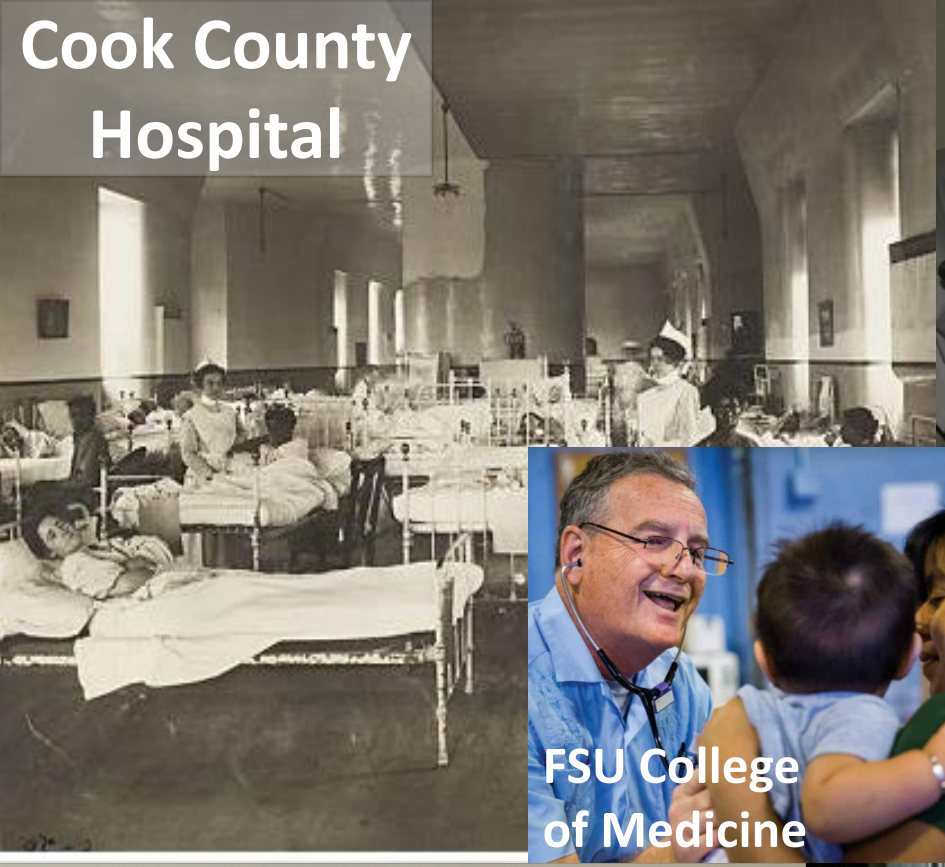
Paths to Health Equity

George Rust, MD, MPH, FAAFP, FACPM
Father of Dan & Christina, Husband of Cindy,
Professor of Behavioral Sciences & Social Medicine
Director, FSU-COM Center for Medicine & Public Health


Cook County Hospital


Honduras

FSU College of Medicine

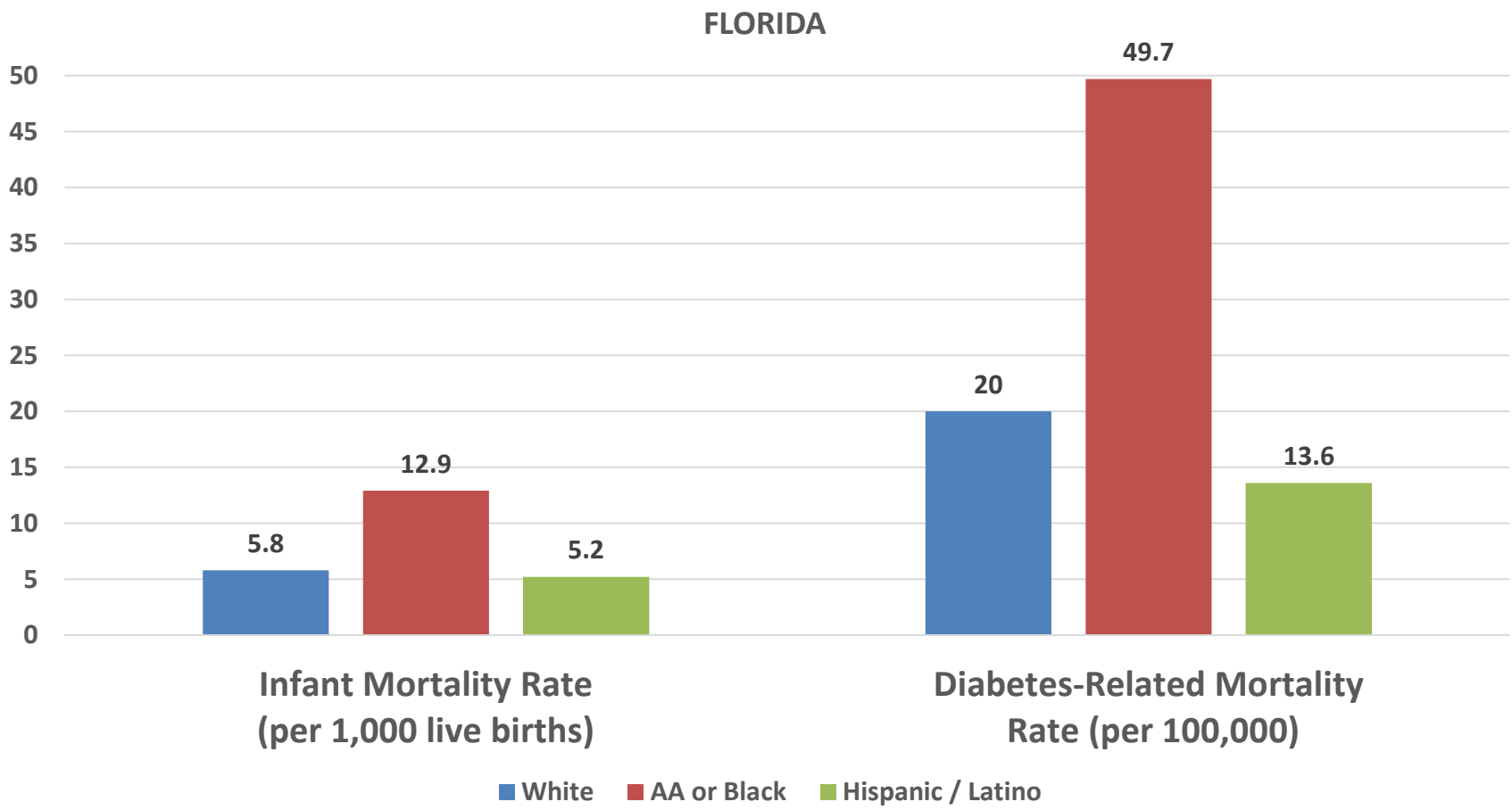

FARMWORKER
HEALTH CLINIC
West Orange
Farmworker Health Association
Farmworker Health Assoc

CHALLENGES:

"THE ULTIMATE MEASURE OF A MAN IS NOT WHERE HE STANDS IN MOMENTS OF COMFORT AND CONVENIENCE, BUT WHERE HE STANDS AT TIMES OF CHALLENGE AND CONTROVERSY." -MARTIN LUTHER KING, JR.

2009 update

Key Health and Health Care Indicators by Race/Ethnicity and State



Disparities: Deadly & Persistent

TRENDS

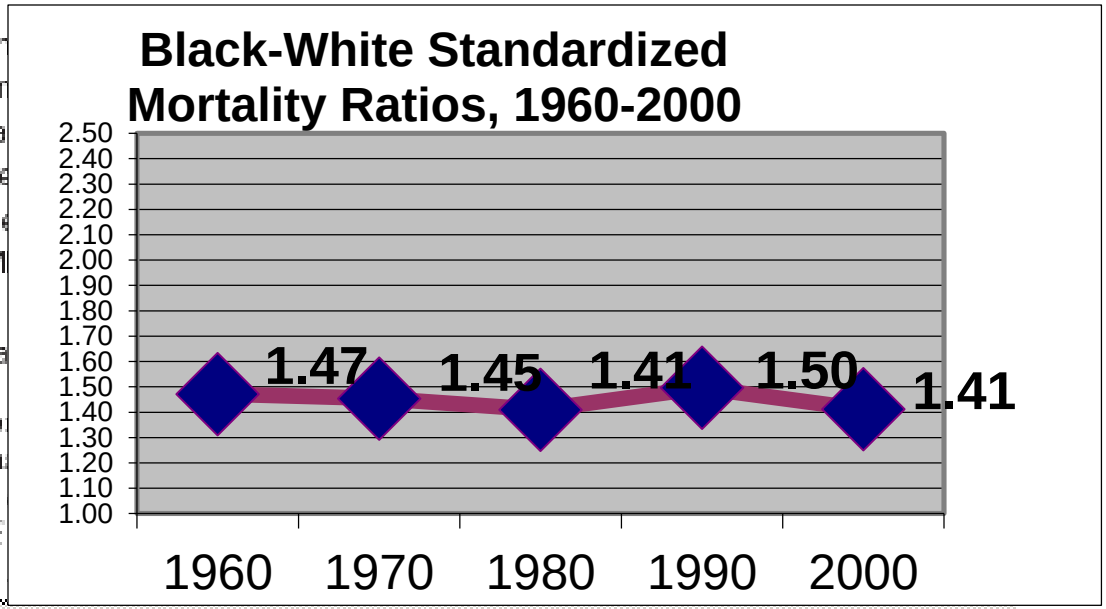
What If We Were Equal? A Comparison Of The Black-White Mortality Gap In 1960 And 2000

Closing this gap could eliminate more than 83,000 excess deaths per year among African Americans.

by David Satcher, George E. Fryer Jr., Jessica McCann, Adewale Troutman, Steven H. Woolf, and George Rust

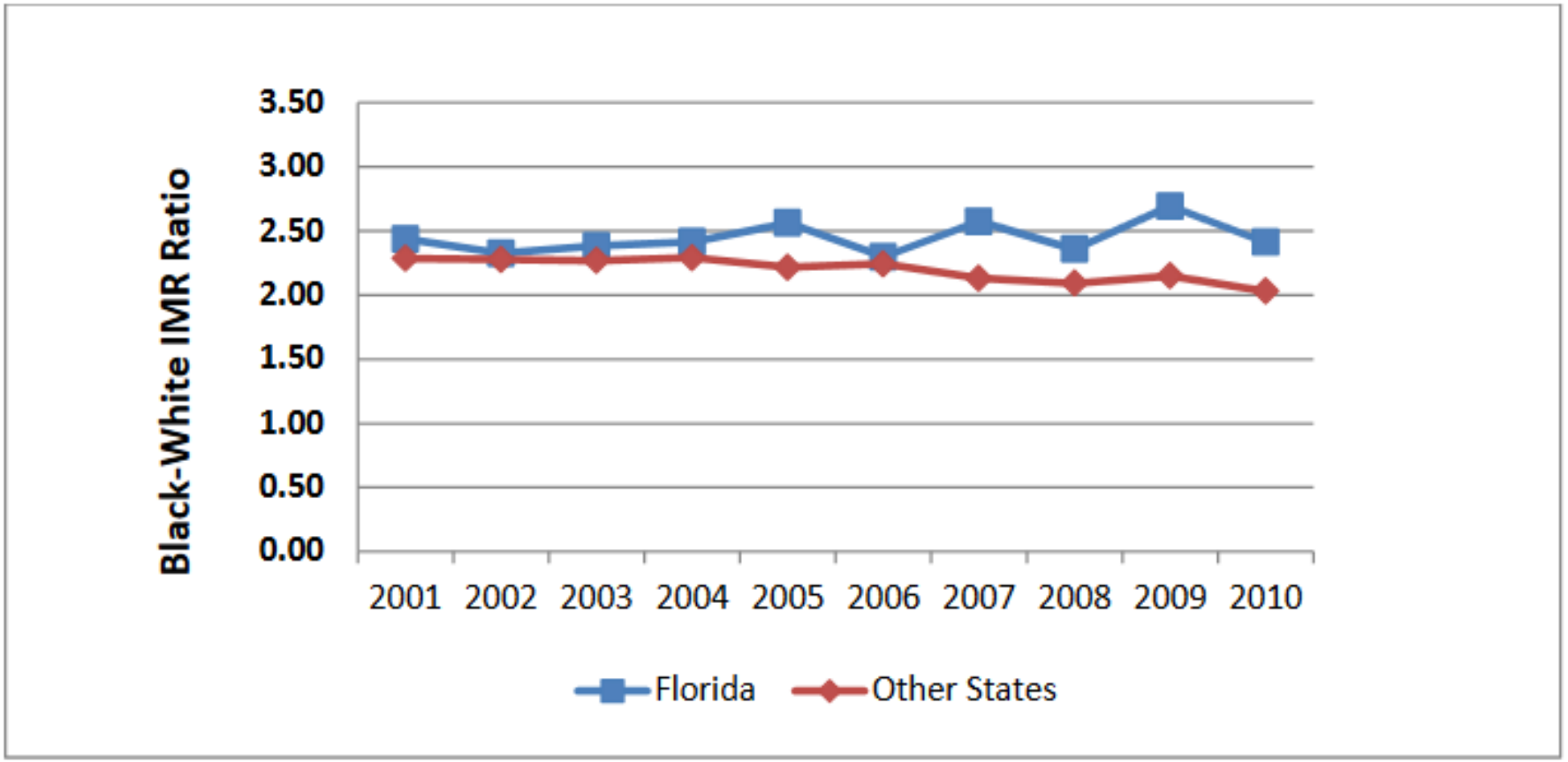
ABSTRACT: The United States has m
rights, housing, education, and incor
amined trends in black-white standa
from 1960 to 2000. The black-white
1960 and 2000 and actually worse
thirty-five and older. In contrast, SM
data, an estimated 83,570 excess
States if this black-white mortality ga

