Envisioning a Better U.S. Health Care System for All: Reducing Barriers to Care and Addressing Social Determinants of Health

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The American College of Physicians (ACP) has long advocated for universal access to high-quality health care in the United States. Yet, it is essential that the U.S. health system goes beyond ensuring coverage, efficient delivery systems, and affordability. Reductions in nonfinancial barriers to care and improvements in social determinants of health are also necessary. This ACP position paper calls for ending discrimination based on personal characteristics; correcting workforce shortages, including the undersupply of primary care physicians; and understanding and ameliorating social determinants of health. The ACP calls for increased efforts to address urgent public health threats, including injuries and deaths from firearms; environmental hazards; climate change; maternal mortality; substance use disorders; and the health risks associated with nicotine, tobacco use, and electronic nicotine delivery systems in order to achieve ACP's vision for a better U.S. health care system.

Ann Intern Med. 2020;172:S50-S59. doi:10.7326/M19-2410 **Annals.org**
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In this position paper, the American College of Physicians (ACP) proposes strategies to address social determinants of health and reduce barriers to care in order to achieve ACP's vision for a better U.S. health care system for all. The ACP's vision, outlined in an accompanying call to action (1), includes 10 vision statements, 4 of which are particularly relevant to the policies discussed in this paper (**Figure**). The companion position papers address improving payment and delivery systems (2) and coverage and cost of care (3). Together, these papers provide a policy framework to achieve ACP's vision for a better U.S. health care system.

The ACP has long advocated for universal access to high-quality health care in the United States (4–7). Although ACP and other organizations advocate for universal coverage and work to achieve it, coverage does not guarantee access. It is essential that the U.S. health system goes beyond ensuring coverage, efficient delivery systems, and affordability because financial barriers are not the only barriers patients face. In fact, a 2012 survey reported that 18% of U.S. adults experienced affordability barriers and 21% experienced nonfinancial barriers (8).

The ACP supports a "health in all policies" approach that aims to optimize elements necessary for good health for all. Whereas public health is generally improving in other developed countries, life expectancy in the United States has been decreasing since 2014 and, at 78.9 years, ranks last compared with peer countries (9). Contributors to this decline—such as environmental health hazards, poor nutrition, tobacco use, substance use disorders, firearm injuries and deaths, and maternal mortality—are reversing progress made over generations of increasing life expectancy and must be part of the health care conversation. In addition, well-documented barriers to health include race and ethnicity, gender or gender identity, sex or sexual orientation, intellectual and physical disability, location, age, language, national origin and immigration status, incarceration status, religion and cultural beliefs, socioeconomic status, and health literacy and ability to access information (10–15). In this position paper, ACP identifies key elements for improving health and offers recommendations to improve nonfinancial barriers to health based on existing ACP policy and available evidence.

METHODS

The ACP Health and Public Policy Committee, which is charged with addressing issues that affect the health care of the U.S. public and the practice of internal medicine and its subspecialties, developed these recommendations. The authors reviewed available studies, reports, and surveys on social determinants of health and barriers to health care from PubMed, Google Scholar, relevant news articles, policy documents, Web sites, and other sources. Recommendations were based on reviewed literature and input from ACP's Board of Governors, Board of Regents, Council of Early Career Physicians, Council of Resident/Fellow Members, Council of Student Members, and Council of Subspecialty Societies. The policy paper and related recommendations were reviewed and approved by the ACP Board of Regents on 2 November 2019. The ACP operating budget was the sole source of financial support for the development of this position paper.

This article is part of the *Annals* supplement "Better Is Possible: The American College of Physicians' Vision for the U.S. Health Care System." The American College of Physicians was the sole funder for this supplement.

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Figure. American College of Physicians vision statements related to barriers to care and social determinants of health.

The American College of Physicians envisions a health system that ameliorates social factors that contribute to poor and inequitable health (social determinants); overcomes barriers to care for vulnerable and underserved populations; and ensures that no person is discriminated against based on characteristics of personal identity, including but not limited to race, ethnicity, religion, gender or gender identity, sex or sexual orientation, or national origin.

The American College of Physicians envisions a health care system where spending is redirected from unnecessary administrative costs to funding health care coverage and research, public health, and interventions to address social determinants of health.

The American College of Physicians envisions a health care system where primary care is supported with a greater investment of resources; where payment levels between complex cognitive care and procedural care are equitable; and where payment systems support the value that internal medicine specialists offer to patients in the diagnosis, treatment, and management of team-based care, from preventive health to complex illness.

The American College of Physicians envisions a health care system where financial incentives are aligned to achieve better patient outcomes, lower costs, and reduce inequities in health care.

Improving Public Health: Elements for the Achievement of Good Health

Nutrition

A healthy diet helps prevent disease and influences outcomes of chronic diseases, including hypertension, diabetes, cardiovascular disease, cancer, and obesity (16). The 2017 Global Burden of Disease Study estimated that over the course of 1 year, 11 million deaths and 225 million disability-adjusted life-years could be attributed to diet-related risk factors (17). Unfortunately, high-quality, nutritional foods are not readily available to everyone in the United States. Food deserts, as defined by the U.S. Department of Agriculture, are areas in which residents lack access to fresh fruits, fresh vegetables, and other whole foods (18). Food deserts are more prevalent in low-income and minority neighborhoods (19), and living in a food desert is linked to higher levels of obesity (20). Food insecurity is defined as living without affordable access to healthy foods (21). In 2016, 1 in 8 American households were food insecure, and these households spent, on average, 45% more on medical care than food-secure households (22).

Tobacco Use and Nicotine Dependence

Despite the decline in tobacco smoking, it remains one of the main preventable causes of poor health and premature death in the United States and worldwide (23). Increasing use of electronic nicotine delivery systems, especially among adolescents, is associated with increased rates of tobacco use and nicotine dependence in this group (24). In addition, there are increasing concerns about lung diseases associated with electronic nicotine delivery systems (25). Efforts to decrease smoking prevalence, including smoke-free air laws, increased prices of cigarettes, and implementation of media campaigns, fail to reach some groups (26). The World Health Organization found that smoking behavior is related to the accumulation of social disadvantage over the entire life course, with such groups as single mothers, long-term unemployed persons, new immigrants, homeless persons, mentally ill persons, and members of ethnic minority groups being most likely to smoke (27). Efforts to decrease smoking prevalence need to reach these disadvantaged groups.

Substance Use Disorders

Substance use disorders involving prescription drugs, including opioids, are also closely related to certain social determinants of health. Of note, the demographic at highest risk for prescription drug and opioid misuse has shifted from inner-city, minority men to white men and women living outside of urban areas (28). Currently, opioid use disorder is most prevalent among non-Hispanic white persons and American Indian/Alaska Native persons, middle-aged adults, and those living in rural areas (29). Persons who overdosed on illicit drugs and methadone were more likely to be nonwhite and nonrural than those who overdosed on other prescription opioids (30). These demographic shifts underscore the importance of looking at how such factors as age, location, and race/ethnicity contribute to risk for substance use disorders and other health concerns.

