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Medicine, Sociology, and the Economic Costs of HBP in the Black Community

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The meeting was formally opened by Frank Douglas, Chairman of the Black subcommittee of the Ad Hoc Committee on Hypertension in Minority Populations. Presenting the history of the National High Blood Pressure Education Program, he eluded to the following facts:

- The NHBPEP established in 1972 by Elliot Richardson is a coordinated effort to involve government and the private sector in a collaborative approach to reducing death and illness associated with hypertension.

- Uncontrolled high blood pressure, a major national public health problem, is the primary cause of 20,000 deaths and a contributing factor in 1.5 million heart attacks and strokes that occur each year in the nation.

- The program focus on high blood pressure in the Black Community formally originated with a forum in minority populations in 1975 which resulted in the establishment of the Committee on Hypertension in Minority Populations.

Pertinent statistics on high blood pressure in the Black population were given by Dr. Douglas including:

- In 1974 estimates show that 20.6% of people 17 years or older had been told at some time they were hypertensive. Proportionately, 22.2% of Blacks compared to 15.0% of Whites were estimated to be hypertensive. The highest proportion was among black women of 25.9% compared with white men of 12.0%. The 1974 data also show rapid increase prevalence of high blood pressure with age in each sex and ethnic group.

- There is a higher prevalence of high blood pressure among Black youth age 12-17 (1.2 per 100) than for White youths 0.7 per 100. The prevalence rate of hypertension increases more rapidly in Blacks, from 1.2 per 100 for 12-17 age range to 55.1 per 100 at age 65-74 in contrast with the white population of a rate of 0.7 per 100 (12-17 years) to 39.1 per 100 at 65-74 years group.

Dr. Douglas noted that the cost of high blood pressure in the Black community affected the total community, the family and individuals with tremendous economic impact which has never been observed by policy makers. No satisfactory economic model exists to study and correct the
health problem. For this reason, the Black members of the Committee on High Blood Pressure in Minority Populations decided to bring various experts responsible for segments of the economic factors to focus on the high blood pressure impact on Black financial and human resources.

After introducing the program staff, Dr. Douglas commended the Program for its continuous support to the Black community in sorting through the high blood pressure control process. Dr. John Karefa-Smart, Chairman of the Committee welcomed the participants and supported the timeliness of the meeting.
Dr. Aubrey Bonnett presented the following paper on Medicine and Sociology as it relates to high blood pressure cost. He stated that good health has always been a prerequisite for the proper functioning of individuals and groups within societies. It is for this reason that from time immemorial, people have been concerned about the effects of social environment upon the health of individuals and the groups to which they belong. (Cockerham, 1973).

Unfortunately, for a very long time modern medicine accentuated the biological and totally neglected the behavioral sciences (save for the medically oriented psychiatry). Cockerham attributes this thrust in the 20th century, to the premise adopted by medical practitioners that every disease had a specific pathogenic cause whose treatment could best be accommodated by removing or controlling that cause within a biomedical framework. (Cockerham, 1973). As medicine moved into the 20th century, there has been a shift from acute to chronic diseases in these United States and because chronic diseases can be influenced by multi causes, health personnel are now beginning to approach medicine from a more holistic perspective and enlisting the help of behavioral scientists.

Medical sociology is a subfield of one of the behavioral sciences that has recently come to the aid of health practitioners.

He noted that it is not uncommon for individuals suffering from chronic diseases to feel perfectly normal, even when irreversible damage to organs and tissues has already occurred. Therefore, argues Cockerham, because of the irremediable damage done to the body by a chronic disease, patients may be required to permanently change their lifestyle and modify their social relationships. (Cockerham, 1978). So, Strauss (1975) has pointed out that health practitioners should know how patients with chronic disorders:

1. manage medical crises
2. control their symptoms
3. carry out their prescribed regimens
4. adjust to changes in the course of the disorder
5. attempt to normalize their interaction with others
6. cope with the social isolation caused by reduced contact with others, and
7. seek the necessary money to pay for their treatment and possibly to support themselves and their dependents.

Indeed, the above mentioned advice is only too relevant when considering hypertension - a major cause of mortality in the Black community. In this paper, I shall try to analyze some aspects of the retention costs of hypertension to the Black patients, by utilizing the Social Network model.
Much of the current thinking and research about Social Networks emerged from the anthropological study of individuals and groups in complex society. In the course of their work on urban area problems and the study of migration, many anthropologists found problems and issues concerning social situations and certain types of societies, that called for a good deal of individual choice in the formation of a person's instrumental relationship. (Anderson + Carlos, 1976).

