EDITORIAL

The Future of Health Disparities Research: 2008 and Beyond

Leonard E. Egede, MD, MS^{1,2} and Hayden Bosworth, PhD^{3,4,5,6}¹Division of General Internal Medicine, Center for Health Disparities Research, Medical University of South Carolina, Charleston, SC, USA;²Ralph H. Johnson VA Medical Center, Charleston, SC, USA; ³Center for Health Services Research in Primary Care, Veterans Affairs Medical Center, Durham, NC, USA; ⁴Department of Medicine, Duke University, Durham, NC, USA; ⁵Department of Psychiatry and Behavioral Sciences, Duke University, Durham, NC, USA; ⁶Center for Aging and Human Development, Duke University, Durham, NC, USA.

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In spite of significant advances in the diagnosis and treatment of most chronic diseases, there is evidence that racial and ethnic minorities tend to receive lower quality of care than non-minorities and that patients of minority ethnicity experience greater morbidity and mortality from various chronic diseases than non-minorities. The Institute of Medicine (IOM) report on unequal treatment concluded that “racial and ethnic disparities in healthcare exist and, because they are associated with worse outcomes in many cases, are unacceptable.”¹ The Institute of Medicine report defined disparities in health care as “racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs preferences, and appropriateness of intervention.”¹ Since the publication of the IOM report there has been renewed interest in understanding the sources of disparities, identifying contributing factors, and designing and evaluating effective interventions to reduce or eliminate racial and ethnic disparities in healthcare.

In the current volume of the *Journal of General Internal Medicine*, there are four articles that address racial/ethnic disparities in healthcare.^{2–5} In this editorial, we will attempt to synthesize the results of these studies and make recommendations on how to shape future research to reduce, but preferably to completely eliminate, healthcare disparities. These recommendations should be useful to clinicians, researchers, administrations, and policy makers.

The manuscript by Saha et al.² reviews the disparity literature in the VA—the largest healthcare provider in the USA. The VA in many ways is an ideal ‘laboratory’ for exploring disparities because access to health care, which is an important cause of health care disparities, is not an issue, and access to affordable medications, a huge barrier in other settings, is of minimal concern. Saha et al.² also provide a nice way of framing the current status of the field of disparities. They summarize the state of health disparities research according to three generations of research focusing on racial/

ethnic disparities. They conclude that a lot of attention has been given to describing racial/ethnic disparities (first generation), some attention has been given to understanding the mechanisms for these disparities (second generation), but relatively little attention has been given to developing interventions to reduce and preferably eliminate health disparities (third generation).

Franks and Fiscella³ acknowledge the importance of addressing upstream or fundamental causes of disparities such as poverty, limited education, and compromised health care. However, they note that this is not sufficient, and that it is important to address the consequences of those fundamental causes within the context of the health care system (i.e., downstream interventions). Using an adaptation of the chronic care model,⁶ they define three domains for downstream interventions (health system, provider-patient interactions, and clinical decision-making), and discuss challenges to implementing the necessary changes. The authors also present two premises underlining disparities: (1) that healthcare is a social good and (2) that disparities in outcomes are a quality problem. However, it is not sufficient to view health care disparities as a quality problem alone. Studies have suggested that improving quality may only result in improvements in processes of care, with minimal to no impact on health outcomes.^{7–9}

By adapting the chronic care model, Franks and Fiscella³ provide a hierarchy of interventions that include the health system, provider-patient interactions, and clinical decision-making to reduce disparities. However, patient-level interventions cannot be ignored. There is growing evidence that for most chronic conditions, patient level factors typically account for 95–98% of the variance in health outcomes, while provider and health systems factors typically account for <10% of the variance in outcomes.^{10–13} Therefore, there is need for greater emphasis on patient-level interventions that can be easily reproduced and with an eye on examining the costs of implementing them.

Sequist et al.⁴ examined views of primary care clinicians regarding racial disparities in diabetes care. Using a large sample (115 physicians and 54 nurse practitioners and physician assistants) with an excellent response rate (86%), the investigators reported that 79% of respondents supported collection of data on patients’ race. However, while 88% acknowledged the existence of racial disparities in diabetes care within the US health system, only 40% reported the presence of disparities among patients they personally treated.

A similar pattern was found when examining treatment concordance with guidelines.

