



The Challenges of Health Disparities

Implications and Actions for Health Care Professionals

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Preface

The purpose of this text is a highly ambitious one. Specifically, it is that of reconstructing the field of health disparities and, by doing so, stimulating change in the approaches used throughout the healthcare arena with regards to differences that characterize health outcomes and health care. For example, health and health care are academic disciplines, and they are rooted in fact and in the natural and computational disciplines. However, definitions of health disparities and approaches to solving disparities have become filled with innuendo. For example, Braveman and colleagues (2011), in a seminal article on health disparities, demonstrated the intrusion of intentional subjectivity rather than intentional objectivity into the study of this field through their summary of the definitions of health disparities that now dominate research and policy. This definition was introduced by a subcommittee that was organized by the U.S. Department of Health and Human Services (2008), Advisory Committee for Healthy People 2020. These authors assert that:

Based on the subcommittee's work, we propose that health disparities are systematic, plausibly avoidable health differences adversely affecting socially disadvantaged groups; they may reflect social disadvantages, but causality need not be established. This definition, grounded in ethical and human

rights principles, focuses on the subset of health differences reflecting social injustice, distinguishing health disparities from other health differences also warranting concerted attention, and from health differences in general.

While other definitions of health disparities have been used, this definition defines the current framework that dominates scholarship and textbooks on this subject. Our argument is that this highly subjective definition of health disparities has been divisive and has adversely impacted the crafting of effective solutions that will advance the whole of humankind. Rather than supporting reductions in health disparities, this definition has supported the emergence of contemporary subtribalism, because, in many respects, the very definition separates individuals into "tribes" based on racial/ethnic, gender, geographic, and/or other commonalities. Rather, the described definition supports "excessive" loyalty to one's own self-defined group to the degree that loyalty to the holistic unit of humankind is subordinated. In other words, as currently defined, health disparities are not approached merely as a statistical concept that is inclusive of disproportionalities in health outcomes that can be empirically verified across any grouping. Thus, the dominant definition literally eliminates data mining processes that seek to identify inequalities

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in health outcomes or healthcare practices across all groupings. Accordingly, it has pitted the economically advantaged against the economically disadvantaged, females against males, nonwhite ethnic groups against whites, and so on.

Furthermore, the current definition uses emotionally charged language such as *social justice and injustice, equity versus nonequity*, and so on. Our argument is that this framework has generated an entire field of study that is supporting the emergence of a “we against them” battleground that is adversely affecting the growth of a unified humanity that can collectively utilize its strengths to ensure human survival. As we point out in various chapters, extraordinary disparities in life expectancy exist between regions and countries. Yet, the definitions used have precluded the identification of the fact that all humankind has also experienced very positive benefits over time.

However, it is not only healthcare researchers who have framed disparities in this way. Disparities in income, education, housing, and so on all support, rather than reduce, a divided humanity and, as a result, preclude the crafting of effective programs, policies, and initiatives to decrease existing disparities. For example, far more healthcare administrators oversee hospitals or clinical care groups that offer women’s health clinics than men’s health clinics. Yet, men die more often from nearly all major diseases. A healthcare administrator who is aware of this disparity can create one clinic that serves all family members, including those with specialized needs.

The prevailing definition of healthcare disparities also explicitly instructs those who would reduce remediable differences to not focus upon health inequalities in general nor on the causes of observed inequalities. In doing so, opportunities for maximizing economies of scale in solutions are lost. Moreover, a “shotgun” rather than a “rifle” approach is applied to the design of interventions. Yet,

from a healthcare administrator’s perspective, a sophisticated analysis of “causes” and the directing of dollars to these “causes” can improve outcomes and lower the costs of reducing remediable differences in health outcomes and in the care received by all subgroups.

This text seeks to demonstrate that humankind has participated in an upward spiral of unequally distributed benefits. Within this context, this text describes empirical data on the “causes” of disparities in health care and health outcomes and recommends strategies for addressing health disparities based not on justice or injustice, but rather on the nature of every remediable cause, whether it is provider based, patient based, environmentally based, or based on education, income, marital status, or other “social determinants.”

