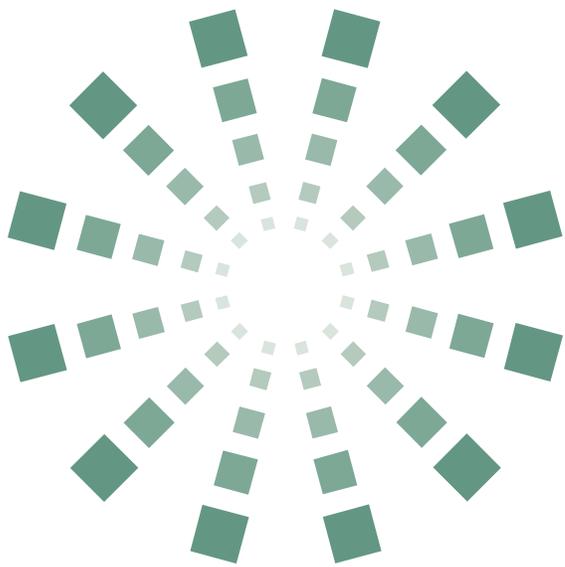


Key Facts

Race, Ethnicity & Medical Care

Update
June 2003

THE HENRY J.
KAISER
FAMILY
FOUNDATION



Prepared by

Marsha Lillie-Blanton, Osula Evadne Rushing and Sonia Ruiz
of The Henry J. Kaiser Family Foundation

Acknowledgments

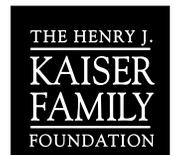
Special thanks to Diane Rowland and Tricia Neuman for their review and comments; Rachel Garfield, Kristina Hanson, Jennifer Kates, and Michelle Kitchman for their analytic support; and Ardine Hockaday, Kinite Holt, Celeste Mitchell, Chris Redwood and Courtney Rees for their production assistance.



Key Facts

Race, Ethnicity & Medical Care

Update
June 2003





Contents

Introduction	.....	1
Section 1. Demographics	.....	3
Figure 1:	Percent Distribution of U.S. Population, by Race/Ethnicity, 2000	4
Figure 2:	Percent Distribution of U.S. Population, by Race/Ethnicity, 2000 and 2050	4
Figure 3:	Poverty Status of the Nonelderly Population, by Race/Ethnicity, 2001	5
Figure 4:	Poverty Status of the Elderly Population, by Race/Ethnicity, 2001	5
Section 2. Health	.....	7
Figure 5a:	Fair or Poor Health, by Race/Ethnicity, 2000	8
Figure 5b:	Fair or Poor Health, by Race/Ethnicity and Income, 2000	8
Figure 6:	Infant Mortality Rates for Mothers Age 20+, by Race/Ethnicity and Education, 1998–2000	9
Figure 7:	Mortality Ratios, by Age and Race/Ethnicity, 2000	9
Figure 8:	Heart Disease Death Rates for Adults 25–64, by Income, Race and Gender, 1979–1989	10
Figure 9:	Leading Causes of Death, by Race/Ethnicity, 2000	10
Section 3. Health Insurance Coverage	.....	11
Figure 10:	Health Insurance Status, by Race/Ethnicity: Total Nonelderly Population, 2001	12
Figure 11:	Health Insurance Status, by Race/Ethnicity: Low-Income Nonelderly Population, 2001	12
Figure 12:	Medicaid Beneficiaries, by Race/Ethnicity, 2001	13
Figure 13:	Medicare Beneficiaries Age 65 and older, by Race/Ethnicity, 1999 and 2030	13
Figure 14:	Sources of Prescription Drug Coverage Among Medicare Beneficiaries Age 65 and Older, June 1999	14
Figure 15:	Nonelderly Uninsured, by Race/Ethnicity, 2001	14
Figure 16:	Nonelderly Uninsured Rates Among Racial/Ethnic Groups, 2001	15
Figure 17:	Uninsured Rates Among Racial/Ethnic and Income Groups, 2001	15
Figure 18:	Nonelderly Uninsured Rates, by State, Region, and Race/Ethnicity, 2000–2001	16
Section 4. Preventive and Primary Care	.....	17
Figure 19a:	No Usual Source of Health Care: Adults 18–64, by Race/Ethnicity, 1993–1994 and 1999–2000	18
Figure 19b:	No Usual Source of Health Care: Adults 18–64, by Race/Ethnicity and Poverty Status, 1999–2000	18

Continued on next page

Figure 20a:	No Health Care Visits in the Past Year, by Race/Ethnicity, 1997 and 2000	19
Figure 20b:	No Health Care Visits in the Past Year, by Race/Ethnicity and Poverty Status, 2000	19
Figure 21a:	Late or No Prenatal Care, by Race/Ethnicity, 1980 and 2000	20
Figure 21b:	Late or No Prenatal Care, by Racial/Ethnic Subgroups, 2000	20
Figure 22a:	No Dental Visits in the Past Year, by Race/Ethnicity, 2000	21
Figure 22b:	No Dental Visits in the Past Year, by Race/Ethnicity and Poverty Status, 2000	21
Section 5.	Specialty Care	23
	<i>Heart Disease</i>	
Figure 23:	Rate of Cardiac Interventions Among Medicare Patients Hospitalized with an Acute Myocardial Infarction, by Race/Ethnicity, 1994–1995	24
Figure 24:	Cardiac Procedure Use in Chronic Renal Disease Patients, by Race and Gender, 1986–1992	25
Figure 25:	Coronary Artery Bypass Surgery by Race/Ethnicity and Insurance Status, 1986–1988	25
	<i>Cancer</i>	
Figure 26:	Cancer Screening, by Race/Ethnicity, 2000	26
Figure 27:	Racial Differences in the Treatment of Early-Stage Lung Cancer Among Medicare Patients, 1985–1993	27
Figure 28:	Untreated Daily Pain Among Elderly Nursing Home Residents with Cancer, 1992–1995	27
	<i>Asthma</i>	
Figure 29:	Asthma; Health Care Use and Outcomes, 2000	28
Figure 30:	Underuse of Medication Among Medicaid-Insured Children with Asthma, 1999	29
Figure 31:	Use of Selected Services by African American Children with Asthma, 1988–1992	29
	<i>HIV/AIDS</i>	
Figure 32:	Health Services Use Among Persons with HIV/AIDS in Care, by Race/Ethnicity, 1998	30
Figure 33:	Reasons for Postponing Care Among Persons with HIV/AIDS in Care, by Race/Ethnicity, 1996	31
Figure 34:	Percent Who Report Ever Having Been Tested for HIV, by Race/Ethnicity, 1999	31
Conclusion	. . . . .	32
Data Notes	. . . . .	33
Bibliography	. . . . .	34

INTRODUCTION

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

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

This update of *Key Facts: Race, Ethnicity, and Medical Care*, like the first, is intended to serve as a quick reference source on the health, health insurance coverage, healthcare access and quality among racial/ethnic minority groups in the United States. The document highlights the best available data and research, providing a selective review of the literature. *Key Facts* is divided into five sections, beginning with an overview of the demographic characteristics of the U.S. population. Section 2 presents health measures, stratified when possible by a measure of socioeconomic status. Section 3 profiles patterns of health insurance coverage. Sections 4 and 5 present findings on access to and use of primary and specialty medical care. Whenever possible, these findings are adjusted for social and clinical factors.

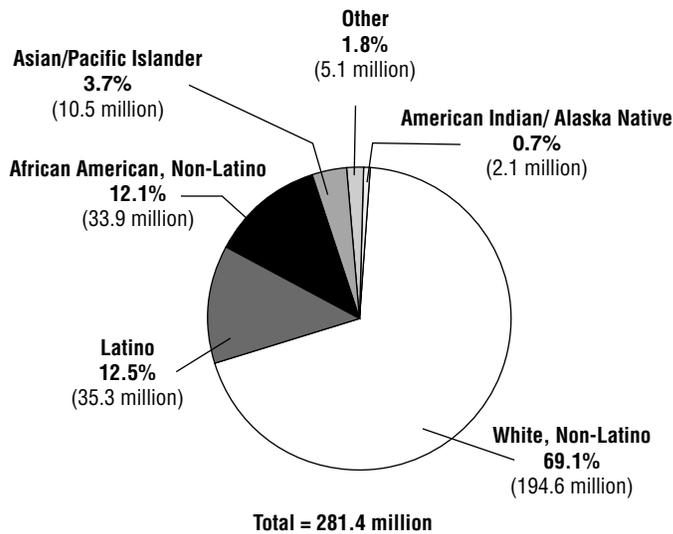




Section 1

Demographics

Figure 1
Percent Distribution of U.S. Population,
by Race/Ethnicity, 2000

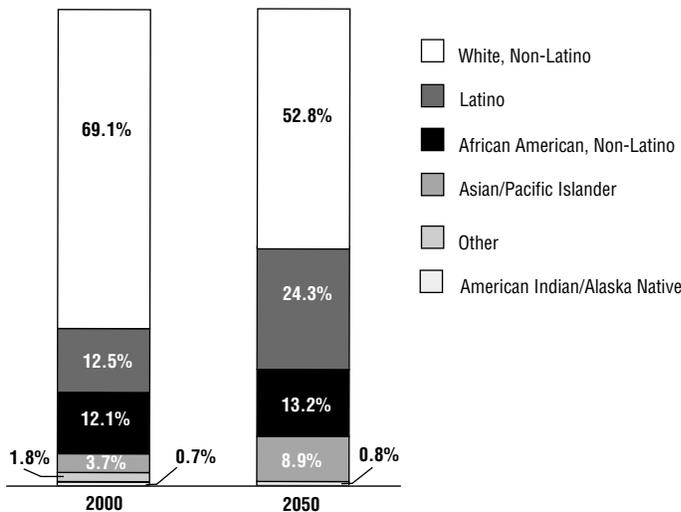


NOTE: Data do not include residents of Puerto Rico, Guam, the U.S. Virgin Islands, or the Northern Mariana Islands. Non-Latino individuals who reported "Some other race" or "Two or more races" are included in the "Other" category. For the purposes of this chart, Asians and Native Hawaiians or Other Pacific Islanders are combined into one category.
 SOURCE: U.S. Census Bureau, Census 2000 Redistricting Data.

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

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

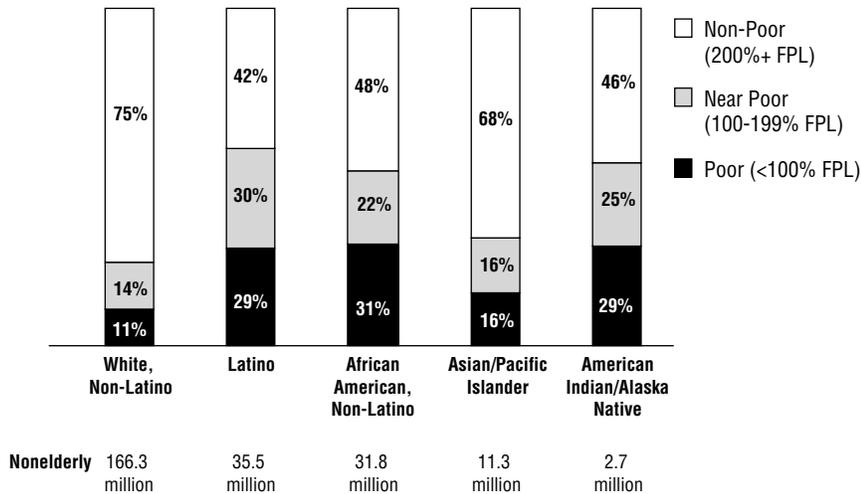
Figure 2
Percent Distribution of U.S. Population,
by Race/Ethnicity, 2000 and 2050



NOTE: Data do not include residents of Puerto Rico, Guam, the U.S. Virgin Islands, or the Northern Mariana Islands. 2050 data do not include estimates for the "Other" category, which includes Non-Latino individuals who reported "Some other race" and "Two or more races."
 SOURCE: U.S. Census Bureau, Census 2000 Redistricting Data and Population Projections Program, Population Division.

