

RACE in AMERICA

Restructuring Inequality

HEALTH

The Sixth of Seven Reports on the Race in America Conference

June 3–6, 2010

CENTER ON RACE AND SOCIAL PROBLEMS
SCHOOL OF SOCIAL WORK
UNIVERSITY OF PITTSBURGH

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RACE IN AMERICA: RESTRUCTURING INEQUALITY

HEALTH REPORT

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Despite significant progress in America's stride toward racial equality, there remains much to be done. Some problems are worse today than they were during the turbulent times of the 1960s. Indeed, racial disparities across a number of areas are blatant—family formation, employment levels, community violence, incarceration rates, educational attainment, and health and mental health outcomes.

As part of an attempt to redress these race-related problems, the University of Pittsburgh School of Social Work and Center on Race and Social Problems organized the conference *Race in America: Restructuring Inequality*, which was held at the University of Pittsburgh June 3–6, 2010. The goal of the conference was to promote greater racial equality for all Americans. As our entire society has struggled to recover from a major economic crisis, we believed it was an ideal time to restructure existing systems rather than merely rebuilding them as they once were. Our present crisis afforded us the opportunity to start anew to produce a society that promotes greater equality of life outcomes for all of its citizens.

The conference had two parts: 20 daytime sessions for registered attendees and three free public evening events. The daytime conference sessions had seven foci: economics, education, criminal justice, race relations, health, mental health, and families/youth/elderly. Each session consisted of a 45-minute presentation by two national experts followed by one hour of questions and comments by the audience. The evening events consisted of an opening lecture by Julian Bond, a lecture on economics by Julianne Malveaux, and a panel discussion on postracial America hosted by Alex Castellanos of CNN.

This report summarizes information by the race and health speakers. The value of this report is that it provides access to the extensive and detailed information disseminated at the conference. This information will be particularly helpful to community and policy leaders interested in gaining a better understanding of health disparities and finding effective strategies for improving these conditions.

Disclaimer: This post conference Race in America report includes detailed summaries of the presentations and subsequent discussions that took place. Any opinions, findings, conclusions, or recommendations expressed in this report do not necessarily reflect the views of the University of Pittsburgh School of Social Work or Center on Race and Social Problems.

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Disparities in Health Care for Minorities: Institutional or Personal?

Presenter: Jeannette E. South-Paul, Andrew W. Mathieson Professor and Chair of the Department of Family Medicine at the University of Pittsburgh School of Medicine

Moderator: Brian Schreiber, President and CEO of the Jewish Community Center of Greater Pittsburgh

Racial and ethnic minorities, compared to Whites, have shorter life spans and higher rates of HIV/AIDS, asthma, obesity, cardiovascular disease, cancer, and infant mortality. Reasons for these disparities include lower socioeconomic status, living in poor social and environmental conditions, lack of health insurance, less access to proper health care, and more sporadic forms of care at the nation's lowest-performing hospitals and medical facilities. Other factors include genetics and health risk behaviors. Diseases and their causes often are co-occurring, and efforts are needed to simultaneously and comprehensively address both. Although Blacks are disproportionately at or near the top of all health and health care disparities, there has been little research focused on how the issues Blacks face with obesity and asthma can be resolved. The latter is similarly true for Latino subpopulations such as Puerto Ricans, who have higher rates of asthma than Mexican Americans.

Research that investigates disease (cause, course, and consequences) as well as solutions is needed to understand within- and between-group health disparities and how issues related to health care access affect the well-being of underserved populations. In addition, disparities in men's health are largely underinvestigated. Resolving health disparities will require improved cultural proficiency among health care professionals, interdisciplinary collaboration between clinicians and scientists and between researchers and advocacy groups, improved access to insurance and supports such as transportation, and a patient-centered team approach to health care services such as is emphasized in the medical home model. In the future, health care practice and policy changes that improve the capacity of health professionals to serve diverse patients, reduce the complex array of social inequities, and emphasize health protection may help to lower health care costs, improve health status, and reduce the divide between the health of racial and ethnic minorities and Whites.

The Problem

There are a variety of health disparities in the United States that have existed for decades across racial and ethnic lines. They often occur across the life span of an individual, from childhood through adulthood, and they encompass physical and behavioral health as well as health care services. Health disparities are causally related to interactions between social (educational, economic) and environmental, cultural, behavioral, and genetic and biological mechanisms associated with certain diseases. In addition, health disparities involve a variety of clinical and

scientific disciplines (medicine, sociology, genetics, etc.) and demand cultural proficiency to manage. Social determinants of health disparities are critical problems. Research shows that patients receive differential treatment by race, ethnicity, and gender in diagnosis, treatment, and prescription of secondary prevention measures. In order to make changes in health disparities in the United States, there need to be focused efforts by a diverse and well-trained workforce.

Infant Mortality Rate

In 1995, the infant mortality rate for African Americans was twice the national average, (14.2 vs. 7.2 per thousand, respectively) and more than twice that of Whites (6 per thousand). Ethnic minority women often do not receive prenatal care as early as White women, which exacerbates disparities. The rate of infant mortality does not improve for African American mothers with higher levels of education as it does for White mothers as they obtain higher education. Presently, African American women with college degrees have a higher rate of infant mortality than White women who drop out of high school.

Asthma Morbidity/Mortality

Environmental risks are major contributors to asthma (a respiratory condition marked by spasms in the lungs, causing difficulty in breathing). Being a minority in America is a stronger predictor of living near commercial hazardous waste than income level, house value, and number of waste sites. Minority communities can be identified on a map by locating neighborhoods that are nearest to garbage incinerators and toxic waste dumps.

There are almost 4,000 asthma-related deaths per year in the United States. A highly disproportionate number of those deaths occur in the African American community. African Americans are generally undertreated, have more obesity, and have lower birth weight compared to Caucasians. This is in part because African Americans generally have less access to “standard” health care, use emergency or “urgent care” more often, and have a tendency to use more Medicaid or subsidized medical care than Whites.

There has been an increase in genetic population studies of Caucasian and Asian asthma patients in the past 10 years. Conversely, there have been very few studies of African American patients despite the high number of asthma-related deaths in the Black community. Disparities in asthma prevalence, severity, quality of care, and outcomes are widely documented across diverse communities. These communities include people with either public or private insurance as well as varying socioeconomic statuses and other patient factors. In order to effectively manage asthma, patients must have affordable access to a full range of services and receive coordinated, quality health care. Thus there is a tremendous need to improve the capacity of safety net providers to meet the needs of people who are uninsured and those who are underinsured.

Burden of Pain

Racial and ethnic disparities exist in perceptions, assessment, and treatment of pain. Similarly, racial and ethnic differences related to pain and pain management have been found regardless of the setting (e.g., postoperative, emergency department). These differences relate to a complex interplay of patient expression of pain and belief in the need for pain medication, clinician bias in the recognition and perception of pain severity in diverse patients, and health care system factors such as access to medications.

Black and Hispanic patients with extremity fractures are less likely to be given analgesics in the emergency room than White patients with similar injuries. Studies have found that

- 57 percent of Black patients as opposed to 74 percent of White patients with similar injuries received pain medications and
- White patients with broken bones are 64 percent more likely than Hispanic patients with similar fractures to receive pain medications in the emergency room.

