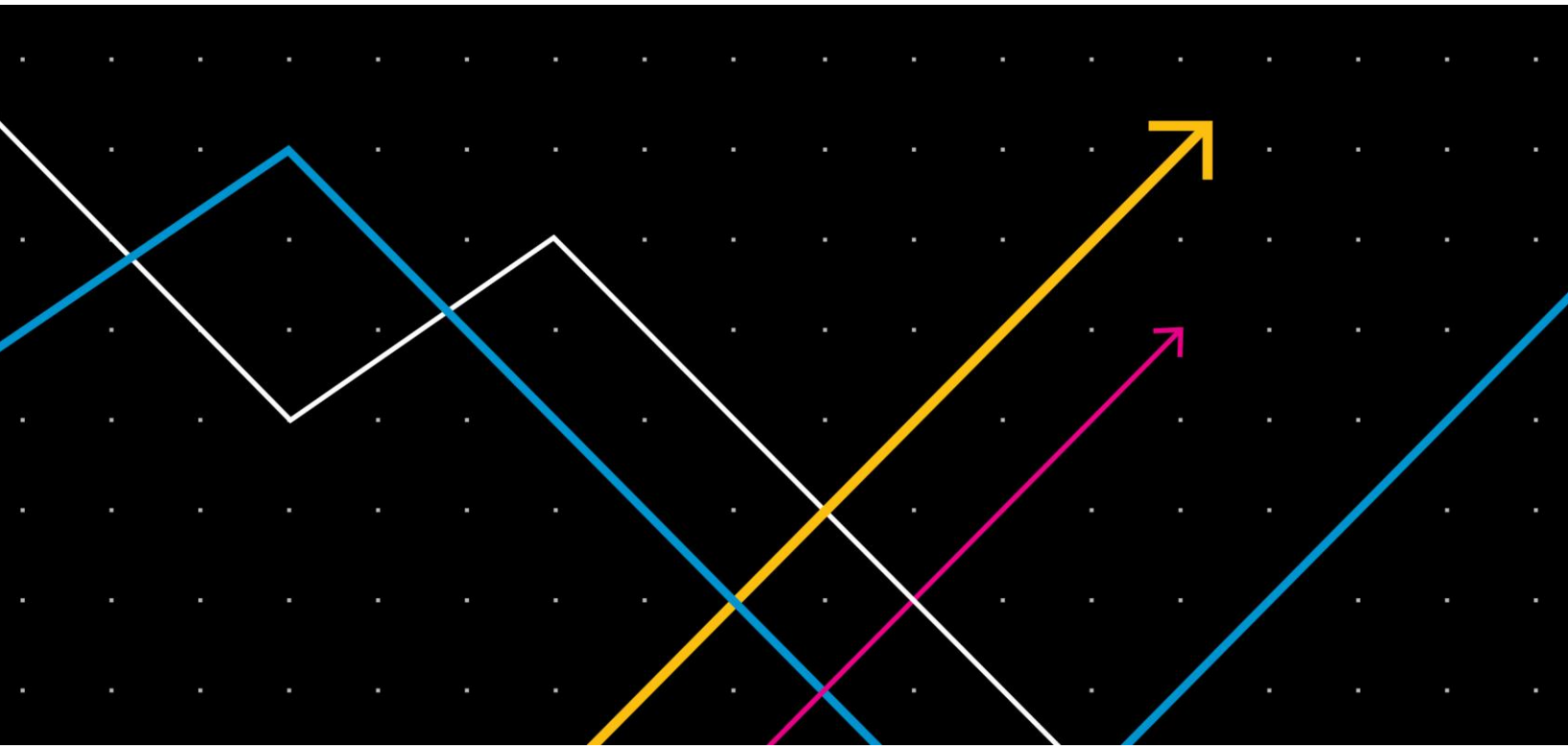

RESEARCH REPORT

The Sociopolitical Context of the Unequal Treatment Report

Then and Now

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Contents

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The Sociopolitical Context of the Unequal Treatment Report: Then and Now

In 1999, the United States Congress passed legislation requesting that the Institute of Medicine (now the National Academies of Medicine) create a report to assess the extent of racial and ethnic differences in health care, evaluate potential sources of inequities, and recommend interventions to eliminate them. The resultant report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (the Report), was a landmark publication released in 2003. It provided evidence and analysis strongly suggesting that health care systems and the people within them were providing inequitable care to individuals based on their racial and ethnic identities, even after accounting for access to care. Chief among its conclusions was that provider bias, stereotyping, and prejudice contributed to these inequities in care. While these and other findings from the Report may seem obvious and conventional when reviewed over 20 years later, they represented a bombshell for much of the health care community at their release. Health care providers and institutions could no longer solely attribute racial and ethnic inequities in health to factors considered "outside" the purview of health care institutions.

Now, 20 years after the Report's release, we can reflect on its impact. At the Urban Institute's "Unequal Treatment at 20: Accelerating Progress Toward Health Care Equity" symposium held in March 2023, thought leaders nationwide convened to explore why racial and ethnic inequities in health care have persisted over the past 20 years (Mitchell, Taylor, and Smedley 2023). Since its publication, there has been much attention given to eliminating racial and ethnic inequities in care but little progress in reducing them. Moreover, pushback against achieving racial justice in many spaces, including health care, has intensified. Implementation of the Report's recommendations, like others of a similar magnitude, has been shaped by broader social and political contexts surrounding them, including the laws, policies, and values that exist in society. This paper will critically reflect on how the sociopolitical context at the time of the Report and since has impacted the implementation of recommendations to eliminate racial and ethnic inequities in care. First, we will discuss how the political context preceding and during the Report's release led to increased attention to racial and ethnic inequities in health care, tempered by a narrow focus on quality of care while deprioritizing large structural drivers of care quality like access to care and socioeconomic status. Then, we will highlight several recommendations influenced by social and political forces and provide a critical analysis of research since the Report's

publication to determine where progress has stalled. Finally, we will briefly review examples of the current state of racial and ethnic inequities in care, followed by key processes we feel are essential building blocks for future success.

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.

Sociopolitical Context: Then

A review of policies related to racial and ethnic health inequities in the US from 1975 to 2002 demonstrates variability in legislative attention to this topic, with an increase in bills enacted in the late 1980s, a peak in 1993, followed by a decline and subsequent rise again in 1999–2000 (Halfmann, Rude, and Ebert 2005). This picture of fits and starts in legislative enactments mirrors the sociopolitical landscape at the time. As the following section will review, the progress of increased attention to racial and ethnic health inequities at the policy level was at odds with a focus on the individual at the expense of naming and addressing structural drivers of inequity, including structural racism.

Prior to the Report

The 1980s marked increased political attention to addressing racial and ethnic health inequities. The Association of Minority Health Professions Schools was created in 1977 to develop and promote programs to improve the health of minoritized communities.[1] As a part of this work, they commissioned a study entitled "Blacks and the Health Professions in the 1980s: A National Crisis and A Time for Action" by Dr. Ruth Hanft. This study demonstrated the underrepresentation of providers from racial and ethnic minoritized backgrounds as well as the significant health inequities between Black and white individuals in the US (Hanft 1984).[2] In 1983, the leaders of the Association of Minority Health Professions Schools met with Secretary of Health and Human Services (HHS) Margaret Heckler to

review the key findings of this study.[3] In response, Secretary Heckler created a task force focused on this issue, directed by Dr. Thomas E. Malone, which published the *Report of the Secretary's Task Force on Black and Minority Health*, often called the "Heckler Report." This report represented the first time that the US government had produced a comprehensive report that substantively documented racial health inequities, particularly among Black Americans (HHS 1985). The Heckler Report elevated this issue on the national stage. It directly led to the creation of the Office of Minority Health in the HHS, prompted the 1986 annual convention of the Congressional Black Caucus to focus on racial and ethnic inequities in health, and influenced legislation (Halfmann, Rude, and Ebert 2005; Gracia 2018). Its focus on racial and ethnic inequities in care would also lay the foundation for the Unequal Treatment Report 18 years later.

In the late 1990s, the White House placed new emphasis on addressing racial and ethnic inequities in health care (Halfmann, Rude, and Ebert 2005). In 1997, President Clinton formally apologized for the US Public Health Service's Untreated Syphilis Study at Tuskegee and issued Executive Order No. 13050 later that year, creating an "Initiative on Race." (Halfmann, Rude, and Ebert 2005). As part of this initiative, the president appointed a national advisory board focused on "examining race, racism, and the potential for racial reconciliation in America using a process of study, constructive dialogue, and action" (Franklin et al. 1998). The resultant report by this group included a section on better understanding the impact of race on health. In 1998, the HHS announced a plan to eliminate disparities in health by 2010 in six key areas: cancer, infant mortality, cardiovascular diseases, diabetes, immunizations, and HIV (HHS 2000).

While this list of reports, initiatives, and policies demonstrated an increase in attention to, discussion of, and funding for efforts targeting racial and ethnic health inequities, racism was rarely mentioned. For example, in the Heckler Report, the word racism was not used in the executive summary to contextualize or explain the inequities described. When President Clinton apologized for the Untreated Syphilis Study at Tuskegee, his speech also did not include the word racism, despite the clear racism at the core of the creation and continuation of the study (Brandt 1978; Clinton 1997). Similarly, while the Initiative on Race included a national advisory board focused on examining race and racism, the report included discussions of structural racism as a contextual factor and past legacy rather than a cause for inequities seen in the present day, including in health care (Franklin et al. 1998). This reluctance to directly name racism likely reflected a larger societal desire to sidestep discussions of racism. However, the failure to directly name the system of racism as a causal factor driving racial and ethnic health inequities no doubt served as a barrier to successfully addressing them.

Instead, these efforts from a few decades ago hewed close to individual-level drivers of inequities, with health care leaders at times asserting that inequities seen were driven by racial and ethnic minoritized populations themselves. A closer look at the Heckler Report suggests a central focus on the individual may have contributed to a lack of attention to policies targeting structural drivers of inequities. The Heckler Report demonstrated that much of the inequities uncovered were related to lack of health insurance, low income, unhealthy behaviors, and poor prenatal care (Halfmann, Rude, and Ebert 2005, HHS 1985). Despite this, Secretary Heckler would propose no new funds or specific programs focused on these drivers, stating that she did "not believe money is the answer."[4] The Heckler report was criticized for overemphasizing lifestyle factors rather than structural drivers.[5] Hecker herself stated that "much of the health gap suffered by minority Americans—perhaps even most of it—is related to knowledge and lifestyle."[6](Halfmann, Rude, and Ebert 2005). These beliefs echo a strong theme of individualism in US culture and health care—an overemphasis on personal responsibility at the expense of upstream structural factors that shape downstream attitudes and behavior.

In the health care research space, Dr. Kevin Schulman's 1999 study, "The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization," and its reception led directly to the creation of the Report (Schulman et al. 1999; Bloche 2001). His article reported the findings from a study in which 720 physicians were shown recorded medical interviews with a hypothetical patient played by an actor. The physicians were asked whether the patient should be referred for cardiac catheterization. The study found that Black patients and women were less likely to be referred compared with white patients and men, suggesting that race and sex bias on the part of physicians was impacting care (Schulman et al. 1999). Its release was widely publicized in newspapers and on TV nationwide, prompting a significant response from the White House, Congress, and medical leaders, including the US Surgeon General, the American Medical Association, and the Association of Black Cardiologists.[7] While these entities were primarily focused on doing "whatever we can to fix it, " several study critics questioned the Report's methods and findings (Bloche 2001).[8] By some accounts, this study "did more than any other single event to put the matter of racial disparities in health and medical care on the American public policy agenda" (Bloche 2001). That year, a report accompanying an appropriations bill funding the Office of Minority Health included reference to the study findings as "concerning" and provided funds to the agency for a "one-time Institute of Medicine study of the prevalence and impact of ethnic bias in medicine" which would become the Unequal Treatment Report.[9] The potential role of racial and ethnic bias in clinical decision-making generated a significant political response. The unambiguous evidence from this study ensured that provider bias had made it solidly onto the health policy stage and directly influenced the charge of the Report (Bloche 2001).

