

Capitalizing on community: A critical discourse on the neoliberal management of diabetes and
inequity

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ABSTRACT

I have taken up the difficult task in this thesis of ethnographically weaving together many strands of theory, practice, and analysis into a coherent narrative about type II diabetes and racial/ethnic disparity to answer the questions: What is the experience like for community health workers for Hispanic and Latina diabetics living in Colorado Springs, CO, and how does their clientele reflect disparate social histories? Further, how can Colorado Springs as a community better understand and strategically address public health efforts? The literature offered in this paper positions a single disease at the intersection of several historical moments and scales of analyses. This work is not meant to be a metanarrative on the phenomenon, but rather a composite picture of public health framing of type II diabetes at a localized level to prompt collaboration to create an integrated system of health.

On my honor, I have neither given, nor received, any unauthorized aid on this project.

Honor Code Upheld.

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INTRODUCTION

Exigency

Growing concerns about “Obamacare” and talk of impending health reform of President Donald Trump has led to the renewed debate about how to create a health care system that cares for everyone efficiently and affordably. ObamaCare—officially called the Patient Protection and Affordable Care Act, but more often called the Affordable Care Act (ACA), for short—is a federal law, said to be set out to reform both healthcare and health insurance industries in the United States (Assistant Secretary for Planning and Evaluation [ASPE] 2017). Forged by the perceived political need to change existing coverage, the law contains over a thousand pages of provisions to combat rising health care costs, ensure Americans’ rights and protections in the health insurance market, and expand access to affordable quality health care to tens of millions of uninsured. The legislation passed at an apparently contradictory moment when neoliberalism, characterized by its’ proclivity for rhetoric damning social programs as bastardizations of free market function and individual responsibility (Hartman 2005), dominates public policy and discourse. Following a long and controversial political and legislative process, the ACA was signed into law by President Barack Obama on March 23, 2010 and upheld by the Supreme Court on June 28, 2012 (ASPE 2017).

In the President’s words, “the bill I’m signing will set in motion reforms that generations of Americans have fought for and marched for and hungered to see,” (Stolberg and Pear 2010) enshrining the core principle that all people should have basic security in terms of health care. To many pundits, the ACA of 2010 is accredited with being the first meaningful healthcare reform since the implementation of Medicare and Medicaid, enacted in 1965. To understand the ACA, in terms of its content and its political debut in the neoliberal era, this paper deconstructs the

provision with regards to its content, stakeholder support, and the surrounding discourse. I present this thesis as an intellectual invitation to dismiss misleading dichotomies, and, thus stray away from a polarized debate of health reform and health insurance (Dao and Mulligan 2016)—between granting universal access and the rationing of limited resources, between social solidarity and individual responsibility, and between private markets and public goods.

Rationale

Public health scholars have identified the need for what anthropologists call a holistic approach (Chapman and Berggren 2005; Nadar 1972; Nguyen and Peschard 2003). A holistic study does more than approach a phenomenon from various disciplinary angles, but rather produces a different form of knowledge that analyzes society as a whole to better understand the realities of one of its' dimensions (Navarro 1986). There is indisputable evidence of deep and persistent racial/ethnic inequalities in health status and health care in the United States. Long-standing health disparities and substantial inequalities and biases in the delivery and quality of medical care have been documented in the comprehensive study by the Institute of Medicine (Smedley et al. 2003). The authors conclude, categorically, that these disparities occur in the context of broader historic and contemporary social and economic inequality, and are evidence of racial/ethnic discrimination in many sectors of life (Smedley et al. 2003). A robust but still marginalized body of anthropological work is actively concerned with exposing the ways in which intersecting racial/ethnic, social, and economic hierarchies affect the health and wellness of disparate communities (Feachem 2000; Oppenheimer 2001; Scheder 1988; Schell and Czerwinski 1998; Weeks and Singer 1993). This dissertation positions diabetes mellitus, hereafter in colloquial terms, “diabetes”, as a critical practice to study health disparities—a praxis. Diabetes and its manifestations articulate well the four-fields of anthropology, providing

an almost seamless example of the relationship between human biology and behavior, society, and culture in the past and the present tense (Ferzacca 2012).

Diabetes is not an entirely new phenomenon, but only in recent times has it assumed the form of a public health epidemic. A special issue of *The Lancet*, titled “Type 2 Diabetes—Time to Change our Approach” (2010) reported that, since 2000, sufferers of diabetes worldwide had more than doubled to 285 million over a ten-year span. Five years later, the International Diabetes Federation (2015) updated these figures, reporting a staggering 415 million people worldwide suffering from diabetes. The enumerations clearly indicate that the suffering of diabetes is quickly becoming a global experience. Anthropological literature is informed by the fact that, ironically, development and prosperity encourage the emergence of chronic degenerative diseases, a disease profile previously referred to as diseases of “development” or “affluence” (Bennett 1983), as diseases of “civilization” (Cohen 1989), or as “Western diseases...which are characteristic of modern affluent Western technological communities” (Trowell and Burkitt 1981). Related to models of the demographic transition, these models of disease and change conceptualize shifts in disease profiles of populations from infectious to chronic diseases as a result of historical transitions of societies and cultures from traditional to modern, developing to developed, third to first world (Ferzacca 2012). The language of disease-change models echoes stages associated with models of progress, modernization, and development that have long-lasting currency as frameworks for conceptualizing and explaining difference among peoples and populations of the world (Ferzacca 2012). While an extensive review of the anthropological literature is beyond the scope of this paper, a key objective is to explore whether and how anthropologists can make a substantial contribution to the

understanding of diabetes and to the development of new lines of inquiry for addressing underlying nuances of chronic disease, care, and cure.

Background

As Melanie Rock (2013) argues, “it is worthwhile to consider how epidemics achieve social significance, both through their material presence and through the symbolic representation of their causes and effects,” (155). The medical and health sciences recognize the diagnostic category of diabetes in correspondence to a statistical association between blood glucose level and the likelihood of developing certain health problems—that named of blindness, renal failure, amputation, and cardiovascular disease (American Diabetes Association [ADA] 2017). Hinged upon the consistent and measurable presence of blood glucose, a plethora of conditions have been groups together under the contemporary definition of diabetes. The bifurcated class of type II diabetes currently accounts for over 90% of all cases (ADA 2017). The bodies of people with type II diabetes produce varying amounts of insulin, but this insulin is not very effective in enabling the transfer of glucose into cells. This is diametrically opposed to those with type I diabetes whose body destructs the ability of the pancreas to produce enzymes, particularly insulin, to digest protein, fat, and starch. Without insulin, the fats, carbohydrates, and proteins consumed accumulate in the blood and can lead to serious damage to many of the body’s systems (ADA 2017). Despite comparable metabolic and physiological consequences at large, the onset and spread of type II diabetes stems from the result of social and cultural processes related to change in quality and quantity of energy consumed and energy expended (Ferzacca 2012). The etiology of type II diabetes, thus, involves a complex intersection of multiple risk factors—some of which are not traditionally the focus of public health research.

Like other communicable and non-communicable diseases, the epidemiology of type II diabetes arguably reflects the social, political and economic environment in which it rests.

Anthropologists and epidemiologists have suggested that the human body translates social structures into health inequality (Bourdieu 1997; Krieger 1999; Mendenhall et al. 2010; Rock 2003; Williams 1999). A significant disparity exists in relation to diabetes outcomes between populations of color and their white counterparts in the United States (Smedley et al. 2003; Adams et al. 2008). Hispanics and Latinxs, residents who trace their roots to Spain, Mexico, and the Spanish-speaking nations of Central America, South America, and the Caribbean, are disproportionately affected by diabetes and its consequences (Smedley et al. 2003). Worthy of regard, the words ‘Latino’ or ‘Latinos’ are derived from Spanish, a language where nouns, adverbs, and some conjugations of verbs connote a specific gender. Latinx is used for the purposes of inclusion across the socially-constructed gender spectrum. Hispanic and Latinx individuals experience a higher burden of illness and mortality due to diabetes than non-Hispanic whites, yet the disease appears to be more poorly managed (Boltri et al. 2005; Heisler et al. 2007; Kirk et al. 2005; Smedley et al. 2003). Effective management of diabetes in communities requires that we move beyond the focus on barriers and promoters that is common in public health discourse and practice. The rising numbers of those affected by diabetes, the multifactorial nature of the disease, and the failure, to date, to prevent and control it, are elements that make diabetes a conundrum and a novel "epidemic of signification," (Treichler 1987) calling for sense-making and the production of a comprehensive, multi-level strategy needed to eliminate it.

Overview of Study

As an undergraduate student at Colorado College, a liberal arts institution located in Colorado Springs, CO, I approached the subsequent research to better discern the local health care system and community engagement efforts outside of the campus confines. I gained foundational knowledge through an extensive array of informal conversations with health providers and community partners, in addition to participant observation at local safety net

clinics, analyses of publically accessible data, and geospatial mapping during the fall of 2016. In the months to follow, I focused my attention towards the American Diabetes Association (ADA) National Diabetes Prevention Program (NDPP) Latinos Initiatives program in Southeast Colorado Springs, an area affected by concentrated poverty. I attended diabetes education and lifestyle change classes, and conducted ethnographic research by the means of semi-structured interviews, qualitative surveys, and participant observation of the community preventative intervention.

I have taken up the difficult task in this dissertation of ethnographically weaving together many strands of theory, practice, and analysis into a coherent narrative about diabetes and disparity to answer the questions: What is the experience like for community health workers for Hispanic and Latina diabetics living in Colorado Springs, CO, and how does their clientele reflect disparate social histories? Further, how can Colorado Springs as a community better understand and strategically address public health efforts? This work is not meant to be a metanarrative on the phenomenon, but rather a composite picture of public health framings of type II diabetes at a localized level. By looking at health disparities in context, and using ethnographic approaches that unflinchingly expose the violence of inequality in all forms, I open the space to formulate better questions and processes that create racial/ethnic disparities and to identify opportunities for interrupting them. In expanding attention to a specific prevention program and disease regime, I sought to discover subjects of the social field and interrogate fresh insights to rightfully correct conditions that are, too often, beyond those whose health status follow the fault lines of social inequality.

Outline of Paper

Health equity is a moral position as well as a logically-derived principal of both political proponents and opponents of its underlying values (Blas and Kurup 2010). To support the equity

position in dialogue it is, therefore, critical to firmly document the context and extent racial/ethnic health disparities are persistently present, and, thus, unacceptable. This paper analyzes health disparity in four interconnected ways: To begin, the literature review focuses on popular and political discourses of the medical industrial-complex to elucidate the neoliberal, capitalist mirage of reform and the safety net that perpetuates the patterned nature of health disparity in society. To the extent that scholars have addressed politics at a local level, they have tended to concentrate on its influence on national politics. Observing these factions at a local level brings contemporary debate, characterizing local, state, and national politics, into sharper focus. Next, I present further literature on social determinants of health disparity that explores how chronic disease, particularly type II diabetes, has been and should be researched, framed, understood, and addressed. Moreover, I provide a contextual and historical perspective that leads naturally to the consideration of the development of racial/ethnic disparities in health as products of specific systems of power. In what follows, we review the concept of the systems of power and their theoretical entailments, and outline the analytical potential and discursive perspective.

The research presented here confronts the convenient ignorance of the structural forces that institutionalize inequality and produce and maintain health disparities. By expanding our theoretical repertoire to include frameworks from social theory, we can reveal dynamics underpinning diabetes in the community that are not commonly the focus of attention in public health research or intervention. I give voice to community health workers, *promotores de salud*, to gain their perspective on aiding Hispanic and Latina women suffering from and managing diabetes within the context of a “regime of disappearance” (Goode and Maskovsky 2001). This “regime” makes health disparity appear as an unavoidable consequence of the natural order of things, reflecting risk factors internal to or specific to individuals, and fosters silos of health from

separated from other dimensions of life. In this regard, a discursive lens helps to reintegrate our understanding of health by illuminating and emphasizing the extent to which the dynamics of disparity are structured by broader sociocultural and political forces. This paper serves as impetus for an integrated action plan that, although ambitious and idealistic, is within reach if organizations and resources are harnessed in a coordinated way to bridge functional agendas. My hope is that this paper serves as a springboard for medical professionals, public health organizations, community groups, and policy makers to take concrete steps to reengage and integrate our system of differentiation, segmentation, and decentralization to health.

NEOLIBERAL CAPITALISM AND HEALTH

Theorist, David Harvey (2005) states that “neoliberalism is in the first instance a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade,” (2). Neoliberalism, Harvey attests, shapes the social imaginary toward a legitimation of a highly problematic practice of democracy. The power of neoliberalism comes, in part, from its seemingly impenetrable logic. It offers compelling explanations and claims success for what apparent progress the nation has made. These logics track with a certain, dominant reading of American culture that deeply distrusts collective action mediated through the federal government—an American culture that dismisses collective concerns in favor of individual rights, privatizes key aspects of shared governance, and warrants antagonistic debate by positioning individualism and collectivism as fundamentally incompatible by supporting the former while maintaining a steady distrust of the latter (Onge 2017).

At a ‘gross’ level, the volume of dollars spent in the U.S. on health care accounts for almost half (44.3%) of the US\$6.5 trillion that is spent globally (Organization for Economic Cooperation and Development 2015). While it is widely agreed that the U.S. has the most advanced and responsive health care system, spends the most on research, and has the most highly trained medical workforce, it does not have the best health outcomes in important areas (Commonwealth Fund 2015). The idea that the nation may not be getting value for money when it comes to health care is frustrating to a populace long steeped in the virtues and benefits of capitalism (Bradley and Taylor 2013). French philosopher and social theorist Michel Foucault presciently argued in 1979 that neoliberalism represents “the extension of economic analysis into a previously unexplored domain ... [and] the possibility of giving a strictly economic interpretation of a whole domain previously thought to be non-economic” (41). The words of Foucault highlight the pervading nature of neoliberal thought, pulling previously non-economic discourses into the sphere of economic rhetoric—like that of medicine.

Healthcare as a Medical Industrial-complex

The social institutions and processes that currently constitute the mammoth edifice we call health care have origins in America’s history. This section provides a brief overview of the historical emergence of medicine in the U.S and a “history of the present” in Foucauldian terms, to extend insight of how our current situation originated, and is motivated by contemporary concerns. Foucault (1963) suggests that, over time, various medical paradigms have provided important systems of knowledge and related practices by which we have not only understood, but also experienced, our bodies. Despite a dominant narrative that conveyed the development of medical practice as an organic process, Foucault argued that, far from a natural accumulation of knowledge, modern clinics arose from the reformation of the ground knowledge in the political, economic, and philosophical milieu (Foucault 1963). Before the Classical Period (XVII),

Foucault notes, Western knowledge was a rather disorganized mass of different kinds of superstitious, religious, and philosophical knowledge that with the work of science, noted all kinds of resemblances. With the advent of the Classical Age, clear distinctions between academic disciplines emerged as scientific explanations of the world and replaced the theological, part of a general enthusiasm for cataloguing and categorizing of what can and could be observed (Foucault 1963). The rationalization, quantification, and abstraction process generated, where the natural was emptied of meaning and reduced to quantitative value, is paralleled in dynamics unleashed by capitalism, in which all things and beings are reduced to exchange value and the pursuit of profit (Best et al. 2011).

In *The Birth of the Clinic: Archaeology of Modern Medicine*, Foucault (1963) highlights the appearance of the clinic, a site of medicine as an authoritative profession, as a turning point in physician and patient dialogue, whereby the question: ‘What is the matter with you?’, was replaced by that other question: ‘Where does it hurt?’, in which to recognize the operation of the clinic and the principle of its entire discourse (Foucault 1963:xvii). He, further, elucidates the reorganization of space and knowledge within clinical interactions to be, “caught up in an ever-greater proximity, bound together, by an ever-more attentive, more insistent, more penetrating gaze,” (Foucault 1963:15). The clinical interaction, in turn, was concerned with the superficial visible and language was understood as simply transparently representing things—a work of clarification. The ubiquitous rhetoric of the “clinical gaze” recurs to develop the flawed view of the physician that renders the body as an object, to which the patient is erased of personhood. The clinical gaze promotes a method for analysis of disease that allows the doctor to immediately perceive a symptom as sign of illness. The newly acquired attention to language and appreciation of the reflexive role of subjects in the inquiry conceives, simultaneously, a subject

and an object. The search began for precisely what is hidden from our view, a knowledge from classical nosology (Foucault 1963). Disease was now conceived in relation to nature and known as an aspect of life and a mode of degeneration in a trajectory toward death (Foucault 1963).

By tracing connections between medical knowledge, politics, economics, and religion, Foucault establishes a way of looking at the revolutionary changes in views toward liberty and social welfare. The understanding of medical knowledge shapes the agenda and function of social institutions. At the mark of the eighteenth century, health providers were typically not paid for their services and received most of their information from older women as living repositories of medical folklore (Weiss 1997). The system of domestic care through oral tradition of folk medicine was largely supplemented by health care manuals thru the century (Weiss 1997). Weiss (1997) documents that before the 1860s, most of the curative elixirs and natural herbal remedies were prepared in the home. Yet, after the Civil War, a period of explosive growth of capitalism challenged and altered the former relations of production. Until approximately the last decade of the 1800s, women of the household ministered most of the births and other health and medical needs in their families (Weiss 1997). The patent medicine industry boomed, increasingly displacing homemade medicines with commercially sold alternatives—but not displacing the providers of health care, still, largely the women of the household.

Standardization grew out of a rich soil of developments in science, medicine, and society. In the last third of the nineteenth century, scientists began to uncover the infectious basis of deadly diseases, including: anthrax, tetanus, gonorrhea, influenza, malaria, pneumonia, typhoid fever, bubonic plague, and dysentery (Brauer 2001). At the end of the nineteenth century and the beginning of the twentieth century, advances in anesthesia and antisepsis and the diagnostic application of x-rays expanded surgery's capability, promise, and safety (Brauer 2001). These

advances gave the public reason to invest in and support the transformation of hospitals from charitable asylums from the indigent into modern scientific institutions. The American Medical Association (AMA), established in 1847, campaigned to raise standards in medical education, medical ethics, and state licensing, while philanthropic foundations selected medical schools and associated hospitals. Medicine underwent significant reform as a profession in the early twentieth century.

A key moment in professional reform was the 1910 report on medical education by Abraham Flexner of the Carnegie Foundation. One of Flexner's recommendations was that medical schools operate in association with hospitals (Brauer 2001). Prior to the adoption of the Flexner report in 1910, it had been possible to graduate from medical school without ever seeing or caring for patients (Brauer 2001). Paul Starr (1982) thickly documents the emergence of physicians as a sovereign profession by the restriction of medical licensure, a weapon repeatedly invoked against challengers to their authority. Largely, the divergence in the organization of the healthcare delivery system in the U.S. and in Europe can be explained in part by examining the growing sovereignty and power (Jacobs and Skocpol 2010; Starr 1982; Weiss 1997). The medical profession edged away from traditional domestic medicine, fending off the challenges of sectarians, forming organizations at the local and national level, responding to economic pressures, reforming its educational system, and building on scientific and technological advances (Starr 1982).

At this disjuncture, the U.S. did not follow a trajectory of European nations by creating a government program to protect the public and socialize risk. A government program of health insurance had been on the liberal agenda since the 1940s, but the working conservative majority in Congress had long resisted it. Throughout the period of resistance, professional groups like the

AMA repeatedly blocked ties of any government measure of compulsory universal health coverage (Horton et al 2014). Horton et al. (2014) highlights the traditional role of charity and government programs for the elderly, disabled, veterans, and poor children that filled gaps within the system, but in a largely uncoordinated and inefficient fashion. Thus, the nation's medical societies, the American Hospital Association (AHA) and, later, the AMA, devised new provider-controlled insurance plans that were nominally nonprofits. The AHA offered insurance for hospitalization (Blue Cross, founded in 1929) and the AMA offered insurance for medical expenses (Blue Shield, founded in 1939). Blue Cross and Blue Shield soon had to compete with insurance plans offered by employers. A system emerged, offering employers a lower rate on healthy, low-risk pools and leaving relatively older and sicker individuals in alternative high-risk pools. This employer-based insurance system ultimately serves class and industry interests remains (Horton et al. 2014). Horton et al. (2014) notes that tax exemptions employers receive to offer insurance subsidizes premiums for the middle class. By automatically deducting health care premiums from workers' paychecks, the health care industry is insulated from recession, and many employees remain oblivious to rising health care expenditures (Horton et al 2014). Meanwhile, those without insurance bear the full brunt of the rising health inflationary effect on the cost of health care and the lack of third-party regulation (Horton et al. 2014).

