ABFE

A Philanthropic Partnership for Black Communities

Health and Healthcare

Fact Sheet

Overview

The availability of healthcare and status of health within the Black community continues to be an important issue. Specifically, research outlines the concern surrounding the health of the Black community is influenced by a variety of dimensions such as consistent access to quality healthcare insurance and health facilities, life expectancy morbidity and mortality rates, and presence of risk factors (e.g., poor nutrition, obesity).

This factsheet is intended to contextualize healthcare in the United States through a racial justice/impact lens. Utilize the contents to create optimal assessments, strategies, and resource deployment.

ABFE is a membership-based philanthropic organization that advocates for responsive and transformative investments in Black communities. Partnering with foundations, nonprofits and individuals, ABFE provides its members with professional development and technical assistance resources that further the philanthropic sector's connection and responsiveness to issues of equity, diversity and inclusion.

For more information, visit www.abfe.org.

Barriers
Policies

Medicaid and State Policies

Established in 1965 under Johnson's War on Poverty legislations as Title XIX, Medicaid provides healthcare to low-income communities through matching federal and state grants. The state has discretion on the administration of these funds under federal guidelines. As a result, state policies impact the availability of healthcare for low-income citizens. Despite the availability of federal matching dollars to expand Medicaid most recently under the Affordable Care Act (ACA) better known as Obamacare, most southern states, where Black Americans have the greatest population share, have refused to expand insurance for the poor. In 2016, Black Americans comprised 28% of the beneficiaries of Medicaid. Black children comprised 54% of the youth beneficiaries.[1]

S-CHIP (State Children's Health Insurance Program)

In 2016 more than 50% of Black children were covered by Medicaid, compared with 30% of White children. U.S. infant mortality is the highest among countries with similar GDP, like Japan and the U.K., and U.S. Black infant mortality is higher than that of U.S. White babies. More alarming, Black neonatal infant mortality is twice as high as that of White neonatal infant mortality.[2] Low birth weight and congenital malformation are the cause of a great cause of these deaths.[3] These patterns can be impacted by the rate in which states are creating eligibility rates and match with Medicaid enrollment .[4]

Environmental Protection Agency (EPA)

EPA policies and practices are administered nationally and locally. The regulation and oversight is not always consistent or equitable as is most disturbingly demonstrated in Flint Michigan.[5]

Barriers

Unequal Opportunities

Environmental Protection Agency (EPA)

The lack of oversight has long term health concerns. Thousands of children have been exposed to lead, resulting in physical and developmental impairment. Emissions regulations, and school locations, and deteriorating schools expose children to a that can cause asthma and other conditions.

Social Determinants

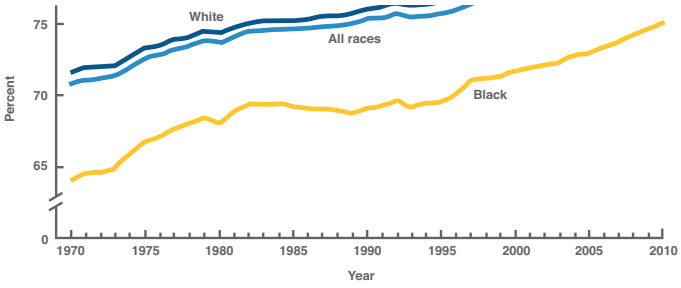
The concept of social determinants involves the factors that are implicated in determining the promotion of health and healthy conditions such as socio-economic status, employment, housing, neighborhoods, available health facilities, quality health practitioners, and healthcare insurance. In this section we will focus on a significant social determinant of health conditions – healthcare insurance. According to Center for Disease Control (CDC) National Health Interview Survey access to insurance among the Black population has increased between 2010-2017. More specifically, the percentage of Black people uninsured declined from 27.2% in 2010 to 14.1% in 2017. Meanwhile Black people with private health insurance grew from 49.3% to 57% in this time period.

Life Expectancy and Health Condition Rate

The discussion of morbidity and mortality with Black community begins with outlining the nature of life expectancy. Research identifies the life expectancy of Black people as increasing at rates faster than other groups however disparities in life expectancy persist; "In 2010 life expectancy at birth was 78.7 years, an increase of 11% since 1970. For the white population, life expectancy increased 10%, and for the Black population the increase was 17%. Nevertheless, differences in life expectancy by race have been observed and have persisted at least since official estimates have been recorded.[6]

According to the Center for Disease Control (CDC), the life expectancy disparity between white and Black people has shifted from 1970 to 2010 from 7.6 years to a current rate of 3.8 years. During this time period, Blacks have experienced a substantial growth from 64.1 years in 1970 to 75.1 years in 2010.

