

ACADEMY FOR HEALTH SERVICES RESEARCH AND HEALTH POLICY

ANNUAL RESEARCH MEETING

UNDERSTANDING DISPARITIES AND IMPROVING HEALTH

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DR. DAVID MECHANIC: Welcome. I'm delighted to invite you to this session. This is a session which is sponsored by the Robert Wood Johnson Investigator Awards in Health Policy Program, and all of the presenters are investigators or past investigators in our program.

I've been asked to announce that this session will also be webcast by the Kaiser program and that webcast will be shown tomorrow afternoon -- Tuesday afternoon.

We have four presentations. Each person will speak for about 15 minutes and, hopefully, we'll have time for discussion.

And the first speaker is an economist, Peter Arno, who is at the Montefiore Medical Center in the Albert Einstein College of Medicine. And he will be speaking on the topic, The Impact of Income Support Programs on Health, Social Security and the Earned Income Tax Credit.

Peter.

DR. PETER ARNO: Thank you. Good afternoon, ladies and gentlemen.

Socioeconomic status, as a major determinant of health status, has been documented for many countries, including the United States, for many years. Most status, measured variously in terms of poverty, income, wealth, education or occupation, has been repeatedly linked to a greater burden of disease and death.

Although this has been one of the most consistent findings in social epidemiology for decades, it has rarely been examined in the context of major social programs that alleviate the burden of poverty, or otherwise improve large segments of the population's economic well being.

What I'd like to do today, is lay out the argument for analyzing some of our major social programs in this context, and present some of our preliminary findings on linking these policies to the public's health.

Now, arguably, the two most important income support programs ever introduced into the United States are Social Security and the earned income tax credit. Although Social Security is much older and

larger than the earned income tax credit, each of these programs target different groups in the population, and each has been credited with alleviating the burden of poverty for millions of Americans.

So, I'd like to begin with Social Security. And, despite increased public attention, from the media and our politicians, most of which has focused on the long-range financial problems and its attempts to privatize the system, surprisingly, little mention is made of Social Security's unsurpassed record of reducing poverty among the elderly and providing retirees a social safety net. We have even seen less discussion of its potential link with the public's health.

There is little doubt that economic well-being of the elderly has improved throughout the post-war period. Poverty fell dramatically, dropping from 35 percent in 1959, the first year official statistics were recorded, to just under 10 percent in 1999. And this compares to children, for example, whose poverty rates fell far less, from 27 percent to 17 percent during the same time period.

However, as early as the 1940s, the average monthly Social Security benefit accounted for 16 to 17 percent of family income for the elderly. And this proportion rose to 28 percent in 1950, when the first in a series of benefit increases were mandated by Congress. And with the help of additional mandated increases and the indexing of benefits to inflation, we go to 1975 and the secular rise in raises over the years, Social Security benefits have accounted for between 28 and 30 percent of income ever since.

Today, there's far more detailed evidence of the role of Social Security in alleviating the burdens of poverty. It remains a key source of income for most recipients. Nearly two-thirds of beneficiaries receive more than half of their total income from their monthly Social Security checks. For 30 percent of the elderly, it provides 90 percent of their income. And for 18 percent of beneficiaries, Social Security is their sole source of income.

The statistics on poverty are no less compelling. In 1999, 40 percent of the elderly were kept out of poverty by Social Security, and this impact is more substantial than all other government programs combined.

So, our primary question then is, given the important role that Social Security plays in alleviating poverty and given the wealth of evidence linking socioeconomic status to health, we ask is it possible to demonstrate that the introduction of Social Security has led to an improvement in health among the elderly?

Our overall empirical approach is to examine the decline in mortality rates in selected age groups throughout the 20th century, to test the plausibility that the introduction of Social Security led to a sharper decline among -- in mortality among the elderly than in other age groups.

And here's a slide of the mortality patterns by age. Four age groups. Two groups younger than 65, the bottom two, and two groups older than 65. And the line placed -- the vertical line in 1940, is just to give you an idea of when Social Security was put into practice.

Now, visually, you can see it looks like there's a decline, at least in the older groups, after 1940. But when many of regression analysis was used to analyze these mortality rate declines for the four age groups, before and after the introduction of Social Security benefits, you can see the yellow bars are 1941 through 1997, the blue bars are 1900 through 1940 and, basically, we're just looking at the average rate of mortality decline pre- and post-1940.

And what this chart shows, basically, is that while mortality rates declined for all age groups throughout the 20th century, there was a statistically significant increase in the decline in rates in the two older groups compared to the two younger groups.

This is the same slide for men, same period of time, same basic pattern. And again, the statistical rates of change in mortality decline, as you can see, the two big yellow bars on the right representing post-1940 mortality decline.

This is the chart for women. What appears like a very steep decline in the eldest group, the 75 to 84 year old group, and that is borne out in the statistical analysis as well. Although, in the 65 to 74 group, its marginally different. But in the older group it's very significant. All right.

Now, a major question associated with attributing declines in mortality to the introduction to Social Security, is whether the observed decline might simply be explained by something else like, for example, the decline in infectious disease mortality. This is a phenomena that occurred over roughly the same time period as the development and dissemination of antibiotics.

So, our first question then, would be is there a pattern in mortality data that would not likely be explained solely by antibiotic dissemination effects? And so, we obtained age-specific infectious disease and all-cause mortality rates for most of the 20th century.

The mortality data were (inaudible) transformed and the various age groups were aggregated into two groups in this analysis, the 65 and older group, and the younger group, age 25 to 64. The data were divided into three categories, three time periods, as you can see, 1900 to 1939, 1940 to '60, 1961 to 1980.

We made a couple of assumptions, that there were separate rates of decline, which might be found for the elderly and the younger age strata, and that the time-trends were piece-wise, log linear, with changes in rates in 1940 and 1960.

Now, what this table shows -- these are the regression estimated annual -- annual relative changes in infectious disease and all-cause mortality for the elderly and the younger age groups. We can see that the decline in all-cause mortality did accelerate after 1940, slightly less than doubling among the younger adults, but more than tripling among the elderly.

The changes in infectious disease mortality were quite dramatic in both the elderly and the younger adults and, relatively speaking, the effect was greater among the elderly. However, the absolute decline and the declining rates were not that different in the elderly and the younger adults.

Now, these explorations provide equivocal answers to the limited question we've posed here. On the one hand, we find that the time trends at all-cause and infectious disease mortality in the three eras do differ between the elderly and the younger adults. While these results are consistent with the dissemination of antibiotic therapy, the difference between the age strata are large enough for an independent effect of Social Security to exist.

The next we describe, affected a trend in non-infectious disease mortality prevailing in these age groups over these time periods. And as expected, non-infectious disease mortality rates declined throughout the entire time-frame. The rates for the elderly were in all instances higher than those for the younger group. The decline appeared steeper in the middle era than in the early era, and steeper still in the most recent era.

We can see in this table, that the rate of decline in the mortality rates in the younger group in the middle era, is about three times what it was in the early era, which compares to the elderly group, where the decline was four and a half times as steep in the middle era.

Thus, heuristically at least, we can say that a decline in non-infectious disease mortality rates accelerated most (inaudible) in the middle era, and that acceleration was substantially more pronounced among the elderly. Further, non-infectious disease mortality has accounted for more than 90 percent of all mortality throughout the entire post-war period.

