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Authors

Adler, Shelley
Chao, Maria

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Integrative Health Equity: Definition, Principles, Strategies, and Reflections

Maria T Chao, DrPH, MPA[1,2] and Shelley R Adler, PhD[1,3]

Abstract

In this viewpoint, we define integrative health equity as optimal health for all through a whole-person approach that explicitly recognizes cultural, social, and structural determinants of health. We describe seven guiding principles, along with organizational goals, strategies, and reflections to advance integrative health equity.

Keywords

integrative medicine, health equity, health disparities

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Introduction

George Floyd's murder prompted widespread outrage at the injustice of anti-Black police violence and a subsequent outpouring of support for the Black Lives Matter movement across the nation and across all sectors of society. Members of numerous health professions, including the field of integrative health,[1] issued statements calling for action to address the racism pervasive in healthcare. Three years later, support for anti-racism efforts has declined precipitously and public outcries for action are no longer as prominent. Yet, the work to achieve justice and equity continues. How do we sustain momentum for change beyond the immediate aftermath of an acute incident? What can we as integrative medicine professionals contribute to advancing anti-racism and equity?

In a 2018 essay, we shared our conviction that the field of integrative health – a healthcare paradigm predicated on medical pluralism and diverse healing practices – has a unique role and responsibility in promoting health justice. We advocated for a three-pronged approach: leveraging integrative medicine to reduce health inequities; promoting an integrative medicine culture that upholds the values of diversity, equity, and inclusion; and addressing intrapersonal attitudes, beliefs, and behaviors that perpetuate bias and discrimination.[2] Here, we propose a definition and principles for integrative health equity to guide our collective work to proactively address social inequities. We also share strategies and reflections from our organizational efforts to advance integrative health equity. We draw from standard definitions of health equity,[3] established principles of integrative health,[4,5] and our experiences as equity-focused integrative health professionals in academic medicine. Our purpose is to actuate structural change in our field through ongoing dialogue and sustained efforts.

Definition and Principles of Integrative Health Equity

We define *integrative health equity* as "optimal health for all through a whole-person approach that explicitly recognizes cultural, social, and structural determinants of health." We distinguish integrative health equity from the overlapping and related concepts of "diversity, equity, and inclusion." We see the former as an ultimate vision for our field, while the latter

[1]Osher Center for Integrative Health, UCSF, San Francisco, CA, USA
[2]Department of Medicine, UCSF, San Francisco, CA, USA
[3]Department of Family and Community Medicine, UCSF, San Francisco, CA, USA

Corresponding Author:
Maria T Chao, DrPH, MPA, Osher Center for Integrative Health, University of California San Francisco, San Francisco, CA 94143, USA.
Email: Maria.Chao@ucsf.edu

refers to societal values and programmatic strategies to manifest those values. Efforts to link social justice, public health, and integrative medicine are not new. The Black Panthers' Free Breakfast for School Children program and provision of free community acupuncture are historical examples[6]; the ongoing work of Integrative Medicine for the Underserved, the People's Organization of Community Acupuncture, and Freedom Community Clinic are contemporary ones.[7-9] Our use of the term *integrative health equity* is intended to capture the vision and the growing momentum of this collective work. Seven guiding principles for advancing integrative health equity include:

1. Everyone has the right to attain their highest level of health and well-being.
2. Our collective future depends on all people in all communities having an equitable opportunity for optimal wellness, including access to affordable integrative healthcare.
3. Integrative health clinicians, educators, and researchers can make distinct contributions to reducing health inequities. Addressing structural and social determinants of health is firmly within the purview of integrative health professionals.
4. Healing traditions are rooted in contemporary and historical international cultures whose contributions to the field of integrative health must be acknowledged and respected. Without this recognition, we risk decontextualizing cultural health practices and causing harm through exploitation and inappropriate application.
5. Successful integrative health equity efforts center the members of society who are most directly and negatively impacted by social injustice, including racial and economic inequality, lack of access to quality healthcare, underrepresentation, and marginalization. We should focus first on people with the greatest need.
6. Achieving integrative health equity requires consistent, ongoing efforts to ensure that gains endure and that improvements are not lost to persisting and opposing healthcare and societal forces. Long-term sustainability requires an appropriately trained and qualified workforce.
7. The complex problem of health injustice requires a complex (multi-pronged, multi-faceted) solution. Although the resolution is long overdue, we must take the time to make evidence-informed changes that are maximally impactful and transformative.

Goals and Strategies to Promote Integrative Health Equity

To translate integrative health equity (IHE) principles into meaningful actions, we developed organizational goals and strategies for the UCSF Osher Center for Integrative Health (OCIH). Our work has been guided by resources on anti-racist and equity-focused organizational change,[10,11] and includes three cyclical phases: (1) *Identify and assess*. We sought input from all OCIH members on priorities, strengths, and potential challenges for IHE work. (2) *Develop program-specific and center-wide plans*. Building on information gathered in phase 1, we developed goals and strategies for IHE work at both program and center levels. (3) *Implement and evaluate.* As phase 2 plans are implemented, we regularly evaluate progress to ensure accountability and also identify opportunities to course correct. While some tactics are applicable to diversity, equity, and inclusion (DEI) work more broadly, we highlight a few concrete examples of our approach to sustain a focus on IHE in an academic medical center.

