Racial Healing and Achieving Health Equity in the United States

> "Of all the forms of inequality, injustice in health care is the most shocking and inhumane."
>
> **– Rev. Martin L. King, Jr.**

The Truth, Racial Healing & Transformation (TRHT) effort was created by the W.K. Kellogg Foundation as a national and community-based process to plan for and bring about transformational and sustainable change and to address the historic and contemporary effects of racism.

Among the many aspects of TRHT is the need to address serious racial and ethnic health inequities — and the causes that contribute to them. Good health is essential to ensuring everyone is able to live a high-quality life, be engaged with their families, communities and workplaces, and have the opportunity to flourish and thrive in everything they do. TRHT's National Day of Racial Healing identifies key steps that will help take collective action to promote positive and lasting change across issues — including to:

1. Find ways to reinforce and honor our common humanity and create space to celebrate the distinct differences that make our communities vibrant;

2. Acknowledge that there are still deep racial divisions in America that must be overcome and healed; and

3. Commit to engage people from all racial, ethnic, religious and identity groups in genuine efforts to increase understanding, communication, caring and respect for one another.[1]

This issue brief was developed to help identify and acknowledge health inequities, influencing factors and policy recommendations that can help the nation achieve health equity.
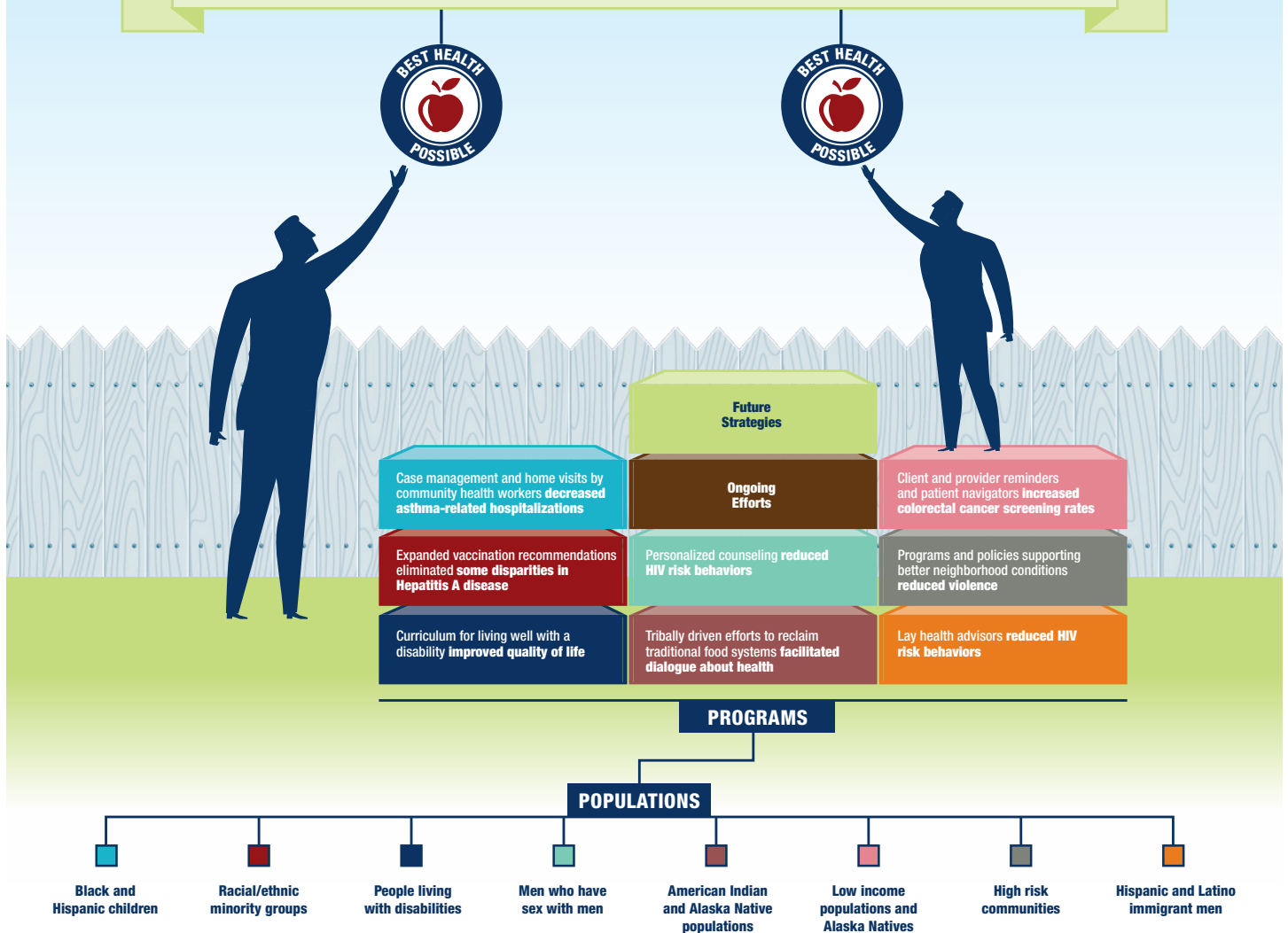
> "Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments and health care."[2]

