

PUBLIC HEALTH LEGACY: HISTORY AND HEALTH DISPARITIES



Dr. W. Michael Byrd and Dr. Linda A. Clayton

On the Roots and Status of the American Health Dilemma: *An Interview with Dr. W. Michael Byrd and Dr. Linda A. Clayton*

W. Michael Byrd, MD, MPH, and Linda A. Clayton, MD, MPH, are physicians, health policy researchers, public health practitioners, and clinical consultants. They currently have faculty appointments at the Harvard Medical School and the Harvard School of Public Health. They are widely published and are co-authors of Volume I and Volume II of “An American Health Dilemma.” Both books were nominated for a Pulitzer Prize.

In these landmark works, the authors used a multidisciplinary approach to identify the origins, evolution, and perpetuation of health and health care disparities based on race, ethnicity, gender, and class.

The authors take us to the beginning of modern medicine in ancient Egypt and Mesopotamia. They then take us to the origins of Western science and medicine in ancient Greece and Rome, revealing in

Volume I the history of race in scientific theory and medical practices in the West and in the United States to 1900. It is a period that includes the horrors of the Middle Passage and slavery, the Civil War, the gains of Reconstruction, and the reversals of Jim Crow laws.

The second volume of this groundbreaking work, which covers 1900 to 2000, brings the story into the new millennium, chronicling how racism and nativism persisted and pervaded American life and

“Of all the forms of inequality, injustice in health is the most shocking and the most inhuman.”

The Rev. Martin Luther King, Jr., at the Second Annual Convention of the Medical Committee for Human Rights, Chicago, March 25, 1966

perpetuated inequalities in health and health care. As a result, African Americans and other disadvantaged groups are still in poor health compared to most whites. However, the book also shows how African Americans fought to open the health care system to disadvantaged groups and made Medicare and Medicaid possible.

Drs. Byrd and Clayton are married and live in Boston. In an interview with *Context*, they talked about their lives, research, and the importance of disseminating history-based information necessary to understand and eliminate disparities and provide health care justice and equity for all Americans.

Q: Dr. Byrd and Dr. Clayton, how and when did you get interested in the issue of health disparities?

MB [DR. MICHAEL BYRD]: Between 1964 and 1968, while attending Meharry Medical College in Nashville, Tennessee, I saw a huge dichotomy in the way patients were treated according to race and

class, especially when white doctors were involved. Black or poor patients were often managed inconsistent with their best interest. I also saw black and poor patients come into the emergency room after being rejected from hospitals that catered to whites and wealthier patients. The reasons given would be: “We didn’t have any more colored beds.” Sometimes they gave no reason at all.

I wondered why my highly cognitive and purportedly ethical profession behaved in such a manner. Unlike some of my classmates, I didn’t get angry. Somehow I simply became scientifically curious about the problem.

LC [LINDA CLAYTON]: My circumstances were different. I graduated from Duke medical school in 1975. Duke was a school that—up until the late ’60s—only admitted black obstetric patients for teaching demonstrations and experimental purposes. In fact, I had learned earlier that, because of segregation, Duke had refused to admit my own mother in the 1940s when she was pregnant with

continued >>



me. Therefore, I was delivered at home by a granny midwife.

In the 1970s, during my oncology fellowship, I noticed that my black patients always did worse and died more frequently from cancer. I then became interested in disparities in cancer. In the 1980s, I took a position at Meharry Medical College, a historically black institution, where I met Dr. Byrd, who started to tell me about his global research dealing with disparities from a larger perspective. So I became very interested in his research, and – by the late 1980s – our collaboration began.

Q: Why did you decide to write the books – the two volumes of “An American Health Dilemma”?

MB: When I graduated from Meharry, though everyone in medicine knew that there were great disparities in health status, no one provided reasons. No one wrote about, analyzed, or considered improving that state of affairs. Prior to our documenting this in “An American Health Dilemma,” there had never been a racial, historical, sociocultural, or even descriptive analysis of American medicine,

health, and health delivery systems from the African-American and disadvantaged patients’ perspective. There had never been a comprehensive study of the effects of race and racism on the United States medical profession, the health delivery system, health profession, and research infrastructure.

