ZS | HEALTHCARE LEADERSHIP COUNCIL

Advancing Health Equity: Practical Solutions to Address Variations in Care

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Executive summary

Health disparities are pervasive and persistent across the country. The goal of this report, a collaboration between ZS, the Healthcare Leadership Council (HLC) and its membership community, is to gain deeper insight into these disparities and, more importantly, identify effective measures to reduce them. This work is focused on addressing U.S.-specific disparities in the quality of care within a broader health equity context. We first identify top issue areas across healthcare, then provide recommendations for individual organizations as well as specific sectors of healthcare.
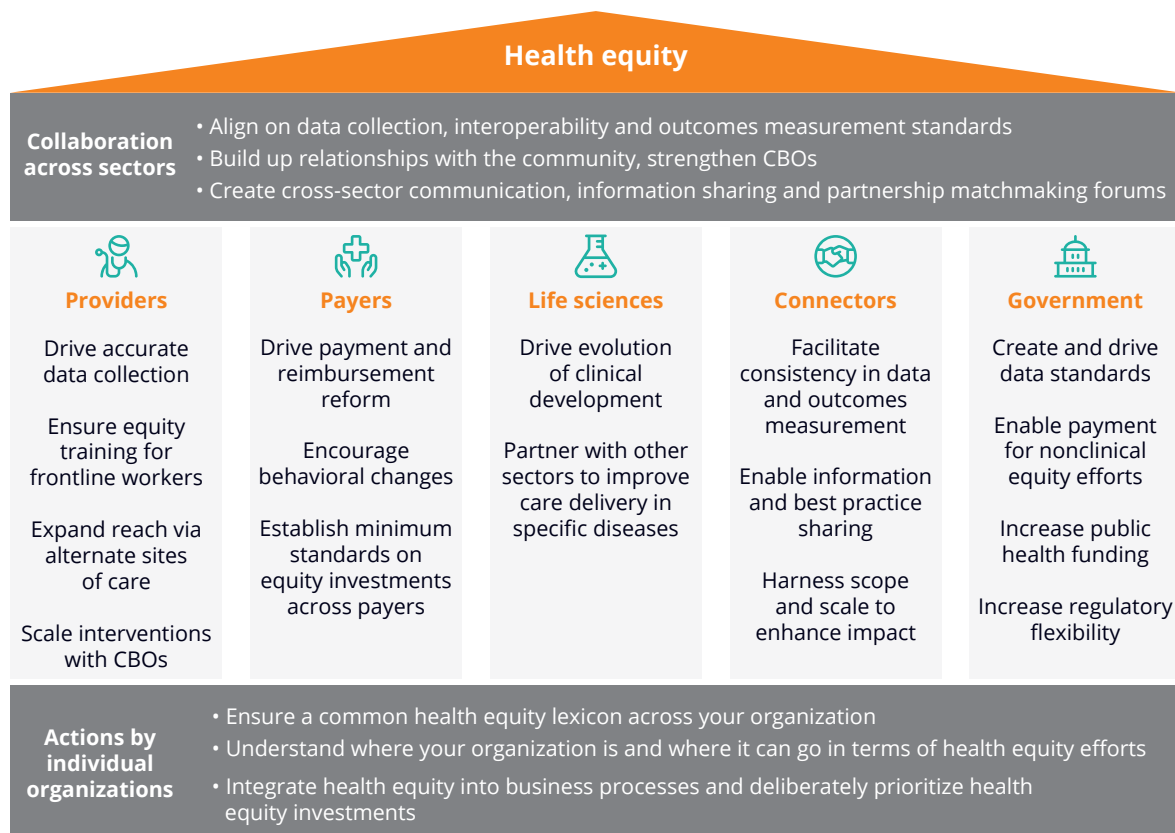
The barriers to health equity have several components. Our work and our report highlight and prioritize the following challenges:

- There are numerous data collection, data sharing and outcome measurement standards that confound insights into health disparities. This inhibits collaboration across organizations and sectors.

- There is a shortage of strong forums for the sharing of data, insights and best practices across organizations and sectors.

- The system provides insufficient training and incentives for individuals and organizations to adopt behaviors that bolster health equity. For example, at an individual level, there is ambiguity around how to collect data from patients. At an organizational level, there is minimal reimbursement to providers for nonclinical interventions.

- Certain populations and afflictions are less likely to benefit from investments in research and development (R&D) and are less likely to be represented in clinical development.

- Regulatory restrictions, such as Stark and anti-kickback laws, limit partnerships due to the potential for uneven value transfer between organizations.

- There is a lack of sustainable funding for health equity endeavors, particularly for interventions developed with community-based organizations (CBOs).

There are no silver bullets for these issues, but as healthcare stakeholders there are actions we all must take. Reflecting this philosophy, ZS and HLC created recommendations to address these barriers at the individual organization level, a healthcare sector level and industrywide level.

FIGURE 1:

Recommended actions to address health equity

Health equity

Collaboration across sectors	• Align on data collection, interoperability and outcomes measurement standards • Build up relationships with the community, strengthen CBOs • Create cross-sector communication, information sharing and partnership matchmaking forums

Providers	**Payers**	**Life sciences**	**Connectors**	**Government**
Drive accurate data collection	Drive payment and reimbursement reform	Drive evolution of clinical development	Facilitate consistency in data and outcomes measurement	Create and drive data standards
Ensure equity training for frontline workers	Encourage behavioral changes	Partner with other sectors to improve care delivery in specific diseases	Enable information and best practice sharing	Enable payment for nonclinical equity efforts
Expand reach via alternate sites of care	Establish minimum standards on equity investments across payers		Harness scope and scale to enhance impact	Increase public health funding
Scale interventions with CBOs				Increase regulatory flexibility

Actions by individual organizations	• Ensure a common health equity lexicon across your organization • Understand where your organization is and where it can go in terms of health equity efforts • Integrate health equity into business processes and deliberately prioritize health equity investments

Recommended actions for individual organizations (bottom), sectors of healthcare (middle) and across healthcare sectors (top) to address barriers to health equity. Connectors are defined as distributors, group purchasing organizations, health technology companies, industry consultancies and other organizations in healthcare.

