Approved: February 6, 2006
Date

MINUTES OF A JOINT MEETING OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE AND THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
Meeting in Room 313-S of the Capitol from 11:30 a.m. to 1:00 p.m.

The meeting was called to order by Chairman Jim Morrison on January 10 at 11:30 a.m.

All members and committee staff were present.

Conferees appearing before the joint committees:
Dr. Howard Rodenberg, Director of Health Division, Kansas Department of Health and Environment
Dr. David R. Williams, Senior Research Scientist, Professor of Sociology and Epidemiology, Institute for Social Research, University of Michigan.

Dr. Howard Rodenberg, Director, Division of Health, Kansas Department of Health and Environment presented the "State of Health in Kansas." (Attachment 1), including a PowerPoint presentation. Dr. Rodenberg stated that he represented 146,000 health-care professionals within the state who are committed to promoting health for Kansans. He commented on various Kansas health statistics, noting that the 2,735,502 Kansans reflect extremes in age, with highs in the 18-24-year age group and those over 85, presenting the opposite of a bell curve. Dealing with the cause of death under the category Years of Productive Life Lost, he said three causes top the list: cancer, heart disease, and unintentional injury. He further observed that 11% of Kansans have no public or private health insurance coverage, compared with 15% nationally.

Dr. Rodenberg commented on three areas of preventable death: tobacco use, obesity, and accidental death, stating that KDHE is developing comprehensive new programs to mitigate these statistics. He listed the most effective health measures as immunization and clean and fluoridated water, and he commented on two pressing issues facing the state: the disparities in health care caused by race, ethnicity, geography, and socio-economic status; and the lack of preparedness for a public health emergency. He offered three avenues for action: education, evaluation of present policies, and setting high goals, the last illustrated by the Healthy Kansans 2010 project. He concluded by comparing Kansas health statistics with national averages and identifying strategic initiatives of the department.

Dr. David R. Williams, Senior Research Scientist, Professor of Sociology and Epidemiology, Institute for Social Research, University of Michigan, presented a discourse on "Race and Health, 10 Key Facts." (Attachment 2), including a PowerPoint presentation. He offered a plethora of statistics and studies to illustrate how race impacts an individual's health, the health-care delivery system, life expectancy, quality of care, and mental health. He said that although the general health of the nation has increased significantly over the years, the health gap between races has changed little. He offered several recommendations, summarizing by saying that policies to reduce inequalities in health must address fundamental non-medical determinants.

The meeting was adjourned at 1:00 p.m.

Kansas: Our State of Health

Howard Rodenberg, MD, MPH

Director, Division of Health

State Health Officer

Kansas Department of Health and Environment

January, 2006

There is an advertisement on television that describes Kansas as a land without limits. As people focused on progress, all of us in the room today see unlimited opportunities to help Kansans reach their full potential. As State Health Officer, it's my honor to represent the over 146,000 health care professionals within our state committed to promoting health as a means towards this goal.

We live in a time where people and communities have more information than ever before about how to achieve and maintain optimal health. Conversely, we also have more opportunities to make choices that do not contribute to good health — the use of tobacco, the excess use of alcohol, inattention to the need for a healthy diet and physical activity, the choice to not use seat belts and motorcycle helmets, and the persistence of lifestyles that foster stress and anxiety. Those of us in leadership positions within the public health and health care community have the responsibility to encourage and empower our citizens to be healthy and achieve the highest quality of life.

Attachment 1
HHS 1-17-06

So how do we evaluate the health status of Kansas? As you know, states are continually compared and contrasted with one another in nearly every conceivable way. This is also true in measurements of health status, and the reports would indicate that in most ways, Kansas is remarkably "average." In the minds of national policymakers, there is really not much worth noticing about the health status of the citizens of the Sunflower State.

I'm not satisfied with the notion that Kansas is "average." While it's true that being average (what the statisticians call being at the median) means that half the states are doing worse than you, it also means that half the states are doing better. Kansas is a great place to live, work, raise a family, and care for our elders. It's my goal to insure that we work towards Kansas being a great place for health.

Allow me to start the discussion by giving you a "snapshot" of the health of Kansas. Basic demographics, those numbers that tell us who and what we are, come first. In 2004, there were 2,735,502 Kansans. Kansas is a diverse state, evenly divided between men and women; 16% of us are Hispanic, African-American, Native American, or Asian. Our population curve encompasses two extremes. Kansas ranks 8th in the nation for percent of residents in the 18-24 year age group, and 9th in the nation for those over 85. Like many states, the Kansas population has its share of baby boomers, and the population as a whole is aging. Our per capita income in 2003 was close to $30,000, ranked 26th in the nation. Nearly 89% of us graduated from high school, and 31% hold a four year college degree. Approximately 70% of Kansans live in urban

areas and 30% in rural communities; Kansans continue to leave these open spaces at a rate of 3% each year. These factors...a graying population, a growing multiethnic culture, and a significant but shrinking rural presence...are all factors which influence the health status of our state. These kinds of factors are described as "social determinants" of health, those demographic and cultural characteristics of our population that affect not only health status, but also use of the health care system.

In terms of health data, our first level of evaluation is with birth and death statistics. In 2004, there were over 39,000 live births in Kansas and nearly 24,000 deaths. The leading causes of death were heart disease, cancer, stroke, respiratory conditions and unintentional injuries. It's often interesting to think about what health events happen each day in Kansas, and we've included a summary in your handout to illustrate this point.

EVERY DAY KANSANS EXPERIENCE:

108 live births
- 11 live births to teenagers
- 8 low birth weight infants
- 1 stillborn and 1 infant death

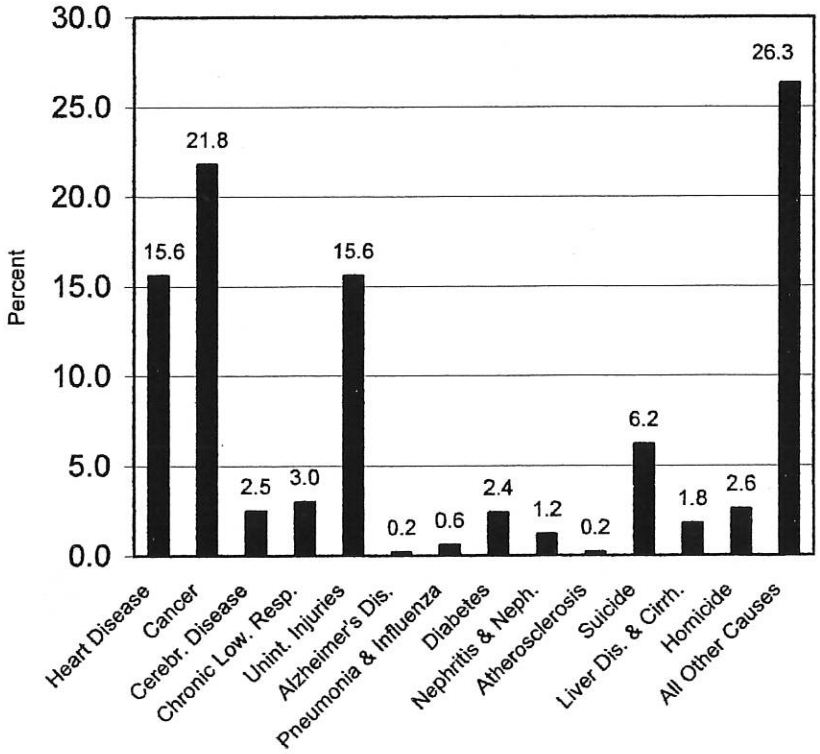
909 hospital discharges:
- 9 hip fractures in the elderly
- 14 victims of heart attack
- 35 pneumonia patients
- 11 diabetics

65 deaths
- 16 due to heart disease
- 14 due to cancer
- 4 due to chronic lower respiratory disease
- 1 due to motor vehicle accidents
- 1 suicide

Source: DOH, Center for Health and Environmental Statistics

In public health and health care policy, looking at raw numbers is never enough. One of our tasks is to identify those opportunities to make the biggest difference in the lives of individuals and in the overall health of society. One of our tools is to review Years of Productive Life Lost , or YPLLs. These numbers represent the impact of disease or injury on young people and those actively contributing to the workforce. In Kansas, the top three causes of YPLLs are cancer, heart disease, and unintentional injury. Even a superficial turn at these numbers demonstrates that simple measures such as decreasing tobacco consumption and enhancing seat belt use can have a major impact on the lives of Kansans.

Percent Years of Potential Life Lost
By Selected Causes of Death
Kansas, 2004



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How do our numbers stack up against national norms? Let's address some of the successes first. Overall, we have much to be proud of. The 2005 Health Care State Rankings places Kansas as 15th in the nation in overall health status. Kansas is a national leader in insuring that women receive early prenatal care, resulting in successful pregnancies and healthier babies. The success can be credited to physicians, nurses, local health departments, and hospitals throughout the state dedicated to serve this vital need. Kansas is also a leader in the number of hospital beds per population, especially in rural areas. This statistic demonstrates our commitment to insuring that medical care is available and convenient, and that we recognize that staying close to home has a healing value all it's own. Kansans also know that health care coverage is important. Eleven percent of Kansans have no private or public health insurance coverage, as compared with a national average of 15%. Our rate of uninsured children is half that of the nation as a whole. That being said, the prospect of even one person, and especially a child, being unable to get the health care they need because of a lack of resources is clearly one too many. Birth to five are the formative years where health setbacks can cause the greatest long-term problems and destroy what should be an exceptional future for a child in our state.

Major Indicators of Health-How Does Kansas Rank Compared to the Nation?