REACHING FOR
Health Equity

Reducing health disparities brings us closer to reaching health equity. The programs below are examples of how addressing disparities can advance health equity.

BEST HEALTH POSSIBLE

BEST HEALTH POSSIBLE

Future Strategies

Case management and home visits by community health workers **decreased asthma-related hospitalizations**

Ongoing Efforts

Client and provider reminders and patient navigators **increased colorectal cancer screening rates**

Expanded vaccination recommendations eliminated **some disparities in Hepatitis A disease**

Personalized counseling **reduced HIV risk behaviors**

Programs and policies supporting better neighborhood conditions **reduced violence**

Curriculum for living well with a disability **improved quality of life**

Tribally driven efforts to reclaim traditional food systems **facilitated dialogue about health**

Lay health advisors **reduced HIV risk behaviors**

PROGRAMS

POPULATIONS

Black and Hispanic children

Racial/ethnic minority groups

People living with disabilities

Men who have sex with men

American Indian and Alaska Native populations

Low income populations and Alaska Natives

High risk communities

Hispanic and Latino immigrant men

HEALTH EQUITY is when everyone has the opportunity to be as healthy as possible.

HEALTH DISPARITIES are differences in health outcomes and their causes among groups of people.

EXAMPLE: African American children are more likely to die from asthma compared to non-Hispanic White children.

Existing Inequities

The causes of health inequities are multifaceted and often intertwined with lower socioeconomic status, differential access to opportunities and other factors that influence health, such as quality healthcare, income, education, housing, transportation and others, sometimes referred to as the "social determinants of health."

Health inequities have a high economic cost. A study by the Urban Institute found that for a set of preventable diseases (diabetes, heart disease, high blood pressure, renal disease and stroke), differences in the rates of diseases among Blacks, Hispanics and Whites cost the healthcare system $23.9 billion annually.[3] By 2050, this is expected to double to $50 billion a year.[4] Eliminating health inequities could lead to reduced medical expenditures of $54 to $61 billion a year, and recover around $13 billion annually due to work lost by illness and around $240 billion per year due to premature deaths (2003-2006 spending).[5,6] According to the U.S. Centers for Disease Control and Prevention (CDC), the rate of preventable hospitalizations for Blacks is almost double that of Whites — which contributes to over a half million hospitalizations and $3.7 billion in hospitalization costs annually.[7]

The following are a number of examples highlighting factors that contribute to inequity:

- Blacks and Latinos have lower median household incomes than Whites and are more likely to live in poverty.[8]

- Black men earned 70 cents for every dollar earned by White men in 2014 and Hispanic men earned 60 cents on the dollar.[9, 10]

- People living in neighborhoods with high levels of poverty have a higher risk of less healthy behaviors —such as smoking, physical inactivity or poor nutrition— which are related to inequities in the physical and social environment.[11] Access to safe neighborhoods and amenities, supermarkets and quality housing provide significant opportunities to be healthier.[12]

