

Health Disparities Do Exist

Jan Odom-Forren, PhD, RN, CPAN, FASPAN, FAAN

I WAS INTRIGUED with a conversation on a nursing listserv recently. The discussion revolved around the topic of health disparities and whether they really exist. A politician had mentioned that health disparities should be addressed regarding maternal mortality and everyone seemed to have an opinion. Many nurses who responded were incensed at the idea that they would be accused of treating patients differently. A common refrain was, “I treat all of my patients the same.” Other nurses joined in the conversation and pointed out that regardless of one’s political beliefs and support for that particular candidate, the data do show that disparities exist and we would be better served by trying to figure out what to do about it than deny it occurs. This conversation on the listserv caused Janie Harvey Garner, who often discusses nursing issues on a video platform, to have a heartfelt video chat about the issue.¹ Janie discussed the issue from her perspective as a woman of color. She reminded nurses that no one was accused of explicitly treating patients differently, and she talked about the concept of implicit bias. She also pointed out that our unwillingness to be introspective about the issue is a problem.¹

What do we mean by *health disparities*? The definition from the National Institutes of Health (NIH) is “differences that exist among specific population groups in the United States in the attainment of full health potential that can be measured by differences in incidence, prevalence, mortality,

burden of disease, and other adverse health conditions.”² A number of groups of stigmatized Americans face the prospect of health disparity, including ethnic and racial minorities (eg, African Americans and Native Americans); people of lower socioeconomic status; and the lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ+) community.³ Disparities can also exist among other groups as well, such as by gender, age, disability status, and geographic location.⁴ These groups often overlap.

Why Do Health Disparities Exist?

Disparities are the result of the complex interaction among genetic variations, environmental factors, and specific health behaviors. Disparities exist in nearly every aspect of health, including quality of health care, access to care, use of health care, and health outcomes.⁵ Many attribute differences in outcomes to reasons other than disparity, such as socioeconomic status. However, disparities in health care are present even when the data are controlled for gender, age, socioeconomic status and health condition.⁵ See [Table 1](#) for examples of health disparities.

Health Equity

Health equity cannot be separated from health disparities. Health equity is “the attainment of the highest level of health for all people.”⁸ Health equity requires that everyone is valued equally and that society focus on efforts to address preventable inequities. Health inequities occur when individuals and communities have barriers that keep them from accessing health care and reaching their full potential. Inequities differ from health disparities. Health disparities objectively identify the differences in health status between people related to social or demographic factors, such as race, gender, or geographic region. Therefore, health disparities are one way to measure progress toward achieving health equity.⁸ One way to achieve health equity is through action on the Social Determinants of Health (SDOH) by creating

The ideas or opinions expressed in this editorial are those solely of the author and do not necessarily reflect the opinions of ASPAN, the Journal, or the Publisher.

Jan Odom-Forren, PhD, RN, CPAN, FASPAN, FAAN, College of Nursing, University of Kentucky, Lexington, KY.

Conflict of interest: None to report.

Address correspondence to Jan Odom-Forren, College of Nursing, University of Kentucky, 751 Rose St, Lexington, KY 40536; e-mail address: jan.forren@uky.edu.

© 2019 Published by Elsevier, Inc. on behalf of American Society of PeriAnesthesia Nurses

1089-9472/\$36.00

<https://doi.org/10.1016/j.jopan.2019.06.005>

Table 1. Examples of Health Disparities

1. **Neonatal Intensive Care Unit**—African American and Hispanic infants were less likely to receive antenatal steroid therapy, a timely retinopathy examination, or any human breast milk at discharge from the hospital. Both groups were also more likely to acquire a health care-associated infection. On the other hand, African American infants were slightly less likely to suffer a pneumothorax and achieved better growth.⁶
2. **Asthma**—The rates of hospitalizations and deaths due to asthma are both 3 times higher among African Americans than among whites. Puerto Ricans have the highest rates of asthma attacks and deaths due to asthma. Women account for nearly two-thirds of all deaths due to asthma in the United States.^{5,7}
3. **Infants**—Native Americans and Alaska Natives have an infant mortality rate that is 60 percent higher than the rate for whites. Infants born to African American mothers experienced the highest rates of infant mortality (11.11 infant deaths per 1,000 births) in 2013. Native Americans have an infant mortality rate that is 1.5 times the rate of whites.⁴
4. **Cardiovascular**—African Americans were 30 percent more likely than whites to die prematurely from heart disease in 2010, and African American men are twice as likely as whites to die prematurely from stroke.^{4,5} African Americans (41%) have higher rates of hypertension than their white counterparts (28.3%).⁸
5. **Homicide and Suicide Related Deaths**—Highest for African American men (4.5%) and are at least 2% for American Indian, Alaska Native, and Hispanic men. The rate of suicide is highest for male American Indians and Alaska Natives.⁴
6. **LGBTQ+**—Youth are more likely than their non-LGBTQ+ peers to be bullied, commit suicide, engage in sexual risk behaviors, run away, or be forced to leave.⁴
7. **Maternal Morbidity**—Maternal deaths of non-Hispanic black women are three to four times that of non-Hispanic white women even after controlling for socioeconomic status.⁹
8. **Diabetes**—American Indians much more than twice as likely to die of complications from diabetes than whites. In addition, racial and ethnic minority populations have a higher risk of complications of diabetes, such as lower limb amputations, retinopathy, and kidney failure than non-Hispanic whites.^{10,11}
9. **HIV and Antiretroviral Therapy**—African Americans are most at risk of death from HIV infection. AIDS is the third leading cause of death among black women aged 25-34 and 35-44 and among black men aged 35-44.¹²

social and physical environments that promote good health for all.^{13,14} SDOH include economic stability, education, social and community context, health and health care, neighborhood, and built environment. Dr Hooper has an excellent editorial on SDOH for further reading.¹⁴

Implicit Bias

There are many ways society can work to increase health equity. One of the ways we as health care workers can contribute to health equity is by individual introspection. Evidence shows one explanation of health disparities for some stigmatized groups is the implicit (unconscious) biases of health care providers.^{3,15,16} (If you don't believe me, go to <https://implicit.harvard.edu/implicit/selectatest.html> and take an Implicit Association Test online.) Despite personal decisions we may have made to provide equal care for all, research has shown that we make judgments that affect our patients' care based on implicit biases.

