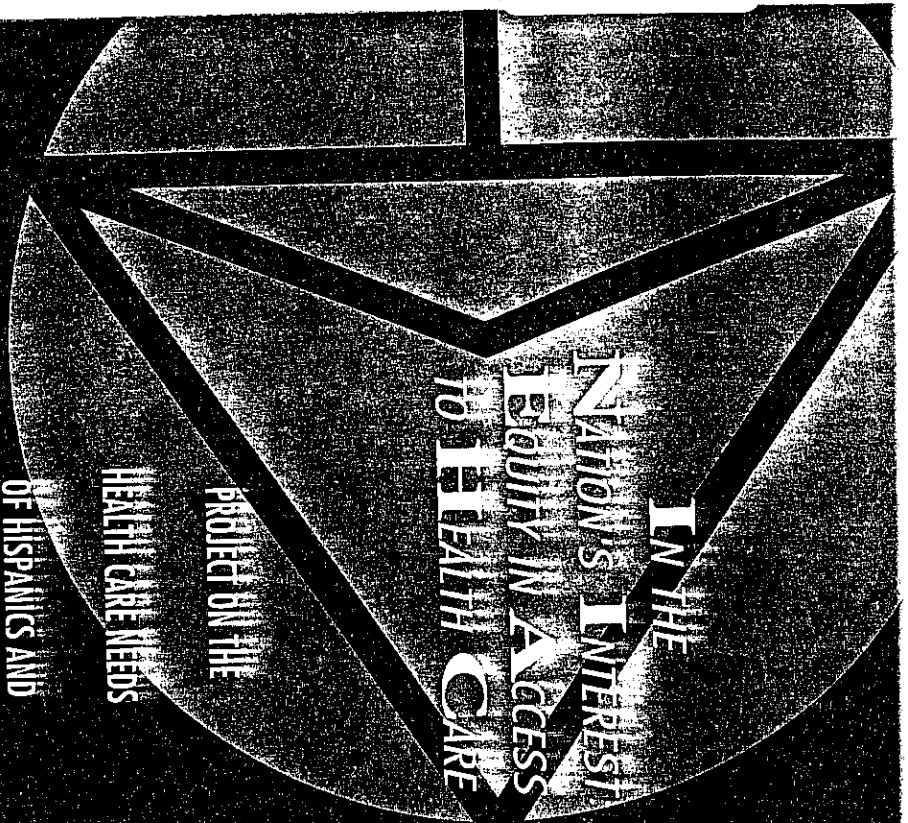


Resource ID# 4994

In the Nation's Interest: Equity in Access to Health Care



PROJECT ON THE  
HEALTH CARE NEEDS  
OF HISPANICS AND  
AFRICAN AMERICANS

MARSHA LILLIE-BLANTON  
ANA ALFARO-CORREA

The Joint Center for Political and Economic Studies is a national, nonprofit institution that conducts research on public policy issues of special concern to black Americans and promotes informed and effective involvement of blacks in the governmental process. Founded in 1970, the Joint Center provides independent and nonpartisan analyses through research, publication, and outreach programs.

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## FOREWORD

The past thirty years have witnessed improved access to medical care for significant numbers of low-income, elderly, and disabled Americans. This has translated into improved health and contributed to a significant decrease in maternal and infant mortality and an increase in life expectancy. However, despite these achievements, inequality in access to health care continues, especially for minorities and other vulnerable groups.

Today, both the past gains achieved in health care access and the promise of future progress are at risk. The erosion of employment-based coverage, together with budgetary pressures placed on public programs and on essential health care institutions, threaten to intensify current inequities. Although it was at the heart of the debate on health care reform just a year ago, universal health insurance coverage now has vanished as a policy goal. Even our existing public programs,

Medicaid and Medicare, face the prospect of restructuring and limits on expenditures, with uncertain implications for beneficiaries. The availability of care for the uninsured is also jeopardized by the cost pressures of managed care and by budgetary pressures at all levels of government.

Of the 41 million Americans who were without insurance in 1993, 42 percent were members of a racial or ethnic minority group. Nearly a fourth of African Americans and more than a third of Hispanics were uninsured. This lack of insurance can easily translate into the postponement of needed care and, ultimately, into chronic illness or premature death. Moreover, the financial means to access services are only one prerequisite for receiving care. Those who do not have a usual source of care, lack confidence in the medical system, or are unable to speak English also face considerable barriers in obtaining the health care they need.

If further gains in reducing racial and ethnic health disparities are to be achieved, a combination of strategies must be developed to strengthen the systems of care now serving millions of uninsured and underinsured minority Americans. In addition, health care providers must become more aware of and sensitive to the social environments and cultures of different racial and ethnic communities.

The Commonwealth Fund and the Joint Center for Political and Economic Studies are pleased to have cosponsored the Project on the Health Care Needs of Hispanics and African Americans. The Joint Center has long pursued a mission that includes working for full social equity for all African Americans, and the Fund has a 77-year-old tradition of supporting programs aimed at

improving the health and productivity of Americans with a special emphasis on bettering minority health.

Led by a research team at the Johns Hopkins University School of Hygiene and Public Health, the Joint Center/Commonwealth Fund Project reflects two years of collaboration among white, Hispanic, and African American scholars from around the country.

This report, which presents the Project's major findings, offers a valuable and detailed examination of the barriers to care that compromise the health of minority populations. It is being disseminated now to provide important background information to enlighten the ongoing debates on improving access to health care for all Americans.

Eddie N. Williams  
*President, Joint Center for  
 Political and Economic Studies*

Karen Davis  
*President, The Commonwealth  
 Fund*

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## ACKNOWLEDGMENTS

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A number of individuals from the sponsoring organizations were critical to this project's work. First and foremost, the authors wish to acknowledge the efforts of Wilhelmina Leigh, senior research associate at the Joint Center and the primary liaison between the sponsoring organizations. In addition to adapting well to a multitude of project roles, her thoughtful critiques of the draft papers and summary report were invaluable in clarifying the project's findings. The Johns Hopkins project staff, of course, deserve the highest of credit for their meticulous efforts throughout the various phases of work. Meriting particular note are the project's associate director, José Muñoz, and the project's data manager and programmer, Darrell Gaskin. In addition, the project greatly benefited from the staff support of others, notably Leslie Allen, Howard Chilcoat, Mary Lou Gutierrez-Mohamed, and Ruth Rios (for biographical sketches see Appendix IV).

Special thanks are due to Rose Martinez, Sally Schwartz, Cecilia Snowden, and Zhouwan Jackson for their support in the critique and editing of earlier drafts of the summary report. Their diligence and willingness to undertake the smallest of tasks helped to bring this document to fruition.

The project researchers deserve to be acknowledged for their persevering efforts and their teamwork. Any effort to achieve

ome uniformity in purpose and definition, while also allowing investigators an opportunity to pursue their independent ideas and interests, is a challenge. Undertaking such a task, however, required extraordinary effort given that the researchers lived in different parts of the country, were working under varying time constraints, represented a cross-section of disciplinary backgrounds, and generally had research experience with only one of the two racial/ethnic minority groups. Their efforts reflected a genuine commitment to the project's goal of improving knowledge of the health care needs and concerns of Hispanics and African Americans.

Finally, we wish to thank other staff at the Joint Center for their efforts in bringing this product into being. Within the Office of Research, we thank Milton Morris, vice president for research, and Margaret Simms, director of research programs, for their review of this document and related materials. We also appreciate the efforts of Diane Simon-Queen who produced early versions of the figures. And for their elegant work in editing and designing this report, we thank Diane Powers, director of communications, Marc DeFrancis, senior editor, Theresa Kilcourse, production coordinator and designer, and Glynda Featherstone, word-processing assistant.

## EXECUTIVE SUMMARY

The U.S. health care system is unquestionably at a crossroads. Most Americans have access to the best of preventive and life-saving care. A growing number of Americans, however, are unable to get care when needed or get less care than is needed.

Hispanics and African Americans are two population subgroups that historically have faced barriers in obtaining access to timely and appropriate care. This report provides an update on the nation's progress in reducing those barriers. Access to care is defined broadly here, to include both the potential to obtain services (e.g., insurance coverage and regular source of care) and the realized access to services (e.g., physician visits and health care expenditures).

That Hispanics and African Americans continue to be disadvantaged in obtaining access to appropriate health care is well borne out by analysis of national survey data on health status,

health care use, and health expenditures. Both financial barriers (e.g., lack of health coverage) and nonfinancial barriers (e.g., language, attitudes, geographic proximity of health resources) contribute to racial/ethnic differentials in the use of health services. Although low-income racial/ethnic minority groups encounter the greatest barriers to care, moderate and higher income Hispanics and African Americans also face barriers.

As policymakers continue the debate on how to reform the U.S. health system, it is important that issues of concern to racial/ethnic minority groups be considered. Many of the issues that were brought to the forefront of the recent policy debate on national health reform are of concern to most Americans regardless of income or race/ethnicity—for example, portability of coverage, coverage for preexisting conditions, and choice in selecting

health providers. However, there are other issues, particular to the historic conditions and current circumstances of Hispanics and African Americans, that also

deserve consideration in the policy debate. This project was, therefore, undertaken to provide

policy-makers, practitioners, and advocates with an objective account of the progress achieved in reducing barriers to care and the nature of problems that persist.

**METHODS AND SOURCES**

To achieve the above aims, this project convened two public policy forums and analyzed national survey data from the 1987 National Medical Expenditure Survey (NMES). The NMES, sponsored by the U.S. Department of Health and Human Services, provides the most current nationally representative estimates of health care use and expenditures. The research undertaken for this project is the most comprehensive examination of the NMES with a focus on Hispanics and African Americans.

This summary report describes key findings from the work of research teams commissioned by the Johns Hopkins School of Public Health project staff. The commissioned papers (see accompanying list on page 5), along with a summary of key issues identified at the policy

forums, will be published in a monograph produced by the Joint Center for Political and Economic Studies.

**KEY FINDINGS AND PUBLIC POLICY ISSUES**

Among the project's many findings, those highlighted below merit special attention.

**Disparities Persist**

**Low-income Hispanics and African Americans are doubly disadvantaged in obtaining health care.** While an astonishingly large share of all low-income Americans with incomes below 200 percent of the poverty level don't get any routine care during the year, low-income Hispanics and African Americans in this income group were the least likely to get such care. About half of these Hispanics and African Americans, compared with about a third of their white counterparts, did not visit a physician during the year.

**Disparities in health coverage are both geographic- and race-specific.** Among low-income Hispanics, those in the South were nearly 3 times as likely to be uninsured as those in the Northeast (55% vs. 19%). Among low-income African Americans, those in the South were 1.5 times as likely to be uninsured as those in

the Northeast (37% vs. 25%). Low-income Hispanics in the South and West also face barriers to coverage particular to their racial/ethnic group: in both regions, they were more likely to be uninsured than were whites with similar incomes.

**Low-income families, regardless of race/ethnicity, face greater financial barriers in obtaining health care than upper-income families.** Low-income Hispanics, African Americans, and whites are disproportionately uninsured. Moreover, they spend a larger share of income out-of-pocket for health care services: 7 to 11 percent of their income, compared with upper-income families' average of 1 to 2 percent.