Obviously, the decline in non-infectious disease mortality is unrelated to antibiotics, and it is clear that the difference in acceleration between the elderly and the young, from the middle to the early era, is large enough to admit explanation by factors which more specifically affect the elderly than other groups during this time.

Now, our results must be considered only as consistent with our hypothesis, not conclusory. Unadjusted comparisons of age groups and parallelisms between -- among time series, cannot exclude alternative explanations.

Other events in the 1940s, 1960 eras certainly have contributed in the decline in mortality. We've presented evidence that antibiotic use, the most obvious alternative explanation, does not account for the entire decline in mortality.

Our strongest conclusion simply, that the data are consistent with the a beneficial health effect of the introduction of Social Security. Further research is needed to determine whether this effect truly exists as an independent phenomena, when other confounding effects are controlled for.

So, let me very briefly turn to the earned income tax credit. It was established in 1975 and significantly expanded in the 1990s. It's a refundable credit designed to off-set the impact of federal taxes on low-income families. Operating through the tax system, it provides a wage subsidy for low-income workers, and adds an important incentive to participate in the labor force. It's a fairly well targeted program. It's half of all payments going to families with incomes below the poverty line.

The earned income tax credit was claimed by more than 18 million families last year and raised an estimated 4.3 million persons, including 2 million children, out of poverty. A number of analysts have reported the earned income credit lifts more families with children out of poverty than any other government program.

To give you a sense of its magnitude, here is a couple of slides comparing the earned income tax credit with what used to be called welfare. In this slide, we can see the number of families receiving the EITC since its beginning in 1975.

Well, it didn't quite come here, but the yellow line is the AFDC/TANF number of families. The red line is the number of families receiving the credit.

In 2001, 18.5 million families received the credit, versus 2.1 million families which received cash assistance under TANF. This slide is a figure in constant '99 dollars. From 1975 through 1999, just looking at total spending, earned income tax credit in yellow, TANF AFDC credit expenditures in red. And clearly, you see here a ten-fold increase in constant dollars from 1975 through 1999 for the credit. And last year, over \$30 billion dollars was spent on the earned income tax credit, with 87 percent was in the form of refunds to tax payers.

And in addition to income support, a number of studies have established a very strong relationship between the seat of the credit and increased employment, particularly among single mothers. According to probably the best study on this, the credit has accounted for nearly two-thirds of the rise in labor force participation by single mothers between 1984 and 1996.

So, with the earned income tax credit, like Social Security, we're interested in the major social program with significant economic impact and whether or not there have been important and unrecognized public health consequences.

I will conclude with two last slides, where we -- very preliminary data, looking at the earned income tax credit and the current population survey. And in this first slide, you can see -- and these are very preliminary, but I just wanted to share them with you. You can see that those families receiving the credit are less likely to report fair or poor health, and more likely to report good or very good health. Okay, we haven't controlled for a lot of things we would control for, but there it is.

And finally, we took a quick look at health insurance coverage. This is -- these are households where the income is below \$30,000. It's for female-headed households with kids, which is the target group for the earned income tax credit. It's the target group for AFDC/TANF. And what these results show,

basically, is that those households that receive the credit are more likely to have some or all of their children covered by health insurance, compared to households that do not receive the credit.

It's our belief that a better understanding of the link between our major social and economic policies, and their potential health consequences, would add an important and missing dimension to the public discourse over the future of income support programs such as Social Security, the earned income tax credit, and others.

And I'd just like to close with a challenge to my colleagues that are interested in improving population health. And that is to broaden your scope beyond the current buzz words of the day, be they access, quality, and even disparity, and take a more holistic picture of health policy and research, and one that incorporates the health consequences of our economic and social policies.

Thank you very much.

DR. MECHANIC: The next speaker is David Williams, who is Professor of Sociology and Senior Research Scientist at the Institute for Social Research at the University of Michigan. David will speak on the consequences of segregation and how it contributes to racial differences in health.

DR. DAVID WILLIAMS: Thank you. It's good to be here this afternoon. And I am taking Peter Arno's counsel seriously, immediately. I am taking a much broader perspective than we usually take, in terms of understanding the persistence of racial disparities in health.

It is well known that there are large racial disparities in health, and one example of this is the data I'm presenting. Looking at the Black-White differences and all-cause mortalities, age adjusted from 1950 to the present.

There is good news and bad news on the table.

The good news is, is that mortality rates have declined for both African-Americans and Whites. The bad news is that the Black-White ratio is relatively constant over time; 50 percent higher death rates for African-Americans, 50 percent higher than that of Whites in 1950, and 50 percent higher in 1998.

The data I presented used a 1940 standard million, the standards of age-adjustment used by the National Center for Health Statistics for the last several decades. It was changed recently to the year 2000 standard million. So, I just wanted to educate you. If you see the numbers look very different, it does not necessary reflect dramatic progress, but if we're using the new standard million, adjusting over time, you can see death rates for African-Americans 20 percent higher in 1950, and 30 percent higher in 1998.

So, although the disparities look smaller, the basic story is still the same of increasing disparities in health over time, looking at all-cause mortality.

If you look at infant mortality, again, you can see the same dramatic good news, death rates much lower for infants for both racial groups but, in fact, a Black infant is 2.4 times more likely to die before his or her first birthday in 1998, compared to 1.6 times more likely in 1950.

How do we make sense of these differences, and how do we make sense of the persistence of these differences in spite of a broad range of initiatives from the Hill-Burton Program, from the war on poverty, from the Civil Rights Movement, from real progress in race relations, from the programs that Peter Arno discussed. How do we understand the persistence of these racial disparities in health?

I want us to go back to a concept well-developed by Stan Lieberson first, of encouraging social scientists to distinguish between basic or fundamental causes and surface causes. This notion has been applied to the health area by myself, by Jim House (sp) and, most recently, really very well developed with a full research agenda by Bruce Link (sp) and Joe Falin (sp).

The notion is that there are two types of causes that we might presume could exist for any particular outcome. There are basic or fundamental causes. These are the ones really responsible for generating the outcome. And if we can make changes in these factors we will, in fact, see corresponding changes in outcome.

On the other hand, there's surface or proximate causes. These are factors related to the outcome. But changes in these factors will not necessarily link to changes in the outcome because, as long as the basic factors remain operative, there will be alternative mechanisms developed to, in fact, maintain the same outcomes.

It is my point that racial residential segregation, a very neglected factor in current discussions of public policy, although that was not the case if you looked at major policy statements over time, is one of the fundamental causes of Black-White disparities in health.

Historian John Sell (sp) wrote the book on residential segregation in the United States and South Africa. And he actually argued that racial residential segregation was one of the most successful domestic policies of the 20th century in the United States. Particularly, because once put into place, its effects are so pervasive and so imperceptible to the average person, but very successful in producing the outcomes it was designed to do.

Now, someone would say, well, every major immigrant -- most major immigrant populations in the United States experience some degree of residential segregation; that's true. The point I want to make is that the segregation of African-Americans has been distinctive.

In fact, it's a feature of 20th century life. African-Americans were not that segregated in the 19th century. And segregation and immigrant enclaves that did exist for immigrant groups, was much lower than what is called in literature, the hyper-segregation that exists for African-Americans.

