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Opportunities for Psychologists to Advance Health Equity: Using Liberation Psychology to Identify Key Lessons From 17 Years of Praxis

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Health and health care inequities persist because the efforts to eliminate them have ignored structural racism, typically using a power neutral approach to diagnose and solve the problem. Critical theory can address many of the conceptual weaknesses of current approaches, help identify how racism operates in health care, and open the door for more effective individual employee and organizational actions to advance health equity. We apply Martín-Baró's (1996) liberation psychology to lessons we learned through implementing a transdisciplinary national health and health care equity program. The program, which began in 2005, conducts equity-focused health services interventions and research, using the best available evidence to assist health and health care policymakers, payers, community-based organizations, care delivery organizations, and patients to transform and align their activities in order to advance health equity. It serves as a rare model to explore how misconceptions resulting from racist structures can hinder progress, even when everyone involved is highly motivated to address health and health care inequities. Liberation psychology guides our interpretation of the lessons learned and recommendations for the field of psychology. Psychologists advancing equity in health and health care should integrate liberation psychology and other critical theories into their own work. In addition, partnerships with other disciplines and communities outside of academia and professional health services are key to success.

Public Significance Statement

Structural racism affects everyone, leads to misconceptions about how and why health inequities occur, and hinders the search for effective solutions. We use the tenets of liberation psychology to examine the experiences of a program to advance health equity and make recommendations for what the field of psychology can do to help reduce and eliminate health inequities imposed upon racialized populations.

Keywords: health equity, critical theory, racism, liberation psychology, health services

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continued

Racial and ethnic health and health care inequities continue in the United States despite decades of significant resources invested in curtailing and eliminating them. And while there have been incremental advances, bold approaches to accelerate progress toward achieving health equity are critical. The Robert Wood Johnson Foundation (RWJF) launched a transdisciplinary national program in 2005 to move beyond simply documenting the existence of these inequities to finding solutions. Since then, the program has evolved through praxis, an ongoing process of action and reflection (Freire, 2018), resulting in several key programmatic transitions. The COVID-19 pandemic, which powerfully exposed the impacts of endemic racism on health in the United States, brought the program to its most recent turning point. It crystallized the need to center antiracism in the program's initiatives and deliberately ground it in critical theory. Critical theory uses historically grounded power analysis to understand and illuminate approaches to transforming unjust sociopolitical conditions. This article uses liberation psychology to reflect upon and examine the program's 17-year history of implementation successes and challenges. We chose liberation psychology not only because it is a critical theory but also because it posits that interactions between intrapsychic and systemic factors produce injustice such as racial health inequities (Comas-Díaz et al., 2019). Utilizing liberation psychology retrospectively to interpret the implementation experiences of the program and lessons learned revealed key insights about the future of our work and psychology's potential role in health equity efforts.

Assumptions

Health equity "means that everyone has a fair and just opportunity to be as healthy as possible" (Braveman et al., 2017, p. 2). Relatedly, the absence of differences in health and its drivers between groups with and without access to social power is an indication of health equity (Braveman et al., 2017). Conversely, Braveman et al. (2017) define health inequities as unjust differences in health outcomes resulting from obstacles to health associated with structural oppression, including racism. Finally, Braveman et al. (2017) note that health care inequities are only one driver of health, illuminating unjust differences in health care access and quality. We use the term health equity to broadly describe and reference the desired goal of our program and its participants, which include multifaceted initiatives to address health care processes as a driver of health. Some initiatives simultaneously address both health care and social drivers of health, such as housing.

The Program History: A Transdisciplinary Approach to Advance Health Equity

Phase 1—Finding Answers: Disparities Research for Change (2005–2014)

In 2005, the RWJF launched a national program called *Finding Answers: Disparities Research for Change* (Finding Answers I), which focused on moving the disparities field beyond simply documenting racial and ethnic differences in health care to eliminating them. The program, housed in the Department of Medicine at the University of Chicago, awarded grants to 33 organizations operating in more than 200 clinical sites focusing primarily on health disparities across race and ethnicity for cardiovascular disease, diabetes, and depression. The program participants considered how they could improve care and health outcomes for their patients (Finding Answers Calls for Proposals, 2006/2007/2008/2010; Finding Answers: Disparities Research for Change, 2013). They collected quantitative and qualitative data to document their initiatives' implementation and

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outcomes. In addition, the program conducted multiple systematic reviews of the health care disparities intervention literature (Clarke et al., 2013). Finding Answers I culminated in the development of the *Roadmap to Reduce Disparities*—later renamed the *Roadmap to Advance Health Equity* (Roadmap)—based on the findings of the grant program and its systematic reviews of disparities intervention literature (Robert Wood Johnson Foundation, 2013).

Since then, the program has offered technical assistance to health care organizations on how to use the Roadmap, including providing curricula and associated implementation resources, hosting conferences and webinars, and delivering in-person and virtual technical assistance. The program also facilitated learning collaboratives in which groups of similar organizations engaged in cross-organization, peer-based learning while using the Roadmap. See Cook et al. (2015), for the summary of lessons learned in this program phase. The Roadmap (see Figure 1) is continuously evolving, based in part on the experiences of organizations implementing it, as a guiding framework that integrates building a culture of equity with concrete operational steps to identify disparities, determine their root causes, and transform care delivery (Cook et al., 2021, Appendix B). While equity interventions may save payers or providers money in the long run, the program has learned that they also require an immediate commitment to infrastructure, staff time, and the ability to continuously innovate. It is important to integrate the necessary resources into the initiative design from the brainstorming phase. In response, the program expanded its focus to include payer organizations, which administer and pay health insurance and medical claims to providers.

Around the same time, the health care arena accelerated experiments in value-based care and payment reform to improve health care quality and cost efficiency, but health equity was largely missing from the national dialogue on these topics. In fact, some early research began to suggest that, if not designed carefully, value-based payment models had the potential to exacerbate existing health disparities or create new ones (National Quality Forum, 2017). In response, the program and the field overall began to combine efforts to advance and learn from payment change with a commitment to transforming care to eliminate inequities. For example, the Health Equity Advisory Team of the Centers for Medicare and Medicaid Services Health Care Payment Learning and Action Network recently released technical guidance on how alternative payment models can use care delivery redesign, payment incentives and structures, and performance measurement to advance health equity (Health Care Payment Learning and Action Network Health Equity Advisory Team, 2021). Over time, the field and program continued to expand focus further upstream from health care to social drivers (e.g., food deserts) as appropriate targets of health and health care equity interventions.

