Who Can Help? Physicians and the Fight for Health Equity

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ABSTRACT

This paper serves as a discussion piece focused on the persistent health inequities within the United States healthcare system and an argument that physicians should play a critical role in addressing these disparities through advocacy, education, and community engagement. Drawing from firsthand experiences working in a hospital in Santa Cruz, Bolivia, the writing compares healthcare inequities in developing countries with those occurring in the United States, thus revealing how marginalized communities in both environments face barriers. These barriers can take the form of limited access to care, quality services, and systemic discrimination. The primary discussion of this paper focuses on the social determinants of health, from race to socioeconomic status to political structure and more, and aims to analyze how these factors contribute to poor health outcomes such as lower life expectancy. Furthermore, the paper explores the responsibility of physicians and providers in addressing these inequities, highlighting both what some physicians have currently implemented and the reforms that still need to be enacted. Finally, the paper argues that medical education needs to progress to include mandatory training in social determinants of health, cultural competency, and community-engaged service learning. By integrating health equity learning and practices into the foundational medical curriculum, physicians have the potential to advocate for underserved populations and help close the growing health equity gap in America.

INTRODUCTION

It was 7 AM in Santa Cruz, Bolivia, and I was assigned to the morning shift at the local hospital. As I walked in, I was surrounded by unevenly painted walls, untamed plants, the heat of a South American February, and hundreds of faces praying they'd get picked for one of the day's free medical visits. I was serving as a medical assistant on a team of doctors from all over the United States taking on the lengthy mission to provide as many surgeries as possible to the community of children born with muscle and bone deformities. When news of *free healthcare* spanned the country, thousands of children, along with their families drove, bused, or even walked for days to our site, each one looking for the once in a lifetime chance to *afford* the essential care they had been waiting for.

Living in this *ciudad*, or city, for weeks, showed me the challenges of developing countries. I was brought to countless cases everyday of families who couldn't access health necessities– from lacking hospitals within a close

proximity, to the inability to pay for a doctor's visit, to the minimal resources in their communities, and so many other disparities. At the time of my visit to Bolivia, it was easy to say I was astonished and deeply saddened to see the state of their healthcare system. Upon returning home to the United States, I became fascinated by the idea of the healthcare system, its policies, and how society is affected. What were developed countries doing differently? How did better healthcare alleviate these disparities? Why did wealthy countries maintain a more improved system? I looked to the United States, my own country that ranks as one of the highest Human Development Indexes in the world, to answer these questions– but it could not. My astonishment that initially arose from the state of health inequities present in the Bolivian medical system only accelerated as I realized that the healthcare of our own country, the United States, was in virtually the same place according to the reported health disparities currently persisting (Konstantopoulos 2023).

The health disparities of the United States resembled so closely what I had seen in Bolivia; lack of access to care for marginalized communities, substandard housing, environmental pollution, and widespread poverty are just some of the inequities in our alleged first-world country (Alpert, 2024). Statistically, the United States ranks so far below its developed counterparts in terms of healthcare quality that it could be perceived as an underdeveloped country itself (Kurani, 2024).

Now that we understand the length to which the United States healthcare system falls behind, we must dive deeper into understanding the root causes of these disparities, what is at stake, and how this affects the future of health equity. It is blatantly clear that intervention is needed for the robustness and utility of society– but *who* can make that difference. Throughout this research paper we will be narrowing down how healthcare providers, specifically medical doctors, are helping improve these challenges, how they have been trained to address disparities, and what more they can do to leverage their medical careers to aid these millions of affected individuals. With this nation being considered such a global leader in development, there is strong potential to lessen these persistent health inequities that reveal such systemic failures. Medical doctors, through targeted training in the social determinants of health and a willingness to implement their advocacy into their practice and communities will play a critical role in closing this health equity gap.

THE SOCIAL DETERMINANTS OF HEALTH

The social determinants of health are the conditions under which people are born, grow, live, work, and age as well as people's access to power, money, and resources (Baker, 2026). These determinants can take several forms. Some examples include a physical disability preventing a person from being able to pick up their needed medication or a low-income parent being unable to afford postpartum checkups for their newborn (Wang, 2026). Furthermore, each of these factors and the diverse forms of them can

become very specific to the individual patient and have lasting effects on an individual's health *throughout* the life course (CDC, 2024).

The social determinants of health can take several forms within America's diverse population. Several of the nation's most pressing medical conditions – viruses, mental health issues, cardiovascular conditions – are heavily influenced by these determinants occurring in the inevitable backgrounds of patients' lives (Konstantopoulos, 2023). In America specifically, these determinants most prominently stem from racial and ethnic differences, socioeconomic status, environmental factors, and structural inequalities (Rossin-Slater, 2026).

