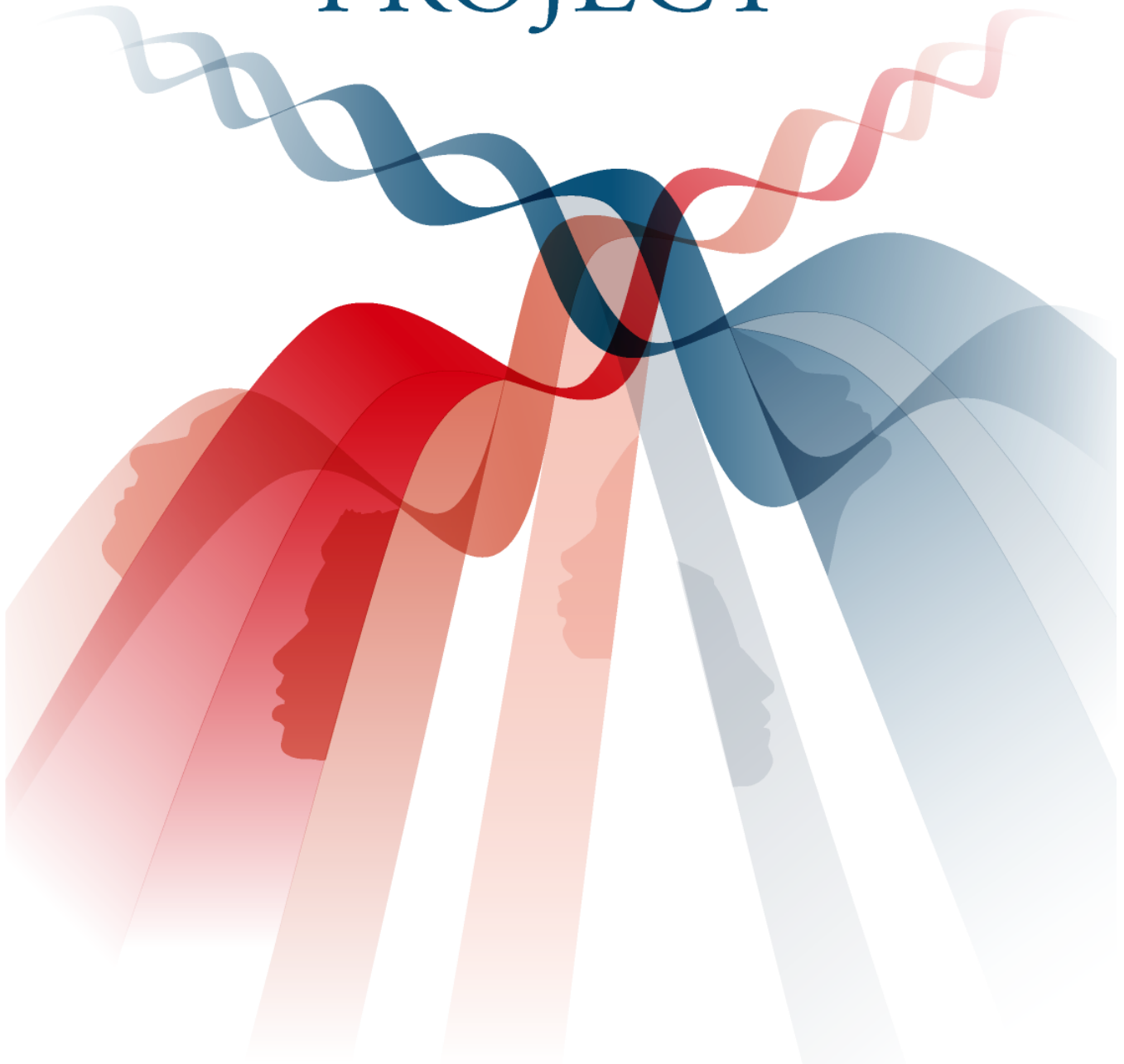


THE **DRA** Accelerating Disparity
Reducing Advances
PROJECT



**Health Equity 2028: The DRA Project
Scenarios**

Preliminary Scenarios – November 2008

The DRA Project Draft Health Equity Scenarios

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Introduction

Americans want to be looked up to as a “city upon a hill” that shines like a beacon for people around the world, but disparities between the health of rich and poor Americans place our country below many others. We see “life, liberty and the pursuit of happiness” as a goal. When the nation was founded this goal was not meant for all Americans, particularly women, slaves, and native Americans.

Yet we are evolving and those goals are becoming all inclusive. The gap between American ideals and the reality of disparities that are unfair and avoidable harms all of us, not just the poor and not just in the eyes of the world. Our ethical, political and economic vitality are all diminished by the low standing of America on key measures of health. Our low scores on international measures of health are driven by these unfair and avoidable disparities.

