PRIORITY 4: Advance Health Equity by Addressing Structural Discrimination.

Structural discrimination is a form of discrimination that limits resources, power, and opportunity for individuals and populations based on social or physical characteristics or other statuses, e.g. race/ethnicity, gender, sexual orientation, gender identity, socioeconomic status, disability, immigration status, geography, etc.[165] Health equity is achieved when everyone can reach optimal health without any one person or population having greater advantage or increased burden based on social characteristics or status.

Evidence supports that health inequities are largely driven by structural discrimination, especially structural racism.[166,167] Structural discrimination shapes the social and physical environments in which people are born, live, grow, work, and age. For example, structural racism in housing, such as redlining, created historical and contemporary barriers to accessing capital for homebuying based on the race of the applicant and the racial composition of the neighborhood. The practice of redlining and other real estate practices created segregated communities resulting in reduced community and economic development, as well as underinvestment in quality, affordable, and safe housing, transportation, education, healthcare, and parks and recreation/greenspace, all of which impact health.

THE PROBLEM

Structural discrimination and the resultant systemic inequities have been perpetuated through the policies, norms, and practices in the United States for hundreds of years. Because of these long-standing and ongoing inequities, disparities in health and well-being have been persistent, resulting in increased risk of poor health and higher rates of deaths from illness and injury among populations that have been disadvantaged.[168]

THE SOLUTION

Achieving health equity requires an intentional focus on ending structural discrimination and taking specific actions to drive systemic change. Given the structural drivers — economic, social and systemic factors — a multi-agency, multi-sector, coordinated response is necessary to eradicate health inequity and disparities. Concerted leadership and action from the Administration and Congress to address the allocation of resources and to transform policies to advance health equity is needed.

Another example of structural discrimination is geographic discrimination, whereby access to and support for resources vary based on geographic boundaries. Most notably in the U.S. is the differential access to resources along rural versus urban geographies. Rural communities across the U.S. are characterized as having high land area with low population density. The most recent Census shows that while rural areas comprise 72 percent of the U.S. land area, only 14 percent of the U.S. population live in rural areas.[169] The vast amount of land and fewer residents have resulted in a serious underinvestment in public health and in indicators that drive health outcomes such as access to quality healthcare, transportation infrastructure, education and economic development.

Similarly, underinvestment in tribal areas has contributed both to chronic health disparities in American Indian/Alaska Native populations and in inadequate public health infrastructure in Tribal Nations.[170] Chronic underfunding and unmet needs in Indian Country were highlighted in a 2018 report of the U.S. Commission on Civil Rights, noting the Trust and Treaty obligations the U.S. government has to federally recognized tribes and the special government-to-government relationship between federal and tribal governments. This trust relationship "obligates the federal government to promote tribal self-government, support the general wellbeing of Native American tribes and villages, and to protect their lands and resources."[171]

Ensuring that all communities have the opportunity for optimal health is a central goal of the public health ecosystem.

Structural discrimination results in reduced aggregate life expectancies for population groups who are systemically marginalized when compared with their non-marginalized counterparts (e.g. those who are white, do not have a disability, cis-gendered, live in urban areas). This is exacerbated when examined through an intersectional lens (e.g. persons who are Black, have a disability, and are LGBTQ+)[172]. The regular occurrences of prejudice, violence, and microaggressions, paired with systemic discrimination, result in trauma, chronic stress, poor mental and physical health, and chronic conditions such as high blood pressure and other forms of cardiovascular disease. This is compounded by community and environmental resource deficits such as a lack of access to nutritious foods, sidewalks and bike paths, quality healthcare and behavioral health services, and central air or other cooling systems to contend with extreme heat.

In addition to the community and individual toll, structural discrimination has an economic toll. It is estimated that the overall economic burden of racial and ethnic health inequities was $1.03 trillion in 2018.[173] The economic burden is mostly driven by premature death but is also due to lost labor market productivity and excess medical cost. When examining healthcare spending alone, health inequities result in nearly $320 billion annually and could reach $1 trillion by 2040.[174]

The insidious and historical nature of structural discrimination and health inequities means there is no panacea to instantly cure the problem. It will take the work of governmental and non-governmental entities to address the discriminatory ills of the county. An important place to start is by ensuring that collected health data is specific and comprehensive enough to detect health inequities. Being able to disaggregate data by population groups and geography is vital to attaining an accurate picture of a community's true health status and needs.[175]

While health equity concepts are foundational to all TFAH's policy recommendations, recommendations in this report chapter highlight programs and policies specifically designed to reduce health disparities.

