

Confronting the Uncomfortable: Health Plans and Health Disparities: A Moral Dilemma in a Morally Driven Industry

By Winston F Wong, MD

American medicine was traumatized when, in the 1970s, it was revealed that hundreds of African-American men were purposefully denied treatment for syphilis for decades at the Tuskegee Medical Institute.¹ For two centuries, American medicine had never confronted the mythology that the practice of medicine was above the fray of power structures that reinforced the status quo.

Historically, physicians have characterized their profession as the practice of the “art of medicine.” The Hippocratic oath inspires young doctors to apply biological knowledge to comfort and to help other human beings, regardless of their background. The complexity of human interactions leads to an infinite set of outcomes and expectations and, as an “artist,” a physician works earnestly to manage conditions resulting in comfort and wellness.

Health plans, in contrast, exist to efficiently organize thousands of individualized encounters by harnessing the power of technology and managing and parceling services to optimize health and mitigate the impact of illness for a defined group of individuals. In effect, health plans have become the invisible “third person” in the exam room, exerting a ubiquitous influence on what had been historically considered a hallowed relationship between physician and patient. Accord-

ingly, the predominant view of health plans (ie, insurers) is that of a necessary, but not altogether welcome third-party arbiter between patient and physician. The arbiter, in this case, has rarely been regarded as a positive force for change. (It should be noted that a number of health plans, eg Kaiser Permanente, are designed with the conviction that optimal outcomes are achieved when patient care incorporates “integrated” delivery, the result of a partnership between clinical provider and insurer. Nevertheless, physicians on one hand, and insurers on the other, represent dichotomous relationships to patients as *individuals*.)

In a generic sense, modern clinical outcomes are the result of physician-patient-health plan interactions. Indeed, thousands of hours and millions of dollars are expended annually to dissect the hidden factors that result in suboptimal population outcomes and adverse individual incidents. The resultant interplay between health plan and individual clinician ultimately defines the patient experience and the outcomes of the health care system as a whole. For the most part, America’s health care system, both heralded and maligned, examines itself through the lens of diagnosis, therapy, and delivery of care. Unfortunately, this

set of parameters falls short when applied to the *aggregate* impact of substandard care and outcomes provided to persons of color, ie health disparities. Our health care system, the composite product of health plans and clinicians, has yet rid “the damned spot” of discrimination and racial inequality and its concordant suffering.

The idea that clinical outcomes are bounded by the therapeutic relationship between patient and clinician results in physician-centric “solutions” to eliminate health disparities. But if we concede that health plans do indeed have a role in defining the clinical encounter, the “third person” in the exam room then might just have a major, if not decisive role in erasing the systematic failure to achieving equity in health care. Health plans wield powerful tools that can instigate positive health care outcomes. Health plans need to harness their assets, including the collection and analysis of copious data, the provision of incentives that accelerate the adoption of positive practices, and the establishment of benchmarks for standards and quality, to be effective change agents in eliminating health care disparities.

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Holding a System Accountable

In the landmark report, the Institute of Medicine's (IOM) "Crossing the Quality Chasm,"² six elements of quality were identified in health care; timeliness, safety, efficiency, efficacy, patient centeredness, and equity. The report concluded that our health care system consistently fails in all domains. Of note, the "equity" domain reflects a commitment wrapped in a core value of American democracy; a belief that all individuals are equal under law and are entitled to equal opportunity. In effect, calling out "equity" as an unaccomplished goal in health care, indicts not only the social conditions giving rise to disparate health, but also a health care system complicit in reproducing unequal access and outcomes. Thus, every instance in the continuum of providing health care, from accessing services to the patient-physician encounter, to referrals between providers, to obtaining emergency care and so on, can be examined as a contributor to inequity.

Elevating "equity" to a principle of an ideal health care system is an admission that disparate outcomes related to race and ethnicity are more than the aggregate impact of physician-patient encounters tainted by individual prejudice and stereotypes. There is no reason to suspect that American medicine has totally eradicated racist and xenophobic stereotypes from the profession, but the reproduction of disparities is much more likely related to a confluence of actions, decisions, and complacency within and by the organizations that deliver care. Thus data and research that paint a picture of disparate outcomes compel a thorough examination of the influences and decision processes that replicate unequal outcomes. Health plans have

the responsibility and accountability to evaluate their progress in achieving equity as diligently as any one of the IOM's other domains.

