On 14 July 1789, the commoners in France stormed the prison at Bastille, an event that ultimately led to the termination of the monarchy of King Louis XVI and Marie Antoinette. The root of their protest was the dramatic disparity between the aristocracy and the ordinary citizens, the majority of whom had poor access to services and suffered mightily. As they stormed into the streets, their rallying cry was “Viva La Revolution!”

In the United States today there are increasing disparities between the “haves” and “have nots,” particularly in the area of healthcare. People living in poverty have worse outcomes by most every metric: life expectancy, prevalence of comorbid conditions, and access to care [1, 2]. Many preventable conditions are exaggerated among the poor, including uncontrolled hypertension, diabetes, and resultant stroke and cardiovascular disease. Healthcare disparities are defined as “potentially avoidable differences in health (or health risks that policy can influence) between groups of people who are more or less advantaged socially; these differences systematically place socially disadvantaged groups at further disadvantage on health” [3].

Perhaps the most representative example of a disease that disproportionately affects people living in poverty is human immunodeficiency virus (HIV). The incidence of HIV in the United States is highest among those with an annual income below the poverty line, and is worst among those with an annual income <$10,000 per year [4]. So it would be expected that outcomes among the disadvantaged poor with HIV is worse than those with higher incomes and those who are not in a disadvantaged minority group.

In this issue of Clinical Infectious Diseases, Moore, Keruly, and Bartlett evaluated differences in key outcome measures among the patients receiving outpatient care in their clinic in East Baltimore, Maryland [5]. Among the 6300-plus patients followed since 1995, 76% were black, 45% were infected via intravenous drug use, and >70% had 6300-plus patients followed since 1995, and 92% had incomes <200% of the federal poverty line. Surprisingly, they found no difference in clinical outcomes among their patients in virtually every key metric: Mortality rates, rates of new opportunistic infections, and access to life-saving antiretroviral medications (87%) did not differ based on race, sex, or HIV risk group. Further testimony to their success, the majority of patients on antiretroviral medications had undetectable viral load values since 2005, and the median CD4 count in 2010 was nearly 500 cells/μL. Perhaps most striking, the life expectancy for a 28-year-old patient in their clinic, regardless of sex, risk group, or race, was >73 years of age. Quite remarkable!

So why is this? At first glance, it would seem to be due to the high quality of the providers at Johns Hopkins, one of the most prestigious healthcare institutions in the United States. But although the providers at Johns Hopkins are indeed among the most knowledgeable and respected in the country, similar outcomes in similar populations of patients are observed at the majority of other HIV-focused clinics in the United States. The remarkable outcomes, as pointed out by Moore and colleagues in their discussion [5], is likely because of the Ryan White HIV/AIDS program. This federal program, administered by the Health Resources and Services Administration of the US Department of Health and Human Services, provides financial assistance to hundreds of HIV clinics in the United States to “fill the gap” in service delivery. This funding covers the costs of outpatient care and medications for those with no health insurance and supplements service delivery for those with some degree of health insurance coverage, creating a true “medical home” for every patient, regardless of their health insurance coverage [6]. A coordinated team of healthcare providers delivers these extra supportive services, including psychology/psychiatry, substance use treatment, adherence...
counseling, and social services. And the positive outcomes are obvious. Most other disease-specific and primary care clinics do not have such funding, and this is likely a fundamental reason why the poor and disadvantaged in the United States have health disparities that cause disproportionately worse clinical outcomes than those with means.

Our healthcare delivery system is a mess; from both a provider and patient perspective it is at best chaotic and fragmented. As a provider, I need to use a sixth vital sign in providing care for my patients. In addition to heart rate, blood pressure, temperature, respiratory rate, and oxygen saturation, I need to know the patient’s insurance status before I can deliver care efficiently, especially in the outpatient setting. Even when providing care for patients with full insurance, it is impossible to keep up with which health insurance company has which specific drug on its formulary or not. Too many times patients go to their pharmacy with a prescription and are told that the drugs are “not on formulary” and are instructed to return to their provider for either a new prescription or a prior authorization. Although the use of formularies can reduce overall costs, the management of such systems falls solely on the backs of healthcare providers, who provide such services with absolutely no reimbursement [7].

The healthcare providers who fill out the forms, rewrite the prescriptions, and spend the uncompensated time doing the little things that make big things happen are the unsung heroes of our healthcare system. I have often said that “the safety net that catches patients as they fall through the cracks of our diseased healthcare delivery system is made up solely of the fabric of healthcare providers who give a damn.” If they simply wrote the prescriptions, or ordered the MRI or CT scan without filling out the paperwork for the prior authorization, or took the phone call from a distressed son or daughter whose mom or dad cannot gain access to the proper rehabilitation facility because the facility is “not covered by their insurance plan,” we would spin into total dysfunction rather than remain in our perpetual state of mostly dysfunction. The additional funding from Ryan White helps reduce this disparity by supporting these types of services, at least in part.

The tragedy is that most of this chaos is invisible to the general public. Healthy individuals don’t interact much with the health system, and to most of them, we have “the best healthcare in the world.” Yet, by most every metric of success, our national healthcare outcomes are worse than the majority of other industrialized nations, and these other nations achieve their better outcomes at roughly one-half the cost than in the United States [8]. As evident by the findings from Moore et al [5], HIV care would have the same poor outcomes as all other disease conditions but for the additional funding provided by the Ryan White program to support the healthcare workers who go the extra mile needed to fill the gaps in our current system. And these gaps exist everywhere: on Wall Street, on Main Street, and on Avenue Q.

We need to overhaul our entire healthcare system. There is no simple or easy solution; however, we can glean hints of what works best by suspending our emotions and empirically examining systems in other countries that have much better outcomes than we do with markedly reduced costs [8]. We should also examine systems in the United States, such as Kaiser and the Veterans Administration, where self-contained care results in high-quality outcomes in a managed uniform system. The components of such a solution would include:

- Expansion of components of the Affordable Care Act (“Obamacare”) to allow only a limited number of insurance companies to participate in the Health Insurance Exchange in each state via a competitive process that includes transparent performance metrics and costs;
- Introduction of a public option in each state’s Health Insurance Exchange to assure common options across all states in the United States;
- Encourage each insurance provider to compete for the lowest prices of pharmaceutical agents; and
- Increase reimbursement for primary care to cover the full costs of care delivery.

The provision of more restricted choice of insurance providers and improved reimbursement of primary care will reduce the chaos that increases costs, reduce the burden of dealing with widely disparate formularies that consume provider time, and encourage newly graduating providers to engage in primary care rather than specialty care, where we have disproportionate numbers of providers. This will help ensure that access to care will be available for all patients, including those with HIV, as the current cadre of providers turn gray and drift toward retirement [9].

The Ryan White Care Act (RWCA) is up for reauthorization in 2013. If we do not have the healthcare solutions as outlined above by that time, we will desperately need the support from the RWCA to continue filling the holes in our primary care safety net for HIV patients. The reauthorization is all the more urgent based on the current understanding that “treatment is prevention”; by identifying those infected, linking them to care, getting them on successful anti-HIV treatments, and retaining them in care, we help each patient live a near-normal lifespan as well as stopping the spread of HIV. If we fail to do this, care will not be available, especially to those most vulnerable, and the goal of testing all persons for HIV and linking those with infection to care becomes futile.

The lesson learned from the remarkable outcomes within the HIV Clinic at Johns Hopkins and other Ryan White-supported clinics in the United States is that supplemental funding for primary
care is needed to overcome health disparities widely evident in our current system. In this case, Moore is not less. Viva No différence!

Notes

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References