



Health equity

Health care organizations are on the front lines of addressing health equity, playing key roles in not only access and care delivery, but also as employers, community members, and advocates for change.¹ What is health equity and why does it matter?

Health equity is more than equitable access to care. It is the ability to fulfill our human potential in all aspects of health and well-being.² It's an opportunity to achieve an overall state of well-being encompassing clinical, mental, social, emotional, physical, and spiritual health, and it is influenced by not just health care, but also social, economic, and environmental factors.³ Health equity has been in the spotlight as study after study has shown that COVID-19 disproportionately impacts historically marginalized and low income groups and that these groups experience barriers that lead to poorer health overall than other parts of the population.⁴ But this type of finding isn't new—it simply highlights structural flaws in the health system, systemic and unintentional bias, and inequities in the drivers of health (DOH; also known as the social determinants of health) have contributed to health inequities in communities across the globe and over centuries in complex and systemic ways. And while the specific way these issues become real in a country or region vary, many are shared. They include:

Structural flaws in the health system

Poverty and lack of effective financing systems for basic services such as primary health care, drug coverage, mental health support, and health screenings are significant barriers to health equity in much of the world, despite efforts to close gaps.

Extreme poverty rose globally in 2020 for the first time in over 20 years,⁵ as the COVID-19 pandemic exacerbated the problems of climate change and geopolitical conflict, which are already impeding poverty reduction efforts. About 100 million additional people are living in poverty as a result of the pandemic, while climate change—a particularly acute threat for countries in Sub-Saharan Africa and South Asia where most of the global poor reside—is expected to drive 68 million to 132 million into poverty by 2030.⁶ More than 40 percent of the global poor live in economies affected by fragility, conflict and violence.⁷

India is among governments including Mexico, Malaysia, China, and others that continue to roll out universal health coverage—even amid the pandemic—in their attempts to improve health equity.⁸ India's out-of-pocket expenditure as a percentage of current health spending is 63%, among the highest in the world. Additionally, a very small population of ~9% is covered under voluntary private insurance, leaving a majority of the population exposed to great financial risks. This situation is gradually changing with the launch of a huge government scheme (The Ayushman Bharat [AB-PMJAY] scheme) in 2018 and State Government extension schemes, which provide comprehensive hospitalization coverage to the bottom 50% of the population (~500 million). However, the COVID-19 pandemic, implementation challenges, and lack of infrastructure has affected the rollout of the program.⁹

Other disparities remain: Brazil's public health system (SUS), for example, offers coverage for the whole population, over 50% of care spend is concentrated in private health care, to which only 23% of the population has access.¹⁰ Other countries simply cannot afford to expand public health services. South Africa's 2021 medium-term budget policy statement proposes further cuts to an already challenging public health system.¹¹

While increasing insurance coverage can help address health care affordability, insufficient and outdated health system infrastructure (facilities, technology, clinicians) remains, for many, a major hurdle to achieving health equity. Fewer than 50% of Africans have access to modern health facilities.¹² Further, around 61% of births were attended by skilled health staff in 2018, far fewer than the 80% global average.¹³ And although more people in India's smaller towns and rural areas now have money for health care through the new PMSBY insurance scheme, they have limited options to use it because clinician and product supply is limited, and government health facilities are few and far between. As of 2019, 9.6% of the 24,855 primary health centers (PHCs) in India had no doctor, 38.4% had no laboratory technician, and 23.9% had no pharmacist.¹⁴ There are also severe gaps in skilled professionals: For rural community health centers in 2019, only 15% of the surgical posts, 13% of the physician posts, 25% of the obstetrics and gynecology posts, and 20% of the pediatrician posts were filled.¹⁵

While there are emerging, scalable, telemedicine solutions in the country, such as apps for self-help, AI-enabled chatbots for diagnosis, and virtual 24x7 counseling, their uptake is hindered by concerns about data privacy and confidentiality. The pandemic-driven economic recession and resulting fiscal deficits are likely to make near-term health care sector capital investment difficult. Many governments will be forced to prioritize spending on filling gaps in clinical workforces even as hospital buildings and equipment deteriorate.¹⁶

Finally, many countries today lack the necessary regulations and policies to counteract and/or eliminate longstanding health inequities. The World Health Organization (WHO) constitution designates "...the highest attainable standard of health as a fundamental right of every human being." This creates a clear set of legal obligations on its 192 member states to enable "access to timely, acceptable, and affordable health care of appropriate quality;"¹⁷ implement policy and programs that "prioritize the needs of those furthest behind first towards greater equity;" and ensure "the right to health must be enjoyed without discrimination on the grounds of race, age, ethnicity or any other status."¹⁸ COVID-19 has made health a priority and many governments are laying the groundwork for post-pandemic health equity improvements.

