What Are Health Disparities?

"People with disabilities…experience health care disparities, such as lower rates of screening and more difficulty accessing services, compared to people without disabilities."

—**Lisa Lezzoni**, Director, Mongan Institute for Health Policy, Massachusetts General Hospital

LEARNING OBJECTIVES

After completing this chapter, each learner will be able to:

- Compare and contrast alternative definitions of *health disparities*.
- List the determinants of health, and identify how society has contributed to different health outcomes.
- Support or critique the hypothesis that social stratification and health outcomes are linked.
- Match one of the three approaches to social stratification (structural functionalism, conflict theory, or hybrid approach) with your belief system.
- Analyze the thesis that healthcare administrators, like public health professionals and clinicians, must to be involved in preventive and other areas of patient health care to improve present and future health outcomes.

▶ Introduction

A variety of definitions of health disparities have been put forward. Consider some of those offered by various government agencies:

- "Differences in access to or availability of facilities and services" (National Institutes of Health, U.S. National Library of Medicine, n.d.).

- "A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group" (U.S. Department of Health and Human Services, 2011).
- "Health inequalities that are considered unnecessary, avoidable, and unfair/unjust" (World Health Organization, 2008).

A primary purpose of this text is to broaden the definition of health disparities so that those working in health care can better address the needs of all subgroups with unique health needs and/or differential health outcomes. Healthcare administrators and other healthcare professionals are uniquely positioned to participate in a growing movement that seeks to advance life outcomes for the whole of humankind. This movement requires maximum health outcomes for all.

Dehlendorf, Bryant, Huddleston, Jacoby, and Fujimoto (2010) provide an excellent summary of current approaches to the field of health disparities. Specifically, these authors address the counter intuitive approach currently used in defining health disparities. They say, "A central aspect of the most accepted definitions is that not all differences in health status between groups are considered to be disparities, but rather only differences which systematically and negatively impact less advantaged groups are classified as disparities," (pg. 212).

We believe that these current approaches must change if health disparities is to become a field of study that supports advancement in the whole of humankind. While the term *disparities* simply means "differences," the field of health disparities has been constructed on an inherently subtribalistic definition. This is because health disparities have been both explicitly and implicitly defined in a way that is exclusive of differences in health outcomes that randomly occur. Rather, the focus is only upon those differential outcomes that are the result of systems of social stratification within a country. This chapter examines social stratification and its effects on health outcomes.

▶ Systems of Social Stratification

What do we mean by the phrase *systems of social stratification*? In this text, **systems of social stratification** are those societal mechanisms whereby people are positioned in a hierarchy based on their wealth, status, power, prestige, gender, race/ethnicity, and other identifying characteristics.

Social stratification is the basis for a caste or class society in which specific subgroups of people are grouped into categories based on certain characteristics. For example, in the United States, one common example of social stratification is the division of the populace by wealth. **FIGURE 2.1** illustrates the three major "classes" of Americans according to their earning power. **TABLE 2.1** includes the income ranges for each "class".

The field of health disparities emerged in the United States as the study of racial/ethnic differences in health outcomes and, over time, expanded to include other demographic factors such as socioeconomic status, sex, age, rural/urban populations, and most recently, gender identification. The concept underlying the field of health disparities, as currently constructed, is that the observed differences in health outcomes are the result of the maltreatment of selected subgroups in a society by other subgroups.

But aren't health disparities a thing of the past? It sounds like the field of health disparities is a type of affirmative action program based on health issues.

This is definitely not the case. Health disparities as a field emerged because differential outcomes that occur in health are directly related not only to historic behaviors of individuals and social systems but to current ones as well.

▶ How Society Has Contributed to Differential Health Outcomes

Penner et al. (2010), in a study of physicians, found that a number of these practitioners embodied and acknowledged bias against
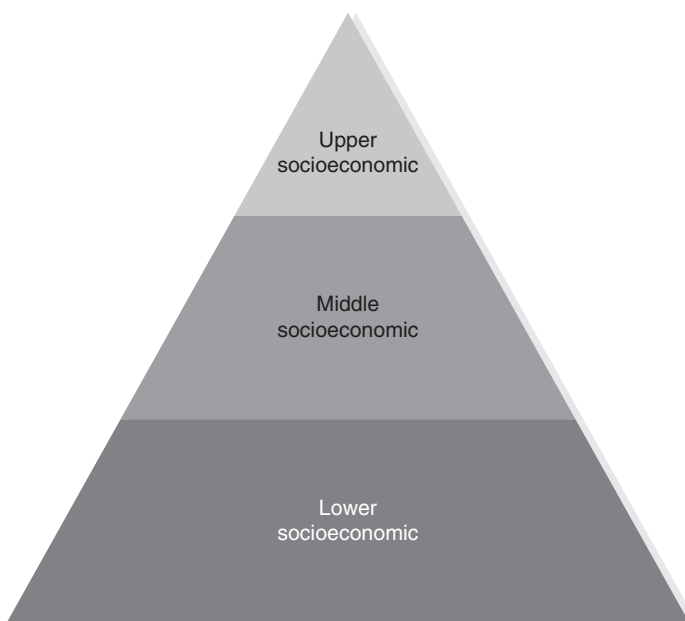
FIGURE 2.1 Social stratification of Americans by income.

TABLE 2.1 Social Stratification of Americans By Income (2014)

- Upper income class: >$124,925 per year for a family of three
- Middle income class: $41,641 to $124,925 for a family of three
- Lower income class: <$41,641 for a family of three

Table constructed by authors based on data found in the Pew Research Center (May 11, 2016) Social & Demographic Trends: America's Shrinking Middle Class: A Close Look at Changes Within Metropolitan Areas. http://www.pewsocialtrends.org/2016/05/11/americas-shrinking-middle-class-a-close-look-at-changes-within-metropolitan-areas/

African American patients and that this attitude affected treatment and treatment outcomes. Hu, Schreiber, Jordan, George, and Nerenz (2017), in a study of 22 primary care sites, found that income, education, race/ethnicity, gender, etc., were associated with 25% to 50% of differences in patient outcomes for persons with diabetes and hypertension. James (2017) completed a literature review which revealed that in the recent past, as well as today, physicians of European descent attributed lower intelligence and other negative traits to persons of Spanish and Indian descent, as well as to persons of African descent.