It was in this policy landscape that the Report was created and released. The Institute of Medicine convened a Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care to develop the Report (Institute of Medicine 2003). The charge to the committee specifically focused on the causes of racial and ethnic disparities in care not attributable to access to care. This charge created a false dichotomy between factors considered "inside" health care and those perceived as "outside" of it. Moreover, the wealth of information on racial and ethnic health disparities had demonstrated over the preceding decades that access to health care was a primary driver of these inequities. The Report authors were aware of this at the outset, writing in the introduction to the Report that "this is a somewhat artificial and difficult distinction, as many access-related factors… significantly affect the quality and intensity of health care that [individuals] receive, and are highly correlated with race and ethnicity" (Institute of Medicine 2003). Nevertheless, the study charge was clear, and the Report focused squarely on sources of inequity that remained once access to care was accounted for.

By the end of their time together, the committee presented undeniable evidence that racial and ethnic inequities were persistent and pervasive throughout health care and made several recommendations spanning many domains, including education, policy, data collection, health systems interventions, and research. While racism was discussed as a historical legacy with persistent effects in shaping life in the US, particularly in several of the commissioned papers, it was mentioned only 11 times in the Report and never explicitly as a root cause of racial and ethnic inequities in care. One committee member explained in a later publication that the word "racism" was avoided in the Report's writing (Bloche 2005). Committee members concluded that while there was "no direct evidence that racism, bias, or prejudice among health care professionals affects the quality of care for minority patients," they had reviewed several "streams of evidence" that suggested bias was contributing to inequities (Institute of Medicine 2003). This included evidence of (1) remaining disparities after controlling for factors related to access to care, (2) the influence of historical racism on the context of health care provisions, (3) patient race influencing provider perception of patients, and (4) the medical care environment containing features known to activate bias in decision-making (e.g., time-pressure, resource constraint, high cognitive demand) (Institute of Medicine 2003). Taken together, this led the committee to conclude that "bias, stereotyping, prejudice, and uncertainty on the part of health care professionals cannot be ruled out—and indeed, appear among the many patient-level, system-level, and clinical encounter-level factors to contribute to racial and ethnic disparities in health care" (Institute of Medicine 2003). It was these two findings—of sweeping racial and ethnic inequities in care quality and the likely contribution of bias, prejudice, and stereotyping to these differences—that would capture the nation's attention.

The Reception of the Report

News of the Report spread swiftly and influenced several areas of health care. Many articles in popular media shared findings of striking racial and ethnic inequities in health care quality in the US, including overseas.[10] Despite the report avoiding the word racism, some articles had titles like "Racism a Culprit in Health Disparities" and "Racism Thriving in American Medicine."[11] Many advocates and health organizations serving minoritized communities valued the acknowledgment of what many had suspected but lacked authoritative scientific evidence to support.[12] Dr. Lucille Perez, then president of the National Medical Association, said that the Report "validates what the National Medical Association has been saying for so long—that racism is a major culprit in the mix of health disparities."[13] The Report also had an impact on the legislature. For example, Rep. Henry A. Waxman (D-CA) and Rep. Elijah Cummings (D-MD), with leaders of the Congressional Black Caucus, Congressional Hispanic Caucus, and the Congressional Asian and Pacific American Caucus sent a letter to the secretary of HHS, Tommy Thompson, to change course on policy actions that would weaken managed care protections for Medicaid patients, cut the Agency for Healthcare Research and Quality budget, and eliminate programs focused on increasing minoritized groups in the health professions.[14] They argued that these changes directly conflicted with recommendations from the Report. Finally, several initiatives in the health care sector focused on reducing health inequities, citing the Report among reasons to pursue these programs.[15]

While there was a largely positive response to the Report among major professional medical and health care organizations, including confidence in its validity, it was not without criticism. Some critics, particularly in conservative circles, took issue with the assertion that provider bias was contributing to racial and ethnic health inequities, calling it premature (Satel and Klick 2005). Moreover, they claimed that "words such as prejudice, bias, and discrimination represent charged and divisive language that is needlessly provocative and potentially counterproductive" (Satel and Klick 2005). They also attacked the quality of the evidence cited in the Report (Satel and Klick 2005; Epstein 2005).

While many of these arguments were directly confronted by other scholars (Bloche 2005), it seemed some critiques were mirrored among federal health agencies. For example, in late 2003, the HHS issued the first national report card on health care disparities compiled by the Agency for Healthcare Research and Quality. The original report released omitted all findings of racial "disparities," replacing the word with "differences" and stated that "there is no implication that these differences result in adverse health outcomes."[16] Later, preliminary drafts of the report that included clear language that health disparities were pervasive and provided benchmarks for monitoring and addressing outcomes were leaked to the public. Senior officials in the HHS had ordered rewrites to "focus on the

positive."[17] This was swiftly critiqued by many, both in the lay press and in the academic medical literature, as a deliberate obfuscation of the inequities present (Bloche 2004).[18] These critiques eventually led to the release of the original draft from the preceding summer (Bloche 2004). Commentaries by Report committee member Dr. M. Gregg Bloche highlighted the rewrite's disturbing disregard for scientific evidence and proposed that the underlying political motivation was a fear among political actors that an emphasis on institutional or systemic accountability for racial inequities in health would distract from the traditional (and perhaps more comfortable) focus on individuals and their personal responsibility—an emphasis that would shift the blame away from individual patients and towards systems in health and government (Bloche 2004).[19]

A Critical Evaluation of Progress in Recommendation Implementation

With over 10,000 citations, the Report has emerged as a pivotal resource in various fields, including psychology, public health, sociology, and medicine. Many public health leaders credit the Report with catalyzing research to investigate root causes of racial and ethnic inequities in health care.[20] However, inequities persist. In the following section, we examine a handful of the Report's recommendations alongside relevant literature from the past two decades to assess and understand the progress, or lack thereof, in implementing them. While all recommendations are subject to contemporary contexts, we focus on three whose implementation is particularly shaped by sociopolitical forces: awareness building, reducing bias, and increasing racial and ethnic diversity in the health professions. By critically evaluating these, we aim to identify lessons learned to inform future research.

Awareness Alone is Insufficient to Reduce Racial and Ethnic Inequities in Health Care

The Report's first recommendations were to increase awareness of racial and ethnic inequities in health care among the general population and health professionals. The authors suggested that "raising public and health care provider awareness of the problem is an important first step" (Institute of Medicine 2003). To this end, the committee suggested campaigns and education efforts to increase awareness of racial and ethnic inequities in health among many stakeholder communities, including policymakers, health care providers, and the public. Examples listed in the Report focused on education campaigns that shared information about racial and ethnic health inequities with these groups. While the Report did not define "awareness," given the examples provided, we will take it to mean an increased

knowledge that something is happening or exists. This prioritization makes sense since a society cannot work together to address a problem if people do not acknowledge that a problem exists. However, this approach assumes that with increased access to information, increased awareness of inequities and actions to address them will follow. Our review suggests that building awareness of inequities is more complex.

Discussion of racial health inequities and societal forces like racism have increased over the last several decades, particularly in the last three to five years. A ProQuest search of the terms "health disparity" and "race" in newspapers produced 5,381 results between 1990–2023 and demonstrated an increase over time (1990–1999: 128; 2000–2010: 1,248; 2010–2019: 1,504; 2020–2023: 2,501). In one analysis of popular news outlets, there is a clear increase in the use of words related to racial inequities and structural racism since the 2010s.[21] There has also been an increase in scientific output on health inequities and research on structural racism (Cash-Gibson et al. 2018; Bouchard et al. 2015; Dean and Thorpe 2022). One article demonstrated that after 1990, the number of scientific papers on health inequities doubled every four years (Bouchard et al. 2015). Another study showed that as of the end of 2021, there had been a 50-fold increase in published papers investigating structural racism in the previous five years (Dean and Thorpe 2022).

Despite this increase in media and scholarship on racial and ethnic health inequities, available evidence suggests that awareness has increased only modestly among the general population. One large nationally representative study conducted in 1999 found that most respondents were unaware of several specific and persistent health inequities between groups (Lillie-Blanton et al. 2000). A study in 2010 found only small increases in awareness of these inequities, from 55 percent overall in 1999 to 59 percent in 2010 (Benz et al. 2011). More recent studies have found similarly low levels of awareness in the general population (Gollust et al. 2020; 2022).[22] It appears that a marked increase in publicly available information on racial and ethnic inequities since the report's publication has not led to a marked increase in awareness of racial and ethnic inequities among the general public.

Data on awareness among health professionals is lacking, with available literature limited by small sample sizes, a focus on physicians, and a concentration on specific specialty areas. Available literature suggests that levels of awareness have grown among health providers since the turn of the century but may still be lower among some provider communities. One national survey of physicians conducted in 2001 demonstrated that 29 percent felt that the health care system "often" or "somewhat often" treated patients differently based on racial or ethnic background compared with 47 percent of the public (KFF 2002). In studies since, respondents tend to endorse racial and ethnic inequities in care at higher levels in certain specialties compared with others. For example, some studies evaluating primary

care providers suggest high awareness of racial and ethnic inequities in health and health care within this population, ranging from 83 to 89 percent (Kendrick et al. 2015; Sequist et al. 2008; Taylor et al. 2019). These levels tend to be higher than reported levels in studies done among cardiologists (Lurie et al. 2005), orthopedic surgeons (Adelani and O'Connor 2017), and general surgeons (Britton et al. 2016), although these also tend to be higher overall when compared to the national survey in 2001, with rates ranging from 30 to 68 percent among these groups.

There is less data detailing levels of awareness for health professionals currently in training or recently graduated from training, but available literature suggests that awareness in this group may be higher than in previous generations (Britton et al. 2016; Sotto-Santiago et al. 2022). Many health professions accreditation bodies have included curriculum standards that mandate teaching on health disparities, social determinants of health, and health equity (AOA 2023; CNEA 2021).[23] Taken together, data is lacking detailing whether health professionals have an increased awareness of health disparities compared with previous generations, however, several trends suggest increased exposure to and awareness of these topics among trainees over the last five to seven years.

While there appears to be some progress in awareness of disparities among the public and even more among current and recent health professions trainees, there are still large numbers of people that may not be aware of racial and ethnic health inequities despite increased media representation, scholarship, and curricular content dedicated to this topic. Why hasn't there been more progress? While multifactorial, who we are may help to explain the gaps in awareness. First, racial and ethnic minoritized groups, women, liberals, and Democrats seem to be more aware of racial and ethnic inequities (Britton et al. 2016; Booske, Robert, and Rohan 2011). How we are presented information, may also shape how we respond. There are several examples of how common framing techniques used when discussing health inequities may result in responses that are not aligned with the goals of many in the public health space. For example, news stories that directly compare health outcomes between different racial and ethnic groups may cause people in the "less at-risk" group to underestimate their risk and make them less likely to engage in relevant mitigation strategies (Gollust, Franklin Fowler, and Niederdeppe 2019). Studies have also shown that news outlets emphasize behavioral causes of health disparities rather than systemic or structural drivers and use episodic framing—a technique that emphasizes specific events and individual cases—rather than discuss broader social trends. This can lead people to blame the inequities experienced on the individuals experiencing them rather than understanding them as social problems, undermining support for governmental intervention (Gollust, Franklin Fowler, and Niederdeppe 2019).

The framing of racism within narratives as well as healthcare providers' underlying beliefs about the cause of disparities may also influence acceptance or resistance to discourse on racial and ethnic inequities in health. One study interviewed providers and explored their responses to different framings of health disparities (Burgess et al. 2019). They stratified providers by whether they felt that provider behavior contributed heavily (high provider attribution) or in a minor way (low provider attribution) to racial and ethnic inequities in care and exposed them to different narratives. The authors found that regardless of whether participants had low or high provider attribution, they all accepted stories where the provider helped overcome an issue linked to racism. However, narratives where problems were not resolved were met with significant resistance among low provider attribution participants and acceptance from high provider attribution participants. This suggests that, like the studies above, the framing used to present information on inequities may influence how this information is interpreted (Burgess et al. 2019). Additionally, the difference in acceptance due to underlying causal attribution may align with literature in the general public demonstrating how ideology shapes responses to different frames of healthcare inequity (Burgess et al. 2019).

Overall, it appears that increased exposure to racial and ethnic inequities in health alone may not increase awareness significantly or result in responses that align with the goals of public health practitioners. Available literature on communication of health inequities, awareness of cultural narratives and beliefs related to health (i.e., individual/personal responsibility), and framing of messages about racial and ethnic health inequities are important considerations that may help improve efforts to both increase awareness and motivation to address health disparities among the public and healthcare professionals.

