

Racism and the Economy

focus on Health

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Introduction

The archetype of a doctor making house calls has endured in our society, even though the practice has all but vanished, and even our eldest citizens struggle to recall the days when it was in vogue. But its persistence is easy enough to understand. In this ideal type of health care structure, the medical system would be centered around the patient. It would be represented by the doctor who must travel to see the individual who needs care. It would be seen in the doctor who must wait until the patient is available. And it would be embodied by the doctor who accepts whatever amount of payment the patient can afford in whatever form the patient can give.

By contrast, our modern medical system is centered around the health care provider. Patients must schedule appointments according to the doctor's calendar. They must travel from their homes to hospitals and medical offices. They must sit in waiting rooms until the doctor is ready to see them.

This health care structure allows doctors to see more patients by prioritizing the number of patients seen per hour. It also optimizes the physician's time by requiring less traveling. Over the course of a day, a year, and a career, more patients get care. As it matured, this system retained the best interests of patients at its core, as they were still afforded the time believed necessary to address their issues.

But about 30 years ago, the economics of this physician-focused system was disrupted. Reimbursement for physician services began to drive the emphasis further toward greater volumes of patients served, rather than high-quality time spent administering patient care. As reimbursement from payer systems declined per visit, the physician needed to increase visits to maintain the same proportion of revenue for his or her practice. Profit margins quickly became the mantra for practice operations.

It was not long before this spread to hospital operations, disrupting the original "stay in the hospital until you are well" model of care. As volume-driven operations rose, so did errors in delivery of care. This led to a general distrust of physicians and health care systems, as they were viewed more as appointment mills rather than places of comfort and care.

Yet, even though it's a relic of a society that no longer exists, that image of a doctor making house calls has endured across the generations. People desire a health care system that values the quality of care given to each individual patient rather than the quantity of patients who are given baseline care. Patients want to be seen and understood by their health care providers rather than overlooked or allowed to slip through the cracks by a health care system that is stretched too thin. The economic drivers of modern health care clearly are misaligned with this desire.

Our current health care system is centered on a pay-for-service model, where the doctor submits a bill that must be paid – either by the patient or by insurance – regardless of whether the patient improves. Decreased reimbursement to providers increased the incentive to focus on patient visits rather than outcomes. A major downside is that those who don't have insurance or can't afford more than one or two visits often, unfortunately, can't receive adequate care.

To put the patient back at the center of our health care system, we must devise a health care infrastructure that is more accessible – to all patients, regardless of their skin color, where they happen to live, or whether they can afford the cost of insurance or care per visit.

Because of the priorities of our health care structure, inequality is embedded into it. Too often, these inequalities can be broken down by demographics that include both geography and race.

African American individuals and African American communities experience stark disparities in health outcomes. Black women have the highest rates of preterm singleton births, at 11.1%. Black individuals are 30% more likely than white individuals to die from heart disease at an earlier age than expected. Black men are more than twice as likely as white men to die from stroke (The National Academies of Science, Engineering, Medicine, 2017). The list of inequities goes on and on.

While there is no need to revert to a structure oriented around a doctor making house calls, we would be wise to improve the health care patients can receive at home. In addition, we must expand community health programs that are critical for reaching patients and building trust in the health care establishment.

Howard University and Howard University Hospital have overcome skepticism in the medical system to become a trusted health care provider and messenger in the Black community. We must continue to empower highly trusted institutions to provide health care services to more patients in a variety of ways. Partnerships between respected health care institutions and institutions patients look up to – including colleges, churches, community centers, nonprofit organizations – can lead to better health care services and greater trust in the medical system as a whole.

By orienting health care services around the patient, and by bringing providers closer to the spheres patients inhabit every day, we can ensure that patients receive the regular care they need.

How Our Current Health Care System Creates and Exacerbates Health Disparities

A health care system that is centered around providers rather than patients will inevitably privilege the already privileged and suppress the disadvantaged. Nowhere is this clearer than in our nation's capital.

In Washington, Black men have a life expectancy of approximately 30 fewer years than white women (Roberts, 2020), according to data from 2016. This represents the most significant life expectancy disparity in the nation, despite the general affluence that exists within the district. These disparities have eroded the Black community's trust in the medical system. Black adults are 19% less likely to trust doctors, 14% less likely than white adults to trust hospitals, and 11% less likely to trust the health care system (KFF, 2020). This is the result of poor care in the past and a major reason why they are less likely to access care in the future.

It is too simplistic to explain the disparity in life expectancy by citing a disparity in resources, although certainly that is a factor. Clinical care accounts for only 20% of a community's health outcomes; 80% is a result of non-clinical social determinants. For example, in Ward 7 and Ward 8, both of which are predominately Black communities, 52.8% of households are considered "severely cost-burdened," meaning they spend over 50% of their gross income on housing (DC Health, 2018). This and other determinants, including the distance between residents' homes and the offices of their health care providers, restrict residents' ability to access the care they need.