Data Paint a Sobering Picture

Race—A Social Construct

While science has thoroughly discounted "race" as a biologically defensible term, its influence on virtually every social interaction, particularly in the United States, is all but universally conceded.³ A purely biologic view of race would impute physiologic and biochemical causality for the more stark contrasts in disease burden and life expectancy. On the other hand, the recognition that racial categories are a social construct that continue to serve a particular role in defining power relations in American society implies that effective interventions that disrupt these associations are multitiered, residing above and beyond physiologic and linear solutions. Some observers suggest⁴ that racial categories, in essence, mask underlying class divisions in American society. Utilizing this framework, "race" is a proxy for "class," and health disparities are yet another by-product of economic and social inequality. As teleologically appealing as this theory is, it cannot explain why disparities persist between minorities and whites even when educational and income levels are adjusted to equilibrate socio-economic differences.

Persistence of poorer outcomes for any group of defined patients raises the specter⁵ of the usual suspects: that is, a disproportionate predilection to poor health, a lack of truly equal access to good care, and a breakdown in effective interactions between patients and the health care system. In the case of health care disparities, we find

that each of these factors is indeed operative and exacerbated by the confounding dynamics of race, power, and culture in the US.

Obesity

For example, Latino, African-American, Native-American, and Native-Hawaiian children are predicted⁶ to be two to four times more likely to develop diabetes in their lifetime compared with Caucasian children in the US. These predictions are based upon studies⁶ indicating a wide preponderance of elevated Body Mass Index ratios for children of these population groups, as well as current trends in diabetes rates among adults of these racial and ethnic groups. Whereas researchers grapple with understanding the complex interaction between genetic predisposition to insulin resistance and diet and lifestyle, there is also the cold social reality that children from these groups are less likely to have access to an array of food choices, recreational facilities and activities that stave off obesity and prevent the onset of disordered metabolism, the physiologic underpinning of diabetes.⁷⁻⁹ The pathogenesis of diabetes in America is arguably rooted in conditions resulting from unequal opportunity and deferred investments in community and economic development. Consequently, among young adults with the highest diabetic "risk factors" are those who grew up in poor minority neighborhoods.⁷⁻⁹

Nor does the influence of race on health outcomes confine itself to childhood. Recent studies examining hypertension among African-American men suggest that a lifetime of recurrent physiologic pulses of cortisol, one of the body's hormonal responses to stress and conceivably, responses to recurrent discrimination, could induce

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the development of persistent hypertension. When viewed as a precursor to hypertension, “African American” might be more accurately considered a condition related to a specific life experience, rather than simply a term associated with physical features or ancestry.

Lack of Access

Compounding the disproportionate prevalence of harbingers of poor health is the difficulty minority groups have in not only obtaining health insurance,¹⁰ but securing a reliable source of health care that meets their needs. Race and ethnicity are highly correlated with lack of health insurance in the United States.¹¹ Of the estimated 47 million Americans without health insurance, 15% are African American, and 29% are Latino, representing a disproportionate level relative to their percentage of the total American population.¹⁰ Moreover, in communities comprised of a high percentage of recent Asian immigrants, some studies have shown alarming rates of uninsured (eg, Alameda County, CA where 30% of Asians were uninsured).¹² Therefore, proponents of an American form of universal health insurance might foresee a future where inequities in health care on the basis of race wither away. This optimism should be tempered by another sobering aspect of unequal access. As the Agency for Healthcare Quality and Research has reported,¹³ even among African Americans and Latinos who have medical insurance, there are consistently higher levels of dissatisfaction in getting care for illness or injury in a timely fashion as compared to Caucasians. And, to make matters even worse, the gap regarding satisfaction with timely care actually increased among African Americans vs Whites as educational levels increased. For groups that have

a greater percentage of non-English speaking individuals, eg Asian Americans, adults reported a significant higher level of dissatisfaction with clinician communication, as exhibited by clear explanations and listening skills.¹³ Again, identifying lack of access to health care as a determining factor in health disparities requires a more detailed understanding of the nuances of obtaining care when one is minority, immigrant, and non-English speaking.

