

**Poverty, Culture and Social Injustice:
Determinants of Health Disparities
George Washington University School of Public Health and
Health Services
December 5, 2006**

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Ruth Katz, J.D., M.P.H.: Good afternoon everyone.

And welcome to Public Health Grand Rounds at the George Washington University School of Public Health and Health Services. I am Ruth Katz, Dean of the school, and we're delighted to have all of you here. This is the fourth session in our nine-part inaugural series. And as you can see and will see as more people come in, it has become a terrifically popular event here at the school and across the entire medical center, so popular in fact that we hope to make Public Health Grand Rounds an annual tradition here at the school. And whether you are with us for the first time today or have attended our earlier sessions I can almost guarantee that you will find today's event well worth your time. Pfizer, Inc. is providing the support that makes this program possible. And I'd like to express my personal gratitude again to the company. We certainly would not be here today if Pfizer had not made the commitment it has.

The theme of our Grand Round series is Milestones in Public Health. That has a special resonance for us here at the school as we celebrate our own milestone this year, the tenth anniversary of our founding. But we also chose that theme to tie into a terrific traveling exhibit and a book of the same name, copies of which are available in the lobby,

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both produced by Pfizer. The Milestones in Public Health exhibit was on display here at the beginning of the semester and is now making its way around the country. This Grand Round series brings us renowned experts from many of the milestone fields to look at the progress we have made and at the unfinished agenda that still demands our attention. Joy Gerberding [ph], Director of the Centers for Disease Control and Prevention, kicked off our program. Later, David Nebarra, [ph], a Senior Advisor from the World Health Organization, talked to us about infectious diseases. And Bernard Goldstein [ph], former Dean of the University of Pittsburgh School of Public Health and an expert in environmental health, took on the milestone of environmental health.

Today, we will hear from Hal Freeman, M.D., an oncologist and expert in health disparities and Senior Advisor to the Director of the National Cancer Institute. I reminded him when we first re-met just a little while ago he would not remember me, but I certainly remember him. I actually first met Dr. Freeman almost 20 years ago when I was counsel to Congressman Henry Waxman's [ph] Health Sub Committee in the early 1990s. He testified before that committee. And I remember quite vividly his careful and thought-provoking testimony back then, and I am absolutely

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certain that he will that he will be equally engaging today as he explores the milestone of cancer. One of the things you can expect to hear from Dr. Freeman and, indeed, from all of our distinguished speakers is passion and the conviction that a strong public health infrastructure is essentially to a healthy society. That is a fundamental belief at this school and one reason why we invite students and faculty in all the fields of study and the general public as well to each of our Grand Round series.

I hope you will join us for as many of the remaining sessions as you can. Our next event is scheduled for January 16. Our speaker then will be Dr. Walter Ornstein, [ph] Assistant Professor of Medicine and Associate Director of Emory University's Vaccine Center, as well as Director of the Emory Program for Vaccine Policy and Development. Dr. Ornstein will discuss the milestone of... very, very good. You're paying attention. More information about the Grand Round series is available on the school's web site. And by the way, if you missed any of these events you need not miss their content. Thanks to the generosity of the Kaiser Family Foundation, we are able to both webcast and podcast the entire series allowing for a much broader audience to participate.

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And now it's my great pleasure to turn the podium over to Dr. John F. Williams to tell you more about Dr. Freeman. Dr. Williams is Provost and Vice President for Health Affairs here at G.W. His strong and effective leadership in both capacities has been crucial in guiding the university's diverse educational and research agendas. Dr. Williams has been a real friend to the School of Public Health and Health Services since it was established ten years ago. I'm sure that reflects at least in part the fact that he holds degrees in both medicine and we are most proud in public health as well. Joining us here today is just one more demonstration of his whole-hearted support for our mission. It is my great pleasure to introduce Dr. John Williams. *[Applause]*

Dr. John Williams: And at the end of this, will someone explain to me what webcast and podcast... what's the difference? I'm a little confused on that. *[Laughter]* But good afternoon everyone and thank you for joining us.

It is, indeed, a great pleasure for me to introduce Dr. Hal Freeman. Dr. Freeman is truly one of the pioneers in public health and in cancer in particular. As you can see, he is a Senior Advisor to the Director of the National Cancer Institute of the NIH. He is also a Professor of Surgery at the Columbia University. He has had a long, distinguished

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career. For 25 years, Dr. Freeman was Director of Surgery at Harlem Hospital in New York. And for a two-year period ending in 2001, he also served as the President and CEO of North General Hospital in New York. He is a diplomat of the American Board of Surgery and a fellow of the American College of Surgeons. He has been Medical Director of the Breast Examination Center in Harlem, a program of the Memorial Sloan Kettering Cancer Center since 1979.

