NATIONAL ACADEMIES Sciences Engineering Medicine

Federal Policy to Advance Racial, Ethnic, and Tribal Health Equity

REPORT RELEASE WEBINAR

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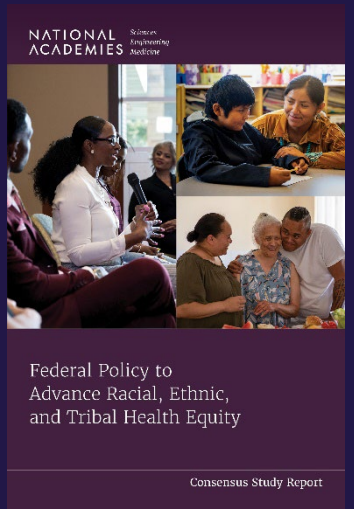

Committee

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Statement of Task

- Provide an evidence-based, independent and objective analysis of **federal policies that contribute to racial and ethnic health inequities**, including those policies that impact the **social determinants of health**

- Focus on **all racial and ethnic minority populations** in the U.S.

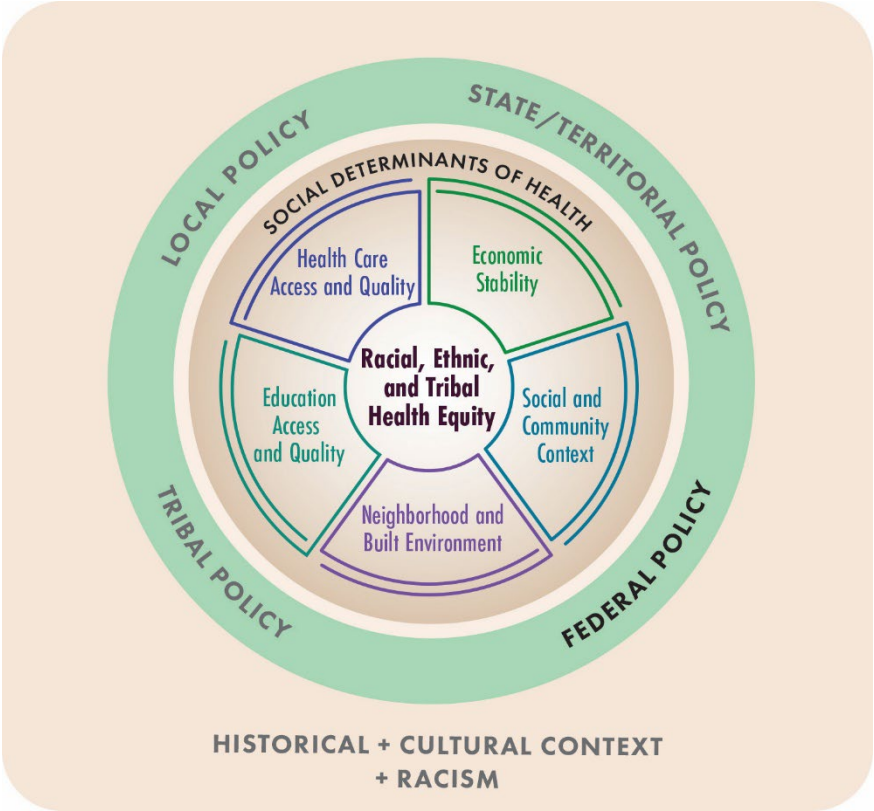
- Identify the **most effective or promising strategies** to eliminate or modify policies to advance racial and ethnic health equity

Background

- Racial, ethnic, and tribal health inequities take on many forms, such as higher rates of chronic disease and premature death. Despite progress to narrow the gaps in some outcomes, there are still ongoing and persistent inequities tied to the social and structural determinants of health.
- The inequitable distribution of disease and well-being in the United States shows that social factors, such as economic stability and education access and quality, play a critical role in health outcomes.
- Research demonstrates that the inequitable patterns of these social risk factors across race and ethnicity are in large part a consequence of structural disadvantages for minoritized communities that were, in no small measure, initiated by historical federal policy decisions.
- In 2018, the estimated economic burdens of racial and ethnic health inequities were $42–45 billion (LaVeist et al., 2023).

Conceptual Framework

- Healthy People 2030 five categories of social determinants of health
- Social determinants of health are shaped by structural determinants and historical and cultural context
- Intertwining relationships among social determinants of health, laws and policies, and historical and cultural factors



Key Principles

- Health is more than physical and mental well-being—it also includes well-being in social, economic, and other factors, all of which are necessary for human flourishing.
- All federal policies have the potential to affect population health.
- Evidence is informed by quantitative, qualitative, and community sources (all of which should be equally valued).
- Federal policies should center health equity.
  - Health equity: The state in which everyone has a fair opportunity to attain full health potential and well-being, and no one is disadvantaged from doing so because of social position or any other socially defined circumstance. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities and historical and contemporary injustices and eliminate health and health care disparities due to past and present causes. It is important to note that equity is not interchangeable with equality.
- To advance health equity, structural and systems change are needed.