- Low-income neighborhoods are less likely to have places where children can be physically active or have access to fully-stocked supermarkets with healthy, affordable foods — contributing to higher rates of obesity and poor nutrition in these communities.[13, 14, 15]

- Low-income and minority communities also experience higher air pollution, which affects respiratory and cardiovascular health as well as birth outcomes.[16]

Examples of some health inequities include:

- American Indians and Alaska Natives are twice as likely to have diabetes as Whites, and diabetes rates among Blacks and Hispanics are more than 1.5 times higher than for Whites.[17]

- Blacks are seven to nine times more likely to die from HIV, and are six times more likely to die from homicide.[18]

- Black children have the highest rate of lead poisoning (5.6 percent).[19]

- Blacks have the highest death rate and shortest survival for most cancers of any racial and ethnic group in the United States.[20]

- Black women with breast cancer are 40 percent more likely to die than White women with breast cancer, despite similar incidence rates of the disease.[21, 22]

- Black men are about twice as likely to die from prostate cancer as Whites.[23]

- Hispanic women are more than 1.5 times as likely to have cervical cancer as Whites.[24]

- Infants born to Black women are 1.5 to almost 3 times more likely to die than infants born to women of other races/ethnicities regardless of education level.[25] American Indian and Alaska Native infants die from Sudden Infant Death Syndrome (SIDS) at about twice the rate of White infants.[26]

- Asthma rates for Black children grew by 50 percent between 2001 and 2009, while the overall asthma rates increased 15 percent.[27] Differences in asthma rates between Black and White children reached a peak in 2011 (with Black children twice as likely as White children to have asthma).[28] And, asthma-related hospitalizations and deaths are more than twice as high among Blacks as Whites.[29, 30]

- Blacks, Hispanics, and American Indians and Alaska Natives received worse care than Whites for about 40 percent of quality measures, according to the 2015 *National Healthcare Quality and Disparities Report*.[31] Blacks and Hispanics were more likely than Whites to report poor communication from healthcare providers. Some examples of implicit bias in healthcare identified by The Joint Commission, Division of Health Care Improvement include: non-White patients receive fewer cardiovascular interventions and renal transplants; non-White patients are less likely to be prescribed pain medications; Black men are less likely to receive chemotherapy and radiation therapy for prostate cancer; and patients of color are more likely to be blamed for being too passive about their healthcare.[32]

INEQUITIES IN LIFE EXPECTANCY

Life expectancy rates vary by as much as 20 years between counties in the United States.[33] Race/ethnicity, socioeconomics and healthcare explained the differences by 74 percent, 60 percent and 27 percent respectively.

As of 2014, five counties had life expectancies below 70 years (the lowest at 66.8 years) — with four of those counties having high American Indian populations. Two counties had life expectancies above 86 years.

