Prepared by

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of The Henry J. Kaiser Family Foundation

Acknowledgments

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Key Facts
Race, Ethnicity & Medical Care

Update
June 2003
Contents

Introduction ................................................................. 1

Section 1. Demographics .................................................. 3
Figure 1: Percent Distribution of U.S. Population, by Race/Ethnicity, 2000 ................. 4
Figure 2: Percent Distribution of U.S. Population, by Race/Ethnicity, 2000 and 2050 .......... 4
Figure 3: Poverty Status of the Nonelderly Population, by Race/Ethnicity, 2001 ............... 5
Figure 4: Poverty Status of the Elderly Population, by Race/Ethnicity, 2001 ................. 5

Section 2. Health .............................................................. 7
Figure 5a: Fair or Poor Health, by Race/Ethnicity, 2000 ................................... 8
Figure 5b: Fair or Poor Health, by Race/Ethnicity and Income, 2000 ......................... 8
Figure 6: Infant Mortality Rates for Mothers Age 20+, by Race/Ethnicity and Education, 1998–2000 .... 9
Figure 7: Mortality Ratios, by Age and Race/Ethnicity, 2000 .................................. 9
Figure 8: Heart Disease Death Rates for Adults 25–64, by Income, Race and Gender, 1979–1989 .... 10
Figure 9: Leading Causes of Death, by Race/Ethnicity, 2000 .................................. 10

Section 3. Health Insurance Coverage .................................... 11
Figure 10: Health Insurance Status, by Race/Ethnicity: Total Nonelderly Population, 2001 .... 12
Figure 11: Health Insurance Status, by Race/Ethnicity: Low-Income Nonelderly Population, 2001 .. 12
Figure 12: Medicaid Beneficiaries, by Race/Ethnicity, 2001 ..................................... 13
Figure 13: Medicare Beneficiaries Age 65 and older, by Race/Ethnicity, 1999 and 2030 .......... 13
Figure 14: Sources of Prescription Drug Coverage Among Medicare Beneficiaries Age 65 and Older, June 1999 ................................................................. 14
Figure 15: Nonelderly Uninsured, by Race/Ethnicity, 2001 ..................................... 14
Figure 16: Nonelderly Uninsured Rates Among Racial/Ethnic Groups, 2001 .................... 15
Figure 17: Uninsured Rates Among Racial/Ethnic and Income Groups, 2001 ................. 15
Figure 18: Nonelderly Uninsured Rates, by State, Region, and Race/Ethnicity, 2000–2001 ....... 16

Section 4. Preventive and Primary Care ................................... 17
Figure 19a: No Usual Source of Health Care: Adults 18–64, by Race/Ethnicity, 1993–1994 and 1999–2000 ................................................................. 18
Figure 19b: No Usual Source of Health Care: Adults 18–64, by Race/Ethnicity and Poverty Status, 1999–2000 ................................................................. 18

Continued on next page
Figure 20a: No Health Care Visits in the Past Year, by Race/Ethnicity, 1997 and 2000 ........................................... 19
Figure 20b: No Health Care Visits in the Past Year, by Race/Ethnicity and Poverty Status, 2000 .......... 19
Figure 21a: Late or No Prenatal Care, by Race/Ethnicity, 1980 and 2000 .............................................................. 20
Figure 21b: Late or No Prenatal Care, by Racial/Ethnic Subgroups, 2000 .............................................................. 20
Figure 22a: No Dental Visits in the Past Year, by Race/Ethnicity, 2000 ................................................................. 21
Figure 22b: No Dental Visits in the Past Year, by Race/Ethnicity and Poverty Status, 2000 ..................... 21
Section 5. Specialty Care ........................................................................................................................................... 23

Heart Disease

Figure 23: Rate of Cardiac Interventions Among Medicare Patients Hospitalized with an
Figure 24: Cardiac Procedure Use in Chronic Renal Disease Patients, by Race
and Gender, 1986–1992 ................................................................................................................................. 25
Figure 25: Coronary Artery Bypass Surgery by Race/Ethnicity and Insurance Status, 1986–1988 ....... 25

