Addressing Health Disparities Through Health Management, Planning and Policy: An Annotated Bibliography

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Abstract

Various healthcare researchers and health policy-makers have long noted that racial health disparities are apart of a broader spectrum of other social disparities that exist in the U.S. A plethora of literature exist which documents racial and ethnic disparities related to both access and clinical health outcomes based on race and ethnicity. The literature in this area of research can be traced as far back as the seminal work conducted by W.E.B. DuBois on the Philadelphia Negro published in 1899. Research attention has recently shifted from documenting health disparities based on comparative disease states, morbidity and mortality statistics to addressing the underlying causal factors that have created what we now broadly term health disparities. Significant recent contributions have been made by various researchers documenting clinical health disparities that exist in the U.S.; however, it has been noted that there are non-clinical factors that must be explored in an effort to seriously understand and ultimately eliminate racial health disparities. This article attempts to present the reader with critically important and useful references focusing on management and institutional factors that must be considered and explored when efforts are made to address racial health disparities in the U.S.

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Overview

Addressing health status disparities among diverse populations has been a priority for our nation since the first national report on health disparities was published in 1985. The Report of the Secretary's Task Force on Black and Minority Health was the work of the task force appointed by then President Ronald Reagan and chaired by then Secretary of Health and Human Services Margaret Heckler. The report highlighted six disease areas in which
significant differences existed between racial and ethnic population groups and the larger majority U.S. population.

It was reported that more than 60,000 excess deaths among minority populations were due to inequities in the delivery of health services. During the last 20 years since the report, resources at the federal, state, and local levels have been directed toward the elimination of health disparities. The theme of that original report was re-emphasized in the report Healthy People 2000, published by the Office of the Surgeon General in 1990, which underscored the fact that inequities in health policy, planning, and delivery continue to create notable differences in the health status of diverse population groups.

Most health disparity literature addresses the clinical aspects of the disparity challenge. This reality may be expected inasmuch as the onset of disease and disability creates the data and statistics for morbidity and mortality that becomes the quantitative measures for health status in a given community. In this regard, the literature is replete with extensive clinical data and information on the six disease areas being addressed by services, programs, and resources.

What is not reflected in the literature is the fact that resource decisions that address clinical service areas are often made by health care managers, planners, and policymakers. Understanding the role and responsibility of the clinical service sector of the health care industry is extremely important since skilled clinicians and enlightened executive decision makers must create a team approach to optimize the allocation of human and financial resources in addressing health disparities. Getting the right services to the right population group at the right time requires the concerted efforts of health policymakers, planners, executive managers, third-party payers, and clinicians.

The purpose of this annotated bibliography is to expand the boundaries of the contemporary health disparities literature to include the role and contributions of the disciplines of health management, planning, and policymaking. The contributions of these disciplines should not be overlooked as our nation continues to meet one of the most complex challenges of the 21st Century.

Annotated Bibliography


The authors performed a systematic literature review to investigate culturally competent healthcare systems. They define a culturally competent healthcare system as one that provides culturally and linguistically appropriate services. The authors selected five measures of a culturally competent healthcare system for review: having staff members who reflect the cultural diversity of the community, providing interpreter services for clients with limited English proficiency, providing cultural competency training, using linguistically and culturally appropriate education materials, and locating healthcare services in culturally specific settings. They were not able to determine the effectiveness of these interventions because of the limited number of studies in the literature involving these interventions.
Ashton, Carol M.; Haidet, Paul; Paterniti, Deborah A.; Collins, Tracie C.; Gordon, Howard S.; O’Malley, Kimberly; Peterson, Laura A.; Sharf, Barbara F.; Suarez-Almazor, Maria E.; Wray, Nelda P.; Street, Richard L., Jr. (2003). Racial and ethnic disparities in the use of health services: bias, preference, or poor communication? *Journal of General Internal Medicine* 18(2):146-152.

The authors presented information that African Americans and Latinos utilize services that require a doctor’s order (e.g., invasive procedures, hospitalization, operations) at lower rates than whites. They propose three explanations for this phenomenon: racial bias on the part of the doctor, patient preferences, and poor communication. The authors use the bias hypothesis to describe how doctors consciously or unconsciously prescribe treatments for African Americans and Latinos that are different from those for Whites. They then discussed how variations in treatment may be rooted in the personal preferences and values of the minority patient. Most of the article discusses effective communication. The authors provided suggestions about what a doctor can do and what can be done for patients to improve communication.


