Racial Health Disparities and the Los Medanos Community Healthcare District

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ABSTRACT

This paper discusses racial health disparities and the Healthy People 2010 initiative with special reference to the implications for the Los Medanos Community Healthcare District Board. Towards this end, the paper presents a secondary analysis of data from federal, state, and county government sources. The paper examines racial health disparities within the Los Medanos Community Healthcare District in relation to the five leading causes of death and death rates. The paper also compares the leading causes of death and the death rates within the Los Medanos Community Healthcare District with the leading causes of death and the death rates for the whole Contra Costa County, whole state of California, and the whole United States of America (USA). It concludes with a set of recommendations for action in social policy and social work practice.

INTRODUCTION

Since the middle of the 1980s, there have been many empirical studies, review articles, and theoretical articles on racial health disparities. Satel and Klick (2006) have asserted that this body of literature can be divided into two categories. One category has been referred to as the "biased-doctor model." The other category has been referred to as the "third factors model."

As Satel and Klick (2006) have noted, whereas the biased-doctor model focuses on the overt or subtle discrimination by medical doctors, the third factor model emphasizes the influence of variations in insurance coverage, quality of medical doctors, geography, and patient characteristics. The literature in the biased-doctor model category includes the U. S. Department of Health and Human Services (1985), National Institutes for Health (2002a, 2002b), Smedley, Stith, and Nelson, (2002), Agency for Healthcare Research and Quality (2003), American College of Physicians (2004), Clark (2004), Stoesen (2004), LaVeist (2005), and Satcher and Pamies (2006). In the third factor

model, the literature includes Mechanic (2002), Epstein (2004), Klick and Satel (2004), and Satel and Klick (2006).

The literature shows that, in 2000, the U. S. Department of Health and Human Services launched its initiative "Healthy People 2010." The initiative has these two main overarching goals: (1) to increase the number of years and improve the quality of healthy life; (2) to eliminate racial and ethnic disparities in health care. Thus, the purpose of the Healthy People 2010 initiative is to address the issue of health disparities (Keppel, Pearcy, & Kelin, 2004; Clark, 2004). As used here, the term health disparities refer to "differences in the incidence/prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States" (Clark, 2004, p. 1).

The U. S. Department of Health and Human Services' Office of Minority Health Resource Center (OMHRC) has reported that African Americans, Asian Americans/Pacific Islanders, Latinos, and American Indians/Alaska Natives are more likely to have poor health and to die prematurely as a result health disparities. The OMHRC has found that health disparities has resulted in (1) higher rates of infant mortality; (2) decreased access to appropriate cancer screening and management; (3) higher rates of cardiovascular disease, HIV Infection/AIDS; and (4) less access to necessary immunizations (Clark, 2004).

The primary research questions addressed in this paper are as follows: To what extent does the Los Medanos Healthcare District have racial health disparities in the five leading causes of death and death rates? To what extent do Contra Costa County, California, and the USA have racial health disparities in the five leading causes of death

and death rates? What are the implications of racial health disparities for the Los Medanos Community Healthcare District?

METHODOLOGY

This paper presents a secondary analysis of data from several sources. The data have been drawn from the National Center for Health Statistics (2002), Henry Kaiser Family Foundation (2007), and Contra Costa Health Services (2004).

Following Contra Costa Health Services (2004), two types of death rates are presented in this paper, namely age-adjusted death rates and crude death rates. On the one hand, age-adjusted death rates have been referred to as "the best summary statistic for comparing the impact of diseases like heart disease, cancer, stroke and diabetes that are heavily influenced by age" (Contra Costa Health Services, 2004, p. 157). On the other hand, crude death rates have been referred to as "a good summary statistic for comparing health outcomes like unintentional injury across groups of different sizes" (Contra Costa Health Services, 2004, p. 117).

FINDINGS

Five Leading Causes of Death, Death Rates, and Racial Health Disparities in the Los Medanos Community Healthcare District

The data show that the five leading causes of death for all people in the Los Medanos Healthcare District from 2000-2002 were heart disease (376 total deaths and a 232.2 age-adjusted death rate per 100,000); cancer (314 total deaths and a 196.2 age-adjusted death rate per 100,000); stroke (143 total deaths and a 93.3 age-adjusted death

rate per 100,000); diabetes (45 total deaths and an estimated 29.7 age-adjusted death rate per 100,000); and unintentional injuries (59 total deaths and an estimated 25.5 crude death rate per 100,000) (Contra Costa Health Services, 2004).

