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Inadequate Access to Healthy Opportunities and Structural Violence: A Case Study of Health Disparities among Hispanics in McLean County

Cecilia Montesdeoca

Introduction

Significant disproportionate human suffering is experienced by socially disadvantaged populations as a result of preventable difference in the burden of disease, injury, violence, and/or opportunities to achieve optimal health. Disparities in health refer to differences between two or more population groups in health outcomes and in the prevalence, incidence, or burden of disease, disability, injury, or death (CNHEOa 2013). Health disparities are discriminatory and are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources (CDC 2007). While such disparities are more visible when comparing health status of whole countries, they are also embedded in the structure within individual countries and even with local communities.

In this thesis I argue that significant health disparities exist between ethnic-minorities and whites in the United States as a result of social and governmental structures, such as national and local policies and lack of accessibility to community social services. Structures that allow such indirect yet noteworthy forms of human suffering are forms of structural violence. On various structural levels, scholars, policy makers, and ordinary people alike, must recognize health disparities as an issue of injustice for the specific groups subjected to systematic racial discrimination.

First, I explore the value of health care in the United States, and then examine differences in health statuses in various social determinants among ethnic-minorities and whites in the United States. Second, I discuss how barriers of inadequate access of healthier opportunities are an act of structural violence. Thirdly, I provide a small case study of health disparities among Hispanics in McLean County Illinois where the Hispanic population has significantly increased in recent years in a predominately white community. Lastly, I explore innovated strategies to eliminate health disparities and strive for health equity. I conclude that (1) health care is fundamentally an ethical issue and a matter of basic human rights, (2) health disparities can be viewed as an act of structural violence and exist on various structural levels, including the community level, and (3) health disparities can be reduced and eventually eliminated by advancing policies, programs or practices that address factors that impact health.

Healthcare in the United States

The United States society is currently embroiled in a battle for the right to accessible and affordable healthier opportunities for all Americans. Among many issues in the U.S., accessible health care opportunities ranks among the top. Some measures have been taken to accommodate for specific needs of low income families, many of whom are ethnic-minority groups, with outreach programs (Head Start, WIC, etc.) and a call for cultural competent initiatives. While these concepts of outreach and cultural competency do assist in making the health care experience more accommodating to some degree, they fail to address the underlying causes of the disproportionate frequency of disease, healthy opportunities, and human suffering.

The racial/ethnic hierarchy that exists in the U.S. healthcare system is not coincidental. It is important to recognize that ideology and public policy are critically linked. Bello et al (1994) suggests that the hierarchy is a complex social process where certain often-unspoken ideologies mediate between interests and policy. Such ideologies manifest in structures that allow few to access a very high quality of life while simultaneously leaving many excluded. While many public health officials are aware of the evident differences in the access and quality of health among various populations, little is done to address the root causes of such inequalities. In public health, these dimensions of socioeconomic differences are referred to as the *social determinants of health*. These social determinants are factors of measurement that include how poverty level, literacy rate, transportation, housing, and crime and violence significantly impact how various ethnic groups interact and reciprocate with their environment on a daily basis. While national political platforms, such as the republican platform, “believe that taking care of one’s health is an individual responsibility” and have attempted to repeal Obamacare thirty-six times by March 2013 on the basis of “In our [republican] view the entire Act before us is invalid in its entirety” (GOP 2012); the statistics of social determinants of health reveal that it is nearly impossible for some population groups to climb up the socioeconomic ladder to achieve and maintain an optimal level of health.

In comparison, the democratic platform on national healthcare is that access to healthcare is a shared social responsibility that can be achieved by having access to affordable health care. These values were the basis for the enactment of the historic Affordable Care Act that sought to correct a healthcare system that was the cause of many people losing their homes, jobs and savings (Democratic National Platform 2012). Democrats “believe accessible, affordable, high quality health care is part of the American promise, that Americans should have the security that comes with good health care, and that no one should go broke because they get sick” (Democratic National Platform 2012).

While the United States as a country might hesitate to make the bold claim of health as a human right, more progressive thinkers already have. In 1984, the General Assembly of the United Nations (UN) adopted The Universal Declaration of Human Rights, Article 25 which states: “ Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or lack of livelihood in circumstances beyond his control.” In 1944 Franklin D. Roosevelt advocated a right for medical access in his proposal for a Second Bill of Rights. The World Health Organization (WHO) followed the UN’s lead and in 1946 when they declared that one of the fundamental rights of every human being is to enjoy “the highest attainable standard of health.” The UN took larger strides toward health as a human right with the addition of Article 12 of the International Covenant of Economic, Social and Cultural Rights in 1966, which guarantees the “right of everyone to the enjoyment of the highest attainable standard of health.” Some nations, such as Sweden, have already taken the moral high in calming that health as a human right with the reasoning that “In order for a person to be able to live a decent and dignified life, the right to health must be satisfied” (Regeringens webbplats om mänskliga rättigheter 2013).

