Science Visioning in Minority Health and Health Disparities

In 1999, US Department of Health and Human Services Deputy Secretary David Satcher, MD, cited the social and moral unacceptability of health disparities by race. His comments accompanied a study published in the *New England Journal of Medicine* showing that Blacks were less likely than Whites to be referred for cardiac evaluation when presenting with classic chest pain symptoms (Schulman KA, Berlin JA, Harless W, et al. The effect of race and sex on physicians' recommendations for cardiac catheterization. *NEJM*. 1999;30:618–626). Two years later, the Institute of Medicine published the *Unequal Care* report, summarizing a legacy of unequal health care and health outcomes for most leading causes of death and disability in the US among African Americans compared with Whites (Smedley BD, Stith AY, Nelson AR, eds. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academies Press; 2003). These two events crystallized the need for rigorous scientific approaches to minority health and health disparities, building on decades of studies addressing social inequality and health, behavioral epidemiology, and access to quality health care. Since that time, sources of data have dramatically improved at the same time that scientific advances in basic mechanisms have enlightened our understanding of etiological pathways and potential intervention points to improve minority health and reduce health disparities.

The Office of Minority Health Research was founded at the National Institutes of Health (NIH) in 1990 to provide a focus for these research questions. Through congressional legislation, the office was upgraded to the Center on Minority Health and Health Disparities in 2000, and to the National Institute on Minority Health and Health Disparities (NIMHD) in 2010. NIMHD is charged with coordinating and leading the NIH's vision and programs on minority health and health disparities research. The topics are broad and include health determinants pertaining to the entire life course, including all populations, diseases, prevention, and health care. Research that advances understanding and improvement of health and disease in minority racial/ethnic groups in the United States mandates a basic understanding of the construct of race in the context of science. Research to understand the causes of and to define mechanisms leading to interventions to reduce health disparities is a parallel mandate. This incorporates socioeconomic, geographic, and cultural factors to address conditions with negative outcomes in specific populations. NIMHD envisions an America in which all populations will have an equal opportunity to live long, healthy, and productive lives.

This special issue of *AJPH* culminates a two-year process of scientific visioning led by NIMHD staff, with participation of several dozen diverse scientists from across the United States. Framing the science of minority health and health disparities within the context of scientific advances has been a crucial step in advancing the field. There is a need to leverage and expand methodological approaches to monitor and reduce disparities. Understanding biological, behavioral, environmental, cultural, and structural components that affect minority health and health disparities outcomes identifies mechanisms and informs at what point interventions may have the greatest opportunity to make a difference. Finally and of critical importance, it is not enough to identify factors that contribute to health disparities: intervention science must be applied in full force to seek solutions. The NIH endorses the research strategies described in the articles in this special issue and will build upon these in implementing its "Strategic Plan on Minority Health and Health Disparities" in the next five years. AJPH

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17 Years Ago

Mobilizing Women for Minority Health and Social Justice in California

Despite notable progress in the overall health of the nation, African Americans, Hispanics, American Indians, and Asians and Pacific Islanders continue to face disproportionate rates of illness and death. . . . Nowhere is diversity more apparent than in California. The changing face of California's families and communities requires culturally appropriate and community-driven approaches to eliminating disparities in health. While women tend to be the health advocates for their families and make many decisions concerning their family's health and well-being at home, women, especially women of color, are underrepresented at the tables of governments and organizations.

From AJPH, *April 2002, p. 576*

106 Years Ago

THE NEGRO: HIS RELATION TO PUBLIC HEALTH IN THE SOUTH

During the past ten years the negro percentage of the city's population has been steadily decreasing, from 57.2 per cent. in 1900 to 51.1 per cent. in 1910. This decrease has been due in part to the great increase from white immigration, but also, to the higher mortality rate among the negroes. . . . I feel, however, that the negro in the South presents a field most barren of sanitary achievements and one deserving of new and better methods of solution. The immense amount of misdirected charity, which has been practiced upon this people, has served but to indicate its folly, and the whole South is today paying the penalty, not only of its own neglect, which has been great, but of the misconceptions of distant philanthropists as to the negro's greatest needs.

From AJPH, *December 1913, p. 300*