By the year 2050, the U.S. Census estimates that nearly half of the U.S. population will be Latino, African American, Asian/Pacific Islander, and American Indian/Alaska Native. The proportion of Latinos and Asian/Pacific Islanders in the U.S. is expected to double in the next 50 years.

Figure 3
Poverty Status of the Nonelderly Population,
by Race/Ethnicity, 2001

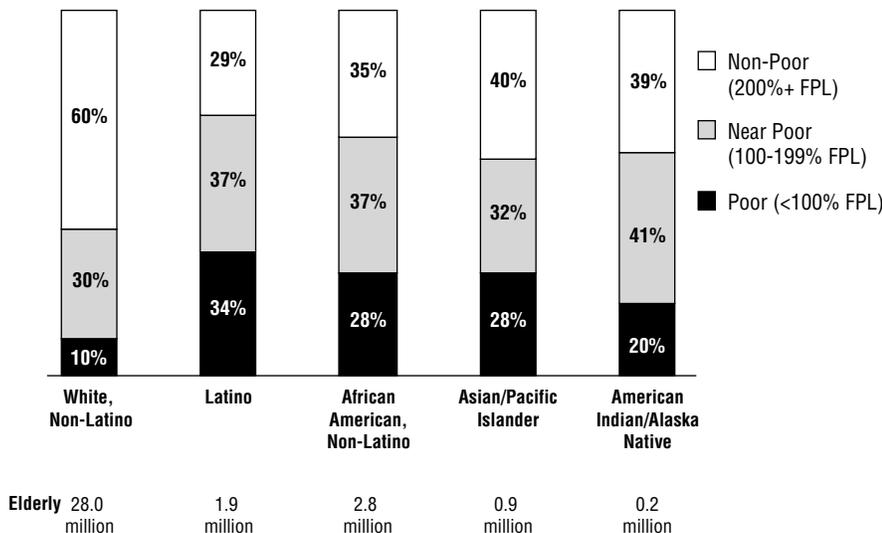


NOTE: Nonelderly includes all individuals under age 65. FPL = Federal Poverty Level.

SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of March 2002 Current Population Survey.

People of color are more likely to have family incomes less than 200% of the federal poverty level than are whites (which, for example, would be less than \$28,256 for a family of three in 2001). Over half of Latinos, African Americans, and American Indian/Alaska Natives are poor or near poor, compared with 25% of whites and 32% of Asian/Pacific Islanders. The proportion of children who are poor or near poor is even higher.

Figure 4
Poverty Status of the Elderly Population,
by Race/Ethnicity, 2001



NOTE: Elderly includes all individuals over age 65.

SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of March 2002 Current Population Survey.

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

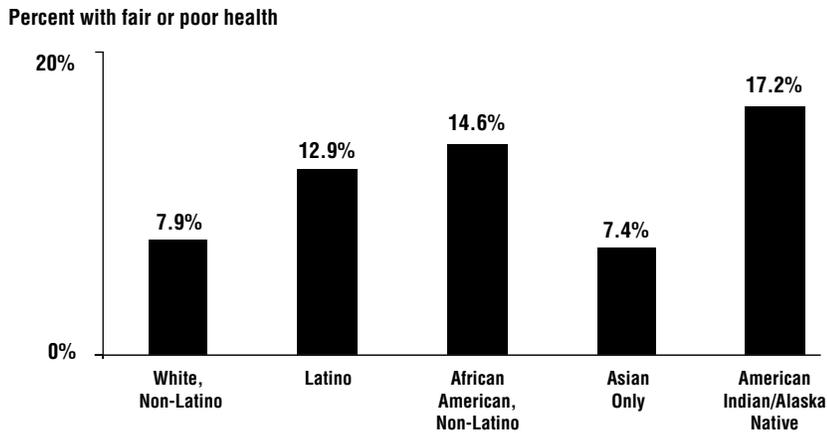




Section 2

Health

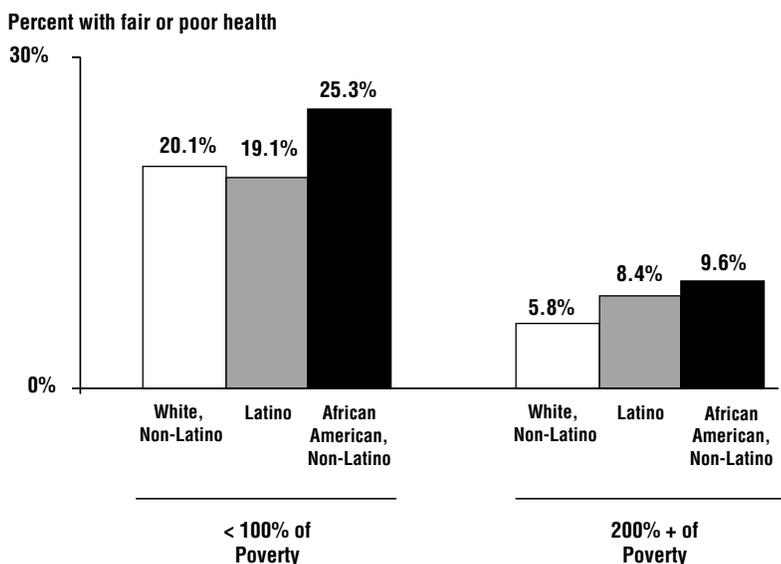
Figure 5a
Fair or Poor Health,
by Race/Ethnicity, 2000



DATA: National Center for Health Statistics, National Health Interview Survey, 2000.
 SOURCE: Health, United States, 2002, Table 59.

American Indian/Alaska Natives, African Americans and Latinos are more likely to rate their health as fair or poor than are whites and Asians.

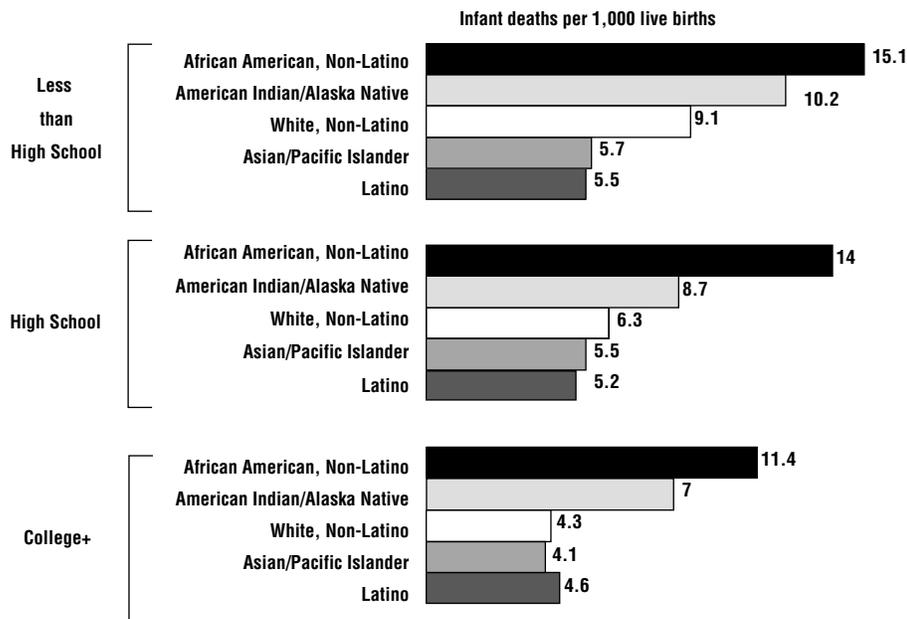
Figure 5b
Fair or Poor Health,
by Race/Ethnicity and Income, 2000



DATA: National Center for Health Statistics, National Health Interview Survey, 2000.
 SOURCE: Health, United States, 2002, Table 59.

When comparing racial/ethnic groups of similar incomes, the disparity in self-reported health is reduced but not eliminated. Regardless of racial/ethnic group, people living in poverty report worse health than the non-poor.

Figure 6
Infant Mortality Rates for Mothers Age 20+,
by Race/Ethnicity and Education, 1998–2000

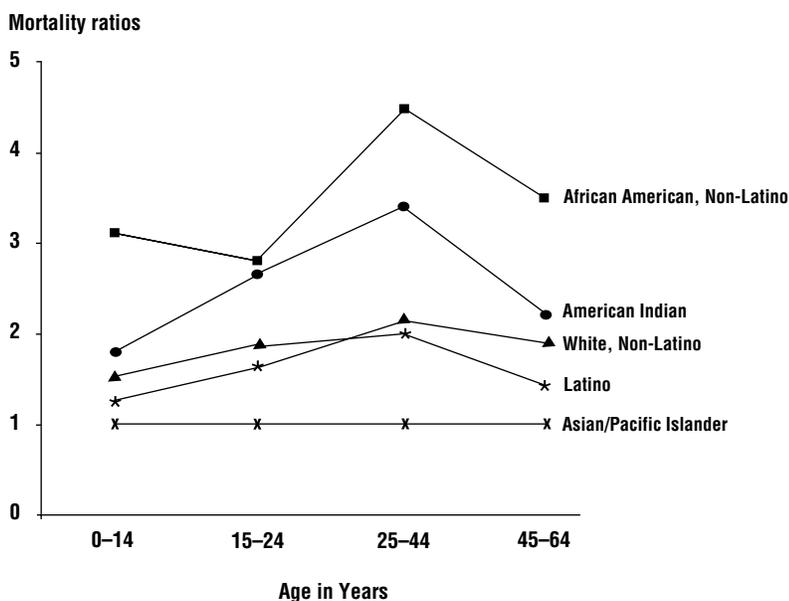


Infant mortality rates, considered one of the most sensitive indicators of the health and well-being of a population, are higher among African American and American Indian/Alaska Natives than among other racial/ethnic groups, even when comparing women of similar socioeconomic conditions, as measured by years of education completed.

DATA: National Center for Health Statistics, National Vital Statistics System, National Linked Birth/Infant Death Data.

SOURCE: Health, United States, 2002, Table 21.

