What Can the Health Care Sector Do to Advance Health Equity?
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Foreword


This report aims to assist those working in health care, public health, and other fields that powerfully shape health—such as education, childcare, housing, and community development—to build a world in which everyone has a fair and just opportunity to be as healthy as possible.

Contents

<table>
<thead>
<tr>
<th>Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>Current Health Care Sector Initiatives to</td>
<td>16</td>
</tr>
<tr>
<td>Advance Health Equity</td>
<td></td>
</tr>
<tr>
<td>A Call to Action: Recommendations to</td>
<td>26</td>
</tr>
<tr>
<td>Guide Health Care Sector Actions to</td>
<td></td>
</tr>
<tr>
<td>Advance Health Equity</td>
<td></td>
</tr>
<tr>
<td>Examples of Relevant Health Care</td>
<td>32</td>
</tr>
<tr>
<td>Sector Efforts</td>
<td></td>
</tr>
<tr>
<td>Additional Resources</td>
<td>42</td>
</tr>
<tr>
<td>Guiding Principles for Advancing</td>
<td>47</td>
</tr>
<tr>
<td>Health Equity</td>
<td></td>
</tr>
<tr>
<td>References</td>
<td>49</td>
</tr>
</tbody>
</table>
### Box 1

#### Definitions

**Health.** Health status or health outcomes. Health is distinguished from **health care** (also called **medical care**), the services provided by trained personnel to treat or prevent illness.

**The health care system.** The multiple organizations and institutions involved in the delivery and financing of health care, including providers of medical care and ancillary services, payers, and training, administrative, and monitoring agencies.

**Health equity.** See definition and discussion of health equity in Section I.

**Health disparities** are used to measure progress toward health equity. Health disparities are plausibly avoidable, systematic health differences adversely affecting socially disadvantaged groups. This definition does not require establishing that the disparities were caused by social disadvantage or exclusion; it requires only observing worse health among groups of people who are and have historically been marginalized, excluded, disenfranchised, and/or discriminated against, for example, American Indians, African Americans/blacks, and some other racial/ethnic groups, persons living with disabilities, and LGBTQ persons. Health disparities are ethically concerning even if we are not certain of their causes because they affect groups already at underlying economic or social disadvantage and put them at further disadvantage with respect to their health; this seems especially unfair since good health is needed to escape social disadvantage.

Health disparity and health inequality are synonyms; disparity is generally used in the United States, while inequality is used in other countries. Health disparities do not include all health differences; they specifically refer to disparities on which marginalized social groups experience worse health; disparities/inequalities imply that further examination is warranted but they do not necessarily imply lack of fairness or justice. This definition is consistent with the conceptual basis for the health disparities movement launched in the 1990s.

**Health inequities.** Differences in health that are unfair and unjust. This requires making an inference about the cause(s) of a difference, for which there may not be adequate evidence. By contrast, calling a health difference a health disparity does not require a causal judgment.

**Social determinants of health.** The World Health Organization has defined the social determinants of health as: “...the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.” The social determinants of health also can be thought of as those conditions or factors that influence health and can be shaped by social (including economic and political) policies and forces. Examples include: education, income, accumulated wealth, race-based and other forms of discrimination, employment, housing, food, air and water quality, transportation, traffic safety, safety at work, social support, and any policies that shape these conditions or factors. Originally, the term social **determinants of health** was coined expressly to distinguish non-health care factors from health care as influences on health, and...
was generally used in that way until recently. The term social conditions is used interchangeably with social determinants of health in this document.

**Social care.** Attention to social (including economic) determinants of health provided by (or through the efforts of) a health care provider or health care system.

**Social risks.** Health risk factors due to adverse social conditions/determinants.

**Structural Racism** is “…the totality of ways in which societies foster racial discrimination, through mutually reinforcing inequitable systems (in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, and so on) that in turn reinforce discriminatory beliefs, values, and distribution of resources, which together affect the risk of adverse health outcomes.” Racial residential segregation is an example of structural racism. It reflects historical injustice that is strongly reinforced by policies, practices, and norms. While it partly reflects ongoing discrimination by landlords and lending institutions it is so deeply rooted in policies, practices, and norms that it can be perpetuated by institutions and individuals who do not have any conscious intent to discriminate.

**Marginalized, excluded, disenfranchised, or socially disadvantaged groups.** Groups of people who historically have suffered and continue to suffer discrimination, whether intentionally perpetrated or not. These groups have been pushed to the margins of society and the health-promoting resources it has to offer. They have had inadequate access to key opportunities to be healthy. They are socially disadvantaged in general and often economically disadvantaged. Examples of marginalized, excluded, disenfranchised, and/or socially disadvantaged groups include—but are not limited to—African Americans/blacks, American Indians/Alaska Natives, Hispanics/Latinos; immigrants; people living in poverty, particularly intergenerational poverty; Muslims, people living with physical or mental disabilities; LGBTQ persons; and women. Many individuals belong to more than one marginalized group—e.g., being a black woman or a disabled, gay American Indian man—and as such, they may experience compound disadvantage.
Introduction

The power of modern medicine is indisputable: health care can prevent many illnesses or make them less severe, save lives, avert disability, and alleviate suffering. Many health care providers, however, know the frustration of seeing patients too sick and too late because they are uninsured or cannot afford out-of-pocket costs, or because of other barriers to access such as language, mistrust, or fear of discrimination. And, too many providers have experienced the helplessness of treating patients, only to have them return—perhaps after an emergency room visit or inpatient stay—without improvement or sicker because their living conditions made it impossible for them to avoid continued exposure to whatever was making them ill.

Widespread inequities in social conditions—such as high quality and secure housing, food security, access to jobs that pay a living wage, good schools, and convenient transportation—have been beyond the traditional purview of health care and yet strongly influence health. And the unequal distribution of health care resources can exacerbate inequities not only in health but also in social conditions, as being sick and lacking access to affordable care makes people lose jobs, housing, education, and access to food. These inequities limit the beneficial effects of health care, frustrate dedicated providers, and hurt the bottom lines of both private and public health care organizations. As a result, health care stakeholders, including private and public payers and providers, increasingly have become aware of the need to look not only at the design and delivery of health care itself, but also beyond medical care as they mount new efforts to prevent needless suffering, premature death, and avoidable costs.

Health equity must be a priority for health care providers and systems because inequities in health and health care are pervasive, lead to poorer health outcomes and premature deaths, and drain health care resources.
What Is Health Equity?

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health, such as poverty, discrimination, powerlessness, and their consequences, including lack of access to good jobs with fair pay, safe environments, and quality education, housing, and health care. For the purposes of measurement, health equity means reducing disparities in health and its determinants that adversely affect excluded or marginalized groups.

Pursuing health equity involves focused and systematic efforts to improve the health and the determinants of health of groups of people who have poor health and who have been marginalized, excluded, and/or disenfranchised, for example blacks, American Indians/Alaska Natives, immigrants, Muslims, low-income people, people living with disabilities, and LGBTQ persons. Equity requires an examination and understanding of the mechanisms by which the advantages of privileged groups are systematically maintained and augmented. Inequities in health also harm advantaged groups by sapping the productivity and collective strength of our society.

Health equity is a value, the principle that motivates us to eliminate health disparities. Disparities—worse health in marginalized groups—are used to measure progress toward greater health equity. (See definitions of health disparities and inequities in Definitions)

NOTE: What Is Health Equity? And What Difference Does a Definition Make? discusses the concepts of health equity, inequities, and disparities, and the causes of health inequities in more depth. The final section of this report contains Guiding Principles for Advancing Health Equity excerpted from that document.
Disparities in Health and Health Care Are Large, Pervasive, and Costly.

An extensive body of literature has accumulated, showing large and pervasive disparities in health affecting low-income groups, African Americans/blacks, American Indians/Alaska Natives, Hispanics/Latinos, some Asian subgroups, immigrants, people with disabilities, and LGBT persons. Disparities in health care also have been documented repeatedly among these groups, in many cases along with evidence of adverse health consequences. Boxes 2 and 3 display several examples of these disparities in the United States.

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**BOX 2**

Marginalized populations experience worse health.

- The richest 1 percent of the U.S. population lives approximately 14.6 years longer than the poorest 1 percent, and income gaps in life expectancy have been increasing over time. Even people in the “middle class” live shorter lives than the wealthiest people.

- A baby born to a black mother is twice as likely to die before reaching her first birthday as a baby born to a white mother. And the average life expectancy of a black man is 4.4 years less than that of his white counterpart.

- American Indians and Alaska Natives have the lowest life expectancy and highest rates of diabetes and hypertension of any racial or ethnic group in the United States.

- Although Hispanics/Latinos have a longer life expectancy and better overall health than other racial/ethnic groups on many health indicators, they experience disproportionately high rates of diabetes, metabolic syndrome, and end-stage renal disease.

- LGB adults experience higher rates of disability and/or activity limitations than their heterosexual counterparts.

- People with disabilities are significantly more likely to suffer from cardiovascular disease and diabetes in adulthood.

- Southeast Asian immigrant children are significantly more likely to be overweight than immigrant children of other Asian subgroups and their U.S.-born white and Asian counterparts.

- A nationally representative study found that the poorest neighborhoods in the United States had a 56 percent greater incidence of stroke compared to the highest SES neighborhoods. Middle- and upper-middle income neighborhoods had a 38 and 28 percent higher incidence of stroke, respectively, than the highest SES neighborhoods.
Lower quality or delayed care can lead to adverse outcomes that are costly for the affected individuals and health care institutions. Mistrust of and/or perceived lack of respect from health care providers or staff contribute to delays in timely care-seeking and non-adherence to treatment, both of which contribute to adverse health consequences, avoidable suffering, and significant costs. Box 4 indicates the savings that could result from greater equity in health and health care.
What Causes Inequities in Health and Health Care?

To develop effective health care sector strategies for advancing health equity, it is important to understand what creates and perpetuates inequities in health and health care. The causes of inequities in health also are causes of inequities in health care, in part because inequities in health care often contribute to inequities in health. Powerful drivers of inequities in both health and health care include lack of insurance and unaffordable out-of-pocket costs of health care; racism and discrimination; and inequities in underlying opportunities to be healthy, such as financial hardship.

