HEALTH DISPARITIES AND SOCIAL JUSTICE

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LEARNING OBJECTIVES

Students will be able to:

- Describe health disparities in the United States.
- Discuss the impact of health disparities on populations and communities occupying unequal positions in society.
- Articulate the relationship between health disparities and different social determinants of health.
- Outline strategies to address health disparities through justice-informed practice.

INTRODUCTION

Social workers are commonly employed in health and behavioral health settings where our clients are often impacted by health disparities. Health is the complex interplay between biological, behavioral, social, and structural factors and is subjected to influence by social and structural injustices such as poverty, unemployment, underfunded and poor education, inadequate housing, poor public transportation, interpersonal violence, and decaying neighborhoods, all of which contribute to health disparities. Health disparities result in discrepancies in disease prevalence, treatment access, utilization and outcomes, and mortality. Largely, health disparities are influenced by social determinants of health, the conditions in which people live, learn, work, and play. Social workers play a key role in addressing and mitigating health disparities, both with the individual and in implementing policy changes that reduce poverty and increase access to healthy, affordable food; stable housing; and sustainable employment income, all of which are impactful in improving the fundamental determinants of health. Justice-informed social work practice is fundamental to implementing and sustaining the key factors for successful reduction of health disparities.

OVERVIEW OF HEALTH DISPARITIES IN THE UNITED STATES

Over the past three decades, a rapidly expanding body of scientific evidence has documented disparities in health status across different groups in the United States. Health disparities are

differences that exist among specific population groups in the attainment of their full health potential that can be measured by variations in incidence, prevalence, mortality, burden of disease, and other adverse health conditions (National Institutes of Health, 2002). Health disparities exist across many dimensions including race, ethnicity, gender, sexual orientation, disability, socioeconomic status, and geographic location (Adler & Rehkopf, 2008). African Americans, Latinx/Hispanics, American Indians and Alaska Natives, sexual minorities, and disabled persons are among the groups that experience disparities in their burden of disease and death in the United States. Unjust disparities have been documented in almost every aspect of health, including quality of healthcare, access to health and social services, utilization of healthcare, and health outcomes. Health disparities can be prevented and addressed. Social workers play a critical role in reducing health disparities.

In most cases, health disparities stem from health inequities—systematic differences in the health of groups and communities occupying unequal positions in society that are avoidable and unjust (Graham, 2004). The root causes of health inequities are historical and ongoing institutional and societal structures, policies, practices, and norms that oppressively shape the experiences of disadvantaged groups and communities in the United States. Only part of a person's health status depends on their biology, behavior, and choice. Social and structural injustices like poverty, unemployment, underfunded and poor education, inadequate housing, poor public transportation, interpersonal violence, and decaying neighborhoods contribute to health inequities. The social determinants of health are the conditions in the environment in which people live, learn, work, play, worship, and age (World Health Organization [WHO], 2009). These conditions affect a wide range of health, functioning, and quality-of-life outcomes and risks. The interplay between biological, behavioral, social, and structural factors is diverse, complex, evolving, and interdependent in nature.

During the past three decades, *Healthy People* has been the main governmental agenda for preventing and addressing health disparities in the United States. This strategy intends to identify the most significant preventable threats to health nationally and to establish goals to reduce these threats. In 2010, the Department of Health and Human Services launched *Healthy People 2020* (Koh et al., 2011), which had four overarching goals: (a) attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; (b) achieve health equity, eliminate disparities, and improve the health of all groups; (c) create social and physical environments that promote good health for all; and (d) promote quality of life, healthy development, and healthy behaviors across all life stages. *Healthy People 2020* contains the Leading Health indicators, a targeted set of 12 topics containing 26 objectives to advance action in high-priority health issues (Institute of Medicine, 2011). This coordinated national strategy encourages collaborations among communities and sectors to address health disparities and serve to measure the impact of prevention activities in the nation.