Cancer

Figure 26: Cancer Screening, by Race/Ethnicity, 2000 ................................................................. 26
Figure 27: Racial Differences in the Treatment of Early-Stage Lung Cancer Among
Medicare Patients, 1985–1993 .................................................................................................................... 27
Figure 28: Untreated Daily Pain Among Elderly Nursing Home Residents with Cancer, 1992–1995 ...... 27

Asthma

Figure 29: Asthma; Health Care Use and Outcomes, 2000 ................................................................. 28
Figure 30: Underuse of Medication Among Medicaid-Insured Children with Asthma, 1999 .......... 29
Figure 31: Use of Selected Services by African American Children with Asthma, 1988–1992 ......... 29

HIV/AIDS

Figure 32: Health Services Use Among Persons with HIV/AIDS in Care,
by Race/Ethnicity, 1998 ............................................................................................................................... 30
Figure 33: Reasons for Postponing Care Among Persons with HIV/AIDS in Care,
by Race/Ethnicity, 1996 ............................................................................................................................... 31
Figure 34: Percent Who Report Ever Having Been Tested for HIV, by Race/Ethnicity, 1999 ............. 31

Conclusion ....................................................................................................................................................... 32

Data Notes ...................................................................................................................................................... 33

Bibliography .................................................................................................................................................... 34
INTRODUCTION

The issue of racial/ethnic disparities in medical care has received a great deal of attention since the Henry J. Kaiser Family Foundation released the first edition of *Key Facts: Race, Ethnicity, and Medical Care* in 1999. Although there had been questions about whether a problem existed, some level of consensus has emerged, due in part to the release of the Institute of Medicine (IOM) report *Unequal Treatment* in 2001. After an exhaustive review of published research, the IOM concluded that racial/ethnic minority Americans “tend to receive a lower quality of health care than non-minorities, even when access-related factors, such as patients’ insurance status and income, are controlled.”

Documented racial/ethnic disparities in health and healthcare have resulted in public and private sector responses at the national, state, and local levels. For example, the field has seen public sector efforts such as the establishment of a National Center on Minority Health and Health Disparities at the National Institutes of Health (NIH), and private sector efforts such as Aetna’s new initiative to gather racial/ethnic background data from its members in order to develop prevention, education, and treatment programs to address disparities in care. The Kaiser Family Foundation and The Robert Wood Johnson Foundation have also partnered with 13 national medical, public health and business organizations to raise physician awareness of disparities in care and to engage doctors in dialogue about how to eliminate them.

This update of *Key Facts: Race, Ethnicity, and Medical Care*, like the first, is intended to serve as a quick reference source on the health, health insurance coverage, healthcare access and quality among racial/ethnic minority groups in the United States. The document highlights the best available data and research, providing a selective review of the literature. *Key Facts* is divided into five sections, beginning with an overview of the demographic characteristics of the U.S. population. Section 2 presents health measures, stratified when possible by a measure of socioeconomic status. Section 3 profiles patterns of health insurance coverage. Sections 4 and 5 present findings on access to and use of primary and specialty medical care. Whenever possible, these findings are adjusted for social and clinical factors.
By the year 2050, the U.S. Census estimates that nearly half of the U.S. population will be Latino, African American, Asian/Pacific Islander, and American Indian/Alaska Native. The proportion of Latinos and Asian/Pacific Islanders in the U.S. is expected to double in the next 50 years.

People of color (Latinos, African Americans, Asian/Pacific Islanders, and American Indian/Alaska Natives) make up nearly a third of the U.S. population. Latinos are now the largest minority group and are identified by the census as an ethnic, not racial, group.

