CCA – Health and Wellness[1]

Sectoral coverage

The Health and Wellness sector of this Long-Term Strategic Plan (LTSP) encompasses: *Medical products, appliances, and equipment*; *Outpatient services*; *Hospital services*; and *Public health services*. These elements cover the range of goods, services, and activities that are associated with the production of high-quality health outcomes. The operative term here is "production." Therefore, it is important to consider the production of health outcomes in the US in its proper context.

It is no secret that the US expends nearly 20 cents of each dollar of total value added (gross domestic product (GDP)) on health.[2] This fact, in and of itself, is a sign that something is amiss with the production of health and related outcomes in the US. It is apparent that those responsible for planning and managing the economy view the health sector as fertile ground for expansion and growth—to create jobs, income, and wealth. Therefore, a considerable amount of energy and effort is expended to ensure that citizens who become, or who are made to become, sick are "diagnosed and treated." Many players get in on the action including: The range of highly "qualified" medical professionals (from the nearly endless list of physicians (medical doctors), who have specializations, to laboratory scientists and technicians, to a spectrum of nurses, etc.); nonprofessional medical workers; managers of health-related operations; producers of medical supplies (including pharmaceuticals), machinery, equipment (including robots), and their research and development staffs; construction workers who build hospitals, clinics, and other types of healthcare delivery centers; agricultural workers who supply food to the health industry; media and advertising workers who market health-related goods and services; other support services, including workers who manage medical waste; educators who prepare health and health-related workers to perform their tasks; and health insurance industry personnel. A search of the historical record will show that the health industry continues to grow persistently, and there is seemingly an endless flow of new diseases and conditions that require medical "diagnosis and treatment."

In contradistinction to the above-described healthcare system, it is common knowledge that, in the Afrikan healing tradition, health concerns are addressed in a holistic manner, and that natural remedies are effective in treating many ill-health conditions. Even after our capture and imprisonment/enslavement in the US, Black Americans continued to use natural remedies in response to illnesses because we were denied access to or could not afford professional medical services. Certain natural remedies that were brought from Afrika and updated in the New World were stolen by Whites and used to generate untold income and wealth. As importantly, Black Americans have been significant players in the healthcare industry—serving as inventors of new medicines and health equipment, procedures, and treatments.

Logic tells us that it is appropriate to question the current intent, design, and operation of the US healthcare system, and to rethink our involvement in it. As we push toward greater independence and self-determination using this LTSP document, we should have a plan concerning how we want to configure our healthcare system to achieve excellent health and wellness. This Common

Country Analysis (CCA) represents such a plan. Like the other CCAs in this document, it contains a plan that spans 100 years. Our ultimate, overarching goal for the Health and Wellness plan is:

> **Own and operate (control) a comprehensive and effective Black American health and wellness system in our areas of influence that is Afrocentric and that reflects a "prevent, fortify, and flourish" paradigm. Through well-being surveys, Black Americans rate our health and wellness as #1 in the world, and this is substantiated by comparative statistics. Black Americans also convey through well-being surveys that plans to provide future health and wellness in our areas of influence are sound and sufficient.**

Note that this Health and Wellness CCA is not intended to address the full spectrum of health issues (training, diseases, diagnoses, treatments, logistics, financing/insurance, etc.) in detail. Rather, it addresses selected and very important health and wellness concerns with the objective of offering a high-level strategic plan that will enable Black America to reach the forestated overarching goal.

Status of Black America's Health and Wellness

Statistics

The following are key statistics that characterize Black America's health and wellness. Initially, a comparison is made of what some might describe as the most meaningful health and wellness statistic: Life expectancy at birth. In this case, a comparison is made between Black American outcomes in 2020 versus statistics for the nation that reflects the longest life expectancy, Japan. Afterwards, statistics are provided on the most prevalent causes of Black American deaths. The section includes other important statistics and concludes with an analysis of adverse conceptual aspects of the healthcare system in the US as a set up for how—in self-determined areas of influence—those adverse health and wellness outcomes can be improved. The latter will be presented in the section entitled, "Sectoral needs and rationale."

