



Dean Stephen M. Shortell

A Monumental Challenge

It is widely recognized that disparities in health and health care exist by ethnicity, race, and socioeconomic status. In California, the infant mortality rate for African Americans is more than twice that of whites; Asian Americans/Pacific Islanders have the highest rate of liver cancer among all the populations; and African Americans living in Los Angeles County have a 78 percent higher death rate from heart disease than that of the overall population (The California Endowment, *Unequal Treatment, Unequal Health*, 2003). Nationally, Hispanic Americans are almost twice as likely as non-Hispanic whites to die from diabetes (*Annals of the New York Academy of Sciences*, 1999). Marked differences in treatment practices also exist by ethnicity and race. For example, minorities are more likely than non-minorities to have inadequate pain management. As summarized by Dr. Harvey Fineberg, president of the Institute of Medicine, "Racial and ethnic minorities in the United States face higher rates of illness, greater amounts of disability, higher mortality rates, and shorter life spans than the white majority. These groups have poorer access to health care providers, are more likely to be uninsured or underinsured, and are more likely than whites to face cultural and linguistic barriers in attempting to access health care" (Remarks at symposium, "Equal Treatment—One Year Later," March 19, 2003).

Addressing these inequalities is a complex challenge that will require deep understanding of the relationships among biology; culture; education; housing; poverty; neighborhoods; social networks; personal behaviors; lack of access to health insurance coverage, health professionals, and health care facilities; language barriers; and discrimination, among others. Relatively little is known about how these factors interact to "produce" health. This research agenda is being addressed by many of our faculty as highlighted in this issue of the magazine. The knowledge that they produce will inform public policy and assist in designing interventions that, over time, can narrow and eliminate the documented disparities.

On the educational front, the School's interdisciplinary Dr.P.H. program marries academic excellence, professional leadership, and collaborative partnerships with communities to address health disparities. In the past two years the majority of students admitted to this highly competitive program have been from underserved communities (African American, Latino, and Native American). These students and recent graduates have made significant contributions addressing health disparities. In addition, the School's Joint Medical Program (JMP) with UCSF will be launching a pilot program, Program in Medical Education for The Urban Underserved (PRIME-US) to attract medical students with a strong interest in caring for the urban underserved.

Finally, on the policy front we are working with public and private sector leaders throughout the state in organizing the California Health Strategy Summit to be held this coming mid-January in Los Angeles. The summit will convene public health and health care delivery system leaders to address both the chronic illness health issues and infectious disease preparedness challenges facing the state with particular focus on the challenges faced by vulnerable populations. It will result in a prioritized action plan for ongoing implementation.

A key feature of "The Berkeley Difference" is our commitment to social justice. I believe that one of the most lasting contributions our School can make over the coming decade is to advance our understanding of the root causes of health disparities, and ensure that this understanding is translated into informed, effective action to improve health for all. We hope you will join us in this effort.

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