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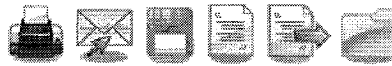

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Title: *Blacks die younger than whites, regardless of income; the health care system begins tackling the complex causes*
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Blacks die younger than whites, regardless of income; the health care system begins tackling the complex causes

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Tracy Wheeler

Sep. 24--disparities are problem

Health

Poor. Working ***poor***. Middle class. Wealthy.

It doesn't seem to matter.

African-Americans, on average, die younger than whites, regardless of the money they make or the neighborhood in which they live.

In Summit County's poorer neighborhoods, whites live almost three years longer than blacks. In more-well-to-do neighborhoods, this gap grows into a chasm: Whites live to an average age of 76.4, compared with just 67.1 for blacks.

That's a difference of 9.3 years.

Nearly a decade of ***life***, gone.

"I think it's the new civil rights struggle," said University of Dayton law professor Vernellia Randall."***African***-Americans lag behind on nearly every health indicator, including ***life expectancy***, death rates, infant mortality, low birth-weight rates and disease rates.

"We have shorter lives. We are quite literally dying from being black."

It's an ugly truth in Akron and Summit County. In Ohio. And across the United States, where a black baby born in 2003 can expect to live 72.7 years, while a white baby is expected to live to be 78.

American Indians and Alaska natives have an even bleaker ***life expectancy*** than blacks: 70.6 years. And at the other end of the spectrum, a newborn Asian-***American*** girl can be expected to live the longest, until 85.8.

There's no single, simple reason for these disparities, but rather a complex set of social, economic, educational, cultural and racial circumstances. A lack of health insurance, a distrust of the medical
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establishment, ***poor*** personal choices and inferior health care all are factors.

Of all theindignities ***African***-Americans have confronted in this nation's history -- from slavery to segregation to inequality in housing, education and income -- the health gap is the one that has remained virtually unchanged.

A 2005 report by former U.S. Surgeon General David Satcher found that in 2002, ***African***-Americans suffered 40.5 percent more deaths -- a total of 83,750 more -- than they would have if they shared the same mortality rate as whites. That works out to 3,138 = [100.0]untimely deaths a year among blacks in Ohio and 173 in Summit County.

"Surprisingly," Satcher's report said, "health disparities may be even more resistant to change" than other social problems ***African***-Americans have faced.

Disease by disease

Pick almost any disease, and blacks are hit much harder by it than whites. Consider these statistics from a variety of national, state and local organizations:

--Heart disease: Nationally, ***African***-Americans are 50 percent more likely to have high blood pressure, which contributes to the risk of both heart disease and stroke, and they're 20 percent more likely to die from heart disease. Yet they're less likely to receive proper, timely treatment, even when they have insurance coverage.

--Stroke: In Ohio, ***African-American*** men are 53 percent more likely to die of a stroke than any other racial or gender group, while ***African-American*** women have the highest overall risk of a stroke.

--Diabetes: Nationally, blacks are 140 percent more likely to be diagnosed with diabetes, 30 percent more likely to undergo a diabetic-related amputation and 120 percent more likely to die from diabetes.

--Cancer: Whatever the cancer -- breast, colon, esophagus, bladder, cervix, uterus, rectum, prostate, leukemia -- blacks are less likely than whites to be alive five years after diagnosis. Even skin cancer, which is uncommon in those with darker skin, is more likely to end in death for ***African***-Americans. In Ohio,***African***-Americans are 6 percent more likely than whites to be diagnosed with cancer and 32 percent more likely to die from the disease.

--HIV/AIDS: Of the 1.2 million Americans living with HIV, the AIDS virus, in 2003, 47 percent were ***African-American***, even though blacks account for only 12.3 percent of the U.S. population. In 2004, black men were diagnosed with HIV/AIDS at a rate 603.7 percent higher than that of white men. Black women were diagnosed in 2004 at a rate 1,993 percent higher than that of white women.

--Homicide: Though violence isn't a disease, it is a health issue -- one that has a significant impact on ***life expectancy***. Between 1999 and 2003, blacks in Summit County were killed at a rate of 14.6 per 100,000, compared with 2.7 per 100,000 whites.

--Infant mortality: Even though infant mortality declined steeply in the 1980s and '90s among all races, the disparity between whites and blacks increased because the improvement was greater among whites. In these two decades, infant mortality among whites declined to 5.7 deaths per 1,000 births (a 47.7 percent drop); among blacks, it dropped to 14 deaths per 1,000 births (a 36.9 percent decline). In Summit County, an ***African-American*** baby is 3.5 times more likely than a white baby to die in infancy.

The statistics are numbingly clear.

