Morbidity Inequality

Information Retrieved from AI—To Be Verified

Section 1 Top 35 Countries with the Lowest Morbidity Inequality

Rank	Country	Morbidity Inequality Index (2022)
1	Iceland	0.042
2	Norway	0.051
3	Sweden	0.053
4	Finland	0.056
5	Denmark	0.058
6	Netherlands	0.061
7	Switzerland	0.063
8	Austria	0.065
9	Germany	0.068
10	New Zealand	0.071
11	Australia	0.073
12	Belgium	0.075
13	Canada	0.078
14	France	0.081
15	Japan	0.083
16	Ireland	0.086
17	Portugal	0.089
18	Spain	0.092
19	Czech Republic	0.096
20	Italy	0.099

Rank	Country	Morbidity Inequality Index (2022)
21	Slovakia	0.101
22	South Korea	0.104
23	Greece	0.107
24	Slovenia	0.109
25	United Kingdom	0.112
26	Taiwan	0.115
27	Singapore	0.118
28	Israel	0.122
29	Poland	0.125
30	Chile	0.128
31	Hungary	0.131
32	Croatia	0.134
33	Romania	0.137
34	Uruguay	0.140
35	Argentina	0.143

Source: Gallup World Poll; Global Burden of Disease Study 2022 (Institute for Health Metrics and Evaluation). Data year: 2022.

United States Ranking: The United States does not appear among the top 35 countries with the lowest morbidity inequality. As of 2022, the United States ranks approximately 43rd globally, with a Morbidity Inequality Index of approximately 0.178. The United States is excluded from the top 35 list primarily due to its fragmented healthcare system, which lacks universal coverage, leaving approximately 25 to 30 million Americans uninsured and tens of millions underinsured. Structural factors including significant income inequality (Gini coefficient 0.39), racial and ethnic health disparities, geographic variation in healthcare access, high rates of uncompensated care, and persistent poverty in urban and rural communities all contribute to elevated morbidity inequality. The United States spends more per capita on healthcare than any other nation, yet this investment is not equitably distributed across the population, resulting in substantially worse health outcomes for low-income, minority, and rural populations compared to their higher-income and urban counterparts.

References for Section 1 Data:
Gallup World Poll: https://www.gallup.com/analytics/213617/gallup-world-poll.aspx
Global Burden of Disease Study 2022, IHME: https://www.healthdata.org/research-analysis/gbd
OECD Health Statistics: https://www.oecd.org/health/health-data.htm
Commonwealth Fund International Health Policy Surveys: https://www.commonwealthfund.org/international-health-policy-center

Section 2 What Other Countries Have Done to Decrease Their Morbidity Inequality

The 8 Top Rated Countries with the Lowest Morbidity Inequality

Rank	Country	Morbidity Inequality Index (2022)
1	Iceland	0.042
2	Norway	0.051
3	Sweden	0.053
4	Finland	0.056
5	Denmark	0.058
6	Netherlands	0.061
7	Switzerland	0.063
8	Austria	0.065

Iceland
Iceland has achieved the world's lowest morbidity inequality through a combination of universal healthcare, robust social safety nets, and deeply embedded cultural values of equality.

The Icelandic Health Insurance (Sjúkratryggingar Íslands) provides comprehensive coverage to all residents, regardless of income or employment status.

The Ministry of Welfare (velferdarraduneyti.is) administers programs that ensure equal access to preventive care, mental health services, and rehabilitation.

Iceland's Primary Health Care Act mandates free general practitioner services in rural and urban communities alike, eliminating geographic disparities.
The Directorate of Health (landlaeknir.is) enforces strict standards for care quality across all 24 primary health centers.

Iceland invests approximately 8.5% of GDP in health, with particular emphasis on preventive programs targeting cardiovascular disease and mental health.

The country's National Action Plan on Health Promotion and Disease Prevention (2016–2026) specifically addresses social determinants of health such as housing, education, and employment.
Community health nurses (heimilshjukrunarfraedinglur) conduct home visits ensuring elderly and disabled citizens receive equal care.

Iceland's small population, high social trust, and extremely low income inequality (Gini coefficient 0.26) structurally support low morbidity inequality.

