

CHAPTER 9

Social Injustice and the Health Care System

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The U.S. health care system both arose from and perpetuates long-standing structural conflicts (Stevens 2006). Medicine (and, more broadly, health care) is not separate from our society. Rather, as explained by historian Charles Rosenberg (2006), health care is “a fundamental social function [that] reflects, incorporates, and acts out more general aspects of social hierarchy, status, and power” (p. 23). In this chapter, we provide a brief overview of how structural inequities are re-created within three domains of the health care system: hospitals, physicians, and health insurance. We then explore two examples in depth—the affordability and geographic availability of mental health services—to illustrate these themes within mental health care.

Social Justice and the Health Care System

In the United States, the term health care system is widely understood to be a misnomer. The name implies the provision or maintenance of health, but providers and policies focus on the provision of clinical services. Likewise, care suggests that these services involve meeting the needs of patients, but services are more often centered on the arrangements of providers. Last, system implies an organized, cohesive, and connected structure, rather than the public-private patchwork of health system conglomerates, hospitals, clinics, private offices, and payers that is characteristic of health care in the United States today. Furthermore, to the extent that mental health services have been historically constructed as separate from medical services, the mental health care system is even more fragmented in addressing the mental health needs of the population. Thus, for the purposes of this discussion, we define *health care system* as the amalgamation of providers of clinical and social goods and services and the attendant payment and policies that support the continued operation of these providers. We provide a historical overview through a social justice lens of three major actors in this system: hospitals, the medical profession, and health insurance.

Hospitals

The history of health care in the United States is one of inequities that continue in the present. In her seminal work on the history of U.S. hospitals, Rosemary Stevens (1999) explained that the first inpatient care institutions were established as places of sick care for the poor, where individuals could live out a potentially terminal illness if they had no home or family to provide care. With the transformation of medicine to a scientific and technological enterprise, hospitals became institutions of treatment—a desirable place for care. Stevens described the rise of charitable hospitals, which served several social functions, including providing the upper class with public means to display their beneficence, while fostering the growth of institutions that did not have an explicit mission to serve vulnerable populations.

As in nearly all other sectors of society, racial segregation was a matter of course in U.S. hospitals. Construction of separate wards or denial of service to patients of color was routine and openly sanctioned until the Civil Rights Act of 1964 and the introduction of Medicare in 1965, which required hospital desegregation as a condition for reimbursement (Burrows and Berney 2019). Teaching hospitals, by contrast, were notable for their deliberate inclusion of patients marginalized by race and income—because

“indigent patients were valuable cogs in the teaching-hospital machine” (Stevens 1999, p. 62).

However, fundamental causes of health inequities are replicated over time, even as the means change (Link and Phelan 1995). Despite the efforts to end *de jure* (legally sanctioned) segregation in the 1960s, hospitals and health systems continued *de facto* segregation by race and income, in part due to residential segregation of communities (Sarrazin et al. 2009). Regardless of federal requirements, hospitals located in affluent, predominantly white communities are typically physically distant from low-income communities of color, and the patient population of hospitals reflects the homogeneity of the surrounding service area.

Furthermore, private hospitals, whether for profit or not for profit, employ deliberate service and marketing strategies to reduce their exposure to low-income patients. For example, for-profit hospitals regularly eliminate unprofitable services that are disproportionately used by vulnerable populations, such as psychiatric emergency care (Horwitz 2005). At the same time, hospitals invest in technologies and amenities to appeal to more affluent communities, such as advanced imaging modalities. As a result, care for low-income communities of color is disproportionately concentrated in a subset of safety net hospitals that operate at zero or negative margins, have fewer resources for new capital such as health information technology, and are particularly dependent on government support (Hall 2012). Studies of safety net hospitals and those serving predominantly Black and/or minoritized populations have found mixed evidence on the quality of care provided by these institutions (Mouch et al. 2014). A major confounding factor is that these hospitals are serving populations with greater severity and complexity of illness.

