I. ADVANCING THE HEALTH OF ARAB AMERICANS: KEY POINTS TO OBTAINING RESOURCES AND ESTABLISHING PROGRAMS FOCUSED ON SPECIAL POPULATIONS

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Racial and ethnic status contributes to health disparity in the United States, a reality that has been demonstrated in many studies.[1] To eliminate these disparities, a disease prevention and health promotion objective of *Healthy People 2010*, research and targeted programs are required.[1] The body of research presented in this journal on the health of Arab Americans indicates that this special population suffers health disparities. Having a distinct minority status or census category at the national level on which to base research, funding allocations, and targeted programs to reduce health disparities. However, Arab Americans are not classified as a minority or included in the US census as a separate category, thus little to no national data are collected on Arab Americans as a sub-group or special population of the United States. Nonetheless, the absence of minority status or census category does not prevent advancing the health of Arab Americans. What, then, is the course for Arab Americans, or for any other special population in the same position? This article and the presentation on which it is based discuss why and how advancing the health of Arab Americans, a "non-minority" minority in the United States, is possible and clarify the relative importance to this objective of minority status, the availability of national data on Arab Americans, and the use of race and ethnicity data.

Unofficially Arab Americans are a minority of the US population. At present, based on the 1990 census, an estimated one million Americans identify themselves as Arabic, although the Arab-American Institute (AAI) in Washington, DC estimates the number to be closer to three million.[1] The Census Bureau has designated the Arab-American Institute as its only Census Information Center dedicated to analyzing data on the Arab-American community, and it participates in the Working Group on Ancestry in the US Census Bureau.[2] That Arab Americans are a minority within the US population is clear from these numbers, whether one or three million, even though they lack official minority status. This circumstance is, however, not a bar to advancing the health of Arab Americans.

Race and ethnicity data can be obtained from the US Census. Currently the Census, all federal programs, and every form or application one can imagine identify five categories for data on race or ethnicity from which to choose. The category of "White" or "a person having origins in any of the original peoples of Europe, the Middle East, or North Africa" is the only one available for those that identify themselves as Arabic. Thus, census and other federal data on Arabs are commingled with those of Europeans and anyone else who selects "White." Before the 2000 decennial Census, the Office of Management and Budget announced that it was revising its standards for the classification of federal data on race and ethnicity and invited input. For anyone who self identifies as Arabic, the matter seems simple. However, input on whether to add a category of Arab/Middle Eastern did not result in an agreement on a definition for this category. Even so, write-ins on the long form census to the ancestry question were agreed to continue so that data on persons who identify as Arab can be collected. Further research will be conducted on this issue. Thus, revised standards went into effect for the 2000 census and will remain in effect until revised again.[2]

The categories are a minimum and

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are the first basis developed to improve the collection of data. Federal agencies and those at the state level that receive federal funding can collect data according to other classifications, should they wish to do so. Reflecting this national policy for health-related matters, former Secretary of the Department of Health and Human Services (DHHS) Donna Shalala established a DHHS-wide policy to encourage the inclusion of subgroups when such inclusion improved the usefulness of the data.[2]

However useful the categories of race and ethnicity on the census and other data collecting forms are, the importance of and uses for the data categories are ultimately social and political and not scientific or anthropologic in nature. The standards have been developed to provide a common language for uniformity and comparability in the collection and use of data on race and ethnicity by federal agencies. Data on race and ethnicity are used for a variety of purposes, including statistical data collection, administrative records, research, evaluation, applications, grants, contract proposals, and reporting systems for civil rights compliance. Federal funds recipients are required to maintain and to make available to the DHHS racial and ethnic data showing the extent to which members of minority groups are beneficiaries of and participants in federally assisted programs.

Key for those who wish to advance the health of Arab Americans is that one use of data is reporting for civil rights purposes. The Civil Rights Act of 1964 states that race, color, national origin, age, sex, disability, or religion may not be the basis of discrimination. Therefore, in the absence of minority status, or a Census category, and national data on Arab Americans, the Civil Rights law stands to ensure that Arab Americans are not the subject of discrimination in any area and that includes health. Minority status is not a condition precedent to protection under this law. Each federal agency has an office of Civil Rights to enforce this law, as does the DHHS. One may file a complaint there to seek redress within 180 days from date of alleged act of discrimination.