- Of the 50 counties with the highest life expectancy rates (82 years and above), 35 of them had a population that was comprised of more than 75 percent non-Hispanic White.
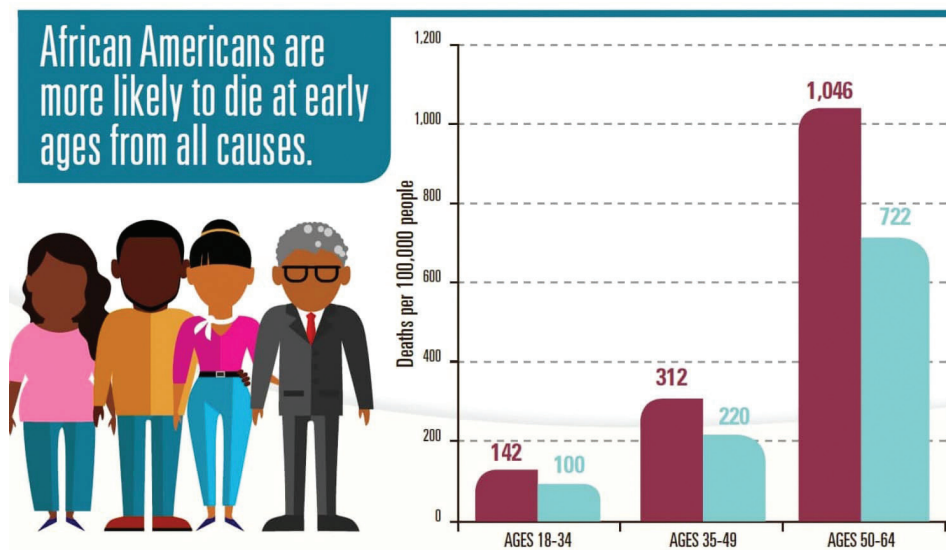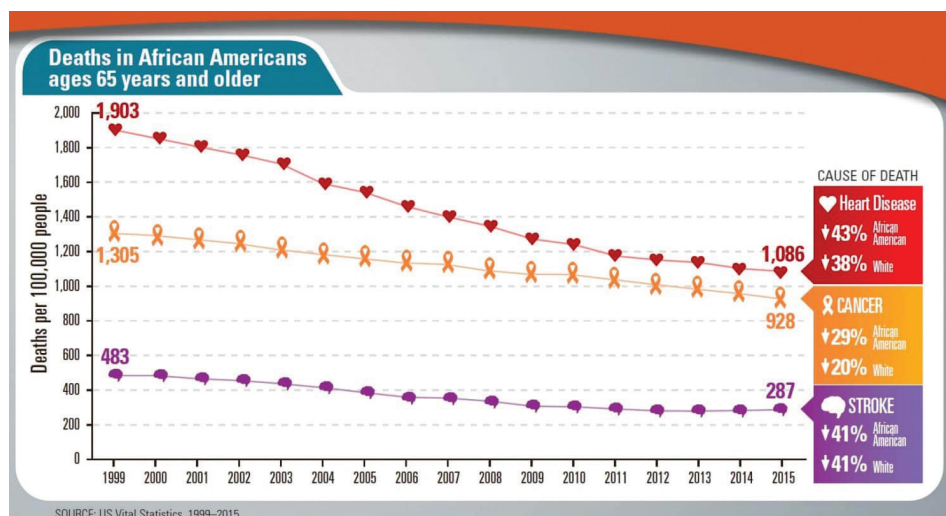
- Of the 50 counties with the lowest life expectancy rates (72.6 years and lower), seven had majority American Indian populations (with five above 79 percent) and 18 had majority Black populations (with nine at 70 percent or above).
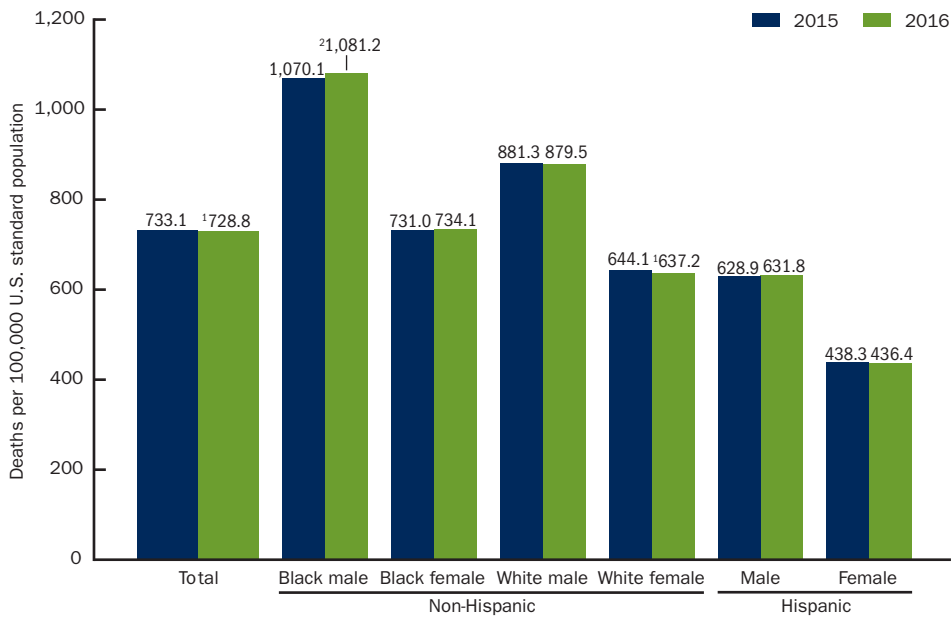
THE BLACK WHITE MORTALITY GAP

