

# Health Affairs

At the Intersection of Health, Health Care and Policy

Cite this article as:

Anne C. Beal

High-Quality Health Care: The Essential Route To Eliminating Disparities And  
Achieving Health Equity

*Health Affairs*, 30, no.10 (2011):1868-1871

doi: 10.1377/hlthaff.2011.0976

The online version of this article, along with updated information and services, is  
available at:

<http://content.healthaffairs.org/content/30/10/1868.full.html>

**For Reprints, Links & Permissions:**

[http://healthaffairs.org/1340\\_reprints.php](http://healthaffairs.org/1340_reprints.php)

**E-mail Alerts :** <http://content.healthaffairs.org/subscriptions/etoc.dtl>

**To Subscribe:** <http://content.healthaffairs.org/subscriptions/online.shtml>

*Health Affairs* is published monthly by Project HOPE at 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133. Copyright © 2011 by Project HOPE - The People-to-People Health Foundation. As provided by United States copyright law (Title 17, U.S. Code), no part of *Health Affairs* may be reproduced, displayed, or transmitted in any form or by any means, electronic or mechanical, including photocopying or by information storage or retrieval systems, without prior written permission from the Publisher. All rights reserved.

Not for commercial use or unauthorized distribution

By Anne C. Beal

DOI: 10.1377/hlthaff.2011.0976  
HEALTH AFFAIRS 30,  
NO. 10 (2011): 1868–1871  
©2011 Project HOPE—  
The People-to-People Health  
Foundation, Inc.

## VIEWPOINT

# High-Quality Health Care: The Essential Route To Eliminating Disparities And Achieving Health Equity

Anne C. Beal (BealA@aetna.com) is president of the Aetna Foundation, in Hartford, Connecticut.

**ABSTRACT** In the past decade and a half, the United States has witnessed major advances in the recognition and reporting of health and health care disparities. Now is the time to move beyond describing these disparities to actually eliminating them. Because of the interlocking nature of disparities in health, disparities in health care, and the role of social determinants, there is a need to focus our efforts on one primary goal: achieving health equity by securing access for the entire population to the highest possible quality of health care. Access to high-quality care for populations of color can have the same impact as it has for majority populations: improving population health, improving patients' experiences of care, and reducing health care costs.

**T**his issue of *Health Affairs* focuses on health and health care disparities, and the Aetna Foundation Inc., of which I am president, is proud to have helped sponsor the issue. We believe that a thorough understanding of disparities is essential to staying focused on what should be our ultimate goals: achieving equity in health outcomes and improving the health of people and the nation. We also believe that the evidence shows clearly that an essential route to health equity will be to achieve high-quality health care for all.

## Shifting The Focus To Disparities

*Health equity* is “the attainment of the highest level of health for all people...with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.”<sup>1</sup> *Health disparity*, in turn, is defined as a difference in health status that results from social disadvantage that is itself associated with characteristics such as race or ethnicity and

socioeconomic status. *Health care disparity* is a difference in the quality of health care experienced by those with social disadvantage.

In the past decade and a half the United States has witnessed major advances in the recognition and reporting of health and health care disparities. To be sure, racial differences in health outcomes have been reported since the advent of public health reporting in the United States—and health care providers have long understood that many of their patients of color had poor health outcomes. However, in the mid-1990s our collective language on health for people of color started to advance from discussions of “minority health” and the expectation of poor outcomes to discussions of “disparities in health” and a focus on closing the gap.

Much of this change in characterization resulted from a major initiative launched during the Clinton administration—One America in the 21st Century: The President’s Initiative on Race. As part of the initiative, then-Surgeon General David Satcher explicitly targeted the elimination of health disparities as a goal in the Healthy People 2010 objectives.<sup>2,3</sup>

In 1999 Kevin A. Schulman and colleagues added considerably to the evidence on health care disparities, publishing research in the *New England Journal of Medicine* that demonstrated bias among physicians in referring African American and female patients for cardiac procedures.<sup>4</sup> Soon afterward the Institute of Medicine released *Unequal Treatment*, which provided further irrefutable evidence that racial disparities in health care existed and were caused by several factors, including physician bias.<sup>5</sup>

These reports helped create a watershed moment, after which it was no longer acceptable to think about minority health as the inevitable poor outcome for patients of color. Since then, both public- and private-sector entities have devoted extensive effort to further identifying disparities.