Indicator	Teenage birth rate	% Mothers receiving prenatal care in 1st trimester	Percent of Community Hospitals in Rural Areas (2002)	Rate of Beds in Community Hospitals (per 100,000 population)	Cancer EDR (All Sites)	Cerebrovascular Disease (Stroke) AADR	Diabetes AADR	Heart Disease AADR	Injury Death Rate AADR	Motor Vehicle Death Rates AADR	Suicide Deaths AADR	Percent of Population Not Covered by Insurance	Percent of Children Not Covered by Insurance
National Statistic	46.1	84.1	44.2	280	194.2	56.2	25.4	240.8	54.9	15.7	10.9	15.1	11.4
Kansas Statistic	47.6	87.7	79.9	387	196.3	59.5	26.3	220.6	58.2	20.3	12.6	10.9	6.4
Rank in US	20	8	10	8	32	19	24	28	23	17	20	35	44
KS Strength		✓	✓	✓				✓				✓	✓
KS Weakness	✓				✓	✓	✓		✓	✓	✓		

EDR=Estimated Cancer Rate
AADR= Age-Adjusted Death Rate
CDR=Crude Death Rate

Source: Health Care State Rankings, 2005
Morgan Quitno, Lawrence, Kansas

While we should all be proud of our successes and resolve to build upon them, comparison with national means also demonstrates areas that need work. In areas such as death from cancer, injury, and heart disease, our standing at or below the national average links with our known leading causes of years of productive life lost. Linking these two sets of information helps us to focus our efforts even more sharply on three major areas of work.

Tobacco use remains a significant problem in Kansas, and it is the leading cause of preventable death within the state. Despite educational efforts, smoking rates have been consistent in Kansas for several years. Twenty percent of Kansans continue to smoke cigarettes. Most concerning is that smokers who quit or die are being continually replaced by new ones. We need to empower our citizens with more tools to achieve success in preventing tobacco use throughout the state. These efforts may encompass tools such as increased tobacco taxation, enforcement of the prohibition of sales to minors, and promoting clean indoor air. The health benefits of such efforts are real and unquestionable. A comprehensive program of tobacco use prevention will, over time, save 4,000 lives each year and up to $720 million dollars annually in smoking-related direct health care costs.

We've also learned that despite the image of the lean, weathered prairie farmer or cottle producer, Kansas ranks 8th in the nation in percent of persons who are overweight, and 23% all Kansans are obese. Since 1992, our obesity rate has soared by 70%. We know that these numbers will continue to rise as long as over half of Kansans do not engage in moderate physical activity for 30 minutes daily, and 80% of adults fail to eat at least five servings of fruits and vegetables each day. Obesity contributes to heart disease, cancer, diabetes, and disability, and it trails only tobacco use as a cause of preventable death. Estimates indicate that over 3,700 of us will die early deaths from the complications of being overweight or obese, and that over $650 million dollars will be incurred each year in Kansas from obesity-related medical expenditures. These costs, both human, and fiscal, simply cannot be ignored. They will continue to plague

us in the decades ahead if we don't act now with programs and policies designed to promote healthy nutritional habits, encourage physical activity, and insure that our schools, our homes, and our communities establish these habits for life in our kids.

An area of personal concern to me, not only as the State Health Officer but also as an emergency physician, is our rate of accidental injury and death. In 2005, the National Highway and Traffic Safety Administration (NHTSA) reported that Kansas ranked 45th in the nation for seatbelt usage. Only 67% percent of our citizens regularly buckle up, compared with 82% of motorists nationwide. Our failure to properly use seat belts means that Kansas ranks in the top 20 for motor vehicle death rates, exceeding the national average by over 30%. Every year 450 Kansans die on our roads. Motor vehicle crashes are the leading cause of death for all Kansans 34 and younger, and death rates are highest for those between 15 and 24. A primary seat belt law in Kansas can raise seat belt usage and save 150 lives and $450 million dollars in health care costs each year. As one who spent the better part of a career treating the victims of motor vehicle crashes and tending to their families, these fully preventable deaths that take the youngest and most promising people from our lives our are totally unacceptable.

When people look at those health measures that have been most effective within the last 200 years, they are often surprised to find that the top items include the advent of immunizations and the provision of clean and fluoridated water. Because we know so much about the benefits of vaccination, it is concerning that here again, Kansas shows

room for improvement. In 2003, only 63% of our children had received the minimum recommended vaccinations by age two. At that time, our Governor convened a Blue Ribbon Task Force to evaluate the immunization process in Kansas. KDHE has been implementing the short-term recommendations identified in the Task Force report, moving forward with innovative programs such as developing a statewide electronic immunization registry, linking immunization to WIC services, and advancing the recommended schedule of vaccination. These efforts have been successful even at an early stage. Our immunization rate for two-year-olds in 2004 was 77%, and over 10,000 more Kansas children had been vaccinated between 2003 and 2004. We are also proud to note that by school entry, over 95% of Kansas kids are "up-to-date" on their required shots. KDHE, the Kansas Health Institute (KHI), and the Kansas Health Foundation (KHF) are now engaged in a joint effort to improve these numbers even more by reviewing those processes and structures within Kansas that may assist or be barriers to us in achieving our goals.

There are two pressing issues I want to bring to your attention which are not well reflected by national comparisons. An emerging issue within Kansas is that of health disparities. Put simply, health disparities are those differences in health status that exist between groups distinguished by race, ethnicity, geography, or socioeconomic status. Despite what many outsiders may think, all of us here today recognize that Kansas is becoming a diverse society. The multiple benefits of diversity also come with some challenges. For example, we know that African-American infants die at rate more than twice that of white infants. Over 18% of Hispanic mothers do not receive adequate

prenatal care, compared to 6% of white mothers. Native Americans have a 75% greater chance of dying from complications of diabetes than the rest of the population. Youth in rural areas use tobacco at twice the rate of their urban peers, and are more likely to use alcohol while driving.

The magnitude of these disparities is such that, taken as a whole, the reduction of health disparities alone would allow Kansas to reach the United States Centers for Disease Control Healthy People 2010 goals. It is our challenge to close this gap, and to identify those cultural and systemic issues we must address so that every Kansan can enjoy good health. Key to this effort is an honest evaluation of cultural competency, the ability of our healthcare system to respond to the unique values and beliefs of every Kansan. At KDHE, we are moving to establish an Office of Minority Affairs to focus our efforts on addressing these issues, and to reinforce the multiple efforts in which we're currently engaged.

The second issue I want to mention is public health emergency preparedness, and specifically the prospect of influenza. Even during this year's "normal" flu season, we've seen challenges in equitable vaccine distribution across the state Many of these challenges are federal, and beyond our control. I am gratified, however, to report to you that local health departments have done a yeoman's job in managing their supplies, and at KDHE we've given all doses of flu vaccine we received to local health departments, state universities, and other state institutions. In the context of pandemic influenza, KDHE has issued a plan encompassing surveillance, emergency response, and

communications aspects in order to help our state prepare. We have a working group at the state level with invitations extended to representatives of the health care, business, education, law enforcement, agricultural, and emergency management communities. We are correlating our efforts with those of our federal partners to ensure coordination and cooperation. During November and December, our State Epidemiologist Dr. Gail Hansen and I toured 13 cities across the state presenting public forums on pandemic influenza. These forums have been focused not only on empowering Kansans to better care for themselves and their communities, but also on promoting multidisciplinary local planning efforts. We'll also be speaking with legislative committees about pandemic flu so we can all plan ahead using the same set of information. While we cannot prevent the possibility of pandemic influenza reaching our state, we can work together to lessen it's impact upon our families and friends.

In the last few minutes, I've tried to provide you with a "snapshot" of the health status of Kansas. Where do we go from here?

I see three avenues in which we as a state must move ahead. The first is in the dissemination of information just as we've done here today. Communities need information on their health status in order to prioritize local efforts and monitor their effectiveness. We have already initiated a project at KDHE to make data such as I've shared today more accessible through our website, and are working to expand our information sharing even more as we acquire new data sets and new technologies for sharing. As another part of this effort, each legislator here today will receive a health

profile of their own Senate or House district in comparison with state norms. The information has also been posted on our website. We encourage you to use this data to identify local health concerns, to share the information with your constituents, and to use this knowledge to further local efforts to promote good health.

