

# Key Facts

## Race, Ethnicity & Medical Care

October 1999





## INTRODUCTION

The Henry J. Kaiser Family Foundation is pleased to release, *Key Facts: Race, Ethnicity, and Medical Care*, which is intended to serve as a quick reference source on the health, health coverage, and health care use of minority Americans. Recent concern about racial and ethnic disparities in the health of Americans has resulted in a number of public and private sector efforts to better understand and address the multiple factors that contribute to the poorer health outcomes of minority Americans. A lack of data and limited research on very diverse ethnic subgroups have hampered understanding of the problems and development of interventions to reduce long-standing racial and ethnic disparities in health.

*Key Facts* provides highlights from the best available data and research, and focuses on one of the many factors shaping the health and well-being of a population group -- medical care. While some would argue that economic and environmental factors are more important determinants of a population's health than medical care, the benefits of medical care in preventing and reducing the burden of illness, injury, disability and premature death are undeniable. As such, we review key health and health care indices to provide a common base of knowledge from which to assess the disparities and possible interventions to address them, if needed. The document provides a selective rather than exhaustive review of the literature. In sum, when researchers have made an effort to control for possible explanatory factors (most importantly, socio-economic conditions, insurance, and disease severity) racial and ethnic disparities are often reduced, and may even disappear under certain circumstances. Nonetheless, the research shows that racial and ethnic inequalities in medical treatment persist in significant measure for many diseases.

This publication is divided into five sections, beginning with an overview of the socio-demographic characteristics of the U.S. population. Section II presents health indices generally stratified by some measure of socio-economic conditions. Section III describes the health insurance coverage of persons under age 65 and aged 65 and older. Sections IV and V present findings from key studies on racial and ethnic differences in access to preventive and primary care and on the use of medical care for specific conditions. The latter two sections draw largely from a synthesis of the literature prepared for the Kaiser Family Foundation by Robert Mayberry and colleagues from the Morehouse Medical Treatment Effectiveness Center (Mayberry et al 1999).



## Section I

# Socio-Demographic Characteristics

## Socio-Demographic Characteristics

- An estimated 1 in 4 Americans (about 67 million) is classified by the U.S. Census as a member of one of the four major racial or ethnic minority population groups: African American, Latino/Hispanic, Native American, or Asian/Pacific Islander.<sup>1</sup> **(Figure 1)**
- Latinos almost equal African Americans in number, representing almost half of minority Americans; and, they are projected to be the largest racial/ethnic minority population by 2025.
- By the year 2050, the U.S. Census estimates that people of color will represent 1 in 3 Americans. This is largely due to higher birth rates and immigration among racial and ethnic minority populations. **(Figure 2)**
- Diversity is found not only between the major U.S. minority population groups, but within them as well. Using Latinos as an example, the health beliefs or practices of a person with origins in Puerto Rico may differ greatly from those of someone from Mexico or El Salvador.
- Minority Americans, on average, are poorer than whites. While more than 20% of whites are poor or near poor (i.e., incomes below 200% of poverty), at least one-half of African Americans, Latinos, and Native Americans are poor or near poor. **(Figure 3)**
- Similarly, elderly minority Americans are far more likely than their white counterparts to live in poverty. **(Figure 4)**

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<sup>1</sup> After October 1997, the Office of Management and Budget Standards for Maintaining, Collecting and Presenting Federal Data on Race and Ethnicity specified that data should be collected for 5 groups as the Asian/Pacific Islander classification was split into "Asians" and "Native Hawaiians or Other Pacific Islanders."

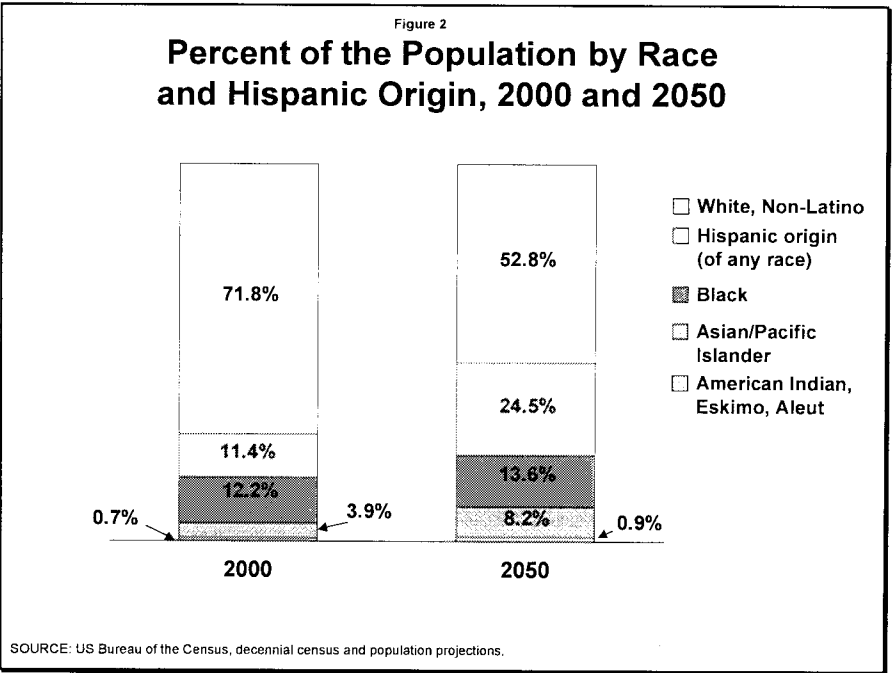
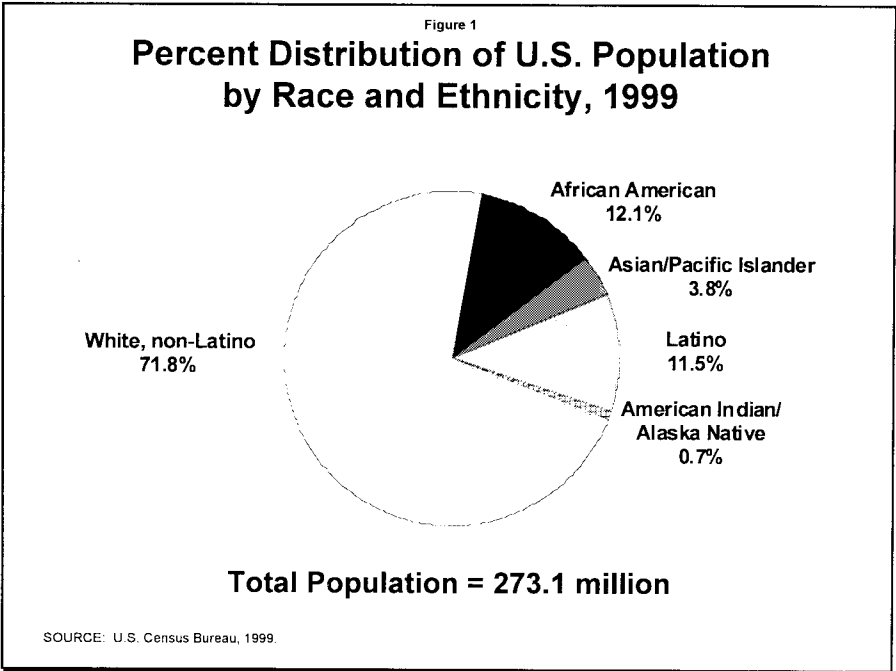
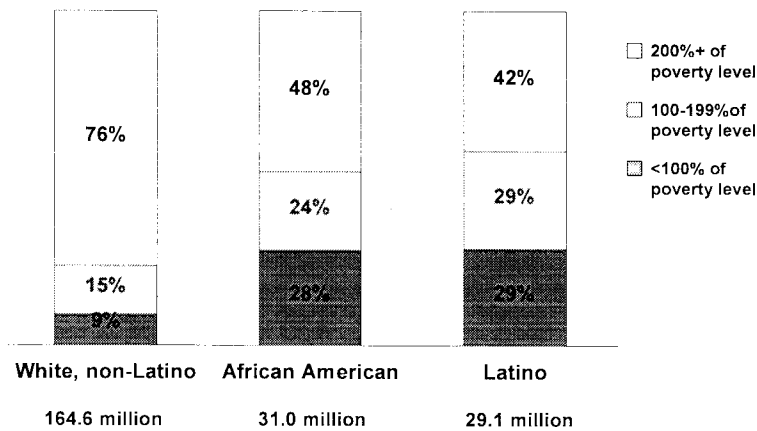


