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**10<sup>th</sup> Annual William T. Small, Jr. Keynote Lecture:  
“The Science and Epidemiology of Racism and Health in the  
United States: An Ecosocial Perspective”  
University of North Carolina at Chapel Hill School of  
Public Health Minority Student Caucus  
February 29, 2008**

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**ADAORA ADIMORA, MD, MPH:** Welcome back to the satellite and internet broadcast of the 10<sup>th</sup> Annual William T. Small, Jr. keynote lecture from the 29<sup>th</sup> annual UNC School of Public Health Minority Health Conference. We have Dr. Nancy Krieger here with us to respond to your questions and comments. Please call us at 1-877-869-7811, e-mail us at [question@unc.edu](mailto:question@unc.edu), or submit the web form at [www.minority.unc.edu/question](http://www.minority.unc.edu/question). Dr. Krieger, thank you so much for joining us here today.

**NANCY KRIEGER, MS, PHD:** Thanks, a pleasure. So you have questions I imagine, some?

**ADAORA ADIMORA, MD, MPH:** The first question, we have one question so far, as a society we must all work together to correct inequalities. How would you begin to convince people that the inequalities due to racism will continue to have detrimental effects on all of us if we don't take steps now to remove them?

**NANCY KRIEGER, MS, PHD:** I think in answering that question, I think one thing that is really important is to even make it understood that racism embodied in racial ethnic health inequities. I think a lot of times there is an approach towards thinking that people's health problems are their own individual problems brought about by their own individual

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failures and yet I think where the public health research is clearly showing the case is that the evidence is in, that essentially the health inequities that we see are the embodied expressions of social inequality, that when you have people who suffer economic social deprivation, have noxious jobs, suffer from environmental pollution, you are going to see these health inequities happen and they are not about just individual bad choices. They are about things not being fair.

So, I think that there is something very compelling about the evidence that our bodies show, whether it is the mental health that we have or the physical health that we have that makes it clear this isn't just "subjective," isn't a matter of just opinion, but is actually embodied suffering and I think that this orientation needs to be much more clear because then it becomes something that I think is more actionable, that it is not just about what if some people are trying hard and others are not? But that there is actual differences in the burdens that people experience because of injustice in our society.

**ADAORA ADIMORA, MD, MPH:** Alright. Thank you. We have an e-mail question from Selmer, North Carolina and here is the question. How would you respond to critics of social epidemiology who feel that issues such as structural

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confounding and reverse causation make it almost impossible to draw causal inferences about the effects of processes such as racism and environmental exposures on health?

And his follow-up to that, which I will go ahead and give you, is what are some innovative ways in which those of us who are committed to this cause can help to move the field forward?

**NANCY KRIEGER, MS, PHD:** So first I think it is really important to say that these are not problems only affecting social epidemiology. Epidemiology in any population, health research has to address issues of whether we are using observational or experimental data, what are the drawbacks and what are the positive features of all of these different kinds of approaches? So I would hate to see this only framed in terms of social epidemiology. We can think that for example there is a lot of work that happens in public health that doesn't take health inequity seriously and as a consequence gets the answers wrong so the issue becomes what is correct science, not what is politically correct science, and what is the best way we can move our science forward?

To give you an example of that, we need only think about all the work that was done in conventional epidemiology for example on hormone replacement therapy and the idea that it

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was supposed to reduce cardiovascular risk and it being shown in fact that a lot of that observational evidence was actually due to confounding by social class who could afford to take hormone therapy, who was given it, who was in better health to be able to be prescribed it in the first place, and we also see so that the experimental study is done, we find there is actually not a benefit. We also find actually additional evidence that shows that in fact the risk for breast cancer was real non trivial and the population of attributable risk that is being linked to that now is anywhere from perhaps 20 percent of cases of breast cancer, so that is really big and that wasn't social epidemiology but the point was because the social class aspect was ignored, what did we end up with? We ended up with misunderstanding the problem. So I want to first really flag this is about thinking about these things seriously because the health inequities are there, whether they are studied or not, and will have an impact on what else is being researched.