THE 1985 TASK FORCE report o
and minority health raised n
concern that 60,000 excess
were occurring annually because of
disparities, primarily among African



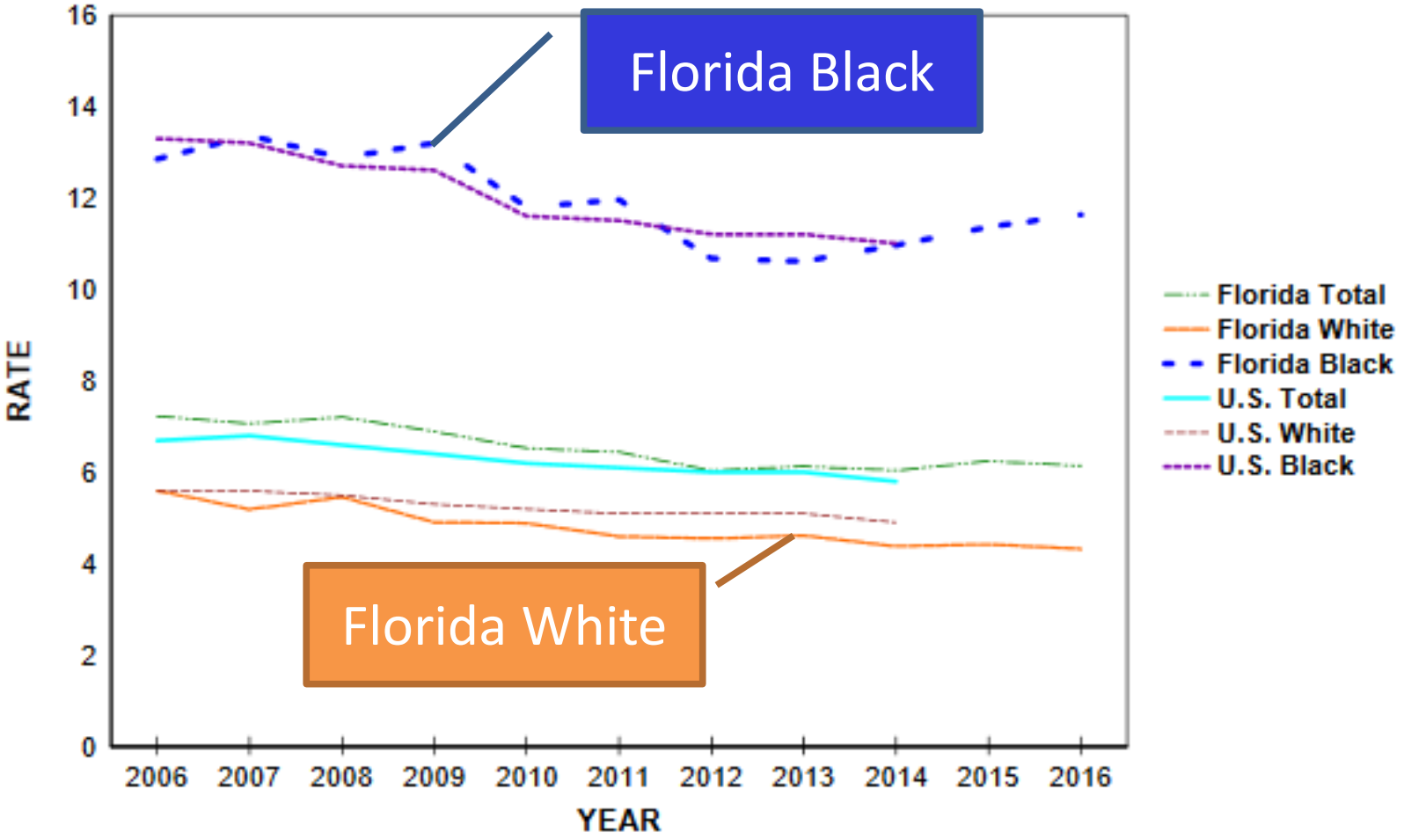
Persistent Disparities

Figure 3 Black-White Infant Mortality Rate Ratios: Florida and All Other U.S. States, 2001-2010



Racial Disparities in Infant Mortality Rates for Florida Compared to All Other States Combined 2001 through 2010
Division of Community Health Promotion ; Florida Dept. of Health. June 2, 2014
http://www.floridahealth.gov/diseases-and-conditions/infant-mortality-and-adverse-birth-outcomes/data/Disparityanalysis06-02-14.pdf

GRAPH F-3: RESIDENT INFANT DEATH RATES PER 1,000 LIVE BIRTHS, BY RACE, FLORIDA AND UNITED STATES, 2006-2016



Equal Outcomes = Opportunity

We could save a baby's life every day in Florida if we could eliminate the black-white difference in infant death rates

There would have been 363 fewer black infant deaths in 2016 if the black infant mortality rate (11.6 per 1000) was reduced to that of white babies (4.3 per 1,000).

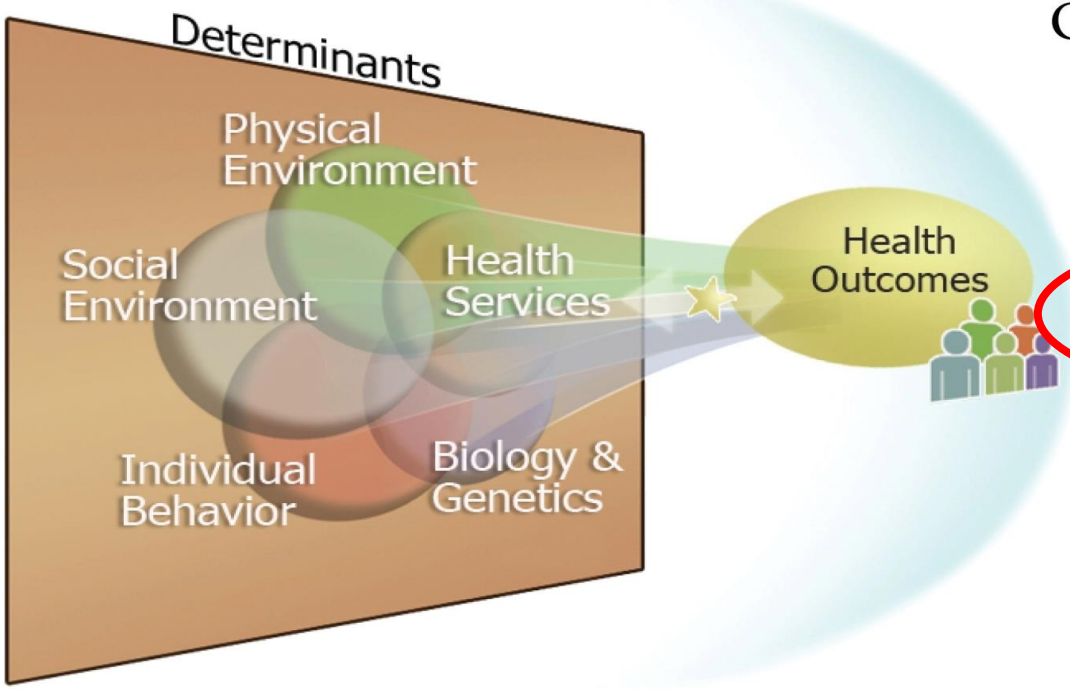

Structural Racism
Medicaid Cut-Backs
Ideology vs Science
POVERTY
Education Inequality
Rollback of Health & Safety Regs
Cuts to Family Planning
Anti-Immigrant Hostility
Cuts to Public Health
OVERWHELMED
SURE, I CAN HANDLE THE LOAD. NO PROBLEM.

What Is Health Equity?

Achieving Equity vs. Eliminating Disparities

Healthy People 2020

A society in which all people live long, healthy lives



Overarching Goals:

- Attain high quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development and healthy behaviors across all life stages.

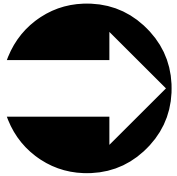
Health Disparities and Health Equity

"The concepts of health equity and health disparity are inseparable in their practical implementation."

-- Health Equity Institute, San Francisco State University

What is Health Equity?

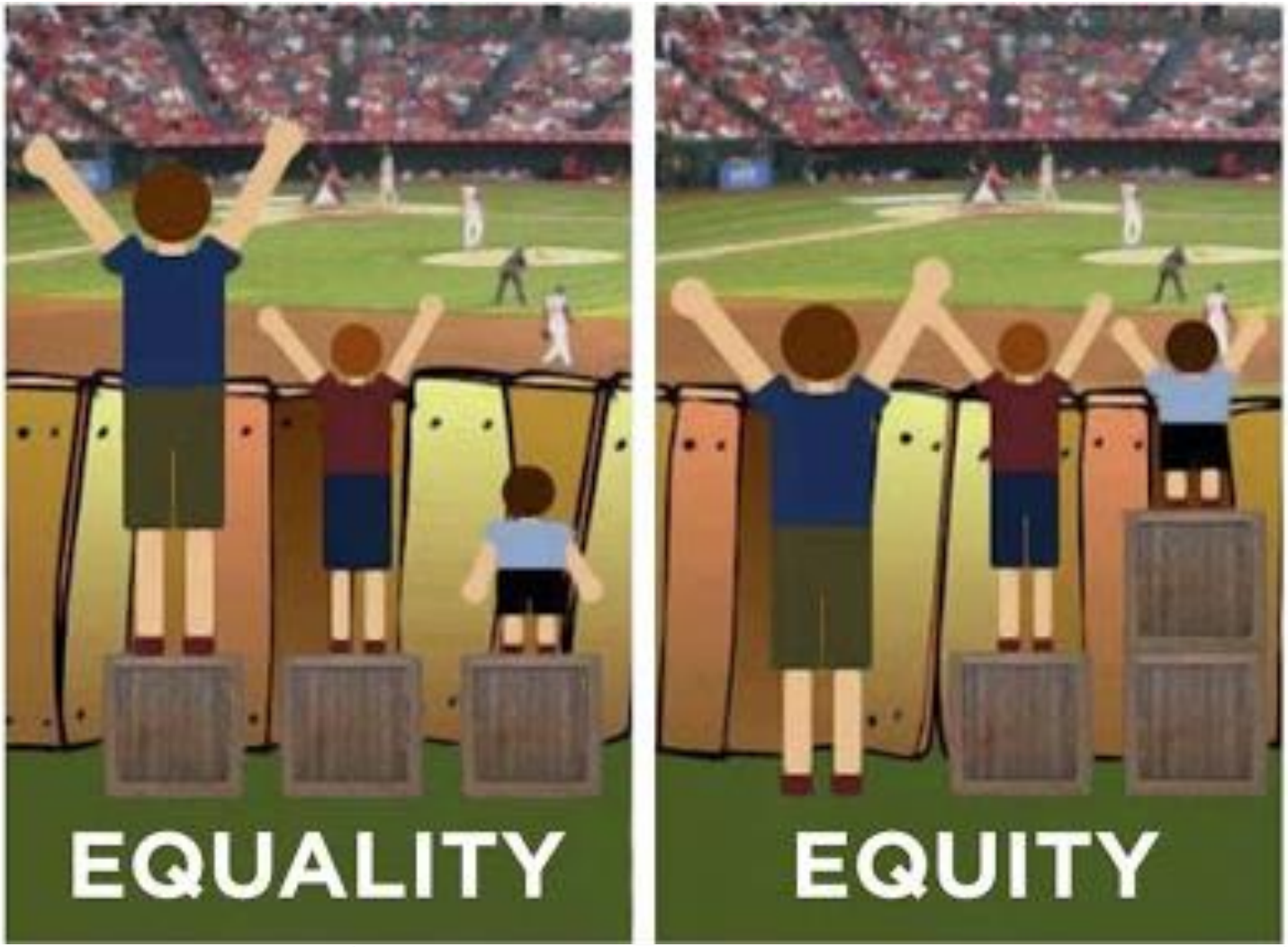
Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, . . .



