



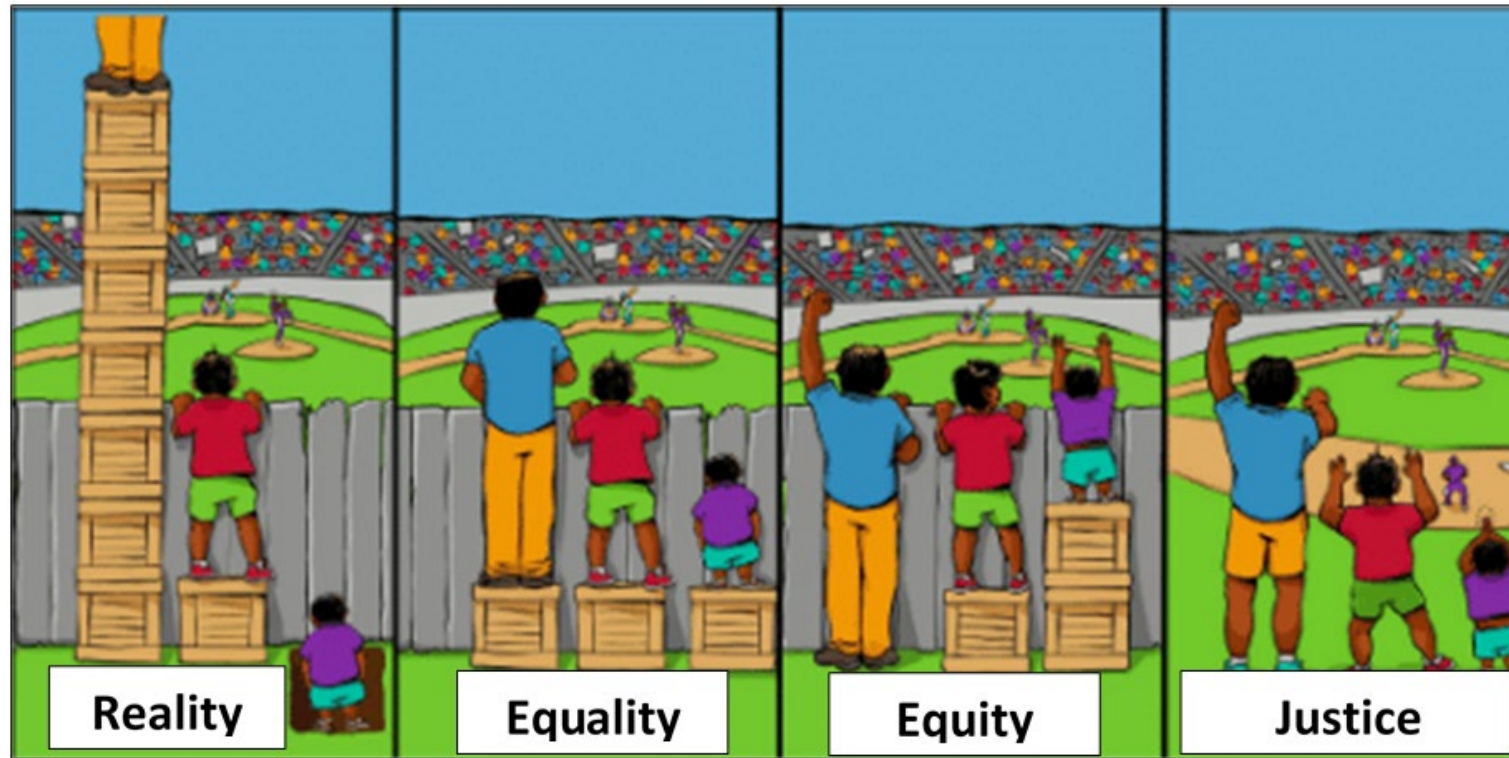
The PhRMA Equity Initiative: Progress Built on Commitment

Addressing Health Disparities and Clinical Trial Diversity

NAIC, Health Innovations Working Group
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What is Health Equity?



*Equity is the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification. "Health equity" or "equity in health" implies that ideally everyone should have a **fair opportunity** to attain their **full health potential** and that no one should be disadvantaged from achieving this potential.— World Health Organization (WHO). 2019*

While Some Progress Has Been Made Towards Reducing Health Inequities . . .