The data indicate that the totals for Pittsburg were as follows: heart disease (300 total deaths and a 246.6 age-adjusted death rate per 100,000); cancer (236 total deaths and a 185.1 age-adjusted death rate per 100,000); stroke (113 total deaths and a 93.1 age-adjusted death rate per 100,000); diabetes (37 total deaths and a 29.7 age-adjusted death rate per 100,000); and unintentional injuries (45 total deaths and a 25.5 crude death rate per 100,000) (Contra Costa Health Services, 2004).

For Bay Point, the data show the following: heart disease (76 total deaths and a 217.8 age-adjusted death rate per 100,000); cancer (78 total deaths and a 207.4 age-adjusted death rate per 100,000); stroke (30 total deaths and a 93.6 age-adjusted death rate per 100,000); diabetes (8 total deaths and the age-adjusted death rate per 100,000 could not be calculated due to small numbers); and unintentional injuries (14 total deaths and the crude death rate per 100,000 could not be calculated due to small numbers) (Contra Costa Health Services, 2004; C. McKetney, personal communication, January 10, 2007).

The available data do not provide a breakdown for the Los Medanos Healthcare District in relation to the five leading causes of death and racial health disparities. However, data from Contra Costa Health Services (2004) suggest that there are a wide range of racial health disparities in the Los Medanos Community Healthcare District in terms of the five leading causes of death.

If the health conditions in the Los Medanos Community Healthcare District mirror those in Contra Costa County, then the Black population is suffering an unfair health burden in the rate of dying from heart disease, cancer, stroke, homicide, diabetes; and HIV/AIDS; the Latino population is suffering an unfair health burden in the rate of diabetes; and the Asian/Pacific Islander population, especially people whose country of origin is the Philippines, is suffering an unfair health burden in the rate of tuberculosis.

Within the Los Medanos Community Healthcare District, the data suggest that the Black population is also suffering an unfair health burden in the level of low birth weight infants. Likewise, the data suggest that the Black population is suffering an unfair health burden in the rate of dying from lung cancer, colorectal cancer, breast cancer, and prostate cancer. As Contra Costa Health Services (2004) has pointed out, cancer refers to a large group of diseases, including lung cancer, colorectal cancer, breast cancer, and prostate cancer.

Further, the Los Medanos Community Healthcare District (2002) has reported that the leading causes of death within the District in 1997 were heart disease, cancer, stroke, pneumonia and influenza, and unintentional injuries. Those diseases continue to plague the District and the present writer has made recommendations below to address the resultant racial health disparities.

Five Leading Causes of Death, Death Rates, and Racial Health Disparities in Contra Costa County

In Contra Costa County from 2000-2002, the five leading causes of death were heart disease (5,623 total deaths and a 198.1 age-adjusted death rate per 100,000); cancer

(5,037 total deaths and a 178.2 age-adjusted death rate per 100,000); stroke (1,810 total deaths and a 63.9 age-adjusted death rate per 100,000); chronic lower respiratory disease (1,116 total deaths and a 40.2 age-adjusted death rate per 100,000); and unintentional injuries (666 total deaths and a 22.8 crude death rate per 100,000) (Contra Costa Health Services, 2004).

With regard to heart disease deaths and the Black population (591 total deaths and a 319.8 age-adjusted death rate per 100,000), there was a racial health disparity when compared with the total population (5,623 total deaths and a 198.1 age-adjusted death rate per 100,000) and the White population (4,434 total deaths and a 201.9 age-adjusted death rate per 100,000). In terms of cancer deaths and the Black population (498 total deaths and a 247.6 age-adjusted death rate per 100,000), there was a racial health disparity when compared with the total population (5,037 total deaths and a 178.2 age-adjusted death rate per 100,000), and the White population (3,895 total deaths and a 187.2 age-adjusted death rate per 100,000) (Contra Costa Health Services, 2004).

