Domestic Health Disparities in the United States

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Objectives

Be	Participants will be able to define health equity, health inequality, health disparities, and social determinants of health.
Review	Participants will review health outcome differences between US domestic populations nationally, regionally, and locally.
Explore	Participants will explore the effects of racial inequity on health care outcomes.

Presentation goals – The Public Health Part

Defining

Health Equality

Health Equity

Social Determinants of Health and

Health Disparities

Equality –

- Equality means each individual or group of people is given the same resources or opportunities.
  - https://onlinepublichealth.gwu.edu/resources/equity-vs-equality/

EQUITY

- Equity recognizes that each person has different circumstances and allocates the exact resources and opportunities needed to reach an equal outcome.
- https://onlinepublichealth.gwu.edu/resources/equity-vs-equality/

Health Equity – World Health Organization

"**Equity** is the **absence of avoidable or remediable differences** among groups of people, whether those groups are defined socially, economically, demographically or geographically."

"**health inequities** involve more than lack of equal access to needed resources to maintain or improve health outcomes.

- **They also refer to difficulty when it comes to "inequalities" that infringe on fairness and human rights norms."**

Health Equity – Centers for Disease Control (CDC)

- Health equity - "when everyone has the opportunity to be as healthy as possible."
- As such, **equity** is a **process** and **equality** is an **outcome** of that process.
- *Race Matters Institute – Paula Dressel*
  - "*The route to achieving **equity** will not be accomplished through treating everyone **equally**. It will be achieved by treating everyone **equitably**, or justly according to their circumstances."*

EXAMPLES OF EQUALITY[2]	EXAMPLES OF EQUITY[2]
A city cuts the budget for 25 community centers by reducing the operational hours for all centers by the same amount at the same times.	The city determines which times and how many hours communities actually need to use their community centers and reduces hours for centers that aren't used as frequently.
A community meeting, where all members of the community are invited, about a local environmental health concern is held in English though English is not the primary language for 25% of the residents.	The community leaders hire translators to attend the meeting or offer an additional meeting held in another language.
All public schools in a community have computer labs with the same number of computers and hours of operation during school hours.	Computer labs in lower income neighborhoods have more computers and printers, as well as longer hours of operation, as some students don't have access to computers or internet at home.

https://onlinepublichealth.gwu.edu/resources/equity-vs-equality/

How about Examples of INEQUITY

Equality

- Anyone with a certain math standard score in 5th grade can enter advanced math classes
- With a certain MCAT and interview score will gain you entrance to medical school .

Inequity

- Some students have families who have taken the advanced math classes in their educational history and can help with homework. Some students have families that have not graduated high school basic math classes .
- Some medical students have relatives that can offer them and their friends private tutorial sessions in anatomy lab .

Addressing Inequities

- “ Thus, to be **effective** and **sustainable**, interventions that aim to redress **inequities** must typically go **beyond remedying** a particular health **inequality** and also **help empower** the group in question through systemic changes, such as law reform or changes in economics.” or educational opportunities.
    - https://www.who.int/healthsystems/topics/equity/en/or social relationships.”

Is Equity The End Result?

https://onlinepublichealth.gwu.edu/resources/equity-vs-equality/

Equity

Justice

Health Disparities

- Health disparities are **preventable differences** in the **burden** of **disease, injury**, **violence**, or **opportunities to achieve** optimal health that are experienced by socially disadvantaged populations.

- **Socially disadvantaged populations** can be **defined** by factors such as **race or ethnicity, gender, education or income, disability, geographic location** (e.g., rural or urban), or **sexual orientation**.

- **Health disparities** are **inequitable** and are directly related to the **historical and current unequal distribution** of social, political, economic, and environmental resources.

  - https://www.cdc.gov/healthyyouth/disparities/index.htm#:~:text=Health%20disparities%20are%20preventable%20differences,experienced%20by%20socially%20disadvantaged%20populations.
  - https://www.cdc.gov/healthyyouth/disparities/index.htm

Health Disparity-**Preventable Differences**

- Burden of disease
- Injury
- Violence
- Opportunities to achieve optimal health.

Who are the socially disadvantaged ?

- **Socially disadvantaged** individuals are those who have been subjected to **racial** or **ethnic prejudice** or **cultural bias** within **American society** because of their identities as members of groups and without regard to their individual qualities.
- The social disadvantage must stem from circumstances beyond their control.

- **Electronic code of federal regulations : 13 CFR § 124.103 – Who is socially disadvantaged?**

Legally recognized socially disadvantaged groups by federal law

https://www.law.cornell.edu/cfr/text/13/124.103

- **Black Americans**
- **Hispanic Americans**
- **Native Americans** (Alaska Natives, Native Hawaiians, or enrolled members of a Federally or State recognized Indian Tribe)
- **Asian Pacific Americans** (persons with origins from Burma, Thailand, Malaysia, Indonesia, Singapore, Brunei, Japan, China (including Hong Kong), Taiwan, Laos, Cambodia (Kampuchea), Vietnam, Korea, The Philippines, U.S. Trust Territory of the Pacific Islands (Republic of Palau), Republic of the Marshall Islands, Federated States of Micronesia, the Commonwealth of the Northern Mariana Islands, Guam, Samoa, Macao, Fiji, Tonga, Kiribati, Tuvalu, or Nauru); Subcontinent Asian Americans (persons with origins from India, Pakistan, Bangladesh, Sri Lanka, Bhutan, the Maldives Islands or Nepal)
- Being born in a country does not, by itself, suffice to make the birth country an individual's country of origin for purposes of being included within a designated group.

Health disparities

- Social
- Political
- Economic
- Environmental

- **Inequitable and directly**

related to the historical and current unequal distribution of resources

Multiple Factors Contribute to Health Disparity

- Poverty
- Environmental threats
- Inadequate access to health care
- Individual and behavioral factors
- Educational inequalities

REDLINING IN LOUISVILLE NEIGHBORHOODS

- These maps assigned grades to neighborhoods to indicate their desirability for investment.
- Black, immigrant and low-income neighborhoods were often given low grades, eliminating their access to mortgage insurance or credit for decades.

REDLINING WAS DISCONTINUED NATIONALLY IN 1951 BUT THE IMPACT OF DISINVESTMENT RESULTING FROM REDLINING IS STILL EVIDENT IN LOUISVILLE AND MOST OTHER U.S. CITIES TODAY.

- Redlining dates to 1933, when the **U.S. government** created the Homeowner's Loan Corporation **(HOLC)** to bolster the housing market and homeownership opportunities across the nation. The HOLC created residential securities maps, better known as redlining maps, to guide investment in U.S. cities.

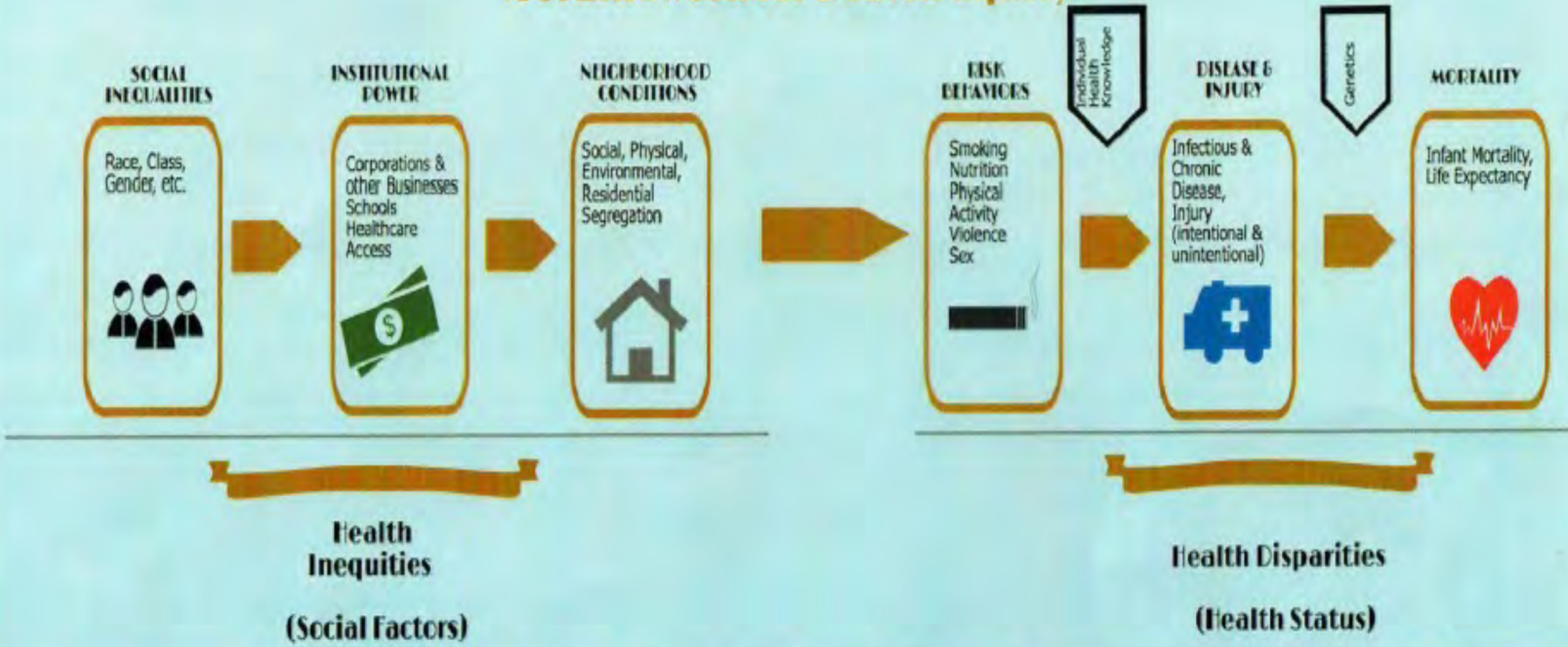
- Historical practices such as **redlining** have resulted in poorer, overcrowded housing, and exposure to more severe levels of air pollution which contribute to chronic disease.
- Redlined areas were restricted to industry , black , immigrant, and low-income communities

REDLINING –CONVENTIONAL & REVERSE

- Examples of **conventional redlining** that still exists today include
  - refusal to provide delivery in certain areas
  - business loan denials regardless of credit-worthiness
  - refusal to write property insurance policies
  - dropping property owners from insurance coverage altogether.

- **reverse redlining**
  - offering services low-income residents at higher prices (car ins.)
  - higher interest rates and excessive service fees or inferior products
    - payday loans
    - cash advances
    - expedited tax returns.

A Framework for Health Equity



"Health Inequities are differences in health status & mortality rates across population groups that are systemic, avoidable, unfair and unjust."

-Margaret Whitehead

WHAT DEFINES A FOOD DESERT? – LOUISVILLE ALL BUT THE N.E. AREA

HTTPS://WWW.ERS.USDA.GOV/DATA-PRODUCTS/FOOD-ACCESS-RESEARCH-ATLAS/DOCUMENTATION/#DEFINITIONS

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Definition

- Accessibility to sources of healthy food, as measured by distance to a store or by the number of stores in an area.
- Individual-level resources that may affect accessibility, such as family income or vehicle availability.
- Neighborhood-level indicators of resources, such as the average income of the neighborhood and the availability of public transportation.

Consequences

- Higher risk of diet related diseases
  - Obesity
  - Diabetes
  - Cardiovascular Disease

REDLINING IN LOUISVILLE NEIGHBORHOODS

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PART II

Recognition of health outcome differences between Americans nationally, statewide and locally.

- Examining social determinants of health
- What are health inequalities in the context of social determinants of health ?
- What is the effect of health inequalities on the health of Americans ?

UNDERSTANDING **SOCIAL DETERMINANTS** OF HEALTH

Social determinants of health are **conditions** in the **environments** in which people are present

- ***Born -Live -Learn-Work-Play- Worship – and Age***

They **affect** a wide range of **health, functioning, and quality-of-life outcomes and risks.**

SOCIAL DETERMINANTS OF HEALTH (SDOH)

HTTPS://WWW.HEALTHYPEOPLE.GOV/2020/TOPICS-OBJECTIVES/TOPIC/SOCIAL-DETERMINANTS-OF-HEALTH

EXAMPLES OF SOCIAL DETERMINANTS

- Availability of resources to meet daily needs (e.g., safe housing and local food markets)
- Access to educational, economic, and job opportunities
- Access to health care services
- Quality of education and job training

EXAMPLES OF SOCIAL DETERMINANTS

AVAILABILITY OF COMMUNITY-BASED RESOURCES IN SUPPORT OF COMMUNITY LIVING AND OPPORTUNITIES FOR RECREATIONAL AND LEISURE-TIME ACTIVITIES

TRANSPORTATION OPTIONS

PUBLIC SAFETY

SOCIAL SUPPORT

EXAMPLES OF SOCIAL DETERMINANTS

- Social norms and attitudes (e.g., discrimination, racism, and distrust of government)
- Exposure to crime, violence, and social disorder (e.g., presence of trash and lack of cooperation in a community)
- Socioeconomic conditions (e.g., concentrated poverty and the stressful conditions that accompany it)

EXAMPLES OF SOCIAL DETERMINANTS

- Residential segregation
- Language/Literacy
- Access to mass media and emerging technologies (e.g., cell phones, the Internet, and social media)
  - i.e.. **Digital Divide**
- Culture

SOCIAL DETERMINANTS OF HEALTH ***ECONOMICS***

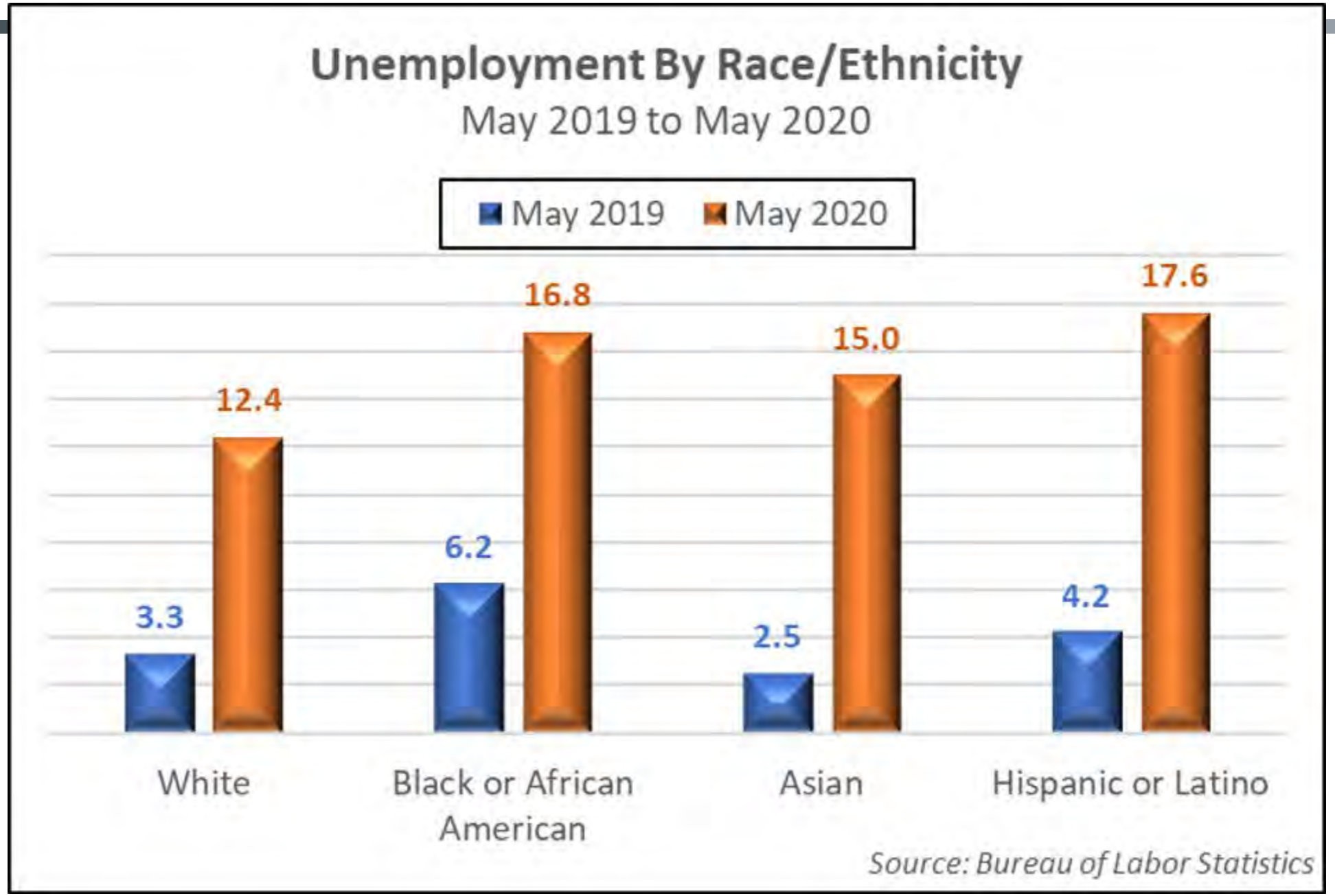
HTTPS://WWW.HEALTHYPEOPLE.GOV/2020/TOPICS-OBJECTIVES/TOPIC/SOCIAL-DETERMINANTS-OF-HEALTH

REVIEW **KEY ISSUES** OF THE 5 SOCIAL DETERMINANTS OF HEALTH – ***ECONOMIC STABILITY***

- Employment
- Food Insecurity
- Housing Instability
- Poverty

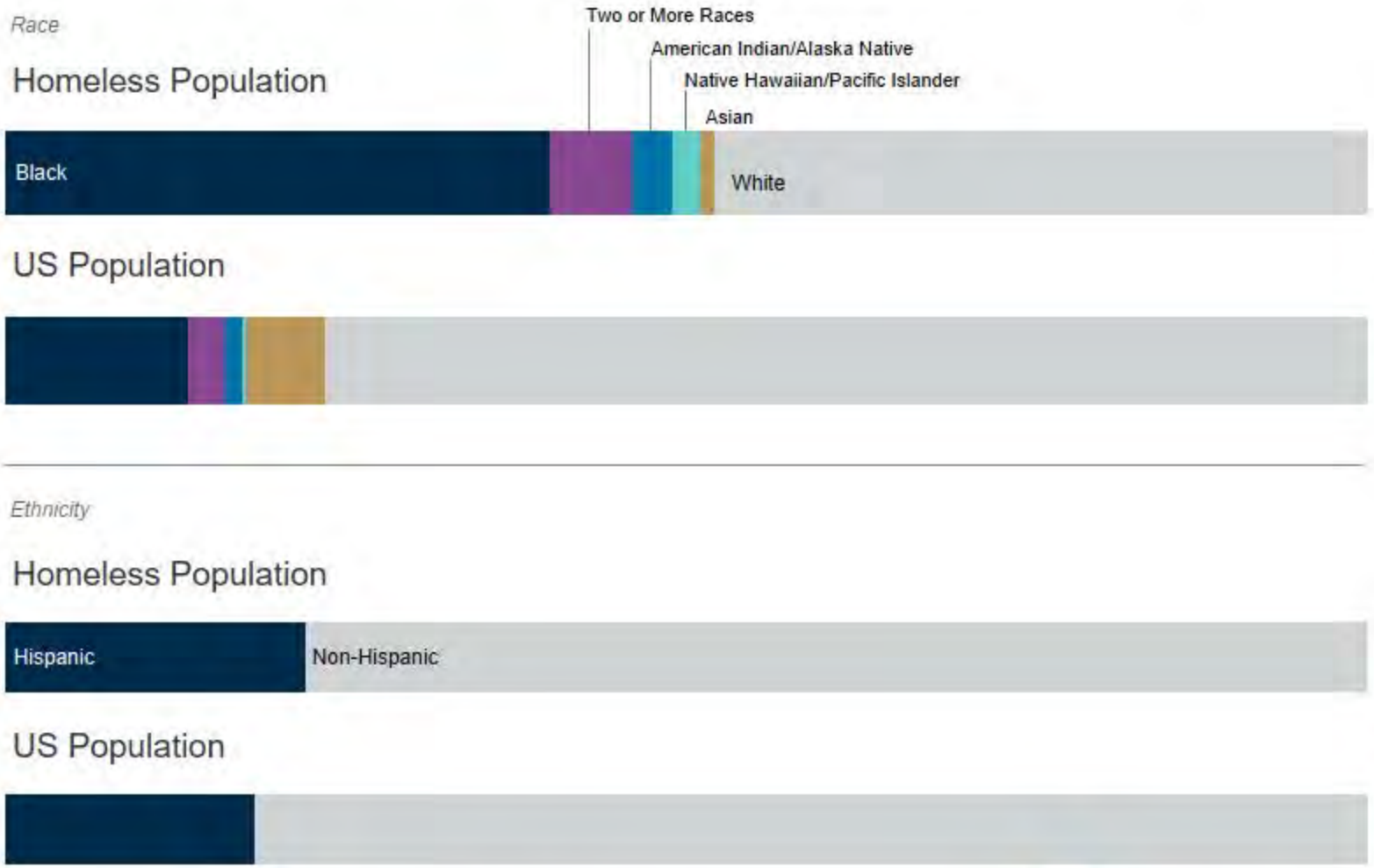
EMPLOYMENT AND ECONOMIC RACIAL DIFFERENCES

- Compared to whites, black Americans face the same risk of unemployment today as in the 1960s.
- Between 2007 and 2013, the net wealth of the median black household fell from 10 percent to 8 percent of median white household wealth, largely the result of the differential impact of the Great Recession.
- The median white household now has a net wealth 13 times greater than the median black household.
- In 2000 the median black household had an income that was 66 percent of the median white household income. In 2015 that figure was 59 percent.
    - https://www.brookings.edu/research/time-for-justice-tackling-race-inequalities-in-health-and-housing/


Unemployment By Race/Ethnicity
May 2019 to May 2020
May 2019
May 2020
3.3
12.4
6.2
16.8
2.5
15.0
4.2
17.6
White
Black or African American
Asian
Hispanic or Latino
Source: Bureau of Labor Statistics

Most Minority Groups Make up a Larger Share of the Homeless Population than They Do of the General Population

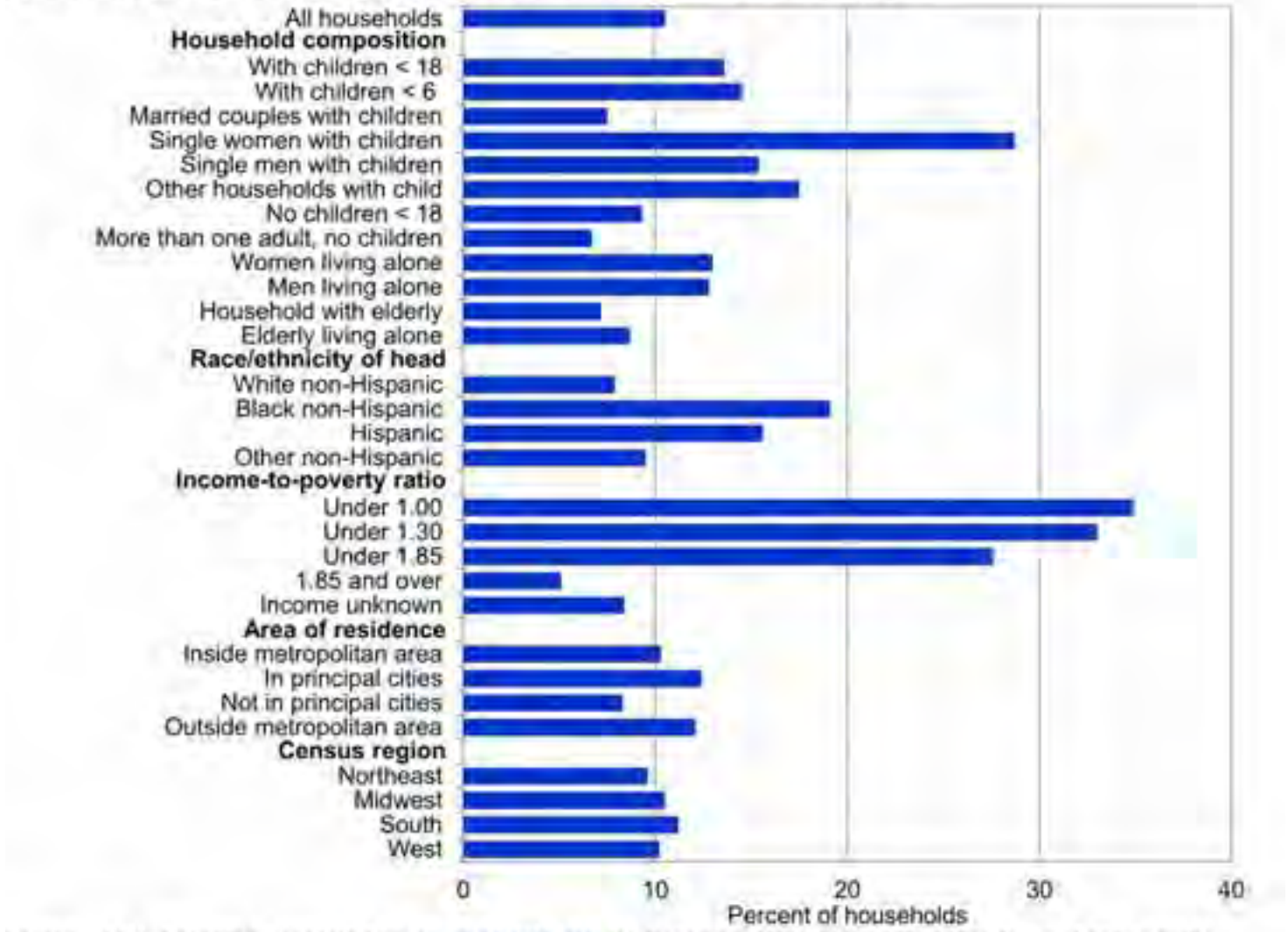
Race and ethnicity of those experiencing homelessness compared with the general population



Homeless population data are for a given night in 2019.
Source: *Annual Homeless Assessment Report to Congress, Part 1*, 2020.

