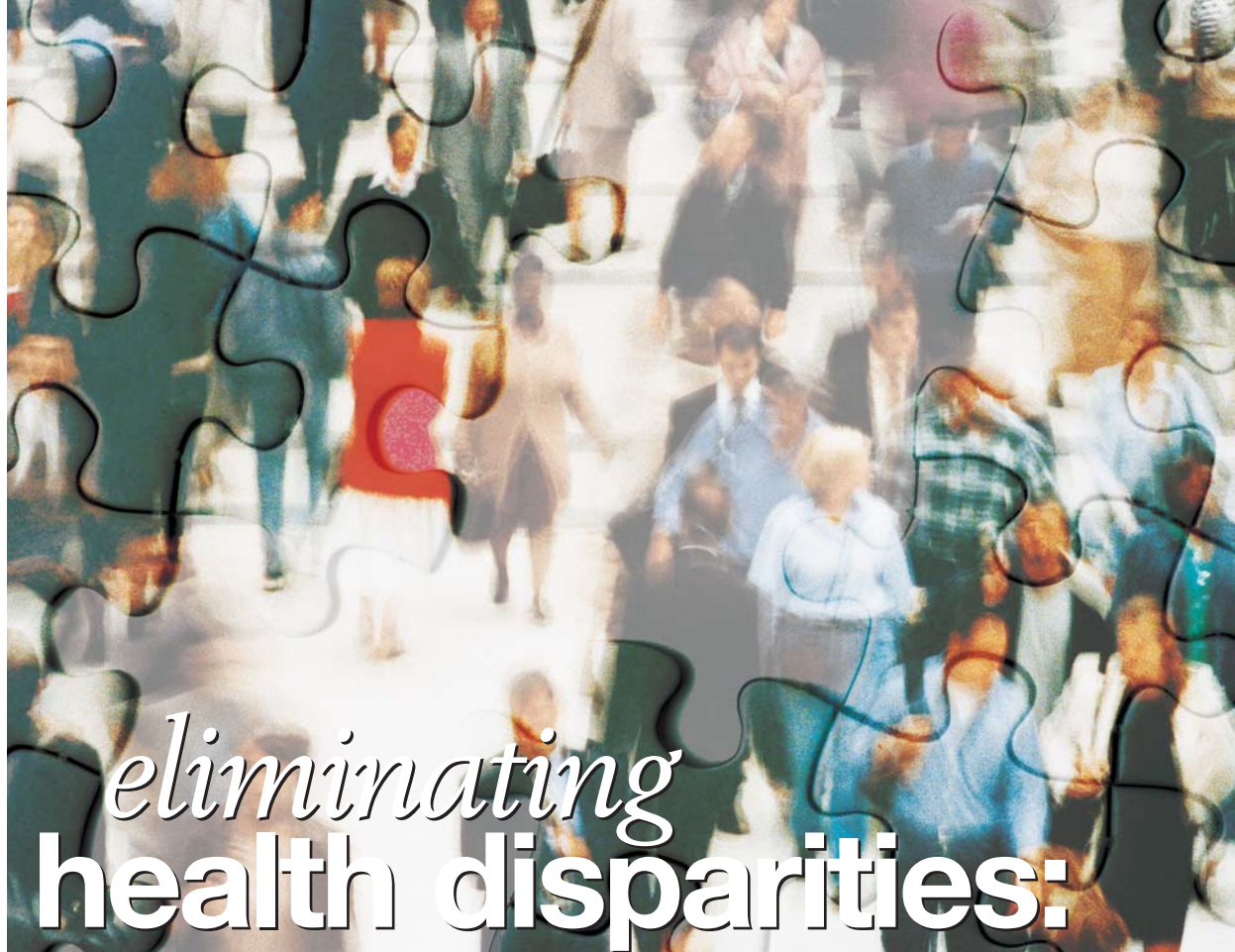


AS BEFITS ITS TITLE, THE CENTER TO ELIMINATE HEALTH DISPARITIES DOESN'T STOP AT IDENTIFYING PROBLEMS; WORKING WITH THE AFFECTED COMMUNITIES, IT INTENDS TO GET RID OF THEM.



# eliminating health disparities:

## Closing the Gaps Created by Social Inequities

When you break down rates of the most common health problems by race, ethnicity and socioeconomic status, the results begin to appear all too predictable. Almost without exception, there are sizable differences – now commonly referred to in public health circles as disparities – in who has these conditions and how they fare with them. Often, exceptions seem to prove the rule. White women, for example, have the highest rates of breast cancer – but African American women are the most likely to die from the disease.

