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# THE USEFULNESS OF HEALTH DISPARITY: STUMBLING BLOCKS IN THE PATH TO SOCIAL EQUITY

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**Abstract:** *Health disparities in the United States have declined little over the past century despite far-reaching technological advances and, especially since the 1980s, heightened consciousness of the problem. Their persistence can be explained in large part by their usefulness to those who hold and seek to consolidate power. Among other things, health disparities help in bolstering master-subservient relationships; shoring up the ideology of rugged individualism; maintaining bureaucratic structures and jobs; providing plausible public enemies; monitoring upstream social ills; and sustaining a flow of research funding. Conditions likely necessary for ameliorating health disparities include open and mutual recognition of several often veiled realities concerning power relations: money equals power; power translates into access to resources; those who hold power are reluctant to part with it; those who lack power serve as convenient scapegoats; and institutions evolve so as to ensure their own survival.*

*Health disparity will remain exceedingly difficult to eradicate so long as health inequities continue to perform useful functions in ways that seem cost effective for groups and individuals seeking to secure their power. A readiness to work around stumbling blocks in the path to equity—arrived at via frank and equitable discourse among community members and leaders in pursuit of vital community goals—will likely hinge upon heightened awareness not only of the cumulative economic burden imposed by health inequality but also of the extent to which even the most powerful are intrinsically dependent upon other members of the community.*

**Keywords:** *health disparities; healthcare reform; minority health; politics; power relations.*

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## 1. Introduction

Health disparities between more- and less-privileged groups in the United States have declined little over the past century, despite remarkable strides in overall

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health-related knowledge and technology and, especially since the 1980s, heightened consciousness of the problem on the part of researchers and policymakers alike (Jones, 1998, 2009; King, Hurd, Hajek, and Jones, 2009). Observations by W. E. B. DuBois (1899, p. 148) regarding racial disparity in Philadelphia at the end of the nineteenth century still ring true today:

“. . . [A] much higher death rate at present among Negroes than among whites: this is one measure of the difference in their social advancement. . . . Broadly speaking, the Negroes as a class dwell in the most unhealthy parts of the city and in the worst houses in those parts; . . . the part of the population having a large degree of poverty, ignorance and general social degradation is usually to be found in the worst portions of our great cities.”

Granted, every society has some form of stratification that ranks individuals on the basis of characteristics deemed important, and this inevitably results in inequality of some sort. Yet, while inequality per se is unavoidable, some forms of inequality have their roots in present or past injustices and thus can rightly be described as *inequities*-or, if the differences are between groups, as *disparities*. For instance, disparities in health can be defined as those differences in outcome that result not entirely from biological differences nor from informed and unconstrained individual choices, but rather from factors over which the individual has little or no control but which systematically reflect the choices, preferences, values, and biases of powerful others, present or past (Hebert, Sisk, and Howell, 2008). In short, health inequity (from the World Health Organization standpoint) implies “differences which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust” (Whitehead, 1990, p. 5).

In today’s climate of fiscal austerity, health disparities figure prominently (whether openly or covertly) in U.S. political discourse surrounding healthcare spending and entitlements. The effects of any cut in funding or realignment of priorities can be expected to vary significantly, depending upon a group’s social positioning and power, and yet the crucial dimension of *differential power* has routinely been overlooked or minimized in much previous discussion of health inequity. In this analytic essay, I argue that effective intervention strategies aimed at ameliorating health disparities will require not only identifying and coping with the *causes* of health inequity, but also pinpointing and neutralizing sources of *entrenched resistance*-starting at the community level. It is my thesis that *health disparities persist because of their usefulness to those who hold and seek to consolidate power*. Accordingly, after summarizing the ideological and political context within which current U.S. health disparities are observed, I provide a set of five working assumptions for use in considering who stands to benefit from perpetuation of health disparities: *money equals power; power translates into access to resources; those who hold power are reluctant to part with it; those who lack power serve as convenient scapegoats; and institutions evolve so as to ensure their own*

*survival*. Next, I describe six positive functions of health disparities in order to illustrate various ways in which health inequity, which is more than simply a manifestation of underlying social inequality, can itself be instrumental in aggravating that inequality. Finally, I show how community-based intervention strategies can provide a window of opportunity for promoting health equity—at least to the extent that the establishment of basic trust, prerequisite to effective community-based participatory research (Burhansstipanov, Christopher, and Schumacher, 2005), implies full and mutual recognition of the power dynamics at play. Overall, by highlighting the role of power relations at many levels in perpetuating health inequities, this essay stands to make an important contribution toward staking out pathways whereby health equity might eventually be attained.

## 2. Contested perspectives on fairness and equity

An initial stumbling block in the path to health equity stems from basic differences in value judgments as to what constitutes “fairness.” The question has to do with the relative importance placed on *equality of results* (a criterion favored in much of Europe) as opposed to *equality of opportunity* (generally preferred in the United States) (Dye, 2003, pp. 32–33). Whereas Europeans tend to stress equitable distribution of resources within the community, Americans most often adhere to the ideal of just reward for individual effort and investment (Esping-Andersen, 1999).

