Preface

Issue 1

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Editor

A health disparity is defined as "a health difference that is closely linked with social, economic, and/or environmental disadvantage."[1] Specifically, disparities result in a disproportionate burden of disease and of potentially avoidable adverse outcomes among groups of individuals who have systematically and oftentimes deliberately been forced to experience barriers to achieving health and high-quality health care. Disparities may be observed by "any characteristic historically linked to discrimination or exclusion," including but not limited to race/ethnicity, socioeconomic status, religion, sexual orientation, gender identity, age, geographic location, or disability.[1]

In this first issue, authors describe the myriad of ways in which disparities adversely affect individuals with chronic rheumatic diseases. Two frameworks: Critical race theory and Social determinants of health, are presented to guide the way disparities are studied, described, and ultimately how they may be addressed. Critical race theory asserts that race is a social construct and highlights the pervasive role racism continues to play in our society and in health care.[2] Social determinants of health refer to the "features of and pathways by which societal conditions affect health and that potentially can be altered by informed action."[3] Studies demonstrating the role of socioeconomic status both at the individual and at the area levels are clear applications of the way in which social determinants directly influence health outcomes. Within the health care setting, the use of quality metrics is described as another potential strategy to guide both the way in which disparities are documented and how they may be addressed. This issue also explores disease-specific disparities by factors including race/ethnicity, gender, and region in rheumatoid arthritis, systemic lupus erythematosus, systemic sclerosis, and gout. Authors also describe population-specific disparities in childhood-onset lupus, and among the American Indian/Alaska Native populations.

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In this issue, we present the striking prevalence of health disparities in the field of rheumatology. The COVID-19 pandemic has further revealed and deepened existing disparities by race/ethnicity and socioeconomic status that require urgent multifaceted, multilevel interventions by our rheumatology community. We offer frameworks to consider these disparities and the impetus to address them through further research, high-quality patient care, and advocacy.

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