

# Health Equity Column: Advancing Health Equity Through the Political Determinants of Health and the Health Equity Tracker

Jenné Johns, MPH



In honor of Black History Month, it is my honor to introduce readers of Neonatology Today to my colleague and friend, Daniel Dawes, Director of the Satcher Health Leadership Institute. Daniel is the author, innovator, and founder of the Political Determinants of Health, a health equity framework, and has dedicated his career to the one-day elimination of inequities in healthcare. Through our interview, I

welcome readers to learn about a new, innovative, and powerful health equity data tracker that seeks to close racial and ethnic gaps in COVID-19 testing and vaccination tracking, monitoring, reporting, and in the near future, maternal and neonatal health outcomes. As you learn more about the various equity-focused initiatives led by Daniel and leaders at the Satcher Health Leadership Institute, I encourage you to leverage these resources within your respective institutions and to support the closing of racial and ethnic disparities in perinatal and neonatal health outcomes based on the political determinant of health framework.

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## What is your definition of health equity?

Thank you for this opportunity. Equity has been defined broadly to help each individual and each population group realize their optimal health or give them a fair opportunity to reach their full potential. Oftentimes, we see this confusion regarding equality, which is what we have been pushing as a nation for decades. Still, to get to equality, we actually have to achieve equity first. So equity, to me, is giving people what they need when they need it and in the amount that they need to reach their full potential. Whereas, equality is giving everyone the same thing regardless of whether they need it. Therefore, equity is a targeted approach to helping every individual achieve their best health.

In terms of the Political Determinants of Health (PDOH), I can

argue that we haven't been as strategic as we should when it comes to addressing the determinants or drivers of inequities in our society. Many public health researchers have helped us understand, since 1984, that there are multiple intersecting determinants of health. Whether it is environmental or social and behavioral health, I argue that undergirding each of these determinants that we flushed out over time is a political determinant. It is the “causes of the causes” of these inequities. If we really think about it and look at the social determinants, these are structural conditions that we live in, are born into, raised in, work in, and die in. If you think about Black and Brown communities in America, oftentimes, what you see when you're going through these neighborhoods is a major highway cutting right through the neighborhood. You'll also see bus depots being disproportionately located in these communities of color. You may even see toxic waste sites, factories, and other toxic infrastructures that hurt our health. This is what public health researchers have put in context and helped us understand why we may see inequities such as higher asthma rates in Black and Brown children. Now, we've been able to tie it to these structural conditions and social determinants of health as a whole. According to researchers, about 40% impacts our overall health [social determinants of health]. If that's the case and they do play an outsized role in our overall health and well-being, then we need to stop and ask ourselves how did those structural conditions get there in the first place. They didn't just magically appear! It was because of an act of law or policy enacted at all levels of our government that are oftentimes working in concert with one another.

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I realize it's always been because we've been afraid to confront policy and politics that are at the heart of all of this. I've defined the PDOH as the involvement of the systematic process of structuring relationships, distributing resources, and administering power because they operate simultaneously and mutually reinforce one another in ways that will either help us to realize health equity or hinder health equity.

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So, what does that look like? What does structuring relationships look like? We have seen the process, and when you think about redistricting, gerrymandering, distributing resources, we realize how difficult it is to get resources into minority communities, especially in a pandemic. However, we are raising our hands and want to provide testing to communities of color. Still, they have a very difficult time accessing resources because resources are being steered to the same affluent white communities. That was extremely troubling to us. You also see the same disparities when you think about the usage of ventilators for those who found themselves needing that to breathe. We see the same thing happening with vaccines because the equitable distribution of vaccines is not being realized. Cases like these were reported in the Los Angeles Times as a case study. Of all the places that should get equity right, it should be California because they have been leaders in this space. However, we see the same trends in South Los Angeles, where the government is not setting up vaccine sites in those Black and Brown communities.

A case for us to think about is the power structure. Even though we have increased our US Congress's diversity over time, we've not seen an increase in equity-focused policies. All of this to say that I've created this framework called the political determinants of health by looking back at public health frameworks, political science legal and historical lenses to understand what evidence there is, what policies levers have been pushed and pulled to effectuate changes, elevate equity, and what has been tried or tested in terms of hindering health equity in this country. This was my best attempt at putting these together in a framework that folks can use and leverage to create equity in their communities.

