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Addressing inequities in medical care: A comprehensive examination of global health disparities

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***Abstract*---Background:** Health disparities and inequities persist globally, significantly affecting marginalized racial and ethnic groups. Medical institutions and educators must address these issues to foster a more equitable healthcare system. **Aim:** This chapter aims to explore the definitions and implications of health disparities and inequities, emphasizing the need for a comprehensive understanding in medical education to address these challenges effectively. **Methods:** The chapter reviews definitions from leading health organizations and examines case studies from various countries to highlight the impact of historical, structural, and social determinants of health (SDOH) on health outcomes. Methodologies for measuring these disparities, including quantitative and qualitative approaches, are discussed. **Results:** Health disparities often arise from systemic and institutional biases, with historical injustices like colonialism and slavery continuing to influence modern health outcomes. Case studies from

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the United States, Brazil, the United Kingdom, and the Netherlands illustrate ongoing inequities in maternal mortality and other health outcomes. **Conclusion:** Addressing health disparities requires an understanding of historical contexts, structural factors, and SDOH. Medical education must evolve to incorporate these elements to equip future healthcare professionals with the skills to combat these disparities effectively.

***Keywords*---**Health Disparities, Health Inequity, Social Determinants of Health, Medical Education, Global Health Inequities, Structural Racism, Systemic Bias.

Introduction

Medical institutions and educators occupy a distinctive position to equip students with the knowledge, contextual insight, and competencies necessary to address issues such as racial and ethnic disparities that contribute to health inequity [1]. This chapter seeks to offer nuanced summaries of essential concepts that can enhance one's comprehension of health disparity, inequality, and inequity. Advancing healthcare towards a more inclusive, equitable, and ethical practice demands a transformation in medical curricula that accurately reflects the complex interplay between health, race, and ethnicity. This transformation also requires a commitment to persistently challenge and rectify systemic and institutional biases and policies. Defining health disparities and health inequities will provide students with foundational terminology used across medical, social, and political discourse. This understanding may facilitate the critical application of these terms in both local and global health contexts, accounting for cultural, historical, and sociopolitical variations among nations. It is crucial to carefully consider these definitions due to the varying ways in which the terms health disparities and health inequities are utilized, valued, and interpreted. The concepts embedded in these terms play central roles across diverse fields such as health education, resource distribution, planning, and health promotion [2].

Defining Health Disparity and Health Inequity

The terms health disparity and health inequity have become standard in the realms of social science and public health. They are frequently employed to shape health policy and guide research that mobilizes health resources [3]. However, as global communities become increasingly interconnected through the internet, rapid communication, and technological advancements, the ability to disseminate and access information instantaneously has significant implications for international visibility and sociopolitical connections [4]. In the context of healthcare, the exposure of significant health inequities disproportionately affecting racial and ethnic minorities has gained prominence on the global stage [4]. This renewed focus necessitates urgent action to promote health equity, presenting significant opportunities within medical education [1, 5].

Health Disparities

The concept of health disparity typically refers to differences in health and health outcomes between distinct groups within a population [6]. This term, predominantly coined and utilized in the United States, implies a sense of injustice often characterized by differences in race, ethnicity, and/or socioeconomic status [7]. The United States Department of Health and Human Services (DHHS) Secretary's Advisory Committee (SAC) published the seminal report Healthy People 2020, defining health disparity as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage [7, 8]." Similarly, the Centers for Disease Control and Prevention (CDC) expanded this definition to encompass inequities related to the "unequal distribution of social, political, economic, and environmental resources," [9] and "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health experienced by socially disadvantaged populations [9]."

Health disparities generally affect individuals who face "systematically greater barriers to healthcare based on their racial or ethnic group, sexual orientation, gender identity, geographic location, or other characteristics historically associated with discrimination or exclusion [8]." However, using health disparity as a direct measure of inequality without context risks reductionism and the pathologizing of race [1]. For instance, presenting health disparities without considering context may overlook differences between first-generation and second-generation citizens and fail to address biracial and multiracial nuances. Such an approach risks "victim-blaming by constructing the non-reference group [i.e., minority populations] as the problem" while neglecting other complex factors [10]. These factors may include historically discriminatory practices, unequal access to resources and information, biased socioeconomic planning and implementation, and other forms of institutional and systemic social and structural violence [1, 9]. Consequently, the US Office of Disease Prevention and Health Promotion (ODPHP) has refined previous definitions of health disparity to emphasize the importance of incorporating social determinants of health (SDOH), including socioeconomic status (SES), geographical location, and sociopolitical impacts, which affect not only health but also functioning, opportunity, and quality of life [8]. Globally, in 2005, the World Health Organization (WHO) established a Commission on Social Determinants of Health, recommending a systematic approach to addressing poverty, sanitation, food security, and other SDOH to fulfill basic human needs and enhance health across global populations [11]. Various surveys, toolkits, and additional resources have been developed and allocated to advance efforts in transforming the healthcare landscape not only in the United States but worldwide.