As described by Camilleri (2018), in the past three decades, hospitals in low-income communities of color have been more likely to close, thus increasing strains on the remaining safety net providers. The Patient Protection and Affordable Care Act of 2010 (ACA) had the potential to bring much-needed financial relief to safety net hospitals by expanding insurance coverage for low-income populations, particularly through the Medicaid program. However, because not all states elected to expand Medicaid coverage, large disparities between hospitals emerged post-ACA. Those in expansion states have experienced substantial reductions in uncompensated care, whereas those in nonexpansion states have not; as a result, hospitals in nonexpansion states are facing increasing risk of closure (Camilleri 2018). Since the passage of the ACA, low-income communities of color have disproportionately borne the brunt of rural hospital closures (Thomas et al. 2019). Inequities in access to hospital care arise from the confluence of residential segregation, hospital imperatives to generate revenue, and state policy making.

Physicians

While hospitals were undergoing their technocratic transformation at the turn of the twentieth century, a parallel trend was playing out among physicians. The 1910 publication of the Flexner Report formalized medicine's evolution into a profession, calling for admissions standards, an emphasis on research and teaching, and the development of academic medical centers with full-time faculty (Miller and Weiss 2012). Arguing the need for technical standards in medical education, the Flexner Report also deliberately led to the dismantling of schools and hospitals that served Black and female medical students, who were otherwise excluded from the predominant institutions of the time (Barkin et al. 2010; Miller and Weiss 2012). For example, the Flexner Report's prioritization of physical facilities for conducting research and teaching brought attention to the inadequacies of the buildings used by Black medical schools. Rather than improve conditions and advance the education of Black and female medical students, the Flexnerian movement led to the closure of all existing Black medical schools except the Medical Department of Howard University and Meharry Medical College, as well as all but one of the women's medical colleges, Women's Medical College of Pennsylvania (Barkin et al. 2010; Miller and Weiss 2012).

At the same time, the American Medical Association (AMA) conducted stricter scrutiny of premedical education requirements and licensing (Miller and Weiss 2012). The AMA and the Association of American Medical Colleges (AAMC) pushed to increase premedical requirements for college-level coursework at a time when educational opportunities were restricted primarily to white men. In fact, only 3% of Black students in the South attended high school in 1910 (Miller and Weiss 2012). Furthermore, states began to require graduation from AMA-approved institutions for physician licensure. Thus, the physician pipeline was effectively constricted both before and after medical education.

Traditional medical schools would not be compelled to consider integration of racial and ethnic minority students until the civil rights movement prompted the AAMC to advance desegregation among its members in 1968. Following affirmative action initiatives, enrollment of Black students rose steadily and peaked in 1995 (Association of American Medical Colleges 2016). Then, starting with California in 1996, eight states banned their public institutions from considering race and ethnicity in admissions decisions, and many universities followed voluntarily. The share of underrepresented minorities in higher education plummeted, and the steady progress to diversify medicine came to a halt (Garces and Mickey-Pabello 2015). In 1996, 9% of all U.S. medical students were Black, versus 7% in 2010 (Association of American Medical Colleges 2016, 2019).

Compounding the lack of racial and ethnic diversity, the medical profession continues to reflect the consequences of economic and social inequality of the U.S. society at large. In 2019, only 5% of medical students reported parental incomes in the bottom quintile of U.S. households, versus 51% in the top quintile (Youngclaus and Roskovensky 2018). The physician workforce is a product of long-standing structured advantages, in which intergenerational wealth enables residence in communities with high-quality public education, purchase of private education, or both (Lucey and Saguil 2019). Children of educated parents are raised with the cultural capital and social networks needed to navigate elite college admissions and the costs of attendance, facilitating success in undergraduate years and medical school admissions. The trends started by Flexner—the emphasis on health technology through a research enterprise—have raised the costs of medical education (Miller and Weiss 2012). Rising debt among medical school graduates has garnered the lion's share of attention, but closer scrutiny reveals growing inequality: from 2010 to 2016, mean debt rose, but the percentage of graduates with zero debt also rose, from 16% to 27% (Grishkan et al. 2017). To the extent that structural racism denies socioeconomic privileges to racial and ethnic minorities, low-income minorities encounter the highest barriers to entering the medical profession (Lucey and Saguil 2019).