The authors presented information that the outcome after a myocardial infarction is influenced by the type of physician who provides ambulatory care. They studied 35,520 Medicare patients in seven states who survived for at least three months after hospital discharge. The patients were followed over a two-year period. Ambulatory visits to cardiologists were associated with greater use of cardiac procedures and a decreased mortality rate. A further reduction in mortality was associated with concurrent care by an internist or a family practitioner. Patients who saw a cardiologist were more likely to be white, younger, and male; have fewer coexisting conditions; and have undergone invasive cardiac procedures while hospitalized. The strengths of this study are its large sample size and longitudinal nature. The authors did not discuss the difference in treatment patterns between minorities and white populations (see Lurie et al. below for a discussion of the health disparity ramifications).


This article is based on the 2002 Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* and used the report’s definition of disparities and sources of discrimination. The article offered an in-depth analysis of “prejudice” and its various root causes and hypothesis and attempts to quantify prejudice and discrimination. Three mechanisms were studied: the prejudice of doctors in interacting with minorities, clinical uncertainty related to minority patients, and stereotypes that doctors have about minorities. The article suggested that understanding the basis of health disparities is critical to social policy development.

The authors highlighted the proceedings of the National Managed Health Care Congress Inaugural Forum on Reducing Racial and Ethnic Disparities in Health Care, held on March 10-11, 2003, in Washington, DC. Managed care industry representatives at all levels and representatives from research organizations, insurers, foundations, and federal, state, and local governments came together to share case studies and operational models to reduce health disparities in the managed care industry. The article suggested that the “top-heavy” system of fragmented health care must be changed to place more emphasis on primary and preventive care. Other major barriers are cited in the article. The following models and programmatic initiatives are presented with insightful detail: community models, state and municipal models, managed care organization models, partnerships, cultural competency, and infrastructure. Community health planners, organizers, and advocates will find examples of how models are expected to operate successfully. However, there is no hard data to indicate that measurable reductions in health disparities are evident at this time.


In the context of investigating vaccination coverage, the authors compared the statistical use of the traditional state of no difference between groups and a method called equivalence testing. In large sample sizes, the authors contend that a statistical finding of no difference will be the usual conclusion and may not be very informative. In equivalence testing, the statistical proof examined whether the groups differ by less than some small amount. Rather than testing whether the groups are different, equivalence testing provides evidence that groups are similar within a certain amount. Equivalence testing is useful when investigators seek increased power through large sample sizes and are asked precise questions about levels of differences in vaccination coverage.


Using two (2) California postpartum surveys, the authors proposed an approach to studying social disparities in health care. The authors presented an example on how to define social groups into socioeconomic and race/ethnicity variables. They also discussed some of the statistical difficulties that may be introduced in social disparities research. Based on their systematic approach, the authors identified and measured disparities in their sample and then identified factors to consider to reduce these disparities. The main strength of this article was the proposal for a systematic approach to studying social disparities.

The authors studied a sample of Black and White alcoholic outpatients. They hypothesized that Blacks would have poorer outcomes than Whites. However, Blacks had statistically similar outcomes compared with Whites even though Blacks had less income on average; were less likely to be married; were more likely to have family histories of substance abuse; were more likely to have previous occurrences of substance abuse; were more likely to have cocaine use disorders; were more likely to have antisocial personality disorders; and were more likely to have poorer health. The authors noted that Blacks reported more social support than Whites and indicated higher levels of motivation than Whites. The researchers suggested that future studies should include measures of levels of social support and motivation.


The author discussed the effects of joblessness on emotional well-being. The expectancy theory was used to motivate discussion of the detrimental effects of discrimination in joblessness on self-esteem, alienation, anxiety, and depression. The author noted that the increased exposure to joblessness experienced by Blacks may lead to increased stress, which leads to lower health outcomes. No studies have directly connected joblessness to the health status of Blackssuggesting that an individual's perception of discrimination may differ from actual circumstances. The author recommends that future studies should pay careful attention to individuals' perceptions of their exposure to discrimination since this perception may have an effect that is not captured in many studies.


