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Inequalities in Health Care Access and Outcomes

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Background

Health Care Disparities

A large body of literature has emerged demonstrating the existence of differences in access to medical care as well as disparities in health outcomes among different patient groups. Patients hailing from certain racial and ethnic backgrounds,[1,2] or having specific linguistic preferences,[3,4,5] may be more likely to receive poor care. Gender[6,7] and sexuality may play a role in determining the level of care that patients obtain,[8,9] and financial factors, such as insurance coverage, also have the potential to affect patients' health.[10,11,12]

Debate abounds regarding how to most effectively address disparities in care. Individual patients may experience numerous, interrelated barriers to quality care,[13] and may also harbor unique strengths in facing the challenges of navigating the health care system. Classical models of cross-cultural education that privilege accounts of the barriers faced by certain patient "groups" thus have the potential to encourage the stereotyping of patients. Renewed efforts to ameliorate disparities ask physicians to simultaneously be conscious of historical as well as contemporary barriers to equitable health outcomes that may impact how patient groups view interactions with the health care system, while also expressing their willingness to learn about the unique experiences of their individual patients.[14,15]

Efforts to attain nuanced understandings of group level disparities have relied on a plethora of frameworks for describing the interrelated factors that impact patient outcomes.[13,16] For convenience, divisions are often made between those factors related to the patient's background, such as the patient's gender or education level, those related to the provider's knowledge about different cultures and ability to communicate information successfully, and those related to the health care system as a whole, such as physician reimbursement structures or the means used to evaluate care delivery.[16]

Among so-called "patient factors,"[16] disparities between individuals of different sexes as well as between patients identifying as members of diverse racial and ethnic groups have received particular attention. Projections from the 2008 US Census suggest a 4.1 year gap in the estimated life expectancies of Black and White individuals,[17] and a study looking at epidemiological trends from 1991 to 2000 suggested that 886,202 lives would have been saved if age-specific African American mortality rates had been lowered to the levels seen in Whites.[18] Gender-based disparities have also elicited concerns, with studies showing that female patients may be less likely to undergo certain appropriate medical interventions, such as receiving specialty cardiology care for the treatment of heart disease[19] or being on Highly Active Antiretroviral Therapy (HAART) for HIV.[20]

Researchers have used a number of methods to discern the extent to which improved health care access and changes to the medical system might aid in the amelioration of such gaps. Studies have examined patient health outcomes, patient satisfaction with care received,[21] differences in physician prescribing practices according to the racial or ethnic background or gender of their patients, and levels of physician awareness of the existence of disparities.[22] One particularly notable, if controversial, study led by Kevin Schulman, brought attention to the issue by having actors of different races and sexes narrate a standardized set of cardiac symptoms. Schulman and his

colleagues asked doctors to assess the mock patients' symptoms and to recommend treatment plans. The researchers then recorded differences in doctors' responses based on the patients' race and sex. Their findings showed differences in physicians' treatment recommendations, and were particularly striking with regards to female, African American patients, who were less likely to be referred for cardiac catheterization procedures than whites and males demonstrating the same symptoms.[23,24]

A number of other socioeconomic factors may also play into a patient's ability to access health care as well as the barriers that they face in attempting to follow treatment recommendations once they have seen a physician. The passage of the Patient Protection and Affordable Care Act (PPACA) in 2010 emphasized expansion of health insurance as a means of improving care. Despite these efforts to increase access through expanded coverage, certain populations may continue to be vulnerable to lower levels of care. Concerns have been raised about the inability of some patients with public insurance to find providers willing to care for them,[25] as well as the challenges faced and health outcomes experienced by "underinsured" patients whose coverage is incommensurate with their medical needs.[26,27] It is also worth noting that lack of insurance is far from the sole access barrier. For example, patients who receive their care through the Indian Health Service often have difficulty accessing specialty services, owing at least in part to the rural geographical location of many Indian Health centers and to the dearth of available specialists.[28] Indeed, even in countries like England where there is a national insurance system, statistically significant differences have been noted between the care received by patients living in disparate geographical locations.[29]

