Mapping Aligning Processes and Outcomes:

Equity, Racial Equity, and Racial Health Equity as Aligning Outcomes

The Robert Wood Johnson Foundation recently partnered with the Georgia Health Policy Center to develop the Framework for Aligning Sectors. This framework identifies several end-goal objectives for aligning efforts.[1] Included among the objectives listed in the framework are health equity and racial equity. Equity is important for aligning efforts for many reasons, both ethical and pragmatic. For example, improving health without a focus on systematically disadvantaged populations could further disadvantage those populations. This can be costly and unhealthy for the disadvantaged individuals themselves, and it can be costly for communities as a whole for reasons such as weakened social solidarity. Addressing the needs of disadvantaged populations can also build relationships between these populations and institutional partners, promoting participation in aligning efforts and increasing learnings from the lived experiences of members of these populations.

To help situate equity in the Framework for Aligning Sectors, the Georgia Health Policy Center recently published a brief identifying common definitions for *health equity* and *racial equity*.[2] The Georgia Health Policy Center is also currently conducting an in-depth review of research on the conceptualization and measurement of health equity, racial equity, and racial health equity specifically.[3] This document draws on those reviews and briefly highlights several questions identified by them as superlatively important for understanding and advancing aligning efforts.

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Health Equity

Health equity is defined in different ways by different analysts, but it is widely understood to involve reducing or eliminating group health disparities (i.e., differences), especially for those experiencing social disadvantage. In this brief, we use a definition for *health equity* by Johnson: "Health equity is the quest to close avoidable health gaps. It is the opportunity for all people to arrive at their full health potential, unencumbered by social disadvantage. Social disadvantage has historically been maintained through a 'social hierarchy.'"[4] Johnson's definition is highlighted here because it contains several elements that, when taken together, represent a range of definitions for health equity across the literature. Such elements include "avoidable-ness," health gaps (disparities), opportunities for full health potential, and social hierarchies. The inclusion of avoidable-ness in this definition underscores the idea that health disparities are often avoidable. The inclusion of language about disparities is important because health equity is typically measured in terms of disparities. The inclusion of language about opportunities underscores the idea that outcomes often rest on opportunities rather than innate characteristics or behaviors of a group or individual. The inclusion of language about hierarchies underscores the idea that health disparities are often observed across socially established boundaries like racial and ethnic identity that are sites of social contest over social hierarchies.

As reflected in the definition above, leading social scientists tend to recommend analyzing equity disparities and their determinants at the same time. This is to reduce the effects that social assumptions can have on the interpretation of otherwise careful inquiry into either disparities or their determinants in isolation. Understanding health equity outcomes requires identifying the health disparity in question, the groups by which that disparity is to be understood, and common determinants of that health disparity, including any potentially related social advantages and disadvantages that might accrue to the social identity groups in question. What follows is a series of questions addressing these factors.

What are the health disparities in question?

- What are the health disparities at the core of the aligning effort's shared purpose? Examples could involve physical health, including rates of mortality (e.g., infant mortality, death from heart disease) or morbidity (e.g., low birth weight, high blood pressure). Examples could also involve mental health (e.g., depression, anxiety).
- What are the health disparities being affected by the aligning effort, directly or indirectly, that may not explicitly be a part of the shared purpose?
- What health disparities are important to the community in question, if not those above?

Who is being affected by these health disparities? Examples could include —

- People living in different areas
- Racial groups
- Ethnic groups
- Gender and sexuality groups
- Class, education, and socioeconomic status groups
- Age groups
- People with different citizenship status
- People with different abilities and disabilities
- Veterans and nonveterans

What determinants are shaping these groups' health disparities? Some examples include —

- Differences in treatment and opportunities
- Differences in whether basic needs and other needs are met
- Differences in the presence of stressors (e.g., from experiencing microaggressions or systematic disadvantage)
- Differences in policy across contexts
- Differences in access to quality health care
- Differences in living environments

Racial Equity

As with health equity, *racial equity* can be defined in different ways. In the simplest terms, *racial equity* is the lack of differences across racial identity groups. Museus, Ledesma, and Parker specifically emphasize diversity and power differences, describing racially equitable systems as "systems in which diverse perspectives are equally embedded in power structures, policymaking processes, and the cultural fabric of institutions."[5] LaBoy and Lanford[2] emphasize barriers and opportunities when they suggest that racial equity requires "the elimination of institutional and individual barriers that deny black, indigenous, and people of color equal opportunity."[1] Taking these perspectives together, racial equity can be understood as the absence of differences between racial identity groups in opportunities for a given outcome or in the outcome itself.

Accordingly, as with health equity, analysis of racial equity ideally involves addressing group differences and their social determinants together. Unlike health equity however, racial equity is not limited to the domain of health. Racial equity and inequity, like general equity and inequity, can exist in a wide range of phenomena. Also, the line between racial equity processes and outcomes is blurred since many phenomena relating to equity could be understood as inputs or outputs depending on the perspective taken. Understanding racial equity therefore requires identifying the phenomenon in question, the racial identity groups in question, and the determinants shaping equity in that phenomenon for those groups. What follows is a series of questions addressing these factors.

What racial equity phenomena are in question?