National Alliance to End Homelessness

Prevalence of food insecurity by selected household characteristics, 2019



Source: USDA, Economic Research Service, using data from the December 2019 Current Population Survey Food Security Supplement.

SOCIAL DETERMINANTS OF HEALTH ***EDUCATION***

HTTPS://WWW.HEALTHYPEOPLE.GOV/2020/TOPICS-OBJECTIVES/TOPIC/SOCIAL-DETERMINANTS-OF-HEALTH

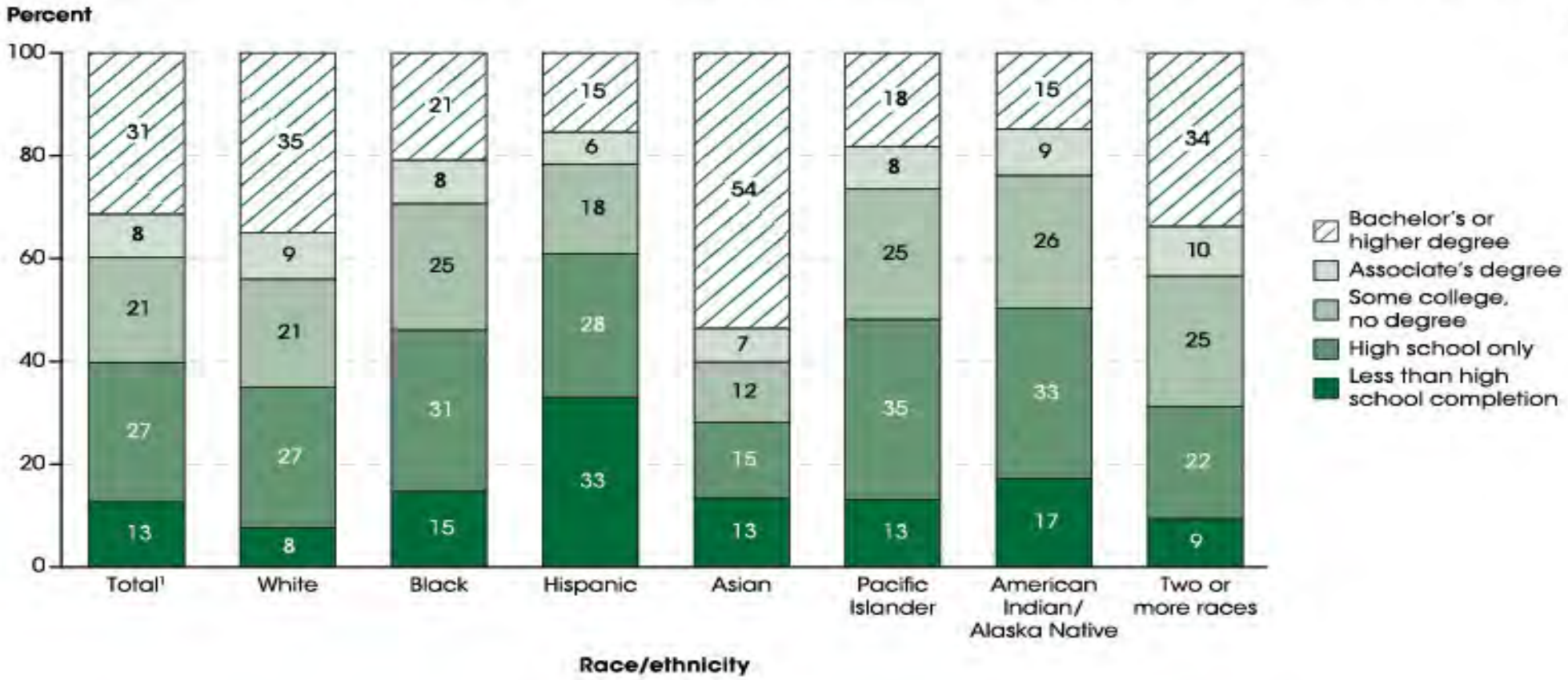
REVIEW KEY ISSUES OF THE 5 SOCIAL DETERMINANTS OF HEALTH – **EDUCATION**

- Early Childhood Education and Development
- Enrollment in Higher Education
- High School Graduation
- Language and Literacy

IES NCES National Center for Education Statistics

HTTPS://NCES.ED.GOV/PROGRAMS/RACEINDICATORS/INDICATOR_RFA.ASP

Figure 27.4. Percentage distribution of educational attainment of adults age 25 and older, by race/ethnicity: 2016



RESULTS OF EDUCATION EQUALITY

- Higher levels of education contribute to having the following outcomes

- A longer life
- Increased likelihood of obtaining or understanding basic health information and services needed to make appropriate health decisions

GOOD HEALTH IS ASSOCIATED WITH ACADEMIC SUCCESS. *THESE ARE HEALTH RISKS TO ACADEMIC SUCCESS*

- Teenage pregnancy
- Poor Dietary Choices
- Inadequate Physical Activity
- Emotional Abuse
- Substance Abuse
- Gang Involvement

SOCIAL DETERMINANTS OF HEALTH

SOCIAL AND COMMUNITY

HTTPS://WWW.HEALTHYPEOPLE.GOV/2020/TOPICS-OBJECTIVES/TOPIC/SOCIAL-DETERMINANTS-OF-HEALTH

SOCIAL DETERMINANTS OF HEALTH – *SOCIAL AND COMMUNITY CONTEXT*

- Civic Participation
- Discrimination
- Incarceration
- Social Cohesion

THE % OF BLACK AMERICANS IN THE US

- **Source:** Humes KR, Jones NA, Ramirez RR. Overview of race and Hispanic origin: 2010. 2010 Census Briefs. Suitland, MD: U.S. Census Bureau; March 2011. Publication No. C2010BR-02. http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf (5.4 MB)

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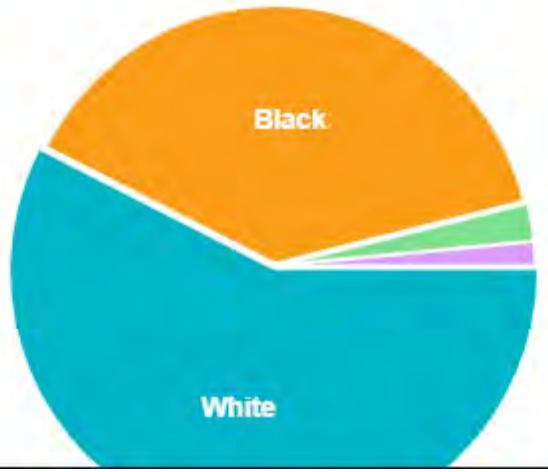
Sentences Imposed

Inmate Race

Statistics based on prior month's data -- -- Last Updated: Saturday, 9 January 2021



INMATE RACE STATISTICS BASED ON PRIOR MONTH'S DATA – LAST UPDATED SATURDAY ,9 JANUARY 2021

Race	# of Inmates	% of Inmates
Asian	2,280	1.5%
Black	58,405	38.6%
Native American	3,596	2.4%
White	87,065	57.5%

FEDERAL DATA FROM NOVEMBER 6,2021

Inmate Race

Statistics based on prior month's data — Last Updated: Saturday, 6 November 2021

Race	# of Inmates	% of Inmates
Asian	2,362	1.5%
Black	59,474	38.1%
Native American	3,876	2.5%
White	90,535	57.9%

SOCIAL DETERMINANTS OF HEALTH

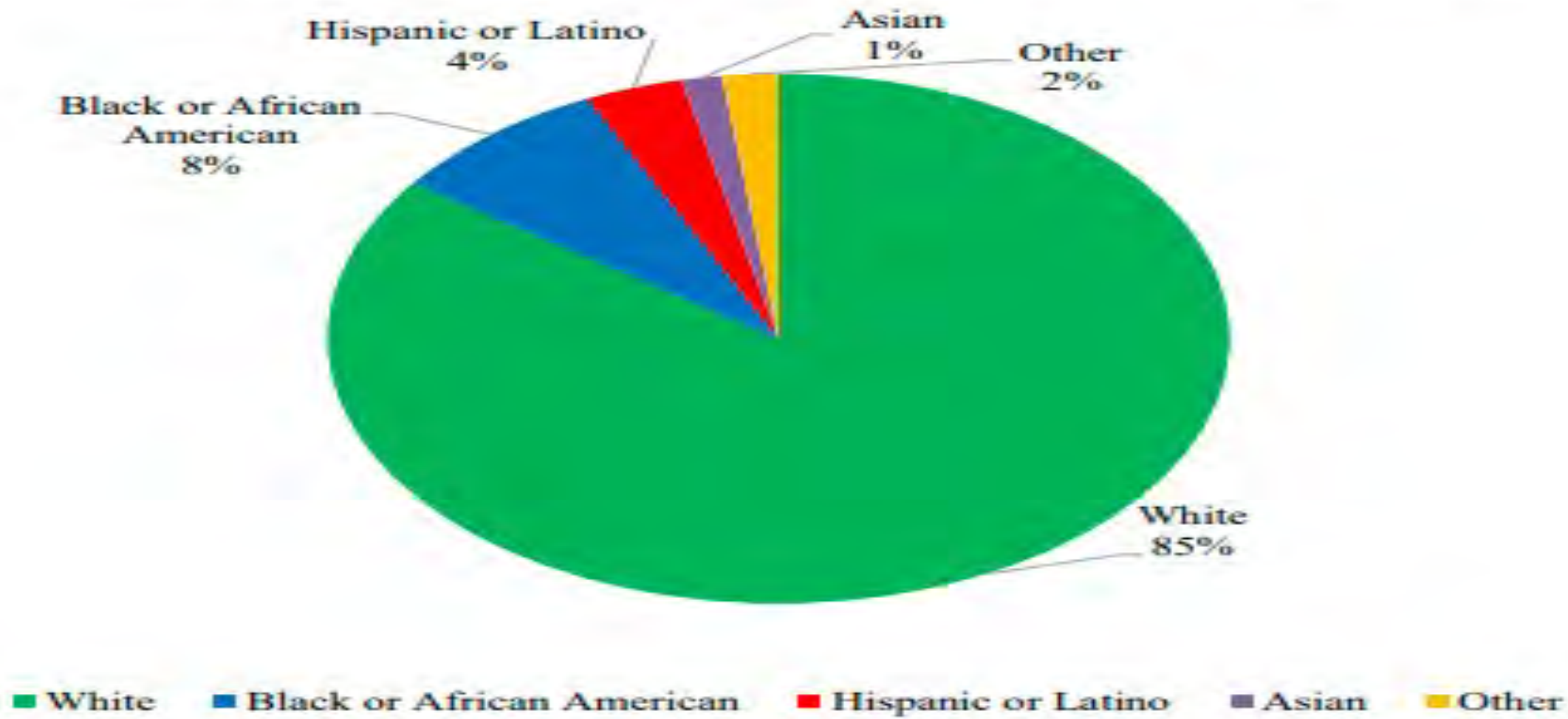
HEALTH AND HEALTH CARE

HTTPS://WWW.HEALTHYPEOPLE.GOV/2020/TOPICS-OBJECTIVES/TOPIC/SOCIAL-DETERMINANTS-OF-HEALTH

Kentucky Minority Health Status Report

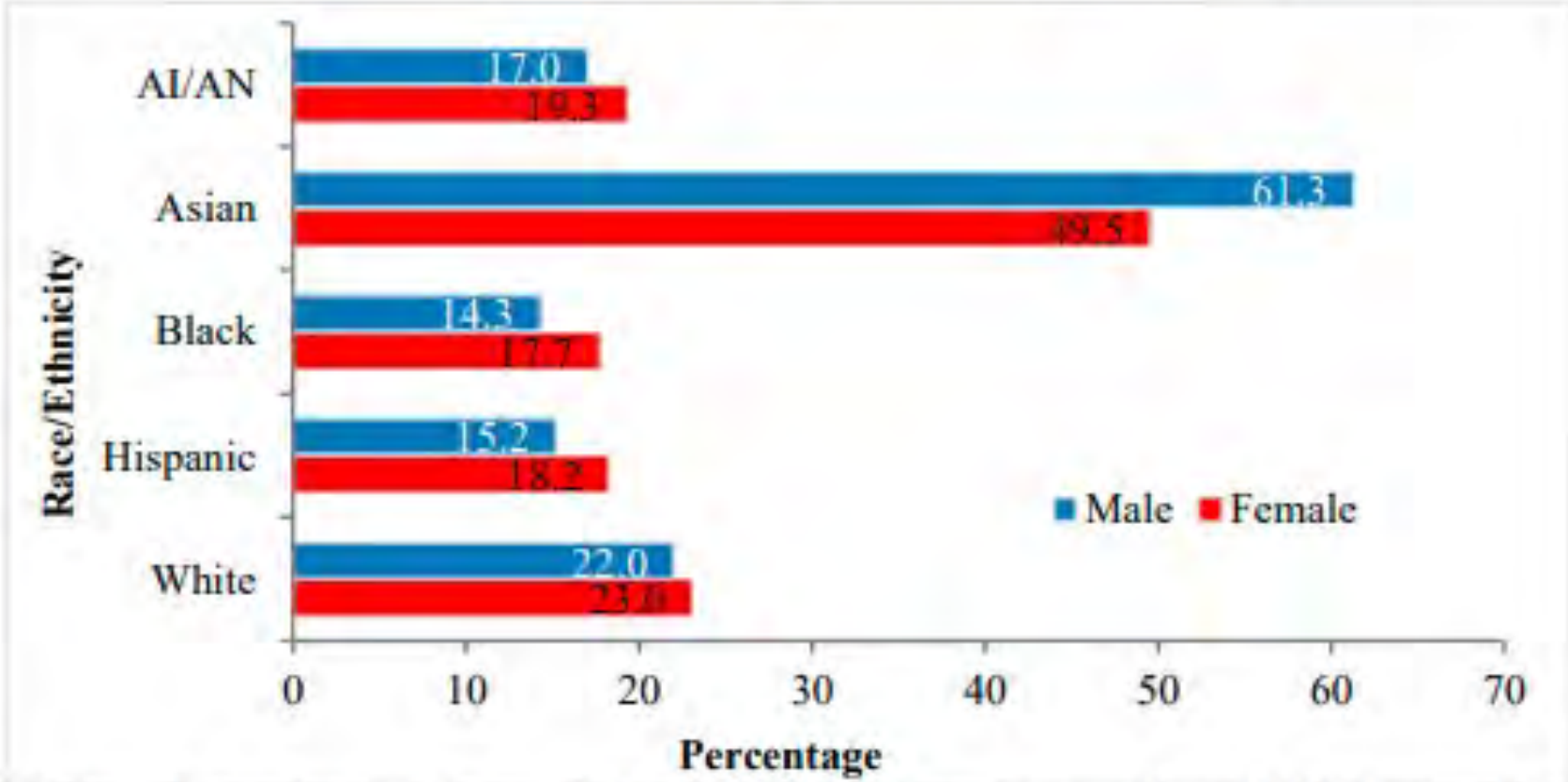
The Cabinet for Health and Family Services presents: The Department for Public Health, Office of Health Equity 2017 Minority Health Status Report

Chart 1: Kentucky Population by Race and Ethnicity, 2016



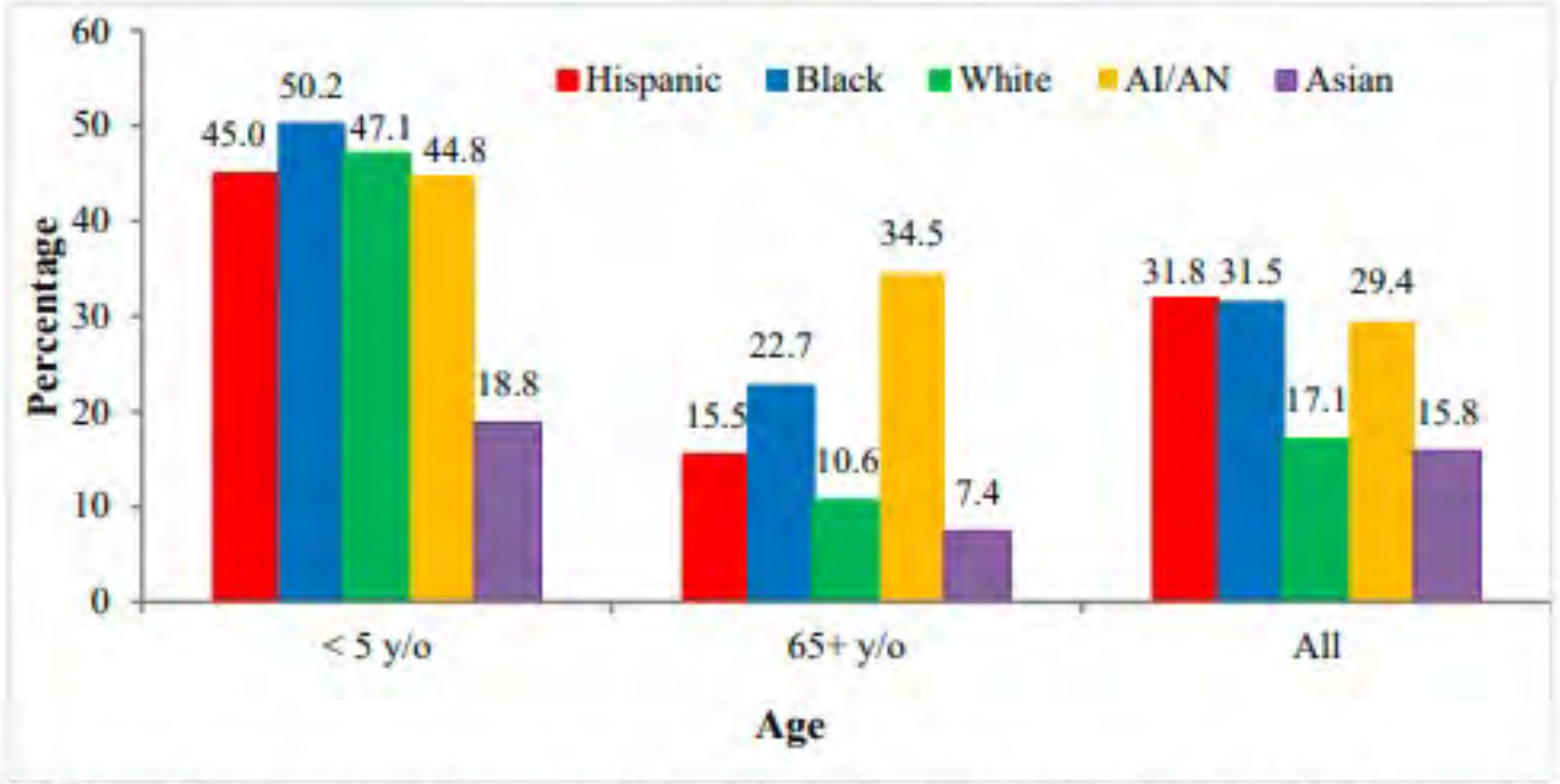
Source: Kentucky State Data Center, U.S. Census Bureau, Population Estimates, 2016

Chart 5: Percentage of Kentuckians over 25 Years Old who have a Bachelor's Degree or Higher, by Race, Ethnicity and Gender 2011 - 2015



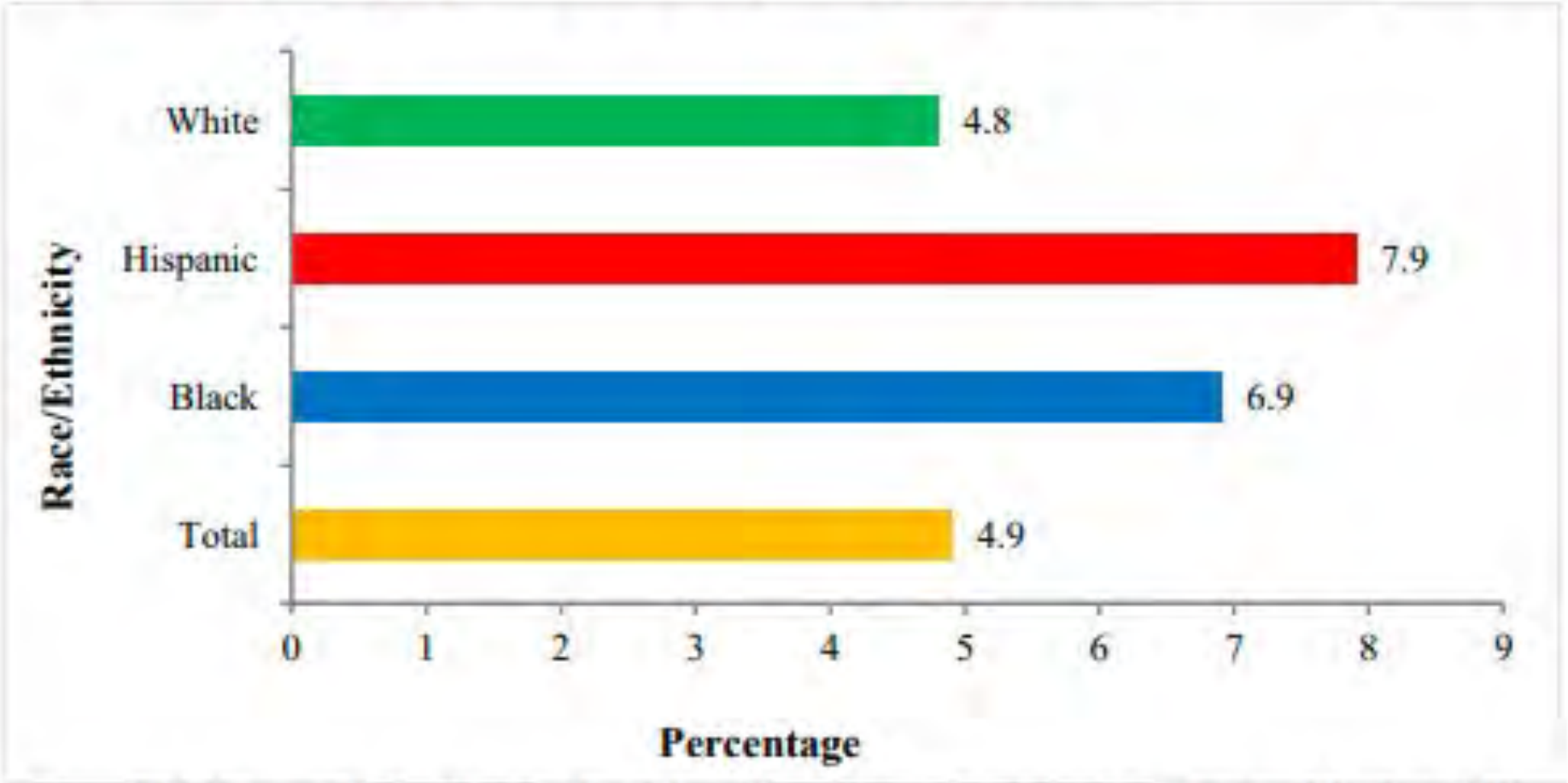
Source: U.S. Census Bureau, American Community Survey, 2011-2015, 5-year estimates. Notes: AI/AN: American Indian/Alaska Native, Hispanic includes Latino

