Key Facts

Race, Ethnicity & Medical Care

January 2007

THE HENRY J. KAISER FAMILY FOUNDATION

Prepared by

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INTRODUCTION

This update of *Key Facts: Race, Ethnicity, and Medical Care,* like its predecessors, is intended to serve as a quick reference source on the health, health insurance coverage, access and quality of health care of racial and ethnic groups in the United States. The document highlights some of the best available data and research in these areas.

Since the first edition of *Key Facts* in 1999, the issue of racial/ethnic disparities in health care has received a significant level of attention. The Institute of Medicine released *Unequal Treatment* in 2002 summarizing the research to date on racial and ethnic disparities in health care and offering guidance as to what questions remained unanswered and what information was needed to answer those questions. The Agency for Healthcare Research and Quality (AHRQ) released the first *National Healthcare Disparities Report (NHDR)* in 2003. The report, which is issued annually by AHRQ, provides a comprehensive review of disparities in health care among racial, ethnic, and socioeconomic groups in the United States.

As more information has become available on health care disparities, the focus of research has turned from documenting disparities to trying to understand their causes and developing interventions to alleviate them. This is not to say that documentation of the problem is no longer needed. Data are still limited for some racial and ethnic subgroups, and for individuals who self-identify with more than one racial group. As such, information that documents health care disparities is important to understanding where progress has been made and the challenges that remain. This version of *Key Facts,* where possible, highlights data that show whether health care disparities are narrowing, widening, or persisting for specific racial/ethnic groups and presents newly collected data for people who identify with more than one racial group.

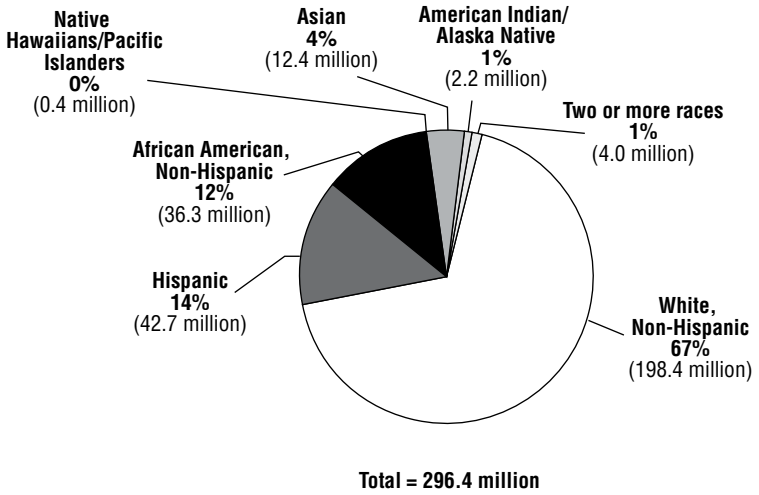
Key Facts is divided into six sections, beginning with an overview of the demographic characteristics of the U.S. population. Section 2 presents health measures, stratified when possible by a measure of socioeconomic status. Section 3 profiles patterns of health insurance coverage. Section 4 offers a picture of the data as they relate to preventive and primary care. Section 5 focuses on three medical conditions: diabetes, HIV/AIDS, and asthma. Finally, Section 6 presents findings from the *2005 NHDR* that are useful in tracking national changes in health care disparities over time.

Section 1
Demographics

The United States is racially and ethnically diverse, and the nation's diversity is growing over time. As of 2005, nearly one-third of the U.S. population identified themselves as a member of a racial or ethnic minority group; by 2050, this share is expected to increase to nearly half. The racial and ethnic composition of the population varies by state, with states in the West and South having the highest shares of minority residents. People of color are more likely than non-Hispanic Whites to have low-incomes, which may have implications for both their health and insurance status.

Figure 1

Percent Distribution of U.S. Population by Race/Ethnicity, 2005



NOTES: Data do not include residents of Puerto Rico, Guam, the U.S. Virgin Islands, or the Northern Mariana Islands. For the purposes of this chart, Asians and Native Hawaiians or Other Pacific Islanders are combined into one category. Totals may not add to 100% due to rounding.

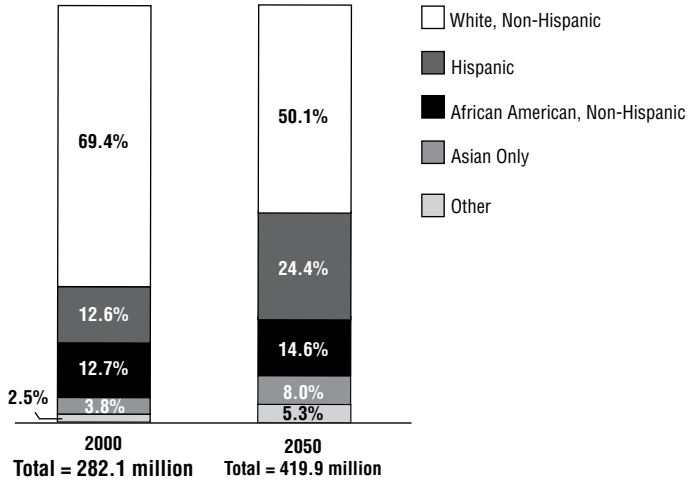
SOURCE: Table 3: Annual Estimates of the Population by Sex, Race and Hispanic or Latino Origin for the United States: April 1, 2000 to July 1, 2005 (NC-EST2005-03). Population Division, U.S. Census Bureau

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

Individuals have been allowed to identify themselves by more than one racial category since the 2000 Census. However, only 1% (4 million people) of the non-Hispanic population in the U.S. identified themselves as being of "Two or more races" in 2005.

Figure 2

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



NOTES: Data do not include residents of Puerto Rico, Guam, the U.S. Virgin Islands, or the Northern Marina Islands. "Other" category includes American Indian/Alaska Native, Native Hawaiian or Other Pacific Islander, and individuals reporting "Two or more races." African-American, Asian, and Other categories jointly double-count 1% (2000) and 2% (2050) of the population that is of these races and Hispanic; thus, totals may not add to 100%.

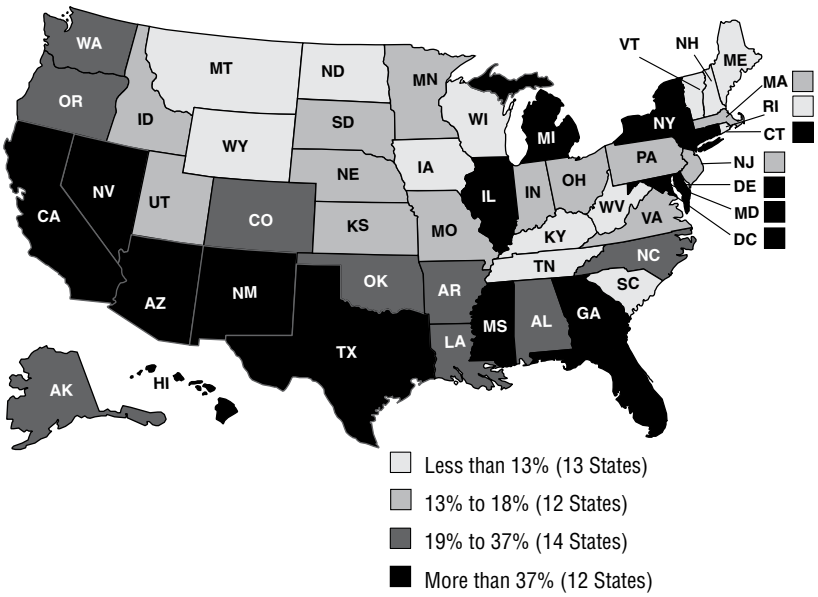
DATA: U.S. Census Bureau, 2004, US Interim Projections by Age, Sex, Race, and Hispanic Origin.

SOURCE: http://www.census.gov/population/www/projections/popproj.html

By the year 2050, the U.S. Census estimates that nearly half of the U.S. population will be Hispanic, African American and Asian. The proportion of Hispanics and Asians in the U.S. is expected to double in the next 50 years.

Figure 3

Share of Population that is a Racial/Ethnic Minority by State, 2004–2005



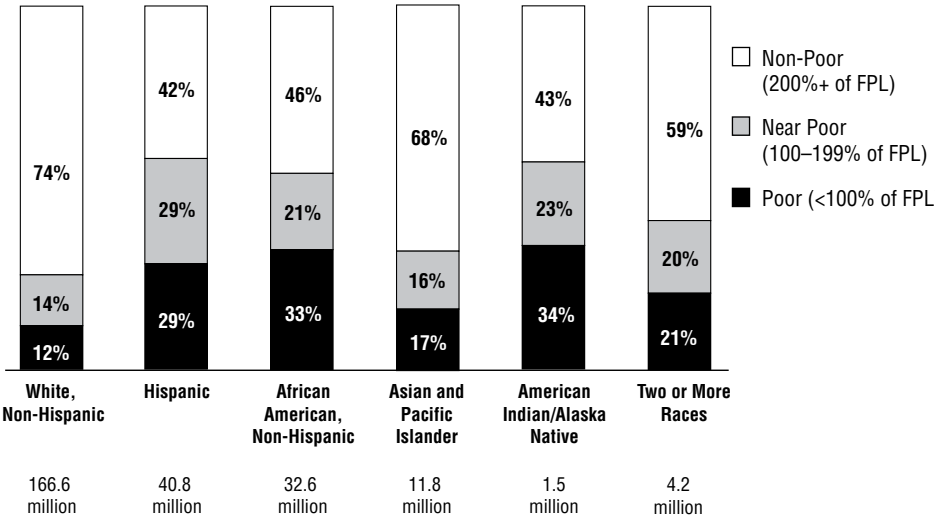
DATA: March 2006 and March 2005 Current Population Survey.

SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates.

There is large variation in the geographic distribution of the racial and ethnic minority population across the United States. States in the West such as Hawaii, California, and New Mexico have some of the highest percentages of individuals who are racial/ethnic minorities. Percentages in these states range from 55 to 81 percent minority, while states in the northeast such as Maine, Vermont, and New Hampshire have some of the lowest percentages, ranging from 1 to 5 percent.

Figure 4

Poverty Status of Nonelderly Population by Race/Ethnicity, 2005



NOTES: Individuals who reported more than one race group were categorized as "two or more races." Nonelderly includes individuals under age 65. FPL= Federal Poverty Level. The FPL for a family of four in 2005 was $19,971.

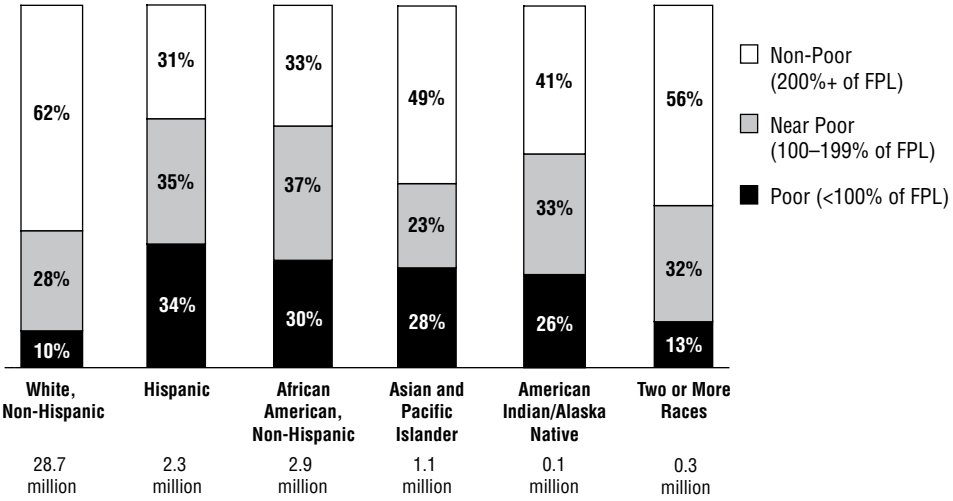
DATA: March 2006 Current Population Survey.

SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates.

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 $39,342 for a family of four in 2005). Over half of Hispanics, African Americans, and American Indians/Alaska Natives are poor or near poor, compared with 26% of Whites and 33% of Asians and Pacific Islanders. The proportion of children who are poor or near poor is even higher.

Figure 5

Poverty Status of Elderly Population by Race/Ethnicity, 2005



NOTES: Individuals who reported more than one race group were categorized as "two or more races." Elderly includes individuals age 65 and over. FPL= Federal Poverty Level. The FPL for a family of four in 2005 was $19,971.

DATA: March 2006 Current Population Survey.

SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates.

Similarly, elderly minority Americans are far more likely than their White counterparts to have family incomes less than 200% of the federal poverty level. Nearly 70% of elderly Hispanics, two-thirds of elderly African Americans, and half of elderly Asians and Pacific Islanders and American Indian/Alaska Natives are poor or near poor, compared with 38% of elderly Whites.

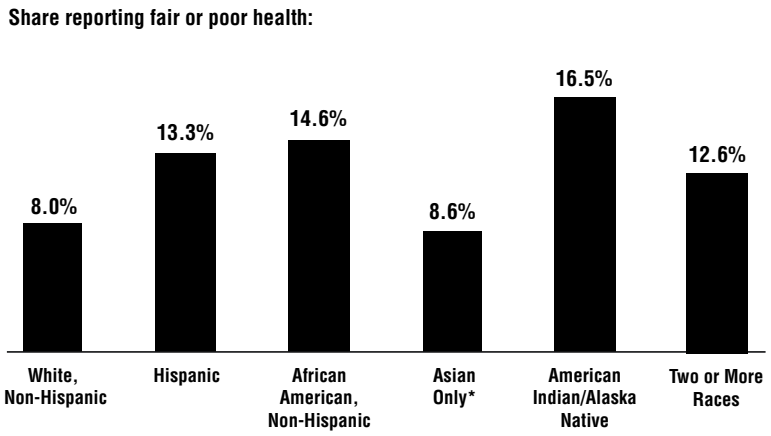
Section 2
Health Status

Health status is a function of several factors, including access to care and insurance coverage, socioeconomic conditions (education, occupation, income, and place of residence), genetics, and personal behavior. Racial or ethnic minority population groups (other than Asians) rate their overall health worse than non-Hispanic Whites. While poor or low-income people of all races report worse health status than higher income people, differences in overall health status by race/ethnicity persist even within income groups. Minority Americans frequently report higher prevalence of specific health problems, such as diabetes or obesity, which can have serious consequences for health and longevity.

