1991 ACE CONFERENCE - TRANSCRIPT SUMMARY

DRAFT

Dr. Castro

The annual incidence of AIDS/million population has risen significantly from 1982-1989. The rate for Blacks was four times that of Whites, and lower for native Americans and Pacific Islanders. The highest rate ratios are among Black and Hispanic bisexual men who inject, relative to non-Hispanic White men who were homosexual.

Between 1986 - 1989, the rate of gonorrhea decreased 50% among Whites and 13% among Blacks. Additionally, the rates of syphilis decreased 11% among Whites and increased 100% among Blacks.

According to Rice et al., individuals of low SES areas have always been at higher risk of gonorrhea infection than individuals residing in upper SES areas. Along with social/economic factors, socio-demographic factors are also associated with higher rates of STDs. For example, injection drug users were 26x more likely in the NE. Interestingly, heterosexually acquired HIV has the same socio-demographic features as injection drug users and related HIV infection.

The role of race is best viewed as a marker for lifestyle risk behaviors. The behaviors that should be examined further include: early initiation of sexual activity, exposure to a large number of causal sex partners, exposure to sex partners from high risk core sex groups, and perceptions of remote risks in competition with immediate lifestyle needs. Lastly, any attempt to overcome disparities must address overcoming financial and non-financial barriers to health care access.

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Received 9/9/92 from Bill Jenkins

1991 ACE CONFERENCE - TRANSCRIPT SUMMARY

DRAFT

Dr. Chen

The pharmacological and behavioral processes that determine tobacco addiction are very similar to those that determine addiction to other drugs such as heroine or cocaine. Today tobacco use remains as the most prevalent form of substance abuse in this country and the number one cause of premature death in the U.S. (responsible for 400,000 deaths yearly). Since 1964, there has been a decrease in per capita cigarette consumption. However, the rate for Blacks has remained constant for sometime. In light of these dismal figures, there is a smaller proportion of Blacks than Whites who have ever smoked but quit smoking. Blacks also tend to smoke less or fewer cigarettes/day and initiate smoking at a later age.

Of the Blacks who smoke, 75% use cigarettes with >15 mg tar/cigarette, compared to 50% of Whites. Blacks are also three times more likely to smoke menthol cigarettes. According to the 1989 Surgeon General's Report, the Black mortality rate, as a result of cigarette smoking related health conditions, from all causes is 50% higher than the rate for Whites. It has been hypothesized that higher rates of lung and esophageal cancer in Blacks is partially attributable to their higher prevalence of smoking.

Education level is considered the best predictor for smoking and quit rate. Occupational level (blue collar vs. white collar), employment status (employed vs unemployed), and stress are all associated with increased likelihood of smoking.

Advertisements for cigarettes amount to 2 billion dollars annually. Tobacco companies advertise very heavily in magazines that are popular among minorities. They have also used billboards extensively in minority populated neighborhoods.

Though men smoke more than women, the health risks are exponentially increased among expectant mothers. The American Cancer Society's Cancer Prevention Study II found cigarette smoking to account for 20 to 30% of LBW infants, 40% of premature deliveries, and 10% of infant mortality deaths. Interestingly, White mothers smoked more, but they did not suffer the most adverse pregnancy outcomes.

Several high priorities need to be addressed: 1) standardized systematic (state/federal) surveillance of tobacco use among adults and adolescents, 2) reliable national estimates on smoking prevalence for minorities, 3) uniform means of recording data (esp. surveys), and 4) measurement of health outcomes with sub-populations of minorities.

1991 ACE CONFERENCE - TRANSCRIPT SUMMARY

DRAFT

Dr. Finlieb

Despite the degree of detail with vital statistics data, it still is not adequate to meet our national needs for data on the health of minorities. Several factors severely limit NCHS's ability to provide vital statistics data on minority populations: 1) inadequacy of census estimates which provide the denominators for calculating the rates for vital statistics, 2) problem of post census estimates of the minority population for states and localities, and 3) validity of racial and ethnic data provided by the Census and in the vital statistics documents.

