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Warning: Urban Living May Be Hazardous to Your Health: A Personal Perspective

by Frederick G. Adams

As a result of remarkable scientific and medical achievements of the 20th century, we now know that full and quality health is within reach for all Americans. Yet, despite these achievements, the burdens of inadequate health services too often falls more heavily on some population groups moreso than on others.¹ The fact that this “gap” in health status occurs more frequently among people with low income and people belonging to racial/ethnic minority groups, in particular African Americans, has been well documented nationally.² Not only does the “gap” in the health status experienced by these groups include consistently higher excess mortality and overall poor health as measured by infant mortality rates and disability levels, but it also involves disparities in health-related information and resources. This lack of information, in turn, leads to behaviors not conducive to good health.

Health priorities relevant to African American populations throughout the United States vary from violence and abusive behavior on the urban scene to diet/obesity and related morbidity on the rural scene. The morbidity and mortality status of African Americans largely relates to the historical “plantation impact” on contemporary health status data regardless of urban, rural or suburban location. Violence and abusive behavior are topics in need of consensus focusing throughout the country.

African American organizations throughout the country are extremely important in fashioning new partnerships to address problems of poor health, including violence, lifestyle behavioral abuses, and premature and preventable morbidity and mortality consequences. Without new partnerships with African American organizations that impact the human infrastructures at risk, the burden of poor health will continue to fall more heavily on the African American population than on any other multi-ethnic population. The disparity in health status, nationally, places African Americans at heightened risk for illness and premature mortality. Not only does this gap in health status include consistently higher chronic disease, excess mortality and morbidity, it also involves disparity in access to disease-related information and resources. An understanding of the essential importance of new institutional partnerships must become a fundamental part of our pursuit to improve the health status of African Americans.



A review of Hartford, Connecticut’s health problems helps to illustrate two points about the institutional partnerships necessary for effective health strategies. The first is that organizations and institutions in the African American community must pursue partnerships to increase health information available to people. But the second is that armed with such information, people must alter or change behaviors that are medically self-destructive.

During my tenure as Commissioner of Health for Connecticut’s Department of Health Services, I collected considerable information that showed the City of Hartford is still in the grips of a number of serious health problems. Hartford has a significant poor infant health problem, for instance. Hartford residents of all ages engage in many activities that are self-destructive. The death rate among residents over the age of 25 for nearly all of the leading causes of death, except suicide, is higher than the statewide rate. Finally, along with poverty, the root cause of much of Hartford’s health problems is poor lifestyle habits.

More than 133,000 people live in the state’s capital; over half the population, 65 percent or greater, is made up of minority populations. For 1993, the last year with available figures, 55 percent of the population fell below the poverty level. In fact, between 1970 and 1980, the city moved up from 45th to 4th, as the poorest city in the nation. Its per capita income, \$8,677, is the lowest in Connecticut. The state health department’s information further shows that Hartford mothers continue to have difficulty with successful births. To list just some of the statistics involving infant health in Hartford, the death rate is over 18 per 1,000 live births. That figure compares with 9.1 per 1,000 live births for the entire state. Of all live births from 1985 to 1993, 33.5 percent were to teens. Less than 9 percent were to teens statewide. Finally, low birth weight rates present a problem for Hartford; 383.9 low

birth rates per 100,000 compared with statewide figures of 354.3 per 100,000.

Hartford's problems could be side-stepped with good prenatal care and good health habits on the part of the mother during pregnancy. Hartford is very much involved with trying to improve the health of its infants. Currently, the Hartford Action Plan on Infant Health pools the resources and expertise of three area hospitals to reduce the mortality and morbidity of infants. There is no question that the city needs to continue these kinds of efforts at addressing its infant health problems.

Hartford residents, however, do engage in too many forms of self-destructive activities. As an example, homicide is the second leading cause of death among the city's children; making up 10 percent of all deaths. It is the leading cause of death among the city's adolescents. Hartford's rate does not differ significantly from other rates in Connecticut in these two age groups. However, the city's homicide rate takes a significant jump among adults. In 1988 there were 25.2 murders per 100,000 residents in Hartford. That figure compares with 5 per 100,000 for the entire state. Drugs, violence, and crime play a significant role in these public health figures, as well. Drugs play a significant role in another of the city's health problems. In 1987, the first year that AIDS began to be reported as a separate cause of death, Hartford adults suffered more than others statewide. The state health department figures show HIV infection in Hartford is more the result of intravenous drug use than heterosexual and homosexual relations. The problem of drug dependency also expresses itself in problems of alcohol abuse and cirrhosis of the liver. During the middle age years, mortality from these two problems is significantly higher in Hartford than throughout the state.

Violence and abusive behavior are topics in need of consensus focusing throughout the country.

Interestingly, problems of death and injury from motor vehicle accidents among the city's adolescents and young adults is significantly lower than statewide. The number one cause of death for this age group throughout Connecticut is motor vehicle accidents. This lower death rate may have something to do with the difference in access to motor vehicles among Hartford teenagers as compared with teenagers statewide. That rate may be one of the few positive aspects of poverty in Hartford.

As in the rest of the state, cardiovascular disease is the leading cause of death in Hartford. However, death rates in Hartford are significantly higher than in the rest of the state. African Americans are known to suffer more from cardiovascular disease than the white population. As a result, the high cardiovascular disease rate in Hartford would be expected since upwards of 45 percent of the population, according to 1990 figures, is African American.

The City of Hartford and the State Department of Public Health and Addiction Services must redirect and

refocus their efforts at solving the aforementioned predictable health problems of Hartford. At both levels there is no existence of a department that focuses on "minority health" and/or multi-ethnic health affairs. To me, that is unconscionable in the year 1995. The city's infant health problems remain atrocious. Programs need to be augmented, including new planning for infrastructure penetration to lower the death rate from self-destructive habits, especially those involving drug abuse. Now the real culprit, improvements in lifestyles (smoking, diet, exercise, stress reduction, etc.) must be planned for and implemented to reduce the ill effects of the city's poor health status. For after all, we are focusing on the capital of the State of Connecticut, one of the richest states on a per capita basis, in the United States.

The major findings in this essay constitute a "wake-up" call. New policies must increase funding for community service and applied research programs applicable to the population. Policies favoring the collection of ethnic-specific data must accompany additional resources which target culturally appropriate community-based programs and services. In order to prevent a shameful exacerbation of the health status of multi-ethnic populations residing in urban centers, community programs should develop ways to increase the use of preventive resources, address system barriers, such as lengthy delays in clinics and satellite centers serving the populations at risk and improve follow-up services. All are critical components of comprehensive primary and secondary preventive measures.

It is my belief that health hazards can be drastically reduced in urban centers throughout the United States, if African American leadership within the community not only advocate for change, but also plan for change in partnership with all interested parties within their communities. In order to run the race of improvement it is essential that we take the first step to encourage others to "get into the race." Partnerships for improvement will happen once the example has been demonstrated and community infrastructure involvement at every level of planning has been utilized. There is every reason to believe that we can accomplish the goals set out in Health People 2000, "The National Health Promotion and Disease Prevention Objectives." The issue is whether or not the wake-up call has been heard and how quickly we will respond. It is obvious, however, that if the wake-up call has not been heard there will be no mobility and a first step will never be taken, thus, no progress or significant improvement will be made.

Notes

¹U.S. Department of Health and Human Services: *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. (Washington, D.C.: U.S. Government Printing Office, September 1990).

²The African American Task Force for the Unity in Health, Diversity in Culture Conference. Sponsored by the California Department of Health Services, Health Promotion Section, (June 1991).

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