

MCH EPI Conference

Plenary I: Measuring and Eliminating Racism and Racial Disparities in

MCH:

The Need for New Paradigms

December 8 – 11, 2008

VIJAYA K. HOGAN: Good morning everybody and thank you for inviting me to this session. My job this morning is basically to set the context for this morning plenary session, and I don't have a lot of time to do it. So, I'm going to go really fast so, how do I change these slides? This? Okay. All right, so what I'm going to cover are four things. Basically, what are disparities, because that sets the context for what we're talking about when we're thinking about racism and maternal and child health. What they look like and both of these, you basically have had, but I need to just, sort of, set the context again for those who may not be familiar with the issues. But, last I'd like to spend a little bit more time on talking about what causes disparities and what are some of the challenges we face in public health when it comes to trying to eliminate them.

So, first what are disparities? And, basically, it's when one group of people get sick or dies sooner than another group of people. The NIH has this, sort of, more technical definition where they put it in terms of incidents and prevalence mortality and burden of disease, and specific populations as the reference. And UNC, a group that I worked with at the University of North Carolina has an even more complicated definition that we thought was important. It was developed by

faculty and community people, but we thought it was important; number one, to talk about inequities as opposed to disparities, to talk about some of the causes so that we are clear what you need to do to prevent the problem. And, to talk about the specific populations that tend to have disparate rates of health.

So, our definition is a little bit more complex, but in general African-Americans, Native Americans, and subgroups of Latinos and Asians are more likely to get sick or die sooner than other groups of people. So, what do disparities look like? Again, I'm going to just zip through these, because you're familiar with these. But basically, if you look at life expectancy, blacks have a disadvantage over whites about a ten-year disadvantage. If you look at age adjusted death rates, blacks have a higher rate than other populations in the United States. If you look at infant mortality, African-Americans and Native Americans have higher rates of infant mortality than other groups. If you look at preterm birth the red line is African-Americans much higher rate of preterm birth than other groups of people. You could look at overall health status, in this case, self-reported health. This is fair, people who rate their own health as fair or poor, and again blacks and Hispanics have a much higher rate of fair or poor self-rated health than whites. You can look at risk factors, you see the same trend. You could look at social factors, and in this case what we're seeing is that, this is not working very well, but African-American women who have high education are still more likely to have homeless shelter incidents compared to women, comparable women in other groups and this is from Philadelphia.

So, I could go on and on through a hundred different health outcomes and you'd see basically the same trend. We get that, it's important to acknowledge that disparities exist, but let's get past that and get to the next step, and I would submit that everything that we do in relation to disparity should be to figure out why they exist and what we can do to undo their effects.

So, let's talk a little bit about what causes disparities. First, we have to understand what contributes to health. And, in our case, I'm sorry I haven't got the hang of this thing yet. Individual health is determined by a number of factors that influence it. So, we have to think about these other rings of influence on health including social risk factors, living conditions, neighborhoods or communities, social and economic policies. So, all of these things have an impact on individual health. So, even if we focused just on changing individual behavior, we have to recognize that those behaviors are determined by these other distal factors.

So, when we look at health disparities, we look at some of the factors, these are some of the factors that contribute specifically to disparities. This list comes from, probably one of the most comprehensive reviews that I've been able to find of the literature looking at what factors actually contribute to disparities. This is from Kingdon and Nickens in *America Becoming*. And what they did, basically, was go through the literature and looked for two criteria in the literature. One is,

does the factor contribute to a health outcome? And two, is the factor differentially distributed between the two populations that you're comparing with the vulnerable population having the higher rate of some particular factor. And so, after sifting through numerous factors, this is the list that they came up with where there is strong evidence that these contributes specifically to the disparity. Now, you notice that some things that you might expect to be on here are not, like genetics and that's, because it doesn't meet both of the criteria, and behavior has an asterisk next to it, because it really depends on which behavior you're talking about, and which health outcome you're talking about. So, you can't always assume that health behaviors are major contributors to disparate rates, and specific health outcomes. You have to look at it in its specific context.

So that being said, as the context, I want to quickly go through what are the challenges we as a nation face in eliminating disparities? The first challenge we have is, if we don't know how to prevent or treat a particular health outcome or disease, then we're probably not going to be very successful in reducing the disparity. And, I'll use preterm birth as an example, because that is something we all are familiar with. And, just looking at this slide, we see that our major emphasis for treating or preventing preterm birth is prenatal care. And if we look at the slide, even African-American women who get care in the first trimester that's the black bar, have higher rates of preterm birth than women of any other race who give birth in the second or who get care beginning in the second or the third trimester. So, our major mechanism for preventing this particular outcome

isn't necessarily working. So, we can't really expect to see much change in the disparity.

The second challenge is that we have to address the fact that reducing the disease is not the same as reducing the disparity. So, if we have an evidence-based intervention for a particular disease, we can't just do it faster, stronger, or better among African-American populations, we really have to do something different to address both the disease and the disparity.

And, just to illustrate it, I'm going to try displaying it one more time. If we look at the rates of decline in SIDS, we see that among African-Americans and among whites both, it's declined over this time period that we're looking at. But if you look at the disparity, the disparity really hasn't changed over time. So, it's good that we're seeing declines in the disease, but if we want to eliminate the disparity, we have to do something above and beyond the elimination of the disease. And, we haven't always addressed that factor.

The third challenge is that we really have not distinguished between healthcare and health outcome disparity, and in a lot of the literature around health disparities or around health in general, you'll see the two terms conflated, where in reality, healthcare is just one contributor to overall health disparities. So, if we want to get rid of health disparities, we have to address all of the contributors to health disparities. And, medical care is only one of those factors. We assume it

looks like this, but it's probably a little bit more like this, this being the distribution of the factors that contribute to health disparities and don't take these numbers literally. This is just an estimated simulation based on what we know from the literature.

