Unequal Burdens and Unheard Voices: The Pursuit for Equity and Inclusion in Pain Care

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1999 U.S. Census Projections (millions)

Population 65 years of Age and Over: United States, 1950-2030

Number in millions

Source: Health, United States, 1999 and U.S. Bureau of the Census
Gender and Aging

Projected Population Growth by Race

White Babies No Longer Majority in U.S.

2011 – Census Bureau

Non-White Babies: 2,019,176
White Babies: 1,988,824

Number (millions): 1.9, 1.98, 1.99, 2.00, 2.01, 2.02

2,019,176
Health care disparities

Mortality Rate

African American
American Indian
Latino
Asian
White

Ages

0-14 15-24 25-44 45-64
Institute of Medicine (2001): Disparities in Healthcare

- Occur in broader context of historic and contemporary social and economic inequality
- Exist and, because they are associated with worse outcomes in many cases, are unacceptable
Disparities: Power, Privilege, Resources

- 3 definitions of health disparities:
  - Disparities in health status
  - Disparities in health care
  - Disparities in access to care

- Differences in health, disease burden, or clinical decisions or outcomes associated with disadvantage

Factors Responsible for Disparities

- Access to care
- Cultural and attitudinal differences
- Bias
- Variability in decision-making
- Lack of coordinated care
- Lack of language proficiency
- Knowledge gap
# Healthcare Disparities by Race/Ethnicity

<table>
<thead>
<tr>
<th>Measure</th>
<th>African American*</th>
<th>Hispanic*</th>
<th>Asian-American</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missed work days in past year</td>
<td>↑</td>
<td>↔</td>
<td>↓</td>
</tr>
<tr>
<td>Physical limitations</td>
<td>↑</td>
<td>↔</td>
<td>↓</td>
</tr>
<tr>
<td>Fair or poor health status</td>
<td>↑</td>
<td>↑</td>
<td>↔</td>
</tr>
<tr>
<td>Obesity</td>
<td>↑</td>
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</tbody>
</table>

*VS NON-HISPANIC WHITE; source: 2009 National Health Interview Survey
Disparities in Quality of Care are Common

Distribution of Core Quality Measures for which members of selected group experienced better, same, or poorer quality of care compared with reference group.
$1.24 trillion
The combined costs of health inequities

$229.4 billion
Reduction in direct medical costs, achieved through disparity elimination

31%
Direct medical expenditures for ethnic groups defined as excess costs due to health inequities
- Chronic pain (2010)
  - >100 million Americans
  - >$560-635 billion/yr

- Cardiovascular disease (2010)
  - 83 Million Americans
  - $444 billion/yr

- Diabetes (2007)
  - 17 million Americans
  - $176 billion/yr

- Cancer (2007)
  - 11 million Americans
  - $226 billion/yr
Consequences of Chronic Pain

- Physical function → Disability, Sleep
- Family/Social role → Caregiver, school, community
- Economic → Work productivity, healthcare costs
- Psychological function → Anxiety, depression, post-traumatic stress disorder

LIVING IN AGONY
Mechanisms Underlying Differences

BIOLOGICAL

Genetics: gonadal hormones; endogenous pain inhibition

SOCIOCULTURAL

Age, ethnicity, family history; sex roles

PSYCHOLOGICAL

Anxiety, depression, cognitive factors, behavioral factors
Aging and Pain

- Prevalence of pain will increase with aging

- Accelerated aging noted in racial and ethnic minorities

- Older patients are less likely to receive adequate analgesic treatment

- High correlation between depression and pain

- Pain diminishes the QOL in older adults
Gender and Pain

- Women have a higher prevalence of most chronic pain conditions which varies by stage in life cycle.

- Despite common beliefs, women have a lower pain threshold and less tolerance to painful stimuli in several experimental studies.

- The pain complaints of women are handled less adequately.

- Gender differences in response to analgesics.
Gender difference in pain and its correlates

- Widespread Pain
- Regional Pain
- Fatigue
- IBS
- Migraine
- Tension HA

The chart shows the percentage of males and females experiencing different pain conditions. Females generally have higher percentages for widespread pain, regional pain, fatigue, IBS, and tension HA compared to males.
Race and Pain Care

- Minority patients have less access to pain management
- Minority patients are less likely to have pain recorded
- Minority patients receive less pain medication
- Minority patients are at risk for under-treatment
- Minority patients with pain have decreased health
Pain Score at Present

PAIN SCORE

*P<0.05

0 = NONE, 6 = EXTREME

AY CAY AAO CAO

AAY

CAY

AAO

CAO

3.3

2.5

3.4

2.6

Y=<50

O=>50
All PDI items at baseline

Pain Disability (0-10)

- AA men
- AA women
- Cauc. men
- Cauc. women

Items:
- Family
- Life support
- Self-care
- Occupation
- Recreation
- Social activity
- Sexual behavior
Health Care Utilization Among African and Caucasian Americans

- Survey study of 286 patients receiving treatment in a tertiary care pain center

![Graph showing health care utilization among African and Caucasian Americans with annotations for difficulty paying for health care, could not afford health care, and chronic pain as a major problem. *p<0.05 indicates statistical significance.]