- There are many phenomena commonly discussed in relation to racial inequities in the United States. Examples include racial differences in inherited wealth; treatment in hiring processes; educational tracking; and arrest, conviction, and incarceration rates. In terms of health specifically, many racial inequities in physical and mental health treatment and outcomes have also been observed. Identifying a focus, while remaining open-minded about unobserved racial inequities, can be a starting point to improving racial equity through cross-sector aligning. Note however that while equity objectives of aligning as a whole are the focus of this brief, the Framework for Aligning Sectors also emphasizes equity in relation to individual elements of the framework, and this subject is directly addressed in a separate brief.

What racial identity groups are in question?

- There are many different dimensions of race, and their boundaries are shifting regularly as their social foundations continue to shift. In this United States, analysts have often focused on White and Black or African American racial identity groups, though people in Asian, Native American, Jewish, Hispanic, and other identity groups are also discussed often in terms of racial equity due to the social dynamics that have historically tended to undermine people identified with these groups.

What determinants are shaping racial equity in a given phenomenon?

- There are many factors shaping racial equity and inequity. These can be understood in terms of their roots. Some factors are rooted in history, like wealth inequality, which is rooted in the past, persists across generations, and continues to affect people in different racial groups today. Other factors are rooted in systemic, structural, or institutional racism, which emerged from past inequities but is carried into the present by systems and people regularly failing to reverse past inequalities. Other factors are rooted in individual or interpersonal biases and racisms. Like historical and systemic inequities, these can be difficult to observe as they are sometimes internalized and often unconsciously perpetrated by well-meaning people, or they are acted-out by people using racially coded or indirect language. However, interpersonal biases and racisms may also be relatively transparent, as in cases of blatant prejudice or hate crimes.

Racial and Health Equity

At the intersection of health equity and racial equity is *racial health equity*. Building on the definitions above, racial health equity is the lack of race differences in opportunities for well-being and in well-being itself. This brief focuses on racial health equity as an objective of aligning as a whole, and, like health equity and racial equity, racial health equity can be understood in terms of group differences and their social determinants. Understanding racial health equity as an outcome of the Framework for Aligning Sectors requires asking three questions:

1. What are the health disparities in question?
2. What racial identity groups are in question?
3. What determinants are shaping these groups' health disparities? In particular, what historically, systematically, and interpersonally rooted factors are shaping the health disparities above? In the context of cross-sector aligning, racial health equity determinants may also be considered in relation to processes, determinants, and the individual elements of the Framework for Aligning Sectors. A separate brief addresses equity in relation to the individual elements of the framework.

Tip

Because of the prevalence of the determinants of racial inequity in contemporary society, many scholars and advocates now suggest that along with trying to reduce or eliminate these determinants, equity-seeking organizations and individuals engage in anti-racism. Anti-racism is the practice of (1) acknowledging the difficulty of combatting racial inequities embedded in society and within ourselves and (2) actively advancing racial equity to offset and perhaps even overcome embedded inequities. Anti-racism can be practiced in many ways, and in terms of measurement, this might involve empowering racial minority communities to make decisions regarding measurement, or it may involve giving such a community control over how its data is used, even when such decisions pose challenges for the original agenda or measurement timeline. Preparing for such situations is part of an equitable aligning effort.

When developing a strategy for measuring health equity, racial equity, and racial health equity as outcomes of an aligning endeavor, researchers and practitioners should keep in mind several important dynamics in the measurement of aligning efforts in general. Consider the following questions:

- How might important concepts be assessed using more objective measures (whether using surveys or nonsurvey data sources)?
- How might questions about important concepts be framed differently —
  - Depending on whether the goal is to aid a specific aligning effort or to learn about aligning efforts across contexts?
  - Depending on the level at which the aligning effort is taking place (and how is level defined)?
  - Depending on the purposes of the parties with different roles (e.g., funder, convener, board member, partner organization leader, back-end staff member, front-line staff member, community organizer, community end user, etc.)?
- What guidance might promote better use of the identified questions —
  - To implement measurement ambitiously or with limited resources?
  - To measure effectively and avoid common measurement pitfalls?
  - To promote equity in measurement?
  - To integrate measurement with everyday aligning operations?
  - To promote community member involvement, or direction of, assessments of aligning efforts?
  - To share findings with community members?
  - To use learnings to improve the measurement system?
  - To share findings with practitioners and researchers across the aligning field?

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[1] Landers, G., Minyard, K., Lanford, D., & Heishman, H. (2020). A theory of change for aligning health care, public health, and social services in a time of COVID-19. *American Journal of Public Health*, 110(S2), S178-S180.

[2] LaBoy, A. & Lanford, D. (2021). *Equity, health equity, and racial equity in the Framework for Aligning Sectors.* Georgia Health Policy Center.

[3] A longer version of this brief, with references from the literature, is available. Please contact aligning@gsu.edu to request a copy.

[4] Johnson, L. (2015). Health equity and health disparities: Defining and addressing the equity deficit. *Willamette Law Review*, 51(4), 573-580.

[5] Museus, S., Ledesma, M., & Parker, T. (2015). *Racism and racial equity in higher education.* John Wiley and Sons.