Health Disparities Teased Out Between Elderly Blacks, Whites

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SAN FRANCISCO — Several analyses of data from a longitudinal study of 3,075 elderly African American and white patients have helped identify some of the causes of health disparities between races in older adults, sometimes with surprising results.

Investigators presented their findings in a joint session at the annual meeting of the Gerontological Society of America. The results can inform the clinical care of older African Americans, several speakers said.

For example, depression was strongly associated with widespread bodily pain in African American men, but not in white men. Socioeconomic status played a big role in racial disparities in death rates. Lung function did not seem to influence racial differences seen in physical performance, contrary to expectations.

All of the studies analyzed data from the Health, Aging, and Body Composition (Health ABC) study of 3,075 well-functioning, community-dwelling adults aged 70-79 years at baseline in 1997-1998. The cohort was 42% African American and 48% female and resided in Memphis or Pittsburgh. They were followed with annual clinic visits and interim 6-month phone calls for the first 6 years.

Widespread pain was present in 8% of women regardless of race and in 3% of African American men and 4% of white men. Socioeconomic status played a big role in racial disparities in death rates. Lung function did not seem to influence racial differences seen in physical performance, contrary to expectations.

Overall, the GDS screen found 41% of residents with probable depression, PHQ-9 found 42%, and MDS 2.0 found 17%.

When the investigators used a measure of agreement (kappa scores), the PHQ-9 had significantly higher agreement with the validated standard than either the GDS or the MDS 2.0 did. In fact, the MDS 2.0 assessment was less accurate than if the results had happened by chance, Dr. Saliba said.

Contrary to the expectations of many, the PHQ-9 did not lead to more classification with depression,” she said.

Not only was the PHQ-9 tool more accurate than the GDS screen, but it also took less time to complete: 4.9 minutes for the PHQ-9 vs. 11.4 minutes for the GDS.

A majority of the residents, including the large number with cognitive impairment, could complete the PHQ-9, Dr. Saliba said.

The findings suggest that standardized mood assessment of older adults could be performed more effectively with the PHQ-9 than with the GDS or MDS 2.0, although more research is needed to confirm the results.

“We hadn’t expected it to be quite so favorable for PHQ-9,” she said. “But it is often difficult for older adults to reduce their life experiences to yes or no questions.”

Lung function had little bearing on differences in physical functioning,” between races, Dr. Thorpe said. “This was contrary to our expectations.” He speculated that other factors that might explain these disparities could include perceived discrimination, residential segregation, or other socioeconomic dimensions.

Amiette Koster, Ph.D., and her associates at the National Institutes of Health, Bethesda, Md., studied data on 2,937 patients with 8 years of follow-up in the Health ABC study to look at mortality rates and causes. A previous report in 2003 found that age-adjusted all-cause death rates were 30% higher and life expectancy was 2 years shorter in African Americans, compared with whites.

In the current study, half of the African American patients and 23% of whites died during 8 years of follow-up. After demographic variables were adjusted for, African Americans had a 60% higher risk of mortality than did whites.

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In the current study, half of the African American patients and 23% of whites died during 8 years of follow-up. After demographic variables were adjusted for, African Americans had a 60% higher risk of mortality. Socioeconomic factors explained about 60% of this difference, Dr. Koster said, and behavioral factors explained another 30% of the difference.

Factors assessed included education level, income, social support, smoking, body mass index, self-rated health, and having supplemental health insurance in addition to Medicare.

After adjusting for both demographics and socioeconomic status, African Americans still had a 25% higher risk of mortality, she said.

A 60% increase in risk of death from coronary heart disease in blacks, compared with whites, resulted primarily from socioeconomic status, which accounted for 96% of the increase. Socioeconomic status explained nearly a third of the 75% increase in risk of death from cancer in blacks, and the lack of supplemental health insurance accounted for 18% of the cancer death risk increase, she added.