The impact of the resource disparity would be less severe if the health care system were centered around the patient rather than the provider. In our existing structure, Black residents in poorer communities often miss out on care opportunities for numerous reasons. They are unable to find transportation. They are unable to take time off work. They are unable to focus on their own health needs because they are busy taking care of a family member. They are unable to afford the appointment or recommended treatment. Here, again, the list goes on.

As a result of these unjust circumstances, many Black residents in poorer communities will be harmed if they make *any* health care decision. If they choose to take an appointment, they might risk losing their job. If they choose to work to retain their employment, they might not get the care they need. This could allow a critical medical condition to worsen, which could jeopardize their ability to retain their employment.

The Subjugation of Generations of Black Communities through an Unequal Health Care System

Whether intentionally or unintentionally, the health care system has been a tool in the long-term and comprehensive oppression of Black communities for generations. Good health is a prerequisite to economic growth and prosperity. Poor health, on the other hand, places individuals in a cycle to nowhere that traps them – and their descendants – in perpetual poverty.

Individuals who report poor health also tend to report unmet needs in other areas, with food insecurity being the most often cited (McKinsey, 2019). Many of the drivers of poor health care outcomes begin in areas outside of health care. For example, food deserts make it difficult to access

nutritious foods. Poor compensation leads to housing inequities and forces people to reshuffle priorities to put a roof over their heads, rather than visit a physician for regular health maintenance. As such, many people in poverty delay care until it becomes an absolute necessity. Poor nutrition and a chronic health condition combined with difficulty accessing health care services creates the downward spiral that drives shorter lifespans.

Recent emphasis on housing discrimination has revealed how redlining practices by government and local communities forced Black individuals out of their homes – properties that would subsequently increase in value with white owners. Wealth that should have been in the hands of Black families was unjustly transferred to white individuals, thanks to discriminatory and racist practices. These acts did not have isolated impacts. Black families that could have generated tremendous wealth from their increasing property value instead were relegated to generations of poverty (Rothstein, 2017).

Health care has a similar narrative. An individual who can't access the health care they need will also see their educational and employment opportunities limited and their earning potential reduced. As a result, any children this individual has would experience similarly reduced educational opportunities, which would constrain employment prospects. And the absence of generational wealth passed from one family member to the next would further restrict opportunities to advance educationally or economically (Weller, Roberts, 2021).

In under-resourced Black communities, current poor health often abets ongoing and future poor health. Having an untreated health condition can also lead to poor nutrition and high stress, as well as hypertension, diabetes, and more. Poor health often forces individuals to live in substandard housing, which worsens their health and adds further complications.

We cannot address any of these issues – health, economic, and educational – without addressing them simultaneously. We cannot hope to improve the economic prospects of Black communities if we are not also improving their health and educational prospects. We cannot improve their educational opportunities if we do not improve the health and economic conditions that enable them to pursue an education. And we cannot improve their health outcomes if we do not support their economic and educational needs.

The following are policy proposals that promote a patient-centered health care system. They promise to dramatically improve health outcomes for Black patients and reduce disparities experienced by Black communities:

1. Deploy midlevel health care providers into communities to identify and assist those most at risk.

Residents of majority-Black, under-resourced communities need greater access to health care providers. The best way to increase access is to send more midlevel providers, like nurse

practitioners and physician assistants, into communities to engage them where they live. These providers can go into churches, corner stores, community centers, pharmacies, and more to conduct screenings, take a patient's blood pressure, and conduct other critical preventive care measures. By involving cornerstones of the community, and by partnering with trusted community messengers and institutions like Howard University, these health care providers will be trusted and perceived to be acting in goodwill and with the best interests of the community members at their core.

Preventive health care is essential for all people, but especially those in underprivileged communities. When health problems are identified early, the outcomes often can be significantly improved. We must address problems like hypertension, malnutrition, and diabetes at the source so we can reduce hospitalizations and prevent patients from losing time when they could otherwise be at work.

2. Deploy a network of mobile health units to deliver primary care within communities.

If patients can't come to their doctors on their own, we must either bring the providers to the people or provide transportation for the patient. Mobile health units are a proven method to increase access for low-income communities to essential health care services. In addition, going into communities with the support and assistance of trusted community leaders and organizations increases the confidence patients develop in health care providers. These efforts demonstrate that the health care system cares deeply about patient needs and health.