It's also true that in the early 20th century, segregation increased for Blacks at the same time that it declined for immigrants so that, for most immigrants, segregation was a temporary feature of life. No immigrant group has ever lived under the high levels of segregation that currently categorize the African-American population. And this is from the work of Massie (sp) and Denton (sp), Lieberson, Sell and others.

Well, what has happened over time? What is the status of segregation today? There's been a slight decline in segregation according to the year 2000 census. The index of dissimilarity calculated at a national level, which is not typically done, but was done in this report, declined from .7 to .6. It's .7 in 1990 to .66 in 2000.

That means that in 1990, 70 percent of African-Americans would have to move to have an even distribution of the population and, in the year 2000, 66 percent would need to move.

The decline in segregation, importantly, is due to Blacks moving to formally all White census brackets. Thus, the decline really occurred most in smaller, growing cities, particularly in the West and Southwest.

In fact, between 1990 and 2000, the number of census tracts where over 80 percent of the population was Black remained constant. There was no decline then in the heavily segregated areas. And this report that touted the progress made between 1970 -- 1990 and 2000, nonetheless concluded that the decline in segregation has had no impact on the very high percentage Black census tracts, no impact on the residential isolation of most African-Americans, and no impact on the concentration of urban poverty. So that those factors remain in place in spite of the progress that has been made.

Well, health researchers think a lot, in terms of understanding racial ethnic disparities in health, of the role of socioeconomic status. But I would argue that we give inadequate attention to where the SES differences came from in the first place. Why are there SES differences between the racial groups? And my contention is, and there's some evidence supporting of it -- in fact, the rest of my talk will kind of try to build a case -- that, in fact, SES differences are, at least in part, a product of segregation.

Analyses of the effects of segregation on young African-Americans making the transition from school to work indicated that, if we eliminated segregation, we would completely eliminate Black-White differences in earnings, Black-White differences in high school graduation rates, and Black-White differences in unemployment.

The elimination of segregation would also reduce Black-White differences in single motherhood by two-thirds. So, it's a powerful driving force of many of these social factors that we look at.

So my point is, segregation affects health, first of all, by truncating socioeconomic mobility. Residents in the United States, especially at the elementary and high school level, determines access to school, which then determines the quality of education that individuals have.

One of the intriguing features of segregation, what it produces, is the concentration of poverty among African-Americans and, to a lesser extent, also amongst Hispanics.

Some would argue that, in fact, there are in fact, more poor Whites in the United States than poor African-Americans, numerically. But most poor White children go to schools where the majority of children come from middle-class homes. Most poor White and Hispanic children go to schools where the majority of children are coming from poor homes.

And the combination of the characteristics of poor kids, and the concentration of the characteristics of poor educational institutions, combine to lead to declines in the quality of education. So here, some of the family problems come in, in poor kids' frequent residential moves. They're more likely to come to school sick, more likely to encounter violence, abuse, alcoholism, divorce, and desertion.

Then poor schools have less qualified teachers, lower teacher expectations, deteriorated buildings, less safe neighborhoods, more limited curricula, fewer connections with colleges and employers, little serious academic counseling.

Research by Gary Alfield (sp) shows that the correlation, nationally, between percent Black and Hispanic and percent poor in schools is .67. In metropolitan Chicago, in elementary schools, the correlation between percent poor and percent Black and Hispanic is .90. So, the concentration of poverty is the fundamental problem driving the challenges that cost the school's faith.

Segregation also truncates socioeconomic mobility because it also restricts employment opportunities, and therefore reduces income. It's well-documented in the work of William Julius Wilsons and others, that there's been this exodus of low-skilled, high-paid jobs from segregated areas to other areas, leading to what (inaudible) calls "both a spatial mismatch and a skills mismatch."

Segregation facilitates individual discrimination based on race and residence. It also facilitates institutional discrimination based on race and residence.

This was from work of Kirschman (sp) and Eckerman (sp), where they looked at what just the notion inner-city, which is often used as a proxy for highly segregated, poor, urban areas connoted to White employers. And you could see what these factors are: Black and poor and unskilled and lacking values, from unstable families, versus suburb connoted to employers being Whites, middle-class, educated, skilled, stable families.

One example of the ways in which institutional segregation can then affect employment opportunities comes from a study done by the Wall Street Journal of 35,000 companies reporting to the EEOC, which found that, during the economic downturn of 1990 to 1991, African-Americans were the only major group that had a net loss of jobs.

Importantly, none of these job losses really reflected individual discrimination. Rather, it reflected the movement of plants from areas or facilities where African-Americans lived, more highly segregated areas, to other less segregated areas.

In fact, studies of the auto industry finds that one of the factors used by both foreign auto companies moving to the United States, or domestic companies in locating plants, is the racial makeup of the potential labor market. They also look at the Union membership as well.

So that the point I'm making is that segregation facilitates institutional discrimination; the systematic movement of employment facilities from areas where African-Americans reside.

So, reviewing here, it determines quality of education, it also produces racial differences in SES. This is the end result of the prophecies of employment and education that I've talked about. Here are racial differences in SES. I'm not going to spend time on this. These are well known. Dramatic racial differences in SES for most major outcomes that we're familiar with.

I want to illustrate an example of the contribution of SES then, to racial differences in health. And the first line shows, if you look at self-rated health, that both African-Americans and Hispanics report poorer health than Whites do. Once stratified by socioeconomic status, we can see that the differences in health within each racial ethnic group is larger by socioeconomic status, than is fact the overall racial or ethnic differences.

So, it really points to the power of SES. So, when we really account for what's driving SES, we are really accounting for one of the major forces responsible for the racial ethnic disparities in health.

However, clearly in the case of African-Americans, but also to some extent for middle-class Hispanics, we can see that SES alone, at least measured imperfectly by this indicator of income, does not capture all of the racial differences in health. And that points to, in addition to the effects of segregation, in determining SES at the individual level, segregation also creates places, particular places, that have conditions that adversely affect health.

And I'm gonna quickly cover the facts, review research that suggests that segregation leads to differences in neighborhood quality, in housing quality, in health behaviors, in medical care and exposure to crime. All of these are major factors that affect health.

So research suggests that, in highly segregated areas, the quality of services, municipal services, are poorer, there's less purchasing power of incomes so that poor African-Americans then have higher costs of a broad range of goods and services in segregated areas, lower access to medical care, there's increased personal and property crime, increased exposure to environmental toxins, increased abandoned buildings, and more commercial and industrial facilities.

Housing quality is also worse in segregated areas. There's higher crowding, higher substandard housing, higher noise levels, higher exposure to environmental hazards, lower ability to regulate temperature -- that's heat and cold.

Medical care in segregated areas is also a challenge. There's research that suggest that hospitals are more likely to close in predominantly Black neighborhoods. There you have the concentration of uninsured and medically under-served. Health facilities characterized by inadequate resources, overcrowded and so on. And some recent research suggest that even the availability of goods at the local pharmacy is a greater challenge in segregated areas.

Research, mainly my work on the case for segregation and health behaviors, is really drawing heavily from research in Glasgow's pattern of looking at poor neighborhoods, and there's not been as much work in the United States. But the suggestion is, in poor neighborhoods, there's fewer recreational facilities, less availability of nutritional foods, there's increased marketing of tobacco, alcohol, as well as fast foods, and then increased exposure to a broad range of stressors.