Figure 3

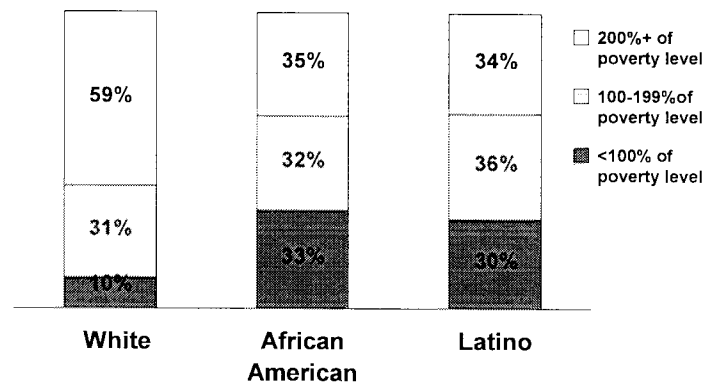
### Poverty Status of the Nonelderly Population, by Race/Ethnicity, 1997



SOURCE: March 1998 Current Population Survey.

Figure 4

### Poverty Status of the Elderly Population, by Race/Ethnicity, 1996



Note: "Latino" refers to U.S. residents self-describing as being of Hispanic origin regardless of country of birth or citizenship. Excludes other races (Asian-Pacific Islanders, American Indians, Eskimos, and Aleuts).

SOURCE: Kaiser Family Foundation, *The Faces of Medicare*.



Section II

Health

## Health

- At each age of the life-span until age 44, African Americans, Latinos, and Native Americans have, on average, higher mortality rates than whites. Only Asians have, on average, lower mortality rates than whites. However, data aggregating diverse ethnic groups mask the higher mortality rates of particular Asian subpopulations, such as Vietnamese. **(Figure 5)**
- When overall mortality is examined by a measure of socio-economic conditions (e.g, income), differences between African Americans and whites are reduced but not eliminated. **(Figure 6)**
- Infant mortality rates, considered one of the most sensitive indicators of the health and well-being of a population, are twice as high among African American infants as whites, even when analyzed by a measure of socio-economic conditions, such as the mother's education. **(Figure 7)**
- African Americans are more likely to rate their health as fair or poor than whites of similar incomes, however, this disparity is smaller between those with higher incomes than between those with lower incomes. As a group, Latinos tend to rate their health more closely to whites than do African Americans. **(Figure 8)**
- In 1996, the top five leading causes of death for whites and minority Americans were very similar, with heart disease and cancer ranking number one and two across all groups. However, in the past decade deaths due to HIV/AIDS have increased dramatically in the African American and Latino populations, moving this disease to the top five causes of death for both groups. **(Figure 9).**

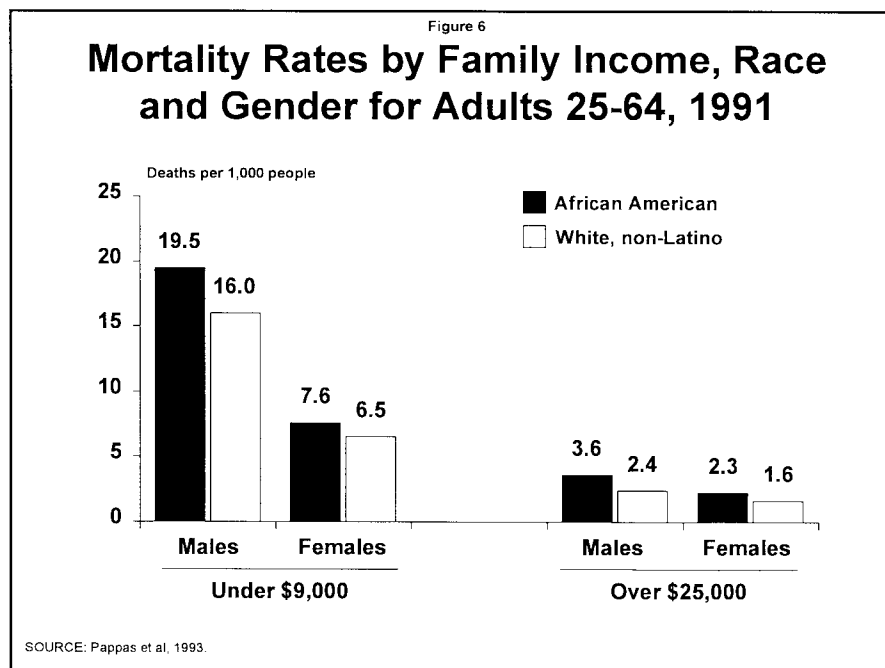
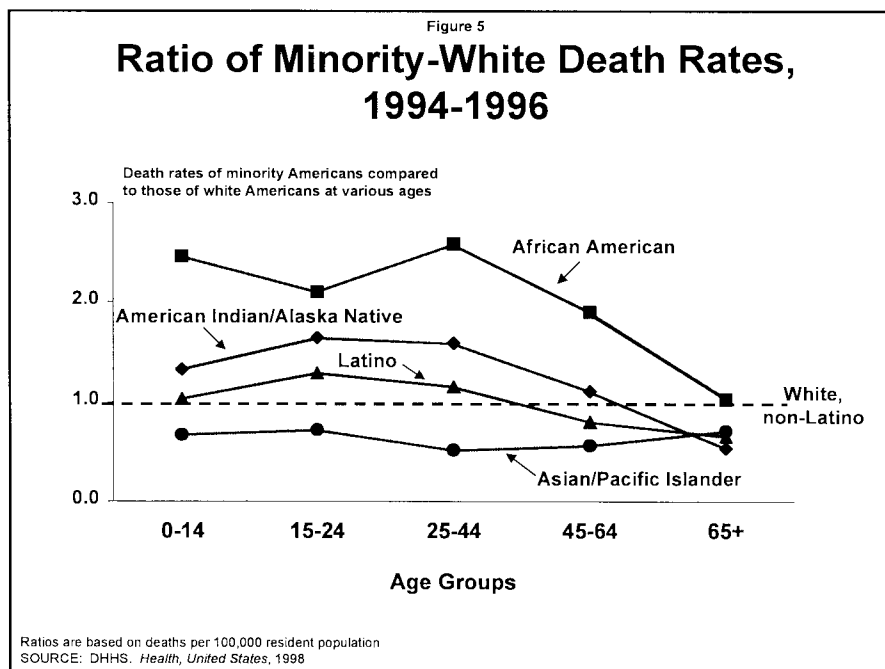
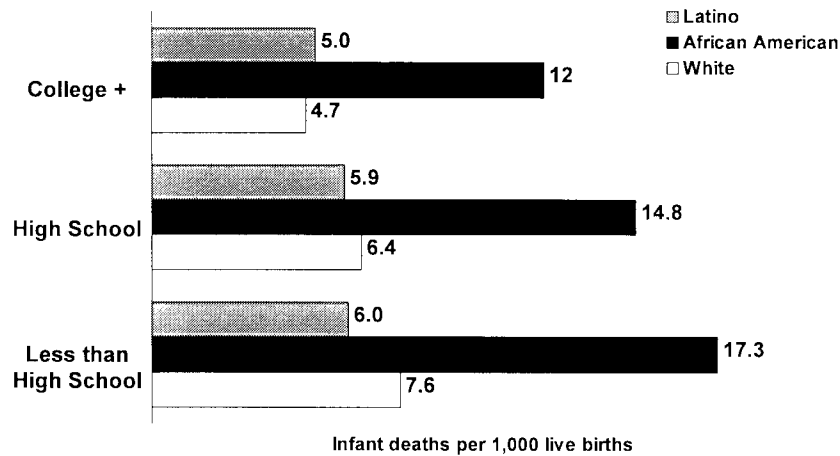


