

The State of Black Health in New Jersey

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FOREWORD

Healthy citizens are the cornerstone of any community. As individuals and as a collective we strive to create the conditions for physical and emotional well-being. Getting to the point of “wellness” in all its manifestations is not an uncomplicated proposition. For some, income is a barrier; for others, the lack of knowledge bars the path to healthy personal and group outcomes.

The following analytical paper by Denise V. Rodgers, M.D., Associate Dean for Community Health at Robert Wood Johnson Medical School, is an important look at the issue of “wellness” and health disparity in New Jersey. Dr. Rodgers’ paper documents both the environmental and individual factors contributing to alarming health disparities in communities of color in the state – disparities that parallel national trends.

While it is clear that race and ethnicity play a significant role in her analysis, Rodgers, a seasoned clinician and researcher, is careful to note the complicated and numerous factors contributing to health disparities. For NJPPRI, the paper is the latest in a series of efforts to document disparities and encourage wellness.

Looking back on NJPPRI’s earlier work and comparing it to Dr. Rodgers’ paper, one cannot help but feel a sense of sadness that we have not made more headway as a state and as a nation in reducing disparities in health outcomes. Sadness is a luxury for policy analysts. Learning, not regret, must always base our work going forward.

In the past six months, NJPPRI has canvassed many experienced public health officials, practitioners and others about continuing disparities in health. Two themes have emerged:

1. While government and major institutions have focused energy and resources on health disparity, the field suffers from a lack of coordinated learning. Institutions and networks often work in silos without points of healthy engagement on appropriate strategies. This is not a recommendation for yet another research institute on health disparity. Rather, many cited a need for a strategic focusing of will and effort on disparities that can be addressed by public policy and the civic infrastructure (e.g. faith and other community-based organizations).

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2. The economics and policy alternatives surrounding the access issue need greater elaboration— questions such as: Are community health centers and school-based clinics significant in reducing health disparities? Are they a viable alternative to the use of emergency rooms as primary means of accessing health care in poor communities? How can we finance the construction of new community-based health centers and increase the capacity of existing community health centers?

These two themes point NJPPRI in a clear direction. In the coming months and years, the organization will take up the challenge of facilitating new discussions of health disparity policies along with defining rigorous, innovative policy alternatives for government and the public to consider.

NJPPRI recommends this report to you in hopes that it provides timely information on an important subject. If you have comments and suggestions, please send them to us.

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INTRODUCTION

Disparities in health status by race, as evidenced by increased mortality and morbidity, have been observed in the United States since the time when health statistics were first collected. Given the inequalities historically experienced by African Americans in housing, employment, and education, it is not surprising that inequalities also exist in health. The first comprehensive examination of health disparity came in 1985, with the publication of the *Report of the Secretary's Task Force on Black and Minority Health* issued by the federal Department of Health and Human Services under the direction of DHHS Secretary Margaret Heckler. This report provided a global view of the degree of disparity and the major causes of disparity. In summary, the report found six causes of excess mortality in blacks, resulting in blacks dying in disproportionately higher numbers and at younger ages when compared to whites. The six causes of excess mortality documented in 1985 were:

1. Cancer
2. Cardiovascular Disease and Stroke
3. Cirrhosis and Chemical Dependency
4. Diabetes
5. Homicide and Accidents
6. Infant Mortality

Soon after the report was issued, the effects of HIV/AIDS on the African American community became evident, and AIDS was added as a seventh cause of excess mortality.

In February 1998, President Clinton launched his "Initiative on Race." As part of this endeavor, the Initiative to Eliminate Racial and Ethnic Disparities in Health was begun under the direction of the Surgeon General, Dr. David Satcher. The goal of this initiative, along with the federal Healthy People 2010 objectives, is to eliminate racial disparities in health status by the year 2010. Initially, six target areas were identified as a starting point for the elimination of disparity:

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While heart disease accounts for the greatest number of deaths in both blacks and whites, the greatest disparities in death are from HIV/AIDS and homicide

1. Cancer Screening and Management
2. Cardiovascular Disease
3. Diabetes
4. HIV/AIDS
5. Immunizations
6. Infant Mortality

As is evident when comparing the problems listed in 1985 and the list above, little progress was made in reducing disparity by race during the thirteen years that elapsed between the release of the Secretary's Task Force Report and the start of the Initiative to Eliminate Disparities in Health. Indeed, as we examine disparity in health status by race in New Jersey, it becomes clear that in some cases disparity has worsened.

