

Comparison of Health Perceptions and Health Status in African Americans and Caucasians

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Purpose: This study was designed to compare the health perceptions of adults based on race (African American and Caucasian) and gender in the southern United States to determine if health perception contributed to health disparity between African Americans and Caucasians.

Methods: A between-groups design was used in this study where African Americans and Caucasians completed an extensive health questionnaire and were compared for health perceptions and self-reported health status differences.

Results: Fewer African Americans ($p < .05$; males, 55.8%; females, 68%) perceived their health to be good to excellent compared with Caucasians (males, 76.6%; females, 77.1%) and more had been diagnosed with 1 or more chronic diseases. Yet, more than three-quarters of all groups thought that their health care provider shared with them good to excellent information about their health, and 75.0% of the African American males and 71.5% of the Caucasian males and more than 62.0% of the African American and Caucasian females stated that medication cost was not a reason they did not take prescribed medications.

Conclusions: Health perceptions of African Americans are often not consistent with their actual health, and this is especially true for African American males. Their perceptions appear to influence the value they place on health behaviors which may result in a reduced health status.

Keywords: knowledge, attitudes, and beliefs ■ African Americans ■ health disparities

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Compared with Caucasians, African Americans suffer disproportionately from many preconditions for and chronic diseases, which results in

premature morbidity and mortality.^{1,2} Forty-eight percent of all African American adults suffer from a chronic disease, compared to 39% of the general population.¹ African Americans typically also experience greater complications and comorbid consequences from these diseases.^{2,3} Many hypotheses have been forwarded as to why African Americans are more vulnerable to chronic diseases. Hypothesized reasons include genetics associated with race, access to health care, socioeconomic status, environmental exposures, dietary patterns, low physical activity participation and less-healthy lifestyle choices.^{3,4} Although many hypotheses have been proposed, little empirical data exist that clearly elucidate or validate many of these hypotheses.⁵ A published report by the Centers for Disease Control and Prevention (Atlanta, Georgia),² states that African Americans have the highest premature death rate in the United States from heart disease, cancer, diabetes, and human immunodeficiency virus (HIV)/AIDS.^{3,4,6} The CDC statistics indicate that the death rate from heart disease is 30% higher in African Americans than in Caucasians, and the death rate for stroke is more than 40% higher. The cancer death rates are high as well, with African Americans dying at a 25% greater rate than Caucasians.^{2,6}

Many studies designed to determine if genetic differences are responsible for the disparity in health, wellness, and quality of life between African American and Caucasian adults have been completed across the years.⁷⁻¹⁰ Due to confounding factors such as socioeconomic status and lifestyle choices such as diet and physical activity, participation difficulty in deriving conclusive outcomes from these studies has been experienced.^{11,12} However, some studies have shown that health disparities exist after controlling for selected genetics influences.^{7,8}

Obesity has been referred to as a “root disease,” as it is a comorbidity with a number of other chronic diseases, has a disproportionately high prevalence in African Americans, and is stated to be a possible link to the greater morbidity observed in African Americans.^{13,14} However, obese African American females have been shown to experience different relationships between chronic diseases and obesity than observed in Caucasian females. For example, African American females with visceral obesity have been observed to have favorable glucose response curves compared with Caucasian females without visceral

obesity, but they have a higher prevalence of diabetes, hypertension and cardiovascular diseases.¹⁵⁻¹⁸

Health perceptions can determine personal health values and have been proposed as one source responsible for the health disparities between African American and Caucasian adults.^{19,20} For example, African American men aged 40 years and older have a higher lifetime risk of developing and dying from prostate cancer than non-Hispanic Caucasian males. Although this higher risk for prostate cancer in African American males is well known in the medical community, it is not clear how prevalent this knowledge or the level of understanding of this knowledge is among African American males. It is also not clear whether men in general are aware of race/ethnicity-specific risk information and the prevalence of prostate cancer. Surveys conducted in the early 1990s show that typically only a small percentage of African American males are aware of the greater risk and consequences of prostate cancer in African American males.²¹