Background and context

Across the healthcare ecosystem, interest in health equity and drivers of health has prompted a flurry of initiatives aimed at addressing health disparities. While health equity has been an area of study for several decades, highly visible disparities wrought by COVID-19 and the deepened public interest in social equity have served as catalysts of renewed focus. Efforts to address equity issues run the gamut from public programs, such as the ACO REACH Model and the Enhancing Oncology Model, to private sector investments, such as improving diversity in clinical trials. Programs that support patients through their healthcare journey have bloomed with support from providers, payers and community organizations. Involvement from these healthcare sectors is critically important due to the pervasive nature of inequities across healthcare and society at large.

Methodology and objectives

It is within this context that HLC and ZS conducted a research project to explore variations in the quality of care for underserved populations and potential solutions to improve health equity. This research included interviews with over 35 HLC members across sectors and analytics of public and patient-level data, a literature review and a workshop involving more than 25 HLC members to discuss implications of study results.

The purpose of our work was to identify insights and recommendations to reduce variations in health disparities. This U.S.-focused report primarily looks at addressing variations in the quality of care. However, we recognize that quality of care is inexorably linked to drivers outside the healthcare ecosystem and we will draw connections to these drivers. Our intention is to provide a cross-sector view of healthcare as well as sector-specific insights and recommendations. This report is organized as follows:

- Identification of issue areas and barriers to health equity across the entire healthcare industry.

- Actions and recommendations to address barriers by individual organizations and across the healthcare industry.

- Insights and recommendations within individual sectors of healthcare as well as policy and regulatory recommendations. Sectors we will cover include the public sector, payers, healthcare providers, life sciences organizations and companies that serve as connectors across healthcare.

Definitions

This report is targeted to healthcare audiences with some familiarity with health equity and related issues. Therefore, we assume readers have a basic understanding of health equity and the social and economic reasons why achieving it is important. However, our research found significant differences in the lexicon used across organizations. To avoid confusion, we have defined relevant terms for this report.

Sector: We divide the healthcare industry into the following sectors: the public sector, including government organizations; payers and health insurers; providers and health systems; life sciences organizations and connectors. When we say connectors, we mean distributors, group purchasing organizations, health technology companies, industry consultancies and others.

Health outcome: Any measurable quantity affecting a person's health due to healthcare interventions, such as screening or treatment for a disease.

Quality of care: The degree to which health services increase the likelihood of a desired health outcome, as defined by the World Health Organization.

Health equity: We defer to the Robert Wood Johnson Foundation's definition that states, "Everyone has a fair and just opportunity to be as healthy as possible." Health equity is one of the goals of studying population health, which refers to both the health outcomes of a group as well as the distribution of such outcomes within the group.

Health disparities: From HealthyPeople, disparities are differences in health outcomes in different groups of people.

Health inequities: This term is often used interchangeably with health disparities. It refers to disparities that can be prevented or circumstances that wouldn't be allowed in an ideal case.
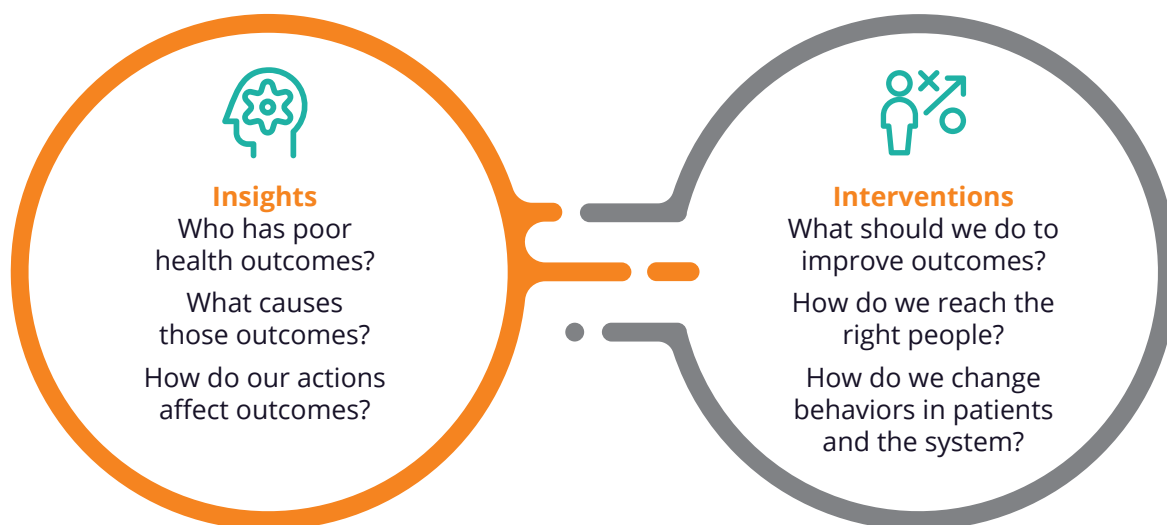
Drivers of health: Much of the literature and discourse to date uses the term **social determinants of health (SDOH)** to describe the factors that influence health outside the realm of medicine and biology. In this report we adopt the drivers of health language to describe any nonmedical and nonbiological determinant of health. We chose this nomenclature to avoid connotations of immutability associated with the term "determinants." We drop the term "social" to clarify that we take behavioral and environmental drivers into consideration as well. Some important drivers of health include, but are not limited to, socioeconomic status, race or ethnicity, age, gender, food insecurity, housing insecurity and access to transportation.

Barriers to addressing variations in quality of care

Our research identified several barriers to mitigating disparities in quality of care. Beyond quality of care, multiple components of our research also confirmed there are variations in the extent to which certain populations interact with the healthcare ecosystem. We will emphasize barriers to quality of care, but note most issues identified also apply to access to care. The top challenges we prioritized in our analysis fall mostly into two categories— barriers to insights and barriers to interventions.

FIGURE 2:

Barriers to addressing variations in care

Insights
Who has poor
health outcomes?

What causes
those outcomes?

How do our actions
affect outcomes?

Interventions
What should we do to
improve outcomes?

How do we reach the
right people?

How do we change
behaviors in patients
and the system?

Barriers to addressing variations in quality of care generally fall into two categories: insights and interventions. For insights, the barriers create ambiguity around where the problems are and what's driving them. For interventions, the barriers hinder actions aimed at addressing variations in care.

