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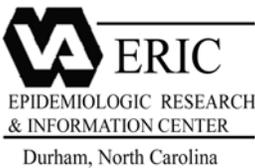


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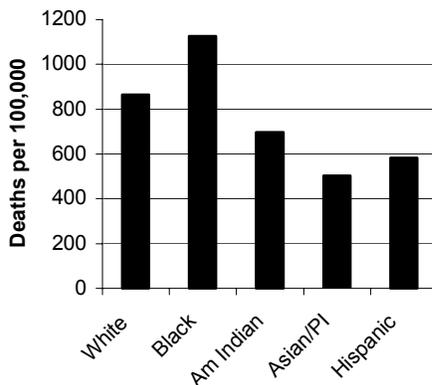
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Introduction to Health Disparities

In recent years, there has been an improvement in the overall health of Americans.¹ Today, the average life expectancy at birth is nearly 77 years of age, with men and women having an average life expectancy at birth of 72.5 and 78.9 years, respectively.² During the 1990s, major declines for heart disease, stroke, cancer, and firearm and occupational injuries were seen.³ However, glaring disparities in health persist, especially between racial/ethnic and socioeconomic groups. For many chronic and infectious diseases, minorities and persons with low income continue to bear a disproportionate burden of mortality, illness, disability, and adverse health conditions.³ For example, the age-adjusted mortality rate for stroke among African Americans is nearly twice that of Whites⁴, and the mortality rate for heart disease among African American men is 1.5 times that of White men.⁵ The prevalence of diabetes among African Americans, Hispanics, and American Indians is more than twice that of Whites.⁶ In 1998, the incidence of tuberculosis among Asian/Pacific Islanders was nearly 15 times that among Whites.⁷

Age-adjusted Death Rates by Race and Ethnicity*, United States, 2000



*Rates are affected by inconsistencies in reporting of race/ethnicity, especially for American Indians, Hispanics, and Asian Americans/Pacific Islanders.

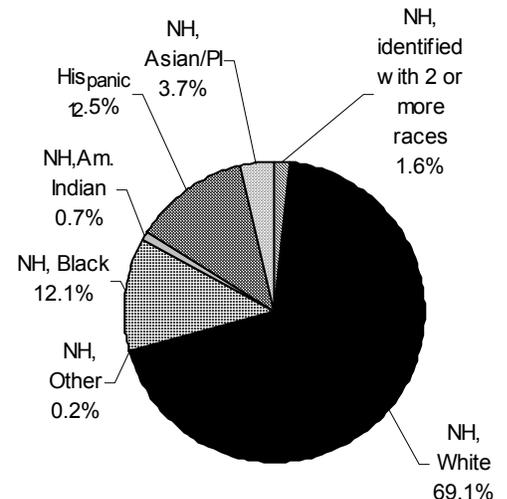
Source: National Vital Statistics Report, 2001⁸

Our Changing Nation

America has long been regarded as an assimilating "melting pot." The term "diverse salad" seems to better describe the varied ethnic makeup of America today.⁹ Understanding this diversity is important in evaluating health disparities. Factors associated with various racial/ethnic groups may be important in health differences that they experience in the United States.

In 2000, there were approximately 281 million people living in the United States, with 72 million people under the age of 18, 174 million between the ages of 18 to 64, and 35 million aged 65 and over.¹⁰ Minorities accounted for nearly 30 percent of the population, with 12.5 percent Hispanic, 12.1 percent non-Hispanic, African American, 3.7 percent non-Hispanic, Asian and Pacific Islander, 0.7 percent non-Hispanic, American Indian, 0.2 percent "some other race", and 1.6 percent designating two or more races.¹⁰

Race and Ethnicity, United States, 2000



NH=Non-Hispanic
Source: Population Reference Bureau¹⁰

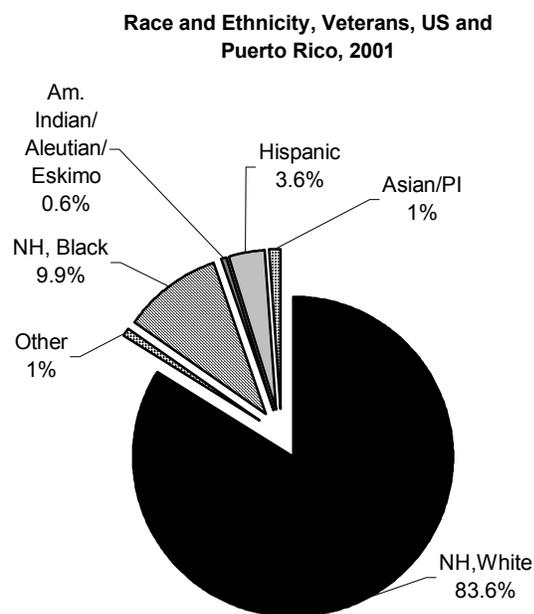
Immigration from various countries and declining birth rates among African Americans and Whites are contributing to the changing ethnic makeup of

the United States.¹¹ The Hispanic population has grown by an estimated 58 percent since 1990,¹² so that Hispanics are now the largest minority group.¹³ By 2050, it is expected that nearly half of the residents of the United States will be of Hispanic, African American, Asian American/Pacific Islander, American Indian, Native Hawaiian, or Alaskan Native ethnicity.¹³