Some American politicians have already demonstrated commitment to the noble fight for adequate health care in efforts to enhance the quality of life of all Americans. Senator Tom Harkin of Iowa stated in a press release in 2004 stating “We must give people the

tools they need to stay healthy and stay out of the hospital. It is time to reorient our health care system away from a sick care system and into a genuine health care system.” As chairman of the U.S. Senate Committee on Health, Education, Labor & Pensions, Senator Harkin has been a long time advocate for the impact of health to be incorporated in all policies, recognizing that health is an intricate part of life and is valuable tool for success.

SOCIAL DETERMINANTS OF RACIAL/ETHNIC HEALTH DISPARITIES

Racial/ethnic discrimination is one of the most experienced social determinants in health disparities. Racism occurs at multiple levels including cultural, institutional, personal, and internal (Jones 2000). “Cultural and institutional racism do not require intent but are inherent in the policies and procedures of the organizations and thinking of many of the individuals in positions of authority (Price, McKinney & Brown 2010:2).” Health professionals are widely aware the health status of ethnic populations vary and target the factors that influence health status for particular racial/ethnic groups. However, little acknowledgment is given to the role of racial/ethnic discrimination as a root cause of health disparities. Racism is something that is learned and in turn can be unlearned. The consequences of racism not only impact racial/ethnic minority groups, but society as a whole. Policy makers and common day discourse must recognize that racism still exists. Statistics demonstrate how racial/ethnic minorities in the United States suffer disproportionately from Whites in nearly every category. These statistics validate a need for health care reform and a call for social justice.

In Schulman et al. (1999) study on the effect of race and sex on physicians recommendations for cardiac catheterization found that a patients race and sex influence a physicians recommendations regardless of the patient’s clinical characteristics.

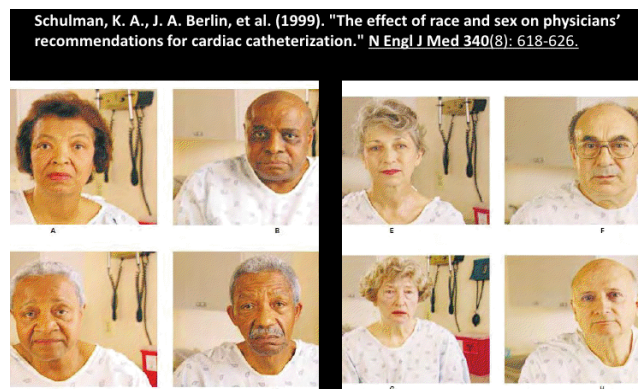


Figure 1

These actors (Figure 1) that posed as patients were clothed identically, were provided recited identical scripts and yet were provided different recommendations due to race and sex. Schulman et al. discussed how a sort of bias on the part of the physicians might have occurred and that bias could not be assessed in such a study. He suggests that such a bias is most likely the result of subconscious perceptions rather than deliberate actions or thoughts.

Poverty rates vary by racial/ethnic groups, with 25.8% of African Americans in poverty, 25.3% of Hispanics and only 9.4% of Whites (Rank 2009). While there are various categories of poverty, severe poverty (50% or less of poverty threshold (Price, McKinney & Brown 2010:3). This form of poverty affects racial/ethnic minority children

more than White children, with 45% of all African Americans in severe poverty being children and 44% of all Hispanics (Woolf et al.). Families and individuals like who experience severe poverty often cannot provide the most basic needs and are vulnerable to inadequate nutrition, growth development, educational success, cognitive skills, and quality of parenting (Woolf et al. 2006). While many families and individuals circle in and out of poverty, “Those who are poor at birth compared to those not poor at birth, are 5 times more likely to be poor as a young adult (ages 25-30), 3 times more likely to not graduate from high school, and 3 times more likely to have a teenage pregnancy (Price, McKinney & Brown 2010:4).

There are numerous challenges in eliminating health disparities. Thomas et al. (2011) describe certain dangers in assumptions that are made regarding health disparities among ethnic-minorities. One is that racism is not relevant in the scientific pursuit of solutions for the elimination of health disparities. As discussed above, we can see how racism is embedded in personal prejudice and over arching structures. Another danger is that some populations will always suffer premature illness and death by culture of their culture bound lifestyle choices. We can relate this back to the issue of poverty. For those in poverty, their selection of options is severely limited when compared to those of higher income that can afford a healthier option. This concept of culture bound lifestyle choices expands into the idea that the elimination of disparities is impossible and health equity (the attainment of the highest level of health for all people) unachievable in a free market society. By encompassing health in all forms of policy with the goal of health equity, social justice, equality opportunity and community well-being will all advance.

