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Envisioning a New Health System Rooted in Equity

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Envisioning a health system that places health, wellness, and equity at its core is a radical but necessary exercise to help America achieve its democratic ideals. This exercise requires imagining a society that has dismantled and repaired a legacy of racism and segregation and that prioritizes the health and social needs of its people over the profit-seeking incentives of major health care industry groups—particularly the needs of people who have been made vulnerable by generations of racism and other forms of injustice. In short, it requires envisioning the pathways and political processes that can realize racial and economic justice and equity (see box 1).

Unfortunately, America today is far from this vision. When it comes to health in this country, zip codes matter more than genetic codes (Iton and Ross 2017). Across cities and rural areas, life expectancy varies dramatically, often between neighborhoods separated by very small distances. This inequity can be traced back to America's history of racism, including 400 years of Indigenous American genocide, more than 200 years of the enslavement of African people, and 100 years of Jim Crow–era segregation (King et al. 2022; Ostler 2015; Luxenberg 2020). Racism has permeated American laws, policies, public and private institutions, culture, and dominant narratives. Racial inequity is the fundamental operating system that shapes all other forms of inequity in this country, including inequitable health and health care.

This essay presents the perspective of its authors, informed by what we have each observed, experienced, and studied in the field of public health for decades. Although we draw upon the research literature to enhance some points, this is not a research paper. Rather, it is a personal analysis of what we believe is wrong with the American health system and what it will take to fix it. We offer our thoughts here as a contribution to the increasingly urgent national conversation about equity, justice, and democracy.

BOX 1

Terms Used in This Essay

Health system is defined by the Agency for Healthcare Research and Quality as "an organization that includes at least one hospital and at least one group of physicians that provides comprehensive care (including primary and specialty care) who are connected with each other and with the hospital through common ownership or joint management."[a] The National Academy of Medicine defines it more broadly as "a collaborative, intersectoral effort that involves public and private organizations and individuals," and includes work directed at social and environmental determinants of health, health care services for individuals, and health behaviors and exposures at the population level.[b]

Opportunity conditions are the conditions into which people are born, live, learn, work, play, worship, and age that either nurture and support opportunities for good health or, in many cases, erode and impede health.

Public health is defined by the National Academy of Medicine as "encompass[ing] a diverse group of public and private stakeholders (including the health care delivery system) working in a variety of ways to contribute to the health of society."[c]

Racial equity is a process of moving toward a vision of racial justice. It seeks measurable milestones and outcomes that can be achieved. According to Race Forward, it is "a process of eliminating racial disparities so everyone can have the same outcomes. It is the intentional and continual practice of changing policies, procedures, systems, and structures by prioritizing measurable change in the lives of people of color and other marginalized populations."[d] Racial equity as a process is necessary, but not sufficient, for racial justice.

Racial justice is defined by Race Forward as "a vision of a society where racial hierarchies no longer exist. In this society, all people (Black, Indigenous, Latinx, Asian Americans, Native Hawaiians, Pacific Islanders, and whites) have the dignity, resources, power, and self-determination to fully thrive."[e] Racial justice involves the repair of past harms and accountability for past practices.

Racism is a system of power that structures access to opportunity based on perceived human value assigned to different racial groups, and it causes both acute and chronic health injury as well as community-level health impacts.

Social contract is an implicit agreement among the members of a society to cooperate for social benefits.

Sources:

a. Agency for Healthcare Research and Quality, "Defining Health Systems," September 2016, https://www.ahrq.gov/chsp/defining-health-systems/index.html.

b. Committee on Integrating Primary Care and Public Health, Board on Population Health and Public Health Practice, Institute of Medicine, *Primary Care and Public Health: Exploring Integration to Improve Population Health* (Washington, DC: National Academies Press, 2012), https://www.ncbi.nlm.nih.gov/books/NBK201583/

c. Committee on Integrating Primary Care and Public Health, *Primary Care and Public Health*.

d. Race Forward, "What Is Racial Equity," accessed August 8, 2023, https://www.raceforward.org/resources/what-racial-equity-1.

e. Race Forward, "What Is Racial Equity."

Unequal Treatment at 20

This work is part of a series of publications that commemorates the 20th anniversary of the 2003 Institute of Medicine report, U*nequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. This report found that people of color received lower-quality health care than white patients, even when access-related factors were held constant. Two decades later, we still observe the same inequities, which has motivated thought leaders to imagine how to redesign the health care system so it works equitably.

The new US health system we envision is organized around four assumptions. The first two assumptions explain what the vision is and where it comes from, and the last two explain what it will take to create the new system and what it will look like.

1. **An equitable health system acknowledges and addresses the fact that health is shaped by a constellation of social and environmental factors,** both within and outside the health system. These opportunity conditions—the conditions into which people are born, live, learn, work, play, worship, and age—serve a primary role in building up and tearing down the health of individuals and populations.
2. **A health system and its structures and policies are part of a broader social contract**, and they directly reflect the strength and quality of that contract. Protecting and preserving health in equitable and just ways requires a strong and inclusive social contract.
3. **Achieving an equitable national health system will require renegotiating the country's social contract** so that it centers racial and economic equity and justice and leverages and strengthens opportunities for all racial and cultural populations.
4. **A health system that reflects an equitable and just social contract is grounded in values of agency and belonging** and built on structures that create springboards to good health.

These assumptions raise several interrelated themes that have racial equity and justice at their core:

- **Health is not the same thing as health care.** Health is the result of the constellation of factors and conditions that act on and interact with individuals and environments in ways that affect how people are able to function. Health is not intrinsically the product of health care treatment.
- **A health system should be a public good,** not merely a commercial undertaking. As such, it requires collective investment and attention, and should have a different purpose and accountability standards than systems driven by purely commercial interests.
- **An equitable and just health system must be centered on people**—the recipients of care—and relationships, not on the professionals and institutions that provide care. A health system that is people-centered rather than profit-centered values individual belonging and community-level agency.

- **Health inequity is politically driven and thus will require democratic solutions,** not merely technocratic clinical interventions.
- **In an equitable health system, as with all public goods, local communities must have ultimate control** of resources, decisionmaking, and policies that shape health opportunities.

These themes will repeat throughout this essay as we consider the factors that shape health, the relationship between social contracts and health, and what a new social contract centered on racial equity and a health system based on that social contract might look like.

Factors That Shape Health

Before envisioning a health system that fosters and preserves health, it's important to understand how health is created and how it is—or is not—maintained. Health is created by complex interactions between individuals and their environment that either support or interfere with their ability to satisfy basic needs, navigate their environment, and identify and develop their interests and talents (Eriksson and Lindstrom 2008). The factors that shape these interactions include the presence of opportunity conditions, the role of place in promoting or injuring health, and the impact of racism and segregation.

Presence of Opportunity Conditions

Despite society's fascination with modern, technological medicine, health does not emerge from a doctor's stethoscope or a pharmaceutical wonder drug, nor is it solely the product of individual behaviors and genetics. The genesis of health lies in the conditions into which people are born, live, and experience aging that either nurture and support opportunities for good health or erode and impede health.[1]

In 1986, the Ottawa Charter for Health Promotion identified eight fundamental conditions and resources that determine health, which subsequently became known as the social determinants of health (SDOH): peace, shelter, education, food, income, a stable ecosystem, sustainable resources, and social justice and equity.[2] Healthy People 2030 further classifies SDOH as conditions pertaining to economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[3]

Collectively, SDOH can be thought of as opportunity conditions, and these conditions begin to affect health the moment a child is conceived.[4] Even before birth, a child will be exposed to many environmental factors, including the nutrients and stress hormones circulating in the mother's bloodstream (Geronimus 2023), which have the potential to shape development and influence the child's life trajectory (Weinstock 2005). When children are born, the conditions of their birth, what and how they are fed, the state of their family's housing, and their parent's income and employment, all shape their developmental trajectory (Halfon et al. 2014). As children grow up, the parks, preschools, foods, air and water quality, and health care available to them all interact to shape their chances for achieving and maintaining good health. Together, these opportunity conditions shape health for each

individual, often creating starkly different environments among neighborhoods that are in close proximity to each other.

While some opportunity conditions occur naturally (e.g., a mild climate, arable land, the presence of various infectious disease vectors), others are mediated by policy (e.g., livable wages, housing quality, the presence/absence of universal health care)—that is, they result from political action and/or societal investments in infrastructure and institutions. When it comes to health, policy-mediated conditions can compensate for adverse, naturally occurring conditions; for example, collective investments in sanitation and vector-control infrastructure can protect against infectious disease and epidemics. However, policy-mediated conditions can also exacerbate adverse, naturally occurring conditions, such as by siting hazardous and polluting industries, freeways, mining, oil extraction, and other toxic land uses in proximity to communities of color. As we have seen in the past several decades, collective policy failures can also adversely shape climate and thereby compromise health opportunity, particularly for low income populations and communities of color.[5]

SDOH, on their own, do not fully explain opportunity conditions and their impact on health or health systems. For example, Indigenous and Aboriginal communities worldwide have highlighted the failure of SDOH to address more holistic conceptions of community health (Carroll et al. 2022). Researchers point to the collective psychological trauma experienced by communities across multiple generations because of radical disruptions to traditional relationships and cultural practices, forced family separations, and loss of autonomy caused by settler colonization (Carroll et al. 2022). They decry the exclusively individual framing of SDOH and argue for a broader community framework that recognizes the ecological relationship between individuals and communities.