THEORETICAL FRAMEWORKS FOR THE STUDY OF HEALTH DISPARITIES

Multiple frameworks have been used to examine how different arrangements of biological, behavioral, social, and structural factors influence healthcare access and utilization, health status, and health outcomes. A life-course perspective is useful to understand the varying health needs and experiences of populations that are harmed by health disparities over the course of their lives (Elder, 1998). This framework posits that the experiences of individuals at every stage of

their lives influence subsequent experiences. This interrelationship among experiences starts before birth and transcends generations. A life-course framework has four key dimensions: (a) social relations influence individuals' perspectives; (b) significant events and experiences have a distinctive effect at various developmental stages; (c) the social and structural environment influence choices; and (d) the historical context influences how different groups experience health events. These four dimensions consider a range of issues that influence the outcomes of different populations experiencing health disparities.

An intersectional perspective is also helpful because it acknowledges simultaneous dimensions of inequality and emphasizes understanding how those dimensions are interrelated and compound one another. Intersectionality encompasses a set of foundational tenets and principles for understanding health inequities and its relationship with marginalized statuses based on dimensions of race, ethnicity, sexual orientation, and social class among others (Crenshaw, 1989; Dill & Zambrana, 2009; Weber, 2010). These include the following: (a) structural inequities are socially constructed—the experiences of marginalized groups can be understood only in the context of institutionalized patterns of unequal control over the distribution of valued goods and resources; (b) to understand health disparities we need to examine the full range of historical and social experiences with respect to class, gender, race, ethnicity, and geographical location; (c) the social positioning of marginalized groups is associated with institutional practices and policies; and (d) the way in which these groups are represented is intricately related to structural, political, and economic factors. An intersectional approach to the study of health disparities recognizes that group identities are complex and dynamic. At different points in life some statuses might be more relevant than others. Individuals cannot be examined as a monolith, but must be understood as shaped by multiple identities and simultaneous intersections of many characteristics.

The minority stress model conceptualizes how groups that are harmed by health disparities are exposed to chronic stress as a result of stigma and discrimination (Brooks, 1981; Meyer, 1995, 2003). In the context of individual environmental circumstances, there are distal and proximal stress processes. In this model, proximal stress processes are subjective and depend on an individual's perspective (e.g., perceived stigma, internalized homophobia, concealment). Distal processes are objective stressors that do not depend on a personal perspective or appraisal (e.g., discrimination, violence). This model, grounded in social psychology, is particularly helpful for explaining the high prevalence of mental health disorders and psychosocial conditions among minority groups as caused by excess in stressors related to stigma and discrimination. Social workers can use this framework to attend to interventions going from the individual to the structural level.

Finally, the theory of fundamental causes can be helpful to understand how some social factors or circumstances remain persistently associated with health disparities over time despite dramatic changes in diseases, risk factors, and health interventions (Hatzenbuehler et al., 2013; Phelan et al., 2010). This theory was initially developed to explain the association between socioeconomic status and health disparities (Link & Phelan, 1995). However, it is relevant to other social conditions such as stigma, racism, ethnocentrism, and homophobia.

Health disparities persist because fundamental causes have certain characteristics. First, a fundamental social cause influences multiple health outcomes through different mechanisms. Second, it involves access to material resources (e.g., money, knowledge, power, social capital) that can be used to avoid risks and minimize the consequences of diseases. Third, across time and place the association between social conditions and health is reproduced via the replacement of intervening mechanisms. This theory highlights the need of addressing the fundamental social causes of oppression through policies and interventions, rather than the recognized mechanisms that link the condition to health.

HEALTH DISPARITIES IN UNIQUE POPULATIONS

Health disparities in the United States manifest in unique ways across vulnerable and marginalized groups, shaping the ways in which they achieve optimal health. When considering the term “health disparities,” it is often used to reflect upon differences in health status across racial and ethnic identity groups; however, the impacts of health disparities permeate across multiple dimensions of identity. The burden of health disparities harms Black, Latinx/Hispanics, American Indians and Alaska Natives, sexual minorities, and disabled persons in unique ways. This injustice must be considered to guide best health practices in social work.

Racial and Ethnic Health Disparities

Health disparities for communities of color assume many forms in the United States. In many cases, communities of color experience higher rates of chronic diseases, such as cancer, diabetes, overweight/obesity, cardiovascular disease, and HIV/AIDS, with Black people disproportionately shouldering the majority of these burdens compared to the majority of White communities (Levine et al., 2001). Additionally, these health disparities mean that many communities of color die prematurely at higher rates than their White counterparts (National Center for Health Statistics [NCHS], 2016).