However, many U.S. social scientists, health professionals, and others close to the issues surrounding health disparity do embrace the World Health Organization perspective that health at the highest attainable level is a fundamental human right (Marmot, 2007). As such, this ideal implies a duty on the part of governments and other responsible agents to take corrective action on behalf of groups and individuals left behind. However, the broader U.S. culture is thoroughly permeated by an individualistic, free-market worldview that looks upon most forms of governmental intervention with suspicion. It sees health as essentially a marketable commodity and fairness as occurring only when each person is fully entitled to the fruits of his or her own productive endeavor. This attitude, in its extreme form (Rothbard, 1982/1998)<sup>1</sup>, boils down to the notion that *taxation* (i.e., the taking of private property for public use via governmental coercion) *is theft*. Such an anti-statist, laissez-faire perspective provides ideological underpinnings—often with widespread public acceptance—for much of today’s political discourse

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<sup>1</sup> Rothbard exemplifies the extreme *anarcho-capitalist* version of libertarian philosophy that calls for a stateless market economy.

that in fact defers largely to the interests of the privileged (such as tax breaks for the wealthy, privatization of Social Security, and cutbacks in “costly” social services such as Medicaid).

### 3. The political climate: Obstacles to “getting it done”

Ever since the Reagan years (1981–1989) that brought increasingly amenability to welfare state retrenchment (Pierson, 1994) researchers and practitioners confronting the destructive consequences of health disparities face an uphill struggle within the current U.S. political climate when it comes to translating their concerns into a consensual *will for political action*. They soon learn that it is simply not enough to stake out an activist moral high ground and then hope to enlist the powerful and influential in a fight for health equity. This point was emphatically driven home during the 2009 debates over U.S. healthcare reform. Given the economic troubles of that period, with thousands of middle- and working-class families losing their employment-based health coverage through layoffs and thousands more reporting increased uncertainty, a certain degree of scholarly optimism prevailed concerning prospects for widespread support and passage of reform (Ornstein, 2009). Yet town hall meetings called by members of Congress repeatedly faced disruption from angry anti-reform protesters-many of them apparently orchestrated by conservative lobbying groups with heavy financial support from industry groups and wealthy individuals (Egger and Rucker, 2009; Urbina, 2009).

Realistically, busy citizens and civic leaders focus primarily on their own immediate and pressing worries-such as making the house payment, staying in business, or getting reelected. They distance themselves from issues they do not perceive as directly relevant to their daily livelihood. As an example, many either fail to comprehend the scope and complexity of societal problems traceable to health disparities, or else simply do not believe that health inequity ranks high on a list of problems calling for funding through tax dollars.

Indeed, during times of economic hardship with declines in tax revenue, pragmatic concerns such as balancing the budget and reducing deficits are likely to overshadow philosophical differences regarding proper functions of government. Healthcare programs-as well as such upstream contributors to health as education, nutrition, and environmental safety-tend to be framed (notably, by those who *already have* access to needed resources) as dispensable luxuries or at the very least as *negotiable*. Thus, interventions looked upon as existing mainly for the benefit of disadvantaged minorities often end up bearing the brunt of calls for belt-tightening and spending cuts at all levels of government.

Under the circumstances, it is not surprising that the ambitious overarching goal of the federal Healthy People 2010 initiative to “eliminate health disparities” remains unmet (Koh, 2010; Sondik, Huang, Klein, and Satcher, 2010). Still, the federal bureaucracy continues to affirm the salience of striving for health equity through institutional measures such as setting Healthy People 2020 goals “[e]mphasizing ideas of health equity that address social determinants of health and promote health across all stages of life” (U.S. Department of Health and Human Services, 2010) and elevating the National Center on Minority Health and Health Disparities to full Institute status within the National Institutes of Health (National Institutes of Health, 2010). These steps are of more than merely symbolic importance because grants from the National Institutes of Health provide much of the lifeblood for ongoing research aimed at closing the gaps. But, as Gilbert Friedell and Lovell Jones have repeatedly cautioned, “If you always do what you have always done, you will always get what you already have” (King et al., 2009, p. S27).

More and more, health disparities research and intervention strategists are seeking out innovative ways to break free from a hit-and-miss (albeit readily fundable) traditional paradigm that focuses on various specific disease outcomes through the lenses of narrow disciplinary specialties (King et al., 2009; Syme, 2008). Increasingly, they are adopting interdisciplinary, biopsychosocial approaches by collaborating closely with members of specific at-risk communities to address pressing health needs identified within those communities—thus taking health disparity out of the shadowy realm of statistical abstraction (King et al., 2009; Syme, 2004). One thing still lacking in much published commentary on health inequity, however, is frank discussion of *power relations* underlying the perpetuation of health disparities.