* Here we use the term “inequities” rather than “disparities” because the question “What Causes Inequities in Health and Health Care?” is specifically about the subset of disparities that one can be reasonably confident are unfair and unjust.

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**BOX 4**

Greater health equity would yield savings in health care costs.

In 2017, the US spent $3.5 trillion—or nearly $11,000 per person—on health care products and services. A number of studies suggest that reducing and/or eliminating inequities in health and health care would yield substantial savings for health care systems, insurers, and providers.

Examples of savings that could result from reductions in health or health care inequities:

- According to one estimate, eliminating health gaps among racial and ethnic groups would cut health care costs by $230 billion and reduce the indirect costs of excess disease prevalence and mortality by over $1 trillion over four years.

- A study on diabetes in North Carolina estimated that eliminating the state’s racial and socioeconomic disparities in diabetes prevalence would save the North Carolina Medicaid program $225 million annually in diabetes-related medical care and prescription drug costs.

- A national study estimated that, among all employed African Americans, a 10-percent reduction in asthma medication non-adherence could save approximately $1,660 in medical expenses per African American employee each year. Medication non-adherence among African Americans has been associated with medical mistrust, which may result from experiences of racism in health care and awareness of historical cases of mistreatment against African Americans in medical settings (e.g., the Tuskegee Syphilis Study).

- At one large hospital, providing convenient access to medical interpreters for patients with limited English proficiency was associated with significantly reduced readmissions and estimated monthly hospital savings of $161,404.
Figure 1 was developed by the Bay Area Regional Health Inequities Initiative to illustrate its framework for understanding the root causes of health inequities. Social and institutional inequities drive inequities in living conditions, which in turn drive inequities in harmful exposures and/or risk behaviors and ultimately in illness and life expectancy.

**Lack of health insurance and/or unaffordable medical expenses contribute to inequities in health and health care.**

Barriers to financial access to health care are perhaps the most obvious cause of inequities in health care and therefore in health. In 2017, 20 percent of uninsured adults delayed or failed to receive necessary care due to cost.\textsuperscript{71} Research consistently shows that uninsured individuals are less likely than their insured counterparts to receive preventive care and chronic disease treatment in outpatient settings.\textsuperscript{72-74} Consequently, uninsured individuals are more frequently hospitalized for preventable conditions, and, when hospitalized, are less likely to receive diagnostic and therapeutic services and more likely to die than insured patients.\textsuperscript{71,75-77}

People of color and people living in poverty or near-poverty bear the heaviest burden of lack of health insurance.\textsuperscript{78} And under current law, most green card holders and lawfully permanent residents must wait five years before receiving Medicaid and CHIP coverage; only 29 states currently do not require a five-year waiting period for lawfully residing children and/or pregnant women.\textsuperscript{79}

Being uninsured or underinsured contributes to unaffordable out-of-pocket medical expenses, which then worsen the likelihood of impoverishment, financial insecurity, and/or bankruptcy,\textsuperscript{80-83} each of which is associated with ill health. (See *Inequities in underlying opportunities to be healthy* below.) Unpaid medical bills accounted for 52 percent of all debts sent to collections agencies in 2014.\textsuperscript{84} More than a quarter (26\%) of respondents to a 2015 Kaiser Family Foundation/New York Times survey reported that they or a household member struggled or were unable to pay medical bills in the past year.\textsuperscript{85} Chronic anxiety further exacerbates risks of chronic disease;\textsuperscript{86} there is no reason to believe that anxiety over unaffordable health care costs would be an exception.
Inequities in health care are salient contributors to inequities in health. Structural racism and economic hardship, and health care’s contribution to each, are particularly important. Source: Bay Area Regional Health Inequities Initiative (BARHII)
Racial and other discrimination in health care settings contributes to health inequity.

Discrimination is unfair treatment directed at an individual or a group of people on the basis of certain characteristics (for example, race/ethnicity, skin color, religion, national origin, gender, disability status, sexual orientation or gender identity), putting members of that group at a disadvantage.

Racial discrimination can damage health in multiple ways. The ways in which health care is delivered can exacerbate health inequity by failing to actively address entrenched obstacles to access and quality for marginalized groups of people. Barriers to health care may include fear of insensitive, disrespectful, exploitative, or otherwise discriminatory treatment. Discrimination can present not only as overt, dramatic incidents but also as ambiguous or less dramatic experiences of unfair treatment, which, when experienced repeatedly over time, can damage health through pathways involving stress.

Clinicians’ behavior and clinical decisions may be influenced by conscious or unconscious bias, with potentially dangerous implications for patients’ health in either case. Studies have documented examples of standard medical care not being given because of prejudicial assumptions about patients’ preferences or capabilities based on characteristics such as economic status, race, or ethnic group. For example, Hoffman et al (2017) found that more than half of white medical students and residents believed that “black people’s skin is thicker than white people’s skin.” Furthermore, the students who held that belief were less likely to prescribe adequate pain medication for black patients than for white patients with comparable clinical presentations. Another study found that, based on tests of racial bias and perceived patient cooperativeness, physicians who were more biased were less likely to administer a potentially life-saving treatment to black patients than to white patients when it was clinically indicated for both. Experiences of racial discrimination in health care encounters—both overt and subtle—can undermine patients’ trust, satisfaction with care, and provider-patient communication. Perceived racial/ethnic discrimination in health care has been associated with a wide range of adverse health and health care outcomes.

While race-based discrimination in health care is documented more than other types of discrimination, there also is growing evidence of treatment bias against LGB persons in health care. A systematic review revealed that LGB persons face multiple barriers to health care access, including communication issues with providers, prejudicial conduct of providers, breaches of confidentiality during consultations, and internalized homophobia. Furthermore, health care professionals are seldom trained in competencies needed to serve people living with disabilities. People
with disabilities often cite discriminatory experiences in health care settings, lack of appropriate accommodations, and difficulty communicating with providers as barriers to health care and mental health/substance abuse treatment.\textsuperscript{104-106} Although evidence of gender inequity in health status in the United States is mixed, gender inequity in health care is seen in the form of refusal by some public and private payers to cover basic reproductive health services needed by women.

**BOX 5**

**Racial discrimination in health care is a long-standing and ongoing problem.**

Often, to understand what needs to be done going forward, we need to understand the past. The impact of 250 years of slavery did not disappear when slavery officially ended, especially because the end of slavery was followed by 100 years of Jim Crow laws that deliberately discriminated against blacks in all domains of life and were enforced by white supremacist terrorism. Furthermore, the health care sector itself has participated actively in racial discrimination. Many blacks are still aware of the infamous 40-year Tuskegee Experiment (1932-1972), in which 399 black men were deliberately, without their knowledge or consent, given no treatment for syphilis so that U.S. Public Health Service researchers could follow the course of the untreated illness. Native American, black, Puerto Rican, and Mexican-origin women have been subjected to forced sterilizations and coerced abortions by some health care institutions in the United States.\textsuperscript{95,96} Before the Civil Rights Act of 1964, hospitals were racially segregated, with two very different standards of care—one for white people and a lower standard for people of color.\textsuperscript{97} Even since the Civil Rights Act forcibly integrated hospitals, examples of unequal treatment along color lines have persisted.\textsuperscript{98}

The 2003 Institute of Medicine report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*,\textsuperscript{90} documented widespread racial/ethnic discrimination in health care; more recent research has shown this discrimination persists.\textsuperscript{99,100}

In the face of this shameful legacy, it may take a long time for health care institutions to win the trust of many blacks and others who feel potentially vulnerable to sub-standard care. The challenges of contemporary systemic racism also cause tremendous suffering but may be much harder to detect and reverse. Health care institutions must make special efforts to earn and sustain the trust of marginalized racial and ethnic groups, especially by ensuring that members of those groups have a voice in decisions that affect the community and are adequately represented within institutional leadership. Health care institutions must proactively work in a sustained fashion to limit the ways in which race-based and other discrimination manifests in clinical services.
Structural racism refers to inequities deeply embedded within systems, laws, policies, institutions, practices, ways of thinking, and values as a result of historical and ongoing injustice. In addition to interpersonal discrimination, structural racism in health care institutions contributes to health inequity. For example, long-standing hiring and promotions practices can put people of color at a disadvantage, resulting in a largely white workforce, particularly at higher professional and leadership levels. Lack of racial/ethnic diversity among clinicians can result in lower patient satisfaction and worse provider-patient communication among marginalized racial and ethnic populations, which may ultimately lead to worse health outcomes. Studies have shown that people are more likely to use recommended health care when providers include individuals of the same race or ethnic group. Lack of diversity among health care organization leaders could result in governance that is less responsive to the needs of disadvantaged populations. Customary contracting practices can mean that contracts for outside services (e.g., laundry, food, janitorial services, maintenance, and supplies) are primarily awarded to white-owned companies, which often results in missed opportunities to invest in businesses owned by people of color.

Another example of how structural racism in health care can contribute to inequities in health and health care is the systematic under-estimation of cardiovascular risk by the American College of Cardiology/American Heart Association (ACC/AHA) Pooled Cohort Equations Risk Model (PCERM) among patients residing in disadvantaged neighborhoods. The ACC/AHA currently recommends tailoring cholesterol-and blood pressure-lowering

**BOX 6**

Physicians and health researchers have been significant contributors to theories of racial inferiority used to justify historical atrocities.

