



National Health Law Program's Equity Stance

Vision:

The National Health Law Program (NHeLP) believes that health equity is achieved when a person's characteristics and circumstances — including race and ethnicity, sex, gender identity, sexual orientation, age, income, class, disability, health, immigration status, nationality, religious beliefs, language proficiency, or geographic location — do not predict their health outcomes. We also believe that these characteristics and circumstances should not limit people's experience in the world or in our organization. Our equity vision is one of collective liberation, where individuals of all identities and backgrounds are valued and where we can all achieve our full potential as individuals and as a society, as well as live with dignity. NHeLP works towards a society where everyone can achieve an optimal state of well-being and where everyone has a fundamental right to their highest attainable standard of health.

Why we do this work:

Our work prioritizes enforcing and advancing health rights for low-income people, including the right to high-quality and comprehensive health coverage and care. We focus on this work because we firmly believe that poverty is not a personal shortcoming. Rather, the extreme income and wealth inequality in our country is a collective failure resulting from structural racism and political and economic systems designed to produce and reproduce disparities in our society. Our responsibility is to build systems that eliminate discriminatory barriers to health, disrupt harmful stereotypes, promote health equity, and support people who may be experiencing difficult circumstances.

We acknowledge the origins of structural racism and discrimination in the United States, starting with the genocide of Indigenous peoples and the enslavement of African peoples, as well as the historical and ongoing U.S. policies that displace, oppress, and control non-dominant populations. Policymakers in the U.S. have too often explicitly and implicitly put in place social policies and practices, for example, by funding public hospitals that segregated patients on the basis of their

race. After Medicaid was enacted in 1965, there was almost no effort by the federal government or the states to ensure that Medicaid-funded providers, such as physicians and nursing homes, complied with the 1964 civil rights law that prohibited them, as recipients of federal Medicaid funds, from discriminating on the basis of race, color, or national origin.

We recognize that discriminatory barriers still exist throughout our health care system. Overt discrimination remains prevalent, but does not explain the full range of health disparities. Implicit bias -- unconscious attitudes or stereotypes that affect our actions and decisions -- and structural racism and discrimination reproduce disparate outcomes. Structural discrimination refers to the systems, public policies, institutional practices, cultural representations, and other norms that generate and reinforce inequities among specific groups, such as racial and ethnic groups.

Together, these various forms of discrimination prevent health equity. Some specific examples are below. These examples are not comprehensive. We also recognize the role that intersectionality plays: various forms of discrimination intersect people's multiple identities in ways that affect their health and wellbeing, often amplifying negative outcomes. We firmly believe that achieving our collective vision of health equity requires naming and confronting harmful systems and practices that are rooted in overt, implicit, and structural discrimination.

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- ▲ Structural and overt racism has led to residential segregation of Black people in the United States with lasting negative health consequences, including increased exposure to air pollutants and contaminated drinking water, increased risk of certain health conditions, reduced access to health care, and decreased longevity. The increased exposure to lead in housing among communities of color is one particularly disturbing example of how residential segregation disproportionately affects Black children, who are three times more likely than white children to experience elevated blood-lead levels.
 - ▲ Medicaid eligibility is limited to citizens and certain narrow categories of immigrants. While not explicitly based on nationality, these limits reflect structural racism. Specifically, they reinforce disparities in health and healthcare access across different racial and ethnic groups by building upon the history of racism in our immigration laws. From the beginning, our immigration laws have relied on explicit racial definitions and have sought to exclude or disadvantage immigrants of colors and other non-dominant groups. For example, the Naturalization Act of 1790

limited immigration to “free Whites;” the Chinese Exclusion Act of 1882 banned immigration to the U.S. from China; the Immigration Act of 1924 sharply limited immigration by Jewish immigrants from Southern and Eastern Europe and all individuals from most Asian countries; and the “Bracero Program” granted temporary visas to immigrant laborers from Mexico and Guam in the 1940s to 1960s but offered no path to residency or citizenship. The long history of racialized animus against immigrants of color has resulted in today’s reality: immigrant communities are significantly less likely to have access to health care, resulting in worse health outcomes for immigrants and their descendants. Medicaid’s immigration restrictions are one salient example of these barriers to health equity.