In the long run, a successful intervention strategy will demand more than simply identifying and coping with the *causes* of health inequity. From a realistic standpoint, it will be equally important to pinpoint, bring to light, and finally neutralize likely sources of *entrenched resistance* to the amelioration of health disparity. In this paper, I propose that health disparities persist not so much because we cannot afford to eliminate them (after all, we do manage to come up with billions of dollars for the military and for corporate bailouts), but rather because they are so *useful*. My perspective here is to some extent intentionally ironic—so as to highlight important consequences (i.e., hidden costs) of maintaining health disparities—consequences usually conveniently overlooked or deemphasized by powerful stakeholders seeking to maintain their vested interests. A key to eventual success in establishing health equity, then, might well be readiness to work together with these stakeholders—mutually recognizing the power dynamics

at play-to develop alternative pathways toward fulfilling the positive functions of health disparities while at the same time minimizing their hidden costs.

#### 4. How are health disparities useful-and for whom?

Some years ago, sociologist Herbert Gans published a series of Mertonian functional analyses (Merton, 1968)<sup>1</sup> detailing the *uses* (or *positive functions*) of poverty and the underclass in American social life (Gans, 1971, 1972, 1994). While poverty is usually thought of as a social evil or blight, Gans pointed out that it nevertheless serves very well the needs of existing institutions-to such a degree, in fact, that its *elimination* (such as through legislation to equalize income) would be massively disruptive. Among other things, having a poverty-stricken underclass ensures ready supplies of (1) cheap labor to perform work that is in demand but either undesirable or illegal, (2) scapegoats and negative examples to shore up societal values and illustrate the dire consequences of deviance, and (3) professional and clerical jobs created to deal with social problems linked to poverty (Gans, 1994).

Health disparities, closely associated with poverty, can likewise be productively studied in terms of their social consequences or functions. Like poverty, health disparities are conventionally looked upon as essentially dysfunctional due to the high social and economic costs they entail and the extensive suffering they bring about. But, as is the case with poverty, health inequities likely owe their considerable staying power to the positive functions they afford in stabilizing social arrangements for the benefit of powerful stakeholders in the status quo. Thus, when we speak of the *usefulness* of health disparity, we are actually talking about the positive functions of perpetuating an inequitable *system*-that is, one structured so as to help certain individuals and groups maintain their advantage over others. In analyzing the power relations that underlie health disparities in the United States, we need to consider *who stands to benefit*, whether directly or indirectly, from perpetuation of conditions that ultimately result in health disparities-and then *follow the money*. Five working assumptions underlying the ensuing analyses are as follows:

1. *Money equals power.* Money is more than simply a medium of exchange for goods and services. More importantly, from the Weberian perspective of power as the ability to realize one's aims despite resistance (Weber,

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<sup>1</sup> Merton defined *functions* as observed consequences of social arrangements that facilitate adaptation or adjustment within a system, and *dysfunctions* as consequences that impede adaptation or adjustment; he acknowledged that what is functional for some groups and individuals may be dysfunctional for others.

1904/1958), money also represents a sometimes substantial degree of control over outside forces that have the potential to challenge or lend uncertainty to one's position.

2. *Power translates into access to important resources and life-choice options* serving to foster better health outcomes (Link and Phelan, 1995)-and, more generally, to facilitate the accumulation of even more power through various processes of cumulative advantage (DiPrete and Eirich, 2006).
3. *Those who hold power over others are reluctant to part with it.* In this regard, two key maxims will continue to hold sway in the ongoing discourse on changes in healthcare delivery and related topics: "Everyone's definition of health care reform is the same-I pay less," and "Every cost reduction is someone's income" (Ornstein, 2009; Zwelling, 2012). The crucial point here is that, in order for any substantial change to be acceptable to a powerful stakeholder, it will have to offer something else of equal or greater value in exchange for whatever power that stakeholder is being asked to relinquish.
4. *Those who lack power serve as convenient scapegoats* to bear the burden of society's failures (Gans, 1994), including those failures related to health and well-being. Existing social structures are represented as being "natural" and essentially immutable; macro- and meso-level structural arrangements contributing to health disparity are framed so as to shift the primary burden of responsibility to the individual or to families-a process of *blaming the victim* (Ryan, 1976).
5. *Institutional structures and policies evolve so as to ensure the survival and continued prosperity of the institution*, regardless of its initial purpose and stated mission (O'Dea, 1961)<sup>1</sup>. Bureaucracies tend to expand exponentially, adding on layer upon layer of structural complexity in response to newly identified challenges. In this way they can present the *appearance* of taking concerted action, while at the same time "spreading the heat"-that is, shielding individuals in responsible positions from blame in case something goes wrong. This is typically accomplished through formalized procedures such as the approval process for funding. As a result of agency review, resources aimed at tackling overarching problems like health disparity frequently end up being diverted away from bold but promising initiatives with uncertain outcomes,

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<sup>1</sup> O'Dea's dilemmas of *mixed motivation*—and especially *administrative order*—apply equally well to any bureaucratic institution: "The tendency of organization to complicate itself to meet new situations often transforms it into an awkward and confusing mechanism within whose context it is difficult to accomplish anything" (O'Dea, 1961, p. 36).

and funneled toward “safe” projects of more limited scope but perhaps only tangentially related to the larger issue at hand (Kolata, 2009).

