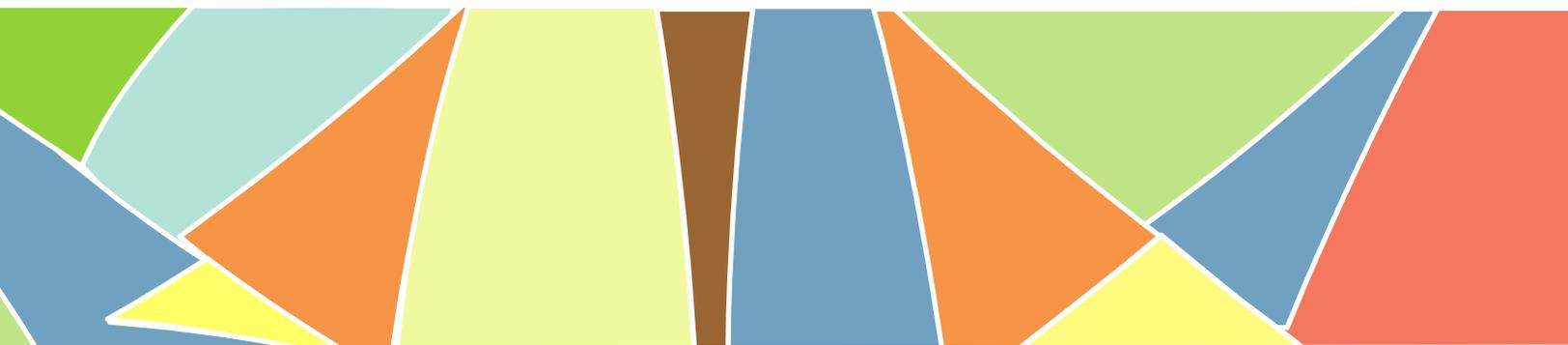


HEALTH DISPARITIES: AN INTRODUCTION



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Health disparities have received increasing attention from public health researchers, policymakers, and healthcare organizations. This brief paper offers an overview of the constructs outlining health disparities and highlights the disparities experienced among patients served by Adventist HealthCare facilities and the larger community. Readers interested in gaining a more extensive understanding of the topics introduced by this paper may consult the resources included in the references section and on our website (www.adventisthealthcare.com/disparities).

HEALTH DISPARITIES: A WORKING DEFINITION

A definition of health disparities requires an understanding of the factors that contribute to a person's health status. Health disparities result from a series of contexts in which there are differences in environment, access, utilization and quality of care, health status, and communication gradients (Carter-Pokras & Baquet, 2002; Maryland Department of Health and Mental Hygiene, 2003). These factors include:

1. Natural, biological variation.
2. Health behavior if freely chosen, such as participation in certain sports and pastimes.
3. Health behavior where the degree of choice of lifestyles is severely restricted.
4. Exposure to unhealthy, stressful living and working conditions.
5. Inadequate access to essential health and other public services.
6. The tendency for sick people to move down the social scale (Whitehead, 1990).

In light of these health determinants, several definitions have emerged to describe health disparities. Health disparities “exist when disease and death affect some communities at a higher rate than others” (Maryland Department of Health and Mental Hygiene, 2003). The definition Margaret Whitehead framed in her address to the World Health Organization, however, has been most widely used in public health research and policy (Braveman, 2006). Whitehead (1990) indicates that the “term [health disparities]...refers to differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust” (p. 7). By this definition, not all group differences in health status are considered health disparities. Instead, the term *health disparities* implies that differential health outcomes result from factors beyond genetic influence and individual control. Health disparities arise from environmental, social, financial, and political contexts that inhibit choices that support health as well as expose persons to factors that negatively impact their health—namely, the last four health determinants listed above.