Health Inequity and Health Inequality:

Unlike "health disparity," which is primarily used within a U.S. context, "health inequity" is a more universally recognized term with global relevance. Although these terms may seem similar at first glance, it is crucial to distinguish between health inequality and health inequity, as they are not synonymous. The World Health Organization (WHO), an international public health entity aiming to shape

global health norms and agendas, defines health inequity (rather than inequality) as avoidable “systemic differences in the health status or the distribution of health resources between different population groups arising from the social conditions in which people are born, grow, live, work, and age [12].” Some definitions characterize health inequity as a moral and social discrepancy—an unjust or unfair difference in health outcomes or social determinants of health (SDOH) rather than a biological variance [13]. For instance, the COVID-19 pandemic highlighted significant health inequities in the United States, particularly affecting Black, Latinx, and American Indian/Alaskan Native populations compared to White individuals. Systemic historical and institutional barriers limiting financial and educational resources for these communities often resulted in higher employment rates in essential, on-site jobs (e.g., grocery store workers), which increased their risk of virus exposure [13]. Conversely, many non-essential workers, who could work remotely, were afforded greater protection from exposure and related health complications.

Another structural example of health inequity is the racially discriminatory housing policy known as redlining in the United States [14, 15]. Redlining was a federal housing program from the 1930s that provided and secured housing exclusively for White middle and lower-class families, while systematically excluding Black families and other non-White communities [15]. Non-White families were often directed to urban housing projects rather than suburban areas, with state and local maps marked with red lines indicating areas where financial services could be restricted based on racial demographics. This practice of housing inequity reflects structural racism and resulted in disinvestment in communities of color, contributing to a lack of access to employment, education, quality grocery stores, transportation, and greater exposure to environmental hazards [16]. Although the Fair Housing Act of 1968 reduced the legality of redlining, its legacy continues to affect the social and economic outcomes of these communities, including poorer mental health, increased chronic conditions, higher preterm birth rates, and reduced longevity [15, 16].

Health inequity is also evident across continents; for example, in India, there is a disproportionate mortality burden on historically marginalized lower caste groups due to previous legal and social discrimination, resulting in economic disadvantages and inequities affecting health status, outcomes, and access to healthcare [17, 18]. A study by Arcaya and Arcaya [13] demonstrated the extensive economic impact of health inequities, estimating a direct cost of $230 billion in the United States and an additional $1.24 trillion when considering indirect costs. These examples underscore the economic, ethical, and cultural imperatives for understanding and addressing health inequities and disparities. Health inequality, on the other hand, refers to quantifiable differences in health outcomes that are sometimes unavoidable and vary across individuals or groups [19]. Some health inequalities are inherent due to natural variations in health status; for instance, younger adults generally recover more quickly from injuries compared to older adults, illustrating a disparity in health outcomes based on age [19]. Similarly, the higher prevalence of Sjögren syndrome among women compared to men reflects an inequality that is not systematically avoidable or socially preventable [21].

In 2011, the Public Health Department at the University Medical Center Rotterdam in the Netherlands assessed the economic costs of health inequities within the European Union (EU). The report found that individuals with lower educational attainment experienced greater health complications, accounting for 20% of the EU's healthcare costs and 15% of social security benefit payments. Additionally, the lost opportunity and productivity costs from unmet health needs amounted to 1.4% of the Netherlands' annual GDP [22]. Although this study used the term "inequalities" to describe the disparities in health due to systemic and socioeconomic factors, this chapter suggests that these disparities are more accurately described as inequities. This highlights the need for precise definitions in academic and global discussions to ensure that terms are used effectively and meaningfully.