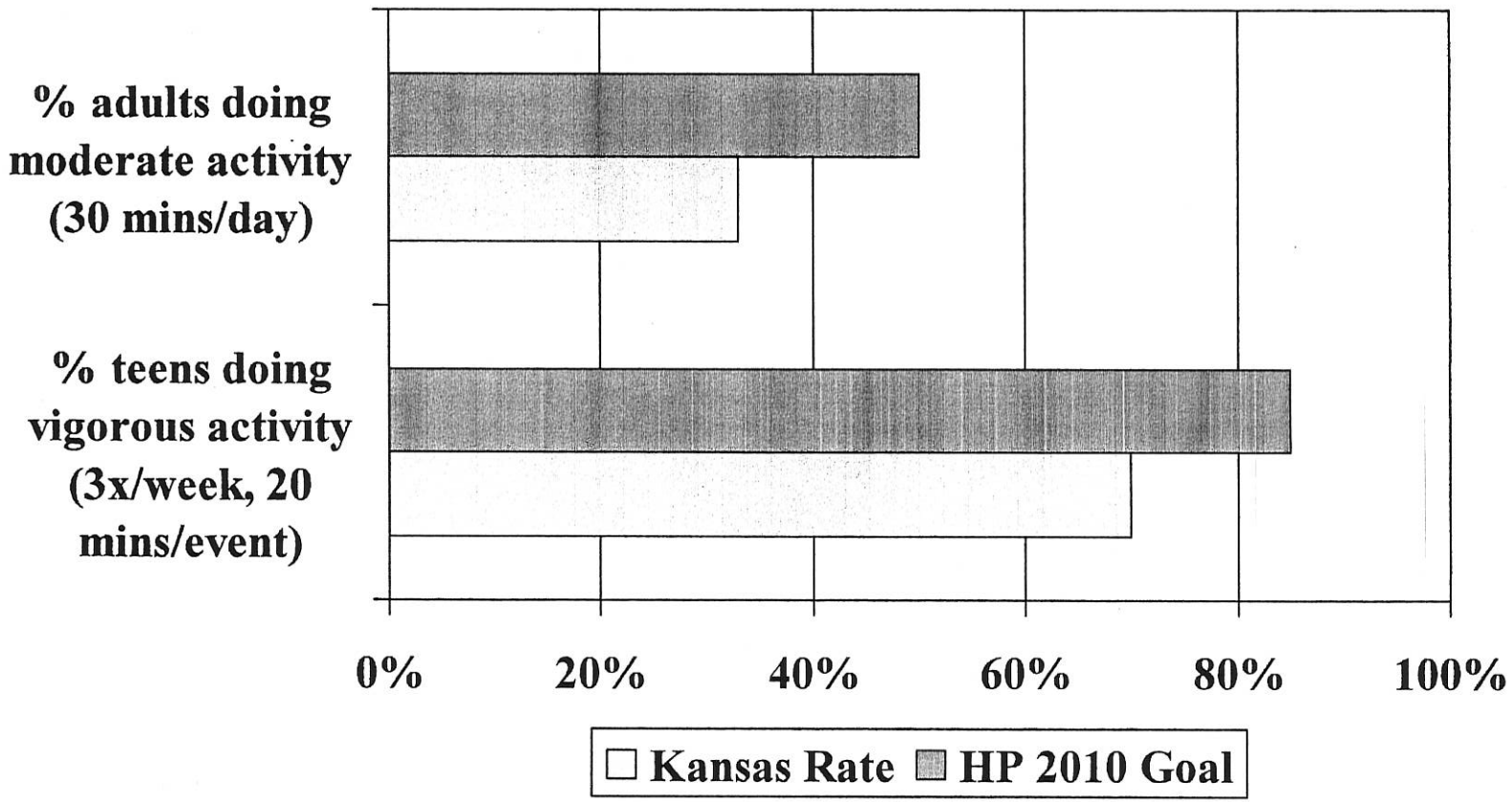
The second action item is to take a hard look at the wide range of policy and program options available to us as we collectively work to improve the health of our state. I have previously testified to legislative interim and oversight committees that I believe one of the critical roles of KDHE and the public health community is to bring best practices in the realm of prevention to the attention of policymakers. These may be primary preventive action designed to halt disease or injury before it happens, such as measures to increase seat belt use and limit tobacco consumption; or they may be secondary preventive measures such as promoting disease management programs and community-based elder care. As we look at our options, we should not be bound by a limited or restrictive definition of what constitutes public health programs and what does not. We must be ready and willing to explore all avenues to improve health, be they educational, fiscal, legislative, regulatory, or environmental. And while there are many issues within health and health care that call for attention, the bottom line for all of them is the health status of our state. It's our task to insure that no matter what subject or nature of the policy change, we develop some measure of the impact upon health status to help judge the ultimate efficacy of these plans.

The last is to set high goals for ourselves, and to hold ourselves accountable to those goals. One of our major accomplishments this year has been the Healthy Kansans 2010 Project. The process was funded by the Kansas Health Foundation, and we're grateful to acknowledge their support.

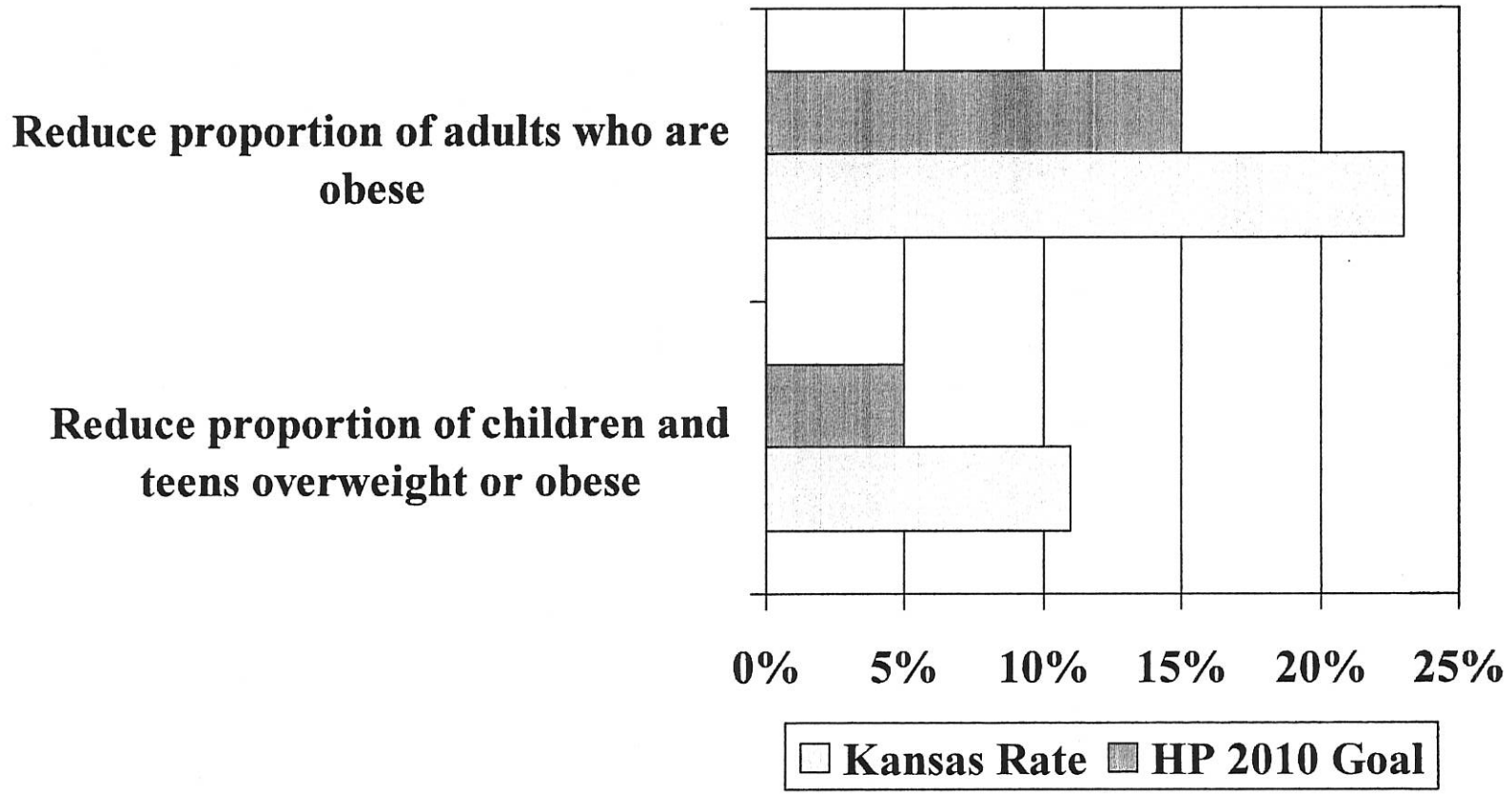
This Healthy Kansans 2010 effort involved a series of 23 meetings involving 200 representatives from over 100 different organizations. The process began by reviewing the Kansas profile of the 10 Leading Health Indicators as identified by the CDC Healthy People 2010 Objectives for the Nation. These ten indicators include rates of physical activity, percent of persons overweight and obese, and rates of use of tobacco and alcohol. They focus on responsible sexual behavior, the mental health of the population, and rates of death from injury and violence. They reflect environmental quality, immunization rates, and the individual's access to medical care. You will have noticed that these indicators do not reflect specific diseases, but rather more specific behaviors and societal structures. The underlying concept is that by changing behavior and enhancing access to care, we can have a significant impact on the preventable causes of death and disability.

The project began with an evaluation of the ten leading health indicators and the status of Kansas relative to these goals. The following pages describe the relationship between the current status of Kansas and the Healthy People 2010 goals. In virtually all cases, it's clear that there is work to be done. (A more complete table of indicators, Kansas measures, and reference sources follows this text.)

