Racial and Ethnic Disparities in Health and Health Care

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KEYWORDS

• Race • Ethnicity • Disparities • Health care • Inequity

KEY POINTS

- Racial and ethnic disparities exist on every level of health care system: the patient, the provider, and the health care system.
- On the patient level, genetic predispositions to inherited conditions that cluster within race groups and shared cultural beliefs within ethnic groups are important mediators of disparities.
- Providers, even though most often well meaning, are subject to implicit biases that can have a negative impact on interactions with minority patients and contribute to disparities.
- Although there are improvements in access to care for racial and ethnic minorities, there remains room for improvements to improve disparities at the health care system level.
- Research dedicated to characterizing, understanding, and ending racial and ethnic disparities in health care is urgently needed.

INTRODUCTION: DEFINING HEALTH DISPARITIES AND THE NATIONAL IMPACT

Few topics generate greater controversy than issues of race and ethnicity in the United States. *Race* — a categorization based on common physical characteristics — and *ethnicity* — a categorization based on shared cultural traits — both have a powerful impact on one's experience in America. Disparities in health care present notable examples of the intersection between race, ethnicity, and the American experience. A *health disparity* is defined as an increased burden of an adverse health outcome or health determinant within a specific subset of the population.[1] Health disparities can and do affect many different groups; however, there is a long-standing history of disparities affecting racial and ethnic minorities in the United States.

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Although from a biological standpoint there are far more similarities between racial and ethnic groups than there are differences,[2] notable differences in outcomes along these primarily socially constructed lines are impossible to ignore. In 2013, the Centers for Disease Control and Prevention reported an average life expectancy of 79.1 years for whites and 75.5 years for blacks.[3] Although this 3-year gap represents an improvement in the life expectancy disparity, which was as high as 15 years at the start of the twentieth century, the scientific community is still in the early stages of understanding the complex causes and implications of disparities along race and ethnic lines.

The distinction between disparities in *health outcomes* and *health care* is worthy of mention. Although differences in prevalence of infant mortality or obesity, for example, are considered disparities in outcome that may have contributions from both inside and outside the health care system, disparities in health care arise distinctly within the health care arena and include such inequities as differential access to care or differences in likelihood of receipt of specific therapies or counseling.

There is mounting interest in research and public policy exploring racial and ethnic disparities because minority populations are growing in the United States. In 2015, the US Census Bureau reported that racial and ethnic minorities comprise 38.4% of the population.[4] It is projected that by 2050 non-Hispanic whites will no longer be the majority group within the United States.[4] With the evolving population demographics, the burden of health and health care disparities is becoming increasingly costly both for the patients who suffer the adverse health affect and the health care system that is ill-equipped to manage the economic effects of these adverse outcomes.

The *Harvard Business Review* estimates the US cost of race and ethnic health disparities to be in excess of $245 billion dollars annually.[5] These costs are directly reflected in health care premiums for employer-based health plans. As an example, it is estimated that if the disparity in effective asthma treatment of African Americans was reduced by only 10%, American workers would save more than $1600 per person on a yearly basis.[5] Additionally, racial and ethnic minorities are known to have increased rates of sexually transmitted infection, unintended pregnancy, and poor pregnancy outcomes, all with far-reaching social and economic effects.[6–11]

The profound economic and social impact of health and health care disparities is notable among minority women who are vulnerable to disparities that affect not only themselves but also their childbearing, children, and, therefore, communities. Obstetrician-gynecologists have a place at the forefront of growing efforts to identify, understand, and narrow these disparate outcomes.

THE ETIOLOGY OF RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE

Social determinants of health, such as income, wealth, and educational and employment opportunities, have effects on health outcomes. Even when controlling for the social determinants that are able to be accurately captured and measured, however, disparities remain.[12] Contributions stemming from multiple levels of health care — from the individual patient to the provider and hospitals to the health care system at large, including the subset that is medical research — all have profound impacts on health disparities.[12] Narrowing outcome gaps requires strategies aimed at improving disparities on each of these levels.

Patient-Level Factors

It is tempting to completely dismiss race and ethnicity as biologically meaningless social constructs with no bearing on medicine beyond their association with social determinants of health. The average proportion of genetic difference between