Figure 7

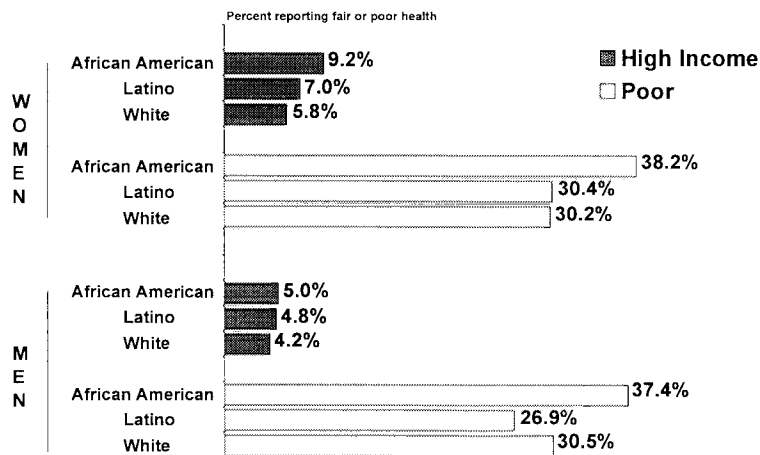
## Infant Mortality Rates: Mothers 20+ years by Education and Race/Ethnicity, 1995



DATA: CDC National Center for Health Statistics  
SOURCE: DHHS. *Health, United States*, 1998

Figure 8

## Fair or Poor Health by Race, Gender, and Family Income, 1995



SOURCE: DHHS. *Health, United States*, 1998.

Figure 9

## Leading Causes of Death by Race and Ethnic Group, 1996

	Rank	White, non-Hispanic	African American	Latino	Native American	Asian American
Cause of Death	1	Heart disease	Heart disease	Heart disease	Heart disease	Heart Disease
	2	Cancer	Cancer	Cancer	Cancer	Cancer
	3	CVD	CVD	AUI	AUI	CVD
	4	Chronic lung disease	HIV/AIDS	CVD	Diabetes	AUI
	5	AUI	AUI	HIV/AIDS	CVD	Pneumonia and influenza

**AUI = accidents and unintentional injuries**

**CVD= cerebrovascular disease**

DATA: National Center for Health Statistics, 1998

SOURCE: DHHS. *Health, United States, 1998.*



## Section III

# Health Coverage

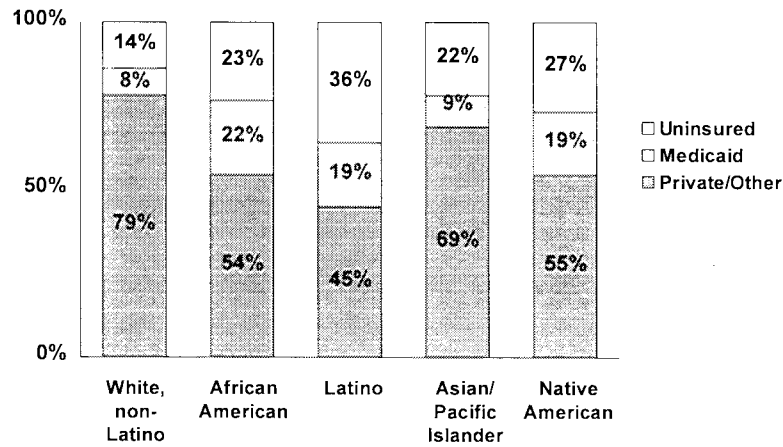
## Health Coverage

- Minority Americans are at least twice as likely to be uninsured as whites, largely reflecting lower rates of private coverage. Latinos are the most likely to be uninsured with about 1 in 3 (36%) nonelderly persons uninsured in 1997. This compared to 14% of whites who were uninsured in 1997. **(Figure 10)**
- Medicaid is a particularly important source of coverage for minority Americans, providing health insurance for about 1 in 5 nonelderly African Americans, Latinos, and Native Americans compared to less than 1 in 10 nonelderly whites. **(Figure 10)**
- Among the low-income population (incomes below 200% of poverty), Medicaid rivals private insurance as a major source of coverage. For example, more than one-third of low-income African Americans (39%) and Native Americans (36%) have Medicaid coverage compared to 32% and 27%, respectively, who have private coverage. **(Figure 11)**
- Of the 26 million Medicaid beneficiaries in 1997, roughly half are white and half are minority Americans. Medicaid's larger role in providing coverage among minority Americans reflects the relatively lower incomes of the population groups and the program's mission in providing health and long-term care services for the low-income population. **(Figure 12)**
- Minority Medicare beneficiaries are far more likely than whites to rely solely on the traditional Medicare program for insurance protection. About a quarter of African American and Latino beneficiaries have no supplemental coverage, compared with 10 percent of all whites. **(Figure 13)**