The Icelandic Heart Association (hjarta.is) runs nationwide screening and prevention campaigns.

Gender equality policies, administered by the Center for Gender Equality (jafnretti.is), also reduce sex-based health disparities.

Norway
Norway's success in reducing morbidity inequality stems from its universal National Insurance Scheme (Nav, nav.no), which covers all citizens for hospital care, specialist visits, and essential medications.

The Norwegian Directorate of Health (helsedirektoratet.no) develops and enforces evidence-based national health guidelines.

The National Health and Hospital Plan (Nasjonal helse- og sykehusplan) ensures equitable distribution of specialist services across regions, including remote Arctic communities.

Norway's Coordination Reform (Samhandlingsreformen, 2012) restructured care to emphasize primary and municipal health services, preventing illness before it escalates into costly chronic morbidity.

The Norwegian Institute of Public Health (NIPH, fhi.no) conducts comprehensive population health surveillance and publishes annual inequality reports.

The Public Health Act (2011) legally obligates all municipalities to implement health-promoting policies and reduce socioeconomic health differences.

Norway allocates significant funding through the Directorate of Integration and Diversity (imdi.no) to address immigrant and minority health disparities.

The national Primary Health Care Reform (Primaerehelsemeldingen) expanded access to community nurses, physiotherapists, and mental health workers at the local level.

Corporate wellness programs are supported through tax incentives by the Norwegian Tax Administration (skatteetaten.no).

The Cancer Registry of Norway (kreftregisteret.no) maintains population-wide cancer screening that reaches rural populations via mobile units.

Sweden
Sweden's approach to morbidity equality is embedded in its Public Health Policy, which aims to create conditions for good and equal health across the entire population.

The Swedish Public Health Agency (Folkhälsomyndigheten, folkhalsomyndigheten.se) oversees national disease prevention and health promotion.

The National Board of Health and Welfare (Socialstyrelsen, socialstyrelsen.se) monitors quality and equity in healthcare delivery across all 21 county councils.

Sweden's Health and Medical Services Act (Hälso- och sjukvårdslagen) explicitly requires equal care on equal terms for the entire population.

Sweden's model includes free school healthcare administered by the National Agency for Education (skolverket.se), ensuring children regardless of socioeconomic background receive regular health monitoring.

The Agency for Health Technology Assessment and Assessment of Social Services (SBU, sbu.se) evaluates and mandates evidence-based treatments to prevent variation in care quality. Regional health boards are legally required to submit annual equity reports to the National Board.
Sweden's Mental Health Strategy specifically targets vulnerable groups including immigrants, homeless persons, and youth.

The Swedish Social Insurance Agency (Försäkringskassan, forsakringskassan.se) provides comprehensive sick pay and disability compensation reducing the health impacts of poverty. Corporate health promotion is incentivized through tax deductions under the Swedish Tax Agency (skatteverket.se).

National coordinated childhood immunization programs achieve over 97% coverage, preventing childhood morbidity disparities.

Finland
Finland's National Institute for Health and Welfare (THL, thl.fi) leads evidence-based public health policy that has dramatically reduced morbidity disparities since the 1970s.

The Health Care Act (2010) mandates equal access to primary health services in all municipalities through a network of over 1,000 health centers (terveyskeskus).

Finland's Primary Health Care Reform ensures that patients are allocated a named responsible physician and nurse, providing continuity and accountability.

The Finnish Government's Action Plan to Reduce Health Inequalities (2008–2011 and subsequent) specifically targets low-income, unemployed, and ethnic minority groups.
The Social Insurance Institution of Finland (Kela, kela.fi) provides universal coverage for medications, dental care, and rehabilitation.

Finland pioneered the North Karelia Project, a world-recognized community-based cardiovascular disease prevention program since 1972, which has since been expanded nationally.

The Ministry of Social Affairs and Health (stm.fi) implements a Healthy Finland Program with measurable equity targets.

Regional State Administrative Agencies (AVI) supervise healthcare provision and intervene when municipalities fail equity benchmarks.

Mental health services are integrated into primary care through the MIELI National Mental Health Strategy.

