U.S. Minority Health: A Chartbook

Karen Scott Collins, M.D., M.P.H.
Allyson Hall, Ph.D.
Charlotte Neuhaus

May 1999

Cover photo: Lynn Johnson

Contents

Health Status and Disease

Substance Abuse

Mental Health

Safety and Violence

Health Care Access and Utilization

Health Insurance Coverage

Minority Health Professionals

Introduction

Introduction

During the last 50 years, the health of the U.S. population has improved substantially. Mortality and morbidity rates are declining while life expectancy has increased. Although minority populations are experiencing some of these improvements, they still continue to lag behind the white population on many important indicators. Despite the overwhelming sophistication of our health care system, minority Americans—especially those who are economically disadvantaged—often do not fully benefit from what it can offer.

A range of health status and health care access indicators attests to this disparity. Black infant mortality, for example, remains more than twice as high as white infant mortality: 14 per 1,000 live births versus 6 per 1,000 live births. Life expectancy for black men is 66 years—eight years less than that for white men. Blacks, Hispanics, and Asian Americans are also more likely to be uninsured. *The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care* found that these groups were more likely to have difficulty getting health care because of financial problems and less choice in where to go for their care. Patient satisfaction with care is also lower among minority populations.

Current projections indicate that the U.S. population will become increasingly diverse. By 2030, 40 percent of Americans are expected to belong to a minority group, compared with 28 percent today. Public policy and the health care system will need to report on and address longstanding disparities in health status and health care delivery and devise approaches to providing appropriate, quality health care for all Americans.

This chartbook is intended to serve as a quick reference for currently available information on minority health. Data sources for the chartbook include the *Current Population Survey*, *Health United States 1998,* and *The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care*. Information was also obtained from a number of Fund-supported projects and journal articles. Although the goal here is to provide an overview of minority health that is as comprehensive as possible, the information presented in no way represents the universe of data on the subject.

Within the limits of available, reliable data, we tried to include information on all U.S. racial and ethnic groups. Many data sources, however, provide information on whites, blacks, and Hispanics only—rarely do they include information on Asian Americans, Native Americans, and ethnic subpopulation groups. This is an important limitation of the chartbook, as it is with minority data in general. Given the growing Asian American presence in the United States and the variations that can exist within broad groups, future data collection strategies must strive to capture the entire spectrum of race and ethnicity in this country.

The chartbook is divided into the following sections:

- **Statistical Profile.** Charts in this section highlight the racial and ethnic composition of the U.S. population and describe the socioeconomic status of each group. Collectively, minority populations are expected to constitute almost 40 percent of the total population by 2030. However, racial and ethnic minority groups are more likely to be poor, lacking a high school diploma, and unemployed.

- **Vital Statistics.** Trends in life expectancy, infant mortality, and low birthweight highlight the most basic, starkest disparities in health status. Of all minority groups, African Americans are at greatest risk: black men and women have the lowest life expectancy, and the mortality rate for black infants remains twice that for all U.S. infants. Low birthweight plays a major role in black infant mortality, yet we do not have a clear understanding of the other factors that contribute to this glaring disparity. What we do know is that improved socioeconomic circumstances and high-quality health care help reduce the risk of low birthweight.

  Trends in teen pregnancy tell a more positive story: rates are down overall in recent years, especially among black teenagers. Rates for Hispanic and black girls, however, are still twice those for all teenage girls.

- **Health Status and Disease.** Differences also exist in the rates at which both chronic and acute conditions affect racial and ethnic populations. African Americans in particular have higher rates of mortality from heart disease, cancer, and diabetes and a higher prevalence of and mortality from AIDS. Reasons for these differences remain only partially explained. Socioeconomic status and access to health care are crucial to understanding disparities in chronic disease rates, although they may not fully account for mortality differences for certain cancers. The role of violence in diminishing life expectancy, particularly for black men, is most striking: homicide is either the leading or second leading cause of death for black males ages 1 to 44. Other health risk factors, including smoking and alcohol use, do not vary greatly across racial and ethnic groups.

- **Health Care Access and Utilization.** Access to health care remains a great problem for minority groups. Many minority Americans do not have a regular doctor, have little choice in where they go for medical care, and have difficulty accessing specialty care. Consequently, medical treatment is frequently obtained through hospital clinics and emergency rooms. Public hospitals provide much of this care.

  Although rates of breast and cervical cancer screening have improved among black women, Hispanic and Asian American women continue to lag behind the national average. Furthermore, elderly minority adults —despite having Medicare coverage—are at higher risk for not receiving preventive care, such as flu immunizations, as well as important specialized care,

such as cardiac surgery. One probable factor behind such access problems is the greater likelihood of minority adults to have negative experiences with the health care system—and to feel that race plays a role in these experiences.

- **Health Insurance Coverage.** Large percentages of minority children and adults, including nearly 40 percent of Hispanics, were uninsured in 1996. While Medicaid is a major source of health insurance for blacks and Hispanics, it still only provides health coverage for less than half of poor adults. For nonelderly adult workers, coverage is most often obtained through their employer. Minority adult workers, though, are less likely to have employer-sponsored health insurance than white workers—a difference that may reflect additional barriers to insurance, such as cost.

  Disparities in insurance coverage are also prevalent among the elderly, despite the availability of Medicare. Minority elderly are less likely to have private supplemental coverage, which can defray the costs of items not covered by Medicare, including prescription drugs.

- **Minority Health Professionals.** Minority underrepresentation in the health professions continues to be an important issue. A diverse health care workforce is crucial to ensuring quality of care for a diverse population. Although minority health professionals typically care for more minorities and less advantaged patients, 7 percent of physicians are black, Hispanic, or Native American—even though these groups comprise 24 percent of the U.S. population. The proportion of minority medical school graduates has increased over the past two decades, though gains have been very slow in recent years; in 1997, 11 percent of medical school graduates were from one of three minority groups listed above. Nevertheless, the most recent medical school enrollment data show a decline in minority applicants and entrants to medical school. This decline is especially pronounced in states that have enacted new anti-affirmative action policies.

The charts that follow illustrate the great variation in health status and health care experiences among Americans of different racial and ethnic backgrounds. No simple solutions would eliminate these disparities, and differences among minority groups are not always reflected by data in predictable ways. Black women, for instance, are screened more for breast cancer, yet they still have higher mortality rates for the disease. Better information on the health experiences of all minorities would provide the basis for a more complete understanding of their unique health care needs and how best to address them.

Adequate access to the health care system—from prevention and primary care to specialty care and, when needed, technologically advanced services—is key to improving health outcomes for all people. Doctor-patient

communication is also critical: patients who are knowledgeable about their health care needs and have a good relationship with their physicians are more likely to enjoy better health outcomes. Priority strategies for improving the health of minority Americans should include extending health insurance coverage to all the uninsured, and assuring the availability of high-quality, culturally competent providers in minority communities.

The health of minority populations often reflects underlying disparities in income and overall socioeconomic status—a link that has been well documented. Significant, long-term improvement in the health and well-being of minority Americans will require improved educational and employment opportunities and safer environments in which to work, live, and raise families. At the same time, the health care system can help identify ways of delivering more effective care to better meet the needs of all Americans.

Basic Definitions: Racial and Ethnic Categories

In 1977, the Office of Management and Budget issued standards for reporting race and ethnicity in federal data collection activities. The basic racial and ethnic categories used in federal reporting as well as in Commonwealth Fund surveys are defined as follows:

American Indian or Alaskan Native A person having origins in any of the original peoples of North America who maintains cultural identification through tribal affiliations or community recognition. The chartbook uses the term "Native American."

Asian or Pacific Islander A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands, including, for example, those of China, India, Japan, Korea, the Philippine Islands and Samoa. The chartbook uses the term "Asian American."

Black A person having origins in any of the black racial groups of Africa, including people from the English-speaking Caribbean. The chartbook uses the terms "black" and "African American" interchangeably.

Hispanic A person of Mexican, Puerto Rican, Cuban, or Central or South American descent or other Spanish culture or origin, regardless of race.

White A person having origins in any of the original peoples of Europe, North Africa, or the Middle East. In the chartbook, "white" refers to people of European descent who are not Hispanic.

The categories above are useful only for providing broad generalizations about populations and do not reflect the increasing racial and ethnic diversity within the United States.

Statistical Profile

Chart 1-1

Projected Resident Population of the United States, 1998–2030

As of 1998, 28 percent of the U.S. population were members of a racial or ethnic minority group. By 2030, 40 percent of the U.S. population will be composed of racial or ethnic minorities (Yax, 1999).

- The U.S. population is expected to grow by 28 percent from 1998 to 2030. Asian American and Hispanic groups will account for much of this increase.
- Growth in the Asian American and Hispanic populations is due to higher fertility rates, increased immigration, and the younger profile of these groups.

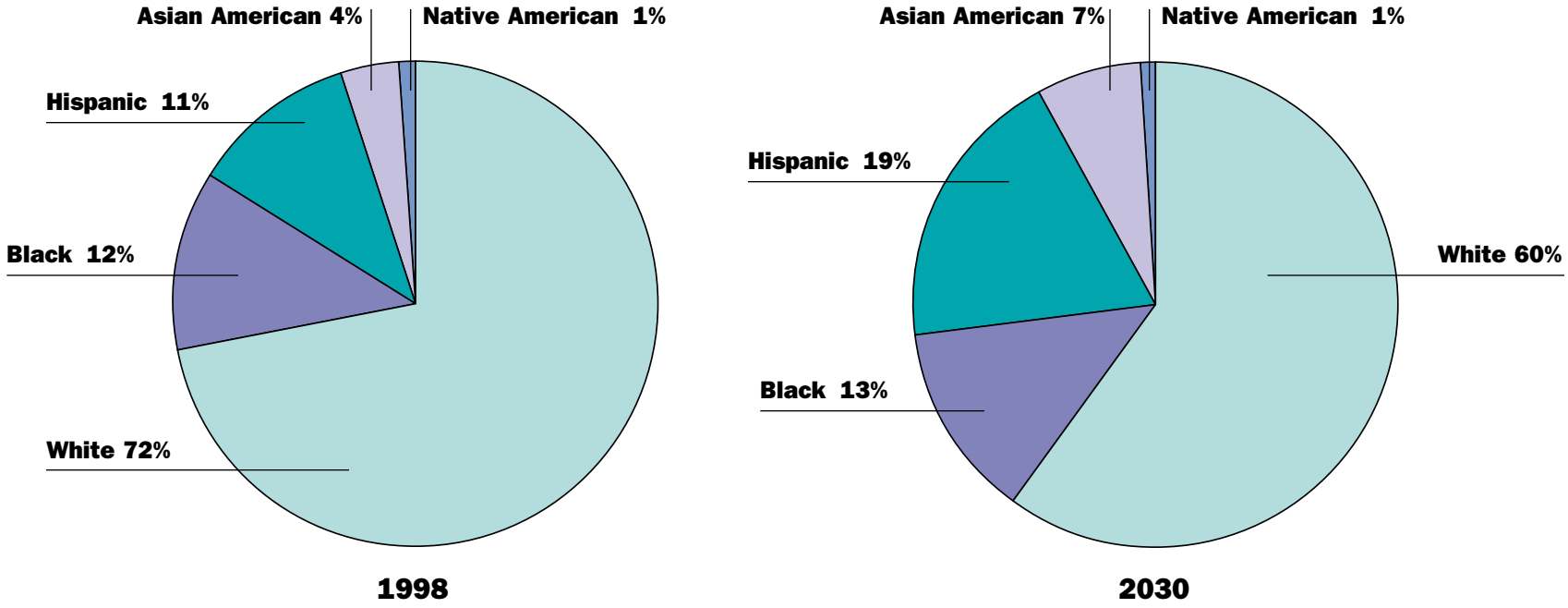
U.S. Population: 1998–2030 (in thousands)

	1998	2030	Percent Change
Total	270,933	346,899	28%
White	195,474	209,998	7%
Black	32,791	45,448	39%
Hispanic	30,769	65,570	113%
Asian American	9,892	22,993	132%
Native American	2,007	2,891	44%

Source: Yax, 1999, and Day, 1996.

Chart 1-1

Projected Resident Population of the United States, 1998–2030



Source: Yax, 1999, and Day, 1996.

Chart 1-2

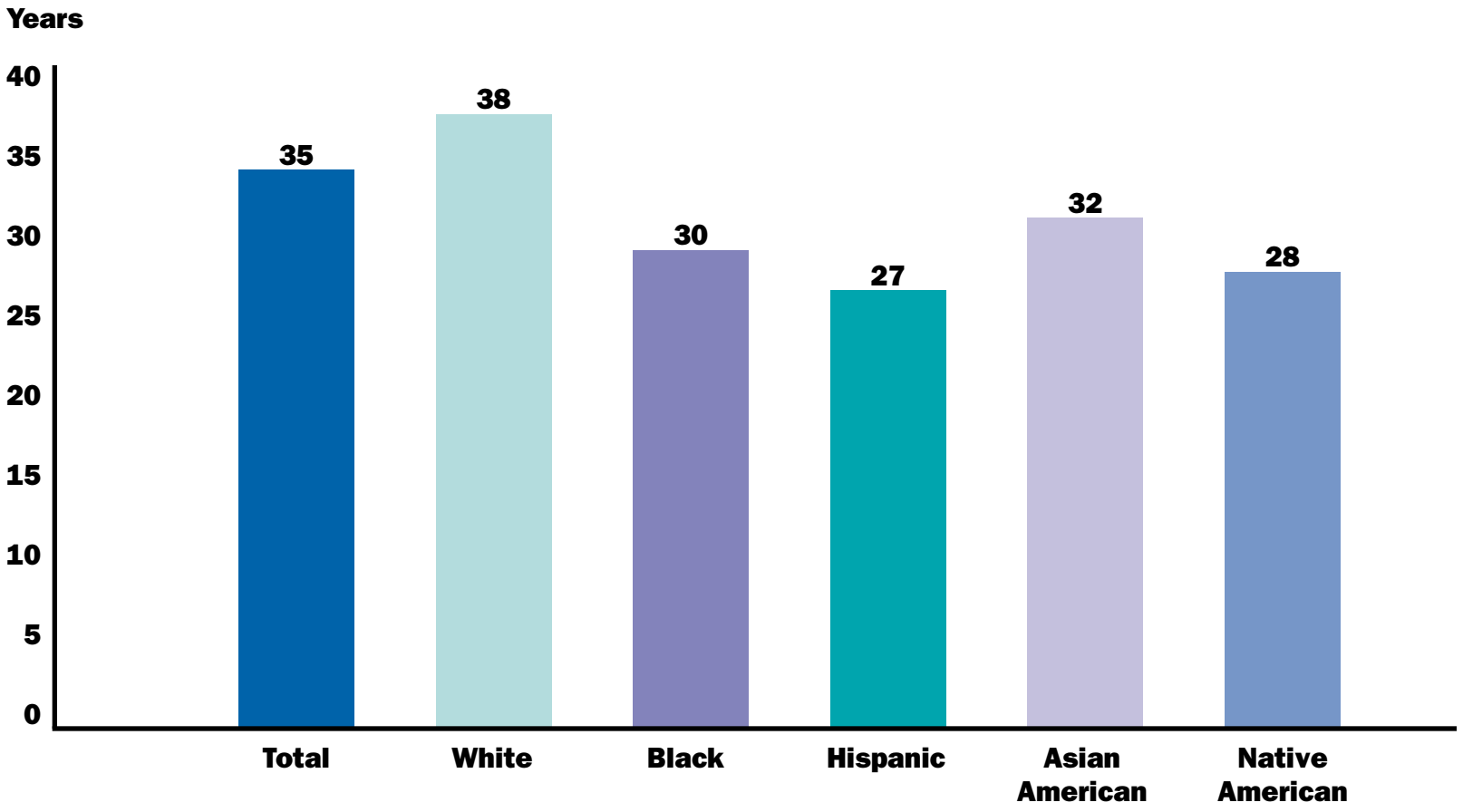
Median Age by Race and Hispanic Origin, 1998

Minority populations in the United States are younger than the white population.

- The median age is 38 years for whites, 30 for blacks, and 27 for Hispanics (Yax, 1999).
- One-quarter of the U.S. population is below age 18. Twenty-four percent of whites, 32 percent of blacks, 36 percent of Hispanics, 30 percent of Asian Americans, and 35 percent of Native Americans are less than 18 years of age (Day, 1996).
- U.S. projections indicate that by 2050, nearly one-quarter of the white population could be over age 65, compared with 13 percent in 1990 (Day, 1996).
- Minority populations will continue to be younger, but the number of persons over age 65 could increase from 8 percent of blacks and 5 percent of Hispanics to approximately 14 percent of both blacks and Hispanics by 2050 (Day, 1996).

Chart 1-2

Median Age by Race and Hispanic Origin, 1998



Source: Yax, 1999.

Chart 1-3
Percentage of Persons Living Below Poverty, 1997

Socioeconomic status is closely related to health status. Minority populations, especially blacks and Hispanics, are more likely to live below the federal poverty level ($16,400 for a family of four).

- Twenty-seven percent of Hispanics, 27 percent of blacks, and 14 percent of Asian/Pacific Islanders—compared with 9 percent of whites—were living below the poverty level in 1997 (Dalaker and Naifeh, 1998).
- Children are more likely to be in poverty than adults: 37 percent of black children, 37 percent of Hispanic children, and 16 percent of white children were living in poverty in 1997 (Dalaker and Naifeh, 1998).
- While large racial disparities in income still exist, the 1997 poverty rate for black Americans (26.5 percent) is the lowest ever recorded, falling nearly 2 percentage points from the 28 percent rate recorded in 1996. In 1959, the black poverty rate was 55 percent (Simms, 1998).

Poverty Rates by Race and Ethnicity, 1975–1997

	All Races	White[1]	Black	Hispanic	Asian American
1975	9.2	9.7	31.3	26.9	*
1980	10.1	10.2	32.5	25.7	*
1985	11.3	11.4	31.3	29.0	*
1990	10.7	10.7	31.9	28.1	12.2
1995	11.4	11.2	29.3	30.3	14.6
1997	10.9	11.0	26.5	27.1	14.0

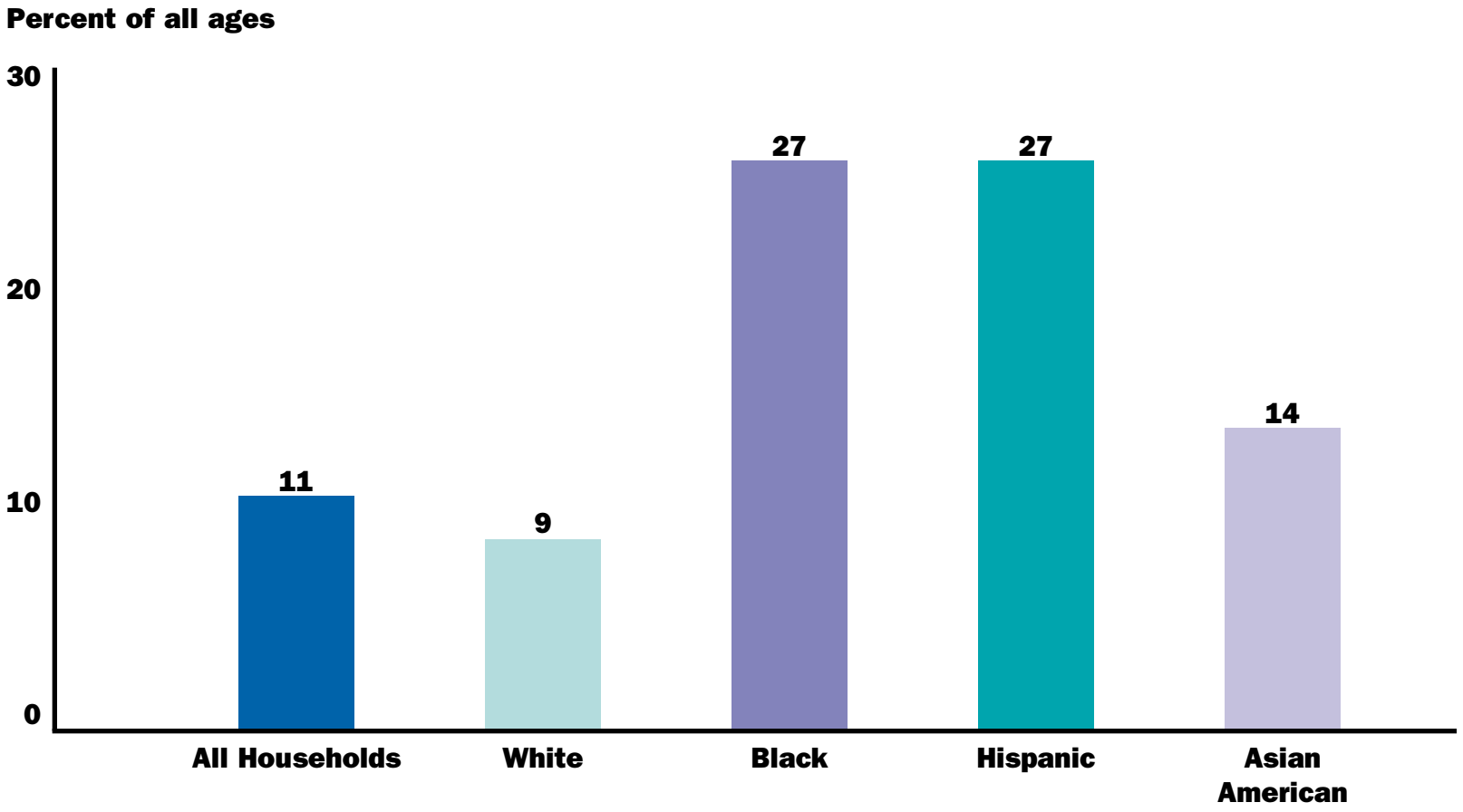
Source: Dalaker and Naifeh, 1998.

[1]The figures under "white" in this table include Hispanics and are slightly higher than those in chart 1-3 under "white."

*Asian American figures are available beginning in 1987.

Chart 1-3

Percentage of Persons Living Below Poverty, 1997



Source: Dalaker and Naifeh, 1998.

Chart 1-4

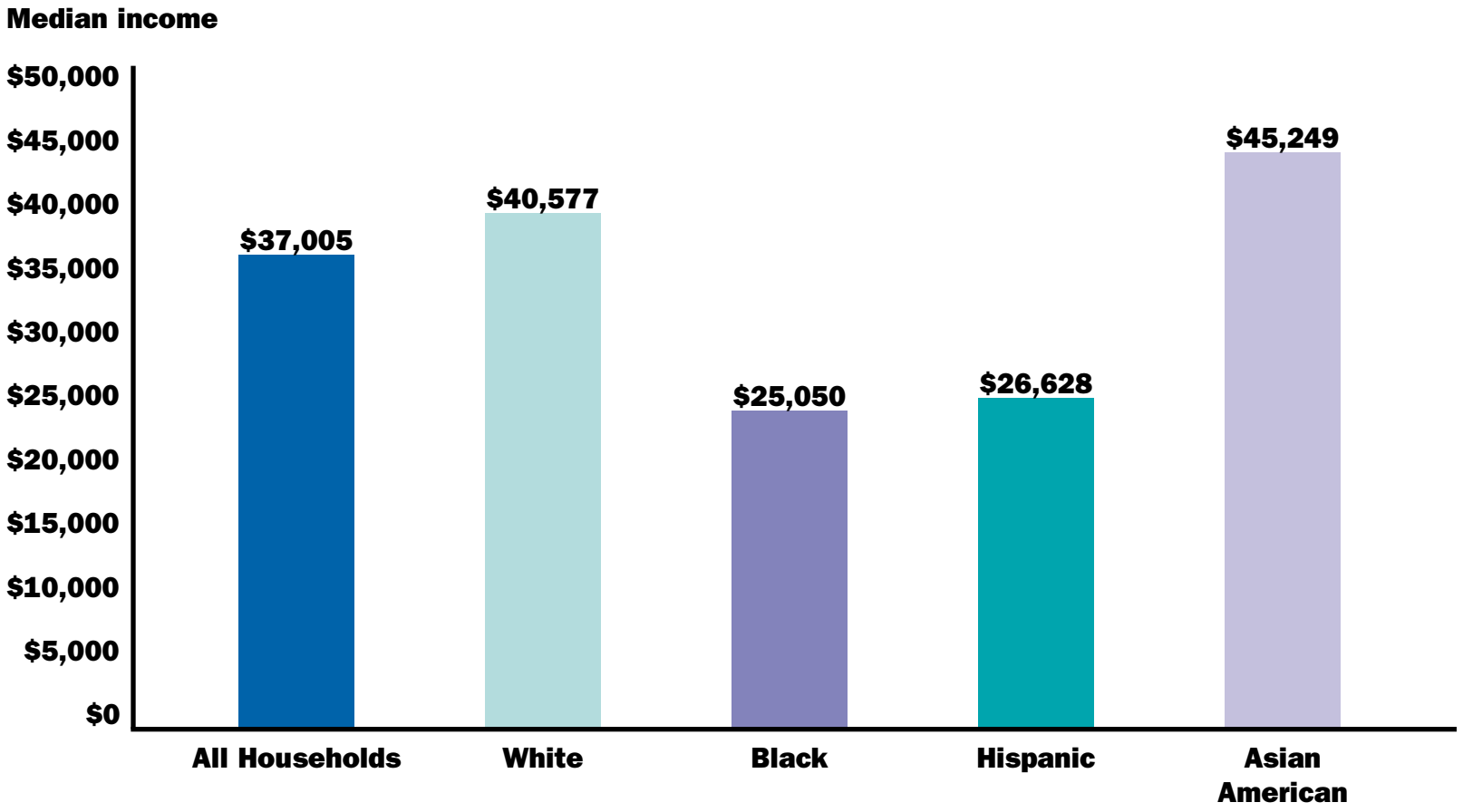
Median Household Income by Race and Hispanic Origin, 1997

Median income (by the householder's race) is $25,050 for black households, $26,628 for Hispanic households, $40,577 for white households, and $45,249 for Asian American households.

- The median income of native-born householders is approximately $10,000 higher than that of noncitizen householders (U.S. Bureau of the Census, 1998).

Chart 1-4

Median Household Income by Race and Hispanic Origin, 1997



Source: U.S. Bureau of the Census, 1998.

THE COMMONWEALTH FUND

Chart 1-5

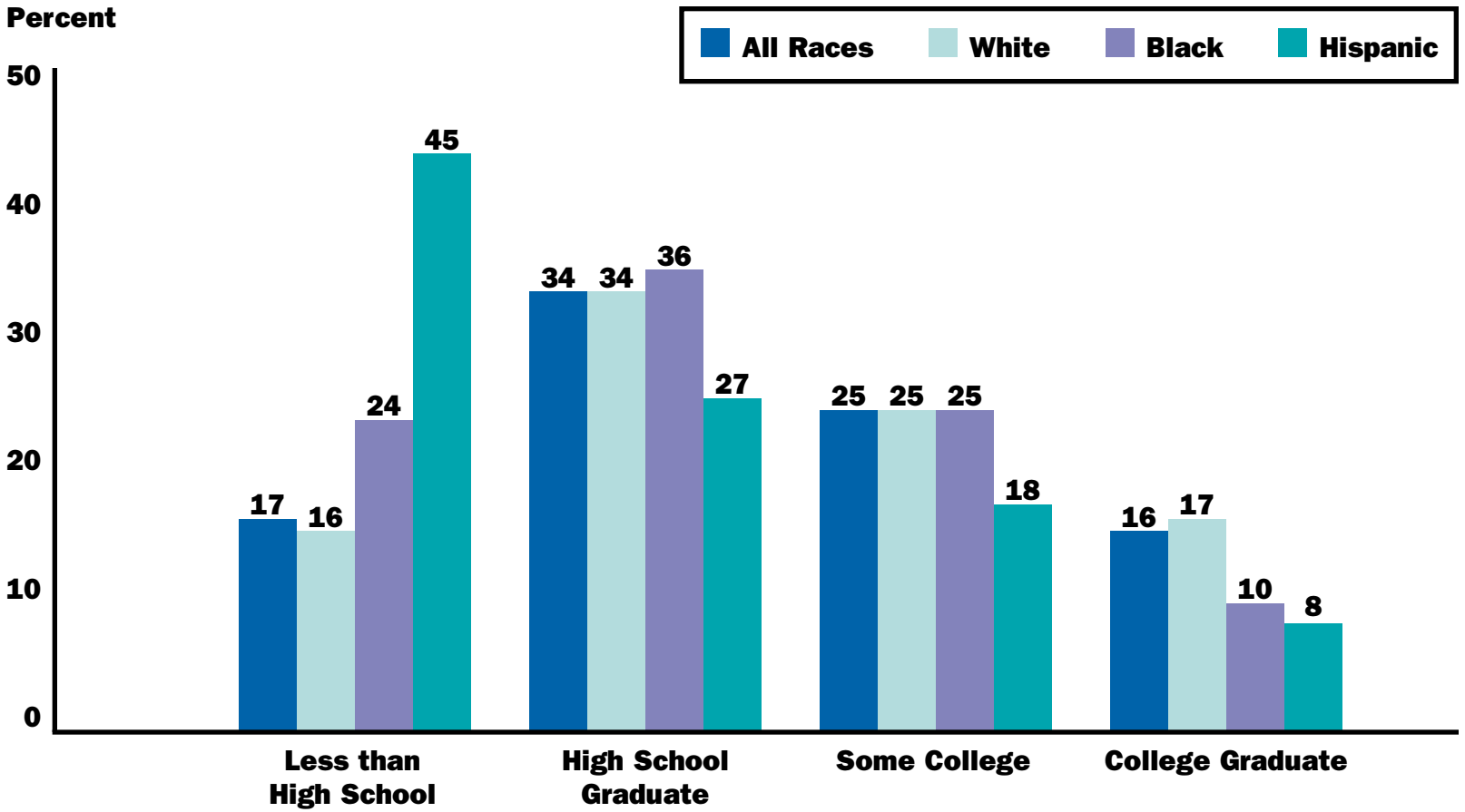
Educational Attainment of Persons Age 25 and Older, 1998

Variation in educational attainment across racial and ethnic groups occurs mostly at the lowest and highest levels of education.

- The portions of the white and black populations who have a high school or some college education are comparable (Day and Curry, 1998).
- Hispanics are less likely than whites or blacks to have graduated from high school. Nearly one-half of Hispanics have less than a high school education (Day and Curry, 1998).
- Seventeen percent of whites, 10 percent of blacks, and 8 percent of Hispanics have completed college (Day and Curry, 1998).

Chart 1-5

Educational Attainment of Persons Age 25 and Older, 1998



Source: Day and Curry, 1998.

THE COMMONWEALTH FUND

Chart 1-6

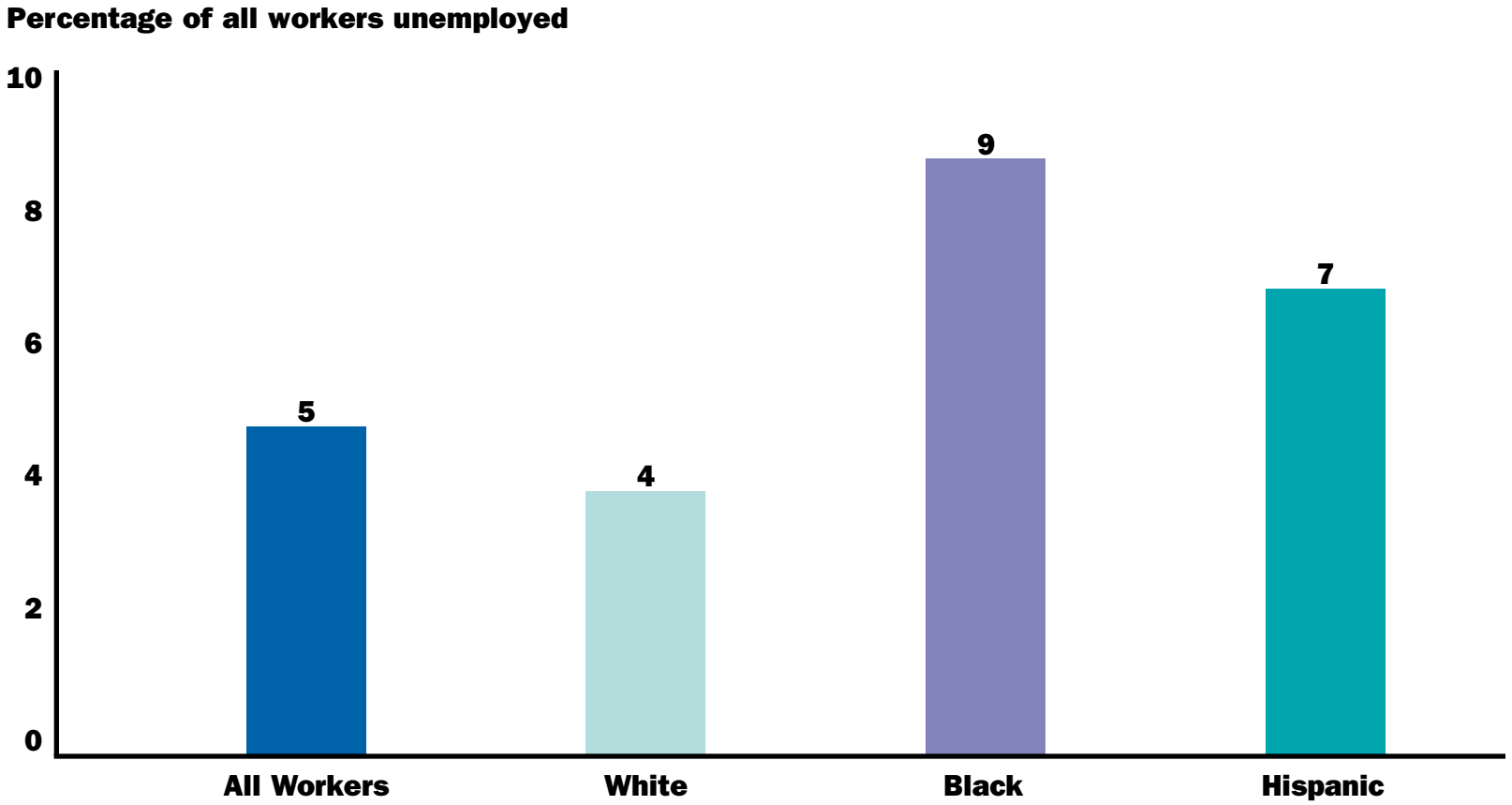
Unemployment Rates by Race and Hispanic Origin, 1998

Unemployment rates are higher among minority populations.

- Nine percent of black and 7 percent of Hispanic workers are unemployed, compared with only 4 percent of white workers (U.S. Bureau of Labor Statistics and the U.S. Bureau of the Census, 1998).
- Rates are particularly high for black teenagers. In 1998, the unemployment rate for black teenagers ages 16 to 19 was 28 percent, compared with 13 percent for white teenagers (U.S. Bureau of Labor Statistics, 1999).

Chart 1-6

Unemployment Rates by Race and Hispanic Origin, 1998



Source: U.S. Bureau of Labor Statistics and U.S. Bureau of the Census, 1998.

THE COMMONWEALTH FUND

Chart 1-7

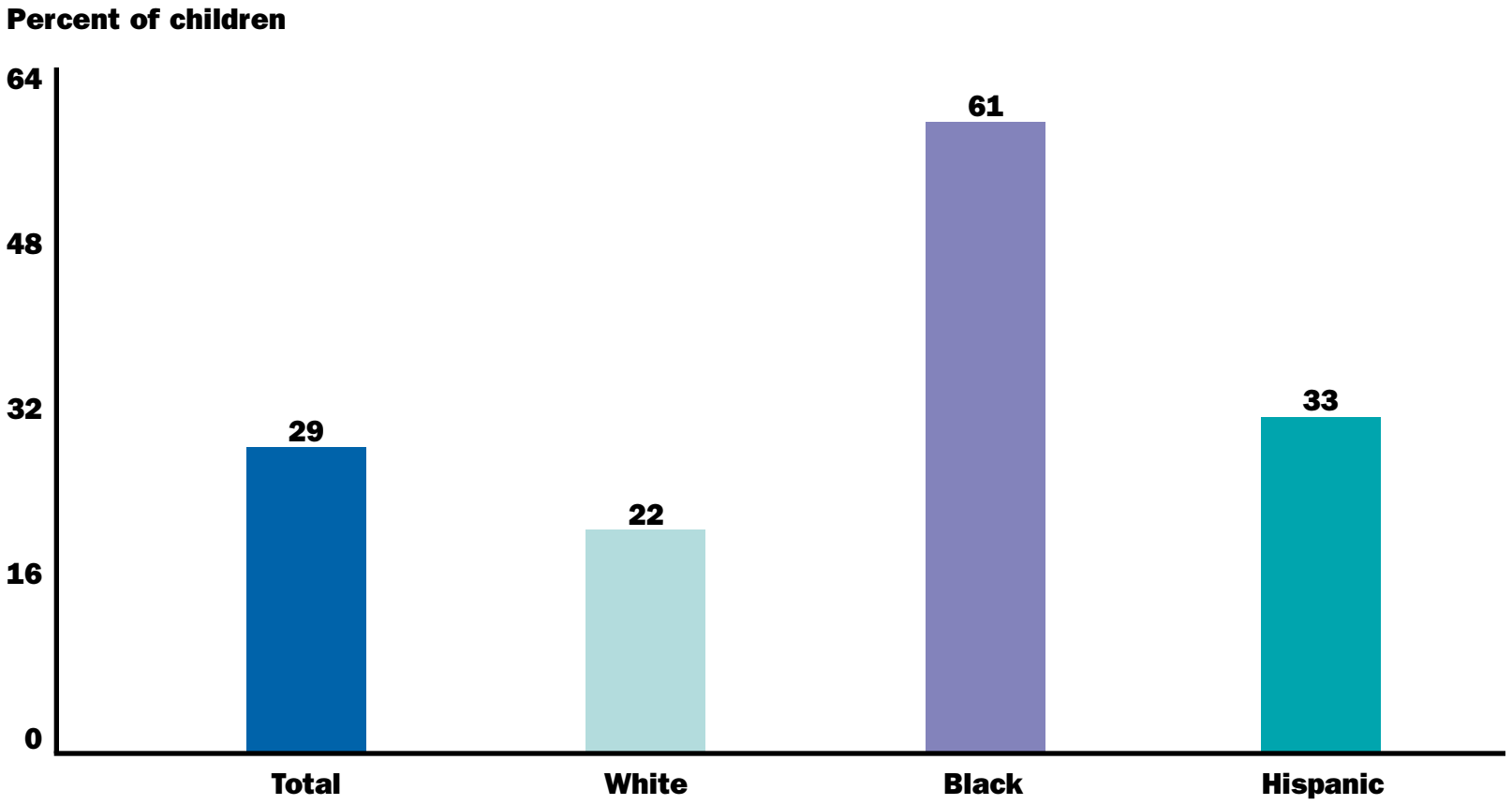
Children Under Age 18 Who Live in a Single-Parent Household, 1997

Over one-half of African-American children under age 18 live in a single-parent household.

- Eighty-four percent of children living with a single parent live with their mother. Ninety-three percent of black children, 85 percent of Hispanic children, and 78 percent of white children in single-parent households live with their mother (Lugaila, 1998).
- Forty-seven percent of children residing with their single mother live at or below the poverty level. Fifty-four percent of black children, 60 percent of Hispanic children, and 37 percent of white children in single-parent households headed by women live below the federal poverty level (Lugaila, 1998).

Chart 1-7

Children Under Age 18 Who Live in a Single-Parent Household, 1997



Source: Lugaila, 1998.

Vital Statistics

Chart 2-1
Life Expectancy at Birth for Men by Race, 1960-1996

Life expectancy and mortality rates have been improving for the U.S. population. Yet across all age groups, life expectancy for blacks is still lower than that for whites.

- Black men have the lowest life expectancy of all Americans: 66 years, versus 74 years for white men. Life expectancy for black men has remained at a nearly constant level since 1980 (National Center for Health Statistics, 1998).
- The greatest differences in years of life expectancy are at birth and at age 25; the gap then narrows as age increases. Mortality rates from infancy through early adulthood are significantly higher for black males (Peters et al., 1998).
- The number of years of potential life lost prior to age 75 per 100,000 people is highest among black men at 18,995 years. Among white men, the figure is 8,744 years (National Center for Health Statistics, 1998).
- *The U.S. Burden of Disease and Injury Study* underscores the vast discrepancies in life expectancy among other minority groups in different parts of the country. Native American men in South Dakota, for example, live on average only into their mid-fifties (*Harvard Public Health Review,* Fall 1998).

