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FROM THE EDITOR

Imagine a World ...

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Imagine a world in which the health needs of all community members are met. A world in which children are born full of life, cared for, and grow without constraints physically, emotionally, and developmentally. A world in which medical interventions and rehabilitation are still needed, but more emphasis is placed on prevention. Within this world, physicians would know how to best support their patients' health needs. At the same time, the health care system would seamlessly incorporate all peoples regardless of how long they have been in the country. Culture and community and each patient's preferred language would be a part of the equation. Imagine a world in which the health needs of all community members are met. One day ...

The reality in the world and the United States is far from the idealized one described. Some are born healthy, with prevention measures in place across their lifespans. For others the reality is different. Health outcomes are influenced by multiple factors,¹ including race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location.² Health disparities are measured differences in the incidence, prevalence, mortality, and burden of diseases between demographic groups.³ For example, heart disease accounts for one-third of deaths in America but impacts minorities at much greater levels.⁴ Asthma has increased over the past two decades and disproportionately impacts minority children.⁵ A wide chasm exists between the imagined world and the realities in which people live.

An extraordinary burden exists on health care systems and communities because of existing health disparities.⁶ The U.S. economic burden alone for health inequities is estimated to be in the trillions.⁷ Individuals, private

philanthropies, community-based organizations and government are all striving to reduce these disparities.^{8,9} With a goal to be part of the solution, *Journal of Patient-Centered Research and Reviews* has issued this second installment of research efforts designed to both describe the complexities of health disparities and promise interventions that might bring us a little closer to the reality we seek.

To support patients needing stroke rehabilitation, Borstad et al describe constant-induced movement therapy (CI therapy) as a means to improve arm function by overcoming the learned response of non-use.¹⁰ Despite its potential benefit, CI therapy remains inaccessible to most patients for several reasons, including availability of programs and insurance coverage. To provide additional access, these researchers turned to increasingly affordable gaming technology. In a 17-patient pilot, community participants documented the feasibility of designing larger studies, the intensity of practice needed, and the achievable improvements in motor performance.

Homelessness is associated with multiple health risks, and there is a need for greater understanding of how women, when presently homeless, can be supported during and after pregnancy to improve their lives and birth outcomes. Ake et al describe a series of focus groups, conducted at a women's shelter and comprised of women who had given birth, in which questions addressing a variety of areas related to the women's pregnancy were asked.¹¹ Session analysis was used to identify recurring themes, which the researchers intend to leverage into future educational programs for both the women and medical students.

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Wars and political unrest have resulted in more than half a million refugees resettling in the United States over the last decade. The racial, cultural, and linguistic diversity of these groups makes it challenging to serve health needs. Kotovicz and colleagues describe perspectives of medical interpreters, case managers, and pharmacists who support refugee health care.¹² Five topical challenges, ranging from inadequate education offered in advance of medical encounters to scheduling follow-up appointments, were covered. Also gleaned from interviewees were ideas on how to address such hurdles going forward.

Americans present certain health problems of their own. Namely, there is limited understanding of what health care, physicians specifically, can do to support weight management, despite the ubiquity of overweight and obesity in the United States. Walker et al describe physician perspectives on barriers to weight management for women.¹³ Out of focus groups conducted with internal and family medicine physicians, a few critical themes emerged — involvement of the primary care setting, communication between patient and provider, and acknowledgment of patient motivation to manage weight. The researchers concluded that a multidisciplinary approach will be crucial to making progress on this often sensitive but serious health concern.

Finally, to reduce health disparities in the present and future, more primary care-trained physicians are needed. Moreover, resident training needs to provide a greater understanding of social determinants of health. Knox et al describe an educational curriculum for family medicine residents designed to integrate the tools and skills built in community health centers into common clinical practice.¹⁴ Their report focused on evaluation of the 3-year curriculum by learners through standardized rotations along with structured interviews. Learners noted adjustments that could improve the program for future residents.

It is easy to put off thinking about the future. The demands of the present are enough for most people, and it may seem that the future is a long way off. However, if we intend to improve health both locally and worldwide, it begins with programs that are designed with the community in mind and with input from the community. Multidisciplinary community-based programs, along with engaged health care providers and better access to

medicine, can reduce health disparities and may bring us closer to an idealized world. Ultimately, the gap society should always be striving to close is the one between current reality and the world in which we want to live.

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