Finland's national alcohol and tobacco control policies, enforced by Valvira (valvira.fi), reduce substance-related morbidity disparities.

Employee health services are legally mandated for all employers by the Occupational Health Care Act.

Denmark
Denmark's National Strategy to Reduce Social Inequality in Health (Sundhedsstyrelsens strategi) guides comprehensive government action to ensure all citizens receive equitable healthcare regardless of income, education, or geography.

The Danish Health Authority (Sundhedsstyrelsen, sst.dk) publishes detailed inequality analyses and mandates corrective actions at the regional level.

Denmark's five health regions are required by law (Healthcare Act 2005) to deliver equal quality services across urban and rural settings.

The Danish Patient Safety Authority (stps.dk) investigates and addresses systematic disparities in treatment quality.
Preventive health checks (Helbredscheck) are funded for high-risk and low-income populations through municipal health centers (kommunale sundhedscentre).

The National Board of Social Services (socialstyrelsen.dk) bridges health and social care to address homelessness, addiction, and poverty as drivers of morbidity inequality.

Denmark's integration health programs, administered by the Ministry of Immigration and Integration (uim.dk), ensure refugee and immigrant populations access timely screening and preventive care.
The Danish Cancer Society (cancer.dk) conducts free national screening programs with outreach to socioeconomically disadvantaged neighborhoods.

National chronic disease management programs (Kronisk sygdom) standardize treatment for diabetes, heart disease, and COPD across all regions.

Employer mandatory sick pay legislation ensures that low-wage workers do not forgo medical treatment due to financial pressure.

Netherlands
The Netherlands has reduced morbidity inequality through a regulated insurance system where all residents are legally required to purchase basic health insurance, with the government providing income-based healthcare allowances (zorgtoeslag) through the Tax and Customs Administration (belastingdienst.nl) to ensure affordability.

The National Institute for Public Health and the Environment (RIVM, rivm.nl) monitors and reports on health disparities and directs targeted interventions.

The Ministry of Health, Welfare and Sport (rijksoverheid.nl) implements the National Prevention Agreement (Nationaal Preventieakkoord, 2018), committing government, employers, and civil society to measurable reductions in smoking, obesity, and alcohol consumption across all socioeconomic groups.

The Netherlands' Care Standard for appropriate and timely care ensures standardized treatment protocols regardless of patient income or education.

The Dutch Healthcare Authority (NZa, nza.nl) regulates insurance practices to prevent discrimination or coverage gaps.

Municipal Health Services (GGD, ggd.nl) operate in all municipalities providing free preventive services including vaccinations, youth health, and infectious disease control.

The Netherlands has pioneered neighborhood-level health programs (WijkGezondheidswerk) that embed nurses and health workers directly into low-income communities.

The Pharos Center of Expertise on Health Disparities (pharos.nl) provides training and tools to health professionals serving migrant and low-literacy populations.

Corporate wellness obligations under the Working Conditions Act require all employers to provide occupational health services.

Switzerland
Switzerland achieves low morbidity inequality despite a decentralized federal system through its Federal Health Insurance Act (KVG/LAMal), which mandates universal basic coverage with canton-specific premium subsidies (Prämienverbilligung) for low-income residents.

The Federal Office of Public Health (FOPH, bag.admin.ch) coordinates national prevention strategies and monitors cantonal health equity performance.

Switzerland's National Health Policy (Gesundheit2020) explicitly targets reducing socially determined health differences.

Cantonal Health Departments (Gesundheitsdirektionen) operate primary care networks ensuring rural access.

Switzerland's Health Promotion Foundation (Gesundheitsförderung Schweiz, healthpromotion.ch) funds workplace health promotion programs and community-based prevention in all 26 cantons.

The Swiss Federal Statistical Office (bfs.admin.ch) publishes detailed health inequality reports by income, education, and region.

Switzerland's suicide prevention strategy, integration health programs for its large immigrant population, and mental health promotion initiatives all specifically address equity gaps.

The Federal Social Insurance Office (FSIO, bsv.admin.ch) ensures disability and chronic illness benefits are accessible regardless of employment status.

The Swiss Cancer League (krebsliga.ch) provides language-accessible cancer screening across all linguistic regions.

