The State of Black Health: Where Do We Stand?

BY JUDITH SPRINGER RIDDLE

Have you ever felt disrespected, rushed or not taken seriously when interacting with doctors or other healthcare professionals? Do you find it difficult to access quality care? Have you ever discovered that you weren't told about the latest therapies or referred to the best specialists?

If you've answered yes to any of these questions, you are not alone. Despite incredible advances and breakthroughs in disease prevention, diagnostic screening, surgical techniques and curative medicine, Black people receive a significantly lower level of health care than Whites. And this has caused a major health crisis in the African-American community.

Black folks are twice as likely to develop diabetes than non-Hispanic Whites, and to experience blindness, lower-limb amputations, kidney failure and other associated complications. Heart disease is now the leading cause of death for us, followed by HIV/AIDS and cancer.

A recent report published by the Institute of Medicine (IOM)—called "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care"—revealed staggering evidence that African-Americans are less likely than Whites to receive bypass surgery, heart-disease medications, cutting-edge therapies for HIV infection, and kidney transplants. The report also shows that many Black Americans aren't getting quality mental-health care, pain-management drugs, and tests and treatments for cancer.

Another recent study, from the *New England Journal of Medicine,* offered more damning evidence: African-Americans are less likely than Whites to receive a potentially life-sparing surgical treatment for early-stage lung cancer, the report shows, and we are dying sooner as a result.

Why are we receiving such inferior health care? There's no single answer. Twenty-two percent of African-Americans lack health insurance. Many of us who do have coverage may find that our insurance plans pay for a limited range of health services. But even when insurance status, income and education levels are equal to those of Whites, we still receive second-rate health care, according to the IOM study. This fact has led many in the medical community to conclude that healthcare workers' racial biases play a major role in the disparities.

A recent study from *Psychosomatic Medicine* bluntly assesses the issue: "Ethnicity impacts the course of illness and medical treatment."

Given this disheartening state of affairs, *HealthQuest* spoke with several top African-American healthcare professionals and thought leaders to get a deeper, fuller understanding of the health status of Black people in this country. In a lively discussion, our panel of 18 experts spoke candidly about the most critical health issues impacting our communities, and about the social, cultural and political dynamics shaping our health experience. Most importantly, they told us what we must do collectively and individually to change our prognosis.

Participants

Claude A. Allen, deputy secretary, U.S. Department of Health and Human Services (HHS) in Washington, D.C.

Otis W. Brawley, M.D., professor of medicine, oncology and epidemiology at the Winship Cancer Institute at Emory University School of Medicine in Atlanta.

W. Michael Byrd, M.D., senior research scientist at the Harvard School of Public Health in Boston, and co-author of *An American Health Dilemma: A Medical History of African Americans and the Problem of Race: Beginning-1900,* and *An American Health Dilemma: Race, Medicine, and Health Care in the United States: 1900-2000.*

Frances J. Dunston, M.D., M.P.H., professor and chairperson of the department of pediatrics, and professor of community health and preventive medicine at Morehouse School of Medicine in Atlanta.

Caswell Evans, D.D.S., M.P.H., scientific editor and project director of the Surgeon General's Report on Oral Health, and director of the National Oral Health Initiative at the office of the U.S. Surgeon General at the National Institutes of Health (NIH) in Bethesda, Md.

Marilyn Hughes Gaston, M.D., medical adviser to National Minority Health Month and author of *Prime Time: The African American Woman's Complete Guide to Midlife Health and Wellness*; former Assistant Surgeon General of the U.S. Public Health Service and director of the Bureau of Primary Health Care in the Department of Health and Human Services.

C. Alicia Georges, Ed.D., R.N., assistant professor and director of the graduate program at Lehman College in the Bronx, N.Y., and former president of the National Black Nurses Association.

Risa Lavizzo-Mourey, M.D., senior vice president, director of health care at the Robert Wood Johnson Foundation in Princeton, N.J., and co-vice chair of the Institute of Medicine.

LeSalle D. Leffall Jr., M.D., chairman of the board of the Susan G. Komen Breast Cancer Foundation and Charles R. Drew professor of surgery at Howard University College of Medicine in Washington, D.C.