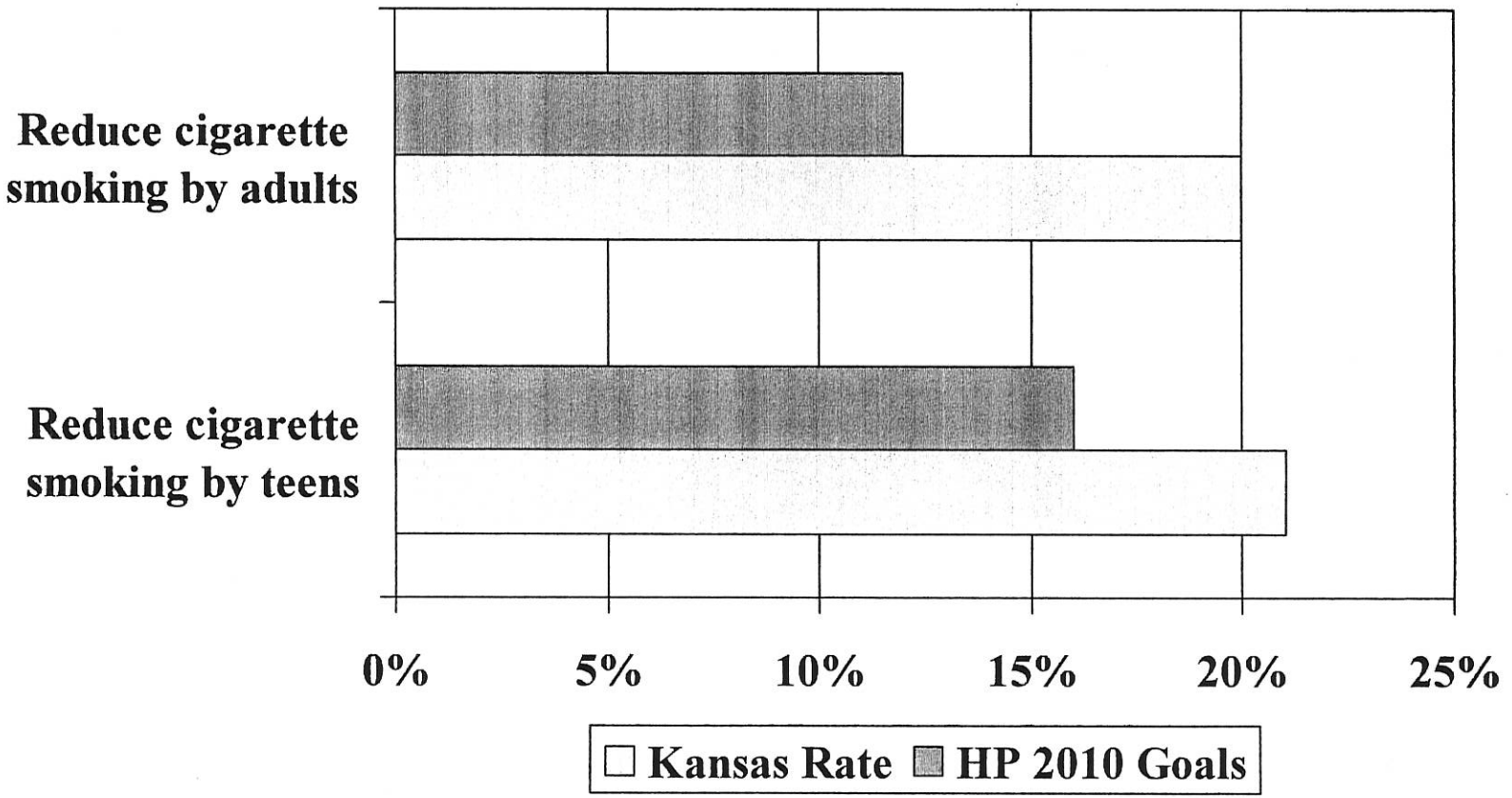
HK 2010: Physical Activity



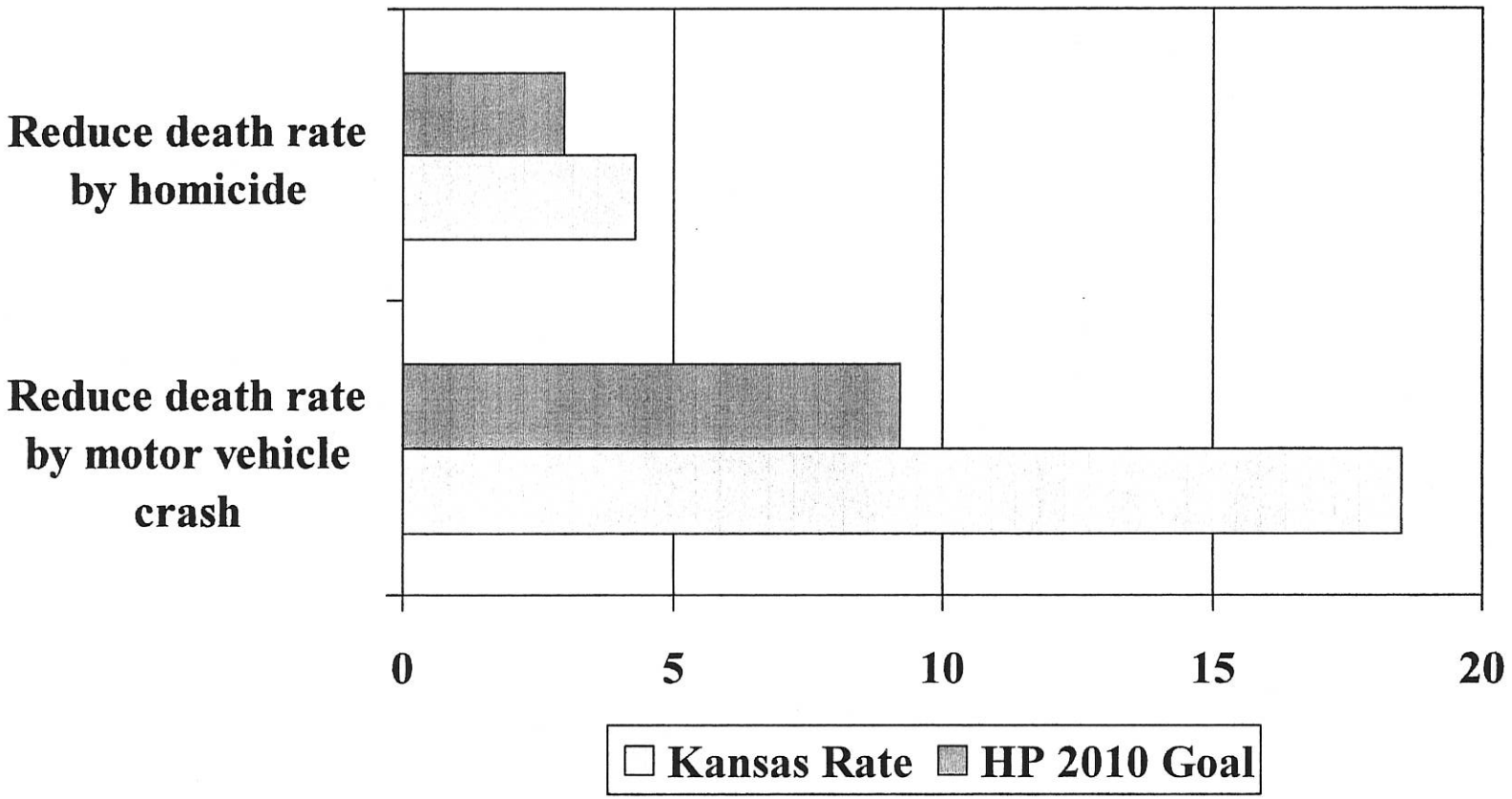
HK 2010: Overweight and Obesity



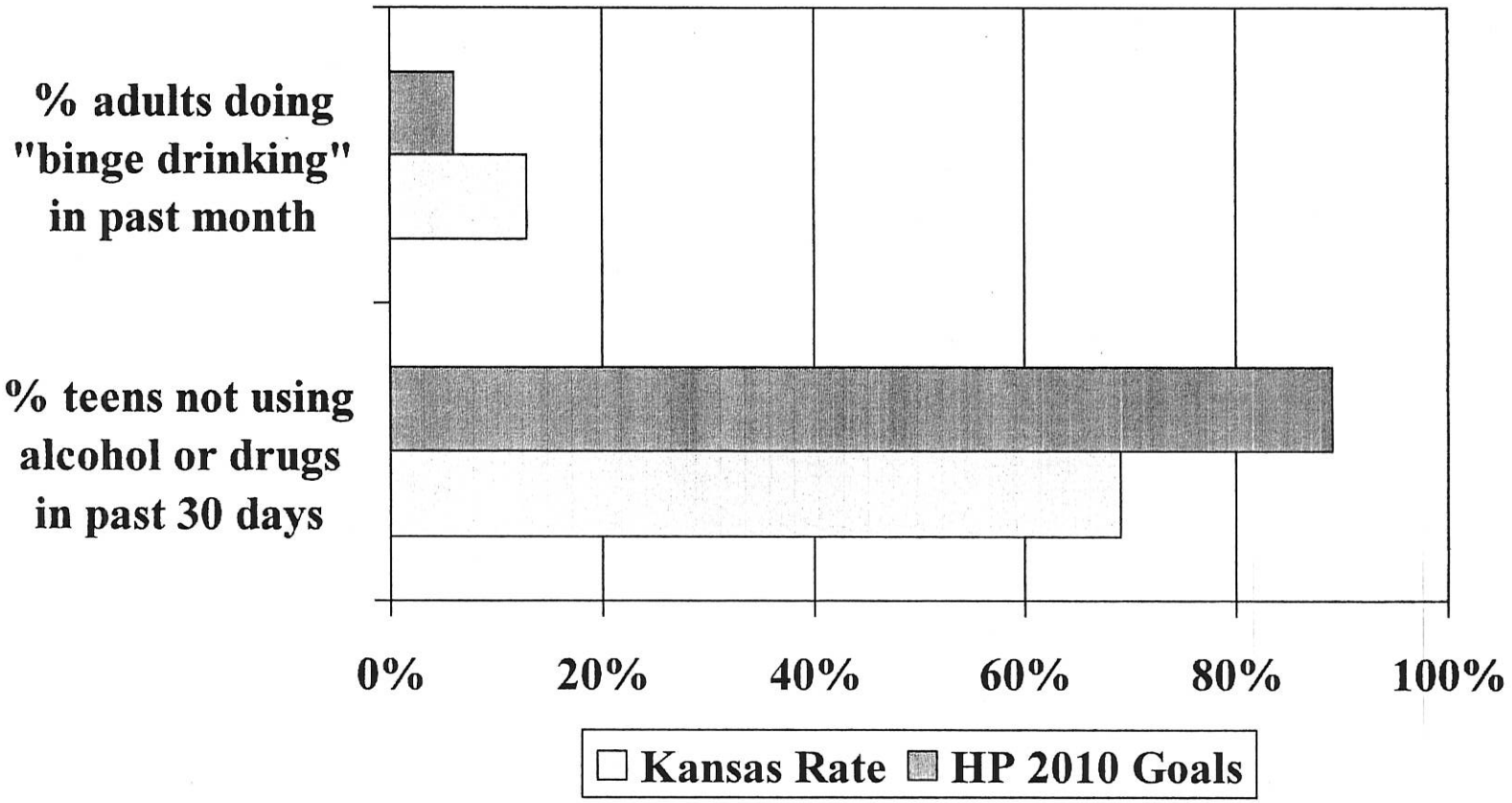
HK 2010: Tobacco Use



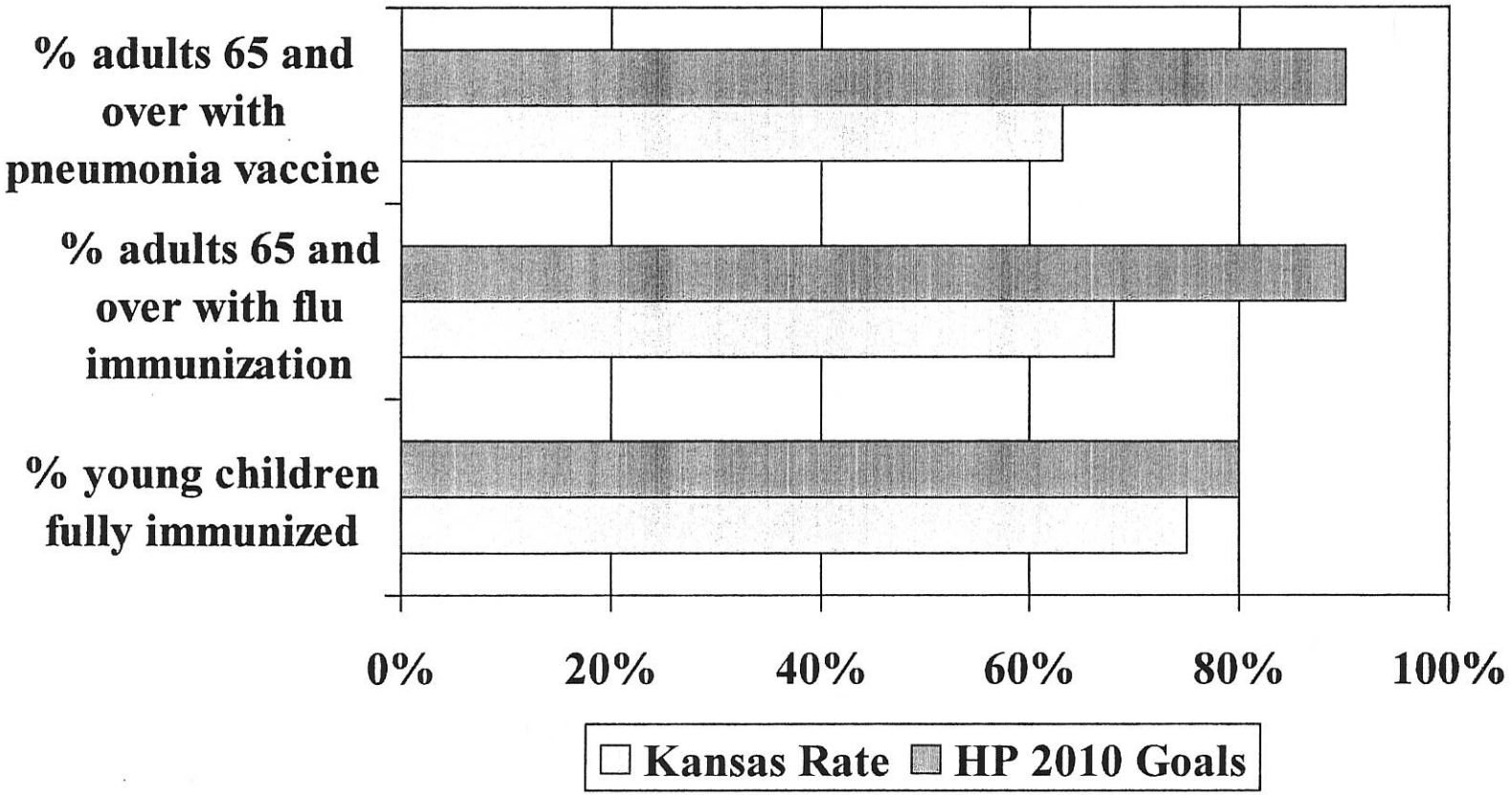
HK 2010: Injury and Violence



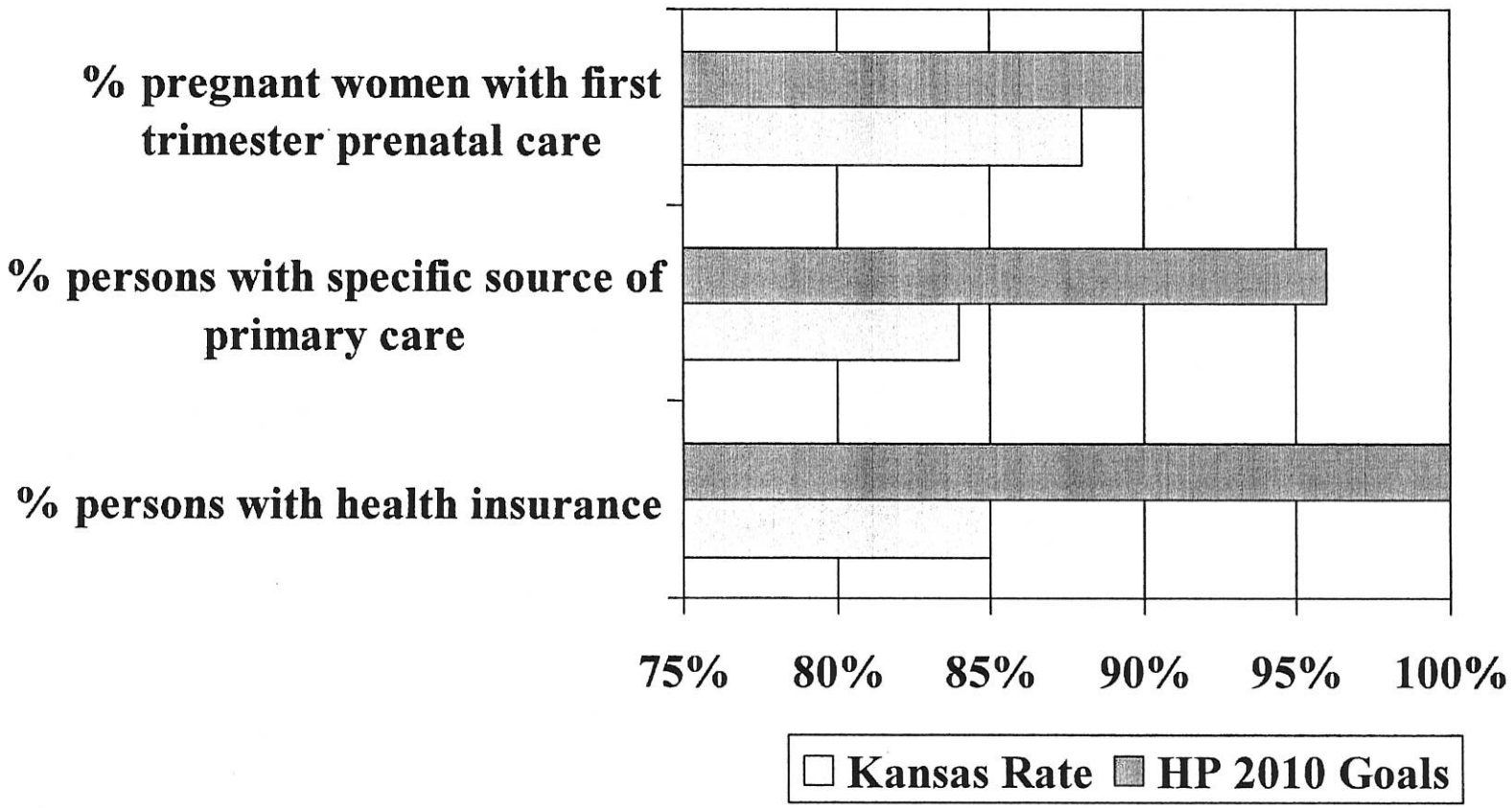
HK 2010: Substance Abuse



HK 2010: Immunizations



HK 2010: Access to Care



To reach these goals, it was important to focus our efforts. Cross-cutting themes which impacted the majority of these targets were considered targets of opportunity, areas in which a dedicated effort could show real benefit to the health of our state. These areas were noted as risk identification and disease prevention in women and children, interventions to address the social determinants of health, and the elimination of health disparities between racial and ethnic groups.

Workgroups have taken these themes and developed sets of action steps to enhance our efforts in these areas. Tobacco control, enhancing healthcare provider cultural competency, and further characterization of health disparities were identified as the realms of activity which could have the most impact on the areas of need. The counsel is wide in scope, and takes full advantage of the range of public health interventions available for use. In the realm of tobacco cessation, the recommendations encompass agency, organization, local, and state tobacco control polices, funding for tobacco control efforts, and clean indoor air legislation. Comprehensive data collection systems and engaging under-represented communities in the collection process are tools used to further examine and categorize health disparities, while the establishment of an information clearinghouse and development of training courses help us to address issues of cultural competency.

As stewards of public resources and the public trust, we must insure that we can measure the effect of these interventions in an objective fashion. While the natural history of disease means that the final impact of an action on our overall health may not