Galen, a Greek physician who profoundly influenced the development of anatomy and physiology in the second century A.D., promoted concepts of inferiority of darker skinned people. False theories such as these remained common in medical research and practice, and were used to justify extermination of indigenous people, slavery and segregation, and forced sterilization in the United States. Eugenics, a set of beliefs and practices that aimed to shape the gene pool of the human population to conform to Northern European norms, was part of mainstream American health sciences in the 1920s and 30s, and American physicians and scientists were influential theorists cited by the perpetrators of the Nazi Holocaust as justification for exterminating Jews and others deemed inferior. These theories are unfortunately making a resurgence today in the discourse on race in the United States.
therapies according to risk estimates derived from the PCERM. A recent study demonstrated that the PCERM systematically underestimated the risk of serious cardiovascular events, including heart attacks and strokes among patients of an urban academic medical center, with larger under-estimates occurring among residents of more disadvantaged neighborhoods. One consequence of this under-estimation of risk is that care aligned with ACC/AHA guidelines would systematically under-treat cardiovascular disease in residents of disadvantaged neighborhoods, where blacks and other marginalized racial/ethnic groups are more likely to live.

Structural racism in society at large is another fundamental driver of health inequities.

Structural racism in society at large systematically puts blacks, Hispanics/Latinos, and American Indians/Alaska Natives at an economic and health disadvantage. Structural racism tracks people of color into segregated areas that cut them off from good jobs with paid leave and health insurance, good schools, economic security, and healthy environments, and expose them to air pollution, other toxic hazards, concentrated poverty, crime, and chronic stress. Structural racism and interpersonal discrimination has resulted in the mass incarceration of youth and young men of color, which destroys opportunities to be healthy not only for the incarcerated boys and men but also for their families and communities. Furthermore, racism can damage health regardless of one’s socioeconomic status. Multiple studies have shown that blacks of higher income and education levels do not experience the same health benefits of higher socioeconomic status as their white counterparts of similar income and education.

Inequities in economic opportunity among people in all racial/ethnic groups also play a critical role in health inequities.

Considerable evidence tells us that health care, while necessary, is not sufficient for health. Economic hardship is also a major driver of inequity. It takes a heavy toll on health and is a barrier to needed health care. Inadequate income and wealth often expose people to multiple health-harming conditions, such as food insecurity, unsafe or insecure housing, a high concentration of fast-food outlets, and pollution. It often denies them the benefit of health-promoting conditions, such as good schools, green spaces, convenient transportation, healthy community norms, participation in society, and social support. Lower educational attainment makes it more difficult to obtain good jobs and therefore limits economic opportunity. Family caregiving responsibilities and lack of paid leave can be obstacles to receipt of health care, especially among low-income persons. Financial hardship exposes people to constant stress, as they face daily challenges—how to pay for child care, medical care and long-term care.
feed their families, get to work on time, or pay the rent or mortgage—with inadequate resources. Chronic stress experienced during childhood or later in life can lead to chronic disease, such as heart disease and diabetes, that typically manifest in later adulthood, causing disability and premature death.

Too many people in all racial/ethnic groups suffer from lack of economic opportunity. Because of a long history of racism and discrimination, however, American Indians, blacks, and Hispanics/Latinos are far more likely than whites to experience chronic financial hardship. Even when the stressful experiences are relatively undramatic, chronic exposure to stress may damage health more than a more dramatic acute stressor that does not persist over time. Chronic stress is likely to be a major reason for the pervasive socioeconomic and racial/ethnic disparities in multiple health outcomes.
Current Health Care Sector Initiatives to Advance Health Equity

While health care is not the only determinant of health, it is a critical one, making inequities in access to or quality of care significant threats to equity in health. Making health care access and quality more equitable would likely lead to more equitable health outcomes.\textsuperscript{134} Increasing access to health care also can reduce impoverishment and financial insecurity due to unaffordable out-of-pocket medical expenses,\textsuperscript{81-83} which in itself should improve health. Evidence also links greater equity in access to health care—for example, Medicaid expansions that substantially reduced the uninsured population—to greater socioeconomic equity,\textsuperscript{42,135} which in turn can be expected to increase health equity.\textsuperscript{136}

Inequities in financial access to health care will generally require policy solutions at the state and national levels, although some local areas have implemented their own county-wide health plans aiming at near-universal coverage.\textsuperscript{137,138} Eliminating inequities in health care access and quality, however, will also require the full engagement and support of healthcare sector leaders at multiple levels.

Beyond efforts to increase health care access, the health care sector is also uniquely positioned to witness, document, and redress disparities in health and health care that must be eliminated to achieve health equity. Health care providers are often on the front line, observing and trying to improve poor health in situations where patients’ social (including economic) circumstances are major contributing factors. When providers are aware of patients’ social conditions, they are strategically positioned to connect patients to social services. Only health care providers and leaders can address racism and discrimination within health care settings. Health care providers and leaders also can play vital roles as highly credible advocates capable of influencing other health care leaders and leaders in other sectors—such as housing, food, education, child care and government—to take actions needed to address health and health care inequities.

Reflecting the growing recognition of the root causes of health and inequity as well their pervasiveness and costs, the health care sector is engaging in innovative efforts to advance health equity. These efforts include a wide range of policy, systems, and practice changes within the health care sector. Additionally, some providers, payers, and systems also are extending the reach of their work beyond the walls of their institutions with the intention of helping to improve social conditions in the communities they serve.
The extent and breadth of these changes reflect the compelling evidence linking social conditions and health, as well as indications that a more holistic, multi-sectoral, and explicitly equity-oriented approach are vital to improve the health of marginalized populations, who constitute a large proportion of the U.S. population overall.\textsuperscript{139-141}

Because many of these efforts are relatively new, for some there is not yet a substantial body of published evidence about effectiveness. There are, however, many relevant initiatives, some of long duration with credible evaluation results that deserve consideration as models that could be strengthened, expanded, and/or adapted to advance health equity in varied settings. While the evidence base should be strengthened, valuable information exists now to guide action and inform research priorities.\textsuperscript{142,143}

The examples described here of health care sector actions to improve equity are grouped into three broad categories (although some examples span more than one category): (1) actions to improve equity in access and quality within the health care system; (2) actions to improve the social conditions of individual patients; and (3) actions to improve social conditions at the community or population level. Examples were selected to reflect diverse and innovative models. To the extent possible, we also have highlighted programs where outcome data are available. Section 4 provides additional examples. Additional resources for those interested in learning more about strategies to address health equity can be found on page 42.

**Health Care Sector Efforts to Advance Equity in Health Care Access and Quality.**

As noted earlier, improving equity in health care access and quality is an important—albeit not the only—way in which health care systems can contribute to advancing equity in health outcomes. Many health care organizations are making systems or practice-level changes intended to improve access and/or quality among those with limited access to and/or lower quality of services.\textsuperscript{144-148} Several examples are below; more examples are described in Section 4. It is important to note that not all efforts to improve access and quality have been shown to lessen disparities—and some have inadvertently increased disparities for specific populations. Involving community members in both the design and evaluation of these initiatives may increase the likelihood of achieving equity impacts.
• **Community Health Centers** have been the foundation of efforts to advance equity in health care access and quality for over 50 years. They operate at more than 8,000 sites in every state and U.S. territory, and have been demonstrated to provide care for chronic diseases comparable in quality to care provided in settings with significantly more advantaged populations. According to one of the founders of the community health center movement in the United States, community governance that ensures care is “of the people, by the people, and for the people” has been key to their success.

• In a partnership between the New York City-based Mount Sinai School of Medicine and Healthfirst (a non-profit provider-sponsored insurance company), Mount Sinai receives enhanced payments for postpartum follow-up. The enhanced payment aims to defray expenses for employing social workers and care coordinators. The program also incorporates clinician education and performance feedback. It focuses on reducing disparities in postpartum care for high-risk low-income women; the program achieved a 27-percent increase in postpartum visit rates among the target population from 2015–2017.

• After pledging to the American Hospital Association’s #123forEquity Campaign to Eliminate Health Care Disparities (see Section 4), Navicent Health in Central Georgia used three strategies to ensure that every person in every community they serve receives high quality, equitable, and safe care, including:

  - Increasing the collection and use of data on race, ethnicity, language preference and other socio-demographic characteristics;
  - Increasing cultural competency training; and
  - Increasing diversity in leadership and governance.

Following these efforts, diversity in leadership and governance increased over 15 percent from 2012–2016, and readmission disparities between blacks and whites with diabetes, heart failure, and chronic obstructive pulmonary disease were eliminated.

• Based on focus group input from the community, the Greensboro, North Carolina Health Disparities Collaborative designed an intervention for black patients undergoing breast or lung cancer treatment using trained nurse navigators. Navigators assisted patients from diagnosis through treatment and recovery (typically three years). The collaborative observed a 10-percent increase in treatment completion among black patients who received this customized support.
• The Henry Ford Health System in Detroit promoted qualified minority employees to leadership positions—an effort that has been associated with increases of 57 percent and 44 percent in the number of the organization’s top leadership positions held by nonwhite persons and women, respectively.155

• Morehouse School of Medicine, an academic medical center in Atlanta long distinguished for its commitment to health equity, has developed a multiplicity of pipeline and training programs to eliminate health disparities in high-poverty and under-resourced communities across Georgia. Morehouse’s admissions policies place a high priority on selecting future providers who reflect the demographics of and will ultimately serve marginalized communities with excellence. An example of its curricular approach is that every year the entire first year class engages in bidirectional learning with a community by collaborating with community members and leaders to complete a needs assessment and develop a health promotion project. Continued service learning in the curriculum allows for further development of skills in promoting community health.

With the intention of improving health care quality, health care organizations also are increasingly collecting information on social risk factors such as financial hardship, language, literacy, and residence in unhealthy neighborhoods (see Box 5). In theory, providers can then adjust or contextualize medical decisions based on an awareness of patients’ social challenges, constraints, and resources. While incorporating an awareness of social conditions and their impacts into medical care should be routine to improve care and outcomes for all patients, multiple studies have shown that it is not routine practice.156,157 When these adaptations are made for patients who face the greatest demands with the least resources, they may help to reduce inequities in health care. It is important to note, however, that these types of strategies may be used—albeit unintentionally—to justify “poor care for poor people” or to otherwise rationalize discriminatory behaviors.

Health Care Sector Efforts to Advance Health Equity by Improving the Social Conditions of Individual Patients.

