Role of hospitals in addressing social determinants of health: A groundwater approach

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Abstract

Adverse social determinants of health, such as unequal access to health care, lack of educational opportunities, and food insecurity are noted for shaping health disparities across race, ethnicity, and geographic context. Underlying racial discriminatory practices and policies catalyze and reinforce these disparities. Health care and academic medicine leaders must consider adopting strategies and programs that target health-related social needs by addressing underlying structural racism that shapes the uneven distribution of adverse social determinants. We present a groundwater allegory from the Racial Equity Institute to describe how leaders can leverage hospitals’ role as anchor institutions within communities to ensure that the communities they serve have equitable resources and opportunities to improve their health. We describe how hospitals—through their economic power, policy influence, and wealth of data—can advance health equity through policies and practices that move beyond the individual level health-related social needs to change local social, political, and economic structural conditions that create disparities. We depict three potential ways for hospitals, by embracing their role as anchor institutions within communities, to address the groundwater conditions that have the most significant impact on community health.

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ABSTRACT

Health disparities by race, ethnicity, sexual orientation, and geographic residence are well described over time and in multiple settings. These inequities are especially evident in the face of the current pandemic wherein COVID-19 morbidity and mortality are disproportionately burdening people of color in our country. Evidence shows that social determinants of health (SDOH)—or the conditions where people are born, live, work, and age—are mainly responsible for catalyzing and reinforcing health disparities (World Health Organization, 2019). In health care, there is recent attention to addressing adverse SDOH within clinical settings. States have leveraged Medicaid transformation to target adverse SDOH. These efforts have emphasized programs that screen for and address health-related social needs such as intimate partner violence, transportation, housing, and food insecurity. While these programs acknowledge the importance of non-medical needs in one’s ability to live a healthy life, these stop-gap measures only address symptoms of powerful and historical underlying practices and policies that constrain or enable individuals in some populations to live healthy lives. To address adverse SDOH, it will require health care and academic medicine leaders to leverage hospitals’ roles as anchor institutions. This approach is one step, among the many needed for systemic change, to ensure that the communities we serve have equitable resources and opportunities to improve their health, especially when state and national policies fail to do so.

1. The groundwater approach

SDOH results from the intersection of economic, social, cultural, and political forces acting at multiple socio-ecological levels. The groundwater allegory, a metaphor for structural racism (Hayes-Greene and Love, 2018), offers a lens through which we can understand the shaping of adverse SDOH. When we encounter a single dead fish in a pond, our first instinct might be to examine the fish; What is wrong with this fish? To find half of the pond’s fish floating belly-up, we are more inclined to explore the state of the pond itself; What is wrong with this pond that is causing all these fish to die? However, when multiple lakes have many sick and dying fish, we are prompted to investigate what connects and explains this phenomenon; Is there something wrong with the groundwater?

In observing health disparities, we have historically focused on the individual – their behaviors, genetics, and environmental interactions. Consequently, most of the implemented interventions are almost...
entirely individualized (i.e., fixing the fish). However, when we see consistent and persistent health disparities, we must examine the ponds and the groundwater system feeding those environments, rather than just fixing the fish. Adverse SDOH are external manifestations of the groundwater that lead to and reinforce health disparities. Racism and discriminatory practices and policies (the “groundwater”) catalyze consistent and persistent disproportionate health burdens and outcomes across race and ethnicity groups, across settings, and across time. Thus, it warrants a shift from a myopic focus on individual behavior change to incremental, consistent, and sustainable structural changes to facilitate optimal health care access and utilization.

If underlying forces shape adverse SDOH, then groundwater approaches are necessary to effect change in health disparities. Hospitals are well-positioned to lead work to address health disparities using groundwater approaches to address policies and practices. By utilizing their economic and social power, hospitals can make significant, meaningful advances in health equity promotion. Hospitals can target the unequal distribution of adverse SDOH through interventions that move beyond the individual (e.g., changing the standard of care) to influencing local social, political, and economic structural conditions that lead to health inequities.

2. Role of hospitals in groundwater solutions

Hospitals and academic medical centers often serve as anchor institutions – organizations, typically large and not likely to move, with a central public-serving mission that inextricably links them to surrounding communities. These powerful institutions can play a critical role in the purchasing, investment, and hiring opportunities in the communities they serve (Ubhayakar et al., 2017). They have an economic and moral interest in helping to ensure that surrounding communities are safe, vibrant, healthy, and stable. We posit that the anchor institution role of hospitals uniquely positions them to target powerful underlying forces that shape adverse SDOH within their communities.

First, health systems and hospitals can harness their economic power and community linkages as a significant regional employer to support the local workforce. They can achieve this through intentional practices such as hiring residents at a living wage, developing pipelines for marginalized groups into healthcare professions, and fostering career advancement and professional development for all employees. With large procurement needs, there is growing interest in hospitals leveraging their economic and social influence to drive community wealth-building. The Healthcare Anchor Network and Democracy Collaborative promotes using hospitals’ sizeable spending power as drivers of community wealth and well-being (Norris and Howard, 2015). Linkage of community-owned businesses with the procurement needs of hospitals and universities can generate living-wage jobs and business ownership within surrounding communities.

Second, hospitals can directly engage in initiatives to address health-related social needs within the community (Franz et al., 2019). For example, hospital leadership can actively participate in and potentially inform policy discussions related to regional transportation plans and zoning policies to promote transit connectivity and affordable housing. The Association of American Medical Colleges highlights several strategies that are implemented by their member hospitals. These initiatives vary from access to healthy food (e.g., hospital food prescription programs) to fostering social support (e.g., reentry of incarcerated individuals into communities through employment) to housing (e.g., recuperative care for homeless individuals). Some have also called on health care systems to examine their environmental impact closely. Greater environmental stewardship includes exploring the sources and quality of food for patients and staff, committing to sustainable energy, reducing waste, and using safer chemicals (Sherman and Lagasse, 2018).

Finally, hospital and health care systems leadership can center equity as a strategic priority within their institutions. Leaders must actively take a systems-level view of generative nature of health inequities and understand how to mitigate them in the future. Medicine and public health have entered a new era in which the expectation is to ensure anti-racism as a strategic priority at every organizational level. This expectation extends to the processes and structures of teams leading organizations. Intentional leadership creates a climate that centers equity, diversity, and inclusion competencies to the same degree as other leadership competencies. It requires leaders to leverage policies and practices that embrace anti-racism both within and beyond the hospital walls, nurture partnerships and professional pipelines within communities, and intentionally act on addressing adverse SDOH.

Pursuing an ‘anchor mission’ requires hospital and health care system leaders to be deliberate in aligning practices, policies, and assets toward addressing fundamental economic, social, and environmental drivers of community well-being. It necessitates reshaping organizational, structural, and cultural practices to be more innovative and equitable. Such a mission must shift institutional norms and be more than the sum of its component efforts. Hospitals are well-positioned to incorporate a groundwater approach beyond “fixing the fish” to target the underlying system shaping the health of communities they serve. They can leverage their economic power, policy influence, and influential leadership to address the uneven distribution of adverse SDOHs. An approach that embraces the anchor mission and community stewardship role of hospitals can facilitate meaningful action to address the groundwater conditions that have the most significant impact on residents’ health and community well-being.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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