CDC-ATSDR Workshop

A Private Sector View of Health, Surveillance, and Communities of Color

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Synopsis

The U.S. population is fast evolving into a patchwork of health behaviors, incomes, and ethnic backgrounds. Simple cultural labeling will not do.

A growing number of Americans, now numbering about 10 million, cannot or will not describe their race in any one of the Census Bureau's standard categories—white, black, American Indian, Eskimo, Aleut, Asian Pacific, or Hispanic. They group themselves as a multicultural population rather than a single racial or ethnic category. To guide health interventions, the private sector now relies more on statistical clusters based on geography, lifestyle, behavior, financial status, and attitudes instead of on race.

In marketing, the challenge is to reach diverse markets without sterotyping the product as one designed for only a certain ethnic group. The emphasis on athletics instead of on race is one example of how some marketers solve this problem of reaching minorities without giving the impression that specific products are only for blacks, or Hispanics, or Asians.

Surveillance professionals can expand the way data are collected and publicized. Blacks, Hispanics, Asians, and Native Americans should not be categorized simply by race; other variables of health, such as income and age, should be given careful attention.

RACIAL AND ETHNIC based surveillance that simply describes populations as black, white, Hispanic, Asian, and other are quickly losing their value in the battle to improve minority health. Instead, the U.S. population is rapidly evolving into a complicated patchwork of behaviors, incomes, and ethnic backgrounds that confound simple cultural labeling and require a fresh look at surveillance approaches.

Fallacies of Cultural Labeling

There is a big difference between Hispanic Americans of Puerto Rican, Mexican, Cuban, or Central American descent. Cubans with higher per capita incomes have different home ownership patterns, disposable income, and food preferences than other Hispanic groups. From a health perspective, Cuban Americans have infant mortality rates that are lower than most white communities. Rates for Puerto Rican infants vary by how long a family has been in the United States (*1,2*).

In the African American population, consumption habits and health indices vary widely by the year of migration from the rural South to the cities of the North—those migrating later have lower disposable income and have poorer health. There is also a big difference among blacks who trace their roots back through slavery and those who recently moved from the Caribbean or Africa to the United States. Unlike the Vietnamese, those who have been in the United States the longest score the lowest on many health indices.

Grouping data for all whites masks large gaps in health between social classes, regions, and urban versus rural populations. How people group themselves further erodes the value of racial and ethnic data. According to Census Bureau data, a growing number of Americans, now numbering almost 10 million, cannot or will not describe their race in any of the standard census categories (white, black, American Indian, Eskimo, Aleut, Asian-Pacific Islander, or Hispanic). States like California, with a large multicultural population, lead the nation in the percentage of the population that will not identify itself by a single racial or ethnic category.

Health statistics compiled on the basis of race also miss a more important determinant of health—poverty. One-third of the U.S. black popu-

lation is middle class with many health problems more similar to those of middle class whites than poor blacks (*3*). A study by scientists at the National Cancer Institute finds that poverty, not race, is responsible for higher rates for most cancers among blacks. And for certain cancers (rectal, breast, and lung) rates for whites, when adjusted for income, are actually higher (*4*).

To adjust surveillance methods to keep up with these changes, statisticians can look to large marketing institutions such as Johnson & Johnson, Procter and Gamble, and MCI. Today, the private sector is relying more on statistical clusters based on geography, lifestyle, behavior, financial status, and attitudes than they are on race. Such information provides more reliable profiles and maps to guide health interventions. Two common clustering approaches—PRIZM and VALS—have fueled a new generation of marketing that divides the nation into scores of target groups based on lifestyle similarities.

PRIZM uses addresses and demographic characteristics to group people, using the premise that "birds of a feather flock together": people living in the same neighborhood are likely to have similar lifestyles, and therefore will buy the same products, use the same media, and have similar knowledge, attitudes, and behavior related to health. PRIZM divides the nation into different neighborhood types, and assigns individual households to one of these types based on their address. VALS groups people based on their responses to questionnaire items measuring values, attitudes, and lifestyles.

Strengths of Communities of Color

Most studies that organize populations by race count problems, but often overlook strengths. Historically, minorities are thought of as "disadvantaged." Health education campaigns based on one-sided studies overlook enormous cultural strengths in communities of color; for example, close family and neighborhood ties; deep and profound religious beliefs; thriving church communities; and greater understanding of verbal and nonverbal communications.