Improving patients’ social conditions has not traditionally been viewed as a responsibility of the health care sector. But with growing evidence that social conditions strongly influence health, and as health care providers are increasingly held accountable for outcomes, some health care systems have launched initiatives to improve their patients’ social conditions as part of a strategy to improve health and health equity.170-175 Many initiatives aim to link patients who have adverse living conditions with relevant resources. Although these types of initiatives initially were implemented in settings
primarily serving patients from marginalized communities, a wider range of health care stakeholders are now supporting or implementing relevant programs. To inform these programs, many health care systems are standardizing the collection of data on patients’ health risks based on the social conditions in which they live (see Box 5). Health care-based initiatives both to collect information on and address patients’ social conditions are presented in a 2019 National Academies of Sciences, Engineering and Medicine report, *Integrating Social Care into Health Care Delivery*.

**Box 7**

Collecting data on social conditions to support health care organizations’ strategies to improve health equity.

Many health care systems are exploring ways to systematically gather and use data on social conditions from individual and/or community-level sources to inform subsequent health care system activities. These efforts include gathering data on food security, housing stability, employment, and the availability of local resources like supermarkets, libraries, and social service agencies.

The National Academy of Sciences, Engineering, and Medicine, the Center for Medicare and Medicaid Innovation, and the National Association of Community Health Centers (among others) have developed new tools to facilitate patient-level social risk screening in clinical settings. Recommended social domains and specific measures differ across organizations. Seven common social risk screening tools are described (e.g., length, translations, reading level, and evidence supporting them) on the Social Interventions Research and Evaluation Network (SIREN) website. Additional guidance for providers on patient-centered approaches to collecting information about patients’ social risks can be found in the Oregon Primary Care Association’s tool *Patient-Centered Priorities for Social Needs*.

Interviewing and in the American Hospital Association’s brief *Screening for Social Needs: Guiding Teams to Engage Patients*.

Although data about social conditions can be used to guide health care sector efforts to improve health equity, collecting these data is not itself a strategy to achieve health equity. In fact, some approaches to identifying social risk factors could unintentionally undermine equity goals: one study found that patients who have previously experienced discrimination in health care settings are less comfortable with efforts to collect social risk data in clinical settings. Others have raised concerns about re-traumatizing some patients if screening for social needs is not administered by providers trained in trauma-informed care. Some groups have developed training methods to ensure that social needs screening is pursued with empathy. While more research is needed to identify the best approaches to social health screening with different populations and settings, enough knowledge exists now to guide development and testing of theoretically promising approaches.
Strategies to improve patients’ social conditions include efforts to provide social services on-site or to refer patients to relevant off-site services. Some clinical systems have opted to focus services on specific social risk factors like food or housing insecurity, financial or legal counseling, or social support; others are more comprehensive. Some programs serve only patients with a particular chronic illness such as diabetes, while others are offered to all patients served by a given health care site or system. While more evidence is needed to identify the most effective and efficient approaches to addressing social needs through health care system efforts, below are selected examples (with additional examples in Section 4) that illustrate a range of approaches.

- The use of **community health workers** (CHWs) dates back many decades, but recent updates reflect increased understanding of how CHWs can help improve health equity. For example, the **IMPaCT model** features the provision of social support, advocacy, and health care system navigation by trained CHWs to help socioeconomically vulnerable patients achieve their health goals. The University of Pennsylvania’s Center for Community Health Workers, which developed the IMPaCT model, currently employs 40 full-time faculty and staff who serve more than 1,500 socially high-risk patients annually. The model has been adopted by the Veterans Affairs Medical Center and Keystone First, the largest Medicaid managed care provider in southeast Pennsylvania. IMPaCT has been associated with improvements in “post-hospital primary care access, chronic disease control, and mental health while also reducing hospital admissions by 65%” among participating patients (in a before-after comparison).

- **CityBlock** is a Brooklyn, New York-based program that relies on highly-trained CHWs, a technology platform called Commons that streamlines individual care plans, and partnerships with community members and organizations to address the needs of people in neighborhoods with high poverty rates and accompanying social challenges; the goal is to improve the health of the highest-risk community residents and reduce costs to Medicaid Managed Care Organizations.

- Many other care coordination/navigation/support models rely on staff other than CHWs, including social workers. One is the **Ambulatory Integration of Medical and Social (AIMS) model** developed at Rush University Medical Center. AIMS social workers in medical centers use a standardized protocol to assess the health and social needs of complex patients and provide risk-focused care coordination and intervention.
• For some patients, legal expertise and action may be needed to address health-damaging social conditions. Such conditions include unhealthy housing conditions that have not been adequately addressed by landlords as well as public benefit denials and delays. Over 300 health care systems in 46 states now have Medical-Legal Partnerships; many embed legal specialists on-site. Different approaches to integrating medical and legal services have been studied\textsuperscript{183} and integrated practice is increasingly endorsed by government agencies and professional medical associations. In 2014, for example, based on growing evidence on the effectiveness of integrated services, the Health Resources and Services Administration (HRSA) designated legal services as an “enabling service,” allowing health centers to use federal dollars to pay for on-site legal services.\textsuperscript{184}

• In a co-located program akin to Medical Legal Partnerships, StreetCred provides free tax preparation services to families receiving pediatric care at Boston Medical Center. The goal is for low-income families to obtain tax refunds and tax credits. Since 2016, StreetCred has filed returns for over 700 families, resulting in total returns of $1.6 million. Research suggests that the greater financial stability achieved through StreetCred contributes to higher participation in pediatric care and lower levels of childhood “toxic stress.”\textsuperscript{185}

• Since 2014, Community Servings of Massachusetts has partnered with accountable care organizations and Medicaid and Medicare managed care plans to provide meals tailored to medical needs to high-cost, high-social-needs patients receiving clinical services at home. Studies on the effectiveness of these and other meal delivery programs suggest that they can lead to both health improvements and health care savings.\textsuperscript{186}

• In 2012, The Center for Medicare and Medicaid Innovation funded University of Chicago researchers to create a system that would assist medical providers in providing referrals to social services.\textsuperscript{187} During the three-year pilot, the technology platform generated over 250,000 “HealthteRxs” (that is, referrals for community services) for over 110,000 patients. All but one of the over 19,000 participating agencies continued using HealthteRxs after the pilot ended.\textsuperscript{188} An evaluation concluded that the resource platform contributed to improved primary care and fewer hospital admissions for Medicare patients.\textsuperscript{189}
Health Care Sector Efforts to Improve Health Equity by Improving Social Conditions in the Community or At a Population-Wide Level.

As the health care sector increasingly recognizes the importance of social conditions for health, more health care organizations are moving beyond the traditional boundaries of medical care to explore opportunities for improving conditions in the communities where their patients live.\textsuperscript{147,190} Community-level strategies reflect the perspective that “upstream” interventions (e.g., housing, food, employment) focused on geographically defined populations are likely to achieve larger and more equitable gains in population health than more traditional “downstream” efforts focused primarily on medical care and behavior change.\textsuperscript{191,192} particularly for communities with many unmet social needs.\textsuperscript{193}

Efforts to strengthen resources in disenfranchised communities can present critically important opportunities to advance health equity. Some community-level strategies focus on particular social conditions, such as housing, while others are more broadly focused. Examples include: shifting hiring and contracting practices of health care organizations to invest in the community and specifically in community members and businesses, and developing pipeline programs (e.g., providing skills training and networking support) that create opportunities for local residents to qualify for employment in the future. Many community-level efforts involve collaborations with other sectors (such as housing, early childhood education, or transportation); the roles played by health care organizations range from being the lead convener to supporting efforts led by others.

Unfortunately, given the often outsized financial power and influence of health care institutions, their actions run the risk of undermining existing community-based plans or initiatives. This can happen especially when decisions are made without adequate consideration of community stakeholders’ perspectives on their own needs and priorities. Real estate decisions are often a point of contention.\textsuperscript{194,195} Even well-intentioned efforts, such as programs to increase contracts with minority vendors, can end up doing more harm than good without strong guidance from the people that the programs are intended to help.\textsuperscript{196} Health care systems should be aware that any large scale effort to intervene in a community may cause harms they have not considered, and ensure that marginalized groups are adequately involved in selecting and guiding interventions.

Some health care institutions have attempted to improve health equity on a community- or population-wide basis through advocacy for policies in a range of sectors that influence health. For example, over the last decade, organizations of health care professionals, including nurses, social workers, and physicians have increasingly adopted formal statements on health
equity that recommend policy action on community-level social conditions. Common recommendations include ensuring that community voices are heard in all decisions affecting the community; the need for more intervention-oriented research on social determinants; and the adoption of a “health in all policies” approach that integrates health considerations into community planning processes in all sectors.171,197-199

The following are examples of health care sector efforts aimed at improving conditions in communities and/or populations. As with the previous examples, current knowledge is inadequate to endorse specific best practices. More examples of community development initiatives involving health care organizations can be found in Section 4 and at BuildHealthyPlaces.org.

- **The Democracy Collaborative** supports a national network of 40 health care anchor institutions (“large organizations with the potential to make communities healthier by leveraging their stature and resources”) working to build “more inclusive and sustainable local economies”—a strategy that could have a particularly significant impact on marginalized communities.

