

HealthCorps Reader

Part One: What Is Health?

There are countless definitions of *health*. Depending on how we look at it and what it encompasses, our definition will vary. For an especially well-written definition, we can turn to the World Health Organization (WHO) which defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (1).

Often, learning about the opposite of a term is useful, too. Consider WHO’s definition of *disease* as “a harmful, and undesirable situation ... associated with impairment or discomfort” (1).

For many years the dominant *model* or way of working with disease was strictly *biomedical*. In other words, it focused on the person’s physical condition and used the biology of molecules as its basic scientific discipline. This model assumed disease to be fully explained by measurable deviations from the normal variables of the human body. It did *not* include consideration of the social, psychological, spiritual, behavioral, or environmental dimensions of illness.

Today’s Model: The Bio-Psycho-Social Model

Today’s model for working with disease includes the biomedical factors but also takes into account much more of the patient’s world. The following example illustrates the difference between this and the older biomedical model:

A patient gets a blood test done at her annual physical exam, and the test results show that she carries the human immunodeficiency virus, or HIV. The patient does not feel ill and did not report any unusual physical symptoms to the doctor that might indicate the onset of auto immune

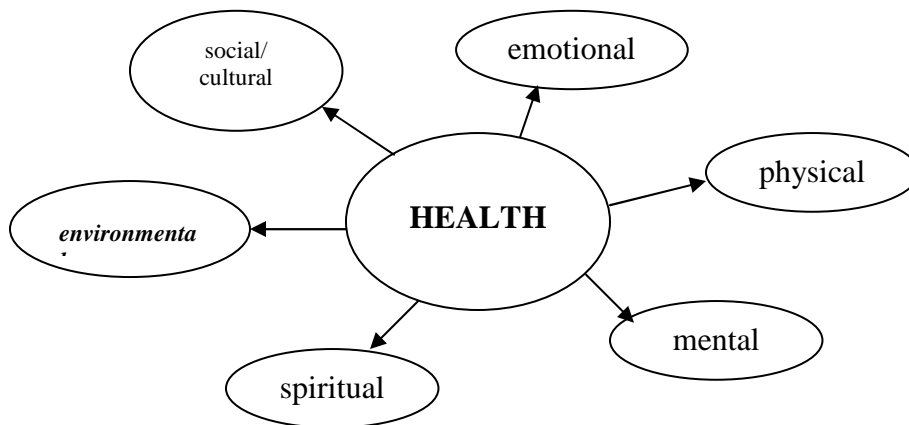
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deficiency syndrome, or AIDS, even though the virus that causes AIDS is present in her body.

When a health care provider orders lab tests for a patient to determine whether disease is present, the results may indicate only the *potential for disease*, not the actuality of that disease at that time. What determines when, if ever, the symptoms appear and how bad they are? What determines whether the patient considers herself to be ill and whether others look at her as being ill? To put it another way, does she believe she is “dying with AIDS” or “living with HIV”?

Like many diseases, the development and evidence of HIV/AIDS are affected by the person’s *living conditions* and *behavior choices*. They can affect the amount of time between the patient’s lab test showing the presence of HIV and when the patient begins to notice actual symptoms. They can have an impact on how fast the disease progresses and which symptoms appear when.

Psychological, social, cultural, and spiritual factors are also important in determining whether patients with HIV in their bodies come to view themselves as “sick,” if so when, and whether the people around them come to regard them as “sick.”



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There are many clinical symptoms associated with HIV/AIDS — indications that a health care professional may identify or a lab test will show — but how any one patient *experiences* the symptoms and *reports* them to a health care provider all require consideration of physical, emotional, mental, spiritual, social/cultural, and environmental factors. *For example*, a patient’s language, religion, and cultural background help determine whether they will see HIV/AIDS as something shameful to hide as long as possible — believing it is an illness that they helped cause — or a disease like any other that can be treated.

Thus, understanding illness requires a basic understanding of the psychological, social and cultural determinants of how patients report their symptoms. One of the most important responsibilities of the provider is to elicit accurately and then analyze correctly the patient’s own account of the illness.