Mandatory employer accident insurance through SUVA (suva.ch) ensures all workers receive equal occupational health protection.

Austria

Austria reduces morbidity inequality through its compulsory social health insurance system (gesetzliche Krankenversicherung), operated by the Austrian Health Insurance Fund (ÖGK, gesundheitskasse.at), which covers over 99% of the population with uniform benefit packages.

The Federal Ministry of Social Affairs, Health, Care and Consumer Protection (BMSGPK, sozialministerium.at) implements Austria's Target-Oriented Health Reform (Zielsteuerung Gesundheit), which includes binding equity targets for all nine federal states.

Primary healthcare reform (Primärversorgung) has expanded general practitioner access in underserved areas through new multi-professional primary care units.

The Austrian Public Health Institute (GÖG, goeg.at) conducts national health equity assessments and recommends policy adjustments.
Austria's Social Assistance Act (Sozialhilfegesetz) ensures that residents without income receive Medicaid-equivalent health coverage.

The Austrian Cancer Aid Society (krebshilfe.at) operates nationwide free cancer screening and counseling services targeting low-income populations.

Workplace health promotion is coordinated through the Austrian Network for Workplace Health Promotion (ÖNBGF, netzwerk-bgf.at), with legal requirements under the Labor Protection Act.
Austria's mental health strategy includes community psychiatric services and crisis intervention available in all regions.

The integration of health and social services at the regional level prevents poverty-related morbidity from falling through service gaps.

Free vaccination programs are administered uniformly by regional health authorities, achieving near-universal childhood immunization.

Morbidity Inequality by World Region (2022 Estimates)

Regional distribution of Morbidity Inequality Index values reflects deep global disparities. Western Europe (excluding Russia) maintains the lowest collective index at approximately 0.065–0.085, reflecting robust universal health systems.

Canada records an index of approximately 0.078 and Australia approximately 0.073, both benefiting from universal health coverage and strong public health infrastructure.

The United States index of approximately 0.178 places it significantly above peer high-income nations. China records a moderate index of approximately 0.195, with major urban-rural and income disparities, while Russia registers approximately 0.218 due to inadequate regional health infrastructure and high cardiovascular disease burden.

Mexico records approximately 0.231 and Central America approximately 0.255, reflecting limited healthcare access in rural and indigenous communities.

South America collectively averages approximately 0.240, with wide variation between countries.

The Middle East records approximately 0.225, shaped by conflict, displacement, and income inequality in several nations.

Asia excluding China averages approximately 0.235, ranging from very low in Japan (0.083) to high in South Asia.

Africa records the highest global morbidity inequality at approximately 0.385, driven by inadequate health infrastructure, disease burden, poverty, and conflict.

These regional figures are estimated from the 2022 Global Burden of Disease Study published by the Institute for Health Metrics and Evaluation (healthdata.org).

Section 3 What the U.S. Can Do to Decrease Its Morbidity Inequality

The United States ranks approximately 43rd globally in morbidity equality, with a Morbidity Inequality Index of approximately 0.178 for 2022. This ranking reflects significant disparities in health outcomes across racial, ethnic, socioeconomic, and geographic lines that have persisted despite decades of incremental reform. Reducing morbidity inequality in the United States requires a coordinated, multi-sector approach involving federal and state governments, the private sector, civil society, and individual citizens.

Federal Government Agencies:
The U.S. Department of Health and Human Services (HHS, hhs.gov) must strengthen the implementation of the Affordable Care Act's preventive services mandates and expand Medicaid eligibility in the remaining states that have not adopted expansion.

The Centers for Disease Control and Prevention (CDC, cdc.gov) must increase funding for community health centers and targeted chronic disease prevention programs in underserved communities.

The Centers for Medicare and Medicaid Services (CMS, cms.gov) must implement value-based payment models that reward providers for reducing health disparities in their patient populations.

The Health Resources and Services Administration (HRSA, hrsa.gov) must expand the Community Health Center Fund and Rural Health Programs.

The National Institutes of Health (NIH, nih.gov) must prioritize research on the social determinants of health and health disparities through the National Institute on Minority Health and Health Disparities (NIMHD).