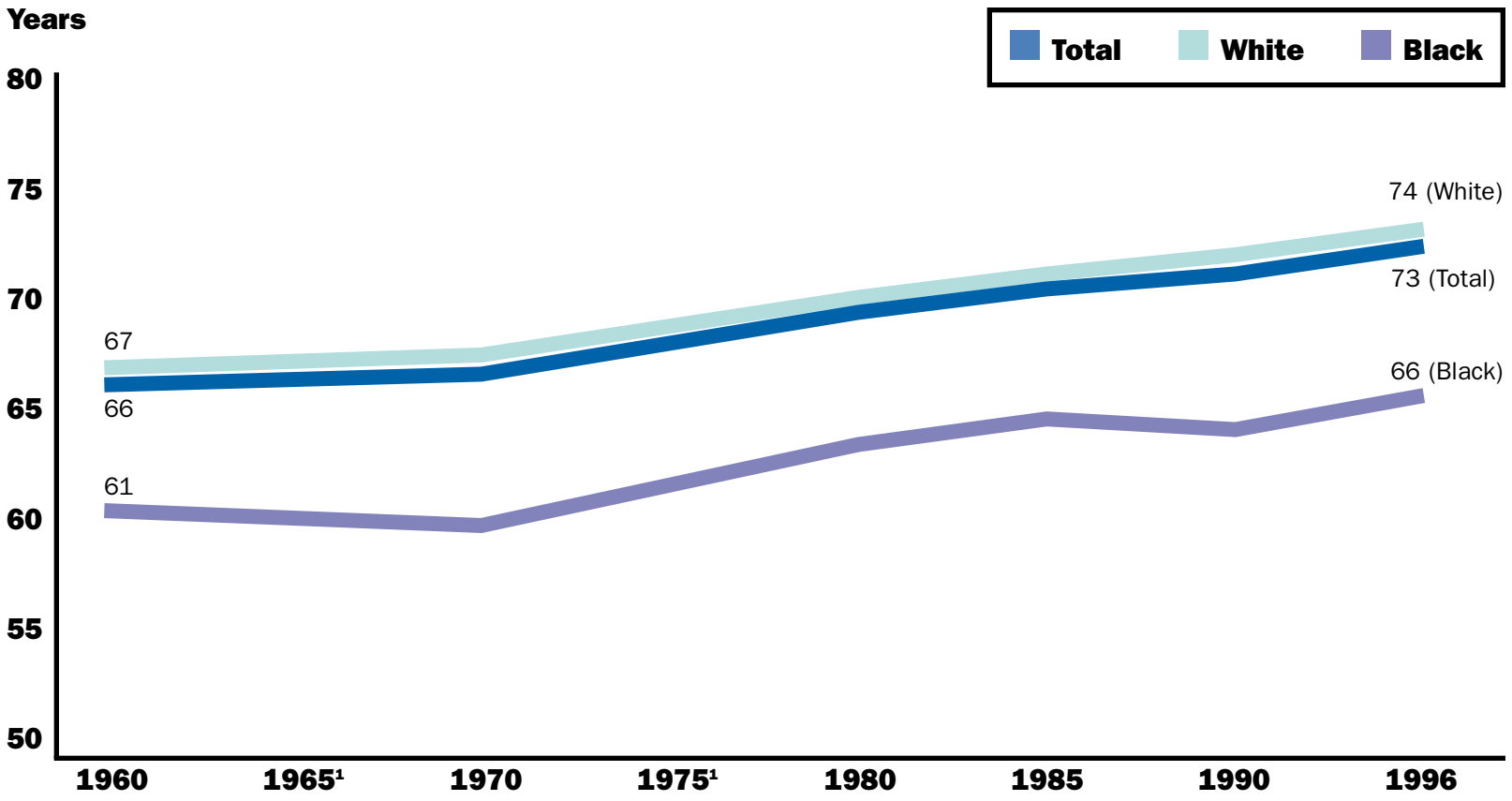
Life Expectancy at Selected Ages by Race, 1996

	All Men	White Men	Black Men	Years Difference Between White And Black Men	Percent Difference Between White And Black Men
At Birth	73.1	73.9	66.1	7.8	11%
At Age 25	49.6	50.2	43.7	6.5	13%
At Age 50	27.2	27.5	23.4	4.1	15%
At Age 75	9.8	9.8	9.0	0.8	8%

Source: Peters et al., 1998.

Chart 2-1

Life Expectancy at Birth for Men by Race, 1960–1996



[1]*Based on authors' estimates.*

Source: National Center for Health Statistics, 1998.

Chart 2-2
Life Expectancy at Birth for Women by Race, 1960–1996

Women have longer life expectancy at birth than men, but there is nearly a six-year difference between life expectancy at birth for white women (80 years) and black women (74 years).

- The number of years of potential life lost prior to age 75 per 100,000 people is highest among black women at 10,013 years. Native American women have the second highest total, 6,797 years. Among white women, the figure is 4,875 years (National Center for Health Statistics, 1998).

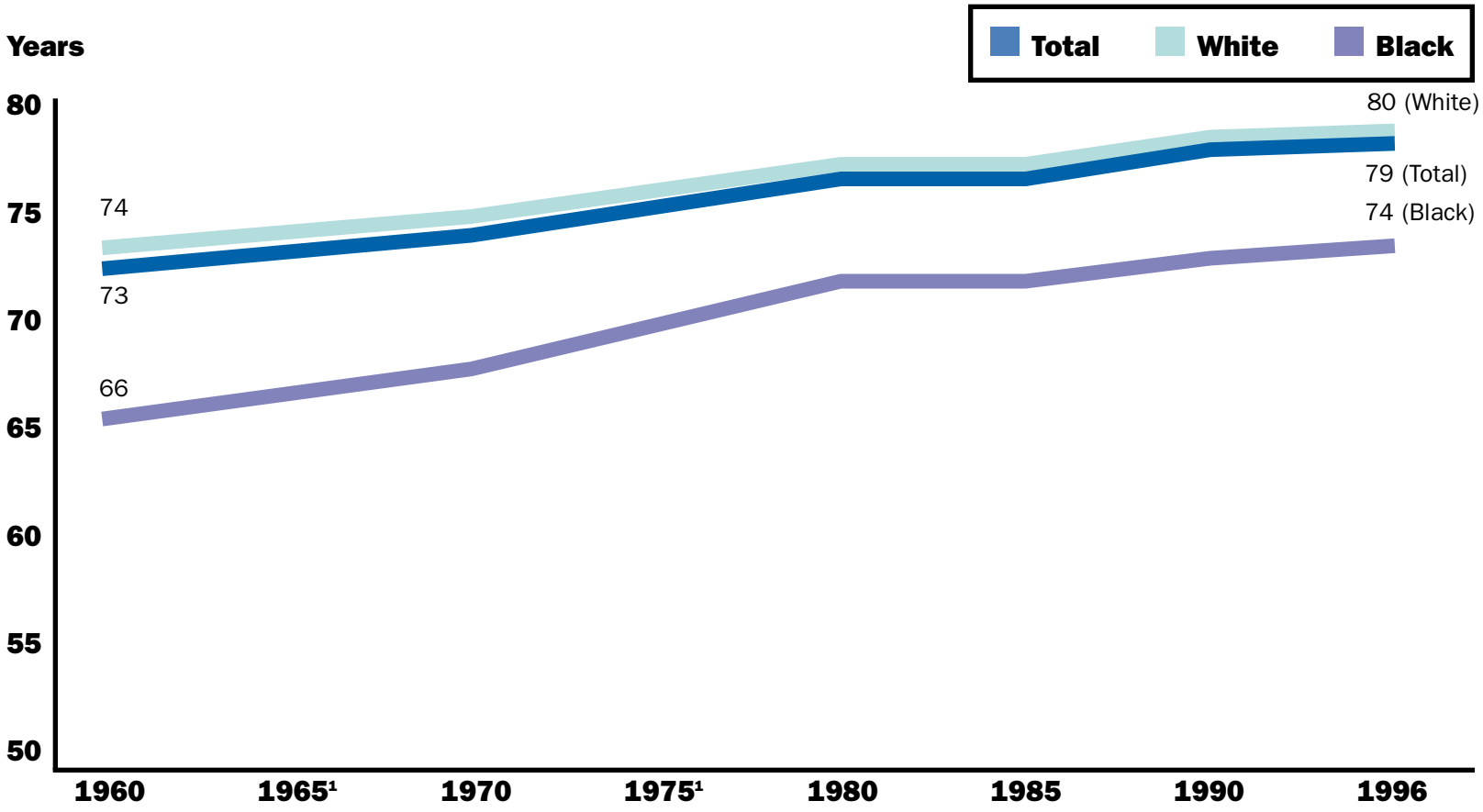
Life Expectancy at Selected Ages by Race, 1996

	All Women	White Women	Black Women	Years Difference Between White And Black Women	Percent Difference Between White And Black Women
At Birth	79.1	79.7	74.2	5.5	7%
At Age 25	55.1	55.6	50.9	4.7	8%
At Age 50	31.5	31.7	28.5	3.2	10%
At Age 75	12.0	12.0	11.2	0.8	7%

Source: Peters et al., 1998.

Chart 2-2

Life Expectancy at Birth for Women by Race, 1960–1996



[1]*Based on authors' estimates.*

Source: National Center for Health Statistics, 1998.

Chart 2-3

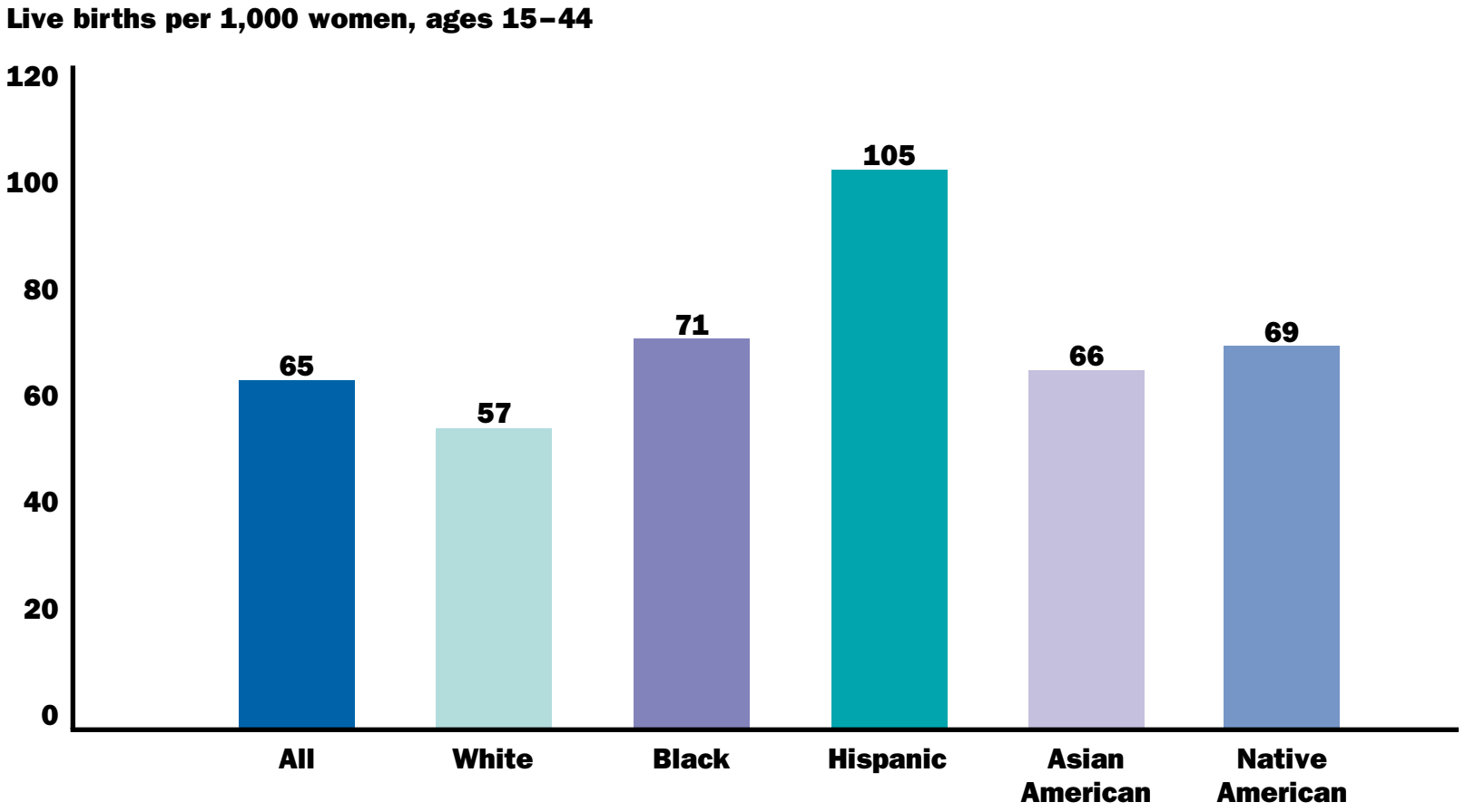
Fertility Rates by Race and Hispanic Origin, 1996

Fertility rates are highest among Hispanic women; rates across other racial/ethnic groups are all very similar.

- Among Hispanic women, the fertility rate is 105 live births per 1,000 women ages 15 to 44 (National Center for Health Statistics, 1998).
- Whites, blacks, Asian Americans, and Native Americans come close to the overall national rate of 65 live births per 1,000 women ages 15 to 44 (National Center for Health Statistics, 1998).

Chart 2-3

Fertility Rates by Race and Hispanic Origin, 1996



Source: National Center for Health Statistics, 1998.

Chart 2-4

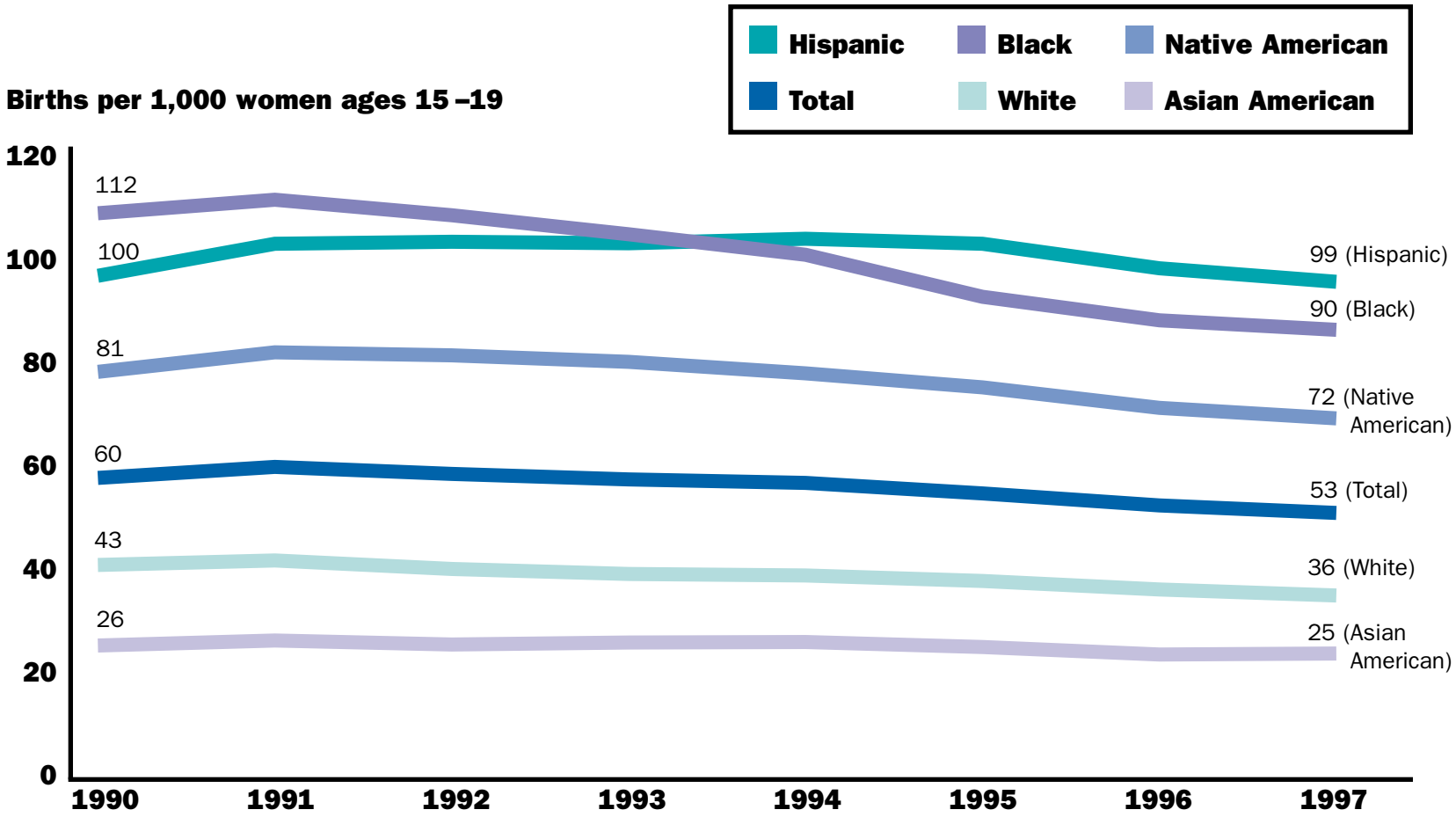
Trends in Births to Teenage Mothers, by Race and Hispanic Origin of the Mother, 1990–1997

Overall, births to teenage mothers are declining, particularly among black teenage girls. However, the rates for black and Hispanic girls are still higher than those for white girls.

- The overall rate of teenage births in the United States was 53 births per 1,000 women ages 15 to 19 in 1997 (Ventura et al., 1998).
- In 1996, 17 percent of Hispanic births, 23 percent of black births, and 11 percent of white births were to females under age 20 (Ventura et al., 1998).
- The rate of births to teenage mothers declined 23 percent among black adolescent girls between 1991 and 1997 (Ventura et al., 1998).
- Declines in teenage births can be attributed to a drop in the number of teens who are having sexual intercourse and an increase in the number who use birth control, including condoms and injectable and implanted contraceptives (Sonenstein et al., 1998, and Donovan, 1998).
- Among sexually active high school students, 56 percent of whites, 64 percent of blacks, and 48 percent of Hispanics reported using a condom during sexual intercourse (Centers for Disease Control, 1998).

Chart 2-4

Trends in Births to Teenage Mothers, by Race and Hispanic Origin of the Mother, 1990–1997



Source: Ventura et al., 1998.

THE COMMONWEALTH FUND

Chart 2-5

Infant Mortality Rates by Race and Hispanic Origin, 1983–1996

Infant mortality rates have been declining for all U.S. racial and ethnic groups. Gaps across groups, however, remain constant.

- Blacks have the highest infant mortality rate, 14 deaths per 1,000 live births. Native Americans have the next highest rate, 10 deaths per 1,000 live births (MacDorman et al., 1998).
- Among Hispanic mothers, Puerto Ricans have the highest infant mortality rate at 8.6 deaths per 1,000 live births. Mexicans (5.8), Cubans (5.1), and Central and South Americans (5.0) have lower infant mortality rates (MacDorman et al., 1998).
- Black infant mortality is related to higher rates of complicated pregnancies and adverse birth events and higher rates of low-birthweight babies. Excess deaths among very low-birthweight infants account for 62 percent of the racial disparity in infant mortality (Rowley, 1995).

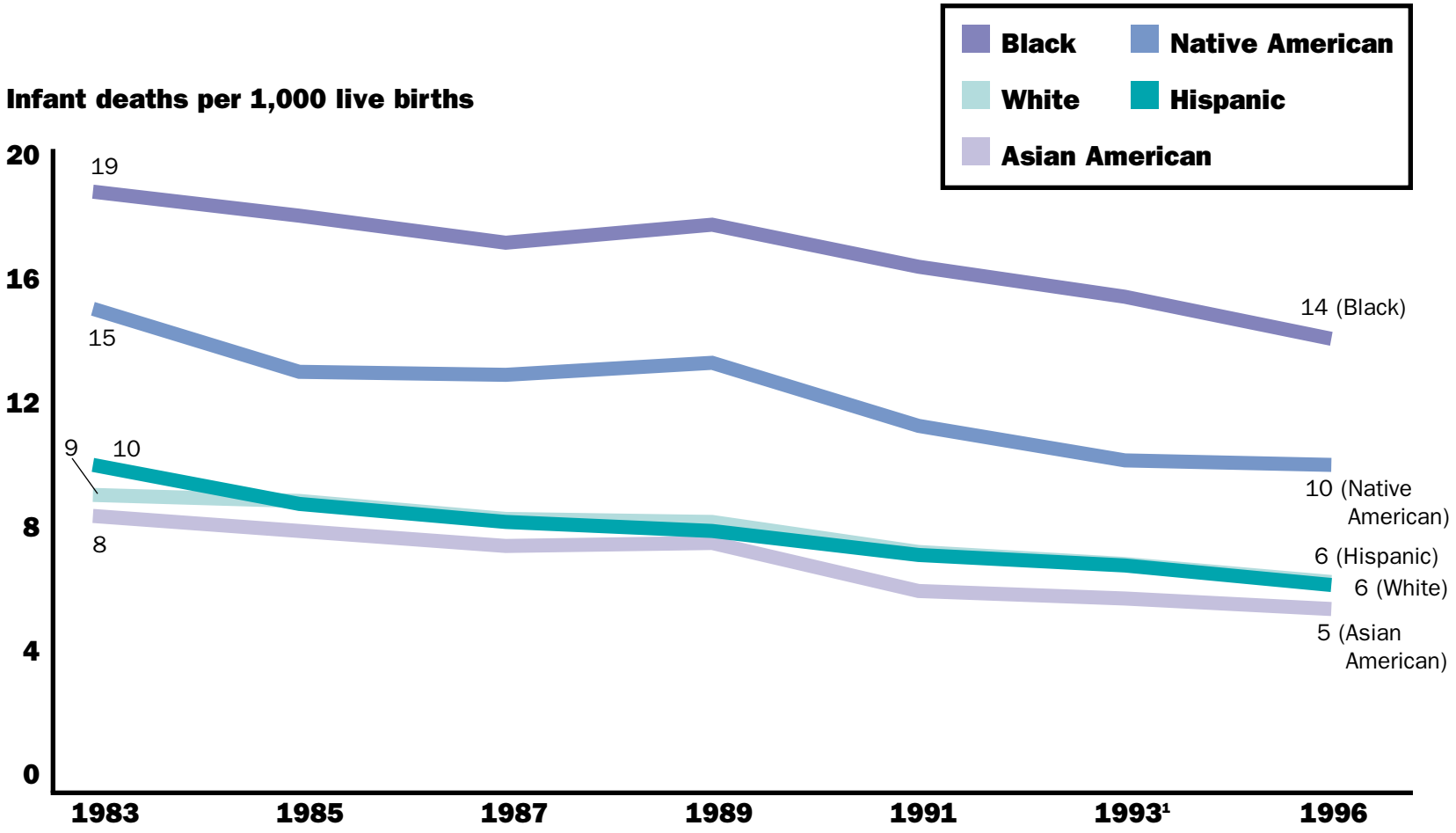
Infant Mortality Rates by Race and Ethnicity, 1988–1996

	All Races	White	Black	Hispanic	Asian American	Native American
1988	10.0	8.0	18.1	8.3	6.8	12.7
1989	9.8	7.8	18.0	8.1	7.4	13.4
1990	9.2	7.2	16.9	7.5	6.6	13.1
1991	8.9	7.0	16.6	7.1	5.8	11.3
1992–94	Figures are not available.					
1995	7.6	6.3	14.6	6.3	5.3	9.0
1996	7.3	6.0	14.2	6.1	5.2	10.0

Sources: Council of Economic Advisers, 1998, Anderson et al., 1997, MacDorman et al., 1998.

Chart 2-5

Infant Mortality Rates by Race and Hispanic Origin, 1983–1996



[1]*Based on authors' estimates.*

Source: Council of Economic Advisers, 1998, Anderson et al., 1997, and MacDorman et al., 1998.

THE COMMONWEALTH FUND

Chart 2-6
Percentage of Low-Birthweight Births by Race and Hispanic Origin of the Mother, 1996

Low-birthweight births, which are closely related to infant mortality, occur most frequently among black mothers.

- Black women give birth to twice as many babies of low birthweight (less than 2,500 grams) as do white or Hispanic women. Three percent of live births to black mothers are very low birthweight (less than 1,500 grams), compared with 1 percent of births to white women (National Center for Health Statistics, 1998). Even among college-educated parents, black low-birthweight births (7 percent) occur at twice the rate of white low-birthweight births (3 percent) (Schoendorf et al., 1992).
- Recent analysis shows that an increased risk of low birthweight can be explained in large part by socioeconomic status, maternal health history, and access to medical care (Hessol et al., 1998).

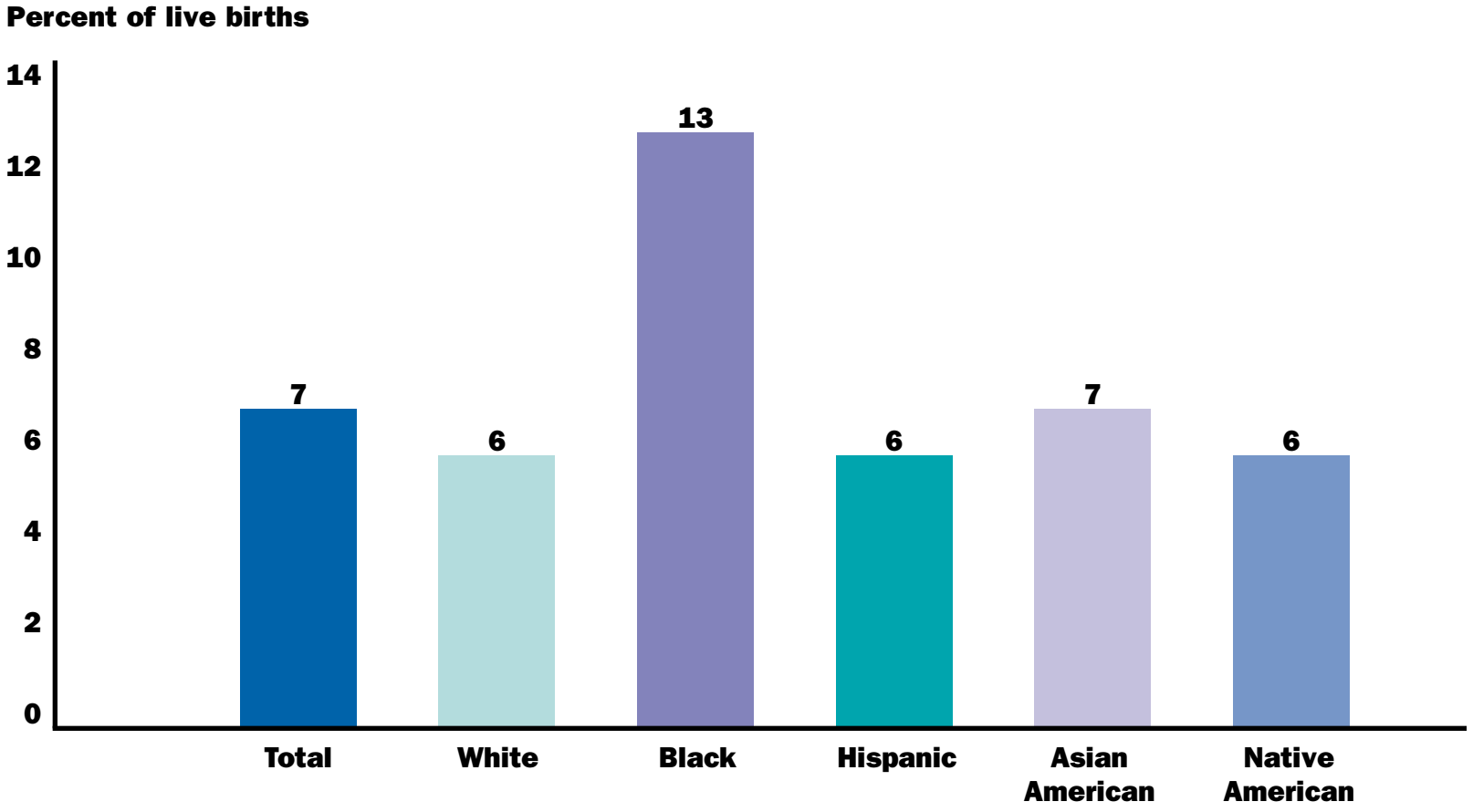
Percentage of Low-Birthweight Births by Race and Hispanic Origin of the Mother, 1980–1996

	All Races	White	Black	Hispanic (selected states)	Asian American	Native American
1980	6.84	5.67	12.71	6.12	6.68	6.44
1985	6.75	5.60	12.61	6.16	6.16	5.86
1990	6.97	5.61	13.32	6.06	6.45	6.11
1991	7.12	5.72	13.62	6.15	6.54	6.15
1992	7.08	5.73	13.40	6.10	6.57	6.22
1993	7.22	5.92	13.43	6.24	6.55	6.42
1994	7.28	6.06	13.34	6.25	6.81	6.45
1995	7.32	6.20	13.21	6.29	6.90	6.61
1996	7.39	6.36	13.12	6.28	7.07	6.49

Source: National Center for Health Statistics, 1998.

Chart 2-6

Percentage of Low-Birthweight* Births by Race and Hispanic Origin of the Mother, 1996



**Birthweight of less than 2,500 grams (5 pounds, 8 ounces).*

Source: National Center for Health Statistics, 1998.

THE COMMONWEALTH FUND

Chart 2-7

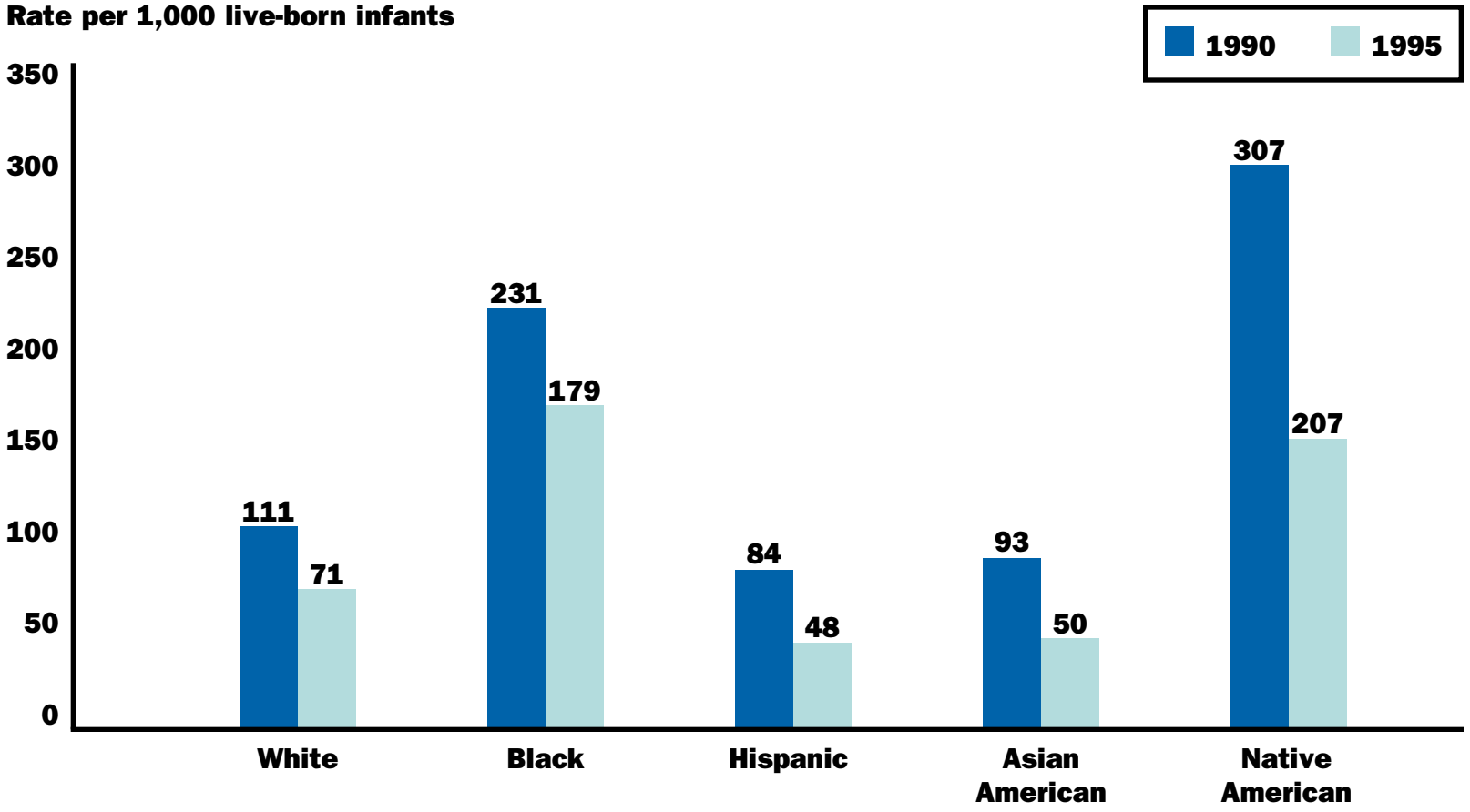
Sudden Infant Death Syndrome (SIDS) Rates by Race and Hispanic Origin, 1990 and 1995

There has been a dramatic decline in the rates of SIDS across all racial and ethnic groups. Still, the rate for SIDS is dramatically higher among Native Americans and blacks than it is for whites.

- Important factors contributing to decreases in SIDS include parental education on proper sleeping position and on the risk associated with environmental smoke (*Morbidity and Mortality Weekly Report,* 1999).
- A recent study found that minority parents who receive care from a low-income clinic were significantly less likely to receive sleeping instructions than high-income parents in a private practice—even though low-income families have higher risk factors for SIDS. Of those families who received sleep instruction, high- and low-income families were as likely to follow the instructions given (Ray et al., 1997).

Chart 2-7

Sudden Infant Death Syndrome (SIDS) Rates by Race and Hispanic Origin, 1990 and 1995



Source: National Vital Statistics System, 1999.

Health Status and Disease

Chart 3-1
Leading Causes of Death for Women by Race and Hispanic Origin, 1996

Among Americans, heart disease and cancer are the leading causes of death.

- Among minority women, accidents and unintentional injuries are among the top five leading causes of death (National Center for Health Statistics, 1998).
- Diabetes is the fourth leading cause of death for black, Native American, and Hispanic women (National Center for Health Statistics, 1998).

The First Two Leading Causes of Death for Females by Age, Race, and Hispanic Origin, 1996

	All Races	White	Black	Hispanic
All Ages	Heart disease	Heart disease	Heart disease	Heart disease
	Cancer	Cancer	Cancer	Cancer
1–4 Years	Accidents	Accidents	Accidents	Accidents
	Congenital anomalies	Congenital anomalies	Homicide	Congenital anomalies
5–14 Years	Accidents	Accidents	Accidents	Accidents
	Cancer	Cancer	Cancer	Cancer
15–24 Years	Accidents	Accidents	Accidents	Accidents
	Homicide	Suicide	Homicide	Homicide
25–44 Years	Cancer	Cancer	HIV infection	Cancer
	Accidents	Accidents	Cancer	HIV infection
45–64 Years	Cancer	Cancer	Cancer	Cancer
	Heart disease	Heart disease	Heart disease	Heart disease
65 Years and Over	Heart disease	Heart disease	Heart disease	Heart disease
	Cancer	Cancer	Cancer	Cancer

Note: Shaded rows indicate first leading cause of death.

Source: Peters et al., 1998.

Chart 3-1

Leading Causes of Death for Women by Race and Hispanic Origin, 1996

All Females	White	Black	Rank	Native American	Asian American	Hispanic
Heart disease	Heart disease	Heart disease	1	Heart disease	Cancer	Heart disease
Cancer	Cancer	Cancer	2	Cancer	Heart disease	Cancer
Cerebrovascular disease	Cerebrovascular disease	Cerebrovascular disease	3	Accidents and unintentional injuries	Cerebrovascular disease	Cerebrovascular disease
Chronic lung disease	Chronic lung disease	Diabetes	4	Diabetes	Accidents and unintentional injuries	Diabetes
Pneumonia and influenza	Pneumonia and influenza	Accidents and unintentional injuries	5	Cerebrovascular disease	Pneumonia and influenza	Accidents and unintentional injuries

Source: National Center for Health Statistics, 1998.

Chart 3-2
Leading Causes of Death for Men by Race and Hispanic Origin, 1996

- For Native American men, accidents and unintentional injuries rank second, before cancer and chronic liver disease, while cirrhosis is the fifth leading cause of death (National Center for Health Statistics, 1998).
- Among black and Hispanic men, HIV infection and homicide are among the top five causes of death. For black men, homicide is the first or second leading cause of death throughout childhood and young adulthood (ages 1–44) (National Center for Health Statistics, 1998).

The First Two Leading Causes of Death for Males by Age, Race, and Hispanic Origin, 1996

	All Races	White	Black	Hispanic
All Ages	Heart disease	Heart disease	Heart disease	Heart disease
	Cancer	Cancer	Cancer	Cancer
1–4 Years	Accidents	Accidents	Accidents	Accidents
	Congenital anomalies	Congenital anomalies	Homicide	Congenital anomalies
5–14 years	Accidents	Accidents	Accidents	Accidents
	Cancer	Cancer	Homicide	Cancer
15–24 Years	Accidents	Accidents	Homicide	Accidents
	Homicide	Suicide	Accidents	Homicide
25–44 Years	Accidents	Accidents	HIV infection	Accidents
	HIV infection	Suicide	Homicide	HIV infection
45–64 Years	Heart disease	Heart disease	Heart disease	Heart disease
	Cancer	Cancer	Cancer	Cancer
65 Years and Over	Heart disease	Heart disease	Heart disease	Heart disease
	Cancer	Cancer	Cancer	Cancer

Note: Shaded rows indicate first leading cause of death.

Source: Peters et al., 1998.

Chart 3-2

Leading Causes of Death for Men by Race and Hispanic Origin, 1996

All Males	White	Black	Rank	Native American	Asian American	Hispanic
Heart disease	Heart disease	Heart disease	1	Heart disease	Heart disease	Heart disease
Cancer	Cancer	Cancer	2	Accidents and unintentional injuries	Cancer	Cancer
Cerebrovascular disease	Cerebrovascular disease	HIV infection	3	Cancer	Cerebrovascular disease	Accidents and unintentional injuries
Accidents and unintentional injuries	Accidents and unintentional injuries	Accidents and unintentional injuries	4	Diabetes	Accidents and unintentional injuries	HIV infection
Chronic lung disease	Chronic lung disease	Homicide	5	Chronic liver disease and cirrhosis	Pneumonia and influenza	Homicide

Source: National Center for Health Statistics, 1998.

Chart 3-3
Age-Adjusted Death Rates by Sex, Race, and Hispanic Origin, 1996

Adjusting for differences in the age distribution among the different racial and ethnic groups, death rates are highest among black men and women. Blacks have the highest age-adjusted death rate at 738 deaths per 100,000 resident population, compared with the overall death rate of 492 deaths per 100,000 resident population (National Center for Health Statistics, 1998).

- Among men, blacks have the highest age-adjusted death rate at 967 deaths per 100,000 resident population.
- Blacks have higher death rates from heart disease, cerebrovascular disease, and cancer than whites and Hispanics. Hispanic and Asian American females have lower mortality from heart disease than white and black females (National Center for Health Statistics, 1998).
- Death rates from diabetes are highest for blacks, Native Americans, and Hispanics (National Center for Health Statistics, 1998).

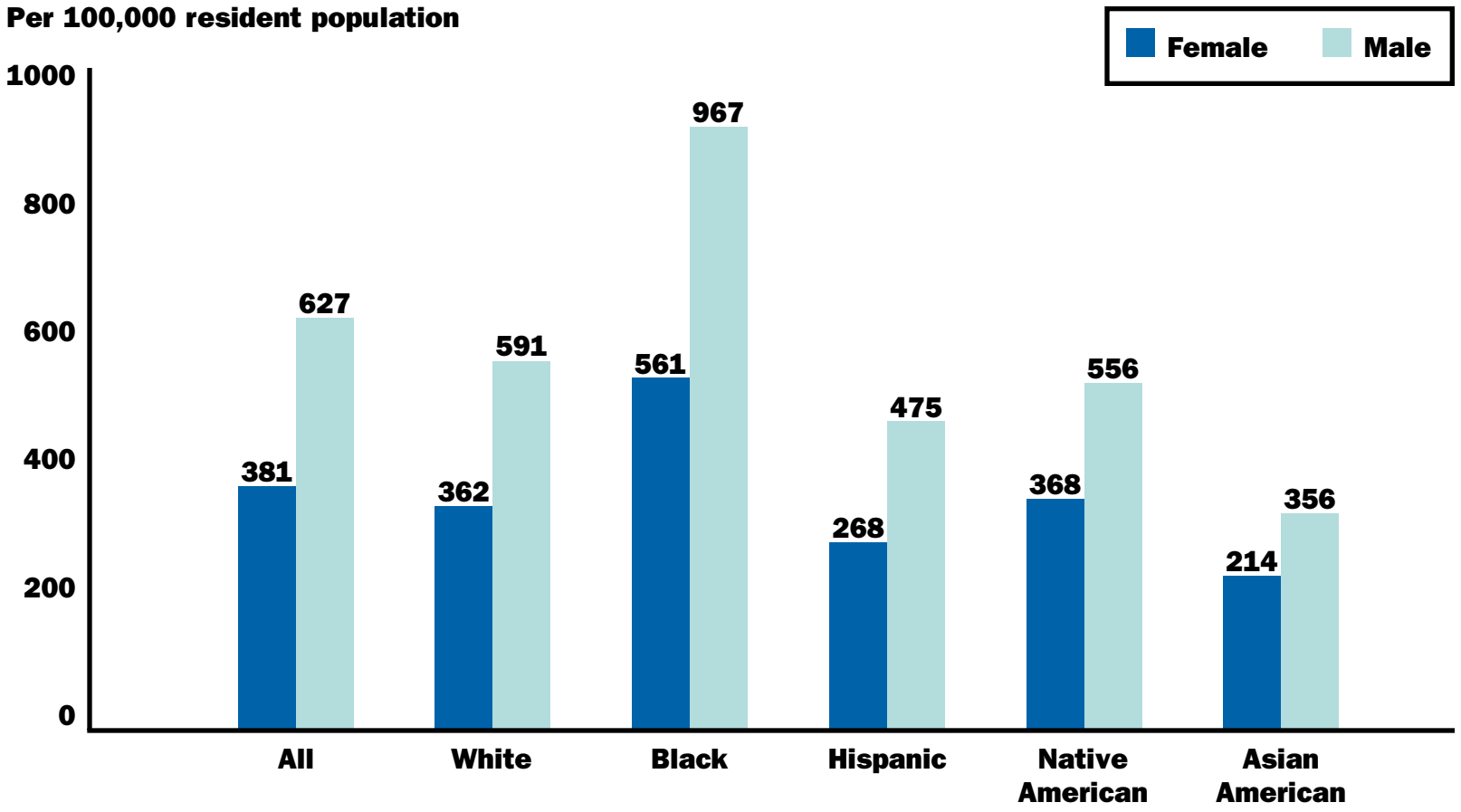
Age-Adjusted Death Rates per 100,000 for Selected Causes of Death by Race and Ethnicity, 1996

	Total	White	Black	Hispanic	Native American	Asian American
All Causes	492	467	738	366	457	277
Heart Disease	135	131	192	89	101	72
Cerebrovascular Disease	26	24	44	20	21	24
Cancer	128	128	168	78	85	76
Diabetes	14	12	29	19	28	9

Source: National Center for Health Statistics, 1998.