In New Jersey, as in the country as a whole, disparities in health status exist between blacks and whites, and between rich and poor. To be poor in America puts one at much greater risk of being in poor health in America. Disparities in health status also exist between whites and other racial and ethnic groups in the United States. Significant disparities exist in Native American and Hispanic populations in the United States when compared to whites. While it is true that African Americans, Native Americans, and Hispanics have rates of poverty that are significantly higher than the poverty rate for whites, data tell us that the disparities in health status observed in these groups are not solely attributable to issues of socioeconomic status and poverty. Finally, it should be noted that even though the United States spends more per capita on health care than any other country in the world, the health status of Americans does not reflect this expenditure. The overall health status of Americans is lower than the health status of citizens of Canada, Great Britain, Denmark, France, and Japan. Therefore, the ultimate goal in the United States must be to eliminate disparity in health status by race and to improve the overall health status of everyone.

This report on *The State of Black Health in New Jersey* focuses on the eight health issues identified when the Secretary's Task Force Report and the Initiative on Race are combined. These focus areas are:

1. Cancer
2. Diabetes
3. Heart Disease and Stroke
4. HIV/AIDS
5. Homicide and Accidents
6. Immunizations
7. Infant Mortality
8. Substance Abuse

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DEMOGRAPHIC OVERVIEW

Data from the 2000 U.S. Census indicates that of people who identified themselves as being from one racial background, 12.3 percent are black, 75.1 percent are white, 3.6 percent are Asian, 0.9 percent are American Indian and Alaska Native, and 0.1 percent are Native Hawaiian and Pacific Islander. Hispanics, of any race, comprise 12.5 percent of the population according to the 2000 Census. Census data for the state of New Jersey indicate that as of the year 2000, 13.6 percent of the population is black, 72.6 percent is white, 5.7 percent is Asian, 0.2 percent is American Indian and Alaska Native, and 7.9 percent identify as some other race or two or more races. Hispanics make up 13.3 percent of the population in New Jersey.

Census data for the country as a whole indicate that the black population is younger on average than the white population; fewer black families are married couples; and black families are generally larger than white families. Additionally, blacks are more likely to be unemployed, earn less income overall, and are more likely to live in poverty. In 1999, 23 percent of black families were poor compared to 6 percent of white families. In families headed by a single black female, 41 percent lived in poverty compared to 21 percent of white, single, female-headed households. Clearly these factors impact health as they influence health insurance status and access to care. Recent data from the New Jersey Department of Health and Senior Services (NJDHSS) Center for Health Statistics (CHS) indicates that in 1999, 13.4 percent of the population under age 65 in New Jersey lacked health insurance. This increased to 14.2 percent in 2000, with most of the increase resulting from a near doubling of the number of uninsured African Americans in the state. In 1999, 158,039 African Americans in New Jersey did not have health insurance. In 2000, this number increased to 263,482, or 23 percent of all blacks in the state. During the same one-year period, the number of whites who were uninsured decreased by nearly 38,000 people. Similarly, the number of uninsured black children increased by 163 percent between 1999 and 2000.

One measure of the disparity in health status observed between blacks and whites in New Jersey is life expectancy at birth. In 1998, life expectancy at birth for a white man was 75.5 years compared to 68.1 years for a black man. The life expectancy for a white woman was 80.5 years compared to 74.9 years for a black woman. On average, a black infant born in New Jersey is expected to live six and a half years less than a white baby born in the same year. The next

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section of this report will examine some of the specific causes of this decreased life expectancy.

CANCER

In 1998, the year for which the most complete state data are available, cancer was the second leading cause of death for both blacks and whites in New Jersey. According to the American Cancer Society, New Jersey ranks 15th in overall cancer mortality among the fifty states and the District of Columbia. The cancer death rate in whites was 789.0 compared to 950.6 in blacks; therefore, the black cancer death rate was 20 percent higher.