Thomas Obisesan, M.D., M.P.H., board member of the National Caucus and Center on Black Aged, chief of geriatric medicine at Howard University Hospital, and medical director of the Washington Center for Aging Services in D.C.

Thomas Parham, Ph.D., assistant vice chancellor of counseling and health services, and director of the counseling center at the University of California-Irvine; past president of the Association of Black Psychologists.

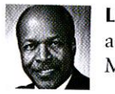
Lucille C. Norville Perez, M.D., president of the National Medical Association (NMA) and associate director for the Center for Substance Abuse Prevention at the mental health services administration at the Department of Health and Human Services.

Deborah Prothrow-Stith, M.D., M.P.H., professor of public health practice at Harvard School of Public Health in Boston.

Barbara Ross-Lee, D.O., vice president for health sciences and medical affairs, and dean of the school of allied health and life sciences at New York Institute of Technology, Old Westbury, N.Y.

Nathan Stinson Jr., M.D., Ph.D., deputy assistant secretary for minority health, Department of Health and Human Services, Rockville, MD.

Gregory Stoute, D.M.D., chief of dental services at Harvard University and president of the National Dental Association in Boston.



Louis W. Sullivan, M.D., former Secretary of Health and Human Services and current president of Morehouse School of Medicine in Atlanta.

Phill Wilson, executive director of the African American AIDS Policy and Training Institute in Los Angeles.

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Barbara Ross-Lee, D.O.

HQ: ***What is your assessment, or prognosis, of the state of Black health in this country?***

LOUIS W. SULLIVAN, M.D.: African-Americans today are a lot healthier than they were 30 years ago. We've made a lot of progress. Blacks have a lower infant mortality rate than the nation did in the 1970s. So that's good news. [Yet] today, the health status of Black Americans is much poorer than that of Whites. Death rates for stroke, heart disease, HIV/AIDS, diabetes and infant mortality are two to three times higher for Blacks than for Whites. Life expectancy for White men and women is 74.5 and 80 years, respectively, versus 75 and 66 years for Black women and men.

CLAUDE A. ALLEN: There have been improvements in many areas of our health in the 1990s. The statistics will tell you that we've made significant progress in recent years, but we have a long way to go. There's no dispute that health disparities exist in our nation. We are impacted gravely by chronic diseases that are devastating our communities. But when you look at the causes of cardiovascular disease, cancer, HIV/AIDS, hypertension, stroke, and diabetes, you realize that all these illnesses can be prevented or treated with early intervention.

BARBARA ROSS-LEE, D.O.: Our health status has improved, but at a much slower pace than Whites. Our nation is capable of delivering the best medical care in the world, but Blacks are still suffering from diseases at a rate comparable to Third World countries.

HQ: ***Define racial health disparity?***

LUCILLE C. NORVILLE PEREZ, M.D.: It's the difference in disease prevalence and death rates in a given population because of racial prejudice, stereotypes and lack of cultural understanding.

HQ: ***What are the major causes of health disparities among our people?***

RISA LAVIZZO-MOUREY, M.D.: Not having health insurance. Many African-Americans are uninsured or under-insured, so they can't afford to see a doctor. And the lack of trust in the healthcare system keeps us out of doctors' offices. The causes of this mistrust, including what can be done to reverse it, are the subject of the Institute of Medicine report, "Unequal Treatment."

OTIS W. BRAWLEY, M.D.: Racism plays a major role. Every NIH-funded clinical trial has to be designed to test whether there are biological differences among the races that influence the effectiveness of drugs. This causes people to assume that certain drugs won't work for Blacks. That whole approach to me is racist. Study after study has proven that equal treatment yields equal outcome. Race doesn't matter biologically; race matters socially and politically.

W. MICHAEL BYRD, M.D.: Historically, racism has been a major cause of health disparities among our people. It has always affected Black people's health and the way they receive health care. The United States healthcare system from its very beginnings was structured on the basis of race and class. As far back as the first century, European and American physicians and scientists began ranking African-Americans and other ethnic minorities as inferior to Whites biologically, physically and intellectually. And these classifications were taught in virtually all science courses and medical schools across the country and abroad.

