Advancing equity in US health and healthcare: Health systems' actions in seven major domains

Received (in revised form): 13th October, 2021

Susan Dentzer
President and Chief Executive Officer, America's Physician Groups, USA

Susan Dentzer is President and Chief Executive Officer of America's Physician Groups. The organisation represents more than 335 physician groups focused on providing coordinated and integrated care and is accountable for both cost and quality for nearly 90 million patients nationwide. She is also a highly regarded health policy thought leader and frequent speaker and commentator on television and radio, besides being author of commentaries in Modern Healthcare, the New England Journal of Medicine Catalyst and other prominent publications. She is the editor and lead author of Health Care Without Walls: A Roadmap for Reinventing U.S. Health Care. Dentzer was previously a Senior Policy Fellow at the Robert J. Margolis Center for Health Policy, the Washington, D.C.-based arm of Duke University that focuses on important health policy issues. She also served as the editor-in-chief of the journal Health Affairs and as the on-air Health Correspondent of the PBS NewsHour. She is an elected member of the National Academy of Medicine and the Council on Foreign Relations and is a fellow of the National Academy of Social Insurance and the Hastings Center. She chairs the board of directors of Research!America, the non-profit, nonpartisan organisation that advocates for health-related research, and is a member of the board of directors of the International Rescue Committee, a leading global humanitarian organisation. She also serves on the RAND Health Board of Advisors and is a fellow of the Hastings Institute and the National Academy of Social Insurance. Dentzer graduated from Dartmouth and holds a Bachelor of Arts and Master of Health Care Delivery Science degrees from the institution.

America's Physician Groups, 555 W. 5th St., Floor 35, Los Angeles, CA 90013, USA
E-mail: sdentzer@apg.org

Abstract A focus on equity has risen to the fore in many US healthcare systems, in reaction to the May 2020 murder of George Floyd and its repercussions, and to the many racial and ethnic disparities highlighted anew by the COVID-19 pandemic. Both senior management and boards of directors of healthcare systems across the country have undertaken new efforts, or redoubled existing ones, to address equity, first, in the context of provision of care and the fundamental operations of health systems and, second, in addressing the broad upstream drivers of social and economic inequity that are largely extrinsic to healthcare. This paper describes some of the actions taken by health systems in seven main categories: speaking out publicly against inequity; taking larger steps internally to address diversity, equity and inclusion (DEI); examining themselves through the lenses of structural racism and critical race theory (CRT); widening their traditional equity lens to encompass widespread discrimination against multiple population groups; ramping up efforts to address the quality of care and reducing undesirable variation as a means of reducing inequity and disparities; harnessing data and information technology to assist in these quality-improvement efforts; and using their resources to address upstream health drivers, including those in priority areas of the social and economic determinants of health. All told, a growing number of US health systems now recognise and accept that they must play a dominant role in a process of social and economic transformation to eliminate structural and institutional racism and other forms of discrimination and place the nation on the road to better health.

KEYWORDS: equity, health equity, racism, race, ethnicity, social determinants

INTRODUCTION

Long-standing social and economic inequality in the United States,[1] and disparities in US health and healthcare,[2] vaulted to a new level of importance during 2020-2021. The COVID-19 pandemic quickly yielded disparities in the rates at which different elements within the population were falling ill and dying[3] — thus serving as a 'magnifying glass that has highlighted the larger pandemic of racial/ethnic disparities in health', as two leading academic authorities on equity, David Williams and Lisa Copeland, wrote in a perspective in the *Journal of the American Medical Association*.[4] Then, in late May 2020, the murder of George Floyd at the hands of a group of Minneapolis, Minnesota police sparked a new nationwide reckoning on racism, including its connection to health and healthcare. As Rochelle Walensky, director of the U.S. Centers for Disease Control and Prevention, said at a health equity conference in June 2021, 'Racism and inequity are persistent, pressing, and serious threats to health. [And] when the structure is a barrier to health for some, it is a barrier to health for all'.

