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Integrating Education on Addressing Health Disparities into the Graduate Social Work Curriculum

JAMIE ANN MITCHELL

School of Social Work, Wayne State University, Detroit, Michigan, USA

Abstract

The purpose of this article is to propose an elective social work course as a means of better preparing social workers entering practice in healthcare to meet the challenges of promoting health and reducing health disparities in minority and underserved communities. Course offerings specifically targeting health or medical social work training vary widely. The additional training provided at places of employment and through continuing education after the master's degree is often inadequate for competently addressing the issues clinicians face in practice.

Keywords

social work; education; health disparities; curriculum; graduate

Considering all that health and medical social workers face in daily practice, the question remains, “are they prepared at the masters level to meet these challenges?” The course proposed in this article introduces students and practitioners to the scope of U.S. health disparities across racial/ethnic groups, socioeconomic status, and gender; while providing expanded theoretical frameworks for contextualizing health disparities. This course also introduces multiple perspectives for understanding how disparities arise, and strategies how social workers in practice can address disparate health in the clients they serve.

The profession of social work has an established history in the health field, and today social workers serve at nearly every site where physical and mental health needs are being met. Social workers are change agents by training, and though their roles in the health field vary depending on the setting, they often are engaged in helping clients make health-promoting behavior changes, providing patient advocacy and education, service provision and referral, and psychosocial counseling. The rapidly changing social, economic, and political landscape highlights the need to address one of the most daunting challenges of contemporary social work practice in healthcare, reducing racial, ethnic and socioeconomic health disparities.

After receiving the master's degree, social workers in healthcare often receive additional training at their place of employment and through continuing education, but little is known about how social work education itself prepares clinicians in practice to respond to the health disparities experienced by client populations. The variance in elective offerings and

field experiences in social work education does not ensure that each social worker employed in health settings is adequately trained to identify, evaluate, and intervene to reduce the burden of inequitable health care provision for the clients they serve. The purpose of this article is to propose a practice-based elective social work course for graduate students to better prepare them to respond to the health disparities they will encounter in practice.

THE SCOPE OF U.S. HEALTH DISPARITIES

Social workers face the daunting task of serving clients experiencing troubling social, material, and economic deprivation. Health and medical social workers daily witness the impact of the differential burdens of poor health, most often in their work with minority and economically disadvantaged clients. The Healthy People 2010 initiative (a program to improve American public health initiated by the National Institute of Health) has the reduction of health disparities as one of its two primary goals (Dressler, Oths, & Gravlee, 2005; Gehlert, Sohmer et al., 2008) and describes health disparities as “inequitable differences in morbidity, mortality, and access to healthcare among population groups defined by factors such as gender, race or ethnicity, education, income, disability, geographic location and/or sexual orientation” (Dressler et al., 2005; Castro, Shaibi, & Boehm-Smith, 2009). Others have expanded this definition of health disparities to include factors that contribute to this inequitable burden such as lifestyle behaviors, social environment, social disadvantage, racial/ethnic discrimination, social institutions, and social policy (Adler & Rehkopf, 2008; Centers for Disease Control and Prevention, 2005).

A critical component in the formal training of any social worker is careful attention to the plight and psychosocial needs of vulnerable, oppressed, and disadvantaged populations. Likewise, social workers must be attuned to the realities of how drastic downturns in the American economy, healthcare policy, rising unemployment and foreclosure rates, and persistent socioeconomic disadvantage create pathways for the proliferation of health disparities. For instance, for nearly every major case of premature mortality, minorities and socioeconomically deprived persons experienced manifest delayed diagnosis, lower survival rates, lower screening rates, decreased access to health services, and higher percentage of disability and mortality (Adler & Rehkopf, 2008; Brondolo, Gallo, & Myers, 2009; Reifsnider, Gallagher, & Forgione, 2005). The American Cancer Society reported in 2007, for example, that “for all cancer sites combined, African American men have a 15% higher incidence rate and a 38% higher death rate than White men” (Jemal et al., 2007, p. 53).

In addition, the Centers for Disease Control and Prevention (2005) noted that Black men are infected with AIDS at a rate eight times that of White men and are less likely to survive 9 years after diagnosis. African American males routinely experience a higher incidence of mortality rates from chronic and infectious disease, are more likely to be hypertensive, less likely to be insured, and have an average life expectancy of 6 years less than White men and 11 years less than White women (Cheatham, Barksdale, & Rodgers, 2008; Casares, Ro, Thomas, Braithwaite, & Treadwell, 2006; Virnig, Baxter, Haberman, Feldman, & Bradely, 2009). In addition, Black men and men of lower socioeconomic status are disproportionately affected by coronary heart disease, stroke, and diabetes (Casares et al., 2006) and the rate of

death among African American men for prostate, colon, and lung cancer is higher than any other group in the United States (Jemal et al., 2007; Toles, 2008).

