

Mortality Outlook: An Overview of African American Health

Chiquita A. Collins

During the past century the United States has experienced substantial improvements in the health of its citizens. Progress has been made in the reduction of mortality attributable to a decline in infectious and chronic diseases for all racial groups. This decline in mortality rates led to an increase in life expectancy, a widely used measure to describe the health status of a population. Life expectancy denotes the average number of years that a person can expect to live based on current mortality rates. Table 1 presents the improvements in life expectancy for individuals born in 1960 compared with 1990. African-American women experienced the greatest overall gain. Both white men and women experienced similar gains, 7.9 and 7.2 years respectively. Black men had the lowest life expectancy for both periods, and gained the smallest increases, 6.3 years.

Table 1

Life Expectancy at Birth by Race and Sex, United States, 1960 and 1990

Year of Birth	Life Expectancy			
	White Men	Black Men	White Women	Black Women
1960	67.4	60.7	74.1	65.9
1990	72.7	64.5	79.4	73.6
Change	+5.3	+3.8	+5.3	+7.7
%Change	+7.9	+6.3	+7.2	+11.7

Source: National Center for Health Statistics. Health, United States, 1992. Table 27, pg. 44. Hyattsville, Maryland: Public Health Service, 1993.

Despite general improvements in health, African Americans continue to experience higher rates of mortality. African Americans die at higher rates than do whites from most leading causes of death. In a 1985 report on African American and minority health, the United States Department of Health and Human Services documented that 42.3% of all deaths among blacks under the age of 70 in 1979-1981 were classified as excess deaths. The concept of excess deaths refers to the difference between the number of deaths observed in a minority population and the number of observed deaths that would be expected if the mortality experience of that group were the same as the white population. Much work has been done since the 1985 report was published; however according to recent statistics, the disparity continues. Deaths from heart disease, stroke, homicide and accidents, cancer, cirrhosis, diabetes and, more recently, HIV/AIDS accounted for 80% of all excess deaths (NCHS, 1994). For African Americans between the ages of forty-five and sixty-nine, excess deaths were attributable to causes that disproportionately affect older individuals, such as cancer, stroke, diabetes and cirrhosis. African Americans under the age of forty-five, however, homicide and HIV/AIDS were by far the largest contributors to excess deaths. Homicide accounted for 27% of the total excess deaths for African Americans, and HIV/AIDS accounted for 14% (NCHS, 1993).

The U.S. government created a specific task force to address mortality differentials. Although one of its primary objectives was to decrease the disparity in life expectancy between white and minority populations to no more than 4 years (DHHS, 1989), this objective has not been met. Overall, the life expectancy gap between blacks and whites declined from 7 years to 6.4 years, a .6 difference. Figure 1 represents the trends in life

expectancy at birth for the four race-sex groups. Racial disparities in life expectancy have declined since 1960. However, the pace of the decline is slower than what occurred in earlier years. For both blacks and whites, improvements in the life expectancy are relatively very small. From 1960 to 1990 the life expectancy for whites increased from 70.6 to 76.1 years, and for blacks the life expectancy increased from 63.2 to 69.1 years. A persistent racial gap in mortality continues between blacks and whites and the disparity is more pronounced for certain causes of death. Table 2 indicates how pervasive racial disparities in health are. It presents the overall death rates for blacks and whites, and the black-white ratios for the 15 leading causes of death in the United States in 1988, where a ratio greater than 1 indicates that the death rate for blacks is higher than for whites. With the exception of suicides, mortality rates from all causes of death were higher for blacks than for whites. The differences are small for some conditions such as atherosclerosis, chronic obstructive pulmonary diseases and accidents, but substantial for others, such as diabetes, septicemia, perinatal conditions, AIDS and homicide.

We can also examine the racial differential in mortality by hypothetically eliminating certain causes of death. Using the most recent data from the National Center for Health Statistics, mortality rates were examined by race, sex and specific causes of death for 1988. For both whites and blacks, the largest contributors to the life expectancy will be made if the following causes were eliminated: heart disease, cancer and stroke (Figure 2). If heart disease was eliminated among women, two years of life would be added to the life expectancy for white women and four years to that of black women. In contrast, men would benefit a greater gain in their life expectancies if heart disease was eliminated. White men would gain four years and black men would gain five years to their life expectancies. Eliminating cancer would add approximately three years to all four race-sex groups. Eliminating stroke as a cause of death would add one year of life to all groups. For African Americans, homicide and HIV/AIDS infection were more detrimental, in terms of their life expectancy, than was the case for whites.