Some researchers who recognize the enduring structural and institutional barriers that prevent some populations and communities from accessing SDOH have developed a modified framework called political determinants of health (Dawes 2020). By framing social conditions as the product of the imbalances of political power and control over resource allocation, the political determinants of health framework calls more explicitly for political solutions as opposed to purely clinical approaches for creating health equity. In short, political determinants of health recognizes the challenges of health equity as democratic as opposed to technocratic.

Role of Place in Promoting or Injuring Health

The role of place in shaping health dates back to the 14th century and bubonic plague epidemics. The effort to design epidemic-resistant cities recognized the impact of place on the health and well-being of populations (Liu 2021). More recently, in the 1980s, the World Health Organization promulgated a movement for "healthy cities" that spread to more than 3,000 cities in over 50 countries.[6] In 1989, the US Department of Health and Human Services launched the US Healthy Communities initiative that led to the Coalition for Healthier Cities and Communities, which brought together over 1,000 local, state, and national organizations to share resources and best practices for creating healthy communities (Norris and Pittman 2000). Today, the fundamental principle that neighborhoods are capable of promoting or injuring health is widely accepted and understood in medicine, public health,[7] urban

planning (American Planning Association 2017), community development,[8] banking, and economics (World Economic Forum 2021).

The role of a physical place in determining health suggests an antidote to the criticism that America's prevailing approach to health focuses too much on treating diseases (a downstream endeavor that intervenes after an injury has occurred) and not enough on promoting and preserving good health by making places healthier (an upstream endeavor). The public discourse on health generally lacks a shared understanding of public health; it tends to conflate health and health care. This preoccupation with pathogenesis drives expenditures deeper and deeper into downstream health care. Reenvisioning the health system around a salutogenic approach (see box 2) provides an alternative: prioritize upstream investments in communities that protect the health of individuals and families to create resilience to health stressors.

BOX 2

SALUTOGENESIS: FOCUSING ON PROTECTIVE FACTORS

Salutogenesis examines factors that contribute to the promotion and maintenance of health (in contrast to *pathogenesis*, which focuses on how diseases develop). The term was coined by Aaron Antonovsky, an American Israeli sociologist.

Antonovsky, after a career of studying social class, discrimination, poverty and health, and the effects of the Holocaust on survivors' health, turned his attention to healthy resilience despite severe stress, which he recognized as a general precursor to disease. He argued that marginalized communities often feel subjugated by hostile actors and the dominant political power structure, causing them to experience ongoing stress as a direct result of lack of autonomy. Other researchers have expanded Antonovsky's concept of salutogenesis and studied the implications of salutogenic communities.

Sources: See Aaron Antonovsky, "The Structural Sources of Salutogenic Strengths," in *Personality and Stress: Individual Differences in the Stress Process*, ed. Cary L. Cooper and Roy Payne (Oxford: John Wiley & Sons, 1991), 67–104; and Lenneke Vaandrager and Lynne Kennedy, "The Application of Salutogenesis in Communities and Neighborhoods," in *The Handbook of Salutogenesis*, ed. Maurice B. Mittelmark, Shifra Sagy, Monica Eriksson, Georg F. Bauer, Jürgen M. Pelikan, Bengt Lindström, and Geir Arild Espnes (Geneva: Springer, 2017), 159–70, https://www.ncbi.nlm.nih.gov/books/NBK435839/.

Impact of Racism and Segregation

Despite an enduring belief in some quarters that health is solely the product of individual behavior (Gollust 2022; Towe 2021), it is impossible to understand the state of contemporary American health without acknowledging how the country's history of racist politics, institutions, policies, and practices—including segregation—created conditions in communities negatively affect the health of people of color.[9] Historically, the main target of American racism has been African Americans and Native Americans, and its primary weapon has been, and continues to be, segregation. The explicit goal of racial segregation is to physically separate people from opportunity and resources and constrain their chances for success—for example, restricting devalued populations' access to hospitals, ambulances,

and health care as well as schools, churches, housing, railroads, public transportation, parks, beaches, swimming pools, courts and juries, stores, theaters, libraries, hotels, restaurants, social clubs, work sites, the military, funeral homes, cemeteries, telephone booths, water fountains, and public restrooms (Massey and Denton 1998; Rothstein 2017).[10]

Racial segregation in various forms has been ubiquitous in American policy for over 300 years, and its legacy indelibly characterizes the landscape of modern American cities, towns, and rural areas. Native Americans experienced genocide, violent land and resource theft, and cultural erasure, with many banished to barren, inhospitable lands bereft of opportunity and rife with health hazards. Families were forcibly torn apart and children were involuntarily confined to Christian boarding schools, where they were brutally compelled to abandon their families, culture, and language (Ostler 2020).[11] African Americans, following the catastrophes of chattel slavery and Jim Crow, continued to be confined to underresourced neighborhoods by racial zoning, redlining, racially restrictive covenants, and other government-sanctioned policies of neighborhood disinvestment, freeway construction, urban renewal, eminent domain, and occasional violent, forced removal and terrorism.[12] Similar policies and institutional practices played a direct role in creating Chinatowns and Latino barrios. Thus, the very foundation of American urban design is grounded in the notion of physically separating people from opportunity on the basis of race. This legacy has been guarded and fortified by laws, narratives, and the complicit behavior of governing institutions.

Racism, by creating starkly different neighborhood conditions for African Americans, Native Americans, and other people of color versus those who are white, has produced enduring health disadvantages. Arlene Geronimus, public health professor at University of Michigan, coined the term "weathering" to describe the adverse physiological effects of living in marginalized communities that bear the brunt of racial, ethnic, religious, and class discrimination (Geronimus 2023). Before ever encountering a health system, the health of many nonwhite Americans is weathered by the cumulative and synergistic effects of discriminatory policies and their enduring legacy that manifests in adverse opportunity conditions.

Geronimus describes how "weathering afflicts human bodies—all the way down to the cellular level—as they grow, develop, and age in a racist, classist society" (Geronimus 2023). And, in one of the most definitive studies on the issue of public health, Harvard professor David Williams observed that segregation is "a fundamental cause of differences in health status between African Americans and whites because it shapes socioeconomic conditions for blacks not only at the individual and household levels but also at the neighborhood and community levels" (Williams and Collins 2001). Williams points to research by Sampson and Wilson, who studied 1980 census data on the 171 largest cities in the United States and did not find any cities where African Americans lived in equality with whites in terms of poverty rates or the proportion of single-parent households (Sampson and Wilson 1995). "The worst urban context in which whites reside is considerably better than the average context of black communities," Williams concludes. (More recent evidence supports this.[13]) Williams further notes that, although most immigrant groups have experienced some residential segregation in the United States, the segregation of African Americans is distinctive in that it was rigidly reinforced by law, policy,

practice, and narrative; it was even justified by Christian churches and other cultural institutions (Williams and Collins 2001).

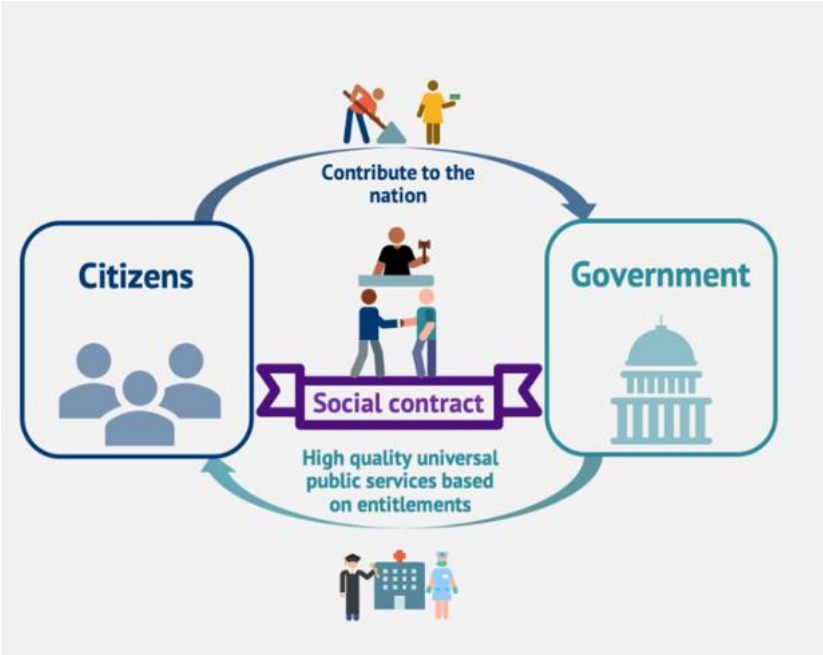
The conditions in which people live, the places where they live, and the racism that affects how they live are all related to the social contract that people hold with those who govern them. The social contract, therefore, is the first place to start when reenvisioning health.

