
Historical and Current Policy Efforts to Eliminate Racial and Ethnic Health Disparities in the United States: Future Opportunities for Public Health Education Research

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In the summer of 2005, the Society for Public Health Education convened a meeting, Health Disparities and Social Inequities, with the task of setting the minority health disparities research agenda for public health educators. The article provides a history of minority health efforts beginning with the Negro Health Improvement Week in 1915 and an overview of National Institutes of Health's (NIH) current 5-year strategic research plan to eliminate health disparities. The plan's goals represent a significant investment in minority health research and the emergence of NIH as the leading federal agency funding health disparity research. Understanding the history of minority health efforts and current health disparity research offers a perspective that will help guide public health educators in reaching the Healthy People 2010 goal of eliminating racial and ethnic health disparities.

Keywords: *minority health; health disparity; Negro health movement; strategic plans; discrimination; Du Bois; Booker T. Washington; policy; health education; history*

In the summer of 2005, the Society for Public Health Education (SOPHE) convened an inaugural meeting titled Health Disparities and Social Inequities: Framing a Transdisciplinary Research Agenda in Health

Education with the task of setting the research agenda in the field of health disparities. One aim of the forum was to envision a transdisciplinary framework for identification and implementation of research, teaching, practice, and policy strategies designed to eliminate racial and ethnic health disparities. To accomplish this aim, we believe it is important to take an historical perspective on the evolution of minority health in the United States. Our approach begins with the issue of racial inequality. The matter of race is a persistent theme throughout the history of our society. Discourse on race matters tend to be focused on the "Black" experience, owing to that particular institution of slavery in America. We must be mindful that American Indian and/or Alaska Native, Asian, Native Hawaiian, or Other Pacific Islander, and ethnic Hispanic/Latino populations have also experienced systematic discrimination based on their race and/or ethnicity. However, as science of the human genome makes clear that we are indeed one race, the human race, we nonetheless must confront the vestiges of discrimination and inequity as evidenced by the poor health status among racial and ethnic minority populations in the United States.

Since the signing of the Civil Rights Act of 1964, we have made great progress toward the goal of one nation in liberty and justice for all. However, as we attempt to demonstrate in this article, the manifold efforts to address the problem of health inequality continues to evolve and incorporate the needs of vulnerable populations

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across the social construct of race and/or ethnicity to include geography, disability, age, income inequality, and other social determinants of health. Although it is beyond the scope of this article to do justice to each of these factors, it is our hope that an historical perspective will provide a framework needed as a point of departure for future scholarship in the field of minority health and health disparity research.

► **ADDRESSING MINORITY HEALTH: AN HISTORICAL PERSPECTIVE**

As early as 1899, W. E. B. Du Bois, one of the most influential African American intellectuals of the 20th century, published *The Philadelphia Negro* where he used social science methods to describe social and economic conditions that shaped the quality of life and health status of African Americans. In 1906, Du Bois published *The Health and Physique of the Negro American* as part of the proceedings of the 11th Atlanta Conference for the Study of the Negro Problems (Brown & Fee, 2003; Du Bois, 1906/2003). Du Bois used the methods of epidemiology to expose as myth the prevailing view that Blacks suffered higher death rates in the North because of their racial inferiority and vulnerability to cold climates in northern cities. This “climate” hypothesis was promulgated by Frederick Hoffman, a noted statistician and executive of an insurance company. Du Bois documented how poor health of Blacks was directly related to the conditions of poverty, social and sanitary degradation. Du Bois was

the first to use the analytic tools of social science research to provide an alternative hypothesis for the impoverished condition of Blacks. In so doing he exposed the myth of innate racial inferiority. He used data to illuminate social conditions of economic poverty, inferior education, segregation, and racism as social determinants shaping the quality of life and health status of Blacks (Brown & Fee, 2003).

Another prominent African American leader of the period was Booker T. Washington, founder and president of Tuskegee Institute in Alabama. Washington made a direct link between the economic progress of Blacks and the negative impact being caused by premature death from disease. As Quinn and Thomas (1996) described, minority health started outside of the federal government with leadership from Booker T. Washington when he launched the Negro Health Improvement Week in 1915. This comprehensive public health education campaign evolved into the National Negro Health Movement and focused on dissemination of modern public health hygiene to Blacks living in poverty in the rural South. The program grew into a year-round campaign across the nation and became so successful that around 1932 it was adopted by the U.S. Public Health Service as part of the new federal Office of Negro Health Works. In 1951, however, the Office of Negro Health Works was decommissioned in the name of integration and thus brought to an end the longest sustained minority health campaign in U.S. history (Quinn & Thomas, 1996).

