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

Executive Summary
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Foreword

This is the Executive Summary of a longer report, *What Can the Health Care Sector Do to Advance Health Equity?* Other reports on health equity from the Robert Wood Johnson Foundation include *What is Health Equity? And What Difference Does a Definition Make?, Early Childhood Is Critical to Health Equity, Wealth Matters for Health Equity, and Mass Incarceration Threatens Health Equity in America*. The first report defines health equity (below) and takes a deeper look at what it means and implications for action. These reports aim to assist those working in public health, health care, 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.

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Introduction

While modern medicine provides powerful tools for preventing illness, alleviating suffering, and saving lives, too many health care providers know the frustration of seeing patients who seek care sicker and later than they should because of financial and other barriers. And too many providers have experienced the helplessness of treating patients who later return—perhaps after an emergency room visit or inpatient stay—still sick because they could not escape the conditions that made them ill in the first place.

Despite growing recognition of the strong links between health and social conditions, widespread inequities in the social determinants of health have traditionally been viewed as beyond the purview of health care. Yet inequities in employment, housing, environment, transportation, and education not only limit the benefits of health care and frustrate dedicated providers, but also can hurt the bottom lines of health care organizations. As a result, health care stakeholders—including private and public payers and providers—have grown increasingly aware of the need to look not only at the design and delivery of health care but also beyond health care when mounting efforts to prevent needless suffering, premature death, and avoidable costs.

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.

According to this definition, health inequities are produced by inequities in the resources and opportunities available to different groups of people based on their racial/ethnic or socioeconomic group, disability or LGBTQ status; gender; and other characteristics closely tied to being marginalized or excluded.

Health Disparities Are Large, Pervasive, and Costly.
Research shows large and pervasive health disparities affecting low-income groups, African Americans/blacks, American Indians/Alaskan Natives, Hispanics/Latinos, some Asian subgroups, immigrants, people with disabilities, and LGBTQ persons. Disparities in health care exacerbate disparities in health for these groups. By one estimate, eliminating racial/ethnic health disparities would reduce health care costs by $230 billion and indirect costs of excess disease and mortality by more than $1 trillion over four years.
What Causes Inequities in Health and Health Care?

- Lack of health insurance and unaffordable medical expenses contribute to inequities in health and health care.\(^4,13-17\)

- Racial and other discrimination in health care settings, including discrimination affecting LGBT persons\(^{19-21}\) and people with disabilities\(^{22-24}\) has been identified as a major contributor to disparities in health and health care.

- Structural racism in health care institutions contributes to health inequity through discriminatory hiring and promotions and lack of racial/ethnic diversity among clinicians\(^{25-28}\) and leadership.

- Structural racism in society at large also is a fundamental driver of health inequities, systematically putting African Americans, American Indians/Alaskan Natives, and other racial/ethnic groups at economic and health disadvantage.

- Inequities in economic opportunity are an important contributor to health inequities.
Current Health Care Sector Initiatives to Advance Health Equity

With growing recognition of the root causes of health inequity and their pervasiveness and costs, the health care sector has sought to advance health equity through a wide range of policy, systems, and practice changes. Although many efforts are new and not all have been rigorously evaluated, many initiatives, including some of long duration with credible evaluation results, provide valuable information to guide future action and inform research priorities.29,30 Some current initiatives are described below; the full report provides many additional examples:

**Health care sector efforts to advance equity in health care access and quality.**

- NYC-based Mount Sinai School of Medicine receives enhanced payments from Healthfirst (a non-profit insurer) to involve social workers and care coordinators in postpartum follow-up for high-risk low-income women. Postpartum visit rates increased by 27 percent from 2015–2017.31