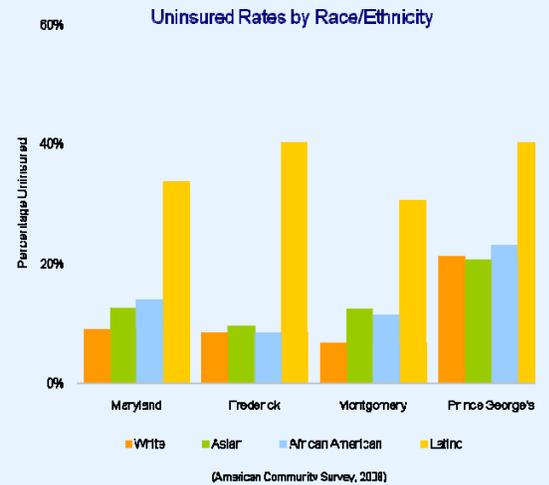
“Health disparities [are] differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust”

HEALTH DISPARITIES IN OUR COMMUNITIES

18.6% of residents living in the tri-county area are linguistically isolated.

Adventist HealthCare aims to provide high-quality medical care for the residents of Montgomery, Prince George's, and Frederick counties. Many residents of this tri-county area, however, face considerable barriers to care including language barriers. Among people living in the tri-county area, 18.6% indicated that they did not speak English well or not at all (American Community Survey, 2008). Patient-provider communication is a significant predictor of patient utilization of preventative health services, including screenings (Carcaise-Edinboro & Bradley, 2008). Patients may also feel that they have less control over the procedures that are conducted because language differences between the patients and providers complicate obtaining informed consent (Schenker, et al., 2007). The number of physicians available in the communities that Adventist HealthCare serves is unevenly distributed. While there are approximately 41 physicians for every 10,000 patients in Maryland, Montgomery County has twice that number available to its population. Comparatively, Prince George's and Frederick counties have 18 and 20 physicians per 10,000 residents, respectively (Area Resource Files, 2005).

Access to health insurance represents another significant barrier to medical care for many persons in the tri-county area. There are significant disparities in the insured rates among racial/ethnic subgroups. Over one-third (33.7%) of Latino residents in Maryland do not have health insurance, compared to 14.3% of African Americans, 12.6% of Asians, and 8.9% of Whites (American Community Survey, 2008). Residents of Prince George’s County are also more likely to be uninsured than those living in Frederick or Montgomery counties. While 14.5% of Maryland’s residents are uninsured, 20.2% of those living in Prince George’s do not carry insurance, compared to 14.7% in Montgomery County and 11.7% of Frederick County residents (American Community Survey, 2008). The rates of uninsured among those living at or below 200% of the poverty threshold are significantly higher; 38.3% of these residents living in Frederick as well as 47.1% and 37.2% of the residents of Montgomery and Prince George’s counties, respectively, do not have health insurance. The source of insurance also differs among racial/ethnic groups in the tri-county area. Among the insured in the tri-county, Latinos are least likely to be insured privately—only 12.3% of Latinos living in Frederick County have private health insurance, 90.6% of Asian residents, 82.3% of Whites, and 74.1% of African-Americans.



African-Americans account for more than 80% of AIDS cases in Maryland.

There are disparate health outcomes for various groups in the tri-county area. In all counties, the rate of low and very low birth weight births was highest among African-Americans (Maryland Department of Vital Statistics, 2005). Similarly, the infant mortality rate among African Americans in Montgomery County is more than four times as high as the rate among Whites; the mortality rate for African American infants in Prince George’s County is more than 150% of the rate for White residents. Across Maryland, 80% of all AIDS cases involve African American patients; in Montgomery and Prince George’s counties, they represent 64% and 88%, respectively (Maryland Vital Statistics Administration, 2005). In Frederick County, however, African Americans account for only 30% of AIDS cases while Whites comprise 53% of AIDS patients. Asian American residents of the tri-county area face a significantly higher risk for stomach cancer—the incidence of stomach cancer per 100,000 Asians is 10.9, compared with 5.2 among Whites, 5.5 among African Americans, and 6.5 among Latinos (Maryland Vital Statistics Administration, 2008). Asian communities, however, are underrepresented in health outcome data for the tri-county area. This may be due to disproportionately lower rates of accessing hospital services—whereas Asians represent 9.0% of the population within the tri-county area, they only account for 4.4% of discharges from area hospitals (Maryland Vital Statistics Administration, 2008).