American ethnic minorities experience significantly higher age-adjusted rates of type 2 diabetes compared to non-Hispanic whites (e.g., 15.0% for American Indians/Alaskan Natives, 11.5% for African Americans, and 10.1% for Hispanics compared to only 6.4% for Whites) (Castro et al., 2009). Moreover, African American adults are more than twice as likely to die of complications from diabetes as White adults (Gehlert, Sohmer et al., 2008). As of 2004, African American women experienced 44.1 per 100,000 deaths due to breast cancer compared to 23.8 per 100,000 among White women (Gehlert, Sohmer et al., 2008). Asian Americans/Pacific Islanders experience double the incidence and mortality rates for stomach and liver cancers; and American Indians/Alaskan Natives have the highest rates of kidney cancer for both incidence and death (Jemal et al., 2007).

In addition to specific disease outcomes, research indicates widespread disparities in healthcare access. For example, Copeland (2005) reported that “compared to white Americans, they [African Americans] are less likely to have private or employment-based health insurance, more likely to be covered by Medicaid or other publicly funded insurance, and twice as likely to be uninsured, even though eight of ten are in working families” (p. 265). The lasting effects of the severe economic recession have had a chilling effect on health care access in recent years. For example, the high rates of unemployment across the nation also mean the loss of job-based health insurance coverage for millions of individuals and families at a time when health providers increasingly are reluctant to accept new Medicaid patients due to declining medical reimbursement rates for clinical services (Holahan, 2011).

Further, state and federal budget cuts have limited the availability of community health safety net services for the uninsured. Recent analyses have shown that, in light of access barriers to affordable healthcare, the most socioeconomically disadvantaged American families now spend over 20% of their income on out-of-pocket health related expenses (Ketsche, Adams, Wallace, Kannan, & Kannan, 2011). Social workers in healthcare often are in a key position to assist marginalized groups in accessing and better utilizing primary and preventive care. The question then becomes: Are health and medical social workers educationally equipped with the tools to respond to and intervene to reduce the burden of disparate health care services for the populations they serve? The following section will highlight some of the challenges health and medical social workers face when attempting to answer this question.

WHAT HEALTH AND MEDICAL SOCIAL WORKERS FACE IN PRACTICE

Social workers working in healthcare may often be trained in specialized practice areas such as oncology, HIV, pediatrics, gerontology, and traumatic brain injury, among other areas of practice. Such clinicians provide a myriad of needed services in health settings such as assessing patients for needed services, discharge planning, case management, psychosocial counseling, conducting groups, patient education, community outreach, crisis intervention, grief counseling, and abuse screening (Auerbach, Mason, & LaPorte, 2007; Zimmerman &

Dabelko, 2007). Social workers thereby improve the quality of patient care by facilitating communication between the medical team and the patient and family; advocating for patients' rights; following up with patients to ensure treatment compliance; advocating for changes in the way services are delivered; helping patients to become informed consumers of services; promoting patient and family-centered care; and using strengths and empowerment perspectives to assist patients in medical decision making (Zimmerman & Dabelko, 2007).

There are significant challenges associated with both delivering quality care to clients (who often face extreme disadvantage) and working within a healthcare system that may not acknowledge the value of social work services as a component in the provision of comprehensive healthcare. Given these realities, social workers operating in all spheres of healthcare face constraints on time and resources and challenges associated with documenting, measuring, and proving the efficacy of services they have provided (Auerbach et al., 2007; Kossman, Lamb, O'Brien, Predmore, & Prescher, 2005). Ethical dilemmas frequently arise from an incongruence between the traditional medical model and social work values, lack of adequate time for counseling and advocacy, and the need to treat clients in single sessions (Altpeter, Mitchell, & Pennell, 2005; Gorin, 2002; Kossman et al., 2005; O'Donnell et al., 2008).