Regarding stroke deaths and the Black population (191 total deaths and a 104.4 age-adjusted death rate per 100,000), there was a racial health disparity when compared with the total population (1,810 total deaths and a 63.9 age-adjusted death rate per 100,000), and the White population (1,352 total deaths and a 60.6 age-adjusted death rate per 100,000). In regard to unintentional injuries deaths and the Black population (84 total deaths and a 29.1 crude death rate per 100,000), there was a racial health disparity when compared with the total population (666 total deaths and a 22.8 crude death rate per 100,000), and the White population (435 total deaths and a 26.3 crude death rate per 100,000) (Contra Costa Health Services, 2004).

Five Leading Causes of Death, Death Rates, and Racial Health Disparities in California

The five leading causes of death in California from 2000-2002 were heart disease (231.1 age adjusted rate per 100,000); cancer (178.7 age adjusted rate per 100,000); stroke (60.8 age adjusted rate per 100,000), chronic lower respiratory disease (43.4 age adjusted rate per 100,000); and unintentional injuries (26.9 age adjusted rate per 100,000) (Centers for Disease Control and Prevention, 2007).

Regarding heart disease deaths and the Black population (333.6 age adjusted rate per 100,000), there was a racial health disparity when compared with the total population (231.1 age adjusted rate per 100,000) and the White population (234.8 age adjusted rate per 100,000). In terms of cancer deaths and the Black population (234.4 age adjusted rate per 100,000), there was a racial health disparity when compared with the total population (178.7 age adjusted rate per 100,000) and the White population (182.8 age adjusted rate per 100,000). With regard to stroke deaths and the Black population (85.5 age adjusted rate per 100,000), there was a racial health disparity when compared with the total population (60.8 age adjusted rate per 100,000) and the White population (59.7 age adjusted rate per 100,000). As for unintentional injuries deaths and the Black population (30.6 age adjusted rate per 100,000), there was a racial health disparity when compared with the total population (26.9 age adjusted rate per 100,000) and the White population (28.4 age adjusted rate per 100,000) (Centers for Disease Control and Prevention, 2007).

Five Leading Causes of Death, Death Rates, and Racial Health Disparities in the USA

In the USA from 2000-2002, the five leading causes of death were heart disease (247.7 age adjusted rate per 100,000); cancer (196.0 age adjusted rate per 100,000);

stroke (58.0 age adjusted rate per 100,000); chronic lower respiratory disease (43.7 age adjusted rate per 100,000); and unintentional injuries (35.7 age adjusted rate per 100,000) (Centers for Disease Control and Prevention, 2007).

With regard to heart disease deaths and the Black population (315.5 age adjusted rate per 100,000), there was a racial health disparity when compared with the total population (247.7 age adjusted rate per 100,000) and the White population (243.6 age adjusted rate per 100,000). In terms of cancer deaths and the Black population (242.8 age adjusted rate per 100,000), there was a racial health disparity when compared with the total population (196.0 age adjusted rate per 100,000), and the White population (193.9 age adjusted rate per 100,000). Regarding stroke deaths and the Black population (78.7 age adjusted rate per 100,000), there was a racial health disparity when compared with the total population (58.0 age adjusted rate per 100,000) and the White population (56.0 age adjusted rate per 100,000). In regard to unintentional injuries deaths and the Black population (29.1 rate), there was a racial health disparity when compared with the total population (35.7 age adjusted rate per 100,000) and the White population (36.1 age adjusted rate per 100,000) (Centers for Disease Control and Prevention, 2007).

AIDS as a Cause of Death in the Los Medanos Community Healthcare District

The data indicate that is AIDS is not one of the five leading causes of death among any racial or ethnic group within the Los Medanos Community Healthcare District, Contra Costa County, California, and the USA. Nevertheless, AIDS does remain a major social problem within the Los Medanos Community Healthcare District.

With regard to a breakdown of AIDS by city of residence as of March 31, 2006, 91 people in Pittsburg and 22 people in Bay Point were living with the disease. Some 137 people in Pittsburg and 50 people in Bay Point had died from the disease as of March 31, 2006. Hence, 66 percent of the people in Pittsburg diagnosed with AIDS and 44 percent of the people in Bay Point diagnosed with AIDS have died. This means that approximately 55 percent of the people diagnosed with AIDS in the Los Medanos Community Healthcare District have died. It also means that 11 percent of the people who have died from AIDS in Contra Costa County were residents of the Los Medanos Community Healthcare District (Contra Costa Health Services, 2006f).

