

ADVANCING HEALTH EQUITY:

LEADING CARE, PAYMENT, AND SYSTEMS TRANSFORMATION

AHE's Health Equity Communication Guide

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AHE'S HEALTH EQUITY COMMUNICATION GUIDE

Advancing Health Equity: Leading Care, Payment, and Systems Transformation (AHE) team members lead and participate in equity-focused conversations, producing publications, reports, and other products for national dissemination as part of their work. This guide offers helpful tips and answers to common questions we receive as we work toward a national landscape where a culture of equity is expected, and health inequities are a thing of the past.

Imprecise, inaccurate, or biased language can perpetuate stereotypes and discrimination and negatively impact the ability to create positive, lasting change. This communication guide is not comprehensive. What works today may not work tomorrow. Yet, we see the daily evolution of language not as a deterrent, but a linguistic representation of the human spirit: always evolving, always striving for the best possible representation of the moment in which we live. We hope this guide will be helpful as you work toward advancing health equity in your respective communities and networks.

We welcome revisions and suggestions for improvement. We recommend using this guide in conjunction with other relevant style and communication guides such as:

- [**1. AMA Center for Health Equity**](#)
- [**2. The California State University: Diversity Style Guide**](#)
- [**3. Reporting of Race and Ethnicity in Medical & Science Journals**](#)
- [**4. AIDS Foundation Chicago Style Guide**](#)
- [**5. National Association of Black Journalists**](#)

Health Disparities vs. Health Inequities

Health Equity is defined as each person having a fair and just opportunity to be as healthy as possible. Improving access to the conditions and resources that strongly influence health are necessary to achieve health equity. Health equity for groups that have been excluded or marginalized requires a focused commitment to eliminating health inequities.¹

Health and healthcare disparities are differences in the quality of care and outcomes, access to or availability of medical facilities and services, and rates of disease occurrence and disabilities among population groups. Populations are often classified using socioeconomic or other characteristics such as age, ethnicity, gender or geography (e.g., rurality or neighborhood).²

Health inequities are differences in health across populations that are systemic, avoidable, and generally unfair or unjust. In 2017, AHE moved toward using “inequities” rather than “disparities” whenever possible. The term disparities has a narrower, healthcare-centric lens while inequities includes the concepts of a fair and just opportunity for health, social drivers of health (e.g., health care, education, safe housing, and freedom from discrimination), human rights, and social justice.³

Healthcare that addresses health inequities:

- ensures that care is equitable across all dimensions of quality.
- recognizes that while equitable care does not always mean providing each person the same care, it does mean addressing individual needs in a culturally responsive manner.
- effectively partners with patients/members and their loved ones as co-developers and decision-makers throughout the duration of the initiatives meant to reduce health inequities, including the identification of the focus area, the root causes, and the solutions.
- measures, monitors, and addresses key health and community-level determinants and inequities.
- creates a culture of equity in which all employees, individually and collectively, identify the organizational dynamics that reproduce health inequities and work to transform those dynamics.
- creates cross-sector collaborations of healthcare with community organizations to address social drivers of health (See the entry: **Social Determinants of Health/ Social Drivers of Health**).⁴

Key Terms in the Fight for Health Equity

Anti-racism

Anti-racism is the practice of actively identifying and opposing racism. The ultimate goal of anti-racism is to change the policies, behaviors, and beliefs that perpetuate racist ideas and actions. **Not being racist is not enough.**

Bias

Bias is a pre-formed opinion or attitude toward a group of persons who possess common characteristics such as skin color, cultural experiences, religion, or national origin.⁵

Explicit bias is when the person is very clear about their feelings and attitudes, and related behaviors are conducted with intent to harm.

Implicit bias operates outside of the person's awareness and can be in direct contradiction to a person's espoused beliefs and values.⁶

Q. Is there an example of how implicit and explicit bias impact healthcare?

A. Within the healthcare system, explicit bias can look like not hiring jobseekers because of their name or accent, which can result in organizations lacking the wide range of perspectives and experiences needed to effectively understand or reach diverse communities. A lack of representation can lead people to falsely believe that job qualifications—not bias—were the determining factor in employment, preventing future applicants from receiving a fair shake during the interview process.