The Agency for Healthcare Research and Quality (AHRQ, ahrq.gov) must mandate and publish standardized disparity metrics across all hospital systems.

The U.S. Department of Housing and Urban Development (HUD, hud.gov) must expand affordable housing programs given the direct link between housing instability and poor health.

The U.S. Department of Agriculture (USDA, usda.gov) must strengthen the Supplemental Nutrition Assistance Program (SNAP) and Women, Infants, and Children (WIC) program to address food insecurity as a driver of morbidity.

State Governments:
All states should adopt Medicaid expansion, enact paid sick leave legislation, fund community health worker programs, require hospital systems to measure and publish disparity data, and establish

State Office of Health Equity positions with adequate authority and funding. States should require cultural and linguistic competency training for all licensed healthcare providers.

Corporations and Private Sector:
Employers must expand access to employer-sponsored health insurance, particularly for low-wage workers, part-time employees, and contract workers.

Fortune 500 companies should adopt formal Health Equity Commitments modeled after Business Group on Health (businessgrouphealth.org) frameworks.

Pharmaceutical companies must ensure that essential medications are available at affordable prices, including through expanded patient assistance programs.

Health insurers must eliminate discriminatory prior authorization practices that disproportionately affect low-income and minority patients.

Retail health companies such as CVS Health (cvshealth.com) and Walmart (walmart.com/health) should expand community health clinic services in medically underserved areas.

Private Individuals and Community Organizations:
Individual citizens, community health advocates, and nonprofit organizations play a critical role in reducing morbidity inequality by providing peer health education, navigating healthcare systems for vulnerable populations, and advocating for equitable policy.

Organizations such as the Robert Wood Johnson Foundation (rwjf.org), the W.K. Kellogg Foundation (wkkf.org), and local community health alliances provide essential funding and coordination for grassroots health equity initiatives.

Faith communities can host health fairs, screenings, and mental health support groups. Academic medical centers must invest in community benefit programs targeted at the populations in their service areas with greatest health disparities.

Section 4 References

The following sources were used in Sections 2 and 3 of this document:

World Health Organization — Social Determinants of Health: https://www.who.int/health-topics/social-determinants-of-health
Institute for Health Metrics and Evaluation — Global Burden of Disease: https://www.healthdata.org/research-analysis/gbd
OECD Health Statistics 2023: https://www.oecd.org/health/health-data.htm
Commonwealth Fund — International Health Policy Center: https://www.commonwealthfund.org/international-health-policy-center
Robert Wood Johnson Foundation — Health Equity: https://www.rwjf.org/en/insights/our-research/health-equity.html
U.S. Centers for Disease Control and Prevention: https://www.cdc.gov
U.S. Department of Health and Human Services — Healthy People 2030: https://health.gov/healthypeople
Norwegian Directorate of Health: https://www.helsedirektoratet.no/english
Swedish Public Health Agency: https://www.folkhalsomyndigheten.se/the-public-health-agency-of-sweden/
Finnish National Institute for Health and Welfare (THL): https://thl.fi/en
Danish Health Authority: https://www.sst.dk/en
Netherlands National Institute for Public Health and the Environment (RIVM): https://www.rivm.nl/en
Swiss Federal Office of Public Health (FOPH): https://www.bag.admin.ch/bag/en/home.html
Austrian Public Health Institute (GÖG): https://www.goeg.at/en
Icelandic Directorate of Health: https://www.landlaeknir.is/english/
European Observatory on Health Systems and Policies: https://eurohealthobservatory.who.int
U.S. Health Resources and Services Administration (HRSA): https://www.hrsa.gov
U.S. Agency for Healthcare Research and Quality (AHRQ): https://www.ahrq.gov
Business Group on Health: https://www.businessgrouphealth.org
National Institute on Minority Health and Health Disparities (NIMHD): https://www.nimhd.nih.gov

Section 5 Draft of a House Bill

H.R. ____ — To Reduce Morbidity Inequality in the United States

IN THE HOUSE OF REPRESENTATIVES

A BILL
To reduce morbidity inequality in the United States by establishing federal requirements for government agencies, officials, corporations, and private citizens, and for other purposes.

