CHAPTER 2

Health Disparities: The Meaning and a Historical Overview

Healthy citizens are the greatest asset any country can have.

—Winston S. Churchill

KEY TERMS

culture
emerging majority
ethnicity
health disparity
health inequality
health status
race
socioeconomic status

LEARNING OBJECTIVES

After reading this chapter, you should be able to do the following:

1. Understand the role that culture plays in health disparities.
2. List the key factors that influence the health status of various groups.
3. Explain the term *emerging majority* as it relates to demographic changes in the United States.
4. Discuss why the widest health status gap is between Black and White people in the United States.

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Introduction

Generally, **health disparity** refers to a difference or gap in **health status** between varying racial and ethnic groups. There are a number of factors to take into consideration when exploring this gap, which will be reviewed in depth throughout this text. These factors include socioeconomic and educational status, **race**, **culture**, **ethnicity**, and other population characteristics. If all of these factors are not taken into consideration when comparing the health status of different groups, then problems may arise in addressing health disparities. For example, it may be erroneously argued that one group is inherently healthier than the other, a type of bias. Or it may be assumed that one factor is the cause of a disparity, and thus solutions to the problem may be based on a myopic focus.

Moreover, it helps to consider examples in looking at this flawed approach to understanding the extent of factors that may contribute to health disparities. Specifically, it is generally understood that in the United States, which is the country of emphasis regarding health disparities in this text, the White, currently majority, population has a higher health status than do members of the African American/Black population. The latter is the largest **emerging majority** racial group if Black Hispanics are included in the group. It is appropriate to include Black Hispanics in the African American/Black group because according to the Office of Management and Budget (OMB), Hispanic is not a racial but rather an ethnic group. Therefore, Hispanic people may be Black, White, or of other racial groups. It gets a bit more complicated when discussing White Hispanic people because White non-Hispanic people are not considered an emerging majority group; therefore, the health experiences of White Hispanic people may or may not be different than those of the White population for a number of reasons, particularly White privilege. But for Black Hispanic people, their experience, in terms of health, is very similar to that of African American/Black, non-Hispanic people, with culture being the salient difference, which will be discussed in a later chapter. Essentially, the health status of Black people (both Hispanic and non-Hispanic), in the United States, is lower than that of the White population.

The Centers for Disease Control and Prevention (CDC) produces a document titled the "CDC Health Disparities and Inequalities Report." The 2013 report provided interesting examples of health disparities, as indicated in **BOX 2-1**.

An example of a myopic view as the rationale for the disparity between these two groups is the argument that genetics is the key factor. Some may argue that genetically there are illnesses that tend to exist within the Black population that contribute to their overall lower health statistics. Race continues to be one of the most politically charged subjects in American life. It involves a sociocultural component that often leads to misleading and inappropriate categorizations (Kittles & Weiss, 2003). According to an Institution of Medicine Committee Report, "genetics cannot provide a single all-purpose human classification scheme that will be adequate for addressing all of the multifaceted dimensions of health differentials" (Hernandez & Blazer, 2006). The argument of genetics, therefore, has no substantial basis as a valid and sole explanation for health disparities. There are other contributing factors that contribute to this gap, such as **socioeconomic status**, educational levels, diet, and health literacy. These factors have a great impact

BOX 2-1 Examples of Important Health Disparities

- African Americans in 2009 had the largest death rates from heart disease and stroke compared with other racial and ethnic populations; these disparities in deaths were also found across age groups younger than 85 years.
- From 2007 to 2010, the largest prevalence of hypertension was among adults aged 65 years and older, African American adults, U.S.-born adults, adults with less than a college education, adults who received public health insurance (18 to 64 years old) and those with diabetes, obesity, or a disability, compared with their counterparts.
- African Americans in 2009 had the largest death rates from heart disease and stroke compared with other racial and ethnic populations; these disparities in deaths were also found across age groups younger than 85 years.
- Infants of African American women in 2008 had the largest death rate, which was more than twice the rate among infants of White women.
- African Americans in 2009 had the highest death rates from homicide among all racial and ethnic populations. Rates among African American males were the highest across all age groups.
- African Americans had the highest incidence and death rates from colorectal cancer in 2008 compared with all other racial and ethnic populations—despite having colorectal screening rates similar to the rates among White adults.