- Cincinnati Children’s Hospital Medical Center is an anchor institution playing a lead role in **The All Children Thrive Learning Network**, collaborating with others including schools, childcare organizations, public health, local government, and community members. The Network’s vision is “to help ensure Cincinnati’s 66,000 children are the healthiest in the nation through strong community partnerships.”201 The Network uses methods promoted by the Institute for Health Care Improvement and the National Academy of Medicine to pursue patient- and community-level improvements, targeting outcome measures agreed upon Network members. Early efforts have been associated with reductions in extremely preterm births and hospital bed days in high-need neighborhoods.202 Similar efforts are happening nationwide.203

- **The Greater University Circle Initiative** in Cleveland is an example of several anchor institutions—including the Cleveland Clinic and University Hospitals—working together toward this end. Promising results include the establishment of a cooperative enterprise that is building community wealth through employee ownership. Others include home improvements, and a business growth and retention program that resulted in more than $200 million of investment in new homes and businesses by the city and private partners in a disadvantaged neighborhood.204 Diverse anchor institution strategies for workforce development, purchasing and investment have been described.205
In 2018, the **Local Initiative Support Corporation** (LISC) and the integrated health system **ProMedica** launched a $45 million investment building on their past efforts to address the social determinants of health in Toledo, OH, and the surrounding region; more than half of the region’s residents live in poverty and 30 percent are unemployed. The initiative provides job-training opportunities, a grocery store offering affordable healthy food, and a health clinic with CHWs. A financial opportunity center provides employment-training opportunities, income supports and coaching/counseling to support clients’ financial well-being. The grocery store, financial opportunity center and job training services are co-located. \(^{206}\) ProMedica reports that the partnership is beginning to observe desired changes in health care utilization and costs. With the large new investment, Promedica will further explore ways the partnership can improve neighborhood conditions.

Since 2011, **UnitedHealthcare** has invested over $400 million to build 80 affordable housing developments across 18 states, aiming to provide homes to more than 4,500 families and individuals in need (including people with disabilities, homeless persons, seniors, and military veterans). Investments are made through regional and national organizations such as the Greater Minnesota Housing Fund and U.S. Bank. UnitedHealthcare’s initiative also includes on-site health care, counseling, job training, childcare, and other critical services. \(^{207}\)

In 2014, **Wake Forest Baptist Health** in North Carolina decided to hire only local housekeepers rather than outsourcing janitorial services, thereby reducing unemployment—a powerful determinant of health—in the community. \(^{208,209}\)

The **Convergence Partnership** “is a collaborative of foundations and healthcare institutions working to foster healthier and more equitable environments for all children and families.” PolicyLink, a prominent national policy think-tank and advocacy group, directs it. Ascension Health, Kaiser Permanente, and Nemours are among the national partners. A core strategy of the Partnership is to advocate for policies that advance health equity, with a focus on community-level social factors, including access to healthy food and transportation. \(^{210}\)

The American Academy of Pediatrics’ **Agenda for Children**: Health Equity recommends a range of key community-/population-wide policies with implications for health equity across the lifespan; these could serve as a source of ideas for initiatives in which the health care sector can play a lead or supportive role. \(^{211}\)
A Call to Action: Recommendations for Health Care Sector Actions to Advance Health Equity

The following recommendations call for actions by the health care sector, which has a sizable stake in advancing health equity: greater equity in both health care and the social determinants of health will contribute to better health outcomes and reduced health care expenditures. Although many of the recommendations require collaborations with other sectors, all of these actions are within reach, if sufficient will is present. These recommendations do not represent a comprehensive agenda for achieving health equity; if pursued successfully, however, they can powerfully advance this goal.

Some of the recommendations below are focused on achieving equity in health care, which is one critical step towards achieving health equity. Yet those inside and outside the health care sector must constantly be aware that this comprises only part of a comprehensive health equity strategy, which must also promote fairness and justice in the full range of underlying factors that ultimately will help achieve good health. A comprehensive health equity strategy would require improving equity in social conditions as well as in health care; it would address structural racism and race-based and other discrimination within and beyond health care delivery systems. This will not be simple. Many stakeholders are involved, some with conflicting agendas; and the issues are complex. While the health care sector alone cannot be expected to cure social and medical ills with deep roots in historical inequities, health care leaders and providers often have the credibility, resources, and influence to serve as key collaborators for greater health equity.

The causes of health inequities are rooted in generations—sometimes centuries—of unfair policies and practices that have systematically given some groups of people fewer opportunities to experience health-promoting social conditions, including good health care. Undoing deeply rooted, cross-sector causes of inequities and creating and sustaining structures, policies, and practices that advance health equity will require a sustained commitment on the part of many organizations and individuals. The relevant science for identifying the most effective community-based and social interventions is in early stages, but the health care sector can take well-informed actions now that are essential for achieving greater opportunities for everyone to be healthy. Long-term commitments and long-term evaluation frames are essential.

**Box 8**

Recommendations for the health care sector to advance health equity

- **Recommendation 1**
  Dismantle Structural Racism and Other Discrimination Institutions

- **Recommendation 2**
  Advocate for Policies to Remove Financial Barriers To Health Care

- **Recommendation 3**
  Advocate for Policies to Improve Equity in the Social Determinants of Health

- **Recommendation 4**
  Engage In and Learn From Respectful Collaborations With Community Members

- **Recommendation 5**
  Conduct and/or Support Rigorous Evaluations of Health Equity Interventions to Identify What Works
Arguably, the need for actions by the U.S. health care sector to address inequitable social conditions reflects an under-resourced social safety-net that should have been put in place and maintained by other sectors, such as employment, housing, education, and transportation. In comparison with other affluent democracies, the United States invests relatively little in social services and public infrastructure. We currently rank 21st on the Organisation for Economic Co-operation and Development’s (OECD’s) list of percent GDP spent on social welfare. Until our society dramatically increases its investment in the social determinants of health, however, the health care sector will continue to be the ‘first responders’ to the health outcomes of inequitable social conditions—and those conditions will continue to hinder health care sector efforts to provide truly effective care. Ultimately, health care and other sectors should work closely together to advance health and health equity.

As described in the previous section—with additional examples in Section 4—many health care providers and payers are currently engaged in innovative efforts to address inequities in health and health care. The following recommendations about how to advance health equity are intended to help health care stakeholders and decision-makers—including providers, payers, academic medical centers, philanthropies, and government, nonprofit, and advocacy organizations—whether they are just beginning to contemplate or are already deeply invested in advancing health equity.

**RECOMMENDATION 1**

**Dismantle Structural Racism and Other Discrimination Within Health Care Institutions.**

While achieving health equity will require more than the efforts of the health care sector alone, health care systems are uniquely positioned to advance health equity through actions within their own institutions and networks. Health care leaders, providers, and payers should shape organizational norms by explicitly calling out health equity as a value and commitment and visibly modeling ways to actively address it. They should not only be vocal in highlighting the importance of equity in health and health care, but they should “walk the walk,” working to identify and redress inequities in internal policies, governance and practices (for example, in hiring, promotions, contracting, and student admissions) and setting an equitable-outcome-based agenda for promised actions. They should create incentives promoting equity, diversity, and inclusion in hiring, staff promotions, contracting, and all organizational functions. Health care leaders should also advocate for similar changes throughout their professional networks, associations and local, state and federal governments.
Health care leaders should routinely assess internal policies, practices and systems that may, however unintentionally, contribute to inequities in access, treatment and outcomes using one of many tools and resources available (see Resources). This regular internal evaluation should include reviewing health system data disaggregated by meaningful markers of social advantage and disadvantage (e.g., racial/ethnic group, insurance status, poverty levels, and English proficiency). The data should be examined routinely and periodically for disparities in health or health care, discussed with community partners, and used to develop strategies to address gaps.

A complementary approach to reducing bias in health care that has received considerable attention is training personnel to recognize and address conscious and unconscious bias, often referred to as cultural humility or cultural competence training. Without the reinforcement of active and sustained efforts to change organizational policies, structures, and procedures, however, the effects of such training programs may be limited.215-218

RECOMMENDATION 2
Advocate for Policies to Remove Financial Barriers to Health Care.

Improvements in health care delivery will not lead to greater health equity if people cannot access care. Given the overwhelmingly powerful role of financial barriers to health care,219 and the health care sector’s unique vantage point and knowledge, the health care sector must be on the front lines in advocating to eliminate inequities in financial access to health care. It is beyond the scope of this report to discuss specific approaches to eliminating financial barriers to health care access, however, diverse approaches have been proposed, including: universal coverage with public, private, or a mixture of public and private health insurance and the direct provision of health care services by government (as done in the United Kingdom). Any solution that aims for equity must promote universal access.

Sustaining an equitable health care system also requires more equitable models of health care payment—such as pay-for-performance incentives—that do not penalize providers who serve disadvantaged populations. More equitable payment models will enable providers to address social conditions alongside medical care.

Removing financial barriers to health care cannot be accomplished solely within the health care sector. It will require major policy changes by government, primarily at the state and national levels, although as noted earlier in this brief, impressive local efforts have been launched as well. Health care leaders, providers, and payers can be powerful spokespersons
for universal access, testifying to the health impact on their patients as well as the increased costs of health care resulting from inadequate access to or quality of care. The health care sector has a proven strength in advocacy, but it has too often not demonstrated a will to act to reverse unfair policies and practices. Health care leaders and organizations, along with influential partners from other sectors, should use their power to advocate for policies that can have a large impact on reducing health inequities.

**RECOMMENDATION 3**

**Advocate for Policies to Improve Equity in the Social Determinants of Health.**

Health care leaders and providers are needed to play a key role in advocacy for policy and system changes that will shape underlying opportunities to be healthy, including social conditions such as housing, education, transportation, community development, employment, minimum wage standards, and childcare. Strategies focused on individual patients or even on individual communities are likely to be insufficient to move the needle on population-level health equity. For example, a health care system may mount an effort to see that patients with unmet social needs are referred to community services; however, the needed services often do not exist, or are so overwhelmed by demand they cannot meet the needs of the population served. And, people often have multiple, co-existing unmet social needs, so addressing only one or a few of those needs may not result in improved health.

Advocacy by health care sector leaders and providers is needed to promote policies that will pay the health care sector for the implementation of effective social interventions.220,221 For example, improvements in early life social conditions can have a great and lasting effect on health and health care utilization.221 These improvements in health, however, often manifest only over long periods of time, typically decades or generations after the improvements occur. Achieving health equity requires a lens that is widened to include multi-generational approaches. New strategies are needed to ensure that entities incurring the costs of interventions will be credited with successes that primarily manifest in other sectors and time periods; this will require profoundly different approaches—particularly inter-sectoral strategies—to planning and funding.

