

MCH EPI Conference

Plenary I: Measuring and Eliminating Racism and Racial Disparities in

MCH:

The Need for New Paradigms

December 8 – 11, 2008

CAMARA JONES: Thank you Wanda, and Atlanta when it rains, the traffic just stops, so that's why I just, sort of, ran up onto the dais right now. With my time, I really hope to accomplish two things, I'm going to at least accomplish one thing, which is to share some data on racism and health that comes out of the CDC. And then, if we have time, I'd also like to share a framework, which contextualizes similarly to what Dr. Hogan did, contextualizes why we as health people should be talking about racism at all.

So, I'd like to acknowledge my collaborators in this work, and start out by providing a global definition of racism. When people ask me, what do you mean when you say racism? I start out by saying that it's a system. So that is, it's not an individual character flaw, it's not a personal moral failing, and it's not even a psychiatric illness as some people have suggested, but it's a system of power, and a system of doing what? It's a system of structuring opportunity and of assigning value. And, on what basis is that opportunity structured and what basis is the value assigned? It's based on the social interpretation of how we look, which is what we call race in this country.

So, just to divert for a minute, here in Atlanta I'm black, you look at me, I'm black. I'm told that in some parts of Brazil, you'd look at me and I'd be clearly white. And, even though I haven't traveled to Brazil yet, sometimes I think that would be a good vacation spot for me, at least for a few weeks. In South Africa, you'd look at me and I'd be clearly colored. So, in three different settings, with the same appearance, I would be assigned to three different racial groups. So, that's what I mean when I say that race is actually the social interpretation of how one looks.

Well, I'm saying that we have a system of structuring opportunity and assigning value based on the social interpretation of how one looks. What are the impacts of this system? Well, it unfairly disadvantages some individuals in communities. And, when we talk about racism at all in this country, that's usually how we talk about it when we do. But at the same time that it's unfairly disadvantaging some individuals in communities, it's also unfairly advantaging other individuals and communities. And, that's the whole issue of unearned white privilege, which is much less frequently discussed in this country.

And, even as we see that we have a system that's either unfairly disadvantaging or unfairly advantaging individuals in communities, racism is sapping the strength of our whole society through the waste of human resources. And, what I mean by that is just look at how we invest or do not invest in public education. It's as if the blinders that don't value those children in the ghettos, or in the barrios, or on the reservations, because we don't think that there is genius there, is allowing us to

let that genius languish. And, if we were to invest in all the genius in all of our communities, we could be doing so much better as a country, and actually as a world. And, sometimes I say, we could be farming on Mars already if that were a good thing to do, if we were to invest in all that genius.

We sap the strength of our society when the blinders of racism allow us to continue just collecting black and brown men disproportionately in our prisons without recognizing that is a waste of human resources or when we don't cry out at the health disparity statistics, when we don't recognize that because Miss May at church died 10 years before she should have that that represents a loss to our society. Well, I'm going to use this definition of racism now as the basis of a question that we asked at CDC by using data from the reactions to race module.

It's a six-question optional module that was developed by the CDC Racism and Health Work Group piloted in 2002, it's now available in all states. Through 2007, these are the 16 states which have used it, several for more than one time. And, the data I'm going to show you come from the states that used it as an optional module in 2004. All the data are going to be aggregated. And the question that we're going to want to ask is, something about racism and health.

Well, the first question on this optional module gets at what we're calling socially assigned race. That is, how do other people usually classify you in this country? And here, you'll note that the response categories include the OMB's race

categories, as well as, Hispanic or Latino, the OMB's ethnicity category we're not making an artificial distinction between race and ethnicity and, nor are we asking how do you self identify?

Now, because BRFSS, as you know, is a phone survey, we don't have measured blood pressures or that kind of thing, but we do have this general health status question. We do say that in general, your health is excellent, very good, good, fair, or poor. And this question has been described as, if you only have one question in health, this would be the gold standard question. It predicts future morbidity and mortality very well. And, what we're going to use is, the proportion of the people who said their health was excellent or very good.

So, the first data slide I'm going to show you is going to be the start of a story. And, this data slide shows the proportion of people who were classified by others as white, black, Hispanic, or American-Indian Alaskan native who reported their health to be excellent or very good. I'm going to put 95 percent confidence intervals on those bars, and you'll see that people who are usually classified by others as white report significantly more excellent and very good health than others. In fact, if you prefer to look at fair or poor health, which people have typically done. So, the green is excellent or very good, the white is good, and the red is fair or poor. Then, people usually classified by others as white report significantly less fair or poor health.

Now, you all might say, oh, oh that's no, like, I knew that, right? Because, we're used to seeing data like that, but it's the first part of a story which says that white social experience is associated with better health. But, now you're starting to have some doubts, "But what is this socially assigned race anyway? And, how does it relate to what we're used to looking at self-identified race ethnicity?" And of course, the BRFSS does collect data on self-identified ethnicity and race. The ethnicity question is, are you Hispanic or Latino? Yes, no? The self-identified race question is, which one or more the following would you say is your race. And, if you pick more than one, which of these groups best represents your race. And a lot of people who use BRFSS combine these into a self-identified race ethnicity variable that's constructed as follows, if you say are you Hispanic or Latino? If you say yes, then you get Hispanic. It doesn't matter what you said on race. If you said no and you picked one racial group, you get that racial group. If you said no to Hispanic or Latino, you pick more than one racial group, you get more than one race.