**What are your organizational priorities for addressing health and racial equity in neonatal care?**

At the Satcher Health Leadership Institute at Morehouse School of Medicine, we were founded by Dr. David Satcher, the 16th US Surgeon General. He is this gentle giant who really cared deeply about racial equity. He devoted his career and life to pushing this

agenda at all levels in this country and internationally. Dr. David Satcher was never afraid to push the racial equity agenda, and he used his platforms to do just that. We know that there was an attempt in 1990 to create the first Minority Health Bill, which was successful post-reconstruction. It was led by Louis Stokes, Ted Kennedy, and Louis Sullivan, who founded the Morehouse School of Medicine. The bill was called the Disadvantaged Minority Health Improvement Act. This bill, along with Healthy People 2000, stated for the first time in US history that reducing racial and ethnic health disparities was a priority for the federal government. While laudable, it set up this separate and unequal standard based on your race and ethnicity. For example, let's say that the infant mortality rate was at 10% for Blacks, 8% for Hispanics, 3% for Whites, and 4% for Asian Americans. The bill's goals would be to lower the infant mortality rate by 2%, meaning cutting off 2% from every racial group. However, this does not eliminate the disparity. So, Dr. Satcher decided that is unacceptable. As Surgeon General, he wanted to create legislation that will help us to eliminate disparities and implement it in the Healthy People 2010 agenda. This was really bold, and he did receive negative feedback, but he kept pushing this agenda. Once he left public service and returned to the Morehouse School of Medicine, he decided to continue this great work and push for health policy issues that were underrated and treated as secondary priorities or not at all. This prompted him to create the Satcher Health Leadership Institute, which would continue to address these issues that the rest of America was too afraid to at the time.

Now Dr. Satcher has passed the baton on to me and asked what we can do to elevate equity in this country and use it as a foundation to advance and create health equity in communities across the world. Our mission is about creating systemic change at the intersection of policy and equity. This is our niche. We have identified three priority areas to do just that: Mental and Behavioral Health, Health System Transformation, which encompasses maternal and child health, and Political Determinants of Health. We will engage and translate this into success through the development of policies, evaluating various policies, and engaging and working with our community. We are now realizing that health equity is acknowledging that this pandemic is negatively impacting communities of color, especially given our history. We've known that every time a pandemic strikes the United States, it negatively impacts the same group of people who are on the downside of advantage and opportunity. These include racial and ethnic minorities, immigrant communities, people with disabilities, and lower socioeconomic statuses. So, as we were delving deeper into the research and understanding why this is happening and why we have never realized an equitable political response during a pandemic, we pinpointed one that we thought could stem the tide of this, and give Black and Brown folks the chance to survive and thrive moving forward. This could surely be achievable with all of the technological capability and knowledge that we've gained with over 7,000 peer review Journal articles on health disparities.

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So, the idea that we found was that there was always an issue with data, and I argue that data is a major political determinant of health. It has long been an issue, and we've been trying to bolster our data collection reporting processes. However, folks would say, at the time, that you're five or ten years ahead, and then five or ten years pass, and I'm looking back and thinking, well, it's happened, so why don't we have the data? Then, 15 years pass, and it's like are you kidding? When will it ever happen? Is it ever going to happen in our lifetime? This is unacceptable!

You and I, (Jenné Johns) and other colleagues got really concerned that we could not get the data early on during this pandemic. Our hypothesis was that communities of color were going to be disproportionately impacted. Still, without the data and without the evidence, we can't make that case for aligning resources with the greatest need. Then, it dawned on us that we need to create a data tracker, and we need to start tracking health inequities in America. With your organization (Once Upon A Premie, Inc), GOOGLE, Gilead Sciences, The CDC Foundation, HHS, and others, we are creating a comprehensive health equity tracker. We are going to look at the inequities relative to COVID as our first phase and priority. This priority will enable us to look at issues regarding testing, ventilators, accessing hospitals, and getting the vaccine.

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Moving beyond that, we can start to look at comorbidities, maternal child health outcomes, infant mortality, maternal mortality, obesity, HIV/AIDS, lupus, sickle cell anemia, cancers, and how all of these impact communities of color disproportionately. For example, we know that diabetes, heart disease, and asthma disadvantage communities of color. We also want to track mental and behavioral health inequities such as depression, anxiety, addiction, suicidality, and Alzheimer's. We also want to make sure that we keep these issues together because they have been siloed before, especially diseases of the brain, and look at the bigger picture. In addition to that, and to not make this a health disparities or health inequities tracker, we want to overlay the social determinants of health factors on top of it. Once that is in place, we will be working with a group of legal epidemiologists to overlay data regarding the political determinants of health and figure out which of those we should be measuring and monitoring.

