
HEALTH EQUITY

AAFP Position

The AAFP supports a [Health in All Policies](#) approach to policymaking, investments in equitable and affordable access to comprehensive primary care, improvements in population health, and advancement of health equity. Investing in primary care is an essential strategy to achieving health equity: Evidence confirms that primary care mitigates health disparities and improves patients' access to and utilization of low-cost, high-value care that ultimately results in better patient outcomes and population health.

What Is Health Equity?

The AAFP adopts the [Healthy People 2020](#) definition of health equity: "The attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities." [Studies](#) have shown disparities in health care and health among racial and ethnic minorities¹. To ensure health equity, the Academy is committed to improving community and population health in collaboration with our members, government agencies, nonprofit organizations, and patients of family physicians.

Role of Family Medicine in Addressing Health Equity

[The AAFP believes](#) health equity is integral to the practice of family medicine. Family physicians are uniquely connected to their communities and witness firsthand the social and structural inequities in health and health care that disproportionately affect racial and ethnic minority communities. In fact, family physicians are also [more likely to self-identify](#) as being a member of racial groups underrepresented in medicine, compared with other specialties². Additionally,

¹ 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/>

²

Health Care Equity for Family Medicine Patients and Family Physician Equity
Marjorie A. Bowman, Dean A. Seehusen, Megan R. Mahoney, Christy J. W. Ledford
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female-identifying family medicine clinicians continue to be [paid less](#) than male-identifying providers³. Thus, further investment in the family physician profession and advocacy at local, state, and national levels is crucial to advancing health equity, supporting underserved physicians, and empowering future leaders in family medicine.

Health Equity Metrics

Advancing health equity requires a full and accurate view of existing disparities and inequities. Currently, most health data collection efforts at the federal, state, and local levels are focused on five broad racial groups, two ethnicities, and variable descriptors for LGBTQ+ individuals. Without specific indicators, these populations may not receive adequate consideration in budgeting processes and resource allocations. The AAFP [supports](#) collecting more detailed data that includes specific ethnic groups within each race, based upon broader similarities such as country/continent of origin, language, religious background, [sexual orientation, and gender identity](#).

The Costs of Health Inequity

Annually, health care economic analyses have estimated around \$35 billion in excess health care spending and \$10 billion in lost productivity. *The [Harvard Business Review](#)* found that more than \$245 billion is lost annually because of racial health disparities, and \$200 billion in premature deaths⁴. In 2019, the U.S. spent \$3.8 trillion on health care and is set to reach \$6.2 trillion by 2028, with the majority being spent in hospital settings.

Underrepresentation in Medicine and Diversity in the Workforce

With the current lack of primary care physicians, there is also a corresponding lack of diversity among primary care clinicians in the United States. Black and Hispanic Americans make up nearly [31%](#) of the U.S. population, however, Black and Hispanic Americans make up only [11%](#) of physicians⁵. [Data have shown](#) that individuals who are historically underrepresented in medicine are more likely to enter primary care, with a significant number entering family medicine⁶. The AAFP continues to support efforts promoting the expansion of access to high-quality education and academic resources for underrepresented groups in medicine (UIM) and those that are diversifying the physician workforce.

Efforts to empower UIM start with outreach programs for school-age children led by medical institutions to introduce careers in health care and continue with ongoing financial, psychosocial,

³ Jabbarpour Y, Wendling A, Taylor M, Bazemore A, Eden A, Chung Y. Family Medicine's Gender Pay Gap. *J Am Board Fam Med*. 2022 Jan-Feb;35(1):7-8. doi: 10.3122/jabfm.2022.01.210086. PMID: 35039406.

⁴ Mitchell, M., The economic and human costs of health disparities. *Intersected*. 2021 Aug. doi: <https://intersectedproject.org/2021/08/10/the-economic-and-human-costs-of-health-disparities/>

⁵ Jensen, E. Jones, N., Rabe, M., Pratt, B., Medina, L. Orozco, K., Spell, L. United States Census Bureau. 2021 Aug. doi: <https://www.census.gov/library/stories/2021/08/2020-united-states-population-more-racially-ethnically-diverse-than-2010.html>

⁶ Xierali IM, Nivet MA. The Racial and Ethnic Composition and Distribution of Primary Care Physicians. *J Health Care Poor Underserved*. 2018;29(1):556-570. doi: 10.1353/hpu.2018.0036. PMID: 29503317; PMCID: PMC5871929.

and mentor-based support through pre-medical, medical, residency, and fellowship studies. Additionally, the reduction of implicit biases during the medical school and residency application processes is crucial for ensuring diversity among admits. [Click here](#) to read more on the **AAFP's recommendations for diversity in medical education.**

When looking at the entirety of the U.S. population, racial and ethnic minority patients have less access to high-quality care, which can be attributed to [systemic racism and associated oppressive systems](#) present in daily life⁷. In order to dismantle systemic barriers, ensure equitable care, and improve health care outcomes for all people, a more diverse family medicine workforce is required. To diversify the primary care workforce, the AAFP recommends strengthening efforts to develop and maintain the medical workforce, being mindful of the attributes unique to each population; encouraging DEI efforts at all levels in academia and medical leadership; recognizing the responsibility all family physicians have in advocating for a workforce more representative of the diverse U.S. population; and promoting the urgent need to dismantle barriers that prevent good health outcomes. [Click here](#) to read more about the **AAFP's recommendations for diversity in the workforce.**

Cultural Competency and Sensitivity

All persons, regardless of linguistic or other cultural characteristics, deserve access to high-quality health services. However, health inequities persist, and health outcome disparities remain an ethical and practical dilemma. Culturally and linguistically appropriate services, broadly defined as care and services that are respectful of and responsive to the cultural and linguistic needs of all individuals, hold the promise to reduce these health outcome disparities. Such services are the hallmark of culturally proficient health care delivery for our nation's increasingly diverse population. The AAFP [supports](#) the broad adoption of cultural sensitivity standards by government, payers, health care organizations, practices, and individuals. When cultural sensitivity is an expected standard in health care delivery, "optimal health for everyone" means everyone.