- ▲ As a result of racial and gender discrimination, the United States has the highest maternal mortality and morbidity in the developed world. Black and Indigenous women are more likely to die or experience serious health complications from childbirth than whites. These disparities persist irrespective of income. For instance, a study in New York City found that Black, college educated-women who gave birth in local hospitals were more likely to suffer life-threatening complications than non-Black women with less than a high school education. Such disparities demonstrate that structural racism as well as implicit bias still play a significant role in health care access. Systemic barriers also exist in other aspects of sexual and reproductive health care like abortion and family planning, reinforcing sexual and reproductive health stigma and limiting access.
- ▲ Individuals with disabilities, substance use disorders, and chronic conditions also experience numerous barriers to achieving health equity. Disability discrimination shows up in many places including the prevalence of physical and equipment barriers; obstacles to accessing employment; reduced availability of medical providers, particularly in rural communities; inappropriate application of criminal penalties and collateral consequences; restrictions on autonomy and freedoms; and difficulty accessing comprehensive health coverage. As the population ages and the number of people with disabilities increases, shortages of qualified caregivers and limited access to community-based, long-term care services threaten people with disabilities’ right to live independently in integrated home and community-based settings.
- ▲ Structural and overt discrimination against Lesbian Gay Bisexual Transgender Queer (LGBTQ) individuals, including ongoing discrimination in coverage and access to health care services, creates

health disparities. For instance, LGBTQ people have higher rates of certain chronic conditions and mental illnesses such as depression. Rates of attempted suicide are also higher among LGBTQ people, especially transgender individuals. Currently, several state Medicaid programs improperly deny coverage for gender-affirming services, leaving low-income individuals without access to these services. Gay and bisexual men and transgender individuals, especially those who are also Black and Latinx, are disproportionately affected by the HIV epidemic. But gay and bisexual men in the U.S. are also more likely to receive poor treatment from medical professionals due to their sexual orientation and are often uncomfortable discussing their sexual behavior with health care providers due to discrimination and bias.

- ▲ Individuals who have a limited ability to read, speak, write, or understand English experience health disparities because they encounter more challenges accessing information they can understand. In the U.S., many Latinx and Asian-Americans speak a language other than English, and may not be able to access health care information in their preferred language. In addition, people who are Deaf or hard of hearing and communicate using American Sign Language (ASL); who have speech impairments; or who are blind or have visual impairments often face challenges accessing health care information. Overall, people who encounter communication barriers are less satisfied with their care, have less access to and use less health care, and face higher costs and lower quality of care.
- ▲ Access to needed health care should never depend on an individual's religious beliefs or lack thereof. Individuals who practice non-dominant religions are often unable to access care consistent with their beliefs without delay. For instance, even though effective treatment alternatives to blood transfusions exist, individuals ascribing to certain faiths often face barriers accessing these services, including Jehovah's Witnesses. In addition, Muslims in the U.S. face overt discrimination and implicit bias in many health care settings; many of them report feeling ignored and rejected to the detriment of their health. Moreover, individuals should not be denied, delayed, or deterred from needed care because they do not hold a particular belief, or because the care they seek is inconsistent with other faiths. For example, individuals with substance use disorders are often subject to faith-based treatment programs that are not evidence-based and may in fact be counterproductive to the individual's health and wellbeing.

Goal:

Every member of our staff defends the fundamental right of all individuals to health. Staff in every role strive to approach their work—internal and external—with an equity lens.

Our goal is to continuously examine the health care system and to advocate for health laws and policies that counteract structural barriers, institutional power dynamics, and examples of overt discrimination and implicit bias that create health inequity. We will prioritize work that breaks down those barriers and advances and enforces health rights. We are committed to expanding and continuing our advocacy, education, and litigation work as a means towards health equity. We seek to learn from, join efforts, and build relationships with partner organizations to lead the fight to achieve health equity.

We also recognize that achieving our health equity vision requires us to embed the principles of diversity, equity, and inclusion in our day-to-day lives and in our organization. We seek to create an inclusive, welcoming environment where staff members with different experiences feel valued and their ideas elevated. We are building—and holding ourselves accountable for maintaining—a work community where every staff member can thrive and where diverse perspectives are voiced, heard, discussed, and incorporated as we collaborate to make decisions that advance our collective equity vision. We realize that advancing our health equity vision requires a coordinated and concerted effort where every staff member plays a key and valued role. We believe that a more diverse staff yields more well-rounded and effective decisions and we seek to learn from one another and grow together in order to do our best work. Being a part of our NHeLP community requires more than just conceptual agreement with this vision; it requires our commitment to proactively take action and make change.

Please see the National Health Law Program's website (www.healthlaw.org) for more information on our [fifty-year history](#) and our [on-going efforts](#) to protect and advance the health care rights of low-income and underserved individuals.