



Eliminating Racial/Ethnic Health Disparities: Reconsidering Comparative Approaches

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Abstract

The focus on eliminating racial/ethnic health disparities has brought critical attention to the poor health status of minority populations. Assessing the health outcomes of racial minority groups by comparing them to a racial majority standard is valuable for identifying and monitoring health inequities, but may not be the most effective approach to identifying strategies that can be used to improve minority health outcomes. Health promotion planning models and public health history both suggest that minority health promotion is more likely to be derived from interventions rooted in culturally and historically grounded contextual factors. In this essay, we highlight limitations of comparative approaches to minority health research and argue that integrating emic (or within-group) approaches may facilitate research and interventions more consonant with national goals to promote health and reduce disparities than comparative approaches.

Keywords

Comparative methodology; Health disparities; Health education; Health promotion; Minorities – Health and hygiene; National Negro Health Movement; Race/ethnicity

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Abstract

The focus on eliminating racial/ethnic health disparities has brought critical attention to the poor health status of minority populations. Assessing the health outcomes of racial minority groups by comparing them to a racial majority standard is valuable for identifying and monitoring health inequities, but may not be the most effective approach to identifying strategies that can be used to improve minority health outcomes. Health promotion planning models and public health history both suggest that minority health promotion is more likely to be derived from interventions rooted in culturally and historically grounded contextual factors. In this essay, we highlight limitations of comparative approaches to minority health research and argue that integrating emic (or within-group) approaches may facilitate research and interventions more consonant with national goals to promote health and reduce disparities than comparative approaches.

Key words: Race/ethnicity, health disparities, comparative methodology, National Negro Health Movement

In the last century, advances in public health and biomedical technology have led to an increased life expectancy for all Americans. During the same period, however, gaps in indicators of health status between White Americans and Americans from racial and ethnic minority groups have remained large (Geronimus, 2000; Kaplan, 2004; LaVeist, 2000), though some indications suggest the disparity is decreasing (Harper, et al., 2007). Such contrasts appear to suggest that a deeply embedded infrastructure of inequality is a very real experience in the lives of all Americans (Adler & Newman, 2002; Kawachi & Kennedy, 2002; Kawachi, Kennedy, & Wilkinson, 1999; Krieger, 2001; Semmes, 1996). It also signifies an uncomfortable truth about the United States: all Americans are not endowed with inalienable rights to life, liberty, and the pursuit of health and happiness.

A series of U.S. government reports published from 1985 to 2000 (e.g., Report of the Secretary's Task Force on Black & Minority Health; Healthy People 2000; Healthy People 2010) confirmed that the health and well being of American racial and ethnic minorities was poor in comparison to Whites. Collectively, these reports proposed a need to marshal resources toward efforts that could potentially improve the health of minority populations. As a result, interest in describing differences between the health of Whites and racial/ethnic minorities intensified – as evidenced by a rapid growth of research published over the last two decades examining racial health disparities (Daniels & Schulz, 2006). Consequently, the elimination of health disparities has become a national priority in the United States and the conventional method for evaluating progress in this endeavor involves comparing racial/ethnic differences in disease incidence, prevalence, morbidity, and mortality (Keppel, Percy, & Klein, 2004).

In this essay, we address two fundamental issues of considerable importance to the dialogue on eliminating racial and ethnic health disparities. First, we contend that although comparative approaches are useful for describing differences in health outcomes, they fail to identify specific causal factors that produce disproportionately poor health outcomes for racial and ethnic minorities. Therefore, comparative approaches are limited with regard to informing interventions that eliminate health disparities. Second, emic (i.e., within-group) approaches that emphasize historical, cultural, and political contexts may be more useful for helping to specify strategies to improve minority health. Because of this emphasis on context, an emic approach may also yield multiple pathways for addressing and ameliorating health disparities – the implications of which will be discussed below.

To support these points, we begin by describing some of the problematic characteristics of comparative approaches in contemporary health disparities research. We emphasize the ways in which these problems present difficulties with regard to fulfilling objectives to eliminate disparities. Then, through a brief exposition of the National Negro Health Movement (NNHM), we illustrate the utility of an emic approach and suggest ways in which lessons learned from the NNHM can be integrated into health policies and action research paradigms that are likely to promote racial and ethnic minority health while simultaneously reducing disparities among specific groups.