African-American Mortality

Among the most shocking indicators of health care inequities is the standardized mortality rate for African-American men over the last 50 years.¹⁴ That is, over the last 50 years, African-American men continue to experience a mortality ratio of 1.5 compared with European-American men.¹⁴ Put in another way, despite investments in addressing social inequality in our schools, housing, and environmental conditions, African Americans, as a group, exhibit a 50% higher mortality ratio than Caucasian Americans.¹⁴ Although great pains are made to emphasize that disparities exist in health status, as impacted by social determinants existing outside the health care system, it is also true that *even when African-American men receive health care, they die sooner*.¹⁵ David Satcher, MD, former Surgeon General of the United States, further elaborated that if mortality rates for African Americans were comparable to Caucasians, 80,000 fewer African Americans would die yearly.¹⁴ Numerous other studies¹⁶⁻¹⁸ illuminate apparent contributors to this failing report card: the disparity of African-American men compared with Caucasian men in terms of percentage receiving life-saving invasive interventions for myocardial infarctions,¹⁶ the rates

of kidney disease associated with poorly controlled diabetes,¹⁷ and the higher incidence of aggressive colon and prostate cancers.¹⁸

Obstacles

Studies¹⁸ confirming that African-American men are impacted by decision making or health care delivery design that renders suboptimal care raise ethical concerns that confront the very nature of healing and the practice of medicine. Faced with this sobering reality, clinicians are morally obligated to reflect whether the care they provide in each individualized encounter is characterized by inherent bias or stereotypes. Euphemistically referred as “clinical” thinking shortcuts, these subliminal, and occasionally explicit prejudices, work to embed unequal processes and outcomes in medicine.¹⁹⁻²² Furthermore, because all clinicians provide care within the context of a delivery system, the system itself becomes an accessory in replicating unequal processes resulting in disparate outcomes. Even a relatively innocent and well-meaning directive, such as obtaining a mammogram at the local hospital or medical center, can become an insurmountable obstacle for a woman who does not speak English, relies on public transportation, and is uncomfortable with the notion of disrobing for what she considers a procedure with dubious intrinsic medical value.²³ A failure in obtaining such a procedure is conventionally (and conveniently) attributed to patient incompetence or noncompliance, but in fact, could be just as aptly attributed to a system’s inability or unwillingness to deliver care that is free from bias.

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An assumption that care is provided without bias or discrimination may often be revealed as something other when seen from the eyes of groups who encounter recurrent patterns of care and service that reflect the values, capacities, and stereotypes of the dominant group.²⁴

The Role of Health Plans in Addressing Health Care Disparities

Faced with the daunting nature and complexity of health disparities in American medicine, health plans face an unsettling reality: variation in care and outcomes is not random. While unwanted variation is never good, variation associated with a demographic characteristic is worse, and worse yet when the defining demographic feature is increasing. Health plans and clinicians must adapt to providing health care to a population that is increasingly non-white, non-European, and non-native English speaking with diverse cultural and religious beliefs. A health plan must work with clinicians to minimize unwanted variation and manage resources to optimize care for a target population especially in wake of dramatic changes in its composition.

Data on Race

Faced with the uncertainty of persistent unacceptable variation in quality and outcomes most²⁵ health plans are at least evaluating the practicality of collecting racial, ethnic, and linguistic background of their members. In some instances, health plans are being required to report some rudimentary data on race and ethnicity by regulatory bodies as sanctioned by government. Operational challenges about