As a result of these socioeconomic inequities, physicians do not reflect the racial, ethnic, and sociodemographic characteristics of the populations they are serving. With insufficient diversity, the medical profession lacks the needed supply of physicians who are committed to working with underserved populations. Across decades of research, the most consistent predictor of practice in underserved communities, whether by race and ethnicity, income, or geography, is having a personal origin from one of those communities (Goodfellow et al. 2016). Physicians without such backgrounds are less likely to express interest in practicing in needed areas, and because of residential segregation, they may select practice locations that are inaccessible to underserved populations and that have no incentive to meet these populations' needs. Black and Latinx communities have fewer physicians across many specialties, from primary care to general surgery to medical subspecialties (Marrast et al. 2014). As discussed later in this chapter (see "Social Injustice and the Mental Health Care System"), accessibility barriers are particularly profound for office-based psychiatrists, who are both less likely to practice in minority communities and far less likely to accept insurance at all, much less public coverage (Bishop et al. 2014; Cummings 2015).

Furthermore, extensive examination of clinical encounters has found that racial, ethnic, linguistic, and cultural patient-physician concordance leads to improved communication and patient engagement (Shen et al. 2018). Lack of

physician diversity contributes to patient reports of discrimination and medical mistrust, which in turn lead to fear of accessing care and reluctance to follow treatment recommendations (LaVeist et al. 2009). In summary, inequities in education, selection, and training in medicine culminate in a workforce that produces inequities in access to and quality of care.

Health Insurance Coverage

With the technocratic transformation in health care in the first half of the twentieth century, patients were increasingly unable to afford the new, scientifically based care. Access to care, therefore, depended on another relatively new development: health insurance. Initially, health insurance remained the purview of the few who were wealthy and worried enough to pay for individual coverage. During and immediately after World War II, the expansion of industrial manufacturing, combined with federal restrictions on raising wages, prompted employers to offer health insurance benefits as a nontaxed alternative to pay increases. From 1940 to 1950, the number of U.S. residents with private health insurance coverage ballooned from 20 million to 142 million; however, employer-sponsored coverage was concentrated among middle-class workers with skilled labor and white-collar occupations (Moseley 2018). Underlying structural processes such as underinvestment in K–12 education, job-location mismatch (in which jobs are located in areas far from communities of color), and hiring discrimination produce inequities in overall employment and types of employment on several intersecting dimensions, including gender, race, ethnicity, immigration status, and disability. Therefore, a system built on a foundation of private employer-based coverage reproduces inequities in health insurance.

Throughout the twentieth and twenty-first centuries, U.S. policy makers have considered multiple options to increase access to care. President Harry Truman advanced a proposal for a national health insurance program in 1947. The AMA launched vigorous opposition and garnered the support of Southern Democrats and a new Republican Congress, and the aim of universal coverage faded in 1948 (Oberlander 2003). The introduction of Medicare and Medicaid in 1965 brought coverage to older adults and to a subset of low-income parents, children, and people with disabilities, but objections of Southern Democrats and the AMA again blocked further expansion. In the intervening 45 years before the ACA, similar attempts, including from Presidents Nixon and Clinton, were handily dismantled by the same stakeholders. Thus, most low-income adults (with the exception of pregnant women) remained ineligible for Medicaid.

Within this historical context of failed attempts to expand coverage, the ACA was developed to meet expectations of political expediency. ACA sup-

porters calculated that a series of policies built from the existing health care system would more likely receive bipartisan support from Congress than proposals that would abolish existing reimbursement structures (e.g., replacing private and public insurance with a national single-payer plan) (Skocpol 2010). Therefore, the ACA called for expanding coverage under the patchwork of public and private systems but included little to address the underlying drivers of inequities in coverage, distribution, and services. Nevertheless, 14 states, including some that blocked coverage expansions from the 1940s to 1990s, filed suit against the ACA, arguing that mandated coverage was unconstitutional (Kaiser Family Foundation 2020).

In 2012, the U.S. Supreme Court ruled that individually mandated coverage was permissible as a tax, whereas Medicaid expansion was unduly coercive to states. Thus, at the start of Medicaid expansion in 2014, only 25 states elected to do so (Kaiser Family Foundation 2020). The majority of Southern states declined expansion and instead pursued increasing restrictions on Medicaid eligibility, such as work requirements and time limits on benefits. Political science researchers have shown that the intersection of racial resentment among whites, low public support for Medicaid among white people, and a relatively larger Black population have driven state decisions not to expand Medicaid (Grogan and Park 2017). Racial animus, rather than party affiliation or ideology, has been consistently associated with opposition to the entire ACA (Maxwell and Shields 2014). As a result of political geography, the United States experienced widening inequities in coverage. In 2019, the percentage of uninsured residents in nonexpansion states was nearly double that of expansion states (18.5% vs. 9.6%) (Garfield et al. 2020).