Lung Cancer

Lung cancer was the leading cause of cancer deaths in both whites and blacks in New Jersey. The death rate from lung cancer in blacks was nearly 14 percent higher in blacks than whites. The 1998 age-adjusted lung cancer incidence, that is, the rate of new cases of lung cancer diagnosed in 1998, was 77.4 for white men and 107.8 for black men in New Jersey. The major cause of lung cancer is cigarette smoking, and estimates from 1999 indicate that blacks are 14 percent more likely to smoke than their white counterparts. At this time there is no good screening test for lung cancer available. The most important preventive measure is to avoid tobacco smoke both as a smoker and from secondhand smoke.

Breast Cancer

The second leading cause of cancer death in both black and white women is breast cancer. In 1998, the age-adjusted breast cancer death rate for black women was 13.7 percent higher than for white women, despite the fact that black women are less likely to get breast cancer than white women. The age-adjusted incidence of breast cancer in black women in New Jersey was 101.3 in 1998 compared to an age-adjusted incidence of 123.2 in white women.

Risk factors for breast cancer include female gender, aging (most breast cancers are diagnosed in women over age 50), a family history of breast cancer, not having children or having a first child after age 30, and excess alcohol intake. Early detection of breast cancer is generally believed to lead to a better prognosis. For this reason, all women are encouraged to have regular mammograms beginning at age forty. Women age 20 to 39 should have annual breast exams by a health-care professional. From 1997 to 1999, nearly 63 percent of black women in New Jersey had had a clinical breast exam and mammogram in the previous two years compared to 66 percent of white women and 57 percent of Hispanic women. Despite this, in 1998, only 58.5 percent of breast

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cancers in black women were diagnosed in the early stage of disease, compared to 66.7 percent for white women and 69 percent for Hispanic women.

Prostate Cancer

The second leading cause of cancer death in both black and white men is prostate cancer. In New Jersey in 1998, the age-adjusted prostate cancer death rate for blacks was 171 percent higher than the death rate for whites. Black men in New Jersey are more than 2.5 times more likely to die from prostate cancer than their white counterparts. The age-adjusted incidence of prostate cancer in black men in New Jersey was 220.2 in 1998 compared to an age-adjusted incidence of 149.3 for white men during the same period of time. The rate of new cases of prostate cancer diagnosed in 1998 was nearly 50 percent higher in blacks than in whites.

According to the American Cancer Society, the risk of developing prostate cancer is 70 percent higher in black men compared to white men. The older a man, the greater the risk of developing this type of cancer. There is some evidence that men who eat a high fat diet that is low in fruits and vegetables may be at greater risk of developing prostate cancer. While routine screening for prostate cancer is controversial, the American Cancer Society recommends that African American men begin getting annual blood tests for PSA (prostate-specific antigen) at age 45. They also suggest that black men undergo an annual digital rectal exam at age 45 and annually thereafter.

Colorectal Cancer

The third leading cause of cancer death in whites and blacks in New Jersey is colorectal cancer. This cancer affects the large intestine (colon) and the rectum. Data from 1998 show that blacks in New Jersey are 20 percent more likely to die from colon cancer than are whites. Blacks are about 10 percent less likely to die from rectal cancer than are whites. In 1998, the incidence of colon cancer was approximately 8 percent higher in black men compared to white men and approximately 18 percent higher in black women compared to white women. Risk factors for colon cancer include increasing age (most people are diagnosed after age 50), family history of colon cancer or family history of certain kinds of polyps in the colon, high-fat diet, obesity, and possibly cigarette smoking. Screening for colon cancer includes yearly testing of the stool for blood and colonoscopy every five to ten years beginning at age 50. Recent data suggests that African Americans in New Jersey are half as likely to get screening for colorectal cancer in comparison to whites.

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Cervical Cancer

Although cervical cancer is not a major cause of cancer deaths in New Jersey, there are a significantly higher number of cervical cancer deaths among black women compared to white women in the state. In 1998, incidence of invasive cervical cancer in blacks was 74 percent higher than the incidence in whites. During the same year, the death rate from cervical cancer was twice as high in blacks, despite the fact that black women are as likely to be screened for cervical cancer as white women.