Implicit bias could look like a member of the care team leaning on stereotypes to make decisions about a person's medical condition, which can significantly impact the quality of care they receive. For example, a care team member could assume certain races of people have a higher pain tolerance and, therefore, need less pain medication than others. Or they could make a passing comment about a patient's hygiene or culture that negatively impacts the relationship between patient and care team.

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Intersectionality

Per Kimberlé Crenshaw: Intersectionality is a prism by which to see the interactive effects of various forms of discrimination and disempowerment. Intersectionality articulates how overlapping vulnerabilities created by systems of oppression create specific social, interpersonal, legal, and economic challenges for People of Color and/or other marginalized populations.⁷ Within healthcare, taking into account intersectionality can lead to more nuanced care and a stronger relationship with the individual being served. Having a better understanding of how gender, sexuality, and class impact people in the same racial group can lead to a more responsive, personally tailored care plan.

Like racial justice work, when health care is not attuned to intersectionality, it will more than likely miss making critical inroads that could positively affect change. "...[F]ailure to recognize and address the powerful effects of structural racism, discrimination grounded in cultural norms for gender expression, or other systemic forms of oppression of marginalized populations prevents clinicians and healthcare systems from providing the best care to LGBTQ people of color," argue Bi, Scott, and Chin.⁸ Applying an intersectional lens to health care makes visible those whose everyday lived experiences are shaped by race, gender, class, sexuality, and/or disability.⁹

Q. Doesn't intersectionality just make things more complicated?

A. To paraphrase Theodore Roosevelt, nothing worth doing comes easy. Creating a meaningful culture of equity requires understanding—and making space for—the varying intersections of race, gender, class, and/or sexual orientation that influences a person's life. For example, a Black woman in America does not experience gender inequality in exactly the same way as a straight white woman, nor does she encounter racial oppression identical to that of a Black man who identifies as gay. A true culture of equity would not only recognize those differences, but embrace them.

Humans may share an experience, such as surviving a global pandemic, but how those events impact each person is singular in nature and impacted by the context in which they have lived, are living, and will live in.

It is impossible to speak to every individual's specific subjectivities at every given moment, but to pretend they don't exist limits the effectiveness of our work.

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Person-centered Approaches

AHE values and promotes a person-centered approach in its communication and dissemination practices. While an organization may use a specific style informed by industry norms or federal guidelines, AHE advocates that whenever possible, communities should be consulted on their preferred naming practices. Every attempt should be made to use person-centered, not circumstance-centered language to describe individuals. Below are some examples.

MEMBER

There has been valid criticism that the term “member” focuses disproportionately on the role one inhabits within the healthcare system and not enough on the human taking an active role in maintaining or improving their health.

If other descriptors can be easily substituted (i.e. person, individual), those are preferred uses. There are, however, moments in which “member” provides the most clarity for the audience at hand. For instance, in speaking to an audience of health insurance executives, member helps to quickly identify that the subject in question is an individual enrolled in a health insurance plan such as Medicaid or Medicare.

PATIENT

There has been valid criticism that the term “patient” positions the person receiving medical care as one who takes help from medical providers rather than one who is an active partner in creating a path to optimal health for themselves.

When possible, avoid using patient if other descriptors can be easily substituted (i.e. person, individual). There are, however, moments in which patient provides the most clarity for the audience at hand. For instance, in speaking to an audience of clinicians and medical caregivers, “patient” helps to refine and narrow the discussion quicker than “person or individual receiving medical care from doctors and nurses.”

The term “member” should not be considered a 1:1 substitute or synonym for patient as that is a specific designation referring to someone enrolled in a health insurance plan.

Power

Power is unequally distributed globally, as well as in U.S. society; some individuals or groups wield greater power than others, thereby allowing them greater access to and control over resources. Wealth, whiteness, citizenship, patriarchy, heterosexism, and education are a few key social mechanisms through which power operates.

