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Report identifies root causes of health inequity in the U.S., outlines solutions for communities

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The burdens of poor health and the benefits of good health and well-being are inequitably distributed in the U.S. due to factors that range from poverty and inadequate housing to structural racism and discrimination, says a new report from the National Academies of Sciences, Engineering, and Medicine. Community-driven interventions targeting these factors hold the greatest promise for promoting health equity—the state in which everyone has the opportunity to attain full health potential and no one is disadvantaged from achieving this potential because of social position or any other socially defined circumstance.

Health inequities are systematic differences in the opportunities that groups have to achieve optimal health, leading to unfair and avoidable differences in health outcomes. Health inequity is costly for the United States with respect to health care expenditures, national security, business viability, and economic productivity, the report says. For example, a 2009 analysis found that eliminating health disparities for minorities would have reduced direct medical care expenditures by $229.4 billion for the years 2003-2006.

Beyond international rankings showing that the U.S. has higher rates of infant mortality and shorter life expectancy than other wealthy nations, racial, ethnic, and socio-economic disparities exist at the state level and among and within counties for these health indicators. Research shows

that where one lives is a greater predictor of one's health than individual characteristics or behaviors. The report describes nine determinants of health that are drivers of health inequities: income and wealth, housing, health systems and services, employment, education, transportation, social environment, public safety, and physical environment.

"When our nation's founders wrote that 'all men are created equal' with the right to 'life, liberty, and the pursuit of happiness', it is unlikely they envisioned a country where health status and life expectancy could be ordained by zip code, economic, or educational status," said committee chair James Weinstein, CEO and president of the Dartmouth-Hitchcock health system and Peggy Y. Thomson Professor at the Geisel School at Dartmouth. "Health inequities are a problem for us all—the burden of disparities in health adversely affects our nation's children, business efficiency and competitiveness, economic strength, national security, standing in the world, and our national character and commitment to justice and fairness of opportunity. It is the committee's hope that this report will inform, educate, and ultimately inspire others to join in efforts across the nation to achieve America's promise for all the people of this country."

Communities—defined in the report as the residents, religious congregations, community-based organizations, and others who live and work in a specific geographic location—can play a powerful role in changing the conditions for health. Their actions need a nurturing environment, supported and facilitated by public and private sector policies, resources, and partnerships. A community-based solution is an action, policy, law, or program that is driven by the community, affects local factors that can influence health, and has the potential to advance health equity. The committee that conducted the study and wrote the report identified nine examples of community-based solutions that address health inequities, all of which share the three elements in the report's conceptual model: making health equity a shared vision and

value, fostering multisector collaboration, and increasing community capacity to shape outcomes.

- Blueprint for Action, Minneapolis, Minnesota: A strategic plan that employs the public health approach to youth violence prevention that arose from a community-driven, grassroots response to the issue.
- Delta Health Center, Mound Bayou, Mississippi: The first federally qualified rural health center, employing a community-oriented primary care model and addressing health-related factors such as transportation and food.
- Dudley Street Neighborhood Initiative, Boston, Massachusetts: A nonprofit, community-driven organization that empowers residents to drive economic development, neighborhood revitalization, and youth education opportunities.
- Eastside Promise Neighborhood, San Antonio, Texas: An implementation site of the U.S. Department of Education's Promise Neighborhood grant program, developing collaborative solutions to address barriers to education.
- Indianapolis Congregation Action Network, Indianapolis, Indiana: A multifaith, nonpartisan organization that catalyzes marginalized people and faith communities to organize for racial and economic equity.
- Magnolia Community Initiative, Los Angeles, California: An initiative that seeks to increase social connectedness, community mobilization, and access to vital supports and services to improve outcomes for children.
- Mandela Marketplace, Oakland, California: A nonprofit organization that addresses issues of food insecurity and economic divestment through the creation of sustainable food systems.
- People United for Sustainable Housing, Buffalo, New York: A nonprofit organization that mobilizes residents to secure quality,

affordable housing, and advance economic justice.
- WE ACT for Environmental Justice, Harlem, New York: A nonprofit organization that engages in community organizing, community-based participatory research, and advocacy to confront environmental injustice.

While it will take considerable time to address the root causes of health inequity, all actors in the community—residents, businesses, state and local government, health care and academic institutions, and other partners—have the power to change the narrative and help promote health equity, the report says. Early and achievable targets might include reducing mortality, increasing graduation rates, reducing environmental hazards, and increasing access to environmental benefits.

In the education sector, infrastructure could be strengthened, modified, or expanded in the interest of improving health outcomes. State departments of education should provide guidance to schools on how to conduct assessments of student health needs and of the school health and wellness environment, the report says. In addition, to support schools in collecting data on student and community health, tax-exempt hospitals and health care systems and state and local public health agencies should make schools aware of existing health needs assessments to help them leverage the current data collection and analyses.

Through multisectoral partnerships, hospitals and health care systems should focus their community benefit funds to pursue long-term strategies including changes in law, policies, and systems to build healthier neighborhoods, expand access to housing, drive economic development, and advance other initiatives aimed at eradicating the root causes of poor health, especially in lower-income communities.

Government and nongovernment payers and providers should expand policies aiming to improve the quality of care, improve population

health, and control health care costs to include a specific focus on improving population health for the most underserved. As one strategy to support a focus on health disparities, the Centers for Medicare & Medicaid Services could undertake research on payment reforms that could spur accounting for social risk factors in value-based payment programs it oversees.

The report notes the importance of factors such as race, ethnicity, disability status, veteran status, rurality, and urbanicity in shaping inequities. The committee made recommendations to enable researchers to fully document and understand health inequities, provide the foundation for developing solutions, and measure their outcomes longitudinally. For example, an expansion of current health disparity indicators and indices to include other groups beyond African-Americans and whites is needed, such as Hispanics and their major subgroups, Native Americans, Asian Americans, Pacific Islanders, and mixed race, in addition to LGBT, people with disabilities, and military veterans. Government agencies, private foundations, and academic centers of higher education also should support research that examines the multiple effects of structural racism and implicit and explicit bias across different categories of marginalized status on health and health care delivery, and explores effective strategies to reduce and mitigate those effects.

This report is the first of a series of activities of the National Academy of Medicine's (NAM) Culture of Health program, a multiyear collaborative effort funded by the Robert Wood Johnson Foundation to identify strategies to achieve equitable good health for everyone in America.

"This report addresses the root causes of health inequity and lays out several specific approaches for communities to take in order to achieve health equity, which is vital to the health and well-being of the nation,"

said National Academy of Medicine President Victor J. Dzau. "With the support of the Robert Wood Johnson Foundation, the NAM is committed to a long term effort to achieve health equity in the United States. Through our Culture of Health Program, we will be working over the next several years with stakeholders from multiple sectors and regions across the U.S. to impact policy, science, and practice to improve many of the social determinants of health that are the drivers of future health of the nation."

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