Institute for Healthcare Improvement

Improving Health Equity: 5 Guiding Principles for Health Care Leaders

In January 2017, a team from IHI argued that health care organizations must make health equity a strategic priority. The authors identified five key steps for health care organizations: make health equity a leader-driven priority, develop structures and processes that support equity, take specific actions that address the social determinants of health, confront institutional racism within the organization, and partner with community organizations. One year later, we offer specific guidance for health care executives in pursuing this goal.

Leaders face a variety of challenges – most prominent among them, fear and ignorance. Some executives are afraid to take a strong stand on health equity because they see it as a no-win situation. Executives who do take a stand face challenges in convincing their organization that they have a problem with disparities and health equity.

Based on interviews, reading, and observation, we offer a set of five guiding principles for leaders:

1) We need substance over show on health equity.

People can smell tokenism if health equity is not taken seriously. Work done should meaningfully impact the lives of people. Health equity is an authentic expression of an organization's commitment to the ideals of social justice, respect, access, and dignity. Health equity initiatives must be action-oriented and embedded in the authenticity of an organization. It requires culture change in most organizations. It is a way of "being" as well as a way of "doing"; it must make a difference in the community and in the lives of people. An example of substance over show: Vidant Health raised the starting wages to $12 per hour for 1,736 employees, costing them $2.8 million a year.

2) Everyone gets to play a part.

In a health system, many departments can impact health equity: quality, safety, HR, IT, community relations, purchasing, physical plant. Because of the connection of the social determinants of health to health and wellbeing, every department can have a role in improving the lives of patients, employees, and people in the community. Improving health equity requires oversight and coordination at multiple levels of the organization. This type of coordinated effort requires leadership to set the tone. The board, CEO, and senior leadership must be committed to this work and must evidence that commitment in their work and actions. It is a walk-the-talk effort. At HealthPartners, for example, health equity is a regular topic of discussion at each board meeting.

3) The last will be first.

Quality improvement often focuses on populations where success is most easily achieved. But if we are going to start reducing disparities, we need to start with the "last" population – one that may be more challenging and just not thriving – and partner with them to develop improvements. The reward for health care organizations is that even though these populations may be small, they can incur great costs to the health system. And if we can solve problems for those at the margins, we may come up with solutions that work better for all. Health equity, by definition, is activity focused upstream on the most vulnerable populations so that the downstream disparities are eventually narrowed. This requires a reprioritization of where upstream investments are made—not just to populations where a demonstrated metric can be easily generated. For example, Kaiser started with reducing hypertension in the black population: "At Gardena Medical Offices, a group practice for Kaiser in Southern California where 65 percent of patients with hypertension were black, BP control rates (< 140/90 mmHg) for blacks improved from 76.6 percent to 81.4 percent, and control rates for whites increased from 82.9 percent to 84.2 percent. The racial gap narrowed from 6.3 percent to 2.8 percent. As these successful practices continue to spread throughout the program, the health disparity gap in BP control has decreased by 50 percent, from 8.1 percent to 3.9 percent."

4) We need to see with new eyes the barriers that exist.

Institutional racism/discrimination is prevalent in all organizations. It may be completely unintended, but it needs to be seen and addressed. Most don't have the vision to see it right away; we need to learn to see it. Acknowledging and calling out the ugliness of the unspoken may be a first step to owning that the barriers exist and that an organization is committed to understanding why they exist and how to eliminate them. For example, IHI has gathered employee satisfaction data since around 2010. Over the years, the percentage of staff who reported that they agreed or strongly agreed that IHI is an excellent place to work was typically in the low- to mid-90s. Last year, for the first time, we gave staff the option of identifying as white, person of color, or not to identify. This allowed us to stratify the data and expose inequities in staff experience. For example, in response to the statement, "Overall, IHI is an excellent place to work," the numbers indicated a 30 percent difference between staff of color and white staff, with 98 percent of white staff agreeing or strongly agreeing compared to 68 percent of staff of color. This substantial inequity has prompted us to learn more about the root causes of this problem, and to start improvement projects aimed at closing this experience gap.

5) This is a personal journey that needs to be undertaken as a group.

There is an emotional component to the work of improving health equity that is much more intense than other work such as quality and safety. Moreover, it cannot just be a personal journey; it needs to be a group journey too that brings the organization along – including employees, physicians, and board members. And the journey should involve those who have experienced the adversities of health inequity. In other words, many can empathize with health inequity, but a smaller number have personally experienced

it. As Jack Lynch, CEO of Main Line Health said, “Both respect and inclusion in the workplace as well as equity of care to our patients are important to me. For instance, we have a policy that we will not switch a caregiver solely based on patient request unless there is a quality or skill-level reason. Imagine what it's like if you're an African-American nurse on a floor and you're being switched out because a racist patient does not want you touching them. That is unacceptable to us. We stand by our staff and want them to know they are valued and appreciated. We also want to ensure our patients receive high-quality care, so we invest significant time in culturally competent care training in addition to other internal efforts.”

Attaining health equity is an eye-opening and often difficult pursuit. If leaders do the hard work necessary to eliminate inequities, they will inevitably face hard questions and choices, have their assumptions challenged, and experience many uncomfortable situations. But if we’re serious about providing the best care to all our patients, then we must also be serious about providing all our patients — regardless of their social position or other socially determined circumstance — with the opportunity to attain their full health potential. That is the very definition of health equity.

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