These disparities across racial and ethnic groups also affect infant health outcomes. The United States has some of the highest infant mortality rates among industrialized nations, largely attributed to the infant mortality rates in communities of color. Nationally, Black women experience the highest rates of preterm delivery, and Black infants are more than twice as likely to die than their White counterparts (NCHS, 2016). American Indians and Alaska Natives also shoulder a disproportionate burden in infant mortality, as rates of infant death in these communities are 60% higher than those of White communities (Office of Minority Health, 2019). Finally, while rates of low birthweight have remained constant for White populations since 2015, Black and Latinx communities have seen increases in their rates of preterm birth (NCHS, 2016).

Homicide, unintentional injury, and mental health-related deaths also show sharp disparities across racial and ethnic lines. Homicide rates are the highest in Black communities, followed by Indigenous and Latinx populations (Centers for Disease Control and Prevention [CDC], 2013a). Indigenous populations experience the highest rates of both intentional and unintentional injury-related deaths (CDC, 2013a). Overall, these data on racial and ethnic health disparities must be evaluated with caution, though, as communities of color are rapidly growing, and further studies must be conducted to reveal how these disparities affect communities across the nation.

Gender-Based Health Disparities

When discussing gender-based health disparities, it must be acknowledged that many of these disparities are rooted in socially constructed conditions including income, education status, cultural norms that lead to drastic differences in life expectancy, substance use and abuse, mental health issues, and victimization by violence.

On average, women in the United States can expect to live approximately 5 years longer than their male counterparts, as the average life expectancy for women is 81.1 years while it is only 76.1 years for men (NCHS, 2016). When stratified by race and ethnicity, these gaps in life expectancy vary drastically. The average life expectancy for Black women, for example, is 78.5 years while it is only 71.9 years for Black men. In Hispanic/Latinx communities, average life expectancy is higher than White communities, with Hispanic/Latinx women living an average of 84.3 years

and Hispanic/Latinx men living an average of 79.1 years (Arias & Xu, 2019). Studies show that this life expectancy gap may be closing, which seems like a positive trend; however, this is likely to be attributed to increasing rates of early death for women experiencing chronic health conditions (Arias, 2016). Research suggests that women are increasingly dying from unintentional drug overdoses (related to the current opioid epidemic), suicide, smoking-related chronic health conditions, and obesity (Astone et al., 2015).

With regard to mental health, women are significantly more likely to report some mental health conditions, such as major depression, posttraumatic stress disorder, and anxiety (Eaton, 2012). Men are more than four times as likely to die by suicide than women (CDC, 2013b). Men are also more likely to report higher rates of alcohol and illicit substance use disorders than women (Eaton, 2012). Mental health disparities must be studied further. People underreport mental health conditions, making it difficult to quantify the true nature of these disparities (Eaton et al., 2012).

Finally, victimization by violence affects men and women in very different ways. Men are more likely to be victims of assault (Morgan & Oudekerk, 2019) or die from assault than women (Prevention Institute, 2011). However, women are significantly more likely to experience, report, and sustain sexual assault (Morgan & Oudekerk, 2019) and/or injury from intimate partner violence (Tjaden & Thoennes, 2000) than men. Research also suggests that sustaining injury from intimate partner violence has many negative long-term health effects for women, as they become more likely to develop chronic conditions, such as arthritis, experience increased rates of sexually transmitted infections, increased mental health issues, and severe gynecological complications (Campbell & Boyd, 2000).

Sexual and Gender Minority Health Disparities

The term “sexual and gender minority” is used to refer to individuals whose sexual identity, orientation, or practices differ from those who identify as heterosexual. This term is used to refer primarily to lesbian, gay, bisexual, and transgender individuals; it can also refer to queer, intersex, and asexual persons. Sexual and gender minorities experience the health disparities faced by society as a whole, while also bearing disproportionate burdens for many other health conditions, such as HIV/AIDS, mental health issues, substance use and abuse, and violence.

