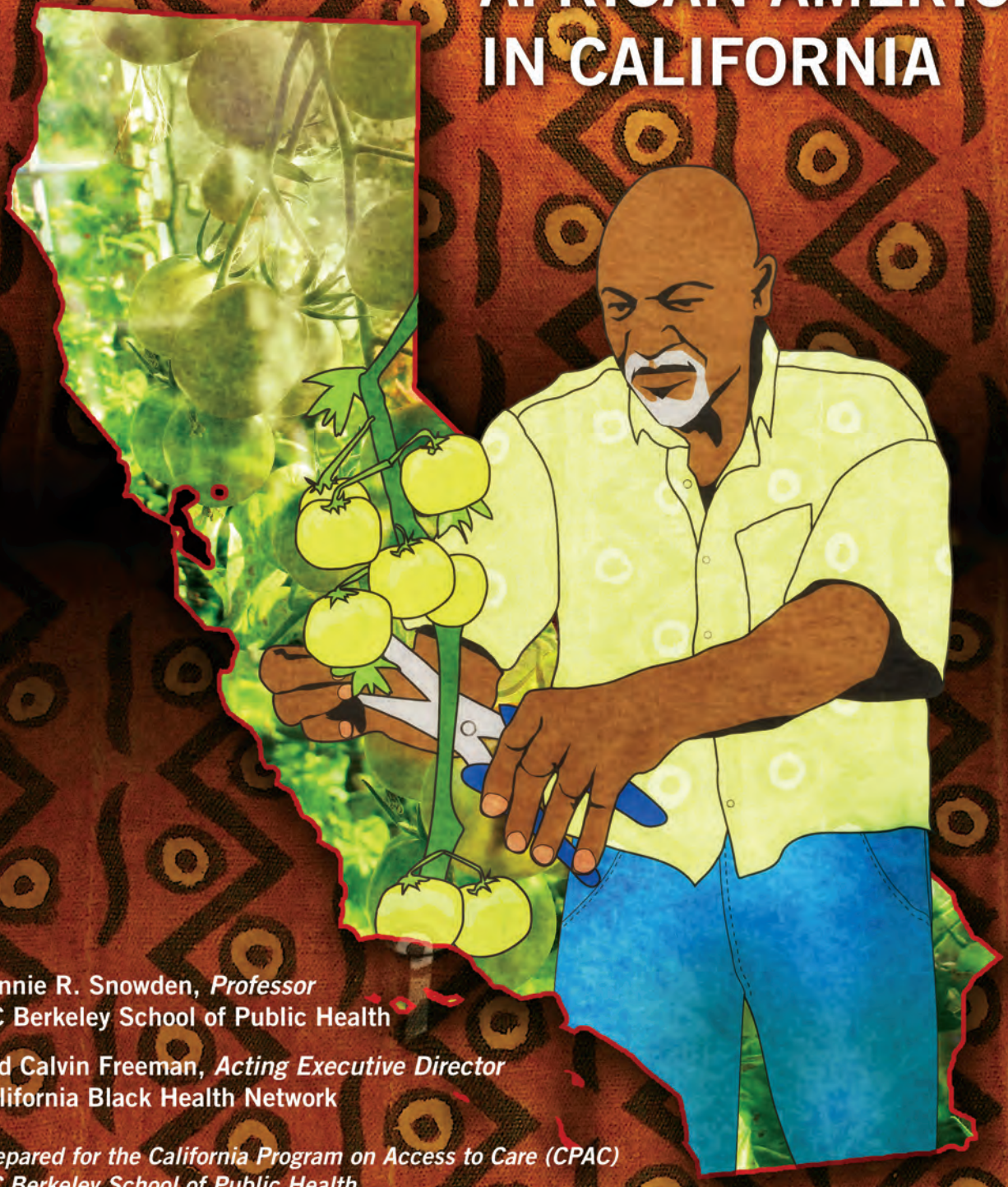
ETHNIC HEALTH ASSESSMENT FOR AFRICAN AMERICANS IN CALIFORNIA



Lonnie R. Snowden, *Professor*
UC Berkeley School of Public Health

and Calvin Freeman, *Acting Executive Director*
California Black Health Network

Prepared for the California Program on Access to Care (CPAC)
UC Berkeley School of Public Health

Funded by The California Endowment

PREFACE

In California, approximately 56 per cent of our state's 38.2 million people are Latinos, African Americans, Asian-Pacific Islanders, and Native Americans. These ethnic groups comprise the four largest communities of color in our state. These groups also contribute extensively to California's economic and social vitality. Therefore, it is in our state's best interest to insure the health and well being of these populations.

The Ethnic Health Assessment Project seeks to clearly frame the health needs of these four population groups and makes recommendations for meeting those needs. The four companion reports generated from the Project are the result of close collaboration between academic researchers, lead ethnic organizations, and ethnic stakeholders.

The Project's leading ethnic organizations and researchers include:

- Latino Coalition for a Healthy California (LCHC) and Michael A. Rodríguez MD, MPH, David Geffen School of Medicine, University of California, Los Angeles
- California Black Health Network and Lonnie Snowden PhD, School of Public Health, University of California, Berkeley
- Asian Pacific Islander American Health Forum and Winston Tseng PhD, School of Public Health, University of California, Berkeley
- California Rural Indian Health Board. (CRIHB) and Carol Korenbrot PhD, CRIHB Research Director

The unique feature of the Project was the inclusion of "stakeholders," or representatives from advocate organizations, provider networks, and consumer and community-based organizations.

The stakeholders brought their real-life experience to the discussion table, and helped frame the content and mold policy recommendations found in each of the four reports. A separate stakeholder list is presented in the beginning of each report.

The four final reports will be distributed to California's decision makers, as well as to decision makers in other states with a significant minority presence, and to national level officials who have an interest in California's racial-ethnic health care issues.

AFRICAN AMERICAN STAKEHOLDER LIST

Below are the names of ethnic stakeholders whose ideas and insights help frame the content found in this report.

1. David Carlisle
   Director
   Office of Statewide Health Planning and Development

2. Crystal D. Crawford, Esq.
   Chief Executive Officer
   California Black Women's Health Project

3. Opio Dupree
   Coordinator
   State Black Legislative Caucus

4. Calvin Freeman
   Acting Director
   California Black Health Network

5. Lark Galloway-Gilliam
   Executive Director
   Community Health Councils (Los Angeles)

6. Arnell Hinkle
   Executive Director
   California Adolescent Nutrition and Fitness Program

7. Fran Jemmott
   Principal
   Jemmott Rollin Group

8. Valerie Scruggs
   Director
   Cultural Health Initiatives
   American Heart Association

9. Shannon Mc Kinley
   Consultant
   Assembly Member Sandre Swanson

10. Melanie Tervalon MD
    Associate Director
    PolicyLink

11. Rhonda West-Peters
    Consultant

12. Kevin D. Williams, JD, MPH
    Director, Development & Policy Interim Director
    Career Development Center
    Berkeley Youth Alternatives

13. Adrienne Collins Yancey, M.P.H.
    Assistant Deputy Director
    County of San Diego
    Health and Human Services Agency
    Public Health Services

ACKNOWLEDGMENTS

We would like to thank The California Endowment for having the foresight to fund this project. Owing to the Endowment's financial support, we are able to articulate the health needs and perspectives of California's African American population during this pivotal era of health care reform.

In addition, we would like to acknowledge the members of the African American stakeholder group who participated in a Sacramento meeting during September 2009. These dedicated individuals shared their insights and real-life experiences that guided the report's content. Special acknowledgements go to Dr. David Carlisle, Director of the Office of Statewide Health Planning and Development, and Fran Jemmot of the Rollins/Jemmot Group of Los Angeles for their contributions.

We also wish to thank David Grant, Director of California Health Interview Survey (CHIS) at UCLA for providing the demographic data used to design the California state map found in this report. Finally, we thank the CPAC staff who facilitated the final editing and production of this report, including Gil Ojeda, Director; Perfecto Munoz, EHAP Coordinator; Donna Fox, Senior Editor; and Yovana Gomez, Administrative Assistant.

