

Editor's Note

Different and Differenced Takes on Disparities

Variouly described in terms of *disparities*, *inequities*, *differences*, or *inequalities*, concerns about distributional equity emerged around the world as a primary theme in health-policy making during the last decade of the twentieth century.¹ Global actors such as the World Health Organization and World Bank strove to more aggressively identify distributional inequalities in particular countries and to develop methods of comparing the extent of inequality across nations. In the United States, disparities were incorporated into the national ten-year plans for health improvement embodied in the *Healthy People* reports. More recently, Congress mandated that the Department of Health and Human Services produce a freestanding annual *National Health Disparities Report*.

The striking emergence of disparities makes this an interesting topic for scholars of health-policy making. It is not simply the case that distributional equity appeared in comparable ways on each country's policy agenda: there was considerable variation in the language used to depict these distributional issues; the extent to which inequities were defined in terms of socioeconomic status, race/ethnicity, or geography; whether pol-

1. There were certainly some earlier seminal commissioned reports, including the Black report (1980) on socioeconomic inequalities in the United Kingdom and the Heckler report (1985) on racial disparities in the United States. But, for reasons discussed in several of the articles in this issue, the full impact of these reports was not evident until well after they were published.

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icy attention focused more on differences in health or health care; and in the processes that brought inequality to the forefront of policy discourse. Analysts need to consider whether these differences were meaningful in terms of the nature of the policies that emerged or their subsequent effectiveness.

Apart from these questions related to the emergence of disparity-related policies, there are several other good reasons for examining more closely public policies related to health (care) disparities. First, the disparities field is replete with curious ironies. Consider a few illustrations. As documented later in this issue, the United States stands out among advanced (using this term loosely) market economies in terms of exhibiting the largest impact of income inequalities on health. Yet American policy making is equally distinctive in its primary focus on race and ethnicity as the defining typologies for disparities, as opposed to socioeconomic status or social class. Other ironies involve the role of transnational organizations. Several articles in this issue document, for example, the important role of the World Bank—once widely criticized for its attention to macroeconomic development at the expense of distributional concerns—in placing health disparities on the policy agenda in developing countries. Still other ironies involve gaps between evidence and policy action. For example, there is clear evidence that economic inequalities are most consequential for health when they affect children, yet one is hard pressed to identify concerns about children's health and well-being in policy discourse around disparities.

A final reason for bringing a more refined analytic perspective to disparity-related policies is that most of the academic research and policy discourse to date has been resolutely focused on the identification and measurement of differences in health or health care. There has been far too little thought given to the meaning of those differences. To be sure, there is a rapidly growing body of empirical research tracing the causal pathways that generate disparate health outcomes. But I have in mind a different sort of meaning related to the moral, political, and cultural import of these differences. Until we better understand the collective interpretation and assessment of health-related differences, it will be difficult to predict their impact on future policy making and impossible to define a coherent normative agenda for addressing the disparities that matter most.

For all these reasons, we considered it fortuitous when the journal was approached by two separate groups with collaborative projects on policies related to health disparities. The first was a group chaired by John McDonough (then at Brandeis University) and funded by the Com-

monwealth Fund, charged with making sense of the role of state policy making in addressing racial disparities in the United States. From this group emerged three articles. The first, by Kala Ladenheim and Rachel Groman, describes relevant state laws enacted in the period 1990–2001 and supplements this accounting with focus groups of state legislators to identify their thinking about disparities-related policies. The second article, by Deborah Stone, develops a case for how advocates *ought* to frame racial disparities to motivate the most active and effective forms of state intervention. The final article in this set, authored by a team of researchers headed by Brian Gibbs, sketches out how researchers might develop indices of racial disparities that can be compared across states and over time, so that one could in the longer run assess the impact of particular state interventions.

