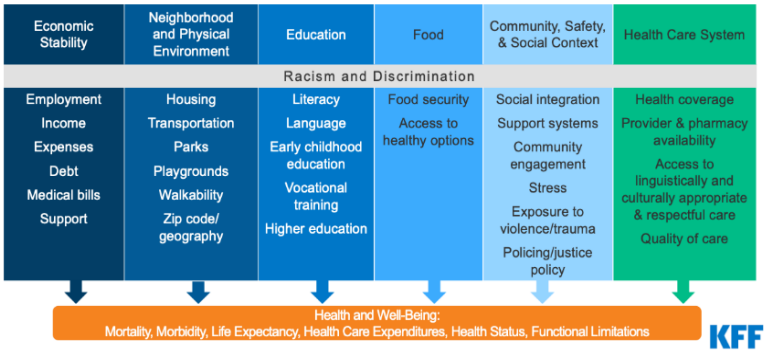
Achieving Health Equity

The focus has shifted to health payers and providers for solutions

U.S. public policy emphasis on Health Equity has been building for years. However, the COVID-19 pandemic and associated calls to action have now shifted attention to all parts of the health care system for potential solutions. The pandemic had a significant impact on the U.S. health and human services landscape, and inequities within the health care system propelled to the spotlight.

COVID-19 deaths were disproportionally high among people of color (13% of the US population, but 23% of COVID-19 related deaths), and evidence of racial and ethnic minorities being at greater risk due to disproportionally higher rates of chronic illness and disease burden became glaringly evident as a consequence of social and economic circumstances.

Health Disparities are Driven by Social and Economic Inequities



Health Equity Defined

Health Equity means that everyone has an equal opportunity to achieve the healthiest life possible. It is achieved through the removal of unfair, avoidable and/or addressable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically.

Avoidable → Systemic → Unfair

As a construct, Health Equity is closely aligned with a focus on Social Determinants of Health (SDOH). *(WSG and Health 2020)* When most organizations say they are pursuing "Health Equity", it explicitly includes extending efforts into the community to identify and help address root causes.

What Can Health Care Organizations and Providers Do to Improve Health Equity?

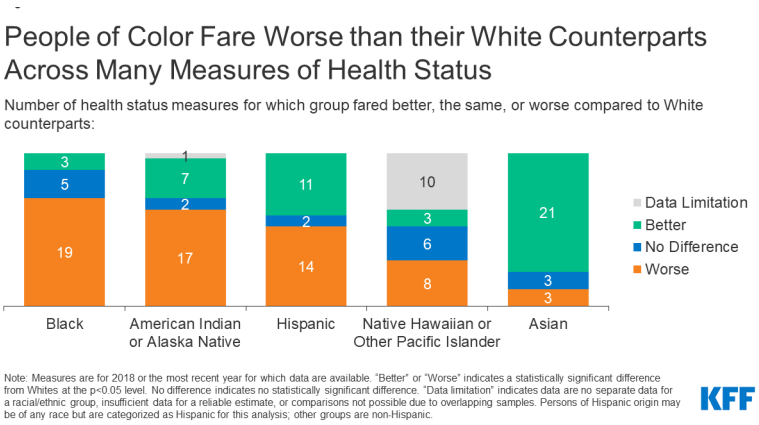
Identification of where Health Equities exist is a good place to start, but not sufficient in our view.

We believe strongly that the time is right for taking action, and we are prepared to partner with our clients to help make the business case for unlocking opportunities for meaningful change.

Let's examine further some of the complexities of grappling with Health Inequalities and identifying avenues for taking action:

Inequities are rooted in health care policies and protocols that inadvertently favor one group over others. These policies and protocols negatively impact people's health in relation to their social, economic, political, cultural, and physical circumstances. Simply put, health and healthcare are deeply connected to where people live and their life circumstances, as much as due to lifestyle and genetic predispositions. This makes it challenging to tease out cause and effect.

Nonetheless, there is no denying that inequities exist. For example, data gathered by the Kaiser Family Foundation prior to the COVID-19 pandemic showed that people of color fared worse compared to their White counterparts across a range of health measures, including infant mortality, pregnancy-related deaths, prevalence of chronic conditions, and overall physical and mental health status.



