonary disease (COPD), another smoking-related disease, among African Americans as compared to the overall population (JAMA, op. cit.)

Scientists are also looking to DNA research to explain the higher incidence of prostate cancer among African Americans. Preliminary data are available that both support and refute this notion. The even higher incidence of prostate cancer reported among Jamaican men in 1992 (compared to African American men) suggests a genetic link. However, other findings reveal similar cell alterations among white and African American cancer patients (J. Urology 1998 Jun; 159(6):1984-6, Clin. Cancer Res. 1998 May; 4(5):1273-8). More light will undoubtedly be shed on this discussion once researchers at Howard University complete their work on the role of DNA in prostate cancer among African American men.

Challenges to the Genetic Explanation for Health Disparities

Notwithstanding the emergence of data suggesting genetic links, challengers also have evidence on their side. Research on hypertension for example is likely to be inconclusive. Onions et al. reported in a 1998 study that the leptin gene (OB) is not a major contributor to the phenotype of essential hypertension in African Americans (Hypertension 1998;

31:1230-1234). On the other hand, Cardillo et al., writing in the same edition of Hypertension, found that blacks have a reduced nitric oxide-dependent vascular response during mental stress, which may play some role in the greater prevalence of hypertension and its complications in this group.

Another explanation links a genetic explanation for hypertension with external stimuli associated with the slave trade. Grim and Wilson hypothesize that the harsh trans-Atlantic voyage eliminated those Africans who were not genetically equipped to conserve salt. These individuals survived and passed their efficient salt-retaining genes to subsequent generations. Their descendants retained therefore a capacity they no longer need to retain salt, and hence, suffer disproportionately from salt-sensitive hypertension (Pathophysiology of Hypertension in Blacks, Oxford University Press, 1993).

Asthma is also a health condition where genetics and external circumstances may intersect. In 1997, Nelson et al. concluded that black middle class children had twice the prevalence of asthma as white children in the same income group with similar access to medical care and in similar environmental conditions. The researchers called for further studies to evaluate biologic and environmental factors (including environmental pollution by toxic substances) in order to explain these differences (Annals of Allergy, Asthma, & Immunology: 78, pp. 21-26.)

The strongest challenges to the "genetics only" theory comes from those conducting cross-cultural studies. Feldman found that there are greater genetic variations within a racial

group than between racial groups (Cancer, Jan. 1, 1998, vol. 82, no.1). The work of David and Collins also weakens the genetic argument. In a comparison of the incidence of low birth weight babies among white, sub-Saharan African and African American women in Chicago, they found that white and sub-Saharan women had comparable rates of low birth weight babies (4.3 and 7.1 percent, respectively), while African American women eclipsed both groups (13.2 percent). (New Engl.J. Med 1997; 337:1209-14)

Focus on Culture and Life Style

More studies addressing risk factors associated with life style differences, such as obesity, physical inactivity and smoking, are also beginning to emerge. Researchers at Stanford University School of Medicine reported in July 1998, for example, on their analysis of NCHS data involving over 5,000 African American, Mexican American and white women. They concluded that cultural or even genetic differences among ethnic groups were more likely to explain variations in heart disease risk than was socioeconomic status. This is an area in which much more research is needed (The Washington Post, op.cit.)

Another important factor to be studied is the impact of the stress of living in an environment in which race remains a compelling reality. This is a dimension of the black experience which may well explain persistent health disparities unaccounted for by other factors. A critically important area for future research is the examination of psychological and physical responses among African Americans to the unique black/white connection in America an experience that no other racial/ethnic group shares.

Call to Action: A National Commitment

Historically, African Americans and other minorities have been underrepresented in all phases of health-related research. For example, blacks have not participated in numbers commensurate with their incidence in the total population in clinical trials as research investigators or subjects. Systems for data collection and reporting on utilization and outcomes by race and ethnicity are uneven and uncoordinated and with respect to managed care plans, nearly non-existent.

Given the complexity of these issues, funds must be allocated for research in all areas genetic, biological, behavioral, anthropological designed and conducted by African American researchers, historically black colleges and universities (HBCUs) and other black organizations involved in health care delivery and research. Systematic data collection by race and ethnicity is also a prerequisite if we are to determine whether discriminatory rationing of health care by health care providers and institutions is a myth or reality. (Editorial, New England Journal of Medicine 1996; 335:11).

Whether they point to genetics, behaviors, environmental factors or institutional racism, nearly all studies underscore one fact. Race has profound effects on the health of African Americans. As Dr. Martin Luther King once said: "Racism is a sickness unto death". Nothing less than a national commitment, commensurate with the challenge, will lead to a cure.