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Hugh Price's Radical Alternative to Farrakhan

It's easy to sound radical. Bluster, hatred and accusation usually do the trick. But messages cast in these terms are usually not radical at all. They don't challenge anybody to do anything except smolder in resentment. They don't lead to change. By contrast, ideas built on cool reason and the possibility of action often sound moderate. But they can be genuinely radical in their analysis of what's wrong and of what needs to be done.

That is what lies behind the important speech given on Sunday by Hugh Price, the new president of the Urban League, at the group's Indianapolis convention. Price's address will rightly get a lot of praise for his denunciation of antisemitism, his call for cooperation across racial lines and his insistence that while racism remains an important problem, it cannot explain all that ails the African American community. Many will also note Price's emphasis on personal responsibility and his call on African Americans who have made it to "tithe with our time and, more importantly, our money" on behalf of inner-city kids.

But if the praise stops there, it will miss a central point of Price's speech and the genuinely radical message that underlies it. Price is challenging complacency by arguing that there is a deep disorder in the American economy that is leading it to fail a large class of Americans—including many African Americans but also many others. Price argues that "the global realignment of work and wealth" is a "bigger culprit" than racism.

"Marvelous as the market economy works for most Americans, it has all but collapsed for inner-city folk," Price declared. "There are fewer and fewer jobs for low-skilled workers, especially males. And the wages for those jobs that exist are just plain lousy, all too often at or below the poverty line," Price declared.

"Government invests lots of money in job training," he added, "but largely avoids the ideologically uncomfortable question of whether the market economy is actually creating enough jobs for everyone in the inner city who wants to or is expected to work."

Price offers the unfashionable but compelling view that if a lack of jobs is the problem, the government should consider creating "a new, labor-intensive public enterprise to perform services valued by the taxpayers."

"Critics of government jobs programs usually say it's the private sector's responsibility to create jobs," Price said. "I agree in principle. But when the private labor market comes up woefully short, as it does today in the inner city, then government must step in if people are to work."

To his great credit, Price is throwing down the gauntlet to both black separatism and white indifference. That takes courage, because neither side will really want to listen to all that he's saying. Maybe that's why his speech got so little publicity. You get more ink and television face time by linking up with Minister Farrakhan.

The problem with black separatism and black nationalism is that by defining the whole problem facing black America as involving an undifferentiated white racism, it actually lets whites get themselves off the hook. Most whites aren't racist now in the sense that Bull Connor and southern segregationists were racist. Racism persists, but the barriers facing African Americans simply aren't the same now as they were 40 years ago. As Price said, "for millions of black folk who, thanks to the civil rights movement, have flooded into higher education, big corporations and their own mainstream businesses, these clearly are the best of times." Even liberal whites have begun to dismiss the "it's all white racism" explanation of inner-city troubles as inadequate.

Anti-white nationalism also plays a terrible trick on the oppressed. Farrakhan's antisemitism is a grave moral evil, as racism is also a grave moral evil. But antisemitism, like racism, is something else as well. It's a con job. Antisemitism asserts something utterly false—that "the Jews" are responsible for the suffering of African Americans—and thereby diverts attention from the real problems facing the inner city, those outlined by Price. As someone might have put it in the '60s, Farrakhan is playing the power structure's game. His message challenges no one. That's what was wrong with Ben Chavis of the NAACP giving Farrakhan a forum. In doing so, he helped legitimize a vision that's not only morally flawed but also leads nowhere.

Nationalism fails in another respect. If the problems of African Americans are defined solely in racial terms, then the solutions come down to new set-aside programs and the like. But "the system"—the power structure, if you will—can easily accommodate a few more set-aside programs. The real challenge to the way the system works comes from Price. On behalf of the poor and the unemployed of all races, he is asking for much farther-reaching change.

That's what white Americans who may be cheering Price need to bear in mind. His is not a soft multi-racialism but a hard challenge. He is challenging well-off white Americans to make changes in an economy that is working well for them is not working well for everybody. He is challenging well-off African Americans to a new engagement with the children of the inner city. He is challenging less affluent whites to see that the workings of the new economy give them a powerful shared interest with African Americans in social justice. And he is challenging the African American poor to fight the culture of violence and despair.

What's the alternative to Price's challenges? Farrakhan is gaining ground in the inner city precisely because of the level of suffering there. If advocates of multi-racialism do not offer realistic hope, all the denunciations of Farrakhan will be useless. As Julius Lester put it in the current issue of Dissent: "Farrakhan offers an ugly and hateful vision. It is no longer sufficient to express disapproval. It is time we offered an alternative. If we do not, we cede moral authority to those who, in their self-hatred, hate us all." The alternative Hugh Price is offering is that we help each other.

URBAN LEAGUE

Health care as a civil rights issue
Econ. empowerment
Black Americans / Urban Americans
Black Med Assn.

Human terms
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Implications of the Clinton Health Reform Proposal for Black Americans

by

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This paper examines the implications for black Americans of the health care reform proposal outlined by President Clinton in his speech to the nation on September 22, 1993. The first section briefly describes the Clinton plan. Next, the socioeconomic and health characteristics of black Americans that have bearing on the impacts of the Clinton reform plan are noted. Third, specific likely implications for black Americans of the Clinton proposal are presented under three broad headings -- programmatic structure, federal role, and state role. The last section contains conclusions from the analysis.

THE CLINTON PROPOSAL FOR HEALTH REFORM

The Clinton reform plan would provide a comprehensive set of health care benefits to all citizens and legal residents as a result of their membership in a national network of health alliances and their receipt of a health security card. Each state would be divided into health alliance coverage areas, and all eligible residents (except those covered by corporate alliances through their places of employment or other affinity group such as Medicare enrollees) would join the alliance for the area in which they live. Although enrollment in a plan would be mandatory, alliance members would have a choice among several types of plans (e.g., fee-for-service, health maintenance organization (HMO), or preferred provider organization (PPO)) for their health services.

Health alliances would function as collective bargaining agents to secure for their members (or enrollees) the best prices for the benefits provided. Alliances would not, however, be service providers. Premiums (paid jointly by employers and enrollees) and federal subsidies

would be paid to the alliances (on behalf of former Medicaid beneficiaries, for example) to finance their operations, and to reimburse providers of health care services through contractual agreements with various health plans. Premiums would be capped as a means to control the growth rate of health expenditures for the nation.

