

**REDUCING HEALTHCARE DISPARITIES  
WHAT ARE THE OPTIONS?**

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## REDUCING HEALTH DISPARITIES- WHAT ARE THE OPTIONS?

Several years ago the alumni of the MHA Program up north invited their Past Chair to present his last lecture as part of his retirement at one of their annual gatherings like this one. He agreed to do so and it was , as far I know, his last lecture in front of that audience. In that context, I have good news and bad news, depending on your perspective. I have not been invited to present my last lecture and I do not intend to make it so. This is not a lecture. I am not retired and continue to have a deep passion for this place and for everyone who has ever been connected to it. I am grateful for the wonderful life I have had at this university and in this community.

To be on the program is a special honor for me. I have been on the scheduling side of this event for many years, in fact from day one of the Alumni Society, but not on the program. I suspect the previous Program Committees were not confident I would stay within the allotted time. Brevity has not been one of my shining attributes. Nevertheless, this year's Program Committee has taken a risk. I want to thank the Program Committee, Elizabeth Seeley, and Tom Wickizer for inviting me to be here and share my perspectives on a topic which has been central to my professional life. This is an occasion I will cherish for a very long time.

The theme of this Institute is timely and challenging for all of us as a new political landscape has emerged in the last ten days. The Affordable Care Act is newly challenged in the Supreme Court, a new enrollment period for health care exchanges starts tomorrow, and hospitals are challenged to provide more secure protocols for potentially contagious diseases. It is easy to lose sight of a grand vision for the many issues which contemporary life on the front lines presents. I want take the side

of thinking about the grand vision and a bridge to cross on the path to a healthier population .

How do we, as a nation, as communities, as health care professionals reach for the vision of a healthier population. Is this the catalyst for what we do? I suggest the answer is a resounding and unequivocal – yes. I am reminded of a statement made by President Ellen Sirleaf Johnson of Liberia—“If your dreams do not scare you, then they are not big enough”

One of the paths to a healthier population requires a reduction in health care disparities. Can we do it? Is this a pipe dream or a real vision? That is my focus this morning.

## **INTRODUCTION**

The starting line includes a couple assumptions. I am assuming that we all want to be successful and make a contribution to the common good. And, we agree that our basic commitment as health care professionals and as part of health care organizations is to improve the health status of the community or region we serve and , take that one step further, the entire population. That is, we take an oath, sometimes explicitly and sometimes implicitly, that our efforts are directed to creating and maintaining a healthier population than exists today. Indeed, the theme of Management Institute 2014 is “Paving the Way to a Healthier Population.” It is timely and right on for what we do individually and collectively in our professional careers.

We need to embrace the significance of the basic assumptions here and significance of evidence based strategies to pave the way. Look in the mirror and ask—do I want to be an agent of change or an agent of the status quo? Organizations can ask the mirror the same questions. The

answer has a profound and direct relationship on our professional effectiveness, to our ability to influence outcomes ,and to our legacy.

Here are a couple more questions to stir the pot. What is our core purpose? After the degree has been awarded, after the career has a jump start by the OSU degree, after we start paying alumni dues and, in the words of the immortal Woody Hayes, paying forward, then what? When the alarm clock rings, what propels us? What do we need to do to be confident in saying—“we made a difference and this is a better place for what I stood for and what I did”.

For the moment, I will be the mirror and talk back to suggest some answers . A conversation is what I have in mind. The conversation is framed by the following objectives:

--To stimulate consideration of why we are here, why we are searching for the right path to pave the way for a healthier population, and what are our core values

--To identify the significance of reducing health disparities and health care disparities as a priority

--To make the case for interventions now on a multi level basis

I want to conclude by making recommendations for change and activism for the College of Public Health, the MHA Graduate Program, the Alumni Society, and for each of us.

A colleague was asked recently how to answer tough questions and make the best decisions. He explained that the sweet spot is found at the intersection of the heart and the head. I will offer a prescription for finding and stabilizing the sweet spot.

## 1. Why Are We Here and What Are Our Core Values

The roots of our professional and organizational motivation are most likely found in our belief in a social theory of justice. Gunnar Almgren, in his book Health Care Politics, Policy, and Services- A Social Justice Analysis, defines social justice as a “ philosophical construct- a political theory or system of thought used to determine what mutual obligations flow between the individual and society.” Social justice is the idea that civil society is predicated on the basis of a social contract that spells out the benefits, rights, and obligations of membership in a society- be that small or large. To be sure, there are several approaches to social justice. A full discussion of these approaches will be left for another day.

Nevertheless, I want to devote a few minutes to the significance of developing, articulating, and acting on a framework for social justice. It is pertinent to my major focus today on reducing health care disparities.

