CONSIDERING ESSENTIAL COMPONENTS OF CARE WHILE MAINTAINING A FOCUS ON BEHAVIORAL HEALTH EQUITY

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DISCLOSURES

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THE SOCIAL DETERMINANTS OF HEALTH

Those factors that impact upon health and well-being: the circumstances into which we are born, grow up, live, work, and age, including the health system

These circumstances are shaped by the distribution of
money, power, and resources at global, national, and local levels,
which are themselves influenced by policy choices

World Health Organization: Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health: Commission on the Social Determinants of Health, 2008.

HEALTH DISPARITIES AND HEALTH INEQUITIES

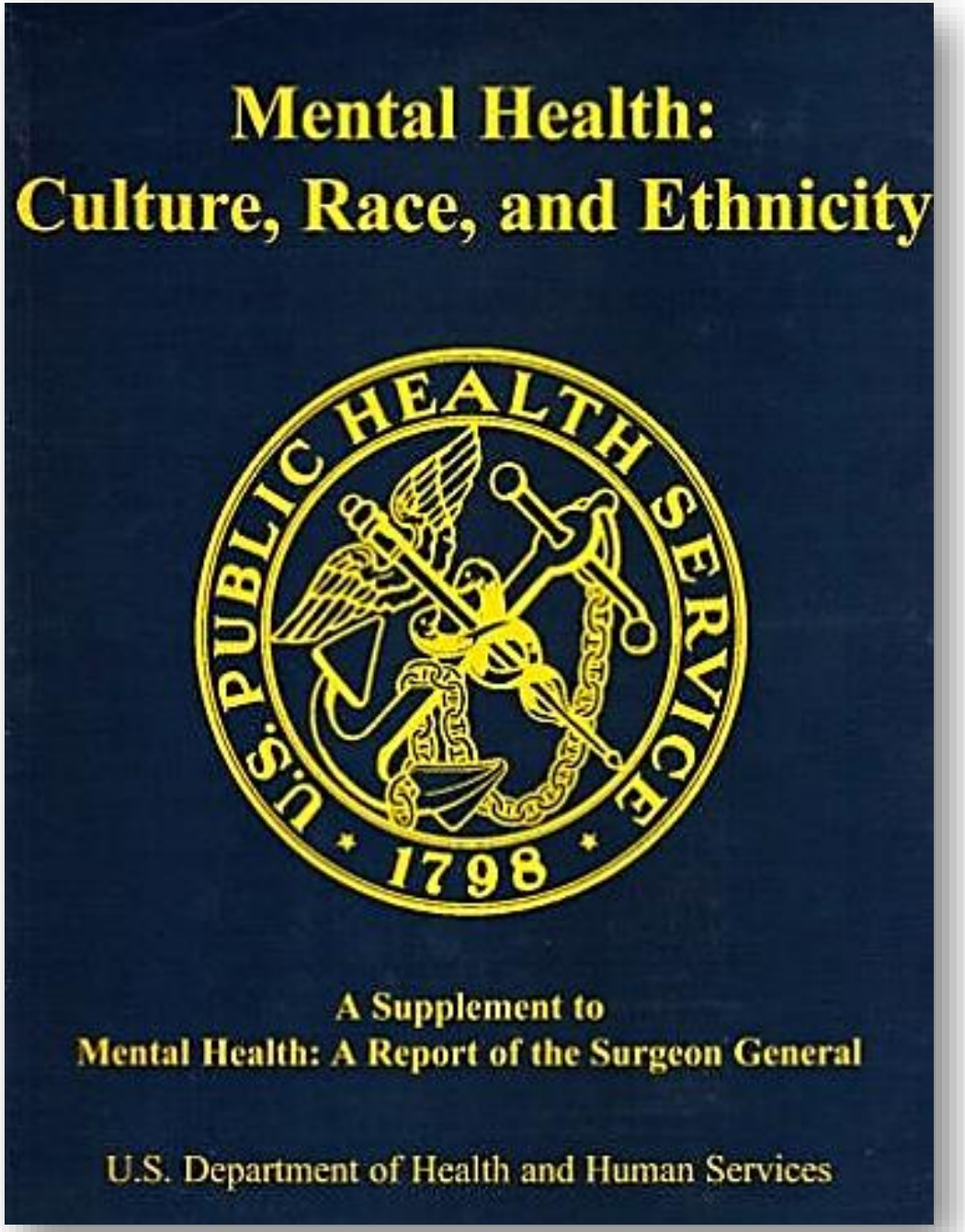
The social determinants of health are prominently responsible for health disparities and inequities experienced within and between countries