. . . To eliminate health and health care disparities and attain the highest level of health for all people.“

Equality vs. Equity

Giving the same or "equal" treatment won't produce equity



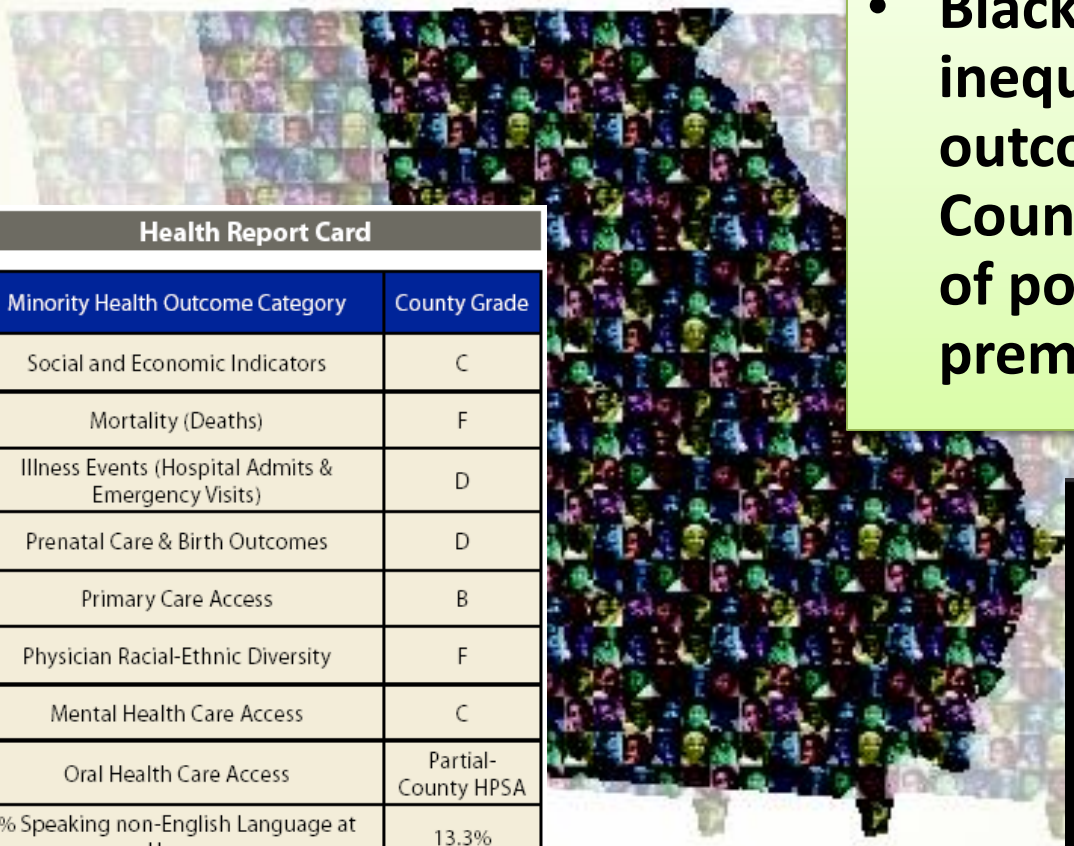
But equity demands that we do work to achieve equality of outcomes

How Do We Measure Health Equity?

Georgia Health Equity Initiative

Health Disparities Report 2008: A County-Level Look at Health Outcomes for Minorities in Georgia

First Edition



Health Report Card

Minority Health Outcome Category	County Grade
Social and Economic Indicators	C
Mortality (Deaths)	F
Illness Events (Hospital Admits & Emergency Visits)	D
Prenatal Care & Birth Outcomes	D
Primary Care Access	B
Physician Racial-Ethnic Diversity	F
Mental Health Care Access	C
Oral Health Care Access	Partial-County HPSA
% Speaking non-English Language at Home	13.3%
% Estimated to Have No Health Insurance	15.5%

- **Black-White racial inequalities in health outcomes cost Fulton County 28,022 excess years of potential life lost due to premature deaths.**

Georgia Health Equity Initiative

Health Disparities Report 2008: A County-Level Look at Health Outcomes for Minorities in Georgia

Excess Cost Due to Racial Variation in Hospital Admissions by Disease

(mid-range estimate)

	Excess Hospital Admissions (mid-range)	Hospital Charges Attributable to Excess Hospital Admissions (mid-range)	Payer Costs Attributable to Excess Hospital Admissions (mid-range)
Asthma	2,044	$28,687,330	$13,339,608.45
Diabetes	3,955	$92,172,057	$42,860,006.51
Heart Disease	5,021	$187,289,234	$87,089,493.81
>Coronary Artery Disease	1,287	$65,156,724	$30,297,876.66
>Congestive Heart Failure	5,868	$162,561,372	$75,591,037.98
HIV	1,644	$76,784,134	$35,704,622.31

- Absolute rate vs relative rate-ratios
- Progress toward **optimal** (best absolute rate)
- Progress toward **equitable** (rate-ratio relative to best-outcome group, or other reference group).
- What reference group?

Objectives—This report discusses six issues that affect the measurement of disparities in health between groups in a population:

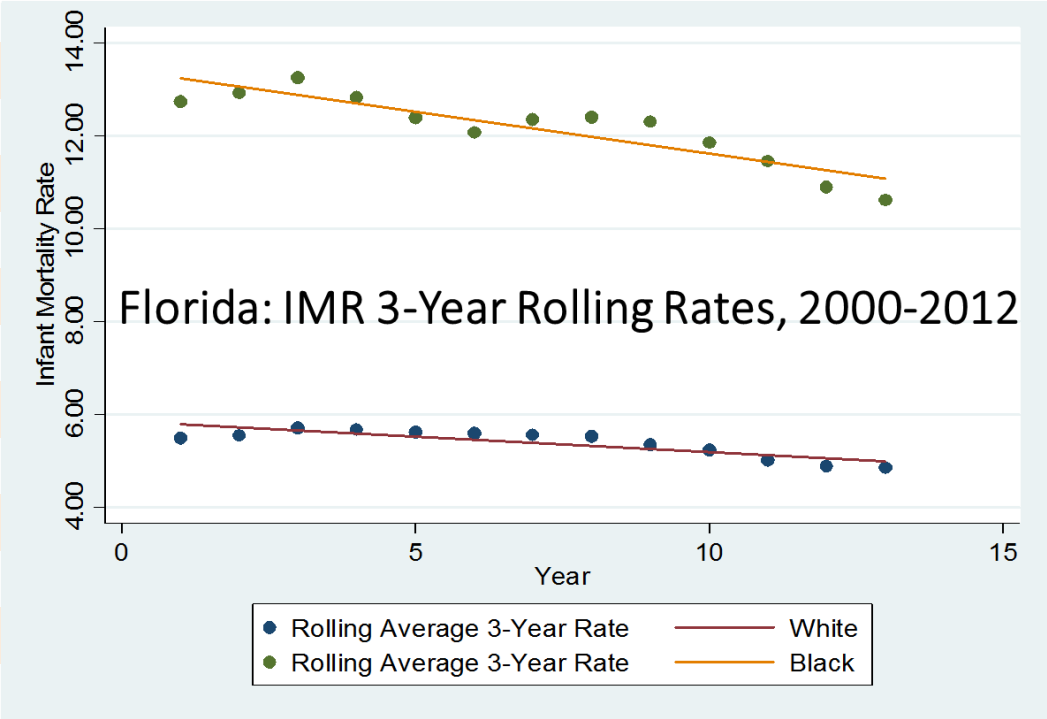
- Selecting a reference point from which to measure disparity
- Measuring disparity in absolute or in relative terms
- Measuring in terms of favorable or adverse events
- Measuring in pair-wise or in summary fashion
- Choosing whether to weight groups according to group size
- Deciding whether to consider any inherent ordering of the groups.

These issues represent choices that are made when disparities are measured.

Progress toward Optimal (Absolute) & Equitable (Relative) Outcomes

Table 3. Top 16 Rankings on Optimal & Equitable Outcomes (2011-2013) and on Progress Toward Optimal & Equitable Outcomes (1999-2013)

Absolute outcome (Closest to optimal)	% progress towards optimal	% progress towards equitable	Relative disparities (Closest to equitable)
Top 16 for lowest black IMR (absolute outcome)	*Top 16 for % improvement in outcome (% decrease in black IMR)*	*Top 16 for % improvement in equality (decrease in b-w ratio)*	*Top 16 for lowest black-white IMR rate ratio (Best in relative outcome)*
1. Massachusetts	1. Arizona	1. Massachusetts	1. Kentucky
2. New York			2. Arkansas
3. Washington			3. Massachusetts
4. Minnesota			4. Mississippi
5. Nevada			5. Tennessee
6. Colorado			6. Nevada
7. California			7. Oklahoma
8. Nebraska			8. New York
9. New Jersey			9. Washington
10. Connecticut			10. Alabama
11. Kentucky			11. Colorado
12. Georgia			12. Louisiana
13. Texas			13. Indiana
14. Arizona			14. Georgia
15. Iowa	15. Nevada	15. Pennsylvania	15. Texas
16. Florida	16. Washington	16. South Carolina	16. Arizona



Florida Ranked 16th Lowest in absolute Black IMR

Florida Ranked 24th Lowest in B-W Rate-Ratio

Discussion/Implications, Part 1

- **Disparities are not inevitable**
  - *Progress toward equality of outcomes is happening!*
- **Progress is also not inevitable**
  - *Rate of progress toward equality varies by state*
  - *Rate of progress even varies by county within each state*
- **Progress can be measured**
  - *Projected dates for achieving equality provide a benchmark against which acceleration of or slow-downs in progress can be measured.*

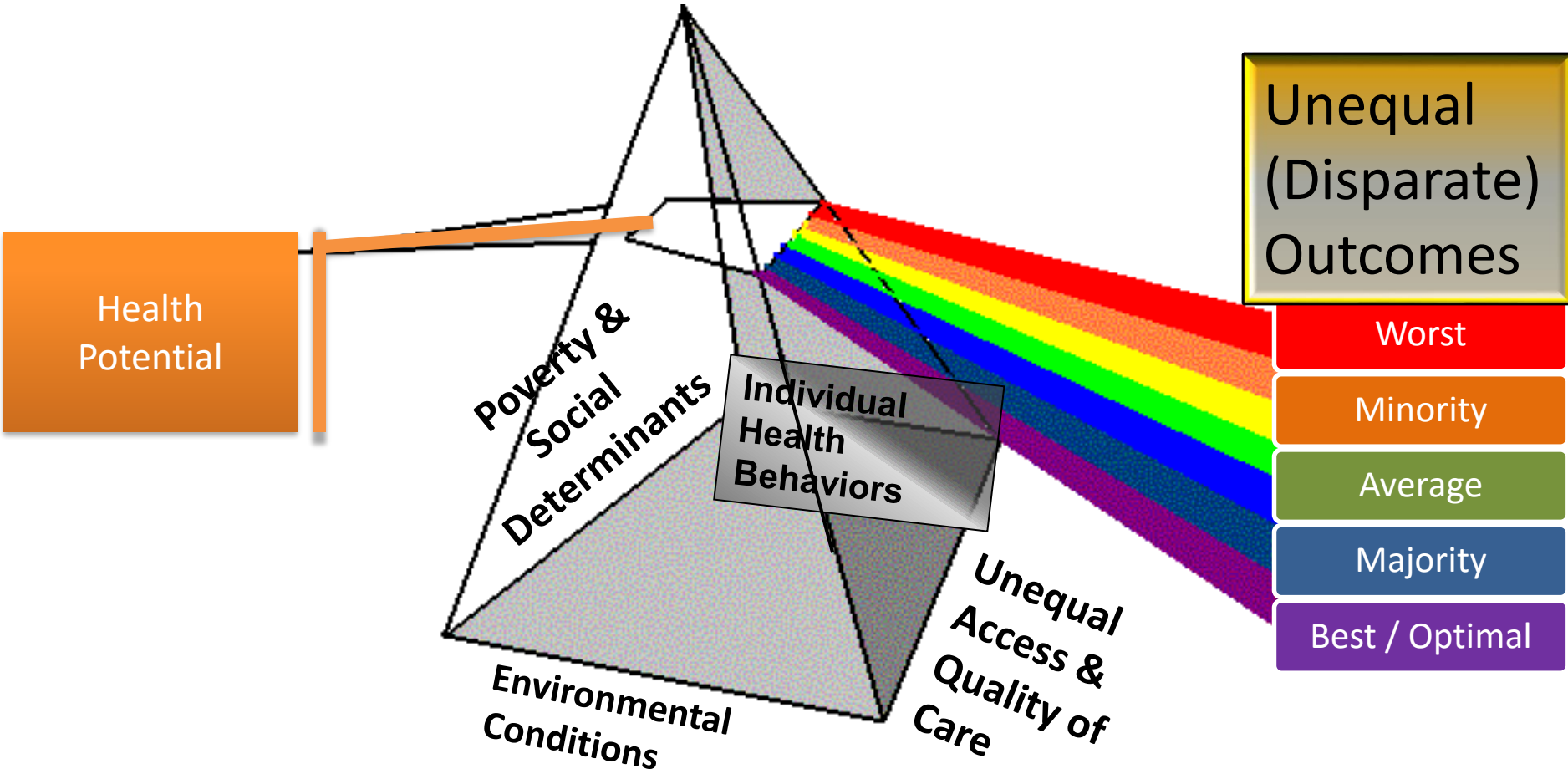
Discussion/Implications, Part 2

- **Measures must be timely and granular**
  - *Community level action needs a rapid-cycle feedback loop to assess impact*
  - *User-friendly, actionable data must be available at the geographic level at which communities identify themselves.*
- **Positive Deviance Model / Paths to Health Equity**
  - *We can learn from communities making the most progress*
  - *The road out may not be the same as the road in – focus on paths to health equity rather than risk factors and "determinants" of disparities.*

What Drives Health Inequities?