Many of these health disparities occur throughout the life course, as the experience of certain forms of violence, such as bullying or being kicked out of their home, leads to poor mental health, substance use and abuse, and physical and/or sexual violence (Robinson & Espelage, 2013). Additionally, some sexual and gender minorities are more likely to engage in risky sexual behaviors, which have been associated with higher risk of HIV and other sexually transmitted infections (Garofalo & Bush, 2008).

Sexual and gender minority individuals experience unique health disparities. Although the term “sexual and gender minority” or the acronym LGBTQ+ is used as an umbrella term, different subgroups represent distinct populations with their own health risks. For example, lesbians are more likely to experience preventable diseases that could have been detected early by health screenings, and also are more likely to experience higher rates of smoking, obesity, and certain forms of cancer (O’Hanlan & Isler, 2007). Gay men experience the highest rates of HIV/AIDS, and also experience many mental health disparities, such as increased body image issues, eating disorders/disordered eating behaviors, and depression (Burns et al., 2015). Bisexual persons often report high rates of intimate partner and physical violence (Brown & Herman, 2015), though overall health disparities for bisexual persons are poorly understood due to lack of population-level

research. Transgender persons, particularly transgender women, experience some of the most striking health disparities in the United States. Persons who identify as transgender face high rates of physical and intimate partner violence, mental health issues, substance use disorders, HIV/AIDS, and other sexually transmitted infections, as well as the potential side effects of hormonal therapy (Lawrence, 2007).

Overall, health disparities among sexual and gender minorities must be looked at through the lens of intersectionality, as many of these disparities also result from lack of adequate access to healthcare, racial discrimination, and income inequity. In order to best study these disparities, quantify their effects, and tailor interventions to promote health equity in these communities, further and more rigorous research must be conducted.

Disability Status and Health Disparities

Disability, whether acquired at birth or obtained throughout the life course, can manifest in physical, mental health-related, or cognitive capacities that ultimately affect health outcomes. People living with disabilities represent almost 20% of the U.S. population (Brault, 2012). There is a large body of evidence that suggests that disability status is directly correlated with overall poor health outcomes (CDC, 2013c), although until recently people living with disabilities were routinely excluded from health data collection and analysis.

In addition to increased reporting of fair or poor health, people living with disabilities, particularly those belonging to other marginalized identity groups, are at an increased risk for developing many chronic health conditions (Krahn et al., 2015). Persons living with disabilities, particularly cognitive disabilities, report higher rates of obesity, cardiovascular disease, and diabetes than the rest of the population. People living with disabilities are often more likely to report decreased rates of physical activity and increased rates of smoking and smoking-related health conditions (Reichard & Stolzle, 2011). Overall, future population-level health research should include this population to determine the breadth of these disparities and to guide public health and social work interventions.

STRUCTURAL FACTORS AND HEALTH DISPARITIES

When analyzing health disparities, it quickly becomes clear that many groups are exposed to multiple co-occurring forms of systemic oppression based on the power dynamics connected to their identities. The intersection of lower ranks of socioeconomic, political, and cultural/normative hierarchies of power results in structural vulnerability (Holmes, 2011; Quesada et al. 2011). This structural vulnerability exposes individuals to discrimination and social marginalization which increases health risk and constrains access to needed healthcare services and the unobstructed pursuit of healthier lifestyles (Botticelli & Koh, 2016; Bourgois et al., 2017).

Structural Inequity

Structural inequities in the United States manifest through personal, interpersonal, institutional, and systemic drivers, such as racism, sexism, homophobia, and transphobia, that affect the fair distribution of health opportunities and overall health outcomes. These structural inequities typically follow individuals and communities throughout the course of their lives, often impacting the health of individuals from birth until death. The effects of interpersonal, institutional,

and systemic biases in policy and practice-based decisions—structural inequities—are key determinants of health.

For example, policy decisions that determine to which school a child goes is based on their geographic location (i.e., children in high-income neighborhoods attend well-resourced schools and children in low-income neighborhoods attend under-resourced schools) which affects their educational attainment and subsequently their future ability to access high-income jobs with health benefits, their overall ability to access quality healthcare, and their ability to relocate to a healthier geographic location later in life (Woolf et al., 2007). These structural inequities also give rise to disparities in an individual's ability to have a voice in policy-making conversations, reducing their access to provide insight on how a policy may affect them and their communities, which gives rise to the cyclic nature of oppression and structural vulnerability (Robert Wood Johnson Foundation, 2009).

