Taking action on inequities: a structural paradigm for quality and safety

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As quality improvement and patient safety (QIPS) practitioners, we aspire to improve care for all patients, caregivers and families using improvement methods. While teams are trained to carefully implement the science of improvement, less is known of how to effectively incorporate equity into QIPS work. Should there be more projects focused specifically on equity, or should equity be embedded into all quality improvement? Inattention to the equity domain in improvement efforts ignores systemic biases and can worsen inequities in health outcomes. How to measure inequity, and growing calls to reframe health equity data measurement, presentation and analysis are central to this discourse.

Arrington and colleagues' article offers strategies to collect, share and interpret quality data using a racial equity lens.[1] The authors first describe the problems with stratifying quality data by race and ethnicity, which can perpetuate the false notion that race or ethnicity is responsible for differences in health outcomes and inhibit teams from identifying embedded structural or systemic root causes of health inequities. They provide concrete examples of reimagining data collection and presentation that are actionable and feasible. These include considering root causes beyond describing differences among racial groups, choosing reference points equitably (eg, avoiding using outcomes of white patients as reference points), presenting the most specific level of aggregation (eg, identifying race as 'Chinese' rather than 'Asian'), collecting data on strengths (eg, describing groups with positive outcomes) rather than deficits, measuring racism instead of race and collaborating with community partners. Using this framework, the narrative shifts away from race and ethnicity to a focus on unjust systems, structures and practices responsible for health inequities.

As articulated by Arrington and colleagues,[1] adopting a racial equity lens to the interpretation of stratified QIPS data is an essential skill that QIPS practitioners must learn and apply. By incorporating education on the concept of racialisation (and by extension, other forms of discrimination) into QIPS curricula, QIPS practitioners will be better equipped to change healthcare processes and achieve the Institute for Healthcare Improvement's quintuple aim of healthcare improvement, that is, that health equity should be included in all improvement efforts.[2] However, improving health equity through QIPS practices will require substantial health equity-focused structural changes at the level of individuals, programmes and guidelines.

At the individual level, we challenge QIPS practitioners to promote necessary structural change to reduce health inequities. The concept of structural change should be familiar to QIPS practitioners, given the Donabedian Model for QIPS evaluation includes structural measures in addition to outcome and process measures.[3] Nevertheless, the prospect of making structural change is understandably daunting for many QIPS practitioners and educators. There are a number of identified barriers to making structural change, namely attitudes (beliefs that social structural change is not in their purview), a hidden curriculum that reinforces biases and discriminatory practices[4] and a lack of knowledge on how to take action to promote equity through QIPS practice. The belief of some healthcare professionals that social structural change is not in their scope is a perspective that commonly takes root during training and is reinforced in practice.[5]

However, the assertion that healthcare professionals do not have a role in promoting social change is contested.[6 7] For example, Sharma and colleagues[8] critique curricula that emphasise cognitivism, *knowing about* the social determinants of health (SDOH), rather than behaviouralism, *knowing how* to take action to help achieve health equity. Use of cognitivism to approach education about SDOH also implies that health inequities are manifestations of a 'natural process', rather than the sequelae of socially constructed systems of power and privilege that should be interrogated and questioned by learners and educators.[8] Worldwide, enduring inequities in health outcomes provide ample evidence of a second flawed assumption associated with cognitivism as the educational approach: teaching about SDOH will somehow lead to action by health professionals to reduce health inequities.[8]

For action on health inequities to be realised through education, educational paradigms, such as transformational and humanism, that align with this learning outcome must be considered. Transformational educational theorists emphasise a pivotal role for learners in altering social structures to reduce oppression, while humanism stresses the value of human dignity, freedom, self-fulfilment and the importance of both knowledge and affect (feelings) in the learning process.[9] Attention to these facets of curricular development in QIPS is particularly important, given that, all too often, the hidden curriculum in health professions education reinforces harmful biases, stereotypes and prejudices that perpetuate health inequities.[4 5] In the absence of substantial curricular reform, we are unlikely to overcome the healthcare educational-culture and affective barriers to QIPS practitioners and leaders taking action to address health inequities through their improvement work.

