FEATURE ARTICLE

Disparity as Indicator Species

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In Richmond, Virginia, if a person is born and lives one's entire life in Gilpin Court, one of many public housing developments in the city where there has long been high poverty and residential concentration, one's life expectancy is 64 years. By contrast, if a person is born and lives one's entire life in Glen Allen, a suburb of Richmond with considerably less poverty and residential concentration, one's life expectancy is 82 years.[1] According to the Robert Wood Johnson Foundation, Richmond's disparate life expectancy picture is not unlike many American cities.[2]

Nationally, in the diagnosis and treatment of type II diabetes, African Americans are significantly less likely than whites to see a doctor and to have a regular source of care, and are more likely to visit an emergency department for ongoing treatment of type II diabetes.[3] African Americans are diagnosed with asthma at a 28% higher rate than whites.[4] Hispanics and African Americans are disproportionately affected by HIV. The HIV infection rate for Hispanics is three times that of whites while the infection rate in African Americans is eight times that of whites.[5]

These disparities have long been known and our understanding of why they occur has increased. The Affordable Care Act contains strategies that purportedly help reduce such disparity, and many national organizations such as the American Heart Association and the American Diabetes Association are working to understand and address such disparities. Still, in the current American health care system reform movement, one in which a community wellness approach to health care delivery is taking priority over the failed practice of episodic care, a simple question arises: what will successful transformation look like? In other words, what needs to be observably different in our health system in the future if we are going to achieve community health?

In order to address these questions, let us consider another sort of system for analogy. In wildlife habitats, an "indicator species" is an organism whose relative abundance serves as a marker for the general health of the ecosystem.[6] For biologists, an indicator species is a monitoring tool – as the indicator species goes, so goes the health of the ecosystem. There are positive and negative indicator species. A spotted owl is an indicator of a healthy old-growth timber habitat. Presence of river otters indicates that a wetland is clean and thriving. Algal

blooms indicate the hazardous presence of excessive phosphorous, as when rain water run-off contains excessive fertilizer. Indicator species abound.

Recent scholarship in the conflict resolution field provides another helpful lens. The philosophical approach to health reform has loosely followed a couple of strategies from a conflict resolution perspective. Our public officials, private industry and health care systems' leadership have chosen, with varying results, to tackle a series of specific points of disagreement about reform standards and requirements seeking *resolution*. Staged implementation of meaningful use standards and negotiations of mandated employer coverage are two examples.[7] Over more than two decades, they have also acknowledged the complexity of reform and *engaged* in ongoing dialogue to further understand interests and needs of many stakeholders, including patients, systems, insurers and government entities. Both of the aforementioned approaches might achieve improvements, but neither, alone, acknowledges the necessity of right relationships in health care delivery. For this to occur, our nation must utilize both engagement and resolution techniques and go beyond those methodologies to achieve *transformation*.[8] Many talk about transformation, but few understand what that effort involves in terms of the health care relationship that necessarily includes those who deliver, receive, fund and oversee health care services.

Assuming that achieving community wellness, not simply the absence of certain diseases, is the ultimate goal of health reform[9], and recognizing that there are many ways to measure success in reform, we argue that neither ongoing engagement nor resolution of specific problems in American health care delivery will ultimately achieve community wellness without transformation. We also argue that *disparity* serves as a leading negative "indicator species" for our health care delivery system. Persistent health care disparities, assuming the structural reform underway, would indicate that we have not truly achieved a necessary transformation – that we are still in conflict.

For the purposes of this work, we use the notion of disparity in two interrelated ways. Structural disparity, defined as the summation of barriers preventing access and utilization of health-related goods and services, leads to outcomes disparity. Structural disparity is the systemic and institutionalized aspect of disparity whereas outcomes disparity is the experience and practice of inequity and exclusion in health care delivery. We know that structural disparity leads to outcomes disparity because, in cases in which historic structural disparity has been effectively addressed, outcomes improve.[10] Structural disparity might be correlated to a number of factors, including, but not limited to, market-driven and commodity-oriented reimbursement techniques, social inequities and physical isolation, and religious and language barriers. The Affordable Care Act and other legislative actions attempt to reduce structural disparities in hopes of affecting outcomes disparities - measurable gaps in quality

and health indicators that exist in virtually every health care arena, as evidenced by a growing body of literature.[11]

Ubiquitous and multidisciplinary presence of outcomes disparities in health care is one aspect that makes disparity a good indicator species. Further evidence is the many successful and failed efforts thus far aimed toward reducing disparities. The Affordable Care Act is perhaps the most comprehensive of all efforts. One stated purpose of passing health care reform is to address disparities in care.[12] This measure is what conflict engagement specialists would refer to as a behavioral remedy.[13] It changes the situation based on compliance with standards of behavior on a societal level. But these experts also know that, for real transformation to take place, resolution must occur on cognitive and emotional levels, as well.[14] These cognitive and emotional components are harder to identify, measure and modulate. So, how can we hope to effect this change? Let us start with historical context and self-reflection.

Although disparities exist in every health system, and not every health-related shortcoming is directly correlated to disparities in care, the United States' socioeconomic picture reflects a prevalence of extremes in poverty that is less apparent in peer nations.[15] In addition, the county by county variation, as measured by U.S. departure from other Organisation for Economic Cooperation and Development (OECD) member countries' median mortality, is most pronounced in poor counties. There is also a similarity among the distribution rates of poverty, obesity, decreased life expectancy and Medicare reimbursement in the United States.[16] While many health care issues that challenge the United States – obesity, cardiovascular disease, addictions – appear to be matters of excess and lifestyle choices, poverty matters because our system is historically market-driven, and poor health accompanies poverty.