TOWARD AN UNDERSTANDING OF HEALTH EQUITY

A discussion of health disparities lacks direction without an understanding of health equity. Whitehead notes, “Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided” (p. 7). Far from attempting to eliminate all health differences, health equity seeks to “reduce and eliminate those which result from factors which are considered to be avoidable and unfair” (Whitehead, 1990, p. 7). Therefore, equity aims to promote equal access to and utilization of available care for equal need and an equal quality of care for all (Whitehead, 1990, p. 8).

“Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential”

PROMOTING HEALTH EQUITY AT ADVENTIST HEALTHCARE

Adventist HealthCare is committed to providing quality care for *all* members of the communities it serves. In light of the diverse cultural, socioeconomic, and linguistic needs of its patients, a panel of community leaders and other stakeholders recommended the creation of the Center on Health Disparities. In 2007, Adventist HealthCare established the Center on Health Disparities to raise community awareness of health inequities, improve the capacity of Adventist HealthCare to serve its communities, and develop solutions aimed at eliminating local health disparities. To reach these goals, the Center is organized into three focus areas: education and training, health care services, and the research institute.



Education & Training: The educational program provides training to health care professionals and staff throughout the Adventist HealthCare system as well as to other organizations in the wider community. The “Culturally Competent Care” training series has been developed to increase awareness of the factors that contribute to health disparities as well as offer instruction in cross-cultural communication strategies. The Center also offers a “Qualified Bilingual Staff” training program to train and assess the language skills of bilingual staff to provide medical interpretation services. These programs enhance Adventist HealthCare’s ability to provide culturally and linguistically appropriate services to all of its patients.

Health Care Services: Adventist HealthCare partners with various community partners to make quality health care and services accessible to people in our community. These organizations include: Mary’s Center, Montgomery County (Department of Health & Human Services, Human Resources, Department of Correction and Rehabilitation, and the Pre-Natal Care Partnership), Mobile Med, Kaiser Permanente, and the University of Maryland at College Park. Through these partnerships, the Center on Health Disparities has facilitated training for community health workers and contributed to community-based research efforts. In 2009, Adventist HealthCare provided over \$62 million in direct health services to community members, training for service providers, and funding to community organizations addressing social determinants of health.

In 2009, Adventist HealthCare provided over \$62 million in resources to benefit its community.

Research Institute: The research branch of the Center compiles current demographic and health data on the communities and patients Adventist HealthCare serves. Since 2007, the Center on Health Disparities has published an annual report, “Partnering Toward a Healthier Future,” to describe racial and ethnic disparities in Montgomery, Prince George’s, and Frederick counties, and highlight efforts to address them. The reports highlight progress made toward the elimination of health disparities in our community, highlight collaborative partnerships, and include recommendations for promoting health equity. The Center has also participated in a local effort to collect patient race/ethnicity and language preference information in order to build Adventist HealthCare’s capacity to track health disparities among its patient population. Health professional training, healthcare services, and research efforts at the Center on Health Disparities help to enhance the quality of care that Adventist HealthCare provides by ensuring the best services to all its patients.

HEALTH EQUITY: A COLLABORATIVE EFFORT

The factors that contribute to health disparities are often beyond an individual’s control and may fall outside of the traditional scope of health care organizations. Caring for the health needs of the most vulnerable members of their communities requires health care organizations to adopt a systemic approach that addresses issues that directly and indirectly impact health status. Partnerships with community organizations—businesses, health clinics, developers, and governmental officials—are an essential part of improving the health of all community members. Another important factor in the elimination of health disparities is an understanding that health equity requires an ongoing commitment. This commitment includes the reduction of the prevalence of health issues as well as continual vigilance by policymakers, healthcare providers, and community organizations. Together, we can eliminate health disparities.

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