Disparities in health care: The black population

In this second installment on disparate populations, the author focuses on the challenges to providing oncologic care to the black community.

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Racial and ethnic disparities can be multifactorial, encompassing socioeconomic factors (eg, education, income, and employment), lifestyle behaviors (eg, physical activity and alcohol intake), social conditions (eg, neighborhoods and work conditions), and access to preventive health care services (eg, cancer screenings and vaccinations).[1] Leading health indicators of progress toward national health objectives for 2020 continue to reflect racial and ethnic disparities.[1] Eliminating disparities requires culturally appropriate health initiatives and community support, in addition to equal access to health care.[1] Furthermore, disparities are not equal among all racial and ethnic populations, and prevalence and incidence of various diseases are also different across the different populations.

As we continue to make strides in oncology care (eg, prevention, screenings, and treatment outcomes from diagnosis through end of life), we must make an effort to include all racial and ethnic groups in this progression. Health care disparities for black persons in the United States can mean loss of economic opportunities, lower quality of life, perceptions of injustice, and earlier death.[1] From a societal perspective, health care disparities for the black population translate into less than optimal productivity, higher health care costs, and social inequities.[1]

The literature suggests the heritage and history of black persons dating as far back as 1619–

1860 had an impact on the black experience in America, thus making their life stories markedly different from that of other immigrants.[2] Elimination of disparities for this group is intertwined with knowledge and awareness that focuses on integration of health-related cultural values and practices, disease incidence and prevalence, and treatment efficacy.[2] This article focuses on the disparities in oncology care that exist for black and non-Hispanic black persons in the United States, and the interventions that may reduce such disparities.

DEMOGRAPHICS

The black population is estimated to be 61 million people by 2050 and will account for 15% of the total US population.[1] The 2000 Census indicated 36.4 million persons, approximately 12.9% of the population, identified themselves as Black or African American, 35.4 million of whom identified themselves as non-Hispanic.[1] Cancer is the second leading cause of death in both non-Hispanic blacks and non-Hispanic whites.[1] In 2001, the age-adjusted incidence per 100,000 population for various cancers, including colorectal cancer (CRC), was substantially higher in black females than in white females.[1,3] Disaggregation studies are examining the relationship between black-white cancer health disparities.[3]

Recent studies disaggregating the US population based on region showed foreign-born people have better general health outcomes than US-born people; but as the number of years living in the United States increases, health status mirrors that of the US-born population.[3] Approximately 6% of persons who identified themselves as Black in the 2000 Census were foreign born.[1] What ultimately has emerged from these studies is that despite the limited studies among US black people, specific subgroups of the black population remain at risk. Health promotion efforts need to overcome the barriers facing these specific groups.[3]

CANCER IN THE BLACK POPULATION

A variety of demographic and sociocultural factors are commonly reported barriers to adherence to suggested cancer screenings. These factors include lack of knowledge or awareness of cancer screenings, lack of access to general preventive health care services, institutional or system barriers, socioeconomic status, language barriers, immigrant status, and cultural beliefs.[2-4] Related specifically to the black population, researchers believe social isolation leads to a lack of social support.[4] This lack of support has a negative impact on worries and concerns often encountered by patients with cancer.[4]

Black persons experience higher overall cancer incidence and mortality rates, excessive burden of disease, and lower 5-year survival rates compared with non-Hispanic white, Native American, Hispanic, Alaskan Native, Asian American, and Pacific Islander populations.[2,5] Approximately 168,900 new cases of cancer were diagnosed among black persons in 2011.[6] The most commonly diagnosed cancers in the black population are prostate (40%), lung (15%), and colorectal (9%).[6] In 2010, 142,570 new cases of colorectal cancer were diagnosed and an estimated 51,370 patients died from their disease; in 2011, colorectal cancer lead to 7,050 deaths.[5,6] Lung cancer is the leading malignancy among both black men and black women, attributing to 65,540 deaths in black persons.[6]

Colorectal cancer is the third leading type of cancer and cause of cancer-related deaths in the black population.[7] A 20% higher incidence and a 40% higher overall mortality are attributed to disparities in access, high-quality screening, and treatment, as well as later stage disease at diagnosis, in this group.[3,5,6]

Breast cancer incidence increased rapidly among black women during the 1980s due to higher detection rates as use of screening increased.

Incidence of cervical cancer in black women is 11.1 cases per 100,000 population compared to 8.7 cases per 100,000 population for white women. Mortality rate for cervical cancer in black women is more than twice that of white women.[8] The 5-year survival rate is 66% for black women compared with 74% for their white counterpart; in addition, advanced stage disease at diagnosis occurs more frequently in black women.[5,6,8] In 2011, 860 deaths in black women were reported as a result of cervical cancer.[6]

As recently as 5 years ago, a review of studies yielded an increased incidence of oral cancers among black men. Oral cancers are ranked as the 10th leading cause of death among black males.[7] Age-adjusted incidence of oral cancer in black males was more than 20% higher than that of white males from 1998 to 2002.[7]

Breast cancer is one of the most commonly diagnosed malignancies in black women, with an estimated 26,840 new cases diagnosed in 2011.[6] Breast cancer incidence increased rapidly among black women during the 1980s largely due to

higher detection rates as the use of mammography screening increased.[6] Incidence stabilized among black women 50 years and older from 1994 to 2007, while rates decreased by 0.6% per year from 1991 to 2007 among women younger than 50 years.[4,6] However, among women younger than 45 years, incidence rates are higher for African American women compared with white women.[6] Breast cancers in black women are more likely to be associated with poor prognosis, such as higher grade, distal stage, and negative hormone receptor status.[6] Risk for basal-like breast cancer (ie, triple-negative cancers), an aggressive subtype of breast cancer associated with shorter survival in premenopausal black women, is even more prevalent.[6]