Figure 10

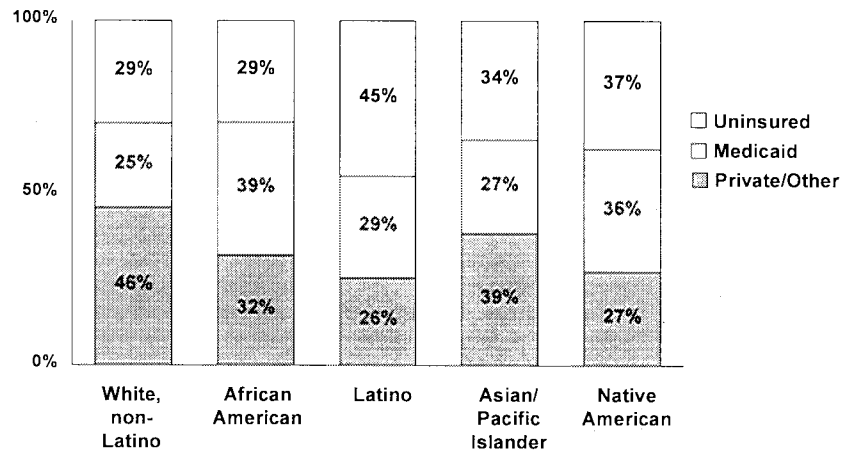
### Health Insurance Status, by Race and Ethnicity, 1997: Total Nonelderly Population



DATA: Urban Institute analysis of the March 1998 Current Population Survey  
SOURCE: KCMU, *Medicaid Today: Profile of a Program and The People it Covers*, 1999

Figure 11

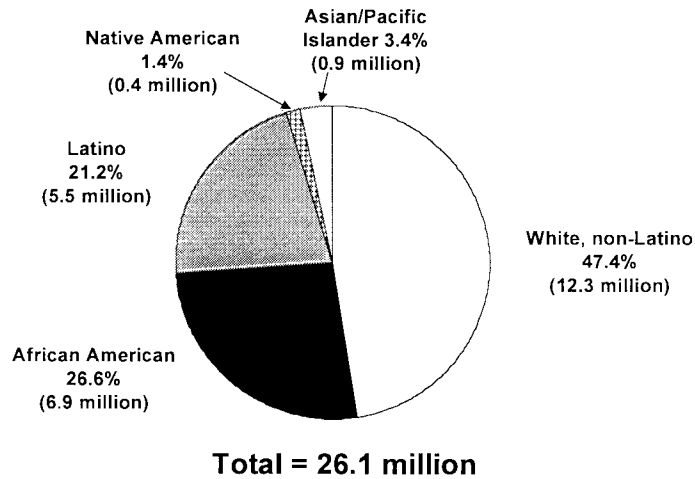
### Health Insurance Status, by Race and Ethnicity, 1997: Low-Income\* Nonelderly Population



\*Low-income is defined as 200% below the federal poverty level  
DATA: Urban Institute analysis of the March 1998 Current Population Survey  
SOURCE: KCMU, *Medicaid Today: Profile of a Program and The People it Covers*, 1999

Figure 12

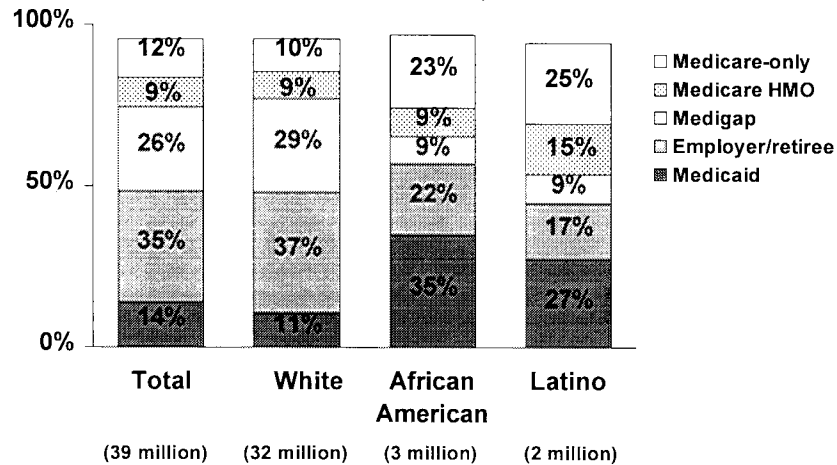
## Profile of Non-Elderly Medicaid Population, 1997



DATA: Urban Institute analysis of the March 1998 Current Population Survey  
 SOURCE: KCMU, *Medicaid Today: Profile of Program and The People it Covers*, 1999

Figure 13

## Supplemental Coverage of Medicare Beneficiaries, 1995



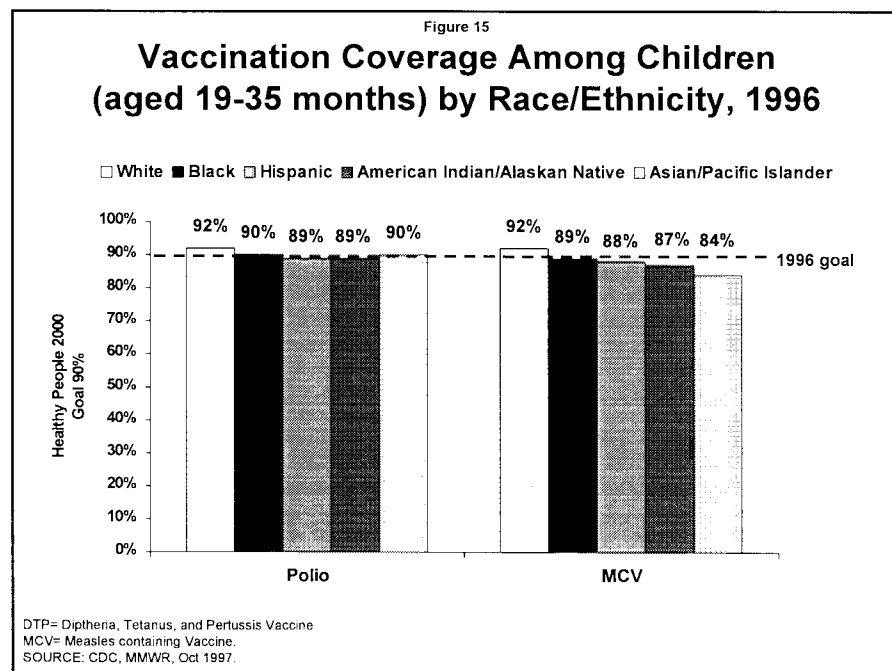
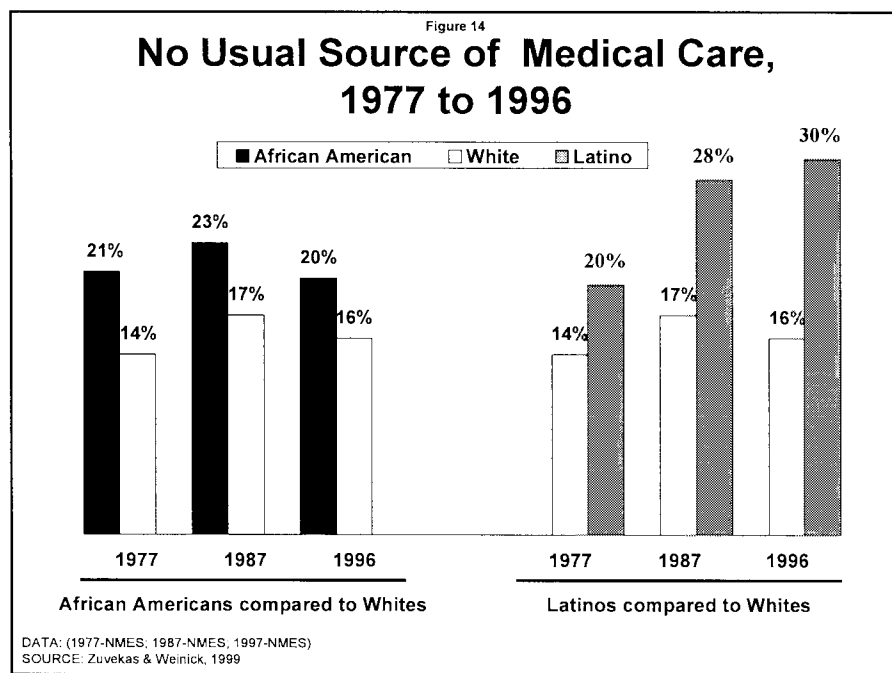
Note: Columns do not sum to 100% because those with "other" insurance are not included. "Latino" refers to U.S. residents self-describing as being of Hispanic origin, regardless of country of birth or citizenship. Analysis excludes other races (Asian-Pacific Islanders, American Indians, Eskimos, and Aleuts).  
 SOURCE: Kaiser Family Foundation, *The Faces of Medicare*.

