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Pursuing Health Equity

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If equity is one dimension of what the Institute of Medicine (IOM) defined as health care quality, what are the obligations of the health care sector to achieve health equity? Early evidence of health disparities led to a focus on the health care system—the roles of bias and discrimination, as captured by the title of the 2003 IOM report *Unequal Treatment*. Yet as Steven Woolf points out in his lead paper, growing understanding of the role of social factors in determining health outcomes makes it clear that achieving equity requires widening the lens. This month's *Health Affairs* examines health equity from both perspectives: equity in care, and the relationship between social factors and health equity.

INEQUITIES IN HEALTH CARE

Evidence of inequity often comes in the form of gaps in access or inadequate care for disadvantaged groups. William Schpero and colleagues take a different approach, comparing receipt of low-value services by Medicare recipients across racial/ethnic groups. Their findings suggest a complex picture, what they call “a possible double jeopardy for minority patients: Long understood to be at risk of receiving less effective care, they also appear to be often at risk of receiving more ineffective care.”

Renee Hsia and colleagues document the life-or-death consequences of disparities in mortality after a heart attack for blacks and whites in California. They find that when hospitals were on ambulance diversion—reflecting overcrowded conditions—blacks experienced mortality rates as much as 19 percent higher than whites. A more optimistic story emerges from an analy-

sis of surgical mortality by Winta Mehtsun and colleagues. They find declining rates of thirty-day postoperative mortality among black and white Medicare recipients, with larger declines for blacks yielding a reduction in racial disparities.

ADDRESSING INEQUITIES

In 2014 the method of allocating available kidneys for transplantation in the United States was modified with the explicit goal of reducing racial and ethnic disparities. Taylor Melanson and colleagues show that the new method essentially eliminated disparities among blacks, Hispanics, and whites in the proportion of patients on the waiting list who received a transplant.

Donna Washington and colleagues examine the effect of the Veterans Health Administration's adoption of patient-centered medical homes on racial and ethnic disparities among people with hypertension and diabetes. Medical homes are thought to be a mechanism for reducing disparities, since they are designed to improve access and coordination—elements of care typically less available to minority populations. While the efforts generally yielded improvements in outcomes, overall they did not reduce previously existing disparities among black, Hispanic, and white veterans.

ADDRESSING HEALTH DETERMINANTS

People released from prison are at high risk of poor health, a problem compounded by their significant social needs. Shira Shavit and colleagues report on the experience of people served by the Transitions Clinic Network, which supports coordinated care and multidisciplinary teams for high-risk, chronically ill people as they leave

prison. They conclude, “Our data suggest that investing in better linkages between corrections and community health systems could yield important returns in the form of more appropriate health care use and health equity.”

Stable, affordable housing is correlated with better health. Alan Simon and colleagues set out to understand whether receiving Housing and Urban Development housing assistance improves access to health care. When comparing current recipients with those on the waiting list who ultimately received assistance (a control group with similar characteristics), they find higher rates of health insurance and lower rates of unmet need for care due to cost.

TOLERATING INEQUITY

Ultimately, achieving health equity depends upon the commitment of people and institutions to taking evidence-based actions that reverse the accumulated social disadvantage of racial, ethnic, gender, income, and geographic minorities. That is hard enough to do within an individual health care setting, but attempts to reach the social determinants of health require social and political consensus. In this context, the paper by Joachim Hero and colleagues is sobering. In a review of survey data from thirty-two middle- and high-income countries, they find that the United States is an outlier in the very large share of people who believe that many people do not have access to the care they need, yet a relatively low share of people consider that phenomenon to be unfair.

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