Health Equity Learning Series

Opportunity, Community, and Health Equity

Dedicated to Achieving Health Equity for All Coloradans
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HEALTH EQUITY LEARNING SERIES

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Opportunity, Community, and Health Equity
The Colorado Trust

PRESENTER: john a. powell
DATE: September 17, 2015
We all live in systems/structures.

These structures are not neutral.

They enhance or retard life outcomes.

We live in Structures and structures live in us.
Structural Racialization

• Race is a process

Structural racialization leads to marginalization (race, gender, ability, etc.) and blocked access to opportunity
Structural Racialization

• How race works today
  – There are still practices, cultural norms and institutional arrangements that help create and maintain (disparate) racialized outcomes

• Structural racialization addresses inter-institutional arrangements and interactions
  – It refers to the ways in which the joint operation of institutions produce racialized outcomes

• In this analysis, outcomes matter more than intent
# Structural Racialization

## Context: The Dominant Consensus on Race
- **National values**
- **Contemporary culture**

## Current Manifestations: Social and Institutional Dynamics
- Processes that maintain racial hierarchies
- Racialized public policies and institutional practices

## Outcomes: Racial Disparities
- Racial inequalities in current levels of well-being
- Capacity for individual and community improvement is undermined

## Ongoing Racial Inequalities

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Adapted from the Aspen Roundtable on Community Change. “Structural Racism and Community Building.” June 2004
...to an understanding of processes and relationships

- Understanding the relationships among these multiple dimensions, and how these complex intra-actions change processes
- Relationships are neither static nor discrete
“Opportunity” is a situation or condition that places individuals in a position to be more likely to succeed or excel.

Opportunity structures are critical to opening pathways to success:

– High-quality education
– Healthy and safe environment
– Stable housing
– Sustainable employment
– Political empowerment
– Outlets for wealth-building
– Positive social networks
Systems Thinking: We are all situated within “opportunity structures”

These structures interact in ways that produce racialized outcomes for different groups, but also in ways that influence identity.
Five decades of research indicate that your environment has a profound impact on your access to opportunity and likelihood of success.

High poverty areas with poor employment, underperforming schools, distressed housing and public health/safety risks depress life outcomes.
   - A system of disadvantage
   - Many manifestations
      - Urban, rural, suburban

People of color are far more likely to live in opportunity deprived neighborhoods and communities.
Opportunity pathways vary...

- How can we be sensitive to inter- and intra-group differences?

- How do the ladders or pathways of opportunities differ for different people?

- Every institution has built in assumptions, i.e. “stairways” are a pathway – but not for people in wheelchairs, baby strollers.
Some people ride the “Up” escalator to reach opportunity.

Others have to run up the “Down” escalator to get there.
People are “differentially situated”

Not only are people situated differently with regard to institutions, people are situated differently with regard to infrastructure.

People are impacted by the relationships between institutions and systems...

...but people also impact these relationships and can change the structure of the system.
Spatial, racial, and opportunity segregation impact a number of life opportunities.
The Arrangement of Structures

• How we arrange structures matters
  – The order of the structures
  – The timing of the interaction between them
  – The relationships that exist between them
  – We must be aware of how structures are arranged in order to fully understand social phenomena
Today,

Institutions and structures continue to support, not dismantle, the status quo. This is why we continue to see racially inequitable outcomes even if there is good intent behind policies, or an absence of racist actors. (i.e. structural racialization)
Spatial Racism and Inequality

• The government plays a central role in the arrangement of space and opportunities
• These arrangements are not “neutral” or “natural” or “colorblind”
• Social and racial inequities are geographically inscribed
• There is a polarization between the rich and the poor that is directly related to the areas in which they live
Historic Government Role

- A series of mutually reinforcing federal policies across multiple domains have contributed to the disparities we see today:
  - School Desegregation
  - Homeownership/Suburbanization
  - Urban Renewal
  - Public Housing
  - Transportation
Place & Neighborhoods: Significant Impact on Child Development and Health - Neighborhoods as Systems of Disadvantage
How Segregation Can Affect Health

1. Segregation determines SES by affecting quality of education and employment opportunities.

2. Segregation can create pathogenic neighborhood and housing conditions.

3. Conditions linked to segregation can constrain the practice of health behaviors and encourage unhealthy ones.

4. Segregation can adversely affect access to medical care and to high-quality care.

Source: Williams & Collins, 2001
Segregation and Neighborhood Quality

- Municipal services (transportation, police, fire, garbage)
- Purchasing power of income (poorer quality, higher prices)
- Access to Medical Care (primary care, hospitals, pharmacies)
- Personal and property crime
- Environmental toxins
- Abandoned buildings, commercial and industrial facilities
Racial Disparities in Health

• Blacks have higher death rates than Whites for 12 of the 15 leading causes of death.

