OPINION

A Prescription for Equitable Access

Katherine Chen

During a year when COVID-19 illness and prevention dominated conversations about health care, the pandemic also made it more difficult for many Americans to go to the doctor for non-COVID-19 care.

In June 2020, more than one in three Americans reported that they had delayed or not received necessary medical care within the past month because of the pandemic. By late March 2021, that figure had improved only slightly, to nearly one in four. The reasons for this delayed or missed care are many, but transportation is one of them.

During the pandemic, trips to the doctor's office, like all travel, became more complicated. Stay-at-home orders, cuts to public transit service, and suspension of some shared-ride programs — not to mention concerns about contracting or spreading COVID-19 — deprived people of their usual ways of moving around. Even when people could travel for health care, many found they had no place to go. Many community clinics temporarily reduced their hours and canceled most in-person visits and non-emergency procedures. Moreover, many people who lost their jobs also lost their health insurance or had to switch to lower-cost plans that covered fewer services at fewer locations.

Although it's difficult to assign transportation a precise share of the blame for the pandemic's disruption of medical care, it is clear that transportation played a role. As we emerge from a year of isolation and uncertainty, we have reason to fear that COVID-19's impact on transportation has widened health disparities that existed well before the pandemic began.

Black, Latinx, and low-income communities have long contended with higher rates of chronic health conditions that require in-person care — such as heart failure, end-stage kidney disease, and prostate or cervical cancer — as well as greater difficulty reaching that care. One study estimated that Black and Latinx patients, compared to white patients, were about twice as likely to have delayed seeking health care specifically because of transportation problems. A big part of the problem is that driving, whether to the doctor's office or anywhere else, is often a privilege of the healthy. In general, the most medically vulnerable patients not only seek health care more often, but also — because of their worse health and lower socioeconomic position — more often rely on public transit, rides from others, or programs like paratransit and Medicaid's Non-Emergency Medical Transportation service, or NEMT, to access that frequent care. Patients with end-stage kidney disease, for example, typically take three to four round trips each week to undergo hemodialysis, a life-sustaining process that filters their blood to remove toxins and excess fluids. About three-quarters of these patients rely on transportation programs or rides from others to get to dialysis.

The COVID-19 pandemic has likely made it even harder for these disadvantaged groups to get health care when they need it. A CDC report from June 2020 found that Black and Latinx adults were 33% and 53% more likely than white adults to have delayed or avoided any

medical care due to concerns about COVID-19. Differences in car access may, again, explain at least part of this disparity. Low-income people and people of color are more likely to rely on modes of travel — such as public transit and carpooling — that make social distancing difficult, and that (in the case of transit) have seen service reduced during the pandemic. In these situations, seeking medical care is more likely to involve tough decisions about whether the benefit of the visit is worth the risk of the trip.

Can technology help address these challenges? Health systems have been able to replace many clinic visits with telehealth (care delivered via phone or video call), which eliminates the need to travel. However, disparities in access to technology and broadband internet mean that telemedicine programs have been less effective at reaching lower-income populations and communities of color. Many tests and treatments, moreover, still require in-person care. There is no way to get hemodialysis over Zoom.

To keep patients healthy and allow them access to needed in-person care, policymakers must ensure continued political and financial support for transportation programs. Maintaining transportation services during the current downturn in transit ridership is important not just for connecting patients to care, but also for reducing crowding and minimizing COVID-19 transmission risk for transit operators and passengers. This ongoing investment will also keep transportation services viable in the long term, especially once people start seeking out the care they have delayed as a result of the pandemic.

Still, the striking pre-pandemic inequities in transportation to health care remind us that sustaining existing transit programs, while necessary, is not sufficient for achieving access to health care for all. The political, economic, and social forces — including structural racism — entangled at the root of disparities in transportation and health mean that transportation leaders would be wise to seek outside help. Progress toward equitable access to health care during and after the pandemic will likely require multiple levels of collaboration among transit agencies, transportation service providers, health care systems, health insurers, and communities.

First, transportation programs should work with local health systems to streamline enrollment in services like paratransit and other non-emergency medical transportation. Because patients who miss care due to transportation problems often return later with more serious health conditions, many health systems have already begun to implement screening tools that ask patients if they need transportation assistance. If they do, social workers or case managers then help patients apply for relevant transportation assistance programs. These screening protocols are helpful because applying to the programs is often confusing and difficult, sometimes requiring in-person interviews with the patient and/or added paperwork from patients' doctors. A still-better reform, however, would be to simplify these cumbersome processes; doing so can decrease delays in care, and thus reduce both avoidable suffering and expense.

Second, policymakers should consider making it easier for Medicaid programs to contract with ride-hailing companies to offer NEMT rides on-demand. Several states have already taken this step in response to stories of patients who missed vital care because of a late ride or other problems with conventional transit services. The more flexible rides offered through these partnerships could offer better service and might also accommodate more social distancing than public transit.

Third, transportation leaders should support efforts by other sectors to help deliver health care, including COVID-19 vaccines, where patients live, shop, and work. For example, policies to increase access to telehealth and mobile clinics in transportation-disadvantaged communities can improve access to certain routine health services while freeing up transportation resources to help the sickest patients get the in-person care they need.

Finally, both transportation and health care providers must partner with patients from the communities most marginalized by both industries. With population health on the line,

we cannot afford blunders like prioritizing drivers in the design of mass COVID-19 testing sites in cities where many people don't own cars. To design better systems that serve a range of health care and transportation needs, we must work harder to include, listen to, and learn from people from historically oppressed communities at all levels of decision-making.

One year into the pandemic, as rollout of the COVID-19 vaccine offers a glimpse of a post-pandemic world, transportation and health care practitioners face a critical moment to act together, across disciplines, to advance equity in health and transportation.

This work is based on a report and manuscript sponsored by the University of California Institute of Transportation Studies. The author wishes to thank Madeline Brozen, Jeffrey Rollman, Tayler Ward, Keith Norris, Kimberly Gregory, and Frederick Zimmerman for their vital contributions to the original report and article.

About the Author

Katherine Chen, MD, is an internal medicine physician, a postdoctoral fellow in the National Clinician Scholars Program, and a Ph.D. student in health policy & management at UCLA. Her research explores equity issues at the intersection of urban planning and population health, with a focus on reducing health disparities and improving access to opportunities for well-being through policies that shape housing, transportation, and neighborhood environments.