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Public health researcher takes on health disparities

By **Sara Michael**

Examiner Staff Writer 1/9/09



Thomas A. LaVeist, professor of Health Policy and Management, and director of the Center for Health Disparities Solutions at the Johns Hopkins Bloomberg School of Public Health, is studying the gaps between ethnic and racial groups and its impact on health care. Kristine Buls/Examiner

Each week, as part of "Power Friday," The Examiner profiles researchers, scientists and health care professionals who are making a difference in the everyday lives of Marylanders.

Thomas LaVeist is a professor in health policy and director of the Center for Health Disparities Solutions at the Johns Hopkins School of Public Health, where he studies gaps between different racial, ethnic and gender groups in health care access, quality and outcomes.

Disparities in health care isn't something that has emerged recently.

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As far back as we go with quality data, we find disparities certainly by race, by gender and by economic status. In fact, the earliest studies on the socio-economic status found disparities more than 100 years ago.

You recently published a study on disparities in hypertension and the effect of environmental factors. Tell me about that.

Up close with Thomas LaVeist

» **Career:** Professor of health policy and director of the Center for Health Disparities Solutions at the Johns Hopkins School of Public Health

» **Age:** 47

» **Hometown:** Brooklyn, N.Y.

» **Current home:** Owings Mills

» **Education:** Bachelor's at University of Maryland Eastern Shore and Ph.D. at University of Michigan

» **Family:** Married, four children and one dog

» **Hobbies:** Playing bass guitar and piano

» **What he's reading:** "Outliers: The Story of Success" by Malcolm Gladwell

» **Philosophy:** No matter what your station in life may be, in the end we are all just people.

When you look at what produces the health of any given individual or population, it's a combination of things. It's their biological makeup or their genetic endowment. It's also what you are exposed to [such as] toxins, occupational exposures and other social exposures, such as living in high-stress environments.

Often what we have done in disparities research is we have looked at race groups and gender groups or socio-economic status groups and we don't account for differences in the types of environmental exposures these groups are getting.

Take for example the study we did. When you look at race differences we know generally the U.S. is a very segregated society. Black and white people don't tend to live in the same communities.

The environmental exposures they have are very different.

When you say there is a race difference in this or that outcome, we don't know if those differences are caused by these very different risk environments people are living in or if it's really something more inherent in that race group, [such as] its culture or even its biological differences.

So you get people making theories about biological differences between race groups when they haven't even accounted for environmental differences, and of course they can't ever identify what that gene is.

When you do find a gene that is associated with an outcome, the association is at best weak.

Explain the concept of the biological differences. Is that genetics?

Mainly it's genetics. People say it in broad terms, but what it really comes down to is the idea that there are genetic differences across what we call race groups.

Some of my own buddies do this sort of research, and we debate about it all the time.

When you see that, what you really find is ... genes are found in all race groups but may be more prevalent in one group versus another.

But in reality there aren't [genetic difference by race]. What you have is a higher frequency in a certain gene or gene mutation in one population or another and that gene mutation is associated with a health outcome.

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[In our study on hypertension] we tried to account for these environmental differences by finding black and white people who are living in racially integrated communities and have similar income and similar education.

Fortunately for us, we found two [communities] right next to each other right here in Baltimore City.

We were able to account for about 1/3 of the race difference in hypertension that you normally see in national studies. The disparities are a lot smaller or in some cases nonexistent.

Which makes a strong case for the environmental factors?

Yes, but what about the environmental factors is the next question. Well blacks are more likely to live in communities like that. That's why we see these disparities. That's the story that has unfolded.

Does that counter the more common notion that it is a genetic difference?

It's a different way of [looking at it]. It's a lot different than any approach any one has taken in the past. Now let me stress, I am not suggesting there is no biology or genetic component to this. Genes interact with the environment and genes interact with behavior.

And so you have populations that are living in different risk environments, some genes are going to express, others are not going to express.

There is certainly a role in genetics but I am suggesting it's much more complicated. It's more nuanced than this simplistic notion that there are black genes and white genes and Hispanic genes and Asian genes, and these genes produce race differences.

What are the solutions to this?

The solutions are in the behavioral and environmental realm. For me, I am not a geneticist. There are people trying to figure out how to get the gene that switched on to switch back off. That's important work also but until we figure that out, we also need to be figuring out how do we modify the behaviors? How do we modify environmental impacts or how do we mitigate the effects of those exposures?

My focus is more in the environmental domain, which is through policy.

Considering how long-standing these disparities are, you would think more is being done to fix it.

It's hard to know what to do. To sort of sympathize a bit, if I was a legislator, what would I do? It's very difficult to come up with something that could be easily incorporated into a bill that could affect health disparities.

To be perfectly frank, we researchers haven't fully explained what causes the health disparities. We have some good ideas but we can't say definitively "here are the three things creating health disparities." We aren't at that point so we can't expect policy-makers to be able to know exactly where those prevention levers are that would lead to change.

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