The poorer health status of racial and ethnic minority Americans is also reflected in higher death rates for many common causes. For example, infant mortality rates, as well as overall mortality ratios at different age groups, are higher among African-Americans and American Indian/Alaska Natives than among other groups. Heart disease and cancer are common causes of death among all races and ethnicities, but African-Americans experience higher death rates from these diseases than other groups.

Figure 6

Fair or Poor Health Status by Race/Ethnicity, 2004



NOTES: Respondents assessed their health status as excellent, very good, good, fair or poor.
*The sample size for Native Hawaiian/Pacific Islander was not large enough for reliable estimates.

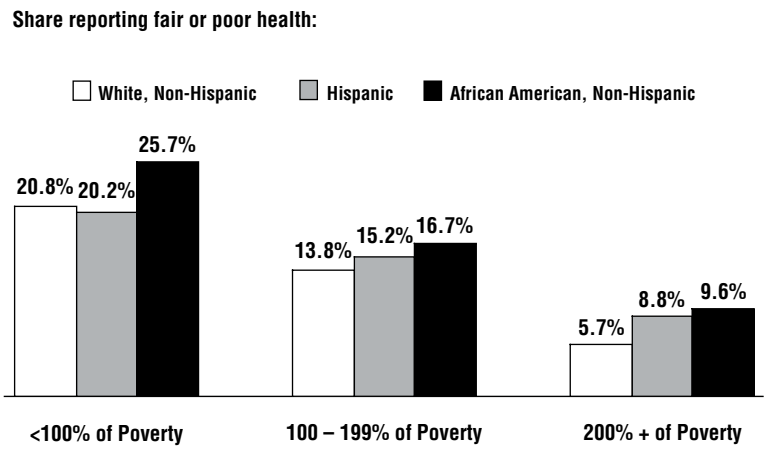
DATA: National Center for Health Statistics, National Health Interview Survey, 2004.

SOURCE: *Health, United States, 2006,* Table 60.

American Indian/Alaska Natives, African Americans, Hispancis, and those who identify themselves as of two or more races are more likely to rate their health as fair or poor compared to Whites and Asians. Estimates for Native Hawaiians/Pacific Islanders were unreliable.

Figure 7

Fair or Poor Health Status by Race/Ethnicity and Income, 2004



NOTES: Respondents assessed their health status as excellent, very good, good, fair or poor. The federal poverty level for a family of four in 2004 was $19,307 (http://www.census.gov/hhes/www/poverty/threshld/thresh04.html).

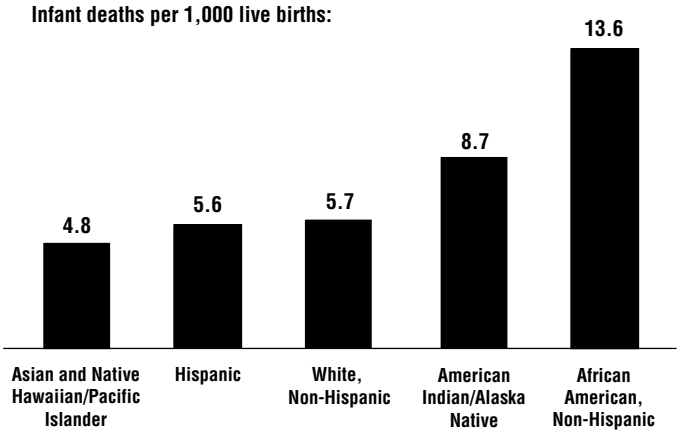
DATA: National Center for Health Statistics, National Health Interview Survey, 2004.

SOURCE: *Health, United States, 2006,* Table 60.

People with family incomes below 100% of poverty are more likely to rate their health as fair or poor compared to the near-poor and non-poor. When comparing racial/ethnic groups of similar incomes, the disparity in self-reported health is reduced but not eliminated.

Figure 8

Infant Mortality Rate by Race/Ethnicity, 2003



NOTE: Births are categorized according to race/ethnicity of mother.

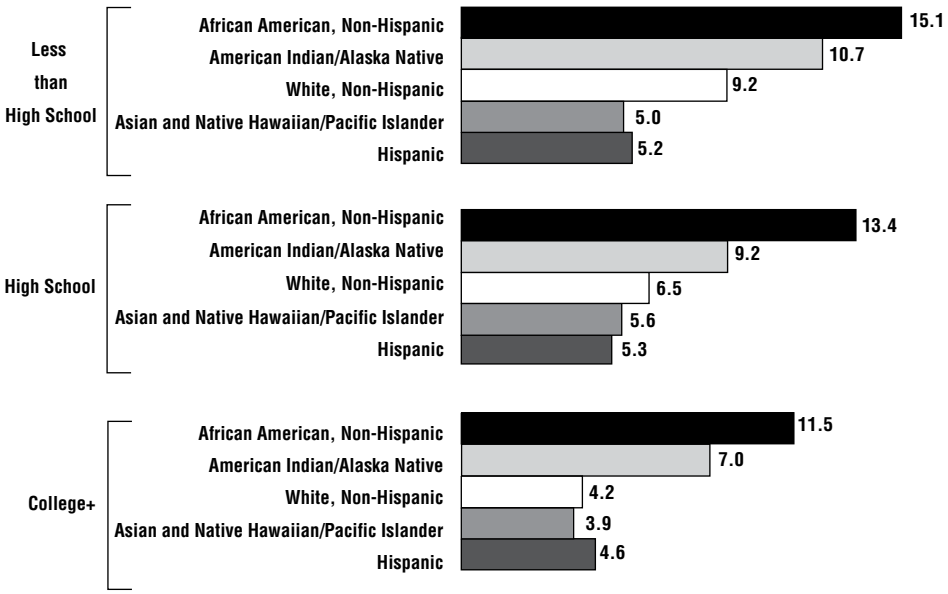
DATA: National Center for Health Statistics, National Vital Statistics System, Linked Birth/Infant Death Data Set.

SOURCE: *Health, United States, 2006,* Table 19.

The infant mortality rate for African Americans is more than twice that of Whites. Infant mortality rates for African Americans and American Indian/Alaska Natives are higher than those for Whites, Hispanics, and Asians.

Figure 9

Infant Mortality Rates for Mothers Age 20+ by Race/Ethnicity and Education, 2001–2003



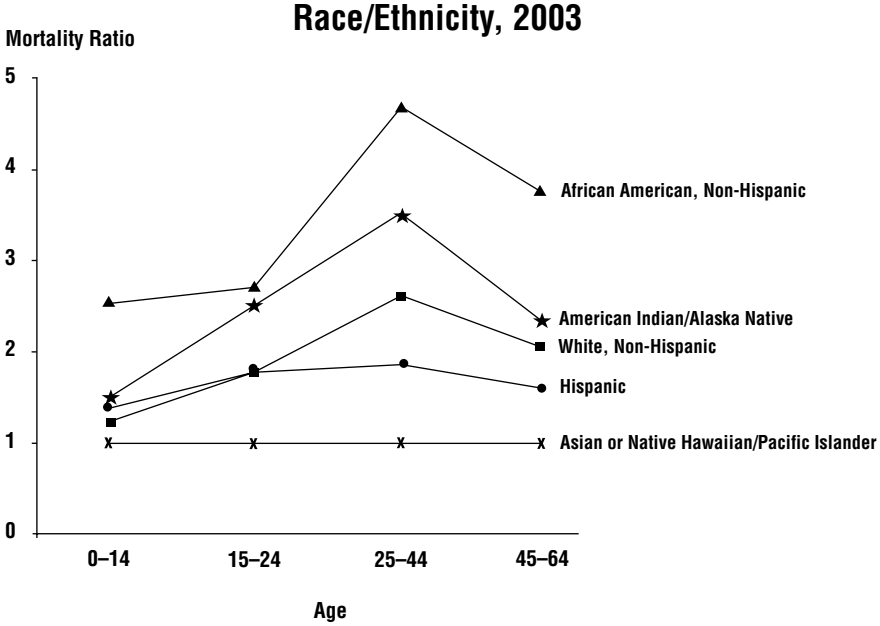
DATA: National Center for Health Statistics, National Vital Statistics System, National Linked Birth/Infant Death Data.

SOURCE: *Health, United States, 2006,* Table 20.

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

Figure 10

Mortality Ratios by Age, Gender, and Race/Ethnicity, 2003



NOTE: The chart compares death rate of each racial/ethnic group to that of Asian/Pacific Islander, the group with the lowest death rates at each age.

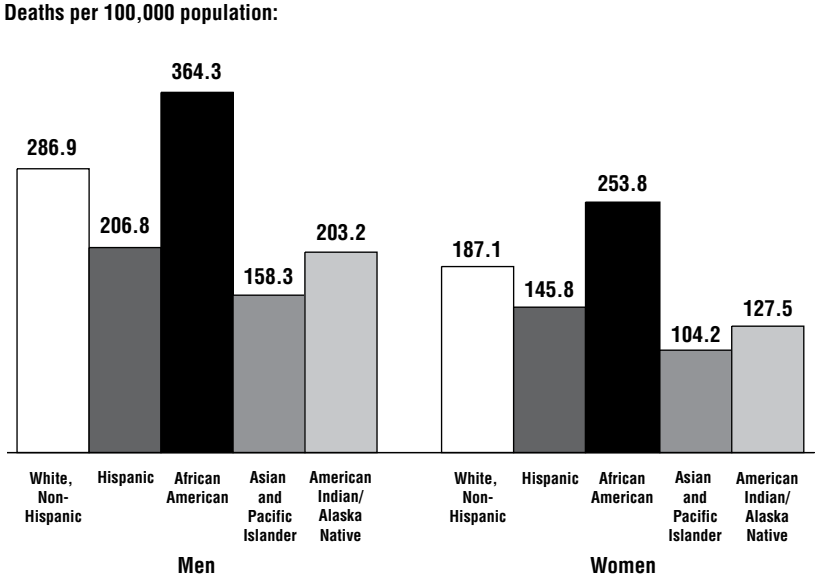
DATA: National Center for Health Statistics, National Vital Statistics System.

SOURCE: *National Vital Statistics Report,* 54(13): April 19. 2006.

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

Figure 11

Death Rate due to Heart Disease by Race/Ethnicity, 2003



NOTE: Rates are age-adjusted.

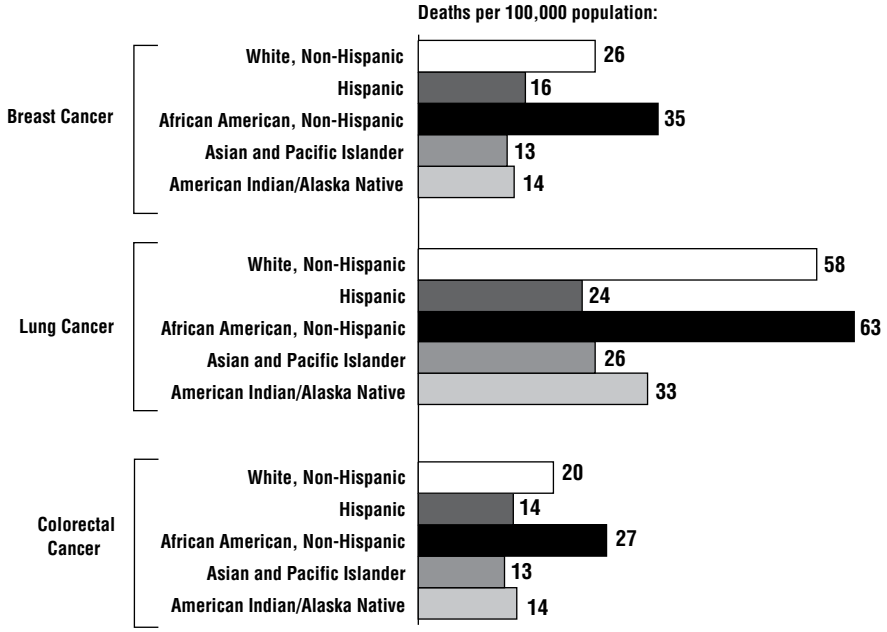
DATA: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.

SOURCE: *Health US, 2005,* Table 36.

In 2003, the death rate due to heart disease for men was higher than the death rate for women. Regardless of gender, the death rate for African Americans was the highest of all groups, while the death rate was lowest among Asian and Pacific Islanders. The death rate for Hispanics and American Indians/ Alaska Natives was lower than that of Whites.

Figure 12

Cancer Death Rates by Race/Ethnicity, 2002



NOTE: Breast cancer rate is per 100,000 female population; other rates are for both genders.

DATA: Centers for Disease Control and Prevention, National Center for Vital Statistics.

SOURCE: National Healthcare Disparities Report, 2005, available at: http://www.ahrq.gov/qual/nhdr05/index.html.

African Americans have a higher death rate from breast, lung, and colorectal cancer than any other racial or ethnic group. American Indians/Alaska Natives, Hispanics, Asians and Pacific Islanders have lower death rates for breast, lung, and colorectal cancer than Whites.

Figure 13

Leading Causes of Death by Race/Ethnicity, 2003

All Ages

Rank	White, Non-Hispanic	Hispanic	African American, Non-Hispanic	Asian and Pacific Islander	American Indian/ Alaska Native
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	Diabetes	Accidents	Diabetes
5	Accidents	Diabetes	Accidents	Diabetes	Liver Disease

Ages 25–44

Rank	White, Non-Hispanic	Hispanic	African American, Non-Hispanic	Asian and Pacific Islander	American Indian/ Alaska Native
1	Accidents	Accidents	Heart Disease	Cancer	Accidents
2	Cancer	Cancer	Accidents	Accidents	Heart Disease
3	Heart Disease	Homicide	Homicide	Heart Disease	Suicide
4	Suicide	Heart Disease	HIV	Suicide	Liver Disease
5	Liver Disease	HIV	Cancer	CVD	Cancer

NOTE: CVD = Cerebrovascular disease.

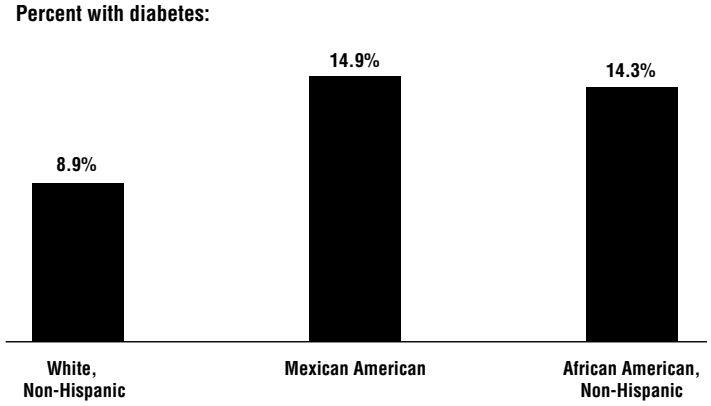
DATA: National Center for Health Statistics, National Vital Statistics System

SOURCE: http://www.cdc.gov/nchs/data/dvs/lcwk3_2003.pdf and http://www.cdc.gov/nchs/data/dvs/lcwk6_2003.pdf.

