

DISRUPTING THE CONVERSATION TO  
TRANSFORM THE FUTURE:

ADVANCING HEALTH EQUITY FOR THE  
NEW MAJORITY

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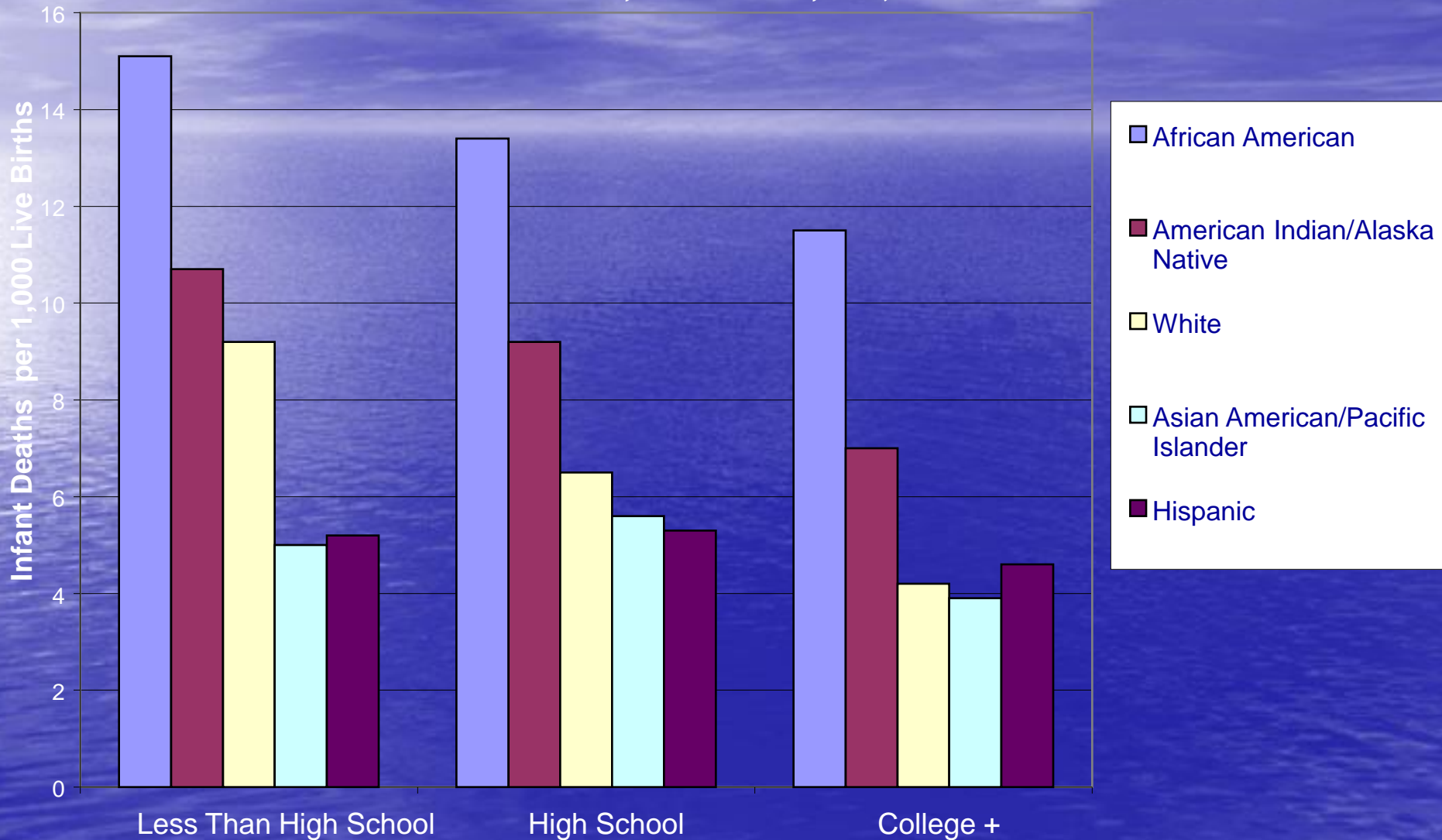
[www.nationalcollaborative.org](http://www.nationalcollaborative.org)

# Health Inequalities and Their Causes

- Many people of color face poorer health from the cradle to the grave relative to national averages.
- These inequalities persist when education and income are controlled.
- While new immigrants tend to have better health than their U.S.-born peers, their health tends to get poorer over time and with succeeding generations.
- These health inequities have their roots in historic and contemporary forces, such as discrimination, segregation, and poverty concentration.