Racism

Inequities rooted in biases toward certain racial and ethnic identity groups are some of the most pervasive and difficult to address. “Racism” is an umbrella term used to describe the interpersonal, institutional, and systemic bias perpetrated against people of color in nearly every facet of our society. Whether it is through racist policies, such as stop-and-frisk, implicit biases in healthcare decision-making by providers, or interpersonally mediated acts of violence through hate crimes, racism can directly and/or indirectly affect health outcomes.

There is a growing body of empiric evidence that suggests that being targeted by racism is linked to mental health, birth, chronic disease, and other health outcomes, in addition to the consistent physical threats due to interpersonal violence (Gee et al., 2009; Uniform Crime Report, 2015). Finally, although racism is often studied and conceptualized through the unique experience of Black individuals, the effects of racism are pervasive across all communities of color in the United States.

Discrimination

The manifestations of discrimination in society can impact health outcomes both overtly through conscious, intentional poor treatment of certain groups, as well as inadvertently through implicit biases that systematically function to suppress and oppress certain groups. Overt acts of discrimination, such as hate crimes and the intentional poor treatment of others based on their identities, can have direct physical impacts on health (i.e., through physical violence) and also can impact mental health outcomes (Sue et al., 2007). Chronic exposure to discrimination may result in stress-induced physiological effects, such as hypertension, increased risk for substance use, poor birth outcomes, and mental health issues, disproportionately affecting marginalized communities (Alhusen et al., 2016; Sims et al., 2012).

Inadvertent forms of discrimination, implicit biases, affect health outcomes often through the lens of patient–healthcare provider interactions (van Ryn & Fu, 2003). If a patient from a marginalized identity group seeks care, the implicit biases held by a provider toward that group may subconsciously affect the type of care that patient receives. For example, some healthcare providers may hold the implicit bias toward Black women that they have a higher pain tolerance, thus leading them to not take the concerns of these women seriously after labor and delivery, resulting in higher rates of maternal mortality from preventable causes (Louis et al., 2015). Discrimination, whether inadvertent or overt, must be addressed at every level of our society to promote health and equity for all populations.

Income Inequality

There is a vast body of evidence that characterizes the implications of income inequality on health and health disparities (National Academies of Sciences, Engineering, and Medicine, 2015). Income inequality drastically impacts women and people of color in the United States, as pay gaps across racial and gender lines are pervasive at every level of educational attainment in almost every job role, and both directly and indirectly influence individual and population-level health outcomes (Zonderman et al., 2016). The vast majority of low-wage, part-time, and hourly paid jobs are held by women and people of color in the United States, which drastically limits socioeconomic standing, ability to access and pay for quality healthcare, and to take time off from work to meet health needs (Clougherty et al., 2010). Income inequality also impacts an individual's ability to live in well-resourced geographic locations, typically leading to socioeconomic segregation, which perpetuates the previously discussed cyclical nature of structural inequity in our society (Roberto, 2008).

HEALTH DISPARITIES AND SOCIAL WORK PRACTICE

Social workers are the nation's largest group of mental health service providers working in the medical, social service, and public health sectors (U.S. Department of Labor, 2020). They play an essential role serving clients experiencing health disparities. Those working in healthcare systems witness daily the impact of psychosocial and material deprivation on poor health. It is critical for them to be vigilant of how economic changes, healthcare policy, unemployment, and structural injustice exacerbate pathways for health disparities (Mitchell, 2012). Social workers participate in improving the quality of patient care, facilitate communication in the healthcare system, advocate for patients' rights, ensure treatment compliance, safeguard patient-centered care, and inform the process of decision-making (Auerbach et al., 2007; Zimmerman & Dabelko, 2007). Social workers are in a key position to assist marginalized and targeted groups in accessing and better utilizing healthcare services.

Social workers face important challenges working in healthcare systems. These challenges might constrain the ability of social workers to draw connections between individual patient experiences and well-recognized population patterns of health disparities. Social workers report a lack of adequate time for counseling, role ambiguity, constraints of resources, difficulties managing conflicts with other medical team members, ethical dilemmas, and low levels of recognition as part of a medical team (Allen et al., 2007; O'Donnell et al., 2008). Linking the social work practice experience with broader population-based knowledge on health disparities, evidence-based interventions, and culturally and linguistically responsive behavioral practices is fundamental to reduce the burden of health inequities.