## 5. Six positive functions of health disparities

To understand why health disparities persist in the United States despite all the attention and resources being directed toward their eradication—especially since the 1985 release of the landmark Heckler Report on black and minority health (U.S. Department of Health and Human Services, 1985; Nickens, 1986)—it is indeed helpful to examine the *benefits* that health inequities offer to those individuals and groups that have a hold on power and would like to consolidate it. As previously noted, many of the factors implicated in the perpetuation of health disparities are closely related to the positive functions of poverty and the underclass as described by Gans (1971, 1972, 1994). However, consideration of health disparities *per se* reveals an additional dimension, in that health inequity can itself severely limit the potential of disadvantaged minorities to compete effectively for a share of the power.

### 5.1. *Bolstering master-subservient relationships*

Contrary to popular belief, slavery in the United States did not end with Lincoln’s Emancipation Proclamation and the 13<sup>th</sup> Amendment to the U.S. Constitution. Although the institution of chattel slavery has long been abolished, involuntary servitude has persisted under various guises, often in connection with debt (Daniel, 1979). Today, health disparities play an important role in maintaining the indebtedness of subjugated individuals and groups (i.e., the status of the less privileged as dependent upon the more privileged). This is accomplished in large measure through the common U.S. practice of tying health insurance coverage to the workplace—whether negotiated in a union contract or provided as a fringe benefit to individual employees (McPhee, 1997; Quadagno, 2004). In either case, employees are compelled to maintain satisfactory working relationships with their current employer and/or union in order to retain affordable health coverage and avoid the unsavory prospect of descent into the uninsured underclass. Such semi-involuntary ties serve as a profound disincentive to workers’ mobility between companies or careers, thus placing a severe damper on any real freedom of choice they might have in the labor marketplace. As a result, employers are able to count on more workforce stability than would otherwise be the case; and those larger, more powerful organizations that offer better health plans hold a competitive edge in attracting and retaining key personnel (McPhee, 1997).



Now suppose the United States were to adopt a single-payer health plan providing universal coverage, paid for through a financially progressive system of premiums or taxes completely separate from the workplace. What sort of impact might this change be expected to have on the interests of business (other than the insurance industry) and organized labor? First, the extent of management control over employees would surely be diminished. If workers were no longer beholden to the company for something as crucial to their families as health insurance, they would likely be much more ready to venture out and leave unfulfilling jobs in search of better opportunities elsewhere. Thus, employers competing for the same skilled or semi-skilled human resources would find themselves having to offer more attractive inducements (wages, working conditions, retirement benefits, etc.) in order to earn the loyalty of “hired help”—all in all, a setback in the power positioning of employers.

U.S. labor unions, too, have historically been reluctant to give up the leverage they have possessed through collective bargaining on behalf of improved health benefits for their constituencies. They have willingly done so only in situations where projected costs to organized labor have exceeded potential benefits such as in the 1950s and early 1960s, when management demands for concessions on wages and other benefits in return for expensive health coverage of retirees sparked an intensive campaign by organized labor on behalf of Medicare (Quadagno, 2004). Establishment of a single-payer national health coverage plan divorced from the workplace would in effect take health benefits off the bargaining table; a prospect union leaders are likely to see as further diluting the relevance of a labor movement struggling for survival, whose growing weakness in recent decades has itself likely contributed to a decline in norms of equity and the concurrent rise in U.S. wage inequality (Western and Rosenfeld, 2011).

Remembering *money as power*, it is important to note that *masters* who currently hold the lion’s share of wealth and power would prefer that *subservients* expend their limited resources through purchases of consumer goods and services (all the better if on credit, thus magnifying indebtedness) whereby most of the wealth and power would end up coming back to the masters. The less palatable alternative from the masters’ perspective would be for currently disadvantaged or subservient groups to focus more on savings (accumulating interest) and investments in education, business startups, etc., that might reduce their dependence on—or even set up serious challenges to—the present holders of power. In this regard, health disparities perform two important functions: they recycle resources back into the hands of the powerful, and they serve as a social Darwinian screening device that helps restrict access to the ranks of the powerful.

First, *health disparities recycle resources back into the hands of the powerful*. Indeed, they open up vast opportunities for profit. Health disparities help preserve the “slave” status of minorities and the poor as dependent and debt-ridden consumers “owned” by the suppliers of addictive goods and services looked upon as helpful in coping with adversity. For example, the less healthful and more stressful living and working conditions experienced within the lower socioeconomic ranks serve to heighten the demand for risky stress relievers such as alcohol and tobacco products—highly profitable to the manufacturer but further degrading to the health of their users. Liquor stores abound in disadvantaged neighborhoods (Duncan, Duncan, and Strycker, 2002; LaVeist and Wallace, 2000), and tobacco marketing strategies target the poor and minority groups (Goerlitz, 1989)<sup>1</sup>. Facilities for the treatment of stress-related physical and mental illness and substance abuse or dependence—many of them operated on a for-profit basis—depend to a large extent on health disparities (as expressed in consistently observed social gradients in health) (Marmot, 2007) for their sustenance. The overcrowding of hospital emergency departments being used as default primary care providers by the medically underserved (particularly adult Medicaid recipients) (Tang, Stein, Hsia, Maselli, and Gonzales, 2010) unleashes a backlash demand for alternatives such as private freestanding emergency clinics. Facilities of this kind, now springing up in more affluent areas across the country, can legally select their own patients; they cater to a clientele willing and able to pay a premium price so as to avoid long waits (Houston Business Journal, 2008) and perhaps discomfiting contact with sick Medicaid patients as well. Additional possibilities for profit from health inequity can involve actively playing off one stakeholder in a disparity against another. A case in point: it is not uncommon for the same high-stakes lobbying firm to represent both the manufacturers of illness that target minorities (e.g., the tobacco and alcohol industries) and the medical institutions established to combat and treat that illness (Goldstein and Bearman, 1996).

