# PRELIMINARY 2007 DOUGLAS COUNTY HEALTH DISPARITIES REPORT CARD

Our Healthy Community Partnership and the Brown/Black Coalition are pleased to release the 2007 Douglas County Health and Disparities Report Card. This report provides a snapshot of local disparities in health among racial groups in Douglas County and tracks progress of activities to reduce disparities.

The purpose of this report card is to provide a complete description of the health, lifestyle, social and economic conditions which contribute to disparities affecting minority populations.

# BACKGROUND

Racial and ethnic minorities continue to experience higher rates of morbidity and mortality. The health disparities are complex, multifaceted and include socioeconomic differences, environmental injustice, direct and indirect consequences of both intentional and unintentional institutional discrimination, and inadequate access to quality healthcare. There are historical trends that impact people of color, including inadequate education, social and economic circumstances, personal lifestyle choices, environmental stressors, and limitations of the health care system. In Nebraska, there is a high percentage of ethnic minorities who are poor, employed primarily in low wage jobs, and who lack health insurance (Health Status of Racial and Ethnic Minorities in Nebraska, 2003). They were less likely to see a doctor and to have had a check up in the last 12 months. Therefore, when one examines the data one must consider these factors along with other social and economic indicators such as culturally-specific values, language, attitudes toward health and wellness, educational attainment, and income levels. Personal lifestyle choices may include not participating in preventive care, a high calorie diet, fewer fruits and vegetables and a lack of exercise.

Nebraska has a growing ethnic minority population comprising about 13% of the state's population. Immigrants make up an increasing proportion of the racial and ethnic groups in the state. According to the 2000 US Census people of color and ethnic minorities comprise about 19.6% of the population in Douglas County, with African Americans (11.4%), Latinos (6.8%), and Asian Americans (1.7%) being the largest ethnic minority groups in the county. It is estimated that over 50% of all Sudanese in the U.S. are found in Nebraska, and their corresponding population in Omaha is estimated to number between 5,000 and 7,000 (Health Status of Racial and Ethnic Minorities in Nebraska, 2003).

Our Healthy Community Partnership and the Brown/Black Coalition believe that addressing racial and ethnic health disparities is essential to addressing our community's health. This report focuses on infant health, diabetes, and STDs, three indicators that have been tracked for several years in Nebraska. Identifying disparities is the first step toward understanding their causes and identifying effective strategies to reduce them. It is hoped that it can provide some insights into the local circumstances that ameliorate or increase disparities (community characteristics).

### Relationship among race, ethnicity, poverty, education and geographic distribution

Racially, Douglas County follows a pattern of a higher concentration of Non-Latino whites in the Western portions of the county and more African-Americans and Latinos in the Northeast and Southeast portions of the county, respectively. Poverty also follows racial and ethnic lines, with African-Americans and Latinos more likely to be living in poverty, a trend especially true for minority women. Education is related inversely to poverty, with increased education correlating with a decreased likelihood of being in poverty.

To meet the challenge of reducing health disparities, it is important to acknowledge the demographics of some of the populations that health disparities impact. For example, Latino and African American populations in Douglas County are younger than non-Latino white populations. With characteristically higher birth rates, the minority populations will not only appear larger in number but also younger in age. This means that in the coming years, health issues of the young such as childhood immunizations, poor birth outcomes, or sexually transmitted diseases will become increasingly important in this group. Moreover, those health-related issues that are significant to Latino or African American populations (e.g., obesity or diabetes) will overshadow other chronic diseases simply due to the changing demographic composition of the county's population.

# INFANT MORTALITY

Infant mortality is a health indicator that is of particular importance. In addition to the tragic dimension that the death of an infant represents for the family, infant mortality demonstrates a breakdown in the system of health care delivery and is of public health concern in many cases. Although some infant deaths are beyond the control of current preventive measures, there are many deaths that could be prevented and it is these deaths which are particularly tragic. In 2004, the infant mortality rate among African-Americans in Douglas County is more than three times that of white infants. Latinos often have lower infant mortality rates than non-Hispanic whites; in Douglas County the rate in Latinos was the same as the rate in non-Hispanic whites in 2004 but 50 % higher in 2003. Although there has been a considerable decrease in the last century in infant mortality rates, the disparity remains and in recent years has grown proportionally larger as gains in health care have disproportionately benefited non-Latino whites. Since 2002, the infant mortality rates among African-Americans and Latinos has increased. According to the Office of Minority Health between 1998 and 2002 25% of all Latino infant deaths during 1998-2002 were caused by birth defects, while 10.4% died of Sudden Infant Death Syndrome (SIDS), compared to 27.9% and 12.7% for white infants. Latino Americans experienced a 21.7% decrease in infant mortality, thus

making Latino infants 1.1 times as likely as whites to die within their first year of life. (Nebraska Minority Health Disparities 2004 Fact Sheet). The exact reason why this has occurred is not fully known. The leading causes of infant mortality among African-Americans are related to short gestation and low birth weight, whereas congenital problems are the leading cause of death among non-Latino whites. (2004 Douglas County Health Department Data) In non-Latino whites, the leading cause of death is congenital anomalies. (Nebraska Health and Human Services System, Vital Statistics, 2003).

