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Racial and Ethnic Health Disparities in the U.S. Their elimination must become one of the nation's top health priorities

By David Satcher, M.D., Surgeon General of the United States

The facts are grim. A baby born to an African American mother has more than twice the risk of dying in the first year of life compared to a white baby. American Indians have more than two times the risk of dying from cirrhosis of the liver compared to the general population. Asian Americans and Pacific Islanders are three to five times more likely to die from liver cancer than whites. And while 61 percent of whites can expect to have their life extended by a year or more after coronary artery bypass surgery, only 42 percent of African Americans can expect such an outcome. (See Figure 1)

The twentieth century brought unprecedented improvements in the health and longevity of the U.S. population. But some racial and ethnic groups have not shared fully in this progress. Our nation must commit to eliminating these disparities. We must do so not just on moral and ethical grounds and because it is the right thing to do, but because our future economic prosperity will depend more and more on the health

of an increasingly diverse population. In some states, minority groups already make up a third to nearly half of the population.

Contrary to widespread belief, health disparities are not explained by the biologic and genetic characteristics of racial and ethnic groups. Instead, they result from the complex interplay

of many factors. These include genetic variations, environmental and economic conditions, specific health behaviors, and discrimination in access to and quality of health services.

Not surprisingly, inequalities in income and education underlie some health disparities. A person who has less than a high school education is more than three times as likely to die from asthma compared to someone who has completed at least some college.

Behaviors and lifestyle patterns also play a major role. Among adults, American Indians and Alaska Natives have the highest rates of smoking, for instance. And African Americans and Hispanics generally are

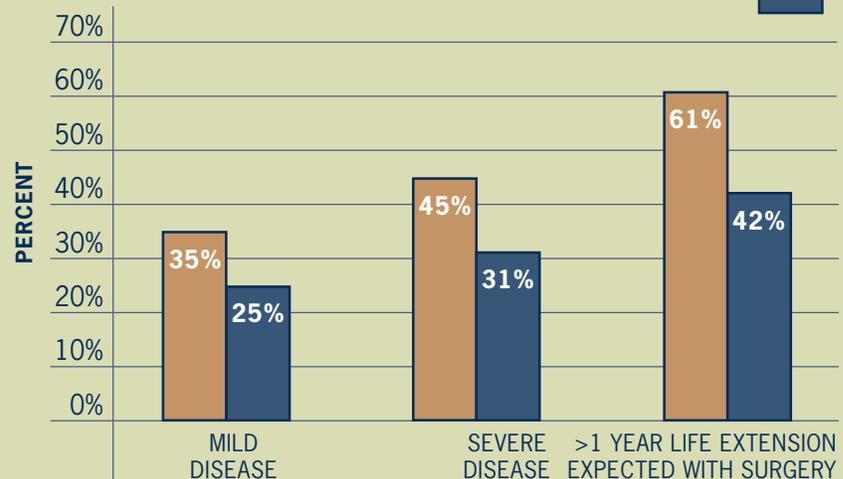
the least physically active. These habits yield poorer health status.

But there is now evidence that disparities exist among racial and ethnic groups in the current structure of the health care system. Minority populations simply have less access to care because fewer doctors and clinics exist in their communities. And where health facilities exist they may be less well equipped or staffed, or be overcrowded. Most importantly, people who are members of minority groups are less likely to be referred for tests, get specialty care or mental health care and needed procedures and surgery. One recent study even found that African Americans in the Medicare program

FIGURE 1

Variations in Heart Surgery Rates

Percentage of people receiving coronary artery bypass surgery



SOURCE: Peterson et al., *New England Journal of Medicine*, 1997, Vol. 336: 480-386.



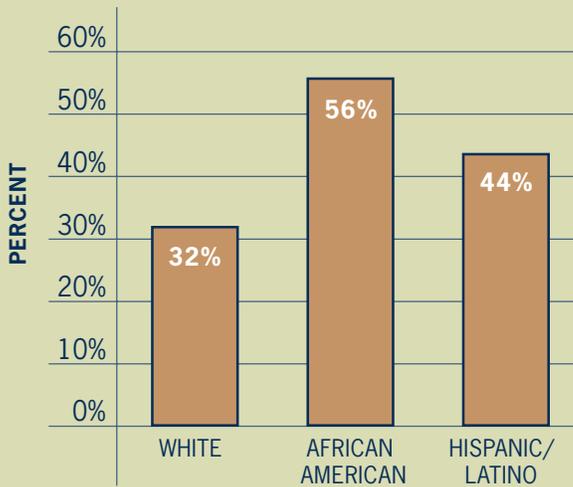
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FIGURE 2

HIV Drug Treatment

Percentage of people who needed but did not receive combination therapy



SOURCE: Shapiro, et al., *Journal of the American Medical Association*, 1999, Vol. 281: 2305–2375.

are far less likely to get an annual flu shot than whites (46% versus 68%).