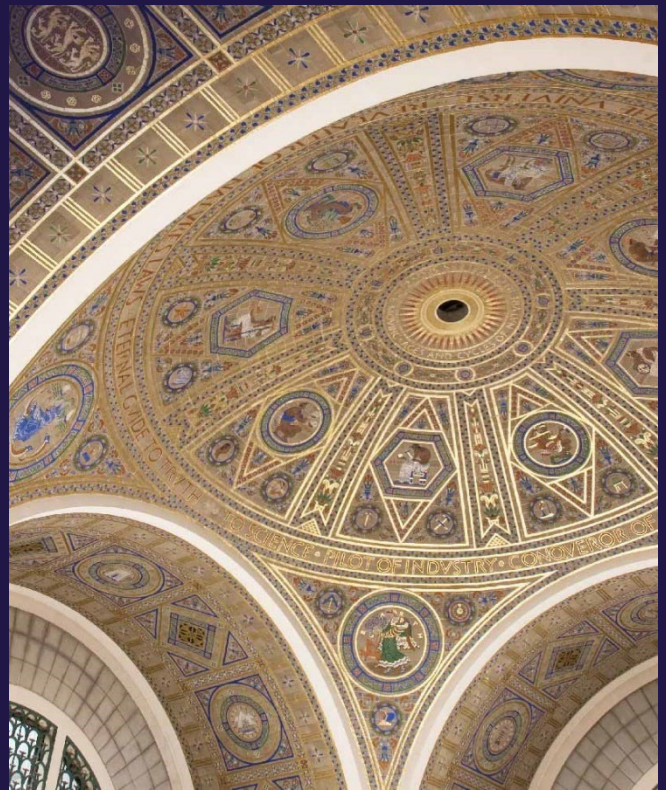
Committee Process

- Information gathering and deliberative meetings
    - Input from a broad range of invited stakeholders (over 100 written and 40 verbal comments); Virtual public sessions included several hundred attendees.
- Policy prioritization
- Build on past and ongoing work
- Prepared 8-chapter report with 36 conclusions and 13 recommendations
  – External peer review by 15 expert reviewers mirroring committee's expertise

Recommendations

- Report recommendations organized under 4 action areas:
  - **Action 1:** Implement sustained coordination among federal agencies
  - **Action 2:** Prioritize, value, and incorporate community voice in the work of government
  - **Action 3:** Ensure collection and reporting of data are representative and accurate
  - **Action 4:** Improve federal accountability, tools, and support toward a government that advances optimal health for everyone

Recommendations: Implement Sustained Coordination among Federal Agencies



Coordination and Accountability

- The federal policy landscape is complex, with over 100 agencies in the executive branch, and the legislative and judiciary branches.

- Many federal policies affect health even if that is not their main focus. Coordination among federal agencies is critical to advance health equity. Some collaborative efforts are currently underway, such as the Federal Plan for Equitable Long-Term Recovery and Resilience.

- Scoring legislation for its effect on racial, ethnic, or tribal equity is not currently required. Without sufficient data or analysis to understand the disparate effects of policies across racial and ethnic groups, policies are often adopted that inadvertently reinforce inequities.

Recommendation 1

To improve health equity, the president of the United States should **create a permanent and sustainable entity** within the federal government that is charged with improving racial, ethnic, and tribal equity *across the federal government*. This should be a standing entity, sustained across administrations, with advisory, coordinating, and regulatory powers. The entity would work closely with other federal agencies to ensure equity in agency processes and outcomes.

Recommendation 2

The president of the United States should appoint a senior leader within the Office of Management and Budget (OMB) who can mobilize assets within OMB to serve as the cochair of the Equitable Long-Term Recovery and Resilience Steering Committee.

Recommendation 3

The federal government should assess if federal policies address or exacerbate health inequities by implementing an equity audit and developing an equity scorecard. Specifically,