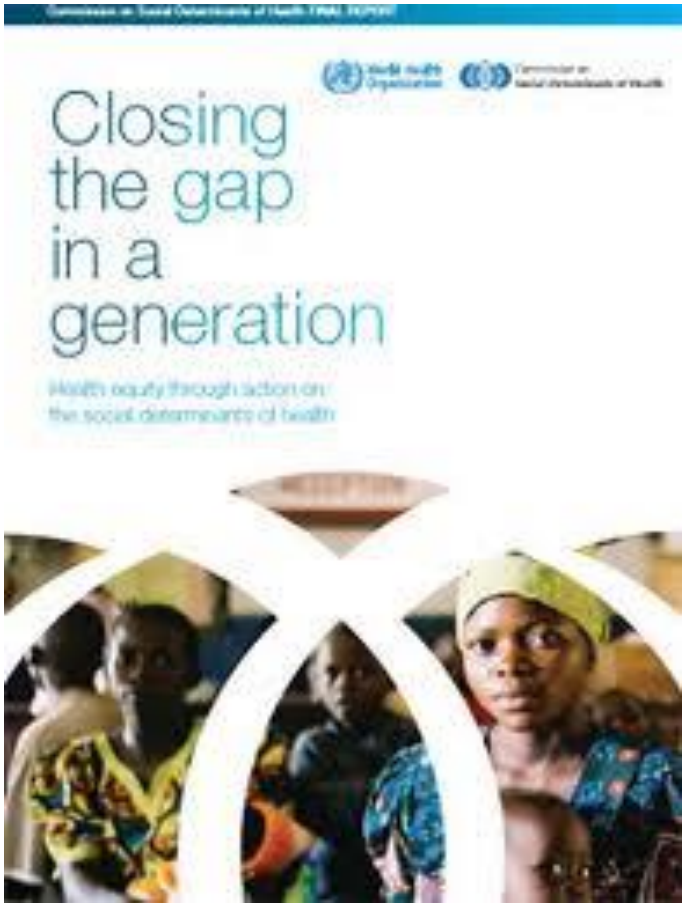
(Health Disparities)?

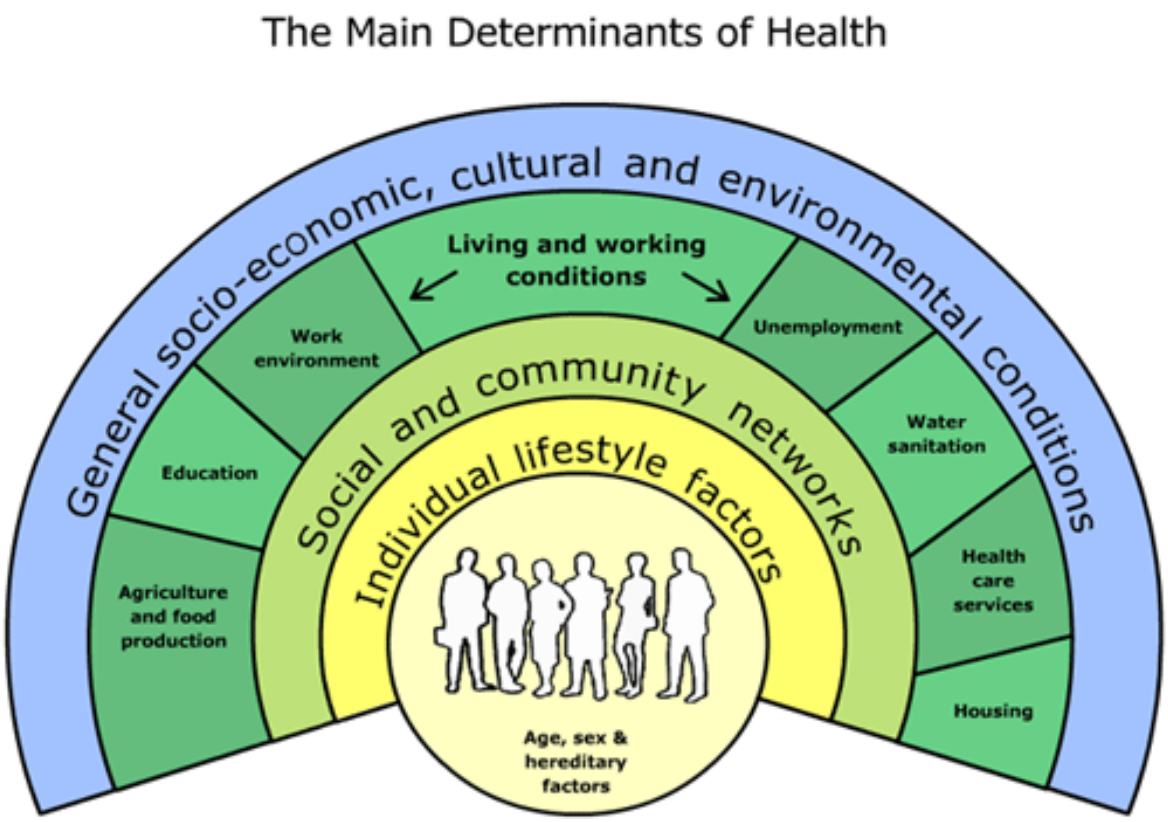
“Determinants” of Disparities



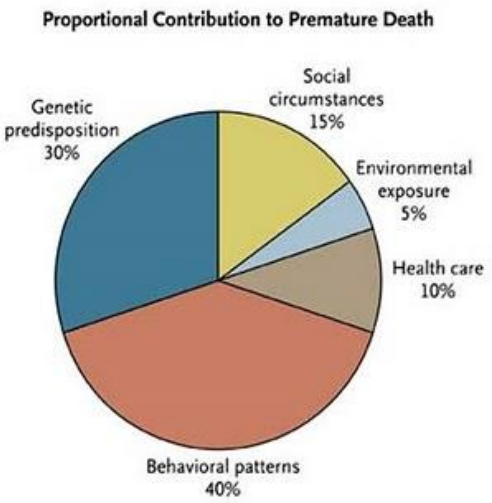
Health Behaviors

Social Determinants Trump Everything!





Poor Outcomes are Rooted in Clinical & Behavioral and Social Complexities



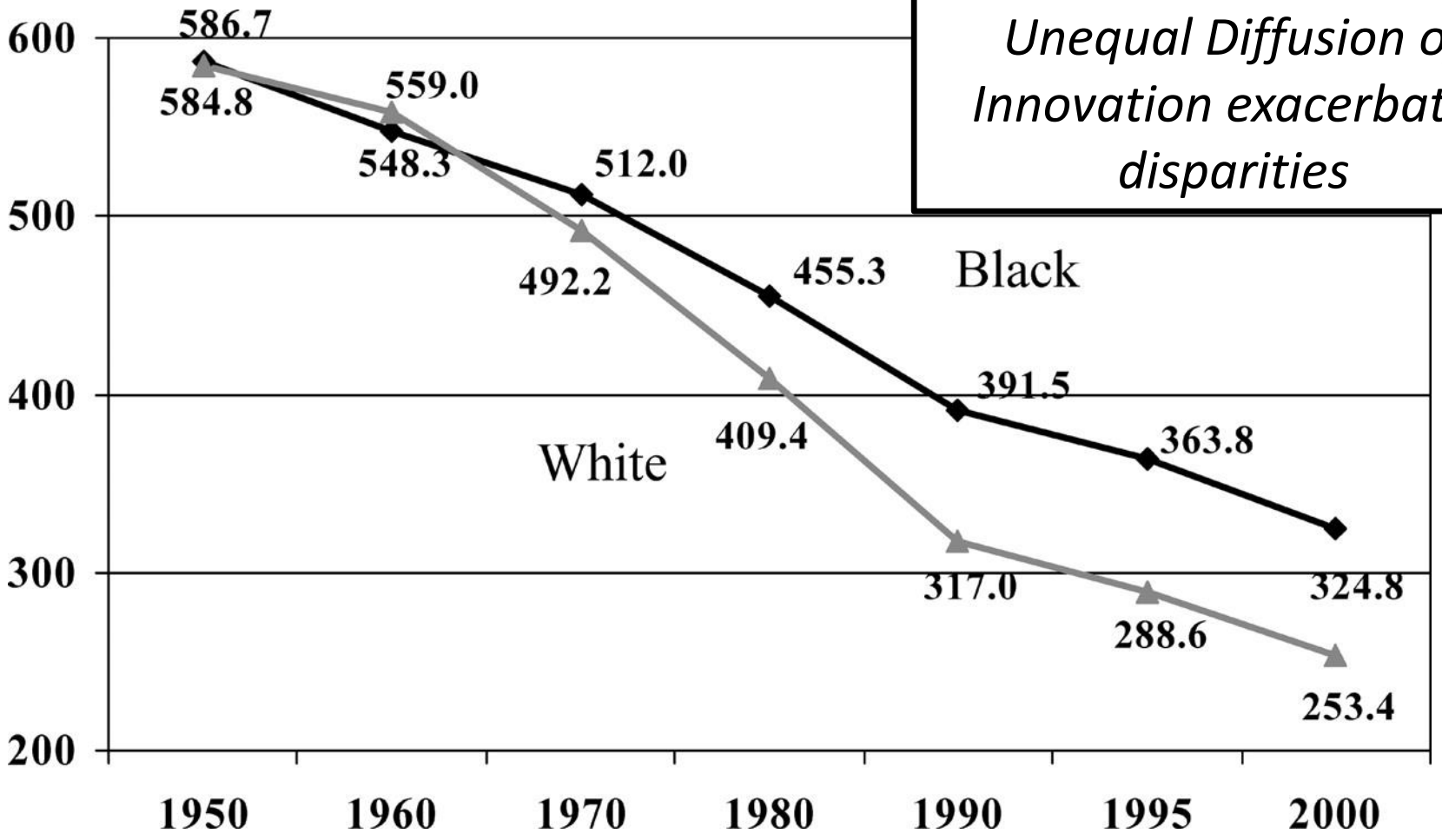
Does Medical Care Really Matter?

" Medical Care only accounts for 10% of health status . . ."

Age-adjusted heart disease mortality rates per 100,000 (1950–2000).