Despite the involvement of private appendages, medical care in the U.S. largely consisted of personal transactions between physicians and patients with variance between urban and rural settings across the nation (Relman 2009). The notion of the health care system as a market or industry largely went unattended to, but Congressional hearings and print and television reports. These media periodically exposed glaring shortcomings in the American health care system, especially the precarious situation faced by many older citizens (Brauer 2001). In 1963, a

seminal analysis *Uncertainty and the Welfare Economics of Medical Care* was published in the *American Economic Review* by Kenneth J. Arrow. He argues that the medical care system was set apart from other markets and, thus, there is a necessity to depend on “non-market” mechanisms for our health care system to work properly (Arrow 1963; Relman 2009). In July of 1965, both Medicare and Medicaid were incorporated in the Social Security Act, signed by President Johnson. It is important to note that this was no easy feat. The confluence of presidential leadership and urgency, Johnson’s political skills in working with a large Congressional Democratic majority, growing civil rights awareness, public support, and the support of hospitals and the insurance industry contributed to the achievement of the most significant health reform of the century (The Henry J. Kaiser Family Foundation [Kaiser] 2009).

With the passage of legislation, large amounts of government money entered the health system through these insurance programs. Funding through private insurance was also expanding greatly, due to the growth of employer-based health coverage (Relman 2009). Ignoring Arrow’s argument, health care continued business model, one best left to market forces. Costs grew rapidly from 4% of the federal budget in 1965 to 11% by 1973 and millions of those under the age of 65 remained without insurance (Kaiser 2009). The economy continued to mature, but inflation was becoming a serious problem and rising health care costs were a growing concern. President Nixon instituted wage and price freezes in effort to curb inflation (Kaiser 2009). Under the wage and price controls, medical care was singled out for specific limits on annual increases in physician and hospital charges (Kaiser 2009). These were lifted in 1974, over a year after most other economic controls had ended. Sixteen months after Nixon lifted health sector controls, the consumer price index for medical care increased at an annual rate of 13.1%, three times faster than during the control period and nearly twice as fast as before the freeze (Coombs 2005).

The emerging ideas about efficiency and standardization from other industries guided further development. Engineering, a profession at the center of a rapidly industrializing and urbanizing society, valued observation, measurement, precision, perfectibility, and results. At the time Medicare was enacted, the federal government lacked the administrative capacity to inspect or regulate hospitals. The states lacked this capacity as well, though Medicare stimulated the growth of state licensure agencies. In the fine print of the Medicare Act there was a provision that hospitals accredited by the Joint Commission on Accreditation of Hospitals were “deemed” to be compliant with most of the Medicare Conditions of Participation for Hospitals and thus deemed to meet eligibility requirements for participation in the Medicare program (Brauer 2001). Therefore, the Joint Commission’s standards effectively set the ceiling. The growth in the Joint Commission’s scope and scale, just from 1968 to 1973, is reflected in its budget. A memorandum prepared for the Executive Committee in March 1973 reported that total income had increased from US\$1.3 million in 1969 to a projected US\$4.5 million in 1973, nearly 250% increase (Brauer 2001). Although inflation contributed significantly to increases in both costs and income in these years, the principal factor was simply growth in the number of personnel (Brauer 2001).

Health care had begun to resemble a gigantic industry, and it was consuming a growing fraction of the national economy. In the *New England Journal of Medicine*, Arnold Relman (1980) described the changing face of American health care as the “new medical-industrial complex”. The term was derived from the language President Eisenhower had used, “military-industrial complex”, when warning the nation about the growing influence of arms manufacturers over American political and economic policies (Relman 2009). As expenditures on care continued to rise, the major payers—employers and the government—began to resist.

Employers revolted against the unpredictable costs and demanded a different kind of coverage. Relman (2009) explains that a new and largely investor-owned industry quickly appeared which contracted with employers to provide managed care insurance plans, or HMOs. The plans controlled their payments for medical services by requiring beneficiaries to select a primary care physician from a network of local healthcare providers who will refer clients to in-network specialists or hospitals when necessary.

An era of health care regulation began, leading to certificate-of need programs, state hospital rate-setting, requirements on health management organizations (HMOs) and health planning to control growth. With the Health Maintenance Organization Act of 1973, the government contributed substantially to the growth of managed care in effort to control costs by contracting with private HMO plans for many of its Medicaid beneficiaries (Relman 2009). During the mid-1990's, private managed-care insurance plans briefly succeeded in controlling the rise in the premiums charged to employers, while still making substantial profits for themselves (Relman 2009). But there ensued a major backlash from employers, who resented the restriction on their care and their access to specialists that soon brought employers to abandon these plans in favor of Preferred Provider Organization (PPO) plans that allow one to visit any in-network physician or health care provider without first requiring a referral from a primary-care physician. In the increasingly profit-driven and entrepreneurial market, piecework payment for specialized outpatient services stimulated an even greater fragmentation of medical care (Relman 2009).

Capitalist Contradictions

In a course of development, revolutionary processes have transformed our democratic capitalist economy and the institutions of health care (Weiss 1997). Twentieth-century historian and economist, Richard Henry Tawney mounted an influential critique of a society based on

such material self-interest and acquisitiveness. In *Acquisitive Society* (1920), Tawney regards capitalism as fundamentally immoral because it is based upon individual gain, rather than service to the community. Societies in which this philosophy held sway could, argues Tawney, be called “*acquisitive*” societies, since their whole tendency, interest, and preoccupation is to promote the acquisition of wealth (1920). It is important to note that Tawney freely acknowledges its attractions and its ideology of possessive individualism that appealed to a powerful human instinct. Yet, in its confusion of means with ends, he notes that is an authentic expression of a society without a common purpose.

To Tawney, capitalism in practice was a realm of power without authority—of claimed rights without acknowledged duties. He stressed that value, therefore, had to be regulated as part of the social organism. In *Religion and the Rise of Capitalism*, he wrote:

Society, like the human body, is an organism composed of different members. Each member has its own function, prayer, or defense, or merchandise, or tilling the soil. Each must receive the means suited to its station, and must claim no more. Within classes there must be equality; if one takes into his hand the living of two, his neighbor will go short. Between classes there must be inequality; for otherwise a class cannot perform its function, or –a strange thought to us—enjoy its rights. Peasants must not encroach on those above them Lords must not despoil peasants. Craftsmen and merchants must receive what will maintain them in their calling, and no more (1926:23).

Equality in this sense is not, as its critics may suggest, about a dull uniformity. It is consistent and supportive of diversity, but a diversity in which there is parity. To turn to health inequalities, more specifically, his ideas lend claim to the danger in assumptions that attribute health disparity simply to the effects of contrasting personal choices. Tawney holds the belief in the worth of each human being as a fundamental building block in any worthwhile social work. He challenges claims that reductions in inequalities require a simultaneous erosion of individual differences. He writes in *Equality*,

While natural endowments differ profoundly, it is the mark of a civilized society to aim at eliminating such inequalities as have their source, not in individual differences but in its own organization.... Individual differences which are the source of social energy [are] more likely to ripen and find expression if social inequalities are, as far as practicable, diminished (1931:50).

Tawney suggests that genuine individuality is more likely to flourish in conditions that prevent unwarranted inequalities.

The ideas deliver not an abstract moral sermon, to only press his own values against capitalism, but an argument for moral reconstruction of contemporary society. A criterion of success, to Tawney, must, “subordinate the inclination, appetites, and ambition of individuals to the rules of an organization which has its object to promote the performance of function,” (Tawney 1920:37). He proposed that the professionalization of occupation would infuse society with a principled dedication to serving society that would counter relentless market forces. He wrote in his 1920 publication:

A profession may be defined most simply as...a body of men who carry on their work in accordance with rules designed to enforce certain standards both for the better protection of its members and for the better service of the public.... So, if they are doctors, they recognize that there are certain kinds of conduct which cannot be practices, however large the offered for them...it is wrong to make money by deliberately deceiving the public, as is done by makers of patent medicines, however much the public clamor to be deceived (94-95).

Professions as a countervailing power to markets, or civic professionalism, lay largely at the center of reforms. When it comes to the restructuring of health care today, the insight offered alerts one to the unrequited appetites and ambitions of acquisitive members of society.

Our healthcare policies fail to meet national needs because they have been heavily influenced by the delusion that medical care is essentially a business (Relman 2009). This delusion stubbornly persists, and current proposals for a more "consumer-driven" health system are likely to make our predicament even worse. The term is used to mean a market for medical

care in which patients, as consumers of medical services, have the responsibility for choosing the services and would share more of the direct costs (Relman 2009). In response, Farmer offers that “it is difficult to achieve equity of access to decent healthcare when neoliberal market paradigms underpin care delivery,” (2015:17). Economists and vendors of drugs and technologies allege that life-enhancing and life-extending benefits are of good value for the money, but when the mediocre performance of our system whole is compared with that of other industrialized countries, which spend far less, it is an unpersuasive argument (Relman 2009). It is an argument that underscores our failure to address the glaring deficiencies and inequities in our health care system with a focus on scientific advancement and “progress” is nothing to be proud of. Our best medical institutions and our most advanced technology lead the world in their sophistication, yet we continue to neglect the poor and uninsured.

A Mirage of Reform

Colloquially known as “Obamacare”, the Patient Protection and Affordable Care Act of 2010 and as amended by The Health Care and Education Reconciliation Act of 2010 represents a significant alteration in healthcare funding and delivery since the introduction of Medicaid and Medicare in 1965 (Obama 2016). Even if partially repealed and amended by future administrations, Congresses, or the Supreme Court, the payment model, insurance marketplace, and the structure of collaboration among industry players has already been altered. The legislation builds on the existing infrastructure of employment-based coverage and the Medicaid program, but requires most individuals to carry health insurance and creates a new option to buy insurance online through federal and state health insurance “exchanges” (ASPA 2017). Eligibility criteria are used to sort people into categories that determine the type and cost of health plans available to them (Obama 2016). The employment-based system of providing health insurance continues under new ACA-required regulations. Large employers, defined as those

with more than fifty full-time workers, are mandated to offer employee health coverage or to pay a penalty. Smaller employers, those with fewer than fifty workers, are not required to offer insurance (ASPA 2017). A more progressive aspect of the ACA is its expansion of Medicaid, the joint federal and state administered health care program for low-income Americans. People with incomes up to 133% above the poverty line have access to Medicaid, a provision accounting for more than half of the additional people who will now have health coverage (Obama 2016). The Medicaid expansion comes with a big caveat, however. The court allowed states opposed to the Medicaid expansion to opt out of implementation, the subject of vigorous public policy debate (Obama 2016).

At large, the law reshapes the architecture of subsidies, insurance coverage, actuarial models, collaboration among the industry players, and expectations concerning the provision and management of care to address the issue of rising cost—and for good reason (Petty 2014). Increased profit extraction by the pharmaceutical, medical supply, and insurance industry that now totals over US\$100 billion annually, the 31% in administrative costs that insurance companies expend to extract their profits, severe and widespread price gouging by major medical centers, and the fact that the U.S. has the highest inequality in the industrialized world and, therefore, a high prevalence of chronic and poorly treated diseases, are among the top contenders (Petty 2014). I point out, however, met with resistance from the medical industrial-complex, the architects of Obamacare did not directly confront these realities. The fiscally-minded reforms embedded in the ACA should be seen both in the longer-term trend of neoliberal restructuring and the acute reality of historic capitalism. In the prolog to the passage of the ACA, Robert Greenberg of the Center on Budget and Policy Priorities reminded Congress, “The new Congressional Budget Office report shows that rising healthcare costs are the largest driver of the

nation's long-term budget problems," (Petty 2014). Moreover, Elizabeth Fowler, a former health insurance executive at WellPoint and well-known signature architect of the ACA, was clear about the chief concern in creating the ACA. She told the *New York Times*, "Everybody is focused on the coverage angle, but the changes in the law designed to address cost could be a bigger and longer-lasting change," (Davidson 2013).

I stress, despite a noted feature of austerity, the central intent of the ACA was not principally to provide access to healthcare for millions of Americans. Fowler's words should be weighted, and so should her class outlook. As Glenn Greenwald (2012) wrote in *The Guardian*, "It's difficult to find someone who embodies the sleazy, anti-democratic, corporatist revolving door that greases Washington as shamelessly and purely as Liz Fowler". With her expertise in how to navigate the details of the roughly thousand-page document, the law acts to control of spiraling health care costs while facilitating a qualitative leap in neoliberal healthcare restructuring in the United States—freeing up tens of billions of taxpayer dollars to further engorge the highly profitable healthcare insurance companies, private equity firms, and hundreds of other healthcare corporations (Petty 2014). The health care industrial complex, created and advocated for by millionaires and billionaires, ultimately serves their material and ideological interests. Reforms fetishize the argument that that rising costs are due to people getting too much health care because their doctors and hospitals are ordering too many tests and procedures because they have a financial incentive to do so, and urge technology and data-driven evaluation. According to Obama administration officials, "The sources of inefficiency in the U.S. healthcare system include payment systems that reward medical inputs rather than outcomes," says WhiteHouse.gov. This premise is false and ideologically loaded. As Charles Idelson (2013) points out, this analysis:

Stems from some highly-publicized abuses of a few practitioners who prescribe diagnostic procedures or medical treatment to profit from reimbursements. But it also coincides with the portrait of patients as a whole class of ‘takers’ who somehow enjoy spending hours waiting in doctors’ offices or undergoing colonoscopies, a theory that has race, gender, and class overtones, blaming minorities, women, and the poor for demanding “too much” care (17).

There is scapegoating rooted in forms of restructuring for those institutions and individuals who provide healthcare to people who cannot afford certain forms of health care coverage. The implicit idea embedded is that mechanisms need to be in place to combat the overconsumption of care deflects from the underlying social conditions and inequalities that fundamentally cause healthcare inequities. To quote President Obama from a health policy platform to which he campaigned in 2008: “Covering the uninsured and modernizing America’s health care system are urgent priorities, but they are not enough. Simply put, in the absence of a radical shift towards prevention and public health, we will not be successful in containing medical costs and improving the health of the American people” (Partnership for Prevention 2008). President Obama echoes the précis to move beyond narrow interpretations of populations to alternatively recognize that the health care delivery system can only be responsible for a modest proportion of what makes and keeps Americans healthy.

In a Special Communication published in the *Journal of the American Medical Association*, President Obama, himself, assesses the progress the ACA has made in improving the health care system and offers ways to upon the accomplishments in the years ahead. President Obama draws three personal conclusions on the broader implications of the ACA in terms of lessons learned, not for posterity, but to be put into practice for both health care and public policy. First, he shares a principal lesson that that any change is difficult, but highlights the distinctive challenge of change in the face of hyper-partisanship (Obama 2016). He explains, “Republicans reversed course and rejected their own ideas once they appeared in the text of a bill

that I supported,” (Obama 2016). Respectively, the second lesson is that special interests pose a continued obstacle to change. President Obama repeats:

We worked successfully with some health care organizations and groups, such as major hospital associations, to redirect excessive Medicare payments to federal subsidies for the uninsured. Yet others, like the pharmaceutical industry, oppose any change to drug pricing, no matter how justifiable and modest, because they believe it threatens their profits (2016:530).

He further deduces, “We need to continue to tackle special interest dollars in politics. But we also need to reinforce the sense of mission in health care that brought us an affordable polio vaccine and widely available penicillin,” (2016). The final lesson is the importance of pragmatism in both legislation and implementation. He presented the necessary approach to find common ground to the ACA on implementation and through adjustments along the way (Obama 2016). President Obama concludes the journal article in stating:

While the lessons enumerated above may seem daunting, the ACA experience nevertheless makes me optimistic about this country’s capacity to make meaningful progress on even the biggest public policy challenges. Many moments serve as reminders that a broken status quo is not the nation’s destiny... As this progress with health care reform in the United States demonstrates, faith in responsibility, belief in opportunity, and ability to unite around common values are what makes this nation great (2016:530).

I offer the rhetoric of President Obama, and the impetus set by the ACA, to prompt collaboration between public health and medicine.

Health for the Public

Throughout the course of the twentieth century, observers have noted important tensions and antipathies between public health and medicine (Weiss 1997; Brant and Gardner 2000).

Brant and Gardner (2000) procure revered dichotomies between the two related fields:

Although public health has come to be identified with prevention, medicine has historically been committed to cure. Medicine is commonly associated with the care and treatment of the individual, while public health's central focus is on populations. Medicine has come to be associated with an objective and reductionist technocratic science, while public health is identified with interest-oriented policing and politics. While public health claims to "focus upstream"—on ameliorating the social and

environmental conditions producing disease—medicine is often assumed to look downstream, late in the process of pathogenesis (708).

Public health and medicine are more often seen as alternative, at times adversarial, approaches to addressing the problems of disease. In history, the fields have been mutually dependent and interactive. Assessing the relationship temporally offers opportunity to develop strategies that could more productively address the full range of forces that have limited effective collaboration.

In the last years of the nineteenth century, medicine and public health, both only weakly professionalized, were viewed as overlapping areas of interest and activity. In comparison to the profusion of proprietary institutions and educational standards of medicine, without consensus about the skills required for practice no official training or certification took place in the field of public health (Brant and Gardner 2000). As scientific advanced, sovereign professionals were more effectively able to prevent, treat, or cure many of the infectious diseases that had been the environmentally-oriented halliwick of public health practitioners (Brant and Gardner 2000). Public health began to change qualitatively about the second decade of the twentieth century. Previous public health tactics, such as cleaning up neighborhoods, improving poor housing, and building treatment facilities to ensure clean water, receded behind the personal hygiene message: “Wash your hands and see the physician regularly for checkups,” (Weiss 1997:7). Public health institutions and activities yielded to the leadership of physicians and the medical establishment, to be considered a contributory to medicine in a position that undermines the core principals of the field. The relatively inferior position keeps public health in a condition of anarchy—balkanized among the states and scattered about federal agencies (Weiss 1997).

Beyond the main purpose of the ACA, several provisions do offer an unprecedented opportunity to shift the focus of health experts, policy makers, and the public beyond health care delivery to the broader array of factors that play a role in shaping health outcomes. The

Roundtable on Population Health Improvement brings together individuals and organizations that represent different stakeholders in a dialogue about what is needed to improve population health. A workshop in June of 2013 formed to explore the likely impact of various provisions within the ACA on population health improvement. Planning committee co-chair George Flores states, “This is an auspicious time in our history to be discussing the nexus between health care and population health in the context of health care reform” (The Roundtable on Population Health Improvement [Roundtable] 2013). The workshop highlighted the law's implementation developments to move down the path of integrating population health into the health care system, elevate the priority for primary prevention and health equity, bridge clinical care and community health in “health homes,” empower consumers and communities to improve health outcomes, and provide incentives to improve workplace wellness (Roundtable 2014).

Also important are the various incentives and penalties included in the ACA, particularly concerning re-hospitalization, that are changing the focus of hospital administrators to keeping beds empty by keeping people healthy (Roundtable 2014). Julie Trocchio acknowledged the many provisions that are pushing hospitals towards public health. However, she noted the significant promise that comes of the tax-exempt hospital provisions in ACA that mandate community health needs assessments (CHNAs) with planning and transparency in the way hospitals charge for their services and collect payment (Roundtable 2014). For reference, the law deems that every tax-exempt hospital facility must conduct a CHNA at least every three years, as well as obtain input from individuals who represent the broad interests of the community and those with special knowledge of or expertise in public health. The CHNA itself must include the definition of the community served and a description of the process used to conduct the assessment—outlining the means to which input was accounted for, detailing the prioritization of

significant community health needs, and considering the necessary resources to address those needs (Roundtable 2014).

Also, the ACA calls for tax-exempt hospitals to develop and adopt an implementation strategy to meet the community needs identified and describe any needs identified in the CHNA that are not being addressed or provide an explanation for the inaction. “Perhaps the most important requirement”, says Trocchio, “is that the CHNA must be widely available to the public, which she said will ensure that hospitals do a good job in preparing this assessment” (Roundtable 2014). Taken together, Trucchio reaffirms, “The bottom line is that hospitals are finding that they can no longer care just for the person in the hospital bed. They must look at the health of the community that the patient is being discharged into.” In closing, “These requirements are getting the attention of the highest level of leadership in hospitals. Boards are paying attention. Chief executives are paying attention. They are accountable now and that is making a huge difference,” (Roundtable 2014).