Business Case for Health Equity – moving from charitable works to solutions

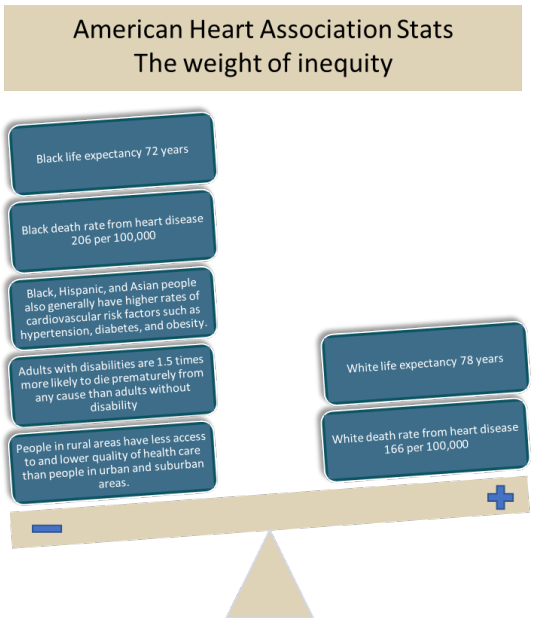
Health care provider organizations, employers and other health payers are uniquely positioned to leverage their purchasing power and influence to drive policies and practices that advance greater Health Equity. However, making investments in sustainable solutions requires a supporting business case.

This requires a clear understanding of where inequities exist and then an examination of how current policies, programs, and practices may inadvertently be contributing factors. Without this understanding, well intentioned strategies may have minimal impact.

A Health Equity business case should identify and address health risks that disproportionately affect certain populations. This knowledge creation begins by establishing foundational baseline measurements of chronic disease, illness burden, and lifestyle differences among populations of interest.

There is ample evidence in the health care literature that demonstrate striking contrasts in health risk and health outcomes among different groupings based on race, ethnicity, geography, and lifestyle.

Once these disparities within a given population are identified, health care leaders can take steps to amend programs and services that have potential to establish greater Health Equity for disadvantaged populations.



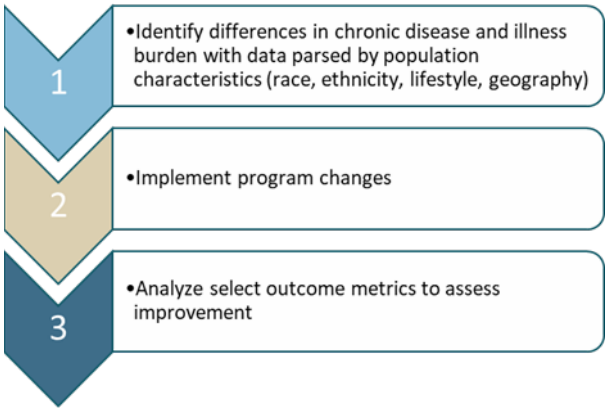
(Source: American Heart Association CEO Roundtable, July 28,2021)

Health care business leaders can address systemic issues underlying discovered disparities in several ways.

In this next section, **Call to Action**, we have provided examples of actions Health Plans and provider organizations can take.

The effectiveness of these actions can be measured by the closure of health disparity gaps, such as health care access, utilization, and health outcomes, between and among impacted populations.

Steps in the Analytic Framework:



Call to Action: Coverage, Access, Affordability

Estimating the direct and indirect cost of Health Inequity is challenging. A recent analysis estimates Health Inequities result in about $93 billion in excess medical care costs and $42 billion in lost productivity per year. Other studies estimate the cost attributable to illness and premature death as a result of Inequities to be as high as $1.2 trillion. *(Ndugga N 2021)*

Health insurance and other systemic or structural factors impacting **coverage, access and affordability** of health are amenable to actions that Health Plans and Health Care Provider Organizations can undertake within the scope of their services and programs. Each of these elements provide an opportunity for informed action to develop innovative solutions supporting equity in both policies and practices.

Coverage

Adequacy

A recent study by the Commonwealth Fund found that in the first half of 2020, a quarter of adults in employer-sponsored plans were underinsured, largely due to increasingly inadequate coverage. *(Collins SR 2020)*

In addition, 12.5% of all adults were uninsured, including many who were employed. *(Garfield R. 2019)*

EXAMPLE

35% of all adults reported at least one cost-related problem obtaining necessary health care services:

- Not filling a prescription
- Skipping a test or appointment
- Not seeking medical care when sick

Racial Bias in Coverage Rules

Health care payors should examine coverage rules that may differ based on gender, race, ethnicity, sexual orientation, and/or gender identity.

EXAMPLE

Some standard medical protocols including organ transplant eligibility, emergent/urgent care treatment decisions, and Cesarean section risk calculations rely to some degree on race-based formulas. Some routine blood tests provide different race-corrected results for Blacks and other minorities, even though there's no underlying biology-based rationale.