Factors contributing to poor health outcomes among African Americans include discrimination; cultural, linguistic, and literacy barriers; and lack of access to health care.

Retrieved from Rittler, L., & Graham, D. (2016). *Multicultural health* (2nd ed., p. 220). Burlington, MA: Jones and Bartlett Learning.

on the situation of the gap between the health status of Black people and other emerging majority groups and that of the White population in the United States. Hence, exploring these factors in depth not only lends to a greater understanding but also enables an opportunity to explore potential solutions. Although the solutions are complicated, they are not unachievable. The United States leads the world in healthcare spending. It is the only industrialized nation that does not ensure that all citizens have coverage (IOM, n.d.). As stated by the National Coalition on Health Care:

> Lack of insurance compromises the health of the uninsured because they receive less preventive care, are diagnosed at more advanced disease stages, and once diagnosed, tend to receive less therapeutic care and have higher mortality rates than insured individuals. (*The Sedona Observer*, 2007)

Health Disparities Defined

The concept of *health disparities* has been define many different ways. A few formal definitions are presented in **TABLE 2-1**.

TABLE 2-1 Varying Definitions of the Term Health Disparities in the United States

Source[a]	Definition of Health Disparities
U.S. Department of Health and Human Services, The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020, 2008	A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.
Dehlendorf, Bryant, Huddleston, Jacoby, & Fujimoto, 2010	In the United States, discussion of disparities has focused primarily on racial and ethnic disparities. In the international literature, and increasingly in the United States, socioeconomic status and gender disparities, disparities between disabled and non-disabled individuals, and disparities by sexual orientation have also been considered.
U.S. Department of Health and Human Services, n.d.	Differences in length and quality of life and rates and severity of disease and disability because of social position, race, ethnicity, gender, sexual orientation, education, or other factors.

[a] The full reference for each source is included in the References section at the end of this chapter.

A Brief Historical Overview

As previously discussed, in terms of key health indices, the health status gap between any emerging majority group and the current majority group (White people) is greatest between Black and White people. Because of the significant health disparity between Black and White people, the focus will remain on these two groups throughout this text. Some of the key indices are mortality and morbidity rates and longevity. In considering longevity, going back to 1850, the average life expectancy of Black people was 21.4 years as compared to that of White people, which was 25.5 years (Talamantes, Lindeman, & Mouton, n.d.). It was a different time and lifespans were much shorter than they are today. Nevertheless, the apparent gap was due to heavier labor, inadequate medical care, poorer living standards, and greater environmental exposure for Black people. Additionally, at that time, Black people were slaves in many parts of the United States, leading to poorer health conditions.

Slavery was a complex and brutal system involving many Americans, including White slavers and Black slaves. The involvement of medicine in the process is often excluded from historical discussions, but it is very important to the understanding of health disparities. According to Washington (2006):

> Enslavement could not have existed and certainly could not have persisted without medical science. However, physicians were also dependent upon slavery, both for economic security and for the enslaved "clinical material" that fed the American medical research and medical training that bolstered physicians' professional advancement. (p. 24)

Life on the plantation was particularly problematic in terms of health care. Slaves were fed a suboptimal diet, were provided with clothing that did not provide protection from the elements, were forced to perform labor each day that was long and hard without benefit of sufficient rest. When they experienced illness, often they did not receive medication. They experienced illness largely because of insufficient work environments. As further stated by Washington (2006):

> Enslaved African Americans were more vulnerable than whites to respiratory infections, thanks to poorly constructed slave shacks that admitted winter cold and summer heat. Slaves' immune systems were unfamiliar with, or naïve to, microbes that caused various pneumonias and tuberculosis. (p. 29)

Moving ahead chronologically, a study in 1997 revealed that White people outlived Black people by 6 years, living to 77.1 years on average, while Black people lived 71.1 years on average (Talamantes et al., n.d.). This finding leads to an obvious question: Given the ending of slavery in 1865 and a considerable difference in time, why did the gap remain? Simply put, why do White people live longer than Black people in the United States? In exploring this question further, it is important to note that there was indeed a medical civil rights movement, which allowed for integration of African Americans into healthcare environments, but still the health status gap was not closed.