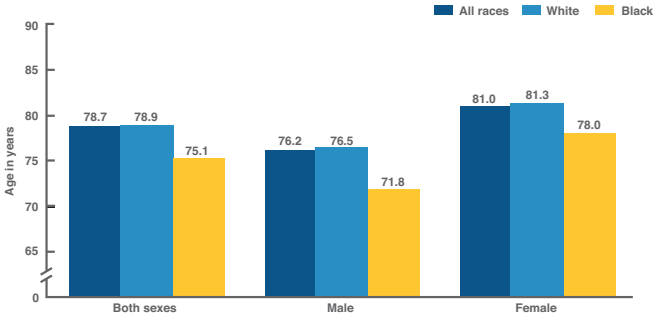
Figure 1: Life expectancy, by race: United States, 1970–2010



Source: CDC/NCHS, National Vital Statistics System, Mortality.

Another dynamic in patterns of life expectancy is the difference in rates by race and sex. The CDC identifies White women with highest rate (81.3 years), and then followed by Black women (78 years), White men (76.5 years), and Black men (71.8 years). The presence of these differences by race and sex raises questions regarding the nature to which social determinants, and risk factors are interacting with race and sex.

Figure 2: Life expectancy at birth, by race and sex: United States, 2010

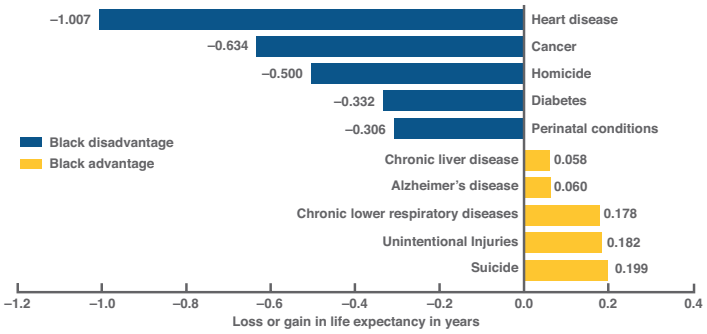


Source: CDC/NCHS, National Vital Statistics System, Mortality.

Given the nature of disparity in life expectancy, understanding the types of diseases and other health conditions which contribute to the life expectancy of Black people can provide a perspective on how to explore social determinants of health. According to the CDC (Figure 3), five conditions contribute to higher death rates among Black people: heart disease, cancer, homicide, diabetes, and perinatal conditions.

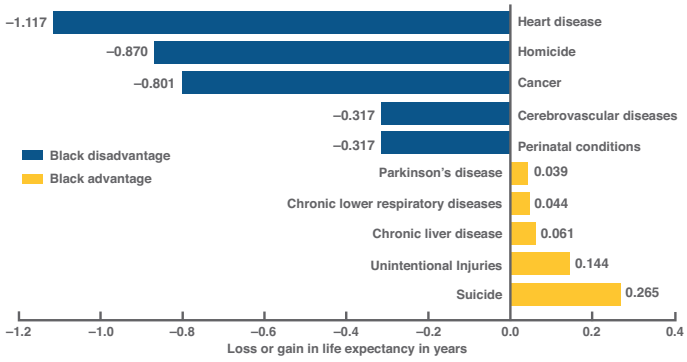
Given the unique life expectancy of Black men compared to White men and women overall, a closer examination of Black men demonstrates differences in their patterns of causes that contribute greatly to their life expectancy. Figure 4 identifies heart disease, homicide, cancer, cerebrovascular diseases, and perinatal conditions as having the greatest impact on reducing their life expectancy. Among Black females, the causes that contribute to the reduction of life expectancy include heart disease, cancer, diabetes, perinatal conditions, and cerebrovascular diseases.

Figure 3: Contribution of the leading causes of death to the difference in life expectancy between black and white persons: United States, 2010



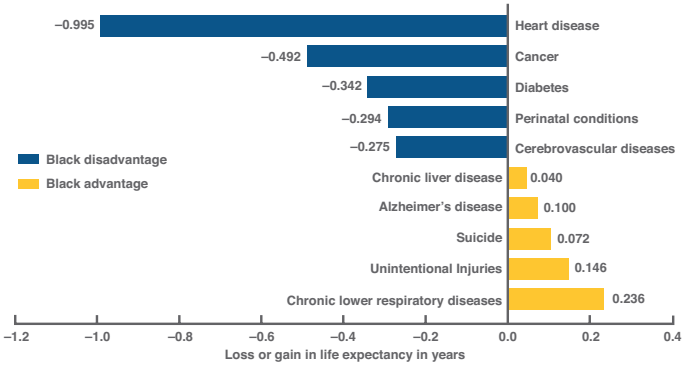
Source: CDC/NCHS, National Vital Statistics System, Mortality.

