Report, Health Equity Working Group

AAPHP General Membership Meeting February 27, 2015, 1-3 pm EST

AAPHP's Health Equity Working Group was formed in January 2015 and has met twice by teleconference. Current members are Kenneth Thompson MD; Kevin Sherin MD; Katrina Rhodes MD; Poornima Oruganti MS-3; Virginia Dato MD; and Dave Cundiff MD. Additional participants are welcome.

We plan to develop policy recommendations for further consideration by AAPHP's Resolutions, Policy, and Legislation (RPL) Committee, on which several of us also serve.

Healthy People 2020 includes health objectives for the United States which are comprehensive for all health outcomes and population health. The two overarching Healthy People priorities include reducing and/or eliminating health disparities among groups.

We recognize health disparities and the social determinants of health in all spheres of medicine, health care, and public health. "Health equity" addresses equity in social determinants — often the root cause of poor access and outcomes — and in health care services. Current Health Equity work in North America is largely based on the work of Sir Michael Marmot in Britain.

Health Equity is about the achievement of equitable health status between groups of people that differ in socially determined ways — i.e., through the exercise of social power. Health Equity is achieved by the just exercise of social power to ensure that all have living conditions that support well-being, and that everyone has opportunities to flourish, building on their capabilities and capacities.

Ken Thompson MD spoke to our AAPHP working group about recent Health Equity work.

Julian Tudor Hart observed that the largest share of health services flow to those who need them least; he published this observation in 1971, calling it the "Inverse Care Law". Privileged people also benefit first, and disproportionately consume more resources, from most attempts to improve health care.

Sir Michael Marmot studied the health of British civil servants in the mid-20th century. Marmot found pervasive health and mortality differences between members of different social classes. Occupational class determined health outcomes and was, in turn, based on variations in social determinants such as education, poverty, crime in the community, and stress. Though all had equal access to the National Health Services, class differences were dramatic and striking.

Marmot's work, cited in the 1980 Black Report (put together by Sir Douglas Black) essentially began the new articulation of the "social determinants of health".

Other studies have linked ill health — and inadequate access to health services — to race, ethnicity, religion, sexual orientation, and membership in other "disfavored" or less-valued groups.

In France, studies found large populations who were using fewer French government resources than others. French scholars began using the term "les exclus" — the excluded ones — to describe these people, whose exclusion could be based on age, gender, race, ethnicity, religion, or other factors. This led to Social Exclusion theories of health inequity, often used in European cultures where governments explicitly recognize the expense and burden of inequality.

A newer French term, recognizing the impact of globalization, is "les precariat" — "the precarious ones". The socioeconomic and cultural changes of globalization interrupt long-standing interdependencies and create new ones. It is harder to feel stable and secure in one's relationships when "all that is solid is melting into air".

Greater exclusion increases health care costs and escalates the burden on national health services. Greater inclusion is needed — not only in health services, but in all social policies. Health services can be tailored to excluded populations. Social policies can reduce exclusions. Cultural competency building (including skills training) can increase everyone's willingness and ability to practice social inclusion in their work. Inclusion policies may include (among many other initiatives) policies such as healthy food security, education, and housing security.

Our Health Equity task as public health physicians is to encourage awareness, leadership, and an attitude of "Health Equity in all policies". Our responsibilities are greatest in our own work — but, because all social exclusion seems to impair health, we have a responsibility to educate other social and professional sectors about the profound effects of health inequities, and the great opportunities to improve health equity everywhere in society.

We are trying to translate these insights into "action steps" for AAPHP. One possibility is to adapt AAPHP's existing Preventive Services Tool Kit (PSTK) models to include health disparities, social determinants, and health equity as learning objectives. Another is to use AAPHP's traditional policy and education channels to educate Public Health professionals and others. Another is to support existing efforts, such as a curriculum on lesbian, gay, bisexual, and transgender (LGBT) health developed by medical students (including Ms. Oruganti).

Many forward-leaning healthcare delivery systems are seeking partnerships for community preventive services, and for strategies that address social determinants of health. It is increasingly obvious that "health care", by itself, cannot efficiently support health. This creates opportunities for well-trained Public Health physicians who understand Health Equity.

AAPHP is blessed with talented people to carry out this work. We may be able to leverage outside resources, including external talent and funds, but we can make progress with existing resources as well. We invite others to join us in this adventure!

Respectfully submitted,

Drs. Sherin, Thompson, and Cundiff

for the AAPHP Health Equity Working Group