FEDERAL COLLABORATION ON HEALTH DISPARITIES RESEARCH (FCHDR)

MEETING MINUTES
FORUM ON GLOBAL AND POPULATION HEALTH

THURSDAY, MAY 5, 2011

The meeting of the Federal Collaboration on Health Disparities Research (FCHDR) Forum on Global and Population Health convened at 2:08 p.m. at the Lawton Chiles International House, National Institutes of Health (NIH). Dr. John Ruffin, Director of the National Institute on Minority Health and Health Disparities (NIMHD) presided.

ATTENDEES:

FCHDR members
John Ruffin, PhD; FCHDR Co-Chair
Garth Graham, MD, MPH; FCHDR Co-Chair
Irene Dankwa-Mullan, MD, MPH; meeting facilitator
Mike Ardaiz, Department of Energy
Peter Ashley, Department of Housing and Urban Development
Francis Chesley, Agency for Health Care, Research and Quality
Laura Ginsburg, Department of Labor
Catherine Hill-Herndon, Department of State, Office of International Health and Biodefense
Laura Hoard, Office of Planning, Research and Evaluation-Administration for Children and Families
Roslyn Holliday Moore, Substance Abuse and Mental Health Services Administration
Melissa Houston, Health Services and Resources Administration
Terris King, Center for Medicare and Medicaid Services
Linda Lipson, Department of Veterans Affairs
Warren Lockette, Department of Defense
Devon Payne-Sturges, Environmental Protection Agency
Michelle Yeboah, Food and Drug Administration
Sherri Yoder, Indian Health Service

Guest speaker
Sir Michael Marmot, MBBS, MPH, PhD, FRCP, FFPHM, FMedSci

Other Attendees
Rick Berzon
Chris Foster
Jane Hammond
Chazeman Jackson
Tiffany St. Cloud
Leha Tilas
Dio Kapura
Nishadi Rajapakse
Alexandra Rosette
Mary Roy

Welcome
Dr. Irene Dankwa-Mullan, of the National Institute on Minority Health & Health Disparities, National Institutes of Health, welcomed participants to the meeting.

Opening Remarks
Co-chair Dr. John Ruffin led into the meeting by reflecting on his own past at the National Institute of General Medical Sciences which sponsored the Minority Biomedical Research Science program (MBRS) and the MARC program, which played critical roles in encouraging young minority researchers to venture beyond the comfort of their home (sometimes mostly minority) institutions to bigger and more distant institutions in the U.S. The Minority International Research Training (MIRT) program was then developed to help these researchers make the even greater transition to global health experiences. Dr. Ruffin made the point that you cannot talk about minority health and health disparities without including global health in the equation, because disease states and the complexities of health disparities know no boundaries. Gathered around the table today is, in essence, the United States government. Instead of working on the social determinants of health within our respective small compartments, this larger group of collaborators can take things an additional step and work together by seeing what is happening in the rest of the world. Using the analogy of a jigsaw puzzle, Dr. Ruffin noted that the agencies represented around the table each represent one puzzle piece, and regardless of whether that piece is a small or large puzzle piece, the puzzle cannot be considered complete without each and every piece.

Introductions
Members of the FCDHR and other attendees introduced themselves and spoke about their respective affiliations' interest/roles in health disparities in the US.

Dr. Dankwa-Mullan briefly introduced Professor Sir Richard Marmot by referencing his distinguished career as a researcher in social and health inequities in the United Kingdom and referring attendees to his biography included in the meeting packet. Professor Marmot is currently president of the British Medical Association, Director of the International Institute for Society and Health, and MRC Research Professor of Epidemiology and Public Health, University College, London. He recently completed an in-depth review of health inequalities in England, chaired the World Health Organization's (WHO) Commission on Social Determinants of Health, and has been asked to chair a similar survey of health inequalities in the WHO European region.

Guest Presentation: Fair Society, Healthy Lives—Ideology and Evidence
Sir Marmot's opening statement summarized an overriding theme of his message: what happens outside the conventional health sector has a profound impact on inequalities in health, and the major determinants of those inequalities lie outside the health care system.

The social gradient has major effects on life expectancy and other measures of health, and is a graded step-wise relation across the whole of society. We need solutions that go right across the gradient and deal with relative—not absolute—inequalities and do not just attend to those in the bottom rung of society. Relative deprivation in the space of incomes can yield absolute

deprivation in the space of capabilities. We should focus not just on where an individual is in the income hierarchy, but what that means for the way he can lead his life.

To get policy makers and stakeholders to buy in to this idea, an irrefutable argument, using unimpeachable evidence with the best science, must be made. Startling disparities in life expectancy and in disability-free life expectancy between countries, cities and even neighborhoods clearly provide such evidence, and show the impact that new policies and practices might have on current health inequalities. The WHO Commission stated that when there are no good biological reasons for health disparities, then they must arise from a toxic combination of poor social policies and programs, unfair economic arrangements, and bad politics.

Everything recommended in the English review has potential applicability to the U.S. situation. It basically states that if you put fairness at the heart of all decision-making, health would improve and health inequalities would diminish. Economic arguments can also be made. For example, at the proposed British mandatory retirement age of 68, Sir Marmot showed that about 75 percent of the English population will already be disabled to an extent that they will have been receiving disability checks instead of paychecks for some time; this is clearly to the detriment of the economy as well as to the community. What are people doing in government if it is not to improve the well-being of their population? And what cruder, more dramatic measure could there be than premature loss of life or quality of life?