In 2003, heart disease was the leading cause of death among all racial/ethnic groups, except Asians and Pacific Islanders, for whom the leading cause of death was cancer. Among 25–44 year olds, accidents were the leading cause of death for three of the five racial/ethnic groups. HIV and homicide were among the top five leading causes of death for African Americans and Hispanics. Yet neither were among the leading causes of death for the three other racial/ethnic groups. Suicide ranked among the top five leading causes of death for Asians and Pacific Islanders, American Indians/Alaska Natives and Whites, but not the other two racial/ethnic groups.

Figure 14

Diabetes Prevalence Among Adults Age 20 and Over by Race/Ethnicity, 2001–2004



NOTE: Diabetes prevalence includes physician-diagnosed (self-reported) and undiagnosed diabetes (fasting blood glucose of at least 126 mg/dL).

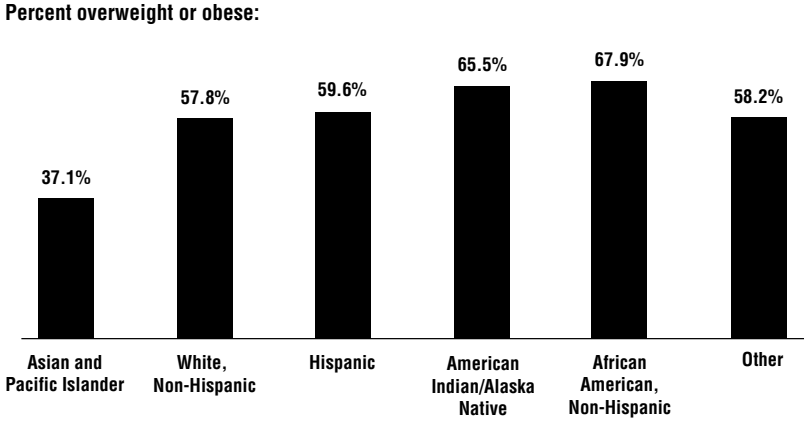
DATA: National Center for Health Statistics, National Health and Nutrition Examination Survey.

SOURCE: *Health, United States, 2006,* Table 55.

People with diabetes are at a higher risk for stroke and dying from heart disease than people without diabetes. Additionally, diabetes is the leading cause of end-stage renal disease. The percent of African Americans and Mexican Americans with diabetes is higher than the percent of Whites with diabetes.

Figure 15

Overweight and Obesity Rate Among Adults by Race/Ethnicity, 2005



NOTE: Overweight or obese is defined as having a body mass index greater than or equal to 25.0 kg/meters squared.

DATA: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Survey Data, 2005.

SOURCE: www.StateHealthFacts.org.

Obesity is a contributing factor to numerous diseases. People who are overweight or obese tend to have higher rates of diabetes and cardiovascular problems. More African Americans and American Indians/Alaska Natives are overweight or obese than non-Hispanic Whites and Asians and Pacific Islanders. Asians and Pacific Islanders are least likely of all racial and ethnic groups to be overweight or obese.

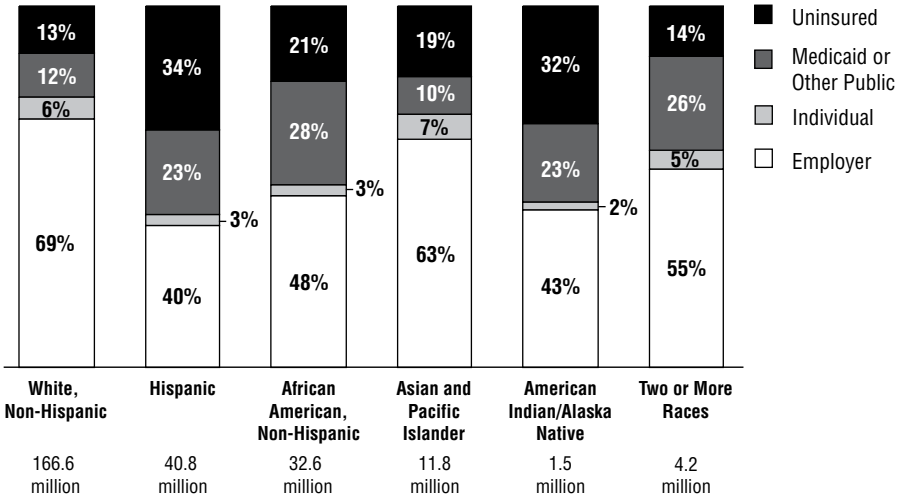
Section 3
Health Insurance Coverage

Health insurance coverage facilitates timely access to healthcare. People may receive health insurance coverage as a fringe benefit through their job, may be eligible for publicly-financed coverage, or may purchase it on their own. Approximately 46 million Americans—half of whom are racial/ethnic minority Americans—have no health insurance coverage at all. Racial and ethnic minority Americans are more likely than Whites to be uninsured, even after accounting for work status. Uninsured rates by race/ethnicity vary by state, reflecting variation in industry and availability of coverage.

Medicaid fills in gaps in coverage for some racial and ethnic groups with lower-incomes. Medicaid's role in providing coverage to racial and ethnic minority Americans is particularly important for children, while the program's reach among adults is more limited due to program rules regarding categorical and financial eligibility. Medicare is the federal program that provides coverage to people over 65 and to persons who are disabled under age 65, regardless of financial means. Racial and ethnic minority Americans are a larger share of Medicare's under 65 disabled population than Medicare's elderly population.

Figure 16

Health Insurance Coverage of the Nonelderly by Race/Ethnicity, 2005



NOTE: Nonelderly includes individuals up to age 65. "Other public" includes Medicare and military-related coverage; SCHIP is included in Medicaid.

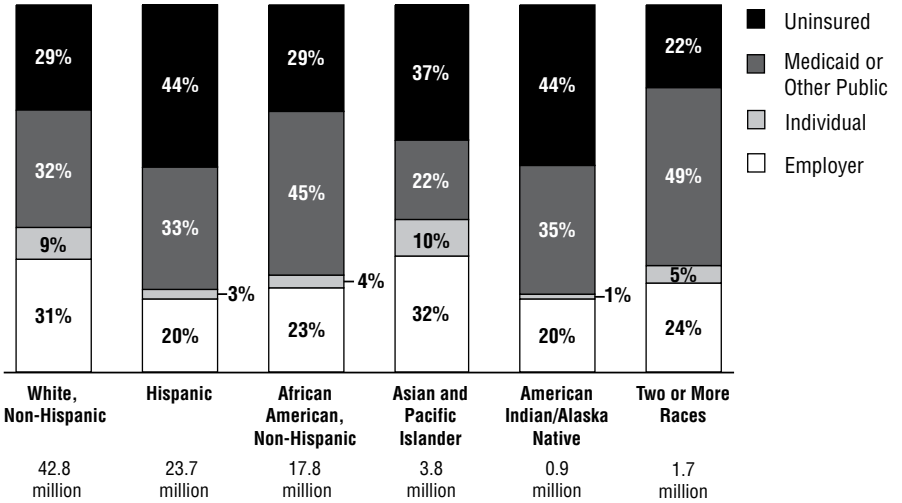
DATA: March 2005 Current Population Survey.

SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates.

Among the nonelderly, Whites are the group most likely to have health insurance. They are also more likely than other racial and ethnic groups to receive coverage from their employer. Hispanics have the largest percentage of uninsured, and the lowest percentage of people with employer coverage. Asians and Pacific Islanders are least likely to receive coverage from Medicaid or other public insurance, while African Americans are most likely to receive coverage from Medicaid or other public insurance.

Figure 17

Health Insurance Coverage of the Low-Income Nonelderly Population by Race/Ethnicity, 2005



NOTES: Low-income is defined as family income less than 200% of the federal poverty level, or $39,942 for a family of four in 2005. Nonelderly includes individuals up to age 65. "Other Public" includes Medicare and military-related coverage.

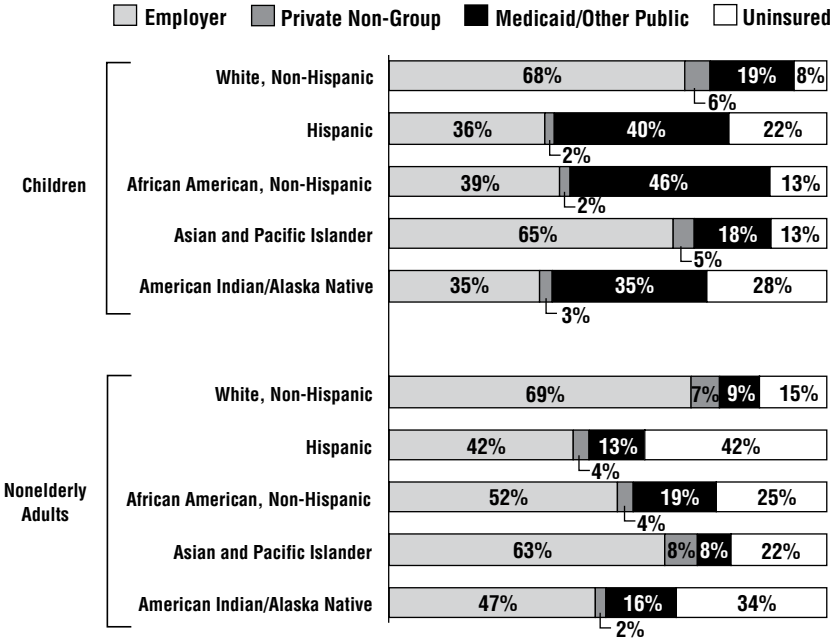
DATA: March 2005 Current Population Survey.

SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates.

Forty-four percent of low income Hispanics and American Indians/ Alaska Natives are uninsured, a higher percentage than Whites, African Americans, and Asians and Pacific Islanders. Hispanics and American Indians/Alaska Natives are also least likely to receive health insurance coverage from their employer compared to other racial and ethnic groups. A higher percentage of low-income African Americans have Medicaid or some other public insurance, than Whites, Hispanics, Asians and Pacific Islanders, and American Indian/Alaska Natives.

Figure 18

Health Insurance Coverage of the Nonelderly by Age and Race/Ethnicity, 2005



NOTES: Nonelderly includes individuals up to age 65. Does not include those identifying themselves as "two or more races." "Other public" includes Medicare and military-related coverage; SCHIP is included in Medicaid.

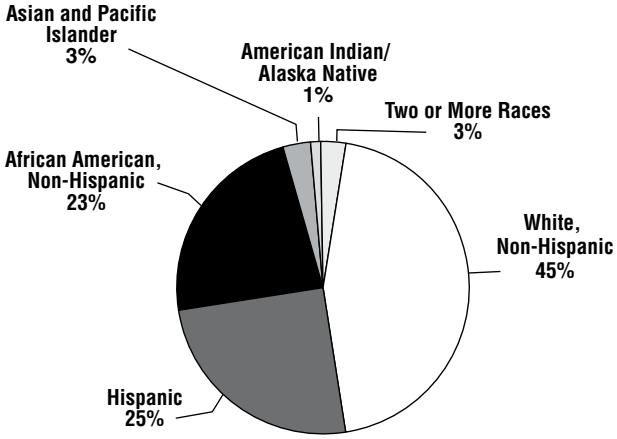
DATA: March 2005 Current Population Survey.

SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates.

Coverage patterns are similar for children and nonelderly adults. White children are least likely to be uninsured compared to all other racial and ethnic groups. They are also the group most likely to have employer coverage. Asians and Pacific Islanders have comparable levels of employer coverage to Whites. Over 45 percent of African American children and 40 percent of Hispanic children are covered by Medicaid or some other public insurance, which is more than twice the percentage of White children. Over 40 percent of Hispanic and more than 30 percent of American Indian/Alaska Native nonelderly adults lack health insurance, compared to 15 percent of Whites.

Figure 19

Nonelderly Medicaid Beneficiaries by Race/Ethnicity, 2005



Total = 35 million

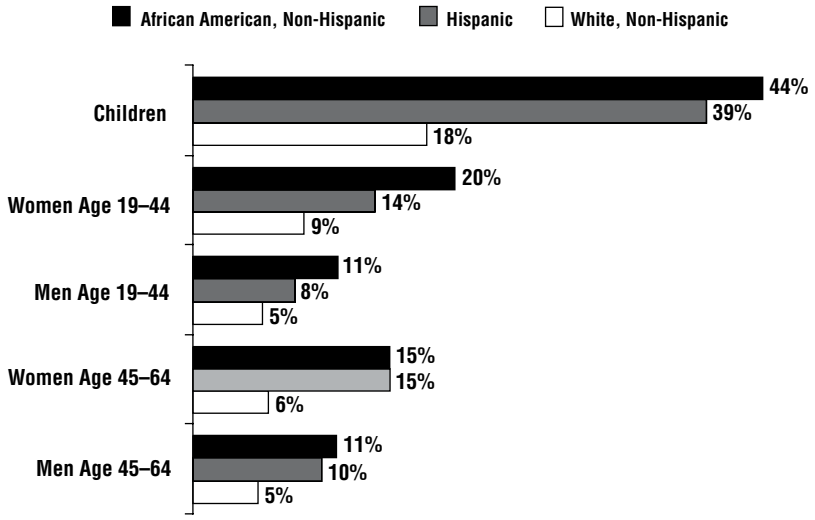
DATA: March 2005 Current Population Survey.

SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates.

Of the 35 million nonelderly Medicaid beneficiaries in 2005, almost half were White and more than 50% were minority Americans. African Americans and Hispanics are disproportionately represented among Medicaid beneficiaries. 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 20

Medicaid Coverage of the Nonelderly by Age, Gender, and Race/Ethnicity, 2005



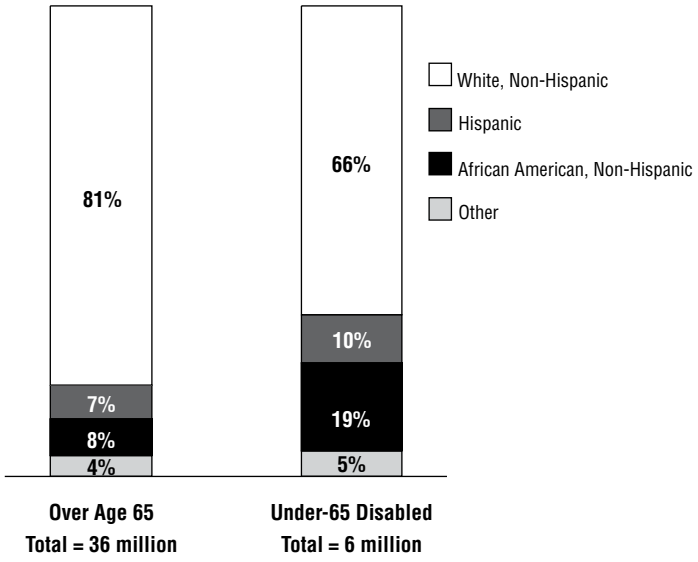
DATA: March 2005 Current Population Survey.

SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates.

The percentage of African American and Hispanic children who receive coverage through Medicaid is more than twice the percentage of White children. Women are more likely to have coverage through Medicaid than men, regardless of age or race/ethnicity. Across the age spectrum African Americans (male or female) are more likely to have Medicaid coverage than Whites or Hispanics. Older African American and White women are less likely to receive coverage through Medicaid than younger and Hispanic women. There is little difference in coverage between younger and older men.

Figure 21

Medicare Beneficiaries by Race/Ethnicity, 2003



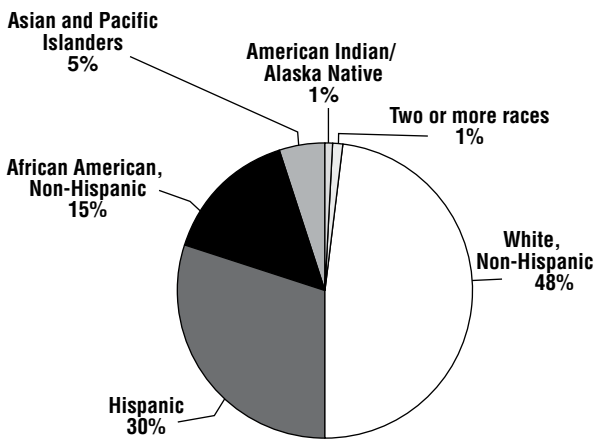
DATA: Medicare Current Beneficiary Survey, 2003.

SOURCE: Centers for Medicare and Medicaid Services, *The Characteristics and Perceptions of the Medicare Population* Data Tables, available at: http://www.cms.hhs.gov/apps/mcbs/PublDT.asp.

Medicare provides coverage for 36 million people over the age of 65 and another 6 million people who are disabled and younger than 65. The majority of beneficiaries in both groups are White. Non-Hispanic African Americans and Hispanics comprise a larger share of Medicare's disabled beneficiaries under age 65 (29%) than beneficiaries age 65 and over (15%).

Figure 22

Nonelderly Uninsured by Race/Ethnicity, 2005



Total = 46.1 Million Uninsuered

NOTE: Nonelderly includes individuals up to age 65.

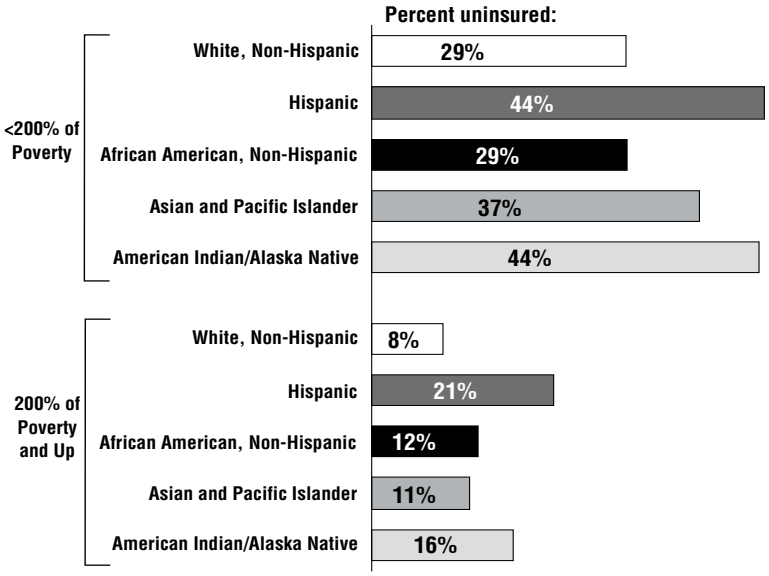
DATA: March 2005 Current Population Survey.

SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates.

Racial and ethnic minorities, comprise just over half of the nonelderly uninsured – in part because they are more likely to be in low-income families whose employers are less likely to offer coverage than workers who are not in low-income families. Almost a third (30%) of the nonelderly uninsured are of Hispanic origin.

Figure 23

Uninsured Rates Among the Nonelderly by Income and Race/Ethnicity, 2005



NOTE: 200% of the poverty threshold for a family of four in 2005 was $39,942.

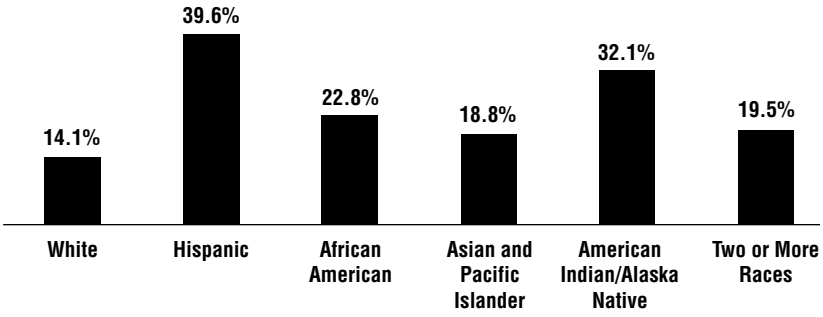
DATA: March 2006 Current Population Survey.

SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates.

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 24

Uninsured Rates Among Workers by Race/Ethnicity, 2005



NOTE: Workers includes all workers aged 18 to 64.

DATA: March 2005 Current Population Survey.

SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates.

Most Americans receive their health insurance through their employers. However, even among workers, disparities persist. More than half of uninsured workers are White, and Hispanic workers represent the largest group of minority workers who lack insurance. However, uninsured rates among workers are higher for all minority groups compared to Whites.

Figure 25

Nonelderly Uninsured Rates by State, and Race/Ethnicity, 2004–2005

Region/State	White	Black	Hispanic	Asian and PI	AI/AN	Two or More Races
United States	13	21	34	19	31	15
Northeast						
Connecticut	10	21	26	*	*	*
Maine	12	*	*	*	*	*
Massachusetts	10	*	22	18	*	2
New Hampshire	12	*	*	*	*	*
New Jersey	9	25	36	19	*	*
New York	12	17	23	21	*	12
Pennsylvania	11	17	26	*	*	*
Rhode Island	11	15	25	*	*	*
Vermont	13	*	*	*	*	*
South						
Alabama	14	18	*	*	*	*
Arkansas	18	25	*	*	*	*
Delaware	13	16	35	*	*	*
District of Columbia	*	14	36	*	*	*
Florida	19	27	37	22	*	*
Georgia	15	21	47	*	*	*
Kentucky	15	*	*	*	*	*
Louisiana	16	27	*	*	*	*
Maryland	11	20	39	*	*	3
Mississippi	15	23	*	*	*	*
North Carolina	13	18	50	*	*	*
Oklahoma	19	*	47	*	43	24
South Carolina	17	20	*	*	*	*
Tennessee	12	23	56	*	*	*
Texas	17	25	40	24	*	*
Virginia	11	20	39	20	*	*
West Virginia	20	*	*	*	*	*
Midwest						
Illinois	11	25	29	13	*	*
Indiana	15	20	30	*	*	*
Iowa	9	*	31	*	*	*
Kansas	11	*	30	*	*	*
Michigan	12	19	*	14	*	*
Minnesota	8	13	37	8	*	*
Missouri	13	21	*	*	*	*
Nebraska	10	*	26	6	*	*
North Dakota	10	*	*	*	43	*
Ohio	12	18	*	*	*	*
South Dakota	12	*	*	*	36	*
Wisconsin	10	13	28	*	*	*
West						
Alaska	17	*	*	15	34	26
Arizona	14	*	34	*	*	*
California	13	18	32	19	*	15
Colorado	13	*	37	*	*	*
Hawaii	*	*	*	11	*	10
Idaho	14	*	36	*	*	*
Montana	19	*	*	*	54	*
Nevada	16	*	36	12	*	*
New Mexico	15	*	27	*	44	*
Oregon	16	*	38	*	*	*
Utah	13	*	38	*	*	*
Washington	14	*	29	16	*	*
Wyoming	15	*	34	*	*	*

NOTE: * = sample size too small for reliable estimate.

DATA: March 2006 and March 2005 Current Population Survey.

SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates.

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 Non-Hispanic Whites range from 8% in Minnesota to 20% in West Virginia. Among African Americans, uninsured rates range from 13% in Minnesota and Wisconsin to 27% in Florida and Louisiana, and rates among Hispanics range from 22% in Massachusetts to 56% in Tennessee.

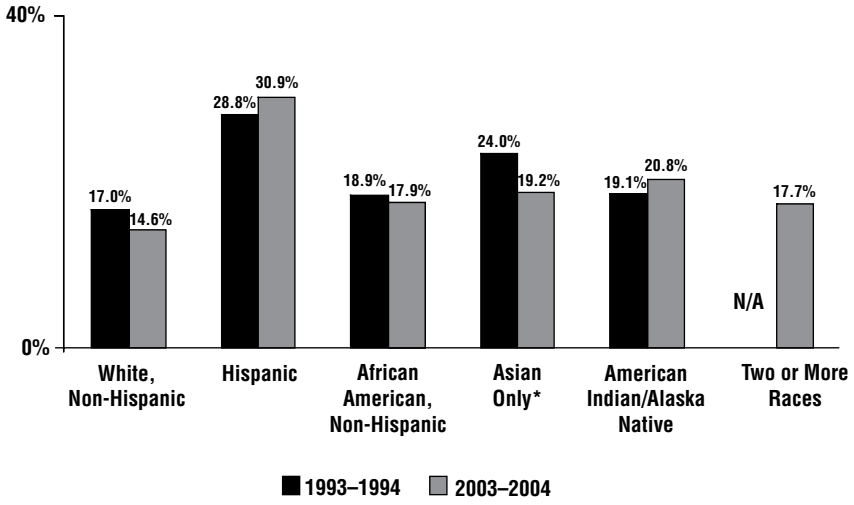
Section 4

Preventive and Primary Care

Preventive and primary care—such as regular doctor visits and health screenings—are crucial to maintenance of good health and prevention of serious health problems; they are also important indicators of overall access to care. Racial and ethnic minority Americans are less likely than Whites to have a usual place to receive care or to have a health care visit; for Hispanics, these differences persist even when accounting for income. Disparities in access to care also appear in many measures of specific services, such as timely prenatal care, dental care, and some cancer screening. In other areas, such as mammography and cholesterol screening, disparities appear smaller or have been reduced over time.

Figure 26

No Usual Source of Health Care: Adults 18–64 by Race/Ethnicity, 1993–1994 and 2003–2004



NOTE: *The sample size for Native Hawaiian/Pacific Islander was not large enough for reliable estimates.

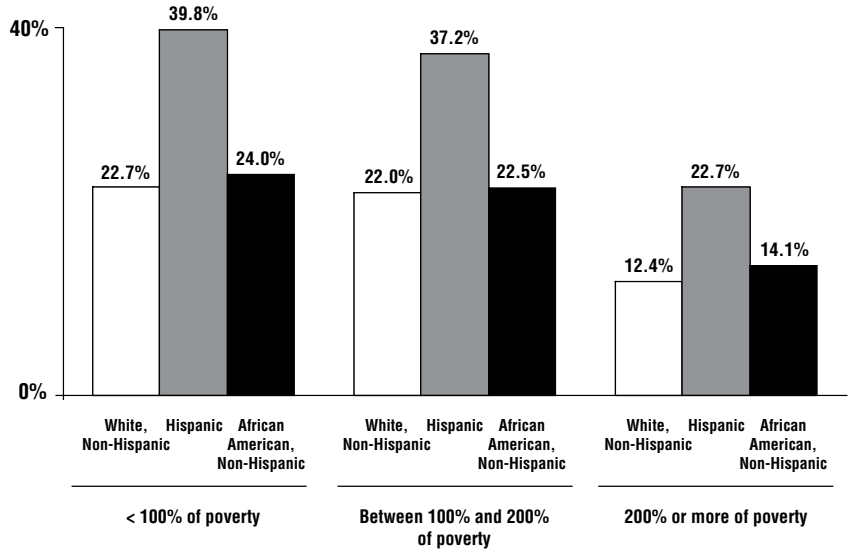
DATA: National Center for Health Statistics, National Health Interview Survey, 1993–1994 and 2003–2004.

SOURCE: *Health, United States, 2006,* Table 77.

In 2003–2004, Hispanics, African Americans, Asians and American Indian/Alaska Natives were less likely to have a usual source of health care than were Whites. Since 1993–1994, rates have improved or remained unchanged among all racial/ethnic groups except Hispanics and American Indians/ Alaska Natives.

Figure 27

No Usual Source of Health Care: Adults 18–64 by Race/Ethnicity and Poverty Status, 2003–2004



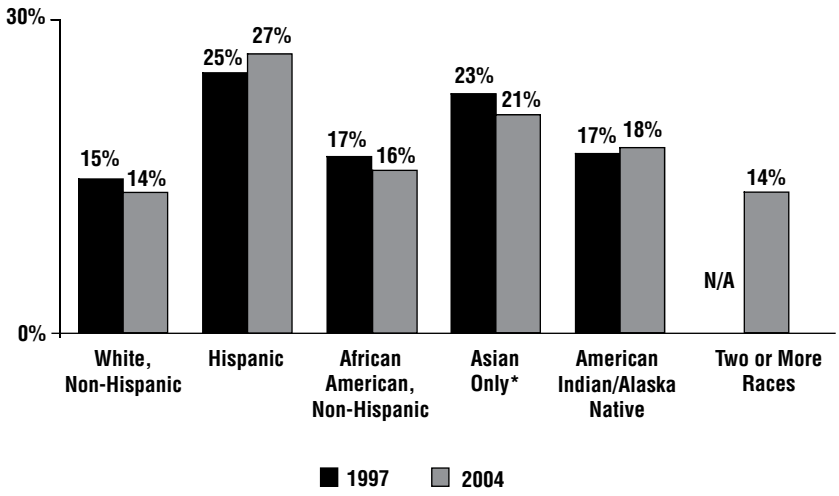
DATA: National Center for Health Statistics, National Health Interview Survey, 2002–2003

SOURCE: *Health, United States, 2006,* Table 77.

