A Singular Focus on Insurance Coverage Will Not Lead to Eye Health Equity

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Recently, a Republican congressman during a meeting with his constituents stated, “Nobody dies because they don’t have access to healthcare.”1 Individuals in the audience vehemently refuted this comment, particularly given evidence to the contrary. Since the passage of the Affordable Care Act in 2010, the number of uninsured Americans has decreased by 43% and the health of newly insured nonelderly adults has improved.2 Moreover, young adults with cancer benefited from earlier diagnosis and initiation of the therapy to treat their disease, further supporting the assertion that increased access does indeed save lives.3 Given the predictions of the Congressional Budget Office related to the House of Representatives bill, H.R. 1628, the American Healthcare Act of 2017, it is likely that more patients currently depending on the expansion of Medicaid may be uninsured in the future.4

As ophthalmologists, an early diagnosis of an ocular tumor could save a life; however, more commonly we are faced with preventable ocular diseases such as diabetic retinopathy and glaucoma. Thus, an alternative question may be does improved access to coverage save eyes? In the article by Elam et al,5 available at http://www.aoajournal.org/article/S0161-6420(17)30320-2/fulltext it is uncertain that access to insurance coverage will absolutely position us as providers to prevent blindness.

Elam et al5 assessed the impact of a patient’s ethnicity on the receipt of commonly used tests to diagnosis glaucoma within 15 months of initial diagnosis. The authors, using claims data derived from a large managed care network and Medicaid data from all 50 states and the District of Columbia, reported that Medicaid recipients were less likely to receive a visual field, fundus photography, or ocular imaging compared with those individuals with commercial insurance. Moreover, patients of European ancestry, African ancestry, and Latino/Hispanic ethnicity evidenced odds ratios of 198%, 291%, and 167%, respectively, of not receiving any of these diagnostic tests compared with those with comparable groups on commercial insurance. Given the higher reported rates of blindness related to glaucoma among patients of African ancestry and Latinos/Hispanics, this finding translates into a public health concern.6 If patients are not receiving the necessary tests to diagnose glaucoma, the question arises if the appropriate diagnosis and treatment is initiated in a timely fashion.

Unequal care of patients despite being insured constitutes a call to action for us as eye health professionals. The forecast for coverage is bleak, particularly if 14 million more Americans become uninsured in 2018.7 If we consider for the purposes of this editorial that Medicaid coverage will continue at least in its current state, how should we as a discipline address the discrepancies noted by Elam et al?8 Before contemplating potential solutions, let us first consider additional points about the context of care currently in the United States.

Disparities in health parallel the growth in the economic inequality in the United States, which has deepened in the last 30 years. The prevalence of chronic diseases such as hypertension and diabetes, and life expectancy are inversely related to income. Medicaid, which covers approximately 58 million individuals, has improved access and outcomes for those covered. The Affordable Care Act provided the opportunity to expand coverage to persons with annual incomes at or below 138%. However, as many as 19 states chose not to expand coverage and some providers have chosen not to see Medicaid patients because of low fees.9 Because communities of color have higher rates of Medicaid coverage, it is likely that health disparities related to ethnicity and income will increase. It is also more likely that minority patients have a greater likelihood of losing health coverage over a lifetime.8 Thus, even if care is initiated, there is a strong possibility that there will be interruptions in the continuity of that care.

Although a recent analysis of the contribution of health insurance to ethnic differences in access suggests that disparities in care experienced by Hispanics/Latinos and African Americans could be reduced if insurance coverage were equal across all minority populations,9 there is evidence that equal coverage will not be sufficient. The receipt of minimally invasive hysterectomy was examined among women insured by TRICARE, the insurance coverage for members of the US Armed Services. The investigators noted that minority patients were less likely to undergo minimally invasive hysterectomy versus a total abdominal hysterectomy compared with patients of European ancestry despite every patient in this cohort presenting with the same coverage.10 In yet another study, insured Native Hawaiians and other Pacific Islanders were more likely to report a fair health status compared with reports of higher health status among insured Asian Americans.11 These observations suggest other factors, beyond insurance coverage, are contributing to inequities in care.

For the purpose of this discussion, we will consider 2 categories for proposed solutions: practice and policy. Regarding clinical practice, 3 discussion points to ponder...
are the role of implicit bias, cultural mindfulness education, and provider adherence to evidence-based clinical guidelines. The impact of provider implicit bias has been demonstrated by several investigators, including but not limited to ethnic inequities in referrals for cardiac catheterization and pain management. Unlike other contributors to health inequities, housing and education are more significant. However, implicit bias is malleable, and interventions at the individual and institutional levels are within the control of healthcare providers and administrators. A common intervention is preparing providers to be more culturally mindful when caring for patients from cultures that differ from the provider. This circumstance often occurs, given that only 6% of underrepresented minorities constitute the ranks of ophthalmologists. The benefits of patient–physician ethnic concordance were reported by Saha et al., noting greater patient satisfaction when the ethnicity of the patient and provider was shared. The investigators reported even when ethnic concordance was not present, demonstration of respect for patients, listening to patient’s concerns, and effective communication skills translated into higher levels of patient satisfaction. As efforts to advance workforce diversity continue, supporting educational initiatives related to the role of implicit bias in case delivery and cultural mindfulness is critically important at all stages of training and continuing education of providers. Furthermore, adherence to evidence-based guidelines provides a framework for considering the best approach to the treatment of patients with specific diagnoses. Observing clinical guidelines when caring for patients reduces the subjectivity when providing care and ultimately has the potential of reducing variation in practice. The National Academy of Medicine (NAM) noted that “evidenced-based guidelines are an important foundational element to anchor a population health approach that advances eye and vision health.” Evidenced-based clinical guidelines, justifying key diagnostic tests critical to the diagnosis of glaucoma, are available to guide providers. To what extent they were used in the care of patients analyzed by Elam et al. is unclear.

Finally, changes in health policy provide a structural context for patients that can facilitate access to care or create additional barriers. The requirement of high out-of-pocket payments by patients can reduce the likelihood that key tests are performed. Cost sharing has increased in the last decade and is present in a commonly offered expanded Medicaid option, the silver tier option, which averaged out of pocket expenditures of $1478 in 2016. Such high deductibles, even with subsidies are not affordable for many patients.

Progress on the policy front could be a reality if eye health was considered a population health priority, an objective that is proposed by a recent report published by the NAM. This report provided 9 recommendations, engaging federal agencies, the entire eye care professional community, and communities in strategies to address eye and vision health. Considering issues beyond eye health, in her book, Just Medicine, Matthew suggests a range of interventions to address implicit bias including “anti-implicit bias discrimination” legislation to reset the social norm. Suffice it to say, as evidenced by the work of Elam et al., providing access to insurance coverage is not sufficient. The quality of that coverage must be considered as well as the effectiveness of the treatment provided, the cultural mindfulness of professional staff, adherence of providers to clinical guidelines, and awareness of our own implicit biases as providers. In other words, we do not have to wait for the wheels of legislation to produce the next set of policies that shape healthcare to correct the variation in care. We can strive to deliver the highest quality, equitable care to patients in our practices every day.

References

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