The Relationship between Social Contracts and Health

The idea of a social contract is integral to the core principles of America's identity and its government, laws, institutions, systems, structures, and policies (see figure 1; Hulliung 2007). The social contract concept dates back to the Enlightenment philosophers Thomas Hobbes, John Locke, Jean-Jacques Rousseau, and Cesare Beccaria, who viewed it as a reciprocal agreement among members of a society to comply with the rules, laws, and institutions of their government in exchange for certain protections and assurances of well-being (Boucher 1994). The Haudenosaunee and other Native Americans also influenced these philosophers and the American concept of democracy.[14] Although the thinkers differed on the degree to which individuals must surrender their rights and interests for the greater good, they concurred that the social benefits of living in a civil society that ensures its citizens' rights and well-being outweigh the costs of sacrificing some individual freedom (Dienstag 1996; Kanzler 2020; Kidd 2020).

FIGURE 1

The Basic Elements of the Social Contract



Source: Development Pathways. From Development Pathways, *The Social Contract and the Role of Universal Social Security in Building Trust in Government*, (working paper, Uppsala, Sweden: Act Church of Sweden, November 2020), 1, https://www.developmentpathways.co.uk/publications/the-social-contract-and-the-role-of-universal-social-security-in-building-trust-in-government/. Reprinted with permission.

The expectations embedded in social contracts—implicit and explicit—have taken different shapes in America and other countries, so we begin with an overview of social contracts before looking into their relationships with health systems.

American Social Contract

Thomas Jefferson borrowed heavily from the Enlightenment philosophers of the 17th and 18th centuries when he and other Founding Fathers drafted the Declaration of Independence to explicitly encompass a social contract (Tate 1965; Pestritto and West 2003). The Declaration asserts that the central purpose of government is to protect the inalienable right to "Life, Liberty and the pursuit of Happiness" (words whose meaning likely had profound public policy implications for the fledgling government).[15] It describes a new government organized to affect the "safety and happiness" of the people, suggesting an affirmative role for the government in protecting and promoting those outcomes. It then states that it is the king of Great Britain's violation of the social contract that compels the colonies to reorganize into independent, self-governing states.[16]

Although the Declaration of Independence embraced the idea of a social contract, American social policy was woefully outmatched when confronted with historical challenges. The first challenge was the institution of slavery, which excluded a significant number of Americans from the contract's implicit and

explicit promise. And the abolition of slavery did not end the challenges—or the evolution of America's social contract. In the 20th century, the stock market crash of 1929 and the resulting Great Depression pushed the country into a profound economic and social crisis. Franklin Delano Roosevelt was elected president in 1932 on the promise of a "new deal" for all Americans that would provide them with employment and economic security,[17] which he later described as lasting from "the cradle to the grave."[18] In crafting the New Deal, Roosevelt set out to rewrite the nation's social contract: he created an enduring precedent of confronting major domestic problems with government action rather than leaving them to be adjudicated by the marketplace (Alter 2006).

To pass a major New Deal legislation, Roosevelt needed the support of the Southern Democrats, who were determined to maintain the racist social, political, and economic hierarchy in the South (Pera 2011; Linder 1987; Dixon 2021; Biles 1994; Katznelson 2013). Therefore, Roosevelt repeatedly backed away from civil rights efforts to avoid antagonizing southern whites. He abandoned antilynching legislation and bills to abolish the poll tax, a discriminatory fee imposed to prevent African Americans from voting (Katznelson 2013). Consequently, most New Deal programs reflected a social contract that discriminated against African Americans and other people of color. The National Recovery Act offered whites the first chance to apply for jobs and authorized separate and lower pay scales for African Americans.[19] The Federal Housing Authority and the Home Owners' Loan Corporation refused to guarantee mortgages or underwrite property insurance for African Americans and originated the practice of redlining (Rothstein 2017).[20] The Social Security Act excluded agricultural and domestic workers, which the NAACP argued would disproportionately exclude African American workers—65 percent of African Americans were ineligible, with an even higher proportion in the South.[21]

Of note, Roosevelt's New Deal programs steered clear of universal health insurance to avoid being stigmatized as socialized medicine (Lubove 1963). Harry Truman, Roosevelt's successor, set out to correct that oversight but failed to deliver on his vision of a "total health program."[22]

World War II shook America out of the trauma of the Depression and facilitated the country's transformation into an industrial workforce and, ultimately, the strongest economy in the world (Dunbar-Ortiz 2021).[23] Buoyed by a sense of invincibility as the world's savior (Garson and Kegley 1990),[24] the United States doubled down on many of the policies and practices that reinforced housing segregation, including redlining, racially restrictive covenants governing who could live where; discrimination in implementing the GI Bill; and expansion of the interstate highway system, which facilitated white flight to the suburbs (Rothstein 2017, 9; Pietila 2010).

Efforts to repair the nation's social contract continued through the 1940s, 1950s, and 1960s, when the predominantly African American–led civil rights movement sought to advance a comprehensive agenda that would fix the New Deal's intentional oversights. Organizing and advocacy by civil rights activists pushed President Lyndon Johnson to carry out his Great Society agenda, which led to nearly 200 new laws designed to address inequity, including Medicare, Medicaid, and various programs to support low-income families, improve infant nutrition, alleviate hunger, enhance early childhood education, facilitate housing affordability, and improve academic supports. However, many of the

programs were means-tested and administered by the states, which still enforced racially discriminatory administrative practices, especially in the south.[25]

Social Contracts of Other Countries

Western European countries, Canada, Australia, and New Zealand also developed approaches to governance that reflect social contracts. As in the United States, these countries' social contracts are built on both philosophical ideals and practical experiences (Grossi and Rayner 2020; Mendelsohn 2002; Welfare Expert Advisory Group 2019).[26] In the late 18th century, the French Revolution was influenced by the American Revolution and the Declaration of Independence (Mackey 1976), just as Jefferson had been inspired by the ideas of Rousseau and other French philosophers. After World War II, the devastation of European cities and its consequent deep human suffering and death were so profound that a growing number of influential thinkers no longer saw charitable support for the poor, which was then the dominant paradigm in European social policy, as sufficient (Obinger, Schmitt, and Seelkopf 2022; Garland 2016).

In 1942, the economist William Beveridge published *Social Insurance and Allied Services*, a report that ultimately provided the blueprint for social policy in postwar Britain (Beveridge 1942; Boyer 2018).[27] Beveridge had worked for a charitable organization in East London, where he saw firsthand that the charity model of addressing social needs could not overcome entrenched poverty and social inequality. He determined that a concerted and coherent government policy effort was necessary to fulfill the social contract. He stated in his report that all children, whether born in or out of wedlock, should enjoy the same social protections, and he called for a cradle-to-grave social program that included free national health service, among other social welfare policies and programs. His plan was popular with the public, and it was readily adopted by Britain's postwar Labor government (Welfare Expert Advisory Group 2019).

Across postwar Europe, countries signed on to the Universal Declaration of Human Rights, which embraced social security and protection against unemployment, sickness, disability, widowhood, old age, and other lack of livelihood in circumstances beyond the control of individuals.[28] Social support was reframed as a form of universal public service. Governments established universal social security, old-age pensions, and child benefits. As they built trust among their citizens, European governments were able to raise levels of taxation to support these new universal benefit policies (Kidd et al. 2020).

Canada, Australia, and New Zealand took similar paths, and today these Western, developed countries continue to have strong, politically resilient social contracts that include universal policies for health care, paid sick and parental leave, child care, unemployment, and other key supports (Welfare Expert Advisory Group 2019; Mendelsohn 2002).[29] Indeed, often the strength of a social contract can be gauged by looking for the word "universal," which is prevalent in the policies of these countries. Moreover, the political will to maintain these universal policies has largely persisted over the ensuing decades.

It is perhaps not coincidental that the countries with the most robust social contracts consistently rank high in the *World Happiness Report*, produced annually by the Sustainable Development Solutions

Network (Helliwell et al. 2023). The rankings reflect people's assessments of the social supports, freedom, healthy life expectancy, and other happiness variables in their countries. Interestingly, many of the happiest countries reported (e.g., Finland, Denmark, Sweden, Norway) are places where people pay the highest taxes—perhaps because those taxes pay for the implementation of strong social contracts. Meanwhile, the United States, despite enshrining the concept of happiness in its founding documents, is not among the happiest countries in the world; it is not even in the top 10 in the report. Why does American social policy not lead to greater happiness? Why does it allow people to fall further and faster when global shocks occur? As we outline in the next sections, we find that the answer is America's weak social contract. And this is not accidental; it is the intentional by-product of American racism.