Systemic and unintentional bias

Ingrained cultural traditions, perceptions, and prejudices (age, race, gender, caste, sexual orientation, disability, mental illness, and more) can interfere with efforts to promote equitable health care. The multigenerational social disease of racism is a prime culprit of health inequity—to the point where racism is a public health crisis.¹⁹ For example, unequal access to quality medical care has led to poor health outcomes for many Black Americans.²⁰ A comprehensive meta-analysis of data from more than 300 articles demonstrates a strong link between racism and poorer mental and physical health outcomes. In addition to the issues of physical safety and security caused by racism, research indicates that racism itself might increase chronic inflammation and the risk of chronic illness.²¹

Gender inequity has proved to be a persistent problem in both high-income and low-income countries, with considerable evidence that shows there is disproportionately less expenditure on the health of girls and women as compared to men. To illustrate, less than 2.5% of publicly funded research in the United Kingdom is dedicated solely to reproductive health, despite the fact that one in three women in the UK will suffer from a reproductive or gynecological health problem.²²

Clinical trials have long lacked meaningful representation of diverse participants that would help provide information about drug response and measures of safety and efficacy in populations that have been historically underrepresented and understudied.²³ Advanced analytics, which include machine learning and artificial intelligence (AI), has the potential to transform the way health care organizations make treatment decisions, detect diseases, and identify rare illnesses. However, this technology also has the potential to exacerbate existing health inequities by embedding unconscious assumptions or biases—gender, racial, or income, and others—of human designers and developers during coding processes.²⁴ Biases that wind up in these tools and models could result in inaccurate clinical decisions, missed diagnoses, worsened clinical outcomes, and substandard patient experiences. For health systems, health plans, health technology firms, and life sciences companies, this can translate to higher costs of care and poorer health among people who already face inequitable outcomes.²⁵ Organizations need to ensure that their analytics solutions make decisions fairly and do not propagate biases when providing recommendations.²⁶

Bridging the trust divide

Consumer and community trust in health care organizations is critical for optimal health, as trust influences willingness to get crucial medical care, preventive screenings, and mental health care.²⁷ Trust is also linked to an improved patient experience, health outcomes, the patient's perception of the care they receive. However, it is also well-documented that in the United States, not all communities feel the same level of trust with their health care organizations. As recently as 2021, there continues to be large disparities in trust by race and ethnicity—a critical focus for health care equity is, therefore, rebuilding trust with racially and ethnically diverse communities.²⁸

Trust remains a top barrier to increasing COVID-19 vaccination rates, especially among certain races/ethnicities. According to the Kaiser Family Foundation, in the US, 38% of unvaccinated adults listed mistrust of the government as a top reason why they did not get vaccinated.²⁹ Deloitte's 2021 consumer vaccine survey shows that identifying trusted sources is essential to get more consumers accurate and safe information on COVID-19 vaccines and treatments, and that these trusted sources vary by race/ethnicity:

- Although doctors were the most trusted source for public health information for all races/ethnicities (70%), Asian (68%), white (66%), and Hispanic (63%) respondents were more likely than Black (54%) respondents to say so.³⁰
- Appointed or elected federal officials were the least trusted sources across racial and ethnic groups. However, they were more trusted amongst consumers who identified as Black (26%), Asian (26%), and Hispanic (28%), compared to only 19% of white consumers.³¹

Where did people go for information about COVID-19? Their personal doctor and friends and family top the list:

- Unvaccinated respondents overall were more likely to go to their friends/family for information (No. 1 source) versus their doctors (No. 2 source). Doctors were the most used source for all other vaccine cohorts.³²
- Black and Hispanic respondents reported nearly equal rates of going to their friends and family as they did to their doctor for information, whereas white and Asian respondents were more likely to go to their doctor.³³

The survey results suggest that personal doctors could be used to get more people vaccinated by offering vaccinations in routine visits or helping people get scheduled. Results also suggest that consumers implicitly trust each other when it comes to vaccine behaviors, highlighting that friends and family could be more influential motivators for change.³⁴