Each year, for example, the Agency for Healthcare Research and Quality releases the *National Healthcare Disparities Report* and the *National Healthcare Quality Report*, which serve as annual updates on national progress toward achieving equity and high quality in health care.<sup>6</sup> All fifty states began at least to some degree to compile and release health reports on populations of color or to develop action plans for promoting health equity.<sup>7</sup>

In the private sector, the insurer Aetna launched an initiative on disparities and began collecting data on enrollees' race and ethnicity in order to identify disparities.<sup>8</sup> Several health plans, including Aetna, banded together to create the National Health Plan Collaborative to share best practices for collecting race and ethnicity data and eliminating disparities.<sup>9</sup> And several national foundations, such as the Commonwealth Fund and the Robert Wood Johnson Foundation, made sizable investments to promote the collection of race and ethnicity data for the identification of disparities.

As these efforts proceeded, so too did our understanding advance about the root causes of health disparities. In the past, many health care providers who recognized the poor health outcomes of patients of color attributed the causes to socioeconomic factors beyond physicians' control.

Now, however, we understand that social determinants such as economic disadvantage and health care determinants such as poor-quality health care both play a major role in affecting health outcomes.<sup>10</sup> Furthermore, within these two broad areas, myriad factors are at work. Within the field of social determinants, everything from income and education levels to location of neighborhoods can have differential effects on health. Within health care, factors that affect health outcomes include dis-

parities in health insurance coverage, access to care, quality of care, prevalence of comorbidities, and patients' adherence to prescribed treatment.

## Health Care Equity And Quality

Because of the interlocking nature of disparities in health, disparities in health care, and the role of social determinants, there is a need to focus our health efforts on a critical goal: achieving equity by securing access by the entire population to the highest possible quality of health care. There are a number of reasons why this goal must be paramount.

**MAINSTREAM HEALTH PROBLEMS** First, what once may have been regarded "minority health status" is rapidly becoming "US health status." Current projections by the Census Bureau are that by 2050, people of color will be in the majority in the United States.<sup>11</sup> In fact, this shift in demographics has already occurred in major urban centers: More than half of US cities are now "majority minority" cities.<sup>12</sup>

**GROWING PREVALENCE OF PREVENTABLE CONDITIONS** Second, as this racial and ethnic transformation of the population occurs, costly preventable health conditions are becoming more prevalent. Hypertension, diabetes, and stroke are among a number of conditions that are more common among African Americans and Hispanics than among non-Hispanic whites. The excess rates of disease in these populations cost an estimated \$23.9 billion in 2009 and are projected to cost approximately \$337 billion over the next ten years.<sup>13</sup> Improving the health of these populations, and the quality and efficiency of the care they receive, must clearly play some role in bending the health care system's staggering cost curve.

**SUCCESS OF QUALITY IMPROVEMENT EFFORTS** Third, quality improvement efforts have been clearly demonstrated to be an effective strategy for addressing health and health care disparities.<sup>14</sup> For example, in 2003 Ashwini R. Seghal reported the results of a program to improve the medical care of Medicare patients who were not receiving adequate hemodialysis dosages.<sup>15</sup>

At the beginning of the intervention, there were health care disparities in appropriate hemodialysis doses: Only 36 percent of black Medicare enrollees were receiving adequate hemodialysis dosages, compared to 46 percent of white enrollees. After eight years of multiple quality improvement interventions, both white and black enrollees had vast improvements: 87 percent of whites and 84 percent of blacks received adequate hemodialysis dosages.

In effect, this was not a disparities interven-

tion but rather a quality improvement intervention. At the same time, the group most in need of quality improvement benefited the most from the intervention. The study demonstrated that basic quality improvement can provide a mechanism for promoting health care equity.