Interestingly, that same research shows that health care workers, for the most part, never intend to have biases and for the most part, do not tend to

have *explicit* or conscious biases. But even those with low or no explicit biases typically have implicit biases. In a systematic review to determine implicit biases of healthcare professionals including physicians and nurses, 35 of 42 articles found evidence of implicit bias, and in all studies where correlations were conducted, a significant positive relationship between level of implicit bias and lower quality of care was found.¹⁵ We may consciously reject biases toward stigmatized groups and even be a member of that group, yet because we are immersed in negative stereotypes we actually have implicit bias against that group. One example is “aversive racist” where someone who rejects racism finds they have implicit racial bias when they take an Implicit Association Test.¹⁵ In one systematic review to investigate implicit bias in health workers regarding race or ethnicity, the authors found that most health care providers appear to have implicit bias with a positive attitude toward whites and negative attitude toward people of color.¹⁶ Even the American College of Obstetricians and Gynecologists recognizes the import of implicit bias care of patients: “Implicit bias may affect the way obstetrician-gynecologists counsel patients about treatment options such as

contraception, vaginal birth after cesarean delivery, and the management of fibroids.”⁹

What can we do to decrease implicit bias in ourselves, or others if we are in a management or teaching position? Importantly, we must not become defensive or deny that implicit biases exist. Self-reflection activities that give us insights and challenge our self-perceptions are commonly used to help students in health care become aware of biases.³ Unfortunately, many of us tend to have a defensive resistance to the issue when provided

information and feedback about implicit bias.³ Efforts to determine how implicit biases result in health disparities is in its infancy, but awareness is the first step.

In conclusion, implicit attitudes are thoughts and feelings that are not within our conscious awareness, which makes them difficult to acknowledge and curb.¹⁶ However, the more we know, the more we can work to ensure that our implicit biases do not affect our care—an ethical and moral imperative.

References

1. Garner, JH. The shift report. Published April, 28, 2019. Video Blog. <https://www.facebook.com/watch/?v=386011552032338>. Accessed July 2, 2019.
2. National Institutes of Health. Health disparities. Available at: <http://www.nhlbi.nih.gov/health/educational/healthdisp>. Accessed June 6, 2019.
3. Zestcott CA, Blair IV, Stone J. Examining the presence, consequences, and reduction of implicit bias in health care: a narrative review. *Group Process Intergroup Relat.* 2016;19:528-542.
4. National Academies of Sciences, Engineering, and Medicine. *Communities in Action: Pathways to Health Equity*. Washington, DC: The National Academies Press; 2017.
5. U.S. Department of Health and Human Services. About health disparity. Available at: <https://www.nhlbi.nih.gov/health/educational/healthdisp/about-health-disparities.htm>. Accessed June 6, 2019.
6. Profit J, Gould JB, Bennett M, et al. Racial/ethnic disparity in NICU quality of care delivery. *Pediatrics.* 2017;140:20170918.
7. US Department of Health and Human Services. Reducing asthma disparities. Available at: <https://www.nhlbi.nih.gov/health-pro/resources/lung/naci/discover/disparities.htm>. Accessed June 9, 2019.
8. Office of Disease Prevention and Health Promotion. Disparities. Available at: <https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities>. Accessed June 8, 2019.
9. The American College of Obstetricians and Gynecologists. Racial disparities in maternal mortality in the United States: the postpartum period is a missed opportunity for action. Available at: <https://www.acog.org/-/media/Departments/Toolkits-for-Health-Care-Providers/Postpartum-Toolkit/ppt-racial.pdf?dmc=1&ts=20190609T2204169412>. Accessed June 9, 2019.
10. American Diabetes Association. Health disparities. Available at: <http://www.diabetes.org/advocacy/advocacy-priorities/health-disparities.html>. Accessed June 9, 2019.
11. Centers for Disease Control and Prevention. Diabetes quick facts. Available at: <https://www.cdc.gov/diabetes/basics/quick-facts.html>. Accessed June 9, 2019.
12. Centers for Disease Control and Prevention. 30 years of HIV in African American communities: a timeline. Available at: <https://www.cdc.gov/nchhstp/newsroom/docs/timeline-30years-hiv-african-american-community-508.pdf>. Accessed June 9, 2019.
13. Office of Disease Prevention and Health Promotion. Social determinants of health. Available at: <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>. Accessed June 8, 2019.
14. Hooper VD. Caring for the most vulnerable: the social determinants of health. *J Perianesth Nurs.* 2018;33:247-248.
15. FitzGerald C, Hurst S. Implicit bias in healthcare professionals: a systematic review. *BMC Med Ethics.* 2017;18:19.
16. Hall WH, Chapman MV, Lee KM, et al. Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: a systematic review. *Am J Public Health.* 2015;105:e60-e76.