Barriers to insights

By "barriers to insights" we mean hurdles to identifying which individuals have good and poor health outcomes, the factors driving those outcomes and how much each factor influences the health outcome. The two most significant barriers to insights, as we have categorized them, relate to data and outcomes standardization and data and best practice sharing.

Data and outcomes standardization

While many organizations have a general and relatively clear understanding of which groups of individuals have worse outcomes, the healthcare industry needs to understand more specifically where disparities are and what is driving those outcomes. Current broadly adopted data standards lack the necessary breadth, granularity of patient characteristics and drivers of health required to get a clear picture of the landscape of disparities. For example, many healthcare organizations mirror the racial classifications used in the U.S. census when collecting data on patient race. However, in our research, several organizations noted that health needs vary significantly within these broadly defined racial groups. These healthcare organizations collect more granular data, but when there is inconsistency in the inputs, it is difficult to form a complete and accurate picture of a patient's situation when integrating data across multiple sources.

A similar issue of inconsistency exists around which metrics to measure to understand a person's health adequately. In other words, how do different stakeholders align on what quantities should constitute health outcomes? Many measurable quantities related to health are specific to certain illnesses. Even within specific diseases, there are many steps along the way, including screening, diagnosis and treatment. Furthermore, outcomes are often only measurable in the long term. For example, it takes a long time to understand the impact of interventions on life expectancy. In these cases, a surrogate measure, such as whether an intervention has occurred, may be preferred. We know certain treatments lead to a longer life, so we measure whether a patient is treated rather than their total life span.

A quantitative analysis across diseases (see the "Methodology" section on page 26 below) shows significant differences in the magnitude of disparities and the importance of specific health drivers across diseases. Certain drivers of health are ubiquitous, while others are highly disease dependent. Local differences manifest across geographies. To understand the true issue areas and potential drivers, data and insights need to be examined closely and in the proper context, including the disease, the outcome metric and local variations in drivers.

It's worth noting that analyzing health disparities and drivers is difficult due to the vast web of relationships and reinforcing loops between causes and effects. Many efforts to unify these relationships for analytical purposes are complex and potentially difficult to use in practice. For our analysis, we developed and used a practical framework involving de-identified patient-level medical and pharmacy claims in addition to data on local drivers of health from public sources.

Data and best practice sharing

Several other organizations and publications emphasize the importance of partnerships between healthcare entities, particularly community organizations, toward addressing health inequities. These partnerships require a secure but smooth exchange of patient information across stakeholders to gain the best insights and deploy the best interventions. The interoperability of systems containing patient information, including data on demographics, outcomes and drivers of health—and alignment on how to secure and use that information— are crucial for addressing disparities in the quality of care. However, access to patients is not equivalent across the ecosystem. Because of this, healthcare stakeholders should work together to clearly delineate their roles in the collection and reporting of relevant patient data, particularly in any policy-driven requirements.

Outside of data and insights on individuals, healthcare organizations can also share their own learnings. Many organizations are currently conducting pilot exercises and experiments to determine the impact and effectiveness of various interventions. While some channels provide a means of sharing best practices at a high level within sectors, deeper collaboration and consultation in the same spirit can improve scalability and efficiency of interventions.

Barriers to interventions

We took a broad look at interventions aimed at improving quality of care, from having the right tools and using them in an unbiased way to resourcing the interventions themselves.

Efficacy and availability of treatment options across populations

Perhaps the most direct issue on the interventions side is ensuring our existing medical interventions are appropriate across populations. Widespread recognition of the lack of representation in treatment development has spurred many companies to diversify recruitment in medical research and clinical trials with some success. However, diverse recruitment alone is not a sustainable solution. Additional innovations, such as protocol design and asset planning for future treatments remain broad areas for improvement.

Training for and incentivizing the right behaviors

Change is hard and working toward health equity is a big change for the industry. Aligning incentives for individuals and organizations can help move the needle on biased behaviors and organizational structures that reinforce health inequities. Efforts to change behaviors cannot happen on just the patient or healthcare system side. Truly meeting patients where they are requires change on both sides. A few of those changes should include:

- Incentivizing patients to provide accurate demographic and health driver information to their providers. Meanwhile, health systems with direct patient access should train staff to collect this information appropriately. Patients need to understand what's in it for them when they seek healthcare.

- Identifying and mitigating implicit and systemic biases in healthcare decision-making throughout the healthcare system.

- Within specific groups, such as people of color, long-lasting discrimination in healthcare has created significant mistrust of these institutions. Bridging this gap requires consideration and understanding of how things may be different for these patients going forward.

Financial considerations such as payment and reimbursement are significant components of incentivizing the right behaviors. Currently, most nonmedical interventions, such as social risk assessments, are not tracked, measured or reimbursed like medical interventions are. Therefore, efforts applied to these drivers of health are implicitly disincentivized. Similar issues apply to payers, where the medical loss ratio generally does not include expenses toward affecting nonmedical drivers of health.

Restrictions on partnerships

Anti-kickback and Stark Law requirements may limit partnerships with noncompliant value exchange. Exemptions have a laborious application process, and exemptions are granted individually, limiting scaling and rapid piloting potential.

Funding health equity endeavors

Many suggested solutions in the health equity arena require new investment or redirection of funding into efforts that address variations in quality of care. The sources of funding for these efforts remain piecemeal at best. While initial funding for pilots and proof of concepts may be possible to obtain from philanthropic sources and ad hoc investments from various healthcare players, the path toward scaling successful programs and self-sustaining financial models is often unclear.

Making progress as an industry: Actions for individual organizations

In this section, we note several actions that should be taken by any healthcare organization interested in pushing to ameliorate disparities in the quality of care.

A simple first step when discussing health equity is to establish a common vocabulary with the organizations you work with. In our research we found differences in what people assume is included in health equity, how different frameworks are created and used, as well as what constitutes drivers and outcomes. When it comes to the scope of health equity:

- All organizations believed health equity includes equity in quality of care. That is, a patient receives the same care irrespective of their drivers of health.

- Some organizations included their own diversity, equity and inclusion efforts in the realm of health equity. And some providers strive for a more diverse and equitable workforce that mirrors the diversity of the patients they serve. They try to ensure their internal ambitions reflect their external ambitions.