Medical Exploitation

Specific studies have pointed out that many Black people distrust White people, specifically in relation to health care, as many Black people feel that White institutions are powerful and experiences within them are frustrating (Levy, 1985). This belief creates a scenario of distrust when seeking health care and may impact the relationship between the healthcare provider and the patient/customer. One way that Black patients/customers may get beyond their feelings of distrust is to seek healthcare providers of the same race/ethnicity, with whom they may feel more comfortable (Kontorinakis, 2005). There is often greater understanding between people who share similar cultures, values, and positive and negative experiences (Levy, 1985). Further, a person may seek out providers of the same race/ethnicity if he or she has personally experienced or knows of historical instances of maltreatment from one race to another.

Unfortunately, this distrust of the medical establishment has been justified. Black people, even since the abolishment of slavery, have still fallen victim to medical exploitation and experimentation (Palmer, Wise, Horton, Adams-Campbell, & Rosenberg, 2011). Many medical atrocities have been thoroughly documented. A key example is the oft-cited Tuskegee Syphilis Study. Beginning in July 1932, the U.S. Public Health Service enrolled approximately 400 African American men with syphilis in an experiment. The men were told that they were receiving treatment. In reality, they received no treatment for their disease; they were studied to determine the effects of the disease, if left untreated, from the time of diagnosis until their death (Gamble, 1997). Treatment became available during the course of the study, but it was never given to the men (Gamble, 1997). Most of the men were poor, uneducated, and unaware that they had syphilis and were merely told that they had "bad blood." The men suffered greatly, while their loved ones (who were also unaware that the men were not being treated) watched helplessly. To add to the atrocity, their wives and children were never tested for syphilis. It was not until 1972, 40 years after the study began, that the men who survived were told that they had syphilis and had been subjects in the study. Former president Clinton would later apologize for the Tuskegee Syphilis Study:

> What was done cannot be undone, but we can end the silence.... We cannot be one America when a whole segment of our nation has no trust in America. We can stop turning our heads away. We can look at you in the eye, and finally say, on behalf of the American people, what the United States government did was shameful and I am sorry. (Spencer, 2010)

Spencer (2010) offers a poignant response to President Clinton's words:

> This apology offered in 1997 by then President Bill Clinton uncovered painful sores that many would like to believe had healed long ago. It is only recently that a growing number of social scientists have appreciated that persisting disparities reflect more than simple socioeconomic and educational parity. By examining the long-term psychological effects of Tuskegee, it becomes apparent that some African-Americans have lost all trust in their former abusers—the medical establishment—unintentionally perpetuating health disparities in their communities.

This study, and other forms of medical and research mistreatment, led many Black people to distrust and fear medical care in the United States. Other forms of mistreatment, oppression, and covert and overt racism have led some members of the Black race, and members of other racial groups, to distrust the medical and public health establishment.

Barriers to Seeking Care

Beyond mistrust of the medical establishment, there are other issues, such as lack of cultural competence and a shortage of Black physicians, that impose a barrier for Black people in seeking medical care. The United States has a long history of lack of access to health care for non-White people. This history of unequal access and quality of care created and continues to foster an environment of higher morbidity and mortality rates among the various emerging majority groups. This lack of or insufficient access to health care in the United States led to poorer health, **health inequality**, and a widening health status gap between the emerging majority and majority population. These trends have raised alarm about the impact of a skewed distribution of societal resources on social and physical well-being. Public health officials have called attention to this problem and pledged to reduce it (Adler & Stewart, 2010).

▸ Persistence of Health Disparities

A look back over the past 35 years shows acknowledgment, on behalf of the U.S. government, that the worsening health disparity gap between emerging majority and majority populations warranted attention and resources. Various initiatives were implemented and new federal-level offices were created in an effort to address emerging majority health issues, the tremendous gap in health disparities, and the worsening emerging majority health status. In 1984 the U.S. Department of Health and Human Services released "Heath, United States, 1983," a report on the health of the nation. The report documented that although the overall health of the nation showed significant progress, major disparities existed in "the burden of death and illness experienced by Black people and other minority Americans as compared with the nation's population as a whole" (Gibbons, 2005, p. 2).