Health in All Policies at the State Level

The AAFP has adopted a [Health in All Policies](#) strategy to acknowledge that policy decisions made at all levels directly affect the health of individual patients and communities by influencing the social and economic factors that drive the social determinants of health. To this end, we have developed a list of state policy recommendations for addressing social determinants of health and mitigating health disparities. We support current and future state policies and programs that

- provide cultural and language-related programs in health care settings that eliminate associated barriers;
- expand access to technology/broadband for telehealth care;

⁷ Feagin J, Bennefield Z. Systemic racism, and U.S. health care. Soc Sci Med. 2014 Feb; 103:7-14. doi: 10.1016/j.socscimed.2013.09.006. PMID: 24507906.

- propose data collection initiatives to better understand existing disparities in order to eliminate them; monitor available data (e.g., school absenteeism, chronic disease prevalence, maternal mortality rates, etc.) for future interventions;
- conduct Health Equity Impact Assessments ([HEIA](#)), as done in [New York](#), [Washington](#), and other states;
 - (this assessment assists in the development of new policies, programs, services, and interventions regarding health equity initiatives);
- expand social services (e.g., childcare, renter protection, education);
- invest in ADA-accessible transportation systems, parks, and other public spaces;
- allow for collaboration between state health departments and communities in expanding health screening programs, creating dashboards and briefs on prevalent state health conditions, conducting home-health visits, engaging in physical activity, and nutrition promotion;
- address population-specific disease through research, programing, educational programs, dissemination of data (i.e., [North Dakota](#) mental health training program for chaplains to address provider shortage);
- analyze funding and expenditures to assess disparities in minority health investment; and
- enhance population-specific emergency preparedness programs (i.e., [Montana](#) American Indian Emergency Preparedness Plan).

The HHS' [2016 State and Territorial Efforts to Reduce Health Disparities](#) special report is a valuable resource outlining recent health equity–focused programs, research, policies, and interventions of 56 states and U.S. territories implemented to reduce disparities.

ADDITIONAL RESOURCES:

- [AAFP's "The EveryONE Project"](#)
 - Provides policy and advocacy tools regarding the social determinants of health, diversity, and health equity to use in your community
- [AAFP Physician Advocate Guide](#) for “The EveryONE Project”
- [AAFP Center for Diversity and Health Equity](#)
- [AAFP's Health Equity Policies](#)
- [The Health Equity Tracker](#) by the Morehouse School of Medicine tracking burden and other health related data by race, ethnicity, sex, age and by state.
- [Black Physician's COVID Death Underscores Health Disparities](#)
- [Leadership Development and Diversity in Academic Family Medicine: An Emphasis on Women and Underrepresented in Medicine](#)
- [Study](#) on medical mistrust in Racially and Ethnically Diverse Californian Adults
- [AFP](#) Diversity, Equity, and Inclusion statement
- [AFP](#) Care of Special Populations
- [FPM From the Editor](#) Systemic Racism and Health Disparities
- [What Can Public Health Programs Do to Improve Health Equity?](#)
- The AAFP's [Career Mobility Resource](#)
- [Health Equity Toolkit](#) for State Practitioners Addressing Obesity Disparities
- [HHS HRSA 2019-2020 Health Equity Report](#) on Housing and Health Inequalities
- [NASHP Resources](#) for States to Address Health Equity and Disparities
- [CDC Community Resource](#) Promoting Health Equity

ADDITIONAL HEALTH EQUITY LEGISLATION:

- [Illinois H.B. 4859](#) Provides financial support to the Illinois Association of Free and Charitable Clinics in the interest of health equity for uninsured and underinsured Illinois residents.
- [Vermont S.B. 241](#) Proposes to include health equity in Vermont's health care reform principles and calls for improved data collection of race, ethnicity, gender identity, sexuality, and other demographic measures for those with Medicaid coverage.
- [New York A.B. 191](#) Requires health equity assessment to be filed with construction application of a hospital or health related service to improve the health of those being served.
- [Oregon H.B. 403](#) Requires the Oregon Health Authority to enhance their financial investment in social determinants of health and health equity.
- [Massachusetts H.D. 1436](#) Proposes commercial rate equity for safety net hospitals to ensure racial and ethnic health equity.
- [West Virginia H.B. 2194](#) Calls for the creation of a Minority Health Advisory Team to advise the commissioner on the health of minorities in West Virginia.
- [California A.B. 1038](#) Amends the California Health Equity Program created to establish an Office of Health Equity at the California DOH to include a health equity grant program for community nonprofits, clinics, and tribal organizations in the interest of health equity.
- [Illinois H.B. 5590](#) Established the "Health Care Billing Equity Act" for the Illinois Department of Health to maintain a database about billing information, codes, and CPT codes used for billing purposes. Provides for transparency and equity in billing practices and holds the Department of Insurance accountable.
- [Illinois H.R. 4387](#) With alarming rates of Black maternal mortality, this legislation serves to amend the Public Health Service Act to improve maternal health and obstetric care in underserved areas.

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