The fourth challenge is that we don't acknowledge the complexity of the causality picture. And just to illustrate, if we were to compare these two populations on four hypothetical risk factors, they look about the same on face value, if we look at each risk factor individually. But if we look at how many have overlapping risks, there's a huge difference between these two populations, where population B is going to be probably more high risk than population A in general. So, what we're looking at is a subgroup of population who has multiple risks overlapping and interacting, and that's going to give you a more vulnerable population than the first population that we looked at.

And, we know that's the case from qualitative evidence that we've derived, in this case from the Harlem Birthrate Project, we identified stressors, racism, class, gender interactions that adversely impact on women's outcome, multiple stressors that impact on women and multiple burdens that they experience, and the fact that racism exacerbates every other risk. This is from the qualitative evidence.

From quantitative evidence we see, in this example, from Paulette Braverman's data from California, they're equivalent to PRAMS' data. She looked at the number of social hardships in African-American compared to Anglo women and for each hardship that you look at on this list, you can see that the African-American women are more likely to suffer these hardships, but if you look at the bottom where there are multiple hardships, black women are almost twice as likely to experience these hardships as other women. So, again, we have to take into consideration the interaction among some these hardships, and how that impacts on risks.

The fifth challenge is the one that some people find difficult to understand, and I'll try to break it down so that it's understandable. And that is that, when we looked at those rates, say of, SIDS and we saw the decline in the rates, and you saw the difference in the intercepts in those rates, that's really what defines the historical context of these health outcomes. The fact that their intercepts are different, is what defines the disparity and these are determined by historical factors. So, we have to figure out a way to undo that impact so that we can have an affect on the health outcome, and on the rates of the disease. But, we have to deal with those historical factors that created those different intercepts to begin with. And in our context, the historical context of slavery is a big factor that we have to take in to consideration.

One way to think about it, is to imagine a marathon race where you have whites and blacks competing in this race, but the black folks have a 500 pound weight on their leg, and you set the race to begin, and off they go and time passes, generations pass who's going to be ahead and who's going to be behind. These are the historical impacts that we have to face and if you look at this table from a group of researchers at Harvard University, we think that there has been a lot of time to undo those historical effects, but if you think about the over 400 years that people of African decent have been in this country, only 10 percent of that time has been under conditions where we have full citizenship rights, at least on paper.

At least 75 to 80 percent of the time has been under either chattel slavery or under no citizenship rights. So, that is not a lot of time to undo without any assistance, the insults from that initial impact of slavery. And, what does that mean? What it means is, if you think again about that marathon, all of those initial insults translate into current day social conditions and social inequities that have an impact in turn on health inequities.

So, we see differences in median family income and net wealth. The fact that African-Americans are more likely to live in segregated in highly poverty areas, less likely to own homes, and now we're beginning to see higher rates of default on subprime loans that were given to African-Americans. So, the point is that, the historical factors have created the current social inequities that have an impact

on the health inequities that we've seen. And so, this new paradigm is going to have to deal with those historical factors.

The sixth challenge which I've, sort of, been talking about all along is that, social factors are the largest contributor to health disparities. This is not in dispute we know this. The NIH will talk about it, the Institute of Medicine will refer to social factors as being the largest contributor to health disparities. And yet, in public health in general, we don't focus on this. We continually brush it under the rug, because we think it's too difficult, and out of our realm to deal with. This is the problem, because if we're dealing with this issue as a scientific issue, we have to deal with the biggest contributors, and we're not doing that.

And, this is just the list of some of the potential contributors, and I'm going really fast because my time is running out. Continuing that point, we haven't made a lot of progress in reducing disparities, because we've assumed that there exists an evidence base, and it really doesn't exist. And, we haven't really supported the development of the evidence base. We've, sort of, jumped three steps ahead and assumed we just do what we already know how to do in the general population, do it the same among more African-Americans and we're going to have an impact and that's not the case. We have to deal with the disease, and we have to deal with the conditions that contribute to the disparity.

The eighth challenge has to do with the fact of social factors being the major contributor. We generally make decisions about what we're going to do in public health based on feasibility. How feasible is it for us to do a particular action given the money and the time that we have to do it. And so, when it comes to dealing with the factors that contribute to disparities, we generally put them low on feasibility. And so, they get kicked out and we never deal with them, and we continue to do the same things, we deal with medical care, we deal with behavior, and maybe a few other issues. But the social factors, we don't.

And, this is the problem, again, so we have to start thinking about how do we make them more feasible, even if it means incrementally getting to the point where we can deal with them. We have to start addressing them more directly than we have been, or we'll never begin to see changes in disparities. So to summarize, we need better science on the health issues in general, and we need an evidence base specific to eliminating disparities, not just relying on the evidence base for reducing the disease, but we've got to focus on the disparity. We have to look at social causes. We have to take into consideration the multiplicity of risks that we see in vulnerable populations, and how those factors interact to create even more risk. And, we have to address the historical insults, the social factors, and stop using feasibility as an excuse to not address the social factors.

So, in terms of developing a new paradigm for addressing disparities, it is complex, it is going to be difficult, but we've got to begin somewhere to do it. And, we have to do all of the following which includes undoing the historic inequities, undoing social inequities, addressing the systems factors, provider practices, health education, the things that we've been doing all along and improving the relevance of the research that we are doing. And, I just want to leave you with this diagram to understand that when we're talking about disparities, we're just seeing the tip of the iceberg and underneath, we have all of these other problems that we have to deal with. So, if we want to be successful, we've got to begin to tackle these other issues. Thank you.