Phase 2—Finding Answers: Solving Disparities Through Payment and Delivery System Reform (2014–2018)

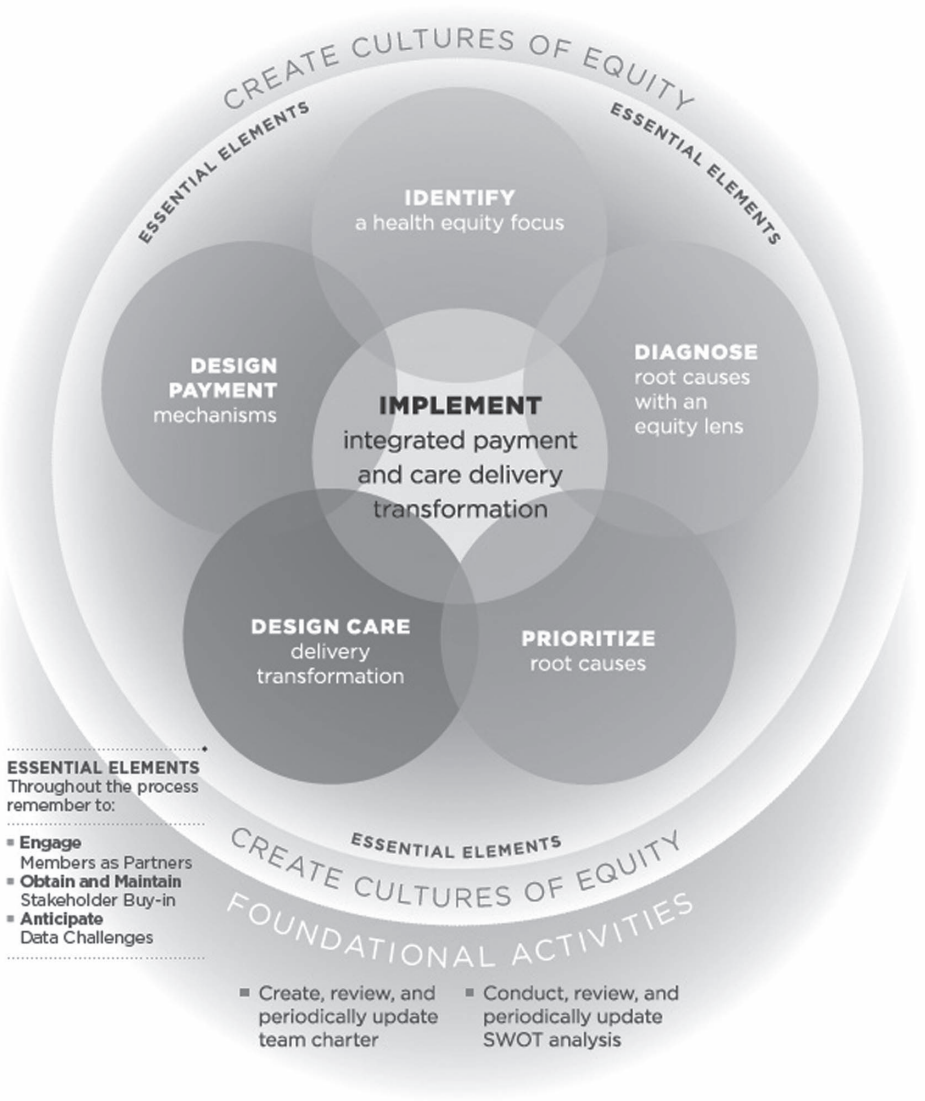
In 2014, based on input from grantees and the evolving health care payment landscape, the program began coupling its commitment to eliminating disparities in health care quality and outcomes with efforts to advance and learn from payment change. That new program, *Finding Answers: Solving Disparities through Payment and Delivery System Reform* (Finding Answers II), worked with three grantee partners to implement the Roadmap and examine how the work could be supported by innovative payment methods—primarily through state Medicaid programs. Each grantee initiative consisted of a health care delivery organization and a payer to explore promising ways to reduce inequities (Cook et al., 2021; DeMeester et al., 2017).

During this phase, the program codirectors (SCC, MHC) also worked in different roles at the University of Chicago Medicine (UCM) and, with the second author (JT), have been actively involved in the medical center's 10-year focus on advancing health equity for its patients and the organization's broad diversity, equity, and inclusion activities (see Todić et al., 2022). These efforts included an external evaluation of UCM's diversity, equity, and inclusion activities conducted by the third author (SS) that highlighted the need for a strategy to help team members translate their motivation to address organizational inequities and structural racism into action. Combined, these experiences generated a model for equity-focused organization-level change that the program incorporated into the Roadmap (Todić et al., 2022).

Phase 3—Advancing Health Equity: Leading Care, Payment, and Systems Transformation (2018–Present)

In 2018, Finding Answers was reimagined as Advancing Health Equity: Leading Care, Payment, and Systems Transformation (AHE) because the program learned that cross-sector and cross-organizational alignment are critical for success. The program team revised and updated the Roadmap based on lessons learned in Phase 2 and incorporated a focus on aligning the care and payment transformation activities of state-level policymakers (e.g., state Medicaid agencies), payers, Medicaid members, community-based organizations, and health care delivery organizations to achieve health equity. AHE grew into a partnership between the University of Chicago, the Center for Health Care Strategies, and the Institute for Medicaid Innovation as the program initiated a new learning collaborative (LC). The LC brought together seven teams, each composed of a state Medicaid agency, a Medicaid health plan, and two or more health care delivery organizations in seven states. The LC was created with the belief that together, organizations can develop shared equity priorities, understand the drivers leading to health and health care inequities, and create equity-focused care transformations supported by tailored payment

Figure 1
The Roadmap to Advance Health Equity



Note. The Roadmap entails a series of activities to reduce or eliminate health and health care inequities. Its aim is to help organizations and collaboratives integrate disparities reduction into all health care quality improvement efforts and to develop equity initiatives that are tailored to their specific populations and available resources. Effective implementation and long-term sustainability are dependent upon each component. SWOT = Strengths, Weaknesses, Opportunities, and Threats. Copyright 2020 by Advancing Health Equity: Leading Care, Payment, and Systems Transformation, a program funded by the Robert Wood Johnson Foundation. Reprinted with permission.

models. The program provides education and technical assistance to participants addressing a wide range of mental and physical health conditions, working within and across a wide range of settings (e.g., state agencies, health plans, inpatient, outpatient, emergency, public health) to intervene at one or more levels of the health system, including patients, health care providers, health care teams, organization-level interventions, community, payment, and policy. The program participants design and implement initiatives to advance health equity by reducing and eliminating disparities in health care and other social and political drivers such as housing and the criminal justice system, supported by tailored payment models (Advancing Health Equity: Leading Care, Payment, and Systems Transformation, n.d.).