While many argue that our healthcare system should be the envy of the world, these measures showing a different reality:

- Over the last quarter century the United States has slipped from 18th in 1980 to 25th in 2002 in infant mortality.
- The U.S. has fallen from 14th in 1980 to 23rd in 2003 in life expectancy.
- Some countries with per capita income half as large as ours have longer life expectancy.
- The U.S. spends more money per person on health than any other country, but our lives are shorter by nearly five years than expected based on health expenditures.¹

While these global measures show our collective failings, the bigger national tragedy becomes clear when we look at the disparities in health among our diverse populations. Health disparities are the gaps in the status of health and quality of healthcare across racial, ethnic, and socioeconomic groups. These gaps in health lead to an overall loss of human potential, ethical standing and economic vitality. Below are just a few of the many disparities in health and healthcare:

- The infant mortality rates among African-Americans are almost twice as high as the median rate.²
- Diabetes rates are significantly higher among African-Americans, Latino-Americans and Native Americans.³
- Heart disease is fifty-percent more common among lower income adults than higher income adults.⁴
- African-Americans are significantly less likely to receive care and more likely to have gaps in care for various types of cancer.⁵
- African Americans are four times more likely to be hospitalized and five times more likely to die of asthma than non-African Americans.⁶

These deep and persistent inequities prevent many Americans, and the U.S. as a nation, from achieving our fullest potential.

And such inequities are costly. Medical care costs are a significant and growing part of the economy.⁷ Reducing these large and growing costs requires us to address the social inequities that cause poor health. The disease burden associated with social inequities raises the demand for medical services, and the costs to employers, private insurers and government health programs such as Medicare and Medicaid.⁸ This is especially true for preventable chronic diseases that cost the U.S. more than \$1 trillion annually in healthcare costs and lost productivity.⁹

Lack of access to care is associated with a 25% higher risk of premature death.¹⁰ But inequities in health stem from more than just access to care. They stem from the social and environmental factors that the underserved deal with on a daily basis. Every year there are hundreds of thousands of preventable deaths due to causes such as poor diet and inactivity, alcohol misuse, tobacco, toxic agents, and gun violence. These deaths and other associated problems occur disproportionately among poor and minority populations, those lower on the socioeconomic ladder. According to the Prevention Institute, an individual's position "on the socioeconomic ladder predicts how long you live and how healthy you are during your lifetime...Premature death is more than twice as likely for middle income Americans as for those at the top of the income ladder, and more than three times as likely for those at the bottom than those at the top."¹¹

The key to preventing these deaths is focusing on more than just access to care. Real elimination of health disparities requires us to focus on eliminating poverty and racism and building strong families and communities among underserved populations.¹² Elimination of health disparities requires lessening the steepness of the socioeconomic ladder and buffering the adverse conditions of those on the lower rungs of the ladder (by enhancing housing, the workplace and environment, and by enabling healthier behaviors).¹³ These scenarios consider the extent to which these changes happen and the implications for health disparities.

Some of the best synthesis of research on health disparities in the U.S. has emerged in a PBS miniseries, [Unnatural Causes](#), a four hour documentary that aired in March and April of 2008 on PBS. The series tackled the complex social and environmental factors that cause health disparities. These social determinants of health influence the high rates of disparities we see in underserved communities. The series illuminates a number of themes for health disparities that reflect our growing awareness of disparities and their causes:

- Health is more than healthcare
- Health is tied to the distribution of resources
- Racism imposes an added health burden
- The choices we make are shaped by the choices we have
- High demand + low control = chronic stress
- Chronic stress can be deadly
- Inequality – economic and political – is bad for our health

- Social policy is health policy
- Health inequalities are not natural
- We all pay the price for poor health

In designing scenarios for the future there are two important questions that will shape health disparities: Will we as a society recognize these themes? Will we act and act effectively to create health equity?

The U.S. periodically sets goals that address these themes and aim to create health equity. Each decade, the U.S. Government releases the Healthy People Objectives for the nation. For the decade 2000 to 2010 there are two overarching goals – longer years of healthy life and the elimination of health disparities. This is a noble, audacious goal. This goal implies that “life, liberty, and the pursuit of happiness” should not be diminished because of economic or racial or other conditions. We should have equal and real opportunities for health. Will we eliminate health disparities?

These Health Equity Scenarios of the DRA Project explore the pathways that yield different answers to those questions. These scenarios use the “aspirational futures” approach of the Institute for Alternative Futures (IAF) to identify alternative plausible paths for health disparities and health equity in the U.S. over the next two decades.