The health care sector’s unique voice is critical to influencing the political, legislative, regulatory, and legal processes that are needed to achieve these policy changes. One of the first steps toward advancing an advocacy agenda will inevitably include systematically planning how to move that agenda forward through the political process. Examples of policies for which the health care sector should advocate based on their likely impact
on health equity include: removing financial barriers to access to care; minimum wage and paid leave initiatives; the Earned Income Tax Credit; access to early childhood education (pre-K) programs; and housing subsidies. The health care sector should work as an advocate along with advocates and leaders from other sectors to seek the reversal of the underlying social inequities that contribute to worse health outcomes among marginalized groups. Policy changes locally, statewide, and nationally in many sectors can lead to better opportunities for good health, tackling the omnipresent dual root causes of health disparities—discrimination and poverty. Health care leaders, providers and payers can be powerful spokespersons, testifying to the health impact on their patients as well as the increased costs of health care resulting from adverse social conditions and inadequate access to or quality of care.

RECOMMENDATION 4
Engage in and Learn From Respectful Collaborations With Community Members.
Residents have unique knowledge of their own community’s assets and deficits. Their voices should be elicited and fully considered in planning and implementing efforts to advance health equity, whether the initiatives are specifically community-focused or not. Healthcare organizations can take several steps to engage community residents. These include not only identifying and acknowledging historical actions that may have harmed some members of the community, but also bringing the community’s formal and informal leaders and advocates to the table to identify existing community resources, needs, and priorities. Community engagement should involve efforts to increase resident awareness, participation, and feedback; and it should support active resident leadership. Many community engagement efforts emphasize the first two types of engagement but fail to include activities initiated and/or led by community residents or to create meaningful opportunities for residents to participate in shared decision-making. Community engagement without active resident leadership risks undermining trust, particularly if residents contribute but fail to see decisions and actions that reflect their recommendations. This can jeopardize the success of current and future investments in community improvements.

RECOMMENDATION 5
Conduct and/or Support Rigorous Evaluations of Health Equity Interventions to Identify What Works.
Evaluations to identify best practices have not kept pace with the wide range of innovations now underway. Yet high-quality evidence is needed to identify which approaches yield positive results, for whom, and at what cost. This information is vital both to ensure the best use of resources for
subsequent efforts, and to ensure continued and increased support for health equity initiatives from the public, policy-makers, and health funders. To accomplish this, health care leaders, providers, researchers, and funders must insist on the rigorous evaluation of health equity interventions. This does not mean that all evaluations must be randomized trials; that would be infeasible in most cases. However, more can and should be done to design strong evaluations, e.g., by having an appropriate comparison group or lengthening follow-up frames. This requires including the perspectives of community and patient stakeholders and considering early how to address potential confounders. Potential limitations of the evaluation design need to be addressed from the beginning, rather than confronted for the first time in the analysis and reporting phases when little can be done to mitigate it. When evaluations have weak designs, crucial lessons learned may never be available to guide others. Research/evaluation funders must be encouraged to recognize the challenges often posed by such research, such as cost, complexity and long timeframes for important health outcomes to manifest.

Fundamental to solid evaluation and research is consensus on research/evaluation tools used in this field. Consensus is lacking on measures of accountability—e.g., ways of measuring the quality of care or improvements in social conditions—for health equity interventions. Federal health and research agencies could play a key role in developing these core outcome measures, but the perspectives of many stakeholders, including patients, families, and communities should be considered. In medicine, the premature adoption of accountability measures without adequate input from key stakeholders has occasionally led to harm.
Examples of Relevant Health Care Sector Efforts

The examples described here of health care sector actions to improve equity are grouped into three broad categories (although some examples span more than one category): (1) actions to improve equity in access and quality within the health care system; (2) actions to improve the social conditions of individual patients; and (3) actions to improve social conditions at the community or population level. Examples were selected to reflect diverse and innovative models. To the extent possible, we also have highlighted programs where outcome data are available.

1. Health Care Sector Efforts to Advance Equity in Health Care Access and Quality

Dismantling bias and making health care services more culturally and linguistically appropriate and respectful.

- The Massachusetts General Hospital Disparities Leadership Program is an example of systematically integrating training on equity-oriented organizational change into routine management training. Training for health-care leaders and providers includes topics broadly related to the social determinants of health and specifically racial equity, implicit bias, diversity and inclusion.228

- The American Hospital Associations launched the #123forEquity Campaign to Eliminate Health Care Disparities in 2015. Health systems and clinicians pledge to take action within their institution within a year to address disparities. Health system leaders and hospitals are advised to provide progress updates and publicly share their accomplishments in promoting diversity and health equity; a form to pledge to the campaign is on the Equity of Care website (link provided in Resources). This document includes a list of additional Equity of Care resources, as well as a link to the #123forEquity Pledge Toolkit, Equity of Care: A Toolkit for Eliminating Health Care Disparities, “a user-friendly “how-to” guide to help accelerate the elimination of health care disparities and ensure hospital leadership and governance reflect the communities they serve.” The toolkit walks through each action that is pledged.

- Case Studies in Social Medicine,229 a new series of articles in the New England Journal of Medicine, presents clinical cases alongside relevant “theories and methods for understanding social processes and intervening to effect change.” The series focuses on the concept of

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32 | Copyright 2019 Robert Wood Johnson Foundation
structure, “durable patterned arrangements...that produce and maintain social inequalities and health disparities,” and teaches specific steps to address structural challenges that arise in the context of clinical practice. For example, the first article in the series focuses on the concepts of “medicalization” and “demedicalization,” highlighting how different understandings of the connections between a patient’s homelessness and his clinical diagnoses lead to different recommendations for and against hospitalization.

**Incentivizing providers and students to work with underserved populations.**

- **The University of California’s Program in Medical Education for the Urban Underserved (PRIME-US)** is a five-year-long program preparing students to work in under-resourced rural and urban settings. Launched in 2006, PRIME-US is funded by the State of California with supplementary support from individual donors, the California Endowment, and other major foundations.

- The **Charles R. Drew/UCLA Medical Education Program** prepares students to practice and advance knowledge in disadvantaged areas within the U.S. and abroad. Drew/UCLA graduates are significantly more likely than their peers in the traditional UCLA medical program to practice in an underserved or physician shortage area.

**Increasing health care workforce diversity.**

- The **Michigan State University College of Human Medicine (MSUCHM)** established the **Rural Physician Program (RPP) in 1974** to address primary care and rural physician shortages. This long-standing program seeks students of rural origin and provides rural clinical experiences. Compared with other MSUCHM graduates, RPP alumni are more likely to choose primary care or other specialties lacking in rural areas and to practice in rural and health professional shortage areas.

- In 2012, **Robert Wood Johnson University Hospital in NJ** launched a three-year strategic plan to improve equity and increase workforce diversity. Beyond efforts in hiring, the plan focused on community engagement, achieving greater equity in patient care, and corporate alignment; together, these areas constituted 15 percent of the dashboard of measures for determining executive compensation. Ethnic and racial minorities now constitute 22 percent of the board of directors and 34 percent of executive leadership.

- See in main text: **Henry Ford Health System.**
Facilitating enrollment of patients in coverage programs.

Sterling Regional MedCenter has partnered with Integrated Health Management Services (IHMS) to help patients enroll in health insurance across 21 Banner Health facilities in six states. In addition to signing patients up for health insurance they qualify for (such as Medicaid or CHIP), IHMS specialists counsel patients on how to obtain a number of other benefits, including housing and utilities assistance and other social services.\(^{232}\)

Systems reforms in payment, organization, and/or health care delivery to improve access and quality for disadvantaged populations.

Fourteen years ago, the Robert Wood Johnson Foundation launched *Finding Answers: Solving Disparities Through Payment and Delivery System Reform*\(^{146}\) to inform health-care system interventions to reduce health disparities. In 2014, RWJF funded the following two projects to examine the effect of combining changes in care delivery with provider payment incentives:

- In a partnership between the University of Washington and Advantage Dental Services in Oregon, staff receive pay incentives if they meet screening, preventive services, and treatment targets for patients screened at Head Start, schools, and WIC offices. The program focuses on reducing dental care disparities affecting low-income pregnant women and children in rural areas. Evaluation is ongoing.

- George Mason University and Molina Health care partnered to implement a system change to increase productivity and improve processes of care to meet disparity reduction targets. The program serves low-income, uninsured, mostly Hispanic residents. Results suggest the program may have significantly improved disparities in blood pressure control; however, disparities in other health outcomes did not appear to change.\(^{151}\)

- See in main text: A third *Finding Answers* project led by the Mount Sinai School of Medicine and Healthfirst.

The Robert Wood Johnson Foundation Advancing Health Equity: Leading Care, Payment, and Systems Transformation Program aims to align state Medicaid agencies, Medicaid managed care organizations, and frontline health care organizations through payment reform that supports and incentivizes care transformations designed to reduce health disparities.
• **Project ECHO** (i.e., Extension for Community Health care Outcomes) at the University of New Mexico Health Science Center connects primary care clinicians in rural and underserved areas with specialists through an inexpensive videoconferencing system. The technology allows clinicians to manage complex health problems while delivering home-based care where access to health care is limited. Project ECHO began in New Mexico and is now used across the whole Veterans Administration system. It has been replicated nationally in prisons, hospitals, and community and military health clinics.233

**Identifying and reducing obstacles to access and utilization of health care experienced by disadvantaged groups.**

• See in main text: [Navicent Health](#) and the [Greensboro Health Disparities Collaborative](#).

**Primary care orientation.**

• Some scholars have argued that orienting health care systems toward more emphasis on primary care and less on specialization is inherently more conducive to achieving greater equity in health and health care.234,235

**Transportation assistance.**

• In February 2019, [Blue Cross Blue Shield and Humana](#) announced a partnership with the ride-hailing service [Lyft](#) to provide Lyft rides to medical appointments for members facing transportation barriers (i.e., those living in so-called “transportation deserts”;236 this could “help put a dent in the US health care industry’s $150 billion no-show problem.”237

• [Uber](#) is engaging in similar efforts as Lyft, hiring two new health care consultants (one from Lyft) to help provide patients transportation to medical appointments. The program, called [Uber Health](#), allows health care organizations to request and manage patients’ rides. Over 100 U.S. health care organizations are using Uber Health, including Georgetown Home Care, the NYU Perlmutter Cancer Center, and Renown Health, among others. Although the program is not exclusively for low-income patients, organizations are responsible for paying for patients’ rides.238

• [Callahan](#), a San Francisco-based ride-sharing company has partnered with Allscripts, Blue Cross Blue Shield and other health plans, the American Cancer Society, non-emergency medical transportation brokers, and large US health systems to provide patients with transportation to their doctor’s appointments.239
Comprehensive health system-wide efforts.