I think in terms of ways that we can start to think about innovative ways, I mean certainly there are ways of asking additional questions in ongoing studies that can then have possibilities of longitudinal follow-up. That has been done in the cardio study. So we actually begin to ask the

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questions and can trace events over time and have more of a sense of what the causable before and after effects are.

Certainly there is work that is being done in terms of experimental work where you give people questions about racism in an experimental setting and you see what their physiologic responses are, but how you go from lab studies to how you go to population studies is a question itself. Can you just infer from an immediate rise in blood pressure that this actually translates to something that actually would turn into hypertension?

So I think the point is that I think we know there is not going to be just one study that will do it and one study design that will do it. Rather what we need to do is triangulate the different kinds of evidence, evidence from observational studies that are done now, historical trends and population health patterns to understand if the inequities are getting bigger or smaller, what else that could be traced to as well as experimental evidence and it is going to be all those different kinds of approaches.

I gave in a lecture one example in terms of moving beyond just self report questions about racial discrimination to using newer technology such as the implicit association test to see if that can help us understand what is going on. I

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think there is room for a lot of innovation there, people that are doing MRI scans to see what happens in people's brains when they are actually exposed to different kinds of racial insults.

There are many different ways to see how the body responds to that kind of interpersonal discrimination. In terms of the institutional, I think that what we have to do very much again is really make sure we are asking the questions at the right time frame, the right periods of history, and the right levels of analysis, but this isn't a problem only for social epidemiology. It is a problem for epidemiology in general.

**ADAORA ADIMORA, MD, MPH:** We have a caller.

**DR. TOM MASON:** Dr. Krieger, this is Dr. Tom Mason at the College of Public Health, University of South Florida Tampa, I am very interested in your comment and reflection on potential for racial discrimination in job placement as it pertains to occupational exposures associated with increased risk for diseases.

**NANCY KRIEGER, MS, PHD:** With that, do you have a particular question, or for me to elaborate on what is happening in the research now on social and occupational hazards?

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**DR. TOM MASON:** The latter would be fine. I am an environmental epidemiologist. I was at the Cancer Institute for 17 years. I have followed your career very closely and I am really interested in some of your recent publications along these lines.

**NANCY KRIEGER, MS, PHD:** So I think, I mean it is great that you are asking this question and I think what it is asking us to start to think about is again how does embodiment work? It is not that someone is just a worker at a particular work place and the only thing that is going on at that work place are the occupational hazards associated with that job, such that any human being put in that particular job might have for example ergonomic strain, might be exposed to dust or to fumes, might be exposed to certain levels of noise, might be exposed to certain kinds of repetitive motions that cause trauma to the wrists. Those are actual job hazards and they are very important to understand but work isn't only about the job hazards as such.

Work is a place that people come together and reproduce the relationships in our society just as they do on the street, just as they do in the neighborhoods. Just as they do everywhere else. So then you have to think about what are the other social hazards that exist that work? Because of what

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policies might be or what policies are not to change them, and what I mean by then is the experiences of racial discrimination, sexual harassment, work place abuse, why do those happen and what might their health effects be? And that the people who come to work aren't just people who sort of materialized out of nowhere and end up at the work place. They bring with them what has been going on in their neighborhoods and in their homes. As you probably know, there is also concerns about kinds of work place violence that happens because intimate partner violence is brought from home into the work place.

So these are the different kinds of things where I think if we want to try to get a sense of what is happening with people's health, we can bring together the profound insights that come from occupational epidemiology, the expertise around exposure assessment that has occurred but also bring to that social epidemiologic blends that allows us to see people more fully as the humans that we are who work, who live, who love, who play, and who also suffer.

**DR. TOM MASON:** Thank you very much and I would just refer to it as holistic epidemiology so that we can bring all the respective complementary components together and improve

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our world view and basically have a marked impact on the health of our population. Thank you.

**NANCY KRIEGER, MS, PHD:** Thank you.

**ADAORA ADIMORA, MD, MPH:** Thank you. We have an e-mail from Cynthia from Quebec, Canada, and here is the question: To what extent does public health which aims to reduce disparities keep reproducing racial difference through indicators of performance where white represents very often the norm?

