Closing Care Gaps Across the Globe

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Filled with good will and new year’s resolution, we resolve to contribute to one or more worthy causes in an effort to close the clinical and economic gaps we see. But how many of us, even those working in healthcare, think beyond this nation’s borders when it comes to addressing gaps in care?

The National Institutes of Health (NIH) define health disparities as “differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups.” Espousing the slogan, Ensuring the Health of All Americans, and following two decades of work to bring attention to the unequal burden of illness and death experienced by racial and ethnic minorities and rural and poor populations in this country, the NIH created the National Institute on Minority Health and Health Disparities (NIMHD). The Patient Protection and Affordable Care Act (P.L. 111-148), also known as the healthcare reform law signed by President Obama on March 23, 2010, re-designated the NIMHD an institute; the official announcement appeared in the Federal Register on September 13, 2010. Although domestically focused, it is noteworthy that the NIMHD’s reach extends beyond US borders to more than 50 countries where undergraduate and graduate students participate in research training each year, as well as to US territories where ongoing multidisciplinary research is taking place.

The NIMHD’s framework of health disparities relies on strictly sociological dimensions such as race, ethnicity, population density of domicile, and poverty versus prosperity. However, some healthcare providers and policy makers recognize that health disparities can occur for less obvious or measurable reasons. Gaps in health literacy (which may have little connection to level of highest formal education attained) create barriers to seeking care or following instructions once a patient is diagnosed and treated. Poor health literacy and weak medication compliance are directly linked, particularly if side effects from a drug are negative or the co-pay is unmanageable. Cultural obstacles are not limited to language barriers — one example is female patients ill at ease with male physicians in matters pertaining to sexual and pelvic health. Lack of access to the healthcare system is not always a matter of physical distance, as in the case with rural population groups. Barriers also can exist for persons lacking familiarity with the structure and requirements of the healthcare delivery system. For example, at the NAFC we routinely witness confused and bewildered women with pelvic organ prolapse seeking a trained expert in pelvic floor dysfunction; it is more than a matter of health literacy when their primary care providers fail to recognize symptoms of prolapse and thus do not refer them to a urogynecologist or urologist trained in gynecology and female urology.

Regardless of the state we live in or our national geographical boundaries, we have a moral and ethical obligation to help close gaps in health disparities among population groups around the globe. When I think about accomplishing this, I am reminded of the diligence with which nations worked to achieve “harmonization” in trade and tariffs across Europe in the first decade of the 21st century as the monetary union, or Eurozone, was established as an economic and political union. The European Union’s Charter of Fundamental Rights affirms that “a high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.” However, harmonization of EU healthcare has yet to be achieved — healthcare in the EU is delivered through a wide range of different systems administered at the national level even though all the member states have either publicly sponsored or publicly provided universal healthcare. As in the US, healthcare in the EU is provided through a wide range of different systems. Effort aimed at placing the patient at the center of decisions, with an eye on safety and rights of access, is gaining momentum daily. The World Federation of Incontinent Patients, an organization dedicated to promoting worldwide the interests of patients suffering from incontinence and related pelvic floor disorders, is leading the way with its Charter of Patient Rights.

Isn’t the patient the central reason all of us have chosen to be in healthcare, regardless of our individual role? No matter what you believe politically about universal healthcare, closing gaps in disparities with a devotion to patient centeredness is why we do what we do, each and every day.

References