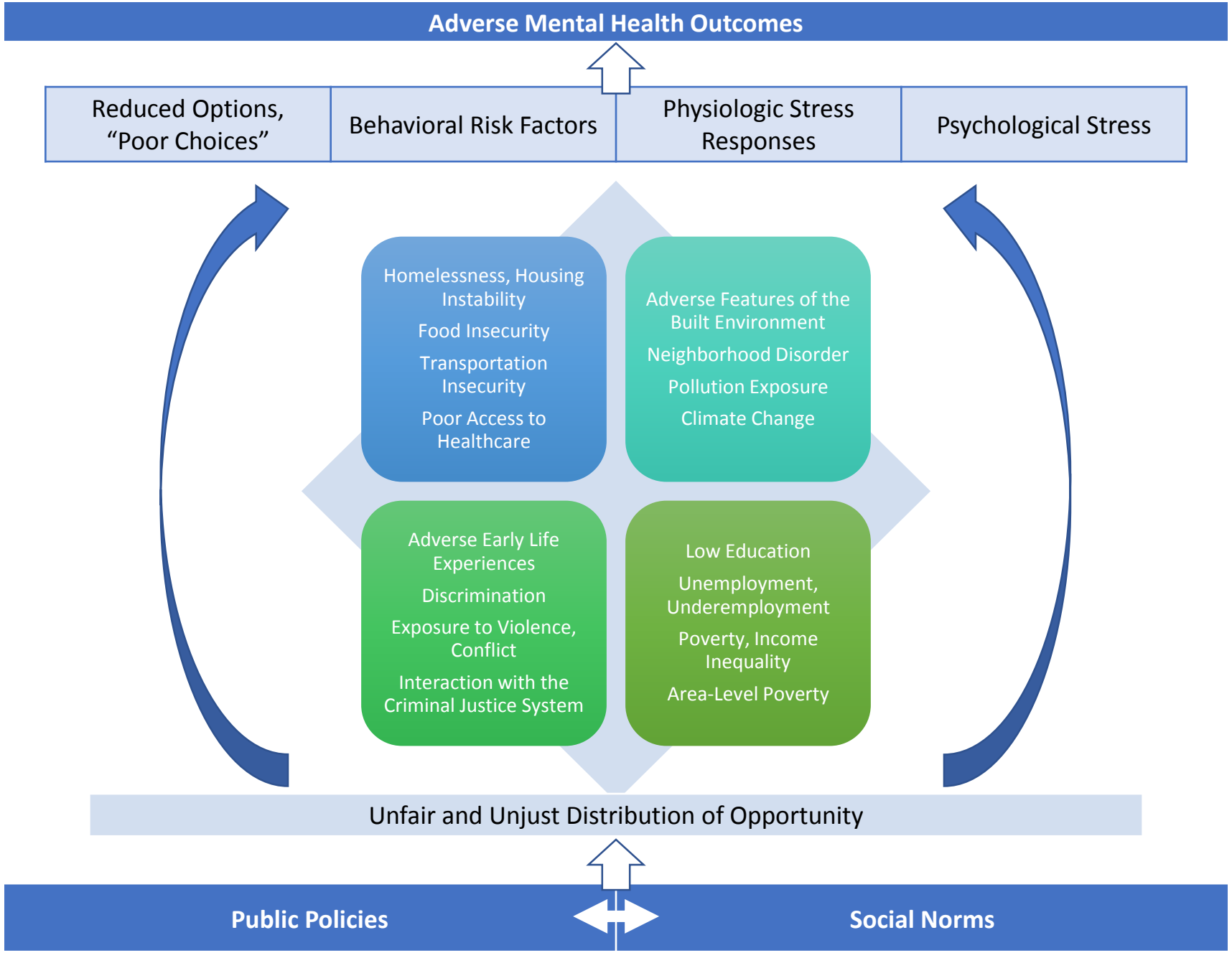
***Health disparities*:** differences in health status among distinct segments of the population including differences that occur by gender, race or ethnicity, education or income, disability, or living in various geographic localities