Currently, on average, the life expectancy for Black men is 4.5 years shorter than for White men; and 3 years shorter for Black women than White women.[34]

The mortality gap among Blacks and Whites has narrowed by around half — from 33 percent to 16 percent — over the past 17 years. Blacks experienced a 25 percent decline in overall death rates during this time compared to a 14 percent decrease among Whites.[35]

Still, Blacks are more likely to die at relatively younger ages from a wide range of causes — including that Blacks ages 18 to 49 were nearly twice as likely to die from diabetes, heart disease and stroke than Whites. However, Blacks ages 65 and older have a lower death rate than Whites ages 65 and older from heart disease, cancer and stroke. CDC attributes the consequences of psychosocial, economic and environmental stressors are the key contributors to these disparities.

Deaths in African Americans ages 65 years and older

CAUSE OF DEATH
- ♥ Heart Disease ▼43% African American ▼38% White
- ✗ CANCER ▼29% African American ▼20% White
- 💬 STROKE ▼41% African American ▼41% White

SOURCE: US Vital Statistics, 1999–2015.

African Americans are more likely to die at early ages from all causes.

Age-adjusted death rates for selected populations: United States, 2015 and 2016[36]

Chart legend: ■ 2015 ■ 2016

Y-axis: Deaths per 100,000 U.S. standard population (0 to 1,200)

Category	2015	2016
Total	733.1	[1]728.8
Non-Hispanic Black male	1,070.1	[2]1,081.2
Non-Hispanic Black female	731.0	734.1
Non-Hispanic White male	881.3	879.5
Non-Hispanic White female	644.1	[1]637.2
Hispanic Male	628.9	631.8
Hispanic Female	438.3	436.4

[1]Statistically significant decrease in age-adjusted death rate from 2015 to 2016 ($p < 0.05$).
[2]Statistically significant increase in age-adjusted death rate from 2015 to 2016 ($p < 0.05$).

Source: NCHS, National Vital Statistics System, Mortality.

AMERICAN INDIAN LIFE EXPECTANCY

Life expectancy for a number of counties with high American Indian populations are 20 percent lower than other counties in the United States.[37,38] Much of the difference is attributed to socioeconomics and access to healthcare in addition to race/ethnicity. For instance, Oglala Lakota County in South Dakota, which includes the Oglala Sioux Tribe's reservation, had the lowest life expectancy in the country in 2014 — at 66.8 years, and three other counties with tribal communities were also among the five lowest for life expectancy rates (Todd County, South Dakota with the Rosebud Sioux Tribe; Buffalo County, South Dakota with the Crow Creek Sioux Tribe; and Sioux County, North Dakota which includes the northern portion of the Standing Rock Sioux Tribe reservation).

Life expectancy rates in nearly all counties with tribal communities increased between 1980 and 2014, as

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overall national rates also increased. For instance, the Oglala Lakota County average life expectancy increased by 5.4 years during this time, from 61.3 years in 1980 to 66.8 years in 2014. However, the average life expectancy for those in predominantly American Indian counties is 12.5 years shorter than the overall life expectancy rate in South Dakota.

Policy Recommendations

TFAH has issued the following set of recommendation to help the nation achieve health equity:

- **Create strategies to optimize the health of all Americans, regardless of race, ethnicity, income or where they live.** All levels of government must invest in analyzing needs and increasing effective policies and programs to address the systematic inequities that exist and the factors that contribute to these differences, including poverty, income, racism and environmental factors. These should include community-driven approaches, including using place-based approaches to target programs, policies and support effectively.