In an effort to improve the availability of data for minority populations (esp. Asian Pacific Islanders and Hispanic populations), Congress passed "The Disadvantaged Minority Health Improvement Act of 1990." Also, the linking of birth/death files has helped to alleviate some of the discrepancies that existed previously with infant deaths.

In order to better the pool of data that is available for minorities, a couple of suggestions are offered. First, there exists a need to develop a conceptual framework and suitable instruments to distinguish race and ethnicity from other variables (e.g. economic status, housing, education, and social stress-including racism). Also, NCHS sees a need to conduct clinical trials and other epidemiological studies in specific racial groups to elucidate variations in the risks and natural histories of diseases, efficacy of therapies, and optimal approaches to enhance patient education and compliance.

1991 ACE CONFERENCE - TRANSCRIPT SUMMARY

DRAFT

Dr. Freeman

The ability to communicate between each other, economic status, and level of knowledge are all factors that override race and racism as causes of health disparities. Many of the answers to questions concerning health disparities deal with value systems (e.g. purpose, meaning and quality). These factors will never be addressed with our current scientific method. As such, we need to determine the distinguishing factors between race, racism, culture, and class (which is economic status).

According to the American Cancer Society, the racial disparities in cancer survival rates are primarily due to differences in the economic statuses of minority and majority groups. Of the poor, 17 million are too rich for Medicaid and too poor for Blue Cross. Not surprisingly, being poor becomes a proxy (marker) for certain human events (e.g. unemployment, inadequate education, sub-standard living conditions, poor housing, poor nutrition, etc.).

Though race has no strong genetic meaning, with respect to disease and survival, it does have a very important cultural meaning. Things like physical and social environment, development of like traditions, similar lifestyles, and beliefs are very powerful determinants of what diseases people may develop and how they will respond to them. Therefore, the cultural meaning of race seems to predominate.

Translated into its cultural meaning, race becomes a prism through which poverty is reflected. If this is true, it would give race or culture the opportunity to modify poverty's impact. Racism is a diffused factor that could be experienced at almost any stage of this problem, but if people escape poverty and become upwardly mobile, it seems as if they will escape the effect of racism as it affects poor health.

Future strategies designed to combat the disparities should: 1) start interventions with the young, 2) target people culturally (e.g. education), 3) study anthropologic approaches, 4) geographically and culturally delineate "third world" communities within the U.S. and intervene with education, housing, social services, and access to preventive services. Access to health care, alone, will not be enough. The environment must also be taken into account.

Remember! Race is not equal to disadvantaged or advantaged. As is evident, our striving to work against racism will not solve the problem. We must go into the communities and do what is necessary for those who reside in the communities.

1991 ACE CONFERENCE - TRANSCRIPT SUMMARY

DRAFT

Dr. Gynam

Now that we have gross ideas of what the problems are (e.g. racism and its sequelae), it is time to move on and design and implement interventions that are appropriate for the health problems among minorities that we are addressing. Unfortunately, due to a historical misuse of science, the minorities that we are trying to address do not "trust" the system.

In one Atlanta church survey, 60% of a "schooled" (at least some college) sample thought AIDS might be a form of genocide. The Tuskegee Syphilis Study provides validation for the common suspiciousness about the ethical handling of the medical research establishment (esp. federal programs). The issue of Blacks believing that governmental scientists uphold the genocidal theory for Blacks must be addressed before public health officials try to design interventions that we hope to be effective in the community. Hence, intervention and prevention efforts will have to be in the form of a community organized effort.

1991 ACE CONFERENCE--TRANSCRIPT SUMMARY

DRAFT

Dr. Henderson

We have become increasingly aware of differences between people, differences in cultures, and differences in religious and social interactions that extend across the world. Unfortunately, the greatest emphasis has been placed on attributes that divide and differentiate without distinguishing one group from another.

Approaches to prevention and intervention in health care have suffered, because they have been based upon false premises. For example, despite similarities, each ethnic/racial group is very heterogeneous. Hence, the steps taken to solve social problems, including those of health, must be specific to local areas. Additionally, any approach to address health issues in the community would have to be a collaborative effort (from professional to grassroots). This effort should focus on three levels/issues: 1) development and sustainment of a local surveillance system, 2) changing strategies and tactics regularly in response to progress or lack thereof (as indicated by the data), and 3) create a user friendly system (paying attention to the consumer and designing a system which provides consumer satisfaction).

