

Inequitable Funding May Cause Health Care Disparities

Of all the forms of inequality, injustice in health care is the most shocking and inhuman.

Martin Luther King, Jr.¹

A LANDMARK SUPREME COURT RULING, THE Civil Rights Act, and Medicare legislation in the early 1960s led to the coerced integration of American hospitals in cities with substantial minority populations.² After 1965, hospitals had to accept both Medicare and nonpaying minority patients. As a result, hospitals in geographic areas with substantial low-income minority populations became increasingly financially disadvantaged in subsequent years. Many hospitals eventually left inner-city areas because high numbers of uninsured and underinsured patients made these hospitals economically unviable. Similarly, primary care providers and clinics have fled low-income inner-city areas for suburban areas with better payer mix and fewer minority patients. Hospitals and clinics have found that geography determines profitability. As a result, in many communities, hospital segregation has recurred along socioeconomic lines. This important study by Hasnain-Wynia et al³ in this issue of the *Archives* raises the simple

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question: Do minority patients sometimes receive lower quality hospital care because of differential treatment by individual providers or because the hospitals that serve minority patients are less capable?

This study's findings demonstrate that most disparities in the quality of hospital care depend on where you seek care, not on your race/ethnicity. The authors demonstrate that minority patients who received lower quality hospital care were more likely to have visited lower performing providers that treat everyone equally poorly regardless of race/ethnicity.³ These findings are consistent with previous studies showing higher mortality in for-profit and public hospitals than in nonprofit and major teaching hospitals.^{4,5}

One encouraging finding of the current study is that disparities in hospital care were generally minor. There were several areas in which minority patients received higher quality care. Specifically, minority patients with acute myocardial infarction and congestive heart failure were more likely to receive needed angiotensin-converting enzyme inhibitors than were other patients. Even when adjustments were made for hospital and patient characteristics, minority patients were signifi-

cantly more likely to receive both aspirin on arrival at the hospital for acute myocardial infarction and angiotensin-converting enzyme inhibitors for congestive heart failure, the 2 therapies most likely of all those considered to promote survival. It is reassuring to discover that for many important hospital quality measures minority patients are not disadvantaged.

The authors find the largest racial/ethnic disparities in documentation of smoking-cessation counseling and hospital discharge instructions to patients with congestive heart failure. Hospitals serving mostly minority patients generally did a much poorer job of documentation in these areas.³ It is critical to identify the underlying reasons for these disparities in hospital discharge and counseling documentation measures between hospitals serving predominantly white patients or minorities. Why is where you seek care the major factor causing these racial/ethnic disparities in hospital care?

Perhaps better-resourced hospitals simply have more money and time to devote to the detailed documentation of smoking counseling and hospital discharge instructions necessitated by new documentation requirements. This hypothesis merits further study. In most hospitals nurses, not physicians, are responsible for documentation of counseling and for hospital discharge instructions. As the authors note, "nurse-patient ratios, size, and funding of quality improvement activities"^{3(p1233)} may have determined performance on the counseling measures. This interpretation is strongly supported by the finding that the observed disparities in the counseling measures were almost entirely eliminated with adjustments for hospital effect.³

Many of the wealthier teaching hospitals studied had strong incentives to improve performance on these indicators because they were simultaneously participating in the Centers for Medicare & Medicaid Services Premier Hospital Quality Incentive Demonstration, which used the same Hospital Quality Alliance indicators to give bonus payments to the top-performing hospitals.⁶ Under this national demonstration, poorer public hospitals, with lower baseline performance and fewer resources to devote to documentation, had less likelihood of entering the top 20% of hospitals eligible for bonuses and were essentially only eligible for avoidance of penalties in the third year of the project if they demonstrated improvement. Most large minority-serving public hospitals did not participate in the demonstration.

The hospital members of the University HealthSystem Consortium with the highest percentage of minority patients and the poorest performance are largely pub-

lic teaching hospitals characterized by nurse staffing shortages, inadequate budgets, lack of technical support such as health information systems, and lack of capital.^{7,8} Public hospitals have much lower revenues than other hospitals and depend on Medicare's disproportionate share payments and other state and federal subsidies.^{9,10} For-profit hospitals serve fewer low-income minority patients, charge more per admission, collect more for every patient, and spend more on administration and documentation.¹¹ It should come as no surprise that poorer public teaching hospitals underperform on measures that depend on administrative and documentation efforts.