These scenarios consider how the themes listed above are recognized and play out, as well as the impact of larger forces such as economic recession, climate change and its responses, and the evolution of our personal and collective values in the U.S. They explore both likely and visionary scenarios. They provide a “best guess” scenario based on the continuation of current major trends, a negative or hard times scenario that explores some of the many things that can go wrong, and finally two “visionary scenarios” which consider different pathways to health equity. These four scenarios are:

- ❖ The Gaps Grow
 - Despite goals and programs to “eliminate health disparities” and universal access to effective healthcare health disparities increase in the US over two decades. Healthcare access and quality improves but the more significant social determinants of health and disparities are not dealt with.
- ❖ Depression, Disasters & Self Protection
 - It’s a dark time in America. Many things can and did go wrong. The worst economic conditions in 80 years, recurring natural disasters lead to an inward focus (me and my family first). Healthcare worsens and health disparities increase.
- ❖ Sharing the Burden – The New Fair Deal
 - The response to the Great Depression of the early 21st Century and a range of natural and manmade challenges paralleled the response to the Great Depression of the 1930s. More personal and family care along with more effective economic and social programs focused on the social determinants of health reduces health disparities. More frugal and

effective healthcare led by community health centers (CHCs) adds its contribution to reducing disparities.

❖ The Mind & Heart Shift

- Society changes its mind. In the 18th century, the country experienced a mind-shift on slavery. In the 20th century, the country experienced a similar shift on segregation and women's rights. In the first part of the 21st century society changes its mind on equity or fairness, including health equity. Inspiring leaders and a new generation made justice and caring an active part of American ideals.

Scenario One: The Gaps Grow

Key Themes

- ❖ In the two decades leading up to 2028, the rich continued to get richer and the poor got poorer and relatively sicker. Gaps in income, employment, housing, healthcare access, education, and safety grew despite widespread efforts.
- ❖ Enhanced access to healthcare was put in place in most states by 2014, and by 2028 access to quality, effective healthcare, including preventive services had contributed to reducing health disparities.
- ❖ But healthcare is related to 25% or less of differences in health status. While healthcare access and quality lessened disparities the other contributing factors to poor health and health disparities grew faster.

Over the next 20 years, incomes of the richest ten percent of Americans continue to grow while the rest of the country sees income gains that barely match the rising pace of inflation. By 2020, the gap between the richest and the poorest in the U.S. grows to levels not seen since the Gilded Age of the late 19th century dominated by extraordinarily rich industrialists and financiers like J.P. Morgan and Andrew Carnegie.

The United States continues to lag behind other nations in international measures in health and the divide in health mirrors the divide in income. The U.S. remains at the bottom of the charts for developed nations in life expectancy, infant mortality and health outcomes for the amounts of money spent per capita on health. These high level comparisons of international health show the U.S. treading water in terms of health.

However, the statistics are misleading as the health improves for the richest Americans while the underserved communities in America fail to make progress. Obesity rates continue to grow in the United States, but are a particular problem in low income communities leading to much higher rates of heart disease, diabetes and certain forms of cancer. For example, by 2020 diabetes becomes more than twice as prevalent among African-American, Latino American and Native American populations as among the population as a whole.

Healthcare Reform

Healthcare reform stalled for several years without any consensus for change in healthcare between the two political parties. Small changes were made on the margins as the government took a larger role in encouraging improved quality and coordination of care. The growing use of electronic and personal health records was hastened by government facilitated standards for interoperability between widely different health information systems. The government also stepped in to help individual doctors, small practices, and community health centers adopt electronic information systems and integrate them into the larger health information infrastructure. Community health centers continued their quality improvement activities, begun in the 1990s and their team-focused approach to care. For those with access, healthcare quality improves, particularly for those with multiple chronic diseases.

Galvanized by an inactive federal government a number of progressive, and wealthy states, move forward on their own versions of healthcare reform. These states look to the successes of the Massachusetts health reform of 2006 as a model. They pass legislation combining reregulation of the insurance industry, a central clearing agency to facilitate more consumer choice, and subsidies for low income citizens without coverage. Some combine these changes with mandates or fees for businesses or individuals who choose not to buy insurance. The plans are successful in extending coverage to the working poor and alleviating some of the burden on hospital emergency rooms. Cost, however, remains an issue, but the percent of people who don't have regular access to healthcare has been reduced by half – to roughly 9%.

Healthcare Inflation

New advances in technology combined with an aging population form the basis of spiraling healthcare costs. New biomarkers enable a shift from population based care to personalized medicine that draws on a patient's genotype and phenotype to select the best course of care. Personalized medicine leads to higher usage of diagnostic tests and the targeting of new therapies to smaller and smaller subgroups of patients. The result is higher costs for care. The reduced costs from reduced use of expensive technologies such as imaging are replaced by a flood of expensive biomarker tests.