**NANCY KRIEGER, MS, PHD:** So I think your question touches on important issues about how race ethnicity classifications are used but actually almost any classifications of public health.

I think we have to understand that public health like any other science is complicated. It has contributed to scientific racism and it has challenged scientific racism and both are true and we need to understand that. The same can be said of work that is done in sociology in terms of its contributions to racism and perpetuating racial stereotypes and also challenging them.

So I think in terms of the question of saying white is norm, I am not sure that is always the way things are necessarily phrased when we are looking at trying to understand who are the different population groups to compare. You have

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to give a basis for what the comparison is. So if you are concerned with racial discrimination, it makes sense to say let's compare the group that is least likely to be exposed to racial discrimination and most likely to practice it compared to those who are most likely to be burdened by it and those who are not. So that is from a conceptual level you are going to want to figure out who is your comparison group to see who is being harmed more by an exposure or not.

The second thing that you also need to think about is just what are the relative sizes of the populations that you are studying? It is going to make a difference if you are studying a case control study when you have been able to select race ethnicity and you actually know who your balance is going to be versus population data where you may have very different proportions of the population and so depending on the study design you may want to think about who your reference group is as well but generally you want to think about who is the reference group in terms of the group that you think is most or least exposed to the exposure of concern and then make the comparison to the other groups accordingly.

So I think that is the fundamental logic. Then you have to just ask where does discrimination of the color line fit in to get what that picture looks like?

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**ADAORA ADIMORA, MD, MPH:** Thank you. Now just a slightly different track of questions, what are the most important steps for insuring that social determinants research is translated into policy and to institutional change.

**NANCY KRIEGER, MS, PHD:** I think that is a great question and what it both points to are the promises and also limitations of any one discipline. I am a social epidemiologist and as that my real responsibility professionally is to make sure to generate the evidence that shows that the population distributions are of health, what the levels are, what the distributions, and what the inequities are, and to do research on what could be causing those, and then to be in communication with people who are both in advocacy and also making policy to try to make a difference, but it would be wrong to suggest that I as the scientist would know how to "fix society." What I can do is work with others who are doing that.

I think that where the working social determinants of health is clearly going is not only about in the academic sense, being extremely interdisciplinary and drawing on history, drawing on other social sciences, drawing on molecular biology, drawing on epidemiology, drawing on all that we can to try to understand what is driving these population patterns of

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health that we see. But then it also means at the government level being much more inter sectorial because the social determinants of health frame work is very much making clear that public health absolutely has its mission and part of that mission has to be working with people that are dealing with education, with jobs and labor policy, with housing policy, with correctional facilities and criminal justice policies, with trade policies, with all these things that can be something that helps bring people to talk about the way we want to create a healthier, better and more equal and just society. I think it is one of the leverages to do that. I don't think it is the only one but I think it is an important one.

So I think what we need to be doing is trying to do research that we understand is fundamentally about causal processes but also that we think is policy relevant and make that when we say policy relevant it doesn't mean just appealing to policy makers because policy makers are going to also be people who are responding to public pressure so how does this get into the public discourse? And that is again where I think initiatives like the PBS series that is coming up on natural causes is a great way to help start getting much more public dialog and debate as to what is going on so that we can sort out the priorities we want for the kind of society we want.

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**ADAORA ADIMORA, MD, MPH:** Thank you. Along those lines, speaking of government, if you were secretary of health and human services, what critical steps would you take to eliminate health inequities? And candidates please take note!

**NANCY KRIEGER, MS, PHD:** I think that there are going to again be a lot of answers to the question and where I also know that I have a narrow advantage is because again I have been predominantly academic researcher, not someone in government. So someone in government would probably have a much more I think insightful reply. That said, outsider views are sometimes useful and so I think on the one hand there would be a proper accounting for what are the magnitude of these inequities? Many of our data systems are still not up to snuff in terms of having appropriate socioeconomic data, appropriate racial ethnic categories, of having data to the level of geography that we need so that cities can understand what is going on as well as counties as well as states in the nation as a whole so there is one who part which is the monitoring effort and I think it is very important because all too often we have problems of no data, no problem, but that is not the case. When we don't have data it is usually because there is a very big problem.

