A Policy Prescription for Reducing Health Disparities—Achieving Pharmacoequity

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In 2019, the US spent $3.8 trillion on health care, including an estimated $370 billion on retail prescription drugs alone. On average, individuals in the US spend more than $1100 per capita annually out of pocket on health care, but this spending is inequitably distributed. Specifically, racial and ethnic minority populations, who disproportionately experience higher prevalence and greater severity of chronic diseases, are more likely to not have sufficient insurance or lack insurance completely. As a result, Black individuals and Hispanic individuals often report the highest rates of cost-related delays in care and lower access to high-quality medication therapy.

Given the important and growing role of prescription drugs in the management of both acute and chronic diseases, ensuring that all individuals, regardless of race and ethnicity, socioeconomic status, or availability of resources, have access to the highest-quality medications required to manage their health needs is paramount. This goal could be referred to as pharmacoequity.

Inequities in access to prescription drugs are well documented. Individuals from racial and ethnic minority groups are less likely to receive novel and high-cost medications, and they are less likely to receive lower-cost generic therapies, guideline-established or emergency use treatments, and preventive or critical care therapies. For example, treatment of patients with COVID-19 has revealed substantial inequities in access to life-saving treatments. Despite being well described, these inequities persist across the therapeutic continuum, from drug development and clinical trial evaluation to prescription receipt and procurement of medications from the local pharmacy. Achieving pharmacoequity must be a public health and policy priority in the US to reduce health disparities and will require innovative solutions that address access, cost, and quality of therapeutic care.

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Enhancing Access to Therapeutic Care

Despite more than a decade of policy advances through the Affordable Care Act, including in improving affordability and availability of lower-cost drugs, an estimated 29 million US residents do not have insurance and lack prescription coverage, many of whom are Black individuals and Hispanic individuals. Of the population with insurance, millions more individuals are enrolled in current plans that leave them without enough insurance and responsible for paying a significant portion of their prescription costs. To achieve pharmacoequity will require adoption of universal, low-cost prescription drug coverage that fills gaps for individuals with insurance and provides medication coverage to all individuals who do not have insurance. Such coverage includes expanding Medicaid in states that have not yet done so. Medicaid expansion has been shown to be associated with improved rates of prescribing of evidence-based cardiovascular pharmacotherapies, medications for opioid use disorder, and oral contraceptives, among other drugs.

Health inequities have also been reduced or eliminated in care settings that offer uniform drug coverage, suggesting that such an approach may reduce overall health care costs and equitably improve quality of life.

Beyond insurance coverage, limited physical access to pharmacies is another barrier to pharmacoequity. Decades of racial segregation through redlining, neighborhood disinvestment, and exclusionary zoning laws have left many individuals from racial and ethnic minority groups residing in communities with limited access to pharmacies. Furthermore, these communities, often comprising lower-income, uninsured, or publicly insured populations, may be exposed to higher retail drug prices, particularly at independent pharmacies, than wealthier communities. Addressing these “pharmacy deserts” will require increased financial community investment to improve prescription drug access in underserved areas.

The presence of a pharmacy is of little yield, however, if there is differential prescribing at the clinician level. Medical specialists, for example, are more likely to prescribe newer, evidence-based therapies and, therefore, patients should have equal access to such clinicians by eliminating specialty referral disparities. Differential prescribing practices for all health care clinicians and organizations should be addressed through improved drug price transparency, system-based audits of prescription rates by race and ethnicity, and enhanced electronic medical record strategies to guide prescribers toward use of high-quality and high-value medications for all patients.

To ensure that new drugs are appropriate for diverse patient populations, policies to increase representation of underrepresented groups in clinical trials could be expanded. These policy solutions include the
widespread adoption of the federal mandate to cover the "routine costs" associated with trial participation. Additionally, researchers should acknowledge their role in the legacy of distrust that some communities hold due to centuries of unethical biomedical research experimentation. Moreover, increased federal investment is needed in research that examines the role of innovative, community-based programs, including those based in local barbershops, salons, churches, and supermarkets. Such programs may serve to help improve prescription drug access and could also help ensure that those who participate in research ultimately benefit from scientific discoveries after they are approved.

Reducing the Cost of Therapeutic Care

Achieving pharmacoequity must include a commitment to address the rising cost of prescription drugs. For decades, drug manufacturers have argued that reducing cost conflicts with promoting an innovative drug development pipeline. However, current drug prices, combined with uninsurance or underinsurance, results in lower use of prescription drugs. Efforts to reduce costs and improve coverage could increase prescription uptake and adherence and likely offset potential losses from price reductions. Myriad solutions have been proposed to reduce out-of-pocket costs, including direct drug price negotiation by the federal government, improving Medicare Part D drug benefits by placing a hard cap on beneficiary out-of-pocket spending, and extending drug coverage for low-income Medicare beneficiaries who are not dually eligible for Medicaid.

Nevertheless, analyses of prescription drug prices and policies governing drug coverage should include an equity analysis to determine the effect of novel therapies on reducing health disparities. Measuring, or even prioritizing, the related equity consequences of policy proposals may ensure that health care spending is distributed to health system solutions that address the social determinants of health disparities, including housing, education, employment, and transportation support, in addition to spending on drugs.

Improving the Quality of Therapeutic Care

National efforts to improve quality of care must include reducing disparities in prescribing practices. Specifically, quality-improvement programs should prioritize pharmacoequity as a key component of quality measurement. Nearly 2 decades since the Institute of Medicine (now the National Academy of Medicine) report titled, "Unequal Treatment," a burgeoning body of research has highlighted the inequities racial and ethnic minority groups encounter in achieving health care quality metrics. From process measures, such as receipt of preventive services, to outcomes measures, such as inpatient mortality, patients from underrepresented racial and ethnic minority populations often have lower performance than White patients. These inequities extend to medication management. As health systems increase resources to enhance quality improvement, including investments in performance dashboards, population health management tools, and chief quality officers, pharmacoequity must also be a key tenet of these efforts. To accomplish this goal, health system leaders should develop standardized approaches to collect data on inequities in prescribing, intervene on known biases in prescribing practices, track and report improvements in equity reduction over time, and share best practices with other systems throughout the process.

The US has an outsized influence on health care practice across the world. Currently, there is a unique opportunity to demonstrate leadership and ensure that all patients have equal access to the high-quality treatment that they need. This goal could also extend beyond prescription drugs to include ensuring equity across the entire therapeutic cascade from novel diagnostic studies to invasive surgical procedures. However, it is important to acknowledge that while pharmacoequity is necessary, it is not sufficient alone to achieve health equity without addressing the structures and policies that have left marginalized populations without sufficient resources to lead healthy lives. Achieving pharmacoequity is critical to the health of the nation. While the tools and ingenuity to reach pharmacoequity are available, the will to pursue this goal is still needed.

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REFERENCES

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