Finally, *health disparities serve as a social Darwinian screening device that helps restrict access to the privileges of power*. Poor health, disproportionately found in historically excluded minority groups, operates through processes of both *socioeconomic drift* (downward mobility tied to loss of assets spent for health services or replacement of lost income) and *social stunting* (inhibiting the initial acquisition of human capital needed for upward mobility) (Haas, Glymour, and Berkman, 2011) so as to place those already in the lower strata at yet a further competitive disadvantage. Especially in

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<sup>1</sup> In this congressional testimony, former Winston model David Goerlitz quoted a tobacco executive as responding point-blank, when asked why he and his colleagues did not smoke: “We don’t smoke the sh—, we just sell it . . . We reserve that ‘right’ for the young, the poor, the black and the stupid” (Goerlitz, 1989, p. 51570-2041).

lucrative professions such as medicine and law, career advancement calls for a remarkable degree of physical and mental endurance and the readiness to put in long hours (Fletcher et al., 2005; Williams, 2007)-expectations largely incompatible with a history of frequent or chronic illness. Thus, members of groups that continue to bear a disparate burden of ill health end up at significantly reduced likelihood of being among the “fittest” who survive to penetrate the ranks of the elite. Those few who do manage to make it are then widely applauded as exemplars of the kind of hard work and exceptional perseverance required to “beat the odds.” They become poster children for the favored ideology of “rugged individualism,” which credits personal effort rather than social location for whatever life success one might enjoy.

### *5.2. Shoring up rugged individualism*

Indeed, health disparities add a crucial element to the systematic inequality that helps perpetuate the ideal of self-reliance as a keystone of American moral fiber. In the absence of stumbling blocks built into the system, “rags-to-riches” stories of heroic individual triumph over formidable obstacles such as ill health would likely lose much of their punch. From a functionalist standpoint, placing the focus on individual responsibility and individual gratification will work to stabilize existing inequalities in social relations so long as higher status is seen as being within reach, and lower status or even destitution a likely consequence of irresponsible behavior. The prospect (however remote) of upward mobility-coupled with an ever-present specter of downward mobility-provides powerful motivation for behavior patterns in accord with the interests of the powerful (e.g., heightened attention to self-preservation rather than collective action that might challenge the status quo). In this regard, medical diagnosis can be viewed as a potent form of social control, and ill health a prime route for the exercise of power over socially and economically disadvantaged groups. Under the expectations of rugged individualism, in the absence of a structural safety net of universal health care, members of groups identified as being at heightened risk may either choose to “tough it out” when sick, or else seek to avert costly health crises through preventative measures such as heightened compliance with health behavior recommendations and the purchase of various health-related consumer products and services.

### *5.3. Maintaining bureaucratic structures and jobs*

For those who hold power and seek to consolidate their position within a hierarchy, the ability to preserve and expand bureaucratic structures under their supervision (and, most importantly, the jobs associated with these structures) is,

without a doubt, a key component of success. While it is well documented that administrative costs comprise a notably higher proportion of rising per capita healthcare expenses in the United States than in comparable countries that provide universal coverage (Bodenheimer, 2005; Reinhardt, Hussey, and Anderson, 2004; Woolhandler, Campbell, and Himmelstein, 2003), it is the need to perpetuate health disparities (so as to bolster individual motivation among the less privileged) that provides substantive justification for this seemingly wasteful and inefficient extravagance. Much of the administrative staffing within healthcare institutions and insurance providers-both public and private-exists primarily for the purposes of rationing benefits and selecting or ranking potential recipients according to criteria such as need, worthiness or unworthiness, extent or type of insurance coverage, insurability, or ability to pay. Indeed, entire industries (e.g., medical billing and coding, along with the requisite software development) have evolved in large part to ease the burden of healthcare providers in sorting through the myriad regulatory requirements, varying compensation formulas, and claims disputes that come with a fragmented system preoccupied with eligibility for benefits and assessment of costs on a case-by-case basis (R., 2003). If the presence of health disparities were seen as less vital to shoring up individual responsibility, a vastly simplified insurance system designed to promote *population* health might save billions of dollars (Bodenheimer, 2005)-but perhaps thousands of administrative jobs would likely be lost.

