DOCUMENT RESUME

ED 326 585 UD 026 889

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|---|---|
| TITLE | Now Is the Time: An Action Agenda for Improving Black and Minority Health in Maryland. The Final Report of the Maryland Governor's Commission on Black and Minority Health. |
| INSTITUTION | Maryland Governor's Commission on Black and Minority Health, Baltimore.; Maryland State Dept. of Health and Mental Hygiene, Baltimore. |
| PUB DATE | Nov 87 |
| NOTE | 228p. |
| AVAILABLE FROM | Maryland Dept. of Health and Mental Hygiene, Policy and Health Statistics Administration, Division of Policy Analysis, 201 West Preston Street, Baltimore, MD 21201. |
| PUB TYPE | Reports - Research/Technical (143) |
| EDRS PRICE | MF01/PC10 Plus Postage. |
| DESCRIPTORS | *Blacks; Demography; *Health Needs; *Health Promotion; Health Services; Hearings; Migrant Workers; *Minority Groups; Mortality Rate; Public Health; *Racial Differences; Refugees; State Surveys; Whites |
| IDENTIFIERS | *Access to Health Care; *Maryland |

ABSTRACT

This document comprises a report on the disparity between the health status of Maryland's blacks and minorities and the white population. Information was gathered from statewide public hearings at which over 50 individuals and groups representing the general public and health care providers testified. The major finding was that a disproportionate number of black and minority Marylanders died needlessly between 1983 and 1985 from diseases, homicide, or accidents that were either preventable or controllable. Although Maryland has one of the best health care delivery systems in the nation, major improvements are needed if the health status of blacks and minorities is to change. Goals for improvement and priority recommendations are discussed. Statistical data are included on one graph and 13 tables. Brief summaries of the following topics are also included: (1) major racial health-related disparities in Maryland; (2) factors contributing to identified racial health disparities; (3) major causes of death and related risk factors; (4) differences in the cultural norms of Anglo-Americans and minorities that may impede health care; and (5) priority goals and recommendations. Lists of the Governor's Commission on Black and Minority Health Task Force members, a national directory of health-related organizations and agencies, and brief discussions of the major health problems of Native Americans, refugees, and migrant farm workers in Maryland are appended. (FMW)

# NOW IS THE TIME: AN ACTION AGENDA FOR IMPROVING BLACK & MINORITY HEALTH IN MARYLAND



The Final Report of the Maryland Governor's Commission on Black & Minority Health

William Donald Schaefer
Governor

November, 1987

# NOW IS THE TIME:

## An Action Agenda For Improving Black And Minority Health In Maryland

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William Donald Schaefer,
Governor

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The Commission recognizes that there are few quick fixes and that significant improvements will not occur overnight. However, it is the Commission's strong belief that more can and must be done by public officials, health care providers, private sector groups, minority individuals, and minority communities to work toward improving the health of Black and minority Marylanders. At a minimum, Maryland's health care system should be changed to assure Blacks and minorities ready access to quality, appropriate care. Additionally, intensive and widespread educational efforts must be initiated to give Blacks and minorities the requisite skills and resources needed to improve their health status.

The State of Maryland has a proven track record of being at the forefront of implementing new and innovative strategies to address complex health issues and problems. Lessening the gaps in health status and access to health services between minorities and non-minorities should prove to be a difficult, but manageable task for a State which has been historically committed to promoting equal access to health care for all.

Larry Young
Chairman

Edward N. Brandt, M.D., Ph.D.
Vice-Chairman

# PREFACE

The goals and recommendations contained in this report reflect the health care needs of Maryland's Black and minority populations. The Governor's Commission on Black and Minority Health has, over the past twelve months, studied the health care problems faced by Black and minority residents in Maryland; this report contains the results of the work of the Commission. The first chapter describes the approach used by the Commission as issues and problems were investigated.

The second section presents an overview of the health status of Maryland's Blacks and minorities and briefly reviews the factors which contribute to the health experience of these populations. The data in this section lay the groundwork for more detailed discussions of major health problems facing Black and minority populations. These problems are addressed in the fifth chapter which is composed of summary reports focusing on cardiovascular disease, AIDS, cancer, maternal and child health, homicide, aging, substance abuse, mental health, medical indigency, and minority health manpower. Each summary report defines the nature of the problem and further details the Commission's findings.

The Commission's findings should not surprise anyone: Blacks and minorities face barriers in obtaining access to health care services, become ill more frequently, and die at younger ages than Whites. The Commission is dismayed at the extent of the disparities in health status between Blacks and minorities and Whites and, further, is concerned with the lack of programs designed to decrease these disparities. The key Commission findings and conclusions are given in the third chapter of this report. The goals and recommendations for improving the health of Blacks and minorities are listed in the fourth chapter and subsquently comprise an "Action Agenda."

While the Commission has formulated goals and recommendations to improve the health status of Maryland's most vulnerable populations, it was the consensus of Commission members that further work is necessary to address the health care problems defined in this report. Due to time, resource, and data constraints, this Commission chose to focus its attention on several key priority areas: infant mortality, Black and minority health manpower development, access to primary health care services, and prevention of cardiovascular disease, cancer and AIDS. A permanent Gubernatorial Commission on Black and Minority Health must be established to continue the work which this Commission has only started.

After reading this report, it should be clear that there is a need to conduct a more rigorous and systematic examination of the programs and services related to the health status of Blacks and minorities than this Commission was able to do. The recommended permanent Commission should be charged to continually monitor Black and minority health trends and problems, and to facilitate the implementation of strategies which reduce racial disparities in health status and alleviate inequities in access to health care services.

**The work of this time-limited Commission is now complete. The recommendations presented do not claim to be the definitive answers to solving Black and minority health problems. However, they are to be viewed as an important initial agenda for addressing priority Black and minority health problems in Maryland.**

The State of Maryland
Executive Department

EXECUTIVE ORDER

01.01.1986.05

Governor's Commission on Black and Minority Health

WHEREAS, The State of Maryland is concerned with enhancing the health of all of the State's citizens;

WHEREAS, Disparities exist in both the health status and utilization of health services between Black, Asian, Hispanic, Native American and other minority citizens and white citizens of Maryland;

WHEREAS, The infant mortality rate for minority citizens of Maryland is 90 percent higher than the infant mortality rate for white citizens;

WHEREAS, The overall age adjusted mortality rate for minority citizens is 40 percent higher than the rate of white citizens;

WHEREAS, Homicide and accidents are the leading causes of death for young black males between the ages of 15-34;

WHEREAS, While the cancer death rate for nonwhite males has been declining, there has been a significant overall increase in the cancer death rate for minority citizens;

WHEREAS, Minority citizens are twice as likely to be uninsured, four times as likely to be poor and twice as likely to be unemployed as white citizens;

WHEREAS, Minorities, particularly poor minority citizens, are less likely to have access to health care resources; and

WHEREAS, There are remaining disparities by race in a number of other key health indicators;

NOW, THEREFORE, I, HARRY HUGHES, GOVERNOR OF THE STATE OF MARYLAND, BY VIRTUE OF THE AUTHORITY VESTED IN ME BY THE CONSTITUTION AND LAWS OF MARYLAND, HEREBY PROCLAIM THE FOLLOWING ORDER EFFECTIVE IMMEDIATELY:

1. The Commission

There is a Governor's Commission on Black and Minority Health.

2. Membership and Procedures

A. The Commission shall consist of up to 30 members appointed by the Governor who are representatives of health providers, human resource, education and legal agencies or organizations as well as representatives of local communities and civic groups. Of the members appointed, the Commission shall include:

(1) One member of the House of Delegates nominated by the Speaker of the House;

(2) One member of the Senate nominated by the President of the Senate; and

(3) A representative of the Governor's Office.

B. The Governor shall select the Chairperson of the Council from among the members appointed to the Council.

C. The Governor may remove any member of the Council for any cause adversely affecting the member's ability or willingness to perform his or her duties.

D. In case of a vacancy, the Governor shall appoint a successor for the remainder of the life of the Commission.

E. A majority of the Council shall constitute a quorum for the transaction of any business. The Council may adopt such other procedures necessary to ensure the orderly transaction of business including the appointment of subcommittees or work groups utilizing the expertise of non Commission members.

F. The members of the Council may not receive any compensation for their services. The members may be reimbursed for their reasonable expenses incurred in the performance of duties, in accordance with the standard travel regulations, and as provided in the State budget.

G. The Department of Health and Mental Hygiene shall provide such staff support necessary for the completion of the Commission's duties and as provided in the State Budget.

3. Scope of the Commission

The Commission shall conduct a thorough examination of the programs and laws relating to the health status of Maryland's minority citizens and in doing so shall:

A. Hold hearings at which persons, organizations, and agencies with an interest in the health status of Maryland's black and other minority citizens may present their views;

B. Conduct meetings, discussions and examinations as necessary to gather information on the laws and services relating to minority health care in Maryland and other states;

C. Identify and examine the limitations and problems associated with existing laws, programs and services related to the health status of Maryland's minority citizens;

D. Examine the financing and access to health services for Maryland's black and minority citizens;

E. Examine the causes and recommend possible measures to address the increase in youth homicide particularly as it relates to young black males; and

F. Identify and review prevention strategies relating to the leading causes of death among minorities including heart disease and stroke, cancer, homicide and accidents, cirrhosis, diabetes and infant mortality, as well as other concerns including teen pregnancy, mental health, chemical dependency, sexually transmitted and communicable disease incidence, lead poisoning, long term care, and access to and utilization of health care resources.

4. Report/Recommendations

The Commission shall provide an interim report by December 1, 1986, and a final report by October 1, 1987.

GIVEN Under My Hand and the Great Seal of the State of Maryland, in the City of Annapolis, this 26th day of March, 1986.

Harry Hughes
Governor

ATTEST:

Lorraine M. Sheehan
Secretary of State

# MARYLAND GOVERNOR'S COMMISSION ON BLACK AND MINORITY HEALTH

## COMMISSION MEMBERS

The Honorable Larry Young, Chairman
Maryland House of Delegates

Edward N. Brandt, Jr., M.D., Ph.D., Vice-Chairman
Chancellor, University of Maryland at Baltimore

Aris T. Allen, M.D.
Medical Affairs Advisor
Health Care Financing Administration

Rudolph Arredondo
President, Community Health
Education and Research Associates

Donald Eugene Brown, Jr., M.D.*
Private Practice

George Foster
Chairperson, Maryland Commission
on Indian Affairs

Sonya Z. Gershowitz
President, Creative Health
Seminars

Robert M. Heyssel, M.D.
President, Johns Hopkins Medical System

Ronald E. Hollie
Private Citizen

The Honorable Paula C. Hollinger*
Maryland State Senate

William L. Jews
President, Liberty Medical Center

Winfield Kelly
Secretary of State

Thomas Krajewski, M.D.
Director, Clinical Programs
Maryland Mental Hygiene Administration

The Honorable Ruth Massinga
Secretary, Maryland Department
of Human Resources

Helen B. McAllister, M.D.
Health Officer, Prince George's
County Health Department

Paula B. McLellan
Executive Director, Maryland Primary
Health Care Association

Maria Pou*
Social Worker, Baltimore County
Department of Social Services

Loretta Richardson, Ph.D.
Dean, School of Nursing
Coppin State College

The Honorable Bishop Robinson
Secretary, Maryland Department of
Public Safety and Correctional
Services

Carl J. Sardegna
President, Blue Cross and
Blue Shield of Maryland

The Honorable Kurt Schmoke*
State's Attorney for Baltimore City

The Honorable Decatur W. Trotter
Maryland State Senate

Andrew Wigglesworth*
Former Executive Assistant to
Governor Harry Hughes

The Honorable Adele Wilzack
Secretary, Maryland Department of
Health and Mental Hygiene

Jose Yosuic., M.D.
Director, Emergency and Community
Medicine, Church Hospital

*Resigned during 1987

# MARYLAND GOVERNOR'S COMMISSION ON BLACK AND MINORITY HEALTH

## COMMISSION AND TASK FORCE STAFF

Karl Aro,* Maryland Department of Legislative Reference

Erica DiBietz, Maryland Department of Health and Mental Hygiene

David Ianucci,* Maryland Department of Legislative Reference

Theressa Johnson, Maryland Health Services Cost Review Commission

Frances May,* Maryland Department of Legislative Reference

Yvette McEachern, Maryland Department of Health and Mental Hygiene, Project Director

Barbara McLean,* Maryland Department of Legislative Reference

Valerie Miller, Maryland Department of Health and Mental Hygiene

Marisa Mirjafary, Maryland Department of Health and Mental Hygiene

Karen Napolitano, Prince George's County Health Department

Kojo Odai, Maryland Department of Health and Mental Hygiene

William Sommerville,* Maryland Department of Legislative Reference

Lynne Taylor,* Maryland Department of Legislative Reference

Linda Walker, Maryland Department of Health and Mental Hygiene

LaVern Ware, Maryland Department of Health and Mental Hygiene

Jeanette Washington, Maryland Department of Health and Mental Hygiene

*Resigned in December, 1986

## ACKNOWLEDGEMENTS

This report could not have been produced without the assistance, contributions, and cooperation of numerous individuals, groups, and organizations.

The Maryland Departments of Health and Mental Hygiene, and Legislative Reference, provided staff support to the Commission and its eight task forces. The Maryland Center for Health Statistics provided statistics and other data to the Commission. The Commission is also most appreciative of the secretarial support provided by Ms. Laura Lambson of the Maryland Department of Health and Mental Hygiene.

Finally, the Commission is deeply indebted to the many task force members, providers and concerned citizens who shared their thoughts and expertise by attending meetings, presenting testimony, and responding to requests for data and information. A listing of these individuals appears in the Appendix.

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# EXECUTIVE SUMMARY

## Introduction

There is a crisis in health care for Black and minority Marylanders. Statistics tell us that far too many Black and minority Marylanders continue to die or suffer needlessly from preventable diseases and conditions. If minority Marylanders had died at the same rate as White Marylanders between 1983 and 1985, on average, approximately 6,000 fewer minority Marylanders would have died. Cardiovascular disease, cancer, homicide, and accidents - all preventable or controllable - were the leading causes of these excess minority deaths.

## Formation of the Maryland Governor's Commission on Black and Minority Health

At the request of Maryland's Legislative Black Caucus, the Maryland Governor's Commission on Black and Minority Health was formed to address increasing concerns about the health of Black and minority populations in Maryland. On the 26th of March, 1986, Governor Harry Hughes signed Executive Order 01.01.1986.05 creating the Commission. Soon after his inauguration in January, 1987, Governor William Donald Schaefer conveyed his support for the Commission by endorsing the Executive Order which created the Commission.

The 27 member Commission was charged with conducting "a thorough examination of the programs and laws relating to the health status of Maryland's minority citizens" as well as identifying and examining limitations and problems associated with existing laws and programs related to the health status of minorities. Additionally, the Commission was directed to examine the causes of, and develop strategies to address the problem of homicide among young Blacks. Finally, the Commission was given broad responsibility to identify and review prevention strategies relating to the leading causes of death among minorities. In the development of this report, the Commission defined the minority population as Asian/Pacific Islanders, Blacks, Hispanics and Native American Indians.

## Process and Methodology

The Commission began its work by assessing the health problems of Maryland's Black and minority populations. A two-pronged approach was employed: public hearings were held across the State and task force groups were established.

The purpose of the public hearings was to receive comments from the general population, health care providers, and others concerned with the unmet health care needs of minority communities. The Commission heard testimony from over fifty individuals and groups.

The public hearings were also used to recruit volunteers to serve on the Commission's task forces. The task forces were chaired by Commission members and included individuals interested in Black and minority health issues.

Eight task forces were established, each with an area of responsibility corresponding to a requirement set out in the Executive Order. The eight task forces were:

- The Task Force on Cardiovascular Disease, Cancer, and Other Leading Causes of Minority Mortality and Morbidity;
- The Task Force on Minority Homicide, Suicide, and Unintentional Injury;
- The Task Force on Minority Substance Abuse;
- The Task Force on Minority Finance, Access, and Indigent Care;
- The Task Force on Minority Aging;
- The Task Force on Minority Mental Health;
- The Task Force on Minority Maternal, Child and Family Health Issues; and
- The Task Force on Minority Health Manpower Development.

The task forces were asked to develop recommendations for consideration by the full Commission for inclusion in the preliminary and final reports. To accomplish this, literature searches and surveys were conducted, public hearings were held, and expert opinions from national, state, and local experts were solicited. An executive committee composed of task force chairpersons directed and coordinated these activities.

The Commission and its task forces found that "a thorough examination of the programs and laws relating to the health status of Maryland's minority citizens", as requested in the executive order establishing the Commission, was impossible given the Commission's inadequate resources. Due to a lack of personnel to staff the task forces and the paucity of routinely collected program data relating to Blacks and minorities, the task forces focused on documenting the disparity in health status between Blacks and minorities and the White population and in beginning to document the difficulties Maryland's minority populations face in obtaining access to health care services. From this work, which included countless hours of discussions and deliberations, the Commission developed goals and recommendations which were condensed into a Commission Action Agenda.

## A SUMMARY OF KEY COMMISSION FINDINGS AND CONCLUSIONS

The following is a summary of the major findings uncovered by the Commission. Based on these findings, the Commission reached several broad conclusions which serve as the basis for the final goals and recommendations.

### KEY COMMISSION FINDINGS

#### Mortality

- If Blacks and other minorities died at the same rate as whites in Maryland, almost 2,000 fewer minority deaths would occur each year. Cardiovascular disease, cancer, homicide, accidents, and infant mortality account for three-quarters of these excess deaths.
- Age-adjusted death rates are higher among minorities/Blacks than Whites for ten of the twelve leading causes of death.
- On average, a minority baby born in Maryland in 1980 will live four years less than a White baby.

#### Cardiovascular Disease (Heart Disease and Stroke)

- Cardiovascular disease (CVD) is the leading cause of death for all minority Marylanders and one of the leading causes of premature mortality for Black males in Maryland.
- Hypertension, a leading controllable cause of heart disease and stroke, frequently goes unchecked and uncontrolled in Black males. This is partially due to a lack of access to health services.
- There are too few culturally sensitive and community based risk reduction programs (e.g. smoking cessation, dietary improvements) which can help to prevent or control CVD risk factors in high risk Black communities.

#### Cancer

- Blacks have the highest cancer incidence and mortality rates of all racial groups in the U.S. and Maryland.
- Blacks tend to be less knowledgeable than Whites about cancer's warning signals and are less likely to see a physician when they experience symptoms.
- Inadequate access to timely screening, diagnostic, and treatment resources contributes to higher rates of cancer deaths for Blacks.

### Acquired Immune Deficiency Syndrome (AIDS)

- Blacks represent 23% of Maryland's population, but comprise over 50% of the reported AIDS cases. Ninety percent of individuals suspected to have contracted AIDS due to intravenous drug abuse are Black.
- Education and outreach are currently the most effective weapons against AIDS, and there are few of these efforts underway in Black and Hispanic communities.

### Diabetes

- Black females have the highest death rate for diabetes of all race/sex groups.
- Community based education, screening, outreach, diagnostic, and treatment programs for diabetics rarely reach high risk minorities living in medically underserved areas.

### Infant Mortality and Low Birthweight

- Maryland's Black infant mortality rate is almost twice as high as the White rate.
- Maryland's Black infant mortality rate has been showing some disturbing trends. Between 1984 and 1985, the Black infant mortality rate increased by 16% to 19.2, while the White rate remained stable at 9.0. In 1986, the Black rate decreased to 17.3, while the White rate increased slightly to 9.4.
- Black babies are twice as likely as White babies to be born at low birthweights. Low birthweight babies, as compared to heavier babies, are 40 times more likely to die in the first month and 20 times more likely to die in the first year of life.
- Although prenatal care has been documented to improve birth outcomes, Black expectant mothers are three times more likely than White expectant mothers to receive late or no prenatal care.

### Child, Adolescent and Family Health

- One-half of Black children in Maryland are poor as compared to one in four White children.
- In 1980, slightly more than one-half (55%) of Black children lived in married couple families.
- Black and minority children are found disproportionately in groups at increased risk of becoming substance abusers, adolescent parents, poor learners, school failures, and juvenile delinquents.
- One-half of adolescent births are to Black females. There are inadequate numbers of successful targeted strategies which reduce adolescent pregnancies.
- There are insufficient early identification and intervention programs which help high and at risk children and adolescents. Primary care services for non-Medicaid eligible low-income children are sorely lacking in many jurisdictions.

### Homicide

- According to the U.S. Department of Justice, Black males have a 1 in 21 lifetime chance of becoming a homicide victim, while the chance for White males is 1 in 131. For Black and White females, the odds are 1 in 104, and 1 in 369, respectively.
- In 1985, the death rate from homicide for minority males was almost 8 times the White male rate at 39.7 and 4.9 deaths per 100,000 population, respectively.
- There is no public health policy concerning homicide in Maryland.

### Substance Abuse (Alcohol and Drug Abuse)

- The prevalence of alcohol and drug abuse by race/ethnicity is unknown in Maryland.
- Morbidity and mortality data suggest that minorities in Maryland suffer disproportionately from the negative consequences of substance abuse.
- There are barriers to receiving and completing substance abuse treatment for minorities, and substance abuse prevention programs are limited.

### Mental Health

- Data and research on the mental health problems and needs of Blacks and minorities are extremely limited.
- Mental health services for children under the age of 12 are virtually nonexistent.

### Minority Health Manpower

- Blacks, Hispanics, and Native Americans are underrepresented in most health and allied health professions when compared to their percentage in the total population. For example, Blacks compose 23% of Maryland's total population, but account for less than 7% of the State's physicians, dentists, and registered nurses.
- Blacks and minorities are underrepresented in upper level health policy and managerial positions in major health-related facilities and organizations, such as boards, commissions, hospitals, academic health centers, HMO's, nursing homes, and public health departments. For example, there is only one Black Chief Executive Officer of a hospital in Maryland and 16 of Maryland's 52 acute hospitals, including five in Baltimore City, have no Black representation on their boards of directors.
- Studies have consistently shown that Black practitioners are more likely than White practitioners to practice in minority and underserved areas.

## Access to Health Care

- Several Maryland reports have documented differences in access to care by race (2,3,4).
- Blacks as compared to Whites are:
  - Three to four times more likely to live in federally designated medically underserved or health manpower shortage areas;
  - Three times less likely to have a coronary artery bypass surgery;
  - Twice as likely to be uninsured;
  - More likely to receive primary care in public clinics and emergency rooms where care is less comprehensive, continuous and preventive in nature;
  - Less likely to receive nursing home care; and
  - Less likely to receive dental care.

## The Black and Minority Elderly

- Blacks are less likely than Whites to reach old age. Eleven percent of Whites and six percent of minorities were over the age of 65 in 1980.
- The Black elderly (29%) were three times as likely as the White elderly (10%) to be poor in 1980.

## Data and Research

- Data and health information for Hispanics, Native Americans, and Asian/Pacific Islanders are particularly sparse.
- Hispanics are not identified on the State's birth and death certificates.
- Estimates of the size of Maryland's Black, Native American, Hispanic, and Asian populations are only available through the decennial U.S. Census.

## KEY COMMISSION CONCLUSIONS

Maryland data show that the health of Marylanders of all races has improved dramatically over the past five decades. The Commission finds that far too many Black and minority Marylanders continue to die and suffer, however, needlessly from preventable diseases and conditions. While Maryland has one of the nation's best health care delivery systems, major improvements are needed if the health status of Black and minority populations is to change. On the basis of these findings, the Commission concludes the following:

1. Education about healthy behaviors, health insurance coverage, and improving access to comprehensive and continuous preventive and primary care services are keys to improving Black and minority health.

2. Intense, well targeted, community based, and culturally appropriate outreach and education programs are often necessary to reach and educate low-income Blacks and minorities and enhance their access to health services. More minority outreach and education programs are required immediately.

3. It is essential that the leadership (e.g., ministers, elected officials, health professionals, community leaders) in Black and minority communities be involved in promoting healthy lifestyles and behaviors in their communities.

4. The adequate representation of Blacks and minorities in the health professions and in key health policy positions is an essential component of improving Black and minority health. Increasing the number of Black and minority health professionals will require immediate targeted State and local interventions.

5. Blacks and minority participation should be sought in the development, implementation and evaluation of programs and services in their communities.

6. The State must ensure that localities have the necessary flexibility and resources to design health care programs which are tailored to address their unique and individual health care needs.

7. Geographic and economic barriers, including lack of access to health insurance coverage, must be eliminated if Black and minority health is to improve substantially.

8. Incentives are needed to promote efficiency and effectiveness in the organization, financing, and delivery of health care services.

9. The development of viable solutions to Black and minority health problems will require public-private partnerships.

## A SUMMARY OF COMMISSION GOALS AND PRIORITY RECOMMENDATIONS

Goal 1: **To triple Black and minority representation in the health professions and in key health policy positions before the year 2000.**

Priority Recommendation:

1.1 Establish a statewide Extra-Curricular Health Professions Career Exploration Program targeted to elementary, middle, and high schools with significant numbers of Black and minority students.

Goal 2: **To improve the health of Maryland's Black and minority infants, children, adolescents, and families.**

Priority Recommendations:

2.1 Appoint a Maryland Advisory Council on Infant Mortality.

2.13 Direct the Departments of Health and Mental Hygiene, Human Resources, and Education, and the Office of Children and Youth to develop and coordinate a continuum of early identification and intervention programs, and strategies to prevent the development of chronic health, psycho-social, learning and behavioral problems in high and at-risk children and adolescents.

Goal 3: **To improve access to a range of health services and programs for medically indigent (i.e., the low-income uninsured and Medicaid recipients) Blacks and minorities.**

Priority Recommendation:

3.1 Develop and implement demonstration projects which increase access to primary health care services for medically indigent Blacks and minorities.

Goal 4: **To prevent excess Black and minority morbidity and mortality.**

Priority Recommendation:

4.3 Maintain and expand existing community based risk reduction programs using churches, neighborhood groups, and other primary social support networks.

Goal 5: To prevent Black and minority deaths and disability due to homicide, suicide and unintentional injuries.

Goal 6: To prevent and treat Black and minority substance abuse.

Goal 7: To improve the mental health of Black and minority Marylanders.

Goal 8: To improve access to community based long term care and mental health services for the Black and minority elderly.

Goal 9: To facilitate the implementation of innovative and culturally appropriate community based Black and minority health strategies, and to monitor progress in improving Black and minority health.

Priority Recommendation:

9.1 Establish a Maryland Governor's Commission on Black and Minority Health.

# I. THE WORK OF THE COMMISSION

## Background

If the 50 states were to be compared and ranked according to the caliber of health care available, Maryland would surely be in the top five. Maryland is also one of the wealthiest states in this nation; ranking seventh in per capita income in 1984. Despite a relatively high standard of living and of health care, statistics indicate that there are serious and dangerous disparities between the level of health and well-being enjoyed by White citizens and that of Black and minority citizens in Maryland. Problems that afflict society as a whole -- AIDS, cardiovascular disease, cancer, infant mortality, adolescent pregnancy, lead poisoning, violence -- afflict Blacks and minorities in disproportionately large numbers. Studies also show that Blacks and minorities have less access than Whites to available health care resources (1,2,3,4).

At the request of Maryland's Legislative Black Caucus, the Maryland Governor's Commission on Black and Minority Health was formed to address increasing concerns about the health of Black and minority populations in Maryland. On the 26th of March, 1986, Governor Harry Hughes signed Executive Order 01.01.1986.05 creating the Commission. Soon after his inauguration in January, 1987, Governor William Donald Schaefer conveyed his support for the Commission by endorsing the Executive Order which created the Commission.

## Governor's Charge to the Commission

The Executive Order which established the Commission outlined several significant disparities in the health status and use of health services that exist between Black and minority citizens and the majority population:

- The overall age-adjusted mortality rate for minority citizens is 40 percent higher than the rate for White citizens;
- The mortality rate for minority infants in Maryland is almost twice as high as the rate for White infants;
- Homicide and accidents are the leading causes of death for young Black males between the ages of 15 and 34; and
- Minorities, as compared to Whites, are twice as likely to be uninsured or unemployed and three times as likely to be poor.

The 27 member Commission was charged with conducting "a thorough examination of the programs and laws relating to the health status of Maryland's minority citizens" as well as identifying and examining limitations and problems associated with existing laws and programs related to the health status of minorities. Additionally, the Commission was directed to examine the causes of, and develop strategies to address the problem of homicide among young Blacks. Finally, the Commission was given broad responsibility to identify and review prevention strategies relating to the leading causes of death among minorities. In the development of this report, the Commission defined the minority population as Asian/Pacific Islanders, Blacks, Hispanics and Native American Indians.

## The Commission's Response

The Commission began its work by assessing the health problems of Maryland's Black and minority populations. A two-pronged approach was employed: public hearings were held across the State and task force groups were established.

The purpose of the public hearings was to receive comments from the general population, health care providers, and others concerned with the unmet health care needs of minority communities. The Commission heard testimony from over fifty individuals and groups.

The public hearings were also used to recruit volunteers to serve on the Commission's task forces. The task forces were chaired by Commission members and included individuals interested in Black and minority health issues.

Eight task forces were established, each with an area of responsibility corresponding to a requirement set out in the Executive Order. The eight task forces were:

- The Task Force on Cardiovascular Disease, Cancer, and Other Leading Causes of Minority Mortality and Morbidity;
- The Task Force on Minority Homicide, Suicide, and Unintentional Injury;
- The Task Force on Minority Substance Abuse;
- The Task Force on Minority Finance, Access, and Indigent Care;
- The Task Force on Minority Aging;
- The Task Force on Minority Mental Health;
- The Task Force on Minority Maternal, Child and Family Health Issues; and
- The Task Force on Minority Health Manpower Development.

The task forces were asked to develop recommendations for consideration by the full Commission for inclusion in the preliminary and final reports. To accomplish this, literature searches and surveys were conducted, public hearings were held, and expert opinions from national, state, and local experts were solicited. An executive committee composed of task force chairpersons directed and coordinated these activities.

The Commission and its task forces found that "a thorough examination of the programs and laws relating to the health status of Maryland's minority citizens", as requested in the executive order establishing the Commission, was impossible given the Commission's inadequate resources. Due to a lack of personnel to staff the task forces and the paucity of routinely collected program data relating to Blacks and minorities, the task forces focused on documenting the disparity in health status between Blacks and minorities and the White population and in beginning to document the difficulties Maryland's minority populations face in obtaining access to health care services. From this work, which included countless hours of discussions and deliberations, the Commission developed goals and recommendations which are given in the subsequent chapters of this report. These recommendations were further condensed into the Commission's Action Agenda.

## II. OVERVIEW OF BLACK AND MINORITY HEALTH ISSUES AND PROBLEMS

### WHO ARE MARYLAND'S MINORITIES?

An estimated 4.3 million persons currently live in Maryland. One in four Marylanders is a member of one of the following racial/ethnic minority groups: Asian/Pacific Islander, Black, Native American Indian, or Hispanic (Figure 1). The majority (91%) of Maryland's racial/ethnic minorities are Black. According to the 1980 U.S. Census, Maryland's minority population is increasing. Between 1970 and 1980, Maryland's minority population increased by 45%, rising from 0.7 to 1.1 million. During this same time period, there was a 1% decrease in the White population.

The geographic distribution of minorities in Maryland varies by racial/ethnic grouping (Table 1). As a whole, most minorities (90%) reside in either the Baltimore or Washington, D.C. metropolitan areas.

**TABLE 1**

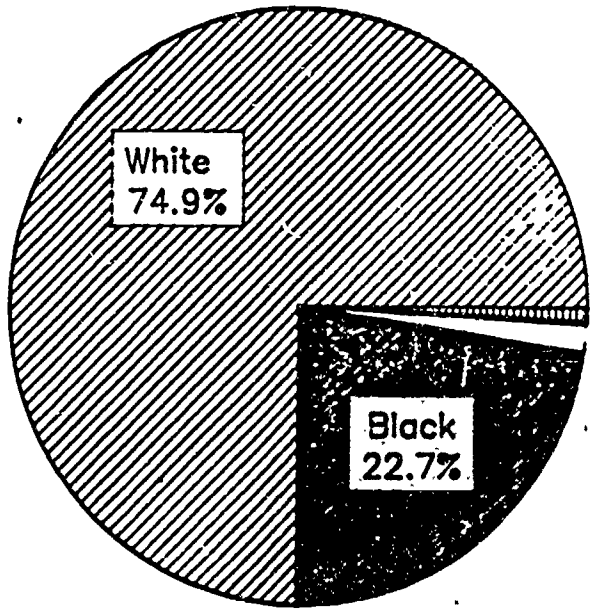
**PERCENT DISTRIBUTION OF MARYLAND'S MINORITY POPULATIONS, BY REGION, 1980**

| Region | Total | Race/Ethnicity | | | | |
|---|---|---|---|---|---|---|
| | | Asian | Black | Native American | White | Hispanic |
| Total | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Central Md. | 51.6 | 33.7 | 58.1 | 51.6 | 50.1 | 33.1 |
| • Baltimore City | 18.7 | 7.7 | 45.0 | 26.3 | 10.9 | 11.7 |
| D.C. Suburbs | 29.5 | 61.1 | 31.2 | 33.2 | 28.1 | 57.5 |
| Eastern Shore | 7.0 | 1.4 | 6.1 | 3.8 | 7.5 | 3.3 |
| Southern Md. | 4.0 | 1.9 | 3.3 | 8.2 | 4.2 | 3.1 |
| Western Md. | 7.9 | 1.9 | 1.3 | 3.2 | 10.1 | 3.0 |

Source: 1980 U.S. Census

## FIGURE 1

## MARYLAND'S POPULATION BY RACE/ETHNICITY, 1980




Native Am. (0.2%)
Asian (1.5%)

### Distribution of Maryland's Population by Race/Ethnicity

| Race | Number | Percent |
|---|---|---|
| • Total | 4,216,975 | 100.0% |
| • White | 3,158,838 | 74.9 |
| • Racial Minorities | 1,058,137 | 25.1 |
| - Black | 958,150 | 22.7 |
| - Asian/Pac. Islander | 64,278 | 1.5 |
| • Korean | 15,089 | 0.4 |
| • Chinese | 14,485 | 0.3 |
| • Asian Indian | 13,705 | 0.3 |
| • Filipino | 10,965 | 0.3 |
| • Japanese | 4,805 | 0.1 |
| • Vietnamese | 4,131 | 0.1 |
| • Hawaiian | 616 | 0.0* |
| • Guamaniam | 400 | 0.0* |
| • Somoan | 82 | 0.0* |
| - Native American | 7,823 | 0.2 |
| - Alaskan Native | 198 | 0.0* |

| • Ethnicity | Number | Perce |
|---|---|---|
| Individuals of Hispanic Descent | 67,746 | 1.6 |
| - Mexican | 12,339 | 0.3 |
| - Puerto Rican | 9,014 | 0.2 |
| - Cuban | 5,315 | 0.2 |
| - Other | 38,078 | 0.9 |

*Less than 1/10 of 1 percent

Source: 1980 U.S. Census

On average, minorities in Maryland are younger than non-minorities. In 1980, the median age for Blacks was 26 as compared to 32 for Whites. Whites (11%) are more likely than Blacks (6%), Native Americans (4%), Asians (3.5%), or Hispanics (4%) to be elderly (i.e., over the age of 65).

Minorities, particularly Blacks, fare far worse than Whites on a number of socio-economic indicators which are related to health status and access to health care. These include employment, health insurance, economic, and educational status. For example:

- Blacks and Native Americans are three times more likely than Whites to be poor. In addition, minorities are twice as likely as Whites to be unemployed.
- Blacks are disproportionately found in the State's poor population representing 50% in 1979. Two-thirds of poor Blacks reside in Baltimore City.
- According to the 1980 U.S. Census, Asians (11%) and Whites (10%) over the age of 25 were more than twice as likely as Blacks (4%) and Native Americans (3%) to have completed college.

## DEFINING AND MEASURING BLACK AND MINORITY HEALTH STATUS

Health and health status are difficult concepts to define and measure. The most commonly accepted definition of health is provided by the World Health Organization (WHO). According to WHO, health is defined as "... a state of complete physical, mental, and social well being and not merely the absence of disease." The Commission chose to use this definition as well.

Several recent federal and Maryland reports have documented racial disparities in health. In 1985, the report of the federal Task Force on Black and Minority Health documented higher morbidity and mortality rates for Blacks and other minorities as compared to Whites and focused national attention on this issue. Similarly, between 1984 and 1985, several Maryland reports and analyses examined differences in the health status of Marylanders by race. In 1984, the Center for Health Statistics, within the Maryland Department of Health and Mental Hygiene, published the first edition of Health, Maryland, an annual series on the health status of Marylanders (5). The 1984 report showed that tremendous improvements in the health of Maryland's population have occurred since 1940, as evidenced by declining infant mortality and death rates from several communicable diseases. However, the report also highlighted racial differentials in health status and access to health resources. Similarly, several recent legislative reports prepared by the Maryland Medical Assistance Program have documented racial differentials in payment and utilization levels within Maryland's Medicaid program (3,4).

The Commission used several statistical methods to further substantiate differences in the health status of Marylanders by race. These methods included a review of the leading causes of death by race, an examination of the major causes of excess minority deaths, a determination of the relative risk of death by cause and an examination of the leading causes of premature mortality. Where available, special population surveys and morbidity statistics were also examined.

## LEADING CAUSES OF BLACK AND MINORITY MORTALITY AND MORBIDITY

The average life expectancy of minorities is shorter than for Whites. Among males, minorities have an average life expectancy of 66, as compared to 71 for Whites. For minority women, the average life expectancy is 74, while the average for White women is 78 (National Center for Health Statistics).

Table 2 defines the leading causes of death by race in Maryland for 1986. Hispanics are excluded because the current Maryland death certificate does not contain an ethnic group identifier. Cardiovascular disease, cancer, and accidents were the leading causes of death for both Whites and minorities.

As Table 3 shows, minority Marylanders often die from certain causes of death at rates which are significantly higher than those for Whites. In 1985, the age adjusted death rates for ten of the twelve leading causes of death were higher for minorities than Whites. The cause of death with the largest mortality disparity between minorities and Whites was homicide. In 1985, minority males were eight times more likely than White males to be homicide victims (Table 3).

Table 4 presents selected causes of excess mortality for Maryland's minority population for the years 1983-85. Excess deaths expresses "the difference between the number of deaths actually observed in a minority group and the number of deaths that would have occurred in that group if it experienced the same death rates for each age and sex as the White population (1)." **Between 1983 and 1985, if minorities had died at the same rate as Whites in Maryland, almost 2000 fewer minority deaths would have occurred (Table 4).** Cardiovascular disease, cancer, homicide, accidents, diabetes, cirrhosis, and perinatal conditions (i.e., infant mortality) were leading causes of excess minority deaths.

Cardiovascular disease and homicide were the leading causes of premature mortality as measured by years of potential life lost for Black males (Table 5). Cancer and cardiovascular disease were the leading causes of premature mortality for both Black and White females (Table 5).

Cardiovascular disease (CVD) - heart disease, hypertension and stroke - result in more death and disability than any other acute or chronic disease in Maryland. Cardiovascular disease is the leading cause of death for all major race and sex groups, a leading cause of premature mortality among Black males between the ages of 1 and 65, and accounts for roughly 27% of excess minority deaths in Maryland. Major or preventable risk factors include hypertension, cigarette smoking, and elevated blood cholesterol levels.

Cancer is the second leading cause of death in Maryland, accounting for 9,000 deaths in 1986. For both the U.S. and Maryland, Blacks have the highest age-adjusted cancer incidence and mortality rates of any racial group. If minorities had died from cancer at the same rate as Whites, on average, between 1983 and 1985, almost 400 fewer minority Marylanders would have died. Major cancer risk factors include cigarette smoking and diet. Alcohol consumption is implicated in the high rate of esophageal cancer among Black males (1).

TABLE 2

LEADING CAUSES OF DEATH IN MARYLAND, BY RACE, 1986
(Numbers in Parentheses Refer to Number of Deaths)

| Rank | Total | Race | | | |
|---|---|---|---|---|---|
| | | American Indian | Asian | Black | White |
| 1 | Cardiovas. Disease (15,457) | Cardiovas. Disease (2) | Cardiovas. Disease (66) | Cardiovas. Disease (2,977) | Cardiovas. Disease (12,412) |
| 2 | Cancer (9,001) | Cirrhosis (2) | Cancer (60) | Cancer (1,932) | Cancer (7,009) |
| 3 | Accidents (1,521) | Perinatal Conditions (2) | Accidents (15 | Accidents (379) | Accidents (1,126) |
| 4 | COPD (1,200) | Homicide (2) | Flu/Pneu. (7) | Homicide (295) | COPD (1,046) |
| 5 | Flu/Pneu. (1,060) | | Cirrhosis/ Liver Disease (6) | Perinatal Conditions (225) | Flu/Pneu. (867) |
| 6 | Diabetes (692) | | Homicide (6) | Diabetes (204) | Diabetes (485) |
| 7 | Septicaemia (590) | | Suicide (6) | Flu/Pneu. (185) | Suicide (458) |
| 8 | Suicide (543) | | | Nephrosis (174) | Septicaemia (439) |
| 9 | Nephrosis (477) | | | COPD (152) | Nephrosis (299) |
| 10 | Perinatal Conditions (447) | | | Septicaemia (148) | Cirrhosis/ Liver Disease (262) |
| 11 | Homicide (422) | | | Cirrhosis/ Liver Disease (118) | Perinatal Conditions (214) |
| 12 | Cirrhosis/ Liver Disease (388) | | | Suicide (78) | Homicide (119) |

COPD - Chronic Obstructive Pulmonary Dis.; Cardiovascular Dis. - Heart Dis. and Stroke
Source: Personal Communication, Maryland Center for Health Statistics, 1987.

## TABLE 3

### FATAL INEQUALITIES: AGE-ADJUSTED DEATH RATES BY RACE, SEX, AND SELECTED CAUSES, MARYLAND, 1985

(RATE PER 100,000 POPULATION)

| | Minority Male | White Male | Relative[1] Risk | Minority Female | White Female | Relative[1] Risk |
|---|---|---|---|---|---|---|
| Total Deaths (All Causes) | 996.7 | 704.8 | 1.4 | 569.1 | 407.4 | 1.4 |
| • Heart Disease | 287.1 | 259.8 | 1.1 | 166.9 | 110.3 | 1.5 |
| • Stroke | 51.6 | 31.5 | 1.6 | 39.9 | 38.4 | 1.0 |
| • Cancer | 266.4 | 170.3 | 1.6 | 144.5 | 119.6 | 1.2 |
| • Homicide | 37.7 | 4.8 | 7.9 | 9.3 | 2.0 | 4.6 |
| • Accidents | 49.2 | 44.8 | 1.1 | 18.2 | 18.1 | 1.0 |
| • Cirrhosis/Liver Disease | 18.8 | 15.5 | 1.2 | 7.8 | 6.3 | 1.2 |
| • Diabetes | 15.3 | 9.9 | 1.5 | 18.7 | 9.0 | 2.0 |
| • Suicide | 12.0 | 18.4 | 0.6 | 1.9 | 6.3 | 0.3 |

[1]Relative Risk is the ratio of the minority death rate to the White rate.

Source: Personal Communication, Maryland Center for Health Statistics, 1987.

TABLE 4

EXCESS MINORITY DEATHS IN MARYLAND BY MAJOR CAUSES OF MORTALITY AND SEX, 1983-1985 AVERAGE

| Sex and Cause of Death | Excess Deaths | |
|---|---|---|
| | Number | Percent |
| Total | 1,978 | 100.0% |
| Cardiovascular Disease | 536 | 27.1 |
| Cancer | 391 | 19.8 |
| Homicide and Accidents | 255 | 13.0 |
| Perinatal Conditions | 168 | 8.5 |
| Diabetes | 60 | 3.0 |
| Cirrhosis | 57 | 2.9 |
| Other Causes | 510 | 25.7 |
| Minority Males | 1,203 | 100.0 |
| Cancer | 276 | 23.0 |
| Heart Disease and Stroke | 255 | 21.1 |
| Homicide and Accidents | 205 | 17.2 |
| Perinatal Conditions | 86 | 7.1 |
| Cirrhosis | 32 | 2.7 |
| Diabetes | 24 | 2.0 |
| Other Causes | 324 | 26.9 |
| Minority Females | 775 | 100.0 |
| Cardiovascular Disease | 281 | 36.4 |
| Cancer | 115 | 14.8 |
| Perinatal Conditions | 82 | 10.5 |
| Homicide and Accidents | 50 | 6.5 |
| Diabetes | 36 | 4.7 |
| Cirrhosis | 25 | 3.3 |
| Other Causes | 185 | 23.8 |

Source: Personal Communication, Maryland Center for Health Statistics, 1987.

TABLE 5

PERCENTAGE DISTRIBUTION OF MAJOR CAUSES OF PREMATURE MORTALITY IN MARYLAND, BY RACE AND SEX, 1986

| Rank | Total | Black Males | White Males | Black Females | White Females |
|---|---|---|---|---|---|
| 1 | Cancer (21%) | CVD (19%) | CVD (43%) | Cancer (25%) | Cancer (34%) |
| 2 | CVD (20%) | Homcide (19%) | Cancer (37%) | CVD (21%) | CVD (19%) |
| 3 | Accidents (18%) | Accidents (16%) | Accidents (24%) | Accidents (10%) | Accidents (16%) |
| 4 | Homicide (7%) | Cancer (12%) | Suicide (23%) | Homicide (8%) | Suicide (5%) |
| 5 | Suicide (7%) | Suicide (4%) | Homicide (5%) | Suicide (2%) | Homicide (3%) |

CVD - Heart disease and stroke
*Premature mortality as measured by years of potential life lost for ages 1-64. Percentages are based on the total years of life lost for each race/sex group.

