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Health Disparities: A Public Health Challenge
George Washington University School of Public Health and
Health Services
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RUTH KATZ, J.D., M.P.H.: I know other folks are going to be wandering in as they grab lunch, but in an attempt to stay relatively on schedule, let me begin first. Once again, good afternoon to all and thank you for coming. I am Ruth Katz the Dean of the School of Public Health and Health Services here at GW and I am delighted to welcome all of you to public health Grand Rounds at our school. A monthly event that is now in its second year. We continue to attract a terrific crowd to these events as you can see here this afternoon and remain committed to making them an annual tradition.

For those of you who have not joined us before, let me take just a few minutes and tell you a little bit about our series. This year's Grand Rounds are built around the theme of translating science in the public health policy. Julie Gerberding, director of the Center for Disease Control and Prevention got us off to a great start in September with her talk about health policy and politics. We were joined next by Doctor Arthur Kellermann from the Emory School of Medicine who helped us understand why people with health insurance should care about people who don't have health insurance and last month Doctor Lynn Goldman of the Johns Hopkins University, tackled the challenges of making public health policy decisions about chemicals in the face of uncertainty.

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Each speaker helped to highlight the real importance of scientific research and public health. Not because it leads to abstract knowledge, but because it generates results that can be applied to real world problems. That is a commitment we take very seriously at the School of Public Health and Health Services. Indeed, our purpose is to shape policy and inform the law, to identify best practices in public health, and to influence the structure and financing of our health care system. To do good science and use the results widely means forging links that cut across many disciplines. We need to reach out to clinicians and bench scientist as well as legislators, policy makers and community advocates and to talk together about what we know, about what we need to know, and how we can use the information that we have.

We do much the same thing right here at Grand Rounds which is one reason we have an open invitation to these lectures. Today's audience includes students and faculty, not only from our school of public health and our medical school, but also other schools throughout the University. We also welcome people from the community. Your presence here tells us that you understand the important role that public health plays in all of our lives.

The next Grand Rounds are scheduled for January 22, at noon right here in this auditorium. Doctor Russell Pate from

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the University of South Carolina will be here to talk about the importance of promoting physical activity among young people. For updated information about future Grand Rounds programs you can log on the school's website and I would encourage you to join us whenever you can.

Finally I want to emphasize our gratitude for the support we receive from Pfizer which make these Grand Rounds possible. Without Doctor Barbara Debono in particular, who is been the company's champion for this series, we simply would not be able to do what we do. We are also indebted to the Kaiser Family Foundation for helping us to webcast and Podcast the entire series so that we can share it with the much wider audience. Thanks to the Foundation's generosity, you can also download earlier Grand Rounds events if you happen to miss any of them.

And now it is my great pleasure to introduce our speaker this afternoon Doctor John Ruffin. Doctor Ruffin is Director of the National Center on Minority Health and Health Disparities at the National Institutes of Health. It is no exaggeration to say that Doctor Ruffin has transformed this nation's approach to minority health issues and health disparities. For decades he has lead efforts to improve the health status of people of color in the United States and to develop educational programs to train minority scientists and

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other health professionals. At the NIH, Doctor Ruffin has been the visionary force behind an enormously ambitious research agenda targeted at the complex scientific and policy issues associated with minority health. Indeed it was largely through his efforts that the NIH developed its first health disparities strategic plan. And across the country, a growing portfolio of research and training activities can be traced directly to the seeds that he has planted. Over the years Doctor Ruffin has demonstrated tremendous talents for forming alliances, recognizing that the solution to minority health challenges will not come from a single institution and that many players have important contributions to make. He has often brought unlikely players to the table. Through his efforts, representatives of key public agencies, community based organizations, academic institutions, and the private sector have actually come together in common cause.

Doctor Ruffin received his PhD in systematic and developmental biology from Kansas State University and conducted post Doctoral Studies at Harvard University. His efforts have been recognized with numerous awards including the NIH Director's Award, The National Hispanic Leadership Award, and the Presidential Merit Award. It is my great pleasure to introduce to you now Doctor John Ruffin. We are so delighted that you could join us today, Doctor Ruffin.