# Infant Mortality Rates for Mothers Age 20 and Over by Race/Ethnicity and Education, 2001-2003

Source: *Health, United States, 2006* Table 20

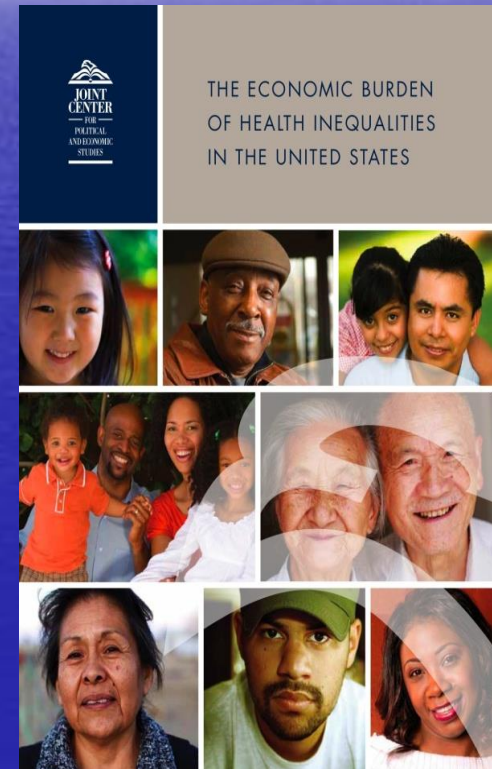




# The Economic Burden of Health Inequalities in the United States

([www.jointcenter.org/hpi](http://www.jointcenter.org/hpi))

- Direct medical costs of health inequalities
- Indirect costs of health inequalities
- Costs of premature death



# The Economic Burden of Health Inequalities in the United States

- Between 2003 and 2006, 30.6% of direct medical care expenditures for African Americans, Asians, and Hispanics were excess costs due to health inequalities.
- Eliminating health inequalities for minorities would have reduced direct medical care expenditures by \$229.4 billion for the years 2003-2006.
- Between 2003 and 2006 the combined costs of health inequalities and premature death were \$1.24 trillion.



# Definitions

**Health inequities** refer to health differences that are rooted in social disadvantage, and are therefore unjust or avoidable.

Health inequities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; disability; sexual orientation; geographic location; or other characteristics historically linked to discrimination or exclusion.

# Definitions (cont'd)

**Health equity** is the *assurance of the conditions* for optimal health for all people.

Achieving health equity requires valuing all individuals and populations equally, recognizing and rectifying historical injustices, and addressing contemporary injustices by providing resources according to need. Health and healthcare disparities will be eliminated when health equity is achieved.

Health equity is a *process, not an outcome.*



EQUALITY is not the same as EQUITY!





# Key Strategies to Improve the National Outlook for Health in 2050:

- **Equity in health care delivery** – better aligning health care resources to match community need
- **Equity in the health care workforce** – improving the diversity of the nation's health workforce to better reflect the population
- **Equity in community conditions for health** – reducing the concentration of health risks in communities of color while increasing access to health-enhancing resources

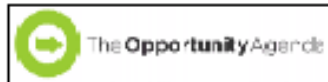
# Equity in Healthcare Delivery: Aligning Resources with Community Need

- People of color are disproportionately concentrated in health professions shortage areas and medically underserved areas
- 28% of Latinos and 22% of African Americans report having little to no choice in where they access care, compared to only 15% of whites
- 34% of Latinos, 24% of AI/ANs, 19% of African Americans, and 15% of whites report having no regular source of health care



# NEW YORK CITY, NY

## PCP and Poverty



This map displays percentage of people below 200% poverty in relation to the rate of primary care providers (PCP) per 10,000 population in New York City between 2001-2003, by zip code. In general, areas with high poverty have lower number of primary care physicians.

