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Interpersonal Violence and Its Impact: a Health Inequity

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MSIP Community and Health Plan Member Violence Reduction Program: Addressing Violence as a Social Determinant of Health and a Challenge to Achieving Health Equity

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Interpersonal Violence and Its Impact: a Health Inequity

The likelihood of being a participant in interpersonal violence – either directly as a perpetrator, victim or witness or indirectly as family or community member – is not randomly distributed through society. Certain groups of people and geographic communities, characterized by a range of factors such as age, gender, socioeconomic status, race/ethnicity, location, are more likely than others to experience interpersonal violence.

Further, there are additional personal and social factors, ranging from social connectedness and opportunities for personal advancement to substance use, possession of weapons and previous involvement in violent incidents that, respectively, either protect people or increase their risk for involvement in interpersonal violence. These same factors, at the community level, also predict the incidence and prevalence of interpersonal violence in particular communities. There is an epidemiology of interpersonal violence and its sequelae.

The epidemiology of interpersonal violence demonstrates that its distribution in society constitutes a health inequity, a burden that is unequal and significantly structured in accordance with societal circumstances. Lack of opportunity, under- or unemployment, poverty, poor access to needed resources such as education, housing and racial/ethnic and economic segregation all contribute significantly to the personal and community level risks of interpersonal violence for victims, witnesses and perpetrators alike. In addition, there is evidence that interpersonal violence increases the burden of general morbidity and mortality in people and in communities. Interpersonal violence is not only a health inequity itself; it magnifies other underlying health inequities.

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Underlying Health Inequities

- Homicide rates among 10-to-24-year-old African American males (60.7 per 100,000) and Hispanic males (20.6 per 100,000) exceed that of white males in the same age group (3.5 per 100,000)[1]. Homicide is the leading cause of death for African Americans, Asians and Pacific Islanders, American Indians and Alaska Natives between the ages of 10 and 24, and it is the second-leading cause of death for Hispanics of the same age.[2]
- American Indian and Alaska Native communities suffer from a violent crime rate that is two to three times greater than the national average.[3]
- Black males 15 to 19 years old are six times as likely to be homicide victims as their white peers.[4]
- Areas of concentrated poverty that have low housing values and schools with low high-school graduation rates put residents at increased risk of death from homicide.[5]
- Low-income neighborhoods suffer disproportionately high rates of street violence.[6]
- Adults who reported exposure to violence as children are more likely to suffer from chronic health conditions, compared to adults who were not exposed to violence as children. Chronic health conditions such as ischemic heart disease (2.2 times), cancer (1.9 times), stroke (2.4 times), chronic obstructive lung disease (3.9 times), diabetes (1.6 times) and hepatitis (2.4 times) were especially likely if adults were exposed to multiple forms of violence as children[7,8]

Interpersonal Violence and Its Impact: a Health Inequity

Understanding that interpersonal violence is a health inequity and realizing its immense health and other related costs – human, economic and societal – should compel health care payers and providers, along with other societal stakeholders, to find ways to intercede at the personal and community level to prevent it or mitigate its multiple sequelae. The discovery of modifiable protective and risk factors has permitted the design and implementation of efforts to identify those persons most at risk and to create initiatives that decrease their likelihood of experiencing interpersonal violence by helping them increase their protective factors and decreasing their risks.

The goal of the MSIP Community and Health Plan Member Violence Reduction Program (VRP) is to help Health Plans mount effective initiatives that are sensitive to the circumstances of their membership and build on the resources of their community. Understanding that interpersonal violence has roots in societal drivers promotes the utilization of trauma-informed, culturally aware, inclusive efforts to identify, engage and aid persons at risk for interpersonal violence. Appreciating the underlying social dynamics of interpersonal violence also helps in defining the role health care payers and providers can play in supporting the development of needed community assets and in identifying whom they need to partner with to do this effectively.

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