Source: Personal Communication, Maryland Center for Health Statistics, 1987.

The report of the federal Task Force on Black and Minority Health suggests that the cancer burden among minorities, especially those in lower socio-economic groups, may be due to inadequate education about cancer and lack of access to effective cancer screening, diagnostic, and treatment services. Once diagnosed, the five year cancer survival rates are lower for Black Americans (38%) than for White Americans (50%) (1).

In 1986, diabetes was the sixth leading cause of death for all Marylanders and the seventh leading cause among Black Marylanders. Minority females have the highest age-adjusted death rate from diabetes of all race/sex groups in Maryland. In 1985, minority females died from diabetes at twice the rate of White females. Obesity is a major risk factor, with minority women significantly more likely than White women to be overweight (1). Although there is no known cure for diabetes, it can be successfully prevented or controlled using "good" dietary practices and medication.

Homicide has reached epidemic proportions in America. According to the Federal Bureau of Investigation, 1 American kills another every 28 minutes. In 1986, homicide was the twelfth leading cause of death for all Marylanders, the fourth leading cause of death for Blacks and the leading cause of death for Black males under the age of 45. The federal Task Force on Black and Minority Health noted that "no cause of death so differentiates Black Americans from other Americans as homicide." In 1985, the death rate for homicide among minority males was 8 times the White rate, at 37.7 and 4.8 deaths per 100,000 population, respectively. Substance abuse and handgun availability are major risk factors for homicide.

According to the U.S. Department of Justice, Black males in the U.S. have a 1 in 21 lifetime chance of becoming a homicide victim. In contrast, the chance for White males is 1 in 131. The comparable chances for Black females and White females are 1 in 104 and 1 in 369, respectively. Most homicides involve relatives and acquaintances of the victim and most are committed against persons of the same race as the offender (1). Approximately 60% of all homicides involve firearms (1).

Black infants in Maryland die at almost twice the rate of White infants (Table 6). If minority infants had died at the same rate as White infants in Maryland in 1985, almost 200 minority babies would still be alive. Many of the risk factors associated with infant mortality - low birthweight, adolescent pregnancy, limited access to prenatal care, poverty, and limited education - occur disproportionately in Black and minority populations.

Black babies are also twice as likely as White babies to be born at low birth weights (i.e., under 5.5 pounds). Low birth weight babies are twenty times more likely to die in the first year of life. In addition, they are more likely than normal weight infants to develop neurodevelopmental, mental, and physical problems.

TABLE 6

INFANT MORTALITY BY RACE IN MARYLAND, 1983-86

| Year | Total | Race | | | |
|---|---|---|---|---|---|
| | | Asian | Black | Native American | White |
| 1986 | 11.7 | N.A. | 17.3 | N.A. | 9.4 |
| 1985 | 11.9 | 5.0 | 19.2 | 6.6 | 9.0 |
| 1984 | 11.4 | 3.1 | 16.6 | 8.2 | 9.0 |
| 1983 | 11.7 | 5.7 | 18.5 | 0.0 | 8.9 |

N.A. - Not available
Source: Personal Communication, Maryland Center for Health Statistics, 1987

Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) infection have generated enormous concern among the general population. The burden of this dreaded disease and its consequences are even more devastating, however, in the minority community. The reported incidence of AIDS is disproportionately higher among Blacks and Hispanics, both nationally and in Maryland. Since 1981, there have been approximately 700 reported cases of AIDS in Maryland. Blacks and Hispanics represent about 25% of Maryland's population, but account for over one-half of reported AIDS cases. Transmission of HIV through the sharing of intravenous (IV) drug abuse paraphernalia is one of the major modes of infection in the minority population. Over 90% of persons who reportedly have contracted AIDS through IV drug abuse are Black. It is estimated that in 4 years, 3,700 Marylanders will have AIDS, 37,000 will have AIDS Related Complex (ARC), and another 170,000 will be infected with HIV.

Substance abuse and mental health problems are also major causes of Black and minority morbidity and mortality. However, the prevalence of substance abuse and mental health problems in Maryland by race is unknown. State and national mortality and morbidity indicators suggest that substance abuse takes a greater toll on the health of minorities than Whites. Alcohol abuse is a major risk factor for cirrhosis, cancer, unintentional injuries, and homicide. In 1985, cirrhosis death rates were significantly higher for minorities than non-minorities. Nationally, Black American men between the ages of 35 and 44 are 10 times more likely than White men to die from espohageal cancer, which is linked to alcohol consumption (1). Nationally, one-half of all accidental deaths and homicides are alcohol-related (1).

Minimal data and research exist on the mental health problems and needs of Blacks and minorities in Maryland. Admissions to the State's psychiatric facilities currently serve as the major source of data. These data show that minorities are admitted to public inpatient mental health facilities at twice the rate of Whites. Conversely, Whites are more likely to be admitted to private institutions. Minority Marylanders are less likely to use outpatient mental health services in comparison to Whites. Several national studies confirm that Blacks are more likely than Whites to be misdiagnosed which may help to explain the greater inpatient utilization rate. Additional data and research are required to allow adequate determination of the mental health problems, and needs of minority Marylanders.

## Factors Contributing to Identified Racial Health Disparities

Exhibit 1 summarizes several major racial health disparities in Maryland. Exhibit 2 provides a summary of the factors which are thought to contribute to the observed disparities in health by race. However, as pointed out by the DHHS Task Force on Black and Minority Health "the factors responsible for the health disparity are complex and defy simplistic solutions. Health status is influenced by the interaction of physiological, cultural, psychological and societal factors that are poorly understood for the general population and even less so for minorities (1)." A multitude of factors such as lifestyle habits, socio-economic status, and access to and use of health services, either alone or in concert, are thought to partially explain Black and minority health status.

### Lifestyle/Health Risk Factors

There are several known risk factors which, if eliminated or reduced, could significantly reduce morbidity and mortality in both minority and majority communities (Exhibit 3). The most important of these factors are cigarette smoking, substance abuse, and poor nutrition. Table 7 details the prevalence of selected risk factors for Blacks and Whites in Maryland.

Cigarette smoking is the chief preventable cause of death in the U.S. It is associated with cancer, cardiovascular disease, low birth weight, bronchitis, and emphysema. Reportedly, 30% of all cancer deaths and 90% of all lung cancer deaths in America are linked to cigarette smoking.

The 1982 Maryland Household Survey indicated that the prevalence of smoking is greater among Blacks than Whites. In Maryland, 47 percent of Black males smoke as compared to 33% of White males, while 38 percent of Black females smoke as compared to 31% of White females.

## EXHIBIT 1

## A SUMMARY OF MAJOR RACIAL HEALTH-RELATED DISPARITIES IN MARYLAND

### COMPARED TO WHITES, MINORITIES/BLACKS IN MARYLAND ARE

twice as likely to:

- die in the first year of life
- be born underweight
- be born prematurely
- be unemployed
- be uninsured
- be institutionalized in a State operated mental institution
- die of cirrhosis/live disease or diabetes (females)

three times more likely to:

- receive late or no prenatal care
- die of AIDS
- be poor
- be placed in an educable mentally retarded class*
- die of known child abuse*
- live in federally designated medically underserved or health manpower shortage areas

four times more likely to:

- be Medicaid recipients

seven times more likely to:

- live in poor female headed households (children under 18)

eight times more likely to:

- die as a result of homicide (males)
- be incarcerated in one of the State's penal institutions

ten times more likely to:

- reportedly contract syphilis or gonorrhea

### COMPARED TO WHITES, MINORITIES/BLACKS IN MARYLAND ARE MORE LIKELY TO:

- die of cardiovascular disease or cancer
- smoke
- be overweight
- not complete high school, college or professional school
- suffer from lead poisoning (children)
- live in low income urban or rural areas characterized by poor housing, high unemployment, high crime, inferior schools, and accessibly limited health care resources.
- DIE OR SUFFER NEEDLESSLY FROM PREVENTABLE DISEASES AND CONDITIONS

*Based on national data.

## EXHIBIT 2

## FACTORS CONTRIBUTING TO IDENTIFIED RACIAL HEALTH DISPARITIES

* SOCIO-ECONOMIC STATUS: POVERTY, UNEMPLOYMENT, AND RELATED SOCIAL CONDITIONS
  - Minorities are three times more likely to be poor than Whites
  - Minorities are also twice as likely to be unemployed
* INADEQUATE ACCESS TO AND UTILIZATION OF HEALTH CARE RESOURCES
  - Lack of health insurance coverage and inadequacies in coverage
    - Minorities are four times more likely to be Medicaid recipients than Whites
    - Blacks are twice as likely as Whites to be uninsured
  - Inadequate prenatal care
    - Minorities are three times more likely to receive late or no prenatal care
  - Lack of access to primary care and other resources, particularly in areas with high concentrations of poor minorities.
* CULTURAL INSENSITIVITY AND RACIAL DISCRIMINATION
* ENVIRONMENTAL AND OCCUPATIONAL EXPOSURES
* LIFESTYLE/HEALTH RISK FACTORS
  - Smoking
  - Diet and obesity
  - Alcohol and drug abuse
* UNDERREPRESENTATION OF MINORITIES IN THE HEALTH PROFESSIONS
* STRESS AND COPING PATTERNS
* HEREDITARY/GENETIC FACTORS

## EXHIBIT 3

## MAJOR CAUSES OF DEATH IN MARYLAND AND RELATED RISK FACTORS, 1985

| Major Cause of Death | Percent of Deaths, 1985 | | Risk Factor |
|---|---|---|---|
| | Total | Blacks | |
| • Cardiovascular Disease | 44.3 | 37.0 | Smoking*, hypertension*, elevated serum cholesterol* (diet), lack of exercise, diabetes, stress, family history |
| • Cancer | 23.9 | 24.1 | Smoking*, worksite carcinogens*, environmental carcinogens, alcohol, diet |
| • Accidents | 4.3 | 4.6 | Alcohol abuse*, drug abuse, smoking (fires), no seat belts, speed, product design, roadway design, handgun availability |
| • Homicide | 1.0 | 3.1 | Stress, alcohol and drug abuse, gun availability, poverty |
| • Influenza & Pneumonia | 2.6 | 2.4 | Vaccination status*, smoking |
| • Diabetes | 1.8 | 2.3 | Obesity* |
| • Cirrhosis | 1.2 | 1.5 | Alcohol abuse* |
| • Suicide | 1.3 | 0.7 | Stress, alcohol and drug abuse, gun availability |
| • Infant Mortality | 1.2 | 2.7 | Low birth weight, inadequate prenatal care, adolescent pregnancy, poverty |

*Major risk factors

Source: Adapted from Donald Inverson, "Making the Case for Health Promotion: A Summary of the Scientific Evidence," Corporate Commentary November, 1984; Maryland Center for Health Statistics, Maryland Vital Statistics Preliminary Report, 1985.

## TABLE 7

## SELECTED RISK FACTORS BY RACE AND SEX, MARYLAND ADULTS, 1982

| Risk Factors | Total Adults | White | | Black | |
|---|---|---|---|---|---|
| | | Male | Female | Male | Female |
| Smoking | | | | | |
| Percent who currently smoke | 34.3% | 33.2 | 31.3 | 47.3 | 39.3 |
| Average number of cigarettes per day | 20.2 | 24.0 | 20.2 | 15.4 | 14.2 |
| Percent who have tried to quit smoking | 69.0 | 70.8 | 69.4 | 66.8 | 64.7 |
| Alcohol Consumption | | | | | |
| Percent who drink 5 or more drinks in one sitting 1-2 times or more per week | 10.4% | 15.5 | 3.4 | 18.5 | 5.2 |
| Percent who drink 5 or more drinks in one sitting 3 or more times per week | 3.0% | 5.5 | 0.6 | 6.0 | 2.0 |
| Hypertension | | | | | |
| Average diastolic blood pressure greater than or equal to 90 or on medication to control hypertension | 21.4 | 22.7 | 17.7 | 24.9 | 28.0 |
| Exercise | | | | | |
| Percent who do not engage in regular exercise | 38.3% | 38.4 | 40.9 | 29.4 | 34.5 |

Source: Personal Communication, Maryland Center for Health Statistics, Maryland Statewide Household Survey, 1982.

Much of the promotion of smoking and alcohol use is targeted to minorities with "good results" for the marketers and disastrous results for the minority population. Cigarette and alcohol advertisements account for a significant proportion of advertising space in many Black owned publications.

Alcohol and drug abuse are also major risk factors, as discussed earlier. Substance abuse is linked to several of the leading causes of minority morbidity and mortality including AIDS, cancer, cardiovascular disease, low birthweight, homicide, and cirrhosis.

## Socio-Economic Factors

Blacks, Native Americans and Hispanics are more likely than Whites to be poor, unemployed or high school drop-outs (Table 8). Studies have consistently shown that the poor, unemployed and poorly educated have poorer health status and less access to health care services than their counterparts.

**TABLE 8**

**SELECTED SOCIO-ECONOMIC CHARACTERISTICS BY RACE IN MARYLAND, FOR SELECTED YEARS**

| Characteristics | Race/Ethnicity | | | | |
|---|---|---|---|---|---|
| | Asian | Black | Native American | White | Hispanic |
| % Poor, 1979 | | | | | |
| - Persons | 8.8 | 21.3 | 20.7 | 6.3 | 12.7 |
| - Families | 7.2 | 18.5 | 17.2 | 4.3 | 10.5 |
| % Unemployed, 1980 | 4.1 | 10.4 | 9.9 | 4.2 | 6.3 |
| % Adults, age 25 and Over Completing High School, 1980 | 82.2 | 56.6 | 60.5 | 69.9 | 72.5 |

Source: 1980 U.S. Census.

While there is a voluminous amount of data that examine either race or income differences in the use of medical services, few studies or researchers have investigated the simultaneous impacts of both factors on health status and/or utilization patterns. In a review of the literature concerning the contribution of socio-economic position to minority health, a working paper of the federal Task Force on Black and Minority Health concluded that there is evidence which suggests that a portion of the difference in health between Whites and minorities can be explained by differences in socio-economic position (1). However, the working paper further concluded that an understanding of the contribution of socio-economic factors to minority health is compromised by the lack of accurate data on racial patterns of disease prevalence and medical care utilization.

There are currently no Maryland data sources which allow for an examination of the effects of minority group status and income on health status. **However, the Commission strongly believes that "quality of life" issues such poverty, housing, education, employment and other environmental conditions play important roles in determining minority health status and problems.**

## Race and Access to Health Care

There is evidence that differential access to health services exists by race in Maryland and the U.S. The observed differences in access partially explain existing disparities in health status by race.

In 1980, the U.S. Office of Civil Rights asked the Institute of Medicine to appoint a Committee to investigate disparities in health services use by race (6). Through a review of relevant research, civil rights enforcement activities, anecdotal data, and findings from a series of hearings and briefings, the Institute attempted to document the extent to which race and ethnicity are associated with the ability to obtain health care and the amount and quality of care received.

The Committee concluded the following:

- Race is associated with differences in the use of health services and these differences do not mirror differences in need. Unfortunately, the causal relationship between these associations are complex and poorly documented.

- A variety of forms of racial separation or segregation exist in the U.S. health care system.

  - Racially identifiable hospitals continue to exist in many large cities.

  - Blacks are more likely than Whites to receive care from general practitioners rather than specialists.

  - Blacks are less likely than Whites to see private physicians regardless of income level or type of health insurance coverage.

- Black Medicaid recipients are subject to double jeopardy, i.e., in addition to whatever discrimination exists against Medicaid recipients, there is also discrimination against Blacks within the Medicaid population.

- There is a strong likelihood that racial discrimination is an important factor in the admission of Blacks into nursing homes, though it is unclear how widespread a factor it is.

- Racial/ethnic patterns in health care deserve much more serious and systematic attention than they have received from researchers.

Access to health care is a multi-dimensional concept which describes the relationship between an individual's willingness and ability to enter along with his actual entry into the health care delivery system. It is influenced by characteristics of the delivery system such as the level and distribution of available resources, cost, provider characteristics, and characteristics of the individual requiring or seeking care.

A framework for understanding differential use of health services has been suggested by Aday and Andersen (7). Within this framework, the use of health services is thought to be dependent upon predisposing, enabling, and need factors. Predisposing factors suggest the likelihood of using services and exist before the onset of illness. They include immutable characteristics which cannot be changed, such as race or ethnicity, age, sex. Additionally, they include factors which are amenable to change such as educational level, knowledge of good health practices, knowledge of the availability of health care services and how to obtain access to them, and general health care attitudes and beliefs. Enabling factors describe the individual's ability to secure services as indicated by: (1) the individual's personal resources such as family income, health insurance coverage, and employment status, and (2) the availability of health resources. Finally, need factors attempt to measure health status and the reasons for seeking care.

Access to or use of health services is thought to be equitable to the extent that need factors explain utilization. Conversely, access is inequitable when use is explained by social variables such as race, insurance coverage, or other enabling factors. Inequities in the use of health services exist, as evidenced by the finding that there are utilization differentials by race which cannot be solely explained by differences in health status. Several recent Maryland studies have indicated that Blacks have less access to health care services than do non-minorities.

A 1986 Maryland Department of Health and Mental Hygiene study of variations in the use of medical and surgical services by the Maryland population found significant racial differentials in Maryland hospital discharge rates (2). Large differences in age-adjusted discharge rates were found between minorities and non-minorities for several diagnostic and surgical procedures. For example, White rates were higher for all surgical procedures studied, except hysterectomy. Whites were found to be over four times more likely than minorities to receive coronary artery bypass surgery.

The study's authors concluded that "racial differences in utilization raise the possibility that institutional barriers preventing access to health services may still exist despite the belief that Medicaid has eliminated many of these barriers. Further investigation must be done to determine the extent to which physician practice patterns, as opposed to insurance coverage and related socio-economic factors, contribute to these racial differentials."

Blacks and other minorities are four times more likely than Whites to be Medicaid recipients. Medicaid was established as a joint federal-state program in 1965 with the goal of reducing inequities in access to health care by income. Medicaid can be heralded as somewhat of a success since it has been documented to have dramatically improved

access to health care for the poor. However, studies have consistently shown that Blacks and Whites have not shared equally in the Program's successes.

Under the Maryland Medical Assistance (Medicaid) Program, per capita payments for services furnished to White recipients have consistently exceeded those for Blacks. The major racial disparities are in access to physician and nursing home services (3,4,5). The reasons for the disparities remain unclear but require further investigation to aid in finding suitable remedies. Possible contributing factors include a scarcity of primary care providers, inadequate outreach, cultural attitudes, economic discrimination and racial bias.

Health insurance status and the availability of quality, comprehensive health care resources have a major influence on access to and use of health services. Minorities are twice as likely as Whites to lack health insurance coverage for hospital care (Table 9). Studies indicate that lack of health insurance coverage and low income serve as major barriers to the use of medical services.

Blacks and minorities are more likely than Whites to report having no regular source of medical care or to receive care in public clinics and emergency rooms where care is less comprehensive, continuous, and preventive in nature. Conversely, Whites are significantly more likely to use private physicians and to receive dental services.

Blacks are three to four times more likely than Whites to live in either federally designated health manpower shortage or medically underserved areas in Maryland (Table 10). These areas are characterized by few primary health care resources, and significant unmet health care needs.

TABLE 9

HEALTH INSURANCE COVERAGE BY RACE IN MARYLAND AND U.S., FOR SELECTED YEARS

| | Black | White |
|---|---|---|
| Maryland | | |
| Percent Lacking Coverage for Hospital Care (Adults, 18+), 1982 | 12% | 6% |
| Percent Covered by Medicaid, FY 1986 | 20 | 4 |
| U.S., 1984 | | |
| Percent Uninsured | | |
| Under 65 | 21 | 14 |
| 65 and over | 2 | 1 |

Source: Maryland Data - Personal Communication, Maryland Center for Health Statistics and the Maryland Medical Assistance Program; U.S. Data - Andersen, R., etal. "Health Status and Medical Care Utilization." Health Affairs, Spring, 1987; p.138.

## TABLE 10

### PERCENT DISTRIBUTION OF MARYLAND'S POPULATION LIVING IN FEDERALLY DESIGNATED MEDICALLY UNDERSERVED AND HEALTH MANPOWER SHORTAGE AREAS, BY RACE, 1987

| | Health Manpower Shortage Areas | Medically Underserved Areas |
|---|---|---|
| Total Maryland Population | 13% | 14% |
| Percent of Black Population Living in Designated Areas | 15 | 39 |
| Percent of White Population Living in Designated Areas | 4 | 10 |

Source: Personal Communication, Maryland Department of Health and Mental Hygiene, Policy and Health Statistics Administration.

## EXHIBIT 4

### DIFFERENCES IN CULTURAL VALUES FOR ANGLO AMERICANS AND OTHER CULTURES

| Anglo-American Values | Other Culture's Values |
|---|---|
| Personal Control over the Environment | Fate |
| Change | Tradition |
| Time Dominates | Human Interaction Dominates |
| Individualism | Group Welfare |
| Future Orientation | Past Orientation |
| Competition | Cooperation |

Source: Cross Cultural Counseling: A Guide for Nutrition and Health Counselors. (September, 1986). U.S. Department of Agriculture.

## Cultural Factors

Cultural factors and the cultural acceptability of services may also serve as a major barrier to health care for minorities. Often, health services and programs are developed and implemented for racial/ethnic minorities without the benefit of input or participation from minority communities. Programs may be culturally insensitive if the values, beliefs, and social structures of minorities are not considered (Exhibits 4 and 5).

The lack of cultural sensitivity by the health care system may also reflect underrepresentation of minorities in the health professions which can result in treatment and care being provided in a context that lacks meaning for minorities. Consequently, outcomes may be less than optimal, resulting in non-compliance with prescribed treatment, missed appointments, and a lack of continuity in health care. The lack of successful outcome is often blamed on the client when the delivery system itself often contributes by its failure to provide culturally sensitive health care.

The Ohio Governor's Task Force on Black and Minority Health conducted a literature review which listed successful health promotion strategies for minority communities. The Task Force found that successful minority health promotion strategies included one of more of the following:

- took into account the beliefs, perceptions, and/or values of the population served;
- involved direct one-on-one, time-intense, outreach activities;
- was conducted in conjunction with other activities of a social, cultural, entertainment or religious nature;
- provided easy access at no direct or indirect cost to services, such as transportation and child care;
- used language that was simple and straightforward without being condescending;
- included culturally specific information on situations relative to a wide range of topics; and
- established a comfort and/or trust level with the person disseminating the information.

## Underrepresentation of Minorities in the Health Professions

Both national and Maryland data revealed that Blacks, Native Americans, and Hispanics are underrepresented in several health professions and in key managerial and policy positions throughout the health industry as compared to their percentages in the total population (Tables 11-13). For example, Blacks comprise 23% of Maryland's population, but only represent 7% or less of the State's physicians, dentists, registered nurses, pharmacists, hospital administrators, optometrists or physical therapists. This observed underrepresentation is of great concern to the Commission because adequate minority representation within the health professions and in key health policy positions is viewed as an integral part of improving the health of Blacks and other minorities. Nationally, Black and minority participation in health profession education programs has

EXHIBIT 5

SOCIO-CULTURAL CHARACTERISTICS HIGH IN IMPACT AND UTILITY BY MINORITY GROUP

| Item | American Indian | Asian/ Pacific Islanders | Black | Hispanic |
|---|---|---|---|---|
| Acculturation | – | X | – | – |
| Acupuncture | – | X | – | – |
| Belief in susceptibility to disease | – | – | X | – |
| Communication w/community leaders | X | X | – | X |
| Communication w/family and friends | X | – | X | – |
| Communication w/health care providers | X | – | – | X |
| Communication with religious leaders | – | X | X | X |
| Diet/food consumption | – | – | X | – |
| Educational level | X | X | – | – |
| Ethnicity of health care providers | X | – | – | – |
| Family structure/influence | X | X | X | X |
| Folk medicine/remedies | – | X | X | – |
| Health awareness and health beliefs | – | X | X | – |
| Health care delivery system | – | X | – | – |
| Herbalists/curandero | – | X | – | X |
| Knowledge of health care | – | X | X | – |
| Language | X | X | X | X |
| Life balance | X | – | – | – |
| Mass media use | – | X | X | X |
| Medicine Men | X | – | – | – |
| Music | – | – | X | X |
| Naturalism | X | – | – | – |
| Political and religious leadership system | X | – | – | – |
| Religious beliefs | X | – | X | – |
| Self determination | X | – | – | – |
| Sensitivity of health providers | X | – | – | – |
| Superstition | X | – | – | – |



In "The Literature on Prevention in Minority Communities: Some Lessons To Be Learned." Minority Health Research Laboratory, University of Maryland, College Park,

started to decline (8,9). Minority representation in the health field is not likely to improve without further targeted federal, state and local interventions.

A major goal of many of the programmatic efforts to increase minority representation in the health professions launched during the 1960's and 1970's was to improve minority access to health care, and ultimately, the health status of underserved minorities. A recent study which evaluated affirmative action programs in medical schools concluded that these programs had been successful (10). This study found that Black, Native American, and Hispanic physicians were more likely than White physicians to serve Medicaid patients, to practice in federally designated health manpower shortage areas, and to serve minority patients.

Racial and cultural differences (e.g., language and lifestyle) between providers and patients can impede access to health services. The Federal Task Force report on Black and Minority Health suggested that "health professionals who are from the same cultural background as their patients may be able to communicate better with their patients and thereby have a positive influence on many of the factors that affect health outcome."

The Commission strongly believes that involving Blacks and other minorities in the planning, development, implementation, operation, and evaluation of programs will enhance the likelihood of success in improving minority health.

TABLE 11

NUMBER AND PERCENT DISTRIBUTION OF SELECTED LICENSED HEALTH AND ALLIED PROFESSIONALS PRACTICING IN MARYLAND, BY RACE FOR SELECTED YEARS*

| Profession | Total | | Asian | | Black | | Hispanic | | Native American | | White | | Unknown/ Other | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| **Health Professions** | | | | | | | | | | | | | | |
| Dentists, 1985-86 | 3,775 | 100.0 | 89 | 2.4 | 244 | 6.5 | 19 | 0.5 | 1 | 0.0 | 3,209 | 85.5 | 193 | 5.1 |
| Nurses, 1986-1987 | | | | | | | | | | | | | | |
| L.P.N. | 6,978 | 100.0 | 31 | 0.4 | 2,073 | 29.7 | 17 | 0.2 | 21 | 0.3 | 3,887 | 55.7 | 949 | 13.6 |
| R.N. | 29,410 | 100.0 | 480 | 1.6 | 1,916 | 6.5 | 114 | 0.4 | 26 | 0.1 | 21,907 | 74.5 | 4,967 | 16.9 |
| Optometrists, 1986 | 318 | 100.0 | 2 | 0.6 | 3 | 0.9 | 0 | 0.0 | 0 | 0.0 | 289 | 90.9 | 15 | 6.8 |
| Physicians, 1985-1986 | 9,509 | 100.0 | 1,298 | 13.7 | 433 | 4.6 | 214 | 2.3 | 6 | 0.1 | 7,194 | 75.7 | 364 | 3.8 |
| Podiatrists, 1986 | 222 | 100.0 | 2 | 0.9 | 5 | 2.3 | 0 | 0.0 | 0 | 0.0 | 200 | 90.1 | 15 | 6.8 |
| **Allied Health Professions** | | | | | | | | | | | | | | |
| Speech Pathologists, 1986 | 603 | 100.0 | 4 | 0.7 | 24 | 4.0 | 3 | 0.5 | 0 | 0.0 | 540 | 89.6 | 32 | 5.2 |
| Audiologists, 1986 | 122 | 100.0 | 3 | 2.5 | 3 | 2.5 | 0 | 0.0 | 0 | 0.0 | 105 | 86.1 | 11 | 9.0 |
| Physical Therapists, 1986 | 1, | 100.0 | 10 | 0.9 | 48 | 4.3 | 8 | 0.7 | 1 | 0.1 | 1,032 | 92.5 | 17 | 1.5 |
| Asst. Phys. Therapists, 1986 | 157 | 100.0 | 2 | 1.3 | 35 | 22.3 | 1 | 0.6 | 1 | 0.6 | 116 | 73.9 | 2 | 1.2 |

*Excludes licensed individuals who did not complete the voluntary statistical section of the licensure renewal form.

Source: Respective Maryland Health Professions Licensing Boards Licensure Renewal Forms.

## TABLE 12

## EMPLOYMENT OF BLACKS AND MINORITIES IN SELECTED UPPER LEVEL POLICY AND MANAGERIAL POSITIONS IN THE HEALTH FIELD IN MARYLAND, 1987

| | Total | | Black | | Other Minorities | | White | |
|---|---|---|---|---|---|---|---|---|
| | # | % | # | % | # | % | # | % |
| • Local Health Officers | 24 | 100.0 | 1 | 4.2 | 1 | 4.2 | 22 | 91.7 |
| • Maryland Health Department[a] | 23 | 100.0 | 2 | 8.7 | 0 | 0.0 | 20 | 86.9 |
| • Hospital Chief Executive Officers | 52 | 100.0 | 1 | 1.9 | 0 | 0.0 | 51 | 98.1 |
| • HMO Chief Executive Officers[b] | 18 | 100.0 | 2 | 11.1 | 0 | 0.0 | 16 | 88.9 |

[a]Includes Secretaries, Deputy Secretaries and Directors of Administrations. Includes one vacancy. [b]Includes Member organizations of the Association of Maryland Health Maintenance Organizations.

Source: Personal Communication, Maryland Department of Health and Mental Hygiene; Survey of Maryland HMO's and Hospitals.

## TABLE 13

## BLACK AND MINORITY REPRESENTATION ON HOSPITAL BOARDS OF DIRECTORS/TRUSTEES IN MARYLAND, BY REGION, 1987

| Region | Number of Hospitals | Boards with No Minority Representation | | Boards with Minority Representation of 20% or More | |
|---|---|---|---|---|---|
| | | # | % | # | % |
| Maryland | 52 | 16 | 30.8 | 2 | 3.8 |
| Baltimore City | 18 | 5 | 27.8 | 1 | 5.6 |
| Central Md. Counties | 10 | 5 | 50.0 | 0 | 0.0 |
| Montgomery-P.G. Counties | 9 | 4 | 44.4 | 0 | 0.0 |
| Eastern Shore | 6 | 0 | 0.0 | 0 | 0.0 |
| Southern Maryland | 4 | 0 | 0.0 | 1 | 25.0 |
| Western Maryland | 5 | 3 | 60.0 | 0 | 0.0 |

Source: Telephone and mail survey of Maryland hospitals conducted during May-August, 1987.

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## III. KEY COMMISSION FINDINGS AND CONCLUSIONS

The following is a summary of the major findings uncovered by the Commission. Based on these findings, the Commission reached several broad conclusions which serve as the basis for the final goals and recommendations.

### KEY COMMISSION FINDINGS

#### Mortality

- If Blacks and other minorities died at the same rate as whites in Maryland, almost 2,000 fewer minority deaths would occur each year. Cardiovascular disease, cancer, homicide, accidents, and infant mortality account for three-quarters of these excess deaths.
- Age-adjusted death rates are higher among minorities/Blacks than Whites for ten of the twelve leading causes of death.
- On average, a minority baby born in Maryland in 1980 will live four years less than a White baby.

#### Cardiovascular Disease (Heart Disease and Stroke)

- Cardiovascular disease (CVD) is the leading cause of death for all minority Marylanders and one of the leading causes of premature mortality for Black males in Maryland.
- Hypertension, a leading controllable cause of heart disease and stroke, frequently goes unchecked and uncontrolled in Black males. This is partially due to a lack of access to health services.
- There are too few culturally sensitive and community based risk reduction programs (e.g. smoking cessation, dietary improvements) which can help to prevent or control CVD risk factors in high risk Black communities.

#### Cancer

- Blacks have the highest cancer incidence and mortality rates of all racial groups in the U.S. and Maryland.
- Blacks tend to be less knowledgeable than Whites about cancer's warning signals and are less likely to see a physician when they experience symptoms.
- Inadequate access to timely screening, diagnostic, and treatment resources contributes to higher rates of cancer deaths for Blacks.

### Acquired Immune Deficiency Syndrome (AIDS)

- Blacks represent 23% of Maryland's population, but comprise over 50% of the reported AIDS cases. Ninety percent of individuals suspected to have contracted AIDS due to intravenous drug abuse are Black.

- Education and outreach are currently the most effective weapons against AIDS, and there are few of these efforts underway in Black and Hispanic communities.

### Diabetes

- Black females have the highest death rate for diabetes of all race/sex groups.

- Community based education, screening, outreach, diagnostic, and treatment programs for diabetics rarely reach high risk minorities living in medically underserved areas.

### Infant Mortality and Low Birthweight

- Maryland's Black infant mortality rate is almost twice as high as the White rate.

- Maryland's Black infant mortality rate has been showing some disturbing trends. Between 1984 and 1985, the Black infant mortality rate increased by 16% to 19.2, while the White rate remained stable at 9.0. In 1986, the Black rate decreased to 17.3, while the White rate increased slightly to 9.4.

- Black babies are twice as likely as White babies to be born at low birthweights. Low birthweight babies, as compared to heavier babies, are 40 times more likely to die in the first month and 20 times more likely to die in the first year of life.

- Although prenatal care has been documented to improve birth outcomes, Black expectant mothers are three times more likely than White expectant mothers to receive late or no prenatal care.

### Child, Adolescent and Family Health

- One-half of Black children in Maryland are poor as compared to one in four White children.

- In 1980, slightly more than one-half (55%) of Black children lived in married couple families.

- Black and minority children are found disproportionately in groups at increased risk of becoming substance abusers, adolescent parents, poor learners, school failures, and juvenile delinquents.

- One-half of adolescent births are to Black females. There are inadequate numbers of successful targeted strategies which reduce adolescent pregnancies.

- There are insufficient early identification and intervention programs which help high and at risk children and adolescents. Primary care services for non-Medicaid eligible low-income children are sorely lacking in many jurisdictions.

### Homicide

- According to the U.S. Department of Justice, Black males have a 1 in 21 lifetime chance of becoming a homicide victim, while the chance for White males is 1 in 131. For Black and White females, the odds are 1 in 104, and 1 in 369, respectively.
- In 1985, the death rate from homicide for minority males was almost 8 times the White male rate at 39.7 and 4.9 deaths per 100,000 population, respectively.
- There is no public health policy concerning homicide in Maryland.

### Substance Abuse (Alcohol and Drug Abuse)

- The prevalence of alcohol and drug abuse by race/ethnicity is unknown in Maryland.
- Morbidity and mortality data suggest that minorities in Maryland suffer disproportionately from the negative consequences of substance abuse.
- There are barriers to receiving and completing substance abuse treatment for minorities, and substance abuse prevention programs are limited.

### Mental Health

- Data and research on the mental health problems and needs of Blacks and minorities are extremely limited.
- Mental health services for children under the age of 12 are virtually nonexistent.

### Minority Health Manpower

- Blacks, Hispanics, and Native Americans are underrepresented in most health and allied health professions when compared to their percentage in the total population. For example, Blacks compose 23% of Maryland's total population, but account for less than 7% of the State's physicians, dentists, and registered nurses.
- Blacks and minorities are underrepresented in upper level health policy and managerial positions in major health-related facilities and organizations, such as boards, commissions, hospitals, academic health centers, HMO's, nursing homes, and public health departments. For example, there is only one Black Chief Executive Officer of a hospital in Maryland and 16 of Maryland's 52 acute hospitals, including five in Baltimore City, have no Black representation on their boards of directors.
- Studies have consistently shown that Black practitioners are more likely than White practitioners to practice in minority and underserved areas.

## Access to Health Care

- Several Maryland reports have documented differences in access to care by race (2,3,4).
- Blacks as compared to Whites are:
  - Three to four times more likely to live in federally designated medically underserved or health manpower shortage areas;
  - Three times less likely to have a coronary artery bypass surgery;
  - Twice as likely to be uninsured;
  - More likely to receive primary care in public clinics and emergency rooms where care is less comprehensive, continuous and preventive in nature;
  - Less likely to receive nursing home care; and
  - Less likely to receive dental care.

## The Black and Minority Elderly

- Blacks are less likely than Whites to reach old age. Eleven percent of Whites and six percent of minorities were over the age of 65 in 1980.
- The Black elderly (29%) were three times as likely as the White elderly (10%) to be poor in 1980.

## Data and Research

- Data and health information for Hispanics, Native Americans, and Asian/Pacific Islanders are particularly sparse.
- Hispanics are not identified on the State's birth and death certificates.
- Estimates of the size of Maryland's Black, Native American, Hispanic, and Asian populations are only available through the decennial U.S. Census.

## KEY COMMISSION CONCLUSIONS

Maryland data show that the health of Marylanders of all races has improved dramatically over the past five decades. The Commission finds that far too many Black and minority Marylanders continue to die and suffer, however, needlessly from preventable diseases and conditions. While Maryland has one of the nation's best health care delivery systems, major improvements are needed if the health status of Black and minority populations is to change. On the basis of these findings, the Commission concludes the following:

1. Education about healthy behaviors, health insurance coverage, and improving access to comprehensive and continuous preventive and primary care services are keys to improving Black and minority health.

2. Intense, well targeted, community based, and culturally appropriate outreach and education programs are often necessary to reach and educate low-income Blacks and minorities and enhance their access to health services. More minority outreach and education programs are required immediately.

3. It is essential that the leadership (e.g., ministers, elected officials, health professionals, community leaders) in Black and minority communities be involved in promoting healthy lifestyles and behaviors in their communities.

4. The adequate representation of Blacks and minorities in the health professions and in key health policy positions is an essential component of improving Black and minority health. Increasing the number of Black and minority health professionals will require immediate targeted State and local interventions.

5. Blacks and minority participation should be sought in the development, implementation and evaluation of programs and services in their communities.

6. The State must ensure that localities have the necessary flexibility and resources to design health care programs which are tailored to address their unique and individual health care needs.

7. Geographic and economic barriers, including lack of access to health insurance coverage, must be eliminated if Black and minority health is to improve substantially.

8. Incentives are needed to promote efficiency and effectiveness in the organization, financing, and delivery of health care services.

9. The development of viable solutions to Black and minority health problems will require public-private partnerships.

## IV. COMMISSION GOALS AND RECOMMENDATIONS

The Commission's goals and recommendations constitute an initial action plan for the State to begin to systematically and diligently address remaining racial disparities in health status and inequities in access to health care services between the "haves" and the "have-nots" in Maryland.

In formulating these goals and recommendations, the Commission recognized that there is a role for the public and private sectors, and more importantly minority communities themselves, to play in addressing Black and minority health problems.

The Commission's 86 recommendations which follow are organized according to 9 broad Commission goals, and several sub-goals. The Commission also prioritized its goals and recommendations and chose four goals and five recommendations for initial priority consideration and action (Exhibit 6).

## GLOSSARY

1. BCHD - Baltimore City Health Department
2. DBFP - Maryland Department of Budget and Fiscal Planning
3. DHMH - Maryland Department of Health and Mental Hygiene
4. DHR - Maryland Department of Human Resources
5. DOP - Maryland Department of Personnel
6. EEOC - Equal Employment Opportunity Commission
7. LHDs - Local Health Departments
8. MCBMH - Proposed Maryland Commission on Black and Minority Health
9. MSDE - Maryland Department of Education
10. OCY - Maryland Office for Children and Youth
11. SBHE - Maryland State Board of Higher Education
12. GACAP - Governor's Advisory Council on Adolescent Pregnancy
13. GACA - Governor's Advisory Council on AIDS
14. MHBPC - Maryland Commission High Blood Pressure and Related Cardiovascular Risk Factors
15. ACA - American Cancer Society
16. ADA - American Diabetes Association
17. DEED - Maryland Department of Employment and Economic Development

## EXHIBIT 6

## PRIORITY COMMISSION GOALS AND RECOMMENDATIONS

- TO INCREASE BLACK AND MINORITY REPRESENTATION IN THE HEALTH PROFESSIONS AND IN KEY HEALTH POLICY POSITIONS (GOAL 1)

  - Establish a statewide Extra-curricular Health Professions Career Exploration Program (Recommendation 1.1)

- TO IMPROVE THE HEALTH OF BLACK AND MINORITY CHILDREN, YOUTH AND FAMILIES (GOAL 2)

  - Reduce infant mortality and related risk factors (Recommendations 2.1-2.7)
  - Develop a continuum of preventive intervention programs for high and at risk children and adolescents (Recommendation 2.13)

- TO IMPROVE ACCESS TO HEALTH CARE SERVICES AND PROGRAMS FOR THE LOW-INCOME UNINSURED AND MEDICAID RECIPIENTS (GOAL 3)

  - Develop and implement demonstration projects which increase access to primary care health care services for medically indigent Blacks and minorities (Recommendation 3.1.4)

- TO PREVENT EXCESS BLACK AND MINORITY DEATHS DUE TO AIDS, CARDIOVASCULAR DISEASE, CANCER AND DIABETES (GOAL 4)

  - Expand community-based cardiovascular risk reduction programs (Recommendation 4.4)

## GOALS AND RECOMMENDATIONS: MARYLAND GOVERNOR'S COMMISSION ON BLACK AND MINORITY HEALTH

### GOAL 1: BLACK AND MINORITY HEALTH MANPOWER - TO TRIPLE BLACK AND MINORITY REPRESENTATION IN THE HEALTH PROFESSIONS AND IN KEY HEALTH POLICY AND MANAGERIAL POSITIONS BEFORE THE YEAR 2000.

Motivating Black and Minority Students to Pursue Health Careers

There is a need to foster increased awareness of health careers among Black and minority students as a long term strategy for increasing representation in the health professions. In meetings and discussions with health providers and concerned individuals, the Commission consistently heard about the need to start early and to systematically expose minority students to the variety of health careers available.

Minority youngsters are more likely to be arbitrarily tracked into vocational or non-college preparatory courses where expectations are low, where they are poorly prepared in the sciences, and where they do not receive appropriate counseling for health careers. Studies have also shown that talented Black students often do not pursue health careers because of non-academic factors, such as poor guidance counseling and insufficient career information.

**Recommendation 1.1:** Establish a statewide Extra-curricula Health Professions Career Exploration Program targeted to elementary, middle, and high schools with significant numbers of Black and minority students.

A Statewide health profession extra-curricular career exploration program should be established to stimulate increased minority interest and participation in the health field. This program could be piloted in selected elementary, middle and secondary schools with high concentrations of minority students for a minimum of five years.

The program should use approaches appropriate for each academic level. At the elementary level, awareness of the health professions would be stressed through the increased visibility of role models, science fairs, tours, and films. In the middle schools, the program should provide greater exposure to the professions through mentoring and general academic and career planning. Finally, at the secondary level, emphasis should be placed on more structured academic and career planning, including internships and summer enrichment programs.

The program should involve appropriate health institutions, academic programs, health professions associations, and health-related corporations (e.g., drug companies and equipment suppliers). Representatives of these organizations could be asked to assist in a variety of ways, including funding the program, sponsoring or participating in health career days or enrichment programs, providing internship opportunities, serving as mentors, and printing materials.

Recommended staffing for the program would consist of a Statewide Coordinator who would be administratively located in the DHMH.

**Recommendation 1.2:** Prepare and encourage middle and high school guidance counselors, faculty, and staff to promote the health professions.

**1.2.1:** Offer seminars which provide counselors with information about health careers preparation.

**Recommendation 1.3:** Ensure that Dunbar High School, the State's only health careers magnet school, has the resources necessary to motivate, educate, and train Black and minority students interested in the health professions.

Since the late seventies, one of the major goals of the Dunbar High School in Baltimore City has been to motivate and prepare eligible students for a broad range of health careers. Theoretically, this model program could serve as a major avenue for increasing Black and minority participation in the health professions. It is recommended that this program be evaluated to determine its effectiveness in increasing access to health careers for Black and minority students in Maryland.

**Recommendation 1.4:** Strengthen the academic capabilities and achievements of Black and minority students.

**1.4.1:** Provide preventive intervention programs which diminish and correct learning problems.

**1.4.2:** Develop supportive programs which encourage Black and minority students to remain in school.

**1.4.3:** Implement the career education concept in the public schools.

**Recommendation 1.5:** Motivate and prepare Black and minority students to take math and science courses.

**1.5.1:** Promote the use of Science Weekly, a weekly reader which stimulates student interest in the sciences, in elementary schools.

**1.5.2:** Train and hire more Black and minority science and math teachers to serve as role models.

**1.5.3:** Develop and implement middle, high school, and college math and science tutorial and enrichment programs.

## Strengthening Black and Minority Recruitment and Retention Efforts

Factors, such as the recent affirmative action court challenges (e.g., Bakke vs. University of California) and decreased federal aid for education programs, have resulted in a weakening of national, university, and state mandates to recruit and retain underrepresented Blacks and minorities in health professions education programs. If the numbers of Blacks and minorities in the health professions is to increase, Maryland's political and educational leaders must be willing to renew and strengthen their commitment to this effort.

**Recommendation 1.6:** Encourage Maryland health and allied health professions programs to develop policies and programs which enhance the recruitment and retention of underrepresented minorities.

**Recommendation 1.7:** Monitor Black and minority enrollment and retention trends in the State's health and allied health professions programs.