So, I'm going to be looking at these four groups and comparing them now. How does this self-identified race ethnicity compare to the socially assigned race. How are you usually classified by others? And, you'll see that for the 26,000 white folks, people who self identified as white, about 98 percent were usually classified by others as white. Of the more than 5,000 who self-identified as black, 95 percent were usually classified by others as black. So, that's pretty close although some of you might be surprised that it's not a hundred percent.

But when you get to those who self-identify as Hispanic, that is, are you Hispanic or Latino? They say yes, 61 percent were usually classified by others as Hispanic but fully 26 percent say that they're usually classified by others as white. So, now this gave me and my colleagues an idea of a wonderful analysis plan. Let's look at the Hispanics, self-identified Hispanics who are usually classified by others as Hispanic, the self-identified Hispanics who are usually classified by others as white, and then the self-identified whites who are usually classified by others as white and see how do they rate their health? Here's what you have, Hispanic-Hispanic, Hispanic-White, White-White. You see that those who self-identify as Hispanic, but usually classified by others as white, their rate is, sort of, intermediate and actually looks a little bit closer to the white. Well, are these significant differences? Well, let's look at the Hispanic-Hispanic, White-White comparison first. Yes, that's a significant difference. But also, Hispanic-Hispanic, and Hispanic-White, the people, all of these people now are self-identifying as Hispanic, but those who are usually classified by others as white report significantly more excellent or very good health than the others. What about Hispanic-White compared to White-White? There's no evidence of a difference there. Hmm, I like the hmm sound there, okay.

Well, let's look in another group. The American-Indian Alaskan natives, we had 321 folks who said are you Hispanic or Latino, they said no, then which one or more race, they picked one race. So, that's not me with my Cherokee great

grandmother or some white person with their Indian ancestry. But out of those people, 34 percent are usually classified by others as American-Indian, 46 percent are usually classified by others as white. We're going to look at the same data analysis, Indian-Indian, Indian-White, White-White. The Indian-Indian, White-White difference is significant as is the Indian-Indian, Indian-White difference. All of these people say they have one race, American-Indian. But the once who are usually classified by others as white report significantly more excellent or very good health and they are not distinguishable from people who self-identify as white and are usually classified by others as white.

Okay, so do you guys understand this? Okay, so this is the second part of our story which is, not only is white social experience associated with better health, that's true even within the same self-identified race ethnic group. But now, you might say what about black folks, you haven't even shown me the main thing when we think about racism, it's white-black. Well, for this analysis, we didn't have enough people who self-identified as black, but were usually classified by others as white to do the analysis, and that's probably, because those people passed. They're now living as white.

But, we can look at black-white difference when you ask the further question what about socioeconomic status in this? So, let's compare socially assigned whites and socially assigned blacks stratified by education, which is the best SES marker we have in the BRFSS data set. The income information was missing on

12 percent on our sample, so we did not use that. Well, if we start looking at those with less than high school, the heights of the bars are the percent reporting excellent or very good health. For less than high school graduates, people who are socially assigned as white report more excellent or very good health than those socially assigned as black although the difference is not significant. When you look at high school graduates, education is doing great things for both groups, but now white folks, again, have more excellent or very good health than blacks, and it is statistically significant. If you look at some college or more, more education is doing good things for both groups, white folks have significantly more excellent and very good health. And, actually, if you stratify it, my labels here are college graduate, some college, high school graduate, and down. At each level of education, people who are socially assigned as white report more excellent or very good health than those socially assigned as black, and the gap widens at higher educational levels, which we have seen. I mean, Dianne Reilly's work and others, you were on that paper, have shown that many, in many aspects.

So, now we have something else. We have white social experience is associated with better health even within the same educational level. And, even though we haven't looked at it yet, because of the data things, when we get more data, even probably, I would guess, within the same income level and, because we see that in many cases. But, let's go back to this slide. Even if we were able to get rid of that differences between those two lines, we still wouldn't have gotten rid of the

difference in the experience of excellent or very good health between socially assigned blacks and whites, because there's something missing from the picture so far. And, what's missing is, what proportion of each educational group is black or white? That is, the underlying distribution of education has been missing. This is the proportion that each educational group that's black versus not, that line is the proportion of black folks in our sample, if education were evenly distributed in the population, then all of those red bars will come up to that white line. This is the white and non-white. All of those white bars will go to that red line. But what we see is that education is not evenly distributed by race, which is not just a happenstance. And, acknowledging that gets us to what do we have to do about health disparities?

