VIEWPOINT

Equity and Quality—Improving Health Care Delivery Requires Both

Victor J. Dzau, MD
National Academy of Medicine, Washington, DC.

Kedar Mate, MD
Institute for Healthcare Improvement, Boston, Massachusetts.

Margaret O'Kane, MHS
National Committee for Quality Assurance, Washington, DC.

Viewpoint page 521

In 2000, the Institute of Medicine (now the National Academy of Medicine) published *To Err Is Human: Building a Safer Health System*,[1] followed a year later by *Crossing the Quality Chasm: A New Health System for the 21st Century*.[2] Together, these reports launched a movement to improve health care quality and patient safety. On the occasion of the 20th anniversary of these landmark reports, the National Academy of Medicine assembled 10 national leaders in health care quality to look back on lessons learned and forward to the field's future.[3] In their paper, the leaders unanimously concluded that "[f]or care to be considered high quality, it must be equitable."[3] This Viewpoint explains that the inverse is also true: It is impossible to deliver equitable health care if it is not high-quality care. In other words, there is no equity without quality, and there is no quality without equity.

Crossing the Quality Chasm identified equity as 1 of the 6 aims of quality. It defined "equitable care" as having "care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status."[2] Thus, quality must not only center equity, providing equitable care also requires that care is of the highest quality.

> There is no quality without equity, and there is no equity without quality. As new quality-improvement measures and approaches are put into place, they should be planned with equity in mind and monitored to ensure they reduce disparities.

However, improving health care quality does not ensure health equity. When quality improvement efforts do not intentionally address equity, they may actually increase disparities. For example, between 1990 and 2005, US mortality rates for heart disease, breast cancer, and stroke decreased, but the gap between mortality rates among Black patients and White patients increased.[4] As quality improvement efforts are implemented, they must be held accountable for both improving care and reducing disparities.

Presently, however, the health system does not have the infrastructure to center and build equity. But it can use the existing infrastructure developed to measure, monitor, improve, and incentivize quality to also build a more equitable health system by focusing on 3 areas: data, leadership and governance, and payment.

Data

It is often said that what is not measured cannot be improved. The health system must be able to measure and demonstrate improvements in health care disparities to show progress toward achieving health equity. But the US health system currently does a poor job of collecting and using these data, for reasons including "an absence of standardized data categories, insufficient institutional incentives, a lack of patient trust, reluctance of clinicians to ask for and record data, and inadequate explanations to both patients and staff regarding the importance and purpose of collecting demographic information."[3]

This needs to change. Equity must be centered in all levels of health data infrastructure, in both the public and private sectors. Public health data collection must capture and address structural racism and other health inequities, including collecting data across population groups by race, ethnicity, and geography and investing resources to support comprehensive data collection at the federal, state, and local levels. Data collection should include "self-reported data by race, ethnicity, income, education, gender identity, sexual orientation, disability, and social position (ie, how people are placed in a hierarchy of value by society, as perceived by the individual)," as well as community-level data.[5]

Leadership and Governance

Health equity should be everyone's business, but advancing health equity will require sustained leadership, supportive governance structures, and dedicated resources. Although health care systems and organizations are responsible for ensuring patient safety, they are not yet legally or operationally responsible for ensuring equity. However, this can change if equity is directly connected to quality and patient safety, and these ties could provide the motivation necessary to begin broad cultural change toward considering health equity with the same seriousness that is currently devoted to ensuring patient safety and quality care.

Payment

Equity also must be part of the equation for achieving high-value health care, and it needs to be brought forth explicitly as part of the value equation.

Health care organizations in predominantly fee-for-service environments are not incentivized financially to ensure equitable care and are only in some instances provided with fee-for-service payments that

Corresponding Author: Victor J. Dzau, MD, National Academy of Medicine, 500 Fifth St NW, Washington, DC 20001 (vdzau@nas.edu).

are linked to quality performance. But organizations that assume financial risk through population-based payment models, such as accountable care organizations, and full capitation are in the position to do just this. These models already reward improvements in population health, but they need to be strengthened to incentivize improvements in the health of marginalized populations. Reducing racial and ethnic disparities in health outcomes must become a requirement for health care organizations in managing population-level financial risk. Equity improvements should also be considered when analyzing quality-based performance payments as an additional incentive.

Delivering high-quality and equitable care does not mean treating every patient the same way. Patients have different circumstances, needs, and preferences that need to be addressed, including those due to the social determinants of health, which may include lack of access to healthy foods, affordable housing, or stable employment. To address these factors effectively, health care organizations need to work with organizations in other sectors, such as food banks, employers, and social service providers, to ensure that patients are adequately cared for.

As the US health care system endeavors to deliver both quality and equity-focused care, it must do so understanding the dynamic between the 2. There is no quality without equity, and there is no equity without quality. As new quality-improvement measures and approaches are put into place, they should be planned with equity in mind and monitored to ensure they reduce disparities. At the same time, to truly move toward delivering equitable care, leaders should draw on existing infrastructure and measures in place for assessing and improving health care quality. The time is now to ensure that patients across the US receive the care they deserve.

ARTICLE INFORMATION

Published Online: January 21, 2022. doi:10.1001/jama.2022.0283

Conflict of Interest Disclosures: Dr Dzau reported previously serving as a board member for Medtronic and receiving deferred compensation until 2018. Ms O'Kane is a board member of the Milbank Memorial Fund, the Institute for Exceptional Care, and EHE Health, as well as a board member and former board chair of Healthwise. No other disclosures were reported.

REFERENCES

1. Institute of Medicine. *To Err Is Human: Building a Safer Health System*. National Academies Press; 2000.

2. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. National Academies Press; 2001.

3. O'Kane M, Agrawal S, Binder L, et al. *An Equity Agenda for the Field of Health Care Quality Improvement*. National Academy of Medicine; 2021.

4. Hostetter M, Klein S. In focus: reducing racial disparities in health care by confronting racism. The Commonwealth Fund. Published September 27, 2018. Accessed January 4, 2022. https://www.commonwealthfund.org/publications/2018/sep/focus-reducing-racial-disparities-health-care-confronting-racism

5. Christopher GC, Zimmerman EB, Chandra A, Martin LT, eds. Charting a course for an equity-centered data system: recommendations from the National Commission to Transform Public Health Data Systems. Robert Wood Johnson Foundation. Accessed January 4, 2022. https://www.rwjf.org/en/library/research/2021/10/charting-a-course-for-an-equity-centered-data-system.html