Although racial disparities in mortality are pronounced for specific causes of death, the magnitude of the black-white differential in overall mortality rates also varies by age with the largest differences (excluding infants) being among young adults between the ages of 15-24 and 35-44. For instance, the homicide death rate in 1988-1990 for whites between the ages of fifteen and twenty-four was 8.6 (per 100,000 population). In comparison, the homicide death rate for blacks age 15-24 was 67.6 (NCHS, 1993). Blacks in this age group were eight times more likely than whites to die from homicide. Deaths due to human immunodeficiency virus infection (AIDS) are three times greater among blacks than whites age 35-44. In 1990, the National Center for Health Statistics reported that the death rate from HIV infection was 15.7 (per 100,000 population) for whites and 51.0 for blacks.

Three factors that are strongly associated with improvements in mortality differentials in the United States are: 1) reductions in infectious diseases; 2) improved standard of living, and 3) accessibility and improved quality of medical services for the poor. Although these determinants had some impact in reducing mortality differentials, the racial disparity continues to persist. Overall, African Americans more so than white Americans have higher incidence rates of mortality. Not only has the gap widened for overall mortality, the gap has widened tremendously for specific causes of death such as homicide and injury related mortality.

In summary, African Americans in the United States suffer a greater disadvantage

concerning their health outcomes compared to whites. High rates of mortality are higher for blacks among the late adolescent and early adulthood age groups than blacks of older age groups. In fact, mortality rates are only lower among blacks at the oldest ages of the life span when compared to whites. This phenomenon is commonly termed as the "mortality crossover". Many have discredited the mortality crossover, stating that it is merely due to misreporting of ages at the oldest ages. Despite the controversy over the mortality crossover, there is reason to suggest that certain determinants are influencing African Americans at earlier ages during their life span that can explain this phenomenon. Socioeconomic status, whether measured by income, education, employment, occupation, poverty or wealth, traditionally has been one of the strongest determinants of variations in health in the general population (Kitagawa & Hauser, 1973; Haan & Kaplan, 1986; Feldman, et al 1989). However, race also has an effect on health which is independent of its relationship with socioeconomic status. African Americans are more likely to receive inferior medical care as a result of their lower socioeconomic status and exposure to continued racial discrimination in the quality and quantity of health care services. Many important questions are raised regarding differential health that need to be addressed in the context of the ways in which racism affects mortality. Without primary policy efforts aimed at minority and ethnic populations for specific causes of death, we can not optimistically believe that racial mortality differentials will be reduced or eliminated anytime soon.

References

- Feldman, J., D. Makuc, J. Kleinman, et al. 1989. "National Trends in Educational Differentials in Mortality." *American Journal of Epidemiology*, 129: 919-933.
- Fingerhut, L., R. Wilson and J. Feldman, 1980. "Health and Disease in the United States." *Annual Review of Public Health*, 1: 1-36.
- Kitagawa, E. and P. Hauser, 1973, *Differential Mortality in the United States: A Study in Epidemiology*, Cambridge, MA: Harvard University Press.
- Haan, M. and A. Kaplan. 1986. "The Contribution of Socioeconomic Position to Minority Health," in *Report of the Secretary's Task Force on Black and Minority Health*. Pp. 69-103, vol. 2. Washington, D.C. United States Department of health and Human Services.
- Manton, K., C. Patrick and K. Johnson, 1987, "Health Differentials Between Blacks and Whites: Recent Trends in Mortality and Morbidity," *The Milbank Quarterly*, 65 (1): 129-199.
- McKeown, T., 1976, *The Modern Rise of Population*, London: Edward Arnold Publishers, Ltd.
- National Center for Health Statistics, "Technical Appendix." In *Vital Statistics of the United States 1988, Volume II: Mortality Part A*. Department of Health and Human Services, Publication (PHS), Washington, D.C.: Public Health Service, United States Government Printing Office.
- National Center for Health Statistics. 1991. *Vital Statistics of the United States, 1988, Vol. II: Mortality Part A*. Washington, D.C.: Public Health Service.
- National Center for Health Statistics. 1991. *Vital Statistics of the United States, 1988, Vol. II: Mortality Part B*. Washington, D.C.: Public Health Service.
- National Center for Health Statistics. 1993. *Health United States 1992 and Healthy People 2000 Review*. U.S. Department of Health and Human Services, Hyattsville, Maryland: Public Health Service.
- National Center for Health Statistics. 1994. *Excess Deaths and Other Mortality Measures for the Black Population, 1979-81 and 1991*. Department of Health and Human Services, Publication (PHS), Washington, D.C.: Public Health Service, United States Government Printing Office.