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JOHN RUFFIN, PH.D.: Thank you so much for that gracious introduction and good afternoon everybody. I am extremely honored to tell you for your public health grand round and to be among such an illustrious group of presenters that you just mentioned and you have chosen for this year's participation. I am also pleased to learn that the issue of health disparities is becoming a notable area of focus on your agenda at GW and in particular, I want to commend Doctor Mahonies [misspelled?] and his team in the Department of Prevention and Community Health for the work that they are doing, not only here at GW, but out in the community and around the globe. I know because we are supporting some of that work. During today's discourse, I want to try to do four things. I would like for us to look at defining health disparities and by that I mean what do we mean when we talk about health disparities? The second thing I will spend some time talking about would be the transformation of health disparities through health policy. What is the history behind all of this? And I will spend some time dealing with the historical perspective. The third thing I want to spend some time talking about would be the consequences of health disparities. What has happened and what will happen if we continue to ignore the escalating problem? What are some of the gaps that still need to be addressed? And then actually if you stick around with me for a

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bit, particularly the students, I will talk with you about progress. What are we doing to overcome health disparities and to tell you where I think you particularly as med students or students in public health field may be able to help us to solve some of these problems. My opinion is that health disparities exemplify the most urgent national economic crisis of our time. I think that each year the United States spends billions of dollars on diagnosis and treating disease. Yet, there are 47 million Americans depending on whose numbers you want to look at, who have no health insurance to access treatment. Racial and ethnic minorities account for more than half of that population. Each year, hundreds of thousands of Americans die from preventable conditions including nearly 300 thousand deaths due to poor diet and inactivity. Not to mention the burden of disability and the high rate of hospitalization. And we ask ourselves where is the public health community, our experts on prevention?

At the turn of the millennium, the issue of health disparities gained national and now increasingly global momentum. Your theme for this year, your theme for this year's grand round, translating science into health policy, is quite fitting. Health disparities is wooded and complex interactions are different factors such as race, such as culture, biology, environment, socioeconomics, politics, stress, access to care,

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and yes, discrimination. Through science we seek to enhance our understanding of ideology of disease and the inter play of the areas determinacy of health disparities. Our goal is to find the underlying causes, develop interventions, and translate our findings into practical tools that would benefit the public in health care professionals. The application of health policy is imperative in improving the systems that are failing too many Americans. Translational research is about sharing what we have learned in a timely and more efficient way. Translating science into health policy is like a puzzle with several pieces. It is about health promotion, it is about prevention, it is about diagnosis, early intervention, risk factors, new knowledge, treatments, cures, and lifestyle strategies. It is also about empowerment, educating people about their rights and opportunities available to them based on discoveries and emerging policy.

Health policy is a powerful tool in advancing the elimination of health disparities. The creation of the National Center on Minority Health and Health Disparities at the National Institutes of Health referred to as NCMHD is evidence of the impact of health policy. The NCMHD was created by the enactment of the minority health and health disparities research education act of 2000. Since the creation of the NCMHD, there has been increase awareness and studies on health

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disparities, but for many people it is still not clear what is meant by health disparities. I think understanding the issue is pivotal especially when we think about measuring progress. At the national Institutes of Health, here is how we define it: We define health disparities as differences in the incidence, prevalence, mortality, and burden of disease and other adverse conditions that exist among specific population groups in the United States.

Our greatest challenge has been to convince people. And when I say convince people, I mean to a grave extent, people like to make a difference that health disparities are real. But thanks to enraging research findings as alarming as they may be, the statistics are quite compelling. I am going to show a few slides. I guess this is my, thank you. If we look at diabetes, a preventable disease, we learn that it is the cause of 5 percent of all deaths around the world. In the US, 50-percent of adult Peemee [misspelled?] Indians have diabetes. I wish I could tell you and had time to tell you the stories. I have visited many, many times the Hela River [misspelled?] Reservation and have witnessed the devastating effect that diabetes is having on the Peemee Indians.

Hispanics for example, Hispanics have a 90-percent increase risk of developing diabetes. My question is what role can you play as public health professionals and helping these

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populations and delaying the onset of diabetes or disease management? Cardiovascular disease is the number one cause of death globally and in the United States. When we look at the different forms of cardiovascular disease we find that high blood pressure is most prevalent in racial and ethnic minorities and is a major risk factor for heart disease, strokes, congestive heart failure and kidney disease. The statistics on heart disease I think are kind of quite interesting. Let me just go back to this slide. I think the statistics are quite interesting. Native Hawaiians and Pacific Islanders have the highest rate of disease. American Indians, Alaskan Natives, and Whites, are on par with an 11.6-percent rate. We get the impression that African Americans are doing pretty good when you look at those rates, but we find that the morbidity rate in African Americans is higher than it is in Whites. And so as researches, this is the type of help disparity that we are seeking to understand.

When we look at cancer the effects of cancer on racial and ethnic minority population varies by the population and the type of cancer. For example, take breast cancer; African American women are much more likely to die from breast cancer. Although they are less likely than whites to develop or be diagnosed with it. Some experts attribute this to African American women having more aggressive tumors and often starting

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care later. My question though, is as public health professional, we have to ask ourselves why are their tumors more aggressive and why do they start treatment later?

When we look at cervical cancer, I think it is appalling, when we look at Vietnamese women they have five times higher rate of cervical cancer than white women. Asian Americans also have the highest rate of stomach and liver cancer. And so when people ask no matter what you, how you want to define health disparities, I think the statistic defines itself when you begin to look at statistics you begin to see that this is what defines what we mean by health disparities.