Interest in health disparities has grown geometrically over the past 20 years. A primary contributor to this surge is the persistence of health disparities despite improvements in medical care and public health prevention initiatives (Adler & Stewart, 2010). The body of research on health disparities over the last 20 to 30 years increased rather significantly and especially as national attention was placed on this important issue. Within the last 20 years, one can identify several distinct eras of work on health disparities' association with socioeconomic status. Adler and Stewart (2010) describe the eras as follows:

> The first era reflected an implicit threshold model of the association of poverty and health. The second era produced evidence for a graded association between [socioeconomic status] and health where each improvement in education, income, occupation, or wealth is associated with better health outcomes. Moving from description of the association to exploration of pathways, the third era focused on mechanisms linking socioeconomic status and health, whereas the fourth era expanded on mechanisms to consider multilevel influences, and a fifth era added a focus on interactions among factors, not just their main effects or contributions as mediators. (p. 6)

Research in health disparities is generally considered to proceed in three generations: (1) research describing relevant disparities, (2) research that addresses the underlying causes of these disparities, and (3) investigations designed to address and resolve these disparities (Dehlendorf et al., 2010). First-generation research studies have provided an abundance of data that significant health disparities exist, including profound differences in life expectancy and cancer-related mortality both by race/ethnicity and by socioeconomic status (Adler & Rehkopf, 2008).

Second-generation research studies have provided insight into pathways through which disparities occur, including individual, provider, and healthcare system factors (Kilbourne, Switzer, Human, Crowley-Matoka, & Fine, 2006). Third-generation research studies have been more limited but suggest that targeted interventions do have success at reducing health disparities (Kilbourne et al., 2006).

TABLE 2-2 highlights select and noteworthy historical U.S. government initiatives over the past 35 years to address health disparities.

TABLE 2-2 Select Noteworthy Historical U.S. Government Initiatives to Address Health Disparities

Date	Initiative
April 1984	The Task Force on Black and Minority Health is established at the U.S. Department of Health and Human Services. This task force is the first coordinated and comprehensive effort facilitated by the department to investigate minority health status in comparison with the majority population.
December 1985	The U.S. Department of Health and Human Services creates the Federal Office of Minority Health. This newly formed office is charged with impacting historical health disparities by developing policy, providing important information that would inform health-related decision making, funding, and providing technical assistance to state minority entities and community-based organizations engaged in improving minority health status.
1986	With significant and increasing gaps in health status among the various racial and ethnic groups, the U.S. Department of Health and Human Services forms the Office of Minority Health. The mission of the office is to develop health policies and programs that will eliminate health disparities while protecting and improving the health of racial and ethnic minority populations.
April 1989	National Minority Health month is designated in an effort to bring greater awareness to health disparities, minority health, and racial and ethnic health status differences.
1990	Congress encourages the creation of the Office of Research on Minority Health.
February 1998	President Clinton announces an Initiative to Eliminate Racial and Ethnic Health Disparities.
September 1999	The National Institutes of Health is charged with developing a plan to reduce health disparities.

(continues)

TABLE 2-2 Select Noteworthy Historical U.S. Government Initiatives to Address Health Disparities *(continued)*

Date	Initiative
2000	The Minority Health and Health Disparities Research and Education Act is passed. The act leads to the creation of the National Center on Minority Health and Health Disparities at the National Institutes of Health.
March 2002	The Institute of Medicine's impactful, influential report "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" is released.
July 2002	The U.S. Department of Health and Human Services Office of Minority Health holds a National Leadership Summit on eliminating racial and ethnic disparities in health.
2009	The Secretary of the U.S. Department of Health and Human Services releases a report on health disparities and health reform.
April 2011	The U.S. Department of Health and Human Services announces a plan to reduce health disparities. The National Partnership for Action initiates a strategy to expand and strengthen community-led efforts to achieve health equity.

