In the Effort to Improve Health Equity, Terminology Matters

In December of 2021, with the COVID-19 Omicron variant raging, the Biden Harris Administration announced that it would make available four rapid home COVID tests to each household beginning in January 2022. This strategy – while a positive step overall toward fighting against the pandemic – highlights the difference between equity and equality. Four test kits to each household provides equal resources yet is not equitable given that the total number of tests offered does not vary by household size. Furthermore, the program requires individuals enrolling with their home address which is not possible for the unhoused. Examples of the distinction between equity and equality are not always so cut-and-dried, however. Which is why having common, consensus-derived definitions of these terms is so critical to the work of addressing inequities and improving outcomes for all individuals.

The graphic below captures the difference between the two: equality provides the same resource to everyone regardless of their specific needs, whereas equity requires that resources are adapted to meet each individual's specific needs. When talking about health equity, we are not only talking about equal access to health care coverage or services. The definition of equity must be grounded in the notion that achieving health equity requires a thorough understanding of each person's unique health needs, and of the necessary changes required both within the health care system and outside of clinical settings to adequately address these needs.

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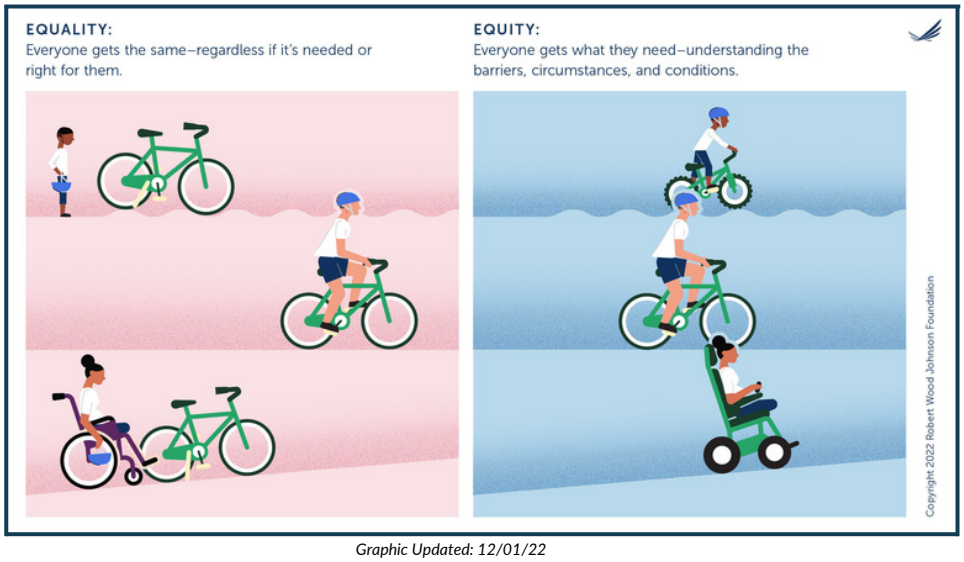

Graphic Updated: 12/01/22

Over the last several years, health system stakeholders have increasingly sought to identify health inequities and implement meaningful programs and models to address them and improve outcomes for underserved individuals. One major roadblock is the fee-for-service payment model, which supports inequity by incentivizing uncoordinated care, and lack of access to preventive care. There is also a fundamental challenge created by a lack of common understanding and use of terminology in the health equity dialogue, namely the following:

- **Health Equity**
- **Health Disparities**
- **Health Inequities**

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The thread that runs across these terms is the agreement that having a common – and to the extent possible, precise – understanding is critical to making the intervention design, implementation, and operation life cycle achieve the desired results.

The Health Care Transformation Task Force's (HCTTF or the Task Force) is a consortium of private sector stakeholders that support accelerating the pace of transforming the delivery system system into one that better pays for value. Representing a diverse set of organizations from various segments of the industry – including providers, payers, purchasers, and patient advocacy organizations – we share a common commitment to transform our respective businesses and clinical models to deliver a health system that achieves equitable outcomes through high-quality, affordable person-centered care.

In 2019, the Task Force published a Health Affairs blog on the importance of industry stakeholders using precise terminology when using the term "social determinants of health" (SDOH) in the dialogue around addressing challenges to health equity. The blog noted that SDOH, social needs, and social risk factors are different concepts that all have a unique role to play in the health equity dialogue. Now, with the health equity conversations evolving, defining the terms and the distinctions between health equity, health inequity, and health disparities will support further progress by promoting clarity of expression.

The Task Force now explores several common definitions that are being used to describe health equity, analyze commonalities and themes that appear across these definitions, and discuss the interplay between health equity and two related but different terms: health inequities and health disparities.

What Elements are Critical to Include in a Definition of Health Equity?

There is no shortage of definitions of health equity, and this blog does not seek to create another definition to add to the mix. Instead, we seek to identify the most relevant elements that should be included in a comprehensive definition. Some commonly referred-to definitions include:

Organization	Health Equity Definition
U.S. Department of Health and Human Services	Access to health resources such that every individual – regardless of genetic, socio-environmental, and/or economic determinants of health – has the opportunity to achieve their highest level of care
White House Executive Order 13985: Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (January 2021)	The consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment.
World Health Organization	The absence of unfair, avoidable, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g., sex, gender, ethnicity, disability, or sexual orientation). Health is a fundamental human right. Health equity is achieved when everyone can attain their full potential for health and well-being.
The Robert Wood Johnson Foundation	Removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

Several priorities rise to the top when looking at these definitions, but they boil down to health equity comprising the following key concepts:

- Access to care that allows for every individual to have the opportunity to achieve their desired health outcomes, including access to different and/or greater resources to compensate for historical denial of access;

- Availability of care and treatment that is consistent, fair, and impartial, regardless of the background/demographics of the person seeking care;
- Elimination of differences in treatment based on non-health-related factors related to social, economic, demographic, geographic, or other variables that lead to inequal treatment in society; and,
- Removal of obstacles to health that go beyond the health care system, including poverty, discrimination, and structural racism.