Health Disparities Research and the Comparative Approach

We define a “comparative approach” or “comparative framework” as any conceptual or methodological process where the health outcome of a particular racial/ethnic group is evaluated by comparison with another racial/ethnic group. The comparative approach is a critical aspect of how the United States

monitors the success of its current health policies, particularly those outlined by *Healthy People 2010*. The two overarching goals of *Healthy People 2010* are: (a) to increase the years and quality of healthy life for individuals of all ages; and (b) to eliminate health disparities among segments of the population. Keppel et al. (2004) point out that because these goals are distinct,

it is important to remember that progress toward target attainment does not necessarily entail progress toward the elimination of disparity and vice versa. Progress toward the target could occur for all subgroups in a domain without any reduction in the disparity between subgroups and progress toward reduction in the disparity between groups could occur without any progress toward the target for specific subgroups. (p.2)

Therefore, *Healthy People 2010* calls for *both* overall health promotion in the general population and reductions in disparities between groups. However, it is important to note that these goals, while complementary, are orthogonal. Unlike the Keppel et al. report, it is often not evident in efforts to monitor and address the public's health that promoting minority health and reducing health disparities are fundamentally distinct objectives. The failure to make this distinction is a significant issue because conflating *disparity reduction* with *minority health promotion* impedes the ability to precisely conceptualize, define, and measure target goals. Since the collection of reliable and valid data informs and determines key criteria for health policies and/or intervention programs (Griffith, Moy, Reischl, & Dayton, 2006), lack of specificity over whether a particular policy or intervention improves overall health or reduces health disparities – or does both – ultimately compromises accurate monitoring and evaluation of health objectives.

Despite the value of comparative approaches in monitoring health disparities and evaluating policy/program effectiveness, comparative studies alone cannot yield an enhanced understanding of ways to promote health-related outcomes among racial and ethnic minority groups. For example, it is well-established in the literature that compared to White American women, African American women have more adverse birth outcomes such as low birth-weight, preterm delivery, and infant mortality (Giscombe & Lobel, 2005). The comparative approach is useful in this regard because it accomplishes at least four important aims: (a) it identifies the problem (i.e., that African American women have worse birth outcomes); (b) it identifies a need (i.e., something should be done to reduce poor birth outcomes among African American women); (c) it suggests a range of potential ways to meet that need (i.e., providing quality prenatal care early in the pregnancy); and (d) it yields a method for evaluating how effectively the need is met (i.e., whether unfavorable birth outcomes among African American women decrease after prenatal care has been provided). However, comparative approaches do not tell us

what is unique about the physical environment, economic circumstances, or cultural norms and practices of African American women that contribute to poorer birth outcomes. Understanding these social and political factors may specify where to intervene, but such an understanding is not accessible through comparative approaches. Thus, comparative approaches to minority health research inhibit a broader understanding of minority health. Here, we focus on three areas in which comparative frameworks limit health disparities research: (a) determination of health promotion priorities; (b) undermining intra-group heterogeneity and assessments of cultural strengths; and (c) diminishing the importance of historical and social contexts of health disparities.

Determining Health Priorities

An important area in which the limitations of the comparative approach are marked involves the processes by which communities make informed decisions on how to prioritize local health issues. Consider that the American initiative to eliminate racial disparities in health is focused on six primary outcomes: infant mortality, HIV/AIDS, cardiovascular disease, cancer screening and management, adult and child immunizations, and diabetes (Allen, 2001; National Institutes of Health, 2003; Satcher, 1999). These focal areas are associated with the overall leading causes of death for all Americans and comparative data that attend to racial and cultural differences in outcomes related to these six foci are abundant (Martins, Tareen, & Norris, 2001). It is well-known, though, that conditions like asthma, sickle cell anemia, end-stage renal disease, iron deficiency, insufficient nutrient intake, environmental hazards, toxic waste, and lead poisoning are also disproportionate contributors to impaired minority health. Yet these conditions, until recently, have been largely overlooked in the dialogue on racial and ethnic health disparities (Jarvis & Miller, 2002; Kirschstein & Ruffin, 2001). One could presume, then, that a by-product of the comparative methodological approach is the creation of a "second-tier" category of health conditions that are given less priority by policy makers, funding agencies, and other stakeholders who have power to shape health research agendas. These agendas may not always reflect the interests and needs of local racial and ethnic minority groups that have poor health outcomes. Consequently, researchers and practitioners may be inclined to orient their programs of research and/or service to focus on the popular or currently fundable topics, rather than those of greatest import and need in local communities. Focusing on what is most critical for relieving the overall public health disease burden, while important, may not be the most prudent approach for local communities that may have very different health needs and concerns. Greater latitude and discretion in prioritizing community needs at the local level is essential for improving minority health outcomes (Griffith et al., 2006).

