Overview. The past ten years health researchers and providers have illuminated the problem of racial, ethnic, and socioeconomic disparities in health in the United States. Several leading publications and books and government reports have been published that describe these disparities and ideas for their elimination. Reducing disparities among different segments of the U.S population is now one of the 10 national health objectives for the United States and of the two overarching goals of Healthy People 2010 issued by the U.S. Surgeon General.

Disparities among different segments of the population have been defined in terms of differences in health status, risk factors for disease and injury, access to and use of health care services, and differences in the quality of care received. While most research and practice has focused on documenting and reducing disparities among selected groups of individuals (e.g., racial/ethnic minorities, low SES families, the uninsured, the homeless, or the elderly), there is good reason to acknowledge that many of these characteristics overlap, creating a need for more comprehensive and broad-thinking approaches to resolving disparities.

- Health status. Most studies regarding disparities describe differences in mortality, and morbidity. For example, African American men and women have mortality rates one and a half to two times that of whites; disproportionately higher mortality rates for African Americans are reported for heart disease, some types of cancer, AIDS, diabetes, homicide and suicide. Disparities in health status are also reflective in infant mortality rates. Over the past 50 years, IM in the US has declined significantly to about 8 infant deaths per 1000 live births in 2004. And while reductions in IM are also reported for all racial and ethnic groups they have dropped much slowly for African Americans compared to other groups. Currently, African American babies die at a rate of over 14 deaths per 1000 births, nearly twice that of Whites, Asians and Latinos in the U.S. High IM rates are also found among Puerto Ricans, native Hawaiians, and American Indians. Both national and state data show higher rates of self-reported diabetes, asthma (for both children and adults), cancer, heart disease, and other chronic illnesses among Latinos and African Americans, compared to White and Asian populations. The prevalence of diabetes is about 1.7 times more among non-Hispanic African Americans, 1.9 times more among Hispanics, and 2.8 times more among American Indian and Alaska Natives than among non-Hispanic white Americans of similar age.
The disproportionately high rate of deaths among African Americans has persisted in spite of gains in jobs and overall socio-economic status, improved living standards and expanded access to health care. Morbidity rates also show differences among racial and ethnic groups.
Disparities in risk for illness and injury. Disparities may also reflect differences in risk for disease. Understanding risk factors, however, requires a much more complex approach to untangling why some groups have higher rates of disease and premature death. For diabetes and other chronic illnesses for example, higher rates of obesity among Latino and African Americans, may contribute to the excess morbidity and mortality we observe in these populations. These risks may reflect differences in behavioral factors such as smoking, consumption of high fat diets and lack of exercise. They may also reflect social, cultural and environmental factors that differentially affect disease risk. For example, obesity may be elevated in communities that have fewer healthier restaurants, grocery stores with fresh fruits and vegetables, and public green space for exercise and fitness.

Access to appropriate and quality care. Researchers most recently have argued that inequalities in access to and delivery of healthcare may contribute to health disparities. Disparities in access to care reflect differences in access to health insurance, physicians and differences in the quality of care. For example, both at a national level as well as among states and counties and cities, Latinos have consistently shown to be more likely to lack health insurance compared to other groups, even taking into account income. This disparity to some extent reflects demographic shifts, immigration, changes in the economy and types of jobs, and the overall costs of care. This may also reflect differences in cultural interpretations of illness and disease that affect help-seeking behavior (such as the decision to seek care), as well as differences in socio economic factors affecting individuals’ ability to seek care when needed. Disparities in access and utilization may also reflect inequalities in the availability of culturally competent health professionals and their distribution in the community relative to
need. For example, there are areas of California that are federally designated medically underserved or professional shortage areas. Disparities could also be tied to the training of health professionals, particularly graduate medical education, the location and scope of residency programs, loan forgiveness programs, and recruitment and selection factors for health professional schools. Finally, several studies have highlighted the differences in quality of care among health consumers. One study, for example shows that Black asthma sufferers are less likely than whites to receive adequate care for the disease, even if they have medical insurance.

![Percent without Health Insurance in California, by Race/Ethnicity, 2003, Source: CHIS](image)

In spite of the increased attention paid to the issue of disparities, and even funding from both public and private sectors, little progress has been made in closing these gaps. Indeed, investigators paint a fairly complex picture in trying to understand these differences. Some lay clearly within the parameters of health care such as access to preventive care, access to primary care and health insurance, and comfort with and acceptability of health care providers. Many factors that determine health lay outside the health care delivery system and are rooted in deeper social and structural including health behaviors, cultural interpretations of illness, poverty, and environmental factors, and stereotyping or racism. The existence of healthcare disparities in this nation can only be fully understood, and therefore changed, when viewed with a combined ecological and individual perspective on attributes of risk.

**Defining a USC Approach**
The University, with its wide range of academic and professional disciplines, has a unique opportunity to develop multi-disciplinary strategies to address disparities, why they exist and how they can be reduced or eliminated. There is great potential for a research collaborative to more comprehensively address the problem of health disparities. Any research agenda or intervention program that is designed to target just a single at-risk group (e.g., the uninsured),
could be greatly strengthened by directing attention to other concomitant risk factors. For example, since uninsured individuals are more likely to be low-income, interventions to address health disparities among the uninsured would theoretically be more effective if designed to take into account the influences of also being low-income (or even other factors such as being an immigrant or working in a low wage job).

Given the complexity of the problem underlying health disparities in the U.S., we propose the following areas of investigation for further discussion:

- Further refining, defining and understanding epidemiological differences in health (e.g., biological, sociological, environmental, and behavioral determinants).
- Differences in access to care and utilization of services including health insurance coverage, risk, enabling factors)
- Diversity in health the health professions, medical education, selection factors, matriculation, loan forgiveness, residency programs, distribution of physicians and other health professionals, types of physicians (primary care vs., specialty), nursing shortage
- Safety net providers including public and DSH private hospitals, community health centers
- Delivery systems factors, (cultural competency and language proficiency of the provider network)
- Other factors affecting the quality of care and receipt of services such as differences in treatment regimens and recommendations among population subgroups
- Broader social and demographic determinants of health affecting disparities (racism, employment factors, homelessness, immigration, aging of the population, transportation, urban sprawl, troop deployment and veterans issues.)
- Testing interventions to reduce disparities.
- Policy issues affecting health and access to care including health care reform.

Sources