To Address Bias, Include Structural and Individual Approaches

One of the commissioned papers in the Report by Dr. Jack Geiger, "Racial and Ethnic Disparities in Diagnosis and Treatment: A Review of the Evidence and a Consideration of Causes," demonstrated a consistent pattern of racial and ethnic differences in diagnosis and treatment across clinical specialties, with white patients being more likely to receive higher-quality care than patients of other racial and ethnic backgrounds, even after accounting for access to care. He asserted that "provider and institutional bias are significant contributors" to these inequities in care (Institute of Medicine 2003). When discussing what the implications of this assertion were for making change, he stated that while the major determinants of these inequities are lack of access to care and differences in social opportunities due to racism, "compared to those deeply entrenched causes, provider and institutional bias are far more directly (though not easily) remediable and represent an opportunity for more rapid

change." Unsurprisingly, since the Report's publication, there has been significant attention to better understanding how bias operates and how it contributes to differential treatment, as there were no studies directly linking provider bias to patient care at the time. There has been great progress in understanding the prevalence and mechanisms of implicit bias in health care. However, efforts to address its negative effects have fallen short. Below, we review progress in understanding implicit bias and investigate why there has been less progress in addressing its negative effects in health care spaces.

Available science has expanded our understanding of implicit bias as something that is deeply embedded in the brain, with studies revealing that noninvasive brain stimulation and the use of beta blockers can reduce implicit bias (Phelps et al. 2000; Marini, Banaji, and Pascual-Leone 2018; Terbeck et al. 2012). Unsurprisingly, health care providers, providers in training, and health care staff are not immune to implicit bias, with several recent studies demonstrating rates of implicit biases in favor of white individuals and against other racial and ethnic groups, similar to those in the lay population (Hall et al. 2015). Furthermore, the effects of bias on provider-patient interaction can lead to lower quality of care for minoritized racial and ethnic groups (Hall et al. 2015; Blair et al. 2014; Penner et al. 2010). For example, Cooper et al. (2012) found that provider-held implicit bias was associated with the quality of the patient-provider interaction, including more clinician verbal dominance and less patient-centered communication when reviewing recordings of patient visits. They also demonstrated that patients have lower trust, confidence, and satisfaction with physicians with higher levels of implicit bias (Cooper et al. 2012). Recognizing this, many health care institutions have begun implementing anti-bias trainings, with some states even requiring it for some health professionals to remain licensed (Cooper, Saha, and van Ryn 2022).

Research has demonstrated that many environmental factors are associated with the activation or reduction of implicit bias. Decisionmakers in environments and situations that increase cognitive load common in the provision of health care (i.e., fatigue, excessive workload, inadequate staffing, time pressure) may have an increased likelihood of bias activation (Burgess 2010). For instance, one study showed an association between emergency department shift overcrowding and increased patient load with increased pro-white bias scores after their shift (Johnson et al. 2016). There have also been studies demonstrating that several features of the medical school training environment were associated with a reduction in implicit bias, including favorable intergroup contact, formal curricula on disparities in health, cultural humility or the health of minoritized populations, and informal curricula including racial climate and role model behavior (van Ryn et al. 2015; Onyeador et al. 2020). Changes to the health professions' work and learning environments that alleviate these factors could be effective strategies to minimize the opportunity for implicit bias to negatively impact care.

If we understand how implicit bias negatively impacts patient care and how environments can be built to minimize bias activation during clinical encounters, why has there not been more progress in addressing implicit bias and its negative effects on care quality? We suggest that a primary reason is that implementation is dominated by implicit bias training focused on increasing individuals' awareness of their and others' bias as the primary approach at the expense of a multipronged strategy that addresses structural drivers of bias in health care.

Despite overwhelming evidence that implicit bias trainings do not effectively reduce bias (Vela et al. 2022; Dobbin and Kalev 2018), it remains one of the most common actions organizational leaderships take to address this issue. Many of these educational interventions seek to reduce or eliminate peoples' biases by raising their awareness of them. However, as demonstrated earlier, awareness alone is unlikely to resolve racial health inequities. Moreover, biases are stubborn, deeply embedded, and reinforced, perhaps calling for interventions that help people manage them by practicing strategies to counter deeply ingrained, routine reactions, and building environments that prevent their activation. Training focused solely on increasing awareness is unlikely to yield substantial and sustained impact without a deliberate, thoughtful, and coordinated effort to address the many structural drivers of implicit bias and inequity embedded within organizations and environments. At the individual level, the most effective trainings are evidence-based, action-oriented, multi-session, and intensive, requiring practice over time (Devine et al. 2012). Such interventions are more likely to be effective when accompanied by protocols to identify and mitigate bias, institutional prioritization with appropriate resource allocation, and accountability systems to meet measurable and time-sensitive goals (Mateo and Williams 2020b). Without the buy-in and commitment of institutional leaders to create the environmental conditions that will help to reduce bias on an institutional scale (e.g., increased diversity, more time with patients, better staffing, less administrative burden, longitudinal anti-bias training), it is unlikely that implicit bias and its effects on patient care will be reduced. In addition, training should be tailored to different clinical areas and populations, qualifications should be established for trainers, and research should focus on advancing the evidence base on effective elements of implicit bias training during implementation (Cooper et al. 2022).

Improving Representation Requires Sustained Efforts to Achieve Critical Diversity

The Report recommended increasing the proportion of racial and ethnic underrepresented groups in the health professions because of a host of benefits associated with improved diversity. Because of many groups' advocacy, there were already several pieces of bipartisan legislation at the time of the Report's release that included provisions for increasing racial and ethnic minoritized groups in the

health professions. The focus on this recommendation likely stemmed from the political will that had already formed behind it before the Report's release (Ready 2001). Since then, progress has taken the form of standards— primarily in training, promoting diversity in recruitment, and making institutional commitments to diversity. However, for all the major underrepresented racial and ethnic groups, there has not been substantial change in representation. We posit this lack of progress can be attributed to a lack of sustained multilevel efforts to achieve critical diversity within health care organizations and to address structural causes of underrepresentation. The situation may worsen, given the current polarization around affirmative action.

Over the last 20 years, medical education and professional organizations have contributed to efforts toward improving diversity across the field by issuing various standards, guides, and normative statements. In 2009, the Liaison Committee on Medical Education introduced several diversity standards, including Standard 3.3, which requires medical schools to have effective policies and practices to achieve mission-appropriate diversity outcomes among students, faculty, and staff. This includes using mission statements, having pathway programs for underrepresented groups, and demonstrating evidence of the effectiveness of stated efforts.[24] Other accreditation bodies have followed suit, including the Accreditation Council for Graduate Medical Education in 2019 (McDade 2019) and the Accreditation Review Commission on Education for the Physician Assistant in 2020 (ARC-PA 2019). Many health profession societies and leadership organizations have also asserted their commitment to improving representation among health professionals as a part of their mission.

Several studies have reviewed the trends in diversity and representation throughout the health professions and found little or even backward progress. One longitudinal study of faculty in clinical academic medicine from 1990 to 2016 across 147 allopathic medical schools and 16 specialties showed that Black and Hispanic faculty were growing more underrepresented over time across most specialties analyzed (Lett, Orji, and Sebro 2018). Another study reviewing racial and ethnic representation across 18 clinical departments from 1977 to 2019 found that while the number of faculty who identified as members of underrepresented racial and ethnic groups across ranks increased in absolute terms, representation when compared with the US population has decreased over time (Kamran et al. 2022). These patterns also hold true among other health care professions (Cain et al. 2022).

Trends in the health professions training pathway mirror those in the workforce. One study of new graduates entering the 10 largest health diagnosing and treating occupations found that American Indian or Alaska Native, Black, and Hispanic graduates were underrepresented across all occupations studied compared with the overall working age population of the US during the study period (Salsberg et al. 2021). American Indian or Alaska Native, Black, and Hispanic individuals were similarly and

consistently underrepresented among medical student applicants and matriculants from 2002 to 2017 (Lett et al. 2019), and there was no significant increase in underrepresented applicants or matriculants to US surgical residencies from 2010 to 2018 (Nieblas-Bedolla et al. 2020).

While there has been increased attention to and discussion of increasing diversity within the health professions, the trends above demonstrate a persistent lack of representation for many groups. There is often a disconnect between the mission statements and institutional diversity initiatives and meaningful, measurable improvements in representation. Scholars have proposed that this uncoupling functions to maintain rather than address underrepresentation (Collins 2011). One hypothesis is that these improvements have not manifested because of a lack of critical diversity as a guiding approach within health care organizations (Herring and Henderson 2012). Critical diversity is an approach to improving representation in an organization that attends to the historical and contemporary experiences of exclusion and discrimination different groups face. It emphasizes the need for parity and equity throughout all levels of the organization and pushes back against all too common and ineffective approaches to diversity, including colorblind diversity (where there is attention to cultural differences without any work to meaningfully change underrepresentation) and segregated diversity (where the diversity of the organization increases, but representation among leadership positions remains largely made up of overrepresented groups) (Herring and Henderson 2012). Additionally, studies suggest that critical diversity is associated with positive outcomes; for example, one study demonstrated that those departments with evidence of critical diversity had higher overall rankings of academic programs (Henderson and Herring 2013). Thankfully, many strategies can help to achieve meaningful improvements in representation, including prioritization (i.e., sustained resource allocation, leadership buy-in, institutional messaging), assigning responsibility to individuals or groups to meet set goals, implementing programs that help to recruit and support underrepresented groups (e.g., pathway programs), structuring recruitment efforts to mitigate the negative effects of bias, and incentivizing success (Mateo and Williams 2020b; Ayedun et al. 2023; Mabeza et al. 2023).

In addition to institutional efforts, effectively addressing the underrepresentation of historically excluded populations of color in the health professions will require major new commitments to dismantle the upstream mechanisms of racism that limit opportunities for these communities to enter the pathway to the field. Residential segregation by race in the US is one of these primary mechanisms (Williams and Collins 2001). In our discussion of residential segregation, we are referring to racial segregation that is a result of discriminatory public and private policies. These policies historically determined where families could live based on their race and are strongly related to areas of concentrated poverty today, in which schools are significantly underresourced (Allegretto, García, and

Weiss 2022). Recently, Acevedo-Garcia et al. (2020) created a childhood opportunity index, ranging from 1 (lowest opportunity) to 100 (highest opportunity), consisting of 29 different indicators of access to opportunities for children, such as the quality of elementary schools, high school graduation rates, median household incomes, homeownership rates, and environmental quality. They found that in the 100 largest metropolitan areas in the US, the child opportunity score of the neighborhood where a child typically lives was 24 for Black children, 33 for Hispanic children, and 37 for American Indian and Alaska Native children compared with above 70 for white and Asian children. They also found that 67 percent of all Black children and 58 percent of all Hispanic children resided in very low- or low-opportunity neighborhoods, compared with about one in five white and Asian children (Acevedo-Garcia, Noelke, and McArdle 2020).

Other research indicates that segregation is the central driver of racial and ethnic differences in income and educational attainment. Higher residential segregation is associated with negative educational and employment outcomes among US-born Latino and African American young adults (De la Roca, Gould Ellen, and Steil 2018). One large national study, using data from the US Census, compared economic outcomes for both Black and white children, controlling for their parents' income. It found that in 99 percent of census tracts in America, Black boys have lower earnings than white boys even when their parents' household income was the same (Chetty et al. 2019). These lower earnings were driven by racial differences in opportunity at the neighborhood level. It is the legacy of residential segregation and resultant neighborhood disinvestment that drives differential outcomes for these communities. To adequately address the underrepresentation of underrepresented groups in the health professions will require our society to implement strategies that will seek to "create communities of opportunity" to minimize, neutralize, and dismantle the systems of racism that create inequities (Williams and Cooper 2019). This will entail enriching the quality of neighborhood environments, including increasing economic development in low-opportunity areas, improving housing quality, and focusing on youth development from early childhood to young adulthood. The good news is that strategies to accomplish these goals exist; what is needed is the political will to implement them (Williams and Cooper 2019).