Most of us have probably not invested much time to understand or articulate our personal definition of social justice, especially when it comes to the larger society. I can honestly admit that I did not try to unravel my own beliefs on health care for several years after I started out on my professional journey. I was stimulated by one of my mentors to wrestle with the topic but without much guidance or socratic type dialogue. Looking back, I regret the vacuum in my intellectual growing up. Part of the explanation or excuse is the absence of curriculum content. That has changed. Part of the explanation may be ambiguity and confusion on the topic. That has not changed. Maybe I was intellectually lazy. That has hopefully changed.

When searching for our roots and our basic beliefs, there is a cloudy picture. There is no consensus on the most appropriate theory of social justice—the national and local dialogue is in fact quite muddled. We live

in a pluralist democracy which labors, in a continuing and sometimes chaotic way, to accommodate diverse points of view.

These points of view define the basic range of beliefs and related priorities on the responsibility of individuals and of society, particularly the role and responsibility of our governments. The way we think and act on societal attributes, and specifically health care attributes in this nation, are framed by the point of view, by the social theory of justice, we embrace. How you engage in the topic of health care disparities, for example, is formed by your selected point of view.

I want to challenge you to think about the theory of social justice which represents your core values. What is your preference and your ideals to improve the health status of your community, your state, and indeed the nation.

The energy and stimulus to push off the starting block and continue the endurance run which we accept is derived from our vision and dreams. In brief, the pathway to improved population health starts with your fundamental belief system of what social justice means.

I do not intend to present the key elements of the dominant theories of social justice. That should be for a separate time. For reference, though, I commend the book by Gunnar Almgren, described earlier and the book Is Inequality Bad for Your Health by Daniels, Kennedy and Kawachi. A comparison of approaches offered by the prevailing moral philosophies and their application to health care is, in my view, a sine qua non for your moral compass. For example, how do you react to the debate on Medicaid expansion in your state or to the components of the Affordable Care Act?

Some time, some where, and at some place you need a compass. Otherwise, the intellectual and action agenda is destined to be anchored

in one place with no formal direction. There is no pathway. I do not believe this a path for OSU folks.

There are certainly choices among theories of social justice. There is no absolutely perfect or required theory, although advocates might say otherwise. An examination of the philosophical and political landscape reveals there are loud and aggressive voices for basic directions of our society and of health care. There is likely to be continuous contention over the right theory and direction.

As for us, here today, the challenge is to think about the application of your choice of a social theory to health care and to the specific topic of health care disparities. Do you advocate for a strict libertarian application? a strict conservative application? a strict liberal application? perhaps a mix? It does make a difference. It will make a difference how you think about and act on many aspects of health care in the United States.

## **2. Identifying the Significance of Selecting Health Care Disparities as a Priority**

The path to creating and sustaining a healthier population than we have at present has a flashing neon sign at the entrance- “Some People Are Healthy and Others Are Not-Proceed With Caution and Information”. This is obviously a metaphor for reality. There is obviously no easy, smooth, singular or linear path to a healthier population. The elements of the path need definition and a disaggregation. It is also precisely the point at which our moral compass kicks in. Our preferred theory of social justice comes alive.

One of the several non linear and complex pathways for consideration is focused on health care disparities. A key source of influence for selecting a focus on health care disparities is the Congress mandated

“Healthy People 2020”- a science based 10 year set of national objectives- an agenda- for improving the health of all Americans. There have been previously published agendas in the form of Healthy People 2000 and Healthy People 2010. They should be on the required reading list for every student in a College of Public Health. And, if any student regardless of degree track or specialization is not informed about these, we should have a talk.

The current overarching goals for Healthy People 2020 include the following:

---Attain high quality, longer lives free of preventable disease, disability, injury and premature death

---Achieve health equity, eliminate disparities, and improve the health of all groups

---Create social and physical environments that promote good health for all

---Promote quality of life, healthy development, and health behaviors across all life stages

These goals direct the public sector and hopefully the private sector on a multi-faceted path to a healthier population. Allocation of resources and programmatic design is anticipated to follow these goals. Each could be a theme of significance for this Management Institute as well as components of strategic planning for most all health care organizations. Together, they are designed to yield a healthier population. The prescription is there in the goals and the measureable objectives for each one are in print.

The topic of health care disparities and the goals of achieving health equity, eliminating disparities, and improving health for all seems to be



all encompassing and a direct challenge to how we think about change and improvement. At the least, it certainly is motivating to understand one of the many paths to a healthier population.