Inadequate Access to Health Care: An Act of Structural Violence

Norwegian peace researcher and founder of contemporary peace and conflict studies Johan Galtung first proposed the theory of structural violence in his 1969 article *Violence, Peace and Peace Research*. Galtung referred to structural violence as violence that results in harm but is not caused by a clearly identifiable actor and positive peace is the absence of structural violence. Medical anthropologist, physician and activist Paul Farmer popularize the term structural violence in relation to health in his 2003 publication title *Pathologies of Power*.

Farmer’s (1999) work relates to issues of human agency behind suffering, specifically structural violence. Structural violence refers to systematic ways in which social structures harm or otherwise disadvantage individuals and usually has no specific person who can (or will) be held responsible (in contrast to behavioral violence). According to Farmer (1999):

Structural violence is one way of describing social arrangements that put individuals and populations in harm’s way... The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people ... neither culture nor pure individual will is at fault; rather, historically given (and often economically driven) processes and forces conspire to constrain individual agency. Structural violence is visited upon all those whose social status denies them access to the fruits of scientific and social progress.

Physical violence is direct, while economic, political, and cultural violence are indirect

forms of silenced harm. It is a type of harm imposed by some people ranked below others through an unequal and unjust social system. To bring this into better perspective, Clements discusses an act of structural violence:

A guerrilla in El Salvador explained the concept to an American volunteer physician this way: ‘You gringos are always worried about violence done with machine guns and machetes. But there is another kind of violence that you must be aware of, too. I used to work on the hacienda. . . . My job was to take care of the *dueño*’s dogs. I gave them meat and bowls of milk, food that I couldn’t give my own family. When the dogs were sick, I took them to the veterinarian in Suchitot or San Salvador. When my children were sick, the *dueño* gave me his sympathy, but not medicine as they died. To watch your children die of sickness and hunger while you can do nothing is violence to the spirit. We have suffered that silently for too many years. Why aren’t you gringos concerned about that kind of violence?’ [Clements 1984: 259–260].

In this case, the violence comes from that fact that people are aware that they suffer disproportional suffering. Suffering that is biased and unjust due to a sense of social and economic hierarchy and discrimination. Such suffering could be prevented if there were changes made to the structures that exist.

Structural violence almost always needs to be placed in larger social context. In this example, it is not as if there are not treatment options for Salvadorans but rather the man must submit to whatever treatment the *dueño* offers. With direct violence there is a specific event, an identifiable victim, and an identifiable perpetrator. Structural violence differs in that it is not visible in specific events but noticed at the societal level as systematic shortfalls in the quality of life of certain groups of people (Kent 2006:54). In structural violence, people suffer harm indirectly, often through a slow and steady process, with no clear identifiable perpetrators.

Violence entails the use of power. Power, which is obtained through forms of violence in the fulfillment of one party’s purposes at the expense of others (Kent 2006:54). It is one thing to know the immediate causes of the massive deaths in clinic terms, but we need an understanding in social terms. Focusing on children and their families and communities alone blinds us to the ways in which their conditions reflect the policies and actions of their societies. While specific deaths may be beyond the control of immediate family member or community, such patterns of mortality can be influenced by public policy. Kent (2006) notes that the dilemma is not so much out of the bad things that have been done directly to people as out of the many good things that have not been done for them.

The problems relating to structural violence are not solely issues relating to poverty itself, but to national and international priorities. Issues surrounding structural violence are not reserved for poor countries. The infant mortality rate in the US is low, but thirty-five other countries have even lower rates (Kent 2006:58). More than twenty percent of the children in the US are under the official poverty line, this is not because the US is a poor country rather the combination of social determinants of health and structural violence (Kent 2006:54). One example is the significantly high infant mortality rates of the seventh district of Chicago. The seventh district is renowned as being home of some of Chicago’s greatest sports teams, twenty-one hospitals, dozens of clinics and many world class research institutions and medical schools. Yet, this district also includes some of the most medically underserved communities in America, with some communities experiencing

infant mortality rates comparable to third world countries (Rep. Danny K Davis 2013).

Farmer argues in *Pathologies of Power* (1999) that “conventional” human rights violations are patterns along the same fault lines as infectious disease. The spread of infectious diseases are symptoms of deeper pathologies of power and “linked” intimately to the social conditions that so often determine who will suffer abuse and who will be shielded from harm (Farmer 1999: 7). Public health and access to medical care are social and economic rights that are every bit as critical as civil rights. One of the great ironies of the global era, in which public health has increasingly sacrificed equity for efficacy, has been the rejection by the poor of separate standards of care (Farmer 1999: 1487). By recasting health as a human rights issue, the unequal distribution of disease can to some extent be redressed. The literature of *Pathologies of Power, Infections and Inequalities* (2003) highlights how instead of viewing illness distribution and treatment choice as a result of cultural difference, it should be viewed as a result of structural violence.

While common discourse is that the formation of unhealthy habits and lack of education derives from cultural difference, it is a matter of lack of opportunity. The Hispanic population in the United States has received much attention in the media over the past years for their growing demographics. In the past year with President Obama’s introduction of the Affordable Care Act, steps have been made towards a universal health care system. Some may argue that undocumented Hispanics or those of lower income do not deserve participation in such a health care system because of their lack of language skills and/or employment. Yet, to deny them the opportunity to health care services is to deny them the chance of a higher quality of health.

