

Working toward health equity

Our choices as physicians can make a difference

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One family struggles with obesity; as a result, their 18-year-old daughter already has hypertension. Another family bikes together on weekends without worry about chronic medical conditions. One patient's child died in infancy. Another patient has a child who is thriving in pre-school. One patient gets her gallbladder out and goes home the next day. Another patient gets her gallbladder out and leaves a few days later with a bill that's \$7,000 larger than that of the first patient. Some patients have better outcomes than others. The factors that contribute to these differences may be a medical mystery, but often there is nothing medical or mysterious about why two seemingly similar stories have different endings.

The history of your ancestors matters. Where you are born matters. Where you grow up matters. Where you live matters. Who your parents are, their health and their history of incarceration matter. Education and opportunity matter. What you look like to those around you and how that impacts your sense of self, matters.

The majority of health outcomes are associated with what happens outside the clinic or hospital—the social determinants of health. It is estimated that only 10-20 percent of health outcomes are directly attributable to health care. The health differences that arise from economic, social or environmental disadvantages are called health disparities.

Minnesota has long been a national leader in health and educational outcomes,



but the outcomes are not the same for every group. White Minnesotans, in general, are healthier than non-white Minnesotans. African American and American Indian babies have twice the mortality of white babies. African American, Latino and American Indian youth have higher rates of obesity than their white counterparts. African American and Latino women are more likely to be diagnosed with late-stage breast cancer ... the list goes on.

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Health disparities can seem overwhelming because they often arise from “upstream” causes. Populations of color have significantly higher poverty rates and unemployment rates and significantly lower income and intergenerational wealth than white Minnesotans. These disparities occur because of systems in our society that were intentionally set up to unfairly advantage certain groups of people and disadvantage others. In America, slavery and the downstream effects of slavery (for example Jim Crow laws, racial housing covenants, redlining) are part of the foundation of this country. The legacy of

slavery as an intentional economic system set up to unfairly advantage certain groups and disadvantage certain groups based on skin color (what we call race) has real and lasting impacts on the health outcomes of people in our state. Implicit bias, explicit bias and structural racism perpetuate these disparities in our healthcare systems. Health inequity saps human potential from our society.

In other words, we are all complicit in the health disparities that exist in Minnesota. Put differently, we all have the opportunity to meaningfully improve these disparities, by working to close the gap between those who have good health and those who do not. This is where the work of health equity lives. Health disparities define the problem; health equity defines the solution.

Health equity is a commitment to reduce and eliminate health disparities. This definition is simple, but it closely relates to massive issues of social justice, education and health in all policies. Seen from this perspective, the work of health equity appears to be overwhelming. However, as with any journey, there are small but significant steps we can all take as physicians to make the daunting become doable. Physicians can advance health equity by working at the personal, community, system and legislative levels. In order to do the work well, physicians also must take the time to understand our nation's history and how the structures of racism in our society perpetuate inequity.

The intentional actions of physicians as citizens and community members can be an important contribution to health equity. Physicians make significantly more than the median income in the United States; that allows us to be discerning in the ways we spend that money. Instead of looking for the best deal on an item, we can look at how a store does or does not contribute to the community. Co-ops, for example, are typically more expensive than chain stores, but provide excellent pay and benefits to their employees. We can support companies that are socially conscious and avoid spending money at companies that act in ways that don't advance health equity. For example, physicians might preferentially shop at Dicks Sporting Goods or Wal-Mart because of their change in stance on selling guns and ammunition. We can put our wealth to work by using banks that contribute to the community, or that are minority-owned or that share our values in other ways.

Physicians vote less often than other professionals. Simply voting and considering the measures we vote for is a step toward advancing health equity. Nearly any policy likely has health equity implications, from education to environment to transportation to taxes. We can bring to light how these policies affect the health

of our communities in discussions with friends, family and community members.

Physicians have the authority and credibility to drive decisions that impact health equity in the clinics and health systems where we work. Most directly, we can address issues related to equitable care. Equitable care is the part of health equity that we as physicians and members of health systems own. A key aspect of providing equitable care is understanding where our own health disparities exist by looking at outcome and process data through a health-equity lens. Typically, this means looking at data sorted by race, ethnicity and language. If we don't collect and view data in this way, then we cannot see the potential for inequitable care. We should be asking our health systems to provide the data we need to make solid clinical decisions in all aspects of care. Shining a light on our own practices can be difficult, but it is a critical step toward insuring that we are providing the best care for all of our patients, not just the ones who look and act like us.