For this reason, we have created a health equity task force, which you are a part of (Jenné Johns), to help us think through how we can actually do this because this is a daunting project. I can even see the anxiety being elevated within the group of engineers we have gathered to help overlay all of this data. The amazing part is that this has never been done before, and that is why we are doing it! So, this is why we need it, and this time, we will be going

after the highest hanging fruit. With your help and others' help in your field and arena, we can make sure that we are getting it right, pulling from the right data sources, and finding the best ways to track this information. Once we get this information, we will upload and populate the tracker with the information that will be democratized. Researchers, policymakers, community leaders, and everyone else will be able to download the data. We also might have a dashboard with our own analysis that folks can pull from so that it's bi-directional.

We've also received a \$40 million grant from the HHS to create a national resiliency. Even though this amount of money is a drop in the bucket when it comes to this work, we will be creating a national COVID-19 resiliency network with it. We have 16 partners from around the country, including Unidos US, the National Hispanic Medical Association, 100 Black Men, the Divine Nine, Black fraternities and sororities, the NAACP, The National Council of Urban Indian Health, Indian Health Service at the US Department of Health and Human Services, CDC, the CDC Foundation, among others. This great group of folks will help us build out something that will apply to those at the grassroots level. The health equity tracker that I just spoke about is geared more towards policy influencers and policymakers trying to leverage the data to change policies or enact new policies. This new resource will be used at the grassroots level to know where to go to get health services, social services, behavioral services, and a COVID test or vaccine. We currently have a group of individuals at the Institute working to make this happen. We are also working with the Healthy Start group out of Saint Petersburg in Tampa, Florida, incubating the PDOH framework for about a year. What we are working on is taking this framework and amplifying it nationally. We have created a Black Health Equity Alliance because all the groups have been disproportionately impacted; black folks in this country have died at a much higher rate than every other group. So, we have been intentional about understanding what is going on within the Black community and working to ensure that they have the facts they need regarding the vaccine and the pandemic, in general. There is a lot of miss information going on right now, including the anti-vax movement. Beyond that, that has caused a lot of confusion. We are trying to correct this as best as we can. As I said, some team members are working now to figure out how we can create this informational pipeline for communities of color, especially Black leaders. Of course, we have the pipeline of information to our Hispanic, Native American groups, and other communities through the NCRN, but we felt it was especially necessary to create one focused on the Black community.

Finally, in addition to that, we have also finished helping create the fourth edition of a Maternal and Child Health textbook and applying what we have been doing at the Institute to that work, and it's pretty exciting! I hope that future professionals in the health space will read it and leverage it to create systemic changes that we need in this country.

**What personal and professional experiences led you to focus on health equity in neonatal care?**

I will say that from an early era, it was the experience I had growing up. I am half Black and half White, and it was always interesting to see that they were really old on the white side of my family. They got into their 90s; however, my family's Black side died rather young and barely making it out of their 60s or even 50s. I have

lost several relatives in their 50s from diabetes, heart disease, and other illnesses. Asthma also runs severely in the Black side of my family, but in my family's white side, they seemed very healthy. Growing up, I always wondered why this was happening, and the response I would get was: it's genetics. We always assumed that the Black side of my family had these particular genes. So, something about it didn't sit well with me, and it kept on gnawing at me. Coupling these experiences with what I saw beyond my family and in the community, I realized the same things were happening to other black communities. One day you'd see Sister such and such looking healthy, and then, a month later, you hear Sister such and such died. So, I started noticing that their life spans were much shorter. They were prematurely dying at higher rates of chronic diseases. This didn't sit very well with me, so one day, I decided that it was a healthcare system fueling these disparities with my own narrow framework.

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I decided that I would become a hospital administrator, and I was going to go in and make sure these hospitals and clinics were treating Black and brown folks with respect and dignity. Much of this stems from what I saw with my grandmother on the Black side of my family, who suffered terribly from these ailments and was treated terribly. This also brings up issues of privilege. My light-skinned privilege versus my grandmother, who was much darker, not as educated, and who may not have spoken as articulately as we can, was one of the brightest people I knew. She was full of wisdom and knowledge from her experiences, and to see people mistreat her and think she was just some ignorant old woman rubbed me the wrong way. These experiences convinced me that the issue was the healthcare system. I was saying that black people could not go in and be treated properly with respect and dignity. In addition to that, many of my family members were locked out of employment opportunities where the bulk of us get our insurance. So, my family had to work in jobs that provided commission, and that's how they sustained our family. However, as a result, they do not have access to health insurance coverage, which then made them scared because they couldn't afford healthcare. This is really problematic from a preventive services perspective, which led me to speak to the leadership at a safety net hospital in South Florida. I said to the CEO that I would love to gain an understanding of their system. In turn, they wanted to build a hospital and leverage me as someone in support of this new establishment, as someone from the community. He allowed me to do this and set me up with the Director of Community Relations. The next thing they did was put me in the emergency department to rotate. When I got there, I saw this Black woman from