The double impact of COVID and the repercussions of Floyd's murder reignited long-smouldering embers of inequity within health systems. At Kaiser Permanente, the large integrated health system, there was 'significant frustration, anger, and disappointment over the disparities and inequities', coupled with 'public outcry and a sense of urgency' to address the situation, said Ronald L. Copeland, MD, senior vice president in charge of the system's national equity, inclusion and diversity strategy.[5] The shock led to a period of internal reflection within the organisation, and Copeland said: 'Do we value all individuals and populations equally? Are we required to rectify historic injustices?' Kaiser 'answered yes to those questions, [and] we used the moment to double down on long-standing commitments and take them to another level', Copeland said. Across the nation, thousands of healthcare organisations underwent a similar process, as the initial outrage gave way to self-examination followed by action.

In general, the initial measures taken by healthcare organisations fell into seven main categories. Firstly, system leaders spoke out publicly about inequity, many for the first time, in large part to communicate to internal as well as external audiences how seriously they took the issue. Second, they appointed people and created internal management structures to approach the issues of diversity, equity and inclusion (DEI), particularly within their own work forces, and to facilitate greater recruitment and retention of persons of colour. Third, they examined themselves and their organisations through the lenses of structural racism and critical race theory (CRT). Fourth, they widened the traditional lens on inequity, acknowledging that, beyond pervasive racism against Blacks and Asian Americans, discrimination against multiple other groups was also rampant. Fifth, many system leaders doubled down on efforts already under way at their organisations to address health care quality as an essential component of reducing inequity and disparities in care. Sixth, they harnessed data from within the system to shed light on care disparities and embedded interventions based on this data into clinical workflows. Seventh, they further acknowledged that health systems had to play a role in addressing the larger societal inequities outside the walls of healthcare and to use their resources and influence to challenge and change existing social and economic paradigms. Many systems undertook important new initiatives in this arena in particular, as described further on.

SPEAKING OUT AND SELF-REFLECTION

One important step many health system leaders undertook in the spring of 2020 was to speak out decisively against racism, in particular, and other sources of inequity in general. Doing so represented a departure

from the past practice of many health system leaders, who often tended to eschew commentary on contemporary social issues.

A case in point was Wright Lassiter, CEO of Henry Ford Health System, a large integrated health system based in metropolitan Detroit, Michigan. 'In today's world organizations expect their CEOs to be communicative, and to bare a bit of their soul', Lassiter said at a health equity conference in June 2021.[6] 'I have not always done that as part of my career'. Floyd's murder, however, 'caused me to reflect on my own story as a human being', including his own childhood in Tuskegee, Alabama, home of the infamous Tuskegee Syphilis Study.[7] 'I spent a couple of really late nights writing [about] things I saw growing up; how it made me feel [then] as we saw scenarios like what happened to George Floyd unfold before our very eyes'. Lassiter recounted that the process caused him to ask whether Henry Ford as a system was 'doing enough' to combat racism and injustice, beyond the existing DEI efforts that the organisation already had under way. 'While we have focused on issues like evaluating our clinical outcomes around real data on race and ethnicity, we never said that we should be advocating for social justice, and rejecting and eliminating all forms of bias and racism', he said. But 'we shouldn't be naïve that bias and racism doesn't exist within our organization . . . The scripture says, "To whom much is given, much is required." I reflected on that to our team members. We are located in one of few majority-minority cities in the country, [and] we ought to be using our resources to do more than we already have'.

Wright said he was 'surprised at the outpouring of energy that the letter generated within our organization'. In short order, Henry Ford launched unconscious bias training for its board of directors and health leadership — training that was subsequently extended to other levels of the organisation, including front-line staff. The board of directors formally adopted as one of the organisation's four pillars the rejection of racial injustice in all its forms, making this area corporate priority. The organisation also moved forward to adopt a minimum US$15 per hour wage as its living wage standard for the organisation — a plan that had been put on hold by the financial exigencies caused by the pandemic. 'We have people coming to work in our health care systems, gainfully employed, who are homeless. We had more than 3,000 people in our organization who were not at that living wage standard . . . We said that one of most important forms of empowerment was to take care of our own backyard', Lassiter said.

ADDRESSING DIVERSITY, EQUITY AND INCLUSION

Although many strategies to address these three characteristics within health systems had been under way at many organisations for some time, they took on new importance in 2020. Varying definitions of 'DEI' exist, but a memorable one was voiced by Verna Myers, vice president of inclusion at the entertainment company Netflix: 'Diversity is being invited to the party; equity is being asked to dance; inclusion is being asked to set the play list'. In the process of self-reflection that occurred at many health systems, a clear realisation emerged that all three aspects were frequently wanting.

