RACISM IN PUBLIC HEALTH SERIES

PART 3 - HOW TO ADDRESS HEALTH DISPARITIES

Guest: Dr. Paul Halverson, DrPH, FACHE, Founding Dean of the Richard M. Fairbanks School of Public Health, University of Indiana

Moderator: Dave Plough, IU Richard M. Fairbanks School of Public Health

Transcription provided by Scribie:

REGION V PUBLIC HEALTH TRAINING CENTER

Region V Public Health Training Center
University of Michigan School of Public Health
1415 Washington Heights
Ann Arbor, MI 48109-2029
rvphtc.org | rvphtc@umich.edu

[music]

Dave Plough (DP): This episode is part of a special series on racism in public health. For ideas for practice, a podcast of the Region V Public Health Training Center. As one of 10 public health training centers across the country, the Region V PHTC aims to strengthen the skills of the current and future public health workforce, in order to improve population health outcomes. We hope this podcast will share insights and spark ideas amongst those working in public health. In this episode, I will be speaking with professor and founding dean of the Indiana University, Richard M. Fairbanks School of Public Health, Dr. Dean Halverson. And we'll begin things the same way we've started the other two episodes in the series, by getting Dean Halverson's perspective on why racism is a public health issue.

Dr. Paul Halverson (PH): It's a public health issue because we all suffer, but we don't suffer evenly. In other words, as we look at the public health spectrum, we ask the question, "Why do people die? And how long do they live?" And you know, when you ask that question, you get a really shocking answer, which is, it really depends on where you live, your zip code is probably your best indication of how long you'll live, and race and zip code are also sometimes very related, and so this is a big issue for public health, because public health is interested and mandated to look not just at individual health, but to look at the health of a community, and in our case, the health of a county or the health of the state. And in Indiana, unfortunately, we rank 41st out of 50 states. Our public health funding is 48 out of 50 states.

PH: So we've got a long ways to go when we've got big issues. So today, as we think about health, we have to think about racism as an emergency because we've got people dying and suffering in disease solely on the basis of their racial characteristics, and we've gotta narrow that gap, we've gotta make sure that everyone has access to health care services, but more importantly, we need to prevent these diseases to start with, and so that's why as public health thinks about its responsibility towards preventing disease and disability, we need to put higher priority on addressing these differences by race and ethnicity.

DP: Something that you used in your answer there, zip code and race add to the determinants of your health. The easy follow-up really is the good question here, why is that?

PH: We're still trying to figure that out, but part of it came as a result of redlining and looking at availability of financing, the emergence of mortgage guidelines and private policies that had substantial impact on where people of color could live based upon lending policies, which now are increasingly referred to as the redlining of particular areas where financing may or may not have been available. It also has to do with the socio-economic status, there are some areas in a community that tend to be lower cost and therefore based upon the social economic status of individuals. And we know that, unfortunately, there is a division by race in particular as it relates to some of the socio-economic characteristics. And that has a lot to do with availability of education, career mobility, a whole host of things that ultimately tie together race and zip code. Now again, there's nothing inherent about living in a particular area, but unfortunately we do see a

consolidation or a concentration of both race and ethnicity and zip code in an association, and so that's part of it.

DP: In your role, are you able to address those disparities related to race?

PH: Yes, and I think what's really important. So if we go back to the founding of the Richard M. Fairbanks School of Public Health, Mr. Fairbanks was a philanthropist that established his own foundation, and one of the things that he had a strong interest in was creating a philanthropic effort that would benefit the health and well-being of the community, and particularly in Indianapolis, the Fairbanks school was created in large part in to respond to a major issue in the state, which is, we don't live as long, we suffer from chronic diseases, longer and harder, and quality of life is not as good. And so the mandate, if you will, for our school, was to focus on not only incredibly top notch education and research and service to the community, but really focusing on preventing disease and improving the health of the public.

PH: And especially here in Indianapolis and across the state, and so our focus as an educational institution is not only the traditional research, teaching and service, but that service has actually manifested itself into a mandate for Public Health Practice, which is both relevant, accessible and impactful, and that's actually built into our strategic plan. It's really in our DNA. It's what we're all about. So at the end of the day, what we need to be about as an institution is focusing on making improvements to the health of the state, and so for us, this is a major issue. And again, as we look at race as a public health emergency, we actually examine what are the strategies that we might use in particular to try to address working in neighborhoods and communities, being able to specifically partner with various neighborhood groups and with various racial and ethnic minority organizations and individuals.

PH: And so much of our work in addition to our terrific educational programs have in common the fact that we do work in the community and that public health at its root is a scientific pursuit of helping protect and improve the health of the public. So can we make a difference? Yes. And do we need to? Yes, every day we need to be out in the community working with communities in partnership to support the strong neighborhoods and to help them help themselves, and so whether we're working with church organization, a community organization, community development organization, working with the county health department, for example, or the state health department, or most recently, Governor Holcomb created this new Governor's Public Health Commission, all of those organizations are focused on day-to-day public health, and we're very active in all of those venues.

DP: That's great. And so it answers and leads to my next question. I know you mentioned your research and you're partnering with community organizations, but what other efforts do you think are necessary to see change?

PH: I mentioned earlier that we're 48 out of 50 states in terms of our per capita investment in public health infrastructure. That means that we don't have the systemic capacity at the

state or local level to work with communities to the extent that we need to, to be able to prevent disease and focus on health improvement, and that has a direct negative bearing on people of color and various racial and ethnic minorities because they're in greater need, and yet there is generally speaking, not the capacity that there is in other states and in other communities to really focus on these issues. Now, Marion County is a special exception to this rule, and my good friend, Dr. Caine I think is doing a marvelous job, and the people in Marion County, I think get it.

