

Health Care Reform and Equity: Promise, Pitfalls, and Prescriptions

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ABSTRACT

The United States has made little progress during the past decade in addressing health care disparities. Recent health care reforms offer an historic opportunity to create a more equitable health care system. Key elements of health care reform relevant to promoting equity include access, support for primary care, enhanced health information technology, new payment models, a national quality strategy informed by research, and federal requirements for health care disparity monitoring. With effective implementation, improved alignment of resources with patient needs, and most importantly, revitalization of primary care, these reforms could measurably improve equity.

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INTRODUCTION

The United States has made little progress toward greater equity in health care quality according to the annual National Health Care Disparities Reports.¹ Recent health care reforms offer an historic opportunity to make inroads. In this commentary, I review key provisions of these reforms, particularly those in the Patient Protection and Affordable Care Act, often shortened to Affordable Care Act (ACA) of 2010,² and discuss their potential promise, pitfalls, and steps (prescriptions) needed to jump-start progress toward more equitable health care (Table 1). I begin by briefly reviewing causes of health care disparities and then discuss selected, key health care reform provisions within 6 interlocking domains: access related to insurance coverage and costs, strengthening primary care, improvements in health information technology, changes in physician payment, adoption of a national quality, and improved disparity monitoring and accountability.

CAUSES OF HEALTH CARE DISPARITIES

Health care disparities related to race, ethnicity, socioeconomic status (SES), and markers of social disadvantage result from a complex confluence of patient, clinician, and system levels factors.³ These disparities often reflect reciprocal influences between social stratification and ensuing social disadvantage and worse health⁴; unconscious clinician bias toward socially disadvantaged persons^{5,6}; separate and often unequal care⁷⁻¹⁰; and a health care system, including primary care,¹¹ that is ill-equipped to address the often complex needs of socially disadvantaged patients, who often become underserved patients.¹²

Equitable health care means more than elimination of bias, it also means creation of patient-centered systems of care that support healing and caring relationships that are responsive to patients' needs, wishes, and context.¹³ Improving equity requires aligning health care resources and capability with patient needs, particularly patients who have been historically underserved.¹²

Conflict of interest: Dr Fiscella served on the Institute of Medicine Committee on Future Directions for the National Health Care Quality and Disparities Report and has consulted for the Health Resources Services Administration.

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Table 1. Promise, Pitfalls, and Prescriptions for Improved Equity Under Health Reform