One of the two overarching goals of Healthy People 2010, the set of health objectives put forth for this decade by the U.S. Department of Health and Human Services, is “to eliminate health disparities among different segments of the population.” The groups consistently on the wrong side of the chasm are communities of color, immigrants, and those with low income and low education. Despite the increased attention, the gaps are, in many cases, widening.

“Disparities can be found in virtually every health condition, across the life-span,” says Dr. Roshan Bastani, the school’s associate dean for research. “Whether we’re talking about infant mortality, childhood vaccinations, pregnancy outcomes, or chronic diseases, all the way up to issues related to aging, it’s almost impossible not to see differences in who gets sick, the type of care received, and health outcomes.”



“Only when everyone benefits in the same way are we going to have a healthy population as a whole.”

—Dr. Roshan Bastani

Through research, training, outreach, and community-based partnerships, the school's Center to Eliminate Health Disparities (CEHD), under the leadership of co-directors Bastani and Dr. Antronette (Toni) Yancey, has set out to reverse these trends. Established in 2005, CEHD brings together faculty from the School of Public Health and other parts of UCLA, as well as community-based groups and local and state health departments, to learn from each other and join forces to make a difference in addressing these concerns.

For the past two decades, Bastani has been a leader in documenting and addressing disparities in which populations are most likely to get cancer and why, through her work as associate director of the Division of Cancer Prevention and Control Research, jointly housed in the school and UCLA's Jonsson Comprehensive Cancer Center. In that time, researchers have learned more about primary prevention strategies that can reduce the risk of developing certain cancers, and methods have improved for detecting malignancies early – when treatment is far more likely to be successful. Bastani has studied factors influencing utilization of screening for a variety of tumors, starting with breast and cervical cancer, then colorectal and prostate cancer. Most recently, her focus has expanded with the advent of screening and vaccines for hepatitis B, which can cause liver cancer, and the human papillomavirus (HPV), which can cause cervical cancer.

“Unfortunately, the populations that are at greatest risk for some of these cancers are the least likely to benefit from the advances,” says Bastani.

There are disparities in who is most likely to have certain risk factors for cancer, such as obesity and exposure to environmental carcinogens. But as with cancer screening, Bastani notes, the same populations that are most likely to be at higher risk are often the least likely to benefit from what is known about how those risks can be avoided.

“Twenty years ago there were disparities, and there are disparities today,” says Bastani. “We have made some progress, but not nearly enough.”

The idea for the center grew out of the realization that many of Bastani's colleagues on the School of Public Health faculty and elsewhere on the UCLA campus have also spent much of their careers focusing on similar issues involving other diseases. Despite striking similarities in the factors contributing to disparities across the spectrum of health conditions, there had been little collaboration. “We felt that by bringing people from disparate areas

together, we could be more effective at producing the changes we hope to bring about,” Bastani explains.

Although genetic factors play a role in differing racial and ethnic incidence rates for a handful of conditions, the term health disparities refers to the gaps caused by social inequities. These inequities, Yancey says, are pervasive and powerful in making disenfranchised populations less likely to be able to adequately prevent, screen for, or get treatment for particular conditions.

“Health disparities generally refer to differences involving higher disease incidence, severity, or mortality rates, and those differences are related to socio-economic marginalization,” Yancey explains. “It can affect people who belong to ethnic minority groups, women, gay and lesbian populations, people who live in rural areas...there are lots of different reasons disparities can exist, all related to social inequity.”

Health disparities are not new, but they have moved to a prominent place on the nation's public health agenda thanks in part to attention drawn to the issue by influential leaders such as former U.S. Surgeon General David Satcher. Yancey also points out that with improved data collection, researchers are now much better able to compare health status across populations over time, in search of trends.



## CANCER SCREENING AND MANAGEMENT

**African American women are more likely to die of breast cancer than are women of any other racial or ethnic group, although they have lower rates of the disease than white women. They are also more than twice as likely to die of cervical cancer as white women.** *Source: National Center for Health Statistics*

All too often, those trends show that disparities are persisting, and sometimes widening. “Most of the progress that's been made has been to elevate everyone, without reducing the disparities,” Yancey says. “Infant mortality rates have improved, but there still are much higher rates among African Americans than among most other groups. Physical activity levels have improved slightly across the board, but Latinos and African Americans, especially women, still fall considerably behind.”

Because health disparities tend to largely reflect societal inequities, simple solutions are hard to come by. But, as befits its title, the Center to Eliminate Health Disparities is taking up the challenge. “We're not just interested in documenting these disparities,” says Yancey. “We're interested in developing the interventions – the policies, programs, regulations,

and organizational practices – that will ultimately eliminate them. We believe it's entirely possible to do so, and that *not* doing so is inconsistent with public health, which addresses the health needs of entire populations, and particularly the groups that are most vulnerable.”