The 2000 census allowed people to identify themselves by more than one racial category. Only a small share (~ 2%) of the U.S. population identifies as being of ‘Two or more races.’ The percent of each racial group who identify that race in combination with another was 3% for whites, 5% for African Americans, 14% for Asians, 40% for American Indian/Alaska Natives, and 54% for Native Hawaiians and Other Pacific Islanders.

By the year 2050, the U.S. Census estimates that nearly half of the U.S. population will be Latino, African American, Asian/Pacific Islander, and American Indian/Alaska Native. The proportion of Latinos and Asian/Pacific Islanders in the U.S. is expected to double in the next 50 years.
People of color are more likely to have family incomes less than 200% of the federal poverty level than are whites (which, for example, would be less than $28,256 for a family of three in 2001). Over half of Latinos, African Americans, and American Indian/Alaska Natives are poor or near poor, compared with 25% of whites and 32% of Asian/Pacific Islanders. The proportion of children who are poor or near poor is even higher.

Similarly, elderly minority Americans are far more likely than their white counterparts to have family incomes less than 200% of the federal poverty level. At least 60% of elderly Latinos, African Americans, Asian/Pacific Islanders and American Indian/Alaska Natives are poor or near poor, compared with only 40% of elderly whites.
Section 2
Health
American Indian/Alaska Natives, African Americans and Latinos are more likely to rate their health as fair or poor than are whites and Asians.

When comparing racial/ethnic groups of similar incomes, the disparity in self-reported health is reduced but not eliminated. Regardless of racial/ethnic group, people living in poverty report worse health than the non-poor.
Infant mortality rates, considered one of the most sensitive indicators of the health and well-being of a population, are higher among African American and American Indian/Alaska Natives than among other racial/ethnic groups, even when comparing women of similar socioeconomic conditions, as measured by years of education completed.

On average, Latinos, African Americans, American Indians and whites have higher mortality rates than Asian/Pacific Islanders at each stage of the lifespan. However, aggregated data mask the higher mortality rates of particular Asian/Pacific Islander subpopulations, such as Vietnamese and Native Hawaiians.
Heart disease is a leading cause of death in the U.S. Heart disease mortality rates for adults 25–64 are almost twice as high among African Americans as among whites. When heart disease mortality is examined by a measure of socioeconomic conditions, differences between African Americans and whites are reduced but not eliminated. Moreover, the disparity by income is larger than by race. African American men with family incomes less than $10,000 have a heart disease mortality rate that is nearly three times that of their counterparts with incomes greater than $15,000.

Figure 8
Heart Disease Death Rates for Adults 25–64, by Income, Race and Gender, 1979–1989

Deaths per 100,000 person years

Under $10,000

Over $15,000

NOTE: These data are the most recently available by race and income.
SOURCE: Health, United States, 1998, Socioeconomic Status and Health Chartbook; Data Table for Figure 27.

Figure 9
Leading Causes of Death, by Race/Ethnicity, 2000

In 2000, heart disease and cancer were the leading causes of death among all racial/ethnic groups. Among 25–44 year olds, accidents were the leading cause of death for three of the five racial/ethnic groups. HIV is the leading cause of death for African Americans in this age group, and is one of the five leading causes of death for whites and Latinos.

CVD = Cerebrovascular disease
Section 3
Health Insurance Coverage
People of color are more likely to be uninsured than are whites, largely reflecting lower rates of employer-based coverage. Latinos are the most likely to be uninsured, with over a third (35%) of nonelderly persons uninsured in 2001. Medicaid is a particularly important source of coverage for minority Americans, providing health insurance for at least 1 in 5 nonelderly Latinos, African Americans, and American Indian/Alaska Natives, compared to about 1 in 10 Asian/Pacific Islanders and whites.

