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

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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.
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”
- Homelessness, Housing Instability
- Food Insecurity
- Transportation Insecurity
- Poor Access to Healthcare

Behavioral Risk Factors
- Adverse Early Life Experiences
- Discrimination
- Exposure to Violence, Conflict
- Interaction with the Criminal Justice System

Physiologic Stress Responses
- Adverse Features of the Built Environment
- Neighborhood Disorder
- Pollution Exposure
- Climate Change

Psychological Stress
- 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

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


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

Meta-Analyses show racism and discrimination are associated with poorer mental health.
Percent of Each Group Saying They Have Been Personally Discriminated Against When Going to a Doctor or Health Clinic Because of Their Race or Ethnicity, Gender, or LGBTQ Identity

- Whites: 5%
- Black Americans: 32%
- Latinos: 20%
- Native Americans: 23%
- Asian Americans: 13%
- Men: 8%
- Women: 18%
- LGBTQ people: 16%

“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 spending (percentage of GDP)**

- France: 36
- Sweden: 32
- Germany: 29
- Netherlands: 28
- United Kingdom: 27
- New Zealand: 26
- Australia: 23
- United States: 22
- Canada: 21

**Life expectancy**

- France: 82
- Sweden: 81
- Germany: 81
- Netherlands: 81
- United Kingdom: 81
- New Zealand: 82
- Australia: 79
- United States: 82
- Canada: 82

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.
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