URBAN INSTITUTE

Unequal Treatment at 20:
Accelerating Progress toward Health Care Equity

#LiveAtUrban

Welcome Remarks

- Kimberlyn Leary, Senior Vice President, Urban Institute
- Xavier Becerra, Secretary, Department of Health and Human Services
- Richard E. Besser, President and Chief Executive Officer, Robert Wood Johnson Foundation
- Risa Lavizzo-Mourey, Robert Wood Johnson Foundation Health Equity and Health Policy Professor Emerita, University of Pennsylvania

POEM

“The Mask,”
Maya Angelou

Welcome Remarks

- **Kimá Joy Taylor**, Nonresident Fellow, Health Policy Center, Urban Institute
- **Brian Smedley**, Equity Scholar and Senior Fellow, Health Policy Center, Urban Institute

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March 21, 2023

Unequal Treatment at 20: Accelerating Progress Toward Healthcare Equity

Brian Smedley

Thank you to the UT@20 Advisory Committee

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Robert Wood Johnson Foundation Population Health and Health Equity Professor Emerita

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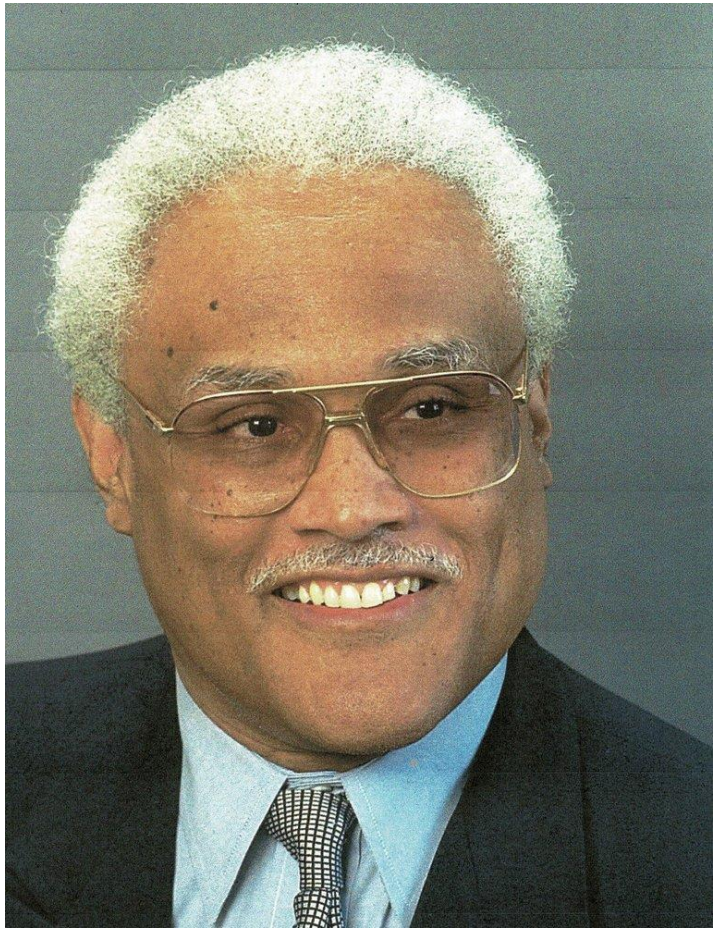
Dr. Nicole Stern
Staff Physician, Sansum Clinic, Santa Barbara, CA
Enrolled member of the Mescalero Apache Tribe of New Mexico

Dr. David Williams
Florence Sprague Norman and Laura Smart Norman Professor of Public Health
Harvard School of Public Health
Professor of African and African American Studies and Sociology
Harvard University

In Remembrance

Dr. W. Michael Byrd



Dr. H. Jack Geiger

Goals and Objectives of the Unequal Treatment at 20 Program

Goals of the Unequal Treatment at 20 Program:

- Identify promising new strategies
- Identify actors accountable for action
- Identify priorities for new research
- Elevate the voices and expertise of people with living experience of inequity
- Curate strategies that can be explored in selected states

Paper Topics Identified to Date:

- Payment Reform and Equity – building on existing initiatives (i.e., Medicaid payment innovations) to incentivize equity – what does the evidence suggest?
- Promoting Equitable Health Through Community Partnerships – the Health System Perspective
- Community led efforts to promote equitable health
- Strengthening the Legal Landscape for Equity

Paper Topics Identified to Date (continued):

- Innovative Uses of Patients' Race and Ethnicity Data to Asses and Improve Healthcare Access and Quality – Next Steps for State and Federal Leadership (Building on Urban's July report)
- Machine Learning, Artificial Intelligence, and Equity
- Delineating Actors in Healthcare Systems
- The Past and Current Social and Political Context of Health Inequities
- Envisioning a New Health System Rooted in Equity

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Past and Current Social and Political Context of Health Inequities

- **David R. Williams**, Florence Sprague Norman and Laura Smart Norman Professor of Public Health and Chair of the Department of Social and Behavioral Sciences, Harvard T. H. Chan School of Public Health; Professor of African and African American Studies and Sociology, Harvard University

The Past and Current Social/Political Context of Health Inequities

David R. Williams, Harvard University

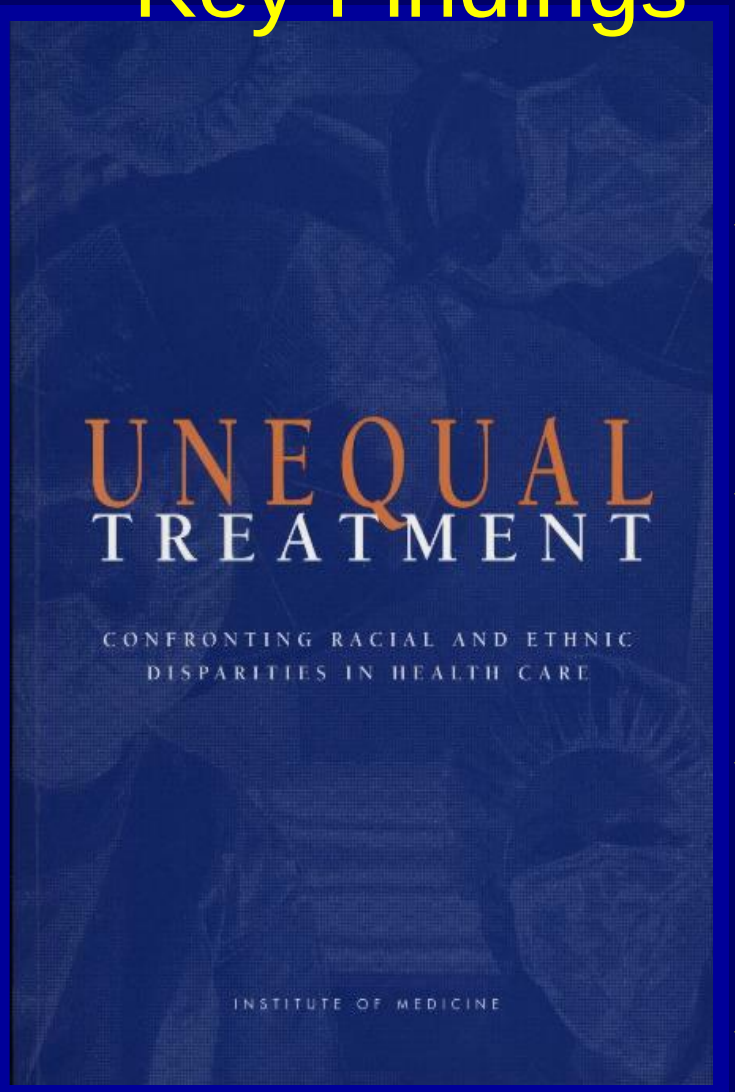
with

Karishma Furtado, Urban Institute

Marie Plaisime, Harvard Chan School of Public Health

Camila Mateo, Harvard Medical School

Key Findings



- ✓ Racial and ethnic disparities in healthcare exist. They are unacceptable because they are linked to worse outcomes
- ✓ They occur in the context of broader historical and contemporary inequality and the persistence of racial/ethnic discrimination in American life
- ✓ Many sources including health systems and healthcare providers and managers may contribute to these inequities in health care
- ✓ Bias, stereotyping, prejudice and clinical uncertainty on the part of healthcare providers may contribute to these disparities in health care
- ✓ Differences in treatment refusal rates between racial and ethnic minority and white patients are small and do not fully account for these disparities

Criticism of the Report

Project MUSE

THE INSTITUTE OF MEDICINE REPORT

too quick to diagnose bias

SALLY SATEL* AND JONATHAN KLICK*†

ABSTRACT The Institute of Medicine report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, claims that medical studies document a systematic causal relationship between race and disparities in health inputs and outcomes among individuals of different races. This article argues that the majority of studies are not powerful enough to establish a causal link, since they do not sufficiently control for differences among patients that happen to correlate with race, and it outlines a powerful audit study that could isolate any effect of race on health care decisions. Even if there are race-based disparities in health inputs, evaluations of welfare and policy prescriptions should be based on health outcomes, since the relationship between care and health is, at least in some cases, weak.

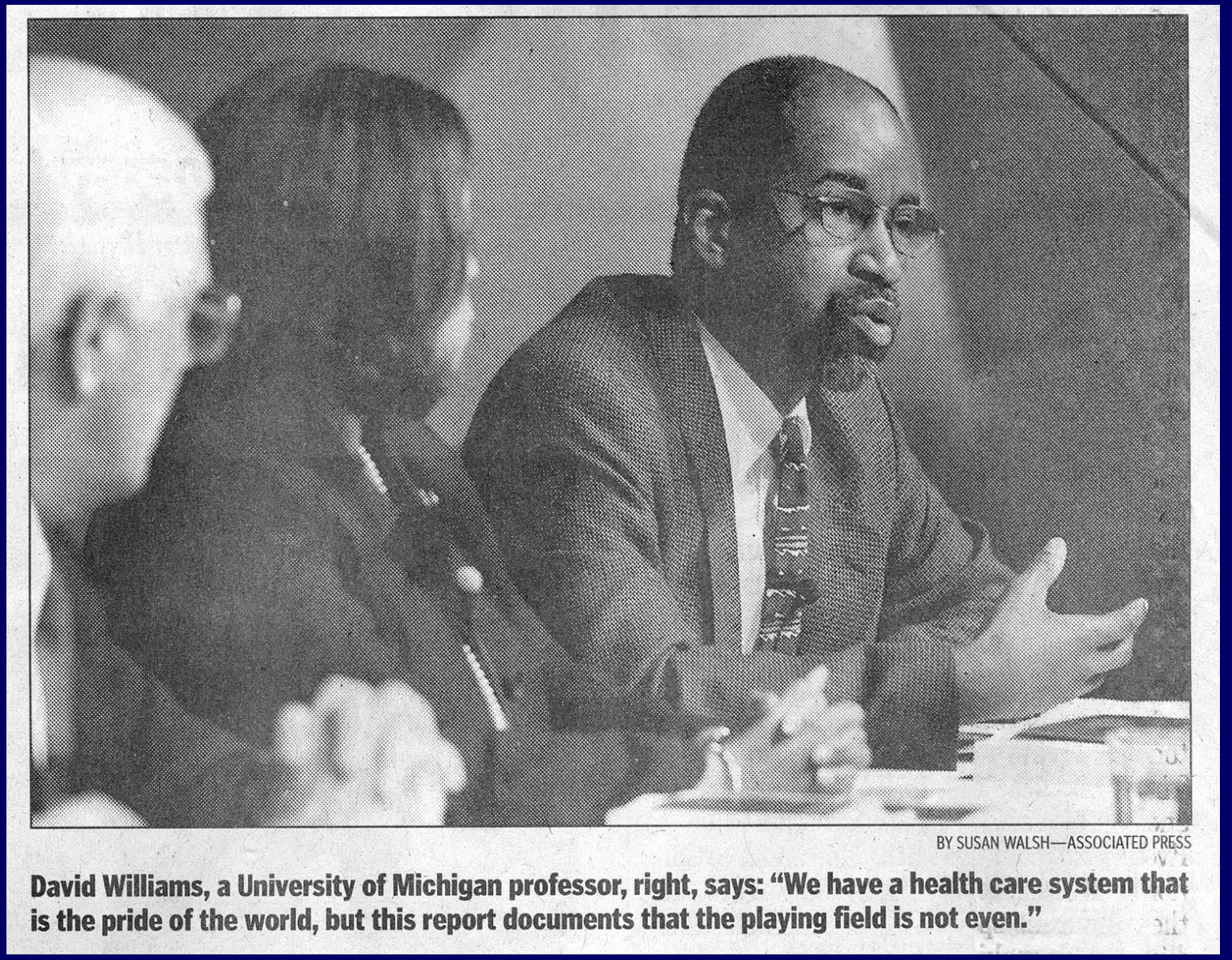
- The view that bias, prejudice, and discrimination by MDs is one reason is premature
- *"Words such as prejudice, bias and discrimination represent charged and divisive language that is needlessly provocative and potentially counterproductive"*
- Most studies reviewed were not powerful enough to establish a causal link and there are alternative research approaches that could isolate any effect of race on health care decisions
- The relative importance of discrimination contributing to health disparities is unclear, especially when compared to factors such as access to care, quality of care, and health literacy
- Race based remedies pose a divisive distraction from more constructive solutions

Sally Satel & Jonathan Klick, FSU College of Law Working Paper no. 110, 2004

Impact of the Report

Media Coverage

- Coverage on TV and newspaper news outlets
- Many articles in popular media reviewing the findings
- Many professional organizations reported on, and developed programs to raise awareness of their members to the findings



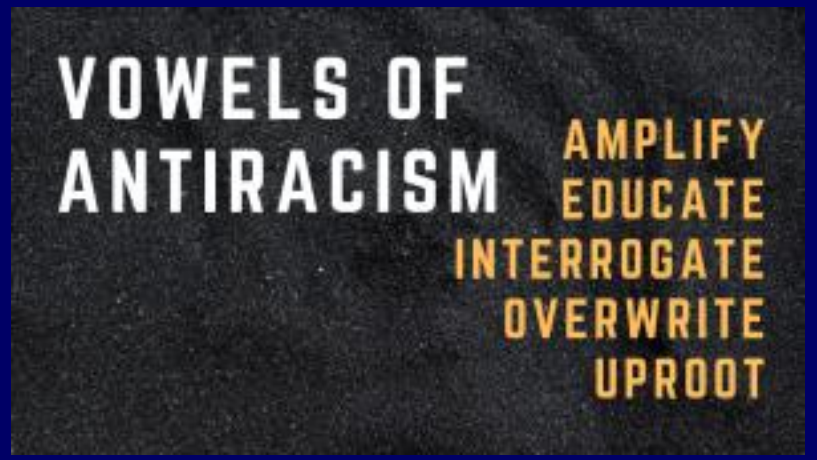
BY SUSAN WALSH—ASSOCIATED PRESS

David Williams, a University of Michigan professor, right, says: "We have a health care system that is the pride of the world, but this report documents that the playing field is not even."

Washington Post, 2002

Awareness Raising: Practice, Research, Policy

- Spurred the design and implementation of anti-racism work in medical care
- Led to an increase in implicit bias and diversity training in health care contexts and medical schools
- Fostered improvement in monitoring and performance measurement using racial metrics
- Stimulated increased research on the topic



Example of Research: Evidence that Implicit Bias Matters in Health Care

Implicit Bias and the Quality of Patient/MD Interaction for Blacks

- More Implicit bias associated with:
  -- more clinician verbal dominance*
  -- less patient-centered dialogue
  -- lower patient positive affect*
  -- lower perception of respect from clinician*
  -- less patient liking of clinician*
  -- lower trust and confidence in clinician
  -- less likely to recommend clinician to others*
  -- less perception of clinician as participatory*
  -- longer visits and slower speech (compensation for mistrust?)

