

CHARTBOOK

Eliminating

Racial and Ethnic

Disparities

in

Health

September 1998



Eliminating Racial and Ethnic Disparities in Health: A Chartbook

This chartbook was prepared by Grantmakers In Health (GIH) for the conference, Call to Action: Eliminating Racial and Ethnic Disparities In Health, held in Potomac, MD on September 11, 1998. The conference was co-sponsored by GIH and the U.S. Department of Health and Human Services (HHS).

The glaring disparities in health among our nation's racial and ethnic groups should prompt all who have the potential to affect the health system to act. To provide the catalyst, HHS and GIH organized a national leadership conference that would generate ideas and identify action steps for eliminating these disparities. The program was structured so that participants would spend most of the day in small group discussions, talking to each other rather than listening to formal presentations. Those invited included a select group of key public policy makers, industry and community leaders, and individuals representing community-based organizations. National organizations with expertise in key health areas and with a mission of serving racial and ethnic groups, providers, insurance companies and managed-care plans, the media, business, faith-based organizations, and consumers were also invited.

GIH became involved in this effort because of both the work of many foundations in supporting projects to improve minority health status and the potential to stimulate interest by those philanthropic organizations not currently funding work in this area. Foundations and corporate giving programs can play an important role in meeting this challenge. They stimulate action and fund innovative projects in the areas of research and analysis, direct services, coalition building, and public education at the local, state, and national levels. Philanthropy can make a difference directly through programs they fund and by using the lessons learned from these efforts to inform both public and private decisionmakers about effective strategies to improve minority health status.

Although disparities exist in many areas of health, this chartbook presents data on racial and ethnic disparities in the six health areas identified by President Clinton in his February 1998 radio address: infant mortality, cancer screening and management, heart disease, diabetes, HIV/AIDS, and immunization. Data are also presented that set the context for considering these issues. The racial and ethnic distribution of the U.S. population, for example, illustrates a growing diversity in the country. In addition, data are presented on the disparities in risk factors, that contribute to the incidence of diabetes, heart disease, cancer, and other health conditions. Finally, we conclude the chartbook with sections on health care use, insurance coverage, and the health professions.

The data are primarily drawn from federal sources, including the Agency for Health Care Policy and Research, Census Bureau, Health Resources and Services Administration, National Cancer Institute, National Center for Health Statistics, and the National Institute of Diabetes and Digestive and Kidney Diseases. In addition, data were drawn from private sources such as the Association of American Medical Colleges. We have relied on published data and gratefully acknowledge the work of analysts in these agencies and organizations.

While great care was given to representing all races and ethnicities in each chart, this was not always possible. The reasons vary, but often, the data are missing from the original sources or are taken from samples too small to allow for calculation of estimates. This is particularly true of Asian/Pacific Islanders for whom national health data are frequently not collected because of the small sample sizes. Much of what has been collected is based on more established national origin groups (e.g. Japanese, Asian Indians) and in selected locations (e.g. West Coast) and then extrapolated to represent the health of all Asian/Pacific Islanders in the U.S. In addition, the Hispanic, American Indian/Alaska Native, and Asian/Pacific Islander populations consist of diverse subgroups. While some are well educated, employed, have health insurance, and access to health care, a large number have little formal education, no health insurance, and poor access to care. Nationally collected data often mask differences among subgroups within those populations. The infant mortality rate presented for Hispanics, for example, conceals the rates of particular subgroups, such as Puerto Ricans whose infant mortality rate is well above the national average. Similarly, the aggregate rate of smoking presented for Asian/Pacific Islanders masks the rates among the subgroups of Chinese and Vietnamese men, in the age-group 25-44, whose smoking rates are well above the national and race-group averages.

Finally, the use of the terms, African-American and black, varies within charts. Many of the original sources highlighted when the race category, black, did not include persons of Hispanic origin (black, non-Hispanic vs. black). Within each chart, we have reproduced the legend as it appeared in the original source. Throughout the body of the text, however, we consistently use the term African American.

The primary GIH staff person responsible for preparing the chartbook was Malcolm V. Williams, with editorial assistance from Anne Schwartz and Lauren LeRoy. Thanks also to Deborah Kramer and Mary Backley of GIH who provided support in the production of this document.

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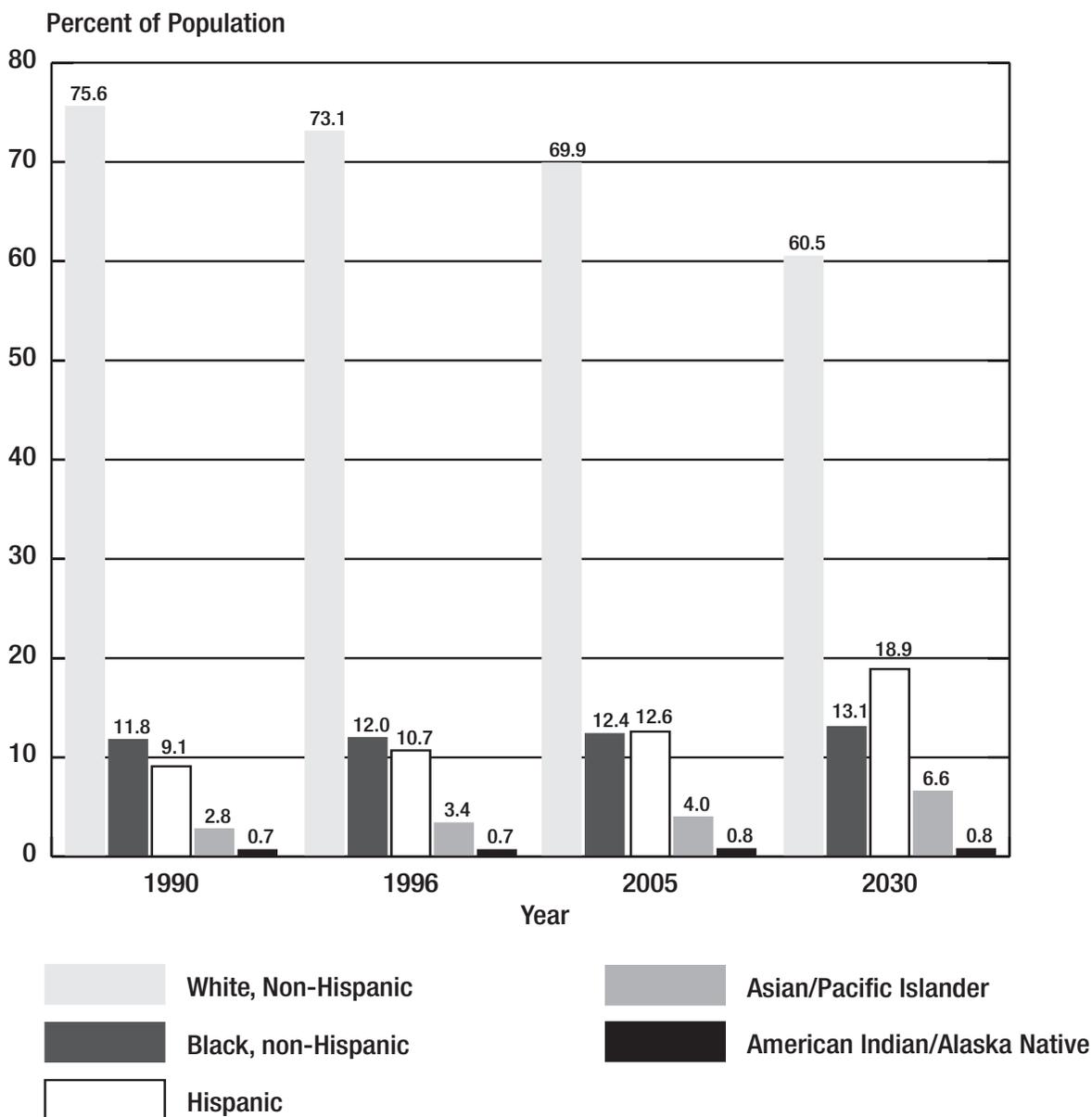
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Figure 1-1. Racial and Ethnic Distribution of the United States Population, Selected Years, 1990-2030

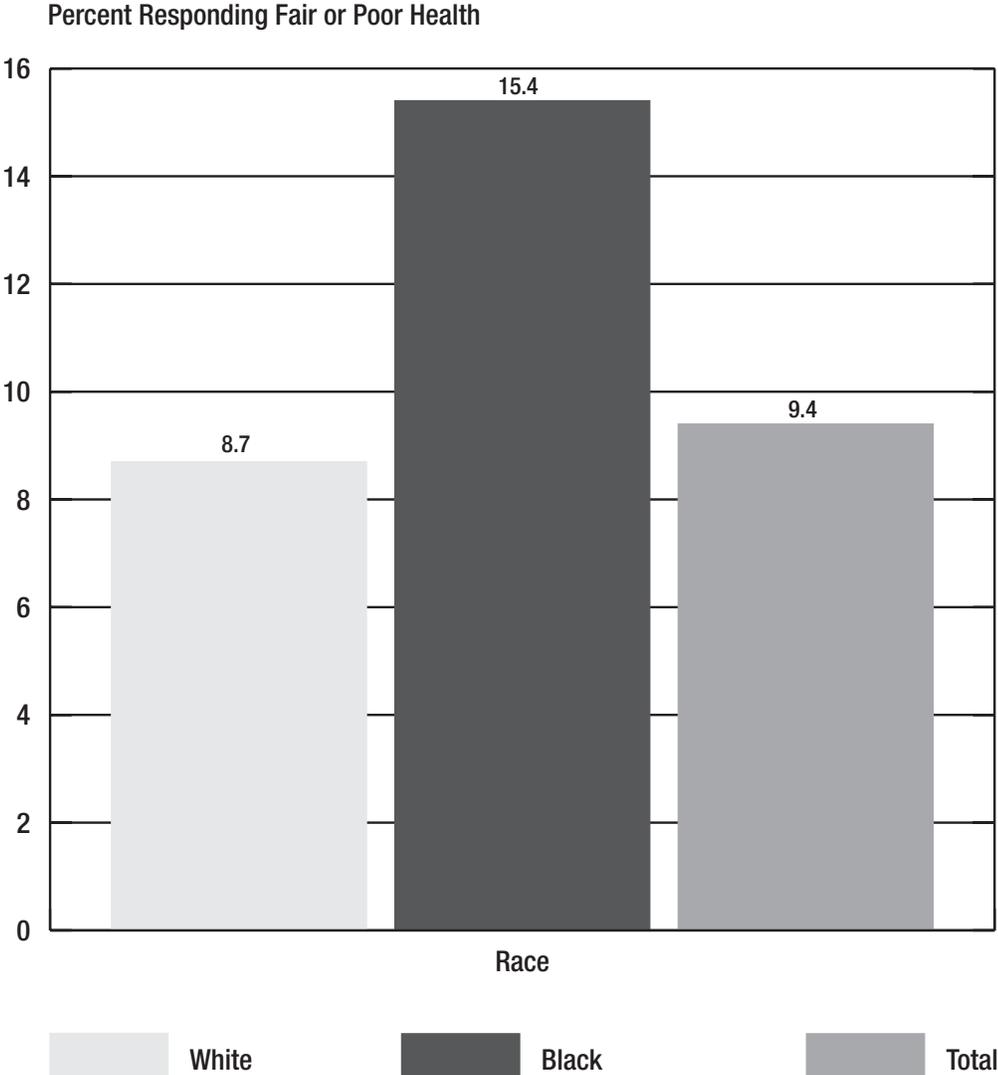


Source: U.S. Bureau of the Census, 1996 and 1998.

Notes: Persons of Hispanic origin may be of any race. The racial categories, American Indian/Alaska Native, and Asian/Pacific Islander, do not include persons of Hispanic origin.

- Racial and ethnic minorities (African American, Hispanic, American Indian/Alaska Native, Asian/Pacific Islander) will make up an increasing proportion of America's population, growing from 24.4 percent in 1990 to 39.4 percent in 2030.
- By 2005, Hispanics will become the largest minority group.

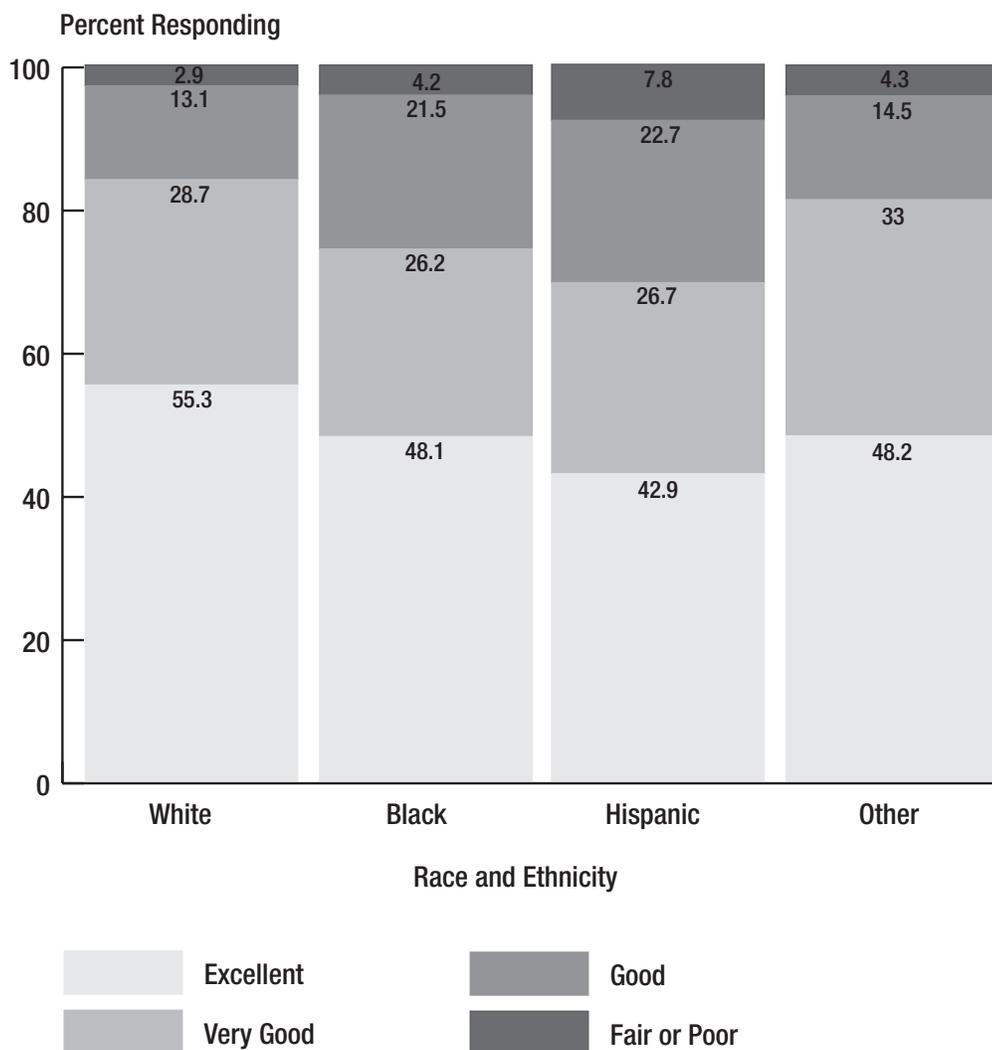
Figure 1-2. Age-Adjusted Self-Reported Fair or Poor Health Status by Race, 1995



Source: National Center for Health Statistics, 1998a.

- There are substantially more African Americans than whites who report that they are in fair or poor health.

Figure 1-3. Self-Reported Health Status of Children Ages 17 and Younger by Race and Ethnicity, 1996

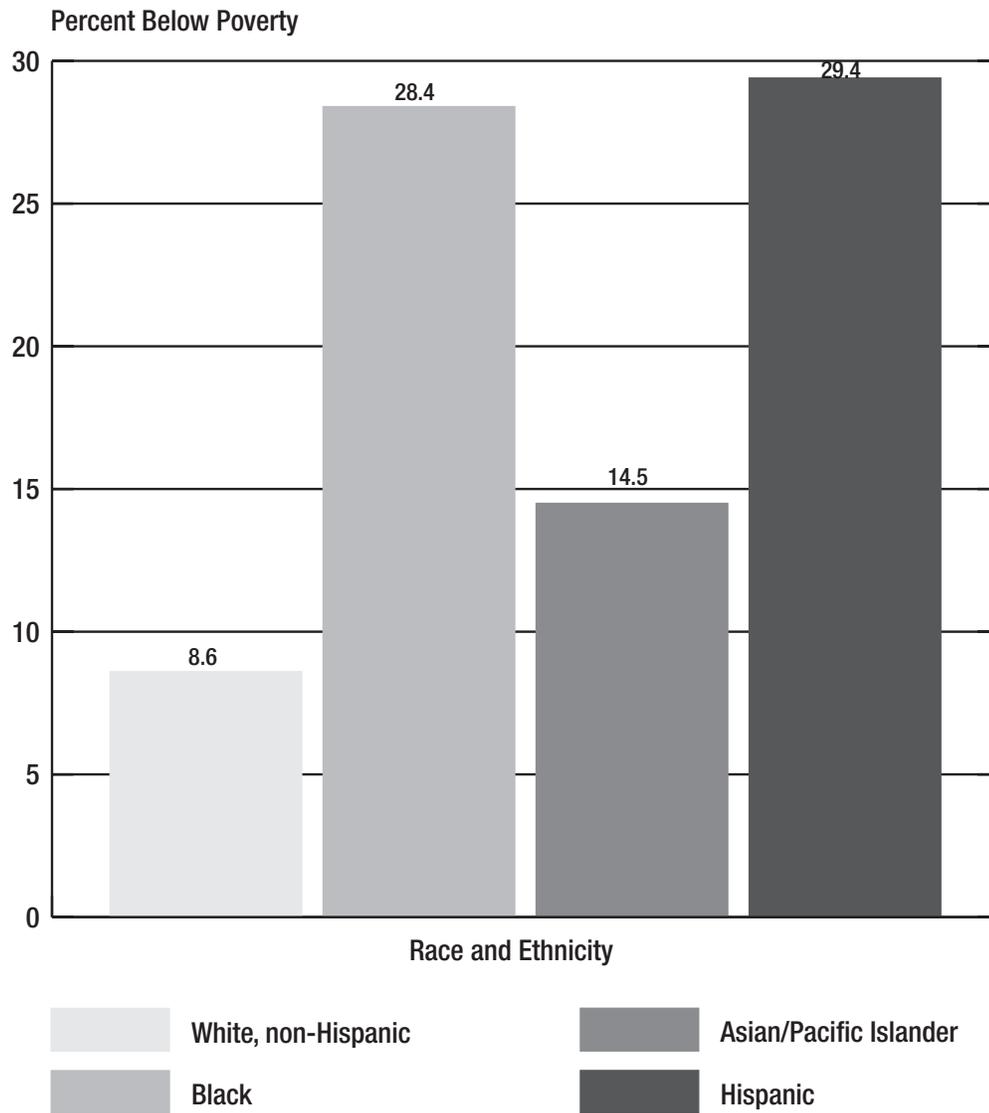


Source: Weinick, Weigers, and Cohen, 1998.

Notes: Children of Hispanic origin may be of any race. The race categories, white and black, exclude Hispanic children.

- **Minority children report that their health is poor more often than white children, and report that they are in excellent health less often than white children.**
- **Hispanic children report most often that their health status is fair or poor.**

Figure 1-4. Persons Below Poverty by Race and Ethnicity, 1996



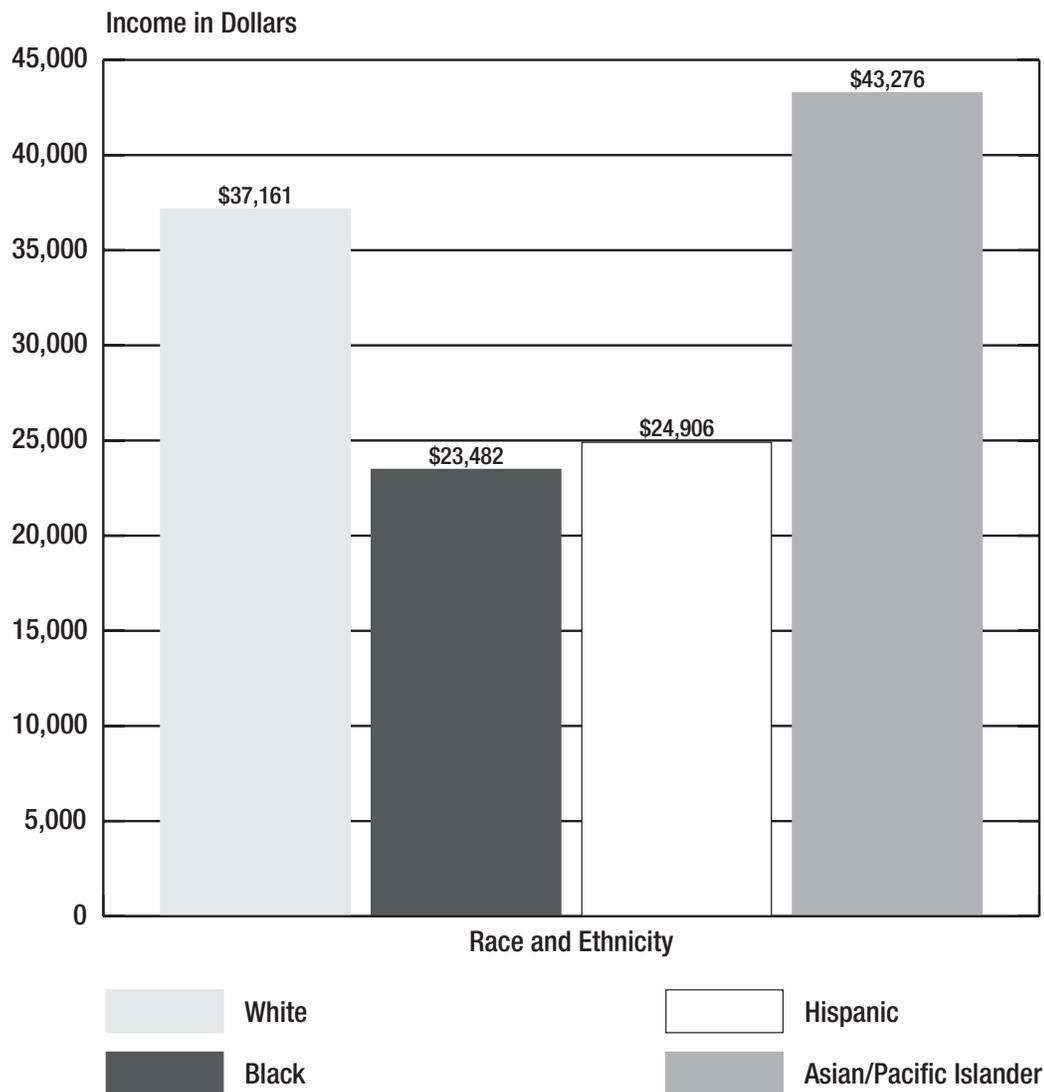
Source: National Center for Health Statistics, 1998a.

Notes: The racial category, black, includes persons of both Hispanic and non-Hispanic origin. Conversely, persons of Hispanic origin may be of any race.

Poverty status is based on family income and family size using Bureau of the Census poverty thresholds.

- The prevalence of poverty is greatest among Hispanics and African Americans.
- The rate of poverty among both African Americans and Hispanics is about twice the poverty rates of whites and Asian/Pacific Islanders.

Figure 1-5. Median Household Income by Race and Ethnicity, 1996

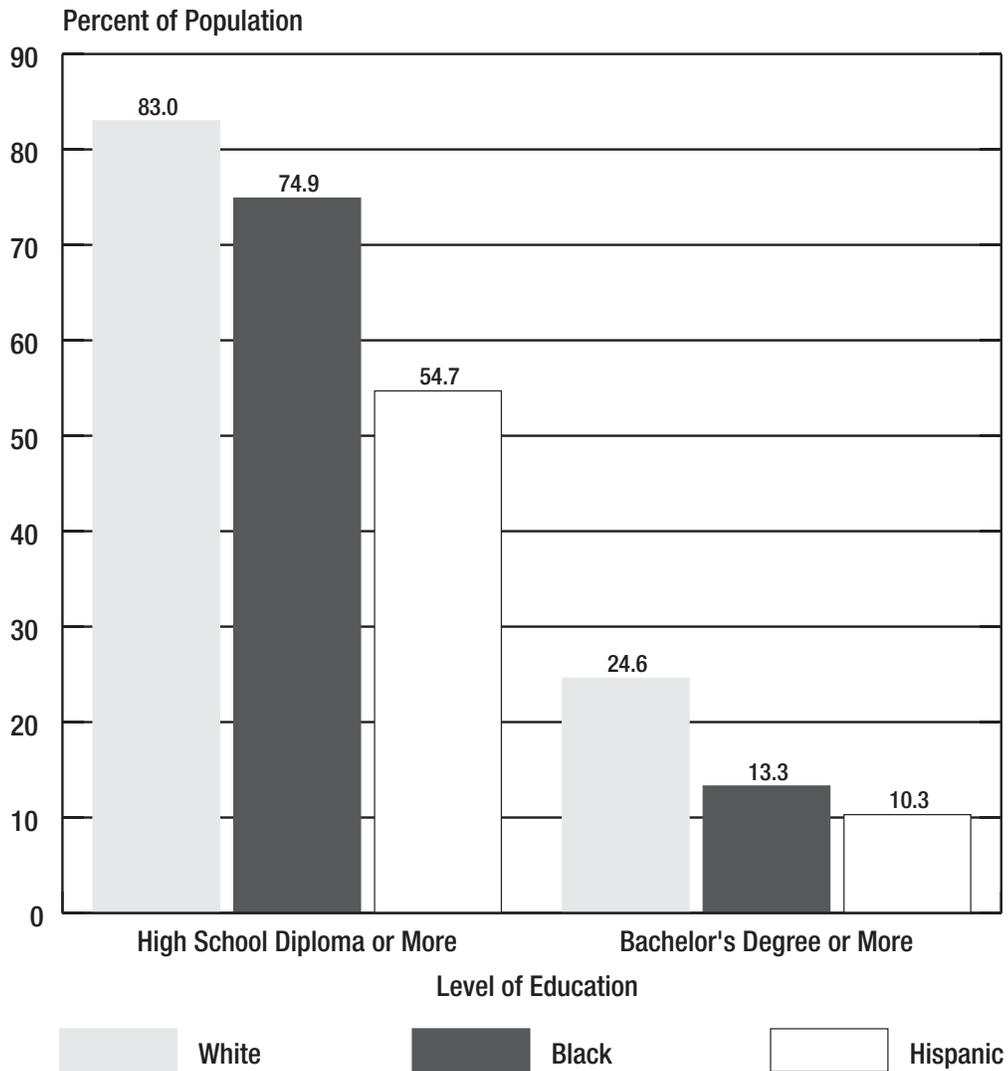


Source: U.S. Bureau of the Census, 1997a.

