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The Double Whammy of Chronic Illness in Underserved Populations: Can We Afford Not to Care?

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"If a free society cannot help the many who are poor, it cannot save the few who are rich." -- John F. Kennedy (1961 Presidential inaugural speech)

The American health system has developed and evolved mainly in response to the needs of caring for acute illnesses, or for acute exacerbation of chronic illnesses. However, over 100 million Americans have a chronic medical condition, and it is projected that by 2020, 134 million people will suffer from a chronic illness.[1] Forty-four percent of these individuals will have multiple chronic conditions. It is also estimated that by 2020, 1 in 6 Americans over age 65 will become limited by chronic conditions.[1]

Currently, 70% of direct medical costs can be attributed to chronic illnesses, and 4 chronic conditions (cardiovascular disease, cancer, chronic obstructive pulmonary disease, and diabetes) cause 75% of all deaths in the United States. Despite the impact of these illnesses, the rates of good hypertension and diabetes control, adherence to lipid management guidelines, and normal weight maintenance are abysmally low.[1-3]

Even though the statistics related to chronic illness are daunting, the US healthcare system has been slow to espouse a system of care focused more on helping patients prevent and manage chronic conditions, in order to improve outcomes and reduce costs. The aging of the population, combined with the (literally) growing epidemic of obesity and its fearsome cascade of increased diabetes, hypertension, and cardiovascular morbidity and mortality, demands the redesign of our health system to better help patients manage their chronic illnesses.[4] The impressive technological advances of the past several decades will not be enough to adequately address the needs of an increasing number of chronically ill individuals.

During this year's National Public Health Week, which focuses on disparity, it is important for healthcare providers, administrators, and community and national leaders to publicly recognize the dirty little secret that is finally catching the attention of mainstream America: Poor, medically underserved, and minority patients experience significantly worse health outcomes than those with higher socioeconomic status, health insurance, or white race.

We now have significant amounts of data to show that not only are we failing in our efforts to prevent or optimally manage chronic illness, but that there is also a growing chasm in the care provided and the outcomes achieved among different socioeconomic and ethnic groups. Evidence of health disparities abound; 51% of Hispanics and 46% of blacks over the age of 55 years are limited by chronic illnesses, compared with 23% of whites. Hispanics, blacks, and other minorities are 2.5 to 3 times more likely to have no medical insurance, compared with whites.[1] It has been well documented that individuals without insurance receive less preventive care, are less likely to have a regular source of care, present later in the stage of an illness, are more likely to have emergency admissions to hospitals, and have a higher mortality rate once admitted than do those with insurance.[5,6]

With or without insurance, the situation is worse for the poor and near-poor. One third of people who live at or below the poverty level, and one fourth of those below 200% of poverty level, lack insurance, compared with only 8.4% of people with a family income greater than 200% of poverty level.[1] It is not surprising that poor and near-poor patients have been shown to receive less

prenatal care, have lower vaccination and higher infant mortality rates, and have a higher incidence of and worse outcomes associated with chronic illness. The poor are 3 times more likely to be limited by a chronic illness than are their nonpoor counterparts.[1]

Although having private insurance can increase access and improve outcomes, those interested in truly redesigning systems to significantly improve health outcomes for the US population must consider multiple other barriers that poverty may bring to bear on those within its grasp:

- **Access to healthcare providers:** Rising copayment amounts may limit utilization, and many communities have few physicians who will accept Medicaid and Medicare reimbursements.
- **Access to medications:** Annual pharmaceutical price increases have averaged over 15% in the past decade. Even those with insurance that covers prescription medications are paying a higher percentage of drug costs.
- **Access to exercise:** Urban or rural areas may not have suitable environments, and paying for private health clubs is not an option.
- **Access to proper diet:** Nutritious food costs more than junk food and may not be readily available, either geographically or financially.
- **Access to information:** Low literacy and lack of computer access and training may make patient self-management of chronic illness more problematic.
- **Access to transportation:** The rural poor especially may face significant problems reaching distant providers.

While millions of underserved patients receive suboptimal care that results in poor health outcomes, the medical divide continues to grow. The advent of "concierge medicine" takes the inequity a step further. A typical concierge practitioner may charge $1500 per month, simply for a guarantee of 24-hour access for visits, rapid access to highly rated specialists, and, in some cases, limousine service to and from the site of care. For-profit management companies organize concierge practices for a 33% cut of the total fees. Therefore, a physician with a practice panel of 600 patients might expect $900,000 in concierge fees alone (in addition to regularly billed medical services), of which $300,000 would go to the management group.[7] There is no clearer example of large financial resources being siphoned off for administrative functions rather than being invested in preventing and treating those most at risk for multiple chronic illnesses.

Concierge medicine is not necessarily the cause of this chasm but rather is a symptom of a system that is broken, prodding those with financial resources to leapfrog to a more accessible and luxurious level of care. However, the consequences of the current health system failure fall squarely on the shoulders of those least able to adapt and cope. Until we advocate for and achieve structural changes at the heart of healthcare delivery, the health of our nation, particularly those most at risk, will continue to suffer. We will all continue to pay the price of a broken system -- increased morbidity and mortality of our citizens, greater financial costs, lost productivity, and an overall decreased quality of life for our country as a whole.

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