Context to Thesis

Congressional Republicans are eager to get rid of the individual mandate to purchase to put a greater focus on personal responsibility and make sweeping changes to publically funded programs. The law’s Prevention and Public Health Fund (PPHF), which was on the chopping block in Congress, has provided US\$57 million to Colorado since ACA began in 2011 and US\$9 million last year alone with the goal of helping to contain the growth of public and private health care costs (Colorado Health Institute [CHI] 2017). The ACA appears safe for now with a failure of proposed plans to reach a vote, however the funding stream appears vulnerable as Congress considers budget recommendations from the Trump Administration that propose deep cuts to public health and environmental protection services. Last year, the Colorado Department of Public Health and Environment (CDPHE) received about US\$8 million, 89% of the state’s PPHF

funding. Seven of ten deaths in Colorado are attributed to chronic disease. About 60% of the fund's dollars, or US\$4.75 million, went for chronic, non-communicable disease prevention and health promotion (CHI 2017). For example, the funds have supported Colorado's Diabetes Prevention Program (DPP), an evidence-based program that works to prevent type II diabetes among at-risk adults. The CDPHE's efforts have led to more than one million Coloradans with DPP as a covered benefit through their insurance (CHI 2017).

Moreover, in terms of insurance, while the ACA law required states to implement the expansion of Medicaid or face a penalty, a ruling by the U.S. Supreme Court made the expansion optional (ASPA 2017). At a state level, Colorado voted to expand Medicaid eligibility beginning January 1, 2014 (Colorado Health Institute [CHI] 2015). Implementation of the ACA legislation aimed to increase access to affordable health insurance for those at or below 400% of Federal Poverty Level (FPL) by subsidizing plans purchased through Connect for Health Colorado (CHI 2015). Health is Local (2014) is a project by Colorado Coalition for the Medically Underserved that aims to tell the story of health reform and its impacts in Colorado, through the eyes and words of the Coloradans living it. In discussion of the health reform in 2013, Colorado Springs seemed to be well-positioned with community-driven innovations and locally focused solutions that state and national health reforms were often welcomed as tools for driving positive change. Community and health leaders of the city spoke proudly about their long-standing, collaborative approach to creating a robust and inclusive health care system (Health is Local 2014).

In response to implementation, Colorado's uninsured rate plummeted from 14.3% in 2013 to 5.7% in 2015 (CHI 2015). About one in three Coloradans is covered by public insurance—Medicaid 19.9%, Medicare 12.9%, and the Children's Health Plan Plus at 1.4% (Figure 1). However, the 2015 Colorado Health Access Survey (CHAS) suggests the benefits of

health reform are not flowing equally and insurance is still unaffordable for many people (CHI 2015). Racial/ethnic minorities historically have had the lowest rates of health insurance coverage. The uninsurance rate declined for all racial/ethnic categories in Colorado, although Hispanics and Latinxs continue to have the highest rate of uninsurance at 11.8%—more than double that of non-Hispanic whites (CHI 2015; Figure 2). This large coverage gap has important implications. Studies have long found a relationship between health insurance and better health (Institute of Medicine [IOM] 2001). Broadly, the health of people with insurance tends to be better because their care is more affordable. This allows them to make more appropriate and timely use of health care, including receiving regular preventative care (IOM 2001). The Colorado Health Institute (CHI) analyzed data from the 2013 CHAS to identify and quantify the factors associated with a large difference in health insurance coverage between Hispanic and non-Hispanic adults in Colorado. Results document citizen status, self-reported health, availability of employer-sponsored insurance, family income, marital status, disability status, and gender to be seven measurable factors associated with about 60% of the state's coverage difference between Hispanics and non-Hispanics (CHI 2015). The limitations of the report reflect both the measurement tools and the fact that race/ethnicity continues to be deeply intertwined with social, economic, and cultural experiences in the United States.

It has been stated that the presence, effectiveness, and accessibility of certain healthcare services have an influence on health outcomes. However, viewing health services as a broad panorama results in abstractions, oversimplifications, and oversights. By deconstructing the facets of health care provision highlights specific areas of efficiency and shortcomings. In the absence of comprehensive health coverage, the country has relied on a set of loosely organized community-based safety net providers to address the health care needs of the uninsured and other

populations (Institute of Medicine [IOM] 2000). The country's health care safety net is a patchwork of providers, funding, and programs tenuously held together by the power of demonstrated need, community support, and political acumen (IOM 2000). Local safety net often serve vulnerable persons of the community. Medically vulnerable, defined by the CHI, refers to one or more of these characteristics: incomes below 300% of the FPL, no insurance, enrollment in a publicly financed health insurance program or high-deductible health plan, a geographically isolated location; no regular source of primary care, cultural, language and other social barriers (CHI 2015).

Although it's been widely regarded as positive change in Colorado Springs for some, there have also been residual effects that leaders were grappling with upon implementation. For example, churn, the movement of individuals between health insurance providers due to income changes, has made it a challenge for patients and providers (CHI 2015). Other issues, such as helping consumers understand their health insurance and how to use it and assisting underinsured consumers with issues of affordability, have become exigent. Chief Operating Officer of AspenPointe, Kelly Phillips-Henry stated,

This has been the year of significant coverage for so many people, many times adults who have either not had health coverage for years, or never. And so, really, the impact of... the Colorado Health Exchange opening and the Medicaid screening... has not only identified a new population that we can serve, much more holistically, but it has also identified folks who have always had a benefit but never knew it or didn't access it (Health is Local 2014).

Phillips-Henry points to the sustained transformation efforts to improve quality, enhance patient health, and reduce costs of care to the expanded patient base of newly insured individuals—all greatly accelerated by the ACA. In many ways, as the primary health care providers for vulnerable populations, safety net clinics are well-positioned to engage in practice transformation. Team-based care, a hallmark of practice transformation, brings together

physicians, physician assistance, nurses, and community health professionals to optimize patient care. In “Safety Net Clinics Leading the Charge for Practice Transformation”, the CHI primer notes that safety net clinics that care for minority patients, can overcome language barriers by pairing patients with teams whose members speak their patients’ preferred language. On tight budgets, the prospect of greater efficiency is appealing. However, they do face unique challenges, namely with a lack of resources tied to the populations they serve. For safety net providers, themselves, CHI depicts the feeling of implementing change while treating patients as ‘building the plane while flying it’ (CHI 2016). Therefore, widespread support is primary for the success and maintenance of integrated care.

SOCIAL DETERMINANTS OF HEALTH DISPARITY

The latest in a series of the Commonwealth Fund cross-national comparisons use health data from the Organization for Economic Cooperation and Development (OECD), as well as other sources, to assess the U.S. health care spending, supply, utilization, and prices, relative to other countries diametrically to a limited set of health outcomes (Organization for Economic Cooperation and Development 2015; Bradley and Taylor 2013). For the purposes of comparing spending and outcomes across member countries, the OECD defined health expenditure to mean all spending on the final consumption of health goods and services plus capital investment in health care infrastructure. Therefore, these expenditures include public and private spending on curative care, rehabilitative care, long-term care, mental health care, and ancillary services, outpatient medical goods, prevention and public health services, health administration, public health insurance, new health care buildings and facilities, health education and training, health research and development, and long-term care services for people with functional limitations (Bradley and Taylor 2013). Not included as health spending are expenditures for social services

and economic well-being that contribute to health, such as investments in housing, nutrition, education, the environment and unemployment support (Bradley and Taylor 2013). What researchers see from health spending data is an incomplete picture of the spending each nation puts forth in pursuit of health on behalf of its population. As Dr. Mahler, director of the World Health Organization (WHO), said in a message to the Inter-Regional Seminar on Primary Health Care that took place under the aegis of the WHO in 1982 in Yexian county in China:

I fully realize that health is not the only thing, but that everything else without health, is nothing. And I think that it is very important to realize this when we look at development at large. Whenever the health component is forgotten, you forget at the same time the vital factor in development, namely the human being, his creative energy, his physical energy (World Health Organization 1983:7).

Given the WHO (1946) definition of health as “a state of complete physical, mental and social well-being” one can see how health spending limited solely to what the OECD measures might leave a population wanting.

All too often, firmly rooted in medicine, the health care system does not demonstrate active engagement with the wide determinants of patients’ health. Findings generated within the field of epidemiology have been successful in identifying relatively proximal risk factors for major causes of disease. Social factors, which tend to be more distal causes of disease, receive far less attention (Link and Phelan 1995). Bruce Link and Jo Phelan (1995) question the emphasis on individually-based risk factors and argue that greater attention must be paid to basic social conditions. These scholars stress that individually-based risk factors must be contextualized, by examining what puts people at risk of risks. Further, social factors such as socioeconomic status and social support are likely *fundamental causes* of disease that affect multiple disease outcomes through multiple mechanisms, and consequently maintain an association with disease even when intervening mechanisms change. Without careful attention to

these possibilities, imposing individually-based intervention strategies that are ineffective may undermine opportunities to adopt broad-based societal interventions that could produce substantial health benefits for our citizens (Link and Phelan 1995).

Changing the medical imagination requires a grasp of the way that risk factors work in populations and the potential for action on social determinants to improve population scale health. Geoffrey Rose (1985) establishes that the determinants of individual health are not the same as those of population health. Rose sets a precedent that that treating high-risk individuals or those already suffering from disease does not have much impact on population health. Thus, if we are to challenge and change the medical mind-set—whether by force of the moral imperative of health equity or the pragmatic imperative of fiscal sustainability—strength comes from the fact that changing a risk factor across an entire population by only a small amount has a substantial impact (Rose 1995). Social determinants in themselves, independent of how they influence behavior, require attention if there is to be significant impact on public health. Social determinants of health (SDOH) are the conditions under which people are born, grow, live, work, and age (Birn et al. 2008). The term is often used to refer broadly to any nonmedical factors influencing health, including health related knowledge, attitudes, beliefs, or behaviors. In a study using Centers for Disease Control and National Center for Health Statistics from 1999 to 2001, reports that a common set of 22 socioeconomic and environmental variables largely explain geographic and ethnic/racial disparities among specific disease groups. For example, social and behavioral factors contribute to more than 70% of colon cancer and stroke, more than 80% of coronary heart disease cases, and more than 90% of type II diabetes cases (Bradley and Taylor 2012).

I begin this section by outlining components of SDOH topically by: personal health practices and coping skills, socioeconomic environment, physical environment, and healthcare services. SDOH have a direct impact on the health of individuals and populations, and help to structure lifestyle choices and behaviors, which interact to produce health or disease. As defined by Camara Phyllis Jones, health equity is the assurance of the conditions for optimal health for all people (Jones 2000). The assurance of the conditions for optimal health for all people requires at least these three criteria: (1) valuing all individuals and populations equally, (2) recognizing and rectifying historical injustices, and (3) providing resources according to need. Simply stated, to later be elucidated, health disparities refer to differences health outcomes, while health equity is all that comes before. Thus, health disparities will be eliminated when health equity is achieved. To eliminate disparity and achieve health equity, it is necessary to address SDOH to achieve large and sustained improvements in health outcomes.

Jones is a family physician and epidemiologist whose work focuses on the impact of racism on the health and well-being of the nation. She is President of the American Public Health Association, member of the National Board of Public Health Examiners, and 2000-2010 research director on social determinants of health and equity within the National Center for Chronic Disease Prevention and Promotion at the CDC. To her, as an MD, MPH and PhD, health equity is not an achievement of the highest level of health for all people, but is clear that health equity is a process (Jones 2000). I, next, discuss the necessity to also address, what Jones names, social determinants of equity (SDOE). The mechanisms of SDOE are in our decision-making processes, including our structures, policies, practices, norms, and values. SDOE include systems of power—that of racism, sexism, heterosexism and economic systems, like capitalism (Jones 2000). These are the systems that create the range of contexts that we see in our nation, and that

differentially distribute different groups to different contexts. These systems must be visible if we want to achieve social justice and eliminate health disparity.

I. Components of Social Determinants of Health

Personal Health Practices and Coping Skills

As previously introduced, type II diabetes is a multifactorial condition occurring when the body becomes resistant or insensitive to the insulin-producing function of the pancreas. The metabolic and physiological consequences cause serious long-term health complications and has significant morbidity (Roper et al. 2001). This reality has implications for prevention and treatment. Conventional treatment strategies place onus upon individuals to self-manage their disease typically through combined clinical interventions and behavioral modifications. The results from the Diabetes Prevention Program (DPP) sponsored by the National Institute of Health (NIH) underlines the influence of volitional choices about health and related behaviors on personal health outcomes (Orchard et al. 2013). The DPP randomized a large cohort of participants with a wide distribution of age, obesity, and ethnic/racial backgrounds that were at high risk for developing type II diabetes. The results of the study showed that eliminating the known risk factors of a poor diet and low levels of exercise sharply reduced the chances that a person with pre-diabetes would develop diabetes (Orchard et al. 2013). In the short term, these efforts aim to lower blood glucose levels, while long-term goals are centered on mitigating further complications, morbidity, and premature mortality associated with the condition. Such recommendations and findings, while impressive, are generated under ideal institutional and financial circumstances that are typically not the reality of the everyday experiences of most patients living with diabetes and the health care settings charged with providing care to them. Further, research has demonstrated that the contributions of clinical factors and behavioral

choices to prevention and management of type II diabetes do not adequately explain poor diabetes-related health outcomes, particularly among those with lower socioeconomic status (Jack et al. 2004; Woolf and Braveman 2011).

Socioeconomic Environment

The socioeconomic environment incorporates a range of factors impacting population health. Socioeconomic status (SES) has traditionally been defined by education, income, and occupation. The effects of social isolation, lack of control in one's life and work life, risky lifestyle choices, food insecurity, lack of educational support and housing, job insecurity, and other psychological stresses have been shown to compromise health (Adler et al. 1994; Link and Phelan 1995). Each component provides different resources, displays different relationships to various health outcomes. Irrespective of the ways in which socioeconomic factors intermingle and influence one another, what is known is that health responds to social factors. The link between SES and health is not simply a reflection of have or have not but also to what degree socioeconomic level exists. The distribution of health is such that with each incremental increase in socioeconomic status, there is an incremental decrease in rates of illness. Morbidity and mortality, as it relates to social gradients, is a reality that affects the lives of children as well as adults (Marmot 2005). In the United States, the indicators of SES are strongly patterned by race/ethnicity, such that racial/ethnic differences in SES contribute to racial/ethnic differences in health (Williams and Collins 2001; Williams 1999). Together, these insights document that income inequality aggravates a deflection from the democratic process, whereby political policies favor the selected interests of the elite to the detriment of the disadvantaged (Kawachi and Kennedy 1999). There is decisive, self-perpetuating momentum towards health inequality. Socioeconomic policy nurtures inequality, and the outcome preserves the decisions and policy implementations consistent with health disparity.

Physical Environment

One's surroundings have a profound effect on health. Surroundings such as local housing conditions, community-level physical features, or broader environmental trends all act as determinants of health status. Multiple characteristics of neighborhoods are conducive to healthy or unhealthy behavioral practices. The environment to which one lives' can influence health through physical characteristics (air and water quality, exposures, access to parks, recreational facilities), the availability and quality of neighborhood, and social relationships within a geographic community (Williams and Collins 2001; Kawachi and Kennedy 1999). The perception of neighborhood safety is positively associated with physical exercise, and this association is larger for minority group members than for whites (Centers for Disease Control and Prevention 1996). Further, the availability and cost of fresh and nutritious products in grocery stores vary across residential areas, and the availability of nutritious foods is positively associated with their consumption (Adler et al. 1994). When barriers to these factors are present to individuals with diabetes, inadequate access to resources among such disadvantaged populations means fewer resources are available to overcome barriers, thus effects are magnified

Healthcare Services

Healthcare services as a social determinant broadly encompasses utilization patterns, quality of delivery, financing, and allocation of resources. Financial and institutional arrangements of health systems, as well as the legal, regulatory, and policy environment in which they operate, have disparate and negative effects on minorities' ability to attain quality care. Particularly, minorities experience a range of barriers (i.e. language, geography, and cultural familiarity) to accessing care, even when insured at the same level as white counterparts (CHI 2015). There is, however, increasing evidence that even after such differences are accounted for, race and ethnicity remain significant predictors of the quality of health care received (Smedley et

al. 2003). The sources of these disparities are complex, are rooted in historic and contemporary inequities, and involve many participants at several levels, including health systems, their administrative and bureaucratic processes, utilization managers, healthcare professionals, and patients. Research supports stereotyping, biases, and uncertainty on the part of healthcare providers can all contribute to unequal treatment (Smedley et al. 2003). The conditions in which many clinical encounters take place—characterized by high time pressure, cognitive complexity, and pressures for cost-containment—may enhance the likelihood that these processes will result in care poorly matched to minority patients' needs (Smedley et al. 2003).

II. Social Determinants of Health Equity

Culture as an Apparatus

There are conceptual pitfalls that sometimes lead social epidemiologists themselves to unwittingly reinforce the emphasis on proximate, individual-level risk factors. Often, a focus on the connection between social conditions to single diseases through single mechanisms, at static points in time, neglects the multifaceted and dynamic processes condition whose effect on health we originally sought to explain. The process of elucidating the mechanisms connecting social conditions to health and illness in this way may result in an incomplete understanding and an underestimation of the influence of social factors on health. In terms of the project, the mosaic of biological, demographic, social, and behavioral factors involved in the onset of type II diabetes is crucial to current renderings of the relationship between diabetes and culture. Although households and communities constitute important field locations of diabetes, various other locations where diabetes therapy, management, and education are mainstays for anthropological research (Ferzacca 2012). Especially salient among these are diabetes programs and educational

activities in clinics, hospitals and communities, and self-help organizations and associations of various kinds; and clinic and clinical encounters (Ferzacca 2012).

Culture has assumed a prominent role and has become a part of health strategies to understand patients' backgrounds. Research methodologies and academic curricula in the health sciences, institutionally sponsored health care and educational programming, in addition to government, non-government, and community-based policy and programming are nearly all organized around the fetish of culture (Betancourt et al. 2005). In fear of essentializing the entire discourse, it is safe to say that the consequences of applying "culture as apparatus" (Malinowski 1960) has resulted in a conceptualization of culture that uses the complex whole various through lists of relevant traits. The result has been a proliferation of experts and expert systems in medical research and practice terms as cultural competency, cultural safety, and so forth to account for and address the location of culture in health and health care (Betancourt et al. 2005). In consequence of the reification of culture, the patients identified are reduced to their allegedly cultural belonging and are converted into monoliths, deprived of their complexities and multiple histories. The procedure is in line with today's tendency to excessively emphasize identity, one identity, thus transforming any kind of problem in a cultural or ethnic conflict. As an anthropologist, I identify this conceptualization and use of culture as example of the misrecognition of the concept that obscures the fields of power within which meaningful action or culture takes place.

III. Local Context

Concentrated Poverty

An element to understanding the processes that lead to health disparities is contextualizing these processes in place, in and outside the seemingly inescapable health care

industrial complex. Medical anthropologist, Gay Becker (2004) argues that our nation's insistence upon neoliberal ideology is responsible for the poor health of 40-million uninsured Americans (258-260). By equating poverty with personal failure, this political and economic philosophy emphasizes, "traditional American values, such as individual, responsibility, productivity, and autonomy" (Becker 2004: 260). Similarly, Gregory Weiss (2006) writes:

The United States is alone [among developed nations] in taking the position that only people with sufficient resources—money or health insurance—have a right not to suffer needlessly from sickness. This position is often seen as being aligned with America's commitment to capitalism and private market forces...with a culture that places a higher value on individualism than community and higher value on self-interest than the general welfare (51).

Becker argues that this mindset leads to a distinction between deserving and undeserving patient populations wherein those without sufficient resources are portrayed as lazy, as drains on the system, and as unworthy to receive assistance (Becker 2004). She claims that patients with low socioeconomic status are depicted in this manner to justify the lack of social programs and the refusal to implement universal healthcare, yet the absence of these services merely perpetuates a system of poverty and inequality

The U.S. Census Bureau annual poverty data show us the aggregate level of disadvantage in America. Rather than spread evenly, the poor tend to cluster and concentrate in certain neighborhoods or groups of neighborhoods within a community (Kneebone, Nadeau, and Berube 2001). Poor neighborhoods face a whole host of challenges that come from concentrated disadvantage. A poor person or family in a very poor neighborhood must then deal not only with the challenges of individual poverty, but also with the added burdens that stem from the place in which they live. The perception of poverty is often subscribed to be synonymous with inner-cities and rural hinterlands, however recent studies indicate that concentrations of poverty over the decade are not confined to urban areas (Kneebone, Nadeau, and Berube 2001). In the 2011

report, *The Re-emergence of Concentrated Poverty* documents Colorado Springs to be a part of the ten metropolitan regions that experienced the highest increases in suburban poverty between 2000 and 2010. The proposition of being poor in a suburb may be beneficial if it means residents are in neighborhoods that offer greater access to better schools, affordable housing, or more jobs, than one would otherwise find in an urban neighborhood.