Intra-Group Heterogeneity and Cultural Strengths

Another consequence of the comparative approach is that it overstates group similarity and marginalizes within-group heterogeneity. For example, data consistently demonstrate that underrepresented minorities in the United States are more likely to live in poverty, have less education, live in poorer environmental conditions, and have a history of social and political disadvantage (Adler & Newman, 2002; Kawachi & Kennedy, 2002; Kawachi et al, 1999; Krieger, 2001; Semmes, 1996). Many health disparities researchers in the United States implicitly use minority group membership as a proxy for these socio-economic variables, as if all minority group members are deprived, poorly educated, concentrated in impoverished areas, and at significant sociopolitical disadvantage.

Social and Historical Context

In addition to cultural factors, social and historical contexts are critical for understanding health outcomes and health behavior. Health disparities are not new; they have existed in the United States ever since the government began collecting health data (Byrd & Clayton, 2000). Yet, the comparative approach to monitoring health disparities often treats health outcomes and determinants of health as though they are the result of contemporary factors, not historical and social inequities. For example, racial segregation across various levels of societal institutions was a fundamental organizing factor in the lives of Americans throughout the majority of the 20th century, and it continues to be relevant today (Schulz, Williams, Israel, & Lempert, 2002; Williams & Collins, 2001). Though most often considered as a phenomenon affecting African Americans in the Deep South, researchers have described segregation as a pervasive force in northern and Midwestern urban areas. Racial residential segregation is a significant marker for differences in social mobility, access to resources, and availability of health care services (Gee, 2002; Massey, 2004; Massey & Denton, 1993; Schulz et al., 2002; Williams & Collins, 2001).

The failure to fully consider how historical antecedents have contributed to the poor health of minority groups does not bode well for the aim of eliminating health disparities. With little or no acknowledgement of “health history,” researchers and policymakers neglect important models that could be modified and updated to tackle the challenge of eliminating racial and ethnic disparities in health. To illustrate this point, we describe the National Negro Health Movement, an important, but rarely studied American health promotion intervention. This intervention provides a number of lessons for researchers and practitioners who aim to eliminate racial/ethnic health disparities.

The National Negro Health Movement: A Critical Event in Health History

The National Negro Health Movement (NNHM) officially began in 1932 and stands as perhaps the largest coordinated intervention to address the poor health of a racial minority group in United States history (Brown, 1937; Quinn & Thomas, 1996; Semmes, 1996; Smith, 1995). As a comprehensive community health promotion intervention, the NNHM addressed a broad range of health outcomes. The national program mobilized the African American community by utilizing a broad cross-section of institutions, including the African American church, civic and benevolent societies, and professional organizations. The NNHM engaged in community-based health education, provided screenings and basic health services, worked with the aforementioned organizations to distribute health education materials throughout African American schools and communities, sponsored training opportunities for health professionals, and published a quarterly journal – National Negro Health News (Quinn & Thomas, 1996; Semmes, 1996; Smith, 1995).

Initiated by African American civic leaders and health advocates, the NNHM quickly garnered support during the 1930's from the United States Public Health Service and its newly created Office of Negro Health Work to hold an annual "Negro Health Week" (which originally began in Virginia circa 1915) and other year-round activities. Statistical records published in the journal corroborate a broad-based effort to promote African American health. One report indicated that during the 1949 fiscal year, approximately 5.5 million individuals attended 10,000 health lectures and 7,500 health sermons that were conducted at churches and houses of worship in 35 states ("Statistical report of the Year 1949 National Negro Health Week Activities", 1949).

In 1949, however, the United States Congress voted to close the Office of Negro Health Work and terminate support of NNHM activities. The rationale for the decision appeared in the final edition of National Negro Health News:

Eighteen years ago there was a pressing need to focus attention on the particular health problems of the Negro and to concentrate efforts in a national Negro health movement. Today, we know that this movement has been successful...so successful that there is not the same urgency to emphasize separate needs. Rather the trend now is for all groups to work together for mutual welfare. The National Negro Health Week movement has helped materially to gain general acceptance of the idea that "health is everybody's business." ("Special notice", 1950).