Personalized medicine lead to intense debates on what should and should not be covered with insurance and what qualifies as a pre-existing condition. The lack of any national consensus on the issue leaves the decisions largely open to payers both public and private. The end result is an inequitable system where many of the advances of personalized medicine are available to the affluent either through additional coverage from their employer sponsored plans or by tax free payments from health saving accounts (HSAs). The poor remain covered by strained Medicaid, while some of the working poor who would be eligible for their state's plans are excluded from healthcare access because of the enlarged set of "pre-existing conditions" identified by personalized medicine.

In terms of health equity, things are worse. Healthcare access and quality still has problems but have been dramatically improved. Yet healthcare is only part of the story. Healthcare makes up

10% to 25% of the difference in premature death. More important are the social determinants – our place on the socio-economic ladder, our income, housing, education, and safety. Some disparities in these social determinants were lessened over the two decades leading up to 2008, but in most of these areas disparities increased. Health disparities increased along the social disparities – the gaps in health grew larger.

Scenario Two: Depression, Disasters & Self Protection

Key Themes:

- ❖ It's a dark time in America. Chronic diseases, including diabetes, cancer, heart disease and asthma get disparately worse. New and reemerging infectious diseases increase health disparities – tuberculosis, dengue fever, even cholera. Disparities in healthcare access and quality grow significantly.
- ❖ Demand for care grows from 2008, but funding does not keep pace. From 2000-2008 the social safety net of health and social programs are underfunded and fraying.
- ❖ Beyond healthcare, a host of challenges that affect the larger economy and social determinants of health occur – peak oil, climate change, responses to climate change that disproportionately affect the poor, economic depression, declining place of the US in the world economy.
- ❖ Social conditions worsen, there is more antagonism among racial and income groups; less security; gains in latter 20th century are reversed; being a minority, particularly with the wrong accent or skin color can be a stressor or even dangerous (and whites are minorities in many places).
- ❖ Decreasing spending by government and businesses affect key determinants of health – jobs, education, housing, transportation, healthcare, public health.
- ❖ Competition limits compassion, fairness & equity – help is confined to one's family, neighborhood and church.
- ❖ Social determinants of health and health disparities go in the wrong direction, disparities increase in income, employment, education, housing, safety, crime, prison; even the destruction from climate change and the costs of slowing global warming are unequally distribute – the poor suffer more.

By 2015, the nation is hit by the triple threats of peak oil, climate change and global economic disarray. Natural disasters hit rural and coastal communities with more frequency and potency leading to growing populations of internal refugees. High oil prices make transportation more costly for all, but particularly for poor in the farther suburbs and rural areas. Poor housing and stress lead to spikes in both acute and chronic disease among poor and minority communities. Public health scourges, such as tuberculosis, once thought eliminated in the United States make a comeback. Global warming and poor public health lead to many infectious diseases, such as tuberculosis, dengue fever, and even cholera, reemerging and moving north.

The United States finds it hard to keep up in a globally competitive world. Even service sector jobs once thought immune to the effects of globalization are moved offshore. This includes health services as countries like India and Thailand become centers of medical innovation and hubs for medical tourism. The poor economy draws private and public funds from the safety net of programs that support the poor and underserved.

Challenges Mount: Energy Crisis, Climate Change, and the US Economy

By 2015, it becomes clear that the global supply of conventional oil and natural gas cannot keep pace with fast growing demand. Oil prices skyrocket, and inflation spikes, creating disarray in a global economy still reeling from the bursting of the U.S. housing and credit bubbles. At the same time, the impacts of climate change come on faster and more strongly than anticipated. Water issues hit struggling rural communities all across the country, especially in the West, where there is a lack of water. Along the Southeast Atlantic and Gulf Coasts communities decline, and are abandoned in the face of more frequent droughts, fires and hurricanes. Those who stay face more and greater disasters; after which FEMA and state agencies can't provide adequate support. Many are left homeless and with few options.

Circumstances like these lead to blaming scapegoats, ruthless pursuit of narrow self-interest, resource wars, and other pathological responses. Minority communities, especially recent immigrants, become the focus of hostility by a nation threatened by deep economic recessions. The continuing stress of racism and bigotry leads to more disparities in communities of color. Access to care reaches an all time low as the safety nets for many of the nation's poorest falls apart. Medicaid sees large, unsustainable increases in patients needing assistance leading many states to cut back eligibility and service levels and raise copayments. Both public and private support for community health centers is cut back during the economic crisis leaving many communities with significantly diminished access to health services.

A Deep Valley in a Flat World

The world continues to flatten due to the persuasive influence of information and communication technology. As the emerging Asian economies continue to grow and move up the value scale manufacturing moves to growing and stable countries in Asia. China and India improve their infrastructure and education to compete with the U.S. in key high value industries while service jobs that can be performed via phone and internet continue to migrate to low cost countries. However, many of these countries experience their own health disparities due to overpopulation and lack of focus on sustainable development in poor, rural areas. The social and economic determinants of health are stacked against the poor and working poor in the U.S. The result is a deep valley in an otherwise flat world where underserved communities try in vain to lift themselves out of poverty. Middle class Americans fall back down the socio economic ladder. This fall is especially significant for African-Americans. Their gains in the latter 20th century are reversed throughout much of the country. The Black middle class shrinks faster than the middle class in general.