We've endured 246 years of slavery, followed by 100 years of discrimination, exploitation and brutalization. Though the march toward racial equality has been unsteady and is far from over, the last great leap forward ended when the civil rights era came to a close in 1970. So we've enjoyed fewer than 50 years of our citizenship rights such as voting, equal protection under the law, and hospital desegregation. America's hospitals were only required to desegregate by law after 1965.

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Louis W. Sullivan, M.D.

C. ALICIA GEORGES, ED.D., R.N.: We don't have enough Black doctors and nurses in the medical profession. There are 2.6 million registered nurses, of which only 4.9 percent are Black. And we're mostly over age 45, so we're not going to be in the profession much longer. Then there's the issue of cultural competence. White doctors and nurses aren't learning about the different cultures within ethnic minority groups. We need to teach them about these cultures to dispel the myths they have about African-Americans and other minorities. We have to bring in more racially diverse physicians to speak to them about cultural differences and how people want to be treated.

HQ: ***What are the most critical health issues impacting the lives of African-American men and women?***

LOUIS W. SULLIVAN, M.D.: African-Americans have the highest incidence of obesity they've ever had due to inactivity and high-fat diets. And this leads to Type II diabetes and heart disease. Black men have the highest incidence of prostate cancer in the world. So clearly our health status leaves much to be desired.

NATHAN STINSON JR., M.D., PH.D.: Medical experts suggest that Black men begin prostate cancer screening at age 40 versus age 50 for White men, because we develop it at a younger age. Prostate screening should become part of a routine physical exam once a Black man turns 40. But we don't go to the doctor; utilization of the healthcare system is low for African-American men between the ages of 15 and 40. It's during those years that you may catch an illness at its earliest stage, when there are no symptoms.

C. ALICIA GEORGES, ED.D., R.N.: What frightens Black women more is breast cancer, when it's heart disease that they should really be worried about. If an African-American woman has a heart attack, she is more likely to die from it than a White woman. The biggest concerns for 35- to 65-year-old Black women are our risk factors for Type II diabetes and heart disease, such as belly fat, high cholesterol and high blood pressure.

MARILYN HUGHES GASTON, M.D.: Premenopausal Black women are diagnosed more frequently with breast cancer and are more likely to die from it than premenopausal White women. If we're postmenopausal, we're diagnosed less often but still die from it more than postmenopausal White females. We don't have access to high-quality care, and we're being diagnosed during later stages of the disease.

OTIS BRAWLEY, M.D.: My greatest concern is colon cancer. In the 1970s, the colon cancer death rate was the same for Black and White men and women. But since 1980, death rates have grown more disparate because of early detection and treatment differences. We have enough data proving that equal treatment yields equal outcome. So one must speculate that there isn't equal treatment.

BARBARA ROSS-LEE, D.O.: In addition to the 15 leading causes of death, which disproportionately affect African-Americans, diet and obesity are emerging as critical health issues. African-American diets are heavy in salt and pork. Obesity is more socially tolerated in the Black community than in the White population. We like some extra meat on our bones. But this [line of thinking] has to change, because exogenous obesity is associated with the incidence of diabetes, hypertension and stroke (to name a few).

HQ: ***What about our children?***

FRANCES J. DUNSTON, M.D., M.P.H.: The good news is that cigarette smoking rates and IV drug use among African-American children have declined. But overall, they

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aren't enjoying the same health status as Caucasian children in this country. The number of children who are adequately immunized by age 2 is lower for African-Americans than for Whites. Chronic asthma and its complications are far worse in Black children than in Whites. Childhood obesity is an epidemic that's causing Type II diabetes in kids as young as 11 and 12. Diabetes and obesity are precursors to cardiovascular disease, which usually results in clogged arteries, heart attack and stroke later in life. So we're very concerned about this in children. Sudden infant death syndrome (SIDS) has decreased dramatically in the last five years, but not in the African-American population. Our children are dying from SIDS at twice the rate of Whites.