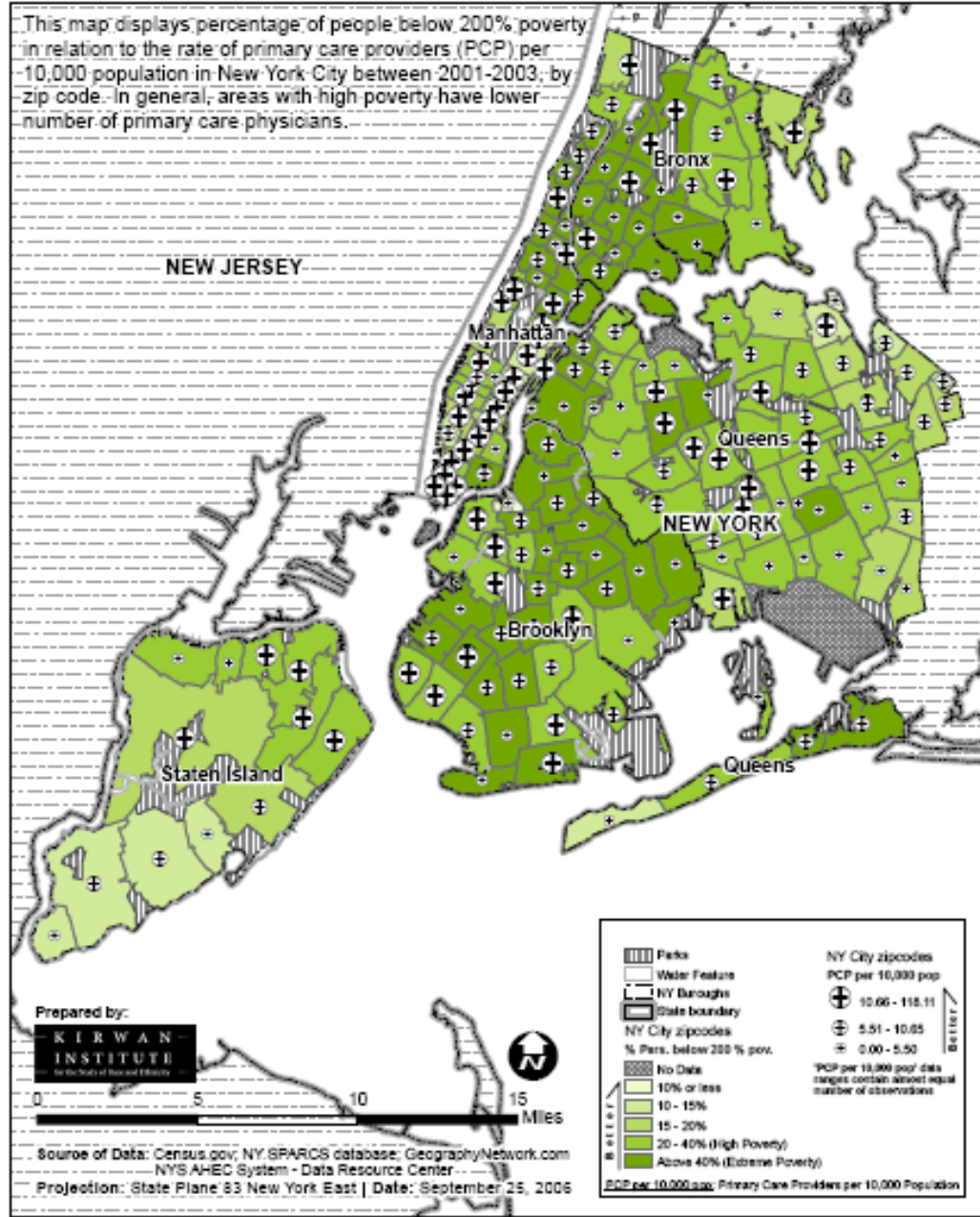
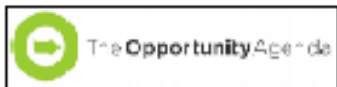
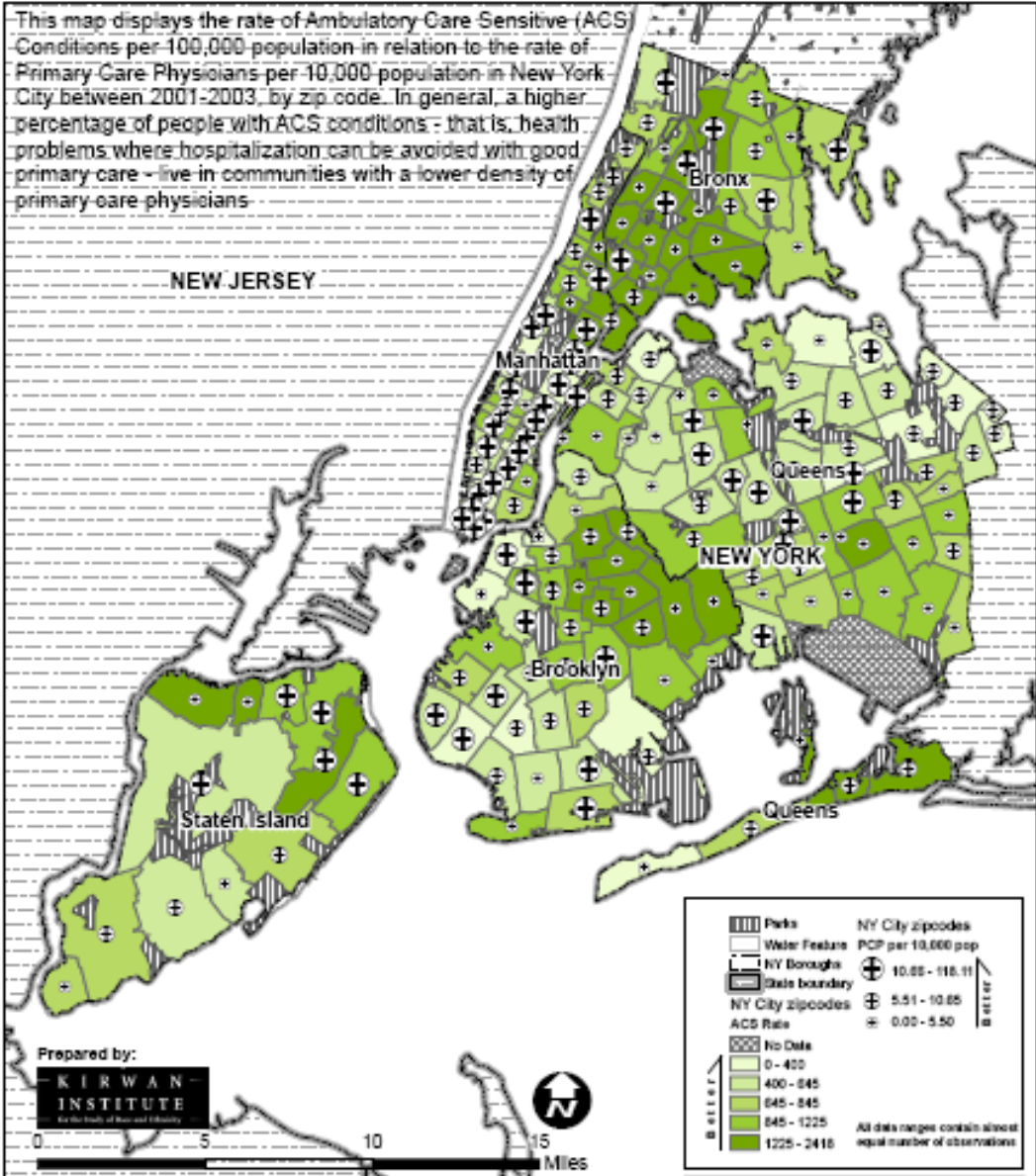


