Addressing Structural Inequalities, Structural Racism, and Social Determinants of Health: a Vision for the Future

Leonard E. Egede, MD MS[1,2], Rebekah J. Walker, PhD[1,2], and Joni S. Williams, MD MPH[1,2]

[1]Division of General Internal Medicine, Department of Medicine, Medical College of Wisconsin, Milwaukee, WI, USA; [2]Center for Advancing Population Science, Medical College of Wisconsin, Milwaukee, WI, USA

ABSTRACT

Significant national discourse has focused on the idea of structural inequalities and structural racism within a variety of societal sectors, including healthcare. This perspective provides an understanding of the historic and pervasive nature of structural inequalities and structural racism; uses well-known frameworks in health equity research for conceptualizing structural inequality and structural racism; offers a summary of the consequences of structural inequalities and structural racism on modern-day health outcomes; and concludes with strategies and suggestions for a way forward. Recommended strategies across different sectors of influence include (a) *employment and economic empowerment sector*: creating capacity for individuals to earn livable wages; (b) *education sector*: developing new funding structures to ensure equal opportunities are offered to all; (c) *healthcare sector*: prioritizing universal access to high-quality health care, including mental health treatment; (d) *housing sector*: improving access to affordable, safe housing through public–private partnerships; (e) *criminal justice sector*: focusing reform on restorative justice that is people-centric instead of punitive; and (f) *environmental sector*: creating sustainable systems that alleviate downstream consequences of climate change. The recommended strategies account for the mutually reinforcing and pervasive nature of structural inequalities/structural racism and target key sectors of influence to enhance overall health outcomes and achieve equity regardless of race, ethnicity, or socioeconomic status.

J Gen Intern Med 39(3):487–91

DOI: 10.1007/s11606-023-08426-7

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Significant national discourse has focused on the idea of structural inequalities within a variety of societal sectors, including healthcare.[1–3] Structural inequalities occur when differences in access, distribution of wealth, availability of resources, or power are reinforced through structural mechanisms.[4–6] When these differences exist based on race/ethnicity, structural inequalities are more appropriately termed structural racism. Structural racism, therefore, is often defined as the ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice.[5, 6] Much of what we see in terms of adverse health outcomes and health disparities results from structural inequalities and structural racism because layers of inequality are experienced in these various systems. Differences in social determinants of health are therefore the result of these structural factors, which exist antecedent to the social risks known to impact health outcomes.[7, 8] Therefore, the convergence of structural inequalities, structural racism, and social determinants of health creates social risks, which impact the health of specific populations and result in health disparities.[9] This perspective offers insight on how we got here, the consequences of our current state, and thoughts on a way forward that focus on improving health outcomes for the entire US population.

HISTORICAL CONTEXT

From the foundation of this country, some groups have been marginalized based on individual action or nationally organized efforts. The Indigenous people of North America were systematically disenfranchised, disempowered, segregated, and exposed to harsh and unjust treatment. Some of the clear examples of this include forced assimilation of Native Americans through boarding schools and forced segregation into reservations. Similarly, from the time of arrival in the USA and through recent times, Blacks/African Americans were forced into slavery, marginalized, and denied basic legal rights such as voting, education, and employment through Jim Crow laws, and brutalized through state-sanctioned violence. Hispanic Americans experienced inequities in immigration laws, limiting their ability to legally obtain employment and a living wage; Asian Americans were systematically detained, forced into unjust imprisonment (internment), and denied due process following Pearl Harbor; and poor Whites in rural areas were denied equal access to jobs and resources, including healthcare. The convergence of these processes created inequities in the way resources, wealth, and power were structured, creating structural inequalities that continue to this day.