***Health inequities*:** disparities in health that are a result of systemic, avoidable, and unjust social and economic policies and practices that create barriers to opportunity

Racial and ethnic minority groups:

- Have ***less access*** to and availability of care
- Receive generally ***poorer quality*** mental health services
- Experience a ***greater disability*** burden from unmet mental health needs




Adverse Mental Health Outcomes
Reduced Options, "Poor Choices"
Behavioral Risk Factors
Physiologic Stress Responses
Psychological Stress
Homelessness, Housing Instability
Food Insecurity
Transportation Insecurity
Poor Access to Healthcare
Adverse Features of the Built Environment
Neighborhood Disorder
Pollution Exposure
Climate Change
Adverse Early Life Experiences
Discrimination
Exposure to Violence, Conflict
Interaction with the Criminal Justice System
Low Education
Unemployment, Underemployment
Poverty, Income Inequality
Area-Level Poverty
Unfair and Unjust Distribution of Opportunity
Public Policies
Social Norms

"Assuring the protection of equal access to liberties, rights, and opportunities, *as well as taking care of the least advantaged members of society.*"

- John Rawls

STRUCTURAL RACISM

- A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity.
- Structural racism identifies dimensions of our history and culture that have allowed privileges associated with “whiteness” and disadvantages associated with “color” to endure and adapt over time.
- Structural racism is not something that a few people or institutions choose to practice. Instead it has been a feature of the social, economic, and political systems in which we all exist.
- Structural mechanisms do not require the actions or intentions of others

Bonilla-Silva, E. (1997). Rethinking racism: Toward a structural interpretation. *American sociological review*, 465-480.

Even if interpersonal discrimination was eliminated today, racial/ethnic inequities would remain due to the persistence of structural racism