According to Contra Costa Health Services (Contra Costa Health Services, 2004), the Los Medanos Healthcare District had at least 24 residents in Pittsburg diagnosed with AIDS between year 2000 and 2002. For Pittsburg, the crude diagnosis rate per 100,000 was 13.6. The available data from Contra Costa Health Services (2004, 2006a, 2000b, 2000c, 2000d, 2000f) do not provide a breakdown for Pittsburg by race. The available data from Contra Costa Health Services (2004, 2006a, 2000b, 2000c, 2000d, 2000f) also do not provide a breakdown for the residents in Bay Point that were diagnosed with AIDS between 2000 and 2002.

AIDS as a Cause of Death in Contra Costa County

As was the case with the Los Medanos Community Healthcare District, the data indicate that AIDS is not one of the five leading causes of death among any racial or ethnic group within Contra Costa County. Nevertheless, AIDS does remain a major social problem within the Contra Costa County.

In terms of a breakdown of AIDS by county of residence as of March 31, 2006, 1,002 people in Contra Costa County were living with the disease. A total of 1,629 had died from AIDS as of March 31, 2006. Thus, 62 percent of the people diagnosed with AIDS in Contra Costa County have died. It also means that two percent of the people who have died from AIDS in California were residents of the Contra Costa County (Contra Costa Health Services, 2006f).

As for Contra Costa County as a whole, 250 residents were diagnosed with AIDS between year 2000 and 2002. The crude diagnosis rate was 8.6 per 100,000. With regard to AIDS and the Black population (37.4 crude diagnosis rate), there was a racial health disparity when compared with the total population (8.6 crude diagnosis rate) and the White population (5.9 crude diagnosis rate) (Contra Costa Health Services, 2004).

AIDS as a Cause of Death in California

With regard to the cumulative total of reported deaths among people with AIDS in California, there were a total of 82,738 through 2005. Of that total, there were 1,435 deaths in California due to AIDS in the year 2005. The age-adjusted death rate for the total California population with AIDS in 2003 was 4.2 per 100,000. Of the 59,754 Californians who were living with AIDS at the end of 2005, some 28,682 (48 percent) were White, not Latino; 17,640 (29.5 percent) were Latino; 11,107 (18.6 percent) were Black, not Latino; 1,803 (3 percent) were Asian/Pacific Islander; 292 (0.5 percent) were American Indian/Alaska Native, not Latino; and 230 (0.4 percent) were in the Unknown Race or Multiple Races, not Latino category. The adult and adolescent annual AIDS case rate per 100,000 reported in 2005 was 43.5 for Black, not Latino; 14.7 for Latino; 12.3

for White, not Latino; 9.3 for American Indian/Alaska Native, not Latino; and 3.8 for Asian/Pacific Islander, not Latino. When the Black population is compared with the rest of the population in regard to the adult and adolescent annual AIDS case rate, the data suggest the existence of a racial health disparity. This is especially true when the Black population is compared with the White population, which is dominant in terms of power (Henry Kaiser Family Foundation, 2007).

AIDS as a Cause of Death in the USA

As for the cumulative total of reported deaths among people with AIDS in the USA, there were a total of 538,310 through 2005. Regarding that total, there were 14,095 deaths in the USA due to AIDS in the year 2005. The age-adjusted death rate for the total USA population with AIDS in 2003 was 4.9 per 100,000. Of the 437,980 people in the USA who were living with AIDS at the end of 2005, some 188,730 (43.1 percent) were Black, not Latino; 150,997 (34.5 percent) were White, not Latino; 89,915 (20.5 percent) were Latino; 4,410 (1.0 percent) were Asian/Pacific Islander; 2,331 (0.5 percent) were in the Unknown Race or Multiple Races, not Latino category; and 1,597 (0.4 percent) were American Indian/Alaska Native, not Latino. The adult and adolescent annual AIDS case rate per 100,000 reported in 2005 was 68.6 for Black, not Latino; 23.3 for Latino; 7.2 for White, not Latino; 9.4 for American Indian/Alaska Native, not Latino; and 4.2 for Asian/Pacific Islander, not Latino. As was the case with California, the data for the whole country suggest the existence of a racial health disparity when the Black population is compared with the rest of the population. This is particularly true when the

Black population is compared with the White population, which is dominant in terms of power (Henry Kaiser Family Foundation, 2007).

