

# The Missing Link: Equity

Medicine is only one part of making people healthier.

By Janet Lee

**D**octors perform a variety of tasks every day to improve their patients' health. They might set a broken bone, assess a heart condition, prescribe medication for diabetes, perform a colposcopy to diagnose HPV or consult about how to treat someone with lung cancer (among many other things). But how much do these tasks really improve health? All of these things can be exacerbated by factors at home or in their environment that the patients have little to no control over.

"Social science tells us that medical care contributes only 15 to 20% to health," says Philip Alberti, PhD, senior director of health equity research and policy for the Association of American Medical Colleges (AAMC) and the founding director of the AAMC Center for Health Justice. Other, often ignored contributors include what are called social determinants of health, such as race and ethnicity, lifestyle habits, socioeconomic factors

(education, employment, income) and environment, to name a few.

These social determinants of health can contribute to health inequities: People, whether due to race, ethnicity, gender, sexuality or disability, don't have the same opportunities to be their healthiest because of racism; lack of transportation; reduced access to affordable, nutritious foods; jobs that require them to work in unhealthy environments; or unsafe living environments.

"There are well documented inequities along the whole trajectory within health care," says Alberti. "There are racial, social and economic inequities, from premature birth to premature death." The lack of equity is what keeps maternal mortality rates in the U.S. at the bottom when compared to other high-income countries. It's what makes life expectancy in the U.S. lower than other developed countries, despite outspending everyone else on medical care. It's what led to Black and

Hispanic people being hospitalized and dying from COVID-19 at far higher rates than white people early on in the pandemic. It's what keeps Black men in New York City from having the same access to the monkeypox vaccine as men in other racial groups, according to data released in August from New York City's health department. While they make up 31% of the at-risk population, they only received 12% of distributed doses to date.

A 2022 study, the first of its kind to look at the relationship between health-related social needs and emergency department (ED) use, found that having multiple social needs, such as difficulty paying utility bills or a lack of transportation, was strongly associated with the risk of having two or more ED visits during the prior year. Those with four or more needs had a tenfold higher risk of ending up in the ED. The study was conducted in the Houston area and published in the *Journal of General Internal Medicine*.

*The infant mortality rate of Black babies is more than twice that of white babies.*

## MAKING PROGRESS

Although the first research reviews on the impact of racism on health were done in the mid-1990s (they showed an adverse effect), there's been a huge push over the last several years to better understand the social and structural determinants of health. Medical schools, hospitals, insurers and policymakers—the different groups responsible for delivering health care in the U.S.—are acknowledging health inequities and figuring out how best to address them. The following are some of the areas that may provide fertile ground for progress.

**Community Engagement** Hospitals, in particular, can't ignore the communities they serve. "We know that health is determined by what happens in the community. Those things aren't random; they're the result of structural racism and the social determinants of health," says Dr. John A. Rich, director of the Rush BMO Institute for Health Equity in Chicago.

Rush University System for Health is, in fact, a great example of how a medical system can embed itself in the community, helping to address those social and structural determinants of health. In 2016, Rush implemented a health equity strategy that centered around its local community. The goal: to address health inequities in their neighboring West Side communities—approximately half a million people—that were contributing to a startling 14-year life expectancy gap between those areas and more white, affluent areas. They wanted to reduce that gap by at least 50% by the year 2030.



## The Rush Model

CREATING A BLUEPRINT FOR OTHER HOSPITALS.

Here are some of the ways the hospital system approaches its mission to improve health and health equity.

**COMMUNITY CLINICAL PRACTICE** Within the community, Rush and its partners provide postpartum home visits, run school-based health centers and more.

**COMMUNITY ENGAGEMENT** Besides treating patients, Rush helps provide free meals to residents in need, hires locally and offers paid high school and college internships.

**HEALTH EQUITY RESEARCH** Rush and the University of Chicago received an NIH grant to establish a Center for Multiple Chronic Diseases Associated With Health Disparities.

**POLICY AND ADVOCACY** Rush has partnered with other local hospitals as well as with city government and other community groups.

**EDUCATION AND WORKFORCE ENGAGEMENT** Rush educates medical students about health equity and social determinants of health.



In addition to establishing community-based clinics, the plan called for hiring, purchasing, investing and volunteering locally. Everything the medical center did was through the community lens.

Because of the ways Rush (along with other partners in the area) has infiltrated the community, at the height of the pandemic, Chicago, which is the third largest city in the U.S., had the seventh highest mortality rates, says Dr. David Ansell, senior vice president for community health equity at Rush. (For a closer look at the Rush plan, which was featured in *New England Journal of Medicine Catalyst Innovations in Care Delivery* in 2021, see sidebar, left.)

“There’s no health equity program that will be successful if the community that it affects is not involved,” shares Seun Ross, DNP, director of health equity at Independence Blue Cross in Philadelphia.

**Training at Schools** Besides teaching medical students about the importance of social determinants of health and how to screen for them (if clinicians can’t collect the data about the determinants, they don’t know what the contributing factors are), medical schools and other training programs should be diverse as well, says Dr. Michelle Albert, president of the American Heart Association and admissions dean at the University of California, San Francisco. “We need to double down on having a workforce that’s representative of the demographics of the community so they can understand the lived experiences of the population they’re treating,” says Albert. “That’s really important. Having that understanding will engender research, care and the clinical concordance [incorporating the wishes and beliefs of the patient] that’s needed to address equitable health care.”



According to the Association of American Medical Colleges, the incoming medical school class of 2021–2022 was the most diverse ever.

**Digital Health** Patients’ access to a computer, the internet or a smartphone will determine how well they can engage with their health care in this new digital era, says Ross. “I think it’s incumbent on all of us to do our due diligence and ensure these new tools are assisting in closing disparities and not exacerbating them,” she adds. “Algorithmic bias is a real thing. We have to ensure that any biases that are already embedded in data are not used to perpetuate them.” Ross gives an example of how bias creeps into data: “Let’s say I’m a product developer and I want to develop a tool that can help increase access to psychiatrists. If I use the

data that shows Black people are disproportionately diagnosed with schizophrenia and bipolar disorder as part of my algorithms, I’ll continue to perpetuate that false idea. The app will send Black users to providers who specialize in those conditions.” In that case, the algorithms developers use can widen the divide between groups.

**Policymaking** From the American Medical Association and the National Academy of Medicine to the Centers for Disease Control and Prevention and the Center for Medicare & Medicaid Services (CMS), key groups are stoking the momentum that’s started to build and analyzing

what laws, rules, regulations and organizational structures need to change to promote health equity. In 2021, the CMS issued guidance to states that encourages them to adopt strategies to address social determinants of health in the Medicaid and Children’s Health Insurance Program as a way to improve health outcomes and reduce costs.

“Health and health equity are not zero-sum games,” says Albert. “It’s not about taking from community A and giving to community B. Our challenge in the next few years is to do a better job of communicating that. A lot of awareness has been raised and that gives me optimism.”