When comparing racial/ethnic groups of similar income, the disparity in usual source of care is nearly eliminated for African Americans but not for Hispanics. However across racial/ethnic groups, the percentage with no usual source of care is higher among people with incomes below the poverty level and between 100% and 200% of the poverty level compared to those with incomes above 200% of poverty.

Figure 28

No Health Care Visits Within the Past 12 Months by Race/Ethnicity, 1997 and 2004



NOTE: *The sample size for Native Hawaiian/Pacific Islander was not large enough for reliable estimates.

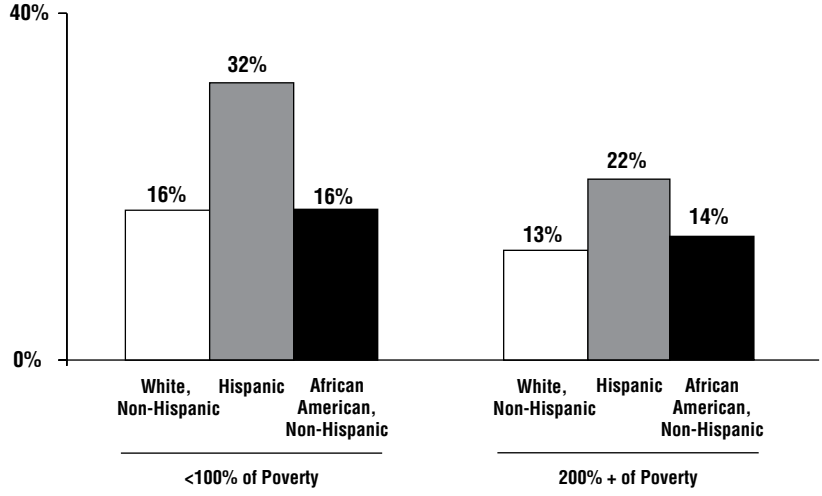
DATA: National Center for Health Statistics, National Health Interview Survey, 1997 and 2004

SOURCE: *Health, United States, 2006,* Table 80.

In 2004, Hispanics, Asians and American Indians/Alaska Natives were less likely to have had a health care visit in the past year than were non-Hispanic Whites. Non-Hispanic Whites were slightly less likely to have had a health care visit in the past year than people who self-identified as two or more races. While improvements have been seen for African Americans since 1997, the situation has worsened for Hispanics and American Indians/Alaska Natives.

Figure 29

No Health Care Visits Within the Past 12 Months by Race/Ethnicity and Poverty Status, 2004



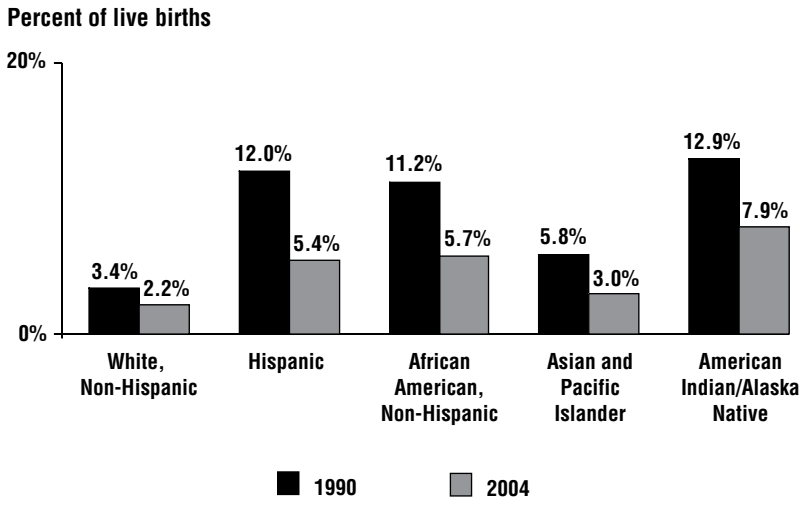
DATA: National Center for Health Statistics, National Health Interview Survey, 2004.

SOURCE: *Health, United States, 2006,* Table 80.

When comparing racial/ethnic groups of similar income, the disparities in the percent with no health care visit in the past year is nearly eliminated for African Americans but not for Hispanics. However, across racial/ethnic groups, the percentage with no health care visit in the past 12 months is higher among people with incomes below the poverty level than among those with incomes above 200% of the poverty level.

Figure 30

Late or No Prenatal Care by Race/Ethnicity, 1990 and 2004



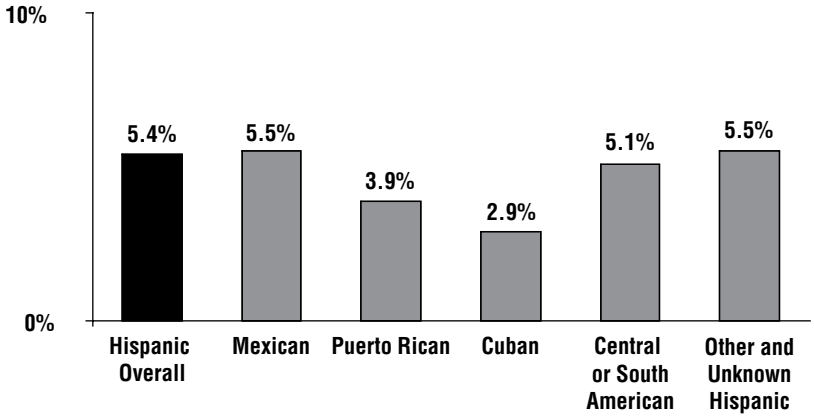
DATA: National Center for Health Statistics, National Vital Statistics System.

SOURCE: *Health, United States, 2006,* Table 7.

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 fifteen years, Hispanics, African Americans and American Indian/Alaska Natives are still more likely than Whites and Asians and Native Hawaiians/Pacific Islanders to receive late or no prenatal care.

Figure 31

Late or No Prenatal Care by Hispanic Subgroup, 2004



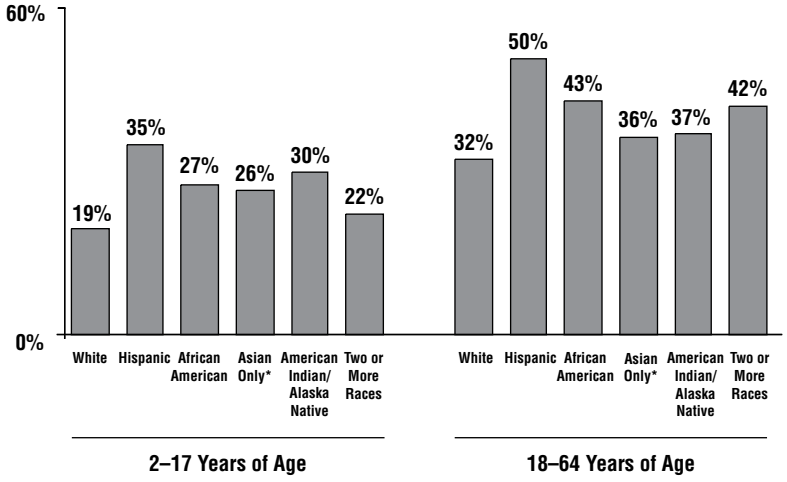
DATA: National Center for Health Statistics, National Vital Statistics System

SOURCE: *Health, United States, 2006,* Table 7.

Variation is found not only among the major racial/ethnic groups, but within them as well. As an example, among Hispanics, 5.4% of live births were to mothers who received late or no prenatal care. This statistic masks differences between Mexican Americans (5.5%), who along with Other Hispanics or Hispanics of unknown origin, are the largest ethnic Hispanic subgroups and Cuban Americans (2.9%), who are the smallest ethnic subgroup.

Figure 32

No Dental Visits in the Past Year by Race/Ethnicity, 2004



NOTE: *The sample size for Native Hawaiian/Pacific Islander was not large enough for reliable estimates.

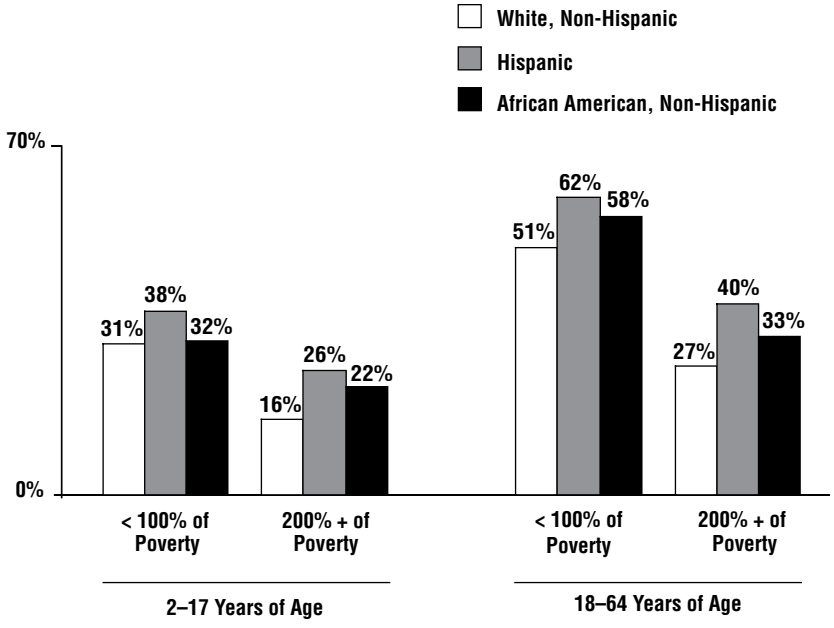
DATA: National Center for Health Statistics, National Health Interview Survey, 2004

SOURCE: *Health, United States, 2006,* Table 91.

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. Hispanics, regardless of age, are the least likely of all racial and ethnic groups to have had a dental visit in the past year.

Figure 33

No Dental Visit in the Past Year by Race/Ethnicity and Poverty Status, 2004



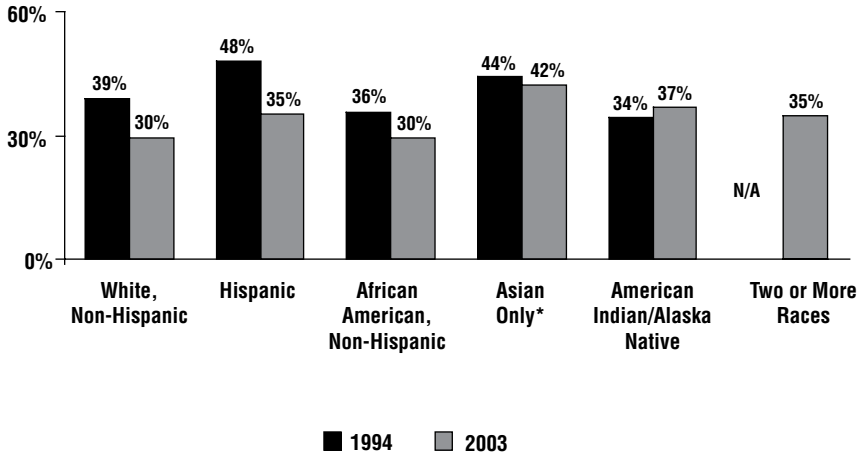
DATA: National Center for Health Statistics, National Health Interview Survey, 2004.

SOURCE: *Health, United States, 2006,* Table 91.

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 Hispanics and African Americans more likely to be without a dental visit than Whites. However among children living in poverty, the disparity persists only between Hispanics and Whites. In this income group, African American children are as likely as Whites to be without a dental visit. Additionally, the gap between African Americans and Whites and Hispanics and Whites is larger for those above 200% of poverty. 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.

Figure 34

No Mammogram Within the Past 2 Years by Race/Ethnicity, 1994 and 2003



NOTE: *The sample size for Native Hawaiian/Pacific Islander was not large enough for reliable estimates.

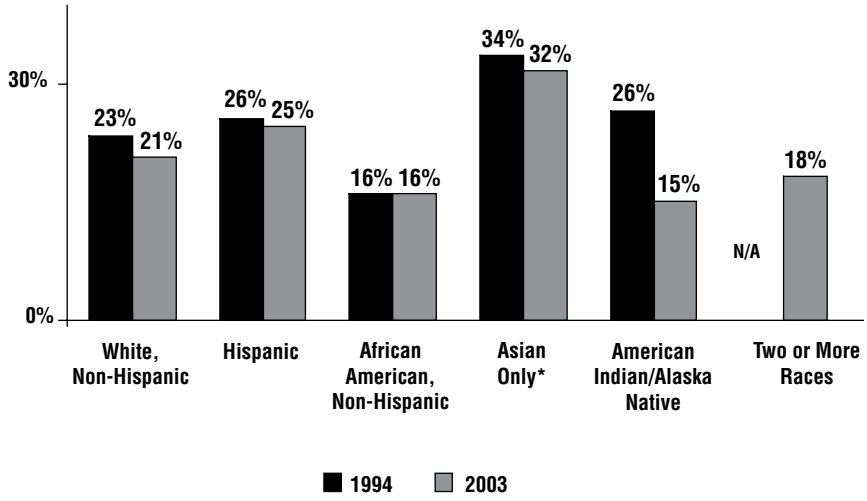
DATA: National Center for Health Statistics, National Health Interview Survey, 1987 and 2003.

SOURCE: *Health, United States, 2005,* Table 86.

In 2003, Hispanics, Asians and American Indians/Alaska Natives were less likely to have had a mammogram in the past two years than were Whites. While improvements have been seen for Whites, Hispanics, and African Americans since 1994, the situation has worsened for American Indians/ Alaska Natives.