HQ: ***How do socioeconomic factors play a role in our receiving lower-quality health care?***

BARBARA ROSS-LEE, D.O.: Poverty is directly related to poor health. Because health care is a business, physicians, hospitals and other healthcare providers avoid delivering services in poorer communities. Furthermore, when you're poor, the environment in which you live tends to be less healthy. For instance, disease-bearing insects (cockroaches, bed bugs, mites), asbestos, lead-based paint and rats are common inhabitants of a poor person's environment—all of which lead to an increased incidence of illness.

OTIS BRAWLEY, M.D.: When a middle-class, insured woman gets a mammogram, she goes to an upscale facility where she's examined first, then given a mammogram. Her films are read immediately while they're still dripping wet. If the film is hard to read, a retest is taken. Poor women get their mammograms from a mobile van, where they are not examined. Their films are taken to another place where it is read by someone else who never examined the patient. The opportunity to compare the physical exam with the films is zero. So the quality of the poor person's mammogram is lower than that of the middle-class woman's.

DEBORAH PROTHROW-STITH, M.D.: Lower socioeconomic status plays a huge role in the type of care Black people receive. But even when we have the same insurance, income level, education and symptoms, African-American patients don't get the same treatment as Whites. There's something about race that shapes the social, cultural and political environment that results in poorer health outcomes for us.

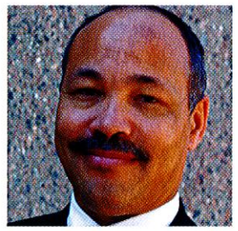
HQ: ***What population in the African-American community is the most vulnerable healthwise? And why?***

LOUIS W. SULLIVAN, M.D.: The elderly poor are suffering the most. Frequently they live alone; they're shut in; they don't have a strong support system; they're unable to get to the doctor, and they may be demented. They need prescription drugs for multiple chronic illnesses such as heart disease, kidney disease, diabetes, and hypertension that aren't covered by Medicare. And this hits them especially hard because they have to pay everything out of pocket on a fixed income. They can't afford it.

THOMAS OBISESAN, M.D., M.P.H.: Depression is another issue. If an elderly person gets depressed, he or she may become socially isolated. Associated poor appetite leads to undernourishment. Combination of undernourishment, social isolation, and low levels of physical activity leads to generalized weakness and rapid loss of physical function. As they slip into deeper and deeper depression, they become bedridden, develop bedsores and other medical complications. Unless they're seeing a geriatrician, their depression will often go unrecognized because it manifests itself differently in the elderly.

HQ: ***What are the concerns regarding the mental health status of African-Americans?***

THOMAS PARHAM, PH.D.: Most Black folks are mentally healthy. We're living very happy, normal, healthy and



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productive lives, and are going about our business, despite the numerous socially oppressive obstacles we must confront daily. There are, however, those who do struggle with mental illness issues that create mild, moderate and even severe debilitations in their lives. They struggle with depression, anxiety, substance abuse and even schizophrenia. Like other areas of health, poverty influences our access to quality mental-health care as well. When accessing treatment, our desire for services is sometimes tainted by factors like the lack of convenient facilities, and a history of being misdiagnosed and inappropriately treated, particularly when clinicians lack the cultural competency skills and the psychological instruments necessary to effectively intervene with African-descent people. Despite these hardships some experience, African-Americans are struggling to persevere in the face of both adversity and perceived prosperity. Their posture is similar to the one advocated in the old [Negro] spirituals, where persevering through hardship and "keep on keepin' on" were the mantras of hope.

So, while the conditions described above are mental-health concerns, it is also true that mental illness can sometimes be related to things that are not easily diagnosed, like the damage to our psyche from oppression, degradation and discrimination in this country. It is true that I also believe that one of the biggest mental-health challenges facing us as a people is the need for mental liberation. That diagnostic possibility will be difficult to find in a standard clinical nosology, however. Instead, we, as African-descent people, will have to examine our own psyches for inappropriate levels of dependence on the larger White society for self-definition.