Figure 10
Health Insurance Status, by Race/Ethnicity:
Total Nonelderly Population, 2001

Figure 11
Health Insurance Status, by Race/Ethnicity:
Low-Income Nonelderly Population, 2001

Among the low-income population (with incomes below 200% of the federal poverty level), Medicaid rivals employer-based insurance as the major source of coverage. For example, more than a third of low-income African Americans (41%) and American Indian/Alaska Natives (43%) have Medicaid coverage compared to 28% and 20%, respectively, who have employer-based coverage. Although Medicaid helps to offset the lack of employer coverage, at least a quarter of the low-income population across each racial/ethnic group was uninsured in 2001.

NOTE: Low-income is defined as income < 200% of the federal poverty level. "Other Public" includes Medicare and military-related coverage.
Of the 31 million Medicaid beneficiaries in 2001, roughly half were white and half were minority Americans. Medicaid’s larger role in providing coverage among minority Americans reflects the relatively lower incomes of minority population groups and the program’s mission in providing health coverage to the low-income population.

Figure 12 Medicaid Beneficiaries, by Race/Ethnicity, 2001

Total = 31 million


Figure 13 Medicare Beneficiaries Age 65 and Older, by Race/Ethnicity, 1999 and 2030

Medicare provides coverage for basic health services but generally does not cover outpatient prescription drugs. However, the majority of Medicare beneficiaries age 65 and older have some prescription drug coverage through a variety of supplemental sources. African American and Latino beneficiaries are less likely than whites to have private supplemental coverage (either employer-sponsored retiree health benefits or Medigap) than whites, but more likely to have Medicaid. Medicaid provides supplemental coverage for beneficiaries with very low-incomes. In June 1999, about 3 in 10 African American (32%) and Latino (30%) Medicare beneficiaries age 65 and older had no drug coverage, compared with almost 4 in 10 (38%) white beneficiaries.

People of color, who now make up 33% of the nonelderly population, comprise a little over half of the uninsured—in part because they are more likely to be in low-income families. At least half of African Americans, Latinos, and American Indians, compared to a quarter of whites, come from families with incomes below than 200% of the poverty level.
People of color are more likely than whites to be uninsured, with Latinos and American Indians being 2 to 3 times as likely to be uninsured as whites. Differences in health coverage across racial/ethnic groups are partially explained by differences in income, types of employment, and eligibility for public insurance programs.

While being from a low-income family raises the risk of being uninsured markedly, it does not account for all of the differences in health coverage across racial and ethnic groups. Insurance disparities persist for most groups at both lower and higher income levels.
Insurance coverage varies not just by race/ethnicity, but also by state and region. Factors such as the proportion of low-income families, the types of employment, and Medicaid eligibility affect the number of uninsured in a state, and thus, region. For example, uninsured rates of Latinos range from 8.4% in North Dakota to 49.2% in Tennessee.

**Figure 18**

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<th>Region/State</th>
<th>White, Non-Latino</th>
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* sample size too small for reliable estimate

Section 4
Preventive and Primary Care
In 1999–2000, Latinos, African Americans, Asians and American Indian/Alaska Natives were more likely to be without a usual source of medical care than were whites. Since 1993–1994, rates have improved or remained the same among all racial/ethnic groups except Latinos.

When comparing racial/ethnic groups of similar income, the disparity in usual source of care is nearly eliminated for African Americans but not for Latinos. However, across racial/ethnic groups, the percentage with no usual source of care is higher among people with incomes below the poverty level than among those with incomes above 200% of poverty.
In 2000, Latinos, African Americans, Asians and American Indian/Alaska Natives were more likely to be without a health care visit in the past year than were whites. While the percent without a visit decreased among Asians since 1997, the situation has worsened for Latinos and American Indians/Alaska Natives.

When comparing racial/ethnic groups of similar income, the disparities in the percent with no health care visits in the past year are nearly eliminated for African Americans, but not for Latinos. However, across racial/ethnic groups, the percentage with no health care visits in the past year is highest among people with incomes below the poverty level.
Prenatal care that begins in the first trimester of pregnancy improves maternal health and birth outcomes. Though the percent of live births to mothers who received late or no prenatal care has decreased over the past two decades, Latinos, African Americans and American Indian/Alaska Natives are still at least twice as likely than whites and Asian/Pacific Islanders to receive late or no prenatal care.