Maternal Mortality

Each year, around 700 U.S. women die of pregnancy-related conditions, and 3 in 5 of these deaths are preventable (31). Compared with white women, African American, Native American and Alaska Native women are about 3 times more likely to die of pregnancy-related causes (32). Maternal mortality rates have been increasing for the past several years, despite advances in health technology (33). The United States has the highest maternal mortality rate of developed countries, but the causes of this disparity are mostly unknown. Social, economic, cultural, and medical issues are all potential factors (34).

Firearm Injuries and Deaths

Firearm injuries and deaths are linked to social determinants of health and individual characteristics. Men, younger individuals, and people of racial/ethnic minority groups are disproportionately affected by firearm violence (35). One study looked at the sociodemographic distribution of gun deaths in counties across the United States and found that the counties most affected were rural, poor, and predominantly minority and had high rates of unemployment and homicide (36). Groups that typically face barriers to care also experienced high rates of firearm injury and death.

Environmental Health and Climate Change

Environmental factors can have a large impact on health. Exposure to environmental hazards early in life has been shown to increase the risk for chronic disease (37). Estimates suggest that reducing environmental hazards would prevent almost one quarter of global

disease (38). Low-income and minority populations are disproportionately affected by environmental hazards. One study found that persons of racial/ethnic minority groups were 38% more likely to be exposed to nitrogen dioxide, a pollutant known to cause increased risk for asthma and heart attack, than their white counterparts (39).

Climate change has also emerged as a key social determinant of health (40), and worries about climate change may also cause emotional distress and anxiety (41). The effects of climate change, such as adverse weather events, increased temperatures, and fluctuation in precipitation patterns, are very likely to affect the food supply, both nationally and internationally. Climate change could cause disruption of the availability of food, reduction in access to food, and a decrease in the quality of food (42).

Eliminating Barriers to Care

Race and Ethnicity

Race and ethnicity have been a major focus of inequity in health care. A 2003 literature review identified 3 areas in which barriers exist: organizational, structural, and clinical (43). The review also outlined a framework for addressing these barriers that included recruiting minorities into the health professions, providing interpreter services for non–English-language speakers, and distributing health education materials.

Stigma is a barrier to care for racial and ethnic minorities. A survey of low-income African Americans demonstrated that stigma can prevent people from seeking care for depression (44). A 2011 study revealed that Filipino Americans and Korean Americans were less likely than white Americans to see a primary care physician or take a prescription medication for a mental health condition, even though they were more likely to report signs of mental distress (45). Similarly, Japanese Americans were less likely than white Americans to use mental health services. The study pointed to structural barriers (lack of awareness of available services), lack of insurance, and language and cultural barriers (stigma and denial) as the potential causes. When attempting to access HIV primary care, U.S. Latino adults face more barriers than white adults: Structural barriers, such as language, and barriers related to stigma and belief prevented Latino adults from accessing HIV care (10).

LGBTQIA Identity

Lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual/allied (LGBTQIA) individuals also face barriers to care. Respondents to a survey of LGBT adults in New York City reported both barriers that included system-level factors, such as lack of LGBT-tailored services, and individual-level factors, such as inhibitions around seeking LGBT-tailored care and an unawareness of the rights to nondiscriminatory care (11). Lesbian and bisexual women are more likely than heterosexual women to delay treatment and avoid routine health care altogether (46). Transgender youth face unique struggles in accessing care tailored to the transgender community. A survey of physicians found that the top 2 factors that prevented physicians from providing proper care were lack of training on transgender-related care and lack of exposure to transgender patients (47). The health access issues faced by the transgender community add to the negative experiences of a community that still faces social stigma regarding which restroom they access in public places. Proper health care is often out of reach for transgender and gender-nonconforming (GNC) adults as well. Transgender women and men are less likely than their cisgender counterparts to have health insurance. There is widespread discrimination in health care, health insurance policies, employment, and public policy, all of which exacerbates this problem. Transgender and GNC adults also report experiencing "providers" who have a lack of knowledge and awareness of their unique health needs (48).

Gender

Although individuals who self-identify as women are not a minority in the United States, they do face discrimination in health care. For example, studies suggest that clinicians underestimate pain in women (49). Clinicians' underrecognition of symptom severity can prevent women from receiving appropriate care and erode patient trust. Studies have also found barriers for women accessing reproductive services. A 2017 study provides clinical examples of these negative effects and also identifies the main barriers women face, including legislation, hospital policies, and business decisions to limit reproductive services (12). Women, especially ethnic minority women affected by intimate partner violence, also face challenges accessing mental health care (50).

Intellectual and Physical Disability

For people with physical disabilities, barriers to care can be actual physical barriers. Physically disabled women seeking breast cancer treatment reported inaccessible equipment, fear of injury when moved from wheelchair to examining table, or incomplete examination while in a wheelchair (13). Physical barriers affect the quality of care patients receive.

Women with physical disabilities also face barriers in accessing perinatal care. These include "inaccessible care settings, negative attitudes, lack of knowledge and experience, lack of communication and collaboration among 'providers,' and misunderstandings of disability and disability-related needs" (51). Lack of perinatal care can result in poor health outcomes for both the mother and child. Lack of appropriate and affordable transportation for those with physical disabilities is another physical barrier to care (52). In a study, people with intellectual and mental disabilities reported barriers to care related to their physicians' lack of knowledge of disability issues (53).

Location

Where one lives can also be a barrier to care. Twenty-one percent of Americans live in rural areas, but less than 10% of physicians practice in rural areas (54).

According to the Health Resources and Services Administration, over 23 million people reside in primary care health professional shortage areas (HPSAs), and almost 60% of primary care HPSAs are located in rural areas (55). Rural hospital closures are also playing a role in health access (56). A 2012 review examined the barriers faced by HIV-positive people living in rural areas and found that the main barriers (transportation needs, discrimination or stigma, and confidentiality concerns) were barriers stereotypically expected in small-town, remote settings (57). Another study found that despite comprising only one fifth of the U.S. population, rural Americans accounted for 55% of the increase in body mass index (BMI) from 1985 to 2017, showing that rural areas are driving the adult obesity epidemic (58). Length of travel to health care centers, need for housing and food while traveling for care, and cost of child care and missed work are other factors that affect the experience of those from rural communities when seeking care. For those in both urban and rural areas, lack of transportation results in difficulty accessing care and decreased pharmacy and medication access (59). Similarly to those in remote settings, people in urban areas face missed work and cost of child care while seeking care as additional barriers while accessing care.

Age

A 2004 survey found "doctors' lack of responsiveness to patient concerns, medical bills, transportation, and street safety" to be the major barriers to care for elderly persons (60). Elderly persons see both psychological and physical barriers preventing them from getting the care they need. A similar study in 2017 again examined the barriers faced by the elderly Medicare beneficiary population. After identifying common barriers (lack of care coordination, financial reasons, transportation, and lack of usual source of care) in a survey of the group, researchers took it a step further: Respondents were queried to see who sought recommended care, despite the barriers. The findings showed that those who reported financial reasons and lack of a usual source of care as the main barriers were the least likely to receive the medical care (61).

