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Health disparities result from lack of caring within the society. Central to nursing, caring makes the profession best suited for leadership in reducing disparities. Nursing is losing its capacity for caring. Nursing's progress in gaining status has alienated it from the needs of other oppressed groups. It has also been seduced by the scientific model and does not always use its best judgment of truths about human suffering. Research has identified unequal treatment, discrimination, workplace and social status, income inequality, and policy decisions to deplete resources as social and economic determinants of health. All involve relationships. Nursing is the profession for which relationships are primary. Nursing can rebuild the capacity for caring and social and relational practice through transforming nursing education on the principle of mutuality. Nursing can also promote nurse-managed primary care and focus on changing local, state, and national policies to increase access, equity, and health protection.

Keywords: *health disparities; access to care; caring; provider–patient relationships; consequence of inequity*

Commentary

Health Disparities: What Can Nursing Do?

Gloria R. Smith, PhD, MPH, RN, FAAN

I value the opportunity to address the issue of health disparities and its interface with the profession of nursing. Both of these subjects are close to my heart. Nothing would be more gratifying than to see my beloved profession lead and succeed in eliminating health disparities.

But many obstacles stand in the way. We know that health disparities confront us with harsh realities. Our understanding of these realities has been deepened by many thoughtful researchers into race, class, and health.

But there are other harsh realities that bear on what nursing can do to eliminate health disparities. They are harsh realities *about our profession itself* and how far it has strayed from its magnificent promise.

Nursing is losing its capacity for caring. Caring is the profession's highest qualification for addressing disparities. But this capacity is dwindling at the same time as disparities have gained some purchase on the agenda for research, policy, and practice. When its capacity for caring is healthy and intact,

Editor's Note: *The following is based on the inaugural Smith-Kellogg lecture, delivered to the American Academy of Nursing (AAN) annual meeting in Naples, Florida, in November 2002. The annual lectureship, sponsored by the American Nurses Foundation, is named in honor the lifelong contributions to nursing and public health made by the author, who is the retired vice president for health programs at the W. K. Kellogg Foundation. Dr. Smith, who is also a member of the Institute of Medicine of the National Academies, was recognized as a Living Legend at the AAN's 2007 annual meeting.*

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nursing is *the* health profession *best suited* for leadership in reducing disparities. With this capacity waning, nursing is ill-prepared for leadership.

But nursing cannot get off the hook: Its moral obligation to address health disparities remains, whatever its level of preparation. Why? Because nursing and health disparities are inextricably linked by their very natures. Nursing is the discipline for which caring—in its fullest and most elaborated and profound meaning—is absolutely central to theory and practice. In other words, if caring stops being central to nursing, nursing stops being nursing. And health disparities are, fundamentally, the result of lack of caring within society.

So the question is not just what nursing can do about health disparities. It is also what nursing can do about nursing. Can the desire to eliminate health disparities by rooting out the social disease underlying them inspire nursing to find itself again? Do health disparities write large enough for us to see what is wrong with us? Ugly, deplorable, and shameful as they are, can we, by our response, make them serve a higher purpose of reawakening caring? Is the decline of caring in nursing another manifestation of the same social disease we see expressed in health disparities? Has the premier profession for caring for others become contaminated? Is it infected by a selfishness that is gaining ground, credence, and sanction within our society?

THE DISEASE OF SELFISHNESS

Let us look at that disease for a moment, as a backdrop for looking more closely at both health disparities and nursing. Contemporary writers have tried to define this disease. In a mild form, the definition that goes around includes the term "bowling alone," coined by Robert Putnam (2000) to describe the loss of social capital and community engagement in the United States. Some say the bonds of love and trust are broken and must be restored.