Lisa Cooper

Lisa Cooper et al., AJPH, 2012; * = significant interaction with race

What are Studies Finding 20 Years Later?

Race of MD & Newborn Survival

- Study of 1.8 million hospital births in Florida from 1992 to 2015
- When cared for by white doctors, black babies are 3 times more likely than white newborns to die in the hospital
- Disparity cut in half when black babies are cared for by a black doctor
- Biggest drop in deaths in complex births and in hospitals that deliver more black babies
- No difference between MD race & maternal mortality

Brad Greenwood, et al. PNAS, 2020

Fewer Prescriptions for Cancer Patients

- Study of 318, 549 Medicare Patients
- Older Black and Hispanic patients with advanced cancer are less likely than white patients to get opioid medications for pain in the last weeks of life
- When Black and Hispanic patients received opioids, they tended to receive lower doses
- Black patients were also more likely to undergo urine drug screening
- Black men experienced the greatest inequality for both opioid access and urine drug testing

ANN Enzinger at al, J of clinical oncology, 2023

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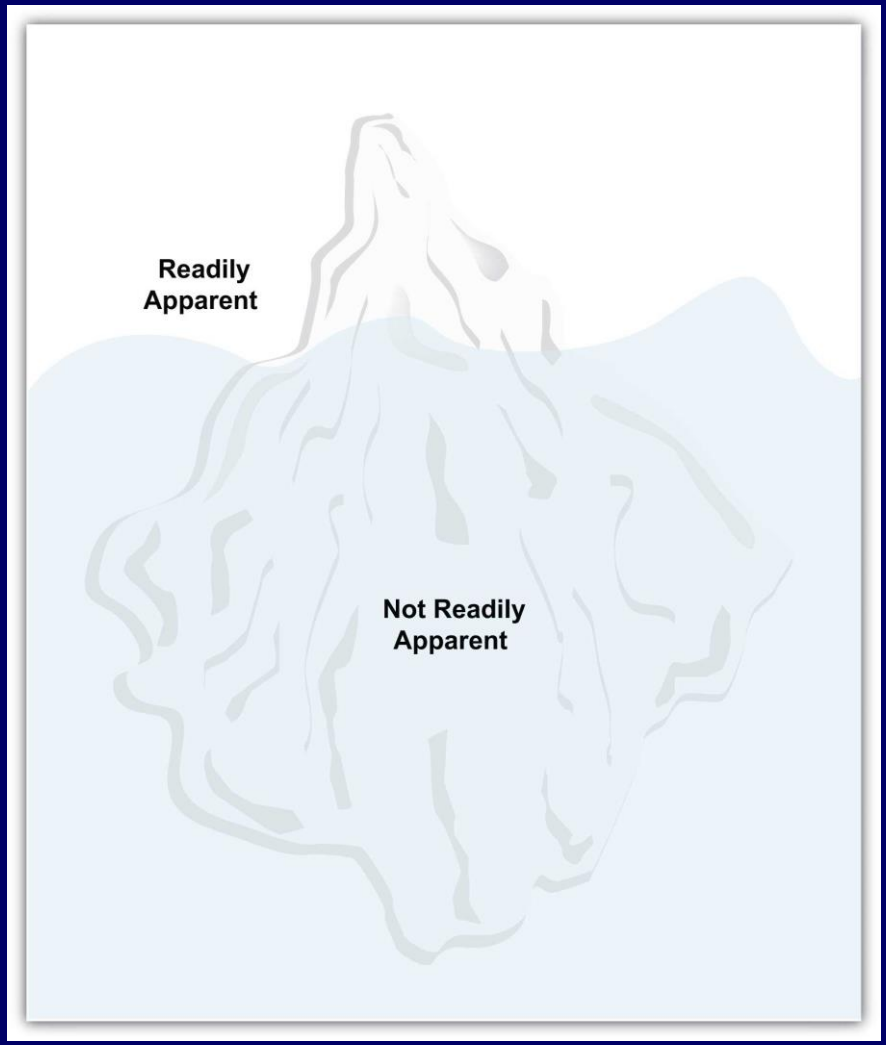

These Studies are just the Tip of the Iceberg

Negatives Descriptions of Patients in the EHR

- Study of 40,113 history and physical notes from 18,459 patients
- Compared to white patients, black patients had 2.5 times greater odds of having at least on negative descriptor in the EHR, such as:

- nonadherent	- agitated
- aggressive	- angry
- challenging	- combative
- unpleasant	- defensive
- hysterical	- exaggerate

Michael Sun et al. Health Affairs, 2022

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Need for Greater Emphasis on Interventions in Research

Racial Inequities in Emergency Medicine

- Review found 221 studies in 28 topic areas of EM
- Harmful consequences in almost every facet of the literature (access, utilization, diagnosis, treatment, outcomes)
- Only 6 studies evaluated an intervention aimed at reducing racial inequities

Anna Darby at al., Academic Emergency Medicine, 2022

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Evidence Exists for Effective Strategies to Reduce Bias

- Evidence-based recommendations for interventions to effectively address unintentional bias among health care provides exist but they are not being systematically utilized
- It is not surprising that progress in correcting these inequities is illusive.

Reducing Racial Bias Among Health Care Providers: Lessons from Social-Cognitive Psychology

Diana Burgess, PhD[1,2], Michelle van Ryn, PhD, MPH[1,3], John Dovidio, PhD[4], and Somnath Saha, MD, MPH[5]

[1]Center for Chronic Disease Outcomes Research (a VA HSR&D Center of Excellence), Veterans Affairs Medical Center, One Veterans Drive, Minneapolis, MN 55417, USA; [2]Department of Medicine, University of Minnesota, Minneapolis, MN, USA; [3]Department of Family Medicine and Community Health, University of Minnesota, Minneapolis, MN, USA; [4]Department of Psychology, Yale University, New Haven, CT, USA; [5]Section of General Internal Medicine, Portland Veterans Affairs Medical Center and Department of Medicine, Oregon Health & Science University, Portland, OR, USA.

The paper sets forth a set of evidence-based recommendations for interventions to combat unintentional bias among health care providers, drawing upon theory and research in social cognitive psychology. Our primary aim is to provide a framework that outlines strategies and skills, which can be taught to medical trainees and practicing physicians, to prevent unconscious racial attitudes and stereotypes from negatively influencing the course and outcomes of clinical encounters. These strategies and skills are designed to: l) enhance internal motivation to reduce bias, while avoiding external pressure; 2) increase understanding about the psychological basis of bias; 3) enhance providers' confidence in their ability to successfully interact with socially dissimilar patients; 4) enhance emotional regulation skills;

minority than with white patients.[32-37] In response to this evidence, significant resources have been devoted to programs to prepare providers to better care for patients from diverse backgrounds. These programs, however, typically focus on improving providers' cross-cultural communication skills and, as such, are likely to have only limited effects on the unconscious cognitive processes that result in stereotype activation and application. In fact, there has been relatively little discussion to date of how to mitigate the negative impact of unconscious racial stereotyping among health care providers, despite the acknowledged need to do so.[32-35] This paper is intended to address this gap by drawing from a highly developed body of research from social cognitive psychology to recommend a set of evidence-based intervention strategies.

First, it is important to note that *overt* expressions of

Diana Burgess et al., JGIM, 2007

But What Our Society is Doing is not Working

In Isolation, Diversity Training is Not Effective

Our Diversity Training Programs Don’t Work

- Research studies reveal little positive effects of diversity training programs on the careers of women and minorities
- In a review of over 900 studies of antibias interventions, Paluck & Green found little evidence that diversity training reduces bias
- Yes, training can increase knowledge about diversity and attitudes toward diversity, but to the extent that it triggers positive changes, they are small and short-term

Pixabay.com

Dobbin & Kalev, Anthropology Now, 2018

Limits of Implicit Bias Training

Before and after scores on the IAT test from over 400 studies found:

- Observed effects of the IAT on reducing implicit bias were small
- There were even weaker effects on reducing explicit bias
- Other evidence also suggests that some participants learn to game the test

Unsplash.com

Dobbin & Kalev, Anthropology Now, 2018

Implicit (unconscious) Bias

Can be reduced under certain conditions

Propranolol Intervention?

- Propranolol is a beta blocker that reduces emotional conditioning and amygdala responses to visual emotional stimuli (e.g. facial expressions)
- Randomized double blind, parallel group, placebo controlled design of a single oral dose of Propranolol (40mg) of 36 whites in the U.K.
- Compared to placebo, propranolol eliminated implicit bias and reduced heart rate, but had no effect on explicit bias (measured by feeling thermometer: warmth to blacks, whites, homosexuals, Muslims, Christians, drug addicts)

Terbeck et al, Psychopharmacology, 2012

Reducing Racial Bias Among Health Care Providers: Lessons from Social-Cognitive Psychology

Diana Burgess, PhD[1,2], Michelle van Ryn, PhD, MPH[1,3], John Dovidio, PhD[4], and Somnath Saha, MD, MPH[5]

Multiple Prejudice-reducing Strategies:

- Stereotype replacement
- Counter-stereotype imaging
- Individuation
- Perspective taking
- Increasing interracial contact

Model Program

- Patricia Devine's Model
- Extensive 12-week curriculum
- Homework exercises to complete
- Observed effects were stronger for persons concerned about discrimination
- Effects stronger for those who completed the homework exercises

Unsplash.com

Devine, P. G., Forscher, P. S., Austin, A. J., & Cox, W. T. L. 2012 *J Exp Soc Psych*

The Devine Solution

- Implicit biases viewed as deeply engrained habits that can be replaced by learning multiple new prejudice-reducing strategies
- Non-black adults were motivated to:

✓ Increase their awareness of bias against blacks

✓ Increase their concerns about the effects of bias

✓ Implement multiple strategies

✓ These were effective in producing substantial reductions in bias that remained evident three months later

Devine, P. G., Forscher, P. S., Austin, A. J., & Cox, W. T. L. 2012 *J Exp Soc Psych*

Other Strategies to Reduce Inequities

Diversifying the Workforce to meet the Needs of all Patients

Physician Race & Health Care

- A RCT of 1,300 Black men
- Recruited from barbershops and flea markets
- Given a coupon for a free health care screening at a Saturday clinic for
  -- blood pressure,
  -- body mass index,
  -- cholesterol,
  -- diabetes

- Men randomized to see black doctors or not
- $50 incentive for clinic attendance
- Free Uber rides if need for transportation

Alsan, Garrick, Graziani, American Economic Review, 2019

Black Illustrations

Black Doctors and Black Health

Men who saw a Black Doctor

- ✓29% more likely to talk about other health problems
- ✓47% more likely to do screening for diabetes
- ✓56% more likely to get a flu vaccine
- ✓72% more likely to do screening for cholesterol

Alsan, Garrick, Graziani, American Economic Review, 2019

MS Online Pictures; Photo by Unknown Author

Progress (or lack thereof) in Medicine

- In 2014, there were 27 fewer African American males in the first year of Medical School than there had been in 1978 (36 years earlier)
- In the mid-1960s, 2.9% of all practicing physicians in the US were black
- In 2019, 5% of MDs were black (6% were Hispanic; 0.3% Indigenous)

MS Online Pictures; Photo by Unknown Author

AAMC, Altering the Course, 2015; Deville et al. JAMA Internal Med, 2015; AAMC, 2019

Provider Cultural Competence

- Study of 437 people living with HIV/AIDS and 45 providers
- Created 20-item scale, self-rated cultural competence
- Racial disparities were found in the receipt of ARVs, self-efficacy and viral suppression among patients of low cultural competence providers
- Minority patients whose providers were high (vs low) on cultural competence, more likely to be on ARVs, have high self-efficacy and report complete ARV adherence
- When cultural competence was high, no racial disparities

Somath Saha et al., Journal General Internal Medicine, 2013 pixabay

Cultural Competence Scale (Selected)

- Family & friends as important to health as doctors
- Social history contributes to how I care for patients
- I am familiar with lay beliefs my patients have
- I ask my patients about alternative therapies they use
- I find out what patients think is cause of their illness
- I involve patients in decisions about their health care

S. Saha et al., Journal General Internal Medicine, 2013

Long-term Strategy

Create Communities of Opportunity to minimize, neutralize and dismantle the upstream systems of racism that create inequities in health

Reducing Inequities
Address Place-Linked Determinants of Health

- Enrich the quality of neighborhood environments
- Increase economic development in poor areas
- Improve housing quality and the safety of neighborhood environments

Shutterstock; Pixabay

What Drives these Large Racial Inequities in Health?

Institutional/Structural Discrimination

Residential Segregation

(restricted residence to particular areas based on race) is an example of institutional racism

- As is the forced removal and relocation of indigenous peoples
- The institutionalized isolation and marginalization of racial populations has adversely affected life chances in multiple ways

How Segregation Works

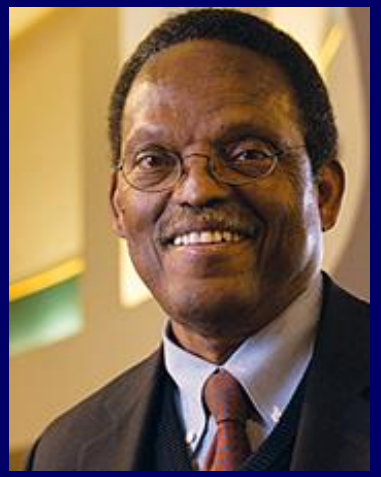
Segregation is like a burglar at mid-night. It slips into the community, awakens no one, but once it shows up, valuables disappear:

- Quality Schools
- Safe playgrounds
- Good jobs
- Healthy environment
- Safe housing
- Transportation
- Healthcare

Pixabay.com

Racial Differences in Residential Environment

In the 171 largest cities in the U.S., there is not even one city where whites live in equal conditions to those of blacks



"The worst urban context in which whites reside is considerably better than the average context of black communities."