A movement to reduce racial and ethnic underrepresentation in the health professions must also contend with the cultural milieu within which efforts at improvement exist. It will be difficult to address this issue without acknowledging social, cultural, and political factions that push back on whether lack of representation is a problem and what should be done about it. Most notable are attacks on affirmative action, a policy that has helped to improve the diversity of the health professions workforce for decades (Ready 2001). These attacks include several statewide bans since the 1990s and have

recently culminated in the most recent Supreme Court cases, *Students for Fair Admissions v. Harvard* (2023) and *Students for Fair Admissions v. University of North Carolina* (2023), where the court held that race-based affirmative action programs in college admissions violated the Equal Protection Clause of the 14th amendment. While it is unclear what the effect of the latest Supreme Court ruling will be on admissions to health professions programs, available data suggest that affirmative action bans are associated with a decrease in representation and have a chilling effect on diversity efforts (Ly et al. 2022; Ko et al. 2023). Notably, several prominent health professions groups have denounced the decision and made clear the importance of considering race and ethnicity in admissions to foster a diverse health professions workforce.[25] In a time where increased representation is a key part of addressing the nation's health, efforts to advance equity in this space will need to consider these broader forces.

Current State of Racial and Ethnic Inequities in Health Care

Given the barriers to progress in implementing the Report's recommendations, it is perhaps unsurprising that the immediate outcomes of the past 20 years of efforts have been mixed overall. In 2016, Fiscella and Sanders analyzed the Agency for Healthcare Research and Quality's National Healthcare Quality and Disparities Reports spanning decades to assess the degree of change since its initial release in 2002 (Fiscella and Sanders 2016). They found that while there were improvements in screening guidance (e.g., breast cancer, colorectal cancer) and testing (e.g., diabetes, glaucoma), there remained continued disparities in several measures, such as access to care (e.g., requesting appointments, specialty care). Similarly, a review of data from 2010 to 2018 found an improvement in care among all racial and ethnic groups and some narrowing, but generally persistent, inequities (AHRQ 2021).

Additionally, several studies continue to find racial and ethnic inequities in the quality of care for several disease processes. Enzinger et al. (2023) found that in a 2023 study of 318,549 Medicare patients, Black and Hispanic patients with advanced cancer were less likely than white patients to receive opioid medications for pain management during their final weeks of life. Additionally, when opioids were prescribed to Black and Hispanic patients, they tended to receive lower doses. The study also found that Black patients were more likely to undergo urine drug screening.

Similarly, a 2022 study identified several inequities in the quality of care provided to American Indian and Alaska Native patients when compared with non-Hispanic white beneficiaries enrolled in Medicare Advantage plans (Martino et al. 2022). While the study's results demonstrated higher rates of breast cancer screening and management of rheumatoid arthritis, it found significant disparities in pharmacotherapy for diabetes care and chronic obstructive pulmonary disease. Also, several measures were related to avoiding the overuse of opioids and high-risk drugs in elderly patients. Among these measures, American Indian and Alaska Native populations appeared to fare better overall. However, as the authors noted, this may be related to more limited prescribing overall to this population because of bias or stereotyping. In each of these studies, observed inequities were present despite patients having access to care, indicating that inequities were related to processes occurring within the health care institution, not outside of it. Overall, there is a continuing and urgent need for targeted interventions to eliminate these treatment gaps. Some of these health care disparities, for example those pertaining to opioid use, hint at the complex ways the health care system's practices and norms are affected by broader societal norms and stereotypes. Understanding why progress toward achieving health equity has been minimal requires engaging with this context.

Sociopolitical Context: Now

Health care is a microcosm of society, a "structural echo" (Brown 2017). The patterns we have seen playing out in the 20 years since the release of the Report resemble and connect to those rippling through our social and political institutions. We can understand the limited implementation of the Report's recommendations and the persistence of the health care inequities they seek to address partly in terms of the current social and political context surrounding the pursuit of racial equity and social justice. That context is one of some progress, an abundance of spinning wheels, and significant resistance and political backlash. As explained below, profound polarization separates those who recognize the validity of structural racism as a fundamental cause of inequity and those who deny that racism is a modern-day issue, all while overt racism moves increasingly into the mainstream.

Grassroots Energy Has Driven Progress toward Racial Justice, but Efforts Often Fall Short

Naming racism as a driver of racial and ethnic health disparities is a critical step in addressing them (Jones 2018). There has been progress in the acknowledgment and discussion of racism as a fundamental driver of racial and ethnic inequities in society at large, and in health care specifically, over

the last three to four years across mainstream media, among policymakers, and within health care institutions. This awareness includes that racism is a structural issue encompassing the individual but not limited to the interpersonal and that we must act through policy and other structural reform. For example, from May 1 to September 30, 2020, 2021, and 2022, news media published 195,536 articles on racial equity and related issues (Garcia et al. 2023). Much of that coverage focused on unprecedented levels of civic action in the name of racial justice. An estimated 15 million to 26 million people in the US, or 6–10 percent of the population, were reported to have participated in demonstrations after George Floyd was killed at the hands of police, leading some to call Black Lives Matter the largest movement in US history.[26] This grassroots energy extended into the health care field, with many health care providers and organizations joining in demonstrations and medical students creating a separate organization, White Coats for Black Lives.[27] The widespread activism speaks to a likely increase in awareness of both racial and ethnic inequities in care and racism as a root cause of those inequities among many health care providers—particularly those in training or recently entering the workforce over the last few years.

Grassroots energy has also spurred policymaking in the name of racial equity. For example, several cities and states have created publicly facing commissions to explicitly study the impacts of systemic racism and make recommendations.[28] Subnational stirrings have maintained momentum for a national bill, H.R. 40, to establish the Commission to Study and Develop Reparation Proposals for African Americans.[29] Federal, state, and local policymakers have developed equity agendas (Balu et al. 2023).[30] We are seeing some signs of progress here as well. For instance, following the killing of George Floyd, states passed over 140 new police oversight and reform laws (Subramanian and Arzy 2021).[31] President Joe Biden stated in his election speech that "to achieve racial justice and root out systemic racism in this country" is one of the great battles of our time.[32] In his inaugural address, he stated that the "sting of systemic racism" is part of an "attack on democracy and truth," and on his first day in office, he signed an executive order on advancing racial equity (Biden 2021).[33]

The private sector has also joined in pursuing racial equity, a sign that this movement has shifted into the mainstream and has started to impact profits. People increasingly report that companies', brands', and employers' action (or inaction) on racial equity informs their spending habits (Edelman 2023). Companies have continuously invested in diversity, equity, and inclusion in the workplace and community.[34] JP Morgan committed $30 billion to addressing systemic racism in the banking system.[35]

However, while discussions of racism and its acknowledgment in the public sphere have increased over the last few years, we see familiar limitations of these efforts that echo limitations of the previous 20 years: where the capacity and will to make decisions that fundamentally reallocate resources, power,

and privilege at the structural level have been inadequate and where programs are insufficient in the face of durable norms and policies that remain primarily untouched. In some instances, actions taken land somewhere closer to appeasement than transformation. Unfortunately, this increase in attention is showing signs of waning. Researchers studied a sample of nearly 200,000 articles on racial equity across three years and found that the volume of coverage in 2020—the year of George Floyd's death—was three to four times higher compared with 2021 and 2022 (Garcia et al. 2023). After a groundswell of giving in the name of racial justice in 2019 and 2020, nonprofits have also witnessed a substantial subsequent decline in private foundation support.[36]

Backlash to Racial Equity Is Extreme and Increasingly in the Mainstream

The decline in mainstream attention to racial justice, while likely attributable to societal inertia, may also be because of the profound backlash we have recently seen, primarily from the far-right conservative movement. This movement places race at the heart of a culture war targeting anti-"woke" topics and programs, including critical race theory; affirmative action; and diversity, equity, and inclusion programs (Rufo 2023). Many pinpoint the election of Barack Obama as an important milestone that brought racism closer to the surface. In 2016, one-third of white Americans surveyed indicated that they were troubled by having a Black president, and his election led to a decrease in positive public opinion of the Democratic Party (Parker 2016). This unease became (or perhaps always was) resentment. Racial resentment festered on the internet and social media. The Southern Poverty Law Center documented a "stunning" spike in hate groups and hate-related incidents in 2014 (Potok 2014). This occurred while some studies suggested that perceptions of anti-Black racial discrimination declined and beliefs that America had achieved "postracial" status increased. In a survey of Americans before and after the election of President Obama, about one in four respondents revised their perceptions of discrimination downward and were less supportive of affirmative action and immigration (Valentino and Brader 2011).

Racial resentment, threat, and animosity helped fuel the Tea Party movement (Willer, Feinberg, and Wetts 2016). The Tea Party movement opposed government spending, taxation, and regulation partly because of the underlying view that the government unfairly rewards the undeserving, from immigrants to participants in social programs like Medicaid, Medicare, and Social Security (Haltinner and Sarathchandra 2017).[37] While the Tea Party movement has largely dissolved, it left its mark on the Republican Party, with several of its ideas and policies making it to the mainstream. It also paved the way for the alt-right movement. This movement is overtly white nationalist, and while made up of a set of far-right ideologies, at the core is that "white identity" is under attack by many multicultural forces.[38]

One study found that affiliation with the alt-right movement was associated with "white victim ideology" (Boehme and Isom Scott 2020).

There are unfortunate signs that the messages of this movement are penetrating: a national survey found that white respondents thought anti-white bias was more common than anti-Black bias (Norton and Sommers 2011). Similarly, a 2021 Pew Research Center survey found that 17 percent of Republican and Republican-leaning Americans said there is "a lot" of discrimination against Black people compared with 26 percent reporting "a lot" of discrimination against white people.[39] Finally, a common reaction to increased discussions of racism, particularly in its structural forms, is racism denial, which is associated with anti-Black prejudice and beliefs that justify racial inequality (Yi et al. 2022).

The mainstreaming of overt racism, growth in perceptions of white victimhood, and the denial of systemic racism all serve as examples of backlash to the increased discourse on racism in the US over the last few years and are substantial barriers to effectively addressing racial and ethnic inequities throughout society, including in health care.

Backlash and Polarization Surrounding Racial Equity in Health Care

Opposition to the concept of structural racism and the growth of the ideologies described above have impacted an array of systems and institutions, and health care is no exception. Echoing critiques following the release of the Report, some today argue that unfair treatment in health care is a myth and a dangerous distraction. Critics, including a vocal minority from within medicine, argue that health care is being profoundly damaged by the radical and divisive belief that health care is systemically racist. In this view, prominent medical journals and associations are compliant in the crusade against medical professionals, medical schools are preparing doctors for social activism at the expense of medical science, and doctors are being pushed to discriminate by providing preferential care based on race.[40] While many in health care, including health care leadership, vehemently disagree with these assertions,[41] they have gotten traction in certain policymaking arenas. For instance, Republican lawmakers in at least a dozen states have filed more than 30 bills in 2023 banning diversity, equity, and inclusion programs in higher education, including some targeting medical education specifically.[42]

Importantly, this backlash may reflect the perception that much social progress has been made in racial justice. Backlash is often paired with progress or perception of progress, particularly progress that occurs quickly. Discussions of structural racism and equity are now common themes in the mainstream political discourse. This is a crucial first step, but the resultant social context has created

new challenges that may undermine or derail our efforts to address inequities. The question remains: what can we do to push through this backlash and continue toward racial equity?

Focusing on the How: Process Matters in the Pursuit of Equitable Outcomes

Two decades ago, the Report issued 21 recommendations across multiple domains. Those recommendations remain highly relevant, if incomplete: a cogent list of *what* must be done. In this paper, we have reflected on the sociopolitical context surrounding these recommendations and efforts to implement them, both at the time of the Report's release and today. Reflection on this context has led us to cross-cutting suggestions of *how* to pursue these recommendations that may amplify future success.

Focus on Communication

As discussed above, in building awareness of health care inequities, simply sharing knowledge about inequities is not enough to grow understanding of the issue. At the same time, assuming a lack of awareness alone explains the lack of equity-oriented action appears overly simplistic. The status quo is, in many ways, comfortable and reinforced by cultural norms and common narratives within society. In the US, these narratives emphasize individualism and personal responsibility for one's health and are continually reinforced within US public health communication and policy, potentially decreasing support of social policies to address health (Hook and Rose Marcus 2020). When it comes to how individuals conceptualize racism and other societal forces that lead to inequity, many hold a narrative that racism has largely improved after the Civil Rights era and that racism is an individual or interpersonal issue rather than one that is systemic (NASEM 2016). Additionally, much of the conversation regarding racial and ethnic inequities has become significantly polarized, with many terms like equity and social determinants of health triggering negative emotions and resistance narratives among some US communities.

