Dear Francis,

I wanted to share this Power Point Presentation with you. I have shared this with the Commission of Health Equity and Some members of the CT. Multi-Cultural Health Partnerships. I presented part of the PPP at Social Determinants of Health Summit in the Lyceum in Hartford, CT on 09 16 15 due to time constraints. I welcome your comments.

Additional Facts to frame the facts in the PPP.:

A. Health:

1. Current Health status of African Americans:

   Premature Deaths due to

   a. HTN 34.2/100K
   b. Stroke 80.2/100k
   c. Heart Disease 321.3/100k
   d. Type II Diabetes 49.9/100k

These rates are higher in comparison to any other racial/ethnic groups in the USA; e.g. Asian/Pacific islanders, American Indians/ Alaska Natives, Hispanics and Whites.

2. These health disadvantages occur in the context of increasing disparities in rates of disease. Poverty cannot explain the differences. Even SES is controlled for there is an excess of 38,000 deaths on annual basis and 1.1 Million life years lost among African Americans.
3. Skin Color alone is not sufficient to explain the staggering magnitude of the differences. A comparison of three groups: African Americans, Blacks of Caribbean Descent and Whites found African Americans had the worst self-described physical health status including higher rates of HTN Stroke and Type II Diabetes.
4. Despite overall improvement in Life Circumstances the Continuing legacy of discrimination, Socio-economic Inequality, Residential Segregation, Intensity of stress due to endemic violence, inescapable poverty, threats to Individual Liberty, Social Justice and Health Inequity has contributed by seriously heightening Allostatic Load which translates into higher risks of Coronary Heart Disease, Inflammatory disorders and Cognitive impairment by increasing risks of Smoking, Alcohol and Drug Abuse.

   a. Culture specific life style, eating habits and food choices.
   b. Inherited Health Risks including Epigenetic effects of Life Style of intervening generations
   c. Social behavior contributes 40% of the patho-genetic factors of key causes of preventable deaths: HTN, Stroke, Heart Disease, Type II Diabetes and Obesity
   d. Social Determinants of Health [WHO: SDOH – Solid Facts]
   e. Social Determinants of Mental Health [Compton and Shim 2015]

B. 1. 1985- The Heckler report- “America was put on notice that the health of African Americans was significantly worse than Whites.”

2. 1990 McCord and Freeman Report: A Black Male in Harlem was less likely to reach age 65 than a male resident of Bangla Desh. Black males fell behind Bangla-deshis in survival rates starting age 40.

3. 100 years since the establishment of National Negro Health Week by Dr. Booker T. Washington and others (1915). This observance ended in 1951

4. 2009 the Connecticut Department of Public Health published the *"2009 Connecticut Health Disparities Report".* The Report clearly documents the nature and extent of health disparities among members of minority populations in Connecticut. Combined with changing population demographics in the State, the 2009 report is a call to action. Population increases in Connecticut are occurring among those who are the poorest, the least healthy, the most poorly educated and housed, and of limited English proficiency who tend to reside in neighborhoods that do not support optimal health

5. Healthy People 2010: Disparities, SDOH, Obesity and smoking are still major concerns. Surgeon General David Satcher describes *HealthyPeople 2010* as "an encyclopedic compilation of health improvement opportunities for the next decade.

6. Healthy People 2020: Disparities and Social Determinants of heath are specifically studied along with specific health Indicators.

7. Healthy CT 2020: **THE PLAN - 7 Key Foci** 1: Maternal, Infant, and Child Health 2: Environmental Risk Factors and Health **3: Chronic Disease Prevention and Control** 4: Infectious Disease Prevention and Control 5: Injury and Violence Prevention 6: Mental Health, Alcohol, and Substance Abuse 7: Health Systems

This presentation is framed by a brief history of key facts from the experience of the original involuntary migrants from the African Continent and Caribbean over the past four hundred years of habitation in the USA.

1. Slavery 1640 – 1863-> 244 years
2. Re- Construction and Jim Crow 1863-1965 -> 102 years. The constant terror and instability of this era may have caused significant Epigenetic Changes that added to propensity of major health risks becoming heritably over the generations.
3. Post CRA and VRA 1965- 2015 - 50 years- Finally the descendants of the involuntary migrants from Africa.
4. Two Hundred and twenty-eight years since the creation of the US Constitution on Sept 17 1787. Article I, Section2 relegated all the involuntary migrants from Africa to 3/5 of a person and didn't confer voting which merely strengthened the political clout of the states where the "Peculiar Institution" of Slavery was harshly applied. Slavery also provided enormous economic clout without any of the benefits trickling down to the producers of the wealth. Most ate very well by the sweat of the brows of the forced migrants from Africa. Most of whom suffered greatly by not having a Lineage, family alliances, a Community, education and ability to assemble freely and from being segregated and subjected arbitrary and capricious Justice. [The Americans- Daniel J. Boorstin and Response to Sam Wilentz's OP-ED in the NYT on Sept 26, 2015, "Constitutionally, Slavery is no National institution- my response I politely but firmly dissented- posted in my Linked-In blog]

Out of nearly 400 years only for 50 years have African Americans have had Civil Rights and Voting Rights protected across the country by Federal Law [All three branches.]