PH: They recognize the importance of having a strong health department, and I think Dr. Caine leads a very strong local health department that doing marvelous thing is to support and improve the health of the public in Marion County. That being said, we still have huge challenges in Marion County, but that's true across the state. And as a consequence, I think one of our big responsibilities systemically is to grow our public health infrastructure. We really need to address this long-neglected public health system, and it's not just the local health department, it's all of those organizations that work together, that should be focused on improving the health of the community.

PH: We often talk about the fact that we have this great healthcare system and we do, Indiana has got some terrific hospitals and great doctors, but at the end of the day, we cannot say that the US health system is the best health system in the world. We'd like to all believe that, but it's not true, we pay the most money, but we don't really get that much for it, and in fact, out of all of the OECD countries, 39 countries, we're 39th than a number of things and we're not leading the pact in just about anything, except with the fact that we pay more money than everybody else does. So our healthcare system is expensive, it's not always available, and we've got a public health infrastructure which is underdeveloped, underfunded and long ignored.

PH: So we need to build public health infrastructure, we need to create an awareness of what public health is, we need to put more money towards it, and we need to be much more purposeful in acknowledging that that public health infrastructure investment is directly linked to our success economically. That's an important first step. We need to understand what public health is, invest in it, and create acknowledged and understood expectations around what Public Health could do for us. But secondly, we need to be able to recognize the issues that minority populations face, we need to better understand how to speak with and to organizations. It's not about what we do to them. It's about what we do with them.

PH: We need to better understand the reality that many of these communities face, and so much of what they face is in large part because of the culture in which we've developed where unfortunately, there's a huge difference between a white populations and black population, and so recognizing that difference and understanding our responsibility collectively to work towards improvements in health status, in availability of health services of specific public health measures that we need to undertake to support improving the health of racial and ethnic minorities in our communities is really, really important.

PH: And so again, it's working with communities to support their interests and to address their concerns. The good thing, and the most important thing is to recognize there is a science around public health, we know what works, we don't have to go out and try a whole bunch of different things and hope that something happens. The United States Preventive Services Task Force has developed a data related to clinical services, we also have the Guide to Community Preventive Services, which is an evidence-based book that describes what works in communities and under what conditions and so forth. So there is a science related to public health, and so what we need to do is we need to fund it, we need to implement it, and we need to work with communities to see the benefits.

DP: If someone were to walk up to you today and ask what they could do to be actively involved in addressing racism, breathing change, what would you tell them?

PH: Well, I think it starts with they need to understand what role they play and recognizing what situation that they're in. We all come to the table with certain characteristics, certain racial characteristics, certain advantages and disadvantages, and recognizing that collectively we need to do better, having that understanding of context, of an awareness, of who we are as an individual and collectively, and then beginning to think through with our neighbors, with our colleagues, with our friends, with people that we wanna help, they recognize that it is about what we collectively want to do and create the political will and get the support to actually do something. We'd like to believe that you push a button and things will be different, it's not quite that simple.

PH: There's no simplistic answer that you can just turn a switch and things happen. So that being said, individuals can make a difference, first of all, by sort of understanding the role that they can play, the role that perhaps they and their ancestors played in essentially creating the conditions that we find ourself in, but then secondly, thinking through, "So what can I do differently? How can I contribute to improving the environment that we find ourselves in?" Contributing towards making things better, and that could be about trying to create awareness about health factors or health education, it could be focused on trying to improve access to health services.

PH: It could be working in your church or synagogue or mosque towards trying to find ways collectively to increase the level of awareness of things like vaccines, or working towards creating greater access, school-based clinics are great. There's a whole lot of things that we can all do and everyone working together, taken together, we can make a difference. You start with where you're at and what you're interested in, and just about everything that we do has some impact on health. There's this concept called Health in All Policies, which basically says that regardless of what industry you're in or whatever we're doing in our occupation or in our hobbies, there's a health aspect related to it, whether it's increasing walkability, whether it's improving access to fresh fruits and vegetables and healthy foods, by having a community garden or focusing on accessibility of clean water, and those kinds of things.

PH: All of those things make a difference. It's not any one thing, it's taken together that increase the likelihood of success, and it's also beginning to recognize politically that these

differences exist and that we need to say enough is enough, we really have got to recognize that just because we have a difference in race, that should not be the excuse for substantial differences in life expectancy, we've got this latest study that was just completed by Tess Weathers, a faculty in our School of Public Health. She updated the numbers around the differences in life expectancy about 17 years different in life expectancy in about 18 miles, and it's gotten worse, it's 23% worse than it was five years ago.

PH: So it's not getting better. We need to begin to address the situation and recognize that this is intolerable, there should not be that kind of difference, and we need to begin to say, "This is not gonna wash anymore. We need to change this, we need to have the political will." Do we essentially say, "This has gotta stop. We gotta change things, we gotta begin to recognize that it starts with us, and we need to begin to say what's acceptable and what's not." And that difference in life expectancy is just completely unacceptable, the fact that people die three times more likely of having a stroke for example, just simply based upon race, the prevalence, higher prevalence of hypertension or high blood pressure based upon race, all of those things create for us, these huge differences, which we know about them, but they should be completely unacceptable to us. And I think by creating that awareness, we're able to begin to address the situation by beginning to recognize that these differences exist and then begin to work towards eliminating them or at least greatly reducing them.

[music]

DP: That is all for Dean Halverson, many thanks to him for taking the time out of his schedule to come join us on this project. We encourage you to check out some great resources in the podcast notes, as well as an evaluation and transcript. This podcast has been brought to you by the HRSA Region V Public Health Training Center at the Indiana University Richard M. Fairbanks School of Public Health. And funding for this podcast is provided by the Health Resources and Services Administration. I've been your host, Dave Plough, and I thank you for listening.

[music]

+++