Homicide is a good case study, I think, in terms of looking at the impact of an area effect on a particular outcome. And it's the last major example I want to close with.

Homicide is striking. If you look at the 15 leading causes of death, the largest racial gap is for homicide. And you can see that African-Americans, males and females, have dramatically higher levels of homicide than do Whites.

Instructively, the homicide rates are relatively stable over time. And I'm showing you what they were in 1950 to what they were in 1996. But there hasn't really been a dramatic increase in homicide in the African-American population. There's actually been a much larger increase, over time, for the White population.

These racial differences in homicide persist at every level of SES. Drawing on the research of Samson (sp), a criminologist from the University of Chicago, he shows that the lack of access to jobs produces high male unemployment and under-employment. This in turn, leads to higher rates of out-of-wedlock births, female-headed households, and extreme concentration of poverty.

Single parent households, in turn, lead to lower levels of social control and guidanceship. And he finds that these factors completely account for the racial differences in homicide and violent crime. In fact, the association between family structure and violent crime is identical in sign and magnitude for African-Americans as it is for Whites.

Now the processes seem to be the same. The rates are higher for African-Americans, because African-Americans are more exposed to these conditions.

Importantly, Samson concludes that racial differences at a neighborhood level, and the availability of jobs, and family structure and opportunities for marriage, and concentrated poverty, underlie racial

differences in violent crime and homicide. In fact, in a review piece, Samson and William Julius Wilson concluded that the sources of violent crime are remarkably invariant across race, and rooted instead in the structural differences among communities, cities and states in economic and family organization.

In fact, in the 171 largest cities that they studied, there was not even one city where Whites lived in ecological equality to Blacks in terms of poverty rates or rates of single parent households. They concluded, and I quote, “The worst urban context in which Whites reside is considerably better than the average context of Black communities.” Okay?

I have made the case of segregation as a fundamental cause of Black-White disparities in health. I would like to argue that each racial group needs to be studied for that group, and look at the specific populations for the group, and segregation may not be as central for all of the other racial populations.

But clearly, for American Indians, I think we can think of reservations as a form of segregation and Massie (sp) suggests that, particularly for Puerto Ricans, segregation may be much more dramatic for that group than for some of the other Hispanic groups.

I also raise the possibility of whether it’s worth, in terms of comprehensive agenda, thinking of the conditions under which segregation may have some positive effects in terms of enhancing group self-identification, empowerment, lower exposure to discrimination, and so on.

My conclusion. Segregation is an important spider, to use the words of Nancy Kreiger (sp), responsible for the multi-factorial web of causation underlying Black-White inequalities in health. It means that effective efforts to reduce racial ethnic disparities in health should grapple with reducing racial disparities in SES, and target interventions not only at individuals, but at the geographic context in which they live.

Thank you so much.

DR. MECHANIC: And now, Sara Rosenbaum and Joel Teitelbaum will be talking some about what we might be able to do about that, in terms of looking at civil rights law and assessing equitable access in quality healthcare for minority patients.

Sara is the Harold and Jane Hirsch Professor of Health Law and Policy at the George Washington University School of Public Health and Health Services, and also directs their Center for Health Services Research and Policy.

Joel Teitelbaum is the Associate Director of that Center and an assistant research professor in the department.

MS. SARA ROSENBAUM: Good afternoon. My colleague, Joel Teitelbaum, and I certainly want to begin by thanking the Investigator’s Award program for supporting both this analysis of civil rights

enforcement in a post Sandoval era, as well as the forth-coming analysis on healthcare as a public accommodation under racial integration laws.

When Joel and I received the award, we conceived our work as building on the very fine research and writing of David Smith, who has chronicled the period of -- in which healthcare and civil rights crossed each other in a very powerful way, culminating with the passage of the Medicare program and its subsequent implementation. And then sort of a strange demise of civil rights enforcement in healthcare.

As a new Office for Civil Rights was formed, and as that office became increasingly attenuated to modern healthcare policy and practice -- and of course, this is a phenomenon that pervades not only civil rights enforcement in health, but civil rights enforcement in human services. We thought that we would spend a lot of our time looking at how individuals essentially frame issues of civil rights violations in the modern health system, which is very different from the healthcare system that was in place at the time that Title VI was enacted, and that our writing would concentrate in this area.

A momentous thing happened within a few months of receiving our investigator's award. One of the more profound developments that could possibly happen in the law. And that development was the Sandoval decision, which is the story I'm going to tell you today.

And in a flash, we essentially had to reformulate how we would go about doing the work that we've done. We've ended-up in not a significantly different place, but you'll see that, far from being an exploration of individual efforts to enforce civil rights statutes, now there are issues that are four-square on the table for the federal government.

The -- in order to convey to you the full meaning of the Sandoval decision, which rocked the country about a year ago -- just at the end of the 2001 term, I've got to give you some background in civil rights law.

Very quickly, Title VI of the 1964 Civil Rights Act is the portion of the act that deals with discrimination in federally assisted programs. The legal basis for this law is the spending clause of the United States Constitution, not the commerce clause.

So, healthcare, unlike the Americans With Disabilities Act, healthcare is not conceived of as a public accommodation in discrimination law, from a race discrimination point of view. It's conceived of as a prohibitive kind of conduct by recipients of federal financial assistance. It's the receipt of federal grants that gives the government power to intervene and rectify discrimination.

Now, of course, in federal -- luckily in the American healthcare system, just about everybody who walks and breaths and who is in the American healthcare system is a recipient of federal financial assistance. You don't have to get a discretionary grant to be a recipient of federal financial assistance.

If you are a hospital participating in the Medicare program, if you are a state Medicaid agency, if you are a Medicare or Medicaid managed care organization or its network, you are receiving federal financial participation.

When Title VI was passed, there was no express private right of action built-into it. In other words, nothing in Title VI specifically addresses the question of whether individuals who believe they've been wronged can go to court to enforce their right not to be discriminated against.

The court, as of the time that Title VI was passed, used a legal theory known as an "implied right of action." It would look at a law that Congress had passed. It would say this law is designed to benefit a group of people. Clearly, when this group of people have had their rights violated, they can go to court to enforce their rights under this law. What good is a right without a remedy?

And to buttress that argument, the courts also looked to a separate law, Section 1983 of the Civil Rights Act of 1871, which gives individuals the legal right to go to court to enforce their rights under the Constitution and the laws of the United States.

Title VI is administered for its health component by the Department of Health and Human Services today, the Office for Civil Rights. The Department of Justice, Civil Rights Division, sets policy for all laws and regulations as they apply to race discrimination.

Specifically, just quickly, what the statute says, Section 601, which is the heart of the Act and it's a very short -- unlike federal healthcare payment programs, civil rights law, at least back then, was mercifully short. "No person in the United States shall, on the grounds of race, color or national origin be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

Every word, obviously, is a loaded word. This is always the case in law. It has been interpreted quite broadly over the years. There was a period of time when the Supreme Court narrowed the meaning of "recipients of federal financial assistance." Congress, in a completely different era from the one we're in today, although only 15 years ago, went and remedied that narrowing of the Act to broaden it once again.

