Dermatologic Health Disparities

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KEYWORDS

• Health disparities • Dermatology • Education • Workforce
• Atopic dermatitis • Skin cancer • Research

Health disparity refers to "a chain of events signified by a difference in: (1) environment, (2) access to, use of, and quality of care, (3) health status, or (4) a particular health outcome that deserves scrutiny."[1] Disparities can be broad and across a variety of demographic variables including, but not limited to, race, age, sex, education, and health insurance status. The 2010 US Department of Health and Human Services National Healthcare Disparities Report confirms substantial health care–related barriers. The report identified access to and quality of care as inadequate, particularly for ethnic minorities and persons with low income.[2] Over the 8 years that the Agency for Healthcare Research and Quality (AHRQ) has reported on the status of health care quality and disparities, they have observed that although quality of care is improving, access to care and the state of health disparities are not.[2] In collaboration with the AHRQ, the Institute of Medicine Committee on Future Directions for the National Healthcare Quality and Disparities Reports identified 8 national priority areas to be addressed, including population health, safety, and access. Evidence of health disparities across race, ethnicity, and socioeconomic status was demonstrated for all 8 priority areas.

The paucity of and great need for data on epidemiology, natural history, clinical presentation, complications, and treatment of specific skin diseases in people of color has also been highlighted recently in the dermatologic literature.[3] According to a recent report, "empiric evidence regarding access to and use of dermatologic care services [in minority populations] is scant."[4]

RACE AND ETHNICITY

Race is a poorly defined term that, at times, is used interchangeably with the term ethnicity. In practical terms, race is a political and social construct more than a biological phenomenon.[5] By contrast, ethnicity refers to "…large groups of people classed according to common racial, national, tribal, religious, linguistic, or cultural origin or background."[6] Despite the complexities of defining race and ethnicity, health disparities between those who define themselves as white compared with others clearly exist. Since 1974 the number of office visits to dermatologists nearly doubled (from 18 million to 36 million by 2000), and the majority of patients seen by dermatologists are white (92%)—whereas this number for nondermatologists is 84%.[7] The reasons for lower use of dermatologic care by racial minorities are unclear.

For this appraisal of dermatologic health disparities, skin cancer and atopic dermatitis were selected for review because each is relatively common, and the association with health disparities has been examined for both diagnoses. Clearly there are numerous other skin diseases seen by both dermatologists and nondermatologists

Funding: Dr Buster was supported by an NIH T32 grant.
Disclosures: The authors have nothing to disclose.
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Dermatol Clin 30 (2012) 53–59
doi:10.1016/j.det.2011.08.002

including acne, rosacea, psoriasis, and many others, but there are few to no data on dermatologic health disparities related to those conditions. Other topics addressed in this review include health reform and the dermatologic workforce, dermatologic education, and research.

SKIN CANCER

Skin cancer morbidity and mortality are disproportionally higher in blacks, Hispanics, and people of low socioeconomic status (SES).[8–12] Melanoma is more common in non-Hispanic whites and people of high SES,[13] yet blacks, Hispanics, people of low SES,[13,14] and older-age persons often present with more advanced disease or have increased mortality.[8–10,15,16] The 5-year melanoma survival is 74.1% for blacks compared with 92.9% for whites.[16] Nonmelanoma skin cancer (NMSC) in blacks is uncommon, with an incidence of 3.4 per 100,000.[17] Despite the lower incidence of NMSC in ethnic minorities, blacks as a whole present with later stage or more aggressive squamous cell carcinomas.[9] The less educated tend to have lower skin cancer screening rates and more often have poor or inaccurate perceptions of their skin cancer risk.[18,19] Like the less educated, ethnic minorities, the elderly, and people with lower income may be more likely to have inaccurate skin cancer risk perceptions.[19] Lack of insurance and increased age also negatively affect skin cancer outcomes.[14,20]

ATOPIC DERMATITIS

The incidence of childhood eczema in the United States is approximately 10.7%.[21] Large-scale reports estimate the prevalence to be between 8.3% and 18.1%,[21–23] and it may be increasing.[24,25] Black race or multiracial background significantly correlates with eczema prevalence.[21] Similarly, black and Asian children are more often seen for the diagnosis of AD than are white children,[25,26] suggesting increased prevalence or severity of this disorder among these racial minorities. Just as increased SES is associated with higher rates of melanoma,[13,14] education beyond high school by a household member is significantly associated with the increased prevalence of eczema.[21] It is unclear whether, like skin cancer, the morbidity of atopic dermatitis is increased with decreased SES. Beyond race, urban setting, health insurance status, single-mother household, and smaller family size are also associated with increased risk of childhood eczema.[21] Presence of eczema appears to be significantly greater in the insured than in the uninsured[21]; however, one consideration is that those without insurance are often without health care access as well and thus are not diagnosed, leading to prevalence data that in all probability are an underestimate.

Multiple studies have shown that breastfeeding is associated with a reduced risk of atopic dermatitis, as well as a variety of other ailments (eg, asthma, obesity, childhood leukemia, and diabetes).[27,28] As a result, the American Academy of Pediatrics[29] and the US Surgeon General[30] have established recommendations to increase breastfeeding initiation and duration. The current level of breastfeeding costs the United States an estimated excess of $13 billion annually[28] in preventable health care costs and death. These costs hold particularly true for populations in which disparities in health care are most prevalent, including blacks, younger women, the less educated, and lower income women.[31,32] Such disparities may help to explain the increased risk of AD among some racial minorities, but conflicts with the increased rate of AD in high SES children.

HEALTH CARE REFORM AND THE DERMATOLOGY WORKFORCE

The Patient Protection and Affordability of Care Act and the Reconciliation Act was passed and signed into law in March 2010 (**Fig. 1**). Despite the varied and polarized opinions on the legislation, it is clear that some of the measures would improve health disparities. Recent figures indicate that there are more than 50 million (16.7%) uninsured persons in the United States, and this number has been increasing since 2000.[33] Ten percent of those uninsured are children (7.5 million).[33] Of the insured, 30.6% are covered by government programs such as Medicare (43.4 million) and Medicaid (47.8 million).[33] The United States economy loses $207 billion each year as a result of the poorer health and decreased lifespan of uninsured persons, and in 2008 $43 billion was spent on the uncompensated health care of the uninsured.[34] A major goal of the health care reform act is to increase insurance coverage to nearly all Americans, thereby providing cost sharing and leading to lower overall premiums. By 2014, the individual mandate for health insurance purchase by most Americans will be enforced and at that time health insurance exchanges will open. It is estimated that the number of uninsured nonelderly people will decline to 21 million within 2 years of this mandate.[35] The majority of nonelderly persons remaining uninsured will be unauthorized immigrants (approximately 30%) and those eligible for, but not