

Health disparities are preventable differences in the burden of disease, or in opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups. This capsule pulls together information from past GAO reports to provide examples of health disparities, barriers that can contribute to disparities, and federal efforts to address these disparities.

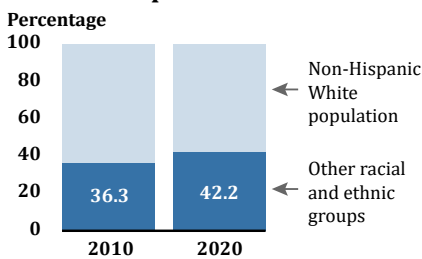


HEALTH CARE CAPSULE

RACIAL AND ETHNIC HEALTH DISPARITIES  
Accessible Version

People of races and ethnicities other than non-Hispanic White make up an increasing proportion of the U.S. population. The percentage of the population representing such racial and ethnic groups grew from 36.3 percent in 2010 to a projected 42.2 percent in 2020, according to the U.S. Census Bureau.

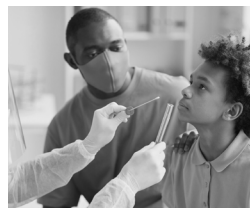
**Figure 1: Percentage of U.S. Population Representing Racial and Ethnic Groups in 2010 and 2020**



Source: GAO analysis of U.S. Census Bureau data. | GAO-21-105354

Over the past few years, federal agencies have taken various actions to help address disparities for racial and ethnic groups. Recognizing the need for additional efforts, executive orders signed in 2021 call for advances in racial equity throughout the federal government. This includes a goal to advance health equity—the opportunity for all persons to attain their best possible health—and the call for government agencies to identify and address the extent to which their work perpetuates barriers for various racial and ethnic groups.

**Figure 2: Examples of Health Disparities Experienced by Racial and Ethnic Groups**



**COVID-19.** Racial and ethnic disparities are reflected in available data on COVID-19 test positivity rates, cases, hospitalizations, deaths, and vaccinations. Between March 2020 and June 2021, Hispanic or Latino persons and non-Hispanic Black persons were hospitalized due to COVID-19 at a rate 2.8 times more than non-Hispanic White persons, after adjusting for age. As of July 2021, American Indian/Alaska Native persons died of COVID-19 at a rate 2.4 times higher than White persons, when adjusting for age. ([GAO-21-387](#))



**Maternal mortality.** Women from various racial groups in rural and underserved communities have higher rates of maternal mortality and other adverse maternal health outcomes. Centers for Disease Control and Prevention (CDC) data from 2011 through 2016 show that in the most rural counties, Black women experienced 59.3 deaths per 100,000 live births, compared to 19.7 for White women in the same counties. CDC stated that these disparities also exist in urban areas. ([GAO-21-283](#))



**Life expectancy and chronic health conditions.** People from some racial and ethnic groups are at greater risk of dying from preventable causes than other Americans. In 2018, the age-adjusted mortality rate for diabetes was higher among Black (47.9 deaths per 100,000 persons) and American Indian/Alaska Native (40.0) persons than White persons (24.8). Additionally, the rate for Hispanic or Latino persons was 31.4 deaths per 100,000 persons compared to the non-Hispanic or Latino rate of 26.8. ([GAO-21-593](#))



**Disparities among veterans.** The Department of Veterans Affairs (VA) has identified worse health care outcomes for some diseases among veterans from various racial groups, such as lower survival rates for Black veterans with cancer and cardiovascular-related illnesses than White veterans. ([GAO-20-83](#))

Source: GAO; Seventyfour; Blue Planet Studio, Andrey Popov/stock.adobe.com; and U.S. Department of Veteran Affairs (photos). | GAO-21-105354

**BARRIERS THAT CAN CONTRIBUTE TO RACIAL AND ETHNIC DISPARITIES**

We've reported that various barriers such as discrimination, economic instability, and lack of health care access can contribute to health disparities. For example, implicit

biases and misperceptions about people from various racial and ethnic groups, especially for Black women, can exacerbate disparities by race and ethnicity in access to care. Additionally, socioeconomic factors, such as being uninsured, are associated with greater risk for maternal mortality.