Figure 4: Contribution of leading causes of death to the difference in life expectancy between black and white males: United States, 2010



Source: CDC/NCHS, National Vital Statistics System, Mortality.

Figure 5: Contribution of leading causes of death to the difference in life expectancy between black and white females: United States, 2010



Source: CDC/NCHS, National Vital Statistics System, Mortality.

COVID-19 Pandemic

COVID-19 has affected Black and Hispanic/Latino communities in a myriad of ways. According to the Centers for Disease Control and Prevention, the rate of COVID-19 infections is approximately 10% higher among Black individuals and 30% higher among Hispanic/Latino individuals compared with White non-Hispanic individuals. The higher incidences may be substantially underestimated because these same communities often lacked access to COVID-19 testing, leaving many cases uncounted. Disparities in hospitalization are even more stark — with Black and Hispanic/Latino individuals being approximately 3-fold more likely to be hospitalized with COVID-19 than White non-Hispanic individuals. Mortality risk is 1.9-fold higher for Black individuals and 2.3-fold higher for Hispanic/Latino individuals compared with White non-Hispanic individuals.

Multiple factors contribute to the higher rates of COVID-19 infection among Black communities, such as higher proportion of people working in essential services, lack of paid sick time, lack of clear public health messaging targeting Black communities, distrust of public health messages and the health care system, poor access to testing, and financial and nonfinancial barriers to care.

COVID-19

Race/Ethnicity

Updated Sept. 9, 2021

Rate ratios compared to White, Non-Hispanic persons	American Indian or Alaska Native, Non-Hispanic persons	Asian, Non-Hispanic persons	Black or African American, Non-Hispanic persons	Hispanic or Latino persons
Cases[1]	1.7x	0.7x	1.1x	1.9x
Hospitalization[2]	3.5x	1.0x	2.8x	2.8x
Death[3]	2.4x	1.0x	2.0x	2.3x

Race and ethnicity are risk markers for other underlying conditions that affect health, including socioeconomic status, access to health care, and exposure to the virus related to occupation, e.g., frontline, essential, and critical infrastructure workers.

Source: Centers for Disease Control and Prevention

Covid-19 Chart:

1 Data Source: Data reported by state and territorial jurisdictions (accessed August 20, 2021). Numbers are ratios of age-adjusted rates standardized to the 2019 U.S. intercensal population estimate. Calculations use only the 64% of case reports that have race and ethnicity; this can result in inaccurate estimates of the relative risk among groups.

2 Data source: COVID-NET (March 1, 2020 through August 7, 2021). Numbers are ratios of age-adjusted rates standardized to the 2019 US standard COVID-NET catchment population.

3 Data source: National Center for Health Statistics (NCHS) provisional death counts (data through August 14, 2021). Numbers are ratios of age-adjusted rates standardized to the 2019 U.S. intercensal population estimate.

Note: Adjusting by age is important because risk of infection, hospitalization, and death is different by age, and age distribution differs by racial and ethnic group. If the effect of age is not accounted for, racial and ethnic disparities can be underestimated or overestimated.

Solutions and Emerging Practices

Solutions for improving life expectancy, reducing health disparities, and increasing access to insurance and quality care are abundant. The types of practices and programs available allude to the notion of equity in health; "Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential" (p.1).[7]

Thus, the strategies for achieving this equity involve the following concepts:

1. Community Engaged Approaches to Build Healthier Communities
2. Understanding Community Based Participatory Practices
3. Strengthening Community-Academic Partnerships
4. Ethical Leadership in Promoting Community Health
5. Understanding Cultural Values and Implications of Planning Community-Based Activities
6. Role of Policy, Systems, and Environmental Change Approaches to Building Healthier Communities
7. Community Partnerships with Hospitals to Address Food Insecurity

References

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3. Kaiser Family Foundation analysis of data from Linked Birth/Infant Death Records 2007-2014, National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. Accessed on Jul 5, 2017
4. https://www.kff.org/medicaid/issue-brief/key-issues-in-childrens-health-coverage/
5. http://www.cornellpolicyreview.com/sdwa-flint-michigan/
6. Kochanek KD, Arias E, Anderson RN. (2013) How did cause of death contribute to racial differences in life expectancy in the United States in 2010? NCHS data brief, no 125. Hyattsville, MD: National Center for Health Statistics
7. Holden, et. al (2016). Community Engaged Leadership to Advance Health Equity Soc Sci (Basel). 5(1): . doi:10.3390/socsci5010002.

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