Notes: Persons of Hispanic origin may be of any race.

- Asian/Pacific Islanders have the largest median household income among all racial and ethnic groups.
- The median household income of African Americans and Hispanics is substantially less than whites and Asian/Pacific Islanders.

Figure 1-6. Educational Attainment of Persons Ages 25 and Older, by Race and Ethnicity, March 1997

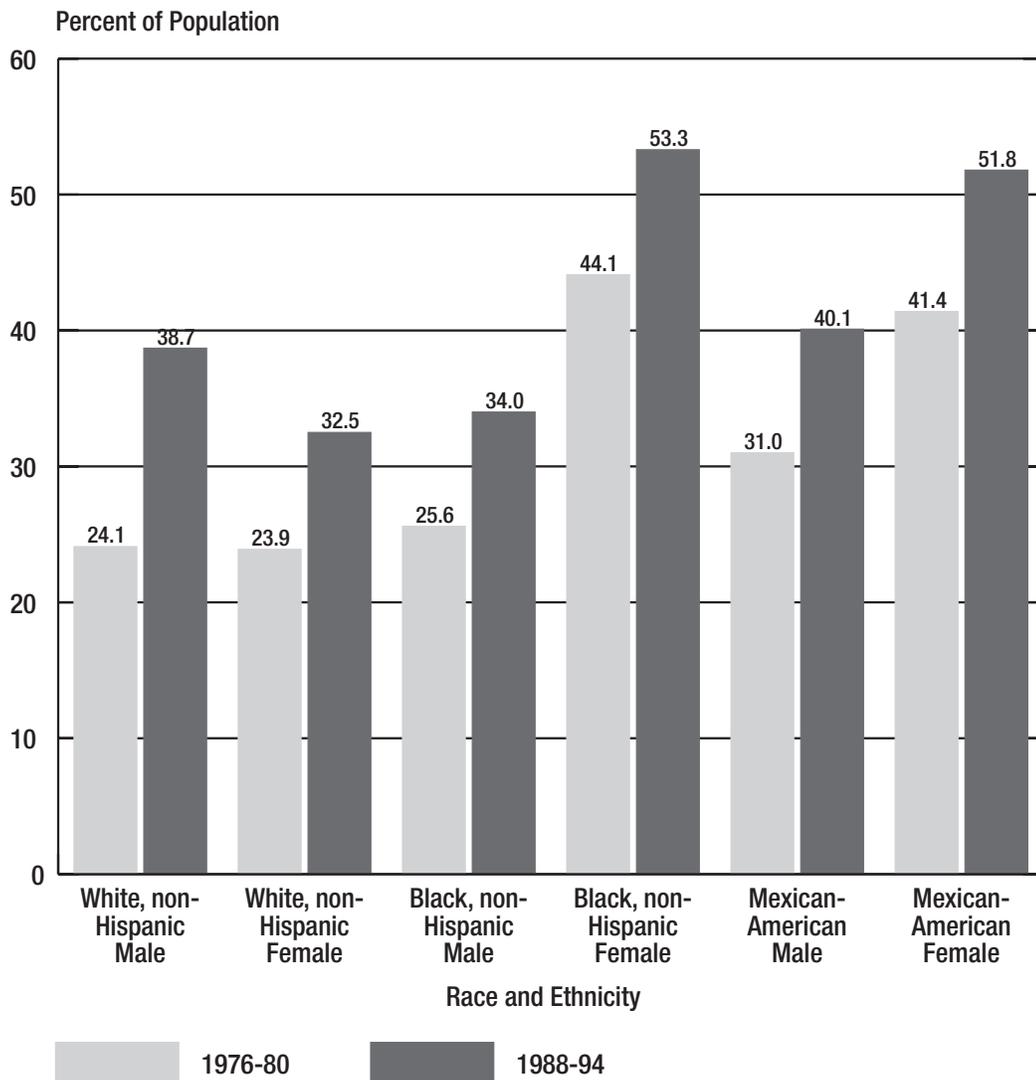


Source: U.S. Bureau of the Census, 1997b.

Notes: Persons of Hispanic origin may be of any race.

- Whites lead both African Americans and Hispanics in educational attainment at the high school and college levels.
- The percentage of African Americans and Hispanics earning a bachelor's degree or more is about half that of whites.

Figure 1-7. Overweight Adults Ages 20 to 74 by Race and Gender, Selected Years, 1976-1980 and 1988-1994



Source: National Center for Health Statistics, 1998a.

Notes: Data are based on physical examinations of a sample of the civilian noninstitutionalized population. Overweight is defined for men as body mass index greater than or equal to 27.8 kilograms/meter², and for women as body mass index greater than or equal to 27.3 kilograms/meter². These cut points were used because they represent the sex specific 85th percentiles for persons 20-29 years of age in the 1976-80 National Health and Nutrition Examination Survey.

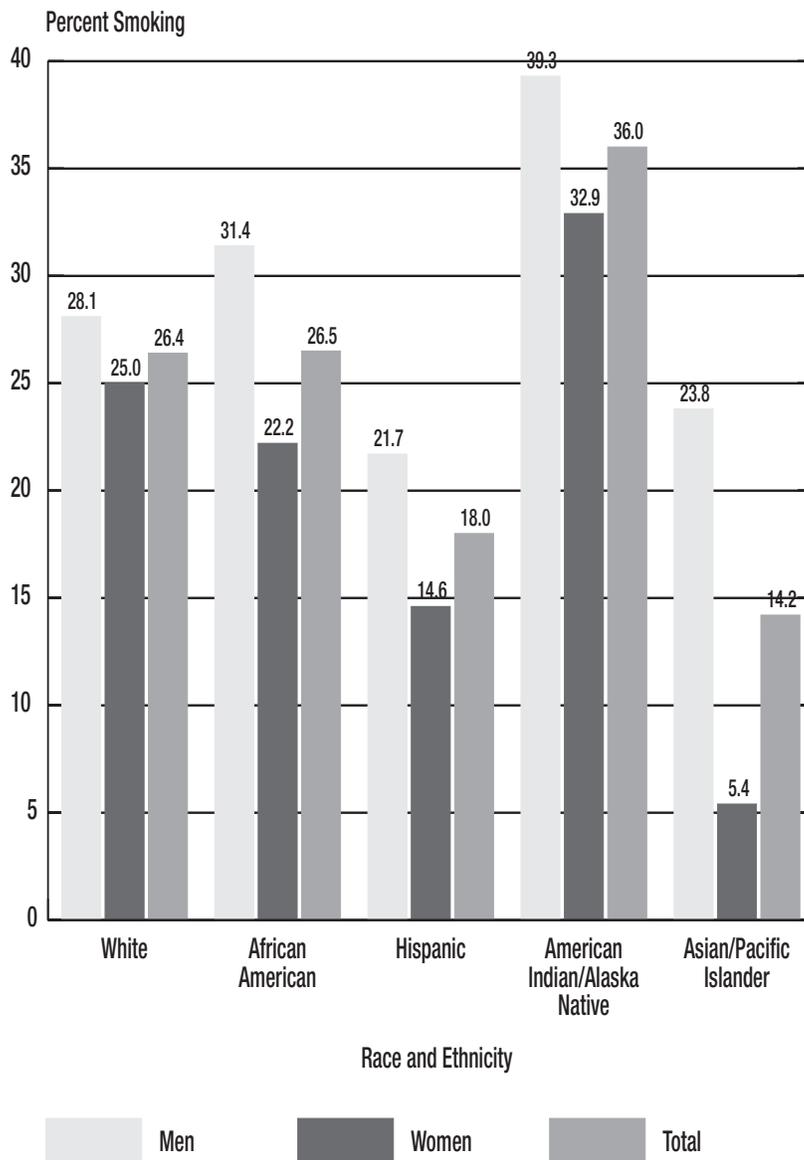
These data do not reflect 1998 changes that lowered the threshold for obesity.

Mexican-American may be of any race. Data shown for white and black populations do not include persons of Hispanic origin.

Being overweight is a risk factor for a number of diseases including coronary heart disease and diabetes.

- The percentage of overweight adults, among all racial and ethnic groups, increased over the 18 year period ending in 1994.
- Mexican-American men have a higher prevalence of overweight than white or African-American men.
- Across genders, the prevalence of overweight remains higher among African-American and Mexican-American women.

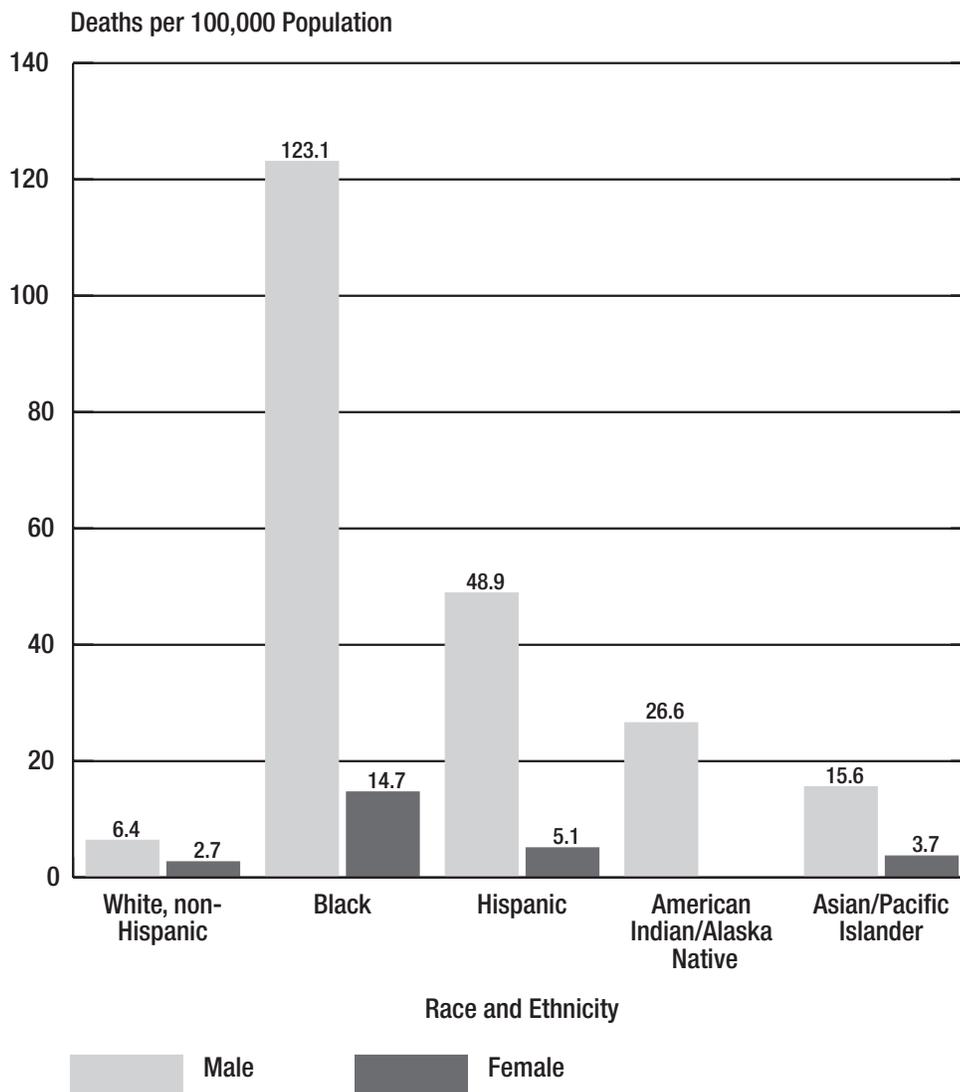
Figure 1-8. Age-Adjusted Prevalence of Current Cigarette Smoking Among Adults by Race, Ethnicity, and Gender, 1994 and 1995



Source: National Center for Chronic Disease Prevention and Health Promotion, 1998.

- Cigarette smoking is highest among American Indian/Alaska Natives.
- Cigarette smoking is lower among Hispanics and Asian/Pacific Islanders than among other racial and ethnic groups.

Figure 1-9. Homicide Rates Among Persons Ages 15 to 24 by Race, Ethnicity, and Gender, 1996



Source: National Center for Health Statistics, 1998a.

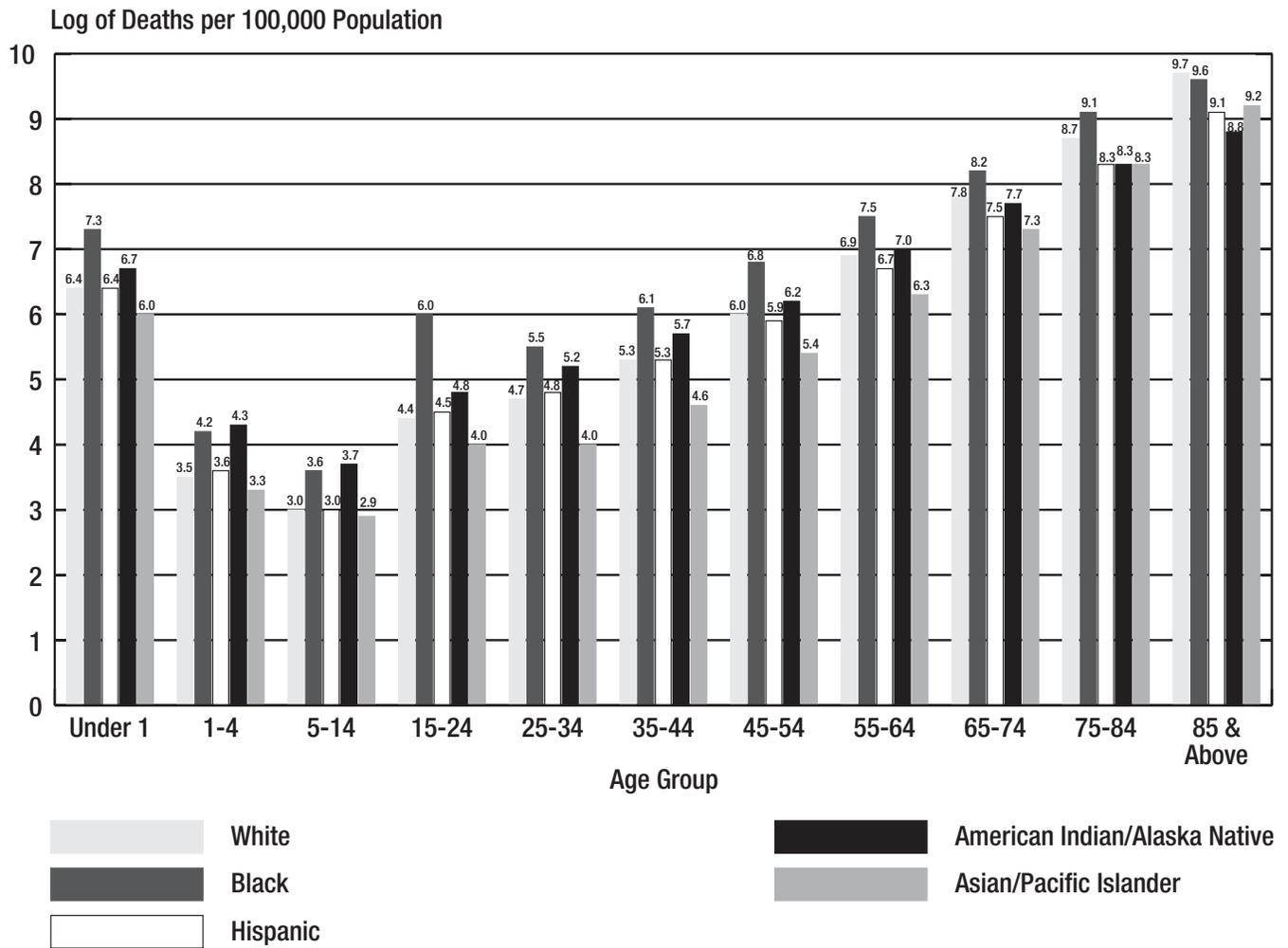
Notes: The racial categories, black, Asian/Pacific Islander, and American Indian/Alaska Native, include persons of Hispanic and non-Hispanic origin. Conversely, persons of Hispanic origin may be of any race.

The homicide rate includes legal interventions such as executions and deaths by police officers acting in the line of duty.

The homicide rate for American Indian/Alaska Native females is based on fewer than 20 deaths.

- For both males and females, the homicide rate in young adults is greater among African Americans, Hispanics, and American Indian/Alaska Natives, than other racial and ethnic groups.
- Young males die more often from homicide and legal intervention than young females in all racial and ethnic groups.
- The young African-American female homicide rate is more than twice that of the young white male rate.
- The rate of death from homicide and legal intervention among young African-American males is more than double the rate for young Hispanic males.

Figure 1-10. Death Rate by Race, Ethnicity, and Age, 1996

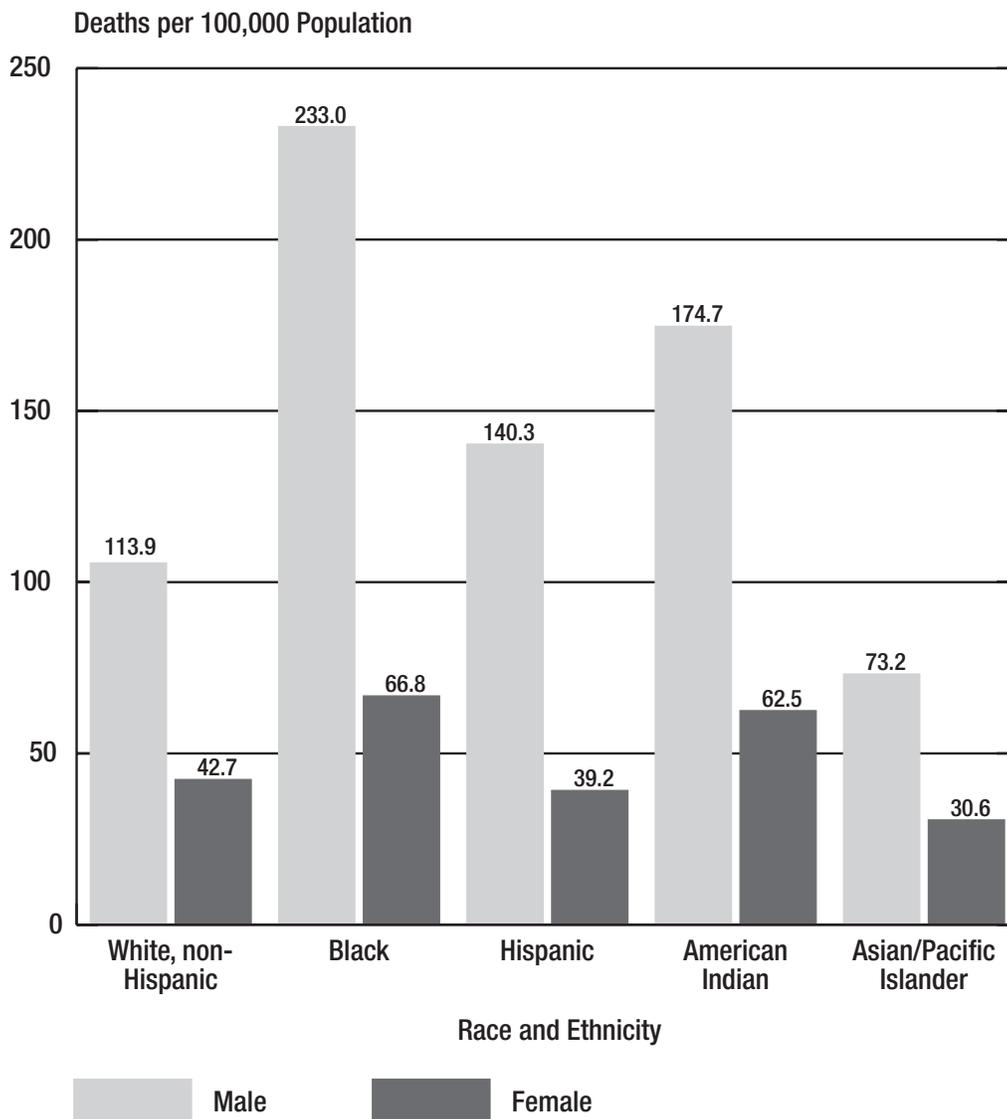


Source: National Center for Health Statistics, 1997.

Notes: Persons of Hispanic origin may be of any race.

- Death rates for African Americans are consistently higher than any other racial and ethnic groups for each age group until the age of 85.

Figure 1-11. Death Rates Among Persons Ages 15 to 24 by Race, Ethnicity, and Gender, 1996

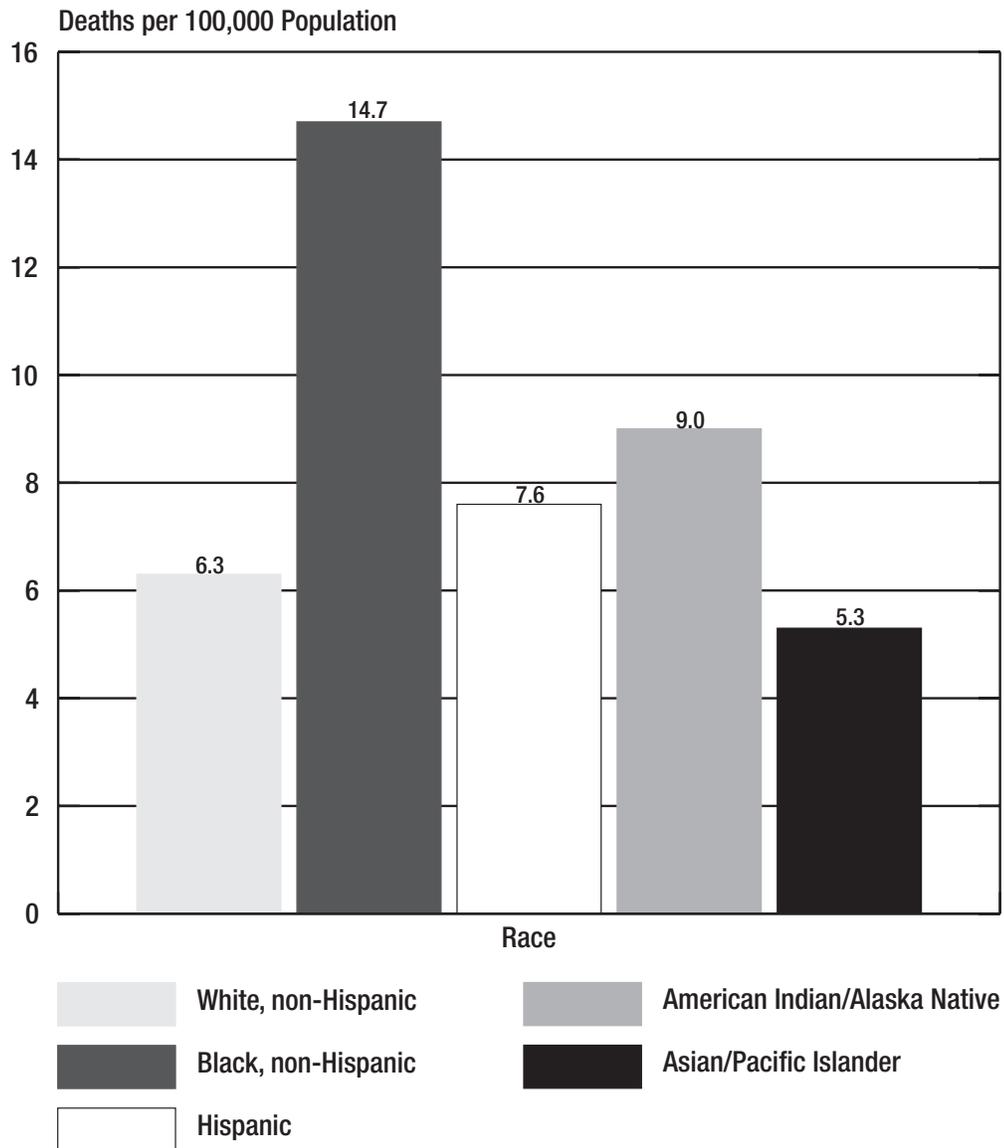


Source: National Center for Health Statistics, 1997.

Notes: Persons of Hispanic origin may be of any race.

- Among persons ages 15 to 24, death rates are significantly higher for males, particularly African-American males. In this age group, the African-American male death rate is more than twice that of white males and 3.5 times that of African-American females.
- Among males, death rates are higher for Hispanics and American Indians than whites.
- Among females, death rates are higher for American Indian/Alaska Natives and African Americans than whites.

Figure 2-1. United States Infant Mortality by Race and Ethnicity, 1995



Sources: National Center for Health Statistics, 1998a.

U.S. Department of Health and Human Services, 1998b.

Notes: Data for Asian/Pacific Islanders and Hispanics do not reflect the diversity in infant mortality among subgroups. Puerto Ricans, for example have an infant mortality rate of 8.9 percent and Native Hawaiians have an infant mortality rate of 6.5 percent.

- African-American and American Indian/Alaska Native children have the highest infant mortality rates among all racial and ethnic groups.

Figure 2-2. Infant Mortality Rates for Selected Countries and United States Racial/Ethnic Groups, 1993, 1994, and 1995

Country and United States Racial/Ethnic Groups	Infant Deaths per 1,000 Live Births	Year
Japan	4.3	1994
Hong Kong	4.4	1994
United States: Asian/Pacific Islander	5.3	1995
Germany	5.6	1994
Northern Ireland	6.1	1994
Canada	6.3	1993
United States: White	6.3	1995
France	6.5	1993
Spain	6.7	1993
United States: Hispanic	7.6	1995
Israel	7.8	1994
United States: All	8.0	1995
Portugal	8.1	1994
United States: American Indian/Alaskan Native	9.0	1995
Slovakia	11.2	1994
Hungary	11.6	1994
Kuwait	12.7	1994
Costa Rica	13.7	1994
United States: African-American	14.7	1995
Poland	15.1	1994
Russian Federation	18.6	1994

Source: National Center for Health Statistics, 1998a.

Notes: Data for countries are based on geographic areas with at least 1 million population and with complete counts of live births and infant deaths as indicated in the United Nations Demographic Yearbook, 1995 edition.