be known for years...if nothing else, public health tends to be a patient science...we must identify markers. Markers are those intermediate steps that we know from experience correlate with long-term outcomes. The markers we use will also vary by the nature of the larger issue. In the realm of tobacco control, markers of progress may include the passage of clean indoor air policies at the state and local level, compliance with laws on tobacco sales to minors, and additional tobacco taxation to pay for the health care costs of smoking. We may judge our movement towards a better understanding of health disparities by insuring our data tools are able to capture the information we need to make informed decisions about the health of our state. Cultural competency may be furthered through noting the number of people participating in training courses and in promoting the linguistic and cultural diversity of the public health workforce to best reflect those people we serve. We are currently developing concrete action plans to lead us towards these goals, and look forward to presenting them for your consideration.

Healthy Kansas 2010 is a critical piece of the new KDHE Division of Health strategic plan. Our balanced scorecard model is based on identifying high-priority outcomes, finding ways to measure them, and formulating means to exert an impact upon those aims. Some of these goals are external, and many more internal; but all are geared towards improving the health of Kansans.

I started this talk with the notion that Kansas is, in many ways, acutely average. In the last few minutes, I hope I've convinced you that average is simply not good enough. I

mentioned the advertisements running on television that promote Kansas as a place of unlimited spaces. I believe that there is unlimited opportunity for the health of Kansas to improve. I also believe that the only place for Kansas as we measure the health status of our nation is in first. I bring you the assurance that all of us at KDHE, and all the health care professionals that we are privileged to call our partners, are fully engaged in making this dream a reality. We ask you to join us in this work.

Thank you for your time and your interest in this topic. I'd be delighted to entertain any questions you might have. Thank you once again.