- The Henry Ford Health System’s (HFHS) Center for Health care Equity initiatives include, among others:
  - investment in Women Inspired Network, which aims to reduce infant mortality in Detroit through peer-support and group prenatal care;
  - collecting patient demographic data for use in “Equity Dashboards” to track quality and service metrics to inform interventions; and
  - trainings in cultural competency for employees and clinicians.155,208

- Allina Health in Minnesota used research and targeted interventions to improve colorectal cancer screening rates among minority populations. The system conducted focus groups to better understand patient’s values, beliefs, and barriers to obtaining recommended screenings. The system used these data to develop interventions, including mailing patients home screening kits, developing culturally- and linguistically-tailored education materials, connecting patients to transportation and other services, launching social media campaigns to reach African American and Spanish-speaking patients, and monitoring intervention effectiveness among the most high-risk patients. These initiatives were accompanied by a small (3%) but statistically significant improvement in colorectal cancer screening rates for targeted populations.240

Advocacy for policies to remove barriers to health care access and quality for disenfranchised populations.

- Under California law as of 2005, Continuing Medical Education (CME) courses are required to include training in cultural and linguistic competency.241 Health care professionals and organizations in other states might advocate for similar legislation in order to help clinicians understand their role in reducing health disparities.

- The American Medical Association recommends five strategies to improve access to care among uninsured populations. In brief, these include ensuring adequate funding of CHIP and expanding Medicaid, “[stabilizing] individual insurance marketplaces and [retaining] ACA market reforms,” remediate physician shortages, expanding digital health solutions including telehealth and remote patient monitoring, and increasing the efficiency of the existing health-care workforce.242
2. Health Care Sector Efforts to Advance Health Equity by Improving the Social Conditions of Individual Patients

Community Health Workers.
- See in main text: the IMPaCT and AIMs Models, CityBlock.

Medical Legal Partnership.
- Through the Medical-Legal Partnership | Boston, health care providers and lawyers team up to ensure patients’ basic needs, such as food, housing, and education are met. The medical-legal partnership exclusively serves vulnerable groups including “children, the elderly, patients with cancer, pregnant women, the formerly incarcerated reentry community” and others.243 Over 300 health-care systems in 46 states now host medical-legal partnerships.

Financial services.
- $tandbyMe Delaware provides free financial coaching to all Delaware residents. The program was born out of a partnership between the State and United Way of Delaware. The program is offered through partnerships with health care providers, social service systems, employers, and others. It also provides free tax preparation through the Volunteer Income Tax Assistance (VITA) program, financial education and access to accounts. Since 2011, $tandbyMe has been credited with helping more than 110,000 Delawareans reach their financial goals, reaching more than 5% of the population of Delaware. The program has been associated with improved credit scores on average by 64 points, savings of more than $3.3 million, and reduction in personal debt by $19.6 million. It has been associated with higher educational attainment among Head Start children.244

- See in main text: StreetCred.

Meal delivery.
- Blue Cross Blue Shield recently launched healthy food delivery service (known as foodQ) for Chicago and Dallas residents living in “food desert” zip codes. Eligible participants do not have to be Blue Cross Blue Shield subscribers. Participants pay $10 for two meals if they subscribe; non-subscribers must pay $10 per delivery plus a $6 delivery fee. In announcing the new service, Health Care Service said, “Through the foodQ service, the companies will offer consumers easy access to affordable, nutritious foods to improve their health outcomes, particularly for diet-related, chronic conditions, while reducing avoidable emergency room visits and hospital admissions.”245
The Cleveland Clinic’s Community Farmers Market program provides fresh produce near hospitals and community health centers. Shoppers are able to utilize WIC Farmers’ Market Nutrition Program (FMNP) benefits, Ohio Electronic Benefit Transfer (EBT) cards, USDA Senior Farmers Market Nutrition Program coupons, and City Fresh Fresh Stops. In addition to improving shoppers’ nutrition, the program can support local farming and help strengthen Northeast Ohio’s economy.246

See in main text: Community Servings of Massachusetts.

Other prominent examples of health care sector actions to promote food security include Anthem’s healthy meal-based benefits247 and ProMedica’s three-acre farm and Veggie Mobile program.248

Technological tools to link medical and social services.

- **Health Leads** is a national nonprofit organization with offices in Boston, MA and Oakland, CA, that assists health systems and community organizations in the design and implementation of programs to screen for social risk factors, assess individual and household social needs, and make closed-loop referrals to community-based resources. For example, staff may support patients to obtain food from a local food pantry or to obtain discounted public transportation passes. Several studies suggest modest improvements in social risk and health outcomes from similar programs for both adult and pediatric populations.249,250 Recent experience suggests that combining individual screening and referral programs with systems change initiatives has the potential to improve population health and health equity.251

- Kaiser Permanente, the largest nonprofit health plan in the US, recently launched **Thrive Local**, the most comprehensive coordinated referral network to date addressing patients’ social needs, including transportation, housing, and food. By 2022, the network will be available to all Kaiser members nationwide (approximately 12.3M) and 60M people in communities the nonprofit serves. Clinicians will be able to match patients’ needs with appropriate services within the network, including nonprofit, public and private resources. The project will monitor referral and service outcomes to evaluate whether members’ needs are met and inform quality improvement. Unite Us, a social care coordination platform, will partner with Kaiser to strengthen the network.252
In partnership with Unite Us, the company CVS Health will launch Destination: Health, a new social care network available to Aetna Medicaid members in Louisville, Kentucky and Aetna dual-eligible special needs members in Tampa, Florida and Southeastern Louisiana. The network will connect members with social services. The company will determine its service priorities based on the market; it is considering using stores as distribution centers for case management, supportive housing, and other community resources. The network’s goal is to eventually cut downstream health care costs by addressing subscriber’s social needs.\(^{253,254}\)

In 2019, Kaiser Permanente and UniteUs launched a coordinated referral network based on patients’ electronic health records linked with information on social conditions. The project aims to enable health care and social services providers to better coordinate care for patients facing social barriers like food or housing insecurity. By 2022, Kaiser plans to make the technology coordination platform available not only to its 12.3 million members nationally, but also to the patients served by community health centers in Kaiser communities across the United States. Multiple other community resource platforms offer similar coordination functionalities.

See in main text: “HealtheRxs.”

Improve data collection and integration to improve access and health outcomes.

UnitedHealthcare and the American Medical Association recently partnered to develop new billing codes that address the social determinants of health in routine medical care. The organizations are working together to standardize data collection, processing, and integration on key social indicators.\(^ {237}\)

Programmatic Partnerships.

In 2019, the global health services company Cigna will launch a five-year, $25 million initiative to combat food insecurity in partnerships with schools and community groups worldwide. The effort will support school- and community-based programs that promote access to year-long nutritional education and access to healthy foods. It also will support nutrition services for expectant mothers, caregivers, and pre-school children. Moreover, Cigna will fund health-care provider initiatives to help patients access nutrition education and/or food programs, and school-based programs that bolster state and/or federal assistance programs efforts.\(^ {255}\)
In 2019, Centene Corporation invested in developing **Social Health Bridge™ Trust** to streamline and accelerate local partnerships between medical organizations (including payers, risk-bearing medical groups and health systems) and community-based human service organizations. The goal of the trust is to facilitate new revenue streams for community-based organizations that can help them increase their collective capacity while also meeting the needs of medical organizations to improve patients’ health outcomes by reducing social determinants-related barriers to health.\(^{254}\)

**The National Association of Country and City Health Officials (NACCHO)** aims to enhance community health by strengthening and advocating for local health departments. The CDC funds NACCHO’s **Health and Disability Program**, one example of the organization’s work to promote equity, diversity, and inclusion. This program gives local health departments tools and resources necessary to promote the inclusion of people with disabilities in health department activities such as hiring, emergency preparedness, community health improvement planning, and maternal and child health services.\(^{256}\) NACCHO’s website includes policy statements and communications to Congress and the administration, funding priorities, legislative resources, and opportunities to take action (link in Resources).

### 3. Health Care Sector Efforts to Improve Health Equity by Improving Social Conditions in the Community or at a Population-Wide Level

**Place-based multi-sector collaboration.**

- The **Aligning for Health (AFH)** coalition, launched in 2018, includes payers like BlueCross BlueShield, CareSource, Humana, WellCare, and UPMC Health Plan, among others, with the goal of decreasing costs and improving outcomes by addressing the social determinants of health. Advocating for “more efficient, integrated and coordinated programs,”\(^{257}\) AFH has explored opportunities to coordinate with housing, food and transportation providers and job training organizations, as well as Medicaid. It has identified strategies that many sectors can pursue—often in partnership—to address social determinants of health. They have collaborated with county and state officials to better understand how to overcome barriers to addressing the social conditions of vulnerable and high-cost patients. The coalition aims to launch an advocacy campaign to enlist and inform supportive politicians, educate stakeholders, and work with state and federal agencies to “assist in developing Social Determinants Accelerator Plans.”\(^{258}\)
Health care anchor institution strategies.
- See in main text: Democracy Collaborative, All Children Thrive Learning Network, and the Greater University Circle Initiative.

Investments in community development and services.
- The city of Baltimore (where an estimated 2,500 people/residents are homeless) recently announced a partnership with 10 hospitals to provide housing and “wraparound” services for 200 people and families. Those housed will live in public housing units and units supported by vouchers, and will receive assistance with utilities, furniture, transportation to medical sites, and other services. These non-medical services will be paid for by Medicaid, while the hospitals will cover the local Medicaid expenses.259

- See in main text: LISC-ProMedica partnership, UnitedHealthcare’s affordable housing investments, and the Convergence Partnership.

