Racial and Ethnic Disparities: Looking Back Seminar Series

Racial & Ethnic Health & Healthcare Disparities & Dysfunction: Historical & Contemporary Issues

W. Michael Byrd, MD, MPH  
Linda A. Clayton, MD, MPH

Tuesday, February 16th, 2016
1:00 – 2:00 pm
Ether Dome, Bullfinch 4th Floor

Reminders

✓ Please complete the evaluation and photo release inside your program. Leave on table outside the Ether Dome or hand to a DSC Staff member on way out.

✓ Follow the Disparities Solutions Center on Facebook and Twitter (info on table outside)

Upcoming Events

DSC Web Series in Partnership with HPOE: Going Beyond REAL Data Collection: Collecting Social Determinants of Health
– February 23, 2016 from 12:00-1:00pm ET

DSC Keeping Current Seminar Series: Disparities in Radiology
– March 24, 2016, 12:00-1:00pm ET in O'Keefe Auditorium

Healthcare Quality and Equity Action Forum
– September 29-30, 2016 at Seaport Boston Hotel

Visit mghdisparitiessolutions.org for more information.

Speakers

W. Michael Byrd, MD, MPH
Director, Institute for Optimizing Health and Health Care (IOHHC)
Health Policy Researcher, Harvard School of Public Health
Health Policy Instructor, Harvard School of Public Health, Harvard Medical School
Adjunct Professor, Obstetrics and Gynecology, Meharry Medical College

Linda A. Clayton, MD, MPH
Co-Director, Institute for Optimizing Health and Health Care (IOHHC)
Health Policy Researcher, Harvard School of Public Health
Health Policy Instructor, Harvard School of Public Health, Harvard Medical School
Adjunct Professor, Obstetrics and Gynecology, Meharry Medical College
AFRICAN AMERICANS HAVE HAD THE WORST HEALTH STATUS... THE WORST HEALTH OUTCOMES, AND... THE WORST HEALTH SERVICES DELIVERY... THAN ANY OTHER RACIAL OR ETHNIC GROUP IN THE UNITED STATES SINCE OUR ARRIVAL IN 1619...397 YEARS AGO

THUS, THEY WILL SERVE WELL AS OUR TEACHING MODEL FOR UNDERSTANDING U.S. HEALTH DISPARITIES, HEALTH SYSTEM DYSFUNCTION, AND THE FLAWED AMERICAN MEDICAL-SOCIAL CULTURE


IF WE ARE TO SOLVE THE PROBLEMS OF: RACIAL-, ETHNIC-, AND CLASS-BASED HEALTH INEQUITIES, DISPARITIES, & LACK OF DIVERSITY WE MUST: UNDERSTAND the Problems

REQUISITE BACKGROUND AREAS FOR THE INEQUITY & DISPARITY INQUIRY

- Medicine & Health Care & their histories
- Medical-Sociology
- Health Care Economics & its history
- Public Health & its history
- Health Policy & its history
- History of Science
- Racial & Ethnic Studies

FOUNDATIONS OF THE INEQUITY AND DISPARITY INQUIRY

- Biology
- History
- Health Care Economics
- Genetics
- Medicine
- History of Science
- Political Science
- Medical Ethics
- Public Health
- Health Policy
- Race/Ethnic Relations
- Philosophy
- Psychology
- Medical Sociology
- Epidemiology
- Biostatistics
- Anthropology
- Public Policy
- Ethnology
- Sociology
- Genetics
- Academic Biography
- Medical History
- Tropical Medicine
- Evolutionary Biology
- Cultural Anthropology
- Afro-American Studies

RACE/ETHNIC/GENDER/CLASS INEQUITIES, DISPARITIES, & DYSFUNCTION IN WESTERN SCIENCE/MEDICINE/HEALTHCARE: THE INQUIRY

- Antiquity
- Greco Roman Period
- Arabic Period
- Renaissance - Age of Reason
- Colonial & U.S. Experience

ORIGINS AND EVOLUTION OF A FLAWED MEDICAL-SOCIAL & SCIENTIFIC CULTURE

**ORIGINS**
- Predating Plato & Aristotle’s 2,500 year-old “Great Chain of Being”
- Hierarchical thinking, ideology, behavior, & practices based on reification of races, ethnicities, classes, & gender

**EVOLUTION INTO**
- Scientific racism
- Misogyny
- Unethical Biomedical & Experimental Exploitation
- Theories of Racial, Gender, Ethnic, & Class superiority & inferiority
- Biases & practices that deeply distort Western medical, scientific, & academic traditions


INEQUITIES, DISPARITIES, & DYSFUNCTION IN WESTERN MEDICINE, HEALTH, AND HEALTH CARE-

GREEK PERIOD [1600-300 B.C.]