"Racial and ethnic disparities are just about everywhere," said Nicole Lurie, co-director of public health for the nonprofit RAND Corporation. "It doesn't matter what diagnosis or health condition. It doesn't matter how you measure it -- whether you measure it by the amount of care, the quality of care, the appropriateness of care. It doesn't matter whether you look at different geographic regions. It's everywhere."

Still, Lurie, who spoke at a health disparities forum at Case Western Reserve University last fall, said those who need to understand the problem the most -- physicians -- don't even see it.

Just one in three cardiologists and one in five cardiac surgeons believes that racial health disparities are an issue, Lurie reported in a study that was published in the journal Circulation. When they were asked whether disparities were a problem in their own hospitals, only 12 percent of cardiologists and 3 percent of cardiac surgeons said yes.

"Despite the fact that this has been incredibly well-documented, our profession -- the profession of medicine -- has got a problem because they're still in denial," Lurie said. "And it's pretty hard to take action on a problem that you don't know or don't believe exists."

Patients lack knowledge

Debra Parmer doesn't need to be convinced. She has witnessed the problem.

In 1997, Parmer left a job in hospital administration to start the Northeast Ohio ***African American*** Health Network, with a focus on getting health information to the underprivileged.

Parmer, now a graduate student at the University of Akron, gained a new perspective on minority health in her nine years running the network, which shut down earlier this year because of funding problems.

"What I saw," she said, "was eye-opening."

Patients who would spread a 30-day prescription over two months because they couldn't afford to refill it every month. Diabetics who didn't monitor their blood sugar or didn't know how. Diabetics who wouldn't exercise, who wouldn't try to lose weight, who continued to cook with fatback and bacon fat -- thinking their medicine was all they needed.

"People really don't know as much as they need to know, and that's a big reason why they get sick," Parmer said.

"They might be told, 'Well, you're a Type 2 diabetic, you need to change your dietary habits. You have to change your whole ***life***,' spending maybe 10 minutes with the doctor.

"We were finding that people didn't understand what it meant to change their dietary habits. They didn't understand what it meant to monitor (their blood sugar) several times a day. Their (blood sugar) numbers were incredible. Their physicians were on their backs about, 'You need to get this under control because eventually you're going to die from this.' But these people really did not know. They didn't understand what they were supposed to do.

"That helps you understand why you see what you see."

Death rates are a concrete measure of health disparities among races. Less obvious is the effect on a person's quality of ***life*** -- the suffering through dialysis or surviving with an amputation or coping with the aches and pain of untreated disease.

"Sometimes, ***African***-Americans have been sick for so long, they don't realize that they're sick anymore," said Gerry Radcliffe, a retired nurse who has focused on reaching ***African***-Americans for diabetes education courses in Canton. "We can do more than we do with a lot of these illnesses."

Mistrust of health system

Poverty, of course, plays a role in health disparities, and ***African***-Americans are more likely to be ***poor*** than whites. In Summit County, for example, 10.4 percent of the white residents live in poverty, while 32.5 percent of black residents do.

A slew of research has shown that the ***poor*** often live in old housing, which is more likely to have lead paint, dangerous wiring, insufficient heating, infestations of cockroaches or rats, and pesticide exposure.

The ***poor*** often work in high-risk jobs that don't offer insurance benefits. And lack of insurance leads them to delay medical attention until symptoms grow worse, meaning serious conditions such as cancer and heart disease are caught in later stages, when treatment is less successful.

But research has shown that even when minorities seek medical attention early, they are less likely to be offered diagnostic procedures for heart disease and cancer. And they're more likely to be treated by doctors with less clinical training and in hospitals with higher surgical mortality rates and less access to needed resources, such as diagnostic imaging and high-quality support services.

Such treatment by the medical establishment only bolsters a general distrust of the health care system among ***African***-Americans, which reinforces their tendency to delay seeking treatment.

Summit data point to race

But Randall, the University of Dayton law professor, said it's too easy to put the blame on poverty. She believes the focus needs to be on race, not income.

"By focusing on the economics," Randall said, "it looks at only one tiny aspect of the issue, and it doesn't deal with the historical disparities -- I call it the slave health deficit -- or the disparities caused by racism."

Without focusing on race, she said, the problem will never be fixed.

"We allow disparities to continue because we're unwilling to do the things we need to do to address them," she said. Society "wants to address them in an egalitarian way, as if to say, 'See, it's not about race, it's about being ***poor***.' "

Statistics from Summit County also suggest that race, and not poverty, is the main reason for the disparities.

In compiling these statistics for 2000 to 2003, the Akron Health Department classified neighborhoods according to U.S. Census tracts. ***Poor*** neighborhoods were defined as places where at least 20 percent of the residents lived below the poverty level. In the more-well-off neighborhoods, less than 5 percent of the residents lived below poverty.