In recent years, there is a growing recognition of the role of integrated care systems on health equity (Holden et al., 2014; Hough et al., 2011; U.S. Department of Health and Human Services & Hogg Foundation for Mental Health, 2012). Social workers play a key role in integrated healthcare systems. Healthcare systems must be patient centered, value cultural humility among providers, and be implemented in physical environments that respect and appreciate patient diversity and represented cultures (Tucker et al., 2007, 2011). These factors facilitate a greater degree of trust among patients, healthcare providers, and staff. In addition to working as mental health providers, social workers coordinate patient needs, monitor health outcomes, and ensure efficiency across care systems (Hogg Foundation for Mental Health, 2008; U.S. Department of Health and Human Services & Hogg Foundation for Mental Health, 2012). Emphasis has been placed on developing a national strategy to improve integrated healthcare for populations that experience health disparities in the United States (Center for Integrated Health Solutions, 2012). This strategy would

utilize social workers and demand training with the associated skills to use integrated healthcare service delivery approaches to address health disparities.

A core strategy for addressing health disparities is training healthcare professionals on cultural and linguistic competency (Barksdale et al., 2017). Cultural competency refers to behaviors, attitudes, and policies on a continuum to ensure that systems, agencies, programs, and individuals function effectively and appropriately in diverse cultural interactions and settings (Selig et al., 2006). Given the complexity of multiculturalism, it is important to understand cultural competence as a process rather than an end product.

“Cultural humility” refers to a process-oriented approach to cultural competency, defined as the ability to maintain an interpersonal stance that is open to others in relation to aspects of cultural identity (Hook et al., 2013). A culturally humble approach involves an ongoing commitment to self-evaluation and a desire to fix power imbalances, starting with oneself (Tervalon & Murray-García, 1998). A healthcare provider might have a body of knowledge critical to health, but the patient is an expert on their life, symptoms, meaning attributed, and strengths. Both must collaborate and learn from each other to achieve the best outcomes. Cultural humility involves examining social norms, policies, institutions, and community practices. Social workers must recognize and value diversity, acknowledging that structural change is needed to achieve health equity.

STRATEGIES TO ADDRESS HEALTH DISPARITIES

Factors that contribute to health disparities occur at multiple levels. The socio-ecological model (Bronfenbrenner, 1977; McLeroy et al. 1988) recognizes that influences on individuals can be much broader than the immediate environment. Intervening on individual- and population-level determinants of health represents opportunities to address health disparities. This model graphically depicts these different levels (Figure 7.1).

The socio-ecological model considers multiple levels, each of which influence individuals who experience health disparities. Beyond the individual, these may include interpersonal relationships, community, and society. The overlapping nature of the model demonstrates how factors at one level influence those at another.

FROM THE FIELD 7.1

USING A SOCIO-ECOLOGICAL MODEL TO ADDRESS HEALTH DISPARITIES

Many chronic health disparities can be linked to smoking, the leading cause of preventable death and more common in those with lower educational attainment and socioeconomic status (CNN Money, n.d.). A social worker can implement a program to reduce smoking behavior (individual level) which would impact that individual's health outcomes. Or, a social worker could intervene in a clinical setting to reinforce healthcare provider recommendations for smoking cessation (interpersonal), thus impacting those clients who participate in that clinical setting. Use of the socio-ecological model would ensure that larger resources are used as well. A social worker could implement changes to modify the point-of-sale environment at gas stations, to reduce smoking advertising influences (community), or could address smoking as a health disparity through policy changes and seek to increase cigarette taxes (societal). Ideally, social workers should address health disparities from each of these levels of intervention.

FIGURE 7.1 Socio-ecological model.

The socio-ecological model is helpful in conceptualizing that behaviors both affect the social environment and are affected by it. Intervening on more distal factors (e.g., community, society) can provide an even greater impact than intervening at the individual level (Cardarelli et al., 2005). For example, neighborhood conditions, poverty, and lack of affordable food, community and societal level factors are significant drivers of behaviors and, consequently, health disparities.