Causes

Socioeconomic Disparities and Health

Those with the lowest income and the least education are the least healthy because they lack the resources that are most important for them to do well in society. In addition, racial and ethnic groups that live in homogenous, socially isolated communities typically experience worse health than those in more racially and economically diverse neighborhoods.

Environmental Factors Influencing Health

In minority communities, there is greater exposure to toxic waste, violence, and disease:

- 17 percent of American children (ages 6 months–5 years) suffer from lead toxicity levels greater than 15 ug/dl. Of these 3–4 million children, 46 percent are African American.
- 15 percent of Mexican American children and 20 percent of Puerto Rican children have lead levels greater than 15 ug/dl.

Uninsured Children and Poor Quality of Care

Families of uninsured children face nonfinancial access barriers to care, such as lack of continuity with a primary care provider and inadequate visit time. These issues are compounded when the family has a child with special needs. Also, 70 percent of children who remain uninsured are actually eligible for Medicaid or government-subsidized health care for children (State Children's Health Insurance Program, or S-CHIP). The lack of coverage inhibits people from seeking appropriate care, diminishes health care provider availability, and compromises

care content. Additionally, minorities are more likely to receive care in lower-performing hospitals where all patients tend to receive worse health care despite racial background.

Interactions among Sources of Disparities in Health Care

Patient Level

- Patient preferences or refusal of treatment
- Care-seeking behaviors and attitudes
- Differences in clinical presentation of symptoms
- Perceptions that erode patients' trust
 - Lack of time and attention given by health care professionals
 - Perceived lack of concern and empathy
 - Perceptions that the provider's desire for profit drives medical decision making
 - Perceptions that managed care plans are not designed to protect patient interests
 - Perceptions that many health care providers hold negative stereotypes of minority patients

Health Care Systems Level

- Lack of interpreter and translation services
- Time pressures on physicians
- Availability and mix of health care providers
- Fragmentation in systems of financing and delivery of care

Provider Level

- Bias toward or against certain racial and ethnic groups
- Clinical uncertainty
- Beliefs/stereotypes about behavior or health of patients

Solutions

Changes in Health Care Policy

- Develop policies that improve overall care in facilities that serve a large percentage of minority patients
- Develop policies that effectively address the underlying reasons for health disparities (e.g., improve education, employment, and socioeconomic status)
- Develop strategies that strengthen primary care capacity and emphasize health protection to improve health status, reduce inequities, and lower costs
- Establish patient-centered medical homes and incentivize interdisciplinary team approaches to care

- Establish initiatives that improve cross-cultural communication between primary care doctors and patients and provide patients with access to a diverse group of doctors to advance adherence, satisfaction, and health outcomes

Culturally Competent Health Care Systems

- Increase culturally and linguistically appropriate services (e.g., interpreters, bilingual providers, health education materials)
- Recruit and retain medical professionals and staff who reflect community diversity
- Provide high quality cultural competence training to develop culturally proficient clinicians (including recognition of historical factors, language literacy, and socioeconomic status)
- Establish culturally specific health care settings
- Improve access to insurance, transportation, and geographic locations of health facilities
- Change the narrative professionals use when caring for patients from deficits to assets

Suggested Reading

Mortenson, G. (2007). *Three Cups of Tea: One Man's Mission to Promote Peace ... One School at a Time*. Penguin Press.

Health Disparities Solutions

Presenter: Thomas A. LaVeist, William C. and Nancy F. Richardson Professor in Health Policy and Director of the Hopkins Center for Health Disparities Solutions at the Johns Hopkins University Bloomberg School of Public Health

Moderator: Brian Schreiber, President and CEO of the Jewish Community Center of Greater Pittsburgh

Health disparities often are considered to be the result of race and socioeconomic status rather than an issue of racism and how it impacts the lives of individuals. Racial and ethnic minorities have the highest prevalence of most illnesses and mortality rates. However, the correlation between race and health disparity is greatly diminished when diverse groups with a similar educational background and income level are compared. There are racial/ethnic disparities at all levels of socioeconomic status.

As a result of racism and discrimination, racial and ethnic minorities often find themselves living in neighborhoods that are not conducive to good health and wellness. In disadvantaged, racially homogeneous neighborhoods, people are exposed to stressors and have inadequate access to health-supporting resources, such as adequate housing, quality medical care, and fresh food. Moreover, they often are exposed to health risks such as environmental pollutants. Add to these conditions the stress of dealing with racism and discrimination and the adverse effects on health and health disparities are compounded. Despite these well-documented facts, many still believe that race disparities in health are the result of genetics/biology or socioeconomic status. In sum, health disparities represent disparate experiences of American life. They result from gaps between diverse groups in four interrelated areas: health, wealth, educational attainment, and criminal justice. The solution to health disparities, therefore, will rely on interventions that collectively address each of these areas. Continuing to pursue medical care as the sole source of solutions to disparities misses the mark and decreases the likelihood of solving this vexing problem.

The Problem

The United States has higher health care costs but fewer optimal health outcomes compared to all other industrialized countries. To compound this issue, there are well-documented inequalities in access to health care and the quality of care available to racial and ethnic minorities. The issue of disparities in health care quality is much more than just an access issue. In its seminal report, the Institute of Medicine compiled the results of a large body of research documenting suboptimal care among minorities who had private health insurance. There has been a steady disparity in mortality rates by gender, race, and ethnicity for as long as data have been collected on this topic (which goes back to the beginning of the 20th century).

The Economic Burden of Health Disparities

Racial/ethnic disparities affect more than just the minorities who suffer from suboptimal care. Disparities have substantial costs to society, affecting all Americans. A 2008 report commissioned by the Joint Center for Political and Economic Studies estimated that about 30 percent or \$229 billion of the direct medical cost to the U.S. economy were “excess costs” attributable to minorities in poor health. The report estimated further that \$1.24 trillion was lost to the economy from 2003 to 2006 when taking into account premature deaths, absenteeism, and lost productivity from work due to poor health among minorities. This \$1.24 trillion is more than India’s economy, the 11th largest economy in the world.

Causes

Socioeconomic Status

While socioeconomic status is not the sole reason for race disparities, it is a contributing factor. Race and socioeconomic status are intertwined, and ethnic minorities are more likely to be at the bottom of the economic strata than Whites. However, Blacks with higher educational attainment still suffer from illnesses like diabetes and hypertension at disproportionate rates compared to Whites. For example, a Black college-educated woman has a higher infant mortality rate than a White woman who has dropped out of high school. Race and socioeconomic status are not synonymous, however. There are disparities that are associated with race and those associated with socioeconomic status. Race-based disparities do not exist merely because of socioeconomic status. Racism and the institutions and policies that support racism create different life experiences and, thus, different outcomes for diverse groups despite similar social standing.

Racism

Because race is a social construct, the measurement of race actually assesses how an individual, group, or community experiences racism. Racism impacts health through a variety of mechanisms:

- **Creating differential opportunity structures:** Opportunities, even within one community, often fall along racial lines, exposing some groups to increased health risks while at the same time protecting other groups. For example, being forced (by not having access to quality education and economic advancement) to live in disadvantaged neighborhoods exposes minorities to more crime, fewer resources, more fast food restaurants, more liquor stores, less access to fresh produce, and fewer places for recreational activities. However, opportunities to choose homes and schools in more affluent areas within a community, by virtue of better educational and economic resources, reduces these health risks.

