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LEGISLATIVE FORUM

REPORT OF THE SECRETARY'S TASK FORCE ON BLACK AND MINORITY HEALTH: A SUMMARY AND A PRESENTATION OF HEALTH DATA WITH REGARD TO BLACKS

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The Task Force on Black and Minority Health was created in early 1984 by Margaret Heckler, then Secretary of the US Department of Health and Human Services (DHHS). The summary volume of the report was released by Secretary Heckler at a press conference on October 16, 1985.[1] As described by her at the press conference, the impetus for the creation of the Task Force was her dismay at the persistent black and minority health disparities when compared with the white population. These disparities had been most recently reflected in DHHS's annual health statistical summary, *Health USA* for 1983.

COMMISSION OF TASK FORCE

The Task Force consisted of about 20 members plus alternates, and was chaired by the Deputy Director of the National Institutes of Health, Dr. Thomas Malone. The Task Force members were generally directors or deputy directors of major units within the Public Health Service that could have an impact on minority health issues. Thus, they represented many of the major health decision makers of the federal health establishment. The rationale for this composition of the Task Force was that these were the people who could make programmatic decisions for their organizations and so health policy could, if necessary, be made or changed on the spot.

The full or part-time staff of about 25 government employees was drawn from all parts of DHHS. In addition, there were outside papers commissioned, the Task Force heard presentations from various individuals, current DHHS programs were inventoried, a large survey of community and professional organizations was done, and Task Force members and staff attended a number of national meetings of health-related groups and made presentations.

For the purposes of the Task Force, minorities were defined as blacks, Hispanics, native Americans (including Alaskan natives and native Hawaiians), and Asian/Pacific Islanders. One of the persistent problems the Task Force faced was a paucity of data on Hispanics, Asians/Pacific Islanders, and nonreservation native Americans. Improved data collection was an important Task Force recommendation, especially in regard to these groups.

The primary epidemiological paradigm used to represent the health disparity between minorities and whites was that of "excess deaths." Excess deaths are the difference between the number of deaths observed in minority populations and the number of deaths that would have been expected if the minority population had the same age and sex-specific death rates as the white population.

In analyzing mortality data from 1979 to 1981, the Task Force identified six causes of death that together account for more than 80 percent of the mortality observed among blacks that is in excess of that in the white population (Table 1). Although the ranking of health problems according to excess deaths differs for each minority

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TABLE 1. AVERAGE ANNUAL NUMBER OF DEATHS BY DISEASE CATEGORY FOR BLACKS, 1979-1981

	CVD*	Cancer	Cirrhosis	Infant Mortality	Diabetes	Unintentional Injuries	Homicide	All Other	Sub-Total**	Total Deaths
Blacks under Age 45										
Males										
Observed	3,236	1,587	961	6,782	201	5,940	6,487	5,900	(31,094)	31,094
Expected**	1,340	1,204	259	3,465	86	6,000	1,019	3,203	(16,576)	16,576
Excess	1,896	383	702	3,317	115	−60	5,468	2,697	(14,518)	14,578
Percent of Total Excess****	13	3	5	23	1	0	38	19		100
Females										
Observed	2,090	1,790	549	5,540	184	1,905	1,488	3,686	(17,232)	17,232
Expected**	674	1,366	130	2,679	77	1,991	343	1,838	(9,098)	9,098
Excess	1,416	424	419	2,861	107	−86	1,145	1,848	(8,134)	8,220
Percent of Total Excess****	17	5	5	35	1	0	14	22		100
Blacks under Age 70										
Males										
Observed	24,913	16,117	2,706	6,782	1,190	8,429	7,935	16,629	(84,701)	84,701
Expected**	16,444	10,335	1,344	3,465	544	7,316	1,227	8,914	(49,589)	49,589
Excess	8,469	5,782	1,362	3,317	646	1,113	6,708	7,715	(35,112)	35,112
Percent of Total Excess****	24	16	4	9	2	3	19	22		100
Females										
Observed	17,788	11,946	1,525	5,540	1,786	2,739	1,796	10,817	(53,937)	53,937
Expected**	8,076	9,677	743	2,679	583	2,605	415	5,614	(30,392)	30,392
Excess	9,712	2,269	782	2,861	1,203	134	1,381	5,203	(23,545)	23,545
Percent of Total Excess****	41	10	3	12	5	1	6	22		100

*Cardiovascular disease (CVD) combines heart disease and stroke
**The expected number is calculated from the rate observed in the white population
***Subtotal is the sum of negative and positive excess deaths. Total deaths sums positive excess deaths only
****Percentages based on total deaths
From Duke University, analysis commissioned by the Task Force on Black and Minority Health, 1984-1985

population, the six health problems became priority issue areas for Task Force study. Listed in alphabetical order, they are:

- Cancer
- Cardiovascular disease and stroke
- Chemical dependency, measured by deaths due to cirrhosis
- Diabetes
- Homicide, suicide, and accidents (unintentional injuries)
- Infant mortality

Overall black death rates exceed that for whites at all ages until the seventh decade. During the seventh decade there is a "crossover," after which black rates are lower. This crossover had been generally interpreted as a product of hardiness among those blacks who survive the higher mortality earlier in life. It was shown that 42.5 percent of black deaths are "excess deaths," representing 59,000 excess deaths per year. This percentage of excess deaths was higher than that for native Americans or Asian/Pacific Islanders. Complete Hispanic death rates were not available because for many data collection purposes (eg, birth and death certification), Hispanics are classified as an ethnic rather than a racial minority and are often noted in vital statistics information as white.