Calvin Freeman
Acting Executive Director
California Black Health Network, Inc
9677 River Thread Ct
Elk Grove, California 95624
916-714-1793
916-714-1993 fax
Calvin Freeman@comcast.net

TABLE OF CONTENTS

TABLE OF MAPS AND TABLES

Maps

Tables

EXECUTIVE SUMMARY

California's African Americans number over 2 million, representing 6.3% of the state's population. California has the fifth largest African American population among states nationwide. A large percentage of African Americans live in cities of Oakland (36%), Long Beach (15%), Sacramento (15%), Los Angeles (11%), San Francisco (8%), San Diego (8%), and Fresno (8%).

Health Disparities

African Americans are more likely than Whites to die from the leading causes of death, including heart disease, cancer, stroke, lung disease, accidents, influenza and pneumonia, diabetes, hypertension, and assault. Diabetes and hypertension are especially prevalent and are significant because of the severe secondary health effects these two conditions create. African Americans are also more likely than the general population to lack health plan coverage, and to report a hospital and its emergency room as a usual source of care.

Significant African American health problems include:

- Low-birth weight: The African American rate of 12% is twice the White rate of 6%.
- High infant mortality: African American infant mortality rates are more than 2.5 times greater than for Whites: 12.7 per 1000 live births for African Americans vs. 5 per 1000 for Whites (US Census, 2005-2007).
- Diabetes: The diagnosed diabetes rate for African American adults was 12%, compared to 7% for Whites.
- Hypertension: The rate of diagnosed hypertension for African Americans was 38%, compared to 28% for Whites.
- Assault: Violence is major behavioral risk factor for African Americans. Homicide is the sixth leading cause of death for African American men and many African Americans are injured in violent encounters.

Social and Economic Elements

Numerous social and economic elements contribute to African American health disparities. For example, African Americans are less likely to be employed than other Californians, are more likely than Whites to live in deep poverty (incomes only 50% of the federal poverty level), and are particularly likely to live in impoverished neighborhoods due in large part to a history of segregation. Unemployment, poverty, and impoverished neighborhoods result in a lack of healthy food, lack of neighborhood safety, and lack of health insurance, both public and private.

While the health dilemmas of California's African American communities may seem persistent and under-addressed by previous change strategies, the disparities can be overcome by policy and community-based initiatives.

Recommendations to Reduce Health Disparities

African American health care disparities are numerous and create unnecessary suffering in African American individuals, families, and communities. However, these disparities are not immutable. The recommendations listed below constitute approaches to coalesce the many social and cultural strengths present in African American communities to improve the health and healthy behaviors of California's African Americans. Recommendations are categorized as Community-Oriented and Policy-Based (State and federal). They are summarized as follows:

Community Oriented

- Expand the roles of African American faith-based institutions in addressing health issues, such as obesity, physical activity, hypertension, communicable diseases (particularly STDs, including HIV), and youth and family violence.
- Recruit credible African American community leaders, such as physicians, clergymen, broadcast media figures, principals/teachers and other opinion leaders, to advocate for better food choices, available through local farmers markets and large grocery stores, and to attack the over-placement of small markets catering to junk food and alcohol.
- Launch with private and public support additional Black self-help networks, like the Oakland based group, *Critical Mass Health Conductors*, which is dedicated to guiding African Americans in making healthy life style choices.
- Promote a community oriented, media supported statewide strategy to ensure that all Black families enroll their eligible children under age 19 into public coverage.
- Community and advocacy groups should collaborate with the media to address the issues of alienated young men in California's African American population.

Policy-Based

- Urge State legislators in their implementation of federal health care reform to promote wellness and managed care programs for Blacks and other vulnerable populations, who too often rely on hospital-based emergency rooms.
- Halt further reductions in Medi-Cal reimbursement to safety net and traditional providers who disproportionately serve low-income Black communities.
- Restore funding for Black Infant Health and maternity care programs through State or Health Care Reform funds.
- Ensure that the current "carve out" for mental health in Medi-Cal eliminates gaps in coverage for high prevalence acute conditions for Black populations.
- Pressure research organizations to aggressively monitor key African American health indicators, which, if improved, could result in a positive health change for California's African Americans. The six key African American key health indicators are: health insurance coverage, personal practitioner (non-hospital) usual source of care, low birth-weight, psychiatric/behavioral health related emergency room visits, preventable hospitalizations from hypertension, and preventable hospitalizations from diabetes.

- Urge policymakers to increase the numbers of African American physicians and other health care professionals. While African Americans represent 6% of California's population, they represent only 3.2% of California's physicians.
- Encourage State legislators to address the current housing crisis in African American communities. Adequate housing is a health issue and subsidized housing programs must be maintained and strengthened.
- Use the momentum of the newly enacted health care reform legislation to promote private and community-based provider health care in African American communities.

INTRODUCTION

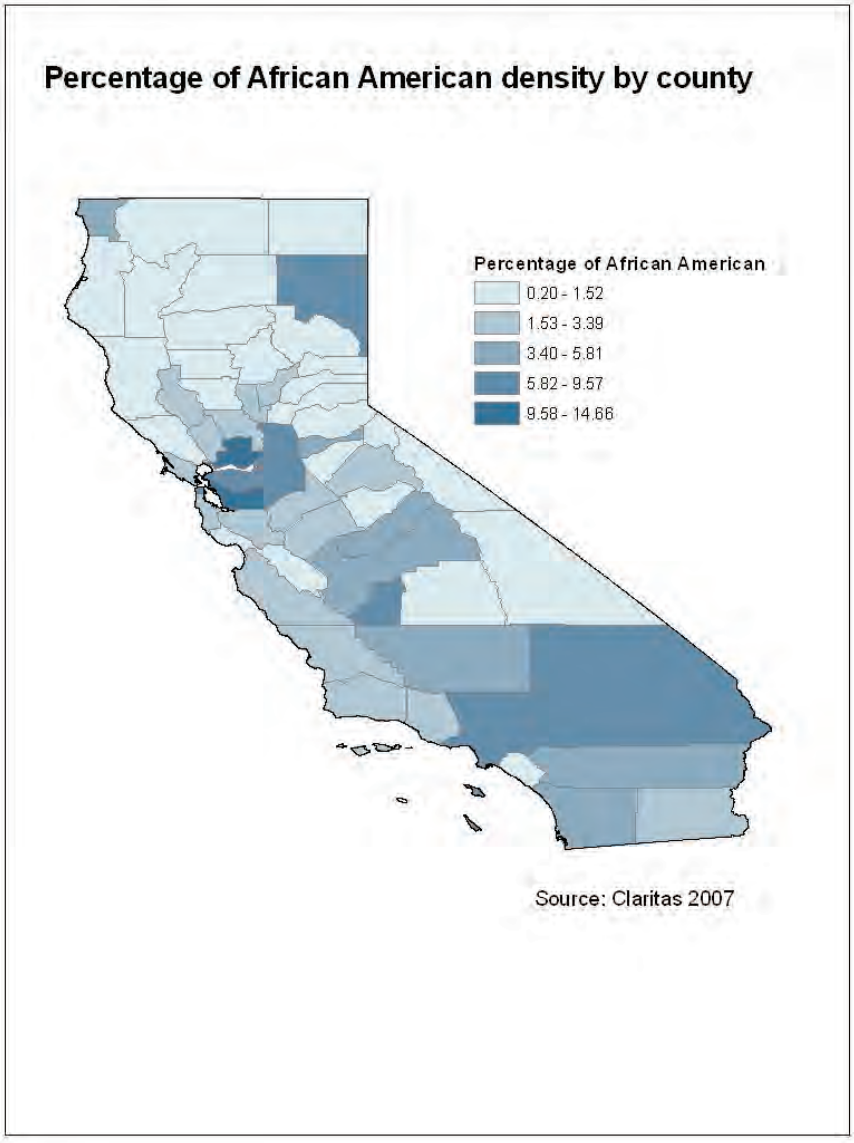
African Americans in California face significant disparities in health status and in access to health care. In order to understand these disadvantages, we must examine how the illnesses and health related behaviors of individual African Americans are influenced by the current health care system and the social character of African American communities.

