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There can be no quality without equity

Derek Feeley CB, DBA, Senior Fellow

Institute for Healthcare Improvement, 53 State Street, 19th Floor, Boston, MA 02109, USA.
Email: dfeeley@IHI.org

2020 saw the rise of one pandemic – COVID-19 – and the (tragically late) broad acknowledgement of another – institutional and structural racism. It's impossible to separate the events of today from a look to the future, but even if the novel coronavirus hadn't disproportionately ravaged communities of colour,[1] or if George Floyd hadn't been killed by the police, equity would still need to be at the core of any conception of what health care quality should look like over the next 20 years.

Twenty years ago, the authors of *Crossing the Quality Chasm*[2] defined what quality in health care should be by articulating six aims for improvement: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. These aims were never meant to be independent. Yet, 20 years since the *Chasm Report*, progress against the first five aims (it's hard not to notice that equity was listed last) hasn't benefitted the sixth.

The inequities in health care that existed at the turn of this century have persisted or worsened. We know why. Decisions made about what to improve and how to improve without first asking crucial questions such as 'Who benefits?' and 'Who gets left behind?' only preserve and cement inequities. Designing quality initiatives *for* certain populations rather than *with* the people most affected will lead to less improvement, less sustainability, less trust, and less equity.

The tools and methods of quality improvement are well suited to an effort to improve equity in health and care. The missing ingredients over the past decades have been strategic intent and a sharply focused equity lens. In practice, applying an equity lens includes actions like codesigning improvements with people who have lived experience of inequities. Applying an equity lens also means stratifying all data by relevant socio-demographic factors.

The Institute for Healthcare Improvement (IHI), together with multiple health systems, has described and tested a framework, and accompanying guidance documents, for pursuing equity in health care that can serve as a foundation for change. We have also produced guidance documents to share case examples and learning. There are five components to the *IHI Framework for Improving Health Equity*[3]:

1. Make health equity a strategic priority;
2. Build infrastructure to support health equity;
3. Address the multiple determinants of health;
4. Eliminate racism and other forms of oppression; and
5. Partner with the community.

We need to avoid thinking of equity as a balancing measure to other indicators of quality. It is an essential outcome. Clearly defining what we are trying to accomplish with regards to health equity, testing new ideas on how to improve health equity, and leveraging existing measures (and developing new ones) to determine whether we are, in fact, improving outcomes, are all crucial steps we must take over the next 20 years. If we don't, another 20 years will pass, and there will still be no quality without equity.

Competing interests

The author is a Senior Fellow at the IHI.

References

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3 Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. Achieving health equity: a guide for health care organizations. Institute for Healthcare Improvement (IHI) White Paper. Cambridge, MA, USA: IHI; 2016. Available at: http://www.ihi.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx [verified 23 June 2020].