## Section IV

# Access to Preventive and Primary Care

## Access to Preventive and Primary Care

- In 1996, 30% of Latinos, 20% of African Americans, and 16% of whites did not have a usual source of medical care. While the gap between Latinos and whites with no usual of care has widened since 1977, the gap between African Americans and whites has remained about the same. **(Figure 14)**
- Survey research has documented that minority children as a group compared to white children receive less primary care. However, immunization rates among minority children have been gradually improving over time and the gap between white children and minority children has narrowed. All racial and ethnic groups have met the Healthy People 2000 goal of 90% immunization rates for DTP (diphtheria, tetanus, and pertussis), and differences for polio and MCV (measles containing vaccine) are small. **(Figure 15)**
- Among uninsured women and men in fair to poor health, Latinos are 1½ to 2 times more likely to not get care from a doctor in the past year as whites (24% vs. 13% for women; 40% vs. 29% for men). While insurance coverage improves access to care, racial/ethnic differences persist for both women and men with coverage. Uninsured Latino men are the least likely to get care in a year. **(Figure 16)**
- Minority children have less access to primary medical care than white children, even when differences in insurance coverage and income are taken into account. A 1996 study found that minority children were less likely to have a usual source of care or a specific physician at an identified source; less likely to have a source of care with after hours emergency care; and less likely to have seen a physician for symptoms which would indicate the need for medical attention. However, minority children were more likely to have long travel times and long waits when they did seek care. **(Figure 17)**
- Compared with younger Americans, Medicare beneficiaries generally report fewer problems with access to care, mainly due to the program's universal health coverage. Nonetheless, more African Americans and Latino beneficiaries report problems in getting needed care than their white counterparts. And, both African Americans and Latinos report problems in getting access to a specialist when needed. **(Figure 18)**



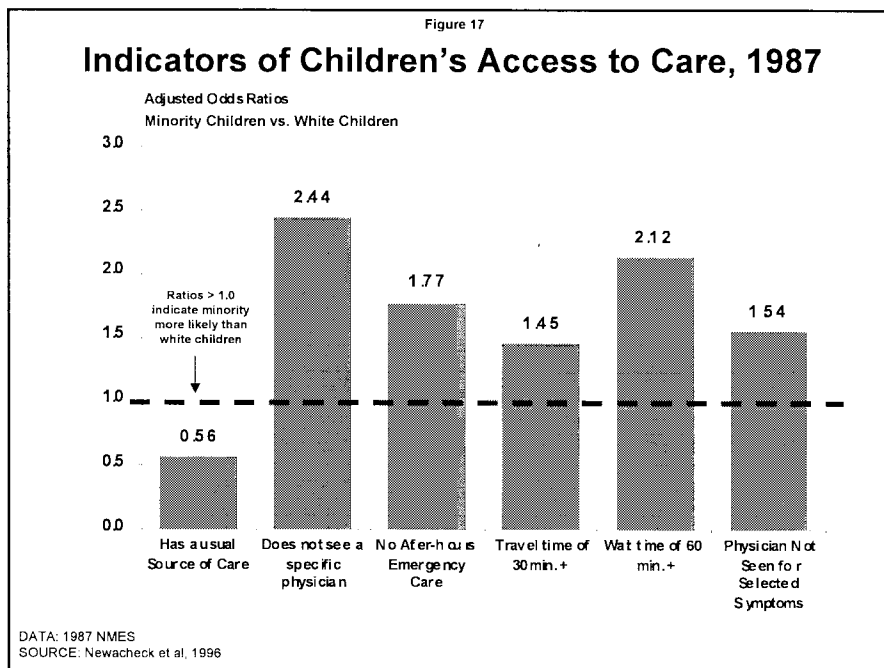
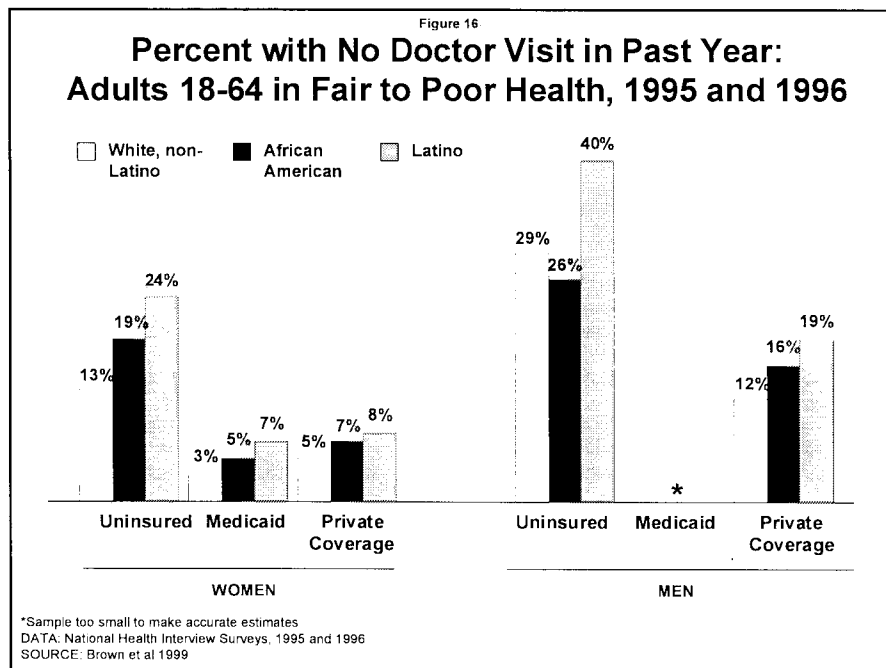
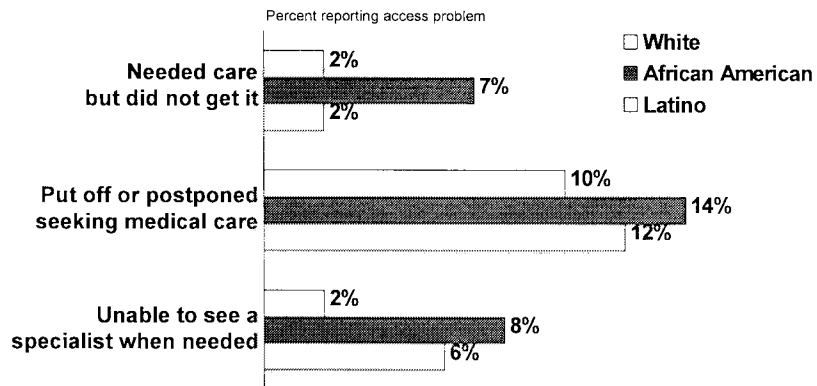


Figure 18

## Access to Care Problems of Medicare Beneficiaries, by Race and Ethnicity, 1997



Note: "Latino" refers to U.S. residents self-describing as being of Hispanic origin regardless of country of birth or citizenship. Excludes other races (Asian-Pacific Islanders, American Indians, Eskimos, and Aleuts).  
Data: Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries.  
SOURCE: Kaiser Family Foundation, *The Faces of Medicare*.