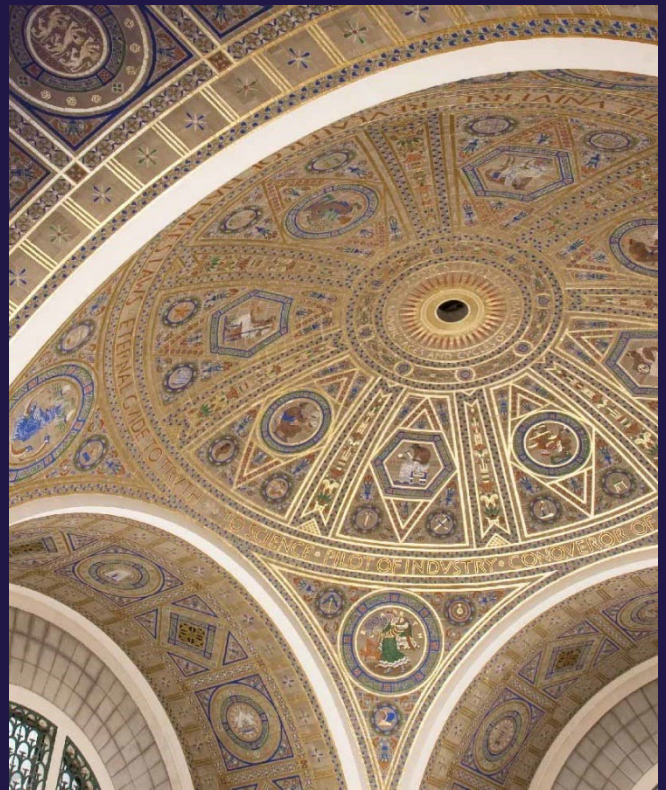
a. Federal agencies should engage in a **retrospective review** of federal policies that had a historical impact on racial and ethnic health inequities that exist today to address contemporary impacts.

b. The Office of Management and Budget should develop, and federal agencies should conduct, an **equity audit of existing federal laws**. The federal laws reviewed should be identified via public input obtained by a variety of means. The equity audit should include a review of how the laws are implemented and enforced by federal agencies and state and local governments. The audit should also include criteria related to equity in process, measurement, and outcomes.

c. Congress should develop and implement an **equity scorecard that is applied to all proposed federal legislation**, similar to the requirement of a Congressional Budget Office score.

d. The process and results from the equity audit and scorecard should be **transparent and made publicly available**.

Recommendations: Prioritize, Value, and Incorporate Community Voice in the Work of Government



Community Voice

- It is essential to base federal policy for all social determinants of health on the best available evidence—this includes communities' experiences, knowledge/expertise, and needs.

- Affected communities need to be an integral part of the legislative process from beginning to end, as well as part of the process to decide how laws, regulations, programs, and policies are administered.

- Racial, ethnic, and tribal communities have been consistently left out of the federal policy-making process, and the effects have sometimes been egregiously inequitable.

- Community voices are needed to redress past harms; earn trust; secure partnership, buy-in, and collaboration; and ensure policies are fully responsive to their needs and advance health equity.

Community Voice

A promising strategy to improve policies that do not currently promote health equity is to elevate and empower community voice and expertise to influence outcomes through the following design principles:

1. Prioritize meaningful community input by moving past simply keeping communities informed about policy and toward a more substantive level of input that involves consultation, involvement, collaboration, and empowerment whenever possible;

2. Ensure effectiveness, efficiency, and equity in the way that community input is collected;

3. Maximize coordination and sharing of information and insights on implementation across federal agencies while maintaining data privacy and client confidentiality; and

4. Within each federal agency, maximize coordinating and sharing information and insights on implementation among federal, state, local, and tribal government counterparts.

Recommendation 4

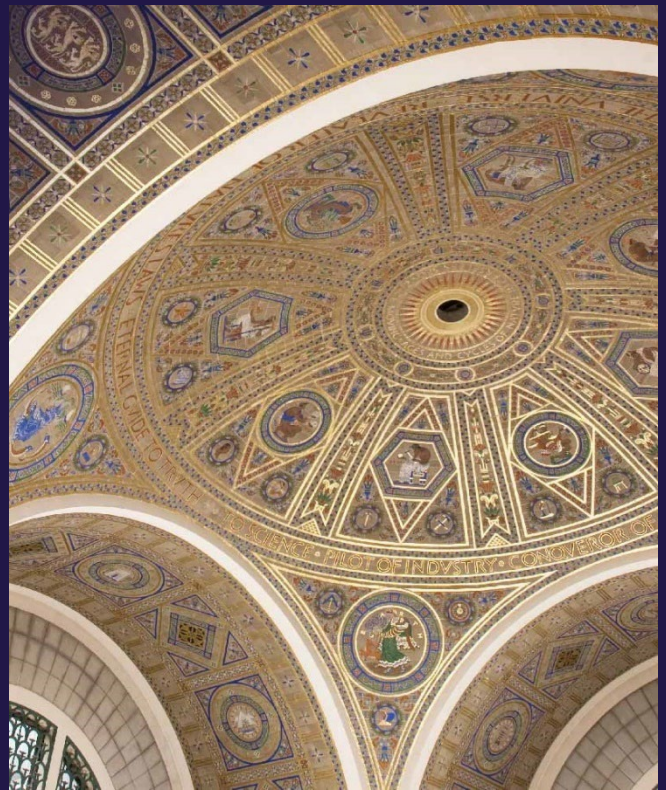
The federal government should prioritize community input and expertise when changing or developing federal policies to advance health equity. Specifically,

1. The president of the United States should require federal agencies relevant to the social determinants of health to **generate and sustain community representation and advisory practices that are integrated with accountability measures and enforcement mechanisms**.
2. Congress should request a Government Accountability Office report to document across federal agencies whose work impacts the social determinants of health, as well as federal statistical agencies, that

    a. **Assesses how community advisory boards are** positioned within their agencies, whom they are composed of, how often they meet, how they report back, and how that work influences the agencies' policies and programs; and

    b. **Identifies promising and evidenced-based practices, gaps, and opportunities** for community advisory boards that could be applied by other agencies.