- The United States ranks 25th in infant mortality among the industrialized nations.
- The infant mortality rate among African Americans is more similar to those of Costa Rica, Kuwait, Poland, and the Russian Federation than to the national average.

Figure 2-3. Infant Mortality Rates for the 10 Leading Causes of Infant Death, by Race and Ethnicity, United States, Preliminary 1996

Cause	Race					
	White		Black		Hispanic	
	Rate	Rank	Rate	Rank	Rate	Rank
Congenital Anomalies	162.8	1	194.6	2	158.4	1
Short Gestation/Unspecified Low Birth-weight	65.0	2	264.1	1	70.4	2
Sudden Infant Death Syndrome (SIDS)	60.3	3	154.0	3	43.9	3
Respiratory Distress Syndrome	27.5	4	78.5	4	29.2	4
Maternal Complications of Pregnancy	25.2	5	67.3	5	17.4	5
Complications of Placenta, Cord, and Membranes	19.3	6	44.1	6	14.1	9
Accidents and Adverse Effects	17.1	7	34.2	8	15.5	6
Infections Specific to the Perinatal Period	15.4	8	41.1	7	15.0	7
Intrauterine Hypoxia and Birth Asphyxia	10.2	9	★		7.5	10
Pneumonia and Influenza	9.9	10	25.0	9	14.8	8
Homicide	★		18.1	10	★	
All Other Causes	191.6		495.3		196.3	

Source: National Center for Health Statistics, 1997.

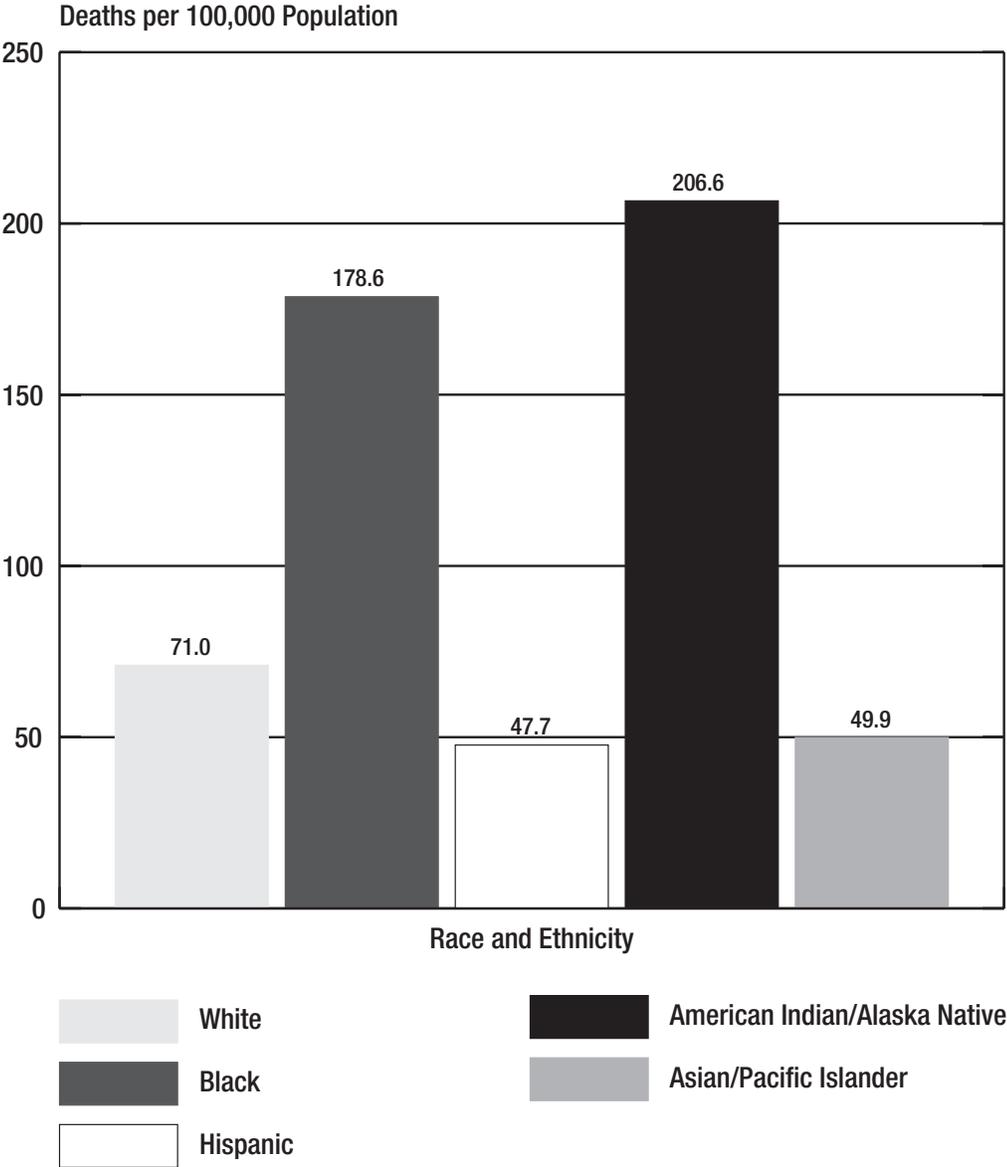
Notes: Children of Hispanic origin may be of any race.

Rates reflect deaths per 100,000 population.

★ Not listed as a top-ten cause of death

- The leading killer among white and Hispanic infants is congenital anomalies, while African-American infants suffer more deaths from disorders relating to short gestation and unspecified low birth-weight.
- Accidents is one of only two causes of death that is non-medical in nature, and yet is the 6th leading killer among Hispanic children.
- Only among African-American children is homicide one of the top ten causes of infant mortality.

Figure 2-4. Sudden Infant Death Syndrome (SIDS) Mortality Rate by Race and Ethnicity, United States, 1995

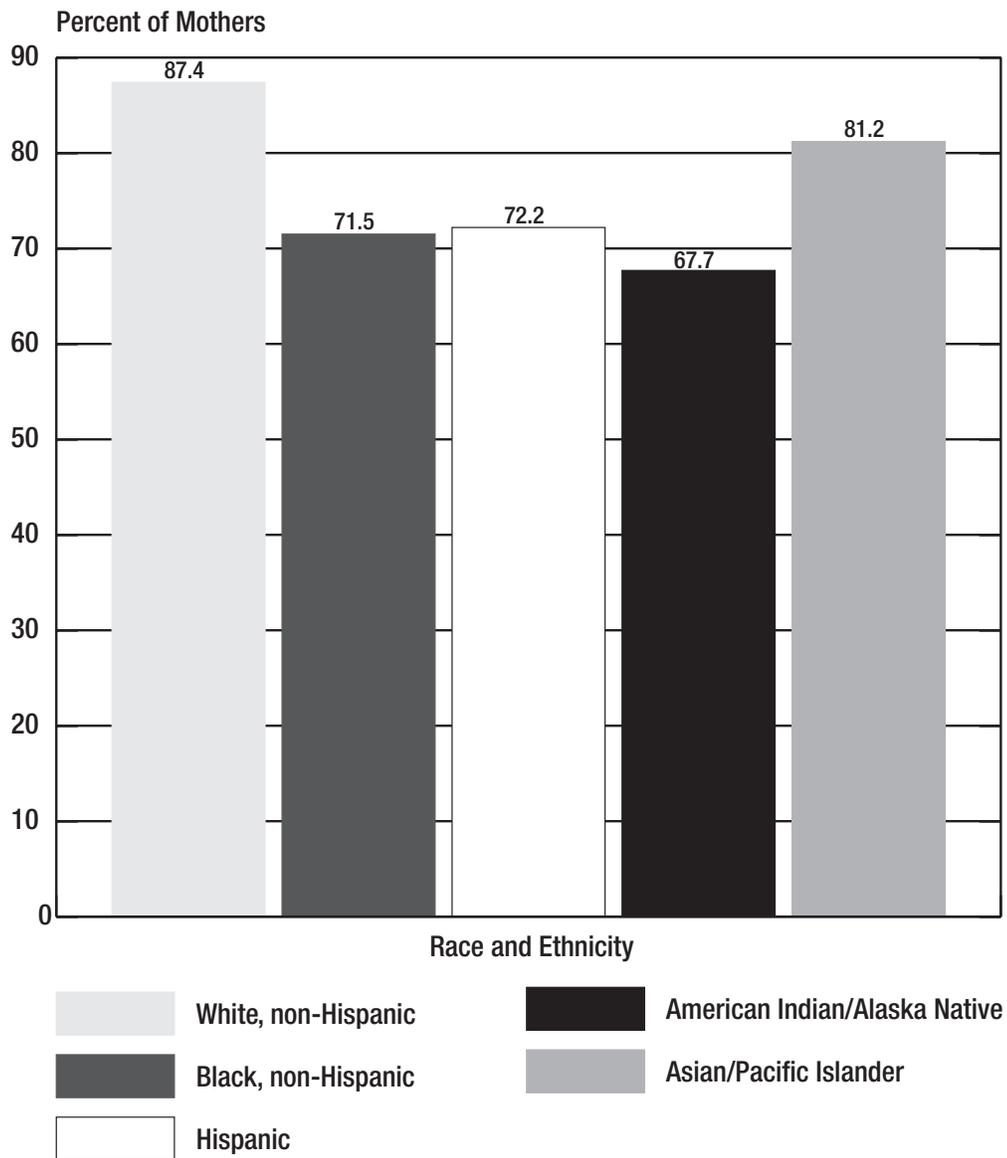


Source: U.S. Department of Health and Human Services, 1998b.

Notes: Children of Hispanic origin may be of any race.

- The rate of SIDS deaths is highest among American Indian/Alaska Native infants.
- The rate of SIDS deaths among African-American children is more than twice that of white children, and more than triple that of Hispanic children.

Figure 2-5. Mothers Receiving Prenatal Care in the First Trimester by Race and Ethnicity, United States, 1996



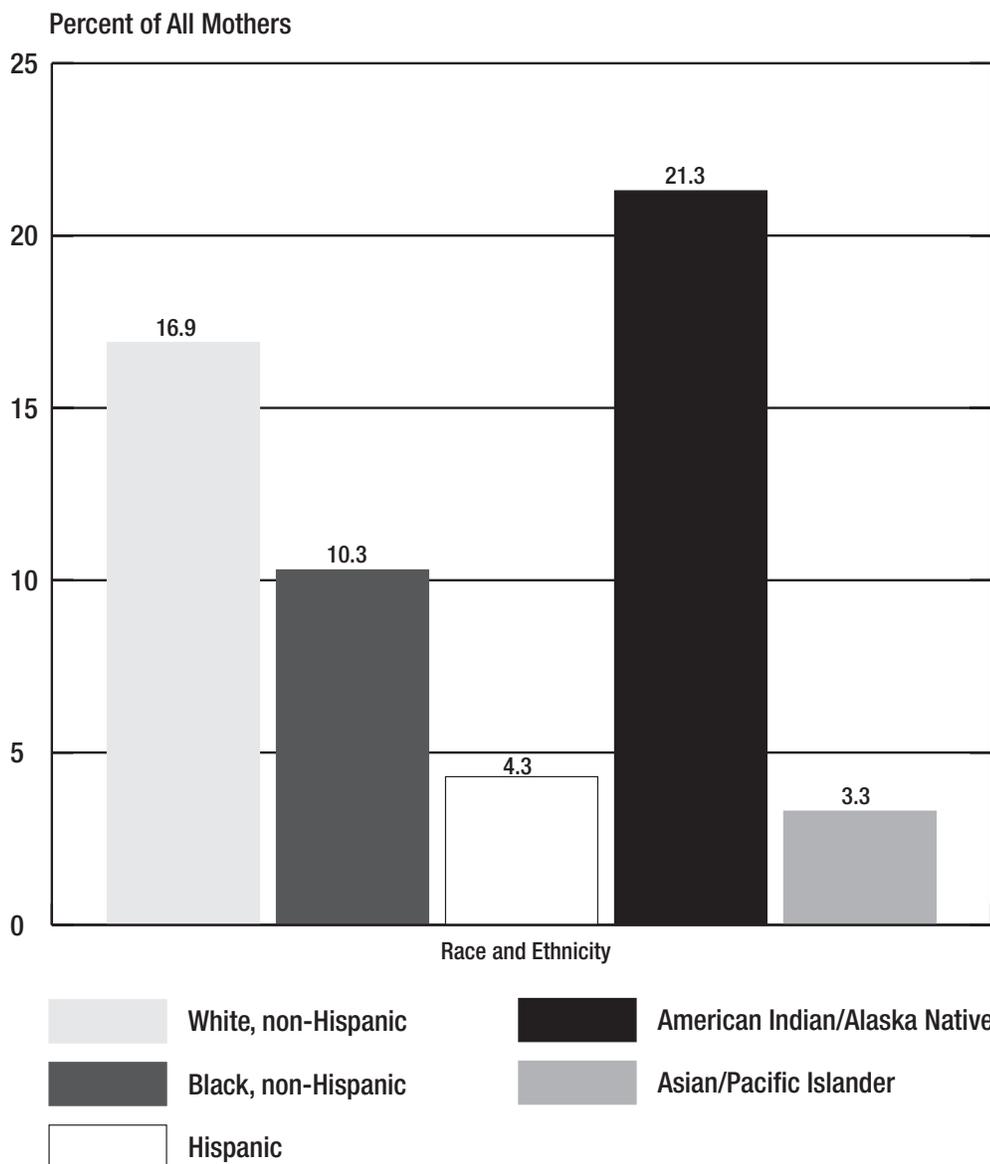
Source: National Center for Health Statistics, 1998a.

Notes: The racial categories, American Indian/Alaska Native, and Asian/Pacific Islander, include persons of Hispanic and non-Hispanic origin. Conversely, persons of Hispanic origin may be of any race.

Receiving prenatal care early and regularly during pregnancy can reduce low birth-weight births as well as complications from low birth-weight births to infants.

- Fewer African-American, Hispanic, and American Indian/Alaska Native women receive prenatal care in the first trimester than their white and Asian/Pacific Islander counterparts.

Figure 2-6. Mothers Who Smoked Cigarettes During Pregnancy by Race and Ethnicity, United States, 1996



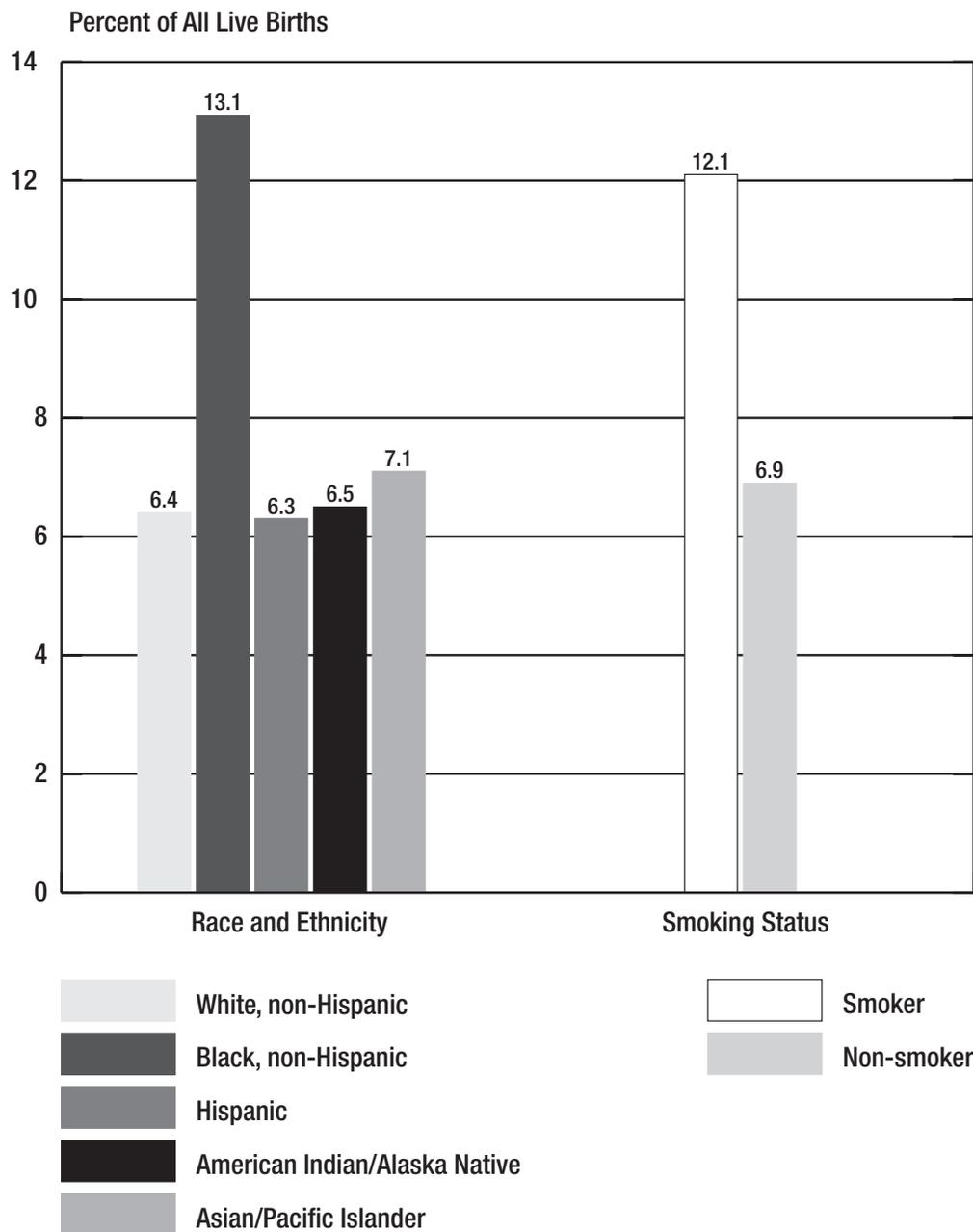
Source: National Center for Health Statistics, 1998a.

Notes: Maternal tobacco use during pregnancy was not reported on the birth certificates of California and New York, which during 1989-1991 together accounted for 43 percent to 66 percent of the births among all Asian subgroups (except Hawaiian).

The racial categories, American Indian/Alaska Native and Asian/Pacific Islander, include mothers of Hispanic and non-Hispanic origin. Conversely, mothers of Hispanic origin may be of any race.

- The rate of smoking during pregnancy in 1996 was highest among American Indian/Alaska Native and white mothers.
- The rate of smoking during pregnancy in 1996 for American Indian/Alaska Native mothers was about twice the rate of African-American mothers, and around five times the rate of Hispanic and Asian/Pacific Islander mothers.

Figure 2-7. Low Birth-weight Live Births by Race, Ethnicity, and Mother's Smoking Status, United States, 1996



Source : National Center for Health Statistics, 1998a.

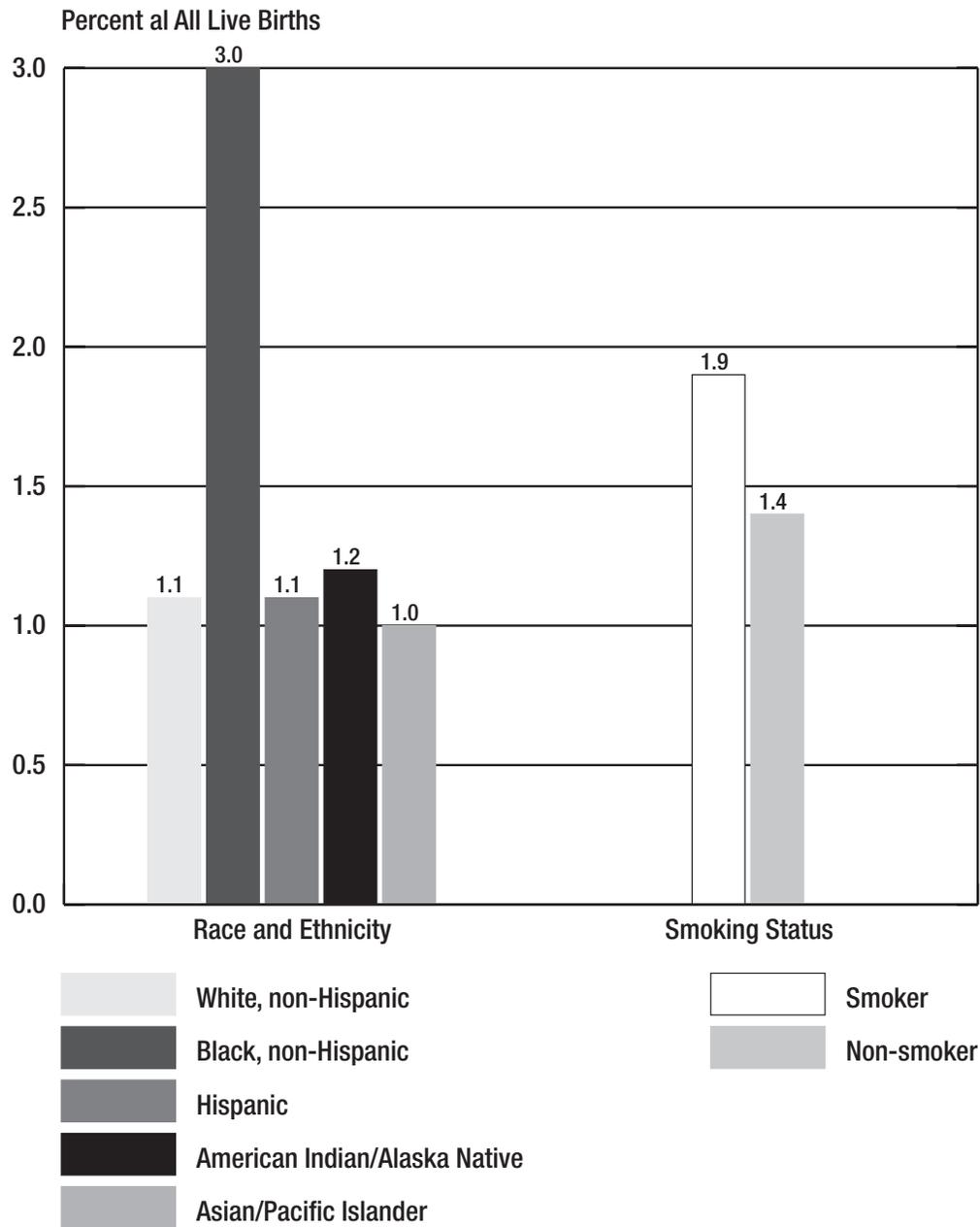
Notes: Low birth-weight indicates children born less than 2,500 grams.

The racial categories, American Indian/Alaska Native, and Asian/Pacific Islander, include mothers of Hispanic and non-Hispanic origin. Conversely, mothers of Hispanic origin may be of any race.

Smoking mothers may be of any race or ethnicity.

- The African-American low birth-weight rate is about twice that of all other racial and ethnic groups.
- African-American mothers have a higher low birth-weight rate than mothers who are smokers of any race or ethnicity.

Figure 2-8. Very Low Birth-weight Rate by Race, Ethnicity, and Mother's Smoking Status, United States, 1996



Source: National Center for Health Statistics, 1998a.

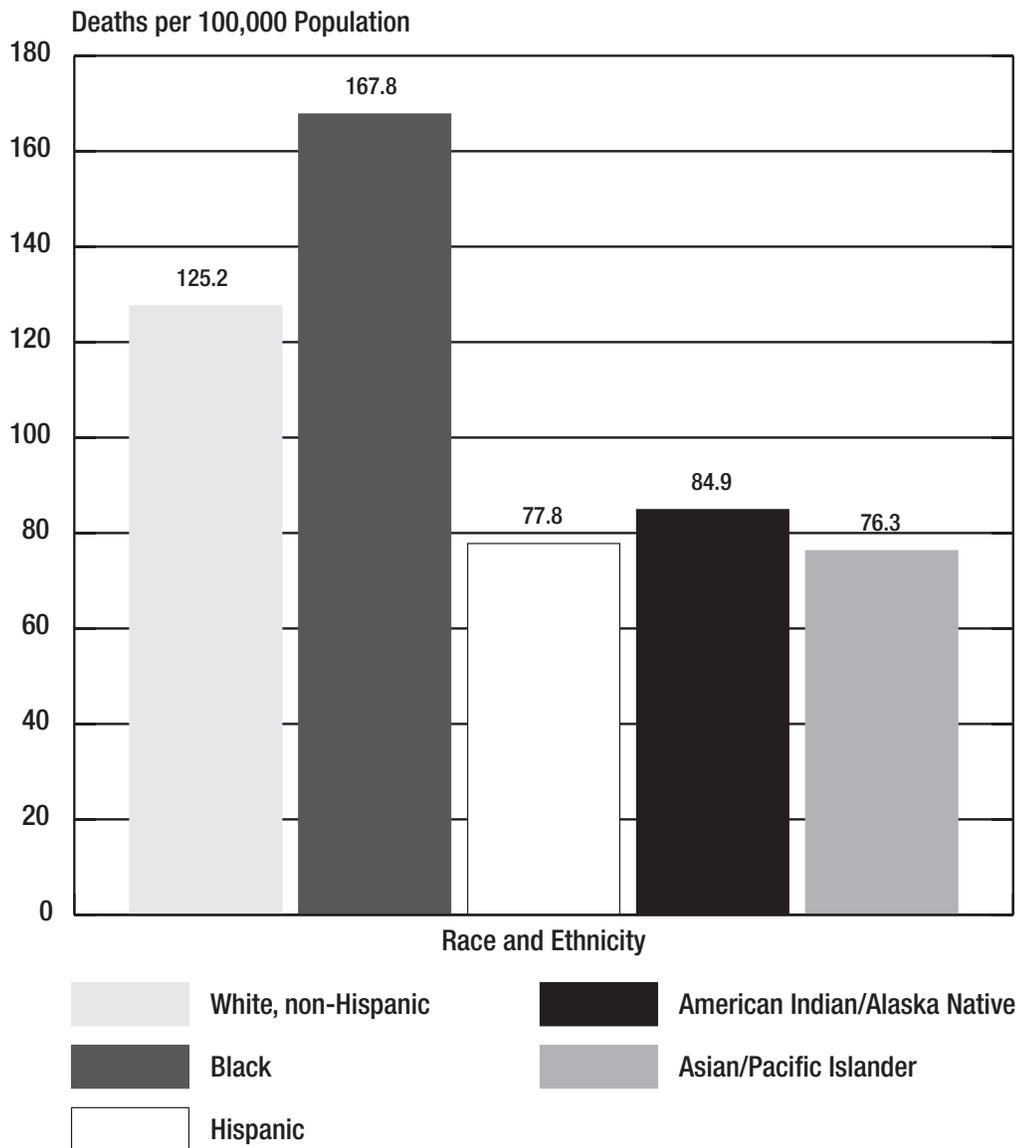
Notes: Very low birth-weight indicates children born less than 1,500 grams.