- **Impacting individuals through stress processes:** Stress affects health through a variety of health processes. Dealing with racism and discrimination is an additional stressor with significant potential risks to health because of psychological and behavioral coping strategies that, while helping to reduce stress, may increase other conditions. One example of a behavioral coping strategy many use to deal with stress is overeating. This coping strategy can have detrimental effects on one's health, especially if individuals are living in a community that provides little opportunity to acquire fresh and healthy food, this coping strategy can have detrimental effects on one's health. Further, overeating with little opportunity to compensate with exercise or outdoor activities exacerbates health risks such as obesity, diabetes, and hypertension and has been shown to contribute to a 7-year shorter lifespan.
- **Internalized racism** American culture has a strong orientation toward individualism and places great value on the idea that American is a meritocracy. The culture suggests that educational attainment and economic self-sufficiency are achievable with hard work, perseverance, and morality. Because racial and ethnic minorities experience lower socioeconomic status than Whites, some individuals internalize the negative images and stereotypes that are often associated with low socioeconomic status. In addition, some racial/ethnic groups internalize portrayals of themselves as lazy, worthless, criminals, etc., and believe that these false images truly represent their character and that of others like them. Thus, for some, these images become a self-fulfilling prophecy. Others may become highly stressed by trying to over-compensate to disprove the stereotypes.
- **Segregation:** The United States is highly segregated. Racial and ethnic groups experience the country in very different ways than Whites. Risk and protective factors, the type and impact of stressors, and availability of and access to health care and other resources differ according to neighborhood and have a powerful influence on health and health disparities. Low-income populations live in mostly segregated neighborhoods with many risk-inducing environmental factors, such as liquor stores, and few, if any, grocery stores, fresh food markets, or banking institutions. Where an individual lives is highly correlated with their racial/ethnic background.

Solutions

A growing body of research is shifting the paradigm to growing recognition that race disparities may be the results of place disparities. For example, researchers at the Hopkins Center for Health Disparities Solutions at the Johns Hopkins Bloomberg School of Public Health have conducted a novel study that compared Black and White Americans living under similar social and economic conditions and receiving health care in the same health care marketplace. They found that the

race disparity we normally see in national samples was attenuated or completely erased when White and Black Americans live under similar conditions. So, when social factors and medical care are equalized, race disparities are minimized.

However, the challenge in developing policies that focus on place is that race also determines place. That is to say, members of racial minorities have fewer options in the housing market. A racially segmented housing market affects health through several routes: limited appreciation in home values leading to attenuated wealth creation, increased exposure to health risks, decreased availability of resources necessary to live a healthy lifestyle, less access to quality health care, and limited access to social capital such as friendship networks.

The impact on health disparities may be greatest if policymakers address the systemic structures that produce inequities in opportunity. Solutions for the health outcomes often have emphasized personal choice. It is certainly true that individuals have the responsibility and agency to maximize their health outcomes. However, a large body of research has documented that each of the leading causes of death in the United States are complex and multifaceted, influenced by a myriad of factors interacting at the individual, family, community, and societal level. Strategies to eliminate health disparities require solutions that address multiple levels, not just individual responsibility.

Even if we assume that the eradication of racial segregation is beyond the reach of policy prescriptions, we can pursue strategies that lessen the impact of place in producing race disparities. This can be done through the adoption of policies that redress the inequitable distribution of power and resources across communities. Adopting a strategy of “health in all policies” is one such approach. It recognizes that health is affected by policies that are not explicitly targeted to health, such as policies related to housing, agriculture, and the environment. Thus, to improve population health, the policies of sectors other than health must be considered.

Suggested Reading

Institute of Medicine (2003). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. National Academies Press.

Breast Cancer and Social Interactions: Identifying Multiple Environments That Regulate Gene Expression

Presenter: Sarah Gehlert, E. Desmond Lee Professor of Racial and Ethnic Diversity at the George Warren Brown School of Social Work at Washington University in St. Louis

Moderator: Candi Castleberry-Singleton, Chief Inclusion and Diversity Officer at the University of Pittsburgh Medical Center

Racial and ethnic disparities in the United States operate across a number of diseases and conditions. Mechanisms for these inequalities are found in rates of screening, treatment, and mortality associated with illnesses like HIV/AIDS and certain cancers. Currently, health disparities in the United States have reached a level that is unconscionable. In regard to breast cancer, ethnic minorities have more aggressive tumors and higher mortality rates than White women, despite the disease's being more prevalent in White women. Nationally, Black women have a 37 percent higher chance of dying from breast cancer than women from any other racial or ethnic group. In addition, Black women have an increased chance of having forms of malignant breast tumors that are resistant to most of the known treatments and medications for breast cancer. These and other health disparities are determined by the interaction among behavioral patterns, genetics, social circumstances, and shortfalls in the medical system. The social environment that Black women and other minorities tend to live in carries risks that can have adverse effects on health and the severity of breast cancer. Stressors such as increased exposure to crime, toxins, and other adversities compound breast cancer in many ethnic and racial minorities. Community-based participatory research is proposed as a solution to decreasing the negative effects of breast cancer on women in minority communities. Community-based participatory research includes focus groups with the target population and development of community advisory boards and task forces to discuss ongoing concerns related to breast cancer and to develop solutions.

The Problem

There is a link between the social environment and biological and clinical outcomes that fuel racial and ethnic disparities in breast cancer. Over the last 30 years, there has been a growing disparity in breast cancer mortality between African American and Caucasian women. Despite the fact that breast cancer is more prevalent in Caucasian women, their mortality rates have been improving faster than those of Black women since the 1980s. In addition, groups like Hispanics/Latinas, American Indians, Alaska Natives, Asian Americans, and Pacific Islanders all have lower rates of breast cancer mortality than African American women. Nationally, Black women have a 37 percent higher death rate from breast cancer than White women. However, this gap is higher in certain geographical areas. In Chicago, Ill., for instance, Black women have a 68 percent higher chance of dying from breast cancer than White women. In Missouri, where breast

cancer mortality has been on a steady decline among White women, there has been virtually no change in Black women since the 1980s.

Causes

Although not much is known about the determinants of health disparities, many agree with the five-point framework established by McGinnis et al. in “Health Affairs” (2002), which states that they may be the result of:

- Behavioral patterns (40 percent causation)
(smoking, diet, adherence)
- Social circumstances (15 percent causation)
(discrimination, availability of services)
- Shortfall in medical care (10 percent causation)
(physician bias, access to health care)
- Genetic predisposition (30 percent causation)
(heritability and genetic propensity)
- Environmental exposures (5 percent causation)
(toxins, pollution, secondhand smoke)

Genetic Predisposition

Only a small proportion of breast cancers (5–10 percent) are due to genes or genetic predisposition. Cancers that occur due to genetics typically cluster within families. A much larger percentage (70–80 percent) of breast cancers are due to sporadic gene mutation that occurs over the course of a woman’s life.

Environmental Exposures

In the past, environmental factors were thought to include only chemical exposures, altered diets, toxins, or things that come from outside the body. Currently, the interpretation of what makes up environment has been broadened to include social exposures.

Social Circumstances

Negative social experiences, like facing discrimination, exposure to violence, and lack of availability of resources, may modify a person’s epigenome, or how a gene is marked and programmed. Social factors may contribute to the disproportionate mortality rate between African American and Caucasian women. Race is not considered biology. However, race in America, to a certain extent, determines exposure to particular social circumstances. Experiencing certain negative social circumstances, as explained below, may cause

psychological responses to those social conditions that may result in changes in neuroendocrine and gene expression or the survival of malignant cancer cells (tumor growth).