The continuing impact of adverse experiences based on race/ethnicity transcends direct experiences with healthcare professionals. Ong, Cerrada, Lee, and Williams (2017) conducted research with 152 first-year Asian American college students. They found that even today, diverse responses to the students' ethnicity had such a severe impact on the students that the length and quality of their sleep were impaired. And, as is known, the duration and quality of sleep intermediate health outcomes. Steptoe, Peacey, and Wardle (2006), in a study of 17,465 students of higher education from 27 universities worldwide, found that the odds of poor health were 46% higher for students who slept 6 hours per night versus 7 to 8 hours. For those students who slept less than 6 hours, the odds of poor health was 99% higher.

Howard (2016) reported that Jewish American, African American, East Indian, and other physicians encountered patients who chose to place their personal health at risk rather than be served by a physician of a different race, ethnicity, or religion. These are just a few examples of how race, religion, income, and other factors across virtually all of America's systems and institutions continue to influence the health status of various subgroups. Thus, the field of health disparities has been established to identify, decrease, and ultimately eliminate remediable disparities in health outcomes that reflect individual behaviors and systemic practices that are a part of a sequence of events that may result in lower life expectancies and a greater burden of illness and disease among various subgroups.

Emergence of Systems of Social Stratification

Systems of social stratification appear to be a natural phenomenon in the evolution of humankind. This social phenomenon seems to emerge in response to the distribution of power in a society and/or other social unit. Tattersall (2003), Gibbons (2006), and other researchers have found anthropological evidence that early modern humans, that is *Homo sapiens*, emerged in Africa. Similarly, Ao, Dekkers, Wei, Qiang, and Xiao (2013) have identified the presence of early hominids in the northern regions of China. Yet, some people are reluctant to accept that either Africa and/or Asia were early sites of *Homo sapiens*. The refusal to accept anthropological evidence is a direct reflection of the cumulative impact of ethnocentrism and other forms of social stratification. Similarly, various beliefs and attitudes based upon tribalism and sub tribalism exist regarding gender and other variables. For example, Streed, McCarthy, and Haas (2017), using data from the Centers for Disease Control and Prevention (CDC), determined that both personal and institutional forces in present and past American society are associated with higher rates of unemployment and lower income among U.S. residents who do not adhere to traditional gender norms. Similarly, transgender, lesbian, bisexual, gay and other sexual minorities have less access to high-quality health care (Albuquerque et al., 2016). Societal factors interact in such a way that health outcomes are disproportionately more likely to be reported as poor or fair among affected populations. Disparities also occur based on sex, independent of gender identification. Because more power has been allocated to males historically, females are oftentimes included as a population that experiences health disparities. Yet, bilateral differentials exist between the two sexes that can lead to men experiencing health disparities (Collier & Williams, 1981).

What do you mean by "bilateral"?

The term "bilateral" is derived from the Latin language and is made up from the two words *bi* meaning "two", and *lateralis* meaning "pertaining to the side." Thus, anything labeled bilateral has two sides. The term "bilateral differentials" is defined as unequal outcomes that affect two sides. Health disparities are currently viewed as a unilateral phenomenon. The continuing theme in this text is that as members of humankind, it is important to identify sub group disparities wherever they exist.

For example, the observation is frequently made that although white females live longer than white males, white females experience illness and disease at higher rates than white males. However, if both males and females were surveyed, it might be expected that not merely a plurality, but a majority would select a longer life expectancy accompanied by greater illness over a lower life expectancy. Thus, an altered definition of health disparities is needed that addresses health outcome differentials by sex in general. For example, Alexandre et al. (2018) demonstrate the criticality of the inclusion of males and females

in disparity research. Their analysis of 1,413 seniors revealed that while some symptoms of frailty are more common in women, others are more common in men. However, the historic placement of women in a lower level within the system of social stratification of all nations has led to this group's identification as a health disparity population under the prevailing definition.

How did systems of social stratification develop in the United States and worldwide that initially subordinated individuals by sex first and then by race/ethnicity?

Anthropological evidence reveals that the lifestyle and culture of early humans was based upon hunting and gathering. In hunting and gathering societies, the smaller stature and weight of females, in combination with women's role as child-bearers, initiated the establishment of **patriarchy**, or male-dominant societies (Hooks, 2004).

However, the skills and competencies needed for the survival of humankind are no longer predominantly linked with physical strength. Indeed, the human assets needed to ensure the future survival of humankind are distributed across all individuals and subgroups. This fact alone suggests a highly critical need for a restructuring of sociocultural beliefs, values, folkways, laws, institutions, and other sociocultural components so that an **axiology**, or value structure, is created that is supportive of human survival, growth, and development. Such an outcome requires the diminution of beliefs, attitudes, and behaviors that create dysfunctions associated with sex or gender.

Are you saying that focusing on health disparities that are primarily based on historical circumstances that have adversely impacted certain groups is dysfunctional to humankind's current and future needs?

That is exactly the argument that this text makes. This text seeks to alter the field of health disparities so that it will better serve humanity by focusing on addressing all remediable subgroup differences—wherever they are identified. The argument is also made that anger regarding past disharmonious relationships among subgroups generates a chain of actions that moves humankind toward greater division, rather than the unity needed for future survival.

What are some of the factors associated with inequalities by race/ethnicity?

In order to understand racial/ethnic inequalities, we must begin with the concept of ethnocentrism. **Ethnocentrism** refers to the tendency of people to view their own subgroup as superior and to reject subgroups with different physical, cultural, behavioral, and/or other characteristics. Ethnocentrism is often based upon visible differences, such as skin color or other physical features, whereas in-group/outgroup alliances are not based on permanent, unalterable differences. The term *ethnocentrism* has its origins in psychology, sociology, anthropology, and the other social sciences. Initially attributed to the psychologist, William Graham Sumner (1906), more recent evidence has revealed that Sumner did not originate this concept but merely popularized the term to describe this highly critical aspect of human behavior (Bizumic, 2014). Bizumic (2014) traces the use of the term *ethnocentric* to scholars before Sumner. Sumner did, however, add to our understanding of current levels of tribalism by originating the terms *in-group* and *outgroup*.