Language and Citizenship Status

Language barriers contribute to health disparities for patients with limited English proficiency (62). According to U.S. census data, more than 21% of people in the United States older than 5 years speak a language other than English in the home (63). Although areas with high populations of non–native English speakers (especially Spanish-speaking communities) often have bilingual materials and clinicians, many communities do not have multilingual resources.

Although many non–native or nonfluent English speakers are U.S. citizens, immigrants face unique challenges navigating the health system. A study that looked at the Latino immigrant community in Cincinnati, Ohio, found that language barriers and lack of interpreters were only 2 of the barriers they faced; these Latino immigrants also named documentation status and discrimination as factors preventing them from receiving care (64). A review of the experiences of undocumented immigrants had similar findings. System-level barriers identified included policy limitations; bureaucratic barriers, such as paperwork and registration; and discriminatory practices. Individual-level barriers included fear of deportation and stigma (65).

Persons with impaired hearing report issues with communication in health care experiences. Deaf patients who use American Sign Language often do not have access to interpreters during health care visits, which prevents them from understanding physicians' instructions, and they fear negative health consequences (66). Privacy concerns arise when deaf patients bring family members to their appointments as translators.

Incarceration Status

Incarcerated individuals often go overlooked and experience low-quality health care services compared with the general population (67). In a study, female inmates identified 3 main barriers that prevented them from getting appropriate care while incarcerated: treatment interruption, health disempowerment, and poor mental and physical health (68). Another study found that clinicians encounter many issues in effectively treating and preventing the spread of tuberculosis in correctional facilities (69). Health literacy of inmates was also cited as preventing individuals from receiving proper care.

Religion and Beliefs

Certain religious, personal, and cultural beliefs can prevent people from receiving proper care, such as evidenced by suboptimal vaccination rates in some U.S. communities. A 2014–2015 outbreak of measles, previously considered eradicated in the United States by vaccination, was related to vaccination rates in the exposed population of only 50% to 86% (70). For herd immunity to highly contagious diseases, a vaccination rate of 96% to 99% is needed. In 2019, a massive outbreak of measles is being attributed by some public health officials to the large swaths of unvaccinated children throughout the country (71). One study found that adolescents whose parents have concerns about baseline harms about vaccines were less likely to complete the 3-dose series of the human papillomavirus (HPV) vaccine (72). Reducing uncertainties in parents resulted in increased likelihood of their children receiving the HPV vaccine. This shows the need for parent education regarding vaccine safety.

There may be other factors related to patients' religions to consider when providing care. For example, sometimes eye contact and physical contact between health care workers and patients of the opposite gender must be avoided. It is possible that male doctors may have to communicate through a spouse if the patient is female, and patients may prefer that physical exams also be conducted by a health care worker who is the same sex as the patient. Modesty guidelines must also be kept in mind for clothing removal during procedures and examinations (73). Fasting during holidays or during the month of Ramadan should be considered and re-

spected by physicians for both patients with diabetes (74) and patients who are pregnant or postpartum (75).

Health Literacy and Access to Information

Patients who lack health literacy may have difficulty understanding clinical information and may not be able to correctly follow directions for prescription drugs or other treatments. Lack of access to digital technologies can also be barriers to health care. One review of online health service use by people with limited health literacy found barriers related to the poor readability of content and poor usability of e-health services (76). Misinformation online is another barrier to the receipt of high-quality care. Efforts should be made not only to make e-health services easier for those with low health literacy to use, but also to create programs that can improve health and digital literacy. Another study that examined barriers to use of online health information among those of low socioeconomic status found that even when these individuals were provided with Internet access, they still experienced trouble seeking appropriate health information (77). Having Internet access is insufficient; health literacy and digital literacy are important parts of gathering health information.

Intersectional Barriers

Intersectionality is important when discussing barriers to health. Intersectionality is "a theoretical framework that posits that multiple social categories (for example, race, ethnicity, gender, sexual orientation, socioeconomic status) intersect at the micro level of individual experience to reflect multiple interlocking systems of privilege and oppression at the macro, social-structural level (e.g., racism, sexism, heterosexism)" (78). Intersectionality occurs when multiple factors in a person's identity leave them more susceptible to facing barriers to care (79). For example, a black LGBTQIA person faces more barriers to care than a white LGBTQIA person or than a straight black person (80). These intersections must be considered moving forward in the discussion on barriers to care and social determinants of health. A study investigating health care access of rural Hispanic immigrants living in the Midwest found that location and race/ethnicity contributed to barriers (81). Another example of intersectionality can be found in the results of a survey of aging, rural-dwelling, HIV-infected people. The survey found that this group faces more challenges in accessing care than those with HIV who are not living in a rural area and that the aging HIV-positive population encounters a unique barrier because it can be difficult to determine whether symptoms are caused by HIV or old age (82). Studies such as these highlight the need to recognize that multiple factors can create barriers to care.

ACP Policy Positions and Recommendations

1. The American College of Physicians believes that all persons, without regard to where they live or work; their race and ethnicity; their sex or sexual orientation; their gender or gender identity; their age; their religion, culture, and beliefs; their national origin, immigration status, and language proficiency; their health literacy level and ability to access health information; their socioeconomic status; whether they are incarcerated; and whether they have intellectual or physical disability must have equitable access to high-quality health care and must not be discriminated against based on such characteristics.

Specific policies and efforts should be directed to ensuring equitable access to high-quality health care for populations at greater risk, by using an intersectional approach to understand their unique circumstances and barriers they face and address these disparities in the quality of or access to health care.

Policies and efforts to reduce barriers to care should acknowledge and incorporate the unique needs of those living in isolated rural areas and inner-city areas when accessing health care. For example, quality of care for the HIV-positive population (14, 57), BMI and obesity level (58), and access to nutritious food (19) have all been shown to be affected by location.

Racial and ethnic disparities should be addressed as outlined in the ACP position paper "Racial and Ethnic Disparities in Health Care" (83), and LGBTQIA identity disparities should be addressed as outlined in the ACP position paper "Lesbian, Gay, Bisexual, and Transgender Health Disparities" (84). Disparities faced by women should be addressed as outlined in the ACP position paper "Women's Health Policy in the United States" (85).

Persons aged 65 years or older make up almost 15% of the U.S. population (86), and elderly people face both physical and psychological barriers when attempting to access care (25). Future action and policies must ensure that the aging population is able to safely and independently access health care services.

Religious, personal, and cultural beliefs and how they affect access to care should be addressed, while respecting religious and cultural beliefs and the First Amendment protections for freedom of religion. Exemptions from evidence-based immunization requirements should be limited to medical indications in order to protect the public's health.