When we look at HIV AIDS world wide the highest rates for people living with HIV AIDS as you know is in Sub Sahara in Africa with 61-percent of them being women. In the United States, 49-percent of HIV AIDS cases are in African Americans. If you live in the Washington DC metropolitan region, then undoubtedly, you must know that this city leads the nation with HIV AIDS cases. Can any of you fathom from last week just dated that we saw, can you fathom the reality that nine out of ten women in this city who have HIV/AIDS are African Americans. That is nine out of ten. This is an, I will back you up. This is not necessarily in our backyards; it is right on our front steps. It is in our sandbox, so my question again is what are

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we doing as public health professionals to deal with these kinds of statistics?

When I look at infant mortality although we have seen some decrease in the overall infant mortality rate, the United States still has one of highest rates among developed countries. In cities like Washington DC, Memphis Tennessee, the infant mortality rate is higher than it is in some developing nations. In Montgomery County for example, the rate is 14.9 deaths per 1,000 live births. Compared to a rate of 3.6 for white women. Can you believe an African American woman living in Montgomery County has four times the infant mortality as a white neighbor? My question is what are we missing? And where are our public health professionals? Now I do know that GW again, under the leadership of Doctor L. Mohandas [misspelled?] I think Winzer [misspelled?] and Blake, all of you I know your work, you are participating in a NIH, DC initiative to reduce infant mortality and I thank you for that. This initiative is supported by the National Institute of Child Health and Human Development and the National Center on Minority Health and Health Disparities. I am pleased to learn about the progress that you have made with Project DC Hope. The external and internal institutional collaboration that you have fostered demonstrate the value of the multi faceted approach that we believe is necessary to solve the health

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disparity crisis. And we look forward to learning more about the behavioral interventions and reducing the risks of smoking, depression, interment pardon of violence in pregnant women.

The other thing that we don't want to forget to mention because I am going to say more about it a little bit later on in my discussion, is that the NCMHD constituency goes beyond racial and ethnic minorities. World populations also experience health disparities. Less than 10-percent of the nations practicing physicians practice in rural communities. This tells you something. People have to go a long distance for help, screaming, almost unheard of because of what is not available to them and when we look at places like rural Appalachia, where they have the highest death rates from lung cancer in the nation, do we still question whether health disparities exist in rural America?

These statistics that I have shown you here just simply portray what we mean by health disparities. And you asked the questions how do we get here? How do we get to this point? Well let me tell you a bit about the transformation of health disparities over the years. From the health of blacks and whites to minority health and now health disparities. We made those kinds of progression.

Disparities in health have existed for centuries. In 1896 statistician Fredrick Hoffman in his thesis on race,

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trade, and tendencies of the American Negro, attributed the poor health status of African Americans to inherent susceptibility and what he called racial inferiorities. And then by 1906, W.E.D. Dubois, began to examine census. Began to look at vital statistics and insurance data. To produce a monograph entitled *The Health and Physic of the Negro American*. A documented the poor health condition of African Americans compared to white Americans. Dubois' findings pointed to socioeconomic conditions as a cause. He later called for improved hygienic conditions, more economic opportunities and better education to increase the health of African Americans. Several resolutions were passed that emphasized many of the same strategies that we are re emphasizing in the 21st century if you can believe it. The resolution underscored the correlation between research and social reform. They emphasized health promotion, prevention, and the creation of programs and health facilities to address the health of African Americans. This was around 1906.

The struggle of contentment for many decades to bring attention to the health problems in this country from the creation of health movement initiatives like national health week, the establishment of the office of Negro Health Work and The United States Public Health Service to the evolution of civil rights movement, but the civil rights movement was

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brought about the abolition of segregation as laws and the dismantling of facilities that denied African Americans equal medical care. The point is a health policy that is unfair, is a proliferation of health disparities.

By the late 1970's., reports promoting prevention such as health people started emerging. But it wasn't until 1983 when Secretary of the Department of Health and Human Services at that time, Robert Heggler [misspelled?] raised the Nations consciousness about the disparities in health status between African Americans and Whites. That is where the issue began to gain some validity. She put together in 19 member task force to study the issue. The result was the 1985 Black and Minority Health Report. It was the first most comprehensive report of our time to illustrate the scope of health disparities in this nation. It revealed that disparities did not only exist among African Americans, but Native Americans, Hispanics, Asians and Pacific Islanders, also some disproportion from many disease death and disabilities. The report recommended improving education, research data, and communications among agencies. And response in office of minority health was created in the office of the secretary of the DHHS. In subsequent years, regional offices of minority health were created nationwide. This time it was not just about African American health, but the health of minorities.