Chart 6: Poverty Rates in Kentucky by Age Group and Race/Ethnicity, 2011-2015



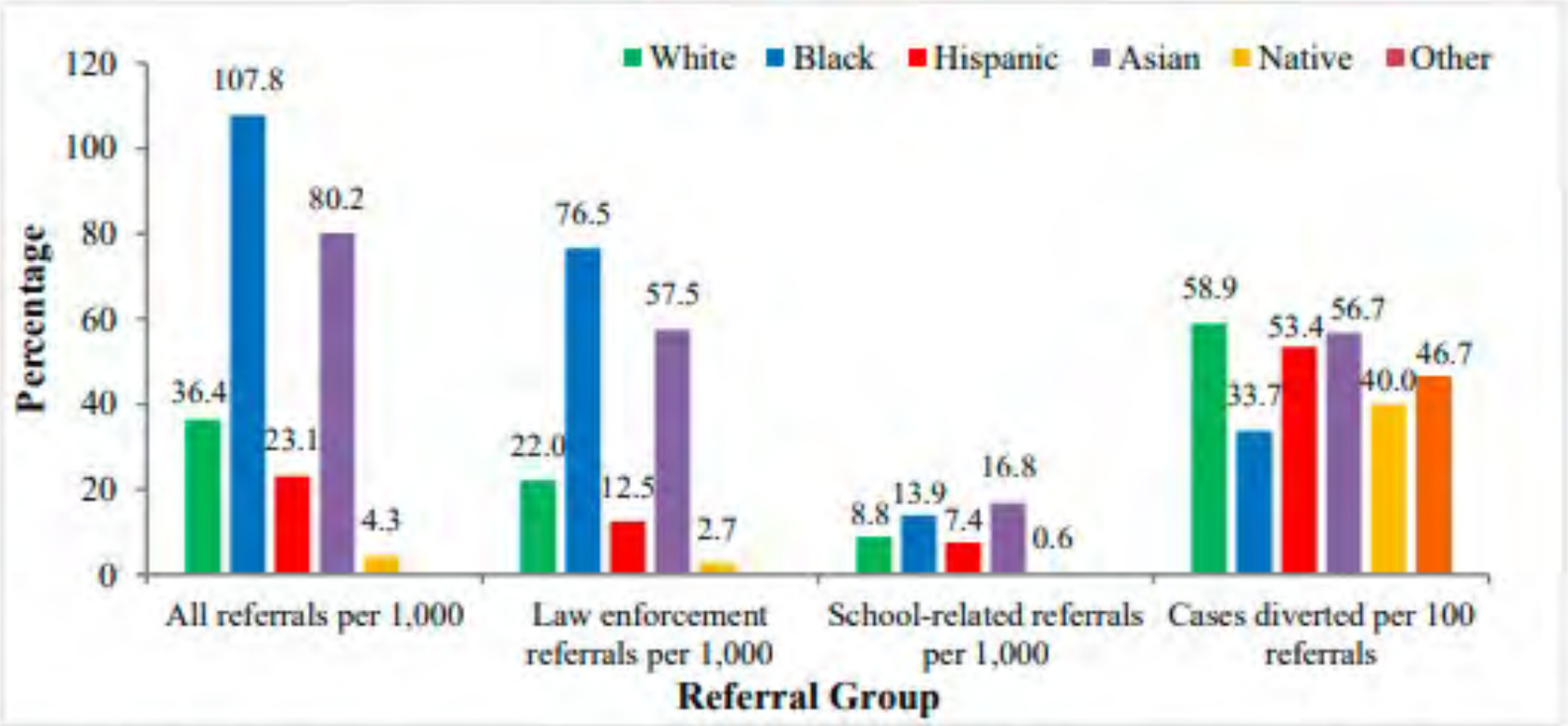
Source: U.S. Census Bureau, American Community Survey, 2011-2015, 5-year estimates. Notes: AI/AN: American Indian/Alaska Native, Hispanic includes Latino

Chart 7: Unemployment Rate in Kentucky by Race and Ethnicity, 2016



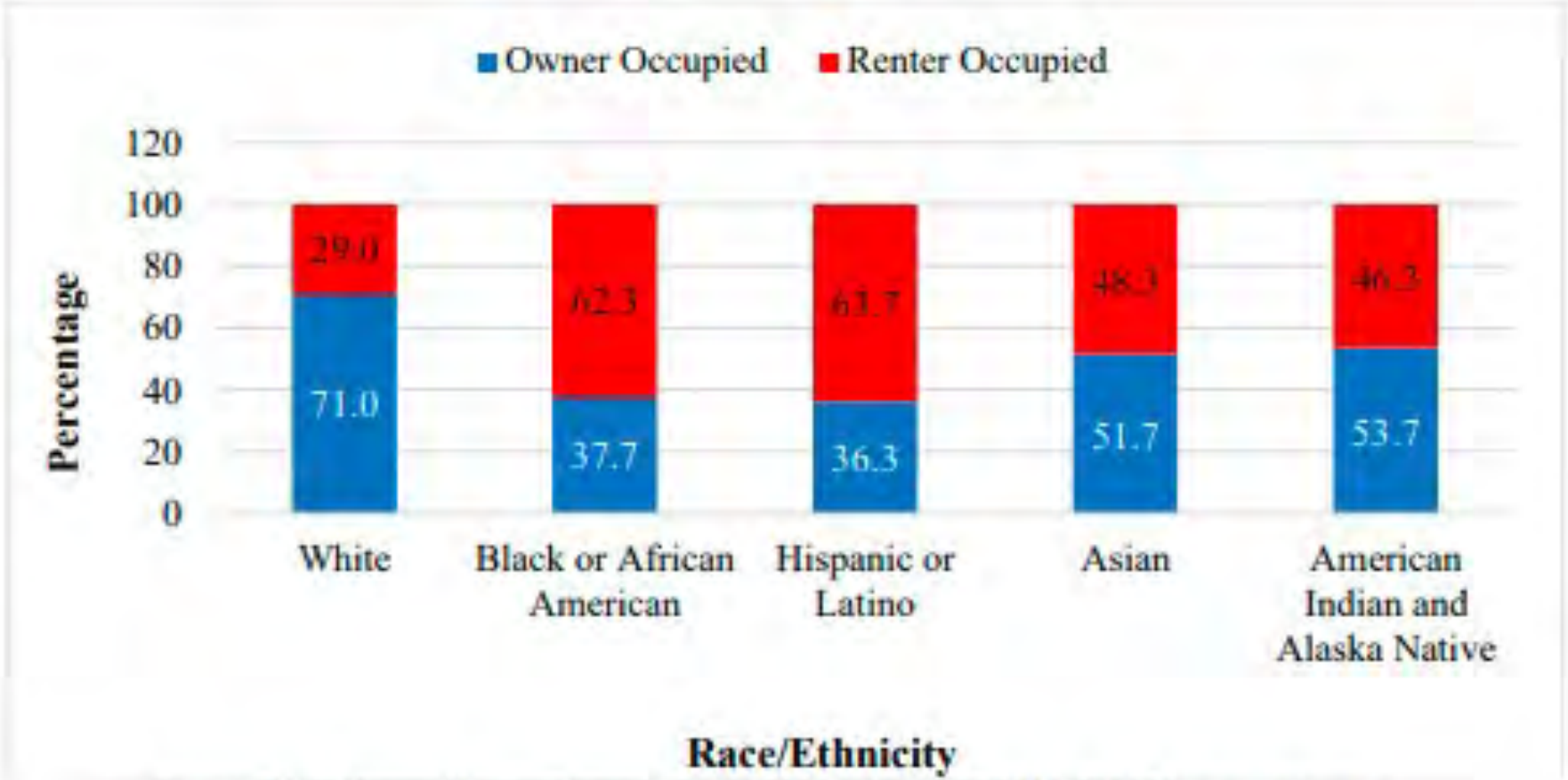
Source U.S. Bureau of Labor Statistics/Local Area Unemployment Statistics Information and Analysis, 2016

Chart 9: Kentucky Department of Juvenile Justice, Annual Statewide Contact Rates by Race and Ethnicity, 2015



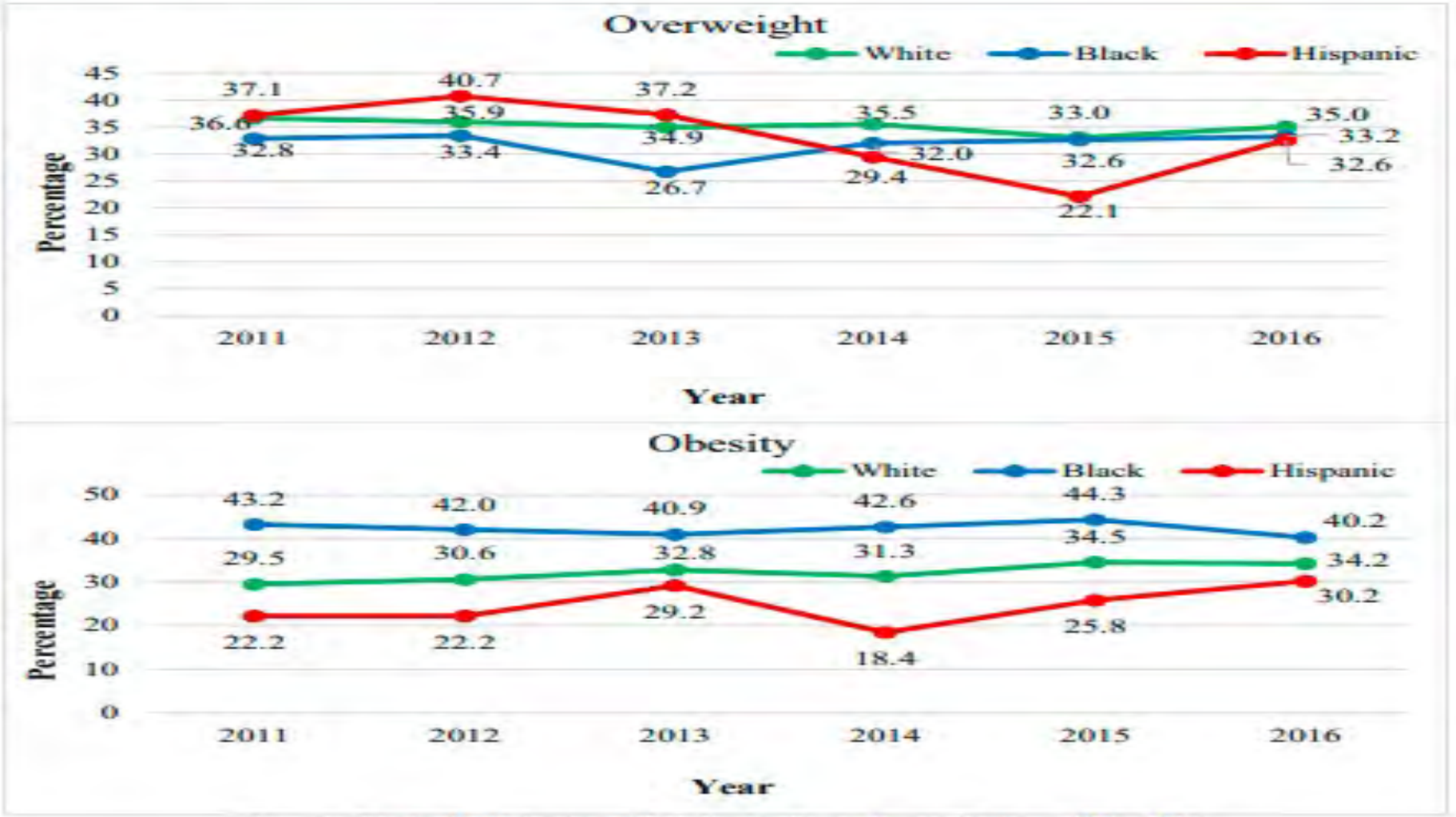
Source: Jenkins, E., Kentucky Department of Juvenile Justice. Kentucky Updated Plan for Compliance with the Disproportionate Minority Contact Core Requirement. Appendix 3. 2017

Chart 10: Home Ownership and Renter-Occupied Homes in Kentucky, by Race and Ethnicity, 2011-2015



Source: U.S. Census Bureau, American Community Survey, 2011-2015, 5-year estimates.
Notes: AI/AN: American Indian/Alaska Native, Hispanic includes Latino.

Chart 19: Overweight and Obesity Prevalence among Adults in Kentucky, by Race and Ethnicity, 2011-2016

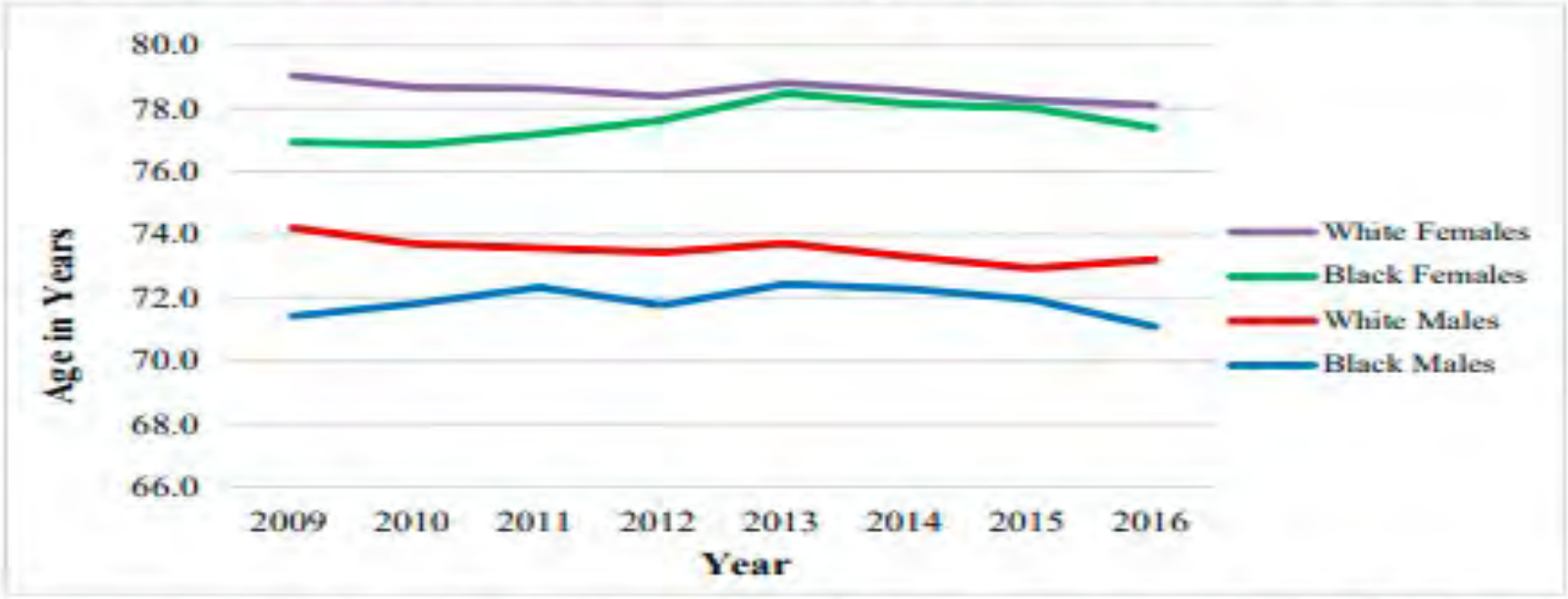


Source: Kentucky Behavioral Risk Factor Surveillance System, 2011-2016

Life Expectancy

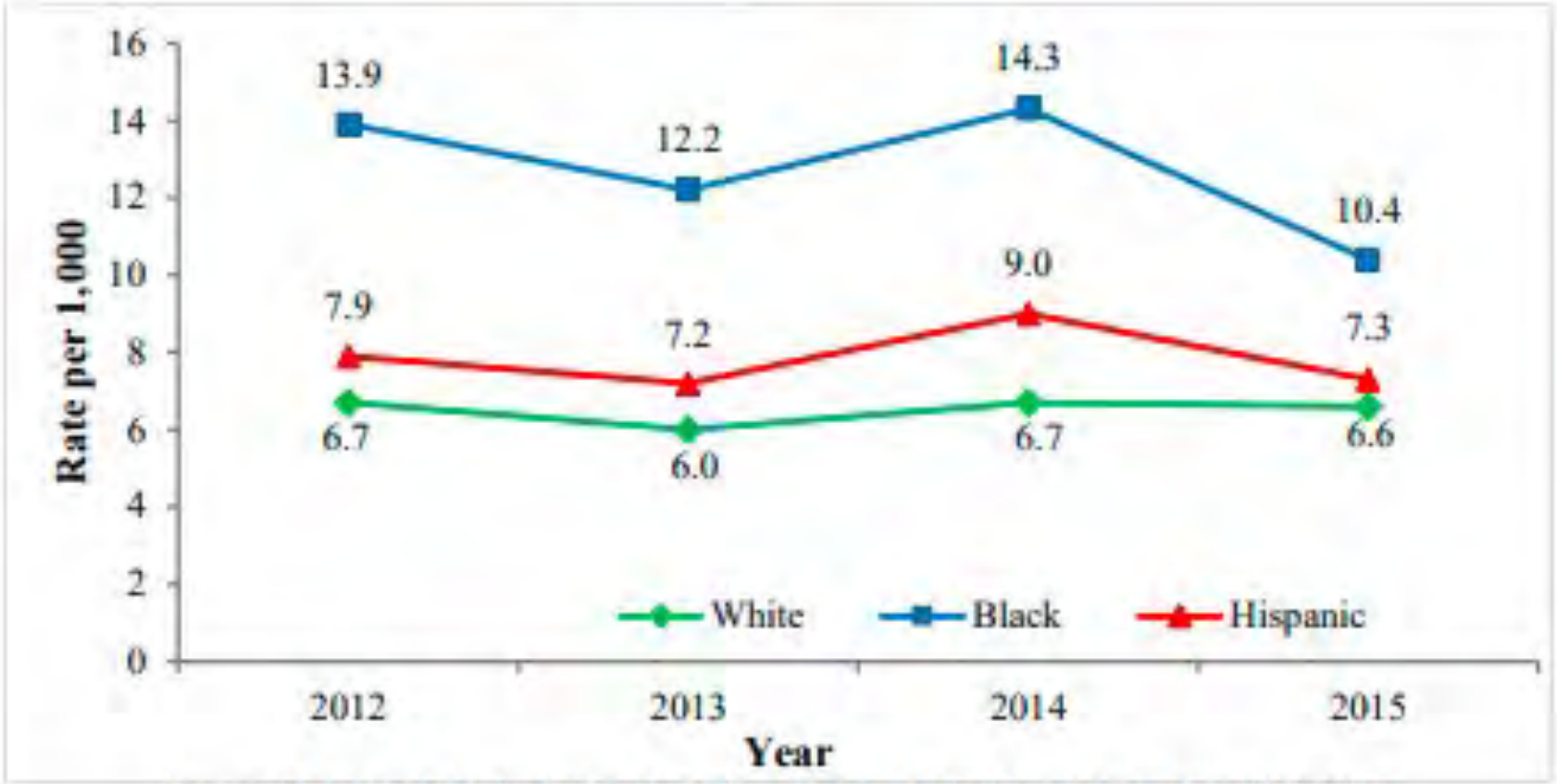
While White females in Kentucky have historically had the highest life expectancy, in 2013 Black women also reached a life expectancy of 78 years. Black men have consistently had the lowest life expectancy of all groups when stratified by race and gender. With the exception of White males, life expectancy has decreased for all groups since 2015. The health disparities that exist among minority groups correlate with life expectancy. Social indicators such as housing, education, income, discrimination, racism, and stress, all contribute to premature death.[35]

Chart 24: Life Expectancy in Kentucky by Race and Gender, 2009-2016



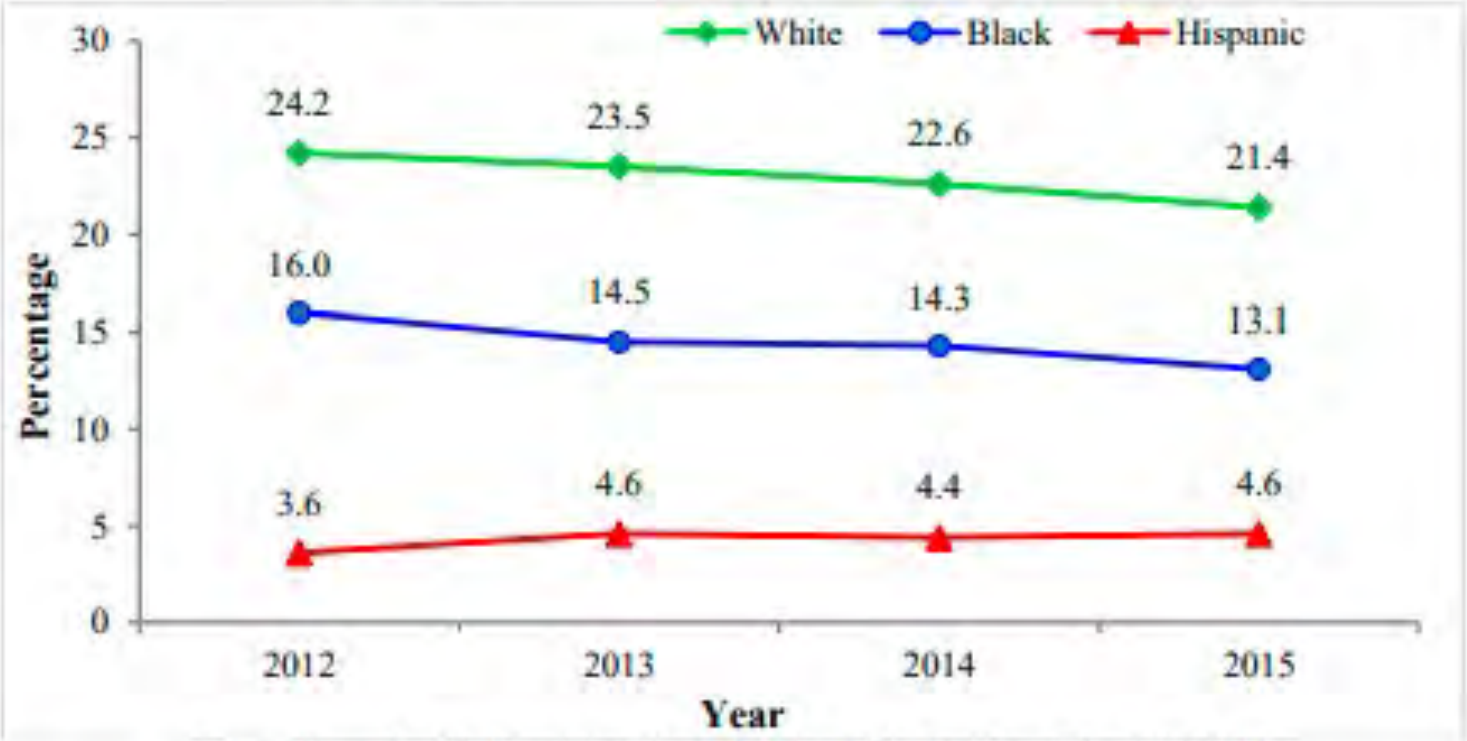
Source: Kentucky Vital Statistics, Death Certificate Files 2009-2016. Analysis by the Kentucky State Data Center, 2017

Chart 25: Infant Mortality Rates per 1,000 Live Births by Year, and by Race and Ethnicity in Kentucky, 2012-2015*



Source: Kentucky Vital Statistics, Death Certificate and Birth Certificate Files 2012-2015
Note: *2013-2015 data are preliminary and may change.