Figure 7
Mortality Ratios, by Age and Race/Ethnicity, 2000



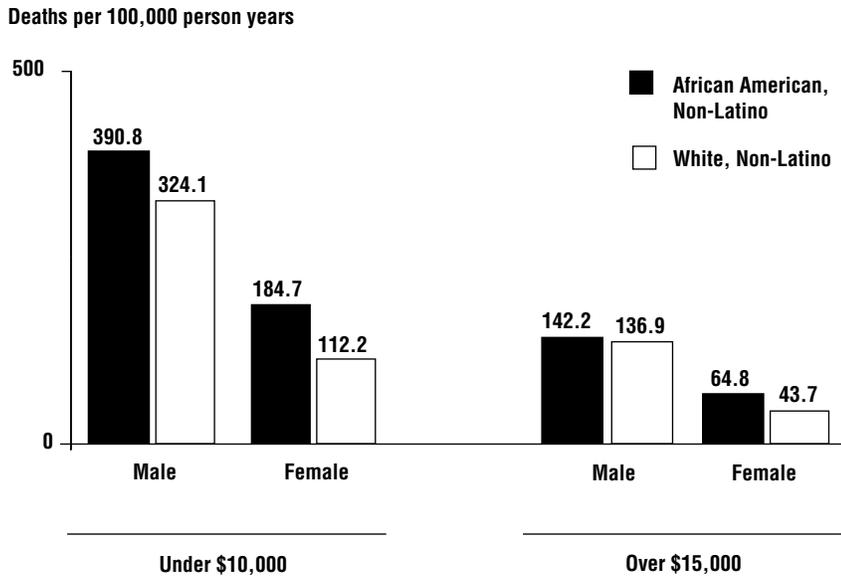
On average, Latinos, African Americans, American Indians and whites have higher mortality rates than Asian/Pacific Islanders at each stage of the lifespan. However, aggregated data mask the higher mortality rates of particular Asian/Pacific Islander subpopulations, such as Vietnamese and Native Hawaiians.

NOTE: These data compare the mortality rate of each racial/ethnic group to that of Asian/Pacific Islanders, the group with the lowest mortality rates at each age.

DATA: National Center for Health Statistics, National Vital Statistics System.

SOURCE: National Vital Statistics Report, Vol. 50, No. 15, September 16, 2002.

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



NOTE: These data are the most recently available by race and income.

SOURCE: Health, United States, 1998, *Socioeconomic Status and Health Chartbook*, Data Table for Figure 27.

Heat disease is a leading cause of death in the U.S. Heart disease mortality rates for adults 25–64 are almost twice as high among African Americans as among whites. When heart disease mortality is examined by a measure of socioeconomic conditions, differences between African Americans and whites are reduced but not eliminated. Moreover, the disparity by income is larger than by race. African American men with family incomes less than \$10,000 have a heart disease mortality rate that is nearly three times that of their counterparts with incomes greater than \$15,000.

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

	Rank	White, Non-Latino	Latino	African American, Non-Latino	Asian/Pacific Islander	American Indian/Alaska Native
All Ages	1	Heart disease	Heart disease	Heart disease	Cancer	Heart disease
	2	Cancer	Cancer	Cancer	Heart disease	Cancer
	3	CVD	Accidents	CVD	CVD	Accidents
	4	Chronic lung disease	CVD	Accidents	Accidents	Diabetes
	5	Accidents	Diabetes	Diabetes	Chronic lung disease	CVD
Ages 25–44	1	Accidents	Accidents	HIV	Cancer	Accidents
	2	Cancer	Cancer	Heart Disease	Accidents	Liver Disease
	3	Heart Disease	Homicide	Accidents	Heart Disease	Heart Disease
	4	Suicide	HIV	Cancer	Suicide	Suicide
	5	HIV	Heart Disease	Homicide	Homicide	Cancer

CVD = Cerebrovascular disease

DATA: National Center for Health Statistics, National Vital Statistics System.

SOURCE: National Vital Statistics Report, Vol. 50, No. 16, September 16, 2002.

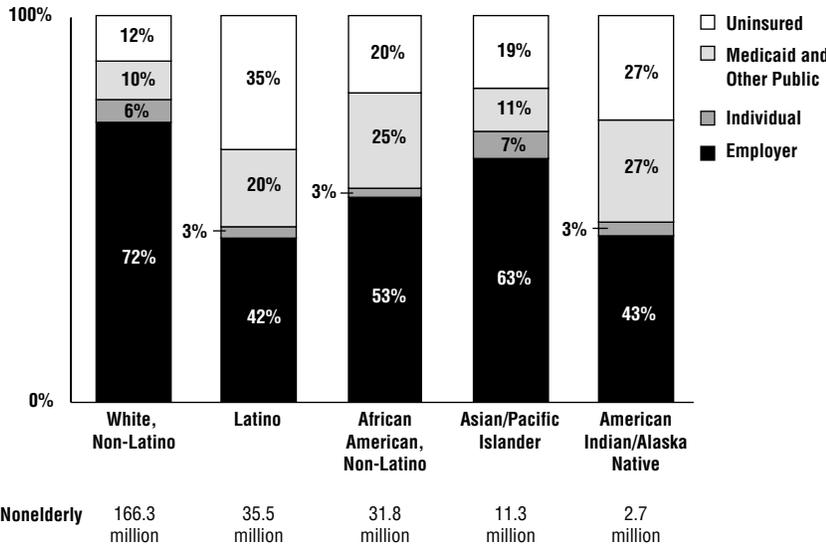
In 2000, heart disease and cancer were the leading causes of death among all racial/ethnic groups. Among 25–44 year olds, accidents were the leading cause of death for three of the five racial/ethnic groups. HIV is the leading cause of death for African Americans in this age group, and is one of the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



Section 3

Health Insurance Coverage

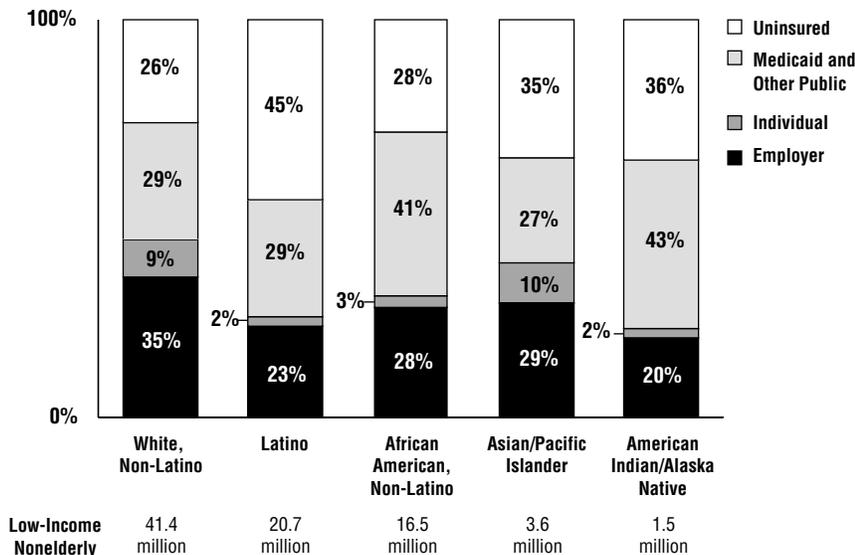
Figure 10
Health Insurance Status, by Race/Ethnicity:
Total Nonelderly Population, 2001



NOTE: "Other Public" includes Medicare and military-related coverage.
 SOURCE: Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America: 2001 Data Update*, 2003.

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

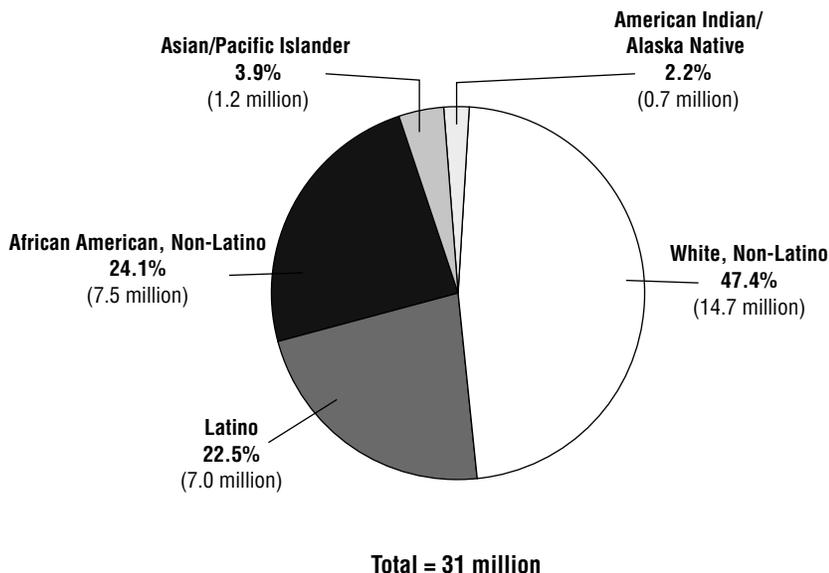
Figure 11
Health Insurance Status, by Race/Ethnicity:
Low-Income Nonelderly Population, 2001



NOTE: Low-income is defined as income < 200% of the federal poverty level. "Other Public" includes Medicare and military-related coverage.
 SOURCE: Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America: 2001 Data Update*, 2003.

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

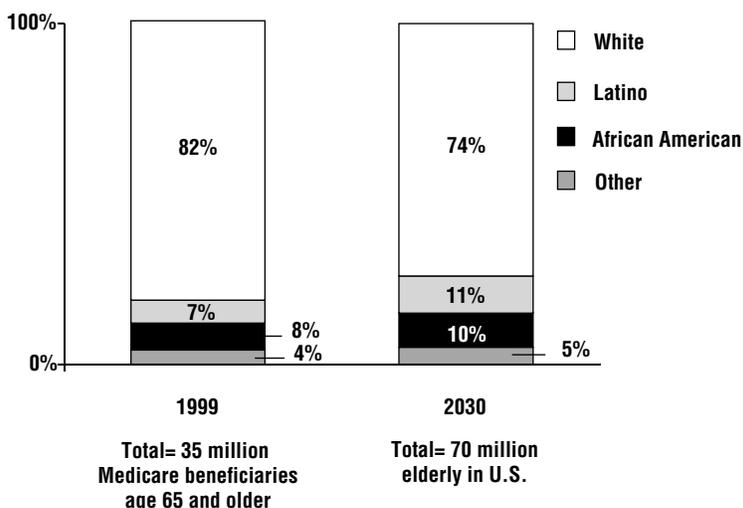
Figure 12
Medicaid Beneficiaries,
by Race/Ethnicity, 2001



SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of March 2002 Current Population Survey.

Of the 31 million Medicaid beneficiaries in 2001, roughly half were white and half were minority Americans. Medicaid’s larger role in providing coverage among minority Americans reflects the relatively lower incomes of minority population groups and the program’s mission in providing health coverage to the low-income population.

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

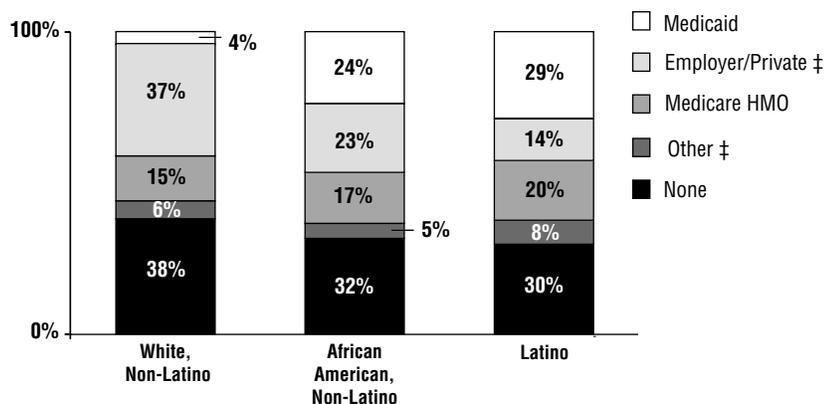


NOTE: “Other” includes Asians or Pacific Islanders, American Indians, or other race not of Hispanic ancestry. Numbers may not add up to 100% due to rounding.