Success is not Shared Equally –

Unequal Diffusion of Innovation exacerbates disparities



Phelan J C , Link B G J Gerontol B Psychol Sci Soc Sci 2005;60:S27-S33

Triangulating on Success to Improve America's Health

Rust G.... Satcher D, et al . AJPH, 2010

TABLE 1—Adjusted Mortality Rates (per 100 000) for Selected Conditions: United States, 1950–2000

	Year 1950 Rate	Highest Rate (Peak Year)	Lowest Rate (Trough Year)	Year 2000 Rate	Decline From Peak Year, %
Stroke	180.7	180.7 (1950)	60.9 (2000)	60.9	66.3
Heart disease	586.8	586.8 (1950)	257.6 (2000)	257.6	56.1
Uterine and cervical cancer	26.2	26.2 (1950)	7.2 (2000)	7.2	72.5
Gastric cancer	24.2	24.2 (1950)	4.6 (2000)	4.6	81.0
HIV	. . .	16.3 (1995)	5.2 (2000)	5.2	67.9
Tuberculosis	25.5	25.5 (1950)	0.2 (2000)	0.2	91.4
Syphilis	6.1	6.1 (1950)	0.0 (2000)	0.0	100
Influenza and pneumonia	48.1	48.1 (1950)	23.7 (2000)	23.7	50.7
Unintentional injuries	78.0	78.0 (1950)	34.9 (2000)	34.9	55.3

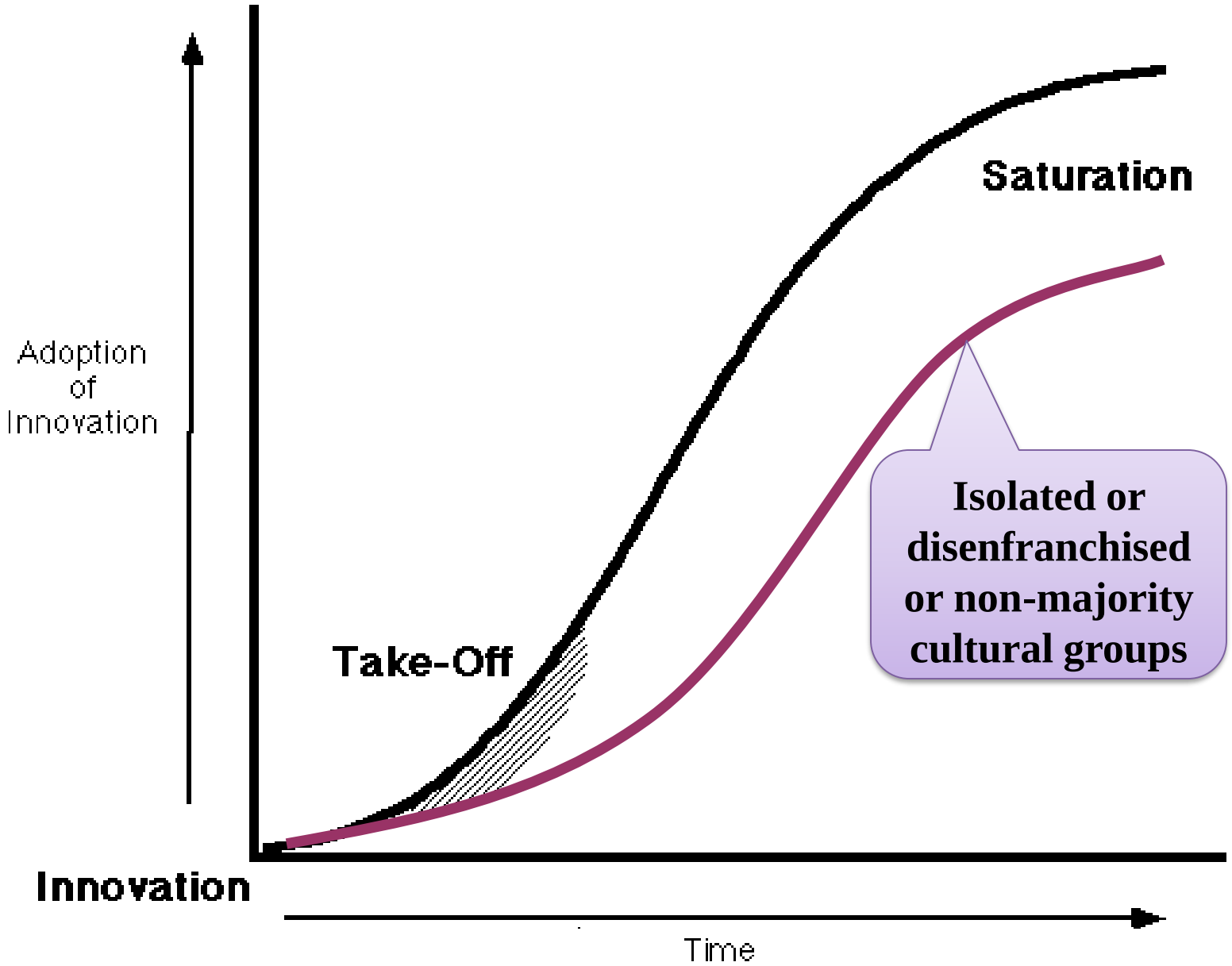
What accounted for the successful reduction in mortality (>50% in 50 years) for most of these conditions?

Research Discovery & Innovation

Public Health & Health Promotion

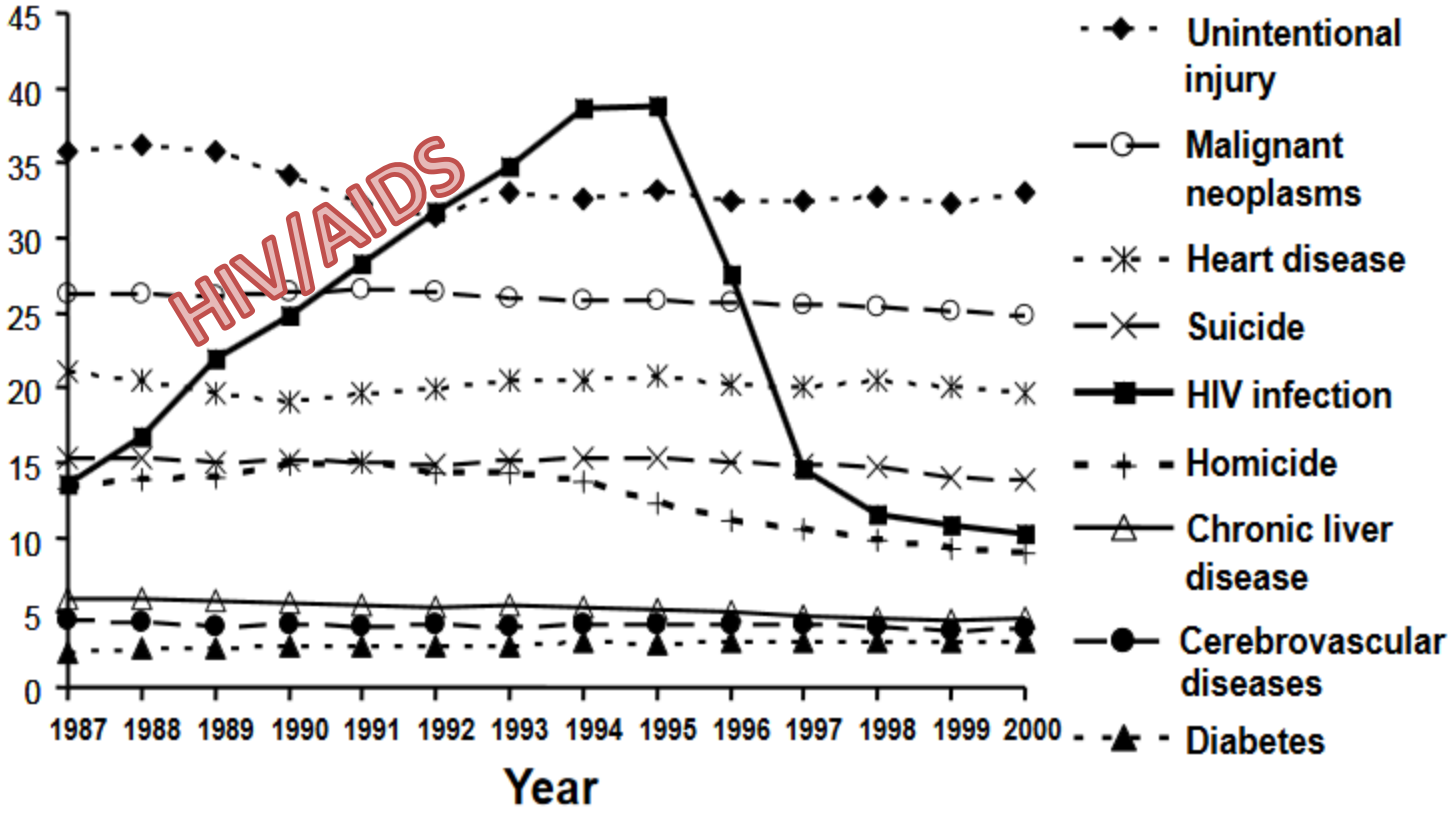
Primary Care / Medical Care Delivery

The Innovation Adoption Curve



How Do We Target Specific Health Disparities?

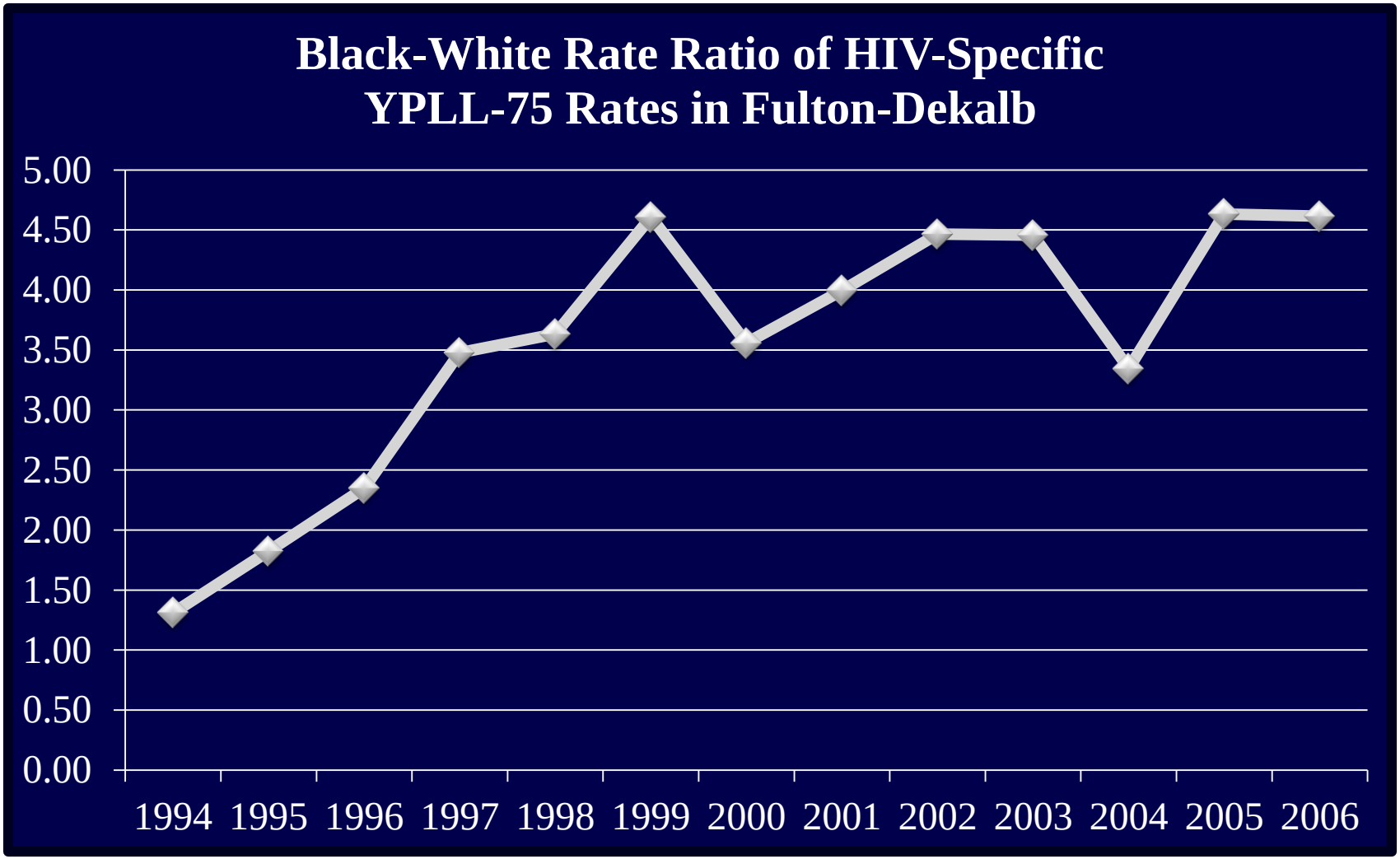
Figure 10. Death rates per 100,000 population from leading causes of death among persons 25–44 years old, United States, 1987–2000



Note: For comparison with data for 1999–2000, data for 1987–1998 were modified to appear as if based on ICD-10 rules for selecting the underlying cause of death instead of ICD-9.

Source: National Center for Health Statistics National Vital Statistics System.

HIV-Disparities Increase with Breakthrough Treatments



Racial, gender and geographic disparities of antiretroviral treatment among US Medicaid enrolees in 1998

W D King,[1,2,3] P Minor,[4] C Ramirez Kitchen,[5] L E Oré,[3] S Shoptaw,[3] G D Victorianne,[3] G Rust[4]

Disparities are not inevitable!