**Recommendation 1.8:** Advocate strongly for increased federal funding of financial aid programs for low-income students.

**Recommendation 1.9:** Develop and strengthen feeder systems between high schools, undergraduate colleges, and health professions programs in Maryland.

**1.9.1:** Evaluate and strengthen undergraduate and graduate faculty commitment to helping minority students succeed.

**1.9.2:** Prepare and support minority students to enter honors programs with direct tracks into Maryland's health professions programs.

**1.9.3:** Develop and implement a model State approach to the recruitment and retention of minority health professions students in Maryland.

**1.9.4:** Involve health professions college and university faculty in the upgrading of high school and college science curricula in Maryland.

## Providing Adequate Financial Assistance for Low-Income Students

**Recommendation 1.10:** Increase the number of State and privately funded sources of financial assistance for low-income students.

**1.10.1:** Expand the number of scholarships and low interest loans available to low-income students through the State Scholarship Board.

**1.10.2:** Encourage health professional associations, churches, and groups to adopt and support health professions students.

## Increasing Black and Minority Representation in Maryland's Health Industry

**Recommendation 1.11:** Establish a five year Minority Health Executive Program to facilitate the advancement of Blacks and minorities into upper level managerial and policy making positions in Maryland's health industry.

A Minority Health Executive Fellowship Program should be established to assist in recruiting and promoting minority individuals into managerial and policy decision-making positions in the health field in Maryland. In its meetings and hearings, the Commission heard that a lack of awareness of the available opportunities by minorities and a lack of mentors often serve as barriers to the

available opportunities for minorities to enter managerial positions. An Health Executive Fellowship Program would provide an opportunity for minority individuals with some training and interest in the health field to acquire and/or strengthen managerial skills under the guidance of acknowledged leaders in Maryland's health field.

The Commission recommends that a voluntary Statewide Coordinating Council be established to develop and oversee the program. The Council would consist of representatives of health groups and industries who agreed to participate in the program by funding fellowship positions. All major health related organizations in Maryland (e.g., the State Department of Health and Mental Hygiene, the Maryland Hospital Association, Med-Chi) should be encouraged to participate.

The program would provide an opportunity for minority individuals to serve as paid fellows for 18 months in entry or mid level management positions in a variety of health care settings. Program participants could rotate through several settings or remain with one organization for the duration of the fellowship. The program would serve as a structured learning experience for the fellow and create a ready pool of minority individuals interested in and qualified for entry and mid level managerial positions in the health field. Mechanisms which seek to find permanent employment for fellows successfully completing the program should also be included.

**Recommendation 1.12:** Encourage public and private health-related boards and commissions to attain memberships which are ethnically and racially reflective of the communities served.

**Recommendation 1.13:** Encourage State and local health departments to recruit and promote at all levels health professionals who are racially and ethnically reflective of the communities served.

**1.13.1:** Investigate salary inequities between local health departments and the private sector which serve as impediments to the recruitment and retention of quality public health providers.

**1.13.2:** Appropriate new monies to the DHMH to hire additional community health nurses. New hires should include an equitable percentage of Black and minority nurses.

**Recommendation 1.14:** Monitor the recruitment, training, hiring, and promotion experiences of Blacks and minorities in Maryland's health industry.

**Recommendation 1.15:** Institute mechanisms to promote the rapid certification of immigrants with professional backgrounds.

Foreign-born health professionals are required to obtain professional certification to practice their vocation in the United States. The certification process is governed by State and federal rules and regulations. It has become

increasingly evident that foreign-born health professionals have difficulty with the certification process. It is recommended that the necessary steps be taken to help eliminate this problem.

Recommendation 1.16: Promote the provision of cross-cultural training and awareness programs in health professional education and in-service training programs.

GOAL 2: CHILD, ADOLESCENT AND FAMILY HEALTH - TO IMPROVE THE HEALTH OF MARYLAND'S BLACK AND MINORITY INFANTS, CHILDREN, ADOLESCENTS AND FAMILIES.

Recommendation 2.1: Appoint a Maryland Advisory Council on Infant Mortality.

The National Institute of Medicine, in its 1985 study on Preventing Low Birthweight, recommended that every state designate a body of experts who could be responsible for monitoring infant mortality and heightening public awareness about the nature of the problem. Similarly, the Southern Regional Task Force on Infant Mortality, formed at the 50th Annual Meeting of the Southern Governor's Association, in its final report recommended that each State establish a permanent state-wide coordinating council which has the authority to oversee planning, delivery and financing of health services in family planning and maternal and infant health.

To this end, the Secretary of Health and Mental Hygiene should appoint an Advisory Committee on Infant Mortality composed of experts from the health professions and representatives of Black and minority communities. The Advisory Committee, appointed by and reporting to the Secretary of Health and Mental Hygiene, should be charged with developing and overseeing the implementation of a long range strategic plan aimed at reducing the risk factors contributing to infant mortality. Components of the plan should be specifically targeted to and tailored for minority communities.

The Advisory Committee on Infant Mortality would:

1. monitor trends in infant deaths in the State and develop recommendations which address accordingly the problems of infant mortality, low birth weight, and prematurity;

2. identify high priority communities in the State requiring targeted interventions for specific infant mortality risk factors;

3. recommend strategies for integrating existing perinatal resources and programs in the public and private sectors; and

4. review existing programs annually, with particular emphasis on program outcomes.

Findings would be reported to the Secretary on an annual basis. The Advisory Committee should be composed of representatives of the American Academy of

Pediatrics, the American College of OB/GYN's, Med-Chi, the American College of Nurse Midwives, the Maryland Hospital Association, the State Board of Medical Examiners, the Monumental Medical Society, the Maryland Primary Health Care Association, the Maryland Perinatal Association, and the Johns Hopkins University Schools of Public Health and Medicine, the University of Maryland School of Medicine, and Black and minority community leaders and consumers. The Council should serve in an advisory capacity to the Secretary with a means for communicating with relevant DHMH program staff, but should not be comprised of Department personnel.

Recommendation 2.2: Improve access to prenatal and infant care services by:

2.2.1: Providing health insurance coverage for all infants and pregnant women with incomes between 100% and 200% of the poverty level.

2.2.2: Ensuring the availability of an "enriched package" of prenatal and infant care services for all pregnant women and infants with incomes below 200% of the poverty level in each jurisdiction.

Recommendation 2.3: Direct the Secretary of DHMH to develop and coordinate the implementation of a community-based long range strategic plan to reduce infant mortality.

Infant mortality in Maryland is a serious and troubling public health problem. In 1984, 40 states in the nation had lower infant mortality rates than Maryland. While Maryland's overall infant mortality rate has declined significantly since 1940, the State's Black infant mortality remains twice as high as the White rate and increased by 16% between 1984 and 1985. Maryland has taken several steps in the right direction to address infant mortality including Medicaid expansion of prenatal and infant care services, and the appointment of a Governor's Council on Adolescent Pregnancy. However, gaps and problems remain.

Maryland currently does not have a long term strategic plan which systematically addresses infant mortality by monitoring trends in infant deaths, identifying high risk communities, assessing programmatic outcomes and effectiveness, coordinating private and public sector resources, identifying strategies which enhance access to primary care services, and targeting resources to high risk communities.

Recommendation 2.4: Direct state and local health departments to systematically determine ways in which current programs can be modified to be most responsive to efforts aimed at reducing infant mortality.

Local health departments currently conduct annual standard reviews which describe service volume and user characteristics. It is recommended, however, that health departments also access pregnancy outcome, including inducements and impediments to positive outcome. Together with the proposed Advisory Council on Infant Mortality, State and local health departments should systematically determine ways programs can be modified to be most responsive to efforts aimed at reducing infant mortality. This should include an assessment of high risk communities which examines the utilization of existing

resources, the potential for increased capacity and coordination among resources, and the outcome of efforts toward coordination.

**Recommendation 2.5:** Develop and expand home visiting and other programs which provide outreach, education, and case management services to high risk expectant mothers and children to assure timely receipt of prenatal care, post-partum care, and infant health services.

**2.5.1:** Replicate the Baltimore's Best Babies and the Prince George's County Infants at Risk Programs in other jurisdictions.

**Recommendation 2.6:** Develop a systematic approach to identifying high risk pregnancies and referring women-at-risk for premature labor into appropriate facilities within each jurisdiction.

**Recommendation 2.7:** Provide culturally relevant counseling and educational programs to encourage healthy behaviors and to reduce the risks associated with smoking, poor nutrition, and substance abuse.

**Recommendation 2.8:** Increase and promote access to reproductive health services for low-income women, including annual preventive check-ups and screenings.

**Recommendation 2.9:** Ensure the adequate availability of family planning services in each jurisdiction to prevent unwanted and unplanned pregnancies.

**Recommendation 2.10:** Improve the effectiveness of the Women, Infants and Children (WIC) program.

## Reducing Adolescent Pregnancy

**Recommendation 2.11:** Encourage the Governor's Council on Adolescent Pregnancy, DHMH, DHR and MSDE to target and implement culturally relevant educational and prevention strategies in high risk Black and minority communities.

**Recommendation 2.12:** Evaluate the effectiveness of the Prenatal Assistance Program in improving access to, and utilization of, prenatal and other health and social support services for Black and minority adolescents.

## Promoting Healthy and Positive Youth Development

**Recommendation 2.13:** Direct the DHMH, DHR, MSDE, OCY to develop and coordinate a continuum of preventive intervention programs and strategies to prevent the development of chronic health, psycho-social, learning and mental health problems in high and at-risk children and adolescents.

Minorities comprise 30% of the State's population, aged 0-18. However, minority children are often disproportionately found in the State's high risk and at risk populations. For example, Black infants comprised 50% of the low birth weight babies born in 1986. Minority babies are twice as likely as majority babies to be born prematurely or with low birth weights. Low birth weight

babies are at increased risk for learning disabilities and vision and hearing problems. According to the Children's Defense Fund, Black children as compared to white children are three times as likely to be poor, three times more likely to die of known child abuse, five times as likely to become pregnant as teenagers, and twelve times as likely to live with a parent who never married. Children born to teenagers are at increased risk for school failure and behavior problems.

High risk mothers-to-be include alcohol, drug, and nicotine abusers, adolescents, low income and poorly educated women. These women are at increased risk of having low birth weight and premature babies. High risk infants and children include premature and low birth weight babies, poor children living in single parent households, children born to adolescent mothers, children who are physically or mentally abused, and children with learning disabilities, such as attention deficit disorder. These children are at increased risk of becoming substance abusers, adolescent parents, poor learners and school dropouts, and juvenile delinquents.

The Commission recommends that new efforts be focused on the early identification of children at risk for developing later behavioral problems. Several intervention programs aimed at minimizing the effects of biologic and psycho-social risk factors at an early age have been documented to be effective. These include preschool programs such as Headstart and home visiting programs. Home visiting programs have been demonstrated to reduce the incidence of pre-term delivery and low birth weight (leading causes of infant mortality), noncompliance with medical regimens, the incidence of child abuse, and inappropriate emergency room use. These programs improve health habits during pregnancy, improve parenting skills, strengthen family functioning, and decrease family stress. It has been estimated, however, that community health nurses in the State's local health departments spend less than 13% of their time on home visits to families.

The Commission recommends that the Department develop and implement a plan which uses home visiting programs and other mechanisms to prevent the development of handicapping psychosocial and behavioral problems in high risk infants, children, and adolescents.

**2.13.1:** Identify and prioritize communities requiring targeted intervention.

**2.13.2:** Expand pre-school programs such as Head Start.

**2.13.3:** Provide school health services in every public school.

**2.13.4:** Develop comprehensive school based health services in high risk communities.

**2.13.5:** Provide funding to enable public schools and local health departments to hire health professionals to identify and treat children and adolescents who exhibit or are at risk of acquiring learning, mental health, psychosocial or chronic health problems.

**2.13.6:** Develop a comprehensive network of services to detect and treat sickle cell anemia.

Sickle cell disease is the most common genetic disorder in the U. S. and Maryland. This hereditary blood disorder affects mainly Black Americans: 1 in 400 has the disease.

Without appropriate medical interventions, children with sickle cell disease are at greater risk of dying in their first year of life due to infectious complications. Therefore, early identification of infants with sickle cell disease is extremely important. It is recommended that all newborns receive hemoglobin screening to detect sickle cell and related diseases.

**2:13.7:** Develop and expand parenting and family support programs.

**2:13.8:** Increase the availability of comprehensive primary care services for children, particularly in rural areas of Maryland.

## GOAL 3: THE MEDICALLY INDIGENT - TO IMPROVE ACCESS TO A RANGE OF HEALTH SERVICES AND PROGRAMS FOR MEDICALLY INDIGENT (I.E., THE LOW INCOME UNINSURED AND MEDICAID RECIPIENTS) BLACKS AND MINORITIES.

### Improving Access to Health Care for the Low-Income Uninsured

**Recommendation 3.1:** Develop, fund, and implement programs and strategies which improve access to health insurance coverage and health care services, including health education for the low-income uninsured.

**3.1.1:** Direct the DHMH to develop and implement a comprehensive strategy using a five year phase-in approach to provide health insurance coverage for all Maryland individuals with incomes below 200% of the poverty level.

**3.1.2:** Increase Medical Assistance income eligibility limits to 133.3% of the AFDC monthly cash payment level as allowed by Federal regulations.

Federal regulations permit the Medical Assistance income standard for families of three or more persons to be as high as 133.3 percent of the AFDC monthly cash payment as determined by the size of the family. Currently, Maryland's income standards for medically needy families under the Medical Assistance Program ranges from 100 to 118 percent of monthly cash payments.

**3.1.3:** Ensure that the Maryland maintains its "waiver" of regular Medicare and Medicaid reimbursement principles by the Department of Health and Mental Hygiene.

Maryland has had waiver of Medicare reimbursement rules since 1977. The preservation of the Medicare waiver is an integral component for assuring access to health care for the citizens of Maryland, regardless of ability to pay. This is achieved by providing mechanisms, through the Health Services Cost Review Commission's (HSCRC) all payer rate-setting system, which guarantees that uncompensated care will be reimbursed to hospitals by means of the rate set for each hospital. In 1986, Maryland hospitals were paid approximately $175 million for providing services to those who could not pay. If the waiver were lost, alternative ways of financing uncompensated care would be required or

access to acute health care services for the uninsured poor would be seriously jeopardized. The loss of the waiver would have a particularly negative impact on the financial viability of (and therefore access to) inner city hospitals, which serves a disproportionate share of Maryland's minority, poor, and uninsured populations.

3.1.4: Develop and implement demonstration projects which increase access to primary health care services for medically indigent minorities.

Primary care is that care which addresses the individual's general health needs. It includes the coordination of the individual's health care with responsibility for the prevention of disease, promotion, and maintenance of health, treatment of illness, and referral to other specialists and more intensive care as appropriate. Primary care is generally provided in an ambulatory setting. By its nature, primary care plays an important role in maintaining health, reducing more serious illness, and determining the overall costs of health care through its referral function for specialty care and inpatient hospital use.

Income and health insurance coverage largely determine the ability of individuals to obtain timely and quality primary care services. Those with low incomes and no health insurance or inadequate insurance are less likely to seek primary care services. Minorities are twice as likely as Whites to be uninsured and three times more likely to be poor. It has also been documented that minorities are more likely than Whites to have no regular source of care or to receive care in public clinics and hospital outpatient departments where care is less comprehensive, continuous, and preventive in nature.

The Commission recognizes a need to increase access to primary care services in the State for the uninsured poor, many of whom are minorities. Demonstration projects which encourage greater use of community based primary care services, such as community health centers (CHC's), should be developed and implemented. There are approximately 21 community health centers in Maryland which provide a comprehensive set of primary care services to the uninsured poor or "grey area" individuals on a sliding fee scale basis. Nine centers receive federal funds to subsidize services to the uninsured poor and another twelve centers are privately funded. These centers are committed to serving the uninsured poor and have the capacity to serve additional individuals. CHC's are forced to operate under financial constraints and, as a result, most have limited outreach programs which inform the community about the availability of services. Innovative methods are needed to encourage communities to utilize these facilities.

As an initial strategy, the Commission proposes that community health centers work with local departments of social services in areas of the State where CHC's are located to encourage referrals of Medicaid and uninsured clients to these centers.

In 1986, the State's Department of Human Resources disapproved 11,320 applications for general public assistance and 16,556 applications for AFDC. During that same year, 37,245 AFDC cases and 23,430 general public assistance cases were closed. With those closings and disapprovals went the denial of Medical Assistance benefits. The Commission recommends that resources within the Office of Eligibility Services of the Department of Human Resources

be coordinated with community health centers across the State to formally refer disapproved and closed cases to providers who are willing to offer care on a sliding fee scale basis to individuals with incomes below 200% of the poverty level.

**3.1.5:** Support the efforts of the Alliance for Responsible Health Policy in the development of recommendations that address financing health care for the medically indigent.

The provision and financing of adequate health care services to the uninsured is a concern of both the public and private sectors. Blacks and other minorities are more likely than Whites to lack health insurance coverage. Joint public-private sector groups, such as the Alliance for Responsible Health Policy should be encouraged to work toward the development policies and programs which promote increased access to health insurance coverage for low income uninsured women and children, the working poor uninsured, the unemployed, and individuals who are uninsurable.

**3.1.6:** Extend Medicaid coverage to all poor children under age five over the next four years as allowed by the Sixth Omnibus Budget Reconciliation Act.

**3.1.7:** Promote the development of private sector initiatives for the uninsured such as Maryland Blue Cross and Blue Shield's Caring Program.

## Improving Access for Medical Assistance Enrollees

**Recommendation 3.2:** Provide rigorous client education to Medicaid recipients to discourage the inappropriate use of emergency rooms and outpatient departments as primary care providers, and encourage the use of community health centers and other appropriate low-cost providers.

The inappropriate use of emergency rooms and hospital outpatient departments may contribute to costs while not necessarily enhancing the quality of health care. The wide use of community health centers, and other appropriate primary care providers should improve access and preserve quality.

**Recommendation 3.3:** Improve the effectiveness of the Early Periodic, Screening, Diagnosis and Treatment (EPSDT) Program.

## Improving Resource Availability and Health Services Utilization

**Recommendation 3.4:** Monitor trends and develop policies and programs to address identified racial disparities in access to and use of hospital, nursing home, and ambulatory care services, as documented in several recent Maryland reports.

**Recommendation 3.5:** Develop and implement a State manpower strategy which addresses the maldistribution of health care resources in Maryland.

Several health manpower issues currently confront Maryland. Chief among these is a shortage of primary care providers willing to practice in poor areas,

the underrepresentation of Blacks and minorities in the health professions, and the cyclical nursing shortage.

- One in seven Marylanders currently resides in a federally designated medically underserved area which is characterized by few accessible primary care physicians, high poverty and a high infant mortality rate. A 1984 study projected the majority of subdivisions in Maryland will experience primary care shortages by the year 2000.

- Blacks, Native Americans and Hispanics are underrepresented in several of the health professions in Maryland. For example, Blacks comprise 23% of Maryland's population, but account for 7% or less of physicians, nurses, dentists, pharmacists, psychologists, or physical therapists. Studies have consistently shown that Black and minority providers are significantly more likely than their counterparts to practice in medically underserved areas.

- Federal support of the National Health Service Corps and similar programs concerned with the maldistribution of health professionals has decreased significantly.

- Most Maryland hospitals are experiencing serious difficulties in recruiting and retaining nursing personnel.

There is a need to develop an ongoing State level health manpower strategy to address these and other health manpower concerns.

Recommendation 3.6: Provide financial and other incentives, such as increased Medicaid reimbursement, to attract and maintain primary care providers in medically underserved inner city and rural areas.

3.6.1: Increase Medicaid reimbursement levels for providers practicing in medically underserved inner city and rural areas.

3.6.2: Develop State educational loan programs, similar to the federal National Health Service Corps (NHSC) Program.

3.6.3: Subsidize the practices of primary care practitioners willing to locate in areas of needs (e.g., low interest loans or grants to establish a practice).

Recommendation 3.7: Improve access to dental services for Blacks and minorities.

3.7.1: Require Medicaid coverage of dental services for adults.

## GOAL 4: MORTALITY AND MORBIDITY - TO PREVENT EXCESS BLACK AND MINORITY MORTALITY AND MORBIDITY

### Preventing AIDS

**Recommendation 4.1:** Develop and expand innovative and culturally sensitive AIDS prevention, outreach, education and treatment programs targeted to high risk Black and minority individuals and communities.

**4.1.1:** Use the media to deliver culturally relevant prevention messages to Blacks and Hispanics.

**4.1.2:** Create and support Black and minority street outreach programs.

**4.1.3:** Provide training sessions for health professionals, drug abuse counselors, and others who may come in contact with individuals at risk of contracting AIDS.

**4.1.4:** Include information on AIDS in the school health curriculum.

**4.1.5:** Develop and maintain adequate prevention and treatment resources.

a. Promote the use of condoms.

b. Participate in AIDS research aimed at prevention.

c. Encourage further development of medical, home health, hospice, housing, and social support services for AIDS patients and their families.

With no cure in sight, AIDS has the potential to decimate a significant proportion of Maryland's Black and minority communities. Preventing the spread of the disease using aggressive minority education and outreach strategies is the only effective weapon currently available. A multi-faceted approach which reaches all ages and high risk groups is required. This approach should use a variety of culturally appropriate techniques and educational resources in order to maximize effectiveness. In addition, these approaches should be coordinated to minimize duplication and successful strategies should be replicated.

Black and minority community, political, and religious leaders must be actively involved in efforts to control the spread of AIDS in their communities.

**Recommendation 4.2:** Develop, fund, and implement additional AIDS education and outreach programs targeted toward Black and Hispanic intravenous drug abusers.

Intravenous (IV) drug abusers are the second largest at risk group for AIDS. Approximately 13 percent of reported AIDS cases in Maryland are associated with IV drug abuse. In turn, the overwhelming majority (90%) of Marylanders suspected to have contracted AIDS as a result of IV drug abuse are Black.

The State's Drug Abuse Administration started the Street Outreach for AIDS Program in 1986. This Program trains and places recovered IV drug addicts as outreach workers. The outreach workers canvas areas known to be meeting places for IV drug abusers and their sexual partners, provide AIDS related educational programs to addicts and make referrals for substance abuse treatment. This program and similar programs should be replicated and expanded in high risk areas.

## Reducing Cardiovascular, Cancer, and Diabetes Risk Factors

**Recommendation 4.3:** Maintain and expand community based risk reduction programs using churches, neighborhood groups, and other primary social support networks.

**4.3.1:** Maintain the current State funded Church High Blood Pressure Program.

**4.3.2:** Replicate the Church High Blood Pressure Program in additional churches and community based settings in Baltimore City, Southern Maryland, and on the Eastern Shore.

The State funded Church High Blood Pressure Control Program provides high blood pressure detection, referral, follow-up, monitoring, nutrition and educational services in 25 Black churches and other community sites in Baltimore City using trained church and community volunteers. Special emphasis is placed on nutritional counseling for weight control and sodium restriction.

Research has shown that primary support networks, such as churches, reinforce and sustain risk factors such as poor dietary habits and that it is necessary to mobilize these networks to encourage and support good habits. The Church High Blood Pressure Program has demonstrated that it is possible for the community to rally together, organize, and effectively address chronic health problems. Funding is required to continue this Program in State Fiscal Year 1989 and to replicate the Program in other communities.

In addition, the Centers for Disease Control has funds available under the PATCH Program (Planned Approach to Community Health) to assist communities which have organized and assessed their health problems and needs. State seed funds are required to assist communities interested in conducting initial needs assessment activities.

**Recommendation 4.4:** Prevent and reduce smoking among Black and minority populations.

**4.4.1:** Expand smoking prevention and peer resistance training programs in the schools.

**4.4.2:** Increase the number of smoking cessation programs for pregnant women.

**4.4.3:** Increase the number of smoking cessation programs targeted to Black males.

**4.4.4.:** Develop and implement policies and legislation to limit or discourage smoking.

See Recommendation 6.4.

**Recommendation 4.5** Encourage dietary habits among Blacks and minorities which include decreasing salt intake, lower cholesterol, reducing saturated fats, and increasing fiber.

**4.5.1:** Hold statewide and regional nutrition promotion programs.

**4.5.2:** Develop culturally sensitive health education materials and media campaigns for dissemination of prevention messages in minority communities.

**Recommendation 4.6:** Develop and implement educational programs to teach physicians and other health care providers who serve Black and minority populations, the counseling skills and health education strategies that have proven to be effective in controlling cardiovascular and cancer risk factors among minorities.

**Recommendation 4.7:** Develop, implement, and evaluate procedures to assess the cardiovascular risk factors status of persons who present at varied and numerous points of contact with the health services delivery system.

**Recommendation 4.8:** Promote the control of hypertension in minority populations with priority emphasis on young Black males and Black men over the age of 50.

## Cancer

**Recommendation 4.9:** Provide access to effective cancer screening, diagnosis, and treatment resources for high risk minorities.

**4.9.1:** Develop and implement approaches to improve the rate of Pap testing among minority women.

**4.9.2:** Develop programs to expand the availability of mammograms for low-income minority women.

**4.9.3:** Develop programs to expand the availability of colon cancer detection and treatment resources for minorities.

## Diabetes

**Recommendation 4.10:** Increase access to quality diabetic self care education.

**4.10.1:** Develop a "lay trainer" program to disseminate information on glucose monitoring, diabetic foot care, diet, insulin regulation, and the importance of eye examinations, smoking cessation and high blood pressure control.

4.10.2: Develop and implement professional education and diabetic care demonstration programs in primary care centers, local health departments, and home health agencies.

In efforts to control diabetes as a leading cause of excessive death and disability among minority populations, it is recommended that specific interventions be implemented to prevent diabetic complications such as blindness, amputations, cardiovascular disease, kidney disease and adverse outcomes to pregnancy. These interventions, based largely on early identification and follow-up, can be delivered through the existing health care system at a cost far less than the eventual costs resulting from the uncontrolled complications.

Diabetes can be successfully prevented or controlled through utilization of appropriate nutrition and other recognized health practices. Additionally, the presence and extent of complications can be significantly diminished by successfully addressing obesity and other compounding risk factors, (e.g., smoking). Community-based efforts, incorporating significant organizations and leaders, are recognized for their effectiveness. Self-care and self-monitoring are important adjuncts to clinical care and treatment.

Recommendation 4.11: Reduce obesity and dietary fat intake in minority populations, particularly Black females, through community based weight reduction and nutrition programs in churches, social clubs, voluntary agencies, and neighborhood groups.

Recommendation 4.12: Increase access of minority diabetics to annual eye examinations and opthamologist provided laser therapy.

## GOAL 5: HOMICIDE, SUICIDE AND UNINTENTIONAL INJURIES - TO PREVENT BLACK AND MINORITY DEATHS AND DISABILITY DUE TO HOMICIDE, SUICIDE, AND UNINTENTIONAL INJURIES.

### Raising Public Consciousness

Recommendation 5.1: Develop a statewide education and awareness campaign to focus continued attention on the magnitude and seriousness of the problem of homicide and related violent behaviors.

5.1.1: Designate a statewide Violence Prevention Awareness Month.

5.1.2: Hold periodic interactive radio and television broadcasts to highlight the problems of homicide and suicide, and to receive remedial recommendations from the community. Several Baltimore television and radio stations have had an interest in this type of forum.

5.1.3: Empower minority citizens to press more actively for comprehensive efforts at violence prevention.

Recommendation 5.2: Establish community consortia on homicide prevention, similar to the Kansas City Ad Hoc Group Against Crime.

Recommendation 5.3: Incorporate an awareness of homicide and violence prevention strategies in training programs for health and law enforcement personnel, including police officers and emergency room and ambulance staff.

5.3.1: Fund training programs for appropriate staff in community health centers, hospital emergency rooms, crisis centers and police departments which center on crisis intervention, conflict resolution and the treatment of victims and co-victims of violence.

## Implementing Prevention Strategies

Recommendation 5.4: Establish an Office of Violence Prevention in the DHMH to be concerned with the prevention of homicide and other assaultive behaviors.

5.4.1: Encourage coordination among other State departments and agencies.

The Commission found that very little attention has been given to issues of homicide, violence and unintentional injuries by Maryland's public health system. Homicide and unintentional injuries are public health problems because they are leading causes of premature minority mortality and because they are linked to substance abuse and mental heath.

A public health approach to the prevention of homicide, violence, and unintentional injuries would require that disparate community groups, academic, and government agencies work in a coordinated manner to combat these complex problems.

The Commission recommends that an office or unit in the State's Department of Health and Mental Hygiene be designated to monitor trends in homicide and injuries and to facilitate the implementation of prevention strategies. Prototypes for such an office exist in several states, including Pennsylvania and Missouri.

Recommendation 5.5: Establish a Center for Violence Prevention Research at one of the State's predominately minority urban colleges and universities.

5.5.1: Develop demonstration projects, public information materials and workshops focusing on violence prevention and targeted at minority urban youths and young adults.

The Commission has identified a clear gap in development and coordination of research, policies, and strategies concerned with the prevention of violence in Maryland's minority communities. The Commission recommends that a Center for Violence Prevention be established and based at one of the State's predominantly Black college campuses. This Center would serve as an interagency conduit for information dissemination, training, and research on violence prevention. This Center would be expected to study the dimensions and causes of violent behavior and to identify strategies to prevent violence in Maryland.

An Executive Council on Violence Prevention could serve as the Center's policy-making board. This Council should include representatives from the Departments of Health and Mental Hygiene, Human Resources, Education, Public Safety and Correctional Services, and Juvenile Services; the State's Attorney's Office, and the Baltimore City and Prince George's County Police Departments. Representatives of recognized community based violence prevention programs, such as Stop the Killing, should also be appointed.

Recommendation 5.6: Develop community based programs (e.g., schools and churches) that foster the development of positive self esteem among Black and minority adolescents.

Recommendation 5.7: Implement school programs which teach children and youth non-violent means of resolving conflict.

Recommendation 5.8: Implement parenting programs which assist parents in raising children who are equipped to handle stress without violence.

Recommendation 5.9: Decrease Black youth and young adult unemployment through the development and funding of government and private sector programs.

Recommendation 5.10: Support legislation which bars access to hand guns.

Recommendation 5.11: Improve data and surveillance systems.

5.11.1: Develop a brief instrument for emergency room and ambulance personnel use which documents the nature of assaultive injuries.

## GOAL 6: SUBSTANCE ABUSE - TO PREVENT AND TREAT MINORITY SUBSTANCE ABUSE.

### Preventing Substance Abuse

Recommendation 6.1: Establish appropriate mandatory health education programs in the public schools at the elementary, middle, and secondary levels.

Substance abuse, AIDS, teen pregnancy, homicide, and suicide are among the issues which are currently confronting adolescents of all races in Maryland. Often, these issues are likely to disproportionately affect Black and minority children and adolescents. Therefore, it is extremely important, now more than ever, that children and adolescents be given the information and guidance which may help to prevent substance abuse, teen pregnancy, homicide, suicide and other health-related problems. It is vitally important that health education curricula and programs in the schools be used to assist in this effort.

**Recommendation 6.2:** Support and implement the substance abuse education recommendations outlined in the 1986 Maryland State Bar Association report on adolescent substance abuse.

- Harmfully Involved: Maryland Youth in Crisis, a 1986 report by a Maryland State Bar Association sponsored task force, contains over 50 recommendations designed to address what was termed as Maryland's "adolescent drug epidemic." The Commission endorses the report's recommendations which address substance abuse awareness training for teachers; the development and implementation of drug/alcohol curriculum for grades K through 12; the establishment of school based self-help groups, counseling and treatment programs; and the placement of limitations on media programming which promote the use of chemical substances.

**Recommendation 6.3:** Develop, fund and implement programs built on culturally appropriate principles and designed to prevent the use and abuse of chemical substances among minority children and adolescents.

There are numerous innovative and model programs which could be funded and promoted by both the public and private sectors to discourage use of illegal substances among youth. Two such approaches identified by the Commission include Parents-In-Action Groups and After School Programs.

Parents In Action groups are composed of concerned parents who organize to convey the message that drug use is unacceptable and to help young people to resist the pressure to use drugs. This grassroots parent-oriented approach has been successfully used by a predominantly Black parent-community organization in Oakland, California since 1984. The National Institute on Drug Abuse has heralded this program as one potential method of preventing drug use among minority children and adolescents.

The Commission was excited to learn about another low cost strategy designed to prevent substance abuse among minority youth. The S.A.N.D. youth drug prevention program is an after school program in West Baltimore which helps enrolled youth to develop positive self-esteem as one means of combating substance abuse. The program teaches decision-making and coping skills and emphasizes goal setting, goal attainment, and the importance of an education. Tutoring, educational, and cultural awareness programs are also components. Similar programs could be replicated in other inner city schools.

Private efforts directed at preventing substance abuse, such as the development of "Just Say No" clubs in the schools by a local sorority in Maryland, should also be encouraged and supported.

**Recommendation 6.4:** Develop and support media campaigns which counter advertising attempts to promote smoking and substance abuse in minority communities.

**6.4.1:** Encourage Black publications to bar alcohol and smoking advertisements.

There is increasing evidence that Blacks are being heavily targeted by the alcohol and tobacco industries. Aggressive educational campaigns and outreach activities which deglamourize substance abuse within minority communities are needed. There is a role for both the public and private sectors to play.

**Recommendation 6.5:** Encourage community organizations, such as churches and neighborhood groups, to take a more active role in preventing and controlling substance abuse.

Minority-community-based institutions are encouraged to play a greater role in prevention and control of substance abuse in their respective communities. For example, substance abuse prevention training programs for community and church leaders could be established. Substance abuse education and peer leadership training programs could also be developed in housing projects, following the Chicago example. Formerly addicted individuals could also be recruited and organized to assist in helping other community residents to stop abusing drugs.

## Improving Access to Substance Abuse Treatment

**Recommendation 6.6:** Support the development, funding, and implementation of programs which allow and encourage substance abuse providers to use a holistic treatment approach.

It is the Commission's strong belief that in order for treatment programs to be successful, treatment protocols which address the myriad of factors which may be related to a client's abuse of drugs or alcohol must be adopted. While dealing with the primary problem of substance abuse is the first priority, other problems confronting the individual, and which may affect treatment outcome should not be ignored. For example, mechanisms for referral for medical services, physical exams, mental health evaluations, and job training and placement programs should be routine.

The Commission heard testimony from several treatment providers who stressed the need to include job training and placement programs as a component of the treatment protocol when working in Black and other minority communities. These programs were funded during the seventies, but were subsequently eliminated due to federal and State budget cuts in the eighties. Treatment providers noted that treatment completion rates were higher when these programs existed. Job training and placement programs could be developed through a partnership with private organizations such as Private Industry Councils.

**Recommendation 6.7:** Provide a continuum of services for low income substance abusers including, publicly-sponsored residential treatment programs for drug abusers and treatment programs for hard core recidivistic substance abusers.

There are currently few publicly funded residential intermediate care facilities and halfway houses for primary drug abuse patients in Maryland. This leaves a serious gap in the continuum of care for low and middle income substance abusers. Clients are left with one of two choices - outpatient services or long-term therapeutic treatment which may last from 12 to 24 months. Quarterway and halfway houses are desperately needed to fill the void.
Publicly funded residential programs could be piloted within various hospitals in the State. By utilizing the hospital setting, the halfway or quarterway house could avoid the community backlash or zoning difficulties that have made it

difficult to open these programs in the past. New and innovative programs are also needed to reach and help the hard core recidivistic substance abuser.

**Recommendation 6.8:** Expand Medicaid coverage of, and reimbursement for, substance abuse treatment services.

Maryland's Medicaid Program currently provides reimbursement for a maximum of 7 days for detoxification services. This time frame works well for alcohol detoxification which usually takes 5 to 7 days, however, most drug detoxification takes from 10 to 15 days. Hence, some providers may refuse to admit a Medicaid client for drug detoxification because of inadequate reimbursement. In addition, outpatient services for drug and alcohol are covered by Medicaid, but the reimbursement only covers about 10% of the cost.

The Commission recommends that Medicaid reimbursement for detoxification be extended to cover up to 14 days of treatment. Increasing the coverage by Medicaid to 14 days would extend drug detoxification to greater numbers of Medicaid clients. Additionally, it is recommended that Medicaid reimbursement be allocated to the State scale for substance abuse treatment programs in the same way that mental health and family planning services are reimbursed.

**Recommendation 6.9:** Encourage treatment providers to accurately determine the race and/or ethnicity of clients.

Available information and data seem to suggest that non-Black minorities in Maryland are not using substance abuse treatment programs at the level that might be expected. For example, Hispanics comprise 1.5% of the State's population, but only 0.5% of clients in certified treatment facilities in 1986. The Commission heard anecdotal testimony about Native American Indians and to some extent Hispanics being mislabelled as Black or White. In addition, the Commission's survey of treatment provider found that a few (5 of the 20 responding providers) determined a client's race without asking the client. It is recommended that treatment providers be encouraged to implement procedures which ensure the accurate identification of the race and ethnicity of clients.

**Recommendation 6.10:** Train additional Black and minority health professionals to serve as substance abuse treatment providers, administrators, researchers, and policy-makers.

**Recommendation 6.11:** Require substance abuse treatment providers who work with minorites to complete cross-cultural training programs.

The Commission heard testimony from numerous substance abuse treatment providers who noted that treatment programs may appear to be less threatening to minorities when staff are representative of the community being served. It is also important for counselors and program administrators serving minority individuals to be culturally sensitive.

In 1984, the State's Alcoholism Control Administration embarked on a program to provide training for staff in the central office and throughout the State's

treatment continuum about the unique needs of women with alcohol abuse or addiction problems. This training covered two and one half years and used one consultant. Sexism and sexist attitudes were challenged and appropriate knowledge, skills and attitudes were proffered. As a result, there was a significant increase in the number of women seeking services and three new halfway houses for women were funded. This model could be replicated to address the treatment needs of Blacks and minorities.

**Recommendation 6.12:** Conduct studies which examine minority substance abuse prevalence and patterns in Maryland.

In the future, it is strongly recommended that any State commissioned studies of substance abuse prevalence include race/ethnicity as a variable. The selected sample sizes should be large enough to allow for an examination of variations in the prevalence and use of substance abuse services within major racial/ethnic groups in Maryland.

## GOAL 7: MENTAL HEALTH - TO IMPROVE THE MENTAL HEALTH OF BLACK AND MINORITY MARYLANDERS.

**Recommendation 7.1:** Increase access to psychiatric services for children and adolescents by:

**7.1.1:** Increasing the number of acute and long term psychiatric beds for children and adolescents, and

**7.1.2:** Increasing the availability of outpatient psychiatric services for children and adolescents.

This is a crisis area. There is no adequate system for inpatient psychiatric care for adolescents and children under the age of 12. Currently, all central Maryland state operated adolescents facilities are overcrowded, and it is difficult to gain access to these services. In addition, there have been a number of middle class and poor minority children below the age of 12 who have nowhere to go because services are not available. Consequently, these children are often referred for expensive out of state placements. It would be more financially feasible to appropriate funds to treat these children so as to discourage expensive out of state placement.

In many instances, children and adolescents, unlike adults, are clearly defined in the psychiatric literature as needing more long term care in order to reconstitute their normal functioning and return to the community. It is evident nationwide that many of the long term care needs are for periods of six to twelve months of intensive psychiatric treatment. Maryland has neither the beds nor an environment conducive to private providers to create these beds.

The number of clinicians to serve children and adolescents in the State is far below adequate levels. The Commission heard testimony that only one certified child psychiatrist is employed in the entire Mental Hygiene Administration. In addition, testimony was heard that there is a wait of several months for a

psychiatric evaluation for children, particularly if the child is poor and of a minority race. There were cases presented by a number of professionals that told of inadequate outpatient services being provided and a child's needs being ignored until that child became involved with the law or became so severely ill that the only recourse was an expensive hospital placement.

**Recommendation 7.2:** Develop a cost-effective network of mental health prevention services.

**7.2.1:** Expand high risk infant identification programs beyond the current pilot stage.

**7.2.2:** Develop mental health screening and referral programs within the public schools.

(See Recommendation 2.10)

## Improving Access to Mental Health Services

**Recommendation 7.3:** Develop data and research bases which examine the mental health problems and needs of Black and minority populations.

**7.3.1:** Develop a comprehensive data system to be used in planning services for minorities.

**7.3.2:** Expand the Mental Hygiene Administration's management information system to include outpatient facilities.

**7.3.3:** Encourage further research into the mental health needs of Blacks and minorities.

There are no prevalence estimates for mental disorders by race in Maryland. The extent of mental disorders in Maryland's minority community is currently unknown. In order for the Mental Hygiene Administration to better serve the needs of the Black and minority populations it is clear that the Administration must have a better data system upon which to base its plans.

The current Management Information System should be expanded and the Mental Hygiene Administration should be instructed to include data systems that permit the collection and retrieval of information on Black and minority populations. Institutions of higher education in Maryland should be encouraged to research the mental health needs of Black and minority populations.

**Recommendation 7.4:** Assure adequate reimbursement for psychiatric care.

**7.4.1:** Increase Medicaid reimbursement for psychiatric care.

**7.4.2:** Develop special financial incentives to promote access to private hospitals.

7.4.3: Assure that mandated psychiatric benefits are preserved and increased.

Poor Black and minority populations are, for the most part, excluded from private psychiatric services. Private practitioners who accept Medicaid are currently reimbursed at approximately one-third the usual and customary fee for psychiatric services. Because of this, poor and lower middle class Black and minority populations are unable to access private psychiatric services. In many instances, this lack of access leads to a deterioration of the mental health of the individual so that eventually expensive psychiatric hospitalization is required.

Recommendation 7.5: Develop a public relations campaign that decreases the stigma attached to mental illness and informs the general population of services available.

The State, in cooperation with the advocacy and professional groups, should develop a public relations campaign geared toward decreasing the stigma attached to mental illness as well as inform the population of the services that are available.

Recomendation 7.6: Expand the pool of mental health professionals and emphasize training in cross-cultural issues.

Recommendation 7.7: Modify the Mental Hygiene Administration's 5 Year Plan to include outreach and employee assistance programs. Fund and support the Plan.

## GOAL 8: THE BLACK AND MINORITY ELDERLY - TO INCREASE ACCESS TO COMMUNITY BASED LONG TERM CARE AND MENTAL HEALTH SERVICES FOR THE BLACK AND MINORITY ELDERLY.

Recommendation 8.1: Develop innovative methods of increasing minority elderly awareness of the availability of health and social support services.

The minority elderly are less likely than the White elderly to seek and use health and social support services. A lack of awareness of the availability of health services and how to access them is thought to serve as a major barrier to the use of these services.

Recommendation 8.2: Increase the availability of community-based long term care services for the elderly, including medical and social support services.

Recommendation 8.3: Expand community based services by training additional home health aides through the Senior Aide Program.

The Senior Aide Program is an employment program for older low income men and women. If offers part-time training and jobs and agencies address unmet community needs. Senior aides are trained and placed in a number of settings,

such as senior centers. More senior aides, particularly minorities, could be trained and placed in private sector home health agencies.

**Recommendation 8.4:** Increase the number of minority health professionals and paraprofessionals working in programs and institutions which serve large numbers of the minority elderly.

**Recommendation 8.5:** Develop a comprehensive network of mental health services for the elderly.

An outreach and early identification and intervention network could be provided based on the Geriatric Evaluation Service model. The model could be expanded so that the elderly receive evaluation and treatment services earlier in their illness and avoid expensive inpatient hospitalization.

## GOAL 9: OVERSIGHT AND DATA COLLECTION - TO FACILITATE THE IMPLEMENTATION OF INNOVATIVE AND CULTURALLY APPROPRIATE COMMUNITY BASED MINORITY HEALTH STRATEGIES AND TO MONITOR PROGRESS IN IMPROVING MINORITY HEALTH.

**Recommendation 9.1:** Establish a Maryland Commission on Black and Minority Health.

The magnitude and seriousness of minority health problems in Maryland warrant the need for ongoing attention to this issue. A Commission could develop minority health goals, monitor minority health status, recommend policy options, and facilitate the implementation of minority health strategies. The Commission should include a representative body of Black and other minority consumers, health care providers, educators, business leaders, and public officials. The Ohio Commission on Black and Minority Health serves as a prototype.

**Recommendation 9.2:** Require birth and death certificates in Maryland to include codes for all major racial and ethnic groups in Maryland.

The major sources of data for natality, mortality and morbidity statistics are birth and death certificates which are analyzed and reported annually by the Maryland Center for Health Statistics. Information on the race of the individual is requested on both certificates. The most recently published reports generally display the data according to racial groupings, most commonly "White and nonWhite" or "White, Black and other." Data which describe American Indians and Asian/Pacific Islanders are available but usually are not published. Additionally, ethnicity is currently not recorded on birth or death certificates in Maryland. Since Hispanics are generally recognized as an ethnic group and not a racial group, vital statistics for this population are currently unavailable.

**Recommendation 9.3:** Encourage data collection and research efforts which further investigate the factors which influence Black and minority health status and access to health services.

In order to develop appropriate strategies to address continuing minority/White differentials in health status in Maryland, a better understanding of the health needs and problems of Blacks and minorities is required. However, the Commission continually found that existing data and information concerning the health problems, needs, and utilization patterns of Blacks and minorities in Maryland to be inadequate.