PLATO

ARISTOTLE

THE WESTERN SCIENTIFIC TRADITION (Focus on Biomedicine, 1500-1900)

Some Contributors to Racism, Bias, Discrimination, & Scientific Racism in Western Science

- Marcello Malpighi
- Anton Leeuwenhoek
- Carolus Linnaeus
- Johann Blumenbach
- Georges Cuvier
- Charles Darwin
- Samuel J. Boss
- Sir Francis Galton

Careers in Scientific Racism

**OUR ANATOMY LESSON**

<table>
<thead>
<tr>
<th>NAME</th>
<th>SCIENTIFIC NAME</th>
<th>SCIENTIFIC RACISM</th>
<th>PRESENT EFFECTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PETER CAMPER</td>
<td>Camper’s fascia; ligament; angle</td>
<td>Traditional racial</td>
<td>Blacks still have negative image. &quot;Race&quot; medicine still taught in U.S. medical schools.</td>
</tr>
<tr>
<td>ANDERS RETZIUS</td>
<td>Retzius ligament; angle; space</td>
<td>Traditional racial</td>
<td>Blacks still have negative image. &quot;Race&quot; medicine still taught in U.S. medical schools.</td>
</tr>
<tr>
<td>PAUL BROCA</td>
<td>Broca’s area of the brain; path breaking</td>
<td>Traditional racial</td>
<td>Taught; Taught female inferiority.</td>
</tr>
</tbody>
</table>

**SCIENTIFIC MYTHS—THE BLACKS-ape CONNCETION**

The English/North American—U.S. health experience

SHORTCUTS TO UNDERSTANDING

CULTURE

STRUCTURE

FUNCTION

of the HEALTH SYSTEM

STRUCTURAL & CULTURAL DEVELOPMENTS CONTRIBUTING TO HEALTH DISPARITIES & DYSFUNCTION

(1607-1619)

NATIVE AMERICANS

ENGLISH COLONISTS

TRADITIONAL HEALTH SYSTEM

MAINSTREAM HEALTH SYSTEM

“POOR” subsystem

SLAVES & THE “POOR”

AMERICAN CHARACTER TRAITS

CALVINIST ETHIC

PURITAN ETHIC

PROTESTANT ETHIC

CLASS

RACE

PRISONERS

WORTHY POOR

UNWORTHY POOR

STIGMA

DISEASE FILTERS

OUT-OF-WEDLOCK PREGNANCY

SYPHILIS

GONORRHEA

LEPROSY

TB

MENTAL ILLNESS

CANCER

WORTHY POOR

UNWORTHY POOR

“Slavery was no side-show in American history—it was the ‘main event.’”

James Oliver Horton

“Slavery was the extraordinary goose that laid the ‘golden egg’”

James Oliver Horton

THE "SLAVE WARS"

THE "ROUND-UPS"

THE MARCH FROM THE INTERIOR...

TO THE WEST AFRICAN COASTS

Goree' Island, Senegal

50% MORTALITY RATE

ELMINA CASTLE, GHANA
CAPE COAST CASTLE, GHANA

SLAVE BARACOON (STORAGE PEN)

SLAVE STORAGE CELL IN “SLAVE CASTLE”

OUTDOOR SLAVE STORAGE

DEATH RATE 25%

THE “DOOR OF NO RETURN”