IMPLICATIONS

The data suggest that the Los Medanos Community Healthcare District needs to take action steps to address racial health disparities related to heart disease, cancer, stroke, diabetes, and unintentional injuries. The data also suggest that the Los Medanos Community Healthcare District needs to take action steps to address AIDS and homicide. As a consequence of the racial health disparities, the data suggest, as Contra Costa Health Services (2004) has pointed out, that more White people may get the aforementioned diseases because of their larger population, but Black people are more likely to die from them.

To address racial health disparities, the following recommendations are offered for the Los Medanos Community Healthcare District Board of Directors: (1) develop a Steering Committee on Racial Disparities in Health (SCRDH); (2) authorize the SCRDH to sponsor forums, symposia, and seminars on racial disparities in the District, with a focus on the following areas: heart disease; cancer (e.g. breast and prostate); stroke; diabetes; unintentional injuries; AIDS; homicide, and other health-related areas, including cultural competency, child neglect prevention, elderly falls prevention, infant mortality, immunizations, and contemporary models of drug prevention and treatment programs operated by faith-based groups; (3) sponsor a seminar on HIV/AIDS wherein 20-30 of the participants will be pre-tested and post-tested on the information in the presentation(s) to assess the effectiveness in terms of learning outcomes; (4) develop,

publish, and disseminate peer reviewed fact sheets related to cancer (e.g. breast and prostate); diabetes; heart disease; HIV/AIDS; Immunizations; infant mortality; etc; (5) develop, publish, and disseminate peer reviewed resource guides related to cancer (e.g. breast and prostate); diabetes; heart disease; HIV/AIDS; Immunizations; infant mortality; etc.; (6) conduct survey research and publish reports on the attitudes of District residents toward racial disparities and other health-related issues; (7) conduct archival research and publish reports (e.g. literature reviews) on cancer (e.g. breast and prostate); diabetes; heart disease; HIV/AIDS; Immunizations; infant mortality; etc.; (8) issue a Health Profile that will provide data on the five leading causes of death broken down by race within the Los Medanos Community Healthcare District; (9) target interventions and preventions to the group that accounts for the greatest number of deaths from a given cause, namely heart disease, cancer, stroke, diabetes, and unintentional injuries; and (10) develop a partnership with California State University, East Bay wherein some of its Master of Social Work (MSW) students will be able to do internships with the Los Medanos Community Healthcare District.

SUMMARY AND CONCLUSION

This paper has examined the extent to which the Los Medanos Healthcare District has racial health disparities in the five leading causes of death and death rates. It has also examined the extent to which Contra Costa County, California, and the USA have racial health disparities in the five leading causes of death and death rates. It has also addressed the implications of racial health disparities for the Los Medanos Community Healthcare District and made a set of recommendations for the Board of Directors.

Both historical and contemporary documents have pointed to the need to address racial health disparities. During the middle of the 1980s, Margaret M. Heckler (1985), Secretary of Health and Human Services, wrote in the *Report of the Secretary's Task Force on Black and Minority Health* that there was "a continuing disparity in the burden of death and illness experienced by Blacks and other minority Americans as compared with our nation's population as a whole" (p. ix). Heckler (1985) also said, "That disparity has existed ever since accurate federal record keeping began--more than a generation ago" (p. ix). Heckler (1985) further stated, "And although our health charts do itemize steady gains in the health of minority Americans, the stubborn disparity remained--an affront both to our ideals and to the ongoing genius of American medicine" (p. ix).

Some 13 years later, on February 21, 1998, William J. (Bill) Clinton, President of the USA, announced his "New Racial and Ethnic Health Disparities Initiative." Although he said that key indicators showed record improvements for the health status of the total population, he condemned the fact that racial minorities suffer from certain diseases at a higher rate when compared to non-minorities. To close the health status gap, Clinton announced "a five-step plan that sets a national goal of eliminating health disparities in six areas by the year 2010: infant mortality; cancer screening and management; cardiovascular disease; diabetes; HIV/AIDS rates; and child and adult immunization levels" (Office of the Press Secretary, 1998, p. 1).

