

EDITORIAL

Closing the Gap in Health Disparities

Marinelle Payton, MD, PhD, MS, MPH
Assistant Dean for Research and Program Development
Professor, Epidemiology and Biostatistics
Principal Investigator and Director, Center of Excellence in Minority Health
and Health Disparities/Institute of Epidemiology and Health Services Research
and Jackson Heart Study Graduate Training and Education Center
College of Public Service
Jackson State University
Jackson, Mississippi

Reports paint a bleak picture of health and healthcare in the United States. Escalating healthcare costs are passing through this land striking its prey, especially racial and ethnic minorities, like the Tenth Plague of God commanding the Death of the First-Born. Furthermore, diseases are running rampant throughout urban and rural streets in the country, leaving no address untouched.

Consider this, can you afford to be sick? There appears to be a backdrop of debates to address this question such as those issues surrounding the economy and the disproportionate gap of health services. The economic burden of being sick and the lack of access to quality healthcare could be incentives for health and well being.

The pervasive ills of health and wellbeing can have a detrimentally indirect impact on the country. Some racial and ethnic communities suffer a disproportionate gap in health and healthcare, known as health disparities. The gap was first documented in the 20th century by W.E.B. Dubois in 1906. Early studies documented the first report of disparities on the incidence and prevalence of cancer (Henschke et al., 1973), mortality rates (Satcher et al., 2005), and poor health care delivery (Institute of Medicine, 2003) associated with racial and ethnic disparities. Today, despite improvements in healthcare, there remains a continuous decline in the health and healthcare of racial and ethnic groups in many sectors in urban and rural settings.

Ethnic health disparities tend to be driven by the context of social and economic inequality that impacts all Americans, regardless of ethnicity. Even when controlling for age, gender, and socioeconomic status, racial and ethnic groups continue to experience the lack of quality healthcare and routine medical procedures and higher morbidity and mortality than non-minorities. Many sources have been identified to be associated with these disparities, including systems of healthcare, healthcare providers, utilization, bias, stereotyping, prejudice, and lack of health education. Moreover, the pervasive reality of subjectivity and discretion in healthcare may lead to racism and classism, such as providing disparate treatment, assumptions about intelligence, and lifestyle. Unfortunately, this could lead to increased disparities in healthcare, as persons might become less trusting and may not seek care.

Although this editorial is far from being an exhaustive analysis of health disparities, it will provide a snapshot of the economic impact of racial and ethnic health disparities at two levels, the individual and the community.

At the individual level, the economic impact of health disparities may include out-of-pocket health care expenses and loss of income due to illness. Many studies have demonstrated that racial and ethnic minorities suffer a disproportionate burden of disease that adversely impacts the work force participation (National Center for Health Statistics, 2008). Increased incidence of disease and conditions, especially obesity, cancer, diabetes, and heart disease, have been shown to be directly associated with poor salary and being absent from work due to illness (Government Accountability Office, 2007). When these diseases and conditions occur at a younger age the opportunity of acquiring competitive jobs and salaries also decreases. Equally devastating, those employees without paid sick leave, may continue to work while sick and fail to meet performance standards. Furthermore this chain of events contributes to poor employee health.

Several reports (Institute of Medicine, 2003; Hospital Accountability Project, 2003; Mayer et al., 2000) show that economically deprived groups are uninsured or underinsured and expend much of their income on health care. Over a decade ago, Wielawski described it well by reporting that many low-income workers depend on publicly financed health insurance programs and discriminatory pricing in health care facilities, when uninsured patients are billed the full gross charge while insured patients receive substantial discounts (Wielawski, 2000). Others explore the disparities of the uninsured in that they may suffer a disproportionate gap in payment for emergency medical treatment services, where they may be charged more for the same services than that charged for the insured (Andrulis et al., 2003).

According to the Institute of Medicine's 2003 Unequal Treatment report: "To the extent that minority beneficiaries of publicly funded health programs are less likely to receive high quality care, these beneficiaries – as well as the taxpayers that support public health care programs – may face higher future health care costs" (Institute of Medicine, 2003). Therefore the economically deprived, who are unable to "pay for quality health care may receive sub-standard health care early in the course of illness due to disparities in quality of care between communities (Institute of Medicine, 2003)." Those who postpone healthcare are at a greater risk of increased morbidity and mortality, thereby becoming a burden to their families, and the community.

At the community level, the economic impact of health disparities may result in a decreased workforce, loss of productivity in the workplace, increased competition for resources, greater spending for taxpayers, and directly impacting health care expenditures. The Healthy People 2010 initiative reported that "the health of the individual is almost inseparable from the health of the larger community and...the health of every community in every State and territory determines the overall health status of the Nation" (U.S. Department of Health and Human Services 2000). It has been estimated that by 2015 racial and ethnic minorities will comprise over forty percent of the workforce (U.S. Bureau of Labor Statistics, 2012). Therefore employers have begun to study the relationship between health disparities and health and well-being of employees and workplace productivity. Moreover, many federal initiatives from agencies such as the National Institutes of Health, Centers for Disease Control and Prevention, and Administration for Children and Families are seeking to eliminate racial and ethnic health disparities (NIH/NIMHD, 2013; CDC, 2013; Administration for Children and Families, 2013). Yet, the lifespan of these programs are threatened by the economy.

Reducing health disparities can reduce health care costs (dollars spent for employee treatment of disease or illness (insurance premiums)) and indirect costs (those that impact on job productivity due to poor health or illness, as well as total loss of productivity due to absenteeism) that result from poor health and illness (National Business Group on Health, 2003). Like the spread of an infection, poor health of one employee is directly related to poor productivity of the workplace, therefore; it is in the best interest of the employer to invest in health education and disease prevention programs.

In consideration of racial and ethnic health disparities, this editorial has addressed economic costs as one of its contributing factors, exploring how the individual and the community at large play an important role in this increasingly complex problem. To ensure closing the gap of health disparities, better social and economic policies need to be implemented to promote social justice, legislation, disease prevention, and policies on health and healthcare in urban and rural settings to determine whether individuals can afford to be sick. In the meantime, rigorous driven healthy lifestyle interventional prevention practices can be employed to ensure health and well being.

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