- **Expand cross-sector collaborations addressing health equity.** Improving equity in health will require supporting and expanding cross-sector efforts to make communities healthy and safe. Efforts should engage a wide range of partners, such as schools and businesses, to focus on improving health through better access to high-quality education, jobs, housing, transportation and economic opportunities.[39]

- **Fully fund and implement health equity, health promotion and prevention programs in communities.** Partner with a diverse range of community members to develop and implement health improvement strategies. Federal, state, local and tribal governments must engage communities in efforts to address both ongoing and emergency health threats. The views, concerns and needs of community stakeholders, such as volunteer organizations, religious organizations and schools and universities, must be taken into account in this process. Proven, effective programs, such as CDC's REACH (Racial and Ethnic Approaches to Community Health) should be fully-funded and expanded.

- **Collect data on health and related equity factors — including social determinants of health — by neighborhood.** There should be a priority on improving data collection at a very local level to understand connections between health status and the factors that impact health to help identify concerns and inform the development of strategies to address them. Collecting and reporting data by neighborhood at a zip code or even more granular neighborhood level are essential.

- **Support Medicaid coverage and reimbursement of clinical-community programs to connect people to services that can help improve health.** Medicaid should reimburse efforts that support improved health beyond the doctor's office — programs such as asthma and diabetes prevention and care management and community-based initiatives, can help better address the root causes that contribute to inequities.

- **Communicate effectively with diverse community groups.** Federal, state, local and tribal officials must design culturally competent, inclusive and linguistically appropriate communication campaigns that use respected, trusted and culturally competent messengers to communicate their message. Communication channels should reflect the media habits of the target audience.

- **Prioritize individual and community resiliency in health emergency preparedness efforts.** Federal, state, local and tribal government officials must work with communities and make a concerted effort to address the needs of low-income, minority and other vulnerable groups during health emergencies. Public health leaders must develop and sustain relationships with trusted organizations and stakeholders in diverse communities on an ongoing basis—including working to improve the underlying health of at-risk individuals, sub-population groups and communities, so these relationships are in place before a disaster strikes. Communication and community engagement must be ongoing to understand the disparate needs of various populations.

- **Eliminate racial and ethnic bias in healthcare.** Policies should incentivize equity and penalize unequal treatment in healthcare, and there should be increased support for programs to increase diversity in and across health professions. Some of The Joint Commission's recommendations for combatting implicit bias include: assiduously practicing evidence-based medicine; supporting cultural understanding and avoiding stereotypes; supporting the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care; and supporting techniques that de-bias care, including through training, perspective-taking, emotional expression and counter-stereotypical exemplars.[40] In addition, efforts should be increased to train more healthcare professionals from under-represented populations so that the workforce reflects the diversity of the patient population.

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- **Incorporate strategies that foster community agency—or a community's collective ability and opportunity to make purposeful choices—into the design, implementation and governance of multi-sector collaborations.** Building community agency can contribute to improved community health by yielding a deeper understanding of the challenges and opportunities influencing a community, and relies on an asset-based approach to leverage existing community strengths and resources. Multi-sector collaborations should include dedicated resources for fostering and measuring community agency. Efforts should maximize and bolster community voice and power as a means to influencing larger policy- and systems-level changes (including those within and outside of the traditional health sector).

Examples of Programs Addressing Health Equity

The following examples illustrate several current initiatives that target the higher rates of preventable injuries, illnesses and deaths. They highlight diverse practices that incorporate organizations and individuals from multiple sectors including education, criminal justice and business as well as public health and healthcare. While every community and effort is unique, they all share an approach of focusing on equity and inclusive work at the local community level.

The California Endowment's Building Healthy Communities

The California Endowment (TCE) created an ambitious $1 billion, 10-year project called Building Healthy Communities (BHC) in 2010. Its goal is to improve the health and well-being of young people in underserved communities by reducing or eliminating harmful conditions. It has provided funding to 14 community-based organizations across the state to undertake activities that were customized to the specific local conditions but which had the potential to affect state policies and practices as well. As a result of its work, BHC has seen improvements in healthcare coverage, including for those who were undocumented; the promotion of healthy school environments and altered school policies such as those related to discipline and suspension; the reform of the justice system; and the implementation of multiple local changes that make communities safer and more walkable.

