# And an Equitable New Year

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*We wish you a merry Christmas.*
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*We wish you a merry Christmas.*
*And an equitable New Year.*

Christmas 2017 is past; hopefully, the spirit remains. It was a time to celebrate giving, selflessness, love, kindness, forgiveness, and hope. It was a time when we remembered that every human being has value and worth. Not because of their special talents or gifts. Not because of their beauty or strength. Not because of their utilitarian or Darwinian value. Not because they are commodities or their presence completes another person's life. Not even because they play a role in the continuation of the species. It is simply because they are human beings, which alone endows them with innate value and worth.

Health equity is the goal for everyone simply because they are human beings.

The Society of Teachers of Family Medicine (STFM) Board of Directors has adopted this guiding definition of health equity—"conditions that allow everyone the opportunity to attain their highest level of health"—and approved related goals for 2018-2019:

1. Increase awareness among family medicine faculty of social determinants of health (SDH) by increasing presence and visibility of STFM offerings related to health equity in STFM communication vehicles, conference offerings, and other activities (eg, Faculty Development Delivered and *Family Medicine*);
2. Provide SDH and health equity education, training, and resources for medical student and family medicine residency faculty;
3. Engage in partnerships across family medicine to advance our health equity goals;
4. Explore partnerships outside family medicine to advance our health equity goals;
5. Develop and support strategies for 25% by 2030 for America's Health as a means of advancing the student choice work and our health equity efforts.

Twenty-five percent by 2030 refers to the goal of 25% of medical students choosing family medicine by 2030. This is a metric of a larger strategy of the organizational and governing family medicine bodies to enhance the care of the US population, which can only be accomplished by enlarging the primary care workforce.

The focus over the next 2 years is to disseminate STFM's and other organizations' existing resources, enhancing communication of what STFM is doing related to health equity, and developing relationships with partners and others doing health equity work. SDH and health equity will influence our strategic plan for 2020-2025.

Key to moving toward health equity is addressing the SDH, which are the nonclinical socioeconomic conditions that influence health outcomes. Incorporating SDH in how we diagnose, treat, and care for patients is already foundational to the biopsychosocial model upon which family medicine is built.

The World Health Organization defines SDH as the circumstances and conditions "in which people are born, grow, live, work, and age."[1] The United States Healthy People 2020 campaign has organized the social determinants of health around five key domains: (1) economic stability, (2) education, (3) health and health

care, (4) neighborhood and built environment, and (5) social and community context.[2]

These five domains have a number of components. Economic stability includes poverty (debt, expenses), employment (income), food security, housing instability, and medical bills.[2-4] Health and health care include access to primary care, access to health care, health literacy, health coverage, quality of care, and cultural awareness.[2-4] Education includes language and literacy, early childhood education and development, high school graduation, and enrollment in higher education.[3] Neighborhood and built environment include crime and violence, housing, access to foods that support healthy eating patterns, and environmental conditions (eg, safety, parks, playgrounds, and walkability).[2-4] Social and community context include discrimination, incarceration, social integration, social cohesion, community engagement, and support systems.[2-4] Race is not explicitly named in any one domain, possibly because there is such confounding between race and socioeconomic status.[5] Although not causal, race is a negative indicator and marker for many health outcomes (eg, 55% of the uninsured are racial minorities, while accounting for only 40% of the population[6]). Race can play an inhibitory role in moving toward health equity.

Determinants sound so fatalistic. Without diminishing how vital they are to the health outcomes of mortality, morbidity, life expectancy, health care expenditures, health status, and functional status,[3,4] they are more accurately influencers of health. Family medicine can positively influence these influencers.

Teach to the test. Family medicine has educational milestones explicitly related to social, psychosocial, and biopsychosocial aspects of care, as well as some specific to SDH. Take the following Accreditation Council for Graduate Medical Education Milestones, for example: (1) Identifies the roles of behavior, social determinants of health, and genetics as factors in health promotion and disease prevention (Patient Care 2); (2) Identifies health inequities and social determinants of health and their impact on individual and family health (Professionalism 3); and (3) Demonstrates leadership in cultural proficiency, understanding of health disparities, and social determinants of health (Professionalism 3).[7] Residents who are ready to graduate have achieved the Milestones and are, therefore, aware of and know how to incorporate SDH in the care of patients.

Primary care improves the health of individuals and the population, specifically lowering cost and improving outcomes.[8] As such, we will continue to advocate for developing a health care system workforce with more primary care physicians.

Payment reform should account for SDH characteristics of the population served. At a minimum, it should not discourage or disincentivize those who work with the poorest, sickest, and neediest among us. To properly move toward health equity, payment reform should encourage and incentivize this work for the good of each individual and the population. Since resources are not infinite and medicine at its core is a moral action, medical resources should be targeted at those who need and would benefit from them most.

As we work to address SDH in order to move toward health equity, we do so because the very "purpose of medicine as a profession is to meet the health needs of people and communities."[9]

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