Many publicly and privately funded health programs either do not collect racial information or may limit it to "White," "Black," or "Other." In addition, intake workers may not correctly identify the race of clients. For example, the Commission heard about an American Indian women who recently gave birth to a baby in a Maryland hospital and requested that the baby's racial identity be listed as American Indian. However, the hospital staff person refused her request; claiming that the parents did not look Indian.

In some cases, prevalence and incidence data for certain diseases and conditions (e.g., substance abuse and mental health problems) are not available by race. Ongoing or special studies which evaluate the effects of Maryland health programs and strategies on health status or health outcomes are virtually nonexistent.

At a minimum, the Commission recommends that the following studies and data collection efforts be undertaken:

- a determination of the prevalence of selected conditions by race/ethnicity including mental health problems and substance abuse;
- an examination of the health problems and needs of Blacks, Native Americans, Hispanics and Asian/Pacific Islanders living in Maryland;
- an evaluation of the impact of current publicly funded programs on health status and outcomes, including an assessment of access to, and use of maternal and child health, substance abuse, disease prevention and treatment, and mental health programs; and
- an analysis of the recruitment, training, hiring and promotion experiences of Blacks and minorities in Maryland's health industry.

# MARYLAND GOVERNOR'S COMMISSION ON BLACK AND MINORITY HEALTH

## COMMISSION GOALS AND RECOMMENDATIONS:

## THE ACTION AGENDA

The Commission condensed its goals and recommendations into the attached 20 page Action Agenda. This Action Agenda arrays the Commission's 86 recommendations according to 9 broad goals and several sub-goals. The Action Agenda also identifies agencies and individual who would be instrumental in facilitating action on the goals and recommendations, and where available, also provides estimated implementation costs.

The recommendations presented do not claim to be the definitive answers to solving Black and minority health problems. However, it is hoped that they will be viewed as an important initial agenda for addressing priority Black and minority health problems in Maryland.

## ACTION AGENDA

**Governor's Commission on Black and Minority Health**
**Goals and Recommendations for Improving Black and Minority Health in Maryland**

| Goals & Recommendations | Responsible and Involved Parties | Estimated Costs |
|---|---|---|
| **BLACK AND MINORITY HEALTH MANPOWER** | | |
| **GOAL 1: TO TRIPLE BLACK AND MINORITY REPRESENTATION IN THE HEALTH PROFESSIONS AND IN KEY HEALTH POLICY POSITIONS BEFORE THE YEAR 2000.** | | |
| Motivating Black and Minority Students to Pursue Health Careers | | |
| 1.1 Establish a statewide Extra-Curricular Health Professions Career Exploration Program targeted to elementary, middle, and high schools with significant numbers of Black and minority students. | MCBMH,DHMH,MSDE, colleges & universities, health professions associations | $500,000 |
| 1.2 Prepare and encourage middle and high school guidance counselors, faculty, and staff to promote the health professions. | Health professionals, MSDE,local schools, MCBMH | Minimal, use volunteers |
| 1.2.1 Offer seminars which provide counselors with information about health careers preparation. | | |
| 1.3 Ensure that Dunbar High School, the State's only health career magnet school, has the resources necessary motivate, educate and train Black and minority students interested in the health professions. | MSDE, BCPS, Dunbar faculty & staff, community & political leaders | Not available |
| Improving the Educational Preparation of Black and Minority Students | | |
| 1.4 Strengthen the academic capabilities and achievements of Black and minority students. | MSDE,local school districts, parents, community & political leaders, churches, advocacy groups | Not available |
| 1.4.1 Provide preventive intervention programs which diminish and correct learning problems. | | |

| Goals & Recommendations | Responsible and Involved Parties | Estimated Costs |
|---|---|---|
| **Manpower (Cont'd)** | | |
| 1.4.2 Develop supportive programs which encourage Black and minority students to remain in school. | | |
| 1.4.3 Implement the career education concept in the public schools. | | |
| 1.5 Motivate and prepare Black and minority students to take math and science courses. | | |
| 1.5.1 Promote the use of Science Weekly, a weekly reader which stimulates student interest in the sciences, in elementary schools. $6.75/student/year | MSDE, parents, community leaders, MCBMH, DHMH, colleges & universities, local school districts | Not available |
| 1.5.2 Train and hire more Black and minority science and math teachers to serve as role models. | | |
| 1.5.3 Develop and implement middle, high school, and college math and science tutorial and enrichment programs. | | |
| **Strengthening Minority Recruitment and Retention Efforts** | | |
| 1.6 Encourage Maryland health and allied health professions programs to develop policies and programs which enhance the recruitment and retention of underrepresented minorities. | SBHE, UMAB, other universities & colleges DHMH | Minimal |
| 1.7 Monitor minority enrollment and retention trends in the State's health and allied professions programs. | MCBMH, SBHE | Minimal |
| 1.8 Advocate strongly for increased federal funding of financial aid programs for low-income students. | Governor's Office of National Relations, Congressional Delegation | None |
| 1.9 Develop and strengthen feeder systems between high schools, undergraduate colleges, and health and allied health professions programs in Maryland. | Colleges & universities, MSDE, schools, DHMH | Minimal |

| Goals & Recommendations | Responsible and Involved Parties | Estimated Costs |
|---|---|---|
| **Manpower (Cont'd)** | | |
| 1.9.1 Evaluate and strengthen undergraduate and graduate faculty commitment to helping minority students succeed. | MCBMH,Colleges & universities | Not Available |
| 1.9.2 Prepare and support minority students to enter honors programs with direct tracks into Maryland's health professions programs. | Colleges & universities SBHE, MCBMH | |
| 1.9.3 Develop and implement a model State approach to the recruitment and retention of Black and minority health professions students in Maryland. | Colleges & universities, SBHE | Not available |
| 1.9.4 Involve college and university faculty in the upgrading of high school and college science curricula in Maryland. | Colleges & universities, Schools | Not available |
| **Providing Adequate Financial Assistance for Low-Income Students** | | |
| 1.10 Increase the number of State and privately funded sources of financial assistance for low income students. | Legislature, Community & political leaders, health professions associations, churches | $100,000 |
| 1.10.1 Expand the number of scholarships and low interest loans available to low-income students through the State Scholarship Board. | | |
| 1.10.2 Encourage health professions associations, churches, and groups to adopt and support health professions students. | | |
| **Increasing Black and minority representation in Maryland's Health Industry** | | |
| 1.11 Establish a five year Minority Health Executive Program to facilitate the advancement of Black and minorities into upper level managerial and policy-making positions in Maryland's health industry. | DHMH, Health Facilities & Organ., MCBMH | $50,000 to hire a Program Coordinator |

## ACTION AGENDA

**Governor's Commission on Black and Minority Health**
**Goals and Recommendations for Improving Black and Minority Health in Maryland**

| Goals & Recommendations | Responsible and Involved Parties | Estimated Costs |
|---|---|---|
| **Manpower (Cont'd)** | | |
| 1.12 Encourage public and private health-related boards and commissions to attain memberships which are ethnically and racially reflective of the communities served. | MCBMH, DHMH Boards & Commission | Minimal |
| 1.13 Encourage State and local health departments to recruit and promote health professionals who are racially ethnically reflective of the communities served. | EEOC, DHMH, LHDs, Legislature | Minimal |
| 1.13.1 Investigate salary inequities between local health departments and the private sector which serve as impediments to the recruitment and retention of public health professionals. | DOP,DHMH, LHDs | Not available |
| 1.13.2 Appropriate new monies to the DHMH to hire additional community health nurses. (New hires should include an equitable percentage of Black and minority nurses). | DHMH, LHDs Legislature | Approximately $30,000 per nurse |
| 1.14 Monitor the recruitment, training, hiring, and promotion experiences of Blacks and minorities in Maryland's health industry. | MCBMH,DHMH DOP, EEOC | Not available |
| 1.15 Institute mechanisms to promote the rapid certification of immigrants with professional backgrounds. | DOP, DHMH | Not available |
| 1.16 Promote the provision of cross-cultural training and awareness programs in health professional education and in-service training programs. | Colleges & universities DHMH, LHDs, health profession & facility assoc. | Not available |

## ACTION AGENDA

Governor's Commission on Black and Minority Health
Goals and Recommendations for Improving Black and Minority Health in Maryland

| Goals & Recommendations | Responsible and Involved Parties | Estimated Costs |
|---|---|---|
| **CHILD, ADOLESCENT AND FAMILY HEALTH** | | |
| **GOAL 2: TO IMPROVE THE HEALTH OF MARYLAND'S BLACK AND MINORITY INFANTS, CHILDREN, ADOLESCENTS, AND FAMILIES.** | | |
| Reducing Infant Mortality and Low Birthweight | | |
| 2.1 Appoint a Maryland Advisory Council on Infant Mortality. | DHMH, Legislature | $40,000 - for support staff |
| 2.2 Improve access to prenatal and infant care services by: | | |
| 2.2.1 Provide health insurance coverage for all infants and pregnant women with incomes between 100% and 200% of the poverty level. | DHMH, Legislature, Governor | $25-42 million |
| 2.2.2 Ensuring the availability of an "enriched package" of prenatal and infant health services for all pregnant women and infants with incomes below 200% of the poverty level in each jurisdiction. | DHMH, Legislature, Governor | Not available |
| 2.3 Direct the Secretary of DHMH to develop and coordinate the implementation of a community-based long range strategic plan to reduce infant mortality. | DHMH, DHR, Governor, Legislature | Minimal |
| 2.4 Direct State and local health departments to systematically determine ways in which current programs can be modified to be most responsive to efforts aimed at reducing infant mortality. | Governor, DHMH | Minimal |
| 2.5 Develop and expand home visiting and other programs which provide outreach, education, and case management services to at-risk infants and expectant mothers to assure timely receipt of prental care, postpartum care, and infant health services. | Governor, DHMH, DHR MSDE, Legislature, BCHD, DHMH | Not available |
| 2.5.1 Replicate the Baltimore's Best Babies and Prince George's County Infants At Risk Programs in in other jurisdiction. | | |

## ACTION AGENDA

**Governor's Commission on Black and Minority Health**
**Goals and Recommendations for Improving Black and Minority Health in Maryland**

| Goals & Recommendations | Responsible and Involved Parties | Estimated Costs |
|---|---|---|
| **Child, Adolescent & Family Health (Con'd)** | | |
| 2.6 Develop a systematic approach to identifying high risk pregnancies and referring women-at-risk for premature labor into appropriate facilities within each jurisdiction. | DHMH | Not available |
| 2.7 Provide culturally relevant counseling and educational programs to encourage healthy behaviors and to reduce the risks associated with smoking, poor nutrition, and substance abuse. | DHMH, DHR, Community leaders | Not available |
| 2.8 Increase and promote access to reproductive health services for low income women, including annual preventive check-ups and health screenings. | DHMH | Not available |
| 2.9 Ensure the adequate availability of family planning services in each jurisdiction to prevent unwanted and unplanned pregnancies. | DHMH | Not available |
| 2.10 Improve the effectiveness of the Women, Infants and Children (WIC) Program. | DHMH | Not available |
| Reducing Adolescent Pregnancy | | |
| 2.11 Encourage the Governor's Council on Adolescent Pregnancy, DHMH, DHR, and MSDE, to target and implement culturally relevant educational and prevention strategies in targeted high risk Black and minority communities. | GCAP, DHMH, DHR, MSDE, community, religious and political leaders | Not available |
| 2.12 Evaluate the effectiveness of the Prenatal Assistance Program in improving access to and utilization of prenatal and other health and social support services for Black and minority adolescents. | DHMH | Minimal |

Governor's Commission on Black and Minority Health
Goals and Recommendations for Improving Black and Minority Health in Maryland

| Goals & Recommendations | Responsible and Involved Parties | Estimated Costs |
|---|---|---|
| **Child, Adolescent and Family Health (con'd)** | | |
| Promoting Healthly and Positive Youth Development | | |
| 2.13 Direct the Departments of Health and Mental Hygiene, Human Resources, and Education, and the Office of Children and Youth to develop and coordinate a continuum of early identification and intervention programs and strategies to prevent the development of chronic health, psycho-social, learning, and behavioral problems in high and at-risk children and adolescents. | DHMH, DHR, MSDE OCY, Governor, Legislature | Not available |
| 2.13.1 Identify and prioritize communities requiring targeted intervention. | | |
| 2.13.2 Expand the availability of pre-school programs, such as Head Start. | | |
| 2.13.3 Provide school health services in every public school. | | |
| 2.13.4 Develop comprehensive school based health services in high risk communities. | | |
| 2.13.5 Provide funding to enable public schools and local health departments to hire health professionals to identify and treat children and adolescents who exhibit or are at-risk of acquiring learning, mental health, psycho-social or chronic health problems. | | |
| 2.13.6 Develop a comprehensive network of services to detect and treat sickle cell disease. | | |
| 2.13.7 Develop and expand parenting and family support programs. | | |
| 2.13.8 Increase the availability of comprehensive primary care services for children, particularly in rural areas of Maryland. | | |

## ACTION AGENDA

**Governor's Commission on Black and Minority Health**
**Goals and Recommendations for Improving Black and Minority Health in Maryland**

| Goals & Recommendations | Responsible and Involved Parties | Estimated Costs |
|---|---|---|
| **THE MEDICALLY INDIGENT** | | |
| **GOAL 3: TO IMPROVE ACCESS TO A RANGE OF HEALTH SERVICES AND PROGRAMS FOR MEDICALLY INDIGENT (I.E., THE LOW-INCOME UNINSURED AND MEDICAID RECIPIENTS) BLACKS AND MINORITIES.** | | |
| Improving Access for the Low-Income Uninsured | | |
| 3.1 Develop, fund and implement programs and strategies which improve access to health insurance coverage and health care services for the low-income uninsured. | DHMH, Governor, Legislature, Businesses, Health facilities, professional associations and organizations | |
| 3.1.1 Develop and implement a comprehensive strategy using a five year phase-in to provide health insurance coverage for all Maryland individuals with incomes below 200% of the poverty level. | | $122-500 million |
| 3.1.2 Increase Medical Assistance income eligibility limits to 133.3% of the AFDC monthly cash payment level as allowed by Federal regulations. | | $5 million: State share |
| 3.1.3 Ensure that Maryland maintains its "waiver" of regular Medicare and Medicaid reimbursement principles by the Department of Health and Human Services. | | Not available |
| 3.1.4 Develop and implement demonstration projects which increase access to primary health care services for medically indigent Black and minorities. | | $30,000-initial recommended strategy |
| 3.1.5 Support the efforts of the Alliance for Responsible Health Policy in the development of recommendations that address financing health care for the medically indigent. | | None |
| 3.1.6 Extend Medicaid coverage to poor children under age five over the next four years as allowed by the Sixth Omnibus Budget Reconciliation Act. | | $1 million to cover 2 year olds in 1988 |

| Goals & Recommendations | Responsible and Involved Parties | Estimated Costs |
|---|---|---|
| **The Medically Indigent (Con'd)** | | |
| 3.1.7 Promote the development of private sector initiatives for the uninsured, such as Maryland Blue Cross and Blue Shield's Caring Program. | MCBMH, DHMH Businesses, Legislature | Not available |
| **Improving Access for Medical Assistance Enrollees** | | |
| 3.2 Provide rigorous client education to Medicaid recipients to discourage the inappropriate use of emergency rooms and outpatient departments as primary care providers; and encourage the use of community health centers and other appropriate low-cost providers. | DHMH, Health Professionals | Not available |
| 3.2.1 Increase the numbers of Medicaid providers. | | |
| 3.3 Improve the effectiveness of the Early Periodic, Screening, Diagnosis and Treatment (EPSDT) Program. | DHMH | Not available |
| **Improving Resource Availability and Health Services Utilization** | | |
| 3.4 Monitor trends and develop policies and programs to address identified racial disparities in access to, and use of hospital, nursing home, and ambulatory care services as documented in several recent Maryland reports. | DHMH, MCBMH, Legislature, Health facility and professional associations | Not available |
| 3.5 Develop and implement a State manpower strategy which addresses the maldistribution of health care resources in Maryland. | DHMH, colleges & universities | Not available |
| 3.6 Provide financial and other incentives, such as increased Medicaid reimbursement, to attract and maintain primary care providers in medically underserved inner city and rural areas. | DHMH, Legislature, colleges & universities | Not available |
| 3.6.1 Increase Medicaid reimbursement levels for providers practicing in medically underserved inner city and rural areas. | | |
| 3.6.2 Expand and develop State educational loan programs, similar to the federal National Health Services Corps (NHSC) Program. | | |

| Goals & Recommendations | Responsible and Involved Parties | Estimated Costs |
|---|---|---|
| **The Medically Indigent (Cont'd)** | | |
| 3.6.3 Subsidize the practices of primary care practitioners willing to locate in areas of need (e.g., low interest loans or grants to establish a practice). | | Not available |
| 3.7 Improve access to dental services for Blacks and minorities. | DHMH, Dental Associations | Not available |
| 3.7.1 Require Medicaid coverage of dental services for adults. | | |
| **PREVENTING MORTALITY AND MORBIDITY** | | |
| **GOAL 4: TO PREVENT EXCESS BLACK AND MINORITY MORTALITY AND MORBIDITY** | | |
| Preventing AIDS | | |
| 4.1 Develop and expand innovative and culturally sensitive AIDS prevention, outreach, and education programs targeted to high risk minority individuals and communities. | DHMH, HERO, Community, political & religious leaders, Advisory Council on AIDS | Not available |
| 4.1.1 Use the media to deliver culturally relevant prevention messages to Blacks and Hispanics. | | |
| 4.1.2 Create and support minority street outreach programs. | | |
| 4.1.3 Provide training sessions for health professionals, drug abuse counselors, and others who may come in contact with individuals at risk of contracting AIDS. | | |
| 4.1.4 Include information on AIDS in the school health education curriculum. | | |
| 4.1.5 Develop and maintain adequate prevention and treatment resources. | | |
| 4.2 Develop, fund, and implement additional AIDS education and outreach programs targeted toward Black and Hispanic intravenous drug abusers. | DHMH, HERO Community, political & religious leaders | Not available |

## ACTION AGENDA

**Governor's Commission on Black and Minority Health**
**Goals and Recommendations for Improving Black and Minority Health in Maryland**

| Goals & Recommendations | Responsible and Involved Parties | Estimated Costs |
|---|---|---|
| **Preventing Mortality and Morbidity (Con'd)** | | |
| Reducing Cardiovascular, Cancer & Diabetes Risk Factors | | |
| 4.3 Maintain and expand existing community based risk reduction programs using churches, neighborhood groups, other primary social support networks. | DHMH, Churches Community and Political leaders | $63,000 covers 25 churches |
| 4.3.1 Maintain the current State funded Church High Blood Pressure Program. | | |
| 4.3.2 Expand the Church High Blood Pressure Program to additional churches and community based settings in Baltimore City, Southern Maryland and on the Eastern Shore. | | |
| 4.4 Prevent and reduce smoking among Black and minority populations. | DHMH, MSDE | Not available |
| 4.4.1 Expand smoking prevention and peer resistance training programs in the schools. | DHMH, LHDs | |
| 4.4.2 Increase the number of smoking cessation programs for pregnant women. | DHMH | |
| 4.4.3 Increase smoking cessation programs targeted to Black males. | Governor, Legislature | |
| 4.4.4 Develop and implement policies and legislation to limit or discourage smoking. | DHMH | |
| 4.5 Encourage dietary habits which include decreasing salt intake, lowering cholesterol, reducing saturated fats and increasing fiber. | DHMH, MHBPC | Not available |
| 4.5.1 Hold Statewide and regional nutrition promotion programs. | | |

| Goals & Recommendations | Responsible and Involved Parties | Estimated Costs |
|---|---|---|
| **Preventing Mortality and Morbidity (Con't)** | | |
| 4.5.2 Develop culturally sensitive health education materials and media campaigns for dissemination of prevention messages in minority communities. | | |
| 4.5.3 Hold mass screening and education programs in minority communities. | | |
| 4.6 Develop and implement education programs to teach physicians and other health care providers who serve Black and minority populations, the counseling skills and health education strategies that have proven to be effective in controlling cardiovascular and cancer risk factors among minorities. | DHMH, Health Professional Associations, MHBPC | Not available |
| Cardiovascular Disease | | |
| 4.7 Develop, implement, and evaluate procedures to assess the cardiovascular risk factor status of persons at numerous points of contact with the health services delivery system. | DHMH, Heart Association, MHBPC | Not available |
| 4.8 Promote the control of hypertension minority populations with priority emphasis on young Black males and Black men over the age of 50. | DHMH, LHDs, Heart Association | Not available |
| Cancer | | |
| 4.9 Provide access to effective cancer screening, diagnosis and treatment resources for high risk minorities. | DHMH, Cancer Society, LHDs | Not available |
| 4.9.1 Develop and implement approaches to improve the rate of Pap testing among minority women. | | |
| 4.9.2 Develop programs to expand the availability of mammograms for low-income minority women. | | |

## ACTION AGENDA

**Governor's Commission on Black and Minority Health**
**Goals and Recommendations for Improving Black and Minority Health in Maryland**

| Goals & Recommendations | Responsible and Involved Parties | Estimated Costs |
|---|---|---|
| **Preventing Mortality and Morbidity (Cont'd)** | | |
| 4.9.3 Develop programs to expand the availability of colon cancer detection and treatment resources for minorities. | | |
| **Diabetes** | | |
| 4.10 Increase access to quality diabetic self care education. | DHMH, Diabetes Assoc., health providers | Not Available |
| 4.10.1 Develop a "lay trainer" program to disseminate information on glucose monitoring diabetic foot care, diet, insulin regulation and the importance of eye examinations, smoking cessation and high blood pressure control. | | |
| 4.10.2 Develop and implement professional education and diabetic care demonstration programs in primary care centers, local health departments and home health agencies. | | |
| 4.11 Reduce obesity and dietary fat intake in minority populations, particularly Black females, through community based weight reduction and nutrition programs in churches, social clubs, voluntary agencies and neighborhood groups. | DHMH, churches, Social groups | Not Available |
| 4.12 Increase access of minority diabetics to annual eye examinations and opthamologist provided laser therapy. | DHMH, Opthamologists, health providers | Not Available |

## ACTION AGENDA

Governor's Commission on Black and Minority Health
Goals and Recommendations for Improving Black and Minority Health in Maryland

| Goals & Recommendations | Responsible and Involved Parties | Estimated Costs |
|---|---|---|
| **HOMICIDE, SUICIDE AND UNINTENTIONAL INJURIES** | | |
| **GOAL 5: TO PREVENT BLACK AND MINORITY DEATHS AND DISABILITY DUE TO HOMICIDE, SUICIDE AND UNINTENTIONAL INJURIES** | | |
| Raising Public Consciousness | | |
| 5.1 Develop a statewide education and awareness campaign to focus continued attention on the magnitude and seriousness of homicide and related violent behaviors. | MCBMH,DHMH,DPSC, MSDE,Community, political and religious leaders | Not Available |
| 5.1.1 Designate a statewide Violence Prevention Awareness Month. | | |
| 5.1.2 Hold periodic interactive radio and TV broadcasts to highlight the problems of homicide and suicide, and to receive remedial recommendations from the community. | | |
| 5.1.3 Empower minority citizens to press more actively for comprehensive efforts at violence prevention. | | |
| 5.2 Establish community consortia on homicide prevention, similar to the Kansas City Ad Hoc Group Against Crime. | Community, political & religious leaders | Not Available |
| Implementing Prevention Strategies | | |
| 5.3 Incorporate an awareness of homicide and violence prevention strategies in training programs for health and law enforcement personnel, including police officers, and emergency room and ambulance staff. | Hospitals, Police departments,DHMH, Colleges and universities | Not Available |

| Goals & Recommendations | Responsible and Involved Parties | Estimated Costs |
|---|---|---|
| **Homicide, Suicide and Unintentional Injuries (Con'd)** | | |
| 5.3.1 Fund training programs for appropriate staff in community health centers, hospital emergency rooms, crisis centers and police departments which center on crisis intervention, conflict resolution and the treatment of victims and co-victims of violence. | DHMH | Not Available |
| 5.4 Establish an Office of Violence Prevention in the DHMH to be concerned with the prevention of homicide and other assaultive behaviors. | | |
| 5.4.1 Encourage coordination among other State departments and agencies. | MCBMH,Urban League,Colleges and universities | Not Available |
| 5.5 Establish a Center for Violence Prevention Research at one of the State's predominantly minority urban colleges and universities. | | |
| 5.5.1 Develop demonstration projects, public information materials and workshops focusing on violence prevention and targeted at minority urban youths and young adults. | Community, political & religious leaders | Not Available |
| 5.6 Develop community based programs (e.g., schools and churches) that foster the development of positive self esteem among Black and minority children. | | |
| 5.7 Implement and evaluate programs which teach children and youth non-violent means of resolving conflict and deter juvenile delinquency. | MSDE,local school districts,DPSC, OCY | |
| 5.7.1 Develop and replicate school based education programs which teach children how to manage hostility and aggression using non-violent means. | | |
| 5.7.2 Evaluate the effectiveness of the Patuxent Institute's voluntary "Reasoned Straight" Program in detering criminal behavior. | | |

## ACTION AGENDA

**Governor's Commission on Black and Minority Health**
**Goals and Recommendations for Improving Black and Minority Health in Maryland**

| Goals & Recommendations | Responsible and Involved Parties | Estimated Costs |
|---|---|---|
| **Homicide, Suicide and Unintentional Injuries (con'd)** | DHMH,DHR,OCY | Not Available |
| 5.8 Implement parenting programs which assist parents in raising children who are equipped to handle stress without violence. | Businesses,DEED | Not Available |
| 5.9 Decrease Black youth and young adult unemployment through the development and funding of government and private sector programs. | Legislature | Not Available |
| 5.10 Support legislation which bars access to handguns. | DHMH,DPSC, Health facilities, Police departments | Not Available |
| 5.11 Improve data and surveillance systems. | | |
| 5.11.1 Develop a brief instrument for emergency room and ambulance personnel use which documents the nature of assaultive injuries. | | |
| **SUBSTANCE ABUSE** | | |
| **GOAL 6: TO PREVENT AND TREAT MINORITY SUBSTANCE ABUSE** | | |
| Preventing Substance Abuse | MSDE, DHMH | Not Available |
| 6.1 Establish appropriate mandatory health education programs in the public schools at the elementary, middle and secondary levels. | MSDE, DHMH | Not Available |
| 6.2 Support and implement the substance abuse education recommendations outlined in the 1986 Maryland State Bar Association report on adolescent substance abuse. | | |

## ACTION AGENDA

**Governor's Commission on Black and Minority Health**
**Goals and Recommendations for Improving Black and Minority Health in Maryland**

| Goals & Recommendations | Responsible and Involved Parties | Estimated Costs |
|---|---|---|
| **Substance Abuse (Con'd)** | | |
| 6.3 Develop, fund and implement innovative programs built on culturally appropriate principles and designed to prevent the use and abuse of chemical substances among minority children and adolescents. | Schools, Community Groups, DHMH | Not Available |
| 6.4 Develop and support media campaigns which counter Madison Avenue advertising attempts to promote smoking and alcohol abuse in minority communities. | Community, political & religious leaders | Not Available |
| 6.4.1 Encourage black publications to ban alcohol and smoking advertisments. | | |
| 6.5 Encourage community organizations, such as churches and neighborhood groups to take a more active role in preventing and controlling substance abuse. | Churches, community leaders | Minimal |
| Improving Access to Substance Abuse Treatment | | |
| 6.6 Support the development, funding and implementation of programs which allow and encourage substance abuse providers to use a holistic treatment approach. | DHMH | Not Available |
| 6.7 Provide a continuum of services for low income substance abusers including, publicly sponsored residential treatment programs for drug abusers and treatment programs for hard core recidivistic substance abusers. | DHMH, treatment providers | Not Available |
| 6.8 Expand Medicaid coverage of and reimbursement for substance abuse treatment. | DHMH | Not Available |
| 6.9 Encourage treatment providers to accurately determine the race and ethnicity of clients. | DHMH | Minimal |
| 6.10 Train additional Black and minority health professionals to serve as substance abuse treatment providers, administrators, researchers and policy-makers. | DHMH, colleges & universities | Not Available |

| Goals & Recommendations | Responsible and Involved Parties | Estimated Costs |
|---|---|---|
| **Substance Abuse (Con'd)** | | |
| 6.11 Require treatment providers who work with minorities to complete cross-cultural training programs. | DHMH | Not Available |
| 6.12 Conduct studies which examine minority substance abuse prevalence and patterns. | DHMH | Not Availat |
| **MENTAL HEALTH** | | |
| **GOAL 7: TO IMPROVE THE MENTAL HEALTH OF BLACK AND MINORITY MARYLANDERS** | | |
| Improving access to mental health services for children and adolescents | | |
| 7.1 Increase access to psychiatric services for children and adolescents by: | DHMH | Not Available |
| 7.1.1 Increasing the number of acute and long term psychiatric beds for children and adolescents. | | |
| 7.1.2 Increasing the availability of outpatient psychiatric services for children and adolescents. | | |
| 7.2 Develop a cost-effective network of mental health prevention services. | DHMH | Not Available |
| 7.2.1 Expand high risk infant identification programs beyond the current pilot stage. | | |
| 7.2.2 Develop mental health screening and referral programs within the public schools. | | |

| Goals & Recommendations | Responsible and Involved Parties | Estimated Costs |
|---|---|---|
| **Mental Health (Con'd)** | | |
| Improving Access to Mental Health Services | | |
| 7.3 Develop data and research bases which examine the mental health problems and needs of Black and minority populations. | DHMH, Colleges and universities | Not Available |
| 7.3.1 Develop a comprehensive data system to be used in planning services for minorities. | | |
| 7.3.2 Expand the Mental Hygiene Administrations' management information system to include outpatient facilities. | | |
| 7.3.3 Encourage further research into the mental health needs of Blacks and minorities. | | |
| Improving Access to Mental Health Services | | |
| 7.4 Assure adequate reimbursement for psychiatric care. | DHMH | Not Available |
| 7.4.1 Increase Medicaid reimbursement levels for psychiatric care. | | |
| 7.4.2 Develop special financial incentives to promote access to private hospitals. | | |
| 7.4.3 Assure that mandated psychiatric benefits are preserved and increased. | | |
| 7.5 Develop a public relations campaign that decreases the stigma attached to mental illness and informs the general population of services available. | DHMH, Advocacy Groups | Not Available |
| 7.6 Expand the pool of mental health professionals and emphasize training in cross-cultural issues. | Colleges & Univ. | Not Available |
| 7.7 Modify the Mental Hygiene Administration's 5 Year Plan to include outreach and employee assistance programs. Fund and support the plan. | DHMH | Not Available |

## ACTION AGENDA

Governor's Commission on Black and Minority Health
Goals and Recommendations for Improving Black and Minority Health in Maryland

| Goals & Recommendations | Responsible and Involved Parties | Estimated Costs |
|---|---|---|
| **THE BLACK AND MINORITY ELDERLY** | | |
| **GOAL 8: TO IMPROVE ACCESS TO COMMUNITY BASED LONG TERM CARE AND MENTAL HEALTH SERVICES FOR THE BLACK AND MINORITY ELDERLY** | | |
| 8.1 Develop innovative methods of increasing minority elderly awareness of the availability of health and social support services. | Office on Aging, DHMH, DHR, Community groups | $50,000 |
| 8.2 Increase long term community based services, including medical and social support services. | | Not Available |
| 8.3 Expand community based services by training additional home health aide through the Senior Aide Program. | | Not Available |
| 8.4 Increase the numbers of minority health professionals and paraprofessionals working in programs and institutions which serve large numbers of minority elderly. | | Not Available |
| 8.5 Develop a comprehensive network of mental health services for the elderly. | DHMH, Office on Aging | Not Available |
| **MARYLAND COMMISSION ON BLACK AND MINORITY HEALTH** | | |
| **GOAL 9: TO FACILITATE THE IMPLEMENTATION OF INNOVATIVE AND CULTURALLY APPROPRIATE COMMUNITY BASED MINORITY HEALTH STRATEGIES AND TO MONITOR PROGRESS IN IMPROVING BLACK AND MINORITY HEALTH** | | |
| 9.1 Establish a Maryland Governor's Commission on Black and Minority Health | Governor, DHMH, Legislature | $200,000 |
| 9.2 Require birth and death certificates in Maryland to include codes for all major racial and ethnic groups in Maryland. | DHMH | Minimal |
| 9.3 Encourage data collection and research efforts which further investigate the factors which influence Black and minority health status and access to health services. | DHMH | Not Available |

# SUMMARY REPORT ON BLACK AND MINORITY HEALTH MANPOWER DEVELOPMENT

## Introduction

Both national and Maryland data reveal that Blacks and minorities are underrepresented in the health professions and in senior managerial and policymaking positions throughout the health industry as compared to their percentages in the total population. For example, Blacks comprise 23% of Maryland's population, but represent less than 7% of the State's physicians, dentists, registered nurses, pharmacists, hospital administrators, and physical therapists. This underrepresentation was of great concern to the Commission because the adequate representation of the Blacks and minorities in the health field was viewed as essential to improving Black and minority health. Each of the Commission's eight task forces echoed the urgent need to increase the number of Black and minority health professionals and policymakers.

During its deliberations, the Commission's Task Force on Minority Health Manpower Development used several methods to research and examine minority health manpower issues. A major initial finding was that there is a paucity of data and information on the status of Blacks and minorities in Maryland's health industry. There is currently no Maryland agency responsible for either collecting data or analyzing trends on the education, training and/or employment experiences of Blacks and minorities in the health care field.

Accurate data on the number of minority health professionals practicing in Maryland are currently unavailable. Some data, although unreliable because it is based on self reported job titles or descriptions, are available through 1980 Census reports. More reliable data on the numbers of health practitioners in Maryland are available through the State's health professions licensing boards. However, even these data have major limitations. For example, a significant proportion of practitioners, (e.g., at least 17% of registered nurses), fail to provide voluntary statistical information about their practice patterns on licensing Board renewal applications. There is also the possibility that some Blacks and minorities fail to reveal their racial or ethnic background for fear of discrimination.

Physicians and nurses are the only two professions for whom data is routinely summarized through their respective licensing boards. Other boards either do not collect information by race or the data was not readily available. The Task Force found that readily available information on the employment of Blacks and minorities within Maryland's health and insurance industries was even more scarce.

Questionnaires were sent to Maryland health facilities to determine the racial composition of hospital and HMO staff, and hospital boards of directors/trustees. Maryland State Board for Higher Education data on the enrollment of minorities in health professions programs was analyzed and a survey of nursing education programs was conducted. Available health professions board licensure files were also computerized and analyzed.

The Task Force also interviewed practitioners and others knowledgeable about Black and minority health manpower issues to ascertain documented and perceived minority health manpower problems and needs. Approximately seventy-five groups and/or individuals were invited to make presentations before the Task Force. Over forty-five individuals, many of whom represented various health professions groups in the State, provided expert testimony to the Task Force.

Regional meetings were held in Southern Maryland and on the Eastern Shore to gain a better understanding of health manpower problems in these regions. Failed attempts were also made to hold meetings in Western Maryland and the Prince George's - Montgomery County areas. The findings from these interviews are dispersed throughout this report.

## Background: Minority Health Professionals and Minority Health

> "Blacks have no obligation to serve the poor, but they identify with this group and share a unique history. It is experience, not pressure, that gives them the orientation to serve."
>
> Dr. David Satcher
> President, Meharry Medical College

The Task Force on Minority Health Manpower Development was charged to assess the likely impact of additional minority providers on minority health status. Although the data and research in this area were inconclusive, the Task Force concluded that the adequate representation of Blacks and minorities within the health professions and the health industry is an integral part of improving minority health. Many national experts and most of the individuals who testified before the Commission or its Task Force also support this concept.

Several studies have indicated that Black and minority practitioners are more likely than their White counterparts to practice in Black and minority communities and in medically underserved areas (1,2). A major goal of many of the programmatic efforts to increase minority representation in the health professions launched during the 1960's and 1970's was to improve minority access to health care, and ultimately, the health status of underserved minorities. A recent study which evaluated the effectiveness of affirmative action programs in medical schools concluded that these programs were successful (1).

The 100th Congress recently passed the "Excellence in Minority Health Education and Care Act of 1987" in recognition of the important role played by minority health professionals in underserved areas. The Act awards funds to the Meharry Medical and Dental College, the Xavier University College of Pharmacy, and the Tuskegee School of Veterinary Medicine; these three institutions have trained a large percentage of the nation's Black health professionals. For example, Meharry has trained 40% of all Black physicians and 50% of all Black dentists practicing in the U.S. today.

The Congress passed and funded the Act on the basis of the following findings:

- Minority health care needs are currently greater than the health care needs of the general population.
- While the number of health professionals has increased, there are still shortages of health professionals from minority groups, and there has been a drop in the enrollment of minority individuals in some health professions education programs.
- Health professionals from minority groups play critical roles in serving low-income minority populations, particularly in inner city areas and rural areas.
- Historically, minority schools have developed a special capacity to conduct activities to prepare health professionals to serve minority populations.

- Health professions schools which train a disproportionate number of minority students also provide a disproportionate amount of health care services to minority populations.

- A disproportionate number of minority students trained at minority institutions choose to practice in underserved areas.

Members of the DHHS Secretary's Task Force on Black and Minority Health recognized that "one of the key elements of quality health care is the availability of well trained health care providers (3). They further concluded that "the degree to which the availability of these professionals differs between minority and non-minority groups may play a crucial role in reducing disparities in overall health status."

Both national and Maryland data indicate that many Black and minority communities are less likely than non-minority communities to have adequate access to health care resources (3,4). For example, Blacks are three to four times more likely than Whites to live in federally designated health manpower shortage or medically underserved areas in Maryland. These areas are characterized by few accessible health providers, high infant mortality rates, and high poverty.

The Task Force heard that recruiting and retaining practitioners in medically underserved areas, regardless of race, is a critical health manpower issue. Financial and other incentives, such as the provision of adequate Medicaid reimbursement, are required to attract and retain practitioners in poor rural and inner city areas. The Task Force learned that manpower shortages are an acute problem in several rural and inner city areas, including the Eastern Shore, Southern Maryland, and Baltimore City.

Racial and cultural differences (e.g., language and lifestyle habits) between providers and patients may also impede access to health services. The federal Task Force on Black and Minority Health suggested that "health professionals who are from the same cultural background as their patients may be able to communicate better with their patients and, thereby, have a positive influence on many of the factors that affect health outcome (3)." Most of the individuals interviewed by the Task Force agreed that the scarcity of minority health professionals limits access to culturally sensitive health care for Blacks and minorities.

Data on the racial preference of health providers by minority and non-minority consumers is sparse. Anecdotally, some Black providers have indicated that some Blacks prefer non-Black providers. The reasons for this preference have not been documented and remain unclear. The Task Force heard from several providers who noted that integration has tended to help White providers more so than Black providers. During racial segregation, Blacks were forced to used Black providers. Following integration and as competition for patients increased, White providers began to serve greater numbers of Black clients. The Task Force heard about several unsuccessful attempts made by Black providers to practice in predominantly White neighborhoods. In some instances, these practitioners found that Whites would not patronize them, and they subsequently relocated to predominantly Black areas.

These findings do not suggest that only minority practitioners should serve minority or poor individuals nor do they suggest that minority health professionals should feel obligated to serve solely poor or minority patients. However, given the absence of "sufficient" numbers of minority health professionals, the Commission strongly recommends that educational institutions, State agencies and health professions associations promote the availability of, and participation in cross-cultural education and

training programs. Culturally, relevant and sensitive curricula should also be consistently included, and reinforced in health professions education and in-service training programs.

In conclusion, these findings suggest that Blacks and minorities are significantly more likely to practice in minority and medically underserved areas, be it by choice or for other reasons. Hence, the availability of increased numbers of Black and minority health professionals should ultimately result in greater access to health services in minority communities and, consequently, improvements in health status. Of course, this relationship is dependent upon adequate reimbursement for the quality of services needed by these communities. Similarly, increased numbers of Blacks and minorities in managerial and policy decision-making positions would provide a greater opportunity for the minority perspective to influence health care delivery policy decisions.

**Findings: The Current Status of Blacks and Minorities in the Health Field in Maryland**

The terms "underrepresented" and "parity" are frequently used to describe the degree to which equity of access exists to the health professions for various minority groups. A group is considered underrepresented if "the percentage of a specific racial/ethnic group in the health professions is less than the group's percentage in the total population (5)." Historically, Blacks, Hispanics, and Native Americans have been greatly underrepresented within the nation's health professions (6). Asian/Pacific Islanders, in the aggregate, have consistently shown higher representation in several health professions, such as medicine, as compared to their percentage in the total population (2). Consequently, Asian/Pacific Islanders are generally not considered underrepresented in the health professions.

The Task Force used the above definition of underrepresentation in determining whether or not Blacks and minorities are underrepresented in the health professions in Maryland. Attempts were made to collect data to conduct this analysis. However, since these data were often unavailable, the Task Force relied on the testimony of State and local experts, and available health professions licensing data to document the numbers of Black and minorities in selected health professions in Maryland.

**Overview**

Census and health professions licensing data for Maryland, displayed in Tables 1.1 and 1.2, show that minorities were underrepresented in several health and allied health professions examined. Blacks were underrepresented in every field studied with the exception of social work and practical nursing. Hispanics and Native Americans were underrepresented in most of the professions studied with the exception of medicine. Asians were underrepresented in several of the allied health professions studied.

Census data for Maryland indicate that in 1980, Blacks represented 23% of the population, but only comprised 6% of physicians, 9% of dentists, 15% of registered nurses, and 8% of pharmacists. Hispanics accounted for 1.6% of the population, 6% of physicians, 2% of dentists, 1% of registered nurses and less than 1% of pharmacists. Native Americans constituted 0.2% of the population, but there were no Native American physicians, dentists or pharmacists in Maryland. Asian/Pacific Islanders represented 1.5% of the population, but accounted for 14% of physicians, 3% of dentists, 3% of registered nurses, and 5% of pharmacists. Conversely, Blacks and Native Americans were disproportionately employed in lower paying positions, such as nursing aides, orderlies and attendants.

TABLE 1.1

PERSONS EMPLOYED IN SELECTED HEALTH OCCUPATIONS IN MARYLAND BY RACE, 1980

| Occupation | Total | White | | Black | | Native American | | Asian | | Hispanic | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | # | % | # | % | # | % | # | % | # | % |
| Physicians | 12058 | 9445 | 78.3% | 791 | 6.5% | 0 | 0.0% | 1694 | 14.0% | 721 | 5.9% |
| Dentists | 2709 | 2372 | 87.5 | 256 | 9.4 | 0 | 0.0 | 81 | 2.9 | 50 | 1.8 |
| Veterinarians | 726 | 671 | 92.4 | 19 | 2.6 | 0 | 0.0 | 26 | 3.5 | 0 | 0.0 |
| Optometrists | 375 | 368 | 98.1 | 7 | 1.8 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Podiatrists | 158 | 148 | 93.6 | 10 | 6.3 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Registered Nurses | 28649 | 23327 | 81.4 | 4323 | 15.0 | 64 | 0.2 | 854 | 2.9 | 374 | 1.3 |
| Practical Nurses | 5906 | 3620 | 61.2 | 2182 | 36.9 | 39 | 0.6 | 52 | 0.8 | 18 | 0.3 |
| Pharmacists | 2636 | 2264 | 85.8 | 214 | 8.1 | 0 | 0.0 | 143 | 5.4 | 16 | 0.6 |
| Dietitians | 1554 | 830 | 53.4 | 651 | 41.8 | 0 | 0.0 | 67 | 4.3 | 40 | 2.5 |
| Inhalation Therapists | 844 | 562 | 66.5 | 241 | 28.5 | 0 | 0.0 | 35 | 4.1 | 6 | 0.7 |
| Occupational Therapists | 306 | 275 | 89.8 | 26 | 8.4 | 0 | 0.0 | 5 | 1.6 | 6 | 1.9 |
| Physical Therapists | 903 | 795 | 88.0 | 79 | 8.7 | 5 | 0.5 | 24 | 2.6 | 0 | 0.0 |
| Speech Therapists | 827 | 756 | 91.4 | 66 | 7.9 | 0 | 0.0 | 5 | 0.6 | 14 | 1.6 |
| Physician's Assist. | 871 | 674 | 77.3 | 163 | 18.7 | 0 | 0.0 | 34 | 3.9 | 11 | 1.2 |
| Psychologists | 2049 | 1787 | 87.2 | 208 | 10.1 | 0 | 0.0 | 47 | 2.2 | 15 | 0.7 |
| Clinical Lab Tech. | 5899 | 4060 | 68.8 | 1288 | 21.8 | 5 | 0.0 | 509 | 8.6 | 146 | 2.4 |
| Dental Hygienists | 881 | 820 | 93.0 | 61 | 6.9 | 0 | 0.0 | 0 | 0.0 | 13 | 1.4 |
| Health Record Tech. | 383 | 242 | 63.1 | 134 | 34.9 | 3 | 0.7 | 4 | 1.0 | 0 | 0.0 |
| Rad. Tech. | 1879 | 1549 | 82.4 | 284 | 15.1 | 6 | 0.3 | 34 | 1.8 | 15 | 0.7 |
| Dental Assists. | 2873 | 2550 | 88.7 | 294 | 10.2 | 4 | 0.1 | 20 | 0.6 | 30 | 1.0 |
| Health Aide | 6657 | 3879 | 58.2 | 2628 | 39.4 | 8 | 0.1 | 124 | 1.8 | 108 | 1.6 |
| Nursing Aides Orderlies & Attendants | 23631 | 10784 | 45.6 | 12391 | 52.4 | 65 | 0.2 | 346 | 1.4 | 292 | 1.2 |
| % State Pop., 1980 | | | 74.9 | | 22.7 | | 0.1 | | 1.5 | | 1.6 |

Source: 1980 U.S. Census

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TABLE 1.2

NUMBER AND PERCENT DISTRIBUTION OF SELECTED LICENSED HEALTH AND ALLIED PROFESSIONALS PRACTICING IN MARYLAND, BY RACE FOR SELECTED YEARS*

| Profession | Total | | Asian | | Black | | Hispanic | | Native American | | White | | Unknown/ Other | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| **Health Professions** | | | | | | | | | | | | | | |
| Dentists, 1985-86 | 3,775 | 100.0 | 89 | 2.4 | 244 | 6.5 | 19 | 0.5 | 1 | 0.0 | 3,209 | 85.5 | 193 | 5.1 |
| Nurses, 1986-1987 | | | | | | | | | | | | | | |
| L.P.N. | 6,978 | 100.0 | 31 | 0.4 | 2,073 | 29.7 | 17 | 0.2 | 21 | 0.3 | 3,887 | 55.7 | 949 | 13.6 |
| R.N. | 29,410 | 100.0 | 480 | 1.6 | 1,916 | 6.5 | 114 | 0.4 | 26 | 0.1 | 21,907 | 74.5 | 4,967 | 16.9 |
| Optometrists, 1986 | 318 | 100.0 | 2 | 0.6 | 3 | 0.9 | 0 | 0.0 | 0 | 0.0 | 289 | 90.9 | 15 | 6.8 |
| Physicians, 1985-1986 | 9,509 | 100.0 | 1,298 | 13.7 | 433 | 4.6 | 214 | 2.3 | 6 | 0.1 | 7,194 | 75.7 | 364 | 3.8 |
| Podiatrists, 1986 | 222 | 100.0 | 2 | 0.9 | 5 | 2.3 | 0 | 0.0 | 0 | 0.0 | 200 | 90.1 | 15 | 6.8 |
| **Allied Health Professions** | | | | | | | | | | | | | | |
| Speech Pathologists, 1986 | 603 | 100.0 | 4 | 0.7 | 24 | 4.0 | 3 | 0.5 | 0 | 0.0 | 540 | 89.6 | 32 | 5.2 |
| Audiologists, 1986 | 122 | 100.0 | 3 | 2.5 | 3 | 2.5 | 0 | 0.0 | 0 | 0.0 | 105 | 86.1 | 11 | 9.0 |
| Physical Therapists, 1986 | 1,116 | 100.0 | 10 | 0.9 | 48 | 4.3 | 8 | 0.7 | 1 | 0.1 | 1,032 | 92.5 | 17 | 1.5 |
| Asst. Phys. Therapists, 1986 | 157 | 100.0 | 2 | 1.3 | 35 | 22.3 | 1 | 0.6 | 1 | 0.6 | 116 | 73.9 | 2 | 1.2 |

*Excludes licensed individuals who did not complete the voluntary statistical section of the licensure renewal form.
Source: Respective Maryland Health Professions Licensing Boards Licensure Renewal Forms.