Misperception among overweight people (belief among overweight people that they are a healthy weight) is more common in African Americans than in Caucasians, and more common in men than women.²² Understanding weight perception may be a key tool in developing interventions to reduce obesity and racial/ethnic disparities in obesity. Previously published reports describing weight perception were often based on data reported preceding an increase in obesity and/or overweight.^{23,24} Current estimates of weight misperception and health choices resulting from these misperceptions are needed to provide timely data that may be useful in developing effective population-specific interventions.²⁵

Health perceptions and beliefs influence health behaviors that may result in less attention provided to regular medical checkups, dietary consumption patterns, stress management, and leisure time physical activity; and this is especially true for African American adults.²⁵ Therefore, the purpose of this investigation was to compare the health perceptions of adults based on race (African American and Caucasian) and gender (male and female) in the southern United States to determine

if health perception contributed to one having lifestyle choices that were associated with a greater prevalence of disease and a reduced quality of life. The hypothesis tested in this study was that African Americans' perceptions of their health and health practices were different than those of Caucasians and were partially responsible for the health disparity between African American and Caucasians.

METHODS

Research Design and the Questionnaire Instrument

A between-groups research design was used in this study where African American and Caucasian participants followed the same protocol and were evaluated for health perception and reported health status differences. This research design allowed for a comparison between self-reported health perceptions and health status of African American and Caucasian males and females that participated in this study.

African American and Caucasian adults (males and females) completed and returned an extensive health questionnaire (Northern Louisiana Health Survey [NLHS]) mailed to them. The participants were selected using a stratified random sampling procedure from 10 parishes in the Northern Louisiana Delta region, which has a high poverty level. A 30% return was obtained from a total of 6000 mailed questionnaires. Participants were asked to complete all aspects of the questionnaire, and selected questions from the NLHS are included in this study. The content and composition of questions for this questionnaire were adapted with permission from a set of previously published and validated materials. Experts on the research staff reviewed each of the NLHS questions to insure that they asked for the information desired and that the questions were culturally sensitive, were appropriate for both African Americans and Caucasians, and could be answered in a reasonable amount of time. Efforts were made to insure that the questions were easy to understand and included both choice-response and open-ended questions. The questionnaire included 67

Table 1. Physical and Demographic Data of Study Participants (N = 1605)

Variables	African American Males		Caucasian Males		African American Females		Caucasian Females	
	N = 44		N = 346		N = 259		N = 956	
	\bar{X}	S _d	\bar{X}	S _d	\bar{X}	S _d	\bar{X}	S _d
Age, y	56.6 ^a	17.2	58.6 ^a	15.3	51.6 ^b	16.0	56.5 ^a	16.5
Height, cm	179.2 ^a	9.0	178.8 ^a	7.5	164.3 ^b	9.1	163.5 ^b	7.4
Weight, kg	90.9 ^a	17.5	89.3 ^a	19.9	83.5 ^a	21.8	73.1 ^b	18.3
BMI, weight (kg)/height (cm ²)	28.3 ^a	5.5	27.8 ^a	7.6	30.3 ^a	9.8	26.6 ^c	9.9
≥12th-grade education, %	63.6 ^a		82.6 ^{b,c}		77.2 ^b		85.6 ^c	
Earn <\$30000 a year, %	59.0 ^a		33.9 ^b		74.6 ^c		44.1 ^d	

^{a, b} Means with different letters are different than other means at $p < .05$.

questions; many requiring multiple responses.

The investigators received permission and adapted questions from the Medical Outcomes Study SF-36 Quality Metric's generic health survey, which captures practical, reliable, and valid information about functional health and well-being from the patient's point of view.^{26,27} The generic health surveys can be used across age, disease, and treatment group, and are appropriate for a wide variety of applications.^{26,28} The SF-36 has been used with African American populations, and outcomes from those studies indicate that health expectations and perceptions may be indicative of the cultural, contextual, and social-political factors that affect the lives of this urban, low-income population.^{29,30}

Questions were also selected from the "The National Health Service Corps Community Assessment Project," which were designed to provide a better understanding of health care for persons in underserved communities.^{28,31} The research team for this study piloted the NLHS by administering the survey to a sample of African American and Caucasian adults within the Lincoln Parish and evaluating their responses to insure that the NLHS obtained the information desired. The investigative team felt comfortable that the population that the questionnaire was designed for would be able to understand the questions and provide appropriate responses. By selecting questions from previously validated instruments for both African American and Caucasian participants, the investigators believe that information collected will be reflective of the perceptions of the participants in the study.