SOURCE: CMS, Medicare Current Beneficiary Survey, 1999. U.S. Census Bureau, CPS, 2000.

Medicare—the federal health insurance program that covers 41 million elderly and under-65 disabled Americans—provides important financial protections against the costs of medical care. Today, people of color account for almost one in five elderly Medicare beneficiaries. In 2030, racial and ethnic minority Americans are projected to account for 26% of Medicare beneficiaries age 65 and older. This trend has particular implications for the Medicare program, as racial and ethnic minority beneficiaries tend to have poorer health than white beneficiaries. While 43% of African American beneficiaries and 42% of Latino beneficiaries assess their own health as fair or poor, only 25% of white beneficiaries do so.

Figure 14
Sources of Prescription Drug Coverage
Among Medicare Beneficiaries Age 65 and Older, June 1999



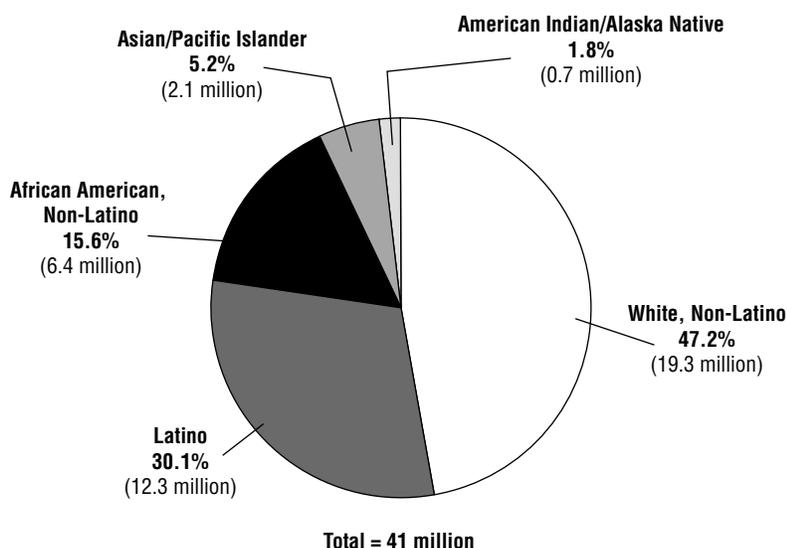
‡ "Employer/Private" includes employer-sponsored coverage or Medigap. "Other" includes other public, other private, or unknown source.

NOTE: Data are point-in-time estimates for the month of June. Coverage groups are mutually exclusive, with individuals categorized based on the following hierarchy: Medicare HMO, Medicaid, employer-sponsored, Medigap, other public and unknown source, and no coverage. Estimates exclude institutionalized beneficiaries and those with ESRD entitlement.

Source: Gaskin/Briesacher analysis of 1999 Medicare Current Beneficiary Survey, Cost and Use File.

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

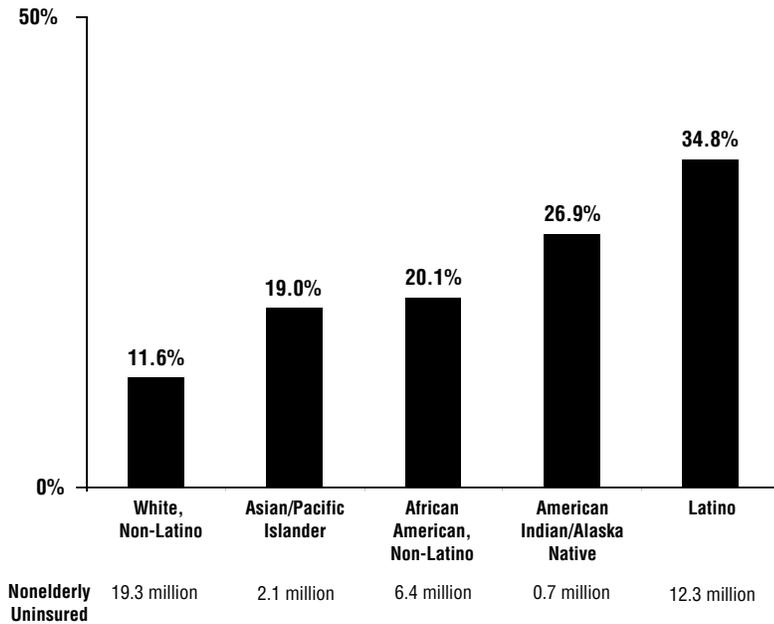
Figure 15
Nonelderly Uninsured,
by Race/Ethnicity, 2001



SOURCE: Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America: 2001 Data Update*, 2003.

People of color, who now make up 33% of the nonelderly population, comprise a little over half of the uninsured—in part because they are more likely to be in low-income families. At least half of African Americans, Latinos, and American Indians, compared to a quarter of whites, come from families with incomes below than 200% of the poverty level.

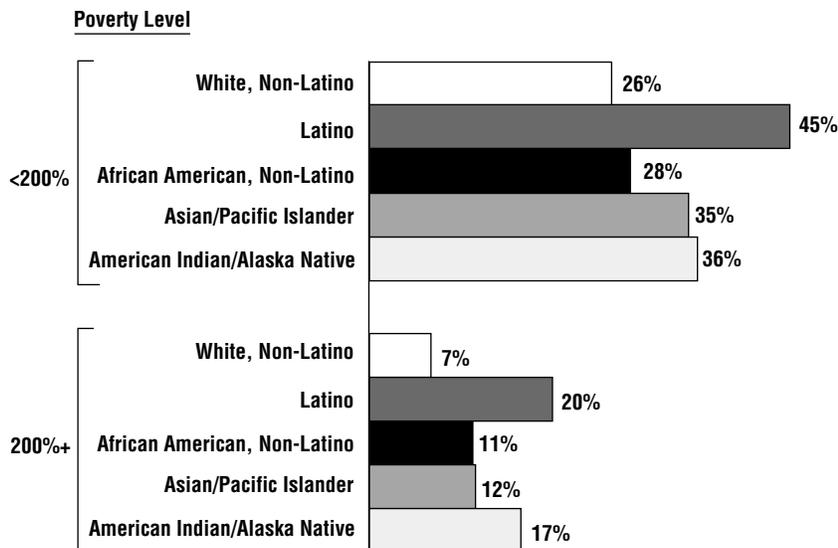
Figure 16
Nonelderly Uninsured Rates Among Racial/Ethnic Groups, 2001



SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of March 2001 Current Population Survey.

People of color are more likely than whites to be uninsured, with Latinos and American Indians being 2 to 3 times as likely to be uninsured as whites. Differences in health coverage across racial/ethnic groups are partially explained by differences in income, types of employment, and eligibility for public insurance programs.

Figure 17
Uninsured Rates Among Racial/Ethnic and Income Groups, 2001



NOTE: Less than 200% of poverty level = \$28,256 for family of 3 in 2001

SOURCE: Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America: 2001 Data Update*, 2003.

While being from a low-income family raises the risk of being uninsured markedly, it does not account for all of the differences in health coverage across racial and ethnic groups. Insurance disparities persist for most groups at both lower and higher income levels.

Figure 18

Nonelderly Uninsured Rates, by State, Region, and Race/Ethnicity, 2000–2001

Region/State	White, Non-Latino	African American, Non-Latino	Latino	Asian/Pacific Islander	American Indian/Alaska Native
United States	11.4%	20.1%	34.6%	18.9%	26.8%
Northeast	9.8%	20.7%	29.0%	25.3%	18.0%
Connecticut	9.4%	18.1%	22.9%	10.4%	*
Maine	12.4%	*	*	30.3%	14.9%
Massachusetts	7.7%	13.8%	22.3%	12.7%	*
New Hampshire	10.0%	9.5%	20.1%	19.0%	*
New Jersey	9.3%	22.1%	31.1%	18.8%	*
New York	12.0%	23.4%	31.0%	33.0%	25.9%
Pennsylvania	8.7%	15.7%	27.2%	20.6%	*
Rhode Island	7.0%	18.8%	21.1%	7.5%	*
Vermont	10.5%	*	*	4.8%	*
South	13.1%	21.0%	39.5%	19.4%	23.6%
Alabama	12.2%	19.8%	49.1%	*	*
Arkansas	15.6%	21.9%	40.8%	*	*
Delaware	9.6%	11.5%	21.4%	11.2%	*
District of Columbia	5.6%	16.7%	34.9%	14.8%	*
Florida	14.6%	26.0%	35.6%	16.0%	22.2%
Georgia	13.1%	20.5%	40.0%	12.3%	*
Kentucky	14.1%	15.6%	37.0%	8.1%	*
Louisiana	17.1%	28.3%	27.1%	19.0%	*
Maryland	8.6%	15.7%	36.3%	19.4%	*
Mississippi	12.6%	23.0%	*	*	*
North Carolina	11.8%	19.8%	46.3%	17.3%	19.9%
Oklahoma	18.9%	23.7%	39.2%	35.3%	29.0%
South Carolina	11.1%	19.0%	31.8%	22.6%	*
Tennessee	10.9%	13.1%	49.2%	6.7%	*
Texas	13.7%	24.7%	41.3%	23.6%	25.6%
Virginia	9.5%	16.5%	33.7%	17.4%	*
West Virginia	15.8%	18.2%	*	*	*
Midwest	10.0%	18.3%	29.1%	16.3%	23.1%
Illinois	10.5%	23.2%	30.8%	19.9%	11.6%
Indiana	12.2%	19.4%	24.5%	23.3%	*
Iowa	8.7%	12.6%	23.1%	8.1%	*
Kansas	11.4%	14.5%	31.8%	18.3%	17.0%
Michigan	9.5%	15.7%	26.2%	8.8%	19.5%
Minnesota	7.3%	17.7%	38.8%	8.6%	27.4%
Missouri	10.1%	15.4%	27.1%	16.4%	*
Nebraska	9.2%	15.9%	23.0%	10.5%	31.9%
North Dakota	10.2%	*	8.4%	*	38.1%
Ohio	11.6%	16.0%	30.7%	28.1%	*
South Dakota	9.3%	36.2%	26.9%	*	38.2%
Wisconsin	7.2%	14.5%	23.1%	14.1%	20.9%
West	12.4%	17.2%	33.5%	17.0%	32.0%
Alaska	14.9%	16.1%	24.9%	20.6%	31.4%
Arizona	12.3%	20.9%	32.7%	13.7%	40.9%
California	12.0%	16.6%	33.6%	18.0%	25.1%
Colorado	11.0%	21.7%	35.6%	26.2%	19.4%
Hawaii	10.5%	17.7%	12.8%	10.7%	*
Idaho	14.4%	*	48.2%	4.5%	32.5%
Montana	16.0%	*	15.3%	*	42.2%
Nevada	12.4%	16.1%	35.5%	17.4%	23.1%
New Mexico	20.0%	28.2%	25.8%	*	44.5%
Oregon	11.4%	21.3%	36.9%	14.1%	17.4%
Utah	12.2%	7.3%	34.4%	21.1%	*
Washington	12.5%	15.3%	36.5%	18.4%	32.6%
Wyoming	17.0%	*	32.9%	*	22.7%

* sample size too small for reliable estimate

SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured analysis of March 2001 and 2002 CPS.