J.A. Barnes' (1975) definition of a Network is still one of the best descriptions:

Each person is, as it were, in touch with a number of other people, some of whom are directly in touch with each other and some of whom are not...I find it convenient to talk of a social field of this kind as a network. The image I have is of a net of points, some of which are joined by lines. The points of the image are people...and the lines indicate which people interact with each other.

In classical sociology, George Simmel also utilized a form of Network analysis by examining individual behavior in terms of a person's web of affiliations. Social Network analysis therefore, rests on the premise that a person's social conduct, decision processes, orientations, and attachments should be viewed in the context of his network of relationships. (Anderson + Carlos, 1976). Viewed in its total dimensions, it refers to sets of direct and indirect social relations, centered around given persons, which are instrumental to the achievement of the goals of these people and to the communication of their expectations, demands, needs and aspirations. (Anderson + Carlos, 1976)

Applying this model of network analysis to an analysis of potential Black hypertensives can, I contend, be very illustrative.

Network Analysis and Retention Costs: A Patient's Perspective.

Retention costs have been conceptualized to mean a number of things, namely:

1) Doctor visits, lab, drugs, etc.
2) Side effects
3) Lost work days, job opportunities and insurance
4) Diet
5) Behavior modification/lifestyle changes, and
6) Costs to disabled victims of hypertension.
An exploration of the Black community reveals a network of social supports and mutual aid mechanisms which must be utilized in the battle against hypertension. A patchwork of clubs, organizations, fraternal orders, church-work associations, and societies, night spots, playgrounds and recreational areas dot the Black community (Gordon and Jones, 1973). Indeed, there are few Black persons who are unattached to these or other similar social support systems. (Gordon + Jones).

The churches, elite social clubs, lodges and the like provide not only value expressive sociability functions, but also cater to the economic needs of some members of the community. But so do the bar and lounges, the night spots, parks, streetcorners, porch stoops. They all are crucial to the survival and coping patterns - the health - of Black people. (Gordon + Jones, 1978). The local tavern, may be seen not merely as a "watering spot" but as a place where the atmosphere is conducive to the communication experience. The same is true of other locales: a pool hall is only secondarily used for the rules of the game; a barbershop or beauty salon with the pool hall, barbershop and streetcorner) the setting is organized primarily as a relaxation preserve where men can "unwind" and talk about things in a personal manner with friends and acquaintances. (Gordon + Jones, 1978)

**Lifestyle Changes**

These social networks in the Black community are designed to enhance information exchange and instrumental learning. It is argued that they should be utilized in an effort to bring about behavior modification, especially in the lifestyle of the most susceptible candidate for hypertension - the Black male. Community health agencies, the outpatient departments of large inner city hospitals must utilize more social workers, rehabilitation counselors, visiting nurses, physician assistants, park attendants, pool room attendants, barbers, etc. in disseminating the message and teaching the Black hypertensive patient about their disease. In conjunction with the local radio stations and minority oriented programs on television an effort must be made to tell the meaning of hypertension, its nature and the manner of the therapy needed to lower blood pressure. The aid of reputable "culture idols" namely Muhammad Ali, O.J. Simpson, Sugar Ray Leonard, etc. should also be enlisted on a massive scale. And if possible, the favorite haunts mentioned earlier should be inundated with educational material urging patrons to lose weight, to learn to relax and reduce stress, to eat a low sodium diet, to develop exercise programs, to stop smoking and to monitor their blood pressure regularly and systematically.
Another significant retention cost to the patient is changing the medical regimen. This may be a crucial issue because physicians must rely heavily on rapport with the patient to influence compliance. Here, members of the social network—members of the nuclear family, especially wives—can be very instrumental. Yet despite the obvious potential of families for playing an integral role in the patient's long-term adherence to medical advice and general adjustment, there is little evidence that physicians give high priority to providing patients and families with information. (Aiken, 1975). One researcher in a study of the role of the wife and family in the patient's social-psychological adjustment to disability, found that wives appeared to adopt one of two roles: providing understanding and reassurance, or becoming the advocate for compliance and hence the adversary in some respects. (Aiken, 1976).

The above holds true for Black wives and lovers who often feel that they have little access to their mate's physician, and hence only have second hand information about diet. This of course can lead to a lack of understanding of how they can aid their husbands to comply. A substantial part of this problem would be eliminated if wives in general—and Black wives, lovers, etc.—were included as active participants in the treatment regimen and given accurate information (Croog, Lipson and Levine, 1972; Adsett + Bruhn, 1968; Bilodeau + Hackett, 1971).