Power often is conceptualized as power over an individual or group. However, *power with* (in the context of building collective strength) and *power within* (which references an individual's internal strength) are two other, equally important forms of power. Being able to articulate how various relations of power manifest and operate is vital to organizing for social change.¹⁰

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Pronouns

It is becoming more and more common for people to include their pronouns in their email signatures, verbally state them during self-introductions, and/or display them as part of their name on video conferencing calls. The reasons for stating one's pronouns are varied and personal. Among those reasons are:

- Alerting others to the preferred way to refer to them (i.e.: she/her; he/him; they/them, she/they; him/they etc.)
- To help others refrain from mis-gendering them or another person
- To normalize not assuming that a person's pronouns match the name on paper or image on the screen

Keep in mind that for those whose preferred pronoun doesn't physically reflect societal expectations of gender, they may have a great feeling of risk in declaring themselves a she/he/they or [xe/ze/fae](#)¹¹ to people who are not close friends or family. The sharing of one's pronouns is a moment to be taken seriously. It is not a time for quips or jokes. Don't allow your discomfort to convince you to dehumanize someone else.

Q. What do I do when I accidentally use the wrong pronoun for someone in front of them?

A. This has happened to many, if not all of us, and it will happen to many, if not all of us, in the future. Apologize quickly and sincerely, either in the moment, if appropriate, or later; then, make it a point to use that person's name and/or correct pronoun before moving on. Outside of the meeting, practice using that person's pronouns until it becomes synonymous with their name as much as your pronouns are synonymous with yours. Finally, be kind to yourself and don't give up. Keep working on it and be intentional and thoughtful about using correct pronouns. Using someone else's correct pronouns is the best way to show them respect in and out of the workplace, both in their presence and the presence of others.

Q. What about grammatical rules? They/them is plural and a person is singular.

A. Language lives like we do and grammar rules, like humans, evolve. Even William Shakespeare, considered one of the greatest playwrights of all time by at least a couple people, did not follow standard grammar rules of his time. We've stopped using some words and phrases ("thou" "thee" "thy" "how now") in favor of others ("you" "yours" "hey there" "hello" "What's good?"). We are now at a point where our language has evolved to be more inclusive of others, forcing a change in grammar rules so they reflect our contemporary moment.

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Racism

Racism is different from racial prejudice, hatred, or discrimination. Racism involves a group having the power to carry out systematic discrimination through a society's institutional policies and practices, ultimately shaping the cultural beliefs and values that support those racist policies and practices. Racism is a system that undergirds white supremacy.¹²

To be sure, white supremacy is not defined by violent acts alone. Rather, white supremacy culture can be equally identified by the ways in which whiteness is privileged to the extent that it retains authority, status, or power (i.e., supremacy) over other racial(ized) groups.

While there are some who claim an act or event is indicative of reverse racism, that's an incredibly high bar to meet. It would require the ability to influence, change, or rewrite societal, institutional, or cultural practices. If that power is not present, then the claim of reverse racism likely will not stand.

Q. What if someone tells me my initiative is racist?

A. It can be difficult to hear that a program or initiative you worked on is considered racist. First, give yourself some grace if you feel frustrated or misunderstood. That's a natural reaction, but don't stop there. Listen to the criticism at hand with an open mind. Remember: intent matters less than outcome. Below are some questions you might ask yourself as you re-examine your initiative with an eye toward the comments you received:

- Who is excluded from the conversation? Who is included?
- Is the racial and ethnic diversity of the United States well represented? What rationale did you provide as to why not?
- What actions were taken to ensure that the representations of Black, Indigenous, and/or People of Color (BIPOC) did not reflect cultural stereotypes or worn-out cultural narratives?
- How much effort was made to meaningfully include the voices of BIPOC individuals at multiple points in the planning process – not just after the project was complete or near completion?
- How was power shared with people of color or other marginalized groups?

Q. What's the difference between structural, systemic, and institutional racism?

A. Think of structural racism as an “overarching system of racial bias across institutions and society,”¹³ systemic racism as the patterns of oppression and discrimination that happens within those structures, and institutional racism as impacting the specific places where we find ourselves every day, such as our job or university.

Let's use the example of a major teaching hospital near a capital city that has had issues with racism and discrimination. How would issues of racism play out on the institutional, systemic, and structural levels?

Structural Racism

As a result of the hospital not having a diverse care team, patients from marginalized communities are disproportionately impacted by a health-care industry that is not supportive of them or their care, resulting in poorer health outcomes overall.

Systemic Racism

Hospital medical staff and students do not reflect the diversity of the municipality they serve, resulting in patients having few, if any, members of their care team from their racial and ethnic community.