Thirty-four years after closing of the Office of Negro Health Works, Margaret Heckler, Secretary of U.S. Department of Health and Human Services (DHHS; 1985), released the *Secretary’s Task Force Report on Black and Minority Health*. The 10-volume landmark report documented “excess” deaths from seven disease conditions (cancer, cardiovascular diseases, chemical dependency, diabetes, homicide, unintentional injuries, and infant mortality) experienced by African Americans, Hispanics, Native Americans, and Asian and/or Pacific Islander, and Alaskan Native populations. In addition, the Secretary’s Task Force report made eight primary recommendations that continue to be relevant 20 years after they were presented (CDC, 1986):

1. “Implement an outreach campaign, specifically designed for minority populations, to disseminate targeted health information, educational materials, and program strategies.” Community outreach and public health education is central to the mission of SOPHE.
2. “Increase patient education by developing materials and programs responsive to minority needs and by improving provider awareness of minority cultural

and language needs.” The work of SOPHE in health communication and health education practice in clinical settings continues to be important.

3. “Improve the access, delivery, and financing of health services to minority populations through increased efficiency and acceptability.”
4. “Develop strategies to improve the availability and accessibility of health professionals to minority communities through communication and coordination with nonfederal entities.” SOPHE’s leadership in professional preparation and collaboration with partners across the health sciences contributes to addressing this recommendation.
5. “Promote and improve communication and coordination among federal agencies in administering existing programs for improving the health status and availability of health professionals to minorities.” SOPHE’s cooperative agreement with Centers for Disease Control and Prevention (CDC) and other agencies is an important contribution to this recommendation.
6. “Provide technical assistance and encourage efforts by local and community agencies to meet minority-health needs.” Local SOPHE chapters are positioned to translate a national research agenda into community-based interventions.
7. “Improve the quality, availability, and use of health data pertaining to minority populations.” SOPHE is a primary partner with the CDC on surveillance and monitoring functions of public health. Much progress has been made to improve reporting of health statistics beyond the “White, Non-White and Other categories.” For example, health statistics on Native American and/or Alaska Native, Asian, and Hispanic populations are now standard.
8. “Adopt and support research to investigate factors affecting minority health, including risk-factor identification, education interventions, and prevention and treatment services.” SOPHE journals (*Health Education & Behavior* and *Health Promotion Practice*) publish research and practice articles directly contributing to this recommendation. (p. 111)

The Heckler report resurrected minority health back onto the national agenda. In response to the Secretary’s report, DHHS established the federal Office of Minority Health (OMH) in 1986 to manage implementation of the report’s recommendations (DHHS, 2005; Quinn & Thomas, 1996). With greater attention to minority health issues, the CDC created an Office of Minority Health in 1988, and the National Institutes of Health (NIH) established an Office of Research on Minority Health in 1990 (CDC, 2005; NIH, 2005b). Also in 1990, Healthy People 2000 (HP 2000; the nation’s agenda for improving the health of the American people) set a target for reaching health objectives for minority populations

(DHHS, 1991). HP 2000 used the practice of setting one objective for the majority population and a separate objective for minorities. For example, the HP 2000 objective for infant mortality stated “reduce the infant mortality rate to no more than 7 per 1,000 live births . . . and reduce the infant mortality rate among blacks to no more than 11 per 1,000 live births” (National Center for Health Statistics [NCHS], 2001, p. 215). The 2000 publication of Healthy People 2010 (HP 2010) changed the way objectives were framed (DHHS, 2000). For example, the HP 2010 objective for infant mortality is to reduce infant deaths from 1998 baseline of 7.2 per 1,000 births to the HP2010 target of 4.5 per 1,000 live births. This new format brought an end to separate objectives for minority populations and challenged the nation to “close the gap” between Whites and racial and/or ethnic minority populations (DHHS, 2000).

The Heckler report also caught the attention of several states. Ohio, for example, created the Governor’s Task Force on Black and Minority Health in 1986 to examine racial differences in health outcomes across the state (Ohio Commission on Minority Health, 2005a). In 1987, the Ohio General Assembly passed H.B. 171 creating the Ohio Commission on Minority Health with a mandate to “promote health and the prevention of disease among members of minority groups” (Ohio Rev. Code Ann. § 3701.78[B] [1987]). The Commission, an autonomous state agency, was the first coordinated state effort established through legislation to address racial and ethnic health disparities.