- Many organizations believe they should strive toward health equity by acting outside of their immediate patient and member bases. These initiatives aim to impact broader population health by partnering in the community and advocating for improvements in the minimum wage and broadband access, which are drivers of health.

Secondly, it's important to understand where your organization stands in order to determine what it needs to do. In our efforts to understand how organizations should work, whether individually or collectively, we found a broad distribution of the current state of organizations and their investments in health equity and quality of care initiatives. These distinctions were summarized into a maturity model, common across all healthcare sectors, with the dimensions shown below.

We recognize the proliferation of lexicon, frameworks and metrics within the health equity space, but believe an understanding of the current state is crucial to making progress. Our intent in sharing the components of this maturity model is to help organizations self-evaluate and contextualize the recommendations of this report.

FIGURE 3:

Cross-sector health equity maturity model dimensions

Dimension	Definition
Strategic intent	Degree to which health equity is incorporated as a core element of business strategy, growth and competitive differentiation.
Business integration	Degree to which business structures and processes include health equity considerations, such as dedicated organization structure, annual planning, goal setting and evaluation.
Culture and institutions	Degree to which employees and leadership commit, establish and reinforce a work environment that identifies and improves areas with unjust biases.
Data and insights	Ability to capture, connect and utilize data to identify disparities, prioritize gaps and track progress.
Interventions and partnerships	Ability to deploy programs to mitigate inequities in care. The ability to identify partners and establish multistakeholder collaborations to address equity in health outcomes across all patient touchpoints.

Healthcare entities in all sectors varied across certain dimensions of health equity effort and investment. Understanding an organization's current state versus best in class, along these dimensions, allows for more specific actions to be taken.

In examining the results across the healthcare industry, we found a few common areas for improvement:

- **Lack of business integration.** Some organizations treat health equity in an ad hoc manner, while more mature organizations create accountability on health equity via organizational structure and integration into the business planning cycle. Organizations without an official structure can benefit from creating one to drive health equity and quality of care efforts forward. The structure should not be standalone and should be integrated into the existing organizational charts and business processes.

- **Ample investments in data and insights, but uneven prioritization.** Many organizations have the right data and systems in place, but do not systematically identify areas of greatest need or impact, thereby diluting its impact potential. These organizations should invest the time to analyze the available data and create systematic and prioritized goals, such as focusing efforts on outcomes within specific diseases or service lines.

- **Barriers to scaling up interventions and partnerships**. Many organizations have pilot interventions and one-off partnerships, but few have found ways to replicate their success at scale. Potential solutions to scaling programs are likely to require collaboration with other healthcare organizations and are detailed in the following sections.

Common actions across all healthcare sectors

In our research we determined there are activities that require coordinated action from organizations across all healthcare sectors to advance equity in quality of care. These activities include:

- Aligning on data collection standards, interoperability standards and outcomes measures, particularly for reimbursement purposes.

  - Establishing a cross-sector coalition to evaluate the current data collection, sharing and usage landscape to make recommendations and drive adoption of data standards. Evaluate whether a coalition from the private sector is sufficient or if government organizations should be involved, such as the Center for Medicare and Medicaid Innovation.

    - Data collection standardization includes but is not limited to patient demographics and drivers of health. Data collection roles should be delineated between entities with direct patient access versus those with only indirect interactions.

    - Data sharing standards include interoperability, access and security.

- Usage measures include common definitions of health outcomes, stratifications and any adjustments needed for local demographic and health context.

    − Stratify existing outcome metrics, such as Centers for Medicare and Medicaid Services (CMS) quality measures, by appropriate demographics and geographies. Using existing metrics may minimize effort required and improve adoption.

    − Monitor and continue activities in the public sector, but do not wait to act until CMS or Congress creates standards.

- Encouraging adoption of data standards and data collection best practices.

    − Shift the organizational mindset of collecting and using these data from an administrative burden to a best practice or norm, particularly for entities with direct patient access.

    − Conduct training for staff to interact with patients appropriately and gather self-reported patient data across all points of direct patient contact in the healthcare system.

    − Collaborate with CBOs and patient advocacy organizations to establish and communicate the benefits to the patient.

    − Create public-facing reports using existing demographics and driver data, where available, to demonstrate the impact of having such data.

- Strengthening ties to the community and CBOs and partnering with them to reach underserved populations. Across both access to care and quality of care, CBOs are important for reaching out and garnering trust with underserved populations.

    − Align on a definition of CBOs and compile a list of such organizations along with their areas of focus, capabilities and needs.

    − Aid CBOs in process efficiency, scaling and connections to resources such as local and state government funding, or funding from foundations and philanthropic organizations.

    − Advocate for CBO resourcing in local, state and national legislative positions.

- Creating cross-sector communication, information-sharing and matchmaking platforms to facilitate the creation, socialization and tracking of multisector partnerships.

    − Identify a space where payers, providers, life sciences and connectors can come together to share areas of focus, such as disease, operational process, health drivers, needs, questions and success stories.

    − Sector-specific forums will be useful for coordination and best practice sharing.

Policy and regulatory recommendations

Government policy and regulation are necessary considerations when assessing areas of need and opportunity for health equity. Policy action could make a difference in several emerging challenges in health equity—specifically, in areas of standardization, reimbursement, funding and regulatory flexibility.

Standardization of definitions, data and metrics

As we've noted, data standardization is a significant need in addressing health equity. Again, in the example of race, insufficient granularity in the existing standard has led to multiple inconsistent efforts trying to fill the gap. Policymakers can bring clarity and consistency if they can articulate a good and common standard for collecting race, ethnicity and language (REAL) and sexual orientation and gender identity (SOGI) data.

Similarly, definition standardization is an opportunity. Health equity terms are sometimes used loosely and inconsistently across—and at times within—healthcare organizations. Metrics to understand progress on health equity priorities are defined anew by each organization. Much as CMS laid out clear markers for various quality metrics, policymakers can facilitate greater standardization in health equity terms and metrics to facilitate more consistent understanding of progress.

Furthermore, policy-driven requirements for data collection and standardization should include a strong healthcare industry voice to ensure feasibility and to minimize undue administrative burden. It's particularly important to delineate data collection responsibilities between entities with and without direct patient access.