#### *5.4. Providing a plausible public enemy*

Perception of a common threat to the social order forms an immensely powerful basis for social solidarity and cooperative effort. However, even such widely touted and feared external menaces as communism, terrorism, and illegal immigration often fail to strike a sufficiently responsive chord among academics and opinion leaders of a more liberal and critical bent. In this regard, salient domestic issues involving palpable threats to shared core values can help fill the void. The specter of unabated health inequity afflicting rapidly growing segments of the population is certainly a case in point. Persistent health disparities help satisfy society's need for a broader *range* of agreed-upon adversaries against which to rally support and carry out organized and extended campaigns.

Indeed, today's strategies targeting health disparity are in many ways analogous to the "wars" declared with much fanfare by U.S. leadership in the recent past against a variety of social menaces including poverty, crime, drugs, and even cancer. In each case, the enemy is both nebulous and thoroughly intertwined in a multitude of complex social arrangements-in short, virtually impossible to isolate and cleanly eradicate. Because of this, there are no clear-cut criteria to indicate

final victory in the struggle—which can thus be protracted indefinitely, so long as funding agencies continue to regard various angles or aspects of the problem as yet to be adequately explored and researched.

Official recognition of health status disparity as a significant public health threat calling for concerted intervention (U.S. Department of Health and Human Services, 1985, 2010; National Institutes of Health, 2010; Sondik et al., 2010) works to the advantage of those in power by affording them at least two opportunities to reinforce their dominant position. First, it expedites the process of *manipulating public perception*, in that it provides implicit reassurance that the problem of health disparities is being treated seriously and that determined efforts are being put forth to solve it. Second, institutionalization of the problem presents a tool that can be used for *steering the direction of research*, through the grants process, toward projects bearing promise of results likely to end up bolstering the interests of the powerful.

### ***5.5. Serving as “canaries in the mineshaft” to monitor upstream social ills***

Not only do health disparities serve as rallying points around which it is possible to organize collective efforts at improving the quality, affordability, and availability of health care; they also help fulfill the need for a measurable way to identify and pinpoint the locations of more fundamental social problems. For social epidemiologists and public health researchers, disparities in health-related outcomes such as infant mortality, life expectancy, chronic disease, and functional impairment presently serve as powerful indicators of those upstream social, economic, and environmental factors likely to “put people at risk of risks” (Link and Phelan, 1995, p. 85). In the case of a utopian society providing quality affordable health care to all in a timely manner, any persisting social inequities would likely become less visible—and thus invoke less in the way of public outcry and impetus for corrective action.

### ***5.6. Sustaining a flow of research funding***

In connection with (5.4) and (5.5) above, persistent health disparities serve the need for maintaining a continuous flow of research funding quite well. Research scientists and the institutions that employ them have become increasingly dependent upon external funding in recent years (Norris, 2011), and have little extrinsic motivation to find workable solutions to a problem like health disparities if that would mean “working themselves out of a job.” The piecemeal, low-risk, incremental approach to addressing complex issues traditionally favored

by funding agencies (American Academy of Arts and Sciences, 2008; Kolata, 2009) provides fertile soil for sustainable long-term research agendas in broad and multifaceted areas of inquiry like health disparities. For instance, a funded research group that establishes a track record of successful publication in one specialized area of concentration (say, lung cancer incidence in African Americans) can then use this record in support of further grant applications in related areas (perhaps lung cancer incidence in Hispanics or lung cancer mortality in African Americans). The cycle of “grant building upon grant” is likely to continue indefinitely so long as health disparities remain both visible and politically salient. That is, the cycle can be expected to continue so long as persisting health disparities remain sufficiently useful to the holders of power that inequity will continue to be tolerated at the same time it is formally being decried.

## 6. Where do we go from here?

Failure to achieve the Healthy People 2010 goal of eliminating health disparities (Koh, 2010; Sondik et al., 2010) points to a need for reassessing the direction of our intervention strategies. Heightened awareness of discrepancies and of the socioeconomic contexts in which they thrive is simply not enough to overcome entrenched stakeholder resistance and systemic inertia. Any workable solution will also require, at the very least, mutual recognition of the often-veiled realities concerning power relations. So long as inequities translating into health disparities continue to perform useful functions for groups and individuals seeking to consolidate power-*and in ways that seem cost effective for them*-health disparity will remain exceedingly difficult to eradicate. Any progress will likely hinge upon effective challenges to the cost effectiveness of the status quo, together with development of innovative ways to satisfy the needs of all parties involved. For example, how might insurance providers retool and develop viable alternatives to the traditional (and discriminatory) for-profit model of health coverage-increasingly seen as unsustainable in light of restrictions on medical underwriting in the 2010 Affordable Care Act as well as spiraling administrative costs (Ungar, 2012)? One successful model program, notably developed and implemented at the *local* level, can be found in Grand Junction, Colorado, where physicians have arranged with an area *non-profit* insurance company to pool Medicare and Medicaid revenue with premiums from private customers so as to provide near-universal coverage for the entire community, and at markedly reduced per-patient cost (Ungar, 2011).