Not only do we have to worry about, kind of, getting our data lines together, we have to think about what is the underlying distribution of education, and income, and housing. But, this also adds to our story. So, not only is white social experience associated with better health, it's associated with higher education, probably higher income and other things.

So, the key question is, why? Why do we see these data? And, I take us back to an understanding that we live in a system that pays attention to socially assigned race. That socially assigned race is actually the substrate on which racism operates. We are in a system where opportunity is structured and value is assigned based on the social interpretation of how one looks. And so, we take

these data as preliminary, but very strong evidence of the impacts of racism and health without even asking questions, have you experienced unfair treatment or that kind of thing.

So, our tasks as health scientists, as citizens are to name racism, to name it, not just start to say race or cultural competence, or discrimination, or anything, but to name racism as a system and a system that actually results in the uneven distribution of the other social determinants of health; to then ask the question, how is racism operating here? And, I don't have time to guide you through answering that question, but that's the most important thing I can leave you with. And then, to organize and strategize to act. Now, do I have three minutes Wanda? Or how much do I have? Okay, I'm going to race through this other thing.

JAMES COLLINS: You can take some of my time, go ahead.

CAMARA JONES: Okay.

JAMES COLLINS: I don't mind.

CAMARA JONES: So, this was the data piece. But I also wanted to give you the framing piece, okay? So, here's the framing piece. The framing piece is, let's talk about levels of health intervention. And so, here we are, whoops, boom,

somebody has just fallen off the cliff of good health. And, if that's you or somebody in your family, you would be delighted to know that there will be an ambulance there at the bottom of the cliff to speed them on to care.

But the question is as public health people, do we want to just have a lot of ambulances stationed at the bottom of the cliff or is there something else that we can do as a health intervention? Well, maybe we'll think, we'll put a net halfway down so people will fall, right? But, we'll keep them from getting crunched at the bottom. But, we recognize that nets have holes in them so some people may fall through the cracks, so maybe we'll that a trampoline halfway down. But, even if it's a trampoline, we'll find the people are just bouncing up and down at half functionality, not really able to get to the top of the cliff.

So, what else can we do? Well, let's put a fence at the edge of the cliff, so that people don't fall in the first place, but that has to be a very, very strong fence if there's a lot of population pressure against it. So, what else can we do as a health intervention? Well, we can move the center of the population away from the edge of the cliff.

So, I'm going to label these as the ambulance being medical care and tertiary prevention, the net or trampoline halfway down, safety net programs and secondary prevention, primary prevention is the fence, and addressing the social

determinants health, that's moving the center of the population away from the cliff.

And, I'm sure you can think of examples of each of these levels in MCH. But the main thing is, so far, we haven't talked about how health disparities arise. So, I'm going to leave this for a minute, talk about how health disparities arise on three levels including differences in quality of care within the health care system, but there's also differences in access to health care. But before people even need to access health care, their differences in life opportunities and life exposures that make some individuals in communities sicker than others in the first place.

So, now we return to the cliff and we recognize that we're not really dealing with a flat two-dimensional cliff but that in fact, we're dealing with a three-dimensional cliff. And, at some parts of the cliff there is an ambulance, but maybe it has a flat tire so it goes in the wrong direction, or it's slow, or maybe there's no ambulance there at all, maybe there's no net, maybe there's no fence. And, usually at those parts of the cliff, the population is closer to the edge. So, now I'm going to label these in terms of how health disparities arise.

The differences in quality of care, that's when the ambulance is slow or goes the wrong way. The differences in access to care, there's no ambulance, no net, no fence. And, the differences in underlying exposures and opportunities is the closer proximity of the population to the edge of the cliff.

Now, we talked about addressing social determinants of health as moving the center of the population away from the edge of the cliff, but now, recognizing the three-dimensionality of the cliff, we have something else to address, which is addressing the social determinants of equity. Which is, first of all, acknowledging the three-dimensional nature of the cliff and then asking, why are there differences in resources along the cliff face and why are there differences and who's found at different parts of the cliff?

So, addressing the social determinants of health which includes addressing poverty and context like that is important, but if we're going to really be about health equity, we have to know that we could address, we could move some of the population away from the edge of the cliff, but unless we understood the three-dimensionality of the cliff, we could actually make disparities worse if we don't address, if we don't move all of the population away from the edge of the cliff.

As I close with this, I just want to highlight that there are three dimensions here. And that, health services can be represented in a single dimension as a line, that's the ambulance, net, and fence. When you move to two dimensions, that's addressing the social determinants of health. We can represent that in a plane, moving the center of the population away from the edge of the cliff. But to really address issues of equity, we have to go into the third dimension and ask the

question why are there differences in the resources along the cliff face and who's found at different parts of the cliff. And, those questions include addressing racism and other systems of power that have the power to create context, and then to differentially distribute people into that context. So, our goal is to move the conversation in this nation even as we have wonderful opportunity now to have universal access to high quality health care. The health services piece is important, but we also need to deal with addressing the social determinants of health. And then, we certainly need to deal with addressing the social determinants of equity. So, thank you for letting me have that extra little say.