Table 7. Life Expectancy at Birth for the US and Best in the World, 2020

Line No.	Groups	Life Expectancy at Birth in Years		
		All genders	Females	Males
1	Non-Hispanic Black Americans 2020*	71.8	75.7	68.0
3	US Overall 2020*	77.3	80.2	74.5
4	Best in the World - Japan 2020**	84.7	87.7	81.6

Sources: *, ** See endnote 3.[3]

Table 7 shows that for 2020, Black American life expectancy at birth trails the world's leader, Japan, by 12.9 years: 12 years for Black females and 13.6 years for Black males. When compared with US averages, the gap for Black Americans is 5.5 years overall; 4.5 years for Black females, and 6.5 years for Black males.[4] These data enable an assessment of how Black America's quality of life results in significantly reduced well-being (years of life) and is indicative of how our well-being (life span) can be extended by improving our quality of life.

Given differences in life expectancies, it is important to consider differences in causes of death. Table 8 presents the top 10 causes of death for Black American females and males compared with those for females and males for the nation overall.

Table 8. Top 10 Causes of Death for Black Americans, 2018

Line No.	Causes of Death	Percentage of Total Causes			
		Non-Hispanic Black Females	US Females	Non-Hispanic Black Males	US Males
1	Heart disease	23.0	21.8	24.1	24.3
2	Cancer	21.2	20.5	19.7	21.6
3	Strokes	6.5	6.2	5.0	4.3
4	Diabetes	4.5	2.7	4.4	3.3
5	Alzheimer	3.9	6.1		2.6
6	Accidents	3.7	4.3	7.9	7.4
7	Respiratory disease	3.6	6.1	3.3	5.2
8	Kidney disease	3.0	1.8	2.7	
9	Septicemia	2.2	1.5	1.7	
10	Hypertension	2.0		1.7	
	Homicides			4.5	
	Suicides				2.6
	Influenza/Pneumonia		2.2		2.0
	Liver disease				1.9

Source: See endnote 5.[5]

Table 8 shows that the top three causes of death are relatively consistent across all groups considered; that Blacks die from diabetes more so than non-Blacks; that accidents and respiratory diseases are significantly larger causes of death for males than females; that hypertension is a significant cause of death for Blacks, but not for non-Blacks; that homicides are an important cause of death for Black males and that suicides are an important cause of death for non-Black males; and that the nation's non-Blacks die at a much more significant rate from influenza/pneumonia and Liver disease (especially males) than Blacks. The key takeaway for Black Americans is that we can extend our lives if we can reduce health issues related to heart disease, cancer, strokes, and diabetes with respect to both genders, and focus on reducing accidental deaths and homicides among Black males.

There are two other important health and wellness-related statistics worthy of consideration: The prevalence of obesity among Black Americans and the stress/anxiety that we endure while living Black in America. According to the Center for Disease Control and Prevention (CDC), obesity is associated with higher incidence of heart disease, strokes, and diabetes, the importance of which as causes of death is highlighted in Table 8.[6] The CDC reports that "Non-Hispanic Black adults (49.9%) had the highest age-adjusted prevalence of obesity…" of all groups surveyed.[7] On the impacts of stress and anxiety, psychologists are quick to conclude that anxiety can be stressful, and affects our physical and mental health. Stress, experienced in sufficient dosages and compounded persistently (i.e., chronic stress) over time, can kill.[8] Therefore, to improve and

preserve our lives going forward, it is important that we attack and reduce obesity and adopt methods and behaviors for reducing anxiety/stress.

Before concluding this statistical subsection, it is important to cover two important causes of death not noted above: They impact pregnant mothers and fetuses. Black Americans are overrepresented in the rate of pregnancy related deaths, and we outpace other racial and ethnic groups in the nation in infant mortality. The CDC reports that, of over 1,000 pregnancy related deaths examined across 36 states during 2017-2019, Black American females accounted for 31.4 percent (we accounted for less than 14 percent of the population during the period).[9] Also, the CDC reports that, for 2019, there were 10.6 infant mortalities for every 1,000 live births among Black Americans—nearly twice the rate for the nation.[10] Clearly, to sustain our population and its growth, we must do more to improve the rate of successful pregnancies and to prevent infant mortality.