Others are more willing to refer to greed and self-centeredness permitted and promoted by a written and unwritten code of materialism and economic elitism. Some believe the permission has found its way into public spending priorities and the tax code on pathways greased by political contributions. Krugman (2002) has even gone so far as to say that we live in the new Gilded Age where the 13,000 richest families have almost as much income as the 20 million poorest households. He argues that inequality has grown in America and suggests that data are deliberately reported in dubious ways to conceal the reality. He claims, for example, that most of the gains in income have gone in actuality to the top one-tenth of 1% but are reported as gains in the top 10%. Another observer has said, "We now confront a moment in history when our unifying moral and political commitments are deteriorating, and when our obsession with expanding individual freedoms outruns our concern for their appropriate use" (Shapiro, 1987, p. 68).

This general picture of social forces at work sets a context for assessing what has happened to the nursing profession and for understanding what forces have to be overcome to make headway on reducing disparities. It is sad and ironic that health disparities appear to have crept up higher on the national agenda whereas the principle of "mutuality" has been slipping down in the national conscience. The late Rhetaugh Dumas, PhD, defined the concept of "mutuality" as referring to (written communication, October 2002):

- committing ourselves to others—without the coercion of legal obligation,
- maintaining human bonds—rather than eroding them,
- serving the shared interests of the community—rather than only our own interests, and
- placing our individuality voluntarily in the service of larger objectives.

You can see that asking me to address nursing's role in eliminating health disparities has touched a nerve! The question of what nursing can do about health disparities has compelled me to say what is likely not palatable or popular. But nursing cannot make progress through denial.

I will offer some ideas that I hope will contribute to progress. These concern (a) caring in nursing, (b) the underlying nature of health disparities, and (c) what nurses can do to bring caring to the forefront in both restoring the promise of the profession and fighting health disparities.

NURSING'S LOSS OF CAPACITY FOR CARING

When I reflect back over 40 years in nursing, what I see both distresses and angers me. My profession has become so preoccupied with its own internal issues, its desire for improved status and

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recognition. As we have made progress on that scale, we have become more alienated from the needs of other oppressed groups. The more that we have achieved affluence and status, the more we have become like oppressors: caught up in our own desires.

I am reminded of a story from my days as dean of the College of Nursing at Wayne State University in Detroit. My director of student affairs was young and doctorally prepared. She came in to see me with her resignation letter in hand. She said

> You nurses talk a lot about caring, but you really don't care about people, about students. You are cruel and uncaring. I watch you with these students. I try to discuss their problems with you. You don't listen, you don't try to understand. You only care about yourselves.

The tears rolled down her face as she attempted to share with me her inability to intercede with faculty on behalf of students, particularly minority students.

I knew exactly what she was saying. When we were equally oppressed with other vulnerable groups, we had more ability to understand and were more willing to join in the fight for access to care. Nursing's voice has become more muted. I compare that voice today to when I was a student nurse. Back then, the messages were very clear: We were in service; nursing was a kind of calling.

Another telling development is that nursing has been seduced by the traditional scientific model. When I was a young student and nurse, I was told that science did not support the claim that race affected the care people received and also their health status. Rather, the problem was their lack of compliance. Why has it taken so long for the science to catch up to the obvious? Why did it take until 1985 for the federal health authorities to issue the first report acknowledging there was a problem?

With respect to the scientific model, is there actually a more correct model waiting to be discovered? The view that the sun revolved around the earth, as the center of the universe, not only persisted for centuries, it was also supported by very substantial science and pictured in a detailed model. Finally, the astronomer Copernicus brought forward a different theory to explain the phenomena. He said that the appearances in the sky, the observable movements of celestial bodies could be explained equally as well *and more simply and consistently* with a model that puts the sun at rest near the center and the earth revolving around it (Kuhn, 1957). Copernicus was able to think—and advance—that daring thought *without* having a crucial scientific datum to support him. That missing datum was a measurement of motion that could not be explained by the earth-centered model, but only by a sun-centered model. The telescope, which allowed that measurement to be taken, had not yet been invented.