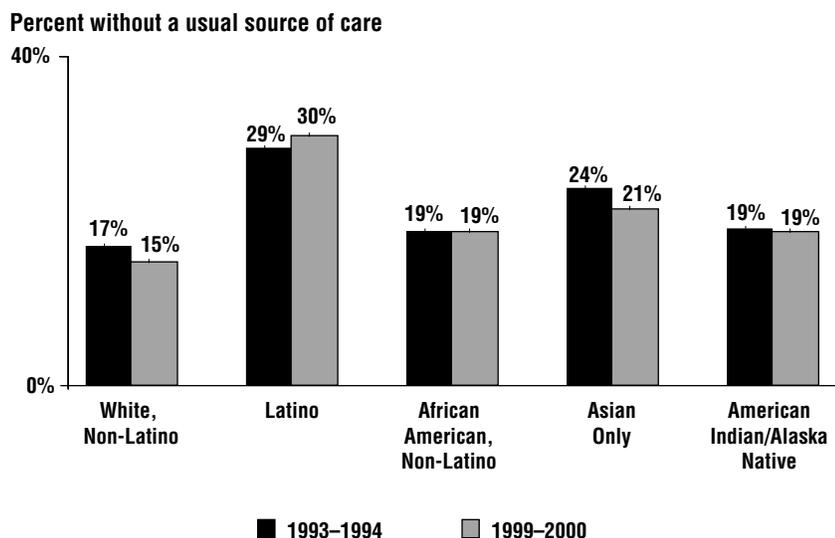
Insurance coverage varies not just by race/ethnicity, but also by state and region. Factors such as the proportion of low-income families, the types of employment, and Medicaid eligibility affect the number of uninsured in a state, and thus, region. For example, uninsured rates of Latinos range from 8.4% in North Dakota to 49.2% in Tennessee.



Section 4

Preventive and Primary Care

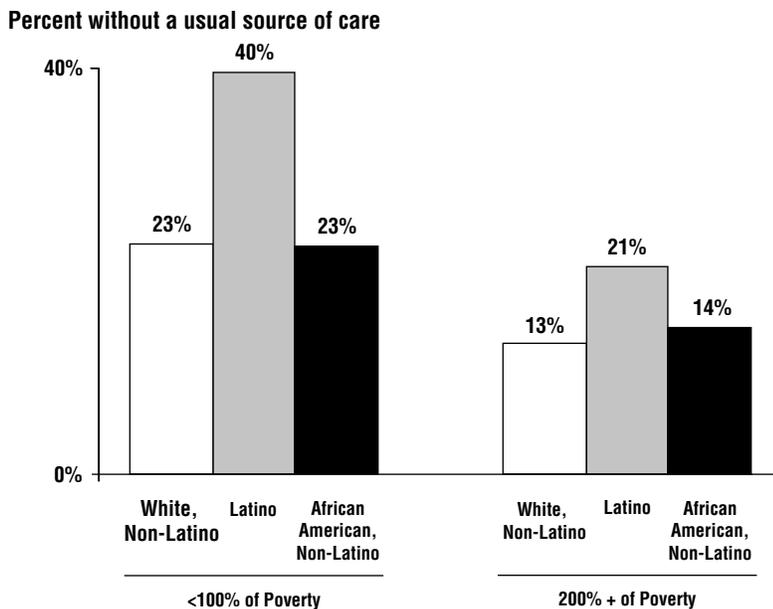
Figure 19a
No Usual Source of Health Care: Adults 18–64,
by Race/Ethnicity, 1993–1994 and 1999–2000



DATA: National Center for Health Statistics, National Health Interview Survey, 1993–1994 and 1999–2000.
 SOURCE: Health, United States, 2002, Table 78.

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

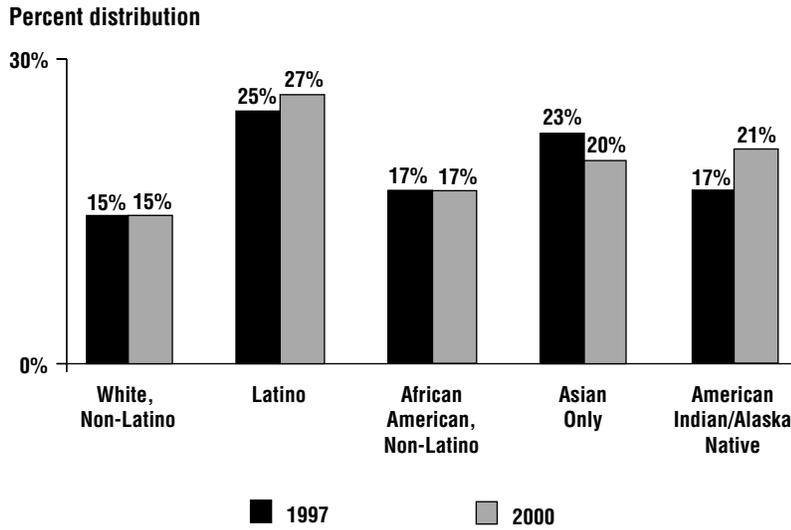
Figure 19b
No Usual Source of Health Care: Adults 18–64,
by Race/Ethnicity and Poverty Status, 1999–2000



DATA: National Center for Health Statistics, National Health Interview Survey, 1999–2000.
 SOURCE: Health, United States, 2002, Table 78.

When comparing racial/ethnic groups of similar income, the disparity in usual source of care is nearly eliminated for African Americans but not for Latinos. However, across racial/ethnic groups, the percentage with no usual source of care is higher among people with incomes below the poverty level than among those with incomes above 200% of poverty.

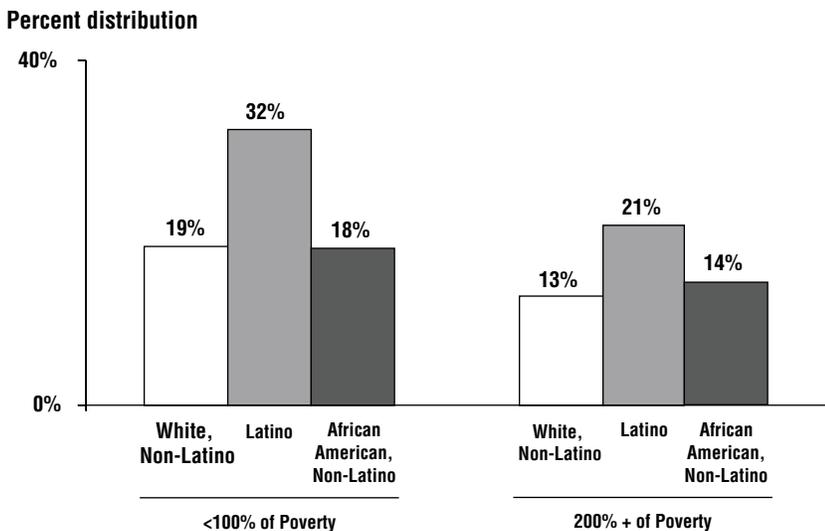
Figure 20a
No Health Care Visits in the Past Year,
by Race/Ethnicity, 1997 and 2000



DATA: National Center for Health Statistics, National Health Interview Survey, 1997 and 2000.
 SOURCE: Health, United States, 2002, Table 72.

In 2000, Latinos, African Americans, Asians and American Indian/Alaska Natives were more likely to be without a health care visit in the past year than were whites. While the percent without a visit decreased among Asians since 1997, the situation has worsened for Latinos and American Indians/Alaska Natives.

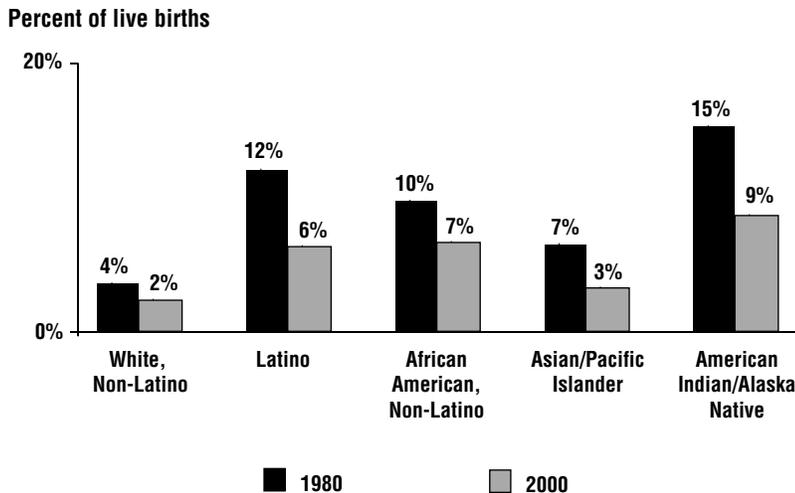
Figure 20b
No Health Care Visits in the Past Year,
by Race/Ethnicity and Poverty Status, 2000



DATA: National Center for Health Statistics, National Health Interview Survey, 2000.
 SOURCE: Health, United States, 2002, Table 72.

When comparing racial/ethnic groups of similar income, the disparities in the percent with no health care visits in the past year are nearly eliminated for African Americans, but not for Latinos. However, across racial/ethnic groups, the percentage with no health care visits in the past year is highest among people with incomes below the poverty level.

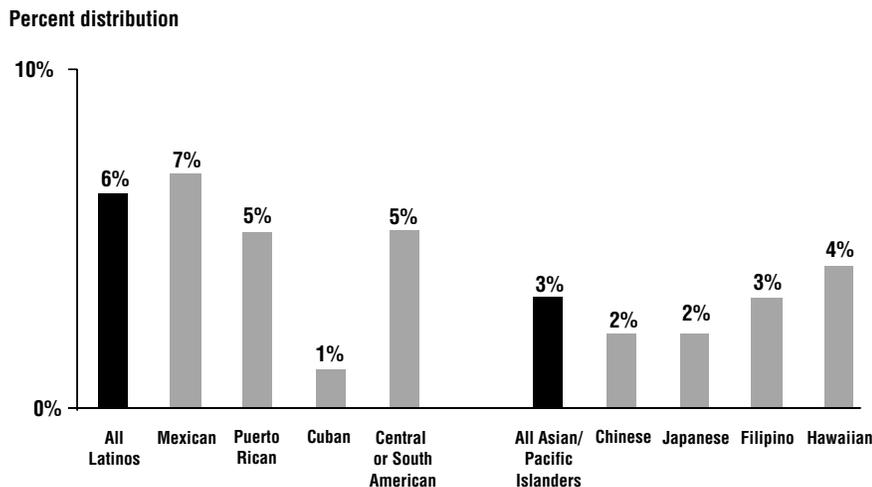
Figure 21a
Late or No Prenatal Care,
by Race/Ethnicity, 1980 and 2000



DATA: National Center for Health Statistics, National Vital Statistics System.
 SOURCE: Health, United States, 2002, Table 6.

Prenatal care that begins in the first trimester of pregnancy improves maternal health and birth outcomes. Though the percent of live births to mothers who received late or no prenatal care has decreased over the past two decades, Latinos, African Americans and American Indian/Alaska Natives are still at least twice as likely than whites and Asian/Pacific Islanders to receive late or no prenatal care.