Drivers of health

Some studies estimate that social, economic, and environmental “drivers of health” (also known as social determinants of health) can account for up to 80% of health outcomes, whether positive or negative.³⁵ 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. Historically marginalized and low-income groups 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.³⁶

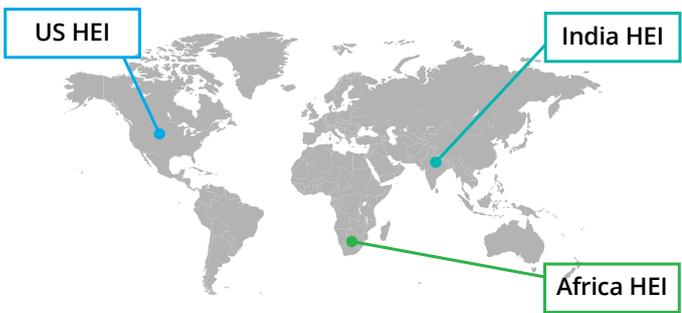
Overcoming systemic, widespread barriers to health equity will require new levels of engagement and collaboration at local, national, and global levels. Leaders from governments, health systems, life sciences/medical device companies, health insurers, academic institutions, community services agencies, and advocacy groups must join forces to design and build systems that advance health equity as an outcome for all.³⁷

The Deloitte Health Equity Institutes

As the pandemic has shined a light on these challenges, Deloitte has established The Deloitte Health Equity Institutes (DHEIs), with initial locations in the United States, India, and Africa (figure 1). The DHEIs are dedicated to advancing health equity as an outcome through an array of cross-sector collaborations, philanthropic investments, and research activity. The three institutes are unified by Deloitte’s commitment to meaningfully contribute to health equity, but designed to deliver against the unique challenges in their respective region.

Figure 1. Deloitte Health Equity Institutes

We have established three **Deloitte Health Equity Institutes (DHEIs)**..



Our DHEIs are looking to address **three root causes** that prevent equitable health outcomes:

- 1** Racial, socioeconomic, gender & other **biases**
- 2** Disparate circumstances in **drivers of health**
- 3** Inadequately designed **healthcare systems**

...to **drive change** through three key reinforcing capabilities



ACTION & IMPACT

Pro bono consulting service to support with health equity initiatives or hard dollar donation to key collaborators



KNOWLEDGE & EVIDENCE

Publicly-available eminence and playbooks to assist both public and private sector efforts to address gaps in health equity



DATE & ANALYTICS

Combining data on health disparities and our data equity to enable insights to inform impactful action

The DHEIs collaborate with local and national organizations across the public, private, and social sectors to advance health equity and achieve better health outcomes. The following are examples of COVID-19 pandemic-related projects that DHEI is conducting in the three service regions:

United States: Increasing COVID-19 vaccination rates in New York City³⁸

Deloitte is collaborating with Robin Hood, an organization that has been fighting poverty in New York City since 1988, to increase COVID-19 vaccination rates among New York's difficult-to-reach populations. The two are funding certain health organizations that are working toward improving access to and acceptance of the vaccine in the hardest-hit communities in New York. These organizations help address issues of misinformation, technology, transportation, as well as fear and distrust rooted in the health care system because of historical mistreatment and bias. As part of their unique collaboration, DHEI and Robin Hood will address the city's other high-need issues, including maternal health and early childhood interventions.

India: Sanjeevani Pariyojana project³⁹

In spring 2021, as COVID-19's delta variant surged in India, Deloitte and northern India's Haryana Karnal district launched a collaborative effort to reduce the strain on hospitals and "extend the hospital ward" by developing a supervised, virtual, in-home care program for people in rural areas with mild or moderate COVID-19 symptoms. Sanjeevani Pariyojana (In Hindi, this translates to The Life Project) mobilized local health care practitioners to help provide early detection (through home test kits), and essential care for home-isolated COVID-19 patients. The program took advantage of Haryana's existing technology infrastructure by adding or enhancing command-center capabilities, and augmenting the availability of telemedicine, virtual triage, and advanced life-support transportation services when patients required higher acuity care.