policy needs when plans evaluate how, when, and what data is to be elicited from members and subscribers. Nonetheless, groups such as the Hospital Research and Educational Trust and the Association of Health Insurance Plans have actively promulgated²⁶ responsible approaches to the collection of race, ethnicity, language, and socioeconomic status. There is currently no major health plan that can claim that a majority of their subscribers have been identified by race and ethnicity. Despite dispelling the misconception that the collection of race and ethnicity data among health plan describers is illegal, advocates of this data collection continue to face misgivings regarding the reliability and applicability, and thus, the inherent value of such data. Indeed, the “problem” of collecting data has begun to supersede the problem of health care disparities in the first place. Health plans, faced with the expectation from payers and consumers to demonstrate value as exhibited by performance and transparency, will inevitably confront race and ethnicity as a predictor of suboptimal outcomes. Those with capacity to aggregate data for race and ethnicity will be in the advantageous and enviable position of reducing risk among its subscribers, while at the same time delivering on their social contract to provide optimal health. Disease and population management approaches could be optimally designed utilizing data that illustrate characteristics of health care received by minority groups. Data likewise provides the opportunity for robust research and quality improvement initiatives regarding the epidemiology and health care of racial and ethnic groups, which can be shared among other health plans, resulting in improved care for all.

Cultural Humility

Cultural competence has emerged as a central component vital to effective care for patients and populations. The recognition that our health care system has been characterized by a historic lack of sensitivity and a certain callousness towards patients who are not of the Western European culture has propelled a greater appreciation for the diversity of America, and the need for health care organizations to not only accommodate, but indeed to embrace cultures from other global regions.²⁷ Thus, health plans are now employing a number of training programs to educate and to sensitize staff to issues and in skills necessary to care for patients of diverse cultures.²⁸ Health plans ought to play a critical role in both endorsing and promoting such activities. Yet it would behoove any plan not to equate cultural competence training as a commensurate response to the complexity of health care disparities. Although cultural competence can help decrease the communication barriers between patients and clinicians, it cannot, in isolation, address systematic issues that are rooted in unequal access and resource allocation that reproduce barriers to care.

Linguistics

Closely related to cultural competence is the provision of hospital and medical services in languages that meet the needs of both non-English-speaking and literacy-challenged populations. Across the continuum of patient care, compromises are continually endured by individuals who do not communicate using college-level English.²⁹ Health plans need to leverage their role in setting standards of care in clinical settings to provide services that assure safety and quality for all patients, regardless of their facility with English. Break-

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downs in continuity of care, patient adherence to therapeutic regimens, safety precautions, transitions in care, patient education, and critical care interventions are often linked to poor communication stemming from linguistic barriers.^{30,31} Health plans need to invest in structures, systems, and processes that reduce communication barriers.

Entry Points

Access to care encompasses at least three entry points. From a macroeconomic view, health plans are accountable to consumers and purchasers to provide affordable health care and ideally to control the costs of health care. When costs spiral upwards more individuals—and disproportionately, more minorities, become medically uninsured. However, as stated earlier, providing affordable health insurance, and even ultimately providing universal coverage, would not dissipate issues related to the lack of a health care home and/or primary care clinician to a great proportion of minority patients. Plans must actively recruit physicians and other clinicians who are skilled and dedicated to the particular needs and interests of minority communities, and must actively reach out to communities that have not been engaged with health care institutions. Additionally, once health plans demonstrate capacity to involve patients from minority groups in shaping their health care needs, they need to assure that the systems and processes surrounding the provision of care are tailored to provide optimal service to diverse populations.

Leadership

Ultimately, the elimination of health disparities will coincide with great leaps in progress in addressing the social inequities of our society. To the extent we can identify and act upon the progeni-

tors of poor health and shortened life expectancy, ie the environment, the lack of social, economic, and educational opportunity, and the impact of racism experienced by communities and individuals, the perpetrators of disparate outcomes will regress. Health plans, by the very nature of their roles in facilitating the healing interaction between clinician and patient, can stand to either impede progress or catalyze actions that lead to the elimination of health disparities. Complacency is, in the final analysis, culpability. With that recognition, health plans, in fulfilling their obligation to provide a reliable, safe, and secure system of care to millions of users, must also assume a leading role in demonstrating a commitment to abrogate the destructive role of racism and social injustice upon the health care of all Americans. ❖

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Things That Matter

Our lives begin to end
the day we become silent
about things that matter.

— Reverend Martin Luther King, Jr, 1929-68,
Nobel Peace Prize winner and civil rights activist