What do you mean by "in-group" and "outgroup"?

An **in-group** is any group with which an individual identifies. This identification is not necessarily based upon race/ethnicity, culture, gender, etc. Nevertheless, once self-identification takes place, it commands the loyalty of its members. An **outgroup** is a group with which an individual does not identify and is often accompanied by hostility toward that group.

From Ethnocentrism to Racism

Ethnocentrism has long been associated with wars and military conflict throughout human history. Early in human history, conditions in hunting and gathering societies were such that it did not make sense to keep one's "enemies" alive and enter them into slavery. As human society became more complex, and the means of survival shifted from hunting and gathering to agriculture, the enslavement of enemies became functional to the survival of the emerging societies. Schiedel (2007) demonstrates this tendency through the growth in the use of slaves in ancient Egypt, Rome, and other societies. Interestingly, although ethnocentric beliefs allowed enemies captured in war to be enslaved, slavery was not accompanied by an ontology that defined the enslaved as being less than human. **Ontology** is a useful framework by which to examine society, as it is the study of the nature of existence, including the nature of things in relationship to each other (Schiedel, 2007).

How did the enslaved come to be characterized as having subhuman status?

The ontology changed from one in which slavery was the natural outcome of losses associated with war to one in which the enslaved were considered as innately inferior to their masters through the influence of the Catholic Church after Christianity became the religion of Rome.

Are you saying that Christianity helped redefine slaves as subhumans?

Yes, that is the case. Saint Thomas Aquinas in his *Summa Theologica* (circa 1270) is credited with arguing that some groups are "naturally" slaves. A litany of biblical scriptures defined an inherently natural order between slaves and masters, with slaves being subservient to their masters. Even those Church philosophers and officials who eventually began to oppose slavery imposed a new hierarchy that legitimized it as a system of social stratification by those who were not a part of the subtribe of people who practiced Christianity. Accordingly, the nature of slavery as a human phenomenon was transformed, thereby leading to the institutionalization of these new beliefs in the very core of Western philosophy.

Shouldn't the field of health disparities primarily address the consequences of this "ontology" upon health outcomes?

The beliefs, values, and other norms and social systems and structures needed to continue to propel humanity forward in one era may be totally unsuitable in a different time period. During periods when various clusters of humankind were spatially and communicatively isolated, ethnocentrism and other forms of tribalism and subtribalism actually enhanced human survival. An excellent example of this is the current debate regarding the constitutional right to guns. During America's early period, when agrarian life created a multiplicity of threats and the criminal justice system was underdeveloped, home-based access to guns was critical. However, in a highly urbanized society populated by individuals with extremely large permutations and combinations of values and beliefs regarding when these objects should and ought to be used, easy access to guns generates highly volatile circumstances that generate a health risk for all. But, let's focus on our primary argument, which is that early tribalism was helpful to the survival of humankind.

For most of human history, strangers were a threat to survival. Tribal units were required to address core human survival needs. **Philosophical anthropology** is a rather controversial area of study that uses philosophy (which focuses on the nature of all that is in existence) to study humankind, including intrapersonal, interpersonal, and all aspects of people as humans (Pihlstrom, 2003). While its validity has been challenged by some thinkers, it nevertheless serves as a framework that can be used to examine humankind.

Arjoon, Turriago-Hoyos, and Thoene (2015) argue that every single aspect of the behavior of humans as individuals and/or as parts of organizations can better support the "common good" when a conceptual framework is applied that enhances harmony among humans. Because current and future healthcare administrators, public health professionals, and clinicians are managers of healthcare institutions, they are thus positioned to adopt and use such a framework.

▶ Redefining Health Disparities

As one considers the definitions of health disparities that were introduced at the beginning of this chapter, it becomes clear that key premises largely left unsaid are embedded within them. The following makes explicit several of these premises.

Premise 1: The American Belief That "All Humans Are Created Equal"

From early childhood, Americans are acculturated into the concept that "all humans are created as equals" (Armitage, 2007). Attributed to Thomas Jefferson and the immortal document that is held sacred to all Americans, the U.S. Declaration of Independence, this concept of equality was introduced into American culture as a *literal* rather than a *symbolic* truth. Moreover, the premise of literal equality has now diffused from the United States and into both the legal documents as well as the consciousness of other countries (Hillier, 1997). Indeed, this principle has been so widely adopted that it is now incorporated into the preamble to the United Nations' Universal Declaration of Human Rights (UN General Assembly, 1948).

This philosophical foundation, when applied as a premise underlying health disparities, suggests that because person A is equal to person B, who is equal to person C, then their health outcomes, as measured by rates of mortality and morbidity, will be roughly equal. Thus, persons using this definition conclude that the absence of equal outcomes indicates that health disparities exist. This premise also indicates that the measurement of health disparities occurs at an individual level; that is, that all Americans "should" have roughly the same life expectancy and the same distribution of illness and disease.

What's wrong with this premise?

This premise, however, is far too literal and too narrow. Even at birth, inequalities occur by race/ethnicity, gender, and other variables in the distribution of congenital conditions. For example, African Americans are more likely to have encephalocele and trisomy 18 than are non-Hispanic Caucasians. Similarly, Hispanics are more likely to experience anencephaly and anotia/microtia than are Caucasians. They are also less likely to experience hypospadias. **BOX 2.1** describes common inequalities that occur at birth for non-Hispanic whites relative to other ethnicities. **BOX 2.2** outlines birth defects that are more common in American Indian/Alaskan Native children relative to white children.

### *Why did you introduce these data on birth defects?*

The data presented in Boxes 2.1 and 2.2 reveal that health disparities cannot be defined based upon the philosophical principle of the equality of all humans. The data on birth defects demonstrate two trends. First, individuals are *innately* characterized by differences in health outcomes. It also demonstrates that health disparities can never be defined by comparing individual outcomes. Rather, the concept must be based upon groups of individuals; that is, the concept of health disparities only exists as a

BOX 2.1 Birth Defects with Higher Rates of Occurrence in Non-Hispanic Whites

Birth Defects More Common Among Caucasians Than American Indians/Alaskan Natives

- Hypospadias is a birth defect that is specific to males. It is a condition in which the urinary opening is not at the usual location on the head of the penis.