The COVID-19 pandemic began shortly after the launch of the LC in October 2019. The stark disparities in morbidity and outcomes for COVID-19 by race, ethnicity and socioeconomic status, and simultaneous public outrage at police brutality against Black people in 2020, heightened the LC participants' and program team members' awareness of the

role of structural racism in health and health care. The LC participants also increasingly recognized the importance of moving beyond primarily focusing diversity, inclusion, and equity efforts on internal human resource processes and employees to include business relationships and processes with external partners and patients (e.g., care delivery). As a result of AHE's internal evolution through praxis over the years and just-in-time learning in the evolving pandemic context, program team members are learning to directly name racism and incorporate principles of antiracism in AHE's programming.

Structural Racism as a Root Cause of Health Care and Health Inequities: Key Concepts

Structural racism is an upstream driver of health. It refers to the "totality of ways in which societies foster racial discrimination" through interconnected institutions (e.g., education, housing or health care), reinforcing "discriminatory beliefs, values, and distribution of resources," ultimately shaping health outcomes (Bailey et al., 2017, p. 1454). Relatedly, white supremacy is "the totality of social relations and practices that reinforce white privilege," including "social, economic, political, social control, and ideological mechanisms responsible for [its] reproduction" (Bonilla-Silva, 2017, p. 9).

Racism is culturally reinforced and operates at three levels; institutional, interpersonal or personally mediated, and intrapersonal or internalized (Bailey et al., 2017; Cogburn, 2019; Jones, 2000). Institutional racism in the context of health care includes differential access to the goods, services, and opportunities of the health care system by race, including differences in health care coverage and financing that have created a two-tier system in which excluded racialized populations have lower access to care and lower quality of care when accessed (Gangopadhyaya, 2021). These inequities result from the cumulative decisions of federal and state institutions such as legislative bodies, regulatory structures, and funding agencies; the decisions of health plans that administer public and private insurance; and the policies and practices of health care provider organizations. Personally mediated racism in a health care context can include care team members holding biases about the nature, abilities, motives, and intents of individual patients and family members by race. Examples of such assumptions include certain groups having higher or lower literacy, higher or lower ability or willingness to follow treatment regimens, or being more or less able to experience pain. These biases have the potential to influence treatment decisions (Chapman et al., 2013). Finally, Jones (2000) defines internalized or intrapersonal racism as "acceptance by members of stigmatized races of negative messages about their own abilities and intrinsic worth" (p. 1213). This can include accepting lower quality or ineffective health care.

The Role of Psychology

Professional socialization reproduces racism and white supremacy (American Psychological Association, 2021b; Bonilla-Silva, 2017; Harro, 2018). Racially biased frameworks rooted in white supremacy that explain and justify racism are deeply embedded in the U.S. cultural narrative and institutions (Bonilla-Silva, 2017; Cogburn, 2019). For example, race has no genetic or scientific basis; however, it continues to serve as a biological construct in health research, education, and practice, resulting in harmful race-based protocols that essentialize race and ignore harmful structures that shape health behaviors and outcomes (American Medical Association and Association of American Medical Colleges [AMA and AAMC], 2021). As a Western-based discipline developed by white men, psychology embodies Eurocentric individualist values such as meritocracy and self-determination (Leong et al., 2017; Vasquez, 2020). It has historically overemphasized the role of individuals, ignoring the role of structure (Comas-Díaz & Torres Rivera, 2020). As a result, it contributes to marginalizing and pathologizing people of color, poor people, women, lesbian, gay, bisexual, transgender, questioning, intersex, asexual and other sexual and gender minority individuals, other historically excluded groups, and those holding multiple marginalized and pathologized identities (Comas-Díaz & Torres Rivera, 2020; Vasquez, 2020). Moreover, Eurocentric mainstream Western psychology has ignored the contributions of psychologists of color and marginalized decades of work by the peace, liberation, community, and critical psychology subfields that have advocated for increased attention to structural racism and ways to intervene (Comas-Díaz & Torres Rivera, 2020).

Mainstream dominant psychology is now poised to reckon with its role in maintaining structural racism and examine its capacity to address and dismantle white supremacy (American Psychological Association, 2021a). It must respond to the organizations, scholars, practitioners, and activists urgently demanding an examination and accountability for how various disciplines have contributed to the production and reproduction of harmful social structures (AMA and AAMC, 2021; Shelton et al., 2021; Wright et al., 2021). Simultaneously, as a discipline that investigates identity, interpersonal dynamics, conflict, and group processes, which are key to mobilizing the complex partnerships required to transform harmful structures that create and maintain health inequities, psychology has much to offer efforts to advance health equity. However, psychology, together with allied professions, must first liberate itself (Comas-Díaz & Torres Rivera, 2020; Martín-Baró, 1996; Vasquez, 2020).

Antiracist Praxis to Advance Health and Health Care Equity

A comprehensive effort to eliminate health inequities must begin with a firm commitment to antiracist transdisciplinary

praxis. Antiracism refers to daily conscious choices to uproot racist ideas, behaviors, and policies (Kendi, 2019). Praxis is the ongoing process of reflection and action aimed at understanding and transforming the world (Freire, 2018). Because the "reality is opaque," "only by acting upon it, by transforming it, can a human being get information about it" (Martín-Baró, 1996, p. 28). Efforts to dismantle racism as a root cause of health inequities require action both inside and outside of the health care system to identify and ameliorate racism on all levels. As health care organizations adopt principles of antiracism, they also begin to influence the broader structural racism of the health care system and produce conditions that enable health equity. Finally, given the structural nature of racism, efforts to eliminate health inequities must be rooted in critical theory to ensure attention to power and structural analysis.

Critical Theory

Integrating critical theory into research and professional education can produce new relevant knowledge and shift practice supportive of health equity (AMA and AAMC, 2021; Paradis et al., 2020; Todić et al., 2022). As an umbrella term, critical theory refers to theories such as feminist and critical race theories that emphasize power analysis as an approach to understanding and transforming structures by targeting the root causes of social injustice (Crenshaw et al., 1996; Paradis et al., 2020). "Structure" refers to "political, social, cultural, historical, and economic forces that influence individual behavior and thus create predictable patterns based on social location" (Paradis et al., 2020, p. 843). For example, Volpe et al. (2019) describe how employing critical race theory in the psychological sciences can propel the field beyond focusing primarily on the impact of individual and interpersonal racism on health to actively exploring the roles that structural racism plays in creating and maintaining health inequities.

