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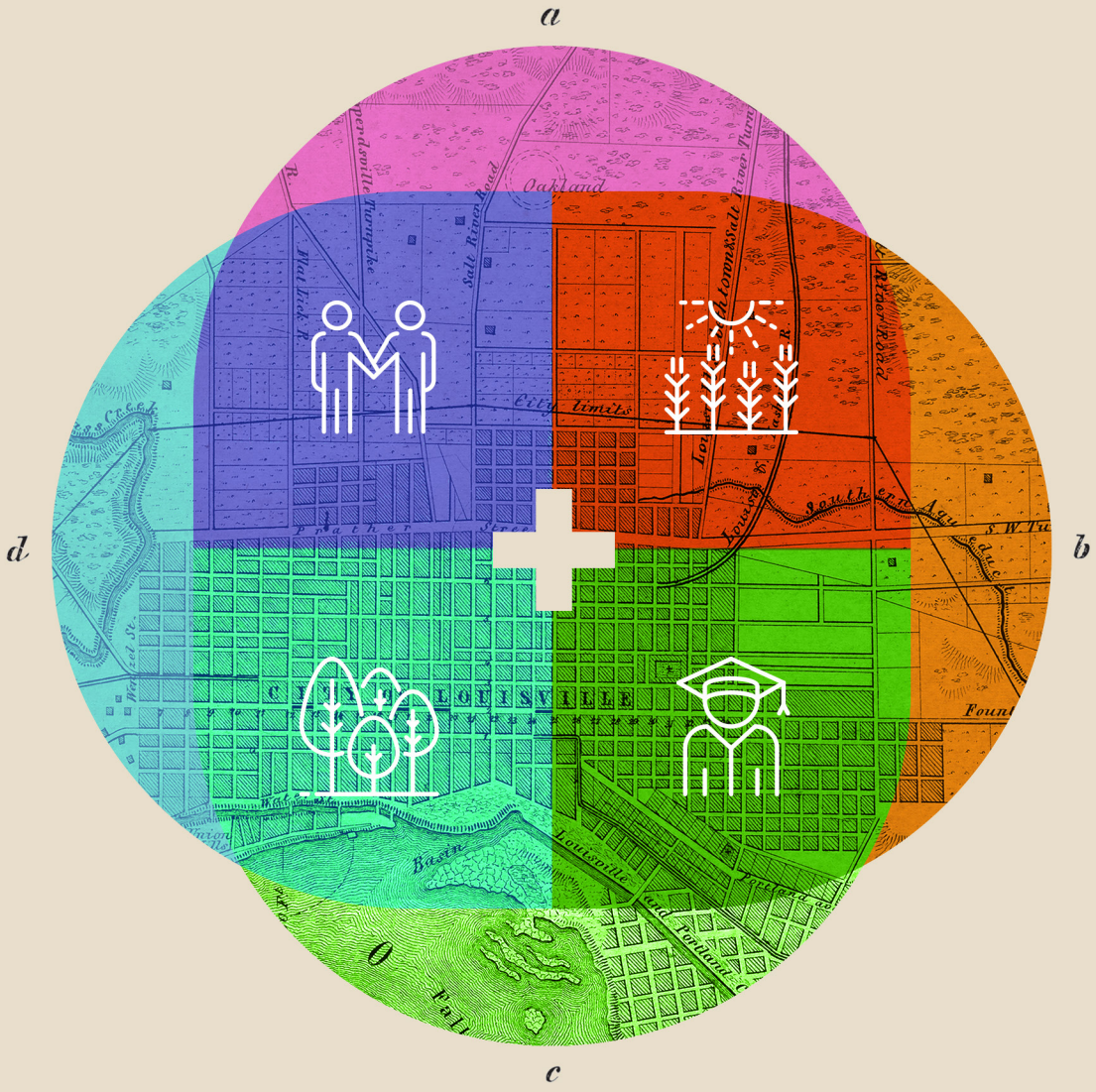
A report from the
Deloitte Health Equity Institute



Activating health equity

A moral imperative calling for business solutions

About the Deloitte Health Equity Institute

Advancing health equity through action

COVID-19's disproportionate impact on low-income populations and communities of color has exposed deep inequalities in health outcomes. Deloitte has established the Deloitte Health Equity Institute to build upon a decade of impact made by the Deloitte Center for Health Solutions. The institute is grounded in our declaration of racism as a public health crisis and, as such, is dedicated to convening and amplifying crisis response. The institute was established to share our most impactful learnings, extend the efforts of others, and meaningfully contribute to broader health equity issues.

