Q&A

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Why is Health Equity so important?

There are considerable disparities in health status and health care among vulnerable populations. Members of underserved groups, such as racial and ethnic minorities, women, people with disabilities, LGBT individuals, veterans, and rural populations experience a disproportionate burden from discrimination and disease, leading to higher mortality rates and earlier onset of diseases. They also receive delays in accessing vital health services, lower-quality health care and experience worse health outcomes.

What are some of the contributing factors to health disparities in America?

The disparities in health status and health care confronting vulnerable populations are many and varied as well as are driven in large part by the social, political, and physical determinants of health. People in these populations may experience symptoms that go undiagnosed, underdiagnosed, or misdiagnosed for cultural, linguistic, historical or other reasons. Oftentimes, these health disparities result from laws and policies adopted without meaningful assessment of their impact on vulnerable populations or on health equity overall.

In many respects, health disparities in this country are rooted in poverty and socioeconomic status. Hispanics and African Americans, for example, experience poverty and lower education attainment at much higher rates than their peers in other racial and ethnic groups. There are well documented links between these factors and poorer health outcomes, like heart disease, obesity, and diabetes. Lower socioeconomic status makes it harder for individuals to get health insurance coverage, and even when they have coverage, lower income individuals often have difficulties accessing care due to factors like a lack of transportation, provider shortages in their communities, or the inability to take time off work.

But health disparities cannot just be linked to socioeconomic status, many factors need to be addressed at the provider level, for example cultural competency and unconscious biases. When providers do not know how to interact and communicate with patients of different backgrounds, languages, and cultures the result is misdiagnoses, ineffective treatment plans, and poorer quality of care. These are just some of the factors we must address if we are to eliminate health disparities and achieve health equity.

What are some of the special considerations for health equity among people with disabilities?

Generally speaking, individuals with disabilities tend to have poorer health, higher rates of secondary conditions like obesity, and often lack health insurance coverage for necessary services or assistive technologies. They also usually receive care from multiple providers, but there is inadequate coordination among those providers. Further, individuals with disabilities can face barrier in access to care due to inadequate provider training or inaccessible medical facilities and equipment. For example, most mammogram machines are designed for the patient to be standing, making them inaccessible for patients unable to stand. These are the sorts of things we need to focus on addressing as we push for health equity.

What are some of the special considerations for health equity amongst minorities?

Cultural competency is a major consideration when it comes to health equity for minority populations. If health care providers do not understand the culture, or have poor communication skills with certain minority groups, then those groups are likely to receive a lower quality of care. Language barriers, for example, obviously must be overcome. But providers must also be able to foster trust and open communication with patients of all backgrounds. They must be able to devise treatment plans that take different cultures, lifestyles, preferences and family situations into account in order to provide patient-centered care.

Beyond cultural issues, certain diseases impact races differently and providers, payors, medical device suppliers, group purchasing organizations, pharmaceuticals, and other health care stakeholders need to

be aware of those differences. For example, some aggressive types of breast cancers are more likely to develop, and develop at a younger age, in African American women than women of other ethnicities. In many cases, the mammography machines were never designed to account for the differences between women of different racial and ethnic groups. Similarly, African American men are more likely to be diagnosed with prostate cancer at a younger age than white men. Latinos also experience grave disparities from chronic diseases, including diabetes and are more than twice as likely to have end stage renal disease. Asian Americans are eighty percent more likely to die from liver cancer, and American Indians and Alaska Natives (AI/AN) youth have a suicide rate that is 50% higher than the national average. Health care providers need to be aware of these differences and take them into account in treatments and screening measures.

What other groups may be overlooked in the discussion of Health Equity?

Racial and ethnic disparities are often most prominent in discussions of health equity, but there are other disparities that should not be overlooked – disparities with the LGBT community, women, and veterans for example. Research and clinical trials are not always diverse or inclusive of women. There are also great disparities for the LGBT community as they face challenges including stigma, discrimination, and violence, and can experience higher rates of depression, HIV/AIDS, and sexual violence. Another major group is our military veterans, who also face higher rates of mental health challenges, PTSD, as well as other unique health challenges. Just like any other culture, our health care providers and other health care stakeholders need to become more culturally competent when it comes to our veterans, and learn to address their unique needs.

What can the community and individuals do to become Health Equity advocates?

First, I would suggest joining HELEN, the Health Equity Leadership & Exchange Network, which is a free online network of individuals, organizations, coalitions and associations committed to the elimination of health disparities. It's a national forum for health equity champions to share information about timely, relevant, and pressing policy issues

impacting health equity. Second, talk to policymakers, write letters, meet with community organizations, and find like-minded people who will help you champion the needs of the vulnerable and underserved in your community. I am a strong believer in the strength of coalitions and the power of advocacy. I would encourage folks to join together and urge their leaders to enact policies that will eliminate disparities and achieve health equity.

What inspired you to write *150 Years of ObamaCare*?

I wrote *150 Years of ObamaCare* so that current and future generations of health equity advocates, students, and scholars can learn from our efforts, build upon our successes—understanding what strategies we employed and why, what challenges we faced internally and externally, and how we overcame them during the incredible efforts to develop and pass comprehensive health reform. This book was written to highlight how history was made, to put readers in the front seat and help them get a clearer view of the incredible turning points in the health equity movement so that we can continue to effect the changes necessary to improve the health of all communities. I wanted to demonstrate the persistence, passion, and patience that is required to inform health policy in the United States, as well as highlight issues impacting and challenging health care transformation in America. Overall, I wanted to give readers an engaging, enlightening and thought-provoking view on the creation, impact, and future of ObamaCare – setting the record straight during this critical time.