Zimmerman and Dabelko (2007) discussed the flexibility and spry thinking that hospital social workers must possess if they are to "engage clients, establish rapport, provide information, validate, challenge beliefs and behaviors, and counsel within a fixed and limited time frame" (p. 39). Medically oriented models of care often place social work services as subordinate to nursing and even administrative services (Allen, Nelson, & Netting, 2007) and lessen the value inherent in psychosocial care that social workers bring to the treatment team. Social workers in healthcare also have reported role ambiguity, difficulty managing interpersonal conflicts with other medical team members, limited strategies to demonstrate the achievement of measurable treatment outcomes, low levels of recognition by medical staff, and the dumping of inappropriate responsibilities on social work staff (particularly in smaller healthcare and nursing home settings; Allen et al, 2007). O'Donnell et al. (2008) found that there is a significant relationship between regularly experiencing value conflicts and job dissatisfaction among social workers in healthcare.

The multifarious barriers to effective practice (e.g., limited resources, managed care, devaluing of social work services) make it difficult for social workers in healthcare to draw connections between the health experiences of their individual clients and well-documented population-level patterns of disparate care. Nonetheless, it is the linking of practice experience with a broader knowledge of health disparities (particularly in a clinician's area of practice specialization) that becomes the building block for innovative interventions aimed at reducing the burdens of inequality and inequity. The following section will propose a practice-based elective course so that graduate social work education can better prepare social workers to identify patterns of disparate health among the client populations they serve, develop interventions aimed at reducing them, and advocate within their practice settings for more equitable and accessible healthcare for clients at highest risk of disparate health outcomes.

UNDERSTANDING U.S. HEALTH DISPARITIES FROM MULTIPLE PERSPECTIVES

Course Description

The purpose of this elective course is to introduce graduate-level social work students to knowledge and theory related to identifying and addressing health disparities in the context of practice. A strong emphasis is placed on students developing a solid understanding of the varied social, ecological, biological, and behavioral causes of health disparities in underserved communities.

In line with the mandate of social work education to deploy competency-based education, the following values, knowledge, and skills are considered core competencies of this course: (1) identify patterns and distributions of morbidity and mortality among U.S. racial/ethnic and socioeconomic status groups from a historical, political, social, and environmental perspective; (2) apply theoretical knowledge to the remediation of barriers to healthcare that contribute to health disparities; (3) respond to contexts where race, gender, socioeconomic status, culture, biology, and other social factors intersect to exacerbate health disparities; (4) demonstrate culturally competent practice behaviors; and (5) engage research evidence to develop intervention strategies to reduce health disparities.

Course Content

Topic 1: Introduction and overview—This course will begin by introducing the concept of health disparities, how they are defined, and where they are most prevalent (see the Appendix for required texts and readings). This topic aligns with the first core competency involving the identification and examination of health disparities from multiple perspectives. Examples drawn from particularly salient data on disparities in infant mortality, cardiovascular disease, cancer, diabetes, and HIV/AIDS (Adler & Rehkopf, 2008; Brondolo et al., 2009; Casares et al., 2006; Centers for Disease Control and Prevention, 2005; Copeland, 2005; Gehlert, Mininger et al., 2008; Lurie & Dubowitz, 2007) will be presented and students would be asked to theorize as to why such disparities exist. Other potential topics for an introductory session might include historical trends in life expectancy, the leading causes of death by race, the debate on how race and social class are in fact conceptualized (Dressler et al., 2005; Link & Phelan, 1995), and identifying the priority areas outlined by Healthy People 2010 (Gehlert, Mininger et al., 2008).

Topic 2: Theories and conceptual frameworks—There are many theories that seek to explain the existence and proliferation of health disparities. In conjunction with the second core competency for this course, students should be exposed to psychosocial, socioenvironmental, and biobehavioral theories and given opportunities to apply theoretical constructs. One such framework germane to the study of social determinants of health disparities is Ecosocial Theory, developed by Nancy Krieger as a multilevel perspective seeking to integrate biological, social, ecological, and historical perspectives to answer the question, “who and what is responsible for population patterns of health, disease, and well-being, as manifested in past, present, and changing social inequalities in health?” (Krieger, 2001a, p. 694).

There are four core concepts included in ecosocial theory: (1) embodiment, (2) pathways of embodiment, (3) cumulative interplay between exposure, susceptibility, and resistance, and (4) agency and accountability. *Embodiment* refers to the ways in which social and material conditions are “absorbed, processed, and reflected” (Casagrande, Whitt-Gloer, Lancaster, Odoms-Young, & Gary, 2009, p. 177) over the course of an individual’s life; more specifically, how we cannot fully understand human biology apart from the historical and societal context in which it interacts (Krieger & Gruskin, 2001; Krieger, 2001b; Krieger, 2002). Pathways of embodiment denotes co-occurring structured “societal arrangements of power and property and contingent patterns of production, consumption, and reproduction; and constraints and possibilities of our biology, as shaped by our species’ evolutionary history, our ecological context . . . and individual trajectories of biological and social development” (Krieger, 2001a, p. 694; Krieger & Gruskin, 2001, p. 138; Krieger, 2002, p. 9).