Chart 23: Percentage of Resident Live Births to Mothers Smoking During Pregnancy, by Race and Ethnicity in Kentucky 2012-2015*



Source: Kentucky Vital Statistics, Kentucky Live Birth Certificate Files 2012-2015

*Birth data from 2012-2015 are preliminary. The percentage was calculated based on live births to mothers smoking during any trimester of pregnancy. Hispanic origin and race not mutually exclusive. People of Hispanic origin may fall into any of the race categories. Resident data includes events which occurred to the residents of the specified geographic area, regardless of place of occurrence.

Chart 28: Age Adjusted Death Rates for Cerebrovascular Diseases by Race for KY and U.S., 1999 – 2015 with 95% Confidence Intervals

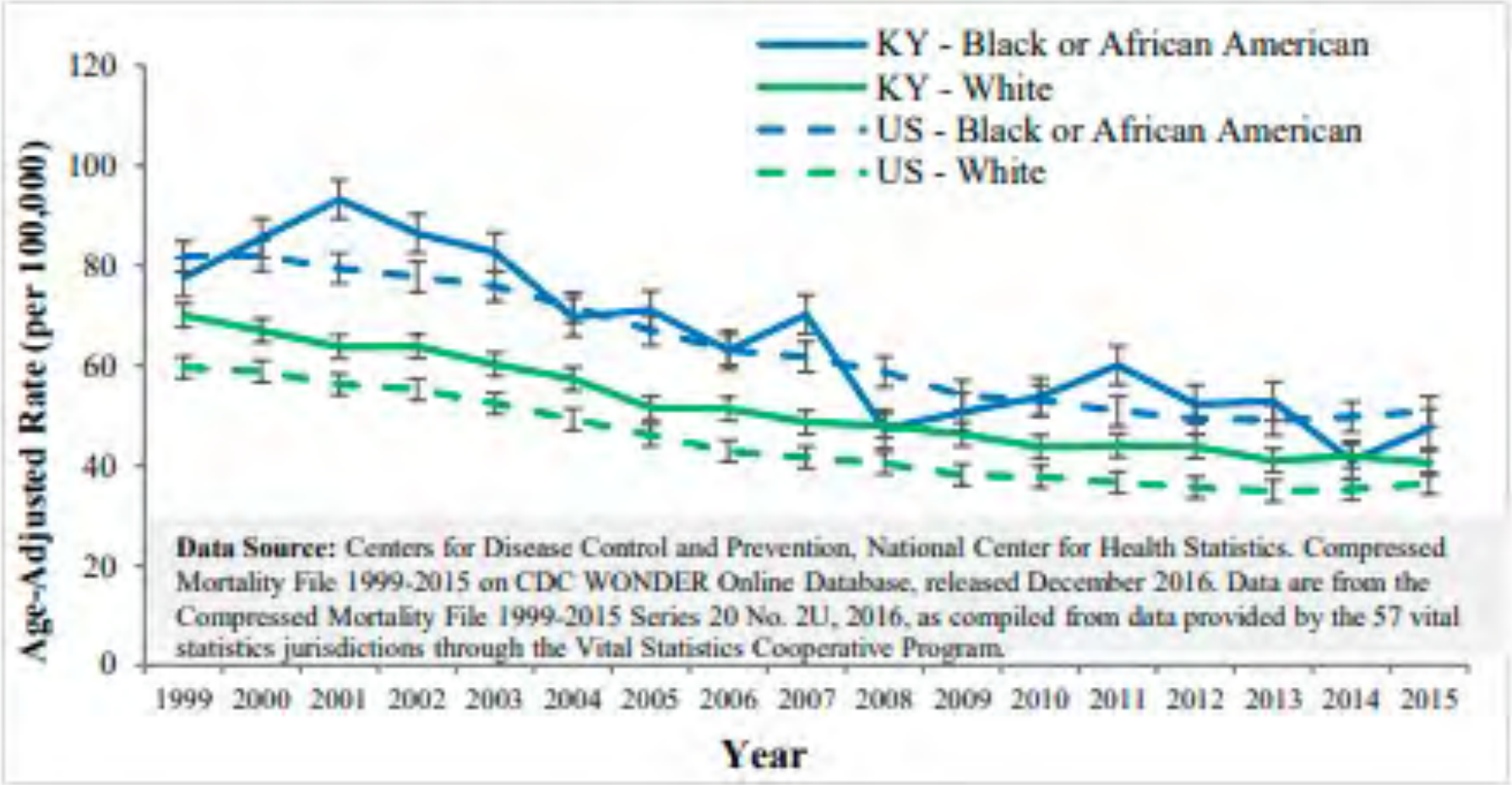
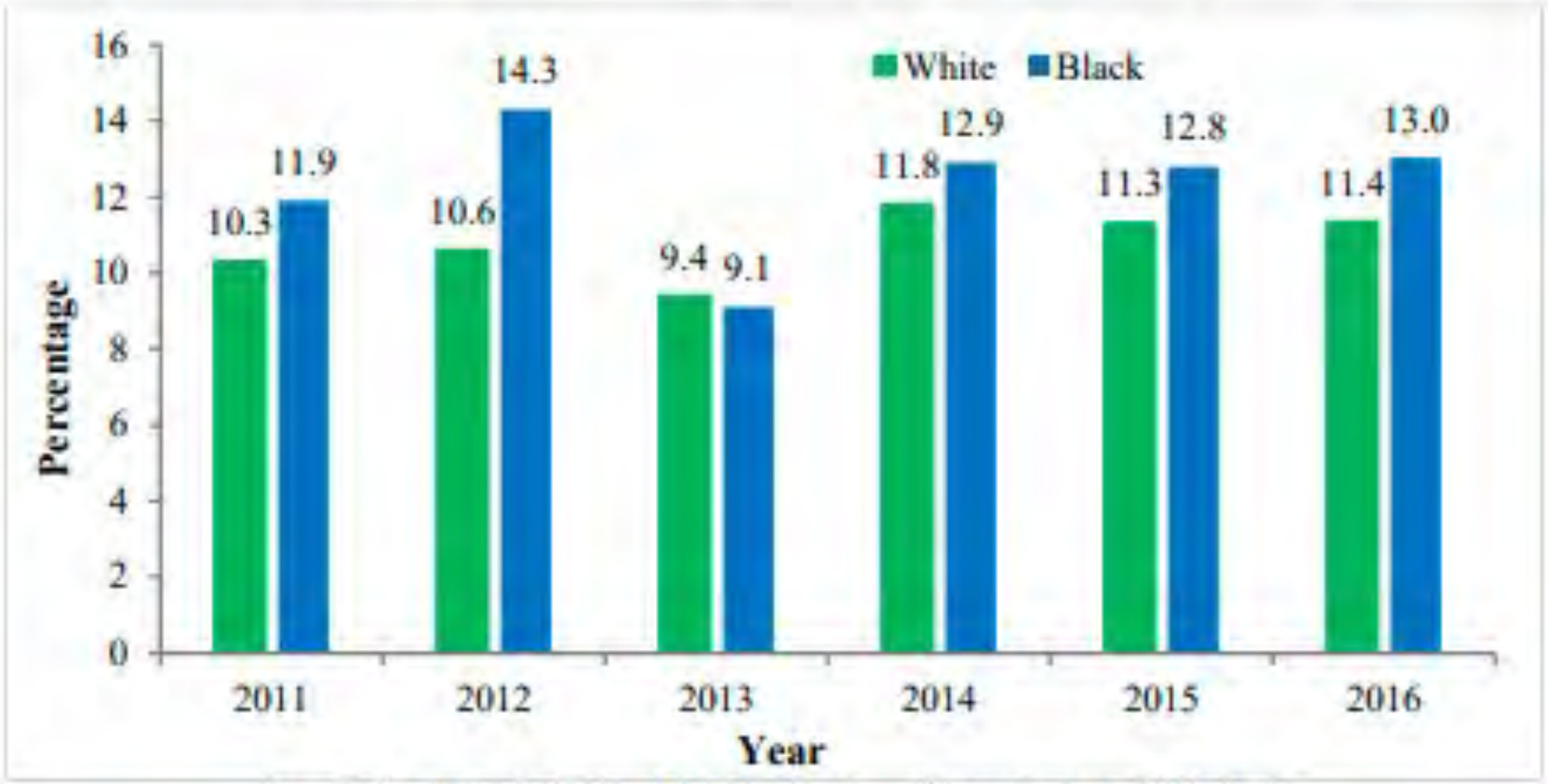
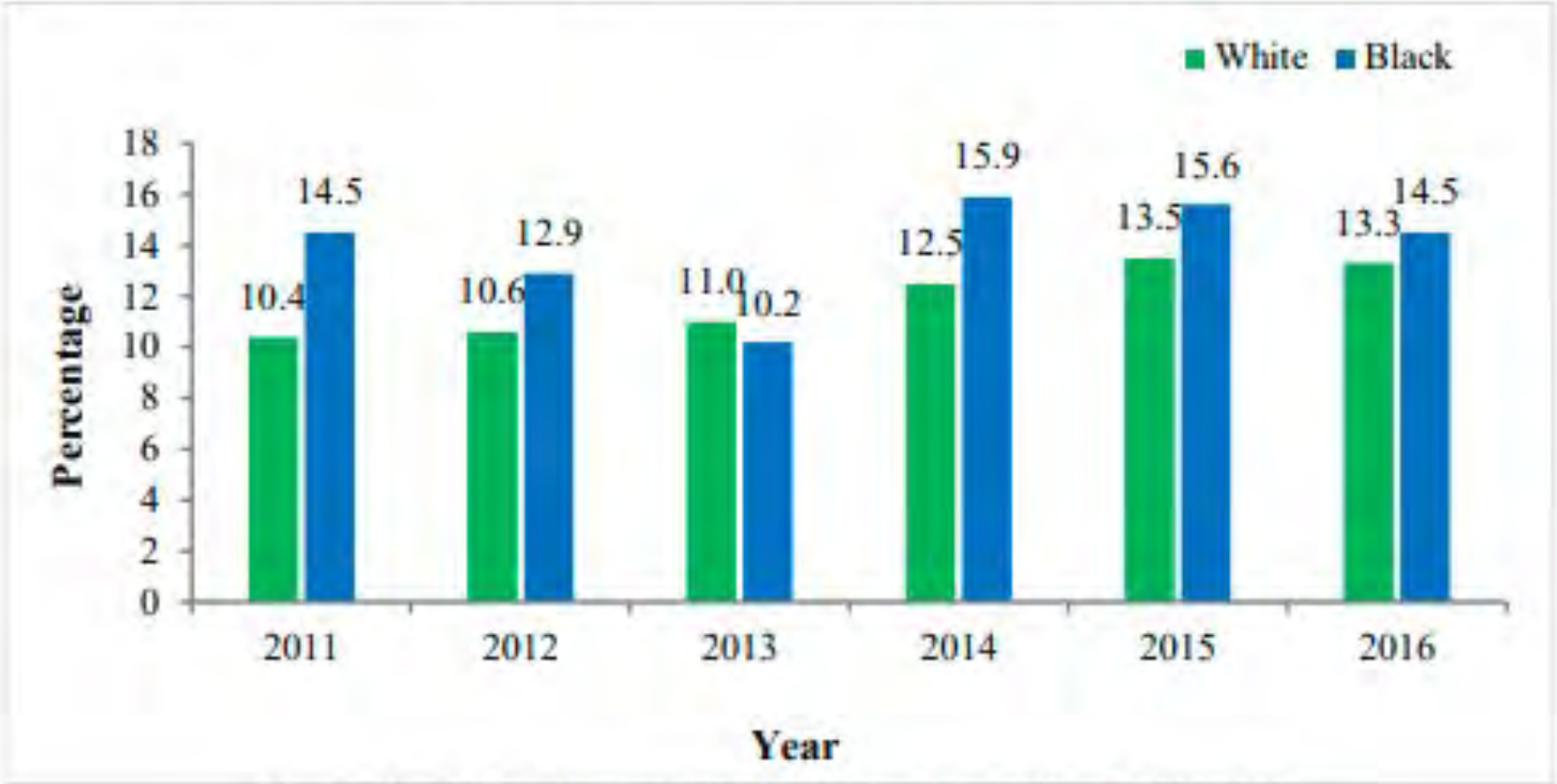


Chart 29: Adult Asthma Prevalence in Kentucky, by Race and Ethnicity, 2011-2016



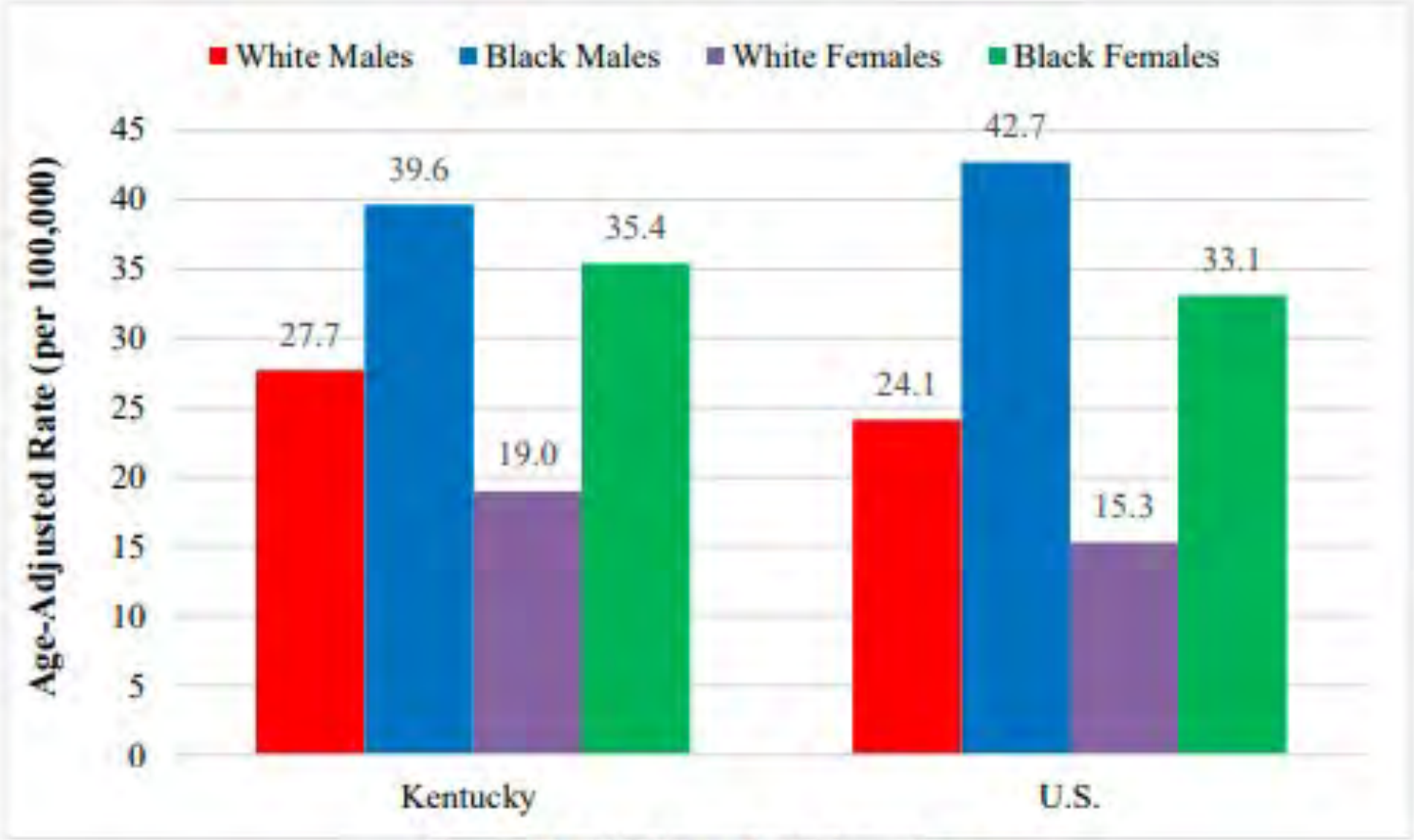
Source: Kentucky Behavioral Risk Factor Surveillance System, 2011-2016

Chart 30: Adult Diabetes Prevalence in Kentucky, by Race and Ethnicity, 2011-2016

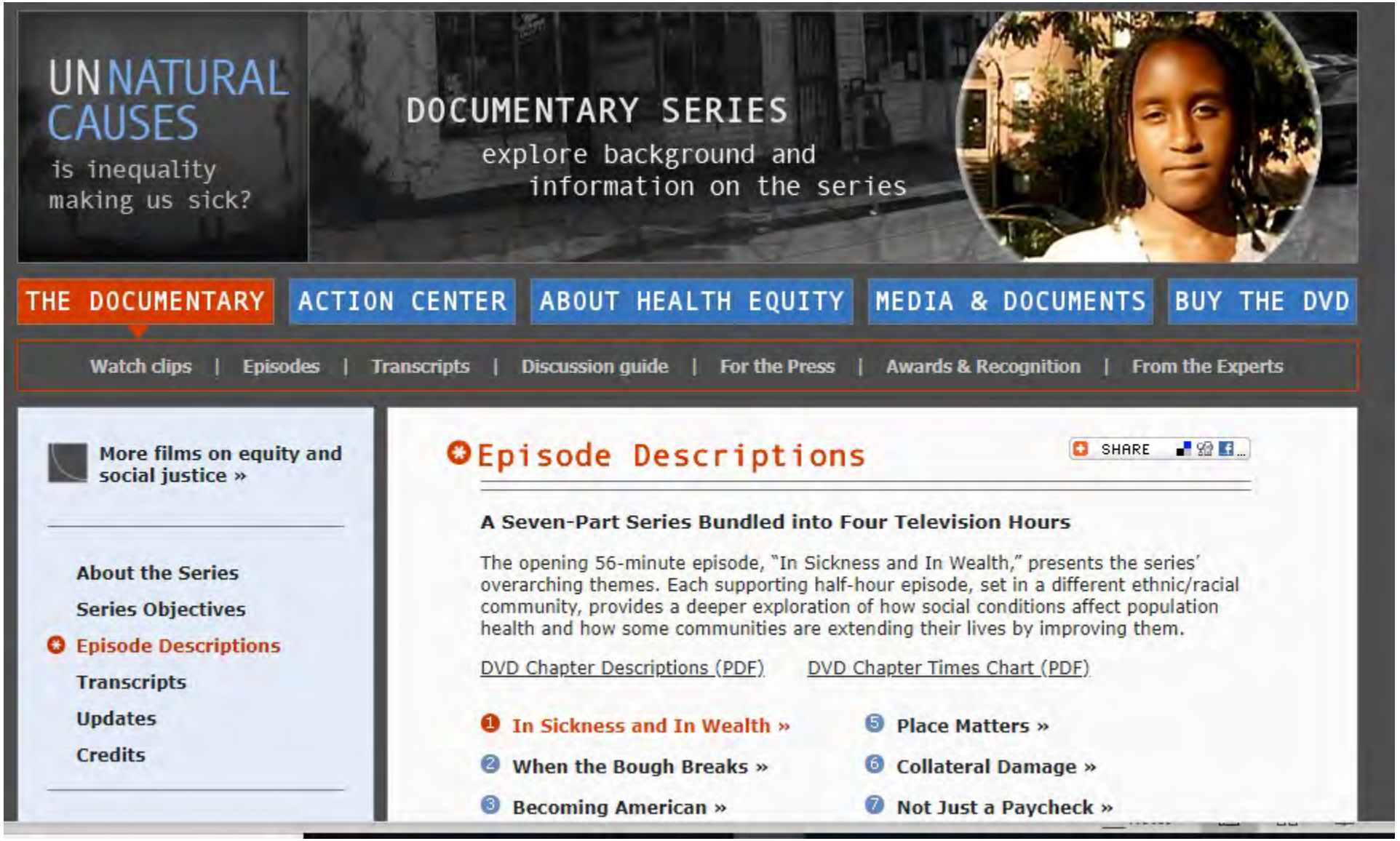


Source: Kentucky Behavioral Risk Factor Surveillance System, 2011-2016

Chart 31: Age-Adjusted Death Rates for Diabetes (All Ages) By Race and Gender for KY and U.S., 2014



Source: The 2017 Kentucky Diabetes Report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A Seven-Part Series Bundled into Four Television Hours
The opening 56-minute episode, "In Sickness and In Wealth," presents the series' overarching themes. Each supporting half-hour episode, set in a different ethnic/racial community, provides a deeper exploration of how social conditions affect population health and how some communities are extending their lives by improving them.
DVD Chapter Descriptions (PDF)
DVD Chapter Times Chart (PDF)
1 In Sickness and In Wealth »
2 When the Bough Breaks »
3 Becoming American »
5 Place Matters »
6 Collateral Damage »
7 Not Just a Paycheck »

❶ In Sickness and In Wealth

EPISODE ONE, 56 MINS

What are the connections between healthy bodies, healthy bank accounts and skin color? Our opening episode travels to Louisville, Kentucky, not to explore whether medical care cures us but to see why we get sick in the first place, and why patterns of health and illness reflect underlying patterns of class and racial inequities.

The lives of a CEO, a lab supervisor, a janitor, and an unemployed mother illustrate how class shapes opportunities for good health. Those on the top have the most access to power, resources and opportunity – and thus the best health. Those on the bottom are faced with more stressors – unpaid bills, jobs that don't pay enough, unsafe living conditions, exposure to environmental hazards, lack of control over work and schedule, worries over children – and the fewest resources available to help them cope.

Read transcript (PDF) »

Get discussion guide (PDF) »

Watch video clips »

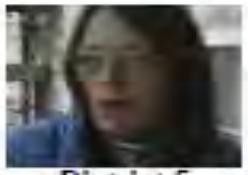
Voices and experts »

See related resources »

The net effect is a health-wealth gradient, in which every descending rung of the socioeconomic ladder corresponds to worse health. And it's not just the poorest among us who are suffering, but the middle classes too. Louisville Metro Public Health Department data maps reveal 5- and 10-year gaps in life expectancy

MAPPING HEALTH AND INEQUITY ACROSS LOUISVILLE

The lives of the four characters featured in the first episode of UNNATURAL CAUSES help us see how wealth differences affect health in Louisville's "council district" neighborhoods. Note the ten-year difference in life expectancy between the richest and the poorest districts. Even middle-class districts lag behind the wealthiest areas.