Sampson & Wilson 1995

Segregation is the central driver of the Large Racial/Ethnic Differences in SES

Residential Segregation and SES

A study of the effects of segregation on young African American adults found that the elimination of segregation would erase black-white differences in:

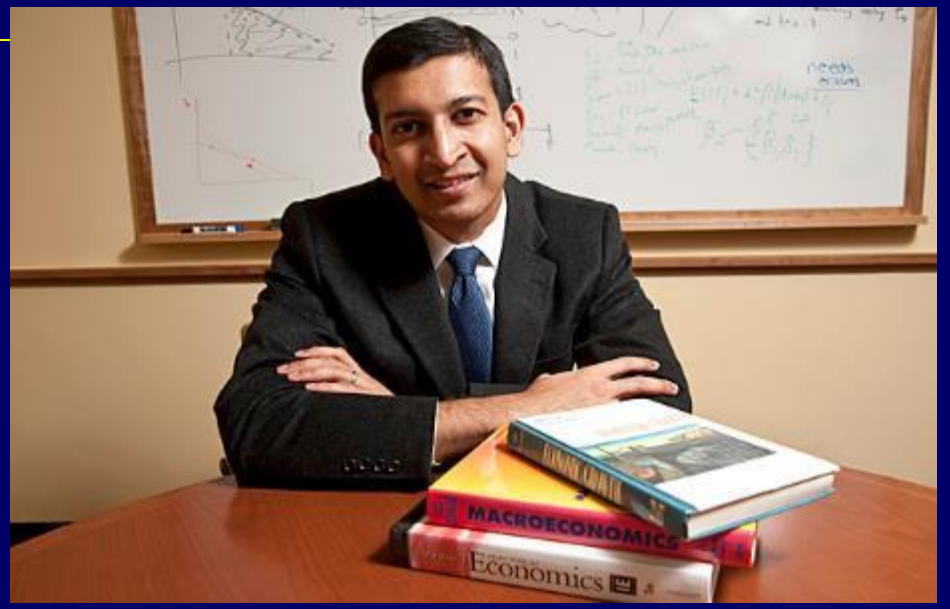
- Earnings
- High School Graduation Rate
- Unemployment

And reduce racial differences in single motherhood by two-thirds

David Cutler & EL Glaeser, Quarterly J Economics, 1997

An Intergenerational Study

- Inequity usu. studied in one generation
- Intergenerational analysis, linking parents & kids, US pop,1989-2015
- Black boys have lower earnings than white boys in 99% of Census tracts in America (controlling for parental income)



- Why? They live in neighborhoods that differ in access to opportunity
- Black boys do well in neighborhoods with good resources (low poverty) *and* good race-specific factors (high father presence, less racial bias)
- The problem: there are essentially no such neighborhoods in America

Raj Chetty et al, "Race & Econ Opportunity" NBER Working Paper, 2018

Median Household Income and Race, 2018

Racial Differences in Income are Substantial:

U.S. Census Bureau, Semega et al., 2019; * For 2017; US Census Bureau, ACS, 2017

Reducing Racial Inequity in Income is on a Treadmill: A Lot of Talk: Little Progress

- In 1978, Black households earned 59 cents for every dollar of income that White households earned

- In 2018, the gap is still 59 cents to the dollar

Median Wealth and Race, 2016

For every dollar of wealth that Whites have,

Blacks have 10 cents

Latinos have 12 cents

Other Races have 38 cents

Dettling et al., FEDS Notes, Federal Reserve Board (SCF), 2017

What Low Economic Status Means

We are in the same storm but in different Boats

Inequities by Design

- Racial inequities in SES that matter for life & health do not reflect a broken system
- Instead, they reflect a carefully crafted system, functioning as planned – successfully implementing social policies, many of which are rooted in racism
- They are not accidents or acts of God
- Racism has produced a truly “rigged system”

Segregation and Medical Care

HSR Health Services Research

DOI: 10.1111/j.1475-6773.2012.01410.x
SPECIAL ISSUE: MEASURING AND ANALYZING HEALTH CARE DISPARITIES

Elucidating the Role of Place in Health Care Disparities: The Example of Racial/Ethnic Residential Segregation

Kellee White, Jennifer S. Haas, and David R. Williams

Objective. To develop a conceptual framework for investigating the role of racial/ethnic residential segregation on health care disparities.

Data Sources and Settings. Review of the MEDLINE and the Web of Science databases for articles published from 1998 to 2011.

Study Design. The extant research was evaluated to describe mechanisms that shape health care access, utilization, and quality of preventive, diagnostic, therapeutic, and end-of-life services across the life course.

Principal Findings. The framework describes the influence of racial/ethnic segregation operating through neighborhood-, health care system-, provider-, and individual-level factors. Conceptual and methodological issues arising from limitations of the research and complex relationships between various levels were identified.

Conclusions. Increasing evidence indicates that racial/ethnic residential segregation is a key factor driving place-based health care inequalities. Closer attention to address research gaps has implications for advancing and strengthening the literature to better inform effective interventions and policy-based solutions.

Key Words. Racial/ethnic residential segregation, health care disparities, health care access, social determinants of health

- Concentration of Black and Brown low-income populations
- Low levels of health insurance
- Providers with reduced ability to refer patients to specialty care
- Fewer Pharmacies, less medication
- Hospitals more likely to close
- Resulting delays in care & receipt of sub-optimal care

K. White, J.S. Haas, and D.R. Williams, Health Services Research, 2012

South LA: Context of MLK Community Healthcare

uclahealth.org

- High levels of uninsurance and underinsurance
- Medicaid is most common insurance
- Rate of diabetes three times higher than the rest of the state of California
- Diabetic amputation is among most frequent surgical procedures performed
- Life expectancy is 10 years shorter than state of CA
- South LA has 10 times fewer MDs than the average US community
- Lowest number of hospital beds (per pop.) in LA county

Elaine Batchlor, Health Affairs Blog, May 4, 2021

Underfunding of Care in South LA

- Medi-Cal has the second-lowest provider reimbursement rates of any state
- Average ER visit in LA earns ~$2,000 from commercial insurers
- Average ER visit in LA earns $650 from Medicare
- Average ER visit in LA earns $150 from Medicaid
- Safety-net hospitals receive supplemental funding for inpatient care
- There are no supplements for most outpatient, community-based care

dhcs.ca.gov

Elaine Batchlor, Health Affairs Blog, May 4, 2021

Reducing Inequities
Address Place-Linked Determinants of Health

- Enrich the quality of neighborhood environments
- Increase economic development in poor areas
- Improve housing quality and the safety of neighborhood environments

Shutterstock; Pixabay

Our Current Environment

We are in an era of increasing hate and Indifference to Addressing Racial/Ethnic Inequities

It was intensified with the election of Barack Obama

Increase in Racial Resentment & Division

- Obama's election led to:

-- 1 in 3 whites feeling 'troubled' that black man was the president

-- Rise of the Tea Party (with racist rhetoric)

-- Resentment of Democrats and loss of white support in 2008 & 2012

-- Less white support for addressing racial inequity

-- increase of Congressional polarization (least productive congresses in 70 years)

-- Increase in belief among whites, especially conservatives, that racism no longer exists

-- No change in implicit biases against blacks

Christopher Parker, Ann Rev of Sociology, 2016

In Wake of Obama's 2008 Election, Democrats Lost ….

13 Senate Seats

69 House Seats

12 Governorships

30 State Legislative Chambers

900+ State Legislative Seats

Worst showing of an incumbent president's party since Nixon years

David Rutz, Meet the Press, November 8, 2015

Marked Spike in Social Media Racial Animosity

- More than 10,000 hate websites in 2009
- Sample hate groups or Facebook Pages: "I Hate Obama," "Obama Sucks," "Michelle Obama looks like a Man," "I hate Michelle Obama"
- Historical racial stereotypes not in mainstream media are commonplace
- Many animalistic photos of Obama and his family
- Posts are outrageously disrespectful and racist

Mia Moody, J of New Media Culture, 2012

Keep Politics Out of Doctor's Office

- A "Healthcare is being profoundly damaged by a radical and divisive ideology"
- At the heart of the problem is the claim that healthcare is systemically racist
- Prominent medical journals are compliant in the crusade against medical professionals
- Medical Schools are preparing MDs for social activism at the expense of medical scence
- MDs are being pushed to discriminate: "Preferential care base on race
- Accusations of racism are contributing to MD burnoutand early retirement

Golfarb Stanley, Wall Street Journal, April 18, 2022

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Health Equity needs to be linked to larger questions of reforming Health Care Funding

Addressing Health Care Financing

Opinion

VIEWPOINT

Salve Lucrum: The Existential Threat of Greed in US Health Care

Donald M. Berwick, MD, MPP
Institute for Healthcare Improvement, Boston, Massachusetts.

In the mosaic floor of the opulent atrium of a house excavated at Pompeii is a slogan ironic for being buried under 16 feet of volcanic ash: *Salve Lucrum*, it reads, "Hail, Profit." That mosaic would be a fitting decoration today in many of health care's atria.

The grip of financial self-interest in US health care is becoming a stranglehold, with dangerous and pervasive consequences. No sector of US health care is immune from the immoderate pursuit of profit, neither drug companies, nor insurers, nor hospitals, nor investors, nor physician practices.

Rapidly increasing pharmaceutical costs are now familiar to the public. Pharmaceutical companies have used monopoly ownership of medications to raise prices to stratospheric levels, and not just for new drugs. Flaws in US patent laws leave loopholes allowing profiteering drug companies to gain control of some simple and long-known medications and to raise prices without constraint. Eye-popping prices for new, essential biological and biosimilar drugs, enabled by the failure of any serious drug price regulation, have yielded enormous profits for drug companies even though much of the basic biological research funding has come from governmental sources.

Particularly costly has been profiteering among insurance companies participating in the Medicare Advantage (MA) program. Originally intended to give Medicare beneficiaries the choice of access to well-managed care

Hospital prices for the top 37 infused cancer drugs averaged 86.2% higher per unit than in physician offices.[3] A patient was billed $73 800 at the University of Chicago for 2 injections of Lupron depot, a treatment for prostate cancer, a drug available in the UK for $260 a dose.[4] To drive up their own revenues, many hospitals serving wealthy populations take advantage of a federal subsidy program originally intended to reduce drug costs for people with low income.[5]

Recent *New York Times* investigations have reported on nonprofit hospitals' reducing and closing services in poor areas while opening new ones in wealthy suburbs and on their use of collection agencies for pursuing payment from patients with low income.[6] The Massachusetts Health Policy Commission reported in 2022 that hospital prices and revenues increased during a decade at almost 4 times the rate of inflation.[7]

Windfall profits also appear in salaries and benefits for many health care executives. Of the 10 highest paid among all corporate executives in the US in 2020, 3 were from Oak Street Health, and salary and benefits included, reportedly, $568 million for the chief executive officer (CEO). Executives in large hospital systems commonly have salaries and benefits of several million dollars a year.[8] Some academic medical centers' boards allow their CEO to serve for 6-figure stipends and multimillion-dollar stock options on outside company boards, including ones that supply prod-

- No sector of US health care is immune from the immune from the immoderate pursuit of profit
- Hospital prices for the top 37 infused cancer drugs 86% higher per unit than in MDs offices
- Hospital prices and revenues increased in the last decade at almost 4 timers the rate of inflation
- Executives in large hospital systems typically have salaries and benefits of several million dollars a year
- Silence is assent. Health care leaders and professionals should lobby congress to pass legislation to rein in greed

Donald Bewick, JAMA, 2023

Health Equity needs to be linked to the normal functioning of health care institutions

Rush University Medical Center Equity Framework

Example of a Comprehensive Approach to Reducing Inequities in Socioeconomic Status and Health by an Academic Medical Center

David Ansell et al. NEJM Catalyst, May, 2021

Reduce Life Expectancy Gap by 50% by 2030

David Ansell et al, NEJM Catalyst, May, 2021

Rush Anchor Mission Initiative: Local Economic Impact

- Employment Preference Initiative
- Using local labor for capital projects
- Career ladder development
- Apprenticeship Initiatives
- Local purchasing program
- Impact investing in local community
- Financial education locally
- Incentivize employee volunteering
- Leveraging employee expertise (e.g., teaching skills class) in local communities

David Ansell et al. NEJM Catalyst, May, 2021

We need to build the science base that will guide us in identifying what framings we should use and what is the optimal language that would facilitate building the political will to address racial/ethnic and SES inequities in health

We need to identify how to tell the story of the challenges of the disadvantaged in ways that resonates with the public

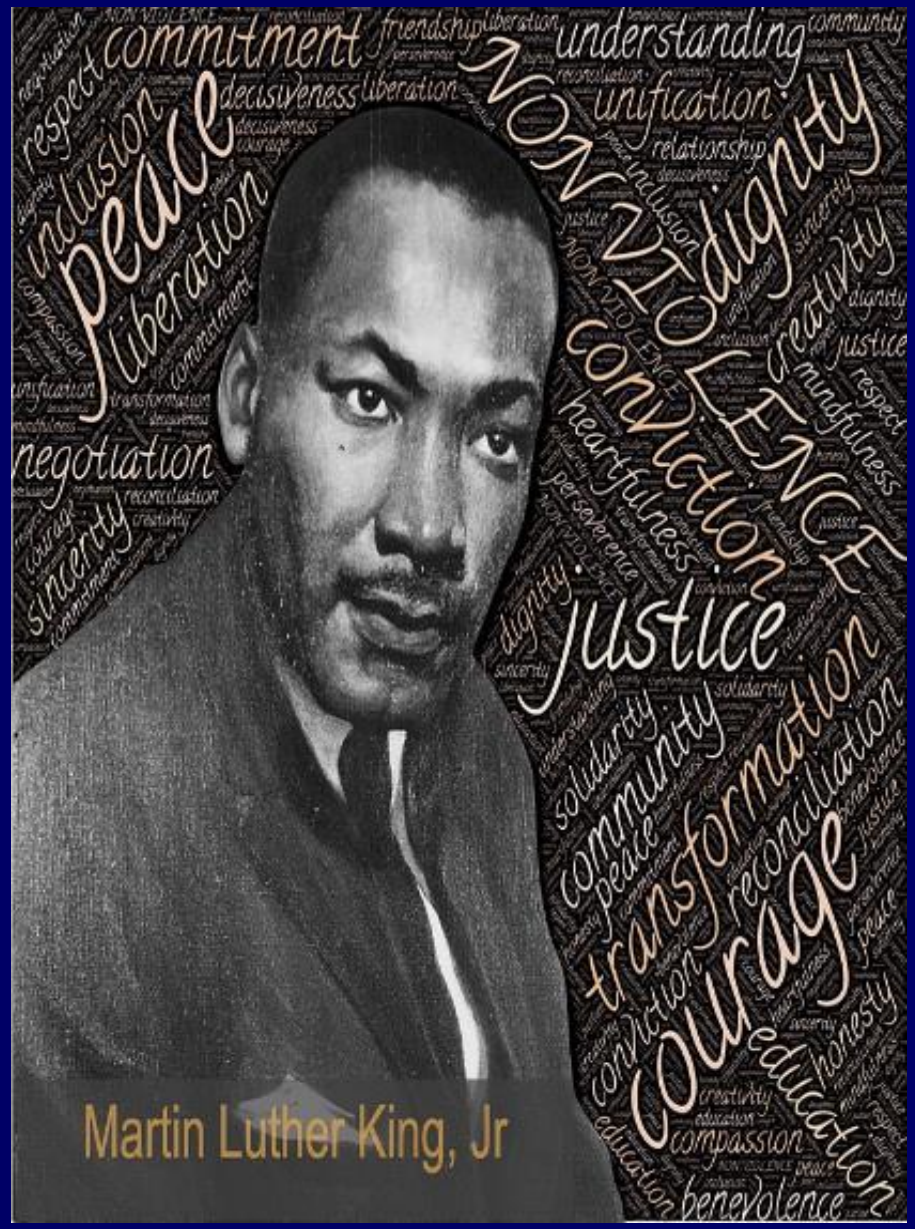
Benefits of Inclusive Policies

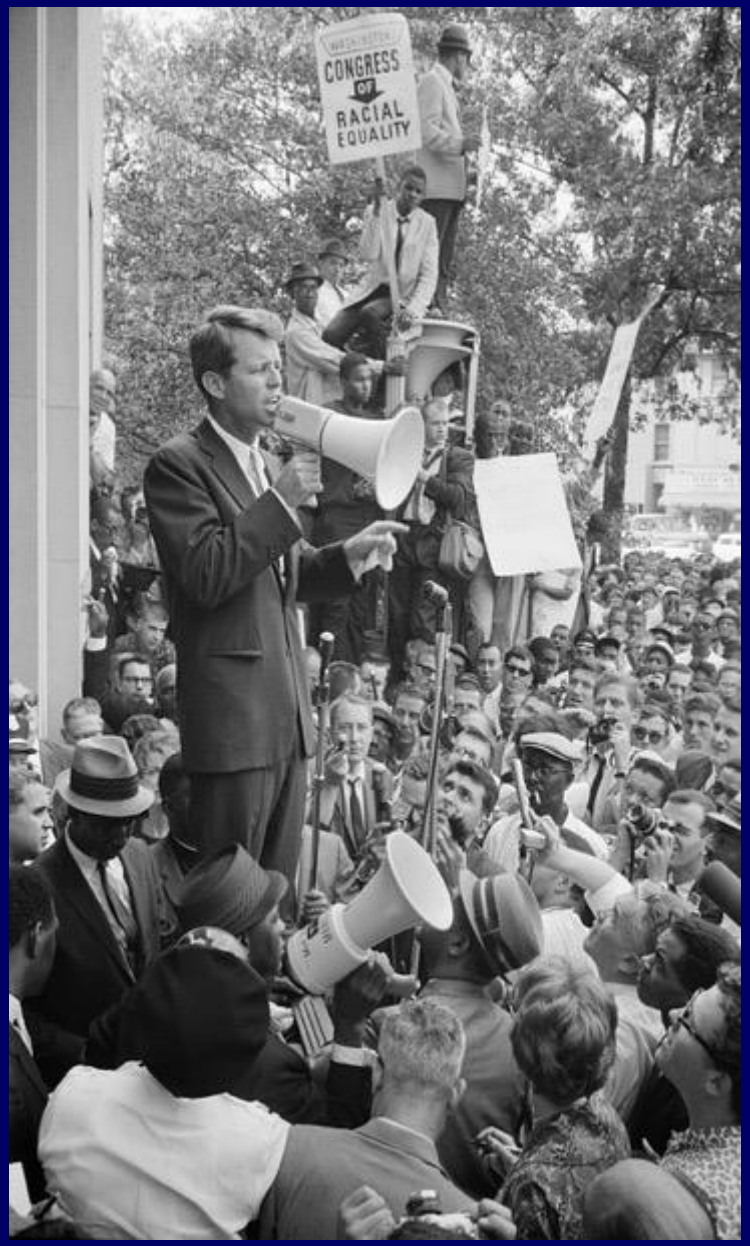
- The creation of communities of opportunity to reverse racial injustice will be beneficial to people of all races
- Policies that benefit communities of color will improve conditions for everyone, including many poor and working class whites

MS Online Pictures

R Godsil & S. Waldeck, The New Tipping Point, Emory Law Journal, 2021.

