Editorial

The Use of Race and Ethnicity in Public Health Surveillance

As the population of the United States becomes increasingly diverse, policy makers have come to recognize critical problems in the way that racial and ethnic variables are assessed in the collection, analysis, and dissemination of health information (*1–3*). For example, although questions on race and ethnicity are asked in the surveillance systems and studies sponsored by the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR), no clear consensus exists regarding the measurement and use of these concepts. Attempts to standardize the system of health statistics on racial and ethnic populations among Federal agencies have not been entirely successful.

Efforts to improve the system of racial and ethnic health statistics are under way. The Public Health Service Task Force on Minority Health Data has issued a report on data needs and recommended several improvements for minority health statistics (*3*). CDC's National Center for Health Statistics has awarded several grants to minority organizations to achieve these ends (*4*). And in 1992, the Bureau of the Census held the Joint Canada-United States Conference on Measurement of Ethnicity to review the assessment of ethnic identity in the U.S. population (*5*).

To promote discussion on issues of race and ethnicity in public health surveillance, CDC and ATSDR sponsored a Workshop on the Uses of Race and Ethnicity in Public Health Surveillance on March 1 and 2, 1993. Objectives of the workshop were (*a*) to describe the current measures of race and of ethnicity and their use in public health surveillance at CDC/ATSDR, (*b*) to assess the epidemiologic basis of the use of race and ethnicity for planning, implementation, and evaluating public health programs at CDC/ATSDR, and (*c*) to propose better use of existing measures for race and ethnicity or identify alternative measures, or both. A brief summary of the workshop has been published recently (*6*).

The papers published in this issue of *Public Health Reports* (pp. 7–52) were presented at the plenary sessions of the workshop and subsequently underwent peer review and editorial revision. Speakers addressed diverse aspects of the use of race and ethnicity in public health.

Donna Stroup and Robert Hahn reviewed current uses of race and ethnicity in public health surveillance in the United States and proposed criteria that categories should meet in order to be useful in surveillance. They indicated that these criteria had not been systematically applied to race and ethnicity.

Nampeo McKenney and Claudette Bennett reviewed the Census Bureau's experience in collecting information on race and Hispanic origins in the U.S. population. They noted the interdependence of census and vital statistics.

Elena Yu analyzed key assumptions underlying the current Federal system of statistics on racial and ethnic minorities. She argued that the concept of race in public health does not meet scientific criteria. She recommended replacing "race" with "ethnicity," subclassifying the major ethnic group categories to minimize the errors of aggregating diverse population characteristics, and collecting additional information consistently across all groups for purposes of targeting public health interventions.

David Williams noted the lack of scientific criteria for a notion of "races" as genetically distinct populations. He favored the continued use of race as a variable, while stressing the importance of explicating the multiple factors that account for variations in health status among racial and ethnic groups.

Steven Rabin presented a perspective from the private sector on the use (and nonuse) of surveillance information for reaching diverse racial and ethnic populations for health promotion purposes. He indicated that standard racial questions in most surveys often miss critical variables such as regional, age, sex, socioeconomic, and other subgroup differentiations of the market that may increase the acceptance of a product or public health intervention program. In his view, public health practitioners should acknowledge not only the problems, but also the strengths of minority

communities. These strengths have broad implications for all of public health.

Richard Cooper argued that, for purposes of public health, it is unlikely that physical measures of race will be developed. He stressed the importance of ethnicity and recommended concentrating on ethnicity as an important risk marker associated with health status.

Plenary sessions were followed by work group sessions in which problems in the current use of race and ethnicity in public health surveillance were considered. Each work group also recommended potential solutions to these problems.

Participants in the workshop agreed on the following general principles:

1. The concepts of race and ethnicity are not well defined or consistently measured among Federal agencies. Common concepts and measures are essential for effective public health surveillance.
2. The concept of race as assessed in public health surveillance is a social measure. Biological or genetic reference, or both, should be made with extreme caution. The relationship between concepts of race and ethnicity should be clarified.
3. Effective use of race and ethnicity in public health surveillance rests on an understanding of the socioeconomic and cultural factors that underlie differences in health status. Racial and ethnic information should be supplemented with relevant information on socioeconomic and cultural variables.
4. Public health information on racial and ethnic populations can be used to stigmatize populations and reinforce traditional stereotypes. Therefore, when race and ethnic information is collected, it is essential to explain why the information is collected, how it is determined, and what it means.
5. To collect valid and reliable surveillance data, it is essential to assess the meaning and use of concepts of race, ethnicity, ancestry, and national origin among the different segments of the U.S. population.
6. It is essential that the racial and ethnic populations that are being surveyed participate in the planning and overall design of public health surveillance programs and in prevention, intervention, and evaluation activities directed towards improving their health status.

The workshop was an important part of the process of clarifying the categories and use of race and ethnicity in public health surveillance. There is a growing need to improve public health surveillance so that health programs directed towards racial and ethnic minorities can be better designed, implemented, and evaluated. Used appropriately, public health surveillance can assist in redressing differentials in health status among racial and ethnic populations in the United States. Towards that end, the following recommendations should be considered:

1. For effective public health surveillance, scientific criteria must be used to define concepts and measurement procedures for categories such as race and ethnicity. The scientific criteria must be based on knowledge derived from the social and behavioral, as well as biological, sciences. All Federal agencies involved in the collection of such information must collaborate in the development of consistent definitions and procedures.
2. Valid and reliable concepts of race, ethnicity, and related notions, such as ancestry or national origin, should be explored. The interrelations among these concepts should also be investigated. It may be, for example, that what is measured as "race" in public health surveillance is closer to the concept of "ethnicity" (that is, self-perceived membership in populations defined by diverse criteria, including common ancestry, nationality, culture, language, and physical appearance).
3. Social, economic, and political forces underlying differences in health status among racial and ethnic populations should be investigated and reported in population studies of health status.
4. When information on the health status of racial and ethnic populations is reported, the explanation should address: (*a*) why the information is collected, (*b*) how the information is collected, and (*c*) what the findings mean.
5. To assure valid and reliable responses to surveillance questions such as "what is your race?" and "what is your ancestry?" it is important to assess concepts of and language for race, ancestry, ethnicity, and related notions among diverse segments of the U.S. population. This assessment will require social and behavioral research and in-depth interviewing among multiple racial and ethnic groups.
6. The term "surveillance" has negative connotations among many racial and ethnic groups. To avoid misunderstandings and to promote good will, the participation of populations whose health status is addressed should be sought by Federal systems

of health statistics in all aspects of surveillance from design, through methods, to dissemination and application. Participation of racial and ethnic communities may enhance the effectiveness of the surveillance itself as well as the use of its results.

The collection, analysis, and dissemination of relevant public health information (that is, public health surveillance) are essential for the design, implementation, and evaluation of any effective public health intervention. Resources should be allocated to clarify the concepts of race and ethnicity for specific purposes of public health surveillance and improvements in health. Within-group analysis should be stressed, in addition to between-group comparisons. Priority must be placed on populations and subgroups within specific populations that suffer the greatest burden of poor health, particularly if the causes are preventable (*7–9*).

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