

Advancing Health Equity by Increasing Access to High-Value Care

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Advancing health equity—ensuring all Americans have the opportunity for good health—is an important policy objective that supports both social justice and economic growth. Differences in the physical and social environments in which people live and in access to health care mean that people of color and those of lower socioeconomic status (SES) on average have poorer overall health, greater prevalence of disease, and lower life expectancy than their higher-income, non-Hispanic White counterparts. The COVID-19 pandemic provides sobering evidence of differences in access to care and life circumstances leading to different health outcomes. The virus is taking a [disproportionately deadly toll](#) on Black and Hispanic/Latino Americans, communities that have traditionally faced challenging environments and structural conditions that have led to less wealth, less opportunity, and poorer health.

Expanding access to health care is an important strategy in advancing health equity; however, a large body of work has established that not all health care that is routinely provided improves health outcomes. We define [low-value care](#) as those health care services that provide little to no benefit to patients, have the potential to cause harm to patients, incur unnecessary cost to patients, or waste limited health care resources. In this paper, we argue that the burdens of low-value care may be especially high for currently underserved populations, and that efforts to increase access to care and advance health equity will be most effective when done with attention to promoting high value and minimizing low-value care.

CURRENT DISPARITIES IN HEALTH CARE ACCESS AND QUALITY

Equal opportunity for good health is a mark of social justice. It is also increasingly important to economic growth, as those population groups with greater health challenges are also the fastest growing and will make up the majority of the country's workforce within a generation.

To reduce disparities in health outcomes, we must reduce disparities in factors that impact health. One such factor is access to health care. While the Affordable Care Act reduced disparities in insurance coverage, populations of color and those of lower SES are still more likely to lack financial access to care. Nationally, the [uninsured rate](#) for those under age 65 is 7.8% for Whites compared to 11.4% for Blacks, 20% for Hispanics, and 21.7% for American Indian/Alaskan Natives. Likewise, Americans of lower SES are more likely to be uninsured, with nearly one-quarter, [23.9%](#), of low-income non-elderly adults (those making under 200% of the federal poverty level) lacking health insurance, compared to [12.9%](#) of all non-elderly adults.

People of color and those of lower SES are more likely to forego care due to financial concerns and less likely to have a usual source of care. Among adults in the U.S., 18.7% of Whites, 22.7% of Blacks, 39% of Hispanics, 24.6% of Asian/Native Hawaiian/Pacific Islander, and 27.8% of American Indian/Alaska Native [do not have a regular physician](#) or health care provider. Similarly, 10.9% of White, 15.7% of Black, and 21% of Hispanic adults report [not seeing a doctor](#) in the past year because of the cost.

Even when there is access to the health care system, studies continue to show systematic differences in the quality of care delivered to people of color. The [2018 National Healthcare Quality and Disparities Report](#) examined a range of health care quality measures by race and ethnicity and found that Blacks, American Indians and Alaskan Natives, and Native Hawaiians/Pacific Islanders received lower quality care than Whites for about 40 percent of the quality measures examined, while Hispanics received poorer quality care for about 35 percent of the quality measures.

THE BURDEN OF LOW-VALUE CARE IN THE CONTEXT OF HEALTH EQUITY

Low-value care is a burden to all patients in time, risk, and resources, but the price tag may be especially high for those who already have less opportunity for good health. In addition to the burdens and risks to individuals, low-value care creates systemic costs and resource tradeoffs.

LOST TIME AND CHALLENGES WITH TRANSPORTATION

Individually, the burden of lost time and the inconvenience of traveling to receive care may be especially high for lower SES patients who are disproportionately people of color. For those working hourly jobs with less flexibility, time spent traveling to and from receiving care may mean lost work time and lost income. For those with responsibilities in the home and fewer financial or family resources, child care arrangements may be challenging. Transportation to and from an appointment may also be a challenge. The risk of adverse outcomes from low-value care or the risk of false positives from low-value diagnostic procedures (which lead to additional burdens of cost and stress) are again more impactful for those who have less flexibility and fewer resources and social supports. Individuals and families incur these burdens and risks without an associated benefit when the care does not contribute meaningfully to better health.

FINANCIAL BURDEN

Of course, low-value care can also represent a financial burden to individuals. For those without health care coverage, any health care is a financial burden. Even for patients with health insurance, many will face significant out-of-pocket costs, whether under cost sharing provisions or in meeting a high deductible.

Systemically, spending on low-value care uses health care resources that are then not available for higher value services, including not only financial resources but health workforce and facilities resources which may be in short supply in underserved communities. Where health care budgets are limited, such as state Medicaid spending, higher spending per person may lead to tradeoffs such as reduced coverage or lower reimbursement rates.