Dr. Freeman was also elected to membership in the Institute of Medicine of the National Academy of Sciences in 1997. He served as the National President of the American Cancer Society from 1988-1989. And he is the Chief Architect of the American Cancer Society's initiative of cancer in the poor and is a leading authority on the interrelationships between race, poverty, and cancer. The Society, in his honor, established the Harold P. Freeman award in 1990 to recognize his work in this area. This award is presented annually by the American Cancer Society's divisions throughout the United States to individuals who have made outstanding contributions to the fight against cancer in the poor. Dr. Freeman pioneered the patient navigation program, which addresses disparities in access to treatment, particularly among poor and uninsured. This program is designed to assist medically underserved patients in navigating their way through a complex

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health system by overcoming barriers to timely diagnosis and treatment of cancer. The success of Dr. Freeman's patient navigated program has lead many of the healthcare organizations to adopt similar initiative. Based on this model, the Patient Navigator and Chronic Disease Prevention Act was signed into law by President Bush in June 2005. Dr. Freeman is a past chairman of the President's Cancer Panel to which he was appointed to four consecutive three-year terms, first by President Bush in 1991 and subsequently by President Clinton in 1994, 1997, and 2000. He is the recipient of numerous honorary degrees, as well as virtually every named cancer award. He is also a recipient of the George Washington University Cancer Institute Distinguished Public Service award. Ladies and gentlemen, I give you Dr. Hal Freeman. *[Applause]*

Harold Freeman, M.D.: Thank you for that wonderful introduction, Dr. Williams and Dr. Katz. I do remember very well, Dr. Katz, in perhaps 1990 or so when I did testify for *[inaudible]* and I do remember you well. And you remember me too. Thank you so much.

It's a privilege to speak here today. And the things I'm going to speak about are very complex. And I'm going to paint a very broad brush in describing these issues. And it would take much more time to filter down to various elements.

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8

As you can see from the title, I'm going to talk about poverty; and poverty is universal of course that affects anyone who is poor [inaudible] of their race. I'm going to talk about the effect of culture [inaudible] behavioral belief system, values. That is a very important determinant in how people survive and if. I'm going to talk about inequities in our society that are very important in driving disparity. So this is a different approach to the subject from the typical way we approach disparities in the biomedical community. And I'm going to give you some ideas that you may debate and you may believe. [inaudible]. Okay, now I've got it. I've got it.

Now, let's start with this. In December 1971, a President of the United States, Richard Nixon, planned a war against cancer. And here is a picture of the President signing the National Cancer Act, which was the Declaration of the War Against Cancer in 1971. Now, I'm going to talk about this because I think it was a wonderful thing that a president would sign a National Cancer Act, and it did bring a lot more resources to cancer research. But I'm going to also talk about the problems surrounding the weight of the war was declared and how it's been fought. Because the history is how big is the war and what is the terrain in which the war should be fought, and we're going to discuss

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that. To introduce my talk, we have two slides that will set forth my own paradigms of thinking about the issues of disparity. Here's the first and I'll show the second in a minute. I believe that there are three major driving forces of disparities, and they are whether people have resources or not, poverty or low-economic [inaudible]; the circle that you see before you, and how people behave, the culture circle, values, belief systems, world view, behavior, lifestyle, the culture circle, and finally, whether or not people have been treated fairly over time, the social justice or injustice circle. I'm going to suggest to you that these are the three major driving forces of disparity and that these three forces overlap and energize each other and also the relative effects of these circles changes over time. I'm going to argue that these three circles of determinacy drive what happens all the way from prevention, on the far left, to detection, diagnosis, treatment, survival, and death. I'm going to suggest also that it is conceivable that these three factors influence the gene environment interaction. For example, if people live in a poor community where there is a toxic environment, what is the effect on the medics of those people? So this is an example of how there may be a gene environment interaction relate to a factor such as poverty and exposures that people get because they don't have

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resources or behavior would be another factor like that. So let me put that forth as a major part. And we're going to examine elements of these three circles as we go forward.

Let me also introduce to you another paradigm that I will put forth for you debate. And we don't have to necessarily believe this. This is what I [inaudible] at this point. Our approach to these other three circles have to be defined. Rarely we could approach disparity issues through biomedical science. And I look at the NCI budget, it's about \$1 billion a year; that budget has primarily been placed in biomedical science research. There are other kinds of science that perhaps we don't express as much. There's a social science such as sociology, anthropology. There's economics. There is psychology. So the social sciences that bring something to the plate too that have disparities. Sociologists, for example, study people as they live in their various neighborhoods and elements such as that. But yet today in my opinion, there's not much of an exchange of ideas between the biomedical sciences and the social sciences. I suggest that maybe we should stimulate that kind of exchange.

Let me add a third element, [inaudible] Human rights. Half the heart of disparities, I believe, is the matter of inequity. You can define inequity in many different ways. You could define inequity related to race, social stages,

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age, or any other factors that you could examine. But I don't think we think of disparities approach combining these three things together, which I suggest overlap and drive the problem as well. So if I presented this well, I'm saying that we're dealing with poverty, culture, and social injustice as the [inaudible] disparities. And I'm suggesting that at least as part of the solution we should think of the marriage between biomedical science and social science as well as history and combining this to approach the human rights.