In this report, we concentrate on social conditions and policies directly affecting African Americans' health. Wider sociopolitical events, such as U.S. health care reform, will provide a context for our discussion of African American health.

Throughout this report, we use term "African American" and its synonym "Black," to describe the population. Use of this term should not be taken to imply that all African Americans are alike. We recognize the broad diversity of this population, which exhibits variations in culture, immigration status, and other factors that influence health status.

I. CALIFORNIA'S AFRICAN AMERICANS: A Demographic and Socio-political Profile

California has the fifth largest African American population of any state in the country. Numbering 2 million, African Americans make up about 6.3% of California's population (1). However, African Americans are distributed unevenly throughout the state. As shown in Map 1, large population densities are in seven California counties: Alameda (13.2%), Sacramento (10.1%), Contra Costa (9.3%), San Bernardino (9.0%), Los Angeles (8.9%), and San Joaquin (7.2%). Large population densities are also found the cities of Oakland (36%), Long Beach (15%), Sacramento (15%), Los Angeles (11%), San Francisco (8%), San Diego (8%), and Fresno (8%) (2). The state-wide distribution of the African American population reflects historical migration and settlement patterns that helped shape the character of African American communities.



Although African Americans are concentrated in a handful of counties, there is a high level of economic, geographic, and political diversity across their communities. These differences create distinct living conditions and variations in physical and sociopolitical environments.

These variations are captured in the "equality index" calculated for a report issued by California's Legislative Black Caucus. The equality index compares African Americans to Whites on several key socioeconomic measures, including finances and economics, housing, education, criminal justice involvement, and in other areas of quality of living (3). According to the equality index, African Americans living in Inland Empire counties scored highest, followed by those living in Sacramento, San Diego, and San Jose. African Americans living in Oakland, Los Angeles, and San Francisco scored lowest.

Table 1: California's African Americans and Whites: Demographic Comparison

Demographics	African Americans	Whites
Average Age (Years)	34.5	37.5
Not High School Grad	14%	7%
Unemployed	12%	3.9%
Out of Labor Force	40%	36%
Families in Poverty	17%	7.6%
Median Family Income	$50,559	$61,842

Source: *US Census Bureau, 2005-2007 American Community Survey*

California's African Americans are somewhat younger than Whites, and a larger proportion of African Americans are minors. African Americans in California show a median age of 34.5 years, compared to 37.5 years for Whites. More African Americans than Whites are below the age of 5 years (7.3% for African Americans vs. 6.4% Whites) and more African Americans are between ages 5 and 17 (18.7% for African Americans vs. 17% for Whites). Also, California's African Americans are less likely than Whites to live to an old age: 5.3% of African Americans are 75 years of age and over, compared to 6.8% of Whites (4).

African Americans in California face limited opportunity for a high-quality education and are often beset by workplace discrimination. These factors contribute to lower levels of education and employment for African Americans when compared to other Californians. About 14% of African Americans have less than a high school diploma, compared to 7% of Whites. During 2008, 12.0% of African Americans were unemployed, and another 39.7% were out of the labor force entirely. During the same year, 3.9% Whites were unemployment and 36.1% were out of the labor force. Even among employed African Americans, fewer are in professional and managerial positions (33.4% for African Americans vs. 38.1% for Whites), and more are in service occupations (19.6% African American vs. 17.9% for Whites) (5).

California's African Americans, in aggregate, are relatively poor. In 2007, African American median family income was $50, 559, compared with $61, 842 for White families. Also, 17.1% of African American families had incomes falling below the federal poverty line compared with only 7.6% of White families (6). The official poverty rate understates the extent of African American poverty and

its impact on the African American population. African Americans are more likely than Whites to live in deep poverty, that is, on incomes less than 50% of the federal poverty level, and African Americans are more likely than Whites to remain in long-term poverty (7).

African Americans have less than one-third the total wealth of Whites. Wealth is often a more stable indicator of resources than is income. Total wealth provides a cushion against temporary misfortune and provides building blocks for future generations. It is calculated as the aggregate value of home ownership, savings and investments, and other financial assets. The history of African American enslavement and their subsequent longtime residence in the impoverished rural south have played a major role in restraining contemporary African Americans' opportunities for wealth accumulation (8). In addition, African Americans' grip on assets is more precarious than that of Whites. Increasing foreclosure rates during the recent economic collapse have hit African Americans especially hard (9, 10). The road to acquiring the most widely-held source of wealth, home ownership, has proven especially treacherous for African Americans.

The African American Migration to California

Historical perspective on California's African Americans helps to provide a context for understanding contemporary African Americans and their living conditions. African Americans can trace their presence in California to an era when racial categorization was often fluid, dating even to the arrival of Spanish explorers and settlers from Mexico during California's mission era. Later in the nineteenth century, English-speaking African Americans came to California as servants of Whites or as slaves, or as sailors who jumped ship (11).

With the transfer of California from Mexico to the United States and the population explosion of the gold rush, California's small African American population increased. This population growth was aided by California's 1849 constitution, which prohibited slavery, although it denied African Americans the right to vote. Enforcement of the anti-slavery provision was uneven, however, as White legal authorities often proved unwilling to challenge slaveholders who defied the State's slavery restriction (12).

In the late nineteenth and early twentieth century, African American settled in Sacramento and San Francisco. These African Americans worked to support the cities' booming economies and they established vibrant local African American communities (13). San Francisco, benefiting from links to the transcontinental railroad, developed a dynamic economy and fluid social structure. African Americans, like many other ethnic groups, tried to capitalize on these opportunities. Former miners and other laborers founded African American settlements elsewhere in northern California, including Stockton, where they worked primarily in service occupations. The 1906 San Francisco earthquake and fire shifted some African American settlements across the San Francisco Bay, predominantly to the city of Oakland (14).

Los Angeles became a more prominent African American enclave at the turn of the twentieth century. Also benefiting from the transcontinental railroad, Los Angeles grew from a thinly settled region to an urban center and attracted increased numbers of African Americans. By 1910, Los Angeles' Black population surpassed those of San Francisco and Oakland (15).

Although small in size, these African American communities were rich in tradition and endowed with vibrant networks and community-based institutions. In 1910, rough estimates showed California's African American population rate at less than 1%, while their population rate was roughly estimated at 2.4% in Los Angeles, 2% in Oakland, 1.1% in Sacramento, and 0.4% in San Francisco. (16).

The "great migration" of African Americans from the rural south, where more than 90% lived at the turn of the twentieth century, fueled significant population growth in California and other regions outside the South. The population concentration and the conditions that fueled the migration of African Americans reflected the tragic history of enslavement in the southern United States. It also reflected the less recognized but also important system of sharecropping that followed slavery and perpetuated social and economic oppression (17). After 1900, large numbers of African Americans migrated to Midwestern and Northeastern states, as southern agriculture became mechanized and as industrial workers were needed elsewhere. This "great migration" (18) brought more African Americans to California than to any other Western state, and it changed the composition of California's Black population, away from a nucleus of early settlers toward a greater representation of migrants from the rural south.

African Americans who negotiated the long journey to California, which was significantly further and more demanding to reach than Midwestern and eastern industrial centers, were especially enterprising. Many who arrived were "secondary migrants" having originally settled elsewhere. Drawn to existing African American settlements and urban employment, as well as California's promise of a better life, many African Americans migrated to California's cities. Smaller numbers of African Americans migrated to California's thriving agricultural communities (19).

In the 1940s, World War II generated a massive growth in California's industrial employment, along with increasing African American migration. The wartime economic growth resulted in high wage jobs for both Black and White Californians and resulted in mounting racial bias and segregation. With the War's end and economic contraction, California's African Americans came to be increasingly concentrated in poor, segregated communities where formerly available economic opportunities became dramatically reduced (20).

