The Challenge of Eliminating Disparities in Health

I'm sick and tired of being sick and tired.
—Fannie Lou Hamer (1917–1977)

Fannie Lou Hamer, an African-American voting rights activist from Mississippi, expresses the complexity of understanding health and illness in her simple declaration that is engraved on her tombstone. Poor and without formal education, she fought to register to vote. In 1964, she challenged the Democratic Party's seating of an all-white delegation to represent the state of Mississippi at the Democratic national convention. In the last years of her life, she organized grass-roots antipoverty projects. Mrs. Hamer had hypertension, diabetes, and cancer, problems common among African-American women. Anyone who knows Mrs. Hamer's story understands that she is not talking about only her physical health when she speaks of being sick. In the moment, she was tired of the day-to-day struggles she faced on an ongoing basis, with no end in sight.[1]

While racial and ethnic disparities in health have been documented in the United States for decades,[2,3] and although the federal government has called for the elimination of racial disparities, we are not completely knowledgeable about what accounts for disparities and what to do to address them. Growing attention to disparities comes at a time when the demographic profile of the United States is changing, with a growing percentage of the population represented by people from racial and ethnic minority groups. To assure the health of the public and the ability of the United States to be an economically strong country requires a healthy citizenry and healthy workers. Several articles in this month's journal demonstrate the difficulty and complexity of the challenge of eliminating racial and ethnic disparities in health.

Corbie-Smith et al.[4] and Stewart and Silverstein[5] report on analyses of data from the Medical Expenditure Panel Survey to understand factors that may contribute to disparities in prevention screening. Although both groups found some disparities in self-report of screening procedures, the extent of the disparities were less than previously described, especially among African Americans. Hispanics reported having fewer preventive services, including breast exams, blood pressure screening, and cholesterol screening. Stewart and Silverstein point out the importance of within-group diversity; they found that Mexican Americans, but not other Hispanics, were less likely to report having blood pressure and cholesterol checked than were non-Hispanic whites and African Americans. Both groups of researchers found that indicators of access to care, such as having a usual source of care and insurance, accounted for some, though not all, of the disparities they did find.

Hill-Briggs et al.[6] demonstrate the strong relationship between the physical environment, socioeconomic factors, and health status among African Americans from an impoverished inner-city community. They report a strong association between health-related quality of life scores and financial difficulties, housing, street crime, and family and caretaker responsibilities. Not surprisingly, the more socioeconomic and familial barriers described by an individual, the lower the health scores. Reduced health-related quality scores were in turn associated with obesity, renal function, insulin use, and comorbid disease. Individuals reported that social and familial factors substantially interfered with their ability to pay attention to their health, even with home visits from community health workers. This is what my patients have told me for years... "I don't always have the time or energy to do what I need to do." Or "Sometimes I'm just too stressed out to pay attention to my health." Eliminating racial disparities therefore requires an understanding of the ecology of health, the interconnectedness of biologic, behavioral, physical, and socioenvironmental factors that determine health.

Cooper et al.[7] provide an extremely valuable framework for designing and evaluating interventions to address disparities. Several layers of intervention are necessary, including improvement of the physical environment, social and economic factors, access to effective health services, and changing personal behavioral risk factors. Cooper et al. suggest, however, that health care professionals have the ability to fix the health care system and little ability to address contextual factors. Thus, they limit their recommendations to designing interventions to eliminate disparities in health care by paying attention to access, financing, quality of care, interpersonal factors, and patient preferences and behaviors. The summary of factors to ensure successful research, including involving the target community or population, should be valuable to funders and to academicians. Funders should pay attention to the additional resources, both in the community and in the academic center, that are required for this research. Academic leaders should pay attention to the groundwork that needs to be laid before research is actually implemented. The recommendations for research design and evaluation are critical in this day of backlash questioning the legitimacy of the extent of racial disparities and their causes.[8]

Moving forward to eliminate disparities will require, as Cooper et al. point out so eloquently, comprehensive approaches and well-designed interventions at the personal, institutional, and community level. The importance of clear objectives, experimental research designs, culturally and linguistically appropriate interventions, standard methods for measuring key variables including race and ethnicity, and appropriate dissemination plans are practical and doable. But we are still not sure about all the factors that contribute to disparities, or about the level

(individual, system, or community) at which interventions are likely to be most effective. There are also long-standing barriers that get in the way of pursuing a comprehensive approach to eliminating disparities.