An important issue for many systems has been diversity — literally, who makes up the ranks of leadership and employees. 'Diversity means recognition and acceptance of the fact that there exist human differences', said Mary Daffin, JD, vice chair of the board of directors at Houston Methodist Hospital. 'If you are going to be representative of those differences in race, gender, socio-economic backgrounds, thought, viewpoint, sexual orientation, ethnicities . . . any organization that claims to be diverse must be representative of all those human differences'. For many systems, the very make-up of the system — and particularly of the leadership ranks — seldom fully reflected the racial and ethnic make-up of the communities served. The situation has prevailed even at health

systems where at least some of the senior leadership was racially diverse.

Airica Steed, executive vice president and chief operating officer at Sinai Chicago Health System, the largest safety net system in Chicago, described how her organisation was prompted to take a holistic look at its staffing in the context of the community it serves: Chicago's heavily Black and Hispanic West Side. The conclusion: in terms of all personnel affiliated with the health system, including physicians with admitting privileges, 'Less than five percent of our organization mirrors the population we serve', Steed said. As a result, a vice president of medical diversity was appointed to foster greater diversity among the providers affiliated with the organisation. The goal, said Steed, is to 'build a structure of cultural competence', closely examining the organisation's medical education and training programmes and working with partner organisations to 'embed a focus on diversity and inclusion within our medical students and residents'. Sinai Chicago is now placing even greater emphasis than before on a workforce development programme created to recruit and train community health workers — front-line public health workers who are trusted members of, or who have a close understanding of, the community they serve.

Similarly, other health systems have prioritised not only diversity in their ranks but also active efforts to combat bias and racism within them. Kaiser Permanente created its Belong@KP programme, a multi-year effort that aims to help participants 'recognize bias and racism in their thoughts and actions, and provides tools to think and act more inclusively'. The programme is also guiding adoption of 'inclusive and equitable practices into how we identify, recruit, develop, mentor, assess, and retain diverse talent', a Kaiser website notes.[8]

As health systems seek to embed DEI throughout their organisations, common strategies are to create board-level DEI committees, as well as to appoint chief DEI officers at the executive level. To keep these roles and responsibilities from becoming mere window dressing, one tactic is to set explicit DEI goals at the board level and then tie executive compensation to the achievement of these goals. Advocate Aurora Health, a large non-profit health system with dual headquarters in two majority-minority cities — Milwaukee, Wisconsin and Downer's Grove, Illinois — has explicitly linked executive compensation to the achievement of goals for diversity of new hires, selection of suppliers and other relevant metrics. 'It means that everybody who is managing is responsible for making sure that this happens', said Michele Richardson, chair-elect of Advocate Aurora's board of directors.[9]

A 'Health Equity Pyramid' published in September 2021 as part of a 'Health Equity Roadmap for Health Care CEOs' places a priority on health systems collecting the raw data on the diversity of their workforce and leadership; creating dashboards for internal analysis using this data; making internal improvements in recruitment and retention; and finally, making their data on workforce and leadership diversity public (see Figure 1).[10]

EMPLOYING A CRITICAL RACE THEORY PERSPECTIVE TO EXAMINE STRUCTURAL RACISM

Other systems have examined themselves through the lens of critical race theory (CRT), a legal and academic framework built on the premise that race is a social construct and that not only is racism the product of individual bias but it is also embedded in legal systems and policies,[11] including in healthcare.

