
October 2015

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Ruth T. Perot

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Recommended Citation

Ruth T. Perot, *The Future of Health in Communities of Color Out of Many, One a Multicultural Action Plan to Achieve Health Parity*, 10 DePaul J. Health Care L. 107 (2006)

Available at: <https://via.library.depaul.edu/jhcl/vol10/iss1/9>

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**THE FUTURE OF HEALTH IN COMMUNITIES OF COLOR
OUT OF MANY, ONE
A MULTICULTURAL ACTION PLAN TO ACHIEVE HEALTH
PARITY**

Ruth T. Perot

I. INTRODUCTION*

Winds of change are stirring and racial and ethnic health disparities have begun to appear on radar screens where policy decisions are made. For the first time ever, government and community leaders have set a date – 2010 – to reach a goal of parity in health.^{1/} The landmark study issued in 2002 by the Institute of Medicine, *Unequal Treatment/Confronting Racial and Ethnic Disparities in Health Care*,^{2/} presents a comparable call for urgent action. Reports released recently by the Agency for Healthcare Research and Quality^{3/} echo similar messages. Racial and ethnic disparities in health persist, their existence is beyond dispute, and they warrant multi-faceted corrective efforts.

African Americans, American Indians and Alaska Natives, Asian Americans, Hispanic/Latino Americans and Native Hawaiians and other Pacific Islanders know their communities – their struggles, hopes, and dreams. Gaps in health status between themselves and the total population have continued for decades, if not for hundreds of years. Representatives of these communities strongly endorse the Institute of Medicine's finding that negative health outcomes associated with these disparities are unacceptable. These representatives know first-hand that living with the *status quo* means dying from preventable causes too soon. For them, inaction must not be an option.

People of color are attaining majority status in states and communities across the nation, and according to the U.S. census, now comprise a third of the U.S. population. New faces and cultures are appearing in communities where they have never been before. Recognition is growing, moreover, that providing *quality* care means responding to racial and ethnic diversity with sensitivity and competence. Further, as cost-effectiveness becomes the watchword, funders are signaling their preference for working coalitions, partnerships, and networks to maximize efforts to tackle common goals.

Underserved racial and ethnic minority groups have responded to these changing realities. They are organizing in neighborhoods, city-wide, across counties, state-wide, and nationally. Tackling health disparities and

expanding access to health care have become common targets for advocacy. People of color are voicing increased demands for services that meet their cultural and language needs. In addition, leaders from communities of color have increasingly embraced collaboration. Some have focused on harmonizing different voices within their communities. Others have joined broad-based coalitions led by non-minority agencies. Still, other people of color have assumed leadership of community networks, in which multiple racial and ethnic groups play a role.

People from diverse communities of color are also turning to *each other* as they focus on shared challenges and the need to mobilize for change. The result is coalitions among communities of color (CACCs.) These coalitions are multicultural, multi-racial, and multi-ethnic. These networks may also be described as racial and ethnic minority coalitions. In these coalitions, persons from diverse groups experiencing disparities provide leadership. These leaders also predominate among coalition participants. Although representatives from non-racial and ethnic minority groups and individuals may be involved, it is clear that they are invited to participate in the CACC in a *supportive*, rather than a leadership role.

Builders of these coalitions have to know the basics. Coalitions of all kinds operate best if certain rules are observed. Demonstrating one's ability to respect and honor other cultures is a "must" in coalition activities of all kinds. Certain communications and group management principles apply no matter who is involved.

At the same time, CACCs are different from other coalitions for many reasons, so experiences with other non-CACC networks do not necessarily transfer. One clear distinction, for example, is this: members of racial and ethnic minority groups share a bond that is linked to their proud histories and common experiences in the U.S. This sharing has given rise to assets for relationship- and coalition-building that are not always valued or even recognized in other kinds of networks. Such coalitions also commonly seek to hasten the day when health parity, equity and wellness become realities in every community.

II. OUT OF MANY, ONE

This presentation describes the coalition-building journey of Out of Many, One (OMO,) a national multi-ethnic/racial network that is committed to the attainment of health parity, equity and justice for all who reside in the U.S. and territories. OMO was created by the five principal communities of color that have experienced disparities. This movement

began in 1999, when Summit Health Institute for Research and Education, Inc. (SHIRE) received a grant from the Office of Minority Health (OMH), U.S. Department of Health and Human Services, to plan and convene a national multicultural conference to advance a Campaign to Eliminate Racial and Ethnic Disparities (CERED). Planning was initiated by a coalition comprising the Asian and Pacific Islander American Health Forum, the Latino Council on Alcohol and Tobacco, the National Indian Council on Aging, Papa Ola Lokahi, and SHIRE. These organizations represent the five primary underserved and uninsured racial and ethnic minorities, which are also identified by the Office of Management and Budget as targeted minority groups in government data gathering and reporting initiatives.