- **Social isolation and stress:** Stress hormone receptors inhibit the death of malignant cells in breast tissue. Everyone experiences cell mutations that in a healthy body, are repaired right away. It is hypothesized that when someone experiences a negative social environment, epigenetic changes that occur as a result do not allow the body to repair mutating cells as it should.
- **Effects of negative social exposure (social isolation) on breast malignancy in lab rats:** Rats are a good model for human disease because they share the rearing of the young, are very social, and have a slight propensity toward breast cancer even without external intervention. In an experiment performed on rats and transgenic mice, it was proposed that increased social isolation and stress would result in larger malignant tumors. This study examined social stressors and breast cancer risk in groups of genetically related (i.e., sibling) rats in which scientists isolated some rats by placing them in separate cages on individual tables and left the others in a group. As expected, while the rats that remained in a group had stress levels that rose and fell normally, the levels of stress hormone in the socially isolated rats rose higher and took much longer to return to normal. Not only did the experiment result in an altered stress response in the socially isolated rats, but some of those with the heightened stress response also spontaneously developed malignant tumors at a rate that was 84 times higher than the rats that were not placed in social isolation.

Triple-negative breast cancer tumors, which are particularly aggressive and resistant to standard treatments, are much more likely to be found in African American women than in women from other groups. In the social isolation experiment, scientists found that as triple-negative tumors became more invasive (malignant) in the rats, the cells reacted as if they were mounting a stress response. When this occurred, there was an increase in stress hormone receptors and a simultaneous decrease in estrogen and progesterone receptors. This made the breast cancers even more aggressive and harder to treat with existing chemotherapies, which may have contributed to lower five-year survival rates.

Solutions

Community-based research to develop solutions was conducted with African American women in Chicago. Focus groups (n=49) were held with 503 residents in 15 Chicago neighborhoods with high concentrations of African American women of diverse socioeconomic statuses. Research staff with similar backgrounds assessed participants' attitudes, beliefs, and concerns about breast cancer and its treatment.

A community advisory board was formed and then focus group participants were brought together for a breast cancer summit at which results of the focus groups were presented. Participants were asked to formulate action steps to address concerns raised about breast cancer. The number one action step identified was to increase the availability of educational materials on wellness for African American youths ages 12–16. A DVD series on wellness was developed and is now a part of the health curriculum in all Chicago public schools.

Also developed was Chicago breast cancer task force and partnerships with six community-based organizations. The summit also led to a research study with women who had recently been diagnosed with breast cancer. These participants allowed researchers to be present during tumor removal and to take samples of the malignant tissue. Investigators also conducted in-home follow-up interviews after surgery and assessed psychosocial functioning, social networks, health behaviors, perceived discrimination, and daily salivary cortisol to monitor stress. In addition, they mapped and coded crime rates, housing, and pollution within a four-block radius of each participant.

Through this research, it was discovered that 32 percent of the women undergoing cancer treatment were clinically depressed, several had trouble securing stable housing for themselves and their children, most reported a high level of loneliness, and 31 percent reported being sexually assaulted during childhood or adolescence.

In general, solutions should include the following:

- Community-based participatory research consisting of focus groups, advisory boards, and task forces composed of members of the targeted groups for the purpose of discussing and addressing concerns related to breast cancer and breast cancer treatment
- Partnerships with community-based organizations to expedite wellness initiatives within the public, including summer apprenticeships to involve youths in educational workshops and innovative programming focused on wellness
- Psychosocial interventions for underserved women with breast cancer, such as:
 - The Sisters Network
 - African American Breast Cancer Alliance
 - Supportive-Expressive Group Therapy for women with ER-breast cancers
 - Resource/system navigator programs for patients
- Multilevel interventions that focus on the intrinsic and extrinsic levels
 - Interventions that focus on individual behavior change may not deal with issues of race and ethnicity.
 - Develop neighborhood- and community-level interventions that achieve policy change.
- Interventions that offer social support and build social networks (e.g., block clubs)
- Extensive case management for breast cancer patients by neighborhood support coordinators to help women navigate different systems and act as a liaison

Suggested Readings

Cacioppo, J.T., Hughes, M.E., Waite, L.J., Hawkley, L.C., and Thisted, R.A. (2006). Loneliness as a specific risk factor for depressive symptoms: Cross-sectional and longitudinal analyses. *Psychology and Aging*, 21(1), 140–51.

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Must, A., Jacques, P.F., Dallal, G.E., Bajema, C.J., and Dietz, W.H. (1992). Long-term morbidity and mortality of overweight adolescents: A follow-up of the Harvard Growth Study of 1922 to 1935. *New England Journal of Medicine*, 327(19), 1350–5.

Racism Matters: Its Deadly Effects on Health

Presenter: David R. Williams, Florence and Laura Norman Professor of Public Health in the Harvard University School of Public Health

Moderator: Candi Castleberry-Singleton, Chief Inclusion and Diversity Officer at the University of Pittsburgh Medical Center

African Americans have higher death rates than Whites for 12 of the 15 leading causes of death in the United States. Thus, there is a need to address the systemic factors that underlie such a diverse array of negative health outcomes. African Americans and American Indians have higher death rates than Whites across the life course, from birth through the retirement years. While official health statistics are fairly accurate for Whites and African Americans, it is important to keep in mind that officially reported data are not as precise for other racial/ethnic groups, including American Indians, Asians, and Latinos, because much of the data is based on observations of physical characteristics.

In addition to the significant disparities that exist between minorities and Whites in terms of illness and death rates, minorities tend to become sicker from illnesses earlier in life. These illnesses also tend to be more severe in minorities even when the illness is more prevalent in Whites. Within certain disease groups, there is variation in prevalence. For instance, among women under 40 years of age, African American women have a higher incidence of breast cancer than White women, illustrating the fact that Black women are more likely than White women to get breast cancer when young.

Much of the health disparity in the United States is driven by segregation. Segregated neighborhoods often lack resources and decent health care facilities. They often have higher rates of crime and airborne pollutants and less opportunity to obtain a quality education and to improve socioeconomic status, a major driver of health disparities. Living in a segregated neighborhood makes it extremely difficult to live a healthy lifestyle, due in part to restricted access to healthy food choices and opportunities for exercise. In order to reduce health disparities, policies and interventions are needed that ameliorate the negative effects of racism and dismantle the structures of racism. Additionally, a greater investment is needed to consciously address deeply embedded cultural stereotypes, build infrastructure, and create opportunities in disadvantaged neighborhoods that address gaps in socioeconomic status, which in turn will improve health.

The Problem

Persistence of Disparities over Time

Although life expectancy has increased for both Blacks and Whites over the past 50 years, on average, Whites still live five years longer than Blacks. In 1950, the life expectancy of Whites

was 69.1 years. Not until the 1990s did Blacks reach an average life expectancy of 69 years. Thus, a 40-year gap exists between the health of Whites and the health of African Americans.

Also persistent is the significant difference in mortality rates from diabetes between Whites and American Indians. For Whites, the death rate from diabetes has remained fairly stable since the 1950s. However, for American Indians, diabetes-related deaths have increased significantly, widening the disparity.