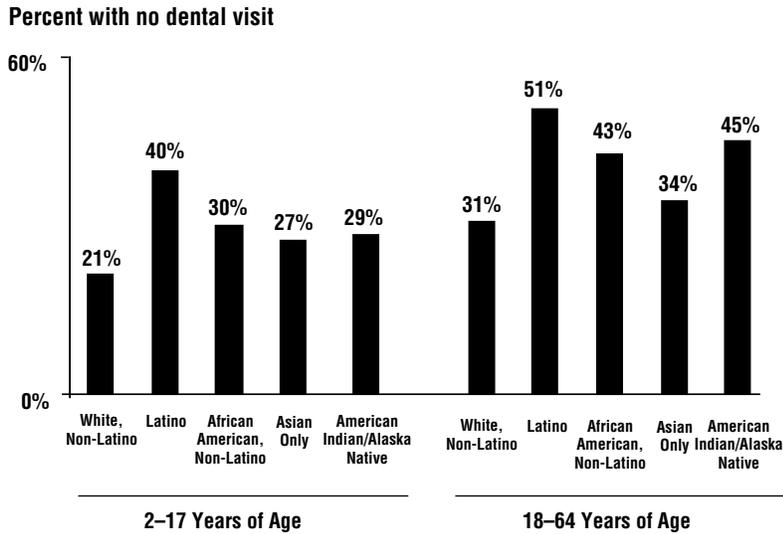
Figure 21b
Late or No Prenatal Care,
by Racial/Ethnic Subgroups, 2000



DATA: National Center for Health Statistics, National Vital Statistics System.
 SOURCE: Health, United States, 2002, Table 6.

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

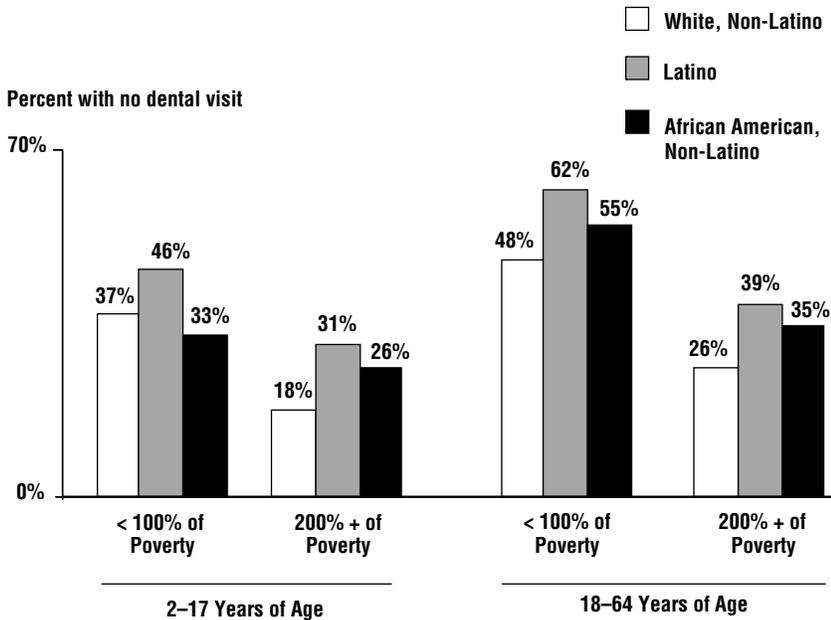
Figure 22a
No Dental Visits in the Past Year,
by Race/Ethnicity, 2000



DATA: National Center for Health Statistics, National Health Interview Survey, 2000.
 SOURCE: Health, United States, 2002, Table 80.

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

Figure 22b
No Dental Visits in the Past Year,
by Race/Ethnicity and Poverty Status, 2000



DATA: National Center for Health Statistics, National Health Interview Survey, 2000.
 SOURCE: Health, United States, 2002, Table 80.

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

Regardless of race/ethnicity, those living in poverty are less likely to have had a dental visit in the previous year than their counterparts with incomes above 200% of poverty.





Section 5

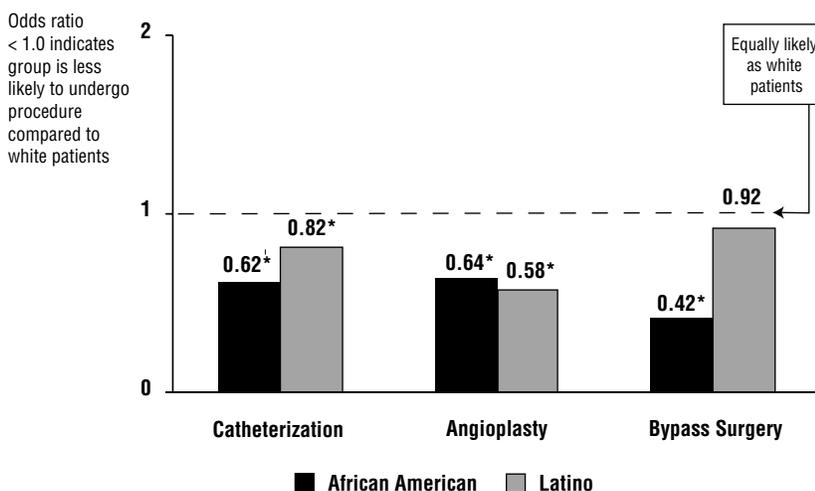
Specialty Care

Heart Disease

Heart disease is the leading cause of death among every racial/ethnic group in the United States except Asian/Pacific Islanders, for whom it is the second leading cause of death. Effective cardiac care has been shown to improve heart disease diagnosis, morbidity and mortality.

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

Figure 23
Rate of Cardiac Interventions Among Medicare Patients Hospitalized with an Acute Myocardial Infarction, by Race/Ethnicity, 1994–1995



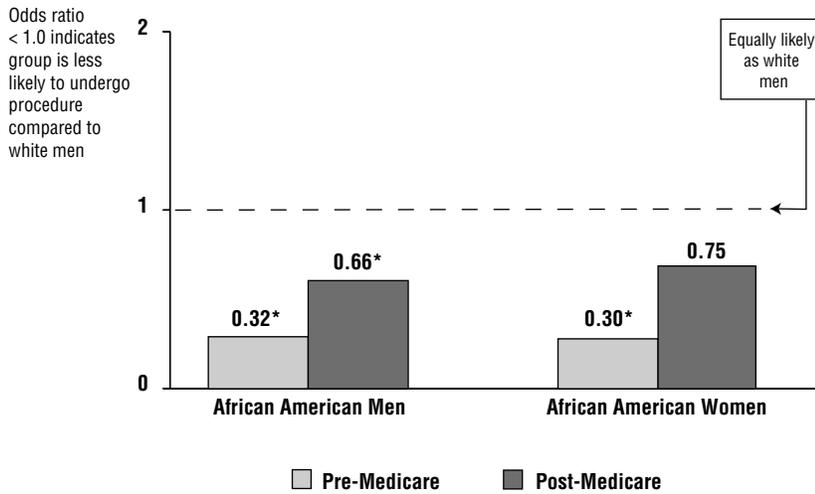
Disparities exist in procedures used both to diagnose and treat heart disease. For example, in a California study, African American Medicare patients were less likely than whites to undergo catheterization, angioplasty and bypass surgery, and Latino Medicare patients were less likely than whites to undergo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

*Difference is statistically significant after adjustment.

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

SOURCE: Ford et al., 2000.

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



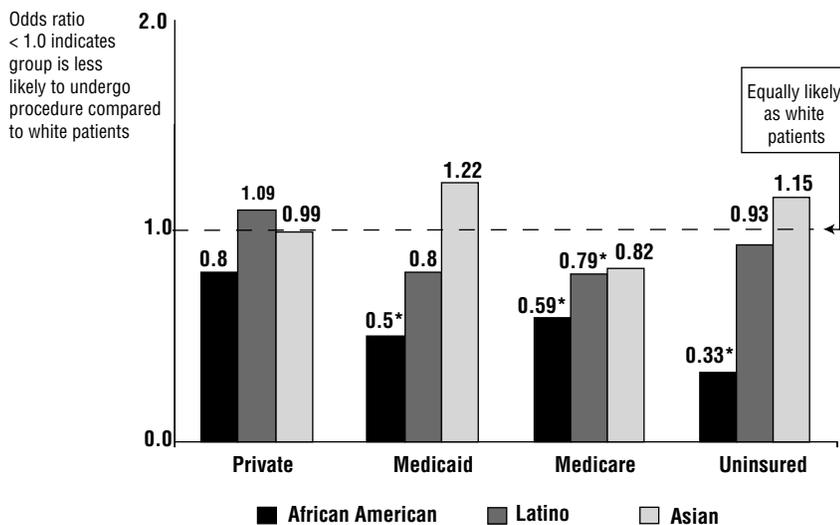
*Difference is statistically significant after adjustment.

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

SOURCE: Daumit and Powe, 2001.

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

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



*Difference is statistically significant after adjustment.

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

SOURCE: Carlisle et al., 1997.

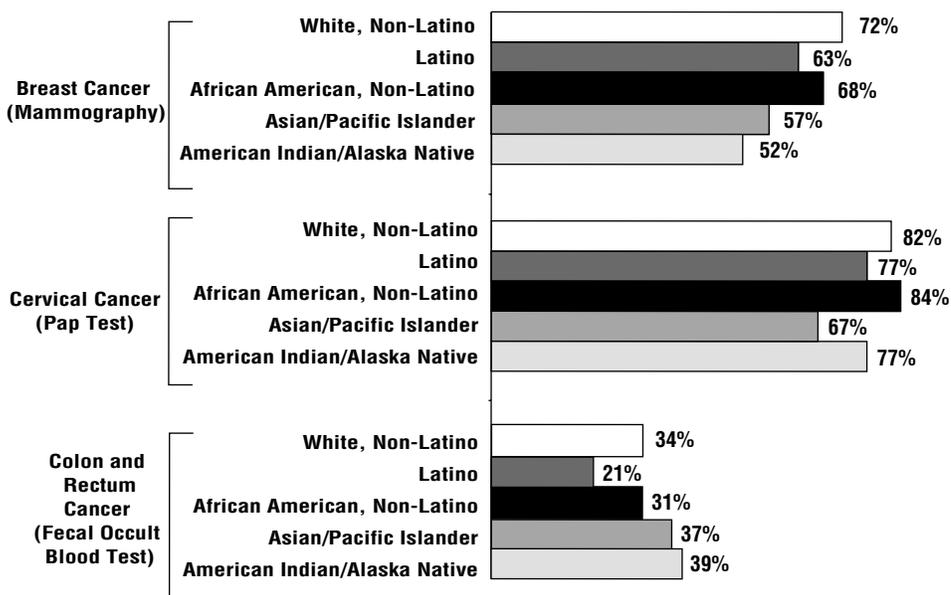
Type of insurance coverage may also have an impact on disparities in care. In a California study, African American Medicaid, Medicare and uninsured patients were less likely than whites to undergo bypass surgery. Latino Medicare patients were also less likely than whites to undergo surgery. However,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

Cancer

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

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

Figure 26
Cancer Screening, by Race/Ethnicity, 2000



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

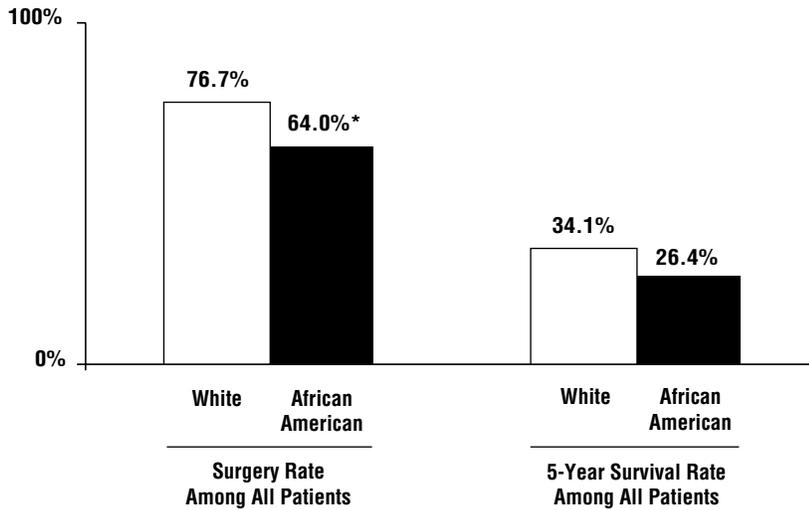
Colorectal cancer screening occurs less frequently among women and men across racial/ethnic groups, and Latinos are the least likely to report having been screened for colon and rectum cancer within the past two years. However, as with breast and cervical cancer, mortality rates from colon and rectum cancer are higher among African Americans than among whites, despite comparable screening rates.

