Racial Health Equity and Social Determinants of Health—What's the Difference?

ECG MANAGEMENT CONSULTANTS

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Reporting on the disproportionate burden of COVID-19 among Black and indigenous populations in the United States has widened the health equity conversation and elicited a strong response from the healthcare industry. In particular, leading healthcare organizations called out racism as a public health threat and committed to addressing long-standing, and now more visible, health disparities rooted in racism. For those in the community and population health arena, the message is clear: it is time to *pair social determinants of health (SDOH)* with a *racial health equity (RHE)* lens to ensure that interventions are as impactful as possible.

These two concepts, SDOH and RHE—while interrelated—are distinct. The differences, as well as the areas of overlap, matter and can lead to smarter decisions and more inclusive strategies for building health equity, especially through primary care, and potentially influence an organization's perspectives on diversity, equity, and inclusion (DEI).

WHAT ARE SDOH?

The term SDOH has its origins in public health and has gained popularity among health professionals over the past few decades. When talking about SDOH, we generally mean the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health issues, the ability to function, and quality-of-life outcomes and risks. Health professionals and community leaders, especially those focused on improving primary care and population health, have built and implemented strategies over the past few decades to improve the social drivers of health.

KEY TAKEAWAYS

This article provides perspectives on how healthcare leaders and practitioners can marry social interventions with those intended to improve RHE.

- In order for SDOH initiatives to succeed, underlying inequities associated with race must also be addressed.
- Without a focus on RHE, those who are most vulnerable and disenfranchised will continue to have unmet healthcare needs.
- Quality and financial performance can be improved by addressing structural, institutional, and interpersonal racism and developing a diverse and inclusive workforce.
- To be effective, healthcare leaders should know whether initiatives are aimed at addressing SDOH, RHE, or both.

Figure 1, from the Kaiser Family Foundation, shows how health outcomes are affected by an ecosystem of socioeconomic factors that are notably influenced by racism and discrimination. These factors, such as housing, food security, and employment, are upstream from traditional healthcare interventions, and they have a broader and larger impact on the health outcomes of individual patients and their communities.

FIGURE 1: SOCIAL AND ECONOMIC FACTORS DRIVE HEALTH OUTCOMES

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community, Safety and Social Context	Healthcare System
Racism and Discrimination					
Employment Income Expenses Debt Medical bills Support	Housing Transportation Parks Playgrounds Walkability Zip code/ geography	Literacy Language Early childhood education Vocational training Higher education	Food security Access to healthy options	Social integration Support systems Community engagement Stress Exposure to violence/trauma Policing/justice policy	Health coverage Provider and pharmacy availability Access to linguistically and culturally appropriate and respectful care Quality of care

Health and Well-Being:
Mortality, Morbidity, Life Expectancy, Healthcare Expenditures, Health Status, Functional Limitations

Source: Kaiser Family Foundation

WHAT IS RHE?

Due to the unique circumstances of 2020, particularly the COVID-19 pandemic and galvanizing political events and policing incidents, a broad range of health professionals are increasingly focused on racial equity. Several major healthcare organizations, including prominent national associations and health systems, have acknowledged that racism is a public health crisis. Healthcare leaders are looking for ways to move beyond SDOH to improve racial equity at all levels. This involves acknowledging and remedying the racial and discriminatory policies that both lead to and compound damaging social and economic factors that drive reduced health outcomes.

The CDC states that health equity is achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." Achieving health equity is not a one-size-fits-all approach. It requires healthcare leaders to think about workforce DEI and the unique needs of their patient population for race, ethnicity, and sexual orientation or gender. Figure 2, from the Robert Wood Johnson Foundation, shows how an equitable solution (in this case, bike riding) requires different equipment for each individual.

