American College of Preventive Medicine
physicians dedicated to prevention

Policy Statement on Health Equity

Policy Recommendation:

For decades, systemic underinvestment in comprehensive strategies has given rise to grossly inequitable health outcomes and increased morbidity and mortality for historically marginalized and excluded populations. This has led to a system in which Black, Indigenous and Latino populations experience higher rates of poor health, disease, and death across a range of health conditions.

The American College of Preventive Medicine (ACPM) advocates for comprehensive, evidence-based, and integrated strategies to advance health equity.

Persistent barriers to health equity include factors at many levels encompassing the social, economic, environmental, political, and structural determinants of health. Addressing these structural inequities requires policy-level solutions that guarantee access to medical care, preventive services, lifestyle interventions, and health education for all and improves the upstream economic, social, and non-medical drivers of health.

A commitment to robust investments in programs and policies is required to address the needs of marginalized populations to live healthy lives and advance health equity. Only in this way can the health and wellbeing of the entire population improve.

To this end, ACPM supports policies that:

1. Mitigate and bring an end to systemic discrimination – racism, sexism, ableism, ageism classism, heterosexism, genderism, neurological discrimination, religious prejudice, and xenophobia.
2. Make significant investments to address inequities by training future leaders and developing infrastructure that empowers physicians to address social determinants of health and advance health equity.
3. Utilize a health equity lens to implement structured and evidence-based methods to measure their impact on health equity at the individual, organizational, and community levels.
4. Support health equity efforts by enhancing health information technology, data acquisition, and reporting with a focus on structural and social determinants of health/health equity.
5. Increase the number of physicians in the workforce who can understand and address health equity. This includes efforts to train more diverse physicians. Social determinants of health should be a core competency at all levels of physician education. Efforts should be made to evaluate and mitigate the social,

economic, and other structural barriers faced by physician trainees from minority populations.
6. Connect with communities to identify and integrate culturally appropriate medical approaches and incorporate feedback, engagement, and ownership from the communities served to achieve health equity for historically excluded populations.
7. Strategically address worsening economic inequality and the resulting poor health outcomes.
8. Support the adoption of prevention and wellness programs as key components to address health inequities in marginalized communities.

Key Issues:

1. Historically excluded populations in the U.S. experience higher rates of poor health, disease, and death in a range of health conditions when compared to their White counterparts. This is in large part due to systemic discrimination and the adverse effects of racism which have led to decreased access to care and a failure of the health care system to demonstrate trust and transparency.
2. Up to 80% of clinical outcomes are impacted by social determinants of health, including food security and nutrition, education, affordable and safe housing, employment, and transportation. Health care accounts for only 20% of health outcomes.[1]
3. Despite ranking among the 10 richest countries by per capita income, the U.S. experiences sizable health disparities among its citizens that are rooted in social, economic, and environmental factors.[2]
4. Population-level inequalities in health care result in $309 billion in losses to the economy annually and disproportionately affect disadvantaged populations.[3]
5. Lack of economic or social mobility affects future generations who are born, live, grow, and work in environments that contribute to negative health outcomes.

Supporting Evidence:

1. Investments in specific types of infrastructure and public health interventions can have a positive impact on health equity.[4,5] These include focused efforts to reach communities of greatest need, as well as efforts to make these interventions broadly available. Successful examples have been seen and best practices have been cataloged of using social support interventions such as housing support, care coordination and other

[1] Hood, C. M., K. P. Gennuso, G. R. Swain, and B. B. Catlin. 2016. County health rankings: Relationships between determinant factors and health outcomes. American Journal of Preventive Medicine 50(2):129-135. https://doi.org/10.1016/j.amepre.2015.08.024

[2] National Research Council (US); Institute of Medicine (US); Woolf SH, Aron L, editors. U.S. Health in International Perspective: Shorter Lives, Poorer Health. Washington (DC): National Academies Press (US); 2013. Summary. Available from: https://www.ncbi.nlm.nih.gov/books/NBK154469/

[3] Ubri P, Artiga A. Disparities in health and health care: five key questions. The Henry J. Kaiser Family Foundation. 12 August 2016. Accessed at http://kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers on 8 October 2016.

[4] Frieden TR . Strategies for reducing health disparities—selected CDC-sponsored interventions, United States, 2014 . MMWR Suppl . 2014 ; 63 (1): 1 – 2 .

[5] Taylor LA, Tan AX, Coyle CE, et al. Leveraging the social determinants of health: what works? PLoS One. 2016;11:e0160217. [PMID: 27532336] doi:10.1371/journal.pone.0160217

practices to yield positive outcomes in diabetes prevention, HIV management, colorectal cancer screening and more.

2. Physician readiness to engage in interventions to impact social determinants of health to advance health equity varies greatly, depending on factors such as the workplace environment, training and competencies and comfort with engaging patients.[6]A more diverse physician workforce, representative of the populations they serve, may improve health outcomes for minoritized populations via stronger cultural competencies.[7] Additionally, studies have shown physicians from racially and ethnically diverse populations are more likely to practice in areas of federally designated physician shortages.[8]
3. There is strong evidence that community engagement in public health decision making – especially among minoritized populations – leads to superior public health outcomes.[9] Because of this, it is critical community-focused public health interventions be developed with a focus on partnership with the communities they intend to benefit.
4. A key factor in the success of interventions to address health equity and maximize health for all people is access to accurate and sufficient information to make decisions about public health practices. Minoritized populations have been systematically underrepresented in clinical trials – as referenced by the FDA.[10,11] Likewise, data outside clinical trials, including in managed care systems, lacks the level of fidelity around race, ethnicity, and other socio-economic variables to effectively address and improve health equity.[12]
5. There are strong data that show people of color routinely experience worse healthcare outcomes relative to White individuals across a wide range of health indicators.[13] These inequities have been further highlighted by the COVID-19 pandemic.[14] These disparities

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[6] Lake KJ, Boyd MA, Smithers L, Howard NJ, Dawson AP. Exploring the readiness of senior doctors and nurses to assess and address patients' social needs in the hospital setting. BMC Health Serv Res. 2022 Feb 24;22(1):246. doi: 10.1186/s12913-022-07642-x. Erratum in: BMC Health Serv Res. 2022 Mar 18;22(1):359. PMID: 35197049; PMCID: PMC8867718.

