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Health Disparities: Definitions and Measurements

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An article in this issue of the journal, titled “Family Planning Disparities” is the first in a series of four articles addressing disparities in the area of obstetrics and gynecology. The remaining articles will appear in subsequent issues, and will address disparities in reproductive endocrinology and infertility, obstetrics, and gynecology. As the field of health disparities research is rapidly evolving and conceptually complex, in this editorial we provide a background on the definitions and current understanding of health disparities to serve as a foundation for understanding this series.

What are Health Disparities?

While the term “health disparities” appears to represent a concept which can be intuitively understood, there is much controversy about its exact meaning. A central aspect of the most accepted definitions is that not all differences in health status between groups are considered to be disparities, but rather only differences which systematically and negatively impact less advantaged groups are classified as disparities¹. In the United States, discussion of disparities has focused primarily on racial and ethnic disparities. In the international literature, and increasingly in the US, socioeconomic status (SES) and gender disparities, disparities between disabled and non-disabled individuals, and disparities by sexual orientation have also been considered.

An additional point of discussion within these definitions is whether to include differences which are not likely to be remediable by social or policy interventions, such as those caused by genetic differences between racial and ethnic groups. In practice, with the exception of certain well-defined genetic conditions, it is often difficult to differentiate the degree to which disparities are related to non-genetic versus genetic influences. From a social justice perspective, we believe it is most important to focus on those differences which society has a role in creating, and therefore has the greatest potential to ameliorate.

“Health care disparities” is another term which requires definition. While many factors contribute to health disparities and are discussed briefly below, differences in the quality of health care is a factor which has received substantial attention. The Institute of Medicine emphasized the importance of health care disparities in the report “Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare”. In this report they detail the most

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commonly accepted definition of health care disparities: “differences in the quality of health care that are not due to access-related factors or clinical needs, preferences or appropriateness of intervention”.² Health care disparities are therefore one particular aspect of health disparities. While the overall impact of these disparities is considered small relative to other determinants of health, it is often deemed to have the most relevance to the medical community since it is the most amenable to changes within the health care system.

Challenges in the Study of Health Disparities

Investigating disparities in health between more and less advantaged groups requires the accurate identification and categorization of those groups. The definitions of race, ethnicity and SES raise measurement issues which researchers in health disparities must consider. With respect to race and ethnicity, measurement strategies have ranged from use of genetic markers to 3rd party assignment to self-identification. While self-identification is generally considered the gold standard for non-genetic studies³, a recent review found that many authors do not indicate the means of identifying the race and ethnicity of subjects in their manuscripts, and that investigators assign race and ethnicity to subjects in a minority of cases.⁴

How best to categorize race and ethnicity is another area of concern. The inclusion of mixed-race categories and the degree of granularity used to categorize ethnicity (e.g. whether to group all Hispanic/Latinos as one category versus considering Mexican-American, Cuban-American etc., separately) are both topics of active discussion in the literature. The most commonly used categories are those delineated by the Office of Management and Budget (OMB) in 1997, which includes five race categories (Black or African American, White, Asian, American Indian or Alaska Native, and Native Hawaiian or Other Pacific Islander) as well as one ethnicity choice (Hispanic/Latino or non-Hispanic/Latino)³. In addition, the OMB allows for the designation of multiple race categories by each individual. A recent report by the Institute of Medicine (IOM) attempted to further clarify reporting of race and ethnicity by calling for use of the OMB categories along with more precise ethnicity categories in accordance with the geographic area in which data collection occurs⁵. It should be noted that the OMB and IOM categories are not universally agreed upon. One area of disagreement is whether to consider race and ethnicity separately, with some arguing that in fact these two categories are overlapping⁶.

SES presents different, but equally complex, measurement issues. The concept of SES represents a composite of many different factors, including income, education, childhood income level, parental education, and wealth. In disparities research, this complexity is often distilled down to the use of one, or at most two, factors. This is often inadequate, as analyses have shown that conclusions can differ widely depending on which measures of SES are utilized⁷. Ideally, the study of health disparities by SES should incorporate multiple factors, with attention to those which are most relevant for the research question being studied.

An additional consideration in measuring race, ethnicity and SES in the study of health disparities is how to account for the complex ways in which these constructs can interact with each other⁸. For example, being of low SES may impact the health of African Americans differently than Whites, and consideration of these types of nuances must be incorporated into the conceptualization and study of health disparities.

The Current State of Knowledge of Health Disparities

Research in health disparities is generally considered to proceed in three generations; first is the descriptive research describing relevant disparities, second is research which addresses the underlying causes of these disparities, and third are investigations designed to address

and resolve these disparities ⁹. These generations of research do not occur in parallel for all fields, and the study of health disparities is most advanced in the area of chronic diseases.

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 SES ¹⁰. Second generation research studies have provided insight into pathways through which disparities occur, including individual, provider, and health care system factors ⁹. In addition, the social determinants of health, such as poverty and unstable housing, have received attention, including the influence that chronic life stress, or allostatic load, has on risk of poor health outcomes ¹⁰. Third generation research studies have been more limited, but suggest that targeted interventions do have success at reducing health disparities ⁹.

Conclusion

The study and understanding of health disparities requires knowledge of the analytic and conceptual framework used by research in this area. We hope that this editorial and the four articles in this series will provide an informative and thought-provoking review of how these concepts have been applied in obstetrics and gynecology as well as a basis from which to pursue the ultimate goal of eliminating disparities in women's health.

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