Data from the health professions licensing boards indicate that fewer racial minorities are represented in the health and allied health professions than is reported by the Census Bureau. The most recent licensure data show that Blacks represented less than 7% of physicians, dentists, registered nurses, optometrists, podiatrists, physical therapists, speech pathologists or audiologists. Conversely, Blacks were overrepresented as practical nurses (LPNs).

Asian/Pacific Islanders comprised 1.5% of Maryland's population, 14% of physicians but less than one percent of optometrists, physical therapists, podiatrists, LPNs and speech pathologists. It was difficult to draw conclusions about the numbers of Native American and Hispanic health professionals without additional data.

Future projections of the numbers and percentages of Blacks and other underrepresented minorities in the health professions, particularly medicine, dentistry and pharmacy, are not encouraging. Although national projections predict sizable increases in numbers of Black and Hispanic physicians, dentists, and pharmacists, minorities will still be represented well below half their percentages in the U.S. population in the year 2000 (7). For example, Blacks currently constitute 12% of the U.S. population, but only 3% of physicians, and this figure is only projected to rise to 5% by the year 2000. There are no projections of Black and minority participation in the health professions in Maryland.

Since education and training programs serve as the major point of entry into health professions and the health care field, trends related to minorities in this area were also examined. Maryland's colleges and universities offer a broad spectrum of academic programs designed to educate and train individuals for a wide variety of health careers. There are currently at least 16 professional and allied health fields for which academic training is available at the bachelor's level or higher. Another 18 academic programs are offered at the Associate of Arts level or lower. These programs are offered through approximately 21 different community and upper division colleges and universities in Maryland. Degrees offered range from the first professional degree in medicine or dentistry to the lower division certificate in dental or medical assisting. For the most part, data for the 1986-87 academic year show that blacks and minorities were more likely to be enrolled in Associate of Arts degree programs than in the Bachelor's level programs or first professional degree programs (Table 1.3).

At the elementary and secondary school levels, there are currently few programs in State which are designed specifically to enhance and support Black and minority participation in the health professions. The Dunbar High School in Baltimore City offers the State's only health careers magnet program. This program was developed to enhance and support black and minority entry into the health and allied health professions.

At the undergraduate, graduate and professional program level, there are a limited number of support programs and services aimed at the recruitment and retention of Black and minority students in the health professions. However, time and staffing constraints precluded the Task Force from undertaking a thorough assessment of the effectiveness of these programs.

## Blacks and Minorities in the Health Professions

The Task Force defined health professionals as graduates of schools of medicine, dentistry, pharmacy, podiatry, psychology or nursing. Task Force findings with regard to each of these professions are provided below.

TABLE 1.3

ENROLLMENT OF MINORITIES IN MARYLAND'S HEALTH PROFESSIONAL AND HEALTH CAREER EDUCATION PROGRAMS, FALL 1986

| Program | Total | | Race/Ethnicity | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Asian | | Black | | Hispanic | | Native American | | White | | Other/ Unknown | |
| | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| **First Professional Degree Programs** | | | | | | | | | | | | | | |
| • Dentistry | 407 | 100.0 | 35 | 8.6 | 48 | 11.8 | 12 | 2.9 | 1 | 0.2 | 306 | 75.2 | 5 | 1.2 |
| • Medicine | 1065 | 100.0 | 110 | 10.3 | 86 | 8.1 | 18 | 1.7 | 1 | 0.1 | 839 | 78.8 | 11 | 1.0 |
| • Pharmacy | 253 | 100.0 | 45 | 17.8 | 24 | 9.5 | 2 | 0.8 | 1 | 0.4 | 181 | 71.5 | 0 | 0.0 |
| **Allied & Other Health Professions Programs - (Bachelors thru Doctorate)** | | | | | | | | | | | | | | |
| • Dental Hygiene | 68 | 100.0 | 0 | 0.0 | 9 | 13.2 | 0 | 0.0 | 0 | 0.0 | 58 | 85.3 | 1 | 1.5 |
| • Medical Technology | 273 | 100.0 | 23 | 8.4 | 66 | 24.2 | 6 | 2.2 | 0 | 0.0 | 159 | 58.2 | 19 | 7.0 |
| • Nursing | | | | | | | | | | | | | | |
| A.A. | 3090 | 100.0 | 58 | 1.9 | 641 | 20.7 | 33 | 1.1 | 11 | 0.4 | 2301 | 74.5 | 46 | 1.5 |
| Bachelors' | 1843 | 100.0 | 45 | 2.4 | 367 | 19.9 | 15 | 0.8 | 5 | 0.3 | 1373 | 74.6 | 38 | 2.1 |
| Masters' | 408 | 100.0 | 6 | 1.5 | 25 | 6.1 | 4 | 1.0 | 2 | 0.5 | 364 | 89.2 | 7 | 1.7 |
| Doctorate | 60 | 100.0 | 1 | 1.7 | 4 | 6.7 | 0 | 0.0 | 0 | 0.0 | 53 | 88.3 | 2 | 3.0 |
| • Occupational Ther. | 205 | 100.0 | 1 | 0.5 | 8 | 3.9 | 3 | 1.5 | 1 | 0.5 | 191 | 93.2 | 1 | 0.5 |
| • Physical Therapy | 141 | 100.0 | 2 | 1.4 | 12 | 8.5 | 1 | 0.7 | 0 | 0.0 | 125 | 88.7 | 1 | 0.7 |
| • Public Health | | | | | | | | | | | | | | |
| Masters' | 323 | 100.0 | 8 | 2.5 | 12 | 3.7 | 1 | 0.3 | 0 | 0.0 | 232 | 71.8 | 70 | 21.7 |
| Doctorate | 399 | 100.0 | 9 | 2.3 | 17 | 4.3 | 2 | 0.5 | 4 | 1.0 | 280 | 70.2 | 87 | 21.8 |
| • Speech Pathology & Audiology | | | | | | | | | | | | | | |
| Bachelors' | 247 | 100.0 | 3 | 1.2 | 22 | 8.9 | 1 | 0.4 | 0 | 0.0 | 213 | 86.2 | 8 | 3.2 |
| Masters' | 129 | 100.0 | 2 | 1.6 | 4 | 3.2 | 1 | 0.8 | 0 | 0.0 | 115 | 89.1 | 7 | 5.4 |
| **Associate of Arts Programs** | | | | | | | | | | | | | | |
| Dental Assisting | 18 | 100.0 | 0 | 0.0 | 4 | 22.2 | 1 | 5.6 | 0 | 0.0 | 12 | 66.7 | 1 | 5.6 |
| Dental Hygiene | 128 | 100.0 | 0 | 0.0 | 10 | 7.8 | 1 | 0.8 | 1 | 0.8 | 113 | 88.3 | 3 | 2.3 |
| Dental Lab Tech. | 11 | 100.0 | 0 | 0.0 | 5 | 45.5 | 1 | 9.1 | 0 | 0.0 | 5 | 45.5 | 0 | 0.0 |
| Emergency Med. Sys. | 64 | 100.0 | 0 | 0.0 | 29 | 45.3 | 0 | 0.0 | 0 | 0.0 | 34 | 53.1 | 1 | 1.6 |
| Medical Assistant | 76 | 100.0 | 3 | 3.9 | 4 | 5.3 | 3 | 3.9 | 0 | 0.0 | 65 | 85.5 | 1 | 1.3 |
| Mental Health Assoc. | 502 | 100.0 | 1 | 0.2 | 101 | 20.1 | 6 | 1.2 | 3 | 0.6 | 383 | 76.3 | 8 | 1.6 |
| Medical Lab Tech. | 218 | 100.0 | 15 | 6.9 | 48 | 22.0 | 1 | 0.5 | 0 | 0.0 | 141 | 64.7 | 13 | 6.0 |
| Medical Records Tech. | 69 | 100.0 | 3 | 4.3 | 38 | 55.1 | 3 | 4.3 | 0 | 0.0 | 23 | 33.3 | 2 | 2.9 |
| Physician Assistant | 75 | 100.0 | 2 | 2.7 | 10 | 13.3 | 1 | 1.3 | 1 | 1.3 | 59 | 78.7 | 2 | 2.7 |
| Physical Ther. Asst. | 53 | 100.0 | 0 | 0.0 | 20 | 37.7 | 0 | 0.0 | 0 | 0.0 | 32 | 60.4 | 1 | 1.9 |
| Radiation Ther. Tech. | 18 | 100.01 | 1 | 5.6 | 2 | 11.1 | 0 | 0.0 | 0 | 0.0 | 14 | 77.8 | 1 | 5.6 |
| Radiography | 136 | 100.0 | 7 | 5.1 | 18 | 13.2 | 0 | 0.0 | 0 | 0.0 | 109 | 80.1 | 2 | 1.5 |
| Resp. Therapy Tech. | 153 | 100.0 | 2 | 1.3 | 43 | 28.1 | 2 | 1.3 | 0 | 0.0 | 99 | 64.7 | 7 | 4.6 |
| **Lower Division[a] Certificate Programs** | | | | | | | | | | | | | | |
| Dental Assistant | 59 | 100.0 | 1 | 1.7 | 2 | 3.4 | 1 | 1.7 | 0 | 0.0 | 55 | 93.2 | 0 | 0.0 |
| Medical Assistant | 75 | 100.0 | 0 | 0.0 | 9 | 12.0 | 0 | 0.0 | 0 | 0.0 | 66 | 88.0 | 0 | 0.0 |
| Operating Room Tech. | 26 | 100.0 | 0 | 0.0 | 17 | 65.4 | 0 | 0.0 | 0 | 0.0 | 9 | 34.6 | 0 | 0.0 |
| Practical Nursing | 55 | 100.0 | 0 | 0.0 | 11 | 20.0 | 0 | 0.0 | 0 | 0.0 | 43 | 78.2 | 1 | 9.1 |
| Radiation Ther. Tech. | 7 | 100.0 | 0 | 0.0 | 2 | 28.6 | 0 | 0.0 | 0 | 0.0 | 5 | 71.4 | 0 | 0.0 |
| Respiratory Ther. Tech | 14 | 100.0 | 1 | 7.1 | 4 | 28.6 | 0 | 0.0 | 0 | 0.0 | 5 | 71.4 | 0 | 0.0 |
| Vision Care Tech. | 14 | 100.0 | 1 | 7.1 | 2 | 14.3 | 1 | 7.1 | 0 | 0.0 | 10 | 71.4 | 0 | 0.0 |

Source: Maryland State Board for Higher Education



[a]Certificate awarded for successful completion of a minimum of 12 semester credit hours at the Freshman or Sophomore levels, or both.

Blacks and Minorities in Medicine

In 1985-86, according to licensing data, there were at least 9,509 licensed physicians working in Maryland. Race was unknown for 3% of this population. Based on these data, Blacks and Native Americans appear to be underrepresented among Maryland's practicing physicians, while Hispanics and Asians appear to be overrepresented.

The majority (88%) of physicians of all races practice in either the Baltimore or Washington metropolitan areas. In 1985-86, over 60% of Black physicians practiced in Baltimore City or one of its surrounding counties. Several counties in Maryland, including four on the Eastern Shore have sizable Black populations , but no practicing Black physicians. Approximately 6% of the State's Black population resides on the Eastern Shore, but available licensing data show that only 1% of the State's Black physicians practice there.

Special programs promoting the recruitment and retention of underrepresented minorities in the medical profession were instituted during the late 1960's and early 1970's. As a result, by 1974, Blacks represented 7.5% of first year U. S. medical students, more than double the percent enrolled in the early 1960's. However, since 1974, the percentage of Blacks enrolled as first year medical students has declined. In 1986, Blacks represented 7% of first year medical students (2).

There are two medical schools in Maryland, one public - the University of Maryland at Baltimore, and one private - the Johns Hopkins University. Although the percentage of minorities enrolled in Maryland's medical schools at 9.9% is higher than the national average, there is still cause for concern since minorities still remain significantly underrepresented. Trend data on the enrollment of underrepresented minorities in Maryland's medical schools were requested, but unavailable.

National studies and data bases report the following about underrepresented minority physcians and medical school applicants:

- Underrepresented minorities have lower medical school acceptance rates than majority students (2).
- Grade point average (GPA) and Medical College Admissions (MCAT) Test scores are among the factors which determine medical school acceptance. Minority students continue to have substantially lower GPA's and MCAT scores than majority students (2).
- Underrepresented minorities have higher medical school attrition rates (2).

The Task Force heard about the difficulties often faced by Black and minority students enrolled in predominantly White medical schools. In many instances, Black students experience cultural shock upon entering a predominantly White setting, where support systems and role models are often minimally available. These students often run into academic difficulties in attempting to cope with their new environment. These environments may also include culturally biased and insensitive faculty and staff.

Competition from managed health care programs, such as HMOs, the medical malpractice crisis, and inadequate reimbursement for services were cited as significant factors affecting minority practice in medicine.

## Blacks and Minorities in Dentistry

Board of Dental Examiners data for 1985-86 show that there were approximately 3,755 licensed dentists practicing in Maryland. These data also show tht Blacks, Hispanics, and Native Americans are underrepresented in the dental profession. The majority of Black and minority dentists practice in the State's two metropolitan areas.

Maryland's only dental school, the University of Maryland, was the world's first dental school. However, the first Black student matriculated in 1968. In 1986, Blacks, Native Americans and Hispanics represented 14% of enrolled students. Howard University in Washington, D. C. is a serious competitor for Black dental school applicants in Maryland. The majority of Black dental school applicants opt to attend Howard possibly because Howard's tuition is lower and there is a perception among some minorities that UMAB is a racist University.

Identified barriers to increasing the number of minorities in the dental profession include inadequate financial assistance, poor educational preparation including a weak science background, a lack of minority role models, and insufficient early career guidance and motivation.

The Task Force heard that several critical issues which are independent of race are currently confronting the profession of dentistry. These include an oversupply of dentists in many urban areas, competition from less time consuming and expensive careers, the expansion of flouridation which has helped to lessen the demand for dental care, and inadequate third party reimbursement. These and other factors have led to a declining enrollment in dental education programs and the recent closure of several schools. The Task Force learned that many dentists are now advising their children and other students not to enter the field.

Suggested strategies for increasing minority participation in dentistry included the implementation of programs which provide early and positive exposure to the field, the provision of financial aid, and better educational preparation.

## Blacks and Minorities in Pharmacy

As of June, 1987, there were approximately 5,000 active pharmacists licensed to practice in Maryland. Data on the number of minorities in the profession were unavailable. Nationally, minorities are underrepresented in the profession of pharmacy. In 1984, of the estimated 157,000 active pharmacists in the U.S., 2.6% were Black, 4.5% were Asian, 1.8% were Hispanic and 0.2% represented other minorities (8).

The University of Maryland at Baltimore houses the State's only pharmacy school. All pharmacy schools require 5 years of academic study for the baccalaureate degree and 6 years for the doctorate (Pharm.D.) The first Black student enrolled in the University of Maryland's program in 1951. During the 1986-87 academic year, of the 253 total UMAB enrollees in the baccalaureate program, 9.5% were Black, 17.8% were Asian, 0.4% were Native American and 0.8% were Hispanic. Minorities represented 16.1% of total enrollment in U.S. schools of pharmacy in 1984.

The Task Force heard that Black and minority pharmacists in Maryland tend to practice in urban and/or poor areas. Most minority pharmacists are employed by one of the retail drug chains. There are currently three black owned pharmacies in Maryland, which is three less than the number in place during 1980.

Identified barriers to the recruitment of additional minority pharmacists included the following: (1) a lack of financial aid and scholarships, (2) a lack of minority role models, (3) insufficient career guidance at the middle and high school levels, (4) inadequate educational preparation in the sciences, and (5) the lack of a full-time minority recruiter at the UMAB School of Pharmacy. Recommended strategies to enhance minority participation in pharmacy included (1) the provision of financial support and (2) the institution of programs which increase the visibility of the profession for minorities, including health career days in the schools, and health careers workshops/training sessions for school guidance counselors.

## Blacks and Minorities in Podiatry

As of June, 1987, there were approximately 400 active podiatrists licensed to practice in Maryland. Podiatry is a rapidly growing field concerned with the diagnosis, treatment and prevention of abnormal conditions of the feet. The demand for podiatric medical services currently exceeds the number of practicing podiatrists. Nationally, minorities represent less than 5% of the approximately 10,000-11,000 active podiatrists (8).

Available Maryland Board of Podiatric Examiner's data show that minorities are underrepresented in the field of podiatry in Maryland. Of the 222 licensed podiatrists practicing in Maryland in 1986 for whom data was available, 5 were Black, 2 were Asian and none were Hispanic or Native American Indian. Podiatry Board data for 1987 indicate that there are no Black podiatrists practicing in Baltimore City. However, the Task Force met with a Black podiatrist who was able to identify at least 3 Black podiatrists practicing in Baltimore City.

There are currently six colleges of podiatric medicine in the United States. All are private and none are located in Maryland. Podiatric training requires a bachelor degree followed by four years of specialized training at a college of podiatric medicine. In 1984-85, minorities represented 13.6% of students enrolled in colleges of podiatric medicine (8).

Perceived barriers to the recruitment of additional minority podiatrists included the perception that the field is "unglamorous" (e.g., there are few life and death situations), competition from other fields, such as medicine and dentistry which have similar training requirements, a lack of career visibility, and a public misperception about the role of podiatrists. The recent popularity of running and athletics was thought to have helped to make the field more attractive.

## Blacks and Minorities in Nursing

In 1986-87, according to available Maryland Board of Nursing data, there were at least 29,214 registered nurses and 6,978 practical nurses licensed in Maryland. Blacks account for 6.5% of registered nurses and are underrepresented in this profession when

compared to their percentage in Maryland's total population. Blacks in the nursing field are more likely than Whites to be L.P.N.'s or nursing assistants; only 46% of Black nurses as compared to 80% of White nurse are registered nurses.

Licensed practical nursing is one of the few health occupations where Blacks are overrepresented as compared to their percentage in the total population. In 1986-87, Blacks comprised approximately 30% of the State's L.P.N.'s.

The Task Force met with representatives of several nursing-related groups, who identified several impediments to the recruitment of additional minorities to the field. Several educational barriers were cited including poor educational preparation, weak training in the sciences, and a lack of financial aid. Impediments which were more unique to the field of nursing included low salaries, a high practitioner burn-out rate, a lack of career ladders, demanding and stressful hospital workloads with very little recognition, and the lure of more prestigious careers with better working conditions.

Participants spent considerable time discussing several issues facing nursing practice. These included differentiating levels of nursing, developing career ladders, and nursing retention. Retaining nurses who are currently in the field was viewed as much of a problem as recruiting additional nurses.

The Task Force also heard concerns about the trend toward the increasing enrollment of young Black females in certificate level nursing assistant programs instead of L.P.N. and R.N. programs. Cited drawbacks to these programs included limited employment options, and a lessening of earning power and career mobility. Concerns were also voiced about the recent closure of several predominantly Black L.P.N. programs in Maryland. The Task Force attempted to gather information on the enrollment of minorities in nursing assistant programs in Maryland. However, most of these programs did not respond to the survey.

O 30 different Maryland colleges and universities, hospitals, and public and private schools of nursing offer nursing education programs ranging from the 6 month certificate program for nursing assistants to the doctorate in nursing. Three year hospital based diploma, associate of arts, and bachelor of science (B.S.N.) programs, prepare graduates for licensure as registered nurses. Blacks as a percentage of the students enrolled in the State's 8 B.S.N. programs ranged from a low of 6.8% to a high of 93%.

Suggested minority recruitment strategies included the provision of financial aid, better presentation of the field as a profession, attracting additional males to the field, the consistent presentation of health career days in the schools, and the promotion of summer jobs in health care.

## Blacks and Minorities in Clinical Psychology

There are currently approximately 1600-1700 active psychologists licensed to practice in Maryland. Accurate data on the numbers and characteristcs of Black and minority psychologists were unavailable. In a meeting with a Baltimore based Black clinical psychologist, the Task Force learned that there are approximately 30 (less than 2% of the total) licensed Black psychologists in Maryland. About 8 to 10 are thought to practice in the Baltimore metropolitan area with the remainder practicing in Montgomery or P.G. counties. The majority of Black psychologists are thought to practice in public institutions, colleges or clinics. There is only one full-time Black psychologist in private practice in the Baltimore area.

Three educational institutions in Maryland grant doctorate degrees in psychology - the Baltimore County and College Park campuses of the University of Maryland and the Johns Hopkins University. The College Park program requires students to pursue study full-time which reduces the number of potential candidates, while the other schools offer part-time opportunities. Most Black psychologists who currently practice in Maryland were trained in other states. Information was not available for other minorities.

There is some indication of an increasing demand for Black psychologists. The Maryland Board of Psychology Examiners and the Maryland Psychological Association have both received increasing numbers of requests for referrals to Black psychologists.

Barriers to the recruitment of additional minorities include a lack of financial aid and scholarships, low salaries (e.g., starting salaries for Ph.D. trained psychologists range from $20-30,000), a lack of career visiblity and few minority role models.

A reintroduction of career education into the public school curriculum was viewed as an important strategy for increasing the number of minority health professionals, including psychologists. The career education approach launched in the seventies was subsequently rejected because it required a major revision of the school curriculum. A Black psychologist noted this approach is important because studies have shown that Blacks tend to make decisions about career choices sooner than Whites, often during the middle school years. This appears to result partially from fewer career choices. Hence, minorities are more likely than Whites to enter the more traditional, high visibility careers, such as education, law and the ministry. It was felt that systematic career education programs in the elementary and junior high schools could help to postpone minority career decisions while broadening minority career choices.

## Barriers to Increasing the Number of Minority Health Professionals

Researchers estimate that at least a threefold increase in the first year enrollment of underrepresented minorities in health professions schools is necessary to approach parity nationally in the next decade. However, several factors and trends preclude the likelihood that Black and minority representation in the health professions will approach parity by the year 2000 without immediate intervention. These factors and trends are summarized below.

### Inadequate Educational Preparation and High Minority Attrition Rates Throughout the Educational Cycle

Poverty and racism are among the factors thought to result in the continuing inadequate educational preparation of many Black and minority students at the elementary, middle and high school levels. Minority youngsters are more likely than Whites to attend schools in high poverty areas characterized by low academic performance, discipline problems, low levels of parental involvement and less motivated teachers. These youngsters are more likely to be arbitrarily tracked into vocational or non-college preparatory courses where they are poorly prepared in the sciences and where they do not receive appropriate counseling for health careers (9).

Black, Hispanic, and Native American students have been documented to be less likely than White students to take and successfully complete math and science courses. A recent National Research Council Study of minority underrepresentation in science and engineering cited the following factors as possible impediments to Black and minority

pursuit of coursework in math and science (10): low socio-economic status; lower expectations held for minority students than for their White peers by themselves, parents and teachers; insufficient counseling and remedial programs; and a lack of minority role models and mentors. The report also noted that role models are particularly important in influencing students to choose quantitative majors. Having a college-educated parent who majored in the sciences was found to increase the likelihood of students choosing a quantitative major.

Suggested strategies for improving Black and minority participation in math and science courses and careers include providing better preparation in math and science at the elementary and secondary levels through special programs such as remedial courses and tutoring; increasing the number of intervention programs designed to promote positive attitudes toward math and science; and hiring more minority teachers to serve as mentors and role models.

A 1987 report on minority representation in the medical profession by the Robert Wood Johnson Foundation reviewed several programs and strategies which have proven to be effective in enhancing minority participation in the sciences and ultimately the medical profession. These included middle, high school and college math and science enrichment programs; and college level enrichment programs which include a summer laboratory.

## Financial Constraints

Rising educational costs coupled with a decrease in federal scholarships and low interest loans has a disproportionate effect on underrepresented minorities who are more likely to be low income. For example, in 1985, Black medical school applicants were three times more likely than white applicants to report parental incomes of $15,000 or less (3). Most Task Force presenters stressed that limited financial assistance is a key barrier for Blacks and minorities who are interested in attending college or professional school.

Educational costs are also increasing. For example, tuition at the Johns Hopkins Medical School currently stands at $13,000 per year. A dental education is one of the most expensive types of health professions training available. At graduation, the average UMAB dental student has loans amounting to $40,000. Dental student loan amounts at graduation are currently increasing at a rate of $3,000 per year.

## Relaxation of the Commitment to Enhancing Minority Representation and Retention

National, university and State mandates to recruit and retain underrepresented minorities have waned since the mid-seventies. Between the mid-60's and mid-70's, several programs aimed at increasing minority career opportunities in health as an indirect means of improving access to health care for the poor were developed and funded by the federal government and private foundations.

However, with the advent of several court challenges to affirmative action in higher education (e.g., Bakke versus the University of California) and a lessening of the civil rights movement, support for these programs decreased. Concurrently, several national reports forecasted health professions surpluses. This led to a shift in federal policy from providing financial assistance to increase the number of health professionals to developing policies and programs concerned with the maldistribution of health resources.

Minority applicants to medical school are better qualified today than in the mid-70's, yet they are less likely to be accepted (9). One study which examined admissions trends found that admission rates have declined even among minority students with the highest MCAT scores, while admission rates for comparable White students rose. The authors concluded that "the commitment of medical schools to affirmative action has slackened (9)."

## Inadequate Career Guidance and Lack of Minority Role Models

In meetings and discussions with health providers, the Task Force consistently heard about the need to start early and to systematically expose minority students to the variety of health careers available. Inadequate and insufficient career guidance counseling, and limited preparation in math and science were viewed as major barriers. Many of the minority health professionals interviewed indicated that they chose their professions because of early exposure to the field or because of a visible role models.

Studies have shown that talented minority students often do not pursue health careers because of non-academic counseling and inadequate career information (9). The early identification, and continued support of highly motivated Black and minority students was viewed as an important strategy for increasing the potential pool of minority health professionals.

An absence of minority role models was also frequently cited as a major barrier to the recruitment of additional minorities to the health field. Relatives involved in the health professions often serve as role models for majority students, while teachers and peer groups are more likely to influence minority students who have fewer role models.

Task Force presenters outlined the following as factors and strategies to be considered if the representation of underrepresented minorities in the health professions is to increase:

- a strong commitment by governors, state legislators and state higher education boards to ensure that state universities implement policies to increase minority enrollment;
- increased scholarships and low interest loans for low-income students;
- a more aggressive federal policy enforcing civil rights and affirmative action programs;
- increased recruitment, training and development of minority faculty;
- recognition of the critical role played by minority schools in educating and graduating a large percentage of Black health professionals;
- early identification of promising students and provision of appropriate career guidance at the middle school, high school and undergraduate levels;
- a willingness to look at criteria other than grades and test scores in admissions to health professions programs; and
- effective support programs to assist minority students in entering and completing health professions programs.

## Status of Minorities in the Allied Health Professions in Maryland

According to available health professions board data, Blacks, Hispanics, and Native Americans are underrepresented in the fields of audiology, occupational therapy, physical therapy and speech pathology. Asians were overrepresented as audiologists and underrepresented in the remaining fields. Blacks were more likely than Whites to be licensed as lower level assistants in the allied health fields. For example, of the Blacks licensed in the field of physical therapy, 42% were licensed as physical therapy assistants as compared to 11% of Whites.

Health professions board data by race was not available for the remaining allied health professions studied. The Commission, therefore, relied on expert testimony for estimates of the numbers of minorities in these fields. It was estimated that Blacks/minorities comprise 3-4% of Maryland's physician assistants, about 33% of social workers, approximately 20% of medical technologists, 14-21% of medical records administrators, and 9% of occupational therapists. On the basis of this information, it would appear that Blacks/minorities are underrepresented in several of the allied health professions.

Table 1.3 shows enrollment by race/ethnicity in selected health and allied health occupations programs in Maryland community and upper division colleges during the Fall of 1986. Black representation in these programs ranged from a low of 3.7% of occupational therapy program enrollees to a high of 55% of medical records technology enrollees. Blacks comprised less than 12% of the enrollees in four of the 15 programs. Hispanic enrollment ranged from a low of 0% in five of the programs to a high of 15% in the medical lab technician program. The majority of programs, 13 out of 15, had no Native American students enrolled. A slight majority (8 of 15) of programs enrolled one or more Asian students. Trend data on minority enrollment were unavailable.

Unlike the more traditional health professions such as medicine, dentistry and nursing, the allied health occupations could be termed the "invisible health professions." Task force presenters representing the allied health occupations identified a lack of awareness of the field, particularly by minorities, as a major recruitment barrier. One speaker noted that "few people, particularly minorities are introduced to the allied health professions at an early age. Consequently, fewer people, especialy minorities, decide to pursue these careers." This lack of professional visibility was thought to be compounded by both a lack of awareness of allied health fields by school guidance counselors, and the availability of fewer minority role models.

Other identified barriers paralleled the findings for the health professions and included inadequate financial assistance, and inadequate educational preparation, including weak science and math backgrounds.

Low salaries were cited as another barrier. A hospital social work director indicated that one of the major barriers to recruiting minority social workers is the low salary. The beginning salary for a Master's trained social worker in the State civil service system is $17,000.

Although most of the allied health professionals interviewed noted that more work remains to be done, several presenters discussed various current minority recruitment efforts. For example, several individuals indicated that they had visited local middle and high schools to promote their professions. There are also groups such as the Coalition of Health Advocates for the Rights of Minorities (CHARM), who act as advocates and role models for the recruitment of minorities into various health fields. Similarly, the

minority subcommittee of the Maryland Academy of Physician Assistants, over the next two years, will attempt to recruit highly qualified minority students for enrollment in schools in Maryland, New Jersey and Pennsylvania.

All persons interviewed agreed that there was a need for representatives of the professions, including minority health professionals, to play a greater role in promoting the professions to minorities. A medical technologist noted that "it's going to come to the place where a lot of the people within the profession will have to do the recruiting themselves."

Several speakers also cited a lack of awareness of health careers and health professions educational requirements on the part of counselors. It was suggested that programs which systematically acquaint counselors with various health careers be developed.

The provision of adequate financial aid was also noted as an important component of enhancing minority participation. Many of the allied health professions are projected to be growth fields over the next decade. A physician assistant concluded her remarks by saying that "The Baltimore 2000 Report shows that unemployment rates are high for Blacks and minorities. There are several allied health areas that are just begging for people. All people need is training."

## Blacks and Minorities in Key Health Policy and Managerial Positions

Maryland's health care industry consists of numerous public and private health organizations including hospitals, insurers, nursing homes, medical and dental labs, public health departments, regulatory agencies and ambulatory care facilities. The health industry is a major employer in Maryland. Little if any previous research, has examined the employment of minorities in Maryland's health industry. The Task Force attempted to secure information on the employment patterns and problems of blacks and minorities within the industry, but was largely unsuccessful.

### State and Local Health Departments

The stated mission of the Maryland Department of Health and Mental Hygiene is to assure the people of Maryland their inherent right to a healthful environment and a high level of physical, mental, and social health. Local health departments located in each of the State's 24 subdivisions serve as the Department's major delivery arm. In June 1986, the Department employed over 15,000 individuals. Although Blacks and minorities represented 40% of the Department's total work force, Blacks were underrepresented as officials/administrators (9.6%) and as professionals (18%). Conversely, Blacks were overrepresented as technicians (41%), protective service workers (77%), paraprofessionals (60%), and service/maintenance workers (55%). As of November, 1987, only 2 of the Department's 23 upper level managerial and administrative positions were held by Blacks and minorities.

Blacks and Hispanics are reportedly experiencing hiring and promotion problems within State and local health departments. A recent Baltimore Afro-American newspaper article headlined "Racism Alleged in Health Department." Black employees were alleged to be victims of "whitecoating," whereby Whites are placed in top management positions to the detriment of Blacks who were alleged to be more qualified.

At a public hearing in Montgomery County, members of the Governor's Commission on Black and Minority Health heard about the difficulties master's-trained Hispanic individuals were having in acquiring positions with local health departments. Partially as a result of this hearing, the Montgomery County Health Department established a Task Force on Minority Health (11). The Montgomery County Task Force noted that the racial/ethnic composition of the health department's staff was not racially/ethnically reflective of the surrounding community. This was thought to serve as a barrier to the receipt of services for some minorities. Recommended Task Force initiatives included the establishment of divisional affirmative action goals and the targeting of professional positions for bilingual/bicultural staff.

In meetings with health professionals on the Eastern Shore and in Southern Maryland, the Task Force heard about limited educational and employment opportunities for Blacks and other minorities within the health industry in these areas. Location, low salaries, the State's bureaucratic personnel process, inadequate educational preparation, and poverty were cited as barriers to the recruitment and retention of minority health professionals and administrators on the Eastern Shore and Southern Maryland.

## Hospitals

There are 52 acute general hospitals in Maryland. At present, only one of the 52 hospitals is headed by a Black or minority individual. The Task Force attempted to collect data on the employment of Blacks and minorities in upper level positions in Maryland's hospitals, but was unsuccessful in gathering accurate data from several Maryland hospitals. In a meeting with several health administrators, the Task Force heard that Blacks and minorities are seriously underrepresented in executive level positions in Maryland's hospitals.

## Nursing Homes

There are approximately 250 nursing homes in Maryland. The Task Force was unable to locate data on the employment of Blacks and minorities in Maryland's nursing homes.

## Health Maintenance Organizations (HMO's)

A health maintenance organization (HMO) is a health care plan that delivers comprehensive. Medical services to voluntary enrolled members on a prepaid basis. There's approximately 21 licensed HMO's operating in Maryland. Approximately 16% of Maryland's population is enrolled in a HMO.

In meetings with several representatives of the HMO industry, the Task Force learned that there are three basic types of HMO's The staff model HMO (e.g., Kaiser-Permanente) employs its own providers, administrators, and support staff. In the group model HMO, the HMO as an administrative entity contracts with one or more group practices to provide medical care (e.g., Health America). Finally, in the individual practice association (IPA) type of HMO, contractual arrangements are made with multiple independent providers (e.g., CIGNA). Because of variations in the structure of HMO's, the Task Force found that it was very difficult to collect consistent data on the numbers of Blacks and minorities who either work for or contract with HMO's in Maryland.

Two of the State's 21 licensed HMO's have Black chief executive officers. Blacks and minorities are employed in administrative positions in several of the State's HMO's, but largely remain underrepresented. A representative of the HMO industry noted that as the health field changes, we will see the creation of new jobs requiring various combinations of skills and expertise. Many people, particularly minorities, may not be aware of the existence of these positions unless they happen to stumble upon them. Because the HMO industry is so new, the Task Force learned that in many cases, positions are filled by individuals who have moved through the ranks.

Several Black and minority practitioners expressed concerns about their inability to compete as private practitioners given the rise of HMO's. They also expressed their fears of being excluded from the HMO market.

## Black and Minority Representation on Health-Related Boards, Councils, and Commissions

### Hospital Boards of Directors/Trustees

Between May and August, 1987, the Task Force conducted a telephone and mail survey of Maryland's 52 acute general hospitals to determine the race and sex composition of hospital boards of directors and trustees. All 52 hospitals eventually responded. (See Table 13 in the full Commission Report).

Board membership ranged from a low of 6 to a high of 43. Blacks, Asians, Native Americans and Hispanics appear to be underrepresented on these boards as compared to their percentage in the total population. There were almost 1,000 board members; racial minorities represented seven percent.

The number of Black board members ranged from a low of zero to a high of seven. Two hospitals in the Baltimore metropolitan area had all White male boards. Nineteen hospitals, including five in Baltimore City, had no Black board members. Four hospitals had Asian board members, two had Hispanic members, and none had Native American representatives. No hospital had a majority of minority board members.

The criteria used to select board members varied by hospital. Emphasis was often placed on individuals who could either provide business expertise or represent community viewpoints. Several hospitals indicated that attempts were being made to recruit Black and minority board members, however, the actions being employed were not specified.

### Health Professions Licensing Boards

The State's various health professions licensing boards review applications for licensure, develop practice standards, investigate complaints, and suspend or revoke licenses, when necessary. Board sizes range from 5 to 12 members. As of November, 1987, each licensing board, with the exception of optometry, had one or more Black or minority board members.

## Other Health-Related Boards, Councils and Commissions

There are numerous independent health-related commissions and councils which were either created by the Governor or Legislature, or established by Federal or State statute. Examples include the Maryland Health Services Cost Review Commission, the Governor's Advisory Council on AIDS, and the Commission on Medical Discipline. Available data show that most of these boards has one or more minority members.

## ACKNOWLEDGEMENTS

This report could not have been produced without the assistance and contributions of several key persons. The Maryland boards of dentistry, physical therapy, nursing, medicine, podiatry, optometry, audiology and speech pathology, graciously allowed the Task Force to computerize and analyze the non-confidential section of their licensure renewal form. Ms. Debbie Woodall of the Center for Health Statistics generated a voluminous data for the Task Force on licensed health professionals in Maryland. Ms. Annette Williams, Mr. Kery Hummel, and Mr. Lewis Jones greatly assisted the Task Force in arranging regional meetings in Southern Maryland, in Western Maryland, and on the Eastern Shore, respectively.

Secretarial staff in the offices of Dr. Louis Murdock and Mr. Carl Sardegna assisted the Task Force by transcribing over 25 hours of recorded interviews. Ms. Laura Lambson of the Maryland Department of Health and Mental Hygiene provided secretarial support to the Task Force and patiently typed and retyped the final report. Ms. Christie Provost and Mr. Mark Clack, two summer interns, provided invaluable research assistance. Ms. Cheryl Rollins and Dr. Michael Keller of the Maryland State Board for Higher Education assisted in providing data on the enrollment of minorities in health professions programs.

The Task Force is also deeply grateful to the following individuals who took the time to meet on a Saturday morning or Wednesday evening:

Dr. Roland Smoot, Dr. Levi Watkins, Ms. Penny Kyler-Hutchinson, Dr. Curtis Adams, Dr. Sidney Burnett, Dr. James Swancar, Dr. Bettye Jennings, Ms. Wilhelmenia Spurill, Ms. Shelia Jones, Mr. Jesse Williams, Dr. John Maupin, Mr. Godfrey Streat, Dr. Robert Blackmon, Mr. William Jews, Dr. Ralph Quarles, Dr. Herbert Trader, Mr. John Murdock, Dr. Glenwood Brooks, Ms. Loretta Wall, Ms. Lynada Johnson, Ms. Judith Baillieul, Dr. Doris Starks, Ms. Joanne Potter, Ms. Demetria Rodgers, Ms. Jean Phaire, Ms. Barbara Santamaria, Ms. Rachel Jones, Ms. Joan Green, Ms. Janie Geer, Ms. Grace Jones, Ms. Sandra Sundeen, Mr. Carl Sardegna, Mr. Vernon Sims, Ms. Pamela Metz, Ms. Stephanie Williams, Ms. Laurie Brenner, Dr. K. Bernard Chase, Dr. Mark Frazier, Ms. Annette Williams, Ms. Constance Row, Ms. Gladys Kent, Dr. LeeRoy Jones, Dr. Douglas Moore, Ms. Debbie Goeller, Dr. Ray Blakely, and Ms. Barbara Duer.

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# SUMMARY REPORT ON MINORITY MATERNAL, CHILD AND FAMILY HEALTH

## Introduction

There are probably few who would deny that children are our most precious resource. They represent our hope for the future. Believing this, the Commission was deeply concerned after uncovering the followingl facts and trends:

- A Black baby born in the 1980's is still almost twice as likely to die in the first year of life as a White baby.

- If Black and White infant mortality rates were equal, about 200 fewer Black Maryland babies would have died in 1985.

- The State's Black infant mortality poses cause for concern because it has been fluctuating. The infant death rate rose between 1981 and 1982, declined between 1983 and 1984, then increased by 15% in 1985 and declined again in 1986.

- The high mortality rate for Black infants is indicative of major deficiencies in the health care delivery system.

- Major risk factors for infant mortality include low birthweight, inadequate prenatal care, prematurity, poor nutrition, age, and lifestyle habits of the mother.

  - In 1986, one in ten Black newborns had low birthweights as compared to one in eighteen White newborns.

  - The Children's Defense Fund estimates that one in nine or 90 of the 812 Maryland infants who died in 1986 could have been saved simply by ensuring that their mothers received early and comprehensive prenatal care. Black mothers are three times more likely than white mothers to receive late or no prenatal care.

  - Black newborns are twice as likely to be born prematurely as White newborns.

- Black children are twice as likely as White children to be poor. According to the 1980 Census, 48% of Black children in Maryland are poor as compared to 28% of White children.

- The percentage of children of all races living in married couple families has been declining. In 1980, 55% of Black children under the age of 18 lived in married couple families.

- According to the Children's Defense Fund, Black children as compared to White children are three times as likely to die of known child abuse, five times as likely to become pregnant as teenagers and twelve times as likely to live with a parent who never married.

- There are inadequate numbers of outreach, patient education and home visiting programs in many geographic areas to adequately address the needs of low-income women and children.

- In some areas of the State, language and other cultural barriers often impede access to prenatal care services for recent immigrants (e.g., Hispanics, Southwest Asians, Haitians).

- Maryland currently does not have a targeted and systematic action plan to address infant mortality and other child health problems.

- Lead poisoning among Black children is a serious health problem in Baltimore City.

- There are inadequate numbers of successful targeted strategies to reduce the number of unplanned Black and minority adolescent pregnancies.

- Less than one in four Medicaid eligible children receive preventive health services through Maryland's EPSDT program.

- Primary care resources for non-Medicaid eligible low-income children are sorely lacking in many areas of Maryland.

- In some areas, maternal and child health programs are duplicative and inadequately coordinated resulting in the inefficient use of scarce health care dollars.

- There are too few early identification and intervention programs aimed at preventing and controlling the development of medical, psycho-social and learning problems among high risk minority children and youth.

## Findings

The risk factors most closely associated with poor health status are socioeconomic in nature and are more prevalent among Blacks and minorities than among non-minorities. These include crowded and dilapidated housing conditions, low income, lack of health insurance coverage, poor nutrition, and lack of transportation (especially in rural regions of the State).

Within Maryland, a myriad of public and private programs are designed to address the health problems of mothers, children and families. The Commission's Task Force on Maternal and Child Health found, however, that little coordination exists between these programs and that private and public services can use their combined resources more effectively. Traditional programs serve large numbers of people, but program outcome must be evaluated to determine ways to serve people better with the resources that are already available.