As mentioned previously, such health inequalities occur on various levels. However, it is often overlooked that such inequalities occur on the local level within the United States.

McLean County, Illinois has experienced exceptional growth of the Hispanic population since 1990 when compared to its surround counties (Figures 2 & 3). McLean County is the largest county by land area in the state of Illinois and includes the Bloomington-Normal area.

According to the 2010 census, the population had increased by 12.7% from 2000 with a population of 169,572. The 2012 census population estimate is now at 172,281. The 2011 census racial makeup of the county is predominantly White (85.5 %).

The ethnic minority groups include Blacks (7.6%), (.3%), Asians (4.5%), and Hispanics (24.6%). With lack of access to opportunities to adequate health care I will explore how health disparities among Hispanic

McLean County – Latino Growth

| | 1990 | 2000 | 2010 |
|---|---------|-------------------------|-------------------------|
| Latino Population | 1,671 | 3,833 | 7,434 |
| Total County Population | 129,180 | 150,433 | 169,572 |
| Latinos as Percent of County Population | 1% | 3% | 4% |
| | | Change from 1990 | Change from 2000 |
| Latino Population Change | | 2,162 | 3,601 |
| Percent Change in Latino Population | | 129% | 94% |

2000 Census – County Comparison

| 2000 | McLean | Peoria | Champaign |
|---|-------------------------|-------------------------|-------------------------|
| Latino Population | 3,833 | 3,827 | 5,203 |
| Total County Population | 150,433 | 183,435 | 179,669 |
| Latinos as Percent of County Population | 3% | 2% | 3% |
| | Change from 1990 | Change from 1990 | Change from 1990 |
| Latino Population Change | 2,162 | 1,231 | 1,718 |
| Percent Change in Latino Population | 129% | 47% | 49% |

2010 Census – County Comparison

| 2010 | McLean | Peoria | Champaign |
|---|-------------------------|-------------------------|-------------------------|
| Latino Population | 7,434 | 7,102 | 10,607 |
| Total County Population | 169,572 | 186,494 | 201,081 |
| Latinos as Percent of County Population | 4% | 4% | 5% |
| | Change from 2000 | Change from 2000 | Change from 2000 |
| Latino Population Change | 3,601 | 3,275 | 5,404 |
| Percent Change in Latino Population | 94% | 86% | 103% |

Figure 2

Figure 3

METHODS AND DATA COLLECTION

The methods research my data included three key informant interviews. All of the interviewees could be considered leaders in the local Hispanic community. They each represent organizations that work towards Hispanic outreach, and are of Hispanic origin themselves. The three organizations/institutions that were represented are Western Avenue Hispanic Outreach Center, Conexiones Latinas de McLean County, and Illinois State University's Latino Studies Outreach sector. Through these interviews a themed approach was used to triangulate qualitative data and identify common themes.

Other forms of data for analysis included the *Hispanic and Latino Community Study: Needs and Assets* (Conexiones Latinas 2009), *County Health Rankings & Roadmaps* (Robert Wood Johnson Foundation 2013), and *IPLAN Community Health Plan* (McLean County Public Health Department 2013).

LIMITATIONS

- Time available for thesis research as a semester long project.
- Case study of McLean County provides a narrow scope of health disparities among Hispanics in the United States and is not to be generalized.
- Number of people able to communicate with was limited.
- Was not able to have time to conduct interviews with members of the McLean County Public Health Department. However, through analysis of other data, I do not suspect any great difference in their perspective.

STRUCTURAL VIOLENCE ON A LOCAL LEVEL: KEY FINDINGS OF HEALTH DISPARITIES IN MCLEAN COUNTY ILLINOIS

Health Disparities Themes among Hispanics in McLean County

The interviews conducted provided exceptional insight as to what it is to be a Hispanic in McLean County three grassroots community organizations (Western Avenue Community Center, Conexiones Latinas, and Latinos United for Change (Latinos Unidos para Cambio)) have been established to assist the needs of individuals and families in the Hispanic community. Latinos United for Change is the most recent addition to local initiatives and was established in 2008. Their focus resides in the growing national discourse of Immigration reform. The mission of the organization is to empower Latinos

and new immigrants to become full partners in the local, state and national dialogue on justice issues that affect their future. The Hispanic Outreach Program at Western Avenue Community Center provides social services, interpretation/translation and counseling for Spanish speaking residents in the area. The program has been serving the local community for over twenty years and currently serves a population of over 5,000.