The foregoing statistics and condition descriptions provide a snapshot of Black America's health status. But beyond identifying diseases and conditions that reduce our life expectancy and cause our deaths, there are conceptual aspects of the existing US healthcare system that contribute to our less-than-optimal health and well-being. They are addressed below.

Adverse conceptual aspects of US healthcare

The following descriptive statements concern conceptual aspects of the US healthcare system. The objective is to highlight these concerns, and then to address them systematically in the "Sectoral needs and rationale" section of this CCA as part of designing a plan for generating excellent health and wellness in our self-determined areas of influence.

- **"Diagnose and treat" versus "Prevent, fortify, and flourish."**—An Afrocentric health and wellness paradigm is holistic. The operating assumption is that all aspects of the universe, including the human body, are designed to work perfectly when correct conditions prevail. Physically, the human body is configured to operate properly when correct and healthy nutrition (foods and fluids) enters the body in the correct proportions and at the correct intervals, when the organs and mechanical aspects of the body are used properly, and when the body operates in a proper environment. The human body and mind work properly when they are not overtaxed and are permitted to alternate between focused activities and calming and healing relaxation. When the body and/or mind of a human malfunction, then all aspects of the environment in which the human exists are examined to determine what has forced a perfectly functioning organism to malfunction. Consistent with this Afrocentric conceptual health and wellness framework is the belief that efforts should be made to prevent malfunctioning of the human body and mind by fortifying them with the already outlined and essential requirements. If essential requirements are in place, then the human body and mind can experience an uninterrupted and flourishing life. In the US healthcare system, the socioeconomic conditions of Black Americans are such that, to date, it has been difficult to adhere to this Afrocentric paradigm, and the environment is often toxic. Therefore, our bodies and minds malfunction. When they do, we are ushered into a healthcare system that simply inquires of the person with a malfunctioning mind/body: Where does it hurt? What does not feel right? Based on answers to these

questions, the medical practitioner may perform tests or scans to diagnose the problem. When the problem is identified, the practitioners cause the malfunctioning mind/body to undergo predetermined treatment that is aligned with the diagnosis—with pharmaceuticals as a primary component of the treatment. Clearly, there is nothing holistic about this approach to "healthcare." Consequently, our health and wellness plan recommends moving from a "diagnose and treat" paradigm to a "prevent, fortify, and flourish" Afrocentric paradigm.

- **Healthcare provision locales.**—It is common knowledge that hospitals are not always the most favorable places to receive healthcare. Hospitals are the home of diseases and harmful bacteria that can cause illness and death. While healthcare demand and related prices have forced the US healthcare system to reduce the length of hospital stays, too many patients go to hospitals to receive healthcare and remain there too long. In response to this situation, over the last few decades, new recovery or convalescence centers have entered the healthcare system. Typically, very low technical levels of healthcare are administered in these facilities—the type of care that could be administered at home. An Afrocentric approach to health and wellness is to only remove a body/mind that is malfunctioning from its well-known, most comfortable, and healthy/clean environment when absolutely necessary. Also, given the role of family and community in an Afrocentric model, a body/mind is expected to benefit most during a recovery process when ensconced in a home environment and with the people who love, care, and will shower it with the attention and support that speeds recovery. Therefore, the health and wellness plan outlined in this CCA calls for movement from healthcare provision mainly outside of the home to more home-centric healthcare arrangements.
- **Hierarchy of healthcare providers.**—The US healthcare system reflects a highly hierarchical structure. The Afrocentric health and wellness paradigm featured in this CCA is based on a much flatter hierarchical structure. This reduced hierarchy is expected to precipitate reduced errors in healthcare delivery, an acceleration in the delivery of healthcare, an increase in efficiency in healthcare delivery (i.e., reduced costs), and improvements in overall healthcare outcomes. In addition, along with revisions to the hierarchical structure of the healthcare delivery system will come revisions to the related personnel and the associated fundamental point of emphasis in the system.
- **Healthcare financing.**—Healthcare financing in the US is complex. Healthcare recipients face a variety of payment options at the service delivery point; they have many choices in insurance coverage; and they may experience complications in receiving preferred treatment due to the type of insurance coverage selected. Too many Americans have no healthcare financing at all. Healthcare providers face a complex matrix of insurance companies and prices, and they must account for this in service delivery in the context of profitability requirements. Also, healthcare delivery is affected significantly by the litigious nature of the US socioeconomic system, and healthcare providers' need to protect themselves with insurance that is often very costly. The Afrocentric approach to healthcare financing in communal-based Black American areas of influence is to employ a single-payer health and wellness financing system.