The second group of articles came from a conference and collaborative effort organized by AcademyHealth and supported by the Rockefeller Foundation and the Department of Health and Human Services. The goal of this project was to assess how evidence and academic research influenced the emergence of health disparities on the policy agenda in a half dozen countries, including an equal number of developing and advanced market economies. Five articles emerged from this project. The first, by Barbara Starfield, summarizes a set of stylized facts about past research relating inequities defined by race, geography, or socioeconomic status to health outcomes. Two of the articles were selected to represent the six case studies. Deborah Stone makes her second appearance in this issue, coauthoring with Vanessa Gamble a comparison of national reports on racial disparities in the United States. Yuanli Liu and Keqin Rao document how a seminal report on geographic inequities in the availability of health insurance galvanized new policy initiatives in China. The final two articles synthesize the findings of all six case studies. Patricia Pittman provides an overview of the cross-cutting themes in the case studies, whereas Richard Freeman focuses on the pivotal role of reports in the political processes that moved disparities onto the health policy agenda.

As one might anticipate from these thumbnail descriptions, this issue embodies a rather varied set of contributions, reflecting insights from a number of different disciplines, applying strikingly different analytic frameworks (ranging from postmodern textual critiques to informal meta-analysis to political history to firsthand personal accounts of policy advocacy). Yet amid this diversity one can discern two themes that represent, in my assessment, the distinctive contribution of this special issue to the emerging policy discourse on health disparities.

First, this is one of the few collaborative efforts to consider seriously the political aspects of the disparities debate. Although political considerations are more central in some essays than others, they are at least secondary motifs in all the essays. Second, this issue represents an unusual opportunity to view health disparities in a comparative perspective. This is evident within each of the two component projects, one comparing across states and the other across countries. But it is equally evident within individual essays (comparing across types of disparities or types of reports about disparities) and between the two projects. Readers have the opportunity to consider how state initiatives might have appeared if compared in terms more like those from the cross-national project. Conversely, the insights about political framing from Stone's dissection of state policy or the promise of disparities indices described by Gibbs and colleagues might well be extended to cross-national comparisons, such as those described more anecdotally in the *AcademyHealth* project.

Politics and Political Discourse Related to Health (Care) Inequities

Although political scientists have long been interested in the politics of social justice and redistributive government programs, these political dynamics may well play themselves out differently for health care than in other policy domains. Although most programs promoting access to medical care, for example, substantially redistribute resources from the rich to the poor, these income-related transfers are masked and politically legitimated by even larger transfers from healthy to sick citizens. And even in politics and political eras in which an activist government is viewed with suspicion, intervention into the financial aspects of medical care has high levels of public legitimacy (Schlesinger 2004). Political scientists have only recently turned their attention to the distinctive politics of fairness in medical settings (Morone and Jacobs 2004).

And even this recent attention has been more focused on the ways in which conventional political factors (e.g., interests, institutions, and ideologies) shape debates over fairness in health care than on the ways in which moral claims about health and medical care induce a distinctive sort of political discourse. The essays in this issue suggest several ways in which the latter perspective may be important in shaping the future of public policies.

First, as Stone notes in her single-authored essay, health disparities gain much of their persuasive moral power because they simultaneously violate

two sets of norms—the first involving notions of societal rights to medical care and the second related to norms of professionalism in medical settings. As Gamble and Stone illustrate in their case study of disparities reports in American politics, either of these perspectives can serve as a suitable platform for critiquing contemporary practices and proposing policy interventions. But they lead to very different types of critiques in their depiction of the nature of the disparities, their attributions of causal responsibility, and the sort of government actions that are proposed as legitimate responses.

One can see echoes of these two perspectives running through the international case studies described by Pittman and the descriptions of state legislators' thinking about racial disparities presented by Ladenheim and Groman. It appears more subtly in the Chinese context discussed by Liu and Rao—though in this case, the paradigmatic shift that captured policy makers involved recasting health care disparities in terms of their financial implications (evoking, implicitly, a rights-related claim that hardworking workers and their families ought not face a life in poverty because they are unable to pay their medical bills).

