Achieving Health Equity by Design

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Disparities in health outcomes by race and ethnicity and by income status are persistent and difficult to reduce. For more than a decade, infant mortality rates have been 2 to 3 times higher among African American populations, rates of potentially preventable hospitalization have been substantially higher among African American and Latino populations, and the complications of diabetes have disproportionately afflicted African American and Latino populations.[1] These and other disparities have persisted despite recognition that inequity costs the economy an estimated $300 billion per year.[2] In addition, health disparities threaten the ability of health care organizations to compete fiscally as insurers increasingly base payments on quality and outcomes, such as reducing preventable admissions and readmissions.

A common explanation for long-standing disparities is the challenge of addressing social determinants of health, including income inequality, poor access to transportation, inadequate educational quality, and substandard housing.[3] These factors have a profound effect on health. At the same time, the increasing appreciation for social determinants can have the perverse effect of undermining the potential role of public health and health care in promoting health equity. It is tempting, when confronted with substantial disparities, for leaders in health to implicate factors beyond their control.

The 2001 Institute of Medicine report *Crossing the Quality Chasm: A New Health System for the 21st Century* cited equity among 6 critical elements for health care quality, including timeliness, patient centeredness, efficacy, safety, and efficiency. Since that report, many health care organizations have pursued broad initiatives such as establishing medical homes, implementing electronic medical records, and eliminating hospital-acquired infections. Work to address "equity" has largely focused on enhancing cultural competence and addressing health literacy and on measures to improve patient safety for patients with limited English proficiency.[4]

Such efforts focused on equity have the goal of helping specific populations gain the benefits of the traditional health care system. Success is generally defined narrowly as creating equity in access to care, rather than targeting equity in outcomes. Although important, these types of efforts alone do not address many underlying social contributors to disease and as a result are unlikely to improve core measures of health dramatically.

It is time to broaden the expectation for what a health care system can do to include redesigning services to achieve health equity. Such interventions promote population health in the original meaning of the term, which includes focus on core contributors to disease.[5] Incorporating these principles into the larger system will promote and sustain equity.

A case example is hypertension. The prevalence of this disorder among African American populations is 10 to 15 percentage points higher than that of the general population, and its effect is more severe, with a substantially greater rate of nonfatal stroke, fatal stroke, end-stage renal disease, and hypertension-associated mortality.[6] Although the overall rate of hypertension control among Americans in general is poor, the rate of control among African American men from 2007 to 2012 was just 40.7%.[6]

In response to this disparity, health care organizations have focused on improving access and quality of traditional health care services. Such strategies include reducing the cost of medications, improving patient education, increasing awareness by both patients and clinicians of atypical presentations of myocardial infarctions, tracking blood pressure control using electronic medical records, and motivating change in patient behavior and diet. These interventions largely aim to retrofit the current health care system to make it more accessible to patients.

To reduce inequity, health care organizations should consider what contributes to disproportionate lack of access and sustained treatment. Historically, distrust of health care has limited the effectiveness of purely clinical interventions.[7] Indeed, with respect to hypertension, there is recent evidence that distrust continues to play an important role in reducing effective treatment among low-income and minority populations.[8] There are options to partner with effective community organizations to measure and respond to blood pressure in places where people live and work. For instance, particularly promising results have been seen in community efforts on blood pressure in local barbershops and beauty salons.[9] Such efforts, although unconventional, are well within the means and reach of health care organizations.

Another case example is infant hepatitis B immunization. Historically, Asian Americans, largely because of a high proportion of first-generation immigrants, have had disproportionate rates of hepatitis B infection with rates up to 7 times higher than whites with commensurate rates of liver failure and cancer.

The first dose of the hepatitis B vaccine is provided within the first few hours of birth. A typical strategy might

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have been to train staff in newborn nurseries in how to provide information in a culturally competent manner to new parents about the vaccine as part of the consent process. Yet the Centers for Disease Control and Prevention, choosing a different approach, funded an initiative 27 years ago based in community health centers. This initiative recognized that the newly immigrated, monolingual parents were far more likely to accept an intervention if recommended by community health care organizations. Thus, the program planners put bilingual teams in community health centers to explain vaccination and set an expectation that parents would demand vaccination after birth and that hospitals would be prepared to provide the vaccine in spite of language and cultural barriers. Patients were provided a hand-carried prenatal record that identified them as a candidate for infant vaccine.

At the completion of the initiative there was near-universal vaccination of infants at risk of hepatitis B infection, a practice that has become the standard of care for all mothers regardless of their ethnicity or immigration status.

To design services that promote health equity, there must be a clear focus on specific communities at risk, a commitment to listen and collect meaningful data to understand local needs and priorities, a conviction to make progress, and ongoing assessment of health outcomes.

Health care systems should recognize that some individuals have concerns that are perceived as more urgent and immediate than their personal health status, such as unemployment, school failure, and housing instability. Such concerns may make it impossible for medical organizations to address health equity if they do not look outside their walls for assistance. To make progress, hospitals, physicians, and others should explore partnering with community agencies to build on the assets of trusted relationships, insight, and visibility. Working together can not only engage patients more effectively in health where they live and work but also indirectly mitigate factors that contribute to significant illness and disability. For example, community-based hypertension control efforts developed in collaboration with local businesses can strengthen those businesses and help connect community members to jobs. Partnerships with community health centers in Asian American communities on hepatitis B vaccine enhanced their role as economic and political strongholds within many neighborhoods. The material support and credibility of a partnership can advance a community organization's other efforts that address the social determinants of health directly.

Ultimately, the recognition that social factors underlie health should motivate health care organizations to consider a new set of tools and approaches—not discourage them by making progress seem unattainable. As more payment systems adapt to reward better outcomes, building equity into program design will be the smart investment for the future.

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