Within the United States, migration is changing the age, racial/ethnic, and geographical distribution of the population. In 1999, the fastest population growth in the nation occurred in the West. The slowest growth was recorded among states in the Midwest and Northeast.¹⁴ Many of the metropolitan areas experienced marked increases in their minority populations.¹⁵ The growing number of Hispanic people contributed to the large overall population increases observed in California, Texas, New York, Florida, and Illinois. Nearly 70 percent of the Hispanic population resides in these five states.¹⁶

American Veterans in the 21st Century

As of September 30, 2001, there were over 25 million US military veterans residing in the United States and Puerto Rico, with 21 percent under 45 years, 41 percent between 45-64 years, 35 percent between 65-84 years, and 2 percent 85 years or older.¹⁷ Women accounted for 5.5 percent of the veteran population, a percentage projected to increase to over 10 percent by 2020.¹⁸ The figure below shows the racial/ethnic composition for the US veteran population in 2001. Partly because of their older age distribution, the ethnic distribution of U.S. veterans resembles that of the U.S. population of about 30 years ago.¹⁹



Source: Department of Veterans Affairs¹⁸

What are Health Disparities?

According to the National Institutes of Health, health disparities are “differences in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific population groups in the United States.”²⁰ Population groups may be defined by age, gender, race/ethnicity, education, social class, disability, geographic location, or sexual orientation.²¹ Disparities in health may arise from biological, social, cultural, occupational, and environmental factors, as well as from specific individual health behaviors. In 1992, Margaret Whitehead identified the 7 factors listed below as determinants of differences in health.²²

1. Natural, biological variation
2. Health-damaging behavior if freely chosen, such as participation in certain sports and pastimes
3. The transient health advantage of one group over another when that group is first to adopt a health-promoting behavior (as long as other groups have the means to catch up fairly soon)
4. Health-damaging behavior where the degree of choice of lifestyles is severely restricted
5. Exposure to unhealthy, stressful living and working conditions
6. Inadequate access to essential health and other public services
7. Natural selection or health-related social mobility, involving the tendency for sick people to move down the social scale

Determinants of Health Disparities

These determinants of health differences are not mutually exclusive. For example, personal behaviors and social mobility are undoubtedly shaped by a person’s social and economic environment.²² Although biology and individual behavior are often responsible for differences in health among individuals, pronounced and pervasive health disparities between population groups can generally be attributed to the social and physical environment.²³ Racism, socioeconomic status, cultural barriers, and power are major determinants of health disparities, and these are all deeply rooted in U.S. history.²³⁻²⁸

The contemporary lives of population groups experiencing health disparities have been shaped by histories marked by major and prolonged traumatic experiences, such as forced removal from homelands, chattel slavery, poverty, chronic malnutrition, family break-up, cultural suppression, psychological indoctrination, violent intimidation, political subordination, and other adverse conditions.²⁷⁻²⁹ For example, although chattel slavery in the U.S. ended nearly 150 years ago, various forms of legally-enforced

discrimination remained in force for another century.²⁹ Many African Americans alive today grew up under the yoke of segregation – separate, and very much unequal – and its associated deprivations and assaults on personal dignity and physical safety.

The major contemporary ethnic differences in wealth, income, educational attainment, occupational opportunity, professional employment, ownership of businesses and land, political influence, psychological assets, and community resources can be traced to the collective actions of the dominant ethnic groups, unrestrained and sometimes abetted by governments, employers, universities, banks, and other institutions.²⁸ Contemporary racism, discrimination, and residential segregation have direct effects on health and indirect effects through constraints on educational and employment opportunities, neighborhood and housing quality, health behaviors, access to health care, and social power within the community.²⁴⁻²⁹

Equity in Health

According to the World Health Organization, “equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that none should be disadvantaged from achieving this potential, if it can be avoided.”³⁰ Two forms of equity have been defined²²:

1. **Horizontal Equity** – the allocation of equal or equivalent resources for equal need
2. **Vertical Equity** – the allocation of different resources for different levels of need

Equity is a generally accepted value, but deciding what is equitable is complex. Consider Peter and Evans’³¹ discussion of the application of perspectives from moral philosophy to health equity.

1. **Utilitarianism** calls for maximizing the sum of individual well-being. This doctrine does not address equity in the *distribution* of aggregate health, so its usefulness for evaluating health disparities is limited. Peter and Evans observe that a utilitarian approach that weights health losses by lost income would downplay existing health disparities, in which affluent persons are already better off.