Health Disparities and Emerging Majority Groups

Currently, health disparities have once again become a central concern in the United States and globally. Populations within the United States continue to experience marked differences in health and longevity (Adler & Stewart, 2010). This difference in health status between emerging majority groups and the White population continues to increase on the whole and has increased over time, adding to the burden of death and illness among the racial/ethnic minorities of the country.

In response to the disparities identified in the report "Health, United States, 1983," the Secretary of the U.S. Department of Health and Human Services established a task force on Black and minority health, marking the first time the U.S. government formed a group of experts to conduct a comprehensive study of minority health problems (Gibbons, 2005). In 1985 the release of the "Report of the Secretary's Task Force on Black and Minority Health" significantly raised awareness of the disparate health of the country's minority groups as compared with the White majority population (Gibbons, 2005).

The Institute of Medicine's (IOM) 2002 report "Unequal Treatment" significantly raised the level of awareness and attention given to emerging majority health and health disparities. According to the report, in 1999 Congress requested that the IOM (1) assess the extent of racial and ethnic disparities in health care, assuming that access-related factors such as insurance status and the ability to pay for care are the same; (2) identify potential sources of these disparities; and (3) suggest intervention strategies (IOM, 2002). The IOM explains the ensuing research as follows:

> To fulfill this request, an IOM committee reviewed well over 100 studies that assessed the quality of health care for various racial and ethnic minority groups while holding constant variations in insurance status, patient income, and other access-related factors. Many of these studies also controlled for other potential confounding factors, such as racial differences in the severity or stage of disease progression, the presence of comorbid illnesses, location in which care was received (e.g., public or private hospitals and health systems), and other patient demographic variables, such as age and gender. Some studies that used more rigorous research designs followed patients prospectively, using clinical data abstracted from patients' charts rather than administrative data used for insurance claims. (IOM, 2002)

The study committee reported being struck by what it found (IOM, 2002): "Even among the better-controlled studies, the vast majority [of published research] indicated that minorities are less likely than whites to receive needed services, including clinically necessary procedures," even after correcting for access-related factors, such as insurance status. In general, the research showed the following:

- African American/Black and Black Hispanic people tend to receive a lower quality of health care across a range of disease areas (including cancer, cardiovascular disease, diabetes, mental health, and other chronic and infectious diseases) and clinical services.
- African American/Black people are more likely than are White people to receive less desirable services, such as amputation of all or part of a limb.
- Disparities are found even when clinical factors, such as stage of disease presentation, comorbidities, age, and severity of disease, are taken into account.
- Disparities are found across a range of clinical settings, including public and private hospitals, teaching and nonteaching hospitals, and so on.

Emerging majority people suffer more frequently and more severely from many diseases than do non-Hispanic White people, and they often receive lower-quality care, which leads to poorer health outcomes. Given the diversity of the U.S. population, comparative effectiveness research should capture the health outcomes of racial and Hispanic groups and investigate whether disparities reflect variations in care or different responses to treatment (Mullins, Onukwugha, Cooke, Hussain, & Baquet, 2010). Racial and ethnic emerging majority patients are less likely to be placed in rehabilitation than are non-Hispanic White patients, even after accounting for insurance status, suggesting existence of systematic inequalities in access. Such inequalities may have disproportionate impact on long-term functional outcomes of African American and Hispanic traumatic brain injury patients and suggest the need for an in-depth analysis of this disparity at a health policy level (Shafi et al., 2007).

Differences among racial and ethnic groups are pronounced; for example, about twice as many Black and Hispanic people report being in fair or poor health than do White people (Adler & Stewart, 2010). Differences are even greater by socioeconomic status; almost five times as many adults in poverty report fair or poor health compared with those with the highest income (Adler & Stewart, 2010). These findings are consistent with the National Healthcare Quality and Disparities Reports and suggest little progress in eliminating health disparities among emerging majority groups. The 2010 National Healthcare Quality and Disparities Report findings indicate that healthcare quality and access are suboptimal, especially for emerging majority and low-income groups (Agency for Healthcare Research and Quality, 2010). Although quality is improving, access and disparities are not improving. The reports emphasized that urgent attention is warranted to ensure improvements to quality and progress on reducing disparities with respect to certain services, geographic areas, and populations.