Conexiones Latinas is perhaps the most integrated and holistic organization among the McLean county community. The nature of the creation and development of this organization was brought upon by the recognition of public officials to reach out to the Hispanic community. In 2004, McLean County Judge Ronald Dozier demonstrated a growing concern for Hispanic families he saw unsuccessfully trying to navigate a complicated legal and non-profit system. A social service providers meeting was convinced to discuss and address the conditions of Hispanic families in the local community through an initiative through Hispanic State Farm staff. The group was initially called Hispanic Families Work Group (HFWG), a volunteer group with the intent of building a stronger community that embraced the Hispanic community and Latino families. Over the past six years the organization has grown to include over one hundred individuals from over forty organizations throughout McLean County. The main purpose of Conexiones Latinas is to encourage collaboration by sharing information on community services, events, news, and resources through community initiatives and social media. With their network they work to identify gaps in the community and pull local resources together to create recommendations and implement solutions.

In the fall of 2006, Illinois State University and State Farm began to discuss a partnership to complete a comprehensive analysis of the Hispanic and Latino community in Bloomington-Normal, McLean County, IL. This analysis was provoked by a reliance on out dated information and lack of local comprehensive scope. Population growth was also a factor in expediting this assessment. The majority of, at the time, recent Hispanic and Latino population growth in McLean County occurred between 1990 and 2000 and that growth more than double the population increase of all groups combined for McLean County. The needs assessment focused on five areas (education, housing, health, social services, and employment) that the steering committee, community members, and stakeholders deemed important to research. In their findings the community feedback demonstrated that some of the topics the steering team believed to be most critical were secondary or less significant issues.

Upon completion of the three key informant interviews and analyzing other documentation, I have come to identify common themes of health disparities among Hispanics in McLean County that demonstrate how the five focus areas of the steering committee are not necessarily significant issues. These themes were overlapped in the interviews and documents and represent the holistic issues the Hispanic population must face. The following are all themes expressed during the interviews and data collection for the local Hispanic community:

- Insurance (For-profit issue)
- Healthcare (Medical issue)
- Bilingual interrupters (Non-profit issue)
- Legal problems (City and government issue)
- Education (City and government issue)
- Communication / Cultural competency (Non-profit issue)

- Transportation (City and government issue)
- Finance (For-profit issue)

It is important to note that all of the interviewees were in agreement that the Hispanic community is at a disadvantage because of the “system” they are in. The term system referred to the social and political culture and policies that impact their everyday life. While none of the key informants had heard of the term structural violence, they found it fitting to describe the occurrence of health disparities among the Hispanics community. They recognized that such inequalities are a holistic issue and need to be approached as such and that essential the collection of barriers experienced leads to a lower quality of health. An example provided by one of the interviews, outlined how many of the above-mentioned categories overlap. He began by describing how on the south side of Bloomington, just past the exit to go to Champaign, IL, there is a trailer park community that some refer to as Little Mexico because of the dense Mexican population. The trailer park is just outside of the city limits and the Bloomington-Normal public transportation system cannot be accessed there. Therefore many Hispanics were driving without a license to go to work. He described the likely reason for them not having a license was because of being undocumented or affordability. It became known that this was happening and police would intentionally go there and wait outside of the trailer park to stop and ticket Hispanics without a license, many of whom were uninsured or undocumented.

In many cases this led to being fired for regularly not being to work on time, if the transportation was lacking. It also led to many court cases for driving without a license, and for others led further investigations into their legal status. With lack of employment and court fines they were not as able to provide for their families, which impacted their children’s education and other financial obligations such as housing, utilities, and car payments. In turn, that affects their overall quality of health and childhood development. Potentially they could drop out of school early to get a low paying job in order help their family financially, only to be caught in this cycle once more.

The interviewees provided many similar scenarios about how one problem for a Hispanic in McLean County is indeed a combination of various problems. Two of the three interviews described such structural disadvantages as racism. However, important to note is that such racism was do to lack of cultural awareness; that there was a lack in recognizing that not everyone is on the same playing field. One interviewee described how this local racism was present because the area had not yet caught up with the shift in the growing Hispanic population and serving their needs and that Bloomington-Normal was 10-15years behind Chicago in term so perception of racism towards minorities.

An example was also provided regarding a situation at the Bloomington Public Library and unsuccessful outreach attempt to the Hispanic population. A few years ago the library had created a section of books in Spanish in hopes that more Latinos would utilize the library’s resources. For months they were disappointed in the low turn out. It wasn’t until a Hispanic individual pointed out that if the section was labeled *Libros en Español* as opposed to *Books in Spanish*, the Spanish readers would be able to clearly identify that they would be able to read the materials. The individual was also asked why they thought Hispanics didn’t want to come to the library. He responded that many people didn’t know that it’s a free public service because many Hispanics come from very small communities in Latin America where there is not likely to be a library, or one that offers more than just books. Another factor he brought up was that some people

feared having to present documentation regarding their legal status to gain library membership when all they actually need is to provide their local address. In this situation the perception of barriers to gain access to the public library, and the library's miscommunication of advertising towards Spanish speakers limited the utilization of a service geared to the Hispanic community. This lack of cultural competency from both sides inhibits promotion of community services and accessibility.