ABSTRACT

Background: In 1998, highly active antiretroviral therapy (HAART) was widespread, but the diffusion of these life-saving treatments was not uniform. As half of all AIDS patients in the USA have Medicaid coverage, this study of a multistate Medicaid claims dataset was undertaken to assess disparities in the rates of HAART.

Methods: Data came from 1998 Medicaid claims files from five states with varying HIV prevalence. ICD-9 codes were used to identify people with a diagnosis of HIV/AIDS or AIDS-defining illness. Multivariate analyses assessed associations between age, gender, race and state of residence for antiretroviral regimens consistent with HAART, as defined by 1998 Centers for Disease Control and Prevention (CDC) guidelines.

Results: Among 7202 Medicaid enrolees with a diagnosis of HIV/AIDS or AIDS, 62% received HAART and 25% received no antiretroviral therapy. Multivariate analyses showed that age, race, gender and state were

regimens, black and Hispanic patients in these programmes have a lower frequency of antiretroviral treatment compared with white patients.[10]

Medicaid Matters!

OPEN ACCESS Freely available online

PLOS ONE

The Potential for Elimination of Racial-Ethnic Disparities in HIV Treatment Initiation in the Medicaid Population among 14 Southern States

Shun Zhang[1]*, Shanell L. McGoy[2], Daniel Dawes[3], Mesfin Fransua[4], George Rust[1], David Satcher[2]

1 National Center for Primary Care, Morehouse School of Medicine, Atlanta, Georgia, United States of America, **2** Satcher Health Leadership Institute, Morehouse School of Medicine, Atlanta, Georgia, United States of America, **3** Office of the President, Morehouse School of Medicine, Atlanta, Georgia, United States of America, **4** Department of Medicine, Morehouse School of Medicine, Atlanta, Georgia, United States of America

Abstract

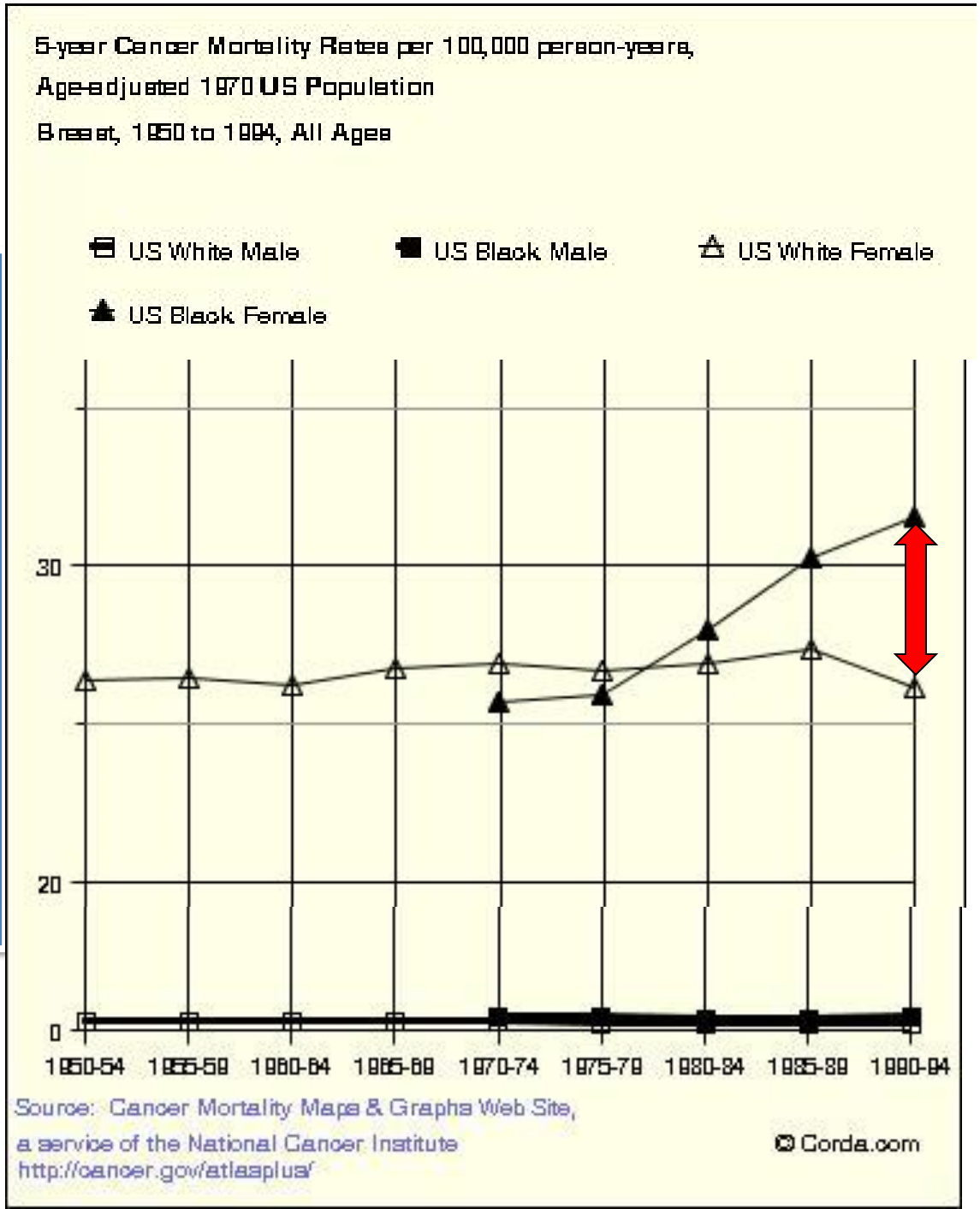
Objectives: The purpose of this study was to explore the racial and ethnic disparities in initiation of antiretroviral treatment (ARV treatment or ART) among HIV-infected Medicaid enrollees 18–64 years of age in 14 southern states which have high prevalence of HIV/AIDS and high racial disparities in HIV treatment access and mortality.

Methods: We used Medicaid claims data from 2005 to 2007 for a retrospective cohort study. We compared frequency variances of HIV treatment uptake among persons of different racial- ethnic groups using univariate and multivariate methods. The unadjusted odds ratio was estimated through multinomial logistic regression. The multinomial logistic regression model was repeated with adjustment for multiple covariates.

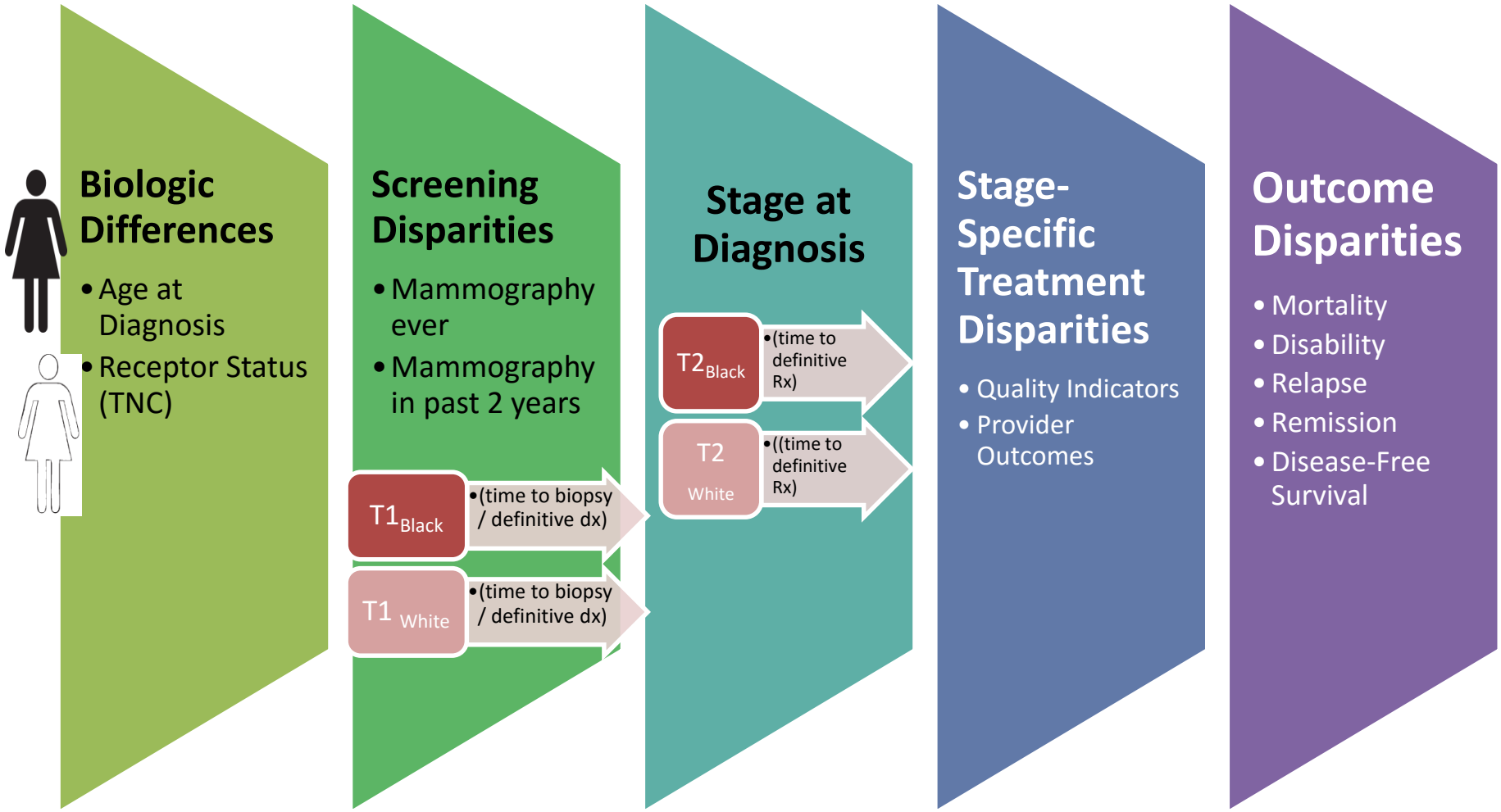
Results: Of the 23,801 Medicaid enrollees who met criteria for initiation of ARV treatment, only one third (34.6%) received ART consistent with national guideline treatment protocols, and 21.5% received some ARV medication, but with sub-optimal treatment profiles. There was no significant difference in the proportion of people who received ARV treatment between black (35.8%) and non-Hispanic whites (35.7%), but Hispanic/Latino persons (26%) were significantly less likely to receive ARV treatment.

Conclusions: Overall ARV treatment levels for all segments of the population are less than optimal. Among the Medicaid population there are no racial HIV treatment disparities between Black and White persons living with HIV, which suggests the potential relevance of Medicaid to currently uninsured populations, and the potential to achieve similar levels of equality within Medicaid for Hispanic/Latino enrollees and other segments of the Medicaid population.

Unequal Benefit – Breast Cancer



Disparities Amplified at Each Level of Care



Complex Problems Require Complex, Coordinated Interventions!

Example: To eliminate disparities in complications of obesity and diabetes, ***all you have to do*** . . . .

. . . . is modify a person's health beliefs and attitudes, daily habits, eating preferences, daily activities, exercise habits, grocery stores, neighborhood walk-ability, food advertising, self-care, employability, economic empowerment, access to medical care, clinical inertia, provider quality, and medication adherence, all in the context of his or her family and social relationships.

Tying it All Together to Achieve Health Equity

Are There Paths to Health Equity?

Triangulating on Health Equity!

Innovation

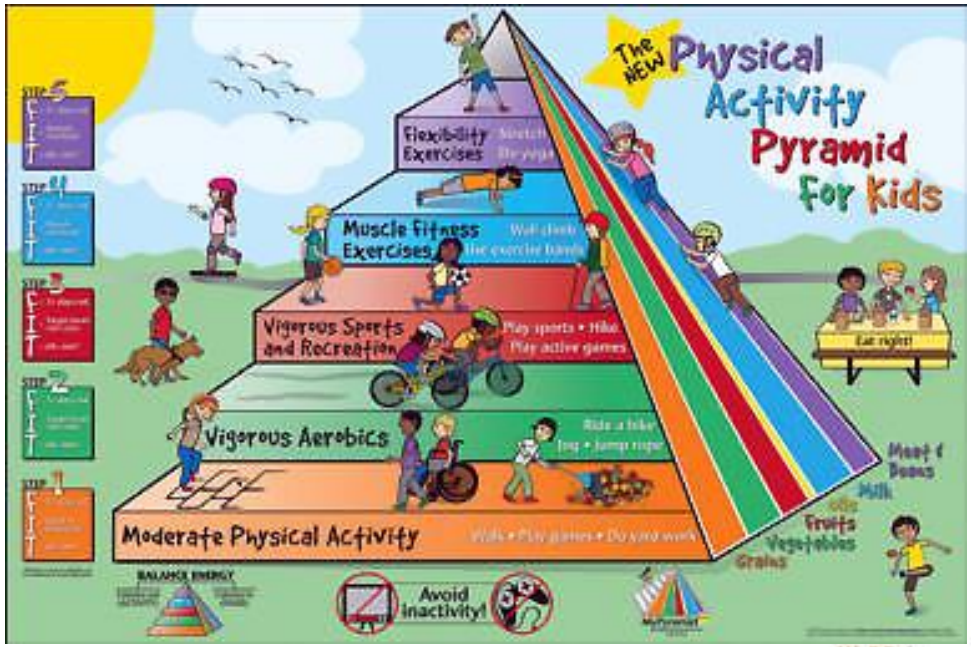
Social Determinants

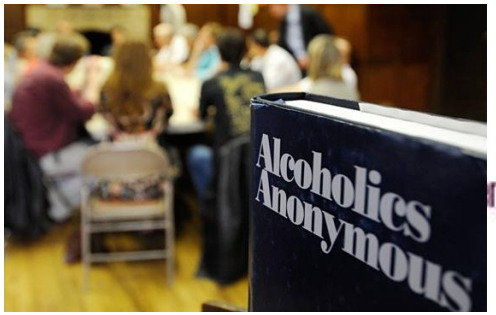
Public Health & Health Promotion

Primary Care / Medical Care

Optimal & Equitable Health Outcomes for All !!!