PARTICIPANTS AND PROCEDURES

Efforts were made to insure that both African Americans and Caucasians were sent the institutional review board-approved questionnaire that included the following information:

As a resident of one of the 10 parishes in northern Louisiana (Lincoln, Morehouse, East Carroll, West Carroll, Union, Caldwell, Franklin, Madison, Richland, Tensas), you have been selected to represent your community. You are asked to complete the accompanying questionnaire. The questionnaire was based on an instrument that was developed to help communities understand their health status. The information you provide will be anonymous and confidential, and will be used only to describe the health status of northern Louisiana as a whole. Your responses will be combined with information from other residents in a way that will not allow you to be identified.

The following instructions were included with the questionnaire:

- (1) Please answer every question that applies to you. Be sure to only answer questions which apply to you; do not answer questions on behalf of other family members. Most people will be asked to skip some questions because they do not apply.*
- (2) Answer the questions by shading the appropriate box(es) or by filling in the answer as requested.*
- (3) If you are unsure about how to answer a question, please give the best answer you can and write any comment you have next to the question. All of your comments will be read, so feel free to make as many comments as you wish.*
- (4) If you have any questions, please call the study coordinator for the NLHS.*
- (5) Please return your completed questionnaire within 1 week.*

Returned NLHS responses were evaluated for differences and response patterns based on race and gender, for health and lifestyle perceptions. Racial determination was based on racial self-identification. A total of 1605 adults (44 African American males, 346 Caucasian males, 259 African American females, and 956 Caucasian females) returned useful questionnaire responses.

Table 2. Participants Perceptions of Their Health Status (N = 1605)

Questions (% of Respondents With Listed Answer)	African American Males	Caucasian Males	African American Females	Caucasian Females
	N = 44	N = 346	N = 259	N = 956
In general, would you say your health is: Very good to excellent.	55.8 ^{a*}	76.6 ^b	68.0 ^b	77.1 ^b
Does your health now limit your participation moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf? Yes, a little to a lot	47.7 ^a	38.4 ^b	45.1 ^{ab}	39.2 ^b
Compared to 1 year ago, how would you rate your health in general now? About the same or better	76.1 ^a	78.0 ^a	75.9 ^a	77.3 ^a
Thinking about your regular doctor or nurse, or regular place of care, how would you rate the following explanations of health problems or treatments that you need. Good to excellent	92.9 ^a	93.7 ^a	87.3 ^a	90.3 ^a

^{a, b} Means that have the same letter are not different at $p < .05$.

* Ethnic groups are different at $p < .05$.

Data Analysis

The data were analyzed using SPSS version 17 as means, and standard deviations of personal characteristics were computed with descriptive statistics. Frequencies expressed as percentages were used to compute results from noncontinuous data responses. The analyses are based on race (African American and Caucasian) and gender (male and female). To further evaluate the data, responses of the participants were dichotomously coded and evaluated for differences based on ethnicity and gender. A cross-tabs χ^2 procedure was used to determine if the responses of the groups were statistically different.

Findings

The mean age of the respondents ranged from 51.6 for the African American females to 58.6 years for the Caucasian males (Table 1). There were no within gender differences ($p < .05$) among the participants for height, but the Caucasian females weighted less ($p < 0.05$) than the African American females. A smaller percentage of African Americans ($p < .05$; African American males, 63.6; African American females, 77.2) had educational levels of 12th grade or higher compared with Caucasian adults (Caucasian males, 82.6; Caucasian females, 85.6) and more African Americans ($p < .05$; African Americans, 72.3%; Caucasians, 41.4%) earned \leq \$30000 a year. Based on self-reported body mass index (BMI) information, the obesity status of the participants was not different and all of the groups except the African American females were overweight. The African American females were classified as obese, but their actual BMI was not different than ($p > .05$) the other groups; therefore, body composition was not a factor that

influenced the perceptions of the participants in this study.

