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Lifestyle and behavior are central to the acquisition and development of major chronic diseases. To influence lifestyle and behavior, health promoters must take into account the values, attitudes, culture, and life circumstances of the individual. If we are to achieve salutary changes in the health status of minority populations, health professionals and designers of health programs must cope with the extraordinary diversity of America’s populations.

There are four generally recognized minority groups in the United States: Asian/Pacific Islanders, African-Americans, Hispanics, and Native Americans. While about one out of five Americans belongs to one of these four groups, their population growth is substantially greater than that of the white population. These groups will make up an increasing share of America’s population in the future; by 2020, approximately 40 percent of school-age Americans will be minority children. Minority people’s well-being is a matter not only of social justice but of enlightened national self-interest as well.

It has long been known that blacks’ health status in the United States is markedly worse than that of whites. This had been documented at least as far back as 1906 by W.E.B. DuBois in his report, *The Health and Physique of the Negro American*. Occasional studies since DuBois’s have documented the disparity between the health status of blacks and whites in America. For many years, the federal government’s statistical reports have broken out health data into nonwhite (the vast majority of whom were black) and white, and more recently into black, white, and other.

The 1985 report of the U.S. Department of Health and Human Services (HHS) Secretary’s Task Force on Black and Minority Health was a landmark document with regard to minority health. The secretary’s task force report was distinctive from previous reports in six ways: (1) it...
focused on all four major minority groups in the United States as well as the white population, a perspective congruent with the increasing racial and ethnic diversity of the United States; (2) it was prepared under the aegis of the National Institutes of Health (NIH); (3) it used the somewhat more dramatic statistical presentation of “excess deaths” rather than the usual comparison of death rates, bringing home the message that lives that were lost would not have been lost had minority death rates been the same as for the white population; (4) it was launched by an HHS secretary in a conservative Republican administration, thus acquiring a legitimacy that would have been less likely had either a nonfederal sponsor or a more liberal administration commissioned the study; (5) the sheer weight of the report (approximately 3,000 pages), as well as its thoughtful analysis of the various causes of death, established a new high-water mark for academic rigor brought to bear on minority health issues and introduced more forcefully than ever the issues of health promotion/disease prevention into strategies about the health of these populations; and (6) as a result of the report, a highly visible Office of Minority Health was created within HHS to advocate for and oversee the implementation of the report.

Demographics And Health Status Of Minority Populations

In the discussion that follows, some of the mortality rates and other health-related data are drawn from the task force report. Those data are in some cases a decade old. It is regrettable that, while the report did stimulate greater awareness of the importance of data on minority Americans, that interest has been only partially reflected in data collection policies and funding levels. Data on non-black minorities in particular are still unacceptably sparse. The data from the task force are used only to sketch broad patterns of illness and death and the relative health status among minority and majority populations. All indications are that, with the exception of acquired immunodeficiency syndrome (AIDS), these data have changed little in the intervening decade.

Asian/Pacific Islanders. Currently the fastest-growing population in the United States, the Asian/Pacific Islander population increased 141 percent from 1970 to 1980, compared to 17 percent for blacks, 39 percent for Hispanics, and 12 percent for the overall population. Asian/Pacific Islander populations are quite heterogeneous. They include not only well-established Asian-American groups that are more likely to have been born in the United States, such as Japanese and, to a lesser extent, Chinese and Filipinos, but also large numbers of Southeast Asians who have recently immigrated to the United States as a result of the Vietnam
War. The median family income for Asian/Pacific Islanders in 1979 was $23,600, higher than for other minority groups and whites, although this figure may be artificially inflated because of larger numbers of workers per household. Vietnamese, by contrast, have an average family income of about half that of the Asian/Pacific Islander population as a whole. As calculated in the secretary’s task force report, the excess death rate of Asian/Pacific Islanders was −14 percent. This means that, in the aggregate, Asian/Pacific Islanders have lower mortality rates than the white population.

Black Americans. African-Americans are currently the largest minority group in the United States. Diversity within this group is less obvious than among other minority groups because of the homogenizing effect of the long-standing black presence in America, with less contribution from recent immigration compared to Asians or Hispanics. Approximately one-third of blacks live below the poverty level, and unemployment among black Americans has been approximately twice that of whites for the past fifty years. On the other hand, the black middle class has grown substantially in the past fifteen years. Mortality rates among black Americans are the highest of the four minority groups—approximately 50 percent higher than whites—and the excess death rate was 42 percent.