There have been a number of landmark studies that have been produced. I will not name all of these studies. Here is a picture for you over time. The first major report of [inaudible] literature was from Howard University on disparities in black and white [inaudible]. And that report was written by Henske and Lefalle [ph] and indicated that looking at data that was available to anyone at that time had been a long increase in [inaudible] cancer in Black Americans in the previous 25 years compared to White Americans. And that sort of came out in the early 70s. So that is the first study that began to really focus the nation on disparities issues. In the 1980s, I led some studies that had an effect. We were going to look at the effect of poverty on cancer as well as race and poverty together because it always appeared

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to me in my own personal experience from a community of poor black people. But I didn't really understand the interrelationship between the point that the people I was treating at Harlem Hospital were coming in late and dying early. They were all black, but they also were all poor. And as a young surgeon in the late 1960s, I began to try to disentangle in my own thinking the meaning of being Black in America at that time, and also the meaning of being poor. What was driving the disparity? Could it be the poverty was overwhelming it or was it race or was it some interrelationship between poverty and race. I began to ask those questions of myself at a very early part of my career. And when I got promoted to National Officers of the Lobby to look at these issues from a national perspective, and that's what drove my career. So for the young people in the audience, look at the situation you are in. Ask the right questions. Go deeper into those questions. The answers may be right before you. Just look for those answers. That's what I attempted to do and found. But my career has been driven by a person, that person being myself, who rose to a high level as a cancer surgeon, who chose to go to a poor black community practice, who began to see people come in with very late cancer and dying of late cancer of the disease. And it raised questions of what was driving this.

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And that's the personal perspective. Now, survival is kind of a fundamental instinct that's seen in all biological forms and man is no exception. But the social, political, and economic environment in which people live determines whether people will survive and the quality of that survival. So that's a very fundamental point, so as we go to study diseases it's important to understand the elements of the disease and all of the other things that you study. But I don't think we've studied these efficiently unless we study the conditions in which people live that may drive disparities. Here's a big finding; life expectancy at birth according to race. And you can see that sex matters and race matters. Women live longer than men in general. And Black people don't live as long as White people will, male or female. So this, if you're going to look at disparities, perhaps the most [inaudible] measure of disparities is who dies too soon. I would take that as the thing drives my definition of disparity. Looking at cancer death rates in particular, you can see that African American males have by far the highest death rate compared to any other group and next African American females. So if you're looking at race and looking at a big, large data, then being Black becomes somewhat of a risk factor according to the results. The question is why.

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Another element to look at with respect to disparities is geography. And here is a very important study produced by the National Cancer Institute along with the [inaudible] data, which shows that in the blue in each racial ethnic group pictured here, you'll see that the blue represents [inaudible] communities that have less than 10-percent poverty. And in each group, the people in the blue have the best results. The red or pink, orange on this chart, represents communities that have 20-percent or high poverty and in each group that is all races, White, Black, Asian, or Hispanic, the poorer people are the worse they do with respect to cancer's oncology. An interesting point here if you look at the three bars, which are Hispanic, some call the Hispanic paradox because Hispanic people seem to do better with respect to outcome of cancer than you would expect from their poverty level. For example, if the orange, on the far side of Hispanic, which represents the poorest community, where Hispanics do better than the middle community and the Black community. So something, whatever Hispanic means, is driving something that is different that we need to understand because of the Hispanic paradox. But still, within being Hispanic in this country the poorer you are the worse would be among Hispanic people. So geography does matter and that's another factor that we need to look

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at. Here's another example of geography. And here again, data is available for researchers to look at. At the county level in America, we know incidence, mortality, and survival of every cancer at the county level. This is fairly new. At the National Cancer Institute, we picked cervical cancer to look at to see what was the result geographically in cervical cancer outcome mortality. And here's a map that deals with White females and cervical cancer. The worst results are in the purple. We see some purple in parts of this slide, and this is at the county level looking at American White women [inaudible] from cervical cancer. We picked this because no one in America should die of cervical cancer at this point, no one, not anyone should die. So the fact that nearly 4,000 women die every year from cervical cancer is unacceptable. And it's even more telling too that people are dying of things from which no one should die in certain communities that can be delineated. And [inaudible] is an important point because if you know where people are dying from what it may give you some opportunity to direct special resources to those geographic areas, which is different from a national approach that would approach say for example the point that there are 46 million uninsured American people and that's not acceptable. So there are approaches that have been taken nationally to fight disparities issues and there are

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approaches that we could take locally. We'll go a little deeper into that later. Look at Black American females and look at their amount of purple in this slide. This is a gross indicator. The purple, as you can see on the scale, is the highest mortality rate. And here you see a lot more purple than you saw in the slide with American White women. It kind of suggests that race and poverty have an effect. We need to figure out what is the synergism. But it looks to me that all of the women who are dying from cervical cancer whether they are White or Black are poor for the most part. There are some exceptions. But it also appears that being Black and poor is a factor that is something to think about. From my own personal experience in Harlem in 1990, a colleague and I wrote a paper which was published in the [inaudible] Journal of Medicine in 1990. My colleague, Dr. McCord, had spent time in Bangladesh in public health. He had the Bangladesh histories. We decided to look at Harlem and compare Harlem to Bangladesh and came up with a very striking conclusion. That is that a Black male from Harlem in 1990 had less of a chance of reaching age 65 than a male in Bangladesh. This stuck the whole national and the world as something that was somewhat incredible, but what it really meant and still means today. And Harlem is a metaphor. It's not just one community, any many Harlems