The participants were asked what they considered to be their health status (Table 2) and fewer African Americans ($p < .05$; African American males, 55.8%; African American females, 68%) perceived their health to be good to excellent compared with CA (Caucasian males, 76.6%; Caucasian females, 77.1%). Interestingly, almost half of the African American males believed that their health was poor to average, yet more than 76.1% of them and 75.9% or more of the other 3 groups believed that their health was the same or better than a year ago. Apparently, this good feeling about their health was supported by the fact that 87.3% or more of all 4 groups thought that explanations of their health issues and treatments by their health care providers were good to excellent. These results suggest that many African American males are content with their health status being poor to average.

An interesting observation from this survey was that more African Americans ($p < .05$, Table 3; 65.0% and 64.1% of the African American males and African American females, respectively; 45.7% and 44.0% of the Caucasian males and Caucasian females, respectively) had been told by their physicians that they had hypertension and 23.7% and 20.9% of African American males and African American females, and 11.2% and 14.8% of Caucasian males and Caucasian females, respectively, had medical diagnoses of diabetes. Further, 2.7%, 14.0%, 13.3%, and 9.9% of the African American males, Caucasian males, African American females and Caucasian females, respectively, had medical diagnoses of cancer; and more of 50.9% of all groups reported that they frequently had low levels of energy. Even though the African Americans had a greater prevalence of diseases compared with the

Table 3. Participants Health Status Based on Physician Assessment or Physical Impairment (N = 1605)

Questions (% of Respondents With Listed Answer)	African American Males	Caucasian Males	African American Females	Caucasian Females
	N = 44	N = 346	N = 259	N = 956
Has a doctor ever told you that you had: hypertension? Yes	65.0 ^{a*}	45.7 ^b	64.1 ^a	44.0 ^b
Has a doctor ever told you that you had: congestive heart failure (heart failure or enlarged heart)? Yes	13.5 ^a	9.1 ^a	11.7 ^a	7.2 ^a
Has a doctor ever told you that you had: Diabetes? Yes	23.7 ^{a*}	14.8 ^b	20.9 ^a	11.2 ^b
Has a doctor ever told you had: Angina? Yes	2.7 ^a	14.0 ^b	13.3 ^b	9.9 ^b
Has a doctor ever told you that you had: Cancer (malignant cancer of all kinds, including skin cancer)? Yes	5.6 ^{a*}	16.2 ^b	7.5 ^{a,b}	13.1 ^{a,b}
Has a doctor ever told you that you had: lung disease (other than emphysema, chronic bronchitis or asthma)? Yes	2.6 ^a	6.1 ^a	3.8 ^a	3.8 ^a
Has a doctor ever told you that you had: a heart attack in the last year? Yes	2.6 ^a	3.0 ^a	2.9 ^a	1.0 ^a
Do you now have: limited use of an arm or leg (missing paralyzed, or weakness)? Yes	35.1 ^{a*}	15.7 ^b	20.3 ^b	13.9 ^b
How much of the time during the past 4 weeks did you have a lot of energy? A good bit to none of the time	56.1 ^a	59.9 ^a	56.2 ^a	50.9 ^a

^{a,b} Means with the same letter are not different at $p < .05$.

^{*} Ethnic groups are different at $p < .05$.

^b Genders are different at $p < .05$.

Caucasians, a similar percentage to the African Americans reported being satisfied with their medical care.