Hispanic Americans. As with Asian Americans, Hispanic Americans—the second largest minority group—come from a variety of different countries. Three-fifths of Hispanics are Mexican in origin; about 15 percent are from Puerto Rico; 6 percent are from Cuba; and about 18 percent are from Central America, South America, and other Hispanic regions. Hispanics are also diverse as to socioeconomic status measures, circumstances under which they came to the United States, and levels of acculturation. The health status of Hispanic Americans in the aggregate appears to be remarkably good—much closer to that of the white population than the black population—despite the fact that the overall poverty rates of Hispanics and blacks are similar. However, national vital statistics data for Hispanics are currently unavailable because “Hispanic” is not a racial category, and data on Hispanics are gathered by some states or cities but not by others.

Native Americans. This is the smallest and perhaps most diverse of all American minority groups. About 1.6 million Native Americans are distributed among about 500 tribes and village units. Overall, Native American poverty rates are similar to those of Hispanics and blacks.
Native Americans, with the second worst health status of any of the minority groups, have a unique set of health problems. Among many tribes, alcohol abuse and resultant high death rates from unintentional injuries and interpersonal violence decimate the population of young Indian people. The excess death rate for Native Americans was 22 percent, according to the secretary's task force report, which calculated that 87 percent of these excess deaths occur prior to age forty-five. These mortality problems, combined with the collision between traditional culture and increasing urbanization, present unique challenges for prevention. Adding to this complexity is the special relationship some tribes have with the federal government, arising from historical treaties and "nation to nation" status. This results in an inconsistent pattern of Indian Health Service and health insurance coverage.

Patterns of mortality. The secretary's task force report identified six important categories of diseases that cause the overwhelming majority of excess deaths in minority populations: cancer, cardiovascular disease, chemical dependency (measured by deaths due to cirrhosis and liver disease), diabetes, infant mortality, and violence (Exhibit 1) The most important contributor to the health status differential between blacks and the other minority populations is blacks' excess deaths from cardiovascular disease and cancer, the leading causes of death in America. Since the task force report, AIDS has become an increasingly important cause of death in the United States. The prevalence of AIDS among blacks and Hispanics is approximately three times higher than among the white

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Exhibit 1
Diseases Or Problems For Which Minority Groups Clearly Show Higher Death Rates Than White Population

<table>
<thead>
<tr>
<th></th>
<th>Black</th>
<th>Hispanic</th>
<th>Native American</th>
<th>Asian/Pacific Islander</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS/HIV disease</td>
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<tr>
<td>Cancer</td>
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<tr>
<td>Cardiovascular disease</td>
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<tr>
<td>Chemical dependency*</td>
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<tr>
<td>Diabetes</td>
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<td></td>
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<tr>
<td>Infant mortality</td>
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<td></td>
</tr>
<tr>
<td>Violence</td>
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<tr>
<td>Homicide</td>
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<tr>
<td>Suicide</td>
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<td></td>
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<tr>
<td>Unintentional injury</td>
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</tr>
</tbody>
</table>

*Deaths are primarily due to liver disease resulting from alcohol abuse.
population. Native Americans and Asian/Pacific Islanders thus far have not demonstrated rates of AIDS in excess of those among white Americans.

The higher rates of mortality among minority Americans give an added urgency to the need for effective prevention; however, our knowledge base regarding health promotion/disease prevention in minority populations is inadequate. For example, cirrhosis death rates among blacks are about twice those of whites, yet surveys of alcohol-use patterns indicate minor differences in alcohol consumption between blacks and whites.

**Factors Affecting Health Promotion For Minorities**

While it is essential to appreciate the diversity that exists among minority populations, several valid generalizations regarding “minorities” have direct implications for health promotion/disease prevention.

**Socioeconomic status.** Socioeconomic status tends to be measured by some combination of occupation, income, and educational attainment. On all three of these indices, the status of minorities tends to be lower than that of whites. In general, minorities have substantially lower incomes than do whites. In 1987, the poverty rate was 33.1 percent for blacks and 28.2 percent for Hispanics, compared to 10.5 percent for whites.\(^{10}\) It is well known that income is an important determinant of socioeconomic status, which in turn is a powerful variable in health and behavior patterns.\(^{11}\) Also, in general, minorities have lower levels of educational attainment than do whites.\(^{12}\) A direct implication of lower educational attainment is that prevention information must be presented in forms that are understandable to the target audience. Rates of other high-risk health behavior also correlate with education.\(^{13}\)

Throughout history, lower socioeconomic status has been associated with higher rates of mortality. However, when one examines the socioeconomic status of the various minority populations, the health status of these populations does not simply correlate. It is necessary that we develop a more multifactorial model of health status causality. We must also be prepared to deal with the possibility that socioeconomic status operates in minority populations with a time component. It may be that populations that have been poor over several generations without substantial progress up the socioeconomic ladder are likely to feel much more powerless and to perceive their lot differently than do newly arrived immigrants who are poor but still hopeful. There is evidence that Hispanic women in southern California have poorer birth outcomes as they become more acculturated.\(^{14}\) To the degree this perception of
frustration is true, it will also influence the strategies required for effective health promotion/disease prevention.