For the last two decades, antismoking programs directed at adolescents have operated under the incorrect assumption that black teens smoke more than white teens. Yet recently the Centers for Disease Control and Prevention turned this assumption on its head by finding that only 17 percent of black teens smoke, compared with 32 percent for Hispanics and 41 percent for whites (*5*).

A Stanford University study funded by National Heart, Lung, and Blood Institute found little relationship between race and poor health attitudes and behaviors. The results, in fact, suggest the opposite. Slater and Flora, using a simple statistical clustering program, took data from the Stanford cardiovascular intervention trials and correlated health risks and attitudes with race. The results showed that a high proportion of those with the healthiest attitudes and behaviors, and those most likely to serve as a role model for others, are Hispanics and other people of color (*6*).

The private sector has already begun to put this understanding to use. Marketing executives today use people of color as national role models as a way to increase sales. Executives at Reebok, the athletic footwear company, look to African American teens in the South Bronx to predict the future fashion and cultural trends of white suburban youth. Latin and African American music forms the soundtracks for commercials, films, and television programs. African American and Hispanic culture are part of the creative engine fueling one of the country's largest exports—entertainment.

It is often assumed that people of color are hard to reach with information because of education or community barriers, but marketing research indicates that blacks are more culturally literate and easier to reach than whites. And those living in poverty, of any culture, may be the easiest to reach of all.

In contrast to their U.S. counterparts, health officials in Africa have learned that the very poor are the easiest to educate. As Joseph Mwongela, a Kenyan Health Education Officer working in Nairobi explained in an unpublished interview, "The impoverished have an asset that makes health education possible—time. They will come to a meeting. They will listen to a 30-minute radio program."

A study led by researchers at De Paul University and the University of Alabama demonstrated that when identical advertisements were shown to white and black audiences, the blacks were more perceptive in identifying independence, success, and family messages contained in the advertisement (*7*).

Communities of color are likely to be "high context" cultures. There are many interlocking family and personal relationships; there is a strong common culture; and there is greater experience in use of nonverbal communications. In contrast, European cultures tend to be what Edward Twitchall Hall would call "low context." The primary social unit is the individual, not the community.

The special understandings that support more efficient interpersonal communication are not as likely to be present in white culture. White people may be the true "hard to reach."

Consequences of Simplistic Definitions

A call for more subtlety in descriptions of populations and health is not a question of just improving current methods. It is an urgent call to stop unintended, yet harmful consequences. Describing disease or epidemics using simple cultural definitions, without greater context, reinforces undesirable social norms within a community and increases discrimination from the outside.

Dr. Felton Earls, in studies of one of the nation's top health emergencies—youth violence—finds that when homicides in the black community receive extensive media attention, those outside and inside black neighborhoods begin to believe that shootings are more prevalent than statistics indicate. Earls, in an unpublished interview at the Harvard School of Public Health, shared his view that media depictions of health emergencies by specific race-identified neighborhoods create a "quarantine that suggests that violence is the norm rather than the exception."

In the case of violence, whites respond by avoiding black neighborhoods out of fear—driving business and jobs away. Blacks increase their rate of gun ownership and use. In 1988, Hispanic groups were horrified as they watched demands for a specific Hispanic campaign on acquired immunodeficiency syndrome (AIDS) backfire. Federally funded and Hispanic-produced public service announcements carried the news, "One Hispanic gets the AIDS virus every 20 minutes, one dies every 2 hours." While the campaign gained the attention of the Hispanic community, it also alarmed whites. In one incident, Hispanics were thrown out of State employment offices because white employees were convinced that all Hispanics were infected and spreading the AIDS virus (correspondence to Lionel Sosa, Sosa Associates, San Antonio, TX, regarding Phase I of the Centers for Disease Control's "America Responds to AIDS" campaign).

Professor Robert Blendon, Chairman of the Department of Health Policy and Management at the Harvard School of Public Health, keeps a running tab on public opinion polls and health. His data show that most Americans are less likely to pay attention and devote resources to a problem defined as a "minority problem."

Put bluntly, whites with resources are unlikely to get involved as long as certain health issues such as AIDS, youth violence, drug use, and infant mortality are defined solely as "minority health" problems. Efforts that focus on the "minority" aspect of a health problem forestall necessary changes in health care delivery, access, funding for testing, pushing for inschool clinics, approving necessary data collection, and other structural changes of extreme importance and urgency.