Given that the chronically ill need consistent, long term monitoring and social psychological support in addition to access to specialty care, a feasible approach would be to use mid level health practitioners, especially nurse practitioners, in their care. (Aiken, 1976). Research has shown that physicians are more concerned than nurses with the biological and technical aspects of diagnosis and management of disease. Nurses, it is stated, described their activities in terms of supporting role functions—more consistent with the majority of needs of the chronically ill. (Lewis, Resnik, Schmidt, Waxman, 1959). Nurse practitioners, physicians assistants and public health nurses could also play the role of ombudsman, helping patients and their families negotiate various aspects of their medical care. (Aiken, 1976).

Finally, another neglected dimension in the area of health prevention revolves around the issue of Black undocumented workers who concentrate in our large metropolitan cities on the northeastern seaboard, especially New York and Boston. Indeed, a similar aggregation can also be found in the U.S. Virgin Islands. These workers—Black and invisible—are not only interspersed residually among native Black populations but also make use of the emergency rooms and other specialty services in the large municipal and voluntary hospitals.
Just recently in New York City a major voluntary hospital - Brooklyn Jewish - serving the largest Black community in the United States (Bedford Stuyvesant) was brought to the brink of bankruptcy as a consequence of providing services to many of these workers. Not covered by Medicare or Medicaid these workers are often without the wherewithal to pay for their services. More so, for fear of detection, many of them fail to seek followup care so necessary in treating chronic diseases, and rather focus on the alleviation of acute ailments. Whatever our position as to the advisability of receiving large numbers of these workers when our economy is depressed the fact remains that they are an ever present problem in our midst, and deserve our attention and care.

The U.S. Census Bureau has recently enlisted the aid of various states in the northeast - especially New York - to help in the enumeration of these workers. These states have argued, and the Bureau agreed, that an accurate count could result in added millions to their coffers and compensate for services which they now provide for free. In New York City just last week, Vice President Mondale brought its beleaguered health care system much more than money to keep bankrupt Brooklyn Jewish Hospital open. An editor of the largest daily stated:

The program Mondale announced last week for the Bedford-Stuyvesant and Crown Heights neighborhoods open a brand new chapter in urban health care. It marks the first time in this country's history that a substantial federal-state effort will be directed at the problems of providing real health care for the poor and working poor from the inner city...better yet, in this plan the federal government accepts its responsibility to help hospitals with the high costs of caring for illegal aliens and the working poor who have no health insurance. (Daily News, 1979).

I submit that in addition to the increased revenues generated from this new federal-state effort an earnest attempt must be made to comprehensively address the health care needs of this neglected body in our Black community. Many of these workers belong to voluntary associations dotting the neighborhoods, have extensive social networks - bakeries, barbershops, etc. These must be contacted and in some way drawn into the fight for preventive care. Further, these workers now have children who are American citizens by birth and who attend American schools and participate in other American institutions. They can become an important adjunct for they can be persuaded by teachers, school nurses, nurse practitioners, scout leaders, etc. to help convince their parents to enter the medical arena for systematic long term chronic care.

Conclusion

This paper was not meant to be either definitive or exhaustive but is rather an exercise in the development of "Sensitizing concepts. (Dežzin, 1970). It is contended that the concept of a social network is a
potentially useful concept for operationalizing ties to the Black community. This concept not only provides knowledge of social supports including family relations but also defines an important level of analysis in the construction of the process mediating the relationship of ethnicity to chronicity. (Liem + Liem, 1973). Convincing Blacks—especially Black males—that they should be tested for hypertension may require changing beliefs about what constitutes a symptom (hypertension is hidden) and about the seriousness of chronic diseases. (Denton; 1978). It is argued that family, friends, co-workers, etc., as they become aware of a potential patient's condition may influence him or her through their interaction and communications with that person. Finally, we contend that some attention be paid the neglected part of our Black community—the invisible Black undocumented worker whose illness drains on our resources but who nevertheless needs our aid.
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IDEAL SOCIAL NETWORK PATTERN

H.M.O. or CLINIC

HOSPITAL

M.D.

interested individual

H.M.O. or CLINIC

R.N.
P.A.
M.S.W.

SPOUSE (LOVER)
CHILDREN
AUNTS, UNCLEs, etc.
PRIEST, MINISTER
CO-WORKERS

CLUBS, LODGES, etc.
TAVERNS, DISCOS, etc.
STREETCORNERS, STOOPS, etc.
TV, STATIONS, BEAUTY SALONS