Methodology and Measuring Health Disparity and Health Inequity:

Currently, there is not universally standardized or systematically accepted methodology for measuring health disparities and their subsequent impacts. Research on racial and ethnic health disparities (REHD) often relies on self-reported data from surveys, which can be limited by socially constructed categories. White et al. conducted a scoping review examining socially assigned race and its connection to health outcomes across the United States, Canada, New Zealand, and Latin America. The review found that while many surveys fail to fully capture the complex and contextual nuances of individual and structural experiences, they still provide valuable insights and reveal patterns in health outcomes based on self-identified race and ethnicity [24]. Despite these limitations, innovative methods have been foundational in the literature on REHD.

Researchers have developed specific, though non-standardized, metrics to empirically assess disparities related to race and ethnicity and their outcomes. These data illuminate gaps in healthcare and opportunities for improvement, highlighting differences in health risk factors, disease progression rates, prognoses, healthcare access, and utilization. The methodologies employed vary depending on the study's objectives and design, including quantitative, qualitative, or mixed methods approaches. Common data sources include national health surveys (e.g., New Zealand Health Survey, Ministry of Health surveys, National Longitudinal Study of Adolescent Health to Adults, Project on Ethnicity and Race in Latin America (PERLA)) [24]. Qualitative reports often rely on self-reported health outcomes from in-depth interviews and surveys to capture REHD. These self-reported measures reflect attitudes about disease, lived experiences, cultural nuances, risk factors, and access to care [25].

Quantitative assessments of health disparities frequently involve pairwise comparisons between different groups, producing ratios such as hazard ratios or relative risks [26]. However, such approaches can be reductionist and may not capture the multifaceted nature of health disparities. Higher-powered studies that examine multiple relationships can address these limitations. Nevertheless, data obtained still provide insights into differences in health utilization, outcomes, and self-rated health statuses [24]. An example of a quantitative metric is the Index of Disparity (ID), a modified coefficient of variation defined as the "average of the

absolute difference between rates for specific groups within a population and the overall population rate, divided by the rate for the overall population and expressed as a percentage [26].” This metric, used in Healthy People 2020, helps inform public understanding of health disparities and SDOH, guiding goal-setting and progress evaluation.

A Chilean study employed Geographic Information Systems (GIS) mapping combined with hospital discharge records to analyze health disparities among the Mapuche population, focusing on differences in health access, utilization, and outcomes [27]. Government agencies often track specific diseases to compare incidence rates across geographic, racial, and socioeconomic groups, or conduct longitudinal studies. For instance, the American Journal of Epidemiology published a 2008 study analyzing trends in U.S. lung cancer incidence by geographical SES position and racial-ethnic disparities. The study highlighted that the measurement of longitudinal health disparities is influenced by the metrics used and recommended employing multiple indicators [28].

In Taiwan, a longitudinal study evaluated changes in health outcomes before and after the introduction of a national health insurance system in 1995. Over a decade, researchers compared “life expectancy, reductions in deaths from cardiovascular diseases, infectious diseases, and accidents [29].” They found that national healthcare implementation increased life expectancy among groups with previously high mortality rates. Such systems can guide governments in addressing REHD more effectively. In Lebanon, a study on refugee health disparities utilized cross-sectional survey data and logistical regressions across five SES measures (e.g., educational attainment, wealth index, crowding, severe food insecurity, and water leakages) to capture inequities [30]. In the U.K., maternal near misses (MNM) represent a racial health disparity, occurring “twice as often for women of African and Afro-Caribbean descent [31].” The WHO defines MNM as “a woman who nearly died but survived a complication occurring during pregnancy, childbirth, or within 42 days of termination of pregnancy [32].” Recognizing this disparity led to the establishment of the United Kingdom Obstetric Surveillance System (UKOSS), which investigates MNM morbidities among different races. Documenting this racial disparity resulted in policy reforms that reduced the maternal mortality ratio for African women in the U.K. from 72/100,000 live births to 28/100,000 between 2000 and 2013 [31]. Awareness of diverse methods for capturing and reporting health disparities underscores the complexity and urgent need for prioritizing this issue [24].

Using Historical Lenses to Describe Health Disparities Around the World:

The impact of historical injustices, such as the trans-Atlantic slave trade, continues to shape health disparities globally. The forced displacement and enslavement of millions of Africans by European countries and the United States had profound and lasting effects on social conditions and public policies, leading to entrenched inequities that persist today.