Community health centers focus on *primary* and *preventive* health care which include:

- Basic services provided at the health center: usually provided through departments of family medicine, obstetrics/gynecology, and pediatrics by a range of providers (such as physicians, nurse practitioners, physician assistants, lab technicians, dieticians), these services include physical examinations, diagnoses, and prescribing of medications.
- Services that are health center-based — as opposed to *secondary* care which is hospital-based;
- Screenings that identify health concerns early; and
- Services to promote overall well being of the individual before signs of disease are present.

Health Literacy

A vital part of understanding the full concept of *health* is to grasp the importance of *health literacy*. A person with health literacy skills is able to access, understand, and use correctly the health-related tools and services that are readily available to them. We use here the phrase “readily available” to underscore the fact that even the most health-

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literate person, if uninsured or underinsured, will find it difficult to access good health care over time outside of the community health movement.

Some people may think of health literacy as simply the ability to read (decode) health-related text such as the label on a medicine bottle or a brochure about breast cancer. However this is a narrow definition; such a skill is only one part of the competency. Rather, health literacy involves the entire set of social and cultural practices that form a backdrop to individuals' and groups' relationship to health care.

Health literacy is contextual, that is, dependent on the position of individuals within a community. "Position" can refer to many factors of life. The following factors, and more, all impact our health literacy: Social status, age, gender, marital status, ethnicity, sexual orientation, ability status, family structure, number of children, the people we relate to, and the condition of the place where we live.

Out of hundreds of possible examples, here are a few that illustrate the impact of health literacy in everyday life:

- A child is sent to the store for toothpaste and must distinguish it from a tube of hemorrhoidal cream;
- A mother and father must get their child to the hospital emergency room quickly using public transit;
- A mother needs to read a medicine bottle, understanding both dosage and contraindications; and
- A man who neither hears nor walks well needs to find treatment for his specific condition by locating a specialist within a highly bureaucratic and complicated health care maze.

Some of these examples of health literacy needs are tied to people's ability to decode text — reading labels, advertising, or bus signs — while others are not. In fact, a person's ability to read text is *not* an indicator of his or her ability to access, use, and understand a particular health care tool or service.

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Needs Assessments and Asset Mapping

Many community health centers use a *needs assessment* as a way of identifying problems, matching programs and interventions to those problems, and developing an action plan with the people they serve. This remains a common model for looking at community development and community health. There are four main steps to take while conducting a needs assessment:

1. Analyze the person's or population's existing situation;
2. Identify the varying importance of the factors in that situation and set priorities among them;
3. Identify causes of performance problems and/or opportunities; and
4. Identify possible solutions and growth opportunities (3).

Asset mapping, on the other hand, focuses primarily on the available resources — also called assets or strengths — that are available in a community, because they can be used by the residents and the health center together to address community-wide concerns. Looking at the community as a collection of strengths, we might see:

- *Strong relationships among residents;*
- *Inclusiveness — the recognition that all people are valuable and able to contribute;*
- *Willingness to welcome and include newcomers;*
- *Desire on the part of many individuals to step forward and improve neighborhood conditions, instead of waiting for formal organizations to take action;*
- *Sustainability over time;*
- *Acceptance of risk (i.e., being able to proceed without knowing all of the answers and results in advance); and*
- *At least some transfer to residents of the power to act on their own behalf from various government agencies, professionals, and experts.*

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Citations

1. *Preamble to the Constitution of the World Health Organization* as adopted by the International Health Conference, New York, June 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.
2. *What is Health Literacy?* Muro, Andres. El Paso Community College/Community Education Program. <http://www.worlded.org/us/health/lincs/muro.htm>
3. **Needs Assessment: The First Step.** Rouda, Robert and Kusy Jr., Mitchell E. http://www.alumni.caltech.edu/~rouda/T2_NA.html

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Part Two: Health Disparities

A *health disparity* is a difference in the presence of disease, health outcomes, or access to health care between two or more populations. How do such disparities come about? By looking at how people achieve health in the United States today, we begin to understand how some people are not in a position to “achieve health.”

Health requires high levels of social, economic, human, political, and cultural capital. This approach to disparities holds that the achievement of health is, at least in part, directly related to adequate living conditions, thriving neighborhoods, opportunities for education and employment, and freedom from environmental hazards. People whose participation in society is restricted, for instance, by segregation according to race and poverty have limits placed on their opportunities for a healthy life.

