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Health care: Created unequal

More sickness among older people, minorities and the uninsured sends Michigan medical researchers hunting for answers

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From birth to old age, poor, uninsured minority people have an unequal chance to live a long, healthy life.

More of their babies die in their first year. They have much higher rates of AIDS, high blood pressure, diabetes and other chronic diseases. Their cancers often are found later, when treatment is costlier and less successful. Late-in-life diseases, such as Alzheimer's, may get overlooked.

Obstacles to good health care may increase. Experts predict that growing numbers of people, young and old, will postpone appointments and tests because they can't afford higher copays; don't work at companies that offer insurance or have coverage that won't get them the help they need.

While lack of insurance increases a person's chance of not getting the best care, there are other obstacles: distrust of the medical establishment. Transportation and language barriers. America's complicated health care system.

Some solutions may come from Michigan, particularly metro Detroit, which has emerged as a leading center in a growing new field called population health, a broad area of study that examines why some groups face greater obstacles to health, focuses on reasons for disparities and designs new approaches to improve health for those at risk.

Local attempts at solutions

At the University of Michigan, health disparities researcher James Jackson, PhD, directs an $8-million, federally funded research study of African-American health, the largest ever conducted. It will survey more than 4,000 black Americans about physical, mental and economic barriers to mental health care. At Wayne State University, separate federally funded projects are using $11 million in grants to intervene earlier in the study and management of African-American health issues. And in Lansing, $4 million from two private foundations transformed the Ingham County Health Department from an aging bureaucracy into a model organization to better meet the needs of underserved people. Research results aren't

It wasn't lack of insurance, but dislike of his doctor that landed Harold Rhim of Southfield in Detroit Receiving Hospital under the care of Dr. Phillip Levy and research assistant Lori Allen. (PATRICIA BECK/Detroit Free Press)

Equitable health care: where to get it, how to speak out

• **Free care:** A list of clinics that accept uninsured patients is on the Web site of the Detroit Wayne County Health Authority, www.dwcha.org.cq • **Your opinion:** You have until Aug. 31 to comment on whether the U.S. should have some type of basic health insurance. The congressionally appointed Citizens Health Care Working Group issued preliminary recommendations in June calling for such a plan. You can comment at:

expected for at least a few more years. And even where programs to help are under way, as in Ingham County, proving that they have resulted in better health may take years.

"We're in crisis," said Jackson, who directs the Institute for Social Research at the University of Michigan. "Over 40% of the adult American population doesn't have any health insurance ... Those numbers rise with ethnic and racial minority groups. People are putting off preventative care because they can't afford it."

Leona Janecke, 27, of Lansing, sought help in May for a lump in her neck, but her limited insurance through the Ingham County Health Department's HMO, the Ingham Health Plan, caused problems.

www.citizenshealthcare.gov. A final report will be sent to the president and Congress.

• More information: Office of Minority Health Resource Center, National Institutes of Health: 800-444-6472; www.omhrc.gov

Staff at Care Free Medical in Lansing tended to her and gave her antibiotics, but they thought it was important she see a specialist. They couldn't find an ear-nose-and-throat doctor in three counties who was accepting patients with Janecke's insurance.

By early June, what was eventually diagnosed as an infection in Janecke's salivary gland had become a leaky, purplish, grapefruit-sized lump.

Dr. Barry Saltman, who founded Care Free Medical to serve the uninsured after he retired from private practice, coaxed a specialist at the Ingham Regional Medical Center in Lansing to operate on Janecke on a weekend the physician was on duty in the hospital's emergency department.

Janecke's medical bills now total $9,503.30.

Most likely, her bills will be written off by the hospital and paid for by taxpayers through government programs.

"People need to realize that the middle class is evaporating in America and we all could be in the same position pretty soon," said Jeannie Quinn, a patient care advocate at the clinic.

Reaching the Asian community

Americans are foregoing mammograms, immunizations and childhood vision and hearing tests because they can't afford to pay even part of a doctor's visit, statistics show. Even when they can afford it, they may not trust the system.

Some programs are attempting to help by bringing health services to communities that need them the most.

Tsu-Yin (Stephanie) Wu, an Eastern Michigan University nurse, is trying to educate Asian Indian women about breast cancer prevention.

