

What Are Health Disparities?

Health disparities are largely preventable health differences that adversely affect populations who experience greater challenges to optimal health and are closely linked with intergenerational social, economic, and/or environmental disadvantages—primarily based on identification as an individual from a racial and/or ethnic minority group and/or by low socioeconomic status (SES) in society.

Health disparities may be observed in the risks, prevalence, or problems resulting from specific behaviors, as well as the incidence, prevalence, and mortality from conditions, diseases, and/or disorders. Health disparities also can be observed in health care access, quality, and utilization, and within the delivery of clinical care.

Understanding and Addressing Health Disparities

Racial and ethnic minority populations and low SES groups, on average, are facing high rates of most chronic diseases, medical comorbidities, and other health problems. These health disparities may be exacerbated by intersecting factors such as living in an underserved rural location, living with a disability, or identification with a sexual minority group. Intergenerational social disadvantages and discrimination are common threads that link all populations that experience health disparities.

Race and ethnicity are social constructs that should not be applied as a proxy for human genetic variation. The use of race and ethnicity as proxies for human genetic similarity can lead to conflation between social groups and genetic heritage.

SES is also a social construct with various indicators, such as educational attainment, employment, and income. There is a need for integrative and holistic research that provides explanations for the mechanisms by which structural, environmental, biological, and other contextual factors interact in additive and nonadditive ways to contribute to disease etiology and health outcomes.

See the [NIMHD Research Framework](#) for more information.

Addressing health disparities in a meaningful way requires a comprehensive view of how health is maintained, improved, or worsened via modifiable influences, which include, but are not limited to:

- Factors such as barriers to high-quality health care, and adverse environmental and macro-level exposures (physical, chemical, and/or community-related elements) that may impact individual level factors such as:
 - 1. Biological factors and reactions**
(e.g., age, inherited conditions, stress hormones, metabolic perturbations)
 - 2. Gene expression**
(e.g., social epigenetics)
 - 3. Lifestyle and behavioral factors**
(e.g., tobacco use, physical activity, food consumption, decision-making)



What Are Metrics of Health and Health Care Disparities?

Health disparities can be identified based on *significantly greater* or *disproportionate* morbidity or premature mortality that is preventable on one or more of the following measures:

1. Incidence and/or prevalence, including earlier onset of disease or higher prevalence of preclinical disease/ biomarkers.
2. Premature or excessive mortality from specific conditions.
3. Population health disease metrics, such as life expectancy, disability-adjusted life years, or health-related quality of life.
4. Condition-specific symptoms on validated self-reported measures that reflect daily functioning in physical, cognitive, or socio-emotional domains.
5. Prevalence of short-term and/or long-term preventable complications.
6. Prevalence of modifiable risks, health risk behaviors, and adverse clinical outcomes.
7. Inadequate, untimely, or differential access, utilization, or availability of high-quality health care services.

How Do Scientists Select an Appropriate Reference Population/Group in Racial and Ethnic Health Disparities Research*?

The choice of a reference population is important for benchmarking health outcomes and evaluating health disparities. The reference population in U.S. health disparities research has often utilized the racial majority group (i.e., White persons) as the reference group.

The traditional conceptual and analytic practices of using White persons as the reference, and thus, the standard, may perpetuate stereotypes through deficit-based hypotheses and/or interpretations. Moreover, White persons often do not have significantly better outcomes than all other populations.

The selected reference group in health disparities research must be chiefly guided by the scientific questions and potential for generalizable results. Reference group options include, but may not be limited to:

1. The majority population/group in the geographic context.
2. The population group with the best health outcome, lowest disease incidence/prevalence, lowest prevalence of risk factors, and/or lowest disease prevalence.
3. The population group with largest sample size (in the study), which is also referred to as the majority-referenced approach.
4. Setting absolute targets for outcomes based on societal goals—such as Healthy People 2030 goals—across all demographic groups, rather than focusing on variation across groups.
5. Using a positive deviance approach, which focuses on people within population groups or subgroups who are thriving or showing positive health-related outcomes despite social, economic, and/or environmental disadvantages, rather than those who are not.

*Similar reference group considerations apply to health disparities research focused on low SES groups, underserved rural communities, sexual minority groups, and people with disabilities.