Reimbursement reform

Reimbursement for activities that advance equity in quality of care have been cited as a challenge by several healthcare organizations. While Z codes exist to help address this issue, utilization of the codes is limited. Reimbursement for data collection and reporting is a good step toward understanding disparities in care. At the same time, only reimbursing in a fee-for-service (FFS) manner for activities associated with nonmedical drivers of health may be discordant with the shift toward value-based reimbursement. Broadening the adoption of existing advanced payment models with health equity components, such as the ACO REACH Model and the Enhancing Oncology Model, could create a template for private payers to follow while maintaining a commitment to transitioning to value-based care (VBC).

Funding for health equity programs

Furthermore, disparities in quality of care—and health equity more broadly—are public health issues. Local, state and federal governments have a responsibility to invest in the improvement of public health. Current solutions are piecemeal and uneven. Policy action tackling the following topics can help ensure a more sustainable source of support for addressing disparities in care:

- Reimbursing healthcare providers appropriately for their health equity expenditures.

- Allowing payers to include these expenditures in the numerator of the medical loss ratio.

- Making funding available to support CBOs.

Regulatory flexibility

Life sciences companies frequently cite anti-kickback statutes as a barrier to health equity collaborations. These statutes create significant friction. Waivers are granted on a one-off basis but do not scale efficiently. Regulators should consider broader health equity-focused safe harbors and streamlined processes for granting waivers.

Another pain point caused by policy and regulation relates to the use of telehealth across state lines. Continuing to allow telehealth operation across state lines and relaxing state border constraints for care provision geared to health equity is another potential area of focus for policymakers.

Insights and recommendations for healthcare providers

Healthcare providers and health systems are the most involved players in patient and community health by virtue of being the frontline ambassador with patients. The sectors span many different sites of care, ranging from hospitals, clinics and long-term care facilities, to testing laboratories. We note a distinction between providers with direct interactions with patients, versus those with only indirect access, such as testing labs. Our recommendations reflect these differences in the appropriate areas.

In our analysis, the provider sector has a broad spectrum of maturity but was overall more advanced than other healthcare sectors. Providers spanning multiple sites of care tend to be more developed in their health equity efforts, as coordinated care across sites allows more touchpoints for appropriate interventions. Regional or multiregional providers, as opposed to national systems, are typically more advanced in health equity, which is likely due to reduced variations in population demographics, market environments and insurance relationships.

Providers have many key roles to play in addressing the issues in access to care disparities. In particular, providers should:

- Lead harmonization of data collection, interoperability and outcome measurement standards across sectors.

- Lead efforts to expand sites of care to improve reach in populations with low utilization of traditional sites of care, such as hospitals, clinics and pharmacies.

- Lead the scaling of interventions and partnerships with CBOs to mitigate health disparities.

Standardization of data and metrics

As the primary interface with patients, providers are often in the best position to gather this data. When direct patient interaction is possible, we recommend providers take the following actions:

- Drive standardization of data collection in collaboration with payers and electronic health record companies. In our research, we talked to one provider who refined the race and ethnicity choice for patients on their forms. When they did this, the rate of "unknowns" fell 10%.

- Encourage adoption of data collection and standards by training frontline staff to collect information in a patient friendly manner, which includes working with the community to identify relevant indicators to inform data collection standards.

- Engage patients and the community to generate awareness around why collecting this information is beneficial to the patient.

- Demonstrate the impact of collecting REAL and SOGI data by publishing reports and insights with existing demographics, as well as the results of interventions or changes in health delivery they inform, to reinforce the impact of having access to such data.

In cases where providers can only have indirect interactions, expectations around the collection and reporting of data should be tempered appropriately given the low feasibility.

Site of care expansion

Certain populations are hard to reach with the current paradigm of centralized hospitals, clinics and pharmacies. Expanding care options to digital channels, such as telehealth and remote monitoring, or to care that can be delivered where the patients live, such as home care, can improve access to care in underserved populations. The use of traveling or rurally focused physicians, in addition to care delivery in nonmedical settings, can also achieve this end. We recommend healthcare providers:

- Continue building capabilities in alternate sites of care, particularly those situated to reach populations with low access to care. Work with local communities to ensure sites of care are appropriately located, designed to be welcoming for these communities, and use effective channels to identify people who would benefit from these settings. Explore the use of nonmedical settings such as areas of congregation and faith-based facilities to broaden reach.

- Advocate for the continued ability to practice across state lines in cases of expanded sites of care, particularly in telehealth.

- Continue to develop educational materials and programs that encourage healthcare professionals to practice in rural areas and other regions with lower rates of doctors per capita.

Scaling interventions and partnerships

Providers and health systems demonstrate a wide range in the maturity of health equity programming, particularly in interventions and partnerships. Many organizations appear to struggle with moving beyond pilot programs toward scaled programs.

Establishing channels for sharing best practices and consulting on program implementation provides a powerful way to accelerate past the pilot stage. We recommend organizations create a path from pilot to sustainability. The components of this path are a combination of recommendations described on page 12 in the "Common actions across all healthcare sectors" section of this report, including strengthening and supporting the community, advocating for sustained resourcing and enhancing communication and matchmaking between interested parties within and across sectors.

Insights and recommendations for payers

In this section, we focus on insights and recommendations for private insurers who manage memberships, including commercial insurance, managed Medicaid and Medicare Advantage. In our assessment, payers are fairly advanced in their health equity efforts. It should be noted that while payers are more advanced in the range of equity activities, the range of their impact is typically limited to the members of their plans. We have seen many early wins, bright spots and best practices in health equity from payers, including:

- Instituting internal incentives, policies and procedures in alignment with health equity and care delivery equity.

- Monitoring progress of equity in health outcomes via dashboards and oversight.

- Expanding diversity of provider networks.

- Researching member needs and acting on them, such as instituting multilingual call centers.

- Beginning to standardize data collection and reporting.

- Simplifying member requirements related to access and administration.

- Instituting leads for health equity with multiyear goals and organizational support.

- Empowering employees and encouraging the right culture.

- Training staff on topics such as unconscious bias and institutional racism.

Payers are uniquely positioned to influence payment and reimbursement policies to drive activities and investments. As such, the primary role of payers in addressing variations in care should be:

- Leading reforms in the policies and procedures with respect to reimbursement rates, prior authorizations and other related aspects.