Causes of a Weak Social Contract

Social contracts are intentionally constructed. They reflect the prevailing political will, which is a reflection of a country's national culture or identity. Consider, for example, the phenomenon that economists Anne Case and Angus Deaton termed "deaths of despair" (Case and Deaton 2020). They demonstrate that between 1990 and 2010, despite consistent declines in mortality rates for many other populations in the United States, mortality rates among white, rural, less-educated Americans actually rose because of suicide, alcohol-related organ disease, and opiate overdoses. Case and Deaton postulate that many of these deaths were driven by despair over being unable to compete in a manufacturing economy decimated by globalization, technology, and profound economic shifts. During the same period of time, other rich countries in Europe and elsewhere faced similar globalization and technology pressures without experiencing long-term wage stagnation or deaths of despair, presumably due to more responsive social policy. Decades earlier, when African Americans experienced a similar opiate-related health and social crisis, federal policy did not respond by strengthening the social contract. Instead, it adopted a punitive tone with the war on drugs, mass incarceration, and welfare reform (Sheely 2021; Pierson-Balik 2003).[30] We can attribute this to a national culture driven by racism instead of unified around the common good.

A sense of solidarity among groups is essential to establish and maintain political will for universal social policies. Policy advocate Heather McGhee makes this point in her book *The Sum of Us*, when she talks about the "solidarity dividend" that occurs when groups come together across a racial divide to address shared concerns, as happened in the successful "Fight for $15" minimum wage campaign that began in the United States in 2012 (McGhee 2021). Too often, however, racism that permeates mainstream American culture divides this ostensibly *united* country, diminishing its ability to come together on behalf of a social contract that protects and nurtures everyone (Alesina, Glaeser, and Sacerdote 2001).[31] Racism has become the common denominator for the most intractable social problems; as McGhee writes, "We suffer because our society was raised deficient in social solidarity" (McGhee 2021).

A second important cause of America's weak social contract is this country's hyper-individualistic national identity. Robin DiAngelo, author of *White Fragility*, describes the "discourse of individualism" as:

> A specific set of ideas, words, symbols, and metaphors—a storyline or narrative—that creates, communicates, reproduces, and reinforces the concept that each of us are unique individuals and that our group memberships, such as our race, class, or gender, are not important or relevant to our opportunities (DiAngelo 2010).

Hyper-individualism masks the structural racism that weakens the social contract by arguing that every individual has equal opportunity and can achieve success merely through hard work.

Health Consequences of a Weak Social Contract

The health consequences of a weak social contract play out in health policies that affect practices and expenditures in life-altering ways. Countries with a strong social contract spend disproportionately more on social benefits and services than on medical care, and consequently people enjoy better health (Bradley and Taylor 2013). The upstream spending on social benefits is an investment that prevents downstream medical care expenditures.

Elizabeth Bradley and Lauren Taylor illustrate the benefit of a strong social contract—and the costs of a weak one—in their book, *The American Healthcare Paradox*. They demonstrate that countries that invest $2 in social services and benefits for every $1 in medical care have the best health. They show that, among Western countries, the United States falls squarely in the middle of the pack when combining per-person health care spending with per-person social benefits spending. However, its ratio of medical care to social benefits spending is dramatically skewed toward medical care: for every $1 spent on medical care, only about 55 cents is spent on social benefits. It is not that the United States spends more on health and social services than other developed countries; it is that it disproportionately overspends downstream in the medical care system and underspends upstream where the greatest opportunities for prevention lie (Bradley and Taylor 2013).

The health consequences of a weak social contract can be seen in who pays the greatest costs. Harmful consequences fall disproportionately on populations that have been made vulnerable by racism and other forms of discrimination. During the entire period that Case and Deaton analyzed in coining the term "deaths of despair" among whites, African American and Native American death rates exceeded white death rates—a sobering reminder that when white America catches a cold, African Americans and Native Americans get pneumonia.[32] A decade later, the brutally disproportionate COVID-19 death rates among African Americans, Native Americans, Latinos, and Pacific Islanders further hammered this reality home (Masters, Aron, and Wolf. 2022).

Nonetheless, everyone pays significant costs for having a weak social contract. In particular, the failure to adopt important health-protective policies and apply them universally leads to millions of lives being disrupted by predictable and preventable crises. This was evident during the COVID-19 pandemic in the United States, the only high-income country in the world that does not offer or mandate universal paid sick leave (Rho et al. 2020), even though it is known to improve use of preventive care and to reduce emergency room visits, the spread of disease during epidemics, and absenteeism from work (Smalligan and Boyens 2020). Paid sick leave also disproportionately helps low-income essential workers and workers of color, who are the ones most likely to get sick, transmit disease to their families,

and die from the disease.[33] The absence of this fundamental component in America's social contract, along with the lack of universal child care and universal health care, likely contributed to the country having the highest COVID-19 death rate among developed countries.[34]

Health crises are not the only time Americans face the harmful consequences of a weak social contract. The costs play out every day, leading to a cumulative effect on life expectancy. Consider the results of a forthcoming study, sponsored by the California Endowment, that compared differences in life expectancy at the neighborhood level among the largest US metropolitan areas and the largest Canadian metropolitan areas.[35] For each US metropolitan area, life expectancy was calculated at the census tract level and a bivariate correlation between life expectancy and neighborhood poverty was depicted. Researchers conducted similar analysis of the Canadian metropolitan areas and compared the results. They found that that in the American metropolitan areas, people living in poor neighborhoods die much younger than those living in high-income neighborhoods, with a steep slope between life expectancy in high- and low-income neighborhoods. In the Canadian metropolitan areas, however, the slope was much flatter and, in some cases, nonexistent. The study's findings suggest that Canada's stronger social contract provides even residents in a low-income neighborhood reliable access to health care, well-resourced parks and civic infrastructure, quality child care, preschool, and secondary and post-secondary education, and affordable housing—all of which results in relatively longer lives. The social cost of living in a poor neighborhood in the US is much greater than in Canada and can be measured by a greater likelihood of premature death. We refer to this cost as a death tax.

The consequences of having a weak or discriminatory social contract can be severely damaging to people's health. It is logical, therefore, that reenvisioning the US health system must start with efforts to reweave the country's social contract.

Reweaving a Social Contract

Partners for Dignity & Rights (formerly the National Economic and Social Rights Initiative) argues that a new social contract—one that that commits to the full range of human rights for all people, including economic and social rights—is both morally necessary and essential for the future of US democracy.[36] Because all people are interdependent, and the essential requirements of life—water, food, education, housing, health care, work, income, transportation, and a clean environment—can best be met through collective efforts, Partners for Dignity & Rights calls for fundamentally reshaping political institutions in ways that rein in the power of private wealth, decentralize bureaucracies, reorient institutions around shared values, and restore community control over the decisions that are most important to people's lives.

Before renegotiating the social contract, however, we have to acknowledge the deep fracture that runs through American society, which arguably has been present since the nation's birth. This cleavage, which Condoleezza Rice referred to as America's birth defect,[37] is built around the social construct of race. Racism animates every major aspect of this country's social policy debates, including criminal justice, welfare, housing, voting, education, employment, and health care (Bailey, Feldman, and Bassett 2021; Braveman et al. 2022; Brown 2019). It also drives public perception of government programs and

government in general (Cramer 2020). Racism stands in the way of social solidarity and contributes to the roiling disagreements about America's core identity and who belongs in this country. Overcoming this burden will require explicit racial reconciliation and the creation of a new narrative of inclusion and belonging. In short, America needs to reenvision and reweave its identity in the 21st century.

American Identity of Inclusion and Belonging

To strengthen its social contract, America must create a forward-looking 21st century narrative about its identity (i.e., who is an American and what it means to be one) and the role of government in supporting and protecting that identity. This new narrative must foster a strengthened sense of belonging and build a deeper sense of shared solidarity across various groups of Americans, particularly racial groups (see box 3). *Belonging* is the security and support people feel when their identity and culture are accepted and included by others in their community or group.[38] It is a fundamental human need that is hardwired into our genes—in Maslow's Hierarchy of Needs, it sits above physiological and safety needs (Maslow 1943). Exclusion and social isolation operate through the same physiological mechanisms that produce physical pain (MacDonald and Leary 2005). In many ways, racism can be seen as the opposite of belonging, because it seeks to exclude, marginalize, and ultimately dehumanize. In the same vein, belonging can be seen as an antidote to racism.

Belonging can be fostered by reflecting the diverse stories and full humanity of the cultures and populations that comprise a community. Creating belonging requires telling a broader story of "we" instead of the incessant story of white supremacy that seeks to erase and dehumanize other cultural stories and experiences.[39] A national identity that is inclusive, in which everyone belongs, must have a health system that is committed to serving everyone and to embracing the unique cultural needs and life experiences of those who have been harmed by the legacy of American racism. This leads, inevitably, back to the concept of universal health care.

BOX 3

THE CALIFORNIA ENDOWMENT'S FOCUS ON BELONGING

In 2010, The California Endowment embarked on a decade-long initiative, Building Healthy Communities, which was designed to tackle the root causes of health disparities across 14 low-income California communities.

After investing over $1 billion and celebrating more than 1,200 health-protective policy wins and systems changes, the foundation concluded that the core ingredients needed to create health equity can be summarized as ABC: agency, belonging, and a strengthened social contract.