Chart 3-3

Age-Adjusted Death Rates by Sex, Race, and Hispanic Origin, 1996



Source: Ventura et al., 1997.

Chart 3-4

Age-Adjusted Prostate Cancer Rates Among Men by Race

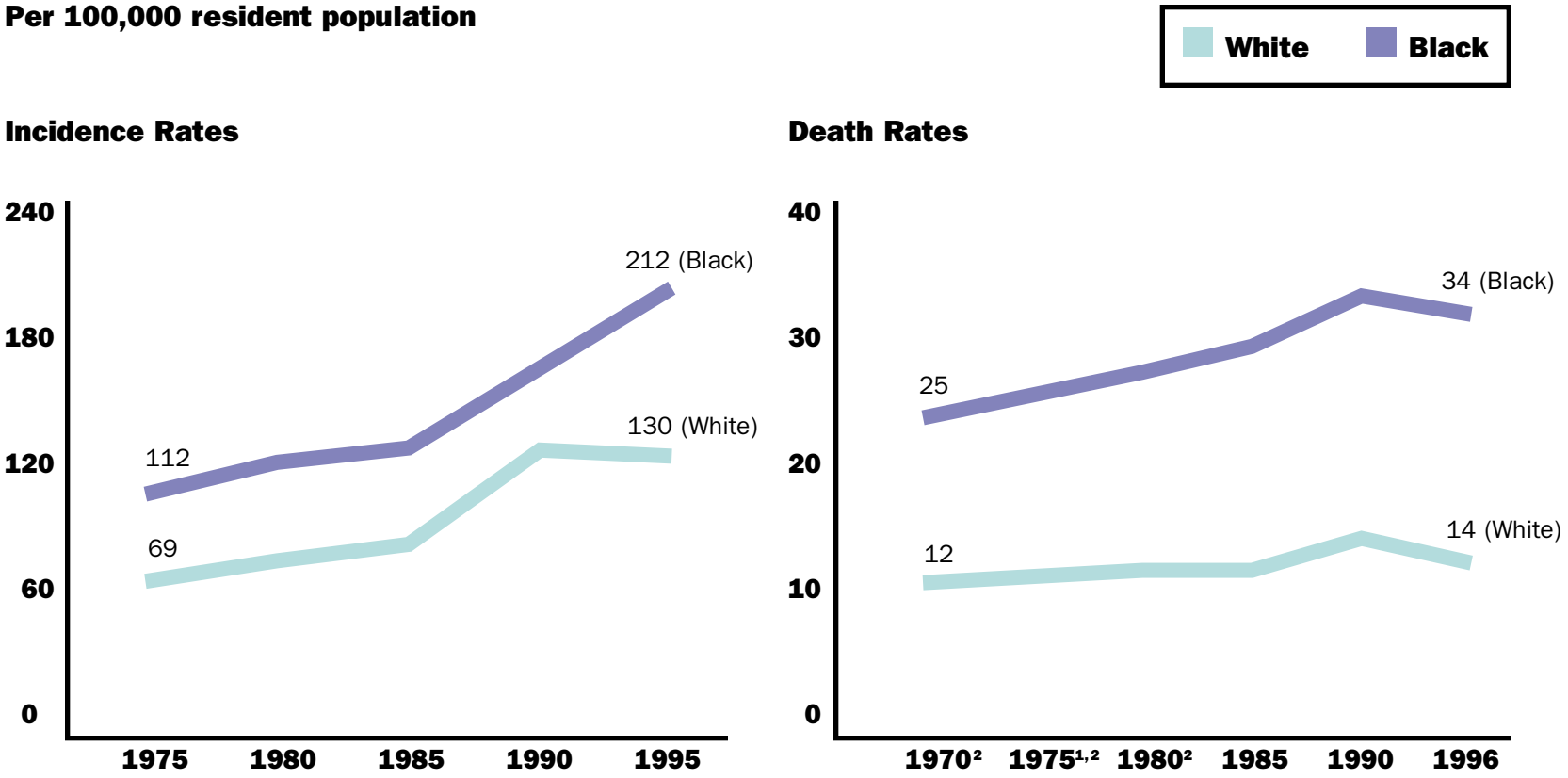
Black men suffer the highest prostate cancer incidence and mortality rates.

- In 1995, incidence of prostate cancer among black men was 212 cases per 100,000 resident population; among white men, it was 130 cases per 100,000 resident population (National Center for Health Statistics, 1998).
- Prostate mortality rates are more than twice as high for black men than for white men: 34 per 100,000 resident population versus 14 per 100,000 resident population (National Center for Health Statistics, 1998).
- Five-year survival rates are greater for whites than for blacks at every stage of diagnosis. Ninety-five percent of white men with prostate cancer are alive five years following diagnosis, compared with 81 percent of black men (National Center for Health Statistics and American Cancer Society, 1998).
- Increased risks for black men may include greater consumption of animal fats, less knowledge of the early symptoms of prostate cancer, and less likelihood of being screened (Hayes et al., 1999, Barber et al., 1998).
- Poor literacy skills may be an overlooked but significant barrier to the diagnosis of early-stage prostate cancer among low-income men and highlights the need for educational programs targeted at this population (Bennett et al., 1998).

Chart 3-4

Age-Adjusted Prostate Cancer Rates Among Men by Race

Per 100,000 resident population



[1]Based on authors' estimates.
[2]May include whites of Hispanic origin.

Source: American Cancer Society and National Center for Health Statistics, 1998.

Chart 3-5

Age-Adjusted Breast Cancer Rates Among Women by Race

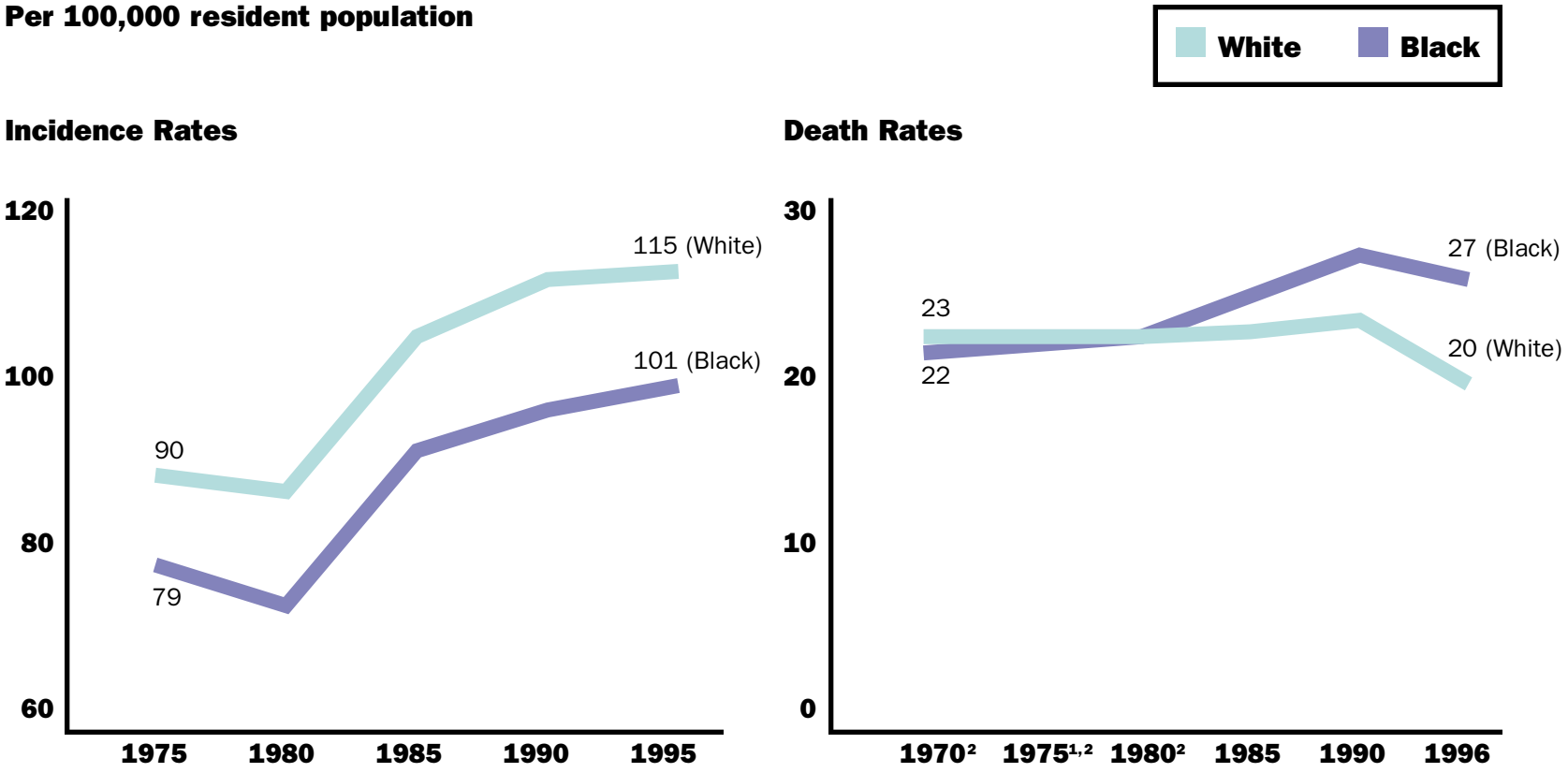
Death rates from breast cancer remain higher for black women than for white women, despite the lower incidence of breast cancer among blacks.

- Among white women, 115 cases of breast cancer per 100,000 population were diagnosed in 1995, compared with 101 per 100,000 black women (National Center for Health Statistics, 1998).
- In 1996, the death rate for breast cancer was 20 per 100,000 white women, and 27 per 100,000 black women (National Center for Health Statistics, 1998).
- Eighty-one percent of white breast cancer patients and 71 percent of black breast cancer patients are alive five years after diagnosis. For all cancers, five-year survival rates are lower for black women than for white women (National Center for Health Statistics, 1998).
- Although disparities in survival rates have not been fully explained, they do include black women's more limited receipt of preventive services, particularly routine mammography; poorer access to care; and greater likelihood of not being diagnosed until a later, more advanced stage of cancer (Mandleblatt et al., 1995, and McCarthy et al., 1998).
- Culturally specific beliefs may also help explain why more black women than white women are first diagnosed with breast cancer in its late stage (Lannin et al., 1998).

Chart 3-5

Age-Adjusted Breast Cancer Rates Among Women by Race

Per 100,000 resident population



Source: National Center for Health Statistics, 1998.

[1]Based on authors' estimates.
[2]May include whites of Hispanic origin.

Chart 3-6

Self-Rated Health Status by Hispanic and Asian Origin, 1994

Chart 3-7

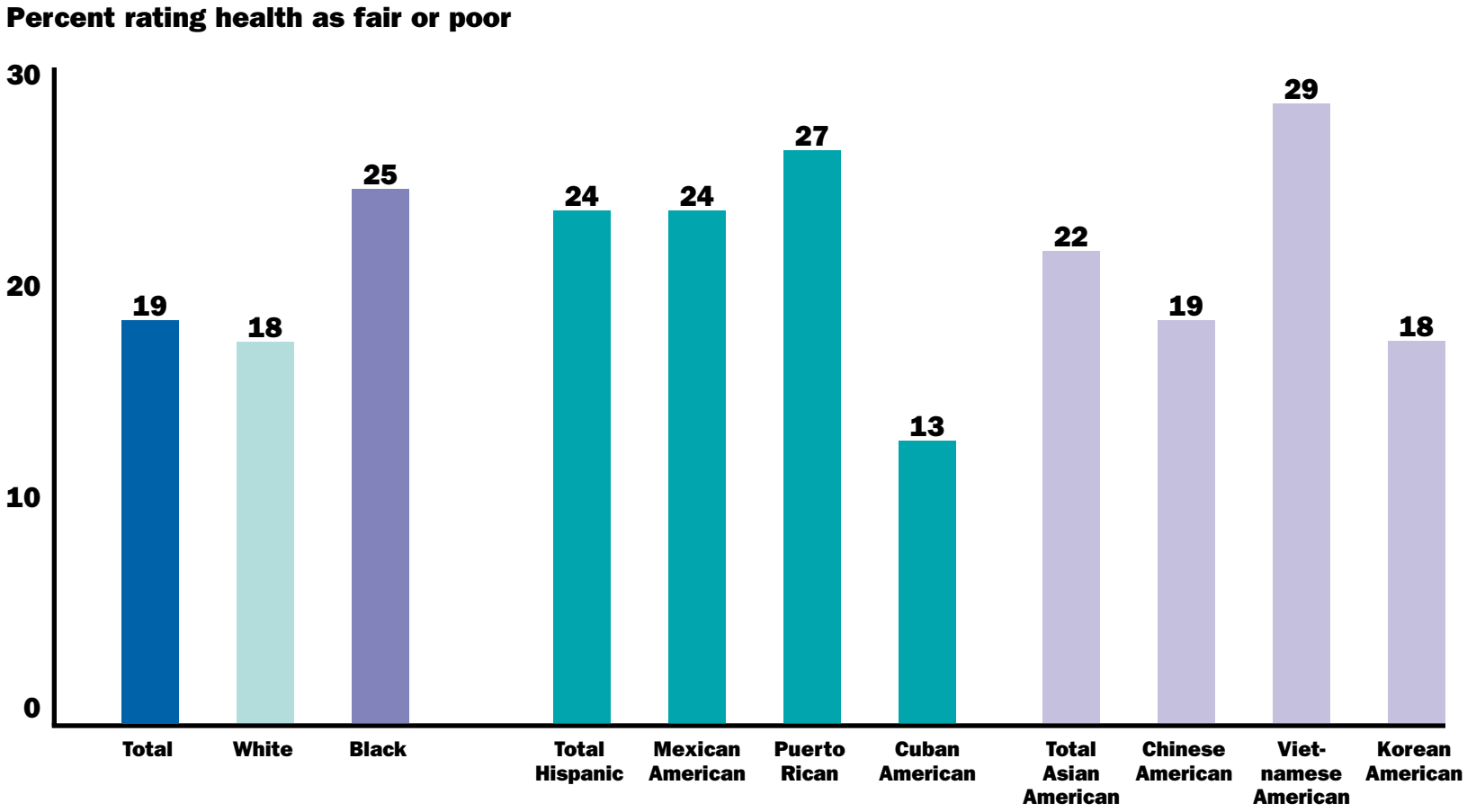
Self-Rated Health Status of Elderly by Race, 1996

Minorities are more likely to rate their health as fair or poor.

- Twenty-five percent of blacks and 24 percent of Hispanics rated their health as fair or poor, compared with 18 percent of whites (*The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care*).
- Wide variation exists within minority groups. Mexican and Puerto Rican Americans were more likely than Cuban Americans to report their health as fair or poor. Vietnamese Americans reported fair or poor health more often than either Chinese or Korean Americans (authors' tabulations of *The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care*).
- Black and Hispanic elderly were much more likely to feel they are in fair or poor health (authors' tabulations of the *1996 Medicare Current Beneficiary Survey*).

Chart 3-6

Self-Rated Health Status by Hispanic and Asian Origin, 1994

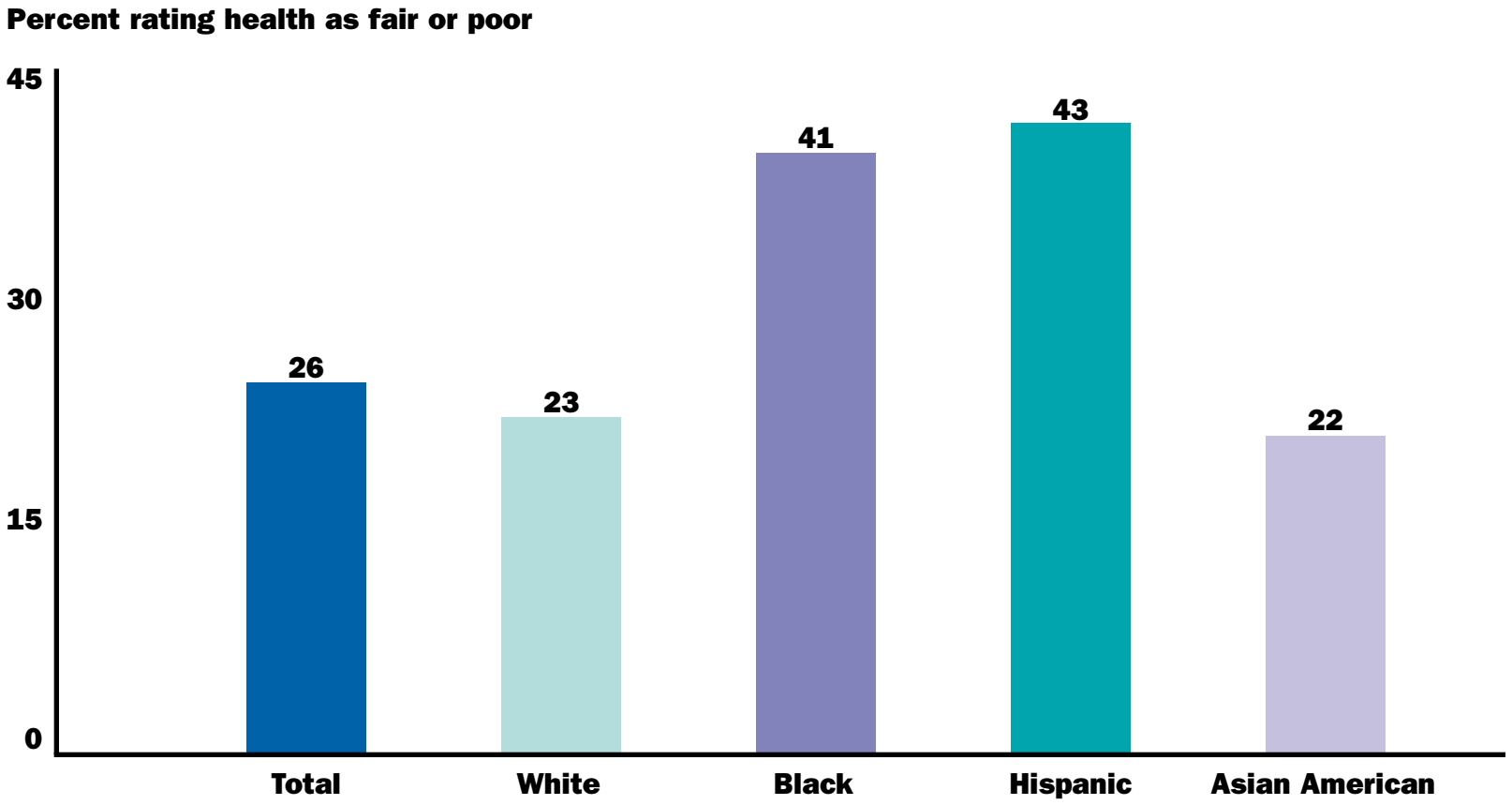


Source: *The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care* and authors' tabulations of *The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care.*

THE COMMONWEALTH FUND

Chart 3-7

Self-Rated Health Status of Elderly* by Race, 1996



**Age 65 and over, community-dwelling.*

Source: Authors' tabulations of the *1996 Medicare Current Beneficiary Survey*.

Chart 3-8

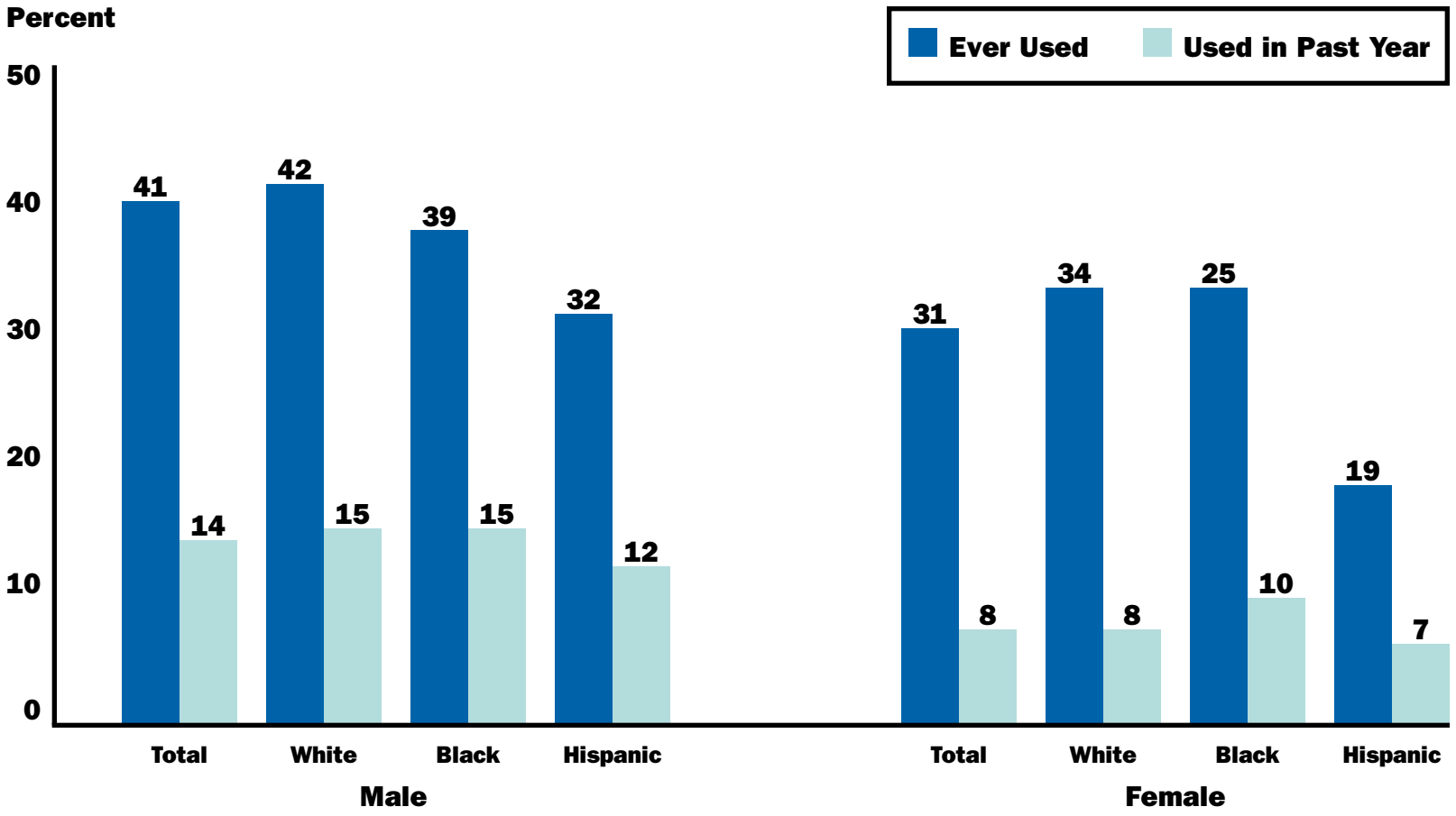
Illicit Drug Use, Age 12 and Older, by Sex, Race, and Hispanic Origin, 1997

Thirty-six percent of the total population report having ever used illicit drugs, while 11 percent report drug use in the past year and 6 percent in the past month.

- Thirty-one percent of blacks and 26 percent of Hispanics have used illicit drugs, compared with 38 percent of whites. Twelve percent of blacks, 10 percent of Hispanics, and 11 percent of whites used illicit drugs in the past year (Substance Abuse and Mental Health Services Administration, 1998).
- A third of the total population have used marijuana, including 36 percent of whites, 28 percent of blacks, and 22 percent of Hispanics. Nine percent of the population used marijuana in the past year, including 10 percent of blacks, 9 percent of whites, and 8 percent of Hispanics. (Substance Abuse and Mental Health Services Administration, 1998).
- Eleven percent of the U.S. population reported ever having used cocaine. Six percent of blacks and 7 percent of Hispanics have used cocaine, compared with 12 percent of whites. In the past year, 1 percent of the total population reported using cocaine. Two percent of whites, blacks, and Hispanics used cocaine in the past year (Substance Abuse and Mental Health Services Administration, 1998).

Chart 3-8

Illicit Drug Use, Age 12 and Older, by Sex, Race, and Hispanic Origin, 1997



Source: Substance Abuse and Mental Health Services Administration, 1998.

Chart 3-9

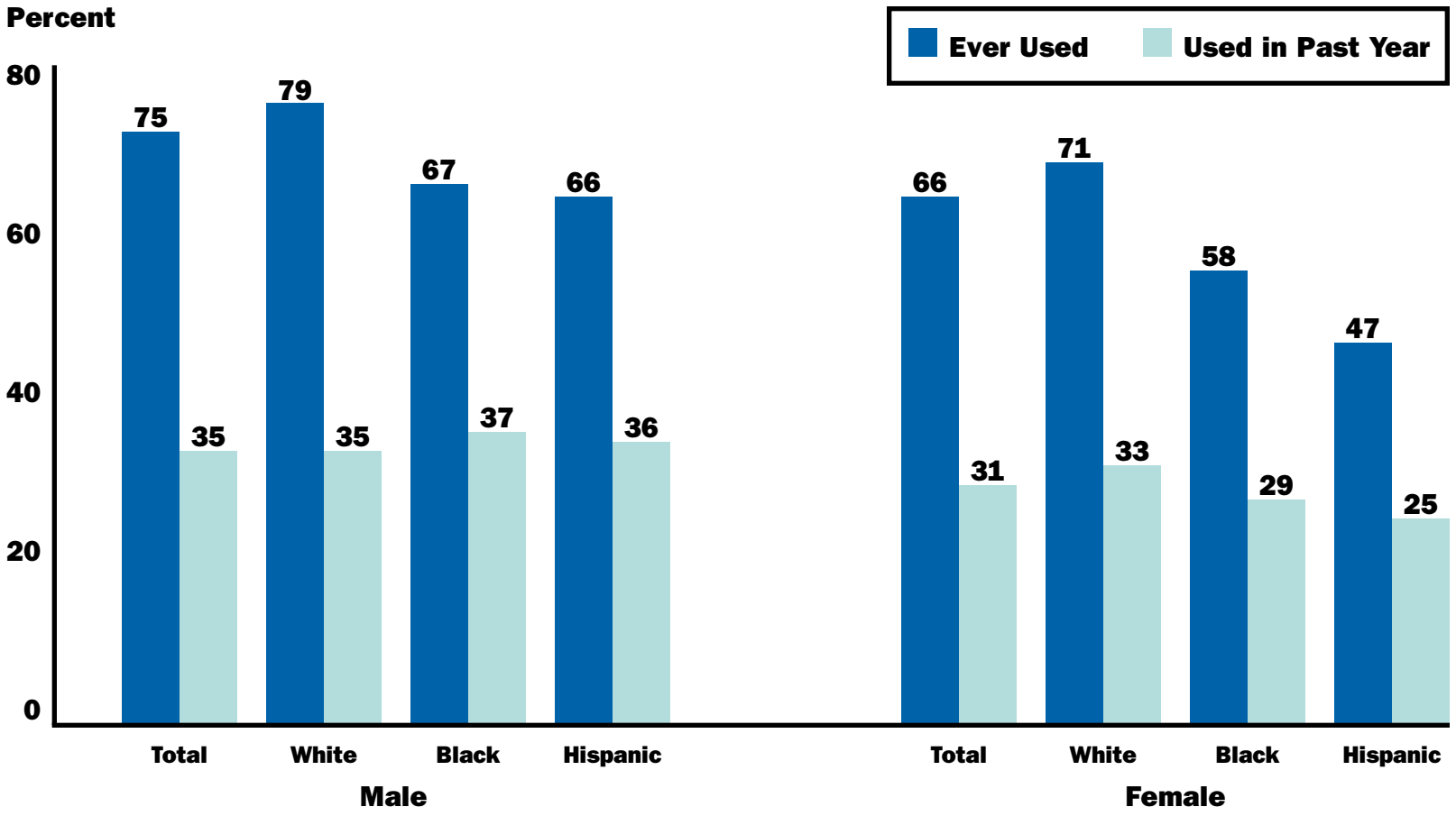
Cigarette Use, Age 12 and Older, by Sex, Race, and Hispanic Origin, 1997

Lifetime exposure to tobacco is higher among whites than among blacks and Hispanics. Current smoking rates, however, are similar across groups.

- Slightly more men than women reported smoking a cigarette in the past year. Hispanic women were least likely to have smoked in the past year (Substance Abuse and Mental Health Services Administration, 1998).
- Blacks have a higher prevalence of smoking-related diseases than whites. A recent study found that blacks' daily nicotine intake and nicotine intake per cigarette were greater than whites, although the two groups' smoking and demographic characteristics were quite similar (Perez-Stable et al., 1998).

Chart 3-9

Cigarette Use, Age 12 and Older, by Sex, Race, and Hispanic Origin, 1997



Source: Substance Abuse and Mental Health Services Administration, 1998.

Chart 3-10

Alcohol Use, Age 12 and Older, by Sex, Race and Hispanic Origin, 1997

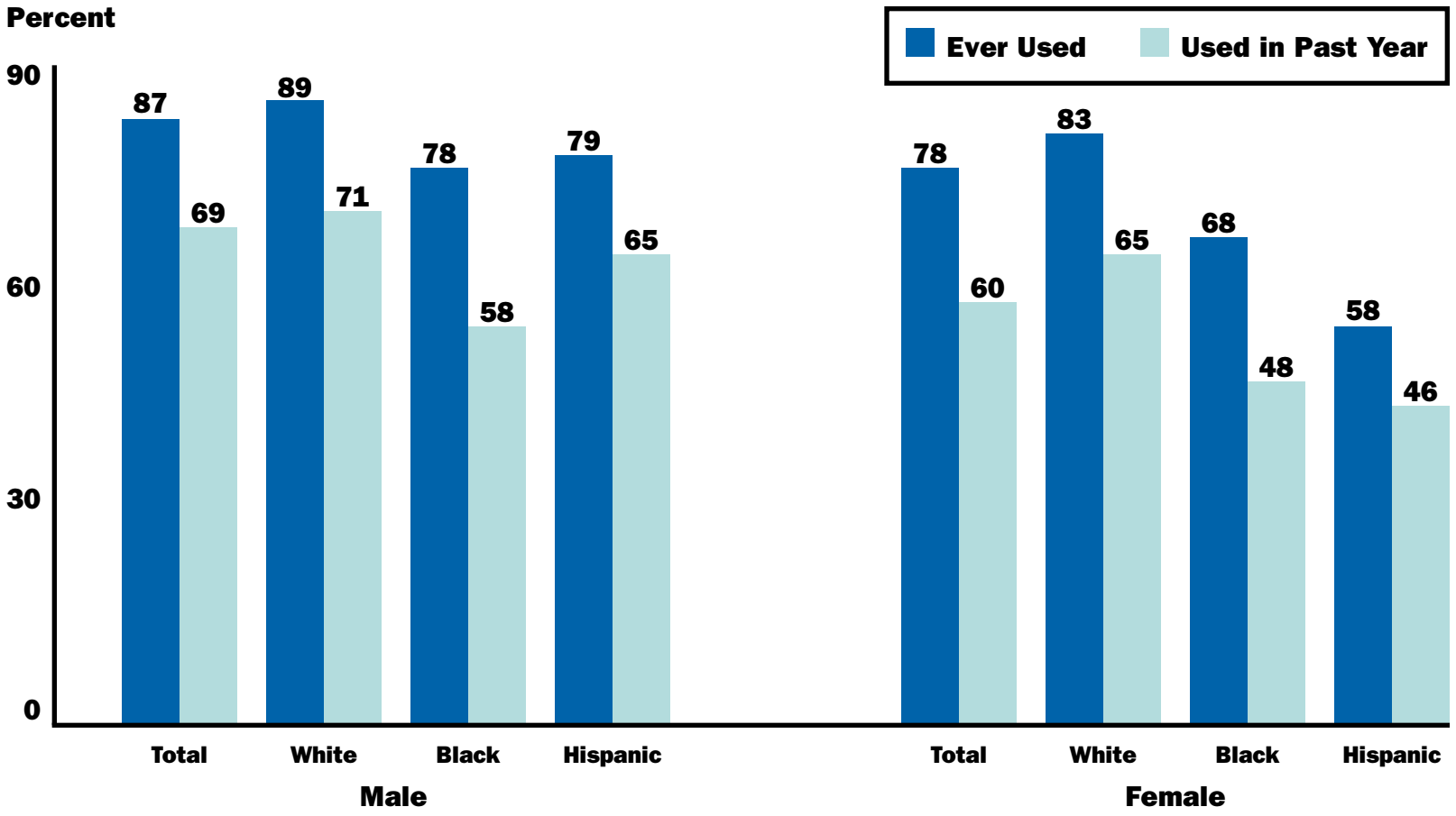
A smaller percentage of black and Hispanic adults consume alcohol compared with white adults. However, alcohol-related illness and death is higher for minorities.

- Eighty-six percent of whites, 72 percent of blacks, and 69 percent of Hispanics reported using alcohol in the past year (Substance Abuse and Mental Health Services Administration, 1998).
- In 1995, the age-adjusted death rate for blacks from alcohol-induced causes was nearly twice that for whites (Peters et al., 1998).
- Fifteen percent of the population reported "binge" drinking: 16 percent of whites and Hispanics, and 10 percent of blacks (Substance Abuse and Mental Health Services Administration, 1998).

  Binge drinking is defined as five or more drinks on the same occasion on at least one day in the past 30 days.

Chart 3-10

Alcohol Use, Age 12 and Older, by Sex, Race, and Hispanic Origin, 1997



Source: Substance Abuse and Mental Health Services Administration, 1998.

THE COMMONWEALTH FUND

Chart 3-11
Risky Behaviors Among Adolescents, 1997

Minority adolescents are less likely to engage in the risky behaviors of smoking, drinking, and using drugs.

- Black adolescents report the lowest levels of smoking and drinking alcohol (Centers for Disease Control and Prevention, 1998).
- White adolescents report the highest levels, followed by Hispanic adolescents (Centers for Disease Control and Prevention, 1998).
- Twenty-four percent of black adolescents who reported that they smoke, as opposed to 13 percent of white and 15 percent of Hispanic adolescents, stated they did so because friends encouraged them (authors' tabulations of *The Commonwealth Fund 1997 Survey of the Health of Adolescent Girls*).

Percentage of High School Students Who Engaged in Risky Behaviors, 1997

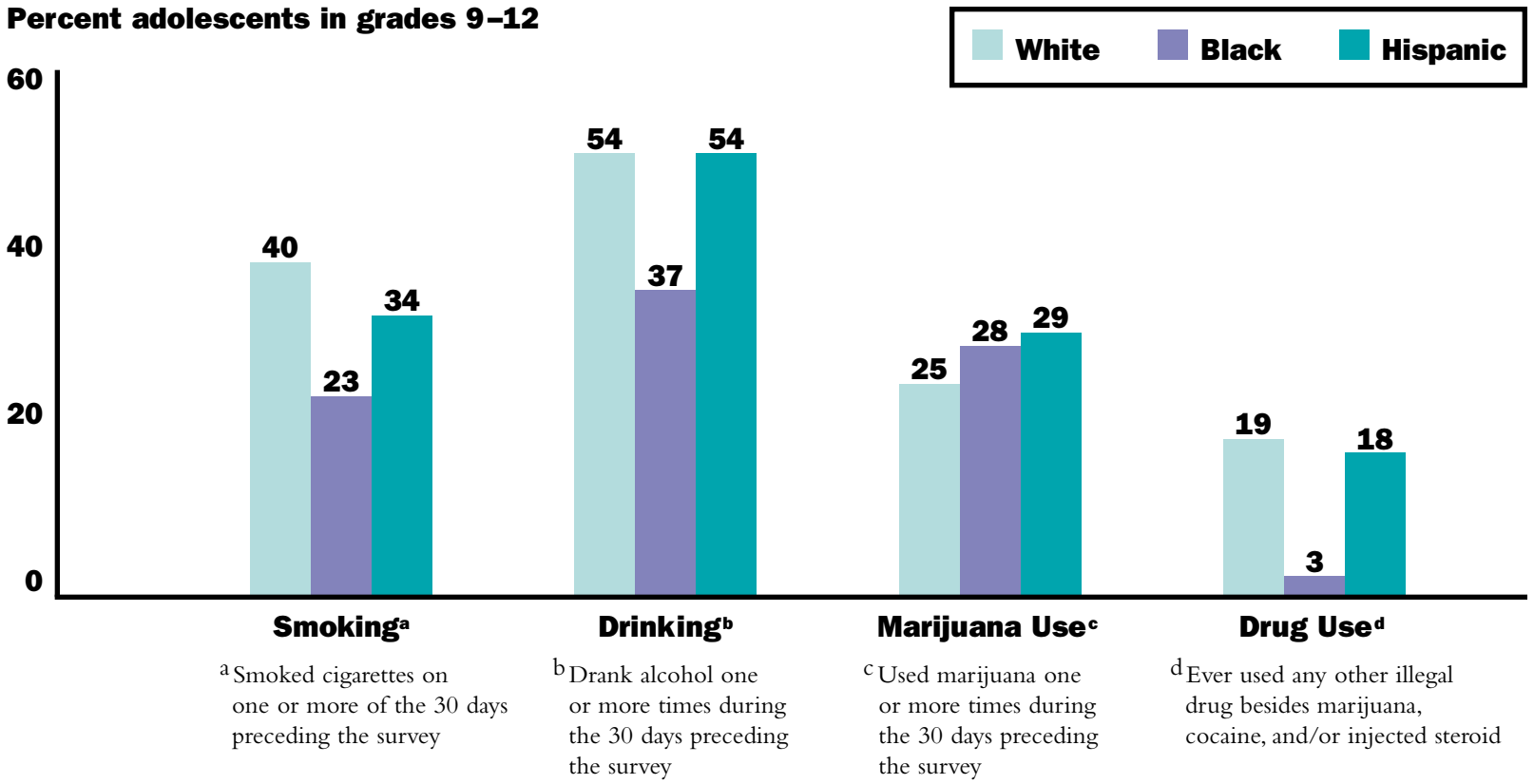
	Smoking[a]		Drinking[b]		Marijuana Use[c]		Drug Use[d]	
	Female	Male	Female	Male	Female	Male	Female	Male
White	40	40	52	56	21	28	17	20
Black	17	28	35	39	21	36	2	5
Hispanic	32	35	51	57	23	33	15	20

[a] Smoked cigarettes on one or more of the 30 days preceding the survey.
[b] Drank alcohol one or more times during of the 30 days preceding the survey.
[c] Used marijuana one or more times during the 30 days preceding the survey.
[d] Ever used any other illegal drug besides marijuana, cocaine, and/or injected steroid.

Source: Centers for Disease Control and Prevention, 1998.

Chart 3-11

Risky Behaviors Among Adolescents, 1997



[a] Smoked cigarettes on one or more of the 30 days preceding the survey

[b] Drank alcohol one or more times during the 30 days preceding the survey

[c] Used marijuana one or more times during the 30 days preceding the survey

[d] Ever used any other illegal drug besides marijuana, cocaine, and/or injected steroid

Source: Centers for Disease Control and Prevention, 1998.