Because Asians (1.4 percent), Hispanics (0.9 percent) and American Indians (0.2 percent) represented such a small portion of the Summit County population, the statistics were limited to blacks and whites.

The health department's findings showed that in Summit County blacks in neighborhoods above the poverty line lived no longer than blacks in impoverished areas. They died at essentially the same age -- 67.1 years compared with 66.8 years, a difference of just a few months.

The same wasn't true of whites, though. In ***poor*** neighborhoods, whites died at an average age of 69.7 years old. But in more well-to-do neighborhoods, whites' ***life*** span was 76.4 years -- more than 6 ½ years longer.

These findings don't surprise Randall. Summit County isn't any different from the rest of the nation. It has long been known by those working to close the health gap that money doesn't vaccinate blacks against ***poor*** health.

Middle class differs by race

There's an inherent difference between the white middle class and the black middle class, she said. Many, if not most, in the white middle class are in their second or third generation of being middle class. Meanwhile, most ***African***-Americans in the middle class are just first- or second-generation.

If a black man is the first generation of his family to reach middle-class status, that means that he was raised in poverty with all the negative health effects that came with it.

And if a black woman is second-generation middle class, it's likely -- according to the statistics -- that she lost her parents at a younger age, meaning she probably had less financial support to get through college -- so maybe she never earned a degree -- and will have less wealth handed down to her later.

They are middle-class, Randall said, but "they're still experiencing the effects of poverty."

Racial health disparities in the United States are older than the country itself, she said. The disparities began with the first slave ships in the mid-1600s, and blacks haven't caught up. She is pessimistic that they ever will.

While Summit County Health Commissioner Gene Nixon believes that race and poverty undoubtedly contribute to the health gap, he believes it's time for people to accept responsibility for their health.

"There's an attitude of, 'I'll worry about my diet and physical activity after my first heart attack.' Well, most people don't survive their first heart attack," he said. "There's this attitude that 'I don't have to worry about it, the health care system will make me well.' "

Meanwhile, obesity rates soar, fueling heart disease and diabetes.

"We've got to get these things under control," Nixon said. "We need to somehow shift the burden of responsibility back to the individual. That sounds cold, I know. But we have to face the facts that technology cannot make us well."

Health care system criticized

Still, the medical establishment isn't without blame, according to the nonprofit Institute of Medicine, based in Washington, D.C.

In its March 2002 report Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, the institute highlighted three main problems contributing to the disparities:

--Bottom-line-driven health-care systems, which may make sense financially but lead to unintended consequences.

"These policies may unintentionally hurt minorities," the report said, "in that cost-savings may come

at the expense of patients who are least educated about their treatment options and least likely to push their doctor for more services."

--Prejudice among doctors and other health-care providers.

Prejudice and stereotyping are a nearly universal human function, even among those who truly believe they don't judge others, the report said, and doctors are no different.

For example, a study of cardiologists -- using videotaped actors as patients -- found that black women were much less likely to be referred for cardiac catheterization than white men and women or black men were.

--Patients' attitudes and behaviors. Some minority patients do not trust health care professionals and delay treatment, and other patients do not follow their doctor's instructions exactly.

"It may seem like an unbreakable cycle," the report said, "but it is not a hopeless situation. The first step toward correcting the problem is to make people aware of it."

Health education stressed

Pauletta Hatchett believes the best place to raise awareness is with children.

As the instructor of the ***American*** Heart Association's Kidz BEAT program in Akron, Hatchett hopes black children can take control of their destiny, at least as it relates to obesity, nutrition and exercise.

She knowsKidz BEAT won't solve the overall problem of health disparities, but it will set kids -- and hopefully their families -- on a healthier course.

The summer program reached about 300 children, as Hatchett visited predominantly black churches during vacation Bible school sessions. She led the children through a series of exercises, taught them how to choose heart-healthy snacks and led role-playing lessons on ways to effectively say no to smoking. Each child was given a duffel bag, along with cookbooks, water bottles, hula hoops, pedometers, jump ropes and kickballs.

"I believe because of the electronic age, children have adopted a sedentary lifestyle and so have their parents," Hatchett said. "That has to change."

Cathy Brown of Akron saw a difference in her 12-year-old daughter, Teneisha, after just four days of Kidz BEAT seminars. Foods that used to be commonplace in the Brown household were suddenly getting thumbs-down reviews from Teneisha.

"She's been coming home saying, 'Mom, that's not good for you.' She's been telling her little brother, too," Brown said. "Just this week, there's been a change in her eating habits. She's eating more salads. We went to McDonald's this week, and I said, 'Don't you want fries with that?' She said, 'No, I want a side salad.' I thought, 'OK, that's a step in the right direction.' "

Yes, it is, but it's just one step in a very long journey.

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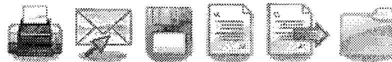

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