### Disparities And Reform Efforts

Framing the elimination of health and health care disparities as a matter of quality is included in the Affordable Care Act of 2010, in section 4302. The law requires both the collection of race and ethnicity data and the reporting of quality performance measures stratified by race, ethnicity, and other demographic data. Quality improvement techniques all have in common using clinical performance data to monitor progress. Now, as health care plans and providers collect and report these data stratified by race and ethnicity, opportunities will surface to improve care for all.

Multiple interventions will surely be required to improve quality performance and narrow disparities, just as many different “micro-interventions” are needed in any quality improvement process, such as Lean or Six Sigma.<sup>16</sup> Furthermore, any set of solutions for one type of disparity—for example, diabetes outcomes—might not be as effective for another type of disparity—for example, cancer screening rates. Nor will solutions for disparities among Latinos necessarily be the same as those for disparities among African Americans.

Context also matters. The root causes of disparities in Texas may be quite different from those in Massachusetts. Any action plan to eliminate an identified health disparity will require a tailored and multifaceted approach that considers the local context within which patients and health systems must function.

Articles in this issue of *Health Affairs* demonstrate the multiple interventions that can target the varied root causes of disparities, be they at

## Basic quality improvement can provide a mechanism for promoting health care equity.

the individual, health system, community, or societal level, and the powerful connection to quality improvement. For example, in their assessment of health care quality improvements in the Indian Health Service, Thomas Sequist and colleagues describe how these have improved care and outcomes for American Indian and Alaska Native populations.<sup>17</sup> Similarly, Henry Pollack and colleagues describe how a New York City pilot program tackled disparities in hepatitis B prevalence through a systematic effort to draw Asian and other immigrants into screening and care.<sup>18</sup>

### Conclusion

We have made much progress in understanding that health and health care disparities exist. Now is the time to move beyond describing them to actually doing something about their elimination. Improving access to high-quality care holds promise as an effective intervention to improve health outcomes for populations of color. Access to high-quality care for populations of color can have the same impact on them as on majority populations: improving population health, improving patients' experiences, and reducing health care costs. This issue of *Health Affairs* reminds us that these goals are not only necessary, but achievable as well. ■

### NOTES

1 Definition formulated by the National Partnership for Action to End Health Disparities' Federal Inter-agency Health Equity Team and Healthy People 2020. Department of Health and Human Services. Developing the National Stakeholder Strategy. Sec. 1 in: National Stakeholder Strategy for Achieving Health Equity [Internet]. Washington (DC): HHS; [modified 2011 Aug 20; cited 2011 Sep 7]. Available from: <http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286>

2 President's Initiative on Race. One America in the 21st century: forging a new future. Advisory board's report to the president [Internet]. New Haven (CT): The Board; 1998 Sep [cited 2011 Sep 7]. Available from: <http://clinton2.nara.gov/Initiatives/OneAmerica/PIR.pdf>

3 Department of Health and Human Services. Healthy People 2010: understanding and improving health. 2nd ed. Washington (DC): Government Printing Office; 2000 Nov.

4 Schulman KA, Berlin JA, Harless W,

Kerner JF, Sistrunk S, Gersh BJ, et al. The effect of race and sex on physicians' recommendations for cardiac catheterization. *N Engl J Med.* 1999;340:618–26.

5 Smedley BD, Stith AY, Nelson AR, editors. Unequal treatment: confronting racial and ethnic disparities in health care. Washington (DC): National Academies Press; 2003.