Short Title: Health Equity and Morbidity Reduction Act of 2025

SECTION 1. Definitions

For purposes of this Act:

1. "Morbidity Inequality" means the systematic differences in the burden of disease, disability, and illness between socioeconomic, racial, ethnic, geographic, and other demographic subgroups of the population.
2. "Social Determinants of Health" means the conditions in which people are born, grow, live, work, and age, including factors such as income, education, employment, housing, and access to healthcare.
3. "Covered Entity" means any hospital, health system, health insurance plan, federally qualified health center, or healthcare provider receiving federal funding.
4. "Health Equity" means the state in which every person has a fair and just opportunity to be as healthy as possible, requiring removal of obstacles to health such as poverty, discrimination, and lack of access to care.
5. "Community Health Worker" means a frontline public health worker who serves as a bridge between healthcare providers and the communities they serve.
6. "Disparity Metric" means a standardized, validated measure of differences in health outcomes, access, or quality between population subgroups.
7. "Underserved Community" means a geographic area or population group designated by the Secretary of Health and Human Services as having inadequate access to health services.
8. "Secretary" means the Secretary of Health and Human Services unless otherwise specified.
9. "Universal Health Coverage" means a system ensuring that all individuals can obtain the health services they need without suffering financial hardship.
10. "Prevention Program" means any evidence-based public health initiative designed to reduce the incidence or progression of disease in a defined population.

SECTION 2. Enacting Clause

(a) FINDINGS. The Congress finds that:

(1) Morbidity inequality in the United States results in preventable suffering, reduced economic productivity, and inequitable distribution of the burden of disease.

(2) Countries with universal health coverage, robust primary care systems, and coordinated social services consistently achieve lower morbidity inequality than the United States.

(3) Federal action is required to coordinate the efforts of government agencies, the private sector, and civil society to systematically reduce morbidity inequality.

(b) PURPOSE. The purpose of this Act is to:

(1) Establish enforceable standards and accountability mechanisms to reduce morbidity inequality across all segments of the United States population.

(2) Align federal health investments with measurable equity outcomes.

(3) Incorporate evidence-based strategies from leading nations that have achieved greater health equality.

SECTION 3. Requirements by Government Agencies

(a) DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(1) The Secretary shall develop and publish a National Morbidity Inequality Reduction Plan within 180 days of enactment, including measurable five-year and ten-year benchmarks.

(2) The Secretary shall require all Covered Entities receiving federal funding to collect, analyze, and publicly report standardized Disparity Metrics stratified by race, ethnicity, income, disability status, and geography on an annual basis.

(3) The Secretary, acting through the Centers for Disease Control and Prevention, shall:

(A) Fund Community Health Worker programs in all Underserved Communities with a population exceeding 10,000 persons;

(B) Establish a National Health Equity Dashboard accessible to the public at no cost;

(C) Issue annual reports to Congress on national progress in reducing morbidity inequality.

(b) CENTERS FOR MEDICARE AND MEDICAID SERVICES.

(1) The Administrator shall implement payment adjustments incentivizing providers who demonstrate measurable improvements in health equity outcomes for low-income and minority populations.

(2) The Administrator shall prohibit prior authorization requirements for evidence-based preventive services in all federally funded insurance programs.

(3) The Administrator shall expand Medicaid coverage for preventive dental, vision, and mental health services in all participating states.

(c) HEALTH RESOURCES AND SERVICES ADMINISTRATION.

(1) The Administrator shall increase the number of Federally Qualified Health Centers in Underserved Communities by no fewer than 500 within five years of enactment.

(2) The Administrator shall establish loan forgiveness programs for primary care physicians, nurses, and community health workers who serve in Underserved Communities for a minimum of five years.

(d) DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT.

(1) The Secretary of Housing and Urban Development shall establish a Health-in-Housing Initiative integrating healthcare navigation services into federally subsidized housing developments.

(e) DEPARTMENT OF AGRICULTURE.

(1) The Secretary of Agriculture shall expand WIC and SNAP benefits to address food insecurity as a direct contributor to morbidity inequality, including incentives for purchase of fresh produce and expansion of eligibility thresholds.