Institutional Racism

Hospital hiring managers reserve higher-paying, high-profile, public-facing non-medical jobs for white candidates and funnel Black and Latine candidates with the same qualifications into lower-paying, lower-profile, non-public jobs using ambiguous, discriminatory language such as “cultural fit” as an explanation.

Structural Racism: among institutions and across society.¹⁴

Structural racism is the normalization and legitimization of historical, cultural, institutional, and interpersonal dynamics that produce cumulative and chronic adverse outcomes for racially marginalized people. Examples of structural racism include longer sentences for People of Color versus white people found guilty of the same crime or homes owned by Black and Latine families receiving lower appraisals compared to homes of equal value owned by white families.¹⁵

Structural racism is insidious precisely because it has been normalized. Phrases like “It's always been that way.” or “That's just the way things are,” are usually a good indicator that an injustice is structural.

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Systemic Racism: discrimination within a system that is foundationally racist.¹⁶

As Braveman et. al, argue, “Systemic racism emphasizes the involvement of whole systems[...] political, legal, economic, healthcare, school, and criminal justice systems [as well as] the structures that uphold the systems.”¹⁷ Systemic racism is perpetuated within multiple spaces and levels of society, to the point that it can seem impossible to overcome. Some examples of systemic racism could be political disenfranchisement, segregation, environmental racism, or financial practices which disadvantage communities of color, such as redlining.¹⁸

It can be hard to reconcile the good we see in our family, community, and country with the understanding that racism was (and remains) a major driver in our economic, educational, juridical, and political systems. Recognizing that duality, however, does not negate the good work we have done and will do. In order to support health equity, we have to acknowledge how the spaces in which we work, live, and learn, were created with inequity in mind.

Institutional Racism: within institutions and systems of power.¹⁹

Institutional racism refers specifically to the ways in which institutional policies, practices and procedures create different outcomes for different racial groups. The institutional policies may never mention any specific racial group, but their effect is that they create advantages for white people and oppression and disadvantages for people of color.^{20,21}

For example, what if a healthcare system or hospital makes a financially driven decision to open new clinics in wealthy, majority-white neighborhoods that have more people with private insurance (which often reimburses for services at higher rates)? Patients in those clinics are more likely to pay for, and expect to receive, individualized, convenient, and concierge-type care in state-of-the-art facilities. Those new clinics, staffed with different care teams, may inadvertently end up delivering a higher quality of care as compared to the health system's older clinics in the city's more racially and economically diverse neighborhoods. That difference can inadvertently lead to a two-tiered system of care in which those with more financial resources are privileged over others.

Interpersonal racism: between individuals.

Interpersonal racism occurs when an individual's personal racial beliefs impact their public interactions.²²

EXAMPLE: A member of the care team who uses racial slurs or makes other disparaging remarks about Asian American patients.

Internalized racism: within individuals.

Internalized racism comprises our private beliefs and biases about race and racism, influenced by our culture. It can take many different forms including:

- **internalized oppression:** negative beliefs a BIPOC individual may harbor about their race or ethnicity
- **internalized superiority:** beliefs white people may have relating to their assumed superiority, credibility, or deserved privilege.²³

Q. What are some examples of internalized racism?

A. A white doctor who believes that their worldview is universal and the same as all of their patients regardless of their race leading them to dismiss other viewpoints as lacking or deficient because they were not informed by whiteness.²⁴

A Latine doctor who assumes that her Latine patients will be unwilling to follow medical advice or unable to pay for services because they are Latine.

Social Determinants of Health/Social Drivers of Health

The social drivers of health (SDOH) are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. While SDOH have contributed greatly to health inequities, they also alert us to the positive impact SDOH can have on one's life, as evidenced by those with more social and economic privilege (e.g., safe neighborhoods with good schools, well-maintained parks, and plentiful employment opportunities)

Although "social determinants of health" is commonly used, AHE prefers social drivers of health. The word "determinants" has an air of inevitability, as if the environmental and social issues it describes were unavoidable rather than a result of structural and institutional forces and decisions. Using "drivers" highlights how health is impacted by external environmental and social factors, particularly so for communities of color.²⁵

Guidelines for Using Inclusive Language

- **Be as explicit as possible when discussing race and ethnicity.**

Whenever possible, identify people through their self-identified racial/ethnic group, following an individual or community's preference while taking care to be specific and avoiding generalizations.