In this article, we model what the commitment to critical antiracist praxis can look like by reflecting on the implementation of our transdisciplinary national health and health care equity program. Our analysis aligns with the APA's Division 45 effort to advance knowledge and science relevant to racial justice. The division released *Liberation Psychology: Theory, Method, Practice, and Social Justice*, edited by Comas-Díaz and Torres Rivera (2020), and challenged readers to explore its application in their work. We welcome the challenge as our program pivots towards utilizing an explicit critical theoretical and antiracist lens. We first describe Martín-Baró's (1996) liberation psychology. Second, we use Martín-Baró's (1996) critiques of some foundational assumptions underlying Euro-American dominant psychology to describe and interpret the experiences of our program. This exercise provides a rare example of applying critical theory, as encouraged by Volpe et al. (2019), and an antiracism framework to a large transdisciplinary national health equity program. Third, we describe Martín-Baró's recommendations to rectify the harms associated with the faulty assumptions of the Euro-American dominant psychology. Finally, we integrate these alternative principles and the observations of our program to generate insights for praxis and research to advance health and health care equity. Our aim is to offer inspiration and tangible strategies for psychology practitioners, researchers, and educators looking to boldly contribute to achieving health equity.

Liberation Psychology

Liberation psychology critiques white supremacist, Eurocentric psychology, understanding and addressing oppression as an interaction between intrapersonal, interpersonal, and structural factors (Comas-Díaz & Torres Rivera, 2020; Martín-Baró, 1996). It is part of the broader Latin American movement to reject colonial and neocolonial power relations, the role of global capitalism in shaping the material conditions in the Global South, and the way these processes produced racist images of the Global South and its people as inferior to Europe and Europeans (Montero et al., 2017). Martín-Baró advocated for the field to identify new ways of pursuing knowledge by collaborating with communities, then using that knowledge to create new approaches to transforming individuals, groups, and society (Martín-Baró, 1996; Montero et al., 2017). While we primarily reference the work of Martín-Baró (1996) who practiced in El Salvador, we acknowledge that these ideas also reflect the earlier work of the African American sociologist W. E. B. Du Bois (Burton & Guzzo, 2020), Brazilian educator Paolo Freire, Latin American bishops who promoted liberation theology, and Latin American philosophers of liberation (Burton & Guzzo, 2020).

Liberatory approaches inform a growing movement of decolonial psychology that emphasizes strategies that Adams and Estrada-Villalta (2017, p. 39) describe as "denaturalizing the modern individualist mentalities that hegemonic accounts portray as a just-natural standard of human development" even though they underlie worldviews and actions that facilitate the creation of inequities and environmental destruction. In addition, Adams and Estrada-Villalta note that the decolonial psychology movement also emphasizes strategies to normalize "habits of mind that hegemonic psychological science portrays as abnormal" that facilitate the development and maintenance of equitable cultures, supporting and nurturing the natural environment (p. 39). Similar movements in the field of medicine have grown out of these liberatory approaches (Smith, 2019). Liberation psychology also parallels developments such as Cuban psychology, community social psychology, and international developments in other regions such as Fanon's work in North

Africa (Burton & Guzzo, 2020). Finally, some liberation psychologies such as feminist liberation psychology and mujerista psychology address criticism of earlier liberation psychology related to limited attention to experiences of women and lesbian, gay, bisexual, transgender, questioning, intersex, asexual and other sexual and gender minority individuals (Burton & Guzzo, 2020; Comas-Díaz & Torres Rivera, 2020).

Methodology

The lead author (SCC), a clinical psychologist and a codirector of AHE, generated a list of observations based on his experiences, the content of numerous program reports (Chin & Cook, 2006–2018), as well as existing white papers and peer-reviewed publications that report qualitative and quantitative findings from the program and its grantees. We cite key publicly available source documents. The coauthors then utilized their unique professional experiences and perspectives to further develop and refine the original observations. Four of the coauthors (SC, JT, SS, MC) also utilized their experiences and quantitative and qualitative data from the diversity, inclusion, and equity activities of the University of Chicago health system reported by Todić et al., 2022. The University of Chicago Institutional Review Board approved all abovementioned primary data collection protocols. The lead author and second author (JT), a social work scholar with a BA in psychology, applied Martín-Baró's (1996) five faulty assumptions of Euro-American dominant psychology to the observations, focusing first on the insights, then on the implications for psychology praxis and research (see Liberation Psychology Application and Insights section below). Subsequently, the other coauthors reviewed the initial findings, provided feedback, and suggested revisions. The process was iterative. See the online Supplemental Material for a positionality description of the multidisciplinary and interracial authorship team and a description of the AHE national advisory committees.

Program Observations

Health Care System Complexity and Inertia

The program's participants increased cross-organizational partnerships as they developed and implemented equity-focused care and payment transformation models. However, the highly complex nature of the health care system inhibits identification and implementation of the strategies necessary for equity-focused change. Within organizations, the teams and individuals with the knowledge and skills required to accurately identify health inequities, diagnose root causes, and design effective care and payment transformation models are physically and administratively siloed and often hold different functional priorities; in practice, they often do not collaborate. Across organizations, competition (e.g., for market share), regulatory factors (e.g., antitrust regulations), and contractual relationships that govern cross-organization interactions actively inhibit collaboration (e.g., inhibit multiple health plans partnering to create equity-focused population health initiatives). Additionally, governmental agencies, health plans, hospitals, and clinics hold different equity-related motivations and goals, if they have any, and have few incentives to develop the relationships required to align them. And critically, patients and communities are typically excluded from health system design and implementation activities, even though there is growing evidence that their involvement improves outcomes and patient satisfaction (Carman et al., 2013).

Program grantees struggled to collect and report implementation and maintenance costs of their interventions given that payment systems do not make this level of information readily accessible or organize it in a usable manner for care team members, even those familiar with health economics. Similarly, the vast majority of program participants struggled to collect high-quality race, ethnicity, language, and other key demographic data necessary to identify inequities and evaluate the progress and outcomes of care transformation interventions. In contrast, the health care system creates and maintains substantial and sophisticated data collection, translation, and communication structures to meet the payers' requirements.

Underestimating the Impact of Health System Complexity and Inertia

The program originally had a linear model of discovery and dissemination. The program would conduct systematic literature reviews to identify effective disparities interventions and fund grantees implementing promising practices, then disseminate findings nationally. However, the program underestimated the importance of context, including the critical differences across communities, health care organizations, and the people who live and work in them. The factors that lead to health inequities in one setting can be quite different compared to those in other settings. In addition, health care organizations vary significantly in the resources available to them, their capacity (e.g., knowledge and skills), and their internal culture. Not surprisingly, the program observed significant implementation and outcome variations across clinical sites, even within the same health care provider organizations.