Excess Deaths

The term “excess deaths” describes how many people die in a year who would not have died if health disparities did not exist. In 1998, the most recent year for data on excess deaths, 96,800 African Americans died who would not have died if there were no racial disparities in health. This amounts to 265 premature deaths per day among African Americans.

These disparities are indicative of a failure in the United States to address the health care needs of its overall population as well as subgroups within the United States. While constituting less than 6 percent of the world’s population, the United States accounts for 50 percent of the world’s medical resources. Despite this fact, Americans have the worst health of any industrialized nation.

Causes

Socioeconomic Status

In every country in the world, one of the strongest predictors of variations in health is socioeconomic status. In the United States, socioeconomic status is a stronger predictor of health than genetics, cigarette smoking, or exposure to carcinogens. Socioeconomic status tends to be patterned by race and ethnicity. Because minorities have markedly lower educational attainment than Whites, they also tend to have lower socioeconomic statuses. Historically, minorities have experienced elevated levels of poverty in comparison to Whites, although nationally there are more poor Whites than there are poor minorities. Thus, the issue of socioeconomic status affects all populations. As income level increases, the chance of death before the age of 60 declines. Low-income Americans are three times more likely to die before the age of 60 than those with high income.

Race in American Society

Despite its powerful and apparent implications, socioeconomic status does not fully explain racial and ethnic disparities in health. Race, while a complex factor, also is an important driver of health disparities. Although, on average, Whites live five years longer than Blacks, Whites with a college degree live 6.4 years longer than Whites who do not finish high school. Within the African American population, there also is a socioeconomic difference whereby, on average,

African Americans with a college degree live 5.3 years longer than African Americans with less than a high school education. However, at every level of education, Whites live longer than African Americans. Whites who drop out of high school live three years longer than African Americans who drop out of high school. This gap widens as education increases such that among college graduates, Whites live 4.2 years longer than African Americans. Similarly, for all mothers, as their education increases, the rate of infant mortality declines. However, disparities exist such that African American mothers with a college degree have higher infant mortality rates than White women and women of all other racial/ethnic groups who drop out of high school (with the exception of American Indian women).

In addition, all of the indicators of socioeconomic status are unequal across race. For example, compared to Whites, Blacks receive less income with the same levels of education; the differences in pay are particularly great for men compared to women. Further, Blacks have less wealth at equivalent levels of income than Whites (differences in economic resources). Finally, Blacks have less purchasing power in part because the cost of goods and services in more disadvantaged neighborhoods is higher than in more affluent neighborhoods.

Segregation

Residential segregation is a fundamental cause and driver of health disparities in the United States. Segregation is basic to understanding inequality in America. It is the linchpin of U.S. race relations and the source of inequality and the gap in socioeconomic status among the races. It is argued that residential segregation is one of the most successful domestic policies of the 20th century in the United States because, once implemented, it has pervasive effects. Yet it is rarely identified as intentional, as a mechanism of racism, or as a target for change.

Segregation has a significant effect on health because where a person lives determines where they attend school, their preparation for college, and their foundation for socioeconomic success. Segregation also affects the quality of neighborhoods. Neighborhoods can either promote health or promote disease. It is more challenging to live a healthy lifestyle in a low-resource, highly restricted community. People get less exercise in neighborhoods where there are high levels of violence and eat fewer healthy foods in neighborhoods where there are no supermarkets that sell fresh fruits and vegetables. There also is less access to medical care in segregated communities.

There is not one city in America where Whites live under similar residential conditions as Blacks. The worst urban contexts in which Whites live is considerably better than the average context of Black communities. Even the wealthiest of Blacks are more segregated than the poorest Latinos and Asians despite Blacks' preference to live in less-segregated areas.

Factors That Make Segregated, Disadvantaged Neighborhoods Unhealthy

Segregated neighborhoods are more likely to be unsafe because they usually have higher levels of concentrated poverty, crime, and blight. Segregated neighborhoods also tend to have higher

levels of exposure to toxins and pollutants. They are less likely to have parks and areas that facilitate physical activity. The quality of housing in segregated neighborhoods has a tendency to be substandard or of poor quality. Streets and sidewalks often are in a state of disrepair in poorer segregated areas. In addition, segregated neighborhoods tend to lack culturally sensitive resources, health resources, access to medical care, and public transportation.

Blacks are more likely than Whites to reside in areas with lower-quality medical care. Hospitals are more likely to close in disadvantaged, segregated neighborhoods. Also, it is more likely that pharmacies in poorer neighborhoods have inadequate supplies and inventory, and physicians are less likely to participate in Medicaid in racially segregated areas. African Americans also are more likely to receive medical care in poorer-quality medical facilities where there are fewer board-certified physicians.

Factors That Foster Segregation

Wealth Distribution

Significant racial/ethnic disparities exist in wealth (i.e., net worth), which is defined as how much is left after all debts and assets have been accounted for. For every dollar of wealth the average White person has overall, the average Black person has 9 cents and the average Latino has 12 cents. Among the poorest populations, for every dollar of wealth poor Whites have (\$24,000 on average), poor Blacks have 1 cent and poor Latinos have 2 cents. When there is a shortfall in income, there is no economic reserve. There is no racial difference in savings behavior at similar levels of income in the United States. Therefore, the racial differences in wealth reflect disparities in the intergenerational transfer of wealth through inheritances when relatives die or through home equity over time due to historical policies and practices that promoted suburban development for Whites and restricted home ownership for Blacks. Thus, determining eligibility for social services by income dramatically understates the economic conditions minorities face. Economic hardship persistently differs for Blacks and Whites, even after adjusting for broad-range sociodemographic and socioeconomic factors.

An analysis of the economic downturn of the early 1990s revealed that African Americans were the only ones with a net loss of jobs. This reflected normal corporate downsizing and restructuring in the United States in that employers moved jobs from areas where African Americans lived. As an example, whereas 16 percent of Sears' workforce was African American, African Americans made up 54 percent of workers who lost jobs. At Coca-Cola, where 18 percent of its workforce was African American, African Americans accounted for 42 percent of workers who lost jobs. It also has been documented that domestic and foreign automakers take into account the percentage of African Americans who live in the market area and strategically locate or move plants away from areas with a high concentration of African Americans.

Negative Stereotypes

It is the persistence of negative stereotypes that drives racism and segregation in this country. Audit studies bear evidence of racism, most recently showing that a White man reporting a criminal record is more likely to receive a job interview and job offer than a Black or Latino man with an identical résumé and no criminal record.

As further evidence of the persistence of negative racial stereotypes, a study showed that

- 44 percent of Whites believe Blacks are lazy;
- 56 percent of Whites assume Blacks prefer to live off welfare and only 4 percent of Whites believe White people prefer to live off welfare;
- 51 percent of Whites believe Blacks are prone to violence;
- 29 percent of Whites believe Blacks are unintelligent; and
- one in five Whites, or fewer, are willing to say that Blacks are hardworking, self-supporting, not prone to violence, and intelligent.

In addition, many Blacks also embrace or internalize these negative stereotypes. Research shows that Blacks who endorse negative stereotypes of their own racial group have higher levels of substance abuse and mental health issues.

Stereotypes also drive unconscious/unthinking discrimination in health care, further contributing to disparities in health and health care. More than 200 studies, many conducted in large, nationally renowned medical centers, reveal that across virtually every medical procedure, minorities receive poorer quality of care and less intensive care.