### Infant Mortality and Related Risk Factors

Infant mortality, the rate of infant deaths per 1,000 live births, is generally used as an indicator of the general living standards and health status of a population. In 1984, 40 States in the nation had lower infant mortality rates than Maryland. This finding is surprising in a State which had the seventh highest per capita income during that same year.

In Maryland, as well as nationally, over the past 20 years, the minority infant mortality rate has consistently been about twice as high as the White rate. However, while both the total and statewide White infant mortality rates have declined or remained relatively stable, the Black infant mortality rate has fluctuated substantially. Recent vital statistics data for Maryland indicate that between 1984 and 1985, the Black infant mortality rate increased by 16% rising from 16.6 to 19.2 infant deaths per 1,000 live births. Concomitantly, the White rate remained stable at 9.0. In 1986, the Black rate declined by 10% to 17.3, and the White rate rose by 4% to 9.4.

There is generally a distinction made between infant deaths that occur during the first 28 days of life (i.e., neonatal mortality) and infant deaths occurring between 29 days to one year of life (i.e., post-neonatal mortality). Low birth weight, lack of access to quality prenatal care services, lifestyle habits of the mother and other influences occurring prenatally, at birth or in the newborn period, are closely linked to neonatal mortality. Post-neonatal mortality tends to be associated with a variety of conditions occurring after birth (e.g., lack of infant health services, SIDS, inadequate nutrition or sanitation, or accidental injury). Low birth weight contributes to two thirds of deaths in the neonatal period and approximately 50% of all infant deaths. Babies born to teenaged mothers are also more likely to be premature, to have a low birth weight and to die in their first year of life.

Low birthweight is a major risk factor for infant mortality. Black babies in Maryland are also twice as likely as White babies to be born underweight (under 5.5 pounds). Low birthweight babies as compared to heavier babies are twenty times more likely to die. Low birthweight babies are also at increased risk of becoming poor learners, school failures, and developing other handicapping physical, mental and psychosocial behavior.

In 1986, of the 69,524 births in Maryland, 8,143 or 12% were to mothers under the age of 20. A disproportionate number of births to teens are to minority women. Blacks comprised 27% of the female teen population and 51% of the teen births. Black teens are almost twice as likely to White teens to have out-of-wedlock births. Teens who become pregnant are less likely to seek early prenatal care or to follow health care advice on matters affecting their pregnancies (e.g., nutrition, abstinence from alcohol and drugs). The result of many of these teen pregnancies is, therefore, a low birth weight infant who is at increased risk for handicapping conditions or death. According to the Children's Defense Fund, "Black teen birth rates are higher than White rates because Black teens are more likely to be sexually active; somewhat less likely to obtain abortions. Half of all Black unintended teen pregnancies end in abortion compared with almost two-thirds of all White unintended teen pregnancies."

Primary care, starting in the prenatal period and extending through the early years of life, has been documented to be a very cost-effective measure, which improves birth outcomes, child health status and reduces overall health and social costs. Studies have documented that the incidence of premature and low birth weight births have been reduced when adequate prenatal care is provided. Such care has been found to reduce infant mortality rates by as much as 20 to 25 percent, cut the rate of mental retardation in half and reduce by two to three times the percent of high risk infants suffering from abnormal physical or mental development.

In 1985, the Maryland Medicaid Program spent $51.7 million to care for babies in neonatal intensive care units. Many of these babies spent the first part of their lives in these units because their mothers did not receive adequate prenatal care. Maryland has a choice. The State can choose to pay for primary care services for mothers and infants

at a much lower cost as a preventive measure or pay more later, through the budgets of the Departments of Education, Health, Juvenile Services and Human Resources.

## Children and Adolescents

Black children in Maryland are disproportionately found in the State's high and at risk populations. High risk mothers include alcohol, drug and nicotine abusers, adolescents, low income and poorly educated women. These women are at increased risk of having low birth weight and premature babies. High risk infants and children include premature and low birth weight babies, poor children living in single parent households, children born to adolescent mothers, children who are physically or mentally abused, and children with learning disabilities, such as attention deficit disorders. These children are at increased risk of becoming substance abusers, adolescent parents, poor learners and school failures and juvenile delinquents.

Minorities comprise 30% of the state's population aged 0-18. However, minority children are often disproportionately found in the State's high risk and at risk groups. This Task Force recommends that new efforts be focused on the early identification of children at risk for developing chronic illness and behavioral problems. Intervention programs, aimed at minimizing the effects of biologic and psychosocial risks at an early age, have been documented to be effective. These include preschool programs (e.g., Headstart) and home visiting programs.

Home visiting programs have been demonstrated to reduce the incidence of pre-term labor and low birthweight (leading causes of infant mortality), non-compliance with medical regimens, the incidence of child abuse and inappropriate emergency room use. These programs improve health habits during pregnancy, improve parenting skills, strengthen family functioning and decrease family stress. They are particularly important, given the large number of adolescent parents. It has been estimated, however, that community health nurses in the State's local health departments spend less than 13% of their time on home visits to families. At present, Medicaid does not reimburse home nursing services, so local health departments have not been able to tap this resource.

## Sickle Cell Disease

Sickle cell disease is the most common genetic disorder in the United States and in Maryland. This hereditary blood disorder affects mainly black Americans: 1 in 400 Black Americans have the disease. There are gaps in the availability and accessiblity of screening and treatment services for sickle cell disease.

Howard University hospital in D.C. has a long-established comprehensive sickle cell center with many ongoing treatment, research and psycho-social programs. On the other hand Baltimore has no similar institution. With the demise in September, 1986 and January, 1987 of the adult sickle cell clinics at Provident Hospital and Johns Hopkins Hospital, respectively, those sickle cell patients living in the metropolitan area have no comprehensive, continuity of care. Although D.C. is just 40 miles away from Baltimore, for those needing medical services for their genetic disorders, 40 miles is a long way to go: the trip may be life-threatening or hazardous to one's health.

Most often, genetic services are delivered on a patchy basis by private and governmental agencies with little networking and no comprehensive plan, resulting in duplication of effort in some instances and under-service in certain areas of the State.

Besides doctors participating in the EPSDT Program, very few doctors in private practice screen the at-risk population: there are only 2 community health centers in Baltimore which include sickle cell education and screening.

Genetic education, screening, counseling and treatment is sporadic. Although the majority of the available services are concentrated in Baltimore City and Washington, D.C., there are still gaps in services in these locales, particularly regarding access to continuous, quality, comprehensive care for adults.

# SUMMARY REPORT ON FINANCE, ACCESS, AND INDIGENT CARE

## Introduction

Is access to health care in America a right or a privilege? An examination of the plight of medically indigent minorities in Maryland and the U.S. would suggest that access to health care is indeed a privilege. There is evidence that poverty, lack of health insurance coverage, and race often combine to create an underclass of individuals who experience tremendous difficulties in acquiring basic health care services.

Over the past decade, hundreds of books, reports and articles, and countless numbers of conferences have focused on the subject of medically indigency. Concurrently, some segments of federal, state and local governments and the private sector have continually sought ways to contain health care costs while maintaining or improving access to care for the medically indigent. In spite of these rhetorical and programmatic efforts, medical indigency looms larger that ever as a social and health problem which must be addressed by American society.

There is evidence that access to health care services is declining for some of the most vulnerable segments of the population. Several recent national studies have highlighted some alarming trends. For example, a 1986 Robert Wood Johnson Foundation sponsored study found that between 1982 and 1986, access to health care deteriorated for the poor, the uninsured and minorities. Another report suggests that the numbers of uninsured individuals are increasing.

Maryland health statistics show that there have been tremendous improvements in the health status of Marylanders since 1940, regardless of race. Additionally, overall access to health services for the poor and minorities has improved substantially since the advent of publicly financed health programs, such as Medicaid and Medicare. Unfortunately, federal budget cuts continue to threaten gains that have been made. Nationally, between 1975 and 1983, eligibility requirement changes at the federal level reduced the percentage of low income Americans covered by Medicaid from 63 to 46 percent. In its budget proposals to Congress, the Reagan Administration has consistently attempted to "cap" the level of federal spending on the Medicaid Program, which would lessen further the federal government's committment to the health care needs of the poor.

Maryland's health care system consists of a broad spectrum of health providers and facilities including hospitals, nursing homes, ambulatory care facilities, local health departments and private office based providers. However, access to services, particularly through the private sector, is limited for a number of the State's 4.3 million residents. These include the poor, the uninsured, and Blacks and minorities who are disproportionately found in the poor and uninsured populations.

The Commission was deeply concerned about current trends in access to health care for medically indigent minorities. The Commission's Task Force on Finance, Access and Indigent Care was charged to examine the broader issues related to access to health care services for Blacks and minorities in Maryland.

## Defining the Medically Indigent

For purposes of this report, the medically indigent are defined as individuals with incomes below 200% of the poverty level, and who are uninsured or Medicaid enrollees. An estimated 723,000 Marylanders meet this definition. According to the Alliance for Responsible Health Policy, there are approximately 570,000 uninsured persons in Maryland. Approximately two-thirds of these individuals (i.e., 382,000 persons) have incomes below 200% of the poverty level. In addition, an average of 341,000 individuals are enrolled in the Medicaid program each month.

Blacks and minorities are disportionately found in the Maryland's population with incomes below 200% of the poverty level. According to the 1980 Census, 50% of Marylanders with incomes below 200% of the poverty level are Black.

## Findings

The Task Force identified five major access issues and problems which currently confront Maryland's medically indigent minority populations as discussed below.

### Finding 1: Significant numbers of Marylanders are uninsured or inadequately insured.

Medicaid, the major financier of health care for the poor, currently covers less than half of the State's poor population. Minorities in Maryland are twice as likely as Whites to lack health insurance coverage. According to the 1982 Maryland Household Survey, 12% of Black Maryland adults as compared to 6% of White adults lacked health insurance coverage for hospital care.

When in need of medical care, there are basically three options available to the uninsured. These include foregoing or delaying health care, using free sources of care, or paying for care out-of-pocket. There is evidence from national surveys that the uninsured are more likely than the insured to forego medical care when they sick.

The uninsured population is composed of a diverse group of individuals including children, young adults, and individuals with special health problems. Data from the 1984 Current Population Survey provides the following profile of the uninsured (under age 65), nationally:

- Children, adolescents, and young adults between the ages of 18 and 24 comprise the majority (57%) of the uninsured.
- Almost two-thirds of the uninsured have incomes below 200% of the poverty level.
- The poor are three times more likely than individuals with incomes 200% or more above the poverty level to be uninsured.
- Three-fourths of uninsured children live in families with incomes below 200% of the poverty level.
- The majority (57%) of uninsured adults are either employed full-time or part-time. Another 12% are unemployed.

- The unemployed are 2 1/2 times more likely than the employed to be uninsured.

- Black (25%) and other minority (21%) adults were significantly more likely than White adults (15%) to be uninsured.

- Racial minorities comprised 21% of uninsured adults and 24% of uninsured children.

The development of appropriate options and strategies for improving access to health services for the uninsured requires an understanding of the magnitude and scope of the problem in Maryland. Population based surveys serve as the major method of deriving information on the uninsured. Several states, including Florida and Missouri, have recently conducted surveys which were specifically designed to identify the extent and scope of the State's uninsured poor problem. These surveys found that the magnitude of the uninsured problem differed significantly from the State's prior to estimates which were based on outdated or national studies. The Maryland Department of Health and Mental Hygiene along with several other organizations commissioned a telephone survey to collect data on the characteristics of the uninsured in Maryland. The results of the survey will be available early in 1988 and should assist in shedding further light on the characteristics of the uninsured in Maryland.

Finding 2: There are racial variations in access to and use of primary health care services.

Primary care is that care which addresses the individual's general health needs. It includes the coordination of the individual's health care with responsibility for the prevention of disease, promotion and maintenance of health, treatment of illness, and referral to other specialists and more intensive care as appropriate. Primary care is generally provided in an ambulatory setting.

By its nature, primary care plays an important role in maintaining health, reducing more serious illness, and determining the overall costs of health care through its referral function for specialty care and inpatient hospital use. Hence, assuring access to efficient, quality primary care services should be a priority concern of those interested in developing an effective health care system.

High cost-benefit ratios for comprehensive preventive and primary care services has been documented. One study found that for every dollar spent for prenatal care, $6.12 were saved in neonatal intensive care costs, while another found a $5 savings. A Texas demonstration found that for every dollar spent in comprehensive diagnostic and treatment services for children, more than $8 was saved in both immediate and long term costs.

There are several factors which determine whether access to efficient, quality primary care exists. These include:

- Financial Ability to Obtain Needed Care

  Income and health insurance coverage largely determine the ability of individuals to obtain timely, quality services. Those with low incomes and no health insurance (or inadequate insurance) face the greatest barriers to receipt of care. Medicaid currently covers less than half of the State's poor and near poor populations.

Unless these individuals have access to lower cost or subsidized services provided by federally financed community health centers, local health departments, or other sliding fee scale clinics, these individuals must rely on charity from private providers or face large out of pocket expenses to obtain care.

- Geographic Proximity to Care

Because they are used frequently, it is especially important that primary care services be located within a reasonable distance of a person's home or work place, and easily accessed by car or public transportation. Transportation tends to be a particular problem in isolated rural areas and in some inner city neighborhoods.

- Provider Willingness to Provide Care

Beyond issues of financing and geography, there has been some concern that certain individuals may have difficulty finding providers willing to provide them with primary care services. This surfaces as an access problem for Medicaid recipients, the uninsured, and racial minorities. Provider unwillingess to serve these populations may be the result of remaining racial prejudices, language barriers, or differences in "style" and "appearance" between individual patients and providers.

- Acceptability of Care to Individuals

Like providers, patients may have certain views on the care they find acceptable. Individuals may be unwilling to cross particular geographic or ethnic barriers to seek care, or may prefer particular types of providers whom they feel they can relate to best. Individual perceptions of the amount or type of care they feel is appropriate may vary from professional assessments of need. In some cases, it may be desirable to shape the care system to respond to these concerns. In others, it may be appropriate to provide information and education to alter attitudes or consumer behavior.

Blacks are less likely than Whites to receive prenatal or dental care. Blacks are also more likely than Whites to receive primary care in public clinics and emergency rooms where care is less comprehensive, continuous and preventive in nature.

Finding 3: There are unexplained racial variations in the use of hospital services.

A 1986 report by the Department of Health and Mental Hygiene entitled, Variations in the Use of Medical and Surgical Services by the Maryland Population found significant differences in age-adjusted hospital discharge rates by race.

- The coronary artery bypass surgery rate was four times higher for White males than Black males.
- Rates for whites were higher than those for minorities for the primary diagnoses of acute MI, chest pain/angina, COPD and medical back pain.
- Minority rates exceeded those for Whites for alcohol/drug abuse addiction and hypertension.
- About 24% of minority admissions were elective as compared to 32% of White admissions.

The study's authors concluded that "racial differences in utilization raise the possibility that institutional barriers preventing access to health services may still exist despite the belief that Medicaid has eliminated many of these barriers. Further investigation must be done to determine the extent to which physician practice patterns, as opposed to insurance coverage and related socio-economic factors, contribute to these racial differentials."

Finding 4: There are racial variations in payment and utilization levels within the Medicaid program.

The Medical Assistance (Medicaid) Program is the major financier of comprehensive health care services for the poor. Medicaid began in Maryland in 1967. The State Program is administered within federal laws and regulations, and pays hospitals, nursing homes, physicians, pharmacies, dentists, health maintenance organizations (HMOs), clinics, home health agencies, and many other providers to furnish necessary health care to Marylanders who receive public assistance or have income and assets below the Program's standards. The federal government pays one-half of the costs of these services for most eligible persons. Program participants receive an eligibility card which they present to participating health care providers when they receive services. Providers bill the Program for the services they render. Applicants who meet the eligibility criteria are entitled to enrollment in the Program, and once enrolled, are entitled to eceive any medically necessary services that are covered under the Program. Eligibles are free to receive services from any participating provider who is willing to treat them.

Although most Medicaid-funded services are delivered by private providers, in keeping with the aim of the Program to provide mainstream health care to Program eligibles, Medicaid also is a major financier of services provided by the Department of Health and Mental Hygiene (DHMH), its grantee agencies, and local health departments. The Program pays for Medicaid-covered DHMH services that are delivered to Medicaid-eligible recipients. Thus, Medicaid serves as one of several sources of funding for these services. Medicaid currently pays for most of the services to the mentally retarded in State institutions and for a limited number of patients in State mental hospitals (only those aged 21 and under or 65 and over). The Program pays for Medicaid eligibles to receive services in local health department clinics, and also through EPSDT outreach, home health, mental health clinics, drug abuse clinics, family planning clinics, primary and preventive care clinics, children and youth clinics, and others.

Blacks and minorities are four times more likely than Whites to be Medicaid recipients. Maryland data have consistently indicated that there are racial differentials in payment and utilization levels within the Medicaid Program:

- On average, Medicaid payments are higher on behalf of Whites than minorities.
- White Medicaid enrollees are nearly 2 1/2 times more likely to receive nursing home care as compared to Black elderly enrollees of the same age.
- In Baltimore City in 1982, Medicaid payments for White AFDC enrolled children were significantly higher than for Black AFDC enrolled children.

Finding 5: Health care resources are maldistributed.

Since 1973, the federal government, through the Public Health Services, has designated areas with high medical need and few financial and/or health resources as either medically underserved (MUA) or health manpower shortage (HMSA) areas. These designations have entitled communities to receive National Health Service Corps health professionals as a result of the HMSA designation or funding to construct community health centers (CHCs) in the case of the MUA designation. The Health Resources Planning Commission is the lead state agency responsible for submitting the necessary documents to the PHS for designating MUAs and HMSAs.

Community health centers receive federal funds to assist in the provision of a comprehensive set of primary care services to uninsured poor or "grey area" populations. NHSC health professionals, include physicians, dentists and podiatrists, who agree to serve for a designated time in underserved rural and urban areas in exchange for health professions school scholarships and stipends.

The identification of underserved and shortage areas has greatly assisted federal, state and local governments in improving access to primary care for vulnerable populations by targeting resources to areas of greatest need. However, under the Reagan Administration, federal support for the NHSC and CHC programs has waned. Since 1981, the numbers of federally funded CHC grantees in Maryland has declined from sixteen to eight.

Blacks are three to four times more likely than Whites to live in medically underserved or health manpower shortage areas. Maryland currently does not have a well developed plan to address the maldistribution of health manpower resources.

# SUMMARY REPORT ON CARDIOVASCULAR DISEASE, CANCER, DIABETES, AND AIDS

## Introduction and Background

There have been major improvements in the health of Marylanders, of all races, since 1940. The 1984 edition of Health, Maryland showed that age-adjusted mortality rates for deaths due to all causes have shown significant declines. However, tremendous differences in the mortality rates remain for different races. Minority death rates exceed the white rate for both gender groups. With few exceptions, this disparity persists for all of the leading causes of death among Marylanders. Similarly, Black rates of infectious diseases, especially for AIDS and sexually transmitted diseases, exceed those of the White population.

Heart disease, cancer, stroke and diabetes account for two-thirds (68%) of all deaths in Maryland. The racial disparity noted in overall mortality rates persists for cause specific mortality with excess minority mortality observed for all these diseases in both men and women.

The sexually transmitted disease (STDs) rates, reported in Maryland are among the highest in the nation. In Maryland more than two-thirds of these cases occur among minorities.

Smoking and poor nutritional habits are the two leading and overlapping risk factors for cardiovascular disease, cancer, diabetes and other negative health conditions. Smoking contributes to 30 percent of heart disease and 85 percent of lung cancer. About one-third of adult Marylanders smoke, but larger numbers of smokers are from the Black population in both gender groups. Additionally, fewer Black smokers report attempting to quit smoking.

Minorities, especially Blacks, experience lower survival rates for cancer than the majority population. The overall survival rate was 12 percentage points lower for Blacks than Whites during 1976-81. In addition to smoking, high blood pressure and elevated blood cholesterol are the major controllable risk factors for cardiovascular disease. Larger proportions of Black Maryland adults are afflicted with high blood pressure than are White Maryland adults. Smaller proportions of diagnosed Black adult hypertensives are effectively controlled than are White adult hypertensives.

Poor nutritional practices and obesity are the major risk factors for type II or non-insulin dependent diabetes mellitus. Additionally, diabetic complications contribute to heart disease, stroke, kidney failure, blindness, circulatory problems, and the need for amputations. The occurrence of these types of complications are more common among minorities, especially Blacks.

While it is useful to examine risk factors for specific disease entities separately, it is important to note that many of these risk factors overlap. Smoking contributes to heart disease, several types of cancer, and other serious health problems. Similarly, dietary practices have been implicated in cardiovascular disease, hypertension, cancer and diabetes.

Access to health care is also an important component in improving and protecting health status. Inequities in access to care have been widely documented for disadvantaged populations. Minorities are often the larger proportions of these populations. Barriers to care can result in the exacerbation of minor problems to more

serious and costly conditions. These barriers are implicated in the poorer cancer survival rates among minorities as well as the rate of complications associated with insufficiently controlled hypertension, diabetes, and sexually transmitted diseases.

Barriers to care may be caused by a range of factors, including finances, geography, and resource availability. Cultural beliefs, and individual knowledge can also precipitate barriers to use of variable resources.

These risk factors and barriers point to the need to: (1) achieve behavioral change to reduce high risk behaviors; (2) improve professional communication skills and public education; (3) increase prevention efforts; (4) increase access to care especially in ambulatory settings; and (5) bridge gaps in existing research.

Education is an effective strategy to prevent and control health problems among Blacks and minorities in Maryland. Professional education programs emphasizing communication skills can help to address cultural and ethnic gaps that may exist between providers and consumers. In public schools, health education curriculums can support healthy life-styles and relate information on sexually transmitted diseases, smoking, drug and alcohol abuse. Self-education programs can encourage patient compliance with treatment regimens for diseases such as diabetes and hypertension. Educational strategies based in community networks can be used to develop peer counseling to combat the risk of chronic and infectious diseases, including AIDS.

## CARDIOVASCULAR DISEASE

### Background

Diseases of the cardiovascular system -- the heart and blood vessels -- are the leading causes of death among the general population(4). These diseases, including coronary heart disease, hypertension, and stroke, are also the major contributors to morbidity and mortality among Blacks and minorities. While the overall rates of these health problems has declined considerably since 1940, there is a continuing disparity between the White and minority rates.

The three major controllable risk factors that contribute to the development of cardiovascular disease (CVD) are high blood pressure, smoking and elevated blood cholestorol. Research has shown that an individual's risk of CVD increases with the number of risk factors present. Thus, co-existing risk factors exert a synergistic effect on the development of CVD. Similarly, the risk of disease increases directly with the magnitude of the risk factor present, e.g., level of elevated blood cholesterol and numbers of cigarettes smoked. Consequently, successful preventive strategies must address multiple risk factors.

The risk factors for CVD overlap with those for other leading causes of morbidity and mortality. High blood pressure can lead to kidney failure as well as heart disease and stroke. Excess dietary fat, especially animal fat, can lead to high blood cholesterol, and has also been implicated in breast and colon cancer. In addition to 30 percent of heart disease, smoking also contributes to 85 percent of lung cancer as well as other serious respiratory diseases. Obesity is a risk factor for high blood pressure and diabetes, and also colon cancer, prostate cancer, endometrial cancer, gout, and gallbladder disease. Therefore, successful management of the risk factors associated with CVD can also assist in controlling other major health problems.

Disability and death due to CVD usually strike adults during their most productive years resulting in tremendous losses in productivity, as well as burdens to families and society. Heart disease and stroke cause more deaths, disability, and economic losses in the United States than any other acute or chronic diseases and are the leading causes of days lost from work.

### National data

CVD is the leading cause of death among all Americans; however, the risk of death due to this cause is 1.5 times greater for Black Americans. Available data on other American minority groups is limited but show that the risk of CVD varies being lower in Mexicans and higher in Japanese men and Native Americans.

Nationally, Blacks as compared to whites (11):

- have higher mean high blood pressure levels;
- are more likely to die of stroke;
- are more likely to acquire end-stage renal disease (linked to hypertension);
- are more likely to smoke; and
- are more likely to be obsese, particularly Black females.

Mean serum cholesterol levels do not differ substantially in Black and White adults.

Available data show that Mexican Americans experience lower stroke mortality than non-Hispanic Whites. However, Hispanics do smoke more than non-Hispanic Whites. Obesity is more prevalent in Hispanic women than non-Hispanic White women. Among Asians, stroke mortality is similar to Whites, except for Japanese men who have a very high stroke mortality. Hypertension is a major concern for Native Americans.

The Federal Task Force on Black and Minority Health noted that varying cultural values, educational and income levels as well as care seeking behaviors and health practices may also contribute to the variations in CVD and associated risk factors among minority populations. These variations should be recognized and addressed by those attempting to design effective interventions for controlling CVD among minority populations. Besides environmental and behavioral factors, access to appropriate medical services is also a key concern.

## CANCER

### Background

As the second leading cause of death in the United States, cancer is a major public health problem. The burden of cancer morbidity and mortality differs among the different racial and ethnic groups in the population. However, Blacks, the largest minority population group in the U.S., have the highest overall age-adjusted cancer incidence and mortality rates of any U.S. population group.

Behavior plays a significant role in cancer development. More than 35 percent of all lung cancers, the most prevalent form of cancer in the U.S, have been causally related to cigarette smoking. Cigarette smoking is also a major cause of cancer in other parts of the respiratory system and a contributory factor in cancers of the bladder, pancreas and kidney. Dietary factors are thought to account for 35 percent of all cancer deaths. Epidemiological study results suggest a link between dietary fat intake and some cancers, particulary those of the breast, colon, endometrium, and prostate gland. Alcohol-related cancers are estimated to be responsible for 3 percent of cancer deaths in this country; these include cancers of the mouth, pharynx, larynx and esophagus. Since half of all cancer deaths result from malignancies of the lung, colon and rectum, breast and pancreas, risk factors for these cancers are among the primary targets of cancer prevention efforts.

Prevention of malignancy formation is foremost in cancer control, but there are also many effective treatment methods available today. If cancer is detected early, treatment with chemotheraphy, radiation, or surgery, as appropriate, can effect a cure. The National Cancer Institute has indicated that half of all Americans diagnosed with cancer can expect to survive at least five years. However, the survival rates among minorities, especially Blacks, are generally not as high as those among the non-minority population. The five-year survival rate among Black Americans is only about 38 percent as compared to 50 percent for White Americans. This indicates a lack of access to effective screening, diagnosis, and treatment for minorities.

The differences in cancer incidence, survival and mortality rates between Whites and minorities include socioeconomic factors (income and educational levels), dietary factors and higher rates of smoking. Black Americans, particularly in urban areas, are more likely than whites to lack health insurance, education and easy access to care. This increases their risk of death from cancer, because many cancers can be successfully treated only if detected early and treated immediately. Studies of large populations suggest that Blacks, as a group, tend to follow diets relatively high in fat and low in fiber ---- thereby increasing the risk of cancer. Alcohol consumption habits among Blacks are implicated in the high rates of esophageal cancer in that group.

The report of the Federal Task Force on Black and Minority Health, suggests that the cancer burden among minorities, especially those in lower socio-economic groups, may be due to insufficient knowledge about pertinent cancer facts. These facts include cancer's early warning signs, the importance and availability of screening and treatment resources, and modifiable risk factors. Reportedly, Blacks also tend to be more pessimistic than non-minorities about their chances for survival should they develop cancer. As a group, Blacks tend to be more fatalistic and less likely to believe that early detection makes a difference and that existing treatments are effective. Belief in myths about cancer is also more widespread among Blacks. Therefore, effective educational strategies to address these misconceptions and practices are important in cancer control efforts among Black and minorities.

**National data**

While the number of cancer cases is steadily increasing as the population grows, the overall age-adjusted total cancer incidence and mortality rates have remained stable during the last 30 to 40 years. Blacks have the overall highest age-adjusted cancer incidence and mortality rates of any group in the U.S. The age adjusted incidence for Black males is 25 percent higher than that of non-minority males and 4 percent higher for Black females than White females.

Lung cancer accounts for over 20 percent of all cancer deaths. The death rate for lung cancer in Black males is 45 percent higher than that in White males. The death rate for lung cancer among Black and non-minority females is about the same, but the expected increase in lung cancer incidence among Black females (98.6%) exceeds the expected increase among White females (86%) between 1980 and 1990. Similar increases in mortality rates for lung cancer are also expected in these two groups.

The breast cancer mortality rates for Black women and White women do not differ markedly. However, the five year relative survival rate for black women is only 63 percent as compared to 75 percent for non-minority women. Similarly, the five-year survival rate for cancer of the rectum is only 37 percent among Blacks as compared to 49 percent for non-minorities.

The incidence of pancreatic cancer among Blacks is 1.5 times higher than that for non-minorities. Black males showed an increase in the incidence of this type of cancer during the 1973-81 time-period. Excess risk for this type of cancer has been found among cigarette smokers and persons with diabetes mellitus.

Other sites of excess cancer mortality in the Black population include the esophagus, stomach, prostate, cervix and corpus uteri. Cervival cancer mortality and incidence rates are 2.5 times higher among Black females than among non-minority females. During the 1973-81 time period, non-minority female mortality due to cervival cancer showed a 20 percent decrease while Black females experienced a 27 percent increase. This is an alarming finding since cervical cancer is 100% curable if detected in time.

Available data on other American minority groups show that the over-all age-adjusted cancer incidence rate for Hispanics is lower than that for Blacks and non-minorities. However, Hispanics have twice the rate of stomach cancer found in non-minorities. Incidence of cancer varies widely within Asian groups with rates for Chinese, Japanese and Filipinos lower than for non-minorities, but showing an upward trend. Compared with the rest of the U.S. population, Native Americans have the lowest overall rates of cancer incidence and mortality, but lower cancer survival rates than non-minorities.

**Maryland data**

The local situation reflects the national picture with nonwhite mortality due to cancer exceeding that of Whites for both gender groups. Additionally, mortality rates for the total state population as well as White and non-white groups exceed comparable national figures. At the state level, it is also important to note that in addition to the racial disparity, the mortality rates for males, especially minority males, is increasing (105% increases between 1940 and 1981). Although the rates for Maryland females have not changed as much, the rates for minority females show an increasing trend while those for White females show a decline.

The leading causes of cancer mortality in Maryland are cancer of the respiratory and digestive systems accounting for 27 percent and 26 percent, respectively, of all cancer deaths. Mortality rates for respiratory cancer are highest among nonwhite males. These rates reflect the local smoking prevalence which is highest among nonwhite males. Mortality rates for digestive system cancer among all race/sex groups have shown some decline since 1940, but remain the highest and show the least improvement among nonwhite males. Mortality rates due to cancer of the genital organs have decreased markedly since 1940 among females but are increasing among nonwhite

males. Rates due to prostate cancer for nonwhites were almost double that for Whites (53.1 vs. 27.6) for 1976-80 time period. Breast cancer mortality rates have decreased only slightly since 1940 with rates for nonwhites females remaining more unstable.

## DIABETES

### Background

Diabetes is a leading cause of mortality in the general population and a major contributor to the disparity in health status between minorities and non-minorities. In general, a person's life expectancy at diagnosis of diabetes is diminished by one-third. Additionally, complications of the disease make it a risk factor for other diseases, including coronary heart disease. People with diabetes have twice as many heart attacks and strokes as non-diabetics. Diabetes accounts for 25 percent of new kidney failure and 12 percent of new blindness. Complications of diabetes associated with circulatory system problems lead to half of all nontraumatic amputations each year. For pregnant women, diabetes can lead to a range of serious health problems for their babies including prematurity, congenital abnormalities, respiratory distress syndrome, and neonatal death.

Primary prevention of type II diabetes is important in efforts to control the development of new cases of this disease. These efforts emphasize healthy nutritional and exercise practices. Secondary prevention, primarily early medical treatment, of diagnosed cases can help to prevent/control development of the serious complications associated with untreated diabetes. This level of prevention focuses on dietary and exercise practices also as well as the control of other unhealthy conditions or practices, including hypertension, hyperlipidemia, hyperglycemia, that may be present. Education in self-care skills and access to adequate medical care are also important in successful prevention/control efforts.

Due to the serious nature of the complications of untreated or uncontrolled diabetes, the economic and quality of life costs are enormous. Any effort to quantify these costs are understated because diabetes is not always the first cause of death listed. People who die with diabetes usually die from its long-term complications, such as heart disease, kidney disease and stroke.

### National data

It is estimated that 10 million Americans have diabetes. Almost half of these cases are undiagnosed. Nearly 150,000 people die annually from the disease and its complications.

Diabetes prevalence is 33% higher in the Black population than in the White population. Most of the Blacks who are diabetic are overweight females. Among persons, mostly elderly, living in long-term care facilities, surveys indicate a diabetes prevalence of about 15 percent. Additionally, several studies indicate that diabetes-related complications are more frequent among Black diabetics than their White counterparts. There are also indications that gestational diabetes, occuring only during pregnancy, is more prevalent among Blacks than Whites. One study in South Carolina indicated the perinatal mortality rate among Blacks was 3 times that of Whites with diabetes and 8.5 times that of Whites without diabetes.

Diabetes is particularly widespread among American Indians. The Pima Indians have the highest rate of diabetes in the world, about 10 to 15 times higher than that of the general U.S. population. Mortality rates for diabetes related disorders are 2.3 times higher among American Indians and Alaska Natives than in the general population.

Reportedly, the prevalence rate of diabetes among Hispanic Americans is more than three times the rate of the non-Hispanic white population. Population-based studies in the southwestern United Stated show that Hispanic women in low-income areas are four times more likely than Hispanic women living in surburban areas to have the disease, and Hispanic men are twice as likely. Concomitantly, obesity also occurs at higher levels among Hispanic women in the low-income areas.

Only very limited data is available on diabetic prevalence among Asian/Pacific Islanders. Although not representative of the entire Asian-American population, available data indicate that Japanese Americans have consistently higher rates of diabetes and associated mortality than the Japanese in Japan. However, unlike other populations, more Japanese American men than women suffer from diabetes.

### Maryland data

Diabetes is the seventh leading cause of death in Maryland. Available mortality statistics show that minority persons are nearly two times as likely to die because of diabetes than White persons. Rates vary according to gender group and are highest among nonwhite females.

In efforts to control diabetes as a leading cause of excessive death and disability among minority populations, it is recommended that specific interventions be implemented to prevent diabetic complications such as blindness, amputations, cardiovascular disease, kidney disease and adverse outcomes to pregnancy. These interventions, based largely on early identification and follow-up, can be delivered through the existing health care system at a cost far less than the eventual costs resulting from the uncontrolled complications.

Diabetes can be successfully prevented or controlled through appropriate nutrition and other recognized health practices. Additionally, the presence and extent of complications can be significantly diminished by the successful address of obesity and other compounding risk factors, e.g., smoking. Community-based efforts, incorporating significant organizations and leaders, are recognized for their effectiveness. Self-care and self-monitoring are important adjuncts to clinical care and treatment.

## ACQUIRED IMMUNE DEFICIENCEY SYNDROME (AIDS)

### Background

Infections caused by the human immunodeficiency virus (HIV) elicits a range of responses, from sub-clinical infection to the most severe manifestation, Acquired Immune Deficiency Syndrome (AIDS). The end result of the infectious process is a breakdown of the body's immune system that allows for development of opportunistic infections and certain rare forms of cancer. AIDS is uniformly fatal, but can be prevented by preventing transmission of HIV. Transmission of the virus occurs through exchange of body fluids as in sexual contact, needle sharing, or in utero. The earliest cases of AIDS reported in this country were primarily for White homosexual men.

However, AIDS is becoming a priority problem in the minority community since the dramatic increase during recent years in the number of cases reported for Blacks and Hispanics.

As the number of reported cases of AIDS grows, it has become the subject of increased local and national attention. Efforts are focused on controlling the spread of the virus, but there are various other related issues including adequacy and financing of medical care resources as well as AIDS related discrimination and other legal concerns. Nationally, the Department of Health and Human Services is leading control, surveillance and related efforts. In Maryland, the Department of Health and Mental Hygiene, and in particular, its AIDS Prevention Unit, is coordinating a similar local effort. The Johns Hopkins and University of Maryland Medical Systems and several private community and professional efforts are also actively involved.

Since there is no cure for AIDS, prevention of the spread of the HIV agent is the only available control. No vaccine is available or expected to be available within the immediate future. Therefore, the principal preventive strategy is education of the public about how to prevent exposure.

Priority efforts are recommended for known high risk groups. In Maryland, testing for antibodies to HIV is widely available on a free and confidential basis at DHMH sponsored screening sites. Counseling is also provided at these screening sites to provide at-risk individuals with information on how to protect themselves. Individuals who test positive are counseled on how to avoid infecting others and about follow-up medical resources.

Although there is, currently, no known cure for AIDS and other HIV infections, supportive treatment is available. This treatment can prolong the course of AIDS without effecting a cure. The course of the AIDS/HIV infection is not uniform in all persons. Treatment requirements vary but usually include in-patient/chronic hospital care. When the patient is not acutely ill, out-patient, nursing home or other less-restrictive care settings may be adequate. Hospice care is also desirable for dying patients. Mental health services are needed for patients with neurological dysfunctions causing abnormal behavior, or other forms of dementia.

The Report of the Governor's Task Force on AIDS pointed out that patients with AIDS and other types of HIV infections often have multiple problems or may even refuse services. Therefore, development of a comprehensive system of care with well-trained counselors and case managers is critical to the successful management of these patients. The need to manage patients must be sensitively coordinated with the patient's need to maintain personal dignity and privacy.

Total treatment costs for AIDS patients vary but are usually very expensive. Originally, the Centers for Disease Control estimated the per case medical costs to be about $147,000; other studies have reported costs closer to $50,000 and some as low as $25,000. These costs are for patients diagnosed with AIDS. Patients with other stages of active HIV infections, including AIDS related complex (ARC) and Lymphadenopathy Syndrome (LAS), may also require extensive treatment resources. Treatment costs vary with the length of the course of illness and the availability of alternatives to in-patient regimens.

National Data

In December 1986, the size of the HIV infected population was estimated to be 1.5 million, nationally. Current evidence suggests that about half of the persons infected with HIV will ultimately progress to AIDS over a 10 year period. The incubation period -- - from infection to the diagnosis of AIDS ---- is long. The median incubation period is estimated to be four to five years and the range as six months to fifteen years. The January 1987 cumulative national total of AIDS cases was in excess of 29,000 cases and more than half of these cases have expired. The majority of the reported cases were diagnosed in homosexual and bisexual men (73%) followed by intravenous drug abusers (17%) and a smaller group that includes hemophiliacs and other transfusion recipients, infants born to infected mothers, and heterosexual partners of members of the previously listed groups. Prior to 1986, the heterosexual proportion of the reported cases accounted for only 1-2 percent; in 1986, these cases are expected to represent 7% of the annual total and that figure is expected to rise to 9% by 1991.

The Centers for Disease control provides data to indicate the disparity in the occurrence of AIDS among minorities and non-minorities. Altogether more than one-third of the 39,219 cases reported natioally have occurred in minorities. Nearly 80 percent of all the pediatric AIDS cases are either black or Hispanic. More than 70 percent of female cases have occurred in minority women. The principal transmission category differences center on sexual orientation and drug abuse. For cases reported among intravenous drug abusers, 12 percent occurred in White men but 40 percent in Black and Hispanic men. Additionally, half of the Black and Hispanic cases occurred among heterosexuals whereas heterosexuals account for less than 15 percent of White cases.

Maryland data

In January 1987, there were an estimated 26,000 people infected with HIV in Maryland. Based on the current infected-to-active AIDS premise, 3,200 of these people may be expected to develop AIDS. The cumulative total of reported cases in Maryland on April 30, 1987 was 572 with 354 of those already expired.

Of special concern, locally, is the fact that the majority of AIDS cases reported in Maryland have occurred among the minority (Black) population. The majority of AIDS cases among both Blacks and Whites have been reported for homosexual and bisexual men. The next largest population of AIDS cases has been reported for intravenous drug abusers; however, in this transmission category, the proportion among Blacks is 22.9% and only 3.7% among Whites. Among females, the disparity is even greater, with 48.6% of the reported cases occurring in Black female intravenous drug abusers as compared to 13.3% in White female intravenous drug abusers. An additional disparity is noticeable among pediatric cases with the majority of all cases in this category reported for Black children (66.6%).

Since AIDS and other HIV infections cannot be cured, prevention, primarily through education, is the only available control strategy. Because HIV infections are widespread in the population, a multifaceted approach to reach all age-levels and risk groups is desirable. This approach should utilize a variety of techniques and educational resources in order to maximize effectiveness. A coordinated approach will minimize duplication of efforts and promote replication of successful strategies.

The course of infection with HIV is variable, ranging from symptomatic to the terminal stages of AIDS. Consequently, a variety of treatment resources are required for supportive services delivery. It is desirable to provide adequate care in the least restrictive setting appropriate in order to enable the patient to maintain as normal a life style as possible. Patients who are not acutely ill may be able to work, study, and pursue other productive efforts.

The Surgeon General has recommended the use of condoms as an intervention which can help to control the spread of HIV during sexual contact. Distribution of these and other contraceptive devices free can enhance control efforts among poor, sexually active populations.

Street outreach programs can increase the potential of control efforts to reach prostitutes and drug-abusers. Support of research to find more effective treatment methods is important for current and future victims of this virus. Additionally, research in one area often produces results that are useful in addressing other maladies.

## COMMUNITY HEALTH EDUCATION

### Introduction

Chronic diseases and disabling injuries are the leading causes of morbidity and mortality in both the general and minority populations. Additionally, several infectious diseases, including sexually transmitted diseasses and AIDS, also precipitate enormous suffering and economic costs for these populations. The underlying causes of these conditions are complex and are often not fully understood. However, an increasing body of scientific evidence has demonstrated that personal lifestyles play a major role in the development of these diseases, and consequently, individual health status.

Other major factors that contribute to the health of a population include human biology, the environment and the health care system. Although the extent of the contribution to mortality by each of these factors varies by cause, lifestyle is generally recognized as the principal determinant.

Factors whose presence is associated with an increased likelihood that disease or disability will develop at a later time are called risk factors. Some risk factors can be altered, as when smokers stop smoking. Others (e.g., family history) are not amenable to change, but their identification may be useful for tagging persons who deserve close medical supervision. Still other attributes, such as age or sex, are unalterable but are still considered risk factors. By decreasing or eliminating the presence of risk factors, the risk of morbidity/mortality can also be decreased.

Changing or eliminating the modifiable risk factors that lead to health problems is the focus of the contemporary disease prevention/health promotion movement. Dietary patterns, physical activity, usage of alcohol, tobacco and other drugs are some of the lifestyles factors that are within the control of individuals and can be modified by effective preventive health interventions.

Preventive health interventions include a variety of health promotion and disease/disability prevention strategies to promote the development of healthful environments and healthy lifestyles. Foremost among these strategies is health

education. The focus of organized health education activity is to maintain positive health behavior or to interrupt a behavioral pattern that is linked to increased risks for illness, injury, disability or death. The educational intervention may be directed at high-risk individuals, families, groups, or at whole communities through mass media, schools, worksites, and organizations. The more successful health promotion programs emphasize individual health but involve the entire commuity in efforts to promote and protect the health of all individuals in the community.

Besides preventing disease, disability and premature mortality, health promotion programs also seek to enhance the quality of life. Good health is more than just the absence of illness or defect. A healthy individual experiences an increased vitality and energy that enables him to fulfill his everyday responsibilities effectively and enjoyably. Individuals who enjoy not perfect health, but a high level of well-being, find life stimulating and are usually more productive and happier individuals. Improved quality of life for the individual and the community as a whole can be the result of well developed, creative and innovative health promotion programs.

Major health problems not only increase human suffering and decrease the quality of life, overall, but also precipitate enormous medical treatment costs. By preventing premature deaths and unneccessary illness, that is, by implementing appropriatley formulated health promotion programs, millions of dollars, for treatment costs can be saved. These dollars can be used for other priority social and human needs including education, housing and transportation.

Health education has been demonstrated to be an effective strategy in changing behavior patterns which are known to contribute to the deterioration of health. Appropriately designed educational interventions may be directed at high risk individuals, families, groups or at whole communities through mass media, schools, worksites, health service sites and organizations. The more successful health promotion programs emphasize individual health but involve the entire community in efforts to promote and protect the health of all individuals in the community.

There is a greater predominance of many of the known behavioral health risk factors present in the minority population, (e.g., smoking and dietary practices). Consequently, efforts to inform and educate minority populations about risk factors and available care resources can yield significant benefits in improving the health status of these populations.

Many factors can enhance or impede the effectiveness of a health education strategy. Development of meaningful health messages and effective dissemination within a given population requires attention to cultural and economic constraints. A successful approach must also be appropriately tailored to the language and educational levels of the targeted group. Additionally, health care providers and lay counselors involved in the educational efforts must be adequately aware of and sensitive to the health problems, attitudes, beliefs and concerns of minority populations.

Although the value of health education and other preventive health services is widely recognized and well documented, these services are consistently underutilized by members of both the minority and general population. The reasons for this discrepancy are multiple and varied with some due to patient factors as well as physician factors. Still others barriers are related to the health care delivery system itself. One of the most significant problems is finance-related. Traditionally, reimbursement for preventive care has been very limited. Restrictive financing mechanisms do not foster the availiability of services, staff and other needed resources. These limitations, in turn,

precipitate access problems, especially in disadvantaged communities. Consequently, support for expansion in the reimbursement for the provision of patient counseling and other preventive services is required.