Africa: Supporting government's COVID-19 response⁴⁰

Deloitte is supporting the South African government, Business for South Africa (B4SA), and other social partners and stakeholders to mobilize business resources and capacity to combat the COVID-19 pandemic. Among specific initiatives, Deloitte created an end-to-end Personal Protective Equipment (PPE) supply chain control-tower dashboard. It consolidates various data sources into a single view from which PPE demand planning and procurement can be monitored and controlled to help reduce gaps for PPE in South Africa.



Q&A with the directors:

Dr. Kulleni Gebreyes, Director, US Deloitte Health Equity Institute

Charu Sehgal, Director, India Deloitte Health Equity Institute

Ashleigh Theophanides, Director, Africa Deloitte Health Equity Institute

What are the challenges for health care leaders who want to have an impact on health equity?

Kulleni Gebreyes: This is a vast and complex issue. When I was working as an emergency room physician, I saw the manifestation of health inequities through individual biases, structural biases, and barriers to care. These quantifiable differences in health-related outcomes have been documented across many dimensions, including race, gender, age, location, disability status, and sexual orientation. These inequities, which include variation in life expectancy, birth outcomes, chronic disease, and morbidity, affect both individual and community health and well-being. One of the biggest challenges for health care leaders is deciding where or how to start. Often, data can help illustrate barriers to health equity and root causes of health care disparities, as in these US examples:

- Black, American Indian, and Alaska Native (AI/AN) women are 2-3x more likely to die from pregnancy-related causes than white women.⁴¹
- 17% of LGBTQ Americans report that they have experienced homelessness in their lifetime, which is more than 2x the rate of homelessness for the general population.⁴²
- About 1 in 8 US women (about 13%) will develop invasive breast cancer over the course of her lifetime.⁴³

Leaders should intentionally design and build systems that advance health equity, and measurement is the only way organizations can know if outcomes are improving. Therefore, leaders must use metric tracking to understand if their programs are having the impact they anticipated. The investment of resources and time also should be aligned with their overall business strategy.

Charu Sehgal: Access to skilled medical care is an issue in India because the clinician supply is limited: 80% of India's doctors cater to 20% of India's population. It takes 10-12 years to become a doctor and a lot of medical practitioners end up choosing high-profile specializations. We need to incentivize more people to become general practitioners in India. In addition, there is an urban/rural divide; there are many open positions for licensed medical professionals in the rural and tribal areas but few physicians want to serve there due to lower pay and lack of professional development opportunities, as well as non-monetary aspects such as living conditions, infrastructure and access to basic medical resources to perform effectively.⁴⁴ There's also a shortage of nurses, ambulance drivers, and Emergency Medical Technicians (EMTs), and the equipment for them to do their job. If you look at every element of the value chain, you will find this problem because health care is underfunded. For example, when it comes to mental health, funding is limited compared to other communicable and non-communicable diseases. India's mental health burden is ~14% of the country's total population, however only 0.05% of the health care budget was allocated to mental health in 2021-2022.^{45,46} It will take increased government investments and incentives to increase supply and improve access to what patients need.

Ashleigh Theophanides: The major challenge on the African continent is access, which we define as both physical access and funding. Rural communities lack health care facilities and have poor infrastructure—roads, power (electricity), communication connectivity—to support the health care ecosystem. Urban areas are more likely to have better infrastructure, but the number of health care facilities remains insufficient to serve the population. A lack of health care professionals (HCPs) also imposes access constraints. Funding is the second major challenge. Governments do not have the funding to invest in major infrastructure projects like hospitals and clinics which would provide access.⁴⁷ Outside of South Africa, the majority of Sub-Saharan countries in Africa rely heavily on Official Development Assistance (ODA) to fund their health care systems. Due to high rates of unemployment and/or low income, the majority of the population is unable to pay for out-of-pocket expenses and, thus, rely exclusively on constrained public health care systems. Also, the majority of ODA funding is directed at specific communicable disease programs like HIV/TB and malaria. This leaves a large gap in the diagnosis and treatment of non-communicable diseases like cancer, diabetes, and heart disease, which we know are increasing on the continent.