Haiti and only spoke Haitian Creole, and was having a hard time being understood by the staff. I observed a white triage nurse from the Midwest trying to talk to her. Still, the communication barrier was immense, so she called over to another black nurse. I noticed the black nurse and the patient talked for a minute or two before the nurse came right back over to the triage nurse, and then an argument ensued. The black nurse explained that she did not understand the patient because she is not from Haiti; she was from Jamaica, where they speak English! You could see the frustration on her face. I understood this because growing up in this melting pot of different cultures and languages, I had picked up on accents very easily. At the time, I did judge the triage nurse from the Midwest because I didn't understand how she did not know that your own nurse was from a different country that spoke a different language than the patient. At that moment, it really dawned on me just how difficult it can be to provide health services in a very diverse society but also how challenging, frustrating, and frightening it can be for individuals trying to see care in our health system.

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I figured that it could not just be happening here, but rather it was happening everywhere, and so I started doing my own research. I wanted to know if anybody else was looking at this issue, and there was. This is when I saw the effort by Dr. Sacher on his racial disparities initiative, and I said, “this guy gets it!” I had never heard of Dr. Sacher before this, but I thought it was really interesting. Then, over the years, I saw that the Institute of Medicine published a report on, “Unequal Treatment”, and the AHRQ did a, “National Health Care Disparities Report”. I thought the people were finally starting to get it! I wanted to find a health system that would allow me to implement these new ideas. So, I started reaching out to other health systems in Florida. There was one system in Orlando that had a leadership development program. So, I went there, and I said I wanted to work with them on a new project. The majority of the leaders, who are white, were uncomfortable with my approach and almost offended. Although I didn't say they were discriminating, I showed them reports that served as evidence of rampant disparities in our societies and in healthcare, particularly. It was then that I connected with a Vietnamese American who is sensitive to the issue and managed the leadership development program who told me that I needed to adopt their vocabulary [hospital leadership] and state my arguments in a way that would resonate with them. So, I put my more conservative head on to think using the economic argument. Finally, I convinced the leadership, but they did put me on a short leash to implement these new ideas. I created a cultural competency toolkit that we used to scale-up to the other hospitals affiliated with them. During this experience, I received pushback from the lawyers, and I realized they were very annoying people to work with. I also didn't realize how much power they had to stop this kind of work. I thought it was frustrating because it didn't make sense that the law wanted to prevent me

from implementing programs that would strive to eliminate disparities. This is what pushed me to go to law school instead of seeking an MBA or MPA. I thought I needed to immerse myself in these laws to learn what is on the books to use that and push back on any lawyer who tries this foolishness again with me in the future!

While in law school, a friend told me about this great fellowship opportunity with the Congressional Black Caucus. He said that I have been talking about disparities for as long as he knew me. Although I had no intention of ever going to DC, I found myself heading there and getting to work on these policies. I was born in Lincoln, Nebraska, and raised there until my family moved to Miami, FL. I figured that after law school, I would head back to Florida, but in DC, I got to work on the new ideas I learned there and have been wanting to implement. While in DC, I worked on something near and dear to my heart now, the Affordable Care Act. I worked with an incredible group of people from 300 national organizations representing virtually every stakeholder in this country. We spoke about maternal and child health and data collection, which were major priorities for us. Sixty two provisions got into the law, and we fought to get them in and keep them in the bill. Although some were struck out right before it was voted on, we fought to make sure that they were implemented and enforced. What motivates me now is knowing that although the forces of racism can be such an abstract notion, I've been given the privilege to be able to go back and study those events and opportunities that health equity leaders had in the past to realize more equity-focused policies. Although there is a dearth of them, how did you manage to get them on the books, and why is there only a dearth of policies focused on health equity? My work allowed me to work with congresswoman Donna Christiansen, Congress, and Louis Stokes, one of the 13 original founders of the Congressional Black Caucus, and Ted Kennedy, who were all major health equity leaders. While I worked with them, I kept on asking what had been tried and tested in the past, but many of them could not recall or could only tell me what they remembered from their tenure as lawmakers. I thought this is very concerning because there was no benchmark from which we could use. There was no guidance to help us understand some of the strategies and tactics that have been employed to undermine these health equity efforts in the past. I wondered how they overcame them? This led me to a journey of researching even more and creating my first book, "150 Years Of Obamacare" <https://www.danieledawes.com/>, to tell our people and understand why it is important to understand our history, power structures, and how to leverage them, and affect changes for our communities. This, then, led me to work on the, "Political Determinants of Health" <https://www.danieledawes.com/> book.