II. SOCIAL DETERMINANTS: African American Communities and Their Health Care Infrastructure

Important sources of strength in African American communities include social support networks, local community organizations, and a small but dedicated cadre of health care and other professionals. Historically, these resources sustained African Americans during times of social exclusion and economic difficulties.

African Americans: Social Capital and Health

African American's social capital, as embodied in social networks, leaders, and local community-based institutions, helps to enhance African American health. This "social capital" (21) favors reciprocity, trust, and social engagement, and permits African Americans to provide mutual support and to act in concert with others. African American community-based organizations and community clinics have advanced positive healthy behaviors by challenging risk-based conditions, such as obesity through poor diet, and have promoted health-enhancing conditions, such as physical activity through exercise. Many African American leaders, including health providers, have demonstrated a commitment to African Americans' well-being and have been inspired to promote positive health messages.

A Promising Model – Critical Mass Health Conductors

In 2005, Critical Mass Health Conductors (CMHC) was launched at the 2nd African American Health Summit in Oakland, California. The purpose of CMHC is to encourage African Americans to make better health choices. Conductors are dedicated to live healthy lifestyles, and influence the health behavior of family members, friends, and the community. To become a Health Conductor a person joins a support group and commits to achieving a health goal to be worked on over the course of a four-month journey. Some of these goals include increased exercise, better nutrition, weight reduction, positive mental health, stress reduction, and solid sleep. In the tradition of Harriet Tubman and the "Underground Railroad," Health Conductors are building an "Overground Railroad" of freedom from chronic diseases by embracing better health practices. African Americans in the Bay Area are creating the changes they want to see. For more information, contact: http://babuf.org/

Historically, African Americans are religious, and derive strength from religious beliefs and practices (22). Belonging to and attending church are mainstays for many African Americans. To maintain mental well-being, African Americans often turn to a network of significant others, including family, friends, neighbors, voluntary associations, and religious figures (23).

Increasing the number of Black health care providers is a critical link to increasing health care access for African Americans. African American providers are substantially more likely to practice in inner city communities and serve African Americans. However, in 1996, California passed Proposition 209, which eliminated consideration of race, ethnicity and gender in admissions to

California's public universities. Proposition 209 has noticeably decreased the proportion of African Americans who are preparing for health professions training. (24).

African American's Concentration in Poor Communities

When individuals and families are highly concentrated in disadvantaged neighborhoods, personal struggles are often heightened by undesirable social dynamics. Acknowledging this problem, federal housing policy has encouraged socioeconomic integration of publicly supported housing for more than 20 years, (25).

Like many African Americans throughout the country, California's African Americans are particularly likely to live in impoverished neighborhoods. Residence in a poverty neighborhood is reliably linked to many adverse health effects. "Poverty neighborhoods" are defined as census tracts where more than 20% of residents have incomes below the poverty line and where many residents live in substandard housing, are unemployed, or live in single parent families. Residence in these neighborhoods is reliably linked to many adverse health effects. The adverse health consequences associated with living in a poverty neighborhood appear to result from specific physical and social-environmental characteristics, and do not emanate from the characteristics of individual residents. Thus, environments themselves bear considerable responsibility for many resulting problems.

Disadvantaged neighborhoods are characterized by physical deterioration, and by economic and social deprivation (26). This dimension is defined by few employment opportunities, poor air quality, low-quality schools, low-quality housing, and few recreational opportunities. California's African Americans are more likely than other populations to live in public housing, which is generally concentrated in disadvantaged neighborhoods. Black Californians comprise over 40% of households receiving federal housing subsidies (27). Because of overcrowding, allergen and lead paint exposure, and other risk factors, improving public housing is vital for improving African American health conditions.

Furthermore, California's African Americans more often live in neighborhoods with few opportunities to purchase healthy food. In one calculation, African Americans were shown to live in neighborhoods with the least healthy food choices. There were almost five unhealthy choices for every one healthy option (28).

Neighborhood deprivation also refers to residents' experience of being refused mainstream services (such as taxi service and food delivery), having credit applications rejected, and suffering the effects of various social stigmas. For example, employers have been shown to discriminate against applicants with addresses known to be in "bad" neighborhoods; these applicants were less likely to be offered employment because they were believed to be less reliable and productive (29). The stress and demoralization accompanying social rejection are associated with poor health.

Social disorder is another dimension of neighborhood disadvantage (30). It refers to the breakdown of processes that maintain order, civility, and safety. Signs of social disorder include unsupervised and delinquent youth, public intoxication, drug use and sales, and poorly maintained or vacant buildings. Unchecked illegal activity and poorly maintained property signal societal disregard and

abandonment, and promote alienation from mainstream society, affecting residents even if they are not themselves victimized. Social disorder also suggests the potential for harm and promotes anti-social norms.

Residents of disordered neighborhoods are less likely to feel safe than residents of other neighborhoods. Along with personally damaging effects from direct experience of physical violence, residents live with the stress of negotiating daily life in a threatening environment, and with the knowledge that basic protections are lacking. These elements can trigger feeling of helplessness and depression (31) and are detrimental to health. African Americans are more likely than Whites to report themselves feeling unsafe: 14% of African Americans reported feeling unsafe, compared to 4% of Whites. African Americans who feel unsafe and are afraid to venture into the outside environment experience a high degree of stress (32). They are more likely to withdraw, and less likely to be physically active than people who feel safe.

III. KEY HEALTH CONCERNS FACING CALIFORNIA'S AFRICAN AMERICANS: Problems, Priorities, and Progress Assessments

Many African Americans are in poor health because of interrelated causes, including 1) personal and family disadvantage and residence in disordered communities, 2) social and political marginalization and racism, and 3) unhealthy behavior and lack of health care. Identification and monitoring of key health-related indicators can distill information about African Americans' health status, and help communities, opinion leaders, and government decision makers monitor improvement or decline in the face of social and economic change.

Table 2: African Americans' Health Status

Indicator	African Americans	Whites
Life Expectancy: Male	68.6	75.5
Life Expectancy: Female	75.0	80.7
Infant Mortality (per 1000 live births)	12.7	5.0
Low Birth Weight	12.0%	6%
Diagnosed Diabetes	12%	7%
Diagnosed hypertension	38%	28%
Diagnosed Asthma	20%	15%
Tuberculosis (per 100,000 population)	9.0	1.4

Source: *US Census Bureau, 2005-2007 American Community Survey*

African American Health Status

African Americans in California have a shorter average lifespan than do Whites. In a glaring difference, African American males can expect to live to 68.6 years, compared with 75.5 years for White males while African American females can expect to live for 75.0 years, compared with 80.7 years for White females (33).

Contributing to African Americans' shorter life expectancy is the high infant mortality rate for African Americans. African American infant mortality rates are more than 2.5 times greater than those for Whites: 12.7 per 1000 live births for African Americans, compared to 5 per 1000 for Whites (34). In turn, African Americans' high infant mortality rates are linked to high rates of low birth-weight. The African American low birth-weight rate of 12% is about twice the White rate of 6% (35).

African Americans are also more likely than Whites to die from the leading causes of death, including heart disease, cancer, stroke, lung disease, accidents, influenza and pneumonia, diabetes, hypertension, and assault (36). Diabetes and hypertension are especially prevalent and are significant because of the severe secondary health effects these conditions create. The rate of diagnosed diabetes for African American adults was 12%, compared to 7% for Whites (37).

Hypertension rates were higher too: 38% for African American adults, compared to 28% for White adults (38).

Several health conditions that are not leading causes of death still have special significance because of their prevalence in African American communities.. The rate of tuberculosis is 9.0 per 100,000 for African Americans, compared to 1.4 per 100,000 for Whites. (39). Asthma is also more prevalent among African American adults and children than among Whites (40). In California, asthma hospitalizations are at 26.4 per 10,000 residents for African Americans, compared to only 8.0 for Whites. Mental health problems among African Americans include bouts of depression that are more severe and long lasting than those of Whites (41), and contribute to high rates of psychiatric crises requiring emergency intervention and psychiatric hospitalization (42).

