

Achieving Health Equity: An Incremental Journey

Racial and ethnic disparities in health and health care have been well documented in a broad range of medical conditions and health care services in numerous settings.^{1–6} These disparities are not trivial. For example, African Americans suffer shorter life expectancy and higher rates of cancer, stroke, heart disease, HIV, and mental illness than do Whites.⁷ American Indians and Alaskan Natives also experience shorter life expectancy than that of Whites.⁸ Puerto Ricans, a subset of Hispanic ethnicity, have a significantly higher infant mortality rate than do Whites.⁹ Racial and ethnic disparities also exist in the utilization of specialist care, preventive services, renal and bone marrow transplants, and orthopedic procedures such as knee and hip replacements.¹⁰

There are several reasons why identifying and understanding health disparities and marshaling the “political will” needed to eliminate them are essential for all Americans. First, health and well-being are measures of social equality and quality of life. This concept was captured by Rudolph Virchow, a 19th-century German physician and public health scholar, who believed that health is an indirect measure of a society’s collective democracy (freedom).¹¹ Second, poor health in one sector of society is a threat to the public health of the whole society. This link was recognized in the days of Hippocrates, who is rumored to have said, “Tell me where you are from and I will tell you what is ailing you.” Third, health and health care disparities represent

moral and ethical problems for health care providers and for society as a whole. To provide unequal care is untenable in a democratic society. For these and many other reasons, not the least of which is the economic cost to society, the elimination of disparities in health status and access to health care is now a national priority.

HISTORY OF INEQUALITIES

Racial and ethnic disparities in health and health care are rooted in historic socioeconomic inequalities that persist in the United States today. Our knowledge about the extent and origins of health disparities has evolved over the years and come to the forefront of national attention over the past 2 decades. For instance, the significantly higher burden of infant mortality and communicable diseases, such as tuberculosis, among African Americans has been evident since the days of slavery. With the advent of “germ theory” and the scientific advances it ushered in at the turn of the century, health improved for all Americans, including racial and ethnic minorities. Advances in public health over the last century, combined with post–World War II expansion of the health care delivery system and creation of the biomedical industry, have all contributed to the collective improvement in the health of the nation.

During the latter part of the 20th century, the public health concept of disease causation,

“host-agent-environment,” became the consensus paradigm. Lifestyle factors such as smoking, excessive alcohol consumption, high-fat diets, and lack of exercise assumed a central role in theories about health and disease. However, it took the passage of the Medicare/Medicaid Act in 1965, along with the social justice victories of the civil rights movement, before Americans from racial and ethnic minority populations, most notably African Americans, were free to enter the nation’s medical care institutions.

ACCESS TO CARE

An examination of contemporary research on disparities in access to medical care provides 3 broad domains for understanding the origins and persistence of racial and ethnic health disparities. The first domain involves patient-level variables, such as biology, individual disease status, and psychosocial characteristics such as cultural or individual preferences. The second domain involves characteristics and practices of health care professionals, such as racism, stereotyping, bias, discrimination, and cultural or professional incompetence. The third domain involves the system of health care delivery, including racial and ethnic diversity of the workforce, geographic proximity of health care facilities to communities in greatest need, accessibility of medical care regardless of the patient’s ability to pay, and representation of minorities in shaping health policy and allocation of resources. Strategies de-

signed to eliminate racial and ethnic health disparities must target all 3 domains as potential mediators of health inequality.

EVOLVING RESEARCH ON HEALTH DISPARITIES

Just as our conceptualization of the origins of health disparities is expanding, so is research on health disparities evolving. The first generation of health-disparities research often relied on the use of large administrative and clinical databases to document disparities in health care access, utilization, and outcomes. While effective in documenting disparities, this research shed little light on the reasons for disparities or on what could be done to eliminate them. Second-generation research on disparities advanced the field a step further by examining the patient-, provider-, and system-level factors that mediate health disparities, often through prospective, primary data collection. Third-generation research, the current frontier in this field, targets specific, modifiable factors and studies interventions to reduce or eliminate disparities.

CLOSING THE GAP

On February 21, 1998, President Bill Clinton announced a new initiative that set a national goal of eliminating longstanding racial/ethnic disparities in health status by 2010. The president announced that the federal government would, for the first time, set high national health goals for all Americans, ending a practice of separate, lower goals for racial and ethnic minorities.¹² Today, with the support of President George W. Bush, there are mounting public and private

coalition efforts aimed at “closing the gap” to eliminate racial and ethnic disparities in health and health care. There is a compelling need, therefore, to bring together representatives from federal, state, and local governments and private foundations, as well as health care providers and payers, academics, research participants, and opinion leaders from minority communities, to gauge progress in this national effort.