The trans-Atlantic slave trade, spanning from the 16th to the 19th centuries, involved European nations and the United States capturing and transporting African individuals to be enslaved and exploited. By the late 18th century, Great

Britain was a major player in this trade, transporting 40% of all enslaved people until the abolition of slavery in 1807 [33]. Despite the end of the slave trade, the legacy of colonial brutality persisted, with marginalized Black populations in these countries facing ongoing discrimination and unequal access to resources. In the United Kingdom, the establishment of the National Health Service (NHS) in 1948 marked a significant step toward universal healthcare. However, disparities remain, as evidenced by recent NHS findings showing a greater than five-fold increased risk of maternal mortality for Black women compared to White women [31]. This illustrates that historical inequities continue to impact health outcomes despite efforts toward equality.

Brazil, colonized by Portugal, also experienced significant racial disparities due to its history of exploiting enslaved Africans for labor in agriculture and mining. Despite the implementation of universal healthcare under Sistema Único de Saúde (SUS) in 1988, disparities persist. For example, maternal mortality rates for Black women in Brazil remain significantly higher than for White women, with a rate of 240.4/100,000 compared to 49.3/100,000 [31]. This disparity highlights the enduring impact of historical racial disenfranchisement. In the United States, the legacy of the trans-Atlantic slave trade includes the systemic mistreatment of Black individuals, who were often used for medical experimentation and faced severe socio-economic disadvantages. This historical context contributes to present-day disparities, such as the significantly higher maternal mortality rates for Black women compared to White and Asian women. From 2005 to 2014, Black women had 3.6 times higher maternal mortality than White women and nearly four times higher than Asian women [31]. Maternal near misses (MNM) also occur more frequently in Black women, reflecting ongoing racial disparities in healthcare.

The Netherlands, while primarily involved in the slave trade in Asia and through the Dutch West India Company, still faces racial health disparities. Despite universal health coverage, migrant populations in the Netherlands experience higher risks of severe morbidity compared to native Dutch individuals. Non-Western immigrant women have a 1.3-fold increased risk of severe morbidity, and Saharan African women face a 3.5-fold increased risk [31]. This underscores that racial discrimination continues to affect health outcomes despite advancements in healthcare systems. The historical context of racial prejudice and systemic injustice profoundly influences contemporary health disparities. By examining the historical roots of these inequities, we gain insight into the persistent gaps in health outcomes between different racial and ethnic groups. Addressing these disparities requires a comprehensive understanding of their historical origins and a commitment to systemic change in healthcare and beyond.

Modern-Day Health Disparity in the Global Sphere:

In addition to historical context, understanding current societal and structural health inequities is crucial for future medical professionals. It is important to recognize that health disparities are not universally experienced in a homogenous manner by racial and ethnic groups. Race and ethnicity interact with various social determinants of health (SDOH) in complex ways and stereotyping or

assuming uniform experiences based on these categories can lead to misinformed and ineffective interventions.

Current and Evolving Contextualized Examples of REHD:

The following data highlights how historical, structural, and SDOH factors contribute to disparities in health outcomes, such as life expectancy, disease burden, and access to treatment. It emphasizes the importance of contextualizing health disparities within the specific regional and cultural frameworks that shape these inequities. Key aspects include:

- **Historical Influence**: Historical injustices, such as colonialism and slavery, continue to impact health outcomes by shaping socio-economic conditions and access to resources.
- **Structural Factors**: Institutional and systemic factors, such as discrimination and unequal healthcare policies, play significant roles in perpetuating health disparities.
- **Social Determinants of Health**: Factors like income, education, and living conditions intersect with race and ethnicity to influence health outcomes.

Examples of Modern-Day Health Disparities

1. **United States**:
    - **Maternal Mortality**: Black women face a significantly higher maternal mortality rate compared to White women, with a rate 3.6 times higher than that of White women [31]. This disparity persists despite advancements in healthcare.
2. **Brazil**:
    - **Maternal Mortality**: Black women in Brazil experience much higher maternal mortality rates compared to White women, illustrating ongoing racial disparities in health outcomes despite the implementation of universal healthcare [31].
3. **United Kingdom**:
    - **Maternal Mortality**: Black women in the UK have a greater than five-fold increased risk of maternal mortality compared to White women [31]. This highlights the need for targeted interventions to address these disparities.
4. **Netherlands**:
    - **Health Outcomes for Immigrants**: Non-Western immigrant women in the Netherlands have a higher risk of severe morbidity compared to native Dutch women, with Saharan African women facing the greatest risk [31].