There are well documented differences in health status and health care among sub groups of the population, There are differences in the presence of diseases, access to health care , and health outcomes across racial, ethnic, sexual orientation, and socioeconomic groups to name a few.

A few examples of disparities should be helpful. Many African Americans, Native Americans, Asian American, and Latinos have higher incidences of chronic diseases, higher mortality rates and poorer health outcomes than white American. Adult African Americans and Latinos have approximately twice the risk of developing diabetes.

Differences in mortality rates or obesity rates between people of different social classes, different races or of different insurance coverage are health care disparities.

Health care disparities adversely affect groups of people who have experienced obstacles to maximum possible health based on their racial or ethnic group, religion, socioeconomic status, gender, age, sexual orientation or gender identity, geographic location or other characteristics historically linked to discrimination or exclusion.

Many dimension of health care disparity exist in the United States. They exist in Ohio. For a chilling reminder of this, if there needs to be, I refer you to the most recent edition of the OSU Alumni Magazine (Nov.-Dec.2014). Also, refer to [buckeyevoices.osu.edu](http://buckeyevoices.osu.edu) for more detail. Dean William Martin of our College of Public Health reports that Ohio ranks 46<sup>th</sup> nationally in infant mortality and 50<sup>th</sup> in mortality of African

American babies. These data should be given much more public attention than many other headlines. They should catch your attention.

Some health disparities are attributable to biologic variations or free choices, such as certain religious practices. These are created by conditions mainly outside the control of individuals concerned. It may be impossible or ethically or ideologically unacceptable to change the health determinants. These relationships make certain health disparities unavoidable.

On the other hand, there are health disparities which are avoidable. The uneven distribution of avoidable disparities are generally considered unnecessary and subject to interventions on a multi level basis. They could set the stage for what we are searching for- the most effective path and option.

Health equity is defined as the attainment of the highest level of health for all people. Achieving this level requires valuing everyone equally with focused and ongoing societal interventions to address avoidable disparities, historical and contemporary injustices, and the elimination of health and health care disparities to the maximum extent possible. The goal of health equity views disparities as unjust and unfair.

These differences set the table for a discussion of options. Is the most effective path a focus of resources on eliminating avoidable disparities or is it a focus on achieving health care equity? Or, is it both? Should we advocate for reducing differences in breast care mortality between white and black women? Or, should we advocate for and demonstrate that health care is a right? Can we and/should we do both? What does this mean? What option leads to a healthier population?. These are options that need constructive conversation- always.

### **3. Making the Case for Intervention Strategies**

The easy answer to the questions I have just framed is—pursue both strategies for eliminating all disparities and strategies for achieving health equity. On looking at these with specificity, the answer is not so easy. There are multiple dimensions in considering the options. One has more short term implications than the other. One has more focus on interventions. The other has more focus on national policy and addressing core values for the nation. Both should have our attention. Time is limited, and I have chosen to focus on the options for intervention strategies.

The case for a focus on intervention strategies in avoidable health disparities is a strong one. A reference to a statement by Jack Geiger, one of the original advocates of neighborhood health centers, now more well known as community health centers , has resonance:

“ The poor are likelier to be sick. The sick are likelier to be poor. Without interventions, the poor will grow sicker and the sick will grow poorer. And, that has troubling consequences for all of us”.

Without the development and implementation of intervention strategies, the exercise of identifying disparities leaves the glass half full. The path to a healthier population must cross the bridge to identifying determinants of health care disparities and effective interventions related to these determinants.

Over the years, efforts to eliminate disparities and even achieve health equity have focused primarily on diseases or illness that present to health care providers for remedy and which identify differences in determinants and remedies between population groups. This approach is often called the medical model or downstream remedies. The downstream includes health system design, patient – provider interactions, and clinical

decision making informed by the impact of social risk on disease risks and outcomes.

One of the best references on these factors can be found in the book- “The Spirit Catches You and You Fall Down” by Anne Fadiman. It is a case study of culture clash between western medicine and a far eastern culture- the Hmong. The book is based on the problems presented to a community hospital in Merced, California and its physicians by a Hmong family with historic and different beliefs and a daughter with severe epilepsy . Years after this culture clash erupted, there have been amazing changes to the protocols at that hospital, and many others, to accommodate the cultural preferences of that population group, within the boundaries of safe practices. Downstream remedies paid off and I will wager a bet that evaluation would show a significant decline in health care disparities in that community.

Advocates of the downstream interventions assert that ongoing downstream interventions to minimize disparities will always be critical. They are within the purview of healthcare providers—which includes most of the people in this room. Here, then, is an optional approach for your consideration- at least for those associated with provider organizations.