A case in point concerning the use of CRT as a point of departure for a health system is an effort that began in 2017–18 at Brigham & Women's Hospital in Massachusetts (part of the system now known as Mass General Brigham) through

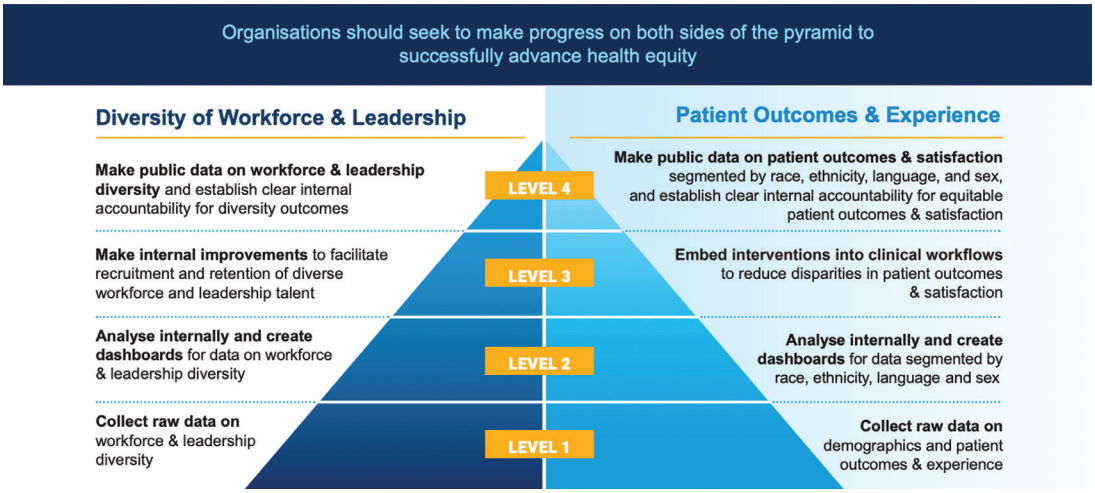

Figure 1: Health equity pyramid.
Source: https://www.healthevolution.com/2021/Forum_Health_Equity_Roadmap.pdf.

its Department of Medicine and its affiliated Southern Jamaica Plain Health Center, a community health centre. More than half of the patients at this community health centre identify as LatinX, and half are on public health insurance.

Dating back to the mid-2000s, a hospital committee had investigated possible racial inequities in cardiovascular care at the institution and surfaced data at the time reflecting apparent race-based care disparities.[12] Then, in 2016, a group of Brigham internal medicine residents who had explored CRT raised concerns that White patients with heart failure diagnoses appeared to be admitted more often to the organisation's cardiology service, compared with Black and LatinX populations, who were more likely to be admitted to the general medicine service. The cohort study that resulted found that Black and LatinX patients who self-referred to Brigham's emergency department with heart failure symptoms were, in fact, significantly more likely to be admitted to the general medicine services than to a cardiology inpatient bed and that being admitted to general medicine also increased the likelihood of readmission within 30 days of discharge.[13]

The group of residents who led the study 'recognized this finding as an example of institutional racism; however, building consensus on this key issue was difficult' within the institution, they noted in a *New England Journal of Medicine:* Perspective.[14] A follow-up study suggested that these different care patterns could be traced in part to complexities in the interactions between healthcare providers themselves; between providers and different groups of patients; and within patients and their families. For example, 'White patients were perceived as advocating for admission to cardiology more frequently (18.9 versus 5.6%) and more strenuously than Black patients'; what is more, ED clinicians 'more often reported having spoken with the patient's outpatient cardiologist for Whites than for Black or LatinX patients (24.3 versus 16.7%, $p = 0.069$)'.[15]

The Brigham subsequently launched repeated efforts to address these institutional disparities, working under a rubric called 'the Healing ARC', in which the acronym stands for *acknowledgment* by an institution's leadership that structural racism is real and that it takes responsibility for documented institutional racism; *redressing* the wrongs through specific actions; and obtaining

closure in the form of agreement by affected communities that new systems are in place 'to ensure that the problem will not reemerge'.[16] For example, the Brigham is now working with the affiliated community health centre in South Jamaica Plain to organise 'wisdom councils' of community members to solicit their views on further steps to address institutional racism and prevent its recurrence.

WIDENING THE TRADITIONAL EQUITY LENS

Discrimination against Blacks was an initial focus of many health systems' attention in the wake of the Floyd murder, and the health disadvantages experienced by both Blacks and LatinX populations amid the COVID-19 pandemic also gained much attention. But as attacks against Asians and Asian Americans also became widespread as the pandemic wore on, health systems began to broaden their traditional equity lens and consider anew the multiple populations discriminated against or otherwise disadvantaged in US health or healthcare. Unfortunately, a long list of affected groups resulted.