Addressing Health Disparities:

Efforts to address health disparities must go beyond acknowledging historical context and include a nuanced understanding of how race and ethnicity interact with other social factors. Medical education and policy development should focus on:

- **Avoiding Stereotyping**: Recognizing that individuals within racial and ethnic groups have diverse experiences and that health disparities are influenced by multiple, intersecting factors.
- **Contextual Understanding**: Tailoring interventions and research to the specific regional and cultural contexts in which disparities occur.
- **Intersectional Approaches**: Considering how overlapping inequities, such as those related to gender, socioeconomic status, and other factors, impact health outcomes.

By incorporating these principles into healthcare practice and research, future medical professionals can better address the complex and multifaceted nature of health disparities and work toward more equitable health outcomes for all individuals [32].

Conclusion

Addressing health disparities and inequities is imperative for advancing global healthcare towards fairness and inclusivity. The review highlights that while health disparities reflect significant differences in health outcomes between groups, health inequities pertain to avoidable and systemic injustices rooted in social conditions. Historical injustices, such as colonialism and the trans-Atlantic slave trade, have left enduring legacies that perpetuate health inequities. These historical factors intersect with contemporary issues, including structural racism and socio-economic disparities, compounding health outcomes for marginalized populations. The case studies reviewed from various countries underscore that health disparities are not confined to a single region or population but are a global issue with localized manifestations. For instance, maternal mortality rates among Black women in the United States and Brazil reveal persistent racial disparities despite advances in healthcare systems. Similarly, immigrant health disparities in the Netherlands and the legacy of discriminatory practices in the UK further illustrate how systemic factors contribute to health inequities. To effectively address these disparities, medical education must evolve to integrate a nuanced understanding of historical and current contexts. Future healthcare professionals need to be trained to recognize and confront the complex interplay of race, ethnicity, socio-economic status, and other social determinants in shaping health outcomes. This includes avoiding stereotypes and acknowledging the diverse experiences within racial and ethnic groups. Moreover, policies and practices must be tailored to address specific regional and cultural contexts, considering the intersecting factors that impact health. By fostering an intersectional approach and emphasizing the importance of contextualized interventions, healthcare systems can move towards more equitable outcomes. This comprehensive understanding and commitment to systemic change are essential for reducing health disparities and promoting health equity on a global scale.

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مواجهة الفجوات في الرعاية الطبية: فحص شامل للفجوات الصحية العالمية

الملخص:

الخلفية :تستمر الفجوات الصحية وعدم المساواة في الرعاية الصحية على مستوى العالم، مما يؤثر بشكل كبير على المجموعات العرقية والإثنية المهمشة. يجب على المؤسسات الطبية والمعلمين معالجة هذه القضايا لتعزيز نظام رعاية صحية أكثر عدلاً.

الهدف :يهدف هذا الفصل إلى استكشاف تعريفات وتداعيات الفجوات الصحية وعدم المساواة، مع التأكيد على الحاجة إلى فهم شامل في التعليم الطبي للتصدي لهذه التحديات بفعالية.

الطرق :يستعرض الفصل التعريفات من المنظمات الصحية الرائدة ويقوم بفحص دراسات حالة من دول مختلفة لتسليط الضوء على تأثير العوامل التاريخية والهيكلية والاجتماعية على نتائج الصحة. يتم مناقشة المنهجيات المستخدمة لقياس هذه الفجوات، بما في ذلك الأساليب الكمية والنوعية.

النتائج :تنشأ الفجوات الصحية غالبًا من التحيزات النظامية والمؤسسية، حيث تواصل الظلم التاريخي مثل الاستعمار والعبودية التأثير على نتائج الصحة الحديثة. توضح دراسات الحالة من الولايات المتحدة والبرازيل والمملكة المتحدة وهولندا الفجوات المستمرة في وفيات الأمهات وغيرها من نتائج الصحة.

الاستنتاج :يتطلب معالجة الفجوات الصحية فهم السياقات التاريخية والعوامل الهيكلية والعوامل الاجتماعية المحددة للصحة. يجب أن يتطور التعليم الطبي لدمج هذه العناصر لتزويد المهنيين الصحيين في المستقبل بالمهارات اللازمة لمكافحة هذه الفجوات بفعالية.

الكلمات الرئيسية :الفجوات الصحية، عدم المساواة الصحية، العوامل الاجتماعية المحددة للصحة، التعليم الطبي، عدم المساواة الصحية العالمية، العنصرية الهيكلية، التحيز النظامي.