As an example of systemic disparity in America specifically, we can look at the historical to modern trend of low birth rates in the United States, a cause of severe physical challenge among offspring. The pattern details that Black American mothers are three times more likely to birth an underweight or very underweight baby than White American mothers. When this data was compared to the low birth weight rate of babies from natively African mothers, their trend displayed the same risk as White American mothers, which was significantly less than Black American mothers' offspring. This eliminates the genetic hypothesis that may attempt to explain the health difference between White and Black American mothers. When analyzed, it is revealed that this disproportionate trend in neonatal health is due to systemic racism experienced by the mothers giving birth. The generational effects of the poor treatment and inequality shown toward marginalized groups, such as Black women in America, creates accelerated life stressors which weather the overall mental and physical health of these women and create substantial differences in their life outcomes (Rossin-Slater, 2026). Racism in the healthcare system and United States nation is the social determinant driving this health disparity, and only one of the many determinants that place communities with a disproportionate burden of disease.

These social determinants of health, and the countless cases of individuals experiencing their negative effects plays a key role in the status of the United States Healthcare System today, which we know to be less than ideal. With this being the case, medical doctors and providers are in a very important place within their occupation to use their careers to help the current state of our country. Seeing these cases on a daily basis, how they individually affect patient lives, and what significant outcomes result, there ought to be ways in which their medical status can be leveraged to help alleviate and advocate for improving these circumstances for the health and equity of their communities.

WHAT IS AT STAKE

Now that we understand the social determinants of health and what inequities they cause for the population of America, it is important to understand *what* and *how much* is at stake by allowing these disparities to persist. To begin, we may take a look at the life expectancy and maternal and fetal health rates in this country. These statistics are two of the most

prominent overall health indicators to use when analyzing a country's healthcare system. These indicators will allow analysts (and us) to reflect upon the combined effects of social and physical environmental factors, risk of disease, and quality of healthcare (Rossin-Slater, 2026).

As of now, the United States life expectancy sits around seventy-eight years, which is, on average, over four years less than the average life expectancy of all other leading and developed countries (Global Statistics, 2025). Furthermore, the average life expectancy in the US for the bottom 1% of the income distribution is comparable to the lower half of the global range of life expectancies (Rossin-Slater, 2026), proving our healthcare system remains comparable to less developed countries. The social determinants of health that prohibit a large portion of the population from receiving proper and adequate medical care are directly responsible for the lower statistic we see for the United States (Blumenthal, 2024).

Maternal and fetal health is yet another persistent concern in the United States. America maintains the highest maternal mortality rate to date in comparison to all other countries classified as "high income." Furthermore, up to eighty percent of the pregnancy related deaths we have had have proven to be preventable. Between 2018 and 2022 we have observed this rate increase even further due to widening disparities based specifically on state, race, and ethnicity (Gibbs, 2025). In this case, we once again see social determinants deciding the fate of our nation's health.

The combination of these statistics give us an astonishing yet realistic view of the state of our healthcare system in the United States. It is indicated that we have a significantly higher rate of people dying than any other developed country due to our chronic health disparities. *So, what is the risk if we allow this to persist?* The Centers for Disease Control and Prevention (CDC) states that by 2050 racial and ethnic minorities will make up nearly 50% of America's population, an incredible accomplishment for the diversity and inclusion of our country. However, if they continue to experience the poor health status, unequal medical treatment, and social determinants of health they are currently living among, the expected demographic changes will magnify the perilous impact of such disparities on public health in the United States (CDC, 2019).

Overall, robustness and equity should be at the forefront of the medical system. However, despite being a global innovator, if the United States healthcare system continues to allow health disparities to persist, we will never achieve this. The severe consequences that range from preventable and delayed diagnosis, to inadequate treatment, to premature death will continue and severely worsen (CDC, 2019). Due to this, change must occur in the medical field. In this modern era, physicians themselves are in a position to make a significant difference and confront these inequities through advocacy and implementation of their systemic reform. Without change, the future of America's health will continue to fall short of its potential and the health equity gap will remain firmly entrenched.

THE ROLE OF DOCTORS

After lengthy discussion of how deeply the social determinants of health affect the injustice and disparities of the United States healthcare system, it is valid to inquire how doctors are utilizing their esteemed medical platforms to help this issue. While virtually all doctors know and understand the concepts that come with the social determinants of health and their effects, not all doctors actively contribute to relieving them. With the understanding of the true gravity of health disparities, and a privileged medical background and career, doctors must do more to help this cause.

There are several examples of how some doctors have devoted active community service that aims at improving health disparities. For instance, in the previously described study, medical providers reported volunteering with a local or underprivileged community to provide health education, joining groups to advocate for policy change, and implementing culturally competent training into their practices. Doctors who have taken their passion for health equity even further have taken action by moving their practice into low-income areas for better access, modernizing their specialty to include expansive lifestyle medicine, and establishing hospitals that are specifically catered to the needs of marginalized communities. These interventions tend to have some of the highest turnouts and make the largest differences as they directly administer patient care in a safe space for the communities they target (Wang, 2026).