"True compassion is more than flinging a coin to a beggar; it understands that an edifice which produces beggars needs restructuring.”





A Call to Action

"Each time a man stands up for an ideal, or acts to improve the lot of others, or strikes out against injustice, he sends forth a tiny ripple of hope, and those ripples build a current which can sweep down the mightiest walls of oppression and resistance."

- Robert F. Kennedy

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Unequal Treatment at 20:
Accelerating Progress toward Health Care Equity

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Welcome from Commonwealth Fund

- **Joseph R. Betancourt,** President, The Commonwealth Fund

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Payment Reform:
How can payment reform work to eliminate inequities?
How can we direct resources where needed?

- **Charmaine Bartholomew**, North Carolina Blue Cross/Blue Shield
- **Marshall Chin**, University of Chicago
- **Mai Pham**, Institute for Exceptional Care
- **Carla Willis**, Principal Research Associate, Urban Institute
- **Damon Francis**, Medical Director, Homeless Health Center Alameda Health System; Chief Medical Officer, Health Leads; Assistant Clinical Professor, University of California, San Francisco *(moderator)*

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KEYNOTE

- **Tony Iton,** Lecturer of Health Policy and Management and Senior Vice President for Healthy Communities, The California Endowment

Paper Outline

To achieve this vision, we believe that there are four fundamental questions that we need to address.

1. What is the genesis of health?
2. How do we preserve and enhance it?
3. How does a health system leverage and strengthen the assets of differing populations and cultural populations?
4. How should the system be governed?

- Related to and embedded within these questions are four principles that we believe to be sacrosanct. The first is that health is not the same as healthcare. The second is that preserving and protecting health relies on a strong social contract. The third is that a health system must be people-centered rather than professional-centered. And the fourth is that local communities must have control and decision-making power. Each of these principles must have racial equity and justice at their core.

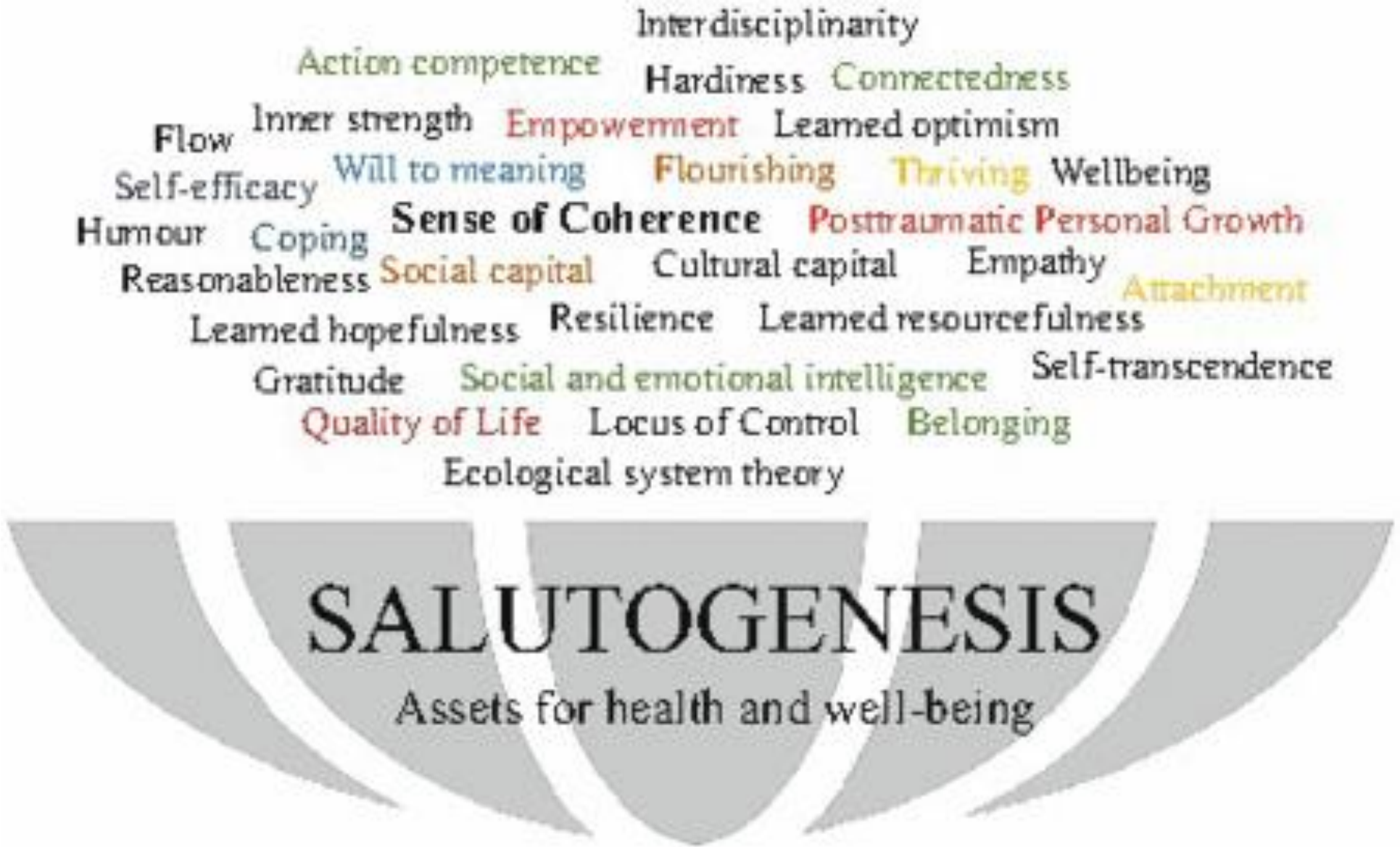
Embedded *Principles*

1. What is the genesis of health?
   - ❖ *health is not healthcare, health is fundamentally about opportunity.*
2. How do we preserve and enhance it?
   - ❖ *protecting health requires a strong social contract.*
3. How does a health system leverage and strengthen the assets of differing populations and cultural populations?
   - ❖ *health system must be people-centered.*
4. How should the system be governed?
   - ❖ *enhance community control and local governance.*

What is the Genesis of Health?

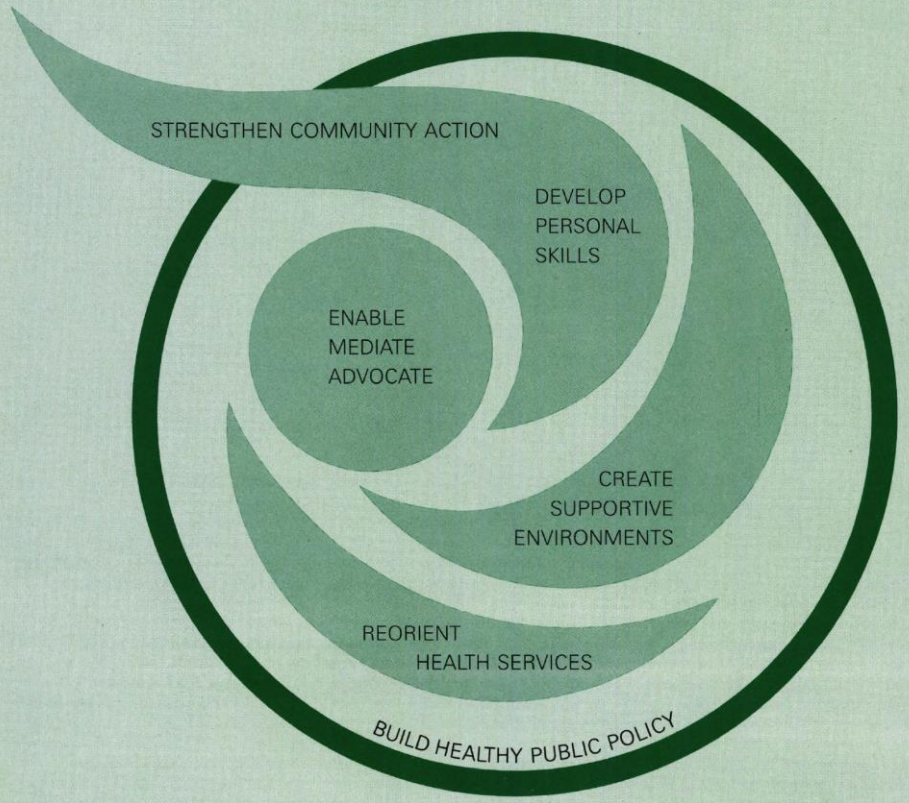
The *conditions* in which we are born, live, work, and play.

- Ottawa Charter SDOH
- Healthy Communities/ Healthy Cities
- Salutogenesis
- Healthy People 2030


Interdisciplinarity
Action competence
Hardiness
Connectedness
Inner strength
Empowerment
Learned optimism
Flow
Will to meaning
Flourishing
Thriving
Wellbeing
Self-efficacy
Sense of Coherence
Posttraumatic Personal Growth
Humour
Coping
Social capital
Cultural capital
Empathy
Reasonableness
Attachment
Learned hopefulness
Resilience
Learned resourcefulness
Gratitude
Social and emotional intelligence
Self-transcendence
Quality of Life
Locus of Control
Belonging
Ecological system theory
SALUTOGENESIS
Assets for health and well-being

OTTAWA CHARTER FOR HEALTH PROMOTION

An international conference, jointly organized by WHO, Health and Welfare Canada and the Canadian Public Health Association, drew up this Charter for action to achieve Health for all by the year 2000 and beyond



A COMMITMENT TO INTERNATIONAL HEALTH ACTION

Photo WHO/Y. Pouliquen

More than 200 participants from 38 countries met in November 1986 in Ottawa to exchange experiences and share knowledge of health promotion. The conference stimulated an open dialogue among health workers, politicians, academics and representatives of governmental, voluntary and community organizations. The charter they drew up reflected their individual and collective commitment to the common goal of Health for all by the year 2000.

Health promotion is the process of enabling people to increase control over, and to improve, their health. So action for health promotion puts health firmly on the agenda of policy makers in all sectors and at all levels. Joint action by many sectors of society will ensure healthier public services, and cleaner and more enjoyable environments.

Consequently, the participants to the Ottawa Conference pledged themselves—among other things—to advocate a clear political commitment to health and equity in all sectors; to respond to "the health gap" within and between societies by tackling inequities in health; and to recognise health and its maintenance as a major social investment and challenge. ■

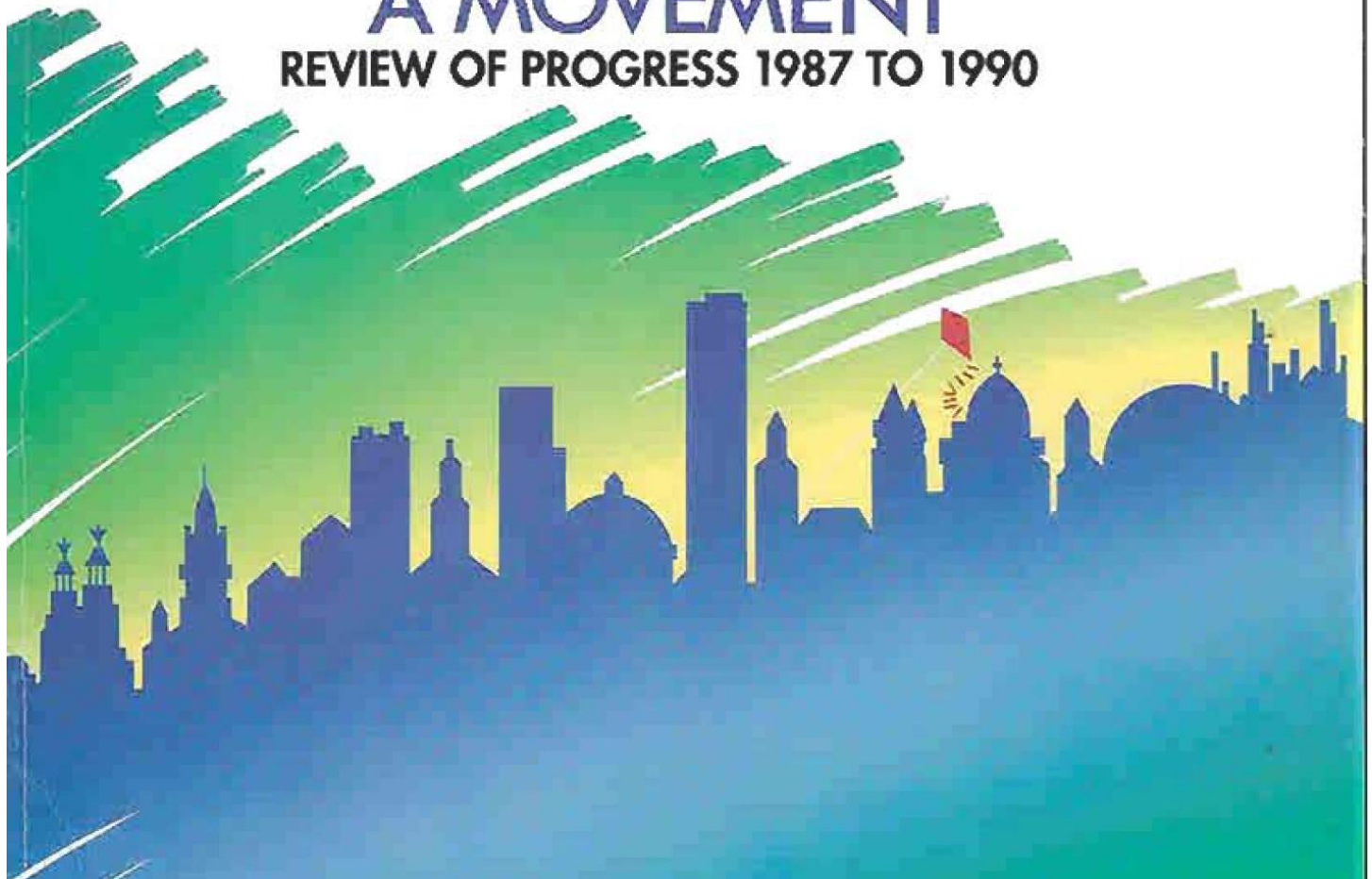
Photo WHO/T. Farkas

Good health must be actively promoted in the community, in the classroom, among "high-risk groups".