Green 2004 JNMA
Distribution of Physician Responses to Cancer Vignettes

Answer Choices for Acute Pain Vignettes

*Statistically significant (p<0.05) were observed between the portions of optimal and referrals and worst than poor in metastatic breast and prostate cancer.
Safe Prescribing Is Not Easy

- Who takes care of the patient?
- Many modalities are available to treat pain
- Balancing fear of misuse, diversion, loss of licensure versus needs of the patient
- Willingness to withhold opioids while continuing to care for patient
The Vicious Cycle of Undertreating Pain

- Concerns about addiction often lead to inadequate analgesia.
- Inadequate analgesia leads to communication barriers, diminished trust, and decreased health.
Sufficient opioid supply by zip code

- ≥70% Caucasian
- ≥70% Minority
The law

- 1986: NIH Consensus Statement
- 1990: Public law 101-613
- 1997: Congress defined pain as a medical emergency
- 2000: Congress creates the Decade for Pain Control and Research
- 2001: Pain Standards developed by JCAHO
- 2008: Military Pain Care Act
- 2010: Provisions from the National Pain Care Policy Act within Affordable Care Act
Underlying Principles

- Pain management is a moral imperative
- Chronic pain can be a disease in itself
- The value of comprehensive treatment
- The need for interdisciplinary approaches
- The importance of prevention
- Wider use of existing knowledge
- Recognition of the conundrum of opioids
- Collaborative roles for patients and clinicians
- The value of a public health and community-based approach
Need to Foster a Cultural Transformation

• Pain is a national challenge
  ▪ All people are at risk for pain
  ▪ Pain is a uniquely individual, subjective experience
• Comprehensive and interdisciplinary (e.g., biopsychosocial) approaches are the most important and effective ways to treat pain
• Such care is difficult to obtain because of structural barriers – including financial and payment disparities
• A cultural transformation is needed to better prevent, assess, treat, and understand pain
• The committee’s report offers a blueprint for achieving this transformation
Pain as a Public Health Challenge - Findings

- **Pain is a public health problem**
  - Affects approximately 100 million American adults
  - Reduces quality of life
  - Costs society $560–$635 billion annually

- **More consistent data on pain are needed to:**
  - Monitor changes in incidence and prevalence
  - Document rates of treatment and undertreatment
  - Assess health and societal consequences
  - Evaluate impact of changes in policy, payment, and care

- **A population-based strategy is needed to reduce pain and its consequences. It should:**
  - Heighten national concern about pain
  - Use public health strategies to foster patient self-management
  - Inform public about nature of pain
Care of People with Pain - Findings

• Pain care must be tailored to each person’s experience
  ▪ Financing, referrals, records management need support this flexibility

• Significant barriers to adequate pain care exist
  ▪ Gaps in knowledge and competencies for providers
  ▪ Magnitude of problem
  ▪ Systems and organizational barriers
Education Challenges - Finding

• Education is a central part of the necessary cultural transformation of the approach to pain
  ▪ The federal, state and local government and professional organizations are in a position to contribute to substantial improvements in patient and professional education
Research Challenges - Finding

- Research to translate advances into effective therapies is a continuing need
  - Significant advances have been made in understanding basic mechanisms of pain but much remains to be learned
  - Data and knowledge gaps remain and have prevented advances from being translated into safe and effective therapies
  - Addressing these gaps will require a cultural transformation in the view of and approach to pain research
2012-15

- Health, Education, Labor and Pensions Committee Hearing
  - Pain in America
- Secretary’s Interagency Pain Research and Coordinating Committee
  - National Pain Strategy working group
- Centers of Excellence in Pain Education
- National Pain Strategy
National Pain Strategy

Public Health: Education and Training
Public Health: Prevention and Care
Public Health: Service Delivery and Reimbursement
Population Research
Professional Education and Training
Public Education and Communication
Suggested Solutions to Promote Equity

- Enhance access
- Address cultural differences
  - Enhance cultural curriculum
  - New requirement for provider licensure
  - Collect self-reported race, ethnicity and language data
- Care coordination
  - Patient centered care
  - Community based clinics and medical homes
- Address provider bias
  - Sensitivity Training
Other Solutions

- **Language**
  - Interpreters
  - Multilingual educational materials

- Increase awareness
- Encourage behavior change
- Increase cultural competency and address the knowledge gaps
- Create effective policies to optimize care and outcomes
I am a victor
for equity in health care!