Healthcare is affected by the economic challenges and global competition. India, in particular, became a globally competitive hub for medical services. Diagnostic service centers receive test results from new biomonitoring and biomarker devices electronically for analysis followed up

with video consults with patients. Asian hospitals offer lower rates and higher quality service for both in-patient and out-patient procedures. “Medical tourism” for surgery and vacation becomes part of the coverage of Americans who continue to have health insurance. Patients from the U.S. often avail themselves of these services leaving fewer patients for high margin, non-emergency and outpatient services at hospitals in the U.S.

Care providers in the U.S. are unable to subsidize other parts of their business with profits from high margin services. The first signs of a problem are in the reduction in the number of physicians accepting Medicare and Medicaid patients. By 2012, most general hospitals are forced to choose between shutting down unprofitable areas of their business and shutting their doors completely. Specialty hospitals continue to proliferate while the broad based community hospitals and community health centers struggle to deal with a growing population in need of services.

Scenario Three: Sharing the Burden – The New Fair Deal

Key Themes:

- ❖ Challenging times (the Depression, natural disasters) led to a greater solidarity and greater understanding of the unfair and avoidable differences in health. The primacy of the social determinants of health was recognized and more effort given to ensuring adequate prenatal and early childhood assistance, graduation rates, job access and a livable wage.
- ❖ The greater solidarity led to more harmony and support for people of all races and socio economic positions. This in turn had important health effects. Health disparities are reduced.
- ❖ Healthcare nearly collapsed before it was reborn. Because of the depression and other challenges to the budget, healthcare spending was decreasing. Community health centers rose to the occasion to continue their processes of quality improvement – bringing optimum prevention and care to low income and minority populations; using the right team of providers as well as information tools, including virtual reality.

The second and third decades of the 21st Century are challenging. The country experiences some of the worst economic times since the depression. The declining mortgage market leads to widespread instability in the financial markets. Lending dries up leading to an anemic job and housing market lead to some of the worst economic times since the Great Depression. Katrina-like hurricane events and other natural disasters hit American cities. The rise in energy prices due to “peak oil” (half of the world’s oil supplies are used up and annual supply plateaus or declines while global demand continues to rise) and the decline of the U.S. dollar hit the poor the hardest.

Widespread economic hardship among the poor and middle class galvanized Americans to support radical change in national policy, in their communities, and among themselves. Realizing the shift in national sentiment, both Democrats and Republicans worked together to take on entrenched interests in American healthcare and enacted laws that drew upon the best thinking of both parties. In the cases where government intervention made sense, regulations were enacted, agencies created and funding provided. In areas where market approaches made sense, the government levied taxes and provided incentives to align the market to achieving the

public good. This shift was part of the development of a shared vision for America as a fair land of opportunity, with a 21st century understanding of what fairness entailed.

The hardships of the 2010s lead to vigorous public policy to help the working and middle class the likes of which has not been seen since the New Deal.¹⁴ Opportunity, freedom, health are seen as fundamental values that should be evenly distributed. National leaders call on the greatness of America in its solidarity and compassion to make major changes possible including recognizing and eliminating discrimination, recognizing that all are deserving of care and respect, and understanding of the need for sharing the burdens, particularly more progressive taxation. The policies put in place in the 2020's include:

- ❖ Living wage laws that provide sufficient income for a family to have food, clothing, shelter and transportation in their community
- ❖ Income support for families with newborns
- ❖ Earned income tax credits for low income families
- ❖ Secure pension plans and increased savings incentives
- ❖ Equalized access for new or enhanced job skills training
- ❖ Functioning and affordable public transportation
- ❖ Job programs, including a focus on “green jobs” that enable service, skill development and infrastructure building or rebuilding; (analogous to the CCC/WPA of the 1930s)
- ❖ New investment in all levels of education including high quality early childhood education for all; quality K through 12 with high rates of high school graduation; financial assistance and more affordable options for college
- ❖ Affordable housing (family housing that takes 30% rather than 50% or more of the worker's income)
- ❖ Zoning that encouraged density and facilitated accessory dwelling units and multiple unrelated persons living in the same home.
- ❖ Safe and activity friendly neighborhoods
- ❖ Enabling access to grocery stores and healthy food in low income neighborhoods
- ❖ Culturally appropriate diets with community supported agriculture favoring local/regional production
- ❖ Universal access to quality, low cost healthcare and enhanced self care
- ❖ Immigration reform