Disparities faced by immigrants should be addressed in a way consistent with the recommendations in the ACP position paper "National Immigration Policy and Access to Health Care" (87). With more than 21% of people in the United States older than 5 years speaking a language other than English in the home (63), language services should be made available to improve the provision of health care services, as outlined in the ACP policy paper "Racial and Ethnic Disparities in Health Care" (83).

Policies and actions are needed to improve health and digital literacy, access to the Internet, and access to evidence-based medical information, which can play a large role in accessing care. In the United States, around 23% of people living in urban areas and 28% of people living in rural areas do not have access to or cannot afford broadband (88). Lack of Internet access prevents people from accessing health information.

Even when a person has access to the Internet and access to health information, it is not a guarantee that the individual is able to understand and process the information.

The United States is the country with the largest number of incarcerated people in the world (89). With over 2.2 million adults behind bars (90), this group makes up a large portion of the population; however, little focus is placed on the health of these inmates. Over one half of prisoners experience addiction, mental illness, or both, which increases their risk for such conditions as HIV, sexually transmitted diseases, hepatitis C, and other infections (91). Policies and actions for advancing public health and access to health should consider this population and the unique risks and barriers it faces.

An estimated 12.8% of people in the United States have disabilities. Those with intellectual or physical disabilities face inaccessible equipment and fear injury during examination (13) and can experience a lack of understanding and thorough communication from clinicians (52). Policies and actions should work to ensure that those with intellectual or physical disabilities can safely and independently access care.

2. The American College of Physicians believes that public policies and efforts should be directed to ensuring an adequate supply and distribution of physicians and other clinicians to meet the nation's health care needs, especially for underserved rural and urban populations. Integrated actions are needed to address the barriers to physicians, including internal medicine specialists, from entering and remaining in the primary care workforce and practicing in underserved communities. Research and policies to address the impact of hospital closures on access and outcomes of care are urgently needed.

An adequate physician workforce is essential to ensuring access to care. Particular attention should be directed at recruiting and retaining ambulatory-based internal medicine specialists in recognition of their unique training, skills, and contributions in providing high-value primary, preventive, and comprehensive care to adolescents and adults throughout their lifetimes, particularly for patients with more complex medical problems. In addition, a diverse and culturally competent health care workforce that is more representative of those they serve is critical to improving health care access and outcomes. Recommendations on achieving a more diverse health care workforce are outlined in the ACP policy paper "Racial and Ethnic Disparities in Health Care" (83).

A comprehensive approach to address shortages and maldistribution of clinicians is urgently needed. This should include increasing graduate medical education training slots for specialties facing shortages, including internal medicine; reducing administrative burdens; easing medical student debt; reforming payment policies to support high-value primary care; and improving and expanding on programs that support primary care physicians who choose to practice in underserved areas. Recommendations to reduce administrative tasks imposed on primary care physicians, and reforming payment and delivery systems to support the value of the care they provide, are discussed in the companion ACP position papers "Envisioning a Better U.S. Health Care System for All: Coverage and Cost of Care" (3) and "Envisioning a Better U.S. Health Care System for All: Improving Payment and Delivery Systems" (2). Previous ACP papers, including "Financing U.S. Graduate Medical Education" (92), "Solutions to the Challenges Facing Primary Care Medicine" (93), and "Putting Patients First by Reducing Administrative Tasks in Health Care" (94), also provide a framework for ensuring a sufficient supply of primary care physicians, including internal medicine physicians trained in primary and comprehensive care of adults.

The maldistribution of health professionals, especially in rural and inner-city communities, must also be addressed by leveraging all appropriate government and institutional resources to enhance the recruitment and retention of physicians for practice in underserved areas through financial incentives, technical assistance, and changes in medical school recruitment and education.

Hospital closures, particularly critical access and safety-net hospitals, can have a substantial impact on patients. With fewer care options, it becomes harder for patients to obtain emergency care and increases the likelihood of major geographic barriers affecting care. In addition, hospital emergency departments in certain areas often serve as a source of primary care because access to such care in community-based outpatient settings is limited. This can have a considerable impact on vulnerable populations, who often cannot afford the cost of transportation or take time off to travel greater distances for preventive care or treatment. Research and policies to address the impact of these closures are urgently needed.

3. The American College of Physicians supports greater investment in the nation's public health infrastructure, research, and public policy interventions to address the social determinants of health and other factors that have a negative impact on health.

Supportive public policies that address environmental, geographic, occupational, educational, and nutritional social determinants of health should be implemented to reduce health disparities and promote health equity. These interventions should be implemented as outlined in the ACP position paper "Addressing Social Determinants to Improve Patient Care and Promote Health Equity" (95).

A greater investment is needed in the nation's public health infrastructure, as outlined in the ACP papers "Strengthening the Public Health Infrastructure" (96) and "Addressing Social Determinants to Improve Patient Care and Promote Health Equity" (95).

4. The American College of Physicians believes that greater resources must be devoted to addressing environmental health, and that strategies are needed to address, prevent, mitigate, and adapt to the health consequences of climate change.

Environmental health should be addressed as outlined in the ACP position paper "Addressing Social De-

terminants to Improve Patient Care and Promote Health Equity" (95). Climate change and its effect on health should be addressed as outlined in the ACP position paper "Climate Change and Health" (97) and in the ACP Climate Change and Health Action Plan (98), commensurate with the immediate, grave, and growing threat it poses and the limited time available to prevent more severe health consequences.

5. The American College of Physicians supports focusing funding priority and policy interventions on promoting critical public health objectives, including but not limited to policies and actions to:

a. Reduce smoking and tobacco-related preventable illnesses, including the health risks associated with the growing use of electronic nicotine delivery systems by teenagers;

b. Reduce and treat substance use disorders;

c. Reduce the rate of maternal mortality in the United States, especially for African American women;

d. Reduce firearm-related injuries and deaths; and

e. Improve access to and the availability of high-quality nutritional food.

Major public health issues as outlined above should be a priority for funding and intervention. Tobacco use should be addressed as outlined in the ACP policy paper "Tobacco Control and Prevention" (99).

Substance use disorders and treatment should be addressed as outlined in the ACP papers "Prescription Drug Abuse" (100) and "Health and Public Policy to Facilitate Effective Prevention and Treatment of Substance Use Disorders Involving Illicit and Prescription Drugs" (101).

To address maternal mortality and the social factors clearly at play in this issue, among other approaches, maternal mortality review committees should be established, and other state or local programs should collect pertinent data and identify causes of maternal death; develop and implement strategies with the goals of preventing pregnancy-related or pregnancy-associated death and improving maternal outcomes in the United States; work to improve health care safety; and expand postpartum Medicaid eligibility.

Firearm-related injuries and deaths should be addressed and reduced as outlined in the ACP position paper "Reducing Firearm Injuries and Deaths in the United States" (102).