The racial categories, American Indian/Alaska Native, and Asian/Pacific Islander, include mothers of Hispanic and non-Hispanic origin. Conversely, mothers of Hispanic origin may be of any race.

Smoking mothers may be of any race or ethnicity.

- African-American mothers have a higher very low birth-weight rate than mothers who are smokers of any race or ethnicity.
- African-American mothers have a very low birth-weight rate that is around three times that of all other racial and ethnic groups.

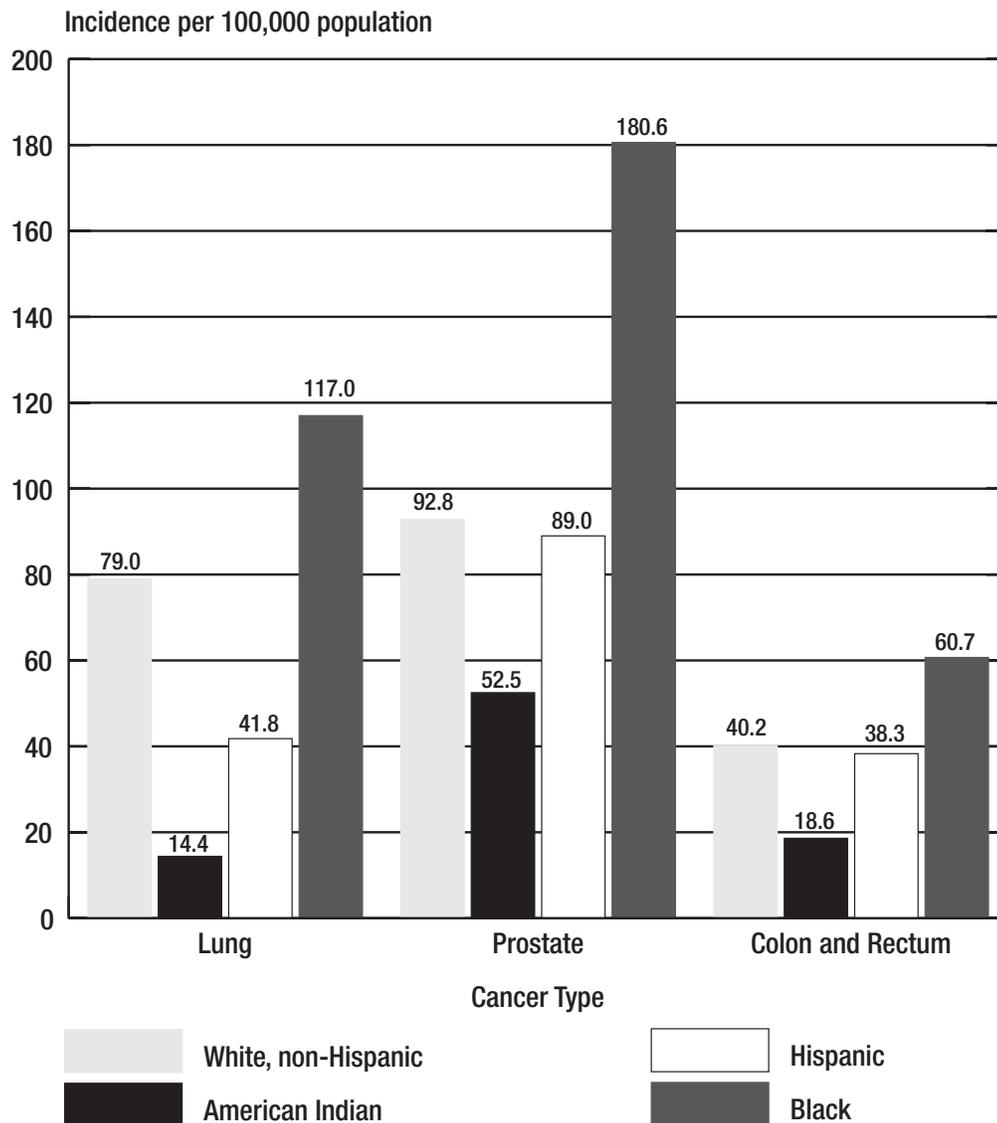
Figure 3-1. Death Rate for Cancer by Race and Ethnicity, 1996



Source: National Center for Health Statistics, 1998a.

- Deaths from cancer are higher among African Americans than other racial and ethnic groups.
- The death rate for cancer among African Americans is around twice the rates for Hispanics, American Indian/Alaska Natives, and Asian/Pacific Islanders.

Figure 3-2. Lung, Prostate, and Colon/Rectum Cancers in Men by Race and Ethnicity, 1988-1992



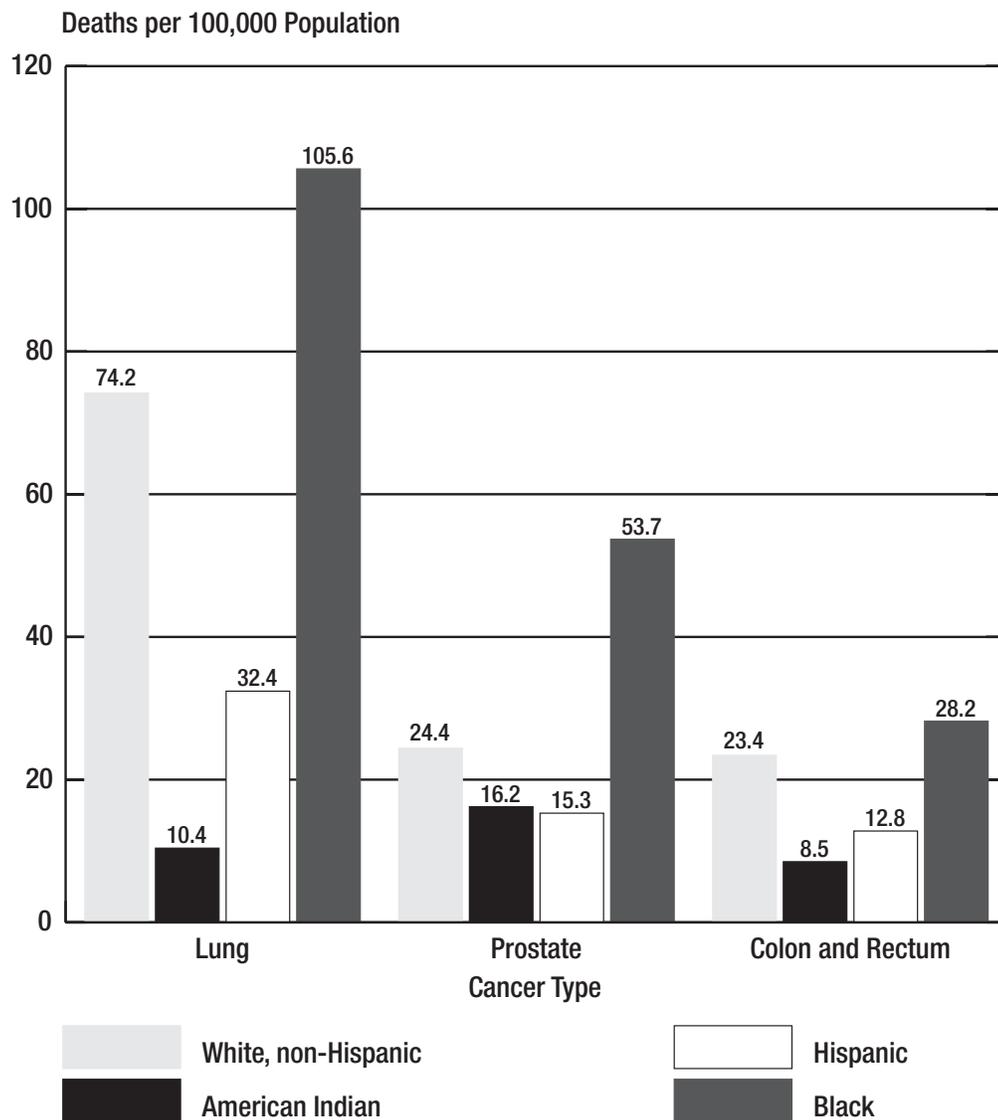
Source: National Cancer Institute, 1996.

Notes: Rates are average annual per 100,000 population, age-adjusted to 1970 U.S. standard.

The rates of cancer for the American Indian population are based on a sample of fewer than 25 cases and may be subject to greater variability than the other rates which are based on larger numbers.

- Prostate cancer is the most common site of new cancers among men in all racial and ethnic populations.
- For three leading forms of cancer, African-American men have significantly higher incidence rates than their peers in other racial and ethnic groups.

Figure 3-3. Death Rates for Lung, Prostate, and Colon/Rectum Cancers in Men by Race and Ethnicity, 1988-1992



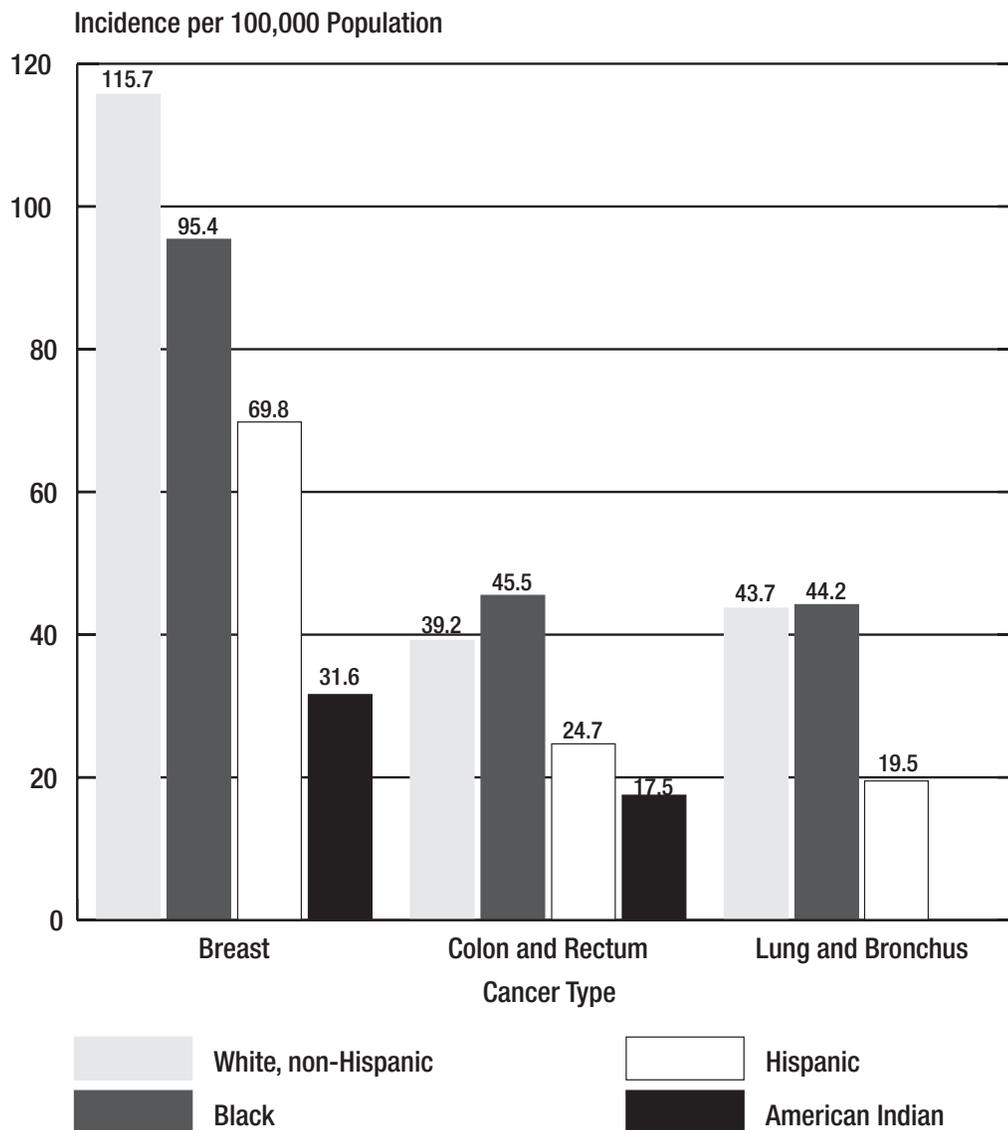
Source: National Cancer Institute, 1997.

Notes: Rates are average annual per 100,000 population, age adjusted to 1970 U.S. standard.

The rates of cancer for the American Indian population are based on a sample of fewer than 25 cases and may be subject to greater variability than the other rates which are based on larger numbers.

- For three leading forms of cancer, African-American men have significantly higher death rates than their peers in other racial and ethnic groups.

Figure 3-4. Breast, Colon/Rectum, and Lung/Bronchus Cancers Among Women by Race and Ethnicity, 1988-1992



Source: National Cancer Institute, 1997.

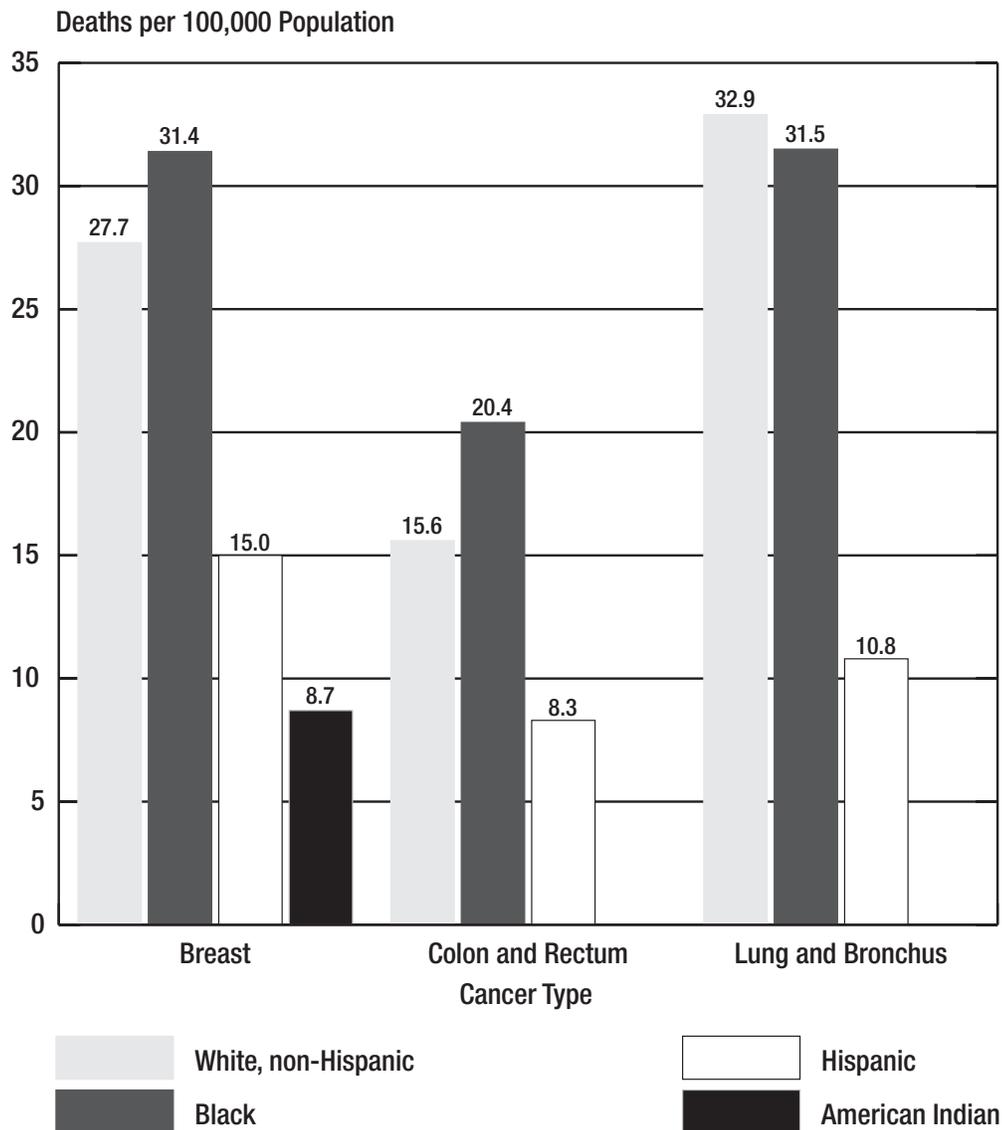
Notes: Rates are average annual per 100,000 population, age adjusted to 1970 U.S. standard.

The rates of cancer for the American Indian population are based on a sample of fewer than 25 cases and may be subject to greater variability than the other rates which are based on larger numbers.

Data for the incidence rate for lung and bronchus cancer among American Indian women are not available.

- Breast cancer is the most common site of new cancers among women in all racial and ethnic populations.
- The incidence of colon/rectum cancer is highest among African-American women. The incidence of lung cancer is higher among white and African-American women than Hispanic women.
- The rate of breast cancer is highest among white women.

Figure 3-5. Death Rates for Breast, Colon/Rectum, and Lung/Bronchus Cancers Among Women by Race and Ethnicity, 1988-1992



Source: National Cancer Institute, 1997.

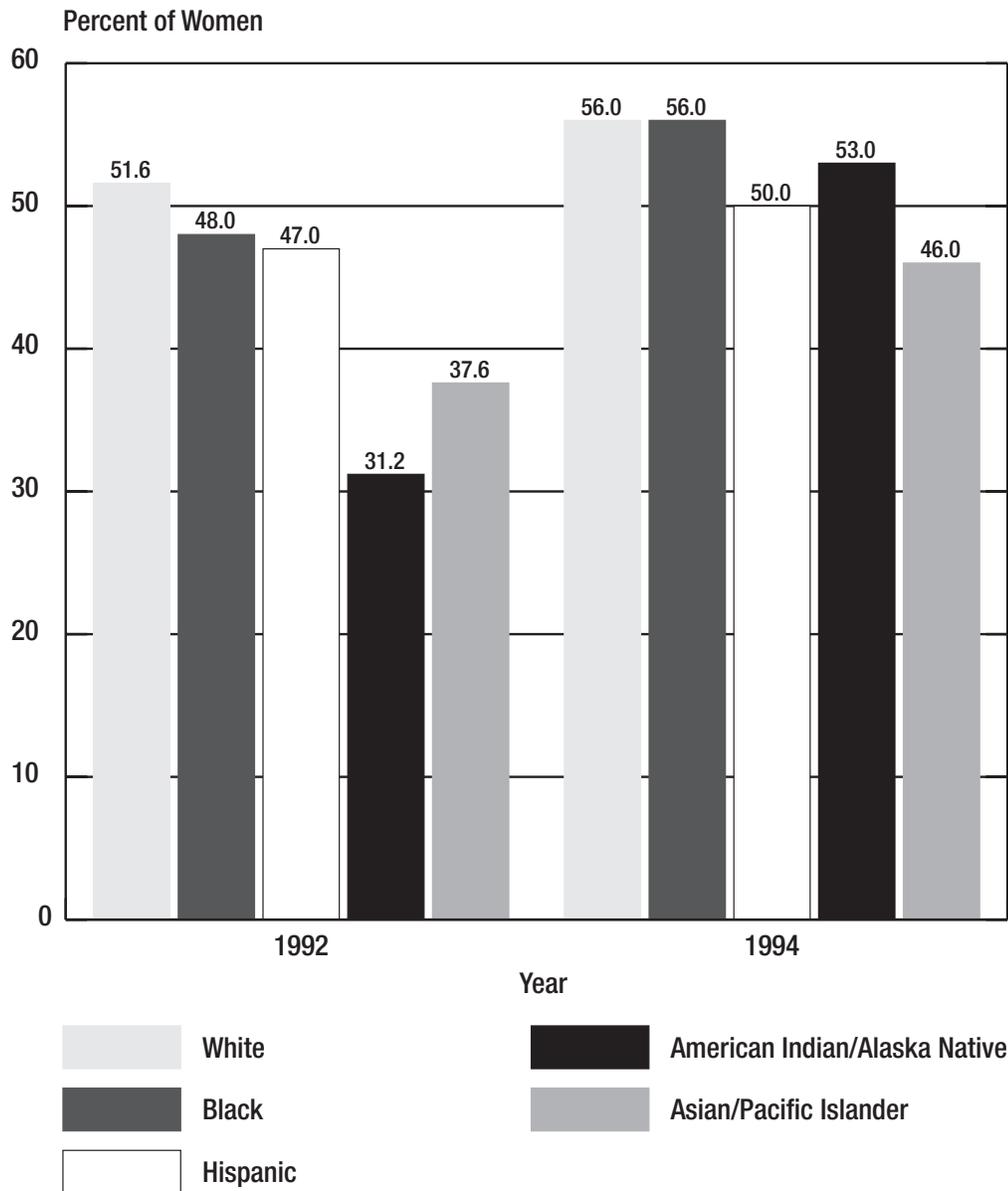
Notes: Rates are average annual per 100,000 population, age adjusted to 1970 U.S. standard.

The rates of cancer for the American Indian population are based on a sample of fewer than 25 cases and may be subject to greater variability than the other rates which are based on larger numbers.

Data for the death rates of colon/rectum and lung/bronchus cancers are not listed among the top five cancer deaths.

- While breast cancer is the most common site of new cancers among all racial and ethnic groups, there are slightly more deaths from lung/bronchus cancer among African-American and white women.
- African-American women lead all ethnic groups in deaths due to colon/rectum and breast cancers.
- While the incidence of breast cancer is higher among white women, deaths from breast cancer are higher among African-American women.

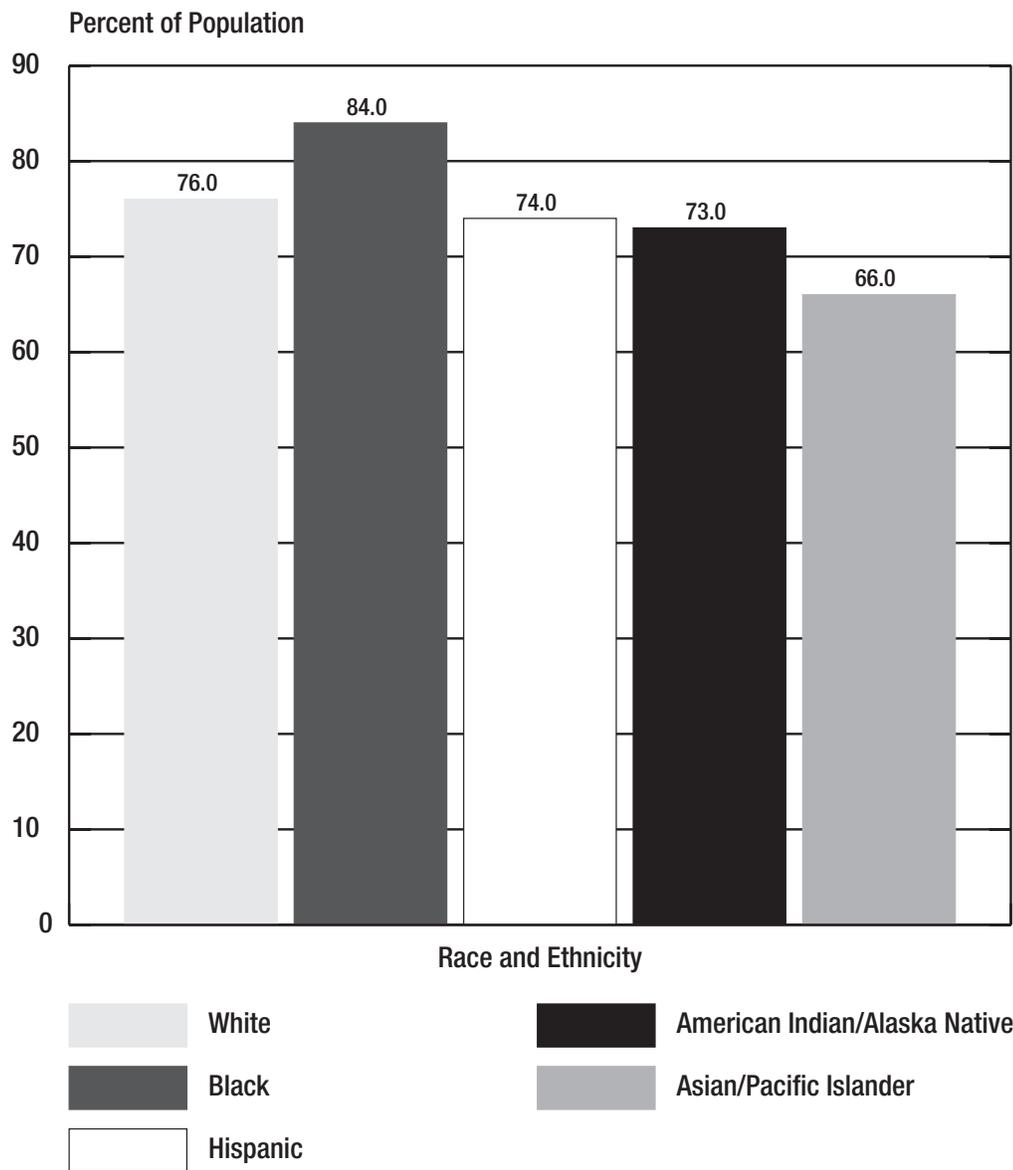
Figure 3-6. Women Ages 50 and Older Who Have Received a Clinical Breast Examination and a Mammogram Within the Preceding Two Years, by Race and Ethnicity, 1992 and 1994



Source: U.S. Department of Health and Human Services, 1998b.

- Between 1992 and 1994, cancer screening through clinical breast examination and mammogram has increased among women in all racial and ethnic populations.
- In 1994, use of mammography was lowest among Hispanic and Asian/Pacific Islander women.