Figure 21a
Late or No Prenatal Care, by Race/Ethnicity, 1980 and 2000


Variation in prenatal care is found not only among the major racial/ethnic groups, but within them as well. As an example, among Latinos, 6% of live births were to mothers who received late or no prenatal care in 2000. This statistic masks differences in prenatal care between Mexican Americans (7%), who are the largest ethnic Latino subgroup and Cuban Americans (1%), who are the smallest ethnic Latino subgroup.

Figure 21b
Late or No Prenatal Care, by Racial/Ethnic Subgroups, 2000

Regular dental visits provide an opportunity for the early diagnosis, prevention and treatment of oral diseases and conditions for children and adults. Racial/ethnic minority groups are less likely than whites to have had a dental visit in the past year, regardless of age.

Figure 22a
No Dental Visits in the Past Year, by Race/Ethnicity, 2000

When stratifying by a measure of socioeconomic status, such as poverty, the racial/ethnic disparity in dental visits persists among adults and non-poor children, with Latinos and African Americans more likely to be without a dental visit than whites. However, among children living in poverty, the disparity persists only between Latinos and whites. In this income group, African American children are less likely to be without a dental visit than whites.

Regardless of race/ethnicity, those living in poverty are less likely to have had a dental visit in the previous year than their counterparts with incomes above 200% of poverty.
Section 5
Specialty Care
Heart disease is the leading cause of death among every racial/ethnic group in the United States except Asian/Pacific Islanders, for whom it is the second leading cause of death. Effective cardiac care has been shown to improve heart disease diagnosis, morbidity and mortality.

Numerous studies over the past two decades have documented racial/ethnic differences in the use of cardiac care services. In most cases, these disparities have persisted even when researchers have taken insurance coverage and disease severity into account.

Disparities exist in procedures used both to diagnose and treat heart disease. For example, in a California study, African American Medicare patients were less likely than whites to undergo catheterization, angioplasty and bypass surgery, and Latino Medicare patients were less likely than whites to undergo catheterization and angioplasty.

* Difference is statistically significant after adjustment.

NOTE: Odds ratios are adjusted for age, sex, insurance, health status, and disease severity.

Though insurance coverage does not eliminate disparities in cardiac care, it does diminish them. For example, a nationwide study examined patients with chronic renal failure who, when they progress to end-stage renal disease (ESRD), acquire Medicare coverage. Before qualifying for Medicare, male and female African American patients with chronic renal failure were 32% and 30% as likely to receive catheterization, angioplasty and bypass surgery as white men (the study reference group). After enrolling in Medicare and entering into a comprehensive system of care, there was no difference in the cardiac procedure use between African American women and white men. However for African American men, the disparity persisted even after enrolling in Medicare.

**Figure 24**
Cardiac Procedure Use in Chronic Renal Disease Patients, by Race and Gender, 1986–1992

Odds ratio
< 1.0 indicates group is less likely to undergo procedure compared to white men

<table>
<thead>
<tr>
<th>Type of Insurance</th>
<th>African American Men</th>
<th>African American Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Medicare</td>
<td>0.32*</td>
<td>0.66*</td>
</tr>
<tr>
<td>Post-Medicare</td>
<td>0.30*</td>
<td>0.75*</td>
</tr>
</tbody>
</table>

*Difference is statistically significant after adjustment.

NOTE: Odds ratios are adjusted for age, health insurance, sociodemographic characteristics, and clinical factors.


Type of insurance coverage may also have an impact on disparities in care. In a California study, African American Medicaid, Medicare and uninsured patients were less likely than whites to undergo bypass surgery. Latino Medicare patients were also less likely than whites to undergo surgery. However, racial/ethnic differences in care did not exist among patients with private insurance, and Asian patients, regardless of coverage, were equally as likely as whites to undergo bypass surgery.

