Toward Community-Engaged Health Care to Bridge Public Health With Clinical Care

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Approximately 20 years ago, the Institute of Medicine, now the National Academy of Medicine, released *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (commonly known as the *Unequal Treatment* report).[1] That report concluded that pervasive health inequities (referred to as health disparities) have been burdening racially and ethnically minoritized populations within the United States.[1] The report revealed that a key driver of these inequities was structural and systemic racism and provided recommendations to eliminate health care inequities. That landmark report—arguably one of the most important health policy reports ever undertaken—provided a roadmap and call to action for our nation to make progress in addressing historical health inequities that were deeply embedded in the process of health care and reflected in the fabric of broader US society.[1]

In June 2024, the National Academies of Sciences, Engineering, and Medicine released a 20-year follow-up to the original *Unequal Treatment* report. This most recent report, *Ending Unequal Treatment: Strategies to Achieve Equitable Health Care and Optimal Health for All,* evaluates the current state of health care in the United States regarding racially and ethnically minoritized populations.[2] In addition, the report committee explored what progress, if any, the United States has made in the elimination of health inequities since 2003.[2] If progress has been achieved, what are some of the reasons behind this progress? If the United States has made inadequate progress, what can explain the lack of progress? Most importantly, the *Ending Unequal Treatment* report[2] identifies the existing evidence for advancing the nation's quest to eliminate health care inequities and bolster both health care and broader societal health equity.[2]

The *Ending Unequal Treatment* report provided several recommendations for public health and health care delivery systems. In this *AJPH* editorial, we seek to address one key overarching conclusion of the report: the US health care system overly relies on the most costly diagnostic and treatment procedures focused on the management of disease, with inadequate attention given to how the health care system can be leveraged to better advance wellness, prevention, and health promotion in ways that are equitable and optimal for all. This dominant approach results in a health care system that suboptimally addresses the health and health-related social needs of our nation.

The disruption of the health care system is most evident among racially and ethnically minoritized communities. However, the spillover effects of our current approach have implications for the entire population. We underscore the urgency of advancing new models of primary care to strengthen population health and eliminate health inequities. The implementation of this recommendation will require individual, organizational, and systemic changes to the health care delivery system.

PREVENTION AND HEALTH PROMOTION VS DISEASE TREATMENT

The United States currently has a health care system that is overly focused on the provision of sick care, which can be defined as health care that prioritizes the management and

treatment of disease versus prioritization of wellness, prevention, and health promotion.[2] The United States expends far more financial resources on the provision of health care than other countries in the world.[3] However, we consistently report worse health and health care outcomes than other developed nations and, increasingly, certain developing nations.[2,3]

The United States spends approximately $4.8 trillion on health care for costs primarily allocated to treating disease.[3,4] The sole type of health care that has the potential for improving population health—primary care—is the segment of health care that receives the least amount of investment,[2] despite its crucial role in supporting our nation's health.[5] The primary care system is underresourced and often overburdened with diagnosing, treating, and managing disease, with much less attention given to supporting wellness, preventing illness, and promoting health.[6] The inability of the primary care system to better address population health and wellness has resulted in an increasingly costly health care system[3,4] that overly utilizes the costliest procedures[6] and misses its greatest potential: elevating the health of our entire nation.

A health status snapshot of the overall US population highlights troublesome trends; for example, most adults 18 years and older in the United States have one or more largely preventable chronic conditions, and 63% of people 65 years and older live with multiple chronic conditions.[7] In addition, over the past decade, life expectancy has on average decreased or stagnated[8] relative to the extent of the financial expenditures associated with our costly health care system and relative to other nations where greater investments in social care have been well integrated into traditional clinical care.[3,4] As a notable exemplar, the Indian Health Service, which is responsible for providing federal health services to the American Indian and Alaska Native population, is chronically underfunded and meets less than half of the health care needs of the population.[9] This contributes to the lower life expectancy of American Indians and Alaska Natives, approximately eight years less than that of the general US population.[8]

Furthermore, projections regarding the future population health status of our nation highlight a trajectory characterized by increasing numbers of individuals developing one or more chronic diseases.[2,7] The effects of chronic disease on the overall well-being and financial stability of the United States cannot be understated.[10] The current trajectory is unsustainable and has far-reaching implications for US households as well as the overall health of the population and the economic stability of our nation.[11] Of dire concern are the billions of dollars that health economists identify as the costs we contribute to maintaining an inequitable health care system.[12] The country desperately needs a paradigm shift: a reimagined model of care that more fully integrates clinical care centered on prevention and health promotion while also embedding social care into an integrated model of health service provision that bridges public health and primary care.