In 2007, at the beginning of the current economic crisis, the top one percent of earners in the U.S. had 24 percent of total household income; these numbers mirror the situation in 1929 as the depression began. This matters for the next generation, because the greater the level of income inequality in a country, the less "social mobility" a young person has, and the smaller his chance of rising to a higher income strata than his parents. The U.S., compared to many other countries, including Denmark and the U.K., has very poor social mobility, meaning that who your parents are matters more in the U.S. than it does in the U.K.

Sir Marmot's strategic review of health inequities in England (called "Fair Society Healthy Lives") described three principle areas of action**: the conditions in which people are born, grow, live, work, and age** (early child development and education, healthy places, fair employment, social protection, and universal health care)**, the structural drivers of those conditions at global, national, and local levels** (considerations of health equity in all policies, tax reform, gender equity, political empowerment, market responsibility, and fair financing)**,** and **the importance of monitoring, training and research.** These areas of action led to six policy recommendations to reduce health inequities:

1. Give every child the best start in life and right through the life course
2. Enable all youth and adults to maximize their capabilities and have control over their lives.
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention

US Efforts in Addressing Health Disparities

Dr. Garth Graham, the Deputy Assistant Secretary for Minority Health in the Office of Minority Health at the Department of Health and Human Services, spoke briefly about what the U.S. government is doing domestically in dealing with health disparities. He stated that there are currently landmark efforts in the works to deal with health inequities, more than ever seen before. The biggest of these is healthcare reform, but that is not the sum total of the efforts. Three weeks ago, his office issued their first strategic action plan on health disparities, dedicating a section to social determinants of health and articulating a series of strategic action steps, many involving how the Office works with other departments. In addition Dr. Graham has just written a section of the National Prevention Strategy which will be released in June; this strategy involves 17 departments within the US government, many of which are not primarily health-related.

Dr. Graham introduced Catherine Hill-Herndon from the Department of State, who is Director of the Office of International Health and Biodefense and the Bureau of Oceans, Environment, and Science to speak about what the U.S. is doing to work on these issues on an international scale.

U.S. Efforts in Addressing Health Disparities: Science Diplomacy

Ms. Hill-Herndon spoke about public health, health diplomacy, and security, and how the U.S. integrates those into foreign policy goals at the Department of State. Global health diplomacy manifests itself in three different ways: by supporting public health goals, such as polio eradication; when diplomatic health and science goals are linked, such as when fostering closer ties between researchers in different cultures; and by using health and science diplomacy to reach countries with whom we have no other basis to connect.

The Department of State—which generally has policy but not programmatic or funding responsibilities—has overseen the signature of more than 50 bilateral multi-ladder science and technology agreements, which allow for a scientific exchange and collaboration, including exchange of research results. The Department recognizes the tension between developed nations wanting protection for intellectual property and economic incentives for invention on the one hand, and sharing these advances with developing nations who cannot afford them on the other.

Public-private initiatives, such as several announced by Secretary Clinton in the past year (the Global Alliance for Cook Stoves, and the Text Messaging Initiative for mothers and babies) as well as the President's Global Health Initiative represent government approaches using multiple agencies and organizations collaborating to improve maternal and child health, address diseases of great economic and societal importance, and foster increased research and innovation.

Water is another major issue with implications for both health and food supply as well as profound political implications. Many river basins supplying water to huge populations are shared between two or more countries. Water can be either a unifying resource or one which creates significant tensions. The Department of State views sanitation and water issues as being not simply resource and capacity issues, but also issues of political will. They try to work closely with our own domestic technical agencies, and to reach out to scientists and technical agencies overseas, to keep the policy/science dialogue going.

Discussion

Dr. Graham posed a question to Sir Marmot about convincing the "haves" that it is in their own best interest to share with the "have nots" who related a story illustrating that government must create structures to help individuals act in a responsible way. Dr. Lockette related that he constantly gets the question "Why are we using U.S. resources internationally when we could be applying those domestically?" at the Department of Defense (DoD). He believes empathy and concern can be taught and that DoD sponsored mission trips can help this. Sir Marmot was "charmed" by Ms. Hill-Herndon's presentation, and spoke of Adam Smith's idea of the better part of human selves. He believes that presumably, all present in the room went into public service because they decided this was a better calling than simply doing something only for self-interest. We need to create structures allowing that to happen for everyone. The United States is being a good global citizen, which also serves its own interests. Dr. Ruffin commented that it's sometimes a challenge to convince people of what it is that they should be doing that they are not already doing. Once needs are articulated, it becomes a little bit easier. Ms. Ginsburg commented on the future need for more healthcare workers to replace and care for retiring baby boomers. Dr. Lockette brought up the John Henry hypothesis about cardiovascular disease and socioeconomic classes, and Dr. Berzon asked Sir Marmot to follow-up on how to conceptualize social determinants within a monitoring framework on a global level. Sir Marmot then described three simple English social determinant measures--a measure of childhood development, the proportion of sixteen- to eighteen-year-olds not in employment, education, or training, and the proportion of the population that were on means testing or some other poverty measure. He emphasized the importance of keeping things simple, and that there is nothing like evidence to capture the attention.

Adjournment

Dr. Ruffin thanked everyone for attending and extended particular thanks to Sir Michael Marmot. The meeting adjourned at 4:50 pm.