A Historical Perspective on Disparities as Context for Our Work Ahead

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BAYLOR HEALTH CARE System's laudable accomplishments in promoting care equity and Dr. Joseph Betancourt's analysis in this same issue illustrate how far we have come toward reducing disparities in care—and how far we still must go. For hospitals and health systems, historical context is important here, as the roots of disparities in the US healthcare system run deep and merit consideration as we push forward to improve how we serve society's most vulnerable people.

HISTORICAL BACKDROP TO CURRENT EQUITY EFFORTS

That Baylor, a system situated in the once rigidly segregated South, has emerged as a leader in reducing care disparities is particularly noteworthy when we consider the long and troubled history of healthcare for minorities and other vulnerable populations in the United States.

As with most aspects of life, medical care in the United States, and especially in the American South, was segregated by race prior to the civil rights era. Across much of the South, and even in northern cities with significant populations of African Americans, a separate system of hospitals served black patients and provided training and practice opportunities for black physicians. African Americans in the South largely received care at "blacks only" hospitals, and even those requiring emergency care often were turned away by white institutions (Zheng and Zhou 2008).

That hospitals for black patients existed at all owes in part to the reaction of African American physicians to the terrible consequences that the lack of hospital care had on sick and injured blacks. Black physicians spearheaded efforts to establish these facilities after the Civil War and through the first half of the twentieth century—from about 40 in 1900 to about 370 by the early 1960s (Zheng and Zhou 2008). But in terms of health outcomes,

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progress was slow—especially in the South, where hospital care for African Americans was scarce. In Mississippi, for example, black lay midwives delivered more than 80 percent of African American babies well into the 1940s, and overall, the health status of blacks changed little between the slavery era and the start of the Great Depression (Smith 2005).

Ultimately, the 1964 Civil Rights Act and the application of its antidiscrimination safeguards to Medicare ended sanctioned separation of races in hospitals. As important were the urban health departments and public hospitals, especially in the North, that stepped in to fill the void of care for blacks and other minorities well before civil rights reforms took hold. The New York City Health Department, for example, worked with the Urban League in 1916 to reduce high infant mortality rates among blacks, lowering deaths from diarrheal and respiratory diseases from 71 and 80, respectively, of every 1,000 black infants to 48 and 50 in one year (Beardsley 1990). Prominent public institutions that in the latter half of the 1900s coalesced into the nation's healthcare safety net trace their beginnings as historically black hospitals—the Civil War–era Freedmen's Hospital in Washington, D.C., which later became Howard University Medical School's teaching hospital, among the first.

That legacy of providing access to society's most vulnerable reverberates strongly today among those essential hospitals and health systems committed to keeping their doors open to the uninsured, the underinsured, and other disadvantaged patients.

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Against the historical backdrop of this nation's profound care inequities, the efforts today of Baylor and other systems like it are all the more remarkable and deserving of recognition.

But clearly, we need to do much more, as Betancourt shows us. All hospitals—not just those that historically have championed the cause of the vulnerable—must recognize the urgent need to ensure that all patients receive the highest quality of care possible. More to the point, they need to follow Baylor's lead and emulate the work of the many other essential hospitals that make understanding and meeting the particular needs of minorities a priority.

Too often, we fall short of that mark. Even with the progress made since the 1960s, vestiges of institutionalized discrimination in healthcare remain. Data on Medicare hospital discharges suggest both wide variation and lingering segregation in US hospital care, and segregation in outpatient and nursing home care also remains a threat (Smith 2005). We have not come as far as we might think.

Role of America's Essential Hospitals

With their status as hospitals and health systems central to the nation's safety net, and historically among the urban institutions that have been the locus of care for minorities, members of America's Essential Hospitals are particularly attentive to this reality. Their commitment to reducing disparities manifests in many ways—from quality improvement within hospital walls to community initiatives to research. America's Essential Hospitals has put care equity high on its agenda through ongoing quality and research work and participation as a proud partner in the Equity of Care National Call to Action, which seeks

to reduce disparities through increased collection of race, ethnicity, and language (REAL) data; cultural competency training; and leadership diversity.