Healthy People/Healthy Kansans 2010: 10 Leading Health Indicators

Objective	Kansas Rate	HP2010 Goal
Physical Activity		
Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion.	70% (2005 KS Youth Risk Behavior Surveillance System, grades 9-12)	85% (grades 9-12)
Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day.	33% (2003 KS BRFSS)	50%
Overweight and Obesity		
Reduce the proportion of children and adolescents who are overweight or obese.	11% (ages 12-18, 2002 KS Youth Tobacco Survey)	5% (ages 12-19)
Reduce the proportion of adults who are obese.	23% (2004 KS BRFSS)	15%
Tobacco Use		
Reduce cigarette smoking by adolescents.	21% (2005 KS Youth Risk Behavior Surveillance Survey, grades 9-12)	16% (grades 9-12)
Reduce cigarette smoking by adults.	20% (2004 KS BRFSS)	12%
Substance Abuse		

Objective	Kansas Rate	HP2010 Goal
Healthy People: Increase the proportion of adolescents *not* using alcohol or any illicit drugs during the past 30 days.	69% of 6th, 8th, 10th, and 12th graders reported *not* using alcohol at least once in the past 30 days 91% of 6th, 8th, 10th, and 12th graders reported *not* using marijuana at least once in the past 30 days (2005 Kansas Communities That Care Survey Youth Survey)	89%
Reduce the proportion of adults engaging in binge drinking of alcoholic beverages during the past month.	13% (2004 KS BRFSS)	6%
Responsible Sexual Behavior		
Increase the proportion of adolescents who abstain from sexual intercourse.	55% (Abstinence only - 2005 KS Youth Risk Behavior Surveillance System, grades 9-12)	95% (includes abstinence or condom use if sexually active)
Mental Health		
Increase the proportion of adults with recognized depression who receive treatment.	No Kansas data available that is directly comparable to HP2010 target.	50%
Injury and Violence		
Reduce deaths caused by motor vehicle crashes .	18.5 deaths per 100,000 population (2004 Vital Statistics, KDHE)	9.2 deaths per 100,000 population
Reduce homicides.	4.3 homicides per 100,000 population (2004 KS Vital Statistics)	3.0 homicides per 100,000 population
Environmental Quality		

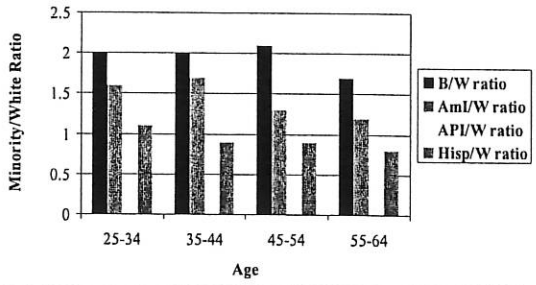
Objective	Kansas Rate	HP2010 Goal
Reduce the proportion of persons exposed to air that does not meet the U.S. Environmental Protection Agency's health-based standards for ozone.	0% (EPA Aerometric Information Retrieval System)	0%
Immunization		
HP2010 Objective: Increase the proportion of young children who are fully immunized (4:3:1:3:3 series)	75% (4:3:1:3:3 series - 2004 National Immunization Survey)	80% (4:3:1:3:3 series)
Increase the proportion of noninstitutionalized adults aged 65 years and older who are vaccinated annually against influenza.	68% (2004 KS BRFSS)	90%
Increase the proportion of adults aged 65 years and older ever vaccinated against pneumococcal disease.	63% (2004 KS BRFSS)	90%
Access to Health Care		
Increase the proportion of persons with health insurance.	85% (2004 KS BRFSS)	100%
Increase the proportion of persons who have a specific source of ongoing primary care.	84% (2004 KS BRFSS)	96%
Increase the proportion of pregnant women who begin prenatal care in the first trimester of pregnancy.	88% (2003 Vital Statistics, KDHE)	90%

Race and Health: 10 Key Facts

David R. Williams, Ph.D., MPH
Senior Research Scientist, and
Harold W. Cruse Collegiate Professor of
Sociology & Epidemiology

Institute for Social Research
University of Michigan

The Racial Gap in Health in Mid Life: Minority/White Mortality Ratios, 2000



Key Fact #1

Racial/Ethnic differences in health are large

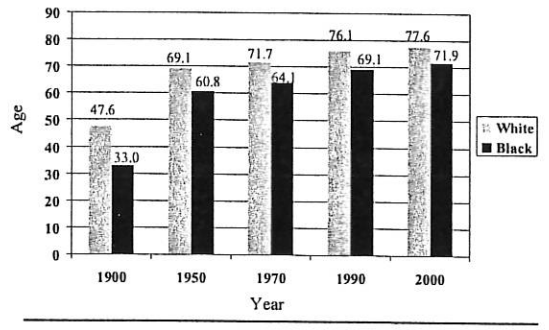
Key Fact #2

In the last 50 years, although overall health has improved, racial differences in health are unchanged or have widened.

Racial Disparities in Health

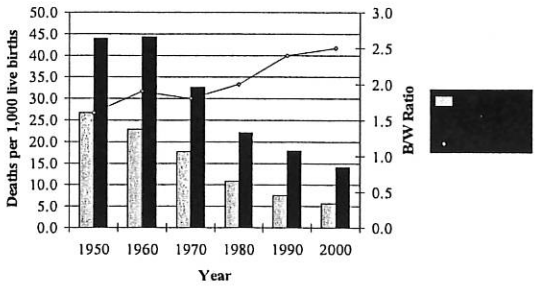
- In 2001, Blacks had higher death rates than Whites for 12 of the 15 leading causes of death.
- African Americans and American Indians have higher age-specific mortality rates than Whites from birth through the retirement years.
- The overall death rate for Blacks today is equivalent to that of Whites some 30 years ago.
- Almost 97,000 Black persons die each year who would not die if there were no racial disparities in health.

Life Expectancy at Birth, 1900-2000



Attachment 2
HHS 1-17-06

Infant Mortality Rates, 1950-2000



Key Fact #3

Racial differences in health are not primarily caused by genetic factors

Excess Deaths for Black Population

Year	Avg.No/Day	Avg.No/Year
1940	183	66,900
1950	144	52,700
1960	139	50,900
1970	198	72,200
1980	221	80,600
1990	285	103,900
1998	265	96,800

TOTAL Premature Deaths, 1940-1999 = 4,272,000

Levine et al. 2001

The Limits of Biology

- Our racial categories predate scientific theories of genetics and modern genetic studies and do not capture well the distribution of genetic characteristics across populations
- Groups with similar physical characteristics can be very different genetically
- "The fact that we know what race we belong to tells us more about our society than our biological makeup"[1]
- "Race is a pigment of our imagination"[2]
- We need to understand how risk factors/resources in the social/physical environment interact with biological predispositions to affect health

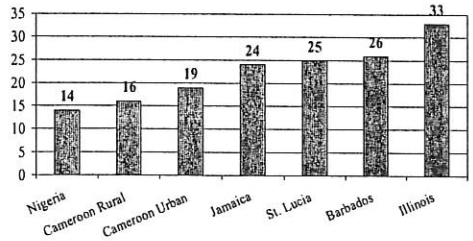
[1]Krieger and Bassett, 1986; [2]Ruben Rumbaut

The Persistence of Racial Disparities

- **We have FAILED!**
- **In spite of a War on Poverty, a Civil Rights revolution, Medicare, Medicaid, the Hill-Burton Act, dramatic advances in medical research and technology, we have made little progress in reducing the elevated death rates of blacks relative to whites.**

Source: NCHS 2000; Deaths per 1,000 population

Hypertension, 7 West African Origin Groups (%)



Source: International Collaborative Study of Hypertension in Blacks, 1995

A Closer Look at Conventional Wisdom

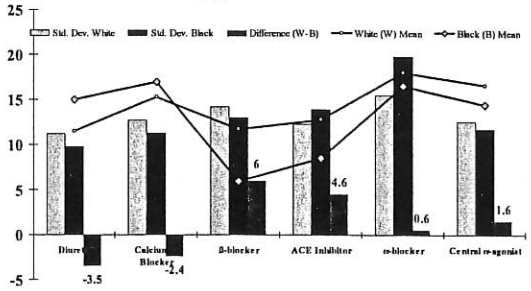
- Blacks and whites differ in their responses to antihypertensive medications
- White patients respond better to beta Blockers and ACE inhibitors
- Black patients respond better to Diuretics and Calcium Channel Blockers

Overlap in Antihypertensive Drug Response
Percent of Blacks & Whites with Similar Responses to Medications

Medication	Systolic	Diastolic
Diuretics	86%	90%
Calcium C Blocker	93%	95%
β-Blocker	83%	90%
ACE Inhibitor	86%	81%
α-Blocker	88%	87%
Central α-Agonist	92%	78%

Source: Sehgal, 2004. Meta Analysis of 15 Clinical Trials.

Decrement in Systolic B.P. with Antihypertensive Tx

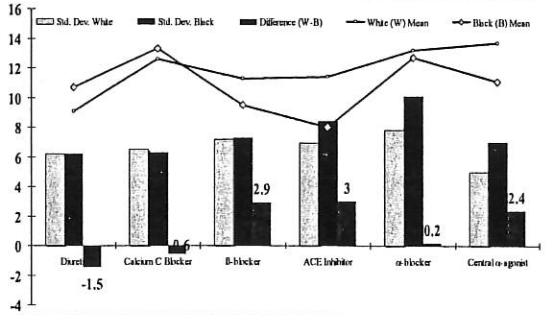


Source: Sehgal, Ashwini R. (2004). Hypertension. Vol. 43:566-572

Skin Color in the Clinical Context

- This meta analysis of 15 clinical trials reveals that the overwhelming majority of blacks and whites have similar responses to all of the common antihypertensive medications
- Thus, simply knowing a patient's race provides precious little guidance to a clinician in the selection of antihypertensive medications

Decrement in Diastolic B.P with Antihypertensive Tx



Source: Sehgal, Ashwini R. (2004). Hypertension. Vol. 43:566-572

Key Fact #4

Socioeconomic Status (SES) is a central but incomplete explanation of racial differences in health.