Perceived Discrimination

Perceived discrimination is an additional source of stress that has negative consequences on health. For instance, a recent study showed that for Arab American women only, six months after the September 11 attacks on the World Trade Center, there was an increase in low birth weight and rate of preterm labor. This suggests that hostility directed at any particular group impacts its health and well-being. People who perceive that they are victims of discrimination are less likely to adhere to medical visits or prescribed medication regimens.

Solutions

- Increase investment in building infrastructures and creating opportunities in disadvantaged neighborhoods to improve the quality of health.
- Consciously address deeply embedded cultural stereotypes.
- Redefine health policy rather than focusing solely on targeted health programs. Health policies should be diversified across all sectors of society that have health consequences. Some examples of policy directions to improve health are the following:

- Housing policy
- Unemployment policy
- Community development policy
- Income support
- Increase political will and commitment to implement strategies that improve living and working conditions.
- Acknowledge the existence of racism and its consequences on health in America. Increase efforts to ameliorate the negative effects of racism, dismantle the structures of racism, and establish countervailing influences to the pervasive processes of racism.

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Using Social Movements to Address Obesity in America

Presenter: Monica L. Baskin, Associate Professor in the Division of Preventive Medicine at the University of Alabama at Birmingham (UAB) School of Medicine and in the Department of Nutrition Sciences at the UAB School of Health Professions

Moderator: Evan Frazier, Senior Vice President for Highmark Inc.

Rates of obesity have greatly increased over the last 20 years among all racial groups. The number of obese and extremely obese women has doubled since 1980. However, the increase in obesity has been particularly high in African American and Hispanic communities. Hispanic boys have higher rates of obesity than any other ethnic subgroup in the nation. Medical costs associated with overweight and obesity are estimated at more than \$90 billion annually. In addition, the medical burden of obesity could be as high as \$147 billion per year. Obesity is related to a number of life-altering illnesses in children and adults, including cardiovascular disease, pulmonary complications, problems with the endocrine system, orthopedic and gastrointestinal complications, and mental health and social/interpersonal problems. The causes of much of the obesity among minorities, particularly African Americans, are lower consumption of fruits and vegetables, greater satisfaction with and acceptance of larger body types, lower levels of physical activity, greater consumption of sugar and artificially sweetened beverages, more total fat consumption, greater preference for sweets, and food insecurity. Unhealthy eating patterns in families also tend to be passed from generation to generation. In addition, racial and ethnic minorities often live in communities with little access to healthy foods and where there is limited access to outlets for physical activity. Some of the ways to combat obesity are to develop, implement, and evaluate community education resources and programs developed in partnership with diverse communities and community groups. In addition, it is vital to work with local government officials to improve recreational options in the community.

The Problem

Short-term Health Consequences

Among adults, obesity is described as a body mass index (BMI) of 30 or higher, and extreme obesity is a BMI of 40 or higher. For children and adolescents, weight status is classified to take into account normal differences in body fat between boys and girls at various ages. As such, obesity for youth is defined as at or above the 95th percentile for children of the same age and sex. The problem of obesity is growing in the United States, affecting a greater number of children as well as adults. There are a number of consequences to being overweight or obese. Some of the short-term effects of obesity are cardiovascular health risks (e.g., high cholesterol, high blood pressure, lipid disorders); pulmonary complications (e.g., asthma, sleep apnea); problems with the endocrine system (e.g., type 2 diabetes, menstrual irregularities); orthopedic complications (e.g., bowed legs, hip disorders); gastrointestinal complications such as liver

disease; mental health conditions (e.g., depression, low self-esteem); and social/interpersonal problems such as teasing, bullying, and discrimination. Some of these short-term problems become longer-term diseases and disorders, including diabetes, heart disease, osteoarthritis, stroke, gall bladder disease, numerous cancers, high blood pressure, and depression.

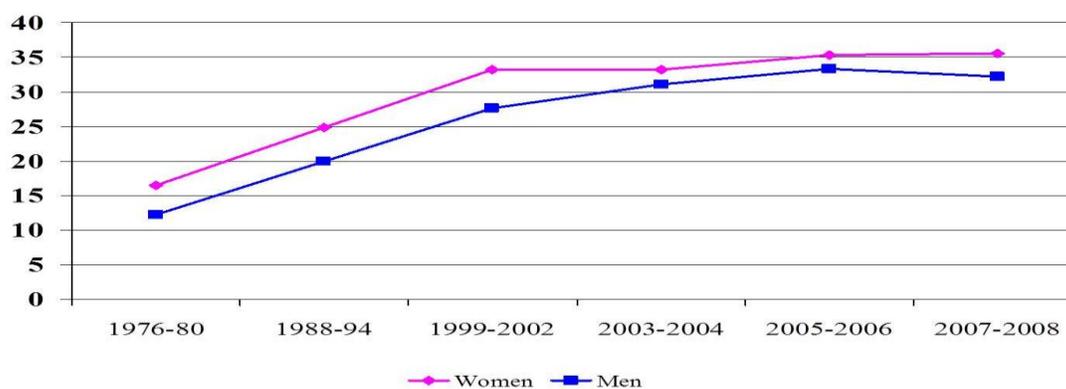
Economic Consequences of Obesity

There is a clear relationship between the rise in obesity and the rise in medical spending in the United States. Medical costs associated with overweight and obesity are estimated at more than \$90 billion annually. About 50 percent of these medical expenditures are paid by Medicare and Medicaid. Consequently, each tax payer contributes about \$180 per year toward obesity-related medical costs for public sector health plans. Across all payers, per capita medical spending for the obese is \$1,429 higher per year (42 percent) than for a normal weight person. Additionally, the annual medical burden of obesity could be as high as \$147 billion per year.

Rising Rates of Obesity by Race/Ethnicity

Rates of obesity have increased steadily over the last 20 years. About one-third of the U.S. population is considered obese, and more women than men are obese and extremely obese. Since 1980, obesity has doubled in women. In particular, non-Hispanic Black women have seen the greatest increase in obesity and extreme obesity—more than any other racial or ethnic group in the United States. While rates of obesity are similar between racially/ethnically diverse men, non-Hispanic Black men have much higher rates of extreme obesity than men of any other racial or ethnic group. Additionally, African Americans and Mexican Americans have a higher prevalence of overweight, obese, and extremely obese young girls ages 6–11 and adolescent girls ages 12–19. Among boys, Hispanic boys ages 6–19, particularly Mexican Americans, have higher rates of overweight, obesity, and extreme obesity than boys from any other racial or ethnic group.