There are multiple factors contributing to infant mortality, but short gestation/low birth weight and SIDS are two major causes of death among infants in Douglas County. Short gestation/low birth weight in Douglas County account for 4 percent of infant deaths (compared to 3.4 percent for the rest of the state -2004 Douglas County Health Department Data). There does seem to be a decrease in the proportion of extremely low birth weight (ELBW <500 grams) babies born to African-American women in Douglas County over the 2002-2004 time frame. However, African-Americans born in Douglas County are more than three times as likely to die within the first year of life as their non-Latino white counterparts. The rate of infant mortality among Latinos is similar to that of non-Latino whites. As mentioned previously, low birth weight is one major risk factor for infant mortality in general. African-Americans as a group experience both higher rates of low birth weight infants and higher mortality rates of those low birth weight infants (2004 Douglas County Health Department Data).

There are a number of factors that separate African-American women in Douglas County from other women, which may contribute/explain the higher rates of infant mortality. The rate of teenage pregnancy is higher among African-American women in general. Teenage motherhood places the infant at a higher risk for infant mortality. Lack of prenatal care, a more common issue among African-Americans, is associated with a high risk of infant death that is much greater than among infants whose mothers receive prenatal care. Although it is difficult to quantify, African-American women report a number of risk factors which affect general health and possibly infant health. For example, African-American women are more likely to be diabetic and to suffer from hypertension.

## DIABETES

The consequences of obesity are serious; long-term effects may include hypertension, cardiovascular disease and diabetes. Diabetes, a chronic disease defined by persistent hyperglycemia (high blood glucose levels) is the sixth leading cause of death in America. Type 2 diabetes has been found to be closely related to obesity. Diabetes also increases the risk for heart disease and stroke, in part because those. diagnosed with diabetes also have more cardiovascular risk factors including high blood pressure and high serum cholesterol, in addition to hyperglycemia. Kidney failure also significantly increases mortality from diabetes as it significantly increases risk for vascular disease mortality, as well. The death rate from diabetes was 2.7 times higher in African Americans than non-Hispanic whites in Douglas County. Yet, over the 2002-2004 time period, Latinos experienced a decline in the death rate from diabetes from 20.5 to 8.0. In 2004, Latinos were 2.4 times less likely to die from diabetes than non-Hispanic whites. "The Office of Minority Health notes that "Diabetes-related deaths ranked third behind heart disease and cancer as the leading cause of death among Latino Americans (109.3/100,000)." (Nebraska Minority Health Disparities 2004 Fact Sheet)

### Diabetes and the underlying impact of obesity

The rates of overweight and obesity have become extremely high among all Douglas County residents; 57% percent of adults in Douglas County are either overweight or obese. The rate of obesity (BMI>30 kg/m2) and overweight (BMI>25 but less than 30 kg/m2) among African Americans is above the county average of 60%, compared to 59% for Non-Hispanic whites and 37% among Latinos. The rate of obesity in the county is particularly alarming because it can lead to increases in other medical problems including hypertension, cardiovascular disease, and diabetes. The long-term burden of the effects of obesity will be magnified with ongoing growth of the populations most affected. The impact of this increased caseload of future disease which will potentially overwhelm the local health care system.

The Behavior Risk Factor Surveillance Systems (BRFSS) identifies a number of lifestyle factors that differ among Non-Latino whites,

African-Americans and Latinos. The percentage of adults that report engaging in moderate or vigorous physical activity in 2004 (defined as 30 or more minutes per day, 5 or more days per week or vigorous physical activity for 20 or more minutes per day, 3 or more days per week) is highest among non-Latino whites (80%) compared to 76% among African American and 62% among Latino adults. Since the factors that contribute to increased rates of obesity in the population include insufficient physical activity and dietary factors, OHCP strongly recommends increased resources to implement school and family-based comprehensive programs in physical fitness and nutrition.