Figure 2

# NEW YORK CITY, NY PRIMARY CARE PHYSICIANS AND AMBULATORY CARE SENSITIVE CONDITIONS



This map displays the rate of Ambulatory Care Sensitive (ACS) Conditions per 100,000 population in relation to the rate of Primary Care Physicians per 10,000 population in New York City between 2001-2003, by zip code. In general, a higher percentage of people with ACS conditions - that is, health problems where hospitalization can be avoided with good primary care - live in communities with a lower density of primary care physicians.



ACS Rate: Ambulatory Care Sensitive (ACS) conditions per 100,000 population  
PCP per 10,000 pop: Primary Care Providers per 10,000 Population



# Equity in Healthcare Delivery: Aligning Resources with Community Need

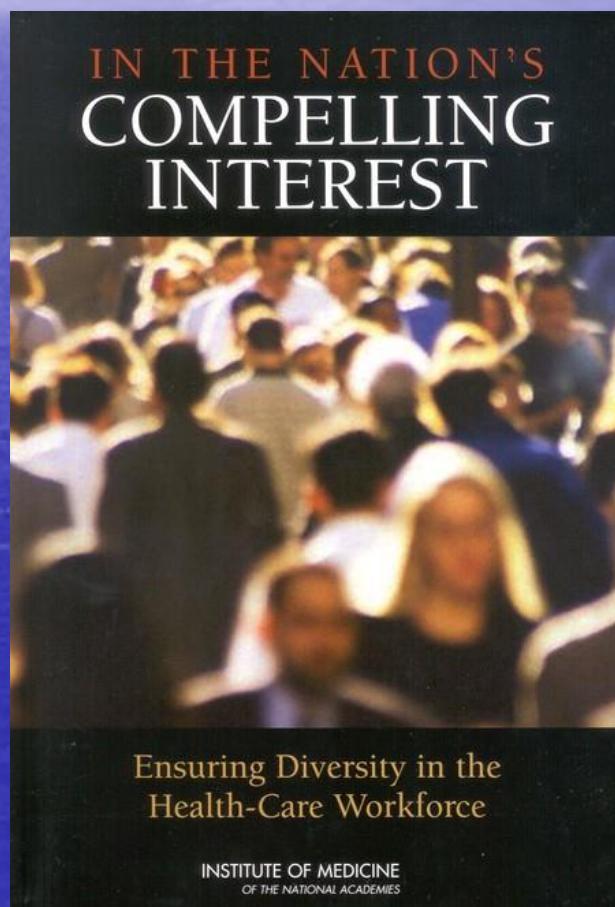
- **Expand health professions training programs.** For example, NHSC funding levels have not been adequate to support the number of clinicians needed to fill all position vacancies (nearly 9,000 vacancies currently remain and nearly 17,000 practitioners are still needed to remove HPSA designations)
- **Continue expansion of Community Health Centers**
- **Match Medicaid reimbursement to that of Medicare**