The four health and wellness concerns just elaborated will be considered and addressed in the next section.

Sectoral needs and rationale

This section reflects on, and addresses from an Afrocentric perspective, the health and wellness statistics and conceptual concerns delineated in the previous section. No attempt is made to be fully prescriptive. However, the 100-year plan that appears at the end of this CCA in tabular form makes provisions for health and wellness Responsible Parties to develop such prescriptive plans using the broad directives presented. Together, the directives immediately below and Responsible Parties' detailed plans can ensure that Black America achieves a state of excellent health and wellness (well-being) in our self-determined areas of influence.

The life expectancy statistics presented in the previous section make clear that Black America has a challenge to reach #1 in the world status. But, barring genetic barriers, we can and should expect to live lives as long as those of any other racial or ethnic groups on planet Earth. We can achieve this primarily by working to lower the current top four causes of death for Black Americans: Heart disease, cancer, stroke, and diabetes. It is also important that we reduce deaths caused by accidents and homicides for Black males. Again, all of this is achievable.

Common knowledge and exposure to trained medical practitioners in the US causes one to know that there are a few significant and critical contributing causes to the top four causes of death among Black Americans: (1) Black Americans, across the board, must recognize the proper role of food and fluids as nutrition and medicine for our bodies, and learn to consume appropriate foods and fluids in correct proportions and at correct intervals (with this recognition and appropriate responses, rampant obesity should disappear from the Black American landscape); (2) we must reduce our consumption of alcohol and make H_2O (water) our fluid of choice; (3) we must make every effort to eliminate cigarette smoking from our behavior; and (4) we must regain our propensity to move (exercise) from the cradle to the grave (a sedentary lifestyle is a prescription for death).

Another important contributor to the top four causes of Black American deaths is anxiety/stress. There is no doubt that "living while Black" in America is a stressful and anxious experience that we endure. However, as Black America comes to own and control our areas of influence, use our culture to regain our sense of protection and communalism, and evolve a self-sustaining and self-reliant economy, we can reduce our exposure to the stress/anxiety and pressure of living in America tremendously, which will enable us to reap enormous health and wellness benefits.

Importantly, self-determined Black American areas of influence will produce a reduction in pregnancy related deaths and infant mortality. As a revival of our Recreation, Religion, and Culture (RRC) pervades our areas of influence, our sense of family and community will increase, and we will all feel, and be, more secure in our everyday lives. Couple that with improved diets and an Afrocentric health and wellness system that is orchestrated by Black health and wellness practitioners, Black mothers and their infants will be healthier from conception, to delivery, and beyond.

To make all the foregoing a reality, Black America must leverage all the tools at our disposal to inform and promote our Afrocentric health and wellness paradigm in our self-determined areas of

influence including educational curriculums, RRC workers, economic and business operations, and media platforms.

The following points address the four health and wellness conceptual concerns that were discussed in the previous section. They are considered in reverse order.