Strategies to increase awareness and motivation to address racial and ethnic inequities will require communication strategies that help to create awareness and acknowledgment of racial inequities. One group that has developed many such strategies is the FrameWorks Institute, a nonprofit that conducts communications research to better understand different frames and their effect on resistance or acceptance of different policy proposals or communications on social issues. They have developed

several strategies to guide individuals in discussing racial and ethnic inequities and social determinants of health to improve effective communication on the part of public health and other professionals (NASEM 2016).[43] These strategies could increase awareness of racial and ethnic inequities in health care and allow individuals to see them as a problem that can be solved through collective action. Additional research that includes collaboration with colleagues in political science and related fields may provide significant insight into how best to increase awareness of and spark action on racial and ethnic inequities in health care and other areas.

Change Must Include Structural Approaches

As mentioned in the Report, providers, administrators, and laypeople that embody the health care system are perhaps the most direct avenue of positive change. As demonstrated through our earlier review of interventions to address implicit bias and diversify the workforce, efforts to improve health care inequities must include holistic structural (e.g., policies, incentives, protocols, etc.) modifications that encourage desired behaviors and outcomes through sustained and appropriate resource allocation. While there has been an increase in the collective understanding of how inequities in care arise through factors like implicit bias, systemic racism, and lack of workforce representation, there has been an absence of sustained large-scale successful efforts in addressing these inequities. Although research shows that coupling evidence-based practices targeting individual-level and structural causes can improve results, the most common pattern of programs addressing these issues is short-lived, narrow in scope, and often falls victim to lack of funding over time.

It is less resource-intensive to create a short course addressing implicit bias than it is for an organization to modify its work or learning environment to decrease the likelihood of bias (e.g., increase time with patients, decrease administrative burden, increase staffing). For example, increased provider awareness of implicit bias can result in positive behavior change that prevents inequities in the provision of care (Burgess et al. 2007). However, interventions on an individual level are necessary but insufficient, missing an opportunity to address the conditions leading to bias activation. It is imperative to consider the root causes of bias, like racism, and structural drivers of implicit bias activation, including factors in healthcare environments, to better construct interventions to mitigate bias (Vela et al. 2022). Using a more holistic framework to address the role of bias in health care provisions may lead to more successful results. Interventions can work to achieve critical diversity in the health care workforce by both supporting underrepresented individuals in the profession and addressing structural barriers that may lead to inequity on the path to becoming a health professional.

Name Racism When Addressing Racial and Ethnic Inequities in Care

There is significant power in naming racism when addressing inequities in health care (Jones 2018). Evidence suggests that racism is a force that negatively impacts health and serves as a barrier to health care practitioners effectively performing their responsibilities (Mateo and Williams 2020a). Racism has been defined as a negative force that hurts society as a whole. By effectively stopping some members of society from accessing opportunities to thrive, society is robbed of the opportunity to thrive because not all members can contribute to their full potential (Jones 2018). Once racism is understood as a phenomenon that hurts everyone, a door can open to creatively theorize, design, and apply solutions to eliminate racial and ethnic inequities that build on the literature of the last 20 years. It allows practitioners to move beyond documenting inequities to designing interventions that get to the heart of the matter. Importantly, when evaluating systems that may perpetuate inequities and designing them to better serve marginalized communities, resultant improvements can benefit everyone through the establishment of a more efficient and effective system for all. Despite this, health care literature has not historically named racism as a core driver of racial and ethnic health inequities (Iheduru-Anderson, Revis Shingles, and Akanegbu2021; Hardeman et al. 2018).

Researchers should name racism explicitly when investigating racial and ethnic health inequities. There has been increased attention to naming racism in health research. For example, Eberly et al. (2019) performed a retrospective cohort study at a large urban academic referral center informed by Public Health Critical Race Praxis (Ford and Airhihenbuwa 2010) that revealed that Black and Latinx patients were less likely to be admitted to cardiology for heart failure care, indicating the ongoing need for interventions to address these inequities in access to specialized care. This study led to the Healing ARC (Acknowledgement, Redress, and Closure) intervention targeting racism in care currently in place at Brigham and Women's Hospital and the University of Virginia Medical Center (Wispelwey et al. 2022). This race-conscious pilot program centers on reparative justice principles and is designed to help support providers and institutions eliminate inequities in their organizations through clinical decision tools. By focusing on a process that centers on principles of racial equity from the start, this intervention may very well lead to the outcomes the Report had been striving for.

Organize and Strategize to Act

In Dr. Camara Jones' National Campaign to Address Racism, she describes three steps to follow: Name racism, ask how racism is operating, and organize and strategize to act (Jones 2018). In the public health research space over the last 20 years, there has been significant progress in naming racism and

investigating how racism operates to affect health. Several studies have demonstrated how pervasive and insidious racism is and the many mechanisms through which it shapes our opportunities to achieve well-being (Williams et al. 2019; Hardeman et al. 2022). The research field must consider how best to organize and strategize to act to keep moving forward. For example, public health research should continue to break silos and forge alliances to work towards improved health outcomes for all. Researchers can focus on shifting from documenting racism to disrupting it through partnerships with different disciplines (e.g., journalists, sociologists, political scientists, psychologists, civil rights advocates, lawyers) and with communities most affected by historical and contemporary racism. Funders can consider how to incentivize this work and break down barriers within the public health research development process that may detract or dissuade researchers from pursuing these endeavors. For example, while there has been significant focus on creating education on racism, bias, and discrimination and its impact on health, there is very little funding that supports the creation and evaluation of educational interventions. Increased funding to better understand best practices in creating and evaluating educational interventions could incentivize more work in this space.

We must also recognize that to improve quality of care, we must improve the quality of contexts in which people live. Before individuals enter a clinic, inequalities are just as, if not more, detrimental to health than those we categorize as "within" health care spaces. To address structural racism, we must also address other interlocking systems of oppression that work to reinforce it. This includes addressing economic deprivation as a central driver of inequitable outcomes for many racial and ethnic groups. One such intervention is the Rush University Medical Center health equity framework, which has named structural racism and economic deprivation as root causes for racial health inequities in its community and has created a multipronged strategy that aims to eliminate racial inequities in life expectancy (Ansell et al. 2021). This approach names root causes, partners with communities, and is informed by an understanding of how racism operates, holding promise in changing outcomes for the better.

Conclusion

The Unequal Treatment Report documented a major challenge in US health care some 20 years ago that leads to poorer quality care and premature death for many in the US each year. Its impact has been sizable, sparking conversation and fueling efforts to improve racial and ethnic inequities in health since its publication, but challenges remain. Throughout this paper, we have reviewed the sociopolitical context at the time of the Report's release and today, highlighted challenges, and provided examples of

progress. The current pushback against racial justice and other social justice efforts in the health professions, and more broadly, is not new. Our understanding of the sociopolitical forces that enable that pushback is evolving. Our grasp of what drives racial and ethnic inequities has improved, and our collection of promising strategies and innovative interventions grows larger and stronger every day. With that knowledge comes opportunity—an opportunity to take individual and collective steps to ensure a health care system that treats all individuals fairly, regardless of background. The data on inequities can be overwhelming, as can accompanying discussions of systemic oppression. However, what is a system if not a collection of actions and norms built by people? Like anything that is built, it can be dismantled and built anew. By better understanding the sociopolitical context in which these systems operate, we gain a window into potential strategies and interventions to eliminate these inequities. Now, we must work together, open that window, and systematically dismantle racism in all its forms.

Notes

[1] Louis W. Sullivan, "The Heckler Report: Reflecting on Its Beginnings and 30 Years of Progress," HHS Office of Minority Health, May 21, 2015, https://minorityhealth.hhs.gov/news/heckler-report-reflecting-its-beginnings-and-30-years-progress.

[2] Sullivan, "The Heckler Report: Reflecting on Its Beginnings and 30 Years of Progress."

[3] Sullivan, "The Heckler Report."

[4] "U.S. Blacks Die Younger than Whites," *Detroit Free Press*, October 17, 1985:6.

[5] "Death Stalks America's Minorities," *The Wichita Eagle*, October 21, 1985:2.

[6] "U.S. Blacks Die Younger than Whites."

[7] The Dallas Morning News, "Doctors Debate Study That Says Racism May Kill Some Patients," *The Courier*, June 3, 1999.

[8] The Dallas Morning News, "Doctors Debate Study That Says Racism May Kill Some Patients."

[9] U.S. Congress, House, *Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Bill* 106th Cong., 1st sess., 2000, H. Rept. 106–370, http://www.congress.gov/congressional-report/106th-congress/house-report/370/1.

[10] Sheryl Gay Stolberg, "Race Gap Seen in Health Care Of Equally Insured Patients," *The New York Times*, March 21, 2002, https://www.nytimes.com/2002/03/21/us/race-gap-seen-in-health-care-of-equally-insured-patients.html; Ceci Connolly, "Report Says Minorities Get Lower-Quality Health Care," The Washington Post, March 21, 2002, https://www.washingtonpost.com/archive/politics/2002/03/21/report-says-minorities-get-lower-quality-health-care/8ebedd8e-8886-4aae-9776-6dee9d5023b9/; B. Lamendola, "Study: Health Services Unequal. Blacks, Hispanics Get Lower-Quality Care than Whites," South Florida Sun Sentinel, March 21, 2002; and V. Griffith, "Health Care 'Has Racial Bias,'" Financial Times, March 21, 2002: 13.

[11] V. Lee and L.J.A. Staff, "Racism a Culprit in Health Disparities," *Afro-American*, March 30, 2002; and M.T. Andrei, "Racism Thriving in American Medicine: Amerasians Denied Quality Health Care," *Filipino Reporter*, July 11, 2002: 28.

[12] "Report Validates NMA's Call For Parity," *Philadelphia Tribune*, September 15, 2002: 19–F; F.L. Wong, "The Evidence Is in on Race and Quality of Health Care," *The Nations Health*, May 2002: 3; and N. Carroll, "The Politics of Medicine," *Michigan Citizen*, October 19, 2002: A7.

[13] "Report Validates NMA's Call For Parity."

[14] "House Members Protest Bush Health Actions," *Precinct Reporter*, June 27, 2002: 1.

[15] "New Employer Initiative Addressing Health Care Disparities Announced," *PR Newswire*, March 21, 2002:1; and "Aetna Announces Initiatives to Reduce the Risks Associated With Racial and Ethnic Disparities in Health Care," *PR Newswire*, March 5, 2003:1.

[16] M. Gregg Bloche, "Erasing Racial Data Erased Report's Truth," *Los Angeles Times*, February 15, 2004: M.1; and H. Jack Geiger, "Why Is HHS Obscuring a Health Care Gap?" *The Washington Post*, January 27, 2004, https://www.washingtonpost.com/archive/opinions/2004/01/27/why-is-hhs-obscuring-a-health-care-gap/93756ea1-4cab-4b4c-85de-ea5d5a555375/.

[17] V. Shankar, "Racial Disparities Played Down: At Request of Top Officials, Report on Health Care Differs From Draft," *The Washington Post*, January 14, 2004: A17.

[18] Bloche, "Erasing Racial Data Erased Report's Truth;" and Geiger, "Why Is HHS Obscuring a Health Care Gap?"

[19] Bloche, "Erasing Racial Data."

[20] Michael Blanding, "Revisiting the 'Unequal Treatment' Report, 20 Years Later," *Harvard Public Health Magazine*, October 3, 2022, https://harvardpublichealth.org/alumni-post/revisiting-the-unequal-treatment-report-20-years-later/.

[21] Zach Goldberg, "How the Media Led to the Great Racial Awakening," *Tablet Magazine*, August 4, 2020, https://www.tabletmag.com/sections/news/articles/media-great-racial-awakening.

[22] "Health Tracking Poll–June 2020," KFF, accessed August 13, 2023, https://www.kff.org/racial-equity-and-health-policy/report/kff-health-tracking-poll-june-2020/.

[23] "Standards, Publications, & Notification Forms," LCME, accessed November 17, 2023, https://lcme.org/publications/.

[24] "Standards, Publications, & Notification Forms."