As described in these examples, the selection of choices to make daily are limited to the options provided by the community. County Health Rankings & Roadmaps ranks almost all counties in the U.S. and allows for counties to share resources and learn from one another. Here is some data collected from their McLean County report. In McLean County, 14% of children live in poverty that limits their ability to live in a housing area that is less inclined towards violence and crime and attend a school that is resource plenty. With 12% of residence experiencing inadequate social support, they might feel incapable of getting assistance to help combat their socioeconomic issues. The combination of 45% of restaurants in McLean County are fast food restaurants, a 24% of physical activity and a 30% rate of adult obesity is a concern within itself. Now to imagine being put into such an environment on an even lower playing field as a ethnic/minority than whites, creating a new level of inadequate opportunities to a healthy lifestyle.

Priorities of McLean County Public Health Department & Health Disparities

Health and economic disparities are mentioned in various reports and health assessments collectively published in the McLean County and IPLAN Community Health Plan. The IPLAN consists of the Community Health Plan 2012-2017 and the Background and Resources for Applicants. The purpose of the county-wide community health plan (CHP) is to improve the health of McLean County residents by developing partnerships to implement CHP strategies, encourage health awareness, and promote healthy lifestyle choices that can reduce the risk of death and disability and improve health. In Illinois, all local health departments must have a five-year community health plan in place, 1) to provide direction for the jurisdiction as it addresses local health concerns, and 2) to meet certification requirements in Illinois, as indicated in Section 600.400 Priority scores for the chosen three health concerns were: obesity, mental health, and oral health.

Throughout the one hundred and twenty eight page document, the term minority populations/groups was only addressed three times. The term Hispanic is only addressed ten times. A mere three bullets are dedicated to describe the economic disparities among race/ethnic groups in McLean County: (1) More people are enrolled in Medicaid benefits than years in the past, (2) Blacks and Hispanics live in greater poverty than white population, (3) Median income for single parent households is significantly less than that of county-wide median household income (IPLAN 2012). In relation to race/ethnic demographics, the greatest change seen in the county between 2000 and the 2010 Census occurred in the Hispanic and Asian/Pac. Isl. Population where the percent change was 98.4% and 130.8% respectively. However, total percent of the population make-up of minority groups remains relatively small. Minority populations including Hispanic, Asian American, and Pacific Islander have slowed since 1980-1990. However in 2000-2010, minority populations have significantly increased than in 1990-2000.

While health and economic disparities are mentioned, no approach or plan is provided in regards to how to eliminate these disparities in the McLean County community. This is an important finding when questioning the priority of all people county. These priorities are likely to be made out of efforts towards the majority population in McLean county

whom are white. But how does this public health department reaching out to enhance the quality of health of all residence? Questions remain as to the selection of healthy priorities as being selected due to financial burden, local politics, or unexamined prejudice towards ethnic/minority groups.

INNOVATIVE STRATEGIES TO ADDRESSING DISPARTIY

Understand holistic dynamics of health disparities

By examining the examples previously mentioned, it is impossible to pinpoint one category that disadvantages a community. The problem is that health disparities are the result of a holistic disadvantage by a population. “We need to understand the reasons for why racial/ethnic health disparities have been with us for a very long time, and the primary reasons are difference in social determinants of health across the life course” (Price, McKinney & Brown 2010:10). While striving to enhance the quality of health among Americans is important, simply providing access to care does not recognize the necessary broader policy changes needed to reduce health care disparities.

Examining and understanding the impact of social determinants of health play in the life course of health status can help guide educational interventions and public polices in reducing racial/ethnic health disparities. “We can no longer place the responsibility for adverse health outcomes solely on individuals health behaviors to eradicate the considerable racial/ethnic health care disparities that continues to exist in the United States today” (Price, McKinney and Brown 2010:2).

Healthy People is an initiative managed by the Office of Disease Prevention and Health Promotion (ODPHP) within the U.S. Department of Health and Human Services (HHS) which provides science-based, 10-year national objectives for improving the health of all Americans. *Healthy People 2020* tracks approximately 1,200 objectives organized into 42 topic areas, each of which represents an important public health area. One of the leading goals of *Healthy People 2010* was to eliminate health disparities among various segments. Over the past three decades, Healthy People has established benchmarks and monitored progress over time in order to: (1) Encourage collaborations across communities and sectors, (2) Empower individuals toward making informed health decisions, and (3) Measure the impact of prevention activates. Achieve health equity, eliminate disparities, and improve the health of all groups has also been established as a leading goal for the present *Healthy People2020*. Determinants of health have been called upon to be one of the four foundation health measures that will serve as indicators of progress towards achieving said goals.