Lung cancer kills black persons more than any other malignancy.[6] In 2011, 23,220 new cases of lung cancer were reported, and an estimated 16,790 deaths occurred. The convergence of lung cancer death rates between young black persons and white adults is the result of faster progression of disease in black persons, likely reflecting a greater reduction in smoking initiation among blacks since the late 1970s.[6] Also, as with most of the malignancies diagnosed in blacks, increased mortality is also associated with advanced stage at time of diagnosis.[6]

Black men and men of Jamaican African descent have the highest occurrence of prostate cancer worldwide. An estimated 35,110 new cases of prostate cancer were diagnosed in 2011, accounting for about 40% of the cancer incidence in the black population.[6] The only risk factors linked with prostate cancer are age, race, and family history.[6]

UNDERSTANDING BLACK CULTURE

Examining the cultural practices within a racial or ethnic group that impact the group's belief system is essential to addressing the disparities that exist among any culture. Models that explain preventive behaviors, such as CRC screening, do not account for all social and cultural factors relevant to the black population.[9] *Culturally sensitive skill* is defined as the ability to collect relevant data regarding patients' presenting problem and accurately conduct a physical assessment in a culturally sensitive manner.[2] This skill coupled with a model of cultural competence and desire can allow clinicians to meet the health care needs of a given population.[2]

The literature alludes to a consensus that most black persons tend to be suspicious of health care professionals. Black persons tend to visit a physician or nurse only when absolutely necessary and may use home remedies to maintain their health and to treat specific health conditions.[2,8-10] The provider-patient relationship with black persons is also influenced by the perception of a lack of respect.[10] One study yielded findings that black persons felt they would have received better or different care if their race was different.[10] The perceived lack of quality care may be associated with a failure to recognize the sociocultural differences between black persons' perception of illness and white persons' perception of illness.[10]

Acculturation barriers include beliefs about the causes of disease (eg, cancer is caused by bad blood or evil spirits), inaccurate self-estimate of risk, and the belief that cancer-preventive measures are ineffective or nonexistent.[8] These barriers are attributed to a history of being disenfranchised, then emancipated, then enfranchised, and then empowered politically.[10] The migration of black people from the rural south to the urban north, economic gains, and shift from caste segregation to social desegregation has had a significant impact on how black people continue to perceive their social, political, and health status.[10]

As US residents for more than 400 years, black people have developed a cultural environment unique to how they cope with their social status.

In an attempt to assimilate into society, the black population created their own social and political environment, as well as health care practices. As residents of the United States for more than 400 years, black people have developed and maintained a cultural environment unique to how they cope with their perceived social status within the larger society.[10] The black population has developed its own view and judgment of the larger American society and cultural guidelines for interacting within the boundaries of the health care institution.[10] Black culture is established around community and social support networks, family and kinship networks, health beliefs, and practices related to understanding health and illness, as well as their understanding of who influences their health-related decisions.[4,10]

IMPLICATIONS FOR PRACTICE

Health care practices aimed toward reducing or eliminating health care disparities in oncology care among the black population must focus on these barriers. Given the variability of influences that contribute to health disparities among the black population, from socioeconomic to historical racial roots, the health care arena must go deeper into the barriers that exist within this population. Addressing concerns of trust

and mistrust within the health care provider relationship, issues of respect, lack of understanding of susceptibility to disease and its impact on one's life, treatment adherence inclusive of preventive measures, and social support systems proven to have positive benefits for patients with cancer regardless of racial or ethnic background can begin to bridge the gaps in care that exist within this population.[2,4,7] Efforts should focus on these key attributes of this ethnic group.

- Improve your understanding of the heterogeneity within the black population to foster more effective nursing care across the cancer continuum in primary care, as well as oncology, settings.[3]
- Recognize the diversity of the US black population and operationalize black ethnicity to determine ethnic subgroup differences that may affect use of cancer services.[3]
- Develop cultural skills for performing physical assessments of black patients, especially in relation to variabilities in skin color, and diagnosing various disease states.[2]
- Deliberately seek face-to-face interactions with black patients, which can help establish trusting relationships with these patients.[2]
- Understand cultural preferences for greeting black patients. Many prefer to be greeted formally (ie, Doctor, Reverend, Pastor, Mr., Mrs.), and also prefer to be addressed by their surname because family names are highly respected and connotes pride in their heritage.[2]

Oncology education must extend beyond our individual institutions, to our surrounding communities for better overall health outcomes.

- Accept cultural influences on nonverbal expressions, such as a louder voice (not necessarily a sign of anger), the comfort level in close spaces, and intimate interactions without misjudgment is an important factor in building a therapeutic relationship with black patients.[2]
- Understand the social structure of the black community to develop appropriate educational strategies that improve health outcomes. Black patients rely on people with similar backgrounds to reassure them that information is accurate.[4]
- Respect the importance of church and religious practices during times of illness. Studies have shown that prayer and constant contact with the church are pivotal to these patients' psychological well-being during cancer treatments.[4]

CONCLUSION

Clinicians providing oncologic nursing care must strive for cultural sensitivity and diversity to close the biases of cultural indifference, increase awareness of culturally sensitive actions, and continue to advocate for programs that span across all racial and ethnic populations regardless of socioeconomic status, disease status, or cultural beliefs. The discipline of oncology must continue to promote early prevention and screening modalities in combination with consistent health care access and follow-up. Oncology education must extend beyond our individual institutions and permeate our surrounding communities for better overall health outcomes for the various racial and ethnic populations we serve. ■

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