Health Equity and Healthcare

Despite the Depression and natural disasters, health disparities in the U.S. were reduced between 2008 and 2028. The cancer and diabetes rates for African Americans and Hispanics remain higher than whites in 2028, and the poor are still sicker and die sooner than the well off, but the differences have been reduced. Healthcare played an important role in achieving greater health equity, but its role is debated in light of the widespread social reforms of the New Fair Deal.¹⁵

Healthcare during the New Fair Deal changes dramatically. Large parts of the healthcare system nearly collapsed in the 2010's due to economic depression, lack of capital, lower payments from

Medicare, Medicaid and insurers. These challenges stressed many struggling providers, particularly in areas prone to weather related disasters. Many struggling hospitals and clinics shut their doors. Doctors were challenged by lower payments, passing the difference on, where they could, to patients.

The healthcare providers that survived realized that business as usual was not sustainable. They looked for cheap, simple ways to improve the health of their patients as their payments per capita decreased. Many looked for inspiration to providers in low income communities who had extensive experience in doing more with less.

Some providers, such as community health centers show that quality improvement processes, such as the Chronic Care Model, could be applied in minority and low income communities. By doing screening and preventive services, these healthcare providers reduced health disparities and increased patient centeredness in their work. Disease was prevented and the progression of existing conditions such as diabetes was slowed.

As the economy turned around in the 2020s, the healthcare system built on the successes of these providers with more resources. As part of the New Fair Deal, patients were required to have a “medical home” and a primary care provider, usually not a physician. Providers worked in teams and continually enhanced their quality, in the rich definition of quality they had adopted from IOM (quality care is safe, effective, patient centered, timely, efficient, and equitable). Lower paying roles in healthcare, such as community health workers, played an important part of these teams and were also part of the job creation efforts coming out of the Depression of the 2010s.

The internet and related health information technology supported the shift to more effective and lower cost healthcare. Electronic medical records and personal health records, with improved electronic security and privacy protection, were common in spite of the challenging times by 2015. Younger people increasingly learned, interacted and obtained services in “virtual reality” such as Second Life and its successors. Much of the healthcare services that did not require in-person treatment migrated to these platforms where the patient’s avatar interacts with their healthcare provider’s avatar, using all of the patient’s medical history, family history, in some cases genetic information. Because community health centers and others serving the poor take advantage of these information advances and make them effective, they reduce health disparities.

The combination of a new healthcare system that focused more on prevention care early rather than heroic care at the end of life combined with better social policies created a decade which economists did not think possible. Healthcare spending shrunk while national measures of health improved despite the aging of the large Baby Boomer generation. Healthcare providers that survived the dark times emerged more efficient and sustainable.

Scenario Four: The Mind & Heart Shift

Key Themes:

- ❖ Society, in the 21st century, changes its mind on health equity, as it did in previous century on slavery, segregation and women’s rights.

- ❖ Society recognizes the most important levers for health equity are the social determinants of health such as jobs, living wage, affordable housing, education, access to healthy foods, and safe and activity friendly neighborhoods.
- ❖ Inspiring leaders and inspired younger generations help made change possible and visible through community action as well as local, state and federal policy.

One of the great, visionary leaders of the 20th century, Martin Luther King said “I have a dream”. As the civil rights movement evolved Dr. King recognized the issues of poverty, war, peace and development, and health had to be addressed to achieve his dream. More than 50 years after his assassination, his dream is realized as society shifts its hearts and its minds to recognize the intertwining of health with socioeconomic status, income, education, where you live and your race.

Like many social trends, slavery, women’s rights, apartheid, the environment, it takes society a long time to “change its mind”. Health equity required an awareness of the determinants of health and of disparities and a concern for fairness strong enough to overcome resistance to change.

By 2028, America has decided that “fairness” was an important value, one that should be pursued. Americans were aware of the “socioeconomic ladder”. We were all aware of where we stand on the ladder, but most had not paid much attention, particularly to the health differences that accompany the steps in the ladder. This changed in the 2010s. Grassroots movements started in communities across the nation that demanded equity. Leaders from this movement inspired younger generations and together they made change possible. New policies were designed to reduce poverty at the bottom of the ladder and lessen the differences at each step of the ladder.

“Health equity”, like fairness or “fair health” became the focus of a powerful movement. The key policies related to health equity – employment with a living wage, education, affordable housing, neighborhoods that were safe, activity friendly, and a place to buy healthy food required a sense of “solidarity” included in social policies and safety nets. The U.S. had put social policies in place in the 20th century, but they were not effective. Our leaders reminded us of the relevance of “life, liberty and the pursuit of happiness” for all. To do so would require a change of mind and a change of heart.

