Racial Disparities in Chronic Kidney Disease: Tragedy, Opportunity, or Both?

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“Of all of the forms of inequality, injustice in health is the most shocking and inhumane.”
—Dr. Martin Luther King, Jr.

In the United States, the recognized world leader in health technology and medical care, racial and ethnic inequalities remain an indictment of the moral compass of our society juxtaposed alongside hidden opportunities for improving the health of the nation. The tragedy is grounded in the continuing disparities as a result of limited access to quality care for the poor and disadvantaged (often minority) and/or increased rates of suboptimal health care recommendations for women, racial and ethnic minorities, socioeconomically deprived, and geographically segmented communities, often based on institutionalized societal biases (1,2). Simultaneously, the recognition of racial and ethnic disparities in health outcomes may provide unique opportunities to advance our understanding of biologic mediators; environmental, psychosocial, and cultural factors; and health risk behaviors that ultimately influence clinical outcomes (3,4). In this issue of CJASN, Gao et al. (5) examine select indicators of quality care for stages 3 and 4 chronic kidney disease (CKD) in a clinical database of more than 13,000 Department of Defense beneficiaries. They assessed whether race (white, black, or other) was independently associated with provider compliance with selected Kidney Disease Outcomes Quality Initiative (KDOQI) CKD recommended targets during a 12-mo period. Their analysis is one of the first to assess CKD care indicators across a diverse group of patients in a uniform health care system that emulates universal care for its beneficiaries. Of note, they found similar rates of provider compliance with selected stages 3 and 4 CKD targets for black and white beneficiaries in this uniform health care system, supporting the ability of quality universal health care to attenuate racial and ethnic health disparities. By contrast, they found that patients who were classified as “other” race were generally less likely to achieve targets than white patients, a finding that was unexpected and needs further evaluation. The main limitation of the study was that the automated estimated GFR reporting during the study period did not automatically correct for black race. The laboratory report suggested multiplying the reported estimated GFR by a constant (1.18), but provider compliance with this extra step was not assessed. Thus CKD referral and additional process measures may have been driven by inaccuracies in GFR values.

The one area in which CKD targets were lower for black than white patients was for LDL cholesterol monitoring. For unexplained reasons, cholesterol monitoring and treatment has been reported to be low for black patients in several other settings. An analysis of more than 15,000 adults in the Third National Health and Nutrition Examination Survey (NHANES III) revealed that both black and Mexican American individuals were less likely to be screened for cholesterol levels and less likely to be to taking cholesterol-lowering medications in the setting of elevated cholesterol levels, even after adjustment for insurance and other socioeconomic factors (6). Trivedi et al. (7) analyzed nearly 2 million individual-level observations for nine Healthcare Effectiveness Data and Information Set measures from 183 Medicare managed health plans from 1997 to 2003 and found improved clinical performance measures for all nine Healthcare Effectiveness Data and Information Set measures for both white and black enrollees and a reduction in black–white differences in seven of the nine measures, with the two for which control worsened being glucose and cholesterol. On balance, their findings also supported the inference that improving quality care with structured performance measures can reduce and/or eliminate many health care disparities.

The importance of specifically assessing the issue of uniform health care on CKD-related measures cannot be overstated, because many studies suggested that CKD-related outcomes do not always mirror that of many other commonly measured health parameters. Karter et al. (8) examined select complications such as myocardial infarction, stroke, lower extremity amputation, congestive heart failure, and ESRD in more than 62,000 ethnically diverse patients with diabetes and uniform health care coverage during a 3-yr period. They found lower rates of diabetic complications in a minority patients for all conditions except for ESRD, suggesting that even in a uniform health care environment, CKD outcomes may be unique in this regard compared with other medical conditions. Indeed, ESRD is one of the most striking and complex medical conditions, beset by race and ethnic disparities, with minority ESRD rates...
ranging from 1.5 to 4 times those of age-adjusted white counterparts (9). The relentless path to ESRD among minorities continues despite having rates for the early stages of CKD that are similar to or even lower than those for white patients (10). For ESRD, Daumit and Powe (11) showed that marked disparities in rates of cardiovascular procedure use for patients who eventually required renal replacement therapy normalized after the initiation of dialysis and the transition of the cohort to a single-payer system. Keith et al. (12) reported that for patients who had CKD and were awaiting cadaveric donor renal transplantation between January 2001 and December 2004, access to placement on the waiting list was markedly worse for patients with Medicare, racial/ethnic minorities, and those with a low level of educational attainment. Adjusted subgroup analyses revealed that for patients who were older than 64 yr, Medicare was no longer a risk for low access to placement on the waiting list, likely because this is the cutoff point when Medicare eligibility restrictions are lifted; however, the large disparity in access to placement on the waiting list for racial/ethnic minorities and those with a low level of educational attainment persisted, suggesting that even for dialysis patients, universal coverage can improve disparities in many but not all clinical outcomes.

For many physicians, researchers, and policy makers who are not directly affected, the issue of health disparities seems nothing more than an academic discussion. For others, the impact of health disparities is an enduring battle for social justice and a requisite issue to overcome for America to achieve its full potential. The report by Gao et al. should also be seen as yet another wake-up call as to how we as a medical community need to lead the health agenda for the nation, including the reduction and/or elimination of health disparities. For many, the issue of racial and ethnic health disparities in America was identified in the 1984 Secretary of Health Task Force Report on “Black and Minority Health,” citing a disproportionately high rate of excess deaths among racial/ethnic minorities for cardiovascular and related disease, diabetes, cancer, and others (13). Unfortunately, many of these issues of racial and ethnic inequalities including excess deaths as a result of socioeconomic issues and preventable health conditions have been well documented for more than 100 yr (14). The ongoing level of apathy is echoed in the lament of Du Bois, who wrote in 1899, “There have been few other cases in the history of civilized peoples where human suffering has been viewed with such peculiar indifference” (15). Former Surgeon General David Satcher and colleagues not only reported that was there no significant indifference” (15). Former Surgeon General David Satcher and colleagues not only reported that was there no significant indifference” (15). Former Surgeon General David Satcher and colleagues not only reported that was there no significant indifference” (15). Former Surgeon General David Satcher and colleagues not only reported that was there no significant indifference” (15). 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used for educational efforts regarding CKD, including transplantation and dialysis options. In addition, these groups are advocating for increased basic and health services research to advance knowledge about CKD and its treatment (A. Kliger, Yale University School of Medicine, New Haven, CT, personal communication, January 2008). Gao et al. have opened a door for the nephrology community to step through and take the opportunity as health leaders to ensure uniform health care to all citizens and move closer to eliminating the tragedy of health inequities and the unacceptable morbidity and mortality associated with CKD.

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Disclosures

None.

References