Figure 35

No Pap Smear Within the Past 3 Years by Race/Ethnicity, 1994 and 2003



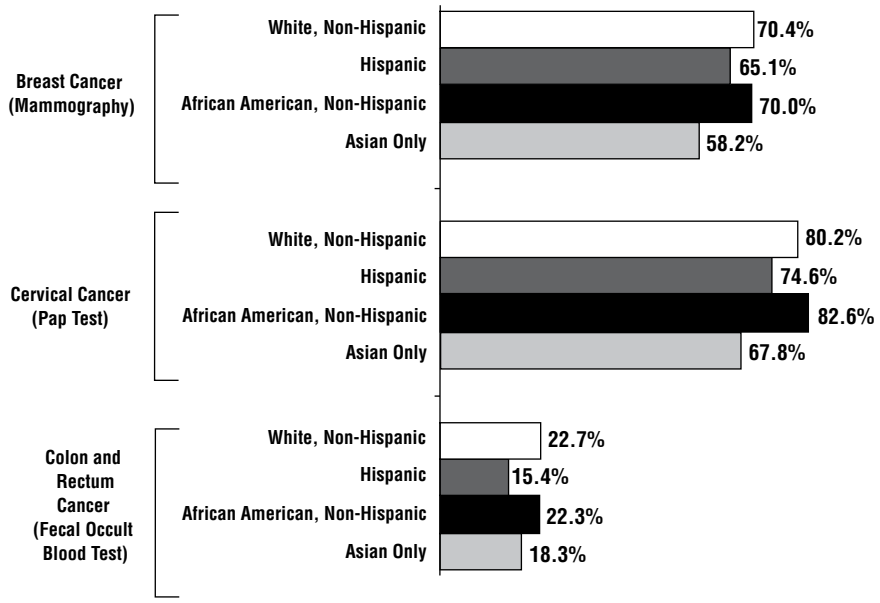
NOTE: *The sample size for Native Hawaiian/Pacific Islander was not large enough for reliable estimates.

DATA: National Center for Health Statistics, National Health Interview Survey, 1987 and 2003.

In 2003, Hispanic and Asian women were more likely to have gone without a pap smear in the past three years than were White, African American or American Indian/Alaska Native women. Between 1994 and 2003 the number of women who did not have a pap smear in the past 3 years decreased slightly for all racial and ethnic groups, except African Americans, for whom the rate remained unchanged. American Indian/Alaska Native women saw the sharpest decline during that time.

Figure 36

Cancer Screening Rates by Race/Ethnicity,* 2003



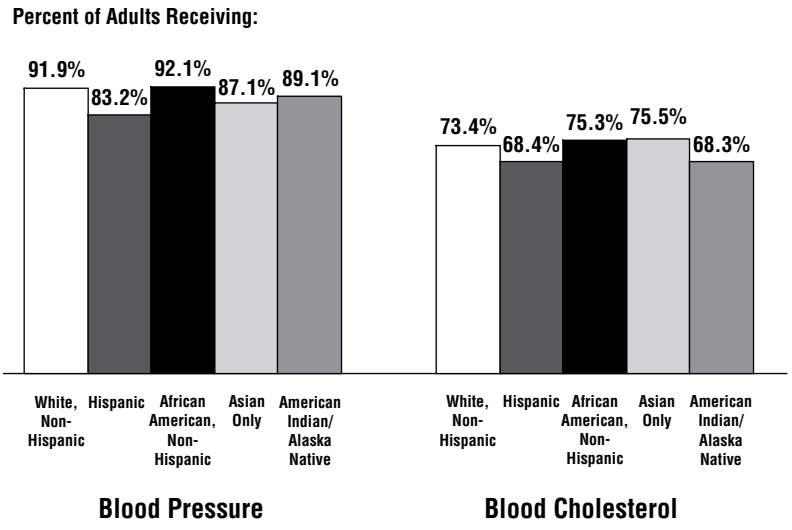
NOTES: *Data for American Indians/Alaska Natives and Native Hawaiians/Pacific Islanders do not meet the criteria for statistical reliability, data quality or confidentiality. Age-adjusted percentages of women 40 and older who reported a mammography within the past 2 years, women 18 and older who reported a pap test within the pas t 3 years, and adults 50 and older (male and female) who reported a fecal occult blood test within the past 2 years.

DATA: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

SOURCE: National Healthcare Disparities Report, 2005, available at: http://www.ahrq.gov/qual/nhdr05/index.html.

Figure 37

High Blood Pressure and Cholesterol Screening by Race/Ethnicity, 2003



NOTES: Blood pressure screening rate is for adults who report receiving screening in past 2 years and can recall the results; blood cholesterol screening rate is for adults who report receiving screening in past 5 years. Data for Native Hawaiians/Pacific Islander not included because data do not meet criteria for statistical reliability, quality, or confidentiality.

DATA: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

SOURCE: National Healthcare Disparities Report, 2005, available at: http://www.ahrq.gov/qual/nhdr05/index.html.

Cancer screening rates have increased over the past two decades but still vary by race/ethnicity. For example, Hispanic and Asian women are less likely to be screened for breast or cervical cancer than are White or African American women. However, despite evidence of 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 than other tests among women and men across all racial and ethnic groups, and Hispanics 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.

Proper management of high blood pressure and cholesterol are critical to the prevention of stroke and heart disease. African Americans have slightly higher rates of screening for both blood pressure and cholesterol than Whites. Hispanics have the lowest percentage of adults screened for high blood pressure, and Hispanics and American Indians/Alaska Natives have the lowest percentage of adults screened for high cholesterol compared with Whites, African Americans and Asians.

Section 5
Specialty Care

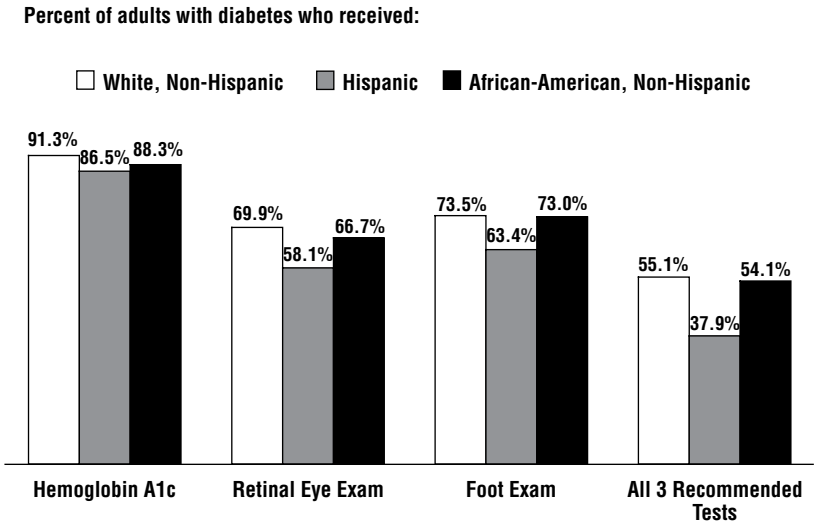
Specialty care is used by individuals with specific health needs. Measures of specialty care therefore allow comparison of access and utilization among people with a demonstrated need for services. Further, many initiatives to eliminate disparities are targeted at specialty care areas; thus, these measures enable us to examine progress and challenges in current efforts. Disparities have been studied for a wide range of types of specialty care, such as heart disease care and cancer care. Specialty areas examined here—diabetes, HIV/AIDS, and asthma—are just a few of the potential areas that could be included.

Diabetes

The number of Americans diagnosed with diabetes continues to rise. African Americans, Hispanics, and American Indians and Alaska Natives have higher rates of diabetes compared to non-Hispanic Whites. Data suggest that prevalence rates are higher for Asians and Native Hawaiians/Pacific Islanders than non-Hispanic Whites, but the total prevalence for these two groups is unknown. Diabetes is among the top five causes of death for all racial and ethnic groups in the U.S. except Whites. Patients with uncontrolled or poorly managed diabetes are at risk for developing complications including higher rates of heart disease, stroke, lower limb amputation, and kidney failure. African Americans are more likely to be hospitalized for complications from diabetes than non-Hispanic Whites.

Figure 38

Receipt of Recommended Tests for Diabetes by Race/Ethnicity, 2002



NOTES: Data show share of adults with diabetes who received test within past year. Data for Asian/Pacific Islander and American Indian/Alaska Native not presented because data do not meet criteria for statistical reliability, quality, or confidentiality.

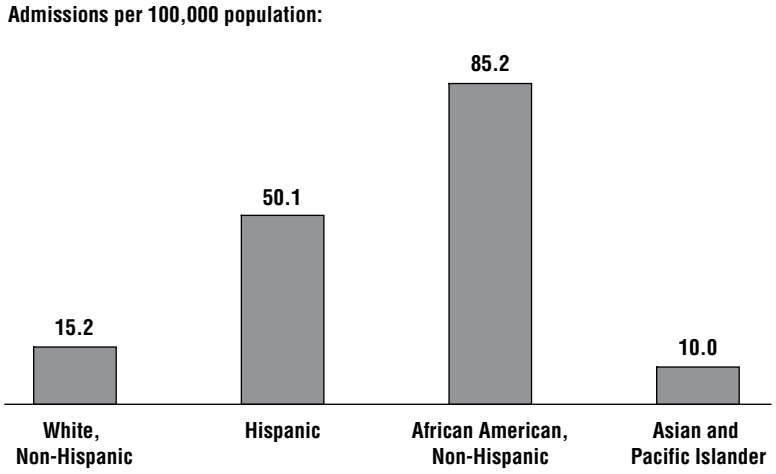
DATA: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey.

SOURCE: National Healthcare Disparities Report, 2005, available at: http://www.ahrq.gov/qual/nhdr05/index.html.

Proper management of diabetes is critical in the prevention of more serious conditions including heart attack, stroke, end-stage renal disease, blindness or amputation of lower extremities. Treatment guidelines for diabetes recommend checking hemoglobin A1c levels at least twice a year and having an eye and foot exam at least once a year. Hispanics are less likely than Whites and African Americans to have had the recommended tests in the past year, and less likely to have had any one of the tests in the past year. African Americans had similar testing rates as Whites.

Figure 39

Hospital Admissions for Uncontrolled Diabetes by Race/Ethnicity, 2002



NOTE: Data are for adult population only and reflect admissions for uncontrolled diabetes without complication.

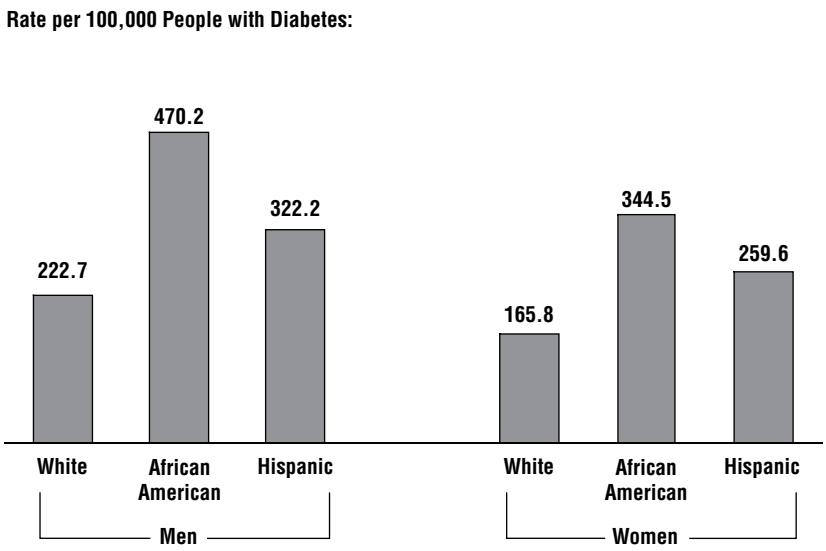
DATA: Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project.

SOURCE: National Healthcare Disparities Report, 2005, available at: http://www.ahrq.gov/qual/nhdr05/index.html.

The rates of hospital admissions for uncontrolled diabetes for African Americans and Hispanics were more than 5 and 3 times respectively, the rate for Whites and Asians and Pacific Islanders. Asians and Pacific Islanders had the lowest rates of hospital admissions with 10 admissions per 100,000.

Figure 40

Rate of Diabetes Related End-Stage Renal Disease Among Diabetics, 2002



SOURCE: http://www.cdc.gov/diabetes/statistics/esrd/Fig5Detl.htm

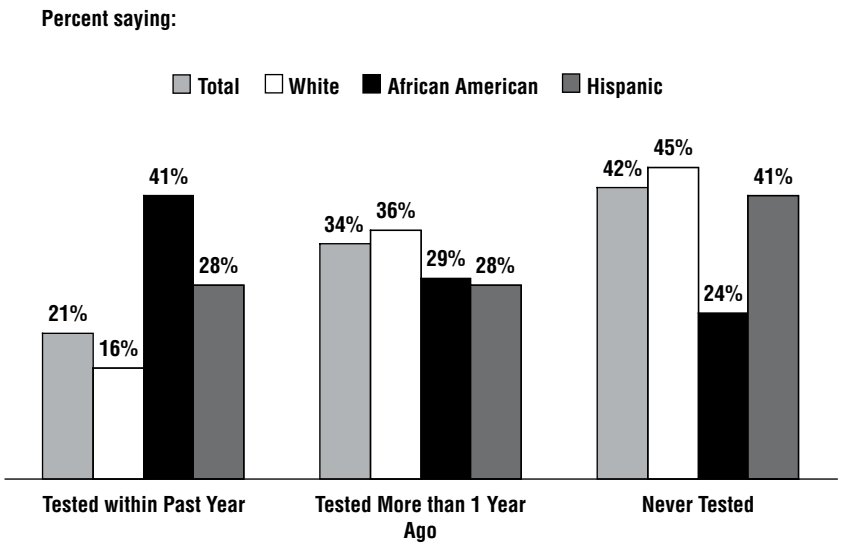
Diabetic men had higher rates of diabetes related End-Stage Renal Disease (ESRD) than women. The rate of diabetes related ESRD among diabetic African American males was more than twice the rate of White males. The rate of diabetes related ESRD among diabetic African American women was higher than the rates of White and Hispanic men and women. Among diabetic Hispanic women, the rate of diabetes related ESRD was higher that that of both White men and women.

HIV/AIDS

The CDC estimated that at the end of 2005 there were 1.2 million people living with HIV/AIDS in the US, 25 percent of whom do not know they are infected. Minority groups, particularly African Americans and Hispanics continue to be disproportionately affected by the disease. African Americans and Hispanics represent 70 percent of new AIDS cases in the US. For African Americans and Hispanics between the ages of 25 and 44, HIV is one of the top five causes of death. Death rates from AIDS have decreased substantially, due in large part to the use of highly active antiretroviral therapy (HAART). However, the only nationally representative study of people with HIV, which was conducted in 1996–1998, found that African Americans fared worse than Whites on several measures of access and quality. These differences diminished over time but were not completely eliminated.