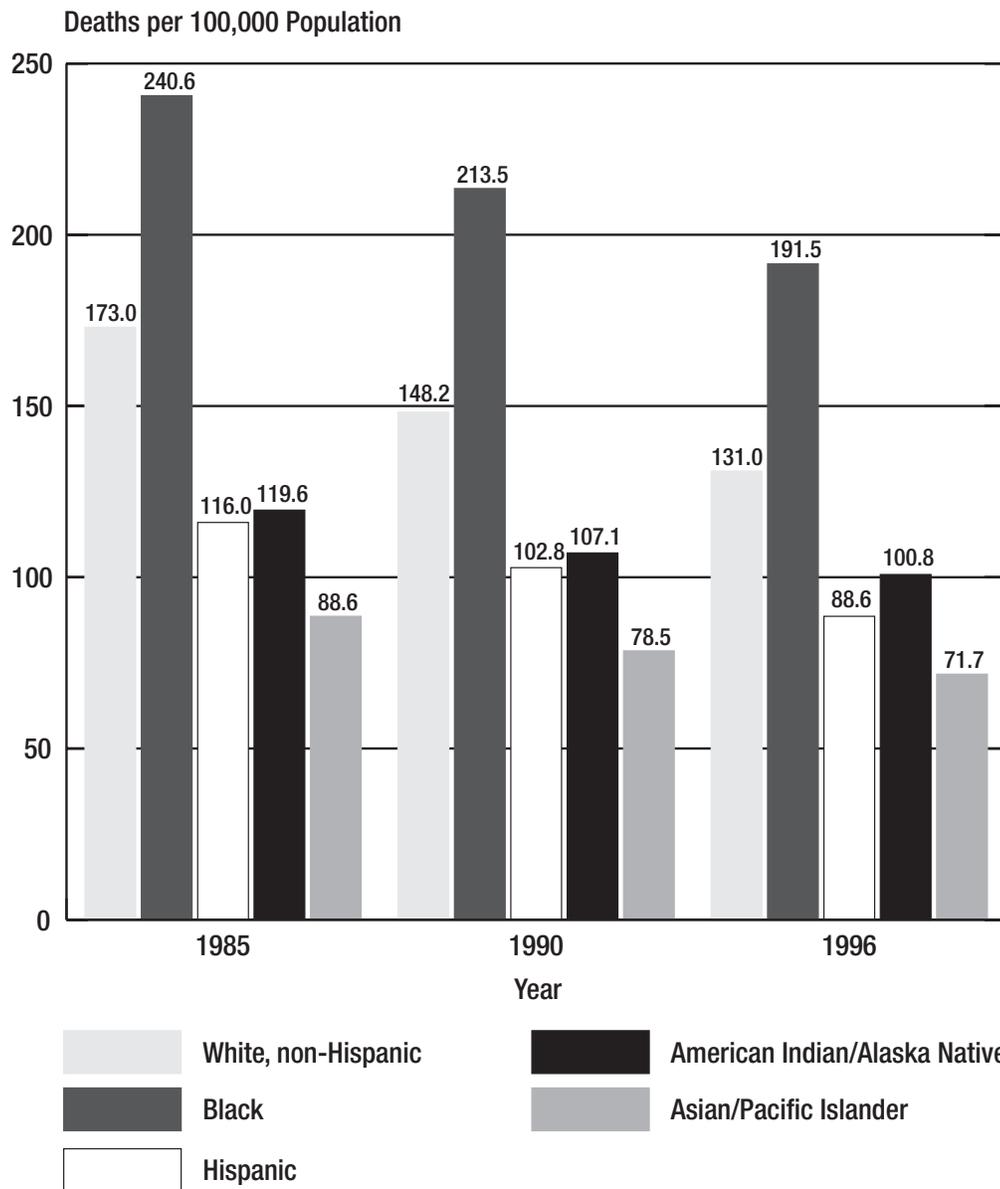
Figure 3-7. Women Ages 18 and Older Receiving a Pap Test Within the Last Three Years by Race and Ethnicity, 1994



Source: U.S. Department of Health and Human Services, 1998b.

- The rate of receiving a Pap test is higher among African-American women than all other racial and ethnic groups.
- The rate of receiving a Pap test is lower among Asian/Pacific Islander women than all other racial and ethnic groups.

Figure 4-1. Death Rate for Diseases of the Heart by Race and Ethnicity, Selected Years, 1985, 1990, and 1996

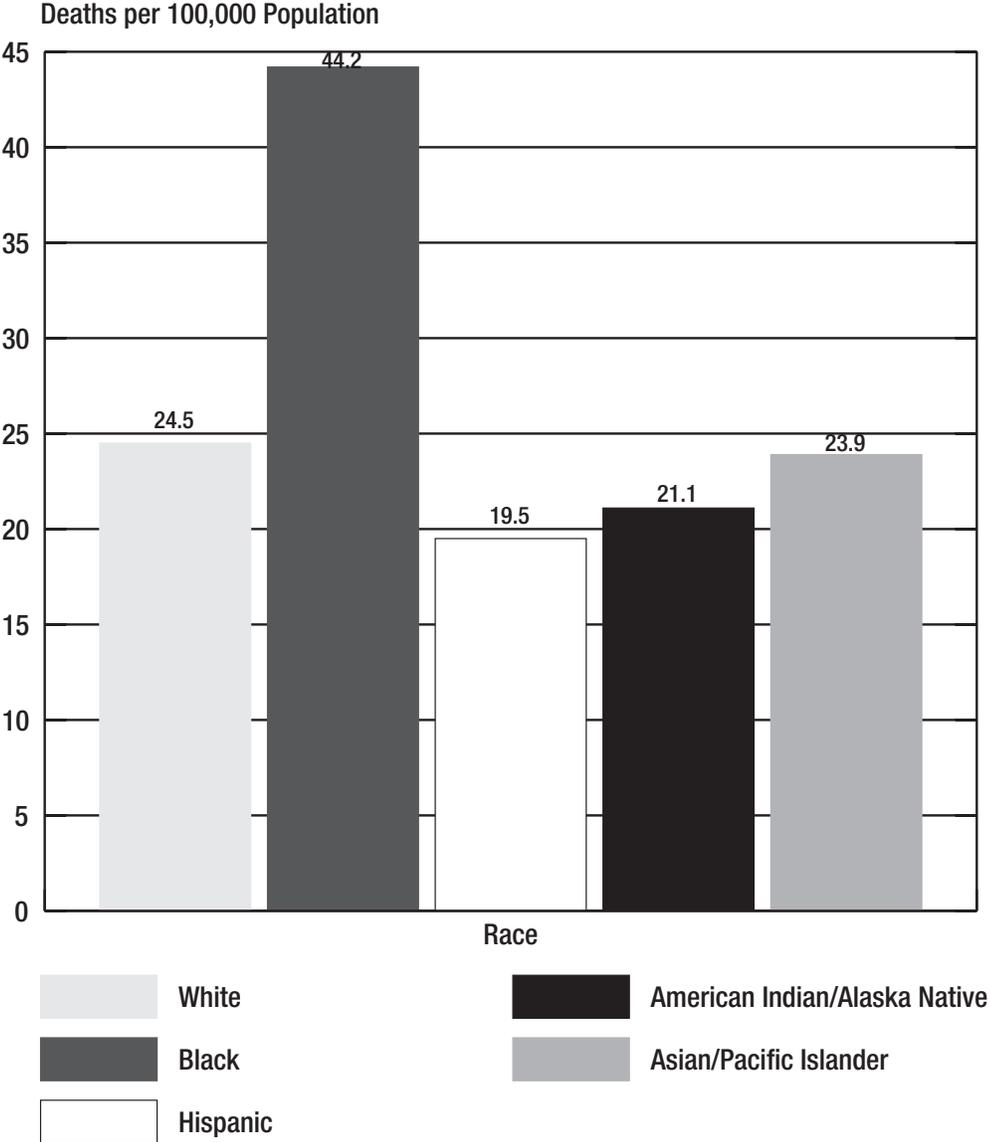


Source: National Center for Health Statistics, 1998a.

Notes: The racial categories, black, American Indian/Alaska Native, and Asian/Pacific Islander, include persons of Hispanic and non-Hispanic origin. Conversely, persons of Hispanic origin may be of any race.

- The death rate for diseases of the heart decreased over the twelve-year period ending in 1996 for all racial and ethnic groups.
- The death rate for African Americans, however, is consistently higher than any other racial or ethnic group across years.

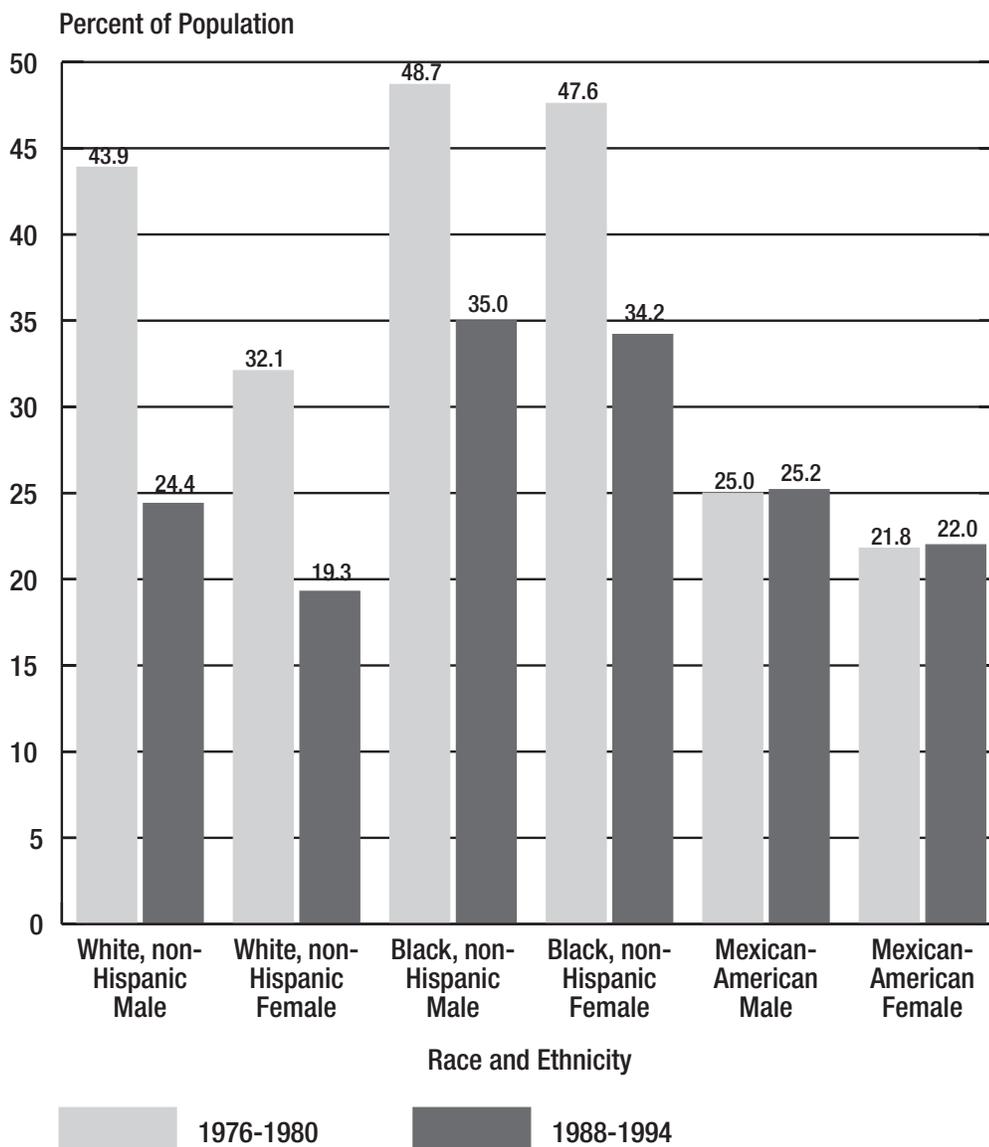
Figure 4-2. Age-Adjusted Death Rates for Stroke by Race and Ethnicity, 1995



Source: National Center for Health Statistics, 1998a.

- African Americans lead all racial and ethnic groups in deaths due to stroke.
- The death rate among African Americans for stroke is almost twice that of whites.

Figure 4-3. Hypertension Among Persons Ages 20 to 74, by Race, Ethnicity, and Gender, Selected Years, 1976-1980 and 1988-1994



Source: National Center for Health Statistics, 1998a.

Notes: Data are based on physical examinations of a sample of the civilian population.

1976-1980 data for Mexican-Americans are from 1982-1984.

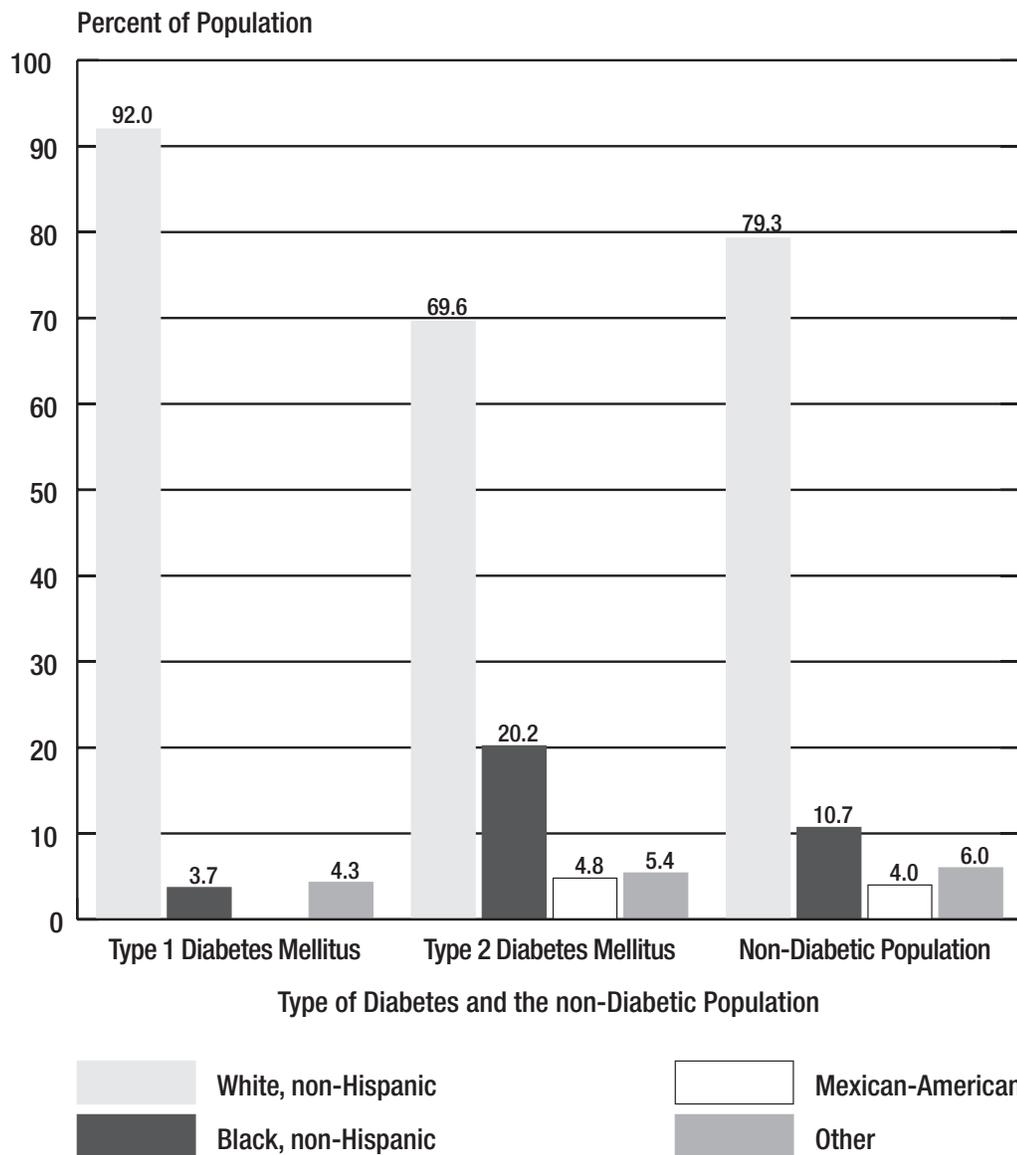
Persons of Mexican-American origin may be of any race.

Other than for pregnant women, hypertension is defined by either having elevated blood pressure (systolic pressure of at least 140 mmHg or diastolic pressure of at least 90 mmHg) or taking anti-hypertensive medication.

Hypertension is one of the leading causes of heart disease.

- Hypertension is more prevalent among African-American men and women compared to other racial and ethnic groups.

Figure 5-1. Racial and Ethnic Distribution of Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus, and the Non-Diabetic Population, Among Persons Ages 18 and Older, 1989



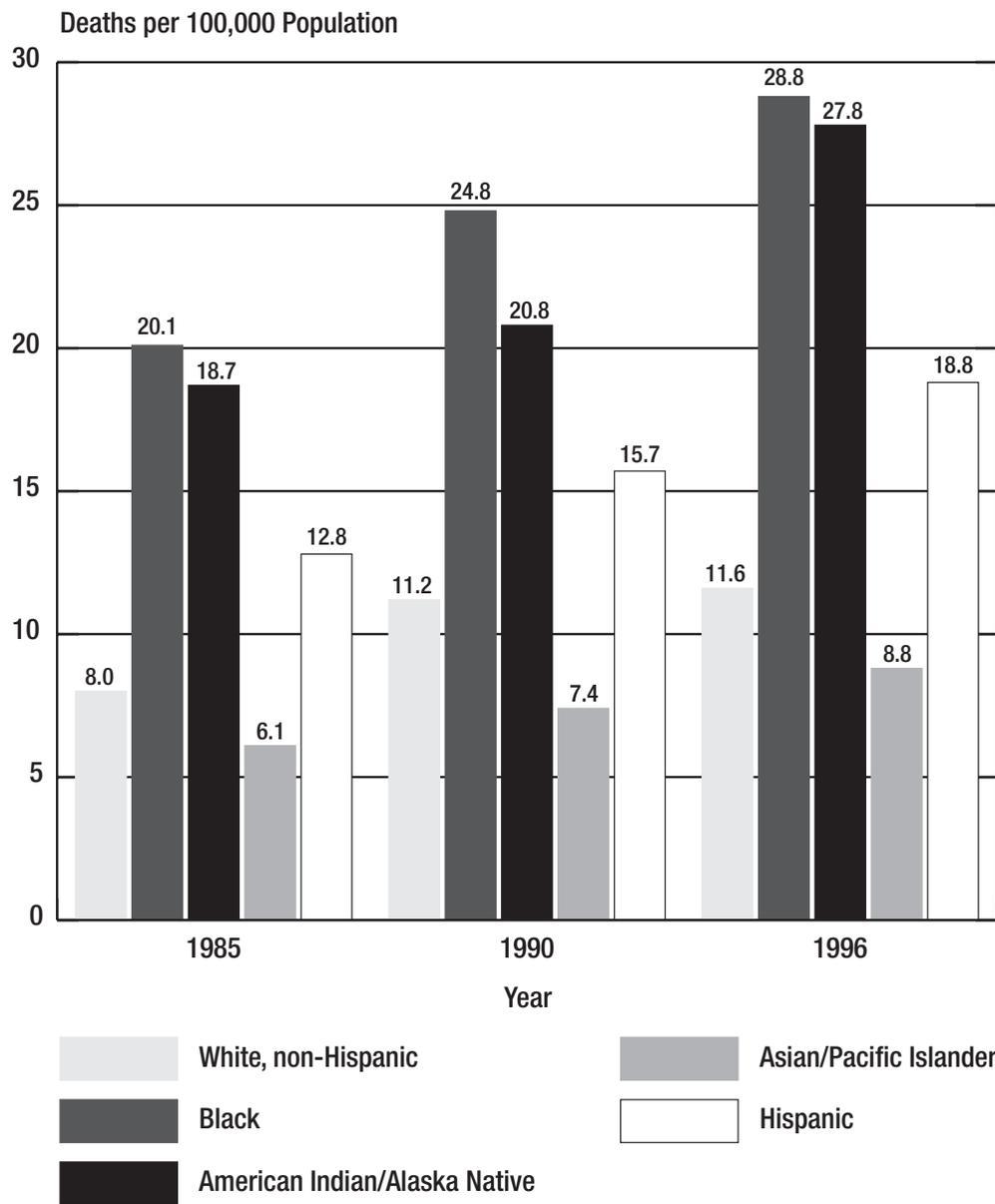
Source: National Institute of Diabetes and Digestive and Kidney Diseases, 1995.

Notes: Type 1 or insulin dependent diabetes may account for 5 percent to 10 percent of all diagnosed cases of diabetes. Risk factors include the autoimmune system, genetics, and the environment.

Type 2 or non-insulin dependent diabetes may account for about 90 percent to 95 percent of all diagnosed cases of diabetes. Risk factors include older age, overweight, family history of diabetes, physical inactivity, and race and ethnicity.

- African Americans carry a disproportionate burden of type 2 diabetes relative to their share of the population.
- Type 2 diabetes is the most preventable form of diabetes when early and regular attention is paid to weight, diet, and exercise.

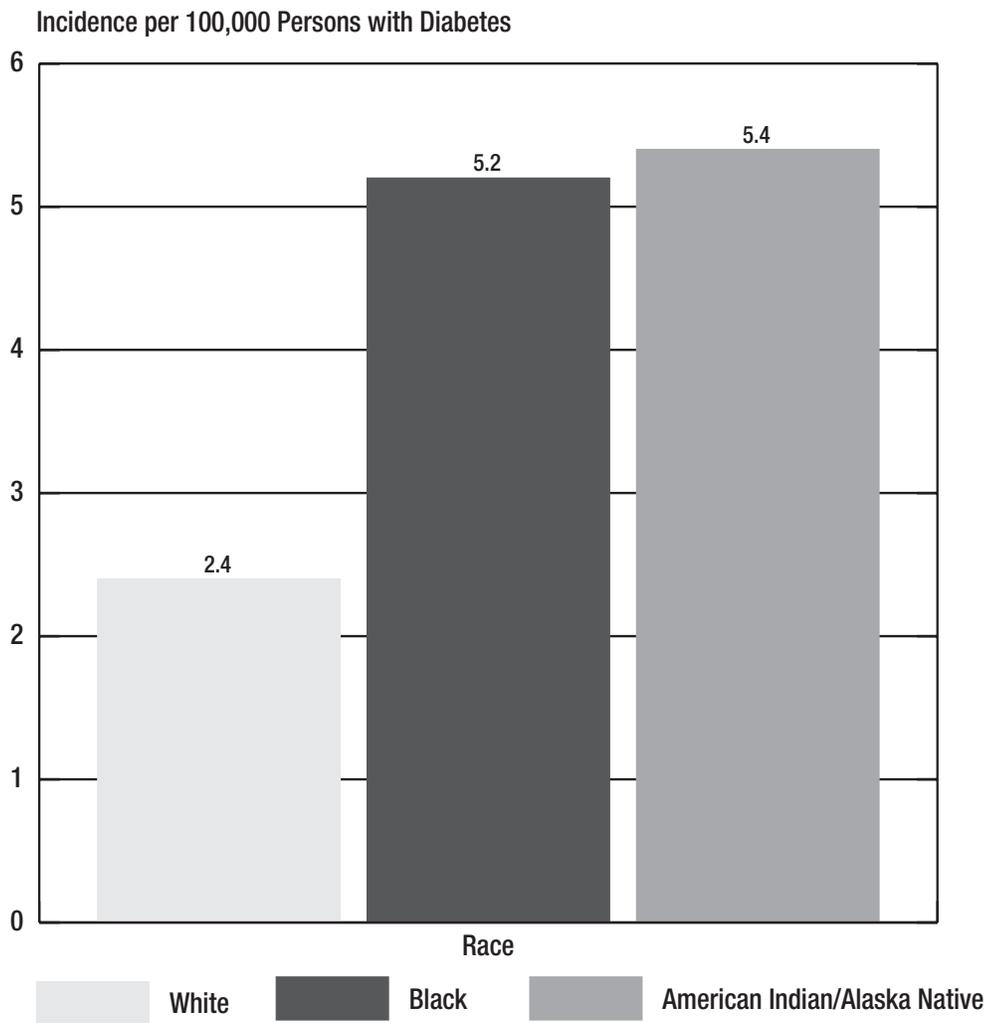
Figure 5-2. Age-Adjusted Diabetes-Related Death Rate by Race and Ethnicity, Selected Years 1985, 1990, and 1996



Source National Center for Health Statistics, 1998a.

- The death rate for diabetes has risen over the 11 years ending in 1996 for all racial and ethnic groups.
- African Americans, American Indian/Alaska Natives, and persons of Hispanic origin have substantially higher death rates than all other racial and ethnic groups.

Figure 5-3. End-Stage Renal Disease Among Persons with Diabetes by Race, 1995

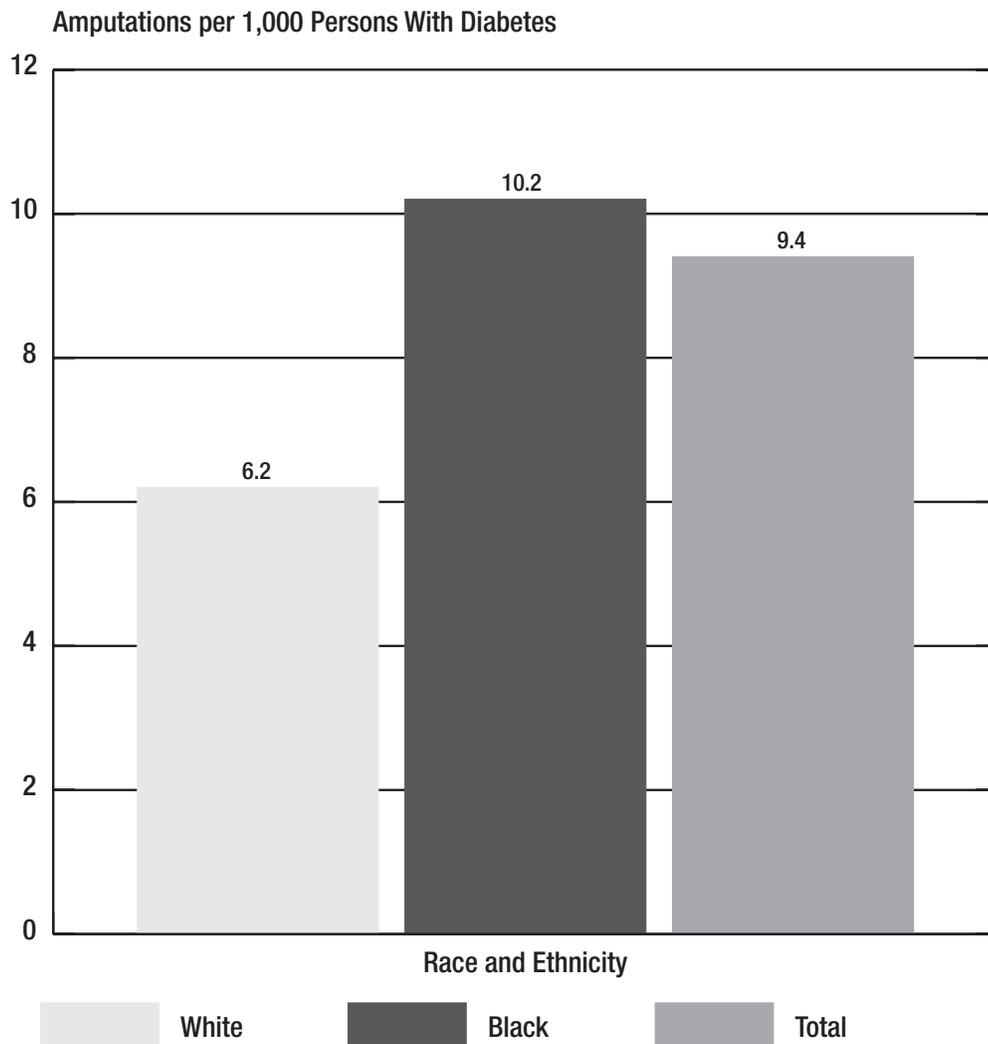


Source: U.S. Department of Health and Human Services, 1998a.