Stress as a Risk Factor

By numerous measures, African Americans are situated lower in America's social hierarchy than are Whites. Occupying a lower social position has been shown to increase disease risk and to shorten life expectancy. Thus, lack of power and respect, to which African Americans are too frequently subjected, has direct, health-related consequences.

Poverty, conditions of living in impoverished neighborhoods, exposure to violence, limited social status and power, and troubling encounters in the wider society, including racism, translate into stressful living for many African American individuals (43). Stress is a risk factor for many diseases and contributes to lifestyle risks, which could account for African Americans' higher disease prevalence's and shorter life expectancy.

While many African Americans manage to successfully cope with the many stressors they face, high levels of stress can take biological toll. "Allostatic load" refers to the cumulative, biological impact of living with stress over long periods of time. Researchers have shown that, even after adjusting for demographic differences, African Americans have a higher allostatic load than Whites. It is very likely that African American's allostatic load contributes to higher disease prevalence and shorter life expectancy (44).

Behavioral Risk Factors

Table 3: Behavioral Risk

Behavior	African Americans	Whites
Smoking	22%	15%
Eat fruit >7 times/week	42%	56%
Eat vegetables > 7 times/ week	50%	38%
Sedentary/ Limited Activity	40%	36%
Overweight and Obese	67%	56%

Societal disadvantage increases the likelihood of African Americans engaging in behavior that places their health at risk. Examples of behavioral risks include smoking (African American 22.0% vs. White

15.0%), unhealthy dietary practices such as eating fewer fruits (African American 42.0% vs. White 56.0%), and a sedentary lifestyle. (African American 16.0% vs. White 12.0%) (45). Because of these lifestyle risks, African Americans are more likely than Whites to be overweight and obese. Among California's African Americans, 67% were overweight or obese, compare to 56% of Whites. Obesity is a wide-ranging risk factor, and contributes to disease and shortened life-expectancy (46).

Violence is major behavioral risk factor for African Americans. Homicide is the sixth leading cause of death for African American men and many African Americans are injured in violent encounters (47). Along with crime victims, who are disproportionately African American, loved ones and bystanders are also at risk of injury and suffer from stress and trauma.

Health Care Services Risk Factors

Disparities in access to and use of health care services also contribute to African American health disparities. African Americans are more likely than Whites to lack health care coverage: 10% of African Americans lack heath coverage, compared to 8% of Whites. Additionally, 13% of African Americans do not have a place to go for routine care for health problems, compared to 10% of Whites, and African Americans are less likely to have a usual source of health care (48). Most African Americans identify a hospital and its emergency room as a usual source of care.

Public health coverage and strong safety net support ameliorate some African American health disparities. Due to their overrepresentation among the poor, African Americans are overrepresented on Medi-Cal, California's version of the state-federal Medicaid program. (49).

IV. TRACKING AFRICAN AMERICAN HEALTH IMPROVEMENT: Key Indicators and Related Policy Agenda

While the health disparities between African Americans and Whites are numerous, they can be addressed through aggressive monitoring of key health indicators. Key indicators provide us with the maximum information for the least effort, and can lead to important courses of action. Learning about African Americans' status on one indicator tells us something about African Americans' status on other indicators and the population's overall health status. At this period in the twenty first century, an active use of indicators requires close, ongoing collaborations among California's research community, policy makers, the media (both mainstream and Black media), and the opinion leaders across the African American community. Examples of African American led collaborations include the Covenant with Black America, a national plan of action that addresses the primary concerns of Black Americas today—everything from housing to health; and the National Action Network, led by Rev. Al Sharpton, which attempts to address the social and economic injustice experienced by Blacks in the United States by involving leaders from media, business, politics, and the civil rights movement from across the country.

The table below displays six key indicators for tracking disparities for African Americans' health conditions and points to a systemic policy agenda for reducing these disparities. These indicators are derived from easily obtainable data sets, are easy for decision makers and laypeople to understand, and can measure changes from policy and community interventions from year to year and over a period of time.

Table 4: Indicators and Policy Agenda for Reducing Disparities

Indicator	Policy Agenda for Reducing Disparities
Health Insurance Coverage	• Expand and simplify existing public programs, with aggressive outreach andsimple auto or "express lane" enrollment. • Promote a community oriented statewide strategy to ensure that all Black families enroll their eligible children under age 19 into public coverage. • Ensure continuity of care and current uninterrupted care and enrollment in Medi-Cal for "aging out" foster care youth through age 21. • Restore Denti-Cal for adults and protect current dental coverage through age 18.
Private Provider (Non-Hospital) as a Usual Source of Care	• Halt further reductions in Medi-Cal reimbursement to safety net and traditional Medi-Cal providers who disproportionately serve underserved Black communities. • Expanded use of Physician Assistants, Nurse Practitioners, and even nurses, particularly in underserved Black communities. • Expanded "pipeline" programs at the college level for Blacks for medical school admission, with an emphasis on primary care. • Secure a maximum number of National Health Service Corp scholarships for California and expand state supported loan repayments going to Black physicians who train in and provide primary care in underserved Black communities. • Expanded use of school based clinics in Black communities, either free standing or through community clinics.
Low Birth Weight	• Restore funding to Black Infant Health and maternity care projects. • Strengthen local non-profit, private sector, and public health department collaborations in low-income urban Black communities • Maintain and increase direct support for low-income pregnant women by ensuring enrollment in WIC and providing outreach and follow-up services.
Psychiatric/ Behavioral Health Related Emergency Care	• Ensure that the current "carve out" for mental health in Medi-Cal eliminates the gaps in coverage for high prevalence acute conditions in Black populations. • Review current Proposition 63 annual county plans to ensure that early intervention programs are supported for Black "at risk" populations. • Promote the use of the Health Families program's largely unused drug and alcohol inpatient and outpatient benefits for low-income Black youth, 12 to 19 years of age.
Preventable Hypertension Hospitalizations	• Continue collecting and reporting data to the media and research communities on hypertension and diabetes readmissions by race for each hospital. • Direct increased support for community health centers and public health departments utilizing health care reform funds to expand outreach and education efforts for these key conditions. • Promote establishment with public and private sector funds of self help groups, such as the "Health Conductors" and other largely community volunteer efforts. • Promote incentives for positive outcomes in primary care practices in public and private sector insurance plans. • Join with State government and local school districts to support school-based and community programs in Black communities that promote physical activity and healthy food choices.
Preventable Diabetes Hospitalizations	

Key Indicator #1: Health Insurance Coverage

Health insurance coverage is key to addressing societal gaps in health care access. The relative lack of health insurance coverage for African Americans (50) is widely believed to lead to problems in health care access and quality of care.

With the adoption of health care reform at the federal level, the health insurance landscape is changing, as will be discussed, and African American health insurance rates are expected to dramatically improve in California. Greater availability of health insurance is expected to improve health care utilization leading to improve health. Biannual coverage data is available through such sources as the UCLA Center for Health Policy Research. Both African American stakeholders and State decision makers must make health care coverage of African Americans their highest priority.

Monitoring African American insurance coverage will require attention to several health indicators. Rates of public and private coverage sources must be tracked separately to determine the impact on the African American population. Such monitoring will also help curb private insurers from excluding Black populations that are known to have pre-existing conditions.

Key Indicator #2: Personal Practitioner (Non-Hospital) Usual Source of Care

Without a trusted primary care provider and the ongoing monitoring such a "one-on-one" relationship provides, health problems will often remain untreated and could easily escalate. Having a primary source of medical care and preventive health care services reduces delays in treatment and improves health status.