HEALTH DATA OF BLACK POPULATION

In the balance of this report, I am going to summarize the health disparity data for the black population in the six previously listed disease categories.

Cancer

Blacks have the highest overall cancer incidence and mortality rates of any of the minority groups that were examined. In fact, all other minorities and subgroups within minorities have lower incidence rates than for blacks or whites with the exception of Hawaiians. Age-adjusted cancer incidence rates are 25 percent higher for black men and 4 percent higher for black women. Overall five-year survival rates are 50 percent for whites and 38 percent for blacks. Excess incidence and mortality are particularly striking for cancer of the esophagus, multiple myeloma, cancer of the cervix in black women and of the lung and prostate in black men.

Blacks have a higher prevalence of smoking, but smoke fewer cigarettes per day per smoker than whites. Beyond tobacco, factors that may contribute to blacks' higher incidence and mortality are: occupational and environmental exposure to carcinogens, late stage of illness at diagnosis, treatment differences, socioeconomic disadvantage, nutritional status, and perhaps genetic differences.

Cardiovascular Disease

The death rate due to heart disease in black men is somewhat higher than that for white men (relative risk, 1.2:1). Black women display a higher rate when compared with white women (relative risk, 1.5:1). However, it should be kept in mind that because heart disease is the leading cause of death in America, these modestly higher relative risks translate to a large number of excess deaths (Table 1). Younger blacks (under 45 years) have a dramatically higher relative risk compared with younger whites: 2.2:1 for men, 3.4:1 for women. Because the death rate for heart disease under 45 years is relatively low, this translates to a smaller number of excess deaths.

Blacks have about twice the death rate from stroke as whites. Probably the most identifiable risk factor for stroke and heart disease among blacks is hypertension. While anti-hypertension campaigns have made an impact on both awareness and treatment-seeking among blacks, hypertension still has a higher prevalence among blacks as compared with whites. An additional factor contributing to high cardiovascular rates in blacks is the higher prevalence, especially in black women, of obesity.

Chemical Dependency

There are limited data on chemical dependency. This is especially true if mortality is the outcome variable, since it is often difficult to directly link chemical dependency and death using routine data-collection methods. In the 1979 Surgeon General's report, *Healthy People,* alcohol abuse was implicated in more than 10 percent of all deaths; tobacco in 16 percent of all deaths and in 90 percent of all deaths due to lung cancer. No good figures are available for illicit drugs. Blacks do have about twice the rate of deaths due to cirrhosis as whites.

Diabetes

As with chemical dependency, good data on mortality due to diabetes is limited. Diabetes was the 7th leading cause of death in the United States in 1980. Blacks do have a one third higher prevalence of diabetes than whites. At least in part, this is due to higher levels of obesity, especially in black women.

Homicide, Suicide, and Accidents

Death rates from accidents are slightly higher for blacks, while suicide rates are considerably

lower for blacks. However, blacks have the highest homicide rate of any group. Homicide is the leading cause of death for black men aged 15 to 44, the second leading cause of death for black women under 45. Black males have a 1 in 21 lifetime chance of being a homicide victim, over six times that for white men. For black women the lifetime chance is 1 in 104, 3½ times the chance for white women. Homicides, in general, are overwhelmingly committed against persons of the same race, a majority involve relatives or acquaintances, and a majority are committed with a firearm.

Homicide is increasingly being seen as a public health problem rather than only a criminal justice problem. One reason for this is that the public health perspective contains a strong emphasis on primary prevention, on detection, and on treatment; in this case, violence is the disease. In fact, the Surgeon General recently convened a conference on violence to generate prevention strategies.

Infant Mortality

Infant mortality in the United States has dropped dramatically since the turn of the century, from about 10 percent then to about 1 percent today. Unfortunately, the black infant mortality rate has remained about twice that of the white rate: 20 per 1,000 for blacks, 10.5 for whites in 1982. Subdivision of infant mortality into neonatal (less than 28 days) and postneonatal (28 days to 1 year) shows a similar unfavorable black ratio.

The most important contribution to infant mortality is low birth weight. Blacks have a higher incidence of low birth weight than any other minority group and have over twice the rate of low birth weight as whites (12.4 percent vs 5.6 percent of live births in 1982). Black mothers also have a higher incidence of many risk factors for low birth weight including young age, low education, single marital status, and late or no prenatal care. Even if you statistically adjust for these factors, blacks still have a higher though diminished risk of low birth weight.

RECOMMENDATIONS OF THE TASK FORCE

The recommendations of the Task Force are too numerous to list. The recommendations are divided into six categories:

- Health information and education
- Delivery of health services
- Health professions development
- Cooperative efforts with the non-federal sector
- Data gathering and development
- Research

IMPLEMENTATION OF THE TASK FORCE REPORT

At the October 1985 press conference, Mrs. Heckler indicated that while no new appropriations to the DHHS budget to fund Task Force recommendations are expected, monies may be generated by redirecting funds from within DHHS's budget. In addition, she announced the creation of an office that will coordinate the implementation of the Task Force Report. This office will have no fixed lifespan; an operating budget of 3 million dollars for the current year has been appropriated.

Literature Cited

1. Report of the Secretary's Task Force on Black and Minority Health, vol 1: Executive Summary. US Department of Health and Human Services, DHHS publication No. (0-487-637), Government Printing Office, 1985.