

SERIES INTRODUCTION

Addressing disparities in health care

IN THE UNITED STATES, minority populations are rapidly increasing. In 1970, minorities—ie, African American, Hispanic, Asian, and Native American—accounted for 12.3% of the US population, but they now account for 25%. And this growth is expected to continue, so that by 2050 one of every two Americans will be African American, Hispanic, Asian, Pacific Islander, or Native American.¹

Also, while advances in medicine over the past several decades have reduced death rates from cancer and coronary artery disease and have contributed to a longer life expectancy for Americans, minority populations have not benefited equally from these improvements.² In fact, the growing minority populations suffer from disparities in health care compared with white patients: minority patients have a higher incidence and burden of disease, and poorer health outcomes, contributing to shorter life expectancy.

Clearly, there is an urgent need for physicians, other health care providers, health systems, and medical researchers to increase their awareness of disparities in health care and their impact on patients, as well as on the US health system and the US economy. Now more than ever, we need to equip ourselves to more effectively engage minorities and to deliver culturally competent health care that improves outcomes in our minority patients.

■ A MULTIFACTORIAL PROBLEM

Disparities in health care are often thought to be the result of poverty and a related lack

of access to quality health care. But clinical experience and research show that this is overly simplistic. In fact, disparities result from a variety of factors. Patient-related factors can include culturally related beliefs,¹ dietary preferences, and health-seeking behaviors (perhaps influenced by a distrust of doctors, researchers, and the health care system), in addition to poor health literacy. Physician-related factors include poor cultural competency, which leads to poor communication with the patient. Other factors are a continuing lack of representation of minority patients in clinical research trials, as well as biologic factors.³

■ TAKING ACTION

In view of the disparities in health care that affect racial and ethnic minorities, and the many factors underlying the problem, the US Department of Health and Human Services launched the initiative *Healthy People 2020*, a continuation of the previous 10-year *Healthy People* initiatives. *Healthy People 2020* calls for health providers and health systems to devise effective ways to eliminate health disparities.⁴ It outlines high-priority health issues, sets 10-year goals for improving the health of all Americans, and suggests specific actions to take to address health disparities.⁴

On another front, in 2010 the National Institutes of Health formally established its National Institute of Health and Health Disparities, which funds research into the pathogenesis of health disparities in racial and ethnic minorities.⁵ Clearly, racial, ethnic, and cultural factors need to be considered for

Many factors contribute to health care disparities in racial and ethnic minorities

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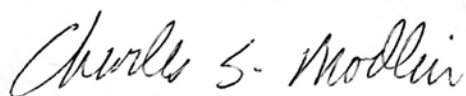
health care to result in better outcomes in minority populations.

■ OUR NEW SERIES

In this issue of the *Cleveland Clinic Journal of Medicine*, we launch a series we hope will provide practical tools for physicians to address the disparities in our health care system. The first installment, by Odesosu et al (page 46), addresses barriers to optimal hypertension control in African Americans by outlining potential tactics for both patients and physicians. Future articles will address the challenge of health literacy and cultural issues in medicine, slowing the progression of renal disease in Af-

rican Americans (especially the complex issue of which antihypertensive agents to use), and the challenges of diabetes in Hispanics. We also plan articles on kidney transplantation in African Americans and on prostate cancer, heart failure, lupus, and diabetes.

We look forward to your comments on this series as well as suggestions for future topics. We believe that as physicians, other health providers, health systems, health insurers and policy-makers become more aware of the disparities in health care, they will embrace ways in which to deliver or promote personalized, culturally competent health care. We hope this series will provide practical tools for physicians to address these complex issues. ■



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