E-Briefings

VOLUME 20 NO. 2 MARCH 2023

Equity, Trust, and Population Health: Governance in a Rapidly Changing Climate

By **Christopher J. King, Ph.D., FACHE**, Associate Professor, Health Management and Policy, and Dean, School of Health, *Georgetown University*

The Case for Transformation

In the United States, healthcare expenditures represent 18 percent of the gross domestic product ($4.3 trillion). Cost per capita is two times higher than many industrialized countries.[1] While there are several explanations for exorbitant spending, health inequities is a key contributor. According to a study by Deloitte, inequities account for $320 billion in annual spending and this figure could escalate to $1 trillion by 2040.[2] While hospitals and health systems cannot be solely responsible for addressing inequitable conditions that compromise health, they are lead actors in the ecosystem. As anchor institutions, they have the agency to influence a broader population health agenda—particularly in communities that have been historically marginalized.[3]

As governing bodies, boards should recognize that the institutions in which they serve operate in an ecosystem built on inequity and injustice. And providers are tasked with creating solutions to long-standing health disparities in populations that have been intentionally disenfranchised. For example, readmission rates and poorer outcomes after hospitalization are more pronounced in communities that have been redlined.[4] While this article focuses on broader systemic issues, efforts must continue within the walls of the medical institutions to uncover clinical bias and inequitable treatment based on characteristics such as age, race/ethnicity, religion, sexual identity, insurance status, and place of residence.

1 CMS, NHE Fact Sheet; Matthew McGough, et al., "How Does Health Spending in the U.S. Compare to Other Countries?," Peterson-KFF Health System Tracker, February 9, 2023.
2 Andy Davis, et al., "U.S. Healthcare Can't Afford Health Inequities," Deloitte Insights, June 22, 2022.
3 See the Healthcare Anchor Network: https://healthcareanchor.network.
4 Adrian Diaz, et al., "Association of Historic Housing Policy, Modern Day Neighborhood Deprivation and Outcomes After Inpatient Hospitalization, *Annals of Surgery*, December 2021.

Each board is on its own learning curve. However, as board members assess their competencies, they must articulate how equity is a prerequisite for advancing the quality and safety agenda, as well as a broader population health strategy. Moving the needle requires boards to interrogate the status quo and engage in bold, generative dialogue that has promise for normalizing atonement, equity, and justice in governance practices.

Reflecting on History, Health, and Place

Whether it's inequality or systemic inequities, each community has a unique history, and that story has shaped the current environment. By engaging a local historian, boards can conduct retroactive analyses of local and federal policies and practices that disproportionately burdened specific populations.[5] This work can be done in conjunction with reflections of the organization's history and the role it may have played in causing harm. These approaches can help boards make sense of seemingly intransigent place-based health disparities as well as negative community perceptions that stem from historical events. For not-for-profit hospitals, historical analyses can inform the IRS-mandated community health needs assessment process, as well as help shape priorities outlined in hospitals' three-year implementation strategies.

Retroactive analyses can also help unearth contemporary vestiges of injustice—whether real or symbolic. For example, institutions throughout the nation have demonstrated atonement through courageous action. They have issued formal public apologies, renamed buildings, and removed physical icons that cause pain and do not reflect appreciation for diversity and the nation's founding values.[6] And in many cases, these iconic figures have been replaced with new representations of hidden figures who have sacrificed for a more perfect union—for all. These acts are key to building trust and fostering environments of care where patients are more comfortable with the services rendered.

Achieving Board Diversity

Board diversity inspires problem-solving, innovation, and enables the creation of strategic plans and institutional norms that are inclusive and culturally nuanced. However, persons of color only represent 13 percent of hospital and health system

5 Christopher King, et al., "Race, Place, and Structural Racism: A Review of Health and History in Washington, D.C.," *Health Affairs*, February 2022.
6 "List of Name Changes Due to the George Floyd Protests," *Wikipedia*, 2023.

board members and cisgendered white males make up the majority.[7] According to The Governance Institute's 2021 Biennial Survey of Hospitals and Healthcare Systems, only 62 percent of boards report having ethnic minorities represented on the board.[8] This lack of representation undergirds the status quo, perpetuates blind spots, and sustains a legacy of distrust in the healthcare delivery system. Boards can make progress by being intentional and employing new recruitment and selection strategies to achieve a composition that reflects the rich and diverse character of the community.[9] For example, instead of board members identifying new members based on who they know, organizations can partner with community-based groups that have access to individuals who are likely to be outside of the existing board's orbit.