Economic, social and environmental challenges continued: global warming and higher energy prices after “Peak Oil”, and the continued rise of the U.S. debt even while the dollar declined. Why were individuals supportive of health equity in the face of these challenges? A new generation of leaders and of young people made a renewed commitment to American ideals. They inspired older generations, in some cases their parents, and many Baby Boomers. New standards were put on “fairness” – health differences that are avoidable and unfair. Being African American in the US had meant a higher likelihood for an earlier death from cancer. Being Hispanic meant higher rates of diabetes. These were among the inequities that no longer looked normal. No longer were they considered differences that could not and need not be changed.

Our responses were shaped by a deepening of American ideals that supported both community and individual opportunity. Our internet, news and information systems continued to evolve and made unjust situations more visible. Documentaries, news programs, internet sites and other news and information sites championed the social determinants of health and provided tool to communities to create change. Internet tools for mapping disparities in your community became wide spread and well used. Grade school and high school projects looking at health equity brought home the issues to students and parents.

In the 1960s there were “freedom riders”, the Peace Corps, and Vista. In the 2010’s there were “justice riders”, who renewed service opportunities in local communities and focused the public on changing the causes of inequality. These included access to housing and healthy food, lack of discrimination, respect, safe activity friendly neighborhoods, prenatal care, early childhood development and preschool, as well as success in and through high school. Sensing the national mood, leaders at the state and national level soon pushed for parallel movements for changes in policy – focused on jobs and a minimum living wage, supporting affordable housing, success in school and access to college.

Healthy Communities Grown From the Grassroots

True to the American philosophy of independence and civic pride, the impetus for this shift came from the community and it is in the community that the greatest changes in health equity occurred. Only after these changes in communities happened did national leaders come forward to bring change to policies at the state and federal level. Many of these leaders came directly from the communities where the movement started as the public demanded change and wielded the mighty power of the ballot box against those leaders who resisted change. After a few notable examples, the other leaders in the legislature and executive offices of the state and national governments soon followed where their constituents led them.

Communities across the country demanded healthier communities. Community organizations, both religious and secular, worked together to build new parks, bike paths, community health fairs, exercise programs, services for the homeless, healthy food banks, safe activities for teens and other projects. Retired Boomers, looking for ways to stay active in retirement, and reconnect with the ideals of the 1960s, led many of these efforts, while younger generations inspired by the health equity movement became an important core of volunteers. Foundations flush with cash from bequests from the richest of the retiring Baby Boomers, entered a new age of philanthropy, and actively provided monetary supported for these efforts.

The value of these efforts in improving health outcomes and reducing health costs were examined using rigorous studies of health data collected through electronic and personal health records. Researchers could develop “health profiles” of communities by correlating health data to geographic information systems. These easy to use, interactive maps were widely available by 2015. Health activists in communities across the nation worked to galvanize support among the community and push for change in government policies. The research was also successful in determining which interventions were the most effective in reducing health disparities and how to alter strategies for different communities. The success of these projects in improving health

and quality of life convinced local and state governments to provide more active financial support for community interventions.

The health equity movement also worked closely with the environmental justice movement to create cleaner, more sustainable communities across the country. Using low cost environmental monitoring devices, these residents and activists looked at ambient levels of pollution in neighborhoods and correlated that data with health data for the community. Their activities were instrumental in shutting down and mitigating pollution from dangerous power plants, factories, agricultural operations, mines, large truck traffic through residential neighborhoods, and unsafe apartment buildings. Simultaneously consumers changed their buying habits to focus as much as possible on healthy, sustainable and locally produced products. The result was lower environmental pollution in low income communities which previously had a profound, if largely unrecognized, impact on the health of underserved communities.

Using These Scenarios

These scenarios present four pathways into the future. They tell the stories of how we in the U.S. did or did not effectively pursue health equity. Scenarios are important for clarifying our assumptions, understanding trends, getting us to think about the implications for our current strategies and directions, and having us consider what we are working to create.

You can use the following questions to explore these scenarios. This can be done with small groups each consider a different scenario at the outset. Have each group answer the first two questions, assuming their assigned scenario occurs. If time permits, then have each group consider a second scenario and answer the first two questions in light of that second scenario. Compare the results and discuss the third question.

1. **Implications:** What are the implications of each scenario for our current goals and strategies for health or health equity?
2. **New Strategies:** What new strategies or approaches should we pursue to be successful in each of the scenarios?
3. **Comparing across the scenarios:** Given the strategies for each scenario, how “robust” are your strategies? Are there new approaches or strategies that would be important to pursue?

The DRA Project is planning a more in-depth scenario guidebook to help leaders of healthcare organizations use the DRA Scenarios in training exercises and strategy sessions. The workbook will be posted on the DRA Website: www.altfutures.com/draproject.

