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Minimizing Health Disparities: A Best Practices Approach

Introduction

In the Bronx, a coalition of community organizations is campaigning against "medical apartheid," their term for a separate and unequal health care system.[1] Attempts over the past two decades to remedy racial, ethnic, and socioeconomic disparities in health have lead to some improvement, yet significant inequalities in disease prevention, health education, and the accessibility, affordability, and quality of medical care persist.[2] The structure of healthcare in the United States, with its focus on private or employer-sponsored health insurance in lieu of a national single-payer system, places everyone without access to quality health insurance at a systemic disadvantage—generally minorities and the poor.[3]

Populations at Risk & Scope of the Problem

Health disparities, or the unequal distribution of negative health outcomes between subpopulations, are found throughout the United States and are most commonly understood to fall along racial, ethnic, and socioeconomic lines.[4] These national patterns are reflected locally in Dallas and more broadly in Texas. Infant mortality rates for African Americans in Dallas County were more than triple the rate for whites in 2004.[5] Meanwhile, 34.2% of Hispanic residents lacked health insurance in Dallas County in 2002, more than three times the rates for non-Hispanic whites and African Americans.[6]

Poverty alone is associated with a number of negative health risks, such as increased contact with environmental hazards, limited health care services, and deficient nutrition, among others.[7] Residential segregation, geographic isolation, psychological stress, poor health care, and other negative life circumstances disproportionately impact individuals and families in poverty, further contributing to health disparities.[8,9] These risks are then compounded by the fact that families near or below the poverty line are 3 times more likely to have no health insurance coverage than other families.[10]

In addition to racial, ethnic, and socioeconomic factors, level of education and gender have been identified as factors producing significant differences in health outcomes. The effects of education are not limited to socioeconomic position—awareness and healthy behaviors also play a role.[11] While women have some biological and behavioral advantages over men, they are also more likely to be in poverty, creating disparate trends.[12,13]

Health disparities are discernible across many indicators of health and disease, particularly alcohol, tobacco, and drug use; obesity; cardiovascular disease; diabetes; pregnancy and prenatal care; HIV/AIDS; and cancer. In many instances, disparities exist not in the prevalence of disease, but in the success of treatment, an outcome heavily dependent on access, consistency, and quality of care, as well as the individual's ability and willingness to understand and adhere to doctor recommendations.[14] For example, African Americans are less likely to have heart disease, but those that do are 29% more likely than non-Hispanic whites to die as a result.[15] Moreover, disparities in health found in infants, children, youth, and the elderly are of particular concern because of the compounded risk experienced by these vulnerable populations.

Components of Successful Programs

Successful health initiatives primarily operate on one of two levels:

- Expanding access to care, including health insurance, preventive care, and management of chronic conditions.
- Disease prevention, reduction of risk factors, and overall health promotion, education, and awareness.

These levels can overlap, as one of the outcomes of expanding access to care is promoting relationships with primary care physicians and consistent, routine check-ups—which in turn can improve health awareness, reduce risk factors, and catch diseases in their earliest

stages.[16] However, other programs focus on promoting healthy behaviors directly through school-based and community-based programs.[17]

On either level, early intervention and prevention are key to significant reduction in health disparities. Deficiencies in childhood health are strongly linked to inferior health outcomes later in life, as well as to weak school performance and other social outcomes.[18] Moreover, poor habits formed early on tend to carry through an individual's life, contributing to the estimated 50% of all preventable deaths in the U.S. attributable to risk behaviors.[19]

The most successful programs typically operate in concert with the community in question, recognizing community concerns, engaging community members, and capitalizing on the strengths of the community. Many poor health outcomes can be traced to complex social, environmental, and behavioral factors directly linked to the community context, yet even the most distressed communities have strengths.[20, 21,22]

Best & Promising Practices

Los Angeles Healthy Kids

The goal of the Los Angeles Healthy Kids (LAHK) program is to ensure that every child under age 18 in Los Angeles County has health insurance coverage. While the basic premise—insuring uninsured children—is hardly anything new, the approach used by Los Angeles Healthy Kids encompasses a number of best practice characteristics that set it apart from other similar programs.