Only by addressing each category of variables in the disparity chain can health disparities be remediated. This may require pediatricians to consult with parents on the educational progress of each child in their care given that education is a strong predictor of health disparities later in life. It may require that case managers be assigned to young patients, who can then link unemployed transition-age youth to college preparatory programs at open admissions colleges given that income is a strong predictor of health disparities later in life. It may also lead to healthcare administrators partnering with clinicians to improve prevention and individual disease self-management efforts by signing a statement of compliance/noncompliance that states the decreases in life expectancy that are associated with morbidity-related behavioral choices. Stated differently, this text can be used to explicitly shift the health disparities framework away from the current “. . . the glass is half empty” approach to one which documents that the glass from which humankind now sips is most certainly “. . . half full.” Research and data clearly demonstrate that an upward trajectory

for humankind requires cooperation and accommodation rather than division and conflict. It is a goal that can only be achieved when we recognize that for humankind, it is both the “best of times and the worst of times.”

Accordingly, the objectives of this book are several. All societies have a division of labor. Within the United States, farmers and ranchers feed the world. Psychiatrists, psychologists, motivational speakers, and religious leaders serve as caretakers of the minds, emotions, and spirits of the residents of this country. Academic institutions, whether community colleges, universities, or research entities, have self-appointed themselves as the “factories” whose tasks include the training of minds and the production of new knowledge. Stated differently, academicians, freed from the burdens of existence in the trenches of lived life, have the leisure to overview reality and to serve as thought leaders. Thus, a primary objective of this book is that of examining health disparities and healthcare disparities through the lens of original thought and from a reflective rather than reactive perspective.

A second and related objective is that of prompting readers to examine, challenge, and synthesize the expressed ideas into even newer thinking that supports growth, solidarity, and the reunification of humankind.

A third aim of this book is to provide a tool on health disparities that is not only of use to students of healthcare administration and professional healthcare administrators but also to clinicians, public health professionals, educators, social scientists, policymakers, community leaders and advocates, and individuals and families. Thus, we have sought to include the dual objectives of preparing a textbook that is also an informational manual that will deliver value to consumers of healthcare services.

Finally, yet foremost, the objective of this book is enhancing the knowledge and skills of current and future healthcare administrators, public health professionals, and clinicians by

developing much-needed skills. In some respects, these occupations embody a tremendous amount of transformational capital. Despite a greater effort to integrate the preventative, we remain a curative-oriented world. Healthcare administrators and clinicians manage curative institutions. Thus, healthcare administrators are positioned to not only link sick or ill patients with diagnostics and treatment services, but those professionals and their staff can also use the occasion of non-freedom from illness or disease to promote wellness to the family members of the injured and/or the sick.

Toward this purpose, we introduce readers to novel views regarding health disparities as a concept. In addition, we shift the measurement of health disparities from the maximal rate difference currently used by the U.S. government to the use of difference analysis with reference groups as a more appropriate measurement tool.

This text also increases knowledge of key disparities in death rates in general as well as by various illnesses and diseases. The data presented have been carefully selected to only include key statistics that should be a part of the intellectual arsenal of any healthcare administrator, public health professional, and/or clinician. If a healthcare administrator is health disparity illiterate, it weakens his or her ability to understand the impact of patient mix upon the quality ratings of the different institutions that comprise the overall healthcare system. Thus, most chapters in this book are somewhat data heavy. Importantly, the text provides attention to multiple types of healthcare delivery institutions. Not only are traditional healthcare disparities in physician care, hospital care, and long-term care institutions reviewed, but disparities in other areas are also examined.

The text also identifies strategies to strengthen self-management and prevention as critical tools for incorporation into the services provided by every component of the healthcare system. More concretely, selected

chapters review a number of preventable chronic diseases and discuss the breadth, depth, and nature of ongoing disparities.

This text is also based upon educational pedagogy and research that shows that the learning process embodies several different levels of learning. At the first level, it is important to know and recall new facts, concepts, and terms, as well as historical information. This type of learning is called level 1 learning. It is based on an approach from the field of education that was introduced by Benjamin Bloom and his colleagues in 1956. However, as a future healthcare administrator, public health professional, clinician, or policy analyst, knowing and remembering alone are insufficient. Data, concepts, historical facts, and so on are simply ingredients, much like the materials needed for building a house or baking a cake. Knowledge is the input into the human brain, which then allows us to analyze and apply it.

But, as humans, we analyze and apply knowledge by deconstructing and examining it, and then putting it back together to determine whether the information is logical. We then apply it to real-world situations in order to make it useful. These activities are considered to be *level 2 learning*. Finally, we evaluate knowledge and information by critiquing it and checking the premises (*level 3 learning*). The findings generated from these processes are then used to generate new knowledge and to plan and design solutions.