To further assess the health environment of the participants, they were asked about their health behaviors. A smaller percentage of African Americans ($p < .05$) (African American males, 48.4%; African American females, 23.3%, Caucasian males, 55.5% and Caucasian females, 40.9%) exercised 30 or more minutes at least 3 times a week (Table 4); more than 52% of all groups stated they had had colorectal screening within the last 12 months and 31.8% of the African American males and 23.8% of Caucasian males had never been screened for prostate cancer, while 8.0% of African American females and 3.9% of Caucasian females had never been screened

for breast cancer. The groups were moderate consumers of alcohol as 20.9%, 24.2%, 5.6%, and 10.3% of African American males, Caucasian males, African American females, and Caucasian females, respectively, consumed 3 or more alcoholic drinks a week and 76.7%, 79.5%, 68.7%, and 74.3% of the African American males, Caucasian males, African American females, and Caucasian females, respectively, thought that their health care provider was good to excellent providing them with knowledge of what worried them most about their health. When asked if they ever skip medication or treatments because the medications or treatments are too expensive, there was a gender difference ($p < 0.05$), as 75.0% of the African American males and 71.5% of the Caucasian

Table 4. Self-report Behavior Health Practices of the Participants (N = 1605)

Questions (% of Respondents With Listed Answer)	African American Males	Caucasian Males	African American Females	Caucasian Females
	N = 44	N = 346	N = 259	N = 956
How often in a week do you exercise for 30 minutes or longer (exercise or work that is hard enough to make you breathe heavier and your heart beat faster)? ≥ 3 days a week	48.5 ^{ab*}	55.5 ^b	23.3 ^c	40.9 ^a
How many alcoholic drinks do you drink in a week, including weekends? (A drink is 1 bottle or can of beer, 1 glass of wine, 1 mixed drink, or 1 shot of liquor)? ≥ 3 a week	20.9 ^{a*}	24.2 ^a	5.6 ^b	10.3 ^b
When was the last time you had the following: cholesterol screening? <i>within the past year</i>	52.3 ^a	63.9 ^b	59.0 ^b	60.7 ^b
When was the last time you had the following: blood pressure screening? <i>within the past year</i>	86.4 ^a	84.6 ^a	85.4 ^a	83.3 ^a
When was the last time you had the following: colorectal cancer screening? <i>never</i>	41.5 ^{a*}	38.9 ^a	52.6 ^b	50.8 ^b
When was the last time you had the following: prostate cancer screening? <i>never</i>	31.8 ^{a*}	23.8 ^b		
When was the last time you had breast exam by a health care professional? <i>never</i>			8.0 ^a	3.9 ^a
When was the last time you had the following exams: mammogram? <i>never</i>			24.8 ^a	19.4 ^a
When was the last time you had the following exams: Pap smear? <i>Within the last year</i>			61.5 ^{a*}	50.4 ^b
How would you rate the following for your regular doctor or nurse, or regular place of care: knowledge of what worries you most about your health? <i>Good to excellent</i>	76.7 ^{ab}	79.5 ^b	68.7 ^a	74.3 ^{ab}
Thinking about your health care, please rate the following: your access to health care whenever you need it? <i>Good to excellent</i>	88.6 ^a	84.7 ^{ab}	77.7 ^b	84.5 ^{ab}
Thinking about how much your health care costs, please answer the following: do you ever put off going to the doctor/nurse because visits are too expensive? <i>No, never, or it does not apply</i>	77.3 ^{a*}	60.3 ^b	49.3 ^c	49.5 ^c
Thinking about how much health care costs, please answer the following: do you ever skip medication or treatments because they are too expensive? <i>No, never, or it does not apply.</i>	75.0 ^{a*}	71.5 ^a	62.5 ^b	62.2 ^b
How satisfied are you with: the quality of your health care? <i>Satisfied to completely satisfied</i>	90.0 ^a	87.5 ^{ab}	80.2 ^b	87.2 ^{ab}

^{ab} Means with different letters are not different at $p < .05$.
 * Genders are different at $p < .05$.

males stated "no" or the situation did not apply to them. On the other hand, 62.5% of the African American females and 62.2% of the Caucasian females stated "no" or the situation did not apply to them. Based on exercise patterns and health screenings, the African Americans had less-healthy lifestyle choices and according to their responses about medication or treatment cost, finance did not greatly influence their choices.

