

We need a Triple Aim for Health Equity

Our thinking about health, policy-making and the capacity of local communities must change if we are to address the wide health disparities in our state.

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Although Minnesota continues to be one of the healthiest states in the nation, its ranking has slowly been falling.¹ A major factor behind its decline from No. 1 to its current rank of No. 6 is the growing disparity between the health outcomes of whites and populations of color and American Indians, populations with high and low incomes, and residents of suburban and some inner city and rural communities. These disparities are not the result of poor medical care (in fact, Minnesota's health care system was rated No. 1 by the Commonwealth Fund in its 2014 scorecard on state health performance).² Rather, they're driven by the socioeconomic circumstances in which people live.

The Institute for Health Care Improvement's (IHI) Triple Aim (the goals of which are to improve the patient experience, reduce per capita costs and improve the health of populations)³ has prompted medicine to focus more intentionally on preventive care and the role health care can play in improving the health of a population. However, with the growing understanding of the influence of the community on individual health (which is not addressed by the IHI Triple Aim), there is an evolving consensus that we need to broaden our focus and embed health care in a community-based framework. We need a Triple Aim that's equity-focused.

Policy, programming and health

We now recognize that many of the policies and systems in our state place populations of color and American Indians at a disadvantage. Whether it's housing, transportation, education, employment/wealth, broadband connectivity, the criminal jus-

tice system or environmental quality, low-income and minority populations have fewer opportunities than others. Rarely is this because of intentional discrimination; rather, it reflects a lack of awareness of how policy and programming decisions affect the most disadvantaged Minnesotans. For example, targeting educational efforts at homeowners (an efficient strategy) doesn't recognize the fact that 75.5 percent of whites but only 21.3 percent of African Americans in the state own homes.⁴ Regardless of intent, our policies and systems can contribute to differences in health outcomes.

Highlighting the effect a lack of opportunity can have on health, a report from the Robert Wood Johnson Foundation showed a 13-year difference in life expectancy between communities that are located less than three miles apart along the Twin Cities' I-94 corridor yet are very different from one another in terms of socioeconomic conditions.⁵ The Minnesota Department of Health's 2014 "White Paper on Income and Health" further documents the impact of economic conditions on the health of Minnesotans, particularly populations of color and American Indians.⁶ The authors note that being on the bottom rung of Minnesota's economic ladder leads to an average decrease in life expectancy of 8.4 years and a nearly 10-fold increase in poor/fair health days. Increases in income lead to improvements in health. This explains why the increase in Minnesota's minimum wage in 2014 was such an important public health achievement.

The health department's 2015 "White Paper on Paid Leave and Health" underscored the impact of one specific social policy on health by demonstrating that ac-

cess to paid family leave (maternity/paternity leave) leads to better health for both infants and mothers; lower rates of infant mortality and maternal depression; and higher rates of breastfeeding, immunizations and well-child checkups.⁷ In making the case for family leave, researcher Jody Heymann, MD, and colleagues wrote in a 2011 article in *Public Health Reports*, "An increase in 10 full-time-equivalent weeks of paid maternal leave has been shown to be associated with a 10 percent lower neonatal and infant mortality rate and a 9 percent lower mortality rate for children younger than 5 years of age."⁸

Similarly, paid sick leave reduces infant mortality and benefits adults and employers by increasing the use of preventive health services and decreasing occupational injuries and emergency room visits. Unfortunately, access to paid leave is disproportionately skewed toward populations that are white, have higher incomes and are educated, rather than those who need it most.⁷

Although having access to excellent medical care is critically important, only 10 to 20 percent of population health is determined by clinical care, whereas more than 40 percent is determined by social and economic factors.^{9,10} It is these social determinants (the conditions in which people are born, grow, work, live and age, and that shape daily life¹¹) that are the major contributors to Minnesota's health disparities.

A new Triple Aim

The Minnesota Department of Health is attempting to reverse the trend of growing health disparities. In collaboration with communities around the state, it has ana-

lyzed data from multiple sectors, worked on health impact assessments, partnered with agencies in the health and non-health sectors, and sought best practices from throughout the country to develop a framework for assuring health and health equity. We call this framework Healthy Minnesota 2020. As a result of this effort, we have developed a Triple Aim for Health Equity. Its focus is to:

- expand the understanding of what creates health
 - take a “health in all policies” approach, with health equity as the goal
 - strengthen the capacity of communities to create their own healthy future.
- Here’s how it should work:

Expand our understanding of what creates health. Our hope is to change the dominant narrative that health is determined mostly by medical care and personal choices. One manifestation of this belief is our nation’s current investment strategy, which allocates more than 50 percent of our total health and human services resources to health care (unique among industrialized countries)¹² and more than 95 percent of our health care resources to treatment as opposed to prevention.¹³ Without diminishing the importance of medical care and personal choice, a new narrative needs to embrace the role of community and acknowledge the impact of local, state and national policies on health. This will bring new voices into the discussion about how to create optimal health for all.

Take a “health in all policies” approach with health equity as the goal. By taking a broader view of what creates health, we can better understand how policies related to transportation, housing, education, public safety or environmental protection can affect health outcomes. However, without a focus on health equity this approach could lead to unintended consequences. For example, a public transportation initiative could trigger gentrification and exacerbate the gap between rich and poor. Similarly, paid leave only made available to full-time employees might

widen the gap between those with high and low incomes.

Strengthen communities’ capacity to create their own healthy future. We need to acknowledge that communities themselves need to be involved in creating policies and systems that improve conditions for their residents. This approach can be effective. For example, when residents of the St. Paul Midway area, which has an ethnically diverse population with a lower-than-average annual income, realized that no stops along the Green Line light-rail route were being planned for their neighborhood, they organized a community effort to demonstrate how this would affect them in terms of economics, housing, education and physical health. Because of their efforts, three stops were added to the line. The residents’ work also changed federal policy about how to evaluate public transportation projects. The initial metric used by the U.S. Department of Transportation to measure success was how long it took to get from one end of a line to the other. Now they must evaluate the impact any project has on the health and well-being of the communities along the line.

Another example is the Statewide Health Improvement Program (SHIP). With funding from SHIP, communities throughout Minnesota have developed strategies for increasing physical activity and promoting good nutrition. Those efforts have started to turn the obesity curve downward. This is in comparison with neighboring states and the entire United States, where obesity rates continue to climb.

Conclusion

The IHI Triple Aim provided an important framework for improving the health of people in the United States and prompted a new focus on preventive and population health. Yet, since its adoption, we have continued to see wide health disparities. That has been particularly true in Minnesota, where people with low incomes or members of certain groups have some of the worst health indicators in the nation while the rest of the popula-

tion enjoys some of the best. The Minnesota Department of Health is proposing that in addition to the IHI Triple Aim, the state should embrace a Triple Aim for Health Equity. Under this new framework, we would expand our understanding of what creates health, take a “health in all policies” approach with health equity as the goal and strengthen the capacity of communities to create their own healthy future. This framework will help reduce health disparities in Minnesota, advance health equity and assure optimal health for all members of our community. **MM**

Edward Ehlinger is Minnesota’s Commissioner of Health.

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