**Multiple Factors Account for Disparities and Inappropriate Use of Services**

**Some barriers to care are rooted in the failure to develop health services that can respond to the needs of socially and culturally diverse populations.** For example, in an analysis of persons with hypertension, more than a third of those not fluent in English lacked a physician who spoke their language. About 1 in 10 Hispanics were not fluent in English. Poor

communication not only is a potential barrier to care but can result in misunderstandings in a patient's diagnosis and treatment.

**Other barriers to care are related to personal circumstances and attitudes about caregivers.** For some individuals, perceptions that services are unavailable or ineffective can prove to be as much a barrier as the reality. Among African Americans, those who were the least confident in providers' ability to offer effective care used services less frequently than those who expressed confidence in their providers. Mexican Americans, Puerto Ricans, and a combination of other Hispanic subgroups<sup>1</sup> did not differ substantially in their attitudes or beliefs about the value of medical care.

However, Hispanics who perceived little need for a regular source of medical care were the least likely to have a regular source of medical care.

**Lack of health coverage and not having a regular provider were among the more notable factors influencing the use of hospital emergency rooms (ERs) and outpatient departments (OPDs) for nonurgent care,<sup>2</sup> although other**

<sup>1</sup> Other Hispanic subgroups consist of individuals who identified themselves as "Other Spanish" or "Latin American." Cuban Americans were excluded from the analysis.

<sup>2</sup> The ER visit was defined as "nonurgent" if it: (1) was not physician initiated; (2) did not result in a hospital stay; or (3) did not entail a surgical procedure. While the three extraordinary indicators do not reveal all cases of persons with "true" emergencies, the data do not allow further sorting for nonurgent and urgent cases.

factors also play a role. Medical conditions most likely to prompt an ER visit that were defined as nonurgent were: digestive system ailments, impairments of the eye and ear, and fractures and sprains. Hispanics and African Americans with no regular provider were, respectively, 1.4 times and 1.5 times as likely to make an ER visit for a nonurgent condition as were their counterparts with regular providers. Additionally, 60 percent of Hispanics and 70 percent of African Americans who were regular users of OPDs were uninsured or had Medicaid, compared with less than half of Hispanic and African American patients of private physicians.

**Some Progress Has Occurred**

Providers who are members of racial/ethnic minority groups appear to be filling a critical void for minority patients. When clients and physicians were matched by racial/ethnic background, a larger share of Hispanics who did not speak English as their native language obtained care from Hispanic physicians than did Hispanics who were native English speakers. A larger share of African Americans with Medicaid coverage obtained care from African American physicians than did privately insured African Americans.

Neighborhood health clinics and hospital OPDs afford a level of entry into the health system that is at least comparable to that enjoyed by those who identify a private physician as their regular source of care. Hispanics and African Americans who identified their regular source of care as a clinic or hospital outpatient department reported access to physician services that was similar to that of persons with a private physician as a regular source of care.

These findings provide evidence that legislative protections, the courts, and Medicaid/Medicare financing have enabled Hispanics and African Americans to gain a "foot" in the door of the health care system. That door has not opened sufficiently wide to ensure equitable access to quality health services, however. Disparities in health coverage, use of health services, and expenditures by race/ethnicity, geographic region, and income are inexcusable in a nation with plentiful health resources. Efforts to achieve equitable access to health care are critical. Like access to societal necessities such as education, housing, and employment opportunities, access to health care is important because of its potential to shape a person's economic opportunities and quality of life.

Based on the national survey findings and discussions held at two policy forums, several goals have emerged as critical for reducing racial/ethnic inequities in access, namely:

- Developing a system of health coverage in which access to coverage is not compromised by racial/ethnic differences in income or employment;
- Fostering the growth of a socioculturally competent health care system;
- Strengthening the health services infrastructure, particularly primary-care services, located in or otherwise available to minority communities; and
- Working toward greater national consensus on federal/state and public/private roles in ensuring equitable access to care.

**Commissioned papers cited in this report**

Felipe G. Castro, Kathryn Gee, and Mary Horron  
 "Ethnic/Racial Matches Between Provider and Patient: Their Relationship to the Use of Health Services by Hispanics and African Americans"

Llewellyn J. Cornelius and Zelma E. Sporer  
 "What Accounts for the Dependency of African and Hispanic Americans on Hospital-Based Outpatient Care?"

Verna M. Keith and Thomas A. Layzell  
 "Social, Economic, and Health Determinants of Health Care Service Use: A Comparative Analysis of Anglos, African Americans, and Mexican Americans"

Morsha Lille-Blanton and Chrissy Lille  
 "Assuring Equitable Access to Health Care: Reexamining Federal and State Roles"

M. Edith Rosell and Jared Bernstein  
 "A Comparison of Health Care Expenditures by Income, Across Racial/Ethnic Groups"

Christine A. Stroup Benham and Linda C. Perkowski  
 "Barriers to Care Among Hypertensives: A Comparison of Financial, Access, and Sociocultural Barriers Across Three Ethnic Groups"

Michael C. Thornton and Shelley I. White-Means  
 "Racial and Ethnic Patterns of Hospital Emergency Room Use"

Ruth E. Zambrana  
 "The Relationships of Cultural Attitudes, Functional Health Status, and Psychosocial Factors to Usual Source of Care, by Hispanic Subgroup"

## BACKGROUND ON THE STUDY POPULATION

In any deliberations on health care reform, the needs of the most vulnerable populations should be a concern for policymakers. With that concern in mind, this report examines issues related to access to health care by Hispanics and African Americans under age 65, the group currently most likely to lack health insurance since

Medicare has provided nearly universal coverage to the elderly. The database used for the analysis is the 1987 National Medical Expenditure Survey (NMES), a nationally representative sample survey with extensive medical care use and expenditure data for the entire U.S. population.

Among the population under age 65, over three quarters (78 percent) are white, not of Hispanic origin; persons of Hispanic origin constitute 9 percent, and African Americans 13 percent. Hispanics and African Americans are disproportionately represented among the poor. In 1987, the year of the NMES

interviews, 28 percent of Hispanics and 33 percent of African Americans reported poverty level incomes. This trend in poverty has worsened slightly since 1987, with 31 percent of Hispanics and slightly more than 33 percent of African Americans reporting incomes below the federal poverty level in 1993.

The distribution of Hispanics and African Americans throughout the U.S. varies from that of whites. A majority of the nation's Hispanics and African Americans reside in the South and the West, while whites are distributed more evenly among the four regions. (See Appendix II for further information.) In 1987, over two-fifths (40.7 percent) of the Hispanic population lived in the West, with an additional third (34.3 percent) living in the South. Nearly three-fifths (58.4 percent) of all African Americans lived in the South, with an additional 8 percent living in the West. Sixteen percent of both Hispanics and African Americans lived in the Northeast in

## BACKGROUND ON THE STUDY POPULATION

1987, while 9 percent of Hispanics and 18 percent of African Americans resided in the Midwest. According to figures from the 1990 Census, this distribution has remained roughly the same, with three fourths (75 percent) of all Hispanics residing in the South and West, and 8 percent and 17 percent in the Midwest and Northeast, respectively. The distribution of African Americans throughout the regions in 1990 was nearly identical to their distribution in 1987, with a total of 62 percent of all persons living in the South and West, and the remaining population split

nearly evenly between the Northeast and the Midwest. Thus, policies and practices of states in the South and West are important determinants of access for Hispanics and African Americans.

The trends in population size, poverty, and geographic distribution noted above all have bearing on access to health care services for both Hispanics and African Americans. (See Appendices I and II for further detail on the NMES and its use in this project, and on the study population.)



# ELIMINATING FINANCIAL BARRIERS TO HEALTH CARE

## A1 Race/Ethnicity, Income, and the Risk of Being Uninsured

**The greatest barrier to obtaining health care in the United States is the lack of health insurance, which disproportionately affects Hispanics and African Americans.** Hispanics are at greatest risk of being uninsured. An estimated 33 percent of Hispanics (6.1 million) and 23 percent of African Americans (6.2 million) were uninsured at some time during 1987, compared with 13 percent of whites (21.9 million). Among Hispanics, Mexican Americans were three times as likely as other Hispanic subgroups to be uninsured. (Figure 1)

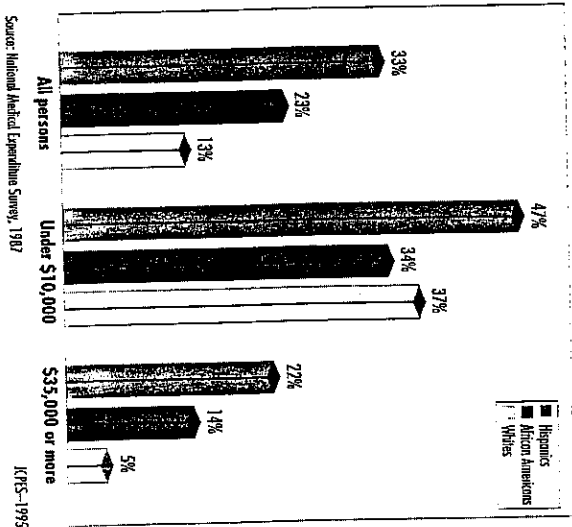
JHU Database

**Barriers to health coverage are most pronounced among**

*Americans with the least income.*

Low-income Hispanics and African Americans were more likely to be uninsured than Americans on average. About a third of low-income whites (12.1 million people) and African Americans (4.6 million people), and nearly half of low-income Hispanics

**Figure 1**  
Percent uninsured, by income, 1987  
Persons under age 65



Source: National Medical Expenditure Survey, 1987

KRCS-1995

(4.5 million people) were uninsured. (Figure 1)

JHU Database

**Racial/ethnic barriers to health coverage also exist for moderate- and upper-income Americans.** Among Americans with incomes of \$35,000 or more, Hispanics were 4.4 times as likely (22% of them) and African Americans were 2.8 times as likely (14%) as whites (5%) to be uninsured. (Figure 1)

JHU Database

## A2 Socioeconomic Characteristics of the Uninsured

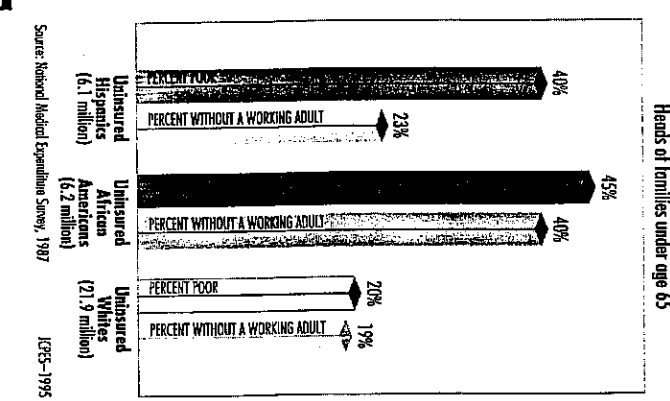
**Uninsured Hispanics and African Americans, when compared with uninsured whites, were more likely to be poor, and uninsured African Americans were less likely than whites to have an employed adult in the household.** At least 2 in 5 uninsured Hispanics (40%) and African Americans (45%) had incomes below the federal poverty level, compared with 1 in 5 whites, (20%). While a large proportion of uninsured Hispanics were among the ranks of the working poor, uninsured African Americans were less likely to have a working adult in the household than either whites or Hispanics. (Figure 2)