On a positive note, diabetes, heart disease and stroke are all lifestyle-related diseases so it may be possible to lower the incidence of morbidity attributed to these diseases through lifestyle changes. However, it may be important to create culturally-specific messages to effectively motivate lifestyle changes. The report noted that African Americans in Douglas County were actually more likely to receive formal diabetes education than Non-Latino whites and Latinos.

Diabetes is the most frequently reported cause of kidney failure in the United States. In 1990, it was the underlying cause of kidney failure in 34 percent of patients starting treatment for End Stage Renal Disease (ESRD). Diabetes-related kidney failure affects a much higher percentage of African Americans than Non-Hispanic whites in Douglas County. African Americans also have higher rates of hypertension than Non-Hispanic whites in Douglas County, which markedly increases risk of renal failure and vascular disease in diabetes. thus, the interaction between hypertension and type 2 diabetes, which occur together more frequently in African Americans than in Non-Hispanic whites, likely contributes to the higher rate of ESRD. However, other factors that are being evaluated nationally to understand a similar disparity across the US include access to preventive screening and medications known to markedly reduce risk, antihypertensive medication compliance, higher dietary salt intake, prevalence of smoking and obesity, and genetic factors.

# SEXUALLY TRANSMITTED DISEASES

Sexually transmitted diseases (STDs), especially chlamydia and gonorrhea, affect men and women of all backgrounds and economic levels. Despite the fact that a great deal of progress has been made in prevention, diagnoses, and treatment, STDs remain a major public health challenge. In addition to the physical and psychological consequences of STDs, these diseases also add billions of dollars to the nation's health care costs each year and are a major burden in affected communities. In March, 2004, both chlamydia and gonorrhea were declared, by the Douglas County Board of Health and the Douglas County Health Department, to be epidemic in this community. As a result, the public health department and collaborating community service agencies began an intensive program of community awareness, testing and education for sexually transmitted diseases.

Compared to other race/ethnicity groups in Douglas County, the African American population has been disproportionately impacted by STDs. In 2004, African Americans comprised 11.5% of the area population but reported 45.9% of the chlamydia infections and 62.2% of the gonorrhea infections. This is in contrast to Hispanics with 6.7% of the population, 8.4% and 5.4% of the chlamydia and gonorrhea infections respectively. The majority population, non-Hispanic whites, accounted for 32.6% of the reported chlamydia infections and 18.9% of the gonorrhea infections.

Chlamydia and gonorrhea infections in both males and females frequently cause no signs or symptoms of acute infection but may progress into complications and long-term health problems. Young women suffer the most severe disease consequences, which include painful pelvic inflammatory disease, ectopic pregnancy, even permanent infertility. In young women, these infections also facilitate the transmission of the HIV virus. In 2004, Douglas County infection rates for chlamydia and gonorrhea were 82% and 45%, respectively, above the national rates. Among large US cities, Omaha ranked 22 for chlamydia infection rate, 38 for gonorrhea. Both rates are disturbing in themselves, but are made more so by the disproportionate impact on African Americans in this community.

# CONCLUSIONS AND RECOMMENDATIONS

This report explores three health indicators that examine racial disparities among residents in Douglas County, Nebraska. All health indicators discussed in the report reveal that the minority population is poorer and has worse health status than the white population. For example, infant mortality rates are over two and a half times higher among black infants than white infants.

The disparities are most glaring and persistent in such areas as infant mortality. The question that is repeated in any discourse about health disparities is far beyond the scope and substance of this basically descriptive report: "What are the underlying causes for health disparities?" The answer is complex. Issues such as access to healthcare, differing educational levels, cultural biases, de facto segregation, proximity to environmental hazards, genetic predispositions, different treatment approaches by healthcare professionals for people of color, higher underemployment and unemployment, low income, low levels of wealth and lifestyle choices are all cited as possible explanatory factors for differences in health outcomes.

Although health indicators such as infant mortality have improved considerably for people of all races over the last century, the disparity between black and white populations has been persistent over time. For example, in 1950, the infant mortality rate for black babies in the U.S. was 1.6 time higher than white babies whereas now it is 2.5 times higher. Clearly health improvements have not impacted both races equally. In fact, when premature deaths are calculated, in 1998 there were 265 deaths every day among African-American that would not have occurred had health disparities not existed!

This is of concern because nearly 50 percent of health care dollars spent worldwide are spent in the United States, yet this racial health disparity has not yet disappeared.

Contributing factors to health disparities include lack of accurate data to measure and document progress, shortage of minority targeted health programs, limited technical assistance to improve the quality of health care professionals, inadequate funding or lack of funding priorities, cultural and language barriers, data collection limitations, geographic isolation and patient/client apathy.