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By 1990, the new HHS secretary, Doctor Lewis Sellerman [misspelled?] continued the implementation of the reports recommendation. At the national institutes of health, he created an office of minority programs. It was referred to as ONP. Within the office of the director at NIH, which I was at that time selected to lead, I want you to watch the evolution of that office because many misunderstood at that time the purpose of this office. And they viewed it as an equal employment opportunity office instead of an office full of minority research programs. With a budget of 1.5 million dollars which came out of the discretionary budget of the director, the ONP saw a public input and to how that money should be used. 53 member multi disciplinary and racially diverse fact finding team, was established and it provided 13 recommendations that formed the basis for the ONP priority. That I must tell you was a very, very important committee. My impression at that time was at the 1.5 million dollars what can you do? What we were going to try and do with that money is to pull together maybe about 15 or so people and have those individuals to talk to us a little bit about what is it that we should be doing that we are not doing? One of the things that you learn right away when you deal with an office such as mine you learn that you are dealing with such a diverse group of concerned individuals that there is no way you are going to get

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away with 15 people, so by the time we started talking about training and you have a group of individuals there that are interested in K-12 education, undergraduate education, training, you are going end up with superintendents and teachers and everybody else. When you are dealing with diseases that disproportionately impact all of the different groups that I just mentioned to you, they all want to be at the table.

Let me tell you, by the time we finished with that group, my first decision in that office was created was to stop this escalation of this group at 53 and that is why we call it the 53 member task force. Let me tell you, and you can get copies of this from my office, be careful when you put groups together because I can tell you that group, just to mention a few people, I had at that time Dave Satcher [misspelled?] who chaired that group for us, but Dave was not at that time surgeon general, I made him Surgeon General. He was not the Surgeon General at that time he was the President of Meharry [misspelled?] Medical College. Also Ben Carson many of you know from Johns Hopkins was also in our group just to mention a few people, Theodore Cooper, some of you here would know Theodore at that time he was the CEO at Upjohn, also on that committee was Barbara Jordan who at that time was at the LBJ School of Public Health, Jill Propedge [misspelled?] was on

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that committee from Howard Hughes, Leon Rosenberg from Yale was on that committee, and you always got to be watch this one, there was a woman on that committee from the University of Wisconsin Madison named Donna Shelayla [misspelled?] who served on that committee. That is an interesting one because I remember when we put this committee together just to sidebar here a little bit, when we put this committee together one of the things that Donna Shelayla said to me was that you know it worked for the NIH before and we have done a lot of work for them and a lot of recommendations have come forth and what happens is that these recommendations sometime were placed on the shelf and they gathered dust, but if you would promise us that these recommendations that we will give to you will not gather dust on the shelf, we will work very hard for you. So little did she know was that she then was going to evolution this whole thing at some point become my boss. So whenever I would call her office and would ask well can I tell her what it is about, I always said the same thing, it is about making sure that these recommendations she gave me is not going to gather dust.

So we had a group of 53, but let me tell you, there is a very, very, strong group of people and all we asked of them was simple, we said, what is it when it comes to health disparities in this country that we should be doing that we are

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not doing? And it took me around the country. At the end of that, the last meeting was in San Diego, I sequestered them in San Diego, and I said this is where you stand until you give me some recommendation. I think you should look at these because these are interesting recommendations that came from the people and all we did was have microphones up and down the aisle and that is all we did. When it comes to training, when it comes to health issues, what is it that we should be doing that we are not doing? And from that, these recommendations evolved.

That is what we did with 1.5 million dollars and I can tell you that was a good use of 1.5 million dollars. And then in 1993, the NIH revitalization act, created the office of research on minority health. Renaming the ONP and increasing the office budget. So ORMH was very significant. It was no longer the office of minority programs, but now consistent with the mission of the national institutes of health. It was the office of research on minority health. And we had an increase budget. The ORMH working in collaboration with the other NIH institutes and centers and other HHS agencies. Continuing the implementation of the fact finding team report, new research and training programs were developed as a result and implemented and proved the office of research on minority health and because the ORMH liked funding authority, many of institutes that administered the programs and so there were a

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number of programs that came up that many of you may be familiar with like the Jackson Heart Study in Mississippi, you may be familiar with the Bridging Program, Bridging to the Future which is conducted out of NIG Madison, many of the other programs, many of those programs came out of the office of research on minority health. But at that time, just to give you a little bit of history, if you were locating in the office of the director at NIH, you want even if you have money, because we have dollars, you are unable to make grants because only the categorical institutes and centers at that time could actually make awards, so while we had money, we had to broker that money with an institute or a center in order to spend that money, and so many of you would not have known for example, that many of those programs originated in the office of research on minority health and was funded out of the office of research on minority health. But in 2000 something very significant happened. In 2000, minority and health disparities research and education act of 2000 was passed by the congress to establish the national center on minority health and health disparities. The center was charged with conducting and supporting research to improve minority health and eliminate health disparities. It was also given authority to coordinate all minority health and health disparities research activities at the national institutes of health. Which included the

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development of the inner age health disparities strategic plan which you heard the Dean mention?

