Health Disparities Research in Global Perspective: New Insights and New Directions

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Abstract

This commentary introduces this volume's symposium on "Comparative Approaches to Reducing Health Disparities." Disparities in the health of socially and economically disadvantaged compared with more advantaged populations are observed worldwide. The lack of progress in addressing these disparities compels a continuing search for new ideas and evidence about potential solutions as well as efforts to understand when and where these solutions work and how they work. The symposium consists of five in-depth reviews led by established scholars who approach the topic from their different disciplinary and topical perspectives. Taken together, these reviews point out the conceptual and methodological opportunities for generating more effective disparities research within biomedical, public health, and health services approaches, the value of also applying theory and methods from disciplines such as political science and economics to health disparities research, and insights to be gained from comparisons of how disparities occur and are remedied in different societies.

SYMPOSIUM INTRODUCTION

Diverse social and political realities create huge, predictable differences in health outcomes among nations and between population groups within nations (2, 3, 8, 10, 12, 19). Observations of health disparities (poorer health in socially and economically disadvantaged populations) are universal (12). Recent (in historical perspective) global commitments to addressing the conditions that create and perpetuate such disparities are reflected in documents such as the Declaration of Alma-Ata (25), the Convention on the Rights of the Child (15), and the Millennium Development Goals (22). For example, the Declaration of Alma-Ata, in making the case for the importance of primary health care, noted that

> The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries. (p. 1, paragraph II)

> A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. (p. 1, paragraph V)

Yet, disparities persist even in the most "egalitarian" societies.

This arena of research and policy is extremely complex as well as political and politically sensitive. The call for remedies that involve government interventions in the lives of individuals and for new resources or new uses of existing resources to achieve equity becomes interwoven with advocacy and political stances to keep the issue on public policy agendas. Health disparities imply or confirm injustice, systematic unfair treatment (e.g., of racial/ethnic minorities, immigrants, the poor, or those less educated), or at least a failure of societies to distribute equitably the resources needed to support health for all. Uncertainties about where and how to intervene to eradicate disparities arise because of the plethora of potentially relevant causes, variations in the effects of these causes across the life course, and cumulatively, the fact that these causes are often interrelated, and the diverse groups that are disadvantaged. In addition, interventions to address disparities must identify focal and leverage points that are modifiable. This is highly problematic because health or social disadvantage is rooted within the institutions, social stratification, and cultural norms of societies. Such societal characteristics are difficult to change, perhaps especially because they provide the underpinnings of power, privilege, and social advantage. Failure to acknowledge these fundamental, structural influences on disparities leads to a futile focus on changing the health-related behaviors of people in the affected populations as a primary or sole strategy. Viewing individual or population subgroup behaviors as primary causes of disparities ignores the critical need for policies that can shift the underlying social structural forces that influence health behaviors in a more equitable direction.

This commentary introduces this volume's symposium on "Comparative Approaches to Reducing Health Disparities." The political nature of the issues underlying health disparities does not obviate the need for good science—to the contrary. The pervasiveness of disparities, the lack of progress in addressing them, and the potential for disparities to worsen in times of political and economic crisis compel a continuing search for new ideas and evidence about potential solutions as well as efforts to understand when and where these solutions work and how they work. The symposium focus is, therefore, global and cross-cultural. Disparities must be addressed within the specific contexts in which they arise, but strategies to address disparities in any setting can be informed by an appreciation of the commonalities and differences in how they occur and are remedied in different societies.

The symposium consists of five in-depth reviews led by established scholars who approach the topic from their different disciplinary and topical perspectives (4, 6, 13, 17, 20). The objective is to uncover what is needed, going forward, to realize the goal of eliminating disparities and achieving equity. Given that health disparities are far from new phenomena and have been an increasing focus of research and policy attention in recent decades (1–3, 5, 7–11, 14, 16, 18, 19, 21, 23), the authors consider why the goal of eliminating them continues to be elusive. The various articles examine disparities with a focus on race and socioeconomic status, changes over time, models of causation, political economies, health systems, specific health outcomes or health care outcomes, and types of interventions. The articles are highlighted below. **Figure 1** provides a visual flavor of the scope of considerations included.

Bleich et al. (4) assess and compare patterns and time trends in disparities in the United States and United Kingdom by sex, race/ethnicity, or socioeconomic status and also compare health data across several member countries in the Organization for Economic Cooperation and Development. They focus on disparities in mortality, life expectancy, lifestyle behavior risk factors, obesity, and other metabolic risk factors for cardiovascular disease; assess evidence of progress over time; and characterize the types of policy responses set forth in different countries to address inequalities. However, they found it impossible to assess the impact of these policy responses on health outcomes, not in the least because of inadequate conceptualization of disparities and of their implications for assessment measures.