Employers would pay up to 80 percent of premium costs (up to 3.5 percent of payroll for small employers and 7.9 percent of payroll for employers with more than 50 workers), and employees would pay 20 percent of costs. Health insurance premiums for part-time employees would be a pro-rated share of premiums for full-time workers, and part-time employees and their employers would pay, respectively, 20 percent and 80 percent of these reduced premiums. The unemployed would join health alliances and pay their own health care premiums up to 2 percent of their income. Employers would be able to deduct contributions for premiums from their taxable income, and these contributions would not be considered as income for the employee up to the value of the comprehensive benefits package. Health insurance premiums paid by the self-employed would be tax-deductible.

A National Health Board would set budgets for the health alliances and review plans submitted by the states for program implementation. Although the Board would monitor the progress of states in establishing health alliances and would guarantee full implementation of the proposed system by 1997, the states would govern the alliances. The reformed health care system would have access to some of the funds currently appropriated for Medicaid and Medicare, but would generate additional needed revenue by levying "sin" taxes (e.g., taxes on tobacco and liquor products).

Additional features of the Clinton proposal include:

- o health insurance coverage could not be denied on the basis of pre-existing conditions;
- o mandated benefits would include: selected preventive services (e.g., immunizations, mammograms); treatment for substance abuse; and long-term care;
- o outpatient prescription drugs would be covered under the Medicare program;
- o corporations with 5,000 or more employees would be able to establish their own health alliances;
- o federal subsidies would be provided to assist low-wage individuals and small, low-wage employers purchase health insurance;
- o subsidies would be provided for cost sharing (i.e., the amount paid by an enrollee when services are received) for families with incomes less than 150 percent of the poverty level, under certain circumstances;
- o a standardized insurance claim form would be used to simplify billing and reduce the bureaucracy of the system;
- o financial incentives would be offered to health care providers to establish practices in areas which are currently underserved;
- o health alliances would assume responsibility for building health networks in rural and urban areas in which residents currently have inadequate access to care; and
- o a system to report outcomes and analyze the quality of care received would be established and made available to assist health alliance members choose among

plans.

The features most likely to influence the type of health care received by black Americans under the Clinton plan are discussed in the section entitled "Implications for Black Americans."

SOCIOECONOMIC AND HEALTH CHARACTERISTICS OF BLACK AMERICANS

Many of the existing socioeconomic disparities by race (in such areas as education, employment, and income) have bearing on the health of black Americans. If these disparities are not redressed in some way, they are likely to have a continuing negative impact on the health of black Americans, under any health care system. The major disparities are noted below:

- o High Percentages in Poverty. The proportion of the black American population below the poverty level (nearly a third in 1990) translates into high eligibility rates for Medicaid -- the federal/state health insurance program for low-income persons (over a fifth of blacks were covered in 1990) -- and a high percentage of uninsured people (over a fifth of all blacks under 65 years of age in 1989). Among whites, only 11 percent were below the poverty level in 1990; over 5 percent were Medicaid recipients in 1990; and 12 percent were uninsured in 1989.

- o Lower Levels of Education Completed. Among persons over 25 years of age, in 1991, comparable percentages of blacks and whites had completed four years of high school -- 38 percent and 39 percent, respectively. Only 12 percent of blacks but over 22 percent of whites, however, had finished four years of college at that

time. Because the percentage of black Americans falls short of the percentage of white Americans who have completed high school and college, the ability of blacks to get jobs (and health insurance, under the current system), their employment rates, and their ability to understand and adapt to any new health care delivery system are also likely to be less relative to that for white Americans.

- o High Unemployment. Among civilians 16 years and older, in 1991, over 12 percent of blacks were unemployed, while only 6 percent of whites were unemployed. Because our current health care system links health insurance coverage to employment, the higher unemployment rates of black Americans translate into higher rates of eligibility for Medicaid and, because of limited state funding for Medicaid, into a higher percentage of blacks than whites who are uninsured.

- o Disproportionate Share in Central Cities. In 1989, over 60 percent of black households but only 28 percent of white households lived in the central cities of the nation's metropolitan areas. Central cities of metropolitan areas often have few providers and hospitals, and the survival of both is threatened by treating too many indigent patients for whom they receive too little compensation.

- o Disproportionate Share of Underserved Populations. Black Americans are significant percentages of the following populations, known to be medically underserved -- migrant laborers, the homeless, the incarcerated, substance abusers, the unemployed, and the rural poor.

- Underrepresentation of Black Americans as Providers. Although black Americans were over 12 percent of the U.S. population in 1990, they are between 5 and 6 percent of all practicing physicians. This is significant because, although 80 percent of black Americans have white physicians, 80 percent of the patients of black physicians are also black Americans.

- Differences in Treatment Received. For heart disease, one of the major killers of all Americans, black Americans have been found to receive treatment which is less aggressive and less technologically advanced -- and thus less likely to be effective -- than the treatment received by white Americans.

- Excess Deaths. Of the more than 75,000 excess deaths for blacks (i.e., the difference between the number of deaths for blacks and the number of deaths for whites of similar age and sex) each year, 80 percent can be attributed to six causes: heart disease and stroke; cancer; chemical dependency; diabetes; homicide, suicide, and unintentional injuries; and infant mortality. This is reflected in the shorter life expectancies reported for black than for white Americans. Life expectancy for black males is 65 years, while it is 72 years for white males; for black females, it is 73 years, and for white females, 79 years.

In the following section, selected features of the Clinton proposal are evaluated for their likely impact on the access to services by and, ultimately, the health of black Americans.

IMPLICATIONS FOR BLACK AMERICANS

Answers to questions such as the following would enable us to say whether the Clinton reform proposal would be beneficial to black Americans:

- Would access to care for the total black population or for the black poor be increased or reduced?
- Would the health status of black American be improved or worsened?
- How would the existing inner-city hospitals that primarily serve a black clientele (but are inadequately funded) fare?