To address health system complexity and inertia, AHE includes a LC in which participating organizations learn the main tenets of the Roadmap. They also receive technical assistance throughout their initiatives. This approach resulted in a robust root cause analysis and intentional focus on the process and activities outlined in the Roadmap. However, the participating organizations tended to also maintain standard modes of operation, focus on unrelated fiscal and

productivity pressures, and silo equity teams and operations, limiting effectiveness.

Health Care Payment

The program considers how payment models and systems directly and indirectly influence health equity. For example, some policies differentially direct financial and other resources to highly resourced organizations serving wealthier patients while leaving safety-net institutions serving historically marginalized patients and communities underresourced (Health Care Payment Learning and Action Network Health Equity Advisory Team, 2021). Organizational leaders frequently require equity-focused initiatives to reduce the cost of care, while they sometimes allow general quality improvement initiatives that improve care or outcomes for more privileged populations to accrue higher costs. This double standard reveals implicit assumptions about who deserves and does not deserve additional resources to be healthy. LC teams have also struggled with the challenge of the "wrong pocket" problem of savings accruing to other organizations that did not make the initial investment.

Challenges of Payment Incentives

Many health care organizations utilize pay-for-performance incentives to change the behaviors of physicians. However, financial incentives are not always the most effective way to improve motivation and change behavior. It was difficult for program participants to determine the ideal amount and frequency of incentives. Determining benchmarking metrics, referent groups, and frequency of performance reports was also challenging. Moreover, nonphysicians such as nurses, medical assistants, community health workers, patient navigators, social workers, and behavioral health providers may have as much or more influence on the outcomes of equity-focused interventions as physicians, yet they are rarely included in incentive-based models. They are also typically underpaid for their services. Finally, professional integrity and positive feelings when inequities are reduced or eliminated can be powerful incentives. For example, a program grantee observed that team members of a multiclinic system were just as or more motivated to improve equity-focused quality metrics by comparing their performance to other clinics as they were by earning team-based financial incentives.

Neglecting to Operationalize the Study of Racism

The program developed and published a conceptual model by its second year that directly named racism and noted that it manifests at all levels of society and health care, including the organizational and structural levels (Chin et al., 2007). And while the program consistently noted the importance of race and ethnicity, it did not directly reference or name structural racism in any other internally or externally facing documents. For example, the Finding Answers I Call for Proposals (CFPs) did not reference racism or provide guidance to program applicants regarding how racism might be considered, addressed, or studied (Finding Answers Calls for Proposals, 2006/2007/2008/2010). The program's technical assistance resources and tools also neglected to directly name racism or provide guidance for addressing it. In addition, the AHE team used racism as a search term and concept in only one of the program's 13 systematic reviews of the health care disparities intervention literature. As a result, the program's understanding of racism, and how to address it, was limited.

Similarly, to avoid potential polarization, RWJF initially advised against utilizing the concept of equity when describing differences in health care processes or outcomes between groups. They recommended using disparities as the primary concept, a quantitative metric-focused approach that concentrated on differences in care processes or outcomes without explicitly incorporating a social justice or antiracism frame. This conceptualization was reflected in our program name at the time: *Finding Answers: Disparities Research for Change*. While a focus on disparities and measuring progress in reducing or eliminating them remains important and useful, the lack of explicit focus on equity and social justice limited our thinking by directing attention away from racism and how it plays out in health care systems.

Our training materials taught and encouraged users to craft key questions for root cause analyses that focused on the patient population living with the health or health care inequity instead of the health system and broader culture. For example, asking "Why is our health system less successful helping Black children with asthma avoid hospitalization than white children with asthma?" leads to different answers and solutions compared to asking "Why do Black children with asthma have higher rates of hospitalization than white children with asthma?" Focusing the question on children inadvertently reinforces biases that patients are solely or primarily responsible for the inequity they experience. The program's systematic literature reviews revealed a similar framing problem in the academic health disparities intervention literature; most interventions to address disparities were directed toward changing patients instead of health care providers, organizations, or policies (Clarke et al., 2013).

Cultures of Equity

The program observed the importance of broad-based diversity, equity, and inclusion work at the organizational level. It was critical to avoid isolating equity efforts into specific programs or departments. Instead, the most successful efforts integrated equity throughout organizational operations. Ideally, all team members understand how to

incorporate equity into their daily work, regardless of their position or role. However, this requires changing not only policies and procedures but also the overall culture, including how people relate to each other.

Relationships and Teamwork

Reducing and eliminating health and health care inequities requires that people within health care systems and organizations, as well as patients and community members, create new relationships and restructure existing harmful relationships and power hierarchies. They must explore equity-related topics that can be emotionally charged and value-laden (e.g., racism, sexism, classism). Difficulty identifying, naming, discussing, and taking action to address racism and other forms of oppression and discrimination in health care is commonplace. Engaging in these activities requires a complex set of skills implemented at various times at the interpersonal, organizational, and structural levels of the health care system (Watkins, 2015). In addition, transdisciplinary teams may require longer timelines to achieve objectives. Most health care organizations and communities come to the work with complex internal and external cross-cultural histories and with varying degrees of trust or mistrust, and cooperation, avoidance, or competition. Conflicting motivations, beliefs, narratives, and values often surface and influence the process. AHE's qualitative implementation data revealed that program participants had a variety of challenges in understanding and negotiating the complex and shifting equity-related relationships and power dynamics within and among organizations (Cook et al., 2015, 2021).

The coauthors and other program team members are not immune to these dynamics or skill deficits. We have learned that we too need to do the intra- and interpersonal work with our team to address how racism and other forms of oppression hinder our relationships with each other and our program participants. We also feel the disconnection, discord, and anxiety that arise in the process of uprooting racism. As we begin to explicitly focus on antiracism, we will evolve the Roadmap through transdisciplinary praxis and transform our own organizational culture as we build solidarity with others in the pursuit of health equity.

Power Imbalance

Marginalized Organizations

Our systematic reviews revealed that even when authors described interventions that succeeded in reducing or eliminating health or health care inequities, they focused primarily or solely on quantitative data. Authors minimized or eliminated the use of qualitative implementation data, likely because of a combination of factors such as journal priorities and article length requirements, overvaluing of quantitative data, and limited training in mixed methods research and data presentation. Such publications reflect what is valued in academic fields and by funders. However, not including key implementation information neglects the needs of people at frontline organizations and individuals delivering care.