Now, some crucial changes that is brought about. People often ask me well what is the difference in being in office, the office of research on minority health and now being the national center on minority health and health disparities. Well let me tell you the significance. First of all the constituency base was broadened which was reflected in the center's name. The national center on minority health and health disparities. No longer was it just about the health of ethnic minorities, but there were low and low socioeconomic populations that experienced similar disparities. Almost 20 million white Americans live in medically unreserved communities and we were charged to develop programs for those populations as well.

So the constituency based considerably brought, secondly the NCMHD was given grant making authority. It no longer had to depend primarily on the other ICs, the other institutes and centers to fund programs. The NCMHD was mandated, this is the third thing, it was mandated to develop some specific programs and I am going to tell you about some of those programs at the end of my discussion here because I want you to know about those programs. Some of those programs were congressionally mandated and those programs were

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congressionally mandated to us to advance the nations understanding of health disparities, build the capacity of academic institutions to study minority health and health disparities and increase the pool of individuals from health despaired populations in bar medical research and the health professional.

This is a snap shot of the evolution of health disparities at the influence of health policy. This is the kind of history that you have to hold on to as you formulate health policy. We have been down some of these paths before, but what has been liking is commitment. At the level where the power resides to make change. We have come a long way, but there is much more to be done and I think the statistics that I mentioned to you earlier tell that story. But I believe that history is vital. It is a vital element in the formulation of health policy especially when we talk about translating signs into health policy. The passing of the health policies, resolutions legislation associated with the evolution of the health disparity issues were contingent upon research findings. Providing the proof to alleviate the problem. Health policy has to be well written in order to be correctly interpretive, adapted and implemented and most importantly, it requires monitoring and sustainability of the initiatives and sanction. Nothing I hear more when I am out in the field talking to

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people is that we start a good effort and before we can finish the job, that particular program no longer exists. If it is working, we have to stick to it until we get something done.

Eliminating health disparities is a public health challenge because of its complexity and because it has taken us centuries to recognize the enormity of the problem. Although data was gradually emerging, we kept ignoring the warning signs. For example, until the CD syphilis experiment it was a historical symbolism of the effect of bad signs and deleterious health policy. For 40 years, 1932 until about 1972, you know the perception and you know the reality, this study on syphilis and blacks and whites ensued. The men were never informed of what disease they had; instead they were told they were being treated for bad blood. In reality, a few men received inadequate treatment to cure syphilis and both received no treatment at all. Thus being left to degenerate, develop complications and die, and worst of all in some instances, to spread the disease to their wives.

I mean the ripple effect that we are still striving to overcome is really distrust for the medical community among minorities. Not just African Americans, it is more action ate that we are challenged today in recruiting and retaining racial and ethnic minorities in clinical trials. That is a big, big job for us. As public health professionals, we cannot continue

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to ignore health disparities. But the skeegy [misspelled?] experiment lead to some changes in health policy at HHS. Changes continued to take place and today for example we have in HHS office for Human Research Protection. Human Subject Research guidelines and a United Age Policy for example on the inclusion of minority and women and clinical research. We have also seen improved guidelines on informed consent and in efforts to enforce the privacy rule. All of this change and all of this is positive change. Health policies can be beneficial. Health policies can be beneficial, but they can be detrimental, and they can also be unjust. Health policies or a lack there of, can also be dehumanizing.

I can tell you about I guess it was about two months ago a group of women came in to talk to me. And what they wanted to talk to me about was that they wanted to give me a copy of a presentation from a seminar that had been actually presented in NIH. To my disgust, it included slides depicting a black woman in Africa undergoing a gynecological examination with no protection of her identity or private parts. What does this do for the dignity of women because there is a group of women who brought this in to me and by the way, none of them, none of them, were minorities, they were all Caucasian woman upset by what they had seen. And what does it do for the progress we are slowly making and recruiting minorities and

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women into clinical trials? And what does it do for our efforts to rebuild trust for the medical community among minorities?

This is a prime example of how the translation of signs and health policy intersects. This is where some common digression, some humanity and cultural sensitivity have to be applied. And it raises the question of whether there is any health policy to protect research participants from this type of indignation. What can you do as public health professionals to alleviate and irradiate these acts of injustice? And what impact might health policy have in a case like what I have just sited?

Health policies can accelerate or delay scientific advances. It all depends on the motive. Our goal is to accelerate research to eliminate health disparities. But what are the consequences about continually neglect? Some of the statistics that I have shared, some of the statistics that I have shared with you are the consequences of having ignored the growing differences in the health status among Americans and global populations. For centuries, we have looked the other way at this health oppression. No longer can we say not in my backyard. The disparities are staring us in the face in our communities. This is a public health challenge and it is a public health challenge that we cannot afford to ignore.