Mental Health

Chart 3-12

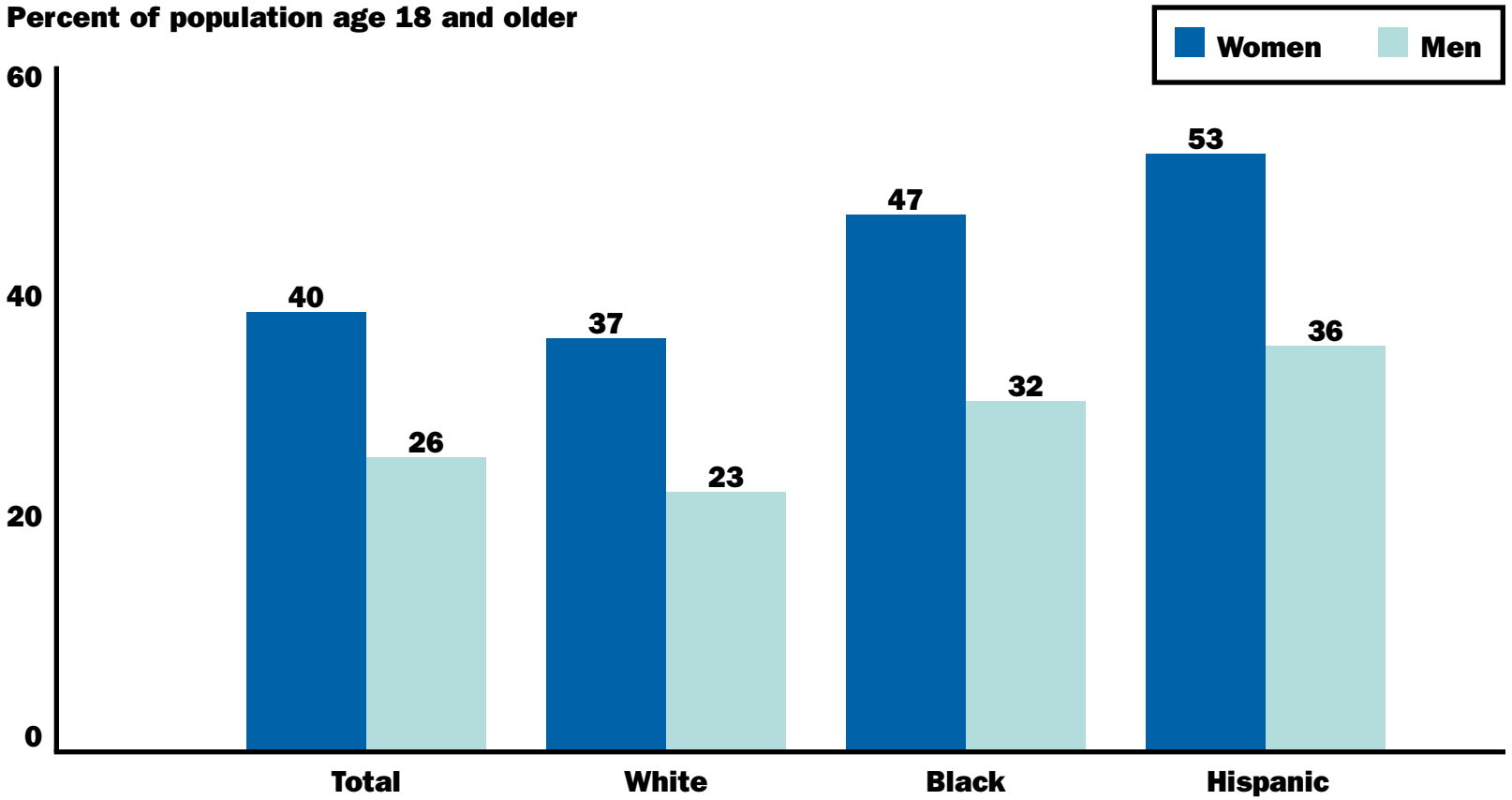
Moderate to Severe Depressive Symptoms in Past Week by Race and Ethnicity, 1993

Minority women and men are more likely to report having depressive symptoms—such as feeling disliked, crying spells, feeling sad, lack of enjoyment of life, feeling depressed, and restless sleep—in the past week.

- Within each racial and ethnic group, women were more likely to report depressive symptoms than men, with up to one-half of black and Hispanic women reporting depressive symptoms (*The Commonwealth Fund 1993 Survey of Women's Health*).
- Reported levels of stress related to racial discrimination and income discrimination are higher for minorities than for white adults. Thirty-eight percent of blacks and 34 percent of Hispanics reported high levels of such stress, compared with 26 percent of whites (*The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care*).
- A great deal of heterogeneity exists within minority groups. Puerto Ricans reported the highest level of stress compared with Mexican Americans and other Hispanics (Williams, 1998).

Chart 3-12

Moderate to Severe Depressive Symptoms in Past Week by Race and Ethnicity, 1993



Derived from ranking responses to six statements regarding symptoms of depression (feeling disliked, crying spells, feeling sad, lack of enjoyment of life, feeling depressed, and restless sleep). A score of 6–11 = moderate symptoms; 12–18 = severe symptoms.

Source: *The Commonwealth Fund 1993 Survey of Women's Health.*

THE COMMONWEALTH FUND

Chart 3-13

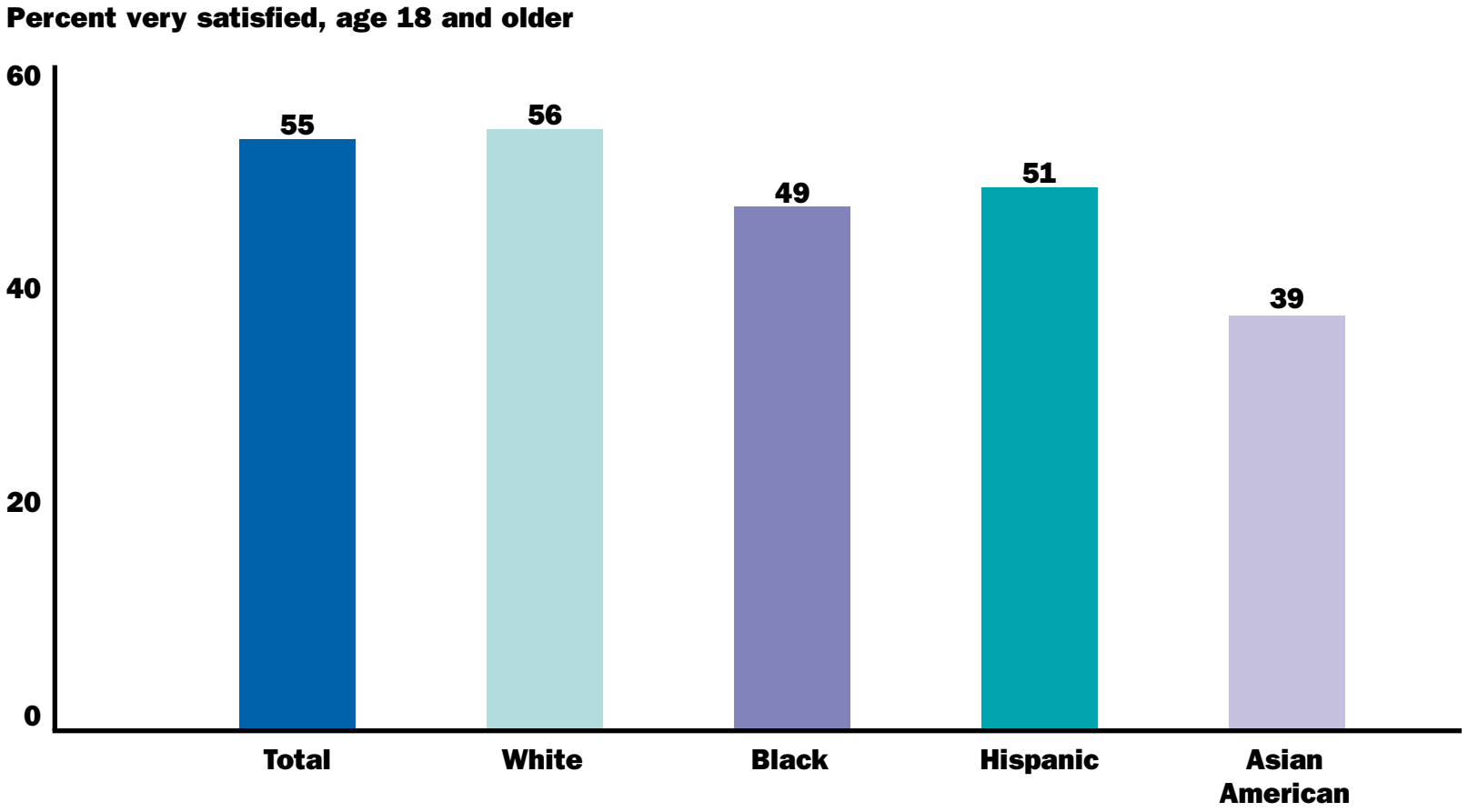
Percentage of Respondents Very Satisfied with Their Lives, by Race and Hispanic Origin, 1994

Minorities are less likely to report feeling very satisfied with their lives.

- Fifty-six percent of whites reported feeling very satisfied with their lives, compared with 49 percent of blacks and 51 percent of Hispanics (*The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care*).
- Far fewer Asian Americans—39 percent—feel very satisfied with their lives (*The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care*).

Chart 3-13

Percentage of Respondents Very Satisfied with Their Lives, by Race and Hispanic Origin, 1994



Source: *The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care.*

THE COMMONWEALTH FUND

Chart 3-14
Percentage of Adults Strongly Affected by Violence, 1994

Minority adults are more than twice as likely as white adults to say they have been affected by violence.

- Eighteen percent of minority adults, compared with 8 percent of white adults, reported being strongly affected by the fear of crime or by violence in the community. Blacks are more likely than other groups to be victims of violent crimes (*The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care* and Rand, 1998).
- Fifteen percent of minority adults and 6 percent of white adults know someone who was a victim of violent crime (*The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care*).

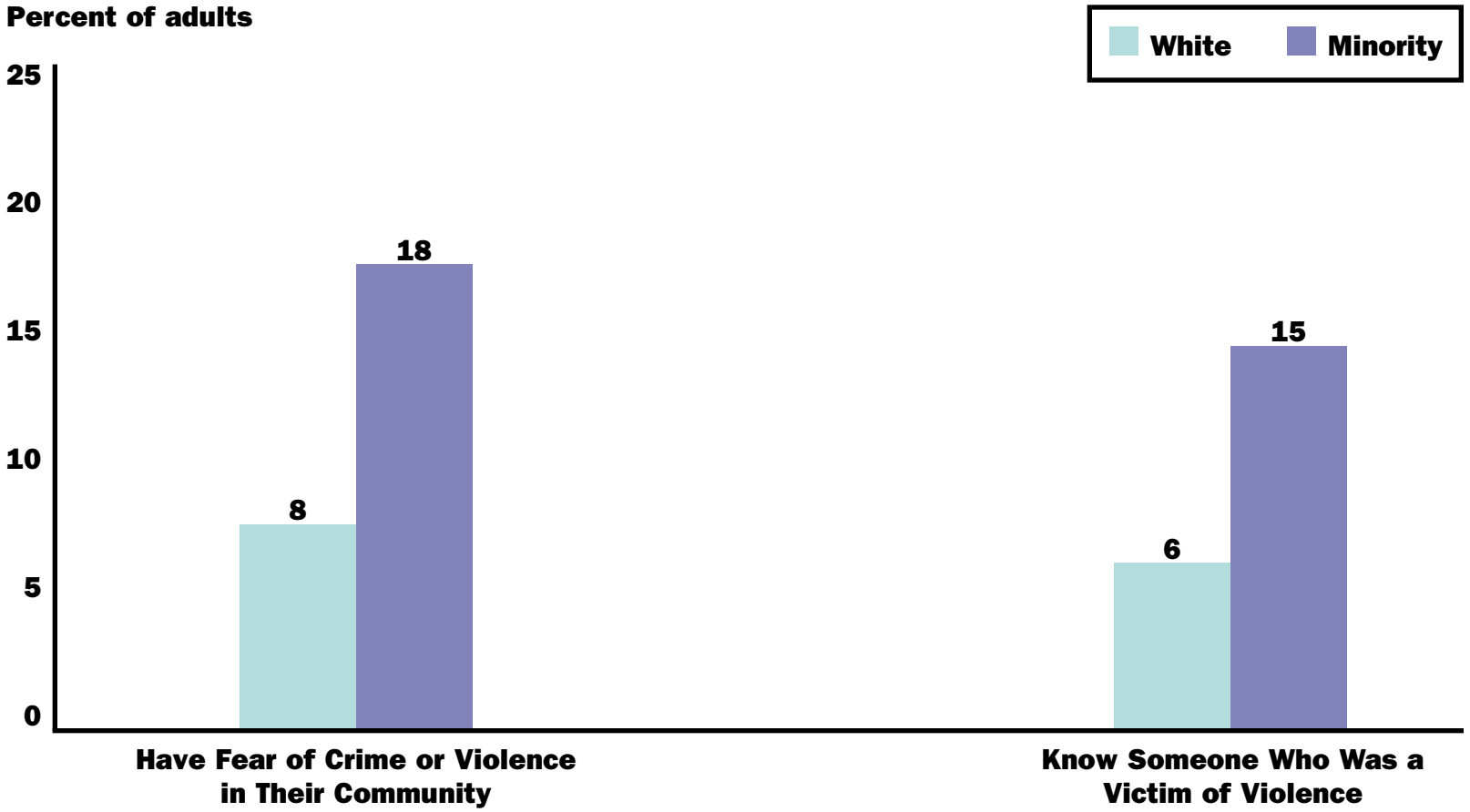
Rates of Violent Crime and Personal Theft by Race and Hispanic Origin, 1997
Per 1,000 Persons Age 12 and Older

	All Crimes of Violence	Robbery	Assault	Personal Theft	Rape/ Sexual Assault
Total	39	4	34	2	1
White	38	4	33	1	1
Black	49	7	40	3	2
Hispanic	43	7	34	2	2

Source: Rand, 1998.

Chart 3-14

Percentage of Adults Strongly Affected by Violence, 1994



Source: *The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care.*

THE COMMONWEALTH FUND

Chart 3-15

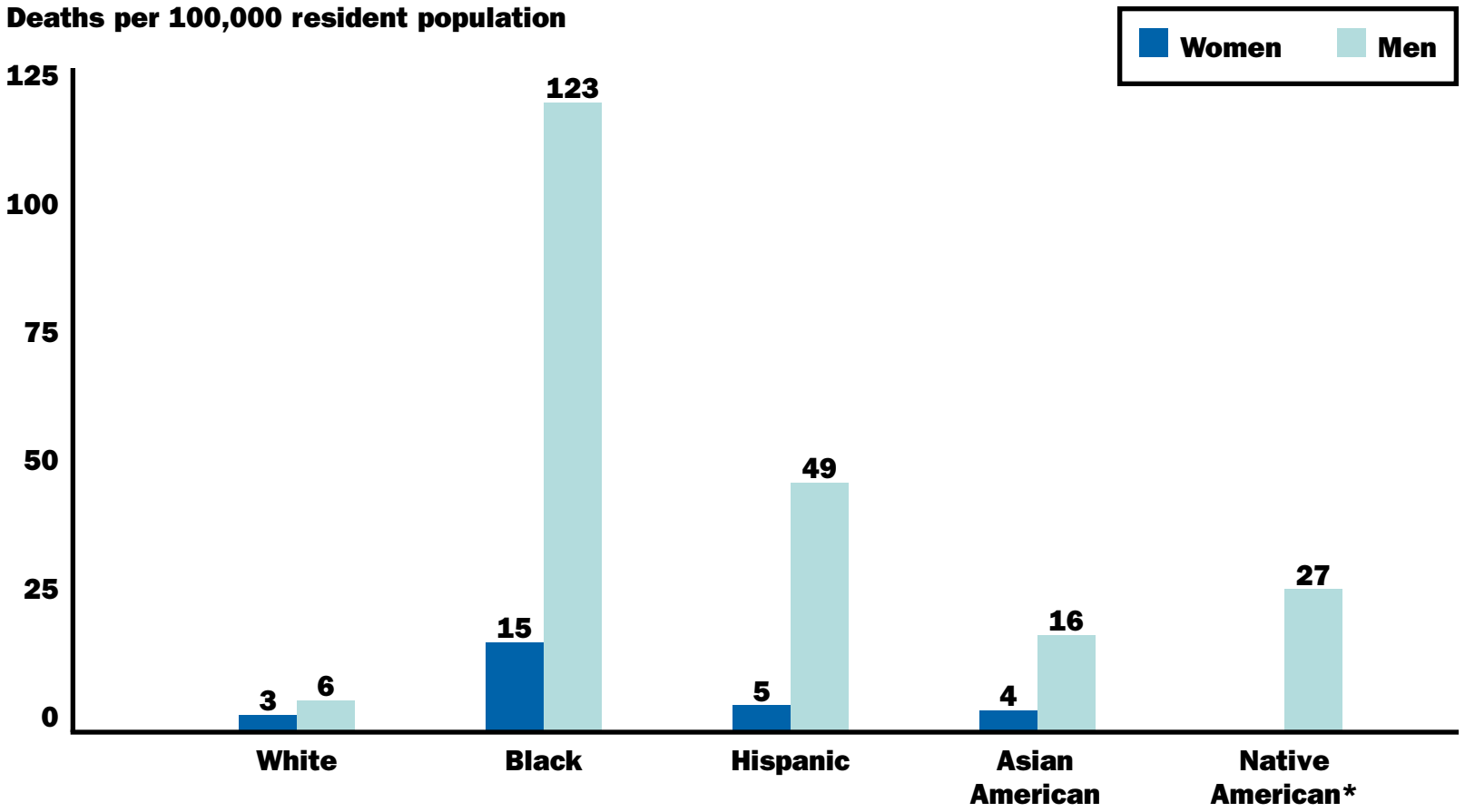
Death Rates from Homicide and Legal Intervention, Ages 15 to 24, by Race and Hispanic Origin, 1996

Black men ages 15 to 24 have a death rate from homicide 2.5 times that of young Hispanic men and close to nine times that of young white men.

- There is tremendous divergence in rates across racial/ethnic groups. In 1996, the death rate per 100,000 from homicide and legal intervention for males ages 15 to 24 was 123 for blacks, 49 for Hispanics, 14 for whites, 16 for Asian Americans, and 27 for Native Americans (National Center for Health Statistics, 1998).
- Death from homicide and legal intervention is the leading cause of death among 15-to-24-year-old black males (National Center for Health Statistics, 1998).

Chart 3-15

Death Rates from Homicide and Legal Intervention, Ages 15 to 24, by Race and Hispanic Origin, 1996



*Sample size for Native American women is too small.

Source: National Center for Health Statistics, 1998.

Chart 3-16

Minority Adolescents Often Feel Unsafe at School, at Home, and in Their Neighborhood, 1997

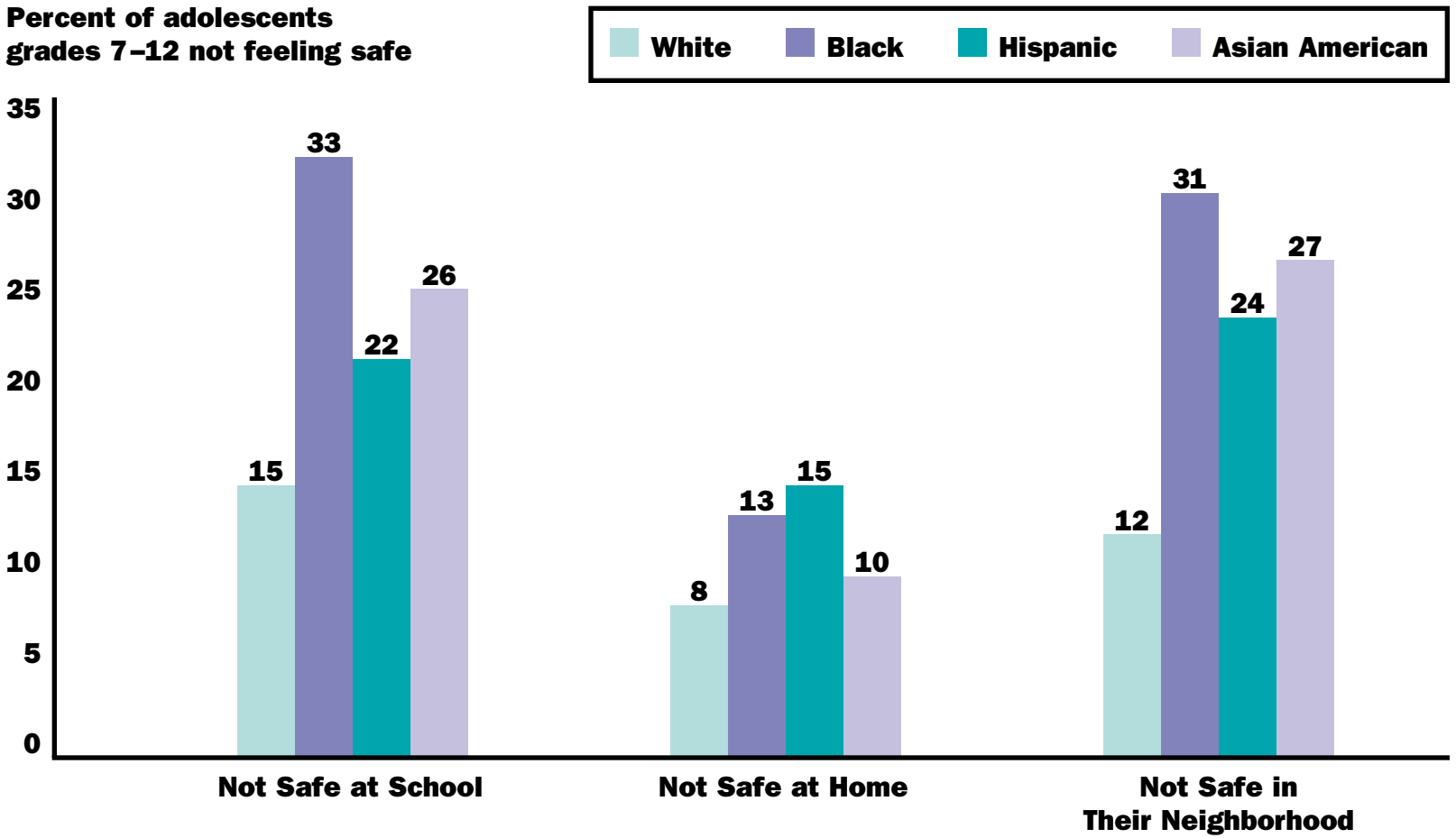
In many cases, minority adolescents are twice as likely as white adolescents to feel unsafe.

- Thirty-three percent of black adolescents reported not feeling safe at school.
- Fifteen percent of Hispanic adolescents reported not feeling safe at home.
- Thirty-one percent of black adolescents and 27 percent of Asian American adolescents did not feel safe in their neighborhoods.

Source: Authors' tabulations of *The Commonwealth Fund 1997 Survey of the Health of Adolescent Girls.*

Chart 3-16

Minority Adolescents Often Feel Unsafe at School, at Home, and in Their Neighborhoods, 1997



Source: Authors' tabulations of *The Commonwealth Fund 1997 Survey of the Health of Adolescent Girls.*

THE COMMONWEALTH FUND

Chart 3-17

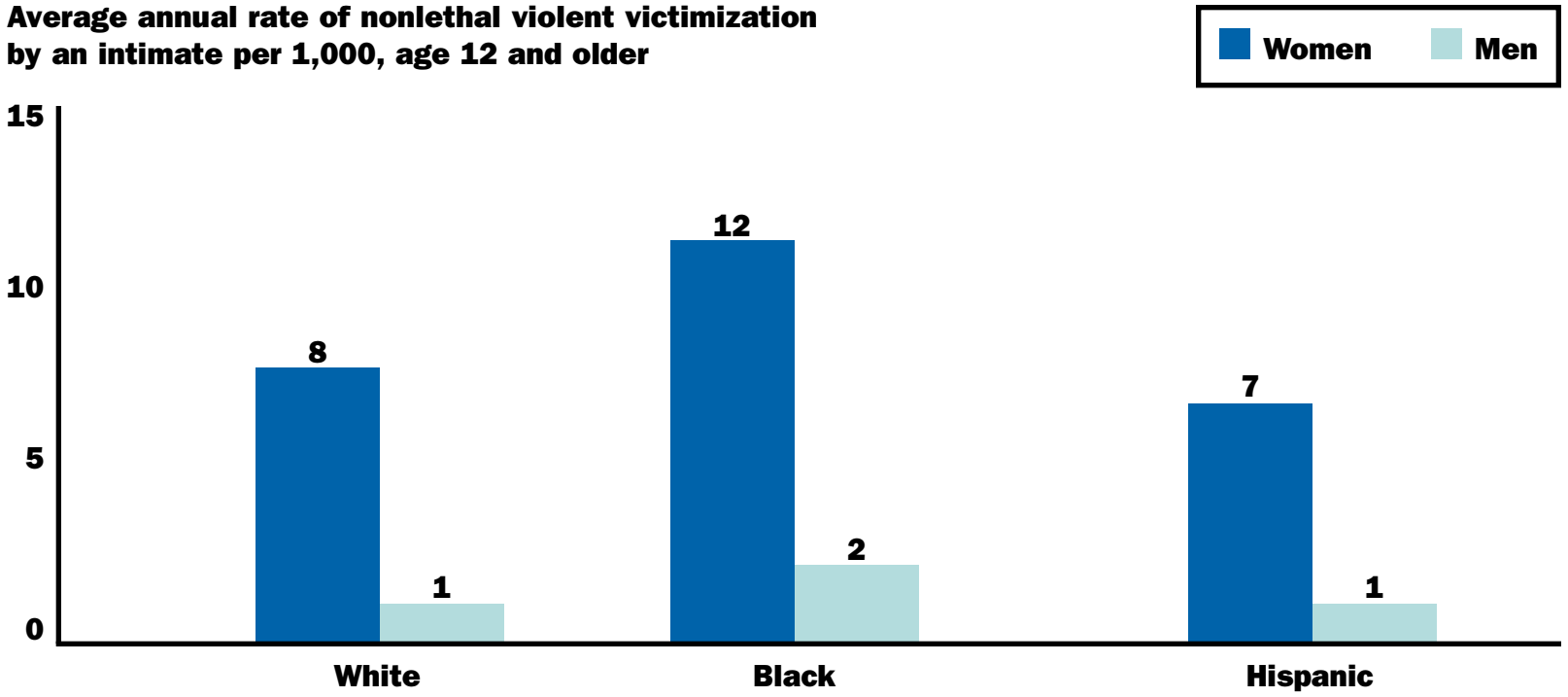
Average Annual Rates of Domestic Violence, by Race and Hispanic Origin, 1992–96

Rates of domestic violence are higher among minorities than among whites. Women are more likely than men to be victims of domestic violence.

- On average, each year from 1992 to 1996 about 12 per 1,000 black females over age 12 experienced some form of nonlethal domestic violence, compared with 8 per 1,000 white females and 7 per 1,000 Hispanic females (Greenfeld et al., 1998).
- Over the last two decades, murder by an intimate fell more rapidly among blacks than whites. From 1976 to 1996, murders of black domestic partners ages 20 to 44 fell from 14 to four per 100,000. Murders of white domestic partners fell from one to 0.85 per 100,000 (Greenfeld et al., 1998).

Chart 3-17

Average Annual Rates of Domestic Violence by Race and Hispanic Origin, 1992–96



Note: An intimate is defined as a current or former spouse, or a current or former boyfriend or girlfriend. Nonlethal violence includes rape, sexual assault, robbery, and aggravated and simple assault.

Source: Greenfeld, et al., 1998.

Health Care Access and Utilization

Chart 4-1

Percentage of Adults Age 18 and Older Without a Regular Doctor, 1997

Chart 4-2

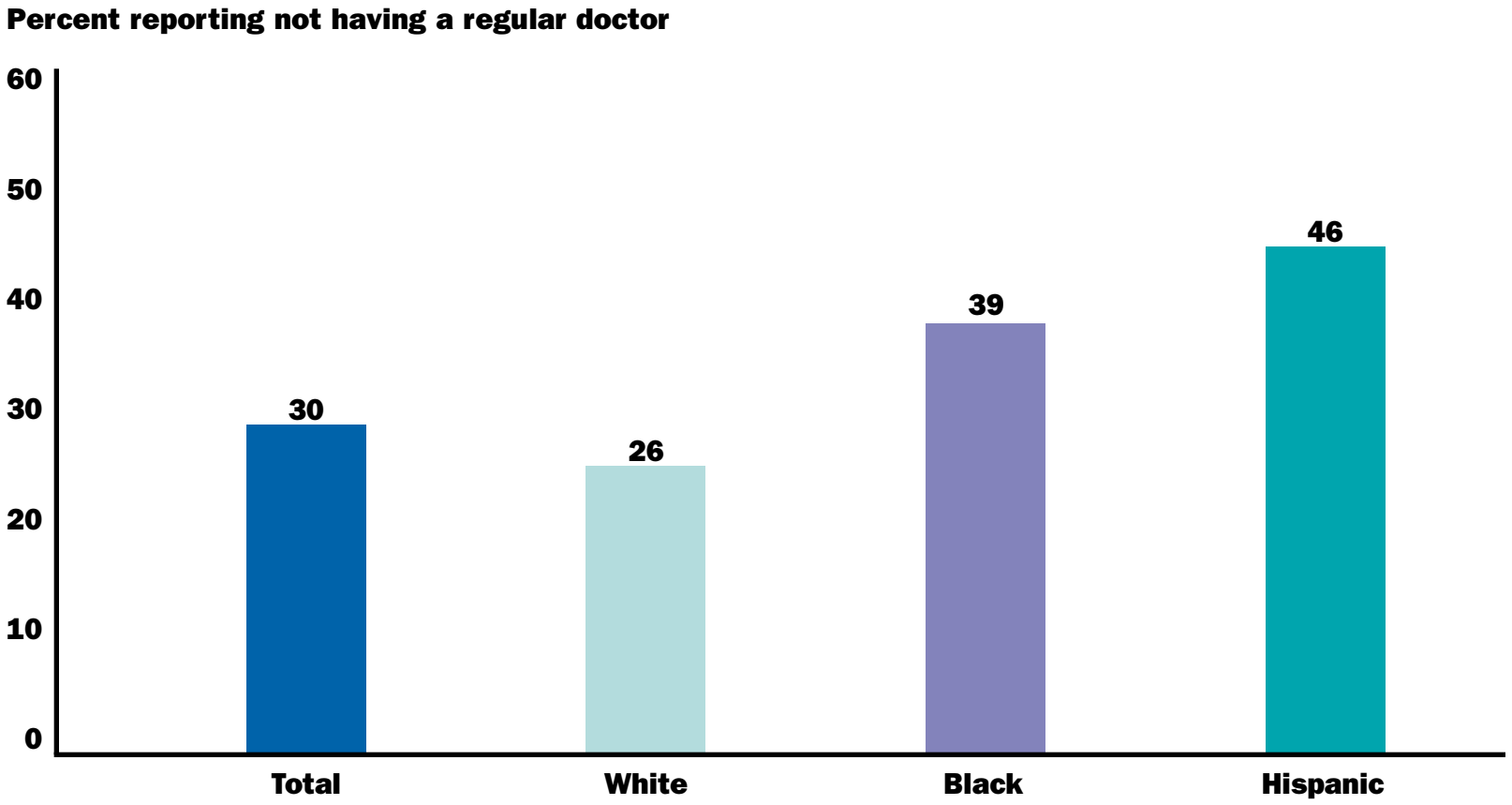
Percentage of Elderly Whose Usual Source of Care Is a Doctor's Office, by Race and Hispanic Origin, 1996

Minorities are more likely to report not having a regular doctor.

- Hispanic adults are almost twice as likely as white adults to be without a regular doctor. Forty-six percent of Hispanic adults, 39 percent of black adults, and 26 percent of white adults do not have a regular doctor (authors' tabulations of the *Kaiser/Commonwealth 1997 National Survey of Health Insurance*).
- Two-thirds of minority elderly have a doctor's office as a usual source of care, compared with 83 percent of white elderly (authors' tabulations of the *1996 Medicare Current Beneficiary Survey*).
- Individuals with a regular provider are much more likely to have better access to care than those without a regular provider (Lillie-Blanton and Alfaro-Correa, 1995).

Chart 4-1

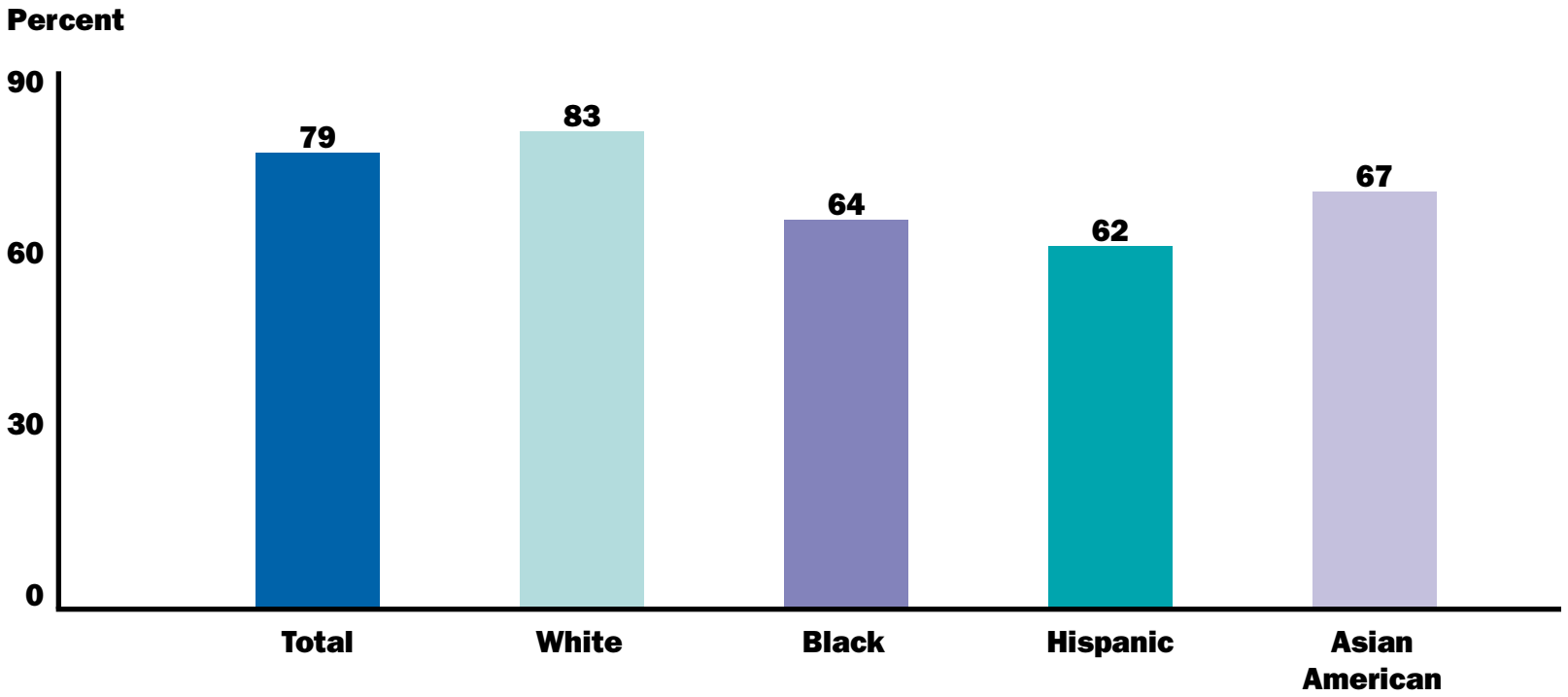
Percentage of Adults Age 18 and Older Without a Regular Doctor, 1997



Source: Authors' tabulations of the *Kaiser/Commonwealth 1997 National Survey of Health Insurance.*

Chart 4-2

Percentage of Elderly* Whose Usual Source of Care Is a Doctor's Office, by Race and Hispanic Origin, 1996



**Age 65 and over, community-dwelling.*

Source: Authors' tabulations of the *1996 Medicare Current Beneficiary Survey*.

THE COMMONWEALTH FUND

Chart 4-3

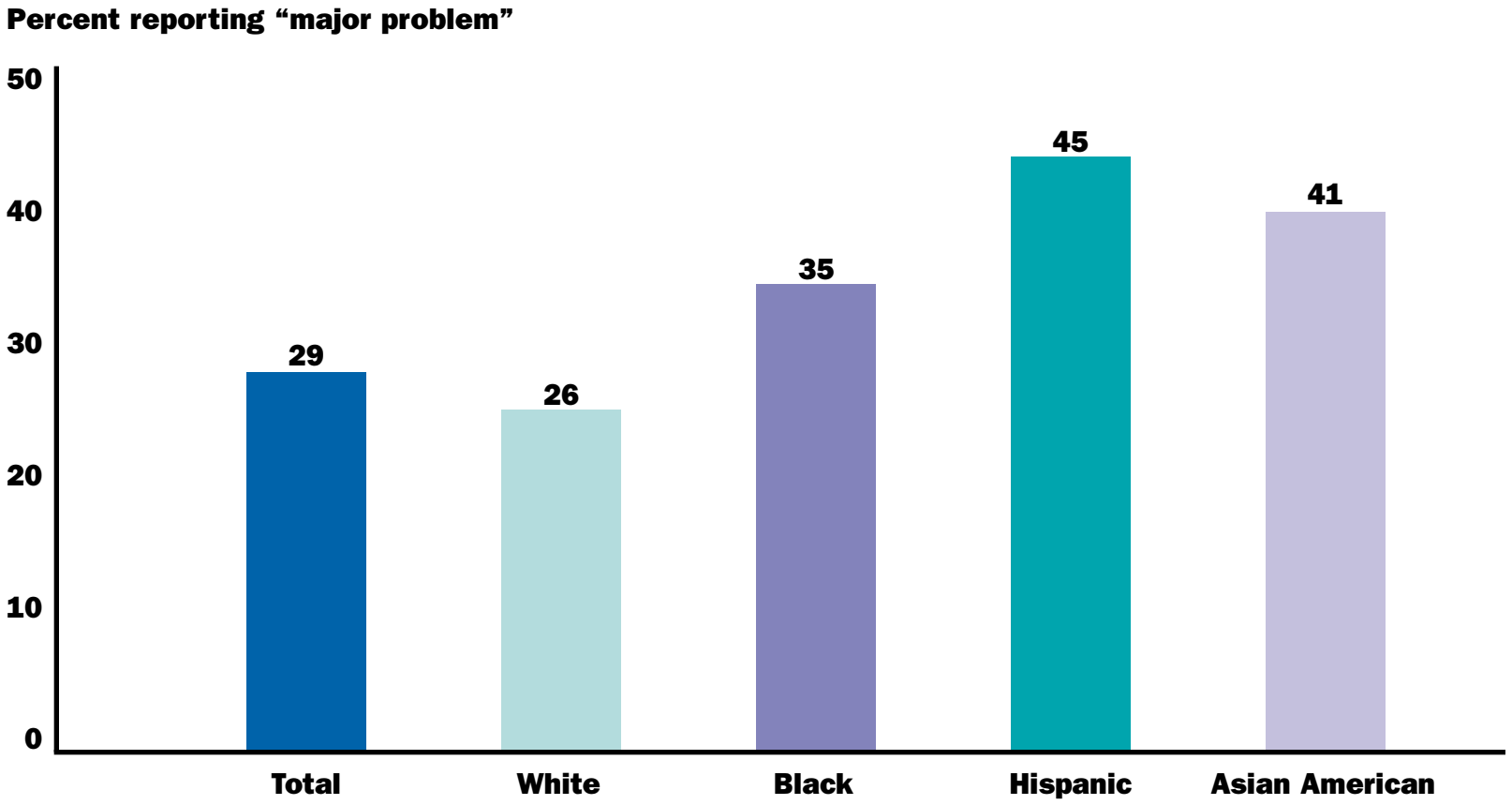
Percentage of Adult Population Age 18 and Older Reporting Difficulty Paying for Medical Care, 1994

Hispanic and Asian American adults are the most likely to report difficulties paying for care.

- Forty-five percent of Hispanic adults, 41 percent of Asian American adults, and 35 percent of black adults reported having a "major problem" paying for medical care, compared with 26 percent of white adults (*The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care*).
- Lack of a regular doctor, limited choice, and difficulties paying for care are all reflected in reduced access to care. Minority adults were also more likely than white adults to report waiting too long before seeking care (27% vs. 16%) and difficulties getting medical appointments (16% vs. 8%) (*The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care*).

Chart 4-3

Percentage of Adult Population Age 18 and Older Reporting Difficulty Paying for Medical Care, 1994



Source: *The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care.*

THE COMMONWEALTH FUND

Chart 4-4

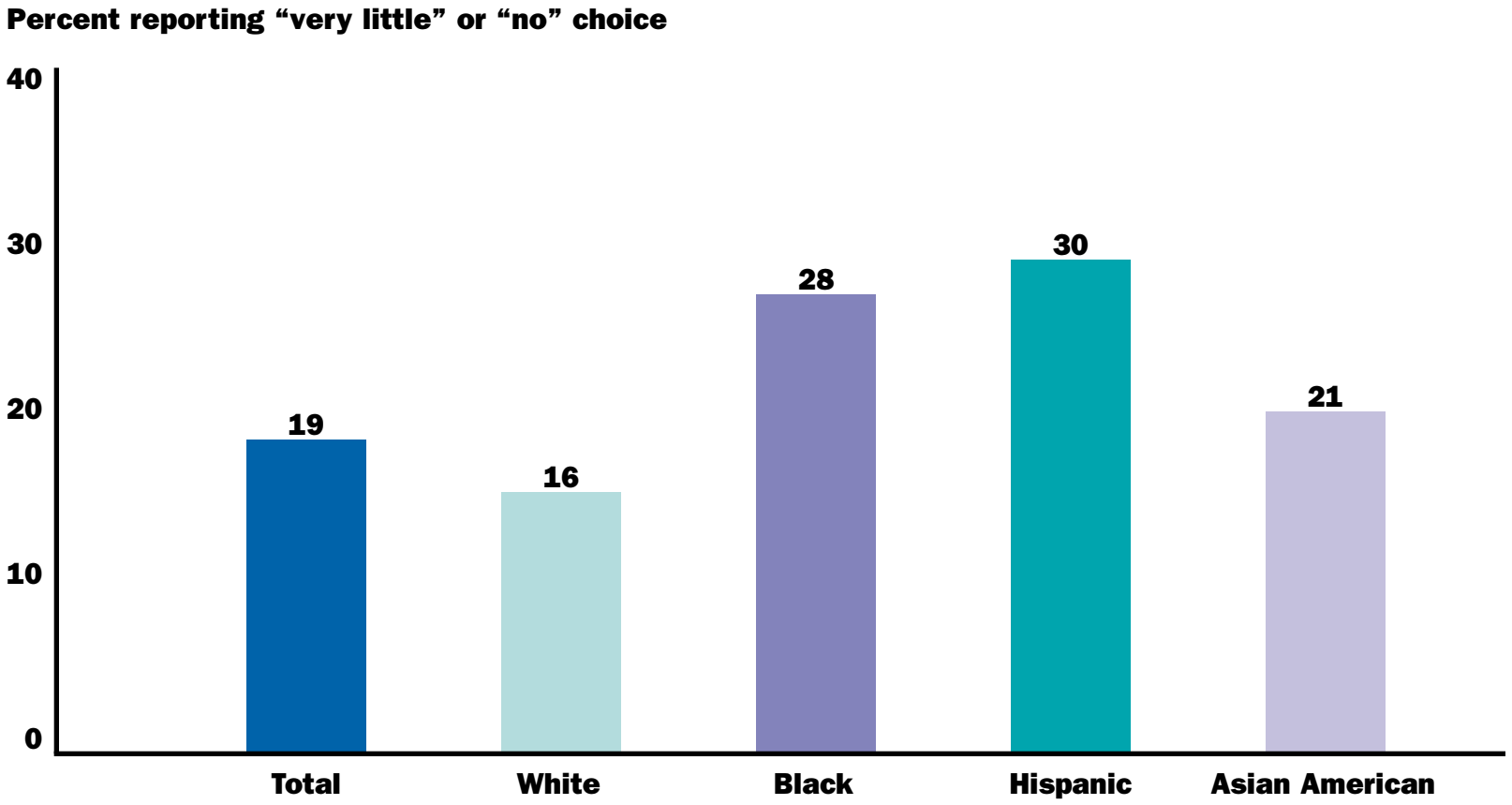
Percentage of Adults Reporting Little or No Choice in Where to Go for Medical Care, 1994

Hispanic and black adults feel most limited in where they can go for care, followed by Asian American adults.