The grants program received multiple proposals with innovative and promising interventions to reduce disparities from frontline, health care safety-net, and community health center applicants. However, many had weak evaluation methodology per our selection criteria. In response, the program offered free technical assistance to improve program evaluation and proposal writing skills to four applicants in the first Finding Answers I CFP who proposed the most innovative interventions that were not funded. Only one applicant expressed interest but did not follow through. It is possible that the applicants did not have sufficient time or resources to participate. It is also possible that the applicants were frustrated that the time and energy they put into their proposal did not result in funding and had a negative reaction to a subsequent offer that did not contain an actual monetary award. It is likely that academic and philanthropic partnership and funding models continue to operate in a similar manner, causing them to potentially overlook innovative health and health care equity interventions at smaller, marginalized health care and social service safety-net organizations.

Marginalized People

The program required direct and active participation of grantee frontline implementers who are typically afforded limited power in their organizations (e.g., project managers and nonphysician care team members such as community health workers). These key team members participated in AHE grantee monitoring and technical assistance meetings and at conferences as presenters and discussants. Their critical contributions guided most of the Roadmap's recommendations.

Patients and Communities

Communities living with health inequities hold knowledge and traditions that promote resilience and health that many health professionals and academics have long overlooked. There is also a growing call to cultivate alternative cultural paradigms that can advance health equity (Consoli & Myers, 2022; Gone, 2021). The national program office initially did not emphasize the need to partner with patients and communities experiencing health and health care inequities. However, it observed that grantees who partnered with patients, families, and communities benefited significantly from the critical information they held about how health care organizations and systems played key roles in the inequities being addressed. In addition, several of the program's successful care transformation initiatives involved peer- and

community-based care transformation models (Houston et al., 2011; Wells et al., 2013), consistent with the wider literature on the promise of peer-based models to address health inequities (Rosenthal et al., 2010).

Liberation Psychology Application and Insights

Martín-Baró (1996) observed five key and typically unexamined assumptions of Euro-American dominant psychology that contribute to maintaining white supremacy and racism. They also apply to the field of medicine and the health care system. In the next five sections, we first explain the unexamined assumption observed by Martín-Baró and then describe how it manifested in our transdisciplinary health equity program.

Positivism

First, Martín-Baró (1996) notes that the use of positivism as the central research paradigm leads to a narrow overemphasis on the "how" of phenomena. Initially proposed by French philosopher Auguste Comte (1798–1857), the Positivist paradigm is grounded in the scientific method of investigation and assumes that the only legitimate approach to understanding human behavior is experimentation, observation, and reason (Kivunja & Kuyini, 2017). As such, it tends to overlook the potential impact of observer bias and underemphasize the "what," "because" and the "why" of phenomena. For example, decades of the U.S.-based research on racial differences in intelligence led to the racist conclusion that the average intelligence quotient of Black individuals was inherently one standard deviation below that of white individuals (American Psychological Association, 2021b), ignoring the structural factors that produced the faulty findings. The health care system's long-standing failure to identify and address institutional racism as a root cause of health and health care inequities inflicted upon people of color can also be viewed as one outcome of overrelying on a positivistic frame.

While the program acknowledged the existence of racism at all levels of society, it did not focus on it as a root cause of health inequities. It is possible that program staff members did not address structural racism in the first phases of the program because it did not align with their mostly positivistic approach to data collection, as indicated in the first program name, *Finding Answers: Disparities Research for Change*. However, the decision to collect detailed qualitative data regarding the implementation experiences of grantees helped the program to identify other types of knowledge and key findings that would prove critical, including the importance of organizational culture and ideological paradigms.

Individualism

Second, as a Eurocentric discipline, dominant psychology also understands an individual as the key subject, ignoring the collective culture that shapes individual meaning. As a result, dominant psychology tends to frame the reality of structural challenges or problems at an individual level. Similarly, the health care system has historically relied on framing the problem of racial and ethnic health and health care inequities as stemming from inadequacies of patients of color, leading to decades of focusing most equity-focused change interventions on them instead of the health care system (Clarke et al., 2013). Relying on the assumption of individualism influenced the program in multiple ways. For example, the program's Roadmap, curriculum, and technical assistance materials initially used language that framed the key question of equity-focused root cause analyses on the individuals and groups impacted by the health inequity instead of on the roles played by health care organizations and structures. Another crucial lesson was the importance of partnering with patients and communities who have other critical ways of knowing (e.g., lived experiences) how to transform the health care system, including the importance of moving beyond the faulty assumptions of individualism.

Hedonism

Third, Martín-Baró (1996) suggests that the hedonism assumption, which is the perspective that all behavior is ultimately explained by a desire to experience pleasure or satisfaction, reflects the capitalist economic system that shapes the field of psychology rather than something inherent in human nature. The capitalistic economic system also strongly influences health care and plays a significant role in creating a two-tiered system of health care in which those afforded more social power benefit from better access to health care, which often has higher quality, compared to people of color historically excluded from power (Gangopadhyaya, 2021; Joynt et al., 2011). Those with decision-making power in health care organizations and systems that have participated in AHE typically relied upon payment incentives to motivate behavior change (Cook et al., 2021). Hedonistic conceptions of motivation within a capitalist economic system caused the program's participants to struggle with imagining the breadth of health care teams' nonfinancial motivations to reduce or eliminate specific health inequities. The program has learned that there are many potential motivators to advance health equity, including the personal values of the people within health care organizations and their relationships with patients.

Homeostatic Vision

Fourth, Martín-Baró (1996) notes that an assumption of a homeostatic vision predisposes people to view disequilibrium and discord, rupture, or crisis within groups and systems negatively. In reality, group or cultural changes typically engender disequilibrium and discord before desired changes

can manifest, as was experienced during the initial and ongoing debates regarding social safety net programs, including Medicaid (Sayeed, 2021). The program repeatedly observed that people consistently had difficulty identifying, naming, discussing, and taking action to address racism and other forms of oppression and discrimination. Participants, including our own team members, tended to hold negative views of the difficult feelings (e.g., defensiveness, frustration, confusion, or anxiety) and the temporary discord that arose when direct engagement of these topics occurred. Individuals and teams need support to reframe this type of disequilibrium as a positive sign of progress that, with the proper skills and practice, can be generative and transformative.

Ahistoricism

Fifth, ahistoricism reinforces the overemphasis on the universal aspects of human nature. Martín-Baró observed that "models created in different circumstances from our own, and assumed to be cross-cultural and transhistorical, can lead to a serious distortion of what our peoples are really about" (Martín-Baró, 1996, p. 23). Most health care and psychological science and intervention assume universal aspects of how European Americans think about and experience health and health care. For example, screening and treatment for mental health disorders have been based primarily on the experiences and needs of the White middle and upper class and have led to models of prevention, screening, and care that are less effective for people of color (Buchanan et al., 2021). Much of the health care system consists of provider and payer organizations as well as government and regulatory agencies (e.g., state Medicaid agencies) that cover multiple cities, counties, or states. These large geographic systems often embody an assumption of ahistoricism that negatively influenced the ability of AHE LC team stakeholders (state Medicaid agencies, Medicaid managed care organizations, and care provider organizations) to develop equity-focused initiatives. They tended to develop universal initiatives that were logical and motivating from their own perspectives but did not fully address the root causes of health inequities, or the needs of patients of color and providers at the local level.