African Americans less likely than Whites to have a usual source of care, and African Americans are considerably more likely than Whites to report a hospital as their usual source of care (51). A hospital-based usual source of care, such as a public hospital outpatient clinic or hospital emergency room, does not offer continuing care in the manner of the primary care physician, so patients often seek medical attention only when a condition becomes urgent. Sound annual data are available to monitor this indicator. Many stakeholders and State decision makers recognize the importance of having a usual source of health care. Federal health care reform is focused on expanding primary care physicians and supporting increased reimbursements for public program providers. State efforts must complement federal policies and increase opportunities for Blacks to enter the health professions and to serve in low-income communities. In addition, the adoption of wholesale changes to Medi-Cal through the proposed waiver to be submitted by the State to the Federal government this fall is projected to restructure Medi-Cal in order to facilitate the capacity for decision makers to monitor this indicator for positive change.

Key Indicator #3: Low birth-weight

Low birth weight disparities are closely associated with disparities in infant mortality. Furthermore, low birth weight is linked to numerous disparities appearing later in life, including asthma and

hyperactivity; low education attainment; and social and economic disadvantage. Reliable data on frequency of low birth-weight are collected by the State on an annual basis. (52).

Low birth-weight rates are reversible and subject to programmatic interventions (53). While the African American-White disparity has endured, overall rates of low birth-weight have greatly declined over the past 50 years for both groups. This reduction is due to improvements in general health, greater access to health care, lifestyle changes, and increased awareness about pregnancy risk factors. By tracking the African American-White low-birth-weight disparity, researchers, stakeholders, decision makers, and the provider community can monitor relative progress in this important health condition.

Key Indicator #4: Psychiatric/Behavioral Health Related Emergency Room Visits

African Americans live with untreated depression and other mental illnesses at higher rates than do Whites. Driving this disparity are African Americans' more frequent psychiatric crises resulting from unmanaged episodes of depression, schizophrenia, and other mental illnesses. Acute alcohol and drug related disorders also lead to more frequent emergency room visits. These episodes of psychiatric and behavioral crisis may be prevented by better access to outpatient care and more timely treatment.

By monitoring visits to psychiatric and medical emergency rooms for African Americans' treatment of behavioral health conditions, we can assess the progress toward alleviating psychiatric crises often brought on by adverse living conditions, and by a lack of responsiveness from a mental health system that too often fails to meet African American's treatment needs. The passage of Proposition 63 in 2004 set the stage for many counties to address the mental health problems for vulnerable populations, including African Americans. However, there has not yet been an effort by African American stakeholders and the provider community to ensure that Prop 63 funds have been appropriately allocated to the African American population. In addition, interventions in a wide range of drug and alcohol related conditions for Black adults and youth have not been adequately addressed either through Prop 63, the mental health "carve out" under Medi-Cal, or through the Health Families program benefits for youth through age 19.

Key Indicator #5: Preventable Hospitalizations from Hypertension

Unmanaged hypertension may require hospitalization to bring its potentially life-threatening consequences under control. Because hypertension can be effectively detected and managed through outpatient care, hospitalization from untreated hypertension is preventable.

On an annual basis, California's Office of Statewide Health Planning calculates preventable hospitalizations from hypertension (54). Because all such hospitalizations could have been prevented by better access to preventive care, their occurrence cannot be attributed to any causes other than the health care system's failure to provide equal preventive care for African Americans

and Whites. This indicator will help frame and assess public and private efforts to address hypertension among the total population. Monitoring this indicator requires a public-private effort that is closely monitored by Black stakeholders, providers, and the media.

Key Indicator #6: Preventable Hospitalizations from Diabetes

Diabetes is widespread among many population groups, but it is especially prevalent in the Black population. Diabetes is a chronic condition that requires monitoring and management in order to maintain general good health and to avoid the many serious health-related consequences.

As with hypertension, California's Office of Statewide Health Planning annually calculates preventable hospitalizations from diabetes (55). Because all such hospitalizations could have been prevented by better access to preventive care, their occurrence cannot be attributed to causes other than the health care system's failure to provide equal preventive care for African Americans and Whites.

High rates of diabetes should motivate African American community leaders and health providers to advocate for making high-quality and low-cost foods available in Black neighborhoods, and to create media messages about the importance of weight control and exercise. Strong, targeted messages for the African American community will allow people to manage their diabetes and take control of their own lives.

V. AFRICAN AMERICAN HEALTH PROFESSIONAL WORKFORCE

Racial diversity in the health professions continues to be a critical factor within African American communities. According to many economic forecasters, the health care workforce is the largest industry in the United States, providing over 14 million jobs. This workforce is predicted to see growth of 3 million jobs by 2016, outpacing any other industry (Career Guide to Industries, U.S. Department of Labor, Bureau of Statistics October 2008). Yet, despite outreach efforts, the number of Californian African American students accepted to U.S. medical schools has declined. As shown in the table below, between 2003 and 2009 the number and percentage of Black Californians accepted to any U.S. medical school has varied from a total of 97 (4.9%) of all accepted Californians in 2004 to 125 (6.0%) in 2009. California Office of Statewide Health Planning and Development (OSHPD) estimated approximately 3,600 Latino, African Americans, and American Indian-Alaskan Native students enter a four-year college in California annually with the goal of becoming a physician. After three years of college, about 750 apply to medical school, and only about 350 are accepted to any U.S. medical school (Montoya, January 2010).

Table 5: Number and Percentage of Under-Represented Minority and Total California Residents Accepted to Enter Any U.S. Medical School (2003-2009)

Year	Latino		Black		American Indian		Sub	Total URM	Total CA
	#	%	#	%	#	%	#	%	#
2003	187	9.3	118	5.9	11	0.5	316	15.8	2002
2004	217	10.9	97	4.9	30	1.5	344	17.3	1987
2005	212	10.4	103	5.1	30	1.5	345	17.0	2033
2006	217	10.6	105	5.1	22	1.1	344	16.9	2041
2007	224	10.8	98	4.7	26	1.2	348	16.7	2081
2008	223	10.5	104	4.9	27	1.3	354	16.7	2119
2009	203	9.8	125	6.0	22	1.1	350	16.8	2080

Source: *Assn. of American Medical Colleges (AAMC)- Admission Action Summaries 2003-04 through 2009-10*

In California, Blacks comprise 3.2% of physicians, 8.2% of physician assistants, 1.3% of dentists, 1.7% of pharmacists, 0.5% of optometrists, and 4% of nurse practitioners (Grumbach, 2008).

The Black population in California is 6.3%, compared to 12.8% at the national level. The table below shows California data on physician race/ethnicity (Grumbach et.al, 2008)

Table 6: California Physician Profile by Race/Ethnicity, 2008

Group	Number	% of CA Physician %	% of CA Population	Proportion of Population Parity
White	45,000	61.7%	42.8%	144%
Black	2,300	3.2%	6.0%	53.3%
Asian/PI	19,300	26.4%	12.5%	211%
Amer Indian	440	0.6%	*0.5%-1.9%	**
Latino	3,800	5.2%	35.9%	14.5%
Other	2,100	2.9%		

**The 0.5% figure excludes American Indians who report another race or Hispanic ethnicity while the 1.9% figure includes American Indians who report another race or Hispanic ethnicity. About 5 of 6 respondents who identified themselves as partially American Indian were multiracial, i.e., American Indian and most often White.*

***Using the 1.9% American Indian population estimate, American Indian physicians are 32% of population parity.*

The challenge of increasing African Americans in the health professions continues to fall directly on the shoulders of African American communities. These communities must work to develop enrichment programs and funding streams to train African American for careers in the health care profession.