# SUMMARY REPORT ON HOMICIDE, SUICIDE AND UNINTENTIONAL INJURIES

"The issue of Black-on-Black homicide is everybody's problem. It is a sociological phenomenon with intricate and complex origins and we would do well to sit up and take notice. Unless we work collectively to address this problem, the time will soon come when none of us can walk the streets safely. It is a burden we all share and we will all suffer the consequences of inaction by those segments of society with the power to make a difference."

The Final Report of the Kansas City Ad Hoc Group Against Crime, January, 1987

## Introduction

Injuries are among the leading causes of death and premature mortality for Blacks and minorities in Maryland. Injuries may be classified as intentional or unintentional. Homicides, suicides, nonfatal assaults, and self-inflicted injuries are considered intentional injuries, while unintentional injuries include motor vehicle accidents, fires, and falls. Between 198_ and 1985, homicides and unintentional injuries were the third leading causes of excess Black and minority deaths. If Blacks and minorities had died at the same rate as Whites from homicide and accidents, on average, 255 fewer minorities would have died in 1985.

## Homicide

Homicide - death due to injuries inflicted by another person with the intent to injure or kill, by any means - has reached epidemic proportions in American society. It continues to rob society and families of adolescent and young Black men in the prime of their lives. According to the FBI, one American kills another every 28 minutes.

Between 1980 and 1986, almost 3,000 Marylanders died as a result of homicide. Blacks represent the overwhelming majority (70%) of the State's homicide victims. In 1986, homicide in Maryland was:

- the twelfth leading cause of death for all Marylanders;
- the fourth leading cause of death for Black Marylanders;
- the third leading cause of excess Black and minority deaths in Maryland;
- the second leading cause of death for all Maryland adolescents between the ages of 15 and 24 (suicide was third);
- the second leading cause of premature mortality for Black males;
- the leading cause of death for Black females between the ages of 15 and 24; and
- the leading cause of death for Black males between the ages of 15 and 45.

The federal Task Force on Black and Minority Health found that "no cause of death so greatly differentiates Black Americans from other Americans as homicide." In 1985, the age-adjusted death rate for homicide for minority males at 37.7 was eight times higher than the White rate at 4.8 deaths per 100,000 population. Baltimore City has the highest age-adjusted death rate from homicide of any subdivision in the State. In 1985, Maryland had the 20th highest age adjusted death rate from homicide in the nation. Baltimore City had the 12th highest homicide death rate of all major cities in the U.S.

Dr. Nollie Wood, a nationally recognized expert on homicide and violence, has provided the following data and information about homicide:

- Most homicides involve:
  - guns.
  - one victim and one offender.
- Most homicide victims are:
  - killed by someone of their own race (80% of homicides are Black-on-Black victimizations and 12% are White-on-White victimizations).
  - killed by an acquaintance.
- Blacks as compared to Whites are:
  - 6 times more likely to be killed by an acquaintance.
  - 6 times more likely to be killed with a gun.
  - 4 times more likely to be killed with a cutting object.
  - 17 times more likely to be killed in felony circumstance.
  - 22 times more likely to be killed in a drug related circumstance.

The causes of homicide are varied and complex. Physiological, environmental, psychological, and lifestyle factors, such as unemployment, substance abuse, poverty, stress, hopelessness, and helplessness are thought to play principal roles in homicide occurence. Homicide has been thrust into the public health arena because of it is a leading cause of premature mortality, and because of its link to mental health, and substance abuse. Approximately 50% of all homicides are related to the use of alcohol, and 10 to 20% of homicides are associated with the use of drugs.

The Commission found that very little attention has been given to the issue of homicide by Maryland's public health system. Violence continues to be viewed by many as strictly social and criminal justice issues instead of the public health crisis that it has become. Creation of an appropriate public health approach to homicide prevention would involve linking disparate community, academic, and governmental agencies in a coordinated, but multi-faceted manner to develop a long term strategy to effectively combat the problem of violence.

Multiple opportunities to help prevent homicide exist in Maryland. For example, all general hospitals and many specialized health providers serve victims of assaultive violence. Fracture and soft tissue injuries resulting from assaultive violence often receive excellent treatment in medical facilities, but the causes of the injury (e.g., drunken quarrels, arugments over drugs, and ongoing disputes) usually are only addressed if the victim and/or perpetrator is viewed as having a psychotic disorder or if the individual is overtly suicidal or homicidal.

Most Maryland efforts directed toward preventing homicide or further violence currently focus on spouse or child abuse victims. This is partially due to the media attention given to these issues. For the most part, Black male victims and perpetrators of assaultive violence are often not identified as such and repeat victims of assaultive violence often do not receive treatment for the underlying causes of violence.

Several groups in Maryland including the Association of Black Psychiatrists and the Baltimore Urban League, as well as several grass-roots level organizations are concerned about Black-on-Black homicide. Community-based efforts which address this problem, such as the "Stop the Killing" program are applauded by the Commission. More of these programs are needed.

In a recent report, the Association of Black Psychiatrists voiced the urgent need to recognize homicide as a public health issue. The report offered several public health and non-public health approaches to preventing homicides in the Black community. These include gun control, adolescent pregnancy prevention strategies, parenting programs, and school based violence prevention programs.

## Suicide

Suicide is one of the few causes of death where the age-adjusted mortality rate is higher for Whites than minorities in Maryland and the U.S. For the past four decades, the suicide rate for the White population has been almost twice the rate for minorities. In 1986, suicide was the eighth leading cause of death for all Marylanders and the twelfth leading cause of death for Blacks. Suicide claimed the lives of 543 Marylanders in 1986, including 78 Blacks and 7 members of other minority groups.

The overwhelming majority (67% in 1986) of individuals who commit suicide are White males. Suicide death rates are lowest for minority females. In 1986, the age-adjusted death rate from suicide for White males at 18.4 was nine times the rate for minority females at 1.9.

Suicide is the third leading cause of death for Maryland adolescents and young adults between the ages of 10 and 24. Between 1970 and 1985, 1520 Maryland individuals in this age group committed suicide, including 254 minorities. The youth suicide rate has tripled in Maryland since the 1950's, according to the recent final report of the Maryland Governor's Task Force on Youth Suicide. The Task Force found that although White male youth die from suicide at a higher rate than minority male youth, the suicide rate among minority male youth is increasing. Between 1950 and 1982, there was a 227% increase in the minority male youth suicide rate. This finding requires further investigation.

Data on the extent of suicide among Native Americans, Hispanics, and Asian Pacific Islanders living in Maryland is virtually nonexistent. The federal Task Force Report on Black and Minority Health found that the death rate for suicide among American Indians at 14.1 per 100,000 in 1980, was approximately 20% higher than that of the general population. Suicide also occurs at higher rates among Chinese women over age 45 when compared to White women of the same age.

The exact magnitude of the problem of suicide is unknown. Deaths which result from factors, such as accidents and drug overdoses, may often go unrecognized as suicides in both the majority and minority communities.

## Unintentional Injuries

Unintentional injuries or accidents were the third leading cause of death for both minority and majority Marylanders in 1986. Motor vehicle accidents accounted for slightly more than half of the 1521 deaths due to unintentional injuries in 1986. Other causes included accidental poisonings (61), accidental falls (203), fires (73), and drownings (72).

The age-adjusted death rate from motor vehicle accidents has consistently been higher for Whites than minorities in Maryland, while the age-adjusted death rate for non-vehicular accidents has consistently been higher for minorities than Whites. Unintentional injuries affect all ages, but especially the young and the elderly. According to the Maryland Center for Health Statistics, accidents were the leading cause of death for both Black and White children between the ages of 1 and 14 in 1986.

The Johns Hopkins University School of Hygiene and Public Health and the Maryland Institute of Emergency Medical Services Systems are two State institutions which are actively involved in the areas of injury prevention, research, and training.

# SUMMARY REPORT ON BLACK AND MINORITY SUBSTANCE ABUSE

## Introduction

Substance abuse is a major contributor to many of the observed racial disparities in health within Maryland. Substance abuse (i.e., alcohol and/or illicit drug abuse) is associated with at least five of the ten leading causes of death in Maryland as well as countless other diseases and indicators of morbidity. Alcohol and drug abuse are direct or indirect causes of such health problems as cirrhosis/liver disease, cancer, homicide, accidents, AIDS, and fetal alcohol syndrome. Many of these health problems disproportionately affect Maryland's Black and minority populations.

The Commission's Task Force on Black and Minority Substance Abuse held meetings with treatment providers, who largely represented Baltimore City and Prince George's County, to ascertain provider perceptions of problems, treatment availability and additional needs specific to Blacks and other minorities in Maryland. The Task Force heard testimony from twenty treatment providers at these public meetings. Surveys were also sent to 75 alcohol and drug abuse treatment providers in the State with twenty providers responding. The findings from the public meetings and the survey are discussed throughout this report.

## Alcohol Use/Abuse and Health

Alcohol abuse is associated with a multitude of diseases and disorders and has been estimated to be a factor in 10% of all deaths (1). Alcohol abuse is a major risk factor for cirrhosis, cancer and unintentional injuries. In 1986, cirrhosis/liver disease was the twelfth leading cause of death in Maryland, killing a total of 388 Marylanders. Nationally and in Maryland cirrhosis/liver disease death rates are disproportionately higher for minorities.

Black American men, ages 35 to 44, are ten times as likely as White men to acquire cancer of the esophagus, a leading cause of which is alcohol consumption (1). Minority Marylanders died from esophageal cancer at a rate twice as high as Whites in 1985.

Nationally, half of all accidental deaths and homicides are alcohol related (2). Victims are intoxicated in about one-third of drowning, boating and aviation accidents and in about one-quarter of suicides (2).

There is evidence that prenatal exposure to alcohol has negative health consequences for the developing fetus (2). An estimated 1 to 3 babies per 1,000 are born with fetal alcohol syndrome which results from maternal drinking during pregnancy. Using this estimate, there are potentially 65 to 195 babies born in Maryland with fetal alcohol syndrome, annually.

## Drug Use/Abuse and Health

There are also many negative health consequences associated with drug abuse. Intravenous drug use increases the risk of acquiring several fatal or potentially fatal diseases, including hepatitis and AIDS. AIDS is a serious life threatening disease which destroys the body's ability to fight infection. AIDS, a condition which has the potential to decimate a significant portion of Black and Hispanic populations, was a major concern

of the Commission because of its link to intravenous drug use. Intravenous drug users are the second largest at-risk group for AIDS. AIDS may be spread among IV drug abusers by the sharing of drug paraphernalia. Contaminated blood left in needles or syringes can carry the AIDS virus from user to user. It has been estimated that 95% of IV drug abusers regularly share their needles (3).

Of the 599 reported cases of AIDS in Maryland as of June 16, 1987, 78 or 13% were attributed to intravenous (IV) drug use by heterosexuals. Another 5% of AIDS cases were linked to drug use by homosexual IV drug users. The overwhelming majority (90%) of individuals suspected to have contracted AIDS due to IV drug use were Black. The State's Drug Abuse Administration estimates that there are an estimated 30-40,000 intravenous drug abusers in Maryland. A significant proportion of IV drug users are believed to be members of minority groups since the majority (64%) of IV drug users in treatment in FY 1986 were Black. A recent study conducted in Baltimore found that 45% of Black IV drug abusers as compared to 9% of White IV drug abusers tested positive for HIV infection.

Available data also suggest a relationship between drugs and homicide. Nationally, an estimated 10-20% of homicides are associated with the use of illegal drugs (1). Drug abuse/dependence is also a significant cause of death. In 1986, there were 222 deaths in Maryland classified as drug-related by the State's medical examiner (4).

Drug abuse may also increase the risk of accidents and injuries, crimes, low birth weight, suicide and psychiatric problems (1). It also may have negative effects on employment, school achievement, socio-economic status and family stability.

## Findings

The Commission's Task Force attempted to discern the extent and causes of substance abuse in minority communities and obstacles that hinder addressing and eradicating the problem. Substance abuse is a major social and health problem for the general population. However, the Task Force found that it has a significantly greater effect on the health of minorities in Maryland as measured by morbidity, mortality and social indicators.

The reasons why individuals or groups of individuals choose to abuse chemical substances are complex and defy simplistic solutions. Some contributing factors are concrete and easily understood, others are not.

The substance abuse problem cannot be "solved" without addressing the broader societal problems and issues which cause and exacerbate substance abuse. Unfortunately, such a study was neither within the Task Force's charge nor its capabilities. Consequently, the Task Force focused on several definable issues and problems as discussed below.

### Prevalence

**Finding #1: There is a lack of substance abuse prevalence data by race which makes it difficult to determine the true extent of substance abuse in Maryland's Black and minority communities.**

**Finding #2: Data on substance abuse among selected sub-populations, such as recent immigrants, high school drop-outs, and minority women are almost non-existent.**

**Finding #3: While prevalence data is not available by race, "proxy" prevalence sources suggest that substance abuse is a major health problem in some Black and minority communities and that minorities suffer disproportionately from the negative consequences of substance abuse.**

Prevalence is defined as a measure of the total number of individuals in a state, or a county, who are involved in a behavior (e.g., drug or alcohol abuse) during a given period of time. Knowing the prevalence of substance abuse in minority communities gives an indication of how many minorities currently use/abuse chemical substances. Therefore, the Task Force attempted to locate prevalence data by race to assist in (1) identifying the extent of substance abuse as a problem in minority communities and (2) determining whether minorities are more likely to abuse substances than members of the majority community. Unfortunately, the Task Force found that there is a paucity of data on the characteristics of substance abusers by race/ethnicity in Maryland.

Perodically, the State's Alcohol and Drug Abuse Administrations commission studies to determine the prevalence of alcohol and drug abuse in Maryland. The most recent study was conducted in 1986. The study estimated that in 1985, 153,610 Marylanders, or 4.7% of the population between the ages of 12 and 65, were either at risk of becoming dysfunctional due to drug abuse or were already dysfunctional. Estimates of the numbers of alcohol abusers range from 259,326 to 334,801 Marylanders over the age of 11, approximately 10% or less of the population. However, a determination of prevalence by race was not included in the study.

The Task Force used proxy measures, such as surveys, vital statistics, and treatment data to estimate the prevalence of substance abuse in Black and minority communities. These included special surveys, vital statistics and treatment/utilization data as discussed below.

The Epidemiologic Catchment Area (ECA) Survey of Eastern Baltimore. The ECA Survey is the only known source of substance abuse prevalence estimates by race for portions of Maryland's adult population. This federally funded mental health household survey was conducted in 1981-82 in portions of Baltimore City. The survey reported lifetime prevalence rates for drug abuse/dependence of 7.3% for Blacks and 4.9% for Whites living in eastern Baltimore City. The lifetime prevalence rates for alcohol abuse/dependence were 14.6% for Black adults and 13.2% for White adults, 18 years and older. (The lifetime prevalence of a particular disorder is defined as the proportion of persons in a representative sample of the population who have ever experienced that disorder up to the date of assessment).

National Substance Abuse Surveys. The National Institutes on Drug Abuse (NIDA) and Alcohol Abuse and Alcoholism (NIAAA) periodically fund and conduct household and other special surveys to determine the extent of substance abuse nationally. In 1985, for the first time, Blacks and Hispanics were oversampled in the NIDA household survey to derive reliable estimates of the extent of drug abuse in these populations (5). The preliminary results indicated that lifetime prevalence rates for cocaine were higher for Black adults (7%) than Whites (4%) or Hispanics (3%). Conversely, Whites (13%) were more likely to have tried or be heavy users of hallucinogens and inhalants (5). Comparable survey data for alcohol abuse/alcoholism currently are unavailable through NIAAA.

Adolescent Alcohol and Drug Abuse Surveys. Since 1973, the Maryland Drug Abuse Administration (DAA) has periodically conducted surveys in secondary schools to collect information on drug use, attitudes and knowledge among Maryland adolescents. The 1984 study concluded that drug and alcohol use did not vary significantly by race (6,7). However, these findings should be interpreted with caution since segments of the most vulnerable populations, such as school drop-outs, were excluded.

Substance Abuse-Related Mortality. Data is available through the Maryland Center for Health Statistics on the numbers of deaths due to selected substance abuse-related causes. Vital statistics show that minorities are significantly more likely than Whites to die from drug overdoses due to drug dependence/abuse. In 1983-85, the death rate from drug overdoses related to drug dependence and abuse was five times higher for minorities than Whites. Conversely, the death rate from drug overdoses related to accidents, suicide and undetermined causes was higher for Whites.

Substance Abuse-Related Arrests. The Maryland State Police collect data on the number of arrests due to sale or possession of illegal drugs, drug abuse violations, and drinking under the influence of alcohol (8). In 1985, minorities were three to four times more likely than Whites to be arrested for the sale or possession of illegal drugs. The majority (52.1%) of individuals arrested for drug abuse violations were Black. Conversely, the overwhelming majority (80%) of individuals arrested for driving under the influence of alcohol were White.

Substance Abuse-Related Morbidity: Hospital Admissions. Admissions to hospital emergency rooms, inpatient facilities and treatment programs are often used as indicators of substance abuse-related morbidity. The national Drug Abuse Warning Network (DAWN) provides information on drug abuse admissions to selected hospital emergency rooms (ER) and drug abuse related deaths encountered by medical examiners. Baltimore and Washington, D. C. metropolitan area hospitals are 2 of the 27 participants in this system. In 1985, Blacks comprised the majority (80%) of Baltimore DAWN reported ER admissions in which heroin was mentioned. Conversely, the majority of PCP admissions were White.

Substance Abuse-Related Morbidity: Utilization of Treatment Programs. All DAA and ACA certified treatment programs in Maryland are required to submit reports for incorporation into the State's Substance Abuse Management Information System (SAMIS). These reports document each admission to, and discharge from a treatment facility. As of May, 1987, 97 DAA and 145 ACA certified treatment programs in Maryland submitted reports to SAMIS.

There were over 17,000 admissions to drug abuse programs reported to SAMIS in 1986. Overall, minorities were disproportionately found in the treatment population as compared to their percentage in the total population. Minorities comprise approximately 25% of Maryland's total population, but represented 50% of admissions. However, a closer look at the data shows that Hispanics, Asians, and Native Americans were underrepresented in the treatment population when compared to their percentages in the State's total population.

Table 6.1 provides information on selected characteristics of drug abuse treatment clients by race. The majority (65% of all clients) were unemployed and a plurality (43%) were uninsured. Heroin, marijuana, cocaine or PCP were the primary drugs used in 87% of admissions.

## TABLE 6.1

## SELECTED CHARACTERISTICS OF ADMISSIONS TO DRUG ABUSE TREATMENT PROGRAMS BY RACE/ETHNICITY, MARYLAND, 1986

| Characteristics | Total | Asian | Black | Hispanic | Native American | White |
|---|---|---|---|---|---|---|
| Number | 17,011 | 25 | 8,342 | 82 | 24 | 8,538 |
| **Socio-demographic** | | | | | | |
| • % Male | 77.0 | 76.0 | 79.9 | 87.8 | 58.3 | 74.1 |
| • % 18 | 15.1 | 60.0 | 9.4 | 22.0 | 29.2 | 20.4 |
| **Socio-Economic** | | | | | | |
| • % Unemployed | 65.1 | 84.0 | 74.0 | 54.9 | 70.8 | 56.4 |
| • % Uninsured | 43.0 | 48.0 | 39.9 | 50.0 | 45.8 | 45.9 |
| **Treatment Modality** | | | | | | |
| • % Methadone | 16.8 | 0.0 | 21.9 | - | 8.7 | 11.9 |
| • % Prison based | 25.3 | 20.0 | 33.6 | - | 30.4 | 17.2 |
| • % Drug Free | 51.9 | 64.0 | 39.7 | - | 60.9 | 63.7 |
| **Primary Drug Used** | | | | | | |
| • % Heroin | 31.5 | 12.0 | 47.7 | 11.0 | 12.5 | 16.0 |
| • % Cocaine | 16.8 | 4.0 | 15.2 | 30.5 | 12.5 | 18.2 |
| • % Marijuana | 28.5 | 56.4 | 22.5 | 30.5 | 37.5 | 34.3 |
| • % PCP | 10.5 | 12.0 | 7.1 | 13.4 | 16.7 | 13.8 |
| **Referral Source** | | | | | | |
| • % CJ System* | 51.9 | 40.0 | 60.2 | 37.8 | 58.4 | 43.9 |
| • % Self | 16.0 | 12.0 | 13.1 | 18.3 | 25.0 | 18.8 |
| **Percent Completing Treatment with No Use** | 22.7 | 50.0 | 17.5 | 25.0 | 36.4 | 27.7 |
| **Percent IV Drug Users** | 35.6 | 16.0 | 46.8 | - | 17.4 | 25.1 |

*Criminal Justice System
Source: Maryland Substance Abuse Management Information System

TABLE 6.2

SELECTED CHARACTERISTICS OF ADMISSIONS TO ALCOHOL TREATMENT PROGRAMS, BY RACE/ETHNICITY, MARYLAND, 1986.

| Characteristics | Total | Asian | Black | Hispanic | Native American | White |
|---|---|---|---|---|---|---|
| Number | 25,484 | 48 | 8,418 | 132 | 65 | 16,821 |
| Socio-demographic | | | | | | |
| • % Male | 82.4 | 91.7 | 84.5 | 81.8 | 76.9 | 81.4 |
| • % 18 | 4.7 | 16.7 | 2.5 | 7.6 | 9.2 | 5.7 |
| Socio-Economic | | | | | | |
| • % Unemployed | 46.0 | 23.0 | 61.6 | 46.0 | 47.7 | 38.4 |
| • % Uninsured | 48.6 | 43.8 | 44.0 | 53.8 | 50.8 | 50.9 |
| Referral Source | | | | | | |
| • % DWI | 34.9 | 43.8 | 22.7 | 48.5 | 36.9 | 40.8 |
| • % CJ System* | 13.7 | 29.1 | 15.7 | 8.3 | 15.4 | 12.8 |
| • % Self | 11.5 | 0.0 | 14.9 | 11.4 | 15.4 | 9.9 |
| Percent Completing Treatment with No Use | 20.1 | 49.1 | 10.8 | 33.1 | 15.7 | 24.4 |

*Criminal Justice System

Source: Maryland Substance Abuse Management Information System.

Blacks were almost three times as likely as Whites to identify heroin as the primary drug used. Conversely, Whites were almost twice as likely as Blacks to identify PCP as the primary drug used. Cocaine and marijuana (60%) were the predominant reasons for Hispanic admissions. Marijuana was the leading cause of admissions for both Asians and Native Americans who tended to be younger than White or Black clients. The majority (60%) of Asians in treatment were under 18.

There were also racial variations in the type of treatment modality/setting. Statewide, there is a greater tendency for Black admissions to be reported in methadone treatment (22%) and prison-based treatment (34%) than Whites (12% and 7%, respectively). Nearly two-thirds of all methadone and prison cases statewide were Black, while over 60% of drug-free outpatient and residential cases were White.

Blacks were almost twice as likely as Whites to report IV drug use. Forty-seven percent of Black admissions reported IV drug use as compared to 25% of White admissions.

Minorities represented about one third of clients in alcohol treatment programs. Asians and Hispanics appeared to be underrepresented in treatment when compared to their percentage in the State's total population. The overwhelming majority (77-92%) of clients in treatment regardless of race were male (Table 6.2). Few (range of 6-17%) were under the age of 18.

Blacks in alcohol treatment programs were almost twice as likely as Whites to be unemployed (62% and 38%, respectively). Almost half of all clients across each racial/ethnic group were uninsured. Whites (24%) were reportedly more than twice as likely as Blacks to complete treatment with no use of alcohol.

The State's Drug Addictions Administration reports that multiple drug addictions and cross addictions to alcohol and drugs are also becoming major problems. In FY 1986, half of all clients reporting a primary drug problem also reported secondary abuse of another drug or alcohol (9).

## Race and Substance Abuse

Until recently, few studies had specifically focused on the extent of substance abuse in Black and minority communities. The Federal Report on Black and Minority Health highlighted this data gap and recommended that culturally sensitive instruments be used to study the prevalence, etiology and consequences of substance abuse among Blacks, Hispanics, Native Americans and Asian/Pacific Islanders (1).

Since true prevalence data by race is unavailable, data and opinions are often inconclusive as to whether or not chemical abuse is a greater problem in Black and minority communities than in the majority community. In a survey conducted by the Commission's Task Force, slightly more than half of the respondents did not view substance abuse as a bigger problem for minorities than Whites. One respondent noted that "drug abuse transcends socio-economic and racial lines. The belief that it is a ghetto problem is a myth."

Several investigators have researched the history of substance abuse within Black, Hispanic and Native American populations (1,10,11,12,13). These authors often speculate that Blacks, Native Americans and Hispanics abuse chemical substances to a large extent

because of cultural changes which often result from movement from agrarian to urban environments, assimilation or integration. For example, Herd (14) has noted an association between cirrhosis mortality and major demographic shifts in the Black population reflective of the migration and urbanization of Blacks.

## Blacks and Substance Abuse

Blacks comprise the majority (91%) of Maryland's minority population and represent 23% of the State's total population. Although, the majority of Blacks do not abuse alcohol or drugs, substance abuse is considered by many to be the number one health problem in the Black community. Black men in American society have been termed an "endangered species." Substance abuse, because of its direct and indirect links to mortality, morbidity, crime, incarceration, and institutionalization, can be viewed as a major threat to the survival of healthy and productive Black men in American society.

Available mortality and morbidity data which measure the consequences of substance abuse suggest that substance abuse takes a tremendous toll on the health of Black Marylanders. Cirrhosis and esophageal cancer rates would seem to imply that Blacks drink more than Whites. However, survey research has not always supported this conclusion. For example, a 1984 national survey found that Blacks of both sexes reported higher rates of abstention than Whites (1). Forty-six percent of Black women, twenty nine percent of Black men, and twenty-three percent of both White men and women were reportedly abstainers. Among those who drank, White men were more likely than Black men to be heavy drinkers (1). However, drinking pattern variations by race and sex were less clear. Some surveys suggest that Black women are more likely than White women to be heavy drinkers, while others suggest the opposite (4).

Few, if any, Maryland studies have focused on substance abuse in the Black community. The 1982 Maryland Household Survey, which was designed to collect data on hypertension prevalence, provides limited information on drinking habits by race. The study found that a comparable percentage of adult Black males (6%) and White males (5.5%) indicated they were heavy drinkers (5 or more drinks in one sitting 3 or more times per week). However, a greater percentage of Black women (2%) than White women (0.6%) reported being heavy drinkers.

Dr. Beny Primm, a prominent Black physician and substance abuse researcher, has noted that "there never has been any reliable epidemiological data supporting the number of Black (substance) abusers reported by the media (15)." Dr. Primm maintains that, historically, Whites fabricated reports about the excessive use of alcohol and drugs by Blacks as a means to diminish the attractiveness of Blacks and to shrink the Black labor pool by creating fears among Whites and employers (15). Unfortunately, what started as a fabrication became a reality.

Dr. Primm also speculates that Blacks are now disproportionately represented among the drug dependent because of unbearably high stress. This stress is thought to be linked to high unemployment and racial prejudice (15).

At a recent national conference on substance abuse in the Black community, Mr. William Haskins of the National Urban League similarly concluded that high employment, poor housing, inferior schools, low self-esteem, and racism contribute to Black drug dependence. He noted that there is economic distress in the Black family and community and a trend toward a declining level of economic well-being. The following national facts and trends were cited:

- 1.2 million Blacks are unemployed. The Black unemployment rate at 16% is twice the White rate. Another 1.0 million Blacks are not accounted for under anyone's employment statistics.
- One-third of Blacks have no assets; White net worth is 12 times Black net worth.
- Only 42% of displaced Black workers find new jobs at an average of 80% of their old salaries.
- 700,000 Blacks are incarcerated, more than the number of Blacks attending American colleges.
- 50% of Black children are poor.
- Eighty-five percent of future new jobs will be in high tech areas requiring communication, math, English, computer and science skills. These are skills that urban minorities are less likely to have. Americans are spending millions of dollars to produce an unemployable workforce.

Mr. Haskins called for the development of a national policy which addresses "qualilty of life" issues as a solution to Black substance abuse. He stated that young people need to have a reason to avoid drugs. However, many Black youngsters are growing up in environments where they face economic and social hardships which often lead to hopelessness and helplessness. He also called upon the Black community itself to play a greater role in acknowledging and addressing this issue.

It has been suggested that alcohol abuse has not yet been recognized as a problem by large segments of the Black community (15). Consequently, the Black community has not developed community-defined standards and mores on the issue of drinking. This lack of community defined standards and mores is often viewed as an obstacle to preventing alcohol abuse.

The State's Alcoholism Control Administration reports that Blacks in particular and other minorities enter treatment late, generally do not complete treatment, and if treatment is completed at one level, the drop out rate is high for the next level of care (16). The reasons for these findings are unclear. Anecdotally, it has been suggested that minorities feel uncomfortable in programs where there are few treatment providers who look like them and understand their unique circumstances. Treatment providers often have difficulty understanding the cultural backgrounds of minorities and connecting their lifestyles into the projected treatment continuum.

Treatment data provide the major sources of information on drug abuse among Blacks in Maryland. In an analysis of DAWN data by race, one researcher concluded that Blacks have a greater tendency than Whites to become involved in more dangerous drug combinations, such as speedballing (17). Blacks are also more likely than Whites to use more dangerous routes of drug administration, such as intravenous administration.

Asian/Pacific Islanders and Substance Abuse

Asian/Pacific Islanders represent about 1.5% of Maryland's population of 4.3 million. Over 80 different nationalities comprise the Asian/Pacific Islander population.

Research and information on substance abuse in the Asian populations is sparse. Generally, the research has suggested that Asian Americans have very low levels of use and abuse of substances (1).

Research on enzymes involved in alcohol metabolism have shown that Asians tend to metabolize alcohol much more quickly than non-Asians (1). It is estimated that 50% of Asians, even at moderate alcohol intake, experience an "alcohol flush reaction," a systematic reaction consisting of facial flushing and rapid heart rate. It has been hypothesized that this flushing reaction may provide some protection against heavy drinking.

At the Commission's Prince George's County meeting with treatment providers, one participant noted that alcohol use is a serious problem among recent Asian immigrants and refugees living in the County. Alcohol abuse seems to be viewed as an accepted form of behavior and thus far, few attempts have been made to provide prevention, outreach and treatment services for this population. Similarly, the Maryland Office of Refugee Health has reported that substance abuse is an increasing unchecked problem among the Asian refugee and immigrant populations (18).

Hispanics and Substance Abuse

According to the 1980 Census data for Maryland, there are at least 67,000 individuals of Hispanic descent, representing approximately 1.5% of Maryland's total population. The majority of Maryland's Hispanic population resides in Montgomery and Prince George's Counties.

Hispanics are a heterogenous group whose origins are Mexico, Puerto Rico, Cuba, Central or South America or other Spanish countries. Information on substance abuse within Maryland's Hispanic population is almost non-existent. There is no data available on substance abuse related mortality since Hispanics are not identified as a ethnic group on State death certificates. However, nationally, there is some indication that Hispanics are overrepresented among those dying of alcohol-related causes (1).

Several national studies have indicated that alcohol abuse may be a significant health problem within segments of the Hispanic community (1,11,12). It has been suggested that societal mores may condone and even encourage the use of alcohol by Hispanic men (11). Research has generally shown that Hispanic women have higher rates of abstention than non-Hispanic women, while Hispanic men have higher rates of use and abuse than non-Hispanic men (11).

Available Maryland substance abuse treatment data shows that Hispanics are underrepresented in the treatment population when compared to their percentage in the total population.

Native American Indians and Substance Abuse

There are an estimated 25,000 native American Indians living in Maryland, comprising approximately 0.6 percent of the population. Alcohol is reported to be the most abused substance among Indians (1). Nationally, it has been linked with high rates of Indian suicide, accidents, criminal arrests and birth defects (1).

The American Indian population is not a homogenous group. There are over 300 different federally recognized tribes. Although, the drunken Indian is often a stereotype, drinking patterns and practices differ from one tribe to another. Some tribes are totally abstinent (1).

Although theories of causation are inconclusive, numerous biological, psychological and socio-cultural factors have been suggested to explain abusive drinking among Indians. One researcher argues that the two main socio-cultural reasons are (1) mourning the loss of an historical condition and (2) reacting to the demands to integrate with the mainstream culture (10). Some researchers have also concluded that drinking among American Indians is often viewed as a social activity and that there is significant pressure to drink (10).

There is very little concrete data available on the drinking and drug use patterns of Native Americans living in Maryland.

## Treatment Barriers

**Finding #4: There are numerous barriers to receiving and completing substance abuse treatment for Blacks and minorities.**

Task Force members strongly agreed that prevention and treatment programs are essential to eliminating the problem of substance abuse. However, no stance was taken on the appropriateness of one form of treatment over another nor did the Commission have time to explore the pros and cons of various treatment modalities, such as methadone maintenance. However, members did agree that it was vitally important for treatment providers and plans to be culturally sensitive and appropriate. An emphasis was also placed on developing holistic approaches to the treatment of substance abuse.

The Task Force identified several barriers to the receipt and completion of substance abuse treatment, particularly for Blacks and minorities as follows:

- insufficient number of treatment programs and slots;
- inadequate reimbursement of treatment services, particularly for the medically indigent;
- lack of a holistic approach to substance abuse treatment;
- language and other cultural barriers/mistrust of treatment providers inadequate outreach;
- individual attitudes;
- inadequate number of treatment programs for the hard core recidivistic substance abuser; and
- inadequate transportation.

### Insufficient Numbers of Treatment Programs and Slots

There are insufficient treatment slots for substance abusers seeking help. Many treatment providers indicate that there are waiting lists for services. Fourteen of the twenty providers responding to the Task Force survey indicated that they currently had a waiting list for treatment. The waiting time ranged from five days to five weeks.

There are few publicly-funded intermediary care facilities and halfway house programs for drug abusers in Maryland. This leaves a serious gap in the continuum of care for middle and low-income substance abusers.

## Lack of a Holistic Approach to Substance Abuse Treatment

The Commission repeatedly heard that educational and vocational opportunities for minorities go hand in hand with effective substance abuse treatment. One treatment provider indicated that "It has been proven that lack of self-esteem and poor self-worth is a great contributor to substance abuse. People who cannot find jobs will commit crimes and abuse drugs. This is not the only reason people abuse substances, but it is a major contributor to the problem. Racial minorities must be given the same educational and job opportunities as everyone else."

He went on to say that "the kinds of strategies I have found to be successful in the past have included the ability of treatment programs to refer clients while in treatment to vocational training programs. Our program's success rate was higher when these programs existed. Federal cuts closed the programs and we have not been as successful without them."

Treatment protocols which address the multitude of factors which may be related to a given client's abuse of drugs or alcohol are essential. The Commission learned that while dealing with the primary problem of substance abuse or addiction should be the first priority, other problems confronting the individual which may affect treatment outcomes should not be ignored. Mechanisms for the referral and follow-up of clients requiring medical, mental health, social, education, and job training and placement services should be a routine part of the treatment plan, where necessary.

## Inadequate Health Insurance Coverage and Reimbursement for Treatment Services

Many of the State's substance abusers are low income and/or uninsured. For example, the majority of substance abuse clients in ACA and DAA approved treatment programs in 1986 were either uninsured or Medicaid recipients. In general, low income and the lack of health insurance coverage serve as major barriers to the receipt of health services. National studies show that poor uninsured individuals are less likely than the insured to seek and receive health care services, even in the face of greater need. The Commission suspects that this same relationship exists between income, insurance coverage and access to substance abuse treatment services. Minorities are likely to be disportionately affected since Blacks are two to four times more likely than Whites to be poor, uninsured or Medicaid recipients.

The State's Medical Assistance Program serves as a major source of funding for substance abuse treatment for the medically indigent. However, there are several problems inherent in the program's reimbursement scheme. First, the program only covers about half of the State's poor population which leaves the potential for large segments of the poor and near poor to have no insurance coverage at all. Secondly, Medicaid reimbursement for outpatient substance abuse treatment services currently is inadequate, covering about 10% of the actual costs.

Language and Other Cultural Barriers/Mistrust of Treatment Providers/Inadequate Outreach

Black and minority clients bring cultural factors that must be considered when providing treatment. Most would agree that it is important to have a basic understanding of the client's cultural/socio-economic background and environment in order to provide appropriate treatment. However, in some instances, program counselors and administrators may not be trained to recognize these cultural differences. Culturally biased or insensitive attitudes may exist among some treatment providers and counselors. A lack of bilingual/bicultural professionals in treatment programs hampers the ability to reach and treat non-English speaking populations.

One respondent to the Commission's Task Force questionnaire noted that "in order for counselors to work effectively in preventing and treating substance abuse in minority communities, they must allow clients to teach them. Counselors must also expose themselves to the available resources, e.g., books and workshops that will enhance their skills in working with different minority communities. The use of appropriate minority group role models, especially in recovery support groups, is vitally important."

Several treatment providers also mentioned the need to provide funding to increase the salary levels of counselors to match the professional job market. Trained counselors were said to be leaving the drug and alcohol counseling field, not because of a lack of commitment, but because of low salaries.

It was the Task Force's general perception that the "gatekeepers" (e.g., decision-makers, and clinicians) of many health and human service entities may not be ethnically reflective of the communities they serve. For example, approximately 17% of local health department based addiction counselors are Black, while approximately 40% of clients are Black.

The Commission heard that outreach is necessary to overcome the mistrust that is prevalent in many minority communities. Some treatment providers saw a need to link prevention and treatment strategies with the indigenous cultural and/or religious activities and groups found in minority communities. Increased community outreach was viewed as necessary to reach the increasing number of Blacks, Asians, American Indians, and Hispanics in Maryland. In particular, it was felt that increasing numbers of Black and minority individuals need to be recruited, trained and empowered to assist in preventing and treating substance abuse in Black and minority communities.

Some individuals may also have insufficient knowledge about how to access available treatment services. Additional culturally sensitive minority outreach workers in minority communities could serve as invaluable resources in getting minorities into treatment.

Individual Attitudes

Hopelessness, helplessness, and the denial of the existence of a drug or alcohol problem undoubtedly also serve as barriers to the effective treatment of substance abuse. The Commission learned that many in treatment are there involuntarily as a result of judicial intervention. Others do not seek help until they have "hit bottom". These and other factors may have a profound effect on treatment outcome.

## Prevention

Finding #5: There are insufficient numbers of preventive substance abuse interventions.

Therefore, while treatment of substance abusers is a necessary element of addressing the problem, preventing people from ever becoming involved with drugs, and alcohol should be at least an equally high priority. The Commission would like to see a greater emphasis placed on prevention. The schools, the public health community, and law enforcement agencies fall short in removing illegal drugs from the community and in educating children and adults to avoid the appeal of drugs and alcohol. Newly instituted prevention efforts by the State's Addictions Administration are to be commended. However, much more remains to be done.

Prevention efforts developed and supported by both majority and minority institutions, such as the schools, churches, families and the medical community are absolutely essential. Greater efforts must also be made to have prevention and educational materials available in languages other than English, where appropriate.

One treatment provider stated that an adequate system for identifying and treating juvenile drug abusers has yet to be developed. Juveniles are not being identified in time to work with them while they are still in school. Hence, they enter the treatment system as adults who have long histories of drug abuse. Drug abuse becomes an integral part of their lives and they cannot imagine life without drugs.

The 1984 Maryland Adolescent Drug Abuse survey found that Blacks and other minorities were more likely than Whites to abstain from alcohol use and less likely than Whites to frequently use (i.e., weekly or more) alcoholic beverages. However, Black and other males were found to be more likely than white males to report frequent use of marijuana. The magnitude of the minority substance abuse problem may be even greater than reported by this survey since populations which include disproportionate numbers of Blacks and minorities, such as school drop-outs, who may be at greater risk for abuse were excluded.

Adolescent drug use/abuse in Maryland has been termed an epidemic which transcends race. As a whole, Maryland youth report more intense involvement in substance use/abuse than youth nationally. For example, one in four high school seniors use alcohol almost daily as compared to one in 16, nationally. Prevention has been identified as the most effective long-range weapon in the war against the adolescent drug epidemic. Culturally relevant prevention strategies are required to reach the racial/ethnic minority segments of Maryland's at-risk adolescent population.

The Commission believes that the glamourization of the use of substances within the media and the ready availability of chemical substances in many inner city minority communities also exacerbates minority substance abuse. A 1987 Washington Post article co-authored by Barbara Jordan, noted that the tobacco and alcohol industries are now heavily targetting Blacks (19). One Commissioner observed that along a 20 block stretch of a Black inner city Baltimore neighborhood, 23 of 26 billboards advertised either tobacco or alcohol. Alcohol and cigarette advertisements are often major revenue sources for local and national Black publications. Sponsorship of sports, cultural, civic and entertainment events by alcohol and tobacco producers is becoming increasingly commonplace in Black and minority communities. Neither the Black and minority nor the majority communities can continue to condone such behavior.

## Minorities, Substance Abuse and AIDS

**Finding #6: There is an increasing minority threat of AIDS due to intravenous drug use.**

To the extent that minorities, especially Blacks, are more involved in IV drug abuse, they are more likely to suffer from the health related consequences which include contracting AIDS. An increasing percentage of Black AIDS cases are attributed to IV drug abuse. AIDS has the potential to decimate a large percentage of minority IV drug abusers and their significant others in Maryland. The overwhelming majority (90%) of Marylanders suspected to have contracted AIDS due to IV drug abuse have been Black.

## Causes of Minority Substance Abuse

**Finding #7: There is insufficient knowledge of causation of substance abuse in minority communities.**

As stated earlier, the root causes of substance abuse are not well understood. The Commission sees a clear need to support research into these sociological and psychological causes, especially as they relate to Black and minority populations. This knowledge should suggest solutions not readily apparent.

# LIST OF TASK FORCE PRESENTERS AND SURVEY RESPONDENTS

Baltimore City Meeting

- Laura McCall, Addict Referral and Counseling Center, Baltimore
- Clarence Williams, Project Adapt, Baltimore
- Dan Iser, Wyman Park Recovery Center, Baltimore
- Ruth Williams, Williams Center, Oxon Hill
- Patricia King, Maryland Commission on Indian Affairs
- Herman Jones, Liberty Medical Center, Baltimore
- Hadassah Gordis, University of Maryland Drug Treatment Center, Baltimore
- Richard H. Sawyer, Mountain Manor Treatment Center, Emmittsburg
- Janice Lockwood, Echo House Multi-Service Center, Baltimore
- Richard Lane, Man Alive, Inc., Baltimore

Prince George's County Meeting

- Thomas Harvard, Palmer Park DICAP
- Rafael Hylton, Prince George's County Police Department
- Eileen Schock, Prince George's County Health Department
- Ronald G. Medlin, Institute of Life and Health, Oxon Hill
- Furman B. Williams, Chemical Addictions Treatment, Bowie
- George Kolark, DICAP, Clinton
- Thomas J. DeCoster, Changing Point, Ellicott City
- H.F. Greene, M.D., PSI Associates, Landover
- George F. Marko, Meadows Recovery Center, Gambrills

Survey Respondents

- Alcohol and Drug Abuse Counseling Center, Howard County
- Caroline Counseling Center, Caroline County Health Department
- Cecil County Health Department Alcohol and Drug Center
- Worcester County Health Department Alcohol and Other Drug Programs
- Talbot County Alcoholism Program
- Publick House, Kent County Health Department
- Addiction Services, Somerset County Health Department
- Sinai Hospital Alcoholism Program
- Dorchester County Addictions Program
- Baltimore City Jail Residential Alcoholism Program
- Cherry Hill Drug Abuse Rehabilitation Program
- Glenwood Life Counseling Center, Inc.
- Valley Bridge Alcoholism Treatment Program
- Baltimore Recovery Center
- Charles County Health Department Alcohol Program
- Hope House, Alcoholism Recovery, Inc.
- Anne Arundel Health Department, Focus on the Family
- Anne Arundel County Health Department, Open Door
- Baltimore County Division of Alcohol Abuse and Alcoholism
- Talbot County Addictions Services

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# SUMMARY REPORT ON BLACK AND MINORITY MENTAL HEALTH

Introduction -

Mental health and illness are major public health issues and concerns. While chemical dependency and homicide, were two major mental health areas examined by the Commission, the broader mental health problems of Blacks and minorities were also deemed important. Unfortunately, the Commission's Task Force on Black and Minority Mental Health found that minimal research and information currently exists on the mental health needs and problems of Blacks and minorities in Maryland.

Based on national estimates, the Maryland Mental Hygiene Administration estimates that 581,905 Maryland residents age 18 and over suffer from mental disorders (including substance abuse). This is 18.7% of the State's population. Of these, 1%, or 31,117 persons are estimated to suffer from schizophrenia, the most serious mental health disorder. Nationally, schizophrenia accounts for almost half of all public mental health dollars spent in treatment programs.

The Commission's Task Force on Mental Health explored a wide range of areas, including child and adolescent mental health, deinstitutionalization, homelessness, and programs and services available through the State's Mental Hygiene and Juvenile Services Agencies. State and national mental health experts were invited to testify before the Task Force and two public hearings were held. The Task Force's work resulted in the following findings.

Findings

Finding 1: **There is a paucity of data and research on the mental health problems and needs of Blacks and minorities in Maryland.**

The Maryland Mental Hygiene Administration reports that there are currently no prevalence estimates for mental health disorders by race in Maryland. In addition, limited research has examined the mental health problems and needs of Blacks and minorities in Maryland. It is clear that comprehensive data and research systems which examine minority mental health needs must be developed if State programs are to appropriately serve Maryland's Black and minority populations.