But the most interesting question related to these paradigmatic frames remains largely unanswered. To develop a persuasive rationale for government action or a coherent strategy of intervention, must policy makers choose between the rights and professionalism frames, or can the two coexist in parallel? Stone argues that, at least for state policy making in the United States, it is more attractive to focus on the professionalism frame—in particular, the notion of treating disparate treatment patterns as a form of medical error. Although the moral power of that position may have been somewhat undercut by the Food and Drug Administration's recent approval of race-specific pharmaceuticals, there are some seemingly supportive bits of evidence scattered throughout the other essays. Several of Freeman's conclusions about disparities reports, for instance, are consistent with the benefits of a narrowed paradigmatic focus. And certainly the Chinese experience suggests that disparities can be framed in ways that have nothing to do with medical care at all, yet have persuasive appeal to at least some key policy makers. I suspect, however, that there are some circumstances (as yet not clearly identified) in which it is desirable to maintain both societal rights and professionalism paradigms in tandem.

A second lesson about the politics of health (care) disparities recurs as a theme in both the cross-national and the cross-state comparisons. In both settings, the politics of health disparities is largely elite driven, with little

evidence of public mobilization about these matters. This is a pattern evident throughout twentieth-century health politics—Medicaid was tacked onto Medicare legislation as a last-minute elite maneuver and geographic inequities in Canadian Medicare or the British National Health Service were almost entirely elite concerns. Consequently, disparity politics are powerfully shaped by the sort of policy entrepreneurs described in the essays by Pittman and Freeman. State policies in the United States appear to be an outgrowth of the idiosyncratic concerns (whims) of politicians or policy advocates in each jurisdiction.

These political origins have important consequences for the diffusion of ideas about disparities and equity-enhancing policies across political domains. Relatively restricted elite networks may serve as the primary channels for propagating these policies, filtering their spread through the mediating effects of a handful of elite activists in each polity. These conditions may also produce considerable policy variation, since there are few national or transnational groups focused on defining a coherent or consistent response to disparities, as opposed to simply motivating policy makers to do *something* to make their health care system more equitable.

One might therefore be inclined to dismiss entirely the role of public participation when thinking about health disparities. But that would neglect an important, albeit small, body of research that is briefly described in Starfield's essay. Dating back to work by Thomas LaViest (1993), these studies show that the magnitude of health disparities and the scope of redistributive policies are themselves consequences of the extent of political participation by different groups of citizens. The exact pathways and direction of causation remain unclear. Do participation and a sense of enhanced self-efficacy directly induce great health for individuals? Does broader participation strengthen the political base of health programs with a redistributive component? Or are both outcomes (participation and improved health status) simply the product of a third factor, such as social capital? Although we have only hints of answers to these questions, they are sufficiently provocative that researchers ought to further explore these linkages in their future investigations.

Finally, the essays in this issue identify several sources of potential tension in the politics of health disparities, beyond the usual political cleavages between the poor and the well-off. For example, Ladenheim and Groman observe that Latinos have been curiously invisible in state initiatives directed at disparities—either ignored entirely or grouped into a general category of ethnic and racial minority groups. This indistinct political identity would have little import if we suspected that health dis-

parities were produced by similar factors for all minority groups. But the limited evidence that exists on this matter suggests otherwise. Disparities experienced by Latinos seem to be disproportionately related to financing (lack of health insurance) and communication (English as a second or third language); by contrast, disparities involving African Americans appear to reflect deeper-rooted tensions in the nature of the physician-patient relationship. Policies that fail to reflect these differences are likely to ill-serve some minority groups.

The case studies of developing countries capture a second potential cleavage—between low-income residents of rural areas and those in the cities. As Pittman describes in general, and Liu and Rao describe in more detail for the Chinese case, policy makers have generally given greater attention to health disparities in rural settings. This may well be justified, if the collocation of rich and poor in urban areas affords the latter greater access to services, as Starfield suggests. But it at least raises the specter that as policy makers strive to reduce one set of (socioeconomic) disparities, they may inadvertently exacerbate another set of (geographic) disparities.