NOTE: Age-adjusted percentages of women 40 and over who reported a mammography within the past two years, women 18 and older who reported a pap test within the past three years, and adults 50 and older (male and female) who reported a fecal occult blood test within the past two years.

DATA: National Center for Health Statistics, National Health Interview Survey, 2000.

SOURCE: American Cancer Society, Cancer Prevention & Early Detection: Facts & Figures 2003.

Figure 27
Racial Differences in the Treatment of Early-Stage Lung Cancer Among Medicare Patients, 1985–1993



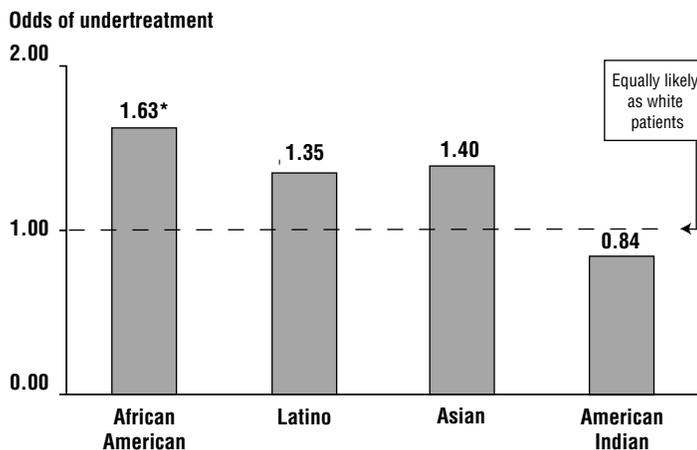
*Difference is statistically significant after adjustment.

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

SOURCE: Bach et al., 1999.

Research has also uncovered differences between the cancer treatment provided to minority patients and that provided to whites. For example, African American Medicare patients with early stage lung cancer had lower surgery rates and five-year survival rates than white patients during 1985–1993. African American patients were half as likely as whites to undergo surgery, after adjusting for age, sex, median income in the zip code of residence, and stage of illness (Odds Ratio = 0.54).

Figure 28
Untreated Daily Pain Among Elderly Nursing Home Residents with Cancer, 1992–1995



*Difference is statistically significant after adjustment.

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

SOURCE: Bernabei et al., 1998.

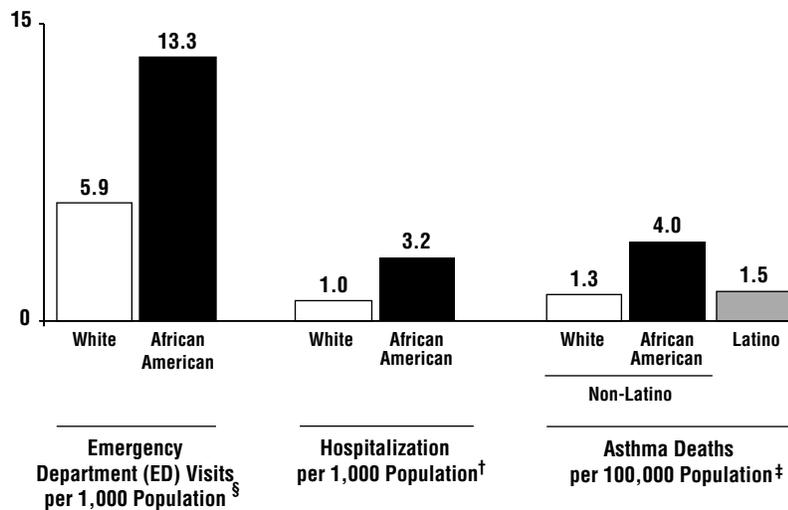
Disparities have also been seen in the receipt of analgesics. For example, a five-state study investigated pain management among cancer patients whose Medicare coverage was extended to include medication costs. Among those with daily pain, African Americans were more likely than whites to receive no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

Asthma

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

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

Figure 29
Asthma: Health Care Use and Outcomes, 2000



NOTE: Age-adjusted to the 2000 population.

DATA: [§] National Hospital Ambulatory Medical Care Survey, [†] National Hospital Discharge Survey,

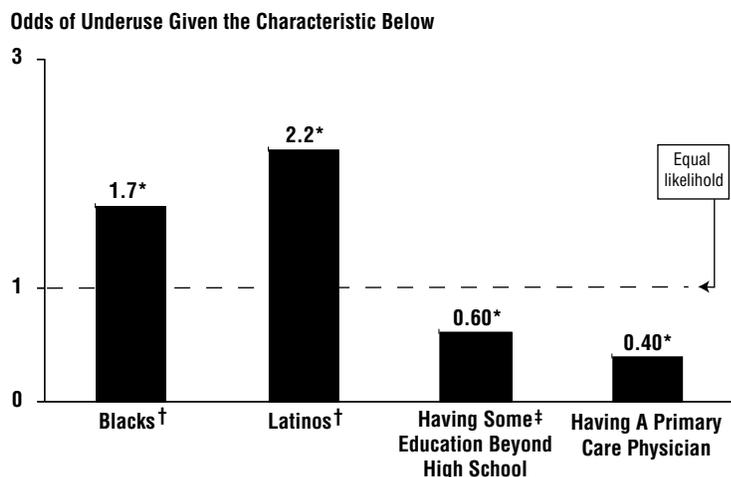
[‡] Mortality Component of the National Vital Statistics System, NCHS, CDC.

SOURCE: CDC, NCHS, 2003.

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

The disparity in asthma hospitalization rates persists in lower- and upper-income communities. For example, analysis of 1989–1991 data for children ages 1–14 shows that African Americans were about 3 times as likely as their white counterparts to be hospitalized for asthma regardless of income (President’s Initiative on Race Chartbook, 2001).

Figure 30
Underuse of Medication Among Medicaid-Insured Children with Asthma, 1999



* Difference is statistically significant after adjustment.

[†] Compared to whites

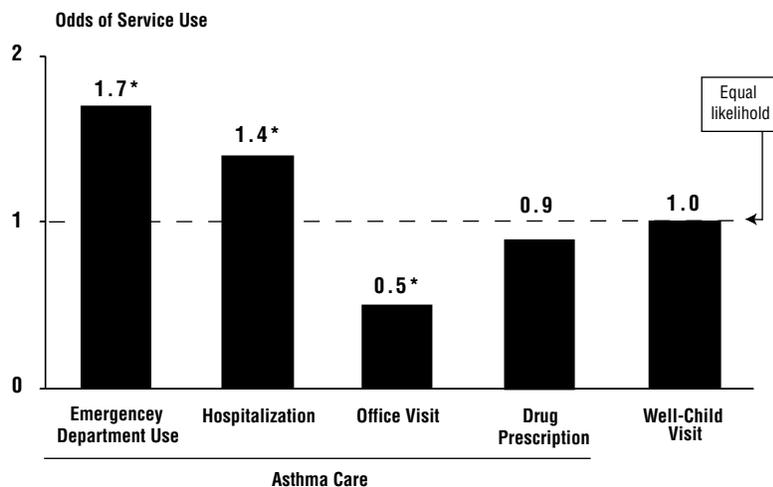
[‡] Compared to families in which the parent had graduated from high school, but had no additional education

NOTE: Model adjusted for socio-demographic factors, symptom level, and reports of processes of care. The children, ages 2–16, were enrolled in managed care plans located in California, Massachusetts, and Washington state.

SOURCE: Finkelstein et al., 2002.

Racial/ethnic disparities are also evident in the use of routine medications for asthma. A study of Medicaid beneficiaries enrolled in several geographically dispersed managed care plans found that African American and Latino children with asthma were more likely to underuse routine medications (i.e., anti-inflammatory agents) than white children. However, parental education and/or having a primary care physician had a protective effect. Children whose parents had some education beyond high school or had a primary care physician were less likely to underuse routine medications than their counterparts.

Figure 31
Use of Selected Services by African American Children with Asthma,[†] 1988–1992 (Seattle)



[†] Compared to white children with asthma

*Statistical difference between African American and white children.

NOTE: Adjusted for age, sex, area of residence, and predominant office provider type (for asthma care).

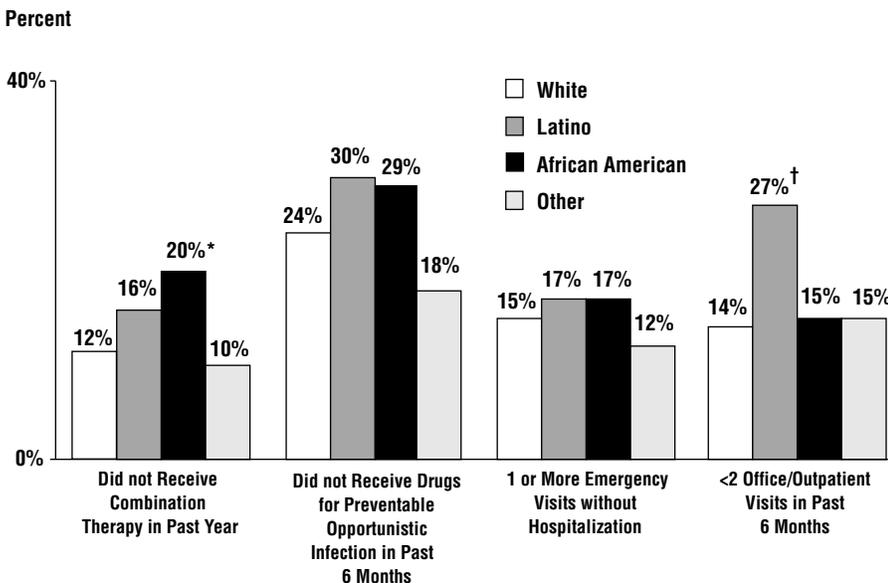
SOURCE: Lozano et al., 1995.

One study of Medicaid beneficiaries shows that outpatient visits are lower for African American children with asthma than for white children, a finding that might contribute to higher asthma hospitalization rates or emergency department use. While there were no differences in the amount of well-child visits or prescriptions for asthma drugs, African American children in this study were less likely to receive the drug therapy recommended in national asthma guidelines.

HIV/AIDS

In 2001, African Americans and Latinos represented 26% of the U.S. population; however, they accounted for 68% of newly reported AIDS cases. Given that HIV infection is now the leading cause of death among African Americans between the ages of 25 and 44 (and the fourth leading cause of death among Latinos in the same age group), there are growing concerns about the adequacy of treatment and the effectiveness of prevention efforts in communities of color.