(f) AGENCY FOR HEALTHCARE RESEARCH AND QUALITY.

(1) The Director shall develop and mandate the use of standardized Disparity Metrics in all federally funded health programs within 24 months of enactment.

(2) The Director shall fund research on effective interventions to reduce morbidity inequality, with results published in an open-access national database.

SECTION 4. Requirements by Government Officials

(a) SECRETARY OF HEALTH AND HUMAN SERVICES.

(1) The Secretary shall personally present the National Morbidity Inequality Reduction Plan to Congress within 180 days of enactment and submit annual progress reports thereafter.

(2) The Secretary shall appoint a Deputy Assistant Secretary for Health Equity with authority to coordinate all departmental offices.

(b) STATE GOVERNORS AND HEALTH COMMISSIONERS.

(1) Each state receiving federal public health grants shall designate a Chief Health Equity Officer responsible for implementing state-specific plans to reduce morbidity inequality.

(2) Governors of states that have not adopted Medicaid expansion are strongly encouraged to do so, with enhanced federal matching rates provided as incentive under this Act.

(c) MEMBERS OF CONGRESS.

(1) Each Member of Congress shall be required to certify annually that they have received a briefing from the Congressional Research Service on current data regarding morbidity inequality in their district or state.

(d) LOCAL GOVERNMENT OFFICIALS.

(1) Mayors and county executives of jurisdictions with populations exceeding 100,000 shall submit annual Health Equity Action Plans to the Secretary as a condition of receiving applicable federal grants.

(2) Local public health directors shall integrate morbidity inequality metrics into all community health assessments.

SECTION 5. Requirements by Corporations

(a) REPORTING REQUIREMENTS.

(1) All Covered Entities with 50 or more employees shall:

(A) Collect and publicly report standardized employee health outcome data stratified by income quintile and race/ethnicity;

(B) Establish an employee Health Equity Committee meeting no fewer than quarterly;

(C) Submit annual health equity progress reports to the Secretary.

(b) INSURANCE REQUIREMENTS.

(1) Health insurance companies operating in the commercial market shall:

(A) Eliminate discriminatory network designs that systematically exclude providers serving minority and low-income populations;

(B) Ensure telehealth services are equally reimbursed and accessible across all plan tiers;

(C) Provide all plan materials in the top five languages spoken in each state of operation.

(c) PHARMACEUTICAL INDUSTRY.

(1) Pharmaceutical manufacturers receiving federal research funding shall:

(A) Maintain patient assistance programs with eligibility thresholds at no less than 400% of the federal poverty level;

(B) Report annually on medication access disparities by income and race.

(d) EMPLOYER WELLNESS PROGRAMS.

(1) Employers with 100 or more employees shall provide:

(A) Workplace health promotion programs that include free preventive screenings for hypertension, diabetes, and cancer;

(B) Mental health Employee Assistance Programs accessible without cost-sharing;

(C) Paid sick leave of no fewer than seven days per year for all employees.

SECTION 6. Requirements by Private Citizens

(a) COMMUNITY ENGAGEMENT.

(1) Private citizens are encouraged to:

(A) Participate in community health worker training programs administered by state health departments;

(B) Engage with local health equity coalitions to identify and address neighborhood-level morbidity disparities;

(C) Complete regular preventive health screenings as recommended by the U.S. Preventive Services Task Force.

(b) NONPROFIT AND FAITH ORGANIZATIONS.

(1) Tax-exempt organizations are encouraged to:

(A) Host free community health fairs, screenings, and mental health support programs in Underserved Communities;

(B) Train volunteers as health navigators to assist community members in accessing government health programs;

(C) Partner with Covered Entities to provide culturally competent health education.

(c) INDIVIDUAL HEALTH BEHAVIORS.

(1) Federal and state agencies shall promote healthy behaviors through evidence-based public education campaigns while recognizing that individual behaviors are shaped by social determinants of health that must be addressed structurally.

SECTION 7. Penalty Clauses

(a) CIVIL PENALTIES FOR COVERED ENTITIES.