THE “MIDDLE PASSAGE”—DEATH RATE 15-50%
SLAVE “BREAKING IN” CAMP
SOUTH CAROLINA, USA
DEATH RATE—30-50%

THE SLAVE HEALTH DEFICIT

STRUCTURAL & CULTURAL DEVELOPMENTS CONTRIBUTING TO HEALTH DISPARITIES & DYSFUNCTION

EARLY HEALTH SYSTEM (1619-1865)
- POPULATION GROUPS: NATIVE AMERICANS, ENGLISH AMERICANS, IMMIGRANTS & POOR, SLAVES
- HEALTH SYSTEM SEGMENTS: TRADITIONAL SUBSYSTEM, MAINSTREAM HEALTH SYSTEM

“SEGREGATED” HEALTH SYSTEM—1865-1965
- POPULATION GROUPS: NATIVE AMERICANS, ENGLISH AMERICANS, IMMIGRANTS & POOR
- HEALTH SYSTEM SEGMENTS: MAINSTREAM HEALTH SYSTEM, “POOR” SUBSYSTEM

PRE-ACA HEALTH SYSTEM (1965-2010)
- POPULATION GROUPS: Veterans, Military & NATIVE AMERICANS, WHITE/MIDDLE CLASS AMERICANS, IMMIGRANTS & POOR, BLACKS ETHNIC AMERICANS
- HEALTH SYSTEM SEGMENTS: MAINSTREAM HEALTH SYSTEM, “PUBLIC” SECTOR SUBSYSTEM (Medicaid, NHCs, PHCs), “NETHERWORLD”

CONTEMPORARY (Post-ACA) HEALTH SYSTEM (2010-PRESENT)
- POPULATION GROUPS: Veterans, Military & NATIVE AMERICANS, WHITE/MIDDLE CLASS AMERICANS, IMMIGRANTS & POOR
- HEALTH SYSTEM SEGMENTS: MAINSTREAM HEALTH SYSTEM, “PUBLIC/PRIVATE” SUBSYSTEM (Medicaid, & Lower Level Plans), “NETHERWORLD”

Inferior
### African American Citizenship Status & Health Experience

**Table 18: From 1619 to 2016**

<table>
<thead>
<tr>
<th>TIME SPAN</th>
<th>CITIZENSHIP STATUS</th>
<th>PERCENT [U.S. EXPERIENCE]</th>
<th>HEALTH AND HEALTH SYSTEM STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1619-1665</td>
<td>248</td>
<td>63.96%</td>
<td>Challenged security</td>
</tr>
<tr>
<td>1865-1965</td>
<td>100</td>
<td>25.25%</td>
<td>Virtually no citizenship rights</td>
</tr>
<tr>
<td>1965-2016</td>
<td>51</td>
<td>12.85%</td>
<td>Most citizenship rights</td>
</tr>
<tr>
<td>1619-2016</td>
<td>397</td>
<td>100%</td>
<td>No strength reserved</td>
</tr>
</tbody>
</table>

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### The U.S. Health Disparities Engine (Modern Configuration)

- **Provider Factors:**
  1. Unequal Treatment (U.S. medical pedagogy & culture)
  2. Biased Clinical-Decision Making
  3. Stereotyping
  4. Discrimination

- **Patient Factors + (Disparities Producing Factors):**
  1. Demographics (e.g., poor neighborhoods)
  2. Language & Communication
  3. Culture
  4. Religion

- **Health System Factors:**
  1. Culture
  2. Racial, ethnic, class Segregation
  3. Financing
  4. Structure
  5. Multi-Tiering
  6. Process Factors

- **Community Factors:**
  1. Social Determinants
  2. Health System and Residential Segregation
  3. Access Factors (e.g., no hospitals, doctor's offices, labs, etc.)

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### Shortcuts to Understanding

**Culture**

**Function**

**Structure**

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### The U.S. Disparities Engine

- **Provider Factors:**
  1. Unequal Treatment
  2. Biased Clinical-Decision Making
  3. Stereotyping
  4. Discrimination

- **Patient Factors (Disparities Producing Factors):**
  1. Demographics
  2. Communication
  3. Language
  4. Culture
  5. Religion

---

THE U.S. DISPARITIES “ENGINE”

**HEALTH SYSTEM FACTORS:**
1. Financing
2. Structure
3. Tiering
4. Segregation by Race & Class
5. Process Factors
6. Medical-Social Culture


THE U.S. DISPARITIES “ENGINE”

**COMMUNITY FACTORS:**
1. Social Determinants
2. Health System and Residential Segregation
3. Access Factors
4. No sense of “community” about Health