Normal urethral opening   Hypospadias
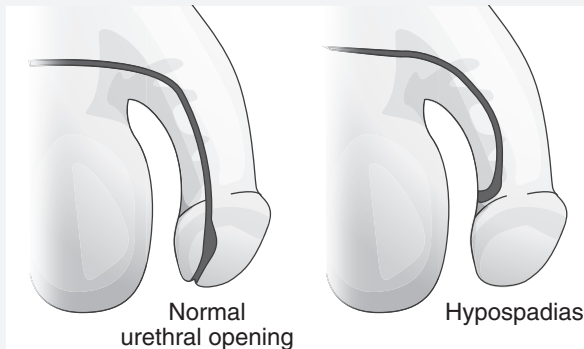
Birth Defects More Common Among Caucasians Than Asian Americans

- Spina bifida without anencephaly is characterized by a defect in the neural tube. Anatomically speaking, the neural tube is hollow at birth but serves as the structure that ultimately allows the brain and the spinal cord to develop. With spina bifida, the formation of the brain, spinal cord, and/ or meninges is incomplete at birth.
- Truncus arteriosus is a congenital heart disease that is characterized by the dislocation of a blood vessel known as the truncus arteriosus. In truncus arteriosus, the vessel is sourced in the right and left ventricles. Normally, two vessels (pulmonary artery and aorta) are attached to this blood vessel.

Aorta

Pulmonary artery

Truncus arteriosus

Ventricular septal defect
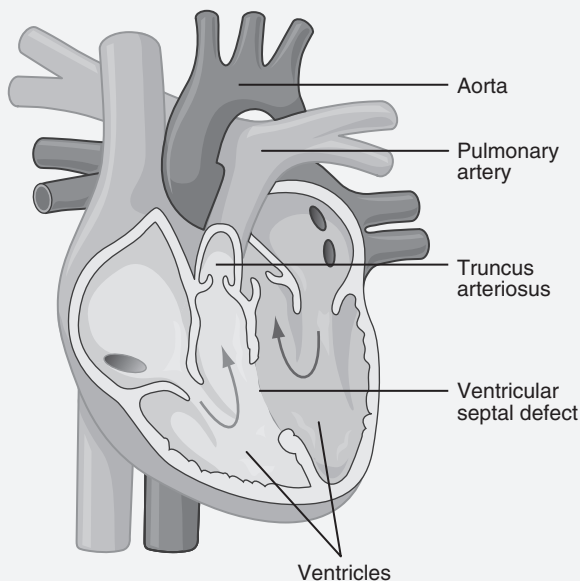
Ventricles

- Aortic valve stenosis involves a narrowed aortic valve. As a result, the flow from the heart's lower left chamber (ventricle) into the aorta and to the body is reduced or completely eliminated. Because the valve does not properly open, the heart must overexert itself as it pumps blood through the valve.

Bicuspid aortic valve with stenosis (congenital defect)

Tricuspid aortic valve with stenosis
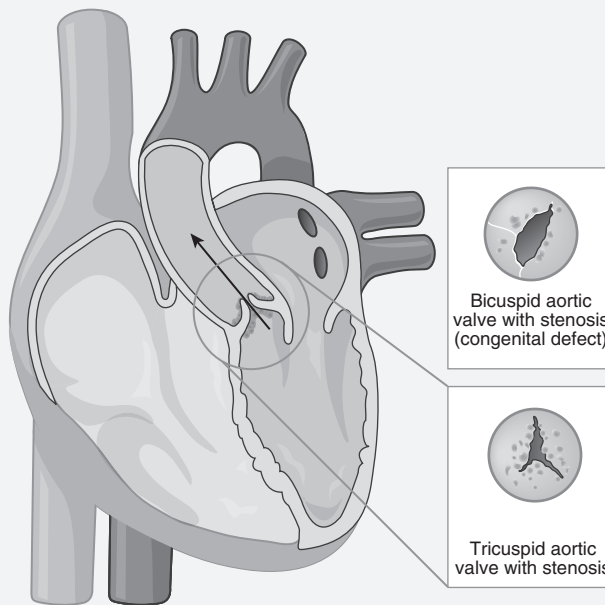
- Hypoplastic left heart syndrome is a rare congenital birth defect in which the left side of the heart is less than fully developed.
- Coarctation of the aorta is another congenital birth defect that is disparately associated with white children. The aorta in this case is undersized. Thus, insufficient oxygen is delivered throughout the body.

Birth Defects More Common Among Caucasians Than African Americans

- Aortic valve stenosis.
- Cleft lip with or without cleft palate occurs when the lip does not fully close during fetal development.
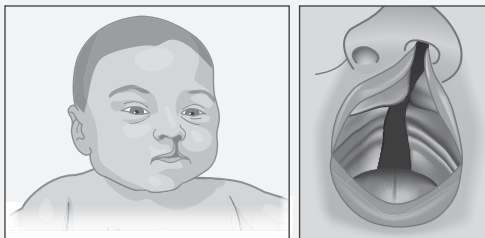
- Pyloric stenosis is a congenital condition that prevents an infant's food from moving into the small intestine.
- Gastroschisis is a birth defect of the abdominal (belly) wall that results in the baby's intestines being located outside of the body.

BOX 2.2 Birth Defects More Common Among American Indians/Alaskan Natives Than Caucasians

- Encephalocele is a neural tube defect where the brain as well as the associated membranes protrude from the skull.
- Anotia is a congenital deformity where the pinna (external ear) does not develop. Microtia is a similar condition where the pinna is underdeveloped.
- Cleft lip with or without cleft palate.
- Limb deficiency, which involves missing, incomplete, or other abnormalities involved in the development of any limb at birth. With upper limb deficiency, the upper limbs are unformed or partially formed. With lower limb deficiency, the lower parts of the legs are unformed or partially formed.
- Trisomy 18, or Edwards syndrome, is a condition that causes severe developmental delays due to an extra chromosome 18.

Mayo Foundation for Medical Education and Research, http://www.mayoclinic.org/

measurement of differences in health outcomes across various "tribes and subtribes." This suggests that another premise is also implicitly operative in the discussion of health disparities.