Cervical cancer is a sexually transmitted disease caused by infection with the human papillomavirus. Women with HIV infection are at greater risk for cervical cancer. Other risk factors include multiple sexual partners and cigarette smoking. Annual Pap smears are recommended for all sexually active women, beginning at age 18, to facilitate the early detection of cervical cancer.

Other Cancers

Data from the New Jersey Department of Health and Senior Services indicate that African American men are significantly more likely to die from cancer of the oral cavity and pharynx, esophagus, stomach, liver, pancreas, larynx, and multiple myeloma than are white men. Many of these cancers are related to cigarette smoking and alcohol use.

DIABETES

Diabetes was the sixth leading cause of death for blacks and whites in New Jersey in 1998. The black age-adjusted mortality rate from diabetes was more than twice that of whites. African Americans are more likely to have significant complications from diabetes. The incidence of end-stage renal disease, also known as kidney failure, is 176 percent higher in blacks compared to whites. This data is consistent with national statistics. Nationally, in 1998, the death rate from diabetes was 121 percent higher in blacks than whites.

Risk factors for diabetes include obesity and a family history of diabetes. Obesity is a particular concern for blacks in New Jersey. Cumulative data from 1996 to 1999 indicate that 24 percent of black adults were obese compared to 15 percent of whites and 16 percent of Hispanics.

HEART DISEASE AND STROKE

Heart disease is the leading cause of death in the United States, in New Jersey, in whites, and in blacks. Age-adjusted death rates from heart disease are similar in both groups. However, there is evidence to suggest that blacks die at a younger age from heart disease when compared to whites.

In 1998, 83 percent of white males who died from heart disease were over age 65, 15 percent were between the ages of 45 and 64, and 2 percent were age 25 to 44. During that same period, 62 percent of black men who died from heart disease were over age 65, whereas 30 percent were age 45 to 64, and 7 percent were 25 to 44. Thirty-seven percent of black men who died from heart disease in 1998 were under 65 years of age, compared to 17 percent of white men. Similar disparity is seen in women. Twenty-three percent of black women who died from heart disease were under age 65 compared to only 6 percent of white women.

The heart disease death rate in blacks between the ages of 45 and 64 is nearly 60 percent higher than the death rate in whites. Clearly, the greater incidence of hypertension and diabetes in African Americans contributes to this difference. Hypertension is also a major risk factor for stroke. The age-adjusted death rate from stroke in 1998 was 75 percent higher in blacks than whites in New Jersey. It should be noted that the age-adjusted death rate from stroke in persons 45 to 64 is 166 percent higher in blacks compared to whites. Eighty-four percent of white men who died from stroke in 1998 were over age 65, compared to only 64 percent of black men. As was the case with deaths from heart disease, similar disparity was seen in women. Twenty eight percent of black women who died from stroke were under age 65, compared to only 7 percent of white women.

In addition to hypertension and diabetes, other risk factors for heart disease and stroke are cigarette smoking, family history of heart disease, elevated cholesterol, and sedentary lifestyle.

HIV/AIDS

HIV infection is the fourth leading cause of death in New Jersey blacks and the fifteenth leading cause of death in whites. The age-adjusted death rate from HIV/AIDS is *ten times* higher in blacks than in whites. In 1998, the incidence of HIV/AIDS was 23 times greater in black women ages 15 to 44 than white women in the same age group. The incidence of HIV/AIDS in black men in the same age group was 12.5 times greater than in white men age 15 to 44. It is estimated that approximately one in fifty black men is infected with HIV compared to one in seven hundred white men. Approximately 1 in 100 black women is infected with HIV compared to 1 of every 1,700 white women.

The age-adjusted death rate from HIV/AIDS is ten times higher in blacks than in whites

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Although African Americans represent just 13 percent of the state's population, 60 percent of all new HIV/AIDS cases reported from July 2000 to June 2001 were African American. Fifty-six percent of all HIV/AIDS cases diagnosed in New Jersey since the epidemic began have been African American. Sixty-five percent of all children diagnosed with HIV/AIDS in New Jersey are African American, as were 55 percent of the children diagnosed from July 2000 to June 2001. Fifty-six percent of adults and 70 percent of children currently living with HIV disease in New Jersey are black.