Ingrained in these priorities are myriad factors that go beyond the direct interaction between an individual and the health care delivery system.

Health Equity, Health Inequity, and Health Disparities: Using Terms Appropriately and Precisely

Traditionally, the gaps in care and outcomes that underserved populations experience have been described as health disparities. However, certain health disparities exist without being the fault of the system. Too often, stakeholders use health disparities when the more accurate characterization would be defined as health inequities.

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These are two distinct concepts, and many in the field would like to see health inequities become the baseline term as our health care system strives to fix these issues.

Health Compass Milwaukee defines health disparities as "differences in health status and mortality rates across population groups, which can sometimes be expected, such as cancer rates in the elderly versus children." The Health Care Payment Learning and Action Network (LAN) defines health inequities as "unjust and avoidable differences in the distribution or allocation of resources between marginalized and dominant groups that lead to disparities." The distinction comes from understanding that: (a) health inequity is often an outgrowth of societal inequity; and (b) health equity does not exist in a vacuum, and neither do the interventions that can be used to address it and improve it.

The Role of Value-Based Payment Models in Pushing for Equitable Health Outcomes

Rethinking the way health care is paid for is integral to addressing health equity. Stakeholders across the system acknowledge that the fee-for-service model is not designed to support the kinds of services, models, and policies that deliver both coordinated health care and provide individuals with access to non-clinical services. Further, there is recognition that the movement toward health care transformation – changing the way care is delivered by replacing the fee-for-service system with value-based payment (VBP) models that prioritize outcomes through coordinated, high quality care – is a key component of creating a truly equitable health care system.

A value-based payment and care delivery infrastructure that incentivizes the health care system to focus on whole-person care, encourages collaboration to address the social drivers of health, and holds payers and providers accountable for quality and cost outcomes is critical to advancing the health equity policy objectives.

The days of designing value-based payment models without acknowledging and interweaving equity into the fabric of the design and implementation are over.

VBP models offer a way to address the underlying SDOH and health inequities that result from decades of structural racism and other systems of oppression. Value-based payment models incent proactive and coordinated care by supplying providers with a set payment rate to care for a patient. Providers that keep the costs of care under the allotted payment receive shared savings, and those that provide care whose costs exceed the allotted payment are penalized with shared losses divided between a payer (e.g., the Center for Medicare and Medicaid Services (CMS)) and the participating provider. The risk of shared losses incentivizes that provider to provide the highest quality care at an efficient cost to the patient and to the system. This results in more proactive outreach to patients, better systems in place to identify high-cost patients to manage their conditions, greater use of care teams to provide patient-centric care, and enhanced data collection and sharing across organizations in legally compliant ways.

At a more granular level, VBP models can be designed to specifically measure and adjust for health equity. Industry leaders have offered important strategies for payers and providers to embrace health equity in the design and implementation of value-based models, including selection of equity-focused quality measures, implementing fundamental changes in payment and performance measurement to address health inequities, and empowering health care organizations to address social needs. Linking performance on health equity measures to payment will make promoting equity not only the right thing to do, but also the financially desirable thing to do.

The process of transforming health care payment from fee-for-service to value-based payment arrangements has resulted in improvements in care coordination and other patient-centered interventions that support improved outcomes.

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However, many historically underserved populations have not yet had the opportunity to participate in these models for various reasons. Namely, VBP models are not designed to reach marginalized populations. Joining and succeeding in a value-based payment models requires participating entities to invest in the necessary infrastructure to build out care teams, data sharing, and more.

For health care organizations with limited financial resources, it is difficult to make necessary upfront investments. CMS, including the Center for Medicare and Medicaid Innovation (CMMI), should design more models that provide necessary upfront costs to participating entities, so that a greater number of historically marginalized communities are incentivized participate.

CMS has taken a positive step in this direction by proposing to add an ACO Incentive Program to the Medicare Shared Saving Program in 2023 that would permit qualifying ACOs to receive upfront investment dollars to help build out this infrastructure.

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Further, CMS should revisit the current benchmarking methodology – the amount of money a participating entity is allotted to spend before potentially experiencing financial risk – which is based on historical spend. Communities that have lower historical spend due to patients not receiving necessary care will then be faced with many untreated conditions, which drives up the costs necessary to properly care for the population. Similarly, to account for the factors outside of the healthcare system that impact an individual's health – that in turn lead to greater costs for caring for the patient - CMS should add social risk factors to model risk adjustment scores

Looking Ahead

Value-based payment models alone are not the solution for achieving heath equity. However, a commitment to value-based payment and care delivery provides the critical foundation for making the necessary adjustments essential to imbuing equity into all aspects of care delivery. This commitment will progress more effectively when all stakeholders use terminology in a standardized, common way, which will promote meaningful discussions built on trust and mutual understanding.

Established in 2014, the Health Care Transformation Task Force brings together patients, payers, providers, and purchaser representatives to act as a private sector driver, coordinator, and facilitator of delivery system transformation. In addition to serving as a resource and shared learnings convener for members, the Task Force is also a leading public voice on value-based payment and care delivery transformation.