EXAMPLES OF STRUCTURAL RACISM

SOCIAL SECURITY ACT OF 1935

THE WAR ON DRUGS

RESIDENTIAL SEGREGATION

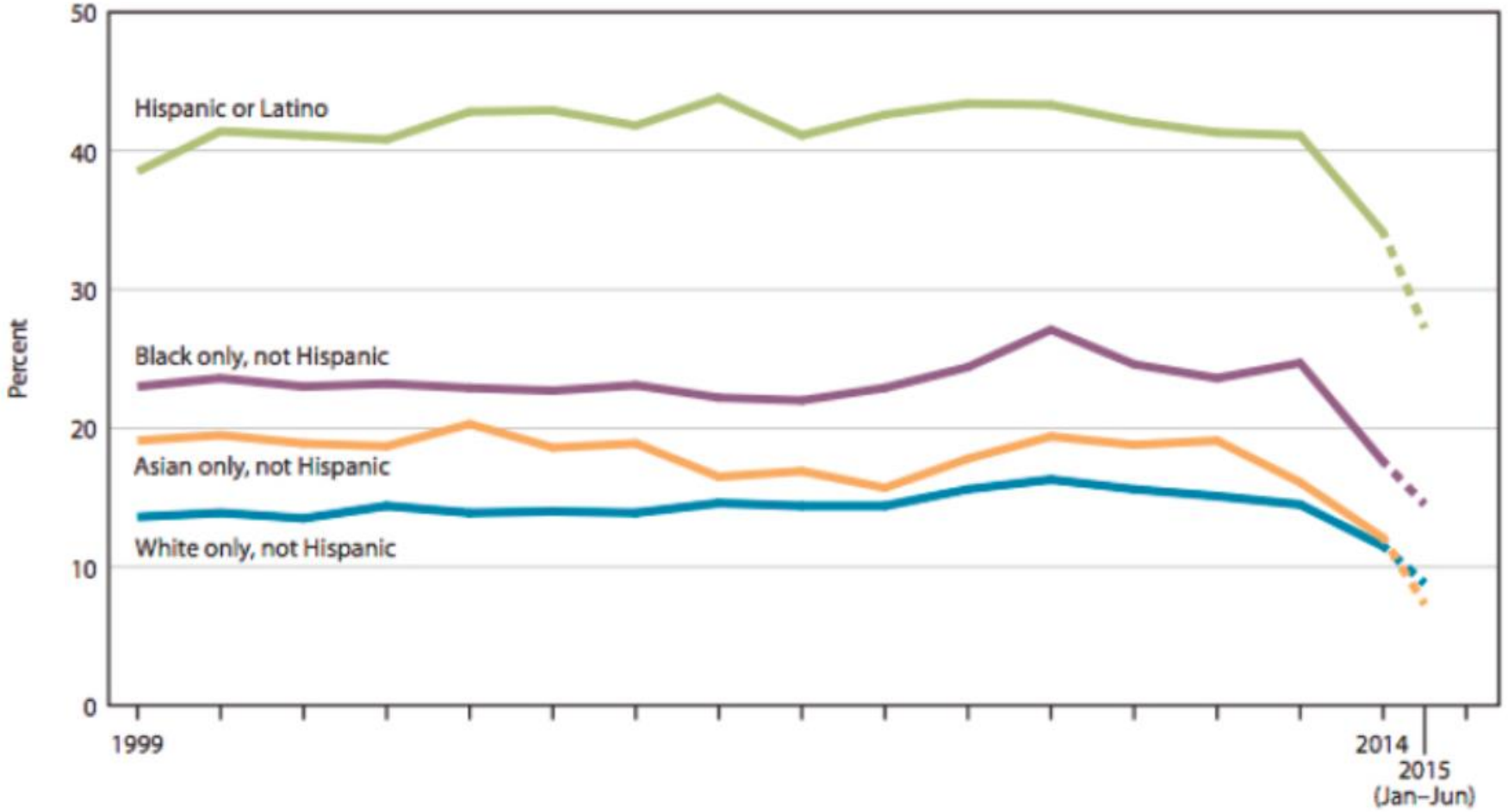
HEALTHCARE QUALITY AND ACCESS

IMMIGRATION POLICY

Gee, G., & Ford, C. (2011). Structural Racism and Health Inequities: Old Issues, New Directions. *Du Bois Review: Social Science Research on Race, 8*(1), 115-132.

Bailey, Z. D., Krieger, N., Agénor, M., Graves, J., Linos, N., & Bassett, M. T. (2017). Structural racism and health inequities in the USA: evidence and interventions. *The Lancet, 389*(10077), 1453-1463.

PERCENT OF ADULTS WITH NO HEALTH INSURANCE COVERAGE BY RACE AND ETHNICITY



NCHS (National Center for Health Statistics). 2016. Health, United States, 2015: With special feature on racial and ethnic health disparities. Hyattsville, MD: U.S. Centers for Disease Control and Prevention.

Meta-Analyses show racism and discrimination are associated with poorer mental health

PLOS ONE

RESEARCH ARTICLE

Racism as a Determinant of Health: A Systematic Review and Meta-Analysis

Yin Paradies[1]*, Jehonathan Ben[1], Nida Denson[2], Amanuel Elias[1], Naomi Priest[3], Alex Pieterse[4], Arpana Gupta[5], Margaret Kelaher[6], Gilbert Gee[7]