By 2005, with leadership from the Ohio Commission, 39 state offices of minority health joined in creation of The National Association of State Offices of Minority Health, “an organization dedicated to protecting and promoting the health and well-being of racial and ethnic minority communities, tribal organizations and nations in all fifty (50) states and territories” (Ohio Commission on Minority Health, 2005b, p. 1; see also National Council of State Legislatures [NCSL], 2005). The individual state offices of minority health, working in concert with the National Association of State Offices of Minority Health (NASOMH), constitute a sustainable national network serving not only as the primary constituent for the federal Office of Minority Health but also for SOPHE and other public health professional organizations. Although a debt of gratitude is owed to the legacy of the National Negro Health Movement, we are in a much better position today to coordinate minority health and health disparity research efforts across a broader range of population groups and geographic regions.

Disparities in health status between Whites and Blacks have been documented throughout American

history. It is beyond the scope of this article to provide an exhaustive delineation of the history of minority health. However, as we recognize the two decades of progress since 1985 now is a good time to make historical linkages and prepare for the future. In summary, starting with Du Bois and his use of social science research methods to expose myths of innate racial inferiority to Booker T. Washington's 1915 launch of the Negro Health Improvement Week created the foundation for establishment of the first federal Office of Negro Health Works (circa 1932). These historical developments represent the origins of contemporary minority health exemplified by the 1986 establishment of the federal Office of Minority Health and the emergence of minority health disparities as an issue of national significance.

► CURRENT EFFORTS TO EXPAND THE FRAMEWORK FOR MINORITY HEALTH

National efforts to eliminate health disparities provide the context in which the federal government has continued to create an organizational infrastructure for coordination and oversight designed to address health disparities across a broad range of issues. Specifically, minority health has received priority status within strategic plans and health policy options across DHHS. The efforts move beyond an exclusive focus on African Americans and include other minority groups and rural populations that may suffer from health disparities. Significant research funding initiatives from the DHHS include, but are not limited to, the CDC's Racial and Ethnic Approaches to Community Health (REACH 2010) launched in 1999, the Agency for Healthcare Research and Quality's (AHRQ) Excellence Centers To Eliminate Ethnic/Racial Disparities (EXCEED) launched in 2001, Health Resources and Service Administration's (HRSA) Bureau of Primary Health Care's 100% Access and 0 Disparities Campaign, the DHHS launch of Closing the Health Gap: Take A Loved One to the Doctor Day in 2001, and establishment of the DHHS Council on Health Disparities in 2004. These are just a few of the federal activities designed to increase community outreach, public education, mobilization of minority populations, and evaluation of community-driven strategies to eliminate health disparities. In addition, the Office of Civil Rights (OCR) has drafted written policy guidance to assist health and social services providers in ensuring that persons with limited English skills can effectively access critical health and social services. The OCR works with states, localities, and recipients of federal financial assistance to enforce compliance with Title VI of the Civil Rights Act of 1964, which pro-

hibits discrimination based on race or national origin (Campanelli, 2003).

NIH Efforts to Combat Health Disparities in the 21st Century

Additional DHHS efforts focusing on health disparities were mandated through the Minority Health and Health Disparities Research and Education Act of 2000 (42 U.S.C. 202). The Act elevated NIH to the lead federal agency responsible for translating scientific research into tangible reductions in racial and ethnic health disparities. Other activities authorized by this legislation, including mandates for the AHRQ to evaluate services and access issues related to health disparities, for the National Academy of Sciences to study the collection of race and/or ethnicity data, for the HRSA to train and educate health professionals regarding cultural competency, and for the DHHS to increase public awareness about health disparities.

Specifically, the Act elevated the NIH's Office of Research on Minority Health (which the NIH established in 1990) to become The National Center on Minority Health and Health Disparities (NCMHD). Specifically, NCMHD's mission is

To promote minority health and to lead, coordinate, support, and assess the NIH effort to reduce and ultimately eliminate health disparities. In this effort NCMHD will conduct and support basic, clinical, social, and behavioral research, promote research infrastructure and training, foster emerging programs, disseminate information, and reach out to minority and other health disparity communities. (NIH, 2005b, p. 1)

The involvement of NIH in health disparity research brings considerable resources to the effort. Congressional appropriations for NCMHD has increased from about U.S. \$130 million in Fiscal Year (FY) 2001 to \$195 million in FY 2006 (NIH, 2006), and funding for health disparities research from all the institutes and centers have increased from \$2.4 billion in FY 2003 to approximately \$2.6 billion in FY 2006 (NIH, 2005a).

In addition, in 2001 NIH released the Trans-NIH Strategic Plan on Health Disparities that included a description of DHHS, NCMHD, and NIH efforts to coordinate an interdisciplinary approach in addressing health disparities. NIH's strategic plan outlined three main goals related to research, research infrastructure, and public information and community outreach (NIH, 2002a, 2002b). Each of the institutes and centers within the NIH described their efforts in the form of 5-year strategic plans related to each of these goals. These

plans were developed in recognition of the existence of differences in health status based on the social constructs of race, ethnicity, socioeconomic factors, and geographic location. This approach informed the identification of barriers and resilience factors that affect the well-being of minority populations. For example, the National Institute for Allergy and Infectious Diseases' (NIAID, 2002) strategic plan focuses on conditions that disproportionately affect underserved minority and poorly served populations, ranging from HIV/AIDS to asthma.