The author discussed the implications of the overall goals of *Healthy People 2010* and the goal for community and personal health by 2010: “health for all.” The use of ethics in addressing health disparities is emphasized. Specifically, the author described how ethics may help health care providers recognize and address health disparities. The author discussed how the principles of respect for individuals, fairness, and trust may be used to examine health disparities. Strategies are presented that professional nurses can use to reduce health disparities. She also suggests assessing values, attitudes, and behaviors; not tolerating disrespectful behaviors; paying close attention to health studies for implications concerning health disparities; and working to remove inappropriate institutional policies.

This article examined the underlying reasons for the growing interest in health disparities research in the U.S. and explored the barriers as well as the opportunities facing initiatives to address this growing important public health issue. The authors noted that the main drivers facing health disparities have a lot to do with the demographic changes; the desire to broaden access to health services and most importantly; and a will on the part of many health care advocates and policy makers to eliminate discrimination in health services delivery. The authors also noted that the U.S. is faced with the difficult task of keeping the matter of health disparities on both the managerial and policy agenda while at the same time seeking ways to integrate strategies into organizational systems and processes.


A telephone survey of 60,446 persons from the Community Tracking Study from 1996 and 1997 measured three independent variables—race, ethnicity, and language—to determine barriers to access to care. Other known barriers such as traveling time, waiting time, and out-of-pocket expenses were not included in the survey. These variables were measured against physician visits, mental health visits, mammographies, and influenza vaccinations. The authors observed significant associations of race and language fluency with health care utilization in this national sample of insured, nonelderly patients.


This research examined whether being discharged against medical advice (DAMA) from general hospitals varied by race/ethnicity and if this variation is explained by individual and hospital factors. The authors conducted a cross-sectional analysis of data from 1998-2000 and the American Hospital Association data on adults admitted for acute general hospital care in the states of California, Florida and New York. Based on the results of the study, blacks had a 2-fold higher age-gender odds of DAMA when compared to whites. The study noted that while Hispanics had an increased risk of DAMA in age-gender-adjusted analyses, the final model revealed a protective effect similar to Asians. Disparities in DAMA affected minority patients in general hospitals and were largely accounted for by individual and hospital socio-economic factors. The study also found that neither race nor ethnic status is independently associated with increased risk for DAMA at the individual level. The authors argued that their findings make it unlikely that DAMA in general hospitals represent another significant area of health care disparities which adversely affected minorities.

This research argued the importance of managing and tracking quality-of-care measures for improving care of our most vulnerable populations. The authors found that managed care plans can begin examining and targeting potential disparities by using indirect measures of enrollee race/ethnicity and Socioeconomic Status (SES) based on geo-coding. The results from their study show that more enrollees met NCQA (National Committee for Quality Assurance) eligibility requirements for diabetes measures than for the two cardiac measures. Their results also showed that Medicare + Choice (M+C) enrollees were older than commercial enrollees, with a higher percentage living in predominately black or poor neighborhoods. Also, their results showed that a higher percentage of diabetics as opposed to cardiac-eligible enrollees also lived in these neighborhoods. Eligible Enrollee Characteristics by the HEDIS Process Measure and Plan type were examined; Eligible Enrollee Characteristics by HEDIS Intermediate Outcome Measure and Plan type were measured; Racial and Socioeconomic Status Disparities by Plan Type; Process Measures were examined; and Racial Disparities in LDL (Low Density Lipoprotein) Checks Among Diabetic Enrollees in Commercial Plans In The Managed Care Organization were studied as well. The authors argued that geo-coding offers managed care plans and other health care providers the opportunity to obtain the race/ethnicity and SES data that the authors needed to begin addressing health care disparities.


