Health Equity and Social Justice: A Health Improvement Tool

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I feel obligated to begin with a warning: this essay may get uncomfortable. It is simply impossible to talk about the roles that racism and discrimination play in the health of our communities without taking a hard look inward—without asking ourselves and our colleagues to think about the ways that our institutions and organizations perpetuate bias and historical trauma. Perhaps more than most fields of work, public health is paved with good intentions, with the worthy goals of alleviating suffering and extending life. But we are at a point in public health history in which good intentions and good science are no longer enough. We must listen more to the people we serve, have uncomfortable conversations, and increase our push for social justice.

Let me explain. Today, the biggest threats to the health and longevity of Americans are preventable diseases. These are the diseases that are burying us in preventable suffering, as well as crippling our communities with mountains of avoidable medical bills. The root causes of many of these health threats are inextricably linked to the social determinants of health and the conditions that shape a person's opportunity to attain good health and adopt healthy behaviors. These social determinants include access to safe housing, good jobs with living wages, quality education, affordable health care, nutritious foods, and safe places to be physically active. They also include racism, discrimination, and bias.

If we travel far upstream to uncover the roots of disease and disability—and by that same token, to uncover the roots of today's persistent health disparities—the roles of racism, discrimination, and bias in perpetuating generational cycles of poor health and risky health behaviors are easier to see. It is easy to see how the blatantly discriminatory policies of our nation's past made it impossible for certain groups of Americans to attain optimal health. What is much harder—and oftentimes uncomfortable—is to realize that the legacy of our history did not disappear with the signing of new laws. It is uncomfortable, but we must continue to confront and acknowledge that history if we truly want to eliminate health disparities and create a nation in which every person has the opportunity to live a long and healthy life.

SOCIAL JUSTICE AND HEALTH: ACHIEVING HEALTH EQUITY

I believe that one of our biggest misconceptions—and perhaps, obstacles—is misconstruing access for equity. Here is a good example: 50 years ago, President Lyndon Johnson signed the Medicare program into law. A year before, passage of the Civil Rights Act prohibited the use of federal funds by programs or organizations that engaged in racial segregation or discrimination. Combined, the two federal measures led to more than 1,000 hospitals integrating their hospitals and medical staff. Today, every older American has access to the health care system and yet, serious disparities persist. For example, older black Americans still have higher rates of premature death from diabetes and often receive a lower quality of care. They also face a higher risk of disability than older white Americans, while older American Indians and Alaska Natives often face the highest rates of disability among all population groups. Only one-half of older Hispanic Americans have received the pneumococcal vaccine.

Why is this? Why do we continue to see such disparate health outcomes across our communities, despite our efforts to widen access to the best medical care in the world? This is a monumentally important question, especially as the Patient Protection and Affordable Care Act expands access to millions of previously uninsured Americans with an ultimate goal of universal insurance coverage. How do we translate access for all into health for all? The answer is health equity, which is intrinsically linked to acknowledging the long-lasting effects of our history, allowing that acknowledgement to shape our interactions with disadvantaged communities, and actively looking for ways in which our institutions and systems may perpetuate bias and historical trauma.

According to Paula Braveman and Laura Gottlieb in a 2014 article in *Public Health Reports*:

> Health equity means social justice in health (i.e., no one is denied the possibility to be healthy for belonging to a group that has historically been economically/socially disadvantaged). Health disparities are the metrics we use to measure progress toward achieving health equity. A reduction in health disparities (in absolute and relative terms) is evidence that we are moving toward greater health equity.

Social justice, on the other hand, is defined as "justice in terms of the distribution of wealth, opportunities and privileges within a society," according to the *New Oxford American Dictionary*. Ensuring social justice is therefore one component to achieving health equity.

The research on the intersections between health, racism, and discrimination is plentiful. Here are just a few examples. A 2013 study published in the *Maternal and Child Health Journal* examined the perceptions of prenatal care among black women with limited incomes and found that the "majority of women described experiences that fit within a definition of institutionalized racism in which the system was designed in a way that worked against their attempts to get quality prenatal care." In particular, many women felt they were treated differently based on their race or whether they had private or public health insurance. A 2004 study published in the *American Journal of Public Health* actually concluded that self-reported experiences of racial discrimination were associated with preterm birth and low birth weight deliveries. A number of studies have found that daily experiences with bias and discrimination contribute to chronic stress among racial and ethnic minorities, which may contribute to higher rates of chronic illness. Another study published this year in the *Journal of General Internal Medicine* found that experiences of discrimination within health care settings were associated with new or worsening disabilities among older patients.

Outside the world of academic journals, our struggles with race and equality are painfully obvious as well. The recent series of deadly altercations between law enforcement officers and unarmed black men are raising the consciousness of Americans to the corrosive nature of racism and discrimination on the well-being of communities and the need to achieve social justice as a component of any effort to achieve health equity.

Public health has a vital role in the health equity movement. Our long-time connections to the communities we serve and our deep understanding of the connections between individual health and community conditions are essential to achieving equity and eliminating health disparities. However, even within the public health field, making an earnest shift toward health equity means having that "uncomfortable" conversation—we must also look inward and ask how our actions may perpetuate feelings of exclusion among the most vulnerable. How can we build relationships of genuine trust?

The American Public Health Association (APHA) recently released a new report on health equity that tells the stories of five health departments and communities that have committed to achieving health equity. I think one of those stories, in particular, is a perfect example of how committing to health equity requires real transformation. The story takes place at the Multnomah County Health Department in Oregon, where health workers had set out to tackle poor birth outcomes and high infant mortality rates within the American Indian and Alaska Native community. They did everything one would expect: collected and analyzed the data, applied for grant funding, and sought out support from the local Indian Health Board. But once they actually went into the community to engage local partners, everything began to fall apart. They quickly realized they had overlooked the most critical aspect: **trust**.

The health workers had no relationship with the people they hoped to help—they were another government entity coming in with a top-down, predetermined agenda. They had no institutional knowledge of how to effectively partner with the Native community. So they let go of their agenda and decided to simply listen to the community's stories and have open, honest discussions about the role of government in perpetuating inequities among Native people. Today, the outcome of those discussions is known as the Future Generations Collaborative, a truly community-driven effort in which acknowledging the role of historical trauma and oppression is essential to shaping effective health interventions. In the APHA report, the collaborative's project manager within the health department said:

> If we really want to get to a place of health equity, we have to dismantle the systems that are preventing communities from reaching their full potential. That means examining how our systems perpetuate inequality....The first day I was able to completely abandon my own agenda was the day I became a transformed professional.

Seeing health through a health equity lens means listening to those we serve and acknowledging their experiences. It means looking deep inside ourselves and our institutions, no matter how uncomfortable the journey. The march toward health equity will be a long one, requiring the support of players across private and public sectors. But at the end of the day, health equity is the ultimate form of patient-centered care.

SOURCES

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