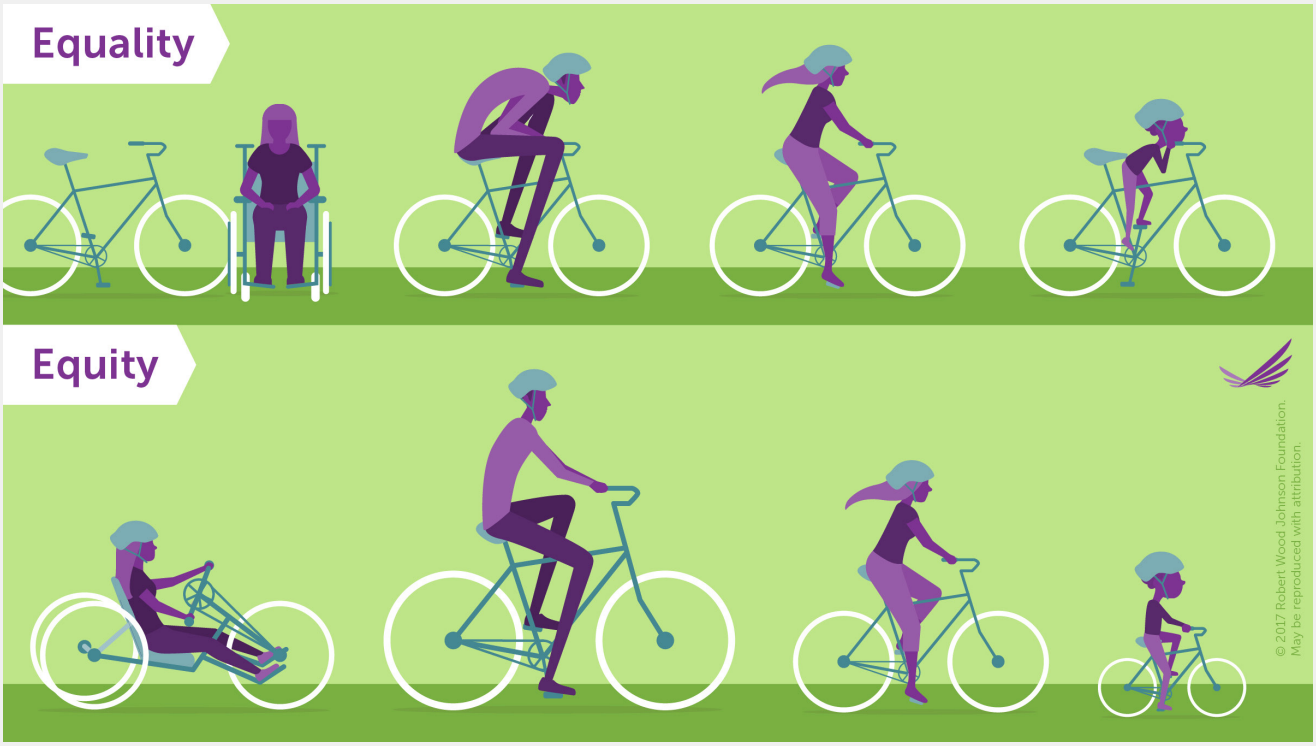
The Relationship between SDOH and RHE

As healthcare leaders interested in building successful health equity strategies, we can benefit from understanding how SDOH and RHE overlap, as well as how they differ. Interventions and solutions that target the areas of overlap will have the widest impact, whereas those targeted at specific SDOH or RHE areas will be more narrowly focused.

> Achieving health equity is not a one-size-fits-all approach.

Let's take, for example, an organization that recruits several providers who are culturally matched to their patient population in an effort to break down barriers and provide culturally competent care. The organization has taken an important step in addressing RHE, but it shouldn't stop there. Leaders may recognize opportunities to partner with medical schools, nursing, or other ancillary

FIGURE 2: EQUALITY VERSUS EQUITY



Source: ***Robert Wood Johnson Foundation***, https://www.rwjf.org/en/library/infographics/visualizing-health-equity.html