A number of instances have arisen whereby addressing specific health problems have brought diverse groups together. For example, the Soviets and Americans effectively worked together in WHO on the Smallpox Eradication Program. In another instance, rebel groups of Sudan, Ethiopia, Nigeria, and Somalia came together to devise strategies regarding health issues. Lastly, the fighting in El Salvador ceased for three days out of each year to allow vaccination teams into the country to immunize the children.

The mortality and morbidity gaps seen between racial/ethnic groups are mere symptoms of a broader set of problems. These problems, as history has told us, cannot be eradicated with a stroke of a pen. Therefore, the city/state/federal administrations cannot simply make a mandate to "whisk" the problems away. In order for changes to take place, the community will have to help develop and embrace the preventive and intervention health concepts to effect the change.

1991 ACE CONFERENCE--TRANSCRIPT SUMMARY

DRAFT

Dr. Hineman

When developing strategies to effectively deal with infectious diseases, it is important to have foci that recognize the following: 1) different cultural heritages and social structures may affect how interventions are perceived or used, and 2) members of said groups may be disproportionately likely to have risk factors for disease.

Though 13.5% of the U.S. population is below the poverty line, the Black population is 31.9% of that total. It is this state of affairs (low SES) that has been inversely associated with syphilis (primary and secondary), gonorrhea, and tuberculosis (TB). Accordingly, Blacks have higher rates of infectious diseases (e.g. gonorrhea, AIDS, and TB). Progressively higher rates have been partially attributed to Blacks being disproportionately likely to be in adverse situations, lack of knowledge about/have access to/or trust available services.

In a study by Steadin et al., Black nursing home residents had a significantly higher risk (relative risk = 1.9) of becoming infected with TB compared to Whites. Prevention efforts also appear to received differently among Whites. For example, it was recently shown that 80% of the students in a predominately White Chicago school were vaccinated (a vaccine that is recommended 12-15 months after birth) before their 2nd birthday, whereas 50% of the students in a predominately Black Chicago school were vaccinated before 2 years.

With hopes of eradicating the disparity, the National Center for Preventive Services has provided technical assistance to state and local health departments, involved representatives of minority and community based organizations in drafting program guidance documents and given technical and financial support to 28 national/regional minority organizations to carry out HIV prevention activities.

To ensure effective disease prevention, the following is suggested: 1) provision of resources to support and strengthen local health departments, 2) development of data systems to measure the magnitude of the problem and the degree to which the needs of at risk populations are being met, 3) involvement with those most affected in planning and implementation of the programs, 4) development of new interventions (e.g. biomedical, behavioral, and social), 5) good will and open minds, and 6) persistence.

1991 ACE CONFERENCE--TRANSCRIPT SUMMARY

DRAFT

Dr. S. James

Though the infant mortality (IM) rate has fallen during this century, the U.S. has recently fallen behind many other countries in their rate of progress. In the 1950's the U.S. ranked 6th in the world now it is 22nd. During that time the Black/White ratio has risen from 1.6 to 2.1. Although the low birth weight rate declined for Black and White women from 1973-1983, the very low birth weight rate declined for White women while increasing for Black women. Thirty-five percent of the increase in very low birth weight infants is attributable to the proportion of births to unmarried women.

According to recent studies, U.S. born Black women have a 2-fold excess risk of neonatal and post neonatal mortality (relative to Whites). Foreign born Black women have heavier babies (~135g) than their U.S. born counterparts. A number of factors have been purported to explain the plight of the U.S. Black female. For example, minority women have access to fewer social/economic resources which increases their likelihood of physical/social/environmental stressors. The amount of stress that is generated depends on the quality and quantity of social support available to the women. In addition to managing stress and utilizing beneficial social support networks, Black women are encouraged to develop alternate cultural frames of reference that can be used as needed to evaluate themselves in a favorable light and thereby remaining psychologically resilient.