Through the establishment of the Deloitte Health Equity Institute, Deloitte is expanding its existing long-term commitment to aligning ecosystems of community-based organizations, government agencies, academics, and the private sector. These efforts are focused on enhancing research, driving equitable care, and activating interventions that help address the activating interventions that help achieve health equity.

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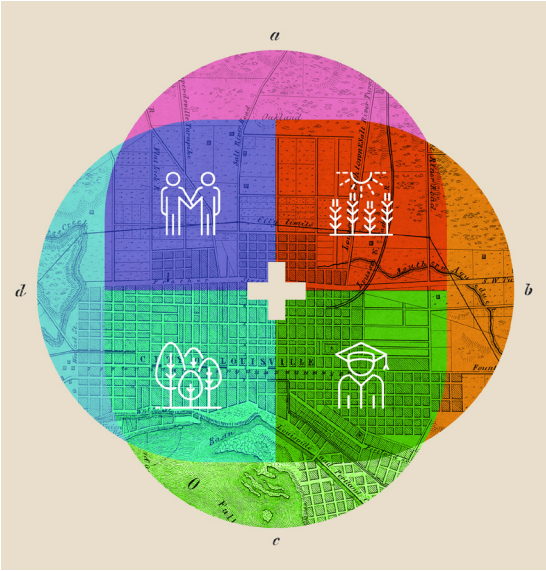
Life sciences and health care services

Amid unprecedented uncertainty and change, the life sciences and health care industry is transforming today to build a digitally enabled, equitable Future of Health™. We help biopharmaceutical and medical technology manufacturers and health systems, health plans, retail health companies, and start-ups orchestrate and deliver a more equitable health ecosystem and transform human health. Our professionals provide strategy, insights, and actions to help enable our clients to reimagine the industry. Backed by consulting, financial advisory, risk management, audit, and tax capabilities, along with software products and platforms, we help companies see what's in front of them and what's ahead. To learn more, visit the LSHC industry page on www.deloitte.com.

Health equity is an imperative

HEALTH EQUITY IS the *fair and just opportunity* for every individual to *achieve their full potential* in all aspects of *health and well-being*. But that's a far cry from what exists in the United States today. Significant health disparities—quantifiable differences in health-related outcomes—have been documented across many dimensions, including race, gender, age, location, disability status, and sexual orientation. These disparities, which include variation in life expectancy, birth outcomes, chronic disease, morbidity, and more, are evidence of systemic structural inequities that affect both individual and community health and well-being.

Health inequity is especially apparent along lines of race, with Black, Indigenous, and people of color (BIPOC) experiencing barriers that lead to poorer health overall than white populations. Racism is a prime culprit—to the point where racism is a public health crisis.[1] In the United States, racism has significantly influenced the way the health ecosystem is built, contributing to poorer health outcomes for BIPOC. Racism also creates barriers in drivers of health such as access to healthy food, affordable housing, a stable physical and social environment, and quality education, which can lead directly to poorer health among the disadvantaged. The worse health outcomes brought about by these unjust systemic and social structures can persist over generations.[2]



Bias and racism [are] built into everyday decisions, which may appear fair on the surface, and which may have even been designed with good intentions, but ultimately have disparate effects on racial and ethnic minorities and other marginalized identity groups.[3]

— Janet Foutty, executive chair of the board, Deloitte US

From a broad economic perspective, racism in general takes a huge financial toll, costing the US economy US$16 trillion in opportunity cost over the past 20 years.[4] With respect to health equity specifically, racial health disparities have been

shown to result in significant avoidable health care spend and economic loss due to their impact on productivity. The Kellogg Foundation estimates that US economic output would increase by $2.7 trillion annually if race-based disparities both within the health care system and beyond were addressed.[5] The same study estimates that eliminating health disparities by 2050 would reduce the need for more than US$150 billion in medical care.