LC: The target audience was primarily physicians, other health professionals, policymakers, and public health practitioners. Hopefully, this data would positively influence the community, policymakers, academicians, the government, and private sector to provide equitable health reform for all Americans.

Q: After publishing both volumes of the book, how much media attention did you receive? Did the level of media interest change after the first book was nominated for a Pulitzer?

MB: There seemed to be a moderate amount of media attention for an academic public health-oriented book. It got stellar reviews in important journals such as the *Library Journal*, the *Journal of the American Medical Association*, and the *New England Journal of Medicine*, and was chosen as an academic book of the year by *Choice* magazine.

LC: After the first volume was released, *The New York Times* Science Section also wrote a very positive piece on the book, and Volume II received good reviews in the *New England Journal of Medicine*, the *Boston Globe* and the *Journal of Health Policy, Politics, and Law*. Local Harvard University publications also lauded both books. But none of these seemed to reach the mass audience that we wanted.

Q: Legendary black scholars such as Carter G. Woodson and W. E. B. DuBois also received little note during their lifetimes. There will be more widespread appreciation of this health system problem if the media learns about it – including the connection between this history and current health conditions.

MB: That’s why we’re taking part in this interview. Our work is known in the medical community. We want the broader American community to understand the context of the current health disparities.

Q: Can you define the terms disparity and health disparity?

MB: Disparity essentially means “different” – when one group is compared to another. Here we’re

talking about differences based on demographics such as gender, race or ethnicity, education or income, disability status, geographic location, or sexual orientation.

Q: What are some of the population groups experiencing health disparities?

MB: African Americans are experiencing – by far – the deepest and most numerous health disparities. However, other disadvantaged ethnic and racial groups such as Latinos – especially Puerto Ricans – Native Americans, Aleuts, native Pacific Islanders, and Asian immigrant groups such as Vietnamese, Laotians, and the Hmong also experience disparities. In addition, the list includes poor whites, certain disabled and homeless groups, inhabitants of inner-city ghettos and barrios, the elderly, and members of the gay/lesbian/bisexual/transsexual communities.

Q: How would you characterize the health status and outcomes of African Americans?

LC: African Americans suffer now, and have always suffered, the worst health status, the worst health outcomes, and been forced to utilize the worst health facilities of any racial or ethnic group in America.

continued >>

HISTORY AND HEALTH DISPARITIES

continued



(Top) Carving of Imhotep, an ancient Egyptian genius who advanced medicine.

(Below) Sketch of Imhotep on the cover of a publication for the first National Conference on Hospital Integration, co-sponsored in 1957 by the NAACP, the National Urban League and the National Medical Association, an African-American organization.

Unfortunately, in some areas the degree of disparity between African Americans and the white population is actually worsening instead of improving – infant and maternal mortality are examples. On average, blacks live 5 to 7 years less than whites. Cancer mortality increased 50 percent for blacks and only 10 percent for whites since 1950, which is very startling. If you look at low birth weight, it's 136 percent higher in blacks than whites. If you look at diabetes, it's 33 percent more common in blacks. Heart disease is one and a half times more common in blacks. And the black maternal death rate is three to four times higher than whites. You can look at the Hispanic maternal death rate, which is two times the white rate. Among Vietnamese women in the United States, the cervical cancer rate is five times the white rate. American Indian and Alaskan Native infant death rates are two times the white rate. New cases of TB are higher in Asian and Pacific Islanders, and the rate of diabetes in American Indians and Alaska natives is more than two times the white rate. We can go on and on.

Q: What are the major factors accounting for the health status and health outcomes of African Americans?

MB: They include race, class, and ethnicity factors; environmental, behavioral, and biological factors. Health system factors are extremely important. There are access factors. There is also the problem of stereotyping, bias, prejudices, clinical uncertainty affecting health providers and institutions, and cultural factors. In addition, there are differences in health care quality.

Of these, we feel decision-making based on stereotyping, biases, prejudice, and clinical uncertainty are the most immediate and correctable factors. Socioeconomic status, environmental, behavior, biological, and health system factors are major factors – but are going to take a much longer time to correct.

Q: Now that we have some information on disparities, what do you mean by an “American health dilemma”?

MB: A dilemma is a situation when you have to make a choice between options that are difficult. The United States' health system, from its beginning, seemingly has committed itself ideologically and institutionally to segregation and discrimination based on race and class at all levels.