- **Use people of color or communities of color as a collective term when referring to diverse racial and ethnic populations/groups.** We suggest avoiding the terms below:

- **Non-white:** Describing subjects as white versus non-white upholds a belief that whiteness is the standard by which all other populations should be measured.²⁶

- **Voiceless:** To claim a person is voiceless is to ignore the ways in which they express their thoughts, feelings, and/or displeasure. It includes an implicit bias toward dominant forms of speech (e.g. vocal articulation) as the best or only way to communicate.

- **Vulnerable:** While vulnerable can be appropriate when referring to those who are clinically vulnerable to disease because of their age, generally calling an entire population vulnerable is vague and relies on a person to supply their own information as to what makes a population vulnerable, which can solidify existing stereotypes and biases.²⁷

- **Minority:** Often used in conjunction with racialized populations (i.e. racial minority), the word minority reinforces ideas of inferiority relating to a group of people. What is more, in light of changing U.S. demographics, it is inaccurate.²⁸ While some official government offices and bureaus may retain the term in their titles and designations, AHE's practice is to avoid using it when possible.

- **Use Native American or American Indian to refer broadly to populations.** Whenever possible, use specific tribal names first. **Indigenous**, if used, should be capitalized and followed by the word(s) Americans, populations, and/or people.

- **Use the term Latine or Latinx.** The term Hispanic refers to individuals with a descendant of Spanish origin. As a direct result of colonialism, many countries within Latin America have been impacted by Hispanic culture and don't identify as Hispanic, but rather Latino/a/e/x.

In the end, refer to individuals or groups how they prefer to be identified while being as specific as possible (ex.: Mexican or Salvadoran, Venezuelan American, etc.). Latine is a term that is gaining in popularity as it is gender neutral, can be easily used in both Spanish and English, and may be more recognized globally than Latinx. For more on Latine and its uses see [this explanation by cartoonist Terry Blas](#)²⁹ or this [discussion by Remezcla media](#).³⁰

- **Black and African American are not interchangeable terms.** Americans from the Caribbean, for example, may refer to themselves as Caribbean American, West Indian, Haitian American, or Jamaican American, among other terms.

Again, once a person has articulated their preferred ethnic or racial designation, use that term.

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- **Capitalize Black.** This recognizes Black in a racial, ethnic, and/or cultural sense, conveying an essential and shared sense of history, identity, and community among people who identify as Black.
- **Do not capitalize white; do not use Caucasian.** The capitalization of white is often associated with white supremacists to establish white dominance. Some argue that not capitalizing white removes accountability from white people and white institutions' involvement in racism.³¹ Still others argue that capitalizing white reinforces the understanding that whiteness is naturally *de facto* capitalized and made primary in society. Capitalization may also lend itself to giving subtle legitimacy to tenets of white supremacy.³² Many racial theorists and journalists have seen the capitalization of white as related to the diminishment of Black people and virulent anti-Blackness in U.S. society and abroad.³³
- **Do not use Black or white as a plural noun (e.g., Blacks, whites).** It should be used as an adjective and followed by a noun (i.e. person, people, or communities) ex.: Black community, white people.
- **Do not hyphenate someone's dual heritage** (e.g., African American, Asian American, Mexican American).
- **Use LGBTQ as a collective term when broadly referring to populations that identify as lesbian, gay, bisexual, transgender, non-binary or queer.** Use specific, self-identified terms when referring to an individual or groups that share identity. LGBTQIA or LGBTQIA+ are also commonly used acronyms.
- **Transgender should be followed by the words “person”, “people”, or “community”.** Do not use “transgendered” as a verb or adjectival description as that is a form of dehumanization.
- **Use sexual orientation (not “sexual preference”) to describe a person's enduring emotional, romantic, or sexual attraction to another person.**
- **Use gender identity to describe a person's concept of self as male, female, a blend of both, or neither.** Gender identity is how an individual perceives and what they call themselves.³⁴
- When focusing on health interventions, be careful to use language that accurately describes the population being served. While language should be inclusive, it should not misrepresent how the intervention is being designed. For example, “birthing individuals” is inclusive language to describe those who are giving birth. However, if an intervention has only been designed for women and not for those who do not identify as women, such as transgender individuals or gender non-binary individuals, then using the term “women” is most appropriate.
- When highlighting data from an outside source, use the demographic categories the researchers used to keep the data consistent. When possible, work with the outside source to understand how the demographics (e.g. racial and ethnic) categories are defined.

