*Invited commentary*

# Opportunities and challenges in health care equity

Dr. Mayberry's article outlining the research agenda in health care equity improvement at Baylor Health Care System (BHCS) highlights the opportunities and challenges that lie before us individually and organizationally. He sheds light upon valuable evidence that suggests that health care equity improvement should be considered part of the unfinished civil rights agenda in the USA. It is difficult, if not impossible, to address health equity without recognizing the link between its ethical foundations and the physical and social science evidence that should guide our interventional strategies. Baylor's faith-based roots and understanding of God's concern for the disenfranchised should provide us with the commitment and steadfast political will to pursue a deeper understanding of the inequities in health and health care delivery.

Over the last decade, BHCS has engaged in a variety of efforts that touch upon many aspects of health care equity. Beginning with efforts to help increase access to health care, we assisted numerous community and faith-based organizations in the development of after-hours charity clinics. To support these clinics, we developed the Volunteers-in-Medicine service initiative as an effective mechanism to facilitate volunteerism among physicians, nurses, and support staff. Additionally, BHCS has been the principal health care system supporting the development and operation of Project Access Dallas, a countywide network of physicians, ancillary providers, and hospitals organized to provide a continuum of health care services for uninsured enrollees. At Baylor University Medical Center (BUMC), the Uninsured Provider Project has enabled numerous specialty care physicians to continue their vital role in maintaining BUMC's status as a level 1 trauma center. By financially supporting physicians and practices willing to accept uninsured medical and surgical patients, BUMC has enhanced quality and access to care for indigent patients with urgent health care needs.

As we move forward within the current economic environment, BHCS hospitals and the HealthTexas Provider Network will need to become creative in their efforts to increase equity in health care access, delivery, and outcomes. It will also be important for us to explore new community leadership roles and build collaborations within at-risk neighborhoods and communities to impact the sociocultural variables affecting health.

One such collaboration is a model community health services program within a downtown Dallas nonprofit organization, Central Dallas Ministries (CDM). BUMC has worked in collaboration with CDM for the last 7 years, helping to expand their health care delivery from episodic after-hours care to a full-time primary care clinic providing uninsured patients with an alternative to the BUMC emergency department. Moving beyond the development of primary care services, the CDM-BUMC collaboration launched a highly effective community care coordination project, utilizing community health workers to assist complex medical and surgical patients in their transition to community-based care after hospital discharge. This project has reduced readmission rates among these patients. Additionally, the collaboration developed a chronic disease management project to provide vital education and support services for uninsured patients with poorly controlled diabetes. Evidence of success of this program can be seen in the *Figure.* The research agenda proposed by Dr. Mayberry will assist in measuring not only the equity in health care but also the effectiveness and efficiency of these types of collaborative community initiatives.

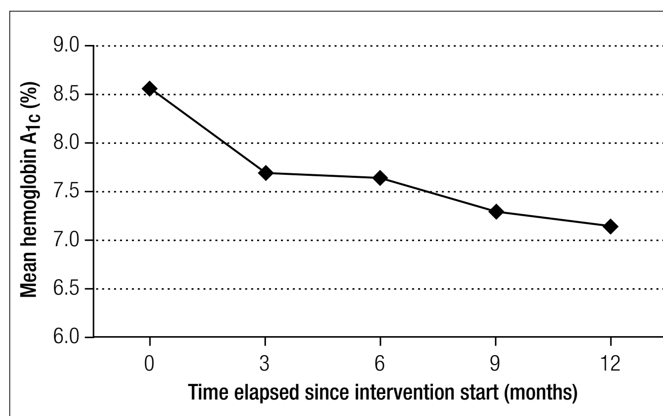


**Figure.** Changes over time in mean hemoglobin $A_{1c}$ level among 55 diabetes patients receiving community-based diabetic health education through the Baylor University Medical Center–Central Dallas Ministries collaboration. From Prezio EA, Walton JW, Culica D. Community health worker as diabetes educator. American Public Health Association Annual Conference, Philadelphia, PA, December 2005.

BHCS's early work is noteworthy, but it is the persisting excess morbidity and mortality among racial and ethnic minorities that solidifies our resolve to address health equity. In spite of the multitude of variables that impact health outcomes, it is clear that health care systems will continue to be held accountable for ensuring progress in this area. The evidence in Tables 4 through 8 in Dr. Mayberry's article suggesting that inequitable health care may exist within BHCS will likely cause tremendous angst throughout the organization. Given this early evidence, it is imperative that we take action to ensure that the necessary evidence-based changes in health care delivery are made. To address this variable, we should heed Dr. Mayberry's call for the development and integration of an "equity tracking and monitoring system" while performing the vital "interdisciplinary research that explores, identifies, monitors, and explains inequities in health care." This capacity will enable us to identify opportunities for improvement in equitable health care access, delivery, and outcomes as we pursue our "best care" objective.

We must recognize that achieving equity in health care delivery within hospitals and outpatient settings may fail to deliver the desired result of equitable health outcomes. There is ample evidence that inequalities in health outcomes among racial and ethnic minority populations are correlated with a multitude of variables: socioeconomics, personal and family education levels, habits and behaviors, trust, access, insurance, and early screening and treatment. In a recent review, Szreter and Woolcock described the foundational epidemiology studies that revealed how community-level variables such as social networks, trust, and norms of reciprocity impact health outcomes and health inequities (1). The article highlighted a number of empirical studies (e.g., Social Origins of Depression and the Alameda County Study) that illustrate improvement in individual health outcomes (e.g., chronic degenerative conditions and acute myocardial infarctions) when strong social support networks are present. These studies give us insight into community-level, social, and cultural variables that we should incorporate into our equity improvement strategies.

As we consider the equity dimensions of BHCS's best care and clinical transformation efforts, we must realize that this endeavor may well define the health of future generations in North Texas. Over the coming years, I suspect much will be made over the definitions of equity and health care (e.g., Does equity infer equality in health care for all? Are health care and health outcomes synonymous?). Even as I write this commentary, I am conscious of the sensitivities associated with these terms. Practitioners, administrators, and board members will be challenged to interpret these concepts in light of their personal background and experiences. The diversity of responses will likely provoke much-needed debate on the implications of creating new lexicons and practices within the modern health care delivery system.

Along with Dr. Mayberry, I believe BHCS's investment in health equity improvement will yield immeasurable societal value to the North Texas region. The aspiration to provide community leadership in health care equity improvement will cause us to avoid complacency with this quality aim while we strive to make important progress within the other domains of quality (i.e., safety, timeliness, efficiency, effectiveness, and patient-centeredness). Our initial steps are to call the system's leaders, trustees, and practitioners to reflect upon how these efforts support the vision of a more compassionate organization. An equity charter has been drafted and is under consideration by the Best Care and Clinical Transformation Executive Committees. This process will define the scope of our work in health equity improvement and clarify the financial and human resource allocations necessary to implement, measure, and report our efforts. Our success in this area has the potential to not only reshape the health care delivery system but also move us closer to a more just and equitable society.

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1. Szreter S, Woolcock M. Health by association? Social capital, social theory, and the political economy of public health. *Int J Epidemiol* 2004;33(4):650–667.