Early and effective use of prenatal care, though associated with better pregnancy outcomes, cannot fully explain the high mortality rates observed for Black infants. Intra-racially, Boucher et al. (1987) found Black mothers on Medicaid who received less than adequate prenatal care and those who did not (though eligible) participate in WIC were more likely to have a LBW infant.

In addition to the VLBW rate, the Black/White difference in heart disease mortality has been on the rise in recent years. Because the risk factors associated with heart disease vary by socioeconomic status within and between racial/ethnic groups, environmental factors are thought to play a crucial role in determining overall group differences. A role that interacts with other factors to defy simple explanation. For example, the contrasting relationship between HDL levels and education for Black and White men may be a part of the explanation for the recent divergence of their CHD mortality rates.

1991 ACE CONFERENCE - TRANSCRIPT SUMMARY

DRAFT

Dr. Johnson

The extent to which health disparities (e.g. death rates, life expectancy, and infant mortality) exist because of environmental risk factors is largely unknown. For example, it is unclear how the health of the 15 million Blacks who live in communities with one or more uncontrolled toxic waste sites is affected. As such, ATSDR's Minority Health Initiative was implemented and designed to address four problems minorities face in the U.S.: 1) lack of demographic information about minority populations' exposure to hazardous substances in the general environment, 2) persistent problem of lower health status, medically underserved, and effects of socioeconomic conditions and how these kinds of factors may exacerbate effects from exposure to hazardous substances, 3) developing effective environmental health messages targeting minority Americans, and 4) addressing problem of scarcity of minorities trained in the environmental and health sciences. In reference to the latter, Congress allotted ATSDR 4 million dollars to assist eight historically Black colleges and universities with the development of faculty and graduate student research in toxicology and environmental science.

Lead exposure is one area that has recently received a lot of attention. Blood lead levels exceeding 24 micrograms/dl delay cognitive development or reduce IQ, impair hearing, and retard growth. Although Blacks, as a whole, comprise 12% of the U.S. population, Black children constitute 44% of the population at risk for lead exposure. The level of risk is positively associated with such economic factors as familial income. The NHANES (1984) indicated that among Black children (6 mths - 2 yrs), the average blood level was 21 micrograms/dl. A considerably lower amount was reported for White children. Much of the lead exposure in urban areas was due to the lead in the paint of older housing, lead in soil, and in dust. These are major contributors to the lead burden born by Black children.

1991 ACE CONFERENCE - TRANSCRIPT SUMMARY

DRAFT

Dr. Kumanyika

There are three categories that can be related to health via one's diet: 1) inadequate nutrition, 2) chronic disease risk factors, and 3) dietary prescriptions.

Latency of effect is a familiar problem in many areas of chronic disease epidemiology and secular trends that are particularly relevant to minority health studies. The trends in diet and disease are different across populations depending on their level (e.g. immigration and economic advancement). For example, some of the population may have full blown expressions of chronic diseases, while they are still having a heavy burden of infectious diseases. Currently, a procedure does not exist that would allow for predictions and adjustments of such factors.

When doing comparative studies, it is important to realize that they are all within population studies. Because minority populations are relatively small, we tend to aggregate them so they will fit into one cell (despite our knowledge that they are very diverse populations). Though often done, the assumptions needed to support aggregation of the data are often not met.

Regarding secular trends, there have been some mortality cross-overs (e.g. colon and breast cancer is on the rise among Blacks). Several of the diet related cancers are in excess incidence in the Black population, and stomach cancer is in excess in most of the minority populations. It seems as if there is something about being a minority in the U.S. that is a risk factor. Chronic ailments like obesity/overweight and cardiovascular disease are almost universal in the Black and minority populations. The only chronic disease that is diet related that does not excessively affect our communities is osteoporosis and hip fracture.

To better understand the disparities that exist in health status, studies examining race-specific risk factors would be suggested. Hence, comparative studies will not allow you to answer a number of pertinent questions. We also need to start looking at the relationship between the prevalence of other risk factors and attributable risks.

