ELIMINATING HEALTH DISPARITIES
BY ADVANCING HEALTH EQUITY
AMERICAN PSYCHOLOGICAL ASSOCIATION (APA)
STRATEGIC INITIATIVE ON HEALTH DISPARITIES

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www.jointcenter.org
Today’s Webinar

• Overview of APA’s Strategic Initiative on Health Disparities
• Webinar Objectives
• Introduction of Featured Presenter
• Questions and Answers
• Announcements and Closing Comments
APA’s Health Disparities Initiative

PURPOSE:
Increase support for research, training, public education and interventions that improve health and reduce health disparities.

Focuses on the health conditions of stress, obesity and substance abuse and addiction
Major Programs and Activities

- Smoking/Tobacco Health Disparities
- Health Disparities in Boys and Men
- Stress and Health Disparities
- Conferences:
  
  *Strengthening Psychology's Role in Reducing Tobacco Health Disparities*
  
  *Summit on Obesity in African American Women and Girls (in collaboration with the Association of Black Psychologists)*

- Health Disparities Seminar Series

  *Health Disparities in Boys and Men: Influence of Masculinity on Health Disparities and Equity (Wizdom Powell, PhD and Waldo Johnson, Jr., PhD)*

  *A Critical Analysis of Drug Laws, Interventions and Policy Based on Research and Life Experiences (Carl Hart, PhD)*
Major Program and Activities (cont’d)

**Behavioral and Social Science Volunteers (BSSV)/ Health Equity Ambassadors**

- A training and technical assistance program aimed at supporting psychologists and others in gaining expertise in health disparities and disseminating information to their colleagues, students and communities.

- Today is the first webinar in a series on health disparities by Brian D. Smedley, PhD
Webinar Objectives:

At the end of this webinar, participants should be able to:

- Define health disparities and health equity
- Identify the determinants of health and their impact on the health and well-being of individuals and communities
- Describe people-based and place-based approaches to achieving health equity
- List ways in which psychologists and other healthcare professionals can work towards reducing health disparities
Today’s Presenter ....

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THE CASE FOR ADVANCING HEALTH EQUITY: ELIMINATING RACIAL AND ETHNIC HEALTH INEQUITIES

2014 AMERICAN PSYCHOLOGICAL ASSOCIATION WEBINAR

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This presentation is divided into four parts:

- **Part I – Definitions:** What are health inequities? What do we mean when we say we are working to advance health equity?
- **Part II – Health inequities and their causes:** What are examples of health inequities? What are their causes?
- **Part III – How can we eliminate health inequities?** Will the Affordable Care Act help?
- **Part IV – Moving Beyond the ACA:** What are the most promising strategies on the horizon?
Part I: Definitions

Social Determinants of Health (WHO, 2008)

“The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.”
Health inequities refer to health differences that are rooted in social disadvantage, and are therefore unjust or avoidable.

Health inequities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; disability; sexual orientation; geographic location; or other characteristics historically linked to discrimination or exclusion.
Part I: Definitions (cont’d)

**Health equity** is the *assurance of the conditions* for optimal health for all people.

Achieving health equity requires valuing all individuals and populations equally, recognizing and rectifying historical injustices, and addressing contemporary injustices by providing resources according to need. Health and healthcare disparities will be eliminated when health equity is achieved.

**Health equity** is a *process, not an outcome.*
Racism is a system of structuring opportunity and assigning value based on phenotypic properties (i.e., skin color and hair texture associated with “race” in the US) that:

- Unfairly disadvantages some individuals and communities
- Unfairly advantages other individuals and communities
- Ultimately undermines the full potential of the whole society through the waste of human resources
Part I: Definitions (cont’d)

Racism operates at many levels:

*Structural racism* results from a system of social structures that produces cumulative, durable, race-based inequalities.

*Institutional racism* results from policies, practices, and procedures of institutions that have a disproportionately negative effect on racial minorities’ access to and quality of goods, services, and opportunities.

*Individually-mediated racism* - an individual with racial bias treating individuals from other racial groups poorly and/or in a discriminatory manner.

*Internalized racism* – the acceptance by marginalized racial populations of negative societal beliefs and stereotypes about themselves—beliefs which can lead to the perception of oneself as worthless and powerless.
Part I: Definitions (cont’d)

The many forms of racism often operate simultaneously.