For organizations, addressing racism and other biases to advance health equity can be a point of competitive advantage. Not only can it help them attract the best talent and elevate their brand and reputation, but healthier workers have fewer sick days, are more productive on the job, and have lower medical care costs. And life sciences and health care organizations have even more reason to pursue health equity, since it can drive direct improvements to their mission to continually enhance the quality of care.

Achieving health equity requires leaders to intentionally and deliberately design and build systems that advance health equity as an outcome. To do this, they should root out racism both within and outside the health care system to break the vicious cycle of inequity that stands in the way of all individuals reaching their potential for health and well-being. Disparities in outcomes should not, and do not have to, be driven by racism and bias.

HEALTH INEQUITY OFTEN CREATES WORSE HEALTH OUTCOMES FOR THE DISADVANTAGED AND DISCRIMINATED AGAINST

- Black and Hispanic Americans are three times more likely to contract and twice as likely to die from COVID-19 than white Americans.[6]
- Compared to 2019, during the period January–June 2020, life expectancy decreased by 2.7 years (74.7 to 72) for non-Hispanic Black people and by 1.9 years (81.8 to 79.9) for Hispanic people. For non-Hispanic white people, life expectancy decreased by only 0.8 years (78.8 to 78). [7]
- Low-income American adults are more than twice as likely to have a stroke and have higher rates of heart disease, diabetes, and other chronic disorders than wealthier Americans.[8]
- More than 50% of individuals living within 1.9 miles of toxic waste facilities—linked with health issues such as cancer and kidney failure—are people of color.[9]
- Lesbian, gay, and bisexual youth in grades 7–12 are more than twice as likely to have attempted suicide than their non-LGBTQ+ peers.[10]
- One in three people with disabilities aged 18–44 did not have a usual health care provider and had a health care need that went unmet in the last year due to cost.[11]
- Historically, BIPOC populations have been underrepresented in clinical trials. A recent study of 230 US-based clinical trials from July 2011 through June 2020 with nearly 220,000 participants found that Black, Native American/Alaskan Native, and Hispanic/Latino people were the most underrepresented groups.[12]

Racism and bias as barriers to achieving health equity

RACISM IS PERVASIVE throughout industries and institutions, and the health ecosystem is no different. Racism can work its way into the health care ecosystem at many levels, ranging from where facilities are located and gaps in physician training and diversity to care coordination algorithms that direct resources to the people using the most services, who are disproportionately higher-income and white. Bias and prejudice operate for other groups of people (e.g. women, LGBTQ+, religion) similarly, while lack of investment in marginalized communities compounds the structural flaws of the health care system. In addition to these structural flaws, the United States' history of medical mistreatment of BIPOC individuals has contributed to mistrust of clinical trials and the health care system among many in minority populations.[13] Instances of this medical mistreatment range from lack of access to care financing, nonrepresentative clinical trials, and lack of representation of BIPOC individuals in the medical field.[14]