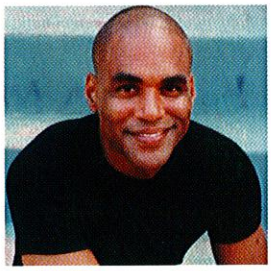
HQ: ***What is your assessment of our oral health in the African-American community?***

GREGORY STOUTE, D.M.D.: Dental disease is the nation's silent epidemic, because cavities are the single most common childhood ailment—five times more common than asthma, and seven times more prevalent than hayfever. So this gives you an idea of where we are. Oral cancer rates for African-Americans are 65 percent higher than those for Whites, whose five-year survival rate is about 52 percent. For Blacks, it's 34 percent, because it's detected too late. Most of this is attributable to inadequate access to care. There simply aren't enough Black dentists in this country to go around, who would normally practice in their own communities.

CASWELL EVANS, D.D.S.: The statistics across the health spectrum are tilted to the bleak side. In general, we've got more of the worst and least of the best of oral health conditions. But there are areas where we fair better than the general population. For example, Whites have three times the rate of cleft lip and palate, a disfiguring facial abnormality that requires surgical correction. African-Americans also have a substantially lower prevalence of oral herpes simplex infections when compared to other population groups.

HQ: ***Describe the impact HIV/AIDS is having on our communities. And what can be done to reverse this damaging trend?***

LUCILLE C. NORVILLE PEREZ, M.D.: The disease is devastating the Black community. It's wiping us out. For the past 20 years, most of the prevention and treatment strategies have been targeted to gay White males. But one size doesn't fit all. Our communities aren't given the money to develop HIV/AIDS prevention programs to educate ourselves. There hasn't been anyone who looks like us to deliver the message. So we don't associate ourselves with the AIDS epidemic. But we can educate our people through the Black churches and community-outreach programs. We need to get more Black doctors involved in clinical trials to attract African-American patients who will then gain access to new drug therapies.



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Phill Wilson

PHILL WILSON: No matter how you look at it, African-Americans are disproportionately impacted by HIV/AIDS. Black women are one of the fastest-growing populations at risk for HIV infection. AIDS is the second leading cause of death for Black women between ages 25 and 40. It's the leading cause of death for Black men in that same age group. Over two-thirds of all children under the age of 13 with AIDS are Black, 40 percent of men with AIDS are Black and over 30 percent of men who have sex with men with AIDS are Black men. In fact, if you are under 30, Black and gay in the U.S., you are more likely to be infected with HIV than if you lived almost anywhere in sub-Saharan Africa. To stop the AIDS epidemic, we have to increase the number of African-American HIV/AIDS organizations. The few that do exist are much too small and under-resourced to sustain an effective response to the HIV/AIDS pandemic.

HQ: ***What steps do you think must be taken to eliminate racial disparities in health care?***

BARBARA ROSS-LEE, D.O.: Policymakers must make a commitment to address and eradicate health disparities. It has to be at the top of the nation's agenda. Our educational institutions must train our doctors and nurses to be culturally sensitive to reduce disparities in screening and treatment decisions. And our communities need to take action in informing the vulnerable populations about health promotion and disease prevention. Then we have a chance to make a radical difference in the next five to 10 years.

CLAUDE ALLEN: HHS is partnering with various media organizations like the ABC Radio Network to launch education campaigns in African-American and other ethnic communities. We're working with the departments of health in different states through our Healthy People 2010 initiative to promote health education. Community involvement is essential to reach under-served areas. We're focusing on infant mortality, cardiovascular disease, cancer, HIV/AIDS, child and adult immunizations, diabetes, and the access to health care issue.

HQ: ***What advice would you give to African-American families to help navigate their way successfully through the healthcare system to ensure they receive the highest quality of care?***

BARBARA ROSS-LEE, D.O.: Your healthcare provider has an obligation to explain what's being done to you, what's going on with you, and what your options are, so that you can make informed choices about your treatment and overall health.

C. ALICIA GEORGES, ED.D., R.N.: Take someone with you when you visit the doctor. Get your doctor's instructions in writing and have him or her go over it with you and your family. Make sure you can call back the doctor or someone else in the practice if you have additional questions. Do some research on the Internet, but only go to sites developed by the government, like the Centers for Disease Control (CDC) or the National Institutes of Health (NIH). The disease-specific societies and organizations like the American Diabetes Association (ADA), American Lung Association (ALA), or the American Heart Association (AHA) are wonderful.■