

Research in the Sociology of Health Care
Volume 31

Social Determinants, Health Disparities and Linkages to Health and Health Care

Jennie Jacobs Kronenfeld
Editor



**SOCIAL DETERMINANTS,
HEALTH DISPARITIES AND
LINKAGES TO HEALTH AND
HEALTH CARE**

RESEARCH IN THE SOCIOLOGY OF HEALTH CARE

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HEALTH DISPARITIES
AND LINKAGES
TO HEALTH AND
HEALTH CARE**

EDITED BY

JENNIE JACOBS KRONENFELD

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PART 1
INTRODUCTION TO VOLUME

SOCIAL DETERMINANTS AND HEALTH DISPARITIES

Jennie Jacobs Kronenfeld

ABSTRACT

Purpose – This chapter provides both an introduction to the volume and a review of literature on health disparities and social determinants.

Methodology/approach – Literature Review.

Findings – The chapter argues for the importance of greater consideration of social determinants of health disparities. This includes a consideration of race/ethnicity and socioeconomic status factors, geographic and place factors, and disparities especially linked to particular diseases.

Originality/value of paper – Reviews the topic of health disparities and social determinants and previews this book.

Keywords: Health disparities; health care disparities; social determinants; race/ethnicity; socioeconomic status; geography

This chapter is an introduction to Volume 31 in the Research in the Sociology of Health Care series. The beginning of this chapter reviews some of the more important material about health disparities, and some of

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the social factors that link to health disparities. The last part of this chapter reviews the overall contents of the volume and the structure of the volume.

HEALTH DISPARITIES

Fields have different areas of research that both grow and decline in popularity and scholarly interest over the years. In medical sociology for the past decade, one of the more robust areas of research has been an interest in health disparities and this interest is not limited only to medical sociology, but is also an area of high interest in epidemiology, public health, and health services research. Beyond researchers, it has also become an area of high interest to providers of care and policymakers, especially within the United States. What do we mean by disparities or differences in health and health care? There are a number of different answers to this question both from within medical sociology and from related fields. The Institute of Medicine (IOM) defines health care disparities as differences in treatment or access between population groups that cannot be justified by different preferences for services or differences in health (McGuire, Alegria, Cook, Wells, & Zaslavsky, 2006). Within the United States, much of the focus on health care disparities has turned to differences in access and quality across racial and ethnic groups, although these are not the only social characteristics that are of interest either sociologically or from a policy perspective. Very importantly, differences based on socioeconomic status (SES) and some of its components such as education and income are of research and policy interest as are factors such as geographic location, gender, sexuality, and even types of health problems. Beyond research and thinking about policy implications, health care disparities matter even more if they result in health disparities, defined as differences in health outcomes across population groups (Schnittker & McLeod, 2005).

Within sociology, some of the focus on health disparities has looked particularly at issues of race/ethnicity and SES. In an address given at the 2008 annual meeting of the American Sociological Association and later published in *Journal of Health and Social Behavior*, Aneshensel (2009) argued that mental health disparities refer to the disproportionate amount of psychopathology among persons of low social status. Following this definition, we can think of disparities in health status as the disproportionate amount of pathology among people, disparities that are often linked to SES, to race/ethnicity, to gender, or to other social factors. In that same address, Aneshensel argued that health disparities have complex causes and

are due to both biological differences and social inequalities, as [Adler and Rehkopf \(2008\)](#) have also pointed out. Sociologists and other social scientists particularly tend to focus more on social inequalities because they may be avoidable and are unjust. In this volume, it is the social inequalities and social determinants that are the focus. While the Aneshensel article entitled “Toward Explaining Mental Health Disparities” focuses on mental rather than physical health, this volume will consider all aspects of health. This chapter is in agreement with one of her conclusions in her article that research that examines differences and disparities in health is somewhat different from research that might focus on improving the mental health (or in this case also physical health) of the population overall. Disparities research has a goal ultimately of helping to connect to interventions that might alleviate health disparities. This is something that is less likely to occur directly from the kinds of research discussed in papers in this volume, but papers focusing on how social inequities become health disparities can eventually also connect to more policy-oriented research.

The large interest in research about social differences in health and health disparities was summarized well by the [Adler and Rehkopf \(2008\)](#) review of US disparities in health by examining literature for the term “health disparities” and finding that while this was a key word in only one article in 1980, and fewer than 30 in the 1990s, it went up to over 400 articles from 2000 to 2004. If the term “health inequalities” was used instead, the pattern of increase was similar.

The interest in this topic is broader than just in the United States and the importance of this in British studies is especially strong. In 1980, the Black Report in Great Britain was one of the first in that country to apply the term inequality to an examination of health differences. Some studies from the late 1970s and early 1980s in Great Britain found significant differences in cardiovascular disease and mortality by occupational level within a population of office-based workers ([Marmot, Rose, Shipley, & Hamilton, 1978](#); [Marmot, Shipley, & Rose, 1984](#)), another indication of interest in that country in health differences. In the United States in this same time period, studies did link together death and health information with information on SES from sources such as the Current Population Study, the US Census, and Social Security Administration records ([Kitagawa & Hauser, 1978](#); [Kliss & Scheuren, 1978](#)). These studies reported higher age-adjusted mortality rates for nonwhites, for individuals with less education and lower income, and for certain occupational categories.