From lower quality health care, disproportionate incarceration rates, diminished collective wealth, to inequities in education, minorities are faced with disparities on every front. Although the circumstances are not the same for all minority communities, the effects remain the same: lessened health and quality of life for people of color in their communities.

It is important that any interventions designed to eliminate health disparities be chosen in such a way that measurable benefits take place. Assessment of efforts and outcome analysis are necessary to determine if any shifts in strategies are needed.

The concept of Culturally and Linguistically Appropriate Services (CLAS) is important to keep in mind when planning and evaluating interventions. Communication, marketing and interventions need to be tuned to the specific target culture in order to create behavioral change. Health services provided to minorities should be appropriate and should address needs. An increase in minority health care providers is one way to better serve the needs of minority populations. Nationwide, minority health care providers comprise a smaller proportion of the healthcare workforce than their corresponding proportion in the general population.

The current approaches are clearly not working. Although minority groups such as African-Americans and Latinos have improved their overall health over time, the actual disparity between populations of color and white population persists. Clearly, the challenge is to find new, creative approaches that actually work, and not to accept anything less than the reduction and ultimate elimination of racial and ethnic health disparities.

# RECOMMENDED TARGETS

It is time to develop a comprehensive, far-reaching set of targets designed to improve the health in a variety of areas both in the early years of life ("Life Start"), as well as to reduce a select set of chronic diseases ("Lifestyle"). In addition, the reduction of health disparities is a vital component in such an initiative, with a target of a 50 percent reduction in the disparity of specific health indicators for minority populations. As an example of the impact of this initiative in one area, achieving the one goal pertaining to infant mortality by 2010 would save thousands infants' lives during the three year period from 2007 to 2010.

### Life Start

1. Reduce infant mortality rate among general Douglas County population.
2. Reduce African-American/white infant mortality disparity by 50 percent.
3. Increase the proportion of pregnant women who initiate prenatal care in the first trimester of pregnancy.
4. Reduce the white/African-American difference in first trimester prenatal care by 50 percent.
5. Reduce the non-Hispanic/Hispanic difference in first trimester prenatal care initiation by 50 percent.
6. Improve the percentage of pregnant women with no or inadequate prenatal care.
7. Reduce the African-American/white difference in the proportion of pregnant women with no or inadequate prenatal care by 50 percent.
8. Reduce the Hispanic/non-Hispanic difference in the proportion of pregnant women with no or inadequate prenatal.

### Lifestyle

1. Decrease obesity among racial and ethnic minorities and other medically underserved Groups.
2. Promote physical activity and nutrition among racial and ethnic minorities and other medically underserved groups.
3. Promote responsible sexual behavior among minority youth and adults
4. Promote adequate Diabetes care among minority populations.

### Recommendations

*Perinatal Outcomes*

- Expand Medicaid coverage for perinatal care. Support legislation to ensure that safety net services will continue to be provided to Nebraska residents based on income eligibility and regardless of citizenship.

- Support funding for appropriate balance of services to include abstinence, family planning, and prevention of sexually transmitted diseases at the community level.

- Strengthen the partnerships between the WIC program and perinatal care providers.

*Obesity, Diabetes, and Cardiovascular Disease*

- Support school-based intervention funding throughout Douglas County.
- Support increased resources to implement Diabetes evidence-based interventions for high-risk populations such as those with limited English proficiency or limited access to care.
- Support additional resources for obesity prevention specifically to support school health educational programs.
- Advocate for insurance reimbursement for nutrition counseling by qualified health professionals when obesity is present in the absence of secondary conditions (i.e. Medicaid, Children's Health Insurance Program (CHIP) related).

*STDs*

- Assist in addressing the impact of STD stigma on prevention efforts and disparities in at-risk populations, especially youth and African American communities.

*Research Opportunities*

- Understanding the alarmingly high rate of STD infection in the African American population.
- Understanding why the lower levels of access to prenatal care among Hispanic women does not correspond to higher rates of low birth weight infants.
- Understanding why African Americans have higher levels of low birth weight births when they access prenatal care with the same frequency as Hispanics.
- Data collection on the health and health behaviors of Asian Americans and Native Americans in Nebraska to better under stand and address disparities in those communities.

References

Nebraska Office of Minority Health, Minority Health Disparities in Nebraska 2004 Fact Sheet.

Nebraska Office of Minority Health, Health Status of Racial and Ethnic Minorities in Nebraska Edition 4, Revision 3 (September 2003).

Nebraska Health and Human Services System, Vital Statistics, 2003

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