At present, the answer to each of these questions would have to be, "It depends," because of the high degree of uncertainty about responses to the Clinton proposal in the markets for health care services and among different subpopulations. For example, how much black Americans or any subpopulation would benefit from the extension of health care coverage to them would depend in part on how highly they value health and how able or willing they are to take advantage of the services made available to them. Populations for whom life has been difficult -- due to poverty, racism, and other socioeconomic ills -- often are the hardest to persuade to change unhealthful behaviors because the lure of increased longevity is not as great for them as for some other groups of people.

In another example, how would one measure increased access to care? Has access to care been increased if, under the Clinton plan, low-income blacks in inner cities or rural areas are required to travel 15 miles each way to a provider who is guaranteed to see them? When compared to the current situation -- when many of the underserved have the hospital emergency

room as their only source of care -- would the scenario that results from the Clinton plan be likely to generate more frequent or appropriate use of services? Or would the distance barrier be sufficient to maintain the status quo of limited use of appropriate services by the black poor?

In yet another example, how can we assess the fate of inner-city hospitals? Will the provisions to support Essential Community Providers and to establish community based health plans be implemented in such a way as to help sustain these facilities? Is outcomes analysis likely to diminish the odds for survival of these institutions? Answers to these questions depend on the timing of financial assistance (and the status of individual hospitals when this assistance is provided) and on the way in which the features of the new plan are administered.

Although the answers to these broad questions are uncertain, the Clinton proposal includes features that suggest additional questions and which may be problematic for black Americans. These features are discussed below under three headings -- programmatic structure, federal role, and state role.

Programmatic Structure

The structure through which the Clinton plan would provide care to all Americans has several features which raise issues for black Americans. They are: health alliances, several tiers of care, enrollment of those who do not choose a plan, caps on premiums, and treatment during research trials. Each is discussed briefly below.

Health Alliances

Grouping individuals together to bargain for better health insurance rates from competing plans -- the idea which underlies health alliances -- is sound and meaningful in areas with providers, clinics, and hospitals, and in which health insurance plans want to do business. However, in central cities and rural areas, many of them with high percentages of black Americans and few providers or health care facilities, this sound concept becomes less meaningful. Only if incentives to encourage providers to practice in underserved areas are instantly effective and/or if funds for the development of health facilities become immediately available could this situation be remedied without continued illness and unnecessary loss of lives in the short run.

Pairing central city or rural areas (which lack providers and facilities) with suburbs (which may have a greater concentration of providers and facilities) when defining the boundaries of health alliances, as mandated by the Clinton proposal, may balance the risk to health insurance companies, due to the anticipated relative costliness of treating suburban enrollees versus central city or rural enrollees. Pairing these areas could thereby reduce premiums for all health alliance members. It would not, however, be a meaningful solution to the dilemma of areas bereft of health care delivery infrastructure, unless convenient transportation to suburban health facilities for central city and rural residents were provided and unless these facilities had hours to accommodate what may turn out to be off-peak demand for services.

To the extent that the system of health alliances provides some freedom of choice among providers and treatment facilities for lower-income persons, then this will benefit black

Americans, since this most American of values has not been operative for the many lower-income black Americans who are Medicaid beneficiaries (over a fifth). The concern here is whether black Americans will be able to choose among plans which have physicians who are comfortable with and competent in their dealings with them. Because patients' views of their doctors affect their health -- i.e., the more satisfied you are, the more likely you are to return and to carry out the physician's orders (whether exercising, losing weight, or taking pills) -- meaningful freedom of choice for black Americans is crucial to improving their health and lessening some of the disparities noted in the preceding section.

Several Tiers of Care

Although the Clinton reform plan promises a comprehensive set of benefits to all eligible persons, it would not provide this coverage through the same mechanism for all residents, thus raising questions of comparability of services and tiering of care. For example, the Medicare program would be retained although, during the annual enrollment period, persons 65 years or older would be able to choose between Medicare and the health alliance which they are eligible to join by virtue of their residence. Incarcerated persons -- a disproportionate share of whom are black Americans (47 percent of all state prison inmates in 1986 were black Americans) -- would not receive coverage through health alliances; they would continue to receive care through the federal or state penal system by which they are confined. Military personnel covered by the Department of Defense, veterans served through the Department of Veterans Affairs, and Native Americans covered by the Indian Health Service also would remain outside the system of health alliances.

What will be the cost implications of different delivery systems such as these? Why retain two options for serving the elderly, if streamlining bureaucracy and controlling cost are among the objectives of the Clinton plan? What quality of health care services are incarcerated persons likely to receive relative to enrollees in health alliances? The high incidence of substance abuse and HIV/AIDS in prisons makes this last question very important.

Enrollment of Those Who Do Not Choose A Plan

The Clinton proposal would allow eligible individuals to be enrolled at the point of service -- i.e., when they are treated by a provider -- in the lowest-cost plan available through their health alliances. Although this feature could guarantee coverage for those who might otherwise remain uncovered, it raises questions about the health status of the group who would not voluntarily enroll in a plan through a health alliance. These are likely to be people who avoid seeking care or visiting providers until it is absolutely essential and, therefore, are treated at a more advanced stage of illness. Because of their mistrust of being counted by government (as reflected in repeated undercounting in the decennial censuses) and because of intergenerational superstitions about and the fear of visiting health professionals, black Americans could be a large proportion of those who do not choose a plan until they are being treated for a health condition. Other black Americans may not enroll simply because they are unfamiliar with the concept of readily available care and do not believe they will get it, even if they enroll.

Thus, the lowest-cost plans may have as enrollees the greatest number of people who are poor and minority and in poor health. If costs are based on services rendered, then the lowest-

cost plans will not be able to remain "lowest cost" without financial subsidies. This feature may lead to the clustering of needy populations in the lowest-cost plans, a situation which could degenerate into poor quality service in plans that will not remain "lowest cost." Although the Clinton proposal acknowledges a need to redistribute insurance risk due to the potential clustering of poor, sick patients in given plans, the proposal does not address what could be done to guarantee the receipt of quality care for enrollees in the lowest-cost plans while adjustments are being made.