Health requires access to care through health insurance or the ability to obtain services free or through sliding-scale payment plans. Also involved are the location of health care services, the availability of transportation to those locations, the hours when such health care facilities are open, and the quality of care available there. This school of thought holds that the ability to secure access to high-quality, culturally competent care is what enables a person to achieve health. Those who face financial and cultural barriers — as well as differences in the quality of care — thus have worse health outcomes.

Health requires personal health decisions. This belief states that people achieve health through personal decisions about tobacco, illicit drugs, nutrition, exercise, stress, and the use of available health services. Such decisions can lead to improved behaviors: People stop smoking or chewing tobacco, start eating more green and yellow vegetables, get up off the couch for a daily walk, and so on. Varying barriers to making good personal health decisions exist for different groups of people. *For example:* Those who grow up in poor neighborhoods are likely to attend worse schools than other people in the same city or county. In turn, they generally learn less about how the human body functions, what

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causes disease, that we make good or bad decisions all the time that impact our own health, how advertising affects that decision making, and so on. This is one of many scenarios that lead to differences in health outcomes.

Healthy People 2010

“Healthy People 2010” is a comprehensive, nationwide initiative of the Federal government involving health promotion and disease prevention. Sponsored by the Department of Health and Human Services (DHHS), “Healthy People 2010 challenges individuals, communities, and professionals—indeed, all of us— to take specific steps to ensure that good health, as well as long life, is enjoyed by all.” It is meant to serve as a roadmap for improving the health of *all* people in the U.S. during the first decade of the 21st century.

“Healthy People 2010” represents the ideas and expertise of a diverse range of individuals and organizations concerned about the nation’s health. It is designed to achieve two overarching goals:

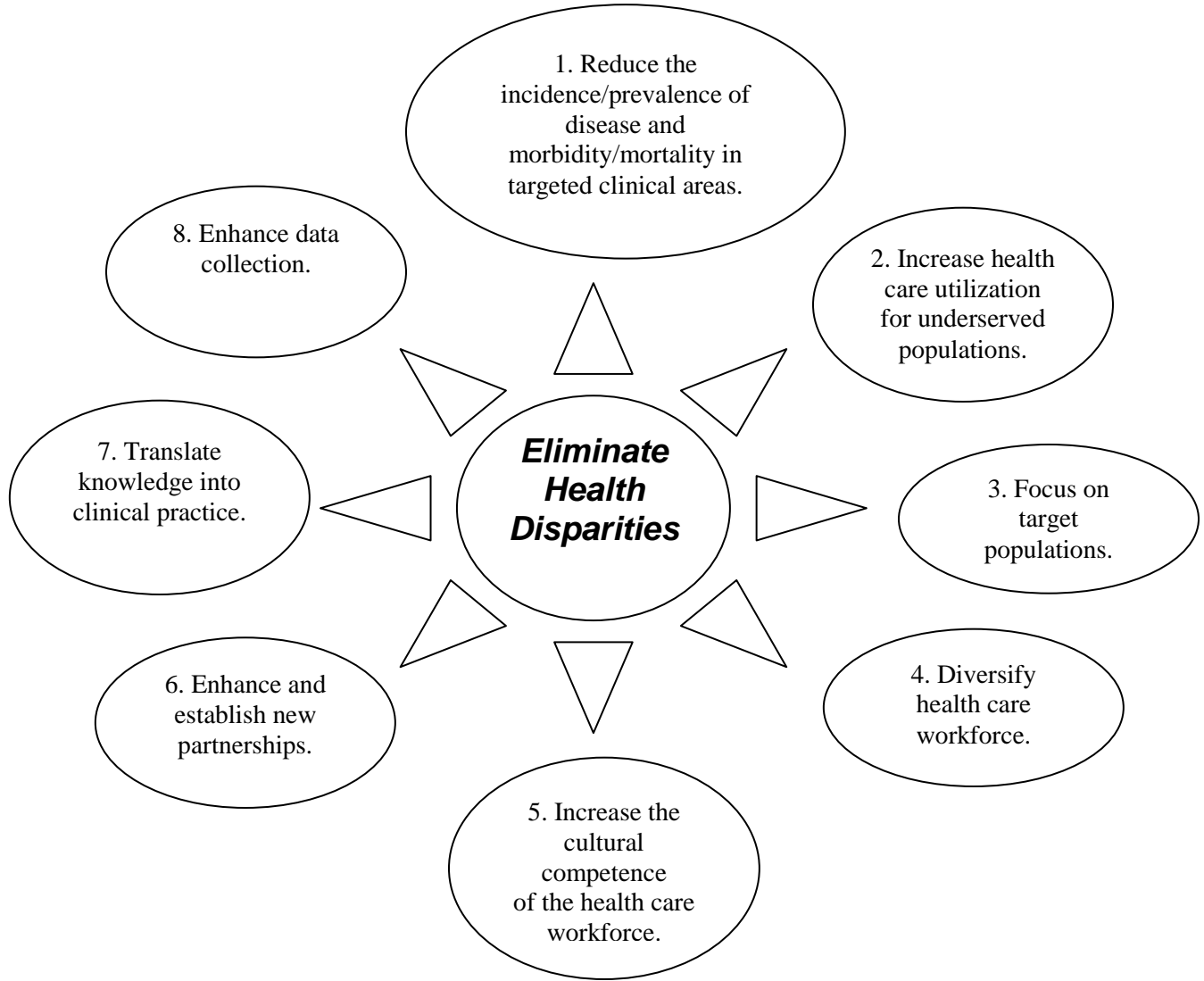
- To increase quality and years of healthy life; and
- To eliminate health disparities.