By studying health conditions across social strata, CEHD researchers are able to glean insight into the causes of disparities, as well as what strategies are most likely to succeed in closing the gaps. African Americans have among the highest hypertension rates in the world – much higher than those of Africans, an indication that environment, more than genetics, is the culprit. Low-income African Americans have much poorer hypertension outcomes than more affluent African Americans, suggesting that class is an important factor.

The history of HIV/AIDS in the United States is also telling. “Gay white males were the group most affected in the epidemic’s early years,” notes Yancey, “but because they had the resources in terms of dollars and communication networks, and were distributed at all levels of the power structure of society, they were able to mobilize and, over the course of a generation, drastically reduce infection rates. Now, HIV in this country is an epidemic among poorer people more than it is among gay white men.”

“Most public health problems are concentrated in poor communities,” says Dr. Alex Ortega, associate professor of health services at the school and a CEHD member. Ortega studies disparities among populations of children with asthma, particularly Latinos (see page 15). Even among the Latino populations he studies, there are significant disparities in asthma rates and outcomes, with Puerto Ricans – the poorest subgroup – the hardest hit. “There are so many possible contributing factors, including the environment, psychosocial issues, cultural issues, lan-

guage issues, and discrimination,” Ortega says.

“What’s important to me is to try to tease out what are the most modifiable factors for improving the health of these populations.”

One such effort involved a visit to Cuba to learn about the country’s primary health care system. As part of the Faculty Community Health Leadership Program, Ortega and other representatives from the School of Public Health, Charles Drew University, and the Los Angeles County Department of Health Services accompanied community health leaders from South Los Angeles on the trip, which was undertaken in conjunction with the non-profit MEDICC (Medical Education in Cooperation with Cuba).

Despite relatively low health spending, Cuba earns high marks on health indicators such as life expectancy and rates of cardiovascular disease, cancer, and infant mortality. The goal of the project was to assist the community health leaders in determining what lessons they might take from Cuba’s system and incorporate in their community, where limited resources lead to poor outcomes. “Most of the program’s participants felt they had learned something positive from going to Cuba, particularly about the integration of public health and medical care, in which medical professionals are expected to also be involved in public health practice in communities,” Ortega says.

The bulk of disparities research has focused on documenting the differences, rather than on studying solutions. CEHD’s primary focus is not only to develop and test appropriate strategies, but also to team with the affected communities at every stage and to ensure that solutions are sustainable. “A lot of disparities work stops at identifying the problem,” says Bastani. “We want to go beyond that and actually conduct interventions in the community to alleviate the problems.”

One of the ongoing initiatives exemplifying the community-university partnership is the UCLA Community Research in Cancer (CORICA) Network, a five-year project aiming to tackle socioeconomic and racial/ethnic disparities in cancer through research that links the university with the community, particularly in underserved areas in Los Angeles. The UCLA CORICA Network is one of eight in the nation funded by the Centers for Disease Control and Prevention and National Cancer Institute.

“There is too often a lack of communication between these two worlds, and so the university research is not always applicable to what’s going on in the community – or if it is, it’s not adequately disseminated,” says Dr. Ritesh Mistry, a postdoctoral fellow and project director of CORICA. Among the



## DIABETES

**In 2000, American Indians and Alaska Natives were 2.6 times more likely to have diagnosed diabetes than non-Hispanic whites, African Americans were 2.0 times more likely, and Hispanics were 1.9 times more likely.**

*Source: National Center for Chronic Disease Prevention and Health Promotion*



## CARDIOVASCULAR DISEASE

**Rates of death from heart disease were 29 percent higher among African American adults than among white adults in 2000, and death rates from stroke were 40 percent higher.** *Source: National Center for Health Statistics*

CORICA initiatives aiming to bridge that divide is the Korean Health Study, which will work with churches in Los Angeles-area Korean neighborhoods to test educational interventions designed to increase screening and prevention for hepatitis B, which is significantly more prevalent in the Korean community than in other minority communities. “The church is a major part of the social and cultural fabric of the Korean community in Los Angeles, so we want to see if that institution can be used to promote health,” says Mistry. Half of the churches in the study will participate in the hepatitis B intervention, while the other half will focus on exercise and nutrition.

### INFANT MORTALITY

**African American, American Indian, and Puerto Rican infants have higher death rates than white infants. In 2000, the black-to-white ratio in infant mortality was 2.5. The disparity between black and white infants has been widening over the last two decades.**

*Source: National Center for Health Statistics*

Bastani notes that disparities research has moved away from a previous bias toward thinking about health in terms of individual decisions. “There is now much more emphasis, although still not enough understanding, on larger, societal factors that are very important in determining these disparities,” she says. When trying to prevent obesity in low-income communities, it’s a mistake to ignore factors such as the lack of grocery stores carrying affordable healthy foods, or the inaccessibility of exercise opportunities because of unsafe streets and parks. Similarly, when transportation to an affordable mammography facility requires catching three buses for a woman who is forced to work long hours, disparities in low-income communities’ utilization of breast cancer screening should not come as a surprise.