Behavior health practices, financial and educational influences on health revealed racial and gender differences. More females of both races had changed their diets due to physician recommendations than males, and more African American females (77.1%, Table 5) attempted to develop effective relaxation techniques than any other group based on the recommendation of their health care providers. More African American males (84.6%) had prescriptions that were not covered by insurance than any other group, and African American females were without insurance more in the previous 3 years than any of the other groups (Table 6).

DISCUSSION

Findings in this study indicate that the middle-aged African American males had lower educational attainment than the other groups and that the African American females earned less than the other groups. Almost 75% of the African American females earned less than \$30,000 a year, and many of them were head of households.

These findings are consistent with results reported in the literature which indicate that education is associated with socioeconomic status and that African Americans often have lower educational levels and earning power than Caucasians.^{32,33}

Findings from this study indicate that an average of approximately 70% of all of the participants reported that their health was good to excellent, yet 60% to 80% of the participants reported 1 or more clinically diagnosed chronic health ailment such as hypertension, diabetes, or heart failure. The perceptions were generally true for both African Americans and Caucasians, with African Americans reporting a lower level of good to excellent health than Caucasians. A confounding issue with African American males was the fact that fewer believed that their health was good to excellent than other groups, yet fewer participated in health care assessments, while more stated that they were pleased with their quality of health care. Wellness behavior and awareness appears to contribute to the lower health status of African American males. This is consistent with results reported elsewhere that health behaviors maybe a source of the health disparity between African American males and Caucasian males.^{19,20}

Health perceptions influence health behaviors, and this appears to be especially true for African American males that responded in this study.²⁵ The African American males generally sensed that their health was not the best but chose not to take steps to improve their health status. They appeared to either be in denial about their health issues or lack the awareness of the potential consequences of making poor health care choices.^{19,20} On the other hand, they may have simply chosen not to focus on negative health beliefs. Negative health beliefs are significant predictors of higher levels of depressive symptomatology which contribute to illness. Illness perceptions are often related to negative health outcomes. This may imply that interventions aimed at changing illness perceptions can contribute to better health outcomes.^{34,35} However,

Table 5. Behavior Health Practices and Willness of Participants to Change Lifestyles (N = 1 605)

Questions (% of Respondents With Listed Answer)	African	Caucasian	African	Caucasian
	Males	Males	Females	Females
	N = 44	N = 346	N = 259	N = 956
What would you say if a health care provider told you to make lifestyle changes to improve your health? <i>Would work hard to change</i>	13.5 ^a	7.9 ^a	25.7 ^b	11.9 ^a
Which of the following have you ever done because of your health care provider's advice: tried to drink less alcohol? Yes	30.0 ^a	16.1 ^b	13.9 ^b	5.0 ^c
Which of the following have you ever done because of your health care provider's advice: cut down or quit smoking? Yes	34.8 ^a	37.9 ^a	33.1 ^a	33.9 ^a
Which of the following have you ever done because of your health care provider's advice: changed your diet in any way? Yes	50.0 ^a	50.2 ^a	67.3 ^b	61.8 ^b
Which of the following have you ever done because of your health care provider's advice: tried to relax or reduce your stress? Yes	56.2 ^{a,b}	49.2 ^a	77.1 ^c	61.2 ^b

^{a,b} Means with the same letter are not different at $p < .05$.

^{*} Genders are different at $p < .05$.

refusing to acknowledge and change poor health practices is likely a major contributor to the health disparity between African Americans and Caucasians.

More African Americans reported having been diagnosed with hypertension, congestive heart failure, and diabetes than Caucasians. When asked about screening for hypertension and risks for coronary heart disease, similar percentages were reported by African American males and Caucasian males. Similar percentages were also reported by African American females and Caucasian females, but the percentage for females was greater than for males. The cause of the disparity between African Americans and Caucasians is not clear but may be related to socioeconomic status and behavior choices such as irregular exercise participation and medical checkups. Racial health disparities have been reported to be due to socioeconomic status, health care access, and lifestyle choices, especially those related to dietary consumption patterns.^{36,37} In fact, socioeconomic status has been shown to have a much stronger association with disease prevalence than race and/or ethnicity.³⁸ This may have influenced the degree of health disparities reported in this study as all group earnings were well below the average income of households in the United States.³⁸