Although significant advances have been made in the diagnosis and treatment of some diseases and conditions, there is still a long way to go. Diabetes and other chronic conditions continue to present a serious obstacle to public health. Many conditions now disproportionately affect women, communities of color, and low-income groups, that is, there are disparities in the presence of these conditions in certain populations within America.

These are addressed by the second goal of “Healthy People 2010.” DHHS seeks to eliminate health disparities, including those that occur by gender or sexual orientation, race or ethnicity, education level or income, physical or mental disability, or geographic location.

DHHS has developed a model with coordinated strategies for addressing health disparities, as shown in the following diagram:

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Each of the eight strategies is detailed on the following pages.

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Strategy 1: *Reduce the incidence/prevalence of disease and morbidity / mortality in targeted clinical areas.* The initiative focuses on:

- Physical Activity
- Overweight and Obesity
- Tobacco Use
- Substance Abuse
- Responsible Sexual Behavior
- Environmental Quality
- Immunization
- Mental health
- Injury and Violence
- Access to Health Care

Strategy 2: *Increase health care utilization for underserved populations.* This involves:

- Removing health care barriers;
- Establishing new health care access points; and
- Increasing employment of lay health workers.

Strategy 3: *Focus on target populations.* Specifically, the focus is on:

- Racial and ethnic minorities;
- Underserved males & females;
- People with low income;
- Rural and urban residents;
- Residents of the U.S. - Mexico border; and
- Lesbian, gay, bisexual and transgendered populations.

Strategy 4: *Diversify the health care workforce.* This strategy:

- Acknowledges that the patient-provider relationship is enhanced by ethnic, cultural and linguistic concordance; and
- Supports increased numbers of health care providers who are people of color and/or multilingual.

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Strategy 5: *Increase the cultural competence of the health care workforce.* The initiative works to:

- Implement a plan to incorporate cultural competence principles throughout certain DHHS programs, practices and policies; and
- Enhance the cultural competence focus related to targeted clinical areas and populations.

Strategy 6: *Enhance and establish new partnerships.* This strategy:

- Acknowledges that communities with multidisciplinary partnerships are reducing health disparities; and
- Seeks new and enhanced partnerships that integrate primary health care and public health services.

Strategy 7: *Translate knowledge into clinical practice.* The initiative:

- Supports consistent utilization of evidence-based health care and population-specific health delivery practices; and
- Plans innovative strategies to bridge the gap between medical knowledge and clinical practice.

Strategy 8: *Enhance data collection.* This involves:

- Developing strategies for the collection of racial/ethnic, other demographic, and clinical data related to people using community health centers;
- Emphasizing data collection activities related to targeted clinical areas and population groups; and
- Identifying specific populations that suffer from health disparities in order to target future efforts accordingly.

To learn more about “Healthy People 2010,” you can visit www.healthypeople.gov.