1991 ACE CONFERENCE - TRANSCRIPT SUMMARY

DRAFT

Dr. Mason

This year, the U.S. will spend 750 billion dollars (13% of GNP) on health care. This nation spends more on health care/citizen than any other country. Despite this, we are ranked 24th among industrialized countries for infant mortality and 22nd in life expectancy at birth. In addition, thirty-five million Americans (17.5 million in urban and 17 million in rural areas) live in health professional shortage areas.

A recent study found 82% of mothers with at least a high school diploma received prenatal care, and 56% of those not finishing high school have received prenatal care. Also, 83% of married mothers versus 55% of unmarried mothers received early prenatal care. If the health care disparities simply boil down to race, why do Mexican Americans have lower infant mortality rates than Whites-given their lower SES? Might other factors like the more frequent presence of the father play a significant role in infant health care? It is clear that public health solutions must address the root causes as well as the symptoms.

Genetics and social/economic status are two categorical groupings that can help to explain the mortality and morbidity disparity. Using race as a surrogate for SES hinders our ability to accurately define the problem, communicate the problem, and create changes to address the problem. Hence, race and social/economic factors in health care statistics need to be untangled for professionals and the public alike.

1991 ACE CONFERENCE - TRANSCRIPT SUMMARY

DRAFT

Dr. Omwachisanders

Injuries are the leading cause of years of potential life loss or premature death before the age of 65. In 1985 (U.S.) death rates from all causes were higher in the U.S. than the other industrialized nations. One in four Americans will be injured annually. One out of ten hospital admissions are due to injuries. One in six hospital days will be due to an injury. Injuries are the leading cause of death from Americans <45 yrs. The (1985) lifetime cost of injuries was 158 billion, and the lifetime cost of injuries for 1988 was 188 billion. They are indeed the leading public health problem facing the nation today.

Injuries are divided into two categories: 1) unintentional injury, and 2) intentional injury. Of all injuries, 1/3 are to violence. In 1987, homicides accounted for 42% of all deaths to Black males 15 - 24 yrs. (26% for females). Homicide is also the leading cause of death for Blacks 15 - 34 yrs. There was a 7 to 1 rate ratio for homicide between Black and White males, followed by residential fires (3 to 1), drownings, and pedestrian mishaps. Surprisingly, the probability of lifetime murder victimization is 1 out of 27 for Black males and 1 out of 205 for White males. In 1988, 9% of homicides were interracial and occurred among people who knew each other. Hence, the majority of the deaths were either Black-on-Black or White-on-White. Research shows that racial differences in homicide rates all but disappear when SES is taken into account.

The reasons for higher death rates among Blacks is unclear, because little is known about race specific risk factors. The risk factors for residential fires include: lack of smoke detectors, residents in poor housing, and slower response time of fire department services. The higher drowning rates may be due to a lack of instruction in swimming and recreation at less guarded bodies of water.

A multi-disciplinary intervention effort is needed. It should focus on teaching conflict resolution skills, firearm safety education, and limiting the availability of firearms throughout the society. Questions about risk factors lie at the heart of the problem of homicide prevention. For example, investigators must define the race and cause specific risk factors that can be used to guide intervention strategies.

1991 ACE CONFERENCE - TRANSCRIPT SUMMARY

Dr. Perez

After a brief introduction, a video tape was presented of a prime time investigation about the institution of racism. A Black and White tester from the Leadership Council for Open Metropolitan Communities were the observers in the St. Louis experiment. The testers set out to determine the way each would be treated (e.g. by employers/employees and residents) in the public realm (e.g. shopping center stores, car dealerships, record stores, apartment complexes, businesses, and predominately white residential areas).

Not surprising for some, the Black tester was followed by the store's security personnel, quoted higher down payment prices at the car dealerships, refused apartments and employment, and stopped by the police. The White tester received treatment that was completely opposite. When confronted, the excuses for differential treatment ranged from completely denying differences in treatment to quoting crime statistics.

In addition to the racism that continues to plague the U.S., certain ethnic groups suffer the brunt of negative health outcomes. For example, the gaps in mortality between Blacks and Whites have been greatest in accidents & homicides (35.1%), infant mortality (29.6%), heart disease/strokes (14.4%), cirrhosis (4.9%), cancer (3.8%), and diabetes (1.0%). Blacks are more likely to die from all major causes of death except suicide.

