

**BEYOND DESCRIPTION: ADDRESSING HEALTH DISPARITIES THROUGH
CAMPUS-COMMUNITY PARTNERSHIPS
MARCH 28-29, 2006
SUMMARY BRIEF**

The National Center for Institutional Diversity, based at the University of Michigan, organized a series of learning activities over two days to focus on health disparities within our society, their causes, their implications, and what can be done to address them at a community, state, and national/international level. Specifically, we examined the implications of these issues for a National Center for Institutional Diversity, for research and teaching across the University of Michigan, for the people who live and work within our community, and for preparing future professionals who will successfully address these problems. At the outset of the colloquium, we invited a framing presentation positing the underlying causes of health disparities in our society and around the world. Subsequent presentations included panels of distinguished speakers who guided us as we delved more deeply into local, state, and national/international examples of health disparities that are being addressed through creative university community collaborations. We concluded with an exploration of ways to initiate and sustain change effectively, specifically examining implications at the individual, institutional, community, and global scale. This conference engaged a broad cross-section of individuals, including educators, researchers, health practitioners, community leaders, policy makers, students, and advocates, to examine the issues that might explain and perpetuate health disparities in our community, state, and nation.

KEY LESSONS

- Campus-community partnerships constitute a form of professional practice that cannot be taken for granted and must be enhanced through constant reinforcement of key principles.
- Whereas knowledge of the factors that shape health and disease is available, we need to do more research to understand how public will and policy solutions can be aligned with publicly expressed values and our understanding of what works.
- There are many "simple," effective interventions that are not attempted or sustained for lack of coherent policy and appropriate cultivation of public opinion.
- Diseases have a political nature; that is, some disease states are more compelling than others because of who is affected, where and with what political implications.
- The influence of racial differences on the etiology and physiology of disease is insignificant when compared with the influence of race on health circumstances, expenditures, and access.
- Children can be motivated to address complex international issues of health given the right information and good teaching.
- Concern for the health of children is intellectually, morally, and emotionally compelling to many adults.
- We must develop the next generation of leaders to take up these issues. Specifically, we must address pipeline issues.

- We cannot spend our way into better health.
- There is a specific form of leadership that operates within effective, sustained campus-community coalitions. This leadership is demonstrably different than that practiced in either institutional settings or in typical community settings.
- Community-Based Participatory Research takes time!
- There are barriers to community-based participatory research inherent in the university system. Adjustments must be made to existing reward structures and expectations for both tenured and tenure-track faculty.
- Warnings should not serve as a deterrent to engagement; they should promote informed engagement.
- Campus-community partnerships are valuable and vulnerable.

COLLOQUIUM FRAMING STATEMENTS

Racial/Ethnic differences in health are large

- In 2001, African Americans had higher death rates than Whites for 12 of the 15 leading causes of death.
- Blacks and American Indians have higher age-specific mortality rates than Whites from birth through the retirement years.
- The death rate for Blacks today is equivalent to that of Whites some 30 years ago.
- Hispanics have higher death rates than Whites for diabetes, hypertension, liver cirrhosis, & homicide.
- In the last 50 years, although overall health has improved, racial differences in health are unchanged or have widened.

Socioeconomic status (SES) is a central but incomplete explanation of racial differences in health

- Institutional discrimination can restrict socioeconomic attainment.
- Segregation can create pathogenic residential conditions.
- Discrimination can lead to reduced access to desirable goods and services.
- Internalized racism (acceptance of society's negative characterization) can adversely affect health.
- Racism can create conditions that increase exposure to traditional stressors (e.g. unemployment).
- Experiences of discrimination may be a neglected psychosocial stressor.

Segregation affects health

- Segregation determines quality of education and employment opportunities.
- Segregation can create pathogenic neighborhood and housing conditions.
- Conditions linked to segregation can constrain the practice of health behaviors and encourage unhealthy ones.
- Segregation can adversely affect access to high-quality medical care.

There are racial/ethnic differences in access to care and the quality of care

- Across virtually every therapeutic intervention, ranging from high technology procedures to the most elementary forms of diagnostic and treatment

- interventions, minorities receive fewer procedures and poorer quality medical care than Whites.
- These differences persist even after differences in health insurance, SES, stage and severity of disease, co-morbidity, and the type of medical facility are taken into account.
 - Policies to reduce inequalities in health must address fundamental non-medical determinants.
 - Health policy must be re-defined to include policies in all sectors of society that have health consequences.
 - Policies which improve average health may have no impact on social inequalities in health.
 - We need policies that improve health overall and targeted interventions to address social inequalities.
 - Major gains are possible through strategies that tackle health problems that occur most frequently.
 - Families with children should be a priority.