District 5
avg. life expectancy: 69.8 yrs
median income: $24,268

District 16
avg. life expectancy: 79.8 yrs
median income: $79,878

District 21
avg. life expectancy: 73.4 yrs
median income: $35,861

District 24
avg. life expectancy: 75.3 yrs
median income: $46,499

UNNATURAL CAUSES: Is Inequality Making Us Sick?
www.unnaturalcauses.org

Health Equity Report

2017 Health Equity Report: Uncovering the Root Causes of Our Health

Contact

400 E. Gray Street
Louisville, KY 40202

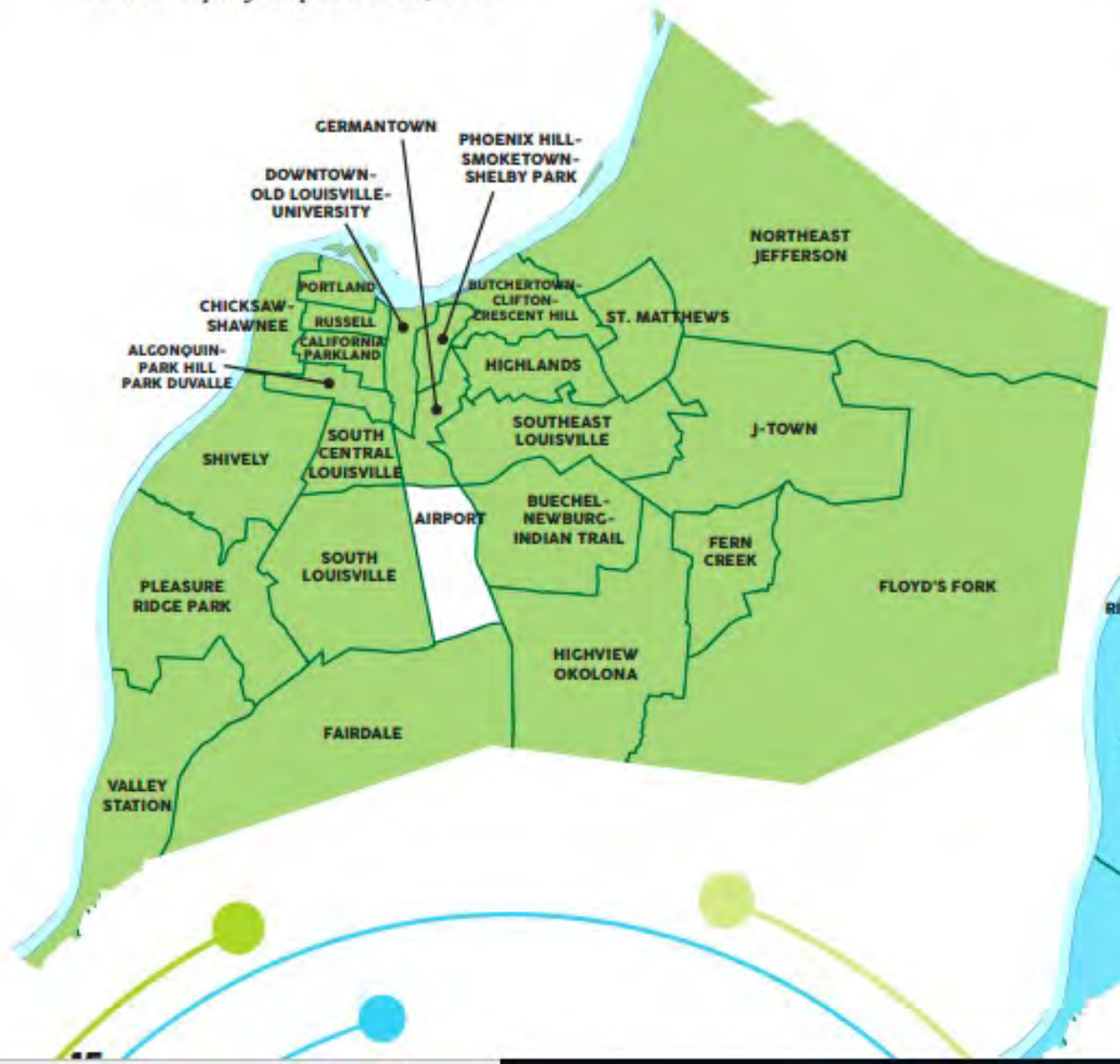
(502) 574-6616

Hours
8 a.m. - 5 p.m.

		2000		2010		2015	
	TOTAL POPULATION	693,604		741,096		763,623	
RACE/ETHNICITY	Other*	**1,658**	0.2%	**1,921**	0.3%	**1,648**	0.2%
	Multiple Races**	**7,120**	1.0%	**13,547**	1.8%	**16,226**	2.1%
	Asian	**9,748**	1.4%	**16,393**	2.2%	**20,201**	2.6%
	Hispanic or Latino	**12,370**	1.8%	**32,542**	4.4%	**37,359**	4.9%
	Black or African American	**130,743**	18.8%	**153,036**	20.6%	**161,960**	21.2%
	White	**531,965**	76.7%	**523,657**	70.7%	**526,229**	68.9%
GENDER	Female	**362,005**	52.2%	**383,397**	51.7%	**394,885**	51.7%
	Male	**331,599**	47.8%	**357,699**	48.3%	**368,738**	48.3%

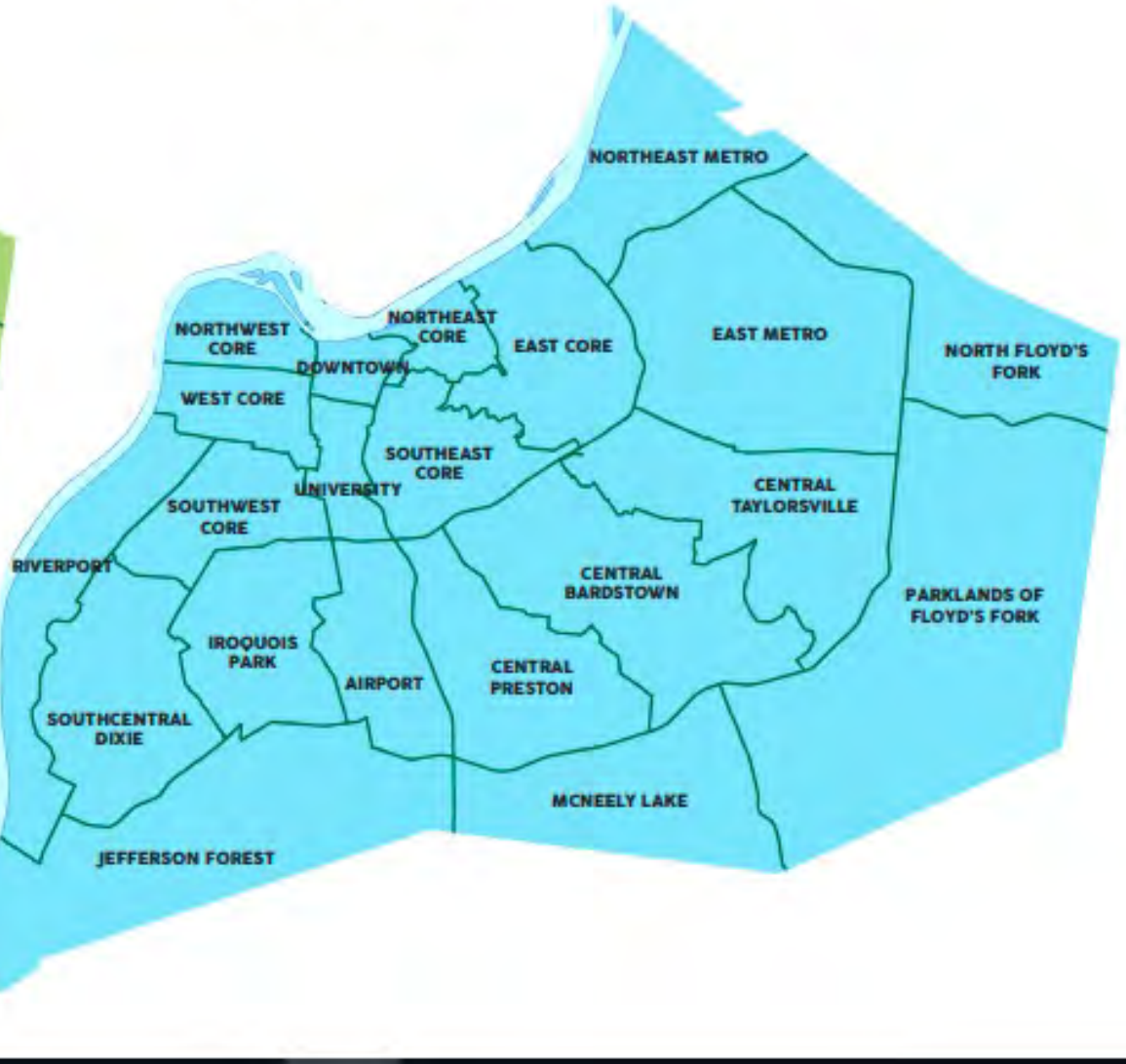
NEIGHBORHOODS

Health Equity Report 2011, 2014



COMMUNITY AREAS

Health Equity Report 2017



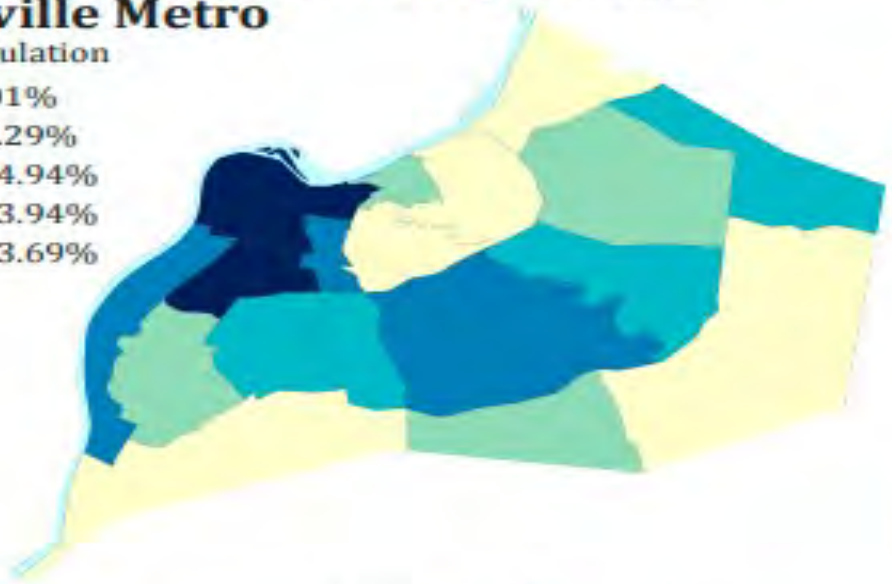
REDLINING IN LOUISVILLE NEIGHBORHOODS

- These maps assigned grades to neighborhoods to indicate their desirability for investment.
- Black, immigrant and low-income neighborhoods were often given low grades, eliminating their access to mortgage insurance or credit for decades.

Black/African American Population in Louisville Metro

Percent of Population

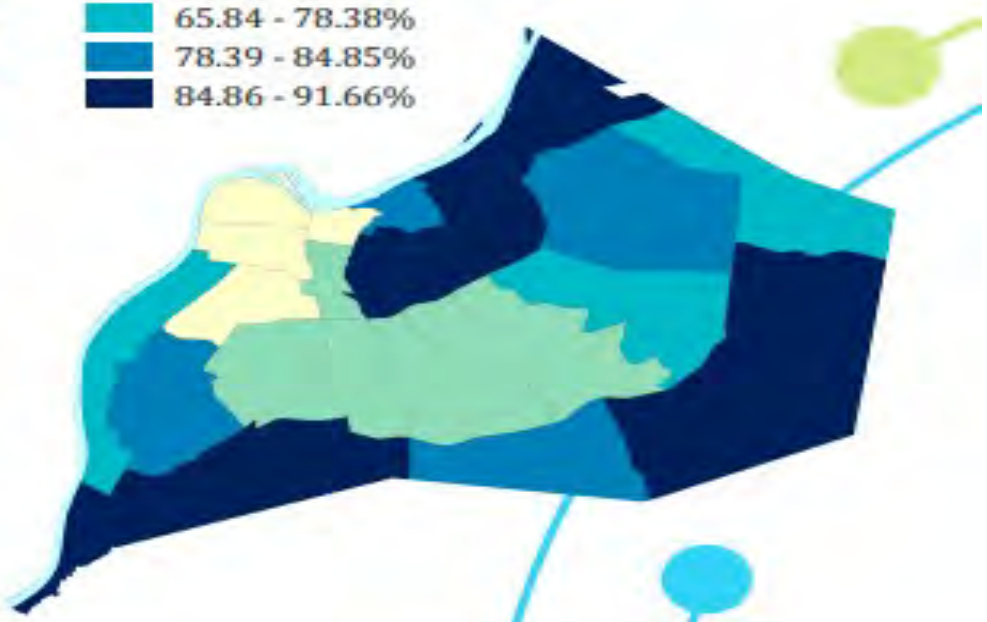
- 2.86 - 4.01%
- 4.02 - 10.29%
- 10.30 - 14.94%
- 14.95 - 23.94%
- 23.95 - 83.69%



White Population in Louisville Metro

Percent of Population

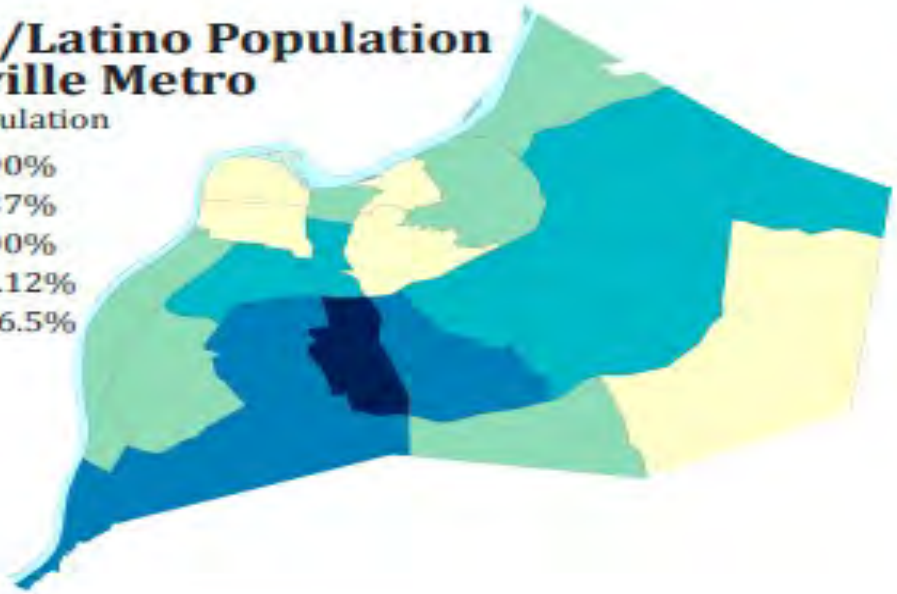
- 12.60 - 41.28%
- 41.29 - 65.83%
- 65.84 - 78.38%
- 78.39 - 84.85%
- 84.86 - 91.66%



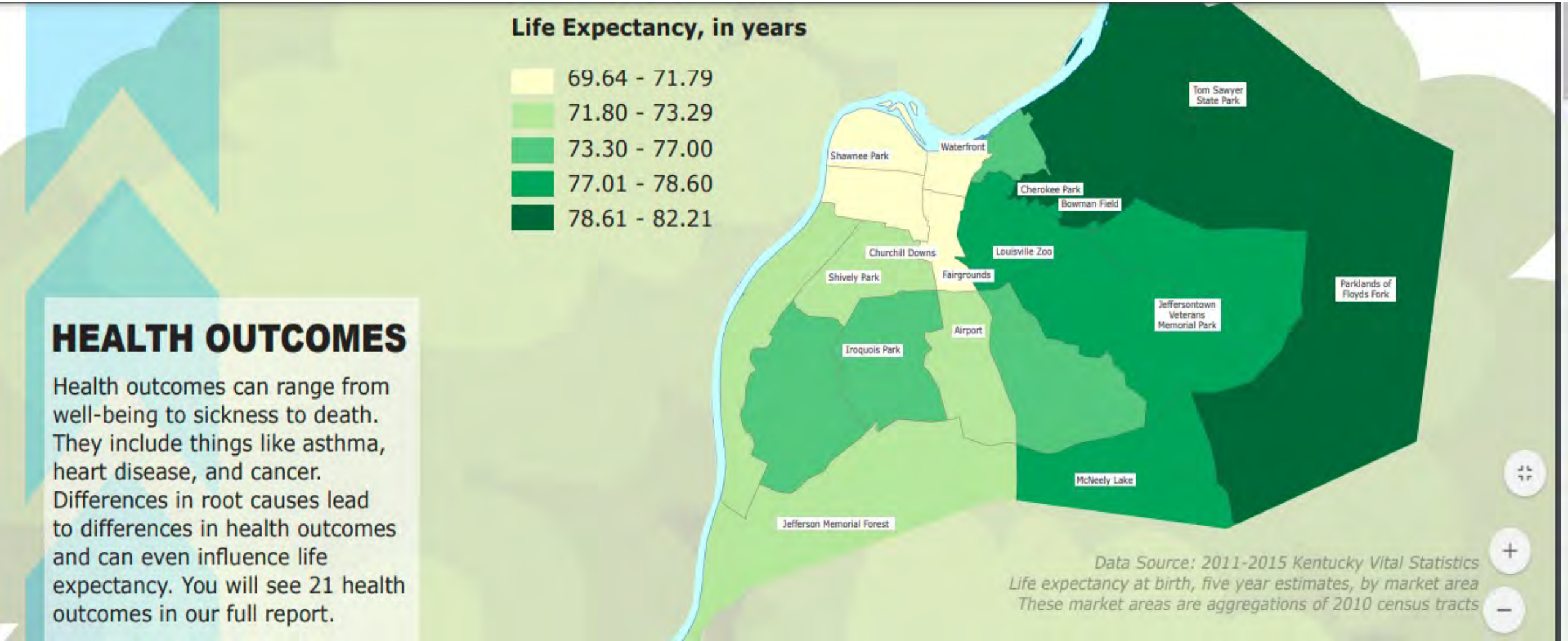
Hispanic/Latino Population in Louisville Metro

Percent of Population

- 0.55 - 1.90%
- 1.91 - 3.37%
- 3.38 - 6.00%
- 6.01 - 12.12%
- 12.13 - 26.5%



LOUISVILLE METRO DEPARTMENT OF HEALTH AND WELLNESS HEALTH EQUITY REPORT 2017

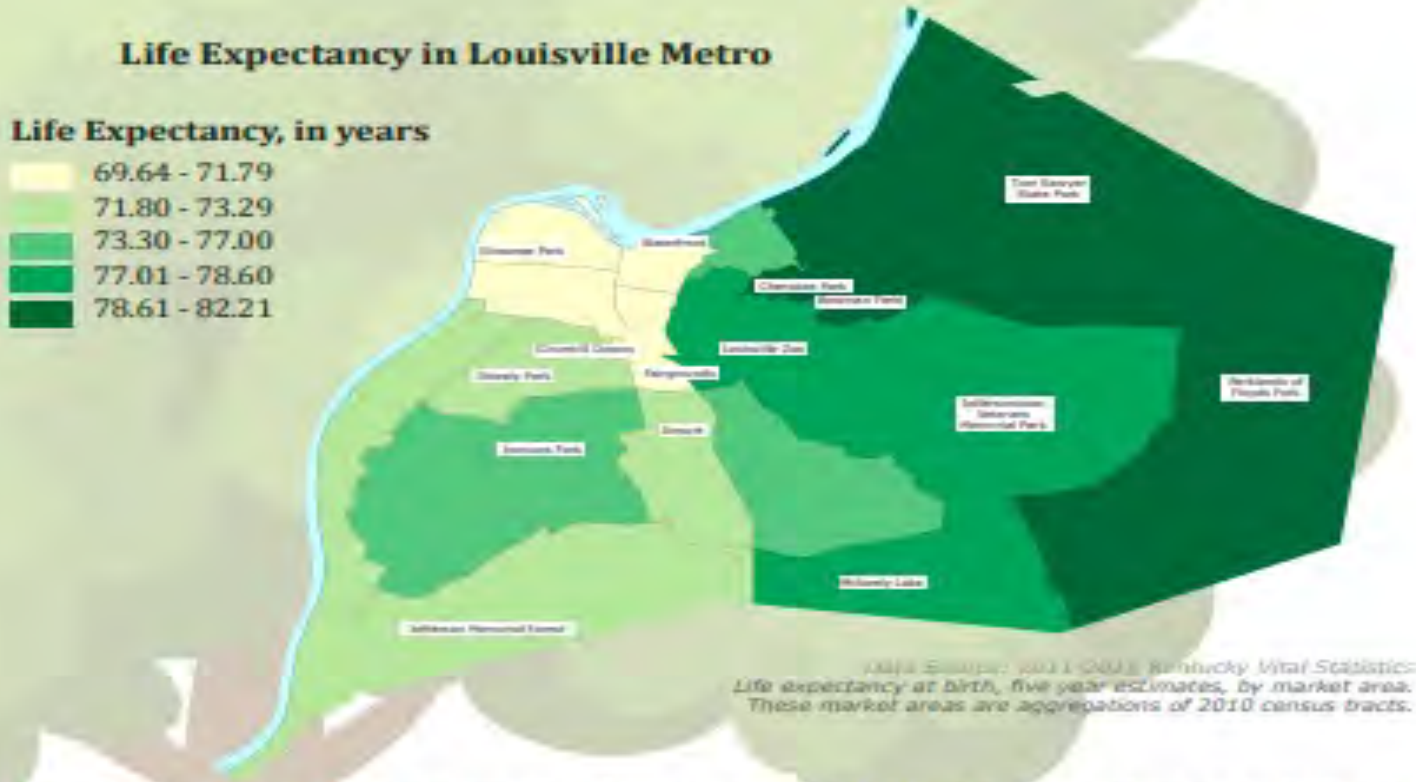


HEALTH OUTCOMES

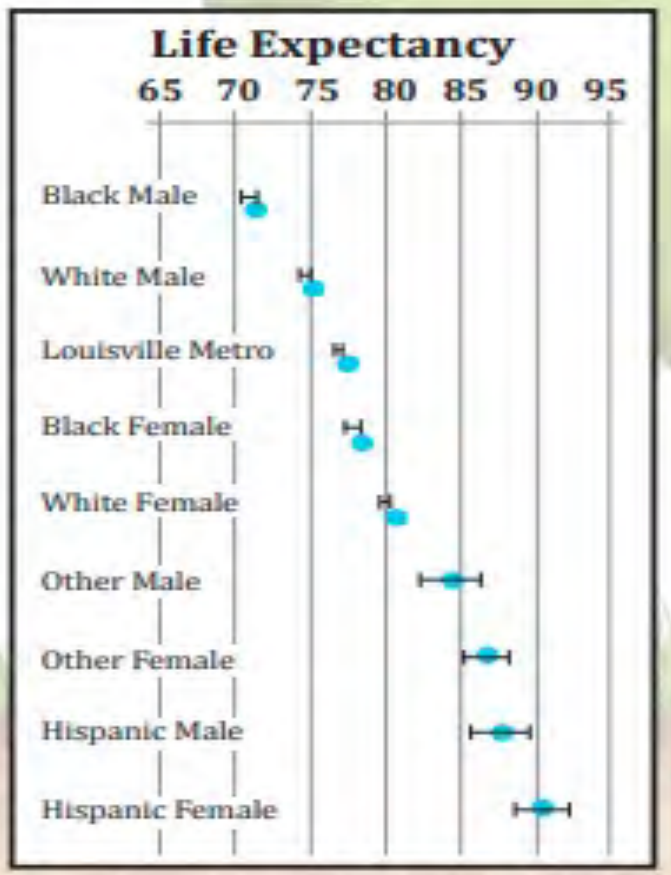
Health outcomes can range from well-being to sickness to death. They include things like asthma, heart disease, and cancer. Differences in root causes lead to differences in health outcomes and can even influence life expectancy. You will see 21 health outcomes in our full report.