• Blacks and American Indians have higher age-specific death rates than Whites from birth through the retirement years.

• Minorities get sick sooner, have more severe illness and die sooner than Whites.

• Latinos have higher death rates than whites for diabetes, hypertension, liver cirrhosis & homicide.
Inequality also affects our health

Structural racialization $\rightarrow$ inequality $\rightarrow$ different health outcomes

Example:
- College educated Black women more likely to have premature babies than white women without high school diploma
  - Due to stress caused by racialization

Example:
- Twins who grow up in different environments of opportunities have dramatically different health outcomes
  - Recommended: “Unnatural Causes...Is Inequality Making Us Sick?” on PBS
Life Expectancy Lags, 1950-2006

Murphy, NVSS 2000; Braveman et al. in Press, NLMS 1988-1998
For every 10% increase in neighborhood poverty there is a 3 year decline in life expectancy.

Every additional $12,500 in household income buys one year of life expectancy.
Relative Risk of Premature Death by Family Income (U.S.)

9-year mortality data from the National Longitudinal Mortality Survey
Infant Mortality by Mother’s Education, 1995

<table>
<thead>
<tr>
<th>Years of Education</th>
<th>NH White</th>
<th>Black</th>
<th>Hispanic</th>
<th>API</th>
<th>AmI/AN</th>
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</thead>
<tbody>
<tr>
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<td>6</td>
<td>5.7</td>
<td>6.5</td>
<td>5.9</td>
<td>5.5</td>
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<tr>
<td>12</td>
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<td>12.7</td>
<td>14.8</td>
<td>7.9</td>
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<td>14.8</td>
<td>11.4</td>
<td>5.1</td>
<td>5.7</td>
</tr>
</tbody>
</table>

0 2 4 6 8 10 12 14 16 18 20

Infant Mortality

Years of Education

Legend:
- NH White
- Black
- Hispanic
- API
- AmI/AN
Video: Race & Infant Mortality
Social Determinants of Health

- Violence and disorder
- Concentrated poverty
- School quality
- Housing quality
- Racialized Segregation
- Neighborhood blight
- Exposure to toxins
- Air and water quality
- Physical hazards
Figure 1. The Stress Response and Development of Allostatic Load
# Allostatic Load

<table>
<thead>
<tr>
<th>10 biomarkers</th>
<th>High-risk thresholds *</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Systolic blood pressure</td>
<td>127 mm HG</td>
</tr>
<tr>
<td>2. Diastolic blood pressure</td>
<td>80 mm HG</td>
</tr>
<tr>
<td>3. Body Mass Index</td>
<td>30.9</td>
</tr>
<tr>
<td>4. Glycated hemoglobin</td>
<td>5.4%</td>
</tr>
<tr>
<td>5. Albumin</td>
<td>4.2 g/dL</td>
</tr>
<tr>
<td>6. Creatinine clearance</td>
<td>66 mg/dL</td>
</tr>
<tr>
<td>7. Triglycerides</td>
<td>168 mg/dL</td>
</tr>
<tr>
<td>8. C-reactive protein</td>
<td>0.41 mg/dL</td>
</tr>
<tr>
<td>9. Homocysteine</td>
<td>9 μmol/L</td>
</tr>
<tr>
<td>10. Total cholesterol</td>
<td>225</td>
</tr>
</tbody>
</table>

* = < 25<sup>th</sup> percentile for creatinine clearance; >75<sup>th</sup> percentile for others

Geronimus, et al., AJPH, 2006
Mean Score on Allostatic Load by Age

Geronimus, et al., AJPA, 2006
Community, Opportunity, Poverty & other Social Determinants of Health

- A person’s health is significantly influenced by social determinants or the socioeconomic and environmental conditions in which they live.