Community Health Promotion





Graphic from Rhode Island College (www. ric.edu)

Primary Care -- Healing Whole Persons with our "Radical Human Presence"

"Radical Human Presence", phrase used in a presentation called "How the Heart Learns" by Landon Saunders; AAMFT, 2004 annual mtg.

- Listening
- Touching
- Affirming
- Comforting
- Diagnosing
- Treating
- Grieving
- Supporting
- Healing

Community Health as Community Development

- Leadership Development
- Economic Development
- Health Development
- Educational Empowerment
- Political Empowerment

H. Jack Geiger (L),John W. Hatch (b1928)(R)

construction of Delta Health Center, Bayou Mound, Mississippi 1968

John Hatch: Head of community organizing Delta CHC; first African-American endowed chair UNC School of Public Health.

Jack Geiger: used "health care as an instrument of social justice and empowerment for those oppressed by racism and poverty."

"The Flint Disaster: Why Doesn't Black Health Matter?" (Geiger. Feb 3 2016 physicansforhumanrights.org/blog)

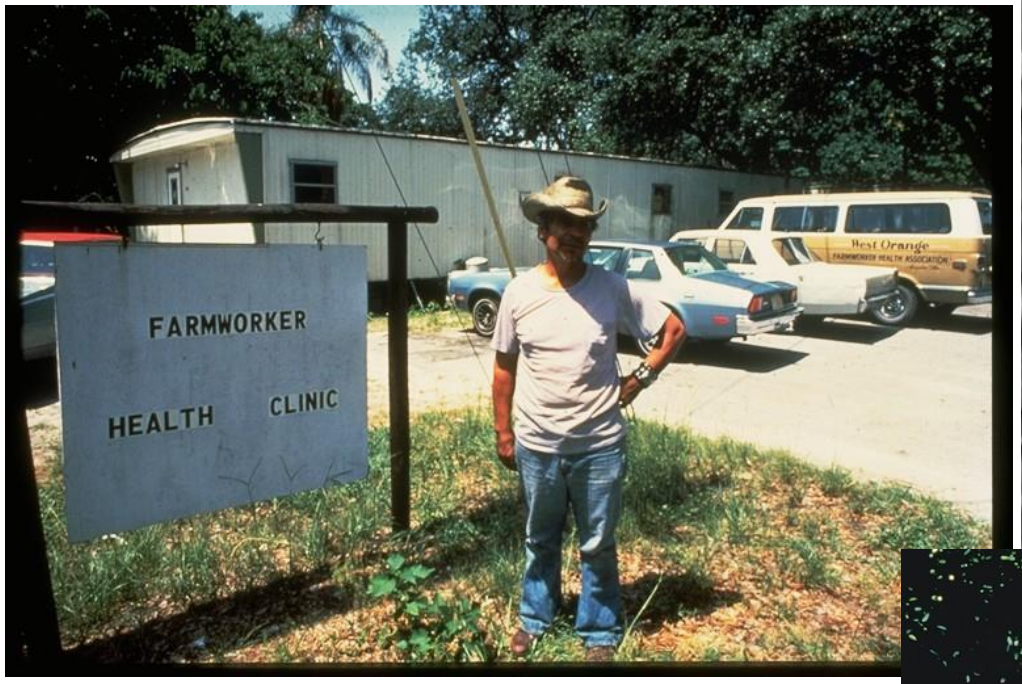
Photo: Dan Bernstein

https://www.slideshare.net/JimBloyd/phyisicans-health-reform-and-health-equity-when-we-fight-we-win

Community as Our Partners & Teachers

Advocacy

Health Justice ⇔ Social Justice



“The physician is the natural attorney for the poor.”

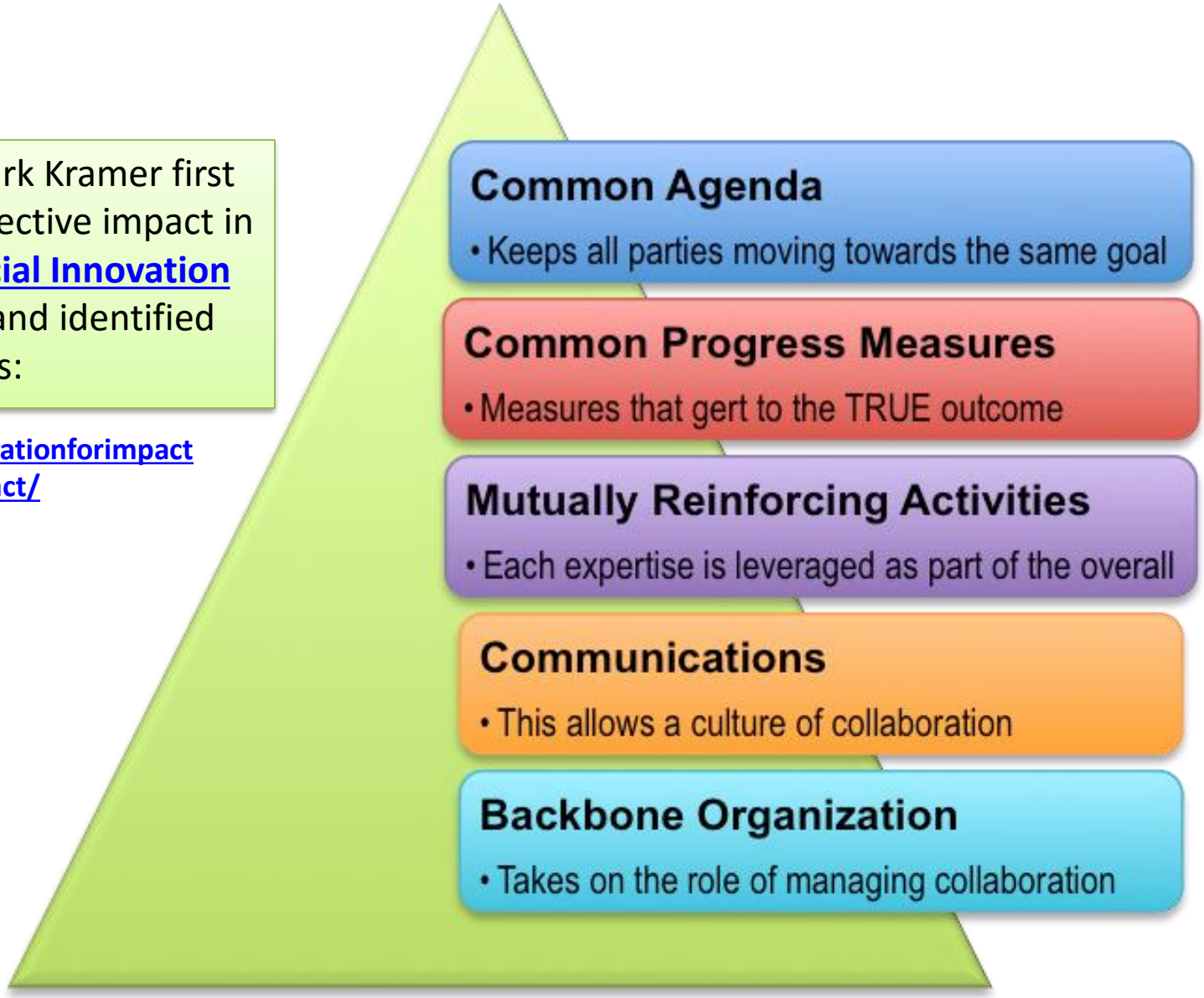
“Medicine is a social science, and politics is nothing more than medicine on a grander scale.”

-- Rudolf Virchow, 1848

Collective Impact

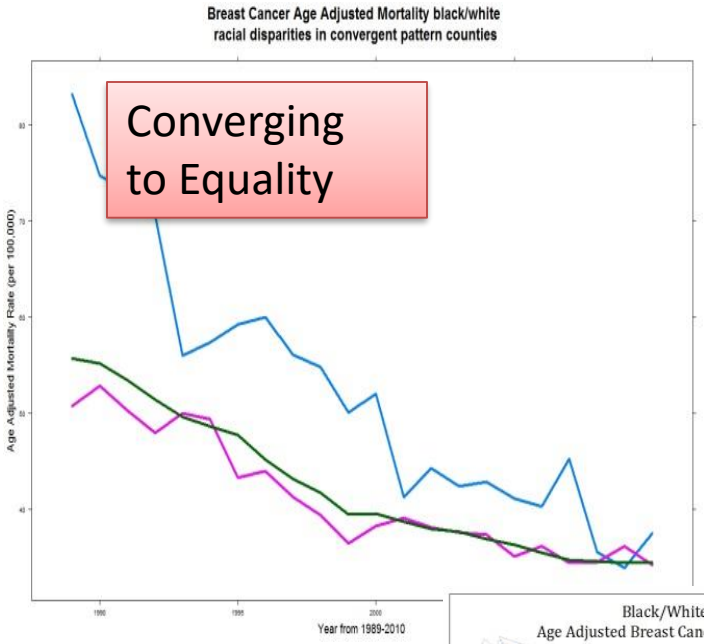
John Kania & Mark Kramer first wrote about collective impact in the **Stanford Social Innovation Review** in 2011 and identified five key elements:

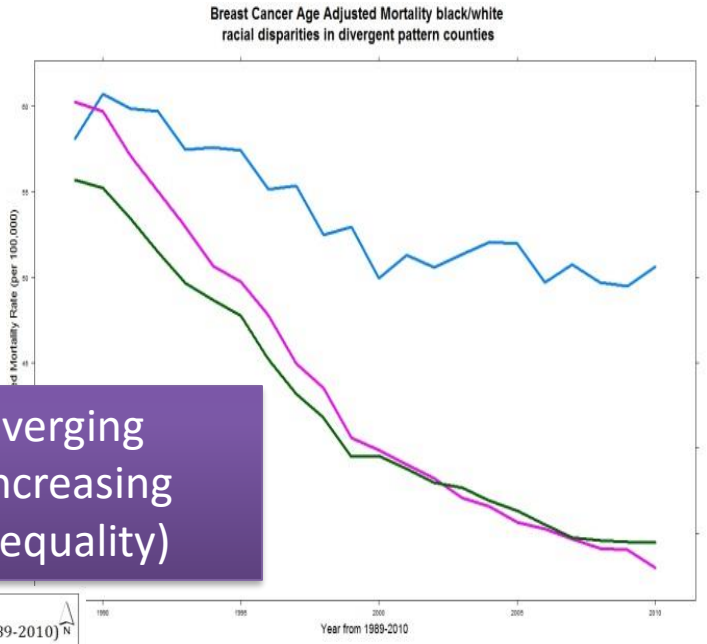
http://www.collaborationforimpact.com/collective-impact/

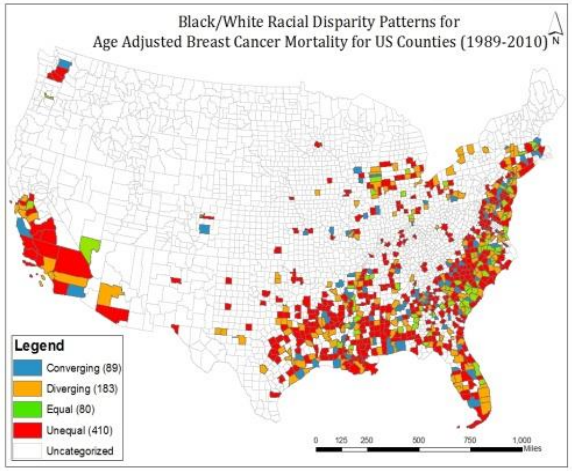


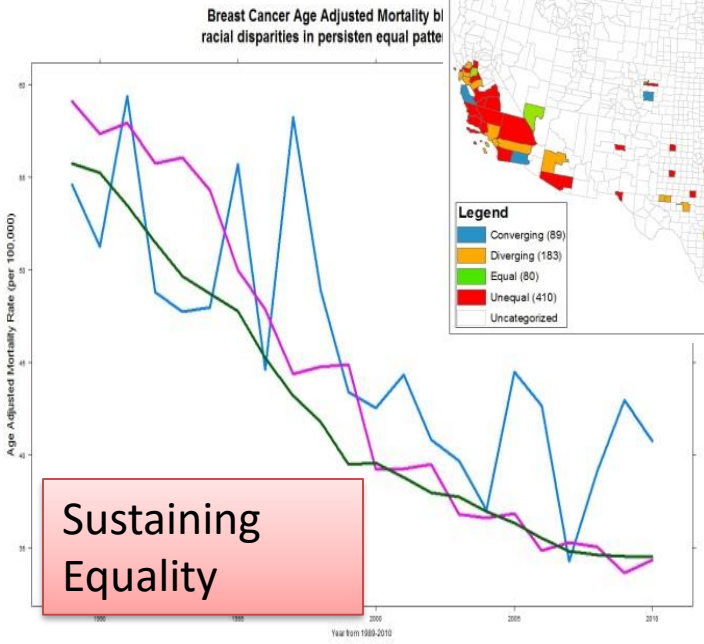
Will We Ever Achieve Health Equity?