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through America and the world. It means that we have third world communities within the [inaudible]. Another [inaudible] of what geography could mean with respect to targeting resources like in Harlem, dying at high rates [inaudible] Bangladesh. I visited China in 1989. That year, I was the National President of the American Cancer Society. A lecturer there who was Chinese brought up this idea; in the Chinese language, the same word that means crisis also means opportunity, the same word. What I learned from that is a philosophical approach. So if you have a crisis, the Chinese say you also have an opportunity, but you have to find what the opportunity is. After you find what the crisis is it opens up possible ways to solve the crisis. That is in the Chinese characters that I am told mean that. I'm not sure about that because I can't speak in Chinese.

Now let me go forward with three major questions. Remember, I'm painting with a very, very broad brush here because I don't have time to filter down in great detail, but I want to leave you with some things to at least think about. So there are three major questions I'm going to raise and in part answer.

The first question is, what are the causes of disparities in cancers? I will introduce the slide and suggest what I believe they are. The second question is, is

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race a determinant of how people are treated? And the third question, reflecting back on the slide that I showed with Nixon signing the National Cancer Act, is how can we fight a successful war on cancer? I'm going to try to answer those three questions.

The first question; what are the causes of disparities in cancer survival. Now let me point out, as I've implied before, that diseases of any type, cancer and other diseases, occur in the context of human circumstances. And if we don't understand the human circumstances in which these occur we don't understand the disease. The thought is that it's necessary to understand the science of the disease, but that's not enough. It's not enough to understand [inaudible]. We need to understand people. Here's another thought, and this reflects back on the Declaration of the War Against Cancer in 1971 by Richard Nixon. That declaration supported the discovery enterprise in America particularly at the NCI, which is very important. Now please don't get me wrong, that was an important thing and a great contribution. But I noticed that in America we had fought wars before. We fought a war against the Nazis. We fought a war [inaudible]. We don't always fight the wars that should be fought, but we do fight wars in a certain way. And I noticed in the wars that we fought militarily, we discovered the weapons to use

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to fight the war are the materium [ph] and then we apply dominance in the area where the enemy was invading. That's seemed to be a principle of the military war. I suggest that we haven't done that so well with cancer. We have a fairly good discovery enterprise. It needs to be more supportive even more than it is. But there is a real disconnect I think between what we discover as a nation and the way we deliver it to the American people. We disconnect between what we know and what we do. I suggest that this is a critical determinant of disparities because if we applied what we know to all people irrespective of their ability to pay, or whether they're short, or whether they're Black or White, or anything else, this would close the gap considerably. It wouldn't enclose it entirely. So I cite this as a huge part of the problem. The discovery/delivery disconnect. Let me define what I mean by delivery because when I speak of delivery, I'm not talking just about delivery of care to people, which is a very important thing to deliver, I'm talking about delivery of information and care because part of delivery has to be to educate people about how they can protect themselves. All American people need to become good soldiers in the war against cancer, a war to save their own lives through behavioral change. So my delivery concept is a concept that involves education and access to care.

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[Inaudible] again, there's a whole spectrum of what happens to people from prevention, detection, survival, and death, reminding you of the three circles that I have already painted the picture of causes of health disparity.

And now let's talk about the issue of poverty, but we don't have long to talk only about poverty. It's a huge issue. First of all as I've said before, poverty doesn't care what race you're in. Poverty will treat you like you're poor. It doesn't care about [inaudible] you're poor or any kind of certain circumstances. Those circumstances include, but are not limited to, poor living conditions to extended housing. Poor people tend to have less knowledge and information. Poor people tend to have a risk-promoting lifestyle but not always try. And poor people clearly have a limited access to healthcare. So this is what poverty means I the paradigm that I'm painting here. So if this is true, then it means that you really can separate diminished access to healthcare from poor housing or poor education. So we medical people, we're thinking of the people. We tend to do what we know. And I'm going to remind all of us to think outside of the box that we're in with respect to the disciplines that we are doing, the surgeon or my case or anything else, because what we do is not truly separated from the rest of the world. So if you're poor you have low access

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to healthcare, but you also have poor living conditions. And I don't believe you can truly [inaudible] your poverty unless you look at what poverty really means.