A 90-95% EUROPEAN WHITE PATIENT POPULATION IN 1900

MULTI-RACIAL, MULTI-ETHNIC, SES-DIVERSE PATIENT POPULATION IN 2016—INTO THE 21ST CENTURY

CONTRIBUTORS TO HEALTH DISPARITIES
- Race, Class, Ethnicity
- The Clinical Encounter
- Health system factors
  - Structural
  - Process
  - Legal/Regulatory
- Environmental, Behavioral, Biological factors
- Access
- Stereotyping, bias, prejudice, clinical uncertainty
- Individual
- Institutional
- Cultural factors
- Quality factors
- SES factors


INEQUITIES, DISPARITIES, & DYSFUNCTION IN WESTERN & U.S. MEDICINE, HEALTH, AND HEALTH CARE

-SUMMARY-
- The Roots of racial, ethnic, and class inequities & disparities in Western and, later, American medicine & health care are over 2,500 years old
- The legacy of health inequities and disparities for African Americans is almost 400 years old
- The African American health experience parallels their citizenship status in many ways


INEQUITIES, DISPARITIES, & DYSFUNCTION IN WESTERN & U.S. MEDICINE, HEALTH, AND HEALTH CARE

-SUMMARY-
- An American Health Dilemma documents two periods of health reform to address Black health inequities and disparities
  - First Reconstruction in Black Health [1865-1872]
  - Second Reconstruction in Black Health [1965-1975]
- The U.S. health system was created, structured and evolved on the basis of race, ethnicity and class

INEQUITIES, DISPARITIES, & DYSFUNCTION IN WESTERN & U.S. MEDICINE, HEALTH, AND HEALTH CARE-

**SUMMARY**

- The over 100 year “Market Experiment” has failed. Racial-, Ethnic-, and Class-Based inequities, disparities, and dysfunction in U.S. health, health care, and health care services remain. These malfunctions persist, and in some cases have worsened—despite “Market Experiments” in health care financing, “MARKET JUSTICE,” market-based structuring, and attempts at market-based health care delivery!


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**SELECT REFERENCES**

- Stevens R. Assessing health reform’s impact on four key groups of Americans.
African Americans

Have had the worst health status...

The worst health outcomes, and...

The worst health services delivery...

Than any other racial or ethnic group

In the United States since our arrival

In 1619...397 years ago


Definitions

Health disparity-

Differences in health among segments of the population (demographic groups) that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation.


Disparities

Disparities exist in many areas, including, but not limited to:

1. Disease specific health outcomes (e.g., cancer, HIV/AIDS, and heart disease)
2. Service Delivery—Health system structural and process factors
3. Health insurance status—Health financing*
4. Access, availability, accountability, acceptability, adaptability, affordability
5. Clinical encounter—Clinical decision making
6. Quality of care

*Focus of recent Patient Protection & Affordable Care Act (PPACA)

Who are we talking about?

• Blacks...most affected
• Other racial and ethnic groups (e.g., Native Americans, Mexican Americans)
• Some employment-based insurance members
  • Unemployed
  • Underemployed
  • Employed, but unaffordable (middle-class), and
  • Medically indigent individuals—many new
• Some other disadvantaged populations
  • Many elderly and poor people
  • Disabled civilians and veterans
  • Children
  • Many single mothers
  • Some uninsured, underinsured, govt. insurance
  • Some rural populations
• Recent immigrants (especially undocumented)

Increasingly diverse groups affected

African American/Ethnic/Disadvantaged Health/Health Care Crisis

• Wide, deep, health disparities (based on race, ethnicity, and class)
• Disparate access barriers
• High uninsured, underinsured rates
• Structural inequalities and inequities
• Large populations trapped in dual, unequal tiers of health system
• A chronic racial & medical-social problem
• Built upon almost four centuries of dysfunctional ideology, philosophy, “science,” biomedicine, and practice
Age-Adjusted Cancer Death Rates by Race and Ethnicity, Massachusetts, 2010

<table>
<thead>
<tr>
<th>Group</th>
<th>Rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>White non-Hispanic</td>
<td>159.7</td>
</tr>
<tr>
<td>Hispanic</td>
<td>182.4</td>
</tr>
<tr>
<td>Black non-Hispanic</td>
<td>181.0</td>
</tr>
<tr>
<td>Asian non-Hispanic</td>
<td>118.1</td>
</tr>
<tr>
<td>Overall</td>
<td>171.0</td>
</tr>
</tbody>
</table>

NOTE: Rates are per 100,000 population. Age-adjusted to the 2000 standard population.
SOURCE: Massachusetts Department of Public Health, Center for Health Information, Statistics, Research, and Evaluation.