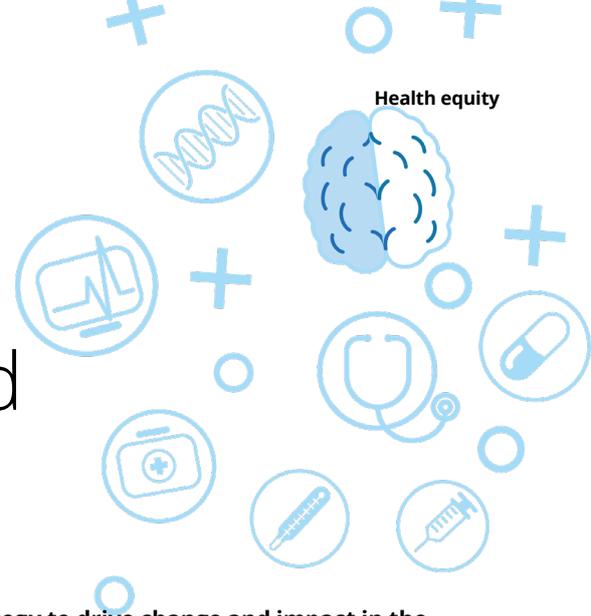
The DHEIs are dedicated to closing the inequity gap in the pursuit of health and well-being for all. Learn how the Institutes are helping to activate health equity around the globe.

[US Deloitte Health Equity Institute](#)

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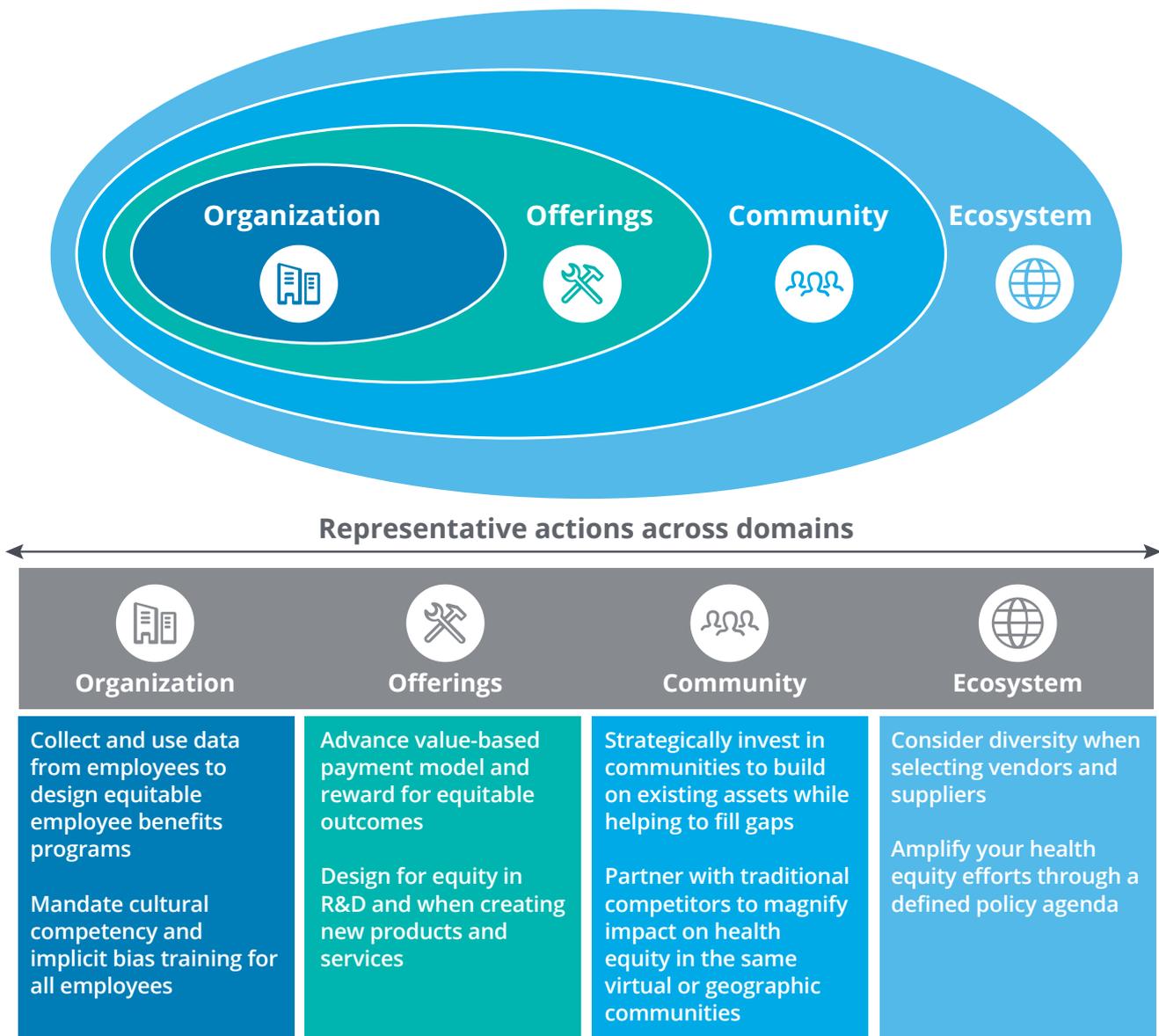
Questions/actions health care leaders should consider for 2022



What steps can health care organizations take to define their health equity strategy to drive change and impact in the communities in which they serve?