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Identity-First and Person-First Language

Identity-first language asserts that a person's disability is an important part of their identity and is sometimes preferred depending on the context. Those who prefer identity-first language may treat their disability in the same way a person may relate to their gender, race, or nationality.³⁵ It is often used as an expression of cultural pride (cultural as in a group of people who share an identity) and a reclamation of a disability that once conferred a negative identity. For example, in the autism community, many self-advocates prefer "Autistic person" over "person with Autism."^{36, 37}

Avoid	Use Instead
Disabled, handicapped, impaired	Person with disabilities
Diabetic	Person with diabetes
Substance abuser	Person with substance use disorder
Elderly, aged, senior citizens	Older adults
Normal/healthy/typical	Person without a disability

When discussing health conditions (e.g. diabetes, hypertension, cancer), use person-first language. Person-first language emphasizes the person rather than their chronic condition and reinforces the idea that a person is not defined by their diagnosis, disability, or condition.^{38, 39}

If you are unsure of which language to use (i.e. person first vs. identity first), seek guidance from self-advocacy groups or other stakeholders specific to a group of people.⁴⁰

Framing Health Equity & Health Inequities for Your Organization

When we think of framing, it is often in relation to how to communicate or explain an idea to an external audience. Yet framing is equally important for your internal organizational audience. When employees know how the organization understands and defines health equity and health inequities, they will be better equipped to provide care that both respects the community it serves and reflects organizational mission and goals. Taking time to clearly articulate the why, how, and what next in your organization's health equity efforts is like writing a roadmap for employees to follow and return to when they think they've lost their way.

Despite its seeming ubiquity in conversations within public health, activist, and medical circles, not everyone will share the same ideas about how health equity is defined and what steps must be taken to achieve it; one's ideas are often contingent upon their personal experience within the healthcare system. For example, someone who has always felt listened to and respected by their physician may not be able to empathize with someone whose physician assumed they felt less pain because of their race. As a result, calls for increased cultural relevance and humility training for staff may feel unnecessary or even like overkill. A person whose childbirth experience was enhanced by a caring and attentive medical staff may not fully grasp calls for comprehensive doula services that reflect the linguistic, racial, ethnic, religious, and gender diversity of the United States as a counterweight to bias.⁴¹ Relatedly, a cisgender person may never truly understand the sting of being repeatedly misgendered by staff and may dismiss the need for access to gender-affirming care.⁴²

To that end, your team—in conjunction with community members with lived experience of the healthcare system and Medicaid—should take great care in creating a shared definition of health equity specific to your organization and the community it serves. Use the definition to identify which health and healthcare inequities to prioritize, and then begin the work of communicating to employees the importance of it.

Below are some steps to help you as you begin framing your team's health equity priorities.

1. Start with the why

Clearly outline the why and the how of your team's efforts to address health inequities. Why were those priorities highlighted? How will they positively impact the community you serve?

2. Don't assume you've written the final draft

Once you've created your whys, take them to the larger team, staff and community members, providing ample time and space for feedback. Then create a plan for when you will adopt suggested revisions to present to the larger community for review.

3. Set clear parameters

Think deeply about what is and is not included in your team's definition of health equity. It may help to visually list those inclusions and exclusions on a white board so you can compare and contrast, and move items from one side to another.

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4. Be transparent

Once you have a solid working draft, share the plans with the community in a way that is accessible and convenient for them, not you. Go to the local festivals, community centers, and religious institutions and ask people for their opinions. Don't expect people to come to your organization to tell you how you're doing.

Creating a framework for how your organization defines and addresses health equity and health inequities is an important first step in outreach, both internal and external.

We hope you have found this guide to be useful. Although addressing and enacting health equity is difficult, it is not impossible. Please use this guide as a supplementary reference tool for your work. Feel free to contact us to tell us how it has been helpful or where it can be improved: info@solvingdisparities.org.

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Endnotes

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Advancing Health Equity: Leading Care, Payment, and Systems Transformation (AHE) is a national program supported by the Robert Wood Johnson Foundation and based at the University of Chicago. AHE's mission is to discover best practices for advancing health equity by fostering payment reform and sustainable care models to eliminate health and healthcare inequities.

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