Action must be taken to ensure access to an adequate and affordable supply of high-quality nutritional food, which is essential to living a healthy and productive life. Current efforts suggest that promotion of healthy eating can be successful, but these efforts are affected by social class, social networks, race and ethnicity, cost, and neighborhood. More research is needed to identify policies that would enhance access to a healthy diet for all.

Conclusion

Ensuring not just health care, but health itself, is the goal of ACP. The constitution of the World Health Organization says, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." The ACP continues to support efforts to achieve this level of health. To ensure optimal health for everyone, social determinants of health and barriers to care must be addressed; the provision of improved access to health care alone will not be sufficient. Other factors shown to influence health outcomes include race/ethnicity, gender, LGBTQIA identity, intellectual and physical disability, location, age, language and citizenship status, incarceration status, religion and cultural beliefs, health literacy, and access to information. The impact of these factors demonstrates the need to go beyond health care coverage, cost, and delivery systems in order to improve health.

Moving forward, policies and interventions must consider these numerous barriers and strive to eliminate disparities. Careful consideration must also be given to environmental health, climate change, nutrition, tobacco use, substance use disorders, maternal mortality, and firearm injuries and deaths, which can also hinder achievement of good health.

The positions recommended in this paper will help achieve the vision described in "Envisioning a Better Health Care System for All: A Call to Action by the American College of Physicians" (1), including a health system that *ameliorates social factors that contribute to poor and inequitable health (social determinants), overcomes other barriers to care for vulnerable and underserved populations, and ensures that no person is discriminated against based on characteristics of personal identity, including but not limited to race, ethnicity, religion, gender or gender identity, sex or sexual orientation, or national origin.*

From American College of Physicians, Washington, DC (R.B., K.R.); Oregon Health & Science University and Portland Veterans Affairs Medical Center, Portland, Oregon (T.G.C.); and Louisiana State University Health Sciences Center, New Orleans, Louisiana (L.E.).

Financial Support: Financial support for the development of this position paper came exclusively from the ACP operating budget.

Disclosures: Authors have disclosed no conflicts of interest. Forms can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M19-2410.

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References

1. **Doherty R, Cooney TG, Mire RD, et al; Health and Public Policy Committee and Medical Practice and Quality Committee of the American College of Physicians.** Envisioning a better U.S. health care system for all: a call to action by the American College of Physicians. Ann Intern Med. 2020;172:S3-S6. doi:10.7326/M19-2411

2. **Crowley R, Daniel H, Cooney TG, et al; Health and Public Policy Committee of the American College of Physicians.** Envisioning a better U.S. health care system for all: coverage and cost of care. Ann Intern Med. 2020;172:S7-S32. doi:10.7326/M19-2415
3. **Erickson SM, Outland B, Joy S, et al; Medical Practice and Quality Committee of the American College of Physicians.** Envisioning a better U.S. health care system for all: health care delivery and payment system reforms. Ann Intern Med. 2020;172:S33-S49. doi:10.7326/M19-2407
4. **Crowley RA, Bornstein SS; Health and Public Policy Committee of the American College of Physicians.** Improving the Patient Protection and Affordable Care Act's insurance coverage provisions: a position paper from the American College of Physicians. Ann Intern Med. 2019;170:651-3. [PMID: 30986852] doi:10.7326/M18-3401
5. **American College of Physicians.** A prescription for a forward-looking agenda to improve American health care. 23 May 2017. Accessed at www.acponline.org/acp_policy/policies/forward_looking_policy_agenda_2017.pdf on 19 April 2019.
6. **American College of Physicians.** Achieving affordable health insurance coverage for all within seven years: a proposal from America's internists, updated 2008. 2008. Accessed at www.acponline.org/system/files/documents/advocacy/current_policy_papers/assets/7yrplan_update08.pdf on 19 April 2019.
7. **Ginsburg JA, Doherty RB, Ralston JF Jr, et al; Public Policy Committee of the American College of Physicians.** Achieving a high-performance health care system with universal access: what the United States can learn from other countries. Ann Intern Med. 2008;148:55-75. [PMID: 18056654]
8. **Kullgren JT, McLaughlin CG, Mitra N, et al.** Nonfinancial barriers and access to care for U.S. adults. Health Serv Res. 2012;47:462-85. [PMID: 22092449] doi:10.1111/j.1475-6773.2011.01308.x
9. **Ho JY, Hendi AS.** Recent trends in life expectancy across high income countries: retrospective observational study. BMJ. 2018;362:k2562. [PMID: 30111634] doi:10.1136/bmj.k2562
10. **Rajabiun S, Rumptz MH, Felizzola J, et al.** The impact of acculturation on Latinos' perceived barriers to HIV primary care. Ethn Dis. 2008;18:403-8. [PMID: 19157242]
11. **Romanelli M, Hudson KD.** Individual and systemic barriers to health care: perspectives of lesbian, gay, bisexual, and transgender adults. Am J Orthopsychiatry. 2017;87:714-28. [PMID: 29154611] doi:10.1037/ort0000306