Sequist et al.⁴ recommend two strategies to expose health care providers to the issue of racial disparities in diabetes care, including provider feedback regarding disparities as well as cultural competency training to improve communication skills. However, recent data suggest that in the business world, mandatory cultural competency is not efficient, and if anything, potentially detrimental.¹⁴ So, an alternative two-step approach may be necessary. First, providers should be provided actual data and feedback on racial/ethnic disparities in process and outcomes measures for patients in their respective panels, and then those providers with significant disparities should be invited to cultural competency training. However, cultural competency training should be provided in an atmosphere that is collegial and non-confrontational. Also, there needs to be some form of incentive to encourage participation in cultural competency training.

The work by Washington et al.⁵ provides a blueprint for translating well-documented recommendations for reducing healthcare disparities into practice—an area where there is a significant disconnect between what we know and how this knowledge is implemented. The authors categorize the key issues as it relates to financial aspects of healthcare delivery; structural aspects of healthcare delivery; communication and cultural/linguistic competence; and quality of care monitoring. The recommendations provided by the authors are practical and reasonable. However, it is important to recognize that implementing these recommendations is likely to be associated with increased practice overhead, especially for small clinics and practices. Therefore, for these recommendations to be widely adopted and implemented, careful thought needs to be given to ways to defray the costs associated with implementing these recommendations. In addition, data on the potential long-term cost savings and financial models for implementing these changes are needed to argue for these changes more convincingly.

An important disparity that is frequently overlooked in the discussion about healthcare disparities is rural-urban disparity in health care access and outcomes. Important determinants of health and disease differ among individuals residing in rural communities compared to urban communities including: poverty, isolation, limited access to medical services, and greater prevalence of obesity.¹⁵ An added dimension to the rural-urban disparity gap concerns the socioeconomic characteristics of rural communities which typically differ significantly from more urban areas. For example, individuals in rural areas often have minimal to no access to health care as they are self-employed or engaged in other careers that do not provide insurance.¹⁵ Further, socioeconomic variables such as poor education, age disparities, increased poverty, and less diversity are believed contributors to declining rural health. The delivery of health care in rural areas is also influenced by the unique characteristics of rural communities such as population density, the remoteness of these communities, the characteristics of the local workforce, and the cultural norms associated with the region at large.¹⁵ The combination of these unique factors translates into rural-urban differences in health, disease, and disease-related outcomes.

The difficulties of adequate access to health care services are a primary contributor to the rural-urban health care disparity

gap that currently exists. The continued escalation of health care costs requires health care systems to seek alternative service provision mechanisms.¹⁶ Telemedicine is one option that offers a low cost alternative to traditional health care practices. Telemedicine can provide immediate access to clinical knowledge and expertise, specialty medical services, or any health care services that are not available to rural communities.^{16,17} Additional applications include interactive video for patient consultations and home monitoring of patients with limited access to urban health care centers.¹⁷ Telemedicine reduces the distance restrictions and disparities in access to care for residents of rural communities that are commonly associated with essential medical services and specialists that are only available in metropolitan areas.¹⁸ Further, telemedicine can serve as a tool for education and training of rural practitioners. For example, the use of telemedicine is endorsed by the American Academy of Family Physicians as a means of providing rural physicians with the most current medical information that typically is not available in medical settings.¹⁹ Telemedicine offers a viable option to health care service provision issues and a potential solution to enhance health and health care in rural communities.¹⁷

Having said all these, it is clear that we have sufficient information from first and second generation health disparities studies to define targets for third generation studies (i.e., interventions to eliminate health disparities). We see four important groups of interventions that are likely to advance the field significantly in the next 10 years, and they include the following:

1. Evidence-based health systems interventions to improve the process of care.
2. Culturally tailored patient-level interventions to enhance self-management, self-efficacy, patient activation and patient empowerment.
3. Interventions to improve patient-provider communication, build trust, and enhance shared decision-making.
4. Telemedicine-based interventions to improve health care access and participation for people who reside in rural areas.

In summary, we have synthesized the results of four important studies in this issue of the journal, discussed the strengths and weaknesses of the various studies, and made recommendations on how to shape future research to eliminate healthcare disparities. These recommendations should be useful to clinicians, researchers, administrations, and policy makers.

Corresponding Author: Leonard E. Egede, MD, MS; Division of General Internal Medicine, Center for Health Disparities Research, Medical University of South Carolina, 135 Rutledge Avenue, Room 280H, Charleston, SC 29425, USA (e-mail: egedel@musc.edu).

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