As we suggest in this essay, those same ingredients are central to the design and governance of a health system that is organized around health equity.

Source: Anthony Iton, Robert K. Ross, and Pritpal S. Tamber, 2022, "Building Community Power to Dismantle Policy-Based Structural Inequity in Population Health," *Health Affairs* 41 (12): 1763–71.

Universal Health Care as a Battlefront for US Identity

Universal health care is a central battlefront on which the issue of US identity has been waged.[40] In a study comparing health systems of 11 high-income countries, the United States was the only country without universal health care, and it ranked last on all measures but one, including access to care, health care outcomes, and equity (Schneider et al. 2021).

Other wealthy countries have taken various policy approaches to ensure universal coverage for health care services, including direct provision of health care by the government or combinations of health insurance mandates and subsidies.[41] In Canada, 90 percent of Canadians support universal health care[42] and see it as a source of collective pride.[43] They view the universality of their health care as a reflection of national identity and belonging[44] and feel a strong sense of shared solidarity in this identity (Schimmele et al. 2022).

In the United States, despite majority support for universal health care, a sizable minority feels that it should not be government's role to provide it.[45] How can America shift its national identity closer to Canada's on this topic? One solution is for the nation to follow the lead of states like California, where leaders have built solidarity and political will for universal health care through a new narrative of inclusion.

In 1994, almost 60 percent of California voters voted for Proposition 187,[46] an initiative restricting undocumented Californians' access to basic services such as education and health care. In 2019, 25 years later, voters made an about-face, voting to allow undocumented Californians to obtain driver's licenses, in-state tuition, college scholarships, medical licenses, membership in the California Bar, and (more recently) access to full-scope Medicaid (Ramos-Yamamoto and Saucedo 2023).

What changed? Sociologist Manuel Pastor, in his book *State of Resistance*, illustrates how California began to reweave its social contract by strengthening a narrative of belonging and redefining an inclusive identity (Pastor 2018). California's identity—Who is Californian?—was remade by the very people who had been targeted and marginalized by Proposition 187. Many current political leaders mark Proposition 187 as the galvanizing force that brought them into politics, and many proponents of this new narrative are people whose life experiences humanize the plight of undocumented people. Together, they helped tell a new story in which California's success hinged on the well-being of its immigrants. As Pastor notes, California foreshadowed the fractious national politics around immigration and moved through the divisiveness to create a new politics, and a new identity, of inclusion and belonging.

Envisioning a Health System Based on an Equitable Social Contract

What would a US health system based on a racially equitable social contract look like? How would care be designed if the system recognized that the genesis of health is in the surrounding environmental, social, and political conditions? What role would caregiving play in a system that ensures healthy places, policies, and systems for everyone? How would the system reflect and incorporate the essential ingredients of the strong social contract outlined in previous sections—racial reconciliation, an inclusive

national identity, a sense that everyone belongs and deserves health care? How would it operate? How would it be governed?

A health system designed in response to these questions would look very different from the current system. It would embody the values of belonging and equity. These values would lead the system to take a people-centered approach and to emphasize cultural coherence and healing as well as community-level agency. Such a system would be built on opportunity structures that create springboards for children and families to achieve good health, including investments in public health and preventive strategies, community-oriented primary care, and integrated health and social services.

Many successful programs offer examples of how such a system would operate, and we explore them in this section. First, however, we need to revisit what a health system is.

Definitions and Framework for Understanding Health Systems

Different organizations define "health system" in different ways. As stated in box 1, the Agency for Healthcare Research and Quality defines it as "an organization that includes at least one hospital and at least one group of physicians that provides comprehensive care (including primary and specialty care) who are connected with each other and with the hospital through common ownership or joint management."[47] Other organizations, such as RAND, the National Bureau of Economic Research, and Dartmouth Institute for Health Policy and Clinical Practice, have similarly hospital-centric definitions.[48]

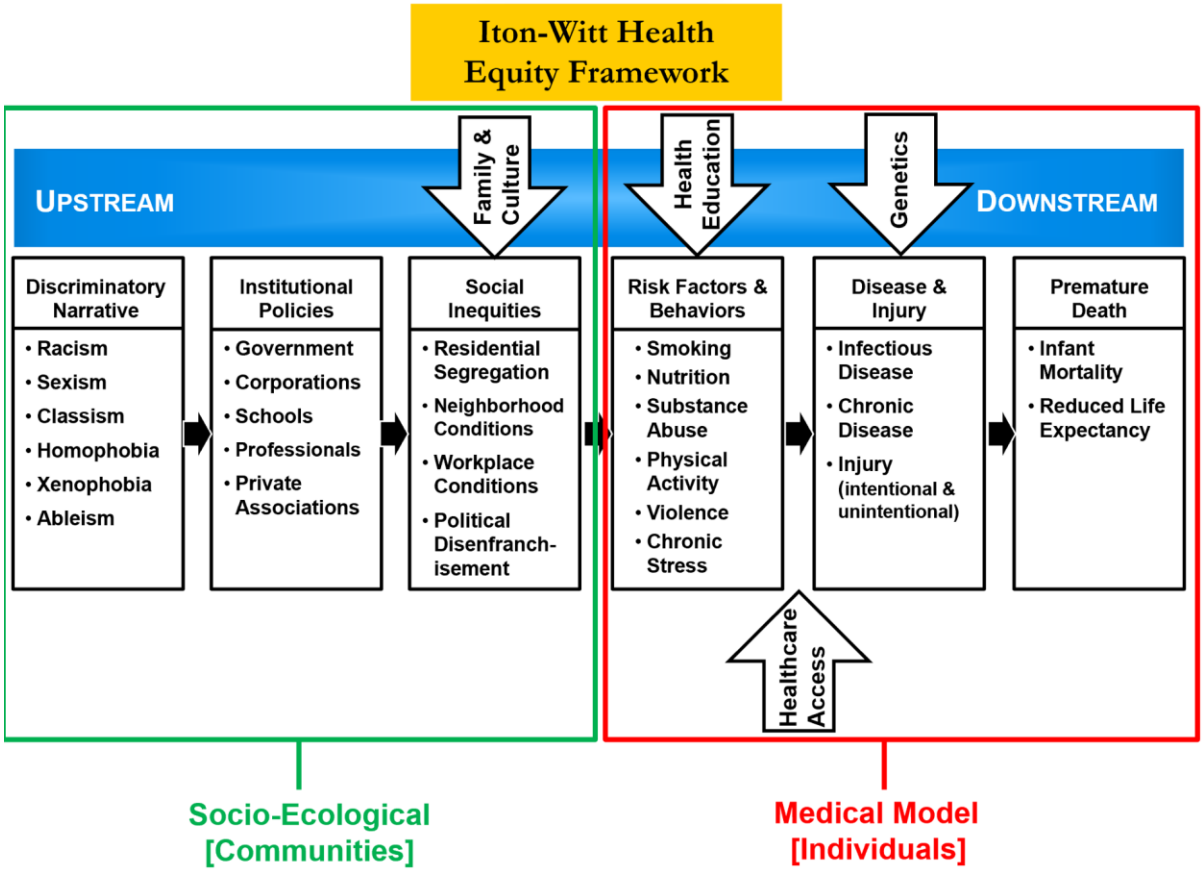
These definitions matter because they encompass expectations for how a more equitable social contract will achieve its health-related promises. A more inclusive national identity requires a broad definition of a health system. In 2012, in an effort to address the seemingly intractable failure of the US health care system to improve population health, the Health Resources and Services Administration and the Centers for Disease Control and Prevention asked the National Academy of Medicine (formerly the Institute of Medicine) to convene a committee to examine opportunities to integrate primary care and public health. Noting that health is influenced by many different factors, the committee stated that "improving the health of populations … will require a collaborative, intersectoral effort that involves public and private organizations and individuals" and includes work directed at social and environmental determinants of health, health care services for individuals, and health behaviors and exposures at the population level (NAM 2012). In other words, the committee called for broadening the definition of health system from a hospital-centered organization that merely provides health care services to a group of aligned organizations that collaborate on a broader scope of upstream activities necessary to improve population health.

The committee stopped short of naming a role for the health system in shaping a more inclusive narrative and policies, but other organizations suggest some options. The Iton-Witt Health Equity Framework is based on the understanding that poor health outcomes are strongly influenced by adverse social and environmental conditions and that the health system cannot merely treat diseases but must operate upstream to help shape the narrative, policy, and institutional practices that can either enhance or erode opportunity conditions for people and neighborhoods (see figure 2). The framework helps visualize and organize health interventions and strategies across a continuum, from downstream

(the medical model) to upstream (the socio-ecological model). It points to the critical role that narratives play in shaping policy and institutional practice; for example, a dominant discriminatory narrative (e.g., racism, classism, sexism, ableism, homophobia, anti-immigrant bias, etc.) shapes institutional policies and practices, which in turn create inequitable conditions that result in poorer health for those who are the targets of the discriminatory narrative.