6 Agency for Healthcare Research and Quality. Measuring healthcare quality [Internet]. Rockville (MD): AHRQ; [cited 2011 Sep 7]. Available from: <http://www.ahrq.gov/qual/>

measurix.htm

- 7 National Conference of State Legislatures. State profiles: minority health and health equity offices [Internet]. Denver (CO): NCSL; 2010 [cited 2011 Sep 7]. Available from: <http://www.ncsl.org/default.aspx?tabid=14299>
- 8 Hassett P. Taking on racial and ethnic disparities in health care: the experience at Aetna. *Health Aff (Millwood)*. 2005;24(2):417-20.
- 9 America's Health Insurance Plans. National Health Plan Collaborative [home page on the Internet]. Washington (DC): AHIP; c2011 [cited 2011 Sep 7]. Available from: <http://www.nationalhealthplancollaborative.org>
- 10 Arah OA, Westert GP. Correlates of health and healthcare performance: applying the Canadian Health Indicators Framework at the provincial-territorial level. *BMC Health Serv Res*. 2005;5:76.
- 11 Commonwealth Fund. Racial and ethnic disparities in US health care: a chartbook. New York (NY): Commonwealth Fund; 2004.
- 12 Frey WH. Melting pot cities and suburbs: racial and ethnic change in metro America in the 2000s. Washington (DC): Brookings Institution; 2011.
- 13 Waidmann T. Estimating the cost of racial and ethnic health disparities [Internet]. Washington (DC): Urban Institute; 2009 Mar [cited 2011 Sep 7]. Available from: [http://www.urban.org/uploadedpdf/411962\\_health\\_disparities.pdf](http://www.urban.org/uploadedpdf/411962_health_disparities.pdf)
- 14 Beal AC, Doty MM, Hernandez SE, Shea KK, Davis K. Closing the divide: how medical homes promote equity in health care: results from the Commonwealth Fund 2006 Health Care Quality Survey [Internet]. New York (NY): Commonwealth Fund; 2007 Jun [cited 2011 Sep 7]. Available from: <http://www.commonwealthfund.org/Publications/Fund-Reports/2007/Jun/Closing-the-Divide-How-Medical-Homes-Promote-Equity-in-Health-Care-Results-From-The-Commonwealth-F.aspx>
- 15 Sehgal AR. Impact of quality improvement efforts on race and sex disparities in hemodialysis. *JAMA*. 2003;289(8):996-1000.
- 16 Lean and Six Sigma are quality assurance systems adopted from the world of manufacturing and more recently applied to health care institutions and processes.
- 17 Sequist TD, Cullen T, Acton KJ. Indian Health Service innovations have helped reduce health disparities affecting American Indian and Alaska Native people. *Health Aff (Millwood)*. 2011;30(10):1965-73.
- 18 Pollack H, Wang S, Wyatt L, Peng C, Wan K, Trinh-Shevrin C, et al. A comprehensive screening and treatment model for reducing disparities in hepatitis B. *Health Aff (Millwood)*. 2011;30(10):1974-83.

## ABOUT THE AUTHOR: ANNE C. BEAL



**Anne C. Beal** is president of the Aetna Foundation.

In this month's *Health Affairs*, Anne Beal, president of the Aetna Foundation, writes that it's time to move beyond describing health and health care disparities to actually eliminating them. She calls for focusing the effort on "one primary goal: achieving health equity by securing access for the entire population to the highest possible quality of health care."

Beal observes that access to high-quality care for populations of color can have the same impact as it does for majority populations:

improving population health, improving patients' experiences of care, and reducing health care costs. At the same time, she urges patience. "It's going to take a lot of interventions to really move the needle," Beal says.

Beal, a board-certified pediatrician, was named president of the Aetna Foundation, which is the independent charitable and philanthropic arm of Aetna Inc., in 2009. The foundation promotes wellness, health, and access to high-quality care for everyone. Before joining the foundation, Beal was assistant vice president for the program on health care disparities at the Commonwealth Fund. She also previously held faculty positions at both Harvard Medical School and the Harvard School of Public Health, where she was the principal investigator on research projects supported by the National

Institutes of Health, the Agency for Healthcare Research and Quality, as well as the Commonwealth Fund and other private foundations.

Beal earned her medical degree from Cornell University Medical College and her master of public health degree from Columbia University. Her ongoing research interests include social influences on preventive health behavior for minorities, racial disparities in health care, and quality of care for children.

She serves on several regional and national advisory boards, including the Institute of Medicine Committee on Future Directions for the National Healthcare Quality and Disparities Reports. She also sits on the board of AcademyHealth, a professional society for health services researchers and health policy analysts.