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Although the issue of health disparities is not well understood for various reasons, it is one that continues to progress and metastasize if we don't intervene with aggressive treatment. The consequences will be individual, the consequences will be institutional, and the consequences will be societal.

Health disparities are expensive. They can take a financial toll on a person, they can take a financial toll on a family, they can take a financial toll on a community, and they can take a financial toll on a country. I am talking to my economic friends all the time and I am told that chronic diseases alone are counted for 1.3 trillion dollars in the United States in 2004. And we know the statistics on who bears the disproportion and burden for these diseases. We are also in the midst of a rapid demographic shift, so think of the long term consequences about the people who are bearing the burden and the people who are likely to be in the majority later on. According to a recent report that I was looking at, the charges for preventable hospitalization in Connecticut for example, totaled about 893 million dollars. A 46-percent increase from about two years ago. Misdiagnosis and late intervention lead to preventable and costly complications, thus increasing the burden of illness. Lost productivity from sickness and disability triggers stress, poor health and higher personal costs. Minorities and person of low socioeconomic status are

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less likely to receive cancer screening services and more likely to have the late stage cancers when the disease is finally diagnosed. Without screening, cancer may not be detected until they metastasize to other sites.

I am talking about the economic burden of all of these diseases. So the question now and I am going to skip a little bit, the question now is what do we do? What progress should we be making in order to look at some of these problems and to diagnose some of these things? One of the things that I know for sure and that is that, you are not likely to get much done unless you have a work force that can deal with many of the issues that I have tried to demonstrate to you. And how do you get these workforces? How do you get a strong workforce? We have learned a lot and I think that what we have to do is to continue to look at good models and to adopt some of those good models. Don't need to do anything new, for example, some of the things that we are doing in the National Center on Minority Health and Health Disparities are things that have been done in other places and done in other things. For example, if you look at the AIDS epidemic, clearly what we have learned from AIDS we wouldn't know if it were not for the fact that we have created some interesting programs. The AIDS loan repayment program for example, that was a great program because the loans that particular program says we will take individuals who come

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and work and we pay your loans off. We have adapted a similar program in the Office of Research on Minority Health. It is our loan repayment program and what we say is for those individuals who are interested in doing health disparity research, we will pay off your loans. You do health disparity research. Now our program differs from the AIDS loan repayment program because it is all health professionals. Keep in mind the AIDS program was only for MDs; this program is for MDs, PhDs; dental, nursing, all health professionals can participate in our program. Over 1400 students are being serviced by this program now. We have got to make some trips where you see the blue stuff, but that tells you that we are all over the country.

Okay, I want you to know one thing that is important for you to know and that is that everybody participates in our loan repayment program. And this is something that I often time have to emphasize because when you evolve as we evolved, I took you through the history because I wanted you to know that when we started out, we were in fact, if you ask me, John how did you spend the money in OMP and how did you spend the money in the Office on Research on Minority Health? It was on ethnic minorities. But keep in mind I told you we became a center right? I mean we became a center, it means that everybody

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participates and helping us to solve the health and disparity problem.

We have like 1400 loan repayment recipients that we are supporting and that are the breakdown. 37-percent of those individuals are Caucasian. 34-percent of them are African Americans and you can see the other and if I had the time and next time you invite me back, I will take you through some of the work that individuals are doing around the country. The important thing here and I am running out of time is that if anybody were to ask me as they used to, am I the life I was a Dean, folks use to call me all the time and say hey can you help me find somebody who can do X, Y, or Z? I said sure, but I am looking for one too. I am telling you that this loan repayment program is working and that if you called me now and asked me if I could help you find them, I can tell you where they are and I can tell you what state they are in and what they are doing in those particular states. These individuals have got to have a place to work. We have centers of excellence around the country now that deals with health disparities. Hey, we didn't have to think of that either. Haven't you heard of the cancer comprehensive cancer centers? If we were to find cures for cancer I can tell you now are going to be in those comprehensive cancer centers. That is where it is going to come from because that is where the

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resources are. This is where our resources are. It goes into our centers because we want to make sure too that some of those loan repayment people cycle right into some of our centers.

I don't have time to tell you about some of the research that is going on in those centers. Dean before you cut me off, I know you want to hear about this because all Deans want to know about indominance. One of the things that came out of the law that created the center was the ability to give indominance to universities to develop biomedical strong base, a good foundation for biomedical research. Particularly as it relates to health disparities. It is a limited program, but there are a number of institutions that we are supporting, but majority and minority institutions that we are supporting to do and they are getting indominance to do those programs. You can see the limit, the limitation of that program by the numbers of them that are in go.

