Achieving Equity in an Evolving Healthcare System: Opportunities and Challenges

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ABSTRACT

For decades, disparities in health have been well documented in the United States and regrettably, remain prevalent despite evidence and appeals for their elimination. Compared with the majority, racial and ethnic minorities continue to have poorer health status and health outcomes for most chronic conditions, including diabetes mellitus, cardiovascular disease, cancer and end-stage renal disease. Many factors, such as affordability, access and diversity in the healthcare system, influence care and outcomes, creating challenges that make the task of eliminating health disparities and achieving health equity daunting and elusive. Novel strategies are needed to bring about much needed change in the complex and evolving United States healthcare system. Although not exhaustive, opportunities such as (1) developing standardized race measurements across health systems, (2) implementing effective interventions, (3) improving workforce diversity, (4) using technological advances and (5) adopting practices such as personalized medicine may serve as appropriate starting points for moving toward health equity. Over the past several decades, diversity in the U.S. population has increased significantly and is expected to increase exponentially in the near future. As the population becomes more diverse, it is important to recognize the possibilities of new and emerging disparities. It is imperative that steps are taken to eliminate the current gap in care and prevent new disparities from developing. Therefore, we present challenges and offer recommendations for facilitating the process of eliminating health disparities and achieving health equity across diverse populations.

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BRIEF REVIEW OF HISTORICAL PERSPECTIVE ON DISPARITIES

Racial and ethnic disparities in health have been noted since federal documentation of health status began.[1] Though some programs addressed minority health, mobilization and coordination of resources were not focused on the issue until the Secretary of Health and Human Services, Margaret Heckler, commissioned a comprehensive investigation in 1984. The Taskforce Report documented a "persistent and distressing disparity" across diseases and minority groups when compared with the nonminority population.[1] The Taskforce analyzed the extent of health disparities by considering excess deaths observed in the minority populations over what was expected in the nonminority population, noting differences in more than 40 disease categories.[1] The Taskforce also found differences in prevalence rates of chronic and infectious diseases, hospital admissions, physician visits, limitations of activity and self-assessed health status.[1]

Because of the Taskforce Report, the Department of Health and Human Services created the Office of Minority Health in 1987 to develop new policies and programs to eliminate disparities. Efforts focused on funding research and demonstration programs, improving race or ethnicity data collection, developing and promoting policies and practices to achieve health equity, and strengthening networks and partnerships. In 1999, Congress mandated an annual National Healthcare Disparities Report and requested the Institute of Medicine (IOM) to assess the factors that contribute to disparities. The IOM report "Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare" found continued variation by race in prevalence and burden of a range of illnesses, as well as differences in healthcare services.[2] These differences often decreased when controlling for socioeconomic differences, but still remained.[2] In addition, the differences remained after accounting for healthcare access.[2] The report focused on the clinical encounter and found evidence of stereotyping, bias and uncertainty that led to disparities in healthcare.[2] Most importantly, the report underscored the continued existence of disparities in the United States and noted a need to increase general and healthcare system awareness of disparities, promote the use of evidence-based guidelines to facilitate equity in care and train a more diverse healthcare workforce.[2]

Research following the IOM report can be grouped into 3 phases using a widely accepted conceptual model for the health equity research agenda: detecting disparities, understanding determinants of disparities and interventions to reduce disparities.[3] Detection of disparities is the most common, including studies that track changes over time and have found that although overall quality in care has improved, disparities in quality and outcomes by income and race or ethnicity are large and

persistent.[4] Understanding determinants of healthcare disparities is becoming more common in the literature, rather than simply reporting the existence of disparities; and recently the importance of social determinants as a major factor leading to disparities has been acknowledged.[5] More work is needed to improve understanding of underlying mechanisms. In addition, there is a need to change policy at different levels that will ensure reduction in disparities such as equitable provision of medical care, broader public health education efforts and increased diversity of the medical workforce.[6]

A major policy change with possible influence on health disparities in the United States is the passage of the Affordable Care Act (ACA) of 2010.[7] A number of provisions in the act aim to increase access to care and make health coverage more affordable.[7] In addition, provisions exist to improve data collection on race or ethnicity, disability and geographical location as well as increase diversity in the healthcare workforce, and expand and improve community health center facilities.[7] Although these provisions exist, the extent of implementation of the health reform policies across states determines the effect on disparities.