Health Reform Provision	Promise	Pitfall	Prescription
Access (insurance and costs)			
Expanded coverage	Coverage for up to 32 million uninsured	Need for robust primary care system Remaining 23 million uninsured Absence of “public option” undermines cost control for care for previously uninsured	Revitalize primary care Universal coverage Expansion of Medicare eligibility and other public options
Behavioral health parity	Reduced cost barriers	Does not address barriers related to stigma related to mental health care	Integrate behavioral health services into primary care
Elimination of co-payments for evidence-based preventive care	Reduce cost barriers	May accelerate trends toward cost shifting to patients for medical and behavioral care, worsening disparities	Restrict cost sharing based on percent family income
Revitalization of primary care including the safety net			
Improved physician payments	Modest improvement in resources	Not sufficient to generate practice adaptive reserve for transformation	Major payment reform
Elimination in Medicare-Medicaid payment differences	Potential to minimize separate and unequal systems	Does not address gap between Medicare and private insurance payments.	Eliminate differences in payment by insurance type. Prohibit segregation of care based on payment type within health care systems that receive federal funds.
Bonus for work in shortage areas	Modest impact on physician maldistribution	Too small to have significant effect	Comprehensive strategy to primary care and workforce issues
National Health Care Work Force Commission	Potential to influence work force maldistribution	Depends on authority of commission to affect key issues	Address student selection, training, payments, and quality of practice in shortage areas
Improvement in federal load repayment	Improved recruitment to shortage areas	Does not address retention following fulfillment of commitment	Enhance quality of practice and payment
Collaborative Care Network	Improvement in care coordination for underserved	Need for vibrant primary care safety net to coordinate care	Strengthen adaptive reserve of safety net
Piloting of new care models	Spark innovation	Modest investments may not be sufficient Practice change is a continuous process	Support innovation in all practices Greater funding for practice-based research for underserved Funding for primary care extension programs
State-operated health insurance exchanges	Opportunity to promote new care delivery models	Not all states will opt for innovation	
Health information technology			
Incentives for physicians and hospitals	Acceleration of diffusion nearing tipping point	Does not ensure improvement in quality Digital divide by practice and patient	Support for quality improvement collaboratives that leverage health information technology Subsidies for safety-net practices and training and support for patients in use of health information technology
Payment model reform			
Payment Advisory Board	Potential move from volume to value payment Potential for changes in primary care payment	Success dependent on members of board	Major changes in needed in quantity and type of financing for primary care
National Pilot Medicare Payment Program	Piloting of bundled payments	Relatively small change Unknown impact of bundled payments on primary care Potential adverse impact on underserved	Build in monitoring of effects on care for underserved patients
National quality strategy			
Formal national quality improvement strategy	Potential to integrate multiple elements of health reform	Potential for neglect of the physician-patient relationship	Need to keep patient and relationships at fore
Reporting of performance by federal programs	Improved accountability for programs for underserved	Inadequate funding for implementation and PBRN research, particularly in safety-net practices	Improved funding for practice-based research, particularly safety-net practices
Monitoring disparities			
Enhance collection of disparity data within health care	Improved detection of disparities	Assessing disparities does not assure they are addressed	Build in continuous loops between reporting, policy/intervention and follow-up
Analyze disparities trends	Identification of key disparities for targeted action	Monitoring alone is not sufficient	DHHS should hold federally sponsored programs accountable for progress in addressing disparities

ACCESS

Improving equity begins with improving health care system access. System access is strongly affected by insurance coverage and cost. Minority and low-SES patients are more often uninsured than their counterparts.¹ Lack of health insurance is a major contributor to health care disparities¹⁴; health care disparities are smaller in such health systems as the Veterans Affairs, where access is more uniform.¹⁵ ACA provisions will eventually expand insurance coverage to an estimated 32 million uninsured persons, but the Congressional Budget Office estimates that health care reform may still leave 23 million persons, including undocumented immigrants, without any coverage.¹⁶

Recent reforms also offer potential for improving access to behavioral care for poor and minority patients and for addressing disparities in behavioral health utilization.¹ Cost represents a key barrier. Parity provisions in the Mental Health Parity and Addiction Equity (MHPAE) Act of 2008 (https://www.cms.gov/healthinsreformforconsume/04_thementalhealthparity-act.asp) and ACA minimize cost differences between behavioral and medical care. Specifically, MHPAE prohibits health plans from imposing deductibles, co-payments, and out-of-pocket limits on mental health and substance abuse coverage that are higher than those imposed for medical-surgical coverage. It also prohibits restrictions on days of hospital coverage and duration and scope of behavioral treatment beyond limits that health plans impose for medical-surgical coverage. Access to behavioral health care for underserved groups could be further enhanced through creation of integrated primary and behavioral health care similar to the Veterans Affairs health system.¹⁷

Health care costs contribute to disparities, even among the insured.¹⁸ Insurance deductibles and co-payments discourage appropriate health care use,¹⁹ affecting those with the least income. ACA will eliminate patient cost sharing for evidence-based preventive services covered by Medicare and Medicaid. It also authorizes Medicare coverage for annual health assessments and eventually eliminates the so-called donut hole in Medicare part D prescription coverage. Prohibitions against exclusions for preexisting conditions and lifetime limits on spending by health plans may provide greater benefit to low-SES patients who are more often affected by chronic conditions.²⁰ These changes may also reduce physician decision-making time devoted to patients' ability to pay²¹ and may incrementally move the country toward improved health care equity. Potential benefits of these changes, however, may be undermined by trends toward increased patient cost sharing.²² Cost sharing disproportionately affects low-income patients.²³ Premiums for obtaining insurance though health insurance

exchanges for the uninsured will be based on household income, but many low-income workers may continue to pay high premiums for employer-based coverage.