Upstream determinants and interventions are linked to features of the social environment, such as socio economic status and discrimination, poverty, limited education, decaying neighborhoods and cultural beliefs. There is also compelling clinical research which demonstrates the relationships between sources of differential levels of stress among population groups and health status.

Interventions prompted by upstream analysis include improving education, providing nutritious food, decent and safe housing, affordable

public transportation, and available health insurance, These are outside the typical network of health care providers. They are included in a public health model for improving population health.

The importance and impact of upstream factors, and particularly social service initiatives on health is powerfully made in the new book The American health Care Paradox- Why Spending More is Getting Us Less by Elizabeth Bradley and Lauren Taylor.

This brings us to a key intersection in considering options for interventions. Should they be upstream or downstream or both?. Overall, advocacy for both makes sense. On the other hand, payors for these interventions look for returns on investment and that is not so clear.

#### **4. Recommendations for New Activism Right Here-Right Now**

A commitment to reducing health care disparities and taking a path to a healthier population will take much more than today's program and the preaching from the pulpit. It is a start and I commend the Program Committee. And, let's be humble, it will take much more than we can muster on this campus. Nevertheless, there are compelling possibilities right here, on this campus and in this room, which I commend for your consideration.. I will bold as to suggest these could be game changers.

The College of Public Health can take new and very proper initiatives. Let's start with the Mission Statement and Strategic Plan. It should include a more public and definitive resolution to implement the goals of Healthy People 2020 and the strategic goals of the Ohio Department of Health. By the way these include a decrease of infant mortality rates, a reduction in the rate of obesity, reduction of tobacco use, and an expansion of patient centered homes. This alignment would be a persuasive statement of intent to collaborate with key stakeholders. I

know this has been on the agenda for the College. Dean Martin has stated that “now it is time to act..we are ready to use evidence based strategies to start reversing the terrible outcomes for the most vulnerable groups of our society”. Let us commit to join the Dean in his call to action.

Every student in a College of Public Health should be aware of and conversant with the goals of Healthy People 2020. Taking this a step further, every student and everyone in this audience should accept the goals as a guiding force for their studies and career objectives.

Establishment of a Center for Health Disparities Research and Practice , or a similar title, would be a most positive step. Other universities have already done this, some of those in the Association of Schools of Public Health and which are our competitors. There is one at Case Western University . Several health systems have also started these Centers. There are funds available for these Centers and they are research engines for faculty. The focus and importance of addressing growing national disparities is a relatively new shift in health research and advocacy. For example, The Robert Wood Johnson Foundation is refocusing its strategies to pursue a Culture of Health. Timing here is important.

The Division of Health Services Management and Policy is a natural home for new initiatives. These would include a graduate level course in healthcare disparities, as well as an undergraduate course. There are increasing examples of these curriculum improvements in other universities. The mission of the Division could include the same commitments as noted above.

The Alumni Society should consider expanding the name of its annual breakfast to "iversity and Health Disparities Breakfast" . This change would send a most positive message and lead to sustained commitment. I believe it would have national leadership implications, as well.

I have presented only a few ideas for new activism, right here. I wear the hat of an advocate, with no apologies. At the same time, I wear the hat of a research based academician with a commitment to finding answers to tough questions and searching for evidence to guide policy and implementation. In this context, as you should be able to conclude, I believe local initiatives on this campus are possible and even necessary to examine and publish the most effective path or paths to a healthier population.

## 5. Conclusion

The challenges of reducing health care disparities are enormous. The path to enhanced population health must go through a reduction, at the least, in health care disparities. The path is uphill and non linear. The precise determinants of health disparities are multi level, multi generational ,and multi faceted. The most effective intervention strategies are complex. The commitment to enhanced population health is a long term, continuing commitment.

I am reminded of an applicable quotation by President Woodrow Wilson, many years ago , and used as the theme for one of the best books ever published on the politics of health- The Dance of Legislation – by Eric Redman. Wilson said:

“Once begin the dance of legislation, and you must struggle through its mazes as best you can to the breathless end—if any end there is”

Substitute the phrase-the reduction and elimination of healthcare disparities-for the dance of legislation. The reality is clear.

These facts bring us back to the reference I made at the start about the decision rule a friend of mine employs. The best decisions are made at the intersection of the heart and head. If this fits, then the take away here is to look at your mirror and listen to your answers to the tough questions and assumptions about the future, A foundation with a belief of what is right must be combined with a conviction that the evidence is compelling for an aggressive and sustained agenda to improve the population's health. It can be done. Are you on the path?

IF NOT YOU, THEN WHO? IF NOT NOW, WHEN?

Thank you so much for listening

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