BHC is noteworthy in its commitment to developing long-term relationships with specific partners, placing the decision-making authority for the usage of the grants at the community level and focusing on youth leadership and organizing.
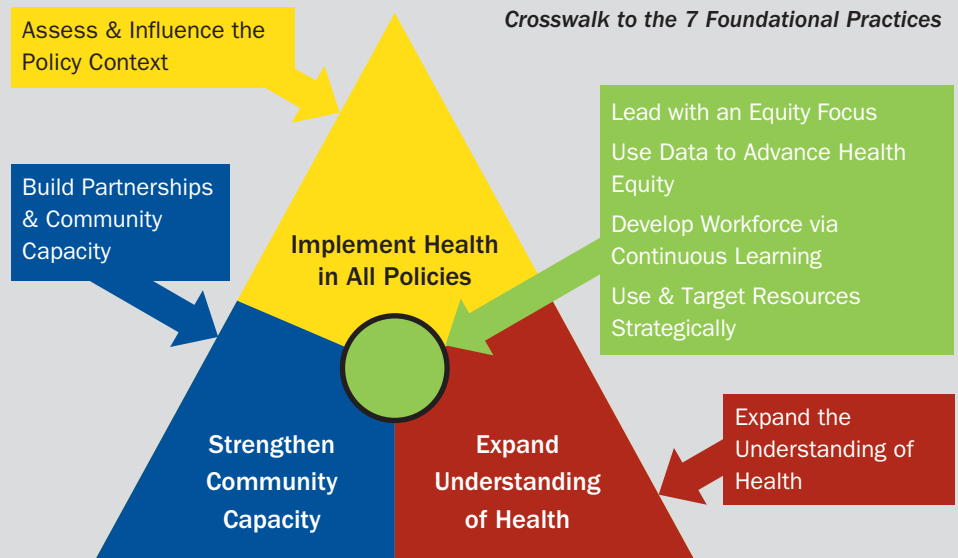
Minnesota Public Health Department

The Minnesota Department of Health prioritized work on health equity. It created an internal Center for Health Equity and a Health Equity Advisory and Leadership (HEAL) Council as part of a broad effort. The Center has awarded scores of grants to community agencies including ones that identify and address the social and economic conditions that contribute to inequities and ones that support the improvement of the health status of groups with poorer health. The Health Department has taken steps to establish an open participatory process for this work, including many members of the populations at highest risk of illness, injury and preventable deaths on the Advisory Council and holding statewide meetings to discuss progress toward health equity.

It has developed a framework for considering the work that is known as the *Triple Aim of Health Equity* with three components: implementing health in all

Triple Aim of Health Equity

Crosswalk to the 7 Foundational Practices

Assess & Influence the Policy Context

Build Partnerships & Community Capacity

Implement Health in All Policies

Lead with an Equity Focus

Use Data to Advance Health Equity

Develop Workforce via Continuous Learning

Use & Target Resources Strategically

Strengthen Community Capacity

Expand Understanding of Health

Expand the Understanding of Health

policies, expanding the understanding of health and strengthening community capacity. The Health Department has developed a series of reports and resources on the topic for those in and beyond the state including materials on emergency communications, paid sick leave and health statistics (http://www.health.state.mn.us/divs/opi/healthequity/resources/).

Roadmap to Health Equity

The health indicators for the Black population of Mississippi are significantly worse than for the White population. Black residents live on average 4 years less than Whites and have more deaths from cancer, heart disease, HIV and many other chronic conditions. The Mississippi Roadmap to Health Equity, Inc., a community-based organization in Jackson, is actively engaged in improving those statistics with its focus on changing the conditions in the lives of the low-income Black population.

