

**University of South Carolina
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Keynote presentation**

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Growing up in Bronx, New York, Dr. Adewele Troutman experienced first-hand health inequities. In a setting lacking an adequate health infrastructure built upon foundations of social injustice, Troutman was able to see inequities played out in his own community.

The setting and the era in which he grew up was also a seat for the cultural nationalist and black power movement. Experiencing this phenomena at the age of 19 created in Troutman a desire to study and understand culture and African American history.

These experiences and interests have lead him to a career in health and pointed him toward the goal of eliminating health inequities through the improvement of social justice throughout the world. As the director of the Louisville, Kentucky, Department of Public Health, Troutman has started this effort in his own community.

Troutman's department hosts the first center for health inequity in the United States. Examples of inequity in Louisville are very prevalent, with a stark contrast between poor African Americans and poor whites versus suburban dwellers with higher incomes, higher levels of education, greater access to resources such as supermarkets, and distinctly higher levels of access to health care.

Louisville is a case study of the connection between occupation, education, income and health. Most living in urban centers in Louisville die prematurely at a rate of three to 10 years earlier than their counterparts living in suburban areas. Those in the wealthier eastern section of Louisville have a life expectancy of 80 years. Downtown Louisville residents are mostly African American, and the conditions in which most adults live are marked by a history of having grown up in poverty, having an income of under \$20,000, and having higher rates of lung cancer, heart disease and infant mortality. There is also a link between lower high school graduation rates and rates of death, prompting the notion that education policy should be linked with health policy.

The income of the wealthiest one percent in Louisville, mostly residing in the eastern section, have a level of wealth that is greater than the lower 99 percent combined. Louisville reflects studies conducted in the United Kingdom that link lower levels of employment with lower levels of health in almost every category of illness. The conditions in Louisville also fit with a 2002 study that projected that millions of Americans have died prematurely due to unnatural causes.

Race and discrimination, says Troutman, must also be part of the discussion. Overcoming racism is still a challenge in 2008, particularly the societal view among some who view past history as someone else's burden and that proclaims, "I had nothing to do with that." While this statement is true, each of us have grown into positions of white privilege or been among those who have been left out for hundreds of years.

Inequities as defined by Troutman can take the form of chronic and acute diseases, as well as exposure to emerging infectious diseases. He is particularly concerned about changing climate conditions and the move northward of bugs and other disease carriers to colder climates. True to disease pandemic situations being played out globally and locally, those who will suffer most in the U.S. when we have pandemic diseases will likely be those who are already struggling with health inequities.

Troutman also views greater exposure to the impact of natural and manmade disasters a characteristic of inequities, and points to those populations who generally were affected more significantly by Hurricane Katrina than other groups.

As is played out in Louisville, where one lives can contribute to one's level of disease exposure. Access to adequate health care is a very critical issue, and refers not just to the location of facilities, but the type and quality of practitioners that are available, whether or not a facility accepts Medicaid or any type of payment, the hours during which a facility operates, and the distribution of resources that permit a facility to stay in business. All, says Troutman, are social determinants of health.

Troutman is confident that we are at the beginning of a great social revolution. He feels that in the United States, some are starting to consider health as a basic human right, yet have not matched other countries and their constitutions that reflect this basic health as a tenet. The U.S. Constitution urges life, liberty and the pursuit of happiness as inalienable rights, yet all are unachievable, says Troutman, without including health.

Troutman reflects on the teachings of Rev. Martin Luther King, Jr., and his statement, “Of all the injustices, inequities in health are the most shocking and inhumane.” Overcoming these health inequities through social justice must include freedom from bias. Troutman cites the “redline” program that provided monthly mortgage subsidies to G.I.s following World War II as an example of institutionalized racism and efforts that established a culture of haves and have nots.

Advancing the United States’ ability to overcome health inequities requires a reframing of issues and restating of questions in a way that modifies focus and direction in resolving the issues, says Troutman.

Health vs. health care: The World Health Organization definition of health talks about community empowerment and having access to goods and services. In the U.S., we spend most of our time addressing symptoms – not the causes of the symptoms such as conditions within our urban centers.