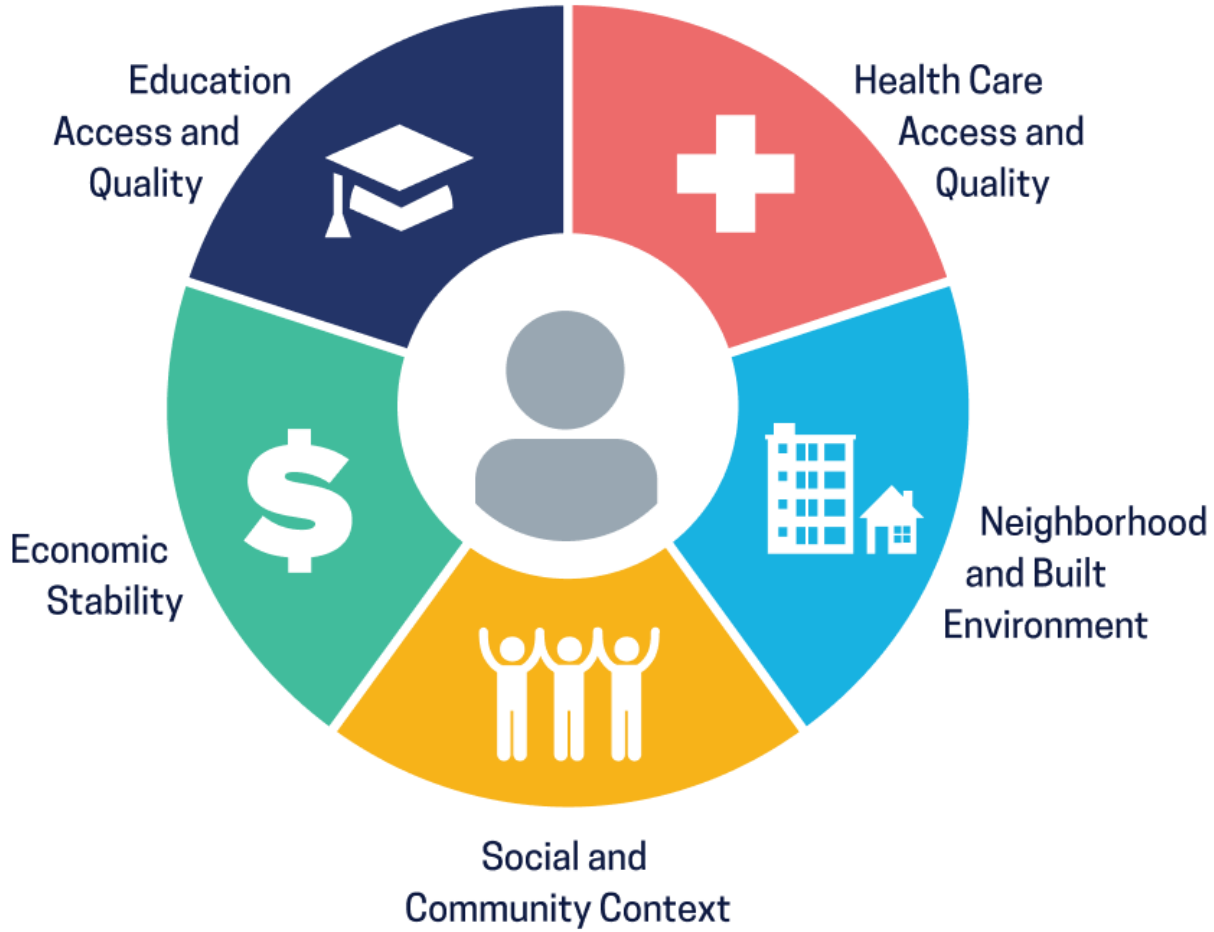
Photo WHO/T. Farkas

WORLD HEALTH ORGANIZATION HEALTHY CITIES PROJECT: A PROJECT BECOMES A MOVEMENT

REVIEW OF PROGRESS 1987 TO 1990



Social Determinants of Health



Social Determinants of Health

Healthy People 2030

When it comes to your health in the US, your zip code is more important than your genetic code.


GREYHOUND
BUS DEPOT
WHITE WAIT
— ROOM —
Intrastate Passe


SAVE SEGREGATION VOTE
STATES RIGHTS
UNPLEDGED ELECTORS
ALL I WAN
FOR
Christma
A
Clean
White
School

Only Members of the

RELIABILITY—CHARACTER—ENTERPRISE.

THE MORNING

OKLAHOMA'S GREATEST NEWSPAPER

AVERAGE SWORN NET PAID CIRCULATION, MAY
Daily 34,137
Sunday 35,292

TULSA DAILY WORLD

THIRD EXTRA

VOL. XV. NO. 243. TULSA, OKLAHOMA, WEDNESDAY, JUNE 1, 1921. 8 PAGES PRICE 5 CENTS

STATE TROOPS IN CHARGE

Barrett Heads Machine Gun-Armed Guards; Negroes Driven From Burning 'Black Belt'

FRUSTRATE ATTEMPT OF PAIR TO ESCAPE FROM JAIL

Boring through the top of their cells, Charles Davis and Harold Morris attempted to escape from the city jail about 2 o'clock Wednesday morning. They were discovered by night jailer E. L. Crawford and officer Ben Meacham just as they were getting through the outside bars of the city prison.

Morris and Davis were each serving a term for carrying concealed weapons and being vagrants. They were arrested last week on Riverside drive and were armed.

The men were discovered after they sawed the two bars from the top of their cell and climbed out on

The Dead

At the Mowbray Undertaking company was an unidentified white man, whose age might be placed between 28 and 33 years, and whose death wound was a bullet which entered the back of the head. He died at a hospital. There were no clues of identification which could be followed last night and he was unidentified up to 3 o'clock this morning.

At Stanley-McClure Undertaking company is an unidentified white man about 35 years of age. Death

Race War Start Came in Arrest of Young Negro

The race rioting that broke out here late Tuesday night grew out of the arrest Tuesday afternoon of Dick Rowland, a negro bootblack, on a charge of assaulting a white elevator girl in the Drexel building on Monday.

There was a movement afoot

Greenwood avenue early Tuesday morning by Officers Henry Cooper and H. C. Park. He was identified by the girl after his capture. The boy did not deny the attack and said he stepped on her foot but did not scratch her in any way.

ARMED WHITE PARTIES ARE TO BE DISBANDED

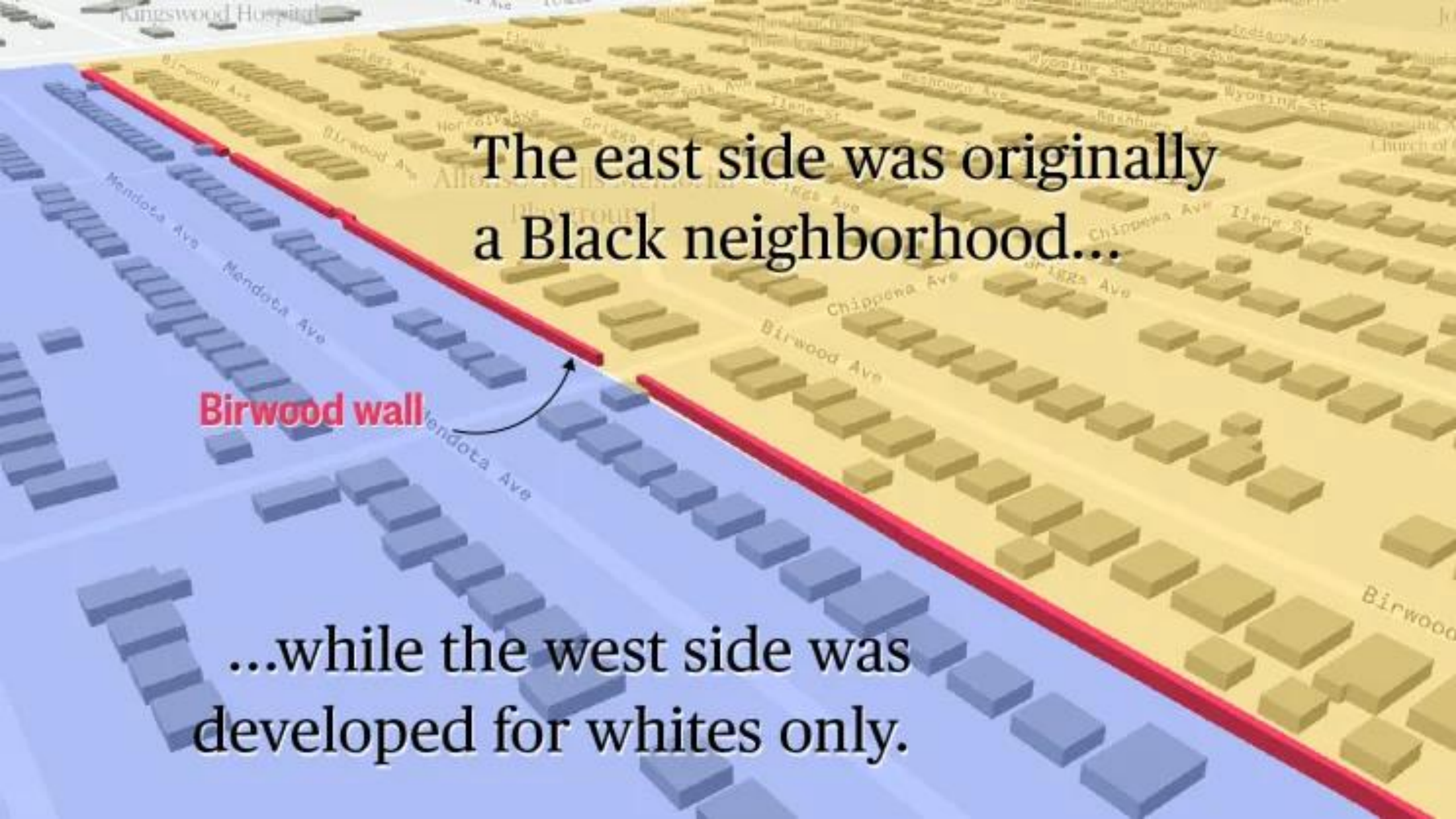
WHITES ADVANCING INTO 'LITTLE AFRICA;' NEGRO DEATH LIST IS ABOUT 15

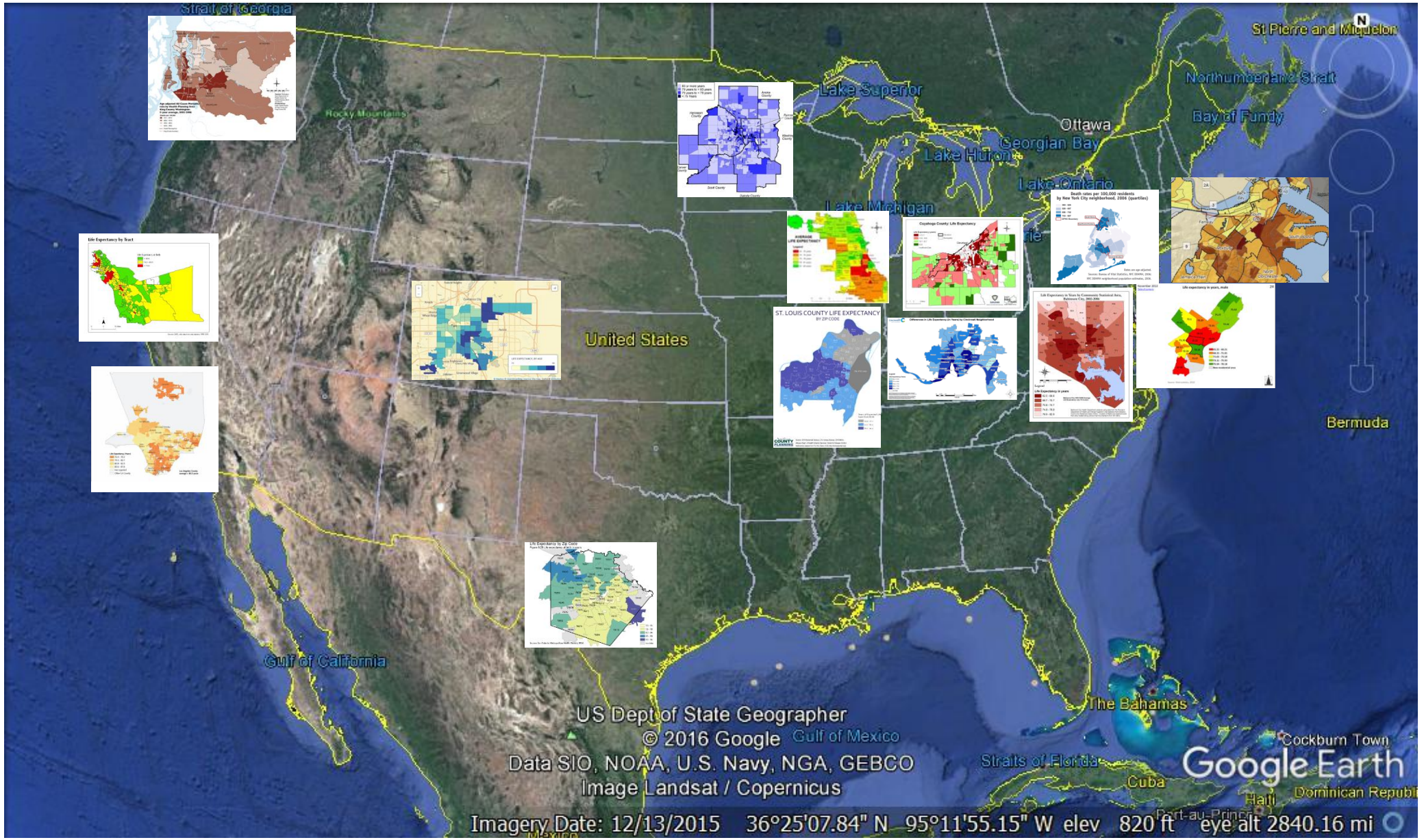
BULLETIN:

At 9:45 armed citizens and one guard corporal marched the prisoners which had been held in Convention hall south through town. It was reported the negroes were to be corralled at the Western league park.

A detachment of state troops from Okla-

· URBAN · IN


The east side was originally a Black neighborhood...
Birwood wall
...while the west side was developed for whites only.


Strait of Georgia
Rocky Mountains
Lake Superior
Ottawa
Georgian Bay
Lake Huron
Lake Ontario
Lake Michigan
St Pierre and Miquelon
Northumberland Strait
Bay of Fundy
United States
Bermuda
Gulf of California
The Bahamas
Cockburn Town
Straits of Florida
Cuba
Haiti
Dominican Republ
Port-au-Prince
Gulf of Mexico
US Dept of State Geographer
© 2016 Google
Data SIO, NOAA, U.S. Navy, NGA, GEBCO
Image Landsat / Copernicus
Google Earth
Imagery Date: 12/13/2015 36°25'07.84" N 95°11'55.15" W elev 820 ft eye alt 2840.16 mi

What Systems, Structures, and Policies Serve to Protect and Enhance Health?

Canadian Social Contract

- Universal health insurance-Canada Health Act
- Universal dental care to age 10
- Universal child care benefit
- Paid sick leave and vacation
- State of the art public transportation
- Highly subsidized post secondary education
- High quality community resources-parks, sports leagues, libraries, community centers


THE
Social
Contract
IN AMERICA

Why the US doesn't have universal child care (anymore)

Other rich countries have family policies the US doesn't.

By Madeline Marshall | Feb 18, 2022, 3:15pm EST

By Krystin Arneson 28th June 2021

The US is the only rich nation offering no national paid parental-leave programme. Why is that – and could it change?

Why doesn't the United States have universal health care? The answer has everything to do with race.