Age-Adjusted Heart Disease Death Rates by Race and Ethnicity, Massachusetts, 2010

<table>
<thead>
<tr>
<th>Group</th>
<th>Rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>White non-Hispanic</td>
<td>149.4</td>
</tr>
<tr>
<td>Hispanic</td>
<td>173.6</td>
</tr>
<tr>
<td>Black non-Hispanic</td>
<td>103.9</td>
</tr>
<tr>
<td>Asian non-Hispanic</td>
<td>101.8</td>
</tr>
<tr>
<td>Overall</td>
<td>131.3</td>
</tr>
</tbody>
</table>

NOTE: Rates are per 100,000 population. Age-adjusted to the 2000 standard population.
SOURCE: Massachusetts Department of Public Health, Center for Health Information, Statistics, Research, and Evaluation.

Age-Adjusted Stroke Death Rates by Race and Ethnicity, Massachusetts, 2010

<table>
<thead>
<tr>
<th>Group</th>
<th>Rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>White non-Hispanic</td>
<td>30.5</td>
</tr>
<tr>
<td>Hispanic</td>
<td>43.0</td>
</tr>
<tr>
<td>Black non-Hispanic</td>
<td>42.9</td>
</tr>
<tr>
<td>Asian non-Hispanic</td>
<td>26.0</td>
</tr>
<tr>
<td>Overall</td>
<td>33.8</td>
</tr>
</tbody>
</table>

NOTE: Rates are per 100,000 population. Age-adjusted to the 2000 standard population.
SOURCE: Massachusetts Department of Public Health, Center for Health Information, Statistics, Research, and Evaluation.

Age-Adjusted Diabetes Death Rates by Race and Ethnicity, Massachusetts, 2010

<table>
<thead>
<tr>
<th>Group</th>
<th>Rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>White non-Hispanic</td>
<td>21.8</td>
</tr>
<tr>
<td>Hispanic</td>
<td>18.1</td>
</tr>
<tr>
<td>Black non-Hispanic</td>
<td>12.9</td>
</tr>
<tr>
<td>Asian non-Hispanic</td>
<td>7.3</td>
</tr>
<tr>
<td>Overall</td>
<td>12.6</td>
</tr>
</tbody>
</table>

NOTE: Rates are per 100,000 population. Age-adjusted to the 2000 standard population.
SOURCE: Massachusetts Department of Public Health, Center for Health Information, Statistics, Research, and Evaluation.

Age-Adjusted Death Rates by Education and By Race and Ethnicity, Adults 25-64 years Massachusetts 2005 & 2007 comparison

<table>
<thead>
<tr>
<th>Education Level</th>
<th>White non-Hispanic</th>
<th>Hispanic</th>
<th>Black non-Hispanic</th>
<th>Asian non-Hispanic</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School or Less</td>
<td>181.0</td>
<td>231.0</td>
<td>231.0</td>
<td>114.4</td>
<td>169.5</td>
</tr>
<tr>
<td>13+ Education</td>
<td>179.6</td>
<td>227.6</td>
<td>227.6</td>
<td>112.7</td>
<td>167.4</td>
</tr>
</tbody>
</table>

NOTE: Rates are per 100,000 population. Age-adjusted to the 2000 standard population.
SOURCE: Massachusetts Department of Public Health, Center for Health Information, Statistics, Research, and Evaluation.
Audience Q&A

Please remember to complete evaluations & photo release. Completed forms can be left on the table outside the Ether Dome or handed to a DSC staff member.

Additional Questions?

Dr. W. Michael Byrd at wmichaelbyrd@rcn.com

Dr. Linda A. Clayton at lclayton@rcn.com

Thank you for attending!

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