Examine our clinic and hospital policies

If we pay attention, we can see how the policies and procedures in our clinics and hospital systems may disadvantage certain populations. We can get at this directly by asking our patients from marginalized backgrounds about their experiences in our systems. We must then act on their concerns, especially if a pattern becomes apparent over time. For example: our clinic late/no-show policy may not take into account that not all our patients have reliable transportation. Posting a police officer or security guard in the emergency room may make patients of color less likely to seek care there. Having a check-in policy that requires homeless youth to explicitly and publicly state their reason for coming into the clinic may keep them away when they need care.

Push our health systems to champion equity

Using our collective voice as the drivers of our health systems is one of the most

significant ways we can begin to champion health equity in ways that go beyond just health care. Health systems employ roughly 5 percent of the workforce in Minnesota. The hiring and employment policies of these systems—systems whose success depends on us—play a direct role in eliminating (or fostering) health disparities. For example: research has demonstrated many benefits to the health and well-being of parents and children when they are able to spend the critical first days and months after birth (or adoption) together. If health systems institute generous paid parental leave policies for their own employees, they can directly impact the health and well-being of a sizable portion of Minnesotans. Some clinics and hospitals have partnered with law firms to help patients get better housing, fight eviction and have access to an array of legal services, recognizing that addressing health issues is nearly impossible if food and housing insecurity are present. These medical-legal partnerships work best when the lawyers are part of the care team—in fact several health systems have “law consult” order sets in their electronic medical records.

Invest in the community

All health systems in Minnesota have traditionally (until a recent change in the law) been non-profit entities. As such, they are required to invest their “profits” back into the communities they serve. Physicians can play a role in advocating for a community voice in these decisions, so that it is the communities, not the health systems, that get to decide how best to use those funds. Additionally, most health system margins are driven, in part, by investment profits. We should be insuring that our systems and employers are taking health equity into account when deciding which funds and opportunities to invest in.

Have a voice with lawmakers

Physicians are a powerful, but not fully realized, voice at when it comes to talking to lawmakers. When we meet with a city councilmember or state representative, we can speak directly to how nearly all policies in some way impact health. More

Get involved with legislation

- Identify an area of policy you feel strongly about and educate yourself on the current background and history of that policy or issue.
- Reach out to an organization working on that issue to identify relevant legislation and help you craft a message.
- Have a conversation with a lawmaker that stays on message, and that shares your personal insight and relevant stories of patients. This can be over coffee, at a town hall or at the Day at the Capitol many organizations hold.
- Follow up your meeting with a legislator. Advocacy is a continuity visit, not an acute one! Ask him or her how you can help move the idea forward.

importantly, we can share patients' stories on how specific instances of inequity play out. Data can start the conversation, but real-life stories are what drive legislative discussions. When physicians speak, legislators listen; we are trusted members of our communities. As a result, nearly any way that we can engage in the legislative and policy making process can be effective, from joining a public health advisory committee to testifying at the city or state level to meeting with our state representatives and senators.

Physicians can't do this work alone, and should not be the only ones leading it. However, we can partner with those who also work day in and out with the people who suffer the most from health inequity. We can spend more time on our patients' social histories and look for opportunities to provide resources, rather than just medications or procedures. For policy discussions, legislators need physicians who see patients every day and can tell their stories.

Ultimately, health equity is at the core of what we signed up to do as physicians: treating the whole patient, with every tool at our disposal. **MM**

The authors practice in the Twin Cities and are members of Minnesota Doctors for Health Equity, a grassroots organization whose mission is to activate health professionals to work towards health equity. Further information can be found at mdhealthequity.com

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Join the MMA at Day at the Capitol

The Minnesota Medical Association (MMA) encourages and supports advocacy by physicians, medical students and residents. Improved health equity is one of MMA's goals.

The MMA's annual Day at the Capitol is an opportunity for physicians to meet with legislators in-person and advocate for MMA's top legislative priorities. MMA's 2019 Day at the Capitol is scheduled for Wednesday, Feb. 13. Go to www.mnmed.org Education & Events for more information.



Achieving Health Equity



MINNESOTA MEDICAL ASSOCIATION

Join the MMA on Facebook Live as we discuss how the medical community can unite to achieve health equity in Minnesota.

The two-part series is presented by the MMA, the Minnesota Chapter of the American Academy of Pediatrics (MNAAP) and the Minnesota Academy of Family Physicians (MAFP).

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January 22 (Noon to 1)
Addressing health disparities within the Native American community

February 20 (Noon to 1)
Structural racism and other barriers to health equity

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