1. *Embed IHE and DEI principles throughout the organization*. Equity should be upheld as a shared responsibility throughout our work, just as principles of quality and safety are part of all aspects of healthcare delivery. To promote this work as an organizational priority, we launched the Integrative Health Equity Initiative to consolidate our efforts and foster synergy across programs and projects (see Figure 1).
2. *Foster an inclusive climate that supports ongoing conversations about and solutions for DEI challenges* impacting faculty, learners, and staff (e.g., bias and microaggressions) and related to tensions particular to integrative medicine (e.g., cultural appropriation). We established a diversity, equity, and inclusion working group with regular, bimonthly meetings. The working group supports interactions between members of the center across programs and across job positions. Meeting topics fall into one of three series: Deep Dives, an opportunity for in-depth information or trainings on specific DEI topics; Uplift, a showcase of current Osher Center work on IHE; and Brave Conversations, a forum to discuss DEI challenges and potentially uncomfortable topics. A component of Brave Conversations, "Everyday -isms," is a format to share examples of daily micro-/macro-aggressions that are experienced by center members, to raise our collective awareness, and to practice skillful responses.
3. *Build infrastructure to support and sustain DEI within integrative health*. Structural change, including financial resources, is needed for meaningful progress to redress racism and inequities embedded in academic medicine.[12] We established a leadership position with paid effort for an Associate Director for Health Equity and Diversity. The incumbent is charged with promoting a culture of DEI across the center; improving DEI competencies among faculty,

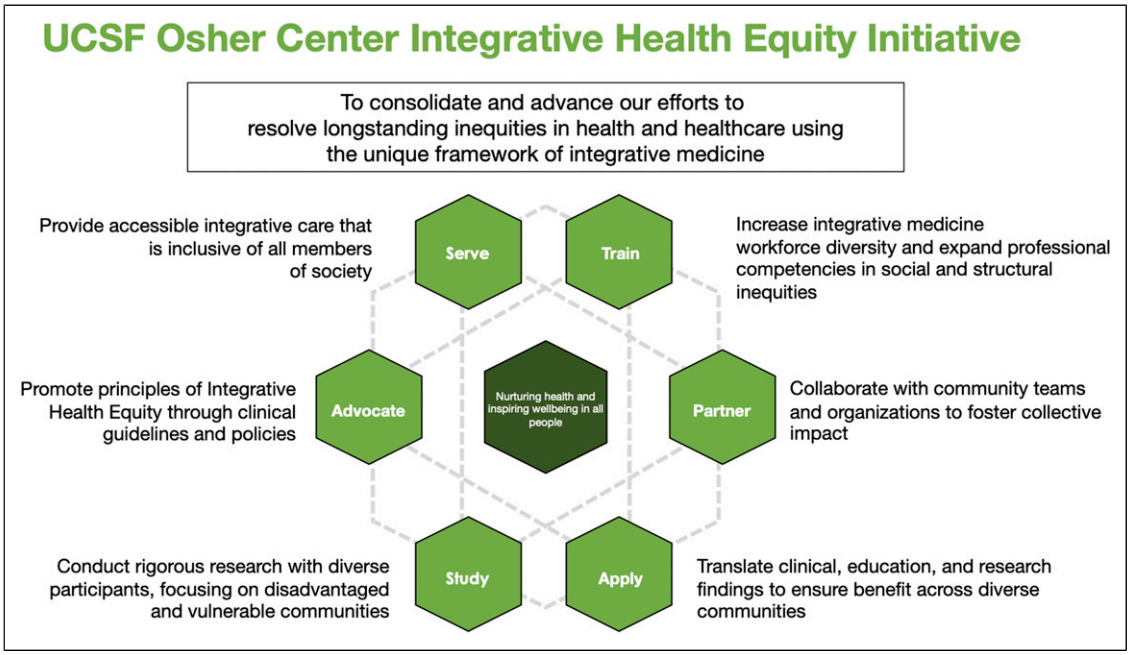

Figure 1. Integrative Health Equity Initiative. Six substantive action areas form a matrix of interconnectivity to enhance and accelerate progress.

staff, and trainees; increasing awareness and fostering dialogue about equity and social determinants of health; applying a lens of social justice and health equity to our work; promoting inclusion and diversity in our faculty and staff; and serving as a liaison between the Osher Center, broader UCSF initiatives, and external organizations involved in related efforts to advance equity. As the number of DEI-related projects has increased over time, dedicated administrative and program staff have been critical for successful implementation.