One of the consequences of the ongoing failure to ensure health care coverage for all U.S. residents is persistent racial and ethnic inequities in insurance coverage. Structural racism has produced barriers to jobs with health insurance benefits for Black and Latinx populations and relegated their opportunities to lower-wage jobs. As a result, Black and Latinx people are disproportionately represented among the uninsured and those with Medicaid coverage (Artiga et al. 2020).

Social Injustice and the Mental Health Care System

Structural inequities over time have produced racial and socioeconomic inequities within the health care system at large, and similar conditions are repeated and amplified for those with mental health conditions and substance

use disorders. In 2018, among Black adults with any mental illness, 69% received no treatment, including 42% of those with severe mental illness; for Latinx adults, lack of treatment is comparable, at 67% and 44%, respectively (Substance Abuse and Mental Health Services Administration 2019). For those with substance use disorders, these gaps are even starker, with 88% and 89% of Black and Latinx adults, respectively, reporting no treatment.

We draw on dimensions from Penchansky and Thomas's (1981) framework on access to care to highlight how structural conditions have contributed to inequities in access to mental health services. See Table 9-1 for dimensions and definitions of health care access as described within that framework.

In the following subsections, we focus on the dimensions of affordability, accessibility, and availability of mental health care services. Barriers associated with these domains of access can interact and compound one another, manifesting as disparities in access by race, ethnicity, and income.

Mental Health Services and Affordability

Barriers related to affordability are exacerbated in the mental health care system relative to other sectors of health care. First, coverage for mental health services and substance use treatment has been historically less generous than coverage for other conditions, leading to greater numbers of uninsured and underinsured for mental health treatment. Second, in the absence of broad-based private coverage, Medicaid has assumed a critical role in mental health coverage, especially for individuals with serious mental illnesses. Federal and state decisions about who is eligible for Medicaid coverage are highly consequential for those with mental health and substance use disorders.

Insurance Coverage and Access to Mental Health Services

From the 1960s to 1970s, private and public coverage expanded for inpatient psychiatric care but not outpatient services (Mechanic and Grob 2006). Health insurance plans capped coverage for outpatient mental health services in numerous ways, such as by limiting the number of visits or days; offering lower reimbursement rates; imposing cost sharing; setting benefit limits; or, in the case of substance use disorder treatment, providing no coverage at all (Cummings et al. 2013a). Congress passed successive laws in 1996, 2008, and 2010 (as part of the ACA) to close the gaps in coverage, but exceptions remain (Cummings et al. 2013a). For example, requirements apply only to individual and small-group markets, not to large-group plans or to self-insured plans offered by large employers. Post-ACA

TABLE 9-1. Penchansky and Thomas's framework on access to care

Dimension	Definition
Affordability	Prices and providers' payment requirements in relation to patients' income, ability to pay, and health insurance
Availability	Adequacy of supply of facilities and providers in a given geographic area
Accessibility	Relationship between the location of patients and the location of health care facilities and providers (accounting for travel distance, time, and cost)
Accommodation	Methods of organization of health care resources for patients (e.g., hours of operation) and alignment of resources with patients' needs and ability to access them
Acceptability	Patients' attitudes about provider characteristics and the providers' practices and perceptions of the patients they serve

Source. Penchansky and Thomas 1981.

because private insurers are requiring more cost sharing across the board (National Academies of Sciences, Engineering, and Medicine 2018).

In addition, reimbursement for mental health services is lower than that for other health care services. In 2015, other physicians received 14%–20% higher payments than psychiatrists for visits of comparable complexity (Melek et al. 2017). With lower reimbursement rates and restrictions on services, it is unsurprising that as of 2009–2010, nearly half of office-based psychiatrists opted out of private insurance networks entirely (Bishop et al. 2014). However, the data used in this study did not provide information about the extent to which some psychiatrists were employed in multiple jobs (e.g., operating a private practice and working in the public sector). The proportion of mental and behavioral health services received out of network was 3.6–5.8 times higher than other medical and surgical services (Melek et al. 2017). When providers decline to accept insurance payments, the financial resources needed to access care increase several times over.