Thus far, the 21st century has been a period of ever-growing globalization, resulting in multiculturalism in the United States and elsewhere. The United States is considered a world leader in medical technology. Nevertheless, equity does not exist in the provision of health care because it is not distributed evenly throughout the U.S. population. Although racial and emerging majorities are fast-growing groups that will have greater numbers than the current majority, the White population, in coming years, a grim picture is provided by health statistics in terms of the health status of some emerging majority groups compared with the mainstream population.

Beyond the definitions provided in Table 2-1, health disparity is often referred to as healthcare inequality or gaps in the quality of health and health care across racial, ethnic, and socioeconomic groups. The Health Resources and Services Administration defines health disparity as "population-specific differences in the presence of disease, health outcomes or access to health care" (Carter-Pokras & Baquet, 2002, p. 430). The focus here is disparities pertaining to the quality of care that different ethnic and racial groups receive. Reasons for disparities in access to health care, specifically, are attributed to many causes, such as low socioeconomic status, lack of insurance coverage, lack of a regular source of care, legal barriers, structural barriers, limits in the healthcare financing system, scarcity of providers, linguistic barriers, lack of health literacy among certain groups and communities, cultural barriers, and lack of diversity in the healthcare workforce. Other factors are education, segregation, and immigration status (Kosoko-Lasaki, Cook, & O'Brien, 2009). Education is significant because there is a correlation between health outcomes and years in school. There is no doubt that education impacts employment, social status, and other factors.

However, in American society, education alone may not be sufficient to explain differences in health outcomes, because African Americans with high education levels (college) also may have poorer health outcomes. Differences in health outcomes may have more to do with exposure to positive or negative healthcare practices generationally; for example, African Americans are descendants of slaves and thus may have inherited the dietary preferences of slaves that have been passed on from one generation to the next, including highly seasoned and fried foods and other preparation methods that are less healthy than the foods and methods of other groups. Research was conducted in St. Louis, Missouri, in which the eating habits of the early African Americans were explored. The following was determined:

> During slavery they subsisted on "scraps" from the master's table, second-line (imperfect) crops, and pork. Organ meats such as brains or liver, fried foods, highly salted vegetables (greens) and unusual animal parts generally discarded by the master were prepared to ingenious fashions to add flavor. Cattle and beef were usually consumed by whites. Pig snoots, pig feet, brains, chitterlings, and tripe became the cuisine of the African American culture. (Kosoko-Lasaki et al., 2009, p. 335)

Furthermore, African Americans, who live largely in poorer socioeconomic conditions, are more apt to be first-generation college students, and may have issues associated with lack of cultural competence when seeking health care. As pointed out by LaVeist (2002):

> … that these disparities exist in some areas … suggests that the cost of care is an important consideration in clinical decisions for ethnic minority groups. Study findings that suggest the disparity is reduced for privately insured patients may also be an indication of payment-conscious clinical decisions. (p. 184)

Again, the less-than-positive health outcomes for African Americans are in part a result of eating patterns and culture; Kosoko-Lasaki et al. (2009) discuss these patterns and their cultural significance:

> A very interesting article from the 2001 *Journal of Archaeology*, entitled "Ham Hocks on Your Cornflakes" examined the role of food in the African American Identity. Excavations in Annapolis, Maryland, and 13 other sites in the Chesapeake region were explored. Findings were consistent; food remains showed a definite pattern. Pork was much more commonly consumed than beef, and shallow water fish not typically purchased from markets where whites typically shopped predominated. Apparently, by the late 19th century as whites turned to beef, blacks did not…. For many people, eating particular foods serves not only as a fulfilling experience, but also a liberating one—an added way of making some kind of declaration. Consumption then is at the same time a form of self-identification and communication. Blacks living under the oppression of slavery, with very few options, gathered at the end of the day for a communal meal with friends and family. They most likely found spiritual strength and regeneration through eating and camaraderie. This experience over generations became a part of the culture. (p. 335)

Hence, although education provides one with more information and insight into what it takes to be healthy, it may not be enough to override social factors and long-term exposure to cultural norms.