PRIMARY CARE

Access to primary care is associated with fewer disparities in outcomes.²⁴ A robust primary care system is the cornerstone for a more equitable health care system. Longitudinal, caring relationships with patients provide the opportunity to minimize stereotypes and foster patient enablement and capability, potentially yielding more equitable care.^{25,26}

Revitalization of primary care is critical to health reform success.²⁷ ACA takes important, although modest steps, in addressing critical primary care needs: payment reform, enhancing the training pipeline, transforming practice, and buttressing the primary care safety net. ACA provisions include establishment of a National Health Care Workforce Commission, increased support for workforce training (Title VII and the Prevention and Public Health Fund), cultural competency training, enhanced payments, expansion of health centers, and piloting of new care models. ACA also provides bonus payments to primary care physicians under Medicare and eliminates differences in payments between Medicaid and Medicare for primary care. It further provides Medicare bonuses to primary care physicians who work in shortage areas, helping to minimize geographically related disparities. These reforms may begin to minimize disparities in resources between primary care practices whose patient populations differ by social disadvantage. These reforms could also conceivably reduce de facto segregation in health care by insurance type (eg, faculty practices vs clinics), although federal regulations prohibiting intra-institutional segregation of care by insurance type within systems receiving federal funding may be needed. To be sure, modest increases in payments alone will not be sufficient to address the maldistribution of primary care physicians, much less avert a primary care shortage.²⁸

Poor and minority patients are at greater risk for lacking primary care; those with access are more often seen within resource-strapped safety-net practices, such as federally qualified community health centers (FQHCs), hospital clinics, and a small portion of community physicians.^{7,29} Strengthening the primary care safety net is critical to ensuring access after expansion of insurance coverage.

FQHCs are the most important source of primary care for underserved patients, currently serving 20 million patients who are largely minority and of low income.³⁰ FQHCs will likely remain the key source for primary care to underserved groups under health care

reform.³⁰ ACA invests heavily (\$11 billion) in FQHC expansion, potentially doubling the number of patients served. Annual federal loan repayment for physicians working in underserved areas increases to \$50,000 (from \$35,000), part-time practice is now permitted, and teaching time within FQHC is now counted for repayment. Furthermore, ACA supports establishing new teaching health centers and provides new systems of payment for this teaching.

These investments alone are not sufficient to ensure transformation of care within FQHCs. Enhancement in health center financing will be needed to generate an adaptive reserve (ie, capability of practices to implement and sustain change)³¹ to facilitate FQHC practice redesign.³² Federal support is needed to sustain and advance quality improvements previously initiated through the Health Disparities Collaboratives.³³ Innovative training programs are also needed to develop future medical home leaders for the underserved.³⁴

ACA also supports establishment of the community-based Collaborative Care Network Program to support local consortia of health care providers (including health centers) to coordinate and integrate health care services for low-income uninsured and underinsured patients. Potentially, this provision could foster innovative, community-wide solutions for care for underserved patients, including promotion of patient capability.³⁵ Success will depend on the strength of local partnerships and creation of sustainable models of primary care delivery that effectively coordinate use of community resources.

ACA aims to transform health care quality (including primary care) through a series of small but potentially synergistic steps.²⁷ It promotes piloting of new care models, including medical homes, chronic disease management teams, and integration of medical and behavioral health care. State-run health insurance exchanges provide states with the opportunity to establish new primary care models. If successful, these models could reinvigorate primary care while creating systems of care that provide the time, resources, and capability needed to respond to the needs of underserved patients.^{11,36}

The path to transformation will not be easy. As the Patient-Centered Medical Home National Demonstration Project has shown, transformation is a slow, challenging process, requiring high motivation and often external support.³¹ Toward this end, ACA authorizes the creation, but no corresponding funding, for primary care extension programs designed to assist primary care practices in quality improvement.³⁷ Funding for this program is critical if primary care is to take full advantage of reforms. Without buttressing key resources in primary care and addressing adaptive reserve within practices,³⁸ the combined stress of care

for more (newly insured) patients coupled with pressure to transform practice, could undermine patients' care, demoralize primary care clinicians, and hinder progress toward a more equitable system.