Premise 2: Health Disparities as a Mathematical Concept

In the second premise that undergirds the concept of health disparities, the notion of equality becomes more than just a philosophical construct and ventures into the realm of mathematics. More specifically, the definition of equality that is embodied in this unstated approach to health disparities is based upon the mathematical concept of equivalence. Mathematically, **equivalence** refers to relationships between numbers that, although different, are equal in value, effect, force, and/or significance:

$5 = 5$ is an equality.

$1 + 4 = 2 + 3$ is an equivalent relationship.

Consistent with this definition, the distribution of illness and disease across various American subgroups would not be considered problematic by policy makers or citizens if the outcomes were equivalent as measured by mortality rates and/or overall health quality. Stated differently, if one individual had the co-occurring

diseases of diabetes mellitus and hypertension while another experienced obesity and asthma, but the length and quality of life were equal, the existence of health disparities would simply require current and future healthcare administrators, public health professionals, and clinicians to understand how to best provide prevention and treatment services that are congruent with the clinical conditions of the consumers whom they serve. Utilizing this premise, healthcare administrators, policy makers, researchers, and scholars would exhibit indifference as to whether the unit of analysis is the individual and/or his or her unique tribe or subtribe.

Premise 3: Health Disparities as a Statistical Concept

The third premise that underlies the concept of health disparities is based upon **nonequivalent inequalities** that are not only observable at the individual level but at the group level as well. As mentioned, equivalent inequalities would have no differential impact upon life expectancy. In contrast, nonequivalent inequalities will result in differential life expectancies. Indeed, each of the definitions of health disparities provided are based on this concept. When deconstructed, it becomes clear that whereas

the first premise was based upon a philosophical concept and the second is grounded in mathematics, the third approach is based upon the statistical concept of a normal curve.

What is a normal curve?

The normal curve incorporates the notion of the simultaneity of equality within inequality. Specifically, the construct of a normal curve requires values of a phenomenon for various groups. The premise is that it is unrealistic to expect perfect equality within the universe. However, we can reasonably expect an *equal distribution of inequalities*. This distribution results in a bell-shaped **normal curve** (**FIGURE 2.2**). With a normal curve, approximately 68.21% of all values fall plus or minus one standard deviation from the mean. Approximately 27.18% of values fall plus or minus two standard deviations from the mean. Finally, an estimated 4.3% of values fall plus or minus three standard deviations from the mean, and 0.2% of values fall plus or minus four standard deviations from the mean. Consider the following additional definitions to enhance your understanding of this concept:

- "A symmetrical bell-shaped curve representing the probability density function of a normal distribution. The area of a vertical section of the curve represents the probability that the random variable lies between the values which delimit the section" (FreeDictionary.com, n.d.).

- "A bell-shaped curve showing a particular distribution of probability over the values of a random variable" (Dictionary.com, n.d.).

One can empirically confirm such a statement by simply observing the belled shape of trees and/or the belled shape of mountains. When applied to health disparities, the implication is that while various individuals with similar human characteristics may have differences in health outcomes as measured by both illness and disease and mortality, *the common origins of humankind would suggest that an equal distribution of inequalities will be observable across subgroups.*

This premise, although most often left implicit rather than made explicit, dominates the study of health disparities. But other premises also co-occur with the statistical approach to health disparities.

Premise 4: Health Disparities as a Sociological Concept

An abundance of well-known data confirms that health disparities are not equally distributed across various groups and subgroups. As a result, several sociological premises have become embedded in the concept of health disparities. As mentioned earlier in the chapter, when systematic asymmetric outcomes occur within a society, sociologists define these skewed patterns as *systems of social*
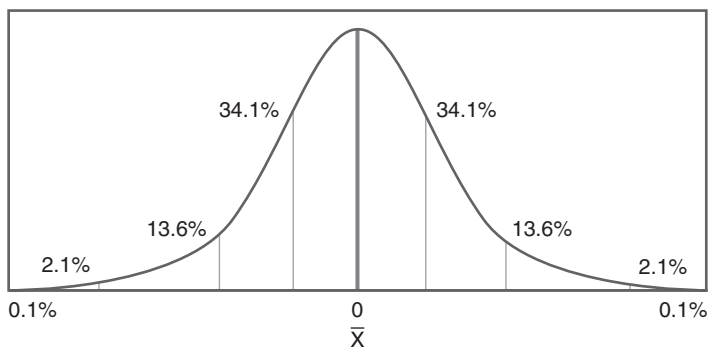
FIGURE 2.2 Normal curve.

stratification. Systems of social stratification may be reflective of differences in the universe from which the subpopulations are drawn (i.e., biological, genetic factors, etc.). In contrast, socioeconomic inequalities may represent the outcome of sociocultural and/or other factors in the physical environment.

While sociologists have, for more than a century, sought to document the causes and correlates of socioeconomic inequalities, it is only relatively recently that a comparable body of research has emerged in the area of health. Known as **health disparities research**, this emerging field seeks to identify those areas of health that are characterized by sustained differences in mortality and morbidity across subgroups. Interestingly, despite the fact that highly significant differences exist in death rates and the incidence of major illness by race/ethnicity, gender, income, education, disability, geography, sexual preferences, religion, and even personality type, many healthcare administrators, public health professionals, and clinicians are unaware of the magnitude of these differences. Indeed, most healthcare personnel would, if queried regarding these trends, probably be unable to cite accurate data descriptive of the nature of currently prevailing health disparities. Even those populations that are at risk of early death and/or avoidable illness and disease are often unaware of the potential impact of their own behaviors upon the quality and length of their lives. Rather, an implicit worldview has been adopted that does not fully hold individuals accountable for their own contributions to health disparities.

▶ Choosing a Worldview for the Analysis of Data on Health Disparities

The importance assigned to health disparities by a healthcare administrator, public health professional, and/or clinician is directly responsive to his or her ontological and axiological perspective regarding the nature of systems of social stratification.

Could you refresh our memory of what you mean by ontology and axiology?

Consider the following definitions of *ontology*:

- "A particular theory about the nature of being or the kinds of things that have existence" (*Merriam-Webster*, n.d.).
- "The branch of metaphysics that studies the nature of existence or being as such" (Dictionary.com, n.d.).
- "A set of concepts and categories in a subject area or domain that shows their properties and the relations between them" (*Oxford Dictionaries*, n.d.).