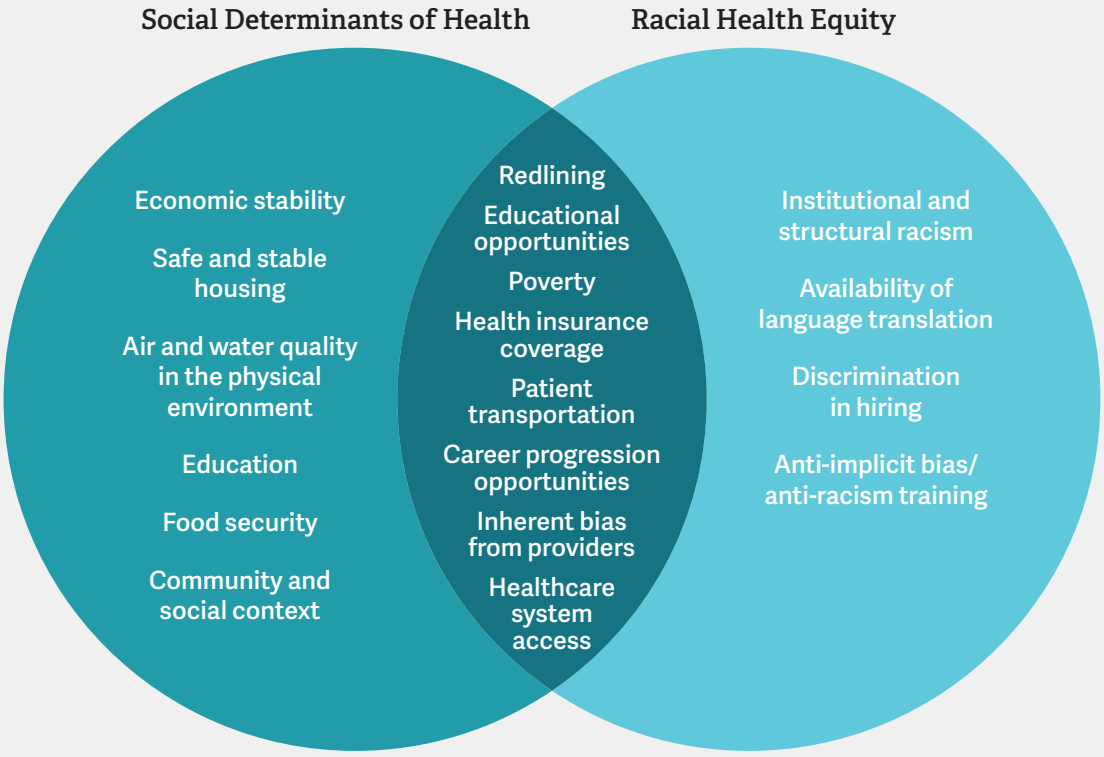
schools to train the next generation of diverse and culturally competent providers. If the organization looks through the SDOH lens at the root issue—providing culturally competent care to vulnerable populations—it will see barriers preventing the patient from getting to the office in the first place, such as inadequate transportation or insurance. Addressing issues from both the RHE and SDOH perspectives will result in stronger solutions.

Another example where health equity can be addressed through the RHE and SDOH intersection is in housing insecurity. Let's say a health system aims to address housing insecurity by connecting patients to public housing. While this approach addresses the SDOH need for safe and affordable housing, it fails to address the underlying RHE context. To better comprehend the RHE needs of its population, the health system might look at how historically systemic racist policies of redlining have harmed members of its community. Redlining, the illegal practice of refusing to offer credit or insurance to individuals from a particular community based on their race or ethnicity, prevented Black Americans from purchasing homes in economically viable communities. Policies rooted in systemic racism, such as redlining, created and continued racial disparities over time.

Addressing the need for safe and stable housing can help improve community health. But if the health system doesn't make a conscious effort to address the specific housing needs of populations who have suffered from systemic discrimination, then the solution is only a Band-Aid for SDOH and misses the mark on RHE. Addressing SDOH and RHE in tandem leads to true health equity.

Figure 3 lists several examples of SDOH, RHE, and where the two overlap.

FIGURE 3: SDOH AND RHE ARE NOT SEPARATE BUT DISTINCT



Bridging the Gap in Primary Care

Primary care plays a huge role in improving health disparities, and we can do even more by deepening our understanding of how racism is the root cause of health disparities. Research conducted by FSG and PolicyLink has shown that integrated healthcare delivery systems that take steps toward improving health outcomes for people of color improve health outcomes for all their patients and strengthen their own economic performance.

> Addressing SDOH and RHE in tandem leads to true health equity.

For example, the report "Health Care and the Competitive Advantage of Racial Equity" profiles ProMedica, an integrated healthcare delivery system located in Toledo, Ohio, that operates 13 hospitals and offers insurance to commercial, Medicare, and Medicaid subscribers through a locally owned insurance company, Paramount.

- ProMedica is focused on understanding the structural racism and potential mistrust that exists within its institution and the communities it serves.
- To invest in these communities, ProMedica is implementing nonclinical solutions, such as a prescription to a food clinic offered to patients who screen positive for food insecurity.
- Because of the food clinic, healthcare costs have dropped 15% for individuals using the service.

We believe it is necessary to incorporate a more specific RHE lens to maximize community benefit and achieve a competitive advantage in primary care. Understanding that resources are limited, we recommend focusing on the factors that lie within the middle of the Venn diagram, at the cross-section of SDOH and RHE, and ensuring that the solutions you deploy will consciously address both.

How do equity challenges affect access to behavioral healthcare? Read more on the ECG Blog.

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