The last program I will tell you about is the community based participatory program. The reason I want you to know about them is because I really think that this is going to be our premier program. Because it comes closer to being what we need and what we want. This program will support you for 11 years. What happens is that you get three years of support which really is like a planning ground. You get three years to work with the community, to figure out who your partners are

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going to be and what it is that you are going to work on. You do that right; you are eligible then to apply for the intervention phase which is five years of support. To do the research - I can count eight years - and that research is completed after five years, translation becomes important to us. It means that if you have done good research, it often now finds its way into the community. So you get three years to do that as well. That is 11 years of support for the community based participatory program.

I am going to stop because I have got perhaps say some of the other things that I like to say if there is some questions, okay?

RUTH KATZ, J.D., M.P.H.: Questions? Mark if you will get us started.

MALE SPEAKER: Yes Doctor Ruffin I just have a question of research agenda. A lot of the policy documents that Commonwealth Fund, the Institute of Medicine and other reports have to do with disparities in health care. But as we know as you mentioned as a lot of the allures mentioned, there are a whole range of issues related to the socioeconomic disparities that figure into the picture that are important so, I just wondered in terms of the research agenda and also in terms of how we figure on measuring progress, and how those things are being addressed.

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JOHN RUFFIN, PH.D.: Yes that is an excellent question. What I didn't get a chance to talk about is partnerships because that is how you are going to get it done. The mission of the various agencies are all different. For example, HERSA, that indominant program that I am talking about, that is a collaborative program between a National Institute of Health and HERSA. We have a number of programs, for example, many of you are familiar with CDC's Reach program. Well that program what you don't know is that too is a collaboration between CDC, NIH, HERSA and all of us coming together. The secretary has now put together a health disparity council within DHHS which consists of the leadership of all of the various agencies, SAMPSA, HERSA, NIH, all; there is no way we are going to get this done except to integrate those missions. To not only integrate the missions as it relates to policy, but integrate the mission as it relates to institutions on the ground. We talked for example about the difficulty of recruitment of minorities in clinical trials. The partnership that you now seeing evolve between Vanderbuilt and Meharry. The partnership that you are beginning to see between Morgan State and Johns Hopkins. Partnership between Tuskegee and the University of Alabama, Birmingham. These are the kinds of partnerships that we support with our centers and these are the kinds of partnerships that are going to make those kinds of things

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happen. No, Tuskegee may not have the research capabilities that the University of Alabama, Birmingham has, but let me tell you, they can recruit the participants to participate in the research. The Jackson Hodge study would not be where it is today if the University of Mississippi had to go it alone. Only because they have two good colleges in Mississippi and have Jackson State to do the recruitment and participation so, it is all of that kind of partnering that is going to take to make this happen and to make this work.

MALE SPEAKER: Well, we applaud you sir and we welcome you one more time amongst our family, but the question I have for you is this new model that you have created in community participatory research center is funding is really a model program and in 11 years from now we are going to look back at the intelligence that produced that concept, but people also want to look at milestones and evaluation of such. A novel concept I must admit. Have you thought about how you are designing the evaluation of the entire initiative so that you can in a generation from now; tell people how important that is in transition design?

JOHN RUFFIN, PH.D.: Congress has helped us along the way with that as well because as you know, when our office was created, in law it says that within five years the secretary of Health and Human Services would design that evaluation to see

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whether or not the program is working. And essentially what we did this last year is that we had the institutes of medicine to come in and design the evaluation of that program and of that program means the health disparities strategic plan. I will take a minute just to tell you this because this is important and a lot of people think that because the law that created the center gave us the authority to develop the strategic plan that the strategic plan is a plan for the center, our center. That is not true; the health disparities strategic plan is a NIH strategic plan. There are 27 institutes and centers at the National Institutes of Health and there are 27 strategic plans that we have to coordinate. Under one umbrella that constitutes the NIH health disparities strategic plan. And that plan by law has a design to it. It says that each institute will put their plan together and they will submit that plan to us. We by law have a consult of people who have to look at that plan. Only after and none of those, none of those individuals, are feds. They are all public people on that counsel. They come in, they look at the plan and they make a decision, yes, this plan has all the elements that we think it should have. When that has been done, the plan then has to be sent to the director of the national institutes of health. The director of the national Institutes of Health can get whatever advice he or she believe is necessary. Send it

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out, send it to another agency for input, et cetera, but at the end of the day, the director of the National Institutes of Health has to sign off on it and once that has been done, they have to send that plan to the Secretary of Health and Human Services. The same thing takes place there, once completed there, the secretary must sign off and it is then sent and forwarded to the Congress. So that plan, that plan then has teeth to it, but before that plan gets to the Congress, you can be involved. There is a place in there where that strategic plan is placed on the NIH website for public opinion, so if you were interested in cancer and you felt that enough emphasis, there wasn't enough emphasis being placed on prevention and you don't say anything? Tough, you lose your right to gripe when you don't say anything, okay? So you have a right to review every plan, every strategic plan at the National Institutes of Health from every IC and the law also says that not a dime is suppose to be spent on health disparity except it be spent through that strategic plan. Do you get it? I mean there are tying our budget and what we spend on health disparities to that input and that information. I don't think there is anywhere else where you are going to see a strategic plan as tightly put together as the one now dealing with health disparities. I would like to take credit for it, but I can't. You know who I think really deserves the credit for it? I

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think it is the smart staffers on the Hill that should take credit for that. They are the ones who did it. Yes sir?