Section 602 instructs federal agencies to enforce 601; 601, of course, is amazingly silent on what it means to be discriminated against. And so, in implementing this law, the federal agencies took two positions. One, you violate this law if you're a recipient of federal financial assistance and you engage in disparate treatment. That is, you knowingly and intentionally treat a racially identifiable group differently. So, there's a level of intent involved. But they didn't stop there.

They went on, in interpreting 601, under their 602 powers, to codify what we know in the law today as the "effects test." And it is the effects test that really matters to us in health policy. It is where all this disparities work keys in.

The intentional discrimination test is, obviously, very important still, but it is really the effects test that, in health services, we are concerned about. And what the effects test says is that, "A recipient may not directly or through contractual or other arrangements utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination."

So, the question is, when do we have facially neutral practices that result in discrimination? And discrimination, in this case, being the segregation or exclusion of individuals from healthcare or the lesser treatment.

If you are mounting a disparate treatment case, which is the rare case, you essentially have the burden of proof. If you're the plaintiff, you have to go forward as an individual plaintiff, showing a lot of evidence of disparate effects. And then you have to put on evidence of a motive, which is very hard to do. Although statistical inference -- statistical evidence would allow an inference of discrimination.

The defense then, has the burden of coming forward and showing any legitimate basis for that conduct, any legitimate basis at all is enough to rebut the inference. And then the plaintiff once again can go forward with, essentially, a subterfuge argument. That the defendant's proper defense of its actions was simply a subterfuge.

It adopted the cautionary rules, not really to raise money to run the hospital, but to keep Black recipients out. It had a rule regarding who could be on the staff of a hospital, not to assure the quality of care of its hospital, but to keep Black physicians off the staff. Those are examples of instances where people have argued subterfuge in pretext.

The disparate impact claim is again the biggie for healthcare. Because here, what the plaintiff is trying to show through statistical evidence, is that there is some facially neutral event that has a relationship to a statistically adverse outcome on a group of people. It could be utilization of services, entry into services, level of care, quality of care, pick your poison. The literature is full of them; hundreds and hundreds of studies.

The defense in this case is that the defendant would argue essentially, that it has -- its attempting to serve a legitimate goal. Again, this legitimate goal test. But this time, it has to show that its practice serves a legitimate goal, and the plaintiff can rebut with evidence of less adverse methods for achieving the same goal.

Now, there has been some litigation over the years. And, quite frankly, most of it has failed. And also, there has been very little litigation in healthcare, compared to education for all kinds of reasons that we go into in the paper, having to do with, probably more than anything, the enormous complexity of the American healthcare system that makes it very difficult for civil rights lawyers to get around health systems and litigate the legality of the health system.

If you look at the whole field, what you tend to see is that market relocation cases lose. It is very difficult to stop the closure of a facility or the relocation of a facility. Courts are loathe to step in and

stop a market from reorganizing itself. They may require some remedial bussing of people or satellite clinics if it's a hospital closure, but they're not going to tell a hospital its got to stay open in a losing market. For example, exactly this issue of concentrations of poverty problem, where the only real remedy is a lot more public support to offset the high poverty.

Where the cases have tended to win is what I call here "intra-market discrimination." Where a court sees the same market, the same hospital, with the same beds, the same nursing home with the same beds, potentially the same managed care company with different books of business using a shared network, with racially identifiable patterns within the network.

And more importantly, it's where the issue of discrimination by payer status becomes so important. Because where the justification for the conduct is, well, Medicaid pays differently because of a disproportionate reliance for minority Americans on Medicaid, if you can come back with a lesser alternative approach, you have a chance of winning.

Now, in unequal treatment, of course, as I mentioned before, we see this barrage of studies that suggest that exactly the kinds of conditions that the disparate impact reg was developed for are all around us still today. A lot of facially mutual practices, simply the ways in which the health system interacts with its patients, that for some reason that we don't understand completely, has a disparate effect on minority Americans in their access, in their use, in their quality of care. That's exactly the kind of dilemma that the Title VI regulation was designed to intervene on.

And then, along came Alexander v. Sandoval and, in a nutshell, what Alexander v. Sandoval held was - and this is about the first time in American law its happened, and it gives you an idea of, essentially, how much has changed in jurisprudence for poor and disenfranchised populations in this country.

The Supreme Court held that individuals may not go to court any longer to enforce the disparate effects test. If they have a case of intentional discrimination, the court, through tortured reasoning, separated out a disparate treatment claim from a disparate effects claim, said you can go to court on the disparate treatment claim, but not a disparate effects claim.

You are solely reliant on the federal government. That is the only remedy you have, is to file a complaint with the federal government. And it is up to the federal government to intervene. It is the only entity that can act. Now, this is unheard of, again, in law. But it suddenly took what was this latent discussion of shouldn't the federal government be doing a better job in this area? And blew it up to epic proportions.

I think actually at this point, very little appreciation among the health policy community of the Sandoval case and what it means -- this electrifying decision, that the issue is all with the federal government now. You cannot -- you simply cannot do anything anymore as a class to protect your interest where facially mutual practices are resulting in discriminatory treatment.

Now, looking at the options for federal government intervention, we think, actually, they're pretty limited. And I put aside for this discussion, the issue of whether the Sandoval case itself should be reversed, whether a private right of action should be restored in law. There are certainly fundamental reasons to do it. There are also reasons why, as a practical matter, it may make very little difference. There's been a limited history of civil rights enforcement work.

One issue is to increase OCR's resources, and all you'd have to do is read David Barton Smith's book to know that OCR was set up to stop all civil rights enforcement. There have been very gallant civil rights leaders over the years -- people who've directed the office. Most recently, a wonderful director named Tom Perez, who made a tremendous run at civil rights enforcement. But, all you have to do is look at the Civil Rights Commission's history of OCR to know that this is not an option.

And so we recommend actually turning back the clock to what was in place before OCR was set up, which was to insist on a restoration of enforcement obligations in the agencies that control the purse. These are the agencies that were charged with enforcing the law.

Title VI is a condition of participation on federal spending. And the net effect -- and this is where we spend all of our time in our -- in the paper that we just finished. What has happened by pulling the two systems apart, is that, rather than aiding civil rights enforcement, we have simply allowed spending agencies to abandon civil rights obligations.

And so today on the books, we have not only a virtual lapse of civil rights obligations in the area of healthcare and federal assistance, we have examples now in which federal agencies have stepped in and repealed anti-discrimination obligations that were on the books, or have allowed discriminatory market division services.

And so, in addition to shifting enforcement obligations back to the federal agencies that control the spending of program funds, we recommend that, to accompany the federalism impact analysis test and the economic impact analysis test, that we develop a disparities impact analysis test that will have to accompany the issuance of public regulations in the area of federal spending. That would put the burden of proof on the federal government, not on individual plaintiffs, to demonstrate the extent to which a particular policy would reduce discriminatory outcomes in a target community.

Thank you very much.

DR. MECHANIC: And the fourth paper is by Dalton Conley, who is an Associate Professor of Sociology at New York University, and also the Director of the Center for Advanced Social Science Research at NYU.

Dalton.

DR. DALTON CONLEY: Good afternoon. Thank you, David, and thank you all for coming.