## Section V

# Use of Medical Care for Specific Conditions

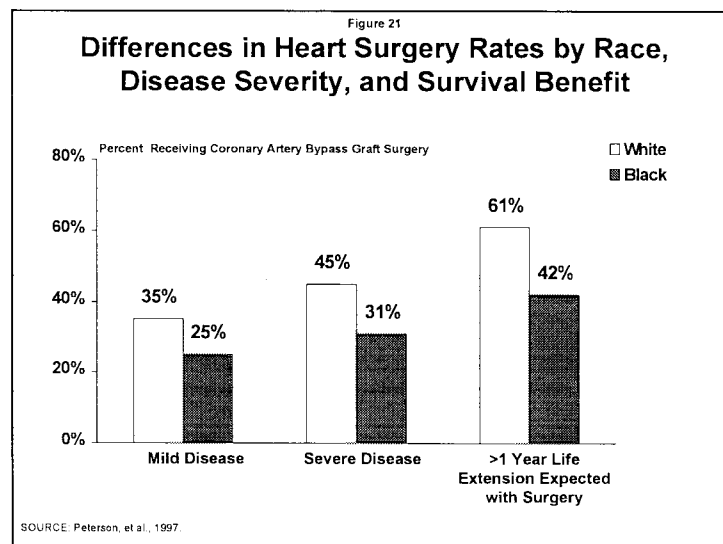
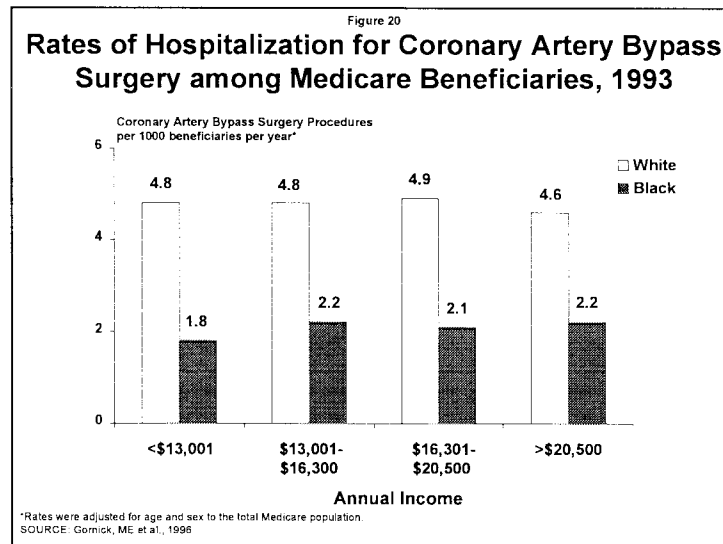
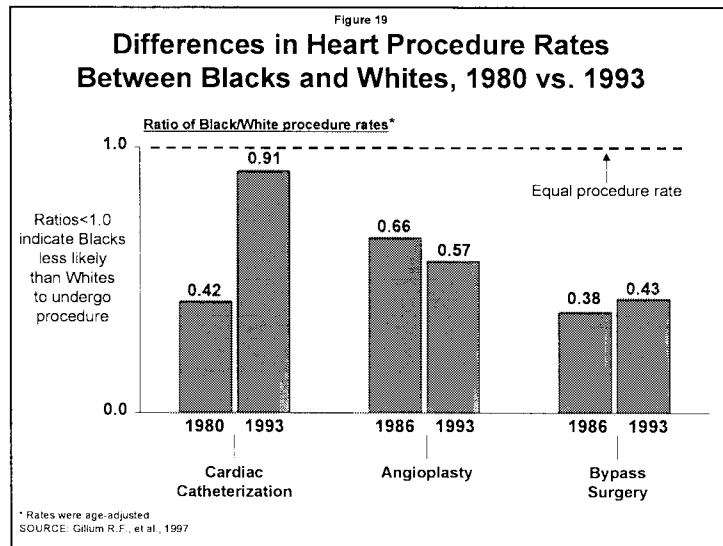
## Heart Disease

Over the past 30 years heart disease mortality rates have been decreasing across all racial and ethnic groups but the decline has been much greater for white Americans. African Americans continue to have the highest mortality rates for heart disease -- about 50% higher than that of whites.

One of the reasons for this difference in heart disease mortality rates may be the fact that African Americans are less likely to undergo medical procedures and surgery known to increase life expectancy. Some of the most consistent findings of racial and ethnic disparities in care have been documented in the medical management of heart disease, including screening, diagnostic, and therapeutic interventions.

- While the gap between blacks and whites cardiac catheterizations (used to diagnose heart disease) has narrowed over time, large racial disparities in the treatment of heart disease with angioplasty and coronary bypass surgery persist, with the chances of blacks undergoing these procedures about half those for whites. **(Figure 19)**
- Even in studies where everyone is similarly insured, racial differences in the use of cardiac procedures remain. For example, among Medicare beneficiaries, blacks were 60% less likely than whites to undergo heart bypass surgery. Adjusting for income made little difference in the findings -- black beneficiaries were still less than half as likely to undergo surgery than white beneficiaries. **(Figure 20)**
- Another important factor in the difference in heart procedures is the severity of the patient's heart disease. In a 1997 study, significant differences in the rates of surgery at the same major teaching hospital persisted between blacks and whites, regardless of the severity of their disease. In fact, the disparity was most pronounced among the sicker patients -- those most likely to benefit from the surgery. **(Figure 21)**
- Racial differences between black and white patients have been found even after **both** the type of heart disease and a patient's insurance status are taken into account. In a study of patients within the Veterans Administration (VA) health system, white patients were more likely to undergo cardiac catheterizations and angioplasties than black patients, and more than twice as likely to have bypass surgery. The disparity held even after adjusting for differences in other complicating diseases, eligibility status within the VA system, the location of the hospital and the availability of heart surgery services at each hospital (Whittle, et al, 1993)

Less is known about heart procedure rates for minority populations other than African Americans, however, some studies suggest that treatment differences between whites and Hispanics may be less pronounced than differences between whites and blacks.



## Cancer

The National Cancer Institute predicts that cancer will surpass cardiovascular disease as this country's leading cause of death in the next century. Cancer, like most diseases, is best treated early in its course. The consequence of inadequate prevention services is that diseases are diagnosed at later stages, when the severity may be greater and options for treatment, as well as the odds of survival, are decreased. While many cancers are now detected and treated with increasing success, the mortality rates for African Americans are much higher than any other group's for breast, colon, prostate, and lung cancer.

