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EDITORIAL

Examining Racial and Ethnic Disparities in Health and Hypertension Control

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A national strategy for improving the health of the American people has been defined for each decade since 1980.[1] When *Healthy People 2010*[2] was released in 2000, there were 2 overarching goals. The first goal dealt with our need to focus more attention on improving quality of life, not just years of life lived. The second goal was the elimination of disparities in health among different racial and ethnic groups. Whereas reducing disparities in health has been part of *Healthy People 2010* for some years, targeting the elimination of disparities in health brought the kind of attention and planning to disparities in health that had not been seen before. In 2002 the Institute of Medicine (IOM), at the request of the government, released the report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare.*[3] It was a very thorough and in-depth examination of the issue of disparities in health care and is considered by many to be the guidebook.

To better monitor progress toward the 2 goals, the government asked the Agency for Healthcare Research and Quality (AHRQ) to monitor and generate annual reports addressing these issues. Although the reviews have been mixed, there are indications that we are making progress in closing some of the gaps in quality of care.[4]

In 2005, my colleagues and I published in *Health Affairs* the results of a study in which we examined mortality ratios of blacks and whites from 1960 to 2000; we found very little change in the ratios during that period.[5] In addition, we showed that had we eliminated disparities in health in the last century; in the year 2000 alone there would have been 83,500 fewer deaths among blacks in America. Although mortality is not the only measure of disparities, it is certainly the most definitive and is a measure of health outcomes that are determined not only by health care but also health behavior, environment, and biological differences in response to medications. Hypertension is a

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major cause of disparities in mortality between blacks and whites in America because of the differences in prevalence and in hypertension control.[6]

In this issue of the *Annals of Family Medicine*, 2 studies look at disparities in health and mortality as it relates to hypertension. In the first study, Fiscella and Holt[7] examine the impact of eliminating disparities in hypertension control and in mortality between blacks and whites from heart disease and stroke, showing that almost 8,000 deaths could be prevented or postponed annually. They used the NHANES survey for the prevalence of systolic hypertension in blacks and whites, as well as a meta-analysis of observational studies to look at systolic blood pressure on the one hand, and a meta-analysis of risk-reduction by control of hypertension on the other. Their bottom line is that by eliminating disparities in hypertension control between blacks and whites, we can eliminate one major cause of disparities in mortality.

In the second article, Millett and colleagues,[8] in a study conducted in London in the setting of universal access to care, examine the impact of pay for performance on disparities in blood pressure management in blacks, whites, and south Asians with hypertension. They also examine the influence of comorbidities on the management of hypertension in these 3 groups. They found that black patients with hypertension were significantly less likely than white or south Asian patients to achieve established treatment targets for blood pressure control. In addition, they found that the presence of 2 or more comorbidities was associated with significantly improved blood pressure treatment in whites but not in blacks or south Asian patients. Also, south Asian patients with fully controlled hypertension were prescribed fewer antihypertensive medications than were blacks or whites. In sum, they did not find that the incentives of pay for performance were successful in eliminating disparities in hypertension control in these groups.

The study by Fiscella and Holt provided encouragement by modeling results showing that eliminating disparities in systolic hypertension control can significantly reduce disparities in mortality from cardiac disease and cerebrovascular disease. The second study by Millett and colleagues makes it clear that we have not yet found the answer to disparities in hypertension management and control, that pay-for-performance programs alone will not solve the problem of disparities in the management of hypertension.

There are at least 4 components to the challenge of hypertension control: (1) access to care, (2) physician management, (3) patient adherence, and (4) hypertension severity or physiological differences in the response to treatment.[9]

Although findings of the NHANES surveys do not show major differences in the management of hypertension between blacks and whites in the United States, Department of Veterans Affairs' studies find that when barriers to access are removed, the gaps in hypertension control are significantly reduced. Likewise, control studies of hypertension treatment show that it is possible to significantly reduce disparities in hypertension control between blacks and whites.[10,11]

Perhaps both the challenge and the opportunity facing primary care clinicians are becoming clearer. First, as community health leaders we must work to remove the barriers to high-quality health care in our system. These barriers seriously limit what we can do to contribute to the elimination of disparities in health. Second, we must commit to providing the best possible quality of care to all of our patients, regardless of race, creed, or color. We must, however, be mindful of the historical and cultural barriers that often complicate some doctor-patient relationships. In fact, our charge is to understand how cultural factors may influence our patients' ability or inclination to adhere to courses of treatment. Certainly we have an opportunity to try to understand our patients, but we must also educate our patients, in groups if necessary, to try to overcome the barriers that may be embedded in cultural differences.

On August 28, 2008, the World Health Organization released a report from its Commission on Social Determinants of Health (CSDH) on which I served for the last 3 years.[12] The CSHD, after visiting several countries and meeting with officials and nongovernmental organizations, concluded that the conditions into which people are born, live, grow, learn, and age have a major impact on their health. Thus, between and within countries we find gradients in health based on education, early child development, poverty, income, working conditions, and violence, to name a few. By targeting social determinants of health, the CSDH believes that our efforts would be most cost-effective and that a goal of eliminating health inequities globally was appropriate for the next generation.

Health care is itself a social determinant of health, as can be seen vividly in the United States, where severe or critical illness can often be a major cause of bankruptcy. Health care also takes place within the context of social determinants of health and must somehow be integrated with programs geared toward improving social conditions.

Hypertension control is an appropriate goal, and certainly the elimination of disparities in hypertension control, while appropriate, must take place in the context of physical and social environments and human behavior. The CSDH believed that primary care was

the appropriate setting in which to integrate health care and social determinants of health and called on primary care to assume that role.

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