


A Five-Step Plan for
**ELIMINATING
INEQUALITY
IN HEALTH
CARE**

IN THE WINTER 2008 issue of Pathways, then-presidential candidate Barack Obama pledged to combat a health care crisis in America that disproportionately affects poor families and poor children. The larger economic crisis that has since taken hold might well have induced President Obama to shelve that commitment, but in fact he has reaffirmed that health care reform is integral to economic recovery. It follows that 2009 provides the first window of opportunity since Hillary Clinton's ill-fated reform in 1993 to fundamentally reshape our nation's health care delivery system.

BY KAREN DAVIS AND
KRISTOF STREMIKIS





We argue here that any such reform must accomplish two goals: (1) promote efficiency and maximize overall health and (2) pay explicit and comprehensive attention to ameliorating health disparities. To date, there has been much discussion of how to make health delivery more efficient, while the issue of health disparities has been addressed principally through the narrow lens of universal coverage. We will argue that the goal of narrowing health disparities is very important for the nation and is unlikely to be achieved by focusing on universal coverage alone.

We will first review how the current health care system fails on both objectives: It is not only grossly inefficient but also generates gross disparities in health outcomes among racial and economic groups. We will then discuss why we should care about disparities, why disparities and efficiency are linked, and how efficiency might be increased and disparities reduced.

A Broken System

The performance of the current U.S. health care system is clearly suboptimal. We spend twice what other major industrialized nations spend on health care yet fail in providing health coverage for all. We rank 19th out of 19 advanced industrial countries on mortality that is amenable to medical care. In the last eight years, the uninsured population has grown 20 percent, and the number with inadequate insurance has jumped 60 percent. For all the vibrancy and innovation in our health care system, it is tragic that so many people find themselves unable to access even basic health care services.

Nowhere is the failure of our health system more evident than in the health outcomes of low-income and minority Americans, or in the quality of care they receive. Disparities are especially acute along racial and ethnic lines and extend across the health care continuum, including prevention, access to care, insurance coverage, quality of care, and mortality. Although these disparities are associated with

poverty, education, stress, and the local environment, inequalities in health care access and health outcomes persist even after controlling for a host of non-medical determinants. Recent studies by the Commonwealth Fund, the U.S. Agency for Healthcare Research and Quality, and the Institute of Medicine have established the pervasiveness of the problem.

As documented in the Commonwealth Fund's recent report *Racial and Ethnic Disparities in U.S. Health Care: A Chartbook*, minorities rate their health as poorer than whites, with African Americans most likely to report having a chronic illness or disability. African Americans also experience higher mortality rates from many cancers and diseases that are amenable to early diagnosis and treatment. For example, while non-Hispanic white women have the highest incidence of breast cancer, African American women have the highest breast cancer mortality rate.

Minority Americans have greater problems accessing high-quality health care than their white counterparts. Racial and ethnic disparities exist on key measures, including having a regular doctor or provider, having a usual place of health care, forgoing needed care, or forgoing dental care or prescription drugs. Minorities are less likely to receive timely access to care and are more likely to suffer conditions that may be caused by delays in care. With respect to effectiveness and efficiency, minorities have lower screening rates for preventable illnesses and are more likely to receive treatment in an emergency room when a primary care provider could have treated the condition. And in terms of safety, Asian Americans and Hispanics are more likely to die from complications during hospitalization than non-Hispanic whites. Finally, minority patients are more likely to report substandard communication with their provider—a problem exacerbated by language and cultural barriers. Clearly, any meaningful reform of the health care delivery system will need to address these widespread and systemic failures.

Why Disparities Matter

The case for caring about disparities rests on three arguments. First, one might treat disparities as self-evidently a problem, a tack that is implicitly taken by those who regard health or access to health care as an inalienable right. When the language of rights is invoked in this way, the claim is that health and health care are such fundamental resources that all citizens should be guaranteed at birth some minimal amount. This language implies that we should care about disparities not because they matter in and of themselves but because they mean that some are falling below a minimum threshold of health or health care. If the health of everyone were elevated by just enough to push even the least healthy person above that threshold, then the disparities that remain after that universal increase in health would by this logic be deemed unproblematic.

The second reason to care about disparities is that they are inconsistent with our shared commitment to equalizing opportunities for access to economic and non-economic goods. If some people are, by virtue of their race or class background, subjected to unhealthy environments and denied access to adequate health care, they are then disadvantaged in the competition for schooling, jobs, and good wages; and our commitment to equal opportunity for all, regardless of race or background, is not being upheld.

Third, even if one disregards any such commitments or values, one might still care about disparities solely because they are costly. It costs all of us money when the poor are denied preventive care, are obliged to resort to expensive emergency room treatment, or become sick because they cannot afford necessary drugs. It is in this sense that the twin objectives of efficiency and disparity-narrowing become one and the same. How, then, might a health policy agenda best redress such pervasive health inequality?