Personal choice vs. structural and systems change: In many communities, such as urban environments, there are a lack of systems that prevent citizens from making health personal choices. “If they’d just eat right, the community would be better,” remark those unfamiliar with the plight of getting five to nine servings of fruits and vegetables per day in urban settings. In many cities in the U.S., there are few supermarkets within walking distance. The same is true in rural settings with limited or no access to transportation. Those living in urban and rural environments consequently face the very definition of a food desert. One example of systems failing people is that of a 56 year-old woman who died due to advanced carcinoma. A papsmear two years earlier revealed lumps under her skin, yet presented conditions that made the carcinoma 97 percent curable. Upon hearing of her death, doctors could not understand why the woman had not sought medical attention. It was recognized later that the woman lived in the housing projects. This was a place where the elevators were often broken, where the mailboxes were broken, and where the postal carriers were scared to deliver mail to the neighborhood. There were also thugs controlling her building who charged residents money to leave the building. For the woman to visit the doctor, she would have had to take three buses to reach the hospital, and likely would have been visited by a foreign doctor beset with seeing 50 patients per day. In the specific instance when she did receive the papsmear exam, the chief physician attending her was male and had left her at one instance to be exposed in the examination room. The wait staff at front desk were of little help as they were underpaid and overworked. The questions that we ask then are about the systems that failed this woman and that prevented her from getting care. Understanding this woman’s life — one of inequity, poverty, and affected by teen pregnancy and incredible stress — help us understand the systems that need to be fixed.

Upstream vs. downstream: Typically, the issues with which we are dealing in health care are “downstream” stuff. Responding to health symptoms and struggling to gain access to healthy foods are examples. The causes of these examples and others are upstream and constitute system issues such as a lack of access to health care and institutionalized racism. A metaphor for viewing this situation is told in the story of two fishermen sitting by the riverbank. The fishermen suddenly notice a baby floating past them. Suddenly, a second baby floats past. The first man jumps into the river to save the babies, while the second man walks away. The first man asks the second where he is going. The second answers, “I’m going upstream to find the person who’s throwing babies in river.”

Individual action vs. social movements: We must reframe the issues confronting society and strive to be active and committed to creating change through social movements and collective action.

Programs vs. policy change: Focus needs to be shifted to the policies that will make a difference in driving health equity and social justice. Education policies and economic development policies must be recognized as having influence upon community health and the distribution of inequities within local settings.

Creating health equity vs. eliminating health disparities: Equity is not the same thing as equality. Lowering the health status of those in the upper levels of society might make things equal but would not be equitable.

Market justice vs. social justice: This conflict represents a philosophical disconnect in our national view of health. Our current health care delivery systems are market driven. It contends that the individual must take advantage of benefits and deal with the burdens of society, and if you cannot do so successfully then it’s your poor luck. The current view represents a social Darwinism based on factors in society that impede the fair distribution of benefits and burdens.

Key to the questions we must ask is the fundamental query, “But why?”. Doing so gets us moving upstream to address the causes of the causes versus repeatedly treating the symptoms only. It overcomes being caught in a cycle of insanity, defined by doing the same thing in the same way and getting the same result.

Next steps in addressing these systemic breakdowns is initiating action at the level of national and community health. It recognizes that health inequities are systemic, avoidable, unfair and unjust. We cannot change social structures but need to work in policy development, community engagement, and establish a social movement. These next steps must

therefore include:

- A mosaic of people and partners who must come together to make vision a reality
- Citizens taking political action beyond issues such as eating healthy
- Empowering communities and improving the social conditions that drive the health of populations
- Pursuing certain things because it's the right thing to do — not just because it's of self-interest — recognizing that a right to health is the most important social goal

Troutman concludes that the foundation for ensuring everyone has a right to better health is based upon the existence of universal principles. This gives this mission a spiritual base and not just a pragmatic base. Health, by Troutman's definition, is a balance of mind, body and spirit. When the spirit is out of whack then one is unhealthy. This can be seen in individuals and in communities. The spirit of both can be either healthy or unhealthy. Achieving spiritual balance and consequently better health is a basic human right — not just a privilege.

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