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I was recently just asked to write a letter in support of a report that is being put out by the Urban Indian Health Institute, trying to say there is so little data available to understand what is happening among American Indian, Alaskan Native populations who live in cities, not in reservations, not covered by the Indian Health Services, so when you have so little data, sometimes one part of what you have to do to even understand what is going on is get the data. That is a piece that is in public health.

The other part that is not in public health, and the other part that I would also absolutely love to see the secretary of health and human services argue for is way more funding for public health as such. Right now when you think about U.S. health dollars, only 1 percent goes to public health. That is inadequate. We need much, much more. We could imagine health departments throughout the country are grossing underfunded. Imagine if people actually had more funds to implement all these pilot projects that are done or demonstration projects that are done which then never get repeated around health inequities which show very promising conclusions because there is not the work to sustain them. There is not the money to sustain them. We can't be as a nation trying to address health inequities by doing research

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projects. That is an overstretch for research and it is clearly ludicrous. So, much more of a commitment to working with what has been demonstrated already to work and funding it, that would be great.

And the third thing that I think would be great is again, as I said in the prior question, using health as one of the discussion mechanisms to get greater inter sectorial work happening that links together our understanding of what we need for economic policy, also around creating health, for example. So I think there are ways you could have a secretary of health and human services do all these things, frame health understanding its importance as a goal and a value and a way to live life more generally with less suffering and to say that inequities are unjust and unwarranted and unacceptable.

**ADAORA ADIMORA, MD, MPH:** Thank you very much. We have another question. This is an e-mail. This is Cynthia from Kentucky and her question is how well do your measures, for example EOD, extend to such groups as whites in Central Appalachia who have more diffuse experiences of social exclusion but well documented health disparities?

**NANCY KRIEGER, MS, PHD:** So the initial version of the measure that I made about experiences of discrimination actually covered discrimination based not only on race

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ethnicity but also class or socioeconomic position, also gender, also religion, also sexual orientation, so I think that methodology can be extended because there isn't only discrimination based on race ethnicity. The work that I was presenting today was focused on that and the validation study that I did was focused on that and I want to emphasize that the validation study was done in a lower income working population.

So for example that you can't necessarily translate those results to other groups that have more education but at the same time thinking about where you have the bulk of people of color, it was the right group in which to do that research, so I would encourage testing of this kind of instrument and refinement of this kind of instrument to meet the actual experiences that you described with regard to whites of Central Appalachia where the question is how are ways in a sense of being denied dignity on discriminatory grounds impairs health. Whether it impairs health through stress mechanisms as some may hypothesize, that is one possibility, maybe, but it was also very possible that it affects how you behave in the world and with yourself in terms of what becomes narrowly called health behaviors, what you do to make sense of the world that it works for you and those all become useful questions.

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I have had people contact me from other countries to ask about this, using the EOD as it is, and I always say you have to put it in context. The questions that I developed were based on what I know of the U.S. experience in the U.S. literature and it is the idea that needs to then be tested elsewhere.

**ADAORA ADIMORA, MD, MPH:** We have a caller. Caller could you please state your name, where you are calling from, and your question?

**AMY:** My name is Amy. I am calling from Virginia and my question is as we look toward the near future in this country's next administration, what steps can we take to be ambassadors for change?

**NANCY KRIEGER, MS, PHD:** Is the "we" in your question we in public health, or who is the "we" in your question? It is always a good thing to know.

**AMY:** I guess I would just say we as citizens.

**NANCY KRIEGER, MS, PHD:** So that gets large and also if ambassadors to change that also presumably means not only in the U.S. but also outside of the U.S. where obviously our efforts on serious sustained and respectful diplomacy could be certainly improved, so I think that what we need to think about is it is not just about change. It is change towards what?