Since publication of the first comprehensive study of racial and ethnic health disparities in the 1985 Heckler Report,¹ there have been steps to close health disparities, including:

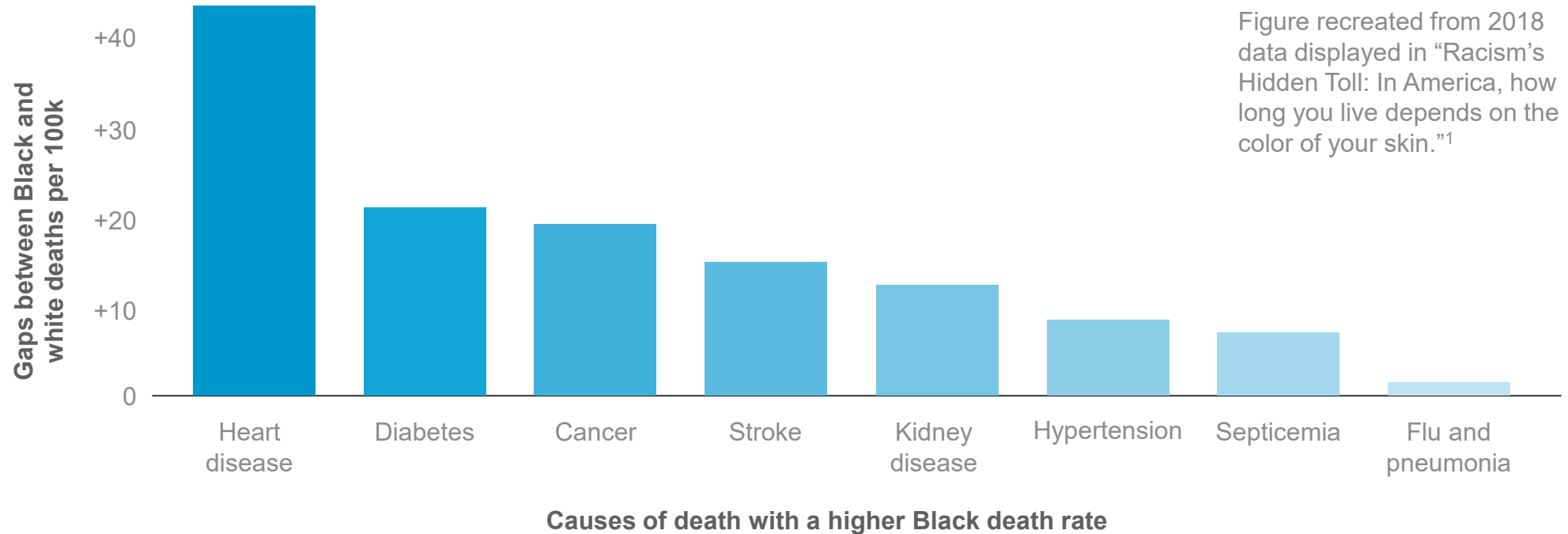


. . . There is Still a Long Way to Go.

1. Report of the Secretary's Task Force on Black & Minority Health. U.S. Department of Health and Human Services. 1985. <https://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset>
2. The Commonwealth Fund. Affordable Care Act Has Narrowed Racial and Ethnic Gaps in Access to Health Care, But Progress Has Stalled. 2020. <https://www.commonwealthfund.org/press-release/2020/new-report-affordable-care-act-has-narrowed-racial-and-ethnic-gaps-access-health>
3. Semilla AP, Chen F, Dall TM. Reductions in mortality among Medicare beneficiaries following the implementation of Medicare Part D. Am J Manag Care. 2015;21(9 Suppl):s165-s171. <https://pubmed.ncbi.nlm.nih.gov/26295437>
4. Medicines in Development for Health Equity 2021 Report. PhRMA. 2021. Available at: <https://phrma.org/resource-center/Topics/Medicines-in-Development/Medicines-in-Development-for-Health-Equity-2021-Report>

Marginalized Communities Experience Disparities in Health Outcomes Across a Range of Common Conditions

Black people are **more likely than white people to die** from the leading causes of death in the U.S.¹



1. “Racism’s Hidden Toll: In America, how long you live depends on the color of your skin.” The New York Times. 2020. <https://www.nytimes.com/interactive/2020/08/11/opinion/us-coronavirus-black-mortality.html>



Increasing Diverse Representation in Clinical Trials Is Critical to Health Equity