If we in nursing are to understand and act on what we see before us in the suffering of humanity, we must not shortchange our own judgment. Should we always wait for permission to call our thought true until it passes a conventional scientific test that we might be well advised to be skeptical about? Should we consider some of the accepted wisdom to be amazing? For example, people in the majority middle and upper classes have all kinds of resources to meet basic needs for food, shelter, transportation, health care, and so on *as a matter of course*. These are reflected in their rank on measures of well-being. But when public health or social science takes hold of an idea to see if poor minority people would be better off if they got x, y, or z, then meeting a basic need is called an "intervention" and you have to do a controlled study to see if it makes a difference and ought to be done again. Why such interventions are not called "compensation" or "compensatory damages" I sometimes wonder. "Justice" would be a yet better term.

The reason majority middle-class people are better off is not that they snatched up all the interventions and are jealously guarding them. One might wonder whether the very model of testing certain interventions puts science in the service of preserving a status quo in which the socially and economically dominant groups have resources and the vulnerable and oppressed groups have pittances doled out to them under the euphemistic rubric of "intervention."

THE UNDERLYING NATURE OF HEALTH DISPARITIES

Health disparities produce avoidable suffering, lost productivity, and discarded human resources. They deny equal opportunity for health. But they

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are not new. They even predate the upsurge of sanctioned selfishness that has recently engaged commentators. The heightened attention given health disparities is relatively new, however. A landmark was the 1985 release of the *Report of the Secretary's Task Force on Black and Minority Health* from the U.S. Department of Health and Human Services. A body of research on health disparities and recommended strategies to address them has been growing ever since.

The research is going beyond comparative rates of morbidity and mortality to expose *unequal treatment*. Racial and ethnic bias in treatment decisions came under scrutiny by the Institute of Medicine in its report by that name published in 2002 (Smedley, Stith, & Nelson, 2002) and in a stream of studies since then. Root causes are under scrutiny in research into the social and economic determinants of health. Let us look at four of these determinants.

1. *Discrimination.* We must ponder hard what the solutions would have to be when an explanatory variable is racial discrimination. Think about the Black–White gaps in birth outcomes and other health status indicators that persist even when socioeconomic status goes up. Disparities in birth outcomes remain, for example, in the Black middle class, where educational and income gaps have been closed. The research that finds that the factor of discrimination is an important explanatory variable in this picture presents some of the most difficult of challenges (Williams, 1998). Where and how would you intervene to change this variable? Can you focus an intervention on an expectant mother to reduce the discrimination directed toward her by others in the medical encounter, the workplace, or in society? If you want to do something about discrimination, should you intervene with the person who is discriminated against or the people who are doing the discriminating?
2. *Workplace and social status.* The studies of British civil servants called the Whitehall studies show, put simply, that the higher you are in the organization, the better your health status is; the lower you are, the worse it is (Mustard, 1999). Studies of health status by social class show similar results.
3. *Income inequality.* The compelling and challenging research findings emphasize the *size of the gap* between the highest incomes and the lowest incomes. Industrialized countries, states within the United States, and U.S. metropolitan areas have been compared to each other, respectively, based on the degree of income inequality and the health status of their populations (Kaplan, Pamuk, Lynch, Cohen, & Balfour, 1999; Kennedy, Kawachi, & Prothrow-Stith, 1999; Lynch et al., 1999; Wilkinson, 1999). Comparative population health status in a state, county, or metropolitan area correlates with the comparative degree of income inequality in the area. The bigger the gap, the lower the overall population health status. All strata in a population are affected although not equally; there is a gradient in the effects based on income level. But the effects can still be seen across the whole population. Some researchers now say that, *within certain limits*, relative poverty may have more to do with health than absolute poverty does (Kawachi, Kennedy, & Wilkinson, 1999).
4. *Systematic depletion of resources.* In *A Plague on Your Houses* Drs. Deborah and Rodrick Wallace (1998) report their studies of the impact of public policies and decisions concerning fire departments on depletion of resources from inner-city areas of New York City. The loss of resources helped create the conditions for the spread of HIV/AIDS and tuberculosis those areas. Dr. Fraser Mustard (1999), a Canadian researcher, discusses failure of British financial institutions during the original Industrial Revolution to invest in the new industrial economy and the resulting negative impact on health status.
5. Each of these four areas of social and economic determinants of health fundamentally involves relationships. Discrimination is a term that describes how people treat people. Income inequality measures relationships that are closely bound to social status and access to and control over resources. Social or workplace status is a measure of relative power, recognition, and control over resources. For example, as the Wallaces documented, decision makers in New York City did not honor their duty to those who would be harmed by the ways in which they exercised control over public resources.

