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Eliminating Health Disparities: What Have We Done and What Do We Do Next?

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The United States, one of the richest countries in the world, spends more than any other on health care, but does not provide the best nor does it provide healthcare equally. Much of this inequity stems from vast socioeconomic inequalities.¹ Conversely, improving the overall health of our citizens depends in large part on eliminating health disparities.² Although we face a battered economy, there is new attention to this problem and to diversifying the workforce; there is new hope that these disparities can be addressed.

As detailed in our Journal, asthma, a treatable condition and the most common chronic disease of childhood, is one in which disparities in care and outcome are prominent.^{3–5} This issue of the Journal is devoted to describing health disparities, particularly as they apply to the management of asthma, along with a discussion of proposals for enhancing the care that we can deliver as a community. Three commentaries emphasize the multiple factors and levels of complexity that converge to form the disparity in health care that we have witnessed.^{6–8} Bryant-Stephens points out that although the prevalence of asthma is greater for Blacks than non-Latino Whites, the disparity in morbidity is far greater. Most disturbing is her reference to the Six City Study that found that even after controlling for factors anticipated to explain disparities such as environmental exposures, parental history, and demographic factors; Black children still had 1.6 times the odds of asthma diagnosis when compared to non-Latino White children.⁹ What are these other factors? Arguably, some are combinations of those multi-level factors presented by Canino et al.⁷ They could include other neighborhood exposures or effects of poverty not characterized in the study, problems with access to medications and health care, or health practice factors to name only a few of the possibilities. Both Bryant-Stephens and Valet et al comment on the burden of asthma for rural minority populations. Valet et al conducted an interesting analysis showing that differences in outcomes for rural versus urban dwellers is not well-established; however, in both rural and urban areas of the United States, poverty is associated with poorer health outcomes. Impoverished rural African Americans may have increased risk for poor asthma outcomes, but this requires further study. Together these three articles emphasize that health disparities operate through direct and indirect effects of unrelenting poverty on health.

What has our subspecialty done to address these disparities? The AAAAI has made a number of efforts and Hugh Sampson MD set a goal for his presidency to address this immense and critical task. Below are some of the AAAAI initiatives.

Academy CAN!

Begun in 2000 with pharmaceutical support and under the leadership of Michael Mellon, MD, the purpose of Academy CAN! is to pair an allergist/asthma specialist with a community clinic in an underserved area. Academy CAN!, no longer funded by industry, has been supported by AAAAI members. There have been relationships with 14 clinics over 8 years, and there are currently 7 active clinic partnerships throughout the US, an impressive effort by those AAAAI members involved. Asriani Chiu, MD currently leads this effort. To make it easier to establish useful relationships with community clinics, Christine Joseph, PhD proposed a structure of three levels of relationships between the allergist and the community clinic. The first level is designed to give the clinic staff and the volunteer allergist the opportunity to become acquainted and establish trust. The allergist may give talks including educational CME conferences, for example, on the updated asthma guidelines or relevant case discussions. In the second level the allergist can act as consultant, providing recommendations either by telephone or accompanying the clinic physicians during patient visits. The third level establishes a community-based Asthma and Allergy team where the volunteer allergist delivers care to clinic's asthma and allergy patients.

This is what Dr. Chiu said about her experiences in The Sixteenth Street Community Health Center, Milwaukee, WI:

“I really enjoy my partnership with my community clinic. It made me better understand the issues that these primary care providers have with some very complicated patients, as well as the process of communication and access (or lack of) to healthcare for this underserved population in the “front line.” I was so impressed by the providers’ dedication and passion to serving the underserved population. In addition, I better understood the needs of the underserved population – from finances, transportation, and health literacy.”

The Commission to End Health Disparities

The AAAAI has been a member of the Commission to End Health Disparities since its origin in 2004. Formed by the American Medical Association (AMA), National Medical Association (NMA), and the National Hispanic Medical Association (NHMA), the Commission was inspired by the Institute of Medicine Report, “Unequal Treatment”, published in 2003.¹⁰ The Commission is a collaboration of health care organizations dedicated “to increasing awareness of racial and ethnic health care disparities among physicians and other health care professionals and implementing solutions to eliminate such disparities.” The Executive Council consists of AMA, NMA, and NHMA representatives with AMA and NMA members as co-chairs. Within the Commission are four working committees: Data/Information Gathering Advisory Committee to identify data needs of physicians to help them understand the scope of the disparities problem, Workforce Diversity Advisory Committee, Professional Awareness Advisory Committee, and Education and Training Advisory Committee. The Commission has developed a tool for assessing physician experiences and physician views on care of ethnic and racial minority patients.¹¹ 12 In addition, the Commission has studied the implications of pay-for-performance for health care disparities,¹³ and it has adopted a “Doctors Back to School” program (<http://www.ama-assn.org/ama/pub/physician-resources/public-health/eliminating-health-disparities/doctors-back-school/doctors-back-school-kit.shtml>). It was the Commission that

