

## agog dinner & discussion | Health Care Equity



Portland residents David Goldberg and Deborah Spanton hosted an **agog dinner discussion** on June 4 focused on **Health Care Equity: Reducing the root causes of health care disparities by improving access to and quality of care for all people.**

Over 20 guests engaged in a vibrant discussion led by conversation leaders **Lillian Shirley**, Director of the Multnomah County Health Department, and **Dr. Yves Lefranc**, a physician with Adventist Health Medical Group and vocal health equities advocate.

The group reviewed the concept of social determinants of health and health inequity. Ms. Shirley defined health inequity as an avoidable, systemic and unjust allocation of the social, environmental and economic conditions needed for health.

Professional healthcare affects only 5-10% of our health outcomes. What about the other 90%? How well can we really control our health?

Several barriers to quality health care were explored:

**Cost, service and access are major issues.** The group exchanged multiple personal and eyewitness stories about outrageous medical bills associated with inefficiency and/or complete lack of service. An unfathomable decision, yet very real problem is parents having to choose between taking their child to the emergency room or losing their house. Dr. Lefranc shared that most people who go bankrupt due to high medical bills had health insurance.

*Where we live, work, learn and play can have a greater impact on how long and how well we live than medical care.*

**Race affects health.** The Institute of Healthcare Improvement shows different national approaches to levels of care, and their results. Second generation immigrants to the US have worse health outcomes than their parents. Back in the 1960's, the government thought it would be beneficial to remove American Indians from their reservations and 'integrate' them into society. Portland was designated as a 'relocation city.' Today, Portland has the ninth largest American Indian population in the United States. And American Indians rank #1 in cases of diabetes. Latinos are a close second.

**Income affects food choices.** The foods and beverages available in lower income neighborhoods are often high in fat/calories and low nutrition found at fast food restaurants or convenience stores. Many lower income people, or who grew up during bad economic times and had been deprived of food focus on eating as much available food as possible, whenever they can.

**Location is a huge factor.** Research done in Leichestor, England found that for every mile closer to the city center one lived, there was a loss of 3-6 years of life. Does isolation from your community – whether cultural, ethnic, or other kind of community – affect your health outcomes? People who live in rural areas have much less access to medical care - either a lack of adequate medical personnel for a given area, long distances to medical facilities, or difficulty getting to and from the doctor. The issue of access and trust is a huge issue for many ethnic communities.

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### **Transportation to and from the doctor costs low-income residents time, and even their jobs.**

Imagine you're a young single mother of a sick two year old and an infant. You have no car, a low paying job, and no health insurance. Using public transportation, it could cost this family about \$10 each time they need to go to the doctor. This trip could take most of the day – a much needed work day. With little job security, people are faced with losing their jobs when medical issues arise.

**How we design our physical environment reflects our values.** Most neighborhoods are not walking or biking areas. Portland neighborhoods have a history of good planning, with gardens and farms. However, there is concern that these planning practices may have contributed to gentrification and higher costs within the city, and driven many lower income families out of the city. While there have been improvements in the past 20 years in health outcomes, some of these measures are starting to reverse.

**Many are unable to advocate for their own health.** Due to factors such as language barriers, lack of education and/or social skills, patients are often not understanding their medical situation and are unable to make truly informed decisions about their or their family members health care.

Dr. Lefranc believes our nation's health care system, in its current state, will collapse within several years.

Guests agreed that health changes will take group effort, but that these efforts must appear small and personal. There are many levels to achieving good health outcomes: individual choice, policy, changing of community norms, rewarding of good behaviors, civic involvement, care for all, and basic safety. Personal accountability can lead to sharing good habits and reducing personal healthcare costs.

### The groups discussed ways to deal with these and other health disparities.

- Promote health equity advocacy. An educated electorate wouldn't allow social injustice.
- Establish role models and health equity proponents from all across ethnic and class backgrounds
- Subsidize primary care doctor education.
- Recruit aspiring doctors while they are in high school.
- Support movements to get people insured. The President's Health Care plan, while diluted, at least gives more people access to needed medical care.
- Focus on preventative health care. It benefits everyone to be healthy. Dollar for dollar, education and prevention is much cheaper than medical treatment.
- Look to other countries for examples of what works in health care delivery. Consider Canada's or the Singapore health care plan, which is similar to a health savings account. People pay on a sliding scale, and there is a financial incentive to get preventive care early on. Now the US health plan is moving in that direction.
- Improve access to healthy foods and safe place for physical activities for all residents.
- Spend public health dollars on literacy, education, public information campaigns, with a focus on education through popular culture (Oprah, for example)

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- Some public health campaigns have been very successful – lead poisoning, tobacco. The group wonders if these campaigns can be duplicated for other health issues, such as eating healthy foods and community gardens
- Demand that our federal government reallocate funding from defense to education.
- Look at food policy nationally to adjust financial incentives around commodity crops versus fruits and vegetables; Representative Blumenauer is taking a leadership role in this effort.
- Support initiatives to help low-income neighborhoods. The California Fund has developed a plan to help low-income neighborhoods which are bound on all sides by freeways, by working with truckers to reduce miles driven, businesses to convert engines into lower polluting engines.

Several books were mentioned as good reading related to a health discussions:

[The Origins of Virtue: Human Instincts and the Evolution of Cooperation](#) by Matt Ridley

[The Working Poor](#) by David Shipler

[In Defense of Food : an Eater's Manifesto](#) by Michael Pollan

[The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures](#) by Anne Fadiman

Lillian suggested that everyone google “environmental justice” for more information on larger aspects of determinants of health.

The mission of Metropolitan Family Service is to strengthen families and individuals while enhancing their participation in community life. Organized by MFS, **A Gathering of Good (agog)** is a series of community events promoting discussion, civic engagement and social change. In addition to exploring important social issues as a community, **agog dinners & discussions** raise public awareness of MFS’s effective programming for children, families, and older adults. MFS is celebrating 60 years of community service in 2010.



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