We all know that eating broccoli reduces your cancer rate. We know that drinking red wine, at least a glass or two, is good for you; it reduced heart attack rates. Green tea, we think is good, living in a rich neighborhood, we're told, is also good for us. Smoking we know is bad for us.

Now, how do we know all those things? We know them, because epidemiologists study large samples of people and they compare the people who smoke with those who don't smoke. They compare the people who are eating broccoli, like their mom told them to, versus the people who aren't. But, they're not going to these people's houses and randomly taking broccoli off their table or forcing half of you to light-up right now and half of you not to light-up cigarettes.

Now, for certain things, we have a very good causal story that it's good or bad for our health. Like, it's pretty obvious that smoking's not good for you. That's not so problematic. We know the whole chain of causation from the point of which we observe some people happen to smoke, some people don't; they die earlier than the other people.

But for things like red wine, broccoli, green tea -- I'm sure you could think of some bizarre things you've read in the Science Times that seem a little bit of a stretch, but based on very big samples -- the nurse's study in Cambridge or other large-scale epidemiological studies, but we don't really know if they're causal because we don't know if people who drink a glass of red wine just happened to be more relaxed in general anyway, than teetotalers. Or that people who are eating broccoli happen to also run three miles every morning because they're really health conscious, and it's not the broccoli, it's the running.

So most of social science has grappled with this problem, or has failed to grapple with this problem, except for certain -- throwing in a control variable. If you think that people who eat broccoli also run a lot, well, measure that and then factor that out. But there's always something else that it can be. There's always some other alternative story that will come up that might dash your assumption of causation between broccoli and good health.

This is particularly true for independent measures or causal factors that we social scientists are interested in. Things like income. Things like where you live. Things like how much education you have or how big your family is, and of course, social policies.

We can't do randomized experiments. I can't mug half of you and take your income away and not the other half of you and then see how you do health-wise. So we have to search for efforts to try to find natural experiments.

And Peter's talk at the beginning makes a nice book end to my talk, because the sort of one-time introduction of a new social policy offers a natural experiment. I'm gonna talk about three other natural experiments, or unnatural experiments in some cases, to address four policies that we don't normally always think of as health policies, but I think are very essential to health and well-being.

The first issue I'm going to look at is the issue of birth weight. What is the impact of birth weight on long-term and short-term health outcomes? And there's a number of policies that affect birth weight; WIC in the United States. But it's a particularly important issue for international development issues.

Second, something that rarely gets talked about in health, is family size. What is the impact of having another child on the health of your entire family? Does it put a strain on the resources such that the health of every body is compromised? Is there a trade-off between quality and quantity of children in terms of health?

The third is military service. What is the impact of military service on your health. Now, that's another issue that's ripe for selection bias, which I'll talk about in a minute. And finally, I'll get back to what Peter started with, the impact of income from a different angle.

So, the idea in the -- from the medical model is that you have a double-blind control group and treatment group, and no one knows whose in which and you can observe the outcomes. And there's -- people are randomly assigned to the control or treatment group and, therefore, you can assume that there's no other potentially biasing factors other than the treatment itself.

Now, what we have to do as social scientists is look for natural experiments. Things where there was a random event that sort of assigned some people into a treatment group and some people into a control group. Of course, the complication with this -- so say we take September 11th. A lot of people lost their jobs in the New York area, where I'm from, because of the economic impact of September 11th. That was a seemingly random event. No one in the community predicted it.

However, that event itself, not only affected the incomes of certain people and not other people, it had other major traumatic effects. So that would not be a good natural experiment, because we can't isolate the pathways through which that's having the effect. That would be the curved arrow around that would mess-up the experiment.

So the first one I'm gonna talk about is what is the impact of birth weight on life chances? There is a colleague of mine says about ones research, if someone's gonna tear down your research, you better do it yourself. If someone's gonna burn down your house, you better burn it -- get outside your house first, and burn it down.

So, in the year 2000, I published a paper which compared siblings as a natural experiment of sorts, and compared low birth weight siblings with normal birth weight siblings and looked at their SES, their socioeconomic attainment 19 years later. Mainly, whether they graduated high school in a timely fashion.

And we found that low birth weight siblings were much less likely to graduate from high school in a timely fashion, as compared to their normal weight siblings. And that's an advance over previous research, because we're comparing people within the same families. So, they otherwise have the same, more or less, experience.

However, we still don't know if birth weight in that case is really meaning prematurity, if its really meaning that a mother smoke and drank during one pregnancy and not the other, or if its really something congenital or genetic that's different about the two siblings; or some other unmeasured changes that were going on between pregnancy one and pregnancy two in the family.

So, to solve that, we looked at twins. Now, we looked at all twin births in the United States from 1995 to 1997 and we asked, what is the impact of a pound of flesh on your chances for survival? Now, twin births are a-typical in a lot of ways, but what we can do is compare the birth weight difference, which there's always some difference in the weight between the twins, and sometimes it's dramatic. And we know that, if the mother drank or smoked during that pregnancy, it affected both twins. If she was poor during that pregnancy, it affected both twins. If she was, you know, residentially segregated, it affected both twins.

So we then followed the twins after they're born, controlling for their sex and their birth order -- the order in which they came out, and we look at the impact of their weight on their chances of survival.

So what you find is that, if you look at the third bar, you see that for fraternal twins, there is about -- if one twin is a pound heavier than the other twin, he or she is about 28 percent less likely to die in the first year of life. But for identical twins, which is the right bar, the effect is much smaller than that. It's about 12 percent.

So what that tells us is that when you're traditionally comparing the impact of birth weight on, let's say infant mortality, which is a major social indicator or health indicator, the estimate -- the impact might be overstated because -- in the fraternal twins, we know that there's genetic differences. And those genetic differences might be underlying the weight difference and therefore causing it to look like the weight is having the effect, when it's really not.

In the identical twins, we know that they're genetically identical and the impact of the weight is much smaller. It's still there though. What's interesting is -- actually, I'm sorry. That was neonatal mortality. The same pattern holds true for overall infant mortality.

When you move further out from the starting gate of life and you go into post-neonatal mortality -- neonatal is death in the first 28 days of life and post-neonatal is death between days 29 and 365, you find that the effect of fraternal and identical twins is the same.

So what this natural experiment tells us is that, after an initial weeding-out process, any longer-term effects of birth weight on health or mortality or possibly child development and education, are really the effects of weight per se. Weight is not acting as a stand in or as a proxy for something else. Okay.

Family size. Again, something that we don't often consider as an important form of social stratification in health, but it's been long believed in sociological literature and educational literature that you come from a larger family, you're disadvantaged. And there's good reason to suspect that. You know, that

there's families pie of parental resources, financial and other, is only so big and if you have to cut out another slice, everyone gets a little less, right?

But again, there's not been an experimental way to determine this. Because, you know, if you're gonna compare a family of eight kids with a family of two kids, they'd probably differ in very cultural and other ways as well -- religious ways -- other ways that are -- you're not gonna be able to measure them all. And it really might be that large families are disadvantaged, even though -- even if they didn't have the actual kids. Their predilection to have kids might be what matters.