Intravenous drug use is the primary mode of HIV transmission in black men, accounting for 67 percent of cases. Fifty-six percent of black women infected with HIV acquired the virus through intravenous drug use. Forty-two percent of black women acquired HIV through heterosexual contact.

HIV/AIDS is having a devastating effect on the African American community in this state. New Jersey ranks fourth in the nation in the rate of AIDS in blacks. In the ten cities with the most people living with HIV/AIDS, 71 percent are African American. It is estimated that a significant number of people are infected with HIV and are unaware of it because they have not been tested. A study by Stephen Crystal, Ph.D., and colleagues published in the December 2001 issue of the *Journal of General Internal Medicine* found that New Jersey African American Medicaid recipients with AIDS initiated treatment, on average, 8 months later than white Medicaid recipients with AIDS. African Americans were also less likely to remain on AIDS therapies once started than whites.

Risk factors for HIV/AIDS include multiple sexual partners, unprotected sex with an infected partner, sharing needles that contain HIV-infected blood, and perinatal transmission of the virus from mother to infant at the time of delivery.

HOMICIDE AND ACCIDENTS

The 1996–1998 age-adjusted death rate for unintentional injuries, excluding motor vehicle accidents, was twice as high in blacks in New Jersey compared to whites. Blacks die from motor vehicle accidents at a rate that is 26 percent higher than whites. The age-adjusted incidence of traumatic brain injury is 52 percent higher in blacks than in whites. The major causes of these brain injuries are assaults and motor vehicle accidents. Blacks in New Jersey are three times more likely to die in a fire and twice as likely to die from drowning than whites in the state.

The age-adjusted death rate from homicide is eight and a half times greater in blacks than in whites. Conversely, the suicide rate is 48 percent higher in whites compared to blacks in New Jersey. The homicide rate in black men is *nine times greater* than the rate

for white men. The homicide rate in black women is six times greater than the rate for white women. Forty-four percent of all deaths in black men ages 15–24 are from homicide, compared to 7 percent of deaths in white men in the same age range. In 1998, ten times more black men ages 15–19 died from homicide than white men in the same age group. Homicide is the leading cause of death in black men ages 15–24 in New Jersey, followed by motor vehicle accidents and suicide. The leading cause of death in white men ages 15–24 is motor vehicle accidents, followed by other unintentional injuries, suicide, and then homicide.

Homicide is the fifth leading cause of death in black men ages 25–44. It is the tenth leading cause of death in white men ages 25–44. (HIV/AIDS is the leading cause of death in black men in this age range.) Most homicides in New Jersey are due to firearms. In 1998, the death rate from homicide due to firearms in black men ages 15–19 was 38.8, compared to a rate of 3.6 in white men ages 15–19. It is important to note that all deaths from homicide are preventable deaths.

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IMMUNIZATIONS

New Jersey-specific data on immunizations by race are difficult to obtain. In recent years, Newark had one of the lowest childhood immunization rates in the country; therefore, a number of initiatives have been developed to remedy this situation. Nationally, in 1999, only 74 percent of black children were fully immunized, compared to 81 percent of white children. Federal data also reveals that African Americans over age 65 are less likely to be immunized against influenza and pneumococcal pneumonia than their white counterparts. New Jersey-specific data for 1997–1999 indicate that 52 percent of African Americans over age 65 were immunized against influenza compared to 65 percent of whites. In 1999, 42 percent of African American seniors in the state were immunized against pneumococcal pneumonia compared to 56 percent of whites. Ideally, 90 percent of all people over age 65 should receive these immunizations.

INFANT MORTALITY

The most widely publicized cause of disparity in New Jersey is infant mortality. The Black Infants-Better Survival Campaign sponsored by the Department of Health and Senior Services and the Black Infant Mortality Reduction Resource Center has been successful in raising awareness about the problem of black infant mortality in New Jersey. In 1998, the black infant mortality rate in the state was 12.7 per 1,000 live births, compared to a non-Hispanic-white infant mortality rate of 4.1. Despite declining infant

The major contributor to black infant mortality is low birth weight

mortality rates during the past 10 years, the black infant mortality rate continues to be three times the white rate.