Demographic Subgroups

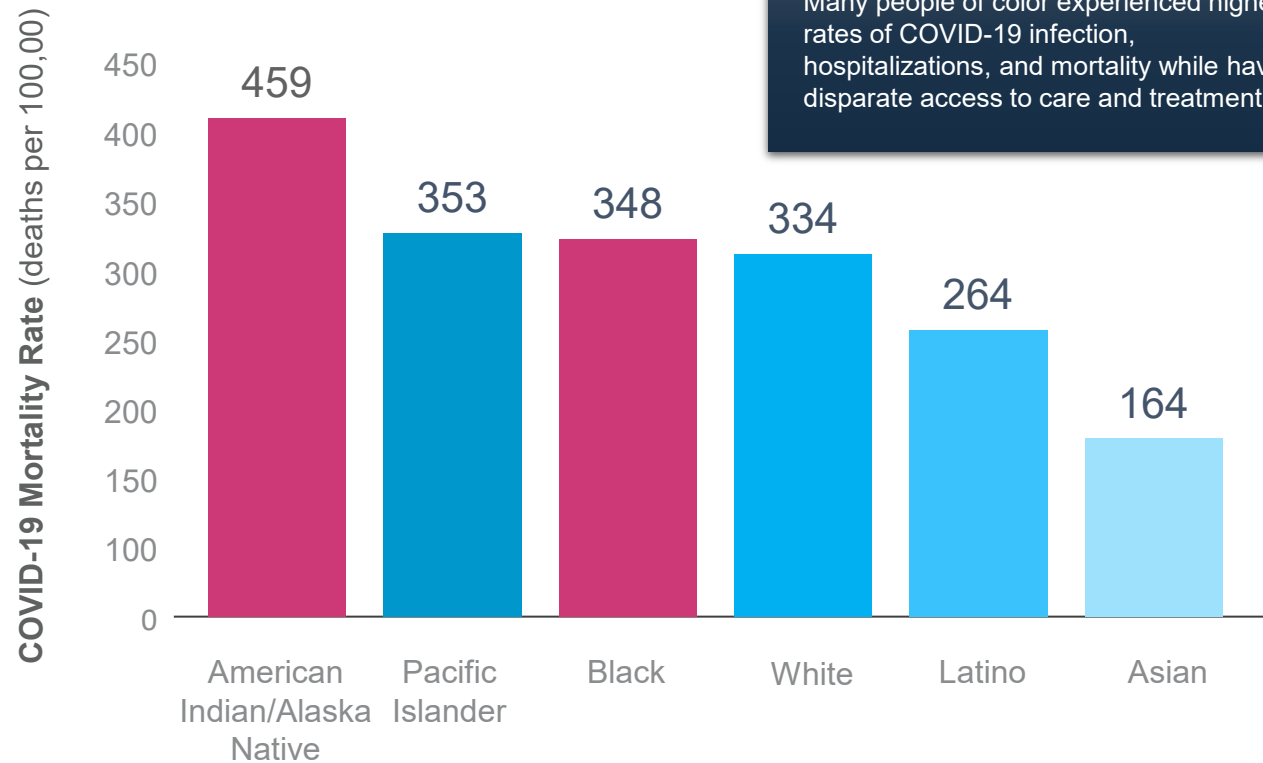
*Racial subgroups include Hispanic and non-Hispanic origin populations
 **Report on 53 novel drugs approved in 2020, FDA Drug Trial Snapshot
 ***United States Census Bureau – 2020 Estimates

Demographic Subgroups*	Black	White	Asian	Hispanic
Average CT Representation ^{1**}	8%	75%	6%	11%
US Population ^{2***}	12%	62%	6%	19%
CT Representation Compared to US Population	-33%	+20%	0%	-42%

1. 2020 Drug Trials Snapshots Summary Report. U.S. Food & Drug Administration. 2021. Available at: <https://www.fda.gov/media/145718/download>
 2. Jones N, Marks R, Ramirez R, Rios-Vargas M. 2020 Census Illuminates Racial and Ethnic Composition of the Country. United States Census Bureau. 2021. Available at: <https://www.census.gov/library/stories/2021/08/improved-race-ethnicity-measures-reveal-united-states-population-much-more-multiracial.html>

The pandemic and its effects

- High COVID-19 mortality among the **Black population** is estimated to have widened the Black-White life expectancy gap.¹ **Disparity in life expectancy widened by 39%.**
- The COVID-19 mortality rate is highest among **American Indian/Alaska Native** populations.²



DID YOU KNOW?