- Thirty percent of Hispanic adults and 28 percent of black adults feel they have limited choice in where they can obtain care (*The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care*).
- Twenty-one percent of Asian American adults report having little or no choice (*The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care*).

Chart 4-4

Percentage of Adults Reporting Little or No Choice in Where to Go for Medical Care, 1994



Source: *The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care.*

THE COMMONWEALTH FUND

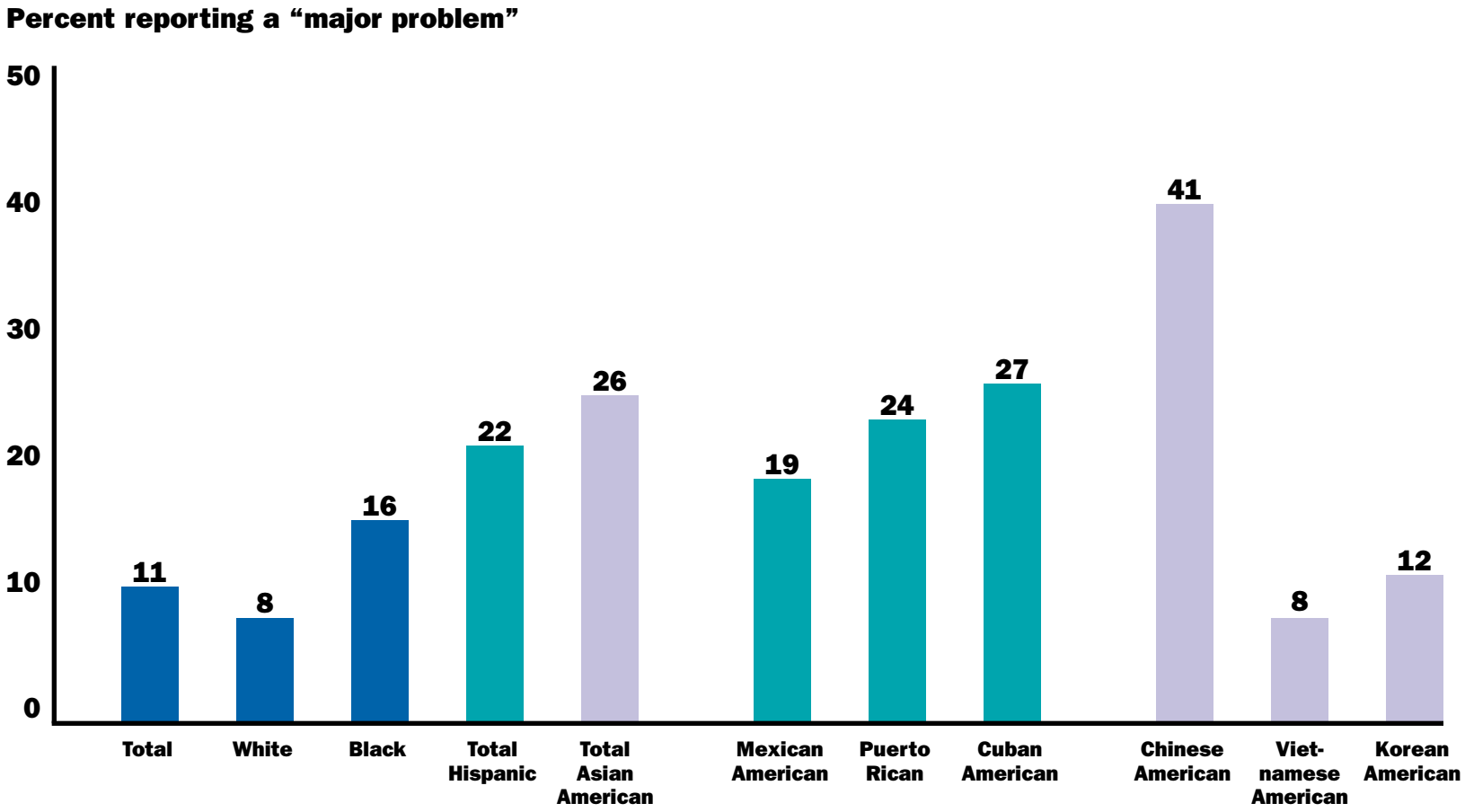
Chart 4-5
Access to Specialty Care by Adults, by Race and Hispanic Origin, 1994

Minority adults, particularly Asian Americans, are more likely to report major problems accessing specialty care.

- Twenty-six percent of Asian Americans, 22 percent of Hispanics, and 16 percent of blacks reported major problems getting specialty care (*The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care*).
- Among Hispanic groups surveyed, Cuban Americans reported the most difficulty.
- Among Asian groups, Chinese Americans reported the greatest difficulty.
- Difficulties in finding specialists able to communicate in Spanish or in Asian languages or able to match other cultural characteristics may explain some of the problems encountered by these groups. Minority physicians were more likely to say they have difficulties making referrals to specialists who can meet the cultural needs of their patients (Lavizzo-Mourey et al., 1999).

Chart 4-5

Access to Specialty Care by Adults, by Race and Hispanic Origin, 1994



Source: Authors' tabulations of *The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care.*

THE COMMONWEALTH FUND

Chart 4-6
Race and Ethnicity of Patients Using Urban Safety Net Hospitals, 1997

Safety net hospitals have a clear mission to provide care to low-income, special needs, and other vulnerable populations regardless of their ability to pay. Safety net hospitals may be the primary source of care for low-income minority populations (Gaskin and Hadley, 1997).

- Minority groups comprise 43 percent of patients seen at urban safety net hospitals and only 19 percent of the total patients seen at other urban hospitals.
- At the largest urban public hospital systems, as many as 80 percent of the patients served are minority (Gage et al.,1998).

Percent Distribution of Selected Socioeconomic Characteristics of Patients of Urban Safety Net Hospitals* and Other Urban Hospitals, 1997

	Urban Safety Net Hospitals	Other Urban Hospitals
Education		
No High School	16.9%	9.9%
Some High School	18.9%	14.4%
High School Graduate	27.3%	30.3%
Some College	22.3%	25.3%
College Graduate	14.5%	20.1%

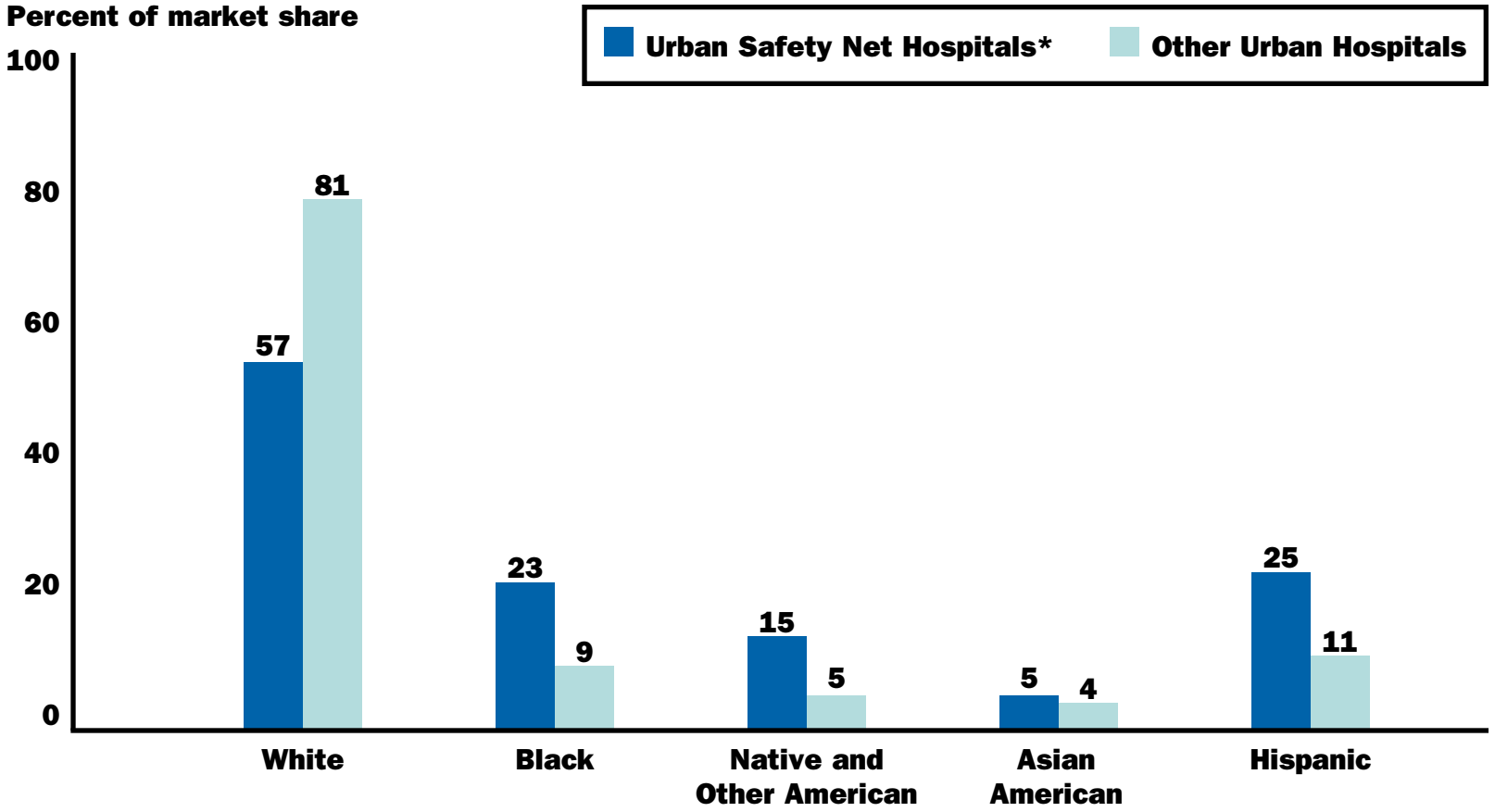
	Urban Safety Net Hospitals	Other Urban Hospitals
Economic Status		
Poverty Rate	19.8%	11.0%
Child Poverty Rate	27.4%	15.3%
Elderly Poverty Rate	14.9%	9.6%
Unemployment Rate	6.1%	4.0%
Median Household Income	$27,536	$34,171
Per Capita Income	$12,148	$15,586

*Urban safety net hospitals were defined as those hospitals whose Medicaid utilization rate exceeded one standard deviation above the mean Medicaid utilization rate for urban hospitals in the state.

Source: Gaskin and Hadley, 1997.

Chart 4-6

Race and Ethnicity of Patients Using Urban Safety Net Hospitals, 1997



*Urban safety net hospitals were defined as those hospitals whose Medicaid utilization rate exceeded one standard deviation above the mean Medicaid utilization rate for urban hospitals in the state.

Source: Gaskin and Hadley, 1997.

THE COMMONWEALTH FUND

Chart 4-7

Percentage Who Use a Hospital Emergency Room, Outpatient Department, or Clinic as a Source of Medical Care, 1997

Minority patients are more likely than white patients to receive health care through emergency rooms, hospital outpatient departments, and clinics.

- One-half of African Americans and Hispanics rely on emergency rooms, outpatient departments, or clinics for their health care (authors' tabulations of the *Kaiser/Commonwealth 1997 National Survey of Health Insurance*).
- African American and Hispanic users of outpatient departments are more likely to be uninsured or to have public insurance and to report long waits for care. However, they are also more likely to report a preference for these sites of care because of more flexible hours and the ability to walk in without an appointment (Cornelius and Suarez, 1996).
- Lack of health insurance and being without a regular provider strongly influence the use of emergency rooms for nonurgent care. Hispanics and African Americans without a regular provider are, respectively, 1.4 times and 1.5 times more likely to make an emergency room visit for a nonurgent condition (Lillie-Blanton and Alfaro-Correa, 1995).

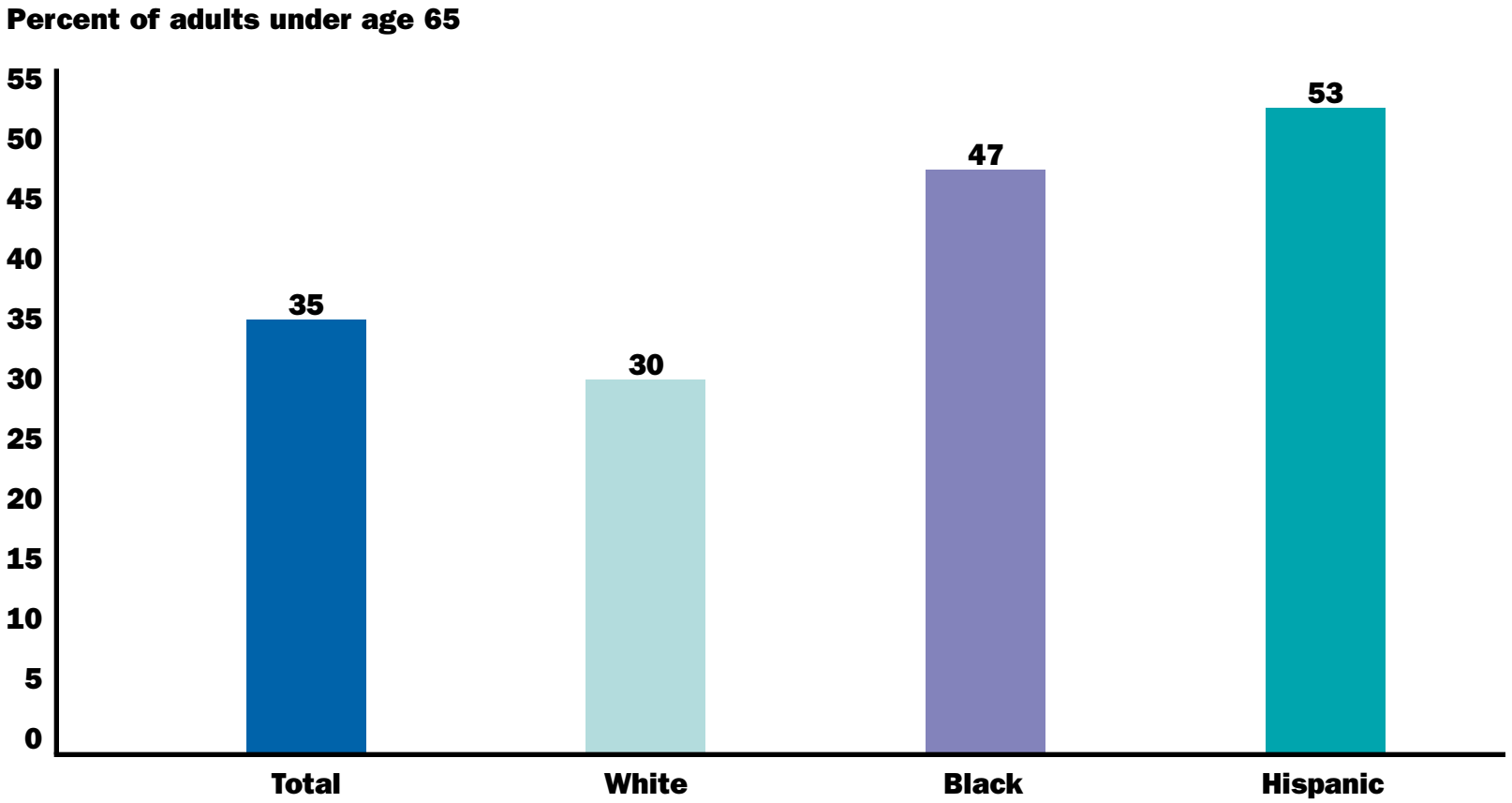
Ambulatory Care Visits per 100 Persons, 1996 (age-adjusted)

	All Sites	Physicians' Offices	Outpatient Departments	Emergency Rooms
Total	330	271	25	34
White	329	277	21	31
Black	368	255	56	56

Source: National Center for Health Statistics, 1998.

Chart 4-7

Percentage Who Use a Hospital Emergency Room, Outpatient Department, or Clinic as a Source of Medical Care, 1997



Source: Authors' tabulations of the *Kaiser/Commonwealth 1997 National Survey of Health Insurance.*

THE COMMONWEALTH FUND

Chart 4-8
Site of Ambulatory Care for Children Under Age 15, 1993–95

Overall, black children make fewer ambulatory care visits than white children and are more likely to receive care in an emergency room or hospital outpatient department.

- Total ambulatory visits among white children are 43 percent higher than among black children.
- The average annual physician office visit rate for white children was twice that for black children. However, the hospital outpatient department and hospital emergency room visit rates were lower for white children than for black children.

Ambulatory Care Visits Among Children Under Age 15 by Place of Visit and Race, 1993–95

Number of Visits per 100 Children Per Year

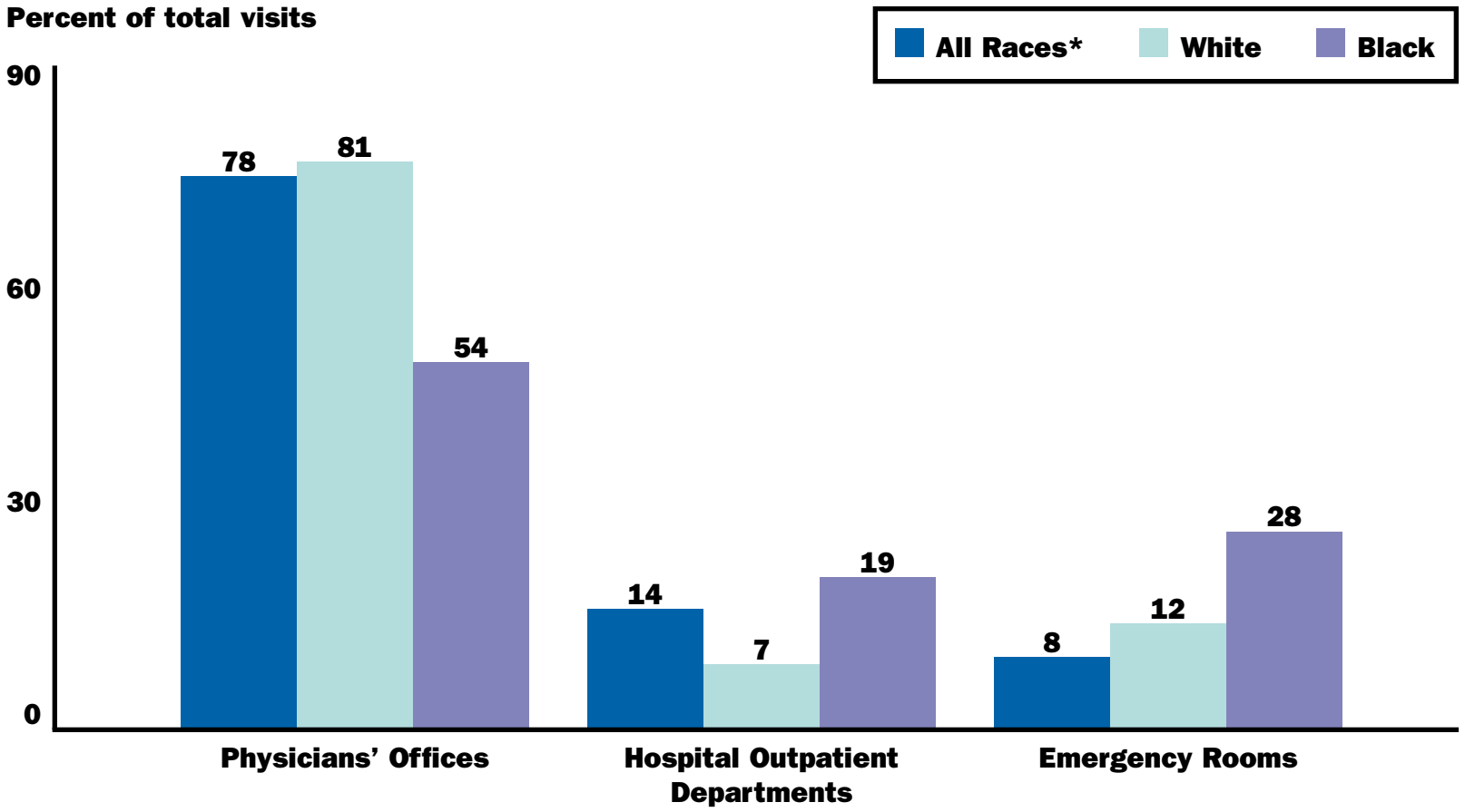
	All Places	Physicians' Offices	Hospital Outpatient Departments	Hospital Emergency Rooms
All Races*	289	225	24	40
White	307	248	22	37
Black	215	115	40	60

*Includes races not shown.

Source: Fried, Malsuc, and Rooks, 1998.

Chart 4-8

Site of Ambulatory Care for Children Under Age 15, 1993–95



**Includes races not shown.*

Source: Fried, Malsuc, and Rooks, 1998.

THE COMMONWEALTH FUND

Chart 4-9
Percentage of the Population Age 25 and Older with a Dental Visit, 1993

Poor dental health may be an indicator of poor overall health. Blacks and Hispanics are less likely to have had a dental visit within the past year.

- One-half (47%) of black and Hispanic adults age 25 and older had a dental visit in the past year, compared with two-thirds (64%) of white adults (National Center for Health Statistics, 1998).
- A disproportionate number of children with dental caries or tooth decay are minority. Mexican American children have the highest rate of dental caries; one-third of Mexican American children ages 2 to 4 and one-half of Mexican American children ages 5 to 17 had dental caries from 1988 to 1991 (Kaste et al., 1996).

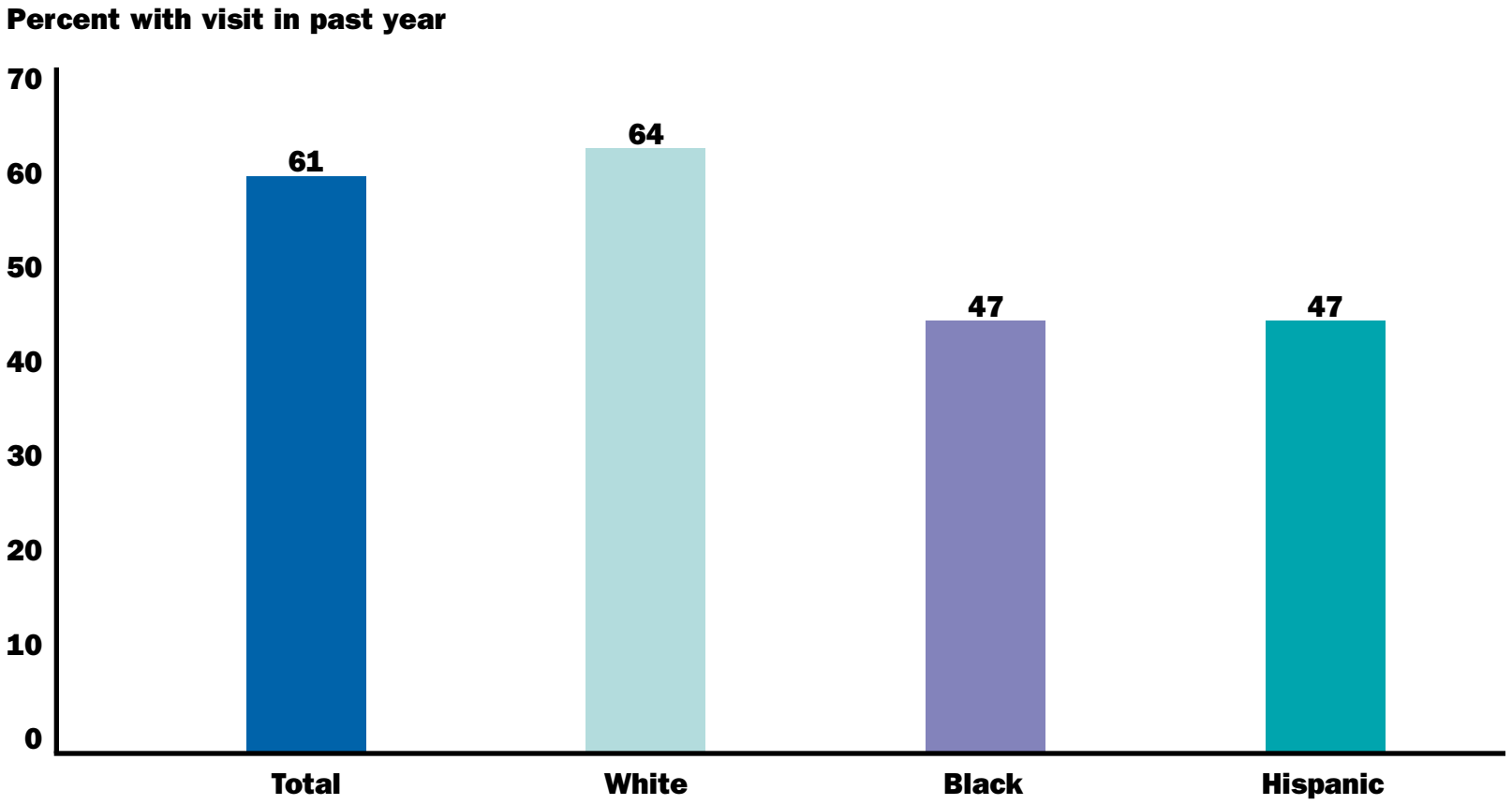
Percent of Children with Dental Caries, 1988–1991

	White	Black	Mexican American
Percent of children ages 2 to 4 with dental caries in primary teeth	13	22	32
Percent of children ages 5 to 17 with dental caries in permanent teeth	45	39	49

Source: Kaste et al., 1996.

Chart 4-9

Percentage of the Population Age 25 and Older with a Dental Visit, 1993



Source: National Center for Health Statistics, 1998.

Chart 4-10
Receipt of a Mammogram Within the Past Two Years by Race and Hispanic Origin, 1994

Among women age 40 and older, Hispanic women are less likely than black or white women to have received a mammogram.

- One-half of Hispanic women age 40 and older had a mammogram in the past two years, compared with 61 percent of white and 64 percent of black women (National Center for Health Statistics, 1998).
- Among females age 40 and older, 19 percent of black women reported never having had a mammogram, as opposed to 20 percent of white women and 29 percent of Hispanic women (authors' tabulations of the *1994 National Health Interview Survey*).
- Mammography rates have risen for all racial groups from 1987 to 1994: rates for white women increased from 30 percent to 61 percent; for black women, from 24 percent to 64 percent; and for Hispanic women, from 18 percent to 52 percent (National Center for Health Statistics, 1998).
- An increase in screening among low-income black women—who have been part of the focus of recent public efforts to increase breast cancer screening—has significantly contributed to the overall rise in mammography rates (Makuc,1999).

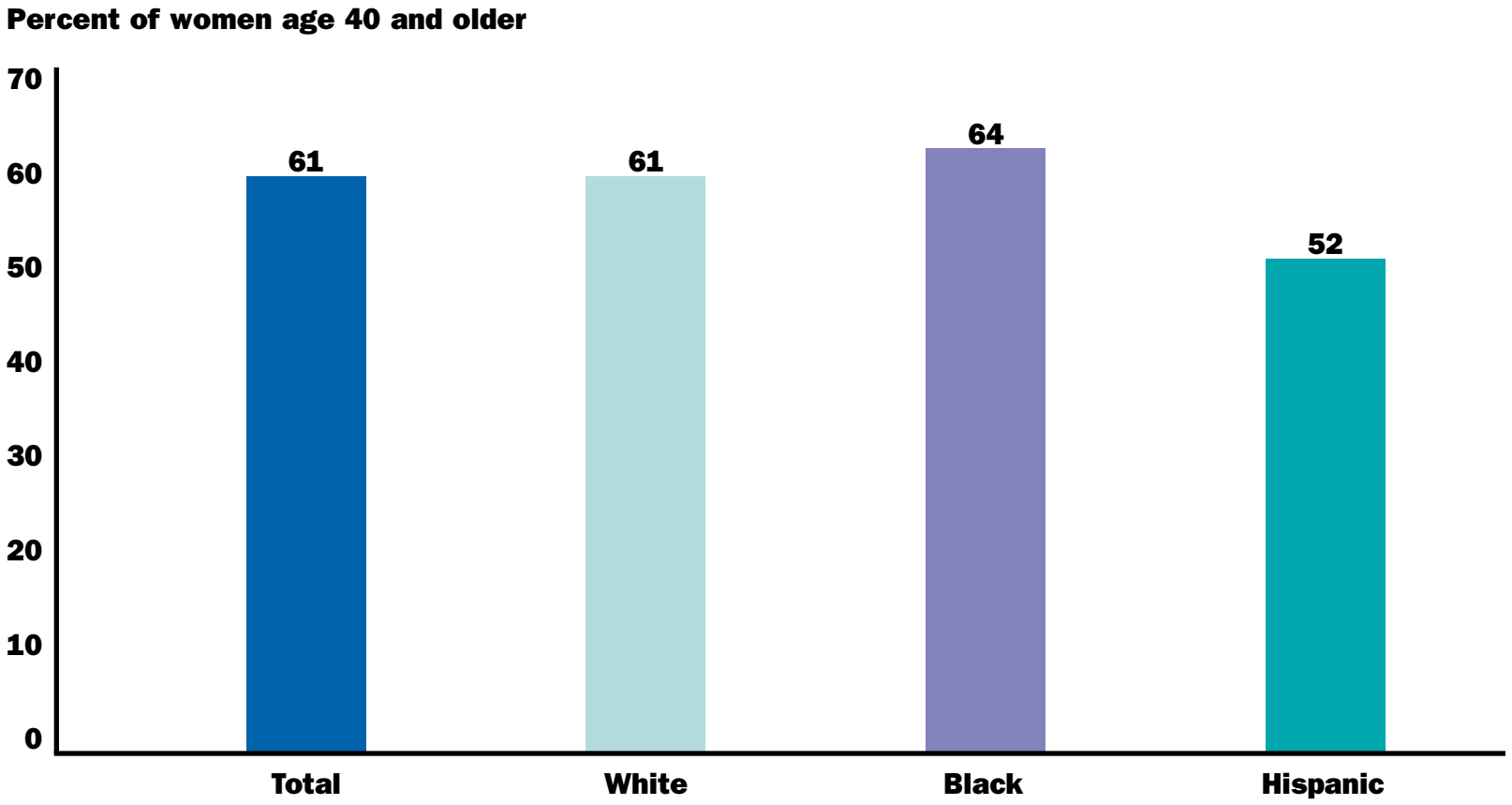
Percent of Women Age 40 and Older Who Have Had a Mammogram in the Past Two Years, 1987–94

	1987	1990	1991	1993	1994
Total	29	51	55	60	61
White	30	53	56	61	61
Black	24	46	48	59	64
Hispanic	18	45	49	51	52

Source: National Center for Health Statistics, 1998.

Chart 4-10

Receipt of a Mammogram Within the Past Two Years by Race and Hispanic Origin, 1994



Source: National Center for Health Statistics, 1998.

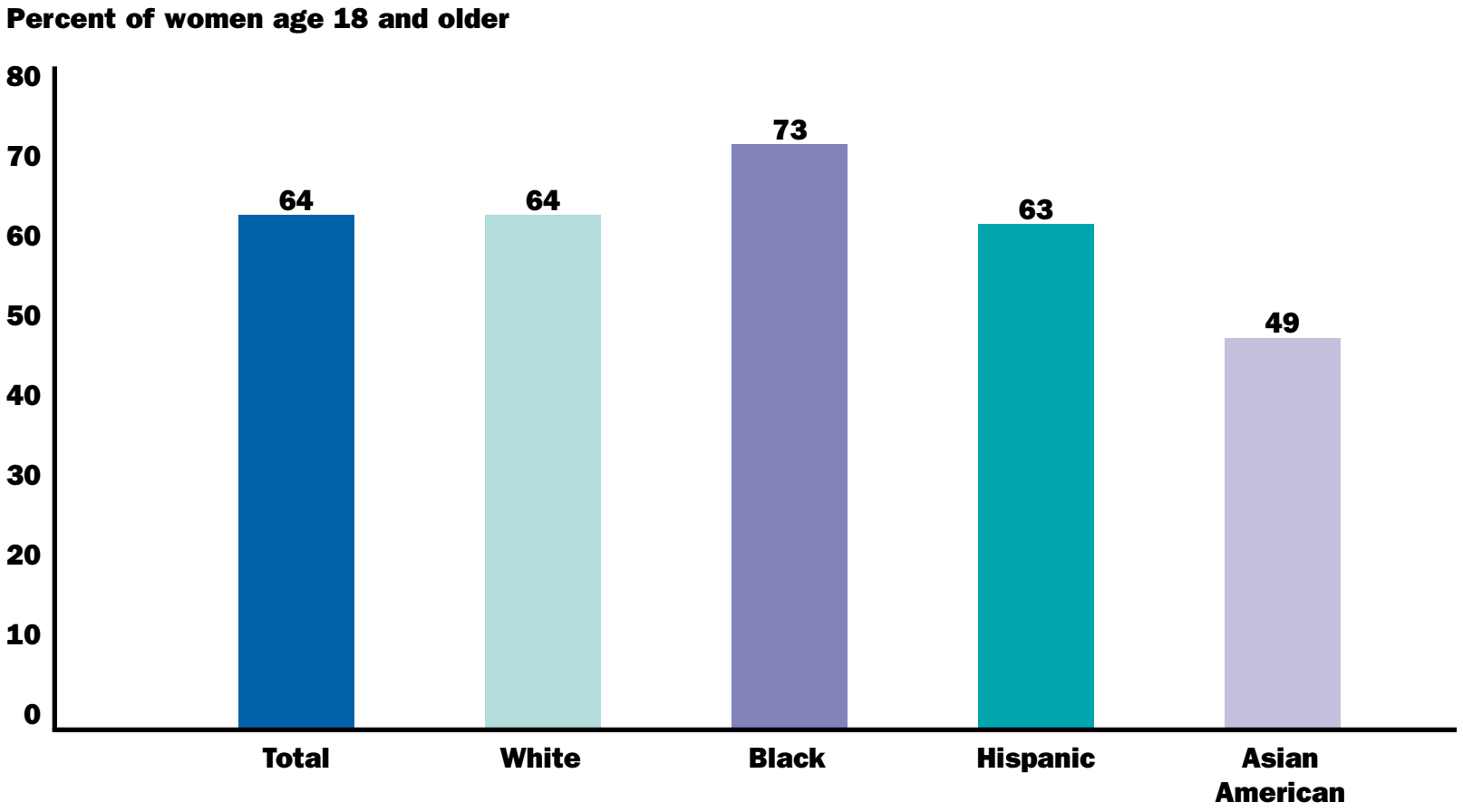
Chart 4-11

Receipt of Pap Test for Cervical Cancer Screening by Race and Hispanic Origin, 1998

- Among women age 18 and older, black women are most likely to have a Pap test. Seventy-three percent of black women, 63 percent of Hispanic women, and 64 percent of white women had a Pap test in the past year (authors' tabulations of *The Commonwealth Fund 1998 Survey of Women's Health*).
- Asian American women have the lowest rate of cervical cancer screening—49 percent (authors' tabulations of *The Commonwealth Fund 1998 Survey of Women's Health*).
- Vietnamese American women have the highest incidence of cervical cancer, 43 cases per 100,000—nearly five times the rate for white women. Recorded age-adjusted mortality rates for cervical cancer are highest for black women. Hispanic women have the second highest rate; data are not available for Vietnamese American women (Miller et al., 1996).

Chart 4-11

Receipt of Pap Test for Cervical Cancer Screening by Race and Hispanic Origin, 1998



Source: Authors' tabulations of *The Commonwealth Fund 1998 Survey of Women's Health*.

THE COMMONWEALTH FUND

Chart 4-12

Receipt of First-Trimester Prenatal Care by Race and Hispanic Origin, 1996

Chart 4-13

Receipt of First-Trimester Prenatal Care by Hispanic Origin, 1996

First-trimester prenatal care has increased over the past two decades, but black, Hispanic and Native American mothers still have lower rates of early prenatal care than whites or Asian Americans.

- Sixty-seven percent of Native American, 71 percent of black, and 72 percent of Hispanic mothers received first-trimester prenatal care in 1996 (National Center for Health Statistics, 1998).
- Eighty-four percent of white and 81 percent of Asian American mothers received care in the first trimester (National Center for Health Statistics, 1998).
- Within the Hispanic population, Cuban American mothers have a very high rate of prenatal care (89%), while Mexican American mothers have the lowest rate (71%) (National Center for Health Statistics, 1998).

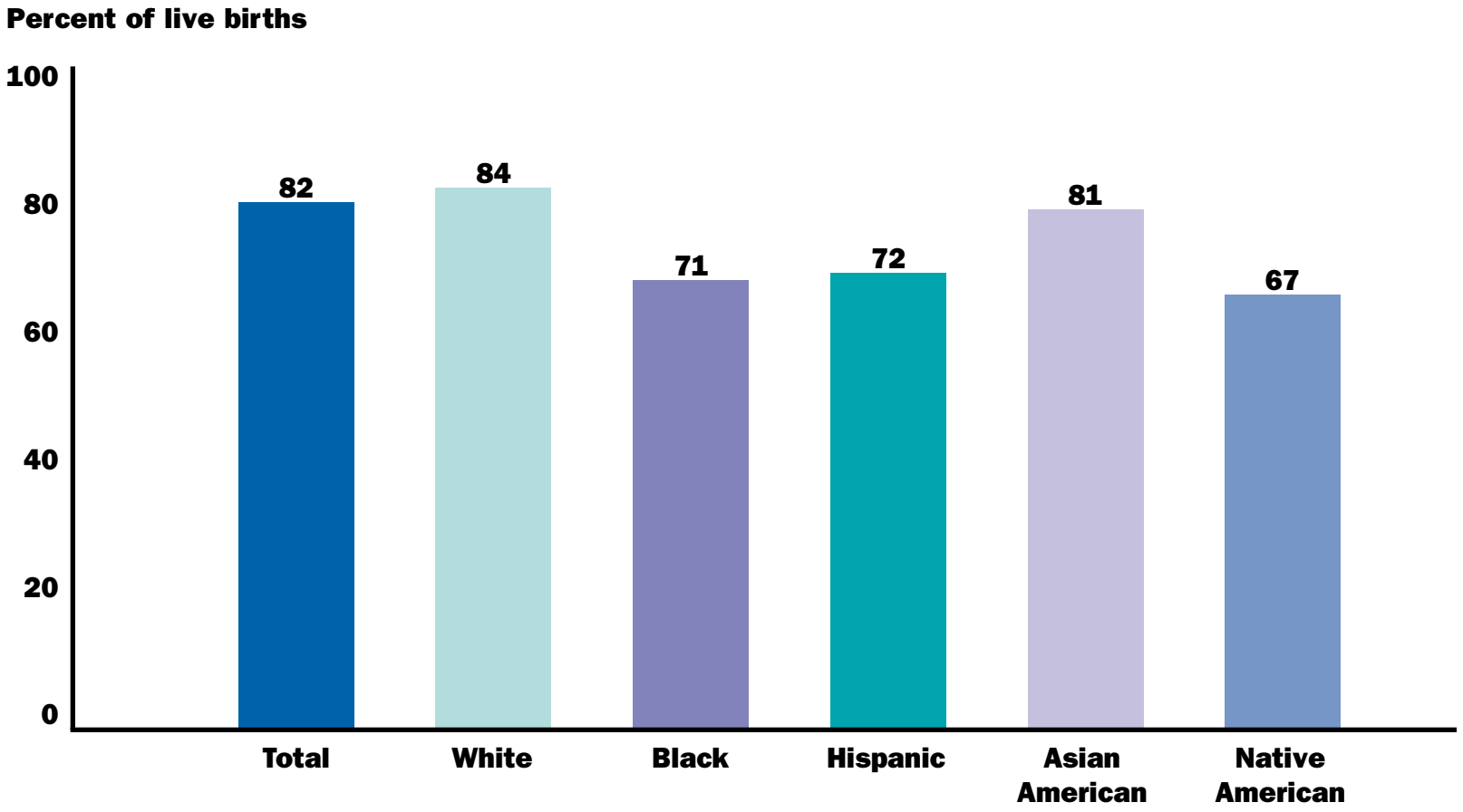
Receipt of First Trimester Prenatal Care by Race and Hispanic Origin, 1980–96
(percent of live births)

	1980	1985	1990	1993	1994	1995	1996
Total	76.3	76.2	75.8	78.9	80.2	81.3	81.9
White (selected states)	81.2	81.8	83.3	85.6	86.5	87.1	87.4
Black (selected states)	60.7	60.4	60.7	66.1	68.3	70.4	71.5
Native American	55.8	58.1	57.9	63.4	65.2	66.7	67.7
Asian American	73.7	75.5	75.1	77.6	79.7	79.9	81.2
Hispanic (selected states)	60.2	61.3	60.2	66.6	68.9	70.8	72.2

Source: National Center for Health Statistics, 1998.