Figure 41

HIV Testing Rate of Adults Ages 18–64 by Race/Ethnicity, 2006



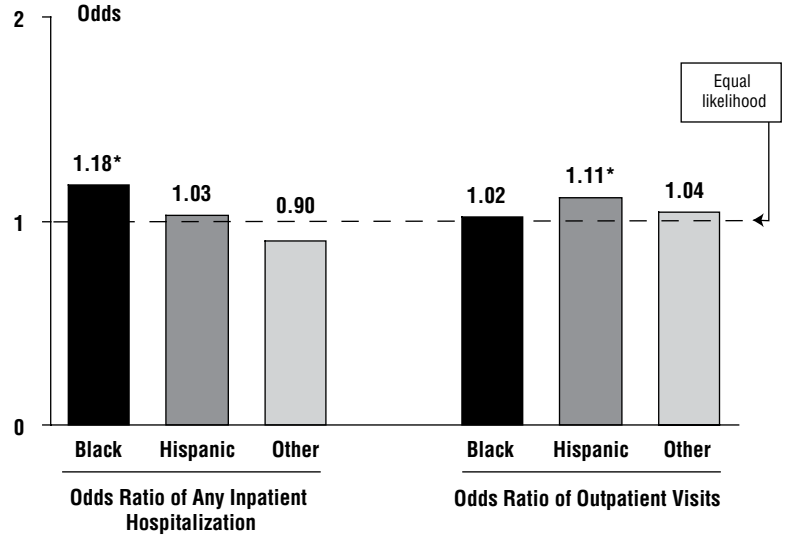
NOTE: 'Don't know' responses not shown; not all numbers may add up to 100 percent due to rounding.

SOURCE: Kaiser Family Foundation, *Survey of Americans on HIV/AIDS* (conducted March 24–April 16, 2006).

Increasing awareness of one's HIV status is critical for the prevention and care of HIV disease. In 2006, over half (55%) of adults ages 18–64 in the U.S. said they had been tested for HIV at some point, including 21% who said they had been tested in the past year. African Americans (70%) reported previous HIV testing more frequently than Hispanics (57%) or Whites (52%). The percent who reported having been tested for HIV in the past twelve months was higher among African American (41%) and Hispanics (28%) than among Whites (16%).

Figure 42

Odds of Health Services Use Among Persons with HIV/AIDS in Care by Race/Ethnicity,† 2000–2002



NOTE: †Compared to Whites

*Difference is statistically significant

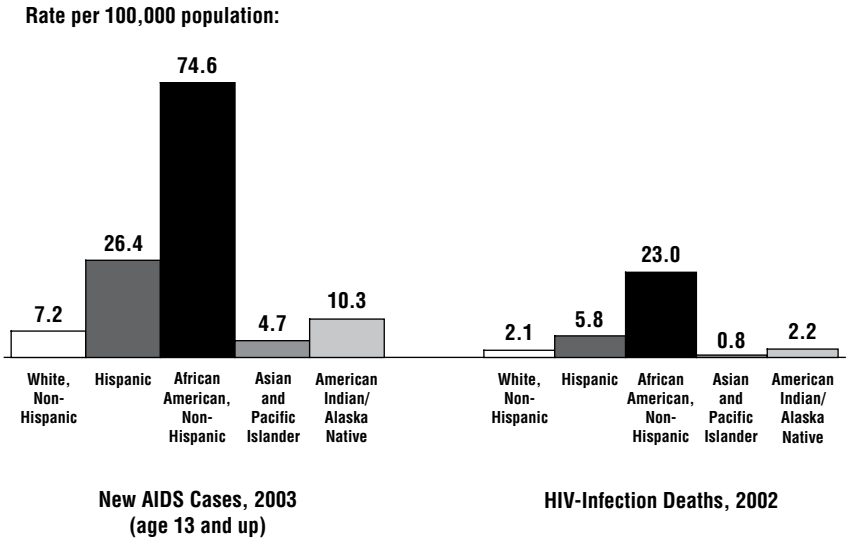
SOURCE: Fleishman et al., *Hospital and Outpatient Health Services Utilization Among HIV-Infected Adults in Care 2000–2002. Medical Care,* Vol. 43, No. 9 suppl, (Sept.) 2005.

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 some health care access and quality measures. Since there are no routinely collected national data sources on HIV, data from the HIV Research Network, which consists of primary and specialty care sites in different geographic areas of the U.S. provide insight into patterns of health services use among HIV-infected adults in care. Data collected from 2000 to 2002 indicate that African Americans did not differ from Whites in the average number of outpatient visits, but they had higher hospitalization rates. Higher inpatient rates, when controlling for differences in population demographic and health characteristics, are sometimes an indication of less than adequate primary care. In contrast, Hispanics had a higher average number of outpatient visits than Whites, but did not differ in their hospitalization rates.

Figure 43

New AIDS Cases and HIV-Infection Deaths by Race/Ethnicity



DATA: Centers for Disease Control and Prevention, HIV/AIDS Surveillance System and National Vital Statistics System.

SOURCE: National Healthcare Disparities Report, 2005, available at: http://www.ahrq.gov/qual/nhdr05/index.html.

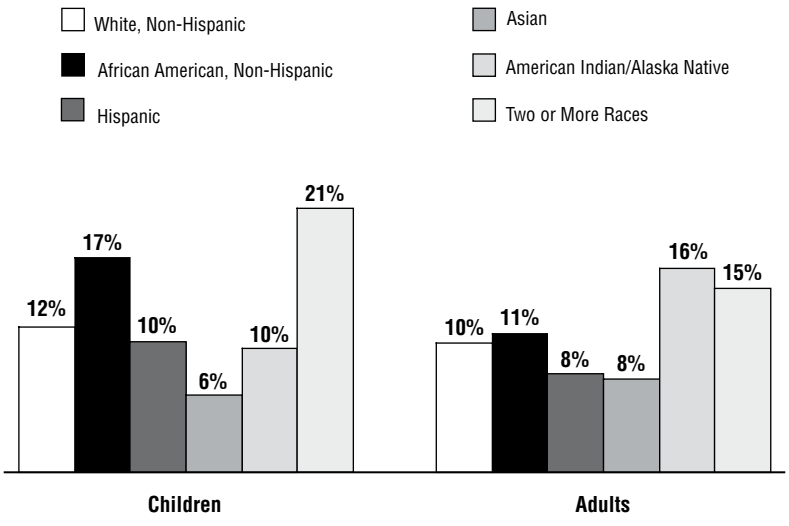
The disproportionate impact of the AIDS epidemic on populations of color is seen in higher HIV mortality rates and new AIDS cases. Rates of HIV deaths and new AIDS cases are potential indicators of differences in quality of care since early, appropriate treatment can delay progression to AIDS. For example, with increasing use of highly active antiretroviral therapy (HAART) in the mid 1990s, rates of new AIDS cases have declined. The National Healthcare Disparities Report tracks new AIDS cases as one of its 46 core measures of quality of care. In 2003, the rate of new AIDS cases among adults/adolescents was 10 times higher among African Americans (75 per 100,000) than the rate among Whites (7 per 100,000). The rate among Hispanics (26 per 100,000) was 3 times higher than the rate among Whites.

Asthma

Minorities, the poor, and children are disproportionately affected by asthma. Regardless of age, African Americans are more likely to be hospitalized for an asthma attack, and more likely to die than non-Hispanic Whites. Among Hispanics, Puerto Ricans have significantly higher asthma rates than non-Hispanic Whites and other Hispanic subgroups such as Mexicans, a fact that is concealed by average estimates for all Hispanics. The environment plays an important role in the onset of an asthma attack. By taking prescribed medications, keeping regularly scheduled appointments with their provider, and controlling exposures to triggers such as dust mites, cockroaches, mold, and second-hand smoke, individuals can better manage their disease and reduce their risk of an attack.

Figure 44

Prevalence of Ever Having Asthma by Race/Ethnicity, 2004



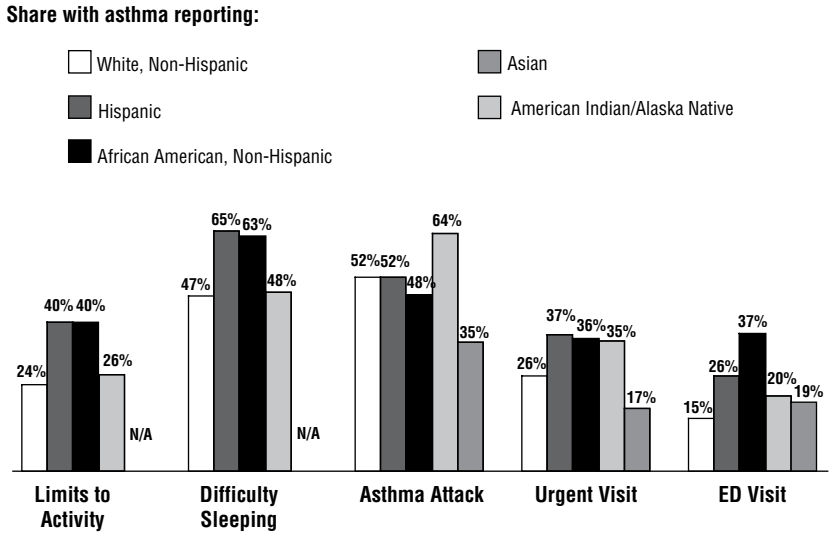
DATA: National Health Interview Survey, 2004.

SOURCE: Summary Health Statistics for U.S. (Children/Adults): National Health Interview Survey, 2004. Vital and Health Statistics. Series 10, Number 228; May 2006.

In 2004, the prevalence of asthma was slightly higher among children than adults for all racial and ethnic groups except Asians. Among children, those who identified as two or more races and African Americans had the highest rates of asthma, while American Indians/Alaska Natives and individuals of two or more races had the highest rates among adults. Data presented in this figure represent the proportion of people who have ever been told they have asthma. The proportion of people who currently have asthma will be smaller, particularly among adults.

Figure 45

Adult Asthma Control Problems by Race/Ethnicity, 2002



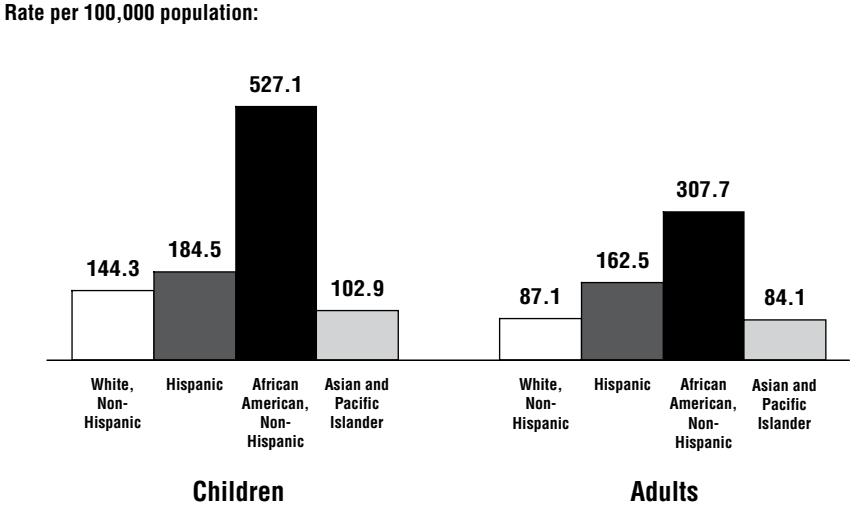
DATA: Behavioral Risk Factor Surveillance System.

SOURCE: Centers for Disease Control and Prevention. "Asthma Prevalence and Control Characteristics by Race/Ethnicity, United States, 2002." *MMWR* 2004: 53: 145-8.

Proper control of asthma symptoms is essential to the prevention of future asthma attacks. In 2002, a higher percentage of African American, Hispanic and American Indian/Alaska Native adults reported more negative indicators of asthma control (e.g. limits to activity, difficulty sleeping, asthma attacks, urgent care visits for worsening asthma symptoms, and visits to the emergency department) than Whites. African American and Hispanic adults visited the emergency department more often than Whites and Asians.

Figure 46

Hospital Admissions for Asthma by Race/Ethnicity, 2002



DATA: Agency for Healthcare Research and Quality, Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project, State Inpatient Databases.

SOURCE: National Healthcare Disparities Report, 2005, available at: http://www.ahrq.gov/qual/nhdr05/index.html.

Asian and Pacific Islander adults and children have the lowest rates of hospitalizations for asthma among all racial and ethnic groups. African Americans have the highest rates of hospitalization. For African American children, rates of hospitalization are 4 and 5 times higher than the rate among Whites and Asians and Pacific Islanders, respectively. For African American adults, the rates are 3 and 4 times higher than the rates for Whites and Asians and Pacific Islanders.

Section 6

Tracking Changes in Quality and Access Disparities

Data from the *National Healthcare Disparities Report* (NHDR) are useful for tracking changes in a broad array of health care quality and access measures among racial, ethnic, and socioeconomic groups in the United States. The report, which has been issued annually by the Agency for Healthcare Research and Quality (AHRQ) since 2003, is a major effort by the federal government to track and disseminate information on disparities at the national level. It is a companion report to the *National Healthcare Quality Report,* which is also issued annually.

The 2005 NHDR reports information for 46 "core report measures" of quality and 8 measures of access. The quality measures capture the effectiveness, safety, timeliness, and patient centeredness of care for a range of clinical conditions, while the access measures monitor facilitators and barriers to care. These measures were chosen based on "clinical importance, policy relevance, and data reliability."

The 2005 NHDR focuses on trend data in an attempt to track progress in eliminating health care disparities and identify areas to target for future improvement. It also emphasizes improvements to measurement and assessment of disparities. The report highlights four themes that emerged from the review of the data; they are:

1) Disparities still exist

2) Some disparities are diminishing

3) Opportunities for improvement remain

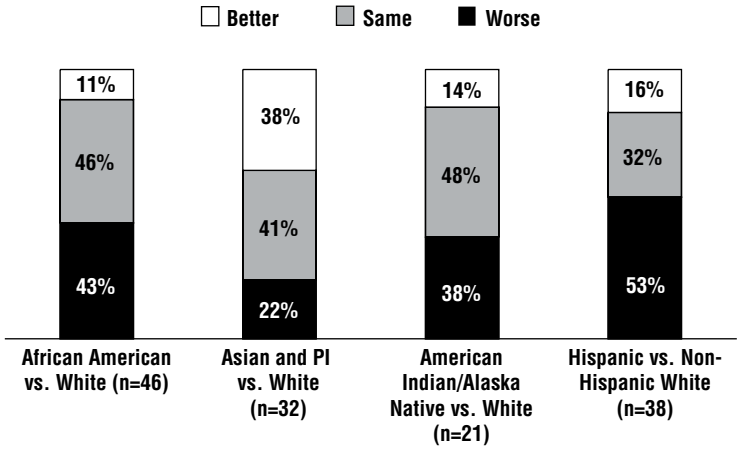
4) Information about disparities is improving

In the following section, we present selected summary highlights from the report.