Notes: Data for American Indian/Alaska Natives are from 1992.

- The incidence of end stage renal disease, one complication of diabetes, is higher among American Indian/Alaska Natives and African Americans compared to whites.
- Of those with diabetes, African Americans and American Indian/Alaska Natives have rates of end stage renal disease that are twice that of whites.

Figure 5-4. Lower Extremity Amputation Among Persons With Diabetes by Race, 1995



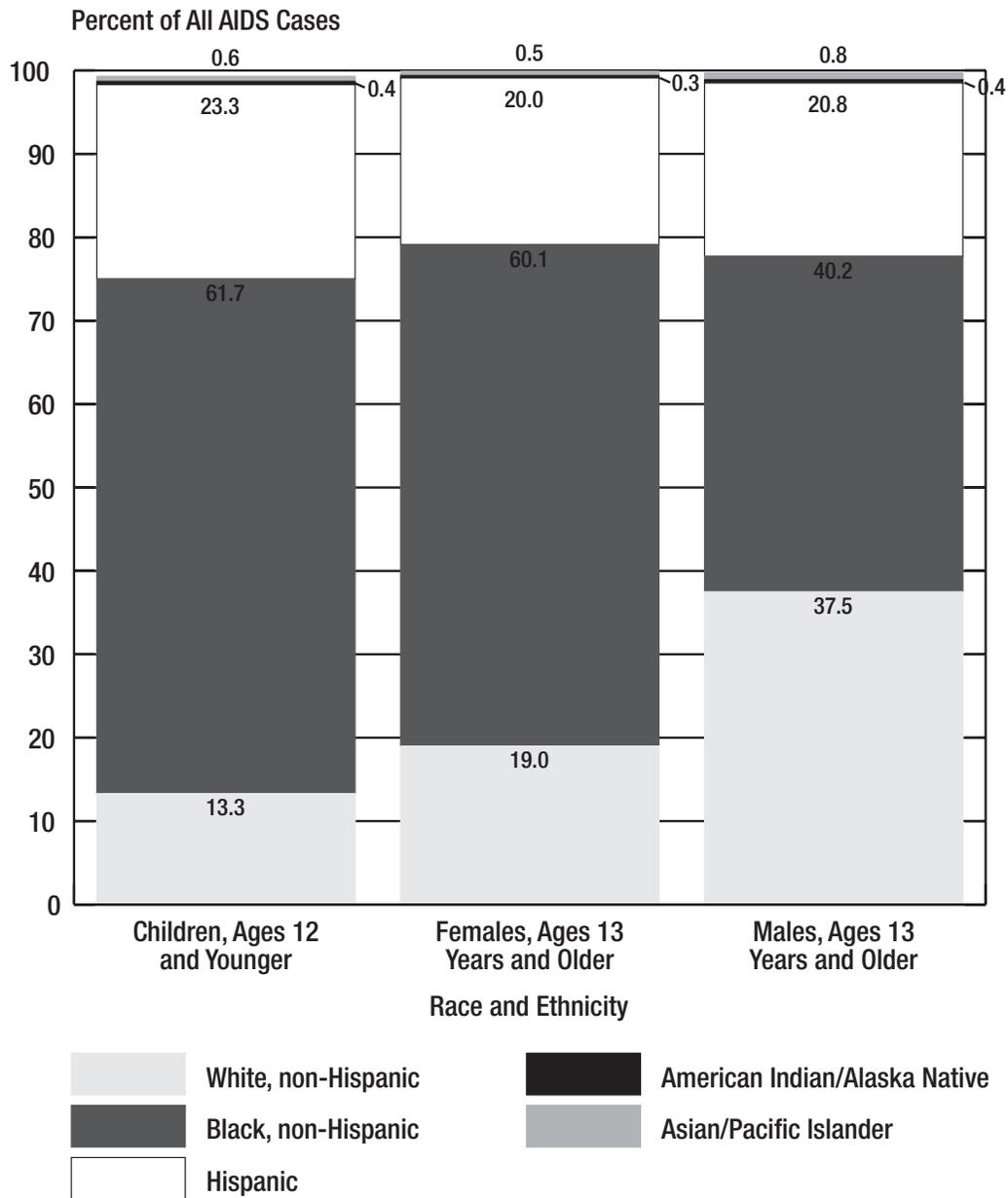
Source: U.S. Department of Health and Human Services, 1998b.

Notes: Untreated diabetes can result in an increase in diabetes-related illnesses and complications such as lower extremity amputations.

One half of all lower extremity amputations can be prevented through proper management of hyperglycemia and blood pressure, attention to foot care, and cessation of tobacco use.

- Among those suffering from diabetes, African Americans have a higher-than-average rate of lower extremity amputation.

Figure 6-1. Distribution of AIDS Cases for Males Ages 13 and Older, Females Ages 13 and Older, and Children Ages 12 and Younger by Race and Ethnicity, 1997



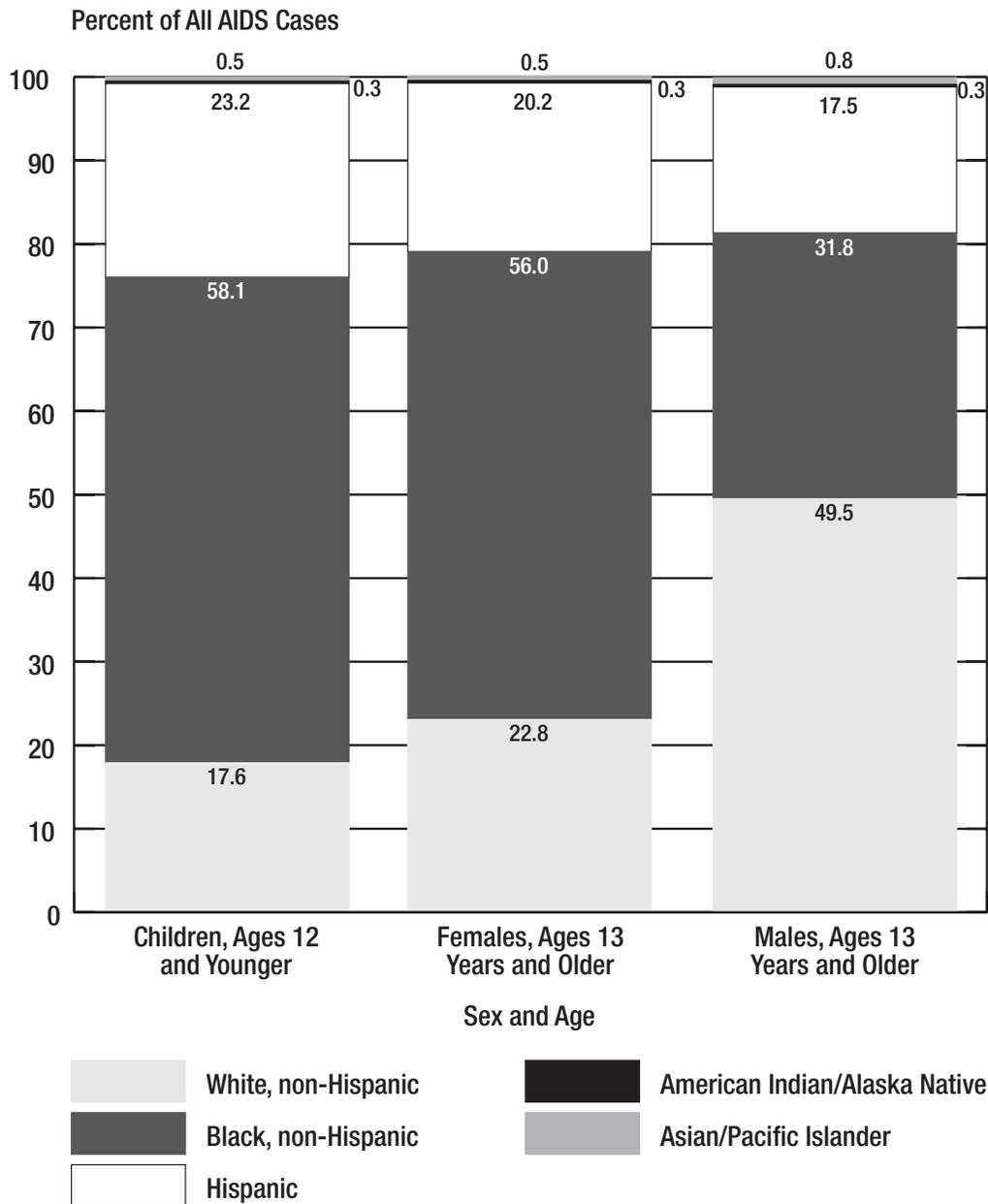
Source: Centers for Disease Control and Prevention, 1997.

Notes: Includes 641 men, 133 women, and 16 children whose race is unknown.

In 1997, 23.0 percent of American men were African-American or Hispanic; 22.0 percent of women were African-American or Hispanic; and 30.0 percent of children ages 14 and under were African-American or Hispanic.

- In 1997, the absolute number and percentage of AIDS cases was higher among African-American men than white men.
- In 1997, African-American and Hispanic women comprised 80.1 percent of new AIDS cases.
- In 1997, the percent of AIDS cases among African-American children was more than 4 times the percent of AIDS cases among white children.
- Only among children is the absolute number and percentage of AIDS for Hispanics higher than those for whites.

Figure 6-2. Distribution of AIDS Cases for Males Ages 13 and Older, Females Ages 13 and Older, and Children Ages 12 and Younger by Race and Ethnicity, All Years Through 1997



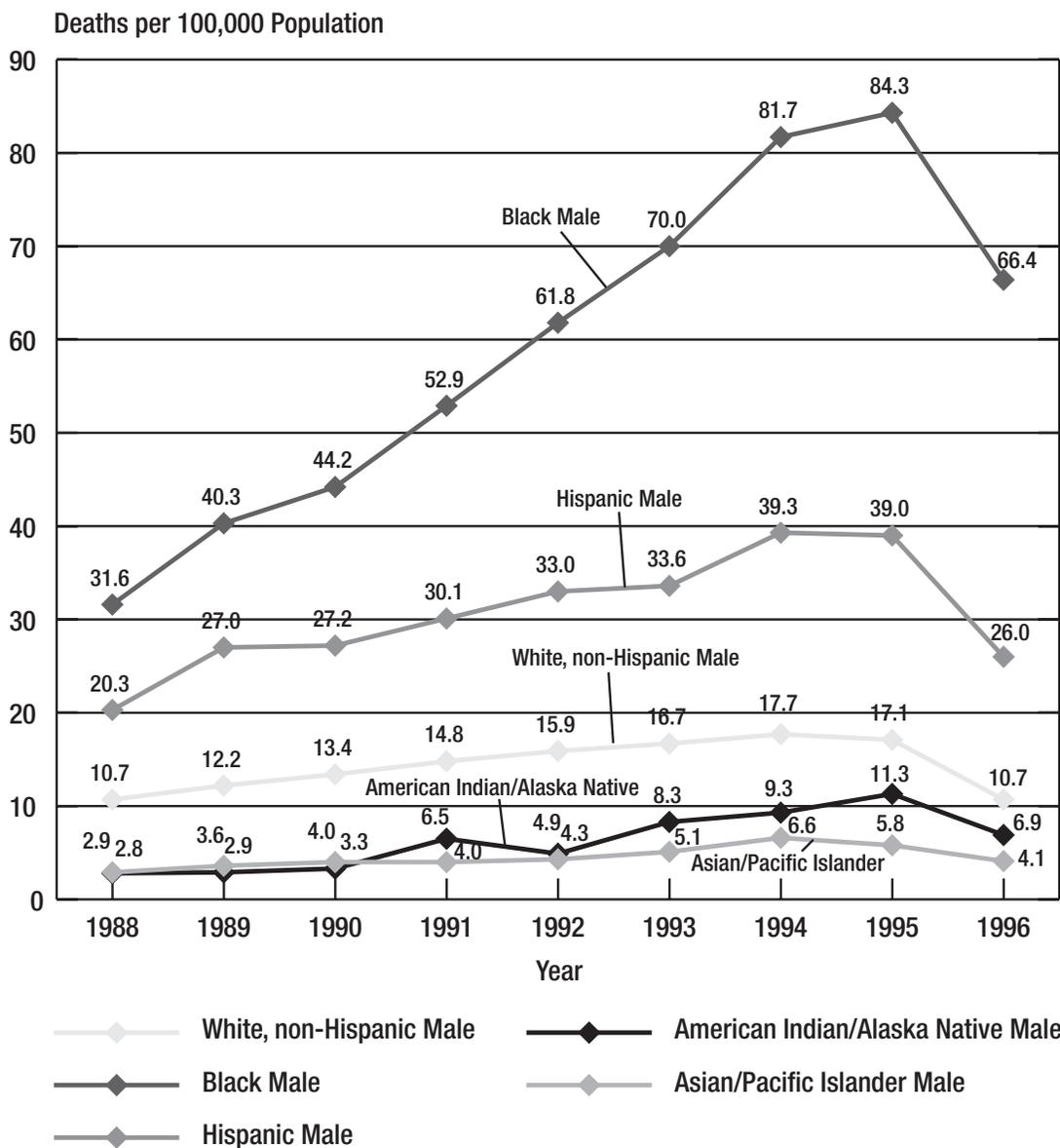
Source: Centers for Disease Control and Prevention, 1997.

Notes: Includes 641 men, 133 women, and 16 children whose race is unknown.

In 1997, 23.0 percent of American men were African-American or Hispanic; 22.0 percent of women were African-American or Hispanic; and 30.0 percent of children ages 14 and under were African-American or Hispanic.

- Of all children diagnosed with AIDS through 1997, 81.3 percent were either African-American or Hispanic.
- Of all women diagnosed with AIDS through 1997, 76.2 percent were either African-American or Hispanic.
- Of all men diagnosed with AIDS through 1997, 49.3 percent were either African-American or Hispanic.

Figure 6-3. Age-Adjusted Death Rates for HIV Infection Among Men by Race and Ethnicity, 1988-1996

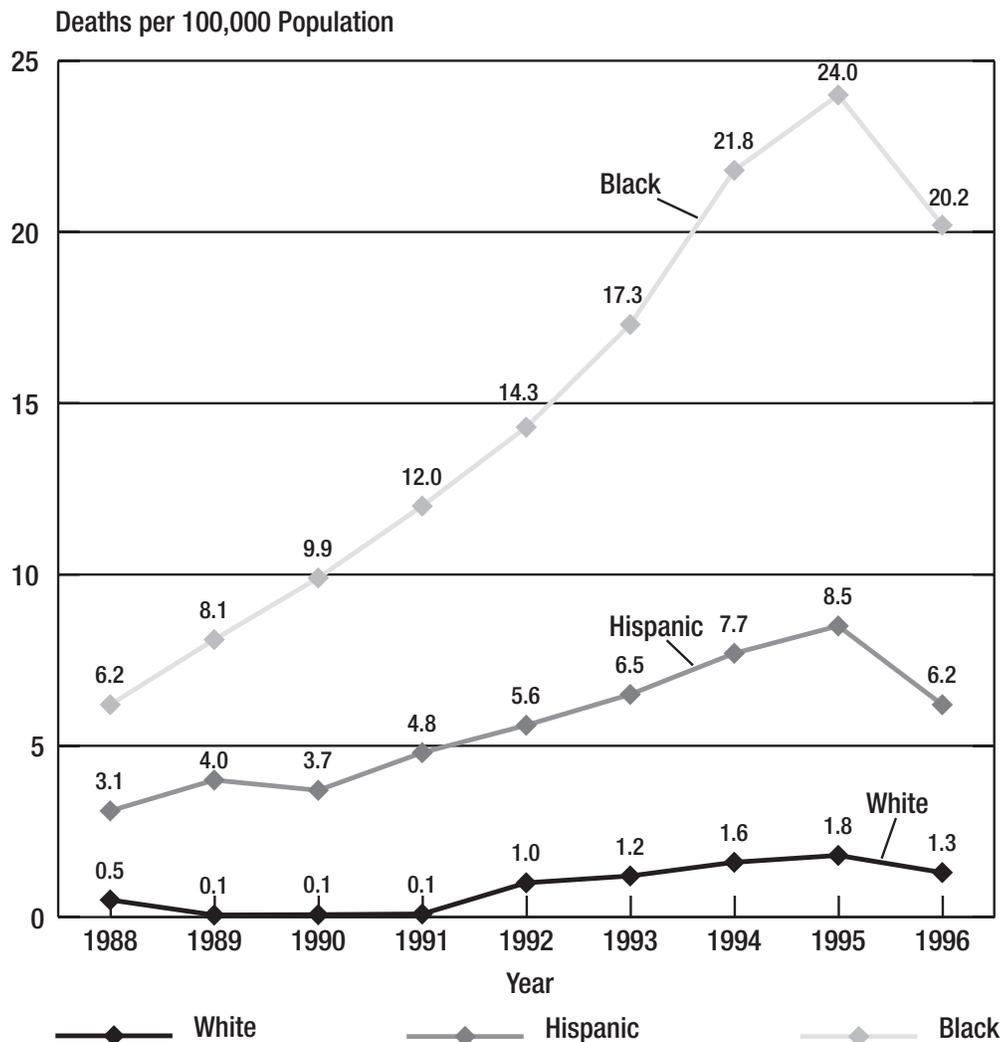


Source: National Center for Health Statistics, 1998a.

Notes: The racial categories, black, American Indian/Alaska Native, and Asian Pacific Islander include persons of Hispanic and non-Hispanic origin. Conversely, persons of Hispanic origin may be of any race.

- In 1996, the death rate for AIDS was higher among African-American and Hispanic men than other racial and ethnic groups.
- In 1996, the death rate for AIDS decreased among all racial and ethnic groups.
- In 1996, the rate of decrease in death rates from 1995 was lowest among African-American men.

Figure 6-4. Age-Adjusted Death Rate for HIV Infection Among Women by Race and Ethnicity, 1988-1996



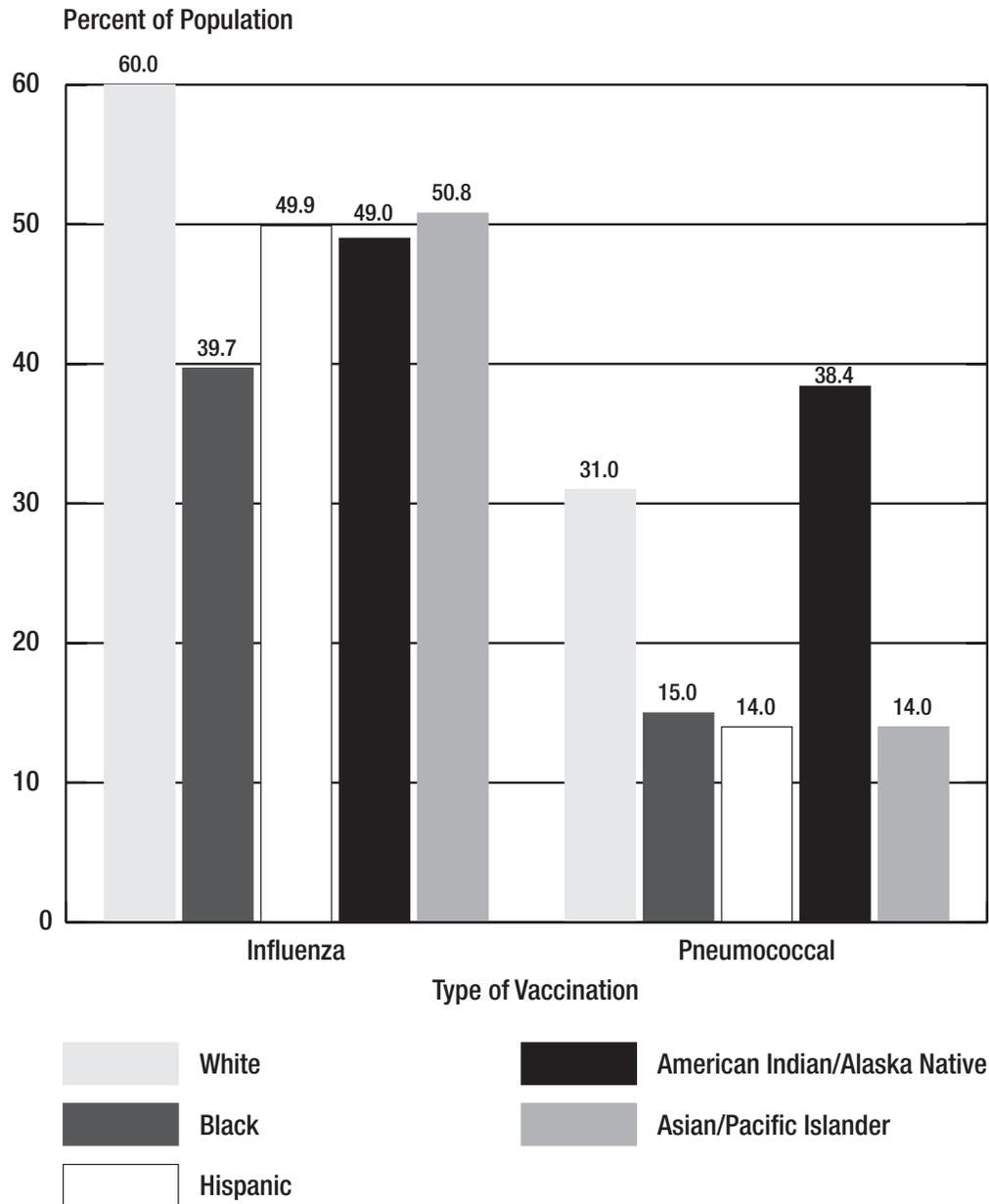
Source: National Center for Health Statistics, 1998a.

Notes: The racial category black, includes persons of Hispanic and Non-Hispanic origin. Conversely, persons of Hispanic origin may be of any race.

Trend data for American Indian/Alaskan Native, and Asian/Pacific Islander women are not available.

- Deaths from AIDS in 1996 were highest among African-American and Hispanic women.
- At its peak in 1995, the death rate for African-American women from AIDS was about 13 times that of the rate for white women and about 3 times that of Hispanic women.
- In 1996, death from AIDS decreased among women in all racial and ethnic groups, however, that decrease was generally less than the decrease in the death rates for males for corresponding racial and ethnic groups (see figure 6-3).
- In 1996, death from AIDS decreased slowest among African-American women.

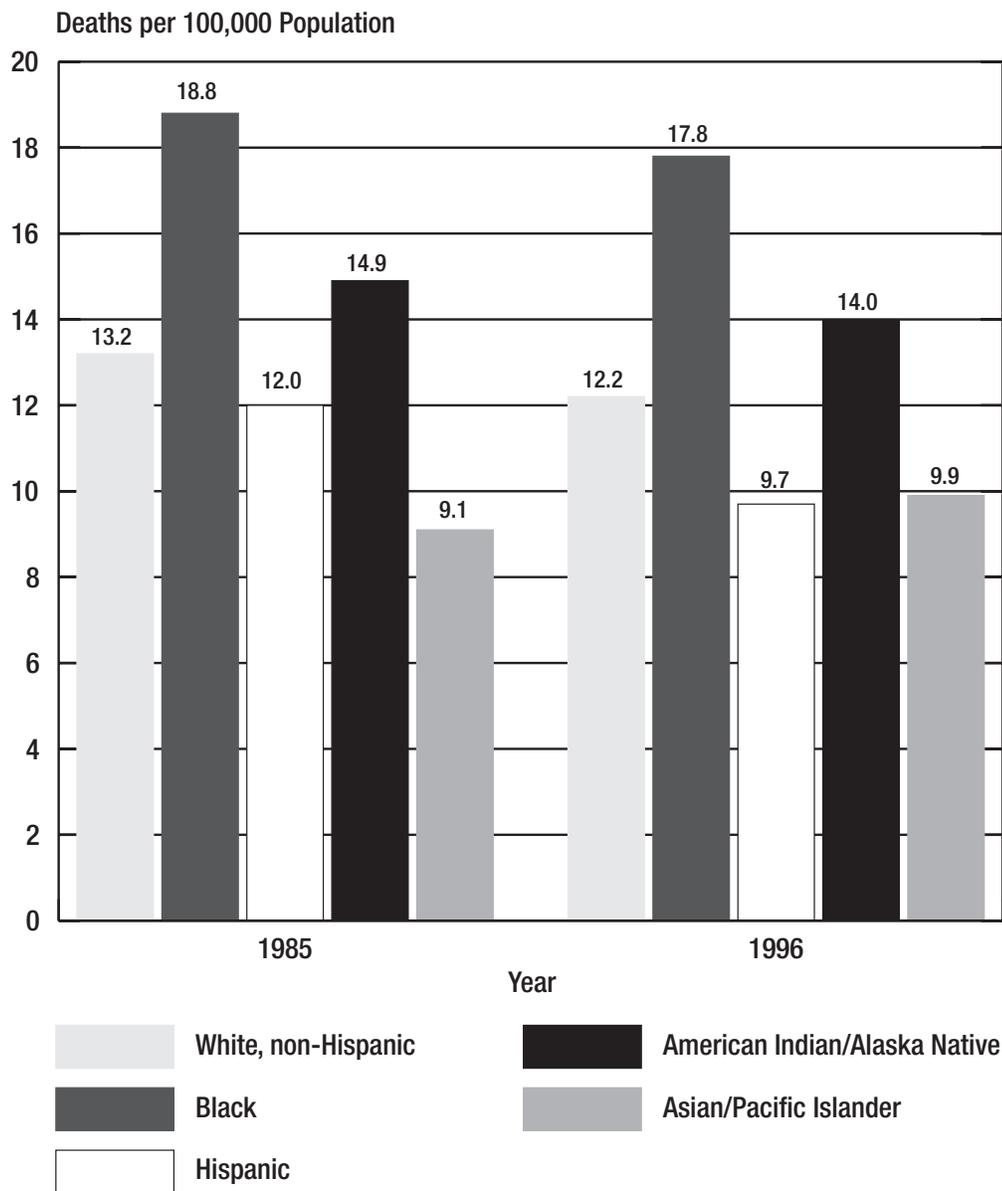
Figure 7-1. Pneumococcal and Influenza Immunization Rates of Persons Ages 65 and Older by Race and Ethnicity, 1996



Source: U.S. Department of Health and Human Services, 1998b.