Caps on Premiums

The Clinton plan would set caps on the growth of the insurance premiums paid by employers and individuals, with an eye toward reducing the rate of growth of premium costs to the overall level of inflation. The implications of this cap for services received by black Americans would depend on how it is defined. If the cap is applied both to premiums and to out-of-pocket expenses, then rationing of services may result from it. Although rationing resulting from a cap on both premiums and out-of-pocket expenses may exclude treatment for conditions from which black Americans suffer disproportionately, it would not be discriminatory against blacks because of their lower incomes. If the cap is applied only to premiums, then those with more disposable income (among whom the share of black Americans is disproportionately low) would be able to acquire a greater quantity and mix of services than others who are poorer. The rationing of services that would result from a cap on premiums would mean that the poorest people and those whose conditions are excluded from coverage would suffer most. The high percentage of black Americans below the poverty line (nearly a

third) suggests that they would be disproportionately disadvantaged by this cap.

Treatment During Research Trials

If someone receives an investigational treatment as part of an approved research trial, the treatment would be a covered benefit under the Clinton proposal. This provision could encourage the development of better treatment methodologies. However, if research trials continue to be conducted primarily using white males, little knowledge will be gained about the effectiveness of treatments for women, for black Americans, or for members of other minority groups. Including investigational treatment as a covered benefit begs for additional mandates that research trials be conducted for diseases that afflict the entire population and that members of all relevant age, sex, and racial subpopulations be included in them.

Role of the Federal Government

The federal government would play a major role in implementing the Clinton health reform proposal. Certain aspects of this role raise concerns for black Americans. They are: funding for health alliances, government subsidies, sin taxes, developing health care delivery infrastructure, outcomes analysis, mandates on drugs used, and job retraining. These features are discussed below.

Funding for Health Alliances

The National Health Board would be a new federal entity with a broad set of regulatory

and enforcement powers, including prohibiting discrimination on the basis of race at all levels in the new health system. One of the tasks of the new Board would be to allocate federal funds to health alliances on the basis of the current regional variation in expenditures. Because the current level of health expenditures in the South is lower than in other regions and because black Americans reside predominantly in the southern states (nearly 53 percent of all blacks lived in southern states in 1990), if future funding for health alliances is determined by the current distribution of funding, then black Americans may be served by health alliances which receive less funding that their counterparts in other regions.

Government Subsidies

Under the Clinton plan, the federal government will subsidize premiums and co-payments for selected low-income persons and for employers with mainly low-wage workers. In addition, individuals eligible for cash assistance (Aid to Families with Dependent Children, or AFDC, and Supplemental Security Income, or SSI) would have their health insurance coverage purchased from the health alliances by the Medicaid program. Although these subsidies could be instrumental in enabling many underserved persons to get health care, establishing a mechanism and a bureaucracy to calculate subsidy payments and to disburse checks to health alliances is not likely to be instantaneous or seamless. To the extent that delays in subsidy payments result, will this identify the subsidized populations within the health plans and thereby subject them to delayed or otherwise differential treatment? Because black Americans (by virtue of their low incomes) are likely to be a large proportion of the subsidized clientele, this issue is of concern.

"Sin" Taxes

Imposing taxes on substances which detract from health (such as tobacco and liquor) to raise revenue to fund the reformed health system has a certain logic to it. However, if the incidence of lung cancer -- lung cancer incidence was 40 percent higher among black than white men in 1977-83 -- can be viewed to reflect the greater consumption of cigarettes by blacks, then "sin" taxes will be paid disproportionately by black Americans. This tax may, however, ultimately change the smoking incidence among black Americans and, thereby, reduce overall costs in the health care system.

Developing Health Care Delivery Infrastructure

Providing Incentives for Primary Care Providers. The Clinton plan rightfully acknowledges that part of the reason people do not get necessary health care is the geographic maldistribution of physicians throughout the nation and the abundance of specialty care providers relative to primary care providers. To redress this imbalance, the Clinton plan would provide financial incentives to encourage medical students to select primary care as their lives' work and to establish practices in underserved areas.

Although black Americans could certainly benefit from an increased number of primary care providers practicing in their neighborhoods, they would also benefit from an increased number of culturally competent health care providers of all types (primary and specialty care alike) with practices in their neighborhoods. The thrust to produce more primary care providers could result in the "tracking" of black medical students into this field and retard the progress

minority medical students have made in recent years to break down the racial barriers to specialty training. In addition, if providers -- of any racial or ethnic group -- decide to practice a given type of medicine in a particular underserved area primarily because of the financial incentives provided to encourage them to do so, how likely are these same people to be empathetic with and competent to treat their clients?

Essential Community Providers. Another means by which the Clinton plan would seek to develop the health infrastructure of underserved areas would be to allow providers in underserved areas to apply to the Department of Health and Human Services (HHS) for designation as Essential Community Providers. Health plans would be required to contract with and reimburse these providers during the first 5 years under the reformed system. By the end of that time, these providers are envisioned to be incorporated into other health plans or to join together to create new, community-based health plans.

What carrots or sticks could the federal government use to guarantee that these providers, many of whom would be black Americans, would receive contracts and reimbursements from health plans? Would problems in the use of Essential Community Providers take so long to uncover and redress that the health of many of the residents of underserved communities would be greatly impaired in the interim?

Fostering Treatment Through Academic Health Centers. The Department of HHS would make grants to academic health centers to enable them to provide services to persons in underserved urban and rural areas. As part of this function, HHS would designate rare diseases

and specialized procedures for which health plans would be required to establish contractual relationships with academic centers to provide care to their enrollees. When grants are being made to academic health centers and when diseases and procedures are being identified, black Americans would be concerned that the diseases and procedures selected have broad incidence in the population and that needy patients with rare diseases be treated as more than human guinea pigs for the training of medical students.

Outcomes Analysis

The Clinton plan indicates the need to develop a system to analyze the outcomes of care provided by the health plans among which health alliance members will select. This information should make it easier to compare providers and facilities among the plans and to select the plan most compatible with one's needs. Health alliances may refuse to contract with plans whose quality of care or service is deemed unsatisfactory on the basis of this analysis.

