

What's Goin' On

Executive Summary

“What’s Goin’ On”, Marvin Gaye’s 1971 hit song, was chosen as the title of the African American Health Status Task Force Report because the Task Force believes that the information and recommendations contained in the report make a statement about the health of African American’s in the Finger Lakes Region as well as raise many questions about why the documented health and social disparities exist.

Beginning in August 2001, the Task Force met on a monthly basis to analyze data, listen to presentations from researchers and providers about health and healthcare in the African American community, talk to community members and to develop recommendations. Throughout the process, at seemingly every meeting, the members came away with more questions than answers. However, these nagging questions led to the Task Force’s clear commitment that this report, *What’s Goin’ On*, be a starting point for action in the community rather than a documentation of disparities that is eventually relegated to a bookshelf.

The Institute of Medicine has defined disparities as ‘racial or ethnic differences in the quality of healthcare that are not due to access related factors or clinical needs, preferences, and appropriateness of intervention.’ Evidence – including substantial evidence in this report – shows racial and ethnic disparities do exist and are found across illness and health care service regardless of insurance status, income, education and other factors influencing access to care.

The findings contained in *What's Goin' On* are both compelling and distressing. Health status does not suddenly happen; it evolves over time. Health, or lack thereof, is determined by many factors: socio-economic status, environment, lifestyle and behavior, access to and use of medical care and genetics. To a large extent these factors are intertwined and highly correlated. *What's Goin' On* looks at all of these factors, to the extent that data is available, and documents the resulting health effects.

Analysis of the demographic profile of African Americans in the Finger Lakes Region provides an overview of the trends and disparities in social and economic characteristics of the African American population compared to other population groups in the Genesee Finger Lakes Region.

The African American population is now 132,700 people, a growth of 27% since the 1990 census. Sixty-nine percent of the population lives in the City of Rochester, although the African American population in the suburbs grew by 53% since 1990.

Unfortunately, for many in this growing population the economic boom of the mid-1990's was not a reality. In 1999, the median household income for African Americans was \$25,300 compared to \$49,500 for white/non-Hispanic households. Thirty percent of the African American households were in poverty, with incomes of less than \$12/day per person for all living expenses. Most affected were children, with 40% of all African American children living in poverty and more than 60% of all African American children living in female – headed households.

Living in poverty can have a profound and direct effect on a person's health as discussed in the chapter entitled "Underpinnings in Health". A person's environment (housing, neighborhood and safety) has an impact on health and can determine the behavior and lifestyle choices a person can make.

By any measure, people who live in communities of concentrated poverty are at greater risk of disease and premature mortality. This risk profile clearly describes the situation of African Americans, particularly in the City of Rochester, where two-thirds of the African Americans in this region live.

African Americans in this community are more likely than white/non-Hispanics to live in housing that is overcrowded and dilapidated and presents exposure to health risks, such as lead and violence.

In unhealthy neighborhoods the practices that contribute to health, such as walking and other neighborhood activities that promote social connectedness, are difficult to pursue.

The Task Force wrestled with the question of the effect that race and racism have on health outcomes. They reviewed studies in which critical variables such as socio-economic status were controlled and still health disparities remained. *The fact is that African Americans are more likely than Whites of the same socio-economic status to die of heart disease and many other diseases.* The Task Force also reviewed national studies that controlled for socio-economic status and documented lower utilization rates for preventive services such as flu shots, pap smears, prostate cancer screening and mortality.

They concluded that:

- there is no evidence that race has a lot of meaning biologically, or clinically, except for certain diseases such as sickle cell anemia;
- finding a primary cause for the disparities was difficult and;
- placing blame, on the ‘system’ or on “African Americans”, was destructive and irrelevant.

Finally, the Task Force believes that until we acknowledge that two of the underlying causes of the health and healthcare disparities identified are mistrust and racism – on the part of the patient and the provider – we will be unable to provide effective health care to African Americans and other people of color or develop successful interventions that enable people to improve their own health.

In order to address the issue of race as a factor in health outcomes we must begin by ensuring that the institutions that provide care are culturally competent. To that end, the Task Force adopted the following definitions of cultural competence:

For the individual, cultural competence is the state of being capable of functioning effectively in the context of cultural differences.