Now with respect to race, you can see that Black and Hispanic people have higher poverty rates. Black and Hispanic people have lower insurance rates. One-third of Hispanic people in America have no health insurance compared to 20-percent of Black Americans and 11-percent of White Americans covered. This is an issue we need to understand, however, and painted this way. But the 11-percent of White people who are uninsured are just as uninsured as the 32-percent of Hispanic people. Here's one we could look at according to race or could look at as what is the condition in and of itself. I think we need to look at it both ways. And here again to illustrate the interrelationships that we believe occur between poverty, culture, and survival, poverty then drives negative events that I've pictured in these boxes such as inadequate physical and social environment, lack of information, tendency to risk-promoting lifestyle, less access to healthcare. Where does culture come into this picture? Perhaps culture becomes a prism to which poverty operates. If this is true, then culture has an opportunity to either diminish or accentuation poverty's expected negative effects. An example, the Seventh Day Adventists are

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a group of people of who, according to their religion, have a certain lifestyle. If you all are Seventh Day Adventists, I've visited with these people and I'm very fascinated by their lifestyle, if you're a true Seventh Day Adventist you don't smoke cigarettes, you don't drink alcohol, and you're close to being a vegetarian. Well, it happens that, that means even if you're poor, this strong cultural background and behavioral factor is going to drive you to survive. You don't smoke, you don't drink, and you eat vegetables as a matter of fact the real fact of the matter is that in studying different groups of people in the country the people who have the highest life expectancy and the lowest cancer death rate are Hispanic people. I'm not there to vote, [Laughter] but to be a virtue, to be a religion. But I think there's something to be learned about that. So here's a case where culture even overwhelms poverty in a sense with respect to outcome. But take the people in Harlem that I've worked with for now 40 years and things have improved over those 40 years, but these are people who are Black and poor, smoke heavier than others, drink heavier than others, and this thing called food is something that men haven't heard of but it's called soul food and hot, high in fat and high in salt. So it's not a really good diet.

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So I went to visit Appalachia too at a certain point. I found the same kind of lifestyle there in Harlem. Harlan, Kentucky is very similar to Harlem, New York with respect to lifestyle. It rolls, dripping, off my tongue to say those two together. So Black and White, same attitudes, same health practices, high death rate. It's was revelation to me in those earlier days when I saw the people in Appalachia very similar to very similar to the people in Harlem with respect to lifestyle and having the same problems, so culture is a very important issue.

Let's go to another factor, and that is race. Then we'll talk about race. And we don't have a long time to talk about race today, but let's put it on the table. Race, I suggest, is perhaps the single most divisive issue in the history of America and let me tell you why. Pictured here is about 500 years of American history. Going back to 1492 with the discovery of America and discovery and quotes about Columbus because it's kind of hard for me to understand how you can discover a country with people already in it. It's always bothered me a little bit. But let's say the history books say Columbus discovered America. I suggest that Columbus was discovered in America by the people who were already here. Now we have slavery introducing [inaudible] and the first slaves. A wonderful history, Declaration of

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Independence in 1776, Thomas Jefferson wrote the beautiful document. A complicated man, very complicated man to write such a document and at the same time have more than 100 slaves. Civil War. Before the Civil War for 40 years in this country and was driven by the slavery problem emancipation and reconstruction, Fourteenth Amendment, all men are equal by 1866. Plessy versus Ferguson, reverse that. Homer Plessy got on a train to test whether Blacks could be on a certain part of a train. They put him off the train. He was taken to Supreme Court and Plessy versus Ferguson with Plessy the complainant who was an [inaudible] of the standard one-eighth Black and seven-eighths White. He argued he should've been considered white but by argument he lost the case. Michigan Decision, 1974, Civil Rights Movement in the 1960s leading up to the current time when we're still debating the race issues with the Michigan Decision and perhaps some reversal could occur in a court case being heard right now. This is American history. So race is a very important issue in American history and is the determinant of what [inaudible]. What I think it means that in this nation with this background we tend to see people through the lens of race. And then we turn to value and behave toward one another through this powerful lens of race. Whereas it would be more ideal if we could see people as people first and then

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think of how people my might de-hyphenate it at a lower level of concern [inaudible]. At this point we do see invaluable toward and behavior toward [inaudible] race. And the problem with that is if you see somebody and you classify them in your mind that you're in a certain race, whether or not you intend harm, and I don't think tending harm is the American problem at this point, the problem is that we tend to see people at all through this lens as opposed to looking at human beings which we should be looking at. And the problem is then what assumptions do you make when you see somebody and put them in a certain class, but occasionally what assumptions do you make because we got to look at them. Cross assumptions can be created even when not intending harm. [Inaudible] in 2003 sort of brought this out that race matters as a determinant of how people get treated for cancer even at the same economic status and same insurance levels. So that report that was very recent brought this out. Now it's hardly true, I just know that doctors don't make exceptions about race in general with respect to how they treat people, but the question is what assumptions do we even as physicians make about people according to race. Do we make decisions that have to do with I don't believe this person is going to be compliant or can talk a certain way. Do we make those assumptions? Maybe. It could be true. So