MALE SPEAKER: [Inaudible] I just wanted to, I have been working with the minority health laws the past few years and there is now actually I think it was finally approved last week the large strategic frame work for eliminating health disparities and I am sure there is some coordination going on, earth gram and now working together with independer, it is also a very broad which can be used for evaluation of both the health care issues and also some of the other mediating variables that go.

JOHN RUFFIN, PH.D.: Yes, I mean that, we work very closely with Garth and with the Office of minority Health because a number of their issues, you know sometime we are defining biomedical research we can find it so tight that sometime we can only get some of the things done and some of the communities that we wish to reach except through the other agencies. We work very closely with Garth and putting some program in place to deal with the aftermath of Katrina and many of the other issues that are kind of far reaching, unanticipated issues that are clearly held disparate, but you have to pull it together the right team of people to get in there and do it and so yes, I know about a lot of work that is going on in Garth's office. Yes mam?

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FEMALE SPEAKER: I want to come back to the point about getting focusing on clinical interventions or health care interventions and trying opening it up a little bit more broadly and I wondered since we know that economic circumstances underlie so much of what drives health disparities, is your office already in the business? Or is it open to thinking about interventions which change people's economic circumstances, better job opportunities, and better financial stability and so forth and so on? Is that under the preview of what the NIH can intervene on?

JOHN RUFFIN, PH.D.: Poverty you know poor people and how you design programs to deal with those kinds of subject is really not going to be done by NIH alone. Both those are just areas where NIH will have to partner and continue to partner with others and it is not just in that health care side for example, let me give you an example on the training side of what I am talking about, NIH is in the business of training, but what we do most of our initiatives is from undergraduate going forward, undergraduate, graduate, post doctoral and so forth. But you know and I know that if we are going to increase the pool sometime if you look at the triangle, we have got to do something at the base of that triangle so K-12 becomes very important and what do we do to get more individuals in general minorities in particular, into signs?

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Well, a K-12 bracket for example is not a bracket where NIH does a lot of work, very, very few programs, but who does? Inner self and what we do is that we exchange dollars with [inaudible] the same way we do with other institutes and centers in NIH. We say to them if you allow us to develop the life science part of this, you develop as you are often time do, the math, the engineering portion of it, and then we will transfer our dollars to you. If you allow us to participate in the evaluation I will come to see how well this is working and who is getting our dollars and whether or not it is doing what we want it to do, we will transfer our dollars to you as opposed to NIH trying to develop a K-12 program on its own. What we have to do the same thing over on that health care side as well. We have to work more closely with Robert Wood Johnson, we have to work more closely with pharmaceuticals, and we have to work more closely with a bunch of other agencies and places, foundations to get this job done because it will not fit with NIH's mission alone. Yes sir?

MALE SPEAKER: My wife would have been on that, two of the examples, one of the examples that you gave that female example is one that is particular interest because that group in the United States has a 50-percent incidence in diabetes, but the same group in Mexico has normal rates. They are not at all affected the way that our population is and so clearly

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something else isn't working and clearly these are not issues that are not genetic issues, they are not necessarily biomedical issues that work and so in terms, since we know this, and since we all know the trend of a lot of century is the disparities are increasing not decreasing in spite of our increase in technology, how then do we translate that knowledge that is barely deviology [misspelled?] into a larger change outside of the narrow view of the institutes and some of the educational programs? This is really a governmental and economic issue.

JOHN RUFFIN, PH.D.: Right, and not only that but it is also a global issue as you are talking about and we have to continue to reach out in the global community. For example, programs that I have not mentioned to you, for example we have a program called MIRT [misspelled?] and I am sure some of you folks know about it, but it is the health disparity international research training program where we have individuals who are studying outside of the country and we have individuals who we are bringing into the country to work on the global aspect of health disparities because the kinds of issues we are talking about transcends these kinds of boundaries, so I think out of that work and we do this with the Fogarty [misspelled?] International Center, working in collaboration with them so many of these issues are on the table, they are

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being discussed in terms of the kinds of information we are seeing as you just mentioned and other countries and what is causing these kinds of things, so it is an exchange and it must be a global exchange if we are going to really get where we want to go.

RUTH KATZ, J.D., M.P.H.: I think that is it. Perfect timing. Please join me and thank our star guest [applause] [inaudible].

[END RECORDING]