PROGRESS MILESTONES

- The Office of Management and Budget (OMB) revised the federal standards for maintaining, collecting, and presenting data on race and ethnicity to include updated race and ethnicity categories and to require the collection of additional detail beyond the minimum categories to ensure further disaggregation.[176]
- Several Executive Orders (EO) have been issued to advance equity through federal agency action:
  - EO 13985 Advancing Racial Equity and Support for Underserved Communities Through the Federal Government,[177] which directed federal agencies to advance equity and equal opportunity, including assessing federal programs through an equity lens. This was followed by EO 14091, Further Advancing Racial Equity and Support for Underserved Communities Through the Federal Government,[178] which established Agency Equity Teams across the federal government and directed OMB and federal agencies to incorporate equity into policies and practices.
  - EO 14031 Advancing Equity, Justice, and Opportunity for Asian Americans, Native Hawaiians, and Pacific Islanders, which created a President's Advisory Commission within HHS.[179]
  - EO 14112 Reforming Federal Funding and Support for Tribal Nations to Better Embrace Our Trust Responsibilities and Promote the Next Era of Tribal Self-Determination, which seeks to identify and mitigate barriers to federal funding and program support for Tribal Nations.[180]
- All federal agencies have developed Equity Action Plans, which seek to address potential barriers underserved communities may face in accessing agency funding, policies, and programs. For example, the USDA plan included outreach and modernization to increase access to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and to school meals, including in rural school districts.[181]
- CDC launched its first agency-wide health equity strategy in 2021, to make equity foundational to its work and workforce. CDC programs are updating the agency's funding opportunities to embed health equity in every notice.
- In 2023, CDC established the Office of Rural Health with a directive from Congress to work across the agency to coordinate and improve rural public health efforts.[182] CDC released a Rural Public Health Strategic Plan in 2024 to advance rural public health science, infrastructure and workforce, and practices over the next five years.[183]
- The Racial and Ethnic Approaches to Community Health (REACH) program marked its 25th anniversary in 2024, and its community partners have demonstrated success in reducing rates of obesity, increasing fruit and vegetable consumption, and reducing exposure to tobacco.[184]

IMPACT STORIES

Partnering for Vaccine Equity

The early rollout of COVID-19 vaccines was marked by disparities, with some racial and ethnic groups less likely to have access to or have confidence in the vaccine compared with non-Hispanic white people.[185] With emergency funding from Congress, CDC launched the Partnering for Vaccine Equity program, which supported partner networks to improve vaccine access and increase vaccine confidence and uptake in communities experiencing disparities in immunizations.[186] The program helped 325,000 trusted messengers conduct community outreach, engaged 550,000 clinicians, and supported 255 educational campaigns in 45 languages, leading to 2.3 million COVID-19 and flu vaccines administered.[187] Congressional rescission of funds for vaccine equity, however, may threaten the ability of these networks to continue, despite ongoing disparities in accessing routine immunizations.

Ensuring vaccine access and confidence is critical to limiting the spread of infectious diseases.

Local Solutions to Health Disparities through CDC's Racial and Ethnic Approaches to Community Health (REACH) program

Through REACH (2023-2028), CDC funds 50 organizations in 32 states and the District of Columbia to carry out proven strategies to improve health, prevent chronic diseases, and reduce health disparities among racial and ethnic populations with the highest risk, or burden, of chronic disease. Local, culturally appropriate strategies include promoting food service and nutrition guidelines, expanding produce prescription programs, increasing safe and accessible physical activity through community design, and implementing policies that achieve continuity of care for breastfeeding support. For example, the YMCA of Coastal Georgia REACH program, in partnership with Healthy Savannah, supports access to safe physical activity, healthy food, and breastfeeding support in communities experiencing high rates of chronic disease and food insecurity.[188] Activities include mobile farmers' markets to increase healthy food access, coordinating with faith organizations and government partners to develop an urban trail network to boost physical activity, and supporting education and continuity of care for breastfeeding to give infants a healthy start.

