# Insurance and Financial Concerns Among Patients Seeking Care for Acute Myocardial Infarction

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*Published in:*
Journal of the American Medical Association

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*JAMA*. 2010;304(5):523 (doi:10.1001/jama.2010.1070)

http://jama.ama-assn.org/cgi/content/full/304/5/523

and clinically more informative to compare new users of one drug with new users of a comparison drug.[4,5]

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**Financial Disclosures:** Dr Schneeweiss reported being a paid member of the scientific safety advisory boards of HealthCore Inc and ii4sm; being a paid consultant to HealthCore, World Health Information Science Consultants, and RTI International; and having received an investigator-initiated research grant on the safety of nonsteroidal anti-inflammatory drugs from Pfizer. No other disclosures were reported.

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## Insurance and Financial Concerns Among Patients Seeking Care for Acute Myocardial Infarction

**To the Editor:** Dr Smolderen and colleagues[1] found that both lack of insurance and concerns about costs among patients with insurance were associated with delays in seeking emergency care for acute myocardial infarction (AMI). They also found that an increased prehospital delay was associated with receiving less subsequent primary reperfusion therapy. Their observations are consistent with the treatment-risk paradox: high-risk patients are the ones who are least likely to access appropriate medical care.

There is a possible role of depression in their findings. Depression is a prominent motivational factor for help-seeking behavior and is associated not only with excess care utilization but also with nonadherence to medical care and reduced access to care. Globally, depression is one of the leading disorders contributing to the overall burden of disease, and it is intertwined with coronary artery disease. Depression in MI patients is associated with an increased risk of new cardiovascular events or death,[2] low socioeconomic status,[3] reduced access to cardiac aftercare,[4] and delays in health care–seeking behavior.[5]

Depressed MI patients seem more likely to have no assurance and more concerns about health care costs. It is conceivable that depression results in inadequate health-related help-seeking behavior, and in combination with poor insurance status leads to suboptimal care.

Current options for depression treatment are only moderately effective. It may be far better to detect high-risk patients early and to prevent depression by reducing wealth inequalities on a national level and promoting access to care for the most vulnerable.

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**Financial Disclosures:** Drs van Riezen and de Jonge reported receiving grant support from the Dutch Medical Research Council.

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**In Reply:** In contrast to the assertion of Drs van Riezen and de Jonge of a treatment-risk paradox in our findings, we would note that the treatment-risk paradox refers to a pattern in which *physicians* paradoxically apply therapies to patients with the least potential to benefit and less often apply therapies to those with the most opportunity to benefit.[1] Instead, we have documented a *patient* behavior associated with insurance status and likelihood of presenting promptly for care of an AMI. Our concern is the implication of insurance status and potential disparities in access to care.

We agree that it is important to examine whether potential psychosocial factors—such as depression—may confound the relationship between insurance status and prehospital delay times in patients with AMI. Indeed, our study found that uninsured patients and insured patients with financial concerns about accessing care each had an independent association with longer times to hospital presentation, even after adjusting for depressive symptoms and other important psychological and socioeconomic variables, such as perceived stress, social support, marital status, educational level, and residential zip code income.

There is a need for increased awareness about the association of depression and cardiovascular disease.[2] Accordingly, the Figure in our article reported that patients with moderate to severe depressive symptoms were more likely to delay seeking care during AMI (adjusted odds ratio, 1.21; 95% confidence interval, 1.03-1.42). However, we did not find that depression was an effect modifier of the relationship between health insurance status and prehospital delays ($P$ for interaction = .27). Although van Riezen and de Jonge have suggested that reducing wealth inequalities on a national level would prevent depression, it remains unclear to us the extent to which depressive symptoms present

in patients with AMI are caused by environmental vs biologic factors.

We do believe our findings underscore important consequences from inadequate health care insurance coverage for the substantial number of US residents experiencing AMIs. Whether evolving changes in health care coverage in the United States are associated with reductions in our observed disparities will be important to assess as these changes take effect.

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**Financial Disclosures:** Dr Spertus reported that he developed and owns the copyrights for the Seattle Angina Questionnaire. None of the other authors reported financial disclosures.

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## Donor Policies for Stem Cell Transplantation

**To the Editor:** In their Commentary, Drs Godley and van Besien[1] wrote of the challenges to finding HLA-matched donors for patients requiring hematopoietic stem cell (HSC) transplantation, especially when seeking unrelated donors in the National Marrow Donor Program (NMDP) registry, and proposed novel scientific approaches to overcome this challenge. However, one simple step toward improving the chance of finding a matched donor—and potentially saving more lives—remains unmet.

According to its Web site,[2] the NMDP appears to defer to the requirements for blood donation of the US Food and Drug Administration (FDA), whose policy states, "Men who have had sex with other men [MSM], at any time since 1977 (the beginning of the AIDS epidemic in the United States) are currently deferred as blood donors."[2,3] This lifelong ban from blood donation is neither medically nor scientifically supported and has been challenged by many leading authorities,[4] including the American Medical Association, whose policy states that "a shift to a 5-year deferral policy for blood donation from men who have sex with men (MSM) is supportable."[5]

Finding matched blood donors is relatively simple; therefore, excluding MSM reduces the volume of available blood products but not the likelihood of finding a certain blood type. The stakes in marrow donation are much higher: every individual who is precluded from donation may represent a patient's only chance for an acceptable HLA match. Given the relatively low number of healthy individuals who have joined the NMDP, the inclusion of MSM could have a significant effect.

At a minimum, MSM could be allowed to join the registry with their risk noted. If they turn out to be the only match for a patient requiring HSC transplantation, that risk could then be evaluated against the potential benefit by the individual patient and his or her medical team.

I believe that the FDA should modify its policies, or the NMDP should develop its own policies that take into account the special challenges faced by those seeking a stem cell donor.

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**Financial Disclosures:** None reported.

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**In Reply:** Mr Tischler raises an important issue surrounding the restrictions put forth by the NMDP for potential donors of HSCs. Although the NMDP health history questionnaire would seem to indicate linkage to the FDA policy on blood transfusion, this is unfortunately misleading. When an individual enters the NMDP system to register, one of the health questions asked (of men only) is " . . . In the past 5 years have you had sex, even once with another male?" However, given the sensitive techniques for detection of HIV and other transmittable viruses, even this has become a controversial issue.

By their very nature, restrictions limit the HSC transplant donor pool.[1] The MSM restriction highlighted by Tischler is one such limitation. Other viral diseases such as hepatitis B and C also preclude someone from registering to be a potential donor. In addition to exposure to viruses, the NMDP excludes donors on the basis of age, only accepting donors 60 years and younger, although many older adults can collect sufficient numbers of HSCs to allow allogeneic stem cell transplantation.[2]

We agree with Tischler that when HLA-matched unrelated donors are limiting, there might be potential matched donors who are excluded based on the current policies of the NMDP. We support a tiered system in which patients and their treating physicians could learn of such potential donors who would have been traditionally excluded if no other HLA-matched donors were available and allow the patient and his or her medical team the option to select such a donor. Unfortunately, such a change to the current system would not help patients with rare HLA alleles, which was the subject of