JHU Database

**A3 The Burden of Rising Health Care Costs on Low-Income Families**

**Low-income families pay a higher share of their income out-of-pocket for health care than upper-income families do.** Low-income Hispanics, African Americans, and whites paid between 7 and 11 percent of their income out-of-pocket for health care. This compared with out-of-pocket spending by their upper-income counterparts of just 1 to 2 percent of income. Out-of-pocket expenses, when compared with other types of health spending

**Figure 2**  
Poverty and employment status of uninsured families, 1987  
Heads of families under age 65



Source: National Medical Expenditure Survey, 1987

KRCS-1995

(such as premiums and spending through the tax system) were the most regressive component of health spending. (Figure 3)

Rasell and Bernstein

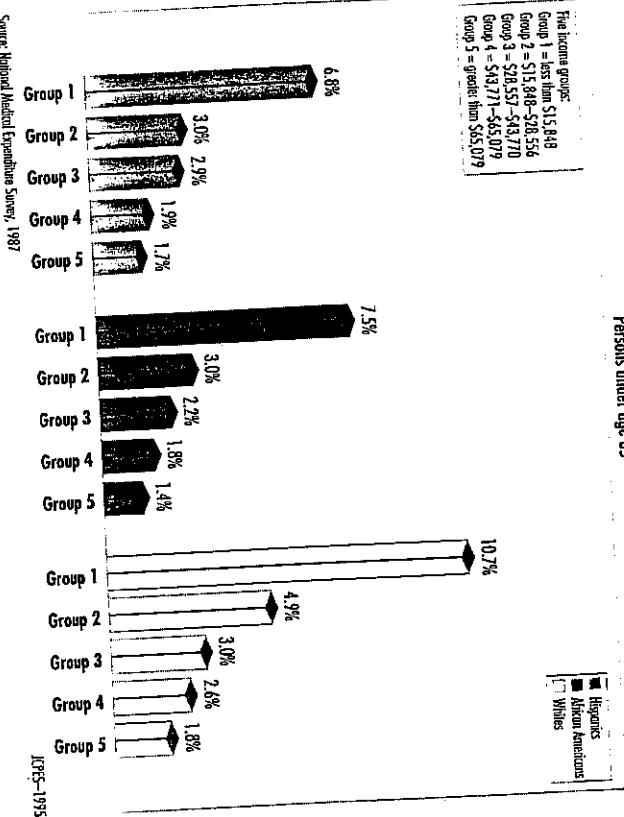
#### A4 Implications for Policy and Practice

**Minority families with private health insurance spend less than white families on health insurance premiums.** Controlling for factors that affect health care expenditures, it was found that minority families (Hispanics and African Americans combined) with African American health insurance spent 6 percent less than white families with similar insurance. However, minority families spent 2 percent

more on health insurance premiums than white families. Rasell and Bernstein

The sizable share of Hispanics and African Americans without health insurance coverage indicates that financial barriers continue to disproportionately affect minority populations' access to care. Since uninsured Hispanics and African Americans are more likely than uninsured whites to be low-income, the financial risks and burdens are apt to be greater for minority than nonminority families.

**Figure 3**  
Out-of-pocket medical expenses as a percent of total income, by income group, 1987  
Persons under age 65



To remedy these inequities, a system of universal coverage is needed, one that is not compromised by racial/ethnic differences in income and employment. The current approach to coverage in the United States, which is employment-based, places Hispanics and African Americans at a disadvantage due to their higher rates of unemployment and their greater employment in part-time and other low-wage jobs with less generous benefits. Moreover, even among upper-income Americans, minorities have lower rates of health coverage than whites, which indicates that factors

other than money influence patterns of coverage. The finding that low-income families bear a greater burden of out-of-pocket health costs than upper-income families, regardless of race or ethnicity, suggests that reform proposals must not only expand coverage but also reduce the out-of-pocket burden on those least able to afford high health costs. Subsidies for purchasing "bare bones" health plans or plans that offer coverage only for catastrophic health costs are unlikely to make health care more accessible to low-income Americans in any racial/ethnic group.

# DEVELOPING THE SOCIOCULTURAL COMPETENCE OF THE HEALTH CARE SYSTEM

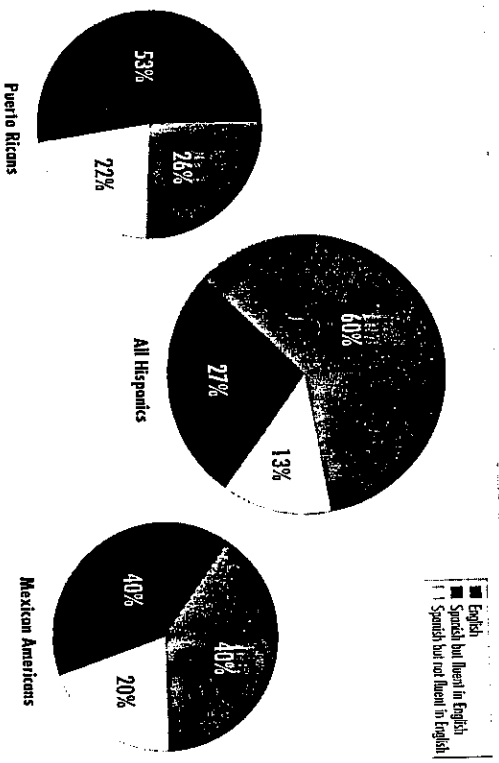
## B1 Language Barriers

A sizable number of Hispanics face potential barriers to care because of communication problems. At least 1 in 10 Hispanics (13%) was at risk of facing communication problems

because of lack of fluency in the English language. This potential barrier is even greater for Puerto Ricans<sup>3</sup> and Mexican Americans, among whom roughly 1 in 5 was not fluent in English. (Figure 4)

JHU Database; Zambrana

Figure 4  
Language use by Hispanics, 1987  
Persons under age 65



JGFS-1995

Source: National Medical Expenditure Survey, 1987

3 It is worthwhile to note that by virtue of Puerto Rico's Commonwealth status, all Puerto Ricans are U.S. citizens by birth. The study population for this project, however, included only Puerto Ricans living in the continental United States.

# DEVELOPING THE SOCIOCULTURAL COMPETENCE OF THE HEALTH CARE SYSTEM

## B2 Confidence in the Medical Care System

Mexican Americans, African Americans, and whites had about equal levels of confidence in the medical profession's understanding and ability to provide effective care. A similar percentage of Mexican Americans (16%), African Americans (14%), and whites (15%) was highly skeptical of the knowledge and ability of the medical profession to provide effective care during an illness.<sup>4</sup>

Keith and LaVeist

Among whites and African Americans, skepticism about medical care was related to less frequent use of health services.

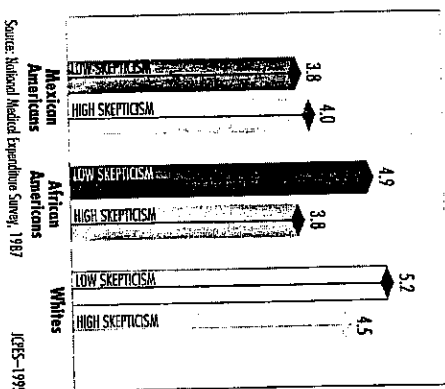
Estimates of health services used, unadjusted for factors such as age and health coverage that could affect care-seeking behavior, provided some evidence to suggest a link between skepticism and health care use among all three racial/ethnic groups. After using analytic techniques to take these factors into account, there was strong evidence that among whites and African Americans—but not Hispanics—persons who

were skeptical about the effectiveness of medical care were less likely to make an ambulatory visit to a health provider.<sup>5</sup> Although skepticism among Mexican Americans was not related to the use of health services measured, it was related to health status: Mexican Americans who were highly skeptical were also the healthiest. (Figures 5a, 5b, 5c)

Keith and LaVeist

Hispanic subgroups are not identical in their ability to access care. Mexican Americans, Puerto

Figure 5a  
Average number of medical visits per person, by degree of skepticism, 1987  
Persons under age 65



Source: National Medical Expenditure Survey, 1987

JGFS-1995

4 Skepticism was measured using a five-item attitude scale that assessed the individual's confidence in the medical profession's ability to intervene effectively. The five items, paraphrased, were these: (1) can overcome most illness without a doctor; (2) home remedies are better than prescription medicine; (3) own behavior determines recovery; (4) understand health better than doctor; and (5) luck is a big part of recovery.

5 After considering population characteristics that could affect care-seeking behavior, the percent of most-skeptical Mexican Americans and least-skeptical Mexican Americans with an ambulatory visit did not differ reliably (see Figure 5b).

Ricans, and "other Hispanics" <sup>6</sup> did not differ substantially in their attitudes or beliefs about the value of medical care. However, Hispanics who perceived themselves to have little need for medical care were more likely to lack a regular source of care. Mexican Americans were more likely to be uninsured than Puerto Ricans and other Hispanic subgroups. In addition, Puerto Ricans and Mexican Americans who did not speak English had greater functional limitations than did their English-speaking counterparts in each ethnic group.

Zambrana

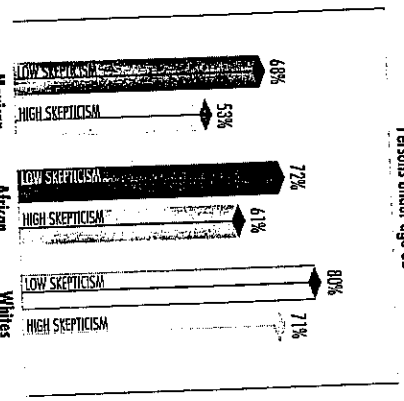
**B3 Ancillary Services**

**Lack of private transportation limits access for those with a known need for care.** Among persons with hypertension, Hispanics and African Americans were more dependent on public sources of transportation to get care than were whites. They were more than five times as likely as whites to take a taxi to get care and nearly 10 times as likely to use public transportation. Dependence on public transportation increases the time and, in some cases, the financial burden of getting care. (Figure 6)

Stroup-Benham and Perkowski

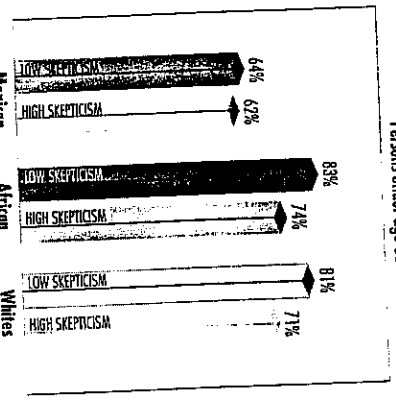
**Language barriers may obstruct access to needed care.** Of the Hispanics with hypertension who did not speak English as their native language, 40 percent were

**Figure 5b**  
Percent that made ambulatory visits, by degree of skepticism, 1987  
Persons under age 65



Source: National Medical Expenditure Survey, 1987  
ICF5-1995

**Figure 5c**  
Percent that had blood pressure checked, by degree of skepticism, 1987  
Persons under age 65



Source: National Medical Expenditure Survey, 1987  
ICF5-1995

6 "Other Hispanics" consisted of individuals who identified themselves as "Other Spanish" or "Latin American." Cuban Americans were excluded from this analysis.

not fluent in English. More than a third of those who were not fluent in English did not have a physician who spoke their native language. Hispanics' ability to access needed care (and information) is likely compromised by their inability to communicate with a provider in their native language. Communication with a health provider is especially important in the management of a chronic condition such as hypertension, which may require complex treatment regimens and significant modifications of behavior.