Received July 2, 2023
Accepted September 12, 2023
Published online September 22, 2023

CONCEPTUALIZING STRUCTURAL INEQUALITY AND STRUCTURAL RACISM

We offer three fundamental considerations when conceptualizing structural inequality and structural racism that help to clarify why addressing inequalities at an individual level will not result in lasting change. First, the World Health Organization (WHO) created a framework to understand how differences in social determinants of health result in inequalities in health and well-being.[3, 10] This framework identifies structural determinants, defined as the socioeconomic and political context, as influencing socioeconomic position and social class, social capital, and differences in intermediary determinants such as material circumstances, behaviors, and psychosocial factors.[3] These, in turn, influence both the health system and equity in health and well-being of individuals.[3] The structural factors that ultimately influence equity, as defined by the WHO, include governance, macroeconomic policies, social policies (i.e., labor market, housing, land), public policies (i.e., education, health, social protection), and culture/societal values.[3] Secondly, the National Institute for Minority Health and Health Disparities (NIMHD) created a research framework to understand how factors relevant to promoting health result in the multifaceted nature of health disparities.[11] This framework identifies five domains of influence (biological, behavioral, physical/built environment, sociocultural environment, and healthcare system) and four levels of influence (individual, interpersonal, community, and societal) through which health outcomes at the individual, family, community, and population level are influenced.[11] Thus, it becomes clear that interventions that target single domains or single levels of influence are insufficient to change population health.[12] Instead, efforts that span levels of influence (i.e., individual, interpersonal, community, and societal) and address multiple domains of influence (i.e., biological, behavioral, physical/built environment, sociocultural environment, and healthcare system) are necessary.[12] Finally, it is necessary to recognize that multiple sectors exist within the societal structures noted by both the WHO and NIMHD frameworks. These include, but are not limited to, the health sector, finance (banking, credit, and investments), the criminal justice system (policing, courts, and correctional facilities), education, employment, housing, and the environment. Because structural factors in the socioeconomic and political contexts operate at multiple levels and through multiple sectors, structural inequalities and structural racism create a mutually reinforcing effect that is pervasive across an individual's life. This has an overwhelming impact on individuals but cannot be corrected at an individual level due to the multiple layers and levels of influence over the life course.[12]

CONSEQUENCES OF STRUCTURAL INEQUALITIES, STRUCTURAL RACISM, AND SOCIAL RISKS

Despite awareness of historical injustices, many are unaware of or have placed less emphasis on understanding the link between the historical context, structural inequalities, structural racism, and current health in the USA. Even more concerning, evidence suggests individuals with varying levels of power (i.e., policy makers, elected officials, scientists, academics, etc.) remain hesitant to acknowledge structural racism as an underlying cause of racial health inequities in both the public and private sectors,[6, 13] despite modern-day medicine being rooted in historical scientific racism or the belief of innate inferiority and superiority among specific population groups.[13] It is clear, however, that the health consequences of structural inequalities and structural racism have occurred due to adverse economic, social, and physical determinants and have resulted in higher rates of illness and disease.[13–15] These factors have resulted in policies, practices, and procedures that have impacted access to resources such as employment, housing, safe neighborhoods and environments, and quality education—all required for optimal health outcomes.[14] As a result, discriminatory practices and ideals and the inequitable distribution of resources result in substandard health care and worsening population health.[6, 13]

For many clinical conditions and endpoints, outcomes are worse for minority groups for whom experiences and exposures to structural inequalities, structural racism, and social risks are pervasive and chronic. Evidence shows that adverse mental and physical health outcomes are linked to self-reported exposures to structural racism.[15, 16] For example, racial residential segregation and redlining are forms of structural racism that have persistently impacted the lives and health of Black/African American and Hispanic/Latino populations,[4, 6, 13, 17, 18] resulting in a higher incidence and prevalence of chronic health conditions such as hypertension and diabetes[7, 19–22]; more healthcare utilization; decreased life expectancy; and increased exposures to social risks such as housing instability, food insecurity, utility help needs, crime and violence, unemployment, and other adverse conditions associated with poor health.[4, 23] Discriminatory incarceration practices have led to poor health outcomes, not only for the individuals directly impacted, but also for their immediate and extended family members and communities.[4] Evidence has demonstrated an association between racism and health outcomes for older Black/African American adults (50 years and older), including mental health and cognition, cardiovascular disease, physical functioning, and telomere length.[24] Additionally, socioeconomic and political (structural) determinants such as low income and lower educational attainment have led to disparities in heart disease and stroke outcomes among racial and ethnic groups.[25] Furthermore, structural racism in the form of limited or no access to healthcare is also an issue.[26, 27] Even when individuals can access the health care system, there are differences in receipt

of optimal care, due to a lack of acceptances of some insurance types for example.[28] Finally, decades of research have shown that for racial and ethnic minority groups, many continue to receive suboptimal care, a metric that has not shown improvement over time.[6] All these factors then lead to poor health outcomes for minority groups. Until the multitude of influences are addressed, differences will continue to persist.