[25] "AAMC Deeply Disappointed by SCOTUS Decision on Race-Conscious Admissions," AAMC, June 29, 2023, https://www.aamc.org/news/press-releases/aamc-deeply-disappointed-scotus-decision-race-conscious-admissions; Jesse M. Ehrenfeld, "SCOTUS Affirmative Action Ruling 'Undermines the Health of Our Nation.'" American Medical Association, June 29, 2023, accessed August 15, 2023, https://www.ama-assn.org/press-center/press-releases/scotus-affirmative-action-ruling-undermines-health-our-nation; "AACN Statement on the Supreme Court Decision Against Race-Conscious Admissions," AACN, June 29, 2023, accessed November 19, 2023, https://www.aacnnursing.org/news-data/all-news/aacn-statement-on-the-supreme-court-decision-against-race-conscious-admissions; and "ANA Responds to SCOTUS Ruling Against Affirmative Action Programs." ANA, June 30, 202, accessed August 15, 2023, https://www.nursingworld.org/news/news-releases/2023/ana-responds-to-scotus-ruling-against-affirmative-action-programs/.

[26] Larry Buchanan, Quoctrung Bui, and Jugal K. Patel, "Black Lives Matter May Be the Largest Movement in U.S. History," *The New York Times*, July 3, 2020, https://www.nytimes.com/interactive/2020/07/03/us/george-floyd-protests-crowd-size.html. Published July 3, 2020. Accessed October 25, 2023.

[27] Matt Berg, "'As Health Care Workers, This Is Our Fight, Too': Health Care Workers Unite to Support Black Lives Matter," *Boston Globe*, June 11, 2020. https://www.bostonglobe.com/2020/06/11/metro/health care-workers-this-is-our-fight-too-health care-workers-unite-support-black-lives-matter/; Jamie Ducharme, "Why So Many Doctors Support Protesting In a Pandemic," *TIME*, June 10, 2020, https://time.com/5848212/doctors-supporting-protests/; Mallory Simon, "Over 1,000 Health Professionals Sign a Letter Saying, Don't Shut Down Protests Using Coronavirus Concerns as an Excuse," *CNN*, June 5, 2020, https://www.cnn.com/2020/06/05/health/health-care-open-letter-protests-coronavirus-trnd/index.html; and "Our Mission," White Coats for Black Lives, accessed August 26, 2023, https://whitecoats4blacklives.org/.

[28] Patrick Hain and Rosanna Mulcahy, "Cities Are Addressing the Past and Building Futures through Reparations," National League of Cities (blog), February 10, 2023, https://www.nlc.org/article/2023/02/10/cities-are-addressing-the-past-and-building-futures-through-reparations/.

[29] US Congress, House, *Commission to Study and Develop Reparation Proposals for African Americans Act*, HR 40, 117th Cong., 1st sess. introduced in House January 04, 2021, http://www.congress.gov/bill/117th-congress/house-bill/40.

[30] "Advancing Equity and Racial Justice Through the Federal Government," The White House, accessed August 24, 2023, https://www.whitehouse.gov/equity/.

[31] Steve Eder, Michael H. Keller, and Blacki Migliozzi, "As New Police Reform Laws Sweep Across the U.S., Some Ask: Are They Enough?" *The New York Times*, April 18, 2021, https://www.nytimes.com/2021/04/18/us/police-reform-bills.html.

[32] Amber Phillips, "Joe Biden's Victory Speech, Annotated," *The Washington Post*, November 8, 2020, https://www.washingtonpost.com/politics/2020/11/07/annotated-biden-victory-speech/.

[33] "Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government," The White House, January 21, 2021, https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/.

[34] "The 2022 Corporate Racial Equity Tracker," JUST Capital, accessed August 26, 2023, https://justcapital.com/reports/2022-corporate-racial-equity-tracker/.

[35] Ken Sweet and Alexandra Olson, "JPMorgan Puts $30B toward Fixing Banking's 'Systemic Racism," *The Associated Press*, October 8, 2020, https://apnews.com/article/race-and-ethnicity-small-business-charlotte-jamie-dimon-racial-injustice-3cf34a097380b3b0813a52994fbce648.

[36] Alex Daniels, Marc Gunther, and Sono Motoyama, "3 Years After George Floyd, Foundations Say They've Changed. Many Racial-Justice Nonprofits Disagree." *The Chronicle of Philanthropy*, May 31, 2023.

[37] Kimberly Amadeo, "The Tea Party Movement's Effect on the Republican Party," *The Balance*, March 4, 2021, https://www.thebalancemoney.com/tea-party-movement-economic-platform-3305571.

[38] Jonathon Morgan, "These Charts Show Exactly How Racist and Radical the Alt-Right Has Gotten This Year," The *Washington Post*, October 26, 2021, https://www.washingtonpost.com/news/the-intersect/wp/2016/09/26/these-charts-show-exactly-how-racist-and-radical-the-alt-right-has-gotten-this-year/; and "Alt-Right," Southern Poverty Law Center, accessed August 28, 2023, https://www.splcenter.org/fighting-hate/extremist-files/ideology/alt-right.

[39] Andrew Daniller, "Majorities of Americans See at Least Some Discrimination against Black, Hispanic and Asian People in the U.S," Washington, DC: PEW Research Center, March 18, 2021. https://pewrsr.ch/3qYScPD.

[40] Stanley Goldfarb, "Take Two Aspirin and Call Me by My Pronouns," *Wall Street Journal*, September 12, 2019, https://www.wsj.com/articles/take-two-aspirin-and-call-me-by-my-pronouns-11568325291; Stanley Goldfarb, "Keep Politics Out of the Doctor's Office," *Wall Street Journal*, April 18, 2022, https://www.wsj.com/articles/keep-politics-out-of-the-doctors-office-racism-woke-ideology-crt-critical-race-theory-medical-care-minorities-systemic-racism-covid-19-regulation-11650308028.

[41] "Politics and the Future of Medical Education," *Wall Street Journal*, July 31, 2022, https://www.wsj.com/articles/politics-and-the-future-of-medical-education-11659286857.

[42] David A. Lieb, "GOP States Targeting Diversity, Equity Efforts in Higher Ed," *The Associated Press*, April 17, 2023, https://apnews.com/article/diversity-equity-inclusion-legislation-7bd8d4d52aaaa9902dde59a257874686; and Missouri State House, HB 489, 102nd General Assembly, introduced in House May 05, 2023.

[43] "Racial Justice," FrameWorks Institute, accessed September 6, 2023, https://www.frameworksinstitute.org/issues/racial-justice/.

References

Acevedo-Garcia, Dolores, Clemens Noelke, and Nancy McArdle. 2020. *The Geography of Child Opportunity: Why Neighborhoods Matter for Equity, First Findings from the Child Opportunity Index 2.0.* Waltham, MA: Brandeis University.

Acevedo-Garcia, Dolores, Clemens Noelke, Nancy McArdle, Nomi Sofer, Erin F. Hardy, Michelle Weiner, Mikyung Baek et al. 2020. "Racial and Ethnic Inequities in Children's Neighborhoods: Evidence from the New Child Opportunity Index 2.0." *Health Affairs* 39 (10): 1693–1701. https://doi.org/10.1377/hlthaff.2020.00735.

Adelani, Muyibat A., and Mary I. O'Connor. 2017. "Perspectives of Orthopedic Surgeons on Racial/Ethnic Disparities in Care." *Journal of Racial and Ethnic Health Disparities* 4: 758–762. https://doi.org/10.1007/s40615-016-0279-z.

AHRQ (Agency for Healthcare Research and Quality). 2021. *2021 National Healthcare Quality and Disparities Report: Executive Summary*. Rockville, MD: AHRQ.

Allegretto, Sylvia, Emma García, and Elaine Weiss. 2022. *Public Education Funding in the US Needs an Overhaul: How a Larger Federal Role Would Boost Equity and Shield Children from Disinvestment During Downturns.* Washington, DC: Economic Policy Institute.

Ansell, David A., Darlene Oliver-Hightower, Larry J. Goodman, Omar B. Lateef, and Tricia J. Johnson. 2021. "Health Equity as a System Strategy: The Rush University Medical Center Framework." *NEJM Catalyst* 2 (5). https://doi.org/10.1056/CAT.20.0674.

AOA (American Osteopathic Association). 2023. *Accreditation of Colleges of Osteopathic Medicine: COM Continuing Accreditation Standards*. Chicago: AOA.

ARC-PA (Accreditation Review Commission on Education for the Physician Assistant). 2019. *Accreditation Standards for Physician Assistant Education*. 5th ed. Suwanee, GA: ARC-PA.

Ayedun, Adeola, Victoria Agbelese, Leslie Curry, Ruth Gotian, Laura Castillo-Page, Marney White, Adwoa Difie Antwi et al. 2023. "Perspectives on National Institutes of Health Funding Requirements for Racial and Ethnic Diversity Among Medical Scientist Training Program Leadership." *JAMA Network Open* 6 (5): e2310795. https://doi.org/10.1001/jamanetworkopen.2023.10795.

Balu, Rekha, Danielle DeRuiter-Williams, Bryan J. Cook, Madeline Baxter, and Travis Reginal. 2023. "Pathways to Equity at Scale: A Synthesis of the 2022 Federal Equity Action Plans and Recommendations for 2023 Plans." Washington, DC: Urban Institute.

Benz, Jennifer K., Oscar Espinosa, Valerie Welsh, and Angela Fontes. 2011. "Awareness of Racial and Ethnic Health Disparities Has Improved Only Modestly over a Decade." *Health Affairs*, 30 (10): 1860–1867. https://doi.org/10.1377/hlthaff.2010.0702.

Biden, Joseph R. 2021. "Inaugural Address by President Joseph R. Biden, Jr." Transcript of speech delivered at The United States Capitol, January 20, 2021.

Blair, Irene V., John F. Steiner, Rebecca Hanratty, David W. Price, Diane L. Fairclough, Stacie L. Daugherty, Michael Bronsert, David J. Magid, and Edward P. Havranek. 2014. "An Investigation of Associations Between Clinicians' Ethnic or Racial Bias and Hypertension Treatment, Medication Adherence and Blood Pressure Control." *Journal of General Internal Medicine* 29 (7): 987–995. https://doi.org/10.1007/s11606-014-2795-z.

Bloche, M. Gregg. 2001. "Race and Discretion in American Medicine." *Yale Journal of Health Policy, Law, and Ethics* 1: 95–131.

———. 2004. "Health Care Disparities—Science, Politics, and Race." *New England Journal of Medicine* 350 (15): 1568–1570. https://doi.org/10.1056/NEJMsb045005.

———. 2005. "American Medicine and the Politics of Race." *Perspectives in Biology and Medicine* 48 (1): 54–S67.

Boehme, Hunter M., and Deena A. Isom Scott. 2020. "Alt-White? A Gendered Look at "Victim" Ideology and the Alt-Right." *Victims & Offenders* 15 (2): 174–196. https://doi.org/10.1080/15564886.2019.1679308.

Booske, Bridget C., Stephanie A. Robert, and Angela M. K. Rohan. 2011. "Awareness of Racial and Socioeconomic Health Disparities in the United States: The National Opinion Survey on Health and Health Disparities, 2008–2009." *Preventing Chronic Disease* 8 (4): A73.

Bouchard, Louise, Marcelo Albertini, Ricardo Batista, and Joanne de Montigny. 2015. "Research on Health Inequalities: A Bibliometric Analysis (1966–2014)." *Social Science & Medicine* 141: 100–108. https://doi.org/10.1016/j.socscimed.2015.07.022.

Brandt, Allan M. 1978. "Racism and Research: The Case of the Tuskegee Syphilis Study." *The Hastings Center Report* 8 (6): 21–29. https://doi.org/10.2307/3561468.

Britton, Breanne V., Neeraja Nagarajan, Cheryl K. Zogg, Shalini Selvarajah, Alexander J. Schupper, A. Gatebe Kironji, Albert T. Lwin et al. 2016. "Awareness of Racial/Ethnic Disparities in Surgical Outcomes and Care: Factors Affecting Acknowledgment and Action." *The American Journal of Surgery* 212 (1): 102–108.E2. https://doi.org/10.1016/j.amjsurg.2015.07.022.

Brown, Adrienne Maree. 2017. *Emergent Strategy: Shaping Change, Changing Worlds.* Chico, CA: AK Press.

Burgess, Diana, Michelle van Ryn, John Dovidio, and Somnath Saha. 2007. "Reducing Racial Bias Among Health Care Providers: Lessons from Social-Cognitive Psychology." *Journal of General Internal Medicine* 22 (6): 882–887. https://doi.org/10.1007/s11606-007-0160-1.