- Partnering in driving data and outcomes standardization using incentives such as payment and reimbursement.

Barriers and challenges

As has been noted elsewhere and in other HLC initiatives, there are several underlying causes of health inequity and care delivery disparities. For example, the absence of data standardization and interoperability mandates, as well as incentive misalignment, all contribute to such disparities.

Because members switch payers from time to time, payers face a version of the "prisoner's dilemma" popularized in game theory. Under this scenario, each individual payer has an incentive to invest less than what would be optimal for the collective good of society. Though many payers have initiatives aimed at health equity despite this dilemma, efforts to reduce disparities can still be improved.

Many of the disparities in care delivery are due to local decisions, including treatment protocols and care setting choices. Those decisions are highly influenced by local network access as well as reimbursement rates in different care settings. Access to appropriate healthcare varies considerably by geography and by member subpopulation. The lack of appropriate, nearby and convenient locations—including virtual visits—contributes to care disparities.

Some payers have been more ambitious than others in embracing the shift from FFS to VBC. VBC will motivate outcome-based improvements and can be defined and tracked for a variety of member subpopulations.

In some cases, processes that payers use for managing the utilization of pharmaceuticals, such as prior authorizations, may hinder treatment. These processes may cause delays or disruptions, which can have a significant influence on outcomes. Those delays and disruptions may be exacerbated in underserved populations due to the lack of resources available to them at their local providers.

Solutions and paths forward for payers

The relatively concentrated payer landscape, which is much more concentrated than other ecosystem sectors, is an area of strength for the payer sector. To leverage this market concentration, we recommend creating a dominant consortium of large payer organizations, gathered principally to further the cause of health equity. In practice, it may be possible to create multiple smaller consortia aimed at addressing issues for Medicare, Medicaid and commercial beneficiaries. Multiple consortia are more feasible if member movement between segments is limited. Key objectives for such consortia could include:

- Standardization

  - Aligning on the societal benefits of health equity and the aspiration to reduce disparities in care delivery.

  - Aligning on key definitions, terminology and data standards.

  - Committing to utilizing the collective capabilities of the group to share information, subject to the appropriate data privacy protocols. This could be further enhanced by utilizing third parties as "clean rooms" to aggregate member information to de-identify it.

- Coordination

  - Committing to making both short- and long-term investments to resolve the prisoner's dilemma. One possible solution could be a 401(k)-inspired system where payer investment follows the patient, such that investments aren't discontinued when the member switches plans. The same consortium can apply peer and public pressure to "defectors" of the dilemma.

  - Committing to pay for programs that address the broader drivers of health outside the traditional medical and clinical definitions of reimbursement. Such programs can include healthy food subsidies, transportation assistance and other services.

  - Embracing VBC, as well as improving outcomes for particularly disenfranchised subpopulations.

  - Refining local incentives, including policies and reimbursement rates across care settings.

  - Broadening healthcare access by expanding local networks and simplifying access to such networks.

  - Reforming prior authorization policies and procedures, encouraging automation, simplification and commitment to short authorization processes.

- Advocate for a common minimal framework for payers to help resolve the prisoner's dilemma. Even in the absence of the formation of such a consortium, the individual payers can commit to many or all of the above, particularly if it is supported or mandated by the appropriate government agencies. Explore potential options to incentivize the consortium on common or aggregated goals across payers.

Insights and recommendations for life sciences

The life sciences sector includes organizations focused on biology-related research and development—mostly pharmaceutical manufacturers, biotechnology and medical device companies. In the past three years, the life sciences sector has increasingly focused on disparities in care and health equity, largely in the realms of clinical development and through environmental, social and governance and philanthropic initiatives.

In our analysis, the life sciences sector shows a broad spectrum of maturity in current health equity activities. Our analysis found the following:

- Most manufacturers are relatively early in their health equity journey, focusing largely on support after a patient is initiated on their products.

- Manufacturers in small markets with underdiagnosis issues, particularly those skewing toward populations who use less healthcare, invest more in community and provider-based collaborations to improve screening and diagnosis. The same is true of many manufacturers of screening and testing devices.

- Large manufacturers with products across multiple diseases are more evolved in their health equity journey.

  - Most such manufacturers have made commitments, joined coalitions and implemented enrollment modifications around representation in clinical trials.

  - Most have created pilot commercial partnerships to improve outcomes in specific diseases.

In general, life sciences should play a couple of key roles in addressing the issues we identified, including:

- Leading improvements in health equity and clinical development.

- Forming partnerships between larger manufacturers with specific interests in screening and diagnosis to improve equity in the delivery of care in specific diseases.

Representation in clinical development

Health equity in clinical development spans across multiple activities, including:

- **Asset planning.** Does the manufacturer invest in a set of assets that span across diseases in an equitable manner?

- **Protocol design.** Do the inclusion criteria and trial burden create difficulties enrolling certain populations?

- **Enrollment.** Do investigator selection and site selection processes create biases in the enrollment and trial processes?

The greatest emphasis has been placed on enrollment, but few manufacturers are making commitments to improve asset planning and protocol design. We recommend the following:

- Going local to improve clinical trial enrollment. Shift away from academic sites and into community care centers and mobile trial sites. Expand awareness of clinical trials and entry points into clinical trials through channels used by underserved populations, such as community and religious centers and local congregation areas.

- Adopting digital and technological approaches to improve clinical trial reach and awareness and to manage decentralized clinical trials. Use objective, data-based and debiased algorithms for determining clinical trial eligibility to mitigate implicit biases.

  - Embrace patient-centric thinking in clinical development, from asset planning to protocol and trial design. Communicate how the clinical trial will benefit the individual patient.

Partnerships to improve care delivery

Life sciences has a role to play in health equity outside of research and development. Manufacturers are partnering with payers, providers and community-based organizations to improve screening, diagnosis and treatment of patients that would otherwise go undetected.

Investment in a disease state overall may help manufacturers build a stronger reputation with patients. Furthermore, long-term partnerships with payers and providers build trust and facilitate deeper business-to-business relationships.