- After pledging to the American Hospital Association’s #123forEquity Campaign to Eliminate Health Care Disparities, Navicent Health in Central Georgia increased: collection and use of data on social factors; cultural competency training; and diversity in leadership and governance. Since then, leadership and governance diversity has increased over 15 percent,32 and black-white readmission disparities among patients with diabetes, heart failure, and chronic obstructive pulmonary disease were eliminated.33
Based on community input, the Greensboro, North Carolina Health Disparities Collaborative relied on trained nurse navigators to assist breast and lung cancer patients from diagnosis through treatment and recovery. Treatment completion among participants increased by 10 percent.34

**Health care sector efforts to advance health equity by improving the social conditions of individual patients.**

- The IMPaCT model developed at the University of Pennsylvania features social support, advocacy, and health care system navigation provided by trained community health workers to socioeconomically vulnerable patients. Adopted by the Veterans Affairs Medical Center and Keystone First, the largest Medicaid managed care provider in southeast Pennsylvania, it has been associated with reducing hospital admissions by 65% among participating patients.35,36

- In over 300 health care systems in 46 states, Medical-Legal Partnerships address legal needs related to social conditions; many embed legal specialists on-site. Based on evidence of effectiveness, the Health Resources and Services Administration designated legal services as an “enabling service,” allowing health centers to use federal funds to pay for on-site legal services.37

- StreetCred provides free tax preparation to families receiving pediatric care at Boston Medical Center. StreetCred has filed returns for over 700 families, producing total returns of $1.6 million. Studies suggest that the greater financial stability achieved through StreetCred contributes to higher participation in pediatric care and lower levels of childhood “toxic stress.”38

- Since 2014, Community Servings of Massachusetts has partnered with accountable care organizations and Medicaid and Medicare managed care plans to provide meals to high-cost, high-social-needs patients receiving clinical services at home. Studies of this and similar meal delivery programs suggest that they can lead to both health improvements and health care savings.39

**Health care sector efforts to improve health equity by improving social conditions in the community or at a population-wide level.**

Because strengthening communities is critical to advancing health equity, some health care sector efforts focus on improving specific resources (e.g., housing), while others are broader. Many of these community-level efforts involve collaborations with other sectors; health care organization roles range from lead convener to supporter of efforts led by others. Given the financial power and influence of many health care institutions, however, their actions may undermine existing community plans or initiatives. This can happen especially when decisions are made without adequate input from community stakeholders,40 including traditionally marginalized groups.
Some health care institutions have emphasized advocacy for social policies to advance health equity. For example, associations of nurses, social workers, and physicians have adopted statements on health equity recommending 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 integrating health considerations into community planning processes in all sectors.41-44

- The Greater University Circle Initiative in Cleveland involves several anchor institutions—including the Cleveland Clinic and University Hospitals—working together. Promising results include a cooperative enterprise building community wealth through employee ownership. Others include home improvements and a business growth program resulting in over $200 million of investment in new homes and businesses by the city and private partners in a disadvantaged neighborhood.45

- Cincinnati Children’s Hospital Medical Center plays a lead role in The All Children Thrive Learning Network, collaborating with schools, childcare organizations, public health, local government, and community members.46 The Network uses methods promoted by the Institute for Health Care Improvement and the National Academy of Medicine, targeting outcome measures agreed upon by Network members. Early efforts have been associated with reductions in extremely preterm births and hospital bed days in high-need neighborhoods.47 Similar efforts are happening nationwide.48

- Since 2011, UnitedHealthcare has invested over $400 million to build 80 affordable housing developments across 18 states to provide homes to families and individuals in need. Investors include the Greater Minnesota Housing Fund and U.S. Bank. UnitedHealthcare’s initiative includes on-site health care, counseling, job training, childcare, and other critical services.49

- The Convergence Partnership, directed by PolicyLink, “is a collaborative of foundations and healthcare institutions working to foster healthier and more equitable environments for all children and families.” Ascension Health, Kaiser Permanente, and Nemours are among the national partners. A core strategy is advocating for policies that advance health equity, focusing on community-level social factors such as healthy food access and transportation.50
A Call to Action: Recommendations for Health Care Sector Actions to Advance Health Equity

The following recommendations 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. While the relevant science for identifying the most effective interventions is in early stages, the health care sector can take well-informed actions now. Long-term commitments and long-term evaluation frames are essential because undoing multi-sector causes of inequities and creating and sustaining structures, policies, and practices that advance health equity will require sustained effort; in addition, the health consequences of social conditions often manifest only after a number of decades.