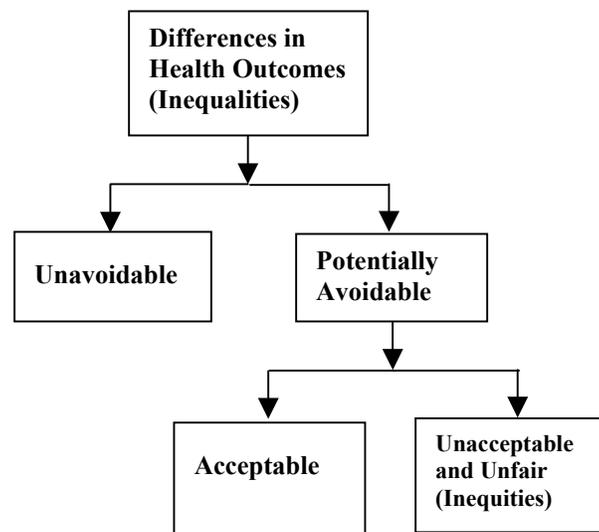
2. **Egalitarianism** emphasizes equality of distribution, even if the aggregate is reduced, and is thus more useful for evaluating health equity. However, equal distribution can be defined in terms of equality of health *status* or equality of *opportunity* for health. The latter may not produce the former. As a minimum, equal opportunity may require disproportionate allocation of resources in favor of disadvantaged groups, rather than simply the

removal of barriers (e.g., discrimination). An alternative is to focus on universal achievement of a “decent minimum”, even if there is inequality above that level. Health benefits are disproportionately given to the sickest members of society in order to maximize their health.

3. **Rawlsian justice** focuses on the *reasons* for inequality rather than on inequality *per se*. In this framework, inequalities that arise or exist from causes other than societal institutions are not regarded as inequitable. The Rawlsian doctrine is satisfied if society’s social, economic, and political institutions do not discriminate or pose special barriers.

Inequities vs. Inequalities

The related concepts of inequity and inequality are distinguished according to judgments about what is considered fair and just.³¹ Inequalities that are considered to be preventable and unjust constitute inequities.²⁰ According to Whitehead, health inequities are “differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust.”²² This definition suggests that health disparities related to variations in individual biology are considered unavoidable and therefore fair inequalities. On the other hand, disparities in health attributed to factors related to limited access to health care or harmful exposures are considered inequities.³¹ The figure below illustrates the judgment process for evaluating inequalities in health.



Adapted from Peter and Evans (2002)³¹, figure 1, p.35

Importance of Identifying and Reducing Health Disparities

In 2000, Woodward and Kawachi outlined the following arguments for the reduction of health disparities:³²

1. **Disparities are avoidable** – Many disparities in health result from identifiable problems within the health care system and should therefore be avoidable. Interventions may be designed to affect policy and the distribution of health status.
2. **Disparities are unfair** – Differences in health are unfair when poor health results from unjust distributions of goods or services. Decisions about what is unfair or unjust are necessary in distinguishing what constitutes unfair and unjust health differences.
3. **Disparities affect everyone** – Adverse effects from many conditions – for example, infectious diseases, substance abuse, violence, and mental illness – go beyond the individuals, families, and communities that are directly affected. Awareness of this reality has been a foundation of public health. In addition, the costs of excess health care, loss of productivity, and dependency from any cause are borne by all of society. The health of American society depends fundamentally on the health and productivity of its workforce and their families.
4. **Reducing health disparities is cost effective** – Programs designed to reduce health differences within society may be cost effective by benefiting members of society who are not direct targets of the intervention, as well as the direct beneficiaries.

Conclusion

The elimination of health disparities among racial/ethnic minorities is one of the two overarching goals of Healthy People 2010.²⁰ This first notebook in the ERIC Notebook series on health disparities has presented an overview of health disparities, their determinants, ethnical perspectives on disparities, and the importance of identifying and reducing them. Future notebooks in the series will cover contextual (environmental) aspects of health disparities and issues related to health care epidemiology and research methodology. Other notebooks in the series will illustrate the concepts of health disparities in the context of specific health conditions. The role of health professionals in the elimination of health disparities will also be explored.

Helpful Web Sites:

CDC-Office of the Assoc. Director for Minority Health
<http://www.cdc.gov/od/admh>

Closing the Health Gap
<http://www.healthgap.omhrc.gov>

Commonwealth Fund
<http://www.cmwf.org>

Health Disparities Collaborative
<http://www.healthdisparities.net>

Indian Health Service
<http://www.ihs.gov/>

Kaiser Family Foundation
<http://www.kff.org>

National Center for Minority Health and Health Disparities
<http://www.ncmhd.nih.gov>

University of Michigan-Center for Research on Ethnicity, Culture, and Health
<http://www.sph.umich.edu/crech>

University of North Carolina at Chapel Hill-Minority Health Project
<http://www.minority.unc.edu>

US Department of Health and Human Services-Office of Minority Health
<http://www.omhrc.gov>

VA Center for Minority Veterans
http://www.va.gov/minority_new/main/index.asp

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Additional Readings on the Topic:

- Association of State and Territorial Health Officials and National Association of County and City Health Officials (2001). *Health Departments Take Action: A Compendium of State and Local Models Addressing Racial Disparities in Health*. Washington, DC: Association of State and Territorial Health Officials.
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- Evidence-Based Care
- Contextual Dimensions of Health Disparities
- Meta-Analysis

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