Similarly, other sectors would benefit from partnering with manufacturers on these issues. Life sciences has more depth of knowledge within specific disease areas and can more effectively understand disparities, drivers and ways to improve outcomes in those diseases. Furthermore, manufacturers have a nationwide purview to be able to learn, compare and contrast across multiple patient situations.

For life sciences organizations, we recommend:

- Building capabilities to generate insights on disparities in care, drivers of health and opportunities for improvement across demographics and geographies, as documented in the "Methodology" section on page 26.

- Enhancing program development capabilities to create partnerships, such as partner needs assessments, mutual value proposition development, streamlined compliance and legal processes, program management and execution competence.

- Identifying potential partners and establishing clear requirements of partnership from both sides—commitments, resources and impact measurement.

- Understanding success drivers behind individual programs in order to help replicate similar programs around other customers and patient groups.

In our own interviews with large life sciences companies, a handful discussed significant investments into areas beyond clinical development, including improving access to medicine and culturally appropriate marketing. They've also worked with patient services and on empowering local communities to directly improve health outcomes.

Insights and recommendations for connectors

Healthcare players that aren't providers, payers and life sciences companies can play a critical connecting role by supporting the development of standards and best practices through which health equity can be advanced. While connectors can be evaluated on the maturity model, they tend to be a step removed from patient care. Generally, they will rate higher on data and insights and lower on interventions and partnerships. Connectors could focus on leveraging these assets and strengths to further health equity.

Each of the core healthcare delivery sectors has inherent limitations in their purviews. Health systems tend to focus on a limited geographical footprint. Health plans may be regional or national, but they cover only a subset of the population. Life sciences companies each focus on a limited specific set of disease areas. By contrast, the connectors in the ecosystem— technology companies, service providers and others—often have national footprints and visibility into how different healthcare entities are operating. This positions the connectors to play an important role in addressing several of the issues we have identified in our study. Specifically, connectors address the following:

- **Bringing consistency to data inputs and measurement.** Healthcare connectors can play a leading role in facilitating more consistency in how information is characterized and measured. In some cases, this may be direct, such as through electronic health platforms. In other cases, it may provide a forum for sharing across healthcare entities that don't interact organically.

- **Sharing best practices and lessons learned more rapidly.** Healthcare connectors can bring expertise and visibility about best practices to individual players in the system. In doing so, they can facilitate the scaling of partnerships or interventions that have been successful in meeting health equity objectives.

- **Providing scale directly.** Some of the healthcare connectors include large national organizations with tens of thousands of employees throughout the U.S. They are, in many cases, members of communities with health needs and a passion for advancing health equity. These organizations can harness that scale and passion through partnerships with health systems, health plans and life sciences companies as a path toward operating locally.

In our research, many connectors we talked to look at health equity-related activities and outcomes across many customers to create benchmarks, reports and insights to aid their networks. A few use the same information to deploy direct interventions.

A call to action

Addressing variations in the quality of care is a daunting task with many different interconnected approaches needed to make a meaningful impact. The primary purpose of this report is to share insights and actionable recommendations. Overall, our research identified the need for:

- Standardization – Giving industry stakeholders the ability to speak the same language.

- Collaboration – Working together to solve variations in care and health equity in a manner that is pre-paradigmatic and pre-competitive.

- Strengthening the community – We need to enhance CBOs' abilities to receive sustainable funding, scale resources and deploy technology to sustain their missions. Healthcare stakeholders from all sectors should actively engage them to reach underserved populations.

- Government framework – Stakeholders should continue advocating for the creation of a minimum framework that helps standardize understanding and align incentives.

- Commitment – The path toward health equity is a long one and requires sustained commitment to see progress.

The sector-specific, maturity-adjusted approach aims to make these concepts actionable. Associated recommendations aim to provide concrete direction on how the healthcare industry can work together to make a meaningful impact on health equity.

Methodology

Quantitative analysis

There is no dispute that disparities in health outcomes exist. What is uncertain is the best way to understand and address the drivers behind these disparities. To study this, we conducted a quantitative analysis that combined longitudinal patient-level data with individual-level demographics and geography-level drivers of health, collected from public sources. Our aim was not to demonstrate the existence or cause of specific disparities, as there is ample proof in established literature. Instead, our analysis spans across diseases and across stages of patients' healthcare journeys. We attempted to answer a couple of higher-level questions:

- How similar are the drivers of health across different diseases?

- How similar are the drivers of health across a disease's healthcare journey?

The answers are complicated in both cases, but they have significant implications for any organization aiming to address them.
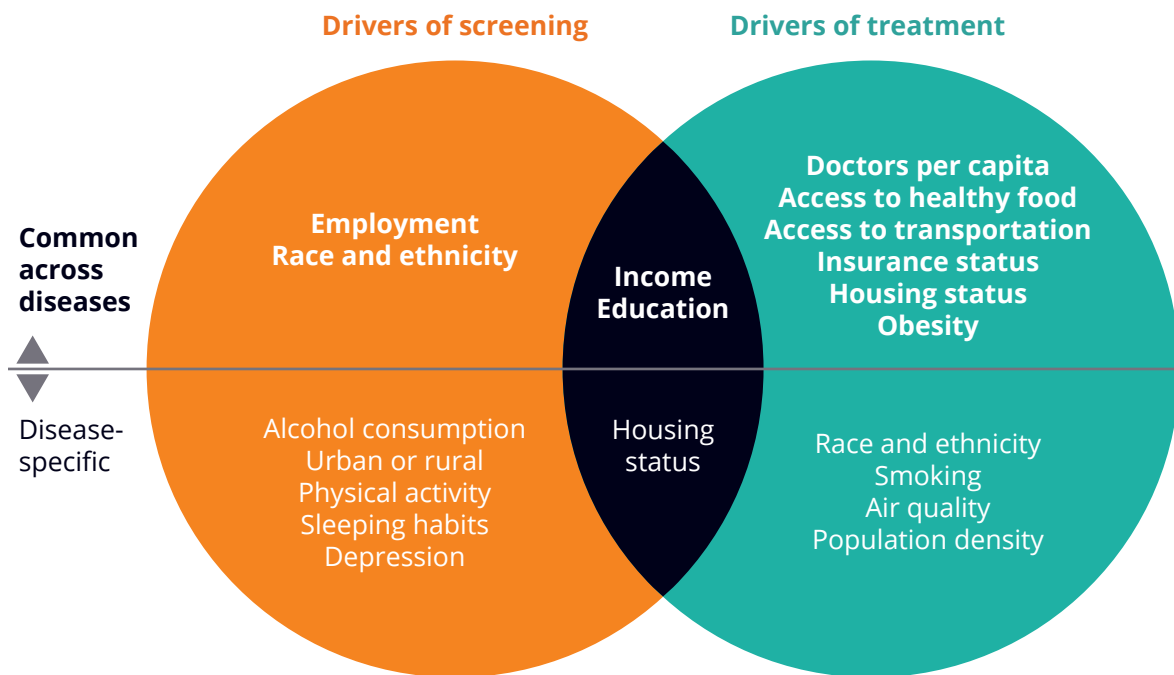
Important drivers of health across diseases and the healthcare journey