Insurance status. Minorities are much more likely either to lack health insurance or to be underinsured. About 15 percent of whites are uninsured, compared to about one-quarter of blacks and Hispanics.15 This has important implications for those aspects of prevention that are related to the health care delivery system.

Alienation from government. An additional important element that impinges on the design of health programs for minorities is alienation.16 Many minority communities feel substantial mistrust of the government, its agents, and its information. The impact of such alienation is that any government-sponsored or even majority-controlled program must first leap a substantial credibility gap before it can begin to operate, and that optimal health program designs require “empowerment” as a necessary component. The political overtones of this latter term often discourage its use by health professionals. However, in this context, it means joint decision making and resource sharing between majority and minority groups.17

**Program Design For Minority Groups**

Two concepts emerge that are of overarching importance for the design of programs, including prevention programs, designed to serve minority populations. These include use of a marketing perspective and community legitimacy.

Marketing strategies. Health behavior-change strategies must involve “social marketing.”18 To reach minority populations effectively with prevention information requires messages and programs that are tailored for and targeted to reach a specific audience. These marketing considerations require attention to socioeconomic and cultural variations. Such variations influence choices of messages and messengers, reflecting a variety of countries of origin, use of languages other than English, preferences for specific media and formats, use of multiple channels for transmission of information, framing that information to reflect differences in value systems and varying age structure of populations, and accommodation to subtle regional variations.19 The U.S. advertising industry has been quick to understand and exploit the segmentation of markets using a complex mix of demographic factors, designing specifically tailored messages for each segment of the market. The health community should use the expertise of the advertising industry as it begins to think seriously about how to influence health behavior.

However, the extensive training and education of health professionals
often leads them to overemphasize behavior change that occurs cognitively by provision of information, particularly written materials. Moreover, our American values also influence the framing of prevention messages. In this country, we highly value self-reliance and place substantial responsibility for life choices on the individual. Given this mind-set, destructive behavior patterns that are often encountered in poor urban populations, such as teenage pregnancy, noncompliance with physicians’ treatment regimens, drug use during pregnancy, and interpersonal violence, are viewed as not only detrimental to health, but morally wrong. The marketing perspective would lead us to deal with this behavior pragmatically but not judgmentally. However, belief in the power of cognitive information and individual responsibility—the value system overlay—must be recognized before pragmatic ameliorative solutions can be crafted. Otherwise, solutions tend to become entangled with inchoate inclinations to punish.

**Community legitimacy.** In a community-based prevention program, community legitimacy can be achieved by including mechanisms to allow communities to buy into the goals and content of the program. This is particularly critical in light of the problem of alienation I mentioned earlier. Mechanisms that can foster community legitimacy include the use of minority health professionals in the design of programs, the use of program governing boards with broadly representative membership, and full involvement of community representatives from the beginning of the project.

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**Focus Of Prevention Activities**

To better categorize the challenges we face in health promotion/disease prevention among minority populations, it is also useful to distinguish different spheres in which prevention activities may be focused: communitywide health information communication, screening/preventive services, and the physician/patient relationship.

**Communicating health information in the community.** Minority communities are exposed to many of the general health messages to which the rest of the population is exposed—antismoking messages, the emphasis on fitness, concerns over high-fat diets, and messages regarding substance abuse. However, the effect of these generic health messages on minority populations is likely to be minimal unless reinforced by more specific ones that are perceived to be more personally “relevant” to minority Americans.

Because of the emergency nature of the human immunodeficiency virus (HIV) epidemic, the necessity to specifically tailor communitywide
prevention information to minorities has received much more attention in the past three years. This has become particularly urgent as the rates of AIDS due to those HIV transmission categories in which blacks and Hispanics predominate are increasing at more rapid rates than in those HIV transmission patterns in which whites and minorities have similar rates of AIDS. The principles that have become accepted for community wide HIV prevention information for minority populations are equally valid for prevention of other diseases among minority populations. These principles include the importance of seeking credible messengers, tailoring messages so that they are culturally sensitive and appropriate, combining national campaigns with locally based ones to personalize the message, and considering the educational levels of target populations.