Recommendations: Ensure Collection and Reporting of Data are Representative and Accurate



Data Needs

- To advance health equity, data need to better capture the experiences and needs of tribal and smaller racial and ethnic groups.
- A lack of representation in data collection, and sharing inaccurate or imprecise data about these communities, has meant that government agencies have been unprepared to understand, let alone reduce or eliminate, health inequities.
- High-quality data are required to understand the full extent of inequities and appropriately distribute resources.
- Federal government data collections have occurred without accountability or consideration of their effects and demands on communities (e.g., time and other resources), matters of tribal sovereignty, and community interest in the use of the data.
- Including measures of racialized social and structural inequities at multiple levels of influence in national health surveys and other federal health data sources can facilitate contextualizing health inequities data and promote investigation of the effects of social and structural factors on these inequities.

Recommendation 5

The Office of Management and Budget (OMB) should require the Census Bureau to **facilitate and support the design of sampling frames, methods, measurement, collection, and dissemination of equitable data resources on minimum OMB categories**—including for American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino/a, and Native Hawaiian or Pacific Islander populations—across federal statistical agencies. The highest priority should be given to the smallest OMB categories—American Indian or Alaska Native and Native Hawaiian or Pacific Islander.

Recommendation 6

The Office of Management and Budget (OMB) should update and ensure **equitable collection and reporting of detailed-origin and tribal affiliation data for all minimum OMB categories** through data disaggregation by race, ethnicity, and tribal affiliation (to be done in coordination with meaningful tribal consultation), including populations who self-identify as American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino/a, and Native Hawaiian or Pacific Islander.

Recommendation 7

The Centers for Disease Control and Prevention should coordinate the **creation and facilitate the use of common measures on multilevel social determinants of racial and ethnic health inequities**, including scientific measures of racism and other forms of discrimination, for use in analyses of national health surveys and by other federal agencies, academic researchers, and community groups in analyses examining health, social, and economic inequities among racial and ethnic groups.

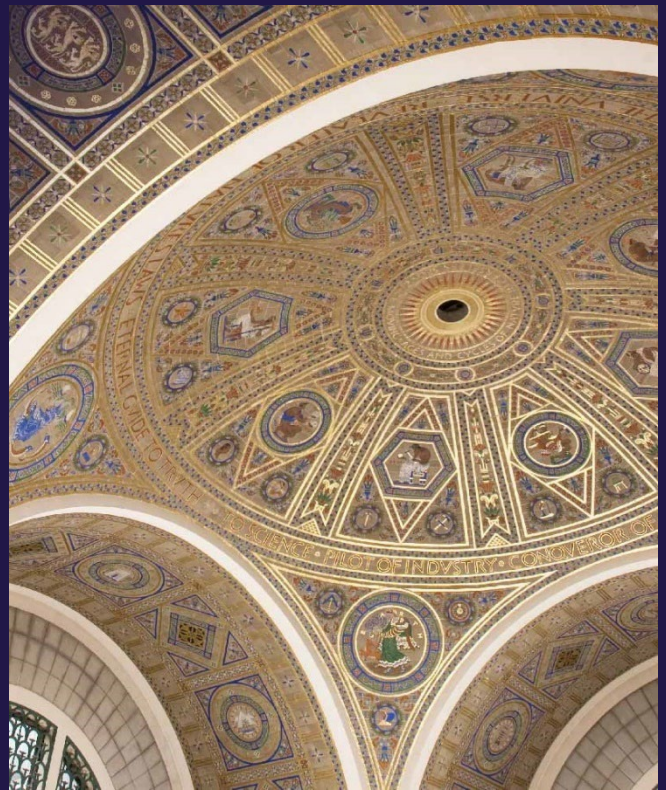
Recommendation 8

Congress should increase funding for federal agencies responsible for data collection on social determinants of health measures to provide information that leads to a better understanding of the correlation between the social environment and individual health outcomes.

Recommendation 9

The president of the United States should convert the Equitable Data Working Group, currently coordinated between the Office of Management and Budget (OMB) and the Office of Science and Technology Policy, into an Office of Data Equity under OMB with representation from the Domestic Policy Council, with an emphasis on small and underrepresented populations and with a scientific and community advisory commission, **to achieve data equity in a manner that is coordinated across agencies** and informed by **scientific and community expertise**.

