

## Issue Brief - Defining Health Disparities

Alison Stratton, PhD, Margaret Hynes, PhD, MPH, and Ava Nepaul, MA

The Connecticut Health Disparities Project · Connecticut Department of Public Health · Hartford, Connecticut · Summer 2007

### Introduction

Public health agencies monitor trends in the type and distribution of disease in the overall population and in selected subgroups. In recent years, national efforts have focused on the unequal distribution of, or “disparities” in, disease and associated risk factors among certain subgroups of the population based on age, gender, race, and ethnicity (U.S. Department of Health and Human Services 1990, 2000). Research has demonstrated that racial and ethnic minority populations, in particular, tend to have poorer health outcomes, more chronic disease, and higher mortality than the White, majority population (U.S. Department of Health and Human Services 1985, 1990, 2000). At the national and state levels, efforts are underway to describe in greater detail and more effectively address health disparities. This Issue Brief addresses these efforts in general terms, and outlines some underlying social factors of health disparities.

### The Context of Health Disparities

Health disparities may be viewed as results of “a chain of events” evidenced by “a difference in: 1) the environment, 2) access to, utilization of and quality of care, 3) health status, or 4) a particular health outcome that deserves scrutiny” (Carter-Pokras and Baquet 2002). Other definitions of health disparities focus not simply on differences, but on *inequities* in health — that is, “differences which are unnecessary and avoidable, but, in addition, are also considered unfair and unjust” (Whitehead 1990:5). For example, a health “difference” between genders would be that women get cervical cancer, and men get prostate cancer. An example of a “health disparity,” would be the differences in life expectancy among racial and socioeconomic subpopulations which are associated with social advantage or disadvantage over the life course (Meyers 2007).

Health disparities may also be understood as a “continual accumulation of unfavorable events” affecting people’s health that are connected to their broader social context. A person’s “social context” includes the wide range of individual, cultural, socioeconomic and political factors that influence health outcomes. These factors include individual constitutional and lifestyle factors; familial and social relationships; housing, neighborhood, environmental, and occupational conditions; societal expressions of discrimination and opportunity; and the access to and quality of health care settings and personnel.

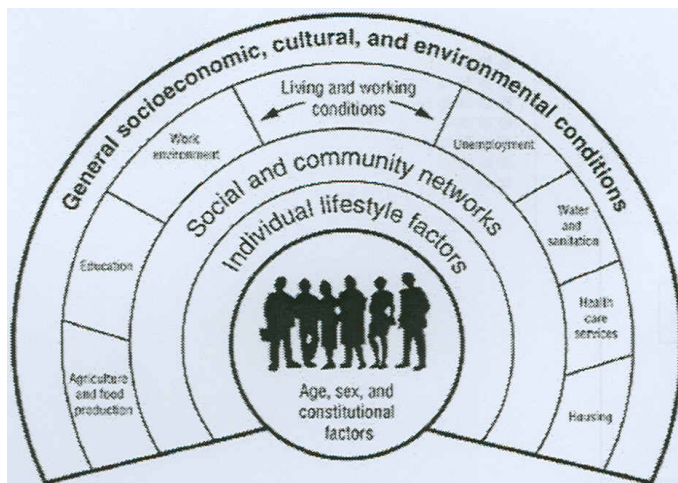


Figure 1. Social Context and Population Health

Source: Institute of Medicine. 2003a.

Original source: Dahlgren and Whitehead 1991. Used with permission of the Institute for Futures Studies, Stockholm, Sweden.

Figure 1 provides a useful model to help us understand the multiple levels and determinants of population health.

An underlying premise of *Healthy People 2010*, the U.S. Surgeon General’s plan and objectives for the nation, is that the health of individuals is closely linked to the health of the larger community. To be effective, therefore, public health interventions and policy change must address the multiple levels of health inequalities, including individual, social structural, economic, and environmental factors that affect health (U.S. Department of Health and Human Services 2000).

### National Efforts

The federal government has provided leadership in defining health disparities and priority populations, and in highlighting the underlying processes and consequences of health disparities. The National Institutes of Health (NIH) defines health disparities as “differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States” (NIH 2000). Although it does not provide detailed, subgroup-specific analyses, NIH recognizes that health disparities exist across a wide range of population groups that vary by socioeconomic position, gender, race, and ethnicity (NIH 2006). One important mission of the NIH is to address health disparities by both improving knowledge about the un-

derlying processes that give rise to and maintain health disparities, and disseminating the interventions based on this knowledge (NIH 2006).