By Jeneen Interlandi

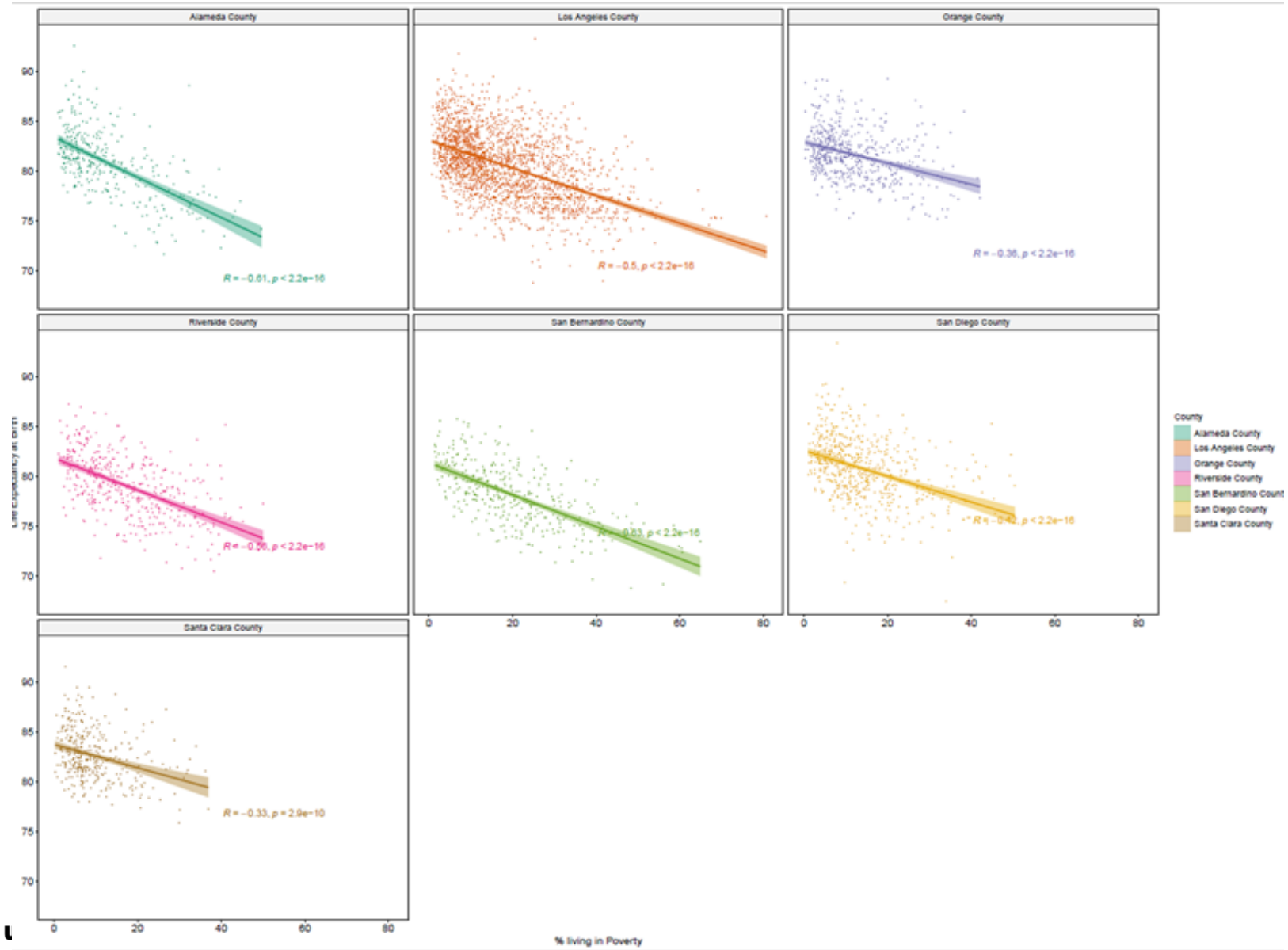
AUG. 14, 2019

Lack of Universal Programs

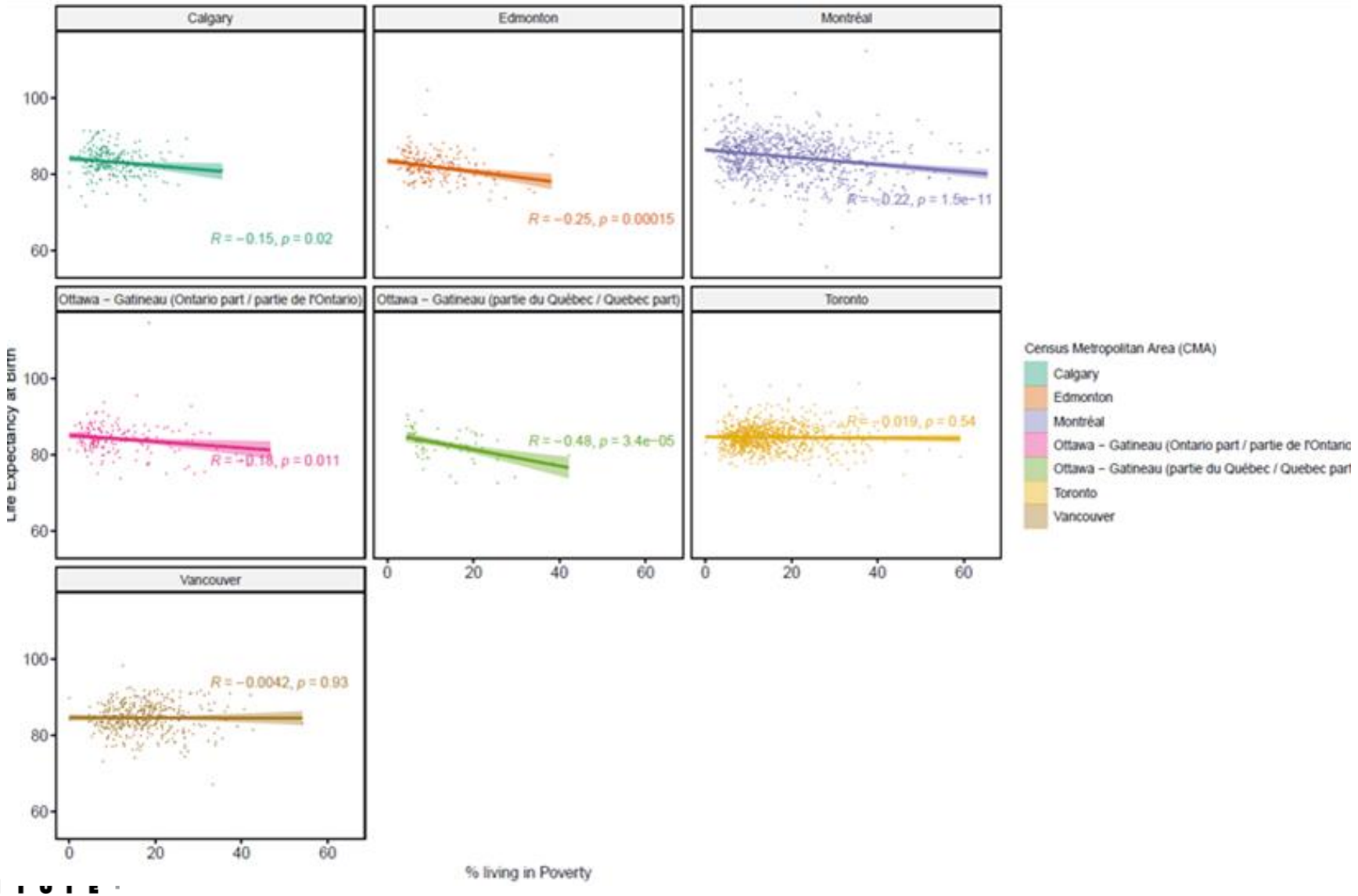
- We stigmatize social benefit and social service programs by means testing and creating onerous and dehumanizing eligibility barriers.
- We subsidize middle class and wealthy people through the tax code.
- We have a thinly veiled racist narrative around “welfare” programs.
- As a result, these programs are characterized by administrative complexity, inefficiency, and costly fragmentation.

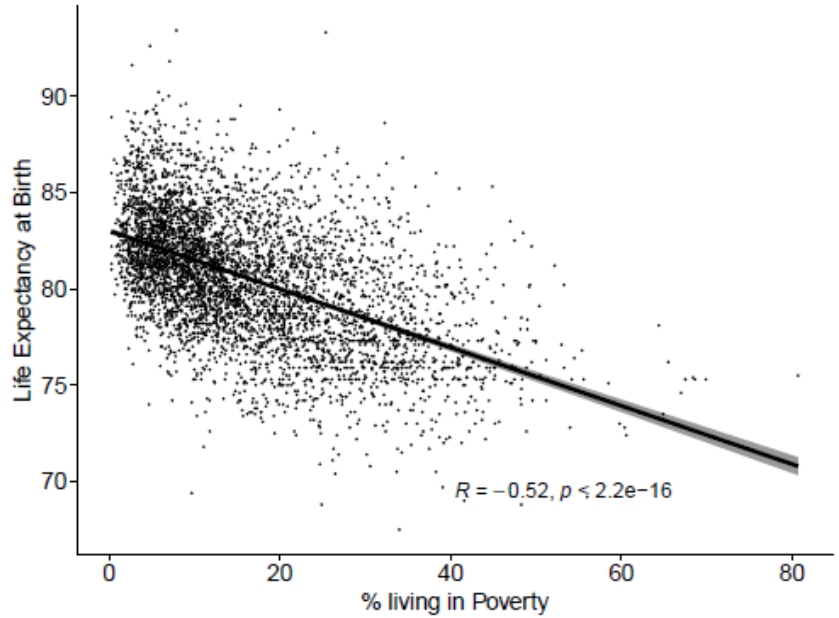
NO SOCIAL SOLIDARITY
=
NO UNIVERSAL POLICIES

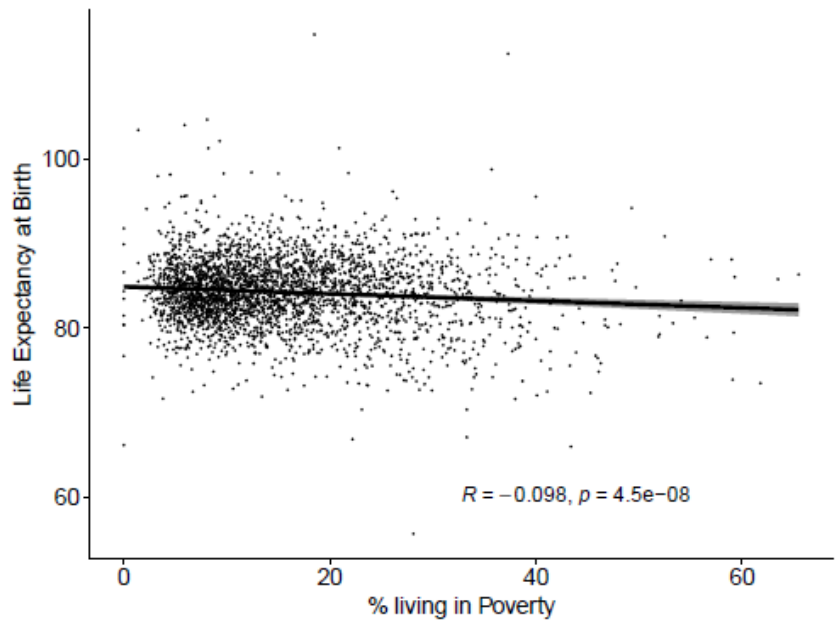
CA Counties

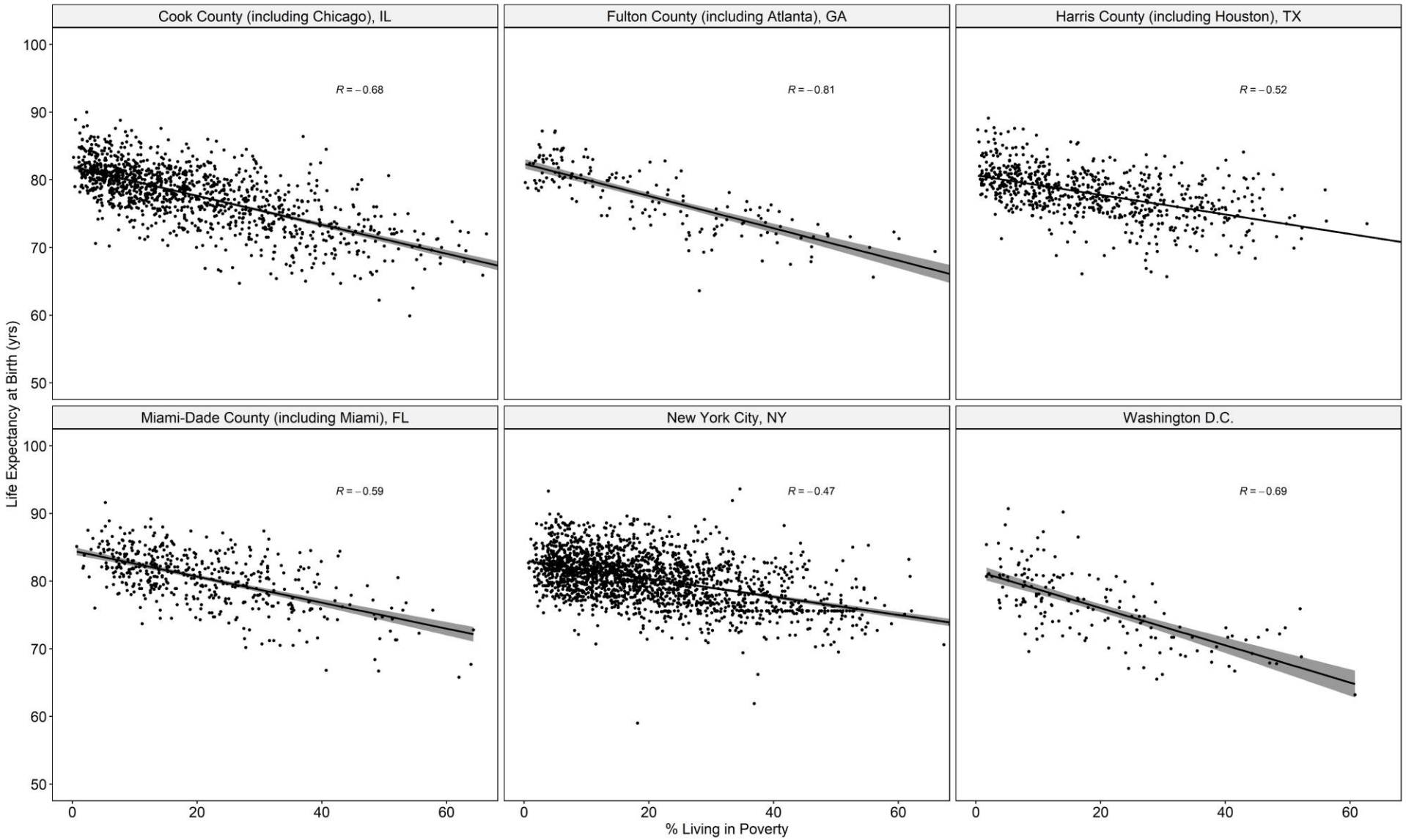

Alameda County
Los Angeles County
Orange County
Riverside County
San Bernardino County
San Diego County
Santa Clara County
R = −0.61, p < 2.2e−16
R = −0.5, p < 2.2e−16
R = −0.36, p < 2.2e−16
R = −0.56, p < 2.2e−16
R = −0.53, p < 2.2e−16
R = −0.42, p < 2.2e−16
R = −0.33, p = 2.9e−10
90
85
80
75
70
0
20
40
60
80
% living in Poverty
County
Alameda County
Los Angeles County
Orange County
Riverside County
San Bernardino County
San Diego County
Santa Clara County