African Americans participated in 30 minutes or more of exercise 3 days a week less often than Caucasians, with females participating less than males and African American females participating less than any of the other groups. Fewer African American males had received prostate cancer exams than Caucasian males; fewer African American females had received breast cancer exams than Caucasian females. However, more African American males stated that they have health care access when needed and that they had never or it did not apply that they had put off doctor visits due to cost. Although the African American males reported that

they found health care access and care provided quite favorable, they listed as the place that they most often go to get health care as the emergency room. This suggests that their care expectations are different than other groups and the likelihood that they do not seek health care as often as other groups. This is supported by the literature, as African American males are reported to be significantly less likely than Caucasian males to see a physician, and 45% of African American males do not have a doctor they see regularly.³⁹ This may be due to the fact that African American males are also more likely to be uninsured as 28% of African Americans were uninsured, compared to 17% of Caucasians. Further, an examination of how different groups of men use Medicare shows that even when health insurance and income differences are accounted for, African American males receive fewer preventive services than Caucasian males.³⁹

African American females were more likely than the other groups to change some of their health behaviors according to data in this study. They are more responsive to physician recommendations, as more African American females changed their diets and tried to improve their relaxation habits due to physician recommendations. While African American females appear to be more willing to make changes related to medical advice, they do not readily change physical activity and cooking patterns. This finding is partially supported by a study of African American female arthritis patients aged less than 60 years of age who were reported to be more likely to take health improvement action based on physician recommendations than Caucasian females.⁴⁰ The literature is replete with studies which report that African American females exercise less than other races and genders.^{13,15,41}

A limitation of this study is that the sample of African American males is much smaller than the other samples. This was related to the fact that participants were

Table 6. Factors Such as Finance and Education that Influenced Participants Health Practices (N = 1 605)

Questions (% of Respondents With Listed Answer)	African American Males	Caucasian Males	African American Females	Caucasian Females
	N = 44	N = 346	N = 259	N = 956
I do not have health insurance.	45.5 ^{a#}	34.6 ^b	43.4 ^a	30.9 ^b
Financial assistance for medical services — used	15.4 ^a	8.6 ^a	28.3 ^b	12.9 ^a
Insurance is Medicaid only — including Medicaid HMO	40.9 ^a	24.5 ^b	32.4 ^b	30.4 ^b
My insurance offered through my employer or that I have individually	47.7 ^a	57.3 ^b	54.0 ^{a,b}	55.9 ^{a,b}
Does your insurance cover prescriptions? Yes	84.6 ^a	70.1 ^c	72.0 ^c	72.7 ^c
How many total months over the past 3 years have you had no health insurance? None	84.2 ^a	84.5 ^a	67.2 ^b	83.3 ^a
What was the highest grade you completed in school? ≤12th grade	61.9 ^{a#}	48.5 ^b	54.0 ^{a,b}	48.6 ^c
Do you own or rent your home? Own	76.7 ^{a#}	91.2 ^b	65.5 ^c	89.9 ^b
What is your current employment status? Working full time or retired not working	75.6 ^a	82.4 ^a	66.3 ^b	63.3 ^b

^{a,b} Means with the same letter are not different at p < .05.

[#] Ethnic groups are different at p < .05.

stratified randomly selected from the identified parishes and the African American males had a low return rate. Follow-up phone calls were made to many African American males, but their response was minimal.

CONCLUSIONS

The hypothesis tested in this study that African Americans' perceptions of their health and health status were different than those of Caucasians and were partially responsible for the health disparity between African Americans and Caucasians is partially supported. The health perceptions held by African Americans are often different than those of Caucasians, and are frequently not consistent with their health status. This is especially true for African American males. Their perceptions appear to influence the value they place on health behaviors, which may be partially responsible for their reduced health status. However, further study is needed to validate the findings from this study, but these data further suggest that helping African Americans, especially African American males, to better understand and appreciate the connection between good health practices and health may aid in reducing the health disparity between African Americans and Caucasians.

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