- **Healthcare financing.**—The Afrocentric approach to healthcare financing in communal-based and self-determined Black American areas of influence is a single-payer system. All parties involved (workers, business owners, governance, and healthcare providers) must commit to the system to ensure that sufficient contributions are made and that resources are available to finance our health and wellness needs. The single-payer system is a collective social security system. Workers and business owners pay into the system. The governance system collects these payments and then uses them to finance healthcare needs. While some single-payer systems have earned a bad name, they work well in places where the population is homogeneous and all parties in the system act to ensure that: The entire system works by being committed to sound health and wellness practices; and that delivery of care is as economically efficient as possible. Such homogeneous population settings are typically less litigious (everyone is everyone else's cousin) and regulatory requirements (especially malpractice insurance) are less onerous. Most importantly, the commitment by all members of these homogeneous populations to practice good health and wellness lifestyles ensures that healthcare requirements are minimized. Black America's homogenous areas of influence will reflect these types of favorable conditions for a single-payer system. Also, it is well known that single-payer systems are significantly less complex than multi-payer systems, and that the former generate tremendous savings in administrative costs alone.
- **Hierarchy of healthcare providers.**—Our proposed health and wellness delivery system will feature an optimally-tiered hierarchical structure and a reassignment of the fundamental point of emphasis. Consider Table 9, which reflects the proposed versus existing structure of the system.

Table 9. Comparison of Proposed vs. Existing Healthcare Delivery System Structures

New Afrocentric Health and Wellness System		**Existing System**	
Tiers	Personnel	Tiers	Personnel
1	Physicians of all specialties and Physician Assistants	**1**	**Physicians of all specialties**
		2	Physician assistants
2	Technicians who operate medical technology	3	Technicians who operate medical technology
3	Nurses (ARNs, RNs, and LPNs)	4	Nurses (ARNs, RNs, LPNs)
4	**Health and wellness Advocates/Home health providers**	5	Emergency Medical Technicians
		6	Home health aides/certified nursing assistants

Source: LTSP Panel analytics.

Table 9 shows that the proposed Afrocentric health and wellness delivery system structure has a two-level reduction in tiers from the existing system. Also, the fundamental point of emphasis (symbolized by **red** lettering) changes from a delivery system that is physician-

centered, to a system that builds from the bottom up and emphasizes personnel, who will work directly and most intensively with the body/mind that requires health and wellness improvement.

The proposed Afrocentric health and wellness delivery system will embody the following features: (1) Expanded use of medical, information, communications, and other technologies; (2) self-directed health and wellness to include self-testing, reporting, and record keeping; (3) provision of health and wellness treatment in the home, except where this is absolutely not possible and where treatment must be delivered in clinics or hospitals; and (4) a transformation of the current *Home health aide* to a much more sophisticated and well-trained *Health and wellness advocate*, who will serve as a home healthcare provider with knowledge, skills, and abilities sufficient to perform a wide-range of health and wellness functions, including emergency health services that are typically performed by today's emergency medical technicians.

The reduced hierarchy and other features of the proposed health and wellness system should precipitate: Reduced errors in healthcare delivery; an acceleration in the delivery of healthcare; an increase in efficiency in healthcare delivery (i.e., reduced costs); and improvements in overall healthcare outcomes.

- **Healthcare provision locales.**—As elaborated immediately above, this health and wellness plan calls for movement from healthcare provision mainly outside of the home (i.e., in clinics and hospitals) to more home-centric healthcare provision. This change in healthcare delivery will help reduce the number of Black Americans who do not die from conditions that cause hospitals and clinic visits, but from the unfavorable conditions that prevail in many hospitals and clinics and from preventable adverse events in hospitals and clinics.[11] The plan also seeks to leverage the optimal conditions for healing that exist in home and communal environments where family and friends can shower love and care on those with health and wellness needs.
- **"Diagnose and treat" versus "Prevent, fortify, and flourish."**—This health and wellness plan calls for moving from a "diagnose and treat" paradigm to a "prevent, fortify, and flourish" paradigm. When Black Americans operate primarily in our own areas of influence and learn to love ourselves, each other, and life again, then we will be motivated to adopt sound health and wellness practices wholeheartedly. We will eat and drink what is favorable for us, in the correct proportions, and at proper intervals. We will engage persistently life's rhythms through movement (exercising). The sociopsychological conditions in our areas of influence will be favorable and our mental health will be sound. We will have excellent health and wellness outcomes. These conditions are designed to **prevent** a breakdown in health and wellness. Understanding this, if our bodies/minds malfunction, our health practitioners will follow Afrocentric traditions and examine our environments holistically to comprehend the cause of the malfunction. Identifying reasons for the malfunction, health and wellness practitioners will prescribe solutions widely: For the bodies/minds that malfunction and for all of those in the associated environments. These solutions will serve as another preventive measure. At the same time, our health and wellness practitioners, educators, RRC workers, businesses, and media platforms will be perpetually on the lookout for, and then promulgate, new and/or improved health and

wellness practices that will **fortify** us and prevent future health and wellness malfunctions. All these actions will serve to ensure that health and wellness remain excellent in our areas of influence, and we will **flourish** as a people.