A concern for black Americans residing in underserved central city and rural areas is whether adverse outcomes (such as death rates for the many terminally ill patients who show up in hospital emergency rooms) will be reported in such a way as to jeopardize the future demand for services at and the solvency of their few neighborhood medical facilities. If the high death rates at inner city or rural hospitals are taken as a measure of unsatisfactory service and render plans that use these hospitals ineligible for enrollment by health alliance members, then these facilities may be forced to close, and access to health facilities to serve central city and rural residents would become worse.

Outcomes analysis could be a useful addition to the arsenal of information to enable

Americans to acquire good health care. It must, however, be designed and implemented in such a way as to avoid unintended deleterious consequences for the existing "safety net" medical facilities.

Mandates on Drugs Used

Under the Clinton plan, the Secretary of HHS would be able to limit the dispensing of drugs -- i.e., approval from HHS could be required before physicians could prescribe non-generic drugs. To the extent that black and white Americans differ in their responses to drugs administered to treat given conditions, establishing a requirement that providers must seek HHS approval to be able to prescribe specific name-brand drugs could delay the receipt of effective treatment by black Americans and, thereby, diminish their quality of life.

Job Retraining

Another feature of the Clinton proposal is the retraining of lower-level administrative and clerical workers in the health field for higher-paying and more highly skilled positions, such as technicians, nurses, and physician assistants. Since black Americans in the medical field hold a larger share of these lower-level positions than they do of the more highly skilled jobs, they stand to benefit from this provision. However, the availability of funding and the details of program implementation will determine to what degree this initiative enables black Americans to get over the hurdles of retraining and of labor market discrimination to gain access to better paying jobs.

Role of the States

The states also would play a major role in establishing and operating the Clinton health care proposal. The features of the state role that are potentially problematic for black Americans relate to state flexibility -- in phasing in coverage and in the use of funds. These issues are discussed below.

Flexibility in Phasing in Coverage

The Clinton plan gives the states flexibility in scheduling the phase-in of health insurance coverage for their residents. Giving states this flexibility could provide room for state-based initiatives already underway to develop into full-blown systems. Although state officials generally are perceived to be closer to the populace and, therefore, more responsive to their needs, historically, some states have been recalcitrant and punitive with respect to black Americans when implementing federally mandated programs. In addition, many of the current state reform efforts have been motivated by the increasing cost of the Medicaid program, and, thus, include cost reduction measures, often achieved by reducing coverage. If we combine the historical reluctance of many states to enforce the rights of their black residents with flexibility in initiating the transformation to the Clinton reform plan, we could have a situation in which health care coverage for black Americans is compromised.

The Clinton proposal would impose a financial penalty -- a tax large enough to provide health care to their residents -- on states who lag in implementing the reform plan. The facts of each situation would need to be evaluated before a penalty could be assessed, however. If

states lack the money to fully fund their Medicaid programs, how likely are they to be able to pay a penalty large enough to provide care to their residents? Even if a penalty were levied and collected from states which fail to perform responsibly, there could be a period during which state residents would not get care.

Flexibility In Use of Funds

Under the Clinton plan, states have the option to fold funds for public mental health and substance abuse treatment into the total available for all health expenditures. States also may add locally generated public health dollars to the total available to health alliances for service expenditures. In addition, states also may get the option to convert the money currently spent for supplemental services (non-emergency transportation, vision care) under the Medicaid program to a block grant to be devoted to whatever health care use(s) the states deem most pressing. At the same time, the Clinton proposal would require states to maintain their current level of financial effort to support health care services within their borders.

The above privileges and requirements could adversely affect the health of black Americans. States that pool their substance abuse and mental health treatment funds with other health care dollars may do so because they are unwilling to provide the needed services for their residents who are mentally ill or substance abusers. Because black Americans are disproportionately represented among substance abusers and more often use public treatment facilities (because of their poverty) than do other population subgroups, the flexibility to pool funds for substance abuse treatment with funds for other health expenditures could translate into diminished access to these services for some black Americans.

Requiring states to maintain the current level of financial effort could merely lock into place the existing state funding disparities of the Medicaid program. The states with the least generous funding for Medicaid are southern; these states also have the largest percentages of black Americans. Thus, requiring states to maintain the current level of financial effort could mean that not enough funding would be provided to cover all eligible residents, even by 1997, in those states with large percentages of black Americans. Similarly, requirements for states to match the federal dollars received for program implementation may mean that the states with the largest percentages of blacks will get fewer implementation dollars and, therefore, may implement their programs more slowly than other states, leaving currently underserved populations without coverage longer than their counterparts in other states.

CONCLUSIONS

President Clinton offered his health care reform proposal to the nation as the key to achieving multiple goals; he hopes it will contain costs in the health care system, stimulate economic growth, and generate savings that can be used to reduce the deficit. Whether the Clinton plan will achieve these goals is much debated. Some reason that the reform plan will stimulate the economy because it will remove the fear of changing jobs or starting new businesses. It also is predicted to stimulate the economy by reducing the amount firms spend on health care, as cost-shifting (i.e., increasing the cost of health care services for those with insurance to pay for the services rendered to those without it) becomes a thing of the past. Others reason that the increased bite out of employer payrolls to cover insurance premiums will

decrease the number of jobs and increase unemployment. The stagnating economies of Western Europe are cited as evidence of this, since many of these countries historically have loaded the costs of the social benefits they provide onto employer payrolls. Which outcome will prevail remains unclear.

The likely impact of health care reform on black Americans, as on all Americans, depends jointly on their current health and their socioeconomic status. For example, the concerns of and impacts on disabled black Americans, generally speaking, will be akin to the concerns of other disabled people, except that the disabled black American has a higher likelihood of being poor and of experiencing racially motivated discrimination when seeking treatment and other services. For nondisabled black Americans with above average levels of income and education, as another example, the concerns and impacts would be comparable to those for other Americans with similar incomes and education, except for differences in health status and in the likelihood of racially motivated discrimination.

This paper has noted the major questions and issues that are likely to arise when one thinks of black Americans collectively and how they will fare under the Clinton health reform proposal. The proposal has potential assets and deficits, and the aim of this paper was to spell out some of them.

