

Reassembling Our View of Vulnerable Populations

TO THE EDITORS:

The article titled “Impact of Copays in Vulnerable Populations” on the November supplement of *The American Journal of Managed Care* makes an important contribution to the literature through the comprehensive review of the healthcare experiences of a wide range of different vulnerable populations and their sensitivity to increasing copayments.¹ This review describes the experiences of the poor, the uninsured, the chronically ill, the elderly, the mentally ill, and others. What is missing from this review, however, is a reflection that these vulnerable groups overlap considerably (eg, the elderly are more likely to be chronically ill and also be poor), and that their experiences are likely to reflect the multiple risk factors that they experience. It is likely that increasing cost sharing may have exaggerated effects on prescription filling and use among those who are both elderly and poor.

Such overlap of populations is nothing new, but rarely do we as researchers explicitly recognize the concomitant and potentially combinatorial effects of risk factors, such as poverty and lack of insurance. Shi and Stevens are only among the latest to argue that we view most vulnerable populations by the collection of health or healthcare risk factors they possess, and work harder to understand their interactivity.² Previous studies have indeed counted the number of risk factors a person has and have shown clear gradients in health services use, quality of care, and health status.³⁻⁵ At its simplest and arguably finest, however, the vulnerability construct can be measured by examining those with multiple risk factors versus 1 or none (as the authors smartly did in reviewing the experiences of dual eligibles for Medicare and Medicaid).

The general lack of discussion concerning multiple risk factors from the review is not the fault of the authors, as it is something that has been missing almost entirely from the literature that was available for review. While each of the studies reviewed fills an important gap in knowledge, it is time that we begin to rethink vulnerable populations as comprehensive wholes, not as just distinct categories, however a difficult challenge. Researchers must identify strategies to comprehensively measure vulnerable populations; administrators need to be flexible enough to design or modify programs to account for multiple, overlapping risks; and practitioners need information and tools for how to serve patients who have multiple risks or comorbidities.

The supplement article provides an important first step because it effectively defines the range of research knowledge on the experiences of many different vulnerable groups. The next important step is to reassemble this information and recognize that in pharmacy and clinic practice, as elsewhere, vulnerability is considerably more than the sum of its parts.

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