Principles of Liberation Psychology as an Antidote to Euro-American Dominant Psychology's Unexamined Assumptions

Fortunately, liberation psychology offers principles to facilitate the process of exposing and undoing the influence of the Euro-American dominant psychology's unexamined assumptions (Torres Rivera, 2020). They can help avoid ongoing repetition of the types of errors that we describe and to accelerate the progress of programs such as AHE. We explain the principles below and then offer pragmatic suggestions for how they can be utilized to advance health and health care equity.

First, reorient from individual-level to structural-level root causes of poor health. Recognize that all organizations of the health care system function as social drivers of health, including public and private payers, health plans, care provider organizations, and regulatory agencies. They are part of the root causes of health inequities, and it is imperative for them to act, both inside and outside of the health care system, to eliminate health and health care inequities.

Second, recover historical memory to understand the etiology of oppression and understand the lived experiences of those experiencing oppression. This requires partnering with the patients, families, and members of excluded communities living with and impacted by health inequities to learn their perspectives and experiences regarding the multisectoral health care system, its organizations, and the roles that they play in creating health and health care inequities.

Third, use the recovered historical memory to de-ideologize everyday experience by critically questioning the imposed dominant messages regarding health and health care equity and why inequities exist. This requires health care organizations and individuals within them to self-reflect about their individual, professional, and organizational socialization that creates and reinforces racism and white supremacy.

Fourth, denaturalize discrimination and oppression. This requires creating strong cultures within health care organizations that emphasize building the knowledge and skills necessary to identify discrimination and oppression operating outside of and within their work settings. This includes skills of power analysis and utilizing cross-discipline knowledge, including the knowledge of nonacademic communities experienced in social justice and antiracism work.

Fifth, problematize circumstances that produce poor health. This can include embedding equity into mission, vision, and value statements and holding health care leadership through all sectors of the health care system accountable for making measurable positive change.

Sixth, see marginalized individuals and communities through a strengths-based perspective, valuing their resilience, knowledge, and lived experiences as critical for transforming unjust social structures and imagining new ones. This requires recognizing the imperative to partner with patients, family members, and community organizations to identify and eliminate the root causes of health and health care inequities; valuing the lived experience and expertise of patients and communities living with health inequities at least as much, if not more, than those working within health care organizations and academic settings; ceding decisional authority and power to them; and providing equitable and adequate compensation for their lived experience and expertise.

Seventh, utilize critical consciousness to engage in praxis to transform unjust conditions and power dynamics. This requires creating strong and accountable cultures within health care organizations that take action to improve internal and external diversity, inclusion, and equity.

Implications for Praxis and Research

Next, we use implementation science and social work perspectives to present implications for praxis and research at the micro (intra- and interpersonal), meso (organizational), and macro (institutional and structural) levels of the health care system drawn from the principles of liberation psychology and the experiences of the AHE program.

Micro (Intra- and Interpersonal) Level Praxis

At an individual level, psychologists need to invest in developing critical consciousness, which is the ability to read the world critically and take action to transform it (Freire, 2018). They must also support others in doing so. This requires reorienting themselves to understand health inequities in the context of structural issues and self-reflection about their own personal and professional socialization in the context of intersecting systems of oppression. Learning and dialoguing about the history of psychology, the organizations they operate within, their communities, and their country from the perspective of marginalized communities is a critical step.

At the interpersonal level, psychologists must examine their internalized assumptions about conflict, including the assumption of a homeostatic vision. Uprooting racism and intersecting systems of oppression require honesty and partnerships with diverse communities and professionals. Given the extent of inequities in the United States, such processes will inevitably result in conflict, requiring abilities to communicate across differences, build trust, take accountability, resolve conflict, and share power. Activist communities engaged in social justice work hold extensive knowledge about transformative conflict and relationship accountability (e.g., Kaba & Hassan, 2019), but the academy has neglected to value and learn from their knowledge developed through praxis.

Meso (Organizational) Level Praxis

Four of the authors (SCC, JT, SS, MHC) codeveloped with other colleagues a framework for advancing equity work in health care settings based upon their experiences at the UCM. The framework, detailed by Todić et al. (2022), is illustrated in Figure 2 and includes five recommended strategies: (a) grounding work in critical theory; (b) replacing a focus on cultural competence with a focus on critical consciousness; (c) hiring implementation teams that model a culture of equity; (d) emphasizing relationships as a vehicle for change; and (d) ensuring equity-focused implementation and operations. Because equity activities must diffuse throughout the health care system and organizations, implementation science is a critical partner to help guide and inform the translation of critical theory conceptual models into equity-related skills (Allen et al., 2021; Shelton et al., 2021; Spitzer-Shohat & Chin, 2019; Todić et al., 2022). Organizations should provide all team members with the training and skills needed to identify equity-related challenges and opportunities, including how racism and other forms of oppression influence their organization and work areas. Do not isolate the responsibility to address equity. Instead, all team members and functional areas should have the leadership support, authorization, and expectation to identify equity-related challenges and to intervene within the scope of their position.

Transdisciplinary partnerships are critical for advancing equity efforts. However, they are challenged by siloed and static disciplinary and organizational contexts. For example, a psychologist, physician, and engineer can benefit from the different knowledge and expertise that each brings to a root cause analysis of a specific health inequity. However, whether each of them embraces a critical theoretical perspective will significantly influence their ability to reach a common understanding of root causes, potential solutions, and even how to navigate their different perspectives. We recommend beginning transdisciplinary partnerships with transparent conversations about the theoretical foundations that guide each partner's thinking. In our experience, diverse transdisciplinary teams grounded in a critical paradigm, which centers on explicit power analysis, will experience less challenges in negotiating worldview differences than transdisciplinary teams that do not share that perspective.