Statement for the Record

Clarification of the statement of Dr. Philip R. Lee regarding protections for minority providers:

The Health Security Act (HSA) includes both direct and indirect provisions to prevent health plans from discriminating against minority providers and their patients.

Direct Protections for Minority Providers and Their Patients

The anti-discrimination provisions that apply to health plans in the HSA are strong. They cover both intentional discrimination and acts that have the effect of discriminating. In addition, the HSA specifically prohibits health plan discrimination against providers based on the personal characteristics of the provider of the provider's patient's. Section 1402(c)(2) states:

"In selecting among providers of health services for membership in a provider network, or in establishing the terms and conditions of such membership, a health plan may not engage in any practice that has the effect of discriminating against a provider -

(A) based on the race, national origin, sex, language, age or disability of the provider; or

(B) based on the socioeconomic status, disability, health status, or anticipated need for health services of a patient of the provider."

Additional Protections for Minority Providers

In addition to the general anti-discrimination provisions, the HSA includes several provisions designed to ensure appropriate access to care and choice of plans for minority patients and to ensure that minority providers may participate in health plans.

1. States are required to ensure that all families have adequate access to enroll in a choice of health plans in their area (including adequate access to low cost plans). States may require one or more health plans to cover the entire service area of the regional alliance. States also have the authority to use financial incentives to ensure that health plans enroll members of disadvantaged groups.

2. Under the HSA, fee-for-service health plans must pay any lawful health care provider of the enrollee's choice, regardless of whether the plan has a contract with the provider. A fee-for-service plan may exclude a provider only it if has evidence that the provider renders poor quality care. Because every regional alliance must offer at least one fee-for-service plan, every provider will have the opportunity to participate.

3. The HSA preempts state laws which require health plans to contract with any willing provider, except for services provided on a fee-for-service basis. Thus, existing state laws which require health plans to contract with any provider who is willing to meet its terms remain in force for fee-for-service plans and for the fee-for-service component of other types of health plans. And, of course, the anti-discrimination provisions described above apply to all types of health plans.

4. The Essential Community Provider provisions in the Act ensure that vulnerable populations will have access to providers with experience in meeting their special needs, regardless of which health plan they choose. Under the HSA, many Public Health Service grantees that serve vulnerable populations are automatically certified as Essential Community Providers (ECPs), and other providers serving underserved populations may apply for certification. Health plans must either contract for payment with any ECP in its service area; or if there is no contract, the health plan must pay the ECP under the regional alliance fee schedule or at applicable Medicare rates.

Minorities

Dr. LEE. Well, I would say we are at an early stage of development in terms of performance measures, and one of the major things we will be doing is to work to develop better performance measures, but there are some areas where we can clearly do this today. And again I would cite immunization, but there we can measure whether a plan does, in fact, immunize children up to the age of two or at an age appropriate level, and second, we can gather data, as we do now, in the community to determine whether, in fact, there are any cases of measles, whooping cough or other preventable infectious diseases that if the children were immunized, those diseases would not occur so we will have several measures.

Now, that is one area. For a number of areas we are at an earlier stage of developing and we have process measures rather than good outcome measures to assess good plan performance.

Question → Mr. LEWIS. Dr. Lee, in my district, I have many minority health providers, and some are telling me that already they are being shut out of these networks. Can you give me some message or some word that I can reassure these minority health providers that they will not be continually locked out of these growing networks?

Dr. LEE. Yes, that problem has arisen. I have had long discussions with physicians in the San Francisco Bay area over the last few years. That problem is not limited to

Georgia. Two things, I think, in the plan that would prevent that.

First, our very strong civil rights protections so that the Civil Rights Act cannot be violated with respect to the opportunity for these physicians to participate and any barrier that is based on race or gender would be assured in the plan.

Mr. LEWIS. What about location, areas, zip codes, certain areas of a city or metropolitan area?

Dr. LEE. There is one other provision, and that is the any-willing-provider requirement in the bill, that any willing provider can participate in the plans unless it is a closed-panel group practice where they don't have a need for an additional physician, let's say, in the plan.

The red lining which has occurred in the past will be prohibited. The plans will be required to provide, to offer the plan to everyone within an alliance area at the community-rated premium for that plan, so that those provisions should help to increase access both for the individuals living in those areas, but also to assure the physicians or other nurse practitioners or other providers who work in those areas and serve patients in those areas that plans will be available and they can participate in the plans.

Mr. LEWIS. Thank you very much, Dr. Lee. Thank you, Mr.

Congress Minorities

Hillary Clinton Visits Minority Caucuses

Black, Hispanic Groups Share Views on Health Care With First Lady

Hillary Rodham Clinton visited with the congressional black and Hispanic caucuses yesterday and expressed a willingness to increase minority group participation in the health care overhaul process now underway.

Her talks with each of the two groups were similar to discussions she had held previously with larger groups of congressional members. She made no commitments but exchanged ideas about the process and her desire to include Congress in health care revisions, meeting participants said.

"We have to understand the problems that all Americans face," Clinton told reporters between the two sessions.

Rep. Kweisi Mfume (D-Md.), chairman of the Congressional Black Caucus, many of whose members support a system similar to Canada's in which the federal government pays for health care, said there will be "substantially increased" contact between the caucus and the administration's health care task force chaired by Hillary Clinton.

Rep. Jose E. Serrano (D-N.Y.), chairman of the Congressional Hispanic Caucus, said his group asked that more Hispanic health professionals and activists be included on the task force's working groups.

Clinton told members that she would assign White House staff members to work as liaisons with the two caucuses.

Hispanic Caucus members told Clinton they want to see universal coverage extended to undocumented and migrant workers and residents of the territories of Guam, the U.S. Virgin Islands and Puerto Rico. They also asked for more research on specific health problems, such as tuberculosis, that have hit Hispanic populations hard.

Members said Clinton took copious notes and impressed them with her fluency in health policy.