Community participation and collaboration are a key part of the LAHK approach. Outreach staff, provided by a network of community-based organizations, screen families for eligibility for state-funded children's insurance programs and assist them with the application rather than simply providing a referral. Children ineligible for other programs are covered directly by LAHK.[23] More than merely expanding access to care, the program encourages early intervention and prevention by explicitly covering routine and preventive care while simultaneously working to improve the quality of care.[24]

LAHK was designed around existing assets, using a network of nonprofit, "safety-net" healthcare providers as the cornerstone of the healthcare network. At the same time, the program conscientiously avoids being a "county government program" by operating similarly to private health insurance, with (very modest) premiums, copays, and a large network of eligible providers.[25]

Evaluation results summarized in Figure 1 show remarkable improvements in access to and utilization of care among children enrolled in LAHK. Two years after its implementation, it had already succeeded in enrolling more than 50% of the target population.[26]

Figure 1. Improvements in Access to Care[27]

Improvement in the likelihood of…	% points
Having a usual source of care	14.7
Having an ambulatory care visit within the past 6 months	7.4
Decline in the likelihood of…	
Having an ER visit within the past 6 months	4.7
Having an unmet need for preventive care in the past 6 months	13.2

Seattle Social Development Project

Health-risk behaviors in teens, such as drug abuse, teen pregnancy, violence, and school failure, are often correlated, suggesting that a comprehensive program seeking to modify a variety of risky behaviors may be more likely to successfully impact any given outcome.[28] Moreover, many risky behaviors are predicted by the same set of early indicators.[29,30] The Seattle Social Development Project is unique in its early intervention, focusing on shared risk and protective factors contributing to a number of health-risk behaviors in high-risk, ethnically diverse school populations.[31] The project targeted children as they entered the first grade, cultivating in students a general, positive sense of bonding or attachment to school and family, which has been shown to protect against the development of high-risk behaviors later in life.[32] By intervening early and consistently in elementary grades, the Seattle Social Development Project reached children prior to delinquent behavior, substance use, and sexual activity becoming commonplace, creating a healthier, more positive development trajectory.[33]

By equipping parents and teachers early with the tools to facilitate stronger student bonds to school, the Seattle Social Development Project sought specifically to reduce violent behavior, heavy drinking, and sexual intercourse through age 18 and beyond. The program used three primary intervention strategies: teacher training, parenting classes, and student social competence training over the course of grades 1 through 6. A comparison late intervention group received interventions in grades 5 and 6 only. Finally, a control group receiving no intervention was also followed throughout the course of the program. A follow-up at age 18 determined that the full intervention program was the most successful in changing risky behavior—no statistically significant impact was observed in the late intervention group.[34]

The Project's primary success was in decreasing violence, regular drinking, and sexual activity. While 25% of the control group at age 18 reported having drunk alcohol 10 or more times in the past year, only 15.4% of the full intervention group had done so. Likewise, the prevalence of any sexual intercourse, multiple sexual partners, and violent delinquency were approximately 11 percentage points lower in the full intervention group than in the control group. These results were statistically significant at the P=.05 level. Differences in students having ever tried alcohol or drugs were minimal and not statistically significant.

Life Skills Training

Similar to the Seattle Social Development Project, the Life Skills Training (LST) uses early and frequent interventions to prevent risky behavior among high risk youths. The LST middle school program targets seventh to ninth graders, focusing on preventing early alcohol, tobacco, and drug use. This school-based initiative, coupled with classes for parents, taught students how to deal with peer pressure, increase self-esteem levels, resist popular media images, and talk to parents and teachers about these drugs. LST boasts impressive results: as compared to a control group, 27% reported less monthly smoking, 26% fewer reported weekly smoking, 54% fewer reported heavy drinking in the last month, and 73% fewer reported heavy drinking at all.[35]

The Seattle Project and LST are probably best implemented in concert with each other. The Seattle Project limited early sexual activity and violent behaviors, which were more clearly an outgrowth of a strong commitment to school, family, and "doing what's right." The Seattle Project was less successful in preventing students from ever trying drugs and alcohol, which may require more activity-specific interventions of the type provided by LST.