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Because, for example, in the study that I showed looking at the trends in premature mortality, there was certainly a change in the period before and after 1980. Not all change is good because after 1980 the inequities widened. So I think we need to be very clear to say what can we do to say that we need to be reinvigorating a discussion in this country that the central value and central good is one of social equity, that is a way to measure how well we are doing as a nation, not simply about GDP because that doesn't tell us where the income is going or the wealth is concentrated.

So I refer back to the ideas of just bringing back the ideas of social justice, of human dignity and human rights as being something that we need to be able to talk about much more freely in this country. It is not about guilt tripping. It is about understanding the present and working for a better future.

**ADAORA ADIMORA, MD, MPH:** We have an e-mail question from Joanna in Arizona and here is the question. Do you perceive that universal health care will have an impact on health disparities? If so, in your opinion will it have a negative or positive effect?

**NANCY KRIEGER, MS, PHD:** So certainly health disparities are due depending on the outcomes being measured

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are due to the things that happen both in and outside the health care system. If for example you are diagnosed with breast cancer, you sure hope that you get good treatment, otherwise your survival will be much shorter and that will contribute. If you don't have good treatment because of discrimination or because of economic deprivation at your level or at the level of the hospital in which you are getting your treatment, it may be under funded for example and under staffed, that ends up translating into a health disparity. I think we are way past the point of pitting health determinants versus health systems. Both matter for health inequities and it depends what outcomes you are looking at. If you are trying to prevent disease in the first place, it is not always obvious that health care systems are the way to do that. If you are trying to prevent poor survival, they may be very useful.

But the other part that is very important to flag in your question is just as I was suggesting to one of the other callers, you have to be very careful what the terms mean. What does universal health care actually mean? Universal health care, if you are talking about simply a mandate that everyone is supposed to buy insurance is not the same thing as a single payer system which actually will be something very different around costs, so that starts to move to a whole other level of

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discussion and I am not a health policy analyst but these are discussions that I have heard and have been around. I do think that if we in the United States had a universal single payer health system, that could be an expansion even of most medicare coverage for all or as many would also say the kind of coverage that we have for our congressional representatives and their families, that we would end up having much less of a problem around the prognosis of many conditions because people could be better taken care of, get proper monitoring treatment for what they do. There is work that clearly shows that if you have better treatment, for example, for diabetes you have fewer complications, but you have to have access to that treatment.

I think it is also important to say that it is not just the insurance itself. It is the quality of the care. That takes us into a whole other domain which is not my area of expertise but I am aware that there are many people doing very good work, trying to understand about how health inequities play out within health systems, even amongst people who have insurance.

So I would just again reiterate absolutely we need to have full coverage of people in this society, not tied to job but just because you happen to be here, and have that be something that is a universal single health payer plan but also

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be paying attention to the content of what that means and what work is done to ensure that there is adequate work force that can work with the varied population that we have here, for example, the need for translators, etc.

**ADAORA ADIMORA, MD, MPH:** We have another e-mail question. This one is from Vidya, California. On an individual level, we have been promoting concepts of individualism to empower the consumer and work on their personal recovery and resiliency. Could you suggest ways to deliver the message of societal factors in health to the consumer without making them feel helpless and powerless?

**NANCY KRIEGER, MS, PHD:** I would actually first challenge the paradigm of consumers. I find it very odd that we are at a point where you will find for example in the CDD the public being defined as consumers of public health. That is not the relationship of government to the people, the people to the government. We are people who are citizens, most some residents, not citizens yet, and we have elected representatives who are there to do government to make our society work well for everyone, not just for the few, and that is not about consumerism. I think that we have way too much consumerism and focus on individualism in this country. Individualism is the quick ready step to go to victim blaming

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with regard to anything that goes wrong. When we are all told that we are just doing it on our own and not seeing what actually binds us together, not seeing the social context that structures or opportunities and also the barriers, so I would actually be very cautious about using language about being consumers. I would like to say that we are participants, we are producers, we are creators and we need to be understanding what are the different factors that are contributing to what might lead to someone having good or bad recovery from a particular problem. Usually it is not just their own individual effort. You have to look at their family context, their social networks, their resources, and much else to begin to understand even how an individual "behaves."