There are many clinical algorithms designed to help doctors decide whether a patient is a good candidate for a particular treatment or other medical intervention. A June 2020 paper published online in the New England Journal of Medicine revealed the presence of race adjustments in 13 different clinical algorithms used across a wide spectrum of specialties: cardiology, pulmonology, nephrology, and others.

Algorithms like these sometimes adjust for age, gender and other factors that can help account for broad physiological differences among patients. However, the use of race adjustments is more controversial.

Racial adjustments are mainly based on studies that report differences in measures such as organ function or responses to treatment between Black people and others. Critics say these studies tend to be flawed in that they assume Black physiology is fundamentally

different than other people – a premise that is not supported by science. It is largely predicated on the idea that Black people as a race are biologically different from others just because of their race. This notion has definitively been debunked. There is no genetic test or biological marker that places someone in one race or another. Instead, race is a sociological categorization that changes as societal norms evolve. Differences noted in studies used to make algorithmic adjustments are likely the result of factors other than race.

Unfortunately, in most cases, the race adjustments tend to indicate that Black patients are less likely to be at risk and thus less likely to be referred to specialty care and treatments. Some race adjustments make specific procedures seem riskier for Black patients, creating a different set of concerns.

EXAMPLE

This can occur in obstetrics. If a pregnant woman had a cesarean section in the past, her doctor can use a risk score to help decide which kind of delivery to recommend. The vaginal birth after C-section risk calculator makes a vaginal delivery look more dangerous for Black and Hispanic patients than for others. That could lead a pregnant woman to get steered toward a C-section, which generally carries more risk. As a result, Black women are more likely to undergo C-sections than members of any other racial group in the U.S.

Several major medical institutions and academic centers are making changes to the way they use race in clinical algorithms. As an example: Massachusetts General Hospital, Brigham and Women's Hospital, Vanderbilt and Brown Universities have removed face factors from algorithms used to assess patients for potential kidney transplantation. *(Waddell 2020)*

Eligibility

In addition to assuring that health policies and protocols consider the diverse needs of all population sub-groups served, health care practices need attention as well.

Criteria for *eligibility* and course of treatment should consider social, economic and diversity characteristics of the served population. The same is true for determinations of medical necessity.

EXAMPLE

Coverage rules that incent movement to more virtual or home-based services may leave out those without internet access and stable housing.

Access

Environmental (geography)

Limited access to care due to environmental factors other than insurance coverage, such as geography, is associated with poor health outcomes. For example, only about a quarter of people (24.2%) with reported or known access issues have their high blood pressure under control compared to nearly half (48.2%) of those with adequate access to care. *(Muntner P and 1190-1200. 2020)*

EXAMPLE

- Access to treatment – at home, retail locations, community centers, places of worship – each has the potential to provide more points of access to care.
- Digital treatment tools can extend the clinical workforce and facilitate redistribution of care.

Network Adequacy

Health care networks are required by the Affordable Care Act (ACA) to maintain access to care without an unreasonable delay. But because the law fails to specify the standard of reasonableness, that determination is left to states and employer-sponsored plans. Individuals may technically have access to a network, but if providers are closed to new patients, patients have limited access to transportation or if diversity among providers does not meet the patient needs, then access to health care is not truly equitable.

EXAMPLE

Health plans and provider organizations can take steps to ensure that provider networks are equitable in terms of both geographies, and more representative of diverse populations and their needs, cultural beliefs, and preferences.

Affordability

The affordability of health care with or without adequate insurance coverage also presents challenges to achieving Health Equity. Consider that the percentage of income that a lower-income wage earner spends on healthcare is significantly disproportionate to those at higher wage levels. For such individuals with serious family health issues, there is nothing left for health care after accounting for basic needs like food and shelter.

Affordability of care is also strongly related to poor health care quality and outcomes. Addressing issues of affordability will require thinking past traditional ways of thinking about how to address the issue.

EXAMPLE

Some potential actions health plans and provider organizations may take include:

- Expand definitions of coverage to include reimbursement for models that include social support services, housing, transportation, etc.
- Establish parity between coverage for physical and mental health, as required by the Mental Health Parity and Addiction Equity Act.
- Include measures of Health Equity within value-based reimbursement programs and services.
- Ensure value-based arrangements account for diversity of the served population relative to health outcomes and this overall patient experience.
- Implement safeguards to ensure the use of artificial intelligence (AI) algorithms and predictive models don't "institutionalize" prevailing racial and other diversity biases.

In summary, even though cause and effect relationships between health care policies and programs are difficult to prove, recognition of where disparities in health risk and health outcomes exist in a served population is a good place to start. Simply raising awareness is a key step toward generating maturity in our ability to take action and make necessary improvements.

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