But there is, in a sense, a natural experiment here again. Pregnancy one, someone has a boy, let's assume. Pregnancy two, some families have a boy and some families have a girl. Basic biology, right? So, because many families, whether they express it or not, want one of each at least, those families that have two of the same sex -- and it really doesn't matter what sex. Here I chose boys -- the -- 7 percent, 6 percent's more likely to have another child than those who have one of each in their first two kids.

So that's essentially a random experiment. So half the population who has two kids gets the same sex and half the population gets the opposite sex. So what you do is you don't actually look at the difference in health between families with three kids and two kids. You look at the sex mix of the first two and don't even actually see if they went on to have additional kids. And then you regress that or check that against the health statuses.

Now, I've done this for education and I find strong effects of family size on likelihood of going to private school, on likelihood of being held back for a grade, and of dropping-out, using the 1990 and 1980 census.

Now, the next step is to take this to health outcomes and --.

Now, the last experiment I want to talk about is the Vietnam draft. In trying to estimate the effect of what does serving in the military, particular in Vietnam, do to your health long-term -- I don't mean, obviously, the short-term risks. But years later, you're presented with the problem of Joe Six-pack, if he got drafted, probably went to Vietnam and, as we know, Dan Quail, Bill Clinton, George W. Bush, the list goes on, if you're coming from an elite background, you're probably not gonna go to Vietnam.

So, how do you know, again, what's the effect of serving in the military on your later health or mortality, and what's the effect of the fact that you're the poor schlep who couldn't get out of the draft and while, you know, Bill Clinton was living large at Oxford.

Now, again, this is a case where you don't look at whether there's two or three children. You don't actually look at whether someone served in Vietnam. You look at something that affects your likelihood of serving, but is random. And of course, here is the Vietnam draft in action.

Now, someone has yet to explain to me why an elected representative would want to pull out the numbers of boys to send to their death. Like that's a good re-election strategy for the parents of those kids, but here is Representative Alexander Pirnie, in 1969, pulling out draft number -- I don't remember what number it is, but I don't have it here. Oh yeah, September 14th.

So if you had a draft-eligible birthday, you're obviously more likely to go to Vietnam than if you didn't have a draft eligible birthday. Some people joined who weren't drafted out of the blue, some people who were draft-eligible didn't go. The Bill Clintons still escaped. But the fact that you had a draft eligible birthday, increased your likelihood of going. And it's distributed randomly.

That is now, if you look at a certificate of live birth, you'll see that the date of birth of the father is listed. So if you want to know what the effect of Vietnam on the veteran's offspring, or we merely need to compare the subsequent births by the birth date of the father -- look at those who have an eligible birth date versus those who don't.

It's the same thing with death certificates. You can calculate the effect of Vietnam on mortality rates. And there was an article in the 1986 in New England Journal, where Norman Hearst and his colleagues did this for the period right after Vietnam, and of course, found increased rates of automobile accidents, death from alcohol, and death from suicide. But the interesting thing is to look now, many years later, at what would be long-term effects on things like cancer and cardiac arrest.

Now, this is also the angle to look at how income might matter to health. Because one of the findings of looking at the Vietnam draft as a sort-of lottery or as a natural experiment is that Whites experienced a 15 percent income drop. You can see on the left is the fact that Whites had, in the 1980s, an income drop for draft eligible birthdays, but non-Whites didn't.

So any increase in mortality or increase in rates of low birth weights, let's say, for the offspring of these men, for Whites, could be attributed to either Vietnam itself -- the trauma and the impact of Vietnam itself, and for the income drop that accompanied serving in Vietnam.

Compare that to what's happening in the non-White population. The non-White population, there was no income drop as a result of Vietnam. Now, that is really a story of the fact that if -- in a racially discriminatory world, in 1970s, if you had limited job opportunities before you went to Vietnam, you probably had limited job opportunities when you came back. So the cost was not as great as to White civilians, where there was more opportunities at that time.

So any increase in mortality or increase in low birth weight among the offspring of the veterans for non-Whites, is not associated -- it's not attributable to any income changes. It's solely attributed to the Vietnam trauma; to the Vietnam experience.

So, in other words, if you think of causation at a random lottery, something happens, then you go to Vietnam, you flee to Canada, you become a conscientious objector, whatever, you have an income drop and they'll say there's a birth weight decrease in your children later on for Whites.

Now, for Whites, there's the effect of Vietnam directly on the birth weight decrease, and you can see that curved arrow, and there's an effect through the income drop.

For non-Whites, there's no income drop, so there's only the effect of Vietnam on mortality or birth weight. So if you -- what you can do is basically, difference the two and you get essentially four groups. A treatment group, those who are eligible for the draft lottery, a control group. Among that treatment group there's two -- there's one subgroup that had stable income, that's non-Whites, and one that had an income change, that's Whites. And again, you have no change income for the non-Whites or Whites in the control group. Do some simple algebra and you can find out the effect of income on health -- on low birth weight and mortality.

So, just to conclude, I'll say that, if we really want to know what the effect of broccoli on our rates of cancer or heart attacks are, or whether the potassium in bananas is good for us, as social scientists, what we want to do is look for changes in the price of broccoli that impact how much -- exogenously impact how much broccoli we eat. We want to look at a hurricane in Honduras that wipes-out the banana crop. And we want to look for natural experiments that are going to give us some leverage in really understanding causation. Otherwise, we're just gonna keep printing the same stuff over and over again in the Science Times.

Thank you.

DR. MECHANIC: We have a few minutes for questions. Would you please come up to the microphone and identify yourself, since we are being webcast.

MS. BARBARA KRIMGOLD: Barbara Krimgold from the Center for the Advancement of Health. This is a wonderful panel. I'm so -- I'm grateful that you all presented it.

I -- my question is -- goes back to the impact of income support programs on health. I think, Peter, you mentioned poverty rates for kids declined to about 17 percent, although I think they remain about 40 percent for African-American and Hispanic American children.

And I recently heard on Ron Walter's report on racial and ethnic disparities in TANF and welfare reform, and I'm wondering whether you can comment on racial and ethnic distribution in EITC?

DR. ARNO: No. But it's a good question and it is certainly something we will be looking at as we get into it.

MR. OLIVER KLEIN: Oliver Klein (sp), from New York.

Peter, one of the explanations for health inequalities from international data, and even your own I believe, is income disparities. The societies that have larger income disparities having in fact better health outcomes.

I was wondering if you're -- if you've looked at that question? For instance, in the period from 1940 to 1960, did income inequalities decline in the United States? And, for instance, have they increased since 1970 to the present? And how would those actually impact on health outcomes?

DR. ARNO: Aye-yie-yie. Yeah, well, the part of inequality, as you already know, followed a U-shaped curve in the post war period and did decline dramatically from the late '40s to about '69, '70, bottomed-out and increased all the way through the mid -- early to mid '90s and as it stayed at the highest levels since then, from -- going back to the -- before the depression.

I moved out of that inequality area to move into this income support area, in part because there is -- as you know, there has been a large body of evidence generated over the last three or four years trying to link increased economic inequality with adverse health outcomes.

However, my own personal view is that this fad of growing income and equality in health has, I think, is turning out to be nothing more than a fad. I do think there may well be some health effects, but all the studies -- or the majority of studies in the last 12 to 18 months or so, have cast a wide degree of doubt over the earlier studies. And let me just give you this simple reason for that, because I don't want to take up more time on that if we don't have to.