- Social & environmental determinants of health can include:
  - resource limitations, social norms, exposure to crime, violence and social disorder, persistent or concentrated poverty, school quality, transportation barriers and segregation, the built environment, quality of housing, exposure to toxins, air and water quality, and physical hazards.
Social determinants of health broadly include both societal conditions and psychosocial factors, such as opportunities for employment, access to health care, hopefulness, and freedom from racism.

These determinants can affect individual and community health directly, through an independent influence or an interaction with other determinants, or indirectly, through their influence on health-promoting behaviors by, for example, determining whether a person has access to healthy food or a safe environment in which to exercise.
Kansas City’s Geography of Health Equity

Source: Table and Map produced by the Kansas City Health Department, 2010 Community Health Assessment
Understanding ER Use

• The health and healthcare system is a complex system—poverty, neighborhood & environmental conditions, and the public health delivery system are all implicated in health disparities.

• To ground the complexity of the system, we are using emergency room visits as an indicator of a larger systemic issue.
  
  – i.e. we know the health care system is broken because people are relying on the ER for things that are not emergencies....The ER is their primary source of care.
Make Healthcare Work for ALL Patients

- Identify patients and barriers to healthcare
- Direct concentrated wrap-around services to those patients with doctors, nurses & social workers
- Re-invest savings in primary/preventative care services and other community health needs
- Capture Savings!
- Lower emergency room and hospital readmission rates
How do we ensure equitable T/U access to health and opportunity for all people?
Targeted Universalism cont.

1. Universal programs alone are not truly universal
   - Often based on a non-universal standard
     - Example – social security: able-bodied white males working outside the home full-time for pay

2. Targeted programs alone are not desirable because they appear to show favoritism toward a certain group, thus stigmatizing them

3. **Targeted universalism** recognizes racial disparities, while acknowledging their presence within a larger inequitable, institutional framework
Structural inequity produces consistently different outcomes for different communities.

Targeted universalism responds with universal goals and targeted solutions.
Universal Goal with Targeted Strategy
Oh, thank goodness, a rising tide!
Oh, thank goodness, a rising tide!
Example contd.

- But the 3 are *not* all in the stormy water in the *same* way...

- Which person would be most likely to survive the 6 hours it would take to reach them?

- If water is a “structure,” (housing, education, etc.) some groups are able to navigate the structure more successfully than other groups...
Othering is a set of common processes that engender marginality and persistent inequality across any of the full range of human differences

- Although the axes of difference that undergird these expressions of othering vary considerably and are deeply contextual, they contain a similar set of underlying dynamics, discursive heuristics, and structurally reinforcing mechanisms
- Mechanisms of “othering” occur the mind
  - We explain not only how group-based differences become socially relevant, but how difference itself is constructed in the first place. Categorical boundaries are not natural, but emerge or are created, often deliberately, from a social context
6. Collective work in health must be...

- **Transformative**
  - Create System Level Change
  - Catalyze change
  - Target Leverage Points
  - Impact Cross-Domain, Cross-Sector, Cross-Issue

- **Power-Building**
  - Support Alliances
  - Build Coalitions
  - Broaden Stakeholders
  - Build Movement

- **Change the Narrative**
  - Inspire Action
  - Raise Consciousness
  - Create Coherence Between Issues
  - Resonate Widely
Developing Network Partnerships in Health

**Infrastructure and Structured Alliances**
- More than a coalition, but less than an organization.
- A shared platform or structure that holds together and has the capacity to support and link critical interdisciplinary and inter-sector relationships, with a particular emphasis on those that bridge across social cleavages.

**Achieve Scale to Play Big**
- Tackle Big Issues/Game Changers
- Alignment: Bring together Advocates, Researchers, Organizers, and Policymakers

**Identify Strategic Partners and Expand Outward**
- Identify core groups
- Grow in stages. Legitimate and communicate community ambition.
- Shared Governance: Participants contribute to and define the agenda.
To achieve transformative change, we must create an environment in which everyone **belongs**.

**Belonging** is the greatest gift society can give us.
Suggested Reading...

For more information, visit:
http://www.iupress.indiana.edu/catalog/806639

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