Krieger described the cumulative interplay between exposure, susceptibility, and resistance as the multiple levels (individual, community, national) nested within multiple domains (such as home, work, public sector) where the pathways of embodiment are expressed over time and place (Krieger, 2001b, 2002; Krieger & Gruskin, 2001). Lastly, accountability and agency bear on the responsibility of individuals and households, public and private institutions, government, and businesses for their role in “generating distributions of health and disease” (Krieger & Gruskin, 2001, p. 139) and how scientists, researchers, and epidemiologists choose to document, analyze, theorize, and interpret social disparities (Krieger, 2001b, 2002; Krieger & Gruskin, 2001;).

Ecosocial theory also allows for the integration of other theories. For example, the concept of Allostatic Load, which describes the cumulative negative effects of chronic stress responses on the body due to repeated psychosocial and environmental challenges, has been used to understand the antecedents of hypertension, cardiac disease, stroke, preterm delivery, and premature mortality among people of lower socioeconomic status (Cox, 2009; Miller, Chen, & Cole, 2009; Szanton, Gill, & Allen, 2005). According to ecosocial theory, allostatic load could be considered a form of embodiment in terms of how social and environmental adversity (i.e., unemployment, material deprivation, or discrimination) become “absorbed” into the body over time resulting in chronic stress responses, consequent poor health, and patterns of health disparities. Ecosocial theory and allostatic load are but two frameworks of many available to shape class discussions.

Topic 3: Biologic and genetic factors—Health is a multidimensional conceptualization. The third core competency of this course invites students to respond to contexts where multiple determinants intersect to influence health disparities. Lurie and Dubowitz (2007) described the factors that must inform a discussion on the multiple determinants of health, saying, “health is the result of an individual’s genetic makeup, income and educational status, health behaviors, communities in which the individual lives, and environments to which he or she is exposed” (p. 1119). Although health disparities often speak to disease patterns across large populations, students must also be knowledgeable about the factors that directly contribute to the health of individual clients they will serve. If social work practice is truly informed by a biopsychosocial perspective, social work students

(as practitioners-to-be) should be able to integrate information about how biologic processes interact with the social environment (Wilkinson, Rounds, & Copeland, 2002). Attention as well to the influence of substrate biological mechanisms can provide insight into health behavior, disease expression, and patterns of disparate burdens of disease—all of which are necessary to develop well-informed and effective interventions.

The majority of diseases characterized by significant disparities are not biologically discriminative toward racial/ethnic minorities or persons of lower socioeconomic status. There is a great deal of room therefore for intervention with biologically mediated factors because they are actionable and not predetermined. For example, there is an established relationship between dietary compounds and gene modulation leading to tumor development. Studies have linked specific nutritional habits (such as high consumption of dairy, red meat, other animal products, and fatty foods) to the initiation and progression of prostate, colorectal, breast, and stomach malignancies (Key et al., 2004; Wu, Hu, Willett, & Giovannucci, 2006; Wolk, 2005). Diet (particularly excessive food intake) also is a primary contributor to obesity, which in turn predisposes the development of certain cancers and other preventable health problems (Campbell & McTiernan, 2007; Casares et al., 2006; Miller et al., 2009).

Additional biological processes, such as stress response, immune function, inflammation, and the physiologic benefits of exercise may also be explored as biological determinants of individual and population health (Miller et al., 2009). Although an in-depth discussion of genetic determinants of health is beyond the scope of the course, it is important for students to understand that although many diseases have an inherited component (e.g., certain cancers) genetics are but one determinant of health outcomes, and most often, social and environmental factors determine how those genes are expressed (Adler & Rehkopf, 2008; Campbell & McTiernan, 2007; Smith, Betancort et al., 2007).