Figure 32
Health Services Use Among Persons with HIV/AIDS in Care, by Race/Ethnicity, 1998



* Results significantly different from whites ($p < .05$) after adjustment for CD4 count.

† Results significantly different from whites and African Americans ($p < .05$) after adjustment for CD4 count.

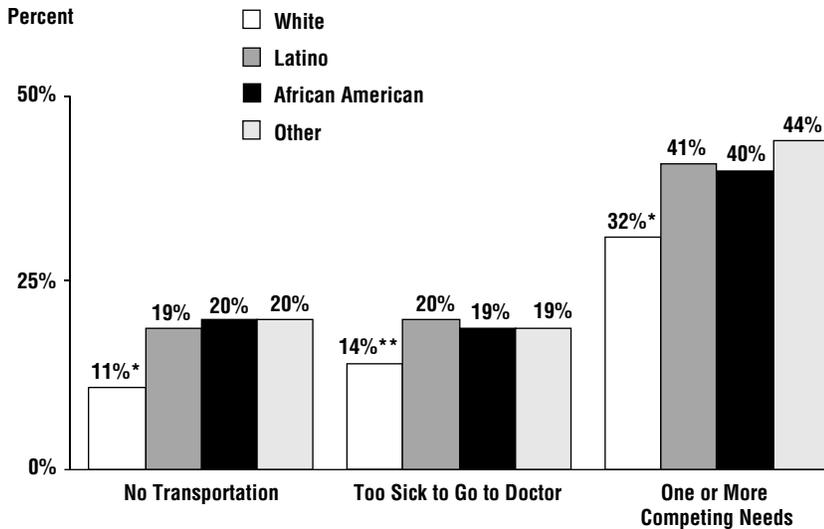
NOTE: Includes persons 18 years and older.

SOURCE: Shapiro et al., 1999.

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

People of color continue to fare more poorly than whites on several access and quality measures. Data from the HIV Cost and Services Utilization Study (HCSUS)—the only nationally representative study of people with HIV who are in care—showed disparities in several measures of health services use in 1996, including the receipt of combination drug therapy (the accepted standard of care). By 1998, many of the racial/ethnic disparities identified no longer existed. However, African Americans were still more likely than whites to not get combination drug therapy. Additionally, Latinos were more likely than whites and African Americans to have fewer than two outpatient visits in the past six months.

Figure 33
Reasons for Postponing Care Among Persons with HIV/AIDS in Care, by Race/Ethnicity, 1996



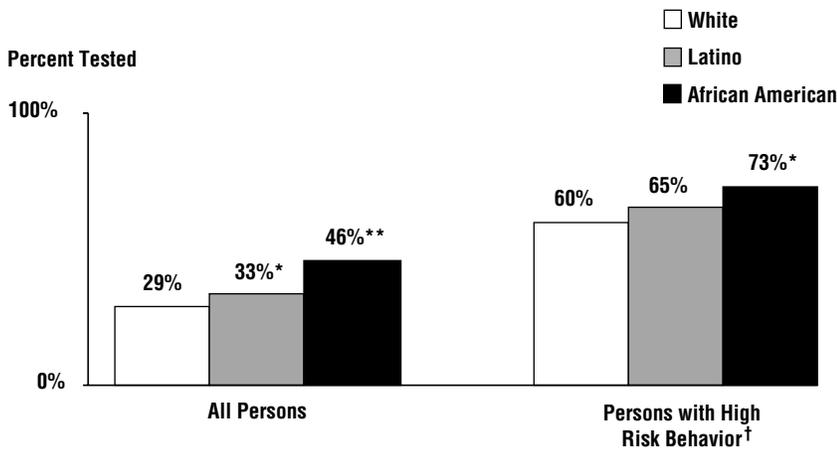
* Results significantly different at $p < .01$; ** Results significantly different at $p < .05$.

NOTE: Includes persons 18 years and older.

SOURCE: Cunningham et al., 1999.

The reasons for disparities in care are not well understood; however, HCSUS provides evidence that people of color with HIV face greater barriers to care than their counterparts who are white. For example, about a fifth of African Americans (20%) and Latinos (19%) with HIV report postponing medical care due to the lack of transportation, compared to 11% of whites. People of color were also more likely than whites to report that they postponed care because they were too sick to go to the doctor or had competing needs (e.g., had to spend limited dollars for food or housing). Data from this national study also indicate that Latinos were more likely than whites to delay care after HIV diagnosis (23% vs. 15%; see Turner et al., 2000).

Figure 34
Percent Who Report Ever Having Been Tested for HIV, by Race/Ethnicity, 1999



* Results significantly different from whites.

** Results significantly different from whites and Latinos.

† Persons with perceived risk, or who reported any HIV risk behavior.

NOTE: Includes persons 18 years and older (excludes testing for blood donation).

SOURCE: CDC Morbidity and Mortality Weekly Report, November, 2001.

Increasing awareness of one's HIV status is critical for the prevention and care of HIV disease in communities of color. A 1999 nationwide survey indicates that African Americans reported previous HIV testing more frequently than Latinos or whites, however less than half of African Americans had ever been tested. Persons with high-risk behavior were more likely than others to be tested, however a substantial portion of whites, Latinos and African Americans with high-risk behavior had never been tested.

CONCLUSION

Key Facts: Race, Ethnicity, and Medical Care presents compelling evidence of racial and ethnic differences in health insurance coverage, access to primary care, and treatment for specific medical conditions. In some studies, these differences are reduced, if not eliminated, when comparing minority populations and whites of similar socio-economic conditions, insurance coverage, and health status. Even when differences persist, it should be noted that differentials in care may not be inherently problematic, and that the level of care obtained by whites is not necessarily the appropriate standard for comparison.

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

DATA NOTES

Race/Ethnicity Data

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

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

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

2000 Census

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

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

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

Population Estimates

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

Federal Poverty Threshold

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

Grouping Household Members

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

BIBLIOGRAPHY

- American Cancer Society. 2003. *Cancer Prevention & Early Detection: Facts & Figures*. Atlanta, GA.
- Bach, P.B., L.D. Cramer, J.L. Warren, and C.B. Begg. 1999. Racial Differences in the Treatment of Early-Stage Lung Cancer. *New England Journal of Medicine* 431:16 (October):1198–1205.
- Bernabei R., G. Gambassi, K. Lapane, F. Landi, C. Gatsonis, R. Dunlop, L. Lipsitz, K. Steel, and V. Mor. 1998. Management of Pain in Elderly Patients With Cancer. *Journal of American Medical Association* 279:23 (June):1877–1882.
- Carlisle D.M., B.D. Leake, and M.F. Shapiro. 1997. Racial and Ethnic Disparities in the Use of Cardiovascular Procedures: Association with Type of Health Insurance. *American Journal of Public Health* 87:2 (February):263–267.
- Centers for Medicare and Medicaid Services. 1999. *Medicare Current Beneficiary Survey*. Washington, DC.
- Cunningham W.E., R.M. Andersen, M.H. Katz, M.D. Stein, B.J. Turner, S. Crystal, S. Zierler, K. Kuromiya, S.C. Morton, P. St. Clair, S.A. Bozzette, and M.F. Shapiro. 1999. The Impact of Competing Subsistence Needs and Barriers on Access to Medical Care for Persons With Human Immunodeficiency Virus Receiving Care in the United States. *Medical Care* 37:12:1270–1281.
- Daumit G.L., and N.R. Powe. 2001. Factors Influencing Access to Cardiovascular Procedures in Patients With Chronic Kidney Disease: Race, Sex, and Insurance. *Seminars in Nephrology* 21:4(July):367–376.
- Finkelstein J.A., P. Lozano, H.J. Farber, I. Miroshnik, and T.A. Lieu. 2002. Underuse of Controller Medications Among Medicaid-Insured Children With Asthma. *Archives of Pediatric Adolescent Medicine* 156:562–567.
- Ford E., J. Newman, and K. Deosaransingh. 2000. Racial and Ethnic Differences in the Use of Cardiovascular Procedures: Findings From the California Cooperative Cardiovascular Project. *American Journal of Public Health* 90:7(July):1128–1134.
- Kaiser Commission on Medicaid and the Uninsured. 2002. *Analysis of March 2002 Current Population Survey*. Washington, DC.
- Kaiser Commission on Medicaid and the Uninsured. 2003. *Health Insurance Coverage in America: 2001 Data Update*. Washington, DC.
- Lozano P., F.A. Connell, and T.D. Koepsell. 1995. Use of Health Services by African American Children with Asthma on Medicaid. *Journal of the American Medical Association* 274:6 (August):229–239.
- Shapiro M.F., S.C. Morton, D.F. McCaffrey, J.W. Senterfitt, J.A. Fleishman, J.F. Perlman, L.A. Athey, J.W. Keesey, D.P. Goldman, S.H. Berry, and S.A. Bozzette. 1999. Variations in the Care of HIV-Infected Adults in the United States. *Journal of the American Medical Association* 281:24(June):2305–2315.
- Turner B.J., W.E. Cunningham, N. Duan, R.M. Andersen, M.F. Shapiro, S.A. Bozzette, T. Nakazono, S. Morton, S. Crystal, P. St. Clair, M. Stein, and S. Zierler. 2000. Delayed Medical Care After Diagnosis in a US National Probability Sample of Persons Infected With Human Immunodeficiency Virus. *Archive of Internal Medicine* 160:2614–2622.

- U.S. Department of Commerce. 2000. Population Division. *Projections of the Resident Population by Race, Hispanic Origin, and Nativity: Middle Series, 2050 to 2070*. Washington, DC: U.S. Census Bureau.
- U.S. Department of Commerce. 2001. Economics and Statistics Administration. *Overview of Race and Hispanic Origin: 2000*. Washington, DC: U.S. Census Bureau.
- U.S. Department of Commerce. 2000. Economics and Statistics Administration. *The Two or More Races Population: 2000*. Washington, DC: U.S. Census Bureau.
- U.S. Department of Health and Human Services. 2000. Centers for Disease Control. *Asthma Prevalence, Health Care Use and Mortality, 2000–2001*. Hyattsville, MD: National Center for Health Statistics (NCHS).
- U.S. Department of Health and Human Services. 2001. Centers for Disease Control. *HIV Testing Among Racial/Ethnic Minorities—United States, 1999*. Washington, DC: Morbidity and Mortality Weekly Report 50:47 (November).
- U.S. Department of Health and Human Services. 2002. Center for Disease Control and Prevention. *National Vital Statistics Report*. Hyattsville, MD: National Center for Health Statistics.
- U.S. Department of Health and Human Services. 2002. *Health, United States, 2002 Chartbook on Trends in the Health of Americans*. Hyattsville, MD: National Center for Health Statistics.
- U.S. Department of Health and Human Services. 1998. *Health, United States, 1998 Socioeconomic Status and Health Chartbook*. Hyattsville, MD: National Center for Health Statistics.



The Henry J. Kaiser Family Foundation is an independent, national health philanthropy dedicated to providing information and analysis on health issues to policymakers, the media, and the general public. The Foundation is not associated with Kaiser Permanente or Kaiser Industries.



The Henry J. Kaiser Family Foundation

2400 Sand Hill Road
Menlo Park, CA 94025
(650) 854-9400 Fax: (650) 854-4800

Washington Office:

1330 G Street, NW
Washington, DC 20005
(202) 347-5270 Fax: (202) 347-5274

www.kff.org

Additional copies of this report (#6069)
are available on the Kaiser Family Foundation's website at
www.kff.org.