The authors summarized and synthesized information regarding the cancer experience of various minority groups. The article extends the discussion of health disparities to Mexican Americans, Puerto Ricans, Cuban Americans, Asian Americans, Native Hawaiians, American Samoans, American Indians, Alaska Natives, and African Americans. The research discussed the demographic and social indicators affecting minority health status such as socioeconomic status and access to health insurance and health services. The authors presented an overview of the major historical and cultural influences that influenced health care disparities. They then compared cancer incidence, mortality, and risk factors between minority and white populations. The authors also proposed future considerations to reduce cancer-related health disparities, particularly among women, such as, more accurate and timely cancer data, identification of mixed racial groups, and greater minority participation in cancer research.

The authors discussed the history and purpose of federal health centers. Although the federal government has increased financial support, the fiscal crisis of individual states led to actions that reduced direct financial support for health centers. Because health centers treat a large number of Medicaid enrollees, indirect financial support in the form of reduced Medicaid reimbursements also affects health centers. The authors argued that if states could increase financial support, states would save money by reducing preventable hospitalizations and emergency room visits for nonurgent conditions.


The authors provide information to help physicians avoid treatment patterns that will result in higher morbidity and mortality rates in African Americans. The article is a concise guide that can be used by health care providers to avoid health disparities in their patient treatment patterns. The authors suggested using clinical guidelines to promote treatment consistency; patient education based on their literacy level; staff members who are sensitive to a patient's culture; patient education provided in a culturally sensitive manner; patient referral systems to community resources; volunteerism within the community; involvement in a community health improvement plan; program creation for special patient populations; plans for translation services; and familiarity with Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, a report of the Institute of Medicine.


The results of a National Institute of Nursing Research-funded study are presented. The authors examined barriers to mental health care services for 24 low-income African Americans. After each individual was interviewed, three levels of barriers were identified: individual, environmental, and institutional. Within these three levels, 14 subgroups were identified. The individual barriers that were found to be the most dominant focused primarily on the family and the community. The authors stressed that understanding how individuals perceive their environment and solve problems is important to preventing health disparities. They also provide direction for future research.


The authors examined three competing causal interpretations of racial disparities in health, including race as a biologically meaningful category, race as a proxy for class and views socioeconomic stratification as the real culprit behind racial disparities and race as a distinct construct. The authors make an argument as to why one cannot talk about race and class together, and they propose two propositions as the basis for their argument. The authors also discuss race as a form of biology and race as a proxy for class and present some of the problems
and complexities related to addressing these interpretations of racial disparities in health. Policy implications are presented along with their perspectives on what will be required to better measure and monitor both race and class disparities.


This study investigated whether area-based socioeconomic measures (ABSMs) can be meaningfully used for public health monitoring in the absence of socioeconomic data when applied to U.S. public health surveillance systems. To assess the meaningfulness of ABSMs when used in this regard for diverse racial/ethnic/gender groups, the authors geo-coded and linked public health surveillance data from Massachusetts and Rhode Island to 1990 block group, tract, and ZIP Code ABSMs. The authors focused on outcomes related to death, birth, cancer incidence, tuberculosis, sexually transmitted infections, childhood lead poisoning, and nonfatal weapon-related injuries. When examining race and gender, the authors found measures of economic deprivation to be most sensitive to what would be expected if socioeconomic gradients in health was applied. The study also revealed that the most consistent results and geo-coding linkage was at the tract levels of analysis.


The authors, through a contract with the Agency for Healthcare Research and Quality, conducted a cross-sectional survey of 15,613 Ohio residents to measure managed care activities and access to care. Study variables included access problems, level of managed care activity and insurance status, individual-level factors, contextual covariates, economic status, population density, and health system factors. The results of this study indicated that greater managed care activity is associated with less favorable access to care, regardless of insurance status. This discovery may be a meaningful factor in addressing access disparities in the current health care environment.


The authors reported on findings from the workshop symposium “Treatment Outcomes and Issues in Clinical Research Related to Race and Ethnicity.” Data from alcohol and other drug treatment studies were analyzed. Two counterintuitive findings were reported. The first outcome was that Black and White clients did not differ when compared using measures of alcohol or other drug use quantity and frequency. The second outcome was that Black and White clients had similar outcomes even though Blacks had lower income and less education; were less likely to be married; had a higher likelihood of personal and family history of substance abuse; and suffered poorer physical health than Whites. The authors suggest that Blacks may have a stronger network of social support than Whites.