Diez Roux (6) reviews and compares four conceptual frameworks for explaining how disparities arise. She shows how different emphases in these frameworks influence the formulation and conduct of disparities research. For example, for racial/ethnic disparities, conceptual models that focus on possible genetic causation lead to different lines of research than do models that emphasize disadvantages embedded within the social structure, whereas models that emphasize gene-environment interactions would combine elements of these approaches. She recommends new ways of thinking based on integrative systems-oriented models, which can be pursued with new analytical approaches and tools from systems science.

McLeod et al. (13) focus on understanding how the underlying economic characteristics of high-income countries cause and perpetuate health disparities. These authors argue for and illustrate an approach that compares countries on the basis of type of capitalism (coordinated, liberal, or mixed market economy). Using data from Germany and the United States (classified, respectively, as prototypical coordinated and liberal market economies), the authors model the effects of unemployment on health using indicators of how the labor market is organized and what income protections and services are provided for those who become unemployed, and for what duration.

The other two articles focus primarily on the health care delivery part of the spectrum. Rowley & Hogan (17) examine differential causes of disparities in infant mortality as they affect U.S. racial/ethnic minority populations. They pose the question of whether interventions known to reduce infant mortality are being applied in ways that will reduce disparities, concluding that the answer is unequivocally "no." In particular, they note that the increased focus on clinical interventions during the pre- and postnatal periods to prevent preterm birth or address specific causes of postneonatal mortality may actually create or increase disparities owing to problems of access to care, biases in the delivery of care, or failure to formulate intervention delivery in ways that are culturally salient. These authors conclude that medical interventions alone cannot resolve disparities in infant mortality. They call for a deliberate shift in research and funding priorities to permit the identification of effective interventions that support women before conception and between pregnancies.

The *Annual Review of Public Health* is privileged to have as part of this symposium one of the last articles authored by Dr. Barbara

Starfield, who passed away on June 10, 2011. Dr. Starfield was a true giant—in both commitment and contributions—in the global field of health equity research. Her review (20) pinpoints several issues that, if understood and addressed, would remove major roadblocks to eliminating health disparities associated with the delivery of clinical care. Citing examples from an array of low-, middle-, and high-income countries, Starfield and colleagues elucidate the many pathways through which the type (i.e., primary versus specialty care), quality (problem recognition, diagnosis, treatment, and follow-up), and focus (e.g., preventive, person-focused versus disease-focused) of health services determine their potential to decrease or, in some cases, increase inequities. They also note that important insights about how disparities arise or are prevented can be gleaned from deconstructing the inconsistent or anomalous findings about patterns of disparities, i.e., findings that run contrary to expectation about which groups have worse health status on a given outcome. Research to pursue these leads will, however, be limited unless the inconsistencies in reporting disparities and assessing outcomes are addressed.

In conclusion, the authors in this symposium take a broad look at a critical topic about which—when judged by progress or even the ability to assess progress—we know much less than we should. The need to address health disparities bears repeating and restudy, often and with sound rationale. However, much more than repetition of traditional approaches will be needed. There is much to be learned from these articles about promising new directions. Taken together, they point out the many conceptual and methodological opportunities for generating more effective disparities research within biomedical, public health, and health services approaches as well as the value of research that applies theory and methods from disciplines such as political science and economics. An overarching theme is that studying disparities as such is not necessarily the same as studying ways to eliminate them. The latter implies asking novel questions or asking more traditional questions in novel ways: conceptualizations that are specific to pathways whereby disparities are created and whereby trajectories that close gaps can be accelerated; study designs and measurement approaches that account for relevant sources of variation in influences on disparities and their often complex interrelationships; more systematic approaches to reporting data on disparities; and specification of data collection approaches that allow for monitoring outcomes linked to policy and programmatic interventions. The articles also emphasize that disparities arise, and must be addressed, at several relevant points on the spectrum from environmental influences to the delivery of high-technology specialty care while emphasizing the advantages of applying effective interventions as early as possible in the causal chain.

DISCLOSURE STATEMENT

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Figure 1

Word map of considerations reflected in the summaries of articles in the symposium on "Comparative Approaches to Reducing Health Disparities," generated with a frequency count of the occurrence of each word or phrase. The size of the word indicates its frequency relative to that of the other words. The most frequently occurring terms ("health disparities," "health inequalities," and "health inequities") were removed to improve visualization of other terms and concepts.