Mobile units have been particularly effective in screening patients for cancer, diabetes, and hypertension, three of the nation's largest contributors to death. Early detection often leads to earlier treatment and improved outcomes. Research indicates that mobile health units improve community health by reducing emergency department visits, lowering hospital readmission rates, and increasing the proportion of patients who report better health (Heath, 2018).

3. Build a national telemedicine network so people can be consistently monitored by a physician, receive health advice, or be given a referral to an accessible location.

Telemedicine is the modern-day version of a doctor making house calls. Patients encounter fewer challenges seeing a provider when they can see them from the comfort of their own home. Receiving care via telemedicine is less likely to take up critical time for the patient when they don't have to travel or wait as long to be seen. Patients may also be more comfortable and more forthcoming when they speak with health care providers from the familiar surroundings of their own homes.

Of course, even access to telemedicine is easier for those with means. Across the country, 34% of Black adults do not have at-home broadband access (Joint Center, 2020), which makes telemedicine an unattainable health care delivery method. In fact, telemedicine disparities are often like in-person health care access disparities (Chunara et. al., 2020). Most wearable and in-home devices require at least 50 megabytes of bandwidth to transmit data from patient to provider. Even this small access point is an expense that many poor families can't afford.

A national telemedicine network could connect communities over wireless and wired access points with enough bandwidth to transmit and receive data.

Building such a network would allow a distributed backbone of medical teams (pharmacists, nurses, physicians, and physician extenders) to collectively diagnose and monitor interventions and identify risks and therapies for any patient. Additionally, such a network would not be as constrained by time of day. Central electronic medical records would allow providers instant access to medical and historical data for patient management. A well-coordinated team would require less intensive use of a single physician provider. With an integrated “virtual” team, providers could offer expert consultations that may otherwise not be available at small local practices. A library of current and cutting-edge treatments could deliver the right information on time and tailored to a specific patient.

To improve telemedicine as a viable option for individuals in lower-resourced Black communities, we need legislation to increase internet access for these individuals. Institutions and governing bodies must partner with internet providers to institute minimum bandwidth standards and make internet access a universal right rather than a privilege.

4. Deliver food to communities that have limited access to fresh and healthy options. Libraries and community centers can serve as ordering and pickup points, making this structure less expensive than trying to build food stores to scale.

In predominantly Black Ward 7 and Ward 8 in Washington, there were only three full-service grocery stores in 2020, down from six a decade earlier. Meanwhile, other wards in the District average six full-service grocery stores, and some in the more affluent areas even have more than 10.

The lack of access to high-quality food contributes to food insecurity and malnutrition among Washington’s predominately Black communities. Short of building new grocery stores, which is expensive and time-consuming, we must create programs where Black residents can have nutritious food delivered to their homes or to convenient locations.

Amazon has been a disruptor in the goods space by eliminating the overhead of brick and mortar and inventory and coupling it with a rapid delivery system. While adopting a complete “Amazon” method may hurt small businesses, having an “Amazon”-like network of small community grocer affiliates could take advantage of lower overhead costs and improved inventory management.

Affordable, fair contracts between these grocers and a large vendor (Giant, Amazon/Whole Foods, etc.) could allow the community to grow and thrive while keeping its identity. Incentives for large companies who would partner with these small vendors would drive competition to further reduce costs.

5. Remove barriers to health care access by building a transportation network to bring people to places of care. Uber and Lyft models can be widely used to take patients to and from care sites.

We must remove transportation as a barrier to care. We cannot expect people in Black communities to endure long commutes, often on multiple modes of transportation, simply to gain access to care. Lowering travel time is particularly important for residents whose employment does not allow for sick hours or other paid time off without threatening job security. Long commutes or limited access to transportation puts those who need regular monitoring and treatment at particularly high risk of diminished care.

We must make transportation to and from providers easier for those who require medical attention in health care offices. We need to build robust community programs that include transportation shuttles and individual pick-up options for those in need.

There is strong evidence that Lyft is improving health care access for minority communities. According to a report of 11,400 people who used the service for health care purposes in 2018 and 2019, there was a 40% decrease in emergency room usage and a 12% decrease in ambulance usage (Lyft, 2020)

6. Increase the minimum wage and scale it to match inflation and the local cost of living, including housing, food, and reasonable transportation. Structure employment contracts to guarantee employees can receive health care without compromising their employment status.

People in Black communities must be able to earn a wage that meets their needs. If the costs of accessing care in their communities are higher, then we need a government program that bridges the gap between what they earn and what they need.

A policy that ties wages to a realistic cost-of-living model that is tiered so a lower wage earner has larger cost-of-living increases can provide an avenue toward more affordable housing and food. In other words, a 3% cost of living adjustment may be reasonable for most jobs, but for the severely disadvantaged, a 5%-7% change is needed just to keep up. The indices we use are not usually tiered by socioeconomic gradients.

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