VI. POLICY RESEARCH AGENDA

As California's policy environment is shifting toward austerity in the present era of economic crisis and retrenchment, it is important to understand the links between policy changes and African American health. Policy makers and society as a whole must be informed about the negative effects on African Americans should existing social commitments falter. Below are some targeted research areas to increase understanding of African American health problems

Research Agenda Area 1: Assess Communities Where African Americans are Significantly Located and Assess their Environmental Risk Factors and Social Capital Resources

Communities in which California's African Americans are significantly concentrated resemble African American communities elsewhere, and yet they are unique. They reflect California's particular history and the particular conditions of African American arrival and settlement in California. Researchers can better understand how local community conditions affect African American life by identifying and describing risk factors. Using data sources such as www.healthcities.org, researchers can locate concentrations of African Americans and describe conditions of community life, including social, physical, and environmental risk factors as well as factors that prevent ill-health. It is important that community-oriented research models identify both higher and lower functioning African American communities. Doing so will enable African American stakeholders and policy makers to use basic research to improve real life conditions in African American communities.

Research Agenda Area 2: Determine the Economic Burden of Poor Health on California's African American Communities

As demonstrated previously, social disadvantage is a leading source of African Americans' poor health. However, the reverse is also true: poor health promotes African American's social disadvantage. Rarely has the economic burden of African Americans' ill-health been considered in determining the future of African American communities. Poor health interferes with the ability to function effectively as a family member, at work, and in the community to fulfill one's true human potential. Too many of California's African Americans experience the social and economic consequences of poor health. As a result, these African Americans are unable to fully function in society, which further contributes to their social and economic misfortune. By determining the economic burden on African Americans of ill-health, researchers can argue persuasively for new public and private sector initiatives to reduce ill-health and simultaneously improve African American social and economic standing and community well-being. Decision makers must view improving African American health as a type of social investment.

Research Agenda Area 3: Document the Impact of Shrinking Safety Net Programs for California's African Americans

Medi-Cal and Healthy Families, California's core safety net programs, have been uniformly cut back over the last few years of deficit State budgets, and will likely be affected by difficult State budgets for at least the next two years. Because African Americans are overrepresented among the poor, African Americans disproportionately participate in these safety-net programs. Research is needed to assess the impact of multi-year reductions on California's complex safety net programs and suggest ways to help African American stakeholders and State decision makers maintain and strengthen these programs until federal reform is fully in place.

Research Agenda Area 4: Project and Document the Impact of Health Care Reform on Key African American Indicators

We cannot assume that health care reform will positively benefit the African American community. Researchers must join with Black stakeholders and State decision makers to vigilantly monitor how reforms play themselves out in California's African American population. For example, research is needed to determine if the proposed subsidies for purchasing health coverage are adequate to overcome the financial barriers facing many African Americans. Subsidies have been proposed to defray costs for the poor, the near poor, and households earning up to $88,200 per year for a family of four. Whether or not these subsidies are sufficient to allow African Americans to purchase mandatory health insurance must be ascertained. Researchers must also monitor any Medi-Cal changes to determine the impact on African Americans' health care access. Not all well-intentioned Medi-Cal changes have improved the lives of African American. For example, 20 years after the passage of Medi-Cal's Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, African American families are the least likely users of EPSDT'S preventive visits, medical diagnostic, and evaluative services.

VII. CONCLUSION AND RECOMMENDATIONS

African American health care disparities are numerous and create unnecessary suffering in African American individuals, families, and communities. However, these disparities are not immutable. Policy makers must not come to an unspoken acceptance of the inevitability of African Americans' poor health. Implementing key policy initiatives can reduce disparities and produce favorable changes in the health status of California's African Americans. Therefore, we make the following major recommendations.

1) Policymakers must work to increase the supply of African American health care providers in California.

An increase in the number of California's African American providers is key to increasing health care access for African Americans. However, educating more African Americans to become health care providers has been made much more difficult by the passage of Proposition 209. Approved in November 1996, Proposition 209 amended the State constitution to prohibit public institutions from considering race, sex, or ethnicity in admissions policies. The result of Proposition 209 was a noticeable decrease in the proportion of African Americans preparing for professional health care training.

2) Research organizations in California should identify and monitor key indicators of African American health.

Key indicators provide us with maximum information for the least effort, and can lead to important courses of action to reduce health disparities. Monitoring of health disparities only has value if California's public and private institutions actively collaborate and engage with the data and reports coming from the monitoring process. Six key African American key health indicators are health insurance coverage, personal practitioner (non-hospital) usual source of care, low birth-weight, psychiatric/behavioral health related emergency room visits, preventable hospitalizations from hypertension, and preventable hospitalizations from diabetes.

3) African American faith-based institutions must be supported in addressing community health issues, including obesity, physical activity, hypertension, communicable diseases (particularly STDs), and youth and family violence.

Faith-based institutions play an integral role in the social and spiritual lives of California's African Americans and can act as a powerful voice in encouraging healthy lifestyles.

4) African American community leaders in California, such as physicians, clergymen, broadcast media figures, principals, teachers and other opinion leaders, should advocate for better food choices.

This should be done via local farmers markets and large grocery stores, and should attack the over-placement of small markets catering to junk food and alcohol.

5) Community and advocacy groups should collaborate with the media to address the issues of alienated young men in California's African American population.

Social disorder in many of California's African American communities is often linked to alienated young men, both those in gangs and those without viable options.

6) African Americans in California should band together to develop self-help networks, such as the Oakland-based group, Critical Mass Health Conductors.

Launched in 2005, this organization is dedicated to guiding African Americans in making health lifestyle choices.

7) State legislators must step forward to address the current housing crisis in California's African American communities.

Due to recessionary pressures, many African American first time home buyers are losing their houses. Adequate housing is a health issue and subsidized housing programs must be maintained and strengthened.

8) State legislators must use health care reform to promote private and community-based provider health care in California's African American communities.

Primary care providers will reduce African Americans' reliance on public hospitals, and hospital outpatient clinics, as a usual source of care.

APPENDIX A: ABOUT CO-AUTHORS

Dr. Lonnie Snowden is a Professor at UC Berkeley's School of Public Health. As mental health policy researcher, Dr. Snowden focuses primarily on racial, cultural, and ethnic disparities in mental health, as well as access to mental health care and quality of care. Professor Snowden has published more than 120 scholarly papers and book chapters on mental health service delivery to ethnic minority and culturally diverse populations. He has consulted for and collaborated with several state mental health departments, and with several California counties, including with the City and County of San Francisco. Dr. Snowden also served as Lead Academic Coordinator of the Ethnic Health Assessment Project.

Calvin Freeman is the Acting Executive Director of the California Black Health Network (CBHN) and the President of its Board of Directors. He has been active in CBHN since its creation in 1978 as a board member, chapter president, and supporter. With his wife, Sue Ann, Calvin is a partner in Freeman and Freeman Consulting and Coaching, a health policy and human resources consulting firm dedicated to promoting improvements in the health status of multicultural communities. Mr. Freeman was the first Chief of the Office of Multicultural Health in the California Department of Health Services. He led California's disaster medical preparedness program as Chief of Disaster Medical Services in the California EMS Authority for ten years. Mr. Freeman is a past-President of the Governing Council of the California Public Health Association – North, and the California Pan Ethnic Health Network. He is currently the President of the Board of Directors of the California Black Health Network, and a past member of the board of the California Center for Public Health Advocacy. Mr. Freeman is from St. Louis, Missouri. He has a B.A. in Mathematics and Economics and a MAT from Reed College in Portland, Oregon, with additional graduate work at the University of Wisconsin.