Based on these definitions, it becomes clear that all individuals have an ontology. Because a healthcare administrator, public health professional, and/or clinician has been granted the authority and the power to serve as an agent of change, it becomes important for his or her ontology and axiology regarding social stratification to be made explicit.

Recall that axiology is a value structure. It can be defined as "The study of the nature, types, and criteria of values and of value judgments especially in ethics" (*Merriam-Webster*, n.d.). An alternative definition is that it is "The branch of philosophy dealing with values, as those of ethics, aesthetics, or religion" (Dictionary.com, n.d.).

Take the brief survey in **BOX 2.3** to better understand your own philosophical beliefs regarding inequality. Based on your answers to the questions in Box 2.3, you will find that your beliefs regarding the nature of inequalities will fall within one of three approaches to social stratification: structural functionalism, conflict theory, or a hybrid approach. Simply count your answers in each category to determine whether you embrace the beliefs of functionalism, conflict theory, or whether your beliefs are hybrid.

BOX 2.3 Uncovering Your Beliefs Regarding Unequal Distributions of Inequality

Directions: Please answer each question below as quickly as possible. Be as honest as possible regarding your values, beliefs, and opinions. (There are no right or wrong answers.)

1.	Society has many parts, and these parts work together to generate a stable and functional society. (Structural functionalism)	T ☐ or F ☐
2.	Inequality in society is equivalent to the functioning of the human body. In order for the body to function, it has various types of organs, muscles, bones, etc. Although human roles and positions differ in responsibility and reward, these differences support the welfare of the whole society. (Structural functionalism)	T ☐ or F ☐
3.	The basic building block of a healthy functioning society is the family. When families lose strength, it reverberates throughout the larger society. (Structural functionalism)	T ☐ or F ☐
4.	Human nature itself is divided between the desire to reward only self and a desire to assist others. (Conflict theory)	T ☐ or F ☐
5.	Continuous conflict exists and always exists in society over the distribution of resources. (Conflict theory)	T ☐ or F ☐
6.	Persons who are physically, emotionally, and/or socially or militarily stronger acquire disproportionate shares of a society's resources and use these resources to their advantage. Therefore, government intervention is needed to ensure that all humans have the basic resources needed for survival. (Conflict theory)	T ☐ or F ☐
7.	Stated differently, the stronger and/or more powerful groups in a society will dominate if the weaker groups do not take social action. (Conflict theory)	T ☐ or F ☐
8.	It is impossible for health and other resources to be distributed in such a way that everybody is better off. In order for one group to be better off, another group or subgroup will become worse off. (Conflict theory)	T ☐ or F ☐
9.	Independent of the odds, individuals can always choose to improve their position in life whether it is their health or their income. (Hybrid)	T ☐ or F ☐
10.	Through investments in the three primary forms of human capital—education, health, and social capital—health disparities can be reduced and everyone can be made better off. (Hybrid)	T ☐ or F ☐

Created by the authors.

Developed by Talcott Parsons (1951) through the integration of theoretical perspectives from a number of philosophers, **structural functionalism** is now seen as a highly partisan approach to systems of social stratification that is supportive of the status quo.

In contrast, the views that appear to dominate scholarly work in the area of health disparities are based on conflict theory. **Conflict theory** assumes that competition and conflict over scarce resources are natural forces between groups and subgroups. Whether the discussion surrounds health outcomes regarding race/ethnicity, gender, and/or other features, the framework used has a subtext that suggests the application of conflict theory. Conflict theory has its origins in the work of Karl Marx (Lenski, 1984). However, contemporary sociologists apply this framework in the analysis of subgroup disparities (Sears, 2005). The question becomes, "*Which of these theoretical frameworks appear to be most descriptive of differential health outcomes by subgroups within the United States?*"

▶ Healthcare Disparities Versus Health Disparities

Health disparities are population and subpopulation differences in outcomes. **Healthcare disparities** are the differential processes and outcomes that occur within the operation of various components of the healthcare system. The emphasis thus far has been upon a redefinition of health disparities. However, it can be argued that current job descriptions of healthcare administrators *do not necessarily give them intervention power over health disparities nor healthcare disparities.*

How do you draw this conclusion?

BOX 2.4 provides summary statements from a number of healthcare administrator job descriptions. However, it is interesting that the duties and responsibilities of a healthcare administrator as described or implied in

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BOX 2.4   Sample Position Descriptions for Healthcare Administrators

Position Description 1

The healthcare administrator will be expected to oversee the day-to-day operation of the family clinic while ensuring the cohesiveness of all services provided. Specific duties include but are not limited to:

- Serving as a liaison on any governing boards with other medical staff and departments heads
- Ensuring that all policies set by the governing board are properly followed
- The recruitment, hiring, and evaluation of other personnel
- Planning and advising on department budgets
- Co-developing quality assurance procedures
- Participating in fundraising (if applicable) and community health planning
- Remaining current on recent healthcare laws and regulations
- Remaining current on healthcare-related technological and other advances
- Mentoring other staff
- Other duties

Position Description 2

The healthcare administrator will manage and coordinate health/medical services at the facility. This personnel will be tasked with the day-to-day management of all healthcare services provided to our clients. Specifically, this personnel's responsibilities will include the following:

- Overseeing at least 20 personnel. (This management directive includes interviewing, hiring, firing, and evaluating prospective and current employees.)
- Co-designing and organizing trainings for new hires
- Maintaining a personnel calendar to conduct scheduling
- Overseeing and managing the health information management systems
- Ensuring that all policies and procedures are current and in-line with federal, state, and local laws and regulations
- Interfacing with accounting as needed to manage fiscal operations (i.e., budget planning, service rate determination, etc.)
- Serving as a liaison between department heads, medical staff, and governing boards, etc.
- Attending all required meetings (i.e., board, interdepartmental, community or other external entity, etc.)
- Co-developing facility objectives and providing input on the evaluation of these objectives
- Conducting regular productivity surveys to monitor the effectiveness of facility resources and assess the staffing and resource needs
- Other

Position Description 3

The health administrator will oversee clinical and administrative operations on a day-to-day basis. Responsibilities will include:

- Supervising all clinic workers
- Performing staffing and department coordination
- Working with the accounting/finance department on budgets and expenditure reports
- Keeping up-to-date with federal, state, and local laws and regulations and ensuring their inclusion into the clinic's policies and procedures
- Serving as a liaison to the board, other department heads, community stakeholders, and others as needed
- Other

scholarly articles differ from those published by employers. **BOX 2.5** describes findings from just a few of the numerous articles on the duties and responsibilities of healthcare administrators.