Such health disparities have persisted, in some cases for many years. And the gap may be getting larger. That means eliminating health disparities will be a major challenge. No single organization — including the federal government — can do the job. Only through sustained leadership and the combined efforts of all segments of society, including the public and private health sectors, business and labor interests, and the faith community, can we make progress.

For its part, the federal government recently set a formal goal of health equity for all Americans. Under the auspices of the *Healthy People 2010* initiative, some 400 national organizations and state health departments are forging a common path to a more equitable health system. Among their approaches:

- **Use Healthy People 2010 as a guide.** The U.S. Department of Health and Human Services in January 2000 launched Healthy People (HP) 2010, which set health priorities for the nation. Amid 467 objectives in 28 focus areas are dozens of specific benchmarks for reducing racial and ethnic health disparities. For example, aiming at the significant disparity in the HIV/AIDS death rates among population groups, HP 2010 seeks to lower the death rate for all Ameri-

ment urges communities and health planners to prioritize strategies to improve health and health care using these indicators. For example, states should build physical education and exercise into school programs from kindergarten to 12th grade. Likewise, states and cities must do more to battle overweight and obesity, especially among minority groups which have higher rates of obesity compared to whites.

- **Engage in partnerships.** The public and private sectors must share the challenge of eliminating health disparities. Partnerships mean less duplication, more lessons shared, more resources maximized, and ultimately more people benefiting from the services offered. In addition, nontraditional partners like faith and labor organizations can support a multidisciplinary approach.

- **Empower individuals through communication and education.** Health communication and education can raise awareness about health risks and empower individuals to make appropriate and more complex health decisions. Emerging media and technologies should be used to reach disadvantaged groups and racial and ethnic minorities. Currently, only 11 percent of African Americans and 13 percent of Hispanics have access to the Internet in their homes compared to 36 percent of Asians and 30 percent of whites. We must increase

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cans to 0.7 per 100,000 by 2010. In 1998, the rate was 22 per 100,000 for African Americans and 3 per 100,000 for whites.

- **Prioritize with leading health indicators.** HP 2010 presents 10 health indicators as key criteria of our national well-being. They are (not in any particular order): physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, environmental quality, immunization and access to health care. The federal govern-

Internet access for these racial and ethnic groups or find alternatives.

- **Encourage diversity within organizations.** Diversity is one of our nation's greatest strengths. We must find ways to ensure that we have a diverse pool of health planners, practitioners, public health advocates and other leaders who will be developing culturally appropriate programs to eliminate health disparities. This effort can start by increasing the proportion of underrepresented racial and ethnic groups trained in health-related fields. During 1996–97, only 0.6 percent of medical degrees were awarded to American Indians/Alaska Natives, 4.6 percent to Hispanics, and 7.3 percent to blacks.

I invite you to use the following resources to join the mission to end racial and ethnic health disparities in the U.S.

Healthy People 2010

www.health.gov/healthypeople

Leading Health Indicators

www.health.gov/healthypeople/LHI

Become a Partner

www.health.gov/healthypeople/Implementation

Healthy People Toolkit:

A Field Guide to Health Planning

www.health.gov/healthypeople/Publications

Healthy People in Healthy Communities: A Community Planning Guide Using Healthy People 2010

www.health.gov/healthypeople/Publications

Prevention Report: Winter 2001

<http://odphp.osophs.dhhs.gov/pubs/prevrpt>

healthfinder®

www.healthfinder.gov

HHS Initiative to Eliminate Racial and Ethnic Disparities in Health

<http://raceandhealth.hhs.gov>

Funding opportunities

www.bphc.hrsa.gov/campaign

<http://healthdisparities.nih.gov>

Leslie D. Hsu and Carter Blakey helped prepare this essay.