It has a strong focus on the health of children by supporting food and nutrition awareness policies within schools. It is responsible for multiple school gardens that are used to teach children about

nutrition and provide them with healthy foods. It offers a leadership program for young students that provides educational lessons in school-work, presentation skills and beneficial eating and exercising practices.

For adults, the Roadmap runs a Mobile Farmer's Market that delivers fresh fruit and vegetables to older residents of geographically isolated housing complexes. And it runs a fitness center for adults and children that is accessible and affordable with minimal membership fees. Support for the Roadmap has been provided by the W. K. Kellogg Foundation. More information on the Roadmap is available at http://mississippiroadmap.org/.

FECAL OCCULT BLOOD TESTING

FOR COLORECTAL HEALTH

Protect Yourself, Your Family and Our Community

www.tribalcolorectalhealth.org

Colorectal Cancer Screening

Racial and ethnic minority populations often have lower colorectal cancer screening rates than White populations (U.S. White rates were 65 percent compared to 62 percent, 54 percent and 50 percent rates for Black, American Indian and Latino populations respectively).[41]

Specialized outreach and education programs have been shown to be effective at closing the gap by using multiple targeted approaches such as patient reminders and patient navigators for outreach and assistance. Two examples of such successful efforts are the Alaska Native Tribal Health Consortium and Washington State's Breast, Cervical and Colon Health program.

The Alaska Consortium collaborated with regional tribal health organizations to hire patient navigators to do outreach and one-on-one patient education and to assist with transportation and other barriers to accessing appointments. In addition, they developed an electronic system to send both clinician and client informational reminders.

Colorectal Health
Protect Yourself, Your Family, and Our Community

The Washington State program utilized patient care coordinators at community health center sites to implement client and provider telephone and electronic health record reminder systems and to provide staff training on the protocols for scheduling of screening. In both cases, colonoscopy rates for populations of color dramatically increased, sometimes doubling what they were before.[42, 43] More information about evidence-based programs to reduce chronic diseases that disproportionately affect specific populations is available at https://www.cdc.gov/chronicdisease/healthequity/index.htm.

Healthy Heartlands

The Healthy Heartlands initiative is an eight-state network of public health professionals and faith-based community organizers working to reduce health inequities through democracy building and policy and system changes.[44] The initiative combines the research, institutional legitimacy and content expertise of public health leaders with the local voice, power and engagement capacities of community organizers. Through their collaborative actions, the network of interdisciplinary leaders works to identify and address the social determinants of health for low-income communities and communities of color using a racial health equity lens. Leaders from across the participating Midwestern states gather regularly to share best practices and advance an action agenda for racial and health equity. Past efforts have included campaigns to increase employment opportunities for formerly incarcerated persons, expand access to healthy food and promote free, quality early education.

Robert Wood Johnson Foundation Culture of Health Sentinel Communities—Stockton, CA

Located in Northern California, Stockton has long been plagued by crime and poverty. The crime rate in Stockton is more than three times the rate in California. And there are high levels of poverty, which are highest among racial and ethnic minority communities, where nearly 50 percent of Black residents and more than 29 percent of Hispanic residents were living below the federal poverty level (compared with less than 17 percent of White residents).[45]

Community members and public officials are collaborating to address these issues by elevating early intervention and education, fostering cross-sector collaboration, reducing barriers to housing and homeownership, and strengthening integration of health services and systems. In 2015, city council and community members created the Reinvent South Stockton Coalition (RSSC) to empower residents and community stakeholders to improve their city's safety, education, housing, job creation, and health. RSSC deploys four outreach workers to build trust and relationships between community members and government officials, assess community needs and appropriately connect residents to available services/supports. Other efforts include a 2014 ¾ cent tax to increase the capacity of the police force from 400 officers in 2015 to a goal of 485 by 2017.

Stockton, CA is one of RWJF's 30 Sentinel Communities chosen to collect, analyze and disseminate community-level data to provide insight on the best practices and lessons for improving health and wellbeing. Baseline data was collected in 2016 and future community snapshot reports will include more in-depth analysis and insight on health equity outcomes and process measures.

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