Kedar Mate, president of the Institute for Healthcare Improvement, the non-profit organisation that is an influential force in improving health quality worldwide, notes that the realities of equity issues that are cutting across multiple groups is in keeping with the findings of work that IHI has done to understand health disparities around the United States and globally through its 'Pursuing Equity' initiative. Just as in some parts of the world, health disparities may exist primarily across gender or ethnic lines, in the United States the greatest differences may not necessarily be along racial lines but may also break along rural-versus-urban, immigration or indigenous population status, LGTBQ-plus or other lines. There is also the notion of intersectionality or the interaction among race, class, gender, age, sexual orientation and other factors in shaping any single person's experience.[17] In other words, a Black man may encounter one set of adverse experiences, but a Black and aged gay man may experience many others.

As health systems widen their internal equity lenses, many are taking steps to address care disparities across these various lines of inequity. Consider the pervasive ageism in society as well as healthcare, notes Terry Fulmer, president of the John A. Hartford Foundation, a non-profit focused on improving the care of older adults. She recounts that when she formerly worked as a nurse, 'I saw ageism was rampant. Older people were called Gomers, which means Get Out of My Emergency Room. We would save 'em and scorn 'em.'

Today, the Hartford Foundation's Age-Friendly Health Systems initiative is working to expand such age-friendly practices as having a separate geriatric emergency department focused on care of elders. One such geriatric ED has been in existence since 2010 at St. Mary Mercy hospital in Livonia, Michigan, where a hallmark of age-friendly care has been careful attention to prescribing the medications that are most suitable to older adults.[18]

Another example of how health systems have substantially broadened their equity lenses is the Healthcare Equality Index, a national benchmarking tool[19] that evaluates the effects of healthcare facilities' policies and practices on equity and inclusion of LGBTQ patients, visitors and employees. Sponsored by the non-profit Human Rights Campaign (HRC), this approach was used in 2020 to evaluate more 1,700 healthcare facilities nationwide. A total of 765 hospitals and other healthcare facilities specifically sought to participate in, and be rated according to, HRC's 2020 survey, which rates organisations according to such criteria as whether they have internal committees focused on LGBTQ patient care issues. Of the 765 surveyed, 495 rated 100 per cent across all categories.

MARRYING QUALITY IMPROVEMENT AND PATIENT SAFETY TO ADDRESSING INEQUITY

A growing number of US health systems now recognise that inequity is yet another hallmark of poor or inadequate quality or lack of safety in health care, and manifested — as with other aspects of quality and safety — in unwarranted variation in health processes and outcomes as well as errors and adverse events. Some organisations have begun to apply the same tools and analytical frameworks used in quality improvement and patient safety, such as root cause or positive deviant analysis, to addressing inequities, notes Mate of IHI.

Meanwhile, at Main Line Health, a four-hospital system in suburban Philadelphia, Pennsylvania, the board of directors renamed one of its long-standing committees as the Quality, Safety, and Equity committee. 'All of us went into this business to make sure that everybody who sought our care received the same level of care', said John Lynch, President and CEO of Main Line Health. 'You're not really committed to safety [and quality] if you're really not committed to equity'.[20] Main Line Health's board even went a step beyond, to expressly highlight the role of structural racism in health inequity. 'We have in our current strategic plan, 'Build trust [and] identify and eliminate disparities in care', with the understanding that structural racism has affected confidence in the health care system', Lynch said.

HARNESSING DATA AND INFORMATION TECHNOLOGY TO IDENTIFY AND ELIMINATE DISPARITIES

A critical tool that enables organisations to unearth patterns of discrimination is their own data — and by the same token, making new uses of data creates an avenue for redressing past wrongs. The use of data to examine and address disparities and discrimination requires collection of data by race, ethnicity and other important demographic variables, which comparatively few US healthcare systems have traditionally done. This information must then be sifted and analysed and fed back within the system to determine the potential causes of disparities and identify appropriate ways of closing the gaps.