The authors discussed the implications of one part of a study by Ayanian and colleagues (see Ayaniam et al. above) and expanded on the study's discussion of health disparities. They suggested that greater use of care from a cardiologist or collaborative care could reduce the health disparities that were found. The researchers discussed strategies for improving the quality of care to minorities, such as improved patient tracking from the beginning to the end of an episode of care and improved coordination of care. Other additional factors were mentioned such as access to timely and patient-centered care, patient confidence in the health care system, and effective communication by health care providers.


A 2001 California Health Interview Survey was used as the sample in this study. The researchers examine disparities in the elderly. In particular, the researchers focused on preventive services and the effect of health insurance. The authors found that the type of health insurance was associated the prevalence of preventive measures. Race/ethnicity was also found to be associated with the frequency of preventive measures.


The author reviewed five Black-oriented women's magazines (*Black Woman, Black Elegance, Essence, Ebony, and Upscale*) and five White-oriented women's magazines (*Family Circle, Working Mother, Good Housekeeping, Ladies' Home Journal*, and *Women's Day*) for a period of three months and compared the numbers and types of pharmaceutical advertisements in each group of magazines. The author found fewer pharmaceutical ads in the black-oriented magazines compared to the white-oriented magazines. Also, drugs represented in the advertisements were different with little or no mention of HIV or contraception in the black-oriented magazines. The authors stated that health disparity may be partly attributable to the fact that blacks are exposed to less health information in black-oriented magazines.

The authors discussed a community-based participatory model to build health promotion capacity. The community-based participatory model applied the concept that health promotion should be conducted in a manner that allows community members to influence and control decisions. The authors applied this model to study the nutritional environment of select African American urban areas. Although this approach was effective, the researchers concluded that health disparities may exist in low-income communities because of lack of resources to adhere to a healthy lifestyle.


Steinbrook highlighted the findings of the National Healthcare Disparities Report, developed by the Agency for Healthcare Research and Quality and released by the U.S. Department of Health and Human Services in December 2003. This report received national attention because of the reported “modifications” by the Bush administration in an effort to provide a balanced summary of the state of health disparities in the United States. The author provided a cursory review of the report and gave a history of the review process and how such a process may be politically influenced.


Stuber and Bradley examined the levels of knowledge of Medicaid eligibility rules. Based on this assessment, the researchers identified factors of perceived enrollment barriers. A cross-sectional study of 1405 patient interviews was conducted in 1999 within 10 states and the District of Columbia. The sample was evenly split between non-Hispanic White, non-Hispanic Black, and Hispanic individuals. The authors identified several factors that was associated with lack of knowledge about Medicaid such as mental health and low education levels. While simplified enrollment procedures reduced the risk of misinformation in the respondents, health and demographic factors were significant factors. The authors warned that as the states’ Medicaid budgets are reduced, the complexity of the application process may increase leading to increased knowledge disparities.


The author stated that the effects of culture on health care are important and should be incorporated into medical school curricula. A description of the core components of culture that should be incorporated into undergraduate medical education was included. Students should be taught why it is important to learn about culture in health care, to explore culture as building blocks to learn about the role of culture in the health care setting, to review data on the health status of all population groups to develop critical thinking about the links between the data and differential health status and culture, and to apply their cultural knowledge in the health care encounter. The instruction within medical curricula should be standardized to avoid negative biases, prejudices, and stereotypes. Medical students should be exposed to members of the community to understand the interface of culture, health, and society. Institutional processes should encourage the study of the role of culture and health.

To identify plans with high quality and low disparity, the authors assessed variations among Medicare health plans in overall quality and racial disparity in four Health Plan Employer and Data Information Set (HEDIS) outcome measures to determine the extent to which high-performing plans exhibit smaller racial disparities. The researchers found that the mean performance on all HEDIS outcome measures was significantly lower for black enrollees than white enrollees. The study also noted that for each measure, more than 70% of the racial disparity was attributed to the same health plan for both white and black enrollees. The study also noted that a much smaller proportion was due to plan disparities and a disproportionate enrollment of black enrollees in lower performing plans. This study is consistent with similar reports that have suggested that performance in the various domains of quality measurement may show little or no correlation.