Pittsburgh Childhood Obesity Study

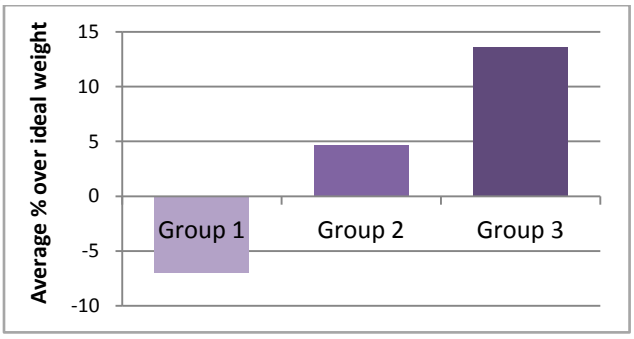
A growing population of obese children are at risk for developing childhood orthopedic problems, asthma, and type 2 diabetes.[36] Moreover, as many as 75% of obese children ages 10-14 years will become obese adults.[37] When parental obesity is coupled with childhood obesity, the risk of children carrying obesity into adulthood is as high as 79%, whereas children who are neither obese nor have an obese parent have only a 5-8% risk of developing adult obesity.[38] Obese parents contribute to their children's obesity through genetic predispositions, dietary and exercise habits, and by simply modeling obesity.[39]

A Pittsburgh longitudinal study hypothesized that the same shared behaviors among obese parents and children that perpetuate obesity could be harnessed to treat it. The program emphasized education and behavior modification in nutrition, diet, and exercise. The participants had at least one obese parent and on average, weighed more than 40% over their ideal weight.[40] Participating families were randomly assigned to three groups. Each group received similar educational materials at weekly meetings during the initial intensive weight-loss phase and follow-up meetings over the next six months. The targets and reinforcement incentives for weight loss and behavioral change varied among the groups:

- Group 1—weight loss and behavioral changes for both child and parent, with incentives & reinforcement.
- Group 2—weight loss and behavioral changes for the child, with incentives & reinforcement.
- Group 3—control, non-specific target with reinforcement only for attendance.[41]

Figure 2 shows the change in the average percentage over ideal weight for children in each group at a 10-year follow-up. Only the experimental Group 1 was able to maintain weight loss after 10 years, measured as a 7 percentage-point reduction in the average percentage over ideal weight.[42] These results suggest that a sense of shared responsibility between parents and children is critical to mitigating and preventing childhood obesity.

Figure 2. Change in average % over ideal weight at year 10[43]



While the Pittsburgh study sheds light on the complex family and behavioral factors contributing to childhood obesity and offers promising programmatic elements, the population studied was primarily white and middle class, with two parents living in the home. Further program innovation and evaluative research will be needed to confirm these findings for children from low-income, minority, or single-parent homes, whose parents may have less time to devote to the critical element of the Pittsburgh program—parental participation.

Conclusion

Eliminating health disparities hinges on expanding access to care and developing effective direct programming promoting healthy behaviors through education and awareness. In both of these domains, however, recognizing the importance of community and family context is critical, and best practices programs will treat behaviors, families, and communities holistically rather than targeting single outcomes in isolated individuals.

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The J. McDonald Williams Institute takes a holistic approach to understanding and examining the complex issues faced by the residents of distressed urban communities, applying that understanding to generate lasting revitalization across all dimensions of quality of life.

Full best practices reports are being developed to accompany the Institute's Wholeness Index, and will be available in early 2008 at www.wholenessindex.org

The J. McDonald Williams Institute was established by the Foundation for Community Empowerment (FCE) in 2005 as a source of objective research and policy recommendations relevant to urban revitalization and quality of life.

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