Research has shown that, instead, the suburban poor often end up in lower-income communities with less economic opportunity than that of higher-income suburbanites (Kneebone, Nadeau, and Berube 2001). Thus, rather than increased opportunities and connections, residents in poor suburban neighborhoods face similar challenges to those that accompany concentrated disadvantage in urban areas, but are less likely to have access to a robust and developed safety net (Kneebone, Nadeau, and Berube 2001). Quantitatively, the share of poor population living in tracts with poverty rates of 40% or higher rose from 1.5% to 3.3%—reflecting in more tangible terms, 40,916 to 76,720 community members (Kneebone, Nadeau, and Berube 2001). Moreover, those with poverty rates of 20% or higher rose drastically from 10.7% across six tracts to 45.2% across 30 tracts (Kneebone et al. 2011). The study indicates that Northern neighborhoods are largely wealthy, while large swaths in the Southeastern Colorado Springs grapple with poverty, high crime rates, and challenges associated with low-income communities (Kneebone, Nadeau, and Berube 2001). The study indicates that Northern neighborhoods are largely wealthy, while large swaths in the Southeastern Colorado Springs grapple with poverty, high crime rates, and challenges associated with low-income communities (Kneebone, Nadeau, and Berube 2001).

HISTORICAL ACCOUNTS

A focus on current events, powerful present-day actors, and the ethnographically visible undermines the process to which inequality is structured and legitimated over time. Erasure or distortion of history is part of the process of de-socialization necessary of for the emergence of hegemonic accounts of what happened and why (Farmer 2014). Farmer (2014) notes that the erasure of history is subtle and incremental and depends upon the erasure of links across time and space. Thus, imbalances of power cannot be erased without distortion of meaning. Without a historically deep and geographically broad analysis, one that accounts for the political economy, the study is at risk of seeing only the residue of meaning. Richly socialized accounts take time and space. This section is long in-length in part because the more one knows about something, the less easy it is to dismiss any twist of interpretation, any ostensibly arcane historical detail, as irrelevant (Farmer 2014). The richer our knowledge of material, the more relevant the burden of significance becomes, and links between apparently disparate acts and distance places are revealed.

Brief on Spanish-Speakers in Colorado

Hispanics and Latinx are a broad and growing community that represents 16.3% of the U.S. population, 20.7% of the state's population, and 16.1% of COS (U.S. Census Bureau 2010). The U.S. Office of Management and Budget guidelines for collecting and reporting race and ethnicity information classifies the ethnic category 'Hispanics and Latinos' to be persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race to the category (OMB 1997). Subscribed to these guidelines, Hispanic or Latin origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the U.S. While both Hispanic and

Latinx refer to a person from, or whose ancestors are, from a Spanish-speaking land or culture, Latinx is also conventional for people who are from Latin America. The process of bifurcation leads to the classification of all members of the ethnic category to be a culturally and genetically heterogeneous group (Figure 2). It is also important to make conceptual distinctions among the diverse migration experiences, in order to understand the transnational processes of migrant and minority populations into the metropolitan societies today.

Three types of transnational immigrants are distinguished as follows: *colonial/racial subjects of empire*, *colonial immigrants*, and *immigrants* (Grosfoguel 2003). *Colonial/racial subjects of empire* are those subjects that are inside the empire as part of a long colonial history that included racial slavery such as African Americans, Chicanos, Puerto Ricans, Pacific Islanders, Filipinos, or Chinese Americans. They arrived in the U.S. as part of a colonization process that gave wealth and privileges to European Americans. Grosfoguel et al. (2005) notes that the metropolitan colonial imaginary, racial and ethnic hierarchy and racist discourses are frequently constructed in relation to these colonial subjects. In the conceptualization, *immigrants* are those migrants who, once they adopt the metropolitan language, accent, demeanors and manners, are assimilated, within the public domain, to the dominant metropolitan populations (Grosfoguel et al. 2005). These migrants are composed of the following: European migrants that after one or two generations become incorporated into mainstream as “white”; Japanese executives that are invited as “honorary whites”; or the 1960s cohort of Cubans anticommunist refugees who, through a combination of U.S. foreign policy and federal government policies, were incorporated as “honorary whites” (Grosfoguel 2005). When the racist discourses constructed toward the “colonial/racial subjects of the empire” are transferred to the recently arrived migrants from the peripheral neocolonial locations in the capitalist world-economy, we

have the reproduction of the experience of *colonial immigrants* (Grosfoguel et al. 2005). Thus, many migrants from formally independent Caribbean, Central American, and South American countries become colonial immigrants in the U.S. and hold a class position higher than the colonial migrants that are part of colonial/racial subjects of the empire (Grosfoguel et al. 2005).

In the United States, the Hispanic and Latinx population is largely fragmented into zones and nodes, best understood and appreciated through the lens of regional inspection, across settlements, scales, and through time. In 1492, three small vessels flying the Spanish flag made their landfall in the Caribbean Sea. From its original toehold in the Caribbean islands, Spain pushed its fledging in all directions of exploration, exploitation, and colonization. The history of Spanish-speaking peoples in present-day Colorado dates to explorers from Spain or Mexico who began to enter the area that has become the Southwestern U.S. in the 1540s. Led by Don Francisco Vásquez de Coronado, a full-scale expedition of some 200 horsemen, 70 foot soldiers, and almost 1,000 Indians assembled in the Spring of 1540 (Ubbelohde, Benson, and Smith 2015). On the basis of grants from the Spanish crown, colonists moved north from central Mexico through desert country, reaching Hawikuh, the first of the Zuni pueblos. From Zuni, Coronado traveled to the upper Rio Grande and discovered land of other indigenous peoples. In 1598, Juan de Oñate started for the valley of the pueblos, under contract with the Crown, with 130 settler-families, a band of Franciscan friars, 270 Indian and black slaves, and 7,000 head of stock (Ubbelohde, Benson, and Smith 2015). The “kingdom and provinces of New Mexico” were born.

By 1609, Spain had founded the Royal City of Santa Fe, for many years to be the capital of the northern outposts of the empire—1,500 miles from the seat of the viceroyalty at Mexico City (Ubbelohde, Benson, and Smith 2015). Cross and Crown played dual roles in New Mexico

as they had earlier in New Spain. Ubbelohde et al. (2015) shares that missionary friars were as eager to save the souls of Pueblo Indians as soldiers were to stretch the boundaries of the empire. Together priest and captain established an ascendancy over the Pueblo tribes as far north as Taos. Apaches and the Navajos kept up a perpetual pressure on the fringes of the New Mexican outpost. Farther north, in the mountains whose streams fed the Rio Grande, lived the Utes. The Utes were the most permanent residents of the Colorado region, in proximity to the mountain passes at the time of the earliest Spanish penetration. Gradually, through expeditions against Indians, the Spaniards pushed northward from Santa Fe, acquainting themselves with the area of present-day Colorado.

For three centuries, the Spanish ruled with viciousness until the Reign of Terror crumbled in 1810 (McIntosh 2016). In 1821, Mexico received independence from Spain, signaling the start of trade relations between the United States and Mexico along the Santa Fe trail (Ubbelohde, Benson, and Smith 2015). The influx of trade and traffic did not quell internal strife, as Mexico was dependent on foreign economies. In effort to populate the region, the Mexican government continued a policy initiated by Spain that allowed Americans to settle in the region. Wealthy immigrants embodied the mythology of Manifest Destiny, purchasing land grants and expanding their land base. By the 1830s immigrants outnumbered Mexicans in Texas. The fledgling nation's liberal policy backfired when Texas declared itself independent from Mexico in 1836, and the U.S. annexed the state in 1845 (King 2000) The U.S. invaded Mexico triggering the Mexican-American War of 1846-1848 (King 2000). During this period, American expansionists interested in laying claim to Mexican territory became increasingly vocal and aggressive. Secretary of State James Buchanan, for instance, recommended U.S. territorial goals be pursued through a policy of "firmness and action

accompanied by moderation of language” toward Mexico such that the “power and true greatness [that] belong to our country ought never waste themselves in words towards a feeble and distracted sister republic,” (King 2000). More accurately described as the U.S. invasion, the war resulted in 50% loss of Mexican territory. The war ended in 1848 when the Mexican army surrendered at Chapultepec Castle and the U.S. army occupied Mexico City.

In accordance with the Treaty of Guadalupe Hidalgo, Mexico ceded nearly half of Mexico’s territory, New Mexico and the southern edge of Colorado, to the United States in exchange for \$US15-million (McIntosh 2016). The land of the Southwest once held by indigenous nations, Spain, then Mexico, was now that of the United States. Polly Baca, descendant of Spanish and Mexican colonists of New Mexico and Colorado of the 1600s and former Colorado state legislator, was featured in the Rocky Mountain PBS documentary, *La Raza de Colorado*. Baca accounted her great-great grandfather living under three different flags without moving—being born a Spanish citizen in 1820, a Mexican citizen at the age of one, and an American citizen by the time he was twenty-eight (Rocky Mountain PBS 2005; Figure 5). People living in those areas were given one year to either move further South to remain a part Mexico or stay on their land and subsequently become American citizens (McIntosh 2016; Rocky Mountain PBS 2005).

As immigrant settlers began to move into New Mexico and Southern Colorado, they joined wealthy Hispanics in court to establish their own claims to property. These new American nationals had a difficult task of adjusting to the “immigrant” economic and political system. Mexican Americans quickly lost their political power they needed to protect their rights. By 1890, 90% of Mexican-American ancestral land was lost to force and fraud (McIntosh 2016). Mexican Americans had become a small minority of second-class citizens. However, by the end

of the nineteenth century, just as immigrant in-migration overwhelmed Mexican culture, early states of what was to become a massive tide of immigration developed. Colorado transformed from an isolated western outpost to a thriving industrial state leading to the first domestic labor shortage with the growth of mining, commercial agriculture, and railways (Rocky Mountain PBS 2005). The diversification and strengthening of the Colorado economy brought an influx of newcomers.

The local research setting, Colorado Springs, stands on a mesa near the eastern base of Pikes Peak, a seat of El Paso County of Central Colorado. Founded in 1871 as Fountain Colony by General William J. Palmer, builder of the Denver and Rio Grande Western Railroad, it was renamed for the nearby Manitou mineral springs (Loeffler et al. 2015). Growth of the area followed gold strikes in the 1890's and the promotion of tourism related to the health-resort trade. The hot mineral springs in the hills beckoned tourists, particularly the health seekers. In 1917, Colorado Springs consolidated with Colorado City, founded in 1859 as El Dorado City. The establishment of military installations gave further impetus to development (Loeffler et al. 2015). Ethnic migrant workers crowded into segregated communities near sugar beet fields, far from the city center. The dynamics of social exclusion and the limits placed on citizenship play out on streets, and in fields, homes and clinics in the form of economic scarcity, food insecurity and hunger, exclusion from care, and restrictions on the professional autonomy of health providers. Further, in 1910s and 1920s political conflict in Mexico led to one million Mexicans fleeing their country to escape danger heightened by the Mexican Revolution (Rocky Mountain PBS 2005). The volume of immigration rapidly took off as a result of deteriorating economic conditions and violence in Mexico. The U.S. depended on the extensive recruitment of Mexican workers during World War I and after the passage of the Immigration Act of 1924, as it restricted

immigration of people from the Middle East and Southern and Eastern Europe. All lines from Mexico converged into El Paso and led to Los Angeles, Chicago, and Denver's Union Station (Loeffler et al. 2015). In 1929, the stock market crashed in which plummeting employment rates led to the Great Depression. Without jobs, Mexicans and Mexican-Americans alike rounded up at Denver's Union Station being deported under the command of President Herbert Hoover (Loeffler et al. 2015). The constant presence of Mexican ancestry that remained in the U.S. did little to appease the bigotry of the Ku Klux Klan vigilante organizations (Loeffler et al. 2015).

At the start of the second World War, the U.S. reverted to the cycle of dependency of migrant workers to fill the jobs of soldiers and fulfill wartime production. Mexican migrant workers, often called *braseros*, toiled U.S. soils replacing agricultural workers in the U.S. Cultural differences were confused with political descent, in which segregated U.S. waged war abroad as well as at home (Rocky Mountain PBS 2005). The vulnerability of migrants is exacerbated by their interactions as economically disenfranchised laborers in a society that regards them as criminals devalues their individual and cultural worth. In the remaining twentieth century, each decade experienced sizeable immigration from Mexico, in which millions of Mexican Americans lived and worked in the U.S. (Noel et al. 2011). The recession after World War II caused many Americans to view their Mexican neighbors as a threat to their personal economic well-being. This devaluation is a routinized, lived experience shared across the U.S., not confined to those lacking legal status (Chavez 2003). A massive roundup and deportation of undocumented Mexicans in 1951 by a special mobile force became known as Operation Wetback, in which human rights and civil liberties of Mexican-Americans were often ignored by the militarized force and deportees were intimidated by harsh and contemptuous treatment (Noel et al. 2011). Following a decade of diminution, undocumented immigration

began to sour after the end of *braserio* arrangements in 1964 (Noel et al. 2011). Daunted by the expenses and increasing bureaucratic red tape of legal entry and abetted by institutionalized migratory patterns and traditions, heavy migration continuously created new, largely unassimilated generations (Noel et al. 2011).

Only a small percentage of today's Mexican-American population is descended from their Mexican ancestors. Immigration to the U.S. and the associated struggle to be accepted into the U.S. mainstream have been constant. Most are descendants of twentieth-century immigrants, who like their predecessors, came primarily in response to economic opportunity and its absence in Mexico (Noel et al. 2011). Migrants occupied a disjunctive liminal quasi-caste status. They were stereotypically presumed to be excluded from the entitlements of citizenship casted as fiscal consequences of population pressure on local governments, euphemized crises of moral turpitude, and threats to national cultural cohesion. Significantly, however, a sharp gradient distinguishes the life chances of Hispanic and Latinx identified individuals according to class, citizenship status, racialized stereotyping, and ethnic hierarchies. Grosfoguel et al. (2005) further notes the reproduction of the old colonial and racial hierarchies of Europeans and Euro-Americans versus non-Europeans along with the hegemony of racist ideologies inside each metropolitan center. Those groups coming from colonial or neocolonial experiences are the ones with the highest poverty rates. Chicano, Puerto Rican, Salvadoran, Guatemalan, and Mexican migrants share the bottom of the racial and ethnic hierarchy together with African Americans, Native Americans, Filipinos, and Pacific Islanders (Grosfoguel et al. 2005). There are migrant groups that, due to their class origin, experience upward social mobility very reflective of the experiences of early century European immigrants. These groups are usually portrayed as model minorities, such as the case of migrants coming from Korea, Cuba, Hong Kong, and Taiwan.

This contributes to the invisibility of the still persistent racial discrimination in America as denials of racism are a common feature of metropolitan discussions about racial and ethnic minorities (Grosfoguel et al. 2005).

Prevalent ideology that holds that racism and colonial relations are a thing of the past is linked to the switch from biological to cultural racist discourses (Grosfoguel et al. 2005). The cultural discourse internalizes the causes inside discriminated communities by explaining their social situation in terms of their own cultural features, concealing the reproduction of racism and old hierarchies inside the metropolis (Grosfoguel et al 2005). In these terms, subjects experiencing higher unemployment rates, higher poverty rates, higher dropout rates, or less quality education at schools it is because they are “lazy,” “unassimilated,” “uneducated,” have “bad habits,” “bad attitudes,” or “un-adapted culture” (Grosfoguel et al. 2005). By implicating social conditions, the framework of structural violence attends closely to those variables and critiques the conceptualization of ethnic categorization as an ‘at risk population’ in which individuals engage in risky practices with an accompanying connotation of individual and collective, cultural guilt (Hernandez-Rosete Martinez et al. 2005). While risk points to a probability and evokes an individual behavior, violence is an indicator of inequity and social inequality and demands responses in the sphere of the social and political structure.

Legally Segregated Healthcare Facilities and Contemporary de Facto

From the earliest periods of America’s history, sharp division across racial and ethnic lines were customary in virtually all sectors of society, including medical practice. This subsection is committed to embedding evidence within the historically given social and economic structures that shape lived experience—as an attempt to depict the social machinery of oppression by bringing connections into relief. Modern medicine has fixed its own date of birth as being in the last years of the eighteenth century. Interestingly, the origins of racially

segregated healthcare systems can be traced back to slavery. While these systems were loosely organized, plantation health services were the earliest and one of the only systems comparable to today's managed-care plans (Smith 1999). Plantation owners, as employers, had a significant financial interest in preserving the health of their "employees". After emancipation, the plantation system of medical care ended and the Freedmen's Bureau was established by the federal government (Smith 1999).

Towards the early and mid 1800s, scientific theories about race had emerged that viewed our human race as bifurcate species towards the early and mid 1800s. These biological theories placed such socially-constructed "races" of into hierarchical classes. These systems of knowledge and power permeated the lives of former slaves. The medical department of the Bureau established nearly 100 hospitals for freed slaves, however, but by 1886 only one remained (Smith 1999). Afterwards, African Americans received healthcare in segregated facilities in northern hospitals created by local governments. In the south, where most African Americans resided, local municipalities and states began to provide payments to hospitals to subsidize care for the underserved, which included segregated care for the poor (Smith 1999). American Indians, who experienced displacement and high mortality, had little contact with health systems until the second half of the nineteenth century. This healthcare, administered by the government was also poor, inadequately funded, and not sensitive to culture (Byrd and Clayton 2000). As the country approached the twentieth century, the passage of Jim Crow laws solidified racial divides by legally separating facilities that provides care to black and white communities (Smith 1999). In the scientific community, theories such as Darwinism, eugenics, and later, psychometric testing were developed to explain and predict the inferiority of certain groups, such as immigrants, African Americans, the poor, and the mentally disabled (Byrd and

Clayton 2000). As hospital facilities became more important to the practice of medicine, standardization processes enabled medical staffs at hospitals to become more organized and exercise control over practices in their facilities (Brauer 2001; Smith 1999). This essentially resulted in the exclusion of minority physicians from practicing in these institutions.

Marginalized groups, including African Americans, American Indians, Hispanic and Latinx Americans, and others from racial or religious minority groups were isolated, excluded from training, and professionally segregated (Byrd and Clayton 2000).

In a parallel movement, issues of payment for medical care became prominent as these services become increasingly important in peoples' lives. Questions about whether care should be based on need or ability to pay became influenced, in part, by racial and ethnic identity. The passage of civil rights legislation in 1965 and Medicare and Medicaid legislation in 1965 stimulated profound changes in the structure of healthcare. With mandated integration, one of the most significant changes was the closing of black hospitals. Between 1961-1988, 70 black hospitals either closed or merged with white facilities (Smith 1999). While on the surface these closings may seem like a mere shifting of service sites, with further examination one can imagine the profound and devastating effects on minority communities—a loss of geographic convenience and accessibility to care, a sense of safety with known institutions, and a loss of a major source of employment in the community (Smith 1999). A similar fate was befalling many public facilities that had provided access to many minority patients. A major, and more recent, shift in healthcare structure began in the late 1980s with the rise of managed care. As noted, this movement was initiated as both private and public payers were overwhelmed by rising costs and were searching for alternative ways to control their expenditures. By 1996, two-thirds of African American and Hispanics with private insurance were enrolled in managed care plans (Smith

1999). The transformation of Medicare programs to managed care formats led to further downsizing of large urban hospitals (Smith 1999).

During the 1960s, several new federal efforts were developed to increase healthcare services in poor communities. Services such as the National Health Centers Program were initiated to help strengthen the workforce in medically underserved communities (Heinrich 2000). By 1996, 625 community health centers (CHCs) provided services at over 3,900 sites (Council on Graduate Medical Education 1998). The large majority of patient served by CHCs are non-white. By the mid-1990s, rates of Hispanic visits to community health centers were 700% higher. The CHC model has proven effective not only in creating access to care, but also in improving health outcomes for the often higher-risk populations they serve. The continuity of care has been found to be better in CHCs than in hospital outpatient or physician offices, and a study examining preventable hospitalizations among medically underserved communities found that in communities served by FQHCs were lower than in communities not served by these centers (Epstein 2001). While CHCs were developed on the premise that they would serve all patients regardless of their ability to pay, limited federal subsidies have forced clinics to reduce the amount of uncompensated care they provide—an item of contemporary exigency (Epstein 2001).