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**What is your call to action for the industry as we seek to eliminate health and racial inequities in neonatal care?**

I know that this health equity work is disruptive and exhausting.

In the past, every time we were making progress, the opposition would ramp up their efforts. Health equity leaders would lose the political will to keep pushing back. We know that the pendulum swings every so often. Unfortunately, we have seen the pendulum swing even harder from the opposition. It has unraveled many of the gains that have taken decades to realize. I just hope that we will continue to muster the energy to continually engage. If we don't, we could lose this opportunity to advance health equity. I've also started to think about how people cry to return to normal. Still, I don't want to get back to normal because what does normal mean pre-pandemic or pre-Trump? The status quo has kept, fueled, and driven the same results that we are now experiencing today. We need to leverage the crisis that we're in and understand that rarely do we have an opportunity to affect systemic change in this country except during a crisis that affects every individual and attracts attention from the entire nation. However, we know that the window of opportunity always closes, and it will close. Still, we can leverage the moment that we have to try to move the needle forward. I will end now with a quote from Dr. Sacher, "what we need now more than ever are leaders who care enough." You have to care enough about these communities and the issues that stem from them. You have to put your heart and soul into it because it's exhausting, and people who do not care can easily give up. You have to know enough about the drivers of inequities and study what created the mess that we're in today that continues to perpetuate and exacerbate health problems and health inequities. You've got to persevere, and it is so easy to give up, but this is not a movement for the faint of heart. This is a movement for folks to believe that time is so precious and life is so short. We've got to persevere until the job is done and be courageous. I'll end with the fact that we need courageous leadership because we have witnessed over the last year, especially during this quadruple pandemic, that the forces of racism, sexism, homophobia, etc. work overtime and do not sleep, so we need to be courageous, push-back back, and say enough is enough. We do not want to return to the status quo. We do not want to return to a society that discriminates against black and brown folks unfairly. It is unjustified, and so if we are truly now moving from equity to justice, it means we're going to have to take all four of those elements to heart. I'll leave by saying that our healthcare leaders have tremendous privilege in power. Many of their predecessors created the mess that we are in today, so it is incumbent upon them to use that power and privilege to push back and change things to chip away at these concretized inequities in our society.

To learn more about the Health Equity Tracker at Satcher Health Leadership Institute, please visit: <https://satcherinstitute.org/>

#### References:

1. <https://www.danieledawes.com/>
2. <https://satcherinstitute.org/>

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**About the Author: Daniel E. Dawes, J.D.:**



Daniel E. Dawes, J.D., a widely respected scholar, researcher, educator, and leader in the health equity, health reform, and mental health movements, is director of the Satcher Health Leadership Institute at Morehouse School of Medicine and a professor of health law, policy, and management. He is the co-founder of the Health Equity Leadership and Exchange Network (HELEN), a nationwide network of governmental and non-governmental leaders, researchers, and scholars focused on bolstering leadership and the exchange of research, information, and solutions to advance evidence-based health equity-focused policies and programs.

Dawes's research focuses on the drivers of health inequities among under-resourced, vulnerable, and marginalized communities and is the pioneer of a new approach to examining inequities, the political determinants of health. He brings a forward-thinking, inclusive, and multidisciplinary approach to health policy, authoring two groundbreaking books, *150 Years of ObamaCare* and *The Political Determinants of Health*, published by Johns Hopkins University Press.

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Jenné Johns, MPH is President of Once Upon A Premie, Founder of Once Upon A Premie Academy, mother of a micropreemie, author, speaker, advocate, and national senior health equity leader. Once Upon A Premie is a non-profit organization with a two-part mission: 1.) to donate Once Upon A Premie books to NICU families in under resourced communities, and 2.) lead virtual health and racial ethnic training programs and solutions to the neonatal and perinatal community through the Once Upon A Premie Academy. Jenné provides speaking, strategic planning and consultation services for fortune 500 companies focused on preemie parent needs from a cultural lens and reading as a tool for growth, development, and bonding. Jenné is also a national senior health equity thought leader and has led solutions-oriented health equity and quality improvement portfolios for the nations' largest health insurance and managed care companies.