A Path Forward

Five strategies, if aggressively pursued by the Obama administration, show great promise for reducing these disparities. These strategies are: (1) extending affordable insurance coverage to all Americans; (2) reorganizing the health care delivery system to make it accessible and patient-centered; (3) providing financial incentives to improve care for all, and especially for underserved and at-risk populations; (4) raising benchmark levels of performance through investing in the infrastructure, information, and workforce required for high performance; and (5) providing leadership to achieve health care opportunity for all.

Providing affordable coverage for all: Health insurance for all is the major prerequisite for eliminating health care disparities and ensuring equal opportunity; in fact, insurance coverage is the single most important predictor of whether people obtain needed care. President Obama's health proposal would guarantee coverage for every child and make coverage affordable for all adults. His plan, which builds on our current mixed system of private and public health insurance, lets people retain their cur-

rent coverage if they so choose. But it also makes new choices available for small businesses and individuals, including a public plan option, through a national health insurance exchange. According to estimates calculated for a similar proposal—the “Building Blocks” plan developed by Commonwealth Fund staff—annual family premiums could be lowered by \$2,500 to \$3,000 by taking advantage of Medicare's lower administrative cost and provider payment rates. Many of the 160 million Americans covered by employer plans would retain that coverage, and all employers except small businesses would be required to either provide coverage to workers or contribute to a fund to finance coverage. The State Children's Health Insurance Program (SCHIP) and Medicaid would be expanded to cover all low-income children and adults.

By building on what currently exists and works, the Obama health plan could quickly reach those most in need. Reauthorization and adequate funding of SCHIP would help about 6 million of 8 million uninsured children, including all children in families with incomes below three times the poverty rate. Letting young adults keep coverage under their parents' plans until age 26 would quickly reduce uninsured rates among the age group most at risk of going without coverage. Eliminating Medicare's two-year waiting period for the disabled and letting older adults buy in to Medicare before age 65 would close the gap in coverage for many disabled and chronically ill adults currently without access to affordable coverage. While achieving affordable coverage for all may take several years, quickly covering those most at risk would be an investment in future health and productivity and would help stimulate economic recovery.

Creating an accessible and patient-centered system: Eliminating health disparities will require reorganizing the health care delivery system to ensure that it is accessible, works for patients, and helps coordinate care in the face of complex problems. Ensuring access to a usual source of care and promulgating the “patient-centered medical home” would greatly reduce disparities among racial and socioeconomic groups. The patient-centered medical home model is one in which patients have access to a regular source of primary care, develop stable and ongoing relationships with a network of health care providers, and receive timely, well-organized health services that emphasize prevention and chronic care management. Enrolling the uninsured and low-income families in such clinics or physician practices would go a long way toward providing these vulnerable populations a point of entry into the health care system. The Commonwealth Fund Health Care Quality Survey found that when patients have a medical home, the racial and ethnic divide in access to needed care, preventive services, and control of chronic conditions closes. The Obama administration could immediately improve care for low-income and minority patients by converting all federally funded community health centers to medical homes and enrolling all Medicaid, SCHIP, and Medicare beneficiaries in practices that meet patient-centered medical home standards.

Reshaping payment incentives: Improving the health system's performance will require changing the way we pay for care. If we continue with current incentives, we will continue to receive inadequate care. The current method of paying physicians and hospitals largely rewards providing *more* care—especially complex, costly procedures. Three changes in the way we pay for care would begin to negate the perverse incentives that currently exist. First, clinics and physician practices meeting the standards of patient-centered medical homes should be paid a medical home fee that rewards providing accessible, coordinated care. This would enable both a team approach to care and the electronic information systems that can facilitate such care. A medical home payment could be supplementary to current fee-for-service arrangements, or it could cover all preventive and primary care for each enrolled patient.

A second fundamental shift would be to hold hospitals accountable for complications and transitional care upon discharge. By bundling payment for all services needed within 30 days of hospitalization into a global diagnostic case rate, hospitals would have a major incentive to ensure that patients do not reappear in emergency rooms for a condition that could have been prevented with appropriate information and follow-up care. In effect, this provides a “warranty” for hospital care. The Commonwealth Fund’s state scorecard on health system performance found wide variations in the proportion of Medicare patients readmitted within 30 days, and its national scorecard on health system performance found that minority and low-income Americans are significantly more likely to experience potentially preventable hospital admissions for a host of conditions, including heart failure, diabetes, and pediatric asthma. The Medicare Payment Advisory Commission estimates that 75 percent of readmissions are avoidable. A global diagnostic case rate (with a warranty) would reward hospitals that provide excellent care.

A third payment reform would be to provide explicit rewards for results. Physicians and clinics that do a good job of managing diabetes or monitoring blood-thinning medications would receive “bonuses,” as would hospitals with the best one-year survival rates for heart attacks or hip fractures, for example. Early evidence from demonstrations suggests that even if such bonuses are targeted to the top 20 percent of health care providers, they would serve as a powerful motivation for all to improve.