In speaking before Kellogg Foundation staff and grantees Dr. Ronald David inspired and enlightened with these words that revealed transcendent meaning: *Relationships are primary, all else is derivative*. This truth helps us see why relationships are the essence of the social and economic determinants of health. We can validly say, I believe, that *relationships determine health*. I also believe that Ron David's words must resound for

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nurses, recall for them who they are, and call them back to their profession, *the* health profession that is founded on the primacy of relationships!

The news about health disparities is fundamentally news about our society. The spectrum of research about health is being expanded at both ends. At one end of the spectrum, the Human Genome Project continues to break through with biological facts about life from the molecular level. At the other end of the spectrum, health disparities research is breaking through with epidemiological facts about life from the social level. It is at this level that nursing must come in as a major force for good.

SOME THINGS NURSES CAN DO TO REDUCE HEALTH DISPARITIES

If nursing is faithful to its discipline, it has unique and essential roles to play in reducing disparities. This is because nursing uses clinical practice not as an end in itself, but only as a platform for "social" or "relational" practice to promote healing and health protection. Nursing has roots in public health service in urban neighborhoods and rural communities and it has a tradition of working within patients' social context.

Nursing focuses on caring—on caring *for* people by providing education and personal services that require clinical skill but also on caring *about* people. Caring about the person infuses patient care and lifts up patients and families as they face difficulties and crises. Through caring for and caring about people, nurses help to enable patients to heal within the context of their own abilities, opportunities, and social circumstances within home, family, workplace, and community. Nurses also help families protect the health of all their members.

How can nurses begin to rebuild the capacity for caring and social and relational practice? Nurse educators can start within their institutions. The Kellogg Foundation has seen institutions of higher education change during the course of its programming. Institutional change occurred, for example, in an initiative that had the purpose of increasing the number of medical students and undergraduate nursing students who chose to go into primary care practice. Health professions schools formed partnerships with communities around training students in primary care in community sites. The partnership approach meant that the schools were not just parachuting in, finding spots to train their students. The community's interest in access also counted. The initiative was called Community Partnerships with Health Professions Education. Two examples of the outstanding results of this initiative are at Northeastern University in Boston, which reoriented its nursing curriculum, training, research, and service toward community, and made the principles of community partnership its own; and at East Tennessee State University, which achieved massive reorientation toward deep and lasting partnership with rural communities, but only after much warring between the schools of nursing and medicine. Both universities ultimately gained new relationships with communities and each other.

Several institutions made real changes in another initiative—Community-Based Public Health. For example, community-based participatory research rose in respectability at the University of Michigan School of Public Health and in other institutions. This type of research is now more of a plus for faculty and more of a focus for teaching students. Enduring connections were also made with neighborhoods in Detroit.

Institutional change is possible, then, and nurse educators *must* pursue it with vigor—as if it were a life and death matter. It *is* a matter of life and death to renew and rededicate the profession and to assure that nursing does not further falter, but lifts its lamp for the disenfranchised, devalued, and forgotten. If nursing cannot do this, how can health disparities be eliminated? If nurses do not do this, then who will? Nursing must reshape its institutions if it is to achieve (a) renewal of the profession, (b) rededication to the downtrodden, (c) regeneration of the capacity for caring, and (d) fulfillment of moral and social obligations to the health of all.

Transformed institutions must live by a golden rule of caring for others *including* all the others who are inside the walls of the institutions. It should never be possible again for a dean to hear a director of student affairs say that "you nurses are cruel and uncaring." Nurse educators and their institutions must prepare themselves to be supportive, in all earnestness, of a diverse student body. It is not acceptable to wait any longer. Inequity and disparity cannot be eliminated outside the institution's walls if they thrive inside.