Healthy People define social determinants of health as conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Social determinants of health involve a variety of contextual factors such as socioeconomic status, discrimination, education levels, housing, transportation, and crime and violence, all of which play a casual link in subsequent adult disease (Price, McKinney & Brown 2010). Price, McKinney & Brown (2010) argue that too many racial/ethnic minorities do not reach their full potential for a healthy rewarding life because of the unjust and unnecessary inequalities in well-being. “Current health interventions, including health education/health promotion, are focusing on downstream interventions that are not likely to eliminate health inequalities. We need a new focus on the social determinants of health

(upstream)” (Price, McKinney & Brown 2010).

Ethical Focus

Inadequate access to healthy opportunities limits peoples potential to achieve their optimal level of health. Hindering the resource options of populations limits their ability to be accessed by the very people they are meant to help. Social services, and adequate access to healthy opportunities is the tool for a healthy lifestyle. However, millions don't have access to this tool because of the structure they were born into, and structure where they were not meant to succeed. The term “unhealthy” may seem generic, but it can lead to a greater frequency of preventable diseases, inescapable costly treatments, and even unnecessary premature deaths. Price, McKinney & Brown (2010) propose multiple solutions for reducing racial/ethnic health disparities which require both poverty and racism to be central themes for interventions. First, we must move away from the American cultural theme of individualism and toward a sense of shared responsibility. We must approach healthcare with a “moral focus” and guarantee minimal levels of income, basic housing, education, food, and health care for all peoples. Second, they call for an immediate expansion of Head Start and Early Head Start available to every disadvantaged child to sooner provide children with the tools to successfully navigate through schooling. They urge to require all schools have a coordinated school health program which includes school health services, comprehensive health education, mental health and social services, etc. to improve overall health of American youths. Increasing the number of extra-curricular activities at the community-based level in disadvantaged communities could provide safe and structured mentorships relationships with adult role models.

Further proposals are attributed directly to public health policy. They call for single adult low-income workers to be eligible for Medicaid if their employer does not offer insurance for their employees. Expansion in childcare support for women who work in low-skilled jobs is also proposed recognizing that the costs of child care remains one of the most difficult barriers for low-income mothers.

Cultural Competency

The importance of “culture” in U.S. biomedicine has received increased attention over the last several decades as a result of significant demographic changes, especially immigration from Latin American. There have been recent calls for enhancing “cultural competence” due to the significant health disparities among racial and ethnic groups (Jenks 2011). Advocates of cultural competency have argued that health care providers and institutions must address the cultural and linguistic barriers that prevent some patients from accessing good care (Brach and Fraserirector 2000; Betancourt et al. 2005). In 2001, the Office of Minority Health (OMH) established national Culturally and Linguistically Appropriate Services (CLAS) standards, a series of 14 requirements and recommendations organized by themes relating to culturally competent care, language access services and organizational supports for cultural competence (OMH 2001). “Cultural competence refers to a diverse range of activities, from the use of interpreters and translated materials to communicate with limited English proficient (LEP) patients to the recruitment of providers from underrepresented racial or ethnic groups and the creation of ethnically specialized clinics (Jenks 2011:210).”

Jenks (2011) claims that medical anthropology can contribute to the further development of a more culturally competent health system. “An increased emphasis on

the culture of providers can simultaneously reinforce the unmarked nature of the culture of biomedicine and prevent an analysis of the role of bias and prejudice in health care, undermining the central purpose of cultural competence efforts” (Jenks 2011:230). Jenks (2011) article uses an ethnographic examination of cultural competence training to highlight recent efforts to develop more nuanced approaches to teaching culture.

Viswanath and Ackerson (2011) sought to examine the substantial social disparities in health knowledge that may be related to media use. The purpose of this study was to investigate how the use of cancer-related health communications is patterned by race, ethnicity, language, and social class. In a nationally-representative cross-sectional telephone survey, 5,187 U.S. adults provided information about demographic characteristics, cancer information seeking, and attention to and trust in health information from television, radio, newspaper, magazines, and the Internet. Viswanath & Ackerson found that health media use is patterned by race, ethnicity, language and social class. Taking into account factors associated with social determinants may contribute to addressing social disparities in health. These factors provide greater access to and enhancing the quality of health media by. The data from their research demonstrates that important social determinants such as race, ethnicity, language, and social class has been found to influence health outcomes and are also strongly linked to health communication behaviors such as cancer information seeking, attention to health in the media, and trust in cancer information from communication sources. The data also points out potential ways to reach the underserved to bridge current disparities in health by improving access to and quality of the health information for socially marginalized groups. These characteristics of understanding a community has played in important role in community public healthy theory. While many public health theories share similar constructs, what varies is the tailored approach each creates to better serve a given community.

