A n article in this issue of the Journal, titled “Family Planning Disparities,” is the first in a series of 4 articles to address 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. Because the field of health disparities research is evolving rapidly and is conceptually complex, in this editorial we provide a background of the definitions and current understanding of health disparities to serve as a foundation for understanding this series.

What are health disparities?

Although the term health disparities appears to represent a concept that can be understood intuitively, 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; only differences that systematically and negatively impact less advantaged groups are classified as disparities.

In the United States, discussion of disparities has focused primarily on racial and ethnic disparities. In the international literature and increasingly in the United States, socioeconomic status (SES) and gender disparities, disparities between disabled and nondisabled individuals, and disparities by sexual orientation have also been considered.

An additional point of discussion within these definitions is whether to include differences that are not likely to be remedi-able 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 nongenetic vs genetic influences. From a social justice perspective, we believe it is most important to focus on those differences that society has a role in creating and therefore that have the greatest potential to ameliorate.

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 that researchers in health disparities must consider. With respect to race and ethnicity, measurement strategies have ranged from use of genetic markers to third-party assignment to self-identification. Although self-identification generally is considered the gold standard for nongenetic studies, a recent review found that many authors do not indicate the means of identifying the race and ethnicity of subjects in their articles and that investigators assign race and ethnicity to subjects in a minority of cases.

How best to categorize race and ethnicity is another area of concern. The inclusion of mixed-race categories and the degree of granularity that is used to categorize ethnicity (eg, whether to group all Hispanic/Latinos as 1 category vs considering Mexican American, Cuban American separately) are both topics of active discussion in the literature. The most commonly used categories are those that are delineated by the Office of Management and Budget (OMB) in 1997, which includes 5 race categories (black or African American, white, Asian, American Indian or Alaska Native, and Native Hawaiian or Other Pacific Islander) and 1 ethnicity choice (Hispanic/Latino or non-Hispanic/Latino). In addition, the OMB allows for the designation of multiple race categories by each individual. A recent report by the Institute of Medicine attempted to further clarify the reporting of race and ethnicity by calling for the use of the OMB categories along with more precise ethnicity categories in accordance with the geographic area in which data collection occurs. It should be noted that the OMB and Institute of Medicine categories are not agreed on universally. One
The current state of knowledge of health disparities

Research in health disparities generally is considered to proceed in 3 generations; first is the descriptive research that describes relevant disparities; second is research that addresses the underlying causes of these disparities, and third is investigation that is designed to address and resolve these disparities. These generations of research do not occur in parallel for all fields; 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 and include profound differences in life expectancy and cancer-related mortality rates both by race/ethnicity and by SES. Second-generation research studies have provided insight into pathways through which disparities occur and include individual, provider, and health care system factors. In addition, the social determinants of health (such as poverty and unstable housing) have received attention and include the influence that chronic life stress, or allostatic load, has on the risk of poor health outcomes. Third-generation research studies have been more limited but suggest that targeted interventions do have success at reducing health disparities.

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 4 articles in this series will provide an informative and thought-provoking review of how these concepts have been applied in obstetrics and gynecology and will provide a basis from which to pursue the ultimate goal of eliminating disparities in women’s health.

REFERENCES