Across diseases and across the healthcare journey, there are some commonalities and differences when it comes to drivers of screening and drivers of treatment (see Figure 4). Our analysis has several implications for organizations hoping to address health equity issues.

- Organizations should generate insights on disparities and drivers of health at the disease level in order to create actionable insights.

- Drivers of outcomes across the healthcare journey differ. For example, drivers of screening and treatment do not align entirely. Therefore, it may be important to define goals specific to a portion of the healthcare journey, even within a disease state.

- Organizations should perform the disease-level insight generation across multiple priority diseases to better understand where the biggest disparities are and where there is the most potential for impact.

- Some drivers are nearly universal across diseases, so programs that address these drivers may consider how to extend across disease states to maximize synergy and coverage.

FIGURE 4:

Key drivers of health across diseases and health outcomes

Drivers of screening   **Drivers of treatment**

Common across diseases

**Employment
Race and ethnicity**

**Income
Education**

**Doctors per capita
Access to healthy food
Access to transportation
Insurance status
Housing status
Obesity**

Disease-specific

Alcohol consumption
Urban or rural
Physical activity
Sleeping habits
Depression

Housing status

Race and ethnicity
Smoking
Air quality
Population density

This diagram shows drivers of screening and treatment across four diseases. Quantitative analysis shows that many drivers are common across diseases and the specific outcomes measured, while others are highly disease or outcome dependent.

Quantitative analysis methodology

We studied two data sets to understand health outcome disparities: the Behavior Risk Factor Surveillance Survey (BRFSS) from the Centers for Disease Control and Prevention and a patient claims data set from Symphony Health Integrated Dataverse (IDV®), which is an ICON plc company. The BRFSS data offers insights into screening rates while the Symphony data gives insights into the drug treatment rate. The outcome measure at each level is a ratio of the number of individuals at that level.

In addition to outcome measures, BRFSS and Symphony data both provide individual-level social determinants used to understand the importance of those drivers, such as age, sex, race and income. The Symphony data was supplemented with a proprietary ZS county-level database of social determinants. Multivariate statistical models (XGBoost) were employed to understand the magnitude of individual drivers. Opportunity is estimated by benchmarking to high performers within the data as follows:

- Divide the total data into groups, as defined by the top driver. For example, if the driver is income, the various income buckets are the groups.

- Increase the health outcome measure to the 80th percentile group, the top group in most cases.

- Repeat for each of the three top drivers, with no double counting allowed. For example, an individual subjected to multiple increases will only receive the maximum increase.

Cross-sector maturity model

We employed a maturity model to understand the variations in the current state of different healthcare organizations. The maturity model is generalized to be applicable across all of healthcare, but sector-specific drilldowns may be beneficial for further action planning. For example, "business integration" may manifest differently across sectors:

- Health systems may consider ensuring physical facilities are welcoming and accessible to different populations.

- Payers and insurance companies may consider specifically modifying payment and reimbursement business processes to further health equity efforts.

- Life sciences may consider clinical development processes in more detail, such as asset investment, protocol design and site selection.

Cross-sector maturity model

	Foundational "Learning the ropes"	**Intermediate** "Testing the waters"	**Evolved** "Scaling the impact"	**Advanced** "Living the vision"
Strategic intent	• Understand impact of health equity (HE) and social determinants of health (SDOH) on patients and business	• Identify and test initial areas for improvement	• Articulate strategy and desired impact • Leverage health equity as business driver	• Use HE as core element of strategy, value proposition or competitive differentiation
Business integration	• Create mission and vision statements around HE	• Apply equity lens to initiatives and resourcing • Create innovative pilots and test ideas	• Integrate HE into service lines and business units • Create accountability metrics for leadership	• Embed HE in business planning and investment activities • Set consistent and measurable health outcome goals
Culture and institutions	• Require diversity, equity and inclusion training	• Conduct training to identify equity gaps and implicit biases	• Establish behavioral norms and standards • Examine institutional policies for systematic biases	• Broadly reconfigure processes and policies to ameliorate systematic biases
Data and insights	• Awareness of existing data and resources for SDOH and HE insights	• Conduct exploratory business unit-specific research and analysis	• Prioritize opportunity with standardized methods • Establish a repository of issues to enable interventions	• Track intervention impact metrics • Systematically generate data and insights assets
Interventions and partnerships	• Awareness of existing interventions • Awareness of HE-related activities at other healthcare companies	• Adjust company-controlled resources • Deploy interventions in focus areas • Explore partnerships	• Deploy interventions across geographies and diseases • Develop structured selection criteria and governance mechanisms • Partner and advocate with government entities	• Formalize or syndicate standard interventions • Create multi-party partnerships across sectors • Help other organizations

The maturity model is used to assess the current state of different healthcare organizations to understand patterns, trends and potential actions.

About the authors

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ZS is a management consulting and technology firm focused on transforming global healthcare and beyond. We leverage our leading-edge analytics, plus the power of data, science and products, to help our clients make more intelligent decisions, deliver innovative solutions and improve outcomes for all. Founded in 1983, ZS has more than 12,000 employees in 35 offices worldwide.

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The Healthcare Leadership Council (HLC), a coalition of chief executives from all disciplines within American healthcare, is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans and programs to achieve their vision of a 21st century system that makes affordable, high-quality care accessible to all Americans. Previous publications on this topic from HLC include a review of creative interventions to address SDOH, a primer on SDOH and a report from a July 2019 roundtable.