# Equity in the Healthcare Workforce: Promoting Diversity and Quality

- Health care providers of color are more likely to work in medically underserved communities and reduce cultural and linguistic barriers to accessing care
- Diversity in health professions training settings is associated with greater cultural competence among all trainees
- Minority providers display better patient care process
- Yet they remain dramatically underrepresented among physicians, dentists, behavioral health professionals, and many other disciplines



*In the Nation's Compelling Interest:  
Ensuring Diversity in the Health Professions*  
(IOM, 2004)



# Health Professions Educations Institutions Should:

- Adopt mission statements that clearly address the value of diversity
- Encourage a comprehensive review of applicants' files
- De-emphasize standardized test data in the admissions equation
- Include representatives from groups affected by the institution's admissions decisions on admissions committees
- Push for diversity accreditation standards
- Develop and regularly evaluate comprehensive strategies to improve the institutional climate for diversity
- Reduce financial barriers to training



# Equity in Community Conditions for Health

Highly Segregated Communities of Color Tend to:

- Host a high concentration of environmental health risks, such as polluting industries
- Be designated as “food deserts,” lacking geographic and financial access to healthy foods, while in contrast hosting a heavy concentration of unhealthy food vendors
- Lack access to safe spaces for exercise or recreation

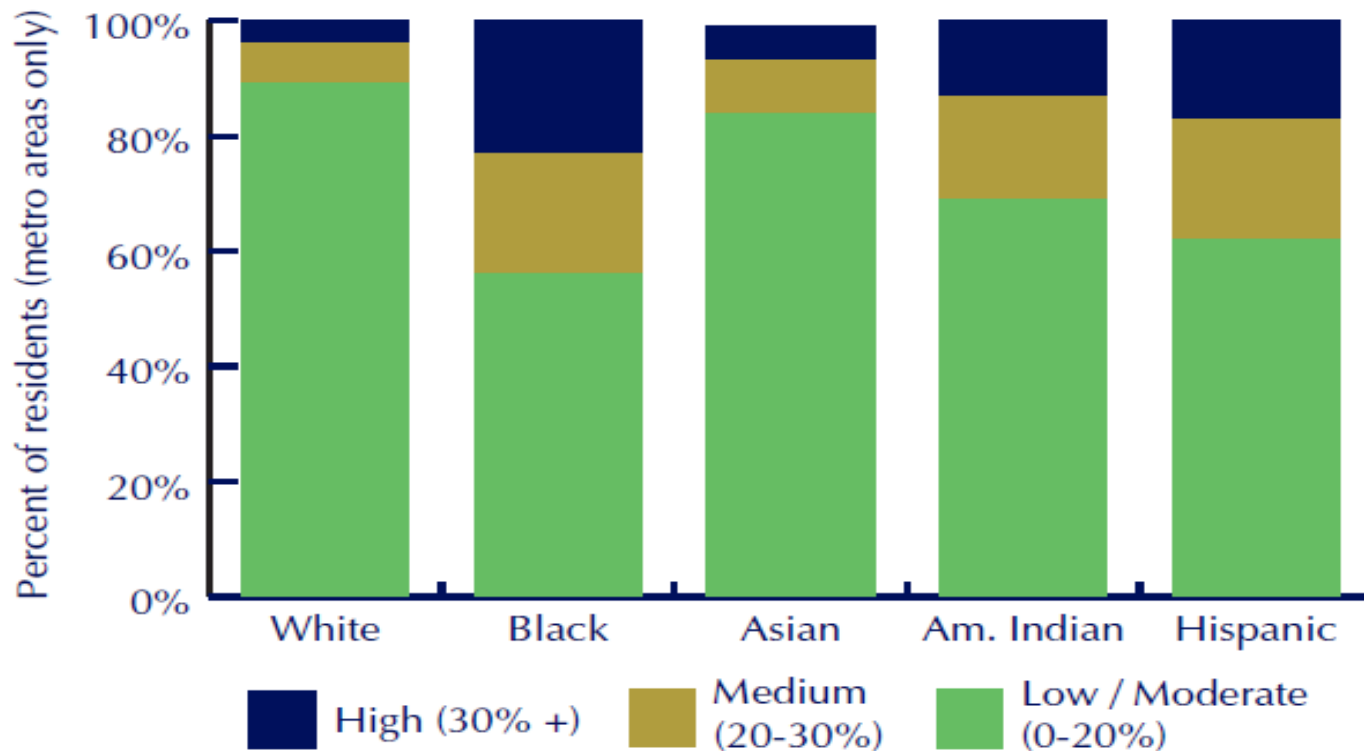
# Equity in Community Conditions for Health