Is this text directed toward all three occupational areas, that is, healthcare administrators, public health professionals, and clinicians?

Yes, it is. Researchers with similar views as those noted in Box 2.5 could also be cited that support the thesis that healthcare administrators have the power and authority to not merely reduce or prevent remediable differences in outcomes across subgroups in terms of the healthcare services which they oversee, but in the disparities in health outcomes in general

as well. However, a collective effort across the disciplines—healthcare administrators, public health professionals, and clinicians—is required if remediable differences in health outcomes are to be diminished in such a way that all humankind experiences improved health outcomes. Thus, this text is directed toward all health professionals in health care.

Why would you argue that healthcare administrators, public health professionals, and clinicians can use their positions to reduce remediable differences in healthcare and health outcomes?

Potter (2018) argues that the time has arrived for nurse administrators to address all complementary areas of health and health care by becoming *involved in partnerships* that

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BOX 2.5 Duties and Responsibilities of Healthcare Administrators: The View of Scholars

- Parand, Dopson, Renz, and Vincent (2014) provide a detailed description of healthcare administrators' duties. These duties include ensuring the quality of the clinical services provided through a given healthcare institution. Because differential healthcare delivery processes and outcomes across, between, and within subgroups are considered as a measurement of quality, healthcare disparities management is, indeed, a duty of healthcare administrators.
- Brennan (2016) emphasizes the fact that all healthcare professionals have a duty to use their skills for the maximization of all patient outcomes. Again, this charge is implicitly inclusive of not delivering any unwarranted differential care via clinical practice, medical education, biomedical research, and/or healthcare administration.
- Suarez-Balcazar, Mirza, and Garcia-Ramirez (2018) describe how all healthcare professionals can partner to not merely prevent or reduce healthcare disparities but community-based health disparities as well.

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support change in the overall way that health care is perceived and delivered. Leng and Partridge (2018) describe the importance of data in quality improvement. This research suggests that healthcare administrators, public health professionals, and clinicians must be able to utilize the large datasets generated by their institutions for quality improvements. These quality improvements may include not just the care that was delivered. Specifically, each of these categories of healthcare professionals has opportunities to improve disparities by refusing to miss opportunities to deliver the highest-quality services in their respective areas.

I still don't understand why healthcare professionals would want to partner to assume duties related to health disparities!

The reason is that existing research reveals that health care determines only 10% to 20% of one's health outcomes! This suggests that if remediable health disparities are to be reduced and/or eliminated, each of these groups of professionals must serve as participants in addressing the other determinants of health outcomes as well. The next section discusses the major determinants of health that must be targeted in order to address disparities in health.

▶ The Determinants of Health Outcomes in the United States

Population health is generally defined as a study of nonclinical and clinical variables that determine the health outcomes of various groups or subgroups of individuals. As one reviews data on health outcomes in the United States, it becomes clear that addressing health disparities is made far more complex by the fact that health care is only a small contributor to health outcomes. Specifically, researchers have discovered that health outcomes by race/ethnicity, socioeconomic status (Braveman & Gottlieb, 2014), gender, geography, and other variables are influenced by five primary factors: (1) modifiable individual behaviors, (2) socioeconomic environment, (3) physical environment, (4) genetics, and (5) health care (McGovern, Miller, & Hughes-Cromwick, 2014).

Researchers have been actively engaged in seeking to quantify these relationships for several decades. For example, as early as 1982, Hadley analyzed data on adults aged 18 to 64 years and discovered that medical care explained a much lower proportion of negative health outcomes

than previously believed. Subsequent analyses have had similar findings. McGovern et al. (2014) report that in 1990, approximately 5% of all U.S. deaths were attributed to alcohol use (categorized as a behavioral determinant of health) whereas in 2000, this percentage had decreased to 3.5%. Moreover, in 1990 approximately 4% of all deaths were due to microbial agents and 3% were due to toxic agents (both categorized as environmental determinants of health). However, in 2000 these percentages had dropped to 3.1% and 2.3%, respectively. Additionally, researchers have also identified the health care social determinants of health as being linked to positive health outcomes. For example, Starfield, Shi, and Macinko (2005) discuss the positive relationship between primary care and more positive health outcomes.

In contrast, lifestyle, a variable that is heavily influenced by one's position in the system of social stratification but yet is individually modifiable, plays a highly significant role in health outcomes. Østbye and Taylor (2004), for example, reconfirmed the loss of life years associated with the lifestyle variable tobacco use. Similarly, McGovern et al. (2014) compiled research that empirically measured the contributions of acknowledged determinants of health outcomes into a single table. While the estimates of the percentage contribution of each of the determinants of health outcomes differed, the data suggest that partnerships are not only needed within the arena of healthcare providers and professionals but with persons from other disciplines as well. For example, one study estimated that 50% of all deaths in the United States in 1977 were directly related to modifiable lifestyle factors (U.S. Department of Health and Human Services, 1980). Another study found that lifestyle/behavior contributed 36% to health outcomes (Danaei et al., 2009). Researchers also confirm that each subgroup's position in the system of social stratification intermediates their individual choices and behaviors. Thus, a greater inclusion of social circumstance is present in more

recent research on the determinants of health outcomes. Booske et al. (2010), for example, applied empirical analysis and credited social stratification as the source of 40% of health outcomes. Independent of the precise contributions of each variable to health outcomes, empirical data support the conclusion that reductions in health and healthcare disparities require facilitated change in every single area of the determinants of health outcomes.

If 36% to 50% of health outcomes are associated with health behaviors, then why doesn't the United States spend that proportion of health expenditures on behavioral and/or mental health preventions and interventions to change behavior?