This section provided broad and clear directives that address most of the important Black American health and wellness needs. Adoption of these directives and the associated detailed plans that are to be developed by health and wellness Responsible Parties will ensure that Black America can mount a steep but systematic climb toward becoming a people who can say 100 years hence that they enjoy the best health and wellness in the world comparatively speaking, and that they possess the tools and knowledges to maintain that position far into the future.

Suggested Responsible Parties

The Responsible Parties that should assume the work highlighted in this Health and Wellness CCA should include, but not be limited to:

National Medical Association
National Black Medical Students Association
National Dentist Association
National Association of Black Psychiatrists and Psychologists
National Nurses Association
National Association of Nurses Assistants
National Educational Association
National Association of Black Media Owners
National Association of Black Journalists

Health and Wellness overarching goal and objectives

Following the overarching goal and selected supporting goals of the coordinated and integrated phased 100-year LTSP, Table 10 presents the phased 100-year overarching goal and selected objectives for the Health and Wellness sector.

Table 10. Health & Wellness Phased 100-Year Overarching Goal and Selected Objectives

No.	Phases	Goals and Subgoals
1	Years 1-5 objectives	Ensure that all relevant Health and Wellness sector Responsible Parties are identified, listed, and invited to join this Long-Term Strategic Plan (LTSP) effort; ensure that this Health and Wellness sector is represented appropriately in the General Public Service (GPS) sector and on its National Black Policy Council (NBPC); early in the phase, Health and Wellness Responsible Parties develop a more detailed ten-year strategic plan for implementing this LTSP; initiate collaborations with other sectors to operationalize the Health and Wellness ten-year strategic plan to meet the following objectives/purposes – Education sector (to ensure appropriate training to fulfill the "prevent, fortify, and flourish" (PFF) paradigm and to produce the required cadre of professional and nonprofessional Health and Wellness workers is embodied in new curriculums), Housing and Community Amenities sector (HCA; to ensure that required facilities are constructed in our areas of influence to meet Health and Wellness needs), Economic Affairs sector (to ensure that business and workers in Black areas of influence concur with the need to factor into compensation structures provisions for contributions to fund a single-payer Health and Wellness system, and to ensure that Black America's media operates in full support of the PFF paradigm), Recreation Religion, and Culture (RRC) sector (to ensure that Culture workers in Black areas of influence inform and convince all of our members of the efficacy of adhering to the PFF paradigm), and GPS and Social Protection sectors (to ensure that sufficient financial resources are collected to meet Health and Wellness needs of those who are unable to meet their own needs); and constituent members of national Responsible Parties work to develop and prioritize local Responsible Parties in as many areas of influence as possible across the nation.
2	Years 5-10 objectives	Continue ongoing work from the previous phase; Health and Wellness Responsible Parties intensify efforts with Black businesses (especially the media), journalists, and educators to saturate Black American areas of influence with appropriate Health and Wellness "Do's and Don'ts" messaging; begin a campaign to convince Black Americans to only utilize Black American providers of Health and Wellness care and to convince Black American Health and Wellness providers to prioritize provision of Health and Wellness care in Black American areas of influence; begin to mount national, state, and local pressure to secure more Health and Wellness resources to be expended in Black areas of influence to address "health disparities;" and at the end of this phase, collaborate with the GPS sector to conduct a statistical gathering and well-being assessment survey on Health and Wellness in Black areas of influence.
3	Years 10-15 objectives	Continue ongoing work from the previous phases; early in the phase, Health and Wellness Responsible Parties in collaboration with relevant sectors update, revise, or develop a new 10-year detailed strategic plan for this sector; Health and Wellness Responsible Parties intensify efforts with Black American-owned media firms and Responsible Parties in the Education and RRC sectors to saturate Black American areas of influence with messaging concerning the very important roles of foods, herbs, spices, and movement (exercise) in promoting excellent health and wellness—to include messages about what is consumed and practiced and about the pattern of consumption and practices; and Health and Wellness Responsible Parties collaborate with GPS, Economic Affairs, HCA, and RRC sectors to begin assembling the physical infrastructure, the four-tiered Health and Wellness services delivery paradigm, and the single-payer Health and Wellness system discussed in this CCA.