TODAY IN CONGRESS

SENATE

Meets at 8:45 a.m.
Committees:
Armed Services—2:30 p.m. U.S. government facilitation of private business investment in former Soviet Union. 222 Russell Office Bldg.
Budget—10 a.m. President's economic plan. Transportation Sec. Federico Peña. 608 Dirksen Office Bldg.
Energy & Natural Resources—9:30 a.m. Mark up Petroleum Marketing Practices Act; Stock Raising Homestead Act; & several pending public land & rivers bills. 366 DOB.
Labor & Human Resources—1:30 p.m. Employment & productivity subc. Career Pathways Act of '93. 430 DOB.
Rules & Administration—9:30 a.m. Congressional election campaign finance reform proposals. 301 ROB.

HOUSE

Meets at noon.
Committees:
Appropriations—9:30 a.m. Agriculture, rural development, FDA & related agencies subc. Federal Crop Insurance Corp. 2362 Rayburn House Office Bldg.
Appropriations—10 a.m. Interior & related agencies subc. National Gallery of Art. B-308 RHOB.
Appropriations—10 a.m. Labor-HHS-Education subc. Programs under its jurisdiction. 2358 RHOB.
Appropriations—10 a.m./2 p.m. Treasury-Postal Service-general government subc. FY '94 approps. for U.S. Customs Service at 10 a.m. & U.S. Secret Service at 2 p.m. H-163 Capitol.
Armed Services—10 a.m. Use of force & role of U.S. military in post-Cold War era. 2118 RHOB.
Banking, Finance & Urban Affairs—11:15 a.m. Housing & community development subc. Rural housing programs. Agriculture Sec. Mike Espy. 2128 RHOB.
Budget—10:30 a.m./2 p.m. President's FY '94 budget proposals. HHS Sec. Donna Shalala, Dept. of Veterans Affairs Sec. Jesse Brown. 210 Cannon House Office Bldg.
Energy & Commerce—9:45 a.m. Health & the environment subc. Lead poisoning during bridge renovation & other construction activities. 2325 RHOB.
Energy & Commerce—10 a.m. Commerce, consumer protection & competitiveness subc. Insurance redlining & urban development. 2322 RHOB.
Energy & Commerce—10 a.m. Oversight & investigations subc. Nuclear Regulatory Commission's efforts relating to nuclear power plant safety in the event of fire. 2123 RHOB.
Foreign Affairs—9:30 a.m. Environmental issues in U.S. foreign policy. 2172 RHOB.
Foreign Affairs—2 p.m. Western Hemisphere affairs subc. Prospects for peace in Guatemala. 2200 RHOB.
House Administration—2 p.m. Office systems subc. Pending business. H-328 Cap.
Judiciary—9:30 a.m. Administrative law & governmental relations subc. Independent Counsel Reauth. Act of '93. 2226 RHOB.
Judiciary—9:30 a.m. Civil & constitutional rights subc. Environmental justice. 2237 RHOB.
Judiciary—10 a.m. Intellectual property & judicial administration subc. Copyright Reform Act of '93. 2247 RHOB.
Merchant Marine & Fisheries—10 a.m. Coast Guard & navigation subc. Passenger Vessel Safety Act of '92. 1334 Longworth House Office Bldg.
Merchant Marine & Fisheries—2 p.m. Fisheries management subc. Reauth. of Magnuson Fishery Conservation & Management Act of '76. 1334 LHOB.
Post Office & Civil Service—4 p.m. Compensation & employee benefits subc. Impact of president's economic proposals on federal civilian work force. First floor, main auditorium, Labor Dept.
Science, Space & Technology—9:30 a.m. Science subc. Mission of National Science Foundation. 2318 RHOB.
Veterans' Affairs—9 a.m. Hospitals & health care subc. Major Dept. of Veterans' Affairs construction projects. 334 CHOB.

The Washington Post
3/3/93

MINORITY

Scarcity of Minority Doctors Vexes Clinton

By LAURIE MCGINLEY
Staff Reporter of THE WALL STREET JOURNAL

Sandra Hullett is exactly the kind of doctor President Clinton would like to have more of: a black physician caring for poor, predominately black residents in rural Alabama.

She moved to Eutaw, Ala., because, after the government picked up a chunk of her medical-school bills, she was obligated to spend two years in an area with few doctors. But unlike Joel Fleischman, television's whiny "Northern Exposure" doctor who ended up in Alaska through a similar arrangement, "I found I really loved it," says Dr. Hullett, an Alabama native, who has stayed in Eutaw for the past 15 years.

One largely overlooked goal in the health-care proposal that Mr. Clinton announced last week is to encourage more minorities to become physicians, dentists and other health-care professionals. As part of his plan, the president wants to increase sharply the size of the National Health Service Corps, which gave Dr. Hullett her training. Though details are still vague, he also proposes to increase medical scholarships and training for minorities.

Currently, only about 3.6% of the nation's doctors and dentists are black, even though blacks comprise almost 12% of the population. A major reason is the high cost of medical school. Fully 92% of minority students have to take on debt – averaging almost $60,000 – compared with about 79% for non-minority students. The American Association of Medical Colleges says minorities often get less financial support from cash-strapped families. Other barriers to medical school range from abysmal center-city public schools to a general mistrust among some students that hard work will pay off, educators and doctors say.

The Minority Doctor Gap

	No. of Physicians, 1990	% of Physicians, 1990	% of Population, 1990	% of Population, 2000	% of Population, 2050
White	472,389	80.8%	82.8%	78.8%	73.7%
Black	20,874	3.6	3.9	11.7	11.5
Hispanic	28,791	4.9	4.4	8.4	8.4
American Indian	869	0.1	0.8	0.9	0.8
Asian/Pacific	53,552	10.9	9.7	2.6	1.8
Other Race	288	0	0.2	1.9	0.7

Source: U.S. Census

Crucial Move

Increasing the ranks of minorities in medicine is crucial to improving care for the poor, administration officials and outside experts agree. "The record shows that minority physicians are almost twice as likely to practice in underserved rural and urban areas, and they are more likely to go into primary care" than other doctors, says David Satcher, president of Meharry Medical College, a traditionally black school in Nashville, Tenn. And minority professionals can serve as valuable role models and provide community leadership on a range of issues.

"People feel more comfortable when their provider is sensitive to their culture, speaks their language and comes from their community," adds Risa Lavizzo-Mourey, deputy administrator of the Agency for Health Care Policy and Research, who worked on the health-reform proposal.