The market-driven nature of the American health care system sets us apart from other Western countries. In the aftermath of two World Wars, European countries' infrastructures were decimated and had no means of supporting a medical market place. Post-war Europe was forced to implement new public health models, those in which community health enjoyed priority in order to attend to the most basic health care needs of the whole population. Today, European health delivery systems vary in degrees of socialization and privatization, but the notion that basic health care could be identified as a commodity remains practically nonexistent.

Not so in post war America. In the U.S. there was no consensus that providing basic health care services was either necessary or desirable, and the American public has demonstrated a greater aversion to government programs.[17] Most health care services remained a commodity, and market values took hold. Considering medicine more in the context of rights and duties and less in the context of the free market is new in America, and it doesn't come naturally to us.

If structural and outcomes disparities highlight the roots of our problems in reform, expensive and episodic interventions appear to be the fruits we have born. The medical marketplace promotes disparity and breeds episodic interventions that occur to temporize medical conditions that society has felt compelled to treat but not to prevent. The system has been reactive rather than proactive. We have not empowered wellness or the equitable distribution of limited resources; we have just kept feeding the market.[18] It appears that, as a nation, we now recognize the limitations of the market place in advancing wellness, and the U.S. health system is working toward what we think will be a better model, but it's not simple to do when the structure is essentially set. We are not creating a new system, *tabula rasa*; we are transforming a broken one. The latter maneuver is far more challenging, and it takes a long time to realize.

Our view is that if we transform the structure of health care properly, especially as it relates to the incentives we bring into emerging quality-based reimbursement schemes, then we will see fewer outcome disparities. Moreover, if our public health infrastructure is properly scaled, innovative approaches to community and neighborhood health promotion will prove beneficial in limiting outcome disparities. But we cannot stop there; authentic transformation will also require modelling institutional and leadership behaviors that demonstrate a cognitive and emotional understanding of patient needs. Yes, changing the structure of the system is a primary imperative, but there is more work to be done.

Just as the Fifteenth Amendment to the Constitution did not immediately lead to equal representation for people of color, so the Affordable Care Act will not eliminate disparities by virtue of its existence. There are complex, value-laden factors that also contribute to disparities. After overt structural issues are addressed, our system is still left with stakeholders whose formal and informal training leads them to uphold disparity. Simply put, we must convert the hearts and minds of health care professionals and the American public.

Intergroup attributional biases leading to systematic or institutional discrimination must also be considered.[19] The rugged individual American pioneer spirit can be a great strength and moral voice for personal freedom, but if we allow it to be an institutional justification for retributive justice - the notion that people ultimately should get what they "deserve" - then it can lead to negative attributions in many health care settings. Instead of seeing a person in need in the Emergency Department, one sees a lazy and unmotivated "frequent-flyer." Instead of seeing a person who lacks transportation and a basic understanding of how and when to follow a doctor's recommendations, one sees a non-compliant patient. Instead of seeing patient questions or complaints as an invitation to relationship, one sees a difficult patient. Such attributions can be subtle and we need to understand how they contribute to structural and outcome disparities.

In this attributional paradigm, an observer, perhaps a health care professional, credits a marginalized person's behavior to his character and disposition rather than to her circumstances and place within health care's distorted incentive structure.[20] A more useful paradigm of restorative justice and perception of a person's circumstances as the cause of Emergency Department utilization can, if more deeply routinized within the care system, lead to cognitive and emotional transformation and empower equity and transformation. Attributional errors are already identified as a source of medical errors; it stands to reason that they inhibit the successful transformation of American healthcare.[21]

Institutional biases are compounded by the belief that simply refraining from overtly discriminatory behaviors – especially those behaviors specified in legislation – constitutes an adequate solution to the problem. Yes, there is more work to do on the structure of reform, but leadership and cultural competence must also become a priority if we are to achieve the cognitive and emotional elements necessary for transformation.[22] Operational stakeholders must believe that disparities exist, that they are not merely the result of personal choices, and all ranks must be viscerally invested in eliminating them. The Affordable Care Act does not clearly address how we should manage the cognitive and emotional aspects of disparity, but we won't realize the benefits of reform until we do. Transformation of our health care system will require transformation of our views – about community, justice, responsibility, and freedom. This is an ambitious undertaking. We have seen and should continue to expect challenges to our deeply held personal beliefs and group identities. Observing how well we affect disparity and reflecting on the environmental conditions that have concomitantly changed must be central in transformation because eliminating health care disparities will mean that we have made a real transformation.

It is difficult to overestimate the particular challenges that structural and outcome disparities pose for the Catholic health care ministry. Their existence challenges our core identity and fundamental values. Given our unparalleled understanding of individual and community need and buttressed by our practical ability to bring health and wholeness to individual persons and communities, the Catholic health ministry in the United States has earned its credible moral platform that will be required for leading the transformation of disparity. While necessary, the Affordable Care Act alone is an insufficient behavioral mechanism in transforming disparity. A wholesale effort, one that requires cognitive and emotional investment, is required to address this complicated problem. Using our creative moral imaginations we engage and transform this indicator for the betterment of our entire human ecosystem.

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