For the organization, cultural competence is a set of congruent skills, attitudes and structures which come together in a system, agency, or among professionals and enable that system, agency or those professionals to work effectively in the context of cultural differences.

What then, are the health consequences for African Americans of:

- 1) concentrated poverty;
- 2) a health care system that is only now recognizing that medical care is only one thread of the fabric of health care – that understanding and respecting a patient’s culture and providing culturally competent services and ensuring an economically and socially healthy community are equally essential; and
- 3) a population that mistrusts the healthcare system because of historical events such as Tuskegee and current interactions with the health system during which they feel they are treated differently?

The final chapter of *What's Goin' On*, entitled “Health Conditions” details these consequences with analysis of health conditions and indicators in chronic disease, infectious diseases, maternal and child health, and mental health.

The significant health disparities findings include:

- The mortality rate among the African American population in this region has not declined in the past 20 years, while the mortality rate among the African American population in the nation, in New York State and in New York City has declined.
- Homicide is nearly four times more important as a cause of death among African Americans as the general population. Homicide causes 2.1% of all African American deaths compared to 0.5% of deaths in the general population.
- The hospitalization rate for Ambulatory Care Sensitive diagnoses is higher for African Americans in the region than for non-African Americans. In Monroe County, the ACS rate for African Americans is almost three times the rate for other populations groups at 1,772 hospitalizations/100,000 African Americans under age 65 compared to 628 for non-African Americans.
- In Monroe County, the heart disease mortality rate for African Americans has declined since 1980. However, the decline has not been steady and has been much slower than the decline for the overall population. Further, African Americans in the City of Rochester were hospitalized 3 ½ times more often for ‘avoidable’ cardiac-related causes, had a higher mortality rate, but received fewer cardiac catheterizations, angioplasties and open heart surgery procedures than Whites living in the City.
- One in three Monroe County African American residents is obese compared to one in five Whites.

- Diabetes prevalence is 70% higher among African Americans than Whites and results in one third more deaths among African Americans than among the general population. In 1980, the regional diabetes mortality rate for African Americans was at least one-third lower than the rate for African Americans in NYS and the nation. It has now surpassed the rates for these comparison areas; in fact, it is almost 50% higher than the rate for New York State as a whole.
- Although the hospitalization rate for asthma in Monroe County has declined among African Americans between 1990 and 2000, it is still more than three times higher than among the non-African American population.
- The African American cancer mortality rate in the region has not declined during the last decade as it has in other areas, and the regional rate now exceeds the rates for African Americans in Upstate New York and New York State as a whole. In the region, the cancer mortality rate for the African Americans population is 1.3 time the rate for the overall population.
- The AIDS prevalence among African Americans in the Finger Lakes Region is almost 5 times the overall rate.
- In Monroe County, white adults over the age of 65 years are twice as likely to have been immunized against flu and pneumonia as are African American seniors.
- Early prenatal care occurs for only half of African American mothers in the Finger Lakes Region and a higher percentage of African American women received late (last trimester) or no prenatal care than white women.
- African Americans have higher rates of infant mortality than do Whites and more than 20 black infants die each year in the region. This disparity occurs regardless of income.
- New York State data indicates that 75% of African American births occur to women who are not married, thus creating the potential for lifelong consequences for mother and child.

Conclusion

The African American Health Status Task Force will re-convene in June 2003 to:

1. Further develop and prioritize the preliminary recommendations contained in *What's Goin' On*,
2. Identify community agencies and providers to join with the Task Force to implement the recommendations contained in the report, and
3. Pursue additional data, particularly in the areas of mental health, substance abuse and child development in order to develop more specific recommendations in these areas.

The Task Force is committed, as discussed in the beginning of this Executive Summary, to keeping the findings of this report on the community's radar screen and, more importantly, to eliminating the disparities identified in this report. To that end, the Task Force will call upon appropriate community leaders to implement the recommendations with the acknowledgment that to eliminate health disparities identified in *What's Goin' On*, community environments (housing, employment and education) that build African American neighborhoods and support families must be re-created.