**ADAORA ADIMORA, MD, MPH:** We have another e-mail question, this one from Wilhemina in Maryland, can a health promoting cognitive or behavioral response to racism be learned and if so do you believe that the learned response will lead to a reduction in racial ethnic health disparities?

**NANCY KRIEGER, MS, PHD:** That is a great question and I think a psychologist would be much better able to answer it than I, and I think one thing that is always very important is to be aware of the limits of one's expertise and what one's discipline allows you to say and what it doesn't. That said,

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reading the literature, certainly there is some experimental evidence that I have seen from the social psychology literature where people are able to modulate some of their responses to different kinds of insults that they receive. They are trained to do that. They are taught that by some of the methods that your question is suggesting, but I think that improving coping mechanisms however necessary is not the same as changing the problem in the first place and they have to go hand in hand. I would hate to see emphasis that is only on how do we respond and improve our response? And not also have active work going on about how to eliminate the chance that we would even need to worry about having to come up with such a response.

So I would love to see that kind of work go hand in hand and I think the idea again is not only about how we cognitively in the sense of how we psychologically react and respond but also how do we fundamentally understand the sources of the inequities and the sources of the institutional and interpersonal discrimination that may exist that requires historical analysis, social analysis, political analysis, economic analysis, even perhaps cultural analysis, and that is part of what helps people understand the world that we are in to give a context to the experiences. Otherwise, it is just reduced to a question of individual psychology, then some

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people are more touchy than others and I don't think that is where we want to go.

**ADAORA ADIMORA, MD, MPH:** We have another e-mail question, this one from Massa in Massachusetts, and the question is how can you translate the research findings into national level policies that target reducing racial disparities in health care?

**NANCY KRIEGER, MS, PHD:** That is again a great question. I think it ties into some of the others that we have also had today. I think that series like a natural cause is going to be one way to get much more of a public dialog. I think it is about also working with local health departments to start to ask for dialogs across city government and then take it up another step, think about county, think about state, and do the work. I mean it would be great if there were shortcuts. It would be great if we could waive a wand and just say let's all just talk and we will come to a better understanding and come up with solutions.

But I think the other thing to realize is that when we are dealing with problems that are as entrenched as they are, there is a reason for that. We need to understand the systematic reasons, the societal reasons that it has been so tough to change things. That doesn't mean people haven't tried

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and it also doesn't mean there hasn't been success because there actually has been. In the data that I was also showing today, there really are declines in every income quintile around premature mortality and infant death rates, but we also know we can go so much further because when you look at where the U.S. is ranking in the world, we don't rank so well, particularly given what the alleged wealth is of this country.

So that means there is much room for improvement and I think that is what we also need to understand and I think that keeping that discussion happening so that we are not only focused on what is going on in the U.S. but the U.S. in relation to other countries expands possibilities for thinking about policies that can make a difference.

**ADAORA ADIMORA, MD, MPH:** We have a phone call. Caller would you please state your name, where you are calling from, and your question?

**ANNE:** Hi, Dr. Krieger and Dr. Adimora, my name is Anne and I am calling from Maryland, and I wanted to just ask Dr. Krieger a question about built environment. I was wondering as you look at trusting the relationship between built environments that often widen the gaps in racial and ethnic health disparities, I was wondering if you could talk a little bit more about urban development and gentrification as local

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states or national items that would be used to kind of close the racial and ethnic health disparities so thinking about the role that the built environment plays?

**NANCY KRIEGER, MS, PHD:** I think you are raising a great question. I am aware of research in that area but it is not the main thing that I personally have studied in my research so I am a little limited in answering but what I know is that there is increasing discussion going on these days between people in public health and urban planning, between people that are making housing projects happen and thinking about health relationships not only about things specifically like asthma but also what it means to have open space, what it means to have space to try to reduce violence on the street and other things like that.