12. **Eisenberg DL, Leslie VC.** Threats to reproductive health care: time for obstetrician-gynecologists to get involved. Am J Obstet Gynecol. 2017;216:256.e1-4. [PMID: 27818131] doi:10.1016/j.ajog.2016.10.037
13. **Iezzoni LI, Kilbridge K, Park ER.** Physical access barriers to care for diagnosis and treatment of breast cancer among women with mobility impairments. Oncol Nurs Forum. 2010;37:711-7. [PMID: 21059583] doi:10.1188/10.ONF.711-717
14. **Eastwood EA, Fletcher J, Quinlivan EB, et al.** Baseline social characteristics and barriers to care from a Special Projects of National Significance women of color with HIV study: a comparison of urban and rural women and barriers to HIV care. AIDS Patient Care STDS. 2015;29 Suppl 1:S4-10. [PMID: 25469916] doi:10.1089/apc.2014.0274
15. **Karliner LS, Jacobs EA, Chen AH, et al.** Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. Health Serv Res. 2007;42:727-54. [PMID: 17362215]
16. **Viswanath K, Bond K.** Social determinants and nutrition: reflections on the role of communication. J Nutr Educ Behav. 2007;39:S20-4. [PMID: 17336801]
17. **GBD 2017 Diet Collaborators.** Health effects of dietary risks in 195 countries, 1990-2017: a systematic analysis for the Global Burden of Disease Study 2017. Lancet. 2019;393:1958-72. [PMID: 30954305] doi:10.1016/S0140-6736(19)30041-8
18. **American Nutrition Association.** USDA defines food deserts. Nutrition Digest. 2010. Accessed at http://americannutritionassociation.org/newsletter/usda-defines-food-deserts on 19 April 2019.
19. **Hilmers A, Hilmers DC, Dave J.** Neighborhood disparities in access to healthy foods and their effects on environmental justice. Am J Public Health. 2012;102:1644-54. [PMID: 22813465] doi:10.2105/AJPH.2012.300865
20. **Chen D, Jaenicke EC, Volpe RJ.** Food environments and obesity: household diet expenditure versus food deserts. Am J Public Health. 2016;106:881-8. [PMID: 26985622] doi:10.2105/AJPH.2016.303048
21. **Economic Research Service.** Definitions of food security. U.S. Department of Agriculture. 5 September 2018. Accessed at www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security.aspx on 19 April 2019.
22. **America's Health Insurance Plans (AHIP).** Access to healthy foods: social determinants of health. Issue Brief. May 2018. Accessed at www.ahip.org/wp-content/uploads/2018/05/HealthyFoods_IssueBrief_4.18_FINAL.pdf on 19 April 2018.
23. **West R.** Tobacco smoking: health impact, prevalence, correlates and interventions. Psychol Health. 2017;32:1018-36. [PMID: 28553727] doi:10.1080/08870446.2017.1325890
24. **Kamat AD, Van Dyke AL.** Use of electronic nicotine delivery systems among adolescents: status of the evidence and public health recommendations. Pediatr Ann. 2017;46:e69-77. [PMID: 28192582] doi:10.3928/19382359-20170111-01
25. **Centers for Disease Control and Prevention.** Outbreak of lung injury associated with e-cigarette use, or vaping. October 2019. Accessed at www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html on 18 October 2019.
26. **Garrett BE, Dube SR, Babb S, et al.** Addressing the social determinants of health to reduce tobacco-related disparities. Nicotine Tob Res. 2015;17:892-7. [PMID: 25516538] doi:10.1093/ntr/ntu266
27. **David A, Esson K, Perucic AM, et al.** Tobacco use: equity and social determinants. In: Blas K, Kurup AS. Equity, Social Determinants and Public Health Programmes. Geneva: World Health Organization; 2010;199-217. Accessed at www.who.int/social_determinants/tools/EquitySDandPH_eng.pdf#page=209 on 19 April 2019.
28. **Cicero TJ, Ellis MS, Surratt HL, et al.** The changing face of heroin use in the United States: a retrospective analysis of the past 50 years. JAMA Psychiatry. 2014;71:821-6. [PMID: 24871348] doi:10.1001/jamapsychiatry.2014.366
29. **King NB, Fraser V, Boikos C, et al.** Determinants of increased opioid-related mortality in the United States and Canada, 1990-2013: a systematic review. Am J Public Health. 2014;104:e32-42. [PMID: 24922138] doi:10.2105/AJPH.2014.301966
30. **Green TC, Grau LE, Carver HW, et al.** Epidemiologic trends and geographic patterns of fatal opioid intoxications in Connecticut, USA: 1997-2007. Drug Alcohol Depend. 2011;115:221-8. [PMID: 21131140] doi:10.1016/j.drugalcdep.2010.11.007
31. **Centers for Disease Control and Prevention.** Vital Signs. Pregnancy-related deaths: saving women's lives before, during and after delivery. May 2019. Accessed at www.cdc.gov/vitalsigns/maternal-deaths on 19 April 2019.
32. **Petersen EE, Davis NL, Goodman D, et al.** Vital signs: pregnancy-related deaths, United States, 2011-2015, and strategies for prevention, 13 states, 2013-2017. MMWR Morb Mortal Wkly Rep. 2019;68:423-9. [PMID: 31071074] doi:10.15585/mmwr.mm6818e1
33. **Neggers YH.** Trends in maternal mortality in the United States. Reprod Toxicol. 2016;64:72-6. [PMID: 27063184] doi:10.1016/j.reprotox.2016.04.001
34. **Clark SL, Belfort MA.** The case for a national maternal mortality review committee. Obstet Gynecol. 2017;130:198-202. [PMID: 28594767] doi:10.1097/AOG.0000000000002062
35. **Fowler KA, Dahlberg LL, Haileyesus T, et al.** Firearm injuries in the United States. Prev Med. 2015;79:5-14. [PMID: 26116133] doi:10.1016/j.ypmed.2015.06.002
36. **Kalesan B, Galea S.** Patterns of gun deaths across US counties 1999-2013. Ann Epidemiol. 2017;27:302-7.e3. [PMID: 28528742] doi:10.1016/j.annepidem.2017.04.004
37. **Sly JL, Moore SE, Gore F, et al.** Children's environmental health indicators in Australia. Ann Glob Health. 2016;82:156-68. [PMID: 27325073] doi:10.1016/j.aogh.2016.01.012