Recognizing the fundamental role of social determinants of health on health disparities by intervening on community and societal factors would mitigate health inequities (Cardarelli et al., 2005). Policy focused on the nonmedical determinants of health has substantial impacts on health disparities, including policy focused on housing, education, the environment, transportation, and the economy. There is scientific evidence to demonstrate that investments in early childhood education; stable, affordable housing; income enhancements; and community development can improve health and reduce health disparities (Thornton et al., 2016).

The federal government has developed multiple action plans to address health and healthcare disparities nationally. For example, the U.S. Department of Health and Human Services (DHHS) released an action plan in 2011 that explicitly built on the *Healthy People 2020* goal to eliminate disparities (U.S. DHHS, 2015). In response to the objectives set in that report, multiple federal agencies have engaged in activities to advance health equity, including expanding access to healthcare, and strengthening the healthcare workforce (U.S. DHHS, 2015).

For example, the CDC funds the High Obesity Program (CDC, 2020), which supports efforts to advance policy, systems, and environmental interventions to make healthy choices such as being physically active and eating more fruits and vegetables. The CDC High Obesity Program focuses on communities with a prevalence of adult obesity of 40% or greater and intentionally employs a community-engaged approach to reduce obesity. In rural Kentucky, the program resulted in increased fruit and vegetable consumption over a multiyear period (Gustafson et al., 2019).

Most notable among federal efforts to reduce health disparities is the Patient Protection and Affordable Care Act (ACA, sometimes referred to as “Obamacare”), a comprehensive healthcare reform law that was passed in 2010. The primary goal of the ACA was to enhance access to health

insurance, and one of the primary components was the expansion of Medicaid to include non-elderly adults whose income falls below 138% of the federal poverty level. This resulted in new health insurance options to individuals in low- and middle-income households, a group in which Black and Latinx people are overrepresented (McMorrow et al., 2015).

Although Medicaid expansion was intended to be national in scope, the Supreme Court in 2012 ruled that states could opt out of this expansion. Since its implementation in 2014, the ACA was associated with statistically significant reductions in probabilities of being uninsured, delaying healthcare, and forgoing any needed healthcare. It was also associated with increasing physician visits, compared to pre-ACA implementation. Racial and ethnic minority populations were particularly more likely to gain access to health insurance and needed healthcare after ACA implementation (Chen et al., 2016).

The ACA included specific provisions to reduce disparities, such as creating Offices of Minority Health within U.S. Department of Health and Human Services agencies to coordinate federal health disparity reduction efforts (Andrulis et al., 2010). The ACA promoted workforce diversity, increased funding for cultural competence training and educational materials, and strengthened data collection and research efforts. Finally, it permanently reauthorized the Indian Health Care Improvement Reauthorization Extension Act of 2009, a bill by the Senate Committee on Indian Affairs that strengthened and improved healthcare for American Indians and Alaska Natives. Many ACA provisions have been eliminated under the Trump administration, including the tax penalty for not having health insurance. Other provisions are currently being challenged in courts, including the work requirement for Medicaid recipients and the individual mandate that encourages young and healthy people to get or stay insured.

Efforts among the states to reduce health disparities vary considerably, which is not surprising given how heterogeneous public health is organized and delivered at the state level. Less than half of all states or territories have a strategic plan addressing health disparities (Office of Minority Health, 2018). Many of those plans that do exist include data collection and analysis; Medicaid expansion; immunization programs; and chronic disease management efforts (Office of Minority Health, 2018). Additionally, many states' health disparity reduction efforts focus on particular populations, such as children, refugees, and/or individuals experiencing homelessness (Office of Minority Health, 2018).

Notable for social work practice, efforts to reduce health disparities should include expanding and diversifying the workforce to increase access to culturally and linguistically appropriate care. Evidence suggests that racial and ethnic minority practitioners are more likely to practice in medically underserved areas and provide healthcare to large numbers of racial and ethnic minorities who are uninsured and underinsured (Smedley et al., 2001). This strategy includes actions to increase the diversity of social workers to address the compelling need for reductions in health disparities (Office of Minority Health, 2018). Additionally, we must increase the availability, quality, and use of data to improve the health of marginalized populations. That is, we must ensure that data collection standards for race, ethnicity, gender, sexual orientation, primary language, and disability status are implemented in activities, and surveys.