CURRENT STATE OF DISPARITIES

Over the past 20 years, Healthy People initiatives have focused on disparities, which according to Healthy People 2020, are "*particular types of health differences that are closely linked with social, economic, and/or environmental disadvantage and adversely affect[ed] groups of people who have systematically experienced greater obstacles to health*" based on characteristics such as race and ethnicity, gender, disability and geographical residence, among others.[8] National policies have been implemented in phases throughout the last 2 decades to reduce and eliminate health disparities, and more recently, attain the highest level of care among all population groups across America (ie, health equity).[8] Despite such policies, however, specific chronic conditions remain prevalent across disadvantaged populations compared with the majority. These disease conditions, briefly discussed later, illustrate the persistent divide in care, thereby requiring an exhaustive review and comprehensive efforts to make considerable improvements in and eliminate disparate care among multiple population groups.

Diabetes Mellitus

Diabetes mellitus affects 29.1 million individuals, or 9.3% of the population in the United States, and is the seventh leading cause of death.[9] It is the leading cause of nontraumatic lower-limb amputations, kidney failure and new cases of blindness among adults.[9] Additionally, it is a major cause of heart disease and stroke, which are 2-4 times more prevalent in individuals diagnosed with diabetes mellitus.[9] Finally, average medical expenditures for individuals diagnosed with diabetes mellitus are 2.3-times higher than for those without diabetes mellitus, estimating $176 billion for direct medical costs and $69 billion in reduced productivity.[9]

The rates of diabetes mellitus vary by race or ethnicity with rates of diagnosed diabetes mellitus being higher for racial and ethnic minority groups. Compared with 7.6% of non-Hispanic Whites (NHWs), 12.8% of Hispanics, 13.2% of non-Hispanic Blacks (NHBs) and 15.9% of American Indians or Alaskan Natives (AIAN) are diagnosed with diabetes mellitus.[9] Although diabetes mellitus affects individuals in all racial and ethnic groups, minorities have a higher prevalence, risk of complications and mortality rate compared with the majority group.[9] For example, compared with NHW adults, the risk of diagnosed diabetes mellitus is 77% higher in NHBs. After being diagnosed, NHBs are 4 times more likely to undergo complications such as lower-limb amputations and end-stage renal disease (ESRD) compared with NHWs.[9]

Cancer

Cancer is the second leading cause of death in the United States, accounting for nearly 600,000 deaths annually and more than 1,600 deaths daily.[10] Nearly 14.5 million Americans currently have a history of cancer, and another nearly 1.7 million are expected to be diagnosed in the upcoming year.[10] Cancer is most common in older people, with 78% of all cancer diagnoses occurring in people at least 55 years of age.[10] As of 2011, it is estimated that the direct medical costs (total of all healthcare expenditures) for cancer was $88.7 billion.[10] Fortunately, given the improvements in early detection and treatment, 5-year survival rates for all cancers improved from a low 49% between 1975 and 1977 to a 68% between 2004 and 2010.[10]

Cancer disparities are associated with multiple factors including race and ethnicity, socioeconomic status (SES), geography and sex. Racial or ethnic cancer disparities are suggested to reflect issues related to poverty, such as obstacles preventing access to healthcare services needed for cancer prevention, early detection and high-quality treatment.[10] For instance, NHBs often undergo diagnostic evaluation less often than NHWs, receive less referral for specialty care and have less follow-up for detectable abnormalities in comparison with NHWs.[11] NHB men and women are more likely to die of cancer compared with any other racial or ethnic group.[10] This trend is even observed in situations where NHB women, for example, have a better incidence of breast cancer, but unfortunately, have a higher mortality rate compared with NHW women.[10] Furthermore, people with lower SES have disproportionately higher rates of cancer incidence and mortality compared with those of higher SES, often times regardless of demographic factors such as race or ethnicity.[10] An example of this is observed in NHB and NHW men with $\leq$12 years of