**Figure 25**
Coronary Artery Bypass Surgery by Race/Ethnicity and Insurance Status, 1986–1988

Odds ratio
< 1.0 indicates group is less likely to undergo procedure compared to white patients

<table>
<thead>
<tr>
<th>Type of Insurance</th>
<th>African American</th>
<th>Latino</th>
<th>Asian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td>0.8</td>
<td>0.8</td>
<td>1.09</td>
</tr>
<tr>
<td>Medicaid</td>
<td>0.5*</td>
<td>0.5*</td>
<td>1.22</td>
</tr>
<tr>
<td>Medicare</td>
<td>0.79*</td>
<td>0.82*</td>
<td>1.15*</td>
</tr>
<tr>
<td>Uninsured</td>
<td>0.33*</td>
<td>0.33</td>
<td>0.93</td>
</tr>
</tbody>
</table>

*Difference is statistically significant after adjustment.

NOTE: Odds ratios are adjusted for age, sex, number of co-morbidities, admission type, and hospital procedure volume.

SOURCE: Carlisle et al., 1997.
Cancer is the second leading cause of death among every racial/ethnic group in the United States except Asian/Pacific Islanders, for whom it is the first. Overall, African Americans are more likely to develop and die from cancer than any other racial/ethnic group.

Early detection of certain cancers has been shown to decrease the amount of treatment needed, improve quality of life, and reduce mortality. A number of studies have found racial/ethnic differences in cancer screening and treatment among patients with similar access to care.

Cancer screening rates have increased over the past two decades, but still vary by race/ethnicity. For example, Latina, Asian/Pacific Islander and American Indian/Alaska Native women are less likely to be screened for breast and cervical cancer than are white and African American women. However, despite comparable screening rates between white and African American women, mortality rates for breast and cervical cancer are higher for African American women than for white women.

Colorectal cancer screening occurs less frequently among women and men across racial/ethnic groups, and Latinos are the least likely to report having been screened for colon and rectum cancer within the past two years. However, as with breast and cervical cancer, mortality rates from colon and rectum cancer are higher among African Americans than among whites, despite comparable screening rates.
Research has also uncovered differences between the cancer treatment provided to minority patients and that provided to whites. For example, African American Medicare patients with early stage lung cancer had lower surgery rates and five-year survival rates than white patients during 1985–1993. African American patients were half as likely as whites to undergo surgery, after adjusting for age, sex, median income in the zip code of residence, and stage of illness (Odds Ratio = 0.54).

*Difference is statistically significant after adjustment.

DATA: Ten study areas of the SEER (Surveillance, Epidemiology and End Results) Program and linked Medicare inpatient discharge records.

SOURCE: Bach et al., 1999.

Disparities have also been seen in the receipt of analgesics. For example, a five-state study investigated pain management among cancer patients whose Medicare coverage was extended to include medication costs. Among those with daily pain, African Americans were more likely than whites to receive no analgesic agent. A similar trend was noticed for Latino and Asian patients.

*Difference is statistically significant after adjustment.

NOTE: Odds ratios are adjusted for sex, marital status, activity level, cognitive impairment, depression, and medical conditions.

SOURCE: Bernabei et al., 1998.
Age-adjusted asthma death rates are three times higher for African Americans than whites. Asthma is now the most common chronic disease among American children. In 2001, 9% of all children had asthma—a prevalence rate that has doubled since 1980. The risk of asthma seems to be closely correlated with socioeconomic status and outdoor and indoor environmental exposures.

Asthma prevalence, as measured through self-report, is estimated to be higher among African American children and adults compared to whites, but lower among Latinos compared to whites (CDC, NCHS 2003). For Latino children, the story is mixed: Puerto Rican children have the highest asthma rates among Latinos (11% in one New York City study population), while Mexican American children have a prevalence rate lower than the national average (Carter-Pokras & Gergen, 1993).