THEORETICAL FRAMEWORK

In this section, the reader explores the intellectual territory of integrated health care through the ideas of Michel Foucault and Pierre Bourdieu. The analytical framework utilized relies on their theoretical foundation of Bourdieu and Foucault to take the social determinant of disparity perspective as a foundation to build upon a wider range of critical social science often outside of medicine and public health theory. Highlighted by terms such as: racial/ethnic disparities in

health, eco-social models of health, upstream factors in health, structural violence, fundamental social causes of health social suffering, patient-centeredness, and cultural competency, I expand and define more practically the diversity of forces both external and internal to the clinical encounter. Deconstruction of data and building of thematic hierarchies are located within the tradition of critical discourse analysis. When translated into practice, the discursive lens can become a productive tool for contextualizing diagnosis of diabetes and informing critical praxis.

I. Bourdieu: Logic of Practice

Economy of Social Being

Pierre Bourdieu first published *Outline of a Theory of Practice* in French in 1972. The pivotal text seeks to define the prerequisites for a truly scientific discourse on human behavior. Bourdieu proposes a structural theory of practice which connects agency in a dialectical relationship between culture, structure, and power. As a political-reflective practice, his social science, which calls for the “*theory of practice*” (Bourdieu 1990) is ultimately aimed at the creation of a new subjectivity in its confrontation with objectified social structures (Delanty 1997). He recognizes the social relations among actors as being structures by, and in turn contributing to the structuring of, the social relations of power among different positions (Bourdieu 1990). To understand the totality of Bourdieu and his work requires the view of social science as an economy of social being, in which being is unequally distributed and actively accumulated.

The conception of the interplay between the self and society and the ability to accumulate being through the following three modes: social investment (*illusio*), recognition (*capital*), and practical efficiency (*habitus*). The concept of *illusio* is crucial to conceiving the interplay between the self and society, linked to illusion. In these terms, society distributes meaning of

life, and, thus, the meaning of life plays a role to grounding oneself to social reality. Bourdieu notes the importance of social aging as an operational function to which being can be increasingly ossified (Bourdieu 2002). Linked to *illusio*, capital—social (relations), cultural (know how), and symbolic (amount of recognition offered by capital)—determines the specific form of accumulated capital is recognized. Capital is arbitrary, in that the value of capital is intersubjective. is arbitrary, in which and that it is what matters to the subject that they want to pursue and gives meaning to life (Bourdieu 2002).

Habitus

To Bourdieu, habitus is present in each agent by their earliest upbringing to produce individual and collective practices, and hence history, in accordance with the schemes engendered by history—not only as a precondition for the coordination of practices, but also for practices of coordination. Bourdieu alludes to habitus as a metaphorical “man” inveterate within us. He writes, “in each of us, in varying proportions, there is part of yesterday’s man; it is yesterday’s man who inevitably predominates us, since the present amount to little compared with the long past in the course which we were formed and from which we result,” (1998:79). We do not sense this meta-*man* of the unconscious, but rather they represent the mediation of orientation and limits, set by historically and situation conditions of its production. Bourdieu more formally defines habitus as:

...a system of durable, transposable disposition, structured structures predisposed to function as structuring structures, that is, as principles which generate and organize practices and representations which can be objectively “regulated” and “regular” without in any way being the product of obedience to rules, objectively adapted to their goals without presupposing a conscious aiming at ends or an express mastery of the operations necessary to attain them and, being all this, collectively orchestrated without being the product of the orchestrating action of a conductor (1990:53).

According to Bourdieu’s proper definition, the dispositions represented by the habitus are durable in that they last throughout an agent’s lifetime. Further, they are transposable in that they

may generate practices in multiple and diverse fields of activity, and they are structured structures in that they inevitably incorporate the objective social conditions of the process.

The habitus can be thought of as a practical sense (*sens pratique*) that inclines agents to act and react in specific situation in a manner that is not always calculated and that is not simply a question of conscious obedience to rules (Bourdieu and Johnson 1993). Rather, it is a set of dispositions that engender practices and perceptions. Bourdieu's work on habitus stands out because of its' sophistication it provides in dealing with complex processes of embodiment. The habitus does not negate the possibility of strategic calculation or conscious obedience to the rules, but it functions in quite a different manner (Bourdieu and Johnson 1993). In *Logic of Practice*, Bourdieu's states:

This system of dispositions—a present past that tends to perpetuate itself into the future by reactivation in similarly structured practices, an internal law through which the law of external necessities, irreducible to immediate constraint, is constantly exerted—is the principle of the continuity and regularity which objectivism sees in social practices without being able to account for it; and also of the regulated transformations that cannot be explained either by the extrinsic, instantaneous determinants of mechanistic sociology or by purely internal but equally instantaneous determination of spontaneous subjectivism (Bourdieu and Johnson 1993:6).

Agents act in accord to social situations governed by a set of objective social relations. Bourdieu terms the socially structured space in which agents play out their engagements with each other, a field. A field is a relational configuration, “endowed with a specific gravity which imposes on all the objects and agents which enter in it” (Bourdieu and Wacquant 1992:17). A field, is also a space of conflict and competition. A field, then, is a space within a network of objective relations between positions. These positions are objectively defined in the determinations they impose on actors and institutions, by their situation in the structure in the distribution of power (Hillier and Rooksby 2005).

In the Field

For the purposes of this thesis, the merit of his constructivist analysis lies in the manner that Bourdieu links, in a theoretical and meaningful way, both lifestyle choices (i.e agency) and their broader material, social, cultural, and symbolic determinants (i.e structure). This has important implications for the understanding of health disparity amongst those and within the context of the different fields of society and the struggle for social distinction. Along these lines, Göran Dahlgren and Margaret Whitehead (1991) developed a graphical model attempting to capture the relationship between different modes of explanation. The socio-ecological model provides a convenient framework within which to discuss existing approaches to the study. Individuals are placed at the heart of the model, surrounded by a series of layers—one on top of the other (Figure 6). The layers represent material and social conditions in which people live and work, determined by various sectors. While the distinction between the layers of the Dahlgren-Whitehead model is a convenient one, these layers have thin membranes, and interact in complex ways. As Alvin Tarlov has it:

the rings are porous... [the model]... is not like a game of pool wherein a ball in the outer ring strikes a stationary ball in the intermediate ring which in turn collides with a resting ball in the inner ring... all of the balls are in motion most of the time (1996:83).

This interaction, or ‘porosity’ between different layers of explanation is central to the work of social theorists, such as Bourdieu (1977, 1990). The philosophical inheritance grounded in Bourdieu’s work positions transcendental views within the social world. Bourdieu challenges boundaries and division of forces of attention to social conditions, and asks social science to engage in empirically asking and answering serious philosophical questions. In terms of dismantling national frameworks of addressing health, complex dynamics of policies implemented render critical analysis. As such, social constructionism provides a counter to medicine’s deterministic logic in ways that can broaden and enrich policy deliberations and

decisions. To that end, we must routinely ask ourselves: What is the definition of the problem upon which this policy is based, how was it developed, and what are the consequences of adopting this definition? Without these theoretically important questions to guide us in decision-making, there is threat of serious errors in the implementation of future health reforms and health-related policy initiatives.

Looking to larger phenomena discussed through a Bourdieuan framework, Ernesto Laclau explains that, on one hand, democracy was the attempt to organize the political space around the universality of the community, without hierarchies and distinctions. On the other hand, democracy has also been conceived in the expansion of the logic of equality to increasingly wider spheres of social relations—social and economic equality, racial/ethnic equality, gender equality, and so forth. If either of these incompatible dimensions prevail beyond a certain point, democracy is not within limits (Hillier and Rooksby 2005). That several forms of this tension are making democracy fragile by recent political acumen in the U.S. is evident—witness to the difficult questions concerning the status of immigrants, women, and those of all kinds of socially-constructed particularities. I find it necessary to accept that both tensions and ambiguity are present, as it is necessary to find a practical way of coping with them.

To add to this, consider democracy to be a type of regime which makes fully visible the contingent character of the hegemonic link (Hillier and Rooksby 2005). All groups are particularities within the social, structured around specific interests to become hegemonic when they take up the universality of the community, conceived as the whole (Hillier and Rooksby 2005). The identification of the interests of a class with those of society as a whole, in this sense, presupposes political mediation and a process of mutual contamination between particularity and universality. Without the unevenness of power at the level of society there would be neither

universality and particularity (Hillier and Rooksby 2005). However, the hegemonic relation is constitutive of the unevenness of power, as a defining dimension. In line with phenomena of the neoliberal capitalist mirage, Lacau notes that democracy presupposes that the place of power remains empty and that it does not predetermine the nature of the force which is going to occupy it (Hillier and Rooksby 2005). Thus, unlike a hierarchical society of continuity, democracy lays a separation between the universal form of the community and the content which fills it. The more democratic a society, in these terms, the more absolute the opposition between power and the fullness of the community is going to be. Thus, in to have democracy there needs to be forces that occupy the empty place of power, but do not identify with it.

II. Foucault:

Philosophical Inheritance

Within the field of health inequalities, there is a widespread acceptance for the need of a deeper understanding of the relationship between the individual and their social context. In *Understanding the Social Science* (1985), Roger Trigg manages within a brief space to reflect upon the shift in interests away from debates of reasons rather than causes and to topics on the nature of social reality—the understanding of other cultures, rationality, and the “*strong programme*” in the sociology of knowledge. To Trigg, the strong program emphasizes a concern with providing a causal explanation of the beliefs that are generally accepted in society. The information comprised in the sociology of knowledge must itself be taken to be socially produced, as adherents of the strong program insist (Collin 1987). Wainwright and Forbes (2000) offer their concern, however, that the philosophical basis of many theories is rarely discussed. They seek to redress these shortcomings by exploring the ontology (what there is) and the epistemology (how we think about ‘what there is’) of social research on health inequalities.

The authors (2000) acknowledge that philosophical discourse within the field of health inequalities presents as a paradox, in stating, “While on one level the philosophical stance adopted by most researches is fairly transparent if only overtly stated, dividing broadly into positivism and interpretivism... on another level the field seems to operate in something of a philosophical void,” (260). Wainwright and Forbes (2000) call for refocused view of the familiar world to explore that which is not already known and transcend the prevailing ontological reductionism of positivism and interpretivism—in either, accepting what is known to exist and can be measured or accepting nearly everything as it is, or is construed to be by those deemed relevant. While these positions result in contextual stripping at the micro and macro level, the following section offers a fruitful means of extending and deepening our understanding of health inequalities (Wainwright and Forbes 2000).

Situating Foucault

Foucault has been particularly useful in locating the historical functions of the clinic as a site of bio-power, power’s hold over life (Foucault 1973, Foucault 1975-6). In effort to pull together the loose threads of my argument, I reach back yet again to phenomena of the nineteenth century through. I refer to the acquisition of power over man insofar as man is a living being, that the biological came under State control that might be termed State control of the biological (Foucault 1975-6). In *Society Must be Defended*, Foucault states:

And I think that one of the greatest transformations political right underwent in the nineteenth century was precisely that, I wouldn’t say exactly that sovereignty’s old right—to take life or let live—was preplaced, but it came to be complemented by a new right which does not erase the old right but which does penetrate it, permeate it. This is the right, or rather the opposite right. It is the power to “make” live and “let” lie. The right of sovereignty was the right to take life or let live. And then this new right is established: the right to make live and to let die (1975-6:241).

The transformation was a process that did not occur all at once. Foucault traces the transformation by mechanisms, techniques, and technologies of power. In the seventeenth and

eighteenth centuries, technologies of power emerged that were centered on the individual body. These devices were used, Foucault proposes, to ensure the spatial distribution of individual bodies—their separation, their alignment, their serialization, and their surveillance—and the organization, around those individuals, of a whole field of visibility. He offers that these were techniques that could be used to take control over bodies.

Foucault compares the disciplinary technology of the body to the emerging regulatory technology of life. He explains, “Unlike discipline, which is addressed to bodies, this new non-disciplinary is applied not to man-as-body but to the living man, to man-as-living-being; ultimately, if you like, to man-as-species,” (Foucault 1975-6:249). Disciplinary technique centers on the body, produces individualizing effects, while the alternative is centered, not on the body, but, on life. Foucault explains that the two sets of mechanisms, one disciplinary and the other regulatory, do not exist at the same level. Thus, these mechanisms are not mutually exclusive and can be articulated with each other. Foucault offers an example a town, a rationally planned layout town:

One can easily see how the very grid pattern, the very layout, of the estate articulated, in a sort of perpendicular way, the disciplinary mechanisms that controlled the body or bodies, by localizing families (one to a house) and individuals (one to a room). The layout, the fact that individuals were made visible, and the normalization of behavior meant that a sort of spontaneous policing or control was carried out by the spatial layout of the town itself... And then you have a whole series of mechanisms, which apply to the population as such and which allow, which encourage patterns of saving related to housing, to the rendering of accommodations and, in some cases, their purchase (251).

The example here relates to health-insurance systems, old-age pensions, rules on hygiene, and so forth. However, Foucault notes, that an element circulates between the disciplinary and the regulatory—the norm. To Foucault, the norm is something that can be applied to a body one wishes to discipline and a population one wishes to regularize. The normalizing society is a

society that in which the norm of discipline and the norm of regulation intersect along an orthogonal articulation—covering the whole surface that lies between organic and biological, between body and population (Foucault 1975-6).

Racism, to Foucault, is primarily a way of introducing a break between what must live and what must die. He documents the appearance within the biological continuum of the human race of races, the distinction among races, and the hierarchy of races all in a way of fragmenting the field of the biological that power controls. Further, the role of racism functions in a way that makes it possible to establish a positive relation of war: “If you want to live, you must take lives, you must be able to kill”, or, “In order to live, you must destroy your enemies,” (Foucault 1975-6:255). In this manner, racism makes it possible to establish a biological relationship: “The more inferior species die out, the more abnormal individuals are eliminated, the fewer degenerates there will be in the species as the whole, and the more, I—as species rather than individual—can live, the stronger I will be, the more vigorous I will be. I will be able to proliferate,” (Foucault 1975-6:255).

III. Discourse of Care

Discourse Analysis

Discourse analysis was grounded upon a multidisciplinary foundation, including the influences of Bourdieu. The methodology involves a focus upon sociocultural and political context in which text and talk occur. Discourse analysis, is above all, concerned with a critical analysis of the use of language and the reproduction of dominant ideologies in discourse—defined here as a group of ideas or patterned way of thinking which can be identified by in textual and verbal communications and located in wider social structures (Lupton 1992). It is a social analytical framework that offers a means to interpret what textual and contextual messages

carry. Textual dimensions are those which account for the structures of discourses, while contextual dimensions relate these structural descriptions to various properties of the social, political, or cultural context in which they take place. The former is therefore concerned with such micro elements of discourse as the use of grammar, rhetorical devices, syntax, sound forms, and the overt meaning and content matter of words and sentences of a text or talk, and macro structures as topics and themes (Lupton 1992). The latter looks at the production and reception processes of discourse, with attention to the reproduction of ideology and hegemony in such processes, and the links between discourse structures and social interaction and situations (Lupton 1992).

Discourse analysis seeks to discover the structures, strategies, or other components of written or verbal text that perpetuate dominance, whether it takes the form of social, political, cultural, racial, ethnic, or gender inequality (van Dijk 1993). The approach recognizes that social phenomena, along with the observer of such phenomena, are historically positioned and, therefore, relative. It does not simple involve cataloging observation of patterns, but rather, aims to identify cultural hegemony and the many by which it is reproduced. Power differentials, are informed as entities requiring redress through such a lens. A discursive analysis, then, was determined to be the most suitable foundation to reconstruct findings.

Carefully Integrated Care

The word ‘integration’ stems from the Latin verb *integer*, that is, ‘to complete.’ The adjective ‘integrated’ means ‘organic part of a whole,’ or ‘reunited parts of a whole,’ that express the merging of components that were formerly separate. To Kodner and Spreeuwenberg (2002), the idea of comprehensiveness overlaps with that of integration. They allude to the original meaning of the Greek verb ‘diagnosis,’ ‘comprehensive’ denotes a ‘full understanding of a situation’, connoting a desire to understand the relationship of elements that constitute the

entirety. In consideration of Bourdieu and reaching to Foucault, systems in the field are comprised of separate, but interconnected components. The division, decentralization, and specialization found in the grid of more complex organization interferes with the fulfillment of all component parts. These ideas are applicable to the medical-industrial complex. Historically, the patterns of development, like with any industry as it develops under capitalism, were increasingly broken into simple, finite tasks. Thus, in theory, the least expensive worker possible then could be hired to accomplish them. At the same time, the gathering of more and more expensive technology under one corporate system requires the increasing division of labor into specialties. In both the development of medicine and capitalism, an aggressive nihilism obliterates the intrinsic value.

To Bourdieu and Foucault, health and health care are viewed as dynamic processes. Thus, discourses of health and place cannot be thought of as abstract, disconnected things because health-related systems of power and knowledge are deployed and practiced by social actors through various organizations and places, structured and situated by history. Furthermore, the ideas demand for the work to consider the interplay of sovereign power, bio-politics, and concepts of security and race. Foucault alludes to these systems of power and knowledge materially constituted in the construction of places as clinics. As noted in practice transformation initiatives in Colorado Springs, integrated care in health systems often denotes a collection of strategies encompassing patient-centered, collaborative processes amongst professions and organizations to address the fragmented, uncoordinated health systems and increase accessibility to care for vulnerable populations. Safety net clinics are known to be sources of primary care for racial/ethnic minorities and other vulnerable bifurcated members of civil society. In this context, primary care, as stated in the WHO declaration of Alma-Ata, is a strategy of public health

derived from a social model of health (WHO 1978). The philosophy derived through the model of primary care goes beyond the realm of medicine and requires links between health and the social. Therefore, settings like safety net clinics, are a place of material promise that underpin a broad collaboration when dealing with community problems.

METHODOLOGY

An anthropologically derived research design was implemented to counter the trajectory of modern epidemiology toward identifying risk factors that are increasingly proximal to disease. The research opens an interpretive framework to understand how health workers conceive why people come to be exposed to risk or protective factors and determine the social conditions under which individual risk factors are related to disease. I present a myriad of data displays and forms to develop a more meaningful and realistic account of diabetes care that is responsive to community capital and capabilities. In this way, this thesis unfolds at uneasy interstices, trying to offer an ethnographic snapshot that lets messy situations remain messy. It considers the complexities of medicine in relation to local environments, as well as the shifting rationales and difficult choices of prioritization that are on the agenda for national and local actors.

I. Research Design

Study Setting

Within El Paso County—a mix of urban, suburban, and rural communities—about two-thirds of the population reside within the confines of Colorado Springs, CO. Colorado Springs lies at the base of Pikes Peak in a high desert with the Southern Rocky Mountains to the west and high plains further east. The life zones of the Pikes Peak region of many ecosystems—from grasslands to forests to tundra—offer a way into local ecosystems to begin to grasp the ecology of the Pikes Peak Region. Much like the people of Colorado Springs, within each zone there are

hundreds of community types depending on slope aspect, soil type, water availability, and countless other factors (Colorado College 2016). The enormity of scale of the geological structure of the Front Range is something that is difficult to perceive at once, but begin to understand gradually over time, and with deepening acquaintance. Acknowledging the intricacies of this place is critical if we are to build roots in this community and fully appreciate all that it takes to live in the city.

The city is home to a bustling high-tech industry, academic institutions, numerous tourist attractions, national governing bodies of sport such as the U.S. Olympic Committee and the U.S. Olympic Training Center, and several military installations of vital importance to the U.S. continental defense. The health service sites of the country at large consist of a mix of 14 community health centers (FQHCs), six mental health centers, eight safety net clinics, one rural health clinic, and three hospitals with an emergency department with two health professional shortage areas (Colorado Health Institute 2015b). Further, although houses of worship of wide-ranging world religions can be found in the city, Colorado Springs has an influx of Evangelical Christians and Christian organizations. These structures of the built environment are noted to frame the reader's understanding of the city's unique ecological landscape of peoples and the environment. On common ground, the peoples of Colorado Springs are subject to navigating the ability to find common ground. The study charge has roots in the ways categories of identity intersect, overlap, and interact in a community—Colorado Springs to be one concentrated in characters.