(1) Any Covered Entity that fails to comply with reporting requirements under Section 3 shall be subject to civil monetary penalties of not less than $10,000 per violation per day of noncompliance.

(2) Covered Entities that demonstrate intentional data falsification in Disparity Metric reports shall be subject to penalties of up to $1,000,000 and potential loss of federal funding eligibility.

(b) CORRECTIVE ACTION PLANS.

(1) Covered Entities found by the Secretary to have significantly worsening Disparity Metrics for three consecutive years shall be required to implement a Corrective Action Plan approved by the Secretary.

(2) Failure to implement an approved Corrective Action Plan within 12 months shall result in suspension of new federal grants until compliance is achieved.

(c) CORPORATE PENALTIES.

(1) Health insurance companies found to have engaged in discriminatory network design practices shall be subject to civil penalties of up to $5,000,000 per violation.

(2) Pharmaceutical companies that fail to maintain patient assistance programs as required shall be barred from participation in federal procurement programs for two years.

SECTION 8. Effective Dates and Implementation

(a) EFFECTIVE DATE. This Act shall take effect 90 days after the date of enactment, except as otherwise provided.

(b) IMPLEMENTATION PHASES.

(1) Phase I (0–12 months after enactment): The Secretary shall publish the National Morbidity Inequality Reduction Plan, establish the National Health Equity Dashboard, issue implementing regulations for reporting requirements, and designate the Deputy Assistant Secretary for Health Equity.

(2) Phase II (12–36 months after enactment): Covered Entities shall begin data collection and reporting. States shall designate Chief Health Equity Officers. CMS shall implement new payment models.

(3) Phase III (36–60 months after enactment): HRSA shall complete new health center expansions. All state Health Equity Action Plans shall be operational. The Secretary shall submit the first five-year progress report to Congress.

(c) TRANSITION PROVISIONS. Any Covered Entity currently operating under an approved waiver shall have 24 months from enactment to transition to compliance with requirements of this Act.

SECTION 9. Appropriations or Budgetary Notes

(a) AUTHORIZATION OF APPROPRIATIONS.
(1) There are authorized to be appropriated to carry out this Act:
(A) $5,000,000,000 for fiscal year 2026 and each subsequent fiscal year for Community Health Center expansion under Section 3(c);
(B) $2,000,000,000 for fiscal year 2026 and each subsequent fiscal year for Community Health Worker programs under Section 3(a)(3)(A);
(C) $500,000,000 for fiscal year 2026 and each subsequent fiscal year for the National Health Equity Dashboard and data infrastructure under Section 3(a)(3)(B);
(D) $1,500,000,000 for fiscal year 2026 and each subsequent fiscal year for health equity research administered by AHRQ under Section 3(f);
(E) $750,000,000 for fiscal year 2026 and each subsequent fiscal year for the Health-in-Housing Initiative under Section 3(d).
(b) BUDGETARY NOTES.
(1) The Congressional Budget Office shall score all provisions of this Act for their expected impact on the federal deficit.
(2) Savings generated by reduced emergency department utilization attributable to programs under this Act shall be tracked annually by the Secretary and reported to the Committees on Appropriations of both chambers of Congress.
(3) The Secretary shall establish an annual Health Equity Return on Investment report measuring cost savings attributable to reductions in morbidity inequality.

Endnotes

Global Burden of Disease Study 2022, Institute for Health Metrics and Evaluation (IHME): https://www.healthdata.org/research-analysis/gbd

OECD Health Statistics 2023: https://www.oecd.org/health/health-data.htm

Nordic Council of Ministers, Health and Social Affairs: https://www.norden.org/en/information/health-and-social-affairs

World Health Organization, Social Determinants of Health: https://www.who.int/health-topics/social-determinants-of-health

European Observatory on Health Systems and Policies: https://eurohealthobservatory.who.int

Commonwealth Fund, Mirror Mirror 2023: https://www.commonwealthfund.org/publications/fund-reports/2023/jan/mirror-mirror-2023

U.S. Department of Health and Human Services, Healthy People 2030: https://health.gov/healthypeople

Robert Wood Johnson Foundation, Health Equity Reports: https://www.rwjf.org/en/insights/our-research/health-equity.html