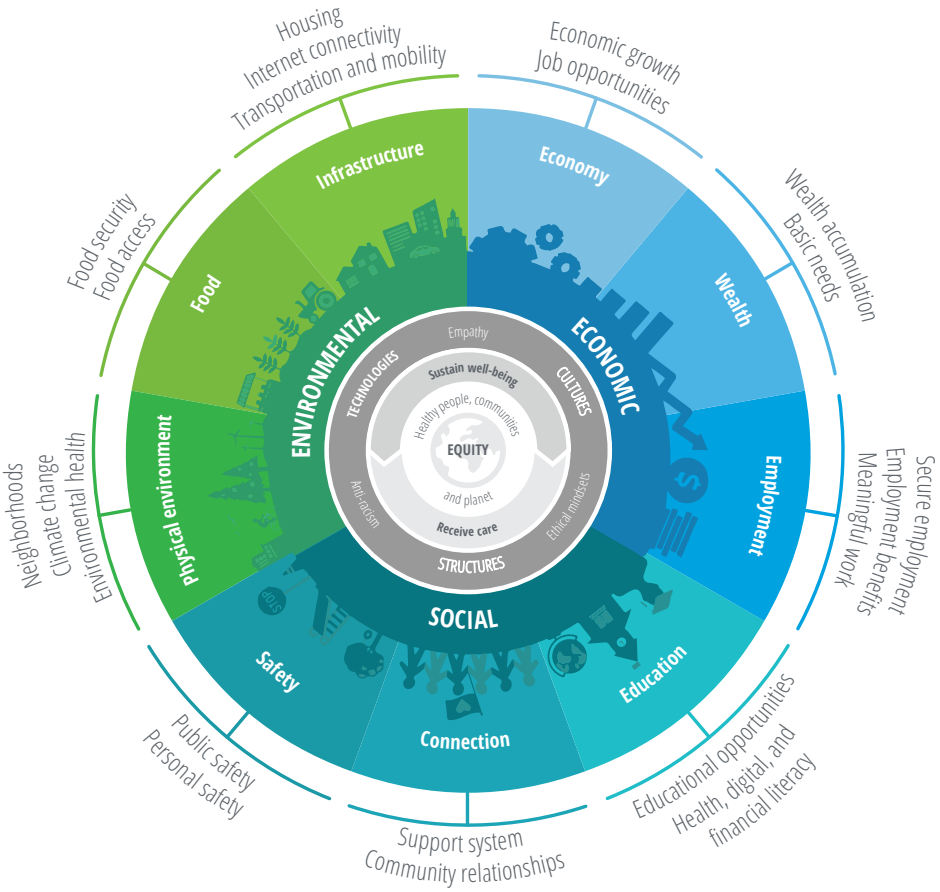
Moreover, health care itself is only one factor that affects a person's health. Some studies estimate that social, economic, and environmental "drivers of health" (also known as social determinants of health) can account for 80% of health outcomes, whether positive or negative.[15] These drivers of health include factors such as income, location of residence, and the quality of social support networks. Discrimination and bias, including racism, often cause these factors to be negative. This compromises health both by creating an unhealthy environment and lifestyle and by creating challenges of access to health care and health care coverage. For example, BIPOC communities may struggle with disadvantages such as multi-generational poverty, homelessness, unemployment, poor nutrition, violence, and adverse environmental exposure. All of these can limit their ability to obtain quality education, jobs with good pay, healthy food, safe housing, and positive family and community relationships, creating unnatural bottlenecks that can stand in the way of good health.[16]

Racism and bias in the health care system interacts in varied and complex ways with racism in the drivers of health, further aggravating health inequity. For instance, a Black woman living in a lower income neighborhood may have had less access to high-quality education and sources of healthy food, which contributes to her high blood pressure and diabetes. The hospital in her neighborhood may see disproportionately more patients without health insurance or insurance that pays low rates, so it may have fewer resources. The individuals working there might treat her differently due to unconscious bias; they may also not have much time to spend with patients with multiple chronic conditions who end up coming to the emergency room often. These factors can multiply to make this woman's health outcomes worse than for a white woman of the same age.

Research even indicates that racism itself can have its own negative impact, separate from that of age, gender, birthplace, and education.[17] For instance, studies show that people who have experienced racism have a higher risk of chronic inflammation and chronic illness.[18] Similarly, recent data from the American Heart Association shows that people who experience racism have higher blood pressure than those who do not, even after adjusting for age, gender, and hypertensive risk factors.[19] And a comprehensive meta-analysis of data from more than 300 articles demonstrates a strong link between racism and

FIGURE 1

The drivers or social determinants of health



Source: Deloitte analysis.

poorer mental and physical health outcomes.[20] Other biases—including, but not limited to, those against LGBTQ+ individuals, low-income people, people with disabilities, and people with more than one of these identities—contribute similarly to poor and inequitable health outcomes. These biases and additional factors were further demonstrated in the past year in the higher rate and greater severity of COVID-19 cases among BIPOC populations—leading to dramatic loss of life and an overall decrease in BIPOC individuals' life expectancy relative to white individuals over the past year.

HOW DO CONSUMERS PRIORITIZE WHAT KEEPS THEM HEALTHY?