Our death rates and life expectancy are determined by root causes and the systems of power that shape them. Here we explore the cumulative effect that root causes and systems of power have on health through all-cause death rates and life expectancy.

Life Expectancy in Louisville Metro



Data Source: 2011-2015 Kentucky Vital Statistics
Life expectancy at birth, five year estimates, by market area.
These market areas are aggregations of 2010 census tracts.



Data Source: 2011-2015 Kentucky Vital Statistics
Life expectancy at birth, five year estimates.
Lines represent 95% confidence intervals.

Life expectancy is the average number of years a newborn is expected to live, if the current rates at which people die stay the same. The life expectancy for Louisville Metro is 76.8, but some areas have a 12.6 year difference in life expectancy. Comparing the life expectancy for Louisville Metro from 2006-2010 and 2011-2015, there has been no significant change. Additionally, the differences in life expectancy between neighborhoods cannot be compared from the 2011 and 2014 reports to the 2017 report given the differences in geographic boundaries.

Top 3 Outcomes That Lead To Death

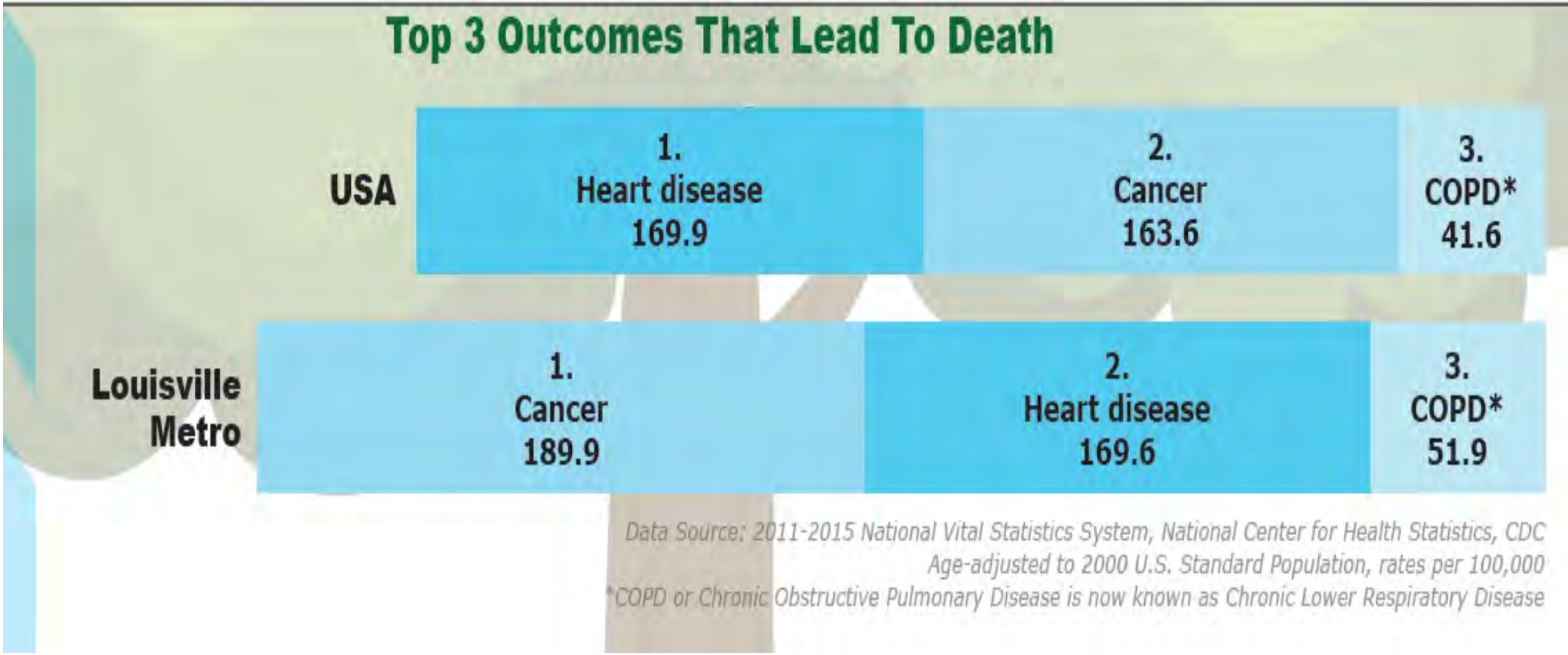
	1.	2.	3.
USA	**Heart disease 169.9**	**Cancer 163.6**	**COPD* 41.6**
Louisville Metro	**Cancer 189.9**	**Heart disease 169.6**	**COPD* 51.9**

Data Source: 2011-2015 National Vital Statistics System, National Center for Health Statistics, CDC
Age-adjusted to 2000 U.S. Standard Population, rates per 100,000.
*COPD or Chronic Obstructive Pulmonary Disease is now known as Chronic Lower Respiratory Disease.

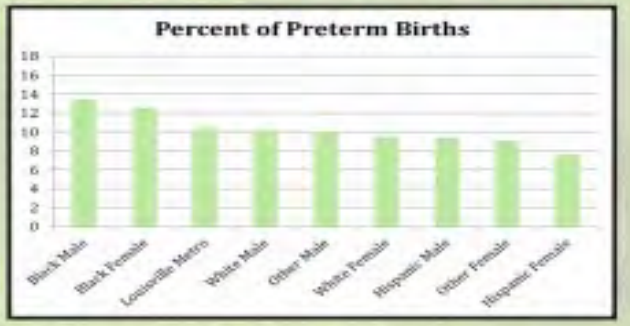
Both Louisville Metro and the USA have the same rate of heart disease deaths, but

LOUISVILLE HEALTH EQUITY REPORT 2017

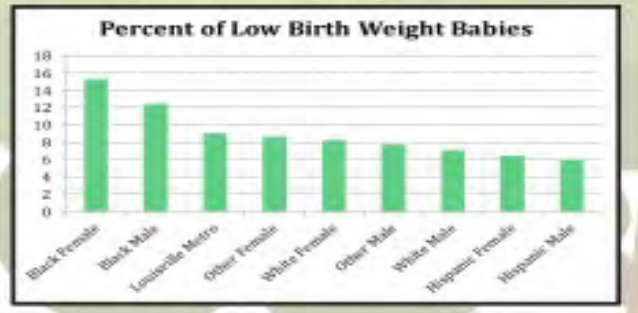
HTTPS://LOUISVILLEKY.GOV/SITES/DEFAULT/FILES/HEALTH_AND_WELLNESS/CHE/HER_-_PREVIEW.PDF



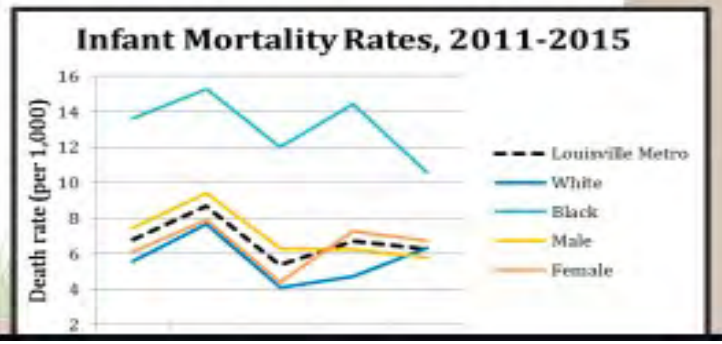
INFANT HEALTH

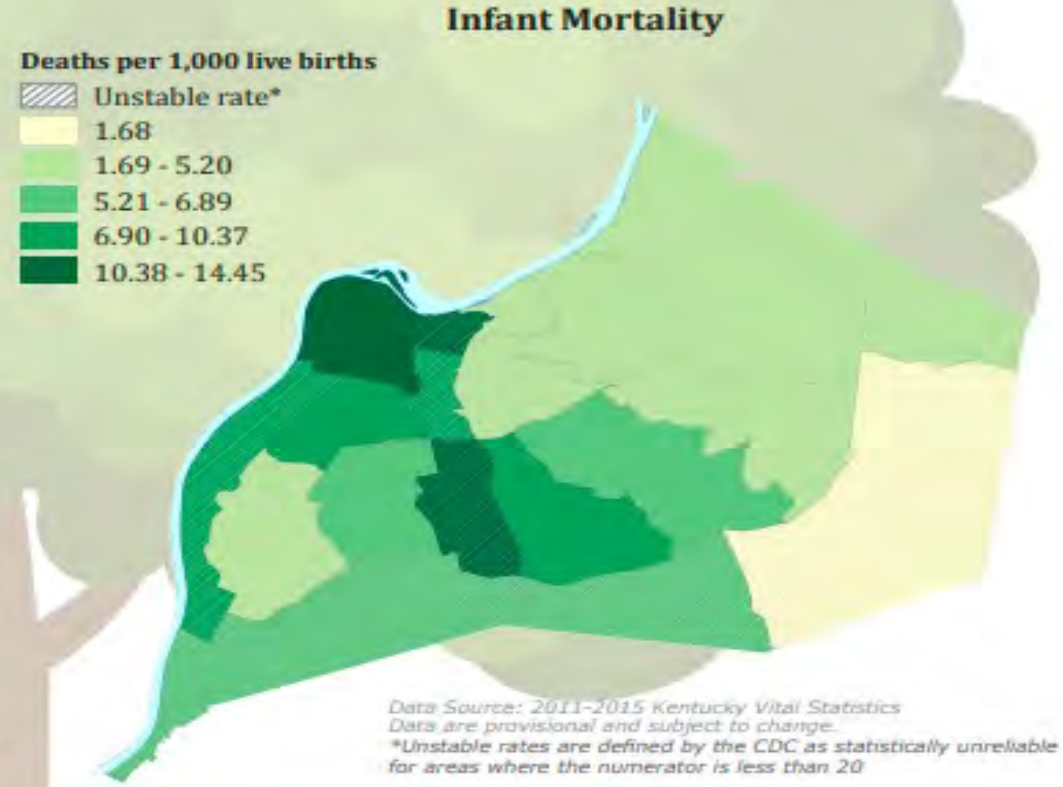


Data Source: 2011-2015 Kentucky Vital Statistics



Data Source: 2011-2015 Kentucky Vital Statistics





Data Source: 2011-2015 Kentucky Vital Statistics
Data are provisional and subject to change.
*Unstable rates are defined by the CDC as statistically unreliable for areas where the numerator is less than 20

Health Outcomes

From 2011-2015, there were 335 infant deaths in Louisville Metro, out of 49,577 total births. Far and away, preterm births, low birth weights and infant mortality disproportionately affect Black babies. This is important because infant outcomes can impact health throughout the rest of one's life. While infant mortality has slowly been falling, the death rate for Black babies from 2011-2015 was 1.95 times higher than for Louisville Metro; 2.31 times higher than

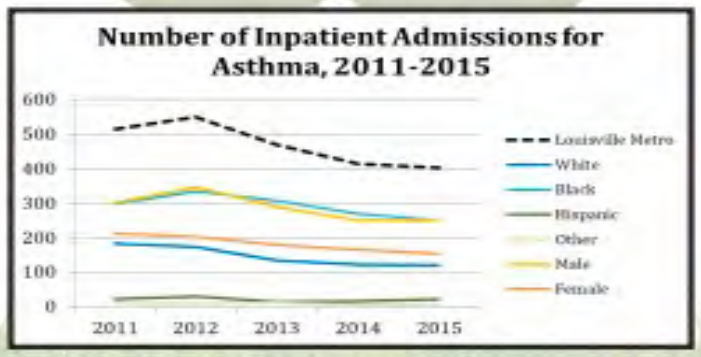
ASTHMA

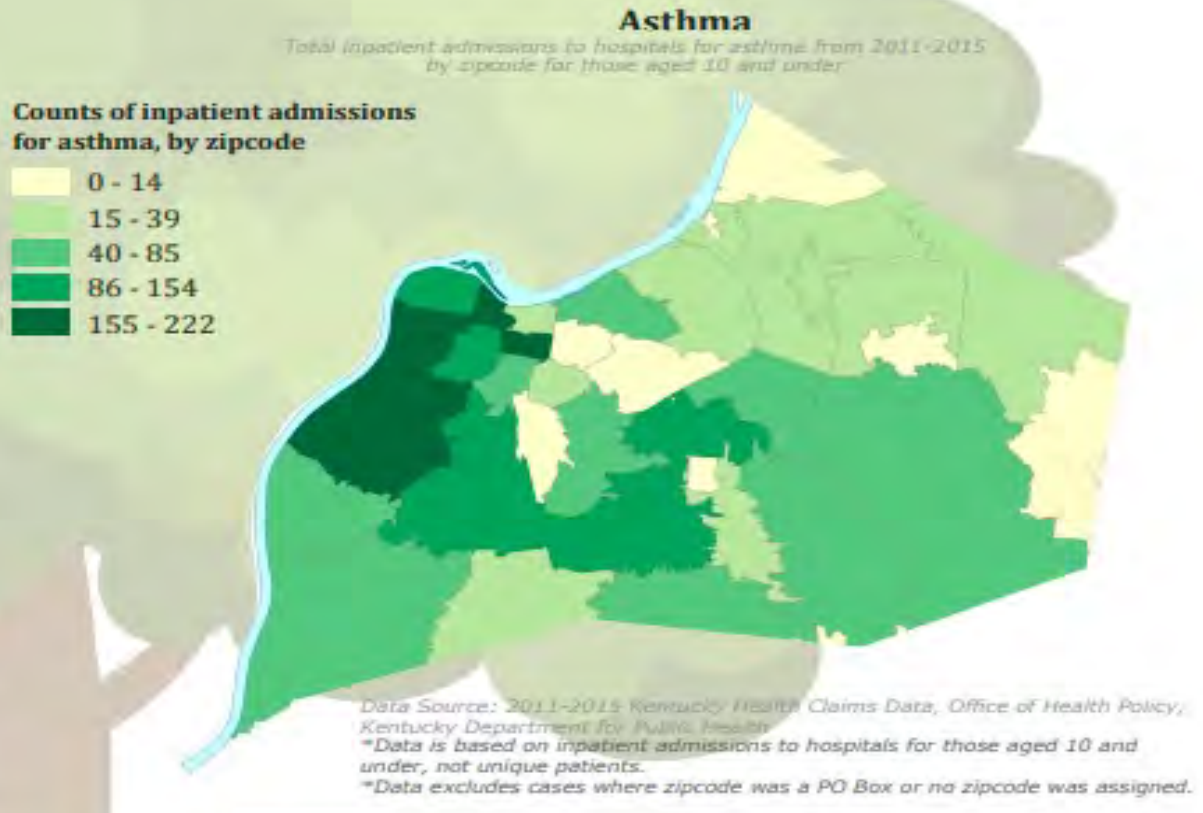
Health Outcomes

Inpatient Admissions for Asthma, 2011-2015

	Count	Percent of Admissions
Louisville Metro	**2350**	**100.00%**
Black Male	881	37.49%
Black Female	578	24.60%
White Male	452	19.23%
White Female	283	12.04%
Hispanic Male	72	3.06%
Hispanic Female	35	1.49%
Other Male	32	1.36%
Other Female	17	0.72%

Data Source: 2011-2015 Kentucky Health Claims Data, Office of Health Policy, Kentucky Department for Public Health
Data is based on inpatient admissions to hospitals for those aged 10 and under, not unique patients.



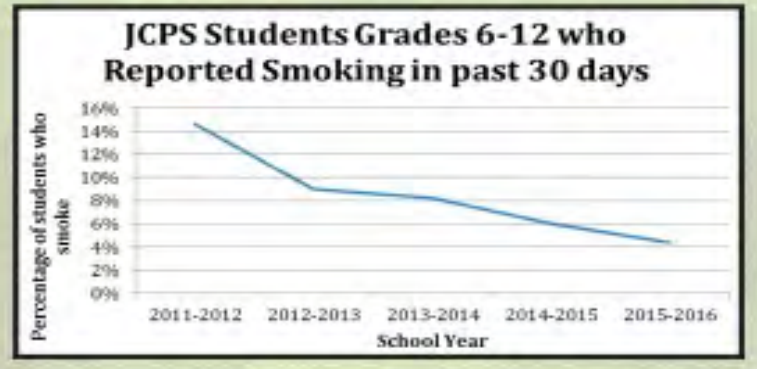


Data Source: 2011-2015 Kentucky Health Claims Data, Office of Health Policy, Kentucky Department for Public Health
**Data is based on inpatient admissions to hospitals for those aged 10 and under, not unique patients.*
**Data excludes cases where zipcode was a PO Box or no zipcode was assigned.*

Currently, there is not a county-wide system that tracks how many children have asthma. The best comparison we have is inpatient hospital admissions, which track the number of times someone is admitted to the hospital for an asthma-related problem.

These visits tend to be predominantly from Black children, although it is hard to know if there are more Black children with severe asthma problems or if a few children are repeatedly going to hospitals for acute care (or a mix of both).

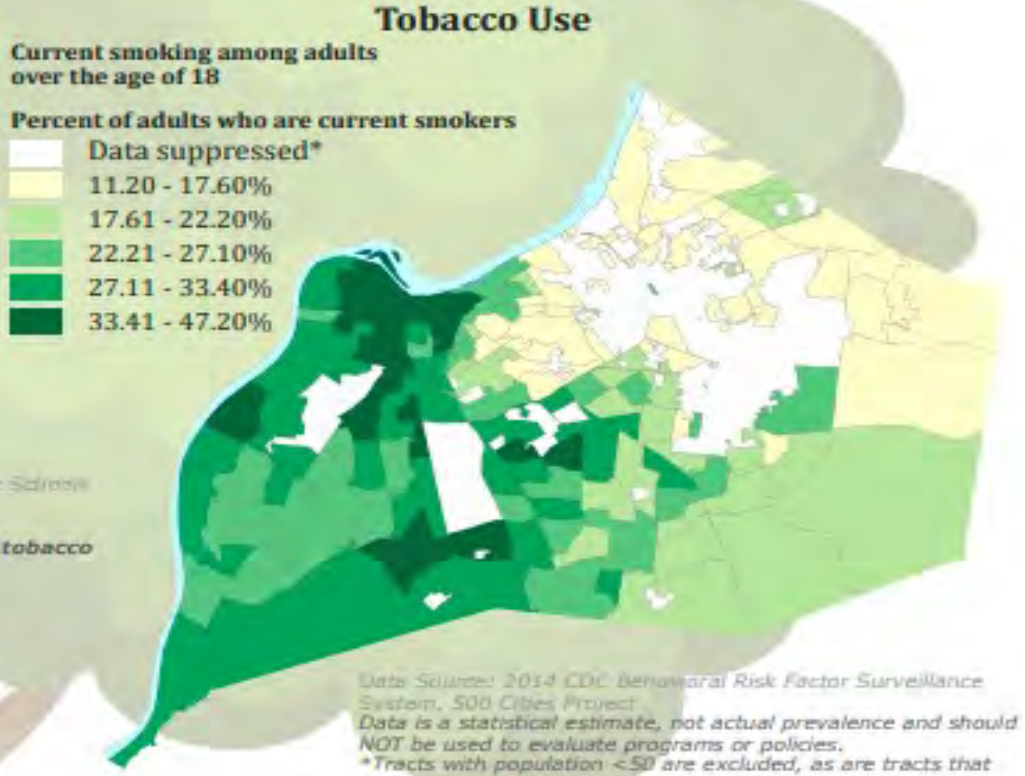
TOBACCO USE



Data Source: 2011-2016, Safe and Drug Free Schools Survey, Jefferson County Public Schools
**Note: Survey question language was changed in 2013.*
Data based on the following questions:
*2011-2012: How many occasions (if any) have you smoked **cigarettes** or used other **tobacco products** during the past 30 days?*
2013-2016: During the past 30 days did you smoke part or all of a cigarette?

In Louisville Metro, 25.5% of those over 18 years old are current smokers.

Data Source: 2014 Centers for Disease Control Behavioral Risk Factor Surveillance System, 500 Cities Project



Data Source: 2014 CDC Behavioral Risk Factor Surveillance System, 500 Cities Project
Data is a statistical estimate, not actual prevalence and should NOT be used to evaluate programs or policies.
**Tracts with population <50 are excluded, as are tracts that include small cities.*

Tobacco use is important because it can cause so many other health problems. There are a few sources of information on tobacco use in Louisville Metro. For teens, the information comes from Jefferson County Public Schools' (JCPS) annual Safe and Drug Free Schools Survey. It appears that smoking has been on the decline, however the questions on the survey changed in 2013, so it is hard to draw conclusions about tobacco use among teens. While JCPS represents a majority of school children in Louisville Metro, there are still other private and parochial schools that are not represented in this data.

Statewide, other counties participate in the Kentucky Incentives for Prevention Survey (KIP) which asks about student substance use and mental health. From these surveys, we know that statewide, e-cigarette usage is on the rise while usage of traditional tobacco products has declined, however this data is not available for JCPS.

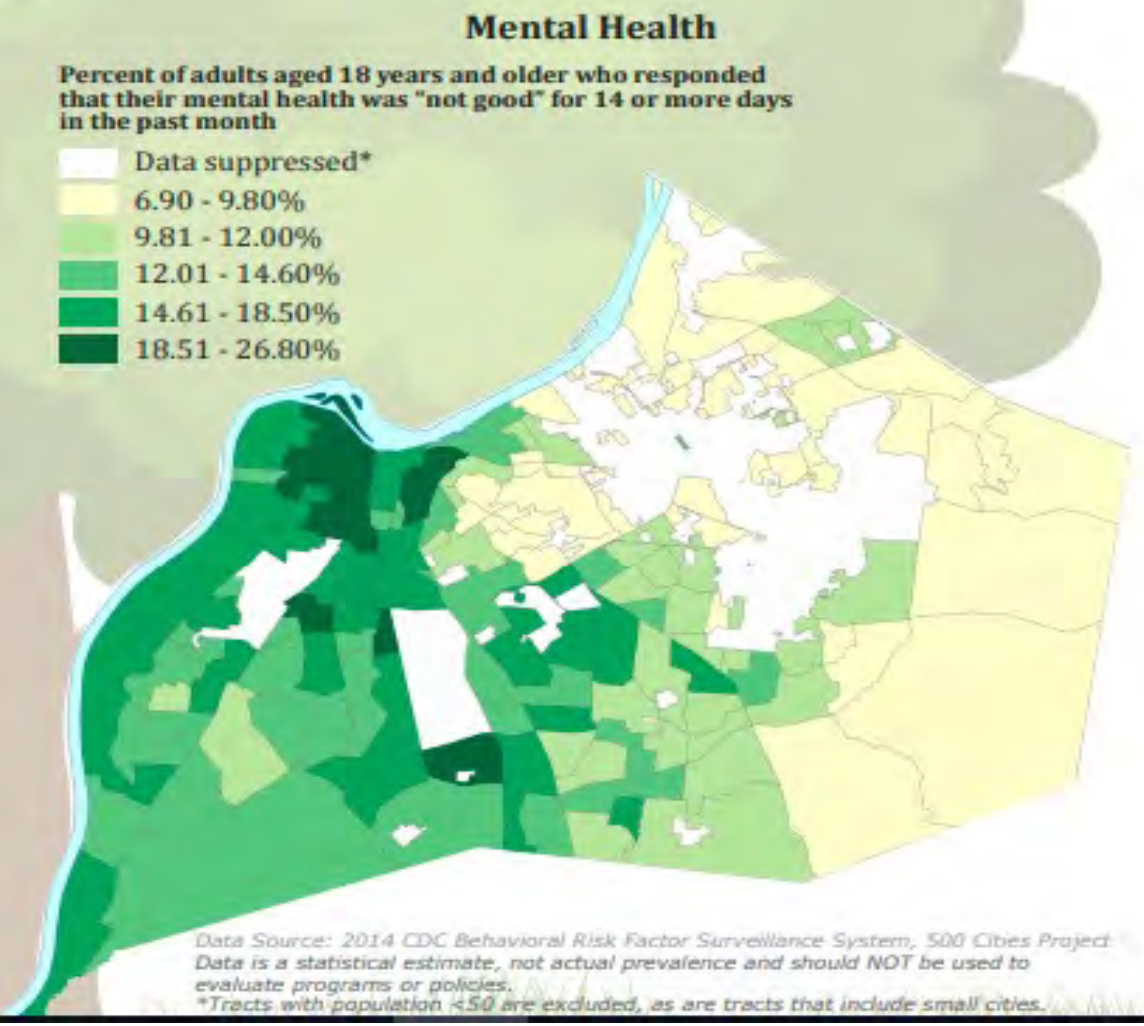
MENTAL HEALTH

Mental health data is not easy to obtain at a population health level. Our best estimates come from calculations created by the Centers for Disease Control. They use county-level data from the Behavioral Risk Factor Surveillance System (BRFSS) and use mathematical formulas to determine which census tracts have higher percentages of adults with poor mental health. This map shows estimates of where a large percent of the population of those over 18 experience poor mental health for more than half of the month.

