The PhRMA Equity Initiative: Progress Built on Commitment
Addressing Health Disparities and Clinical Trial Diversity

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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:

- **10-15%** point decrease in the share of uninsured Black and Hispanic adults from 2013 to 2018²
- Medicare Part D implementation resulted in **100,400** fewer deaths from diabetes³
- **800+** medicines in development for diseases that disproportionately affect racial and ethnic minority communities⁴

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

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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

- Gaps between Black and white deaths per 100k

Figure recreated from 2018 data displayed in “Racism’s Hidden Toll: In America, how long you live depends on the color of your skin.”¹

Increasing Diverse Representation in Clinical Trials Is Critical to Health Equity

*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

<table>
<thead>
<tr>
<th>Demographic Subgroups*</th>
<th>Black</th>
<th>White</th>
<th>Asian</th>
<th>Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average CT Representation**</td>
<td>8%</td>
<td>75%</td>
<td>6%</td>
<td>11%</td>
</tr>
<tr>
<td>US Population***</td>
<td>12%</td>
<td>62%</td>
<td>6%</td>
<td>19%</td>
</tr>
<tr>
<td>CT Representation Compared to US Population</td>
<td>-33%</td>
<td>+20%</td>
<td>0%</td>
<td>-42%</td>
</tr>
</tbody>
</table>

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.\(^2\)

### COVID-19 Mortality Rate (deaths per 100,000)

<table>
<thead>
<tr>
<th></th>
<th>COVID-19 Mortality Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian/Alaska Native</td>
<td>459</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>353</td>
</tr>
<tr>
<td>Black</td>
<td>348</td>
</tr>
<tr>
<td>White</td>
<td>334</td>
</tr>
<tr>
<td>Latino</td>
<td>264</td>
</tr>
<tr>
<td>Asian</td>
<td>164</td>
</tr>
</tbody>
</table>

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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

- Bias in Health Care
- Inequities in Access to Screenings and Diagnostics
- Gaps in Health Equity Data and Measurement
- Lack of a Diverse Healthcare Workforce
- Gaps in Access to Medicines
- High Out of Pocket Costs and Other Insurance Barriers

https://www.youtube.com/watch?v=jtUzM8j_ZM4&t=108s
Sharing rebates directly with commercially-insured patients could reduce:

- 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\(^1\)

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

**Research and Development**
Bringing innovative medicines to the market

**Use of Health Data and Tools**
Measuring outcomes and impacts of medicines to inform use and future innovation

**Access to a Provider and Screenings**
Receiving a diagnosis to be treated

**Ability to Fill a Prescription**
Accessing and adhering to medicines that improve and manage outcomes

**Receipt of the Right Prescription**
Prescribing medicine that is best for a patient given their needs and preferences
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.
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.

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.
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

Empowering people with chronic conditions 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 TARGETS

BY RACE AND ETHNICITY OVER 10 YEARS

<table>
<thead>
<tr>
<th>SAVINGS ACHIEVED FROM IMPROVING DISEASE CONTROL FOR SELECT CHRONIC CONDITIONS:</th>
<th>NON-HISPANIC</th>
<th>HISPANIC</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHITE</td>
<td>BLACK</td>
<td>ASIAN</td>
<td>OTHER</td>
</tr>
<tr>
<td>Total medical cost savings from improved control</td>
<td>$1.6 T</td>
<td>$424 B</td>
<td>$82 B</td>
</tr>
<tr>
<td>Total savings from reducing absenteeism (missed work)</td>
<td>$464 B</td>
<td>$115 B</td>
<td>$55 B</td>
</tr>
<tr>
<td>Total US Savings (10 years)</td>
<td>$2.3 T</td>
<td>$539 B</td>
<td>$137 B</td>
</tr>
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TIMELY ACCESS TO PRIMARY CARE

TIMELY ACCESS TO PRIMARY CARE NOT AVAILABLE FOR MANY

PRIMARY CARE HEALTH PROFESSIONAL SHORTAGE AREAS: 84 million

84 million US Population Living in a Health Professional Shortage Area

% 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. 2011.
Follow Our Progress on phrma.org/equity

MAT.org

SYSTEMIC RACISM IS A PUBLIC HEALTH CRISIS #WHITE COATS 4 B