The major contributor to black infant mortality is low birth weight. In 1998, 13.9 percent of all black infants born were of low birth weight, compared to 6.3 percent of white infants and 7.3 percent of Hispanic infants. In general, black women are at significantly higher risk for low birth-weight babies regardless of other risk factors. A lack of prenatal care appears to be one of the risk factors for low birth weight. In 1998, the percentage of black women who received no prenatal care was 13 times greater than the percentage of white women without care. Eighty-three percent of white women started prenatal care during the first trimester, compared to only 60 percent of black women. Black women were also more likely to smoke cigarettes, use drugs, and drink alcohol during pregnancy than white women.

Black infants are almost twice as likely to die from SIDS (sudden infant death syndrome) as white infants. The risk of SIDS is significantly reduced if babies are put on their backs to sleep and if they are not exposed to cigarette smoke. Data suggests that black infants are less likely to sleep on their backs and more likely to be exposed to secondhand smoke than their white counterparts.

In 1998, 61 percent of pregnant white women had no medical-risk factors during pregnancy. In comparison, only 48 percent of black women were without medical-risk factors. Sexually transmitted diseases were a significant cause of medical risk in pregnant black women. Socioeconomically disadvantaged pregnant black women are also at higher risk since a higher percentage of black women are unmarried and live in poverty. In 1998, 68 percent of all black infants were born to unmarried women. This is in comparison to only 13 percent of white infants who were born to unmarried women.

SUBSTANCE ABUSE

In 1998, the alcohol-related death rate for black men was 63 percent higher than the alcohol-related death rate for white men. The alcohol-related death rate for black women was 54 percent higher. This is despite the fact that whites over age 18 are 178 percent more likely to engage in binge drinking than blacks. The 1998 drug-related death rate in black men was nearly twice the rate in white men. While the overall death rates from drug use are lower in women than in men, the drug-related death rate in black women was nearly three times that of white women in 1998. These data do not include deaths from HIV/AIDS that are related to intravenous drug use. As noted earlier, the majority of cases of HIV/AIDS in African Americans in New Jersey are related to intravenous drug use.

Although blacks comprise approximately 13 percent of New Jersey's population, they accounted for 39 percent of people seeking treatment for drug abuse and 19 percent of people seeking treatment for alcohol abuse in 1999. Fifty percent of African Americans seeking drug treatment used heroin as their primary drug. Nineteen percent used cocaine as their primary drug. Seventy-nine percent of blacks using cocaine smoked the drug (also known as using "crack") compared to 59 percent of whites. Prevalence data regarding drug use in African Americans in New Jersey is not available.

SUMMARY

Nearly seventeen years ago, the *Report of the Secretary's Task Force on Black and Minority Health* was issued by the Department of Health and Human Services. As is evident from the data presented in the present paper, relatively little progress has been made to date in eliminating or even significantly reducing the striking disparities in health status observed when comparing blacks to whites. African Americans in New Jersey have a higher death rate than whites from all of the top ten causes of death in the state. What is even more disturbing is that blacks are much more likely to die at a younger age than whites. This is particularly apparent when looking at "Years of Potential Life Lost to Age 65" data. "Years of Potential Life Lost" (YPLL) is a measure of premature death. The report on "Health Disparities by Race and Ethnicity in New Jersey," written by Rose Marie Martin, M.P.H., and published by the NJDHSS Center for Health Statistics in September 2001, says,

The rate of YPLL in the black non-Hispanic population in 1996–1998 was 2.7 times the YPLL rate in the white non-Hispanic population. The high YPLL rate in the black population is particularly influenced by relatively high rates of deaths at young ages from homicide, HIV infection and stroke compared to the rates from these causes in the white population.

The focus on death-rate data also underemphasizes the burden of illness and disability that often precedes death. Clearly, one can infer from the mortality data presented in this paper that a substantially larger number of people in the African American community are living with disease and are therefore less productive and less employable than their white counterparts. Furthermore, given the greater burden of illness in the community, black families are more likely to have to provide care to a sick family member than are white families. This contributes to physical, psychological, and economic stress for all involved.