KEY ELEMENTS FOR SUCCESS

The Committee on Community-Based Solutions to Promote Health Equity in the United States (National Academies of Science, Engineering and Medicine, 2017) has suggested three key elements for successful mitigation of health disparities: (a) creating a shared vision of health

equity; (b) building community capacity for health promotion and disease prevention; and (c) fostering multisector collaboration. Each of these is detailed in the following.

First, in order to foster sustainable change in a community, several approaches are important. Two examples are creating a shared sense of urgency around health disparities (including the use of community health data) and reinforcing solutions that come from and involve community members. Articulating the shared purpose and identifying one or more champions can also bolster sustainable change. Such champions need not be elected officials, but they should be trusted, well-respected individuals in a community who can communicate with elected officials.

Second, another important approach to reducing health disparities is building community capacity for prevention. Defined by Wallerstein and Duran (2010) as the intersection of science and practice to improve health equity, community-based participatory research (CBPR) employs an approach to research that pairs community engagement and social action. CBPR employs tactics that combine research methods and community capacity building to bridge the gap between knowledge produced by research and interventions or policies (Lantz et al., 2006). CBPR requires equitable contributions by community members and investigators and can be particularly important when conducting research to reduce health disparities.

FROM THE FIELD 7.2

BUILDING COMMUNITY CAPACITY FOR PREVENTION

The Dallas Cancer Disparities Coalition worked with academic investigators to identify cancer health priorities in South Dallas, which faced disproportionately high levels of cancer death relative to other areas of Dallas or Texas. Using a CBPR approach, investigators and community members co-designed and piloted a breast cancer prevention program (Cardarelli et al., 2011). The program was found to be effective in increasing knowledge of risk factors for breast cancer and in increasing uptake of screening mammography. Furthermore, healthcare system-level barriers were identified and addressed in subsequent years. In this project, community members reviewed data, designed a focus group moderator guide, analyzed and interpreted data, codesigned an intervention, and assisted with dissemination of study findings. Community members were instrumental in providing community context, history and perspectives of feasibility, and acceptability for the intervention. Furthermore, they enhanced their research skills and provided a built-in dissemination mechanism for reporting back the findings of the study. Ongoing CBPR collaborations have the potential to mitigate mistrust of institutions and build sustainable partnerships to collectively address health disparities.

As From the Field 7.2 illustrates, community partnerships are an integral component of addressing health disparities and considered one of the most effective ways to do so. Understanding data-related health disparities is an important component of the process and sets the stage for the needed interventions.

Finally, bringing together nonhealth sector partners to contribute to health disparity reduction efforts is critical. Given that factors such as transportation, education, community development, and environmental quality all impact health and health disparities, it makes sense that collaboration from these sectors will contribute to the reduction of health disparities. This requires a

clear articulation of shared values, successful working relationships, and usually a lead organization from health or public health to guide the collaborations. Collective impact represents one approach to a multisector collaboration for health (Kania & Kramer, 2011). Collective impact projects typically represent long-term commitments from multiple partners to solve a common problem.

CONCLUSION

Despite some progress in the United States, additional efforts are urgently needed to reduce health disparities. In particular, policy changes that reduce poverty and increase access to healthy, affordable food, stable housing, and employment with increased minimum wages will be most impactful in improving the fundamental determinants of health. These root causes of health disparities are deeply entrenched in the U.S. society and will take collective community and elected officials' will to address. Solutions that include direct input and leadership from affected health disparity populations will likely be most sustainable. Social work practice has an important role in implementing and sustaining the key factors for successful reduction of health disparities.

DISCUSSION QUESTIONS

1. Identify two ways in which intersectionality impacts health disparities.
2. How can policy efforts reduce health disparities?
3. Describe how only part of someone's health depends on their biology, behavior, and choices.
4. How will your own health and health-related decisions impact how you engage clients regarding their health?

REFERENCES

Only key references appear in the print edition. The full reference list appears in the digital product on Springer Publishing Connect: connect.springerpub.com/content/book/978-0-8261-3539-1/chapter/ch07

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