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this paradigm is reflecting itself even through the field of medicine and even the field of medicine where I suggest that no doctor is going to mistreat anybody, but what are the assumptions. What does race mean genetically? Probably not much. How could it mean so much when the categories of race in America are undetermined or what part of government offers the management of the budget. That's what determines the categories. But if you take that framework and then clear it into the record number 15 of the OMB on race they say these categories have nothing to do with biology or anthropology but if you take the same categories and put them into science at the NIH, which we do, what does that mean? And then you begin to make [inaudible] according to race. What does it mean? You've taken a false set of categories and put them into science. There are some dangers to that, and perhaps there are some things that make sense about that and we'll go a little further. We're racialized as a country, but we don't have time to go deep into this either. But people are not biologically in races. We were put into races by a historical process again called racialization. And we go through this process and make consumptions about categories of race and put it into science and to consumption and circulate it in science you already have built in cross assumptions into science [inaudible], and yet there are

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arguments about why we can't give up the racial categories because they had equities that need to be measured, [inaudible]. Race is a determinant of how people treat [inaudible]. Let me give you some examples of that, Peter Bach, oncology, in 1999, publisher of an important paper showing that race mattered as a determinant of who go the curative treatment for lung cancer, which was early-stage. And it mattered to the point that there was 12.7-percent lower for Black people getting the curative treatment having corrected for insurance and economic status, so something is happening here and it reflected itself into survival. The same research in 2005 pointed out another point, that 80-percent of Black patients received care from one-fifth of all physicians, but Black patients in the country in general are less likely to have access to board certified specialists and that Black patients in general included these obstacles in accessing [inaudible] treatment. So this is a fact that has to be weighed and involves the fact of race and how people see [inaudible] or how people are geographically placed in America. This is something that I have a serious dialect about. An interesting study by [inaudible] on who gets transplanted kidneys, and he looked at it very scientifically. And I'll go quickly through this. This slide illustrates patients who wanted to have transplantation

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and the differences of race or [inaudible] at all. What about the people who really had access to [inaudible] the patients who really wanted transplantation? The referral pattern, much lower impacts, and the wait list much higher involvement. And these were people who had been corrected for insurance and other factors. So something is going on here that we need to put on the table. Race matters as a determinant of [inaudible] who gets treated. Who gets treated for pain, race matters.

Now going to the last part of my talk, but because of time, I'm going to move very rapidly now. The question is how can we fight a successful war against cancer. We say that [inaudible] war against cancer. It was a research war. We then connect the research to delivery of care and that's a huge problem. The first think I would suggest that we need to do as a society is to apply whatever we know at any given time to all American people with respect of their ability to pay. That's the first and major suggestion. That's how the war, I think, should be fought. The second point I would make is that it's not acceptable that we have 46 million uninsured people and won. We have 35 million additional American people who are underinsured if they have a strong enough test for being treated for disease that are complex as cancer, they will find that they are not insured enough to

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pay for their care, certainly not acceptable. We need to provide universal access to health care for all American people. Our third major point, I've given you information about geography. I suggest this, we've had tsunami, we've had Katrina. It's pointed out to the point that there are natural disasters that occur in this world that should direct how we target our resources. We didn't do so well with Katrina, but it at least raised the point. I suggest that in health care we need to delineate geographic and cultural areas of extreme excess mortality in America such as the Harlem people that we pointed out in 1990 and we need to not only delineate, we need to provide special resources to these areas of excess mortality as is commonly done in natural disaster areas with the exception of Katrina wasn't done so well. Specifically, we need to target such areas with intense education, culturally a lot of them, and trail of tobacco, and access to any diagnosis and treatment or other support. We need to in addition create a high level of awareness among medical trainees and professionals regarding their roll in eliminating bias in medical care to the extent that that occurs. We shouldn't stop with educating professions. We should monitor what happens. It's not enough to educate. Cultural sensitivity is a wonderful thing. But we have not tracks on what is really happening.

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As result, we probably won't correct this situation. This happened in the Civil Rights Movement. Monitors were placed. So you say you're doing the right thing, but what are the results. We need to monitor in this area as well. Here is something that may not be a proper thing to say, but I believe that every individual regardless of economic status needs to share in the responsibility of learning of his or her home [inaudible]. People have to be responsible for their own lives to the extent that they can be responsible. And I want to discuss the issue of patient navigators, which is particularly something that I pioneered myself [inaudible] about it. In Harlem, we noted the problems of excess mortality. At a certain point in 1990, we created something called patient navigation essentially assigning people from the community to within the healthcare system to go one on one with people who came into the system and had a positive [inaudible] such as an abnormal mammogram. And the job of the navigator is to resolve the case no matter what it takes. The amount of communication, there's a matter of lack of insurance, transportation, whatever it is. Fear. And so the patient navigators were brought into the picture operating from the point of finding to the point of resolution primarily and to go quickly to the point. We find and mention that with patient navigational screening we had a 39-

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percent [inaudible] rate with breast cancer at Harlem Hospital. I opted the intervention in both public studies. We have a 70-percent five-year survival of breast cancer in Harlem, same hospital, people just as poor, just as uninsured, and just as minority. We did something to change this. What we did was ensured them that the screen that they had and had a finding and assured them that resolved all the way through the treatment. It's a simple set of principles, but it does work, patient navigation. And here is the President of the United States signing the Patient Navigation Act on June 29, 2005 in the Oval Office and you can see that he appears to be very happy on this particular thing.