Many people of color experienced higher rates of COVID-19 infection, hospitalizations, and mortality while having disparate access to care and treatment.^{3,4}

1. Andrasfay T, Goldman N. Reductions in 2020 US life expectancy due to COVID-19 and the disproportionate impact on the Black and Latino populations. Preprint. medRxiv. 2020;2020.07.12.20148387. Published 2020 Oct 15. doi:10.1101/2020.07.12.20148387
2. The Color of Coronavirus: COVID-19 Deaths by Race and Ethnicity in the U.S. APM Research Lab. <https://www.apmresearchlab.org/covid/deaths-by-race>. Accessed July 2022
3. Rubin-Miller L, Alban C, Artiga S, Sullivan S. COVID-19 Racial Disparities in Testing, Infection, Hospitalization, and Death: Analysis of Epic Patient Data. Kaiser Family Foundation. Sept 2020. <https://www.kff.org/coronavirus-covid-19/issue-brief/covid-19-racial-disparities-testing-infection-hospitalization-death-analysis-epic-patient-data/>
4. Wiltz JL, Feehan AK, Molinari NM, et al. Racial and Ethnic Disparities in Receipt of Medications for Treatment of COVID-19 — United States, March 2020–August 2021. MMWR Morb Mortal Wkly Rep 2022;71:96–102. DOI: <http://dx.doi.org/10.15585/mmwr.mm7103e1>

What Makes Us Healthy?

Social Determinants of Health: where we live, work, play



Rx Access: Over **40%** of US counties are pharmacy deserts, where most people have to drive **more than 15 minutes** to reach nearby pharmacies.



Environment: **48%** of tribal households in Native communities lack access to reliable clean water.³



Income/Education: Americans in the top 10% of earners **make 9 times more than** Americans in the bottom 10% of earners



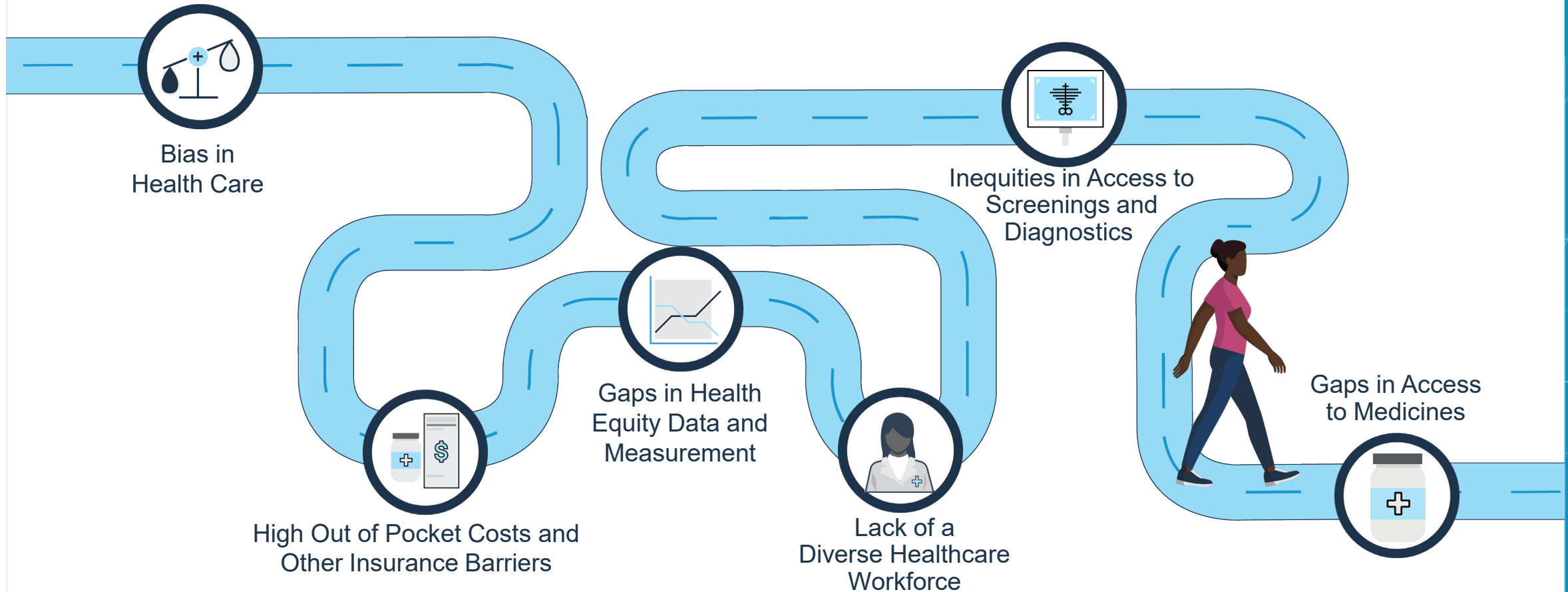
Digital Divide: **28%** of adults living in rural areas lack access to broadband internet access.