1991 ACE CONFERENCE - TRANSCRIPT SUMMARY

DRAFT

Dr. Prim

According to a recent poll by USA Today, the majority of Whites viewed Blacks and Hispanics as less hard working, more violent prone, living off welfare, less patriotic, and less intelligent. Asians were viewed similarly, but not overwhelmingly so.

In most instances, where poverty exists so does a higher prevalence of substance abuse (and its disease sequelae) and drug availability. For example, a report by Califano found 1 liquor store/1000 residents in the predominately Black Bronx and Harlem areas of NY versus 1 liquor store/5,500 residents in the predominately White Staten Island and Queens areas of NY. Among the young Black and Hispanic men of Harlem and Bronx, cirrhosis of the liver was one of the biggest killers. Despite this, no attempt has been made by the state liquor authority to restrict the number of new stores opening in the Black communities.

During periods of high unemployment and recessions, the downwardly mobile are hit hardest. Also, during recovery, this group (mostly minorities) remain so. (Brenner, M.) Environmental stressors, like unemployment, are theorized to disrupt a homeostatic state that Blacks and blue collar workers try to rectify via smoking.

Because addiction is a disorder plagued with chronic relapse, in order to combat it, individuals (public health officials) will definitely have to commit time over a long period. In doing so, the host, chemical, and environment will have to be addressed.

1991 ACE CONFERENCE - TRANSCRIPT SUMMARY

DRAFT

Dr. E. M. Smith

To date, a fair amount of studies has been conducted to examine drug (e.g. alcohol consumption and tobacco use) usage among minorities and non-minorities. Theses studies have examined adolescents as well as adults.

According to the National High School Senior Survey (Bachman et al.), Blacks have the third highest drug use rate, followed by Whites (#1) and Hispanics (#2). In addition, the 1990 Youth Risk Behavior Survey found (9 - 12 graders) the prevalence of cigarette use and smokeless use among White students to be approximately 6 times that of Black students. Despite the greater use of cigarettes by Whites, Blacks have significantly higher death rates from lung cancer than Whites. Another study, the Epidemiological Catchment Area Study (Anthony & Hessler), found no difference in lifetime history of illicit drug use between Blacks, Whites, and Hispanics. Lastly, a CDC Catchment Study found incidence rates of fetal alcohol syndrome to be 0.9/10,000 for Whites and 6/10,000 for Blacks.

The one year prevalence of both drug use and dependance revealed a dominance among Whites, Blacks and Hispanics (in that order). In corroboration, NHIS (1988) found a higher drug use prevalence among Whites (9.3) than for non-Whites (5.6).

1991 ACE CONFERENCE - TRANSCRIPT SUMMARY DRAFT

Dr. Weisner

In 1990, HIV/STD was the leading contributor to years of potential life loss for Black and White men in the U.S.

Public health officials should heed the following: 1) disband with numbing statistics, 2) opposed to concentrating on risk factors, an emphasis needs to be placed on determining enhancement factors (those factors that enable high-risk individuals not to suffer adverse health outcomes), 3) realize that issues surrounding patient/targeted group non-compliance are mirrored by agency/epidemiologist/service group incompetence, and 4) epidemiologists need to start involving those who are affected to form/develop techniques.

1991 ACE CONFERENCE - TRANSCRIPT SUMMARY

DRAFT

Dr. Warren

Most race research efforts have been to prove that people of color, for the most part, are inferior to the White population. Hence, there has been little directed toward public health interventions to help close the gap.

In 1990, 75,000 excess deaths were estimated among Blacks. A number of associations with these excess deaths have been determined (e.g. income, education, access to care, and preventive practices). Despite the associations, the basic causal factors associated with ill health and race remain unanswered. Along these lines, because years of studying race has not reduced the health gap, the limited study of racism is at least worth further pursuit.

Institutional racism is more insidious than individual racism and more difficult to identify. In public health, officials have used identification difficulty as a reason not to study it. Accordingly, in all of public health, virtually nothing has been done to address the question of racism and its relationship to health. Commenting on this issue, Oden et al. stated that given racism is a behavior, it should be sensitive to public science intervention.