Trust for America's Health
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Our Vision for a Healthier America

A HEALTHIER AMERICA: 10 TOP PRIORITIES FOR PREVENTION

Improving the Health of Low-Income and Minority Communities

WHY ARE HEALTH DISPARITIES A THREAT TO OUR NATION'S HEALTH?

Low-Income and Minority Communities Systematically Have Less Access to Health Care, Higher Exposure to Health Threats, and Worse Health Outcomes:

- Rates of death from heart disease were 29 percent higher among African-American adults than among white adults in 2000, and death rates from stroke were 40 percent higher.[1]
- African-American males are over twice as likely to die of prostate cancer.[2]
- Cervical cancer incidence rates in Vietnamese women have been found to be 5 times higher than the rate among white American women.[3]
- African-American, American Indian, and Puerto Rican infants have higher death rates than white infants. African-American babies are two-and-a-half times as likely to die in infancy as white infants, a statistic that has remained unchanged for the past 2 decades.[4]

Racial and Ethnic Minorities Are More Likely to Have Less Access to Care:

- Thirteen percent of white Americans are uninsured, however, that figure nearly doubles to 22 percent among African-Americans, and nearly triples to 36 percent among Latinos.[5]

People with Lower-Incomes Have Fewer Opportunities to Make Healthy Choices:

- There is limited access to nutritious, affordable foods in low-income areas. Low-income zip codes tend to have fewer and smaller grocery stores, and people in these areas often pay more for fresh fruits and vegetables when such foods are even available.[6] The presence of supermarkets is related to lower rates of obesity, while higher rates of obesity are related to the presence of convenience stores.[7]
- Even before Hurricane Katrina, Gulf Coast populations - many of them low-income, minorities - were among the most chronically ill in the nation. After the hurricane, one in five survivors with chronic illness reported a disruption in his/her treatment, which researchers attribute to the loss of healthcare facilities and personnel in the region, as well as unemployment and associated income loss among survivors.[8]
- The states with the highest rates of obesity in the nation are also the poorest; these states often have high rates of adults lacking health insurance. Obesity is a risk factor for more than 30 serious diseases. Eight of the states with the highest poverty, diabetes, and hypertension rates were also in the top 15 in the country for obesity.[9]

"OF ALL THE FORMS OF INEQUALITY, INJUSTICE IN HEALTH CARE IS THE MOST SHOCKING AND INHUMANE."

-- MARTIN LUTHER KING, JR.

MARCH 2008

PREVENTING EPIDEMICS.
PROTECTING PEOPLE.

HOW CAN WE ELIMINATE HEALTH DISPARITIES?

- **Create Strategies to Improve the Health of All Americans, Regardless of Race, Ethnicity, Income, or Where They Live.** All Americans should have the opportunity to be as healthy as they can be. As a nation, we must invest in first understanding the systematic disparities that exist and the factors that contribute to these differences, including poverty, income, racism, and environmental factors like exposure to pollution and quality of housing. Resources must be devoted to implement community-driven approaches to address factors.

- **Engage Entire Communities in Addressing Disparities.** Efforts to eliminate disparities in health must also include addressing the range of community factors that influence health, such as safe and affordable housing, safe streets and recreation spaces, and affordable and accessible nutritious foods. This will require taking a community-wide approach, involving federal, state, and local government, businesses, and community groups.

- **Partner with a Diverse Range of Community Members in Developing and Implementing Health Strategies.** Federal, state, and local governments must engage communities in efforts to address both ongoing and emergency health threats. The views, concerns, and needs of community stakeholders, such as volunteer organizations, religious organizations, and schools and universities must be taken into account when developing strategies if they are to be successful. Established proven programs, such as REACH (Racial and Ethnic Approaches to Community Health) should be fully-funded and expanded.

- **Communicate Effectively with Different Community Groups.** Federal, state and local officials must design culturally competent communication campaigns that use respected, trusted, and culturally competent messengers to communicate the message and appropriate channels for reach target audiences.

- **Prioritize Community Resiliency in Health Emergency Preparedness Planning.** Federal, state, and local government officials must work with communities and make a concerted effort to address the needs of low-income and minority communities during health emergencies. Public health training should be targeted to include disaster scenarios in at-risk populations' neighborhoods. For example, planning for how emergency responders would react to an event in a neighborhood of primarily Spanish-speaking residents.

- **Promote Health Services, Including Preventive Care Services, in Underserved Communities.** Policies must address the ongoing gaps in services to low-income and underserved minority communities. Inadequate preventive care means problems are often left untreated until they become higher-cost emergency care or serious chronic care issues.

ENDNOTES

1 Office of Minority Health and Health Disparities. "Disease Burden & Risk Factors." U.S. Centers for Disease Control and Prevention. http://www.cdc.gov/omhd/AMH/dbrf.htm (accessed October 11, 2007).

2 National Medical Association and Pfizer, Inc. *Racial Differences in Cancer: A Comparison of Black and White Adults in the Unites States.* New York, NY: Pfizer, Inc. and National Medical Association, 2005. http://www.pfizer.com/files/products/Racial_Differences_in_Cancer.pdf (accessed January 10, 2008).

3 B.A. Miller, et al. *Racial/Ethnic Patterns of Cancer in the United States 1988-1992: NIH Pub.* No. 96-4104. Bethesda, MD: National Cancer Institute, 1996.

4 Office of Minority Health. "Highlights in Minority Health: April 2004." U.S. Centers for Disease Control and Prevention. http://www.cdc.gov/omh/Highlights/2004/HApr04.htm. (accessed October 11, 2007).

5 Kaiser Family Foundation. "Uninsured Rates for the Nonelderly by Race/Ethnicity, States (2004-2005), U.S. (2005)." Washington, D.C.: Kaiser Family Foundation, State Health Facts. http://statehealthfacts.org/comparebar.jsp?ind=143&cat=3 (accessed October 10, 2007).

6 Trust for America's Health. *F as in Fat: How Obesity Policies are Failing in America 2006.* Washington, D.C.: TFAH, 2006. http://healthyamericans.org/reports/obesity2006.

7 K. Morland, et al. "Supermarkets, Other Food Stores and Obesity: The Atherosclerosis Risk in Communities Study." *American Journal of Preventive Medicine* 30, no. 4, (2006): 333-339.

8 The Hurricane Katrina Community Advisory Group. "Hurricane Katrina's Impact on the Care of Survivors with Chronic Medical Conditions." *Journal of General Internal Medicine* 22, (2007): 1225-1230.

9 Trust for American's Health. *F as in Fat: How Obesity Policies are Failing in America 2007.* Washington, D.C.: TFAH, 2007. http://www.healthyamericans.org/reports/obesity2007.

FIND OUT MORE AT
www.healthyamericans.org
OR CONTACT TRUST FOR AMERICA'S HEALTH DIRECTOR OF GOVERNMENT RELATIONS RICHARD HAMBURG, RHAMBURG@TFAH.ORG OR 202-223-9870 X 18

1730 M Street NW • Suite 900
Washington, DC 20036
(t) 202-223-9870
(f) 202-223-9871
www.healthyamericans.org