- Multiple examples of community development initiatives in which health care organizations play a key role can be found at BuildHealthyPlaces.org.
Additional Resources

**Resources and tools for research and evaluation.**

- County Health Rankings and Roadmaps *What Works for Health* lists evidence-based policies and programs that can advance equity in health and health care. [https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health](https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health)

- Aligning for Health’s website includes a number of resources on how to take action, including a list of best practices and research to develop integrated, efficient, and coordinated programs that will advance health equity. [http://aligningforhealth.org/](http://aligningforhealth.org/)

- The National Institute of Minority Health and Health Disparities’ website lists funding opportunities, reports, and data resources. [https://www.nimhd.nih.gov/](https://www.nimhd.nih.gov/)

- The 2014 *Public Health Reports* article, *Transitioning from Health Disparities to a Health Equity Research Agenda: The Time Is Now*, reviews NIH research projects that “hold promise for advancing population health and improving health equity.” [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863705/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863705/)

- A presentation by Kirsten Bibbins-Domingo (UCSF) discusses the future of integrating social care into health care. [http://sirenetwork.ucsf.edu/sites/sirenetwork.ucsf.edu/files/SIREN19_BibbinsDomingo.pdf](http://sirenetwork.ucsf.edu/sites/sirenetwork.ucsf.edu/files/SIREN19_BibbinsDomingo.pdf)

- The Social Interventions Research & Evaluation Network at UCSF provides reports, commentaries, screening tools, implementation resources, and webinars and videos to advance “efforts to identify and address social risks in health care settings.” [https://sirenetwork.ucsf.edu/](https://sirenetwork.ucsf.edu/)

- The nonprofit organization Community-Campus Partnerships for Health lists resources for Community-Based Participatory Research. [https://depts.washington.edu/ccph/pdf_files/resources_CBPR_108.pdf](https://depts.washington.edu/ccph/pdf_files/resources_CBPR_108.pdf)

- The Robert Wood Johnson Foundation Advancing Health Equity: Leading Care, Payment, and Systems Transformation website has systematic reviews of the health disparities intervention literature and other resources to help implement the Roadmap to Reduce Disparities. [https://www.solvingdisparities.org](https://www.solvingdisparities.org)
Resources on measures for accountability.


- The Minnesota Department of Health has a guide for local health departments on conducting a health equity data analysis. [https://www.health.state.mn.us/data/mchs/genstats/heda/index.html](https://www.health.state.mn.us/data/mchs/genstats/heda/index.html)

- The Government Alliance on Race and Equity’s (GARE) website lists a number of racial equity and communication tools for advancing racial equity in health care and other sectors. [https://www.racialequityalliance.org/](https://www.racialequityalliance.org/)

- A form to pledge to the #123forEquity Campaign to Eliminate Health Care Disparities, which urges health systems and clinicians to pledge to take action within their institution within a year to address disparities, is located here: [http://www.equityofcare.org/pledge/resources/pledge_to_act.pdf](http://www.equityofcare.org/pledge/resources/pledge_to_act.pdf). Health system leaders and hospitals are advised to provide progress updates and publicly share their accomplishments in promoting diversity and health equity. The linked PDF includes a list of additional Equity of Care resources, as well as a link to the #123forEquity Pledge Toolkit, *Equity of Care: A Toolkit for Eliminating Health Care Disparities*, "a user-friendly “how-to” guide to help accelerate the elimination of health care disparities and ensure hospital leadership and governance reflect the communities they serve."

Resources for training providers and leaders on equity and inclusion.

- Racial Equity Tools, supported by the Project Change Anti-Racism Initiative and the Aspen Institute, offers a guide for training for racial equity and inclusion. [https://www.racialequitytools.org/resourcefiles/shapiro.pdf](https://www.racialequitytools.org/resourcefiles/shapiro.pdf)


- The EveryONE Project has a toolkit for advancing health equity through family medicine. [https://www.aafp.org/patient-care/social-determinants-of-health/everyone-project/eop-tools.html](https://www.aafp.org/patient-care/social-determinants-of-health/everyone-project/eop-tools.html)
In 2000 by the HHS Office of Minority Health released enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards). These standards are still considered the blueprint for health care organizations to provide culturally and linguistically appropriate services. (https://www.thinkculturalhealth.hhs.gov/clas) The document, and a compliance checklist, may be a helpful tool for providers and organizations to review their own practice.

The People’s Institute for Survival and Beyond (PISAB) hosts “Undoing Racism” trainings and workshops for health care and other organizations. http://www.pisab.org/

General readings and other resources related to policies to increase equity in health and health care.


Health Catalyst’s post, Health Equity: Why it Matters and How to Achieve It (2018) outlines the role of health care in health disparities and provides recommendations on how health systems can make health equity a strategic priority, address the social determinants of health, and collaborate with community based partners. https://www.healthcatalyst.com/health-equity-why-it-matters-how-to-achieve-it
• PolicyLink’s report, *Leveraging Anchor Institutions for Economic Inclusion*, offers recommendations on how anchor institutions, including hospitals and health care facilities, can develop anchor strategies to advance health equity and economic inclusion. [https://www.policylink.org/resources-tools/leveraging-anchor-institutions-for-economic-inclusion](https://www.policylink.org/resources-tools/leveraging-anchor-institutions-for-economic-inclusion)

• A podcast from the Institute for Health Care Improvement, *How Health Care Organizations Can Create Equity in the Community*, explores health system opportunities to reduce disparities and improve health equity, such as by providing living wages, engaging with low-income communities, and using their resources to develop neighborhood green spaces. [http://www.ihi.org/resources/Pages/AudioandVideo/WHIIEquityHealthOrganizations.aspx](http://www.ihi.org/resources/Pages/AudioandVideo/WHIIEquityHealthOrganizations.aspx)

• The Build Healthy Places Network showcases stories about how hospitals are investing in community development. [https://www.buildhealthyplaces.org/whats-new/bhpntopic/community-close-ups/](https://www.buildhealthyplaces.org/whats-new/bhpntopic/community-close-ups/)

• The journal *Health Affairs* published an open-access issue in 2017 entitled “Pursuing Health Equity” with several articles detailing key disparities in health care and actions to overcome them. [https://www.healthaffairs.org/toc/hlthaff/36/6](https://www.healthaffairs.org/toc/hlthaff/36/6)

• *UNNATURAL CAUSES …Is Inequality Making Us Sick?* is a seven-part documentary exploring racial and socioeconomic inequalities in health. The series has published an Action Toolkit for organizations who would like to use the series to educate, organize and advocate for effective policy change. [https://unnaturalcauses.org/download_toolkit.php](https://unnaturalcauses.org/download_toolkit.php)

• The RWJF funded project, *Finding Answers: Leading Care, Payment, and Systems Transformation*, which focuses specifically on practical solutions to reduce disparities through payment and systems transformation, has resources—such as program evaluations, systematic reviews, and a Roadmap to Reduce Disparities—on its website. [https://www.solvingdisparities.org/about/accomplishments](https://www.solvingdisparities.org/about/accomplishments)


• The National Association of County and City Health Officials’ (NACCHO) policy statements and communications to Congress and the administration, funding priorities, legislative resources, and opportunities to take action are located here: [https://www.naccho.org/advocacy/take-action](https://www.naccho.org/advocacy/take-action). Although NACCHO’s work does not focus exclusively on health equity, a large number of its programs and resources are relevant.

• The American Medical Association’s five recommendations to improve access to care among uninsured populations is located here: [https://www.ama-assn.org/delivering-care/patient-support-advocacy/5-ways-improve-access-health-care](https://www.ama-assn.org/delivering-care/patient-support-advocacy/5-ways-improve-access-health-care)
Guiding Principles for Advancing Health Equity

The following principles, first published in *What is Health Equity? And What Difference Does a Definition Make?*, the first report in this series, are fundamental to guide action to achieve health equity:

1. Achieving health equity requires societal action to remove obstacles to health and increase opportunities to be healthier for everyone, focusing particularly on those who face the greatest social obstacles and have worse health. It also requires engaging excluded or marginalized groups in identifying and addressing their health equity goals.

2. Policy, systems, and environmental improvements have great potential to prevent and reduce health inequities, but only if they explicitly focus on health equity and are well designed and implemented. Otherwise, such interventions may inadvertently widen health inequities. For example, public health anti-smoking campaigns inadvertently led to widened socioeconomic disparities in smoking because the untargeted messages were picked up and applied more rapidly by more educated, affluent people.

3. Opportunities to be healthy depend on the living and working conditions and other resources that enable people to be as healthy as possible. A population’s opportunities to be as healthy as possible are measured by assessing the determinants of health—social and medical—that people experience across their lives.

4. Pursuing health equity entails striving to improve everyone’s health while focusing particularly on those with worse health and fewer resources to improve their health. Equity is not the same as equality; those with the greatest needs and least resources require more, not equal, effort and resources to equalize opportunities.

5. Approaches to achieving health equity should build on and optimize the existing strengths and assets of excluded or marginalized groups.

6. Piecemeal approaches targeting one factor at a time are rarely successful in a sustained way. Approaches are needed that both increase opportunities and reduce obstacles. Successful approaches should address multiple factors, including improving socioeconomic resources and building community capacity to address obstacles to health equity.
7. Achieving health equity requires identifying and addressing not only overt discrimination but also unconscious and implicit bias and the discriminatory effects—intended and unintended—of structures and policies created by historical injustices, even when conscious intent to discriminate is no longer clearly present.

8. Measurement is not a luxury; it is crucial to document inequities and disparities and to motivate and inform efforts to eliminate them. Without measurement, there is no accountability for the effects of policies or programs.

9. The pursuit of equity is never finished. It requires constant, systematic, and devoted effort. A sustained commitment to improving health for all—and particularly for those most in need—must be a deeply held value throughout society.