This has significantly contributed to the disparities that have been our legacy for almost 400 years and that remain today.

The dilemma puts the nation at a crossroads, and the United States has to make a choice. The right choice would be to make high-quality health care available to all its citizens, regardless of race, class, ethnicity, or other social factors.

Q: Can you give us a snapshot of some of the methods you used to develop the material in Volume I and Volume II of your books?

LC: Both books grew out of the desperate need to establish a database for understanding the origin, the evolution, and the perpetuation of the pervasive race and class problems that have contributed to disparities in health and health care in the contemporary U.S. system.

MB: Using a multidisciplinary approach, the books reveal the effects that these problems had on the medical profession, the health delivery system, the health professions, and the educational and research infrastructure relative to the health outcomes of African Americans and other poor or stigmatized

populations. What we have is a gripping, previously untold story.

Q: What are some of the major findings in the first volume?

LC: One of the most rewarding findings in Volume I was the discovery that the first physician of note was a black man. His name was Imhotep and he lived about 2,600 years before the birth of Christ. His methods of practice and care of patients dominated Western medicine for over 2,000 years, and this is a little-known fact.

Q: Imhotep, an Egyptian physician, who preceded Hippocrates, right?

LC: Absolutely.

MB: By 500 B.C., Plato and Aristotle started Western science's preoccupation with human inequality with Plato's “Great Chain of Being” theory and Aristotle's modification of Plato's theory, the *Scala Naturae*. They attempted to rank the family of man – with blacks at the bottom of the chain. Much later, lower quality and discriminatory health care for blacks and other

continued >>



people of color were carried into the 15th century Age of Discovery via colonialism and slavery that was spearheaded by the Spanish and Portuguese in that geographic area – the Iberian Peninsula. Based on pseudoscientific biological superiority and inferiority criteria, reinforced by the social and religious beliefs and customs of the 17th through 19th century, scientific racism became pervasive. Biological racial inferiority theories were taught in medical schools. Blacks and other disadvantaged groups – and we’re including women, many of the poor, Native Americans, and Latino groups – were victims of unethical experimentation, unethical surgery, and unethical sterilization.

Q: Dr. Clayton, what about race, class, gender, and slavery. What is it about those factors that contributed to poor health and health outcomes?

LC: Basically, if you were black, female, or a member of any of the other racial or ethnic groups other

than white European male, you were considered at that time scientifically, socially, and biologically inferior. Remnants of that remain today. So that meant you lived in more threatening environments and you got inferior care.

“African Americans fought to open the health care system to disadvantaged groups and made Medicare and Medicaid possible.”

Q: Can you tell us more about slavery and disparities?

MB: You may remember that the Atlantic slave trade existed for over four centuries. Africans were captured in Africa and brought to the New World against their will. This included English North America, South America, Central America, and the Caribbean.

The Atlantic slave trade caused high sickness, suffering, and death rates among our ancestors. Death rates for each stage of the slave trade – for instance, the march from the African interior to the West African coast – were between 20 and 50 percent, with the trail being littered by skeletons of fallen Africans. Africans were held captive in slave fortresses – some still exist as

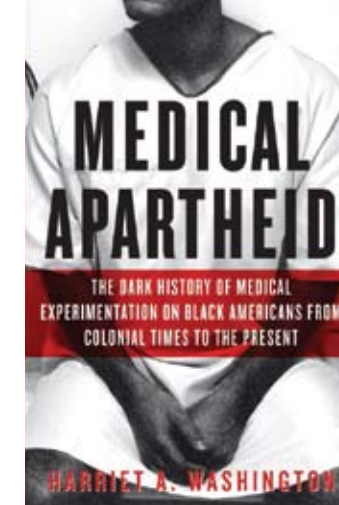
tourist sites in West Africa. These populations suffered a death toll of at least 25 percent. During the Middle Passage – the transatlantic voyage from Africa to the New World – the death toll hovered between 15 and 50 percent.

Upon their arrival, the breaking-in period for Africans, which lasted from six months to five years, carried a death rate of at least 30 percent.

In essence, in order to produce the 10 million to 15 million black slaves who survived in the New World to build and finance the economic system that still dominates today, 100 million to 150 million Africans died. These high sickness and death rates were but the beginning of what I defined as the “Slave Health Deficit.”