## EXAMPLES OF FEDERAL EFFORTS TO HELP ADDRESS DISPARITIES

Agencies within the Department of Health and Human Services developed action plans and strategies to address health disparities. For example, in July 2020, CDC released its COVID-19 Response Health Equity Strategy, which aims to reduce health disparities by using data-driven approaches to attain the highest level of health possible for all individuals.

In 2019, VA updated its Health Equity Action Plan aimed at eliminating disparities for veterans. Goals of the action plan include strengthening leadership to address disparities; increasing awareness of the significance of health disparities; improving racial and ethnic data availability and health care outcomes; and increasing health-related workforce diversity.

## POLICY CONSIDERATIONS

- Complete reporting of race and ethnicity information by states, jurisdictions, and federal health systems and the routine analysis of health outcomes using these data can help the federal government better understand existing health disparities and take actions to promote health equity.
- The consideration of racial and ethnic disparities within federal government programs can help agencies determine how their goals can be operationalized to advance health equity.

## ADDRESSING GAPS IN RACE AND ETHNICITY DATA

Gaps in race and ethnicity data may affect the federal government's ability to identify and address health disparities for various racial and ethnic groups. GAO has made several recommendations to help address these gaps, and the responsible agencies are taking steps to respond to these recommendations.

**Table 1: Examples of GAO Recommendations to Address Gaps in Available Race and Ethnicity Data**

What data gaps exist?	Why do they exist?	What has GAO recommended?
<b>COVID-19 Race and Ethnicity Data</b>		
COVID-19 data show gaps exist for testing rates, cases, hospitalizations, deaths recorded through case reporting, and vaccinations by race and ethnicity. GAO reported in March 2021, that race and ethnicity information sent to CDC was incomplete for almost half of reported COVID-19 cases (47.2 percent) and for people who received at least one vaccination dose (46.7 percent).	CDC stated that it does not have the authority to require states and jurisdictions to include race and ethnicity with reported COVID-19 data such as cases, hospitalizations, and deaths. Further, CDC officials noted that information on race and ethnicity for COVID-19 vaccine recipients is missing for a variety of reasons, including a lack of consistent collection and reporting of this information by physicians and pharmacists and challenges with sharing data with CDC.	CDC should (1) determine whether having the authority to require states and jurisdictions to report race and ethnicity information for COVID-19 cases, hospitalizations, and deaths is necessary for ensuring more complete data; (2) involve key stakeholders to help ensure the complete and consistent collection of demographic data; and (3) take steps such as working with states and jurisdictions to ensure more complete reporting of race and ethnicity information for recipients of COVID-19 vaccinations. For more information, see <a href="#">GAO-20-701</a> and <a href="#">GAO-21-387</a> .
<b>Veteran Race and Ethnicity Data</b>		
In 2019, we reported that VA officials and researchers noted weaknesses in the completeness and accuracy of race and ethnicity data, such as missing values for patients' race and conflicting race and ethnicity information.	VA officials reported that intake clerks sometimes enter race and ethnicity information based on observation, which may be inaccurate. According to VA researchers, each veteran's race and ethnicity information is uploaded from his or her electronic health record after each visit, resulting in multiple records for each veteran's race and ethnicity that may be both observational and self-reported.	VA should conduct an assessment to determine the completeness and accuracy of race and ethnicity data captured in VA's electronic health record, and implement corrective actions as necessary to resolve any identified deficiencies. For more information, see <a href="#">GAO-20-83</a> .

Source: GAO; Production Perig, HSNKRT/stock.adobe.com (photos). | GAO-21-105354

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This document is based on GAO audit products and is subject to update. For more information about this Capsule, contact:

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Source: GAO and olly, Sidekick, Krakenimages/stock.adobe.com (cover photo).