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# Editorial Column

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## Addressing Health Disparities: Where Should We Start?

It has long been recognized that the health status of minority populations is poorer than that of whites. The recent Institute of Medicine report titled *Unequal Treatment* has compiled a convincing body of evidence that among similarly insured groups, minority populations receive less care than whites (Institute of Medicine 2002). While most of the studies have focused on African American–white comparisons, disparities exist across all race and ethnic groups studied and span a wide clinical spectrum. While the causes of disparities are clearly multifactorial and extend well beyond the health care system, improving health care will address an important contributor to disparities. It is now time to move from documenting the problem, to taking action.

The challenges of knowing what to do—what actions to take—are significant. For example, many health care providers are unaware of the fact that disparities exist, or of their magnitude. This finding has led the Kaiser Family Foundation and the Robert Wood Johnson Foundation to partner with professional organizations in mounting a physician awareness campaign. Other research has suggested that subconscious bias on the part of health care providers may contribute to disparities, and has pointed to potential interventions in the patient–doctor interaction as a way to address disparities. Not surprisingly, many health care professionals are offended by the notion that they may harbor such biases, and reject the need for interventions directed at their attitudes or behaviors. An additional body of research points to inequalities in quality of care, and suggests that interventions to improve quality could succeed in addressing disparities (Fiscella et al. 2001). Unfortunately, most health systems do not currently collect data on race and ethnicity of their patients, so measuring disparities will be a challenge (Bierman et al. 2002; Nerenz et al. 2002). Furthermore, it has not been clear that there is a compelling business case for doing so. Finally, uneven performance of public health systems has been identified as a potential contributor to disparities in use of services, suggesting that improved function of the public health systems could at least increase awareness of the need for care (Lurie 2002).

How are we to choose among such a wide array of potential strategies? Two papers in this issue of *Health Services Research* may provide some needed guidance. First, Krein et al. examine practice variation among primary care providers, provider groups, and health care facilities in a Veterans Affairs' integrated service network (Krein et al. 2002). These service networks are unique in that they are linked through the VA Health Information System. Interestingly, they found that the greatest amount of variation potentially attributable to practice variation was at the facility level, not the primary care provider level. This would suggest that intervention at a facility level might be expected to provide greater opportunity to improve quality than intervention with individual providers, at least in terms of the measures studied. While empirical evidence is still needed, it seems likely that such interventions would go far to address gaps in quality of care that are associated with race and ethnicity. One challenge to quality improvement is the frequent lack of data on race and ethnicity with which to directly measure differences in quality. However, as awareness of disparities grows, numerous systems are finding ways to surmount the data collection challenges so that quality for different groups can be measured directly. Meanwhile, facility and systems level interventions can be implemented and progress can be monitored for populations overall.

Schoenbaum et al. report additional findings from the Partners in Care study, which was a randomized controlled trial of quality improvement for depression (Schoenbaum et al. 2002). While the parent study reported impressive improvements in depression outcomes for a diverse group of patients achieved through system changes in primary care practices (Wells et al. 2000), this study addresses issues surrounding the business case for quality. Using state-of-the-art methods to address issues of selection bias, the authors report dramatic increases in employment for those that received appropriate care for depression. While this finding is important in its own right, it is also important to remember that depression is a major determinant of outcomes of other chronic diseases, including diabetes and heart disease. Hence the benefits of system-based approaches to attaining appropriate care are likely to have even further-reaching effects on chronic disease outcomes, and potentially on the employment status of those for whom depression complicates other chronic disease. Approximately a third of the study group for Partners in Care was Hispanic. In addition to the presentation of overall findings, it would be useful to examine health and social outcomes, including employment status for major race and ethnic subgroups. This would advance our knowledge about whether intervention effects are indeed generalizable

across different populations and would be additionally important because minority populations have worse outcomes from chronic disease.

While these studies do not demonstrate that approaching disparities from the perspective of quality will abolish disparities in health or in health care, they do suggest that system interventions are reasonable places to start in the quest to eliminate disparities.

Nicole Lurie, M.D., M.S.P.H.  
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## REFERENCES

- Bierman, A., N. Lurie, K. S. Collins, and J. M. Eisenberg. 2002. "Addressing Racial and Ethnic Barriers to Effective Health Care: The Need for Better Data." *Health Affairs* 21 (3): 91-102.
- Fiscella, K., P. Franks, M. R. Gold, and C. M. Clancy. 2000. "Inequality in Quality: Addressing Socioeconomic, Racial, and Ethnic Disparities in Health Care." *Journal of the American Medical Association* 283 (19): 2579-84.
- Institute of Medicine. 2002. *Unequal Treatment*. Washington, DC: National Academy Press.
- Krein, S., T. Hofer, E. Kerr, and R. A. Hayward. 2002. "Whom Should We Profile: Examining Diabetes Care Practice Variation among Primary Care Providers, Provider Groups, and Health Care Facilities." *Health Services Research* 37 (5): 1159-80.
- Lurie, N. 2002. *Measuring Disparities in Access to Care* (in press, Institute of Medicine). Washington, DC: National Academy of Sciences.
- Nerenz, D. R., V. L. Bonham, R. Green-Weir, C. Joseph, and M. Gunter. 2002. "Eliminating Racial/Ethnic Disparities in Health Care: Can Health Plans Generate Reports?" *Health Affairs* 21 (3): 259-63.
- Schoenbaum, M., J. Unützer, D. McCaffrey, C. Sherbourne, and K. B. Wells. 2002. "The Effects of Primary Care Depression Treatment on Patients' Clinical Status and Employment." *Health Services Research* 37 (5): 1145-58.
- Wells, K. B., C. Sherbourne, M. Schoenbaum, N. Duan, L. Meredith, J. Unützer, J. Miranda, M. F. Carney, and L. V. Rubenstein. 2000. "Impact of Disseminating Quality Improvement Programs for Depression in Managed Primary Care: A Randomized Controlled Trial." *Journal of the American Medical Association* 283: 212-20.