Such an approach is critical to the learning process. Roberson (2013) and other

psychologists have suggested that ensuring that each learner understands the relevance of the materials to be learned supports the overall learning process. In addition, the competencies at each of these levels are so critical to the skills needed by future and current healthcare administrators, public health professionals, and clinicians that they are now embodied in the accreditation process.

But, competency-based knowledge is also important for another reason. In today's advanced society every person needs to know how to acquire new knowledge, analyze and apply that new knowledge, and use it innovatively to improve the human condition. We urge each reader to continue to explore, debate, and addend the overall theory that in spite of the need for additional progress, humankind has, indeed, continually improved the human condition.

Critical to our aim, the entirety of this text is designed to prompt readers to formulate their own analyses, strategies, and solutions to ongoing health and healthcare disparities. Through this journey, it is anticipated that current and future healthcare administrators, public health professionals, and clinicians will gain skills needed to accelerate positive change.

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Foreword

In *The Challenges of Health Disparities: Implications and Actions for Healthcare Professionals*, Darren Liu, DrPH, MHA, MS; Betty Burston, PhD; Shartriya Collier-Stewart, EdD; and Heidi H. Mulligan seek to broaden and redefine current approaches to the study of health disparities. In doing so, the authors seek to encourage hands-on exploration of issues that in the past have often clouded discussions of remediable differentials in health and healthcare outcomes. In seeking to prepare readers to approach this much-discussed health issue, the authors query rather than tell, and analyze instead of describing, addressing queries such as “What are the implications of different definitions of disparities for research and policy?” and “How do data sources vary in quality and relevance for investigating different facets of health disparities?” The text will be useful for students seeking to confront one of the greatest challenges of health policy and public health in the United States.

After decades of research into the causes and consequences of health disparities in the United States, what is new, and what is likely to push this field forward? What have we learned that will allow us to reduce the avoidable mortality and morbidity that disproportionately affects vulnerable segments of the U.S. population?

One important line of inquiry comes from research examining the ratio of spending on social services and public health versus spending on medical care. In the United States, this ratio is often calculated as the sum of social service and public health spending divided by the sum of Medicare and Medicaid spending. States (and countries) with a higher ratio have better health outcomes by a number of indicators, including adult obesity; asthma; days with poor mental health; days with activity limitations; and mortality associated with lung cancer, acute myocardial infarction, and type 2 diabetes (Bradley et al., 2016). Thus, investing in health through social spending may be critical for reducing health disparities. A Brookings Institute study found that members of the Organization for Economic Co-operation and Development (OECD) spend, on average, about \$1.70 on social services for every \$1 on health services, whereas the United States spends just 56 cents (Butler, Matthew, & Cabello, 2017). This is more than a threefold difference.

A 2016 RAND study quantified the population health benefits of greater social spending in a multicountry study (Rubin et al., 2016). This study reported a positive relationship between social expenditures and life expectancy at birth, even after adjusting for gross domestic product (GDP). Increasing social expenditures as a percentage of GDP

by 1% was associated with an additional 0.05 years (18 days) of life across populations. The study authors note,

If we imagine for a moment that this is a direct causal effect, then increasing social expenditures by one percentage point in the United States would result in 16 million additional years of life across the entire U.S. population (320 million \times 0.05).

Since this effect is largest for vulnerable populations, such as those with low incomes, this policy lever is likely to reduce health disparities.

On a clinical level, this approach can be buttressed with routine collection of data on “non-medical, health-related social needs” during patient encounters. A *National Academy of Medicine* review has identified key indicators for social needs that are in themselves not medical but that are highly related to health outcomes (Billieux, Verlander, Anthony, & Alley, 2017). Most centrally, these include housing quality and security (including utilities), access to healthy food, interpersonal safety, and access to transportation. A broader approach would add literacy, community support, and financial strain. Collecting this information routinely in clinical encounters would help the healthcare establishment recognize the significance of these health-related social needs for medical care. New efforts to link social services to medical care, such as HealthLeads, have emerged to provide wraparound services, but a more general connection at the level of policy and funding is needed.

The problem of health disparities persists, but these new lines of inquiry and evaluation suggest that we can close the gap and improve population health. A key question is whether

changing social determinants of health, whether through increased social spending or specific targeting of health-related social needs, yields benefit in population health outcomes for the most vulnerable segments of society. This text seeks to advance these new approaches to the remediation of disparate health outcomes wherever they may exist.

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► References

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