EDITORIAL

Health Disparities and Public Policy

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Health-related disparities are significant differences in the incidence, prevalence, morbidity, mortality, and burden of disease among specific population groups. Medical research has demonstrated glaring disparities for a wide range of health problems and among different groups. It is important that we improve our understanding of what causes health disparities and work to address them. In doing so there is a tendency to discuss health disparities solely in terms of differences among racial and ethnic groups; however it is a myth that only these groups experience disparities. Unfortunately, health disparities occur in all segments of society.

Medical research working to achieve the goal of alleviating health disparities in the United States is a goal with broad support that adopts the well-established perspective that various forms of discrimination and poverty are the major contributors to unequal health status. One idea that has been put forth is that genetic research plays a significant role in alleviating this national problem, which may overstate the importance of genetics in explaining health disparities. Over reliance on genetics as a factor in explaining health disparities may lead us to miss the factors that we can control, thus reinforcing stereotyping which contributes to disparities in the first place.

Access to care is a primary reason for disparities. For example, disparities due to limited access to coronary artery bypass graft (CABG) surgery are well documented. Evidence shows that even when patients do receive CABG surgery, the poor, people living in rural areas, and racial minorities are more likely to be treated by lower quality providers. In addition, some disparities occur due to the hospital to which patients are admitted and to a lesser degree to being treated by a low-volume surgeon. Efforts to eliminate health disparities should address not only access to care, but also access to high-quality care.

Obesity is a major concern nationally that crosses all socioeconomic groups. Genetics, and lack of access to dietary/nutritional information, healthy foods, and needed exercise all contribute to the problem of weight control. A recent study, funded by the National Institutes of Health, analyzed a sample of Americans' weight. The results show continuing disparities by sex and between racial/ethnic groups in the prevalence of obesity.

Adults with developmental disabilities experience disparities that are often not as obvious. A recent study found this population to be more likely to lead sedentary lifestyles and seven times as likely to report inadequate emotional support compared to adults without disabilities. Adults with disabilities and developmental disabilities were also more likely to report being in fair or poor health than adults without disabilities. Significant medical care utilization disparities were found for breast and cervical cancer screening as well as for oral healthcare in this group.

Mental health and drug abuse, e.g., nicotine, alcohol, and illicit drug problems, are a classic example of disparities at both the prevention and treatment level. These types of behavioral problems face stigmas that further contribute to the disparity problem. For example, in a national study the prevalence of smoking during pregnancy ranged from 9.0% to 17.4%. Younger (age <25 years) women, white women, American Indian women, non-Hispanic women, women with a high school education or less, and women with low incomes consistently reported the highest rates of smoking. In the same study the prevalence of alcohol use during pregnancy ranged from 3.4% to 9.9%. In seven states, women age >35 years, non-Hispanic women, women with more than a high school education, and women with higher incomes reported the highest prevalence of alcohol use during pregnancy. Although prevalence data cannot be used to identify causes or interventions to improve health outcomes, they do indicate the magnitude of disparities and identify populations that should be targeted for intervention.

We recognize that a number of groups experience inferior medical care and health status, but may not appreciate the seriousness of the problem. Each year the United States spends billions of dollars to perfect the 'technology' of healthcare, e.g., development of new drugs, new pieces of equipment, and to modernize delivery systems, thereby saving thousands of lives. Correcting known disparities could prevent five times as many deaths. If policymakers adhered to the goal of optimizing population health, greater priority would go to resolving disparities rather than to developing new technology, but unfortunately reverse priorities prevail.

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