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OPEN ACCESS

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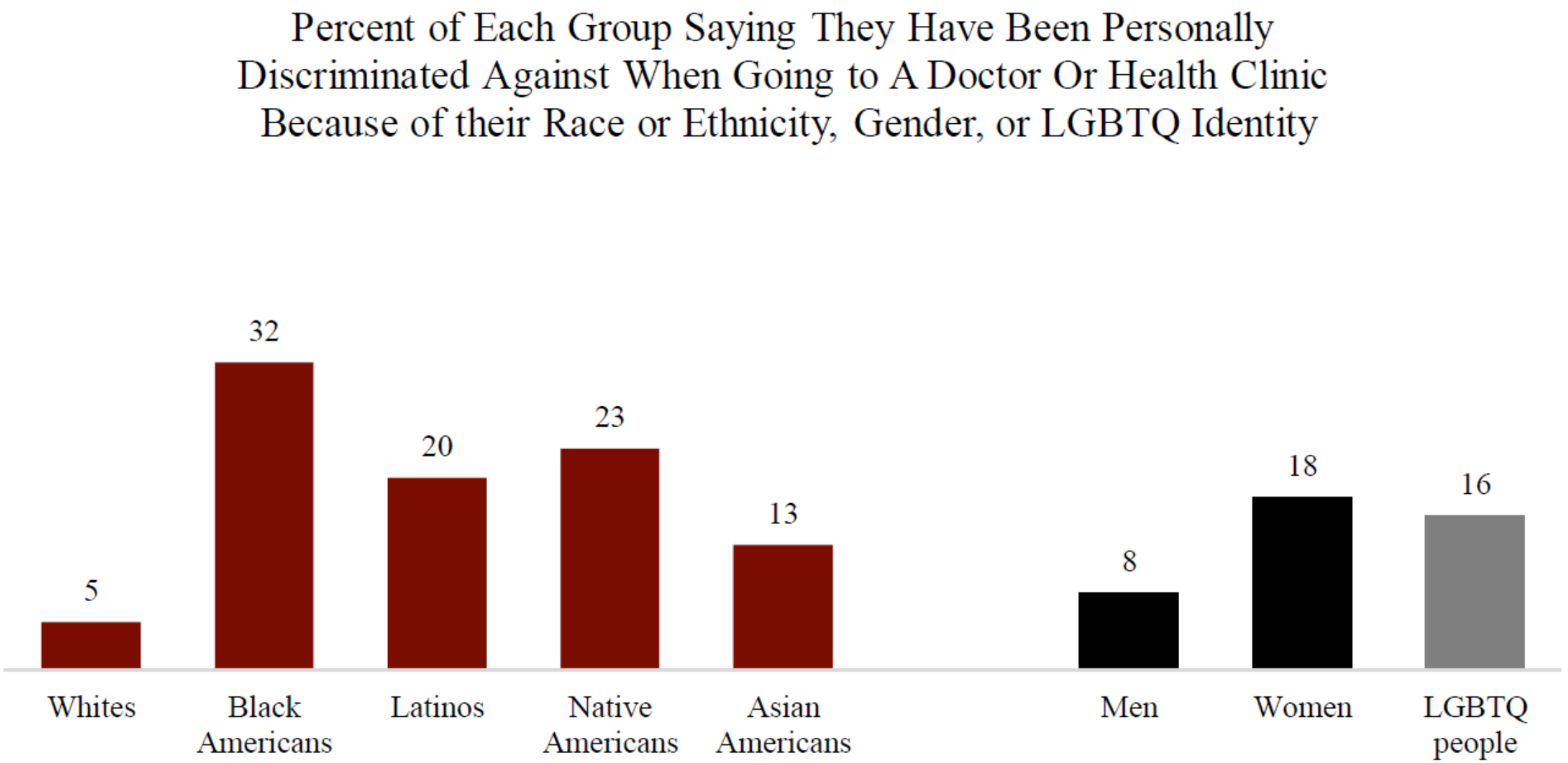
Abstract

Despite a growing body of epidemiological evidence in recent years documenting the health impacts of racism, the cumulative evidence base has yet to be synthesized in a comprehensive meta-analysis focused specifically on racism as a determinant of health. This meta-analysis reviewed the literature focusing on the relationship between reported racism and mental and physical health outcomes. Data from 293 studies reported in 333 articles published between 1983 and 2013, and conducted predominately in the U.S., were analysed using random effects models and mean weighted effect sizes. Racism was associated with