According to the *Ending Unequal Treatment* report, greater investments in Centers for Medicare & Medicaid Services Section 1115 Health Related Social Needs Demonstration projects are promising and should be further scaled up.[2,13] These projects use Medicaid dollars to address the health-related social needs of program participants. Preliminary evidence suggests that there are promising outcomes regarding cost savings, reductions in unnecessary emergency room visits and hospitalizations, and strengthening of community-based organizations now receiving Medicaid dollars for service provision.[2,13,14] Receipt of these Medicaid reimbursement funds has provided transformative revenue and infrastructure to community-based organizations traditionally not eligible for these funds.[2,14] In addition, the workforce employed by these organizations has been more readily conceptualized as essential for interprofessional health care team members.

COMMUNITY-ENGAGED CLINICAL AND SOCIAL CARE

Health inequities reflect unjust and unfair negative health outcomes that are most noticeably observed in minoritized and marginalized populations.[2] Furthermore, health care inequities reveal the deliberate and unconscious ways in which health care systems and providers allocate services and deliver care.[2] Health care inequities occur within a broader context of health inequity and are inextricably tied to the social environments where people live, learn, work, and play (i.e. the social and structural determinants of health), and they involve both the tangible provision of public goods and services such as housing and education and social processes such as systemic and structural racism and anti-immigrant sentiment that are embedded throughout health care systems and broader society.[15–17]

The distinction between health care inequities and health inequities is meaningful and warrants consideration

regarding how a novel, more effective primary care system could be designed to better integrate both clinical and social care into a robust delivery system across multiple levels, including the individual provider–patient level and the health care institutional level. Also, there is a need to adopt broader societal policies related to health and social welfare.[2]

Eliminating health care inequities will necessitate a sustained commitment to this effort, readiness to implement systemic change within health care, and meaningful engagement of the communities that health care systems are intended to serve. This mandate is most evident in the lack of meaningful engagement of racially and ethnically minoritized groups who experience the majority of the health care inequities observed in the current US health care system.[2] Meaningful engagement moves well beyond cursory community advisory groups and other more performative mechanisms for eliciting superficial input from racially and ethnically minoritized groups.[2,18,19] Rather, meaningful engagement requires a commitment to the deliberate alignment of the health care system to the needs of the communities served.[2,18,19] This alignment is built on a set of principles and practices that reflect equal levels of power, trustworthiness, willingness to allocate financial incentives to all partners in equitable ways, and willingness to address how, where, by whom, and what kind of health care is provided.[18–20]

Given the horrific racial/ethnic morbidity and mortality inequities our nation endured, the COVID-19 pandemic again reminded us of the importance of meaningful community engagement for public health. However, is the health care delivery system ready for the systemic change required to adequately engage with communities and sustain health care inequity interventions? Lack of individual and organizational readiness for change within the health care delivery system may hamper such efforts.

Nevertheless, numerous articles published in *AJPH*[18,19,21] have highlighted the instrumental role of community engagement in eliminating health inequities and the profession's endorsement of a paradigm shift away from a health system with unilateral delivery of health services to a deliberate and committed partnership between health systems, communities, nonprofit organizations, and other stakeholders. At the heart of a newly envisioned partnership with communities are trusted relationships[17–21] in which communities perceive that their best interests are reflected in the actions, programs, and policies implemented within their local health systems. The *Ending Unequal Treatment* report highlights the need for our health care system to move away from episodic and sporadic care to a predictable "relationship-based" system characterized by person-centered and whole-person care.[2]

REDEFINING THE HEALTH CARE WORKFORCE

Currently, the US health care workforce is too narrowly defined. Historically, the health care workforce has been conceptualized as consisting of primarily clinicians such as physicians, nurses, and pharmacists.[2] Too often, interprofessional health care workforce team members' contributions to eliminating health inequities are omitted.[22] For example, there is compelling evidence that community health workers, social workers, behavioral health and addiction providers, and so forth are highly effective members of the health care workforce.[22] Despite compelling data on the important contributions of these health care workforce team members, dominant models of health care delivery underprioritize their utilization in eliminating health inequities.[2,22] This is most notable in the lack of reimbursement for services provided by community health workers and other health care team members, even though changes in reimbursement policies would contribute to eliminating health inequities.[22]

In addition to the historical omission of the full cadre of interprofessional health care workers, the traditional paradigms associated with the current US health care system have restricted the scope of practice of nonphysician members of the health care workforce.[23,24] These restrictive practices are most evident in professions such as nursing, in which there is significant variation in what is permissible regarding what advanced practice nurses are permitted to do.[23,24] These restrictions are not rooted in the preponderance of evidence, which shows the benefits of permitting all members of an interprofessional health care workforce (e.g., dental and oral health professionals, pharmacists, and physician assistants) to practice at the highest levels of their education, licenses, and competencies.[23,24] These restrictions often reflect "turf wars"[23] rather than health care delivery models that prioritize supporting the full interprofessional health care team with greatest demonstrated efficacy in eliminating health care inequities.