- The African American immunization rate for influenza is the lowest among the racial and ethnic groups presented.
- The rate of immunization for pneumococcal pneumonia is lower among African Americans, Hispanics, and Asian/Pacific Islanders, than whites and American Indian/Alaska Natives.
- The African American, Hispanic, and Asian/Pacific Islander rates of pneumococcal immunization are less than half that of the white and American Indian/Alaska Native rates.

Figure 7-2. Influenza and Pneumonia Death Rates by Race and Ethnicity, Selected Years, 1985 and 1996

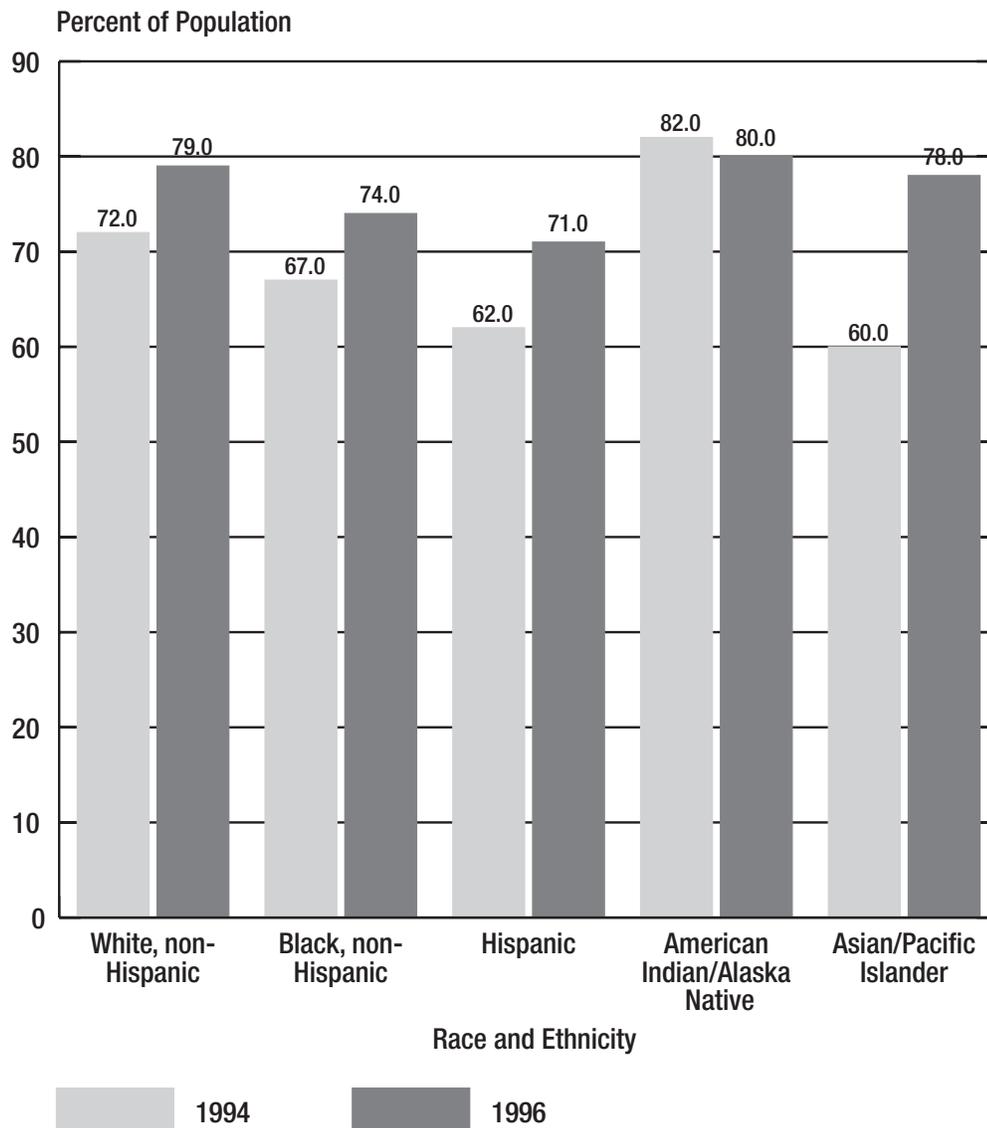


Source: National Center for Health Statistics, 1998a.

Notes: The racial categories, black, American Indian/Alaska Native, and Asian/Pacific Islander include persons of Hispanic and non-Hispanic origin. Conversely, persons of Hispanic origin may be of any race.

- During the 12 year period ending in 1996, the death rate for influenza and pneumonia rose only among Asian/Pacific Islanders.
- The rate of death from influenza and pneumonia is highest among African Americans which in part may be due to the lower immunization rate among African Americans 65 and older (see Figure 7-1).

Figure 7-3. Vaccination Rates for Children Ages 19 to 35 Months by Race and Ethnicity, 1994 and 1996

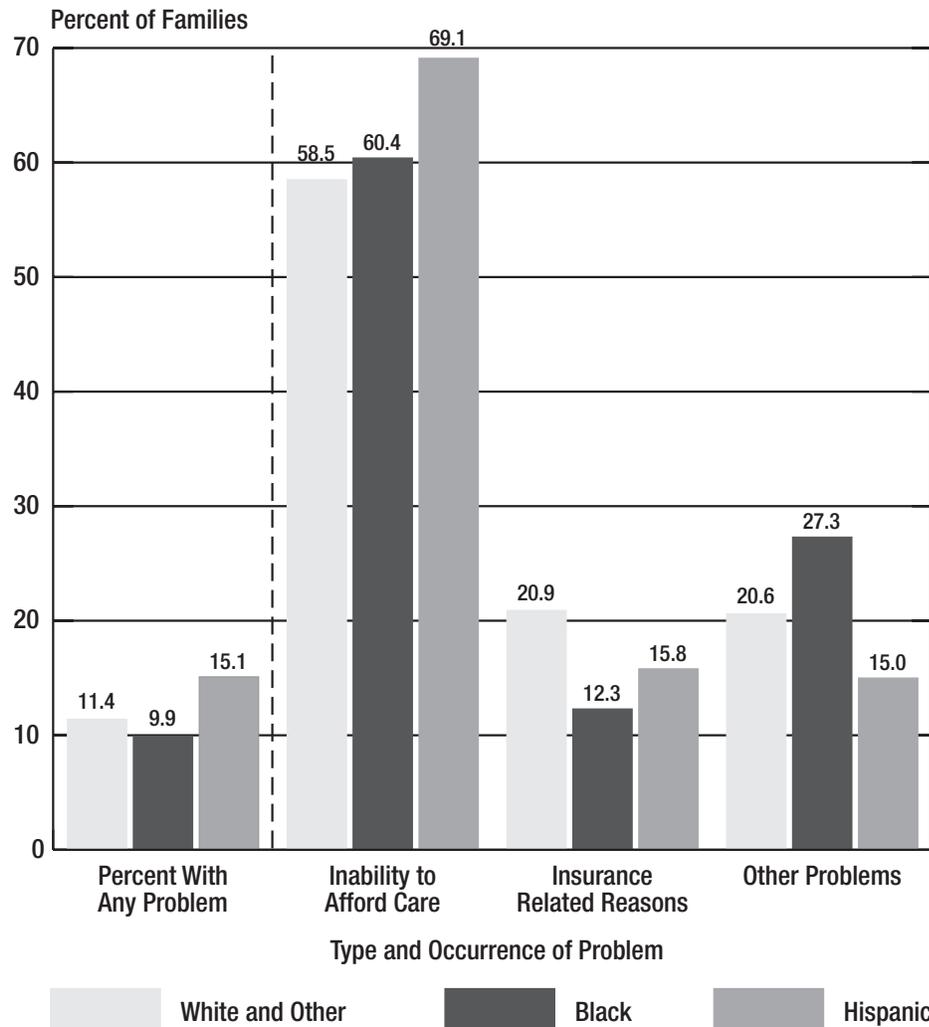


Source: National Center for Health Statistics, 1998a.

Note: Immunization rates are based on receipt of the 4:3:1:3 combined series consisting of 4 doses of DTP vaccine, 3 doses of polio vaccine, 1 dose of a measles-containing vaccine, and 3 doses of Haemophilus influenza b (HIB) vaccine.

- The proportion of children receiving vaccinations increased among all racial and ethnic groups from 1994 to 1996.
- In 1996, Hispanic, African-American, and Asian/Pacific Islander children continued to lag behind their white and American Indian/Alaska Native counterparts in receiving vaccinations.

Figure 8-1. Families with Members Experiencing Difficulty or Delay in Obtaining Health Care by Main Problem in Receiving Care, Race, and Ethnicity, 1996



Source: Weinick, Zuvekas, and Drilea, 1997.

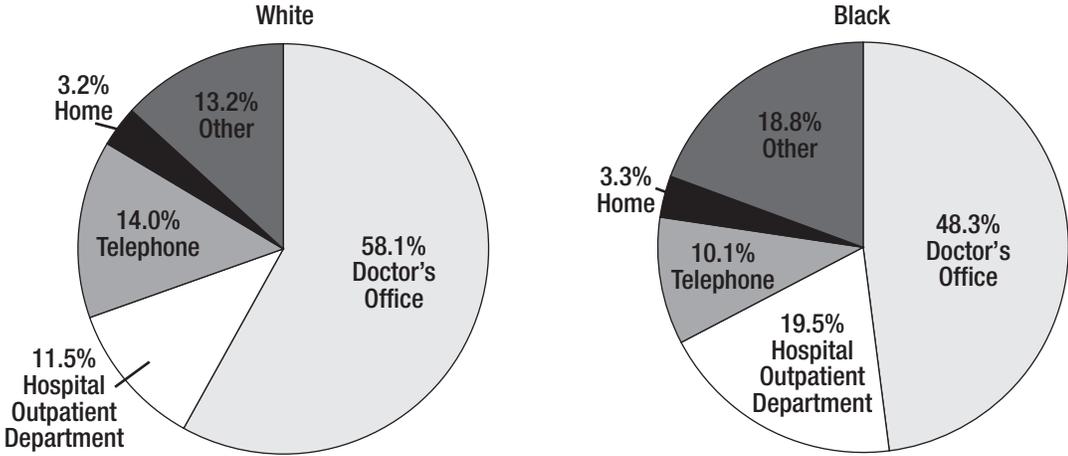
Notes: The category, "Insurance Related Reasons," includes insurance would not approve, cover, or pay for care; pre-existing condition; insurance required a referral but could not get one; and doctor refused to accept family's insurance plan.

The category, "Other Problems," includes transportation problems (medical care was too far away, cannot drive or do not have car/no public transportation available, too expensive to get there); communication problems (hearing impairment or loss, different language); and other problems (could not get time off work, did not know where to go to get care, was refused services, could not get child care, and did not have time or took too long).

Figures for "Inability to Afford Care," "Insurance Related Reasons," and "Other Problems" reflect percentage reporting problem type among all those reporting any problem.

- Hispanic families are more likely to report a problem with receiving health care than all other families.
- More Hispanic families have problems affording care.
- African-American families are less likely to report any problems in obtaining health care. For those who experienced problems, these problems were less likely to be insurance related and more likely to be "Other Problems" than for other racial and ethnic populations.

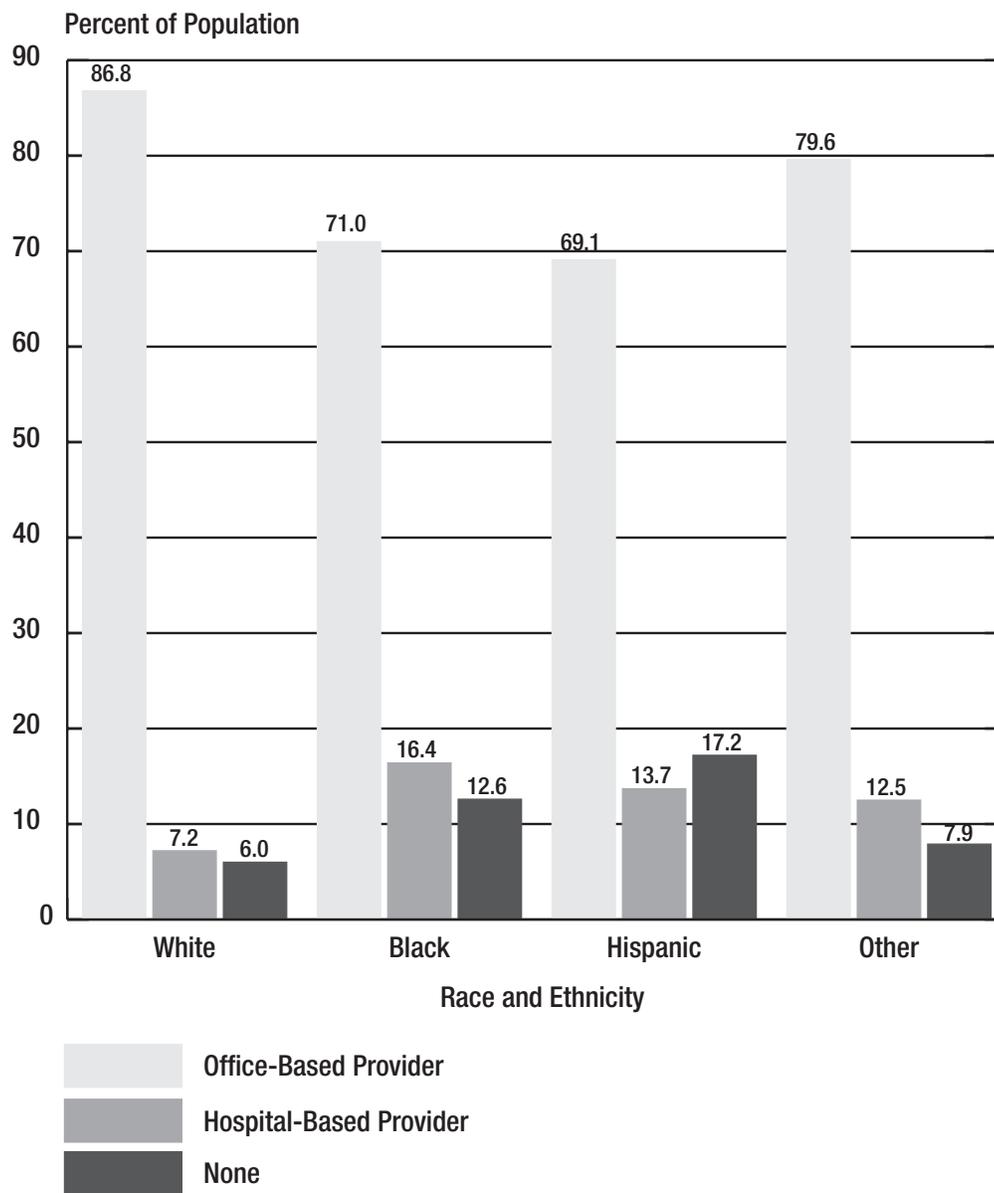
Figure 8-2. Physician Contacts by Place of Contact and Race, 1995



Source: National Center for Health Statistics, 1998a.
 Notes: Care in hospital outpatient departments includes care received through outpatient clinics, emergency rooms, and other hospital contacts.
 Data are age adjusted.

- African Americans are more likely than whites to receive care in hospital outpatient departments.
- White patients are more likely to receive care in a physician's office than African Americans.

Figure 8-3. Usual Source of Health Care Among Children Ages 18 and Younger by Race and Ethnicity, 1996

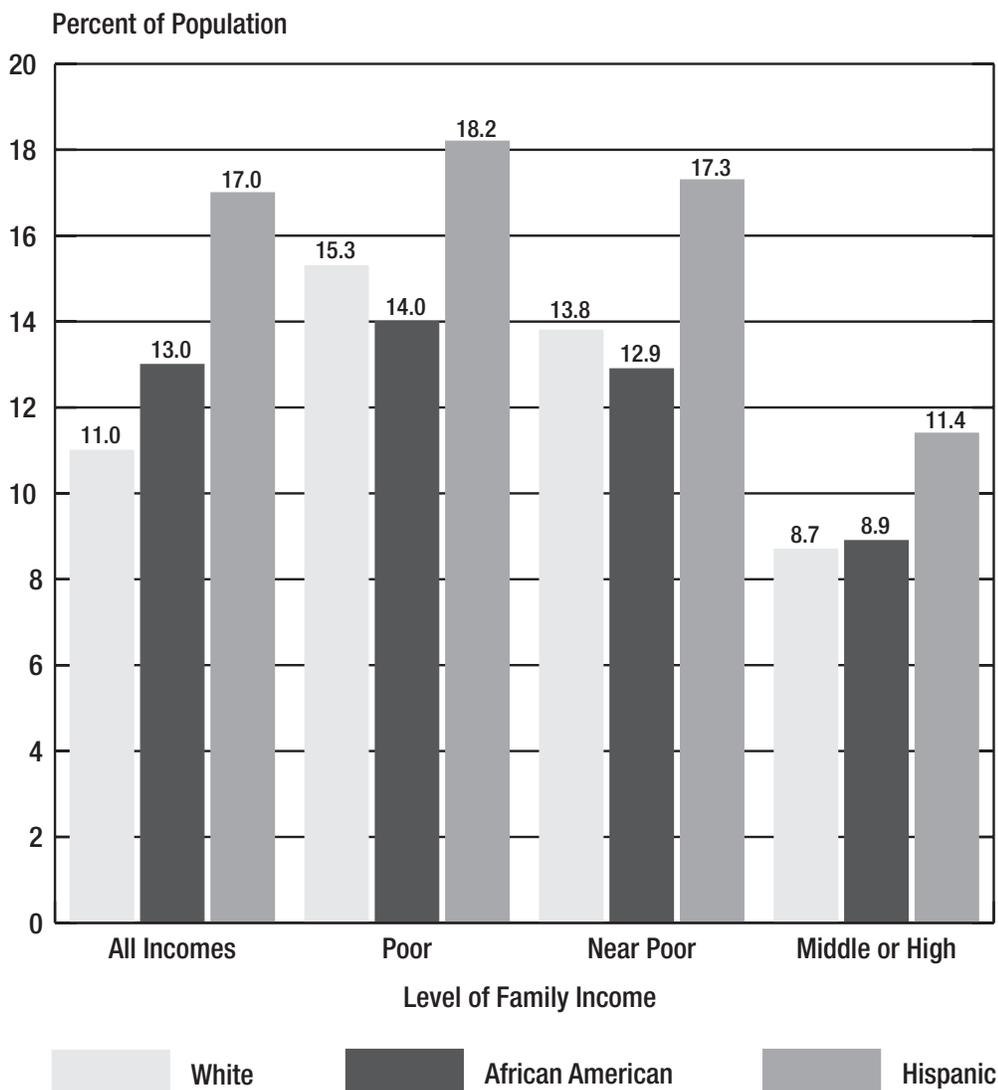


Source: Weinick, Weigers, and Cohen, 1998.

Notes: Children of Hispanic origin may be of any race.

- Children of Hispanic origin are the most likely to lack a usual source of health care, and the least likely to rely on office-based providers.
- Use of hospital-based providers within the African-American population is more than twice that of the white population.

Figure 8-4. No Physician Contact in the Past Year Among Persons Ages 18 to 64 with a Health Problem by Family Income, Race, and Ethnicity, 1994-1995



Source: Health Resources and Services Administration, 1998.

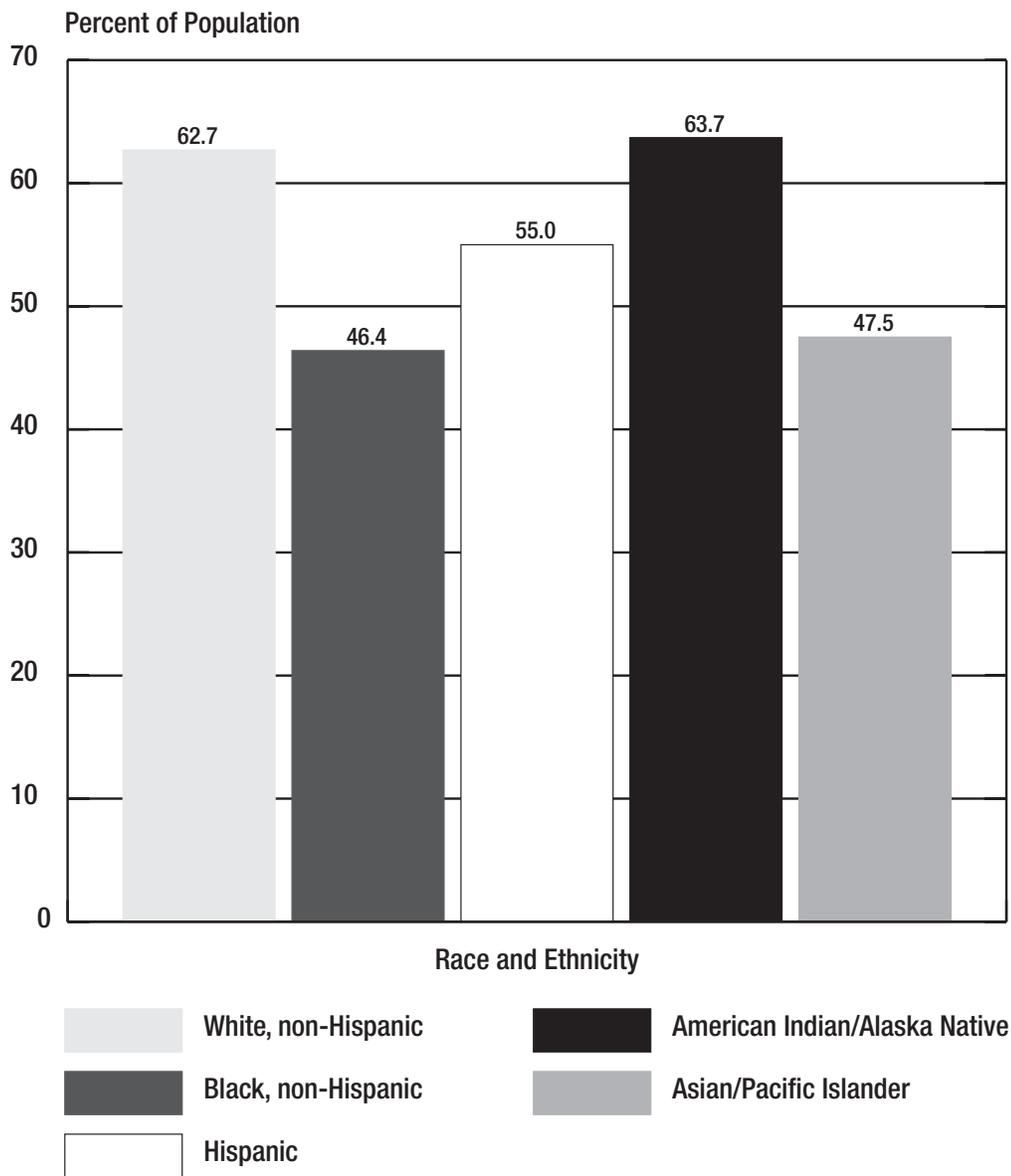
Notes: The numbers for other racial groups, Asian/Pacific Islander and American Indian/Alaska Native, are not sufficient to calculate reliable estimates.

People with a health problem are defined as those who met one of the following criteria: 1) reported fair or poor health status; 2) had a limitation in activity due to a chronic condition; 3) had 10 or more bed-days within the past 12 months where a bed-day is defined as staying in bed for at least one half day due to a health condition. These data are age adjusted.

Family income categories are based on family income and family size using the poverty thresholds developed by the U.S. Bureau of the Census.

- At every income level, there are more Hispanics with a health problem who have not received care from a physician than whites or African Americans.

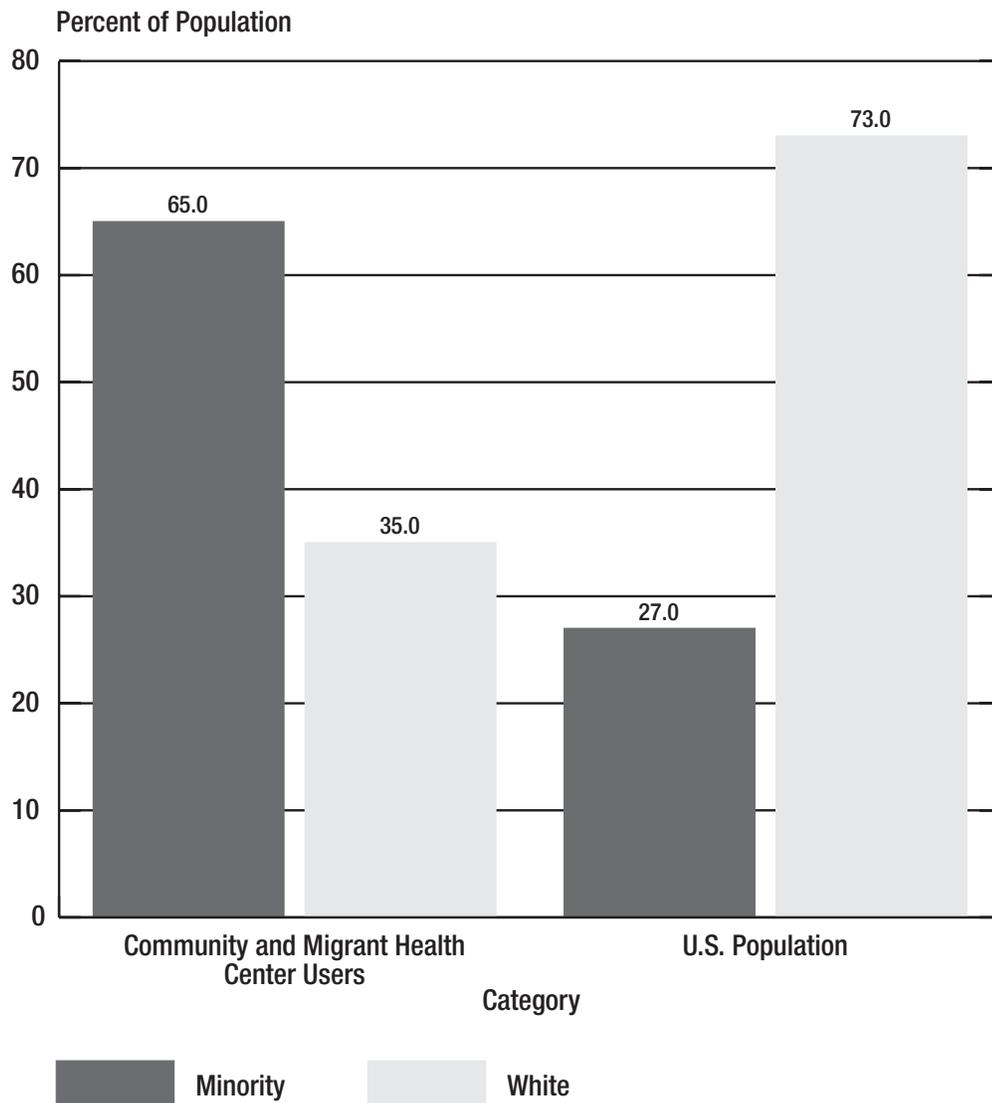
Figure 8-5. Regular Dental Visits In the Past Year Among Persons Ages 35 and Older by Race and Ethnicity, 1993



Source: National Center for Health Statistics, 1998b.