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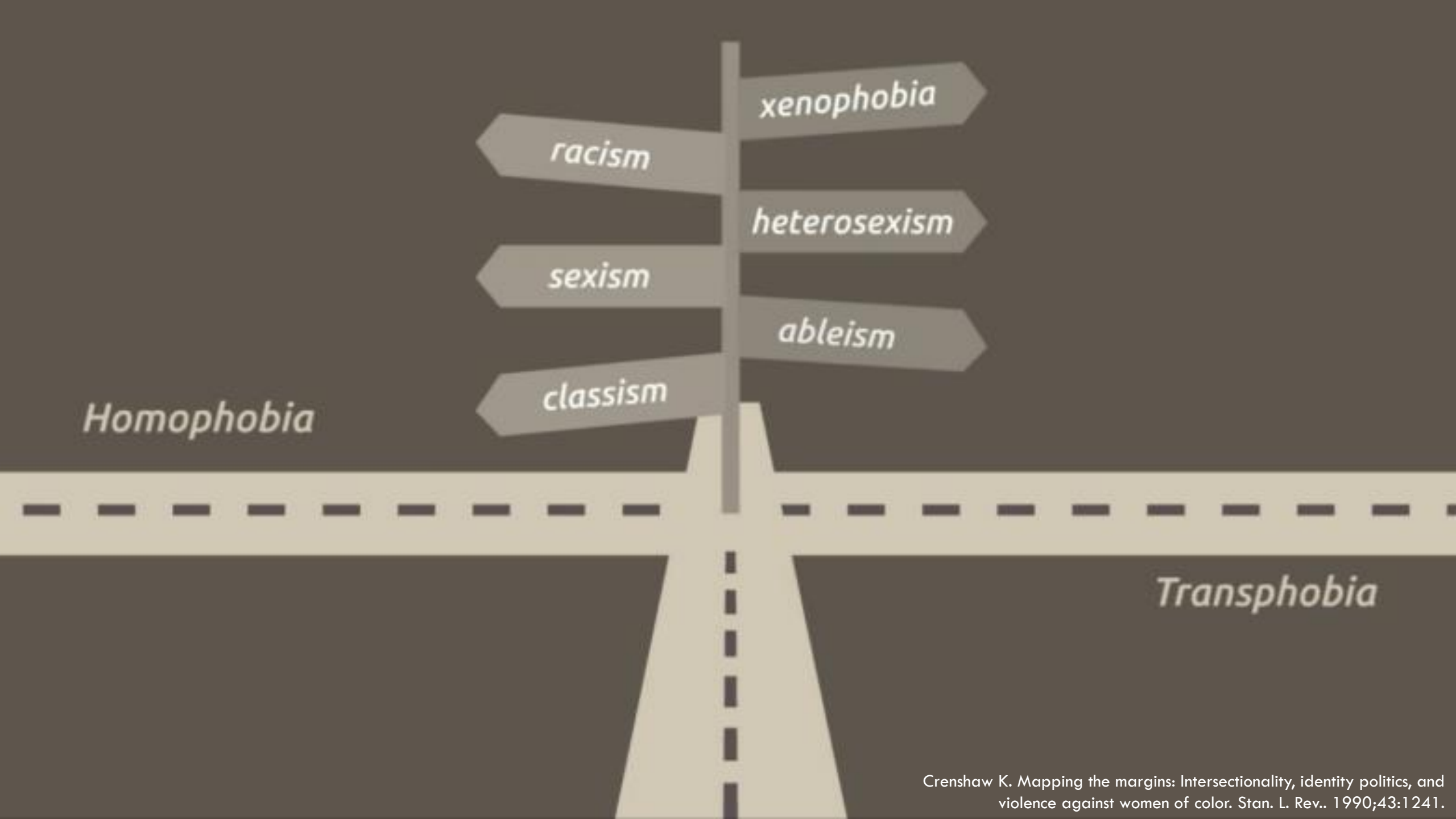