[Laughter] I won't say much more about that. [Laughter] I'm very thankful the President would consider signing this into law. It put \$25 million on the plate, a small amount of money. But when a President signs something into law it has a deeper effect, and that's what has happened. I believe there are some 300 patient navigation programs around the country, maybe more, doing different elements of navigation and this thing is catching on fast. You have a program here at this center for example.

Going back to the Declaration of the War Against Cancer, December 23, 1971, Richard Nixon, I would suggest that the War Against Cancer having been declared did have

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some benefits that we didn't use our guns very well in the neighborhoods of America where people were having the worst problems. We still are not. We need to fight our war as the way we fight a military war, apply the guns to where the enemy is invading. We need to connect our discovery system to our delivery system. What we know that should be applied should be applied for everyone in respect of who they are and whether they are insured or not. We see each other in this society according to race. We need to somehow begin to see each other as we are, which is as human beings. The fact of the matter is with the 6.5 billion people on this planet are of African origin. If we could accept that, maybe we could solve this problem or [inaudible]. That's the truth.

I would like to connect the area of justice and [inaudible] medical resources to the argument to the paradigm. Poverty should not be an offense, which is punishable by death. It's just not right. We shouldn't let that happen in this country. Here's the paradigm that I'm going to suggest again that we should certainly continue to stress the paradigm of biomedical science, the War Against Cancer, the billions of dollars that have been spent in this circle so far. But there are social sciences, the anthropologists and historians and sociologists and others who can contribute to our knowledge of disparities. And we

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should have greater discussion between biomedical science and social science. We need to overlay this with concern for injustice and human rights versus a higher level than civil rights. Human rights are more important than civil rights. And so this is the paradigm that I would recommend [inaudible] paradigm because these three circles so far are separated in this great nation. We need to create a dialogue across these areas because inequity is driving disparities more than anything else. Inequity is seen clearly in the civil and human rights circle more than in any other way. Finally, the great Civil Rights leader, the one that became and said there is a ball that forms inequality and justice in health is the most shocking and inhumane. I'll end with a comment of a scientist whom I respect the most, Albert Einstein, who in the series of relativity determined that what you see depends on where you stand. As an example, if a bolt of lightning stuck in the middle of Washington D.C. and if Dr. Williams was standing in the south and I'm standing in the north we would see this event differently from our perspective and we would be accurate from our perspective. What you see depends on where you stand. But I have said also true that there is a constant in nature, the speed of light. It moves at 186,000 miles per second. There's always something we use as a monitor for everything else, a

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constant. We look for constants while we see things from different perspective. Perhaps the greatest constant for our nation is the Declaration of Independence itself that all men are created equal. And perhaps we could use that as the speed of light for this nation we'd be much better off.

Thank you very much. [Applause]

Ruth Katz, J.D., M.P.H.: [Inaudible] we can take a few questions [inaudible]. Juan?

Juan: Dr. Freeman, you talked about the diet [inaudible] referring to Harlem, but in the diet you referred to soul food. That actually has been a transition over the years and now actually junk food would be a better description. How do you see the campaigns against what this promotes better eating and to beat obesity as part of this [inaudible] the major preventers of fast food in poor communities as being outlined for entities at that point?

Harold Freeman, M.D.: Well, you know I think it's a very important point. I say this that obesity is now in a recent study from the CDC and others have been shown as contributive to as high as 20-percent of cancer is related to obesity. And that's just one disease. People in America are fatter than they have ever been if you look at the maps from CDC, which have shown a decade by decade obesity rate is increasing and is having a deeper effect on longevity of the

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American public. Certainly, if diet becomes a critical issue in that and in New York City for example there is a risk of health in New York City is trying to pass; it may not be successful, a law that the restaurants eliminate trans-fats from all restaurants, so some things are happening around America. But I do believe that the issue of diet is very critical to health and something we cannot legislate I don't think very well, but it's a matter of training young people to adhere to certain diets. That's the best that we can do. Beginning in the school systems we can begin to train young people about the right diets. And beginning in the homes of America. So it's a very important point. I suggest that if you can control your mouth you can control your life.

[Laughter] Because if you can control your mouth you wouldn't smoke, you would eat the right foods, and then it gets into sexual activity and swallowing; things that could occur. So I think that you raise a very important point.

Juan: Could you comment on the issue of [inaudible]? Is there anything specifically about the ways of being educated [inaudible]? Recently a publication came out looking at provider activity [inaudible] describing HIV medications and [inaudible]. And the study looked at whether providers prescribed heparin vial therapy differently based

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on race. It seems to point to me that there is something within [inaudible] that actually may be [inaudible].