inspired the recent AMA apology for its long history of discrimination against African American physicians.^{14, 15}

Workforce Diversity

In our specialty we have a shortage of minorities underrepresented in medicine (African American, Latino/Hispanic, American Indian/Native Alaskan, and US Pacific Islander/Native Hawaiian). Increasing workforce diversity is a critical and potentially achievable step toward ending health disparities that the AAAAI can accomplish. While promoting cultural competence among us all is important, greater diversity among health care providers is associated with improved access to and satisfaction with care among patients of color.¹⁶

Currently, the AAAAI has several programs in place. The Chrysalis Project supports early exposure to the field of Allergy/Immunology (A/I) for US and Canadian medical students. While this program is not aimed strictly at minority students, the Chrysalis Project increases awareness of our discipline among potential trainees. Grant recipients attend the AAAAI Annual Meeting including sessions designed specifically for medical students as well as scientific workshops and symposia of their choice. They are paired with a Fellow-in-Training Mentor. The Odyssey Program is designed to provide an opportunity to explore a career in A/I for medical residents who are underrepresented in medicine. In 2009, 10 internal medicine and pediatric residents who received Odyssey grants were paired with a Fellow-in-Training Mentor and attended the AAAAI Annual Meeting. These residents had a chance not only to develop professional contacts within the subspecialty, but also to view the spectrum of career opportunities available in A/I. The Fellowship of Excellence Award supports the training of an A/I fellow from an underrepresented minority community at an ACGME-accredited A/I training program in the U.S. Applicants for this award providing two years of training must be members of an underrepresented minority community, a graduate of a U.S. medical school, trained in an accredited Internal Medicine or Pediatrics program, and a U.S. citizen.

Recently, the AAAAI has partnered with the NMA, which has a longstanding commitment to eliminating health disparities. This partnership includes designing an A/I ambassador program that will recruit minority A/I faculty to visit medical schools with large numbers of underrepresented minority students and lack a significant presence of A/I educators. These and other efforts all need our support in order to increase the number of A/I specialists providing care to underserved communities as well as increasing exposure of our discipline to primary care physicians.

WHAT NEXT?

We have come a long way from thinking that allergic rhinitis is a disease of the “upper class,” forgetting that the poor could not go to doctors and that only the most privileged could go to a physician for such a non-life-threatening problem.¹⁷ The AAAAI and many of its members are proud participants in a number of endeavors to eliminate health disparities. We applaud programs like Academy CAN! and the contributions of AAAAI members who volunteer their time to support underserved community clinics. We strongly suspect many members may already be volunteering their time and expertise of which we are not aware and salute them. Efforts to increase the diversity of our work force are underway. The Committee on the Underserved led by Melody Carter, MD and Asriani Chiu, MD is AAAAI’s home for such efforts. Please join our Committee!

There is much more to do. A start is the recognition of the complex, multi-level, and intertwined factors outlined by Canino et al⁷ that contribute to inadequate asthma and other health outcomes for poor and minority patients within our own geographic region of

practice. At the patient level these authors offer strategies for patient-physician communication and practice procedure modifications that may increase the diversity of our practices and as a result help all patients. We need to go forward with our efforts to increase the diversity of our workforce and we need to increase the visibility of our specialty in all medical schools where primary practitioners are trained. In this way, patients using the ED or filling the primary care sites for asthma will be referred to us. We must engage in conversations with the communities that bear the burden of health disparities. We must accommodate language-minority patients. We also need to consider the environment from which our patients come. For example, poor communities where asthma morbidity is high are frequently located in areas of high pollution, i.e. near highways.