Mental health data can be difficult to collect because not everyone who is experiencing poor mental health will go to the doctor. There is still a lot of stigma that keeps people from seeking the help they need.

In Louisville Metro, 13.3% of those over 18 years old have had 14 or more unhealthy days in one month.

Data Source: 2014 Centers for Disease Control Behavioral Risk Factor Surveillance System, 500 Cities Project



ealth Outcomes

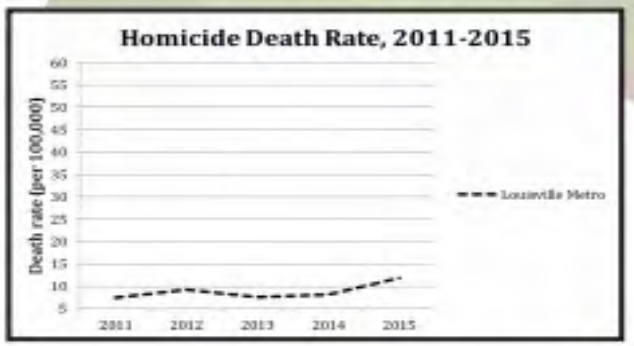
HOMICIDE

Health Outcomes

Homicide Deaths Total 2011 - 2015

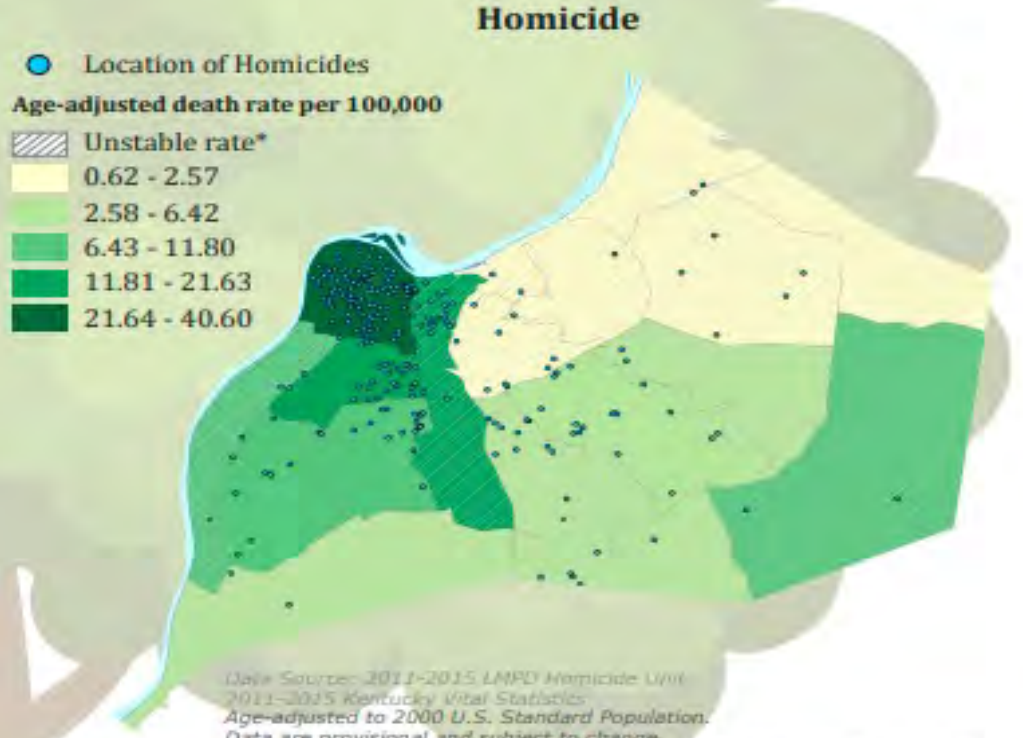
	Count	Age-adjusted rate (per 100,000)
Black Male	187	49.12
Other Male	6	9.71*
Hispanic Male	9	9.10*
Louisville Metro	**333**	**8.90**
Black Female	29	6.43
White Male	73	4.72
Other Female	**	3.33*
White Female	27	2.01
Hispanic Female	0	0*

Data Source: 2011-2015 Kentucky Vital Statistics
Age-adjusted to 2000 U.S. Standard Population.
Note: Vital Stats gathers data differently than the LMPD homicide unit and numbers may not be comparable.
**The CDC defines rates as statistically unreliable when the numerator is less than 20.*
***Data suppressed (counts less than 5).*
Racial categories are non-Hispanic.



Data Source: 2011-2015 Kentucky Vital Statistics
Age-adjusted to 2000 U.S. Standard Population

Top 3 methods:
1. Guns 78.68%
2. Assault, unspecified means 9.01%



Data Source: 2011-2015 LMPD Homicide Unit
2011-2015 Kentucky Vital Statistics
Age-adjusted to 2000 U.S. Standard Population.
Data are provisional and subject to change.
**Unstable rates are defined by the CDC as statistically unreliable for areas where the numerator is less than 20.*
Rates based on residence at time of murder; Points based on location of death.

While homicide has generally been declining for decades, in recent years, rates have increased. Far and away, the group that is most affected is Black men, whose death rates are 5.5 times that of the Louisville Metro rate for homicide. Additionally, this violence is geographically concentrated in the northwestern areas of the county, meaning that certain communities are disproportionately experiencing the chronic stress of community violence. However, the downtown and south areas also have clusters of homicides. Homicides are also disproportionately the result of gun violence. What is not well documented is the proportion of these homicides that are linked in some way to intimate partner violence.

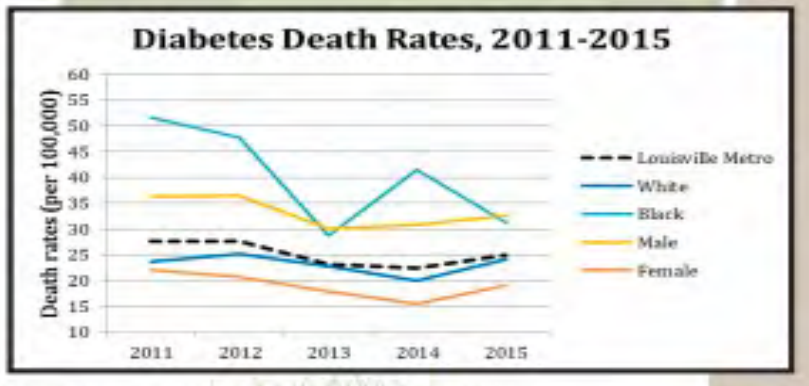
The median age of those who died from homicide in Louisville Metro from 2011-2015 was 30.

DIABETES

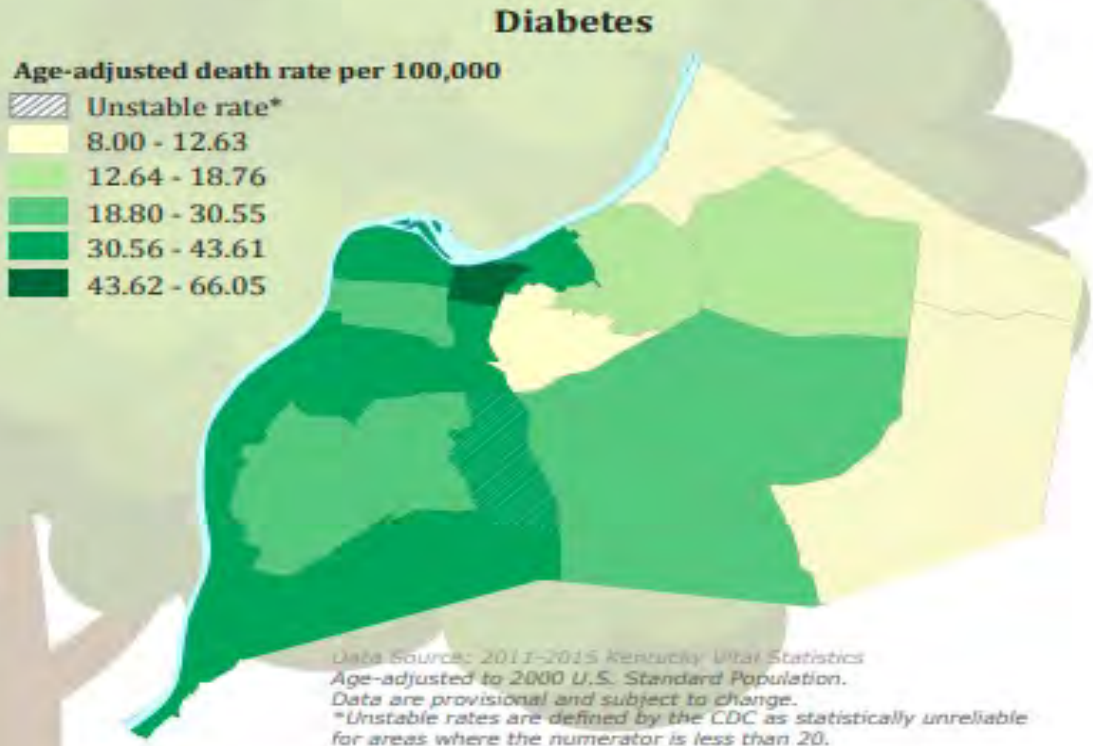
Diabetes Deaths
Total 2011 - 2015

	Count	Age-adjusted rate (per 100,000)
Black Male	131	48.21
Black Female	137	34.75
White Male	478	32.04
Louisville Metro	**1096**	**25.16**
White Female	338	16.33
Hispanic Female	**	15.00*
Other Male	**	10.82*
Hispanic Male	**	8.19*
Other Female	**	5.22*

Data Source: 2011-2015 Kentucky Vital Statistics
Age-adjusted to the 2000 U.S. Standard Population.
**The CDC defines rates as statistically unreliable when the numerator is less than 20.*
***Data suppressed (counts less than 5).*
Racial categories are non-Hispanic.



Data Source: 2011-2015 Kentucky Vital Statistics
Age-adjusted to the 2000 U.S. Standard Population.



Data Source: 2011-2015 Kentucky Vital Statistics
Age-adjusted to 2000 U.S. Standard Population.
Data are provisional and subject to change.
**Unstable rates are defined by the CDC as statistically unreliable for areas where the numerator is less than 20.*

This data shows deaths that are directly attributable to diabetes. These represent the most severe cases, those who die from complications or who do not have the resources to properly manage their disease. It does not reflect people who die from other causes but also have diabetes. Geographically, the downtown area has the highest rates of death due to diabetes. Black men are dying at rates almost two times higher than the rate for Louisville Metro. Men generally had rates that were 1.75 times higher than women.

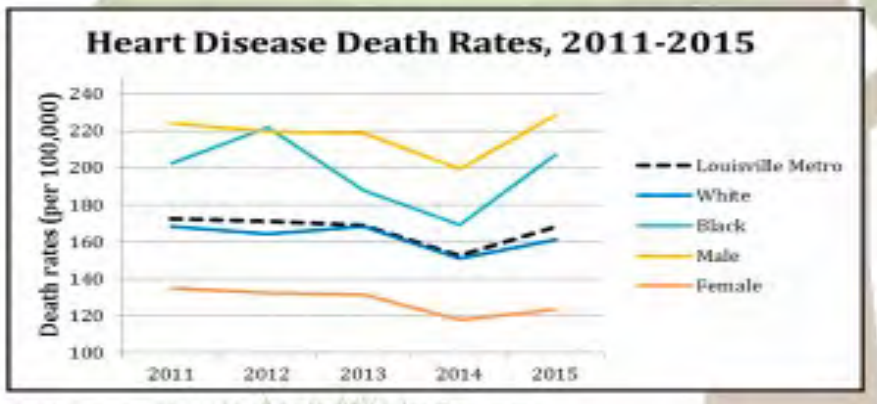
The median age of those who died from diabetes in Louisville Metro from 2011-2015 was 70.

HEART DISEASE

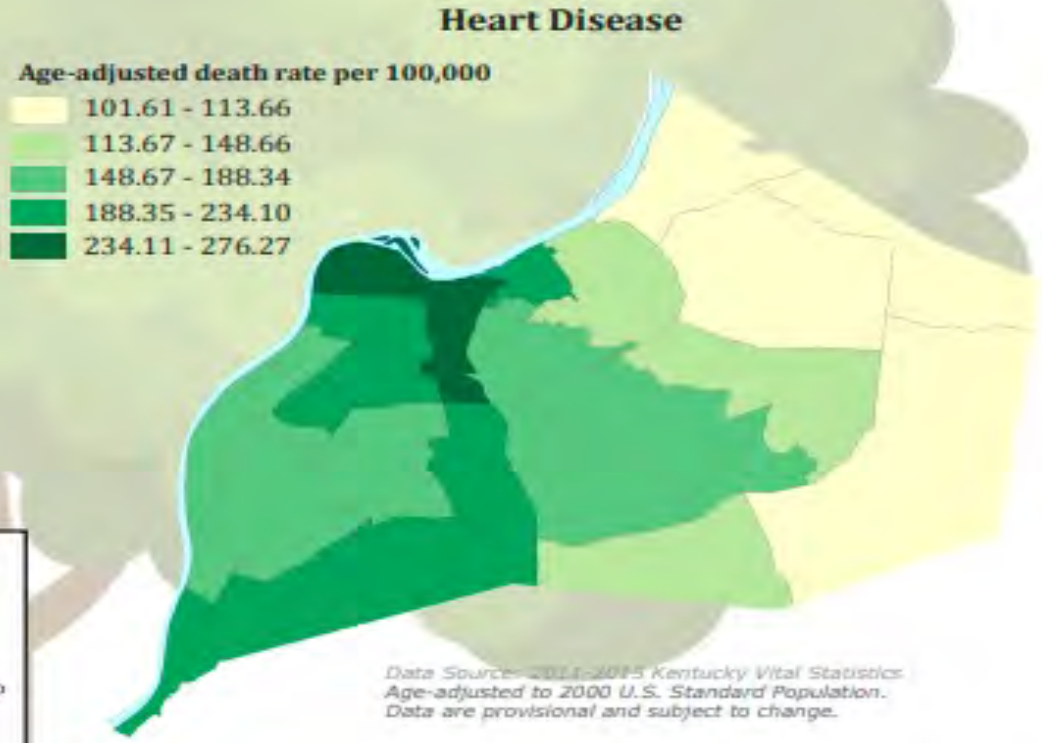
Heart Disease Deaths
Total 2011 - 2015

	Count	Age-adjusted rate (per 100,000)
Black Male	699	257.84
White Male	3,129	214.16
Louisville Metro	**7,400**	**166.43**
Black Female	605	154.98
White Female	2,874	123.61
Other Male	31	122.25
Hispanic Male	27	80.43
Other Female	18	69.92*
Hispanic Female	17	53.99*

Data Source: 2011-2015 Kentucky Vital Statistics
Age-adjusted to the 2000 U.S. Standard Population.
**The CDC defines rates as statistically unreliable when the numerator is less than 20.*
Racial categories are non-Hispanic.



Data Source: 2011-2015 Kentucky Vital Statistics
Age-adjusted to the 2000 U.S. Standard Population.



Data Source: 2011-2015 Kentucky Vital Statistics
Age-adjusted to 2000 U.S. Standard Population.
Data are provisional and subject to change.

Heart disease is the second leading cause of death in Louisville Metro. Men die from heart disease at higher rates than women, and Black people die at higher rates than their White counterparts. Heart disease death rates are higher in the downtown core, Old Louisville and the Northwest core.

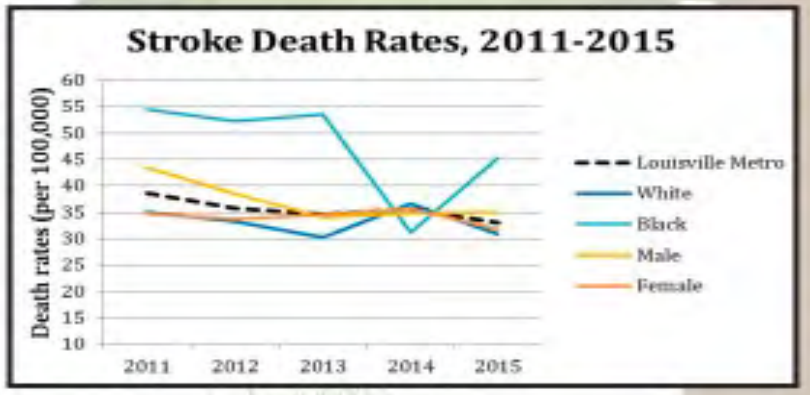
The median age of those who died from heart disease in Louisville Metro from 2011-2015 was 79.

STROKE

Stroke Deaths
Total 2011 - 2015

	Count	Age-adjusted rate (per 100,000)
Black Male	130	52.19
Black Female	171	43.67
Other Female	12	42.46*
Louisville Metro	**1560**	**35.56**
White Male	488	34.53
Other Male	9	32.61*
White Female	740	31.96
Hispanic Male	5	22.95*
Hispanic Female	5	16.74*

Data Source: 2011-2015 Kentucky Vital Statistics
Age-adjusted to the 2000 U.S. Standard Population.
**The CDC defines rates as statistically unreliable when the numerator is less than 20.*
Racial categories are non-Hispanic.



Data Source: 2011-2015 Kentucky Vital Statistics
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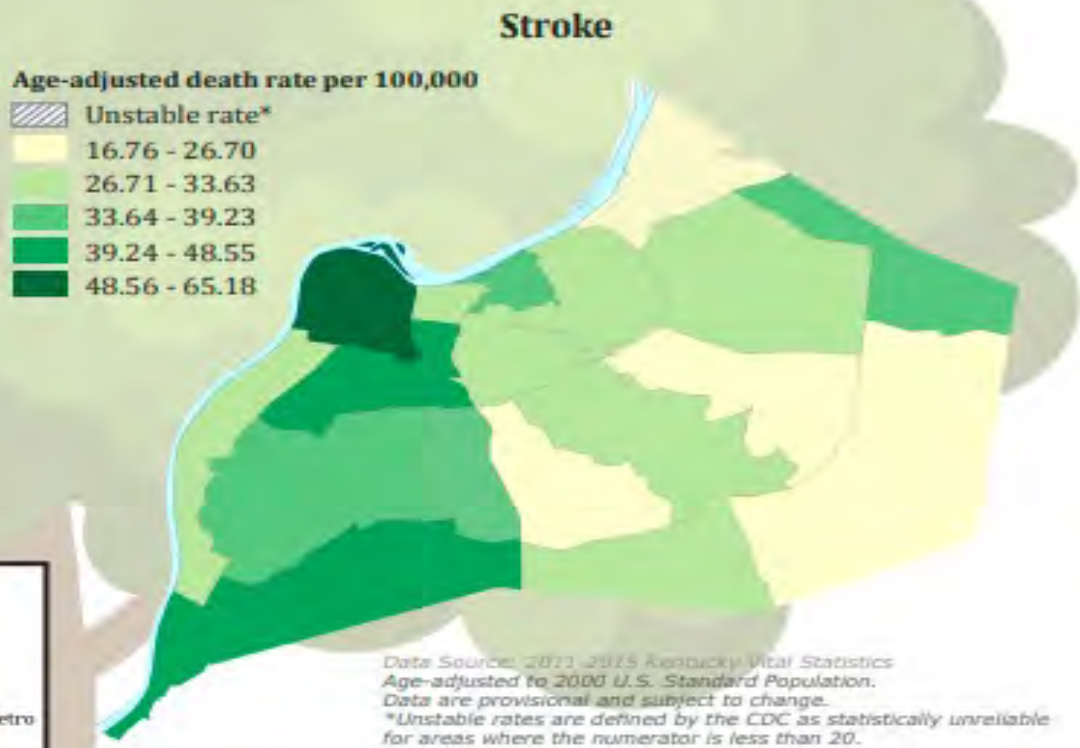


Data Source: 2011-2015 Kentucky Vital Statistics
Age-adjusted to 2000 U.S. Standard Population.
Data are provisional and subject to change.
**Unstable rates are defined by the CDC as statistically unreliable for areas where the numerator is less than 20.*

The highest rates of stroke death are in the northwest corner of Louisville. Both Black men and women are dying at higher rates from stroke than the rate for Louisville Metro. Although stroke death rates have generally remained consistent across time, there have been some changes in the Black population.

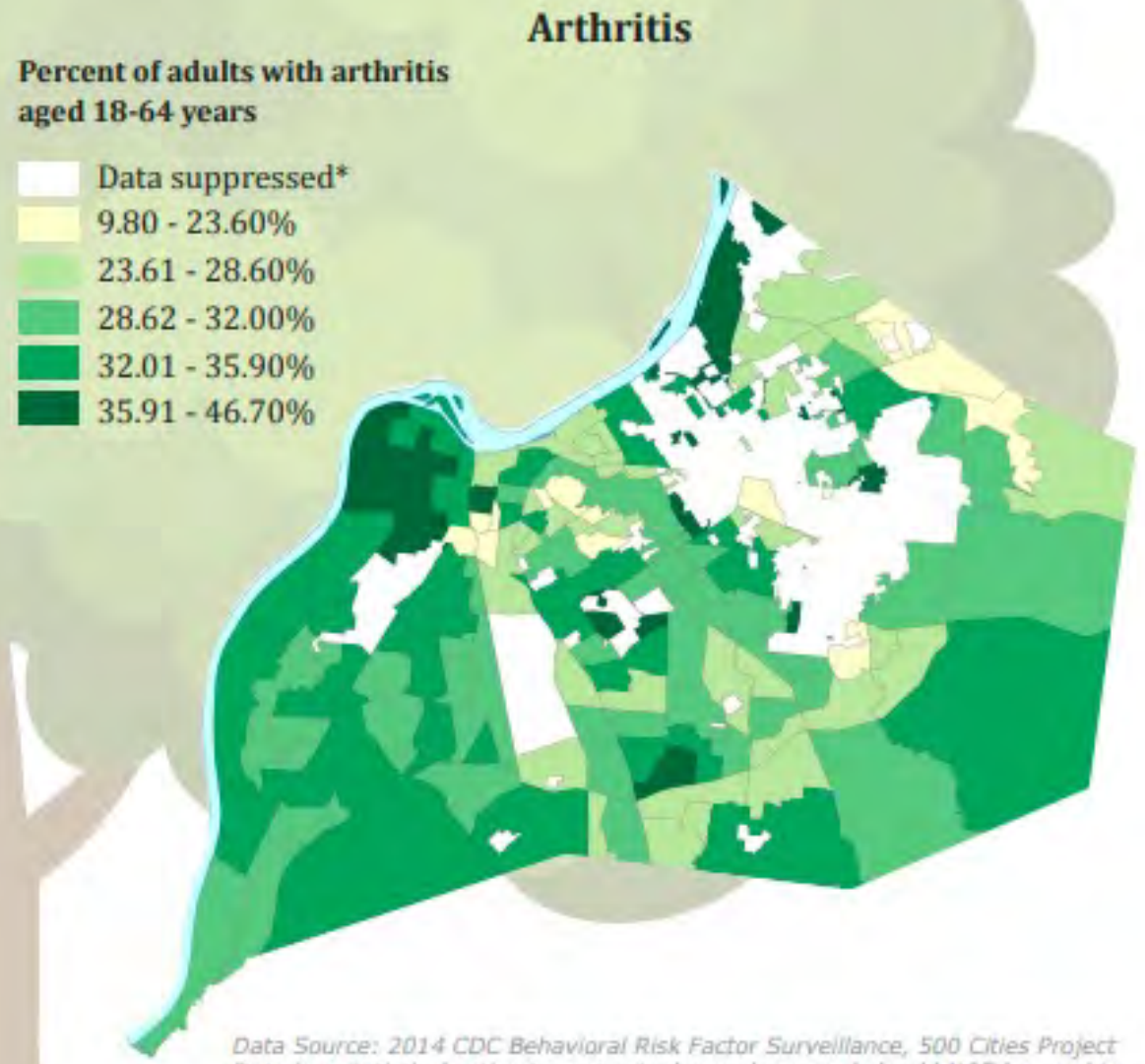
The median age of those who died from stroke in Louisville Metro from 2011-2015 was 82.