No.	Phases	Goals and Subgoals
4	Years 15-20 objectives	Continue ongoing work from the previous phases; Health and Wellness Responsible Parties collaborate with all relevant sectors to ensure that not only are forceful Educational and media messages pervasive in Black areas of influence concerning appropriate sources and uses of Health and Wellness care, but also concerning the very important roles of foods, herbs, spices, and movement (the what and how thereof) in generating excellent health and wellness; ensure that Health and Wellness physical infrastructures, the four-tiered Health and Wellness services delivery system, and the single-payer Health and Wellness financial system continue to be assembled in Black areas of influence; and at the end of this phase, collaborate with the GPS sector to conduct a statistical gathering and well-being assessment survey on Health and Wellness in Black areas of influence.
5	Years 21-40 objectives	Continue ongoing work from previous phases; early in the phase, Health and Wellness Responsible Parties update the existing, or develop a new, 20-year strategic plan for execution; in the plan, account for significant improvements in Black America's Health and Wellness and collaborate with the Education sector to begin to reduce the future production of Health and Wellness workers and to prepare existing Health and Wellness workers for new and different careers; collaborate with the GPS, Economic Affairs, HCA, and RRC sectors to plan for redirecting Health and Wellness resources to other industries/sectors; retain certain conserved Health and Wellness resources within the sector to perform research on potential future Health and Wellness challenges; Health and Wellness Responsible Parties establish targets that align with this sectors 100-year overarching goal; at the end of this phase, collaborate with the GPS sector to conduct a statistical gathering and well-being assessment survey on Health and Wellness in Black Americans areas of influence; and use the results of the just mentioned survey to prepare an analytical report on improvements in Black America's Health and Wellness in comparison to the statistics collected at the outset of this LTSP.
6	Years 41-60 objectives	Continue ongoing work from previous phases; early in the phase, Health and Wellness Responsible Parties update the existing, or develop a new, 20-year strategic plan for execution that accounts for improvements in Black America's Health and Wellness and reprograms relevant human and financial resources; review the health targets established in the previous phase and tweak the Health and Wellness strategic plan to assist in meeting the 100-year goal for this CCA; develop and implement a consultative program for other Afrodescendant people to assist them in improving their health and wellness; and at the end of this phase, collaborate with the GPS sector to conduct a statistical gathering and well-being assessment survey on Health and Wellness in Black Americans areas of influence.
7	Years 61-80 objectives	Continue ongoing work from previous phases; early in the phase, Health and Wellness Responsible Parties update the existing, or develop a new, 20-year strategic plan for execution that accounts for improvements in Black America's Health and Wellness and redirects relevant human and financial resources; review the health targets established in the previous phase and tweak the Health and Wellness strategic plan to assist in meeting the 100-year goal for this CCA; at the end of this phase, collaborate with the GPS sector to conduct a statistical gathering and well-being assessment survey on Health and Wellness in Black areas of influence; and use the results of the just mentioned survey to prepare an analytical report on improvements in Black America's Health and Wellness in comparison to the statistics collected at the outset of this LTSP..