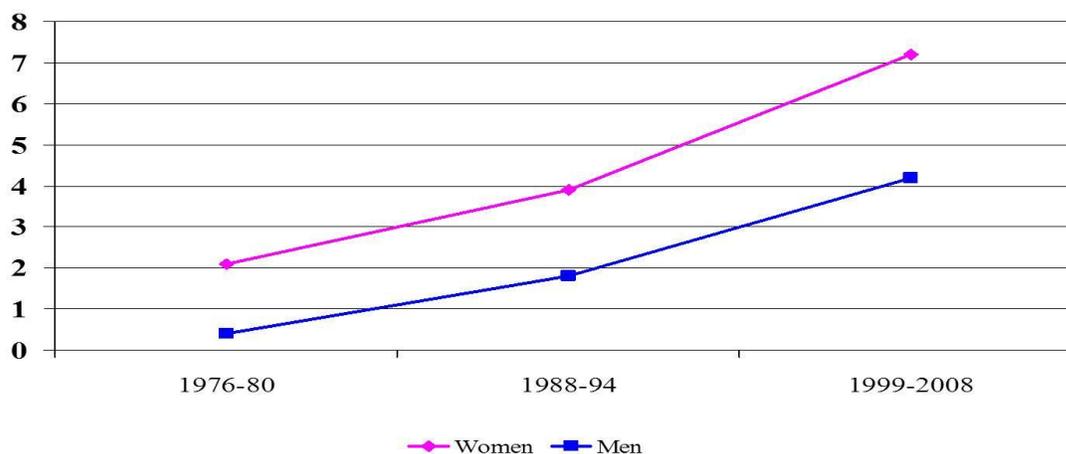
Prevalence of Obesity* among Adults \geq 20 Years (1976–2008)



*BMI \geq 30; † age-adjusted

Source: Centers for Disease Control and Prevention, National Center for Health Statistics' National Health Examination Survey, National Health and Nutrition Examination Survey

Prevalence of Extreme Obesity** among Adults ≥ 20 Years[†] (1976–2008)



**BMI ≥ 40 ; [†] age-adjusted

Source: Centers for Disease Control and Prevention, National Center for Health Statistics' National Health Examination Survey, National Health and Nutrition Examination Survey

Obesity by Geographic Location: Place Matters

It has become increasingly clear that living conditions have a strong bearing on adult obesity. Maps depicting rates of obesity from 1990 through 2008 show a higher concentration of obesity in the states of the deep South, where there is a higher percentage of minorities, specifically African American and Hispanics. The same is true for children. In southern states where obesity is highest among adults, obesity also is high among children. In addition to state rates of obesity, maps of obesity across U.S. cities show that communities with higher concentrations of minorities also have higher rates of childhood obesity.

Causes

Obesity may be a normal response to an abnormal environment—a function of the interactions between family, community, workplace, culture, economics, physical environment, and social relationships that do not adequately support health and wellness.

Individual Factors

Among minorities, particularly African Americans, there are lower consumptions of fruits and vegetables, greater satisfaction and acceptance of larger body types (excluding those body types that may be considered obese), lower levels of physical activity, greater consumption of sugar and artificially sweetened beverages, more total fat consumption, greater preference for sweets,

and food insecurity. Food insecurity describes a condition among individuals who are concerned about food availability and access to basic needs. They may have a tendency to overconsume food when it is available because there is uncertainty (i.e., insecurity) about where their next meal will come from. Relatively unaddressed is the relationship between obesity and African American women's need to protect their hairstyles from sweat and water. Seeking to maintain a hairstyle that may be costly and time consuming, they may be less likely to engage in vigorous physical activity.

Family Factors

Children learn eating habits and preferences within the context of their families. This includes norms about meal size and frequency of eating. Overweight children are more likely to have at least one overweight parent, which may relate to biology and genetics or learned behavior/patterns of eating within the family. Additionally, meals are increasingly likely to come from fast food restaurants or be prepackaged in stores, resulting in a higher intake of fats, sugars, and extra calories. Food traditions also are meaningful to families, and unhealthy ingredients or methods of food preparation may be intergenerational. Also, many parents assume children will “grow out” of their early overweight condition. However, an overweight child or adolescent has a 75 percent chance of being obese as an adult.

Cultural Factors

In addition to cultural factors such as acceptance of a larger body type, many cultures consider the preparation and sharing of large portions of food a symbol of affection. Thus, it is often customary to finish one's food entirely and eat as many helpings as possible as a sign of gratitude and respect for the person who prepared the meal. For some groups, physical activity may be seen as “work” and thus competing with the need or desire for rest and relaxation. In groups or populations that hold multiple jobs, people may choose not to engage in physical activity when off from work. Different populations also prefer different sorts of activities. For instance, African Americans are more likely to play basketball or jump rope while Whites are more likely to hike or ice skate.

Institutional Factors

There are a number of institutional disparities influencing the types of foods available to minorities. More minority children attend public schools where meals contain less nutritional value. Also, school beverage/food contracts and fundraising goods (e.g., cookies, candy bars) often are high in fats, sugars, and calories, yet many public schools rely on these fundraisers to support programs and extracurricular activities. Additionally, the reduction in opportunities for physical activity in schools and the increase in sedentary adult work have been associated with increased risk of obesity.

Community Factors

Predominantly Black neighborhoods have 2.5 fast food restaurants per square mile compared to 1.5 fast food restaurants in predominantly White neighborhoods. Black communities also are less likely to have as many “sit-down” restaurants where it might be easier to find fresh fruit and vegetables. Supermarkets are far less prevalent in low-income and predominantly Black communities, further reducing access to healthy foods. There also is less access to parks and recreational facilities that are safe and well kept in predominantly African American neighborhoods.

Organizational/Policy Factors

Exposure to unhealthy foods and beverages also is prevalent among minority youths and families via advertisements for desserts, soda, candy, and fast food during television programs with large African American audiences. This is problematic given that minority youths are more likely to engage in television viewing and playing video games, which are sedentary activities. There also are fewer African American families with adequate health insurance and access to health care facilities in their communities.

Solutions

Individual and Intrapersonal Strategies

- Offer culturally appropriate literature on prevention and weight control.
 - There are efforts by the National Institutes of Health to target programming to African American women to address some of the unique elements and needs of this group.
- Review benefits of healthy eating and regular physical activity to show the benefits of acquiring a healthy lifestyle.
- Refer (who?) to community education resources.
 - There are often resources available in the community, such as weight management programs or workout facilities, which residents are not aware of.
- Help to organize exercise and cooking classes in community settings (e.g., civic clubs, neighborhood association meetings).
 - Show people healthier ways to prepare their favorite meals, or convene community potluck dinners with a healthy focus.
- Work with local vendors to arrange for donations of food/activity products and/or discounts.
- Organize focus groups of community members to identify other strategies to foster healthy communities at a local level rather than just focusing on making changes at a policy level.

Institutional Strategies

- Organize coalitions to develop strategic plans for promoting healthy eating and physical activity.
 - Enlist members from recreation departments, school nurses, school administrators, owners of exercise facilities, grocers, local government, and faith-based leaders.
- Provide literature to local groups (e.g., faith-based organizations, civic clubs, neighborhood associations) to help them form walking clubs and cooking classes.
- Increase local media attention (e.g., newspaper articles, interviews on local TV/radio stations).
- Work with local schools to develop programs for youths (e.g., walk to school days).
- Work with local businesses to display health education materials/brochures in their establishments.
- Work with local health clinics to distribute information about community programs.

Community and Public Policy Strategies

- Work with local government officials to improve recreational options in the community.
- Educate community leaders about the lack of access to healthy food options in the community.
- Lobby for more physical education and health education in local schools.
- Develop community gardening programs.
 - Very effective at aligning older generations with younger ones
 - Initiatives like urban farming can rejuvenate dilapidated or blighted spaces.
 - Economic boost by profiting from sales of produce
- Participate on school wellness teams designed to monitor school nutrition programs.
- Send press releases to local media and health departments on research related to health benefits of exercise, healthy eating, and weight management.