Roles and Relationships

Research was conducted in collaboration with Julissa Molina Soto. She one of the current leaders in public health in the State and holds a position at the ADA as the Regional Director of Community Health Strategies on Health Disparities for Colorado and beyond, including: WY,

AZ, NM, UT, and NV (Soto, e-mail, February 11, 2017). The research design builds upon her stewardship to advocacy, health promotion, and disease prevention in the Colorado Springs area. Soto has demonstrated the capacity to mobilize public and private organizations and community representatives to address diabetes in the Hispanic and Latinx community through partnerships, cooperative arrangements with clinics, churches, and community coalitions (Soto, personal conversation, February 23, 2017). In honor of her functional commitment to the social good and to stress the capacity of the relationship to this paper, I share her numerous awards, although in list form, as follows:

- 2016 - Wells Fargo - *People Who Make a Difference Award*
- 2015 - Colorado Nonprofit Association - *Building Stronger Communities Award*
- 2014 - Latinas First Foundation *Unsung Heroine Award*
- 2012 - Denver Business Journal's *40 Under 40*
- 2007 - Martin Luther King Jr. *Humanitarian Award*
- 2007 & 2006 - Colorado Rockies *Leadership Award Finalist*
- 2006 - Denver Hispanic Chamber of Commerce's *Excellence in Education Award*
- 2006 - Colorado Coalition for the Medically Underserved *Layperson of the Year*
- 2005 - Latino/a Research & Policy Center *Courage and Valor Award*

Further outreach efforts of hers include: hosting a radio show, leading exercise groups and teaching NDPP and evidence-based yearlong lifestyle change program. Additionally, Soto is the former Vice President of the Board of Directors of Families Forward Resource Center and a former Board member at Learning Source, and an Emerging Leaders in Health Institute mentor. She also was a member of The Denver Foundation's Health Advisory Committee and a Board member of Inner City Health Clinic (Soto, e-mail, February 23, 2017).

Additionally, I collaborated with members of the YMCA of the Pikes Peak Region, Catholic Charities of Central Colorado, and a number of safety net clinics. The YMCA of the Pikes Peak Region ("the Y") is an association of community members driven to strengthen youth development, healthy living, and social responsibility. Catholic Charities is one of 1,640 Catholic

Charities USA social services agencies in the country. The human service organization provides social services throughout a ten-county area with most of the services targeted to people living in Colorado Springs and El Paso County. Moreover, I worked with local safety net clinic providers and representatives of Peak Vista Community Health Centers, AspenPointe, and SET Family Medical Clinics. Peak Vista Community Health Centers is a nonprofit Federally Qualified Health Center (FQHC) dedicated to providing premier medical, dental and behavioral health care in a collaborative setting for people of all ages. AspenPointe integrates behavioral health care with community physical health care providers, such as Peak Vista. AspenPointe provides a broad range of high-quality behavioral health services, including: behavioral health and psychiatric support, counseling and therapy, employment/career development, mental wellness programs, personal development, physical and psychological exams, specialty referrals, and substance use treatment. Lastly, SET Family Medical Clinics (SET) is a nonprofit Centura Health Physicians Group Entity and is sponsored by Centura Health. The local health care system is overwhelmed by the needs of the uninsured, thus, SET serves as an important safety net by providing care to the uninsured, under-insured, homeless and Medicaid populations in the community.

I. Data Collection and Analysis

Fieldwork

Findings are based on fieldwork and conversations surrounding the ADA National Diabetes Prevention Program Latinos Initiatives. I conducted a semi-structured interview with Julissa Molina Soto at a local-coffee shop. I asked a series of questions, from general questions about diabetes to specific questions about key intervention strategies. The interview lasted approximately 45 minutes in length. Careful notes were taken and a summary of the interview was created immediately following the interview. Additional information and details were

provided by Julissa following the interview via e-mail and phone conversations. In accordance with Julissa's permission and guidance, I proceeded research through the means participant observation and interviews focused on the Latinos Initiatives program of the ADA. The Latinos Initiatives program, formerly called "*Por Tu Familia*" has been in existence since 2006 and was originally funded by the Office of Health Disparities, how the Office of Health Equity (Soto, e-mail, February 23, 2017).

Participant observation included visiting the program for the month of March. The program was located at a local school in Southeast Colorado Springs and each weekly session lasted two hours in the afternoon. I recorded field notes at the natural setting of the program. I was provided participant guides to follow along with the session each week. I collected data ranging from general descriptions of the program site and curriculum to narratives elucidated by lay persons. The participatory method was fundamental to reflexive reflection of the phenomena. I find it important to share that prior to attending the program I considered interviewing participants of the program about their experience with diabetes and how they presumed to come of this disease regime of either pre-diabetes or diabetes. Partly due to the limited time and intensity of my involvement with the participants themselves, I decided that it would not be appropriate for me at the time, a time situated by an unsettling political climate. Rather, Additional findings were based on interviews with community health workers (CHW), also called "*promotores de salud*," of the Latino Initiatives program.

Approval was obtained by the Colorado College institutional review board prior to the conduct of any data collection in the form of an exemption. Participants were interviewed on March 31, 2017 at the program site. The criteria for entry was to currently hold a role as a CHW for the program. I interviewed two CHWs in total, both participants self-identifying as Hispanic

or Latina females and Spanish-speakers. Subjects willingly chose to participate in the study. At the interview and program location, the participant was given an informed consent form in English. If the participant had difficulty reading the consent form, it was read aloud. After informed consent was obtained, the participant received a survey regarding demographic parameters and experience in their role. Following the survey, semi-structured interviews were conducted. The interviews lasted on average of ten to 15 minutes. The semi-structured format was chosen to allow for follow-up inquiry and probes to pursue discussion threads relevant to the research question. Interviews were audio-recorded and transcribed verbatim. Respondents were interviewed in English. Spanish was used for clarification on the part of both parties intermittently. Audio-recorded materials were transcribed and field notes were completed for interviews. Time was spent listening and transcribing field notes during the participant observation process at the programs. Additionally, field notes were reviewed after each program and organized based on general observations and themes. With these notes, emerging themes revealed ideas, insights, and explanations. Themes and information that were recognized were followed up with subsequent research based on relevant data and local information sources. Furthermore, publically accessible data provided a means of comparing quantitative and qualitative measures.

Community Informants

Foundational knowledge on community engagement efforts was based on relatively unstructured interviews that occurred consecutively over the course of several weeks with members of community partners. Affiliates of Catholic Charities and YMCA of the Pikes Peak Region served as key informants to provide insight of social services and priorities in the area. Interviews were ranged in length from a total of thirty minutes to an hour. The interviews were conducted at either at their place of work or at a local coffee shop. Both informants held

positions of distinction within their organization. In addition, interview questions were identified to establish the competence of the informants on issues relevant to the research project.

The accuracy with which the informant answered these questions served as a validity check on the informant's status. Unstructured interviews relied heavily on knowing how to probe effectively to stimulate informant to provide more information, such as echoing the most recent response, providing verbal affirmation or approval of the informant's response, asking directly for more information, and offering open-ended questions. These unstructured dialogues provided information that might not have emerged with more formal querying, such as discussion of the ADA NDPP Latino Initiatives program in the area. I also engaged members within the medical field, specifically the local safety net. I attended several open house tours of the facilities and shadowed health care providers to gain a foundational understanding of the daily workings within these spaces. Further, I conducted semi-structured interviews with safety net clinic representatives at Peak Vista Community Centers, AspenPointe, and SET Family Medical Clinics. Conversations focused on the effects and impact of the ACA and the ability to address social determinants of health given infinite health needs and finite resources.

Local Data

To address the local environment, I utilized publically accessible data from the following locations: Community Commons, the Centers for Disease Control and Prevention (CDC), and El Pomar Foundation. Respectively, Community Commons is a site that provides access to thousands of meaningful data layers that allow mapping and reporting capabilities to thoroughly explore community health—a place where data, tools, and stories come together to inspire change and improve communities. The goal of Community Commons is to increase the impact of those working toward healthy, equitable, and sustainable communities. The creators of note the benefits of Commons users to gain a deeper understanding of community assets and

opportunities and the strength of data visualizations to convey such knowledge through partnerships and collaboration. I conducted a Health Equity Assessment Report of Colorado Springs including the following data categories: demographics, social and economic factors, physical environment, clinical care, health behaviors, and health outcomes.

In terms of the CDC, I utilized the organization's 500 Cities Project public data. The 500 Cities Project: *Local Data for Better Health* is a collaboration among the Robert Wood Johnson Foundation, the CDC Foundation, and the CDC. The purpose is to provide high quality small area estimates for behavioral risk factors that influence health status, for health outcomes, and the use of clinical preventive services. These estimates can be used to identify emerging health problems and to develop and implement of effective, targeted public health prevention activities. Data was obtained from the CDC Behavioral Risk Factor Surveillance System (BRFSS) 2013, 2014, the Census Bureau 2010 census population data, American Community Survey (ACS) 2009-2013 and 2010-2014 estimates, and Esri ArcGIS Online basemaps. El Pomar Foundation has invested staff and financial resources in the Regional Partnerships program. Initially, conceived as a method to expand grant making and programs beyond the Front Range, the partnerships evolved into a network of committed residents providing information, insight on local issues and opportunities, and connections to local leaders and nonprofits. I used a community proposal by El Pomar Foundation (2016) focused on Southeast Colorado Springs, defined as primarily zip codes 80910 and 80916. The Possibilities report began as a project to better understand the needs and assets in Southeast Colorado Springs, which included relevant demographic data and interviews that will supplement my findings.

I created tables, figures, statistical and geospatial maps to represent the findings. Tables of demographic and socioeconomic data are presented as a point of reference to offer a

quantitative comparison of the report area to county, state, and country levels. I compared qualitative and quantitative phenomena through the presentation of geospatial maps of the publically-accessible data. The maps were generated as part of the 500 Cities Project. The CDC used small area estimation methodology called multilevel regression and post-stratification that links geocoded health surveys and high spatial resolution population demographic and socioeconomic data to produce local level health-related estimates. This approach also accounts for the associations between individual health outcomes, individual characteristics, and spatial contexts and factors at multiple levels. Such an approach predicts individual disease risk and health behaviors in a multilevel modeling framework and estimates the geographic distributions of population disease burden and health behaviors at city and census tract level.

RESULTS

Targeted Public Health Program

The CDC-recognized lifestyle change program is a structured program developed specifically to prevent type II diabetes and, thus, designed for people who have prediabetes or are at risk for type II diabetes. The trained lifestyle coaches (CHWs) aid the participants to change certain aspects of their lifestyle and create a group to share goals and challenges. The program runs year-long and is focused on long-term changes to learn new habits, gain skills, and build confidence. In Colorado Springs, the Latinos Initiatives program was held in the mid-morning to afternoon at a local school. Placed in an open classroom in the back of the school, participants walked through the main office of the school and through two hallways. Stackable chairs were unstacked each week and organized in rows. Additional, chairs were placed on the outskirts along the built-in-counter along the front wall.

A CHW presented the curriculum for each weekly session, while at another three to four attended to alternative duties. Those duties were either an assistant in charge of recording the participants' information each week (i.e. weight, activity log, and dietary journal) or taking care of children in an open classroom of the school for the daycare that is provided. It is important to note that many CHWs were involved in other programming and promotion efforts as well, outside of Latino Initiatives sessions—such as a physical-activity boot camp that is held at another community center in the area. The setting, a home economics classroom presumably, was lined with cooking stations. At least two CHWs would reside within the nooks between stations for participants to check-in on their progress. By progress, I refer more so to their weight, dietary journal, and activity log for the week. However, this time also gave participants the opportunity, as well as the CHW, to better understand what is or isn't working for the individual to figure out how things can be maintained or altered to, ultimately, achieve “progress”. Participants slowly trickled into the classroom throughout the first hour of the session to reach on average 35+ participants for the four sessions I attended. The age of participants ranged from those in their mid-twenties to those in their early sixties, as a rough estimate. The large majority of participants were women, with only a select man and/or husband that appeared to come regularly over the course of the four weeks.

From Julissa Soto and I's dialogue, as well as participant observation and interviews with the CHWs of the ADA NDPP Latinos Initiatives program, the following three themes emerged: (1) community capital, (2) cultural capacity, and (3) context of disease management. These themes were generated using an assets-based approach to identify community and cultural strengths rather than emphasizing deficits and weaknesses. These catchall themes provide a

means to generate thoughts, ideas, and fluid answers to the questions at hand without rigid distinctions amid and between the categories.

(1) In terms of community capital, ADA NDPP is a partnership of public and private organizations working to reduce the growing problem of pre-diabetes and type II diabetes. The Latinos Initiatives program was selected as one of eight from around the country that the CDC would like to learn from through the CDC best practices project. The project identifies promising outreach and enrollment strategies being used in the field, particularly for populations with inadequate access to care, poor quality of care, or low income. Through the project, the CDC gains insight on how and why strategies are effective and about what may hinder successful enrollment into the CDC-recognized lifestyle change programs (Soto, e-mail, February 23, 2017). Soto noted that their success in bringing key players together, coupled with effective communications, organizational capacity, and ability to reach low-income, Spanish-speaking Latinos, and engage in local, and state partnerships enhances the program. I understand the interest of the CDC for inquiry, given the city of Colorado Springs at this moment of history being a place known to for its' conservative agenda and military strongholds.

Along these lines, I asked in an interview with a CHW about the challenge of integration and collaboration in the community. She began by offering suggestions of resources that are in the community such as Catholic Charities which offers English as a Second Language Courses at Our Lady Guadalupe Church along with Colorado Springs Food Rescue—a partner organization under common goals and metrics of evaluation through collective impact. I moved on to further questions about the way the program responds to components of social determinants of health and equity, as described previously in this paper. She responded, “As a presenter, I always give information that branding does not mean health. I say this so there can be other options and to

talk to me if they need”. She, then, mentioned that a feeling of security can prevent individuals from going outdoors. In her own words, she explained: “At times, parks do not have enough lighting and sometimes we want our kids and members to be outside but it is not entirely safe.” As the conversation progressed, the political acumen of the city was discussed, without mention of the occupants of the city specifically. She stated, “As an ‘old school’ city. I think it is open to tolerance and to interact with everyone. I don’t see a community barrier between all of the citizens here”.

(2) In moving to discuss the cultural capacity of the program, the sheer size speaks to such a derivative. The program is Colorado’s largest primary prevention program for monolingual, Spanish-speaking Latinos. Furthermore, those who worked for the organization shared general sentiment to movement and history. For example, the Region Director, Julissa Molina Soto, immigrated to the U.S. 21 years ago from Michacán, Mexico and demonstrated an understanding of the dynamics of health disparities faced by Latinos from a personal as well as professional perspective. The ramifications of the marginalization and the discrimination that she has faced has supported desire to empowering new immigrants through a family and community-based perspective. Her high degree of motivation and dedication to the Latino community has been recognized by those she serves and works with. In introducing her aim for prevention and promotion of diabetes to be at a local setting with the large majority being women, Soto brought up notions of structural violence and a need for empowerment among those she works with. Similarly, in talking with another CHW, I was impressed by her awareness and importance that all participants’ feel safe in the space. She specifically, mentioned language to be a point that she as a presenter works to ensure that all participants feel confident that they understand and can ask for clarification if she is using slang or phrases that do not align with all Spanish-speakers.

(3) Lastly, in the terms of disease management, a CHW noted the involvement with the local health care system in this sense. She explained that health care providers at local clinics refer pre-diabetic patients to the program oftentimes. Thus, increased numbers of community participants have previously gained access to health care and treatment services. Additionally, the goal of the Latinos Initiatives program is to improve the lives of Latinos by using prevention strategies to assure positive health outcomes and for participants to make better lifestyle choices every day. The program demonstrates improvements in knowledge and awareness of obesity, cardiovascular disease and diabetes risk factors, and physical activity, intake of fruits and vegetables, along with decreases in intake of sugary beverages, high fat foods, and body mass index. Progress is measured as meaningful decreases in blood pressure, lipids, glucose, and body weight. Specifically, the ADA CHWs have delivered the DPP to over 350 high-risk monolingual Spanish-speaking Latinos from 2013-2015. The program has exceeded the target weight loss of 5% achieving an average of 7.2% weight loss for participants, in addition to a retention rate of which over 75% of participants complete the 12-month DPP. Further, over 95% of participants met the goal of 150 minutes of physical activity per week. The CDC has recognized the ADA-Colorado Area's DPP lifestyle change program as the only Spanish-speaking program to have year-long data demonstrating weight-loss and physical activity minute goals that meet or exceeded CEC standards in Spanish (Soto, e-mail, February 23, 2017).

Community Safety Net Providers

Through informational interviews with healthcare providers in Colorado Springs at Peak Vista, Aspen Pointe, and SET Family Medical Centers, I gained insight grounded by an understanding of larger phenomena. As a common thread amid the provider representatives, safety net providers spoke of their urge to engage in practice transformation to create a more integrated patient pathway. These safety net providers stressed their role and mission to offer a

combination of comprehensive medical and enabling or “wraparound” services (e.g., language interpretation, transportation, outreach, and nutrition and social support services) specifically targeted to the needs of the populations they serve. These services rarely generate sufficient revenues to cover their costs and are thus less likely to be provided by others in the community at large. For example, the workforce at Peak Vista includes 136 doctors and mid-level providers, 254 clinical support staff, 258 administrative support staff, and 137 administrative staff. Furthermore, volunteer providers deliver specialty services on an as-needed basis. Peak Vista annually serves over 90,000 patients through 27 outpatient centers in Colorado's Pikes Peak and East Central regions. The large majority, quantitatively 86.2%, of the patient population are at or below 200% of the Federal Poverty Level. Further, Hispanics and Latinxs constitute roughly 27% of the patient population. The team partners with various local organizations to help their patients, and members of the community, find and connect with extended support services, such as the ADA.

The respondent of AspenPointe, as an administrative representative, spoke of the internal efforts to support the Hispanic and Latinx community referencing the introduction of translated patient forms, bilingual providers, and translational phone services. I attended the Health Home Open House on November 8, 2016 open to the public and community partners. The event was scheduled to introduce the community to the integration of full-time primary care services by Value Care Health Clinic providers at the Moreno site location. Further, on March 8, 2017 AspenPointe professionals met for a “Latino Community Luncheon: Building Community, Uniting Cultures” event to bring together the community to share information and ideas, promote cultural awareness, and educate the community on the events and issues impacting Hispanics and Latinxs in El Paso County.

In terms of SET Family Medical Centers, the interview session was all-encompassing and very fruitful to my understanding. I shadowed the respondent during their afternoon shift at the Homeless Clinic on a Saturday, November 4, 2017. It was clear that there was a large capacity to serve these patients in need. The dynamic between chronic and acute care as well as uninsurance and underinsurance was particularly common throughout the shift. Several patients noted that they had recently been to a local safety net clinic for care, however did not have the time to address their health conditions and priorities. I also toured the Family Clinic on November 14, 2017. This opportunity allowed for me to ask the respondent as well as other SET staff questions. The respondent of SET spoke proudly of their health-literacy screenings and new patient process to meet with a SET representative just prior to the patients' appointment. The process follows the socio-ecological approach to address SDOH. SET has also joined efforts to help educate, navigate and enroll people into the new health insurance exchange. In the rapidly changing health care and health insurance system, safety-net clinics, like SET, play a huge role in the future of health care.

Local Data, Local Health

A total of 442,040 individuals live in the 195.21 square mile report area of Colorado Springs defined for this assessment according to the U.S. Census Bureau American Community Survey 2011-15 5-year estimates (Table 1). The population density for this area, estimated at 2,264.39 persons per square mile, is greater than the national average population density of 89.61 persons per square mile (Table 1). The data for age, race, and ethnicity is displayed in the appendix for reference (Tables 2-4). The estimated population that is of Hispanic, Latino, or Spanish origin in the report area is 76,225. This represents 17.24% of the total report area population, which is greater than the national 17.13% rate. Figure 4 offers a visual breakdown of ethnic populations represented in the catchall Hispanic or Latinx category. Figure 7 provides

visual representation of the geographic distribution in the region. A snapshot of Colorado Springs highlights the ethnically integrated area of Southeast Colorado Springs. The population with limited English proficiency reports 4.79% of the population aged five and older who speak a language other than English at home and speak English less than "very well." Data reflects that there is far greater proportion of the Hispanic and Latinx population with limited English proficiency (Table 6). This indicator is relevant because an inability to speak English well creates barriers to healthcare access, provider communications, and health literacy and education.