Such approaches track with the recommendations in the aforementioned 'Health Equity Roadmap for Health Care CEOs', which endorses organisations asking patients to voluntarily self-report their demographic data as 'the gold standard source for analysis and for comparison against other demographic data sources'. Combined with clinical data, these demographic data can then be mined to create the recommended dashboards for monitoring disparities in the quality of care and both relative and absolute changes over time.[21]

The case of Brigham & Women's Hospital described previously illustrates these multiple uses of these data tools. Since it was data that ultimately confirmed the Brigham residents' suspicions that Blacks and LatinX populations were being treated differently from Whites with heart failure, collecting even more real-time data, and making the information actionable, also appeared to be essential to remediation. As a result, the Brigham's electronic health record system has been re-engineered so that when self-identified Black and LatinX people present with a potential diagnosis of heart failure, an alert flashes. The treating clinician is thus notified or reminded of the documented institutional inequity involving such patients and can then route the patient to the cardiology speciality service rather than to general medicine.

Although 'niche' strategies such as these, to redress particular past wrongs, are important, health information technology specialists caution that organisations will need holistic strategies around appropriate data use to

avoid exacerbating current inequities. For example, many systems are now also taking care to ensure that their existing uses of data and analytics do not inadvertently worsen care disparities and discrimination.

An example is the use of a 'race multiplier' that adjusts for higher rates of certain conditions in Blacks, and then factors these adjustments into clinical guidelines. A race multiplier that accounted for aspects of chronic kidney disease (CKD) in Blacks — including higher rates of anaemia and hypertension — was shown in one analysis to be likely to result in fewer Black patients being categorised as having severe CKD or referred for transplantation than would have been the case without the use of the multiplier.[22] Several leading institutions that had employed these race multipliers have now abandoned them, including the University of Washington, Vanderbilt University and Mass General Brigham.

ADDRESSING UPSTREAM DRIVERS OF HEALTH

Decades' worth of the health literature has illuminated that the primary drivers of health inequity lie far afield from healthcare, in what Michael Marmot has characterised as six 'priority areas' of social determinants: 'quality of experiences in the early years, education and building personal and community resilience, good quality employment and working conditions, having sufficient income to lead a healthy life, healthy environments, and priority public health conditions — taking a social determinants approach to tackling smoking, alcohol, and obesity'.[23] Since these drivers are so far upstream from the healthcare system, the obvious conclusion is that 'we won't find health through health care' — even if the US healthcare system, in particular, is frequently the place where the products of societal neglect will inevitably end up, noted Donald Berwick, former administrator of the U.S. Centers for Medicare and Medicaid Services and former president and chief executive officer of the Institute for Healthcare Improvement.[24]

The inequities that result from breakdowns in the priority social determinants do not merely affect those who are worst off but also create a 'social gradient in health and disease running from the top to bottom of society', as Marmot and his colleague, Jessica Lee, wrote. As a result, Berwick says, opportunities exist to seek redress through the approach of 'targeted universalism', a concept advanced by John Powell at the University of California-Berkeley.[25] In this approach, universal societal goals are set — for example, for universal early childhood education — and then pursued through targeted processes that set goals for all affected groups. This approach leaves room, for example, for subsidising early childhood education in poor communities, while emphasising that early childhood programmes and their benefits must be available for all children in society, regardless of their income or socio-economic status.

A growing number of health systems recognise that their role in the social and economic life of communities is large enough to be able to influence the priority social determinants in positive ways, if they are intentional about doing so. They also recognise that 'targeted universalism' is a principle that they can put to good use by making particular investments that will redound to greater health for all. 'We may have considered ourselves a world-class system, but we weren't delivering health equitably for everybody', says John Vu, national vice president for community health at Kaiser Permanente. 'We asked, "How can we go upstream and think about shaping healthy behaviours differently?"'

As large economic players, or 'anchors', in their individual communities, these health systems hire and train tens of thousands of people, buy billions of dollars' worth of supplies and invest their own funds in financial markets as a routine matter

of business. In 2017, 10 leading health systems founded the Healthcare Anchor Network to identify and share strategies for employing these resources to boost economic opportunity as a long-term means of advancing health. Thus, Rush University Medical Center, in Chicago, an original Anchor Network member, is using its human resource dollars to help shrink a 16-year gap in life expectancy across that city's disparate neighbourhoods. It partnered with three other local health systems and local universities to educate and train new medical assistants and then hired 400 local community members as a first step in building their healthcare careers.[26] Meanwhile, Kaiser Permanente invested US$50m in a real estate 'impact fund' managed by SDS Capital Group to help build 1,800 permanent supportive housing units for people experiencing homelessness in California.[27]