Health in all polices perspective

As we have previously discussed there are numerous daily factors that impact the overall quality of people’s health. By enhancing the environment in which people live, and accommodating them to be able to make healthier choices, policy makers have the potential to eliminate health disparities. While the concept of Health in All Policies (HiAP) was first introduced by the Finnish European Union Presidency in 2006 it is coming to back its first appearances in American politics. This approach was brought forth through the acknowledgement that both old and emerging major diseases share mainly the same risk factors. And that “Instead of seeing major diseases as a challenge to the health sector only, HiAP highlights the fact that the risk factors of major disease, or the determinants of health, are modified by measure that are often managed by other government sectors as well as by other actors in society. Broader societal health determinants – above all, education, employment and the environment – influence the distribution of risk factors among population groups thereby resulting in health inequalities” (Health in All Polices 2006).

While HiAP has already become an integrated concept in some state policies such as California, it is beginning to shed light on a national level through the Healthier Lifestyles and Prevention America Act (HeLP America Act). Iowan Senator Tom Harking introduced the HeLP America Act in January 2013. The bill outlines critical public health and prevention initiatives to fight chronic disease, encourage healthier schools, communities and workplaces, and improve physical activity opportunities for individuals with disabilities (CNHEO 2013b). One manner in which HiAP occurs in

requiring the Department of Health and Human Services to conduct health impact assessments of major non-health legislative proposals and to detail staff to other departments to assist them with consideration of health impacts of their activities (CNHEOb 2013). Another example is the creation of recommendations for standards for food marketed to children. Progressive policies such as the HeLP America act make a case for prevention and demonstrate how increasing funding and spending in public health leads to declines in preventable diseases and deaths for all Americans.

CONCLUSION

In this thesis I have argued that significant health disparities exist between ethnic-minorities and whites in the United States as a result of social and governmental structures, such as national and local policies and lack of accessibility to community social services. Structures that allow such indirect yet essentially intentional forms of human suffering can be considered forms of structural violence. Forms of such systematic violence can lead to a greater frequency of preventable diseases, inescapable costly treatments, and even unnecessary premature deaths among population groups which lack accessibility to adequate healthy options as part of their daily life. On various structural levels, scholars, policy makers, and ordinary people alike, must recognize health disparities as an ethical issue of injustice for the specific groups subjected to systematic racial discrimination.

I have explored the value of health care in the United States, and highlighted differences in health statuses in various social determinants among ethnic-minorities and whites in the United States. Secondly, I discussed how barriers of inadequate access of healthier opportunities can be considered acts of structural violence which cause indirect forms of physical disproportionate suffering. Thirdly, I provided a small case study of health disparities among Hispanics in McLean County Illinois. And lastly, I explored innovated strategies to eliminate health disparities and strive for making healthy opportunities an accessible option.

Upon completion of this research project I came to three conclusions. First, health care is fundamentally an ethical issue and a matter of basic human rights. The notion that seven out of ten disease are preventable and are caused by lifestyle choices (CNHEOb 2013) is evidence enough that it the burden of injury, disease and death is unnecessary. To allow continue to leave the current environment unchanged and not accommodate for its health impact is to continue to allow people to suffer. We need to eliminate the ongoing presence of a hierarchy in health status, for all people have a right to achieve their optimal level of health. The issues surrounding health care accessibility should not be seen as a matter of independent responsibility and costs, but a matter of social justice and valuing America's health and productivity.

Second, health disparities can be viewed as an act of structural violence and exist on various structural levels, including the community level. To make the comparison of general health care status from a developed country to developing country portrays obvious strengths and weaknesses of national health care systems. However, as mentioned previous, even within major cities such as Chicago, they are experiencing infant mortality rates of low income developing countries. We must acknowledge the options, and lack of healthy opportunities that exist within our nation, state, and community. We must empathize with the members of our society who were dealt a disadvantage hand from the beginning and have make the choices they have with the

limited options that they possessed.

Last, health disparities can be reduced (and eventually eliminated) by advancing policies, programs or practices that address factors that impact health. Health goes beyond one's physical state of being. The everyday life choices we make impact our overall quality of health. People who were raised in a low-income neighborhoods likely not to have chosen to want to live there. Low-income housing is usually low-income because of its location in polluted environments or rates and reputations as being unsafe due to crime and violence. Such areas are like to have their children attend nearby public schools with limited resources where they are more likely to drop out and worked lower paying jobs. With lower paying jobs they are less likely to afford private forms of transportation. Living in areas that are food deserts (an area where a grocery store is not within walking distance), and lacking safe public spaces such as accessible playgroups and community centers that promote physical activity take away from ones ability to maintain physical health. The combination of this scenario alone includes issues of housing, crime and violence, education, employment, transportation, food options, physical activity and overall build up of unnecessary risk factors which make people more susceptible to disease and unnecessary suffering.

Recognizing health disparities as an ethical issue is the first step to advancing holistic policies that enhance Americans direct environment and allows for the healthy choice to be the easy choice. It is not the diseases themselves that make people suffer, but the environment of increased risk factors for disease and determinants of health which are products of human agency and governing sectors. Health is a human right, for to deny people of that right, is to unjustly deny them from achieving an optimal level of health.

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