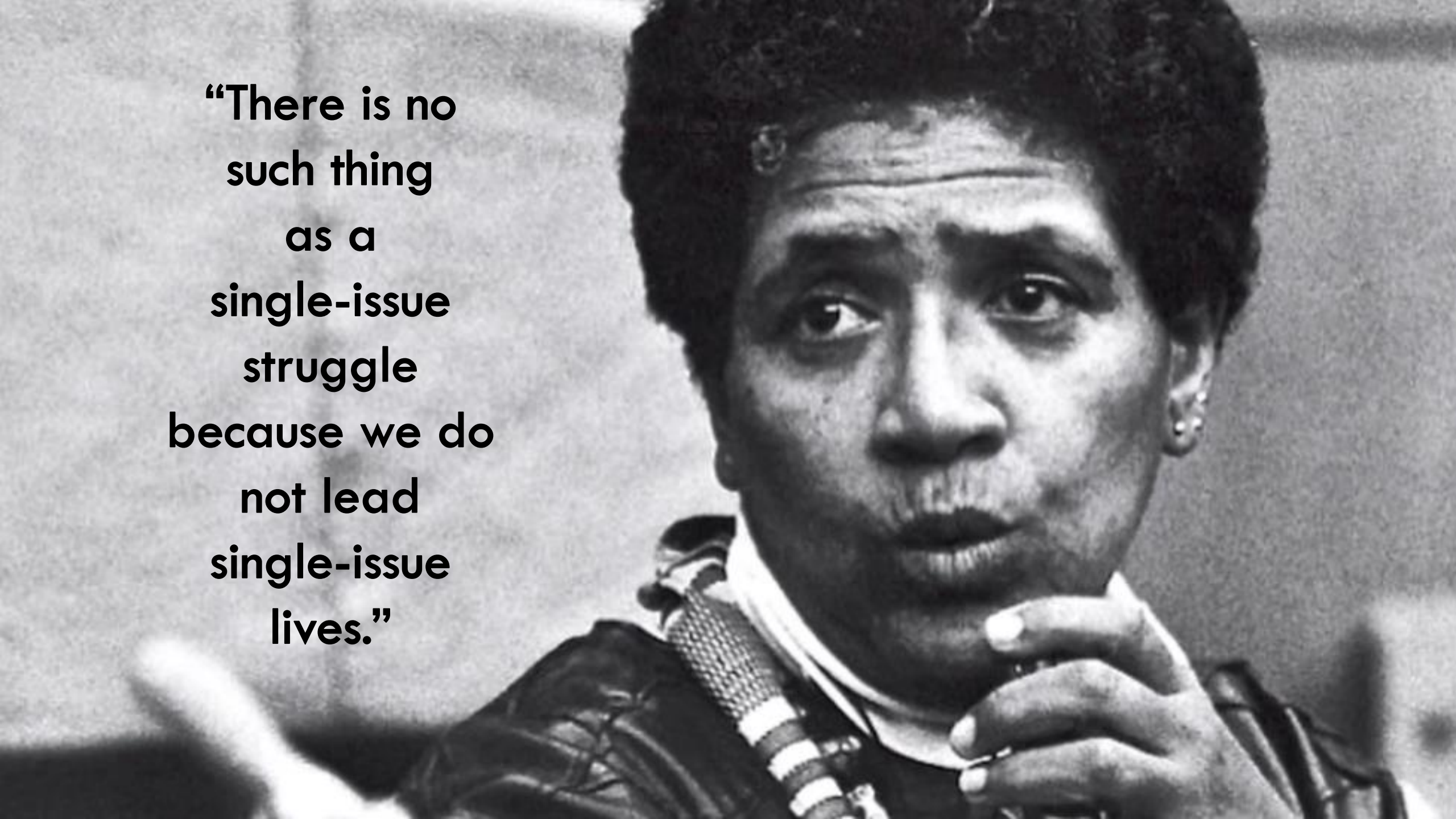
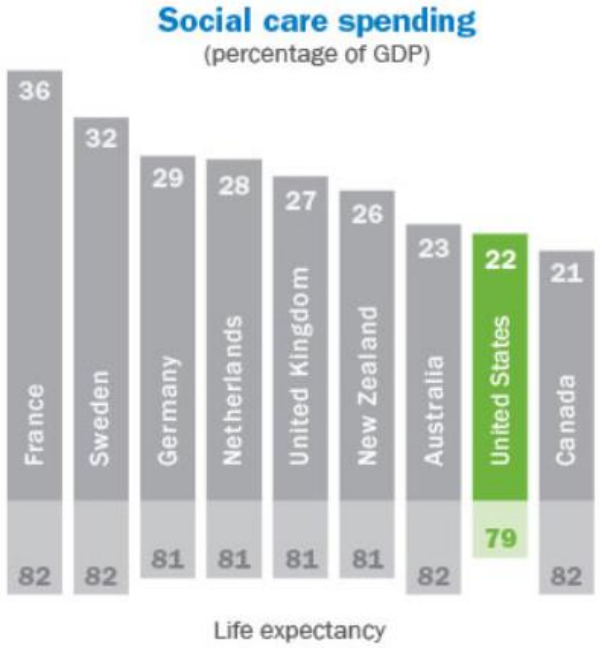