No.	Phases	Goals and Subgoals
8	Years 81-100 objectives	Continue ongoing work from previous phases; early in the phase, Health and Wellness Responsible Parties update the existing, or develop a new, 20-year strategic plan for execution that accounts for improvements in Black America's Health and Wellness and redirects relevant human and financial resources; and at the end of the phase prepare a new 100-year Health and Wellness strategic plan for Black America's areas of influence.
	OVER ARCHING GOAL	**Own and operate (control) a comprehensive and effective Black American health and wellness system in our areas of influence that is Afrocentric and that reflects a "prevent, fortify, and flourish" paradigm. Through well-being surveys, Black Americans rate our health and wellness as #1 in the world, and this is substantiated by comparative statistics. Black Americans also convey through well-being surveys that plans to provide future health and wellness in our areas of influence are sound and sufficient.**

[1] This title expands on the title given by the *Classifications of the Functions of Government*, which is simply "Health."
[2] Robert Kornfeld, Micah Harman, Nathan Espinosa, Regina butler, and Aaron Catlin (2020). "A Reconciliation of Health Care Expenditures in the National Health Expenditures Accounts and in Gross Domestic Product." BEA Working Paper Series, WP202-8. https://www.bea.gov/system/files/papers/BEA-WP2020-8.pdf (Ret. 020523).
[3] US life expectancy statistics (nationally and for Non-Hispanic Black) for 2020 are from: Elizbeth Arias *et al* (2020). "Provisional Life Expectancy Estimates for 2020." *Vital Statistics Rapid Release, Report No. 015*. Center for Disease Control and Prevention, US Department of Health and Human Services. https://www.cdc.gov/nchs/data/vsrr/vsrr015-508.pdf; Japan's life expectancy statistics are from the Organization for Economic Cooperation and Development; https://data.oecd.org/healthstat/life-expectancy-at-birth.htm. (Ret. 020523).
[4] Notably, the 2020 life expectancy at birth statistics reflect a COVID-19 impact, which took hold during the second quarter of 2020. The latest available life expectancy statistics for the year 2021 show and even more severe, full year impact from COVID-19. Accordingly, statistics for 2021 are not presented. Data for 2022 were not available at this writing.
[5] Melonie Heron (2021). *"Deaths: Leading Causes, 2018." National Vital Statistics Reports*. Vol. 70: Number 4. Center for Disease Control and Prevention, Department of Health and Human Services. https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-04-508.pdf (Ret. 020523).
[6] Center for Disease Control and Prevention (2023). "Adult Obesity Facts." US Department of Health and Human Services. https://www.cdc.gov/obesity/data/adult.html#:~:text=Obesity%20affects%20some%20groups%20more%20than%20others&text=Non%2DHispanic%20Black%20adults%20(49.9,Hispanic%20Asian%20adults%20(16.1%25). (Ret. 020523).
[7] *Ibid*.
[8] Jennifer Morey, *et al* (2015). "Current Directions in Stress and Human Immune Function," *Current Opinion Psychology*. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4465119/ (Ret. 090622).
[9] Susanna Trost, *et al* (2022). "Pregnancy-Related Deaths: Data from Maternal Mortality Review Committee in 36 US States, 2017-2019." Centers for Disease Control and Prevention, US Department of Health and Human Services. https://www.cdc/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html (Ret. 020623).
[10] Center for Disease Control and Prevention (2020). "Infant Mortality." US Department of Health and Human Services. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm (Ret. 020623).
[11] This statement concerns "preventable deaths" (Preventable Adverse Events (PAE)) in healthcare facilities. This topic carries considerable controversy concerning the volume of such occurrences. Scientific studies during 1999 to 2020 placed the volume of US preventable deaths in healthcare facilities in the range of 40,000 to over 400,000 annually. However, a 2020 study by professors at Yale University, who developed a meta-analysis of previous studies, concluded that previous estimates overstated dramatically the actual volume of preventable deaths. Consult: Benjamin Rodwin, *et al* (2020). "Rate of Preventable Mortality in Hospitalized Patients: A Systematic Review and Meta-Analysis." *Journal of General Internal Medicine*: Vol. 35, No. 7; pp. 2099-2106. doi: 10.1007/s11606-019-05592-5 (Ret. 020723). Note that the just-cited article includes citations to earlier studies. To our knowledge, studies on this topic do not provide statistics on preventable deaths by race/ethnicity.