FIGURE 2

The Iton-Witt Health Equity Framework



Source: Created by Anthony Iton and Sandra Witt for the Alameda County Public Health Department and later adopted by the California Endowment and published in Iton and Ross 2017. Reprinted with permission.

A framework of six key strategies for centering equity in health care delivery (figure 3), created by the California Pan-Ethnic Health Network, shifts health care spending from a corporate-driven model to a transparent public system that "proactively invests in prevention and community health" (CPEHN 2020). The framework seeks to improve social determinants of health; center equity in quality and payment; engage patients, families, and caregivers; strengthen culturally and linguistically appropriate care; improve and integrate physical, behavioral, and oral health care; and hold health plans and systems accountable.

FIGURE 3

A Framework of Six Key Strategies for Centering Equity in Health Care Delivery

Source: California Pan-Ethnic Health Network, *Centering Equity in Health Care Delivery and Payment Reform: A Guide for California Policymakers* (Berkeley, CA: California Pan-Ethnic Health Network, 2020), https://cpehn.org/publications/centering-equity-in-health-care-delivery-and-payment-reform-a-guide-for-california-policymakers/. Reprinted with permission.

Both frameworks share a structure rooted in equity. We turn now to how the values of equity and belonging in a renewed social contract can shape a reenvisioned health system by prioritizing a people-centered approach, cultural coherence and healing, and community-level agency.

A People-Centered Approach

The predominant culture of American health care is not people-centered, despite its origins in charity and community service and the number of nonprofit, religious-based, and cooperative organizations that administer health care. Health care in the United States is organized around a capitalistic and technocratic ethos that is focused on packaging and selling medical services at a profit to purchasers made up of employers, government agencies, insurance companies, pension funds, and individual consumers. Capitalism argues that health care is not a fundamental human right but a privilege of the wealthy; thus, market justice, rather than social justice, is the central hallmark of the American health care system. Researchers have shown that both for-profit and nonprofit hospitals in the United States are more likely to offer services when those services are relatively profitable than when they are relatively unprofitable. For-profit hospitals, in particular, are likely to determine service lines based on profitability and to spend less on charity care (Horwitz and Nichols 2022). Research also has shown that growth in for-profit health care decreases care for low-income and uninsured patients (Valdovinos, Le, and Hsia 2015; Moon and Shugan 2020).[49]

In this sense, American healthcare is akin to an industrial commodity, not unlike transportation or apparel; its shares are traded and speculated on in the stock markets, its executive leaders are trained in business schools, and its corporate salaries are among the highest of all sectors.[50] Meanwhile, the country—alone among most Western developed countries—comfortably tolerates millions of people being uninsured and underinsured. People who need health care for communicable diseases, such as HIV or hepatitis C, and people who need psychiatric care or substance-use services may lack access to health care because those service lines may be deemed unprofitable (Chen, Bazzoli, and Hsieh 2009). Without the ability to participate in resource allocation and service-design decisions, people who face disproportionate health challenges are often left bereft of the health care services and resources needed to prevent, manage, and treat their health issues.

Conversely, a health system that strengthens the health assets of differing populations and cultures—for example, modes of interpersonal connection, healthy food, opportunities for physical activity, and purpose or outlook[51]—is centered around people and around harmonious relationships with the natural environment and other living beings, as Indigenous people have long understood. A people-centered approach affirms the dignity of each human being and their capacity to be rational and kind, and it prioritizes fundamental human needs, such as cultural coherence and belonging. Its principles underlie modern practices, such as patient-centered health care and human-centered design.

Cultural Coherence and Healing

Over the course of history, culture has been the primary means of reproducing the social and environmental conditions necessary for human survival. As Jerry Tello, cofounder of the National Compadres Network, puts it, "*la cultura cura*" (culture heals).[52] Any serious effort to create a health system based on racial equity must be organized in ways that are culturally coherent—in other words, that correspond to people's cultural norms, support their cultural roles, and enhance their power to ensure optimal conditions for themselves and the various communities to which they belong (Trostle

2005; Napoleon 2020). Often, this means focusing on groups, not just individuals, and supporting traditional perspectives and practices around healing.

For instance, many Indigenous cultures give the same consideration to the well-being of animals, plants, rivers, lakes, hills, mountains, rocks, soil, and landscapes as they give to humans. They also value past and future generations in addition to the present generation (Carroll et al. 2022). A health system committed to cultural coherence must respect these assets and resources and make investments that align with them, including foods that can be sustainably cultivated to support healthy living, activities that help youth become strong and caring adults valued by their culture, and stewardship practices that ensure the natural environment will be able to sustain human life for generations to come.

It is especially important to support cultural healing for African American and Indigenous groups, because their power to make decisions about the conditions that determine their well-being has been disrupted and denied in the past. It is also important to support the multiple cultures of other residents, including those of European ancestry. America must build an alternative to the idea of "whiteness" as a privileged and superior cultural designation. The examples in box 4 illustrate ways in which health systems designed to enhance cultural coherence have shown significant promise with programs that prevent drivers of chronic diseases, such as obesity and loneliness, while including people who have been disregarded by traditional medical approaches.

BOX 4

CULTURAL COHERENCE AND HEALING IN HEALTH SYSTEMS

BElovedBIRTH Black Centering is a collaboration among the Alameda County Public Health Department, Alameda Health System, and community partners based in Oakland, California, to address severe and persistent racial inequities in birth outcomes for pregnant and birthing people. The program's unique group care model provides perinatal care by, for, and with African American people. Based on the CenteringPregnancy[a] care model of group visits for people at the same stage of pregnancy, the program provides culturally tailored wraparound services, such as delivery of care packages and postpartum meals from African American–led community organizations. In 2022, BElovedBIRTH Black Centering received the California Association of Public Hospitals and Health System's Quality Leader Awards—Top Honor in recognition of significant reductions in preterm and low-birth-weight births.[b]

Curando la Comunidad—Na' Sanaeé Nañueé is an initiative of the Mixteco Indigena Community Organizing Project in California's Central Coast that supports traditional healing practices as part of equitable behavioral health care services. The program provides plant medicine, energy work, and other traditional Indigenous practices shared by community *curanderas* (healers) and practiced by trained *promotoras* (community health workers). It grew out of a community-based research project, supported by the State of California and Ventura County, which demonstrated that nearly all 280 Mixteco/Indigena community members served by the program reported positive outcomes, including a 20 percent overall reduction in stress scores, 15 percent reduction in anxiety, and 12 percent reduction in depression.[c] The program's participants are among the most poorly served groups in the state because of multiple access barriers, including language, immigration status, and racial discrimination.[d]

Football Fans in Training is a collaboration between the Universities of Glasgow, Aberdeen, Dundee, and Edinburgh, Scotland. It was devised to motivate overweight men to attend weight management groups by giving them behind-the-scenes access to professional football clubs. A trial of the program

was funded by the United Kingdom's National Institute for Health Research, and it proved to be extremely popular among both participants and coaches and relatively inexpensive to conduct. A year after completing the program, participants' step counts were higher and they had lost 4.94 kg (almost 11 pounds) more than nonparticipants, on average.

a. "CenteringPregnancy," Centering Healthcare Institute, accessed August 14, 2023, https://www.centeringhealthcare.org/what-we-do/centering-pregnancy.
b. "KQED Features AHS Midwife and BelovedBIRTH Black Centering Program Director Jyesha Wren," Alameda Health System, March 17, 2023, https://www.alamedahealthsystem.org/kqed-features-ahs-midwife-and-belovedbirth-black-centering-program-director-jyesha-wren.
c. "Mental Health Services Act Innovations: Mixteco/Indígena Project: Healing the Soul – Curando el Alma – Na Sánna é Inié," (project report, Ventura: CA, Ventura County Behavioral Health Department, July 30, 2020), https://vcbh.org/images/Appendix_C_Healing_the_Soul_Apendix.pdf.
d. "Health & Healing," Mixteco Indigena Community Organizing Project, accessed August 14, 2023, https://mixteco.org/health-healing/.

Community-Level Agency

The term "agency" can be defined as control over resources, decisionmaking, and policy that shapes opportunity. Community-level agency is people power. It is the ability to hold systems and institutions accountable for equitable decisionmaking and resource allocation. It is a core element of a democratic society.

Partners for Dignity & Rights and RaceForward argue in their report, *Co-Governing Toward Multiracial Democracy*, that "government must belong to the communities it represents and serves." The report explains:

> That means protecting electoral integrity and voting rights while also going beyond traditional representative government to build democratic spaces and processes that give communities and workers direct ways to participate in decisions. Communities and workers must have a say in decisions made by legislatures, regulatory agencies, employers, and institutions like hospitals whose decisions have important public impact. We must establish ways for communities to hold powerful public and private actors accountable to human rights and to democratic decisions. And, because we are starting from such an uneven place, we must design democratic models that explicitly and enforceably build racial, economic, gender, and other forms of equity into both processes and real-world outcomes. (Partners for Dignity & Rights 2023).