Since January 2000, the Center for Minority Health in the Graduate School of Public Health at the University of Pittsburgh has hosted the Annual National Minority Health Leadership Summit to provide such a forum. The 2001 summit theme was “Mapping a Course for Community Action and Research,” the theme for 2002 was “The Impact of Discrimination on Health Status,” and the theme for 2003 was “The Role of Community-Based Participatory Research.” The summit is funded by the Office for Civil Rights, the US Department of Health and Human Services, the National Institutes of Health, the Veterans Administration Health Services Research and Development Service, and the University of Pittsburgh Medical Center. In addition, generous financial support is provided by local foundations, including the Maurice Falk Medical Fund, the Pittsburgh Foundation, the Heinz Endowments, and the Jewish Healthcare Foundation.

The articles and editorials featured in this issue of the Journal reflect the content and scope of the scientific and community-based interventions presented during the 2003 summit.¹³ Collectively, these articles and editorials describe the continuum of observational, explanatory, and

interventional research on racial and ethnic health disparities.

Two of the articles report results from community-based participatory research. Ammerman et al. describe effective strategies for reaching out to pastors and lay community leaders to facilitate health care research at the community level.¹⁴ McAllister et al. review community-based participatory research methods using the Early Head Start Program as a model.¹⁵ Translating scientific evidence from research on health disparities to the community level is critical to improving the health of the community.

Other featured articles address the importance of early diagnosis in HIV/AIDS and the impact of comorbidity on prostate cancer survival. McGinnis et al. show that African American HIV-positive veterans experience poorer survival than White veterans and that this difference may be related to comorbidity and disease status.¹⁶ Freeman et al. found that race, age, and income are important predictors of all-cause mortality in prostate cancer.¹⁷ In a subsample of veterans, they found that comorbidity was a key determinant of all-cause mortality in prostate cancer.

Brown et al. and Saha et al. examined, respectively, quality of diabetes care and satisfaction with and use of health care among Hispanic, Asian, African American, and White patients. Brown et al. report that Latino patients with diabetes have lower rates of self-monitoring of blood glucose levels and worse glyce-mic control than their White counterparts.¹⁸ Saha et al. found that Hispanic and Asian patients report lower satisfaction with and use of health services than do African American and White patients.¹⁹ These 2 articles point to

the role of patient-level factors and patient-physician communication in racial/ethnic disparities in health care and utilization of services.

Ibrahim et al. report findings from a sample of VA and private-sector patients regarding physician recommendations for cardiac revascularization.²⁰ They found that in a sample of VA patients with confirmed coronary artery disease, cardiologists were less likely to recommend revascularization to African American patients than to White patients with similar disease severity, suggesting that provider-level factors may play a role in the marked racial/ethnic disparities observed in utilization of this procedure. This finding is noteworthy because the VA health care system is considered a “colorblind” single-payer system with universal access to care for all veterans, regardless of ability to pay.

In an example of third-generation research on disparities, where the goal is to effect change, Zimmerman et al. present findings that support the effectiveness of tailored interventions to improve immunization rates in inner-city health centers.²¹ Finally, Kressin et al. address an important methodological issue in VA research on health care disparities, namely missing race/ethnicity data.²² They suggest that previous studies using large VA databases to examine racial/ethnic disparities may have underestimated the extent of these disparities. This work demonstrates that although we may be ready to act on observed disparities, there are still methodological challenges to be overcome if we are to accurately assess the extent of these disparities and our progress in eliminating them.

ONE STEP CLOSER

Racial and ethnic disparities in health and health care are an important measure of equality in our nation. These disparities are historically rooted in inequities from the past that persist today. Research during the last several decades has made a significant contribution in outlining the extent of these disparities, determining the factors that contribute to them, and setting in motion a national initiative to eliminate them. The University of Pittsburgh's National Minority Health Leadership Summit, to which this theme issue is dedicated, provides a forum for gauging progress in this campaign and for facilitating dialogue among researchers, advocacy groups, and communities committed to eliminating health inequalities. The articles featured in this theme issue represent the diversity of research on public health and medical disparities and set the agenda for action that is needed to take us one step closer in the journey to health equity—the elimination of health inequalities. ■

Said A. Ibrahim, MD, MPH,
 Stephen B. Thomas, PhD,
 and Michael J. Fine, MD, MSc

About the Authors

The authors are with the VA Center for Health Equity Research and Promotion, Pittsburgh, PA. Said A. Ibrahim is also with the Department of Medicine, University of Pittsburgh School of Medicine and Graduate School of Public Health. Stephen B. Thomas is also with the Center for Minority Health, University of Pittsburgh Graduate School of Public Health. Michael J. Fine is also with the Center for Research on Health Care, University of Pittsburgh, and the Department of Medicine, University of Pittsburgh School of Medicine.

Requests for reprints should be sent to Said A. Ibrahim, MD, MPH, Center for Health Equity Research and Promotion, VA Pittsburgh Healthcare System, Univer-

sity Dr C, 11-East (130 A-U), Pittsburgh, PA 15240 (e-mail: said.ibrahim2@med.va.gov).

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