Topic 4: Socio-environmental context—One’s socioenvironmental surroundings greatly impact one’s ability to lead a healthful life and to prevent disease. Using the previous example of diet as a biological and behavioral determinant of health, if one does not have access to supermarkets and farmers’ markets, which offer fresh, affordable, high-quality and nutrient dense (vs. calorie dense) foods, one’s ability to make salubrious dietary choices may be limited (Reifsnider et al., 2005; Link & Phelan, 1995; Gehlert, Mininger et al., 2008). This topic reflects upon the first and third core competencies of the course, with a focus on identifying patterns of health disparities, while responding to conditions that exacerbate inequitable burdens of health. There is a growing body of literature on the relationship between “built environment” and health. Research has established that neighborhood level characteristics such as overcrowding, safe and affordable housing, public parks and recreational spaces, noise levels, crime, and availability and quality of local services (i.e., police protection, social services, good schools, garbage, and snow removal) all impact health and access to and use of health services (Airhihenbuwa & Liburd, 2006; Casagrande et al., 2009; Castro et al., 2009). Other socioenvironmental contexts such as employment, working conditions, and social supports also influence health behaviors and health outcomes (Berkman & Lochner, 2002; Bronstein, Kovacs, & Vega, 2007; Gorin, 2002).

Topic 5: Socioeconomic status and income inequality—Research indicates that socioeconomic status (income, education, and occupation) is a strong predictor of many health outcomes (Adler & Rehkopf, 2008). Socioeconomic variables influence an individual's access to healthcare (e.g., employer-based health insurance and paid sick time), ability to use health services and engage in healthy behaviors (e.g., ability to afford copays, prescription drugs, preventive care, and healthful foods), and exposure to potential health threats, such as work with toxins (Cheatham et al., 2008; Furin et al., 2006). Course discussions also should focus on the intersection of socioeconomic disadvantage and ethnic/minority group status and how barriers to health, unique to each group, may be compounded.

Topic 6: Racism and health—Literature on the association between discrimination and negative health outcomes has increased significantly in recent years. Researchers have described the experience of racism (actual or perceived) as a barrier for ethnic/racial minorities seeking healthcare and a reason African American men specifically tend to distrust and underutilize medical resources (Cheatham et al., 2008; Brondolo et al., 2009; Copeland, 2005). When healthcare providers are not culturally competent when working with diverse patient populations, they may rely (consciously or subconsciously) on stereotypical representations of population groups and personal biases to guide clinical (Betancourt, Green, Carrillo, & Park, 2005; Brondolo et al., 2009; Brown, Heaton, & Wall, 2007; Fisher, Burnett, Huang, Chin, & Cagney, 2007).

Beyond experiences in the healthcare system, discrimination in general and racism in particular may have a wide reaching impact on the life-course and health status of ethnic minority Americans, particularly Black men. For instance, institutional racism has taken the form of social exclusion and residential segregation for many urban dwelling African Americans. Research has shown that nearly 60% of African Americans in the United States live in racially segregated census tracts and that the different social environments (and access to resources) between ethnic minorities on the one hand (Blacks and Latinos) and non-Hispanic Whites on the other does contribute to differential health outcomes (Thorpe, Brandon, & LaVeist, 2008).

Residential segregation caused by discriminatory policies (House, 2001; Oliver & Muntaner, 2005) often leads to social exclusion and living conditions, which bear heavily upon health outcomes (Thorpe et al., 2008; Copeland, 2005). The consequences of such conditions include unaffordable housing, overcrowding, high crime rates, pollution, traffic, excess fast-food franchises (Casagrande et al., 2009), a dearth of grocery markets with fresh affordable foods (Ball, Timperio, & Crawford, 2009), lack of public space for exercise and recreation, and lack of available public health and social services (Castro et al., 2009; Gehlert, Mininger et al., 2008). Students could be asked to conceptualize how the cumulative effects of racism and discrimination, social exclusion and segregation, depressed neighborhoods, and invalidating experiences with the healthcare system could be “embodied” by clients (in keeping with ecosocial theory).

Topic 7: Healthcare quality and access—Although being a person of color certainly should not automatically be equated with being poor or having poor health, such minorities

are more likely to be uninsured, which puts them at risk for delays in diagnosis and poorer health outcomes (Lurie & Dubowitz, 2007). This topic therefore explores the impact of barriers to and access on health disparities. However, because having some form of health insurance does not guarantee the receipt of quality healthcare, Lurie and Dubowitz (2007) emphasized that “actions to eliminate health disparities must go well beyond equalizing insurance coverage” (p. 1119). Even after acquiring health insurance, minority patients still must navigate a complex and sometimes hostile managed healthcare system and build a relationship with a regular healthcare provider. In fact, research has indicated that individuals enrolled in publicly funded health insurance plans such as Medicaid and Medicare are having difficulty identifying health providers who continue to accept new patients, given the decreasing rates of provider reimbursement (Holahan, 2011).