SAT Scores by Income

Family Income	Median Score
More than $100,000	1129
$80,000 to $100,000	1085
$70,000 to $80,000	1064
$60,000 to $70,000	1049
$50,000 to $60,000	1034
$40,000 to $50,000	1016
$30,000 to $40,000	992
$20,000 to $30,000	964
$10,000 to $20,000	920
Less than $10,000	873

Source: (ETS) Manuals: N=898,596

Life Expectancy at Age 25, U.S. Men
Race and Income Differences

Income (2000 dollars)	White	Black	Race Diffs.
All	50.1	45.7	4.4
Less than 20,000	45.0	41.6	
$20,000-$49,999	50.2	47.4	
$50,000 or more	52.9	50.2	
SES Diffs	7.9	8.6	

Source: NLMS: Lin et al., 2003

SES and Race

- African Americans and multiple other minorities have lower levels of education, income, professional status, and wealth than whites. These racial differences in SES are the major reason for racial differences in health.
- Education and income are generally more strongly associated with health status than race.
- Racial differences in health status decrease substantially when racial groups are compared at similar levels of SES.

Life Expectancy at Age 25, U.S. Men
Race, Income, and Gender Differences

Income (2000 dollars)	White	Black	Race Diffs.
All	50.1	45.7	4.4
Less than $20,000	45.0	41.6	3.4
$20,000-$49,999	50.2	47.4	2.8
$50,000 or more	52.9	50.2	2.7
SES Diffs.	7.9	8.6	

Source: NLMS: Lin et al., 2003

Life Expectancy at Age 25, U.S. Men
Race and Income Differences

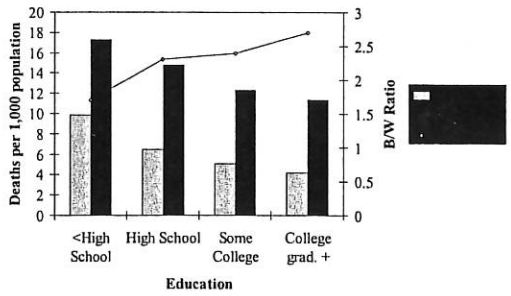
Family Income (2000 dollars)	White	Black	Race Diffs.
All	50.1	45.7	4.4

Source: NLMS: Lin et al., 2003

Race/Ethnicity and SES

- Race and SES reflect two related but not interchangeable systems of inequality
- In national data, the highest SES group of African American women have equivalent or higher rates of infant mortality, low birth-weight, hypertension and overweight than the lowest SES group of white women

Infant Death Rates by Mother's Education, 1995



Why Race Still Matters

1. All indicators of SES are non-equivalent across race. Compared to whites, blacks receive less income at the same levels of education, have less wealth at the equivalent income levels, and have less purchasing power (at a given level of income) because of higher costs of goods and services.
2. Health is affected not only by current SES but by exposure to social and economic adversity over the life course.
3. Personal experiences of discrimination and institutional racism are added pathogenic factors that can affect the health of minority group members in multiple ways.

Infant Death Rates by Mother's Education, 1995

Education	Black	White	B/W Ratio
All	14.7	6.3	2.3
< High School	17.3	9.9	1.7
High School	14.8	6.5	2.3
Some College	12.3	5.1	2.4
College grad. +	11.4	4.2	2.7

Source: Health United States 1998. Non-Hispanic Mothers = 20 years of age and older.

Race/Ethnicity and Wealth, 2000 Median Net Worth

Income	White	Black	Hispanic
All	$79,400	$7,500	$9,750
Excl. Hm. Eq.	22,566	1,166	1,850
Poorest 20%	24,000	57	500
2nd Quintile	48,500	5,275	5,670
3rd Quintile	59,500	11,500	11,200
4th Quintile	92,842	32,600	36,225
Richest 20%	208,023	65,141	73,032

Source: Orzechowski & Sepielli 2003, U.S. Census

Key Fact #5

All indicators of SES are not the same across racial/ethnic groups.

Wealth of Whites and of Minorities per $1 of Whites, 2000

Household Income	White	B/W Ratio	Hisp/W Ratio
Total	$ 79,400	9¢	12¢
Poorest 20%	$ 24,000	1¢	2¢
2nd Quintile	$ 48,500	11¢	12¢
3rd Quintile	$ 59,500	19¢	19¢
4th Quintile	$ 92,842	35¢	39¢
Richest 20%	$ 208,023	31¢	35¢

Source: Orzechowski & Sepielli 2003, U.S. Census

Key Fact #6

In addition to SES, racism is an added burden.

Discrimination Persists

- Pairs of young, well-groomed, well-spoken college men with identical resumes apply for 350 advertised entry-level jobs in Milwaukee, Wisconsin. Two teams were black and two were white. In each team, one said that he had served an 18-month prison sentence for cocaine possession.
- The study found that it was easier for a white male with a felony conviction to get a job than a black male whose record was clean.

Source: Devan Pager; NYT March 20, 2004

Racism Mechanisms

- **Institutional discrimination can restrict socioeconomic attainment a group differences in SES a health.**
- **Segregation can create pathogenic residential conditions.**
- **Discrimination can lead to reduced access to desirable goods and services.**
- **Internalized racism (acceptance of society's negative characterization) can adversely affect health.**
- **Racism can create conditions that increase exposure to traditional stressors (e.g. unemployment).**
- **Experiences of discrimination may be a neglected psychosocial stressor.**

Percent of Job Applicants Receiving a Callback

Criminal Record	White	Black
No	34%	14%
Yes	17%	5%

Source: Devan Pager; NYT March 20, 2004

MLK Quote

"..Discrimination is a hellhound that gnaws at Negroes in every waking moment of their lives declaring that the lie of their inferiority is accepted as the truth in the society dominating them."

Martin Luther King, Jr. [1967]

Every Day Discrimination

In your day-to-day life how often do the following things happen to you?

- **You are treated with less courtesy than other people.**
- **You are treated with less respect than other people.**
- **You receive poorer service than other people at restaurants or stores.**
- **People act as if they think you are not smart.**
- **People act as if they are afraid of you.**
- **People act as if they think you are dishonest.**
- **People act as if they're better than you are.**
- **You are called names or insulted.**
- **You are threatened or harassed.**

Key Fact #7

Place makes an added contribution to health.

Residential Segregation and SES

A study of the effects of segregation on young African American adults found that the elimination of segregation would erase black-white differences in

- Earnings
- High School Graduation Rate
- Unemployment

And reduce racial differences in single motherhood by two-thirds

Cutler, Glaeser & Vigdor, 1997

Social Context of Homicide

1. Lack of access to jobs produces high male unemployment and underemployment
2. This in turn leads to high rates of out of wedlock births, female-headed households and the extreme concentration of poverty.
3. Single-parent households lead to lower levels of social control and guardianship
4. The association between family structure and violent crime identical in sign and magnitude for whites and blacks.
5. Racial differences at the neighborhood level in availability of jobs, family structure, opportunities for marriage and concentrated poverty underlie racial differences in crime and homicide.

Source: Sampson 1987

Segregation: Distinctive for Blacks

- Blacks are more segregated than any other racial/ethnic group.
- Segregation is inversely related to income for Latinos and Asians, but is high at all levels of income for blacks.
- The most affluent blacks (income over $50,000) are more highly segregated than the poorest Latinos and Asians (incomes under $15,000).
- Thus, middle class blacks live in poorer areas than whites of similar SES and poor whites live in much better neighborhoods than poor blacks.
- African Americans manifest a higher preference for residing in integrated areas than any other group.

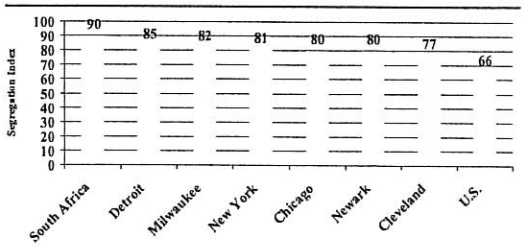
Source: Massey 2004

Racial Differences in Residential Environment

- "The sources of violent crime...are remarkably invariant across race and rooted instead in the structural differences among communities, cities, and states in economic and family organization," p. 41
- In the 171 largest cities in the U.S., there is not even one city where whites live in ecological equality to blacks in terms of poverty rates or rates of single-parent households.
- "The worst urban context in which whites reside is considerably better than the average context of black communities." p.41

Source: Sampson & Wilson 1995

American Apartheid: South Africa (de jure) in 1991 & U.S. (de facto) in 2000



Source: Massey 2004; Iceland et al. 2002; Glaeser & Vigitor 2001

Improving Residential Circumstances

Policies to reduce racial disparities in SES and health should address the concentration of economic disadvantage and the lack of an infrastructure that promotes opportunity that co-occurs with segregation.

That is, eliminating the negative effects of segregation on SES and health is likely to require a major infusion of economic capital to improve the social, physical, and economic infrastructure of disadvantaged communities.

Source: Williams and Collins 2004

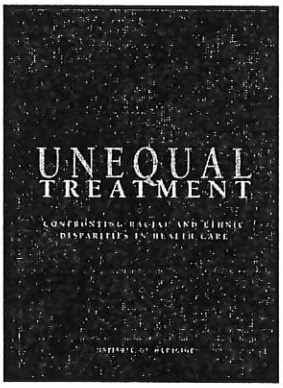
The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization

- **Women (OR =0.60) and blacks (OR =0.60) were less likely to be referred for cardiac catheterization than men and whites, respectively.**
- **Black women were significantly less likely to be referred for catheterization than white men (OR= 0.4)**

Source: Schulman et. al., *NEJM* 1999;340:618.

Key Fact #8

There are racial/ethnic differences in access to care and the quality of care



The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization

- **720 physicians viewed recorded interviews**
- **Reviewed data about a hypothetical patient**
- **The physicians then made recommendations about that patient's care**

Source: Schulman et.al. *NEJM* 1999;340:618.

David Williams, a University of Michigan professor, right, says: "We have a health care system that is the pride of the world, but this report documents that the playing field is not even."

Race and Medical Care

- **Across virtually every therapeutic intervention, ranging from high technology procedures to the most elementary forms of diagnostic and treatment interventions, minorities receive fewer procedures and poorer quality medical care than whites.**
- **These differences persist even after differences in health insurance, SES, stage and severity of disease, co-morbidity, and the type of medical facility are taken into account.**
- **Moreover, they persist in contexts such as Medicare and the VA Health System, where differences in economic status and insurance coverage are minimized.**

Institute of Medicine, 2002

What are potential sources of disparities in care?