RECOMMENDATIONS

Federal agencies should regularly update and report progress on agency equity plans, ensuring metrics are inclusive of and extend beyond tracking disparities. The Administration should continue to update departmental equity action plans and report on their progress toward successful implementation and impact on equity. Reporting should show progress on measurable advances toward equity that are more than reporting data or updates on disparities. Equity based metrics that track process and outcomes, as well as awareness, understanding and reach of program information are essential to demonstrating progress. Tools such as MITRE's Framework for Assessing Equity in Federal Programs and Policies offers the Administration guidance on how to establish multi-level equity goals.[189] In some instances, measures may exist in other agency documents or plans and thus should be incorporated into the agency equity plans. To ensure accountability of federal policies and programs in achieving equity, an evaluation report should be issued annually on the progress to Congress and the public.

Congress and the Administration should ensure accurate and complete data collection to report health-related information by race/ethnicity, age, sex, disability, language, sexual orientation, gender identity, and geography. Congress should provide adequate funding for agencies to implement the updated, revised Statistical Policy Directive No. 15: Standards on Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity. The Administration should require universal adoption of the updated standards among all government agencies and any entities that collect data that support or interface with federal programs and/or receive federal funding. Additionally, the Administration should expand on the updated data collection standards to ensure that accurate and detailed demographic data on age, sex, sexual orientation, gender identity, disability, language, and geography are standardized to reflect the broad identities of the nation, which will allow for equity analyses of federal programs.

Congress should enact, fund and build on the Health Equity and Accountability Act (HEAA) and similar legislation to improve healthcare access and to reduce disparities among communities of color and other populations that are disproportionately impacted by health risks. The legislation includes 10 titles that cover a range of provisions aimed at improving health outcomes, boosting health workforce diversity, ensuring culturally and linguistically appropriate care, and advancing disaggregated health data collection and reporting.

Congress should increase funding for existing, effective programs that address health disparities such as CDC's Racial and Ethnic Approaches to Community Health (REACH) program and the Healthy Tribes program. REACH grantees work to decrease rates of smoking, reduce obesity, and improve healthy behaviors within specific racial and ethnic groups in communities with high incidence rates for chronic diseases. The programs within Healthy Tribes provide tribal organizations with resources, technical assistance, and evidence-based policies so that each grantee can then develop its public

health infrastructure and epidemiology capacity and create chronic disease prevention programs that center tribal history, traditions, and beliefs.

Federal health agencies should focus funding on populations at elevated risk for chronic disease and poor health outcomes due to the impact of structural discrimination and disinvestment. Communities disadvantaged by systemic discrimination, including those living with health disparities as part of systemic marginalization, must receive appropriate funding and investment to support their ability to improve health outcomes. Federal health agencies should consider factors such as disease burden when determining grant-making eligibility criteria and enable capacity-building funding so the communities with the greatest need can access and benefit from competitive grants. Congress and federal agencies should ensure funding is reaching communities that are under-resourced, marginalized, and disproportionately impacted.

Congress should appropriately and adequately fund and resource agencies with the expressed role of addressing health disparities and advancing health equity. The HHS Office of Minority Health, the National Institute on Minority Health and Health Disparities, and each agency office of minority health and health equity, (Agency for Healthcare Research and Quality Office of Extramural Research, Education and Priority Populations, CDC Office of Health Equity, Centers for Medicare & Medicaid Services Office of Minority Health, Food and Drug Administration Office of Minority Health and Health Equity, Health Resources and Services Administration Office of Health Equity, and Substance Abuse and Mental Health Services Office of Behavioral Health Equity) must have the authorities, budget, and resources comparable to other offices, institutes, and centers within the respective agency and/or aligned to the statutory mandate of that office or institute.

The Administration and Congress should respect and honor the sovereignty of Tribal Nations by rectifying the funding shortfalls to support programs identified as a result of Executive Order 14112 — Reforming Federal Funding and Support for Tribal Nations to Better Embrace the Country's Trust Responsibilities and Promote the Next Era of Tribal Self-Determination. The executive order starts the process of fully respecting the sovereignty of Tribal Nations and their right to self-determination by removing barriers to federal funding and reporting that currently prevent full, equitable, and adequate support for tribal related programs.