Investing in infrastructure, information, and the health workforce: Some providers serving low-income and minority patients are concerned they would be disadvantaged by such performance-based policies, since it is inherently more difficult to obtain the best results for patients who do not speak English, have limited education, or lack a family support structure. Undoubtedly, additional provider allowances would be needed to treat such patients. But rather than resist rewarding results, we must invest in the infrastructure, information, and workforce that would help safety-net clinics and hospitals meet high standards of care. In particular, funds should be made available to help safety-net providers adopt information technology and expand opportunities for minorities to train in the health professions and practice in underserved communities.

Investing in the promulgation of electronic medical records and health information technology will help bring coordinated care to underserved communities and reduce disparities in health outcomes. Commonwealth Fund studies have shown that advances in information technology make it easier for physicians to remind patients when preventive care is due, establish disease registries for monitoring appropriate care, prescribe and refill medications, and obtain information from specialists and hospitals on the care patients have received outside a primary care practice. Health plans and safety-net providers should, therefore, be encouraged to expand the use of electronic medical records through financial incentives, as well as clear standards and definitions for interoperable systems.

Ensuring the availability of well-trained, culturally competent health professionals will require adequate funding and expansion of workforce initiatives within the Depart-

It costs all of us money when the poor are denied preventive care, are obliged to resort to expensive emergency room treatment, or become sick because they cannot afford necessary drugs.

DENVER HEALTH: A High-Performance Public Health Care System



Denver Health, a comprehensive and integrated medical system that is Colorado's largest Medicaid and safety-net provider, is nationally regarded as a high-performance organization. According to a recent

Commonwealth Fund case study, Denver Health has succeeded in providing coordinated care to traditionally underserved communities. The keys to Denver Health's success are (1) promoting a culture of continuous quality improvement, (2) building and using an innovative information technology infrastructure, and (3) training a culturally competent health care workforce sufficient for Colorado's expanding need. Moreover, Denver Health accomplishes its mission while remaining a fiscally sound leader in health care delivery.

Denver Health's investments in health information technology and workforce infrastructure are particularly noteworthy. Widespread use of electronic medical records allow patient information to be retrieved by providers across facilities, ease the production of patient reminders for needed preventive services and immunizations, and help providers safely and efficiently prescribe medication. Meanwhile, the organization exposes a new generation of health professionals to the benefits and rewards of practicing within an integrated delivery system capable of providing high-quality care to traditionally underserved populations. This, in turn, helps Denver Health develop a talent pool of clinicians trained to understand the challenges that are often faced by such populations.



ment of Health and Human Services. In particular, the health professions grant and loan programs under the umbrella of the department's Health Resources and Service Administration offer an especially effective avenue for meeting health workforce needs in shortage areas, increasing minority presence in health profession schools, and placing residency training in safety-net sites such as community health centers, public health agencies, and public hospitals. In establishing policy and funding priorities, senior leaders should focus on the need for an increased number of culturally competent medical graduates in a variety of specialties, especially in primary care disciplines.

Providing the leadership: Finally, the Obama administration should make it clear that eliminating racial and ethnic disparities in health care is a priority by providing the leadership required to achieve health care opportunity for all. By establishing and empowering a deputy assistant secretary for quality and disparities within the Department of Health and Human Services, the administration could bring high-level attention and resources to health disparities while reducing variation in quality along racial, socioeconomic, and geographic lines. Key first steps include requiring consistent data collection on race and ethnicity across federal programs; expanding funding, improving targeting, and setting performance goals for community health centers; and outlining a workforce policy that addresses the adequacy, diversity, and geographic dispersion of the primary care workforce.

This is an ambitious, but achievable, agenda. As a number of health and hospital systems have demonstrated, it is possible to increase access to care for vulnerable populations and transform hospitals and clinics into high-performing facilities. Ensuring that everyone has access to affordable insurance coverage, using the medical home model in health centers, clinics, and practices serving low-income communities, and improving the quality of care delivered by doctors and hospitals caring for minority patients are all proven strategies for providing Americans with an equal opportunity to lead healthy, productive lives.

As Robert F. Kennedy urged 40 years ago, the nation should have a better system of accounting for and measuring the benefits of investing in health care. President Obama should issue an annual report to Congress establishing health system goals, setting priorities for improvement, and monitoring the benefits, costs, and progress in maximizing health care spending value. Doing so would help the nation realize that health spending is not just a cost but an investment in the health of our people and the productivity of our economy.

Karen Davis, Ph.D., is the President of The Commonwealth Fund and a former deputy assistant secretary for health policy in the Department of Health and Human Services. Kristof Stremikis, M.P.P., is Research Associate to the President at The Commonwealth Fund.