Clinton also announced that David Satcher, a newly confirmed Surgeon General and Assistant Secretary for Health, would lead the campaign to send critical treatment and prevention messages to "local communities, churches, nurses, physicians, and other community-based programs and experts in minority health. It will improve education

and outreach effort and develop innovative strategies to address racial and ethnic health disparities" (Office of the Press Secretary, 1998, p. 1). Clinton's plan also included over $400 million with the express purpose of developing new approaches and building on existing successes to address racial and ethnic health disparities. During, before, and after his stint as the Surgeon General, Satcher (2000) issued a number of reports alone or as a co-author (Satcher& Pamies, 2006) wherein he pointed to the need to address racial health disparities.

Although the next president failed to address racial health disparities with an initiative, his Surgeon General and Assistant Secretary for Health, Richard H. Carmona, dealt with the matter in a keynote speech for the National Managed Health Care Congress Summit. Carmona stated that reducing racial and cultural disparities in health care was critically important to the lives of all people in this country although it was not making the headlines like the threat of bioterroism.

Additionally, Carmona (2003) said that closing the gap in health care disparities for minorities "is one of President Bush and Secretary Thompson's priorities and of course one of my priorities as Surgeon General" (p. 1). Carmona related that the President and the Secretary had asked him to concentrate on these three priorities: (1) prevention; (2) public health preparedness; and (3) closing the gap in health care disparities for minority groups. Thus, even the conservative Bush Administration acknowledged that racial health disparities need to be addressed.

Contra Costa Health Services (2004) has stated that to reduce unfair health differences, it is important to focus on the population with the highest death rates. Contra Costa Health Services (2004) has also stated that to reduce unfair health

differences "it may be better to target interventions to the group that accounts for the greatest number of deaths from a given cause" (p. 69). Contra Costa Health (2004) has further reported that to reduce unfair health burden "efforts must include those residents who account for the highest percentage of deaths" (p. 91).

Following Contra Costa Health Services (2004), Clark (2004), Stosen (2004), Gonzalez, Gooden, and Porter (2000), and W. E. B. Du Bois (1899/1970), the present writer, among other things, has called for the Board of Directors of the Los Medanos Community Healthcare District to (1) develop a Steering Committee on Racial Disparities in Health (SCRDH); (2) issue a Health Profile that will provide data on the five leading causes of death broken down by race within the Los Medanos Community Healthcare District; (3) target interventions and preventions to the group that accounts for the greatest number of deaths from a given cause, namely heart disease, cancer, stroke, diabetes, and unintentional injuries; and (4) develop a partnership with California State University, East Bay wherein some of its MSW students will be able to do internships with the Los Medanos Community Healthcare District.

In his classic book titled, *The Philadelphia Negro*, Du Bois (1899/1970) emphasized the importance of having reliable data regarding the physical health of Black people. Du Bois said that when considering the health statistics of Black people, it is imperative to know their absolute condition rather than their relative status. Likewise, Du Bois (1899/1970) said that it is imperative to know what is the death rate of Black people and "how it has varied and is varying and what its tendencies seem to be" (p. 148).

After those facts have been gathered, Du Bois (1899/1970) said that it is imperative to address the meaning of the death rate among Black people. Hence, Du

Bois (1899/1970, p. 148) posed that the following questions must be addressed: "Is it, compared with other races, large, moderate or small; and in the case of nations or groups with similar death rates, What has been the tendency and outcome?" To intelligently interpret statistics related to the health of Black people, Du Bois (1899/1970) said that it was imperative to compare the death rate of Black people with that of the communities in which they live so that the social difference between neighboring groups can be measured. Last, but not least, Du Bois (1899/1970) stated that, "we must endeavor also to eliminate, so far as possible, from the problem disturbing elements which would make a difference in health among people of the same social advancement" (p. 148).

The record is clear that Du Bois (1899/1970) pointed out a path for social scientists and other professionals to follow. Now social scientists and other professionals must have the will to follow in the footsteps blazed by the legendary Du Bois.

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