Topic 8: Cultural competence—As previously noted, some population groups that have had negative experiences with the healthcare system, or have heard of historic instances of mistreatment of minorities by healthcare systems, may not seek regular or preventive healthcare for fear of maltreatment. Hence, it is imperative for clinicians (and those educating them) to be skillful in working with diverse populations and have a thorough understanding of how cultural factors may impact individual belief, behavior, and expectations of the healthcare system. Instructors should present students with empirical data on health disparities that may well impact the communities where students may be in practicum.

Cultural competence has long been a requirement for skilled social work practice and is increasingly valued and taught in medicine, nursing, pharmacy, and the allied health professions (Brown et al., 2007; Furin et al., 2006; Smith, Betancort et al., 2007; Vela, Kim, Tang, & Chin, 2008). *Cultural competence* has been defined by Selig, Tropiano, and Greene-Morton (2006) as “behaviors, attitudes, and policies that can come together on a continuum that will ensure that a system, agency, program, or individual can function effectively and appropriately in diverse cultural interactions and settings. It ensures an understanding, appreciation and respect of cultural differences and similarities within, among, and between groups” (p. 249).

Because of the diverse landscape of the United States and the varying perspectives that patients may have regarding health (and how those perspectives are informed by cultural and social norms), it is imperative for students to have both knowledge of and practice experience working with diverse client cohorts (Betancort et al., 2005). Research has shown that cultural competence takes several forms and is not limited to communications between patients and providers/clinicians. Cultural competence should also be demonstrated by the diversity of staff, the availability of interpreter services, the availability of culturally competent staff, and the ability to assess and track the continual improvement of services impacting health outcomes (Betancort et al., 2005).

Topic 9: The role of the clinician—Social workers, of course, are not medical practitioners. However, there is a growing body of literature on effective social work interventions that directly target health disparities, particularly in cancer detection and care (Altpeter et al., 2005). Social workers therefore need to stay abreast of clinical evidence and

be knowledgeable in interpreting the literature on health disparities interventions not only in social work but also in other fields such as medicine, public health, and nursing. There is a growing need in social work for evidence-based (also called evidence-informed) interventions that are clearly articulated and widely disseminated. Only through the expansion of clinical social workers' contributions to practice-based research will social work interventions gain respect in this arena and flourish.

Potential Course Activities and Assignments

Instructors may use a wide variety of strategies for teaching the course content and engaging students. Other disciplines teaching health disparities have used a combination of case studies, guest lectures and panels, developmental exercises, journal assignments, service learning, and reflective group work (Selig, Tropiano, Greene-Morton, 2006; Smith, Cohen-Callow et al., 2007; Vela et al., 2008; Furin et al., 2006; Brown et al., 2007). Instructors should consider available resources, time constraints, and class characteristics when choosing assignments and activities for the delivery and integration of course content. (Potential required and supplemental texts for this proposed course are included in the Appendix.)

LIMITATIONS AND CONCLUSIONS

It is critically important that social workers be well-trained for the challenges they will face in modern healthcare practice. Student must be aware of the realities of the differential burdens borne by disadvantaged clients and familiar with evidence-informed strategies to advocate for and intervene effectively on behalf of such clients. A course on understanding U.S. health disparities from multiple perspectives would be a valuable addition to the educational curriculum of any graduate social work student, but certain potential barriers should be noted. First, there may be resistance by faculty or administration at a school of social work to adding new content (even an elective) to an already dense and time-restricted curriculum. Second, social work schools may not have faculty with interest or expertise in teaching on health disparities. Third, faculty and staff may suggest that instead of adding a social work elective course, that students pursue electives in schools of public health or other departments offering health related courses (Wilkinson et al., 2002).

However, given the challenges that health or medical social workers face in delivering quality care to ever more diverse client populations, it stands to reason that social work students would benefit from learning from members of their own profession about the specific role that social workers can play in reducing health disparities. Students completing such a course will be able to identify the health profiles of vulnerable groups including distributions of morbidity and mortality; identify barriers to healthcare and pathways to increased client engagement in preventive health behaviors; critically analyze the intersection of race, culture, gender, socioeconomic status, and similar non-medical factors that contribute to good or poor health; apply both novel and common theoretical frameworks for understanding pervasive present health disparities; and develop interventions to address such disparities in their practice. We feel these are goals worth pursuing.

APPENDIX: POTENTIAL COURSE TEXTS

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