

Why inequity should be treated as an unwanted variation in care

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The tools and methods that are used to improve health care quality and safety can also be employed to promote health equity, according to the physician experts who gathered for a recent AMA panel discussion.

“All of our work in quality, reliability and systems science is aimed at essentially improving undesired variation in a system,” said Kedar Mate, MD, president and CEO of the Institute for Healthcare Improvement. “Inequities are exactly that: Undesired, unjust, historically driven and structured variation in our systems.”

Positive changes can be seen when the methods of quality improvement science are applied to inequities, said Dr. Mate, but he warned there are some important differences.

The root causes of inequities “may not be so apparent in how we think about, for example, a wrong-site surgery or a nosocomial infection,” he said. “When you do a root-cause analysis around an inequity, you reach back hundreds of years into history and structural injustice, which are part of the story around why we have the inequities that we have today.”

Dr. Mate spoke during a recent episode of the AMA “Prioritizing Equity” video series examining how quality and safety can drive equitable health care during the COVID-19 pandemic and beyond. The panel was moderated by Karthik Sivashanker, MD, MPH, the AMA Center for Health Equity’s vice president of equitable health systems and innovation. He is also Brigham Health’s medical director for quality, safety and equity.

“Equity is not a zero-sum game,” Dr. Sivashanker said. “When you improve care for our most historically oppressed populations, it makes care better for everyone because the system is more reliable and resilient.”

Data collection needed

Panelist Louis H. Hart, MD, the director of equity, quality & safety at NYC Health + Hospitals, said it's important to collect patient race and ethnicity data—even though race is a social construct and not a proxy for genetics.

Data shows the ways that disease manifests among racial groups as well as the effects of concentrated poverty, lack of opportunity and poor access to care, Dr. Hart said. At NYC Health + Hospitals this data has been used to inform its “Medical Eracism” program. The effort identifies and eliminates medical practices, such as race-based health assessment formulas that lead to inequitable outcomes in care for kidney disease or in maternal perinatal morbidity and mortality.

Unless organizations emphasize equity in the design of their quality improvement work, the panelists stated, it is difficult to know whether inequities are being reduced even as other performance metrics improve.

“It’s easy to assume that your interventions are benefiting all because the mean is going up,” Dr. Hart said. Once disparities are identified, organizations need to be transparent and collaborate on how to eliminate them—just as they would use existing infrastructures to attack other quality issues.

Need to act in the community

Applying the tools used to reduce undesired variation in health care to reducing inequity can also expose root causes that cannot be solved by health systems alone, Dr. Mate said.

“Health care alone will not be able to solve all the inequities that we see in our emergency rooms and in our hospital wards and our systems,” he said. “We have to go well beyond that into education, public safety, criminal justice and a variety of other social factors that are contributing to the inequities that we eventually see in our hospitals and in our clinic environments.”

Physicians and health systems should use their social, economic and political clout in communities to help bring together the “necessary actors” to tackle deeply entrenched inequities, Dr. Mate said.

Learn how the AMA is fighting for greater health equity by identifying and eliminating inequities through advocacy, community leadership and education.