A 2018 study commissioned by Rebecca Onie and Rocco Perla from The Health Initiative discovered that, when asked how they would invest their health care dollars, people prioritized drivers of health over formal health care by a large margin. Respondents said they would spend about US$30 out of every US$100 on hospitals and health clinics, but they would choose to spend the rest on various nonmedical drivers of health such as food, employment, and housing. This pattern was consistent across lines of race, gender, socioeconomic status, and political views. Evidently, people recognize the importance of factors outside the health care system in supporting good health.[21]

The business case for health equity in life sciences and health care

THE IMPERATIVE FOR health equity is undeniable, but the issue's economics are equally compelling. Though health inequity can harm all organizations by reducing worker productivity, many life sciences and health care organizations have an especially strong interest in improving health equity in that it can bolster their commercial success. For example, decreasing health disparities by advancing equity could lower health plans' and systems' costs associated with poor health outcomes that lead to more emergency room visits, more neonatal intensive care unit stays, longer hospital stays, and unnecessary hospitalizations. This in turn could generate value for the businesses that pay for health care as well as state and federal agencies and the people they serve. Improving health outcomes could also improve plans' and providers' quality ratings, making them eligible for higher payments from Medicare and other value-based care programs designed to reward quality. These efforts align toward the industrywide trend of prevention and well-being. In the future, we will likely see value-based equity programs that reward not only improvement in average outcomes but also parity of outcomes among different populations.

Health equity can also enable organizations to save lives and deliver more value to the individuals and communities they serve. Health plans that increase access to care for mental health and well-being services can prevent deaths from suicide and drug overdose while reducing hospital admissions and emergency care use. Providers that build oncology programs that focus on prevention and early detection of cancer can reduce the overall cost of care as well as cancer's human impact. Under payment systems that reward better outcomes and lower cost of care, providers can share these types of benefits with patients and health plans. And life sciences companies that drive equitable representation in research and development, clinical trials, and market access may be able to develop and deliver cures and treatments that will be more clinically effective and gain greater market adoption.

Finally, efforts to advance health equity can make organizations more attractive ecosystem partners to others that also prioritize health equity. These partnerships can both increase organizations' health equity efforts' effectiveness and reach, and deliver additional benefits such as opportunities for research and/or clinical collaboration.

Activating health equity: How life sciences and health care leaders can accelerate progress

ACHIEVING HEALTH EQUITY will likely require more than small changes and targeted interventions. Life sciences and health care organizations can work toward overarching systemic change to address health inequity's drivers, including inequities in both the health care system and in nonmedical drivers of health, through a strategy that places health equity at the center and expands across four domains: the organization, its offerings, its community, and its ecosystem. As shown in figure 2, industry players can take specific actions in all these domains to meaningfully advance health equity.

Organization

The *organization* domain refers to how an employer addresses diversity, equity, and inclusion in the workplace. This is how organizations get their own house in order, to make an impact and demonstrate commitment. Increasingly, as large organizations look at their own workforce, they are identifying real needs and barriers to health. Leading organizations are beginning to act through initiatives such as anti-racism and unconscious bias training programs for employees, including programming that educates people on how to address the health care system's structure based on an organization's positioning in that system. Other efforts along these lines include performance incentives based on commitments to diversity, equity and inclusion, and diversity and inclusion hubs to foster innovation through diversity.

In addition, some large employers are even looking at screening their own workforce to surface issues such as food insecurity among their people.

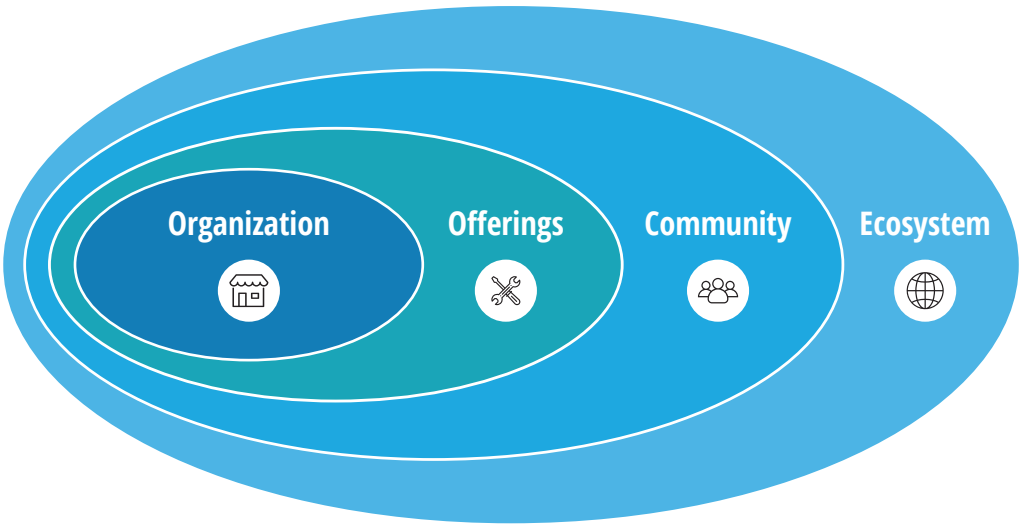
Employers should ask themselves questions such as: Is pay equitable, and is it sufficient to support employees' needs for food, shelter, and transportation? Do BIPOC communities have the opportunities and the support to advance and thrive in the organization? Is there a strong sense of inclusion and belonging across all levels and for all individuals regardless of race, ethnicity, belief system, gender, or sexual identity?