Hospitalization for asthma, generally considered an avoidable admission if adequately managed, is more likely to occur for African Americans than for whites. Data from several national data sources indicate that age-adjusted ED visits, hospitalization rates, and mortality rates are about three times higher for African Americans than for whites.

The disparity in asthma hospitalization rates persists in lower- and upper-income communities. For example, analysis of 1989–1991 data for children ages 1–14 shows that African Americans were about 3 times as likely as their white counterparts to be hospitalized for asthma regardless of income (President's Initiative on Race Chartbook, 2001).
Racial/ethnic disparities are also evident in the use of routine medications for asthma. A study of Medicaid beneficiaries enrolled in several geographically dispersed managed care plans found that African American and Latino children with asthma were more likely to underuse routine medications (i.e., anti-inflammatory agents) than white children. However, parental education and/or having a primary care physician had a protective effect. Children whose parents had some education beyond high school or had a primary care physician were less likely to underuse routine medications than their counterparts.

One study of Medicaid beneficiaries shows that outpatient visits are lower for African American children with asthma than for white children, a finding that might contribute to higher asthma hospitalization rates or emergency department use. While there were no differences in the amount of well-child visits or prescriptions for asthma drugs, African American children in this study were less likely to receive the drug therapy recommended in national asthma guidelines.
In 2001, African Americans and Latinos represented 26% of the U.S. population; however, they accounted for 68% of newly reported AIDS cases. Given that HIV infection is now the leading cause of death among African Americans between the ages of 25 and 44 (and the fourth leading cause of death among Latinos in the same age group), there are growing concerns about the adequacy of treatment and the effectiveness of prevention efforts in communities of color.

Advancements in HIV treatment have benefited all racial/ethnic groups. However, AIDS deaths, which have declined overall, have decreased more dramatically among whites than among other racial/ethnic groups.

People of color continue to fare more poorly than whites on several access and quality measures. Data from the HIV Cost and Services Utilization Study (HCSUS)—the only nationally representative study of people with HIV who are in care—showed disparities in several measures of health services use in 1996, including the receipt of combination drug therapy (the accepted standard of care). By 1998, many of the racial/ethnic disparities identified no longer existed. However, African Americans were still more likely than whites to not get combination drug therapy. Additionally, Latinos were more likely than whites and African Americans to have fewer than two outpatient visits in the past six months.
The reasons for disparities in care are not well understood; however, HCSUS provides evidence that people of color with HIV face greater barriers to care than their counterparts who are white. For example, about a fifth of African Americans (20%) and Latinos (19%) with HIV report postponing medical care due to the lack of transportation, compared to 11% of whites. People of color were also more likely than whites to report that they postponed care because they were too sick to go to the doctor or had competing needs (e.g., had to spend limited dollars for food or housing). Data from this national study also indicate that Latinos were more likely than whites to delay care after HIV diagnosis (23% vs. 15%; see Turner et al., 2000).

* Results significantly different at p < .01; ** Results significantly different at p < .05.

NOTE: Includes persons 18 years and older.

SOURCE: Cunningham et al., 1999.

Increasing awareness of one’s HIV status is critical for the prevention and care of HIV disease in communities of color. A 1999 nationwide survey indicates that African Americans reported previous HIV testing more frequently than Latinos or whites, however less than half of African Americans had ever been tested. Persons with high-risk behavior were more likely than others to be tested, however a substantial portion of whites, Latinos and African Americans with high-risk behavior had never been tested.
Key Facts: Race, Ethnicity, and Medical Care presents compelling evidence of racial and ethnic differences in health insurance coverage, access to primary care, and treatment for specific medical conditions. In some studies, these differences are reduced, if not eliminated, when comparing minority populations and whites of similar socio-economic conditions, insurance coverage, and health status. Even when differences persist, it should be noted that differentials in care may not be inherently problematic, and that the level of care obtained by whites is not necessarily the appropriate standard for comparison.