Recommendations: Improve Federal Accountability, Tools, and Support toward a Government that Advances Optimal Health for Everyone



Implementation, Accountability, and Tools

- Although states and other levels of government need to tailor their health equity efforts to the needs of their populations, they need the federal-level tools and support to do so.
- Often, politics can stand in the way of or stall good policy, so processes and guardrails are needed to support state, local, tribal, and territorial needs.
- For example, guidance that has been vetted for health equity effects at the federal level needs to be in place for the implementation of policies and access requirements and to set expectations.
- Accountability mechanisms and processes can play a vital role in driving progress for health equity and require engaging with multiple diverse actors using dynamic accountability processes.
- The committee's review illustrates numerous examples of barriers in implementation and access to federal programs that exacerbate inequities, such as administrative burden. In addition, state variation in program implementation (such as in Medicaid expansion and participation in social benefits programs, such as SNAP) can lead to differential access based on geography.
- Access to federally funded programs for all people in the United States who meet requirements is essential to move toward health equity.

Recommendation 10

Congress and executive agencies should leverage the full extent of federal authority to **ensure equitable implementation of federal policies and access to federal programs.**

a. Relevant federal departments and agencies should design and implement policies to improve the administration of assistance programs to facilitate access to the benefits to which individuals and families are entitled. Such activities should include **implementation and delivery processes, including administrative burden, eligibility, enrollment, enforcement, and client experience;** and, where applicable, the **creation of performance standards** in federal programs administered by other (state, local, and tribal) governments.

b. Congress should ensure that **sufficient funding** is made available to conduct these activities.

Recommendation 11

The president of the United States should direct the Office of Management and Budget to **review federal programs that exclude specific populations,** such as immigrants and those with a criminal record and, in some cases, currently incarcerated people (e.g., Medicaid coverage), to assess the rationale and implications for equity of excluding these populations, including potential impacts on their families and communities. A report on the findings and suggested changes (when applicable) should be made publicly available.

Health Equity for the American Indian and Alaska Native Population

- For most measures of health, American Indian and Alaska Native people are worse off than other racial and ethnic groups; this includes life expectancy, suicide, homicide, and chronic diseases resulting in earlier and increased functional disability and death.
- The traumas that have unfolded over generations have resulted in cumulative harm, the effects of which are still being felt today.
- The 574 federally recognized tribes are sovereign nations and have a formal nation-to-nation relationship with the U.S. government with a trust responsibility that has not been fully upheld. Federal responsibility for American Indian and Alaska Native health care was codified in 1976 to form the legislative authority for the Indian Health Service, which receives less funding per person than Medicaid, Medicare, Veterans Affairs, or federal prisons.
- Furthermore, American Indian and Alaska Native voices in federal leadership and influence in the executive and legislative branches have been few, although several notable appointments were made recently.

Recommendation 12

The federal government should undertake the following actions to **advance health equity for American Indian and Alaska Native communities** in both urban and rural settings by raising the prominence of the agencies that have jurisdiction. Specifically,

a. The president of the United States and Congress should raise the level of the Director of Indian Health Service (IHS) to an Assistant Secretary.

b. Congress should authorize funding of IHS at need/parity with other health care programs. This funding should be made mandatory and include advance appropriations.

c. The House of Representatives should re-establish an Indian Affairs Committee.

Health Care Access & Quality

- One major barrier to health equity is health care access, which includes health insurance coverage and the availability of and access to culturally appropriate, high-quality care, including preventive care, primary care, specialist care, chronic disease management, dental and vision care, mental health treatment, and emergency services.

- Lack of access to health insurance leads to adverse health outcomes and negative economic effects that exacerbate racial and ethnic inequities.

- However, health insurance is just one piece of the equation. Increasing access to high-quality, comprehensive, affordable, accessible, timely, respectful, and culturally responsive health care would advance racial and ethnic health equity.

Recommendation 13

The Departments of Health and Human Services, Defense, Veterans Affairs, Homeland Security, and Justice, as federal government purchasers and direct providers of health care, **should undertake strategies to achieve equitable access to health care across the life span for the individuals and families they serve in every community.** These strategies should prioritize access to effective, comprehensive, affordable, accessible, timely, respectful, and culturally appropriate care that addresses equity in the navigation of health care. While these strategies have a greater chance of success when everyone has adequate health insurance, there are ways the executive branch can improve and reinforce access to care for the adequately insured, the underinsured, and the uninsured.

Key Messages

- Although federal policy has played an important role in advancing racial, ethnic, and tribal inequities and correcting past harms, substantial opportunities remain.

- Staying vigilant for unintended consequences of implemented policies is essential and needs to be built into feedback monitoring loops and measured in equity audits.

- Federal policy can play a key role in eliminating health inequities by collecting and employing accurate data, doing a better job of including and empowering communities who are most impacted, and coordinating and holding those who implement policy accountable.