- Patient-level factors – including patient preferences, refusal of treatment, poor adherence, biological differences
- Health systems-level factors – financing, structure of care; cultural and linguistic barriers
- Disparities arising from the clinical encounter – stereotyping, prejudice, and clinical uncertainty

Ethnicity and Analgesia

A chart review of 139 patients with isolated long-bone fracture at UCLA Emergency Department (ED):

- **All patients aged 15 to 55 years, had the injury within 6 hours of ER visit, had no alcohol intoxication.**
- **55% of Hispanics received no analgesic compared to 26% of non-Hispanic whites.**
- **With simultaneous adjustment for sex, primary language, insurance status, occupational injury, time of presentation, total time in ED, fracture reduction and hospital admission, Hispanic ethnicity was the strongest predictor of no analgesia.**
- **After adjustment for all factors, Hispanics were 7.5 times more likely than non-Hispanic whites to receive no analgesia.**

Todd, et al. 1993

Potential Sources of Racial and Ethnic Healthcare Disparities – Healthcare Systems-level Factors

- Cultural and linguistic barriers – many non-English speaking patients report having difficulty accessing appropriate translation services
- Lack of stable relationships with primary care providers – minority patients, even when insured at the same level as whites, are more likely to receive care in emergency rooms and have less access to private physicians
- Financial incentives to limit services – may disproportionately and negatively affect minorities
- "Fragmentation" of healthcare financing and delivery

Procedures with Higher Rates for Blacks than Whites Medicare Beneficiaries Age 65 or Older, 1992

	Procedure Rates	Mortality Rates
Procedure	B/W Ratio	B/W Ratio
1. Amputation (lower limb	3.62	0.79
2. Excisional Debridement	2.65	1.22
3. Arteriovenostomy	5.17	0.66
4. Bilateral Orchiectomy	2.21	0.99

Source: McBean and Gornick, 1994

1 = Usually a consequence of diabetes
2 = Removal of tissue, usually related to decubitus ulcers
3 = Implanting shunts for chronic renal dialysis
4 = Removal of both testes, generally performed because of cancer

Disparities in the Clinical Encounter: The Core Paradox

How could well-meaning and highly educated health professionals, working in their usual circumstances with diverse populations of patients, create a pattern of care that appears to be discriminatory?

Unconscious Discrimination

- When one holds a negative stereotype about a group and meets someone who fits the stereotype s/he will discriminate against that individual
- Stereotype-linked bias is an
  - Automatic process
  - Unconscious process
- It occurs even among persons who are not prejudiced

'I'm not racist: I know I don't stereotype

- Conclusive evidence that stereotypes are activated automatically (without intent).
- Individuals frequently are not aware of activation nor impact on their perceptions, emotions and behavior.
- They are activated more quickly and effortlessly than conscious cognition.
- Many cognitive processes result in confirmation of expectancies (we process information in ways that support our beliefs).

Source: van Ryn, 2003

Whites Stereotypes of Blacks (and Whites) %

1. Lazy		
Blacks are lazy	44	(5)
Neither	34	(36)
Blacks are hard working	17	(55)
2. Violent		
Blacks are prone to violence	51	(16)
Neither	28	(42)
Blacks are not prone to violence	15	(37)
3. Unintelligent		
Blacks are unintelligent	29	(6)
Neither	45	(33)
Blacks are intelligent	20	(55)
4. Welfare		
Blacks prefer to live off welfare	56	(4)
Neither	27	(22)
Blacks prefer to be self-supporting	13	(71)

Source: 1990 General Social Survey

Factors that Increase Stereotype Usage

- Time Pressure
- Need for Quick Judgments
- High Cognitive demands
- Task Complexity
- Resource constraints
- Anger or Anxiety

Medical Encounter: Time pressure, brief encounters, need to manage complex cognitive tasks.

Source: van Ryn 2002

White Americans' Stereotypes Percent Agreeing that Most Group Members Prefer to Live off Welfare

	Whites	Blacks	Hispanics	Asians	Jews	Southern Whites
Prefer to live off Welfare	3.7	56.1	41.6	16.3	2.4	12.9
Neither	21.5	26.5	30.5	31.6	14.6	35.2
Prefer to be Self-Supporting	70.5	12.7	18.3	40.6	75.7	41.4
DK/NA	4.3	4.7	9.7	11.5	7.3	10.5

Source: General Social Survey 1990

Generalizability of Unconscious Bias

- An important characteristic of social interaction across a broad range of cultures and societies where individuals are characterized into social groups
- In the U.S., race, sex and age are the three primary characteristics of individuals that are attended to across a broad range of social contexts

Key Fact #9

Minorities are still under-represented among health professionals.

Key Fact #10

African Americans have much better mental health than expected.

Enrollment in Dental School: Blacks, Other Races, Women

	1970-71	2000-01
	Percentages	
Black	4.5	4.7
White	91.4	64.4
Hispanic	1.0	5.3
American-Indian	0.1	0.6
Asian	2.6	25.0
All Women [1]	3.1	37.6

Source: National Center for Health Statistics, 2003; [1] Comparison years for women are 1971-72 with 1999-2000.

Disparities in Mental Health

Blacks have lower rates than whites of :

1. **Any Affective Disorder**
2. **Any Anxiety Disorder**
3. **Any Substance Abuse/Dependence**
4. **Any disorder**

Source: Kessler et.al. (1994)

Enrollment in Medical School: Blacks, Other Races, Women

	1970-71	2000-01
	Percentages	
Black	3.8	7.4
White	94.3	63.8
Hispanic	0.5	6.4
American-Indian	0.0	0.8
Asian	1.4	20.1
All Women [1]	13.7	44.4

Source: National Center for Health Statistics, 2003; [1] Comparison years for women are 1971-72 with 1999-2000.

Disparities in Mental Health Care

Compared with whites:

- **Minorities have less access to, and availability of, mental health services.**
- **Minorities are less likely to receive needed mental health services.**
- **Minorities in treatment often receive a poorer quality of mental health care.**
- **Minorities are underrepresented in mental health research.**

Source: Mental Health: Culture, Race, and Ethnicity (2001) [Supplement to the Surgeon General's Report on Mental Health]

Religious Services as Therapy?

1. Several aspects of some religious services are distinctive in the provision of opportunities to articulate and manage personal and collective suffering.
2. The expression of emotion and active congregational participation can promote "collective catharsis" in ways that facilitate the reduction of tension and the release of emotional distress.
3. There are parallels between all the key elements of formal psychotherapy and the rituals of some religious services.

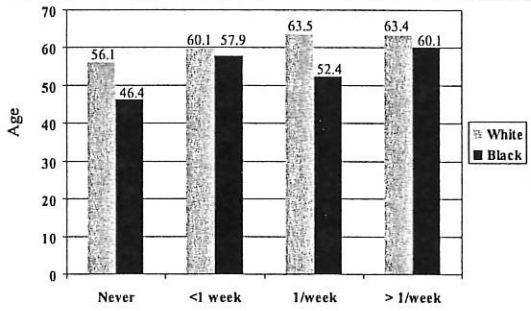
Griffith et al. (1980); Gilkes (1980): Pargament et al. (1983)

International Comparisons in Health

Infant Mortality, Rank 1999		Life Expectancy at Birth, 1998 Men	Women
1	Hong Kong (3.1)	Hong Kong (77.4)	Japan (84.0)
19	Ireland (5.5)	Austria (74.7)	U.S. WHITE (80.0)
20	New Zealand (5.5)	U.S. WHITE (74.5)	Northern Ireland
21	Portugal (5.6)	Belgium (74.3)	United States (79.5)
24	U.S. WHITE (5.8)	United States (73.8)	Puerto Rico (79.3)
26	Cuba (6.4)	Finland (77.6)	Portugal (78.9)
28	United States (7.1)	Chile (72.3)	Chile (78.3)
34	Costa Rica (11.8)	U.S. BLACK (67.6)	Hungary (75.2)
35	Bulgaria (14.5)	Bulgaria (67.4)	U.S. BLACK (74.8)
36	U.S. BLACK (14.6)	Romania (66.3)	Bulgaria (74.7)

Source: National Center for Health Statistics, 2003

U.S. Life Expectancy at Age 20 by Religious Attendance



Reducing Inequalities Address Underlying Determinants of Health- I

- Improve living standards for poor persons and households
- Increase access to employment opportunities
- Increase education and training that provide basic skills for the unskilled and better job ladders for the least skilled
- Invest in improved educational quality in the early years and reduce educational failure

The Bottom-Line

Policies to reduce inequalities in health must address fundamental non-medical determinants.

Reducing Inequalities Address Underlying Determinants of Health- II

- Improve conditions of work, re-design workplaces to reduce injuries and job stress
- Enrich the quality of neighborhood environments and increase economic development in poor areas
- Improve housing quality and the safety of neighborhood environments

Reducing Inequalities
Health Care

- **Improve access to care and the quality of care**
  - **Give emphasis to the prevention of illness**
  - **Provide effective treatment**
  - **Develop incentives to reduce inequalities in the quality of care**

Possible Solutions

- Perspective-taking can reduce stereotypes and prejudice. (Compared to a no-instruction control group and a "stereotype suppression group" that was instructed to actively try to avoid thinking about the person in a stereotypic manner.)
- For example, whites who wrote about a day in the life of an elderly or black person, showed less *explicit* and *implicit stereotyping*.
  - "imagine a day in the life of this individual as if you were that person, looking at the world through his eyes and walking through the world in his shoes."

Source: Van Ryn and Burgess 2003 (JPSP)

Reducing Inequalities
Engage Multiple Communities

- **Knowledge of the extent of disparities and their causes is a prerequisite for effective action**
  - **In the U.S., over 50% of whites, blacks, and Hispanics are unaware that racial disparities in health exist.**
- **Partnerships needed with government, industry, and other private organizations**
- **Important role for community involvement in the identification and management of interventions**
- **Strengthen the capacity of community organizations to take action**

MLK Quote

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."

--Martin Luther King Jr.