Finding 2: **Mental health services for children and adolescents in Maryland are virtually nonexistent.**

The Maryland Mental Hygiene Administration estimates that almost 15% of children and adolescents suffer from diagnosable mental disorders. However, mental health services for children and adolescents are sorely lacking. In particular, inpatient psychiatric care facilities for children under the age of 12 are virtually non-existent. These children are often referred to the State's Coordinating Council which often results in expensive (i.e., $100,000 or more) out of state placements.

There are also few mental health clinicians available to care for children with mental health problems. For example, there is currently only one certified child psychiatrist employed by the Maryland Mental Hygiene Administration. It was also learned that there is a several months wait in many areas of Maryland for the psychiatric evaluation of children, particularly if these children are poor or members of a minority group.

Finding 3: **There are currently too few Maryland programs and services which are designed to prevent the development of mental health problems in high and at-risk infants and children.**

There are currently few Maryland programs which are designed to prevent the development of mental health problems in high risk infants and children. Infants and children known to be at-risk include those whose parents are adolescents, unmarried, abusive, and chemical substance abusers. Studies have shown that at-risk children can be identified as early as infancy and can be treated along with their families to set the stage for positive childhood growth and development.

Finding 4: **Minority health services for low-income Blacks and minorities are often either unavailable, unaccessible, inapplicable or inappropriate to the needs of Blacks and minorities.**

The report of the 1978 President's Commission on Mental Health concluded that while the mental health needs of low-income minority groups are high, needed mental health services are often either unavailable, inapplicable or inappropriate to the needs of minority groups. The report identified the need to improve outreach efforts, to increase the supply of Black and minority mental health professionals, to develop culturally specific service models, to incorporate content relevant to minorities in training programs, and to expand minority prevention and research efforts.

Nationally, as in Maryland, Blacks and minorities tend to be overrepresented in inpatient admissions to public facilities and underrepresented in outpatient facilities when compared to their percentages in the total population. The reasons for these disparities are unclear but warrant further investigation. Several studies confirm that Blacks are more likely than Whites to be misdiagnosed which may help to explain the greater inpatient utilization rate. Inaccessibility to outpatient services may be another factor.

The Commission's Task Force found that poor Blacks and minorities, for the most part, are excluded from private psychiatric services. Private practitioners are currently reimbursed through Medicaid at approximately one-third the usual and customary fee for psychiatric services. Anecdotally, the Task Force heard that because of this low reimbursement rate, Black and minority populations are often unable to obtain access to private psychiatric services. In many instances, this lack of access leads to a deterioration of the mental health of that individual so that eventually expensive psychiatric hospitalization is required.

Finding 5: **There is a need to increase the available pool of Black and minority mental health professionals.**

Blacks and minorities are underrepresented as mental health professionals (e.g., psychiatrists, psychologists, program administrators) in Maryland. For example, according to 1985-86 Board of Medical Examiner licensing data, Blacks represented 3% of the State's psychiatrists. This lack of Black and minority mental health practitioners was thought to serve as a major barrier to the use of mental health services by Blacks and other minorities.

**Finding 6: There is a need to develop a network of mental health services for the Black and minority elderly.**

Mental health services for the elderly are inadequate, partially due to the a common misconception that a person's mental health deteriorates with age. There are only a handful of psychiatrists in Maryland who are trained to deal with the mental health needs of the elderly and this limited pool is over-stretched with the demands for services.

## Maryland Programs and Services

The Maryland Mental Hygiene Administration within the Maryland Department of Health and Mental Hygiene is the chief State agency responsible for planning and developing programs and services for the mentally ill in Maryland. This Administration oversees a major, largely publicly funded, mental health delivery system. Care is provided through a variety of service delivery systems, including 14 State operated institutions and regional hospitals, outpatient treatment facilities, community rehabilitation, community mental health, housing, and day treatment programs. There are also programs providing for emergency services, mobile-crisis treatment, respite care, and case management. Local health departments operate mental health clinics in every jurisdiction, with the exception of Baltimore City which contracts out for these services. Mental health services are also provided by several private providers in the State.

Numerous mental health education and advocacy groups also operate throughout the State. These include Mental Health Associations located in Metropolitan Baltimore and in 14 other subdivisions, and the Black Mental Health Alliance. These organizations offer community education programs to eliminate the stigma of mental illness, and advocate for improved care and services for persons with mental illness.

The Commission's Task Force on Minority Mental Health was unable to thoroughly examine barriers to the receipt of mental health services by Blacks and minorities.

# SUMMARY REPORT ON BLACK AND MINORITY AGING

## Introduction

There are probably very few people who would question that the elderly are a great resource. They not only have spent a great portion of their lives working and contributing to their communities, but they continue to have a great deal of expertise to share. However, growing older can mean the development of a range of problems. For the Black and minority elderly, the golden years may be tarnished by a host of debilitating conditions such as poverty, chronic health problems, and inadequate access to health care.

The elderly are the fastest growing age group in the U.S. and Maryland. While most of the elderly are in relatively good health, the Commission found that there are major and disturbing differences between the length and quality of life of older Blacks and minority Marylanders as compared with White Marylanders. These disparities may be attributed to many factors. However, it is clear that many of the problems faced by Black and minority elderly are simply reflections of the disadvantages faced in their earlier lives.

It is still true that many of the jobs held by Blacks and minorities are without the benefit of health insurance coverage, sufficient incomes, or retirement provisions. This often results in a lifetime of less than adequate food, housing, education and health care which impacts upon one in youth and continues to negatively impact upon the individual in old age.

## Background

In 1980, 396,000 Marylanders or 9 percent of the population was 65 or older, compared to 11 percent, nationwide. Whites are disproportionately represented in Maryland's elderly population. Minorities represent 25% of the total population, but comprise only 15% of the elderly population. The State's minority elderly population is rapidly increasing. The minority elderly are projected to represent 21% of the elderly population by the year 2005 (1).

Maryland's minority population has a smaller proportion of elderly persons than the White population. Eleven percent of Whites and six percent of minorities were age 65 or over in 1980.

The geographic distribution of the State's elderly population varies by race. The majority (59%) of the Black elderly lived in Baltimore City in 1980. The majority (55%) of the White elderly lived in the counties surrounding Baltimore City and the District of Columbia.

## Findings

Average life expectancy at birth differs according to race with Whites living longer than Blacks in the U.S and Maryland. Far too many Blacks and minorities in Maryland fail to reach old age because they die in the prime of their lives from preventable diseases and conditions. For example, in 1982, the death rates from heart disease,

cancer and stroke were one and one-half to three times higher for minority men between the ages of 45 and 54 than for White men in this age group.

| | Maryland Death Rates Per 100,000 Population, 1982 | | Ratio Minority/White |
|---|---|---|---|
| | Minority Men | White Men | |
| Heart Disease | 341.0 | 234.6 | 1.45 |
| Cancer | 329.8 | 178.4 | 1.85 |
| Stroke | 49.4 | 16.9 | 2.92 |

Source: Personal Communication, Maryland Center for Health Statistics.

Differences in life expectancy by race are smaller once an individual reaches age 65. At age 80, what has been termed the "cross-over effect" occurs, whereby life expectancy is higher for minorities than Whites as the following Maryland data show.

**Elderly Death Rates Per 100,000 Population From All Causes, Maryland, 1982**

| | Males | | Females | |
|---|---|---|---|---|
| | White | Minority | White | Minority |
| Age | | | | |
| 65-74 | 4150.2 | 5275.6 | 2239.5 | 2985.4 |
| 75-84 | 8782.2 | 9281.7 | 5318.7 | 5898.5 |
| 85+ | 17598.2 | 16603.8 | 13551.0 | 11048.2 |

Source: Personal Communication, Maryland Center for Health Statistics.

Most Black and minority females can expect to spend most of their golden years living without their husbands. Black females, on average, live nine years longer than their mates. Because of past discrimination in employment and promotional practices, most of these women can expect to live their remaining years at or below the poverty level. In 1979, two-thirds of elderly Black women in Maryland who lived alone had incomes below the poverty level (2).

Although economic factors play a significant role in the health status of all persons, these factors play an even greater role in the lives of the elderly. Low economic status has a negative impact on health status at two fundamental levels. First, it heightens the risk of functional impairment and increases the need for long-term care services. Secondly, it limits access to quality care for those in need of long-term care.

The ability to properly maintain one's own health is as much an economic issue as an educational one. Poverty rates are much higher among minority elderly than among the White elderly. In 1979, the poverty rate among the Black elderly (29%) was three times the White rate (10%) (1980 U.S. Census). Blacks represented 15% of the State's total elderly population in 1980, but accounted for 33% of the poor elderly.

While low economic status does not necessarily cause disease, it does increase the risks of diseases associated with poor living conditions and intensifies the severity of their impact. Chronic illnesses such as diabetes, heart disease and hypertension place large demands on the financial resources of the elderly and can severely diminish the quality of life.

Maintaining a good preventive health care regimen in the U.S. today is costly. An office visit to the doctor alone costs about $30. When one considers the cost of prescriptions, tests or other needed services, the costs become astronomical for the low-income elderly. Since Medicare as well as private health insurance plans for the most part no longer pay for diagnostic treatment, the patient must cover these costs. Needless to say, for those already living at the poverty level, who can barely afford to pay for shelter or food, health care is often an unaffordable item.

Medicare is a major source of health insurance coverage for the elderly. National data show that 99% of the White elderly and 98% of the minority elderly were covered by Medicare in 1984. Most older Blacks rely very heavily on Medicare benefits and are unable to afford Medigap policies designed to cover services not covered by Medicare. Only 31% of Blacks over the age of 65 supplement Medicare coverage with private insurance, compared to 69% of Whites. While Medicare has been successful in helping the elderly pay for acute services such as hospital care, it does not cover the types of care most often needed by the elderly - nursing home services.

It is important to note that many Blacks and other minorities who spent their younger years working as domestics and did not pay into the Social Security system may not even be eligible to receive Medicare benefits. For these individuals the situation is even more critical, especially in light of the fact that as reported by the Congressional Budget Office in March 1986, medical bills for the average elderly American averaged $4,200 annually. At least half this bill is paid for by the elderly individual.

Limited information is available on the health status of the Black and minority elderly in Maryland. Preliminary Maryland data available from a community elderly survey confirms that the Black elderly in Maryland have significantly higher rates of chronic diseases such as heart disease, hypertension, stroke, cancer and diabetes than the White elderly (4). These preliminary findings are important because they are based on a reliable sample of Maryland's elderly population and can be used to plan health programs which address the unique needs of Black and minority elderly Marylanders.

Maryland data show that there is differential access to and use of health services within the elderly population by race. For example, at any given point in time, approximately 5 percent of the elderly population is institutionalized. However, White Medicaid enrollees are twice as likely to receive nursing home care as compared to Black elderly enrollees of the same age (5). On average, Medicare and Medicaid payment levels on behalf of the elderly are higher for Whites than minorities (5).

A recent report by the National Caucus and Center on the Black Aged cited the following as factors in the lower use of nursing home services by Blacks (6).

- Many Blacks simply cannot afford the high cost of nursing care.
- Discrimination, whether covert or overt, still exists, although this practice is prohibited.

- Some facilities, which serve primarily Blacks, are unable to meet fire, safety, and other code requirements because of limited resources.

- Nursing homes are often viewed with suspicious and deep concern by older Blacks because of news accounts about dreadful conditions that exist in some facilities.

According to the 1982 Maryland Household Survey the Black elderly are less likely than the White elderly to seek health care services even when they feel it is needed, 36 and 22 percent, respectively (7). The Black elderly are also less likely than the White elderly to report having a private physician as their usual source of care, 57 and 83 percent, respectively. Reasons for these disparities remain unclear; however, poverty and lack of health coverage are thought to play major roles.

## Maryland Programs and Services

While there are numerous health-related concerns linked to the aging of Black and minority populations, addressing the long term care needs of the elderly was identified as a priority issue by the Commission's Task Force on Aging. Long term care is defined as a range of health and social support services designed to assist individuals with chronic illnesses and conditions. The purpose of these services is to help the client achieve an optimum level of physical, social, psychological and vocational functioning, and to prevent the degeneration of functional ability. Long term care services can be either community based, such as home health care or institutional, such as nursing home care.

Long term care services are provided and financed by both formal support systems, such as Federal and State governments, and informal support systems, such as the elderly themselves and their families. The federal government administers the Medicare Program which provides health insurance benefits to Social Security beneficiaries, age 65 and over. A major problem with this entitlement program for the elderly is its limited coverage of most long term care services, including nursing home care.

Medicaid is the joint federal-state health insurance entitlement program for the poor which has also evolved into the major long term care financing program for the elderly. Medicaid supplements Medicare coverage for the very poor elderly as well as those elderly who become poor as a result of heavy medical expense. Over 50 percent of all nursing home care in Maryland is paid for by Medicaid.

Three Maryland agencies - the Maryland Office on Aging, the Maryland Department of Health and Mental Hygiene, and the Maryland Department of Human Resources are responsible for financing, providing, or coordinating community based long term care services for the elderly.

The Maryland Office on Aging manages the allocation of federal and state grants to Area Agencies on Aging, which administer local programs, including senior centers, in-home services and legal assistance. The Maryland Department of Health and Mental Hygiene administers several health programs for the elderly including Adult Day Care, STEPS, and Medicaid. The Maryland Department of Human Resources funds or administers income maintenance, social service, and in-home aide programs for the elderly.

The Commission's Task Force on Aging was unable to conduct a thorough assessment of access to and use of these programs by Maryland's Black and Minority elderly.

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6. National Center and Caucus on the Black Aged. "The Status of the Black Elderly in the United States." Report prepared for the U.S. House of Representatives, Select Committee on Aging: Committee Publication No. 100-622, July, 1987.

7. Personal Communication, Maryland Center for Health Statistics.

# APPENDIX A

## COMMISSION TASK FORCE MEMBERS

### Task Force on Minority Health Manpower Development

**Loretta Richardson, Ph.D., Chairperson**
**Carl Sardegna, Vice-Chairperson**

Geneva Bowser, R.N.
Bernellyn Carey
Fabian Desbordes, D.D.S.
Patricia Ghiglino-Lopez
Francis Green
Miles Harrison, M.D.
Warren C. Hayman, Ed.D.
Louis Murdock, Ph.D.
Phillip Neary
Morton Rapoport, M.D.
Doresa Taylor, R.N.
Levi Watkins, M.D.
Carol Weems, R.N.

### Task Force on Maternal, Child and Family Health

**Paula McLellan, Co-Chairperson**
**Maria Pou, Co-Chairperson**

Gwendolyn Barbour
Lillian Blackmon, M.D.
Robert Drachman, M.D.
Jacquelyne Fulton, M.D.
Roberta Gill, Esquire
Elizabeth Gong
Polly Harrison, M.D.
Patricia King
Juanito Lopez, M.D.
Ruth Massinga
Nathania Miles
David Nagey, M.D., Ph.D.
Donna Petersen
Raymond Terry, Sr., Ph.D.
Emmaline Woodson
Annelies Zachary, M.D.

### Task Force on Finance, Access and Indigent Care

**Rudolph Arredondo, Chairperson**
**Robert Heyssel, M.D., Vice-Chairperson**

Elizabeth J. Blocker
Susan Feigenbaum, Ph.D.
Monica Ferraro
R. Dena Green
Jacqueline Hargrove
Barbara Knox
William Jews
Paula B. McLellan
Katheryn Miller
Douglas Morgan
Frank Monius
Amy Spanier
Stephanie Williamson, M.D.

## Task Force on Substance Abuse

**Helen McAllister, M.D., Chairperson**
**Decatur Trotter, Co-Chairperson**

Charles Alexander
John Bland, M.S.W.
Nuria Alvarez-Grant
Eugenia Connelly
Michael Fuller
Grady Dale, Ph.D.
Nancy Lowe Connor, D.P.A.
Frank Jordan
Asenith Mayberry
Robert McDaniel, M.D.
Charles T. Rosendale
Ulder Jane Tillman, M.D., M.P.H.
Stephen Roane
Nollie Wood, Ph.D.

## Task Force on Homicide, Suicide and Unintentional Injuries

**Kurt Schmoke, Chairperson**
**Bishop Robinson, Co-Chairperson**

Alda Anderson
Susan Baker
Timothy Baker, M.D.
Gustavo Caballero
Phyllis A. Diggs
Leroy Durham, Ed.D.
Joyce Fair
Adele Wilzack, R.N.
Edward Tilghman
Lois McBride, R.N., M.S., Esquire
Ronald E. Hollie
Colin Loftin, Ph.D.
Daisy Morris Murphy
Mable Palmer
Moses B. Pounds, Ph.D.
Richard Rowe
Egya Quaison-Sackey, M.D.

## Task Force on Cardiovascular Disease, Cancer and Other Leading Causes of Minority Morbidity and Mortality

**Paula Hollinger, Chairperson**
**Jose Yosuico, M.D., Co-Chairperson**

Edna Amador
Lee R. Bone
Kay Edwards, Ph.D.
Donald O. Fedder, Ph.D.
Jean Gaffney
Harry Johnson
Joyce Harper, M.D.
Michaeline Silverstein
John Southard, M.D.
I. Michael Miles, M.D.
James Moore, D.D.S.
Aschaw Osei-Wusu, M.D.
Pearl Price
Elizabeth Ramsey
Elijah Saunders, M.D.
Betsy Simon
Carmine Valente, Ph.D.

## Task Force on Aging

Aris T. Allen, M.D., Chairperson
Sonya Gershowitz, Co-Chairperson

Mack Bonner, M.D.
Edward Brandt, Jr., M.D.
Wendy Garson
Judith Hannes
Patricia Harris
Peter P. Lamy, Ph.D.
John Maupin, D.D.S.
Ellie Wang
Shirley Whitfield
Edgar Rivas
Paul Ruskin, M.D.
Jean Snyder
Marta Sotomayer, Ph.D.
George Taler, M.D.
Ulder Jane Tillman, M.D., M.P.H.
Darlene Wakefield
Sallie L. Welles

## Task Force on Mental Health

Thomas F. Krajewski, M.D., Chairman

Andre M. Davis, Esquire
Debbie Deshields
Michael Jefferies, M.D.
Patricia L. King
Raymond C. Love
Gayle McCleary, R.N.
Judge David Mitchell
Shirley Pulliam, R.N.
Paul Ruskins, M.D.
Janice Stevenson, Ph.D.
Archer L. Stith, LCSW

# APPENDIX B

## Health-Related Organizations and Agencies in Maryland and U.S.

### AIDS

Minority Affairs Office
Health Education Resources Organization (HERO)
Suite 812
101 West Read Street
Baltimore, Maryland 21201
(301) 685-1180

Minority Outreach Program
AIDS Administration
Maryland Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201
(301) 225-6707

Earth-Tide, Inc. (An AIDS Minority Outreach Program)
2901 Druid Park Drive
Suite 104
Baltimore, Maryland 21215
(301) 225-9635

### Cancer

Office of Community Services
American Cancer Society
Metropolitan Baltimore Chapter
P.O. Box 544
1840 York Road
Timonium, Maryland 21093
(301) 561-4790

American Lung Association of Maryland
1301 York Road
Lutherville, Maryland 21093
(301) 494-1100

Maryland Department of Health and Mental Hygiene
Division of Cancer Control
201 West Preston Street
Baltimore, Maryland 21201
(301) 225-6774

## Cardiovascular Disease

Maryland Commission on High Blood Pressure and Related
Cardiovascular Risk Factors
201 West Preston Street
Baltimore, Maryland 21201
(301) 225-5891

Maryland Department of Health and Mental Hygiene
201 W. Preston Street
Baltimore, Maryland 21201

A. Health Education Center
(301) 225-1362

B. Family Health Services Administration

Division of Chronic Disease Prevention
(301) 225-6778

Division of Chronic Disease Nutrition
(301) 225-6783

Division of High Blood Pressure Control
(301) 225-6783

American Heart Association - Maryland Affiliate, Inc.
415 North Charles Street
P.O. Box 17025
Baltimore, Maryland 21203

Urban Cardiology Research Center
2300 Garrison Blvd.
Suite 150
Baltimore, Maryland 21216
(301) 945-8600

## Diabetes and Dietary Practices

American Diabetes Association - Maryland Affiliate, Inc.
3701 Old Court Road
Baltimore, Maryland 21208
(301) 486-5515

Maryland Department of Health and Mental Hygiene
Maryland Diabetes Control Program
201 West Preston Street
Room 306-B
Baltimore, Maryland 21201
(301) 225-6778

Maryland Dietetic Association
1301 York Road
Lutherville, Maryland 21093
(301) 321-6200

## Health Professions Associations

Maryland Dental Society (Association of Black Dentists)
c/o Dr. Joyce Park, President
6305 York Road
Baltimore, Maryland 21212
(301) 323-3446

Monumental Medical Society (Association of Black Physicians
c/o Dr. Miles Harrison, President
2300 Garrison Boulevard
Suite 104
Baltimore, Maryland 21216
(301) 566-6446

Association of Black Psychologists
c/o Dr. Glenwood Brooks, Coordinator
3213 Pinkney Road
Baltimore, Maryland 21215

Association of Black Social Workers, Inc.
Baltimore Chapter
P.O. Box 18635
Baltimore, Maryland 21216

Medical and Chirurgical Faculty of Maryland
1211 Cathedral Street
Baltimore, Maryland 21201
(301) 539-0872

Maryland Nurses Association
5820 Southwestern Boulevard
Baltimore, Maryland 21227
(301) 242-7300

American Physical Therapy Association of Maryland, Inc.
2985 Valley View Road
Annapolis, Maryland 21401
Ms. Danneene Kipp, President
(301) 997-0999

Black Nurses Association of Baltimore
P. O. Box 6975
Baltimore, Maryland 21216

Maryland Pharmaucetical Society
(Association of Black Pharmacists)
c/o Dr. Ralph Quarles, President
4214 Bonner Road
Baltimore, Maryland 21216

National Association of Black Social Workers
271 W. 125th Street
New York, New York 10027

National Association of Health Services Executives
820 N. Lake Shore Drive
Chicago, Illinois 60611
(301) 280-6465

National Associaton of Hispanic Nurses
2014 Johnston Street
Los Angeles, California 90031

National Association of Black Psychologists
P. O. Box 2929
Washington, D. C. 20013
(202) 462-7553

National Association of Black Nurses Association, Inc.
P. O. Box 18358
Boston, MA 02118
(617) 266-9703

National Medical Association
1012 Tenth Street, N.W.
Washington, D.C. 20001
(202) 347-1895

National Dental Association
National Dental Hygients Association
National Dental Assistants Association
5506 Connecticut Avenue, N.W.
Washington, D. C. 20015
(202) 244-7555

National Black Women's Health Project
1237 Gordon Street, S.W.
Atlanta, Georgia 30310
(404) 753-0916

## Health Facilities Associations

Mid-Atlantic Primary Health Care Association
2301 Katcef Street
Annapolis, Maryland 21401
(301) 841-6278

Maryland Association of HMO's
P. O. Box 374
Annapolis, Maryland 21404
(301) 644-2502

Maryland Hospital Association
1301 York Road
Baltimore, Maryland 21204
(301) 321-6200

Health Facilities Association of Maryland, Inc. (Nursing Homes)
229 Hanover Street
Annapolis, Maryland
(301) 269-1390

## Maternal and Child Health

Children's Defense Fund
122 C Street, N.W.
Washington, D. C.
(202) 628-8787

Maryland Governor's Council on Adolescent Pregnancy
311 W. Saratoga Street
Baltimore, Maryland 21201
(301) 333-0270

National Black Child Development Institute, Inc.
1463 Rhode Island Avenue, N.W.
Washington, D. C. 20005
202-387-1281

Maryland Coalition of Healthy Mothers/Healthy Babies
c/o Donna Petersen, President
Department of Maternal and Child Health
JHU School of Hygiene and Public Health
615 N. Wolfe Street
Baltimore, Maryland 21205
(301) 955-6836

## Mental Health

Black Mental Health Alliance
2901 Druid Park Drive
Baltimore, Maryland 21215
(301) 523-6670

Mental Health Association of Maryland
323 E. 25th Street
Baltimore, Maryland 21218
(301) 235-1178

## Aging

The National Caucus and Center on
Black Aged, Inc.
1027 Central Street
Baltimore, Maryland 21201
(301) 576-1116

National Caucus and Center on Black Aged
1424 K Street N.W., Suite 500
Washington, D.C. 20005
(202) 637-8400

National Hispanic Council on Aging
2713 Ontario Road, N.W.
Washinton, D.C. 20024
(202) 265-1288

Maryland Office on Aging
301 W. Preston Street
Baltimore, Maryland 21201
(301) 225-1102

## Substance Abuse

American Council on Alcoholism
8501 LaSalle Road
Suite 301
Towson, Maryland 21204
(301) 296-5555

National Black Alcoholism
Council
417 South Dearborn Street
Chicago, Illinois 60605

Addictions Administration
Maryland Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201
(301) 225-6925

## Sickle Cell Disease

Central Maryland Committee on
Sickle Cell Anemia, Inc.
828 E. Baltimore Street
Baltimore, Maryland 21202
(301) 837-3050

ASSERT
3939 Reisterstown Road
Baltimore, Maryland 21215
(301) 578-1800

## Related Advocacy Organizations, Commissions, and Councils

U.S. Office of Minority Health
118F Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20001
(202) 245-0020

National Association for the Advancement of Colored People
(Baltimore City Branch)
26 West 25th Street
Baltimore, Maryland 21218
(301) 366-3300

National Association for the Advancement of Colored People
National Headquarters
4805 Mt. Hope Drive
Baltimore, Maryland 21215
(301) 358-8900

Baltimore Urban League
1150 Mondawmin Concourse
Baltimore, Maryland 21215
(301) 523-8150

National Urban League
500 E. 62nd Street
New York, New York 10021
(212) 310-9000

Maryland Commission on Indian Affairs
15 W. Mulberry Street
Baltimore, Maryland 21201
(301) 333-4986

Maryland Governor's Commission on Hispanic Affairs
Globe Building, Suite 404
817 Silver Spring Avenue
Silver Spring, Maryland 20910
(301) 565-3211

Maryland Governor's Commission on Migratory and Seasonal
Farm Labor
1123 N. Eutaw Street, Room 310
Baltimore, Maryland 21201
(301) 333-0075

Health and Welfare Council of Central
Maryland, Inc.
22 Light Street
Baltimore, Maryland 21202
(301) 685-0525

Maryland Black Congress on Health, Law and Economics
c/o The Black Mental Health Alliance
Suite A-11
2901 Druid Park Drive
Baltimore, Maryland 21215
(301) 523-6670

## APPENDIX C

## THE MAJOR HEALTH PROBLEMS OF NATIVE AMERICAN INDIANS IN MARYLAND

### Introduction

Issues related to health and access to health services for the American Indians of Maryland have largely gone unexplored. This report was prepared by Patricia King of the Maryland Commission on Indian Affairs at the request of the Maryland Governor's Commission on Black and Minority Health. The report's purpose is to provide a preliminary glimpse at the health issues facing the Amerian Indians of Maryland. The report highlights the need to ascertain a better understanding of the health problems and needs of this population.

### Who are the American Indians of Maryland?

Unless a person has a very good grasp of the Indian relationship with the federal government, identifying who is an Indian is an incredibly painstaking exercise. Anyone who is familiar with the issues that revolve around Indian tribes, sovereignty, treaty rights and the like will know that the definition of an Indian (and who is an Indian) is an endless debate. There must be over 100 definitions used by the federal government and by other organizations that provide services to Indians.

No individual in any other population in the U.S. is required to prove his/her racial/ethnic background which, in part, determines that extent of benefits and services to be received by federal or state governments, and which serves to identify the Indian individual's position in the Indian and non-Indian world. His/her status, i.e., recognition, federal, state or non-recognition (the status of Maryland's Native Indians), is important in determining how the individual sees him/herself as an Indian and is seen by other Indians and non-Indians. This can directly or indirectly affect an individual's sense of belonging, dignity and worth. Our discussion here includes all Indians recognized and non-recognized since they all represent Maryland's Indian population. The non-recognized Indians, for our purposes, include individuals who are of Indian descent and who identify themselves as Indians; these include the Native Indians of Maryland.

The Census figures for 1980 identify 8,021 American Indians, including Alaskan Natives in Maryland; less than 1% of the state's population. The Census Bureau is revising the Census questions for 1990 since a large percentage of the country's Indian population was not identified in the 1980 Census. The Bureau agreed that the questions regarding Indian descent were not clear and did not count American Indians of mixed blood accurately or Indians belonging to more than one tribe (1). In addition, many Indians living in Maryland count themselves in the Census on their reservations or in the state where they are recognized thus assuring them when they return the benefits provided by their federal or state status.

The Indians of Maryland, like Indians throughout the nation, have had to bear the burden of forced assimilation. In order to preserve their identity and values, many Indians have gone "underground". Discrimination and racism have played a role in Maryland. Today as in the past, it has frequently been a stigma to identify one's self or family as an Indian. Although there has been a greater expression of "Indianness" in Maryland recently, there are still Indians in the State who are fearful to identify themselves as Indians and may not do so on the Census.

The Commission on Indian Affairs, the State agency which serves as liaison between the State and the American Indian Community, maintains that the Indian population in Maryland is closer to 25,000 and seeking funds to conduct a study to as ascertain a demographic and health profile of Maryland's Indian population. This is a far larger number than the Census figures, but this is borne out by other resources. For instance, the Smithsonian Handbook of North American Indians estimated in 1970 that there were approximately 7000 Piscataways residing in Charles, St. Mary's and Prince George's Counties, and approximately 4000 Lumbees and Haliwas living in Baltimore City. This is almost the total number identified in the Census, yet this represents only a small segment of the entire Indian population. The numbers used in this paper are Commission estimates unless specifically stated as Census numbers.

There is a great diversity among the Indians who reside in Maryland. The Indian Commission estimates that there are over 200 tribes represented in the State. They are composed of the recognized and non-recognized groups described above, and also represent rural and urban communities, reservation and non-reservation communities. These groups speak several different languages, and practice different lifestyles.

They include:

1. Piscataways - This is the largest Native Indian population in the State, most of whom live in Prince George's County (e.g., Brandywine area) and Charles County (Accokeek area). They number about 7000. Early Maryland history indicates that they were referred to as "Wesorts" distinguishing themselves from the White and Black populations. Anthropologists also referred to them as tri-racial isolates due to their blood mix with the White and Black populations. The Piscataway however, continued to intermarry. Some of their features described in early accounts included albinoism, deafness, eye lobes, and sickle cell disease.

2. Lumbees and Cherokees - The majority of American Indians in Baltimore are from North Carolina. These include Lumbees and Cherokees who migrated during the Second World War for jobs. The majority settled in clusters in Fells Point. Baltimore is not necessarily considered "home" since they move between North Carolina and Baltimore frequently. Many of them are in seasonal jobs, are frequently unemployed, and have to move to other locations. This group experiences high rates of unemployment (2). They have a difficult time adjusting to the environment and exhibit low self-esteem due to a lack of cultural identity in their environment. There are approximately 3,500 living in Baltimore.

3. Haliwas-Saponi - They also came from North Carolina for the same reasons as the Lumbees. Most of them live in Baltimore and Montgomery County and, on the whole, maintain steady, permanent employment. Their numbers are uncertain and may be about 500.

These are the largest groups in the State. In addition, there are other Native Indians whose numbers may extend from two to 50 or more individuals who live on the Eastern Shore, and include descendants of the Choptanks and Pocomokes.

Marylanders are not so familiar with tribes and bands who have come from the mid-west and west and reside in many areas of Maryland. Many work for the federal government or national Indian organizations and live in Maryland. It is not known what population figures they represent since many may not be counted in the Maryland Census.

Over half of the Native Americans lived in Baltimore City and its surrounding

counties in 1980. Another one-third lived in Montgomery and Prince George's counties. According to the 1980 Census, eleven subdivisions had Native Indians populations numbering one hundred or more. These included Baltimore City (2078), Prince George's County (1641), Montgomery County (936), Baltimore County (755), Anne Arundel County (681) and Charles County (477).

The 1980 Census also indicated that Native American Indians were three times as likely as Whites to poor and almost twice as likely to be unemployed. The media age was 26 and less than 4% of the population was over the age of 65.

**Health Problems, Needs and Concerns**

Data is sorely lacking on the major health problems of this population in Maryland. Although it is rarely enumerated or analyzed, mortality and natality data for Native Americans is available through the Maryland Center for Health Statistics.

A major concern was found to be a lack of recognition of Native Indians by health and social service institutions, and the broader community. For example, an American Indian mother recently gave birth to an infant in an Prince George's County hospital and requested taht the newborn's race be listed as Indian. The staff refused claiming that the infant was not Indian because the parents did not look Indian. This attitude serves to reinforce the prejudice and discrimination that Indians have known for hundreds of years. Not only does it take away the individual's dignity, but it also discourages Indians from seeking services that they may desperately need.

Indians are not likely to share information about themselves with non-Indians. American Indians, on the whole are private individuals who prefer to resolve problems within the family, extended family, or within the community. American Indians are less likely to use a health/mental health facility if they have their own support systems. If one does not exist, and this is often true for many Indians in the urban community, they will use the available facility, once a crisis has occurred. The degree of adaptation (acculturation) to the non-Indian world as opposed to the degree of maintenance of traditional values determines how readily a person will seek help from an entity outside the family and community.

Because of the poor relationship with the federal government, American Indians remain suspicious of "government' and may be reluctant to identify themselves as Indians or to provide information about their situation and needs. This lack of response can prevent them, from receiving needed services, and information.

Some Native Americans will also have a tendency to deny the existence of problems. This was one conclusion of a study by the Baltimore Indian Center in 1982 (2). Residents denied the existence of substance abuse problems among their youth. However, Center staff and other City agencies had noted an increase in both adolescent substance abuse and the school drop-out rate. Indian residents who knew about the Center's resources were also failing to use them. The resources include job training, emergency shelter, and family and alcoholism counseling.

The Center is aware that is cannot provide for all the needs of the community. Programs cannot be planned due to the availability of funds which must be sought yearly. There is a limited number of Indian staff due to a scarcity of Indians with in the health professions. Because of their workload the staff is not always able to see that their clients receive or get to health/mental health resources which are located far away. The Center would like to do more outreach.

Indians in the Fells Point area, where the population of Baltimore is largest, use the following health facilities: Church Outpatient Hospital Clinic, John Hopkins, and Matilda Colwell Clinic. These facilities offer a sliding scale fee. According to a counselor at the American Indian Center, in may cases Indian families cannot afford to pay for their health care and therefore do not receive treatment at all. Hypertension is a frequently identified problems.

Previously, the federal Indian Health Service maintained a contract with one of the health facilities. This was not so helpful to the eligible Indian community as they could only use the services up to six months after their arrival in the urban community.

The Baltimore Indian Center study may mirror the situation in Prince Georges County where the next largest population is located; however, there is not an Indian center there or elsewhere in the State that can identify and respond to the health/mental health needs of the Indian population. In an informal discussion with a health nurse who worked with the Piscataways, there is evidence that their diseases and their prevalence bear some relationship to many of the death related diseases that affect Indians nationally. These include heart defects, tuberculosis, and cirrhosis. Accidents are also prevalent. Data is sorely needed to verify these causes and identify other causes of disease and death among this population.

Most Indians now live off the reservation. Health/mental health services that would be available to federally recognized Indians on reservations are not always available to them off the reservation or are only available for six months after leaving the reservation. This is particularly true in Maryland which has only one Indian Center with limited services. Consequently, recognized Indians will use the same services as the general public. The Native Indians of Maryland are neither federally or state recognized and cannot take part in the health/mental health programs provided by the Bureau of Indian Affairs (BIA) and Indian Health Service (IHS). They use the same services as the general public.

Given the fact that Indians are dispersed throughout the State and not easily identified, gathering health/mental health data is difficult. There is a great deal of data on Indians living on or near reservations. However, there is paucity of information on the health of the urban Indian.

**Other Barriers**

Health professionals are in agreement that health data is sketchy, often not available and often not reliable when acquired. When an American Indian visits a clinic for service, he/she many not be identified as Indian, for most application forms do not request this information. If race/national origin/ethnicity data is requested on a form, it is often limited to "white", "black" "other". Application forms such as those used by some alcohol and substance abuse clinics which make an effort to seek out this kind of information may include Aleuts and Alaskan Natives as well. In other instances, the nurse, intake worker, therapist, etc., may fill in race, nationality or ethnicity by asking the patient or client or by looking at the individual and using their own judgement. The Indian population claims that the latter means of identification is more frequent and it is widely criticized in the community since the judgement is always an incorrect one. There are special health needs of diverse populations; therefore it is important to know the background of the patient or client as it could be helpful in diagnosing problems.

American Indians are not always easily recognizable. Physical identification is unreliable as Indians in Maryland do not possess any particular physical features which

distinguish them from the general population. Some may "look" Indian; others may not, but one's stereotype of an Indian should not be the basis with which to ascertain their racial/ethnic background. Anthropologists state that Maryland's Native Indian population is the most acculturated of all Indians due to an early history of inter-marriage. Consequently, there are no visible physical or cultural characteristics that may distinguish them from others, such as language, dress and behavior.

Recently, in the Washington Post Health Section, it was stated by a Hispanic leader that "more complete health and demographic data could be found on Native American Indians...than on Hispanics". This statement was based on the federal government first report on Black and Minority Health. The Bureau of Indian Affairs (BIA) and the Indian Health Service (IHS) provide services to federally recognized Indians who live on or near reservation land and the latter provides health clinics in urban areas to federally and state recognized Indians. Data on these populations is easily available given the defined boundaries BIA and IHS serve and the specific individuals eligible for service. But this statement is not correct when one considers the urban Indian.

### Commission on Indian Affairs Recommendations

It is evident that little and scattered data is available on the health needs and access to health needs and access to health of the Indians of Maryland. It is recommended that:

1. A study and data collection on the health/mental health needs and access to health of the Indians of Maryland be conducted and that this information be used to plan and provide health services to the American Indian population.

2. Culturally sensitive training programs be conducted for health professionals which would include learning about specific cultural values and behaviors of the contemporary Indian population.

3. Efforts be made to increase the number of Native American health professionals in Maryland. There are only a handful of qualified Indians in these professions.

4. Efforts be made to present mental health issues to the American Indian community in a positive, non-threatening and helping manner.

5. Indian organizations be assisted in attempting to help the Indian population utilize non-Indian health resources.

6. Indian organizations be assisted in obtaining funds to provide health/mental health programs to the Indian population.

## REFERENCES

1. Census Bureau Information quoted by Indian Department of the Census.

2. Cited from "A Social and Economic Development Plan for the Baltimore American Indian Center, 1983."

3. Ibid.

## APPENDIX D

## THE MAJOR HEALTH PROBLEMS OF REFUGEES IN MARYLAND

### Introduction

This report was prepared by Ms. Jeannette Rose of the Maryland Department of Health and Mental Hygiene's Office of Refugee Health at the request of the Maryland Governor's Commission on Black and Minority Health. The report details selected health and demographic characteristics of refugees in Maryland. The term Refugee is one of political assignment and is reserved for those individuals in peril who flee their countries because of political or religious persecution. Refugees enter this country with some expectation of assistance in language training, social services, or health care.

The magnitude of refugee immigration in the years 1975 through 1977 was never appreciated formally. Arrivals were completely unanticipated, and programs to meet their needs were instituted on an ad hoc basis. Approximately 80% of these 2,500 refugees were Vietnamese who settled predominately in Baltimore City, Baltimore, Howard, Montgomery, and Prince George's counties. The unique feature of this first group was that they were healthier. Most had ties to the military presence in Vietnam, and they did not suffer the indignities of camp life. They were more educationally endowed representing the "cream" of their society. Medical care was a part of their repertoire.

Data on refugee immigration between 1977 and 1979 are inexact. A dramatic influx of refugee immigration began between 1978 and 1979. The estimated refugee immigration was 3,500 and included three ethnic groups: Vietnamese, Cambodians and Laotians. Seven areas experienced the initial impact of this immigration - Baltimore City, Baltimore, Anne Arundel, Howard, Montgomery, Prince George's and Worcester counties. The second wave of refugee immigration occured from January, 1979 to December, 1980. Over 7,000 new refugees settled in these seven counties. Between 1981 and 1986 data on the numbers of refugees entering Maryland became more precise.

Southeast Asian Refugee Immigration, 1981 - 1986

| | |
|---|---|
| Anne Arundel | 94 |
| Baltimore County | 175 |
| Baltimore City | 299 |
| Carroll | 127 |
| Cecil | 2 |
| Charles | 6 |
| Dorchester | 8 |
| Frederick | 14 |
| Garrett | 14 |
| Harford | 26 |
| Howard | 133 |
| Kent | 4 |
| Montgomery | 2268 |
| Prince George's | 2928 |
| St. Mary's | 10 |

| | |
|---|---|
| Somerset | 4 |
| Talbot | 19 |
| Washington | 35 |
| Wicomico | 21 |
| Worcester | 86 |
| Total | 6273 |

## Health Problems, Needs and Concerns of Southeast Asian Refugees

Southeast Asian refugees are predominately the working poor, uninsured or underinsured. Most are working in entry level jobs and receive health care on an episodic and erratic basis. Refugees tend to cluster together in overcrowded housing units.

The Cambodian population stands stark in its need for health care. Most have never seen a physician or had the benefit of medical care prior to immigration. When Cambodia fell, the population was rounded up to identify those "intellectuals" who were thought to present problems for the new regime. This included all those who had attended school above a sixth grade level and ALL THOSE WHO WORE GLASSES. Wearing glasses indicated a desire to read which translated into an "intellectual". All of those in the former group were put to death. The Cambodians who eventually found refuge here were herded in overseas' camps for long periods of time, were subject to crowded, unsanitary conditions, preyed upon by marauding bands, raped physically by guards and psychologically by camp life.

Some identified health problems and needs of the Southeaset Asian population include:

- Low height/weight ratios in children
- Parasitism - Approximately 70% exhibit parasitism upon immigration.
- Tuberculosis - Approximately 58% are infected with tuberculosis organisms.
- Approximately 69% of this group needs dental care.
- Approximately 30% of refugees have HBsAG markers.
- Hypertension is a frequent problem. A cultural disposition for highly salted food makes dietary control difficult.
- Family planning programs are utilized poorly. Teen pregancies are increasing.
- Some malnutrition and suboptimal nutrition exists in mothers, infants, and children. Incomes are inadequate. Transportation to ethnic food markets is limited.

## Mental Health Problems

State and local program personnel report very little overt mental illness in this population. However, common sense suggests that there must be mental health problems throughout the refugee community. Brutal uprooting and separation from culture,

country, and family are the seeds of mental health problems. Refugees remain apprehensive for long periods after they reach sanctuary in the State. Many suffer from survivor guilt. Many have been victims or witnesses to physical and psychological torture. The presence of a cultural taboo against verbalizing mental health symptoms, and the accompanying family shame compounds the existing problem.

Most of the following identified mental health problems are anecdotal. They include experimentation with alcohol, antisocial behavior, anxiety, depression, and intragenerational conflict.

### Barriers to the Receipt of Health Care Services

- Inadequate transportation to health facilities
- Inadequate numbers of translators/interpreters
- Reductions in federal funding for refugee screening and follow-up
- Inadequate (nonexistent) State and local funding for refugee services
- Few mental health professionals with cross-cultural training

### Office of Refugee Health Recommendations

- Increase federal funding for translators
- Increase local funding for translators, particularly in Prince George's County
- Increase the availability of rental housing and transportation services
- Promote the availability of culturally sensitive health care services

## APPENDIX E

## THE MAJOR HEALTH PROBLEMS OF MIGRANT FARM WORKERS IN MARYLAND

### Introduction

This report was prepared by Patricia Fields of the Governor's Commission on Migratory and Seasonal Farm Labor at the request of the Governor's Commission on Black and Minority Health. It presents a demographic and health status profile of migrant workers in Maryland. There are an estimated 5,000 migrant farm workers in Maryland.

### Demographic Profile

| Racial Composition | Percent |
|---|---|
| Hispanic | 40% |
| Haitian | 33% |
| Black | 24% |
| Other | 3% |

| Geographic Distribution | Percent |
|---|---|
| Lower Eastern Shore | 37% |
| Upper Eastern Shore | 32% |
| Western Maryland | 24% |
| Other (Charles, P.G., Balto., Harford & Carroll Counties) | 6% |

### Major Health Problems, Concerns, and Needs

- Well child care/immunizations
- Hypertension
- Iron deficiency anemia
- Otitis media
- Sexually transmitted diseases
- Substance abuse and mental health problems
- Maternity and family planning
- Lack of primary care services in some subdivisions

### Barriers to the Receipt of Health Services

- Limited formal education
- Conflict of cultural beliefs with traditional Western medical practice
- Language barriers
- Inability or unwillingness on part of local providers to accept new patients or patients who are unable to pay
- Long waiting lists for appointments at local providers

- Inaccesibility of local services -limited weekend and/or evening hours

Commission on Migratory and Seasonal Farm Labor Recommendations

- Provide funds and resources to address health care needs - translators, transportation, dental care, health care, hospitalization
- Provide increased health education programs
- Provide additional adult basic education and English as a second language classes
- Improve the coordination of local, state and private health care services
- Improve the Medical Assistance process for obtaining Medical Assistance cards
- Develop a substance abuse/mental health program

Appendix 16

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Date Filmed

March 29, 1991