Stroup-Benham and Perkowski

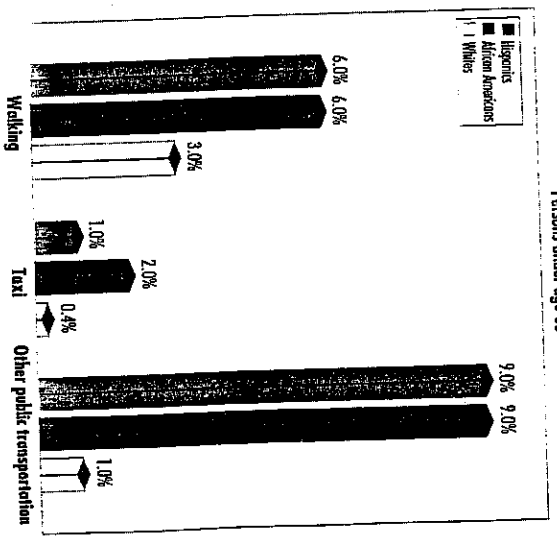
**B4 Patient Preferences for Physicians of the Same Racial/Ethnic Background**

**More Hispanics than African Americans have physicians of the same racial/ethnic background.** Fifteen percent of Hispanics compared to 10 percent of African Americans had physicians of the same racial/ethnic background. Castro, Coe, Harmon

**Language appears to be an important factor in explaining why Hispanics obtain care from physicians of the same race/ethnicity.** Nearly 2 in 5 Hispanics who obtained care from non-Hispanic physicians spoke English as their native language, compared with only 1 in 5 Hispanics who obtained care from Hispanic physicians. The finding suggests that Hispanics who did not speak English as their native language may have sought out a physician who spoke Spanish. (Figure 7)

Castro, Coe, Harmon

**Figure 6**  
Percent of hypertensives using selected types of transportation to medical care, 1987  
Persons under age 65



\* Percentages using a car (driving or being driven) were 84%, 81%, and 95% for Hispanics, African Americans, and whites respectively.  
Source: National Medical Expenditure Survey, 1987  
ICF5-1995

Insurance coverage appears to be an important factor in explaining why African Americans obtain care from physicians of the same race/ethnicity. Health coverage among African Americans was obtained through Medicaid for about a quarter (26%) of those whose physicians were of the same race/ethnicity but for only 16 percent of those whose physicians were of a different race/ethnicity. The finding indicates that African Americans with Medicaid coverage may be more comfortable with physicians of their own race or else that physicians of other racial groups are less available to African Americans with Medicaid. (Figure 8)

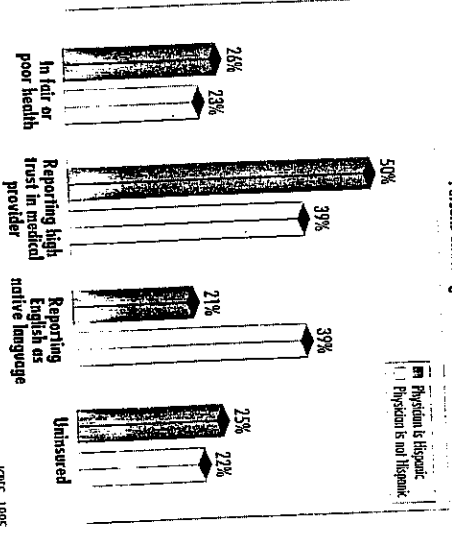
Castro, Coe, Hannon

**B5**  
**Implications for Policy and Practice**

Health care providers are increasingly serving clients from diverse socioeconomic and racial/ethnic backgrounds. Culture, language, past experiences, and

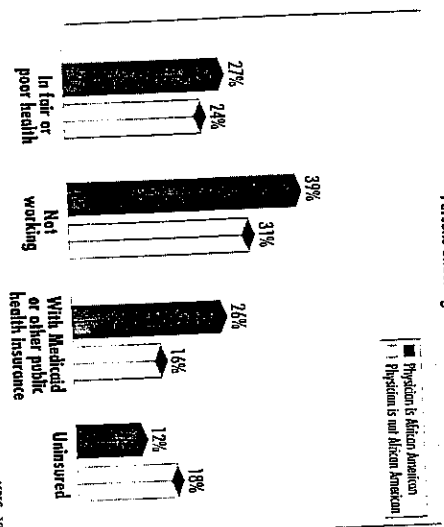
financial means all help shape the social environment of both clients and providers. Social environment in turn influences the way clients and providers perceive medical practice and personal behavior.

**Figure 7**  
**Characteristics of Hispanics by ethnicity of physician, 1987**  
Persons under age 65



Source: National Medical Expenditures Survey, 1987

**Figure 8**  
**Characteristics of African Americans by race of physician, 1987**  
Persons under age 65



Source: National Medical Expenditures Survey, 1987

JGCS-1995

and so influences the way they interact with each other. For example, a provider who is insensitive to certain cultural practices may perceive clients as uncooperative or reluctant to improve their health, and clients may question the provider's ability to improve their health. Two project studies offer evidence that persons lacking confidence in health providers were less likely to seek care.

The social environment also includes the method of communication. When a common language is not shared and translation services are not available, communication between clients and providers is hindered, and a barrier to care may be erected that can result in misunderstandings in diagnosis and treatment. Language

barriers, presumed to be of concern primarily for immigrant populations, were found to be problematic even for Hispanics who are U.S. citizens by birth.

The organizational structures of health providers generally have an operating culture of their own. The study matching physicians and patients by race/ethnicity provides insight into how Hispanics and African Americans negotiate these operating cultures. These findings do not necessarily reflect barriers to care; however, they are an indication of the options available to and the preferences of each population group. Knowledge of the social environment of the client population is important for an understanding of the barriers, real or perceived, that may affect care-seeking and care-giving.

# IMPROVING TIMELY AND APPROPRIATE USE OF HEALTH SERVICES

## C1 Usual Sources of Care

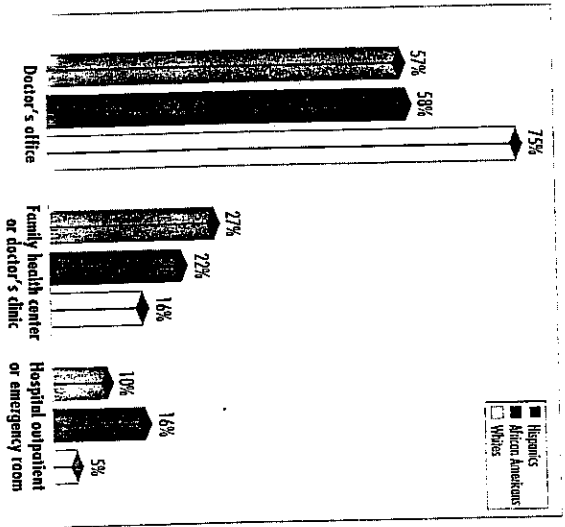
**Hispanics and African Americans are less likely than whites to identify as their regular source of care a physician's office and more likely to identify a health center, a clinic, a hospital outpatient department, or an emergency room.** Twenty-seven percent of Hispanics and 22 percent of African Americans, compared with 16 percent of whites, identify their regular source of care as a neighborhood health center or physician clinic. Similarly, Hispanics are twice as likely (10 percent) and African Americans are three times as likely (16 percent) as whites (5 percent) to identify a hospital outpatient department or emergency department as their usual

source of care. Greater reliance on institutional or organized systems of care is an indication that Hispanics and African Americans either prefer these sources or have limited access to physicians in their private offices. (Figure 9)

JHU Database

source of care. Greater reliance on institutional or organized systems of care is an indication that Hispanics and African Americans either prefer these sources or have limited access to physicians in their private offices. (Figure 9)

**Figure 9**  
Usual sources of care: percent reporting each type, 1987  
Persons under age 65



Note: "Other" sources of care not included.  
Source: National Medical Expenditure Survey, 1987

## C2 Use of Physician Services

**Large numbers of low-income Americans do not obtain any care from a physician during the year, and low-income minority Americans are the least likely to get such care.** About half of low-income Hispanics (4.8 million) and half of low-income African Americans (7.4 million), compared with slightly more than a third of whites (13.6 million), reported having made no visits to a physician during a year. Although this analysis does not control for health status, it provides suggestive evidence of disparities in use of physician services, assuming the need for care does not vary substantially among low-income Americans. (Figure 10)

JHU Database

### Hispanics and African Americans, regardless of income or age, made fewer physician visits per year than whites.

Racial/ethnic differences were most pronounced for children. Hispanic and African American children (under the age of 14) made half as many visits on average as white children. (Figures 11a, 11b)

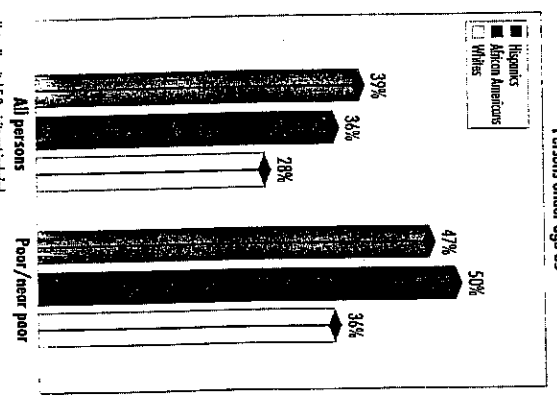
JHU Database

**Individuals with some linkage to a provider (e.g., private physician, clinic, or hospital outpatient department) fare better in gaining**

access than those without a regular provider. When individuals' sociodemographic characteristics, health status, and insurance coverage were similar, the likelihood of their having made a visit to a medical provider was the same whether their regular source of care was a private physician or a clinic or hospital outpatient department. However, Mexican Americans, African Americans, and whites with no regular source of care were less than half as likely to have had contact with a physician as those who identified a private physician as a regular source of care. (Figure 12)