**Screening/preventive services.** Because screening and preventive services often are provided outside the physician’s office, these services need to be examined separately from prevention in the context of the physician/patient dyad. Poor populations frequently make use of a wide variety of publicly provided screening and prevention services often carried out in separate clinics for sexually transmitted diseases, maternal and child health services, drug treatment, and mental health. This results in fragmentation of services—one of the most problematic elements of health care delivery to disadvantaged populations. This fragmentation has especially pernicious effects since disadvantaged people are already burdened with excess disease, have the least skills to navigate a complicated bureaucracy, and face continual pressures to meet the needs of day-to-day life; all of these already mitigate against a focus on prevention.

**Physician/patient relationship.** Minorities have substantially lower rates of health insurance, which is the minimal “ticket” for access to the health care system. Moreover, even for those minorities who are insured, that insurance is disproportionately likely to be Medicaid, which reimburses so poorly for physician visits that many Medicaid patients enter the health care system only when an emergency occurs. Therefore, fragmentation of services is more destructive to minorities because they are more likely than whites to lack a usual source of care. Prevention services as well as optimal management of chronic disease are more likely to occur in the context of a long-standing relationship with a physician. Thus, minority populations who have little contact with the health care system between illnesses are even less likely to receive primary, secondary, or tertiary preventive care.

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**Health Issues Of Special Concern For Minority Populations**

**Genetic causality of disease.** Unfortunately, the myth of “inherent”
inferiority has long been used to justify the inferior status attributed to a wide variety of populations, including white immigrant groups such as Irish Americans. The same potential for stigma exists for any putative inherent susceptibility to illnesses. The evidence suggests that the contribution of genetic susceptibility to minority health disparities is relatively small. The genetic etiology of sickle-cell disease is clear; however, sickle-cell disease is not a major contributor to death rates among blacks. Hypertension among blacks and noninsulin-dependent diabetes mellitus among blacks, Hispanics, and Native Americans probably do have some genetic component. However, even in these latter examples, where there may be a genetic predisposition, development of disease is far from inevitable. Therefore, genetic screening and counseling do not offer much promise for improving minorities’ health status and carry the baggage of eugenics.

**Environmental hazards and pollution.** Exposure to environmental hazards often is related to occupational and housing patterns. In my view, environmental hazards and pollution in minority communities pose a problem that, politically, is potentially explosive, particularly when it can be shown that toxic hazards may have been dumped or tolerated because the local area or occupation was predominately minority. Racial/ethnic as well as socioeconomic patterns influence the distribution of minorities into jobs with greater occupational hazard, such as those of migrant farm workers, foundry workers, or semiconductor production workers. Similarly, while poor housing is certainly related to poverty, the intense urbanization and concentration of minority populations in certain areas of cities is related to other factors as well, including continuing housing discrimination. Future attention must be devoted to reducing these environmental risks and their impact on the health of minority populations.

**Homicide.** Although homicide and interpersonal violence are increasingly seen as public health problems and amenable to preventive interventions, progress to develop and evaluate model prevention programs has been slow. More vigorous development of programs must take place, but because violence is essentially a social rather than a biologic phenomenon, even more scrupulous attention must be paid to cultural sensitivities and community legitimacy.

**Tobacco.** Tobacco has been identified as the most important preventable cause of mortality in our country. Black and Hispanic males have substantially higher smoking rates than white males (about 40 percent versus 30 percent, respectively). Data on Asians and Native Americans are less complete. Black women smoke at rates similar to those of white women, while Hispanic women smoke at lower rates. The targeting of
blacks and Hispanics by tobacco companies for special marketing attention has given smoking particularly sinister overtones. This takes the form of large numbers of billboards in minority communities, ads in ethnic publications, and sponsorship of black and Hispanic cultural events and organizations. Recently, Secretary of Health and Human Services Louis W. Sullivan publicly criticized R.J. Reynolds for its planned introduction of the Uptown brand, a cigarette that was admittedly targeted toward blacks; subsequently, Uptown was withdrawn from the market. Tobacco is singled out for this kind of criticism because it is probably the only legal product that is a serious health hazard even when used as intended.

**Conclusion**

In this Commentary, I have highlighted a number of issues that must be addressed if we are to move toward health status parity between minority and nonminority Americans. A comprehensive solution will require both restructuring of our health care financing and delivery system, and increasing the representation of minorities within that system. However, incremental measures such as producing bilingual health information, providing outreach services, or changing clinic hours can lower barriers sufficiently to make measurable differences. The profundity of the changes that are ultimately required should not be a justification for inaction until the “whole fix” is at hand.
NOTES

1. U.S. Bureau of the Census, Current Population Reports, Series P-25, no. 1022 (Washington, D.C., March 1988), 12, Table 1; and no. 995 (November 1986), 14, Table T.
4. Ibid.