Within the report area, 13.4% or 58,337 individuals are living in households with income below the Federal Poverty Level (Table 6). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status. According to El Pomar Foundation, 25% of individuals of Southeastern Colorado Springs are living in poverty compared to 12.4% of El Paso County and 13.2% statewide CO. Further, the population in poverty is patterned by socially constructed categories, such as gender, race, and ethnicity, regardless of report area chosen (Tables 7-9). Of relevance to this paper, 25.87% of the Hispanic population is impoverished in comparison to 10.79% of their non-Hispanic counterparts (Table 9). In addition, there are 19,546 persons aged 25 and older without a high school diploma or equivalency or higher. This represents 6.85 % of the total population aged 25 and older and 22.41% of the Hispanic or Latinx population. This indicator is relevant because educational attainment is linked to positive health outcomes. The school district data and educational attainment are critical indicators of the current and future health of a community, as well.

The two school districts in Southeast Colorado Springs, District 2 and District 11, are unique in a variety of ways and reflect the greater Southeast Colorado Springs community. For

example, 73% of District 2 students are minorities, compared to 45.5% statewide, both District 2 and District 11 receive nearly US\$3,000 less revenue per student than the state average, 78% of District 2 students qualify for free and reduced lunch compared to 41.6% of students across the state (El Pomar Foundation 2016). The data regarding the percent of households receiving SNAP benefits by racial and ethnicity reflects a familiar pattern—21.94% of the Hispanic or Latinx population in comparison to 6.99% of the white, non-Hispanic or Latinx population (Table 10). Of those for whom insurance status is determined, 11.96% of the total population in Colorado Springs is uninsured (Table 12). This indicator is relevant because lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contributes to poor health status. By viewing this data alongside CDC 500 Local Cities data mapping, there is reference to variation in health outcomes, prevention, and unhealthy behaviors (Figures 7-12).

DISCUSSION

The widely-distributed discourse of diabetes is characterized by notions of patient self-control and disease management through making choices to be educated and engaged in health-promoting behaviors on the part of public health or medicine. This can be seen in the statements posted on the ADA website:

Diabetes is a common disease, yet every individual needs unique care. We encourage people with diabetes and their families to learn as much as possible about the latest medical therapies and approaches, as well as healthy lifestyle choices. Good communication with a team of experts can help you feel in control and respond to changing needs (“Living with Diabetes”).

The meta-function of this message is to put in place a neo-liberal discourse of agency as being the hands of individuals. The first sentence presents the reader with a generic disease and juxtaposes it with a unique care-system. It purports that people with diabetes can gain “control”

through self-education (“learn as much as possible”) and engaging in “healthy lifestyle choices.” The role of the individual is clear in the clause of the last sentence in which the pronoun ‘you’ is placed in the role of experiencer: “you feel in control” and agent: “[you] respond to changing needs.” The abstract complexity of these data requires us to keep in mind the interconnected, dialectical and recursive relationship between individual agency, structure and social practice in terms of bio-power. A similar message appears on a separate page of the same website, focused on the prevention of complications:

Diabetes can affect any part of your body. The good news is that you can prevent most of these problems by keeping your blood glucose (blood sugar) under control, eating healthy, being physical active, working with your health care provider to keep your blood pressure and cholesterol under control, and getting necessary screening tests (“Living with Diabetes”).

The authoritarian voice mirrors the approach to manage of diabetes professionals. The mode of address is associated with more traditional forms of top-down communication from medical professionals who are discursively positions as experts on the bodies that are that of the patient.

In relation to the NDPP, prediabetes is a condition in which individuals have high blood glucose levels but not high enough to be classified as diabetes. People with prediabetes have an increased risk of developing type II diabetes, heart disease, and stroke, but not everyone with prediabetes will progress to diabetes. The ADA website offered messages of prevention, this one aimed at people who are ‘prediabetic’:

Don’t let the “pre” in prediabetes fool you into thinking it’s not really a problem now. You can take action right away to prevent prediabetes from becoming type 2 diabetes. You can also reduce the risk of heart attack and stroke associated with prediabetes (“Prediabetes”).

The NDPP focuses on lifestyle intervention that resulted in weight loss and increased physical activity in this population can prevent or delay type II diabetes. Examining the textual factures of the diabetes texts produced allows us to lay bare the power relations underlying the messages

found in texts. Therefore, it is important to not examine the text in isolation from the contexts of their productions, but, rather, in relation to the wider processes in which people with diabetes are emeshed. Mechanisms at work in the data identified as relevant to the ADA information resources, fieldwork of the community-level Latinos Initiatives program, and publicly-accessible data sources, offer intertextuality and re-contextualization. The data demonstrates the need to conceptualize societal determinants more broadly, more effectively, and more dynamically than often considered.

The CHWs offer promise as a community-based resource to increase racial/ethnic minorities' access to health care and, more importantly, to serve as a liaison between healthcare providers and the communities they serve. In speaking with Julissa Soto, there is a support on her part to enhance community advocacy and leadership skills among the *promotores de salud* in a way that benefits them and their communities (Soto, personal conversation, April 1, 2017). For community health worker programs to be successful, they must be designed proper and workers must be adequately trained. From the data collected, the CHWs and community participants offer strength in terms of cultural capacity, community capital, and context of disease management. These assets are important to identifying community culture and values, needs and issues, identifying and maintaining community partners, advocacy and leadership, as well as celebration and evaluation to generate a shared vision among and amid community members within and outside the program and at large. It is evident that community public health leaders and workers have a solid foundation to build upon.

Moreover, the safety net holds a position of weight to advance health equity within the contemporary environment—as a reframed neoliberal outgrowth of charity care. The safety net is intricately tied to current research addressing gaps, inconsistencies, and failures in care. For

example, the concept of a health care safety net conjures up the image of a tightly woven fabric of federal, state, and local programs stretched across the nation ready to catch those who slip through the health insurance system. Rather, neither secure nor uniform, the safety net varies greatly from state to state and from community to community—depending on the number of uninsured people, the local health care market, the breadth and depth of Medicaid and other programs, as well as the general political and economic environment (Baxter and Mechanic 1997). These variations notwithstanding, most communities can identify a set of hospitals and clinics that by mandate or mission care for a proportionately greater share of poor and uninsured people. I see collaboration with local safety net facets to be a stepping stone to further involvement between public health efforts and the medical field.

In-depth qualitative and quantitative exploration of local context and the intersectionality are key factors is important when considering achieving change—a change that results in a process towards health equity and elimination of health disparities. Detailed health data help to measure and address health of a population within a community and at the individual level. Collection and sharing of data between community members can be a powerful platform of collaboration and communication to bridge the gap between stakeholders. Of note, the CHI and Safety Net Advisory Community (SNAC) Learning Labs bring together policy makers, advocates, providers, and philanthropic organizations to address health care landscape changes, much like this project. The interactive programing gives a space to raise the collective knowledge, supply data and information, leverage the expertise, and synthesize data with community discussion to develop and share resources affecting Colorado’s health care safety net. Facilitated discussions, with the goal of hearing a variety of perspectives from people engaged in

community health work, is a great starting point to identify questions and challenges, as well as innovations and thoughtful solutions.

Limitations

Like scholars in other disciplines, anthropologists have diverse views and approaches to their disciplines, nevertheless, there are perspectives shared by most within the discipline (Hahn and Inhorn 2009). I am accustomed to communication within the discipline, thus, much of what is produced is not comprehensive to those in other fields. At various points, I lack the capacity to communicate beyond the discipline. Often anthropologists attempt to understand public health problems within a larger social, cultural, historical, and political–economic context, yet stopping short of developing public health or promotion programs (Hahn and Inhorn 2009). I realize that this research project does not present clear-cut solutions or the development or a clear direction of future development. However, such contextualized studies of public health problems are imperative to begin generating questions that, ultimately, lead to positive solutions.

CONCLUSION

Over the past three decades, both the health care system itself and ideas about how it should be reformed have changed, but an equitable, efficient, and affordable arrangement still eludes us. Stemming from history, U.S. health systems, as a medical industrial complex, are dominated by the paradigm of a disease-focused view that neglects the underlying causes of health and wellness. This view is dysfunctional in a population that has a growing number of people suffering disproportionately from chronic and overlapping health problems. The challenge facing the nation, the opportunity afforded by the ACA, and the exigency presented by proposals of the Trump Administration is to move from a culture of sickness to a culture of care—and, then, to a culture of health. As Stephen Shortell, a keynote presenter at the IOM

Roundtable, says, “We [U.S.] have a market for disease and a market for care, but I would argue that we do not yet have a market for health,” (Roundtable 2014). A key to creating a market, Shortell weighs in, “calls on the health care enterprise to engage people, not just patients, and it also calls for a community-wide population focus that extends beyond individual Accountable Care Organizations or integrated delivery systems,” (Roundtable 2014). Recent health reform efforts offer bifurcated segments of the population at highest risk for developing chronic conditions opportunities for improved and coordinated medical care through insurance coverage and innovative care arrangements. Yet, these measures do not go far enough to systematically support the development of policies to make social institutions less arbitrary, institutions less unjust, distributions of resources and opportunities less unbalanced, and recognition less scarce (Bourdieu and Wacquant 2004).

The literature offered in this paper positions a single disease at the intersection of several historical moments and scales of analysis. The theoretical grounding in the powerful works of Pierre Bourdieu and Michel Foucault links relations of power to the construction of knowledge and identity. In context, medical discourse is grounded in its traditional practice to isolate, regroup, and classify those that are the same to those who are different—phenomena enveloped into a collective, despite supreme diversity and heterogeneity. However, these works were presented not to say that the plurality and fragmentation of identities and social actors in society should be a source of complete pessimism. Instead, there must be an embark upon more radical undecidable terrain as a condition of strategic thinking. Bourdieu’s work centers the sources of power of economic, cultural, social, and symbolic capital. They emphasize the structures within which power is enacted—being mobilized to operate through habitus within structured fields. Compared to Bourdieu, Foucault’s keen focus on processes and relations of power show how

people and groups become positions in specific ways in relation to each other and in relation to norms and structures. These perspectives expose ways in which certain discourses come into being, circulate, and are transformed over time. With no simple framework to power emerging, the ambiguity of democracy requires unity that can only be conceived through diversity. The task requires unraveling the complexities, one to be shared in collaborative work and dialogue. Rather than minimize determinants and management of disease to the individual, together, we can more accurately and more honestly complicate them to reflect the chronic intricacies of the multidimensional, intergovernmental, and multi-sectoral challenges of sovereignty and functionality in today's *acquisitive* society.

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APPENDICES

I. Tables

Table 1. Total Population

Report Area	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
Colorado Springs*	442,040	195.21	2,264.39
El Paso County, CO	655,024	2,126.86	307.98
Colorado	5,278,906	103,640.80	50.93
United States	316,515,021	3,532,070.45	89.61

Table 2. Total Population by Age Groups

Report Area	Age 0-4	Age 5-17	Age 18-24	Age 25-34	Age 35-44	Age 45-54	Age 55-64	Age 65+
Colorado Springs*	30,899	75,958	50,000	68,499	54,953	58,572	50,988	52,171
El Paso County, CO	45,980	120,063	74,257	98,166	82,104	87,761	74,321	72,372
Colorado	336,874	904,982	516,873	782,545	716,788	719,011	656,993	644,840
United States	19,912,018	53,771,807	31,368,674	42,881,649	40,651,910	43,895,858	39,417,628	44,615,477

Table 3. Total Population by Race Alone

Report Area	White	Black	Asian	Native American / Alaska Native	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Races
Colorado Springs*	79.16%	6.08%	3.06%	0.60%	0.27%	5.75%	5.08%
El Paso County, CO	80.25%	6.04%	2.74%	0.64%	0.37%	4.53%	5.43%
Colorado	84.22%	4.05%	2.91%	0.95%	0.15%	4.25%	3.48%
United States	73.60%	12.61%	5.13%	0.81%	0.17%	4.70%	2.98%

Table 4. Total Population by Ethnicity Alone

Report Area	Total Population	Hispanic or Latino Population	Percent Population Hispanic or Latino	Non-Hispanic Population	Percent Population Non-Hispanic
Colorado Springs*	442,040	76,225	17.24%	365,815	82.76%
El Paso County, CO	655,024	104,686	15.98%	550,338	84.02%
Colorado	5,278,906	1,112,586	21.08%	4,166,320	78.92%
United States	316,515,021	54,232,205	17.13%	262,282,816	82.87%

Table 5. Population with Limited English Proficiency

Report Area	Population Age 5+	Population Age 5+ with Limited English Proficiency	Percent Population Age 5+ with Limited English Proficiency
Colorado Springs*	411,141	19,679	4.79%
El Paso County, CO	609,044	23,608	3.88%
Colorado	4,942,032	306,225	6.20%
United States	296,603,003	25,410,756	8.57%

Table 6. Population with Limited English Proficiency by Ethnicity

Report Area	Total Hispanic / Latino	Total Not Hispanic / Latino	Percent Hispanic / Latino	Percent Not Hispanic / Latino
Colorado Springs*	12,309	7,370	18.14%	2.15%
El Paso County, CO	14,503	9,105	15.53%	1.77%
Colorado	213,353	92,872	21.23%	2.36%
United States	15,846,293	9,564,463	32.27%	3.86%

Table 7. Poverty Rate (100% FPL)

Report Area	Total Population	Population in Poverty	Percent Population in Poverty
Colorado Springs*	434,651	58,237	13.40%
El Paso County, CO	637,278	75,033	11.77%
Colorado	5,161,722	653,969	12.67%
United States	308,619,550	47,749,043	15.47%

Table 8. Population in Poverty by Gender

Report Area	Total Male	Total Female	Percent Male	Percent Female
Colorado Springs*	26,438	31,799	12.24%	14.54%
El Paso County, CO	33,973	41,060	10.70%	12.84%
Colorado	302,676	351,293	11.76%	13.58%
United States	21,410,511	26,338,532	14.18%	16.71%

Table 9. Percent of population in Poverty by Race

Report Area	White	Black	Native American / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Races
Colorado Springs*	10.94%	25.27%	20.68%	9.47%	12.31%	31.74%	18.07%
El Paso County, CO	10.01%	19.66%	17.37%	8.25%	10.34%	28.97%	15.78%
Colorado	11.22%	24.02%	24.27%	11.96%	14.63%	26.29%	15.69%
United States	12.70%	27%	28.30%	12.57%	20.96%	26.53%	19.94%

Table 10. Population in Poverty by Ethnicity

Report Area	Total Hispanic / Latino	Total Not Hispanic / Latino	Percent Hispanic / Latino	Percent Not Hispanic / Latino
Colorado Springs*	19,447	38,790	25.87%	10.79%
El Paso County, CO	22,823	52,210	22.31%	9.76%
Colorado	242,079	411,890	22.27%	10.11%
United States	12,915,617	34,833,426	24.30%	13.63%

Table 11. Percent of Households Receiving SNAP Benefits by Race/Ethnicity

Report Area	Total Population	Non-Hispanic White	Black	Asian	American Indian / Alaska Native	Other Race	Multiple Race	Hispanic / Latino
Colorado Springs*	10.93%	6.99%	26.21%	6.87%	28.36%	29.63%	18.63%	21.94%
El Paso County, CO	9.84%	6.50%	21.58%	5.56%	26.30%	28.88%	16.57%	20.51%
Colorado	8.67%	5%	22.07%	6.77%	22.72%	22.16%	14.86%	19.56%
United States	13.17%	8.06%	28.31%	7.59%	26.64%	24.32%	20.21%	22.48%

Table 12. Population with no High School Diploma by Ethnicity

Report Area	Total Hispanic / Latino	Total Not Hispanic / Latino	Percent Hispanic / Latino	Percent Not Hispanic / Latino
Colorado Springs*	8,699	10,847	22.41%	4.40%
El Paso County, CO	10,391	15,329	19.85%	4.23%
Colorado	183,760	143,462	30.91%	4.90%
United States	10,512,401	17,716,693	35.10%	9.76%

Table 13. Total Uninsured Population

Report Area	Total Population (For Whom Insurance Status is Determined)	Total Uninsured Population	Percent Uninsured Population
Colorado Springs*	428,413	51,251	11.96%
El Paso County, CO	624,178	67,944	10.89%
Colorado	5,187,214	638,851	12.32%
United States	311,516,332	40,446,231	12.98%

Table 14. Households with no Motor Vehicle

Report Area	Total Occupied Households	Households with No Motor Vehicle	Percentage of Households with No Motor Vehicle
Colorado Springs*	174,441	9,993	5.73%
El Paso County, CO	245,287	11,440	4.66%
Colorado	2,024,468	113,163	5.59%
United States	116,926,305	10,628,474	9.09%

*Tables generated through Community Commons. Data was collected from the U.S. Census Bureau American Community Survey 2011-15.

II. Figures

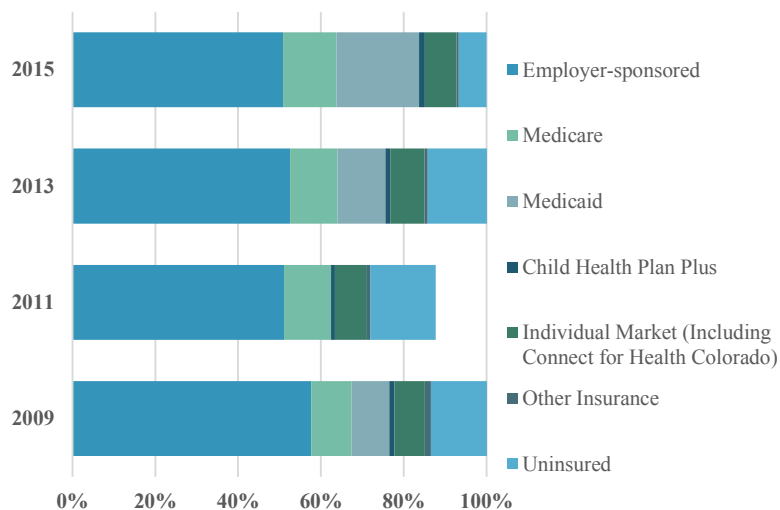


Figure 1. Health Insurance Coverage in Colorado: The ACA law requires everyone to obtain insurance or pay a penalty, presented by the individual mandate. It seeks to make insurance shopping easier with online insurance marketplaces, including Connect for Health Colorado. Additionally, it gives states financial incentives to make more low-income people eligible for Medicaid, which Colorado opted to do when the program expanded in 2014. Based on data for all ages, the figure serves to visually represent the effects of the ACA insurance coverage. Of significance, the percentage of Coloradans without insurance fell by more than half to 6.7% in 2015 from 14.3% in 2013 (Colorado Health Institute 2015).

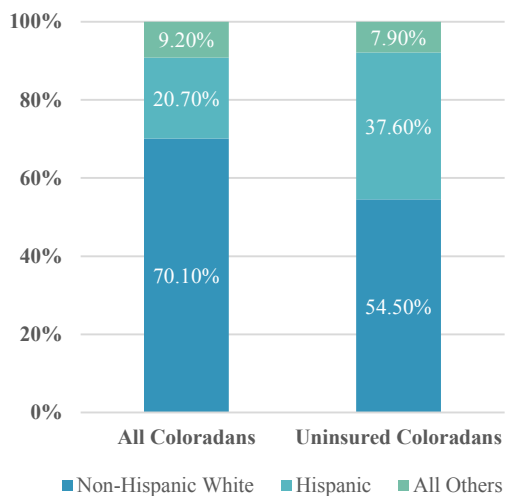


Figure 2. All Coloradans Versus Uninsured Coloradans by Race and Ethnicity: By viewing the bar graph from the Colorado Health Access Survey, it is evident that Hispanics constitute a larger percentage of the uninsured population than the population at large. This speaks to the fact that Hispanics, who have been disproportionately uninsured in Colorado, continue to have the highest rate of uninsurance (Colorado Health Institute 2015).