Highly Segregated Communities of Color Tend to:

- Have lower access to means for economic mobility, such as good schools, capital to start businesses, property that appreciates in value to accumulate wealth
- Pay more for the same goods and services as more advantaged communities
- Suffer from high levels of stress as a result of all of the above

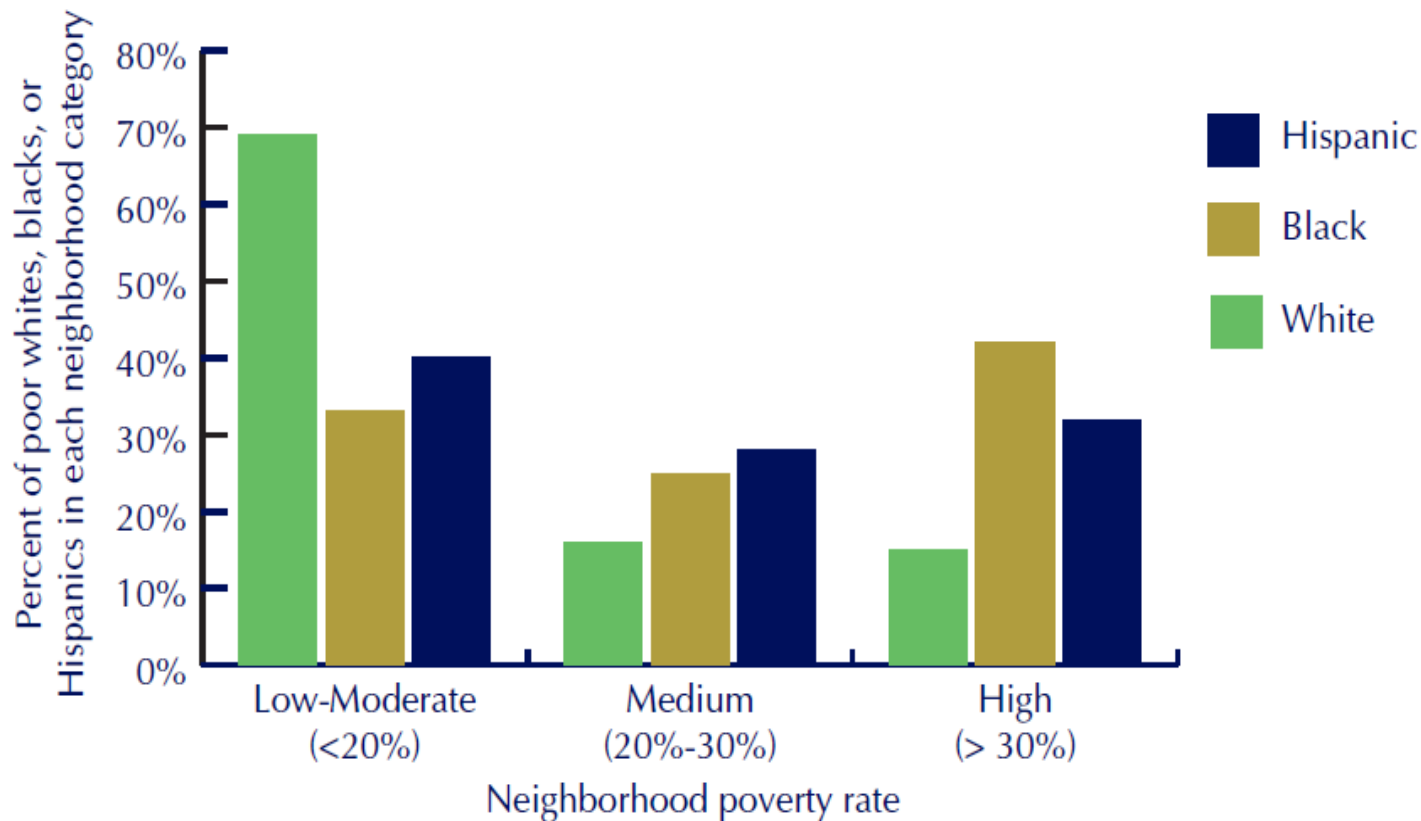


# Blacks, Hispanics, Amer. Indians over-concentrated in high-poverty tracts



Source: U.S. Census Bureau, Decennial Censuses of Population and Housing and American Communities Survey five-year estimates, based on authors' calculations.