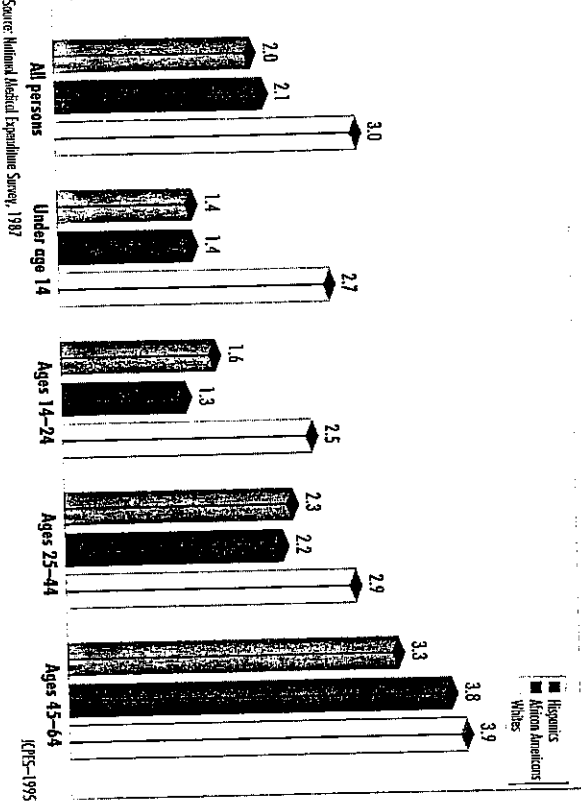
Keith and LaVeist

**Figure 10**  
Percent without physician visits, 1987  
Persons under age 65

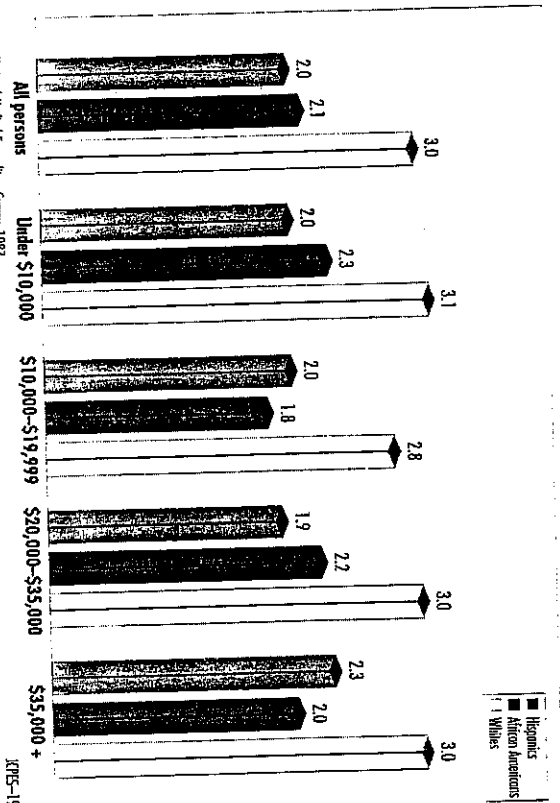


Note: Hospital L.E. visits not included.  
Source: National Medical Expenditure Survey, 1987

**Figure 11a**  
Average number of physician visits per person, by age group, 1987  
Persons under age 65



**Figure 11b**  
Average number of physician visits per person, by income group, 1987  
Persons under age 65

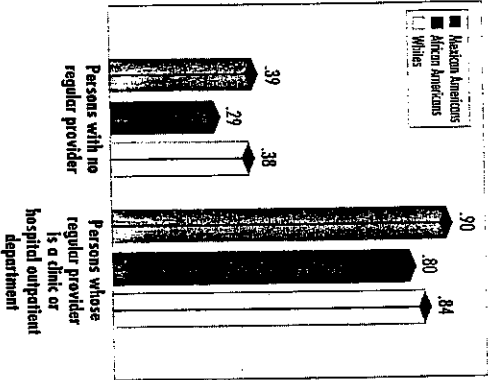


**C3**  
**Use of Hospital Outpatient Services**

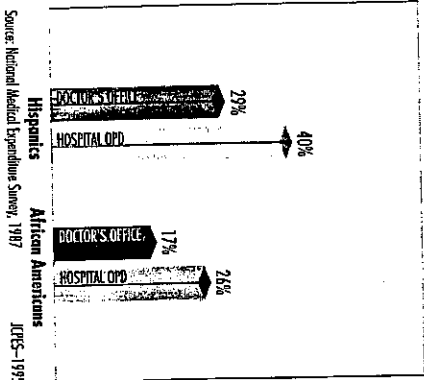
Many regular users<sup>7</sup> of Hospital Outpatient Departments (OPD) would find it financially burdensome to obtain care from private providers because they are uninsured. Regular users of OPDs were sicker and more likely to be uninsured than regular users of private physicians. Hispanics and African Americans who are regular users of OPDs reported about 50 percent more average bed disability days<sup>8</sup> than regular users of private physicians. Additionally, 60 percent of African Americans who were regular users of OPDs either were uninsured or had Medicaid; this compared with less than half of the Hispanic and African American patients of private physicians. (Figures 13a, 13b, 13c)

Cornelius and Suarez

**Figure 12**  
Likelihood\* of an ambulatory visit for persons without a private physician, 1987  
Persons under age 65



**Figure 13a**  
Percent uninsured, by site of care, 1987  
Persons under age 65



Hospital OPDs have the advantage of being more readily accessible, but they lack some of the conveniences of private providers. A larger percentage of regular users of hospital OPDs reported obtaining care on weekday evenings, weekends, and without an appointment than the patients of private physicians. However,

7 A regular user was defined by an individual's self-report of usual source of care.  
8 Bed disability days are defined as days in which illness or injury caused a survey participant to miss work or school, stay in bed more than half the day or otherwise cut down on usual activities, but which did not result in a hospitalization.

more than a quarter of Hispanic (33%) and African American (28%) users of OPDs reported waiting more than one hour to be seen by a medical provider. This compared to 17 percent of Hispanics and 10 percent of African Americans who reporting waiting more than one hour to see their private physicians.

Cornelius and Suarez

Although regular users of hospital OPDs do not necessarily have an ongoing relationship with the same provider, they were as likely to maintain a long-term relationship with the OPD as were regular users of private physicians. Close to two-thirds of African Americans and more than half of Hispanics who were regular users of either OPDs or private physicians had been with the same provider for more than two years.

Cornelius and Suarez

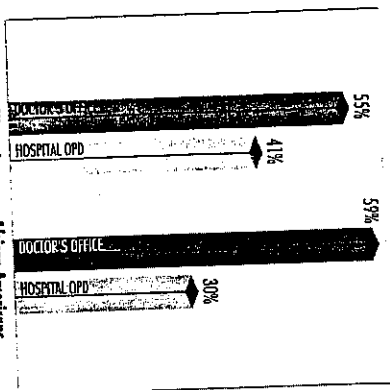
**C4 Use of Emergency Room Services for Nonurgent Care**

African Americans and Hispanics were more likely than whites to make a visit to a hospital emergency room (ER) for a nonurgent medical problem. Twenty-one percent of African Americans and 13 percent of Hispanics, compared with 11 percent of whites, visited the ER for a nonurgent condition.

Thornton and White-Means

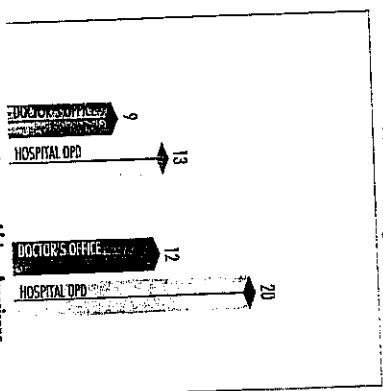
Among Hispanics and African Americans, emergency room use for nonurgent medical problems is more frequent than among whites, and use of other health providers is less frequent. Among people who

**Figure 13b**  
Percent with any private coverage, by site of care, 1987  
Persons under age 65



Source: National Medical Expenditure Survey, 1987  
ICPS-1995

**Figure 13c**  
Mean number of bed disability days,\* by site of care, 1987  
Persons under age 65



\*Bed disability days are defined as days in which illness or injury caused a survey participant to miss work or school, stay in bed more than half the day or otherwise out of town on usual activities, but which did not result in a hospitalization.  
Source: National Medical Expenditure Survey, 1987  
ICPS-1995

made ER visits for nonurgent medical problems. Hispanics and African Americans made 5.7 visits on average to other health providers, while whites made 7.4 visits to other providers. (Figure 14)

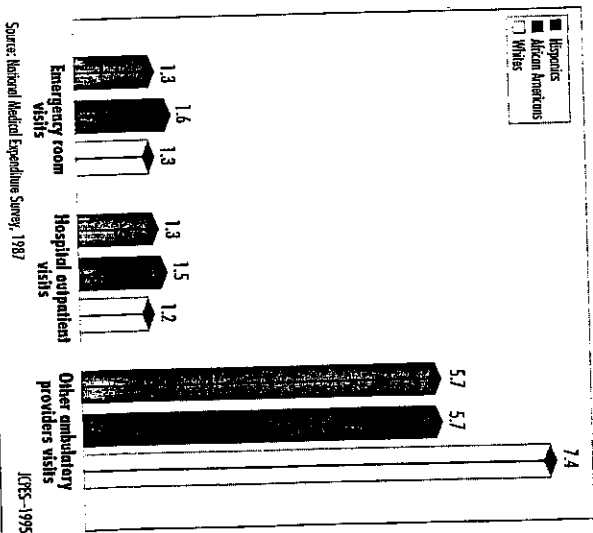
Thornton and White-Means

Lack of a regular provider was one of the most notable factors influencing the use of hospital emergency rooms for nonurgent care.<sup>9</sup> Hispanics and African Americans with no regular provider were, respectively, 1.4 times and 1.5 times as likely to make an ER visit for a nonurgent condition as were their counterparts with a regular provider. Medical problems most likely to prompt a visit to an ER that were classified as nonurgent were: digestive system ailments, impairments of the eye and ear, and fractures and sprains.

Thornton and White-Means

**Among those who received nonurgent care, the average**

**Figure 14**  
Average number of visits, for those with at least one visit to an ER for a nonurgent medical problem, 1987  
Persons under age 65



Source: National Medical Expenditure Survey, 1987  
ICPS-1995

9 The ER visit was defined as "nonurgent" if it: (1) was not physician initiated; (2) did not result in a hospital stay; or (3) did not entail a surgical procedure. While the three exclusionary indicators do not reveal all causes of persons with "true" emergencies, the data do not allow further sorting for nonurgent and urgent cases.

10 See Shelley L. White-Means and Michael C. Thornton, "What Cost Savings Could Be Realized by Shifting Patterns of Use From Hospital Emergency Rooms to Primary Care Sites?" *The American Economic Review*, Vol. 85, No. 2 (May 1995), pp. 138-142.



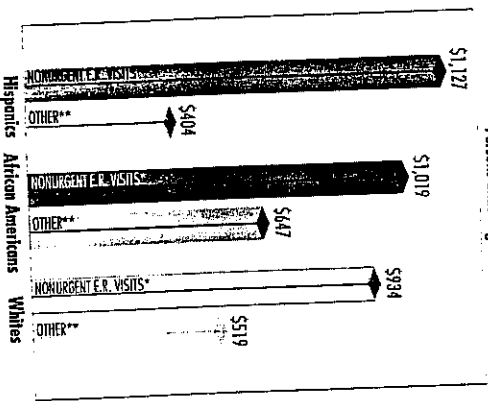
**C5**  
**Implications for Policy and Practice**

Since physicians generally are the primary point of entry into the health system, the failure to make a physician visit during the year is a revealing indicator of a population's access to a range of health services, including preventive, primary, and specialty care. That low-income racial/ethnic minority groups use physician services less frequently than whites of comparable income suggests that minority and economic status combine to create a double disadvantage in the health marketplace.

