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How to Achieve Health Equity

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Two studies in this issue of the *Journal* indicate that differences in how we deliver care to patients in various racial or ethnic groups have narrowed nationally, but health outcomes remain worse for blacks than for whites. Trivedi et al.[1] studied hospitalizations of patients for acute myocardial infarction, heart failure, and pneumonia from 2005 through 2010. They found that racial or ethnic differences decreased for processes of care (i.e., what clinicians do for patients), such as evidence-based prescribing of medications and the administration of flu shots. In contrast, Ayanian et al.[2] discovered that black enrollees in Medicare Advantage health plans had worse outcomes (i.e., the actual health result) than did whites for control of blood pressure, cholesterol, and glucose, except in the West.

These divergent findings illustrate that reducing racial and ethnic disparities in health outcomes is more difficult than simply standardizing the care provided to patients. Indeed, although it is a positive step that improvements are being made in processes of care in hospitals, providing standardized care for a limited set of inpatient measures is unlikely to lead to equity in health outcomes. Inpatient processes, such as the administration of aspirin,[1] represent a narrow slice of time and depend primarily on technical actions of the health care team rather than on patients. In comparison, to improve outcomes such as control of blood pressure, cholesterol, and glucose, clinicians must work closely with patients over a period of years to ensure that they take their medications, consume healthful diets, and are physically active. The best care spans outpatient care, inpatient care, and self-care and is tailored to the needs of each patient. Clinicians must help patients manage their health while patients are outside the clinic and living in the community — which is most of the time. Bottom-line outcomes such as hospital readmissions, for which rates are higher for blacks,[3] are harder to improve and ultimately more important than the improvement of process measures such as echocardiography for patients with heart failure. Eliminating disparities requires truly patient-centered care — that is, individualized care by clinicians who appreciate that patients' beliefs, behaviors, social and economic challenges, and environments influence their health outcomes.

Despite these challenges, the good news is that we know much about how to achieve equity in outcomes. Several key principles should guide efforts to reduce disparities. First, we

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should look for disparities. Currently, most governmental and private payers do not report clinical performance data that are stratified according to patients' race, ethnic group, and socioeconomic status, and so disparities are hidden. Change cannot occur if clinicians and administrators believe that their care is optimal and that disparities are society's problem. We should track outcomes that matter to patients, such as quality of life and the ability to function. Process measures are easy to collect and are one step along the pathway to better outcomes, but they are often too crude to capture truly outstanding care.

To reach adequate outcomes, we must talk to patients and meet their individual needs. Successful interventions tailor care to individual patients and their cultures. Such interventions frequently involve the use of teams, "patient navigators" (culturally sensitive health care workers who help patients navigate through the health care system), and community health workers who learn about patients' strengths and challenges, monitor patients closely, and involve families and community partners in solutions.[4,5]

We should align incentives to reduce disparities and address social factors, because a business case to achieve equity motivates and sustains improvement. Clinicians and administrators are more likely to implement interventions to improve equity if those efforts are paid for. A fee-for-service system rewards volume and procedures but does not reward prevention and does not address the social, economic, or cultural factors that drive disparities. Governmental and private payers have largely been silent with regard to creating incentives explicitly to reduce disparities. We should test projects that specifically provide incentives for achieving equity[6] and reward both high levels of quality and reductions in disparities. Payment systems should support approaches to population health that create healthy communities, provide strong primary care, and prevent costly hospitalizations.[7]

Finally, we should provide additional assistance to the safety net. Achieving equity is an issue for all providers, but safety-net institutions face special challenges. They care for uninsured or underinsured patients who have major social and economic barriers, and they have limited resources. They are at a disadvantage in pay-for-performance programs, as compared with organizations caring for healthier, richer, and more-educated patients. We should help safety-net institutions enact quality-improvement programs so that they can escape the death spiral in which they do poorly in pay-for-performance programs and their reimbursement rates are cut, which decreases their quality of care further, ultimately harming patients.[8] In addition, as recommended by the National Quality Forum, payers should "risk-adjust" clinical performance scores for the socioeconomic status of patients to create a level playing field in pay-for-performance programs.[9]

Leadership matters. It is our professional responsibility as clinicians, administrators, and policymakers to improve the way we deliver care to diverse patients, including patients of any racial or ethnic background. We can do better.[10]

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