Additionally, “eliminating health disparities” is one of two goals of *Healthy People 2010*. *Healthy People 2010* defines health disparities as health “differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation.” The federal government recognizes these groups as priority populations, although not all of the 467 *Healthy People* objectives have specific target objectives for each of the groups identified (U.S. Department of Health and Human Services 2000).

Furthermore, the Institute of Medicine (2003b) report, *Unequal Treatment – Confronting Racial and Ethnic Disparities in Health Care*, was developed in response to the U.S. Congress’ request for an assessment of differences in the kind and quality of health care received by U.S. racial and ethnic minority populations relative to the non-minority population. The report found that racial and ethnic disparities in health care are well documented; that they are associated with worse outcomes in many cases; and that such disparities “occur in the context of broader historic and contemporary social and economic inequality, and evidence of persistent racial and ethnic discrimination in many sectors of American life” (Institute of Medicine 2003b). The report further states that because racial and ethnic disparities are associated with worse health outcomes in many cases, they “are unacceptable” (Institute of Medicine 2003b).

### Connecticut’s Efforts

In 1999, the Connecticut Department of Public Health (DPH) published a report, *Multicultural Health – The Health Status of Minority Groups in Connecticut*, which documented health disparities for the Black/African American, Hispanic, Asian/Pacific Islander, and Native American populations relative to the White population in Connecticut (Connecticut DPH 1999). The 1999 report also documented racial and ethnic disparities across 29 different indicators for mortality, chronic and infectious disease incidence, pregnancy and birth outcomes, and hospitalizations. The 2005 report *Mortality and Its Risk Factors in Connecticut, 1989-1998* examined trends in the leading causes of death and premature mortality by age, gender, and race and Hispanic ethnicity (Connecticut DPH 2005). Many other Connecticut DPH reports have documented health disparities across a wide range of conditions, and are available on-line at the DPH Health Disparities web page.

Many DPH programs, such as the Heart Disease and Stroke Prevention, and Diabetes Prevention and Control programs, have incorporated the *Healthy People 2010* objectives related

to eliminating racial and ethnic health disparities as a priority in their programmatic plans. In addition, the DPH Planning Branch has undertaken an inventory of programmatic activities related to the *Healthy People 2010* goal of eliminating health disparities. Information about these programs may be accessed online through the following website: <http://www.ct.gov/dph>.

### Defining Health Disparities in Connecticut

In addition to the priority populations identified in national and Connecticut reports, there are other population subgroups likely to experience health disparities. These include immigrants, refugees, limited English proficiency populations, and homeless persons. Public health research has shown that these groups tend to have limited access to health care and/or adverse health outcomes relative to the majority population (Friedman 2005; Donohoe 2004). Refugee populations suffer from high rates of tuberculosis, parasitic diseases, dental problems, and post-traumatic stress disorder diagnoses due to war, torture, displacement, and culture shock (U.S. Department of Health and Human Services 2006). Immigrants and persons with limited English proficiency often have difficulty getting appropriate medical interpreter services and culturally competent health care, which often leads these groups to defer health care services (Capps, Karin, and Cook, et al. 2005). Homeless persons tend to die much earlier than the general population, and they suffer disproportionately from chronic and infectious diseases (Donohoe 2004).

Considering the national definitions and other available research evidence, we have developed the following working definition of health disparities for Connecticut:

**Health disparities refer to the differences in disease risk, incidence, prevalence, morbidity, and mortality and other adverse conditions, such as unequal access to quality health care, that exist among specific population groups in Connecticut. Population groups may be based on race, ethnicity, age, gender, socioeconomic position, immigrant status, sexual minority status, language, disability, homelessness, and geographic area of residence. Specifically, health disparities refer to those avoidable differences in health that result from cumulative social disadvantages.**

While it may not be appropriate or possible to provide detailed analyses of each population subgroup in our state, DPH recognizes these as priority population groups in its monitoring, or surveillance, of health disparities. Although health disparities among racial and ethnic minority populations are a main concern of DPH surveillance and intervention efforts, DPH recognizes that multiple factors, such as socioeconomic position and discrimination, language spoken, and geography may underlie these disparities. As such, they are important

...[H]ealth disparities refer to those avoidable differences in health [among specific population groups] that result from cumulative social disadvantages.

factors to consider in monitoring, reporting, and eliminating racial and ethnic disparities in health.