38. **Prüss-Ustün A, Wolf J, Corvalán C, et al.** Diseases due to unhealthy environments: an updated estimate of the global burden of disease attributable to environmental determinants of health. J Public Health (Oxf). 2017;39:464-75. [PMID: 27621336] doi:10.1093/pubmed/fdw085
39. **Clark LP, Millet DB, Marshall JD.** National patterns in environmental injustice and inequality: outdoor NO2 air pollution in the United States. PLoS One. 2014;9:e94431. [PMID: 24736569] doi:10.1371/journal.pone.0094431
40. **Bennett CM, Friel S.** Impacts of climate change on inequities in child health. Children (Basel). 2014;1:461-73. [PMID: 27417491] doi:10.3390/children1030461
41. **Fritze JG, Blashki GA, Burke S, et al.** Hope, despair and transformation: Climate change and the promotion of mental health and wellbeing. Int J Ment Health Syst. 2008;2:13. [PMID: 18799005] doi:10.1186/1752-4458-2-13
42. **Brown ME, Antle P, Backlund ER, et al.** Climate change, global food security, and the U.S. food system. U.S. Department of Agriculture. U.S. Global Change Research Program. December 2015. Accessed at www.usda.gov/oce/climate_change/FoodSecurity2015Assessment/FullAssessment.pdf on 19 April 2019.
43. **Betancourt JR, Green AR, Carrillo JE, et al.** Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. Public Health Rep. 2003;118:293-302. [PMID: 12815076]
44. **Cruz M, Pincus HA, Harman JS, et al.** Barriers to care-seeking for depressed African Americans. Int J Psychiatry Med. 2008;38:71-80. [PMID: 18624019]
45. **Sorkin DH, Nguyen H, Ngo-Metzger Q.** Assessing the mental health needs and barriers to care among a diverse sample of Asian American older adults. J Gen Intern Med. 2011;26:595-602. [PMID: 21321793] doi:10.1007/s11606-010-1612-6
46. **McNair RP.** Lesbian health inequalities: a cultural minority issue for health professionals. Med J Aust. 2003;178:643-5. [PMID: 12797855]
47. **Vance SR Jr, Halpern-Felsher BL, Rosenthal SM.** Health care providers' comfort with and barriers to care of transgender youth. J Adolesc Health. 2015;56:251-3. [PMID: 25620310] doi:10.1016/j.jadohealth.2014.11.002
48. **Gonzales G, Henning-Smith C.** Barriers to care among transgender and gender nonconforming adults. Milbank Q. 2017;95:726-48. [PMID: 29226450] doi:10.1111/1468-0009.12297
49. **Schäfer G, Prkachin KM, Kaseweter KA, et al.** Health care providers' judgments in chronic pain: the influence of gender and trustworthiness. Pain. 2016;157:1618-25. [PMID: 26934512] doi:10.1097/j.pain.0000000000000536
50. **Rodríguez M, Valentine JM, Son JB, et al.** Intimate partner violence and barriers to mental health care for ethnically diverse populations of women. Trauma Violence Abuse. 2009;10:358-74. [PMID: 19638359] doi:10.1177/1524838009339756
51. **Tarasoff LA.** "We don't know. We've never had anybody like you before": barriers to perinatal care for women with physical disabilities. Disabil Health J. 2017;10:426-33. [PMID: 28404229] doi:10.1016/j.dhjo.2017.03.017
52. **World Health Organization.** Disability and health. Fact sheet. 16 January 2018. Accessed at www.who.int/en/news-room/fact-sheets/detail/disability-and-health on 19 April 2019.
53. **Harrington AL, Hirsch MA, Hammond FM, et al.** Assessment of primary care services and perceived barriers to care in persons with disabilities. Am J Phys Med Rehabil. 2009;88:852-63. [PMID: 19661771] doi:10.1097/PHM.0b013e3181b30745
54. **Hyer JL, Bazemore A, Bowman R, et al.** Medical school expansion: an immediate opportunity to meet rural health care needs. Robert Graham Center. 15 July 2007. Accessed at www.graham-center.org/rgc/publications-reports/publications/one-pagers/medical-school-exp-rural-2007.html on 19 April 2019.
55. **Rural Health Information Hub.** Rural Healthcare Workforce. Where are HPSAs located in rural areas? 19 July 2018. Accessed at www.ruralhealthinfo.org/topics/health-care-workforce on 26 June 2019.
56. **Wishner J, Solleveld P, Rudowitz R, et al.** A look at rural hospital closures and implications for access to care: three case studies. Kaiser Commission on Medicaid and the Uninsured. Issue brief. July 2016. Accessed at www.urban.org/sites/default/files/publication/82511/2000857-brief-a-look-at-rural-hospital-closures-and-implications-for-access-to-care.pdf on 27 June 2019.
57. **Pellowski JA.** Barriers to care for rural people living with HIV: a review of domestic research and health care models. J Assoc Nurses AIDS Care. 2013;24:422-37. [PMID: 23352771] doi:10.1016/j.jana.2012.08.007
58. **NCD Risk Factor Collaboration (NCD-RisC).** Rising rural body-mass index is the main driver of the global obesity epidemic in adults. Nature. 2019;569:260-4. [PMID: 31068725] doi:10.1038/s41586-019-1171-x
59. **Syed ST, Gerber BS, Sharp LK.** Traveling towards disease: transportation barriers to health care access. J Community Health. 2013;38:976-93. [PMID: 23543372] doi:10.1007/s10900-013-9681-1
60. **Fitzpatrick AL, Powe NR, Cooper LS, et al.** Barriers to health care access among the elderly and who perceives them. Am J Public Health. 2004;94:1788-94. [PMID: 15451751]
61. **Kurichi JE, Pezzin L, Streim JE, et al.** Perceived barriers to healthcare and receipt of recommended medical care among elderly Medicare beneficiaries. Arch Gerontol Geriatr. 2017;72:45-51. [PMID: 28544946] doi:10.1016/j.archger.2017.05.007
62. **Smith DL.** Health care disparities for persons with limited English proficiency: relationships from the 2006 Medical Expenditure Panel Survey (MEPS). J Health Dispar Res Pract. 2010;3:57-67.
63. **Ryan C.** Language use in the United States: 2011. American Community Survey Reports. U.S. Census Bureau. August 2013. Accessed at www2.census.gov/library/publications/2013/acs/acs-22/acs-22.pdf on 19 April 2019.
64. **Jacquez F, Vaughn L, Zhen-Duan J, et al.** Health care use and barriers to care among Latino immigrants in a new migration area. J Health Care Poor Underserved. 2016;27:1761-78. [PMID: 27818437]
65. **Hacker K, Anies M, Folb BL, et al.** Barriers to health care for undocumented immigrants: a literature review. Risk Manag Healthc Policy. 2015;8:175-83. [PMID: 26586971] doi:10.2147/RMHP.S70173
66. **Steinberg AG, Barnett S, Meador HE, et al.** Health care system accessibility. Experiences and perceptions of deaf people. J Gen Intern Med. 2006;21:260-6. [PMID: 16499543]
67. **American College of Physicians–American Society of Internal Medicine.** Public policy paper. Correctional medicine. 2001. Accessed at www.acponline.org/acp_policy/policies/correctional_medicine_2001.pdf on 19 April 2019.
68. **Ahmed R, Angel C, Martel R, et al.** Access to healthcare services during incarceration among female inmates. Int J Prison Health. 2016;12:204-15. [PMID: 27921632]
69. **Dara M, Acosta CD, Melchers NV, et al.** Tuberculosis control in prisons: current situation and research gaps. Int J Infect Dis. 2015;32:111-7. [PMID: 25809766] doi:10.1016/j.ijid.2014.12.029
70. **Hussain A, Ali S, Ahmed M, et al.** The anti-vaccination movement: a regression in modern medicine. Cureus. 2018;10:e2919. [PMID: 30186724] doi:10.7759/cureus.2919
71. **Thebault R.** CDC finds 78 new measles cases as outbreak sprints toward record and experts blame anti-vaxxers. Washington Post. 9 April 2019. Accessed at www.washingtonpost.com/health/2019/04/09/measles-outbreak-cdc-seventy-eight-new-cases-one-week/ on 19 April 2019.
72. **VanWormer JJ, Bendixsen CG, Vickers ER, et al.** Association between parent attitudes and receipt of human papillomavirus vaccine in adolescents. BMC Public Health. 2017;17:766. [PMID: 28969653] doi:10.1186/s12889-017-4787-5
73. **Attum B, Shamoon Z.** Cultural competence in the care of Muslim patients and their families. StatPearls. Treasure Island, FL: StatPearls Publishing; 29 May 2019. Accessed at www.ncbi.nlm.nih.gov/pubmed/29763108 on 19 April 2019.
74. **Babineaux SM, Toaima D, Boye KS, et al.** Multi-country retrospective observational study of the management and outcomes of patients with type 2 diabetes during Ramadan in 2010 (CREED). Dia-