If we are to expect meaningful change on a broader scale, perhaps we need to rephrase the fundamental question. Instead of considering how we might be able eventually to *rid our society of health disparity*, it might be more practicable to envision how we might best *work together to establish health equity*. In this regard, the revised

Healthy People 2020 goals “[e]mphasizing ideas of health equity that address social determinants of health and promote health across all stages of life” (U.S. Department of Health and Human Services, 2010) may represent more than just a subtle rhetorical shift. Focusing more on making tangible differences in people’s daily lives—as opposed to looking for changes in quantitative tables and trendlines—suggests a kind of paradigm shift that bears the potential to bypass many of the aforementioned stumbling blocks in the path to social equity. Indeed, substantial progress toward health equity will likely occur only insofar as we move beyond an *adversarial* paradigm (competing ideological viewpoints) in our societal discourse, or even a *dialectical* one (thesis-antithesis-convergent solution) (see Rappaport, 1981), to a dynamic and overtly *collaborative* approach based in large part on lessons learned through community-based participatory research (Burhansstipanov et al., 2005) and community empowerment projects (Syme, 2004; Wallerstein, 2002).

Central to the *community-based participatory research* paradigm is the principle enunciated by Gilbert Friedell (1997) that “if the problems are in the community, the solutions are in the community.” Key elements of *community empowerment*, in addition to critical awareness, are *participation* and *control* (Wallerstein, 2002), implying a fundamental shift away from the lopsided hierarchical relationships that have traditionally positioned researchers as superior to the subjects of their study. Community-based programs are developed collaboratively at the local level and in response to specific needs and areas of concern identified by community members and leaders rather than by academicians or politicians in pursuit of their own ends. In line with a Foucaultian understanding of power relations as localized and continually subject to challenge (Foucault, 1978/1990, pp. 92–102)<sup>1</sup>, a new approach can involve the building of new coalitions—and disruption of old stakeholder alliances that get in the way—as common values and goals (and dysfunctional aspects of existing arrangements) are brought to light. Successful implementation of community-based participatory research hinges upon the initial establishment of basic trust and effective working relationships among community members and researchers in addition to the equitable sharing among all partners of resources, responsibilities, leadership, and ownership in the project (Burhansstipanov et al., 2005). Since *money equals power*, fair distribution of

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<sup>1</sup> Power, as addressed by Foucault, can be understood as a multiplicity of force relations—always local in scope and unstable, produced moment by moment—operating through successive confrontations and continual struggles. Knots of resistance, most often mobile and transitory, cut across individuals, social stratifications, and institutions so as to fracture previous unities and bring about regroupings. Indeed, the strategic codification of points of resistance can sometimes result in a revolution.

reimbursement from funding sources (including pay for all participants) symbolizes equitable distribution of power.

As community-based participatory research operates at the local level, there is no automatic need to tie it in to policies existing or proposed at the state or national level. Indeed, an important advantage of this approach is its flexibility and adaptability. What happens in one circumscribed community will likely pose a much lower level of threat to stakeholders in the status quo-and thus encounter less resistance-than what happens on a broader scale. However, research findings from one community may well prove helpful to others in similar circumstances (Burhansstipanov et al., 2005)-and community participants are typically eager to network and share (Friedell, 1997). For the future, we can envision a snowballing effect, leading to the development of a knowledge database from community-based participatory research and community empowerment case studies perhaps comparable in scope to the existing body of knowledge derived from medical case studies.

## 7. A four-level approach to health equity

A visionary comprehensive agenda for building health equity in the twenty-first century might thus be based to a large extent on collected insights from the community-based participatory research and community empowerment experience, encompassing an array of strategies ranging from interventions targeting specific diseases or populations to those challenging upstream social conditions that serve as breeding grounds for ill health. Such an agenda might take the form of a four-level approach to eliminating or forestalling health disparities, patterned after the *four levels of prevention* commonly evoked in public health and epidemiology (Last, 2001; Bonita, Beaglehole, and Kjellström, 2006). Just as in public health and epidemiology, levels of prevention would overlap and merge to some extent; tertiary and secondary prevention would be conceived primarily for the benefit of disadvantaged and underserved groups and of those at higher risk, while primary and primordial prevention would target the entire population (Bonita et al., 2006).

Interventions in the category of *tertiary prevention* would be those designed to minimize the social costs of existing health disparities. A pivotal goal might be, *in the short term*, to provide equitable access to adequate health care and appropriate medical treatments for all, regardless of social status or geographical location. Depending on varying needs and availability of resources, different solutions might be found most satisfactory in different communities. Then, for example, if it were shown *in enough cases* that high-quality routine care could be made available



at affordable prices and without long waits through clinics staffed with specially trained physician extenders, (1) insurance providers would adjust their rate structures accordingly; (2) insured patients would likely opt for the most economical of what they perceived to be acceptable alternatives; and (3) resistance to implementation of broader solutions such as single-payer health coverage would predictably fade, as positive patient experiences accrued so as to mitigate fears of high cost and poor service.

*Secondary prevention* would aim at narrowing existing health discrepancies between more- and less-privileged groups. While researchers and practitioners in health-related fields understandably tend to focus on health care as a key determinant of health equity, consistent gradients in morbidity and mortality by socioeconomic status-tied to the conditions under which people grow, live, work, and age-have been found even in countries where adequate access to quality health care is not an issue (Marmot, 2007; Syme, 2004). Within a time frame of *months or years*, the goal of secondary prevention would be to implement specific and tangible interventions-identified at the community level-designed to promote equitable access to adequate nutrition and opportunities for a more healthful lifestyle. Such interventions would be directed toward facilitating health-promoting behaviors and removing obstacles to wise choices, taking into account the realities of what people in different social locations are likely to face-and have to contend with-in the context of their daily lives.