Canadian Metro Areas

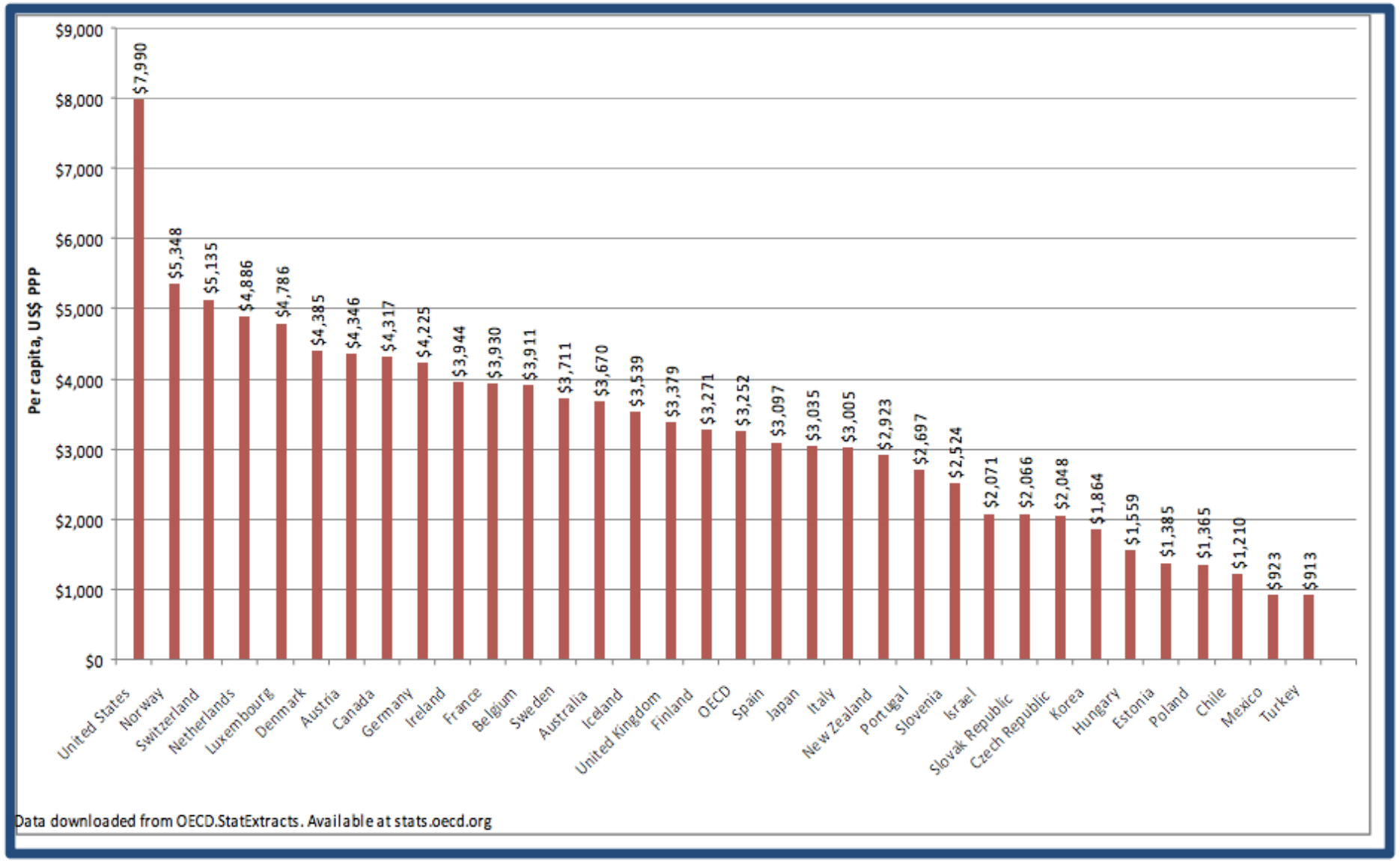



Life Expectancy at Birth
90
85
80
75
70
0
20
40
60
80
% living in Poverty
R = −0.52, p < 2.2e−16

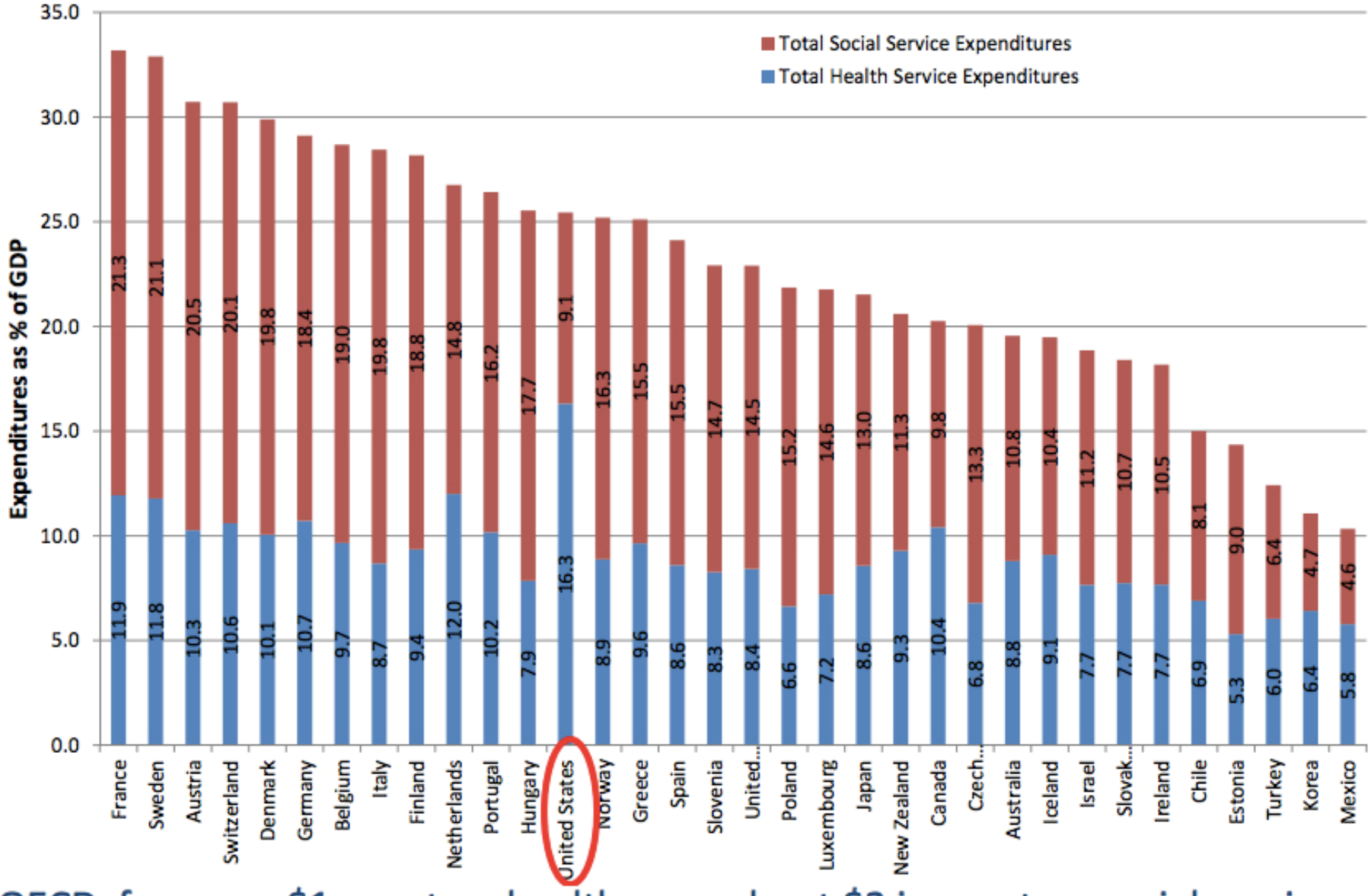

Life Expectancy at Birth
100
80
60
0
20
40
60
% living in Poverty
R = −0.098, p = 4.5e−08


Cook County (including Chicago), IL
Fulton County (including Atlanta), GA
Harris County (including Houston), TX
Miami-Dade County (including Miami), FL
New York City, NY
Washington D.C.
R = −0.68
R = −0.81
R = −0.52
R = −0.59
R = −0.47
R = −0.69
Life Expectancy at Birth (yrs)
% Living in Poverty
100
90
80
70
60
50
0
20
40
60

Spending on health care



Total health care investment in US is *less*



In OECD, for every $1 spent on health care, about $2 is spent on social services

In the US, for $1 spent on health care, about 55 cents is spent on social services


an old problem | Betsy Bradley and Lauren Taylor | TEDxYale
Health ≠ Health Care
TEDxYale

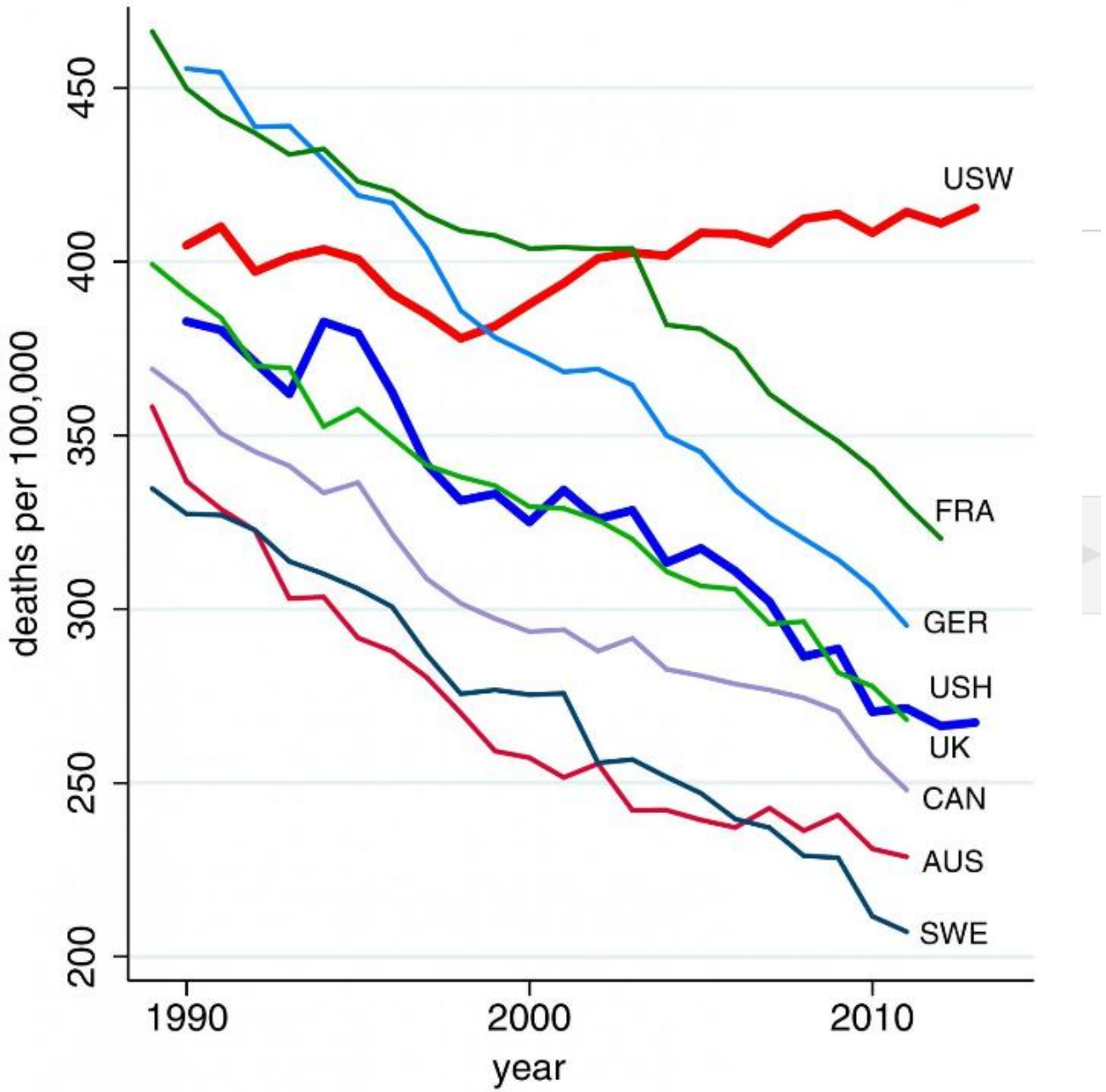
Racism Is A

SECTIONS HOME SEARCH

HEALTH

Death Rates Rising f

By GINA KOLATA NOV. 2, 2015



Death rate for U.S. non-Hispanic whites (USW), U.S. Hispanics and six comparison countries, aged 45-54. (Source: Proceedings of the National Academy of Sciences.)

How Do We Design Healthcare Services That Strengthen the Health Assets of Differing Populations and Cultures?

California Pan-Ethnic
HEALTH NETWORK

Patient Centered Medical Homes

Nuka Model of Care

KKV Returning to Our Roots Program

4. How Should Health Systems Be Governed?

HealthAffairs COVID-19 Topics Journal Forefront Podcasts

By Anthony Iton, Robert K. Ross, and Pritpal S. Tamber

POLICY INSIGHT

Building Community Power To Dismantle Policy-Based Structural Inequity In Population Health

DOI: 10.1377/hlthaff.2022.00540
HEALTH AFFAIRS 41, NO. 12 (2022): –

ABSTRACT **Population health strategies tend to focus on individuals' behaviors, genes, or health care access, yet it is well established that socioecological conditions are fundamental to health and strongly influenced by policy. In the US, health and other policies continue to be shaped by the country's unique legacy of racial and economic segregation. Policy reform must be at the center of population health. This requires communities to have power. We present theoretical and empirical research linking community power and health, and we share an example of our work in which communities organized to hold policy makers accountable for advancing health equity in the distribution of parks. We call this a democratic approach to health improvement and discuss how population health, whether part of public health, philanthropy, or health care, needs to focus on community power and include funding for power-building organizations. We conclude that achieving health equity requires enhancing the quality of democracy.**

Anthony Iton (aiton@calendow.org), California Endowment, Oakland, California; and University of California Berkeley, Berkeley, California.

Robert K. Ross, California Endowment.

Pritpal S. Tamber, Pritpal S. Tamber Consultorio Ltda., São Paulo, Brazil.

Health as a:

DEMOCRATIC

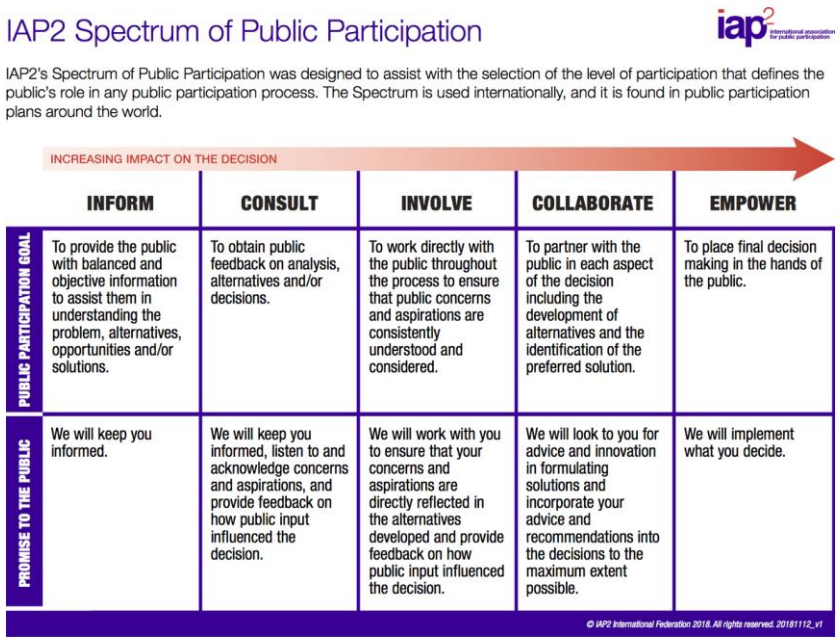
VS

TECHNOCRATIC

Issue

Strengthening democracy will take many strategies, including protecting voting rights and political institutions, repairing racial harms, resisting all forms of oppression, reining in corporate power, and building cooperatives and other community- and worker-controlled economic institutions. But to build people's faith in government and the potential for collective action to meet shared needs and improve real outcomes in people's lives, we also need to go deeper, building modes of participatory democracy from the ground up.