A health equity lens is critical for better consumer engagement and a healthy community. Deloitte’s recent research on health care executives’ perspectives on health equity showed that many see the strong connection between diversity and inclusion within their own workforce and improved health equity outcomes among patients.⁴⁸ Health care organizations can work toward systemic change through a strategy that places health equity at the center and expands across four domains: the organization, its offerings, its community, and its ecosystem. Industry players can take specific actions in all these domains to meaningfully advance health equity (figure 2).⁴⁹

Figure 2. Four domains of action to advance health equity



Source: Deloitte analysis and National Academy of Medicine

Deloitte is outlining the steps an organization's leaders can take to define a health equity strategy to drive change and impact in the communities it serves.⁵⁰ Importantly, organizations should bring together both Diversity, Equity, and Inclusion (DE&I) and Drivers of Health (DOH) perspectives when advancing health equity internally.

Phase 1: Understand your organization and market. Assess your organization's current state of health equity and DE&I—including employees' perspectives, feelings, opinions, and experiences—to understand their social, economic, and environmental needs. Identify potential levers (e.g., housing, food insecurity, income) that can lead to more equitable health for your workforce. Also assess your organization's health equity and DEI market positioning. Aggregate internal and public data inputs to profile the insight markets to understand where the health disparities exist today in comparison to the state and national averages. Identify potential foundational changes (people, process, technology) that lead to health equity and develop potential health equity levers of action (e.g., data infrastructure, reporting, interventions, training).

Joint research by the Deloitte Center for Health Solutions and the US National Association of Health Services Executives (NAHSE) on the current state of DE&I initiatives in the health care workforce showed that health care leaders recognize that improving DE&I in the workforce can support quality of care and financial performance goals. Addressing racism and other biases can give organizations a competitive advantage, helping them attract the best talent and elevate their brand and reputation.⁵¹ A diverse and inclusive health care workforce—both in clinical and nonclinical/corporate settings—can also help improve trust and empathy and strengthen the connection with patients and communities.⁵²

Phase 2: Define the health equity vision. Engage leadership and key stakeholders across the organization to gather input to inform and shape the health equity vision. (It is important to share updates on the work with leaders to gain organizational alignment early, which can lead to more effective implementation.) Using the levers identified in Phase 1, align with leadership on the organization's vision—its aspirations and purpose for pursuing health equity—and use it to define specific priorities. Only one-third (31%) of respondents to a recent survey⁵³ said they have a dedicated leader or team committed to establishing and developing processes to systematically address DOH as part of clinical care. Effectively linking DOH initiatives to health equity strategy, as well as the strategy for the larger organization, will likely require assigning accountability and teams with oversight into and responsibility for creating efficiencies across the organization.

Phase 3: Develop a roadmap for the future. Consolidate inputs from Phases 1 and 2 into organization-wide priorities and tactical initiatives—with both short- and long-term outcomes—to advance health equity internally and across the communities that the organization serves. Define the business case for taking action to understand how doing so will lead to positive financial, workforce, and clinical impacts.

Throughout the process, organizations should be guided by the numbers: harness data and technology to understand where to act, monitor success, and scale health equity efforts. For example, Deloitte is developing a health equity index that we hope all corporations and governments will report against on an annual basis as they consider their products' or services' impacts on health equity. The idea is that public disclosure and scrutiny will encourage organizations to act responsibly and address any health inequalities to which they are contributing. Finally, measure results—it's the only way to know if outcomes are improving or worsening⁵⁴ and if health equity programs are making a difference.

Health equity is emerging as one of the most important issues of our time--and not just for health care organizations. Companies around the world are realizing that they have a role to play. In the same way that organizations measure and try to mitigate their carbon footprints, they are starting to consider their "health equity footprint" in a more systematic way.



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