Similarly, the main goals, objectives, and policy implications in the various institutes' 5-year strategic plans are to (a) increase the knowledge base related to disease and/or condition-specific research, (b) develop new and improved preventive and/or therapeutic drugs and vaccines, (c) increase the number of trained minority researchers and students, (d) encourage the formation of partnerships between minority research centers, (e) promote minority enrollment into clinical trials, and (f) disseminate and publish relevant health information. SOPHE has a role in each of these objectives. The NIH's aim to ultimately decrease the incidence and disproportionate burden of disease and aid in the formulation of evidence based policy is also shared by SOPHE.

► IMPLICATIONS FOR PUBLIC HEALTH EDUCATION

The NIH Strategic Research Plan to Reduce and Ultimately Eliminate Health Disparities and the resulting 5-year strategic plans of the National Institute of Allergy and Infectious Diseases (NIAID; 2002), National Cancer Institute (NCI; 2002), National Institute of Child Health and Human Development (NCHHD; 2002), National Heart, Lung and Blood Institute (NHLBI; 2002), and National Institute of Mental Health (NIMH; 2002) clearly delineate opportunities for public health educators to craft a transdisciplinary research agenda for health disparities and social inequality. The three main goals of each strategic plan are related to research, research infrastructure, and public and community outreach and are consistent with SOPHE's (n.d.) stated mission:

to provide leadership to the profession of health education and health promotion to contribute to the health of all people through advances in health education theory and research, excellence in health education practice, and the promotion of public policies conducive to health. (n.p.)

Public health educators can make meaningful contributions toward achievement of objectives in these NIH

strategic plans. Public health education is a common thread running through the history of minority health in the United States. Public health education principles can be seen in Du Bois's use of social science research methods to document the social determinants of health. In addition, Booker T. Washington's National Negro Health Movement may be characterized as a classic public health education campaign. It is important for SOPHE to embrace this legacy as a framework for devising a research agenda.

Demonstrating commitment and purpose to the issue, SOPHE has used its professional journals for dissemination of minority health information and formulated policy resolutions to eliminate racial and ethnic health disparities. In addition, the documented evidence of closing the health disparity gap in perinatal transmission of HIV, cervical cancer screening, and selected immunizations must be celebrated as feasibility accomplishments made possible through implementation of best practices and evidence-based policy.

Yet, despite scientific advancements in medicine and improvements in delivery of public health to the population, the persistence of racial and ethnic health disparities is evidence of unequal treatment. SOPHE's research agenda should be designed to inform public policy solutions that address factors beyond the biomedical model such as poverty, racial discrimination, exposure to environmental toxins in homes and neighborhoods, and the delivery of health promotion and disease prevention interventions that are culturally tailored to community needs.

Recommendations for Public Health Education

As SOPHE prepares its research agenda for the 21st century it will be important to consider the following recommendations:

1. utilize the SOPHE Code of Ethics to inform the research agenda
2. establish formal collaboration with DHHS on integration of NIH strategic objectives to eliminate health disparities with SOPHE's research agenda
3. establish formal collaboration with DHHS on a national public health education media campaign
4. establish formal research collaboration with National Association of State Offices of Minority Health as part of a comprehensive plan to build infrastructure for national coordination of minority health disparity research
5. establish minority health disparity intelligence service as an independent "think tank" to monitor federal, state and local progress toward closing the health disparity gap

6. expand professional training in policy advocacy
7. increase racial and/or ethnic diversity in the health education academic and practice workforce
8. provide professional training in cultural competence
9. maximize use of geographic information systems to target interventions at the neighborhood level
10. continue to develop and advance community-based participatory research as one of many promising tools

In launching the National Negro Health Movement, Booker T. Washington made a direct link between the economic viability of Black people and poor health status. Du Bois used social science to expose the social determinants of health and the utility of assessing social context as an analytic tool. Such an economic and ecological framework can be made today considering growth in the number of people uninsured from all racial and/or ethnic groups, threats to employer-based health insurance, and no hope in sight for a single-payer government-financed health care delivery system. From this perspective, the very economic viability of the nation is threatened, and there is no “magic bullet” quick fix. There is an urgency now for SOPHE to develop a comprehensive research agenda linked to the NIH strategic plans and focus our efforts on shaping public policy to eliminate racial and ethnic health disparities.

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