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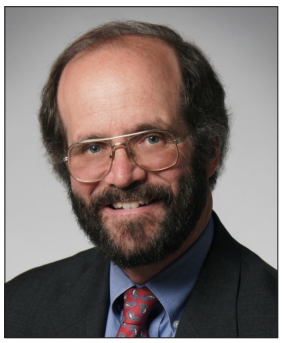

Robert N. Golden, MD

A Health Equity Mindset

Sheri Johnson, PhD; Robert N. Golden, MD

Why should Wisconsin, where most people identify as white, include racial equity as a priority? What is the role of University of Wisconsin-Madison in advancing knowledge, practice, policy, and system change that can reduce unfair gaps in health between socially defined groups? Who decides what is fair or unfair? Do these topics blur the line between scholarship and advocacy?

The UW School of Medicine and Public Health is committed to expanding our knowledge and strengthening our commitment to advancing health equity. As the first school to fully integrate clinical medicine and public health training and research, we have a track record of foresight. Transformational change is an ongoing process. Upon the first author's arrival as the new UW Population Health Institute (PHI) director in 2018, these questions greeted her. Many stakeholders are eager to seek answers to the above questions together, while others may be concerned that any misstep might tarnish the well-earned reputation of the institute, school, and university. This is the reality of working to advance equity. There is often limited consensus. It is not easy work. As Geoffrey Canada from the Harlem Children's Zone noted, "It's not rocket science we're doing here, it's harder than rocket science." (We intend no disrespect to rocket scientists!)

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What Does the Evidence Tell Us?

Gaps in health between socially defined groups are well documented. The PHI's triannual report card consistently demonstrates that the health of American Indian and African American people in Wisconsin is worse than that of white people. The Wisconsin Collaborative for Healthcare Quality (WCHQ) found that racial/ethnic disparities in health care quality and outcomes exist.[1]

Interestingly, the drivers of poor health across places in Wisconsin are strikingly similar. More than 60% of the state's 72 counties are considered rural, and Wisconsin's rural residents tend to be white. Yet, compared to Wisconsinites overall, residents of the state's rural areas and the large, urban Milwaukee County share common challenges. Those who live in rural or large metropolitan areas tend to have higher rates of smoking and obesity, experience higher rates of unemployment, and are less likely to have health insurance.

Despite these obstacles to health, the zeitgeist accentuates perceptions of a rural-urban divide. Pitting groups against each other in an effort to maintain power for a select few is not a new tactic. Groups defined by geography and/or race often collide in the pursuit of a mirage of public and private investments that could foster health. But we can leverage evidence to build alliances, as we emphasize "how systems of racial inequity" affect not only the health of people of color, but of white people, as well.[2] A 2019 article by David Kindig, MD, PhD, the founding director of our Population Health Institute, reflects this approach in analyzing the absolute numbers and relative rates of infant mortality among African American and white mothers in Wisconsin.[3] He argues that two types of systematic oppression—racism and classism—produce poor birth outcomes for urban African American mothers and for rural

white mothers. However, inherited blinders may interfere with our ability to find common cause.

What Remains Unclear?

A growing body of research connects historical US policies to today's differences in health between groups. Yet, this remains unclear, even to those who work in population health and health care. A lack of knowledge about broken treaties and policies such as the 1819 Civilization Fund Act serves as an example. Beginning in the early 19th century, the US Congress passed a series of laws intended to assimilate American Indians by requiring that children be sent away to boarding schools. The systematic removal of American Indian children from their families and communities persisted in various and increasingly devastating and abusive forms into the 20th century. Scholars report that 29% of American Indian children were in boarding schools by 1931.[4]

These are not simply old wounds with no current relevance to health. Evidence links historic trauma and toxic and cumulative stress with poor physical, behavioral, and mental health. Recognizing the centrality of early-life experience on long-term outcomes, Adverse Childhood Experiences (ACEs) have been proposed as a Leading Health Indicator.[5] Yet, health consequences related to policy-driven experiences of Indigenous people and African Americans—including dehumanization and restricted opportunity to amass economic wealth—are not easily communicated. The dominant narrative attributes worse health outcomes for people of color to bad behaviors and poor choices, while a more empathetic lens is emerging for white populations. Despair, as a legitimate driver of poor health, is reserved for some but not for all.[6-7] Cultural and systemic racism have shaped dominant narratives, making it difficult to understand how the decisions we have made as a society confer advantages to some groups more than others.

Is Racial Equity Everyone's Problem?

How might systems of racial inequity impact everyone? First, we must acknowledge that our ideas about "race" are social constructs that artificially elevate the value of some groups over others. Then, we can interrogate whether our policy choices serve overall population health. If evidence-based policies are rejected or implemented unevenly, primarily due to beliefs about which groups are "deserving," the harm to all in need cannot be contained.[2] While most of us believe that everyone should be treated fairly, our laws and practices are not always aligned with that belief.

What's Next for the PHI?

Why should the PHI generate, test, and disseminate ideas that can reduce health inequities? We believe the stakes are high. Because there is evidence that too many people are dying prematurely and the burden of poor health is unevenly distributed, the PHI will:

- build a framework and metrics that uncover drivers of health and equity.
- create reports, tools, and resources.
- engage diverse stakeholders to create and advance a transformative narrative.

We have what it takes to make Wisconsin and the nation a place where everyone thrives. Shared values and aspirations form the foundation from which we can implement solutions together. Creating healthy and safe communities is within our reach.

We must be willing to test ideas, acknowledge mistakes, and start again. Sound familiar? Kind of like rocket science?

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