The authors sought to identify physician-patient relationship indicators that would be considered culturally sensitive from the patient’s perspective. Groups of low-income patients from three ethnic/cultural groups—African Americans, European Americans, and Latino Americans—participated in focus group interviews. The interviews consisted of five questions. The results of the interviews were reported as primary and secondary “themes” that reflected the cultural sensitivity of each ethnic/cultural group. The most consistent theme reflected in the study was that physicians convey positive personal qualities when interacting with patients. The study concluded that cultural sensitivity may improve patient health care satisfaction and reduce health care disparities.


Wasson and colleagues presented results from self-reported information from adults (n=13,271) as well as the results from several controlled trials to construct a planned care management strategy that cuts across diseases and conditions to address health disparities attributed to low socio-economic status. The authors identified seven common barriers to effective resource planning when planning a management strategy for patient-centered collaborative care. This resource planning construct was built on a body of knowledge in industry known as production planning or repetitive master scheduling. The authors reported that a prospective planned-care management strategy is likely to be more efficient and effective than strategies based on concepts of disease management that focuses on either a single disease or groupings of patients who are “high-utilizers” of health care.

This article investigated the impact of patterns of utilization on the health status of HIV-positive patients. The study was conducted in New Orleans and compared HIV-positive patients based on entry into the health care system. The authors compared patients whose initial treatment was in an inpatient setting with those patients who entered the system through an outpatient setting. The different utilization patterns were analyzed based on race, gender, drug use, and AIDS diagnosis. The authors used data from the Louisiana Office of Public Health and the Prevention Adult Spectrum of Disease Study, in New Orleans. HIV positive patients from the inpatient setting were more likely to have a rapid progression of the disease and to be African-American. The authors posited that HIV positive patients entering through the inpatient setting may require more effective early intervention.


Whetten and others examined factors related to trust between health care providers, the government, and health service use and outcomes. Interviews of 611 HIV-infected individuals who received care in the Deep South were used as the data source. The authors found significant differences in minority responses to trust issues. Minorities were less likely to trust their health care providers. A lack of trust was also found to be a significant factor in lowering certain health outcome variables.


The author reported that six of the ten leading causes of death reported in the 2001 *Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health, A Report of the Surgeon General* were behaviorally based and psychologists should focus on prevention and early interventions for these causes. With projections that the minority populations in the United States will become the majority population within 20 to 30 years, the education and health of minority children must be ensured. There should be collaborative relationships among agencies, organizations, and communities. These relationships are essential to meeting the social, physical health, and mental health needs of low-income, ethnic minority children. The author identified several approaches to these collaborations.

The authors discussed how racism may affect rates of cardiovascular disease (CVD) in African Americans. For example, CVD mortality rates for Blacks are declining at a slower rate than for Whites. Three levels of racism that would affect CVD rates were discussed: institutional racism, perceived/personally mediated racism, and internalized racism. Institutional racism is defined as systematic, subtle forms of racism sustained in society through customs, standards, and regulations. Perceived/personally mediated racism is defined as the subjective experience of an individual who has encountered discrimination. Internalized racism is the acceptance of cultural stereotypes of a societal group.


The authors examined the effect of Medicare reimbursement on the race and disparity of colorectal cancer screening among the elderly in the U.S. The policy of covering colonoscopy for average-risk beneficiaries was implemented by Medicare in 2001. This policy alleviated the screening disparity between non-Hispanic whites and blacks; however the gap between Hispanics and non-Hispanic whites has widened. The authors used 2000 Cancer control Module (CCM) and 2003 Cancer Screening Supplement (CSS) of the NHIS (National Health Interview Survey). The key variable examined in the study was the use of endoscopic colorectal cancer screening. Medicare beneficiaries’ racial and ethnic characteristics were examined including age and sex as explanatory variables. The authors compared the differences in colorectal cancer screening rates between the 2000 and 2003 samples for the four defined racial/ethnic groups while controlling for other variables found to be associated with the screening such as socioeconomic status or access barriers. Results from the study found that across the four racial/ethnic groups, a significant increase in the rate of screening from 2000-2003 was found for non-Hispanic whites and non-Hispanic blacks. Also, the disparity in screen rates between non-Hispanic whites and non-Hispanic blacks was reduced.