THE WAY FORWARD: A VISION FOR THE FUTURE

The question before us is, where do we go from here? Given the mutually reinforcing, multi-sectoral, and multi-level nature of structural inequalities and structural racism, it is necessary to attack the problem from multiple fronts simultaneously and focus on upstream policies. Table 1 provides recommended strategies to address structural inequalities and structural racism across different sectors of influence. This list is not intended to be exhaustive but provides a place for activities to begin. Strategies are also deliberately broad, instead of being prescriptive, to allow policy makers flexibility in design and implementation. The specific sectors chosen and strategies identified were based on a review of current literature[1, 4, 6, 7, 29–32]; however, future research is needed to guide policy efforts and policy makers within each of these sectors. Therefore, though medicine sits within the healthcare sector, general internists interested in addressing structural inequalities and structural racism will need to step out of their comfort zone and engage the mutually reinforcing structures and sectors that perpetuate structural inequalities/structural racism to improve health outcomes. This will require engaging sectors typically outside of health care, including finance (banking, credit, and investments), the criminal justice system (policing, courts, and correctional facilities), education, employment, housing, and the environment, via advocacy, research, education, and community engagement.

First, poverty and economic disempowerment are at the foundational core of structural inequalities and structural racism. Poverty is multifaceted and has significant impact on health, so without addressing it, everything else will remain the same. Therefore, within the employment and economic sector, we need to identify ways to create a safety net structure that aims to create capacity in those currently marginalized. One example of this is creation of livable wages that allow individuals to meet basic needs. Many economists identify a strong job market and low unemployment as one of the greatest drivers of recent drops in wealth gaps by race/ethnicity.[33–35] Therefore, efforts should focus on creating equal opportunities for employment so that poverty is not addressed with short-term protections, but with long-term capacity.

Second, within the education sector, funding structures that ensure equal opportunities to high-quality education are needed. Education systems tied to property values or local sales tax will always result in a system of unequal opportunities. Therefore, new funding structures for the

Table 1 Strategies to Address Structural Inequalities and Structural Racism Across Sectors of Influence

Employment and economic empowerment
- Region adjusted livable wage that allows individuals to meet basic needs
- Tax incentives to create employment opportunities in low-income communities
- Increase new homeownership through coordinated tax credits for developers building in low-income neighborhoods

Education
- Create school funding system that is independent of the local tax base
- Develop a federally funded retention program for skilled educators in public schools
- Expand proportion of funding allocated to low-income students and students living in high poverty school districts

Healthcare
- Ensure universal healthcare access
- Tax incentives to support safety net hospitals and health systems in low-income communities
- Design value-based health system payments to incentivize addressing social needs
- Expand coverage for behavioral health, ensure consistent implementation of the Mental Health Parity and Addiction Equity Act of 2008, and create a unified oversight committee for violations
- Address mental health professional shortages and maldistribution across the country
- Standardize medical necessity standards, integrate medical and mental healthcare, and expand use of telemedicine for mental health treatment

Housing
- Expand use of community development block grants
- Reform zoning for mixed income housing
- Expand voucher programs through broader eligibility, increased acceptability of use, and increased funding

Criminal justice system
- Retrain law enforcement officers, strengthen community policing, and increase trust of law enforcement system
- Establish systems to ensure fair and equitable sentencing, reduce extreme sentencing, and ensure sentences align with crimes committed
- Limit incarceration for probation and parole violation, reduce use of solitary confinement, and create programs that optimize reentry and reintegration post-incarceration

Environmental sector
- Use special use districts to protect specific types of land use based on community input
- Incentivize greenspace development, development of open lots, and restoration of older buildings through tax and zoning structures
- Invest in development of sidewalks and bike lanes in low-income communities

K-12 educational system, programs that focus on assets of individuals in identifying educational paths, and efforts to increase readiness in individuals for future educational opportunities are needed.