Community Governance



IAP2 Spectrum of Public Participation

IAP2's Spectrum of Public Participation was designed to assist with the selection of the level of participation that defines the public's role in any public participation process. The Spectrum is used internationally, and it is found in public participation plans around the world.

INCREASING IMPACT ON THE DECISION

	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
PUBLIC PARTICIPATION GOAL	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.	To place final decision making in the hands of the public.
PROMISE TO THE PUBLIC	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.

- Move from consultation to shared decision making at provider, plan, and system levels.
- Allow for community design across health system sectors – health care, behavioral health, public health, oral health.

Community Governance Models

- FQHC Model
- Accountable Communities for Health (ACH-CACHI)

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Technology and Healthcare Systems of the Future: Considerations for Equity

- **Sinsi Hernandez-Cancio**, National Partnership for Women and Families
- **Ameina Mosley**, Manager of Community Organizing at Vital CXNs
- **Carolina Reyes**, Associate Physician, Maternal Fetal Medicine, UC Davis Medical Center
- **Anna Zink**, Principal Researcher, Chicago Booth's Center for Applied AI
- **Joseph R. Betancourt**, President, The Commonwealth Fund *(moderator)*

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BREAK

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Political and Legal Determinants of Health and the Current Backlash Against Equity – How Can We Move the Pendulum Forward?

- **Dayna Bowen Matthew**; Dean and Harold H. Greene Professor of Law, The George Washington University Law School
- **Margaret Moss**, Professor and Director, First Nations House of Learning
- **Tom Saenz**, President and General Counsel MALDEF - Mexican American Legal Defense and Educational Fund
- **Juliet Choi**, Asian & Pacific Islander American Health Forum
- **Daniel Dawes**, Senior Vice President, Global Health & Executive Director, Institute of Global Health Equity at Meharry Medical College *(moderator)*

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KEYNOTE

- **Oxiris Barbot**, President and Chief Executive Officer, United Hospital Fund

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IMPORTANCE OF ACCOUNTABILITY

- **Robert Otto Valdez**, Director, Agency for Healthcare Research and Quality

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Vanquishing Unequal Treatment

Robert Otto Valdez, PhD

Director

Agency for Healthcare Research & Quality

Concepts of Race

- “A system for classifying human beings that is grounded in the belief that they embody inherited and fixed biological characteristics that identify them as members of a racial group” - Ann Morning, *Nature of Race: How Scientists Think and Teach about Human Difference (2011)*

- Race remains poorly understood

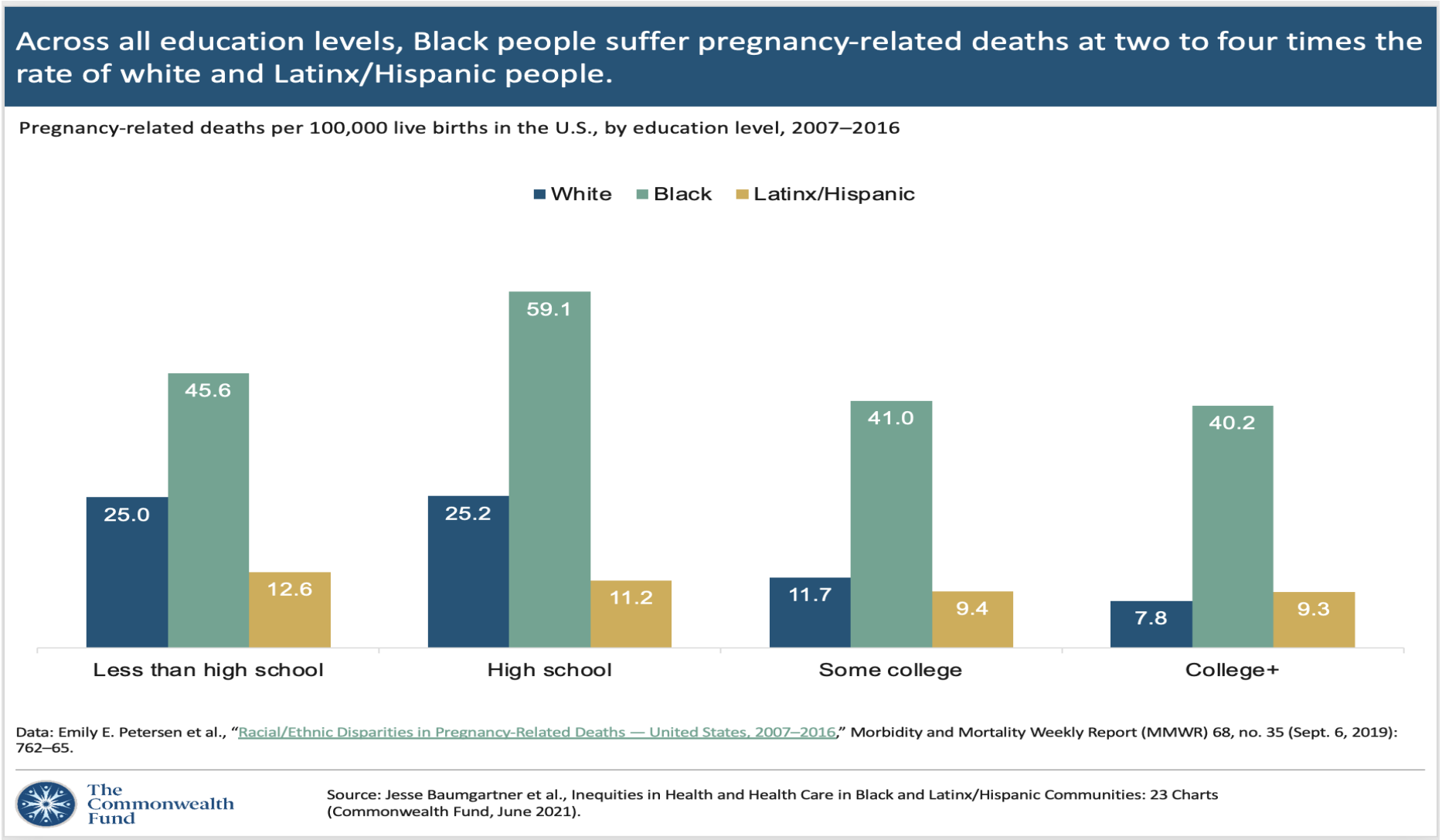
- Racial classification systems are imprecise and bizarre
    - “one-drop rule”
    - broad Census categorizations such as “octoroon” and “Hindu” (regardless of religion)

- Social constructions of race advanced as justification for racism

Concepts of Structural Racism

- No single accepted definition of structural racism
- “A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with “whiteness” and disadvantages associated with “color” to endure and adapt over time,” Aspen Institute
- Vanquishing unequal treatment requires dismantling and transforming policies and institutions that underpin racial hierarchy.

Healthcare Inequities – reflected in maternal deaths across educational levels



Structural Racism in the Healthcare System

- Misdiagnosis, overdiagnosis, and poor treatment and management contribute to unsafe practices and quality inequities

Number and percentage of quality measures for which selected racial or ethnic groups experienced worse, same, or better quality of care compared with White

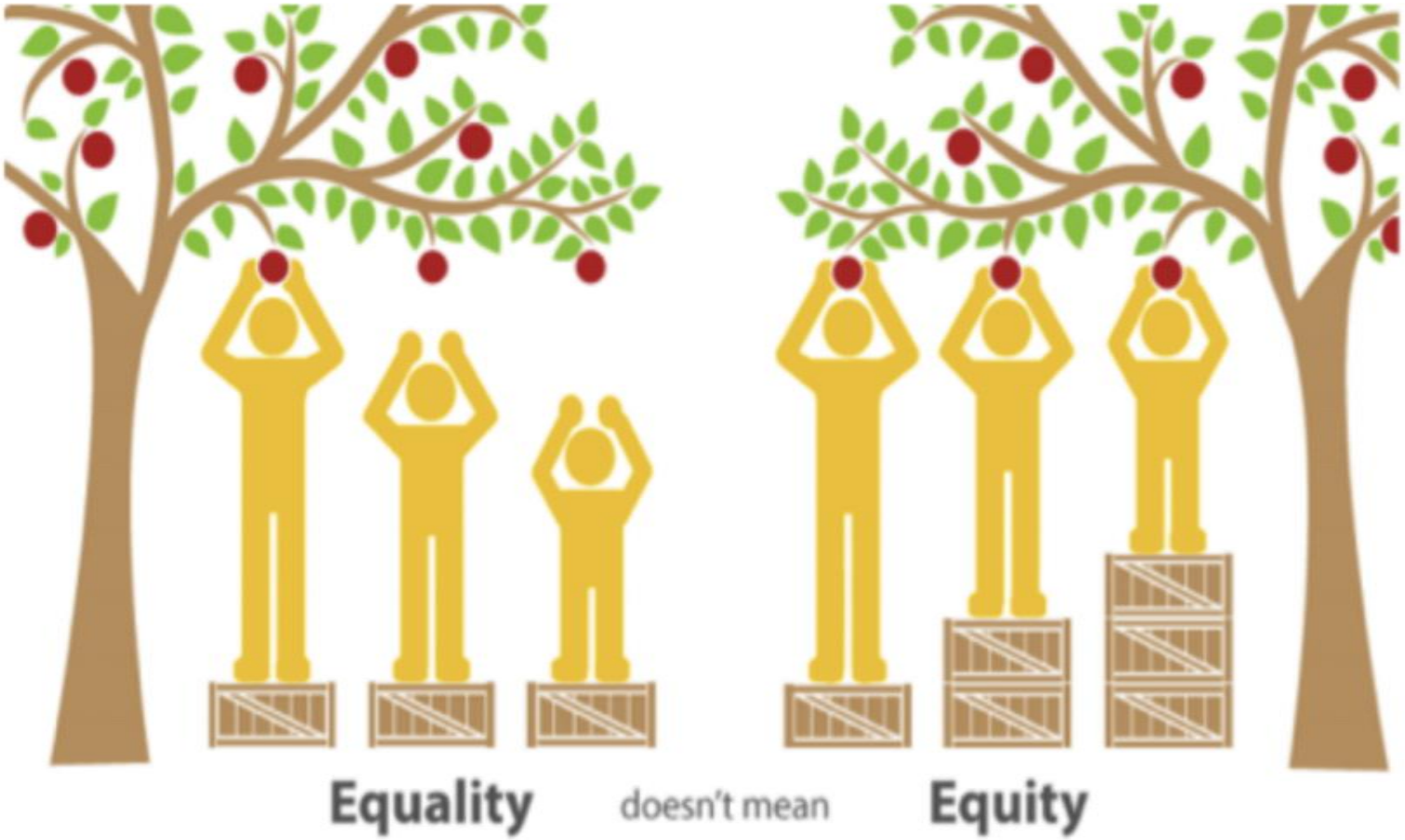
Racial or Ethnic Group	Worse	Same	Better
Black (n=190)	85 (45%)	86 (45%)	19 (10%)
AI/AN (n=110)	47 (43%)	50 (45%)	13 (12%)
Hispanic (n=190)	73 (38%)	84 (44%)	33 (17%)
NH/PI (n=73)	27 (37%)	33 (45%)	13 (18%)
Asian (n=172)	48 (28%)	76 (44%)	48 (28%)

Note: AI/AN = American Indian or Alaska Native; NH/PI = Native Hawaiian/Pacific Islander.

2022 National Healthcare Quality and Disparities Report

Healthcare is not safe, until it is safe for all

Goal: Systems that value equality but also adjust for individual equity needs



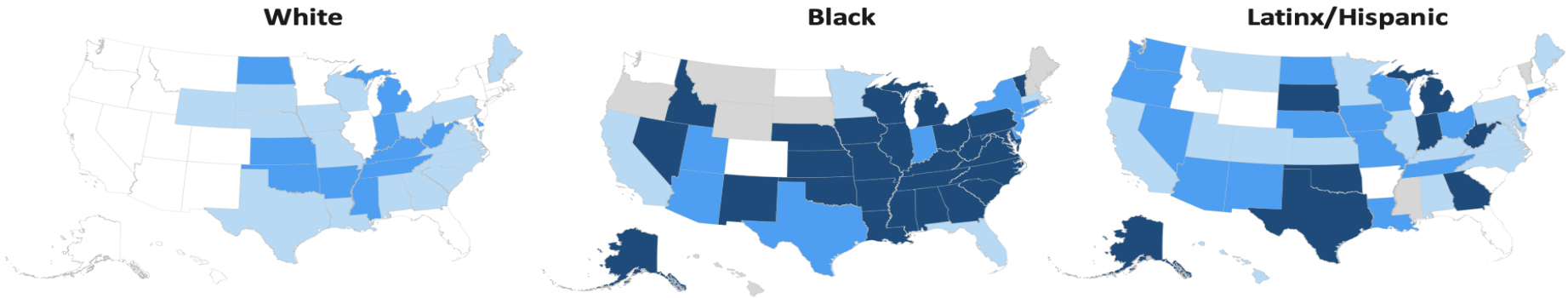
Unequal Treatment at 20

- "Unequal Treatment" did not address the fundamental social and economic inequities (upstream factors) head-on.
- Addressing the upstream policies and inequities could reduce the social needs patients bring to a clinic and allow healthcare treatments an opportunity for maximal effect.
- Address the structural issues that lead to UNEQUAL CARE in our delivery systems
- We need evidence and direction for Interventions addressing BOTH the upstream factors that produce illness, disease, and death AND the inequities in our care delivery.

Health Inequity – reported elevated obesity

All groups report elevated obesity. Black and Latinx/Hispanic adults, whose living environments can be impacted by policies like residential segregation, report higher rates in most states.

Percent of adults ages 18–64 who are obese, by state, 2019



Share of adults with BMI ≥ 30	White	Black	Latinx/Hispanic
9.3%–30.3%	22 states + D.C.	3 states	9 states + D.C.
30.4%–34.8%	17 states	4 states	15 states
35.0%–40.2%	11 states	9 states	16 states
41.0%–77.5%	0 states	27 states + D.C.	8 states
Missing data	0 states	7 states	2 states

Notes: Obesity is measured by adults with BMI ≥ 30. Map groupings are calculated by taking the 25th, 50th, and 75th percentiles across the full distribution of state rates for all three racial/ethnic groups.

Data: Behavioral Risk Factor Surveillance System (BRFSS), 2019.

The Commonwealth Fund

Source: Jesse Baumgartner et al., Inequities in Health and Health Care in Black and Latinx/Hispanic Communities: 23 Charts (Commonwealth Fund, June 2021).

What interventions are needed to create more equitable healthcare systems?

- Creating equitable healthcare organizations requires:
  - Assessing entrenched practices and policies
  - Engaging in internal and external systems changes
  - Acknowledging structural barriers that compromise equity

What strategy should we be pursuing to:

- Eliminate racial bias in clinical support and other algorithms;
- Eliminate fragmentation in care delivery;
- Improve lower-quality services and increase safety in low-resourced communities;
- What interventions work to dismantle the structural racism in our delivery systems?
- How do we use segregated healthcare systems for investing more or better resources in communities with greater health risks?

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CLOSING POEM

"Cabrona con Corazon"
Goat Woman with a Heart,
Ana Castillo

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CLOSING REMARKS

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