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Health Care Inequity Affects Everyone

Health care inequity between different **ethnic and income groups**, between **wealthier and poorer communities**, and between **urban and rural areas** produces wide variations in available care and health care outcomes.

Despite having one of the most advanced economies in the world, the United States has built, and continues to tolerate, a health care system that is rife with inequity. Access to care can vary across a dismayingly large array of factors, including race, insurance coverage, and whether one lives in an urban community or a more rural one.

According to the Kaiser Family Foundation, health care disparities amount to approximately $93 billion in excess medical care costs and $42 billion in lost productivity per year, as well as additional economic losses due to premature deaths.

"Health care inequity exists across every market in the country," says **Dr. Philip Brown, chief community impact officer** for **Novant Health**. "For example, we see huge racial disparities in maternal outcomes, in infant mortality. We also have inequities in things that are harder to see. We have inequities between rural health services and metropolitan health services."

"A transformation in health care inequity requires broad and wide-reaching points of access that make it particularly easy and affordable for people who are underserved and a massive campaign to educate the populations to participate in their own health care," says **Insigniam partner June Zeringue**. "We need to look at what the barriers are from the patient's point of view and solve to remove those barriers, to a user experience that pulls for engagement. There are >>>

25%

The percentage of total **hospitals in the U.S. that are located in rural communities**, according to the American Hospital Association.

very few people who, when given the opportunity to access health care in a user-friendly environment, won't take the right actions to access their benefits."

The U.S. is not alone—there are dramatic inequities in healthcare globally. Child mortality rates are 14 times higher in sub-Saharan Africa, for example, than they are in the rest of the world, according to the World Health Organization. Children from the poorest 20% of families face nearly twice the odds of dying before age 5 as their peers in the richest 20% of families. There are similarly dramatic differences in maternal mortality: a 1 in 16 lifetime risk for a woman in Chad, compared to less than 1 in 10,000 for a woman in Sweden.

In the U.S., a large amount of health care inequity is driven by differences in access to insurance, says **Georges Benjamin, executive director** of the **American Public Health Association**. But even among those who do have insurance, there are differences in the ability to access care. "There are people who have insurance that is relatively generous and does not place substantial financial barriers preventing their ability to seek care. And there are others with skimpier health insurance," says **Matthew Fiedler, fellow** with the **USC-Brookings Schaeffer Initiative for Health Policy**.

While improvements to the system of insurance present one avenue for improvement, countries with significantly different payment systems—and their own health disparities—provide inspiration for other approaches. In France, legislation passed in 2004 gives physicians financial incentives to practice in underserved areas. Israel requires all health care providers to meet "cultural responsiveness" guidelines, in order to better meet the needs of minority populations. A national translation call center also helps ensure that patients receive care and instruction in a form they can understand. The New Zealand government requires health plans to consult with Maori communities.

Two Steps Forward, One Step Back

In the U.S., the Affordable Care Act was designed to close the gap between those with and without insurance, but several states chose not to expand the Medicaid program to cover low-income people who weren't insured by their employers and couldn't afford to buy insurance on their own, say Mr. Benjamin and Mr. Fiedler.

The ACA was also intended to eliminate "junk" insurance plans—plans that didn't cover or only offered very limited coverage for numerous types of illnesses and procedures. But the number of junk plans offered to individuals has been growing, Mr. Benjamin says.

Even for those with insurance, recent consolidations have left some communities without the access to care that they once had.

Closures have hit rural areas particularly hard. According to the American Hospital Association, there are 5,141 community hospitals in the U.S. today, but only 1,805 in rural communities. Those numbers are down from 5,280 and 1,887, respectively, in 2015. Forty-seven percent of the rural hospitals had 25 beds or fewer. In urban areas, many of the closures have been in communities of color.

There is also a shortage of pharmacies in some communities, further contributing to inequities, Mr. Benjamin says. He notes additional contributing factors to health care inequity: lack of full-service grocery stores for access to healthy foods, and lack of public transportation to reach health care facilities and full-service grocery stores.

47%

The number of **rural hospitals in the U.S. with 25 beds or fewer**, according to the American Hospital Association.

PREVIOUS SPREAD, IVAN PANTIC/GETTY IMAGES; ABOVE, MARKO GEBER/GETTY IMAGES

"Health care inequity exists across every market in the country." —**Dr. Philip Brown**, chief community impact officer, Novant Health

Differential Access Means Differential Outcomes

Health care disparities have real effects. Using rates in North Carolina as an example, Dr. Brown says that African American infants are 2.4 times more likely to die than white infants. Indigenous infants are 1.7 times more likely to die than white ones.

"Does that make any sense?" Dr. Brown asks, going on to list a number of other disparities. "Why is it that African Americans are 2.3 times more likely to die from kidney disease than whites? Why are American Indians 2.4 times more likely to die from that? None of those disparities make sense."

"As organizations start to grapple with these questions, they become uncomfortable," Dr. Brown says. "It's at the point of this discomfort that we find ourselves at a crossroads. We can choose to say this can't be right, or we can choose to do the difficult work of analyzing how we are contributing to these differences and create better outcomes for everybody."

Health inequities became glaringly obvious as COVID-19 vaccines were first rolled out. As of August 2021, nearly 4 billion doses of vaccines had been administered. But only 1.1% of people living in low-income countries had received even one dose. South American countries overall had administered 59 doses for every 100 people, while Africa overall had administered less than five. By January 2022, the U.S. had administered 154 doses per 100 people (some received more than one), and India had administered 106, according to Our World in Data.

Attempting To Close the Gap

There is no magic bullet to solve the health care equity gap—but there is a process, says Dr. Brown. "It's about shaping your culture to meet the needs of all of the people that you serve and using your data systems to ascertain when there's a difference in outcomes," he says. "Then you need to peel back multiple layers to understand why. When we correct for the patients who are not being served well, the improvements actually carry over to the entire patient population. That is the critical thing to understand.

"Twenty percent of the nation's gross domestic product is spent on health care. A lot of that can be eliminated through this type of work."

The current transition to value-based care should help close the equity gap, according to Dr. Brown. With value-based care, payment is based on the delivery of health at higher levels to all people. If a significant portion of the population has poor outcomes, it's in the provider's economic interest—in addition to their moral one—to deliver a higher level of health care. "When you point out the financial implications to an organization, then it gets attention immediately," says Dr. Brown.

Increasing federal subsidies to enable more people to afford good insurance would also help improve health care equity. Another potential solution, Mr. Benjamin says, is to offer tax and other financial incentives for health care providers to operate clinics and other facilities in underserved areas. But even with financial incentives in place, there must be a relatively high patient volume, so that the facility makes economic sense for the provider.

Another strategy is to allow nurse practitioners or medical assistants to administer an increased number of health care procedures, freeing up physicians for other types of care, Mr. Fiedler says. That requires cooperation from health care providers, regulators and insurers.

Private organizations can help by offering their employees insurance, and by advising them on the best use of their insurance options, Mr. Benjamin added. "When we are successful at this, we can see levels of health that we've never dreamed about in our country," Dr. Brown says. "That's enough motivation to do this work for any organization that's involved in health care." IQ34