These recommendations for action by the health care sector do not represent a comprehensive agenda for achieving health equity; if pursued energetically, however, they can powerfully advance this goal. 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 influence and resources to be key proponents for greater health equity.

Arguably, the need for health care sector actions to address inequitable social conditions reflects an under-resourced social safety-net that should have been put in place by other sectors, e.g., employment, housing, education, childcare, and transportation. 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 adverse health consequences of inequitable social conditions—and those conditions will continue to hinder health care sector efforts to provide effective care.

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, 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 also “walk the walk,” working to identify and redress inequities in internal policies, governance and practice, and set an equitable-outcome-based agenda for action. They should create incentives promoting equity, diversity, and inclusion in hiring, staff promotions, contracting, and all organizational functions. They should advocate for similar changes throughout their professional networks.

Health care leaders should routinely assess internal policies, practices and systems that may, however unintentionally, contribute to inequities in access, treatment or outcomes using tools and resources that are readily available (see Resources in full report). This routine, periodic internal evaluation should include reviewing health system data disaggregated by meaningful markers of social advantage and disadvantage (e.g., racial/ethnic group, poverty level, insurance, and English proficiency). The data should be examined routinely for disparities in health or health care, discussed with community partners, and used to develop health equity strategies.

One approach that has received considerable attention is training health care 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 programs may be limited.51-54

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 adverse health consequences of inequitable social conditions—and those conditions will continue to hinder health care sector efforts to provide effective care.
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 impact of financial barriers to health care, and the health care sector’s unique vantage point, the health care sector must be on the front lines in advocating to eliminate inequities in financial access to health care. Any solution that aims for equity must promote universal access. Health care leaders, providers, and payers have unique credibility when speaking to the health impact on their patients and/or avoidable costs of health care resulting from inadequate access to care.

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 medical care providers to address social conditions that affect health and health care.

RECOMMENDATION 3
Advocate for Policies to Improve Equity in the Social Determinants of Health.
Health care leaders and providers should advocate for policy and system changes that will shape underlying opportunities to be healthy, including housing, education, transportation, community resources, employment, minimum wage standards, and childcare. Strategies focused on individual patients or even on individual communities are necessary but insufficient without well-planned advocacy for enduring policies. For example, a health care system may mount an effort to refer patients with unmet social needs to community services; however, the needed services may not exist or may be inadequate to meet the population’s needs.

Advocacy by the health care sector is needed to promote policies that will pay for the implementation of effective social interventions. For example, improvements in early life social conditions can have a great and lasting effect on health and health care utilization. These improvements, however, often manifest only over long periods of time. The entities incurring the costs of interventions must 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 should advocate—along with other sectors—to seek the reversal of the underlying social inequities that contribute to worse health outcomes among marginalized groups. 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 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 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 community members, but also bringing the community’s formal and informal leaders and advocates, especially leaders from traditionally marginalized groups, to the table to identify existing community resources, needs, and priorities. Community engagement also 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. Authentic engagement requires significant investments of time and sometimes money. Community engagement without active resident leadership risks undermining trust, particularly if residents contribute but fail to see 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 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 rigorous evaluation of health equity interventions. This does not mean that all evaluations must be randomized trials; that would often be infeasible. More can and should be done, however, to design strong evaluations (e.g., by including an appropriate comparison group, lengthening follow-up timeframes, and/or selecting appropriate intermediate outcome measures). Strong evaluations require including the perspectives of community and patient stakeholders and considering early-on how to address potential confounders. Potential limitations of evaluation design need to be addressed from the beginning, rather than confronted for the first time in analysis and reporting phases when little can be done to mitigate them. 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, including the long timeframes for significant health outcomes to manifest.
References