# Poor blacks and Hispanics are more likely than poor whites to live in medium- and high-poverty tracts

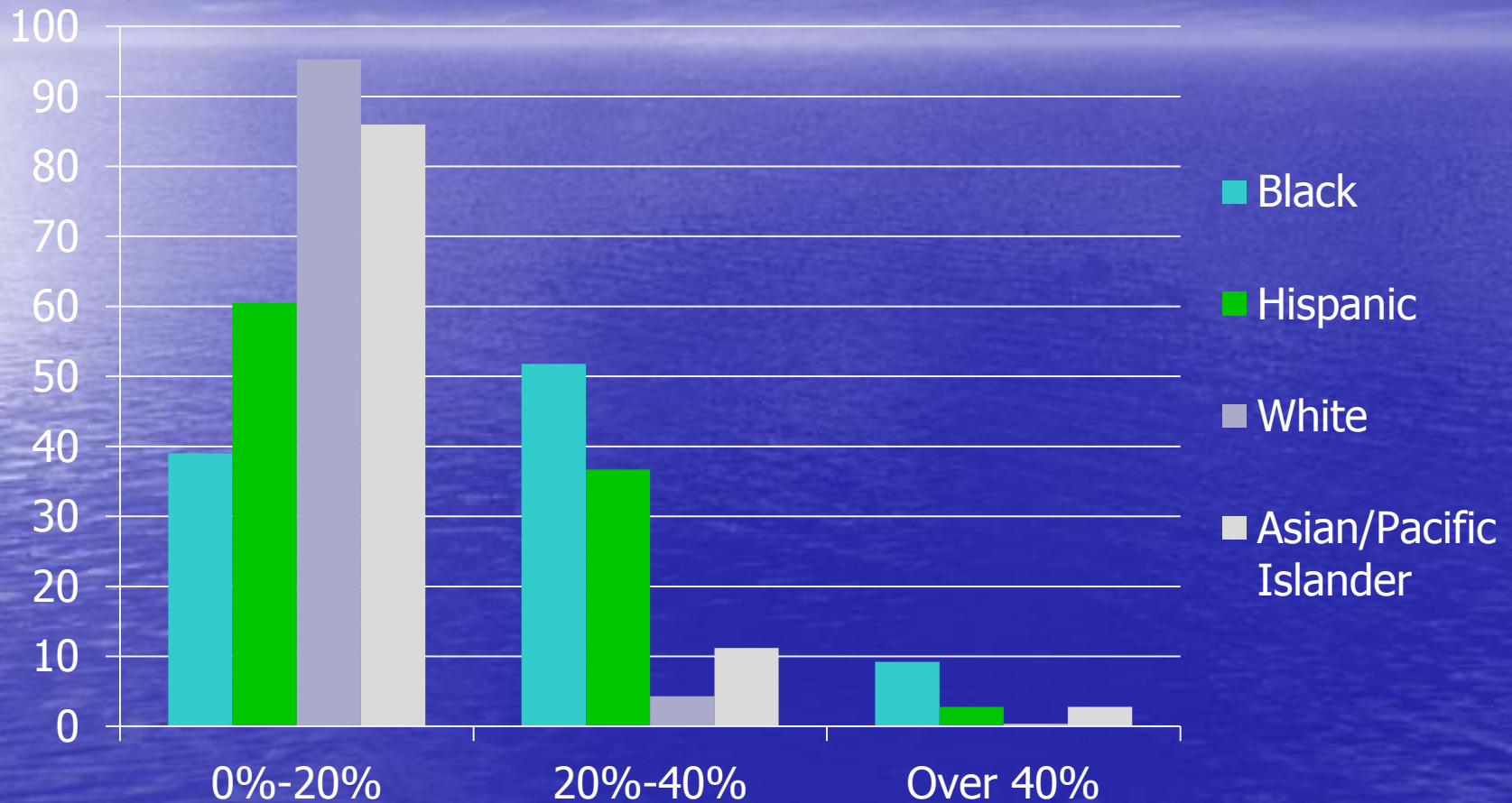


Source: U.S. Census Bureau, Decennial Censuses of Population and Housing and American Communities Survey five-year estimates, based on authors' calculations.