The full report and supporting documents and data are available at http://www.ahrq.gov/qual/nhqr05/nhqr05.htm

Figure 47

Comparison of Quality of Care Measures for Minority Population Groups vs. Whites



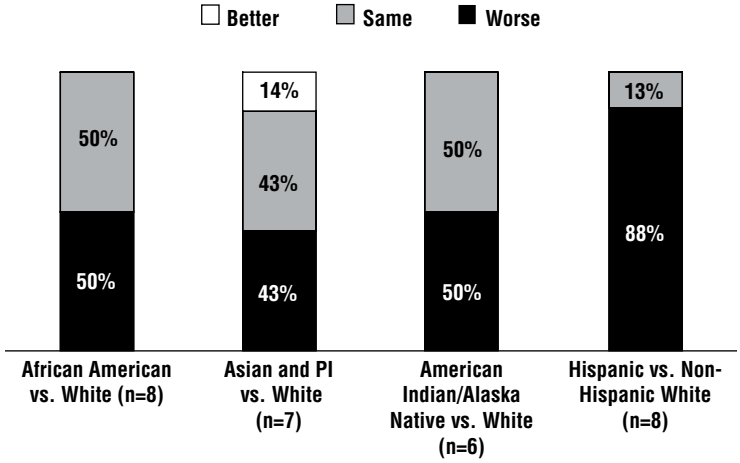
NOTES: Data on all measures are not available for all groups; "n" refers to the number of measures on which the groups were compared. "Better" means population received better quality of care than comparison group for the measure; "same" means population received quality of care about the same same as comparison group for the measure; and "worse" means population received poorer quality of care than comparison group for the measure. Totals may not add to 100% due to rounding.

SOURCE: AHRQ, National Healthcare Disparities Report, 2005

The 2005 NDHR's summary of the core report measures of quality concluded that, for a large number of measures, minority populations receive lower quality of care than Whites. For African Americans, quality of care was poorer than that for Whites for 20 out of 46 measures (43%), while care was better quality than Whites for just 5 out of 46 measures (11%). Among the 38 measures that were available for Hispanics, 20 (53%) showed that they received poorer quality than non-Hispanic Whites, and just 6 (16%) showed better quality than non-Hispanic Whites. Of the 21 measures available for American Indians/Alaska Natives, 8 (38%) showed poorer quality than Whites and just 3 (14%) showed better quality than Whites. Asians and Pacific Islanders had better quality than Whites for 12 of the 32 available measures (38%) but still had poorer quality for 7 out of 32 measures (22%).

Figure 48

Comparison of Access to Care Measures for Minority Population Groups vs. Whites



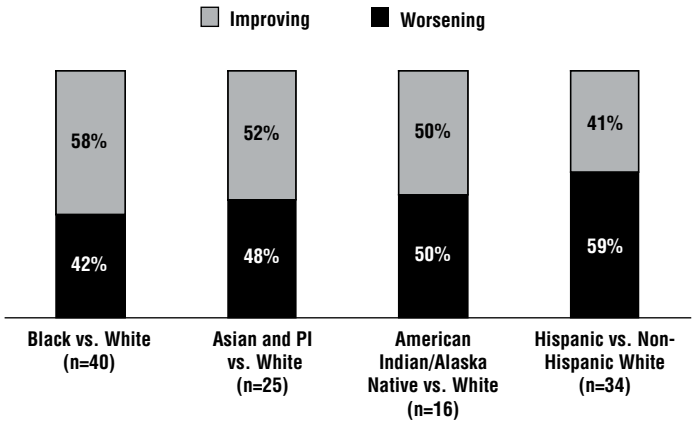
NOTES: "Better" means population received better quality of care than comparison group for the measure; "same" means population received quality of care about the same same as comparison group for the measure; and "worse" means population received poorer quality of care than comparison group for the measure. Data on all measures are not available for all groups; "n" refers to the number of measures on which the groups were compared. Totals may not add to 100% due to rounding.

SOURCE: AHRQ, National Healthcare Disparities Report, 2005

To monitor facilitators and barriers to care, the 2005 NHDR provides information on two core report measures of access for each of the following areas: insurance coverage, usual source of care, problems obtaining health care, and patient-provider communication. The measures showed that, for many measures, minority population groups have poorer access to care than Whites. Hispanics fared worse than Whites on nearly all access measures (7 out of 8). African Americans and American Indians/Alaska Natives fared worse than Whites on half of the available measures (4 of 8 and 3 of 6, respectively). Only Asians had better access to care than Whites for any measure (1 out of 7 available); however, Asians and Pacific Islanders fared worse than Whites for a larger number of measures 3 out of 7).

Figure 49

Changes in Quality of Care Disparities Over Time: Summary by Race/Ethnicity



NOTES: "Improving" means disparity is becoming smaller over time; "worsening" means disparity becoming larger over time. Data on all measures are not available for all groups; "n" refers to the number of measures on which the groups were compared. Totals may not add to 100% due to rounding. Time period differs by measure and includes oldest and newest years of available data.

SOURCE: AHRQ, National Healthcare Disparities Report, 2005

The 2005 NHDR summarized trends in disparities in quality for the core report measures for which data were available over time. For African Americans, 42% of the core quality measures were worsening and 58% were improving. Roughly half of the core measures for Asians and Pacific Islanders and for American Indians/ Alaska Natives were worsening and half were improving. Hispanics did not see the same level of improvement as any of the other population groups, and fared worse in over half (59%) of the core quality measures. The NHDR defined a disparity as worsening when both the absolute difference and relative difference between the population and comparison group were becoming larger over time.

Table 1
Worsening Quality of Care Disparities by Race/Ethnicity

Core Measure	Black N=44	Hispanic N=35	Asian and Pacific Islander N=25	American Indian/Alaska Native N=18
1) Mammography screening				
2) Diagnosis of advanced stage breast cancer		X		X
3) Death rates for breast cancer	--			X
4) Receipt of recommended diabetes care		X		
5) Amputation rates for patients with diabetes				
6) Adequacy of hemodialysis for ESRD patients		X	X	
7) Transplantation registration for ESRD patients			X	X
8) Smoking cessation counseling		X		
9) Hospital care for heart attack patients	X	X	X	X
10) Death rate for heart attack patients	X	X		
11) Hospital care for heart failure patients			X	
12) HIV patients with PCP prophylaxis				
13) New AIDS cases		X		
14) Receipt of prenatal care			X	—
15) Infant mortality rate			X	
16) Child vaccination rates	X	—		X
17) Hepatitis B vaccination rates among teens				
18) Hospital admissions for pediatric stomach flu		X		
19) Exercise counseling among children				
20) Dental care for children		X		
21) Receipt of needed mental health care		X		
22) Suicide death rate	X	X	X	
23) Receipt of needed substance abuse care	X	X		
24) Completion of substance abuse treatment				
25) Flu shots among the elderly	X	X	X	
26) Hospital care for pneumonia patients	X		X	X
27) Antibiotic prescriptions for common cold	X			
28) Completion of TB treatment	X	X		
29) Hospital admissions for pediatric asthma	X			
30) Physical restraint of nursing home patients	X			—
31) Pressure sores in high-risk nursing home patients			X	X
32) Pressure sores in short-stay nursing home patients				
33) Improvement among home health patients	X		X	
34) Hospital transfer of home health patients			X	X
35) Hospital-acquired infections	—			
36) Ventilator-associated pneumonia	X			
37) Postoperative hip fractures		X		
38) Postoperative blood clots	—			
39) Hospital-acquired pneumothorax	X	X		
40) Central venous catheter complications				
41) Obstetric trauma	X	X		
42) Elderly with inappropriate medications				
43) Timely receipt of care among adults	X	X		
44) ED visits when patient left without being seen	—			
45) Listening, explaining, respect, and visit length of providers for adult patients		X		
46) Listening, explaining, respect, and visit length of providers for child patients	X	X		

NOTES: "X" indicates measures for which the difference between Whites and the racial/ethnic group is became larger. "—" indicates measures for which the difference between Whites and the racial/ethnic group remained the same. Shaded area indicates measures for which data over time are unavailable. Time period differs by measure and includes oldest and newest years of available data.

DATA: Special data request from Kaiser Family Foundation to Agency for Healthcare Quality and Research.

SOURCE: National Healthcare Disparities Report, 2005.

Table 1 shows the core measures for which quality of care disparities were worsening for specific population groups. This information is helpful in identifying specific opportunities for improvement in a single population group or across more than one population group. For example, NHDR analysis shows worsening quality of hospital care for heart failure patients of all four racial and ethnic groups. This measure is a composite indicator that includes six measures of recommended care after a heart attack. Improving the quality of care for heart failure may improve outcomes of care for one of the leading causes of death.

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 cases, these differences are reduced, if not eliminated, when comparing minority populations and Whites of similar socio-economic conditions.

For many measures presented in the *2007 Key Facts,* there are only modest changes between the data presented in this edition and the prior one. However, there are several differences worthy of a concluding note. First, there was a slight decrease in the share of the U.S. population that self-identified as White and not of Hispanic origin, reflecting the nation's growing racial/ethnic diversity. Second, there was an increase in the number of uninsured from 41 million in 2001 to 46 million in 2005. Persons from low-income families and communities of color are at greater risk of being uninsured than their counterparts, and thus more likely to experience disparities in healthcare access and quality of care. Third, the change to the 2000 Census allowing individuals to identify with more than one racial group has allowed a more accurate portrayal of the health needs of this very diverse group, yet poses a new set of challenges when describing racial/ethnic groups. When data were available, this report presents findings separately on persons who reported a single racial category and persons reporting two or more racial groups. For populations such as American Indians/Alaska Natives (AI/ANs), in which about 40% report two or more racial groups, this change has implications for our knowledge about the population overall.

Findings from the *National Healthcare Disparities Report (NHDR)* are an important new component of the *2007 Key Facts.* The NHDR provides evidence that, in many cases, minority population groups receive worse care than Whites, and for some measures, gaps in care are getting larger rather than smaller. The NHDR provides mixed evidence about the nation's progress in addressing disparities in the quality of healthcare. Further research is needed to better understand the causes and consequences of the health care differentials presented in this report. 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, site of medical care, or neighborhood of residence influence patterns of care obtained. This research is needed to disentangle the many complex factors that account for these differentials, so that the sources of health care inequity can be addressed.

Appendix

Distribution of U.S Population by Race/Ethnicity, With and Without Territories, 2000

	Population without Territories*	Population with Territories	Population of Territories	Percent Distribution of Territories
	Number in Thousands			
White	194,553	194,611	59	1.4%
Hispanic‡	35,306	39,084	3,778	89.8%
African American	33,948	34,031	81	2.0%
Asian	10,123	10,217	93	2.2%
Native Hawaiian/Pacific Islander	354	497	144	3.4%
American Indian/Alaska Native	2,069	2,069	1	0.0%
Two or More Races	4,602	4,639	37	0.9%
Some Other Race†	468	478	11	0.3%
Total	**281,422**	**285,621**	**4,199**	**100%**

NOTES: *Data were reported by race and ethnicity. ‡Only individuals surveyed in Puerto Rico and the U.S. Virgin Islands were asked a question about Hispanic origin. As a result, data from Puerto Rico were reported by race/ethnicity, while data from the other territories were reported only by race. †In the U.S. Virgin Islands "Some Other Race" category includes American Indian/Alaska Native, Asian, Native Hawaiian and Other Pacific Islander and individuals reporting "Some other race." Total may not sum due to rounding.

DATA: 2000 Census of Population and Housing.

SOURCE: U.S. Census Bureau, 2000.

According to the 2000 Census of Population and Housing, more than 4 million people or 1.5 percent of the total U.S. population live in the U.S. territories, which include Puerto Rico, Guam, American Samoa, the U.S. Virgin Islands, and the Commonwealth of the Northern Mariana Islands. The majority (3.8 million) of these individuals live in Puerto Rico, and 90 percent of them are Hispanic. Native Hawaiians/Pacific Islanders represent the next largest racial or ethnic group with 144,000 or 3 percent of the population living in the U.S. territories.

DATA NOTES

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 six 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 (which is a sum of *responses* rather than *respondents*).

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, the presentation of data on racial/ethnic groups may vary from figure to figure. In some instances, "Asians" and "Native Hawaiians or Other Pacific Islanders" are combined into one category. In a number of 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 other cases, due to small sample size, the "Other" category includes American Indian/Alaska Native, Native Hawaiian or Other Pacific Islander, and individuals reporting "Two or more races." These classifications are noted on figures where applicable.

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

For a more detailed discussion of this topic, see the Census Brief *Overview of Race and Hispanic Origin 2000,* March 2001.

Population Estimates

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

Because of the need to have census data comparable with the reporting categories used by state and local agencies and for compiling other administrative data used in producing population estimates and projections, the Census Bureau developed a procedure to assign an OMB race to those who reported "Some other race." Thus, individuals who identified themselves as "Some other race" were assigned to one of the five OMB race categories. For more information about race classifications in Census 2000, visit the Census Bureau's Internet site: www.census.gov/population/www/socdemo/race/racefactcb.html.

Federal Poverty Threshold

The federal poverty threshold for a family of four was $19,971 in 2005. 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 2005 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: 2004 Data Update,* November 2005.

National Healthcare Disparities Report

Developed by the Agency for Healthcare Research and Quality (AHRQ), the *National Healthcare Disparities Report* (NDHR) is the first national comprehensive effort to track and measure differences in quality and access to health care services in the United States for both the general population and for congressionally designated priority populations. These "priority populations," are defined in AHRQ's authorizing statute (section 901 (c) of the Public Health Service Act) as encompassing both specific population groups as well as geographically-defined groups.

In accordance with these guidelines, the NHDR includes data and analysis on the following: low-income groups; racial and ethnic minority groups (federally recognized racial categories are: American Indian or Alaska Native; Asian; Black or African American; Native Hawaiian or other Pacific Islander; and White; and federally recognized ethnic categories are: Hispanic or Latino, or not Hispanic or Latino); women; children; the elderly; individuals with special health care needs, the disabled, people in need of long-term care, people requiring end-of-life care, and place of residence (e.g., rural communities). Although other demographic groups may also suffer from health care disparities, they are beyond the scope of this report.

Required by Congress in 1999, this annual report, which has been compiled since 2003, presents data on differences in the use of services, access to health care, and impressions of quality for seven clinical conditions, including cancer, diabetes, end-stage renal disease, heart disease, HIV and AIDS, mental health, and respiratory disease as well as data on maternal and child health, nursing home and home health care, and patient safety.

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