Q: Could you explain what you mean by the “Slave Health Deficit”?

MB: Because this Western and – later – English North American tradition started in slavery, logic dictates that it be called the “Slave Health Deficit.” It has been a continuum – from the time of the English colonies through the history of the United States – for 388 years. Today, we call it “disparity.”



African Americans’ distrust of the white medical establishment grew even more after the press exposed the “Tuskegee experiment” that denied syphilis treatment to hundreds of black men for decades as physicians monitored the death and debilitation from the disease. Harriet Washington explores this in a new book on U.S. research atrocities.

Q: What was the role of black doctors and healers in trying to address black health issues and slavery?

MB: In the era of Imhotep – about 2,600 B.C. – black Africans controlled ancient Egypt and had a major influence on Egyptian medicine. Egyptian medicine, in turn, had a major influence on ancient Western medicine.

Caesarian sections may have been initially performed in sub-Saharan Africa and entered the Western medical practice through ancient Egypt. The Africans brought their strong healing traditions to the New World with them and these traditional healers – along with African midwives and nurses – provided the hands-on care in what Linda and I have called the “Slave Health Subsystem.” This established a pattern that persisted until the end of the Civil War.

continued >>

HISTORY AND HEALTH DISPARITIES

continued

Africans did not readily accept Western medicine and preferred their African traditional healers. Thus, there was always conflict and tension about health matters in the slave quarters of the New World. Therefore, the African-American reaction to the Tuskegee Experiment is probably not unprecedented.

Q: Can you briefly explain what happened at Tuskegee?

MB: The Tuskegee Experiment (1932-1972) was initially funded by the charities associated with the Rosenwald Fund, an institute for disadvantaged populations that was funded by Sears & Roebuck. It was initially going to be a treatment program for African Americans who were discovered to have syphilis in about five different rural locations. Macon County, where Tuskegee is located, was just one of the sites.

As a result of the Great Depression, funding for this program was strapped. The researchers, who were United States Public Health Service doctors, were so interested in the project by that time, they decided to continue the project. Due to lack of resources, they decided not to treat the patients.

John Sweat Rock was an abolitionist, journalist, dentist and physician. He obtained a medical degree in 1852 and treated fugitives who escaped slavery. He later became a lawyer who was a successful advocate for black participation in the Civil War, personally recruiting for two regiments.



They were going to make a comparison of untreated syphilis in a group of approximately 500 black males.

Therefore, deceptively, not only did these doctors refuse to administer treatment to these 500 men, they told them that they were receiving treatment and that the only disease that they were suffering from was “bad blood,” instead of telling them that they actually had syphilis and describing the debilitating, potentially fatal, effects of the disease.

This experiment continued for a full 40 years. These men were denied treatment and were monitored to ensure that they would not receive treatment anywhere – even after penicillin was discovered (1941) and during World War II, when the federal government mandated that everyone who had a positive syphilis test

receive free treatment. This, of course, hastened their deaths, and they suffered all the complications of untreated syphilis.

Q: How did this hidden story of unethical experiments reach the public?

MB: It was a journalist who broke the story in 1972 in *The New York Times*. An outraged doctor who was aware of the experiment informed the reporter. If it had not been for the news report, the experiment might have remained secret and continued.

You must remember that Tuskegee was only the tip of the iceberg and there were thousands of similar unethical experiments being conducted in private and public sectors of the United States – as documented in Volume II.

Q: This is one of the outrages in medical research. I want to go back in time to a key point in health history. Was it during the Civil War or after it that there was a change in the health status of blacks?

MB: The Civil War was a turning point. During the Civil War, it became very evident that new

government public health initiatives actually worked and made a difference in health status.