TRADEOFFS

Spending on low-value care by public or private insurers also creates tradeoffs between health spending and non-health priorities. In a private insurance environment, higher spending translates into higher insurance premiums (or less generous coverage). Higher premiums paid by employers are a part of employee compensation that is not taken home in wages. In a publicly funded environment, the more that is spent on health care, the less that is available to fund other priorities such as social services, education or infrastructure—investments that may actually have a larger beneficial impact on lifetime health. Finally, lowering the cost of care by reducing low-value care also lowers the price tag for expanding coverage, increasing the number of people who can be covered or making it politically more feasible.

EROSION OF TRUST

Apart from economic or budgetary impacts, the provision of low-value care may erode trust in providers and the medical care system. Lack of trust may discourage patients from seeking needed care or lower patient compliance with important, high-value treatment. Trust and respect between the provider and patient plays an important role in the health care outcome and likely contributes to health disparities. For decades, researchers have measured patients' [trust in their physicians](#) and the impact it has on adherence to medical advice and compliance. A recent [meta-analysis](#) across multiple clinical settings and multiple countries found that when patients had higher levels of trust in their health care professional, they reported greater satisfaction with their treatment, exhibited healthier behaviors, had fewer symptoms, and experienced a higher quality of life. Patterns of trust across different components of the health care system vary by race. In research by [Boulware and colleagues](#), non-Hispanic Blacks were less likely to trust their physicians than non-Hispanic Whites, and non-Hispanic Blacks were more concerned about their personal privacy and potential for harmful experimentation in hospitals compared to their non-Hispanic White counterparts.

EVIDENCE IS MIXED ON LOW-VALUE CARE TO DISADVANTAGED POPULATIONS

We know there are challenges to accessing health care, accessing quality health care, and trust in providers for patients in groups that have been marginalized, but what is less clear is the relationship between race, ethnicity, or SES and the likelihood of receiving both low-value care and high-value care. Where there is access to care, do patients in these groups tend to receive more or less low-value or high-value health care?

There are mixed findings when it comes to our current understanding of the intersection of patients of color, disparities in health and health care, and the incidence of low-value and high-value care. It stands to reason that if patients of color do not receive health care services at the same rate as their white counterparts, they should also not receive as much low-value care (and, arguably, not as much high-value care either). Indeed, research by [Reid and colleagues](#) examining a large, commercially insured population found that low-value care spending was lower among non-Whites and lower income patients, possibly due to these groups experiencing underuse of health care services overall.

However, research conducted by [Schpero and colleagues](#) using Medicare data revealed that Black and Hispanic beneficiaries were actually more likely to receive low-value care for certain services than Whites. For example, after adjusting for covariates, the odds of a Black beneficiary with dementia receiving a feeding tube were 2.6 times greater than the odds of a White beneficiary receiving that same service. Similarly, Hispanic beneficiaries with dementia were 1.6 times more likely to receive a feeding tube compared to Whites.

These and other mixed findings to date point to a more complex and multi-dimensional answer to the question of low-value care being provided to currently underserved populations. It may be that the likelihood of low-value care provision depends on the patient's health care coverage in the context of the provider's payer mix, the type of care being provided, the capacity of the provider at the time, and other factors. We cannot automatically conclude that less care corresponds to less low-value care, nor can we conclude in all cases that there is considerable spending on low-value care to underserved populations that could be recovered or redirected.

CONCLUSIONS

There is much that cannot be predicted about an individual's response to a disease or to a treatment, and the value of care provided may be clear only in retrospect. Nevertheless, the costs to patients and society and the outsized share of our national resources going toward health care argue for doing the hard work of identifying and reducing spending that does not improve our health. There is an especially heavy low-value care burden in the context of health equity, which includes limited resources, competing priorities, and the need to overcome mistrust in the medical care system.

There are questions that policy makers and researchers can investigate to drive a more comprehensive research agenda to fill in the gaps of knowledge that currently exist. These questions should include:

- How much low-value care is currently being provided now to underserved populations and can it be reduced, freeing up resources for more high-value care?
- What do those resources represent in terms of the potential to be redeployed to cover more care or more people or to incentivize high-value care?
- How do levels and trends in low-value differ by population group (e.g., the uninsured; Medicaid or low income; Black, Hispanic, other race/ethnicities; Tribal communities; LGBTQ+)?
- How do physician characteristics, payer mix, and patient trust influence the level of low-value provided?

Answering these and other research questions through greater tracking and more study of the prevalence of low-value and high-value care for underserved and marginalized groups will better inform efforts to leverage limited resources to increase access and improve health. In this way, a better understanding of low-value care can also support greater health equity.



ABOUT US

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