To view the report (free PDF download) and related resources, see:

https://nationalacademies.org/health-equity-policies

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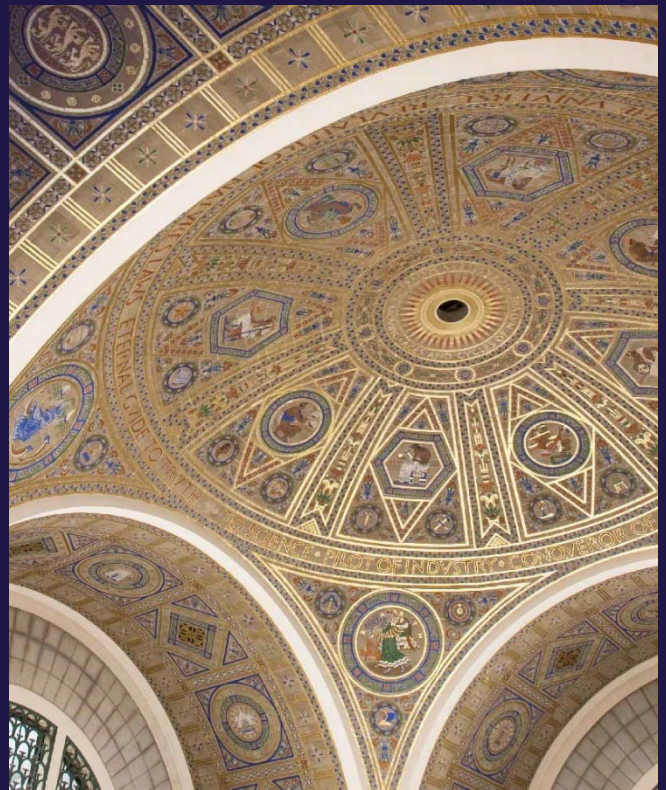
Report Conclusions



Conclusions: Chapter 2

- Conclusion 2-1: The lack of oversampling of underrepresented racial, ethnic, and tribal populations in national health surveys and other relevant federal data collection efforts—for example, the Office of Management and Budget categories of American Indian or Alaska Native and Native Hawaiian or Pacific Islander—limits the availability of reliable data, and therefore meaningful action, by federal programs, researchers, and advocates to advance health equity for these communities.

- Conclusion 2-2: Disaggregated data on social, economic, health care, and health indicators that reflect the heterogeneity of racial and ethnic groups, including in relation to country of origin, are needed to inform targeted actions that promote health equity across and within groups.

Conclusions: Chapter 3

- Conclusion 3-1: Evidence demonstrates that pretrial detention substantially reduces lifetime income, and strongly links incarceration with lower lifetime earnings and family income for incarcerated individuals. Given racial and ethnic inequities in incarceration and pretrial detention, there are opportunities in these areas to address racial and ethnic inequities in income and, thereby, health and well-being.

- Conclusion 3-2: Stagnation in the federal minimum wage, coupled with inflation, has left the real value of the minimum wage at a level not seen since the 1950s. Increases to the federal minimum wage raise incomes among low- and moderate-income families and lift families out of poverty. Since racially and ethnically minoritized populations and tribal communities are disproportionately represented in the groups that would be impacted by an increased federal minimum wage, such an increase is one method to address racial and ethnic inequities in economic stability and, therefore, health and well-being.

- Conclusion 3-3: Federal social benefit programs, such as the Supplemental Nutrition Assistance Program, Special Supplemental Nutrition Program for Women, Infants, and Children, and the Earned Income Tax Credit, significantly alleviate poverty and reduce the negative health consequences of poverty; however, there are barriers that prevent participation among many people who would otherwise qualify for these programs. Some racial, ethnic, and tribal populations have lower participation rates in these programs, contributing to racial and ethnic health inequity. Therefore, policies that address administrative barriers, hold programs accountable for participation rates, and improve administrative capacity can improve participation rates and reduce racial and ethnic health inequity.

Conclusions: Chapter 3, continued

- Conclusion 3-4: Federal social benefit programs, such as the Supplemental Nutrition Assistance Program, Special Supplemental Nutrition Program for Women, Infants, and Children, and the Earned Income Tax Credit, significantly alleviate poverty and reduce the negative health consequences of poverty. In some cases, eligibility for these and similar programs has been restricted for some groups, including childless adults, formerly incarcerated individuals, and immigrants. Because these groups disproportionately represent racially and ethnically minoritized populations, these restrictive policies contribute to racial and ethnic health inequity.

- Conclusion 3-5: Nonprofit sector partnerships play an important role in poverty alleviation and emergency food assistance that can influence racial and ethnic health inequities. Federal programs, such as the Emergency Food Assistance Program, help the nonprofit sector more effectively serve those in need by providing food for distribution and grants for infrastructure and capacity building.