She found that many Asian women don't understand the importance of mammography and self-exams. They also fear cancer, have privacy issues about exposing their breasts and often lack insurance.

"Pink ribbons mean nothing to these people," said Wu, who held several breast cancer prevention programs this spring at the Hindu Temple of Canton.

U-M nurses do similar work at the temple and other community sites serving the diverse Asian Indian community in metro Detroit.

Some studies suggest that breast cancer occurs six times more often in women of Asian descent in the United States than in their native countries and that those women who get breast cancer are diagnosed later than whites, Wu said.

Help comes from the Michigan Association of Physicians of Indian Origin, which runs a free clinic each Wednesday in Oak Park.

"We can do all of this in our hospital, but if you go to the community, where it's convenient, you get a better turnout and comfort level in the community," said Tom Kochis, division president of Oakwood Annapolis, which provided 10 staffers and paid for several thousand dollars for blood tests at the spring event in Canton.

Race and hypertension

Prevention of heart disease before it becomes costlier health problems is the focus of a one-year study at Detroit Receiving Hospital.

The project expects to screen 254 African Americans. Patients must be 35 or older and diagnosed with poorly managed high blood pressure when they are under treatment at Receiving's emergency department.

Besides improving and prolonging life, earlier treatment of high blood pressure could bring big potential savings for the economy, said Dr. Phillip Levy, who directs the study.

Drugs to treat high blood pressure cost as little as $150 a year, compared to $10,000-$15,000 a year to treat heart failure and $66,000 for dialysis for kidney-failure patients, Levy said.

For reasons not entirely clear, blood pressure "begins earlier in the black population in the United States and is more severe," said Dr. John Flack, a high blood pressure specialist at the Wayne State University School of Medicine and director of the school's Center for Urban and African American Health.

Black patients also may not be treated as aggressively, Flack said studies show. Levy found discrepancies between Detroit Medical Center hospitals.

Patients at Receiving, for example, which serves a predominately black population, were less likely to get certain blood pressure medicines than patients at the health system's Huron Valley Sinai Hospital in Commerce Twp., which serves a largely white clientele, according to statistics collected between 1999 and 2004.

But race can't always be blamed, as Harold Rhim's story suggests.

Rhim, 59, of Southfield is African American. He has had high blood pressure for two years. He has health insurance to pay for his medicines and doctor visits. He is lean and healthy looking.

Unbeknownst to his wife, Rhim stopped taking his medicine earlier this year because he didn't like the new doctor he was assigned to see when his health coverage changed, he said.

When his prescription for blood pressure medicine ran out in the winter he didn't bother to call for a refill. His wife was very upset when she got the call to meet her husband at a hospital and found out he hadn't been taking his medicine. He'd been taken to the hospital as a precaution after slipping on a wet floor at work.

"Here's a person I want to be with forever and he's not doing what he needs to do to be with me for forever," said Zondra Rhim.

Through Levy's study, Harold Rhim received free tests to pin down the extent of his blood pressure problem, including an ultrasound test of the heart, and an appointment with a cardiologist to recommend the best drugs and hypertension strategies.

By June, Rhim's blood pressure was at normal levels.

"If you take good care of yourself, you'll live as long as anybody else," Dr. Peter Vaitkevitcius, a cardiologist, told him.

The insurance bill

Two experts at the Kaiser Family Foundation, a nonprofit research group, argue that closing the health care gap may not be as expensive as everyone thinks. It might add as little as $7 million to the $41 million the nation already pays to reimburse hospitals for uninsured care, according to researchers Jack Hadley and John Holahan. Extending full health coverage to the nation's uninsured would cost $48 million, they estimate.

Currently, private insurance, Medicare and Medicaid in the United States cost $735.6 billion a year, they say.

Opponents to extending some basic insurance to all Americans say the nation first should fix its broken, costly health care system, which relies too heavily on expensive hospital-based care. They estimate millions could be saved by shifting care to more cost-efficient, outpatient settings and primary care doctors.

Others see the problem as one for state and local governments, not federal agencies. They are looking at Massachusetts, where a new law requires all businesses to provide employee health insurance or pay $295 a month for each employee without it by July 1, 2007.

Other solutions include training more minority practitioners; adding translators and advocates to help people understand complicated health systems; and hiring more community people to build rapport and promote awareness of good health practices.

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