Committing to Intentionality and Unlearning

While achieving board diversity is important, diversity alone, is not the silver bullet for building trust or upending negative perceptions caused by a legacy of harmful practices. COVID-19 illuminated these nuances as well as many flaws in public health and healthcare delivery systems, such as institutions' inability to effectively partner with communities that are disproportionately burdened during times of crises. In a commitment to health equity, intentionality and unlearning are key as boards are performing in a broader ecosystem that has systemically normalized inequitable policies and practices—whether intentional or unintentional. As part of the journey towards equity, boards must reimagine institutional cultures that publicly demonstrate humility; adopt new language; eliminate ivory tower, paternalistic approaches; and recognize the importance of neutralizing or shifting power. For example, instead of creating a program "for the community," hospitals will "co-create programs with the community" or instead of "adopting" a non-profit organization, hospitals will "partner" with non-profit organizations.

Broadening Performance Indicators

Since health status is mostly shaped by social, political, economic, and environmental forces outside of clinical care, there is an opportunity for institutions to augment

7 Morgan Haefner, "'We've Made No Progress': Healthcare Boards 87% White, Leverage Network Study Finds," February 23, 2021.
8 Kathryn Peisert and Kayla Wagner, *Advancing Governance for a New Future of Healthcare*, The Governance Institute's 2021 Biennial Survey of Hospitals and Healthcare Systems
9 For more on how boards can accomplish this, see *Building a More Diverse Board*, The Governance Institute, Fall 2018.

common scorecard indicators with measures that extend beyond direct clinical care. Hospitals and health systems are uniquely poised to use their voices and resources to shape policy and improve the structural conditions of distressed communities. Performance measures may be organized by core functional areas commonly monitored by boards, and may be contextualized as strategic components of a comprehensive population health agenda. Examples include but are not limited to:

- **Human resources:** local hiring practices and career progression incentives for employees who reside in specific jurisdictions
- **Operations:** purchasing and procuring services with local businesses housed in distressed neighborhoods
- **Finance:** community benefit and community health improvement investments
- **Patient care:** strategic partnerships and volunteerism with community-based organizations that provide patient wraparound services or have missions that influence policies and practices that promote equity

→ Key Questions for Boards

- Can we articulate how equity is a prerequisite for advancing the quality and safety agenda, as well as a broader population health strategy?
- Do we have protected time, resources, and expertise to conduct historical analyses and engage in meaningful dialogue?
- Do we know the history of our organization and the origins of the names associated with the facility (i.e., names of buildings, rooms, streets, etc.)?
- How can we partner with community-based organizations to recruit and yield board members from underrepresented populations—particularly those who reside in historically disenfranchised communities?
- Do we have access to expertise to help us conduct critical audits of existing norms, practices, and our broader environment to identify issues that are inconsistent with our commitment to equity and inclusion?

Governance in a Rapidly Changing Climate

Health disparities are measurable differences in health status or health outcomes across comparable populations. These outcomes occur when inequities exist—meaning one population has more access to resources and opportunities than the

other. A legacy of policies, practices, and social norms that stripped segments of the population from "access" helps explain contemporary disparities in health. To undo the damage, all sectors of society must reflect on their histories and identify and dismantle contemporary practices that sustain the status quo. However, the work must be orchestrated from the top. In light of new and emerging value-based payment models, the proliferation of disruptors and innovation in the healthcare landscape, and public demands for equality and accountability, this is a critical moment for boards to reconceptualize their responsibility in a dynamic and rapidly changing world.

The Governance Institute thanks Christopher J. King, Ph.D., FACHE, Associate Professor, Health Management and Policy, and Dean, School of Health, Georgetown University, for contributing this article. He can be reached at christopher.king@georgetown.edu.