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Equality-in-Quality in the Era of the Affordable Care Act

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Health care received by patients in the United States is of inadequate quality.[1] As part of the federal response to this major shortcoming, ensuring high-quality health care is a central theme throughout the Patient Protection and Affordable Care Act (ACA) signed into law in 2010.

The focus on improving quality in the ACA, however, effectively overshadows other major concerns about the US health care system—among them, pervasive and persistent disparities in health care related to factors such as sex, race/ethnicity, social class, insurance status, and language that fundamentally constrain how much overall quality can improve. The comparative inattention in the ACA to known inequalities in health care is noteworthy, not only in comparison with the focus on quality, but also because the lack of emphasis on disparities in the ACA language is inconsistent with recent positions of the Agency for Healthcare Research and Quality (AHRQ)[2] and the Institute of Medicine (IOM).[3] The AHRQ and IOM have indicated that reducing disparities is an unambiguous priority in working to improve quality in health care.[1-3] This approach is consistent with analyses suggesting that reducing disparities based on social factors may improve health care quality more than would marginal improvements in overall medical care.[4]

Given this disconnect between provisions within the ACA and federally endorsed approaches to pursuing what amounts to "equality-in-quality," it is worth examining the philosophical and empirical underpinnings of arguments for considering disparities while working to improve quality. Striving for equality-in-quality is not merely aspirational but should be foundational. Failing to address disparities may consign health care quality improvement efforts—originating from the ACA or otherwise—to less success than otherwise could be realized.

Philosophical Underpinnings of Equality-in-Quality

Moral arguments offering grounds for the obligation of a just society to address disparities in health care are rooted in philosophical theory and provide a framework for addressing these issues. One prominent argument, presented most thoroughly by Daniels et al,[5] is an extension of the theory of "justice as fairness" originally proposed by Rawls.[6] Through the principle of fair equality of opportunity, Daniels et al defend the role of medicine and public health to maintain or promote health because health "makes a significant contribution to protecting the range of opportunities open to all individuals."[5] Because the principle of fair opportunity is to be applied to the entire population, Daniels et al argue that it justifies not only improving population health, but reducing health inequalities while doing so.[5] The expansion of Rawls' theory by Daniels et al offers a framework and justification for how to distribute societal resources, including the social determinants of health and health care, while specifically emphasizing the need to improve the position of less-fortunate individuals in society and reduce disparities.

A second moral foundation is offered by proponents of a "capabilities approach" that aims to specify constitutional principles that should be adopted by governments as a minimum standard to adequately respect human dignity. This theory, defended or espoused by Sen[7] and Nussbaum,[8] is the basis for the human development index developed by the United Nations. The theory argues that human capabilities—ie, the freedom to achieve functionings that allow an individual to pursue what he or she wants to do and wants to be (eg, being healthy, being safe, having self-respect)—should be pursued for all people by society. In particular, bodily health is listed by Nussbaum[8] as 1 of 10 capabilities that all individuals should have societal support in pursuing. Because health is central to freedom to choose other functionings in life, Nussbaum[8] argues that it is essential that governments promote health for all of its citizens. Where disparities exist, they should be reduced to ensure that all people meet the minimum standard of capability.

A major advantage of philosophical arguments such as those of Rawls, Daniels et al, Sen, and Nussbaum is that they provide a framework for discussions about problems such

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as disparities that start with common values. A disadvantage, however, is that political opinions that drive public programs and shape government intent can diverge from that point. Even when political opponents agree that all persons in a society should be given a fair starting point and that disparities are unfair, they may differ substantially about how to address such disparities. Therefore, empirical evidence may bolster the case for addressing disparities as a way to improve quality.

Quantifying the Benefits of Equality-in-Quality

Childhood immunization coverage provides an example of a success story of equality-in-quality in the United States. Such success is exemplary because it involves an area of medicine and public health that has been addressed with a national program that acknowledged disparities related to race/ethnicity, social class, coverage, and place (ie, urban vs rural settings) and made concerted efforts to measure these disparities over time.

For instance, a generation ago, fatal outbreaks of measles in predominantly minority communities in major metropolitan areas in the United States highlighted stark disparities in vaccination coverage that left disadvantaged children at increased risk for disease, sometimes with vaccination coverage rates of less than 50%. Just a few years later, prompted to measure quality and disparities because of these outbreaks, the Centers for Disease Control and Prevention found that national childhood vaccination coverage rates for the combination of the universally recommended immunization series (polio, measles, diphtheria and tetanus toxoids and pertussis, and *Haemophilus influenzae* type b) reached 77% at the national level.[9] Yet this national mean clearly did not tell the full story because it masked 8-percentage-point immunization coverage disparities by race/ethnicity and 11-percentage-point disparities for children living in poverty vs their peers.[9]

The policy, public health, and clinician communities worked together with a multifaceted approach to improve childhood vaccination rates while reducing disparities. In particular, the federal government addressed economic disparities through the Vaccines for Children Program that purchases increasingly expensive vaccines for children who are uninsured, are on Medicaid, are of Alaska Native or American Indian background, or have private insurance that does not cover universally recommended vaccines. In 2010, while national vaccination performance quality (as measured by overall vaccination coverage with multiple recommended series) has remained stable or increased slightly over 15 years, racial/ethnic disparities have decreased to 4 percentage points (for minority groups vs non-Hispanic white children) and poverty-related inequalities have declined to 3 percentage points.[10]

The effect of improved measles vaccination coverage on measles incidence has been profound. In 1989 during the national measles outbreak, almost 18 000 cases of measles were reported in the United States; by comparison, during the years 2006-2010 there were fewer than 150 measles cases annually. While there was likely benefit to the population through herd immunity from broader vaccination coverage, that is a minor theme within this quality improvement effort. Reducing acknowledged disparities through a targeted federal effort paved a clear road to improving quality at the national level.

The example of measles vaccination highlights 2 messages about equality-in-quality. First, improving program quality by addressing inequality is sound practice. Second, accurate, timely monitoring is not optional. Rather, objective measurement is critical for the monitoring and eventual success of disparity-reduction efforts.

Conclusions

Although efforts to improve health care quality are squarely in the sights of the ACA, disparities seem to fall in its programmatic blind spot. On both philosophical and empirical grounds, the highest-quality health care will not be realized unless inequalities are also addressed. Individuals deserve health care that is not only of high quality, but of equally high quality for all.

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