

# PERSPECTIVE: THE FUTURE OF HEALTH EQUITY IN AMERICA: ADDRESSING THE MULTIPLE, INTERSECTING DETERMINANTS OF HEALTH

Daniel E. Dawes, JD<sup>1</sup>

Even though health equity is a key component of the transforming journey of health that our nation is embarking on, little has been done to trans-disciplinarily coordinate health policy research and collaboratively address issues driving health inequities. This article examines the past and present health policy issues affecting health equity in the United States and discusses the need to address the multiple, intersecting determinants of health in order to fully realize health equity and eliminate health disparities in the future. *Ethn Dis.* 2019;29(Suppl 2): 343-344; doi:10.18865/ed.29.S2.343.

**Keywords:** Health Equity; History; Affordable Care Act; Public Policy

<sup>1</sup> Complex Health Systems, Nova Southeastern University; Fort Lauderdale, Florida

Address correspondence to Daniel Dawes, JD; Nova Southeastern University; 3301 College Avenue; Fort Lauderdale, FL 33314

**About the Author**  
Daniel E. Dawes, JD is the author of *150 Years of Obamacare*, co-founder of the Health Equity Leadership and Exchange Network (HELEN), associate professor of complex health systems at Nova Southeastern University, and senior adviser and general counsel to the Satcher Health Leadership Institute at Morehouse School of Medicine.

## INTRODUCTION

*“Science will not allow you to justify discriminatory behavior.”<sup>1</sup> --- Francis Collins, PhD, director, National Institutes of Health*

The United States health system continues to grow more complex as it tries to move away from a patchwork of fragmented components, to one pushing and pulling providers and consumers toward better health outcomes and value in an ecosystem that is increasingly embracing health equity and the power of transdisciplinary collaboration to address the multiple, interacting determinants of health. Underlying this complexity and stifling its resiliency is a major issue that has eluded scientists, health care leaders and policymakers for decades -- the impact of health disparities and the development of evidence-based, effective and community-centric solutions to eliminate these disparities. In 1985, the World Health Organization defined health equity as “that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential”<sup>2</sup> and, today health

equity has become a key component of the transforming culture of health that our policymakers and health leaders are increasingly supporting. Yet, little has been done to transdisciplinarily coordinate health policy research, collaboratively address issues driving health inequities, and develop the comprehensive evidence-based public policies needed to effectively achieve this goal.<sup>3</sup>

For more than 225 years, the United States has struggled with aligning the constitutional notions of equal protection and general welfare to our health policies, which resulted in a chasm between researchers and the patients who need their discoveries. Despite this struggle, there have been researchers, policymakers and advocates who have worked diligently throughout the years to uphold the integrity of scientific research and build longer and stronger bridges to ensure that the discoveries made in a lab, a clinical setting or in the field translated positively to all communities, including those that have historically been marginalized and underserved, such as racial and ethnic minorities, women, children, veterans, rural individuals, and most recently LGBTQ+ individuals.

About 150 years ago, after the Civil War, there was a collaborative effort to address the social determinants of

health by the federal government with the passage of An Act to Establish a Bureau for the Relief of Freedmen and Refugees (also referred to as the Freedmen's Bureau Act [H.R.51], this statute was passed and signed into law on March 3, 1865, but it struggled to prevail against the political headwinds determined to undermine it after President Abraham Lincoln was assassinated less than a month and a half after the bill was signed into law). This new law gave newly freed slaves, primarily African Americans and refugees who were poor Whites displaced by the Civil War, access to education, employment, housing and health care. However, after seven years, that effort was terminated by policymakers, since Congress had failed to muster the votes to reauthorize the Freedmen's Bureau Act in 1869 after doing so every year since it was passed, and it was officially terminated in 1872. It would take more than a hundred years thereafter before there was another coordinated federal effort to address the disparities in health status among racial and ethnic minorities.

Thanks in part to a group of clinicians and researchers who developed a report highlighting the latest evidence concerning minority health and health disparities, the Reagan administration through Secretary of Health and Human Services Margaret Heckler, recognized that while the overall health of the nation had been improving, the health status of African Americans and other racial and ethnic minorities was alarming. As a result, the Reagan administration convened a task force to more closely examine this issue. It was the first federal attempt to look at racial and ethnic disparities in a comprehensive manner and was realized, in part, because of

the evidence collected and reported in several hundred peer-reviewed articles published in medical, nursing, public health, and behavioral health journals.

As a result of these journal articles, two significant pieces of legislation were passed: the Disadvantaged Minority Health Improvement Act passed during the George H.W. Bush administration in 1990, and the Minority Health and Health Disparities Research and Education Act passed during the Bill Clinton Administration in 2000. Paralleling these two landmark pieces of legislation were the introduction of major federal agendas to improve the nation's health, *Healthy People 2000* and *Healthy People 2010*, which prioritized reducing and eliminating health disparities, respectively. Collectively, these federal policies resulted in increased attention to, and investments in, studying and developing solutions to the issues impacting minority health and health disparities.<sup>3</sup> From there, further research ensued and led to the publication of more than 6,000 scholarly articles, which informed later public policy.

Today, our understanding of health disparities demonstrates that it is not one factor that has driven the inequities in health care and health status, but multiple interacting determinants, driven in large part by policy. This affords researchers, policymakers and communities an opportunity to address not only the negative outcomes of health disparities, but also the imbalance of inputs, as we strive for a more accessible, equitable and inclusive health system. Addressing this complex issue is even more critical today considering the fact that in 25 years, racial and ethnic minorities are expected to comprise a majority of

the US. population.<sup>4</sup> The problem will only become more pronounced with the rising incidence of chronic diseases, including mental illness and substance use disorders, the increasingly vulnerable aging population, and the disparities experienced by certain groups in health status and health care. Hopefully, now we have learned that we cannot afford to wait for a direct threat, outbreak or other national security reason before acting to address the minority health crisis in our country because as one prominent physician and health equity leader, Dr. Camille Davis-Williams, puts it, "we are only as healthy as our sickest people." (personal interview with Dr. Camille Davis-Williams, Washington, DC, August 25, 2017).

Following in the footsteps of incredible researchers, scholars and leaders who refused to accept the false conclusion of their day that certain racial and ethnic groups were scientifically inferior, participate in insidious experiments on our most vulnerable populations, or accept the dearth of investments and prioritization of health equity in public policy, we have an opportunity to leverage the advancements in science, medicine, technology, public health, and policy to push the needle further toward health equity in America and beyond than ever before.

### REFERENCES

1. Collins F. Presentation at National Institutes of Health RCMI Translational Science Conference. Washington, DC; October 30, 2017.
2. World Health Organization. *Targets for Health for All*. Copenhagen: World Health Organization Regional Office for Europe. 2985
3. Dawes, DE. *150 Years of Obamacare*. Baltimore, MD: Johns Hopkins University Press. 2016.
4. Colby, S.L. and Ortman, J.M. (2014). *Projections of the Size and Composition of the U.S. Population: 2014 to 2060*, Current Population Reports, P25-1143, U.S. Census Bureau, Washington, DC.