With constraints on both coverage and the supply of providers who will accept that coverage, access to mental health services has been narrowed to individuals with the financial means to pay a substantial part of, or all, out-of-pocket costs for care. In 2011, of the non-older adult respondents to the National Survey on Drug Use and Health who had any mental illness, only 25% of the uninsured received any treatment; of those with private insurance, treatment increased only modestly to 38% (Walker et al. 2015). Because structural inequities have fostered a system in which people of color

have lower average incomes, affordability issues contribute to racial inequities in access to mental health services. Among Black adults who reported unmet needs for mental health treatment, cost was reported twice as often as minimization of symptoms and nearly five times as often as stigma as the most common reason for not seeking care (Alang 2019).

Medicaid and Mental Health Services

In the absence of broad coverage, Medicaid has become an especially important payer of mental health services, especially for individuals with the most severe mental health disorders (Buck et al. 2000). Individuals with mental health and substance use conditions have higher rates of poverty and disability and thus are more likely to be eligible for Medicaid. In 2016, Medicaid covered 9.1 million adults with mental illnesses—21% of all non-institutionalized adults with any mental illness and 26% of those with serious mental illness (Zur 2017). Medicaid accounted for 25% of U.S. spending on mental health services in 2014 (Mark et al. 2016). As stated earlier in this chapter (see “Health Insurance Coverage”), people of color are disproportionately represented within the Medicaid population.

Given the outsized role that Medicaid plays in affordability of mental health services, access depends on state policy decisions on eligibility. In states that elected to implement Medicaid expansion under the ACA, low-income adults with mental health needs, and particularly people of color, experienced substantial gains in coverage (Lipton et al. 2019). Multiple studies found that expanding Medicaid coverage increased access to mental health and substance use disorder treatment (Finkelstein et al. 2012; Wen et al. 2015). States that expanded Medicaid coverage witnessed increases in prescriptions and treatment for opioid use disorders (Antonisse et al. 2017). Conversely, the net implication of Medicaid expansion studies is that low-income adults in nonexpansion states remain uninsured and underinsured for mental health services. Given the racialized political dynamics with respect to states’ decisions on Medicaid eligibility, the result is inequities in affordability by geography. The case of Medicaid, a core component of mental health and substance use treatment, also illustrates how structural racism produces barriers to care for whites as well as people of color.

Geographic Accessibility and Availability of Outpatient Mental Health Services

Penchansky and Thomas (1981) described two dimensions of health care access—accessibility and availability—that further capture how health care resources are distributed by geography at the local level (see Table 9–1).

Many of the same historical and social forces that produce inequities in the geographic distribution of health care system resources in general may apply to mental health care services.

Deinstitutionalization and the Emergence of Outpatient Specialty Mental Health Care

Accessibility and availability first must be understood through the historical context of how outpatient mental health care services emerged in the United States. The first steps began in the 1950s to 1960s with deinstitutionalization, the shifting of care of people with serious mental illnesses from residential institutions to community settings (Mechanic and Grob 2006). Proponents called for deinstitutionalization in part because of the efficacy of new psychotherapeutic medications, as well as growing concerns over patient safety in state mental hospitals. However, when they called for community-based care, they assumed that the community had mental health care providers, in addition to adequate housing and family and social support—an assumption unfounded in low-income communities (Mechanic and Grob 2006).

The Community Mental Health Act of 1963 provided subsidies for the construction of outpatient community mental health centers, but local communities bore the responsibility of raising funds for day-to-day operations. The act also offered no provisions to grow the psychiatry workforce needed to staff community mental health centers. The Carter administration attempted to address these gaps through the Mental Health Services Act of 1980, only to have the legislation be immediately repealed by the Reagan administration in 1981 (Mechanic and Grob 2006).