Offerings

Life sciences and health care organizations also should address health equity within their *offerings*, meaning the products and services they deliver. Though these will differ across providers, health plans, life sciences companies, health technology vendors, and government agencies, there are some common questions that these organizations can ask. These include: Are we making products and services accessible and supportive of all populations' health? As we design our offerings, are we considering accessibility for all the populations that will use the products and services? Given how integrated data and analytics are to services, are we considering the possibility of bias in artificial intelligence tools and the algorithms they use that may be perpetuating inequities?

FIGURE 2

Four domains of action



Representative actions across domains

Organization	Offerings	Community	Ecosystem
Collect and use data from employees to design equitable employee benefit programs Mandate cultural competency and implicit bias training for all employees	Advance value-based payment models and reward for equitable outcomes as well as overall outcomes Design for equity in R&D and when creating new products and services	Strategically invest in communities to build on existing assets while helping to fill gaps Partner with traditional competitors to magnify impact on health equity in the same virtual or geographic communities	Consider diversity when selecting vendors and suppliers Amplify your health equity efforts through a defined policy agenda

Source: Deloitte anaylsis.

For a health care system or health plan, pursuing equity might involve looking at the quality and type of care or services by race, ethnicity, and language to identify and address gaps. More and more health plans and health systems are bridging health and social services to address drivers of health through technology-enabled referral networks with local community organizations. Health systems and health plans can consider questions about pricing, especially what patients and consumers end up having to pay for services. They could also consider other aspects of access, such as whether care is available virtually as

well as in person and whether individuals have the ability—enough broadband and technical savvy—to use virtual care.

Government and commercial health plans are starting to think about how to integrate an equity lens into reimbursement through equity-based contracting—looking at value based not just on average population outcomes, but also as a function of equity across subgroups. More broadly, policymakers can continue to explore ways to advance health equity through reimbursement policies and regulatory requirements.

For life sciences companies, diversity in R&D has been top of mind in order to bring equitable therapeutics into the market. Life sciences companies are also beginning to think about the impact of nonmedical drivers of health on their go-to-market strategies, thinking about what communities their products are targeting, and what role they can play in mitigating barriers to access, diagnosis, and treatment. And organizations actively engaged in mergers and acquisitions might think about whether such deals might support or enhance their equity strategy.

Community

The *community* domain is what an organization can do to improve health and equity in its own community—both geographic and virtual. Is the organization a good neighbor, actively listening to its community, and partnering to drive change? Is the organization thoughtful about where it invests in major capital projects? Are community-oriented philanthropy strategies consistent with the organization's broader approach to health equity?

Comprehensive and tailored strategies rooted in communities can connect clinical with nonclinical organizations and foster public-private partnerships to take on the challenges of improving wellness in those communities. For example, to address structural flaws and mistrust of the health system, bidirectional targeted education should be deployed to BIPOC communities. Organizations should partner with trusted community leaders to effectively deliver educational messages in a culturally appropriate manner. In particular, data shows that churches are an extremely trusted community member for Black people and could be leveraged to effectively relay educational messages.[22]

Organizations can also look for opportunities to invest in infrastructure critical for equitable health, ranging from affordable housing to finding ways to mitigate adverse childhood experiences through building more resilient communities. A range of analytic tools are available that can help inform such strategies by identifying the community's most pressing issues. Moreover, organizations can engage in communitywide education efforts.