4. *Representation matters*. While diversity is not the end goal in and of itself, at a minimum integrative health faculty, staff, and trainees should reflect population demographics. This standard extends to patients, research participants, and other groups with whom we work. Towards this goal, we use a holistic review process for selecting new trainees, as well as for new faculty and staff hires. For each of our speaker series (e.g., grand rounds and research seminars), health equity and diverse representation among speakers are ongoing priorities. We have also developed tracking systems with benchmarks to improve representation of participants in integrative medicine research. Additionally, in an effort to expand our expertise in IHE, we have posted new faculty and staff positions as part of a cluster hire to attract applicants with shared interests and demonstrated work in health equity as it relates to clinical practice, education, or research.
5. *Define programmatic objectives to advance IHE through clinical care, education, and research*. Our clinical efforts include developing sustainable models of delivery to improve access to integrative medicine, such as integrative group medical visits and a dedicated philanthropic fund to subsidize integrative care. Our education program includes a training fellowship to build capacity and increase diversity of the clinical and research workforce to advance IHE. Our research program includes studies to address disparities through studies of integrative health using culturally sensitive, strengths-based approaches and multilevel, multimodal interventions.

We recognize that specific local contexts—including stage of development, organizational readiness, and resources—must be considered for appropriate implementation. Equity frameworks and resources for organizational change can be adapted to develop a course of action,[10,11] beginning with assessing current status; developing context-specific IHE goals; and implementing IHE plans, with ongoing evaluation.

Reflections

As more academics realize that health injustice harms everyone in society, increasing numbers of previously unengaged clinicians, educators, and researchers have pivoted to IHE work without prior experience or commitment. While well-intentioned, this practice can slow or even derail progress. We call this phenomenon of quickly dropping into

established areas of inquiry with insufficient training and limited experience "integrative health equity tourism" (adapting and expanding the definition developed by Lett and colleagues in *Health Equity Tourism: Ravaging the Justice Landscape*).[13] It is essential to continue to center professional expertise and personal experience to avoid one-off, short-term responses to what are likely temporary increases in public interest and resources. Additionally, representation, inclusion, and transparency are just a few of the factors that must be considered in selecting leaders, forming teams, and establishing truly collaborative partnerships to do the work of IHE.

Even in contexts where the imperative of health justice and equity is recognized and endorsed, it is difficult to sustain the broad engagement needed for long-term change. Exhaustion can lead to frustration and disillusionment. On the one hand, we see "equity fatigue," in which academic health professionals—often members of privileged social groups—feel that issues of diversity and inclusion in healthcare are focused on disproportionately or for too long. This is the sentiment behind comments like "Didn't we already cover this?" and "There are so many other things we need to be working on." Significantly, there is another form of frustration and disillusionment felt by integrative health professionals who have persisted in their engagement with health justice work and may themselves be members of underrepresented, marginalized groups: "How much longer before there is meaningful change?" and "There's a lot of lip service paid to DEI, but my life has gotten any better." To contextualize (and anticipate) responses to our center's IHE efforts, we find it helpful to be explicit in locating our work on the path to health justice by naming the phases of evolution in this work.

The global protests of racial injustice that followed the police murder of George Floyd awakened many people to how much change is necessary to move significantly closer to racial equality and justice. This time of crisis was followed by a period of action and introspection, with many people developing hopeful expectations about what could be accomplished by working together toward the common goal of social justice. As hoped-for reform proved to be slow in coming, however, enthusiasm waned and exasperation and exhaustion increased.

We see this cycle as analogous to the "phases of disaster response" models used to illustrate community responses to major emergencies: the impact phase is characterized by a range of intense emotional reactions, which are succeeded by a heroic period of high levels of activity and a sense of altruism. The following "honeymoon" phase is characterized by a shift to feelings of optimism as people appear to be bonding and working together. When change is either slow or stalled, though, a period of intense discouragement begins. It is in this dispirited space that equity fatigue manifests. Our approach to sustained IHE efforts is to anticipate a degree of pushback and name the phenomenon to normalize it—and we are careful to emphasize that this trough of disillusionment and exhaustion is what inevitably precedes a phase of renewed energy and focused purpose.

Finally, we can anticipate that academic work in DEI—and, correspondingly, IHE—will become more challenging in the wake of the Supreme Court's decision to ban race-conscious admissions policies. This ruling against recognizing and responding to the structural barriers that have denied underrepresented students access to higher education represents broader and increasing opposition to strategies to promote equity and diversity (e.g., pushback against diversity trainings, misinterpretations of and opposition to critical race theory). Despite this current trough, however, we are inspired by the many examples of progress. Integrative health colleagues are advancing discourse and practice to raise awareness about cultural misappropriation;[14] to decolonize mindfulness;[15,16] and to elevate the radical and diverse social histories of acupuncture and of mindfulness.[17-20] Along with the increasing equity-focused research in our field, these trends move well beyond simply describing disparities towards identifying solutions and building a movement to advance integrative health equity.

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ORCID iDs

Maria T Chao https://orcid.org/0000-0001-9846-7044
Shelley R Adler https://orcid.org/0000-0001-6637-9533

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