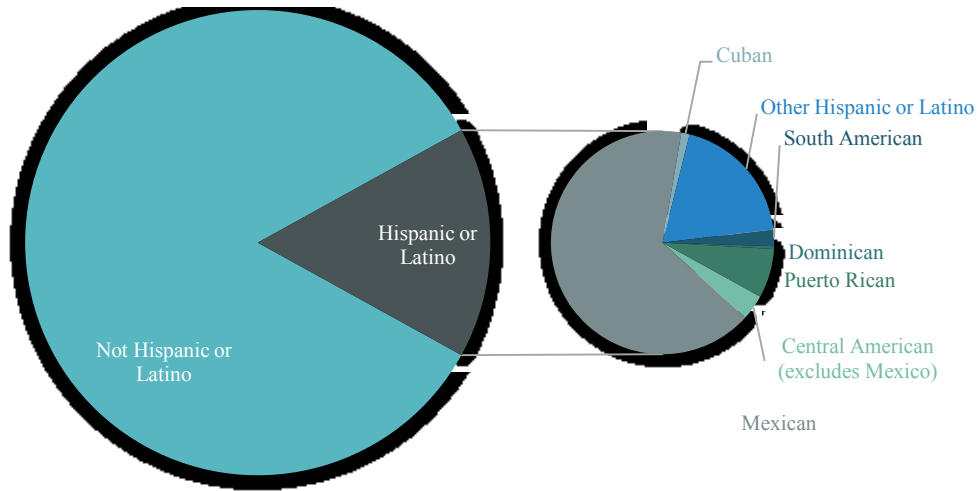


Figure 3. Breakdown of the ‘Hispanic or Latino’ Census Data for Colorado Springs, CO: Based on data from the U.S. Census Bureau American Community Survey 2011-15, the pie charts serve to illustrate the subpopulations within the socially-constructed ethnic category of ‘Hispanic or Latino’. It is important to keep in mind when thinking about aspects of identity that only hold truth subscribed to social conditions and categorizations (American Factfinder).

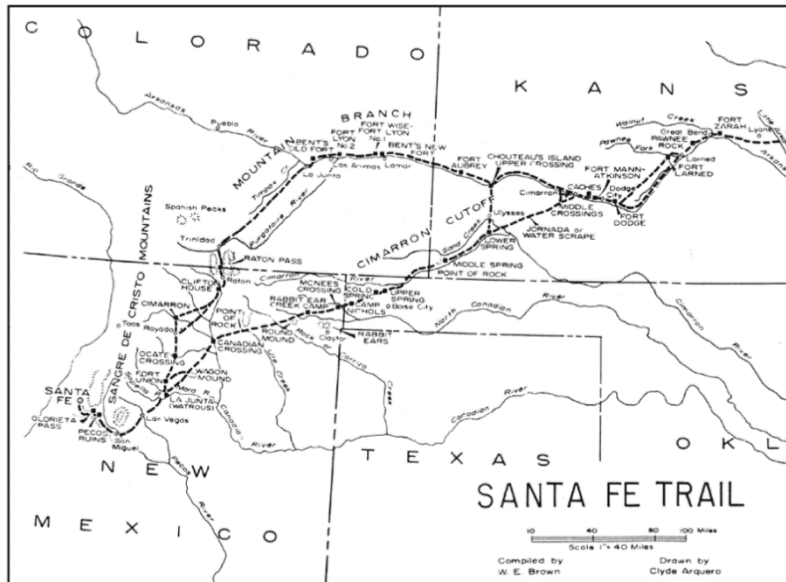


Figure 4. Map of the Santa Fe Trail: The trail started at Independence, Missouri, a town connected by river boats with St. Louis, the emporium of all western trade. From Independence, the wagoners crossed prairies 150 miles to Council Grove. Leaving Council Grove, the wagon train lumbered southwest to the Arkansas River where the route divided to cross the Cimarron Desert, which led directly southwest into Santa Fe. The alternative route continued upstream leading to present-day La Junta and then cutting across Raton Pass into Taos or Santa Fe (Ubbelohde, Benson, and Smith 2015:32).

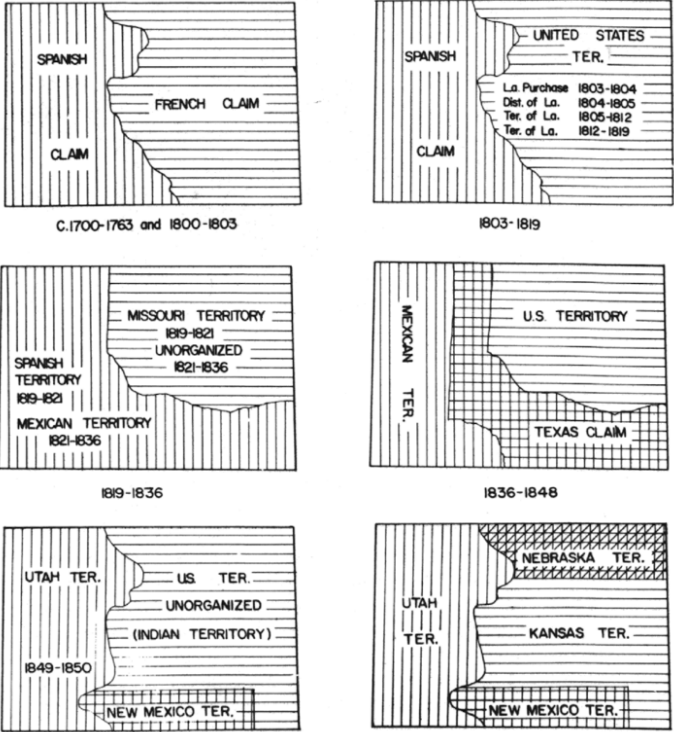


Figure 5. Claims over Colorado prior to 1861: The series of maps provide a visual to understand the land of the Southwest that was once held by indigenous nations, Spain, then Mexico, is now that of the United States (Ubbelohde, Benson, and Smith 2015).

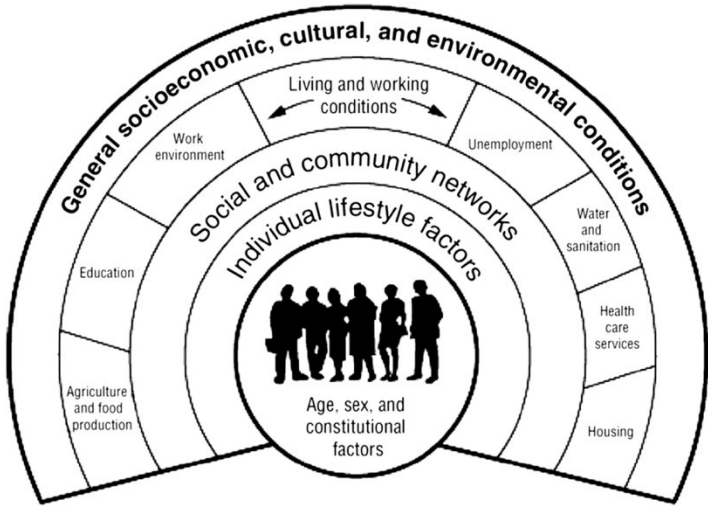


Figure 6. Dahlgren-Whitehead Model: This framework helps to construct a range of hypotheses in regards to determinants of health, to explore the influence of these determinants of health outcomes and interactions within the layers of determinants (Dahlgren and Whitehead 1992).

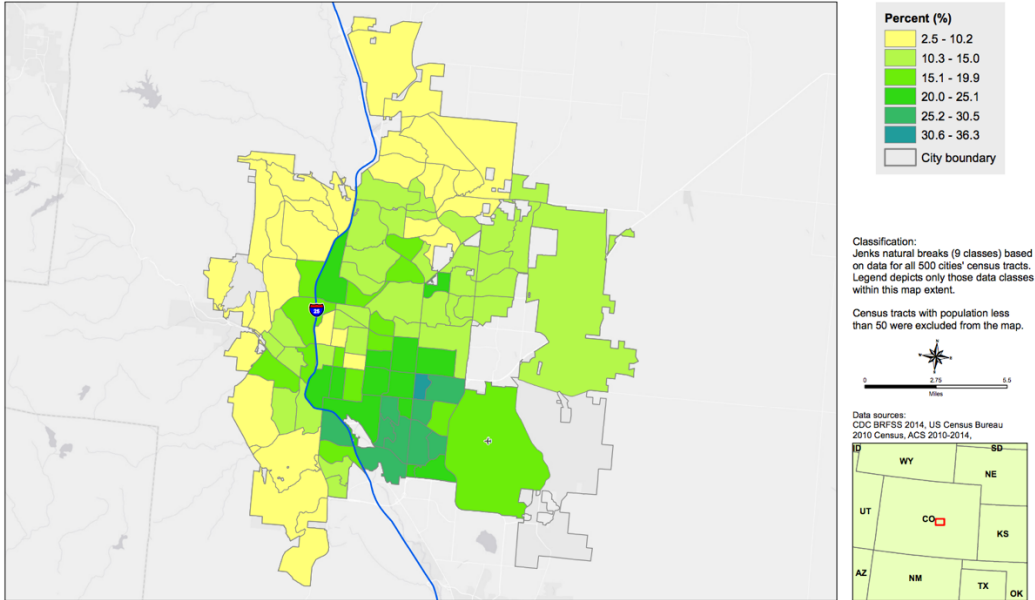


Figure 6. Current lack of health insurance among adults: This map illustrates the concentration of respondents aged 18-64 years who report no current health coverage. Lack of health insurance remains a major determinant of access to necessary health services, including preventative medicine. Certain socioeconomic conditions, including a lack of health insurance coverage and poverty, are associated with poor health status and chronic disease (CDC 2014).

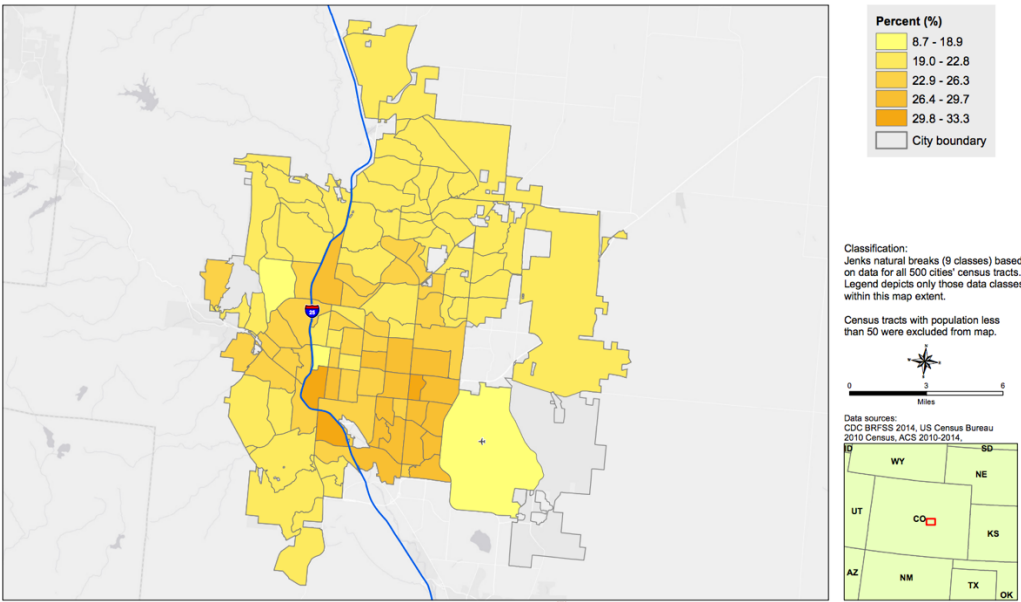


Figure 7. Map of obesity among adults in Colorado Springs, CO: This map serves as a representation of residents ≥ 18 years who have a body mass index ≥ 30.0 kg/m² from self-reported weight and height by census tract. This has important implications because being overweight or obese increases the risk for multiple chronic diseases, including heart disease, hypertension, and type II diabetes (CDC 2014).

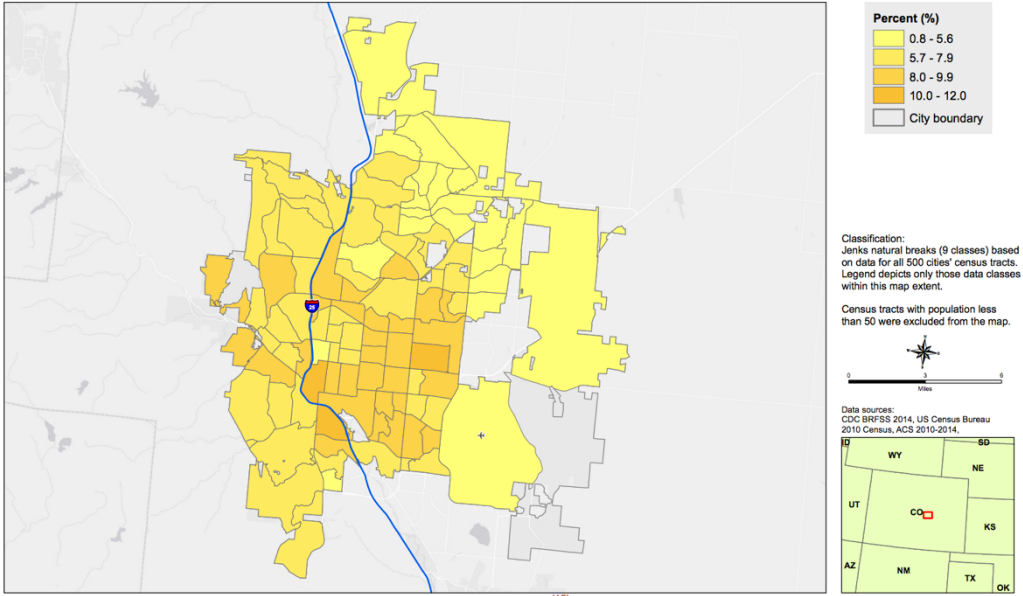


Figure 8. Map of diagnosed diabetes among adult in Colorado Springs: This map presents the distribution of residents ≥ 18 years who report ever been told by a doctor, nurse, or other health professional that they have diabetes other than diabetes during pregnancy by census tract in 2014 (CDC 2014).

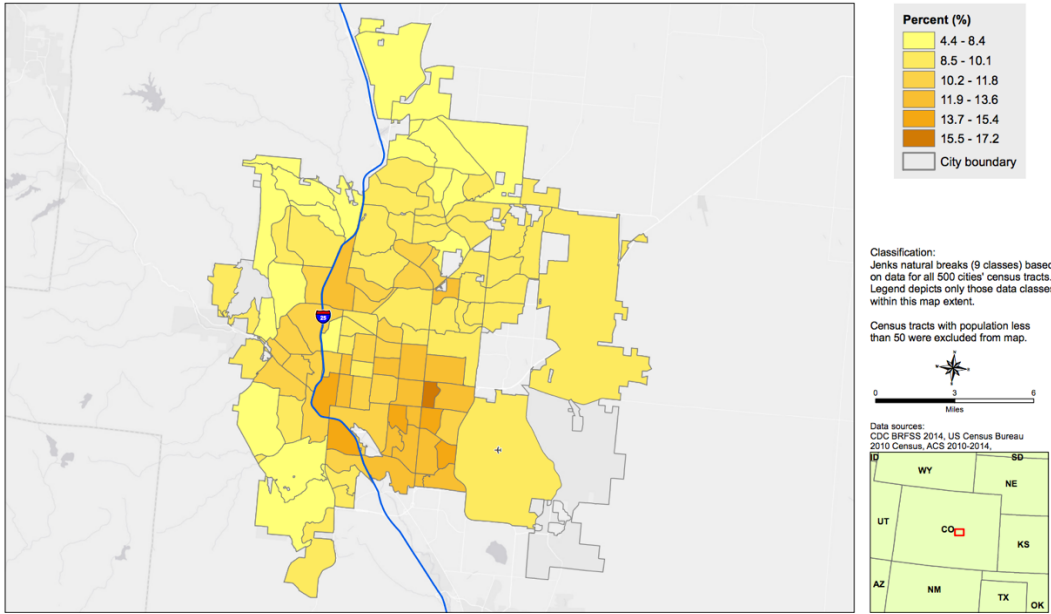


Figure 9. Mental Health not good for ≥ 14 days among adults: This map portrays the variation in residents aged ≥ 18 years who report 14 or more days during the past 30 days which their mental health was not good by census tract in Colorado Springs, CO (CDC 2014).

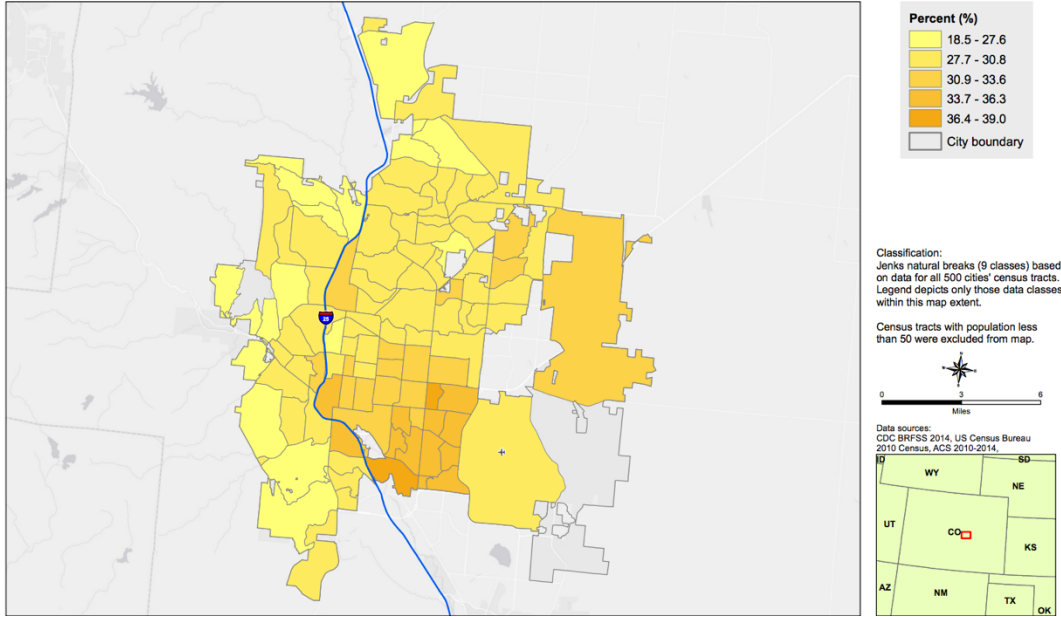


Figure 10. Sleeping less than 7 hours among adults: A map of residents aged ≥ 18 years who report usually getting insufficient sleep on average during a 24-hour period by census tract in Colorado Springs, CO. Insufficient sleep is associated with numerous chronic diseases and conditions, such as diabetes, obesity, and depression (CDC 2014).

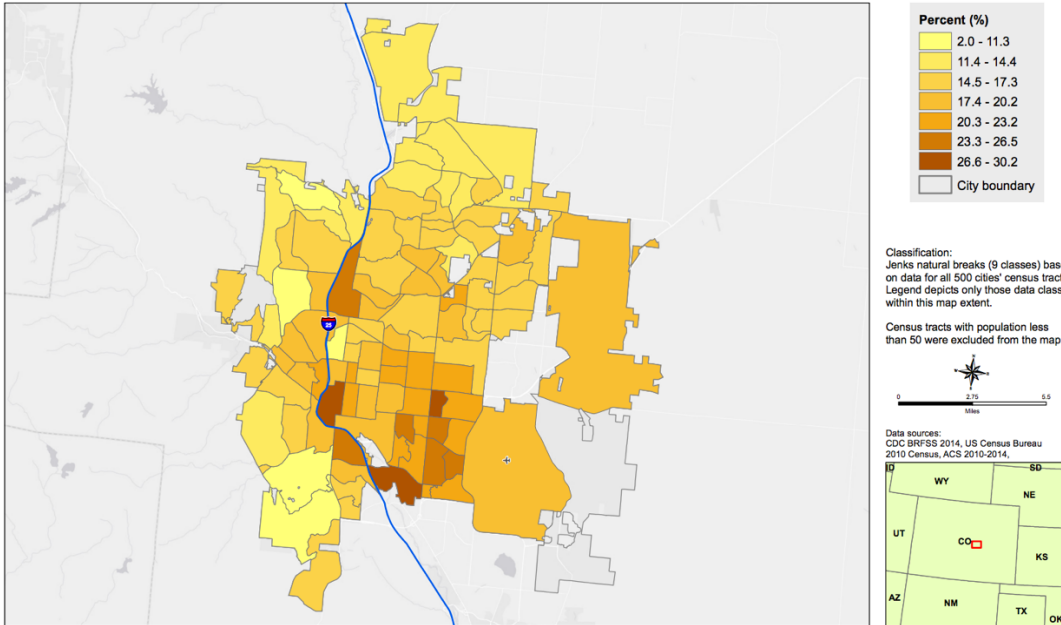


Figure 11. Current smoking among adults: This map refers to residents aged ≥ 18 years who report having ≥ 100 cigarettes in their lifetime and currently smoke every day or some days by census tract in Colorado Springs, CO (CDC 2014).