Research on access to cancer services by minority populations remains inconclusive. While clearly some gains have been made in cancer screening for minority groups, many studies, though not all, have documented racial and ethnic differences in the stage of cancer at the time of diagnosis, meaning opportunities for early detection have been missed.

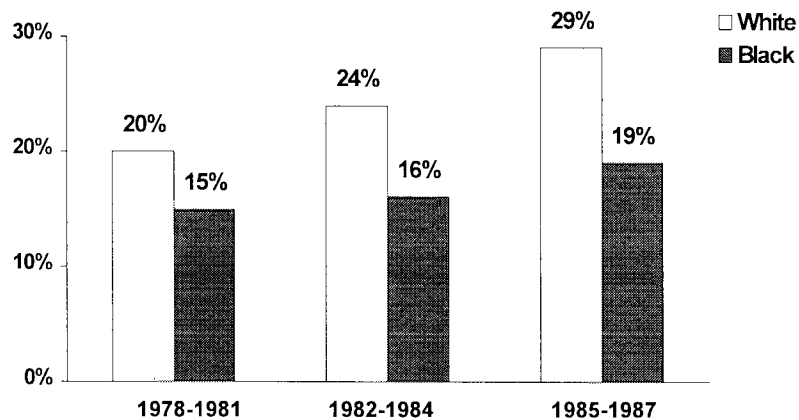
- The racial gap in breast cancer screening with mammography between whites and non-whites appears to be narrowing for some groups, however, elderly African American women are less likely to have had a mammogram than their white peers despite Medicare reimbursement for the service. (Gornick, et al, 1996) Hispanic women are also less likely to be screened for breast cancer than white women (Tortolero-Luna, et al, 1995).
- African American women are at greater risk for being diagnosed with more advanced forms of breast cancer and are less likely to be diagnosed with smaller, non-metastatic breast cancer than white women. (**Figure 22**)
- Both African American and Hispanic men are at higher risk of advanced prostate cancer at diagnosis compared to whites.
- In contrast, there are no differences in the rates of cervical cancer screening by Pap smear between Hispanic and white women; and, Pap test rates for African American women are actually higher than rates for white women (Martin, et al, 1996).

Research has uncovered differences in the cancer treatment provided to minority populations as compared to that provided to whites. However, in studies where differences in disease stage are taken into account, and/or where there is equal financial access to treatment (e.g., in the VA or the Department of Defense [DOD] systems) the disparities are narrowed or eliminated.

- For example: After accounting for differences in the stage of prostate cancer, no racial disparities have been found in the type of treatment men receive in the DOD medical system. For example, among those with local stage cancer, over two-thirds of both black and white men have the tumor surgically removed. However, even in this system, black men are more likely to be initially diagnosed with a higher stage of cancer than white men. (**Figure 23**)

Figure 22

### Screening: Percent with Early Stage Cancer\* Among Women with Breast Cancer, 1978-1987 (Detroit)



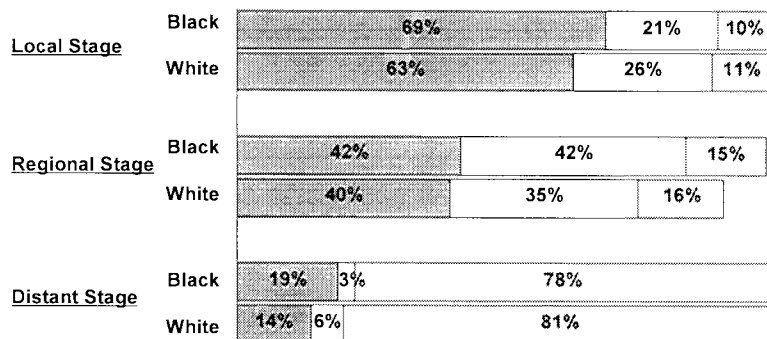
\* Tumors <2cm and no axillary lymph node involvement at diagnosis  
SOURCE: Swanson, M et al., 1990

Figure 23

### Prostate Cancer Treatment by Disease Stage and Race (US Department of Defense Medical System)

Treatment Differences are not statistically different

■ Surgery □ Radiotherapy □ Hormone Therapy/Other/No Treatment



SOURCE: Optenberg et al., 1995

## Asthma

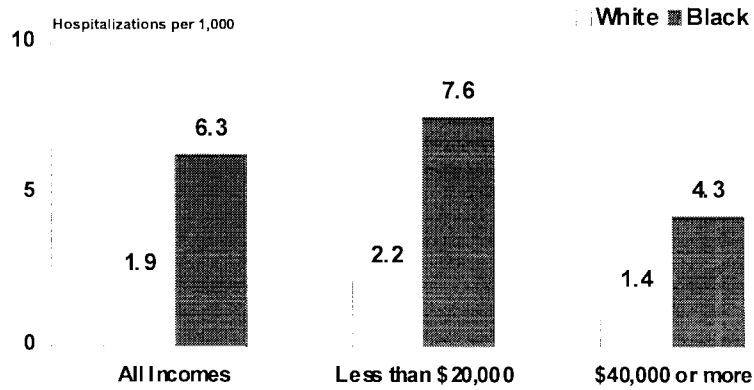
Asthma is now the most common chronic disease among American children. Today 7% of all children have asthma – a prevalence rate that has doubled since 1980 and continues to grow. The risk for asthma seems to be more closely correlated with low socioeconomic status than race. However, even after accounting for such differences, African American children are twice as likely to have asthma and six times as likely to die from it than white children.

For Latino children the story is mixed; prevalence varies by ethnicity. Puerto Rican children have the highest asthma rates among Latinos (11% in one New York City study population). In contrast, asthma prevalence is lower than the national average among Mexican American children, at less than 3% (Carter-Pokras & Gergen, 1993).

- Along with higher prevalence, asthma hospitalization rates are also higher in urban, low-income, and minority communities. Hospitalization for asthma is generally considered an admission that should be avoidable if the condition is adequately managed. Analysis of data from the National Hospital Discharge Survey shows that African American children were about 3 times as likely as white children to be hospitalized with asthma. Racial disparities persist across income groups and are similar among children in upper and lower income communities. **(Figure 24)**
- In a study of Medicaid beneficiaries (all from low-income families with health coverage for preventive services) African American children were more likely than white children to be treated for their asthma in emergency departments, to be hospitalized for asthma, and were less likely to have office visits for their asthma. While there were no differences in the amount of well-child care visits or prescriptions for asthma drugs, African American children were less likely to receive the drug therapy recommended in national asthma guidelines. **(Figure 25)**
- A study of previously hospitalized African American and white adults (age 18-50) enrolled in a health maintenance organization, where financial barriers to care are minimized, found that African Americans made more emergency department visits, while whites made more primary care and allergy/pulmonary visits. In addition, while there were no racial differences in rehospitalization for asthma, African Americans with Medicaid coverage were twice as likely to be rehospitalized than African Americans with private coverage (Blixen, et al, 1999).

