

Patients, Doctors Affect Health Care Disparity

BY RICHARD HYER

EXPERT ANALYSIS FROM A SYMPOSIUM
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RHEUMATOLOGY

CHICAGO — Health care disparity in rheumatic disease stems from multiple sources, not just the patient's race or the physician's bias.

Disease incidence and prevalence, access to care, choice of provider and health system, and individual patient preferences can all contribute to disparity, said Dr. Agustin Escalante, professor of medicine and clinical immunology at the University of Texas Health Science Center in San Antonio. Besides, concepts of race are often invalid.

"The traditional concept of race assumes or proposes a small number of defined groups (whites, blacks, Asians, among others) but in fact you don't have the discrete groups the traditional concept assumes," said Dr. Escalante.

Hispanics, for example, may have European, Asian, or African ancestry, with disease consequences. A 2003 study found the risk of systemic lupus erythematosus in a Caribbean population to be associated with West African admixture (*Hum. Genet.* 2003;112:310-8).

As to physician bias, "nobody goes into medical school to set up an apartheid system in their clinics," said Dr. Escalante. But bias can still creep in.

A 1999 study used actors of different races and sexes to portray patients with cardiac and noncardiac chest pain and found that women and African-Americans were less likely than white males to be referred for catheterization (*N. Engl. J. Med.* 1999;340:618-26).

Alternatively, health disparity can simply be a matter of access to care. If a local physician does not accept Medicaid, the patient may have to travel a distance to find one who does. Insurance may likewise have an impact. A study of patients with rheumatoid arthritis found that those in an HMO were significantly less likely to receive anti-tumor necrosis factor agents than were those who had fee-for-service policies (*Arthritis Rheum.* 2005;53:423-30).

Language may also have an impact on disparity. A study of pain in the emergency department found that Hispanics

were much less likely to receive analgesics than were whites after long-bone fractures (*Pain Manag. Nurs.* 2008;9:26-32).

"If the patient doesn't speak English and the doctor is uncertain what's going on with them, it will take longer to decide," said Dr. Escalante.

But the main source of health disparity, according to Dr. Escalante, is patient preference and willingness or unwillingness to receive treatment. A 1995 study found that blacks were half as likely to receive hip replacements as were whites, and Hispanics were one-seventh as likely, despite all patients' being insured with Medicaid (*Ann. Rheum. Dis.* 1995;54:107-10). A study of referrals found that patients were referred irrespective of race (*Arthritis Rheum.* 2009;61:1677-85).

A study of preferences for joint replacement for knee arthritis found that for those with severe arthritis, more whites and Hispanics chose total knee arthroplasty than did blacks, by far (*J. Clin. Epidemiol.* 2006;59:1078-86).

Knowledge was not necessarily a factor: When asked whether they had heard of the procedure before, 100% of whites said yes, compared with 90% of blacks and 80% of Hispanics (*Arch. Intern. Med.* 2005;165:1117-24).

"Studies have shown that African-Americans tend to be more fearful of the complications of total knee replacement, and they tend to underestimate the benefits," said Dr. Escalante.

Dr. Escalante concluded by saying that the simplest way to think about cultural competency is language. Symposium chair Dr. John J. Cush, professor of medicine and rheumatology at Baylor University Medical Center, Houston, asked what one bit of advice he would give the audience.

"Everybody could learn Spanish," said Dr. Escalante. ■

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Pay Increased for DXA

Starting June 1, Medicare is increasing payments for dual-energy x-ray absorptiometry services. With the increase, DXA payments will be slightly less than 70% of what they were in 2006, when Congress first mandated payment cuts. The current increase is required under the recently enacted Patient Protection and Affordable Care Act. The act increased payments for 2010 and 2011 and called for a study of the impact of past payment reductions. Officials at the Centers for Medicare and Medicaid Services said that procedures performed between Jan. 1 and May 31, 2010, will be retroactively paid at the higher rates, but details on handling those claims are still being worked out, according to the American College of Rheumatology. The college, which praised the increased DXA payment, estimates that the nonfacility fee for CPT code 77080 will rise from the current \$45.21 to \$97.92. The same service was paid at \$143.32 in 2006.

Osteoporosis Screening Increases

The percentage of women aged 65 and older who are being screened for osteoporosis has risen dramatically, from 34% to 64% in 2001-2006, according to new data from the Agency for Healthcare Research and Quality. The increase occurred among all racial, ethnic, and income groups. However, the rise was the most pronounced among white and Hispanic women. Black women on Medicare had a screening increase from 16% to 38%.

Women Hear More About Lupus

Efforts to educate women about lupus through the media may be working, according to the results of a survey commissioned by the Ad Council and the Department of Health and Human Services. In an online survey of more than 400 women without lupus (aged 18-44 years) 15% said they had recently heard, seen, or read something about lupus, compared with 10% in 2009. Officials at the Ad Council and HHS have been working to raise awareness of lupus among young, minority women for the past year. "When we started this campaign, we faced a very limited awareness and knowledge about lupus among women at greatest risk," Frances E. Ashe-Goins, acting director of the Office on Women's Health at HHS, said in a statement.

NIH OKs 13 Stem Cell Lines

Officials at the National Institutes of Health have approved an additional 13 human embryonic stem cell lines for federal funding. The lines have also been added to the NIH Stem Cell Registry. The registry now includes 64 stem cell lines that are eligible for fed-

eral funding. Another 100 lines are pending approval at NIH. Four of the recently approved stem cell lines were originally approved under the Bush administration, and two of them were widely used by researchers over the years, said the NIH. NIH Director Francis S. Collins said the approval of these older lines should provide reassurance to researchers who have been working with lines developed earlier. "Scientists can continue their studies without interruption, and we can all be assured that valuable work will not be lost," Dr. Collins said in a statement. In March 2009, President Obama issued an executive order removing some previous barriers to federal funding of stem cell research.

Providers Asked to Find 'Bad Ads'

The FDA has launched a program to get health care providers to detect and report misleading drug ads. The "Bad Ad" program seeks to educate health care providers about their role in ensuring that prescription drug advertising is truthful and not misleading, the agency said. Initially, FDA officials will meet with providers at selected medical conventions and will partner with a handful of medical groups to distribute educational materials. The agency said it will then expand its collaborations with medical societies. The announcement encouraged health care professionals to report any potential violation in drug promotion by sending an e-mail to badad@fda.gov. Reports can be submitted anonymously, but the FDA is asking providers to include contact information so that staff members can follow up.

Health Information Grants Set

Fifteen communities are splitting about \$220 million in grant money from the DHHS to build their health information technology infrastructures and capabilities. The Beacon Community grants provide funding to "communities at the cutting edge of electronic health record adoption and health information exchange," the HHS said. For example, Delta Health Alliance in Stoneville, Miss., received about \$14 million to electronically link systems for care management, medication therapy, and patient education in diabetes, whereas the Indiana Health Information Exchange in Indianapolis—the largest health information exchange in the country—received about \$16 million to improve cholesterol and blood sugar control in diabetic patients and to reduce hospital readmissions through telemonitoring. The program is intended to demonstrate the advantages of health information technology to other communities.

—Mary Ellen Schneider

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