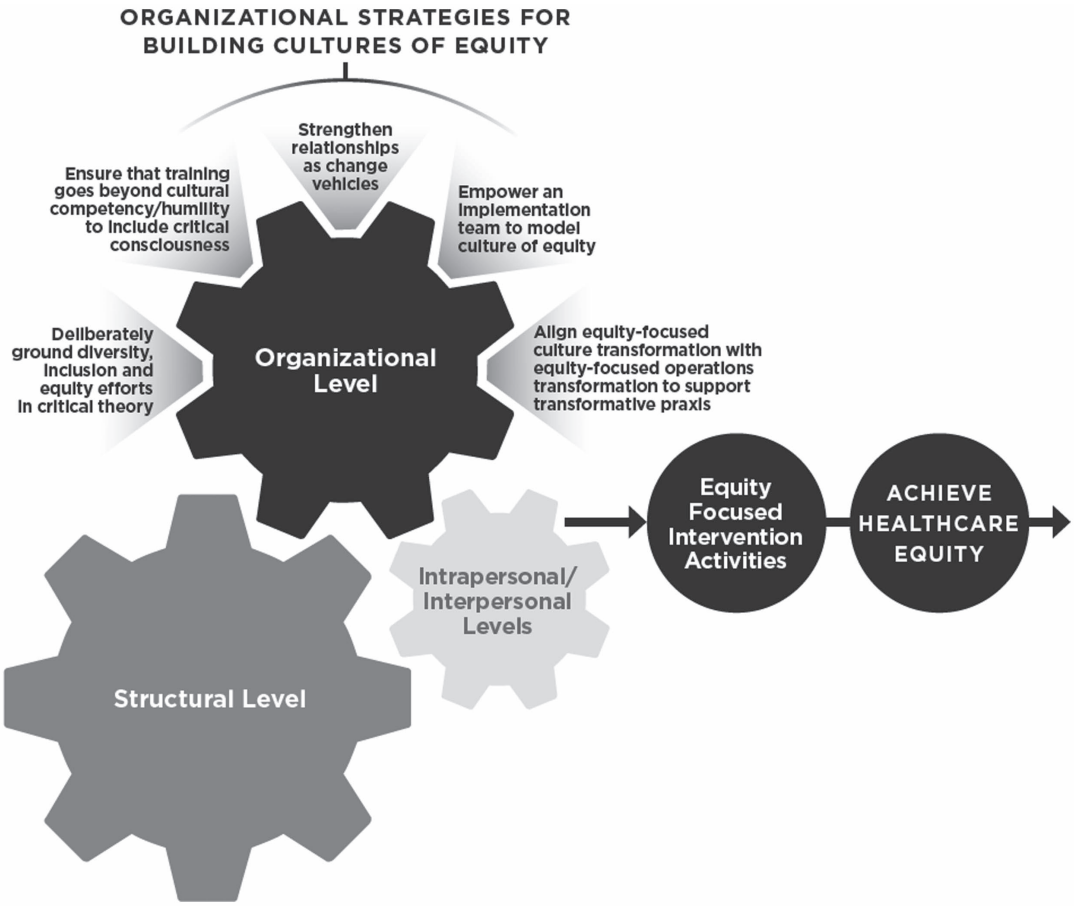
Macro (Structural) Level Praxis

At the macro level, psychologists need to advocate for a public health and health care policy landscape that can support the micro- and meso-level efforts. The processes are complex, take time, and require experimentation. It is critical to ensure adequate funding, long-term evaluation periods, and support for experimentation, including failure. The liberation psychology key concept of praxis offers a helpful frame. It is essential to embrace historical analysis, and a cycle of action–reflection–action–reflection given the complex and opaqueness of the conditions that produce health care inequities. Revisiting Martín-Baró's (1996) quote, it is:

> necessary to involve ourselves in a new praxis, an activity that transforms reality that will let us know not only what is but also about what it is not, and by which we may try to orient ourselves towards what ought to be. (pp. 28–29)

AHE offers a concrete example of a transdisciplinary team committed to praxis and a funding partner that embraces the

Figure 2
Diversity, Inclusion, and Equity Theory of Change



Note. The health care system includes multiple organizations, each impacted by structural-level factors and able to influence each other across organizational and interpersonal levels. Changes at intrapersonal, interpersonal, organizational, and structural levels are necessary to eliminate racism and other intersecting forms of oppression. An organizational culture of equity can begin to undermine internal systems of oppression and support change at intrapersonal and interpersonal levels. The five culture of equity strategies are foundational for effective implementation of actions to eliminate health inequities. Copyright 2021 by the Department of Diversity, Equity, and Inclusion on behalf of the University of Chicago Medical Center. Modified and reprinted with permission.

process. Professional organizations like APA and health foundations can play a key role in advocating for the necessary resources and changes at the federal, state, and municipal levels of policy formation. They must also consider their role in maintaining inequities when their funding cycles or learning collaboratives do not consider the complexities of the issues their grantees are addressing.

Knowledge Production

We have identified the following needs within psychology that can support health equity efforts:

- Improving the field of psychology's ability to identify, recognize, and value knowledge produced outside academia and the profession of psychology.
- Effective approaches to adopt a norm of collaboration across disciplines.
- Ways to problematize discrimination and oppression by incorporating antiracist approaches in knowledge production.
- Enhancing accountability through the use of tools to measure antiracism and movement towards becoming an antiracist professional and organization.
- Support for recovering historical memory by partnering with individuals, families, and community members impacted by health inequities to learn about the experiences of oppression they are carrying.

- Incorporating power analysis into change efforts, including tools to identify relevant types of power (e.g., financial, professional, political), how they are utilized in organizations and systems, who benefits, and who is marginalized.

- Approaches to reorient from the individual level to the structural level by evaluating health inequities and how racism manifests at the health care organization and payer levels.

- Improved participatory action and codesigned research methodologies.

- Methods and organizational support for the development of a community-based diverse research and clinical workforce.

- Improved methods for documenting and communicating communities' rich, authentic voices that go beyond traditional psychometric measures and *p* values, particularly for use by journals and grant study sections and to arrive at community-identified solutions.

- Adoption of critical consciousness to question the dominant messages regarding health and health care equity, and develop the skills to identify and act upon manifestations of racism within organizations and systems.

Conclusion

The complex nature of the health care system within the intersecting systems of oppression makes achieving health equity challenging, but not impossible. The AHE program's successes and challenges during its 17-year history can inform psychology's efforts to identify its role in upholding and eradicating racist structures. We recommend that those working to advance equity in health and health care assess the utility of critical theories to their own work. In this article, we used Martín-Baró's (1996) work in liberation psychology to synthesize our program observations and to frame recommendations. Other critical theories and approaches have the potential to open new insights and intervention pathways. While we derived these recommendations from our work in health care, psychologists working in a variety of contexts may find them useful. Finally, learning from communities is key; Indigenous communities, community healers, mutual aid groups, artists, and activists have much to teach about health and wellness. Marginalized communities have a long history of addressing their health and health care needs, even while living within structures that harm them. It has been our experience that it is impossible to fully illuminate how the field is damaging the physical and mental health of people it is looking to support without direct partnership. Forming long-term partnerships based on genuine mutuality and accountability is critical for achieving health equity.

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