One can infer from the mortality data presented in this paper that a substantially larger number of people in the African American community are living with disease and are therefore less productive and less employable than their white counterparts

The state of black health in New Jersey requires increased individual, family, community, and government attention

The state of black health in New Jersey requires increased individual, family, community, and government attention. There is no one solution that will significantly improve the health status of blacks and eliminate disparity. A multifaceted, longitudinal approach is required. The elimination of health disparity will require a renewed dedication of human and financial resources. Specific recommendations for the elimination of disparity include the following.

1. At the individual level, people must commit to engaging in health-promoting behaviors and eliminating unhealthy ones. Specifically, individuals must commit themselves to eating a diet that is low in fat, salt and sugar. Five servings of fruits and vegetables per day are required, along with adequate amounts of complex carbohydrates, fiber, and protein. Eating a healthy diet plays a major role in preventing heart disease, diabetes, and certain types of cancer.
2. Individuals, families, and the community must take a zero-tolerance approach to cigarette smoking. Nicotine is the substance most frequently abused in the black community. Smoking is a major cause of death from heart disease, lung cancer, cancer of the mouth and pharynx, and esophageal cancer. It is a risk factor for cervical cancer, bladder cancer, low birth weight, and sudden infant death syndrome.
3. Individuals must also become more physically active. Regular exercise lowers the risk of premature death from heart disease, certain cancers, and diabetes. Exercise is also an important method to use in reducing stress. While exercise alone will not eliminate obesity, it can help those who are obese to become more fit, hereby benefiting overall health. If individuals are to successfully incorporate exercise into their lives, community efforts must be made to ensure safe neighborhoods where children and adults can participate in outside activities without fear.
4. Education is another important strategy that must be implemented in order to eliminate health disparity. Health education on the importance of diet, exercise, safer sex, accident and violence prevention, and the need to quit smoking should be incorporated into family life and community-based activities.
5. In view of the devastating effects of HIV/AIDS on the black community in New Jersey, a number of initiatives should be implemented. Perhaps the most important and controversial is the implementation of needle-exchange programs to reduce the spread of HIV through the sharing of needles. A number of highly respected medical organizations, including the American Public Health Association, the American Medical Association, the Institute of Medicine, President Clinton's Commission on AIDS, and the office of the Surgeon General of the United States, have all endorsed needle-exchange programs as an effective part of a comprehensive approach to reducing the spread of AIDS. In addition to needle-exchange programs,

improved AIDS education and testing should be implemented by community and faith-based organizations that are located in, and serve, the black community. Attention must be given to teaching women and men how to practice safer sex. The reality of 68 percent of black infants being born to unmarried women reflects the degree to which people are engaging in sexual activity outside of marriage. For this reason, adults and adolescents should be equipped with the knowledge and skills necessary to prevent the transmission of HIV/AIDS as well as to prevent unwanted pregnancy.

6. Government leaders and agencies must be strongly encouraged to devote attention and resources to the unacceptable level of health disparity that exists in New Jersey. The NJDHSS Office of Minority and Multicultural Health must be strengthened so it can serve as the coordinating body for the state's efforts to eliminate disparity by race and ethnicity. In 2001, the Office received a \$1.5 million allocation to help in this effort. Clearly, this funding must be increased if substantial progress is to be made. Furthermore, a number of initiatives in other divisions and offices within the Department of Health and Senior Services should be funded to address the problem of excess illness and death in the black community.
7. The formal recommendations from "The Health of Minorities in New Jersey, Part I: The Black Experience" were published in May 2000 by the state's Office of Minority and Multicultural Health and should be fully implemented. These recommendations resulted from a summit held in September 1999 that focused on the health of African Americans. Twenty-eight recommendations in five areas resulted from the summit. The five target areas to be addressed are:
 - Data
 - Overall Health Disparities
 - HIV/AIDS
 - Cultural Competency
 - The Office of Minority and Multicultural Health

Specific recommendations were made under each of the target areas, along with a detailed action plan with recommendations detailing those agencies or groups that should be responsible for implementing the plan. In June 2000, a summit on "The Health of Minorities in New Jersey, Part II: The Latino Experience" was held. This summit also resulted in a set of specific recommendations and action plans. Many of the recommendations from that summit reflected those of Part I. For this reason, it would seem especially important for leaders from minority communities in New Jersey to join forces in advocating for initiatives that will improve the health of all people of color in the state.

*The elimination of health
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