REFERENCES

1. US Census Bureau, 2005-2007 American Community Survey.
2. US Census Bureau, State and County Quickfacts. Quickfacts.census.gov
3. The State of Black California: A Report from the California Legislative Black Caucus. Sacramento, CA.
4. US Census Bureau, 2005-2007 American Community Survey
5. US Census Bureau, 2005-2007 American Community Survey
6. US Census Bureau, 2005-2007 American Community Survey
7. Massey, Douglas S. (2007). Categorically Unequal: The American Stratification System. The Russell Sage Foundation.
8. Shapiro, Thomas M. (2004). The Hidden Cost of Being African American: How Wealth Perpetuates Inequality. Oxford University Press.
9. Amaad Rivera, Brenda Cotto-Escalera, Anisha Desai, Jeannette Huezo, Dedrick Muhammad. Foreclosed: State of the Dream. www.faireconomy.org
10. African American Home Ownership Rates "Falling Like a Rock". wwwplanetizen.com
11. DeBow, K & Syer, J C. (2006). Power and Politics in California (8th Edition). (P. 79-82)
12. De Graaf, L.B. & Taylor, Q. Introduction. In De Graaf, L.B., Mulroy, K., & Taylor, Q. Seeking Blood in El Dorado: African Americans in California. Autry Museum of Western Heritage, Los Angeles in association with University of Washington Press, Seattle.
13. De Graaf, L.B. & Taylor, Q. Introduction. In De Graaf, L.B., Mulroy, K., & Taylor, Q. Seeking Blood in El Dorado: African Americans in California. Autry Museum of Western Heritage, Los Angeles in association with University of Washington Press, Seattle.
14. De Graaf, L.B. & Taylor, Q. Introduction. In De Graaf, L.B., Mulroy, K., & Taylor, Q. Seeking Blood in El Dorado: African Americans in California. Autry Museum of Western Heritage, Los Angeles in association with University of Washington Press, Seattle.
15. Bunch, L.G. (2001). "The Greatest State for the Negro": Jefferson L. Edmonds, Black Propagandist for the California Dream. In De Graaf, L.B., Mulroy, K., & Taylor, Q. Seeking Blood in El Dorado: African Americans in California. Autry Museum of Western Heritage, Los Angeles in association with University of Washington Press, Seattle.
16. De Graaf, L.B. & Taylor, Q. Introduction. In De Graaf, L.B., Mulroy, K., & Taylor, Q. Seeking Blood in El Dorado: African Americans in California. Autry Museum of Western Heritage, Los Angeles in association with University of Washington Press, Seattle.
17. Lehmann, Nicholas (1992). The Promised Land: The Great Black Migration and How It Changed America. Vintage Books.
18. Lehmann, Nicholas (1992). The Promised Land: The Great Black Migration and How It Changed America. Vintage Books.
19. De Graaf, L.B. & Taylor, Q. Introduction. In De Graaf, L.B., Mulroy, K., & Taylor, Q. Seeking Blood in El Dorado: African Americans in California. Autry Museum of Western Heritage, Los Angeles in association with University of Washington Press, Seattle.
20. De Graaf, L.B. & Taylor, Q. Introduction. In De Graaf, L.B., Mulroy, K., & Taylor, Q. Seeking Blood in El Dorado: African Americans in California. Autry Museum of Western Heritage, Los Angeles in association with University of Washington Press, Seattle.

21. Kawachi, I. & Berkman, L. (2000). Social cohesion, social capital, and health. Chapter in L. Berkman & I. Kawachi (Eds.). Social Epidemiology. New York: Oxford University Press.

22. Lincoln C.E., Mamiya L. H. (1990). The Black Church in the African-American Experience. Durham, NC: Duke University Press, 1990.

23. Chatters, Linda M.; Taylor, Robert Joseph; Jackson, James S.; Lincoln, Karen D. (2008). Religious coping among African Americans, Caribbean Blacks and Non-Hispanic Whites. - Journal of Community Psychology 36, 371-386.

24. Undergraduate Access to the University of California. After the Elimination of Race-Conscious Policies. University of California – Office of the President Student Academic Services. March 2003

25. Schwartz, A. (2006). *Housing Policy in the United States*. New York: Routledge.

26. Massey, D.S. & Shibuya, K. (1995). Unraveling the tangle of pathology: The effect of spatially concentrated joblessness on the well-being of African Americans. Social Science Research, 24, 352-366.

27. U.S. Department of Housing and Urban Development. (2007). Resident characteristics report, 9/1/2006-12/31/2007.

28. See: "Retail food environment index" (p.15) California Pan-Ethnic Health Network. The Landscape of Opportunity: Cultivating Health Equity in California.

29. Massey, D.S. & Shibuya, K. (1995). Unraveling the tangle of pathology: The effect of spatially concentrated joblessness on the well-being of African Americans. *Social Science Research,* 24, 352-366.

30. Massey, D.S. & Shibuya, K. (1995). Unraveling the tangle of pathology: The effect of spatially concentrated joblessness on the well-being of African Americans. *Social Science Research,* 24, 352-366.

31. Hastings, J., Snowden, L., & Kimberlin, S. (in press). African Americans, depression, and neighborhood disadvantage.

32. Calculated from the 2007 California Health Interview Survey by the Center for Mental Health Services Research, University of California, and Berkeley.

33. California Department of Health Services Death Certificates.

34. California Department of Health Birth Records, 2006.

35. Calculated from 2005 California Department of Public Health cohort files.

36. Calculated from California Department of Health Services, Vital Statistics for California.

37. Calculated from the 2007 California Health Interview Survey by the Center for Mental Health Services Research, University of California, and Berkeley.

38. Calculated from the 2007 California Health Interview Survey by the Center for Mental Health Services Research, University of California, and Berkeley.

39. Calculated from California Department of Health, 2008. Report on Tuberculosis in California. California Department of Health, Tuberculosis Control Branch.

40. Calculated from the 2007 California Health Interview Survey by the Center for Mental Health Services Research, University of California, and Berkeley.

41. McGuire TG, Miranda J (2008). New evidence regarding racial and ethnic disparities in mental health: Policy implications. Health Affairs, 27, 393-403.

42. Snowden, LR, Catalano, RF, Shumway, M (2009). Emergency mental health treatment and African American populations. Psychiatric Services, 60, 1664-1671.

43. Williams, D. R., H. Neighbors, H., & Jackson, J.S. (2003). "Racial/Ethnic Discrimination and Health: Findings from Community Studies. American Journal of Public Health, 93, 200–208.

44. Geronimus, A.T., Hicken, M, Danya Keene, D. & Bound, J. (2006). "Weathering" and age patterns of allostatic load scores among Blacks and Whites in the United States. American Journal of Public Health, 96, 826-833.

45. Calculated from the 2007 California Health Interview Survey by the Center for Mental Health Services Research, University of California, Berkeley.

46. Calculated from the 2007 California Health Interview Survey by the Center for Mental Health Services Research, University of California, Berkeley.

47. Calculated from the 2007 California Health Interview Survey by the Center for Mental Health Services Research, University of California, Berkeley.

48. Calculated from the 2007 California Health Interview Survey by the Center for Mental Health Services Research, University of California, Berkeley.

49. Calculated from the 2007 California Health Interview Survey by the Center for Mental Health Services Research, University of California, Berkeley.

50. Calculated from the 2007 California Health Interview Survey by the Center for Mental Health Services Research, University of California, Berkeley.

51. Kass, B., Weinick, R., & Monheit, A. (1999). Racial and ethnic differences in health. *MEPS Chartbook No. 2. Medical Expenditure Survey of the Agency for Health Care Policy and Research.* (AHCPR Publication No. 99-001. pp 539-545). Washington D.C.: Agency for Health Care Policy and Research.

52. Satcher, D., Fryer, G.E., McCann, J., Troutman, A., Woolf, S.H., Rust, G. What if we were equal? A Comparison of the black-white mortality gap in 1960 and 2000. Health Affairs, 24, 459-464.

53. Satcher, D., Fryer, G.E., McCann, J., Troutman, A., Woolf, S.H., Rust, G. What if we were equal? A Comparison of the black-white mortality gap in 1960 and 2000. Health Affairs, 24, 459-464.

54. Racial & Ethnic Disparities in Healthcare: The California Picture 1999 to 2007. Presented by David M. Carlisle, M.D., Ph.D., Director, Office of Statewide Health Planning and Development at African American Stakeholders meeting, Sacramento, CA.

55. Racial & Ethnic Disparities in Healthcare: The California Picture 1999 to 2007. Presented by David M. Carlisle, M.D., Ph.D., Director, Office of Statewide Health Planning and Development at African American Stakeholders meeting, Sacramento, CA.