Finally, beyond the current restrictions in the scope of practice for the existing health care workforce, expansion of current roles, practice settings,

BOX 1— Contrasting Traditional Health Care With a "Bridged Model" of Public Health and Primary Care

Current Clinical Care Approach	Bridging Public Health and Clinical Care
Primarily focused on the diagnosis, treatment, and management of disease (i.e., sick-care model)	A primary care model that fully integrates social and clinical care and prioritizes wellness, prevention, and health promotion
Health care expenditures primarily allocated to costly diagnostic and treatment procedures	Equitable financial investment in primary care to address population health and wellness and health-related social needs
Health care workforce primarily consisting of clinicians (e.g., physicians, nurses, pharmacists)	Expanded definition of the health care workforce to include omitted actors (e.g., community health workers, social workers, behavioral health and addiction providers)
Scope of practice restrictions on nonphysician workforce members	All members of the health care workforce practicing at the highest levels of their education, licenses, and competencies
Clinical care with referral to health-related social needs	An integrated, interprofessional, team-based workforce with collective responsibility and leadership in the delivery of clinical and social care
Health profession training that primarily occurs in clinic settings (e.g., hospitals) and is patient focused	Health profession training that occurs across a range of settings (e.g., correctional facilities, schools, hospitals) with families in communities
Health care workforce largely not representative of the communities served	Representative and diverse health care workforce with cultural/linguistic preparedness
Delivery of services primarily within traditional clinical settings	Locational flexibility of services aligned with community needs (e.g., telehealth, home based, community-based organizations)
Episodic/sporadic clinical care delivery	Predictable, relationship-based, person-centered and whole-person care
Lack of meaningful engagement of racial and ethnically minoritized communities	Intentional engagement and alignment of the health care system with community needs built on trustworthiness, equal power, and shared decision making
A health care system that overly emphasizes cost containment and, to a lesser degree, access and quality without specific prioritization of the elimination of health care inequities and the achievement of health equity	Sustained organizational commitment to the elimination of health care inequities through implementation of systemic and structural changes within the health care system that prioritize health equity on par with addressing access, quality, and cost containment

and care delivery processes is needed.[22] A more effective interprofessional workforce will increasingly require that we consider alternative settings where care can be provided—homes, via telehealth, within community-based organizations, schools, and so forth—and a team with collective responsibility and equal leadership in the provision of integrated care.[2,22–24]

A NEW VISION: BRIDGING PUBLIC HEALTH AND CLINICAL CARE

A primary health care system for the future will undoubtedly benefit from bridging the traditional aspects of public health to reimagine a more effective and robust primary health care system. In this new model of integrated care, population health is the primary goal. At the cornerstone of this integrated clinical and social primary care model is public health, which has a strong "bridge" to traditional health care service delivery. Public health provides a framework for prevention and health promotion within primary care. In addition, public health workers are accustomed to engaging with interprofessional teams across multiple levels of intervention (e.g., individuals, institutions, communities and broader societies)[17] and across diverse settings such as schools, correctional facilities, substance use treatment programs, community centers, and homes.

As noted by Baum et al., however, significant barriers such as siloed funding, resource limitations, and a lack of collective awareness and action in the integration of clinical care and public health hinder such efforts.[25] Nevertheless, a "bridged model" of primary care that draws on the clinical expertise of the primary care workforce and shifts the emphasis to prioritization of health prevention and promotion, consistent with the field of public health (Box 1), has the potential to dramatically shift the current trajectory of illness in the United States.

To achieve this goal, we need to engage health profession schools and licensing and accreditation bodies and advocate for changes in curricula and clinical experiences. Much greater emphasis will need to be placed on training the future health care workforce in communities and alongside a broad set of team members who are experienced in working together without unnecessary restrictions and under equal footing with respect to their contributions to eliminating health inequities.

Substantial challenges related to multilevel change within health care systems must be forcefully addressed to eliminate health care inequities. AJPH

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