Our emphasis on equity reflects our members' expertise in caring for those patients who are most often the victims of disparities: More than half are racial and ethnic minorities, and a majority are uninsured or qualify for Medicaid. Our hospitals know well the challenges of caring for these populations—and of ensuring that their care meets the same high bar set for all patients. Toward that end, we have come to recognize the particular value in collecting REAL data and giving it context as an indispensable component of quality improvement work.

Our Essential Hospitals Engagement Network (EHEN), one of more than two dozen hospital engagement networks in the federal Partnership for Patients, has made collection of REAL data a tangible dimension of its work in 2014. Cultural competence in care and the ability to understand the varied needs of a diverse patient population complement well the Partnership for Patients' core goal of reducing patient harm and preventable readmissions. We believe better care and better patient experience result when hospitals and physicians have REAL data in hand.

America's Essential Hospitals and its research arm, the Essential Hospitals Institute, have much experience and expertise helping hospitals reduce disparities. More than five years ago, the Office of Minority Health, in the US Department of Health and Human Services, awarded the association a grant to identify effective, hospital-based strategies to reduce disparities. The project, in collaboration with the Institute for Healthcare Improvement and Betancourt's Disparities Solutions Center,

culminated in the guide *Assuring Healthcare Equity: A Healthcare Equity Blueprint,* which offers hospitals and other providers care equity strategies that employ hospital-specific interventions and emphasize patient and community involvement (Essential Hospitals Institute 2008).

The current focus on REAL data builds on a foundation of earlier EHEN work toward reducing disparities, including surveying our member hospitals about their data collection practices and identifying opportunities for improvement; promoting patient and family engagement initiatives to mitigate the impact of low health literacy, a common roadblock to better care for vulnerable patients; and supporting a health equity collaborative that will offer REAL data education as part of its curriculum. None of this will occur in a vacuum—our goal is to work with other hospital engagement networks to analyze, under the light of REAL, the data their members collect and provide tools other hospitals can use to improve the consistency and usefulness of data collected.

Call to Action for Hospitals and Policymakers

Every hospital and health system in the United States must take up the challenge of reducing care disparities. With minorities projected to constitute a majority of the nation's population by 2043 (US Census Bureau 2012), the need to make meaningful improvements to care for vulnerable populations grows more prominent with each passing year. In the near term, Affordable Care Act (ACA) mandates add a layer of urgency that could both help and hinder our work. With the best of intentions, the law's creators set important standards for value-based purchasing and quality improvement, including through

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reducing avoidable readmissions and promoting a better patient experience. But for some hospitals—especially those that serve populations most at risk of disparities—the penalties for not meeting these goals could have the unintended consequence of widening gaps in care by reducing the resources needed to provide the best care to those most in need (Jha, Orav, and Epstein 2011).

We must be mindful of these challenges. Policymakers have it in their power to make course corrections and to provide the funding necessary to maintain momentum toward eliminating disparities. They need only muster the political will in the face of budget and deficit reduction proposals that make frequent targets of Medicaid and similar programs designed to support care for the vulnerable. Disproportionate share hospital (DSH) funding is foremost among sources of federal support at risk. Substantial cuts to DSH funding under the ACA, made with the expectation of a nationwide Medicaid expansion, now threaten to deepen care disparities in states that have chosen not to expand—about half, including many with vast populations of uninsured and other residents who could benefit from expansion.

Conclusion

We have come far since the early days of hospital care and the struggle to end the segregation of US hospitals and other healthcare settings. Baylor stands as a testament to that work and a model for other hospitals. But the fight is far from over, and we risk sliding backward without a commitment by all hospitals and health systems—combined with strong federal, state, and local support—to elevate care for all patients by ensuring the best possible care for those most in need.

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