- African Americans and Hispanics are less likely to have seen a dentist in the past year than whites.

Figure 8-6. Racial and Ethnic Distribution of Community and Migrant Health Center Users in Medically Underserved Areas, 1997

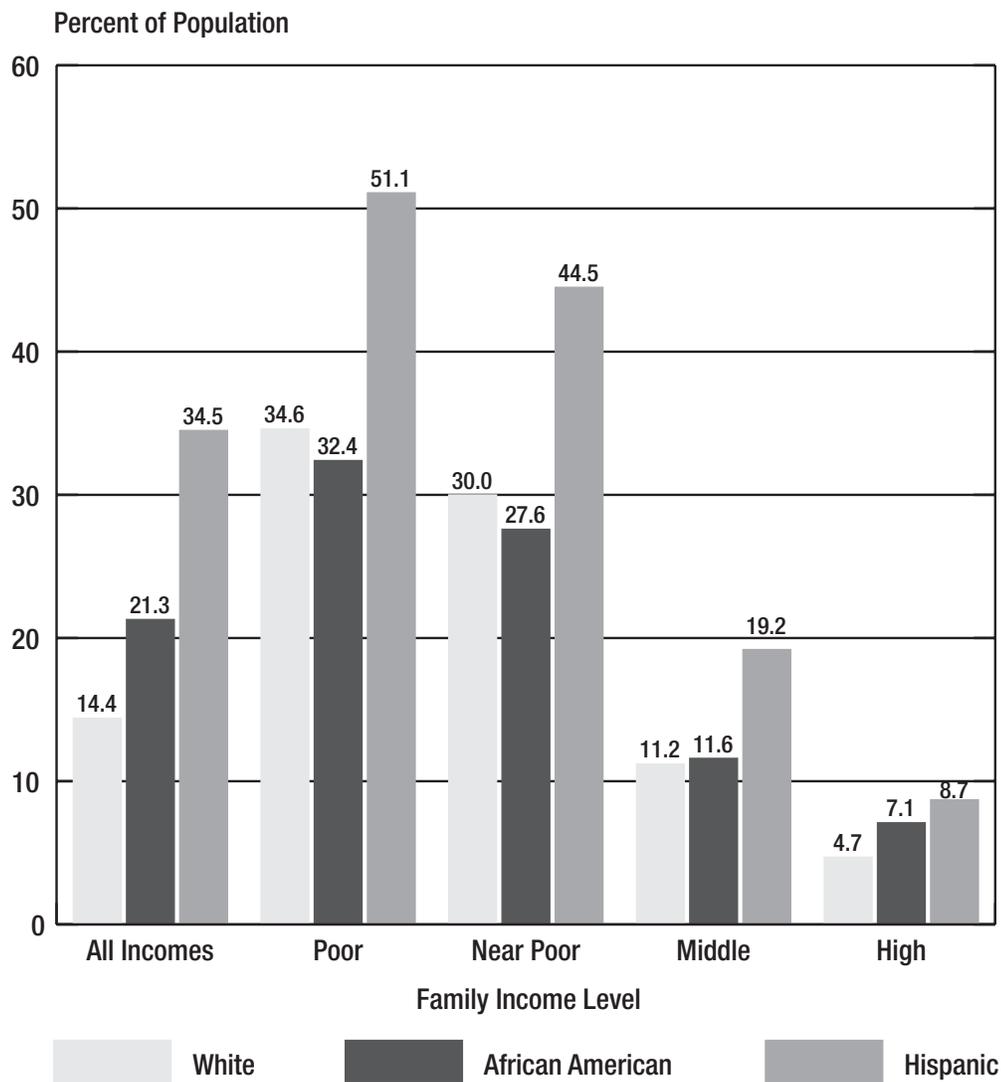


Source: Health Resources and Services Administration, 1998

Notes: Community and migrant health centers deliver services to underserved individuals and families.

- Although racial and ethnic minorities account for only one third of the U.S. population, they account for about two thirds of the community and migrant health center users.

Figure 8-7. Adults Ages 18 to 64 with No Health Insurance by Race, Ethnicity, and Family Income Level, 1994-1995



Source: Health Resources and Services Administration, 1998

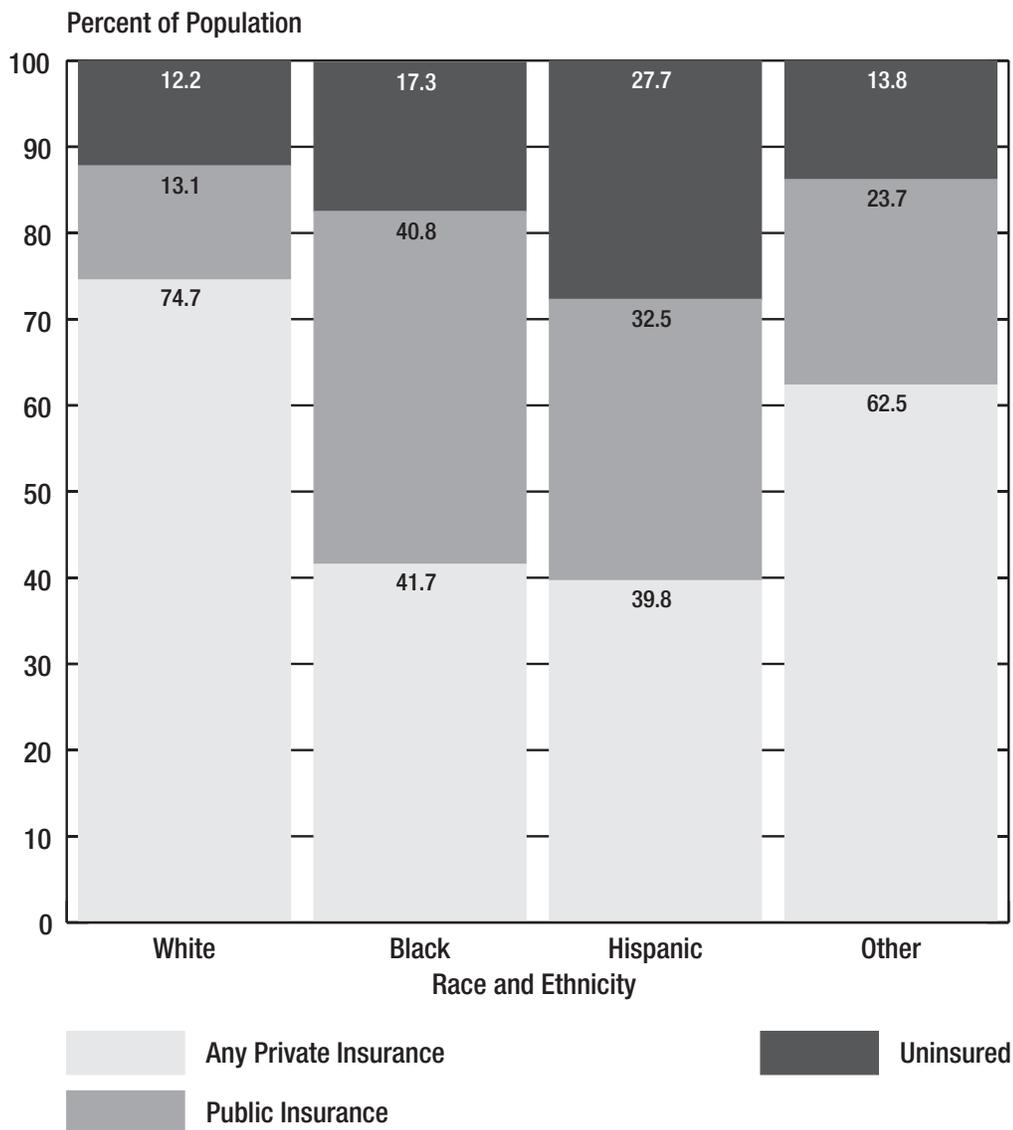
Notes: The numbers for other racial groups, Asian/Pacific Islander and American Indian/Alaska Native, are not sufficient to calculate reliable estimates.

People were defined as uninsured if they did not report any of the following types of health insurance coverage: private health insurance, Medicare, Medicaid, other public assistance, CHAMPUS, or military coverage.

Family income categories are based on family income and family size using poverty thresholds developed by the U.S. Bureau of the Census.

- In 1995, at every family income level, the percentage of Hispanics lacking health insurance was higher than any other racial or ethnic group.
- At middle and high income levels, the percentage of African Americans lacking health insurance was greater than that for whites.

Figure 8-8. Health Insurance Coverage of Children Ages 18 and Younger by Race and Ethnicity, 1996



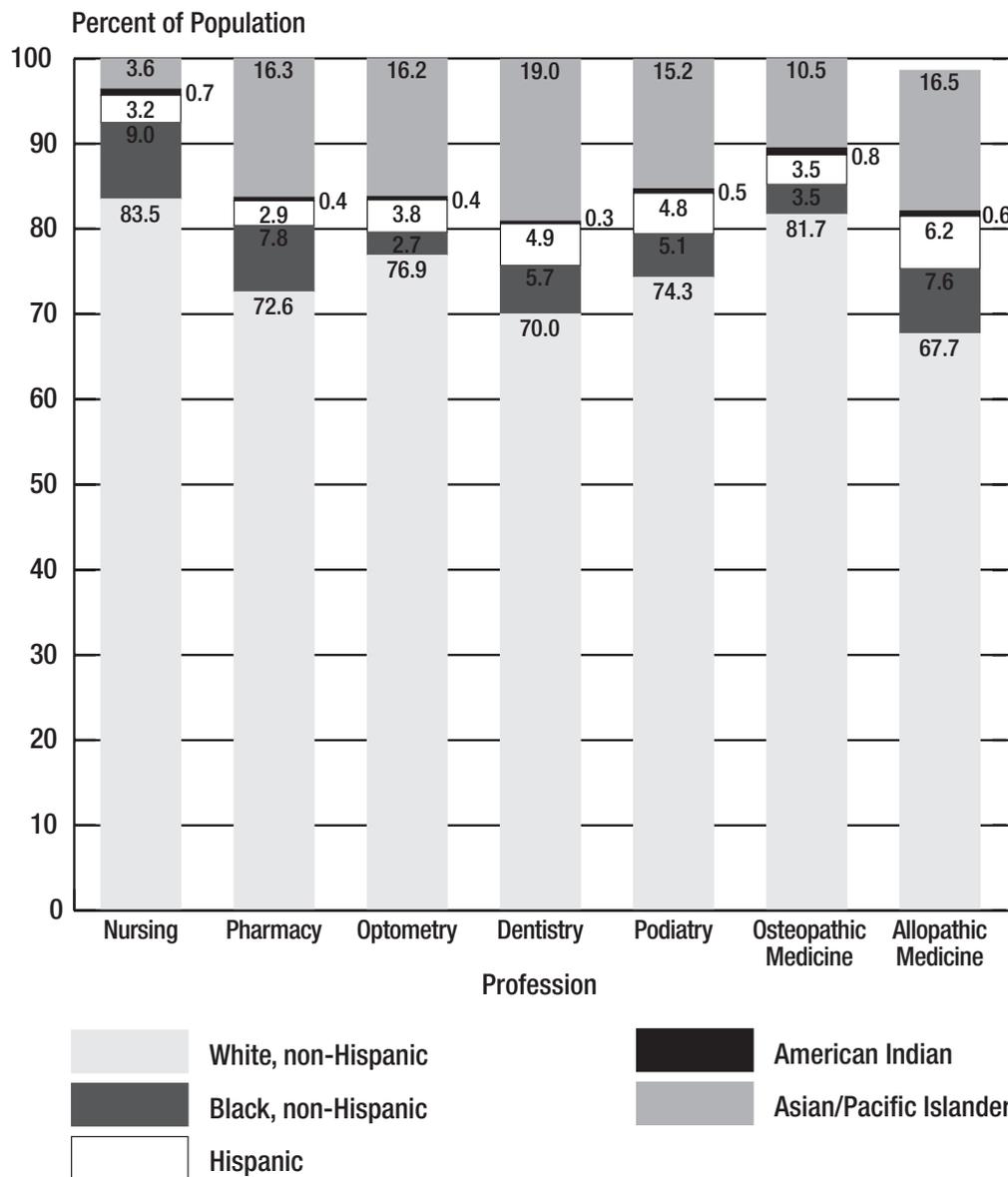
Source: Weinick, Weigers, and Cohen, 1998.

Notes: Children of Hispanic origin may be of any race.

Public insurance encompasses programs such as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and Medicaid.

- The percentage of Hispanic children lacking health insurance is greater than that of any other racial and ethnic group.
- The rate of public insurance coverage is highest among African-American children.

Figure 9-1. Enrollment in Health Profession Schools by Race and Ethnicity, 1995

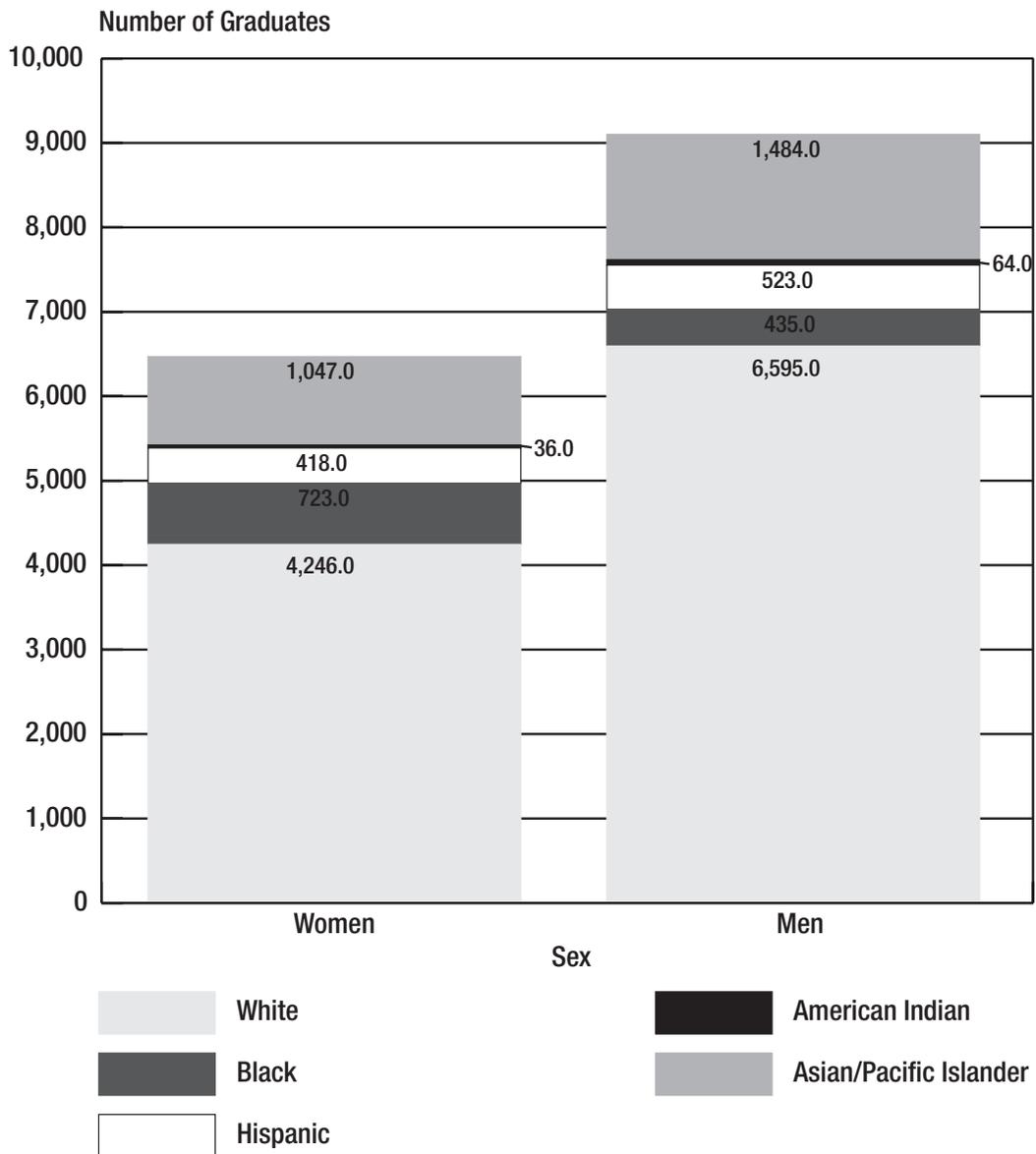


Source: Association of American Medical Colleges, 1995.

Notes: In 1996, the proportion of the population that was white was 73.1 percent; the proportion that was black was 12.0 percent; and the proportion that was Asian/Pacific Islander was 3.4 percent (see figure 1.1).

- White students are disproportionately represented in osteopathic medicine, podiatry, optometry, and nursing.
- Similarly, Asian/Pacific Islander students are disproportionately represented in all of the professions other than nursing.
- Only in nursing is the proportion of African-American students similar to the proportion of African Americans in the population.

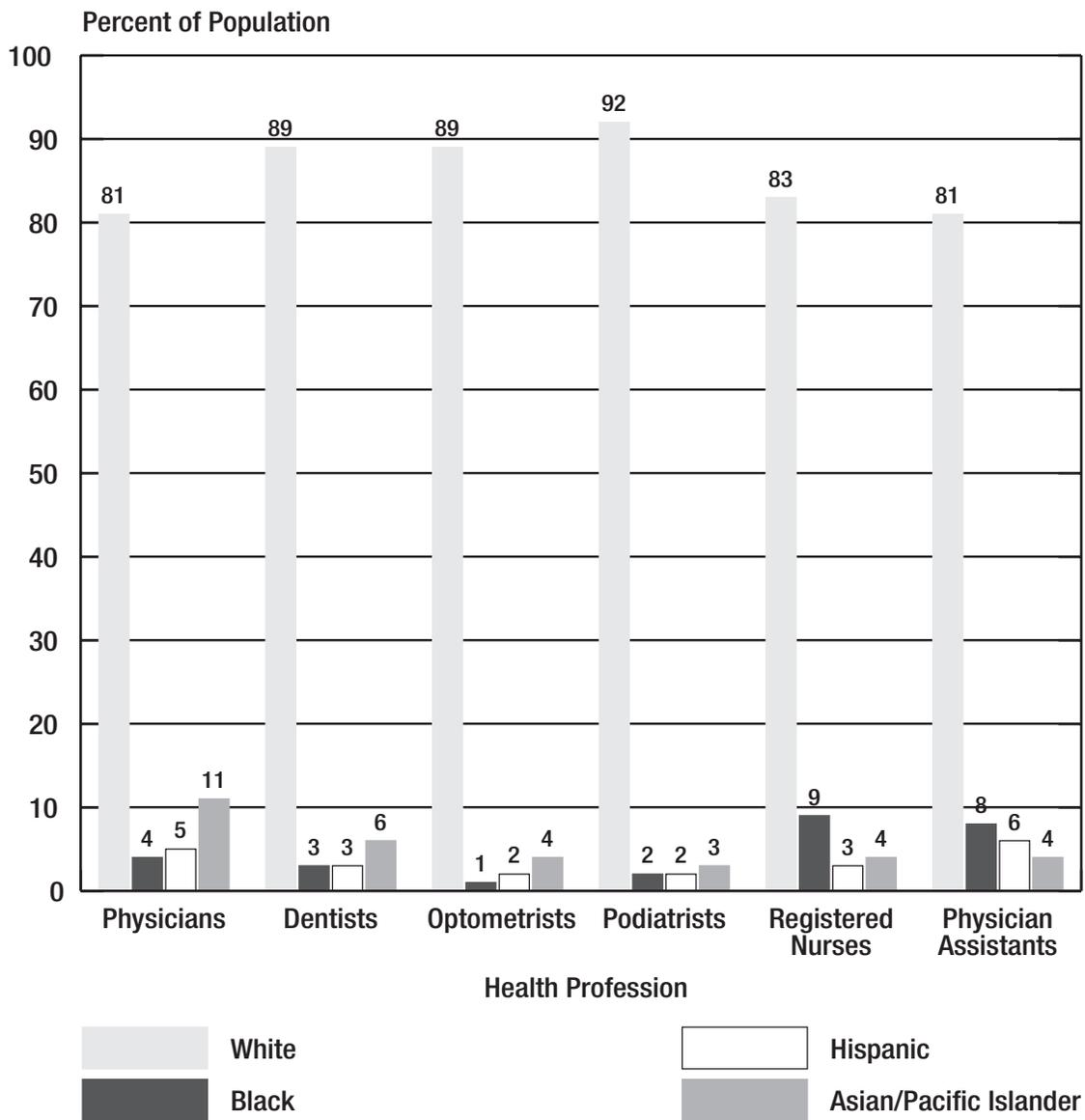
Figure 9-2. Medical School Graduates by Race and Ethnicity, 1997



Source: Association of American Medical Colleges, 1998.

- The number of students graduating from American medical schools is highest among white and Asian/Pacific Islander students.
- There were four times as many white graduates than Asian/Pacific Islanders.
- In 1997, there were more white male graduates from American medical schools than women of all races and ethnicities.

Figure 9-3. Racial and Ethnic Distribution of Selected Health Professions, 1990



Source: U.S. Bureau of Labor Statistics, 1990.

Notes: Persons of Hispanic origin may be of any race. American Indians compose one percent of the population of physician assistants, however, in other fields they make up less than one percent of the population.

In 1990, the percentage of the population that was white was 75.6; the percentage that was black was 11.8; the percentage that was Hispanic was 9.1; the percentage that was American Indian was .7; and the percentage that was Asian/Pacific Islander was 2.8.

- In all of the health fields presented, whites make up a disproportionate share of health professionals, relative to their population.
- Asian/Pacific Islanders also make up a disproportionate share of professionals in each field.
- Only among registered nurses and physician assistants does the percentage of African-Americans approach their proportion of the population.

Sources

Association of American Medical Colleges, *AAMC Data Book: Statistical Information Related to Medical Education* (Washington, DC: 1995).

Association of American Medical Colleges, Information available on web-site (<http://www.aama.org>), (Washington, DC: 1998).

Centers for Disease Control and Prevention, U.S. Department of Health and Human Services *HIV/AIDS Surveillance Report*, Vol. 9, No. 2, 1997.

Health Resources and Services Administration, U.S. Department of Health and Human Services, *Health Care Rx: Access for All*, The President's Initiative on Race (Rockville, MD: 1998).

National Cancer Institute, National Institutes of Health, U.S. Department of Health and Human Services, *Racial/Ethnic Patterns of Cancer in the United States 1988-1992*, NIH Publication No. 96-4104 (Bethesda, MD: 1996).

National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, *Tobacco Use Among U.S. Racial/Ethnic Minority Groups—African-Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General* (Atlanta, GA: 1998).

National Center for Health Statistics, Centers for Disease Control, U.S. Department of Health and Human Services, "Births and Deaths: United States, 1996," *Monthly Vital Statistics Report*, Vol. 46, No. 1, Supplement 2, September 11, 1997.

National Center for Health Statistics, Centers for Disease Control, U.S. Department of Health and Human Services, *Health, United States, 1998 With Socioeconomic Status and Health Chartbook* (Hyattsville, MD: 1998a).

National Center for Health Statistics, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Unpublished Data (Hyattsville, MD: 1998b).

National Institute of Diabetes and Digestive and Kidney Diseases, National Institutes of Health, U.S. Department of Health and Human Services "Sociodemographic Characteristics of Persons with Diabetes," *Diabetes in America, 2nd Edition*, NIH Publication No. 95-1468 (Bethesda, MD: 1995).

U.S. Bureau of the Census, Current Population Reports, Series P25-1130, *Population Projections of the United States by Age, Sex, Race, and Hispanic Origin: 1995 to 2050* (Washington, DC: 1996).

U.S. Bureau of the Census, Income 1996, Information available on web-site (<http://www.census.gov/hhes/income/96/in96sum.html>) (Washington, DC: 1997a).

U.S. Bureau of the Census, Current Population Reports, Series P20-505, *Educational Attainment in the United States: March 1997* (Washington, DC: 1997b).

U.S. Bureau of the Census, Population Division, Release PPL-91, *United States Population Estimates, by Age, Sex, Race, and Hispanic Origin, 1990 to 1997*, with associated updated tables for recent months (Washington, DC: 1998).

U.S. Bureau of Labor Statistics, Information Available on website (<http://www.bis.gov>) (Washington, DC: 1998).

U.S. Department of Health and Human Services, *Racial and Ethnic Disparities in Health: Responses to the President's Initiative on Race* (Washington, DC: 1998a).

U.S. Department of Health and Human Services, *Racial and Ethnic Disparities in Health*, Information available on web-site (<http://www.raceandhealth.hhs/>) (Washington, DC: 1998b).

Weinick, Robin M., Zuvekas, Samuel H., and Drilea, Susan K., "Access to Health Care—Sources and Barriers, 1996," *MEPS Research Findings* No. 3, AHCPH Pub. No. 98-0001 (Rockville, MD: Agency for Health Care Policy and Research, 1997).

Weinick, Robin M., Weigers, Margaret E., and Cohen, Joel W., "Children's Health Insurance, Access to Care, and Health Status: New Findings," *Health Affairs* March/April 1998.



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