For example, much of the residential segregation in the United States is reliant on both institutional discrimination in the real estate and housing finance market and individual interpersonal discrimination in real estate and housing transactions.
Part II: Health Inequities and Their Causes

- Many people of color – including African Americans, American Indians, Pacific Islanders, and Hispanic and Asian American subgroups – face poorer health from the cradle to the grave.
- Inequalities persist when education and income are controlled.
- While new immigrants tend to have better health than their U.S.-born peers, their health tends to get poorer over time and with succeeding generations.
- Roots exists in historic and contemporary forces, such as discrimination, segregation, and poverty concentration.
Infant Mortality Rates for Mothers Age 20 and Over by Race/Ethnicity and Education, 2001-2003

Source: *Health, United States, 2006*, Table 20
Percentages of AIDS Diagnoses among Adults and Adolescents, by Race/Ethnicity, 1985–2010—United States and 6 U.S. Dependent Areas

Note. All displayed data have been statistically adjusted to account for reporting delays, but not for incomplete reporting.

- Hispanics/Latinos can be of any race.
- Includes Asian/Pacific Islander legacy cases.
Rates of AIDS Diagnoses among Adults and Adolescents, by Race/Ethnicity, 2000–2010—United States

Note. All displayed data have been statistically adjusted to account for reporting delays, but not for incomplete reporting. Rates are per 100,000 population.

* Hispanics/Latinos can be of any race.

* Includes Asian/Pacific Islander legacy cases.
The Economic Burden of Health Inequalities in the United States
(http://goo.gl/zbtrqw)

- Direct medical costs of health inequalities
- Indirect costs of health inequalities
- Costs of premature death
The Economic Burden of Health Inequalities in the United States

• Between 2003 and 2006, 30.6% of direct medical care expenditures for African Americans, Asian Americans, and Hispanics were excess costs due to health inequalities.

• Eliminating health inequalities for minorities would have reduced direct medical care expenditures by $229.4 billion for the years 2003-2006.

• Between 2003 and 2006 the combined costs of health inequalities and premature death were $1.24 trillion.
Examples of Health Care Quality Gaps
AHRQ, National Healthcare Disparities Report, 2012

- African Americans have higher rates of hospital admissions for lower extremity amputations than whites

- Asian Americans are less likely than Whites to get care for an injury or illness as soon as wanted

- American Indian and Alaska Native women are twice as likely as whites to lack prenatal care

- Parents of Hispanic children are twice as likely as whites to report problems communicating with health care providers
Is health care unequal for minorities when insurance and income are the same?
Sources of Health Care Disparities (IOM, *Unequal Treatment*, 2003)

- Clinical uncertainty on the part of health care providers
- Health care institutions serving minorities face resource, quality challenges
- Bias (often implicit) and stereotyping on the part of providers
- Patient preferences
Part III How Can We Eliminate Health Inequities?

What is the potential of the Affordable Care Act for advancing health equity?

http://goo.gl/zbtrqw
Implications of PPACA for Addressing Health Inequalities in the United States

Insurance coverage expansions

- Expand Medicaid income eligibility to 133% of FPL (some states have set eligibility well below 20% of FPL).
- Employers with 50+ employees must offer coverage or pay a penalty for FTEs receiving tax credit to purchase insurance.
- Small employers with fewer than 25 employees are eligible for tax credit to purchase insurance (among workers in small firms, 57% of Hispanics, 40% of African Americans, 40% of American Indians, and 36% of Asian Americans are uninsured).
Improving Access to Health Care:

- Doubles funding to expand Community Health Centers.
- Funds to expand oral and behavioral health care services in CHCs.
- Expands funding for National Health Service Corps.
- Increases Medicaid payments for primary care services to 100% of Medicare payment rates for 2013 and 2014.
- Authorizes funds for school-based health centers, nurse-managed health clinics, and Community Health Teams to support medical homes.
Implications of PPACA for Addressing Health Inequalities in the United States (continued)

Data Collection and Reporting

- Require that population surveys collect and report data on race, ethnicity and primary language
- Collect and report disparities in Medicaid and CHIP
- Monitor health disparities trends in federally-funded programs
Implications of PPACA for Addressing Health Inequalities in the United States (continued)

Other Important Provisions:

• Reauthorizes Titles VII and VIII, health workforce programs to increase diversity and improve the distribution of providers
• Authorizes cultural competence education and organizational support
• Increases investments in health disparities research
• Establishes Prevention and Public Health Fund
Part IV: More Needs to Be Done

Despite the Important Provisions in PPACA, Public Health and Health Systems in Partnership with Communities Can Take Steps to Address Root Causes of Health Inequities
The Role of Segregation

Source: Massey 2004; Iceland et al 2002; Glaeser and Vigitor 2011
Negative Effects of Segregation on Health and Human Development

• Racial segregation *concentrates poverty* and excludes and isolates communities of color from the mainstream resources needed for success.

• African Americans are more likely to reside in poorer neighborhoods regardless of income level.