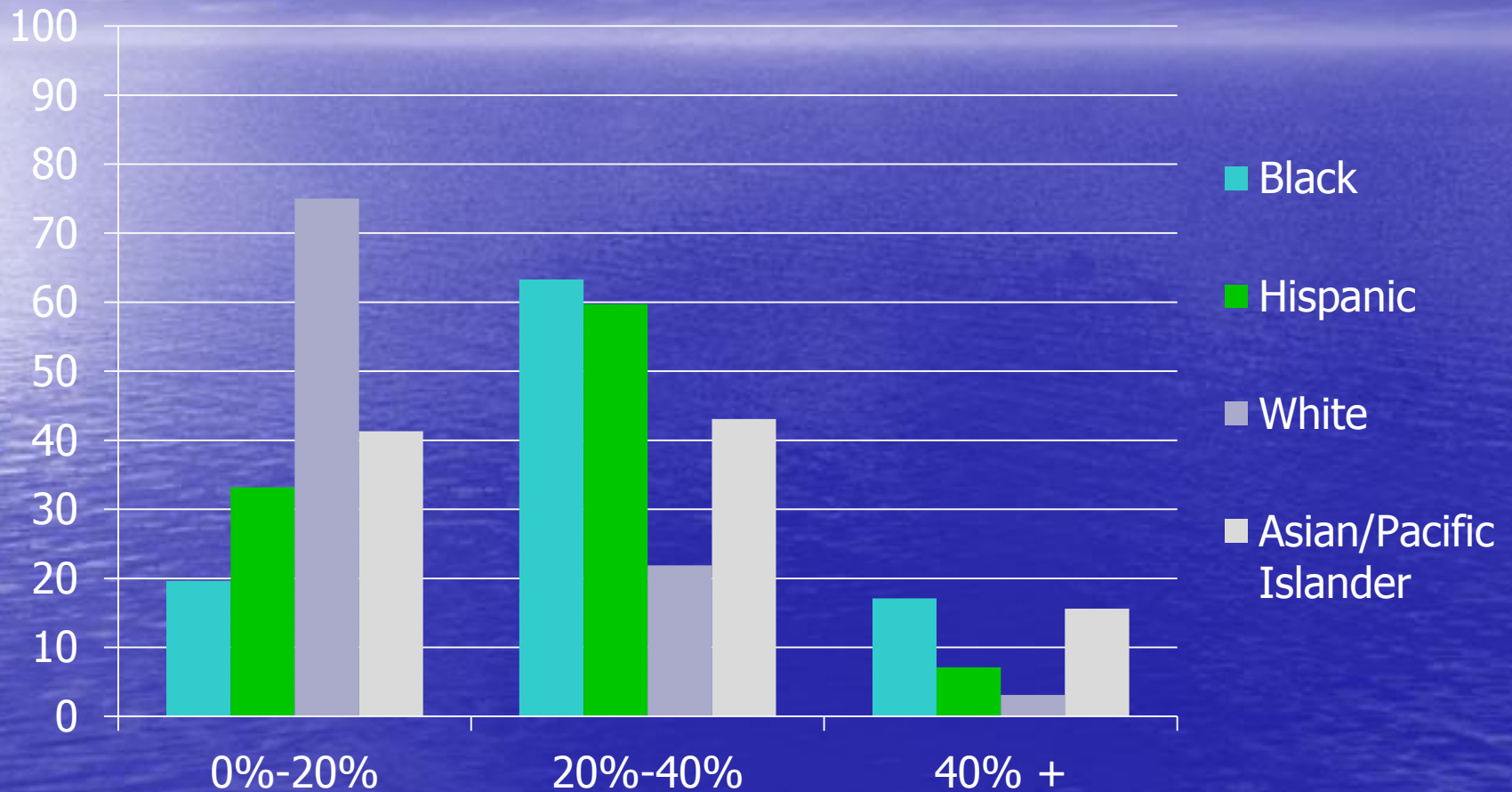
# Metro Detroit: Poverty Concentration of Neighborhoods of All Children

Source: Diversitydata.org, 2011



# Metro Detroit: Poverty Concentration of Neighborhoods of Poor Children

Source: Diversitydata.org





# How can we eliminate health status inequality?

- Place-based Investments: Reducing the concentration of community-level health risks while increasing geographic access to health-enhancing resources.
- People-based Investments: Investing in people through individual and family interventions designed to improve access to opportunity and maximize the ability to harness opportunities.

*These strategies should be employed simultaneously*

# Examples of Place-Based and People-Based Investments

- Fresh Food Financing Initiatives
- Land use and zoning to reduce the concentration of health risks
- Joint Use Agreements (e.g., with schools)
- Health Impact Assessment
- Housing Mobility (e.g., MTO)
- High-Quality Early Childhood Educational Programs



“[I]nequities in health [and] avoidable health inequalities arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces.”

World Health Organization Commission on the Social Determinants of Health (2008)