Alternatively, groups who feel they have been the subjects of discrimination, either directly or in the application of a program, can bring the situation to the attention of the authorities in question and seek an equitable result. Indeed advocacy should always be the first step; it can be extremely effective and have other positive consequences. There are numerous cases in which Arab-American businesses successfully sought to obtain a share of government contracts in situations in which no Arab-American company had done so. The State of Michigan Office of Minority Health provides an exemplary story of how the health of Arab Americans can be advanced and resources allocated, even though Arabs and Chaldeans are not a minority for federal purposes.[2] Therefore, data specifically on Arab Americans are not necessary to receive health-related benefits if, otherwise, Arab Americans are not receiving their proportionate share of the government benefit in question. Were government officials unwilling to address the concerns of these Arab Americans, the Civil Rights Law would still have been available for a lawsuit.

The nature and scope of health-related benefits is broad and directs that ill persons in the United States have a right to receive health benefits, which include research and program funding, and participation in programs in a non-discriminatory manner from federal, state, and local social and health service agencies, hospitals, clinics, nursing homes, or other agencies receiving funds from the federal government. In this area, it is important to bear in mind that substantial federal funds and benefits are administered by states and municipalities. Federal financial assistance programs include Medicaid, Medicare Hospital Insurance (Part A), Public Health Service grants, Aid to Families with Dependent Children, funds given to a facility (such as a hospital, clinic, or social service agency) or an individual service provider (such as a doctor or dentist) by the government. Social Security benefits, Supplemental Security Income, and Medicare Supplemental Medical Insurance (Part B) are not considered federal financial assistance when applying the Civil Rights laws.

Substantial support and guidance are available to those who wish to advance the health of any sub-population such as Arab Americans, especially if the project is in the areas of infant mortality, HIV/AIDS, diabetes, cardiovascular disease, obesity, physical activity, and tobacco use prevention, which have been identified as key areas in *Healthy People 2010*.[2] Several programs are available to support efforts to increase services to special populations at the federal level, including the Office of Minority Health, which lists state liaisons and departments.[2] It has published an excellent guide on strategies to reduce disparities in health and a tool to assess what your state offers.[1] The four top priorities identified as essential to minority health infrastructure are data collection and analysis on specific populations, cultural competence, access to health care, and the development of health professionals.[3] Other federal agencies such as the National Institutes of Health and the Substance Abuse and Mental Health Services Administration among others target programs to minorities.[3] Again, even though the titles of these offices contain the term minority, Arab Americans need not be reluctant to seek their services.

To augment these existing programs to reduce health disparities in general, Arab Americans should take the lead in setting their own priorities and distinguishing their health needs from those of other sub-populations in America. Several suggestions are offered as to how this may be accomplished. At a national level, concerted efforts are needed to settle the Census category issue and to develop public education programs to inform Arabs on the importance of responding to the Census. The Census work of AAI should be supported. In addition, the DHHS has a Data Advisory Council under the office of the Assistant Secretary of Planning and Evaluation and a Minority Health Advisory Committee (MHAC). The MHAC will have met before the time of this publication to hear public comments on health issues of racial and ethnic populations.[3] Effort should be made to contribute to meetings like this one and at other opportunities to inform the process by which the DHHS establishes programs and determines funding priorities for minority populations.

Arab Americans may also wish to produce a report on the health of Arab Americans as a means of setting their own health objectives and priorities, as the South Asian community did.[3] This step would be important in distinguishing overall the goals for Arabs that may be different from other minority communities and is essential to allocate federal funding. Some basic elements that may be included in such a report are to identify the Arab-American social and cultural constructs; the etiology of their health and illness; the consequences of poor health for Arabs; the links between science and practice to improve prevention, treatment, and health services; and the ethical issues in research in Arab-American populations. Given that many Arab Americans are recent immigrants, the report may detail the health situation of countries of the Arab world so that US healthcare professionals may be better informed and capable of treatment and care. This direction for the report may also inform foreign policy makers when considering aid programs for the Arab world.

Neither the absence of minority status nor a separate Census category is an impediment to the advancement of the health of Arab Americans. The Civil Rights law assures that Arab Americans can receive health-related benefits. A number of steps can be taken to succeed. These steps are organized advocacy efforts aimed at settling the Census category issue, contributing when the Department of Health and Human Services addresses health issues in racial and ethnic populations, developing formal relationships at state and federal levels to ensure that there is no discrimination against Arab Americans in fact or result, and to set an Arab health agenda for Arabs at home and abroad.

REFERENCES

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