We need to develop a common language with which to talk to each other and with "the community" about factors that are related to race and racial discrimination. In not talking explicitly about race and racism, the medical community loses credibility. A significant percentage of the American public believe that racism in medicine is a major problem,[9] and a significant percentage of African Americans, Latinos, and Asian Americans report experiencing bias, discrimination, or disrespect in the health care system.[9,10] Talking about race and racism often engenders an affective response that overwhelms the reasoned scientist in us. It is painful for most Americans to confront racism and particularly painful for health professionals because we are, after all, the caring profession. We need a better understanding of what racism means at the individual, interpersonal, and institutional level, and we need to know how these various forms influence health. Some researchers believe that chronic low-grade stress, as experienced by some people of color in the United States, is bad for one's health.[11–13] We also need a better understanding of the extent to which social and economic factors contribute to disparities, and of the degree to which the differential can be addressed in the health care system. Cooper's recommendation to begin with monitoring quality of care is an important place to start. But even defining what constitutes quality care requires a better understanding of whether the same quality measures can be applied across all groups to assess whether quality care is present.

What we do to further our understanding will have tremendous implications for funders, researchers, policy makers, health care leaders, and clinicians. Researchers who choose to study strategies for addressing disparities face significant challenges in terms of funding, the time it takes to establish interdisciplinary research, the commitment it takes to develop community-based research, and the need to develop a range of measures (including a reasonable mechanism to measure racism) to track all the possible factors that contribute to disparities. Furthermore, we need to better understand how to change systems of care and implement recommendations that result from disparities research.

And perhaps we are going at this the wrong way. In spite of the burdens placed on many individuals of color (and many communities of color), not all of these individuals will die prematurely or have a bad outcome in the health care system. Why do foreign-born blacks have better health outcomes than those who were born in the United States? What can we learn from those who are doing well? What is unique about these individuals?

The lessons we learn about how to eliminate health disparities will likely not lead to a one-size-fits-all approach. Isolating the aspects of health care that contribute to health disparities is an important but difficult task. An even bigger challenge will be to pull together all the pieces and develop a health care system that will work for all Americans within the context of what could be a better society. Fannie Lou Hamer knew that we could be a better society, and sometimes she got tired of fighting for it. And that is what made her sick. — **JUDYANN BIGBY, MD,** *Brigham and Women's Hospital* and *Harvard Medical School, Boston, Mass.*

REFERENCES

1. Mills K. This Little Light of Mine: The Life of Fannie Lou Hamer. New York: Dutton; 1993.
2. Keppel KG, Pearcy JN, and Wagener D. Trends in Racial and Ethnic-Specific Rates for the Health Status Indicators: United States, 1990–98. Healthy People 2000 Statistical Notes. Atlanta, Ga: Centers for Disease Control and Prevention; 2002.
3. The Morehouse Medical Treatment and Effectiveness Center. Racial and Ethnic Differences in Access to Medical Care: A Synthesis of the Literature. Menlo Park, Calif: The Henry J. Kaiser Family Foundation; 2000.
4. Corbie-Smith G, Flagg EW, Doyle JP, O'Brien MA. Influence of usual source of care on differences by race/ethnicity in the receipt of preventive services. J Gen Intern Med. 2002;17:458–64.
5. Stewart SH, Silverstein MD. Racial and ethnic disparity in blood pressure and cholesterol measurement. J Gen Intern Med. 2002;17:405–11.
6. Hill-Briggs F, Gary TL, Hill MN, Bone LR, Brancati FL. Health-related quality of life in urban African Americans with type 2 diabetes. J Gen Intern Med. 2002;17:412–9.
7. Cooper LA, Hill MN, Powe NR. Designing and evaluating interventions to eliminate racial and ethnic disparities in health care. J Gen Intern Med. 2002;17:477–86.
8. Satel S. Racist doctors. Don't believe the media hype. Wall Street Journal. April 14, 2002:5.
9. Henry J. Kaiser Family Foundation. Survey of Race, Ethnicity and Medical Care. Menlo Park, Calif: The Henry J. Kaiser Family Foundation; 1999.
10. Collins KS, Hughes DL, Doty MM, et al. Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans. Findings from The Commonwealth Fund 2001 Health Care Quality Survey. New York: The Commonwealth Fund; 2002.
11. McEwen B. Protective and damaging effects of stress mediators. N Engl J Med. 1998;338:171–79.
12. Jackson JS, Brown TN, Williams D, Torres M, Sellers S, Brown K. Racism and the physical and mental health status of African Americans: A thirteen year national panel study. Ethn Dis. 1996;6:132–47.
13. Krieger N. Racial and gender discrimination: Risk for factors for high blood pressure. Soc Sci Med. 1990;30:1273–81.