Several factors are at play here. First, the public health framework has not defined failure to change an unhealthy behavior as a mental and/or behavioral health problem. Second, it has not identified the processes required to transition the American public's knowledge of what constitutes "healthy" behaviors into behavioral health change.

But isn't it a mental and/or behavioral health problem when people know how to prevent illness and diseases but do not change their nonhealthy behaviors?

It is, indeed. Healthcare administrators, public health personnel, clinicians, and others are uniquely positioned to treat nonadherence to "healthy" behaviors as a behavioral and/or mental health problem and design cognitive behavioral prevention and intervention programs for families that begin with the birth of a child and continue until behavioral change actually occurs. We, the authors, define addictions to unhealthy foods despite knowledge of the impact of such choices on human health as a mental and behavioral health problem that is fully equivalent to a substance use disorder. We define physical activity aversion as a mental and behavioral risk problem.

Are you saying that successful programs of behavioral change can do much to improve health disparities by not mandating change, but rather by supporting individuals in reversing past choosing behaviors that generate positive health outcomes?

Yes, this is one of the implications of this discussion.

But aren't there prevention and intervention programs that have already been implemented by public health professionals?

Yes. However, the failure of an individual to adopt behaviors that support longer life expectancy and wellness over their life span has not yet been defined by American society as a form of behavior that is so irrational as to comprise a mental and/or behavioral health dysfunction. Yet, such a definition is necessary in order to make these behaviors eligible for "treatment" using mental and behavioral health dollars.

But the research indicates that social determinants of health are also major determinants of health outcomes, including health disparities. Right?

Yes. The determinants of health outcomes imply that healthcare administrators and other personnel must partner with schools and other educational systems to assist children, youth, and their parents in accumulating educational capital. Educational capital is needed to support financial investments so that families have non-labor-based income streams. Other information is also needed regarding accumulating income and gaining financial literacy because deficiencies in these areas can lead to families' residency in neighborhoods characterized by smokestacks, landfills, food deserts, medication deserts, and other conditions that adversely impact human health.

Are you saying that the position descriptions of healthcare administrators require broadening in order to link the healthcare sector with appropriate partners to better address health disparities and not merely healthcare disparities?

Yes, indeed.

Chapter Summary

Health and healthcare disparities cannot be viewed from the perspective of a single discipline. Examination of disparities involves philosophy, mathematics, statistics, and history. Before a healthcare administrator, public health professional, or clinician can begin to provide leadership in crafting policies, programs, and initiatives to ensure that their organizational entity does not explicitly or implicitly support avoidable disparities, reflection is required. The purpose of this chapter has been that of stimulating original thought leadership regarding an area in the field of health that is rapidly becoming populated by intellectual clichés. In this regard, this chapter began with a discussion and comparison of alternative definitions of health disparities. It then provided a historical overview that provides an understanding of how current asymmetries in health outcomes emerged. It then introduced concepts from sociology to support the discussion of current definitions of health disparities. Finally, the chapter emphasized the importance of addressing every single determinant of health so that remediable health disparities can be ultimately reduced or eliminated.

Review Questions and Problems

1. Several definitions of health disparities that have been adopted by thought leaders in the field have been introduced in this chapter. Do these definitions have subtle differences in meaning, or do they all have equivalent meanings?
2. If you heard a speaker at a conference make the statement, "These subgroups are blaming others for their health outcomes when they should be blaming themselves!," how would you respond?
3. Do you find yourself leaning more toward structural functionalism or conflict theory? Explain.
4. Review three or more articles about structural functionalism and conflict

theory. Blend both theories together into a new one that can be used to explain health disparities.

5. Were you surprised to discover that health care contributes such a small proportion to health outcomes? Why or why not?
6. Define *health disparities* in your own words.
7. What is the origin of the concept that "All men are created equal"?
8. How does mathematical equality differ from mathematical equivalence?
9. Describe the normal curve.
10. Define *ontology* and *axiology*. How do they differ?
11. Who is considered the "father" of structural functionality? Of conflict theory?
12. List the five determinants of health.
13. Select two studies that examine a determinant of health outcome, such as unhealthy nutrition practices, alcohol consumption, tobacco use, etc. Compare the studies (250 to 350 words).

Key Terms and Concepts

axiology The study of the nature of value and valuation, and of the kinds of things that are valuable (Oxford Dictionary).

conflict theory Assumes that competition and conflict over scarce resources are natural forces between groups and subgroups.

equivalence Relationships between numbers that, although different, are equal in value, effect, force, and/or significance.

ethnocentrism Tendency of people to view their own subgroup as superior and to reject subgroups with different physical, cultural, behavioral, and/or other characteristics.

health disparities Population and subpopulation differences in health outcomes.

health disparities research Emerging field that seeks to identify those areas of health that are characterized by sustained differences in mortality and morbidity across subgroups.

healthcare disparities The differential processes and outcomes that occur within the operation of various components of the healthcare system.

in-group Any group with which an individual identifies; identification is not necessarily based upon race/ethnicity, culture, gender, etc.

nonequivalent inequalities This term references relationships that are mathematically different that do not equate to the same sum. For example, if an individual with hypertension had the same life expectancy as one with out diabetes, it would be an equivalent inequality. If these differences are associated with different life expectancies, it becomes a nonequivalent inequality.

normal curve A bell-shaped curve that shows the probability distribution of a continuous random variable.

ontology The study of the nature of existence, including the nature of things in relationship to each other.

outgroup A group with which an individual does not identify; often accompanied by hostility toward that group.

patriarchy Male-dominant societies.

philosophical anthropology Controversial area of study that uses philosophy (which focuses on the nature of all that is in existence) to study humankind, including intrapersonal and interpersonal relationships and all aspects of people as humans.

population health The study of nonclinical and clinical variables that determine the health outcomes of various groups or subgroups of individuals.

social stratification Basis for a caste or class society in which specific subgroups of people are grouped into categories based on certain characteristics.

structural functionalism A highly partisan approach to systems of social stratification that is supportive of the status quo.

systems of social stratification Societal mechanisms whereby people are positioned in a hierarchy based on their wealth, status, power, prestige, gender, race/ethnicity, and other identifying characteristics.

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