[7] Rampeearee S. Thomas LaVeist: framing the debate on health disparities. The Lancet, 318. Jan 2013. https://www.thelancet.com/action/showPdf?pii=S0140-6736%2813%2960122-1

[8] Smedley BD, Stith AY, Colburn L, et al.; Institute of Medicine (US). The Right Thing to Do, The Smart Thing to Do: Enhancing Diversity in the Health Professions: Summary of the Symposium on Diversity in Health Professions in Honor of Herbert W.Nickens, M.D.. Washington (DC): National Academies Press (US); 2001. Increasing Racial and Ethnic Diversity Among Physicians: An Intervention to Address Health Disparities? Available from: https://www.ncbi.nlm.nih.gov/books/NBK223632/

[9] O'Mara-Eves, A., Brunton, G., Oliver, S. *et al.* The effectiveness of community engagement in public health interventions for disadvantaged groups: a meta-analysis. *BMC Public Health* **15,** 129 (2015). https://doi.org/10.1186/s12889-015-1352-y

[10] Noah, B. (2003). The Participation of Underrepresented Minorities in Clinical Research. *American Journal of Law & Medicine, 29*(2-3), 221-245. doi:10.1017/S0098858800002823

[11] https://www.fda.gov/consumers/minority-health-and-health-equity/clinical-trial-diversity#:~:text=This%20is%20often%20not%20the,diverse%20participation%20in%20clinical%20trials.

[12] Data On Race, Ethnicity, And Language Largely Incomplete For Managed Care Plan Members
Judy H. Ng, Faye Ye, Lauren M. Ward, Samuel C. "Chris" Haffer, and Sarah Hudson Scholle
Health Affairs 2017 36:3, 548-552

[13] Latoya Hill. Key facts on health and health care by race and ethnicity. KFF. https://www.kff.org/racial-equity-and-health-policy/report/key-facts-on-health-and-health-care-by-race-and-ethnicity/. Published January 26, 2022. Accessed May 2, 2022.

[14] Covid-19 racial and ethnic disparities. Centers for Disease Control and Prevention. https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/index.html. Accessed May 2, 2022.

are not limited to the pandemic – racial disparities exist across chronic and infectious disease categories: HIV, pre-term births, infant mortality, obesity, and most other measures of health and wellness.[15]

6. On average, there is a 15-year difference in life expectancy between the most economically advantaged and disadvantaged citizens in the U.S.[16] An estimated 38% of the excess mortality among Black adults versus non-Latino White adults is related to income.[17] Areas of high poverty are also associated with clustering of other factors that lead to health risk factors – including poor housing, increased pollution, and limited access to healthy food, among others.[18,19,20,21] Residents of impoverished areas face higher mortality and lower life expectancy.[22] Likewise, higher levels of neighborhood economic status are positively associated with economic status for all racial and ethnic groups.[23]

[15] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Baciu A, Negussie Y, Geller A, et al., editors. Communities in Action: Pathways to Health Equity. Washington (DC): National Academies Press (US); 2017 Jan 11. 2, The State of Health Disparities in the United States. Available from: https://www.ncbi.nlm.nih.gov/books/NBK425844/

[16] The association between income and life expectancy in the United States, 2001–2014. JAMA. 2016;315:1750-66. [PMID: 27063997] doi:10.1001/jama.2016.4226

[17] Braveman PA, Cubbin C, Egerter S, Chideya S, Marchi KS, Metzler M, et al. Socioeconomic status in health research: one size does not fit all. JAMA. 2005;294:2879-88. [PMID: 16352796]

[18] Hood E. Dwelling disparities: how poor housing leads to poor health. Environ Health Perspect. 2005;113:A310-7. [PMID: 15866753]

[19] Hajat A, Hsia C, O'Neill MS. Socioeconomic Disparities and Air Pollution Exposure: a Global Review. Curr Environ Health Rep. 2015 Dec;2(4):440-50. doi: 10.1007/s40572-015-0069-5. PMID: 26381684; PMCID: PMC4626327.

[20] https://www.annualreviews.org/doi/10.1146/annurev.publhealth.29.020907.090926

[21] Cook WK, Li L, Tam CC, Mulia N, Kerr WC. Associations of clustered health risk behaviors with diabetes and hypertension in White, Black, Hispanic, and Asian American adults. BMC Public Health. 2022 Apr 15;22(1):773. doi: 10.1186/s12889-022-12938-y. PMID: 35428232; PMCID: PMC9013099.

[22] Singh GK, Siahpush M. Widening socioeconomic inequalities in US life expectancy, 1980–2000. International Journal of Epidemiology. 2006;35(4):969-979.

[23] Mode NA, Evans MK, Zonderman AB. Race, neighborhood economic status, income inequality and mortality. PLoS ONE. 2016;12;11(5):1-14. doi:10.1371/journal.pone.0154535