I have been very encouraged to see initiatives that are beginning to happen that are connecting people in public health and urban planning, also thinking about issues that relate to transportation where people work, where they live, what that means around air pollution. What that means about sedentary or not, all these different kinds of things, what commute times even mean for people in terms of what time they have to do things other than just simply commuting, as in time to be with friends or family, what it means for times for meals and all of

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that so I think we are beginning to start to see these kinds of discussions happen and my sense is that the more this discussion occurs and the more people start to make creatively these kinds of links and look not only as I mentioned from the work place example, not only look at buildings in terms of the actual physical hazards that are there, whether you are concerned about radon, whether you are concerned about air quality, but thinking about them as places that house social interaction, the interaction of the people who live within each unit and also whatever the entire building may be or the block may be, how can that get structured? And my sense is that this is beginning to be a discussion that is happening now and the discussion that has historically happened in the past when you think of a lot of the innovative public health work that was done to try to address problems of tenement housing in the late 19<sup>th</sup> to early 20<sup>th</sup> century.

So I would just encourage you and your colleagues who are concerned about these questions to pursue them, talk to each other, look at what is going on, and let's test the ideas and see if it makes a difference.

**ADAORA ADIMORA, MD, MPH:** We have an e-mail question from Eulagetta, South Carolina, what is the difference between consciously self perceived discrimination and self perceived

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discrimination? Please give me examples of how you could measure one and not the other?

**NANCY KRIEGER, MS, PHD:** If I understand your question correctly, I think the issue is that people can be subject to experiences of discrimination and then there are two different things that can happen. One is they may not register consciously but they may register unconsciously so that is one part where you can get a difference between them so that if you ask someone they would say no and yet if you use something like the implicit association test as we showed, you actually may get a sense that there is some understanding that happens. To think that we humans only work at the conscious level is not true and there is much psychology work that shows that and so trying to understand what some of those processes are behind the level of cognitive thinking is I think what is being asked for.

But the other thing that I want to flag about the distinction is that people also can have experiences that they can report cognitively but they don't want to because they don't like to study, they don't like who is interviewing them, they don't like the context, they don't trust it, and so that is why you always have to be very careful and this isn't true discretions about discrimination but for any self report data

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you always have to think about the context, which people are providing that information and why they may or may not provide accurate information, even knowing what they are cognitively able to identify.

**ADAORA ADIMORA, MD, MPH:** One question, of the health inequities perpetuated by racial and economic injustice that you have detailed, which do you believe has the most detrimental long term consequences from the perspective of individual and societal levels?

**NANCY KRIEGER, MS, PHD:** That is a hard question to answer because it is not again like our body easily partitions out all the different experiences and exposures so it is not as if you could have someone for example exposed in utero even to lead and also exposed to bad air quality and also exposed to later in life to experiences of racial harassment on the job, for example. Those things may be all true simultaneously so to pick and choose which one is going to be the most important, I am not sure. I think you could come up with estimates for example and it also depends on what metrics you choose because you could choose to look at for example what the relative risk is but that doesn't really capture the population burden where you want to take into account what the distribution of the exposure and also what the relative risk is. Something that

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doesn't have a huge relative risk that is widely dispersed can cause a huge public health burden so I think that sometimes you are forced to ask these questions in ways that don't let us just basically say we have a problem here which is that of many different ways that racial injustice harms health.

How can we begin to make a dent in what these forms of racial injustice are and see how that translates into many different health outcomes for better improvement. That is at least the hope. That is the hypothesis.

**ADAORA ADIMORA, MD, MPH:** Well thank you. That is all the time we have for today. Dr. Krieger, thank you so much for your work to understand and eliminate health inequities and for making this broadcast possible. Your breath of knowledge, incisive analysis and commitment to social justice are an inspiration to all of us, and to our participants, thank you for joining us and for your excellent questions and comments. We invite you to mark your calendar for one year from today when we will broadcast the 11<sup>th</sup> annual William T. Small, Jr., keynote lecture on Friday, February 27, 2009.

The University of North Carolina School of Public Health provides other programs during the year, including the upcoming 14<sup>th</sup> annual summer public health research video conference on minority health on June 3, 2008, on the topic of

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men's health disparities. For information about this and other  
minority health related events and organizations at UNC, please  
visit [www.minority.unc.edu](http://www.minority.unc.edu). I am Adaora Adimora, thank you for  
being with us today.

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