Effect of Race Category Redefinition on Hypertension and Hypercholesterolemia Prevalence in the Behavioral Risk Factor Surveillance System, 1999 and 2001

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BACKGROUND

For decades, race and ethnicity data have been collected and used in medicine and public health to identify US populations with an increased risk for disease or risk behaviors, particularly for chronic diseases such as cardiovascular disease, stroke, and hypertension. Race and ethnicity data have influenced policy decisions, culturally sensitive health programs, legal cases, and research development.1

Over time, racial categories used by government surveys have changed. However, these defined racial constructs are quickly being blurred by interracial and interethnic marriages in the United States. The increasing emergence of racially mixed people has caused a reexamination of the construct of racial identity as well as the inclusion of ethnicity in data collection instruments in the United States.1,2

In 1997, for the first time, the Office of Management and Budget (OMB) allowed people to select more than one race category on federal data collection surveys to account for the increasing number of people with multiple racial heritages.3 Another change was the separation of the category of Asian/Pacific Islander into two categories: Asian and Native Hawaiian/Other Pacific Islander. These standardized race/ethnic category selections were added to the Behavioral Risk Factor Surveillance System (BRFSS) in 2001.

We believed that the addition of the multiracial category to the BRFSS in 2001 might have influenced the prevalence of two main cardiovascular risk factors—hypertension and hypercholesterolemia—among the adult population in the United States. Examining any shifts in prevalence could yield important information about the racial/ethnic populations most in need of primary and secondary interventions. Approximately one in four American adults has high blood pressure (HBP), or hypertension,4 which is defined as systolic blood pressure (SBP) ≥140 mm Hg, diastolic blood pressure (DBP) ≥90 mm Hg, or use of an antihypertensive medication.5 High blood pressure (HBP) remains a major public health problem, even though effective therapy has been available for >50 years.5,6 High blood pressure (HBP) is a major risk factor for heart disease and stroke, end-stage renal disease, and peripheral vascular disease, as well as a chief contributor to adult disability.7

Healthy People 2010 objectives for the nation (objective 12–14) include reducing the proportion of US adults with HBP and increasing the proportion of US adults with controlled blood pressure (BP).8 Over the last decade, however, personal awareness of having HBP and prevalence of physician-diagnosed hypertension increased for Blacks, Whites, and Hispanic populations, although both measures were lower in Hispanic populations than in other racial/ethnic groups.9,10

The other major risk factor for heart disease, high blood cholesterol (HBC) or hypercholesterolemia, is defined as...