An objective of these efforts, as Lisa Cooper and David Williams observe, is to create a variation on the COVID-era theme of 'herd immunity' — one in which all members of the community would be immune to negative social and economic factors that predispose so many to poor health. As they wrote, 'If we can provide that kind of herd immunity, that will protect us from greater pandemic of health inequity'.[28]

CONCLUSION

History has left the United States with social and economic structures, including embedded racism, that discriminate against individuals and groups and consign tens of millions to poorer health. But because these structures were created by human beings, they can be changed.

A growing number of US health systems now recognise and accept that they must play a dominant role in this historical transformation process. They must not only eliminate racial and ethnic disparities in health care, but also work within their power to address upstream drivers of poor health and to bring about better health for all.

Although racial and ethnic disparities in US health care have been documented and acknowledged for years, a major evolution in thinking has taken hold among many US health systems in recent years. This new mode of thinking recognises and embraces important elements of CRT, namely that race is a cultural construct, not a biological reality; that racism is structural, systemic and embedded within institutions and society; and that addressing and eradicating racism and the resultant disparities in health and health care requires equally systemic and structural solutions.

The seven main categories of activity described in this paper represent health system leaders' current agenda for creating these systemic solutions. As noted, these activities include publicly denouncing inequity; taking larger steps internally to address DEI; examining themselves through the lenses of structural racism and CRT; widening the traditional equity lens to encompass widespread discrimination against multiple population groups; ramping up efforts to address the quality of care and reducing undesirable variation as a means of reducing inequity and disparities; harnessing data and information technology to assist in these quality-improvement efforts; and using health system resources to address upstream health drivers, including those in priority areas of the social and economic determinants of health.

As with any major efforts in organisational change, health systems will need to consider carefully how to approach all of these activities. It may be beneficial to, first, set forth an overall 'equity strategy' that is fully articulated by each system's leadership and officially adopted by the board of directors. Second, metrics should be created to establish a baseline set of facts and create accountability for progress — for example, in dashboards chronicling diversity-oriented hiring and retention that would be subject to regular senior management and board review. Third, as again is the case with all major

organisational change efforts, it is best to begin with the steps that are easiest, to build momentum for further change. Publicly denouncing inequity would be a natural place for health system leadership to begin, particularly to set the future course for the organisation and rally support for change.

In 1966, speaking just before he addressed a convention of the Medical Committee for Human Rights, Dr Martin Luther King, Jr., said this:

> Of all the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death . . . .I see no alternative to direct action and creative nonviolence to raise the conscience of the nation.[29]

More than 50 years later, the United States is still coming to grips with the shocking and inhuman inequity in health and health care. As this paper has shown, health systems now have urgent and unprecedented opportunities to correct these long-standing wrongs.