Solutions Suggested by the Marketing World

In the marketing world, the similar challenge is to reach diverse markets without stereotyping the product as one designed for only a certain ethnic group. Some marketers have already solved the dilemma of how to reach minorities without creating the impression that specific products are only for blacks, or Hispanics, or Asians. Nike's "Just Do It" campaign uses athletic figures familiar to most Americans, yet the campaign carries a special message for black youth. Television advertising for Maxwell House Coffee depicts a small town parade complete with the prominent featuring of a stoic and strong black woman waving a small American flag. Such "layering" of general public and target audience messages allows special outreach without ostracism.

In a parallel vein, leaders of public health surveillance systems, seeking to describe minority health challenges, need to provide educators with information that explains the salience of the problem within targeted communities but also addresses bonds that are common to all sectors of the population.

Education campaigns that rely on family and children imagery have an enormous capacity to carry health messages across race and class barriers. A 1987 survey by the Roper Organization found that more than 90 percent of all cultural groups studied list being a good parent as the most important aspect of fulfilling the American dream (*8*). In a 1987 planning session on HIV education programs, the National Institute on Drug Abuse found that an effective message to use in motivating black male drug users to use condoms or stop sharing needles was concern about being the father of an "AIDS baby." Knowing a person's parental status is a critical key to understanding and solving health problems. Surveillance needs to help us look for common bonds—information and population groupings that remind us of how we are the same.

Because we have become so focused on race and health, we are missing possibly a more important common denominator of health risks in all commu-

nities—age. There are 54 million adolescents and young adults in the United States—1 in 5 Americans. Teenagers—prime candidates for high-risk sexual, tobacco, alcohol, drug, and violence behaviors—are arguably the most important "risk group" in public health today. Black, Hispanic, Native American, and Asian community leaders who place their focus on adolescence instead of race will find a common bond across all classes and cultures. White parents may not respond to the concerns of black teens alone, but they are likely to respond to the needs of all adolescents.

If a health campaign targets adolescents and young adults, it can reach most of the people of color at risk for sexually transmitted diseases, excessive alcohol use, tobacco use, drug use, and violence. Because of immigration patterns and low rates of white births, almost one-third of the U.S. population younger than 25 are people of color. In fact, 30 percent of all African Americans and 38 percent of all Hispanics are younger than 20 (versus only 22 percent for whites).

There are other common denominators to consider when designing health education programs. The consuming national interest in Magic Johnson's human immunodeficiency virus (HIV) infection is another reminder of the power of sports as an enormous common denominator across race, age, and class. In the 3 days following Magic Johnson's announcement, the Washington Post carried an average of five Magic Johnson-related stories a day by reporters who regularly cover not only sports, but the White House, television, and cultural events. Those expressing personal concern ranged from President Bush to adolescents in the very poorest sections of the city.

Knowing a person's religious preference and worship habits may help provide a critically relevant insight for health communications planners. Today more than half of the churches in the United States provide some type of health care or prevention service.

And, from a marketer's perspective, one of the most interesting differentiations of populations is not race, but media habits. Information on how health issues affect television watchers, versus magazine readers, versus radio listeners allows public health officials to use limited resources wisely in reaching target groups.

Conclusion

Social marketers designing health promotion and disease prevention campaigns need surveillance experts to pay more careful attention to differentiation within minority populations regarding year of migration, family status, income, age, daily work habits, religion, media habits, and even sports affiliations. Reports written with a sensitivity to the similarities, as well as the differences, between racial and ethnic groups can help avoid dangerous stereotyping or misdirecting resources. Information should be collected to understand better the strength of cultures. Health educators and social marketers can then build on these strengths and multicultural similarities to improve chances for success.

Surveillance professionals can lead the way by expanding the way data are collected and presented to the public. Sophisticated marketing research techniques can be used to better target health education programs and resources by looking at specific census blocks, age, psychographic data, attitudinal data, and the date of migration to the United States or to urban areas. All blacks, Hispanics, Asians, and Native Americans should not be casually lumped together in "minority" charts, or lumped solely by race, without careful attention spent on other variables of health, particularly income and age. Simple statistical clustering techniques can yield a wealth of insight into predictors of risk and opportunities that transcend racial and ethnic stereotypes.

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