HEALTH INFORMATION TECHNOLOGY

Adequate health information technology, including availability of electronic health records (EHRs), is one of the pillars for transforming primary care and improving health care quality and equality.³⁹ Adoption has been relatively slow, but a tipping point may be near. By 2009, 44% of office physicians in the United States reported use of some type of EHRs.⁴⁰ With funding through the American Recovery Reinvestment Act (ARRA) of 2009 (http://www.recovery.gov/About/Pages/The_Act.aspx), physicians and hospitals will receive financial incentives through Medicaid or Medicare for acquiring and engaging in federally defined meaningful use of EHRs. Federal certification of EHR vendors for meaningful use should spur improvements in EHRs.⁴¹ Features, if sufficiently user-friendly, such as patient registries, reminders, decision support, computerized order entry, and electronic prescribing, offer the potential for improving equity through improved tracking, population management, standardization of care, and possibly reduced decision-making bias.⁴² Establishment of regional Health Information Technology Extension programs and Beacon Community Cooperative Agreement programs may further facilitate technology diffusion, infrastructure, and exchange capabilities within regions across the country.

Slower diffusion of this technology to practices serving minority patients, however, could have the unintended consequence of worsening health care disparities by further widening inequalities in resources between providers.⁴³ In addition, powerful incentives may be needed to promote effective information exchange between systems and between patients and providers. Last, in the absence of targeted initiatives, the digital divide in knowledge and access to technology could worsen disparities when practices begin to implement online scheduling, patient portals, and patient health records.⁴⁴

PAYMENT MODELS

New payment models may potentially promote equity by fostering quality improvement, including the development of new care models, such as the patient home, potentially better suited to meet the needs of poor and minority patients.¹¹ Payment systems that reward payment for health care value (ie, better quality relative to cost) rather than volume might produce better alignment between patient needs and resources.

ACA innovations designed to enhance value include allowing providers who are organized as accountable care organizations to share in cost savings, creation of an innovation center within Centers for Medicare and Medicaid Services (CMS), establishment of an independent payment advisory board, reduction in hospital payments for hospital-acquired conditions, and establishment of a national Medicare pilot program to develop and evaluate bundled payments (a type of limited capitation). Provided that bundled payments take into account the greater health care needs of underserved patients and do not penalize safety-net providers,⁴⁵ they offer the potential for promoting equity by redirecting resources to health care value and population health. As with any major reform, however, unintended consequences are possible. Implementation of bundled payments could discourage accountable care organizations from enrolling underserved patients because these organizations may fear potentially higher costs, unless payments take into account patients' social disadvantage in addition to case-mix.⁴⁶ Bundled payments could also undermine the sustainability of small private practices that often provide care to underserved patients in many rural communities.

A NATIONAL HEALTH CARE QUALITY STRATEGY

Equity represents a core dimension of health care quality.⁴⁷ Efforts to promote health care quality offer potential for promoting equity, particularly if efforts include explicit focus on addressing disparities⁴⁸ or produce "zero defects."⁴⁹ ACA directs the Secretary of the Department of Health and Human Services (DHHS) to develop a national quality improvement strategy including selecting and reporting on uniform quality measures by federally sponsored programs. The secretary has charged the Agency for Healthcare Research and Quality (AHRQ) with leading this effort. The appointment of quality improvement maven, Donald Berwick, to lead CMS may further energize health care reforms. ACA calls for equity to be one of the considerations in the development and selection of quality of measures. Improved measurement of quality and equity could focus more attention and resources on addressing health care disparities and aligning resources with needs.