It is the 52nd Anniversary of Dr. Kings March on Washington, DC, and sadly the bombing of the 16th Street Baptist Church, Birmingham, Alabama. The day before the Social Determinants of Health Summit on Sept 16th 2015 in Lyceum, Hartford, CT. fifty two years ago in 1963 four young women Ms. Addie Mae Collins, Ms. Carole Robertson, Ms. Cynthia Wesley and Ms. Denise McNair were murdered and 22 others were injured. They were there preparing for the church's "Youth Day". The day after the Summit was the 228 anniversary of the creation of the US Constitution was created on the next day September 17th 228 years ago. Please review the attachment on Slavery.

Warm Regards,

Velandy Manohar, MD

The Power Point Presentation is based on this report.

Key Points: [**Excerpts from the View Point Article in the JAMA by Williams. D.H. and Wyatt. R**.]

1. This View point discusses the potential contribution of societal racial bias to disparities in Health care and Health Status

2. The negative stereotypes of Black Individuals [violent, lazy, and dangerous] reflect, in part, how often US Adults have seen these words paired with *black* over their lifetime

3. Implicit Bias by Clinicians has also been associated with poorer quality of patient- physician communication and lower patient ratings of the quality of the medical encounters.

4. Racial/ ethnic disparities in HC are costly to Society in terms of loss of life in the most productive years. **E.g. Black-White differences in mortality have been estimated to account for the premature deaths of 260 African Americans every single day.**

5. Although Racial disparities in access to care, as well as in the quality and intensity of care, contribute to racial/ethnic disparities in the severity and course of the disease, **most racial disparities in the onset of the illness occur prior to the presentation of patients to receive health care.** Racial Ethnic differences in SES are large and contribute to the racial/ethnic disparities in Health**. In 2013, for every $ of household Income white people earned, Hispanics earned 70 cents and Black households earned 59 cents. [Identical to the earnings Gap in 1978]** SES whether measured by income, education, or occupational status in the US and globally is a central factor associated with variations in Health**.** [And access to, the quality and intensity of the health care. VM]

6. The opportunities to be healthy in the environments in which individuals live, learn, work, play and worship are key determinants of health. **In US Data, SES tends to be stronger factor related to variation in health than Race, and SES disparities in health are evident within each Racial Group.**

7. When the health of black and white people is compared at equivalent levels of income and education, racial disparities are reduced but remain evident at all levels of SES. **A growing body of evidence suggests that societal racial bias contributes to these residual effects of race in multiple ways**.[especially important to check this research out. VM] Perceived discrimination has also been associated with lower levels of seeking Health care and adherence behaviors, and research in the US, South Africa, Austrailia and New Zealand has **revealed that discrimination makes an incremental contribution over SES in accounting for racial disparities in health.**

8. **Racial bias also affects health through Institutional mechanisms**. Segregation also leads to residence in poorer-quality housing and in neighborhood environments with elevated risk of exposure to toxic chemicals and reduced access to resources and amenities to enhance health, including medical care.

9. **Successfully addressing** the possibility of Clinician Bias begins with awareness of the pervasiveness, of disparities, the ways in which bias can influence clinical decision making and behavior, and a commitment to acquiring the skills to minimize these processes.[Some physicians are

unaware that racial discrimination exist and there are others who question the evidence of disparities.]

10. **Medical Schools, HCO, and Credentialing bodies should pay greater attention to disparities in health and HC as a High National Priority**. Leadership on Racial Equity to address health disparities in the United States could have positive National effects and additional potential effects on Stigmatized Racial populations around the World.

11. The HC system cannot eliminate racial/ethnic disparities in health[en toto.VM]. **HC professionals need to collaborate with other sectors of society to increase awareness about health implications of social policies in domains far removed from traditional medical and public health interventions.** Multi-level policies and interventions in homes, schools, neighborhoods, work places, and religious organizations can help remove barriers to healthy living and create opportunities to usher in a new culture of health in which the healthy choice is the easy choice[and I might add the default choice.VM]

12. This is a key proposition to bear in mind. We need to improve the health status of all in an equitable, effective, efficient, sustainable and a compassionate manner. **Focussing only on racial disparities in health, in which the health of white people is used as reference , obscures a major challenge that the US faces in improving Health Status**. A recent IOM [Wolf et al 2013] indicated that people in the US have poorer health than individuals residing in other high income countries and that even the most advantaged individuals had worse health than their peers in other affluent nations. Health policy initiatives in the US are needed to improve the Health of ALL [my emphasis.VM], even while those policies seek to enable those farthest behind to improve their health more rapidly than the rest of the population so that the large gaps in health by Race and SES will ultimately be reduced.

13. Large social inequities in health are unacceptable in a nation founded on the principles of liberty, equality and justice for all, and there is inadequate recognition that **dismantling racial bias in all its forms is likely to a potent healthy intervention.[**my emphasis.VM]

All the Best,

Velandy