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In new institutional cultures that nourish mutuality, the capacity for caring in students and faculty will flourish. The new institutional cultures must be deliberately and consciously shaped and brought into being. The capacity for mutuality must be explicitly attended to in the many decisions, structures, and procedures that give an institution its character and culture. For example, the policies and criteria for the admission and advancement of students and the appointment and promotion of faculty and staff can address the principle of mutuality.

Nurse educators and nurse executives can give much more attention to nurse-managed primary care. The experience of a Kellogg Foundation grantee may be instructive on this point. The Michigan Consortium for Nurse-Managed Primary Care comprises the schools of nursing at four universities and the state's public health institute. The consortium developed practice sites to train advanced-practice nurses in business and other skills needed for nurse-managed primary care clinics. By establishing new primary care clinics for underserved people, the institutions have made commitments to help overcome disparities.

Nurse-managed primary care is an extremely promising strategy to increase access for vulnerable people. It has the potential, as well, to open up new avenues for renewing nursing. But policy change is a make-or-break determinant of whether nurse-managed primary care will become widespread and live up to its promise. Such clinics are generally not recognized for purposes of reimbursement. This makes them vulnerable. The Kellogg Foundation has sponsored follow-on work for the pioneers in this kind of care around the country to move a policy agenda and also help others develop initiatives. One of the clinics established by the Michigan Consortium had great success in tapping into a funding stream. The Veterans' Administration recognized the clinic in Lansing as a primary care provider for its clientele.

Under enormous pressure and working environments of scarcity and competition, nurses have little time to see the possibilities for even small steps in addressing disparities in their practices. If patients of a primary care practice are always asked, for example, whether they smoke, is there a way to make sure that patients who smoke are counseled and that those who want to quit are supported and monitored in ways that work for them? Suppose this practice were to become the norm around the country, as it is now in some places? Nurses have the presence in health care to make this happen.

Focused on pressing, immediate tasks, nurses also have little chance to lift up their eyes to policy—to the difference policy change could make and the difference they could make in changing policy. Local policy opportunities abound, however. Local action has, for example, made a significant contribution to the prolonged campaign against tobacco waged on many fronts and at many levels.

Although nurses may not often be *thinking* policy, many of the ingredients for them to be *practicing* policy are already at hand. Creative leaders in practice and education can pull them together to awaken nurses' understanding that informing policy belongs to the essence of nursing. Nurses focus on individuals and families who are exercising responsibility for themselves, making decisions and choices directed toward improving and assuring health and avoiding harm to health. Many nurses are prompted by nursing's vision of the whole person to work on the community context for their patients. When this happens, the essence of what they do does not change, but the level within the social structure at which they do it does change. *Nursing practice in and with communities keeps the focus on people who are helping themselves but moves the locus for making decisions and choices to the collective.*

Policy can be defined as the result of collective decision making. The inherent nature of nursing practice—to help people help themselves—undergoes a developmental unfolding when nurses widen their scope of practice to include the communities of the individuals and families they serve. The move to the collective venue might be said to transform patient education into policy education.

The fundamental thrust of nursing as a discipline does not change when the venue changes, but the potential impact of that thrust does. Sound, collective community decision making is essential to the health of individuals and families because the decisions shape the social determinants of health. Nurses can make vital contributions to health through informing policy. Change in policy can affect many individuals and families, more than a single practitioner can serve with personal services. And, by reshaping some of the social determinants of health, policy

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change can contribute to reducing and eliminating health disparities.

CONCLUSION

I have given much agonizing thought to the topic I was asked to address. Traditionally, the three great professions of Western society are the ministry, the law, and medicine. But to me, and I hope to you, nursing is among the highest callings of the greatest moment. I am not prepared to be silent as I see it decline in its most essential and sacred capacity—the capacity for caring. When I consider that nursing is the profession most suited, by its traditions, to play a leading role in reducing disparities, I feel even more painfully that we must not allow the greatness of the profession to be swallowed by pettiness. Our profession is of value because it is of value to others, and the vulnerable need us most of all. I hope you agree.

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