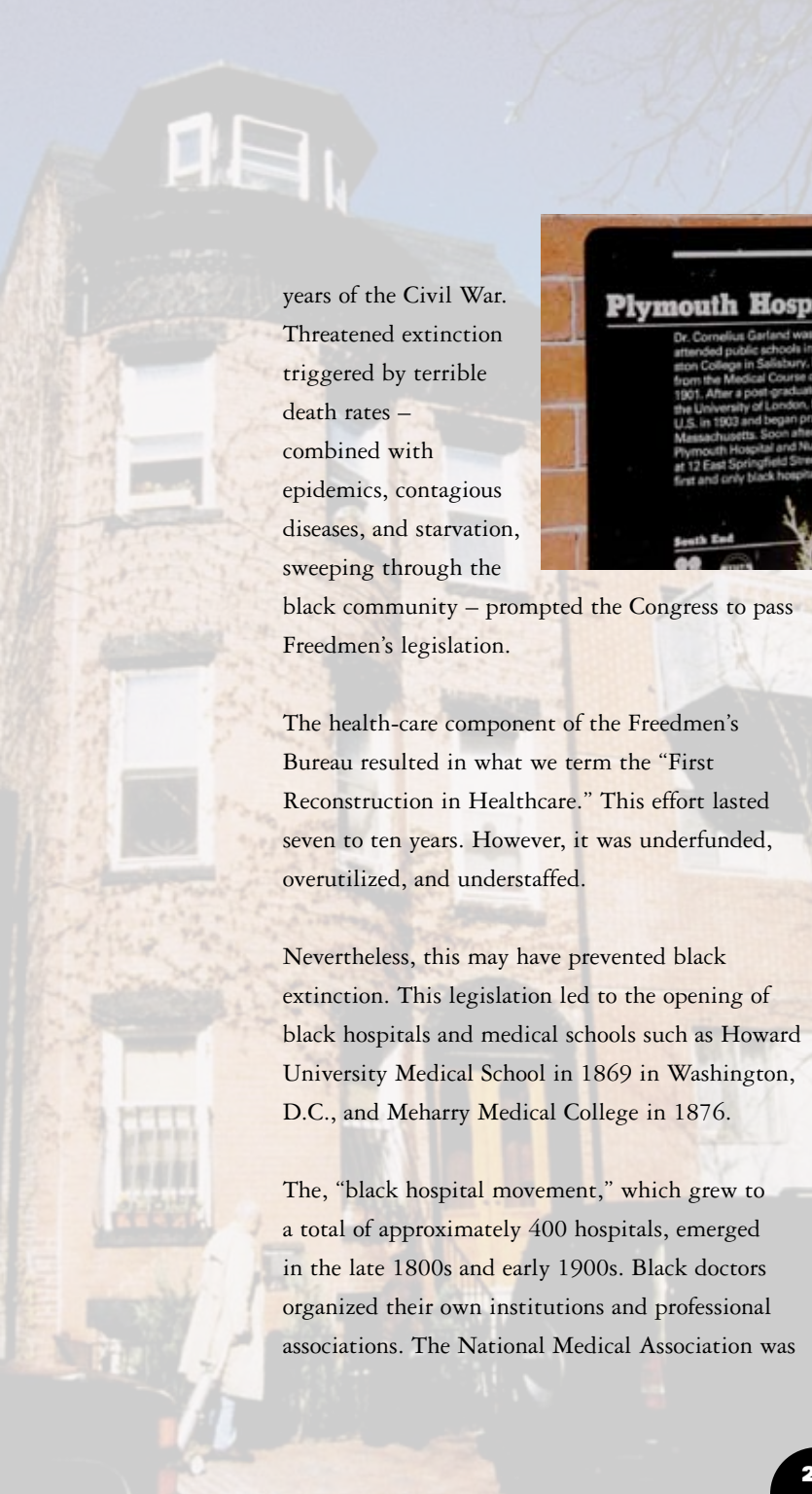
As a result, people began to realize that health care and public health could no longer be considered a luxury or something just for upper-class people and that world-class, standardized health professions training would be necessary.

LC: This also led to general acceptance of hospital treatment by the public. Previously, people were treated in their homes for the most part. A national medical training, hospital, and public health movement emerged. There was a surge of medical schools and hospitals after the Civil War to train doctors, nurses, and dentists, and other health-care professionals.

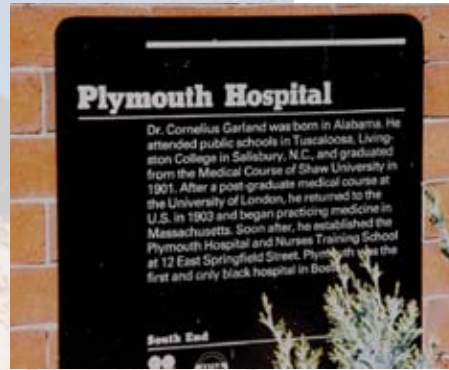
After the Civil War, the slave health subsystem – which included the traditional African healers and midwives – was formally dismantled. That had a huge impact on the health of the freed slaves because blacks were denied access to any health system.