¹ Robert Wood Johnson Foundation (Feb, 2008) *Overcoming Obstacles to Health: Report From the Robert Wood Johnson Foundation to the Commission to Build a Healthier America*; 32-39.

² The high rates of infant mortality among racial and ethnic groups remains even after access to prenatal care is taken into account. After taking other risk factors into account, the odds of newborn infants dying were 3.4 times higher in blacks, 1.5 times higher in Hispanics, and 1.9 times higher than whites.

Save the Children (May, 2006) *State of the World's Mothers 2006: Saving the Lives of Mothers and Newborns*; 37-8. Retrieved 2/12/2008 at http://www.savethechildren.org/publications/mothers/2006/SOWM_2006_final.pdf

³ In 2005, approximately 13.1 million (8.7%) of all non-Hispanic whites aged 20 years or older had diabetes. Adjusted for population differences and estimating across racial and ethnic groups, 3.2 million (13.3%) of African-Americans, 2.5 million (9.5%) of Latino Americans and 118,000 (15.1%) of Native Americans and Alaska Natives.

American Diabetes Association (2005) National Diabetes Fact Sheet. Retrieved 2/12/2008 at

<http://www.diabetes.org/uedocuments/NationalDiabetesFactSheetRev.pdf>

⁴ Robert Wood Johnson Foundation (Feb., 2008) *Overcoming Obstacles to Health: Report From the Robert Wood Johnson Foundation to the Commission to Build a Healthier America*; 22.

⁵ A recent article published in the journal *Cancer* showed no improvements in reducing disparities in care among African-Americans during a ten year period starting in 1992. The study looked at colon, lung, rectal, breast and prostate cancer in Medicare patients.

Gross, C.P., Smith, B.D., Wolf, E. and Andersen. M. (Feb, 15th 2008) Racial Disparities in Cancer Therapy: Did the Gap Narrow Between 1992 and 2002? *Cancer*; 900-908.

⁶ Gupta, R.S., Carrión-Carire, V., Weiss, K.B. (2002) The widening black/white gap in asthma hospitalizations and mortality. *Journal of Allergy and Clinical Immunology*; 351-358

⁷ If current trends continue, medical care costs will rise from 16 percent of the Gross Domestic Product (GDP) to 20 percent of GDP by 2015.

Borger, C., Smith S., Truffer C., Keehan, S., Sisko, A., Poisal, J., Clemens, M.K. (2006) Health Spending Projections through 2015: Changes on the Horizon. *Health Affairs (Millwood)*, 25(2): W61-W73.

⁸ Robert Wood Johnson Foundation (Feb, 2008) *Overcoming Obstacles to Health: Report From the Robert Wood Johnson Foundation to the Commission to Build a Healthier America*; 40.

⁹ The Milken Institute estimates that in 2003 the most common chronic diseases cost \$277 billion to treat and that does not include follow-on health consequences or institutionalized Americans. They estimate that lost productivity adds another \$1.1 trillion dollars in indirect costs. They estimate the total could reach \$6 trillion by the middle of the decade unless steps are taken to prevent more chronic disease.

DeVol, R, and Bedroussian, A. (Oct, 2007) *An Unhealthy America: The Economic Burden of Chronic Disease*; 1-7.

¹⁰ Franks P, Clancy CM, Gold MR, "Health insurance and mortality: Evidence from a national cohort" *JAMA*. 1993 Aug 11;270(6):737-41.

¹¹ Nancy Adler, et al. Reaching for a Healthier Life: Facts on Socioeconomic Status and Health in the U.S., The John D. and Catherine T. MacArthur Foundation Research Network on Socioeconomic Status and Health, pp. 4, 5.

¹² The Prevention Institute (Oct, 2006) *The Imperative of Reducing Health Disparities through Prevention: Challenges, Implications, and Opportunities*. Retrieved 2/12/2008 at

http://www.altfutures.com/DRA/DRA_Reducing%20HD%20thru%20Prx1.pdf

¹³ Nancy Adler, et al. op. cit. pp. 42-47.

¹⁴ The 1930s had significant leaders, particularly Franklin D. Roosevelt. An active, vigorous leader, who in 1921 at age 39, lost the use of his legs as a result of polio. As a result he became more sensitive to both disabilities and to those suffering other challenges. He was better prepared to take on the challenges of the Great Depression. From 1933 to 1937 the New Deal created the minimum wage, regulated child labor and 40 hour work week, established government work programs (the WPA), ensured some degree of equity of access to these job programs for African Americans (in a very segregated America), and created Social Security.

¹⁵ Carolyn Clancy and colleagues argued that lack of access to healthcare raises the risk of dying by 25% while others would argue the percentage is closer to 30%. Michael McGinnis and his colleagues argue that only 10% of differences in health, as measured by premature mortality, are associated with medical care. So, based on this range, 70% to 90% of health can be attributed to other factors.