In a health context, people's agency to shape their own care often incorporates holistic and functional outcomes that extend beyond the measures typically used by health professionals. For example, people who have agency look for a personal doctor who will provide relationship-centered care, rather than the institutional- and professional-centered care typical of the current health system. Instead of thinking about health as the absence of disease, communities with agency conceive of health in collective terms, as a rich network of people and places that support diverse human activities and a thriving natural world that will be sustained for future generations.

The California Pan-Ethnic Health Network, in their report on centering equity in health care delivery, affirms the idea of community-level agency and notes that "patient, family, and caregiver engagement is more effective when individuals and community members are not just given advisory roles but instead have the power to make decisions and are given some control over the resources being spent." This more equitable model of engagement is necessary to ensure that providers "are focused not only on quality improvement but also [on] addressing the social determinants of health" (CPEHN 2020).

A growing number of hospitals and health systems are embracing the concept of collective impact and incorporating community agency into their governance approach. Collective impact is a form of community collaboration that has been around for years in many loose and imprecise forms. It was codified more systematically by John Kania and Mark Kramer (Kania and Kramer 2011) as a process for aligning community interests and efforts toward a common outcome. In 2016, noting that health care is evolving to focus on community and population health, the American Hospital Association summarized several award-winning collective impact efforts in their report, *Learnings on Governance from Partnerships that Improve Community Health* (AHA 2016).

The main constraint of collective impact models in community health is that the goals of hospital and health system governance and community partners are often in conflict. According to the American Hospital Association's report, health systems and community partners often have "different cultures, with their participants living in very different worlds." More precisely, hospitals and health systems generally have incentive structures that are anchored in a business model reliant on income generation, whereas community partners view health fundamentally as a public health endeavor with health improvement as their primary goal. Other writers with long experience in community-institutional collaborations have noted similar challenges to health equity.[53]

What does a health system that prioritizes community agency look like? In the early 1960s, Jack Geiger, then a medical student at Case Western Reserve University, traveled to South Africa to work at a health clinic in a rural Zulu community. He was struck by how well the clinic addressed the drivers of poor health through feeding centers for children, sanitation, and vegetable gardens. He recognized that this happened because patients at the clinic were able to identify what the community needed and propose appropriate changes. This insight shaped how Geiger designed the first community health center in Mound Bayou, Mississippi, in partnership with social worker John Hatch and local residents (Robinson 2014). Their design empowered communities to establish and direct health services at the local level through consumer-majority governing boards, which enabled the people closest to the problems to control the resources dedicated to the solutions.

Today, all Federally Qualified Health Centers require their governing boards to "represent the individuals being served by the center" and have at least 51 percent of the board members be patients.[54] Some centers have expanded their commitment to community governance by holding general meetings to organize and inform community members of health threats and policy opportunities, enlisting and training patients as community advocates, and holding voter registration drives.[55]

As examples in box 5 illustrate, health systems designed with community agency at their core often outperform conventional health systems, even when measures are based on traditional results defined by health professionals.

BOX 5

COMMUNITY AGENCY IN HEALTH SYSTEMS

Southcentral Foundation's Nuka System of Care, which primarily serves Native Alaskan communities, was redesigned to emphasize relationships and shared decisionmaking with patients (called "customer-owners") and their families. Nuka focuses on understanding each customer-owner's unique story, values, and influences in an effort to engage them in their care and to support long-term behavioral change. Its focus on relationship extends beyond the delivery of health care services, and includes compliance, human resources, and financing. Nuka's strong relationship between primary care teams and customer-owners has helped to manage chronic diseases, control health care costs, and improve overall wellness. It dramatically reduced avoidable hospital visits and increased numerous quality metrics. Nuka has been awarded the prestigious Malcolm Baldrige National Quality Award twice in the past 15 years.[a]

Kokua Kalihi Valley Comprehensive Family Services is a community health center that serves the community of Kalihi in Honolulu, Hawaii. Its mission is to advance health, inspire healing, foster reconciliation, and celebrate abundance in the community through strong relationships that honor culture and place. In 2011, it developed a program called "Returning to Our Roots" (Roots), which engages community members in growing, preparing, and sharing organic and culturally relevant foods. Roots works to increase food sovereignty, strengthen cultural identity, and nurture *waiwai* (abundance and wealth in all its forms). Its staff and volunteers operate a café and gardens, annually producing more than 6,000 pounds of fresh produce that is distributed to the community. They also help more than 200 Kalihi residents reconnect with their land, culture, food, and community through more intensive programming, such as Ehuola, an experiential and intergenerational learning initiative that helps family members clarify and progress toward their health goals by exploring the community food system and participating in family-centered, food-oriented workshops. More than 20 families currently participate in the program.[b]

Hoʻoulu ʻĀina Nature and Cultural Preserve, operated by Kokua Kalihi Valley Comprehensive Family Services, is situated on 100 acres of state conservation land deep in Kalihi Valley. Dedicated to cultural education and community transformation, Ho'oulu ʻĀina—which means "to grow the land" and "to grow because of the land"—welcomes more than 5,000 residents and visitors each year to join in native reforestation, organic gardening, green job training, environmental education, and the preservation of cultural and healing practices. The community garden and nature reserve provide communities of Kokua Kalihi Valley ways to counter the inequities they faced by reweaving relationships—among people and between people and the land—that are crucial for health and healing.[c]

a. "About Us," Southcentral Foundation's Nuka System of Care, accessed August 15, 2023, https://scfnuka.com/about-us/#what.
b. "Returning to Our Roots," Kokua Kalihi Valley Comprehensive Family Services, accessed August 15, 2023, https://www.kkv.net/returning-to-our-roots-1.
c. Sharon Kaʻiulani Odom, Puni Jackson, David Derauf, Megan Kiyomi Inada, and Andrew Aoki, 2019, "Pilinahā: An Indigenous Framework for Health," *Current Developments in Nutrition* 3, (S2): 32–38.

We have covered how key values in a social contract should shape a health system's priorities. But some structural elements are also needed to ensure that the health system operates equitably in promoting good health for all. These fundamental building blocks include investments in public health and preventive strategies, community-oriented primary care, and integrated health care and social services. Together, they comprise a structure that a health system's users and providers can leverage to maximize equitable health opportunities.

Public Health and Preventive Strategies

Put simply, public health is "what we, as a society, do collectively to assure the conditions in which people can be healthy" (NASEM 1988, 1). Although the conditions in which people live are the main drivers of health, spending on health in the United States is heavily weighted toward treating people who have already become sick. And, although it is well documented that environmental and population-based interventions to prevent disease are more cost-effective than clinical care, public health remains chronically underfunded, disjointed, and inconsistent—as was demonstrated by the deaths of more than 1 million Americans during the COVID-19 pandemic and the disease's disproportionate impact on marginalized racial groups (Chokshi and Farley 2012).

A health system rooted in equity would invest significantly more in public health. On a national level, public health would be coordinated and led by a strong federal agency that administers enhanced funding to states and localities to target the major drivers of poor health, invest in proven preventive strategies, and ensure that health departments across the country meet minimum practice standards. State and local public health agencies would be experts in transformative methods that are explicitly focused on improving racial equity and avoiding the unintended consequences of population health approaches that can often increase inequality (Frohlich and Potvin 2008). Local public health leaders would have a deep understanding of the historical and contemporary policies and institutional practices that have created racial inequity, and they would use strategies at scale to explicitly build power within communities that have the most to gain from tackling inequities (Heller et al. 2023).

Community-Oriented Primary Care

High-quality, generously financed primary care is necessary to implement a renewed social contract that achieves equity through universal health insurance and stronger public health institutions. The National Academies of Sciences, Engineering, and Medicine, in a recent report *Implementing High-Quality Primary Care*, defines primary care as "comprehensive person-centered, relationship-based care that considers the needs and preferences of individuals, families, and communities" (NASEM 2021). Because primary care is inherently designed to serve everyone, not just those who are ill, it is a key component of any universal approach to health care services. Indeed, as the report notes, "people in countries and health systems with high-quality primary care enjoy better health outcomes and more health equity" (NASEM 2021).

Currently, however, the US health system is organized as a collection of products and service lines. This mechanistic approach to caring for the human body—which holds that health is optimized by purchasing the right combination of specialized practitioners, procedures, and pills—misses the

opportunity to address the main causes of ill health (Wallace and Wallace, 2013). Technological advances within this paradigm lead to a proliferation of treatments for narrowly defined biological conditions, many of which cause serious side effects that in turn require additional treatments. Even though this type of health system produces miraculous results for some individuals, its overall outcomes, including for the wealthiest in the country, are disappointing and do not justify the costs (National Research Council and NAM 2013).

Primary care is the only health care service that can provide an antidote to the escalating costs and diminishing returns that characterize the current US health system. Currently, primary care accounts for 35 percent of health care visits but receives only about 5 percent of health care expenditures (NASEM 2021). A small increase in spending on primary care—with special attention to localities with the greatest needs—funded by a modest reduction in spending on other health care services would likely yield large dividends in population health *and* health equity.