Areas where there's a lot of inequality also has areas with a lot of poverty. And what the literature in the early days was not able to take into account very well was the fact that, in high income inequality areas, that it was the poverty -- what I'm saying in controversial and there's a lot of debate on both sides. But the literature was never methodologically able to very well take into account the confounding of a great deal of poverty in those inequality areas.

And, you know, there are studies that come up on both sides of this, and I think it's a story that remains to unfold. And I'm sure there's been a lot of very, very bright people looking at it.

But what I like personally about the Social Security, earned income tax credit stuff is that it went to the heart of poverty reduction itself. And -- which is why we were looking for potential health effects. Now, if the inequality confounds our long-term trend analysis in Social Security, it's something we need to be concerned about. And all I could say is that we will look at it a little more carefully.

DR. MECHANIC: I thought you had a rather ingenious model on looking at the dates on the Vietnam individuals. And I was wondering, have you done any of that analysis and where are you on that analysis?

DR. CONLEY: I'm -- the CDC used to keep -- prior to 1987, used to keep the birth dates of fathers on natality records, and I think also had birth date on the death records. After 1987 they changed their policy for privacy concerns to get rid of it. And, I thought, okay, well, I'll study pre-1987. I'll study the 1980s. And not only did they eliminate it post '97, my understanding is they actually purged everything backwards. So you have to get special permission.

So, the person -- I'm gonna collaborate with the person who wrote the original article in the New England Journal, Norman Hearst at UCSF Med School and we're -- have to apply specially to get the birth -- because the birth date information on the dads is still there -- or the dead men, are still there, somewhere in the CDC. But we have to get special permission to get it. So that's the -- so, we don't have any data yet.

There is, you know, like I said, that one study that came out. And there is evidence from administrative records and Social Security about these income changes. That's there. You just have to sort of link them together by getting these sensitive data.

Worse comes to worse, we can do it at -- many states have already found -- California, Pennsylvania, a lot of the big states, that we can get the data with the birth dates there.

MS. JENNIFER STUBERG: Hi, I'm Jennifer Stuberg (sp) from New York City. I have a question for Professor Williams. I wanted -- actually two questions. One is more methodological and I think a little easier and the other one is more conceptual.

The first one is the methodology question, is just in terms of -- I do some work looking at the disassociation between discrimination and health outcomes. How do you actually go about, you know, measuring segregation on a community level? Say if you're doing a survey on several different communities, how would you actually go about measuring the effects of segregation across communities? So how would you measure segregation, I guess is the question?

DR. WILLIAMS: There are multiple measures for segregation if you look in the literature at the work of Stanley Lieberson, Massie (sp) and Denton (sp) have outlined -- the index of dissimilarity is the most widely used measure, but there are more than 20 different indices that have been developed that capture some aspect of segregation. So there's a huge literature in demography particularly, on that subject.

MS. STUBERG: Okay. But are there certain ones that you think would be the best to look at in terms of health, that would capture the, you know, the most significant effects, or --?

DR. WILLIAMS: There is in fact, also literature. There's a book by Anthony Polednak on segregation and health that reviews the literature that has looked at segregation and mortality. So there are at least about 15 studies that have looked at segregation in either adult or infant mortalities. There's a literature on that already.

Most of them have used the dissimilarity index, but some of the more recent studies have also used the isolation index. I think it is -- if you -- in the literature that we -- there has not been enough theoretical articulation of what aspects of segregation may be most important and, therefore, what measures might be most relevant for studying health outcomes. But I could talk to you later about -- there's a literature on that.

MS. STUBERG: Okay, I guess, just the second question is, in many ways I felt like -- at least in respect to me, you're kind of preaching to the choir. I go to work in East Harlem every day and I see, you know, what a depressed community that is and how powerful, you know, small things are in terms of, you know, the impact of Harvey and how that could affect people's health. But I guess I'll ask, just in terms of your own work, what would be your response to sort of the pull yourself by your bootstraps mentality in terms of -- you know, other groups have come to this country and have managed to get around some of the segregation or -- you know, why is it that these depressed communities remain so depressed?

And I know this is a very large question, but I guess maybe I'll come ask you that after, if you don't want to go into that now. But I just, sort of feel like this is the argument that always comes up. I was arguing about it with someone last night over dinner. I just sort of feel like I don't have the tools to really dispute that argument.

DR. WILLIAMS: There's actually a good book. A Piece of the Pie, by Lieberman, accurately addresses that question of what has been different? Why is the experience of African-Americans in this country in the last 100 years different than that of other immigrants? And I think it's -- that's my knowledge -- it's best laid-out in that book, entitled, A Piece of the Pie, by Stan Lieberman.

But, I mean, part of what I was talking about is in fact the distinctiveness of segregation. Those are a unique set of circumstances that no other group has experienced in this country except, again, American Indians in Indian reservations, I think would be the other similar -- most similar type of situation.

DR. MECHANIC: We'll take one more question.

DR. WILLIAMS: By the way, the other point -- although it's preaching to the choir, and those of you who would like to see the argument better developed, the most recent issue of Public Health Reports has a special issue on disparities, and this presentation is drawn from the paper there. But I think segregation is not an issue that's on the health policy agenda at all. And that's the importance of recognizing some of these really basic fundamental causes.

MR. KEVIN FACALIS: Kevin Facalis (sp), from Rochester, New York.

Again, I want to applaud you for putting segregation on the map. I absolutely agree that it is, in fact, a fundamental cause. My question is, is where do we go from here? And I think bussing has been an absolute dismal failure in terms of desegregating the schools, much less neighborhoods. But do you have thoughts about specific policy that might be helpful?

DR. WILLIAMS: Yeah, the word is not good. I think if we look at the work of Larry Bobo (sp) and others and the Science Treaty Study (?), that the data from California suggests -- I showed you 2000 census data suggests the persistence of relatively high levels of segregation on the one hand.

What the work from California indicates that great racial and ethnic diversity is unlikely to lead to lower levels of segregation in the future. And that is that Hispanics -- as negative as Whites in their viewing Blacks as neighbors, and Asians are more negative than Whites in viewing Blacks as neighbors.

So, in context of greater racial ethnic diversity, although African-Americans reflect the highest desire of any racial group in the United States of living in racially diverse neighborhoods, all other racial groups view them negatively as neighbors. So that the current demographic trends wouldn't encourage me to think that we will see some dramatic progress on the segregation front. That's my sense of the literature.

What that means -- I don't think there is any thing inherently bad about living next to persons of your own race. So the issue is not segregation, per se, but it's the social disadvantage and the concentrated poverty and the concentration effects that Wilson talks about that co-occurs with segregation.

What clearly is therefore needed is, if we can't change the segregation, but we could have an infusion of resources to change the structure, the economic conditions, and the economic opportunities in those communities. That would really be a massive investment.

I think persons who talk about reparations, I think, and I make the case with one use of reparations would not be to targeted individuals, but to targeted at communities to improve the infrastructure of communities. That's certainly one option. Whether that's a viable option politically, at this point in time, I'm doubtful of.

But I think that's the -- you really have to think of ways in which we can improve the structure and economic conditions of communities to improve living circumstances and, thus, improve health.

DR. MECHANIC: I want to thank the panel for excellent presentations and I want to thank you all for coming.

END

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