Some of this disparity results from the limited supply of health resources in poor and racial/ethnic minority communities. A number of strategies, including the expansion of hospital outpatient departments and establishing neighborhood health centers, have been undertaken since the 1960s to expand the number of providers in underserved communities. Evidence shows that these resources are in fact being used as intended, an indicator of their success. Evidence that hospital-based providers and neighborhood health centers afford a level of access to the system commensu-

rate with that available through the use of private providers is promising news. However, the use of hospital-based delivery sites for primary care, particularly the use of emergency rooms, must be carefully monitored. Diagnosis and treatment are enhanced by a provider's knowledge of a patient's history and the quality of the provider-patient relationship, and this type of knowledge and a quality relationship both suffer in the hospital-based setting, where costs are higher as well. Nonetheless, the finding is an indication that individuals with some linkage to a provider fare better in gaining access to care than those without a regular provider.

**Figure 15**  
Average medical expenditure for persons with nonurgent ER visits vs. all others, 1987  
Persons under age 65



\* Indicates at least one nonurgent ER visit during the year.  
\*\* Indicates at least one ambulatory visit during the year, with all nonurgent visits made at non-ER sites.  
Source: National Medical Expenditure Survey, 1987

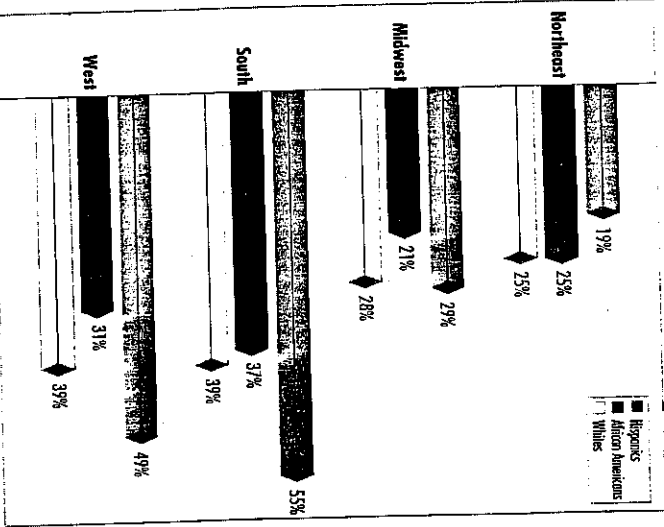
**GEOGRAPHIC AND RACIAL/ETHNIC DISPARITIES IN ACCESS TO CARE**

**D1**  
**Disparities in Health Coverage**

The extent of health coverage is influenced by geographic-specific policies and practices as well as factors such as income and race/ethnicity. Compared with their counterparts in the Northeast, low-income Hispanics in the South were nearly 3 times as likely to be uninsured (19% vs. 55%). Similarly, among low-income African Americans, those in the South were 50 percent more likely to be uninsured than their counterparts in the Northeast (37% vs. 25%). (Figure 16)

the South, 40 percent more Hispanics than whites were uninsured (55% vs. 39%). In the West, about 30 percent more Hispanics than whites were

**Figure 16**  
Percent of poor/near-poor persons with no health coverage, by region, 1987  
Persons under age 65



Source: National Medical Expenditure Survey, 1987

uninsured (49% vs. 39%).  
(Figure 16)

Lillie-Blanton and Lillie

**D2**  
**Regional Differences in Use of Physician Services**

**Low-income African Americans and whites have easier access to care in the Midwest than their respective counterparts in the South.** The proportion of low-income African Americans who did not get care from a physician within a year was 20 percent higher in the South than in the Midwest (53% vs. 44%). Similarly, low-income whites in the South were more likely than their counterparts in the Midwest to get no care from a physician within a year (41% vs. 32%).

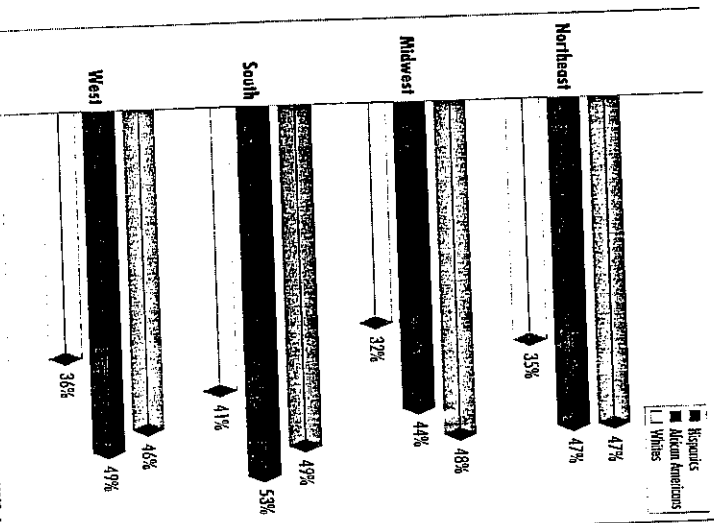
Low-income Hispanics had equally poor access in all four regions, with the percentage not making a physician visit ranging from 46 percent in the West to 49 percent in the South.  
(Figure 17)

Lillie-Blanton and Lillie

**Racial/ethnic disparities in the use of physician services exist in all four regions.**

Racial/ethnic disparities in the percent without a physician visit were largest in the Midwest and smallest in the South. In the Midwest, low-income Hispanics were 50 percent more likely than low-income whites to be without a physician visit (48% vs. 32%), and low-income African Americans were 36 percent more likely than low-income whites to be without a physician visit (44% vs. 32%). Even in the South, which had the poorest access to care for all three

**Figure 17**  
**Percent of poor/near-poor persons without physician visits, by region, 1987**  
Persons under age 65



Source: National Medical Expenditure Survey, 1987

IGHS-1995

racial groups, there was evidence that Hispanics and African Americans experience greater barriers to care than whites.<sup>11</sup>

Lillie-Blanton and Lillie

**D3**  
**Implications for Policy and Practice**

The consistency of racial/ethnic disparities in the use of physician services in all regions of the U.S. indicates that race-specific as well as geographic-specific factors contribute to lower rates of service use. Even in regions where the percentages without health insurance coverage are similar, 12 racial/ethnic disparities exist in the care obtained. Disparities in the South and West are of particular concern, since these two areas have the largest concentrations of Hispanics and African Americans.

Disparities in access among these regions reflect both employment patterns and public policies. The South has greater agricultural employment and less generous health benefits than the Northeast. Federal and state policies, which differ significantly, affect the

number of individuals with publicly financed coverage and the number that have no insurance at all. Some public policies also have differential impacts on specific racial/ethnic population groups. For example, Medicaid eligibility requirements that exclude two-parent families adversely affect Hispanics and whites more than African Americans, since more low-income Hispanic and white children are in two-parent families. In addition, the role that subtle and overt discriminatory practices can play in limiting minority populations' access to health care must be considered.

These differences in access have implications for proposals that seek to limit the federal role in health. They suggest that state-driven health reforms could fall short of achieving equitable access to care within and between states. While the federal government is perceived in some places as an intruder in the sovereign affairs of state and local governments, efforts to limit federal involvement in the financing of health care will likely perpetuate geographic

<sup>11</sup> The percentage of African Americans without a physician visit differed reliably from the rate for whites in all four regions. Estimates of health services used by Hispanics differed reliably from that of whites only in the Midwest; the failure to find a reliably different rate, however, could also have been a consequence of the smaller Hispanic sample sizes for analyses by region.

<sup>12</sup> For low-income Hispanics, the percent uninsured did not differ reliably from that of low-income whites in the Northeast and Midwest. For low-income African Americans, the percent uninsured did not differ reliably from that of their white counterparts in any of the regions.

inequities in access. These inequities themselves are a consequence of variation by state in financial

wealth, in employment, and in the public's commitment to achieve more equitable access to care.

## CONCLUSIONS

Although the U.S. has achieved tremendous gains in access to care in the last 25 years, the nation's system for financing and delivering health services continues to exclude millions of Americans and inadequately care for others. This reality exists even though the U.S. health system is more costly per capita than the health systems of most other industrialized nations. Unfortunately, race and ethnicity in the U.S. continue to be powerful determinants of life experiences and opportunities. Although low-income minority groups experience the most acute barriers in access to care, higher-income Hispanics and African Americans also confront barriers.

If further gains in reducing these racial/ethnic disparities are to be achieved, a combination of strategies will be required, including some restructuring of the financing and service delivery systems that have been built over the last 30 years. The existing mix

of public/private financing is flawed in many respects, but it has also provided the means for the gains achieved to date. The public/private service delivery infrastructure within Hispanic and African American communities is generally weak, ill-equipped, and undercapitalized for the transitions currently occurring toward more organized systems of care delivery. Nonetheless, until a better system can be created, the challenge facing those concerned with the health of minority populations is to build upon the foundation that exists and to resist political pressures that threaten to erode the systems of care now serving millions of uninsured and underinsured minority Americans.

Through the analysis of national survey data and discussions at policy forums organized by the project, several issues have emerged as key for remedying the inequities described in this report.

### System of Universal Coverage

Of utmost importance is the need for a system of health coverage in the U.S. that does not compromise access to coverage based on racial/ethnic differences in income or employment. Without greater equality in the opportunity to obtain coverage, the current disparities will persist. Inequities in health coverage have consequences for the availability of health resources in low-income communities and compromise the health of a sizable sector of the population.

Given an increasingly diverse workforce, reducing inequities in access to coverage is a social investment. *Including* all Americans in the system of health insurance coverage not only is an issue of fairness but also could foster the development of a health care sector that is financially sound. It is shortsighted and ultimately costly public policy to exclude millions of Americans—who in percentages are disproportionately Hispanics and African Americans, though in absolute numbers are primarily whites—from the benefits of the U.S. health care system.

### Sociocultural Competence of the Health System

This research provides evidence of the importance of systems of care

that are socioculturally competent. Obstacles to care sometimes arise from people's responses to sociocultural differences, which can reflect their prejudices about racial/ethnic minority groups or about institutional practices. In other cases, obstacles to care arise from insufficient and inaccurate information or differences in expectations. Access to care, therefore, is hindered by individual attitudes, such as patients' distrust of providers and the prejudices of providers themselves. Moreover, these patient and provider attitudes heavily influence one another, with new barriers arising from negative experiences.

Some of the cultural insensitivities of providers are not intentional efforts to discourage the use of health resources, but arise from a lack of awareness of social customs or of the social environment of the populations served. For example, providers may well be unaware that services usually defined as ancillary (e.g., transportation, translation, and interpretation) are in fact essential for access by low-income minority patients. One means of promoting cultural and linguistic competency is to increase support for the training, recruitment, and retention of a workforce that reflects the sociocultural composition of the

## CONCLUSIONS

communities served. In short, public and private health providers must become more sensitive and responsive to these and other needs of a diverse client population and workforce.