Chart 4-12

Receipt of First-Trimester Prenatal Care by Race and Hispanic Origin, 1996

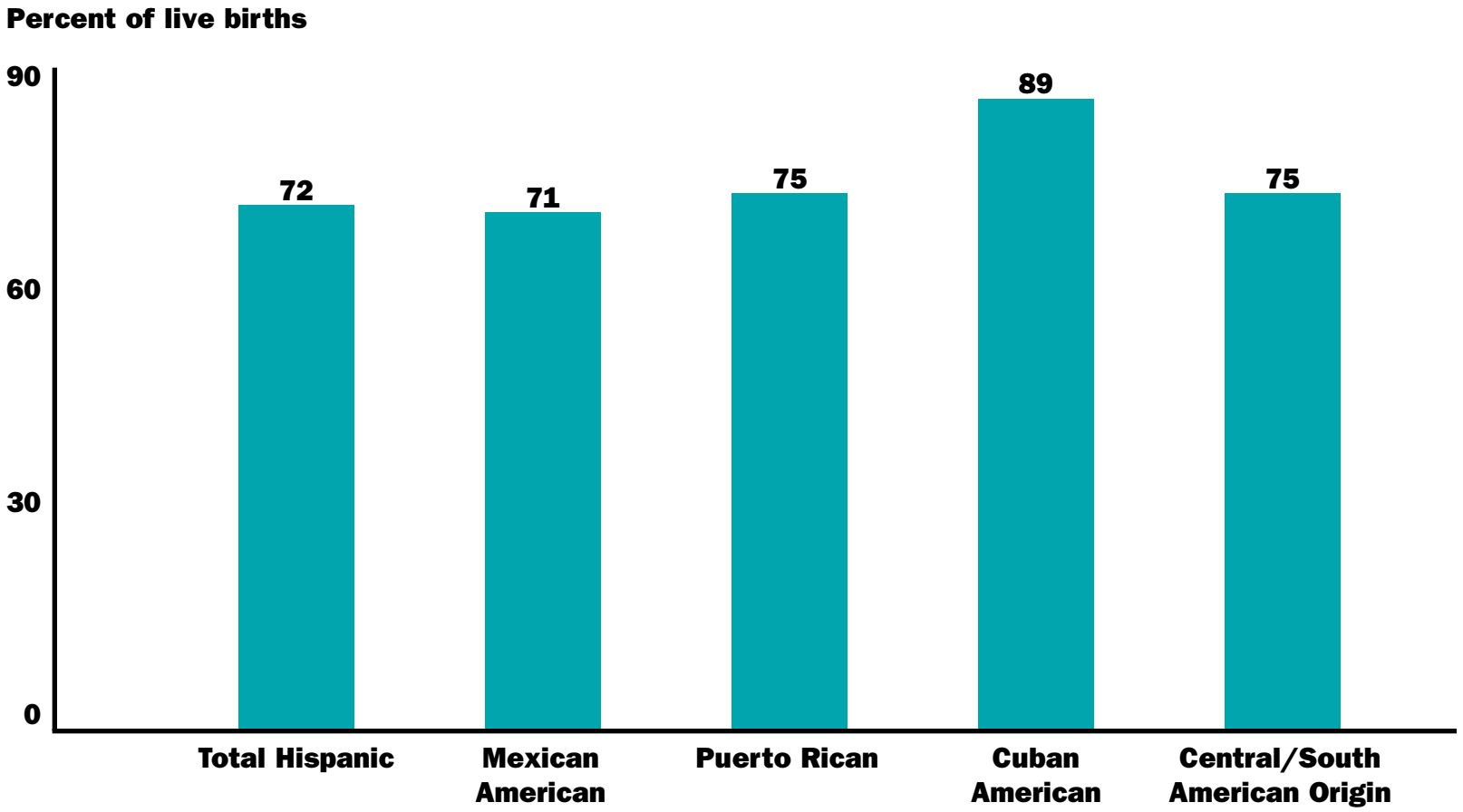


Source: National Center for Health Statistics, 1998.

THE COMMONWEALTH FUND

Chart 4-13

Receipt of First-Trimester Prenatal Care by Hispanic Origin, 1996



Source: National Center for Health Statistics, 1988.

Chart 4-14

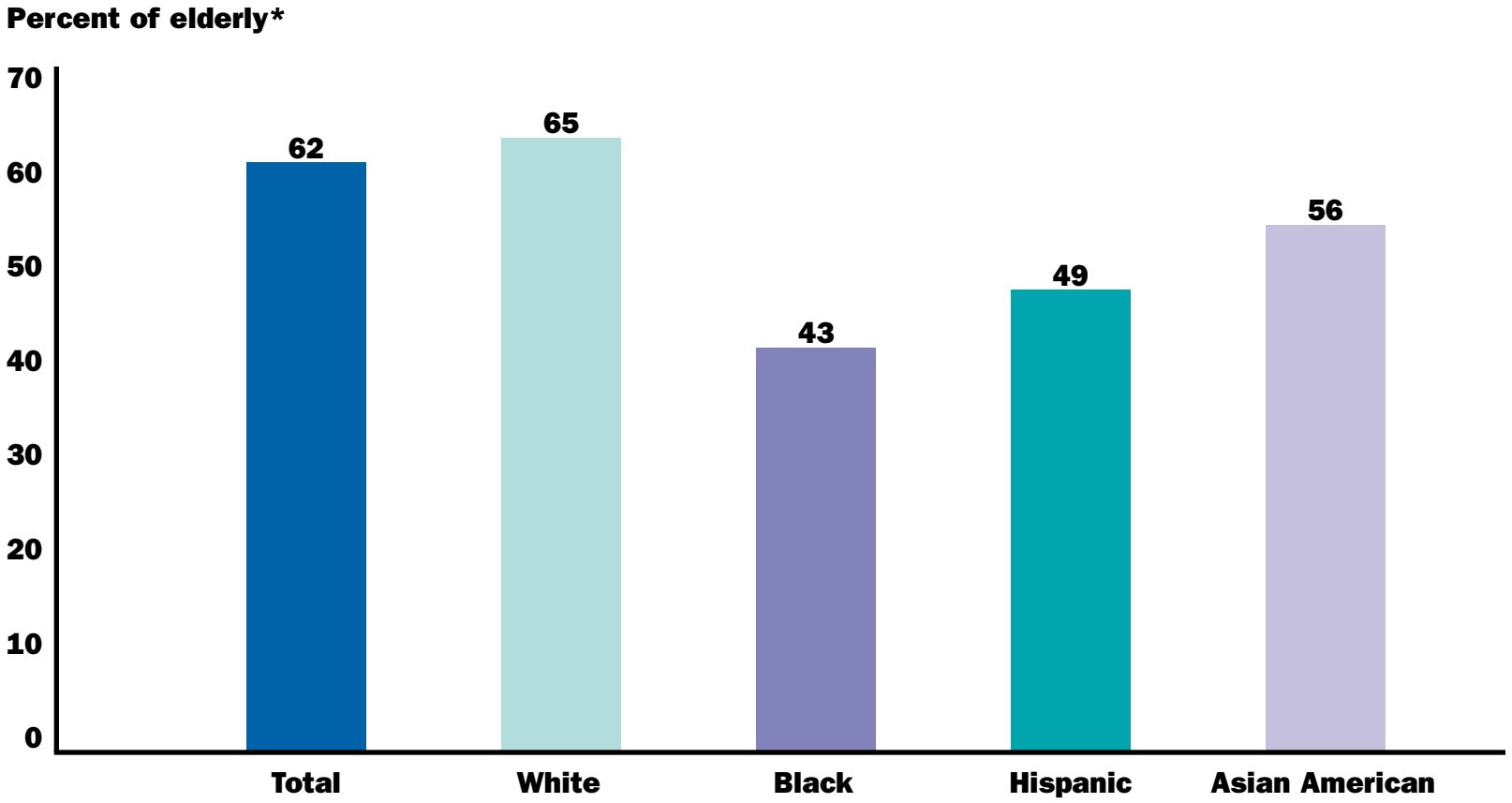
Receipt of Influenza Vaccine in Past Year Among Elderly Medicare Beneficiaries, by Race and Hispanic Origin, 1996

Adult immunizations for influenza and pneumonia can save lives, particularly for adults over age 65. Minority elderly are less likely to have received these vaccines than white elderly.

- In 1996, less than one-half of elderly blacks and Hispanics, and 56 percent of Asian Americans, had received the influenza vaccine in the past year (authors' tabulations of the *1996 Medicare Current Beneficiary Survey*).
- Black and Hispanic elderly also lag behind in rates of receiving pneumococcal vaccine. Thirty percent of blacks and 34 percent of Hispanics age 65 and older have received the vaccine, compared with 47 percent of white elderly (Thurm, 1998).
- Since 1993, the pneumococcal and annual influenza vaccines have been covered benefits under Medicare Part B (Thurm, 1998).
- African Americans have the highest death rate for pneumonia and influenza: 17.8 deaths per 100,000 persons (Thurm, 1998).

Chart 4-14

Receipt of Influenza Vaccine in Past Year Among Elderly Medicare Beneficiaries, by Race and Hispanic Origin, 1996



**Age 65 and older, community-dwelling.*

Source: Authors' tabulations of the *1996 Medicare Current Beneficiary Survey.*

THE COMMONWEALTH FUND

Chart 4-15

Black and White Differences in Specialty Procedure Utilization Among Medicare Beneficiaries Age 65 and Older, 1993

Black patients are less likely to receive the same level of highly technical and specialty diagnostic and treatment procedures as white patients.

- Among Medicare beneficiaries, black patients are about one-half as likely to receive specialty services such as angioplasty, coronary artery bypass graft surgery, mammography, and hip fracture repair (Gornick et al., 1996).
- Black patients are more likely to have a limb amputated—often the final stage of poorly managed diabetes (Gornick et al., 1996).
- The race and sex of a patient has been found to be significantly associated with a physician's decision to make referrals for cardiac catheterization. Men and whites are more likely to be referred than women and blacks (Schulman et al., 1999).

Chart 4-15

Black and White Differences in Specialty Procedure Utilization Among Medicare Beneficiaries Age 65 and Older, 1993

	Black	White	Black-to-White Ratio
Angioplasty (procedures per 1,000 beneficiaries per year)	2.5	5.4	0.46
Coronary Artery Bypass Graft Surgery (procedures per 1,000 beneficiaries per year)	1.9	4.8	0.40
Mammography (procedures per 100 women per year)	17.1	26.0	0.66
Hip Fracture Repair (procedures per 1,000 women per year)	2.9	7.0	0.42
Amputation of All or Part of Limb (procedures per 1,000 beneficiaries per year)	6.7	1.9	3.64
Bilateral Orchiectomy (procedures per 1,000 beneficiaries per year)	2.0	0.8	2.45

Source: Gornick et al., 1996.

Chart 4-16

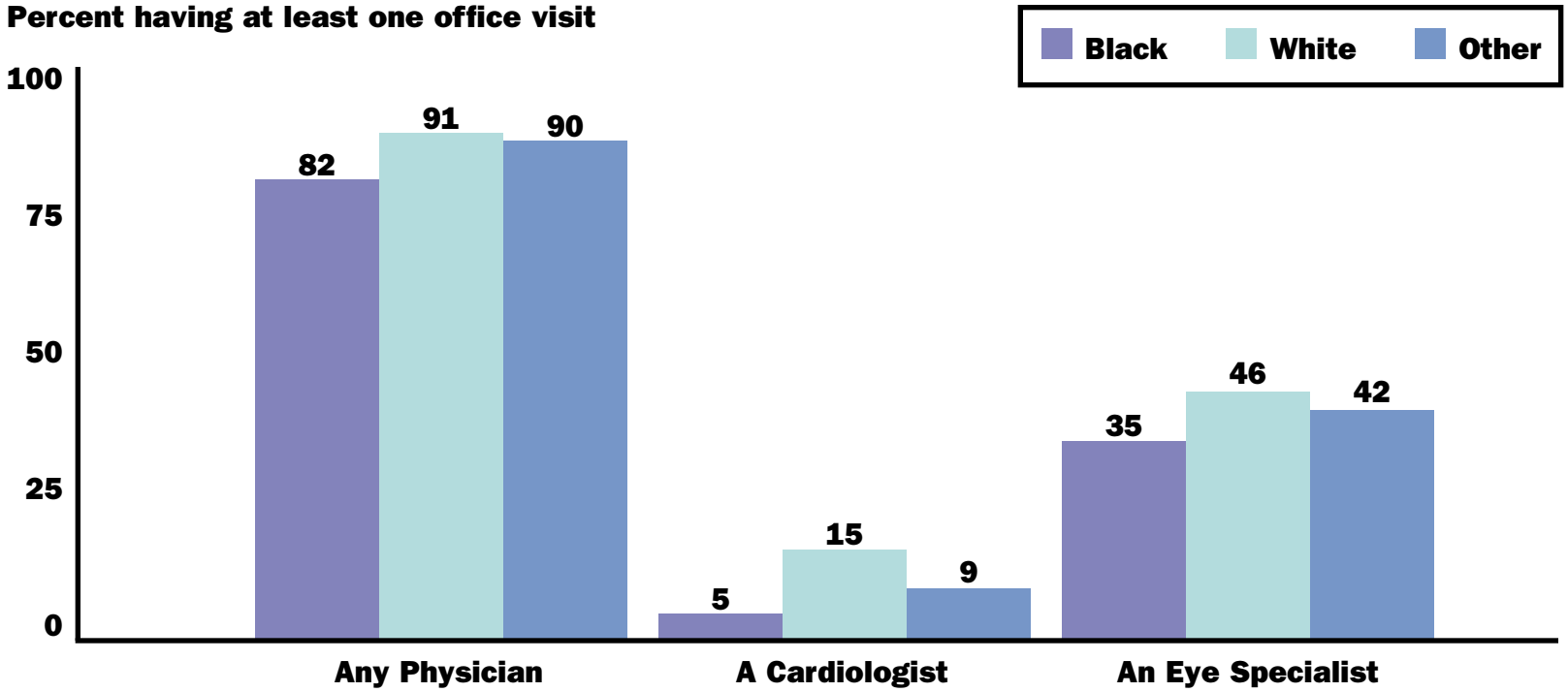
Percentage of Medicare Beneficiaries Age 65 and Older with Diabetes Having at Least One Office Visit to Physicians Practicing Various Specialties, by Race, 1992

Overall, 64 percent of white elderly Medicare beneficiaries saw a specialist physician in 1992, compared with 50 percent of black elderly Medicare beneficiaries (Blustein and Weiss, 1998).

- Black patients with diabetes were less likely than their white counterparts to have visited a cardiologist or eye specialist (Blustein and Weiss, 1998).
- Analysis of the *Medicare Current Beneficiary Survey* has shown that among diabetic patients age 65 and older, African Americans are more likely to visit emergency rooms and less likely to receive preventive exams than whites. White elderly diabetics, for example, were more likely to have had an eye exam in the past year than black elderly diabetics (Chin et al., 1998).

Chart 4-16

Percentage of Medicare Beneficiaries Age 65 and Older with Diabetes Having at Least One Office Visit to Physicians Practicing Various Specialties, by Race, 1992



Source: Blustein and Weiss, 1998.

Chart 4-17

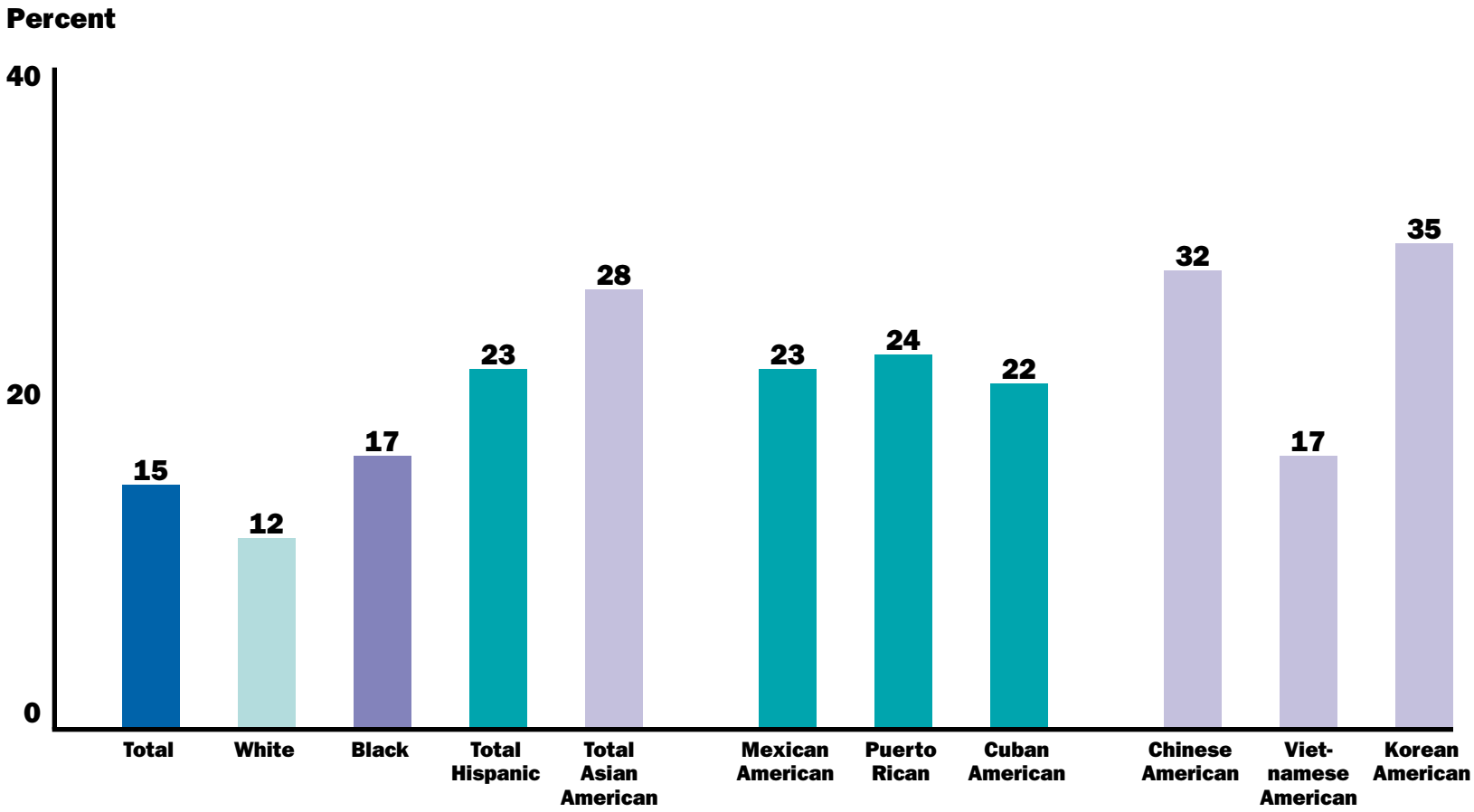
Adult Use of Herbal Medicine, by Race and Hispanic and Asian Origin, 1994

Asian Americans and Hispanics are more likely to report using herbal or traditional medicines in addition to Western medicine.

- Twenty-eight percent of Asian Americans, including one of three Chinese and Korean Americans, and 23 percent of Hispanics reported using herbal medicines (*The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care*).
- Home remedies are used by one-third of American adults, including 39 percent of Native Americans, 36 percent of blacks, 31 percent of Hispanics, and 31 percent of whites (Mackenzie et al., 1998)
- Eleven percent of Asian Americans reported using acupuncture, compared with 1 percent of whites, blacks, and Hispanics. Thirteen percent of whites used chiropractic services, compared with 5 percent of blacks, 8 percent of Hispanics, and 5 percent of Asian Americans (Mackenzie et al., 1998).

Chart 4-17

Adult Use of Herbal Medicine, by Race and Hispanic and Asian Origin, 1994



Source: Authors' tabulations of *The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care*.

THE COMMONWEALTH FUND

Chart 4-18

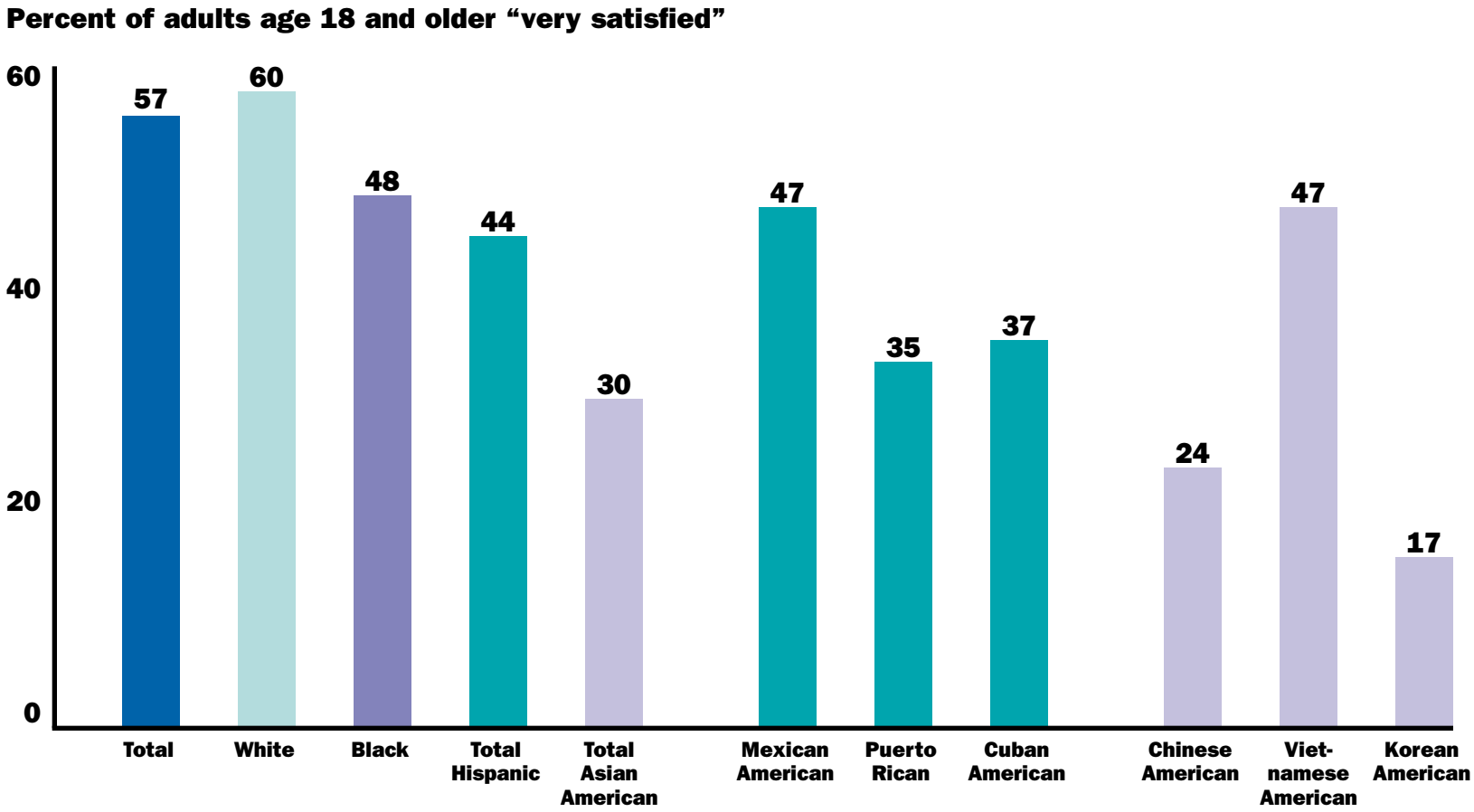
Satisfaction with Quality of Health Care Services, by Race and Hispanic and Asian Origin, 1994

Minority adults are less likely than white adults to feel "very satisfied" with the care they receive.

- Less than one-half of blacks and Hispanics, and less than one-third of Asian Americans, feel very satisfied with their care (*The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care*).
- Among Hispanic groups, satisfaction with health care is lowest for Puerto Rican and Cuban Americans (*The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care*).
- Chinese and Korean Americans reported the lowest levels of satisfaction with their health care services—24 percent and 17 percent, respectively (*The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care*).

Chart 4-18

Satisfaction with Quality of Health Care Services, by Race and Hispanic and Asian Origin, 1994



Source: Authors' tabulations of *The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care*.

Chart 4-19

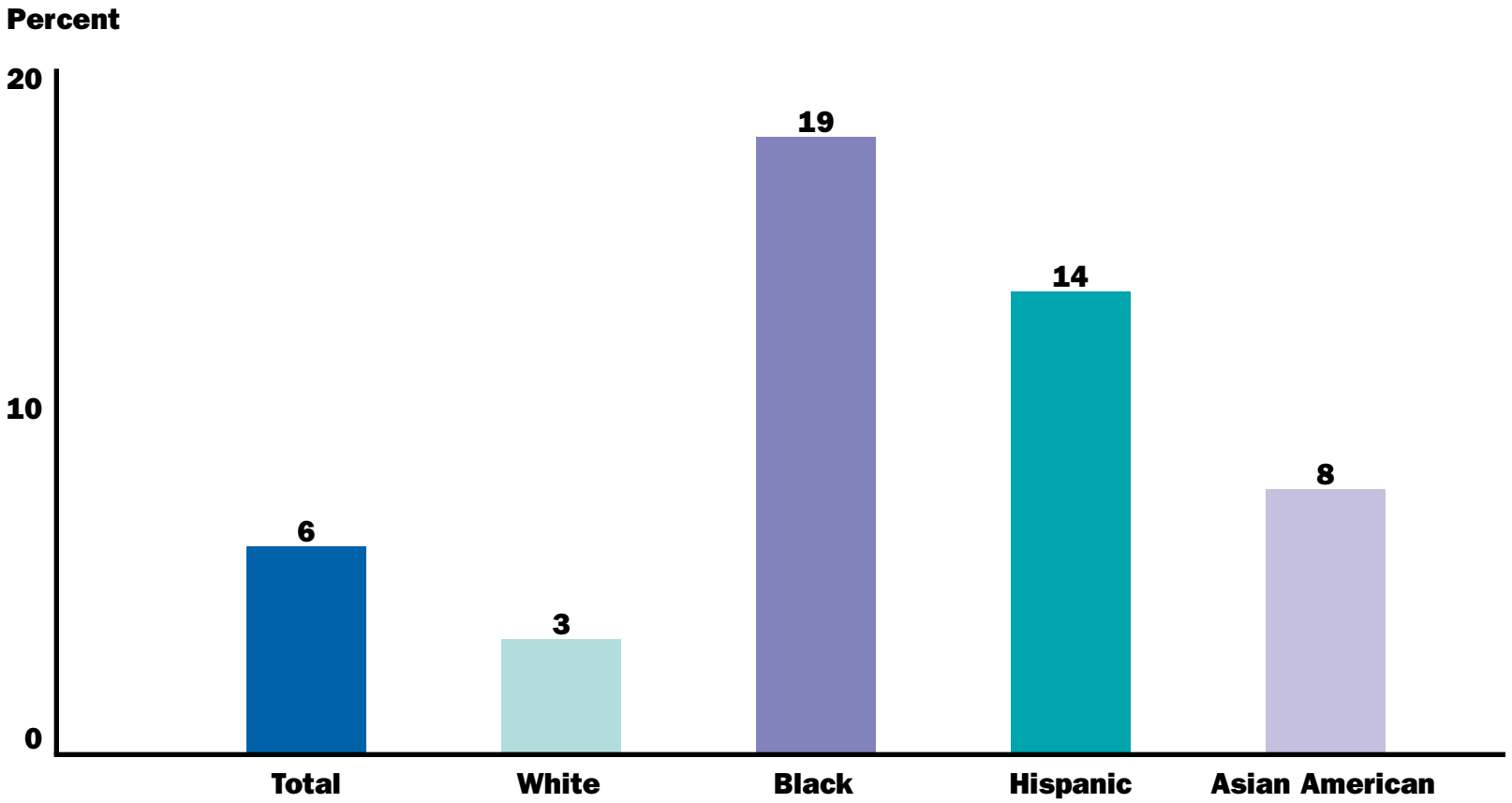
Percentage of Adults Who Believe They Would Receive Better Health Care If They Were of a Different Race and/or Ethnicity, 1994

Fifteen percent of minorities believe they would receive better care if they were of another race.

- Nearly one of five blacks felt they received inferior care, as did 14 percent of Hispanics and 8 percent of Asian Americans. Only 3 percent of whites felt this way (*The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care*).
- Perceived discrimination on the basis of income, sex, or race was cited by groups as the main reason they did not receive better health care (LaVeist and Diala, 1998).
- For blacks, one-half felt that income was the reason they were discriminated against; 40 percent felt the reason was their race; and nearly one-third cited their health or disability status. Hispanics were also more likely to cite income or race discrimination. Whites reported income as the most common cause of discrimination, but did not report race as a significant factor (LaVeist and Diala, 1998).

Chart 4-19

Percentage of Adults Who Believe They Would Receive Better Health Care If They Were of a Different Race and/or Ethnicity, 1994



Source: *The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care.*

THE COMMONWEALTH FUND

Health Insurance Coverage

Chart 5-1
Uninsured Adults by Race and Hispanic Origin, 1996

Public health insurance programs are an important source of coverage for minorities. Minorities ages 18 to 64 are less likely than whites to have employer-sponsored health insurance.

Minorities have higher rates of being uninsured:

- 38 percent of Hispanics, 24 percent of blacks, and 24 percent of Asian Americans were uninsured in 1996. Fourteen percent of whites were uninsured (Hall, Collins, and Glied, 1999).
- Trends in being uninsured have remained relatively unchanged for each group over the past 10 years (Hall, Collins, and Glied, 1999).
- Forty-four percent of Hispanics and 37 percent of blacks were not continuously insured during a two-year period, compared with 20 percent of whites (authors' tabulations of *The Kaiser/Commonwealth 1997 National Survey of Health Insurance*).

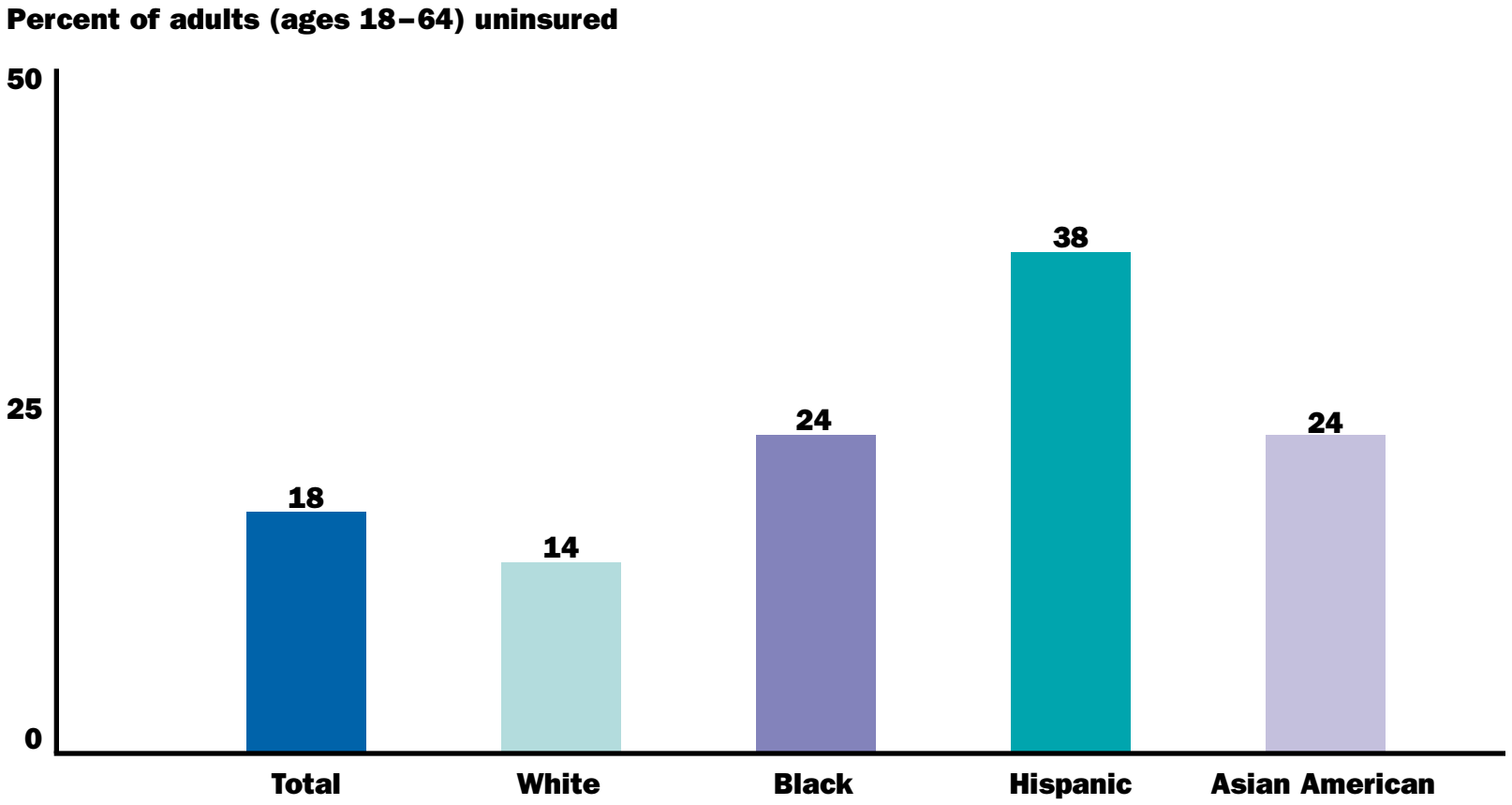
Health Insurance Coverage by Race and Hispanic Origin, 1996 (Ages 18–64)

	Medicaid	Employer	Purchase	Other	Uninsured
Total	6	64	6	6	18
White	5	69	7	6	14
Black	13	52	3	8	24
Hispanic	11	44	3	4	38
Asian American	5	59	8	4	24

Source: Authors' tabulations of the *Current Population Survey, 1997 March Supplement*.

Chart 5-1

Uninsured Adults by Race and Hispanic Origin, 1996



Source: Hall, Collins, and Glied, 1999.

Chart 5-2
Uninsured Poor Adults by Race and Hispanic Origin, 1996

Medicaid provides health insurance coverage to less than half of adults with incomes less than 100 percent of poverty.

- Forty-two percent of poor blacks, 31 percent of poor Hispanics, 27 percent of poor whites, and 24 percent of poor Asian Americans have Medicaid coverage (authors' tabulations of the *Current Population Survey, 1997 March Supplement*).
- One-half of poor Hispanics and Asian Americans, and more than one-third of poor blacks and whites, are uninsured.

Sources of Health Insurance Coverage Among the Poor* (ages 18–64) by Race and Hispanic Origin, 1996

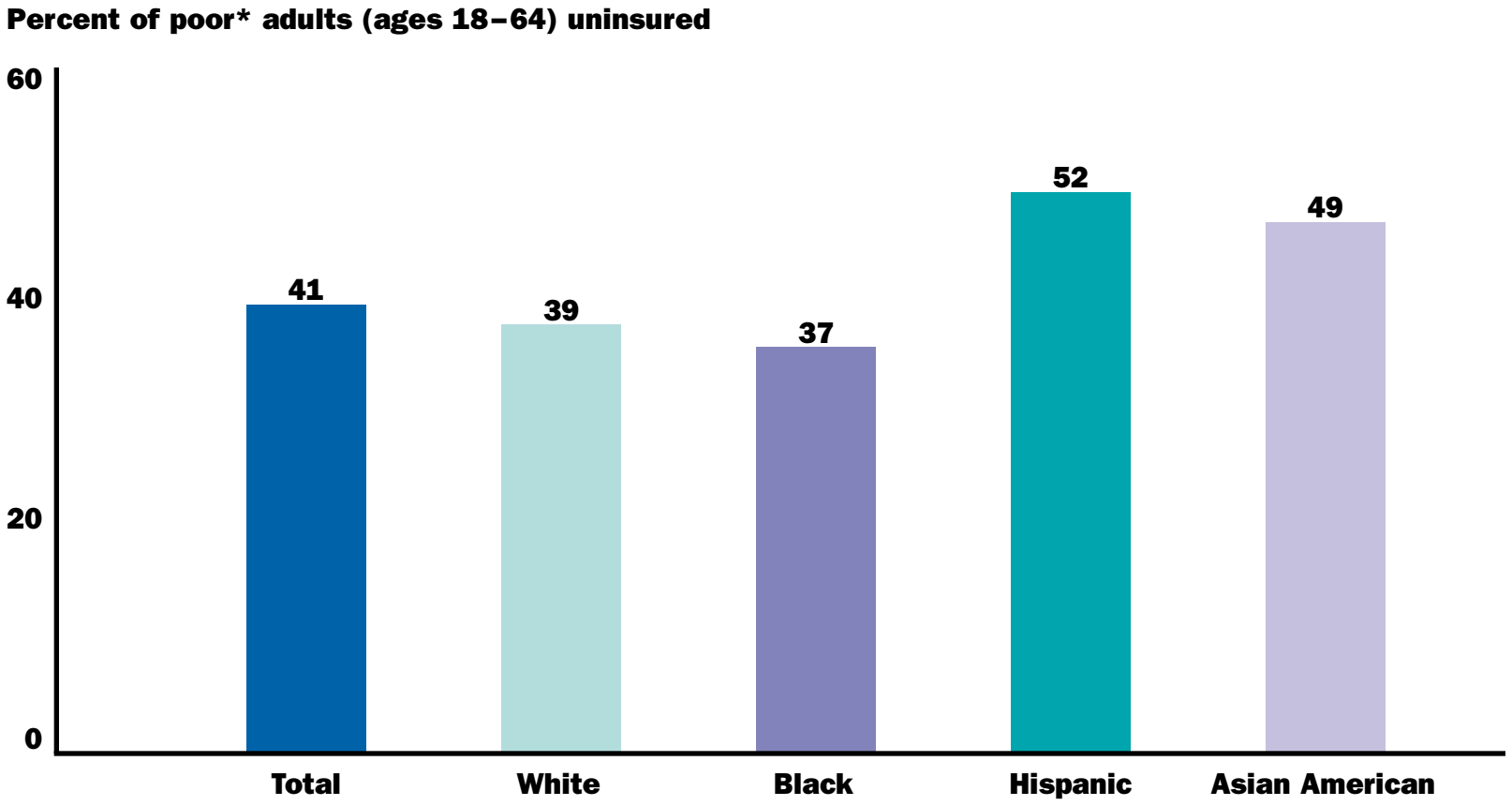
	Medicaid	Employer	Purchase	Other	Uninsured
Total	31	12	8	8	41
White	27	12	12	10	39
Black	42	9	3	10	37
Hispanic	31	11	2	4	52
Asian American	24	9	14	4	49

*Poor = <100 percent of poverty.

Source: Authors' tabulations of the *Current Population Survey, 1997 March Supplement*.

Chart 5-2

Uninsured Poor Adults by Race and Hispanic Origin, 1996



Poor = Less than 100 percent of poverty.

Source: Author's tabulations of the *Current Population Survey, 1997 March Supplement*.

THE COMMONWEALTH FUND

Chart 5-3
Uninsured Near-Poor* Adults by Race and Hispanic Origin, 1996

Near-poor adults are as likely to be uninsured as poor adults, across all racial and ethnic groups. There is some increase in employer coverage compared with poor adults, but not sufficient to close the gap for those not eligible for Medicaid.

- Medicaid covers 18 percent of black, 14 percent of Hispanic and 12 percent of Asian American adults who have incomes between 100 percent and 124 percent of poverty. (authors' tabulations of the *Current Population Survey, 1997 March Supplement*).
- Employers provide coverage to about one of four near-poor adults, though Hispanic adults in this income group are less likely to have coverage than others.