Integration of Health Care and Social Services

Just as health is not the same as health care, the social contract is not the same as social services. Social services are an essential part of an equitable health system. Yet, critical social services, such as caring for children and the elderly, delivering and preparing food, and maintaining healthy living environments for vulnerable groups, are poorly coordinated and funded in deeply inequitable ways in the United States (Johnson-Staub 2017; Campbell et al. 2016). This situation contributes to health inequities and challenges the dignity of human life.

Integrating health care and social services can help address the fact that health outcomes often are influenced by a combination of health and social factors. For example, addressing food insecurity could reduce hospitalizations for diabetes (see Weil 2022), and providing permanent housing with integrated health care support may reduce chronic homelessness.[56] Longstanding programs such as the Nurse-Family Partnership (Olds et al. 1997) and the Program for All-Inclusive Care of the Elderly (Kwiatkowski 2013) are examples of integrated community-based services with strong evidence of improved health outcomes. Community health workers, *promotores de salud*, doulas, and other community-based workforces that extend health care outside the clinic have been foundational components of health care in other countries, and they are becoming increasingly established in the United States (WHO 2020). There is also a long and growing list of newer models that improve outcomes, including programs that integrate housing, nutrition, and income supports with health care, medical-legal partnerships, and more (Taylor et al. 2016).[57]

Driven by payment reforms that seek value over volume and by a growing understanding that social factors influence health outcomes, health care organizations are rapidly expanding efforts to integrate health care and social services. But this has triggered concerns about the "medicalization" of social services, which can add needless costs and complexity and transfer power and agency from community members to technical experts (Lantz 2019). One example of a medicalized approach to integration is "social prescribing," which addresses individual social needs (e.g., food insecurity) as if they were specific diagnoses that respond to targeted treatments (e.g., referrals to food banks or social services agencies).

Health care organizations' efforts to close the loop on referrals to social services organizations has fueled rapid growth in new digital tools for referral management, although there is modest evidence of improved outcomes overall and a relative lack of evidence about effectiveness or improvements in health equity from these types of interventions (De Marchis et al. 2022). Critics say that these solutions emanate from "fantasy paradigms" closely tied to savior narratives of health care providers (Mackenzie et al. 2020).

While it is clear that integrated health care and social services is a key feature of equitable health systems, it is also clear that the primary route to health equity is a stronger social contract that ensures all people have the resources they need to be healthy. Approaches that treat social risks as market opportunities for new products and service lines are likely to inflate costs and contribute to greater inequities, whereas integrated models that are grounded in public health principles and methods and are explicitly designed to strengthen and supplement the social contract are promising. Encouraging examples of integrated models come from the autonomous region of Catalonia in northeastern Spain and from the Cincinnati Children's Hospital Medical Center in Cincinnati, Ohio (see box 6).

BOX 6

INTEGRATION OF HEALTH CARE AND SOCIAL SERVICES

Inter-ministerial Social and Health Care Interaction Plan (PIAISS) was created by the government of Catalonia in 2014 to improve coordination of health and social care for the elderly and expand integration to other populations facing complex health and social needs. PIAISS's approach is grounded in the social contract and leverages a collaborative approach to public health, health care, and social services.

Integrating health care and social services led PIAISS to create a home hospitalization initiative, provide prehabilitation care for major surgeries, and establish community-based interventions for frail, elderly patients with chronic conditions. These strategies emphasized a people-centered approach, leveraged the social determinants of health, and helped to anticipate and prevent health crises. They have demonstrated efficacy on traditional individual-level measures, and an evaluation of the home hospitalization initiative has shown positive outcomes on cost-effectiveness and on composite indicators of patient experience and population health.

Cincinnati Children's Hospital Medical Center (CCHMC) bridges the divide between the traditional, narrow definition of a health system and the expanded health system of the future. CCHMC's most recent strategic plan strives to "help Cincinnati's kids to be the healthiest in the nation through strong community partnerships." While CCHMC acknowledges that their focus remains on health care services, their aim is to support and participate in community-led efforts that address social and environmental conditions and improve population health.

As part of its explicit goal to drive "excellent and equitable health outcomes," CCHMC operates a Safe and Supported Families initiative, which coproduces programs in partnership with communities most impacted by racism. The initiative addresses community priorities, such as trauma and healing as well as food equity. The Health Equity Network, a partnership between CCHMC and the local Medicaid Accountable Care Organization, uses a learning network structure to accelerate progress toward equitable health outcomes. Through these and other partnerships with neighborhood leaders, schools, social services organizations, public health agencies, philanthropies, businesses, and universities, CCHMC has helped reduce racial disparities in infant mortality, hospital admissions, and diabetes care.

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Conclusion

The US health system is dominated by a downstream-focused approach that is organized to make profits for purveyors and to sell lucrative services to payers. This model, in which too many health care decisions are driven by financial motives instead of medical knowledge, is incompatible with community health improvement and, ultimately, public health.

Reenvisioning the US health system around a more equitable, salutogenic approach poses a values question: What and whom do we prioritize—a corporate model of health care that benefits mainly those who hold the most power, or a community-based model in which health care is a public good and a human right? The answer ties directly to America's identity and its social contract. National leaders have been reluctant to embed in that social contract a guarantee that everyone will have access to the conditions and opportunities that produce good health; that everyone is entitled to the security of having their culture, identity, and humanity accepted as an integral part of the American tapestry; and that everyone can have a say in the control of the public resources, decisionmaking, and policies that shape their opportunities.

Americans saw that reluctance during the 1965 signing ceremony for the Medicare and Medicaid Acts, when Lyndon Johnson declared that no citizen should be "abandoned to the indignity of charity."[58] We saw it again 45 years later, when Barack Obama signed the Affordable Care Act and highlighted the principle that "everybody should have some basic security when it comes to their healthcare."[59] Avoiding the "indignity of charity" and acquiring "some basic security" seem like a pretty low bar for highly trumpeted major social policy achievements, especially when virtually all peer countries have gone much further in creating durable government guarantees of affordable health insurance for all their citizens.

In 2003, the groundbreaking report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,* published by the National Academy of Medicine, observed that "racial and ethnic disparities in health care occur in the context of broader historic and contemporary social and economic inequality and evidence of persistent racial and ethnic discrimination in many sectors of American life" (NAM 2003). Twenty years later, the United States has made little progress in eliminating racial health

disparities. As a consequence, the US health system is not organized around achieving health equity. In fact, it is not organized around improving American health in general.

To develop a high-performing, universally accessible health system that eliminates racial health disparities and creates health equity, we believe that government must play a central role. Over multiple generations, however, America's political divisions have aggressively constrained the role of government in health care. This ambivalent stance toward a more democratic approach to public health allowed corporate capitalism to dominate the health system, unopposed and often aided by the prevailing technocratic approach to health care, in ways that are unheard of and unthinkable virtually everywhere else in the world. Other wealthy countries, even those with a capitalist economy, have balanced public health and private interests in diverse ways and have not abandoned their health systems to the ravages of market justice. All outperform the United States on measures of health, health equity, and cost.

Unbridled capitalism and treating the health system as an industrial sector will not lead to health equity. To optimize health opportunities for all Americans, and to help repair the harms caused by racism and other forms of structural disadvantage, the health system must be thought of as a public good and a democratic concern—a shared resource into which everyone invests, not to increase profits but to meet human needs, and one that is an essential part of reinvigorating our democracy. This understanding gives government a role in establishing, supporting, and maintaining the health system's infrastructure, much like it does for K–12 education.

A deep fracture runs through American society that impairs the country's ability to reach an enduring consensus on the role of government to ensure the most fundamental human needs. Reweaving the US social contract requires taking a people-centered approach, emphasizing cultural coherence and healing, and supporting community-level agency. It requires learning from other developed countries and focusing on society's opportunity structures for children and families—investments in public health and preventive strategies, community-oriented primary care, and integrated health and social services—and optimizing the performance of those structures so they help people participate in the 21st century economy, rather than trapping them in despair and hopelessness.

The growing diversity of the United States poses a potential challenge to many of the solutions envisioned in this essay, including incorporating cultural assets into health care practice, centering relationships, and integrating social services. In particular, care must be taken when leveraging the benefits of cultural belonging to make sure the principles of fairness, tolerance, and individual choice are strongly enforced. Emphasizing these principles for the people and communities with the worst outcomes will ensure that a focus on belonging does not become a novel mechanism to further oppress and exclude marginalized people.

In the face of these challenges, hope lies in many communities across the country that have found a way to center human needs in the design, operation, and governance of their local health systems. Often, they have leveraged Indigenous wisdom and other deeply held cultural values in their efforts to heal the deep psychological and emotional injuries that our racist society has inflicted. This is where we

must look for inspiration to repair our social contract and reenvision our health system on a national scale. This is where we will find clues for building a sense of solidarity that can power a new inclusive narrative about health and national identity—one that lifts up shared humanity, intertwined fates, and common destiny. This is where we will see that if we find a way to create solidarity and embrace shared humanity, it can reinvigorate our democracy as well as our health system.

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