In November 2000, history was made when these five organizations were joined by 75 other organizations, 15 each from Native Hawaiian/other Pacific Islander, Latino/Hispanic, Asian, American Indian/Alaska Native, and African American communities, in a national multicultural working summit. Their task, to create a united health parity agenda, was accomplished in less than two days. Intense and unprecedented multicultural participation and collaboration resulted in the development of a ground-breaking document, *A Multicultural Action Plan to Achieve Health Parity*. This plan was published in its final form by January 31, 2001 and it provides strategic directions for achieving health parity and equal access for communities of color within the next decade (See www.outofmany1.org).

Even more significant, organizations participating in the planning and creative process decided to continue to work together on an ongoing basis under the umbrella of Out of Many, One. OMO emerged and has thrived for five years with the invaluable support and leadership of Hardy Spoehr, the Papa Ola Lokahi staff in Hawaii, and many other organizations. Through our collective efforts, OMO has become established as an advocacy presence in public and private venues and at national and community levels.

OMO's principal goal is to help empower racial and ethnic communities, individually and collectively; to provide leadership to those working toward parity and equity in health; and to promote the attainment of optimal health in all communities. OMO's effective functioning as a multiethnic/racial coalition has also provided guidance for the publication of a handbook on coalition-building, scheduled to be released by the Office of Minority Health in early summer 2005.

III. HIGHLIGHTS OF THE OMO MULTICULTURAL ACTION PLAN

OMO's *Multicultural Action Plan to Achieve Health Parity* makes several important contributions to those who would seek to reshape the future of health in communities of color.

First, the plan articulates a compelling *vision*:

We believe that the attainment of the highest level of health and quality of life is a basic human and civil right. We embrace a vision of healthy communities that respects diverse cultural and spiritual values and empowers all people – individuals and families – in a loving, holistic, healing and compassionate manner. We are committed to develop diverse leadership to build healthy environments and a prosperous, just and humane society.....

Second, the plan places emphasis on *health parity*, a positive concept, which establishes that the parity sought is that consistent with the best level of health achieved by *any* group.

Third, the plan reflects its creators' honest appraisal of the *assets* and *barriers* to working together that must be acknowledged when representatives from different racial and ethnic groups come to the table. Examples of *assets* include:

- Our shared historical bond of commitment to achieve social, racial, economic, environmental justice;
- Our diverse cultural richness of families and communities, spiritual vision, traditions and values;
- Our rapidly growing populations, becoming an emerging majority as a whole; and
- The existence of successful, collaborative, respectful, multicultural networks.

Examples of *barriers* include:

- Lack of access to benefits, infrastructure, capacity;
- Lack of funds and resources;
- Competition for funds;
- Limited number of political advocates; and

- Colonial mentality, internalized/lateralized oppression among ourselves.

Finally, the *Multicultural Action Plan* sets forth a platform with six major goals: 1) achieve universal health care, 2) establish comprehensive health systems, 3) improve cultural, institutional, and educational development, 4) improve research and data, 5) achieve empowerment, and 6) develop community leadership. Each goal is accompanied by specific objectives that have been revisited on a periodic basis as guidance for OMO's strategic planning process.

A review of specific objectives associated with these goals reveals several key points. First, it is clear that OMO is prepared to think and act globally as well as locally. While many of the proposed objectives are community-specific, many call for broad advocacy efforts that impact data and allocation issues and systems of care at the national level. Second, there is a clear emphasis on individual and community self-determination, in such areas as community leadership, consumer rights, and patient care. Third, the collection, reporting, and dissemination of data by ethnicity, race, primary language, and other indicators are seen as essential requirements if health parity is to be attained. Fourth, there is great respect for complementary cultural healing practices and other approaches that recognize the importance of broader, more holistic views of communities of color.

IV. CONCLUSION

I have shared the highlights of a journey of discovery that has widened horizons and deepened relationships among people of color in extraordinary ways. As important, the groundwork has been laid for the creation of a national partnership in which Native Hawaiians, along with other communities of color, are playing a significant leadership role. Out of Many, One will continue its efforts to brighten the future of health in people of color communities -- by thinking strategically, acting effectively, and working collaboratively and harmoniously. We invite your involvement and support as we work to attain the vision of a just and healthy nation and world.

REFERENCES

1. Healthy People 2010 is a comprehensive set of disease prevention and health promotion objectives for the nation to achieve over the first decade of the new century. Created by scientists both inside and outside the federal government, this initiative identifies a wide range of public health priorities and measurable objectives. Its overarching goals are: 1) increase quality and years of healthy life; and 2) eliminate health disparities. This program is administered by the Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services.
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* The *Introduction* was adapted from *Building Coalitions among Communities of Color/A Multicultural Approach*, authored by Summit Health Institute for Research and Education, Inc. in collaboration with Out of Many, One, Cooperative Agreement #US2MP98011-05, Office of Minority Health, U.S. Department of Health and Human Services.