Crenshaw K. Mapping the margins: Intersectionality, identity politics, and violence against women of color. Stan. L. Rev.. 1990;43:1241.

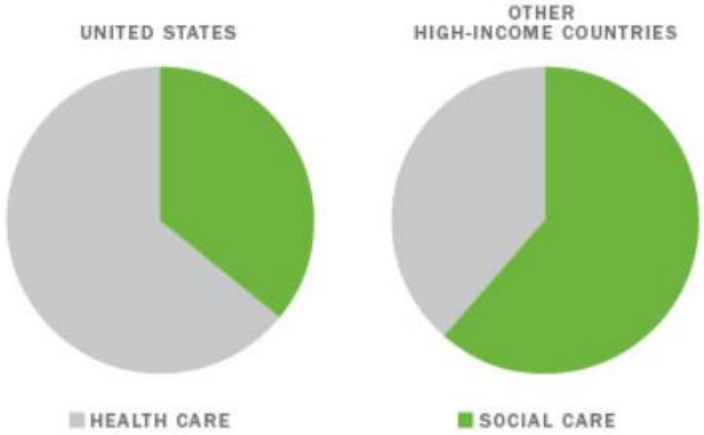

“There is no such thing as a single-issue struggle because we do not lead single-issue lives.”

People **live longer** in countries that **spend more** on **"social care" programs*** that support health



*"Social care" includes programs like education, retirement benefits, housing assistance, employment programs, disability benefits, food security

The **United States** is the **only country** that **spends more** treating **health issues** vs **social care programs**



And **prevention programs** get only **3 percent** of **US health care dollars**

https://apha.org/what-is-public-health/generation-public-health/take-action/invest-in-health

By Elizabeth H. Bradley, Maureen Canavan, Erika Rogan, Kristina Talbert-Slagle, Chima Ndumele, Lauren Taylor, and Leslie A. Curry

Variation In Health Outcomes: The Role Of Spending On Social Services, Public Health, And Health Care, 2000–09

ABSTRACT Although spending rates on health care and social services vary substantially across the states, little is known about the possible association between variation in state-level health outcomes and the allocation of state spending between health care and social services. To estimate that association, we used state-level repeated measures multivariable modeling for the period 2000–09, with region and time fixed effects adjusted for total spending and state demographic and economic characteristics and with one- and two-year lags. We found that states with a higher ratio of social to health spending (calculated as the sum of social service spending and public health spending divided by the sum of Medicare spending and Medicaid spending) had significantly better subsequent health outcomes for the following seven measures: adult obesity; asthma; mentally unhealthy days; days with activity limitations; and mortality rates for lung cancer, acute myocardial infarction, and type 2 diabetes. Our study suggests that broadening the debate beyond what should be spent on health care to include what should be invested in health—not only in health care but also in social services and public health—is warranted.

Equality

Equity