Health Insurance Coverage Among the Near-Poor* (ages 18–64) by Race and Hispanic Origin, 1996

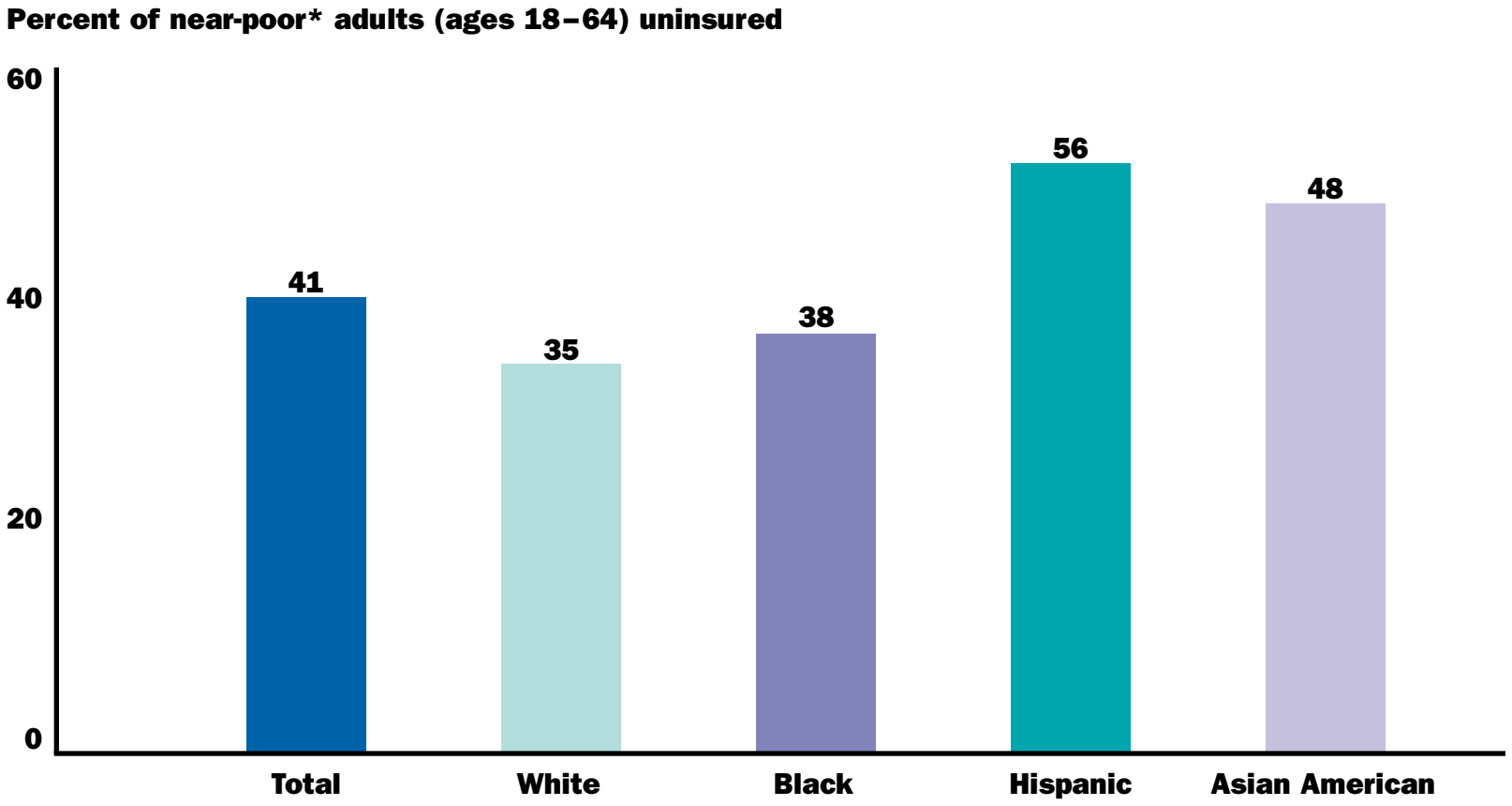
	Medicaid	Employer	Purchase	Other	Uninsured
Total	16	27	7	9	41
White	16	28	10	11	35
Black	18	29	5	10	38
Hispanic	14	23	3	4	56
Asian American	12	27	5	8	48

*Near-Poor = 100–124 percent of poverty.

Source: Authors' tabulations of the *Current Population Survey, 1997 March Supplement*.

Chart 5-3

Uninsured Near-Poor Adults by Race and Hispanic Origin, 1996



**Near-Poor = 100–124 percent of poverty.*

Source: Author's tabulations of the *Current Population Survey, 1997 March Supplement*.

THE COMMONWEALTH FUND

Chart 5-4
Uninsured by Citizenship, 1996

Insurance coverage also varies by citizenship.

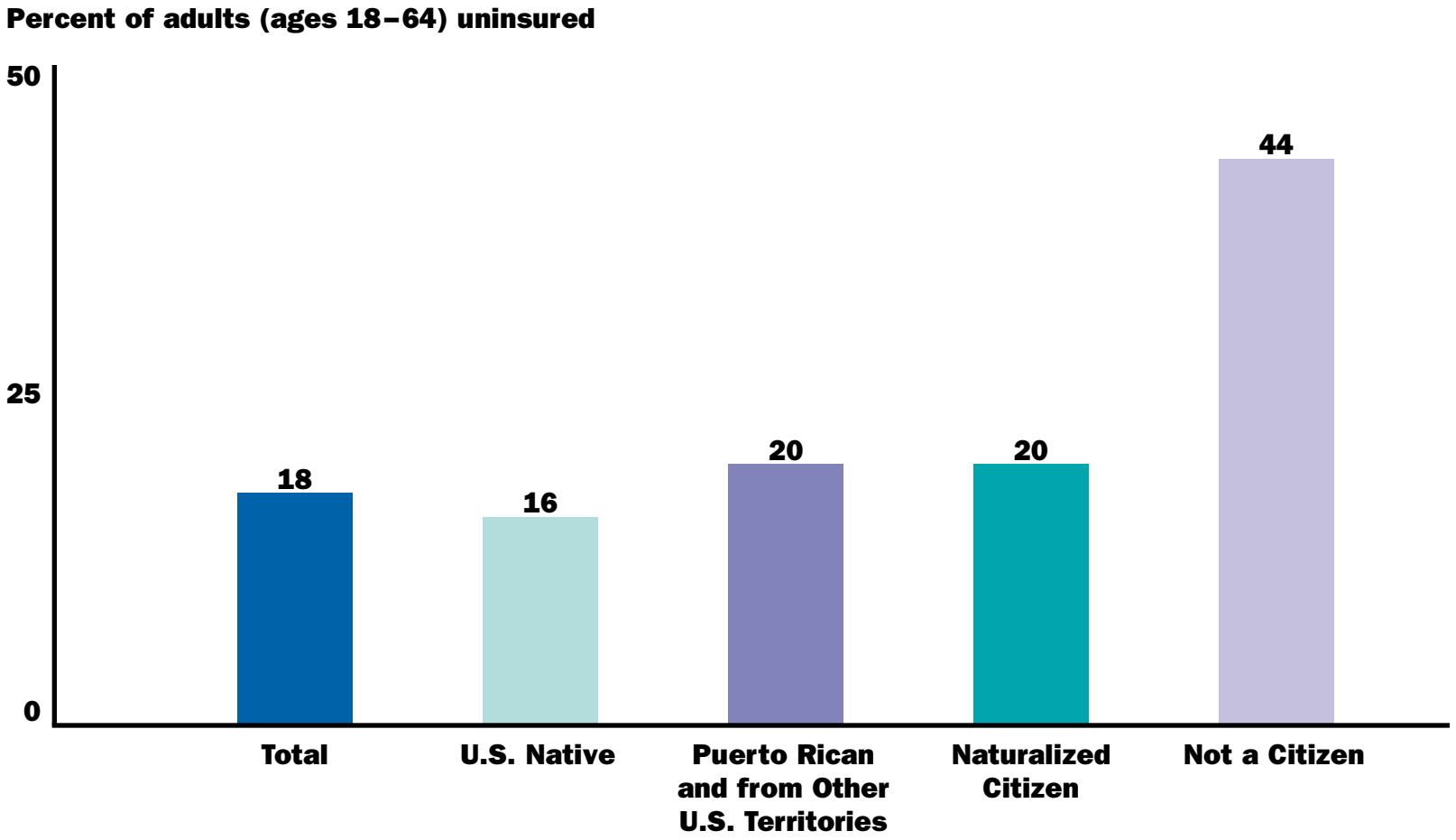
- Almost half of noncitizen adults ages 18 to 64 do not have health insurance.
- One-quarter (26%) of Puerto Ricans and individuals from other U.S. territories are enrolled in Medicaid (authors' tabulations of the *Current Population Survey, 1997 March Supplement*).
- Twenty percent of naturalized citizens, Puerto Ricans, and individuals from other U.S. territories do not have health insurance, whereas 16 percent of U.S. natives are uninsured.

Health Insurance Coverage by Citizenship, 1996 (ages 18–64)

	Medicaid	Employer	Purchase	Other	Uninsured
Total	6	64	6	6	18
U.S. Native	6	66	6	6	16
Puerto Rican and from Other U.S. Territories	26	44	2	8	20
Naturalized Citizen	5	64	6	5	20
Not a Citizen	9	40	5	3	44

Source: Authors' tabulations of the *Current Population Survey, 1997 March Supplement*.

Chart 5-4
Uninsured by Citizenship, 1996



Source: Authors' tabulations of the *Current Population Survey, 1997 March Supplement*.

Chart 5-5

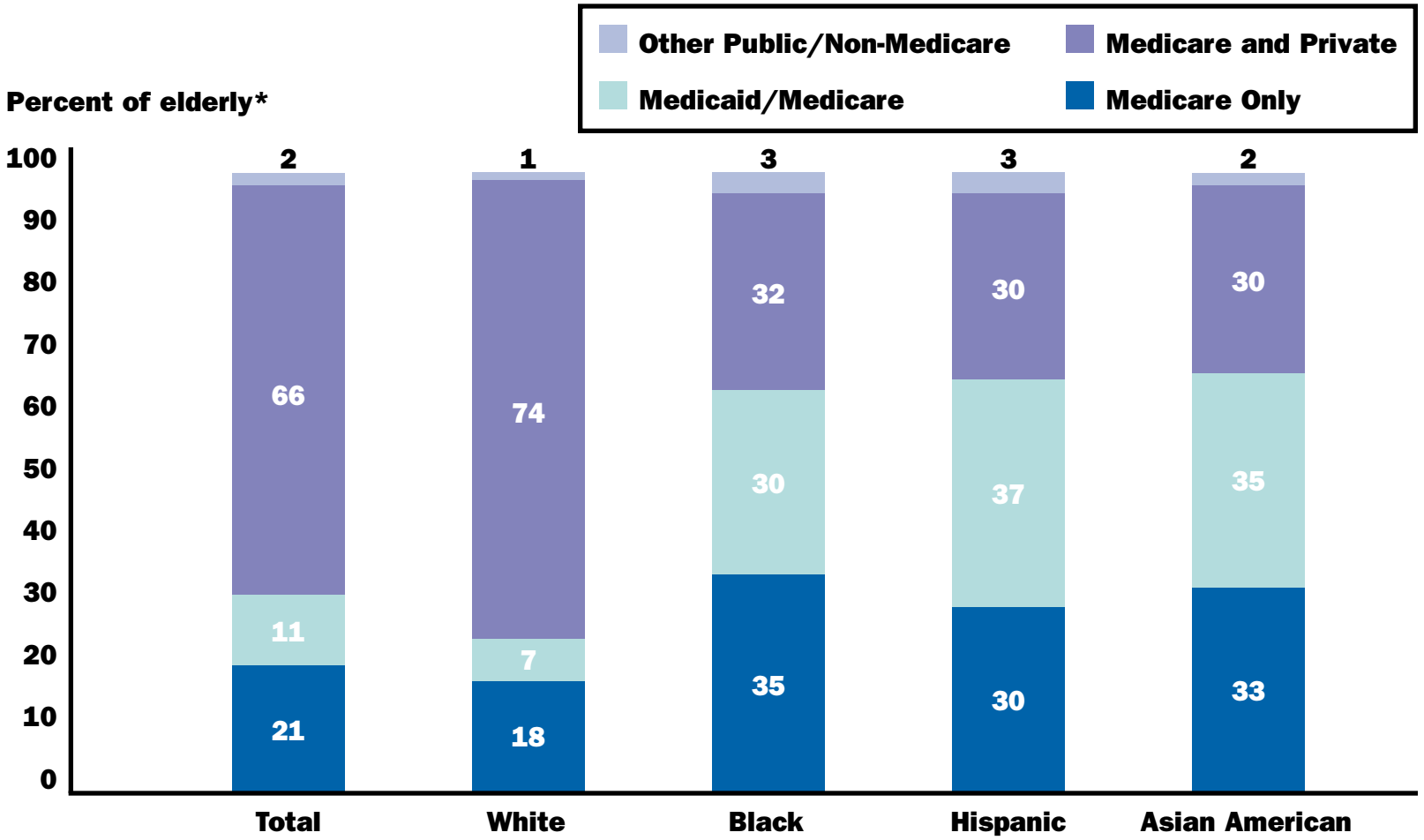
Supplemental Insurance Coverage Among the Elderly, by Race and Hispanic Origin, 1996

Medicare does not cover all the health care expenses incurred by elderly individuals. Supplemental health insurance coverage does cover some expenses not covered by Medicare, such as prescription drugs, copayments, and deductibles.

- White elderly Americans are more likely to supplement Medicare with private insurance: nearly three-quarters have private supplemental insurance, compared with about one-third of minority elderly Americans (authors' tabulations of the *1996 Medicare Current Beneficiary Survey*).
- Minority elderly Americans are more likely to have Medicare as their sole source of coverage, or to be dually enrolled in Medicaid and Medicare. Approximately one-third of minority elderly have only Medicare and another third have Medicaid and Medicare.

Chart 5-5

Supplemental Insurance Coverage Among the Elderly, by Race and Hispanic Origin, 1996



**Age 65 and older, community-dwelling.*

Source: Authors' tabulations of the *1996 Medicare Current Beneficiary Survey.*

THE COMMONWEALTH FUND

Chart 5-6

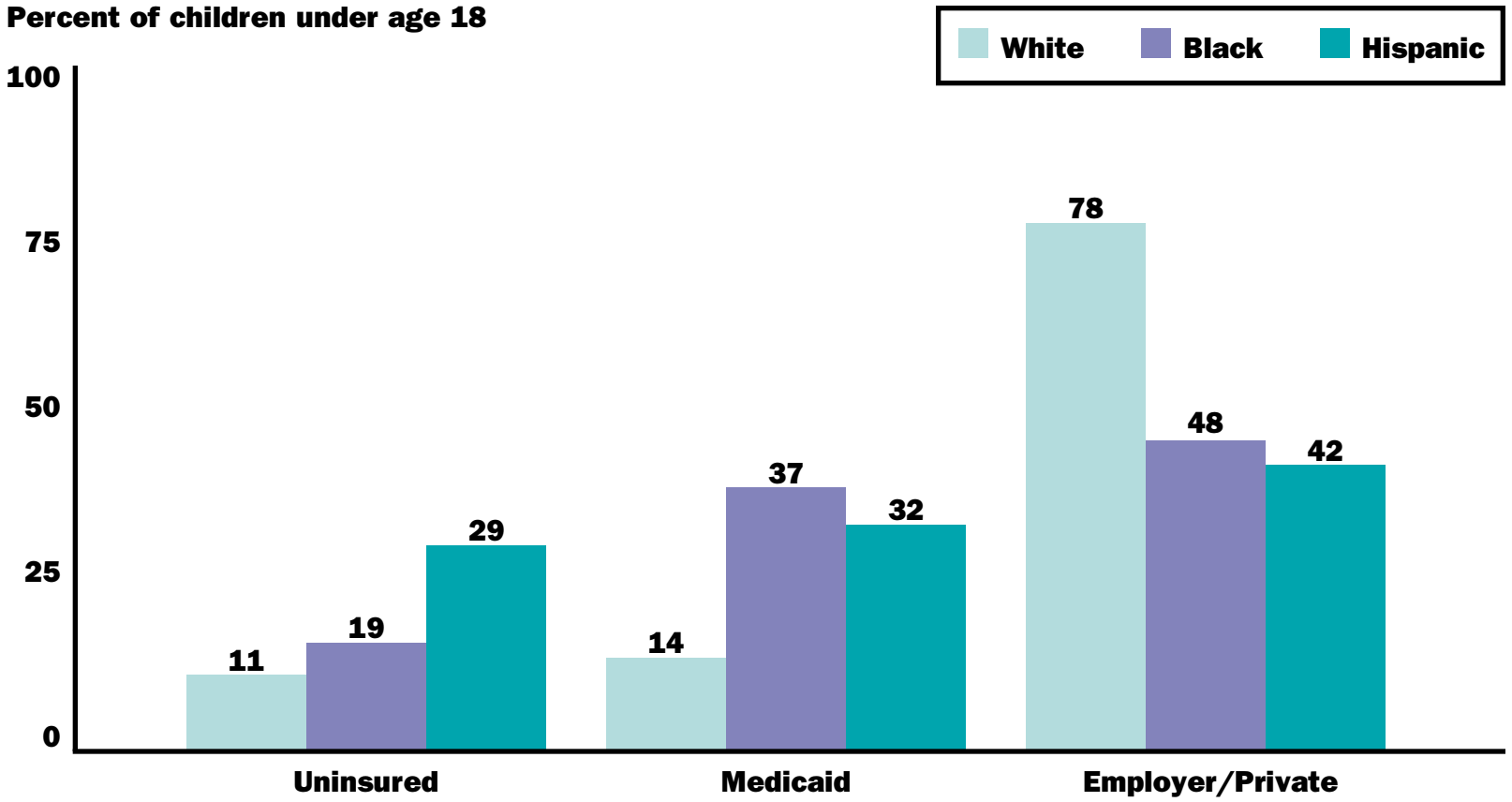
Children's Health Insurance Coverage by Race and Hispanic Origin, 1997

Minority children are more likely to be uninsured or to rely heavily on Medicaid.

- Twenty-nine percent of Hispanic, 19 percent of black, and 11 percent of white children did not have health insurance in 1997 (Fronstin, 1998).
- More than one-third of black children and nearly one-third of Hispanic children have coverage through Medicaid (Fronstin, 1998).

Chart 5-6

Children's Health Insurance Coverage by Race and Hispanic Origin, 1997



Source: Fronstin, 1998.

THE COMMONWEALTH FUND

Chart 5-7

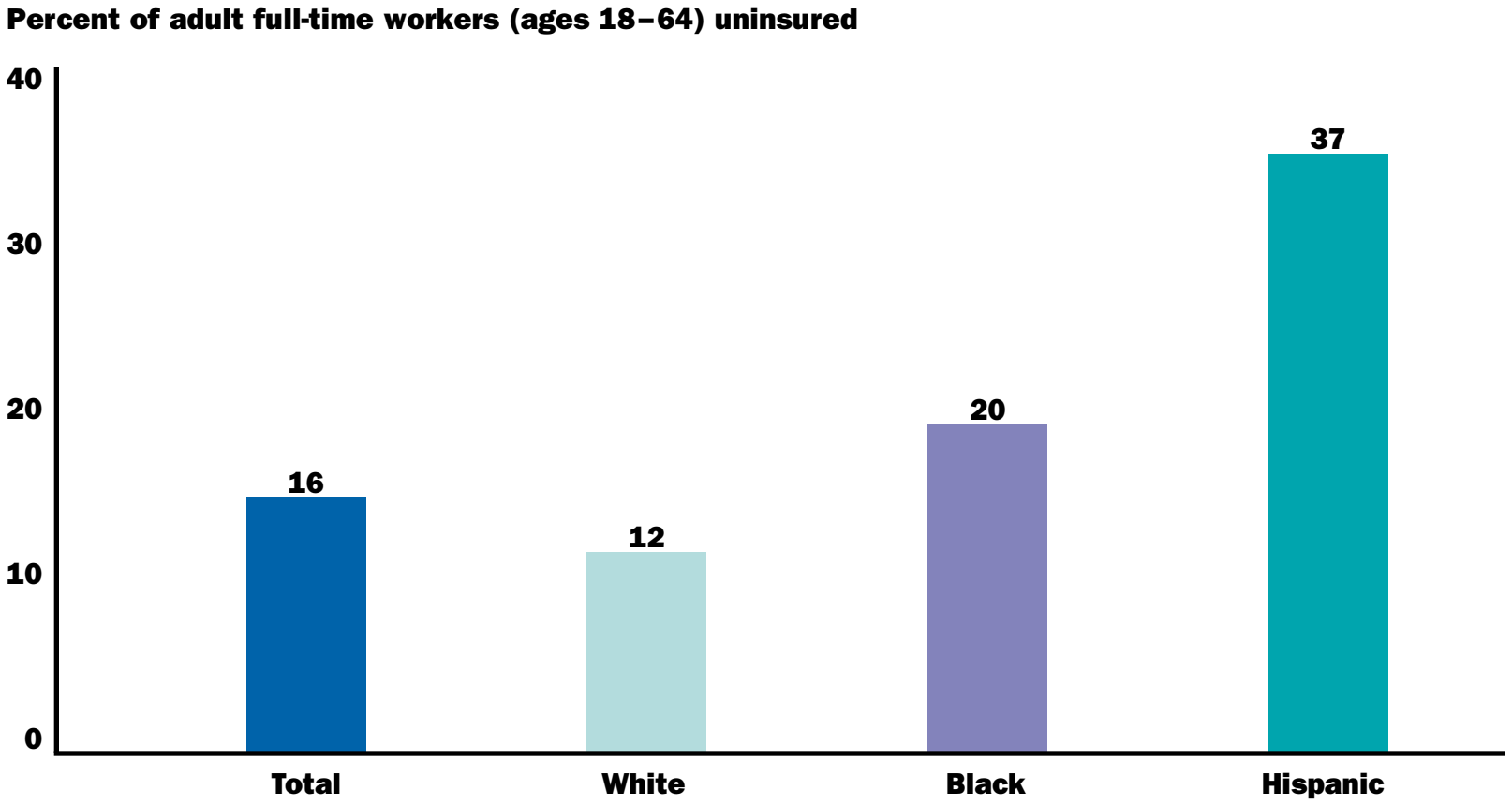
Percent of Full-Time Workers Who Are Uninsured, 1996

Even when employed, minorities are disproportionately more likely to be uninsured.

- Among adult full-time workers, 37 percent of Hispanics, and 20 percent of blacks were without health insurance in 1997, compared with 12 percent of whites (Hall, Collins, and Glied, 1999).
- More-educated workers are less likely to be uninsured than less-educated workers. Among workers with less than a high school education, 28 percent of whites, 35 percent of blacks, and 53 percent of Hispanics have no health insurance.

Chart 5-7

Percent of Full-Time Workers Who Are Uninsured, 1996



Source: Hall, Collins, and Glied, 1999.

THE COMMONWEALTH FUND

Chart 5-8

Employer-Based Health Coverage by Firm Size, 1996

Chart 5-9

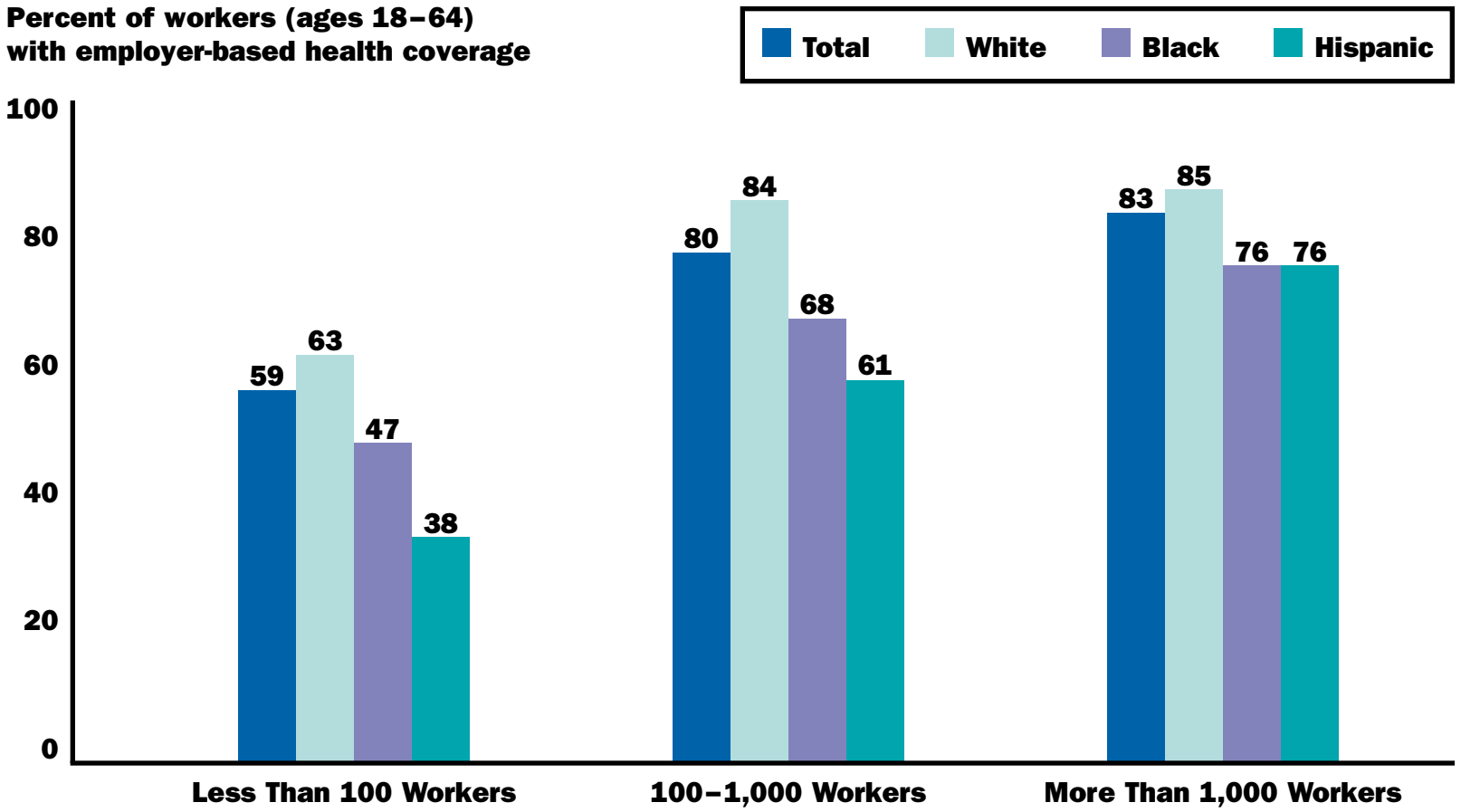
Employer-Based Health Coverage by Industry Type, 1996

Variation in employer-based health coverage by race/ethnicity is found among employers of different sizes, and among different types of employers.

- Among small, medium, and large employers, black and Hispanic full-time workers are less likely to receive employer coverage than white and Asian American workers.
- Full-time workers in the manufacturing sector have higher rates of health coverage from their employers than service workers; however, the disparity across minority groups remains within these categories. The public administration sector has the least variation in coverage across groups (Hall, Collins, and Glied, 1999).

Chart 5-8

Employer-Based Health Coverage by Firm Size, 1996

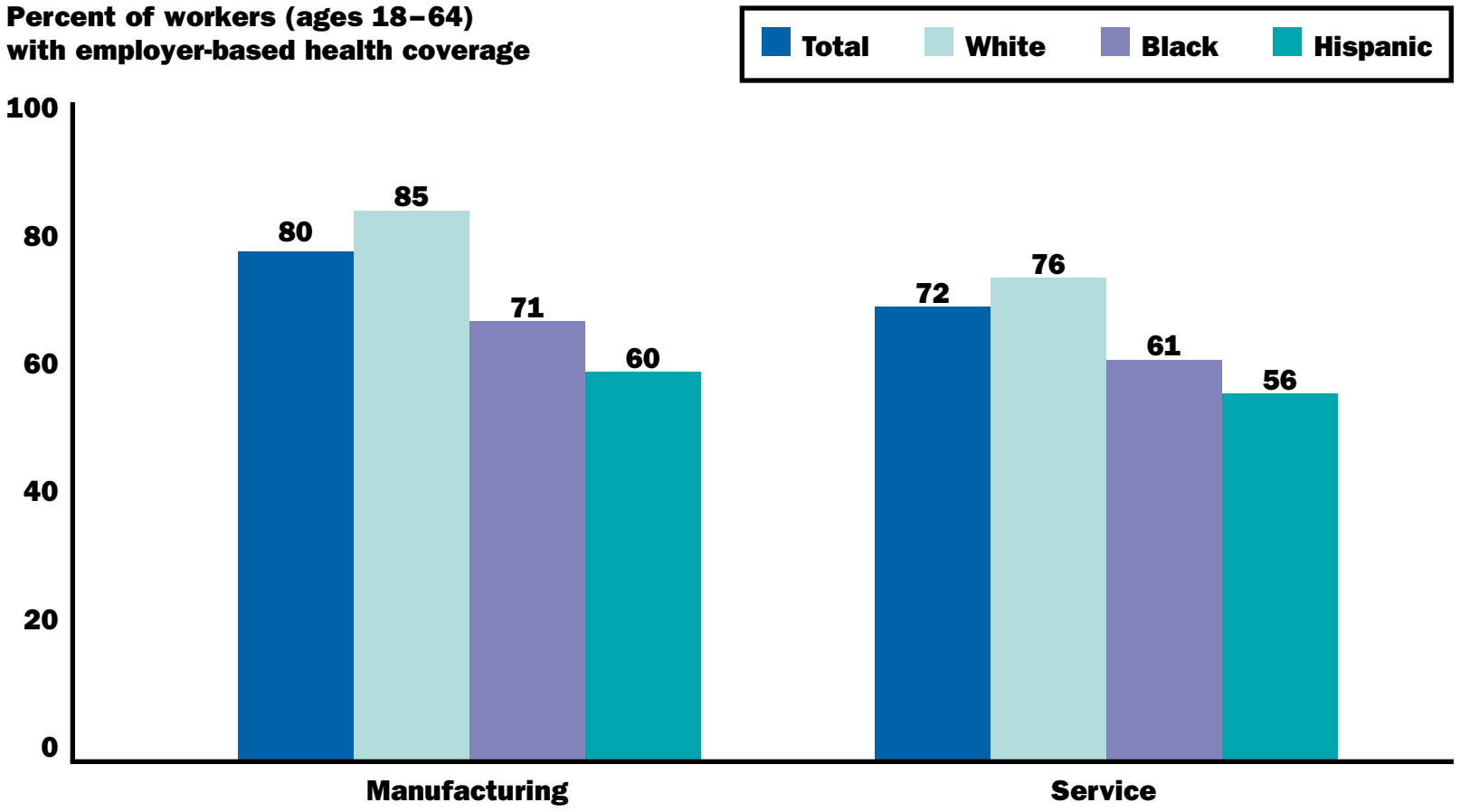


Source: Hall, Collins, and Glied, 1999.

THE COMMONWEALTH FUND

Chart 5-9

Employer-Based Health Coverage by Industry Type, 1996



Source: Hall, Collins, and Glied, 1999.

THE COMMONWEALTH FUND

Chart 5-10
Enrollment in Managed Care by Race and Hispanic Origin, 1996

Higher percentages of privately insured minorities are currently enrolled in managed care plans.

- Nearly two-thirds of privately insured blacks and Hispanics were enrolled in managed care in 1997, along with one-half of privately insured whites.
- Privately insured minorities appear to have led enrollment in managed care since the early 1990s. Enrollment among privately insured whites, however, is now catching up, as managed care continues to grow (authors' tabulations of the *1996 Medical Expenditure Panel Survey*).
- Managed care enrollment among the publicly insured is similar for whites and blacks and reflects trends in Medicaid managed care growth.

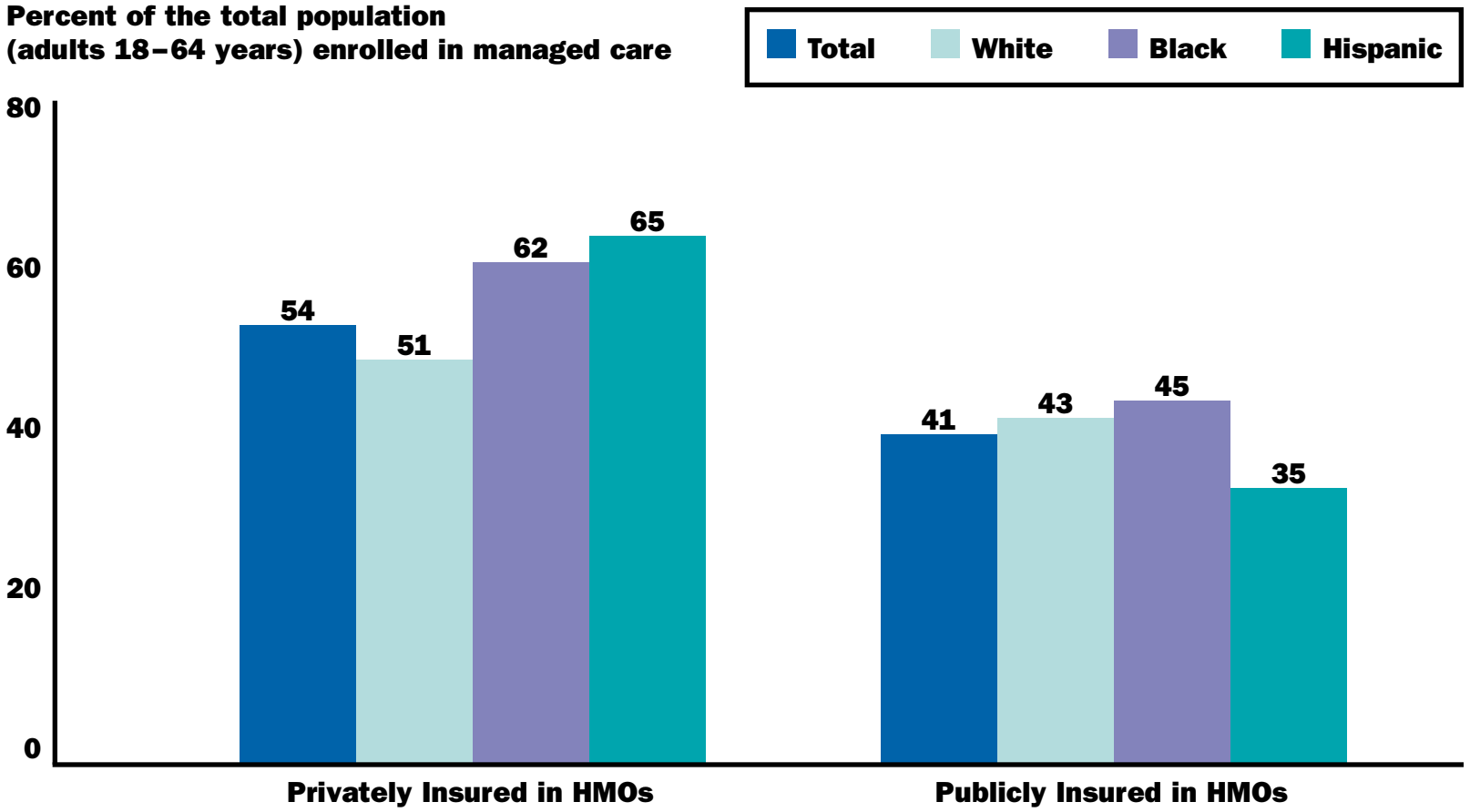
Medicaid Managed Care Enrollment, 1991–97

	Total Medicaid Population (in millions)	Percent Enrolled in Managed Care
1991	28.3	9.5
1993	33.4	14.4
1995	33.4	29.4
1997	32.1	47.8

Source: Health Care Financing Administration, 1997.

Chart 5-10

Enrollment in Managed Care by Race and Hispanic Origin, 1996



Source: Authors' tabulations of the *1996 Medical Expenditure Panel Survey*.

THE COMMONWEALTH FUND

Minority Health Professionals

Chart 6-1

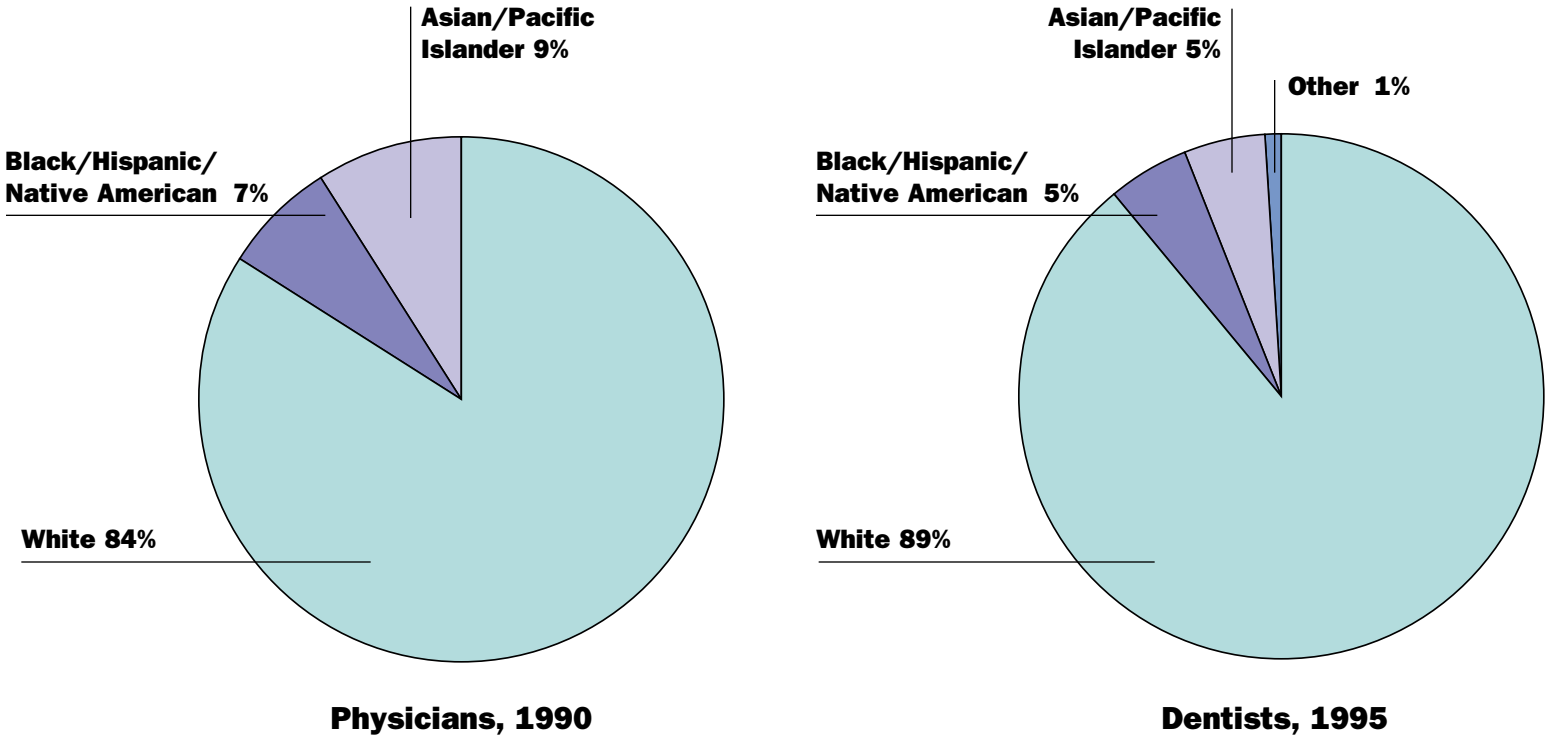
U.S. Physicians and Dentists by Race and Ethnicity, 1990 and 1995

Blacks, Hispanics, and Native Americans together make up 24 percent of the population, yet these groups are underrepresented among physicians, dentists, and other health professionals.

- Seven percent of U.S. physicians are black, Hispanic, or Native American (Bureau of Health Professions, 1990).
- Five percent of U.S. dentists are from one of these minority groups (American Dental Association, 1995).

Chart 6-1

U.S. Physicians and Dentists by Race and Ethnicity, 1990 and 1995



Source: Bureau of Health Professions, 1990, and American Dental Association, Survey Center, 1995.

Chart 6-2

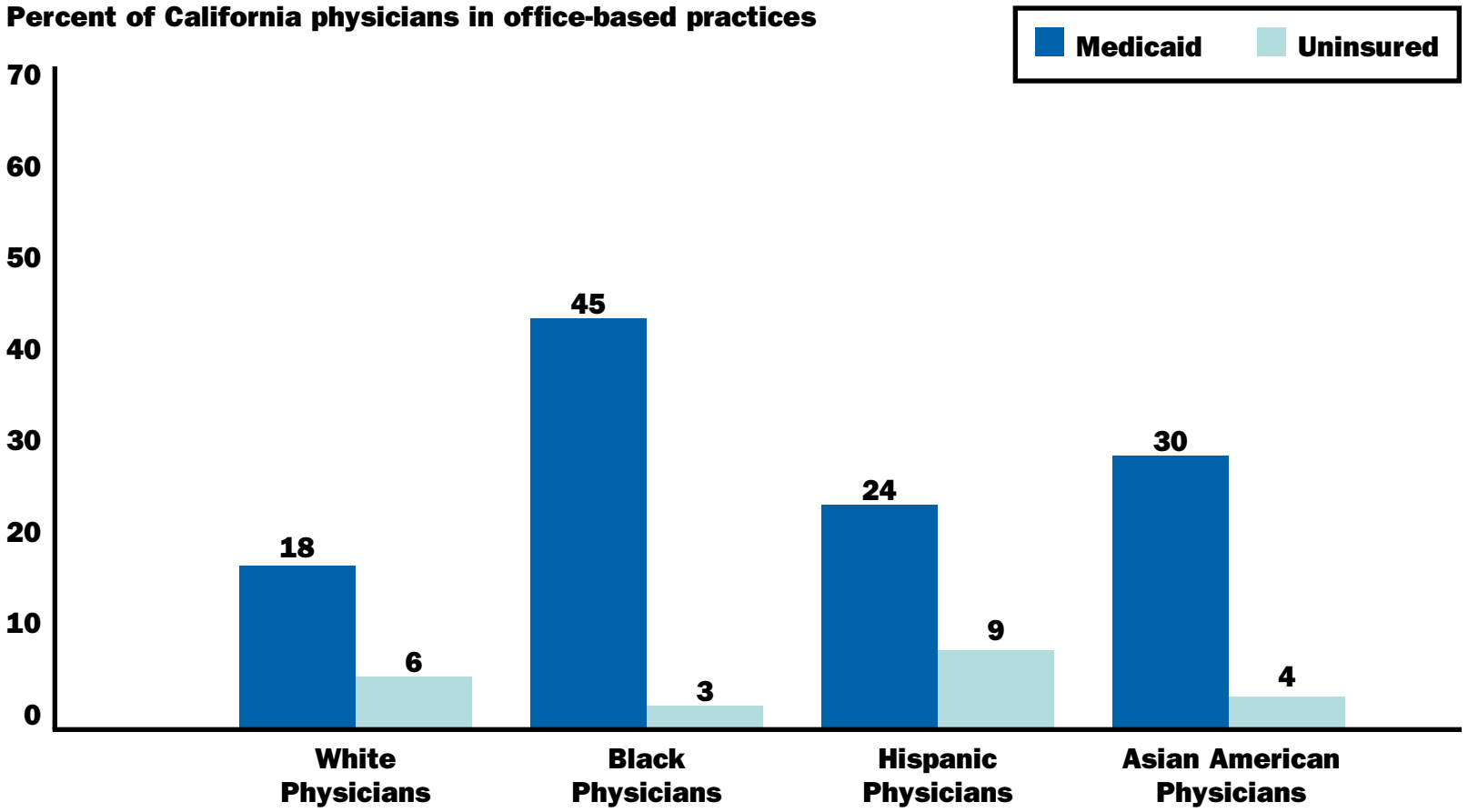
Physicians Who Treat Medicaid and Uninsured Patients, by Race and Ethnicity of the Physician, 1993

Minority physicians are often providing care for the most underserved populations.

