# Health Inequities in America

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Do you practice institutional racism? When I first heard this question, I was admittedly taken aback. It's not a charge anyone would take lightly. It's a socially unacceptable label. In short, it's something we care deeply about in the nation's first College of Population Health. Let me set the context for leveling this charge, and find a way to connect the dots with improving the health of the US population. Frankly, I had never come across the term "institutional racism" until reading a recent publication from our colleagues at the Institute for Healthcare Improvement in Boston, MA, which is their key white paper and is titled *Achieving Health Equity: A Guide for Health Care Organizations*.[1]

Our College of Population Health, which is located on the campus of Thomas Jefferson University in Philadelphia, PA, also supports 2 offsite research centers—one in rural Johnstown, PA, and the other at the Lankenau Institute for Medical Research, on the campus of the Main Line Health system in suburban Philadelphia. Our faculty members at both sites are actively engaged in research and in program planning as it relates to reducing health inequities. Institutional racism is not a label anyone with a moral compass can ignore.

In their white paper, Wyatt and colleagues note that the goals of the Triple Aim—that is, improving the health of the population, reducing per-capita costs for healthcare services, and improving the individual experience of care—although laudable, cannot be achieved until they are achieved for all.[1] When we take into account that "life expectancy of black Americans in 2010 was equal to that of white Americans in 1980,"[1] something is clearly amiss.

So, let's define our terms first, using the definitions in this white paper. For example, for "health equity," the authors suggest that, "ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, no one should be disadvantaged from achieving this potential, if it can be avoided."[1]

"Health disparity" is defined as "the difference in health outcomes between groups within a population."[1] And as the authors note, "While the terms may seem interchangeable, 'health disparity' is different from 'health inequity.' 'Health disparity' denotes differences, whether unjust or not. 'Health inequity,' on the other hand, denotes differences in health outcomes that are systematic, avoidable, and unjust."[1]

I am particularly interested in the nuanced difference the authors note between health "equity" and "inequity." Wyatt and colleagues note that "institutional racism is not the bigotry that many people think of when they hear the term 'racism.'…Institutionalized racism is defined as differential access to the goods, services, and opportunities of society by race. Institutionalized racism is normative, sometimes legalized, and often manifests as inherited disadvantage. It is structural, having been codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator."[1]

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So, what exactly does this mean in the real world? Consider the ever-expanding geographic footprint of an academic medical center. Do we specifically take into account that parking fees may exceed what low-income individuals can afford? Do we guarantee that all patient care areas in the facility are clean and neat, in the emergency department and triage area, as well as the high-end concierge private rooms? Do we identify ways to improve healthcare access by reducing waiting times in all areas of our work, not just those areas where persons of "means" might be the typical patient clientele? Do the older buildings have relative ease of access? Do we guarantee that persons with disabilities can navigate our increasingly complex physical environment?

As the authors of the white paper ask, "Is the allocation of newer facilities or care areas equitable to provid-

ing services for all patient populations? When institutions build new wings or buildings, sometimes they house patients with conditions that generate more revenue for the institution in these new facilities."[1]

Or, finally, when we build that new ambulatory care center, is it accessible via public transportation for persons who cannot afford a private vehicle? These are the signs and symptoms of what the experts refer to as "institutional racism," which is a cornerstone of inequity.

> I believe there is a strong business case to support a deeper understanding and more concerted effort to tackle health disparities. As Wyatt and colleagues point out, "The economic burden of these health disparities in the US is projected to increase to $126 billion in 2020 and to $353 billion in 2050 if the disparities remain unchanged."

Beyond being labeled with this seemingly pejorative term, why should current leaders frankly care about this nuanced difference between health equity and health inequity? As the authors of the white paper point out, I believe there is a strong business case to support a deeper understanding and more concerted effort to tackle health disparities. For example, Wyatt and colleagues point out that "health disparities lead to significant financial waste in the US healthcare system. The total cost of racial/ethnic disparities in 2009 was approximately $82 billion—$60 billion in excess healthcare costs and $22 billion in lost productivity. The economic burden of these health disparities in the US is projected to increase to $126 billion in 2020 and to $353 billion in 2050 if the disparities remain unchanged."[1]

In addition, and here is the core economic argument, the authors note that "there is an opportunity cost of not reducing health disparities; for example, if death rates and health outcomes of individuals with a high school education were equivalent to those of individuals with college degrees, the improvements in life expectancy and health would translate into $1.02 trillion in savings annually in the US." Wow!

I know what some readers are thinking: poorly educated individuals with bad health-related habits are more costly than highly educated and engaged patients. But, frankly, do we engage with patients in these lower socioeconomic strata with the same level of energy and commitment as we do with patients in a higher socioeconomic level? What if we found a way to reach out to communities that really need our help, but that may not represent a high-margin business? I believe that practicing population health, "turning off the spigot" rather than "mopping up the floor," mandates that we tackle these complex and vexing social challenges.

I'm going to share this outstanding white paper with all our faculty members, especially the scholars working in this area. The authors end with a checklist, of sorts, to help all healthcare organizations create a benchmark and map their progress in assessing and eliminating health disparities. I envision a day when senior executive compensation in the healthcare delivery system might be tied, at least in part, to some of these measures. From my perspective, placing incentive compensation at risk for achieving health equity is a great population health advance.

What is your organization doing to counter institutional racism, and are your leaders economically incentivized to achieve health equity? These are provocative questions, and I'm anxious to hear about your progress in this area. As always, you can reach me via e-mail at david.nash@jefferson.edu. ■

## Reference
1. Wyatt R, Laderman M, Botwinick L, et al. *Achieving Health Equity: A Guide for Health Care Organizations*. IHI white paper. Cambridge, MA: Institute for Healthcare Improvement; 2016. www.ihi.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx. Accessed June 12, 2017.