Structural Racism

Racism and discrimination often underlie these determinants of health and drive inequities in health care.



In Addition to Addressing SDOH, Dismantling Structural Barriers Within the Health Care System Is Necessary to Advance Health Equity



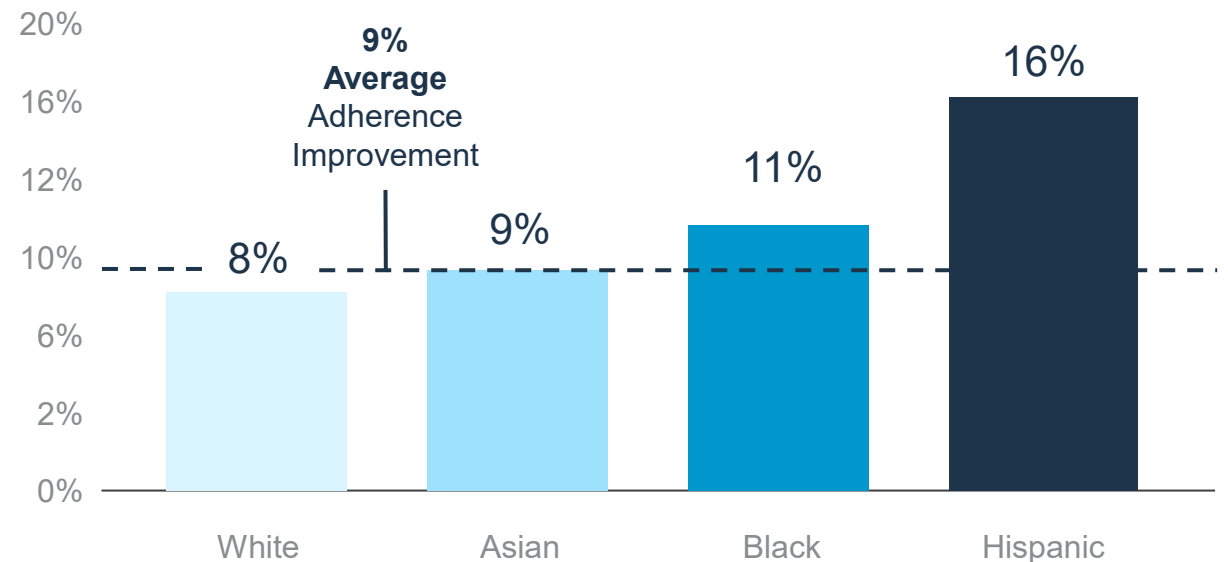
Sharing Manufacturer Rebates Directly with Patients Is One Way to Improve Access, Especially for Black and Hispanic Communities

Sharing rebates directly with commercially-insured patients could **reduce**¹:

- Total health care costs by **\$1,000 per person annually or \$8 billion over 10 years**
- Patient spending by **\$1.5 billion over 10 years**
- Mortality by **700 deaths annually**

Sharing manufacturer rebates directly with commercially-insured patients can result in a **9% average improvement in adherence**¹