bet Med. 2015;32:819-28. [PMID: 25581456] doi:10.1111/dme.12685
75. **Shahawy S, Deshpande NA, Nour NM.** Cross-cultural obstetric and gynecologic care of Muslim patients. Obstet Gynecol. 2015;126:969-73. [PMID: 26444117] doi:10.1097/AOG.0000000000001112
76. **Kim H, Xie B.** Health literacy in the eHealth era: a systematic review of the literature. Patient Educ Couns. 2017;100:1073-82. [PMID: 28174067] doi:10.1016/j.pec.2017.01.015
77. **McCloud RF, Okechukwu CA, Sorensen G, et al.** Beyond access: barriers to internet health information seeking among the urban poor. J Am Med Inform Assoc. 2016;23:1053-9. [PMID: 27206459] doi:10.1093/jamia/ocv204
78. **Bowleg L.** The problem with the phrase women and minorities: intersectionality-an important theoretical framework for public health. Am J Public Health. 2012;102:1267-73. [PMID: 22594719] doi:10.2105/AJPH.2012.300750
79. **López N, Gadsden VL.** Health inequities, social determinants, and intersectionality. National Academy of Sciences. 5 December 2016. Accessed at https://nam.edu/wp-content/uploads/2016/12/Health-Inequities-Social-Determinants-and-Intersectionality.pdf on 19 April 2019.
80. **Hsieh N, Ruther M.** Despite increased insurance coverage, nonwhite sexual minorities still experience disparities in access to care. Health Aff (Millwood). 2017;36:1786-94. [PMID: 28971924] doi:10.1377/hlthaff.2017.0455
81. **Cristancho S, Garces DM, Peters KE, et al.** Listening to rural Hispanic immigrants in the Midwest: a community-based participatory assessment of major barriers to health care access and use. Qual Health Res. 2008;18:633-46. [PMID: 18420537] doi:10.1177/1049732308316669
82. **Quinn K, Sanders C, Petroll AE.** "HIV is not going to kill me, old age is!": the intersection of aging and HIV for older HIV-infected adults in rural communities. AIDS Educ Prev. 2017;29:62-76. [PMID: 28195783] doi:10.1521/aeap.2017.29.1.62
83. **American College of Physicians.** Racial and ethnic disparities in health care, updated 2010. Policy paper. 2010. Accessed at www.acponline.org/system/files/documents/advocacy/current_policy_papers/assets/racial_disparities.pdf on 19 April 2019.
84. **Daniel H, Butkus R; Health and Public Policy Committee of American College of Physicians.** Lesbian, gay, bisexual, and transgender health disparities: executive summary of a policy position paper from the American College of Physicians. Ann Intern Med. 2015;163:135-7. [PMID: 25961598] doi:10.7326/M14-2482
85. **Daniel H, Erickson SM, Bornstein SS; Health and Public Policy Committee of the American College of Physicians.** Women's health policy in the United States: an American College of Physicians position paper. Ann Intern Med. 2018;168:874-5. [PMID: 29809243] doi:10.7326/M17-3344
86. **U.S. Census Bureau.** Facts for Features: Older Americans Month: May 2017 [Press release]. 10 April 2017. Accessed at www.census.gov/newsroom/facts-for-features/2017/cb17-ff08.html on 19 April 2019.
87. **American College of Physicians.** National immigration policy and access to health care. Policy paper. 2011. Accessed at www.acponline.org/acp_policy/policies/natl_immigration_policy_access_healthcare_2011.pdf on 19 April 2019.
88. **Molla R.** More than 60 million urban Americans don't have access to or can't afford broadband internet. Vox. 20 June 2017. Accessed at www.vox.com/2017/6/20/15839626/disparity-between-urban-rural-internet-access-major-economies on 19 April 2019.
89. **Institute for Crime & Justice Policy Research, Birkbeck University of London.** Highest to lower–prison population total. World Prison Brief. Accessed at www.prisonstudies.org/highest-to-lowest/prison-population-total?field_region_taxonomy_tid=All on 19 April 2019.
90. **Kaeble D, Cowhig M.** Correctional populations in the United States, 2016. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. April 2018. Accessed at www.bjs.gov/content/pub/pdf/cpus16.pdf on 19 April 2019.
91. **Hammett TM.** HIV/AIDS and other infectious diseases among correctional inmates: transmission, burden, and an appropriate response. Am J Public Health. 2006;96:974-8. [PMID: 16449578]
92. **Butkus R, Lane S, Steinmann AF, et al; Alliance for Academic Internal Medicine and American College of Physicians Graduate Medical Education Task Forces, for the Health and Public Policy Committee of the American College of Physicians.** Financing U.S. graduate medical education: a policy position paper of the Alliance for Academic Internal Medicine and the American College of Physicians. Ann Intern Med. 2016;165:134-7. [PMID: 27135592] doi:10.7326/M15-2917
93. **American College of Physicians.** Solutions to the challenges facing primary care medicine. Policy monograph. 2009. Accessed at www.acponline.org/acp_policy/policies/solutions_challenges_primarycare_2009.pdf on 19 April 2019.
94. **Erickson SM, Rockwern B, Koltov M, et al; Medical Practice and Quality Committee of the American College of Physicians.** Putting patients first by reducing administrative tasks in health care: a position paper of the American College of Physicians. Ann Intern Med. 2017;166:659-61. [PMID: 28346948] doi:10.7326/M16-2697
95. **Daniel H, Bornstein SS, Kane GC; Health and Public Policy Committee of the American College of Physicians.** Addressing social determinants to improve patient care and promote health equity: an American College of Physicians position paper. Ann Intern Med. 2018;168:577-8. [PMID: 29677265] doi:10.7326/M17-2441
96. **American College of Physicians.** Strengthening the public health infrastructure in a reformed health care system. Policy paper. 2012. Accessed at www.acponline.org/system/files/documents/advocacy/current_policy_papers/assets/public_health.pdf on 19 April 2019.
97. **Crowley RA; Health and Public Policy Committee of the American College of Physicians.** Climate change and health: a position paper of the American College of Physicians. Ann Intern Med. 2016;164:608-10. [PMID: 27089232] doi:10.7326/M15-2766
98. **American College of Physicians.** Climate Change Toolkit. Climate change action plan. 2016. Accessed at www.acponline.org/advocacy/advocacy-in-action/climate-change-toolkit on 14 June 2019.
99. **American College of Physicians.** Tobacco control and prevention. Policy monograph. 2010. Accessed at www.acponline.org/system/files/documents/advocacy/current_policy_papers/assets/control_tobacco.pdf on 7 May 2019.
100. **American College of Physicians.** Prescription drug abuse. Policy paper. 2013. Accessed at www.acponline.org/system/files/documents/advocacy/current_policy_papers/assets/prescription_drug_abuse_2013.pdf on 7 May 2019.
101. **Crowley R, Kirschner N, Dunn AS, et al; Health and Public Policy Committee of the American College of Physicians.** Health and public policy to facilitate effective prevention and treatment of substance use disorders involving illicit and prescription drugs: an American College of Physicians position paper. Ann Intern Med. 2017;166:733-6. [PMID: 28346947] doi:10.7326/M16-2953
102. **Butkus R, Doherty R, Bornstein SS; Health and Public Policy Committee of the American College of Physicians.** Reducing firearm injuries and deaths in the United States: a position paper from the American College of Physicians. Ann Intern Med. 2018;169:704-7. [PMID: 30383132] doi:10.7326/M18-1530

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