Burgess, Diana. 2010. "Are Providers More Likely to Contribute to Healthcare Disparities Under High Levels of Cognitive Load? How Features of the Healthcare Setting May Lead to Biases in Medical Decision Making." *Medical Decision Making* 30 (2). https://doi.org/10.1177/0272989X09341751.

Burgess, Diana, Barbara G. Bokhour, Brooke A. Cunningham, Tam Do, Howard S. Gordon, Dina M. Jones, Charlene Pope, Somnath Saha, and Sarah E. Gollust. 2019. "Healthcare Providers' Responses to Narrative Communication About Racial Healthcare Disparities." *Health Communication* 34 (2): 149–161. https://doi.org/10.1080/10410236.2017.1389049.

Cain, Lisa, Michelle Brady, Marita R. Inglehart, and Emilia C. Istrate. 2022. "Faculty Diversity, Equity, and Inclusion in Academic Dentistry: Revisiting the Past and Analyzing the Present to Create the Future ." *Journal of Dental Education* 86 (9): 1198–1209. https://doi.org/10.1002/jdd.13013.

Cash-Gibson, Lucinda, Diego F. Rojas-Gualdrón, Juan M. Pericàs, and Joan Benach. 2018. "Inequalities in Global Health Inequalities Research: A 50-Year Bibliometric Analysis (1966-2015)." *PLOS ONE* 13 (1): e0191901. https://doi.org/10.1371/journal.pone.0191901.

Chetty, Raj, Nathaniel Hendren, Maggie R. Jones, and Sonya R. Porter. 2019. "Race and Economic Opportunity in the United States: An Intergenerational Perspective." *The Quarterly Journal of Economics* 135 (2): 711–783. https://doi.org/10.1093/qje/qjz042.

Clinton, William Jefferson. 1997. "Apology For Study Done in Tuskegee." Transcript of speech delivered at The White House, May 16, 1997.

CNEA (NLN Commission for Nursing Education Accreditation). 2021. *Accreditation Standards for Nursing Education Programs*. Washington, DC: CNEA.

Collins, Sharon M. 2011. "From Affirmative Action to Diversity: Erasing Inequality from Organizational Responsibility." *Critical Sociology* 37 (5): 517–520. https://doi.org/10.1177/0896920510380072.

Cooper, Lisa A., Debra L. Roter, Kathryn A. Carson, Mary Catherine Beach, Janice A. Sabin, Anthony G. Greenwald, and Thomas S. Inui. 2012. "The Associations of Clinicians' Implicit Attitudes About Race With Medical Visit

Communication and Patient Ratings of Interpersonal Care." *American Journal of Public Health* 102 (5): 979–987. https://doi.org/10.2105/AJPH.2011.300558.

Cooper, Lisa A., Somnath Saha, and Michelle van Ryn. 2022. "Mandated Implicit Bias Training for Health Professionals—A Step Toward Equity in Health Care." *JAMA Health Forum* 3 (8): e223250. https://doi.org/10.1001/jamahealthforum.2022.3250.

De la Roca, Jorge, Ingrid Gould Ellen, and Justin Steil. 2018. "Does Segregation Matter for Latinos ?" *Journal of Housing Economics* 40: 129–141. https://doi.org/10.1016/j.jhe.2017.10.003.

Dean, Lorraine T., and Roland J. Thorpe, Jr. 2022. "What Structural Racism Is (or Is Not) and How to Measure It: Clarity for Public Health and Medical Researchers." *American Journal of Epidemiology* 191 (9): 1521–1526. https://doi.org/10.1093/aje/kwac112.

Devine, Patricia G., Patrick S. Forscher, Anthony J. Austin, and William T.L. Cox. 2012. "Long-Term Reduction in Implicit Race Bias: A Prejudice Habit-Breaking Intervention." *Journal of Experimental Social Psychology* 48 (6): 1267–1278. https://doi.org/10.1016%2Fj.jesp.2012.06.003.

Dobbin, Frank, and Alexandra Kalev. 2018. "Why Doesn't Diversity Training Work? The Challenge for Industry and Academia." *Anthropology Now* 10 (2): 48–55. https://doi.org/10.1080/19428200.2018.1493182.

Eberly, Lauren A., Aaron Richterman, Anne G. Beckett, Bram Wispelwey, Regan H. Marsh, Emily C. Cleveland Manchanda, Cindy Y. Chang et al. 2019. "Identification of Racial Inequities in Access to Specialized Inpatient Heart Failure Care at an Academic Medical Center." *Circulation: Heart Failure* 12 (11): e006214–e006214. https://doi.org/10.1161/CIRCHEARTFAILURE.119.006214.

Edelman. 2023. *2023 Edelman Trust Barometer Special Report: Business and Racial Justice*. Chicago: Edelman.

Enzinger, Andrea C., Kaushik Ghosh, Nancy L. Keating, David M. Cutler, Cheryl R. Clark, Narjust Florez, Mary Beth Landrum, and Alexi A. Wright. 2023. "Racial and Ethnic Disparities in Opioid Access and Urine Drug Screening Among Older Patients With Poor-Prognosis Cancer Near the End of Life." *Journal of Clinical Oncology* 41 (14): 2511–2522. https://doi.org/10.1200/jco.22.01413.

Epstein, Richard A. 2005. "Disparities and Discrimination in Health Care Coverage: A Critique of The Institute of Medicine Study." *Perspectives in Biology and Medicine* 48 (1): 26–S41.

Fiscella, Kevina and Mechelle R. Sanders. 2016. "Racial and Ethnic Disparities in the Quality of Health Care." *Annual Review of Public Health.* 37 (1): 375–394. https://doi.org/10.1146/annurev-publhealth-032315-021439.

Ford, Chandra L., and Collins O. Airhihenbuwa. 2010. "The Public Health Critical Race Methodology: Praxis for Antiracism Research." *Social Science & Medicine* 71 (8): 1390–1398. https://doi.org/10.1016/j.socscimed.2010.07.030.

Franklin, John Hope, Linda Chavez-Thompson, Suzan D. Johnson Cook, Thomas H. Kean, Angela E. Oh, Robert Thomas, William E. Winter. 1998. *One America in the 21st Century: Forging a New Future—The President's Initiative on Race*. Washington, DC: The White House.

Garcia, Kim, Sarah Perez-Sanz, Pamela Mejia, and Heather Gehlert. 2023. *Elevating Latino Experiences and Voices in News about Racial Equity: Findings and Recommendations for More Complete Coverage*. Berkley, CA: Berkley Media Studies Group.

Gollust, Sarah E., Erika Franklin Fowler, and Jeff Niederdeppe. 2019. "Television News Coverage of Public Health Issues and Implications for Public Health Policy and Practice." *Annual Review of Public Health* 40 (1): 167–185. https://doi.org/10.1146/annurev-publhealth-040218-044017.

Gollust, Sarah E., Rachel I. Vogel, Alexander Rothman, Marco Yzer, Erika Franklin Fowler, and Rebekah H. Nagler. 2020. "Americans' Perceptions of Disparities in COVID-19 Mortality: Results from a Nationally-Representative Survey." *Preventative Medicine* 141: 106278. https://doi.org/10.1016/j.ypmed.2020.106278.

Gollust, Sarah E., Erika Franklin Fowler, Rachel I. Vogel, Alexander J. Rothman, Marco Yzer, and Rebekah H. Nagler. 2022. "Americans' Perceptions of Health Disparities over the First Year of the COVID-19 Pandemic: Results from Three Nationally-Representative Surveys." *Preventive Medicine* 162: 107135. https://doi.org/10.1016/j.ypmed.2022.107135.

Gracia, J. Nadine. 2018. "Remembering Margaret Heckler's Commitment To Advancing Minority Health." *Health Affairs Forefront*.

Halfmann, Drew, Jesse Rude, and Kim Ebert. 2005. "The Biomedical Legacy in Minority Health Policy-Making, 1975–2002." In *Health Care Services, Racial and Ethnic Minorities and Underserved Populations: Patient and Provider Perspectives* vol. 23, edited by J. Jacobs Kronenfeld, 245–275. Leeds, UK: Emerald Group Publishing Limited. https://doi.org/10.1016/S0275-4959(05)23012-0.

Hall, William J., Mimi V. Chapman, Kent M. Lee, Yesenia M. Merino, Tainayah W. Thomas, B. Keith Payne, Eugenia Eng, Steven H. Day, and Tamera Coyne-Beasley. 2015. "Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review." *American Journal of Public Health* 105 (12): e60–e76. https://doi.org/10.2105/AJPH.2015.302903.

Haltinner, Kristin, and Dilshani Sarathchandra. 2017. "Tea Party Health Narratives and Belief Polarization: The Journey to Killing Grandma." *AIMS Public Health* 4 (6): 557–578. https://doi.org/10.3934/publichealth.2017.6.557.

Hanft, Ruth S. 1984. "Minorities and the Health Professions in the 1980s." *Health Affairs (Millwood)* 3 (4): 71–84. https://doi.org/10.1377/hlthaff.3.4.71.

Hardeman, Rachel R., Katy A. Murphy, J'Mag Karbeah, and Katy Backes Kozhimannil. 2018. "Naming Institutionalized Racism in the Public Health Literature: A Systematic Literature Review." *Public Health Reports* 133 (3): 240–249. https://doi.org/10.1177/0033354918760574.

Hardeman, Rachel R., Patricia A. Homan, Tongtan Chantarat, Brigette A. Davis, and Tyson H. Brown. 2022. "Improving The Measurement Of Structural Racism To Achieve Antiracist Health Policy." *Health Affairs (Millwood)* 41 (2): 179–186. https://doi.org/10.1377/hlthaff.2021.01489.

Henderson, Loren, and Cedric Herring. 2013. "Does Critical Diversity Pay in Higher Education? Race, Gender, and Departmental Rankings in Research Universities." *Politics, Groups, and Identities* 1 (3):299–310. https://doi.org/10.1080/21565503.2013.818565.

Herring, Cedric, and Loren Henderson. 2012. "From Affirmative Action to Diversity: Toward a Critical Diversity Perspective." *Critical Sociology* 38 (5): 629–643. https://doi.org/10.1177/0896920511402701.

HHS (United States Department of Health and Human Services). 1985. *Volume I Executive Summary: Report of the Secretary's Task Force on Black and Minority Health*. Washington, DC: HHS.

———. 2000. *Healthy People 2010: Understanding and Improving Health.* 2nd ed. Washington, DC: US Government Printing Office,

Hook, Cayce J., and Hazel Rose Markus. 2020. "Health in the United States: Are Appeals to Choice and Personal Responsibility Making Americans Sick?" *Perspectives on Psychological Science* 15 (3): 643–664. https://doi.org/10.1177/1745691619896252.

Iheduru-Anderson, Kechi, René Revis Shingles, and Christiana Akanegbu. 2021. "Discourse of Race and Racism in Nursing: An Integrative Review of Literature." *Public Health Nursing* 38 (1): 115–130. https://doi.org/10.1111/phn.12828.

Institute of Medicine. 2003. "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care". Washington, DC: National Academies Press. https://doi.org/10.17226/12875.

Johnson, Tiffani J., Robert W. Hickey, Galen E. Switzer, Elizabeth Miller, Daniel G. Winger, Margaret Nguyen, Richard A. Saladino, and Leslie R. M. Hausmann. 2016. "The Impact of Cognitive Stressors in the Emergency

Department on Physician Implicit Racial Bias." *Academic Emergency Medicine* 23 (3): 297–305. https://doi.org/10.1111/acem.12901.

Jones, Camara Phyllis. 2018. "Toward the Science and Practice of Anti-Racism: Launching a National Campaign Against Racism." *Ethnicity & Disease* 28 (Suppl 1): 231–234. https://doi.org/10.18865/ed.28.s1.231.

KFF (Kaiser Family Foundation). 2002. "National Survey of Physicians Part I: Doctors on Disparities in Medical Care." San Francisco: KFF.

Kamran, Sophia, Karen M. Winkfield, Joan Y. Reede, and Neha Vapiwala. 2022. "Intersectional Analysis of U.S. Medical Faculty Diversity over Four Decades." *New England Journal of Medicine* 386 (14): 1363–1371. https://doi.org/10.1056/NEJMsr2114909.