In addition, the investigators found that hospitals serving mostly minority patients were less successful in providing antibiotic therapy for pneumonia within 8 hours of arrival at the hospital. This finding is likely attributable to the emergency department overcrowding in urban hospitals that serve low-income minority populations. Emergency department overcrowding is a direct result of poor access to primary care in low-income urban areas. Paradoxically, improving access to primary care may prove to be the most effective strategy to eliminate disparities in hospital care for pneumonia.

This research has profound implications for hospital payment policy. Pay-for-performance strategies that simply pay for static high levels of performance or that require substantial documentation efforts could undermine our struggling safety net institutions.¹² Some authors advocate targeted funding for poorer hospitals to reduce disparities in the quality of care.¹³ Similarly, a more equitable hospital payment system could help correct disparities and encourage true competition on the basis of quality. Equitable pay-for-performance models should give providers in disadvantaged areas incentives to improve quality metrics. Emphasizing pay for improvement rather than just pay for performance will likely prove equally as important for primary care providers as it is for hospitals.

This study has 3 major limitations. First, the reasons for disparities in quality may vary with the service being provided. As the authors suggest: "Some services may be of low quality because of where they are provided and others because of bias, racism, or difficulties with intercultural communication."^{3(p1233)} Second, the Hospital Quality Alliance measures consider only a few dimensions in the entire spectrum of quality and results might differ substantially for measures not studied here. For example, hospitals serving lower income minority patients may provide higher quality hospital discharge planning for patients with complicated social needs, and wealthier and for-profit hospitals may perform poorly on efficiency measures and rates of unnecessary procedures. Third, the authors had limited ability to adjust for differences in patient characteristics. Patient socioeconomic status and educational level could also affect the quality of care because well-educated patients may demand more testing or timely care. Future studies should seek to overcome these limitations.

The authors use strong language to attribute differences in quality of care received by minorities to lower quality hospitals and providers in the areas where minorities live, as do Baicker et al^{14,15} in their seminal stud-

ies on the effect of race/ethnicity and geography on disparities in care. This causal inference may be unjustified. The authors recognize that "these same hospitals may have providers who are hardworking and efficient, providing care with fewer resources to more disadvantaged patients."^{3(p1233)} Minority physicians are more likely to serve disadvantaged minority populations.¹⁶ Are these minority providers necessarily of lower quality? The less pejorative term the authors use, "lower-performing hospitals," may be more appropriate.

Future studies should consider whether disparities in the counseling measures of hospital quality are the result of differences in documentation, and the root causes of these differences should be evaluated. They should consider the effects of transfers of care between inpatient and outpatient settings and whether the quality of hospital discharge instructions varies within a hospital depending on who manages the patient: a teaching service, hospitalist service, or private physicians. Studies should determine whether disparities in ambulatory care are similarly accounted for by where you seek care rather than by your race/ethnicity. If this is the case, equitable pay-for-performance models for ambulatory care should pay primarily for performance improvement and include incentives for practices to develop the infrastructure to improve quality. The Integrated Healthcare Association has done this by providing pay-for-performance bonuses to practices purchasing electronic medical records.

The findings of Hasnain-Wynia et al³ suggest that the most pressing inequalities in health care may be driven by economics. Are disparities in hospital care simply one more manifestation of the lack of equal pay for equal work? Minority hospitals are frequently poor. It is impressive that, given their relative lack of resources, these hospitals frequently provide care of equal or better quality than hospitals with more resources. However, on quality measures that emphasize documentation more than action, poor hospitals are unlikely to yield competitive performance.

It is tempting to blame the victim. Pay-for-performance strategies that only pay for static levels of performance may favor richer hospitals with more administrative capacity. Why should we pay less to poorer hospitals if their quality problems are, in truth, attributable to their lower level of available resources?

Further intervention and observational research will likely show that financial status profoundly affects hospital quality differences. The elimination of health care disparities in hospital settings may prove to be simple: ensure that hospitals get equal resources for equal work. The current study correctly concludes that efforts to reduce disparities in care at hospitals should "target resources to facilities that serve a high percentage of minority patients"^{3(p1233)} rather than "direct them toward reducing potentially biased treatment."^{3(p1233)}

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