MB: The freed slave had nowhere to turn. As a result, up to one-third of blacks died within five

continued >>



Boston's Plymouth Hospital was founded in 1908 to serve African Americans, who were excluded from white medical institutions.



years of the Civil War. Threatened extinction triggered by terrible death rates – combined with epidemics, contagious diseases, and starvation, sweeping through the black community – prompted the Congress to pass Freedmen’s legislation.

The health-care component of the Freedmen’s Bureau resulted in what we term the “First Reconstruction in Healthcare.” This effort lasted seven to ten years. However, it was underfunded, overutilized, and understaffed.

Nevertheless, this may have prevented black extinction. This legislation led to the opening of black hospitals and medical schools such as Howard University Medical School in 1869 in Washington, D.C., and Meharry Medical College in 1876.

The, “black hospital movement,” which grew to a total of approximately 400 hospitals, emerged in the late 1800s and early 1900s. Black doctors organized their own institutions and professional associations. The National Medical Association was

founded in 1895 because of the segregationist policies of the American Medical Association (AMA). The AMA officially supported and promoted racial segregation from 1847 to 1968 until mounting public pressure and embarrassment and legal rulings in the federal courts forced it to change.

Q: Now we’re getting into a period that’s really central to Volume II. Can you talk a little bit about your key findings in that book?

LC: One of the things we found was that the U.S. tradition of unequal health and health care based on race, ethnicity, class, and gender continued. This strongly contributed to disparities and until recently was considered normal.

We also found that there was a disproportionate use of blacks and other disadvantaged groups for scientific teaching, demonstration, and experimental purposes – and this grew until the late 20th century. Tuskegee was only one example of a pervasive practice. In Volume II, an entire chapter is dedicated to unethical experimentation and demonstration.

MB: White medical educational “reform,” augmented by the Flexner Report in 1910, closed all but two of the remaining ten black medical schools, with Howard and Meharry being the only survivors. Only one of the 17 women’s medical schools survived. Until the Civil Rights era, black and women doctors were almost totally denied membership in professional organizations such as the AMA and specialty colleges by their white male peers.

For the most part, neither black nor women doctors were permitted to have hospital privileges at white hospitals until the late 1960s and early 1970s. Discrimination and segregation continues against black doctors and their patients in medical practice, often through managed care mechanisms such as economic credentialing of patients or exclusion from managed care panels and from invitations to join or establish practices in lucrative settings or with large influential group practices, and a virtual redlining of certain communities.

However, between 1965 and 1975 health reform and desegregation efforts led to rapid improvement in health status and outcomes. It was a period we call the “Second Reconstruction in Black Health.”

Black health has stagnated or deteriorated since 1975. Minority admissions to medical schools, for example, have declined over the past six years, even though it is known that graduation of disadvantaged minorities from medical school improves the access and quality of care for minority and disadvantaged patients.

You could say that it has gotten worse in many areas.

Q: What’s the connection between the Civil Rights movement and health improvement between 1965 and 1975?

MB: Beginning in 1964, hospital desegregation rulings for the first time were made in the federal courts. Medicare and Medicaid amendments to the Social Security Act, passed in 1965, opened the mainstream system to millions of black and poor people who had not had access to it before.

Q: If I could ask you to elaborate on that point? Medicaid and Medicare – there’s a connection between those programs and the push for black health?

MB: Both were amendments to the original Social Security Act passed by President Franklin Delano

continued >>

HISTORY AND HEALTH DISPARITIES

continued

Roosevelt during the Great Depression, and they are amendments – Title 18 and Title 19 – that have Civil Rights legislation attached, though they have never been fully enforced.

In the original legislation, two-thirds of African Americans were not eligible under the Social Security Act because farm workers and domestic workers were not included.

LC: In 1965 Medicare and Medicaid allowed for health insurance coverage for the elderly and the poor. Medicare is an entitlement program for individuals over the age 65 if they meet the requirements of the Social Security Act and its recent amendment. Medicaid is not an entitlement program, although people think it is. It is a means-tested benefit for poor people and disabled people as a part of the Social Security Act.