Now we may inquire why all doctors don't enact advocacy for better health equity into their practice and what this means for the United States healthcare system. The National Institute of Health answers this very bluntly stating, "We are part of the problem." Throughout several research findings, this is proven to be true and it is due to a variety of reasons (Campbell, 2025). To start, the greatest contributor stated to why doctors are "part of the problem" is explained by implicit bias. Providers struggle to commit to unbiased, ethical care which heavily results in misdiagnosis and undertreatment, outcomes that severely widen the health disparities we see today. Another reason for the lack of contribution to the health equity initiative is due to the familiarity providers find in using the traditional algorithms and calculations when it comes to treating a patient (Campbell, 2025). For example, doctors may use the same approach to treating a man as they do a woman, or a Black woman as they do a White woman. However, these methods are outdated, biased, and do not account for the unique disparities of individuals. It is traditional methods like these that need to be updated with cultural competency in order for health equity to improve. Overall, there is blatant systemic reform that several providers must realize within themselves and the field before change can ensue.

From analyzing the two sides of the spectrum when it comes to providers' attempt to close the health equity gap, we can see that there are an array of different viewpoints, initiatives, and motives going into this work. Although it is clear that all physicians can be incredibly different in how they perform their practice, there is one thing they all have in common: an

obligation to improve patient lives. With this, the solution to bridging the great health equity gap is, in part, the physicians' responsibility to enact.

THE MEDICAL EDUCATION CURRICULUM

Within the past sections we have discussed diverse disparities and physicians' views of them. These views are likely formed by the lived experiences and personal biases each provider has specifically had. However, there is a common foundation in every doctor's background that meaningfully influences their future practice and outlook – their medical education. Medical school is the core curriculum all doctors must go through in order to work as a physician. The typical layout includes two preclinical years of foundational science such as anatomy, biochemistry, etc, and two years of clinical rotations in an operating hospital where the student will work with various departments (Wang, 2026). Throughout this section, we will dive deeper into what this curriculum means in terms of shaping doctors' outlooks and motivation toward improving the health equity gap.

Analyzing the outline of a typical medical school curricula, and looking through specific foundational medical school classes, it was found that the majority of medical schools are vastly devoid of integration of the social determinants of health (Yaqub, 2026). In contrast, some articles do suggest that over the past few years, wealthier, more prestigious medical schools have implemented social determinants of health into their medical school curricula (Lewis, 2020). However, after interviewing a Harvard Medical School student, it was stated that these trainings are never a universal requirement, and at several of these schools just an elective course. Likewise, community service and outreach are also not required by any medical school for graduation (Wang, 2026). Overall, this tells us that doctors may not prioritize the social background and disparities of a patient because it was likely not prioritized in their medical education.

With the social determinants of health playing such a vital role in the health care system today, the act of improving health equity should be professionally implemented into the average medical curriculum. However, Wang also revealed that, to the students' credit, there are several limitations to seeking out these opportunities for service even if they were to pursue them in medical school. This type of outreach is classified as an "extracurricular" for them, making it difficult to obtain a meaningful number of service hours while also balancing the longer hours they are expected to be in class or studying (Wang, 2026). With service work and advocacy being built into the medical school curriculum, physicians can fulfill their obligation to help this cause and be set on a path to prioritize it in their future career.

CONCLUSION: THE FUTURE OF ACHIEVING HEALTH EQUITY

The status of the United States Healthcare System and the overall poor health we see throughout the nation is a sufficient source of reasoning to take the initiative to close the health equity gap. While US inhabitants, from

politicians to people of high societal power, should do what they can to improve this issue, doctors are a uniquely powerful source for doing so. Holding such an important career and role in society in combination with their highly educated background, they are obligated to pursue the change our country needs to see.

Medical school curriculums, the universal prerequisite to working in healthcare, is the perfect place to begin training doctors in not only rigorous scientific background, but also how to interpret the social determinants of health, educate themselves on modern cultural competency, eliminate persistent bias, and ultimately promote health equity through service and advocacy. Studies have shown that the social determinants of one's health can equal or even outweigh genetic influence and risk (Baker, 2026). This shows that medical schools should put an emphasis on these key social concepts just as they do with the science education in their curriculum.

The most prominent way to truly learn the field of medicine is through real, hands-on work in the field (Cindrea, 2025). Doctors build on their practical skills and experiences best when in these settings. With hands-on experience being so prominent and influential, this would be an extremely meaningful way for medical schools to allow their medical students to best learn how social determinants of health directly affect marginalized communities and their health outcomes. This could be implemented into the curriculum in a variety of ways. For example, medical schools could establish a community-service hour requirement in which the students must spend a certain amount of time each month meaningfully serving an underserved community. As for another idea, medical schools could administer certain clinical rotations for doctors to do in clinics that are designed specifically for low-income families or a hospital in a low-income area. In each of these cases, medical school students would learn to effectively understand, communicate with, and treat marginalized communities.

By igniting these changes in the medical curriculum, all doctors would have experience addressing social determinants of health. Furthermore, shedding an emphasis on these principles as they foundationally learn medicine will make them more likely to prioritize them in the future. Truly integrating this into their mindset as a core part of medical education can set a new standard of practice in medicine – one that emphasizes personal needs, reduces disparity, and ultimately, closes the health equity gap for Americans.

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