Recent Policy Level Changes with a Positive Effect on Obesity

- Patient Protection and Affordable Care Act (2010)
 - All restaurants with 20+ locations are required to display calories on menus and have additional nutrition information available: calories from fat, total fat, saturated fat, cholesterol, sodium, carbohydrates, sugars, dietary fiber, and protein. This includes vending machines.
 - Insurance companies will now be required to provide coverage for preventive health services. This includes obesity screening—a doctor’s physical exam combined with a measurement of body mass index (BMI)—and nutritional counseling.

- The U.S. Department of Health and Human Services awarded \$372 million in stimulus money to 44 urban and rural communities to fight obesity by increasing the availability of nutritious foods and providing safe places for exercise and play.

Obesity-related Health Promotion in Minority Communities

- Include community members as partners in developing, implementing, and evaluating programs and policies.
 - Community-based participatory research is a good way to identify the community's perspective of the most important issues related to obesity prior to program development, as there may be culturally driven concerns such as body image, perceived need for weight control, or parenting styles.
- Build on existing traditions with respect to food, music, and types of activities rather than “force-fitting” participants into a preconceived model.
- Embed programs within an existing minority community institution or organization (e.g., church, social/civic group).
- Include program content (e.g., terminology, language, symbolism, role models, choice of incentives) that respects and matches the target population.
- Select recruitment strategies and venues for programs appropriate for the minority population targeted (e.g., use community members to recruit participants and choose locations where the target groups are most likely to be).
- Include some form of evaluation to gauge the program's successes and shortcomings and use this information for ongoing improvement.
- Engage policymakers in program development and/or share success stories.
 - Data showing the effectiveness of an initiative justify the importance and need for continued support.

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Race, Culture, and Cardiovascular Health

Presenter: Goutham Rao, Clinical Director of the Weight Management and Wellness Center at Children’s Hospital of Pittsburgh of UPMC and Associate Professor of Pediatrics at the University of Pittsburgh School of Medicine

Moderator: Evan Frazier, Senior Vice President for Highmark Inc.

Obesity is a universal phenomenon with a significant impact on cardiovascular disease, one that affects populations worldwide except in sub-Saharan Africa (with the exception of South Africa). In the United States, however, African Americans and Latinos experience disproportionately high rates of obesity and its consequences. Further, the number of obese children in America is increasing at a rapid rate, for some populations more than others. Presently, obese adolescent boys ages 13–18 are twice as likely to die from cardiovascular disease in adulthood, and adolescent obesity is now a better predictor of cardiovascular disease mortality than adult obesity.

The built environment, which refers to man-made infrastructure, is a major contributor to this health disparity. America’s urban centers are often rampant with pollutants and are not configured in a way that facilitates physical activity. In U.S. suburbs, resources are often spread out, making it necessary to drive rather than walk to most destinations. One proposed solution to improving health disparities is to begin to incorporate mixed land use into ongoing community and neighborhood development projects so that they are more conducive to physical activity. It also would be beneficial for research and medical communities to have open dialogue with local neighborhoods to discover new and innovative ways they could adapt healthy habits into the neighborhood residents’ lifestyles.

The Problem

Childhood Obesity

Children who are obese are twice as likely to develop high blood pressure and three times as likely to develop diabetes. From 1982 to 1992, the number of children diagnosed with type 2 diabetes increased tenfold, and currently about half of all new cases of childhood diabetes are type 2. Childhood diabetes contributes to a number of poor health conditions, including dyslipidemia, sleep-related breathing problems, Blount’s disease, and gallstones.

Psychosocial Impact: Childhood Bullying and Adult Discrimination

Obese children and children who appear overweight but who may not be obese may experience bullying in school, camp, and other settings. As obese children become adults, employment discrimination may affect their earning potential. Discrimination also may affect their medical care. A survey of family practitioners conducted in the early 1980s revealed that family

physicians perceived patients with obesity, alcoholism, drug addiction, and mental illness as less desirable. In addition, 24 percent of nurses found caring for obese patients to be repulsive and 12 percent preferred not to touch obese patients, 17 percent of physicians reported being reluctant to perform pelvic examinations on obese women.

Economic Impact of Obesity

In the United States, \$93 billion is spent on health care for obesity-related conditions each year. Individuals spend an additional \$33 billion a year on weight loss products and services for children and adults. While surgery is appropriate for some patients, it would cost \$50 trillion if every obese American had bariatric surgery.

Causes

The Built Environment

The built environment refers to the man-made structure of communities and neighborhoods, including schools, workplaces, community-based practices, restaurants, and grocery stores etc. Much of the built environment in urban neighborhoods is not conducive to health and wellness because neighborhoods are structured in ways that make healthy eating and physical activity significantly challenging. The most disadvantaged neighborhoods lack grocery stores and places to buy fresh fruits and vegetables (“food deserts”). Also, as many Americans move away from their city’s urban center into the suburbs, the distance between their homes and their schools and grocery stores makes driving a necessity. Thus, the built environment across U.S. cities makes it increasingly difficult to incorporate physical activity into everyday life.

Race and Obesity

On average, communities with large African American and Latino populations have less access to recreational facilities that promote physical activity than other communities. As a result, Whites tend to be more physically active than Blacks and Latinos. Despite popular belief, African Americans and Latinos tend to be more concerned with the effects of obesity than Whites due to the prevalence of illnesses like diabetes and hypertension in these communities. Whites are generally more concerned with the social aspects of obesity, mainly discrimination and physical appearance. Blacks and Latinos, on average, have unhealthier food purchasing habits than Whites. However, Latinos and Asians tend to eat home-cooked meals more often than other groups. Also, African American and Latino children are more susceptible to unhealthy food and beverage advertising on television. Fast food restaurants and companies that manufacture products with high sugar and fat contents, or convenience foods, market their goods in ways that target children in poorer communities.

Ten Key Statements Related to Health, Wellness, and Obesity

1. It costs less to have a healthy diet than an unhealthy diet.
2. Minority families (African Americans and Latinos) have less access to recreational facilities that promote physical activity than other families.
3. African Americans and Latinos are more concerned about childhood obesity and its consequences than others.
4. African Americans and Whites differ in their concerns related to obesity. African Americans are more concerned about obesity-related diabetes because of its impact on their communities, while White Americans are more concerned with social aspects of obesity (e.g., appearance, employment discrimination).
5. Latinos and African Americans have different food purchasing and dining habits than Whites.
6. African Americans and Whites differ in their taste preferences (African American children are more likely than White children to favor sweet foods).
7. African American and Latino children are less physically active than their White counterparts.
8. Latinos and Asians spend more time preparing food at home than Whites and African Americans.
9. African American children are more susceptible to food and beverage advertising on television than White children. (Fast food and foods high in fat and sugar are targeted toward African Americans.)
10. African Americans spend more time purchasing food than Asians or Latinos. (African Americans spend three times as much time shopping because they buy more diverse foods and also spend more time reading labels and comparing prices, whereas the diets of Asians and Latinos center on the foods of their cultures, which are often given their own section in stores.)

Solutions

- Be culturally sensitive when approaching communities about health and wellness. Also be mindful of differences in children by age and gender.
- Be direct when approaching the subject of obesity and be open about the health risks.
- Gather information on how individuals eat and live. Factors like fast food consumption, beverage consumption, frequency of eating, hours of television watched per day, and computer time are good indicators of habits people have that may be a benefit or detriment to their health and wellness.
- Help families to set individualized goals that focus on changing or eliminating one particular behavior at a time.
- Advocate for changing the built environment within disadvantaged communities to reinforce healthy living.

Suggested Reading

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