Efforts to address racial/ethnic differences in health care require data systems and analyses to assess problems and progress. Further research is needed to better understand and assess the extent to which these differentials reflect barriers to needed care and compromise health outcomes. While it is known that financial incentives and barriers affect patterns of health care use, less is known about how other factors, such as patient preferences or site of care affect patterns of care. The challenge facing health policy researchers and health providers is to identify and disentangle the many complex factors that account for these differentials, so that the sources of health care inequity can be addressed.
DATA NOTES

Race/Ethnicity Data

In a Federal Register Notice of October 30, 1997, the Office of Management and Budget (OMB) announced revisions to the standards for classification of Federal data on race and ethnicity. The OMB specified two categories for data on ethnicity (“Hispanic or Latino” and “Not Hispanic or Latino”) and five minimum categories for data on race (“American Indian or Alaska Native,” “Asian,” “Black or African American,” “Native Hawaiian or Other Pacific Islander,” and “White”).

In this document, “Asians” and “Native Hawaiians or Other Pacific Islanders” are combined in one category. In a few cases, data were available for “Asians” and not for “Native Hawaiians or Other Pacific Islanders.” In those circumstances, data are reported for “Asians Only.”

In all cases where data are presented for “White, Non-Latino” and “African American, Non-Latino,” the other racial groups are also Non-Latino.

2000 Census

The 2000 Census asked respondents to choose from two ethnicities: “Hispanic or Latino” and “Not Hispanic or Latino.” The questionnaire then asked respondents to choose from the five OMB-specified race categories, and gave respondents the option of selecting one or more race categories to indicate their racial identities. For respondents unable to identify with any of these five race categories, the Census questionnaire also included a sixth category: “Some other race.” Most of the respondents who reported “Some other race” were Latino.

People who responded to the question on race by indicating only one race are referred to by the U.S. Census Bureau as the “race alone” population, or the group that reported only one race category. Individuals who chose more than one of the six race categories are referred to as the “Two or more races” population, or as the group that reported more than one race. All respondents who indicated more than one race can be collapsed into the “Two or more races” category, which combined with the six alone categories, yields seven mutually exclusive and exhaustive categories. Thus, the six race “alone” categories and the “Two or more races” category sum to the total population.

In this report, data for the “Some other race” and “Two or more races” categories are used only in the Demographics section. For a more detailed discussion of this topic, see the Census Brief Overview of Race and Hispanic Origin 2000, March 2001.

Population Estimates

The population estimates in the Demographics section are drawn from the U.S. Census Bureau. The Census Bureau’s estimates include data on the 50 U.S. states and the District of Columbia, but do not include data on residents of Puerto Rico, Guam, the U.S. Virgin Islands, or the Northern Marina Islands.

Federal Poverty Threshold

The federal poverty threshold for a family of three was $13,738 in 2000 and $14,128 in 2001. Poor persons are defined as those with incomes below the poverty threshold. Near poor persons are defined as those with incomes of 100% to less than 200% of the poverty threshold. Low-income persons are defined as those with incomes less than 200% of the poverty threshold. Non-poor persons are defined as those with incomes of 200% or greater than the poverty threshold.

Grouping Household Members

Family income and the work status of family members are important factors related to health coverage, so the way in which individuals living together in one household are grouped becomes important to the analysis. In the Urban Institute and Kaiser Commission on Medicaid and the Uninsured analyses of the March 2002 Current Population Survey used in this report, individuals are grouped according to their insurance eligibility, rather than relatedness. Other analysts, including the U.S. Census Bureau, may group individuals by households or relatedness. Grouping individuals by health insurability versus relatedness or households increases the number of low-income people. For a more detailed discussion of this topic, see the Data Notes section of Health Insurance Coverage in America: 2001 Data Update, January 2003.


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