MB: Medicaid has never covered more than two-thirds of the poor and currently covers less than 50 percent.

Q: But both of these major programs stem largely or partly from black health advocates pushing the notion of equitable medical care and public health?

MB: Absolutely. If it had not been for the Civil Rights movement, black doctors, and the National Medical Association – who were excluded from the AMA until very recently – allied with other Civil Rights organizations, Medicaid and Medicare probably would not have been passed.

Q: Can you tell us what has happened in the past 30 years or so – why we’ve seen this decline after the achievements during the Civil Rights period?

MB: The passage of Medicare and Medicaid had been the first health policy “defeat” of mainstream American medicine, the AMA and its cabal of health organizations. That defeat in 1965 seems to have thrown them into some disequilibrium.

Seemingly, by 1975 the mainstream medical establishment had re-gathered its equilibrium and began fighting back. Health-care progress stagnated, funding began to be cut, people’s benefits began to be trimmed, and health progress stopped due to the Reagan and Bush administrations’ regressive Civil Rights and health policy agendas during the 1980s.

Q: What about the theories of biological and

genetic differences that have been used for centuries? Has that all been discounted?

MB: Yes and no. Western science and scientific racism have been major contributors to our deeply embedded racial, social, and medical-social problems in the past. Ironically, the scientific progress, especially the recent scientific progress in molecular genetics, population, and evolutionary genetics, and the mapping of the human genome, have scientifically dismembered virtually all of these racist theories. Though genetic scientists have now proven unequivocally that we are all the same under the skin, many whites continue to believe that blacks and people of color are biologically inferior.

Moreover, the species *homo sapiens*, which is what we are, evolved and migrated out of Africa approximately 60,000 years ago. Therefore, we are all Africans. Though we all share 99.9 percent of our genes, there are minute genetic differences in that .01 percent of our genes, which are biologically insignificant, and probably account for differences that we think are important, such as skin color, hair texture, and certain physical features. In fact, there are more genetic differences within “races” than between “races.”

We wish we could say that scientific abuse problems, unequal treatment, unethical experimentation and sterilization have ended. They have simply morphed into new configurations and in many cases shifted overseas.

Q: Dr. Byrd, you were on the consensus panel that developed the Institute of Medicine report released in the form of a two-volume book called “Unequal Treatment.” What were the key findings and recommendations?

MB: Let me make it clear that the charge of the consensus panel was to only look at people who had health insurance and access to the health system – the most privileged regarding health care.

The first finding was that racial and ethnic disparities in health care exist and, because they are associated with worse outcomes in many cases, are unacceptable.

The second major finding was that racial and ethnic disparities in health and health care occur in a context of broader historic and contemporary social and economic inequality, and are evidence of persistent racial and ethnic discrimination in American life – confirming the findings of “An American Health Dilemma.”

continued >>

HISTORY AND HEALTH DISPARITIES

continued

The third finding was that many sources, including health systems, health-care providers, patients, and utilization managers, may contribute to racial and ethnic disparities in health care.

The fourth major finding was that stereotyping, prejudice, and clinical uncertainty on the part of health-care providers may contribute to racial and ethnic disparities in health care.

Finally, the study found that more research on these factors is needed.

Q: Can you talk a little bit about some of your more recent research on the health status of immigrants?

LC: In the background paper that we wrote for “Unequal Treatment” we outlined the immigrant experience and found immigrant populations also experience disparities. One’s position in society in terms of one’s socioeconomic, sociopolitical, socio-cultural status in society practically dictates one’s health-care experience.

MB: I tracked the experience of other immigrant populations from the 1600s to the 1800s and found that indentured servants and enslaved Africans

certainly did not receive the same health care as did the masters or wealthy whites.

Also, I looked at Irish Catholics who were immigrating at a higher rate from 1830 to 1860 and found that they were relegated to the lower tiers of the health system. When you look from 1865 all the way to 1920, there were waves of Chinese, Italian, and other immigrants such as the Jewish population and Japanese. All were relegated to the lower tiers of a multitiered health system, which helped create disparities.