CEHD researchers are focused on policies and programs that would reduce disease rates in disadvantaged communities, with a particular emphasis on tobacco, physical inactivity, poor nutrition, and alcohol, which account for the lion’s share of preventable illness in this country. That means, among other things, working toward policies that reduce tobacco usage and secondhand smoke; ensuring that fruits and vegetables are available in low-income neighborhoods through school programs, farmers’ markets and incentives offered to stores; advocating for conditions that increase physical activity, through greater park access, more mass transit and incentives for worksite policies that promote exercise and healthy food choices; and pushing for improved access to health care.

In addition to working directly with the community stakeholders, CEHD is forging strong ties with local health departments, particularly the Los Angeles County Department of Health Services. One of the center’s largest projects is a partnership with the county to go into 30 workplace settings with health and social services staff in a joint effort to identify the types of policy and environmental changes that would help the workers to eat more healthfully and engage in more physical activity during the work day in their own settings; the hope is that by assisting these workers in adopting healthier practices, the workers will be better equipped to assist their clients in doing the same.

The collaboration with public health practice and community leaders is part of CEHD’s strategy to ensure that the interventions designed to address health disparities will be both practical and sustainable. “It’s one thing to come up with a great program, but if it can’t be continued once you’re gone, what good is it?” says Yancey.



**“We’re interested in developing the policies, programs, regulations, and organizational practices that will ultimately eliminate [disparities]. We believe it’s entirely possible to do so, and that *not* doing so is inconsistent with public health.”**

—Dr. Antronette (Toni) Yancey



## HIV INFECTION/AIDS

**African Americans and Hispanics, who represented 26 percent of the U.S. population in 2001, accounted for 66 percent of adult AIDS cases and 82 percent of pediatric AIDS cases reported in the first half of that year.** *Source: National Center for Health Statistics*

Effectively addressing disparities also means increasing the pool of public health practitioners and academics who are interested in these issues, particularly those who come from the underserved communities themselves. The center has obtained funding from The California Endowment and California Wellness Foundation to support students serving, and often themselves from, underrepresented populations.

Neetu Chawla, a second-year Ph.D. student, is the lead instructor for Youth Into Health Professions, an introductory public health course offered by the school at the Watts Labor Community Action Committee. The course, which draws high school and community college students from the Watts and Compton areas, is an effort to increase the pipeline of underrepresented minority students pursuing education in public health.

“We are one of the only industrialized countries that doesn’t have a system of universal health care, which means that health care becomes part of the market economy and certain groups get left out,” Chawla says of her interest in addressing disparities. “It’s important to document health disparities and the reasons for them, so that we can adopt strategies to address them.”

First-year Dr.P.H. student Marina Alvarez has been motivated to find strategies to eliminate health disparities since she was a teen. When Alvarez was 14, her father, who brought his family to California from Mexico, was diagnosed with a brain tumor. Although Alvarez’s mother became a strong advocate for her husband, Alvarez saw the barriers to adequate care that could hinder families with limited education and English-language skills. While studying for her doctorate, Alvarez is serving as project director of CEHD’s Latino Men’s Health Study, which is testing a community-based educational intervention designed to increase informed decision-making about prostate cancer screening among Latino men. With a fellowship from The California Endowment that funded her first year in the program, Alvarez conducts outreach at community events to recruit students to the School of Public Health and promote CEHD and its activities.

Where Mistry grew up in Bombay, India, everyone was poor. He moved to the United States as a child and was struck by the difference that affluence could make in people’s lives, particularly as it affected their health. “That really shaped my thinking,” he says. “I began to ask why life tended to be so much more difficult for certain people, and what could be done about it.” Mistry earned his Ph.D. from the school in 2004, studying how people’s social environment affects their health behaviors. He is continuing that focus as a postdoctoral fellow, looking specifically at the influence of the social environment on adolescents’ tobacco use.

Bastani believes the work of Mistry and the other CEHD members is central to the public health mandate. “If there are some populations that are being left behind, it is our responsibility to address those disparities,” she says. “Only when everyone benefits in the same way are we going to have equity in society and a healthy population as a whole.”



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—Dr. Ritesh Mistry



## IMMUNIZATIONS

**African Americans and Hispanics are approximately half as likely as whites (31% and 30%, respectively, vs. 57%) to receive the pneumococcal vaccine.**

*Source: Morbidity and Mortality Weekly Report, 2002*