Adherence Improvement from Sharing Rebates on Oral Antidiabetic Drugs, by Race

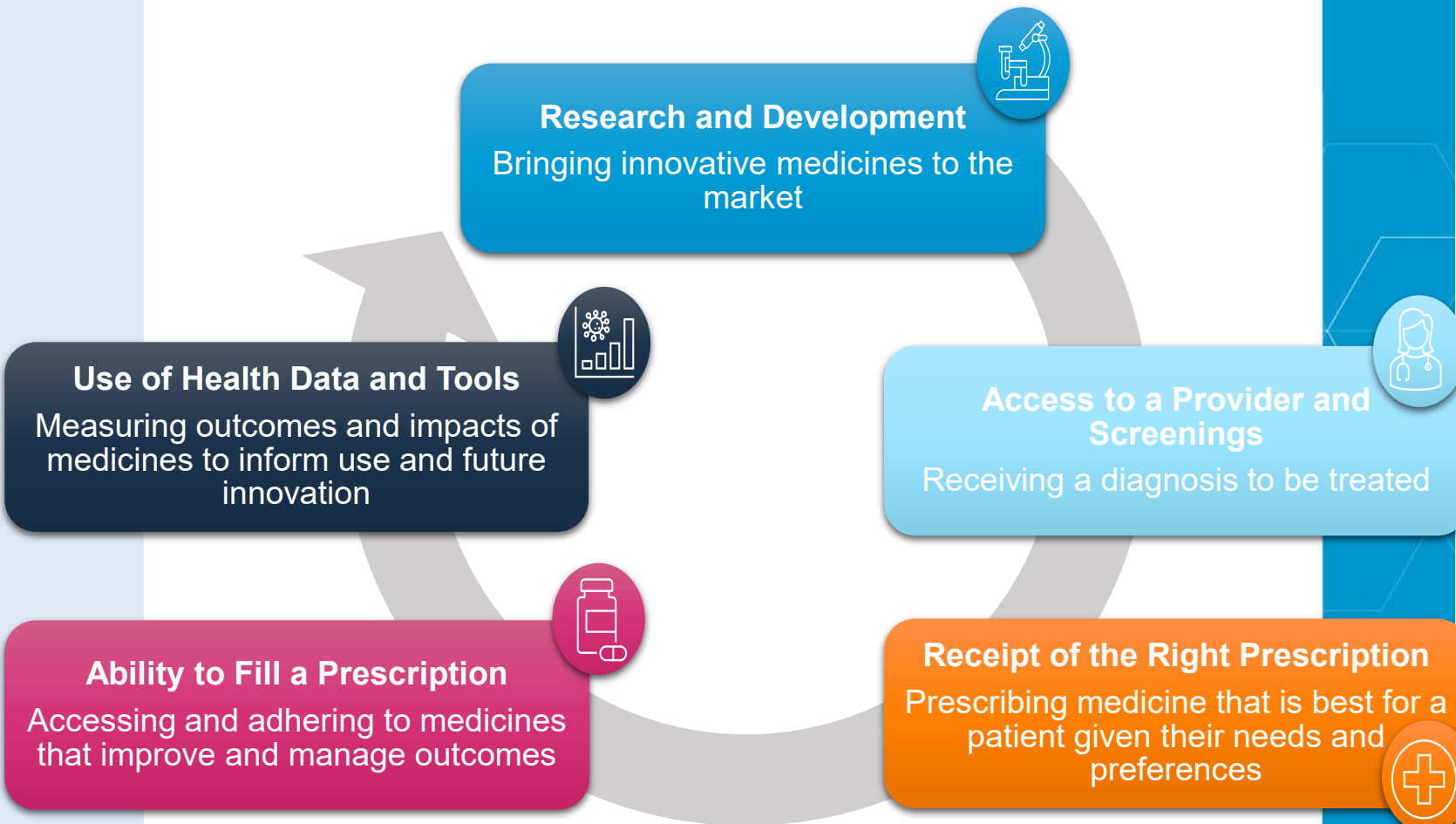


1. The Impact of Sharing Manufacturer Rebates for Oral Anti-Diabetic Medications at the Point of Sale with Patients in the Commercial Market: Analysis by Race and Ethnicity. GlobalData. 2022. Available at: <https://www.globaldata.com/reports/1-the-impact-of-sharing-manufacturer-rebates-for-oral-anti-diabetic-medications-at-the-point-of-sale-with-patients-in-the-commercial-market/>





Health Equity Depends on Removing Social and Health System Barriers to Medicine Access Across the Continuum of Care





Being for Solutions: The PhRMA Equity Initiative



Clinical Trial Diversity

Support community-based clinical trial infrastructure so patients who want to participate can



Health Equity

Work towards addressing health system and social factors that impact health inequities



