GUEST EDITORIAL

EXPLAINING HEALTH DISPARITIES BETWEEN AFRICAN-AMERICAN AND WHITE POPULATIONS: WHERE DO WE GO FROM HERE?

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Over the past several decades, we have witnessed substantial improvements in the health status of Americans. There has been an unprecedented explosion in scientific knowledge and the phenomenal capacity of medicine to diagnose, treat, and cure various diseases. For example, extraordinary progress has been made in understanding the causes and risk factors for heart disease and cancer. Because of advances in the long-term management of chronic diseases, conditions such as hypertension and diabetes need no longer result in disability and premature death. Additionally, individuals are becoming more health conscious and are increasingly engaging in activities to safeguard their health (such as lowering dietary sodium and fat intake, reducing or discontinuing cigarette smoking, and engaging in a regular exercise regimen). Unfortunately, African Americans have not benefitted equitably from the scientific and technological advances of the medical profession or various national prevention and educational efforts.

INCIDENCE OF HEALTH DISPARITIES

Disparities in the health status of African-American and white populations are evident across the entire life span. Compared with whites, African Americans suffer an excess mortality in 13 of the 15 leading causes of death. The exceptions are chronic obstructive lung disease and suicide. In 1987, infant mortality was highest among African Americans with rates of 17.9 per 1000 live births (compared with 8.6 per 1000 live births for whites). The age-adjusted mortality rates for heart disease are approximately 40% higher for African Americans than for whites, with a greater disparity evident between white and African-American males. The incidence rates for all types of cancer are higher for African Americans than for whites, and the survival rates of African Americans are poorer. African Americans suffer disproportionately higher prevalence rates of diabetes, hypertensive disease, glaucoma, high serum cholesterol level, and obesity. Additionally, African Americans are almost six times more likely to die from homicide and legal intervention.

Overall, life expectancy for African Americans is approximately 6.2 years less than that for whites.[1] It has been estimated that out of the average 227 000 African Americans who died each year between 1979 and 1981, approximately 60 000 (annually) of these deaths would not have occurred had African Americans experienced the same age-sex death rates as white Americans. These "excess deaths" represented 42.3% of all African Americans who died prior to reaching the age of 70.[2]

REASONS FOR RACIAL DISPARITIES

Consistent patterns of differential mortality rates have been documented in virtually every multi-ethnic society. That is, while marked improvements in health have been observed for all individuals over the last century, relative ethnic and racial differentials continue to persist. Dressler summarized four basic models that have been formulated to explain disparities in the health status of African Americans and whites: racial-genetic models, health behavior models, socioeconomic status models, and social structural models.[3]

Racial-Genetic Models

A recurrent feature of scientific inquiry has been

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concerted efforts to prove the existence of inherited racial differences. Thus, it is not surprising to find that biological determinism has been used to explain racial disparities in health outcomes. Proponents of racial-genetic models would have us believe that African Americans' higher rates of infant mortality and shorter life expectancy, as well as lower levels of educational and occupational achievements are all the result of their lower levels of genetic endowment or some distribution of genes that results in poorer health outcomes. While a review of available data indicates no evidence supporting the theory that a major proportion of the observed racial differentials in health can be explained in population genetics,[4] racial-genetic and Darwinian approaches have recently been reincarnated under different guises.[5,6]

Health-Behavior Models

Another model that has been hypothesized to explain health disparities between African-American and white populations takes a health behavior perspective. This approach suggests that health outcomes are primarily the result of individuals' habits, customs, and lifestyles. It is well-known that major risk factors associated with many chronic diseases are related to lifestyle and that African Americans are often highly represented among individuals engaging in high-risk behaviors. For example, cigarette smoking among African-American males is more prevalent than among white males. This, of course, places African-American men at a much higher risk for certain types of cancer. African Americans are also more prone to hypertensive disease due to high-fat and high-cholesterol diets. African-American women are almost twice as likely to be overweight compared with their white female counterparts, which places African-American women at greater risk for diabetes and heart disease.