• Segregation also *restricts socio-economic opportunity* by channeling non-whites into neighborhoods with poorer public schools, fewer employment opportunities, and smaller returns on real estate.
Negative Effects of Segregation on Health and Human Development (cont’d)

• African Americans are five times less likely than whites to live in census tracts with supermarkets, and are more likely to live in communities with a high percentage of fast-food outlets, liquor stores and convenience stores.

• Black and Latino neighborhoods also have fewer parks and green spaces than white neighborhoods, and fewer safe places to walk, jog, bike or play, including fewer gyms, recreational centers and swimming pools.
Negative Effects of Segregation on Health and Human Development (cont’d)

• Low-income communities and communities of color are *more likely to be exposed* to environmental hazards. For example, 56% of residents in neighborhoods with commercial hazardous waste facilities are people of color even though they comprise less than 30% of the U.S. population.

• The “Poverty Tax:” Residents of poor communities *pay more for the exact same consumer products* than those in higher income neighborhoods—more for auto loans, furniture, appliances, bank fees, and even groceries.
Trends in Poverty Concentration
Steady rise in people in medium, high-poverty neighborhoods

Source: U.S. Census Bureau, Decennial Censuses of Population and Housing and American Communities Survey five-year estimates, based on authors’ calculations.
2000s: Population soars in extreme-poverty neighborhoods

Source: U.S. Census Bureau, Decennial Censuses of Population and Housing and American Communities Survey five-year estimates, based on authors’ calculations.
Blacks, Hispanics, Amer. Indians over-concentrated in high-poverty tracts

Source: U.S. Census Bureau, Decennial Censuses of Population and Housing and American Communities Survey five-year estimates, based on authors’ calculations.
Most poor blacks, Hispanics live in medium- and high-poverty tracts

Source: U.S. Census Bureau, Decennial Censuses of Population and Housing and American Communities Survey five-year estimates, based on authors’ calculations.
Metro Detroit: Poverty Concentration of Neighborhoods of All Children
Source: Diversitydata.org, 2011
Metro Detroit: Poverty Concentration of Neighborhoods of Poor Children
Source: Diversitydata.org

The chart demonstrates the concentration of poverty in Metro Detroit, categorized by race. The data is sourced from Diversitydata.org.

The x-axis represents the percentage range of poverty concentration (0%-20%, 20%-40%, 40% +), while the y-axis indicates the number of neighborhoods.

- **Black**: Represented by teal bars, with the highest concentration in the 0%-20% range.
- **Hispanic**: Represented by green bars, with a significant presence in the 20%-40% range.
- **White**: Represented by gray bars, showing a moderate concentration in the 0%-20% and 20%-40% ranges.
- **Asian/Pacific Islander**: Represented by white bars, with the lowest concentration across all ranges.
Science to Policy and Practice—What Does the Evidence Suggest?

• A focus on prevention, particularly on the conditions in which people live, work, play, and study

• Multiple strategies across sectors

• Sustained investment and a long-term policy agenda
Science to Policy and Practice—What Does the Evidence Suggest?

- **Place-based Strategies:** Investments in Communities

- **People-based Strategies:** Investing in Early Childhood Education and Increasing Housing Mobility Options
Create Healthier Communities:

• Improve food and nutritional options through incentives for Farmer’s Markers and grocery stores, and regulation of fast food and liquor stores

• Structure land use and zoning policy to reduce the concentration of health risks

• Institute Health Impact Assessments to determine the public health consequences of any new housing, transportation, labor, education policies
Improve the Physical Environment of Communities:

• Improve air quality (e.g., by relocating bus depots further from homes and schools)

• Expand the availability of open space (e.g., encourage exercise- and pedestrian-friendly communities)

• Address disproportionate environmental impacts (e.g., encourage Brownfields redevelopment)
Expanding Housing Mobility Options:

Moving To Opportunity (MTO)


- MTO targeted families living in some of the nation’s poorest, highest-crime communities and used housing subsidies to offer them a chance to move to lower-poverty neighborhoods.

- Findings from the follow up Three-City Study of MTO, in 2004 and 2005, answer some questions but also highlight the complexity of the MTO experience and the limitations of a relocation-only strategy.

- Away from concentrated poverty, would families fare better in terms of physical and mental health, risky sexual behavior and delinquency? Adolescent girls benefited from moving out of high poverty more than boys.
Bernalillo County Life Expectancy by Census Tract 1990 - 2007
“[I]nequities in health [and] avoidable health inequalities arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces.”

QUESTIONS ??????
THANK YOU!!!

To access fact sheets, seminars, conference materials and more, please see our website at:
http://www.apa.org/topics/health-disparities/initiative.aspx

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