Health inequities are global. With our diversity as a nation increasing, it is an ideal time to seek solutions and there is new hope that we can. In December 2008, the National Center on Minority Health and Health Disparities sponsored the NIH Summit: The Science of Eliminating Health Disparities. This conference, which included international speakers, presented and advocated for more research. Discussions targeted how best to translate this science into policy and practice. The American Recovery and Reinvestment Act of 2009, the Stimulus package, designates health disparities research as among those areas with high priority for funding. Most important, legislation for health care reform is being proposed; inequities in insurance coverage are at the heart of health care inequities.⁶ Our advocacy, ideas, and partnerships such as with The Commission are required. We need hope and our A/I community's contributions!^{18, 19}

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References

1. Berkman LF. Social Epidemiology: Social Determinants of Health in the United States: Are We Losing Ground? *Annu Rev Public Health*. Jan 19;2009
2. Marmot MG, Bell R. Action on health disparities in the United States: commission on social determinants of health. *Jama*. Mar 18; 2009 301(11):1169–1171. [PubMed: 19293419]
3. Stingone JA, Claudio L. Disparities in allergy testing and health outcomes among urban children with asthma. *J Allergy Clin Immunol*. Oct; 2008 122(4):748–753. [PubMed: 19014766]
4. Ginde AA, Espinola JA, Camargo CA. Improved Trends but Persistent Racial Disparities in Emergency Department Visits for Acute Asthma, 1993–2005. *J Allergy Clin Immunol*. 2008; 122(2):313–318. [PubMed: 18538382]
5. Rand CS, Apter AJ. Mind the widening gap: have improvements in asthma care increased asthma disparities? *J Allergy Clin Immunol*. Aug; 2008 122(2):319–321. [PubMed: 18678342]
6. Bryant-Stephens T. Disparities in Urban Environments. *J Allergy Clin Immunol*. 2009; 123:1199–206. [PubMed: 19501229]
7. Canino G, McQuaid EL, Rand C. Addressing asthma health disparities: a multilevel challenge. *J Allergy Clin Immunol*. 2009; 123:1209–17. [PubMed: 19447484]
8. Valet RS, Perry TT, Hartert TV. Rural health disparities in asthma care and outcomes. *J Allergy Clin Immunol*. 2009; 123:1220–5. [PubMed: 19233453]
9. Gold DR, Rotnitzky A, Damokosh AI, et al. Race and gender differences in respiratory illness prevalence and their relationship to environmental exposures in children 7 to 14 years of age. *Am Rev Respir Dis*. Jul; 1993 148(1):10–18. [PubMed: 8317784]
10. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, D.C: Institute of Medicine. The National Academies Press; 2003.

11. Alexander GC, Lin S, Sayla MA, Wynia MK. Development of a measure of physician engagement in addressing racial and ethnic health care disparities. *Health Serv Res.* Apr; 2008 43(2):773–784. [PubMed: 18370978]
12. Vanderbilt SK, Wynia MK, Gadon M, Alexander GC. A qualitative study of physicians' engagement in reducing healthcare disparities. *J Natl Med Assoc.* Dec; 2007 99(12):1315–1322. [PubMed: 18229768]
13. Casalino L, Elster A, Eisenberg A, Lewis E, Montgomery J, Ramos D. Will Pay-for-performance and quality reporting affect health care disparities? *Health Aff (Millwood).* April 10, 2007 published on line:w405–414.
14. Davis RM. Achieving racial harmony for the benefit of patients and communities: contrition, reconciliation, and collaboration. *Jama.* Jul 16; 2008 300(3):323–325. [PubMed: 18617634]
15. Baker RB, Washington HA, Olakanmi O, et al. African American physicians and organized medicine, 1846–1968: origins of a racial divide. *Jama.* Jul 16; 2008 300(3):306–313. [PubMed: 18617633]
16. Smedley BD. Moving beyond access: achieving equity in state health care reform. *Health Aff (Millwood).* Mar–Apr; 2008 27(2):447–455. [PubMed: 18332501]
17. Cohen SG. Disparities in Allergic Disease: Hypersensitivity and Social Disorders. *J Allergy Clin Immunol.* 2009; 123:1422–4. [PubMed: 19501238]
18. Obama, B. *Dreams From My Father: A Story of Race and Inheritance.* New York: Crown Publishers; 1995.
19. Obama, B. *The Audacity of Hope.* New York: Crown Publishers, a division of Random House; 2006.