- Black, Hispanic, and Asian American physicians are more likely to care for a large share of Medicaid patients (Komaromy et al., 1996).
- Hispanic physicians are likely to care for more uninsured patients (Komaromy et al., 1996).
- Racial concordance between patient and physician seems to improve patient satisfaction with health care. Blacks who see black physicians, for example, were almost two-and-one-half times more likely to rate their care as excellent than blacks who see physicians of other races (Saha et al., 1999).

Chart 6-2

Physicians Who Treat Medicaid and Uninsured Patients, by Race and Ethnicity of the Physician, 1993



Source: Komaromy et al., 1996.

THE COMMONWEALTH FUND

Chart 6-3

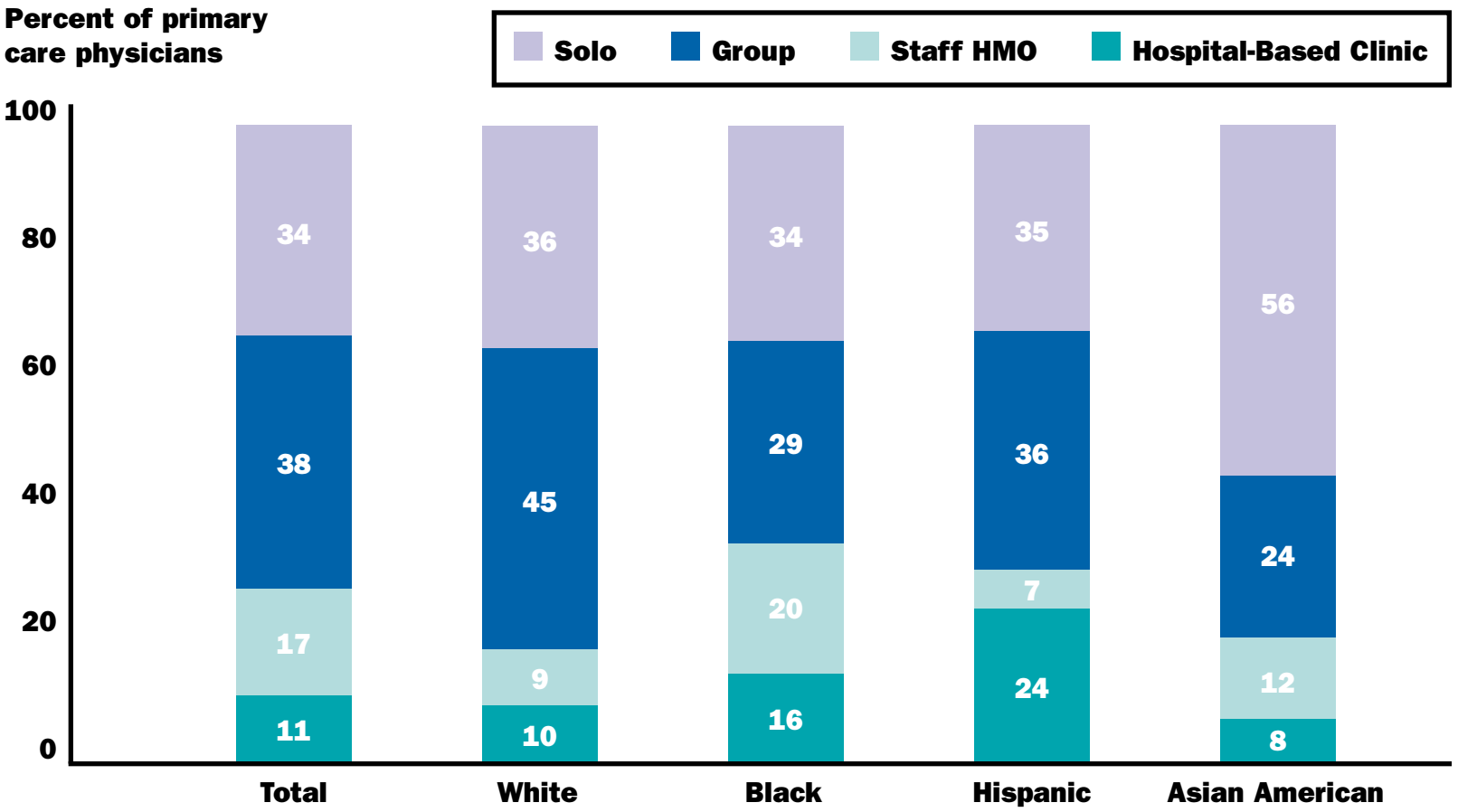
Types of Practice Arrangements Among Primary Care Physicians, by Race and Hispanic Origin, 1995

Types of practice arrangements vary across groups.

- Hispanic and black primary care physicians are more likely to work in hospital-based clinics than other physicians (Lavizzo-Mourey and Mackenzie, 1999).
- More than one-half of Asian American primary care physicians were in solo practice in 1995 (Lavizzo-Mourey and Mackenzie, 1999).
- Black primary care physicians were most likely to be part of a staff-model health maintenance organization (Lavizzo-Mourey and Mackenzie, 1999).

Chart 6-3

Types of Practice Arrangements Among Primary Care Physicians, by Race and Hispanic Origin, 1995



Source: Lavizzo-Mourey and Mackenzie, 1999.

THE COMMONWEALTH FUND

Chart 6-4

Minority Representation in Public Health and Nursing Professions

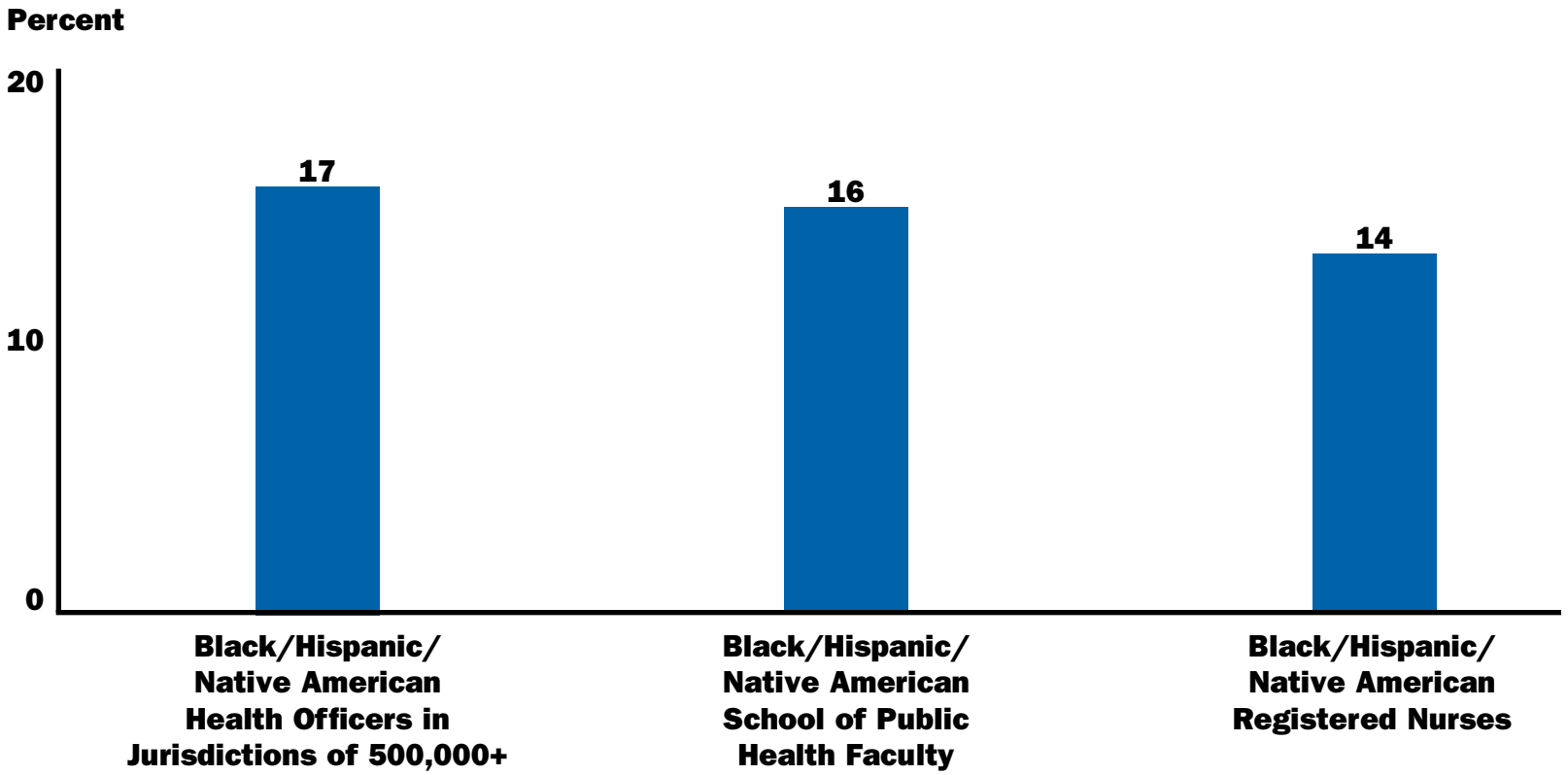
Minority representation among senior or leadership positions is greater in public health and nursing than in medicine, though still not at levels that reflect the overall population.

Blacks, Hispanics, and Native American professionals represent:

- 17 percent of city or county health officers in jurisdictions with more than 500,000 persons (National Association of County and City Health Officials and Centers for Disease Control and Prevention, 1995).
- 16 percent of faculty in schools of public health (Association of Schools of Public Health, 1997).
- 14 percent of registered nurses (National Center for Health Statistics, 1998).

Chart 6-4

Minority Representation in Public Health and Nursing Professions



Source: National Association of County and City Health Officials and Centers for Disease Control and Prevention, 1995.

Source: Authors' communications with Association of Schools of Public Health, 1997.

Source: National Center for Health Statistics, 1998.

THE COMMONWEALTH FUND

Chart 6-5
Minority Faculty Representation Among Medical Schools, 1997

Black, Hispanic, and Native Americans make up a small portion of medical school faculties and differ in their professional experiences.

- Six percent of medical school faculty positions are held by black, Hispanic, or Native Americans (Association of American Medical Colleges, 1998).
- Black and Asian American faculty members spend more time on patient care and less time on research, relative to white and Hispanic physicians (Palepu et al., 1998).
- Black physicians on medical school faculties spend 40 percent of their time caring for patients and 19 percent of their time conducting research. White doctors spend 32 percent of their time in patient care and 29 percent in research (Palepu et al., 1998).

Percent Distribution of U.S. Medical School Faculty, 1980, 1990, 1995, 1996, 1997 (all medical schools)

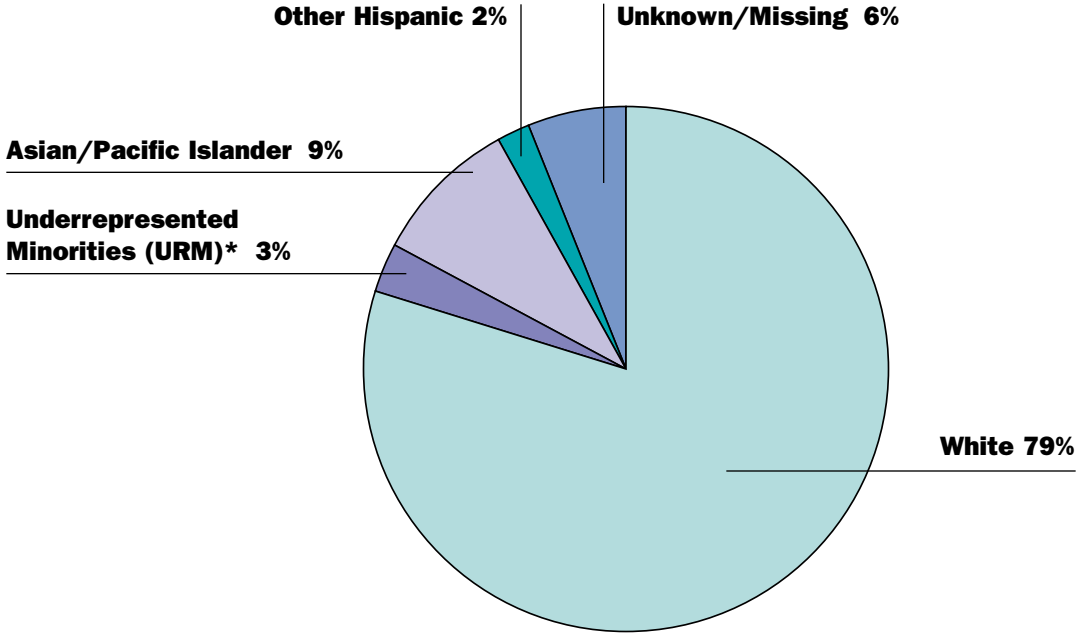
Total	1980	1990	1995	1996	1997
Black	1.7%	2.0%	2.5%	2.6%	2.6%
Native American	0.1%	0.1%	0.1%	0.1%	0.1%
Mexican American	0.2%	0.3%	0.9%	0.4%	0.4%
Puerto Rican	0.6%	0.7%	0.8%	0.8%	0.8%
Total URM	2.5%	3.1%	3.8%	3.9%	3.9%
White	82.8%	81.4%	80.1%	79%	78.9%
Asian American	6.6%	7.5%	8.7%	8.9%	9.1%
Other Hispanic	1.5%	1.5%	1.8%	1.8%	1.8%
Unknown/Missing	6.6%	6.5%	5.7%	6.4%	6.2%

Note: Sixteen percent of black faculty are at Howard, Morehouse, and Meharry; 53 percent of Puerto Rican faculty are at the three medical schools in Puerto Rico.

Source: Association of American Medical Colleges, 1998.

Chart 6-5

Minority Faculty Representation Among Medical Schools, 1997



*Black, Mexican American, mainland Puerto Rican, and Native American.

Note: Medical schools include those that are traditionally black and Puerto Rican. Sixteen percent of black faculty (373) hold faculty appointments at Howard University College of Medicine, Meharry Medical College, or Morehouse School of Medicine. Fifty-three percent of Puerto Rican faculty (358) are on faculty at Ponce, U. Puerto Rico, and U. Central del Caribe.

Source: Association of American Medical Colleges, 1998.

Chart 6-6
U.S. Medical School Graduates by Race, 1997

Blacks, Hispanics, and Native Americans remain underrepresented among medical school graduates.

- Eleven percent of medical school graduates in 1997 were underrepresented minorities (black, Mexican American, mainland Puerto Rican, or Native American) (Association of American Medical Colleges, 1998).
- The level of underrepresented minorities graduating from medical school has been increasing over the last 20 years, following the adoption of affirmative action policies by higher education beginning in 1969 (Bowen and Bok, 1998).

Percent of Medical School Graduates by Race and Ethnicity, 1979–1997

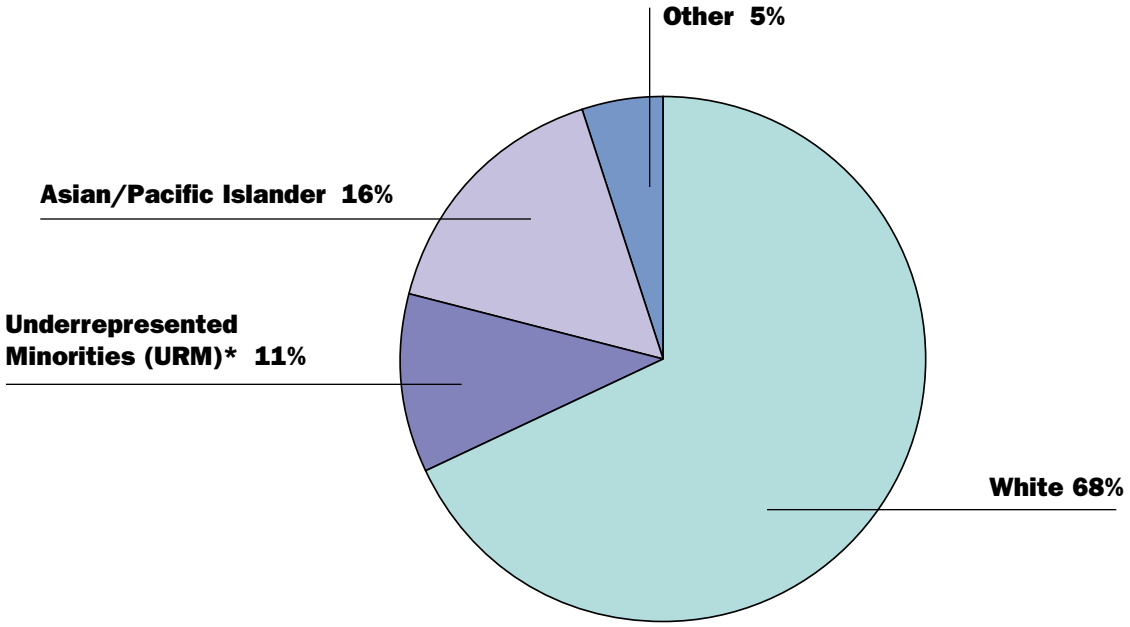
	1978–79	1980–81	1982–83	1984–85	1986–87	1988–89	1990–91	1992–93	1994–95	1996–97
Black	5.1	4.9	5.6	5.1	5.1	5.3	5.9	6.1	6.1	7.3
Native American	0.3	0.3	0.3	0.4	0.4	0.4	0.3	0.5	0.4	0.6
Hispanic[a]	1.7	1.6	1.9	2.0	1.9	2.2	2.4	2.3	2.5	2.8
Total URM	7.2	6.9	7.8	7.5	7.5	8.0	8.6	8.8	9.0	10.7
White	85.4	84.4	85.5	84.5	82.5	80.7	76.4	73.2	69.7	68.2
Asian	2.6	2.9	3.8	4.6	5.9	7.9	10.9	13.1	16.2	15.9
Other Hispanic[b]	1.3	1.7	2.7	2.9	2.8	1.9	3.1	3.0	3.2	3.2
Unknown[c]	3.5	4.1	0.4	0.5	1.2	0.3	1.0	1.9	1.9	2.2

[a] Includes both Mexican Americans and mainland Puerto Ricans.
[b] Includes both Commonwealth Puerto Ricans and other Hispanics.
[c] Includes foreign students; racial counts include only U.S. citizens and permanent residents.

Source: Association of American Medical Colleges, 1998.

Chart 6-6

U.S. Medical School Graduates by Race, 1997



*Black, Mexican American, mainland Puerto Rican, and Native American.

Source: Association of American Medical Colleges, 1998.

Chart 6-7
U.S. Medical School New Entrants by Race, 1996–97

The number of minority entrants to medical school has declined in the past two years.

- Nationwide, underrepresented minorities experienced a decline in matriculation from a high of 12.4 percent in 1994 to 10.9 percent in 1997. This represented declines across all groups, but larger declines for Native Americans, Mexican Americans, and mainland Puerto Ricans (Association of American Medical Colleges, 1998).
- From 1996 to 1997, the drop in underrepresented matriculants has been greatest in states with new anti-affirmative action policies—California (16% decline), Texas (29% decline), Louisiana (13% decline), and Mississippi (13% decline) (Association of American Medical Colleges, 1998).

Percentage of New Entrants for Each Racial/Ethnic Group, 1990–98

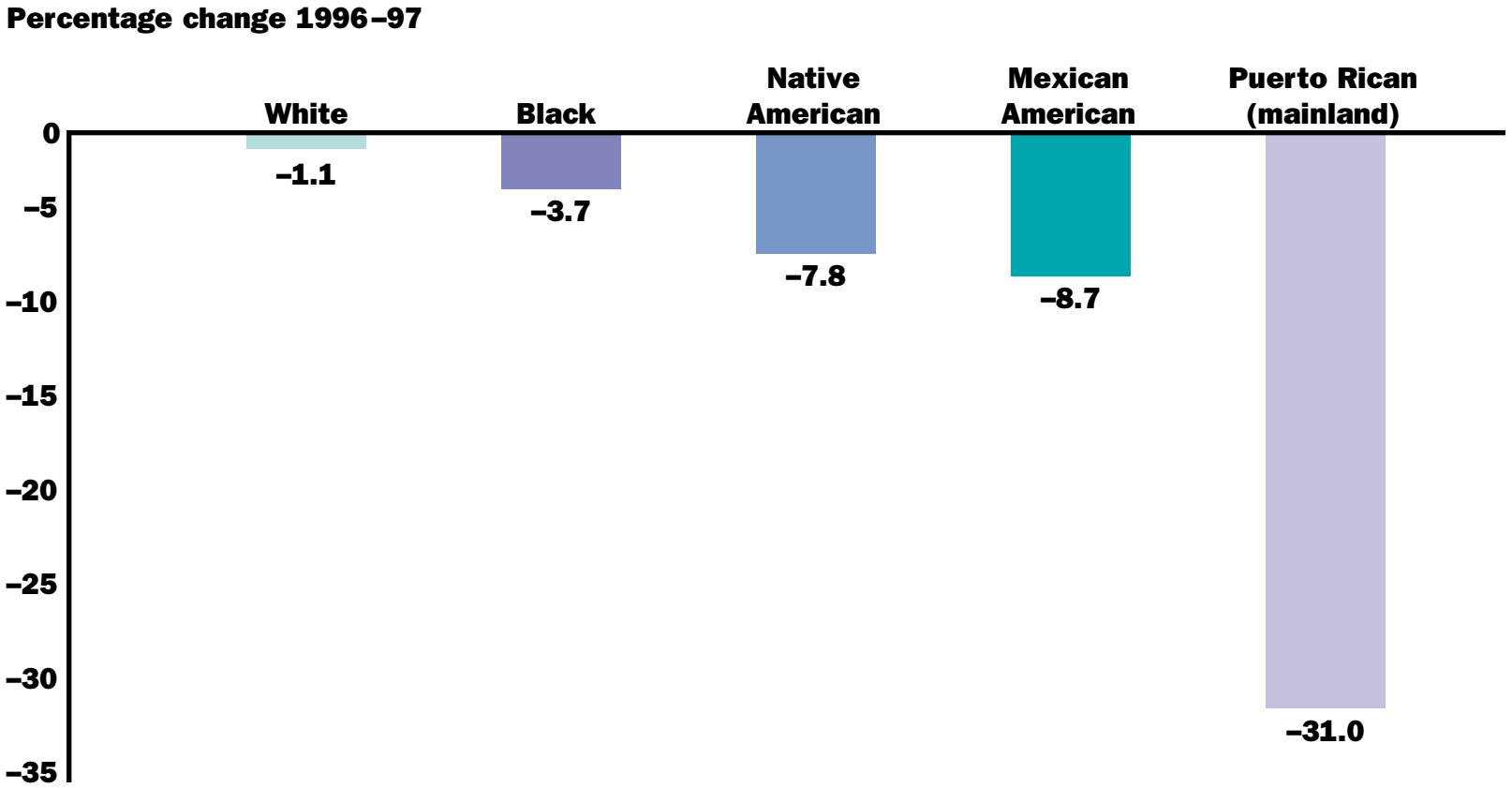
	1990–91	1991–92	1992–93	1993–94	1994–95	1995–96	1996–97	1997–98
Black	6.6	6.6	7.4	7.8	8.1	7.9	7.4	7.1
Native American	0.4	0.5	0.6	0.7	0.7	0.8	0.8	0.7
Hispanic[a]	2.2	2.7	3.2	2.9	3.6	3.6	3.6	3.1
Total URM	9.2	9.8	11.2	11.4	12.4	12.3	11.8	10.9
White	71.1	69.4	68.7	67.9	65.8	64.9	65.5	65.0
Asian	15.2	16.3	15.5	16.4	17.4	18.2	18.2	19.6
Other Hispanic[b]	3.1	3.1	3.0	3.1	3.0	3.2	3.3	3.0
Unknown[c]	1.5	1.4	1.5	1.2	1.5	1.3	1.2	1.4

[a] Includes both Mexican Americans and mainland Puerto Ricans.
[b] Includes both Commonwealth Puerto Ricans and other Hispanics.
[c] Includes foreign students; racial counts include only U.S. citizens and permanent residents.

Source: Association of American Medical Colleges, 1998.

Chart 6-7

U.S. Medical School New Entrants by Race, 1996–97



Source: Association of American Medical Colleges, 1998.

References

References

American Cancer Society. *Cancer Facts and Figures–1998*. Atlanta, GA: American Cancer Society, Inc., 1998.

American Dental Association. *Distribution of Dentists in the United States by Region and State*. Chicago, IL: 1995.

Anderson, R., K. Kochanek, and S. Murphy. "Report of the Final Mortality Statistics, 1995," *Monthly Vital Statistics Report* 45(June 12, 1997), supplement 2. Hyattsville, MD: National Center for Health Statistics.

Association of American Medical Colleges. *Minority Students in Medical Education: Facts and Figures XI*. Washington, DC: 1998.

Barber, K.R., R. Shaw, M. Folts, D.K. Taylor, et al. "Differences Between African American and Caucasian Men Participating in a Community-Based Prostate Cancer Screening Program," *Journal of Community Health* 23(1998):441-51.

Bennett, C.L., M.R. Ferreira, T.C. Davis, J. Kaplan, et al. "Relation Between Literacy, Race, and Stage of Presentation Among Low-Income Patients with Prostate Cancer," *Journal of Clinical Oncology*, 16(1998):3101-4.

Blustein, J. and L. Weiss. "Visits to Specialists Under Medicare: Socioeconomic Advantage and Access to Care," *Journal of Health Care for the Poor and the Underserved*, 9(1998):153-69.

Bowen, W.G. and D. Bok. *The Shape of the River: Long-Term Consequences of Considering Race in College and University Admissions*. Princeton, NJ: Princeton University Press, 1998.

Bureau of Health Professions. *Detailed Occupation and Other Characteristics from the EEO File for the United States*, 1990 Census of Population Supplementary Reports. Rockville, MD: 1990.

Centers for Disease Control and Prevention. "Youth Risk Behavior Surveillance–United States, 1997," *Morbidity and Mortality Weekly Report*. Atlanta, GA: 1998.

Chin, M.H., J. X. Zhang, K. Merrell. "Diabetes in the African-American Population: Morbidity, Quality of Care and Resource Utilization," *Diabetes Care*, 21(1998):1090-95.

The Commonwealth Fund. *The Commonwealth Fund 1998 Survey of Women's Health*. New York, NY: 1998.

The Commonwealth Fund. *The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care*. New York, NY: 1995.

The Commonwealth Fund. *The Commonwealth Fund 1993 Survey of Women's Health*. New York NY: 1993.

Cornelius, L.J. and Z. Suarez. "What Accounts for the Dependency of African Americans and Hispanics on Hospital-Based Outpatient Care," in M.D. Lillie-Blanton, W. A. Leigh, and A. Alfaro-Correa (eds.), *Achieving Equitable Access: Studies of Health Care Issues Affecting Hispanics and African Americans*. Washington, DC: Joint Center for Political and Economic Studies: 1996.

Council of Economic Advisers and National Center for Health Statistics. *Changing America: Indicators of Social and Economic Well-Being by Race and Hispanic Origin*. Washington, DC: 1998.

Council on Graduate Medical Education. *Minorities in Medicine, Twelfth Report*. Rockville, MD: 1998.

Dalaker, J. and M. Naifeh. *Poverty in the United States: 1997. Current Population Reports,* series P60-201. Washington, DC: U.S. Bureau of the Census, 1998.

Day, J.C. *Population of the United States by Age, Sex, Race, and Hispanic Origin: 1995 to 2050. Current Population Reports,* series P25-1130. Washington, DC: U.S. Bureau of the Census, 1996.

Day, J.C. and A. E. Curry. *Educational Attainment in the United States: March 1998 (Update). Current Population Reports,* series P20-513. Washington, DC: U.S. Bureau of the Census. 1998.

Donovan, P. "Falling Teen Pregnancy Birthrates: What's Behind the Declines?," *The Guttmacher Report: On Public Policy* 1(1998).

Fried, V.M., D.M. Malsuc, and R.N. Rooks. "Ambulatory Health Care Visits by Children: Principal Diagnosis and Place of Visit," *Vital and Health Statistics*, series 13, no. 137. Rockville, MD: National Center for Health Statistics, 1998.

Fronstin, P. "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1997 *Current Population Survey,*" EBRI Issue Brief no. 178. Washington, D.C.: 1998

Gage, L., L. Fagnani, J. Tolbert, and C.C. Burch. *The Safety Net in Transition: America's Uninsured and Underinsured–Who Cares?* Monograph no. 8. Washington, DC: National Association of Public Hospitals and Health Systems, 1998.

Gaskin, D., and J. Hadley. "Population Characteristics of Safety Net Hospitals and Other Urban Hospitals," report to The Commonwealth Fund. New York, NY: 1997.

Gornick, M.G., P.W. Eggers, T.W. Reilly, R.M. Mentnech, et al. "Effects of Race and Income on Mortality and Use of Services Among Medicare Beneficiaries," *New England Journal of Medicine* 335(Sept.12, 1996):791–99.

Greenfeld, L.A. et al. *Violence by Intimates: Analysis of Data on Crimes by Current or Former Spouses, Boyfriends, and Girlfriends.* Washington, DC: Bureau of Justice Statistics: 1998.

Hall, A.G., K.S. Collins, and S. Glied. *Employer-Sponsored Health Insurance: Implications for Minority Workers*. New York, NY: The Commonwealth Fund: 1999.

Harvard School of Public Health Office of Development and Alumni Relations. "Study Finds 'Life Gap" in U.S," *Harvard Public Health Review,* 1998. http://www.hsph.harvard.edu//review/life_gap.html

Hayes, R.B., R.G. Ziegler, G. Gridley, C. Swanson, et al. "Dietary Factors and Risks for Prostate Cancer Among Blacks and Whites in the United States," *Cancer Epidemiology Biomarkers Prevention*, 8(1999):25-34.

Health Care Financing Administration. *National Summary of State Medicaid Managed Care Programs–June 30, 1997*. www.hcfa.gov (1998).

Hessol, N.A., E. Fuentes-Afflick, P. Bacchetti. "Risk of Low Birth Weight Infants Among Black and White Parents," *Obstetrics and Gynecology,* 92(1998):814-22.

Kaste, L.M., R.H. Selwitz, R.J. Oldakowski, J.A. Brunelle, et. al. "Coronal Caries in the Primary and Permanent Dentition of Children and Adolescents 1-17 Years of Age: United States, 1988-1991," *Journal of Dental Research* 73(1996):631-41.

Komaromy, M., K. Grumbach, M. Drake, K. Vranizan, et al. "The Role of Black and Hispanic Physicians in Providing Health Care for Underserved Populations," *The New England Journal of Medicine* 334(1996):1305-10.

Lannin, D.R., H. Mathews, J. Mitchell, M. Swanson, et al. "Influence of Socioeconomic and Cultural Factors on Racial Differences in Late-Stage Presentation of Breast Cancer," *Journal of the American Medical Association* 279(June 10, 1998):1801-7.

LaVeist, T. and C. Diala. "Social Status and Perceived Discrimination: Who Experiences Discrimination in the Health Care System, How, and Why?," report to The Commonwealth Fund. New York, NY: 1998.

Lavizzo-Mourey, R. and E. Mackenzie. *Experiences of Minority Physicians with Managed Care: A National Survey*, report to The Commonwealth Fund. New York, NY: 1999.

Lillie-Blanton, M., and A. Alfaro-Correa. *In the Nation's Interest: Equity in Access to Health Care*. Washington DC: Joint Center for Political and Economic Studies, 1995.

Lugaila, T.A. *Marital Status and Living Arrangements: March 1998 (Update). Current Population Reports*. Rockville, MD: U.S. Bureau of the Census, 1998.

Mackenzie, E., L. Taylor, and B. Bloom. Analysis of *The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care*, Institute of Aging, University of Pennsylvania, 1999.

MacDorman, M.F., and J.O. Atkinson. "Infant Mortality Statistics from the 1996 Period Linked Birth/Infant Death Data Set," *Monthly Vital Statistics Report* 46(1998), supplement. Hyattsville, MD: National Center for Health Statistics.

Makuc, D., N. Breen, and V. Freid. "Low Income, Race, and the Use of Mammography," *Health Services Research* 34(1996):229-39.

Mandelblatt, J., H. Andrews, R. Kao, and R. Wallace, et al. "Impact of Access and Social Context on Breast Cancer Stage at Diagnosis," *Journal of Health Care for the Poor and Underserved* 6(1995):342-51.

McCarthy, E.P., R.B. Burns, S.S. Coughlin, K.M. Freund, et al. "Mammography Use Helps to Explain Differences in Breast Cancer Stage at Diagnosis Between Older Black and White Women," *Annals of Internal Medicine*, 128(1998):729-36.

Miller, B.A., L.N. Kolonel, L. Bernstein, J.L. Young, Jr., et al. *Racial/Ethnic Patterns of Cancer in the United States: 1988–1992*. Bethesda, MD: National Cancer Institute, 1996.

Morbidity and Mortality Weekly Report. "Decrease in Infant Mortality and Sudden Infant Death Syndrome Among Northwest American Indians and Alaskan Natives-Pacific Northwest, 1985-1996," *Morbidity and Mortality Weekly Report*, 48(1999):181-84.

National Association of County and City Health Officials and Centers for Disease Control and Prevention. *1992–1993 National Profile of Local Health Departments*. Washington, DC and Atlanta, GA: 1995.

National Center for Health Statistics. *Health, United States, 1998 with Socioeconomic Status and Health Chartbook*. Hyattsville, MD: 1998.

National Vital Statistics System. "The Initiative to Eliminate Racial and Ethnic Disparities in Health," raceandhealth.hhs.gov/secrac1f.gif (1999).

Palepu, A., P.L. Carr, R.H. Friedman, H. Amos, et al. "Minority Faculty and Academic Rank in Medicine," *Journal of the American Medical Association*, 280(1998):767-71.

Perez-Stable, E.J. et al. "Nicotine Metabolism and Intake in Black and White Smokers," *Journal of the American Meidcal Association* 280(July 8, 1998):152-56.

Peters, K.D., K.D. Kochanek, S.L. Murphy, et al. "Deaths: Final Data for 1996," *National Vital Statistics Report* 47(1998). Rockville, MD: National Center for Health Statistics.

Rand, M. *Criminal Victimization 1997: Changes 1996–97 with Trends 1993–97*. Washington, DC: Bureau of Justice Statistics, 1998.

Ray, B.J., S.C. Metcalf, S.M. Franco, and C.K. Mitchell. "Infant Sleep Position Instruction and Parental Practice: Comparison of a Private Pediatric Office and an Inner-City Clinic," *Pediatrics*, 99(1997):E12.

Rowley, D.L. "Framing the Debate: Can Prenatal Care Help to Reduce the Black-White Disparity in Infant Mortality?," *Journal of the American Medical Women's Association*, 50(1995):187-93.

Saha, S., M. Komaromy, T. Koepsell, and A. Bindman. "Patient-Physician Racial Concordance and the Perceived Quality and Use of Health Care," accepted by the *Archives of Internal Medicine,* 1999.

Schoendorf, K., C.J. Hogue sJ.C. Kleinman, and D. Rowley. "Mortality Among Infants of Black as Compared with White College-Educated Parents," *New England Journal of Medicine*, 326(1992):1522-6.

Schulman, K.A., J.A. Berlin, W. Harless, J.F. Kerner, et al. "The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization," *New England Journal of Medicine*, 340(1999):618-26.

Simms, M. "Black Poverty Reaches a Record Low," *Focus* 26(November 1998). Washington, DC: Joint Center for Political and Economic Studies.

Sonnenstein, F.L., L. Ku, L.D. Lindberg, C.F. Turner, et al. "Changes in Sexual Behavior and Condom Use Among Teenaged Males: 1988 to 1995," *American Journal of Public Health*, 88(1998):956-59.

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *1997 National Household Survey on Drug Abuse.* Rockville, MD: 1998.

Thurm, K. "Adult Immunizations Save Lives," *Closing the Gap*. Rockville, MD: Office of Minority Health, 1998.

U.S. Bureau of the Census. *Money Income in the United States: 1997. Current Population Reports,* series P60-200. Washington, DC: 1998.

U.S. Bureau of Labor Statistics. "Current Labor Statistics," *Monthly Labor Review Online*, www. stats.bls.gov/opub/mlr/curlabst.htm (1999).

U.S. Bureau of Labor Statistics and U.S. Bureau of the Census, *The Employment Situation: April 1998.* www.bls.census.gov/cps/pub/empsit_0498.htm.

Ventura, S.J, M.S. Mathews, et. al. "Declines in Teenage Birth Rates, 1991-97: National and State Patterns," *National Vital Statistics System*, 47(1998). Hyattsville, MD: National Center for Health Statistics.[a]

Ventura, S.J., K.D. Peters, J.A. Martin, J.D. Maurer. "Births and Deaths: United States, 1996," *Monthly Vital Statistics Report,* 46(1997) Supplement 2. Hyattsville, MD: National Center for Health Statistics.[b]

Williams, D.R. "Race, Stress, and Mental Health," report to The Commonwealth Fund. New York, NY: 1998.

Yax, L.K. *National Estimates: Annual Population Estimates by Sex, Race, and Hispanic Origin, Selected Years from 1990 to 1998*. U.S. Bureau of the Census, Population Division: 1999.

Appendix

Appendix

A variety of data sources where used in compiling this chartbook, including the authors' analyses of several Commonwealth Fund surveys and federally funded national surveys. Following are descriptions of these surveys.

The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care. The survey consisted of 25-minute telephone interviews by Louis Harris and Associates, Inc., from May 1994 to July 1994. The survey sample of 3,789 adults age 18 and older included 1,114 whites, 1,048 African Americans, 1,001 Hispanics, and 632 Asian Americans (including 205 Chinese, 201 Korean, and 201 Vietnamese Americans). Interviews were conducted in English, Spanish, Mandarin, Cantonese, Korean, and Vietnamese. The sample was designed to contact nationally representative samples of adults in telephone households in the 48 contiguous United States. The data were weighted to the 1993 *Current Population Survey* on the basis of gender, race, age, educational attainment, and health insurance status.

The Commonwealth Fund 1993 Survey of Women's Health. Louis Harris and Associates, Inc., conducted 25-minute telephone interviews with 2,854 women and 1,000 men age 18 and older from February to March 1993. The sample included an oversample of 439 African American women and 405 Hispanic women. The data were weighted by age, race, education, insurance status, and census regions to the 1992 *Current Population Survey*. A second round consisting of 2,850 women and 1,500 men was completed in 1998. This round included 429 African American, 404 Hispanic, and 400 Asian American women.

Kaiser/Commonwealth 1997 National Survey of Health Insurance. The survey of 4,001 adults age 18 and older was conducted by Louis Harris and Associates, Inc., from November 1996 to March 1997. The total sample consisted of 3,761 adults interviewed by telephone and 240 adults interviewed in-person (because they did not have telephones in their homes). The data were weighted to the March 1996 *Current Population Survey* for accurate representation of Americans by sex, race, age, education and health insurance status. The sample includes 413 African Americans and 296 Hispanics.

Commonwealth Fund 1997 Survey of the Health of Adolescent Girls. This survey consisted of in-class questionnaires completed by 6,748 students (3,586 girls and 3,162 boys) in grades 5 through 12 and a separate sample of 218 high school dropouts. The total sample included 3,615 whites, 949 blacks, and 622 Hispanics. The classroom sample included a nationally representative cross-section of schools, with 265 public, private, and parochial schools participating. The sample also consisted of an oversample of 32 urban schools. The fieldwork was conducted from December 1996 to June 1997. The data were weighted to reflect known distributions of adolescents by grade, region, race, ethnicity, and gender.

Current Population Survey, 1997 March Supplement. The *March Supplement,* also known as the *Annual Demographic Survey,* is conducted by the U.S. Census Bureau each year and provides detailed information on income and work experience in the United States. Information is gathered on a variety of sources of income, including noncash sources such as food stamps, health insurance, and energy assistance, for persons age 15 and older. Approximately 62,500 households were surveyed—90 percent over the telephone.

1996 Medicare Current Beneficiary Survey. The *MCBS* is a longitudinal in-person survey of 16,000 community-dwelling beneficiaries. The primary goal of the *MCBS* is to determine sources of payment for services rendered to Medicare beneficiaries and to determine types of health insurance coverage for each recipient. The survey is sponsored by the Health Care Financing Administration.

1996 Medical Expenditure Panel Survey. The *MEPS* collects data on the specific health services that Americans use, how frequently they use them, the costs of these services, and how they are paid. Data are also collected on the cost, scope, and breadth of health insurance. The 1996 *MEPS* is the most recent in a series of medical expenditure surveys that began in 1977. The household component collects data on 10,500 families and 24,00 individuals. The Agency for Health Care Policy and Research began fielding the *MEPS* in March 1996 in conjunction with the National Center for Health Statistics.

1994 National Health Interview Survey. The *NHIS* is nationwide survey collected via household interviews. Each week a probability sample of the civilian noninstitutionalized population of the United States is interviewed by personnel of the U.S. Census Bureau. Information is obtained about the health and other characteristics of each member of the household. The interviewed sample for 1994 consisted of 45,705 households containing 116,179 persons.