### Primary Care Health Services Infrastructure

The analyses provide evidence that health insurance coverage is "essential but not sufficient" for improving access to care. Among both insured and uninsured alike, having a regular provider was an important determinant of access. Moreover, having any regular provider was a *more* important determinant of access than the specific caregiver (i.e., a private physician, a community health center, or hospital-based primary care site). Thus, efforts to improve the health services delivery infrastructure within and available to minority communities are important. Assuming that every individual has a regular provider, one that is both geographically accessible and culturally competent, should be the goal.

### Federal/State and Public/Private Roles in Assuring Equitable Access

Finally, the persistence of geographic and racial/ethnic disparities weakens the capacity of the nation as a whole to face the challenges ahead. Yet the current

public-private mix of health coverage reflects state-specific as well as region-specific patterns of employment and financial resources. Thus, remedying these inequities cannot be the sole responsibility of either the federal or the state governments. State and local governments, faced with reductions in federal funding of local services in the 1980s, have inadequate resources in the 1990s to manage current services, much less to anchor expansions into new areas of need. As such, a shared responsibility is required. Both levels of government have used a combination of approaches to improve access to care. (See Appendix III: Federal and State Laws Affecting Minority Access to Health Care.)

In the current political climate, the use of government planning and regulatory mechanisms to achieve national goals of equitable access is discouraged. It is argued that market forces should and can correct deficiencies in the U.S. health system. Yet historically government has intervened in the health market because of the inability or, in some cases, unwillingness of the private sector to address long-standing problems in access. If current policies are maintained, there is little basis to assume that market forces will respond any differently *now* than

in the past to those who are uninsured or inadequately insured.

Although the sentiment of the voting public toward the role of government certainly has shifted, there is little evidence that the public wants government to abandon its role of protecting this country's national interests. There

is considerable evidence, however, that the public wants government to perform its job in the most cost-efficient manner possible. As such, there is an urgent need to heighten awareness and achieve some level of consensus on public/private and federal/state roles in assuring equitable access to care.

## THE NATIONAL MEDICAL EXPENDITURE SURVEY: A DESCRIPTION OF THE DATABASE

### Data Source

To provide policymakers, practitioners, and advocates with an objective account of the nation's progress in reducing barriers to care that confront Hispanics and African Americans, this project analyzed national survey data and convened two public policy forums to discuss issues regarding the research agenda and findings. Findings presented in this report are based on analysis of the 1987 National Medical Expenditure Survey (NMES) data. NMES, sponsored by the U.S. Department of Health and Human Services, provides the most nationally representative estimates of health care use and expenditures that are currently available. The research undertaken for this project is the most comprehensive examination of the NMES data with a focus on Hispanics and African Americans.

### Methodology

NMES obtained information from a nationally representative sample of the civilian noninstitutionalized population

in the continental United States. The survey was fielded in four interview rounds at approximately four month intervals. The study design included an oversampling of low-income, African American, and Hispanic households. The household sample was selected using a stratified multistage probability design yielding a sample of 36,400 individuals in roughly 15,000 households.<sup>1</sup> Data were obtained for about 86 percent of eligible households in the first round of interviews and 80 percent in the fourth round.

Project researchers primarily analyzed data collected during the first round of interviews. The statistical package called SUDAAN (Professional Software for Survey Data Analysis)<sup>2</sup> was used to obtain weighted population estimates and standard errors. This package allows weights to correct for oversampling and biases due to nonresponse and the complex multistage sampling design of NMES. All but one research team used SUDAAN in developing estimates and testing relationships between measures of health services use or expenditures.<sup>3</sup>

1 For a detailed description of the questionnaire design and data collection procedures, see W. S. Edwards and M. Behin, *Questionnaires and Data Collection Methods for the Household Survey and the Survey of American Indians and Alaska Natives*, DHHS Pub. No. PHS 89-3450 (Rockville, Md.: Public Health Service, 1989).

2 Research Triangle Institute, Research Triangle Park, N.C.

3 The research team of Thornton and White-Means chose not to use SUDAAN. These authors acknowledge that SUDAAN could yield slightly larger standard errors, resulting in some statistically significant variables becoming insignificant. The authors, however, note that population characteristics used in the sampling design were controlled in the multivariate analysis to account for possible sources of bias due to oversampling. Thus, they have confidence in their results.

Appendix II

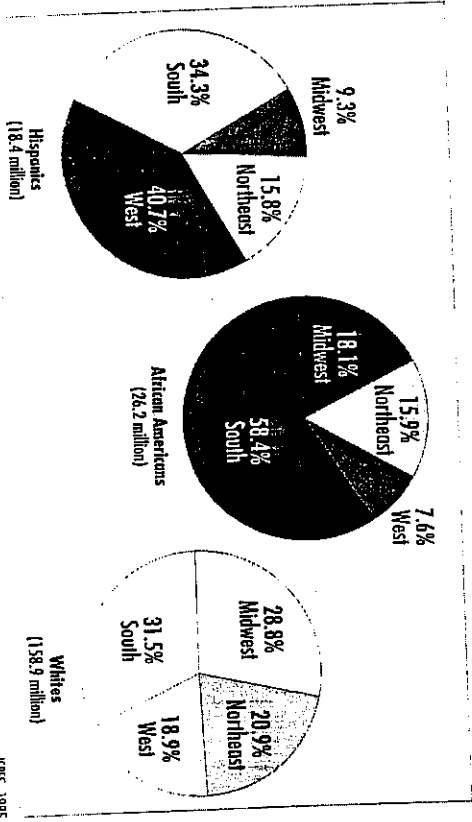
# THE STUDY POPULATION: A SOCIODEMOGRAPHIC AND HEALTH PROFILE

The study population for these analyses consists of persons under age 65 who were Hispanic, African American, or white. Of this population (204 million persons) in 1987, 9 percent were of Hispanic origin and 13 percent were African Americans. About three-quarters (78 percent) of the population were white, not of Hispanic origin. Race and ethnicity were defined based on self-reported survey information. Three mutually exclusive racial/ethnic categories were constructed for the analysis and used by all the research teams: (1) black, not of Hispanic origin; (2) Hispanic; and (3) white, not of Hispanic origin.

Respondents who reported their racial background as American Indian, Alaskan Native, or Asian and Pacific Islander were excluded from this analysis.

**Demographics.** In contrast to whites, Hispanics and African Americans are geographically concentrated in several regions of the U.S. While Hispanics live predominantly in the South and West, the majority of African Americans live in the South (see Figure A1). Of the 26 million African Americans, over half (58%) live in the South. African Americans also represent a larger share of the total population in

**Figure A1**  
Geographic distribution of study population, 1987  
Persons under age 65



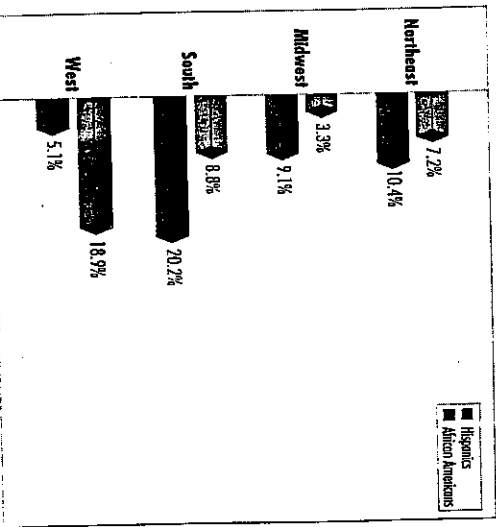
the South (20%) than their average of 13 percent of the U.S. population. Of the 18.4 million Hispanics, three-quarters live in either the West (41%) or the South (34%). However, only in the West is the proportion of Hispanics (19%), as a share of the total population, greater than their average of 9 percent of the U.S.

population (see Figure A2). Both Hispanics and African Americans are more likely than whites to live in large urban areas. Thus, policies and practices of states in the South and West and in urban areas are important determinants of access for Hispanics and African Americans.

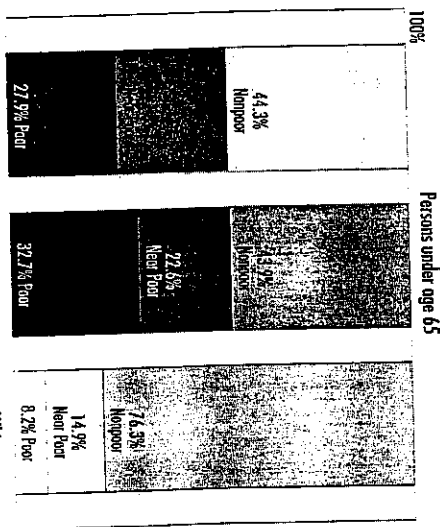
**Income.** Hispanics and African Americans are financially less well off than whites. Not only were poverty rates in 1987 higher among Hispanics and African Americans than among whites, but a larger percentage of Hispanics (27%) and African Americans (23%) than of whites (15%) have incomes between 100 and 200 percent of the poverty level (see Figure A3).

**Health.** The health of racial/ethnic minority Americans continues to lag behind that of white Americans. The proportion of Hispanics (20%) and African Americans

**Figure A2**  
Percent of population that is Hispanic or African American, by region, 1987  
Persons under age 65



**Figure A3**  
Poverty status of U.S. population: distribution within race/ethnic groups, 1987  
Persons under age 65



Note: The incomes of the poor are defined as 100% or less of the poverty level; those of the near poor are 100-199% of the poverty level, and those of the nonpoor are 200% or more of the poverty level.  
Source: National Medical Expenditure Survey, 1987

(20%) who are in fair or poor health is twice that of whites (11%). There are also racial/ethnic differences in work days lost due to illness or injury. Differences are most pronounced for persons ages 19 to 44. Sixty percent more African Americans (5%) than whites (3%) report they are unable to work because of their health. Hispanics, despite evidence of being in poorer health, do not differ greatly from whites in lost work days due to health reasons.

Analysis of 1988 mortality data shows that for several leading causes of death, racial/ethnic disparities persist for children and adults (see Figure A4). For example:

- Not only are African American children more likely than whites to die during their first year of life, but deaths from homicide for children ages 1 to 14 are at least two times higher for African American and Hispanic children.
- African Americans, ages 45 to 64, have a three-times-higher rate of mortality from stroke than whites of the same age group.
- Hispanics and African Americans, ages 25 to 44, have at least a twofold higher risk of mortality from HIV infection and homicide than whites.
- It is not until age 65 that racial/ethnic disparities are reduced or eliminated.