Currently, there are at least two separate outpatient specialty mental health systems. One system comprises solo and small group practices, including psychiatrists and therapists with master’s and doctoral degrees. This group is more likely to be located in higher-income communities (Cummings et al. 2017). The presence of a wealthier patient base also makes it feasible to choose not to accept insurance because this population is most likely able to pay the full cost of care without the need for insurance support. Medicaid participation among psychiatrists is especially low and declining. As of 2015, only 35% of office-based psychiatrists accepted Medicaid (Wen et al. 2015).

The second system includes specialty outpatient mental health treatment facilities, which offer a structured service setting or program that provides ambulatory mental health care. These specialty outpatient facilities can be publicly or privately owned, and they play a critical role within the continuum of mental health care services for two key reasons (Cummings

et al. 2013b). First, they typically offer a breadth of services for individuals with acute and persistent mental health needs, including psychotropic medication management, individual psychotherapy, family and group therapy, and supportive services such as case management and peer services (Substance Abuse and Mental Health Services Administration 2018). Second, in contrast to solo or small group practices, the vast majority of these facilities are financially accessible to people with public insurance (Jacobs et al. 2005) and part of the safety net system. Safety net providers deliver significant health care to vulnerable patients, including those who qualify for Medicaid or are uninsured (Institute of Medicine 2000). According to a 2017 survey, 94% of outpatient mental health treatment facilities accepted Medicaid (Substance Abuse and Mental Health Services Administration 2018).

Geographic Access to Outpatient Mental Health Services

Research has documented socioeconomic inequities in geographic access to mental health services in private solo or small group practices. These smaller practices of mental health specialists are more likely to be located in higher-income than in lower-income communities. In contrast, specialty outpatient mental health treatment facilities are more likely to be located in lower-income compared with higher-income communities (Cummings et al. 2017). Geographic access is especially important for low-income communities because many residents also encounter barriers related to transportation (Syed et al. 2013).

A growing body of evidence has documented persistent inequities in geographic access to mental health services both in private solo or small group practices and in the mental health safety net. Consistent with studies on providers in other specialties, a study by Cummings et al. (2017) found that psychiatrists and therapists were less likely to be located in communities with high percentages of Black and Latinx residents (>25% and 50%, respectively) than in communities with less than 1% of residents from either group. Earlier research has likewise shown that Black and Latinx communities, and particularly those with greater levels of residential segregation, have fewer available mental health providers (Dinwiddie et al. 2013).

Outpatient mental health treatment facilities are also less likely to be located in communities of color. Counties with a higher percentage of Black and Latinx residents are significantly less likely to have a facility that accepts Medicaid, even after controlling for poverty and rurality (Cummings et al. 2013a, 2017). Moreover, outpatient mental health treatment facilities are also less likely to be located in smaller communities (i.e., zip code tabula-

tion areas) with >50% Black and Latinx residents than in communities with <1% of residents from either group, respectively (Cummings et al. 2017).

The literature to date has not explicitly tested the mechanisms to explain why these communities of color experience shortages of the very safety net providers intended to make up for private sector inequities. Limited federal investment in the outpatient mental health care safety net may be a contributing factor. In contrast to primary care community health centers, outpatient mental health facilities operate without additional federal grants or reimbursements and receive little attention or support for quality improvement. Because federal investment in the outpatient mental health care safety net is limited, mental health facilities may be unable or unwilling to operate in the same way that community health centers operate, thus being less likely to exist in communities of color.

Conclusion

Structural inequities shape the affordability, accessibility, and availability of mental health services in the United States. These barriers intersect with structural and institutional racism to produce even greater inequities for communities of color. In their review of deinstitutionalization, Mechanic and Grob (2006) described the consequences of moving services to persistently underresourced community settings: a rise in homelessness, substance use disorders, and admissions to nursing homes, along with the criminalization of people with mental illnesses. They coined the term *transinstitutionalization* because individuals with severe mental illnesses were simply shifted from one institutional setting to another. Unfortunately, none of these alternative institutional settings have been properly equipped to provide adequate services to the populations most in need of accessible, high-quality mental health care.

Questions for Self-Reflection

1. If I have mental health care coverage, how good is this coverage? How does my own health care coverage improve or exacerbate mental health inequities?
2. What decisions went into my choosing what type of mental health care delivery system to practice in?
3. What was my state's decision regarding Medicaid expansion? How has this decision impacted my patients, if at all?

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