Talent

Support growth in a diverse industry talent pool



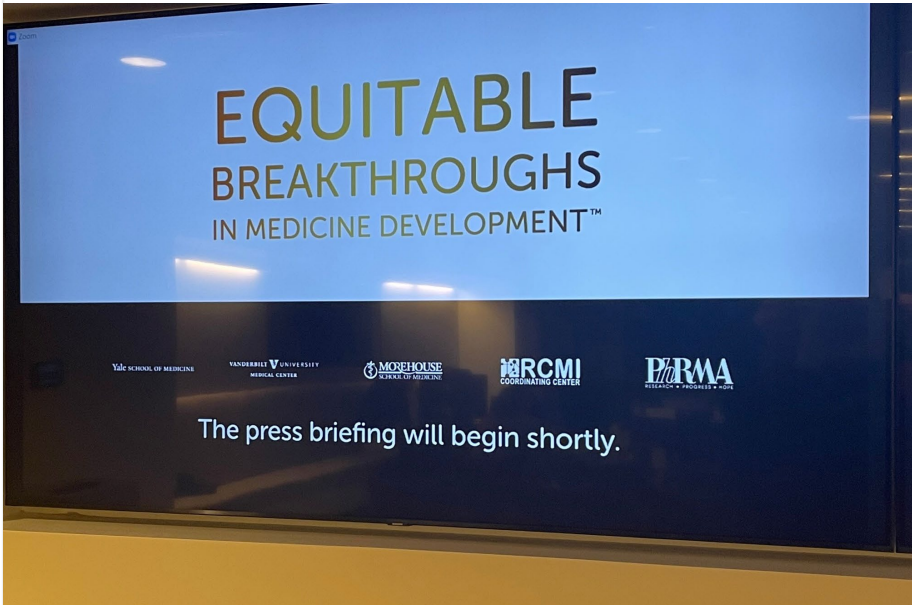
Provided grant funding to Morehouse School of Medicine (MSM), Satcher Institute:

Enhance the MSM Health Equity Tracker to include real-world data on **disease burden, screenings, and use of medicines across racial, ethnic, and other important social and systemic factors**



Launched Collaborative Actions to Reach Equity (CAREs) grant program:

Awarded \$500,000 community-based projects to address disparities in treatment of chronic disease, increasing access to COVID-19 vaccinations in underserved communities, and reducing social and economic barriers to health care and medicines.



Growing Clinical Trial Diversity:

Provided grant funding to support an industry-wide, community-based effort focused on **supporting sites and patients in underrepresented communities** to enhance clinical trial diversity in a sustainable way.

Offer annual **Pathways to Success Summit:**

Connecting students from underrepresented communities to industry to discover career pathways.

ADVANCING HEALTH EQUITY WOULD SAVE \$3.8 TRILLION



PARTNERSHIP TO FIGHT
CHRONIC DISEASE



Empowering people with chronic conditions¹ to achieve better health outcomes would save **\$2.7 trillion** in medical costs and **\$1.1 trillion** in less absenteeism over 10 years.

HEALTH EQUITY SAVINGS FROM ACHIEVING RECOGNIZED HEALTH TARGETS²

BY RACE AND ETHNICITY OVER 10 YEARS

SAVINGS ACHIEVED FROM IMPROVING DISEASE CONTROL FOR SELECT CHRONIC CONDITIONS	NON-HISPANIC				HISPANIC	TOTAL
	WHITE	BLACK	ASIAN	OTHER		
Total medical cost savings from improved control	\$1.6 T	\$424 B	\$82 B	\$107 B	\$466 B	\$2.7 T
Total savings from reducing absenteeism (missed work)	\$664 B	\$115 B	\$55 B	\$45 B	\$196 B	\$1.1 T
Total US Savings (10 years)	\$2.3 T	\$539 B	\$137 B	\$152 B	\$662 B	\$3.8 T

IMPROVE ACCESS TO PRIMARY CARE

TIMELY ACCESS TO PRIMARY CARE NOT AVAILABLE FOR MANY

PRIMARY CARE HEALTH
PROFESSIONAL
SHORTAGE AREAS:



US Population Living in
a Health Professional
Shortage Area

84 million

% of Primary
Care Professional
Access Need Met

46%

SOLUTIONS INCLUDE:



Address shortages and enhance
workforce diversity



Build on telehealth success

Source for shortage data: Kaiser Family Foundation, Primary Care Health Professional Shortage Areas as of Sept. 2021.

Follow Our Progress
on phrma.org/equity

MAT.org