Figure 24

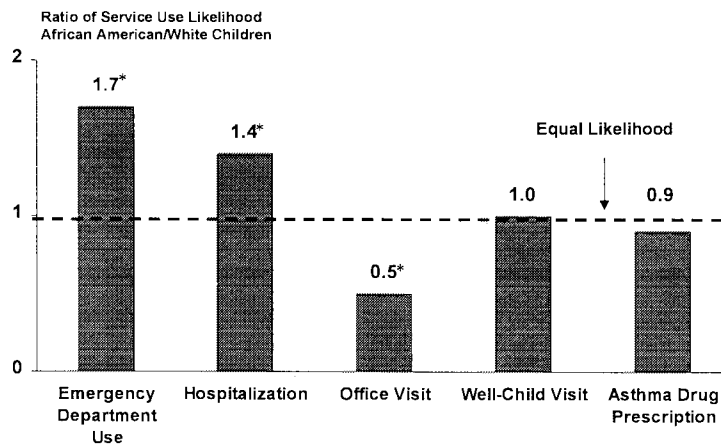
## Asthma Hospitalization: Children 1-14 years of age, by Income, 1989-1991



NOTE: Persons of Hispanic Origin included in both racial groups.  
 DATA: CDC, National Hospital Discharge Survey.  
 SOURCE: The President's Initiative on Race Chartbook, *Health Care Rx: Access for All*

Figure 25

## Use of Selected Services by African American Children with Asthma Compared to White Children with Asthma, 1988-1992 (Seattle)



\*Statistical difference between African American and White Children  
 SOURCE: Lozano P, Connell FA, Koepsell TD., 1995.

## HIV/AIDS

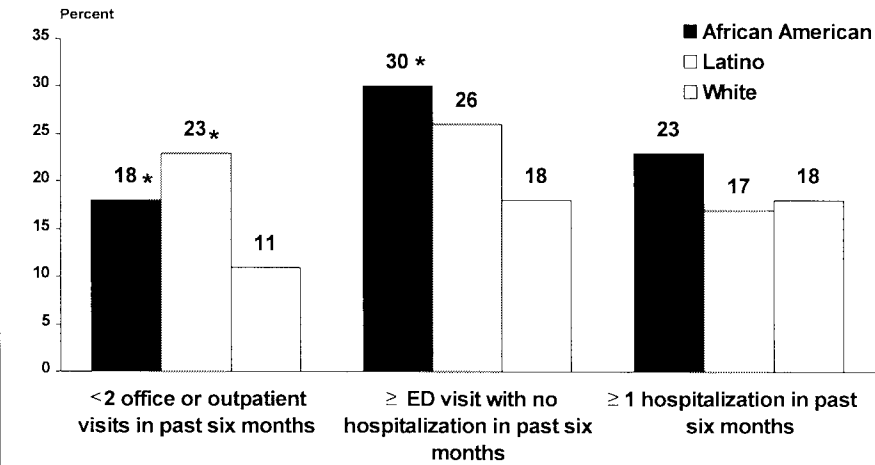
Together, African Americans and Latinos accounted for two-thirds of the new AIDS cases in 1998. Given that HIV infection is now the leading cause of death among African Americans between the ages of 25 and 44 (and the second leading cause of death among Latinos in this same age group), there are growing concerns about the adequacy of treatment and the effectiveness of prevention efforts in minority communities.

- Since 1990, several key studies have been published that assessed racial and ethnic differences in the care obtained by HIV-infected persons and that also adjusted for severity of illness and socio-economic indicators. These studies provide evidence that insurance status and race/ethnicity are associated with the adequacy of the care obtained.
- Data from the HIV Cost and Services Utilization Study (HCSUS), a national probability sample of persons with HIV receiving medical care in early 1996 found that access to care had improved for whites, African Americans, and Latinos; but it was still less than optimal for African Americans and Latinos. In the analysis of the baseline data that adjusted for differences in CD4 counts and insurance coverage, African Americans did poorer than whites on four of the six measures of health service and pharmaceutical use. Latinos did poorer than whites on two of these six indicators. (**Figures 26, 27**)
- Most telling are HCSUS indicators that looked at the use of triple drug antiretroviral therapy, a treatment regimen that is very effective in delaying disability and prolonging the life of persons with HIV. African Americans were more than twice as likely as whites to not receive combination drug therapy and 1.5 times more likely to not get preventive treatment for pneumocystic carinii pneumonia (a common, but preventable, infection in people with HIV) than whites. Latinos were 1.5 times more likely than whites to not get combination drug therapy (Shapiro et al, 1999).



Figure 26

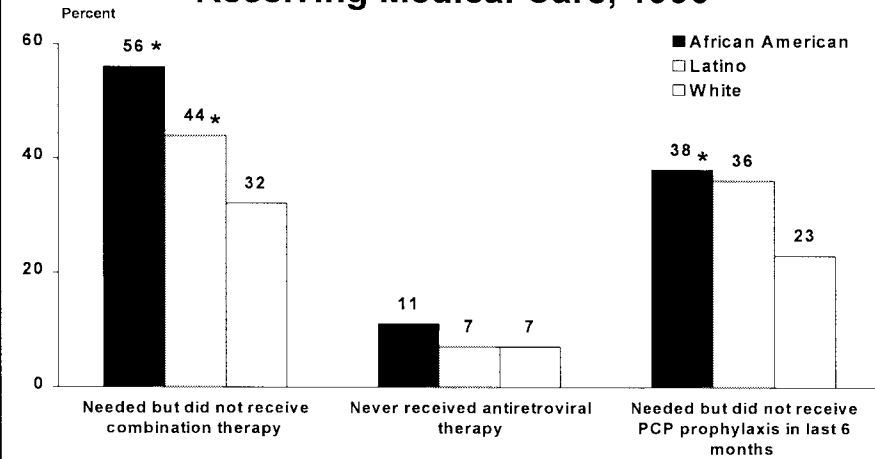
## Health Services Use for Persons with HIV Receiving Medical Care, 1996



\* Significantly different from whites in multivariate analysis to adjusting for CD4 counts, sociodemographic characteristics, and insurance  
 DATA: HIV Cost and Services Utilization Study (HCSUS)  
 SOURCE: Shapiro et al. 1999

Figure 27

## Pharmaceutical Use by Persons with HIV Receiving Medical Care, 1996



\* Significantly different from whites in multivariate analysis to adjusting for CD4 counts, sociodemographic characteristics, and insurance  
 DATA: HIV Cost and Services Utilization Study (HCSUS)  
 SOURCE: Shapiro et al. 1999



## CONCLUSION

A lack of data and insufficient research have hampered efforts to make the U.S. health care system more responsive to the needs of an ever more racially and ethnically diverse population. *Key Facts: Race, Ethnicity, and Medical Care* presents compelling evidence of racial and ethnic differences in health insurance coverage, access to primary care, and treatment for specific medical conditions. In some studies, these differences are reduced, if not eliminated, when comparing minority populations and whites of similar socio-economic conditions, insurance coverage, and health status. Even when differences persist, it should be noted that every differential in care is not necessarily a problem and the level of care obtained by whites may not be the appropriate standard for comparison. Further research is needed to better understand and assess the extent to which these differentials reflect barriers to needed care and compromise health outcomes. Financial incentives and barriers are known to affect the care that is obtained and provided, but less is known about how other factors, such as patient preferences or provider biases, affect patterns of care. The challenge facing health policy researchers and health providers is to identify and disentangle the many complex factors that account for these differentials, so that the sources of health care inequity can be addressed.



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