Once they have accessed care, patients from different socioeconomic backgrounds may also face a series of diverse socioeconomic and cultural barriers to following physician recommendations and achieving positive health outcomes more broadly. For example, smoking is more prevalent among individuals of lower socioeconomic status,[30] and exposure to other environmental carcinogens is often higher.[31] Recent analyses have suggested that these patients may also have more barriers to achieving healthy outcomes and following physician recommendations than previously recognized. For example, a study of African Americans in a low income neighborhood of Boston suggested that for a family of four to eat a heart healthy diet cost an average of $227 a month more than would be compensated by food stamps.[32] New investigations are further expanding the lists of barriers to good health experienced by individuals from low-income backgrounds. For example, it has been hypothesized that high stress levels experienced by low-income individuals may impact health.[33,34]

Responding to Health Care Disparities

A variety of initiatives have attempted to target health care disparities, although far more remains to be done.[35] The most high profile of recent initiatives to improve health care disparities came with the passage of PPACA, which aimed to decrease the number of uninsured patients. The bill also sought to secure certain protections for underinsured individuals, including the 10 million Americans covered by high deductible plans, through such initiatives as the regulation of the sorts of coverage that insurers must provide, particularly in the realm of preventive services.[26]

Several further initiatives have been targeted at improving preventive medical work with low-income families. The government-run Women, Infants, and Children

(WIC) program, for example, aims to bolster the nutritional intake of "low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and… infants and children up to age five who are found to be at nutritional risk."[36] It has been shown to be effective at reducing mortality among both Black and White individuals, although racial gaps persist.[37] Projects aimed at getting information about preventive health to women receiving WIC have also proven successful.[38] The government-sponsored Senior's Farmer's Market Nutrition Program similarly helps subsidize the cost of access to fresh, local produce for older individuals in need.[39]

Concerns have been raised that targeting low-income and under-insured groups may not sufficiently address other latent disparities, including racial, ethnic, and gender-based inequalities. The Institute of Medicine's 2003 report on racial and ethnic disparities concluded that minority patient groups "receive a lower quality of healthcare than non-minorities, even when access-related factors, such as patients' insurance status and income, are controlled" (p. 1), and offered recommendations for such targeted interventions as the expansion of the diversity of the medical workforce.[40] Early evidence from Massachusetts, where efforts to reform health care by expanding insurance access took effect before the rest of the nation, similarly suggests continued racial disparities.[41]

Historically, a variety of initiatives have aimed to target inequalities, among the more groundbreaking of which was the NIH Revitalization Act of 1993, which aimed to address the under-representation of women and minorities in clinical trials that form the bedrock of evidence-based medicine.[6,42,43] The guidelines it set-forth have been successful at diversifying clinical trials,[44] thus enabling physicians to make decisions for their patients using a more representative evidence base.

Another major initiative has emphasized the education of clinicians regarding disparities. Programs aimed at educating medical professionals regarding health care disparities have been thought to raise awareness of disparities, although there are some concerns that such awareness may not always translate into better health outcomes.[22,45,46] More research on how best to prepare clinicians to ensure equitable care for their patients is needed.

Efforts have also been made to address the role of health care systems in propagating or alleviating disparities, in particular through an emphasis on the effect of disparate provider payment methods on disparities. Traditional pay-for-performance measures, for example, have been critiqued as having the potential to give doctors incentives to avoid caring for vulnerable patients who they see as more likely to have poor outcomes.[47] Novel systems of using pay-for-performance techniques in order to decrease disparities are currently being designed and tried. In 2006, for example, a system was implemented in Massachusetts whereby Medicaid reimbursement is allocated through a pay-for-performance system that includes incentives to decrease racial and ethnic disparities in care. Implementing the program in such a way as to truly capture existing disparities has proved difficult,[48] but the initiative represents one of many possible novel manners of attempting to advance the quest for greater equality in health care access and outcomes.

Case:

Part I:

Rosa Bennett is a 59 year-old single mother of three living in Roxbury. She worked for many years at a restaurant, but was laid off owing to the economic downturn. Since then, she has been working three part-time temporary jobs to try to make ends meet, but has not had private health insurance. A friend in the area where she lives helped her enroll in Medicaid.