Harold Freeman, M.D.: That's a very interesting and point and let me point out too that [inaudible] days ago in New York City that a man was killed by policemen on his wedding day. You've probably read this in the newspaper. The interesting point about it though is that two of the policemen that shot him were black and to raise the part of the point that you are making is are their cultural things that are happening that happen to not only whether people are white providers but to whether there's a culture providing to as you see people through the lens of race. I think that we have a very long way to go on this, but there's hardly any doubt that this is true. There are so many proven examples that race matters as a determinant as to how people get treated. It's more information to suggest that the race of the provider may not be the major difference. That's somewhat needed information. So this is why I believe that the only way to get around this is certainly we should do the cultural sensitivity activities that evolve in all of our institutions and that could pay up to a certain extent. But nothing would matter as much as monitoring outcome. Sometimes people are doing the wrong thing and don't know they're doing the wrong thing. I don't believe there's

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anything that we can do but there are ways to point of picking some parameters to monitor and then it could come to discussions such as this group of people did not receive this care as much as others, then make the point. So it's the issue of culture sensitivity and education, which I think is important. But don't stop there anymore than we stopped there in the Civil Rights Movement, states in the south in particular, when they began to be monitored and then some penalties were placed. That's when the behavior began to change. So monitoring is the key.

Female Speaker: Dr. Freeman, I teach a course here at this school regarding policy and practice and I was very happy to hear you mention the Patient Navigator Legislation as our class looks at policy interventions that might be successful in [inaudible], so my question is what do you think is the chance of having the Patient Navigator Legislation really [interposing]. Do you think there are any options [inaudible].

Harold Freeman, M.D.: It's concerning that it could happen. I'll tell you why. There are now three government agencies that are providing money for patient navigation sites to be set up. One is the Patient Navigation Act from the President, which gives \$25 million through HERSA; that's [inaudible]. It hasn't started yet. Another is \$25 million

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over five years given from the National Cancer Institute to set up patient navigation programs and nine of them are around the country and one of them is here in this very facility, one of those nine. And there's a third one, which may turn out to be the most important one of the three, another \$25 million has been assigned by the Centers for Medicaid and Medicare. This is serious because if they set up sites around the country and it improves the cost effect and beneficial, that would be the one that would lead to the greatest chance I think of putting it into Medicare and Medicaid. So right now, \$75 million being put by government from those three agencies and actually \$25, \$25, \$25 million adding up to \$75 million. That is a strong task of money, not a lot of money, for the nation to try to show whether these programs work or not. In addition to that, the American Cancer Society, the Coleman Foundation, Avon, and others are supporting the circle around the country. So I think it's a pretty dramatic thing that an idea that began in 1990 in Harlem created a model that by 2006 is supported by three agencies of government and much of the private community. And I think that my prediction is that this is going to at a certain point be adopted into the healthcare system. And the reason I say that is not because it does so much good for people, which it does, but I believe it even

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saves money. And that's how decisions are made in healthcare, when money is saved.

Ruth Katz, J.D., M.P.H.: [Inaudible]

Male Speaker: [Inaudible] and I have had this discussion many times. You articulate so well the gap between discovery and delivery and how we need to fix that gap or stop it, but it's actually widening. In the pace of discovery and the ultimate likely targeted therapeutics is racing ahead of our ability to deliver those therapeutics and act on them with a passion. I am wondering if you might comment.

Harold Freeman, M.D.: One of the penalties of scientific advance is that the more you advance the greater the gap you create. Because as you go forward, now we're getting into targeting treatments on a molecular level for cancer, which you know very well because that's the field that you're in. So the advances in science always are going to be advances that the people who can afford it can get highest advances. This is the way that the capitalistic is set up. I'm not against capitalists, but this is the way it is. So there is this conflict between making progress, which we must do, and the idea of that leading edge of the progress at least in the beginning of the progress will be given to those that only cannot afford what it is. So I don't think

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there's a really good answer for that particularly when medicine more and more is being treated as a commodity instead of an art. And I think when a society that has a lot of good points, and I don't think any of us want to move out of the society, but we're in a market-driven society. The market is very powerful, whether it's pharmaceutical industries or hospitals, there's a financial element where there's research, cutting edge, and it cannot be afforded by everyone. We're in a capitalist system. As long as you have a system in which the determinant in whether you will get care is whether you can pay for it or not we're going to have this problem. It's going to take a change in thinking of the American society to fix this problem. I would suggest that as the problem is moving up in society the problem of the very poor are assigned to the middle class there's a chance that we could change the political will by public outcry as long as only the poorest people are complaining it won't happen, but now it's moving up into society. We might be at a point now as part of its solution but not all that corporate America, people that make automobiles, are now saying we can't compete with the Japanese because we have to pay for the benefits for our people. So now you're getting interesting bed partners on the access issues. You're getting people from corporate America in the same bed with

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people who were advocates. This may be a healthy thing for change, but it won't ever solve the problem that you have asked the question about and that is that the cutting edge treatment will always be a distinction about who can get the most cutting edge treatment. On the other hand, most treatment that saves lives is not cutting edge. If we can provide the routine things like everyone getting tested in the four areas of cancer that can be screened for, everyone with a finding would get treated rapidly and would get quality of care. This will solve the major part of the disparities issue. We haven't gotten there yet. It's another thing to solve the target area of top line treatment we will always have in society, I think, where paying for it would be very important.

Ruth Katz, J.D., M.P.H.: [Inaudible] [Applause]

[END RECORDING]

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