How, then, can we equip QIPS practitioners and leaders with the necessary knowledge, skills and attitudes to tackle the wicked problem of health inequities? At a programmatic level, QIPS education needs to evolve in several critical ways.

First, we suggest integrating *structural competency*[10 11] as a core concept into QIPS curricula. Structural competency involves training health professionals to recognise and respond to health and illness as the downstream impacts of larger social, political and economic structures, including healthcare systems; food production and distribution systems; zoning laws; justice systems; housing, sanitation and transportation infrastructure; and variations in the conceptualisations of illness/health.[12] The structural competency paradigm extends the racial equity lens articulated by Okoli and colleagues,[1] to help health professionals to consider health inequities in relation to not only race and ethnicity but also many other facets of social privilege and oppression. In healthcare, these include, but are not limited to, sexism, ableism, classism and discrimination based on gender identity, sexual orientation, housing status, body habitus, migration/citizenship status, substance use or mental health co-morbidities.

Second, to increase the likelihood that education will lead to action on health inequities, the structural competency approach focuses on *structural intervention*.[11] That is, the development of skills to recognise that the social structures, which shape experiences of health and illness, are not absolute. Learners are encouraged not only to examine how social structures impact experiences of health and illness in their clinical settings but also to empower themselves with skills to take action to redress health inequities. Accordingly, QIPS initiatives focused on reducing healthcare inequities represent a critical opportunity for healthcare professionals to apply their skills in structural intervention. To facilitate the practice of structural intervention, QIPS education programmes would benefit from providing worked examples of QI initiatives aimed at improving health equity. Fortunately, there are an increasing number of QI studies that have targeted health equity in a variety of specialty areas, including internal medicine, paediatrics, obstetrics and primary care targeting inequities in cancer screening[13] and asthma management,[14] among others.

Third, QIPS education must adopt competency frameworks, to guide curricular design and trainee evaluation, which include equity-related concepts. For example, the Association of American Medical Colleges Quality Improvement and Patient Safety Competencies Across the Learning Continuum framework includes health equity as one of its five core domains.[15] QIPS educators can use these frameworks to outline the key concepts and approaches relevant for equity-based QIPS learning. QIPS education must also account for broader shifts occurring in health professions' education as training programmes introduce equity and diversity concepts more routinely. For example, the General Medical Council recommends that 'learners are equipped to understand the needs of diverse patient groups' and there is 'evidence of patients and the public with protected characteristics being consulted about and involved with curricular changes'[16]

In tandem with programmatic change, QIPS guidelines must evolve to make explicit the ways that QIPS methodologies can address health inequities. The Standards for QUality Improvement Reporting Excellence (SQUIRE) are the international publication guidelines for the reporting of QIPS research and scholarship, which have been adopted by many QIPS education programmes as the teaching framework that guides how to conduct QIPS work.[17] The current version, SQUIRE V.2.0, was last updated in 2015 and does not include any overt references to equity. Subsequently, a number

of viewpoints and perspectives have outlined key considerations for how QI frameworks could address health equity.[18] Common among these suggested approaches are the need to direct QIPS efforts towards (1) addressing the needs of people experiencing health inequities, (2) engaging with communities to identify priorities, (3) coproducing change that moves beyond process improvement to target structural change and (4) stratifying outcome data to ensure both overall improvement and reduced inequities. These newer insights and approaches can and should inform revisions to the SQUIRE guidelines to shape QI practices towards those that are more equity-focused.

In summary, Okoli and colleagues[1] offer important recommendations to apply a racial equity lens to the collection, sharing and interpretation of quality data, thereby broadening the skillset of QIPS practitioners to address health inequities. However, achieving the quintuple aim[2] of healthcare improvement will not only require the expansion of knowledge, skills and attitudes but also a commitment to equity-focused structural change within the QIPS community itself.

Correction notice This article has been corrected since it was first published online. Reference 1 has been updated.

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