- Conclusion 3-6: Gaps in wealth for many racially and ethnically minoritized populations are linked to past and current federal policies, including redlining, disparate access to benefits of the 1944 GI Bill, and the financialization of the criminal legal system. Furthermore, policies that reward existing wealth, like the mortgage tax deduction, can exacerbate these gaps. Since wealth operates in tandem with income to enable access to healthier living conditions, quality health care, and amelioration of stress, these racial and ethnic inequities in wealth produce racial and ethnic inequities in health and well-being.

Conclusions: Chapter 3, continued

- Conclusion 3-7: Policies to support savings and wealth accumulation, for example, government subsidies of savings accounts for children, can increase wealth and narrow racial and ethnic differences in savings rates and wealth holding.

- Conclusion 3-8: Unequal access to safe and affordable financial services, including bank accounts and low-cost credit, is a driver of inequities. Enabling the provision of financial services that allow all Americans to spend, save, borrow and plan will enable greater economic stability and increase health equity for low-income and racially and ethnically minoritized populations.

Conclusions: Chapter 4

- Conclusion 4-1: There remain large differences in educational achievement and attainment between White and Asian students, on one hand, and Black, Latino/a, and American Indian and Alaska Native students, on the other. The empirical evidence that education is associated with health is strong. The causal evidence that more education can improve health is compelling given the many pathways through which education can affect health.

- Conclusion 4-2: There is strong evidence some federal policy changes and investments can improve educational outcomes and narrow differences in educational attainment and quality across racial and ethnic groups. However, the best mix of changes to policy and practice to improve student outcomes will vary across states, districts, schools, or groups of students. Thus, evidence-based policy, accountability, and community engagement play a critical role in improving federal policy for education as it relates to equity.

- Conclusion 4-3: Increases in per-pupil school spending have been shown to improve a range of student outcomes in the short and long run, including test scores, educational attainment, and earnings—all of which in turn are correlated with better health outcomes. Decreases in school spending lead to worse student outcomes, especially for children living in low-income neighborhoods and Black students. Federal policy could play a role to offset differences in cross-state spending and close spending gaps across racial and ethnic groups.

Conclusions: Chapter 4, continued

- Conclusion 4-4: In 1994, the federal government disqualified incarcerated people from Pell Grant eligibility, and in 2020, lawmakers reinstated Pell Grant access for incarcerated people enrolled in qualifying prison education programs. This is a promising example of how removing erected barriers to access for specific populations, such as incarcerated people, can address unequal access to federal programs that are linked to social determinants of health and health inequities.

- Conclusion 4-5: Minority serving institutions have demonstrated value on investment in economic outcomes for their students, and their effects on the racially and ethnically minoritized communities they serve merit research and measurement.

- Conclusion 4-6: Schools have unique opportunities to advance health, ranging from assisting in outreach and enrollment of eligible children in public health insurance programs and income support programs, to offering direct care through school-based health centers, to reducing food insecurity and improving dietary quality through school meals programs. Evidence shows that when schools adopt or improve these opportunities, both health and educational outcomes can be improved.

Conclusions: Chapter 5

- Conclusion 5-1: Medicaid and the Children's Health Insurance Program are the most important federal policies that address the racial and ethnic inequities in access to affordable health care. The Medicaid expansions in eligibility incentivized in the 2010 Affordable Care Act have increased insurance coverage, improved health outcomes, and reduced racial and ethnic health inequities in access to preventive services, delayed care, and unmet health care needs.

- Conclusion 5-2: Among those eligible for Medicaid under the current federal eligibility criteria, racial and ethnic inequities in enrollment and participation remain. While acknowledging the important role of states, the federal government can play a role in addressing these issues, such as by reducing administrative burden and examining the racial and ethnic health equity implications of policies that exclude specific populations, such as immigrants and people involved with the criminal legal system.

Conclusions: Chapter 5, continued

- Conclusion 5-3: State variation in implementation of the federal Medicaid law, most notably the state variation in the implementation of ACA Medicaid expansions, creates barriers to enrollment and differences in program eligibility and accessibility that have widened the gap in insurance coverage and access to care. The barriers disproportionately affect racially and ethnically minoritized populations, thus contributing to place-based racial and ethnic health inequities. While federal policies can address these barriers by limiting restrictive use of Medicaid flexibilities and effectively incentivize increasing access, these policy changes will require overcoming political and philosophical barriers related to Medicaid, federalism, and the role of government to ensure universal access to health care.

- Conclusion 5-4: Value-based payment and other programs intended to improve quality have, to date, not prioritized health equity. For example, such programs do not measure and incentivize reduction of racial and ethnic health inequities.

- Conclusion 5-5: A lack of inclusion and representation in clinical research may perpetuate health inequities because it limits the ability to identify issues of safety or effectiveness that might be specific to the populations that are not well represented. A lack of inclusion and representation in the health care workforce may perpetuate health inequities given the evidence that suggests better health outcomes when there is identity concordance between patients and providers.