References and notes

1. National Academies of Sciences, Engineering, and Medicine. (2017) 'Communities in Action: Pathways to Health Equity', The National Academies Press, Washington, DC. https://doi.org/10.17226/24624.
2. Institute of Medicine. (2003) 'Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care', The National Academies Press, Washington, DC. https://doi.org/10.17226/12875.
3. Millett, G., *et al.* (2020) 'Assessing differential impacts of COVID-19 on black communities', *Annals of Epidemiology*, Vol. 47, pp. 37–44.
4. Williams, D. R., Cooper, L. A. (2020) 'COVID-19 and health equity — A new kind of "Herd immunity"', *JAMA*, Vol. 323, No. 24, pp. 2478–2480. DOI:10.1001/jama.2020.8051.
5. Dr Copeland's remarks were delivered at the 2021 Congress on Healthcare Leadership of the American College of Healthcare Executives, held virtually in March 2021.
6. Dr Lassiter's remarks were delivered at the Health Equity Summit, a virtual conference held in June 2021. Archive is available at www.healthequitysummit.com.
7. Alsan, M., Wanamaker, M. (2018) 'The Tuskegee and the health of black men', *Quarterly Journal of Economics*, Vol. 133, No. 1, pp. 407–455. DOI:10.1093/qje/qjx029.
8. See https://about.kaiserpermanente.org/our-story/news/equity-inclusion-and-diversity (accessed 25th February, 2022).
9. Ms Richardson's remarks were made at the Health Equity Summit in June 2021. Archived version is at www.healthequitysummit.com.
10. Health Evolution Forum. (2021) 'Health equity roadmap for health care CEOs: Part I: Patient outcomes & experience', available at: https://www.healthevolution.com/2021/Forum_Health_Equity_Roadmap.pdf. Vol. 12, No. 11, Nov. 2019. https://doi.org/10.1161/CIRCHEARTFAILURE.119.006214 (accessed 7th January 2022).
11. Crenshaw, K., Gotanda, N., Peller, G., Inglis, C. (1996) 'Critical Race Theory: The Key Writings that Formed the Movement', The New Press, New York.
12. Morse, M., Loscalzo, J. (2020) 'Creating real change at academic medical centers — How social movements can be timely catalysts', *The New England Journal of Medicine,* Vol. 383, pp. 199–201.
13. Eberly, L., *et al.* 'Identification of racial inequities in access to specialized inpatient heart failure care at academic medical center', *Circulation: Heart Failure*. (accessed 7th January, 2022)
14. *Morse*, ref. 12 above.
15. Cleveland Manchanda, E. C., *et al.* (2021) 'Heart failure admission service triage (H-FAST) study: Racialized differences in perceived patient self-advocacy as a driver of admission inequities', *Cureus*, Vol. 13, No. 2, p. e13381. DOI: 10.7759/cureus.13381.
16. Wispelwey, B., Morse, M. (2021) 'An antiracist agenda for medicine', *Boston Review*, 17th March, available at: https://bostonreview.net/science-nature-race/bram-wispelwey-michelle-morse-antiracist-agenda-medicine (accessed 15th December, 2021).
17. Norris, A., Murphy-Erby, Y., Zajicek, A. (2007) 'An intersectional perspective in introductory sociology textbooks and the sociological imagination: A case study', *Race, Gender & Class*, Vol. 14, No. 1–2, pp. 333–344.
18. Slootmaker, E. (n.d.) 'Michigan providers adopt age-friendly health system model to give elders better care', available at: https://www.secondwavemedia.com/features/agefriendlyhealth03122020.aspx (accessed 7th January, 2022).
19. See https://www.hrc.org/resources/healthcare-equality-index.
20. Mr Lynch's comments were made at the Health Equity Summit in June 2021; see archive at www.healthequitysummit.com.
21. *Health Evolution Forum*, ref. 10 above.
22. Ahmed, S., *et al.* (2021) 'Examining the potential impact of race multiplier utilization in estimated glomerular filtration rate calculation on African-American care outcomes', *Journal of General Internal Medicine*, Vol. 36, No. 2, pp. 464–471. DOI: 10.1007/s11606-020-464-471.
23. Marmot, M., Allen, J. (2014) 'Social determinants of health equity', *American Journal of Public Health*, Vol. 104, Suppl 4, pp. S517–S519. DOI: 10.2105/AJPH.2014.302200.

24. Dr Berwick's remarks were delivered at the virtual Health Equity Summit in June 2021. Archive is available at www.healthequitysummit.com.
25. Powell, J., Menendian, S., Ake, W. (2019) 'Targeted universalism: Policy & practice', Haas Institute for a Fair and Inclusive Society, University of California, Berkeley, available at: haasinstitute.berkeley.edu/targeteduniversalism. (accessed 7th January, 2022)
26. Goldberg, S. (2018) 'Chicago hospitals team up to help entry-level workers advance careers', *Modern Healthcare*, 12th December, available at: https://www.modernhealthcare.com/article/20181212/NEWS/181219972/chicago-hospitals-team-up-to-help-entry-level-workers-advance-careers (accessed 25th February, 2022).
27. See https://www.sdsgroup.com/la-based-sds-supportive-housing-fund-raises-106-million-to-fight-homelessness-by-financing-up-to-1800-units-of-permanent-supportive-housing-psh-in-california/
28. *Williams*, ref. 4 above.
29. Galarneau, C. (2018) 'Getting King's words right', *Journal of Health Care for the Poor and Underserved*, Vol. 29, No. 1, pp. 5–8.