Rosa's stress level has been dangerously high. Some of the part-time work that she has found requires her to keep very late hours. She is not getting regular sleep, and finds herself getting most of her meals from the local 24-hour convenience store. She is concerned that one of her daughters might be using drugs. Rosa becomes even more stressed when her sister is laid off and, in an effort to stave off homelessness, her sibling moves in with Rosa and her children.

Rosa starts getting headaches and notices that she is having difficulty reading the microwave directions on one of the ready-meals that she picked up for herself and her kids for dinner. She thinks briefly about going to a doctor, but decides against it. She believes that she has to stay strong for her family, and, having not learned about the $3 generics available through MassHealth, she doesn't think that she can afford the medications a doctor would prescribe.

Part II:

One morning, walking up the subway steps, Rosa feels dizzy. She sits down for a few minutes and then continues on to the building where she is working as a cleaner. The dizziness worries her so much that she calls her doctor while on her break. However, the doctor that she used to see when she had private health insurance will no longer see her now that she has Medicaid. Rosa is complaining about this situation to her co-workers when one of the executives at the building she is cleaning overhears Rosa's conversation. The executive tells Rosa that her husband is a physician and maybe he could help out.

Rosa feels fortunate to get an appointment with the executive's husband, and feels even luckier when her co-worker agrees to switch shifts with her so that she can make it across town to an appointment at the doctor's office without getting fired. Rosa is grateful to see the doctor and puts on her best clothes for the occasion in order to "fit-in" with what she perceives is the way that his other patients dress.

The doctor is kind, but rushed; he has squeezed Rosa into a packed schedule of appointments as a favor to his wife. He tells Rosa that she has high blood pressure and will need to take some pills. She is a bit embarrassed, but asks if there might be generic versions of the drugs. He tells her that the pharmacist should be able to help her get the pills at a discount. He goes on to tell her that it is important that she start eating a healthy diet, and recommends a diet book that "a lot of his patients like" because they can eat tasty food while still staying healthy. He also tells her that she needs to "join a gym." He warns her that if she feels crushing chest pain or pain radiating down her arm, she needs to come to an emergency room immediately.

Part III:

Rosa leaves feeling somewhat bewildered. She goes to her local pharmacy, where she finds that she only has enough money in her purse at that moment to afford some of the pills. She fills those prescriptions, but ignores the others, having little time to go back and forth to the pharmacy. She wonders to herself how she is going to be able to take the pills at regular intervals with food when she usually doesn't get time for breakfast or even, some days, for lunch. She knows that she will not be spending time at a gym.

However, she makes what effort she can to follow the doctor's instructions. She asks her son to see if the local library has the diet book that the doctor recommended since she usually is not home during the library's operating hours, but they don't have it. Eventually, she takes a look at the book in a bookstore, but decides that she cannot afford to cook any of the recipes. Instead, she congratulates herself on choosing the frozen pizza with vegetables on it from the convenience store instead of her regular pepperoni.

Not long after her visit to the doctor, Rosa finds herself feeling nauseous. Her chest hurts, but like many women who experience different heart attack symptoms than men, she is more focused on jaw pain than on the sort of crushing chest pain her doctor had talked to her about.[49] Scared of the idea that she could be having a heart attack, she convinces herself that her symptoms don't sound like what her doctor described. Only hours later, does she go to the emergency room, where she learns that she has sustained heart damage from a myocardial infarction.

Questions to consider:

1. The Institute of Medicine report, *Unequal Treatment* (2003), posited that some doctors might not feel as confident about their assessment of signs and symptoms when treating patients from backgrounds other than their own.[40] What resources would aid the physician in this case in offering Rosa the best possible care? What questions would he have had to ask in his social history? How can the doctor both give the patient the best care possible and also give her care that realistically fits with her economic and social needs?
2. What financial or other incentives might make the doctor and the health system more likely to provide better long-term care to patients like Rosa? Who do you think should be responsible for putting these incentives in place?
3. What effect do you think the new Massachusetts pay-for-performance measures might have on Rosa's decisions about where and when to seek care? What about its impact on the doctor?
4. How would this case be different if Rosa had private insurance? What aspects of this case would remain the same?

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