Kendrick, Jessica, Eugene Nuccio, Jenn A. Leiferman, and Angela Sauaia. 2015. "Primary Care Providers Perceptions of Racial/Ethnic and Socioeconomic Disparities in Hypertension Control." *American Journal of Hypertension* 28 (9): 1091–1097. https://doi.org/10.1093/ajh/hpu294.

Ko, Michelle, Mark C. Henderson, Tonya L. Fancher, Maya R. London, Mark Simon, and Rachel R. Hardeman. 2023. "US Medical School Admissions Leaders Experiences With Barriers and Advancement of Diversity, Equity, and Inclusion." *JAMA Network Open* 6 (2): e2254928. https://doi.org/10.1001/jamanetworkopen.2022.54928.

Lett, Elle, Whitney U. Orji, and Ronnie Sebro. 2018. "Declining Racial and Ethnic Representation in Clinical Academic Medicine: A Longitudinal Study of 16 US Medical Specialties." *PLOS ONE* 13 (11): e0207274. https://doi.org/10.1371/journal.pone.0207274.

Lett, Elle, H. Moses Murdock, Whitney U. Orji, Jaya Aysola, and Ronnie Sebro. 2019. "Trends in Racial/Ethnic Representation Among US Medical Students." *JAMA Network Open* 2 (9): e1910490. https://doi.org/10.1001/jamanetworkopen.2019.10490.

Lillie-Blanton, Marsha, Mollyann Brodie, Diane Rowland, Drew Altman, and Mary McIntosh. 2000. "Race, Ethnicity, and the Health Care System: Public Perceptions and Experiences." *Medical Care Research and Review* 57 (supp-1): 218–235. https://doi.org/10.1177/1077558700057001S10.

Lurie, Nicole, Allen Fremont, Arvind K. Jain, Stephanie L. Taylor, Rebecca McLaughlin, Eric Peterson, B. Waine Kong and T. Bruce Ferguson, Jr. 2005. "Racial and Ethnic Disparities in Care." *Circulation* 111 (10):1264–1269. https://doi.org/10.1161/01.CIR.0000157738.12783.71.

Ly, Dan P., Utibe R. Essien, Andrew R. Olenski, and Anupam B. Jena. 2022. "Affirmative Action Bans and Enrollment of Students From Underrepresented Racial and Ethnic Groups in U.S. Public Medical Schools." *Annals of Internal Medicine* 175 (6): 873–878. https://doi.org/10.7326/M21-4312.

Mabeza, Russyan Mark, Briana Christophers, Sophia A. Ederaine, Emily J. Glenn, Zachary P. Benton-Slocum, and Jasmine R. Marcelin. 2023. "Interventions Associated With Racial and Ethnic Diversity in US Graduate Medical Education." *JAMA Network Open* 6 (1): e2249335. https://doi.org/10.1001/jamanetworkopen.2022.49335.

Marini, Maddalena, Mahzarin R. Banaji, and Alvaro Pascual-Leone. 2018. "Studying Implicit Social Cognition with Noninvasive Brain Stimulation." *Trends in Cognitive Sciences* 22 (11): 1050–1066. https://doi.org/10.1016/j.tics.2018.07.014.

Martino, Steven C., Marc N. Elliott, David J. Klein, Ann Haas, Amelia M. Haviland, John L. Adams, Jacob W. Dembosky et al. 2022. "Disparities In The Quality Of Clinical Care Delivered To American Indian/Alaska Native Medicare Advantage Enrollees." *Health Affairs (Millwood)* 41 (5): 663–670. https://doi.org/10.1377/hlthaff.2021.01830.

Mateo, Camila M., and David R. Williams. 2020a. "Addressing Bias and Reducing Discrimination: The Professional Responsibility of Health Care Providers." *Academic Medicine* 95 (12S): S5. https://doi.org/10.1097/acm.0000000000003683.

———. 2020b. "More Than Words: A Vision to Address Bias and Reduce Discrimination in the Health Professions Learning Environment." *Academic Medicine* 95 (12S): S169. https://doi.org/10.1097/acm.0000000000003684.

McDade, William A. 2019. "Increasing Graduate Medical Education Diversity and Inclusion." *Journal of Graduate Medical Education* 11 (6): 736–738. https://doi.org/10.4300%2FJGME-D-19-00760.1.

Mitchell, Faith, Kimá Joy Taylor, and Brian Smedley. 2023. "Unequal Treatment at 20: Accelerating Progress Toward Health Care Equity." Washington, DC: Urban Institute.

NASEM (National Academies of Sciences, Engineering, and Medicine). 2016. *Framing the Dialogue on Race and Ethnicity to Advance Health Equity: Proceedings of a Workshop*. Washington, DC: National Academies Press. https://doi.org/10.17226/23576.

Nieblas-Bedolla, Edwin, John R. Williams, Briana Christophers, Christopher Y. Kweon, Estell J. Williams, and Nathalia Jimenez. 2020. "Trends in Race/Ethnicity Among Applicants and Matriculants to US Surgical Specialties, 2010–2018." *JAMA Network Open* 3 (11): e2023509. https://doi.org/10.1001/jamanetworkopen.2020.23509.

Norton, Michael I., and Samuel R. Sommers. 2011. "Whites See Racism as a Zero-Sum Game That They Are Now Losing." *Perspectives on Psychological Science* 6 (3): 215–218. https://doi.org/10.1177/1745691611406922.

Onyeador, Ivuoma N., Natalie M. Wittlin, Sara E. Burke, John F. Dovidio, Sylvia P. Perry, Rachel R. Hardeman, Liselotte N. Dyrbye et al. 2020. "The Value of Interracial Contact for Reducing Anti-Black Bias Among Non-Black Physicians: A Cognitive Habits and Growth Evaluation (CHANGE) Study Report." *Psychological Science* 31 (1): 18–30. https://doi.org/10.1177/0956797619879139.

Parker, Christopher Sebastian. 2016. "Race and Politics in the Age of Obama." *Annual Review of Sociology* 42 (1): 217–230. https://doi.org/10.1146/annurev-soc-081715-074246.

Penner, Louis A., John F. Dovidio, Tessa V. West, Samuel L. Gaertner, Terrance L. Albrecht, Rhonda K. Dailey, and Tsveti Markova. 2010. "Aversive Racism and Medical Interactions with Black Patients: A Field Study." *Journal of Experimental Social Psychology* 46 (2): 436–440. https://doi.org/10.1016/j.jesp.2009.11.004.

Phelps, Elizabeth A., Kevin J. O'Connor, William A. Cunningham, E. Sumie Funayama, J. Christopher Gatenby, John C. Gore, and Mahzarin R. Banaji. 2000. "Performance on Indirect Measures of Race Evaluation Predicts Amygdala Activation." *Journal of Cognitive Neuroscience* 12 (5): 729–38. https://doi.org/10.1162/089892900562552.

Potok, Mark. 2014. *The Year in Hate and Extremism*. Montgomery, AL: Southern Poverty Law Center; Montgomery, Alabama.

Ready, Timothy. 2001. "The Impact of Affirmative Action on Medical Education and the Nation's Health." In *Diversity Challenged: Evidence on the Impact of Affirmative Action*, edited by Gary Orfield, 205–219. Cambridge, MA: Education Publishing Group.

Rufo, Christopher F. 2023. *America's Cultural Revolution: How the Radical Left Conquered Everything.* New York: Broadside Books (HarperCollins).

Salsberg, Edward, Chelsea Richwine, Sara Westergaard, Maria Portela Martinez, Toyese Oyeyemi, Anushree Vichare, and Candice P. Chen. 2021. "Estimation and Comparison of Current and Future Racial/Ethnic Representation in the US Health Care Workforce." *JAMA Network Open* 4 (3): e213789. https://doi.org/10.1001/jamanetworkopen.2021.3789.

Satel, Sally, and Jonathan Klick. 2005. "The Institute of Medicine Report: Too Quick to Diagnose Bias." *Social Science Research Network*. https://doi.org/10.2139/ssrn.515955.

Schulman, Kevin A., Jesse A. Berlin, William Harless, Jon F. Kerner, Shyrl Sistrunk, Bernard J. Gersh, Ross Dubé et al. 1999. "The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization." *New England Journal of Medicine* 340 (8): 618–626. https://doi.org/10.1056/NEJM199902253400806.

Sequist, Thomas D., John Z. Ayanian, Richard Marshall, Garret M. Fitzmaurice, and Dana Gelb Safran. 2008. "Primary-care Clinician Perceptions of Racial Disparities in Diabetes Care." *Journal of General Internal Medicine* 23 (5): 678–684. https://doi.org/10.1007/s11606-008-0510-7.

Sotto-Santiago, Sylk, Norma Poll-Hunter, Traci Trice, Lee Buenconsejo-Lum, Sherita Golden, Joy Howell, Nicole Jacobs et al. 2022. "A Framework for Developing Antiracist Medical Educators and Practitioner-Scholars." *Academic Medicine* 97 (1): 41–47. https://doi.org/10.1097/acm.0000000000004385.

Subramanian Ram, and Leily Arzy. 2021. "State Policing Reforms Since George Floyd's Murder." Washington, DC: Brennan Center for Justice.

Taylor, Yhenneko J., Marion E. Davis, Sveta Mohanan, Sandy Robertson, and Mark D. Robinson. 2019. "Awareness of Racial Disparities in Diabetes among Primary Care Residents and Preparedness to Discuss Disparities with Patients." *Journal of Racial and Ethnic Health Disparities* 6 (2): 237–244. https://doi.org/10.1007/s40615-018-0518-6.

Terbeck, Sylvia, Guy Kahane, Sarah McTavish, Julian Savulescu, Philip J. Cowen, and Miles Hewstone. 2012. "Propranolol Reduces Implicit Negative Racial Bias." *Psychopharmacology* 222 (3): 419–424. https://doi.org/10.1007/s00213-012-2657-5.

Valentino, Nicholas A., and Ted Brader. 2011. "The Sword's Other Edge: Perceptions of Discrimination and Racial Policy Opinion after Obama." *Public Opinion Quarterly* 75 (2): 201–226. https://doi.org/10.1093/poq/nfr010.

van Ryn, Michelle, Rachel Hardeman, Sean M. Phelan, Diana J. Burgess, John F. Dovidio, Jeph Herrin, Sara E. Burke. 2015. "Medical School Experiences Associated with Change in Implicit Racial Bias Among 3547 Students: A Medical Student CHANGES Study Report." *Journal of General Internal Medicine* 30 (12): 1748–1756. https://doi.org/10.1007/s11606-015-3447-7.

Vela, Monica B., Amarachi I. Erondu, Nichole A. Smith, Monica E. Peek, James N. Woodruff, and Marshall H. Chin. 2022. "Eliminating Explicit and Implicit Biases in Health Care: Evidence and Research Needs." *Annual Review of Public Health* 43: 477–501. https://doi.org/10.1146/annurev-publhealth-052620-103528.

Willer, Robb, Matthew Feinberg, and Rachel Wetts. 2016. "Threats to Racial Status Promote Tea Party Support Among White Americans." Stanford, CA: Standford Graduate School of Business.

Williams D.R., and C. Collins. 2001. "Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health." *Public Health Reports* 116 (5): 404–416.

Williams, David R., and Lisa A. Cooper. 2019. "Reducing Racial Inequities in Health: Using What We Already Know to Take Action." *International Journal of Environmental Research and Public Health* 16 (4): 606. https://doi.org/10.3390/ijerph16040606.

Williams, David R., Jourdyn A. Lawrence, Brigette A. Davis, and Cecilia Vu. 2019. "Understanding How Discrimination Can Affect Health." *Health Services Research* 54 (S2): 1374–1388. https://doi.org/10.1111/1475-6773.13222.

Wispelwey, Bram P., Regan H. Marsh, Michael Wilson, Sula Mazimba, Scott K. Heysell, Imoigele P. Aisiku, Akshay S. Desai, Cassandra Georges, and Michelle E. Morse. 2022. "Leveraging Clinical Decision Support for Racial Equity: A Sociotechnical Innovation." *NEJM Catalyst* 3 (4). https://doi.org/10.1056/CAT.22.0076.

Yi, Jacqueline, Helen A. Neville, Nathan R. Todd, and Yara Mekawi. 2022. "Ignoring race and denying racism: A Meta-Analysis of the Associations between Colorblind Racial Ideology, Anti-blackness, and Other Variables Antithetical to Racial Justice." *Journal of Counseling Psychology* 70 (3): 258–275. https://doi.org/10.1037/cou0000618.

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