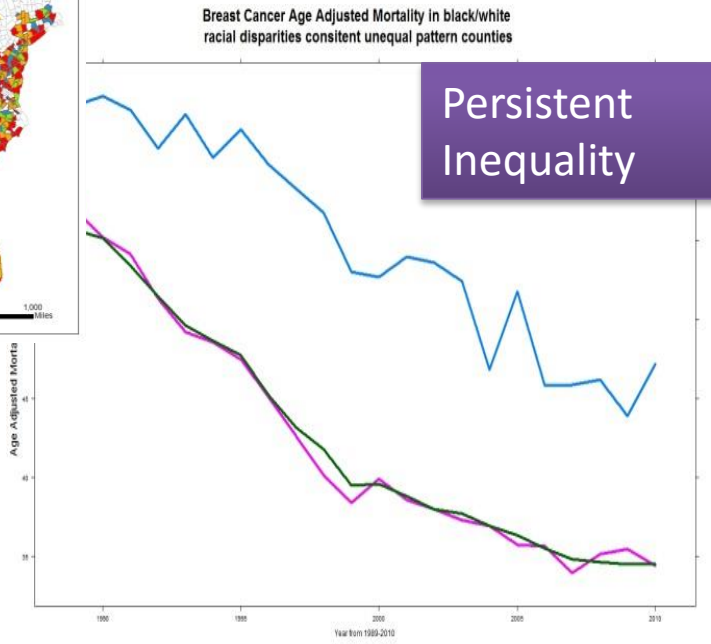
When Will We Get There?


Breast Cancer Age Adjusted Mortality black/white
racial disparities in convergent pattern counties
Converging
to Equality
Age Adjusted Mortality Rate (per 100,000)
Year from 1989-2010

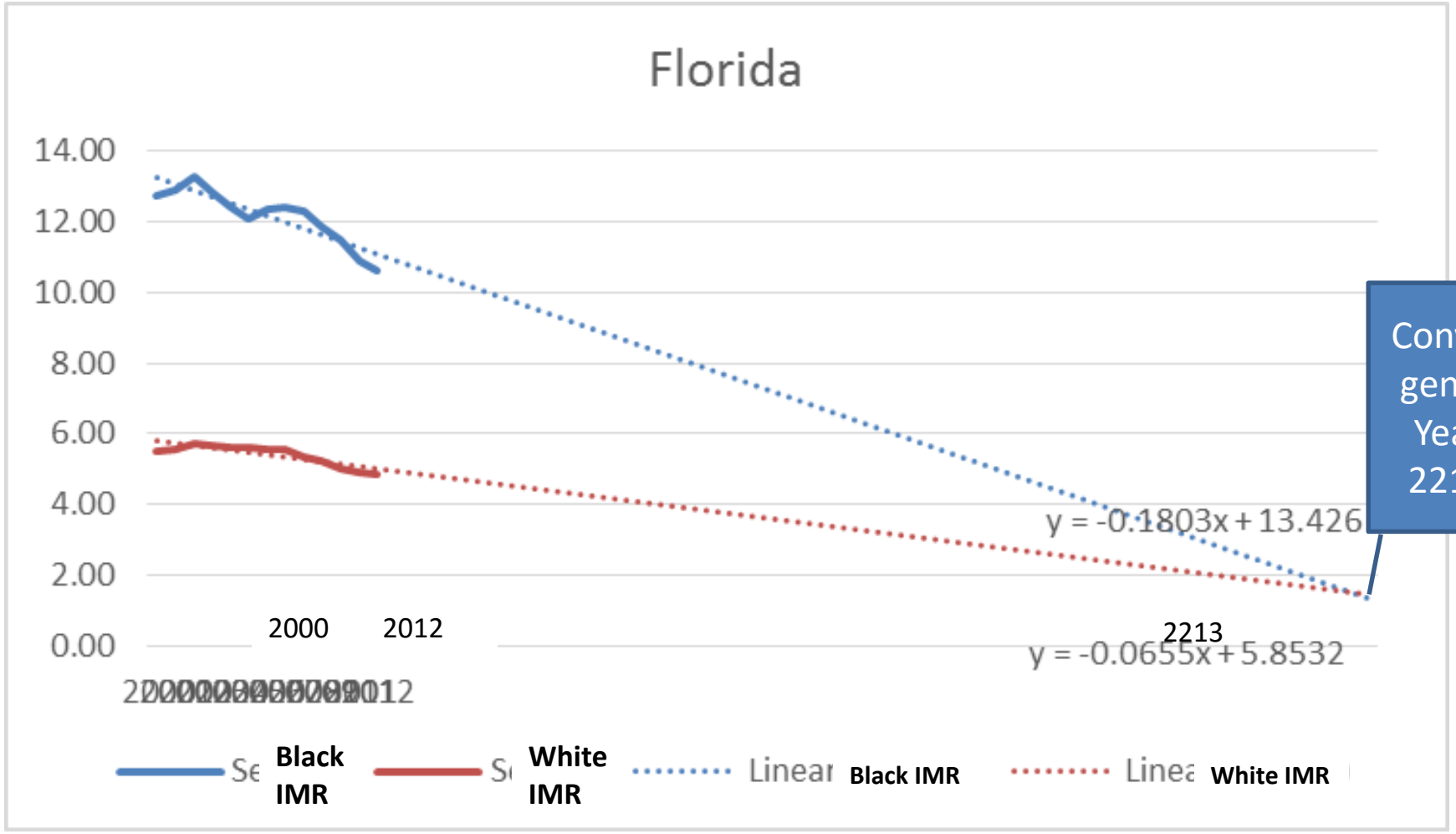

Breast Cancer Age Adjusted Mortality black/white
racial disparities in divergent pattern counties
Diverging
(increasing
Inequality)
Year from 1989-2010


Black/White Racial Disparity Patterns for
Age Adjusted Breast Cancer Mortality for US Counties (1989-2010)
Legend
Converging (89)
Diverging (183)
Equal (80)
Unequal (410)
Uncategorized
0 125 250 500 750 1,000
Miles


Breast Cancer Age Adjusted Mortality bl
racial disparities in persisten equal patte
Sustaining
Equality
Age Adjusted Mortality Rate (per 100,000)
Year from 1989-2010


Breast Cancer Age Adjusted Mortality in black/white
racial disparities consitent unequal pattern counties
Persistent
Inequality
Year from 1989-2010

Florida Forecast for Achieving Racial Equality in Infant Mortality



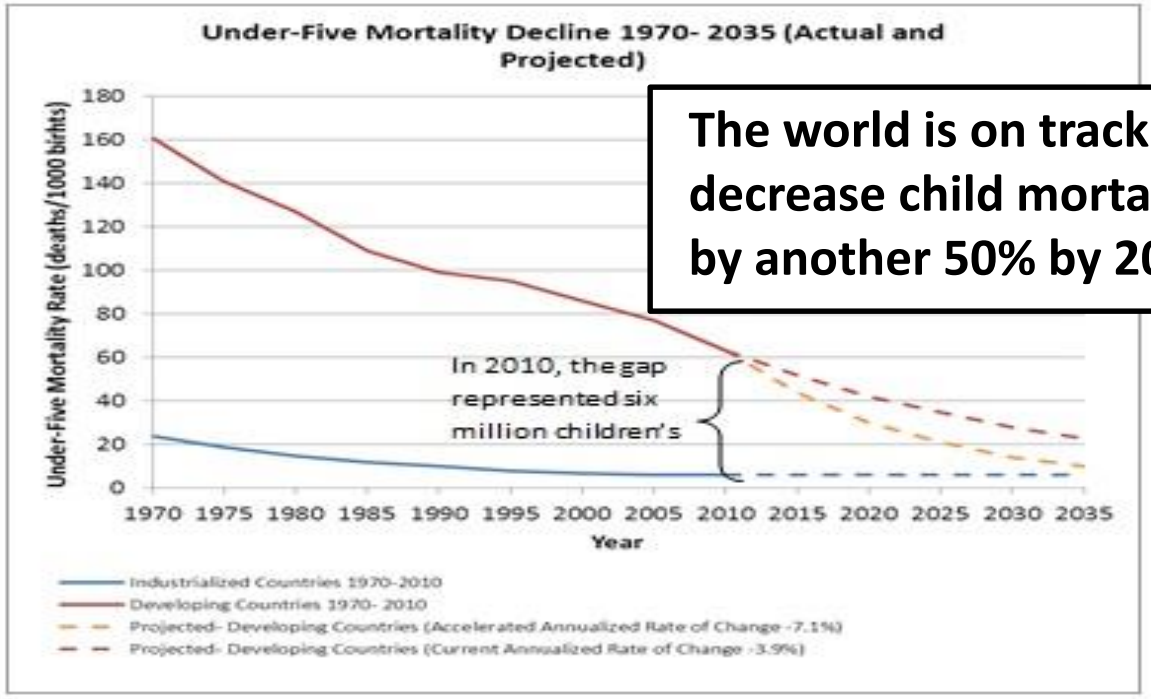
Naively Optimistic?

- The United Nations has established 17 Sustainable Development Goals:
  - **No Poverty**
  - **Zero Hunger**
  - **Good Health & Well-Being**

The campaign to eradicate smallpox eradication from the world began in 1966. In 1972 this poster indicated that the objective was in sight, and would perhaps be achieved within 2 years. Worldwide smallpox eradication was ultimately achieved in 1980.

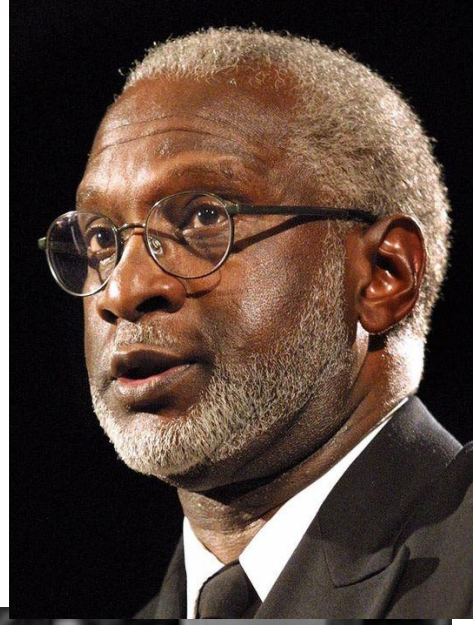
Global Child Mortality Rate Has Fallen 47% Since 1990

Under-five mortality rate (per 1,000 births) 1990-2012



The world is on track to decrease child mortality by another 50% by 2030.

How do we make progress?



"Living through the Civil Rights movement showed me that I could be a part of change. I realized then that you don't have to accept things the way they are."

-- David Satcher, MD, PhD

The Community Foundation for Greater Atlanta; http://www.cfgreateratlanta.org/Giving/Donor-Stories/The-David-Satcher-Fund1.aspx

Making Health Equity a Reality

Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has.

-- Margaret Mead

If we know enough . . .
If we care enough . . .
If we do enough . . .
and if we stay at it long and hard enough.

-- Dr. David Satcher
16th U.S. Surgeon General

Working Together

"We are all as angels,
with only one wing;

We can only fly
when we embrace each other.

-- *Luciano de Crescenzo*