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Movement Advocacy, Personal Relationships, and Ending Health Care Disparities

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Abstract

Deep-rooted structural problems drive health care disparities. Compounding the difficulty of attaining health equity, solutions in clinics and hospitals require the cooperation of clinicians, administrators, patients, and the community. Recent protests over police brutality and racism on campuses across America have opened fresh wounds over how best to end racism, with lessons for achieving health equity. Movement advocacy, the mobilizing of the people to raise awareness of an injustice and to advocate for reform, can break down ingrained structural barriers and policies that impede health equity. However, simultaneously advocates, clinicians, and health care organizations must build trusting relationships and resolve conflict with mutual respect and honesty. Tension is inherent in discussions about racial and ethnic disparities. Yet, tension can be constructive if it forces self-examination and spurs systems change and personal growth. We must simultaneously advocate for policy reform, build personal relationships across diverse groups, and honestly examine our biases.

Keywords

Disparities; Advocacy; Equity; Race; Ethnicity

Some people felt that the United States had entered a “post-racial” period in which the color of one’s skin did not matter.[1–3] Their hopes have been shattered. Police brutality against racial/ethnic minorities has been caught on cellphone and dashcam video, and minority students have been systematically mistreated and marginalized in our universities. Movement advocacy, the mobilizing of the people to raise awareness of an injustice and advocate for reform, has spread across the nation over these issues. These protests over policing and higher education can inform our approaches to ending health care disparities. Tension is inherent in discussions about racial/ethnic disparities, but it can be constructive. We are most likely to achieve health equity if we simultaneously advocate for policy reform, build personal relationships across diverse groups, and honestly examine our biases.

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HEALTH AS A HUMAN JUSTICE ISSUE AND THE ROLE OF MOVEMENT ADVOCACY

Dr. Martin Luther King, Jr. famously stated, “Of all the forms of inequality, injustice in health is the most shocking and the most inhuman.”[4] When the injustice is great, power differential between oppressor and oppressed is large, and willingness of the powerful to reform the system is low, then movement advocacy is necessary. Think the 1960s Civil Rights Movement, or Rodney King, Freddie Gray, Laquan McDonald, and the police departments of Los Angeles, Baltimore, and Chicago. Deeply rooted structural problems in culture, attitudes, and procedures resulted in systematic discrimination and violence against racial and ethnic minorities. Movement advocacy compels action through public outcry. This advocacy has not led to quick fixes, but has started the journey to a better place, judging by advances since the Civil Rights Movement began and improvements in the Los Angeles Police Department and its relationship with communities since a federal court ordered systematic reform.[5]

Health care disparities are central human justice issues. People are dying from disparities on a much larger scale than from police brutality. Note, for example, the estimated 3.1 million low-income Americans shut out of insurance coverage in 20 states that rejected the Affordable Care Act’s Medicaid expansion.[6] Advocates inside and outside the health professions need to make health equity such a high priority that policymakers, administrators, and clinicians enact reforms to improve access to care and systems of care for all patients.[7,8] These interventions include expanding health insurance, tailoring care to different patients,[7,8] addressing social determinants of health with innovative population health management,[7,8] and reforming our payment system so that health equity is sustainable.[9] In our pluralistic society, we typically change organizational behavior with regulation (e.g. require reporting of clinical performance data stratified by race, ethnicity, and socioeconomic status) and the free market (e.g. create financial incentives for reducing disparities).[9] Both regulation and market are influenced by the democratic process, so advocacy can move the systems that impact access to care and quality of care for diverse patients.

MOVEMENT ADVOCACY TO CHANGE SYSTEMS

Presidential candidate Hillary Clinton described the power of advocacy when she met with representatives of the Black Lives Matter group. She stated, “Look I don’t believe you change hearts. I believe you change laws, you change allocation of resources, you change the way systems operate. You’re not going to change every heart. You’re not. But at the end of the day, we could do a whole lot to change some hearts and change some systems and create more opportunities for people who deserve to have them….”[10]

Secretary Clinton emphasized that we need to change systems – laws, regulations, and resource allocation – to improve criminal justice and health care disparities. Movements require well-chosen policy agenda that advance coalition politics. Passion and protest are most immediately effective when focused on specific constructive demands that public officials and candidates can meet.

Secretary Clinton also noted that we can change some hearts. Advocates want to be heard and understood, and most clinicians, policymakers, and organizational leaders ultimately want their decisions to be motivated by what is best for patients and the public. Successful appeal to the best in everyone is critical for sustainable change. We need to bring people along with us.

However, movement advocacy may be necessary to make a privileged majority fully understand the depth and consequences of injustice, and to motivate them to change systems and their behaviors. Consider how students at the University of Missouri protested racial and anti-gay bigotry incidents and the administration's slow response to change the culture.[11] African-American, gay, and Muslim students might wonder if most white, heterosexual, Christian school administrators can truly understand their daily experiences as marginalized groups.

The pain of protesting racial and ethnic minority students is palpable. The immediate issue is often just the tip of deep concerns students have about systematic marginalization and subtle and not so subtle oppression.[12] In his Letter from Birmingham Jail, Reverend King stated, "I have earnestly opposed violent tension, but there is a type of constructive, nonviolent tension which is necessary for growth."[13] Movement advocacy can create this constructive tension that forces self-examination and spurs systems change and personal growth.

INTERPERSONAL RELATIONSHIPS, TRUST, AND ACHIEVING HEALTH EQUITY

A key challenge, however, is that the daily work of achieving health equity requires trusting interpersonal relationships, difficult to attain when addressing charged issues such as racism, heterosexism, and class distinctions. Reducing disparities requires self-awareness and commitment, whether by clinicians understanding their subconscious biases in shared decision making with patients,[14] administrators recognizing that how their clinic delivers care may systematically lead to worse outcomes for vulnerable patients,[15] or protesters and reformers combining emphatic protest with effective coalition politics. Instructors of health disparities courses wisely attempt to create a non-threatening learning environment,[16] yet discomfort might be necessary to convince some of the need for change.

RECONCILING MOVEMENT ADVOCACY AND TRUSTING RELATIONSHIPS

So, is it possible to reconcile movement advocacy and constructive tension with the creation of trusting relationships and safe spaces required to achieve health equity? I attended a workshop on conflict resolution led by Jennifer Smith, MD, whose perspectives were shaped by countless difficult family situations she encountered as a palliative care physician and general internist at Cook County Hospital.[17] Dr. Smith explained that a conflict is a personal narrative with a beginning, middle, and end. At the beginning, parties frequently experience powerful emotions such as anger, frustration, fear, and surprise, and often make assumptions based on their values and biases. The middle phase encompasses listening and telling, adjusting facts, and clarifying options. In the end, one can hope for agreement, compromise,

and reconciliation, but at a minimum it should be possible to envision a new future with common facts, decreased emotion, and more clarity moving forward.

I believe movement advocacy can break down ingrained structural barriers and policies that impede health equity, while clinicians, health care organizations, and advocates build trusting relationships and resolve conflict with mutual respect and honesty. However, we must recognize the power differential between racial/ethnic minorities and the establishment that makes level free speech more easily said than done. White institutional leaders bring the weight of the status quo to a discussion, while racial/ethnic minority protestors have frequently been marginalized. Acknowledging this dynamic and difference in lived experiences is key to building understanding and trust. Establishing strong relationships with communities upfront is critical for weathering inevitable conflicts. We must combine advocacy and relationship building to end disparities. Achieving health equity will require policy changes, and personalized clinical care and organizational transformation that are dependent on good will and trust.

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