When you look beyond the 1920s to the present, I again found that as immigrants – Mexicans, various Caribbean groups, and Asians – come to the United States, they are always relegated to the lower tiers of the U.S. health system.

The unfortunate thing for African Americans is that we have always remained in the lower tier. While immigrant, ethnic hospitals have become mainstreamed – for example, we can still see the names of Catholic and Jewish hospitals that now serve the general public – the black institutions remained in the lower tiers until they were eliminated.



Drs. Byrd and Clayton in the library at their home.

Q: Why do these disparities exist when we are told that we have the best health-care system in the world?

LC: First of all, we have to debunk a major myth. We don’t have the best health system in the world. It is true that we have some of the best technology, we have some of the best health-care specialists, and we have some of the best health institutions in many areas. However, most of the United States’ population does not have consistent, reliable access to this level of care. The hodgepodge of providers, institutions, not-for-profit, and for-profit businesses is – in fact – a health non-system.

MB: Looking at the myth from a global perspective, a group of Harvard professors noted

in 2004: “Despite what the United States spends to stay healthy, about \$1.5 trillion a year, more than any other nation, this country ranked 37th among Western nations in 2000.” Clearly, “the best” is for those who can afford it. Currently, the United States spends at least \$2 trillion.

LC: Even among populations who are insured, many can’t afford deductibles and co-payments. Then, there are dysfunctions such as vaccine shortages, high-priced prescription drugs, and hospital and community health system closures.

Q: Do you have any recommendations on how to overcome the disparities in U.S. health and health care today?

LC: There must be equal access to high-quality care through a unitary health system, meaning we have to eliminate this tiering of the health system.

There has to be one system of care for everyone. There must be programs and projects that target the patient populations that are doing worse in terms of health status and outcomes.

continued >>

W. Michael Byrd, M.D., M.P.H., an obstetrician gynecologist, is a senior research scientist and instructor in the Department of Health Policy and Management/ Division of Public Health Practice at Harvard School of Public Health. He is also a research associate with the Disparities Solutions Center at the Massachusetts General Hospital. In addition, he is a clinical instructor and consultant physician at Beth Israel Deaconess Medical Center of Harvard Medical School.

HISTORY AND HEALTH DISPARITIES

continued

Linda A. Clayton,
M.D., M.P.H.,
an obstetrician

gynecologist and
gynecologic
oncologist, is an
associate medical

director of the Office
of Clinical Affairs/
Massachusetts
Commonwealth

Medicine and senior
research scientist
and instructor in the
Department of Health

Policy Management/
Division of Public
Health Practice.

She is also a clinical
instructor and consultant
physician at Beth Israel

Deaconess Medical
Center of Harvard
Medical School.

Next, we must have cultural competence and anti-bias or anti-racism training for all health-care providers.

In addition, information on disparities and other health and health system problems must be widely disseminated through a multiprong media strategy.

Q: Speaking of the media, can you elaborate a little bit? What can the media do to improve coverage of this whole issue of health disparities?

MB: Media consolidation, conglomeration, and commercial interests have almost co-opted the burgeoning health media. It's a real problem because media corporations do more than sell news and information – they sell products and lifestyles that affect the health system, health practices, and health outcomes. There has to be a reorientation towards a service agenda – or what used to be called the “public trust” function of the media – based on scientific evidence, public health, and facts, instead of advertising information and marketing propaganda. This will be necessary if the media is to be effective and meaningful in health and health-care reform and dissemination of information about health disparities.

LC: Discussions around disparities, our ailing health system, and its problems should be held throughout the nation. There should be town hall meetings. There should be radio and TV stations that are promoting dialogue. It should be in the print media. It should be everywhere.

MB: We think that scholars should reframe health messages again from a commercial to a public health focus. Every day you see physicians on TV promoting products. That should not be the case. Scholars and providers and health policy experts who understand the problem and are committed to eliminating health and health-care disparities should be advising government at all levels. In this short interview, we can't expand on every dimension. But we must understand that there are medical, public health, and public policy tools and approaches that are available to start solving them.

As Dr. Benjamin E. Mays of Morehouse College often stated in the 1960s, “It takes skill as well as will to do right.” Solving this huge problem will require major human and financial resources. Whatever is done to eliminate health and health-care disparities must be grounded in history, hope, and healing. ■