Segregation is also a factor in health disparity. Although the United States is extremely diverse, groups of people are largely segregated by race. According to Massey and Denton (1994), affluent Black people earning $50,000 or more per year are more segregated than are Hispanic/Latino or Asian people earning less than $15,000 per year. This finding may largely be due to the fact that many Hispanic/Latino people classify themselves as White Hispanic/Latino because Hispanic/Latino is not a race but an ethnicity; thus, they are more apt to live among White people and function as White Hispanics/Latinos. Members of various Asian groups tend to assimilate more rapidly in the United States than do other racial groups and, as a consequence, may not segregate to the same degree as African Americans. In addition, Asian and White Hispanic people have better access to credit and mortgage loans in the United States, as they face less discrimination than do Black people. Thus, Asians and White Hispanics can more easily avoid the negative outcomes of segregation and acquire homes in largely White communities where there is greater access to health care and other health-related services.

Immigration is another significant factor in health disparities primarily because many immigrant populations do not have access to health care. Although community health centers in the United States are available to serve undocumented people, the problem is that most people, including immigrant and nonimmigrant groups, are not aware of these facilities and the fact that people can be seen at these facilities regardless of their ability to pay or their immigration status. Hence, many immigrants have poorer health because they will seek care in emergency rooms or not seek care at all because they believe they will be asked for documentation that may lead to their deportation. The health disparities framework in **TABLE 2-3** provides further insight. Some of the key disparities among the various racial/ethnic groups are listed in **TABLE 2-4**.

Cultural competence is "evolving from a marginal to a mainstream health care policy issue and as a potential strategy to improve quality and address disparities" (Betancourt, Green, Carillo, & Park, 2005). For healthcare organizations, cultural

TABLE 2-3 Health Disparities Framework

Health—Before Care	Access to Care	Healthcare Delivery
Income levels, poverty, and other social conditions	Financial resources	Insurance coverage and type
Safety and adequacy of housing	Availability and proximity of providers	Cultural competence levels
Employment status and type of employment	Access to transportation	Patient–provider Communications
Education levels	Insurance coverage	Provider discrimination or bias
Lifestyle choices—diet, exercise, tobacco, and alcohol use	Regular source of care	Differential propensities for certain diseases by racial/ethnic populations

Health—Before Care	Access to Care	Healthcare Delivery
Environmental conditions—air and water quality, pesticide exposure, green space	Language barriers	Patient preferences and adherence to treatment plans
	Legal barriers (e.g., eligibility restrictions, illegal immigrants)	Diversity of the healthcare workforce
	Prior experience with the healthcare system	Appropriateness of care
	Cultural preferences—care-seeking behaviors	Effectiveness of care
	Health literacy levels	Language barriers
	Diversity of the healthcare workforce	

Courtesy of Health Policy Institute of Ohio. (2004, September). Understanding health disparities. Retrieved from http://a5e8c023c8899218225edfa4b02e4d9734e01a28.gripelements.com/pdf/publications/healthdisparities.pdf.

competence strategy and training must be responsive to aims developed toward improving quality of care. Some of these aims have been developed by the Institute of Medicine, for example, and include safe, effective, patient-centered, timely, efficient, and equitable care. Furthermore, responsiveness to the national standards for culturally and linguistically appropriate services in health care, set forth by the U.S. Department of Health and Human Services Office of Minority Health, will also help in relieving health disparities (Curtis, Dreaschslin, & Sinioris, 2007). A successful example of a culturally competent system of care is described in the Child and Adolescent Service System Program, where the care and services focus on the family as the primary support and community-based approaches as part of informal support systems (e.g., churches, neighborhoods, healers). This effort also entails the introduction of choice in service, incorporation of cultural knowledge into practice and policy-making, less restrictive alternatives, and adequate cross-cultural communication to achieve goals (Cross, Bazron, Dennis, & Isaacs, 1989).

The American College of Physicians (2010) stated in their position paper that racial and ethnic disparities in health care result from the interaction of multiple complex factors, including past and current discrimination in health care, genetics, unequal educational opportunity, income and healthcare access disparities, cultural beliefs, and community systems. They went on to emphasize that the College believes that although improving access to quality care, reforming the healthcare delivery system, improving cultural and linguistic understanding, diversifying the healthcare workforce, and improving the inequities in the social influences of health may not fully close the disparities gap, achieving these worthy goals would dramatically improve the lives of all people and the future of the nation.