A shift in federal research funding priorities is necessary, however, to fully enable a national strategy to improve health care quality and reduce disparities.⁵⁰ In 2007, the United States spent 4.5% of total health care expenditures on biomedical research, but only 0.1% on health services research.⁵¹ The National Institute of Health (NIH) director, Francis Collins has made research relevant to health reform an NIH priority,⁵²

but this new NIH priority presumably refers mainly to comparative effectiveness research rather than research designed to optimize health care delivery. The ACA has also upgraded the National Center on Minority Health to an NIH institute. Although this change bodes well for improved community-based health disparities research, it is not clear whether it will shift funding toward health care disparities research. A center of innovation will be established within CMS. Even so, developing and implementing a national quality and disparity strategy will require adequate and stable PBRN funding (eg, to support practice facilitators who can boost practices' adaptive reserve), particularly implementation of new care models within safety-net practices.⁵³ Given the growing federal investment in FQHCs and their pivotal role in addressing disparities, research funding is needed to inform optimal care delivery models in these sites.

MONITORING HEALTH CARE DISPARITIES

ACA directs DHHS to evaluate health and health care systems to enhance collection and reporting of health care data by race, ethnicity, sex, primary language, disability, and rural residence. Similar directives are included in EHR meaningful use requirements. Availability of these data will facilitate better assessment and implementation of interventions to address disparities by health plans and hospitals.⁵⁴ ACA directs DHHS to analyze data to detect and monitor trends in health disparities for each federally conducted or supported health care or public health program or activity. These requirements may facilitate greater accountability for assessing and addressing health care disparities within federally sponsored programs. With sufficient commitment from DHHS leadership, this requirement could potentially result in a systematic effort by federally sponsored programs to publicly report on and address health care disparities within their programs. These efforts could be aided by changes in the National Healthcare Quality Report and National Healthcare Disparity reports recommended by the Institute of Medicine.⁵⁵ Included are national priorities in areas of quality and disparities, improved actionability including accountability, and an expanded quality framework that includes the domains of health care access and health care infrastructure required to improve quality and equity. Closing the feedback loop between quality and equity reporting and corrective federal, state, and local policies will be critical given the enormous complexity of reforms.

CONCLUDING THOUGHTS

Health care reforms, many not slated for enactment until 2014, offer an unprecedented opportunity to cre-

ate a more equitable patient-responsive health care system. ACA targets access by expanding insurance coverage and the FQHC safety net. Further legislation will be required to address access for the remaining 23 million uninsured. Other provisions related to costs may improve equity, but trends toward greater patient cost sharing may offset gains unless ways are found to mitigate their impact on low-income persons.

Health reform also offers promise in a number of areas besides system access, including primary care, health information technology, payment reform, a national quality strategy, and disparity monitoring.

Two fundamental challenges lie in the way. The first challenge is aligning health care resources with patients needs. At the level of the patient visit,¹¹ practice,⁷ and hospital,⁹ resources are misaligned.¹² Health care reform takes small steps toward addressing this problem, but trends toward pay for performance and bundled payment could worsen this mismatch if they fail to account for the needs of underserved patients and practices serving them.^{56,57} Ultimately, systems of payments must account for patient morbidity as well as patient complexity,⁵⁸ including contextual capability related to language, culture, health literacy, and disempowerment.

The second challenge relates to revitalization of primary care, particularly for underserved patients. Whether health reform promotes equity may depend partly on how health reforms affect key relationships, not only between clinicians and patients, but also between clinicians and other team members. This means creating systems that provide the time, space, and interpersonal relationships necessary to ensure high quality primary care. It also means creating primary care teams in which all members' experience and training are optimally utilized.⁵⁹ With the diffusion of health information technology and emerging changes in payment, transformation to team-based care may prove to be primary care's greatest challenge. Emerging data suggest that teams improve patients' health status.⁶⁰ Transformation to team care, however, is enormously challenging. Transforming primary care requires not only major changes in medical training⁶¹ but also supportive infrastructure, such as primary care extension programs and learning collaboratives. Federal agencies charged with implementing health reform should take notice.

Assuming health care reforms survive the looming political and legal land mines during the next four years, primary care will likely confront a period of extraordinary change. Success in creating a more equitable and patient-responsive health care system may depend in part on our ability as primary care clinicians to seize these opportunities and champion systems of care responsive to the needs of all patients.

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