Even when comparing African Americans and whites in the same income groups, differentials persist, although the magnitude of the differences is smaller (see Figure A5). The poorer health of minority populations is a consequence of a combination of factors, including years of neglected health needs, exposure to social

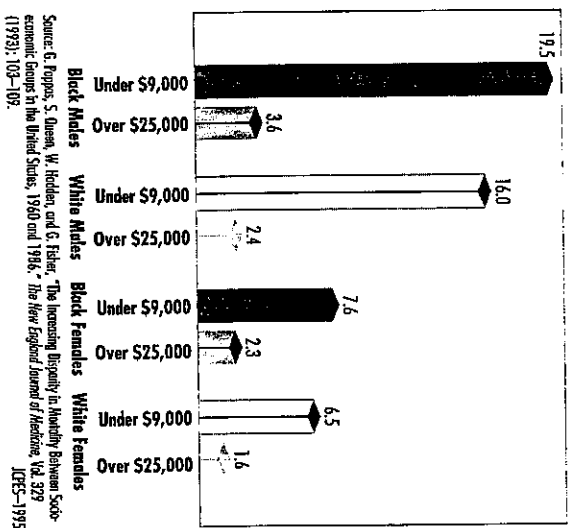
**Figure A4**  
Ratio of African American and Hispanic death rates to white death rates, for selected causes and age groups, 1988

Selected causes	Ratio of African American and Hispanic death rates to white death rates, 1988	
	African Americans	Hispanics
<b>Age group 1-14</b>		
Total	1.6	1.0
Injuries	1.5	0.9
Homicide	5.0	2.0
Malignant tumors	1.0	1.0
Other	1.6	1.1
<b>Age group 15-24</b>		
Total	1.5	1.2
Injuries	0.7	0.9
Homicide	7.4	3.5
Suicide	0.6	0.7
Other	2.0	1.2
<b>Age group 25-44</b>		
Total	2.5	1.2
Injuries	1.4	1.2
Homicide	7.0	3.1
Diseases of the heart	2.6	0.7
HIV infection	3.6	2.3
Other	2.3	1.1
<b>Age group 45-64</b>		
Total	1.7	0.8
Injuries	1.7	1.2
Diseases of the heart	1.7	0.7
Malignant neoplasms	1.4	0.5
Cerebral vascular diseases	3.0	1.1
Other	2.1	1.1
<b>Age group 65+</b>		
Total	1.1	0.7
Diseases of the heart	1.1	0.6
Malignant neoplasms	1.2	0.6
Cerebral vascular diseases	1.2	0.6
Other	1.1	0.8

Source: M. Ulfshagen, R. Muntner, et al., "Latin and African American Women: Continuing Disparities in Health," *International Journal of Health Services*, Vol. 23, No. 3 (1993), based on data from the U.S. Department of Health and Human Services, *Health United States*, 1992. ICR5-1995

environmental conditions that are risks for ill health, and persistent barriers in access to health care. This project examined the extent to which barriers to care continue to compromise the health of minority populations.

**Figure A5**  
Mortality rates by family income, race, and gender, 1986 (deaths per thousand people) Adults 25 to 64 years of age



Source: G. Foggs, S. Queen, W. Hodges, and G. Fisher, "The Increasing Disparity in Mortality Between Socioeconomic Groups in the United States, 1960 and 1986," *The New England Journal of Medicine*, Vol. 329 (1993): 103-109. ICR5-1995

# FEDERAL AND STATE LAWS AFFECTING MINORITY ACCESS TO HEALTH CARE

**Table A1**  
Key federal laws affecting minority populations' ability to access care

PROVISION <sup>1,2</sup>	DESCRIPTION <sup>3,4</sup>
<b>Financing to expand access to third-party coverage</b>	
<ul style="list-style-type: none"> <li>• Medicare<sup>1</sup></li> <li>• Medicaid<sup>2</sup></li> <li>• Disproportionate Share Hospital (DSH) payment provision of Medicaid<sup>3</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Federal health financing program for the elderly (age 65+) and disabled.</li> <li>• Federal/state health financing program for certain categories of the poor.</li> <li>• Additional payment to providers by HHS for provision of services where hospitals serve a disproportionate share of low-income people.</li> </ul>
<b>Financing to develop health resources (providers and facilities)</b>	
<ul style="list-style-type: none"> <li>• Migrant and Community Health Centers (MHCs CHCs)<sup>4</sup></li> <li>• Public Health Service Act; Title VII: Physicians, dentists, physician assistants, and allied health professionals<sup>5</sup></li> <li>• Title VIII: Nurses, nurse practitioners, and nurse-midwives<sup>6</sup></li> </ul>	<ul style="list-style-type: none"> <li>• MHCs provide a comprehensive range of primary health services to migrant and seasonal farmworkers and their dependents. CHCs and provide basic primary medical services to persons located in rural and urban areas with financial, geographic, or cultural barriers to care.</li> <li>• Since 1962, Congress has established over 40 programs to improve the supply and distribution of health providers. Of these, at least eight programs targeted the recruitment and retention of health professionals from minority and/or disadvantaged backgrounds</li> </ul>
<p><sup>1</sup> 42 USC sect. 1396 (a).    <sup>2</sup> 42 USC sect. 1396.    <sup>3</sup> Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.    <sup>4</sup> Sections 329 and 330 of the PHS Act.    <sup>5</sup> 1963.    <sup>6</sup> 1964.</p>	

*Continued on next page*

*Table A1 continued*

PROVISION <sup>7,8</sup>	DESCRIPTION <sup>9,10</sup>
<ul style="list-style-type: none"> <li>• The Disadvantaged Minority Health Improvement Act, 1990<sup>7</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Established the Office of Minority Health within the Office of the Assistant Secretary of Health. Provides grant programs and medical and health education loan programs for improvement of minority health.</li> </ul>
<b>Protections to reduce the potential for discrimination by providers on the basis of race, income, public insurance status, or disability.</b>	
<ul style="list-style-type: none"> <li>• The Hill-Burton Act<sup>8</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Provided federal matching dollars for local governments to renovate, expand, or construct hospitals in order to equalize resources among states and among urban/rural areas. The recipients of such funds made certain assurances known as the "community service obligation and the uncompensated care obligation."</li> </ul>
<ul style="list-style-type: none"> <li>• Title VI of the Civil Rights Act, 1964<sup>9</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Prohibits discrimination by a service provider that receives federal funds. Provides for enforcement in the event of a breach of the statute or regulations.</li> </ul>
<ul style="list-style-type: none"> <li>• The Emergency Medical Treatment and Active Labor Act<sup>10</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Enacted to combat the practice by hospitals of refusing to treat patients unable to pay or transferring such patients to another, usually public, hospital. Hospitals under Medicare agreements cannot transfer or discharge a patient who has an "emergency medical condition" or who is in active labor.</li> </ul>
<ul style="list-style-type: none"> <li>• Section 504 of the Rehabilitation Act of 1973<sup>11</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Prohibits discrimination against people with disabilities by recipients of federal funds, the federal government itself, and federal contractors.</li> </ul>
<ul style="list-style-type: none"> <li>• The Americans with Disabilities Act, 1990<sup>12</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Prohibits discrimination on the basis of disability by private entities in the workplace and places of public accommodation. Requires new places of public accommodation and commercial facilities to be designed and constructed to be readily accessible by persons with disabilities. Combines elements of the Civil Rights Act of 1964 and Title V of the Rehabilitation Act of 1973.</li> </ul>

<sup>7</sup> 42 USC sect. 3004 et seq.    <sup>8</sup> The Hospital Survey and Construction Act of 1946, P.L., 42 USC sect. 291 et seq.; superseded by the National Health Planning and Resources Act of 1975, P.L. 42 USC sect. 601-2/42 USC 2000d    <sup>9</sup> 42 USC sect. 1395dd.    <sup>10</sup> 42 USC sect. 1395dd.    <sup>11</sup> 29 USC sect. 794    <sup>12</sup> 42 USC sect. 12102(2).



**Table A2**

**Key state-administered laws and programs affecting minority populations' ability to access care**

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PROVISION	DESCRIPTION
<b>Financing to expand access to services in the private marketplace</b>	
<ul style="list-style-type: none"> <li>• Medicaid<sup>2</sup></li> <li>• Provider payment mechanisms, trust funds</li> </ul>	<ul style="list-style-type: none"> <li>• Federal/state health financing program for certain categories of the poor.</li> <li>• Hospital rate setting mechanisms, trust funds.</li> </ul>
<b>Provision of services directly</b>	
<ul style="list-style-type: none"> <li>• Preventive health services</li> <li>• Primary care services</li> <li>• Public hospitals</li> </ul>	<ul style="list-style-type: none"> <li>• Traditional public health functions of infectious disease control, immunization.</li> <li>• Community clinics, neighborhood health services for the medically indigent.</li> <li>• Provide inpatient, primary, and specialty care services.</li> </ul>
<b>Regulation of insurance industry by state insurance department</b>	
<ul style="list-style-type: none"> <li>• License and monitor insurer financial solvency</li> <li>• McCarran-Ferguson Act of 1945</li> <li>• National Association of Insurance Commissioners</li> </ul>	<ul style="list-style-type: none"> <li>• State legislatures establish rules under which insurance companies must operate, enforced by state insurance departments. They approve rates and protect consumers from unfair business practices.</li> <li>• Affirmed the primary responsibility of states for regulating the insurance industry.</li> <li>• A voluntary association consisting of heads of the insurance departments of the 50 states, the District of Columbia, and four US Territories. The (NAIC) model laws, regulations, and guidelines models are not mandatory, but some states have adopted the same or similar models.</li> </ul>

*Continued on next page*

<sup>1</sup> Legislative provisions, if any, vary by state. Health care policies and statutes are developed under a state's broad police powers to regulate for the health, safety, and welfare of its citizens. 42 USC sect. 1396 (a).  
<sup>2</sup> 42 USC sect. 1396.

*Table A2 continued*

PROVISION	DESCRIPTION
<ul style="list-style-type: none"> <li>• Employee Retirement Income Security Act (ERISA)</li> </ul>	<ul style="list-style-type: none"> <li>• Constrains the ability of states to regulate employer-sponsored health funds that choose to self-insure. The ERISA exemption, as interpreted by the Supreme Court, has produced a divided system for regulating health benefits in each state such that the federal government has authority to regulate self-insured employee health plans, but not health policies sold by insurance companies.</li> </ul>
<b>Constitutional requirement</b>	
<ul style="list-style-type: none"> <li>• Fourteenth Amendment to the US Constitution</li> </ul>	<ul style="list-style-type: none"> <li>• Equal protection clause prohibits discrimination based on race, national origin, or alienage.</li> </ul>

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## BIOGRAPHICAL SKETCHES OF RESEARCHERS AND STAFF

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Dr. Alfaro-Correa, coauthor of the project summary report, is currently a research fellow in the Department of Epidemiology and Preventive Medicine at the University of Maryland School of Medicine. She earned her Sc.D. from the Johns Hopkins University School of Public Health.

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Dr. Bernstein, a labor economist at the Economic Policy Institute, does research on labor markets, wage and employment trends, income and earnings inequality, and issues related to poverty. He earned his Ph.D. in social welfare from Columbia University.

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Dr. Castro is an associate professor in the Department of Psychology and has served as director of the Hispanic Research Center at the Arizona State University. His research interests include the prevention and treatment of AIDS and drug and alcohol abuse. Dr. Castro earned his Ph.D. in clinical psychology at the University of Washington.

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Ms. Coe serves as a research administrator for Compainers en la Salud with the Hispanic Research Center at the Arizona State University. Her research interest is in the effect of cultural

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Ms. Harmon was a senior research specialist at the Hispanic Research Center at the Arizona State University between 1992 and 1994. She currently works for the AIDS Research Consortium in Atlanta, Georgia. Her research interests are in sociology and demography. Her M.A. in sociology is from the University of Kentucky, and she also has taken Ph.D. courses in rural sociology and demography at the Pennsylvania State University.

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