Conclusions: Chapter 5, continued

- Conclusion 5-6: The Indian Health Service is the primary source of health care for many American Indian and Alaska Native people. The current structure and inadequate funding level of the Indian Health Service contributes to health inequities for American Indian and Alaska Native people.

- Conclusion 5-7: A lack of coordination, measurement, and prioritization of equity activities across the Department of Health and Human Services contributes to racial, ethnic, and tribal health inequities.

- Conclusion 5-8: Increasing access to high-quality, comprehensive, affordable, accessible, timely, respectful, and culturally appropriate health care would advance racial and ethnic health equity. Progress toward universal health care access can be achieved through many federal policy avenues, including but not limited to increasing access to public and private insurance coverage.

Conclusions: Chapter 6

- Conclusion 6-1: Redlining and associated policies and structures resulted in residential segregation and neighborhood disinvestment, which have led to measurable health inequities present today. Safe, quality housing is necessary for maintaining an adequate standard of living, and there is a compelling link between housing and health equity. Increased federal investment in housing interventions for low-income people, such as the housing voucher program, could improve housing security and health outcomes for children and adults, especially among Black, Latino/a, American Indian and Alaska Native, and Native Hawaiian and Pacific Islander populations, and advance racial and ethnic health equity. Federal investment in housing would benefit from evidence-based guidelines to ensure that such investments do not contribute to future health inequities.

- Conclusion 6-2: The federal infrastructure policies governed by the Department of Housing and Urban Development, the Environmental Protection Agency, the Department of Transportation, and other agencies play critical roles to ensure health equity. Essential in these policies is the protection for those most vulnerable to the health effects of infrastructure investments, since, in many cases, federal funding propels infrastructure spending from state and local governments. While the role of federal funding may be limited in terms of the types of state and local infrastructure projects, there are missed opportunities for the federal government to monitor and address the health inequities tied to infrastructure. Coordination, monitoring, and guidance on infrastructure spending are lacking across federal agencies.

Conclusions: Chapter 6, continued

- Conclusion 6-3: There is a lack of coordination among relevant federal agencies to address workplace protection from pesticides, such as among the Occupational Safety and Health Administration, the Environmental Protection Agency, and the Centers for Disease Control and Prevention. Inadequate workplace protections from pesticides for agricultural workers disproportionately impact Latino/a workers, their children, and surrounding communities.

- Conclusion 6-4: Community voice through advocacy has played a positive role in shaping iterations of the Agriculture Improvement Act. However, given the bill's size and scope, an audit of the equity implications of the bill could identify additional areas of improvement, such as areas to expand further tribal self-determination and self-governance in relevant programs and other mechanisms to advance racial and ethnic health equity.

Conclusions: Chapter 7

- Conclusion 7-1: Community safety is critical for health and well-being. Racial and ethnic inequities in gun homicides and recent increases in firearm suicide among young Black adults suggest the need for more evidence-based policies that can prevent harm.

- Conclusion 7-2: There are clear racial and ethnic inequities in policing. Improved data collection is needed to increase accountability, better understand the extent of these inequities, and determine which policy changes may help reduce them.

- Conclusion 7-3: The criminal legal system is an important driver of health across the life course, as well as the health of communities and families. Racially and ethnically minoritized communities have experienced and continue to experience disproportionate contact with the criminal legal system. Evidence suggests that policies regarding mandatory minimum sentences, long sentences, and mass incarceration merit re-examination.

Conclusions: Chapter 7, continued

- Conclusion 7-4: Generations of Black, American Indian, Alaska Native, Native Hawaiian, Pacific Islander, Latino/a, and Asian communities have been negatively affected by past actions, practices, policies, and laws that inflicted lasting harm and undermined access to social, economic, and political resources and opportunities, contributing to current racial and ethnic health inequities. There is a need to continue to study and address the impacts of historical and contemporaneous laws and policies that sustain racial inequity.

- Conclusion 7-5: Research demonstrates that civic engagement and belonging have powerful effects on population health, well-being, and health equity. Civic infrastructure and civic engagement are important factors in building social cohesion and inclusionary decision making that lead to better design and implementation of policies that affect health equity.

- Conclusion 7-6: Important considerations when crafting federal action on health equity include leveraging existing policies and authority, considering the limitations of executive orders, and articulating elements that build belonging, community inclusion, and civic muscle into federal agency policy development processes.

Conclusions: Chapter 8

- Conclusion 8-1: The widespread inequities in education, income, and other factors that impact health are the result of the disparate and harmful impact of trauma, laws, and policies at all levels of government, both past and present. Health inequities are prevalent, persistent, and preventable and federal policy is an important tool for correcting historical and contemporary harms.

- Conclusion 8-2: Federal policy can play a key role in eliminating health inequities by collecting and employing high-quality and accurate data, doing a better job of including and empowering communities that are most affected, and coordinating and holding those who implement policy accountable.