Within the United States, some of these earlier studies and traditions in various fields including sociology of research into variation in health, health

care utilization, and health services issues by SES and race/ethnicity led to the now well-known efforts in the United States to examine and try to eliminate health disparities due to race/ethnicity and SES in the *Healthy People* series. From the federal government level, one of the pushes for more research on health care inequalities came from the passage of Public Law 106-129, the Healthcare Research and Quality Act of 1999. That law directed the Agency for Healthcare Research and Quality (AHRQ) to develop two annual reports, one focused on quality and one focused on disparities. AHRQ's responsibility was to track prevailing disparities in health care delivery as they relate to racial and socioeconomic factors among priority populations such as low-income groups, racial and ethnic minorities, women, children, the elderly, individuals with special health care needs, the disabled, people in need of long-term care, people requiring end-of-life care, and places of residence (rural communities). The first [National Healthcare Disparities Report \(2004\)](#) was built on previous efforts by the federal government, especially *Healthy People 2010* (U.S. Department of Health and Human Services, 2000) and the IOM Report, *Unequal Treatment: Confronting Racial and Economic Disparities in Healthcare* (Smedley, Stith, & Nelson, 2003). Elimination of disparities in health was a goal of *Healthy People, 2010*. *Unequal Treatment* extensively documented health care disparities in the United States and focused on those related to race and ethnicity, but not on SES, a weakness of the report. The IOM report on *Unequal Treatment* also looked at factors related to providers of care and argued that providers' perceptions and, from that, their attitudes toward patients can be influenced by patient race or ethnicity (Smedley et al., 2003).

The [National Healthcare Disparities Report \(2004\)](#) did focus on the ability of Americans to access health care and variation in quality of care. Disparities related to SES were included, along with racial/ethnic disparities. As part of this, the report began an exploration of the relationship between race/ethnicity and socioeconomic position. Some key findings from the report are important to review. First, inequality in quality of care continues to exist. These disparities often are particularly true for some more serious health care problems, such as minorities being diagnosed with cancer at later stages, less often receiving optimal care when hospitalized for cardiac problems, and higher rates of avoidable hospital admissions among blacks and poorer patients. Differential access to health care may lead to disparities in quality of care actually received. In addition, opportunities to provide preventive care may be missed.

In 2005, the third [National Healthcare Disparities Report \(2005\)](#) was released. One advantage of continuing reports is a comparison to

previous years. The 2005 report focused on findings from a set of core report measures. The two measures of access covered were facilitators and barriers to care and health care utilization. The overall summary indicated that disparities still exist, but some disparities are diminishing, an encouraging result, but one that clearly leaves opportunities for further improvement. Disparities remain in areas of access, quality, and across many levels and types of care including preventive care, treatment of acute conditions, and management of chronic disease. This applies to a variety of specific clinical conditions including cancer, diabetes, end stage renal disease, heart disease, HIV disease, mental health and substance abuse, and respiratory diseases.

Looking at access more specifically, major issues of disparity occur for poor people and Hispanics, with lesser but important issues for Blacks, American Indians, and Asians. Poor people have worse access to care than high-income people for all eight core report measures. Hispanics have worse access for 88 percent of the core report measures, while Blacks and American Indians have worse access on half of the measures. Asian Americans have worse access on 43 percent of the measures. The 2005 report also tracks changes in the core measures over time. For each core report measure, racial, ethnic, and socioeconomic groups were compared with a designated comparison group at various points in time. For racial minorities, more disparities in quality of care were becoming smaller rather than larger, while for Hispanics, 59 percent were becoming larger and 41 percent smaller. For poor people, half of disparities were becoming smaller and half were becoming larger ([National Healthcare Disparities Report, 2005](#))

Federal government's focus on these efforts has continued, with the Healthy People 2020 publication, much of which is now easily obtainable through US government websites ([U.S. Department of Health and Human Services, 2013](#)). For the 2020 effort, the report points out that in Healthy People 2000, the goal was to reduce health disparities among Americans, and in Healthy People 2010 the goal was to eliminate, not just reduce, health disparities. By Healthy People 2020, that goal was expanded even further: to achieve health equity, eliminate disparities, and improve the health of all groups. Healthy People 2020 defines health equity as attaining the highest level of health for all people. It points out that both efforts to eliminate disparities and achieve health equity have focused primarily on diseases or illnesses and on health care services.

The Centers for Disease Control and Prevention (CDC) is another US federal agency that works on issues linked to health differences and health disparities. In a special report they issued in 2011, the agency consolidated