Ecosystem

The *ecosystem* domain refers to what the organization can do with others—similar or even dissimilar businesses, the government (including as an influencer of policy), and private organizations—to advance an agenda for better health and equity. Examples of action in the ecosystem domain may include promoting and collaborating with minority-owned businesses, or building and sharing free operational tools or technology resources to help organizations across industries take more effective action on health equity. Leaders should consider how their political donations do or do not align with a strategy that promotes health equity. Questions to ask include: Where are the natural synergies? Who can we work with to gain insight and capability? Which opportunities have the potential to have the greatest short- and long-term impacts? What could the industry or sector take on as a group? What are we and others willing to do publicly and, on the record, and what is the vision for our legacy?

How to move forward

AS LEADERS CONSIDER how to activate health equity within their organizations, for their customers, and for the nation, we recommend the following practices:

1. **Build health equity into your strategy.** Health equity should be part of everything that your organization does. The health equity strategy should not be separate or siloed. Integrating process and outcome metrics that account for health equity into your business objectives and organizational KPIs can accelerate adoption. As you design your strategy, it is important to take into account the current state of your organization's culture and capabilities. We suggest a strategic road map that focuses on where you want to be in the future and sets a course based on where you are today.

   An example from the leading edge: As evidenced by its "total health" approach, insurer Kaiser Permanente is committed to leading the industry in developing and implementing innovative approaches to improve health equity and eliminate disparities in health care quality and access.[23]

2. **Expect active involvement from all your people.** Heath equity is everyone's job—not just that of HR or customer-facing employees. Demand active allyship and anti-racism, and embed equity into all organizational functions to set new industry norms for improving health.

   An example from the leading edge: Wake Forest School of Medicine has implemented a new health equity curriculum to help ensure those receiving clinical education and training would understand and bring a health equity perspective into their future work and teams.[24]

3. **Look for opportunities to address drivers of health.** Commit to innovatively addressing non-medical drivers of health within your organization, for your consumers, and throughout your communities. Partner, invest, and coordinate to maximize impact.

   An example from the leading edge: Through its Bold Goal program, coverage provider Humana works with community partners to cocreate solutions to address health-related social needs, including helping members access healthy food, connect socially, and address housing needs.[25]

4. **Let the numbers be your guide.** Harness data and technology to understand where to act, monitor success, and scale health equity efforts. At the same time, make efforts to identify and eradicate bias from AI and technology solutions.

   An example from the leading edge: The University of California San Francisco examined its algorithms and data tools to understand how they reflected bias and discrimination, and made changes to support more equitable decisions and action in health care operations. These actions include, for example, proactively reaching out to patients who might be at risk of not appearing for appointments due to transportation risks.[26]

5. **Hold people and organizations responsible.** Go on the record with commitments to health equity, be transparent about initiatives, and challenge peers and partners in other sectors to move forward.

An example from the leading edge: Merck partnered with Drexel University to invest in diversifying leadership across the pharmaceutical supply chain, publicizing its support of this topic and encouraging peer organizations to make similar investments in equity.[27]

6. **Measure results.** Measurement is the only way we can know if outcomes are improving or worsening. Health care and life sciences organizations, as well as governments and other interested parties, can assess the extent of health inequity by measuring health care disparities, which quantify differences in health outcomes between different groups.

   An example from the leading edge: Brigham Health developed dashboards to measure and track differences in health outcomes between groups served at Brigham, and used this data to design strategies to proactively address racial disparities in health care operations.[28]

As our nation continues to grapple with the far-reaching impacts of racism and bias on health, the time has come for life sciences and health care leaders to take meaningful action. As we look to the future of health, toward a consumer-centered system that promotes health and wellness, we hope to begin to see the basis of competition in the industry shift from providing care to delivering equitable health outcomes. To position themselves for success in this future, leaders should make health equity core to their organization's strategy and take action to activate health equity within their organizations, their offerings, their communities, and their ecosystems by addressing inequities in both the life sciences and health care industries and in the social, economic, and environmental drivers of health.

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Sarah Thomas is the executive director of the Deloitte Center for Health Solutions, the Life Science & Health Care practice's primary source for thought leadership and industry insights. The center's research agenda is designed to inform and engage industry stakeholders, as Thomas aims to spark meaningful dialog and continuous two-way learning.

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