While a health-behavior approach certainly has some utility, its primary weakness lies in its "victim blaming." An underlying notion of this approach is that African Americans engage in risky behaviors because they choose to do so. The deficiency is viewed as strictly within the individuals because they are thought to lack motivation, be ignorant about health matters, delay seeking care when they experience obvious symptoms, and avoid rational efforts to prevent illness. The health-behavior model fails to consider how the historical, cultural, and structural aspects of society continue to oppress African Americans and impact on their health behaviors and health-care delivery service.

Socioeconomic Models

A third model takes a socioeconomic approach in accounting for health disparities between African-American and white populations. Some scholars take the position that ethnicity and socioeconomic status are often confounding variables in epidemiological studies and, in reality, that many of the observed differences are economically based. There is an abundance of work in the published literature documenting the relationship of low income (irrespective of race) to poor health outcomes. Yet, Kessler and Neighbors suggest that socioeconomic status is insufficient in explaining health disparities between African Americans and whites.[7] Their work clearly demonstrates that race and socioeconomic status combine in an interactive, rather than additive, manner to create health disparities between African-American and white populations.

Social-Structural Models

The social-structural model, embedded in the recent work of Dressler[8] and based on the sociological concept of social closure,[9] stresses the critical role of continuing discrimination against African Americans within a minority health perspective. Both health status and health care can be ultimately viewed as social phenomena. No social or cultural phenomenon can be explained in simple reductionist terms, such as racial-genetic or health behaviors, but instead, it requires a social contextual explanation that considers both environmental forces and social conditions. Social structural explanations urge that the underlying class structure of American capitalism has produced a social system that has grossly unequalized life chances for certain individuals, namely, minorities and the poor. It is this social stratification in American society, which promotes racial inequality, that has, in large part, resulted in poorer health status and health service delivery for oppressed groups. Since the social and economic conditions under which all African Americans live facilitate significant differences from their white counterparts irrespective of socioeconomic status, the social-structural perspective seems most promising for providing a comprehensive model for explaining racial disparities in health outcomes.

WHERE DO WE GO FROM HERE?

The health of African Americans is more than a medical issue. The physiological and biochemical aspects of health for African Americans should be examined within the social context in which health outcomes normally occur, taking into account the social position of African Americans, the communities where they live, and the stressful life events they experience.

Health psychology, a relatively new field, offers some needed innovative shifts in health models. One of the most critical aspects of health psychology is that of focusing on the prevention of disease and the promotion of health through behavioral change.[10] Issues such as lifestyle risk, wellness behaviors, and perceived control are of significance in health psychology models. However, for African Americans, health psychology models must be coupled with sensitivity to the environmental, social, and structural conditions under which attitudes and behaviors are developed, reinforced, and expressed.

African Americans become ill, in large part, because of inadequate nutrition, substandard living conditions, high levels of stress, and reduced access to health care. In this country, access to health care and the quality of care are largely dependent on an individual's ability to pay. Given that African Americans are much more likely than whites to be poor, and once impoverished, to remain poor for longer periods of time, it is clear that African Americans are disadvantaged in terms of quality of and access to health care. Utilization of health-care facilities is also affected by a number of factors other than financial considerations such as dominant beliefs about illness, accessibility, stigma associated with seeking help, and organized barriers.[11,12] A great deal of health care, particularly within the African-American community, occurs outside the formalized health-care delivery systems. All of these factors have serious ramifications for the efficacy of treatment and survivorship for many chronic diseases.

RECOMMENDATIONS FOR PREVENTION, TREATMENT, AND RESEARCH

Improving the health status of African Americans will require multidisciplinary, broad-based efforts involving practitioners, researchers, and policy makers. Earlier analyses proposed that resolving the health-care crisis of African Americans must include efforts that expand health insurance protection, increase manpower resources, promote education and preventive medicine, and increase the number of African Americans in federal and state health policy, administrative positions, and peer review and quality assurance efforts.[13]

A comprehensive health perspective for addressing the health needs of African Americans involves actions on the three levels—prevention, treatment and services, and research. While not exhaustive, the following list suggests 10 overlapping directions for future work:

1. In theorizing about race disparities in health, race must be viewed as a dynamic concept that interacts with various physiological and social factors and varies across sociodemographic factors such as social class, geographic region, gender, and educational level.
2. Preventive measures that focus on individual change are crucial; however, there also must be more efforts focused on environmental and societal factors as they impact on preventive measures.
3. Appropriate and culturally relevant education, training, and dissemination strategies should be initiated, particularly for African Americans who have special needs such as the poor, uninsured, handicapped, and elderly.
4. Studies need to be conducted that more clearly specify potential risk and protective factors among diverse groups of African-American populations; such studies must not treat African-American populations as a homogeneous group.
5. Research on health outcomes (eg, sickle cell anemia and hypertension) that disproportionately or almost uniquely affect African Americans must be the focus of increased consideration.
6. African Americans must be studied independently and in methodologically sound racial-comparative research in the areas of prevention and behavioral management, biochemical processes, neuroscience, psychosocial factors, psychopharmacology, and clinical research.
7. Empirical studies that address how the social position of African Americans impacts on the development and facilitation of health beliefs, health attitudes, and health behaviors must be conducted.
8. The special health needs of African-American women must be addressed in research and prevention efforts.
9. African-American populations must be included in longitudinal and life-course perspective studies.
10. There must be increased federal and private support for health studies that specifically focus on African-American populations.

CONCLUSION

Medical care begins with the sick and seeks to keep them alive, make them well, or minimize their disability. Disease prevention, which is vital, must begin with a threat to health (either a disease or an environmental hazard) and a specification that will protect as many individuals as possible from the harmful consequences of these threats. Environmental factors that are critical to good health such as a safe

environment, adequate income, access to services, and education must be readily available to all citizens. Health disparities between African Americans and whites are not, for the most part, genetically determined, but are significantly affected by the deleterious social, economic, and physical environments in which many minorities live. Until there are concerted efforts to equitably distribute opportunities and resources within the existing political and economic framework of this society, the health outcomes of African Americans will continue to lag behind those of white populations.

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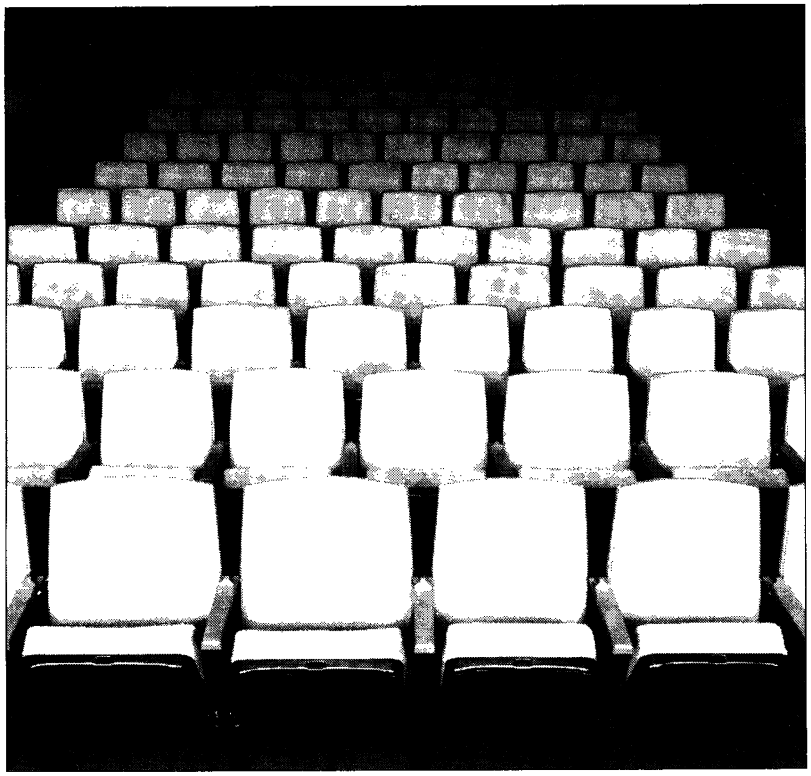

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