Redefining Health in the Age of COVID-19

Image: Georgia Tech Community COVID-19 Response

In the era of COVID-19, it's easy to become **numb.**

Numb to the millions of cases. The thousands of stories cut short. The ever-depressing onslaught of headlines describing overwhelmed hospital staff and floundering relief legislation. The disproportionate effect the virus has had on indigenous, African-American, and Latinx communities. The many cancelled events that characterize life at Duke: March Madness, E-Ball, and LDOC, to name a few. The next email from Duke administration describing even greater restrictions on who will be on campus in the fall.

Viruses don't see race. They don't select their hosts based on the color of their skin or the content of their character. No. Viruses invade wherever they can easily infiltrate—replicating and finding new hosts as quickly as possible is their way of life. So why are people of color being so severely hit by this virus? Prior to my work this summer at Duke's Margolis Center for Health Policy, I wouldn't have had a good answer for you.

Image: HIT Consultant

Policy wonks call it the "***social determinants of health:***" the upstream nonmedical factors such as education, neighborhood safety, and food insecurity that have a significant downstream influence on patients' health decisions and outcomes. I call it **numbness**. Numbness to the decades of entrenched inequities that dictate who lives and who dies.

These inequities have persisted for a variety of reasons, one of which is the narrow, constricted definition of "health" and "health care" that providers have operated under for years. For so long, we have told providers to care for the sick, when we should be telling them to also care for the well who are most at-risk of becoming sick. A patient who has gained control of their asthma following discharge from a hospital can only remain well-controlled for so long in a moldy house with poor ventilation. In the words of Atul Gawande, it's a "hospitalization waiting to happen." For an asthmatic living in poverty and struggling to keep the lights on, who's going to pay to replace the moldy HVAC system and insulation exacerbating the problem in the first place? Not the healthcare system, under our current definition of health, even though it might save thousands on a future hospitalization. We have a sick-care system in the United States, not a healthcare system.

The sick-care system waits until the patient is in the emergency room before taking concrete action to solve the imminent crisis at hand. In fact, that system gets paid when someone enters the hospital. It procrastinates like a lousy student, twiddling its thumbs while its patients deal with crippling homelessness and unemployment, moving the clock ever closer to the next hospital

admission (assuming they have access to healthcare in the first place). All because of a narrow definition of health that doesn't incentivize the necessary preventative actions in the first place.

So how do we get healthcare to help fight these inequities? It starts by expanding our definition of health to include all aspects of well-being: mental, physical, social, and financial alike. We start by changing the way we reimburse providers to encourage integration of health and social care, while building the necessary infrastructure, partnerships, and data capabilities to serve these historically marginalized populations. We build care delivery systems that treat patients as people rather than dollar signs, that can address both imminent health concerns and the associated upstream factors. We do what the United States does best—we innovate, undergoing that familiar process of creative destruction to fundamentally transform healthcare as we know it.

Image: LiveWell @ Univ. of Maryland

In concert with this global pandemic, my work this summer has drastically changed the way I view healthcare and health policy. Previously, I saw health policy as one of many intersections between science and policy, an interesting way to bridge two seemingly unrelated topics. What both COVID-19 and my experience at Margolis have shown me is that it is so much more involved than that. Whether it's sociology or statistics, every discipline has something to contribute—even indecisive undergraduate biomedical engineering majors like me. Coming from a background of siloed high school graduation requirements and one-year of Pratt prerequisite classes, I never thought so many different disciplines could come together in such a cohesive manner.

Reading and screening through thousands of abstracts and hundreds of articles may not have been extremely fun in the moment, but the end result was certainly rewarding in seeing the broader picture and exposing me to the variety of topics included under the umbrella of health policy. Even within the subarea of healthcare transformation (the team at Duke-Margolis where I was based and did most of my work), there's a host of new and emerging topics ranging from addressing health disparities to health behavior interventions to telehealth. Outside of our team, there's even more to explore: the role of artificial intelligence in healthcare, best practices for population health studies, and global health innovations, to name a few. I have had the privilege of hearing about many of these cool projects from my fellow interns and mentors, who I hope to remain in touch with for years to come.

What truly has impressed me about my summer at Margolis, however, was not just the intellectual reward, but also the amount of people who were willing to help me out with whatever my needs were, be it a pending decision on pursuing pre-med, another weird healthcare abbreviation, or the general process of conducting a systematic literature review and converting it into an issue brief tailored towards an audience with the power to enact change. Whether it was spending a whole workday litigating categorization methodology for state payment systems via email or taking five minutes during morning check-in meetings to talk about interesting things that happened over the weekend, people did their best to make themselves open and available to me, something I haven't

experienced on such a massive scale since orientation week. Even when I felt incompetent, there was always someone there to help me out and keep me moving forward.

If nothing else, my summer has motivated me to think about what I can do to impact people, whether it be on a macro- or micro- level. Will I be a practicing physician that cares for patients, one at a time? Will I be an academic researcher that seeks to publish groundbreaking findings that could change the lives of many people, one article at a time? Maybe I'll be lucky enough to straddle the line between both—to see the internal workings of health policy in both practice and research.

Where does my path lead? (Image: Personal Photo, Great Sand Dunes National Park & Preserve)

I originally joined Duke's Margolis Center a student, desperate for something to do over the summer. I now leave a rising scholar, desperate for something to experience over a lifetime.