ARTHRITIS

In Louisville Metro, 30.8% of those over 18 years old reported having arthritis.

Data Source: 2014 Centers for Disease Control Behavioral Risk Factor Surveillance System, 500 Cities Project

Our best estimates on arthritis come from calculations created by the Centers for Disease Control. They use county-level data from the Behavioral Risk Factor Surveillance System (BRFSS) and use formulas to try to determine which census tracts have higher percentages of adults with arthritis. This map shows estimates of where a large percent of the population of those over 18 experience arthritis.



Data Source: 2014 CDC Behavioral Risk Factor Surveillance, 500 Cities Project
Data is a statistical estimate, not actual prevalence and should NOT be used to evaluate programs or policies.
**Tracts with population <50 are excluded as are tracts that include small cities.*

CANCER

Cancer Deaths Total 2011 - 2015

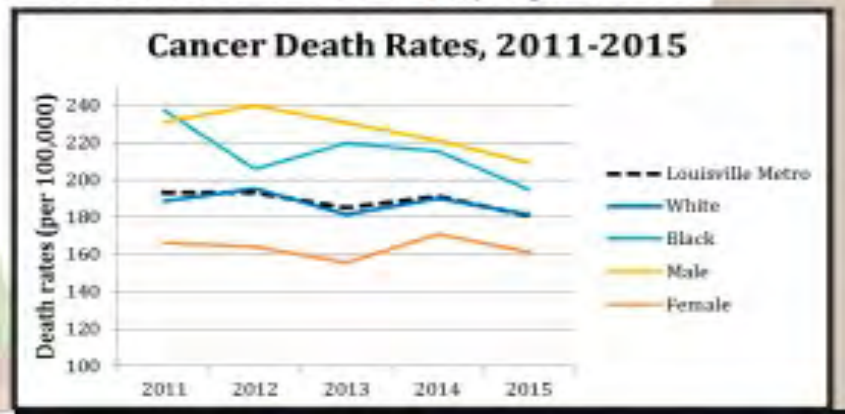
	Count	Age-adjusted rate (per 100,000)
Black Male	701	263.08
White Male	3,366	225.01
Louisville Metro	**8,240**	**188.47**
Black Female	733	184.89
White Female	3,308	162.04
Hispanic Male	38	113.89
Other Female	36	106.82
Hispanic Female	33	93.60
Other Male	25	85.08

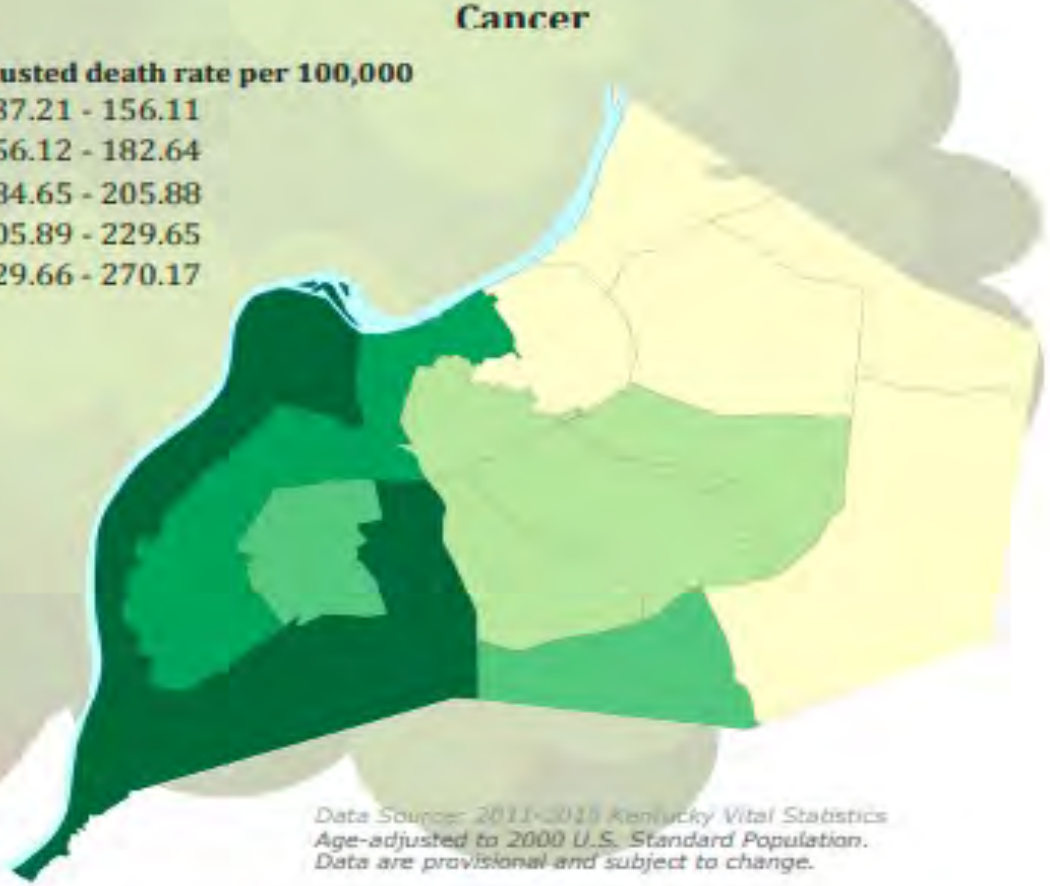
Data Source: 2011-2015 Kentucky Vital Statistics
Age-adjusted to the 2000 U.S. Standard Population.
Racial categories are non-Hispanic.

Cancer Incidence & Death Rates 2011 - 2014

Cancer Type	Louisville Metro Age-adjusted Incidence Rate	Louisville Metro Age-adjusted Death Rate
All Cancers	593.3	191.8
Lung and bronchus	89.0	59.5
Breast (female only)	172.2	23.2
Prostate	135.9	20.1
Colorectal	54.6	15.5
Pancreas	14.3	11.9
Leukemia	17.9	8.0
Liver and intrahepatic bile duct	10.6	7.9
Non-Hodgkin lymphoma	21.7	6.7
Urinary bladder	22.0	4.3
Cervical	8.6	3.2
Melanoma of the skin	38.7	3.1
Oral cavity and pharynx	14.7	2.7

Data source: Kentucky Cancer Registry http://www.cancer-rates.info/ky
Rates are age-adjusted to the 2000 U.S. Standard Population per 100,000 for the years 2011-2014.
Incidence describes the number of newly diagnosed cases.





Data Source: 2011-2015 Kentucky Vital Statistics
Age-adjusted to 2000 U.S. Standard Population.
Data are provisional and subject to change.

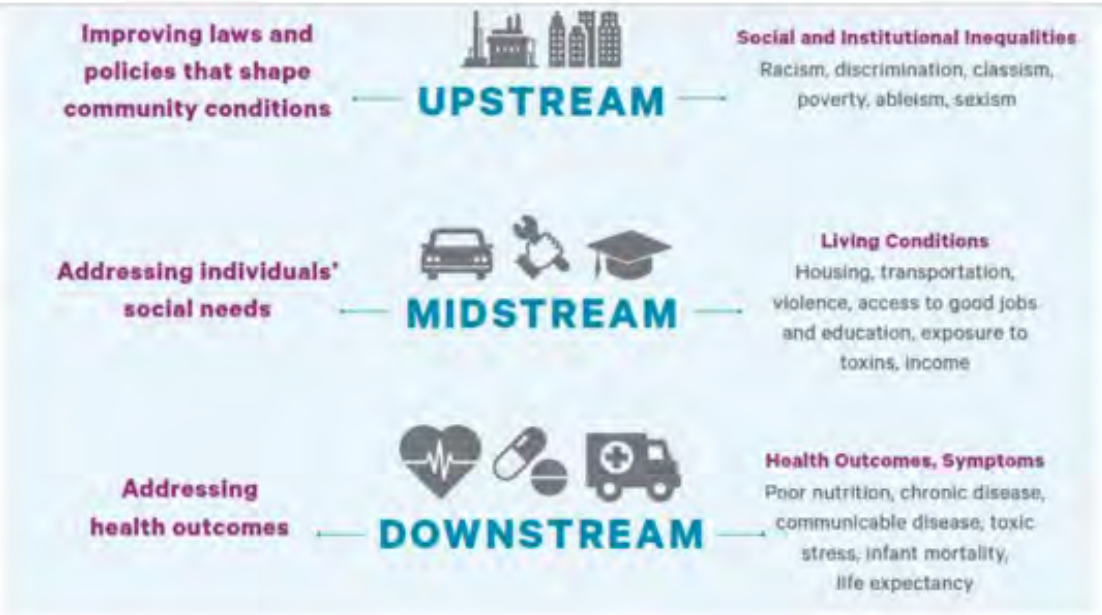
Cancer is the leading cause of death for Louisville Metro. Breast and prostate cancers are those that predominantly affect residents. Not all those who get cancer die from it, as the incidence rate (how many new people are diagnosed each year) is almost 3 times higher than the death rate for Louisville Metro, and has slowly been declining. Elevated cancer death rates are clustered in the entire western half of the county. Overall, White and Black men are dying at higher rates than women from any kind of cancer.

The median age of those who died from cancer in Louisville Metro from 2011-2015 was 72.

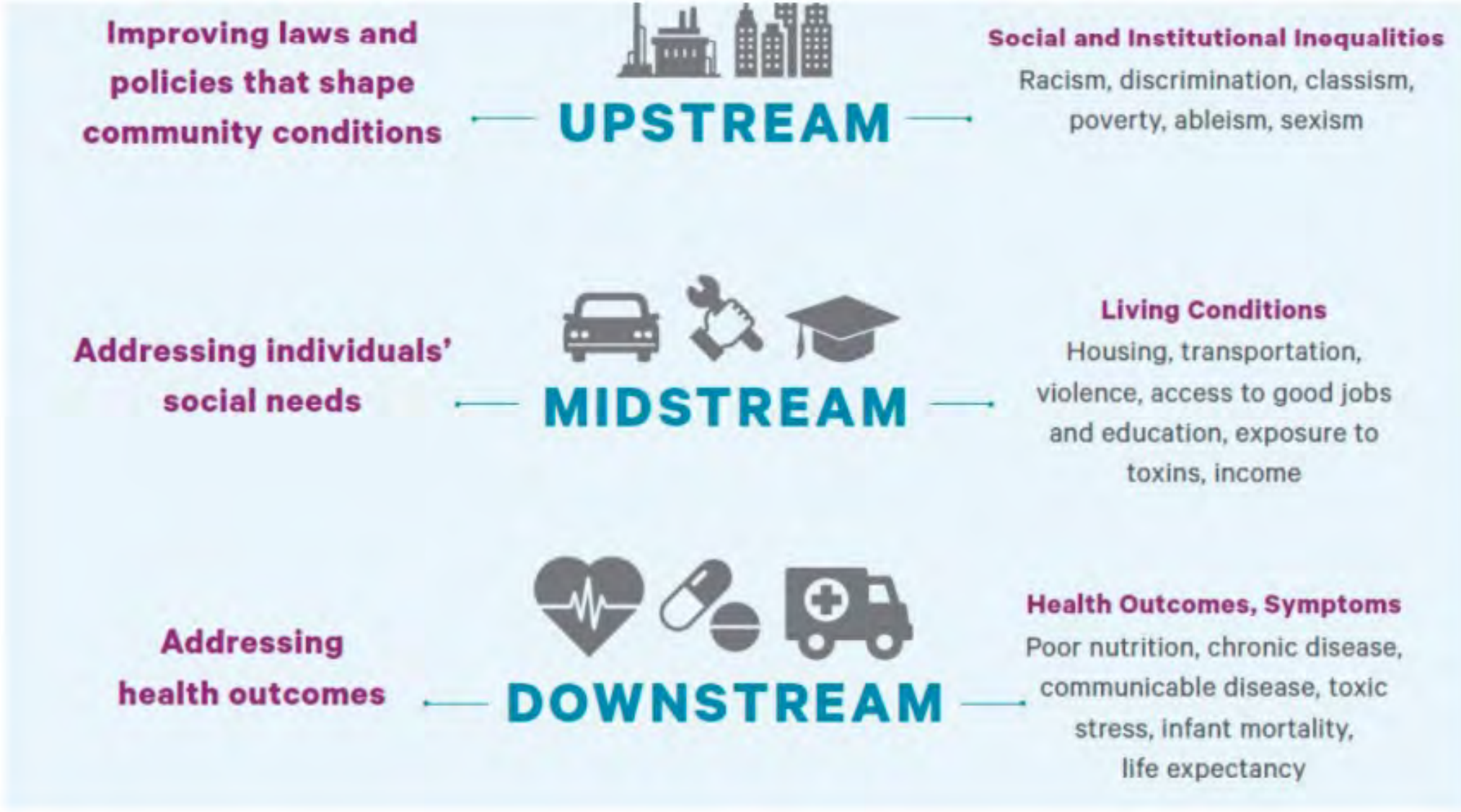
PART III RESULTS OF RACIAL INEQUITY ON HEALTH CARE OUTCOMES

COVID -19 ARRIVES AND SHINES A LIGHT OF OUR SYSTEM

Society of Critical Care Medicine Sept. 12, 2020



- 'Addressing Disparities in COVID-19 Care'
- Sue S. Bornstein MD FACP
- American College of Physicians


Improving laws and policies that shape community conditions
UPSTREAM
Social and Institutional Inequalities
Racism, discrimination, classism, poverty, ableism, sexism
Addressing individuals' social needs
MIDSTREAM
Living Conditions
Housing, transportation, violence, access to good jobs and education, exposure to toxins, income
Addressing health outcomes
DOWNSTREAM
Health Outcomes, Symptoms
Poor nutrition, chronic disease, communicable disease, toxic stress, infant mortality, life expectancy

SCCM SEPT 2020 COVID-19 THE NEXT WAVE – WHAT'S COMING NEXT

SUSAN BORNSTEIN MD AMERICAN COLLEGE OF PHYSICIANS

- Black and Latinx persons in the US have been 3 times more likely to contract COVID-19 than White residents and nearly twice as likely to die from it.
- Some counties with a majority of Black residents have almost 6 times the death rate compared to predominantly White counties.
- In New Mexico, native Americans comprise only 11% of the population yet account for more than ½ of COVID-19 cases.

Wen LS, Sadeghi NG. Addressing Racial Health Disparities in the COVID-19 Pandemic: Immediate and Long-Term Policy Solutions. Health Affairs Blog July 20, 2020

SCCM SEPT 2020 COVID-19 THE NEXT WAVE – WHAT'S COMING NEXT
SUSAN BORNSTEIN MD AMERICAN COLLEGE OF PHYSICIANS

Living conditions as a contributing factor

- In the Navajo Nation in the US Southwest, up to 1/3 of residents lack access to clean running water or indoor plumbing.
- Up to 30% of Navajo dwellings may not have electricity.
- Multi-generational housing is commonplace in the Navajo Nation as well as in many other low wealth communities in the US; social distancing is challenging at best in these settings.
- The "digital divide" is especially pronounced in lower income communities which limits access to telemedicine and other health-related services.

Sequist TD. The Disproportionate Impact of Covid-19 on Communities of Color. NEJM Catalyst. July 6, 2020.

SCCM SEPT 2020 COVID-19 THE NEXT WAVE – WHAT'S COMING NEXT

SUSAN BORNSTEIN MD AMERICAN COLLEGE OF PHYSICIANS

Work conditions as a contributing factor

- A greater number of Black and Latinx workers are unable to work from home compared to White workers.
- Certain industries that have workers that are predominantly minorities face higher rates of COVID-19.
- For example, at meatpacking plants, where the rate of COVID-19 infections is higher than the rate in 75% of counties, nearly half of workers are Latinx and a quarter are Black.
- To get to work, these essential workers must travel using often crowded public transportation thus increasing their risk of exposure.

Wen et al.

SCCM COVID-19 WHAT'S NEXT – PREPARING FOR THE 2ND WAVE SEPT 2020 – SUSAN BORNSTEIN DISPARITIES IN HEALTH CARE

Food insecurity and obesity as contributing factors

- Long-standing disparities in nutrition and obesity play a crucial role in the health inequities unfolding in the pandemic.
- Lower wealth communities frequently have limited options for healthy food (food deserts) yet options for unhealthy food may abound (food swamps).
- In children hospitalized with COVID-19, 42% had one or more underlying conditions with obesity being the most prevalent condition.
- Obesity is a state of chronic, low grade systemic inflammation that may predispose to cytokine storm.

Belanger MJ et al. Covid-19 and Disparities in Nutrition and Obesity. New England Journal of Medicine. DOI:10.1056/NEJMp2021264

https://bit.ly/341UCFj

A NEW BEGINNING

CDC Expands U.S. Diabetes Surveillance System with new Social Determinants of Health Module

New tool identifies Diabetes-Related Health Disparities

Press Release

For Immediate Release: Tuesday, November 17, 2020

- "The impact of **poverty**, **education, geography**, **access to care and healthy food, transportation**, and many other factors continue to have a profound effect on diabetes and other chronic conditions in the U.S.."

A new beginning

The Centers for Disease and Control and Prevention (CDC) has expanded the U.S. Diabetes Surveillance System with **15 new social determinants of health in the (SDOH)** module to help **identify under-resourced areas of the United States** and assess the potential impact of health disparities on diabetes burden and risk factors.

SOCIAL DETERMINANTS OF HEALTH ***SOCIAL AND COMMUNITY CONTEXT***

HTTPS://WWW.HEALTHYPEOPLE.GOV/2020/TOPICS-OBJECTIVES/TOPIC/SOCIAL-DETERMINANTS-OF-HEALTH

RACIAL INEQUALITY AND PERSONAL FRAMES OF REFERENCE

- Implicit Bias – I encourage you to take the test
  - Bias that results from the tendency to process information based on unconscious associations and feelings, even when these are contrary to one ‘s conscious or declared beliefs.
    - Dictionary .com
- Patient’s experiences in the past and present
  - Patients in their 60’s and higher may remember a time in the south when you entered the white doctor’s office through the back door- whites only entered through the front door .
  - How do you or your staff address your patients? By their first name or surname and title (Mr. , Ms. , Mrs., Dr.) for all patients as a sign of respect?

RACIAL INEQUALITY AND PERSONAL FRAMES OF REFERENCE

Immortal Life of Henrietta Lacks

- Scientists know her as HeLa. She was a poor black tobacco farmer whose cells—taken without her knowledge in 1951—became one of the most important tools in medicine, vital for developing the polio vaccine, cloning, gene mapping, in vitro fertilization, and more. Henrietta's cells have been bought and sold by the billions, yet she remains virtually unknown, and her family can't afford health insurance

Tuskegee Syphilis Study of Untreated Syphilis in the African American Male

- In 1932 the United States Public Health Service started a study of 400 black men in Macon County ,Tuskegee ,Alabama . Despite available treatment with penicillin in 1940 , the study group, wives, and children remained untreated until the study was stopped in 1972 by the Department of Health ,Education and Welfare.


Michigan Journal of Race and Law

Volume 7

2001

Racial Profiling in Health Care: An Institutional Analysis of Medical Treatment Disparities

René Bowser
University of Illinois College of Law

RACIAL INEQUALITY AND FALSE ASSUMPTIONS

- "Hidden in Plain Sight-Reconsidering the Use of Race Correction in Clinical Algorithms"
  - Darshali a. Vyas, M.d. , Leo G. Eisenstein, MD and David S. Jones M.D. , PhD
  - August 27, 2020
  - N Engl J Med 2020; 383:874-882
  - DOI:10.1056/NEJMms2004740
  - https://nejm.org/doi/10.1056/NEJMms2004740

- "Despite mounting evidence that race is not a reliable proxy for genetic difference, the belief that it is has become embedded"
- " By embedding race into basic data and decisions of health care, these algorithms propagate race- based medicine".

ISSUES OF MARGINALIZED POPULATIONS

- Time spent with patients by medical providers is directly proportional to what they feel they have in common with the patient .
- Faulty expectations of healthy lifestyles when the patient has no access to healthy, affordable food, safe exercise – *know your community resources*
- Low paying jobs without adequate medical insurance ,medical leave, or knowledge/accessibility to Family Medical Leave Act (FMLA) for chronic disease surveillance.

Issues of Marginalized populations

- Lack of medical literacy about drug formularies , co-pays , deductibles , chronic disease management, etc.
- Limited community resources in their neighborhoods for primary care, specialty care, urgent care, and pharmacies
- Issues of transportation as a barrier to timely arrival to appointments – *Federation transport through Medicaid often requires 2-hour prior home pickup and 2 hour or more office pickup to deliver home .*

SUMMARY- HEALTHY PEOPLE 2030

- Patients of color have poorer health outcomes nationally, regionally, and locally from a myriad of societal conditions reflective of complicit historical and current racism.
- Until we recognize and address these conditions our health care system will continue to be the most expensive with the poorest outcomes of the developed nations.

https://www.apha.org/topics-and-issues/health-rankings

Sue Bornstein, MD

Regent
American College of Physicians
Dallas, Texas

Closing thoughts

"The rapid spread of Covid among communities of color is *not* because race or ethnicity is a risk factor for disease spread. Racism – not race – is the risk factor for spread."

Thomas Sequist, MD

"Of all the forms of inequality, injustice in health is the most shocking and the most inhuman because if often results in physical death."

Reverend Dr. Martin Luther King, Jr.

REMEMBER THESE KEY ISSUES OF THE 5 SOCIAL DETERMINANTS OF HEALTH

- **Health and Health Care**
  - Access to Health Care
  - Access to Primary Care
  - Health Literacy
- **Neighborhood and Built Environment**
  - Access to Foods that Support Healthy Eating Patterns
  - Crime and Violence
  - Environmental Conditions
  - Quality of Housing

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- https://nejm.org/doi/10.1056/NEJMms2004740
- https://www.law.cornell.edu/cfr/text/13/124.103 **§ 124.103 Who is socially disadvantaged?**
- https://www.apha.org/topics-and-issues/health-rankings