TABLE 2-4 Health Disparities at a Glance

African Americans[a]	Hispanic Americans[b]	American Indians/Alaska Natives[c]	Asian and Pacific Islanders[d]
■ In 2011, African American men were 1.3 times and 1.5 times, respectively, more likely to have new cases of lung and prostate cancer, as compared to non-Hispanic White men. ■ Have the highest cancer death rate of any racial or ethnic group. ■ In 2010, African Americans were 30% more likely to die from heart disease than non-Hispanic Whites. ■ Twice as likely to have diabetes than are Whites. ■ African Americans have 2.2 times the infant mortality rate as non-Hispanic Whites. They are 3.5 times as likely to die as infants due to complications related to low birth weight as compared to non-Hispanic White infants.	■ Among Mexican American women, 77% are overweight or obese, as compared to only 64% of the non-Hispanic White women. ■ Hispanic women are both 40% more likely to have cervical cancer, and to die from cervical cancer as compared to non-Hispanic White women. ■ Among Mexican American women, 77% are overweight or obese, as compared to only 64% of the non-Hispanic White women. ■ Puerto Rican infants are twice as likely to die from causes related to low birth weight than are non-Hispanic White infants.	■ The incidence of diabetes is more than twice that of Whites. ■ American Indians/Alaska Native women were twice as likely to die from diabetes as non-Hispanic White women in 2013. ■ In 2010, American Indians/Native Americans were 2.7 times more likely to be diagnosed with end-stage renal disease than were non-Hispanic whites. ■ American Indian/Alaska Native men are 1.5 times as likely to have stomach cancer as are non-Hispanic White men, and are over twice as likely to die from the same disease.	■ Both Asian/Pacific Islander men and women have 2.1 and 2.5 times, respectively, the incidence of liver and irritable bowel disease–related cancer as the non-Hispanic White population. ■ Asian/Pacific Islander men are twice as likely to die from stomach cancer compared to the non-Hispanic White population, and Asian/Pacific Islander women are 2.6 times as likely to die from the same disease. ■ In Hawaii, native Hawaiians have more than twice the rate of diabetes as Whites.

[a] Data from Department of Health and Human Services. (n.d.). African American Profile. Retrieved from http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=61.

[b] Data from the Office of Minority Health. (n.d.). Hispanic American Profile. Retrieved from http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=.

[c] Data from the Office of Minority Health. (n.d.). Cancer and American Indians/Alaska Natives. Retrieved from http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlID=31.

[d] Data from the Office of Minority Health. (n.d.). Cancer and Asians/Pacific Islanders. Retrieved from http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=46.

Wrap-Up

Chapter Summary

Racial and ethnic disparities in health care persist despite considerable progress in expanding healthcare services and improving the quality of patient care. Many factors contribute to these disparities in complex ways, but the quality of health care can be improved for all patients with a comprehensive strategy that includes ensuring that strategies are implemented to not only reduce healthcare disparities, but also to improve the efficiency and equity of care for all patients (Betancourt, Green, Carrillo, & Ananeh-Firemong, 2003). This effort includes taking into consideration the improvement of communication and comfort levels between healthcare providers and their patients/customers. Many healthcare organizations are facing dramatic demographic shifts in their customer patient populations and, therefore, are challenged to provide quality healthcare services to an increasingly diverse patient base. This chapter has discussed complex, sensitive, and challenging issues related to health disparities, emerging majorities, and the health status gap that has historically existed in the United States between different racial groups, with special focus on the substandard health status of Black people, with insight regarding contributing factors.

Chapter Problems

1. List three factors that contribute to health disparities.
2. Explain the notion of medical exploitation in terms of Black people in the United States.
3. What are some key barriers to accessing health care? Explore potential solutions.
4. Consider the following statement: Education level is a significant determinant in health disparities because there is a correlation between years in school and health outcomes. Is this statement true or false? Why?
5. What is the difference between the terms *emerging majorities* and *minorities* as they relate to populations in the United States?

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