Though the health outcomes of African Americans were not fully equal to that of White Americans, the NNHM had been deemed so "successful" that specific resources and efforts no longer needed to be allocated to solely to improve the health of African Americans. Leonard Scheele, who at the time

was Surgeon General of the United States Public Health Service, similarly argued that it was time for the health problems of African Americans to be incorporated into the national health agenda, and that “the process of integration is the way to future health progress” (Scheele, 1949)¹. He observed that the average life expectancy for African Americans increased faster than White Americans in the previous 17 years, and that African American death rates decreased more rapidly than that for White Americans over the previous 35 years (Scheele, 1949). He observed that the average life expectancy for African Americans increased faster than White Americans in the previous 17 years, and that African American death rates decreased more rapidly than that for White Americans over the previous 35 years (Scheele, 1949). Despite noting a shortage of facilities and health professionals to serve this population, Scheele agreed that there was no longer an “urgency to emphasize separate needs” and supported the decision to close the Office of Negro Health Work, end support of the Negro Health Movement, and cease publication of its journal. He argued that African Americans had benefited from the nation’s economic, social, and public health progress, and that what was needed to improve African American health was to provide, in his words, more (emphasis in original). If Scheele’s sentiments were representative of the zeitgeist of the time, then the underlying assumption was that the gains made in improving African American health status would be better served by creating a national health agenda that would benefit all Americans (e.g., improve quality of life) than by maintaining a separate strategy (e.g., eliminate racial/ethnic health disparities). He minimized the influence of racism and segregation on the health of African Americans, and assumed that the provision of health care and social services would be open to all citizens through the existing infrastructure.

With the benefit of hindsight, we now know that the “trend for all groups to work together for mutual welfare” never gained full momentum. For example, African Americans have never gained equal access to health care, equal quality of care, or equal access to a variety of social determinants of health (Smedley, Stith, & Nelson, 2003). Instead, by the mid-1980’s – only three decades after the closing of the Office of Negro Health Work effectively ended the National Negro Health Movement – statisticians documented over 60,000 “excess” deaths when comparing mortality rates between African Americans and White Americans (Heckler, 1985). Recent reports estimate that

1 According to data from the National Center for Health Statistics (2004), Scheele’s assessment was true. In 1932, the life expectancy at birth of whites was 63.2 years as compared with 53.7 for blacks, a disparity of 9.5 years. In 1947, the life expectancy for whites increased to 68.8 years and blacks’ life expectancy increased to 60.6 years, a disparity of 8.2 years. While both increased dramatically during this 17 year period, whites’ life expectancy increased 5.6 years versus blacks’ life expectancy increasing 6.9 years, resulting in a reduction in the racial disparity in life expectancy of 1.3 years during that time.

closing this gap alone could eliminate over 80,000 excess deaths per year among African Americans (Satcher et al., 2005).

There are several important lessons to be learned from this historical example. First, we know from primary source documents that both the NNHM and the Office of Negro Health Work were successful in their efforts to promote minority health. This suggests that significant improvements in health can be achieved using national health education programs that help to organize, galvanize, and mobilize communities. Second, along with advances in preventing and treating communicable diseases, the NNHM efforts were associated with reductions in mortality between African Americans and White Americans (National Center for Health Statistics, 2004). The concomitant improvements in the health of White Americans provide additional support for the notion that it is feasible to concurrently improve minority health and promote national health outcomes. Third, the termination of the NNHM and the Office of Negro Health Work also illustrate the pitfalls of the comparative approach. Public Health Service documents and editorials in *National Negro Health News* suggests that the decision to close the Office of Negro Health Work and cease support of the NNHM was informed by what was ostensibly perceived as the trend toward health parity between African Americans and White Americans. In other words, since African American health outcomes – relative to those of White Americans – were improving, there was no need to exclusively focus on improving African American health.

The reduction in disparities between the two groups was sufficient evidence that improvements in African American health outcomes were taking place. Unfortunately, Keppel and colleagues' report (Keppel et al., 2004) was not available in 1949 to inform the U.S. Public Health Service that this line of thinking was flawed. Had it been clear that progress toward target attainment does not necessarily entail progress toward the elimination of disparity, we can only speculate on the impact organizations such as the NNHM and the Office of Negro Health Work might have had on contemporary minority health if they had been permitted to continue their work. This leads to the fourth lesson learned from the NNHM: the importance of institutionalizing a progressive health ethic. Semmes (1996) defines the process of institutionalizing a health ethic as stimulating a "tradition of values and behaviors that promote and preserve the organizational basis of health in the community" (p. 153). We interpret this to mean that an infrastructure must be created in American racial and ethnic minority communities where coordination between health professionals, health institutions, health resources operate in tandem with authentic cultural values to enhance and promote community health and well-being.