Toward solutions

- Knowledge of the extent of disparities and their causes is a prerequisite for effective action.
- In the U.S., over 50% of whites and over 50% of Blacks are unaware that racial disparities in health exist.
- Partnerships are needed with government, industry, and other private organizations.
- There is an important role for community involvement in the identification and management of interventions.
- There must be efforts to strengthen the capacity of community organizations to take action.

Source: Williams, March 2006

MALARIA: AN INTERNATIONAL EXAMPLE
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- Malaria is the leading killer of children in the world.
- It kills over 3000 children in Africa every day.
- It is a treatable and preventable disease.
- Both an awareness and a funding gap exist.
- International community must be engaged in seeking solutions.
- Issues of race and racism are fundamental to an understanding of why malaria persists on the scale that it does.
- Universities are playing an increasingly central role in advocacy efforts.
- Malaria control efforts must engage the endemic communities, regional governments, NGO's, and international aid organizations as respected and indispensable partners.

Source: Galinski & Wilson, March 2006

OBESITY AND ORAL HEALTH: A STATE-LEVEL EXAMPLE

- Must attack policy, behavior, and environmental concerns.
- Overweight & obesity rates increased for all age groups over the past 30 years.
- 65% of adults are overweight & obese.
- 16% of children & adolescents ages 6-19 are overweight.
- Rates increased in younger children and adolescents across all socioeconomic strata and among all racial and ethnic groups.
- African American, Hispanic, and Native Americans are disproportionately affected.

Implications of Obesity

- Type 2 diabetes is rapidly becoming a disease of children and adolescents.
- Obesity increases risks for other chronic conditions.
- Younger people are at risk of developing serious psycho-social burdens related to being overweight.
- Financial costs of obesity related health care expenditures range from \$98-\$129 billion annually.

Source: Doctor, March 2006

Oral Health

- Oral health is too often overlooked or neglected.
- Access to dental care is one of the top health issues that has consistently been identified by participants in focus groups in Detroit.

Source: Ismail, March 2006

ASTHMA: A LOCAL EXAMPLE

- Childhood asthma in Washtenaw County is almost twice the national average.
- Asthma has a complex set of symptoms, diagnostic criteria, causes and outcomes.
- Globally, asthma prevalence has increased steadily (20-50%) during the past two decades.
- Nationally, asthma prevalence and hospitalization rates have increased during the past two decades, especially for children and Blacks (mortality).
- Locally, asthma prevalence (not mortality) rates for Washtenaw County residents were higher than those for Michigan or U.S. These rates decreased during the period of 2000-2002.
- Children living within zip codes in the southeastern portion of Washtenaw County (Ypsilanti, Milan, & Pittsfield), have higher prevalence, hospitalization, and ER visits.
- Asthma hospitalization rates are highest in young children, black residents, and in urban areas.
- Asthma hospitalization rates in Michigan are three to five times higher for Blacks than for Whites.
- Mortality rates are higher for black residents and in urban areas.

Reasons for disparities include:

- Differential access to care
- Exposure to environmental pollutants
- Crowded conditions leading to increased exposure to allergens and infections

Source: Stoermer-Grossman, March 2006

COMMUNITY-BASED PARTICIPATORY RESEARCH : PART OF THE SOLUTION
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- Historically, research has rarely directly benefited and sometimes actually harmed the communities involved, and it has excluded the communities from influence in the research process (e.g., The Tuskegee Syphilis Study).
- Past research has been termed the “parachute model” of research.
- The old model of research includes no community benefit.
- Past practices have resulted in an understandable distrust of and reluctance to participate in research.
- CBPR is a result of increasing calls for more comprehensive partnership approaches to research and practice.
- There is an increasing interest in and support for such partnership approaches (e.g., funding opportunities through W.K. Kellogg Foundation, Robert Wood Johnson Foundation, Skillman Foundation, National Institutes of Health)
- Community-based participatory research is one such partnership approach.

CBPR:

- recognizes community as a unit of identity.
- begins with and builds on strengths and resources within the community.
- facilitates collaborative, equitable partnership in all phases of the research, involving an empowering and power sharing process.
- promotes co-learning and capacity building among all partners involved.
- integrates and creates a balance between knowledge generation and action for mutual benefit of all partners.
- emphasizes local relevance of public health and social problems and ecological approaches that address the multiple determinants of disease and well-being.
- involves systems development through a cyclical and iterative process.
- disseminates findings to all partners and involves all partners in the process.
- involves a long-term process and commitment.

Source: Israel, March 2006

QUESTIONS FOR FURTHER CONSIDERATION
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- Why is this topic an issue for a Center on Institutional Diversity?
- What are the implications of this colloquium for teaching, research and service in higher education?
- What are the implications of this colloquium for our health professions schools?
- What are the implications for us as citizens and community members?

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