Differencing and Comparative Insights about Health (Care) Disparities

In the empirical analysis of health policy effectiveness, it has become standard practice for researchers to assess this impact by way of comparison. Some comparisons involve the same individuals over time (before and after the policy is implemented) whereas others group those covered by the policy with those who are not. In the argot of applied economics, these are termed *differencing* models. Over time, the sophistication of the empirical analysis has come to be equated with the number of differences embedded in the comparison. For example, a *differences-in-differences* model that compares outcomes before and after policy implementation for groups who are covered by the policy and those who are not is seen as more reliable than one that relies solely on either cross-group or cross-time comparisons.²

One can think of this issue as presenting an analogous form of differencing, albeit more qualitative in orientation. Although a number of the essays are themselves comparative, readers may derive as many insights

2. To date, the apotheosis of this approach applies *differences-in-differences-in-differences* to assess the impact of policy, though I am fairly certain that it is only a matter of time before some researcher devises a means of estimating models with fourfold differences.

from thinking about comparisons among comparisons. For example, how do the comparisons of the national politics of disparities depicted by Pittman or Freeman compare with the comparisons among states presented by Ladenheim and Groman? How does Starfield's take on the role of evidence in the politics of health inequities compare with the approach taken by Gibbs and colleagues to evaluating American policies targeted at reducing racial disparities?

Several of the essays can be seen as applying a qualitative version of a differences-in-differences analysis. For example, as Gamble and Stone describe the role of disparities reports in American politics, one can view them as contrasting reports that tackle the question of racial/ethnic disparities to reports in other countries that focus more on socioeconomic disparities. But they also derive important insights from their comparison *between* reports about racial disparities. Similarly, though one can view Ladenheim and Groman as primarily comparing disparities policies across states, they also compare policy initiatives among different minority groups across states. These second-order comparisons may be at least as consequential as the primary comparisons in generating insights about the policy-making process related to health disparities.

Health Disparities and Future Policy Initiatives

So what does all this bode for the future of disparity-reducing health policy? Because both the cross-national and the cross-state comparisons focused largely on policy making at the turn of the millennium, it is difficult to tell whether the contemporary focus on health disparities will be a lasting phenomenon or a temporary policy fad spread from elites in one country to the next, the political equivalent of the flu virus. Precisely because the politics of health disparities appear so elite driven, they are subject to sharp discontinuities in salience as partisan control of national or state governments shifts from liberal to conservative hands and back again (see Pittman's account of the Black report in the United Kingdom under Margaret Thatcher). However, those hoping for greater resilience for equity-enhancing policies may be heartened by the apparent failure of the Bush administration to gut the content of the first National Health Disparities Report in the United States (described by Gamble and Stone).

It is equally difficult to discern the long-term consequences of the distinctive interpretation of the disparities debate found in developed and developing countries. As Pittman recounts, the equity issue tends to be

more nuanced and multidimensional in advanced market economies. Whether this makes the resulting policies more or less politically stable depends in part on the questions of political framing that we discussed above. But it also raises questions about whether the disparities agendas in the two sets of nations are so distinctive that they will have quite different political dynamics. If, for example, disparities in China are viewed by policy makers entirely in terms of their financial consequences, one would expect them to be powerfully influenced by macroeconomic trends and other factors that affect the financial stability of the worst-off households. By contrast, if disparities in developed countries are characterized primarily in terms of differences in health or medical care (even if not narrowly defined as medical errors in the manner proposed by Stone), one would expect these concerns to be more affected by changing notions of medical efficacy and access. If concerns about equity are on such distinctive evolutionary tracks, their apparent commonalities at the end of the twentieth century may, in retrospect, be seen as little more than an interesting historical coincidence.

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References

- Black, D., J. Morris, C. Smith, and P. Townsend. 1980. *Inequalities in Health: Report of a Research Working Group*. London: Department of Health and Social Security.
- Heckler, M. 1985. *Report of the Secretary's Task Force on Black and Minority Health*. Washington, DC: U.S. Department of Health and Human Services.
- LaViest, T. 1993. Segregation, Poverty and Empowerment: Health Consequences for African Americans. *Milbank Quarterly* 71: 41–64.
- Morone, J., and L. Jacobs. 2004. *Healthy, Wealthy, and Fair*. New York: Oxford University Press.
- Schlesinger, M. 2004. Reprivatizing the Public Household? Medical Care in the Context of American Public Values. *Journal of Health Politics, Policy and Law* 29: 969–1004.



"You'll be happy to know that race played no part in this decision."