Third, within the healthcare sector, it is critical to implement strategies to provide equal access to high-quality health care. This could take the form of universal health care, expansion of Medicaid, Medicare for all, or a host of other frameworks for equal access. The key underlying issue is creating a system where universal access to healthcare is a right for everyone, as opposed to being conditional on where an individual lives, how much they make, or what health insurance they can afford. It is also critical to include access to evidence-based mental health programs. Mental health affects employment, housing, criminal activity, suicide rates, and physical health. The poor and marginalized are often least able to access the few programs that are available, creating a structural barrier to mental health treatment. In addition, without addressing mental health professional shortages across regions and states, we are unlikely to make a dent in the current pervasive lack of access to mental health services.

Fourth, given the incredible influence housing has on health, within the housing sector, it is necessary to focus on improving access to affordable, safe housing. In a country as affluent as the USA, it is critical to establish best practices that incorporate public–private partnerships. Viable solutions need to be economically feasible and tailored to the unique differences encountered by different regions and states.

Fifth, within the criminal justice sector, there is a need for justice system reform. The USA has some of the highest rates of crime and violence, incarceration, police brutality, and mass shootings compared to other countries in the world. The US justice system is also often punitive, instead of focused on restorative justice that is people-centric. While violent crimes cannot be ignored and must be addressed, most of the populations experiencing criminal legal involvement are a result of unfair sentencing practices, a focus on punishment for non-violent crimes, or a lack of treatment for mental health conditions. A system where sentences align with the crimes committed and are reevaluated to provide the necessary treatment and rehabilitation will result in a more equitable and fair system.

Sixth, within the environmental sector, climate change is expected to disproportionately affect low-income and minority populations, making it relevant for conversations on health equity. This effort should not be polarizing, but instead focus on how to create sustainable systems that alleviate downstream consequences of climate change on those with less resources to address it. This will require a national and international dialog among an interdisciplinary group of people who bring different perspectives to the table.

Finally, an unaddressed issue is how to deal with historic injustices that have existed from the founding of this nation. As we saw in Rwanda and South Africa, injustices of the past cannot be addressed without some level of reconciliation and consolation. Therefore, a national dialog centered on historic injustices that includes broad stakeholders with lived experience and diverse perspectives will be critical for forward movement across all sectors. In addition, incorporating discussion on the impact of different strategies on health outcomes will align efforts with the Center for Disease Control and Prevention's Health in All Policies approach.[36] A starting place for this conversation may be a national taskforce to address the issue of reparations. The key to this effort is a focus on restoration of opportunities and addressing the impact of the past on the present.[34, 37] Therefore, reparations should be viewed as a way of trying to reconcile and address the injustices of the past to allow us as a nation to move forward on a more equal and just foundation. Similarly, reversing laws that continue to support historic injustices will be equally as important as identifying new policies to address structural inequalities and structural racism.

CONCLUSION

Because many remain reluctant to recognize structural racism as an underlying cause of racial health inequities, this work provides an understanding of the historic and pervasive nature of structural inequalities and structural racism; uses well-known frameworks in health equity research for conceptualizing structural inequality and structural racism; offers a brief summary of the consequences of structural inequalities and structural racism on modern-day health outcomes; and concludes with strategies and suggestions for a way forward. The overall goal of this work is to create a holistic society where wellness and health are prioritized for all population groups. It is important to recognize and remember that health is not just the absence of disease, but the existence of a totality of factors influencing our physical and mental well-being. If the underlying issue is structural, then we must address the structural factors that resulted in inequalities. Through this work, we as a society can create structures where regardless of race, ethnicity, or socioeconomic status, outcomes will improve, and equity can be achieved.

Corresponding Author: *Leonard E. Egede, MD MS; Division of General Internal Medicine, Department of Medicine, Medical College of Wisconsin, Milwaukee, WI, USA (e-mail: legede@mcw.edu).*

Funding *Effort for this study was partially supported by the National Institute of Diabetes and Digestive Kidney Disease (R01DK118038, R01DK120861, PI: Egede), National Institute of Diabetes and Digestive Kidney Disease (R21 DK123720, PI: Williams), and the National Institute for Minority Health and Health Disparities (R01MD013826, PI: Egede/Walker; R01MD017574, PI: Egede/Linde; R01MD018012, PI: Linde/Egede).*

Declarations:

Conflict of Interest: *The authors declare that they do not have a conflict of interest.*

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