According to the Minority Health Archives of the University of Pittsburgh's Graduate School of Public Health ("The National Negro Health Movement, 1915-1951", 2006), the NNHM played a significant role in advancing a progressive health ethic in several key ways. Three of these, in particular, deserve mention. First, it helped to modify attitudes towards illness and created both an appreciation and demand for better living conditions. Second, by addressing multiple ecological levels of influence, it also demonstrated sensitivity to culture, tradition, and community needs. Finally, the implementation of NNHM activities demonstrates utilization of what would now be called "community based" approaches to public health. What should be evident here is that these significant advances were not derived from comparative approaches. In fact, a comparative approach is very limited in how it can be used to modify, address, or implement behaviors to improve minority health. In our view, the NNHM serves as a prototypical example of an emic or "within-group" approach.

Integrating Emic Approaches in Racial/Ethnic Health Disparities Research

An emic perspective represents privileged knowledge that: (a) reflects the viewpoints of people who are members of a particular group; and (b) represents locally defined beliefs and behaviors that have been shaped by one's social position in that group, culture, and society (Merton, 1970; Steuart, 1985). According to Eng, Moore, Rhodes, and colleagues (2005), "As "professional strangers," researchers do not have direct access to the [emic or] Insider's view, and in some communities with prior negative experiences with and cultivated resentment of "professional strangers," researchers may be excluded from access to the Insider's view (Kauffman, 1994). At the same time, researchers can provide an Outsider's view, which is not complicated by membership in or socialization by the community being studied, and therefore, is relatively "objective." In addition, researchers can raise questions and seek new understanding about a people's ways of living that community Insiders would be less likely to recognize without Outsider assistance (Kauffman, 1994; Merton, 1970; Steuart, 1985)" (p. 78). The combination of these differing perspectives can lead to new knowledge that is not currently emphasized in health disparities research but that is essential for understanding the role of health in context (Eng et al., 2005).

Much of the existing research on health disparities represents the etic approach: descriptive data that articulates how one group compares to another. Etic data provides useful information for identifying the extent of a problem in a given community. However, in addition to the etic approach, it is also important for health disparities research to use emic approaches that can help ground research on racial and ethnic health disparities in an ecological

context that highlights the lived experiences of community members (Israel, Schulz, Parker, & Becker, 1998; Viswanathan et al., 2004). As a collaborative research approach, community-based participatory research (CBPR) is an ideal strategy for integrating etic and emic approaches as the goal is to respect and combine community and professional expertise to provide a comprehensive understanding of both the population and health issue of interest. It also recognizes the importance of allowing the research process to provide more contextually relevant methods, interventions, and outcomes (Israel et al., 1998; Viswanathan et al., 2004). As an example, the Detroit Community-Academic Urban Research Center used a CBPR approach to develop the East Side Village Health Worker Project – a multi-level intervention designed to address racial/ethnic health disparities. By providing information, referrals, and direct assistance at the individual level, advocating for organizational change, and working toward community change through community organizing and policy change, the Village Health Worker Project was able to demonstrate improvements in research methods, practice activities, and community relationships. This project was also able to demonstrate the utility of an emic approach in identifying several benefits for sustaining community engagement and promoting minority health (Schulz, Israel, Becker, & Hollis, 1997; Schulz et al., 2001; Schulz et al., 1998).

Conclusion

The call to eliminate racial and ethnic health disparities has brought much needed attention to the poor health of racial and ethnic minorities. However, it is critical to discern the difference between reducing racial/ethnic health disparities and promoting minority health: the former does not necessarily lead to the latter. While comparative studies are important for identifying and monitoring disparities and telling us where to intervene, they tell us relatively little about how to intervene. The health of racial and ethnic minority groups must be understood beyond the level of analysis yielded by comparative frameworks if the dual aims of Healthy People 2010 are to be fulfilled – to reduce disparities and improve health outcomes (Griffith et al., 2006). Exclusive focus on reducing disparities between American racial and ethnic groups without emphasizing health promotion within minority groups may render health disparity reduction efforts null and void. Focusing on within-group health promotion efforts among racial/ethnic minorities does not require resources or services to be siphoned away from efforts to improve the health of all Americans. In fact, the NNHM clearly demonstrated that it is possible to promote health and well being for all Americans while simultaneously institutionalizing a specific, culturally relevant health ethic in racial and ethnic minority communities. However, if this possibility is to be realized, a funda-

mental requirement is that American health disparities research must move beyond comparisons between racial/ethnic groups' disease-specific health outcomes and pay equal (if not more) attention to recognizing and institutionalizing adaptive structures, traditions, and processes that will promote health. Similar to the broader goals of Healthy People 2010, it should be clear that coordinated efforts that promote minority health and concurrently reduce disparities in health outcomes between groups are needed if the United States public health establishment wants to successfully improve the health and well being of all Americans.

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