*Primary prevention* would encompass a broad array of actions, policy decisions, and the like targeted toward suppressing the development of costly health disparities over the life course. In most cases, these *long-term* interventions would not be readily identifiable as health interventions per se. Ideally, they would be implemented in response to heightened awareness of the cumulative economic burden of health inequality (LaVeist, Gaskin, and Richard, 2009) and of the extent to which even the most powerful are dependent upon other members of the community (Piven, 2008). These interventions would evolve from frank and equitable discussions among representative samples of community members and leaders, and would entail deliberate modification of social institutions and infrastructure so as to minimize identified sources of strain (largely at the meso level) that lead to poverty, malnutrition, risky patterns of substance use, etc. In practice, primary prevention could include steps toward improving educational opportunities, working conditions on the job, transportation, and the safety of neighborhoods. Implementation might prove difficult, however, especially in cases of conflicted interest such as where the community's primary source of livelihood is also a major source of pollution that endangers the community's health.

The ideal of *primordial prevention* would be to forestall the future onset of health disparities. Its objective would be, *over the long haul*, to modify not only existing social arrangements (institutional structures, norms, and the like) *but also* the values and assumptions that underpin them so as to maximize life chances for all from the very start. This would in no way require the wholesale rejection of capitalism and individualism. The United States is, and will likely remain, a thoroughly market-based society. Both individual and cooperative effort in addition to innovative enterprise will continue to be valued and rewarded. Within this context, however, certain changes will be called for if life chances are to be maximized for all. Based on the changes demonstrated to improve health and well-being at the local level, many bureaucratic rules and regulations may need to be set aside or relaxed so as to allow adequate flexibility and adaptability. That being said, a more open and realistic perspective on power relations is likely to emerge in the course of community-based participatory research, as people come to learn from one another what it means to experience life “from the other side.” Ability to see through the ideological smokescreens that have long obscured the manner in which power is exercised will sometimes point to the necessity for government to intervene as the regulator, motivator, or employer of last resort who has the responsibility to step in whenever and wherever private business, voluntary organizations, etc., fail to adequately satisfy a critical societal need.

## 8. Conclusion

Today, well over a century past the Philadelphia observations of DuBois (1899) and more than a quarter of a century beyond the Heckler report (U.S. Department of Health and Human Services, 1985), significant differences remain in health outcomes between the *haves* and *have-nots* in the U.S. population, despite sometimes dramatic overall improvements in morbidity and mortality. The guiding thesis in this essay is that *health disparities persist because of their usefulness to those who hold and seek to consolidate power*. The implication is as follows: So long as inequities translating into health disparity continue to perform useful functions for stakeholders in the status quo-*and in ways that seem cost effective for them*-health disparities will remain exceedingly difficult to eradicate. Accordingly, I propose that intervention strategies aimed at ameliorating these disparities can succeed only insofar as they deliberately engage several often concealed realities concerning power relations: *money equals power; power translates into access to resources; those who hold power are reluctant to part with it; those who lack power serve as convenient scapegoats; and institutions evolve so as to ensure their own survival*. Successful interventions will likely be those that (1) effectively challenge stakeholders’ assumptions of cost effectiveness and (2) chart out innovative alternative paths to fulfillment, starting at the community level.

In the end, health equity will come about only insofar as social justice becomes a reality. This will require, above all else, abandonment of the implicit notion that some persons are more valuable or worthy than others in addition to the tenacious master-subservient relationship model that health disparities have for so long played a part in reinforcing. Fortright discussions and negotiations carried out in various community-based projects and the ensuing experiences of community members from all walks of life should help build momentum for wider acceptance of the *interdependency* model of power described by Frances Fox Piven (2008, p. 5) in her 2007 presidential address to the American Sociological Association:

*“I propose that there is another kind of power ... rooted in the social and cooperative relations in which people are enmeshed by virtue of group life. ... Even people with none of the assets or attributes we usually associate with power do things on which others depend. They clean the toilets or mine the coal or tend the babies. ... [W]orkers ... have potential power over capitalists because they staff the assembly lines on which production depends. In the same vein, ... tenants have power over landlords because without their labor the fields are idle.”*

Indeed, it is only when we as a society come to fully grasp the extent of our interdependence and the inherent value of every person’s contribution that we will finally cease to tolerate and make excuses for health disparity. The biggest challenge in coming years will likely be that of driving home the message—both to the general public and to politicians and policymakers—that *a healthy population is essential to a sustainable economy*. Restricting access to fundamental resources such as education and health care on the basis of individuals’ ability to pay is not only shortsighted but also potentially suicidal for a nation’s future. A healthy, confident, and reliable base of *workers and consumers*, as well as business owners and corporate executives, is necessary in order to stimulate the creation of jobs and keep the economy thriving.

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