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The Office of Minority Health, Michigan Department of Public Health: Expanding the Bridges of Access to Close the Gap

Cheryl Anderson-Small, RN, MSN*

In 1985, a federal report entitled “Black and Minority Health” documented the wide disparity in health status between the white population and the four minority groups—the African-Americans, Hispanic Americans, Asian Pacific Islanders, and Native Americans. In response to the devastating statistics published in this report (1), the federal Office of Minority Health (OMH) was established.

After a careful review of the statistics, it was noted that Michigan was also experiencing higher death rates and levels of illness within its minority communities. In response to this marked mortality and morbidity, former state health director Dr. Gloria Smith convened a group of scientists, health professionals, and public policy leaders to examine the nature and causes of the discrepancy in health status between minorities and whites and to recommend potential solutions to close this gap.

Paralleling the national statistics, the most prominent mortality and morbidity for minorities in Michigan exist in the seven disease categories (now categorized as priority areas) of heart disease/stroke, cancer, diabetes, chemical dependency/liver disease, infant mortality, homicide/suicide/unintentional injury, and the acquired immunodeficiency syndrome. The Michigan task force report (2) also identified five prominent racial/ethnic groups in Michigan: African-American, Hispanic American, Native American, Arab/Chaldean, and Asian Pacific Islander.

Under the leadership of state health director Raj Wiener, the comprehensive and committed work of the task force was realized by the establishment of the OMH by executive order of Governor James Blanchard in 1988.

Impact of Minority Mortality Rates

In 1985, it was established that the minority population in Michigan totaled almost 1.8 million. One in five Michigan residents is a minority. The wide discrepancy in mortality rates between the white population and the minority population of African-Americans, Hispanic Americans, Arab Americans, Asian Pacific Islanders, and Native Americans is growing.

This mortality can be translated in terms of excess deaths—deaths caused by a particular disease which exceed the projected mortality rate. In 1985, Michigan death rates were higher for minorities than for whites for the four leading causes of death and for seven of the ten leading causes of death. Death rates for minorities are 27% higher both for diseases of the heart and for cancer. Overall, the death rate, which is age-adjusted for a population of per 100,000, was 48% higher for minorities than for whites.

We must consider this grave situation as more than just the reporting of statistics. We must look at how many minorities are dying who need not have died if our health care system and health programs were more accessible to address their needs. If there were no disparities in death rates, a total of 3,241 people in minority America would not have died in 1985. In ranking order, for heart disease there were 658 excess deaths for the aggregate of the minority population; for homicide there were 653 excess deaths; for cancer there were 473 excess deaths; for infant mortality there were 289 excess deaths; for chemical dependency as it relates to liver disease there were 209 excess deaths; for stroke there were 206 excess deaths; for diabetes there were 91 excess deaths; and for accidents there were 32 excess deaths.

How does this disparity in the mortality rates of minorities impact Michigan? What nation or state can long survive if one-fifth of its population fails to reach its full potential and contribute its unique gifts to society?

OMH’s Mission and Objectives

The OMH is striving to work diligently to serve as a catalyst for coalition building within our state and within our nation. A total of six states have established Offices of Minority Health, including Michigan, Ohio, Indiana, Missouri, South Carolina, and New Jersey.

Expanding the collaboration among national, state, local, private, and community organizations is the key strategy of the OMH to strengthen the impact of programs targeting Michigan’s minority communities. Coalition building is critical for several reasons. First, there will always be strength in numbers. Additionally, the OMH is based on the premise that people with disadvantaged lifestyles will not prioritize preventive health if survival needs such as food, shelter, and employment are not met. Therefore, costly acute care is often the outcome for the minority population. The OMH is committed to the holistic ap-
exact number of people within our communities who are in need
of services. It is impossible to count the number of people if we
have no consistent mechanism up-front, for instance, during the
intake process to identify to what racial/ethnic group an individu-
also been a prime mission of the OMH. The OMH formed what
can be termed a Michigan model for an interstate departmental
consortium. Formed in 1989, this consortium consists of many
state departments such as Social Services, Mental Health, Labor,
Commerce, Corrections, Agriculture, Department of State, Nat-
ural Resources, Office of Substance Abuse, and Education. The
OMH convenes this consortium bimonthly to discuss strategies
for facilitating access of these multiple resources by our minor-
ity communities. A similar consortium (the Intra-Departmental
Consortium) was also formed within the state Health Depart-
ment by the OMH in 1989.

**Development of Culturally-Specific Programs**

The establishment of the OMH, however, did not herald the
beginning of action and concern. There are many well-designed
programs currently in progress in Michigan. The OMH does not
seek to duplicate current programs within the state or local pub-
lic health departments, but to expand initiatives directed toward
minorities.

The OMH has awarded approximately $1.3 million for dem-
stration or seed funding. These funded projects must specifi-
cally relate to either implementation (hands-on) or training and
education for minorities. The funded programs target minorities
spanning from birth to the elderly. Examples of types of pro-
grams funded include outreach and home-care; needs assess-
ments, screening, and referrals; nonviolence community inter-
ventions; workshops, student internships, consumer education,
and conferences/seminars. Additionally, the OMH administers
and provides over $250,000 for Native American Community
Health Representatives serving our Native American popula-
tion.

The design, marketing, and implementation of state and local
programs for our minority communities are concerted initiatives
in which the state health department and local public health agen-
cies are engaged. The OMH serves as a focused channel through
which our communities can access and utilize these state and
local program services.

**Racial Identification**

We as human and health service providers must know the
exact number of people within our communities who are in need
of access to a myriad of “life-supporting” re-

resources. It is hoped that when these other survival needs are met,
people will then be able to view health as a priority in their lives.

The task at hand is for us as human and health service provid-
ers to understand and know better the resources which are avail-
able so that we can ensure smooth and timely access of these
services by the community. Knowing about these resources has
also been a prime mission of the OMH. The OMH formed what
can be termed a Michigan model for an interstate departmental
consortium. Formed in 1989, this consortium consists of many
state departments such as Social Services, Mental Health, Labor,
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ity communities. A similar consortium (the Intra-Departmental
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ment by the OMH in 1989.

**Legislative Initiatives**

In the legislative area there are two bills which are signifi-
cant. One of these is Senate Bill 393. SB393 is considered to be
a loan forgiveness bill; that is, it will provide an incentive to ex-
pand the ranks of health professionals to work, upon graduation,
in underserved areas. We hope that through this bill and other
programs the need to preserve our most valuable asset—human
resources—will be further promoted. Committed, qualified, and
compassionate people of color are critically needed in health
care systems, both in the public health sector and in the tertiary
care sector. Culturally-specific programs and personnel are es-

tential in bridging the gap for at-risk minorities.

Another bill, House Bill 4671, would establish the OMH in
the Public Health Code, thus allowing continued focus and visi-
bility on the critical problems before us.

**First National Regional Conference on Minority Health**

The Michigan OMH presented the first National Regional
Conference on Minority Health in September 1990. This his-
toric conference was cosponsored, among others, by Federal
Region V, state universities, and the Region V states of Ohio, In-
diana, and Minnesota. The conference entitled “Minority Health
in the Nineties: Issues, Resources, Strategies and Interventions”
was designed to bring people together to discuss current positive
intervention strategies and to become more energized collec-
tively to meet head-on the challenges and responsibilities of
state and national health objectives. We all need to work to-
gether to halt the widening gap, elevate the quality of health, and
expand the bridges of access to close the gap.

**References**