### **Target Areas for Eliminating Health Disparities**

The U.S. Department of Health and Human Services has targeted six major areas for the elimination of health disparities including: cancer, cardiovascular disease, infant mortality, diabetes, HIV/AIDS, and child and adult immunizations. In Connecticut, the Department of Public Health currently conducts major surveillance and programmatic efforts in these six areas, as well as in the areas of asthma, obesity, oral health, infectious and sexually transmitted diseases, and environmental health.

In the areas of data collection and institutional transformation, the Connecticut Health Disparities Project, a two-year cooperative agreement between DPH and the Connecticut Health Foundation, is providing leadership in enhancing the infrastructure for documenting and reporting health disparities by improving data collection and reporting, coordinating agency planning efforts related to eliminating health disparities, and partnering with other state agencies in efforts to measure and report on health disparities.

By employing interdisciplinary and creative approaches to examining inequalities in health, we shall better explicate the social, institutional, and moral dimensions of health and contribute to the elimination of health disparities in Connecticut and beyond.

### **References**

Capps, R., F. Karin, A. Cook, et al. 2005. *Immigrants in Connecticut: Labor Market Experiences and Health Care Access*. Washington, DC: The Urban Institute.

Carter-Pokras, O. and C. Baquet. 2002. What is a "Health Disparity"? *Public Health Reports*. 117: 426-434.

Connecticut Department of Public Health. 1999. *Multicultural Health – The Health Status of Minority Groups in Connecticut*. Hartford, CT: Connecticut Department of Public Health.

Connecticut Department of Public Health. 2005. *Mortality and Its Risk Factors in Connecticut, 1989-1998*. Hartford, CT: Connecticut Department of Public Health.

Dahlgren, G. and M. Whitehead. 1991. *Policies and Strategies to Promote Social Equity in Health*. Stockholm, Sweden: Institute for Futures Studies.

Donohoe, M. 2004. *Homelessness in the United States: History, Epidemiology, Health Issues, Women, Public Policy*. Retrieved on March 13, 2007 from: [http://www.medscape.com/viewarticle/481800\\_print](http://www.medscape.com/viewarticle/481800_print).

Friedman, E. 2005. *White Coats and Many Colors: Population Diversity and Its Implications for Health Care*. Chicago, IL: American Hospital Association.

Institute of Medicine. 2003a. *The Future of the Public's Health in the 21<sup>st</sup> Century*. Washington, DC: National Academies Press.

Institute of Medicine. 2003b. *Unequal Treatment – Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academies Press.

Meyers, K. 2007. *Issue Brief: Racial and Ethnic Health Disparities*. Oakland, CA: Kaiser Permanente Institute for Health Policy.

National Institutes of Health. 2000. *Addressing Health Disparities: The NIH Program of Action*. Bethesda, MD: National Institutes of Health. Retrieved on March 20, 2007 from: <http://healthdisparities.nih.gov/whatare.html>.

National Institutes of Health. 2006. *NIH Conference on Understanding and Reducing Health Disparities (Conference Proceedings)*. Bethesda, MD: National Institutes of Health.

U.S. Department of Health and Human Services. 1985. *Report of the Secretary's Task Force on Black & Minority Health*. Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services. 1990. *Healthy People 2000*. Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services. 2000. *Healthy People 2010*. Washington, DC: US Government Printing Office.

U.S. Department of Health and Human Services. 2006. *Silent Trauma: Diabetes, Health Status and the Refugee: Southeast Asians in the United States*. Washington, DC: US Government Printing Office.

Whitehead, Margaret. 1990. *The Concepts and Principles of Equity and Health*. Copenhagen: World Health Organization Regional Office for Europe.



Keeping Connecticut Healthy

410 Capitol Avenue  
Hartford, CT 06134  
(860) 509-7658  
<http://www.ct.gov/dph>

J. Robert Galvin, MD, MPH, MBA  
Commissioner

The Connecticut Health Disparities Project is generously supported by a grant from the Connecticut Health Foundation.