The Clinton administration, in the draft of its health-care plan, has set as a goal the doubling to 3,000 the number of "underrepresented" minorities, such as blacks and Mexican-Americans, enrolled in the first year of medical school by the year 2000. Other organizations, such as the American Association of Medical Colleges, have been pursuing the goal on their own, but this marks the first time the White House has embraced it.

Details Left Out

It is unclear, however, exactly how the administration plans to accomplish its goal. Officials say details probably won't be spelled out until late October, when the health-care legislative proposal goes to Congress. And some actions probably won't be in the proposal at all but will happen as a result of a reshuffling of priorities of the Department of Health and Human Services.

The uncertainty is generating concern among minority health-care professionals. "It's easy to say we have a program, but

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Scarcity of Doctors From Minority Ranks Is Vexing to Clinton

Continued From Page B1

you have to have a long-term commitment," says Kenneth Chance, federal relations adviser at the University of Medicine and Dentistry of New Jersey. Others wonder whether major progress can be made without a comprehensive plan to help urban youth by overhauling public education, reducing crime and creating mentoring programs.

Administration officials insist their strategies can make a difference. For example, they say Mr. Clinton is committed to expanding scholarship and loan-forgiveness programs that benefit minorities. "We want to make sure that funds are available in sufficient quantities that qualified students interested in health professions aren't thwarted by financial constraints," says Dr. Lavizzo-Mourey. The health-care draft also calls for the encouragement of more minority representation on medical-school faculties and in research.

Also being watched carefully is the administration's position on community health centers. This is a network of 600 federally funded groups that operate 1,400 clinic sites, providing health care to the urban and rural poor. In the past, both the president and Hillary Rodham Clinton have spoken positively about the centers, but it isn't clear whether the administration's plan would provide them with more money.

Three years ago the Sequoia Community Health Foundation, which provides care to migrant farm workers in Fresno, Calif., became the first center in the country to offer a family-practice residency program in connection with the local hospital. Residents do their inpatient work at the hospital and their outpatient work at Sequoia. Founders say the work experiences are at least as valuable as those provided by the elite medical centers. "Our patients come in with everything – diabetes, hypertension, work injuries, chronic lung disease," says Jaime Cruz, the center's [illegible]. The [illegible] the end of residency training, but [illegible] "have left [illegible] to a community like this," says Dr. Cruz. Of the

Other organizations also are working to try to train and recruit more minority professionals. Two years ago, the American Association of Medical Colleges launched a program to encourage medical schools to form partnerships with local high schools to provide enriched science classes and magnet schools for talented students. This "pipeline" effort, says Herbert Nickens, an AAMC vice president, is to produce minority high-school graduates more likely to succeed in college and medical school.

At the Charles R. Drew Medical Center in South-Central Los Angeles, six-to-13-year-olds can attend the Saturday Science Academy, dressed in whites and addressed as doctor. And there is a magnet school for older teens that is run jointly with the city's public schools. Drew's president, Reed Tuckson, says he hopes the federal government will provide grants for such activities.

The Clinton draft plan only mentions in passing expanding the National Health Service Corps. But administration officials and outside observers expect the White House to push for increasing the number of participants in the field to 5,000 or 10,000 from the current 1,500 over the next five years. The corps provides both scholarships and loan forgiveness programs for those interested in primary care in exchange for their serving in one of 1,800 counties suffering from a shortage of health professionals. Though not specifically aimed at minorities, the program nevertheless offers opportunities for minority students with limited financial resources, administration officials say.

Alabama's Dr. Hullett, who graduated from the Medical College of Pennsylvania in Philadelphia in the mid-1970s, says she wouldn't be a physician if it weren't for the program. It paid for the last two years of medical school, plus living expenses. "There's no other way I could have done it," she says. "My father was a barber and my mother was a cook, and I had borrowed everything I could for the first two years."

WALL ST.J.:06/16/93

Drug Switching Called a Danger For Minorities

100/102/122

By Elyse Tanouye
Staff Reporter of The Wall Street Journal

A pharmaceutical industry group contends that the efforts of managed-care health plans to hold down prescription drug costs may endanger blacks, Hispanics and other minority patients.

The contention is contained in an article on race, ethnicity and drug reactions by Richard A. Levy, vice president of scientific affairs at the industry-supported National Pharmaceutical Council. Dr. Levy charges that a "proliferation" of managed-care and government programs that limit the variety of drugs that doctors can prescribe may result in minority patients' receiving medications that produce "suboptimal, adverse, uncontrolled or unexpected responses." His article is in the June issue of Pharmaceutical Medicine, coming out today.

"We're seeing the emergence of policy proposals" that tend to treat all patients the same, "or give doctors less choice in treating patients," Dr. Levy says.

The report attacks efforts by managed-care plans to reduce prescription-drug costs. The plans use "formularies," or lists of drugs for which they will pay. The plans also may allow "therapeutic substitution" that fills a prescription for a brand name drug with a similar, usually cheaper, generic version.

Officials of managed-care organizations say racial and ethnic differences in drug responses are taken into account in their formulary and therapeutic-substitution decisions.

In his article, Dr. Levy says ethnic and racial differences in drug reactions have been shown in a number of drugs. Blacks and Hispanic patients suffer greater side effects from some antidepressants, while Asians require lower dosages of antidepressants, for instance. The schizophrenia drug Clozaril, made by Sandoz Pharmaceuticals Corp., is linked to a serious blood disorder, agranulocytosis, in 20% of Jewish patients, but only 1% of patients overall.

A recent study in the New England Journal of Medicine showed that Marion Merrell Dow Inc.'s Cardizem, a calcium channel blocker used to treat high blood pressure, was most effective in black patients, but Bristol-Myers Squibb Co.'s Capoten, an ACE inhibitor for hypertension, was among the least effective in blacks. In young white patients, however, the reverse was true.

One study cited by Dr. Levy found that blacks don't respond as well as whites to another class of heart drugs, beta blockers. But one beta blocker, labetalol, has been shown to be equally effective in controlling blood pressure in black and white patients. A health-care organization that substitutes another beta blocker for labetalol might put black patients at a health risk, Dr. Levy says.

Genetic differences in metabolism account for most racial and ethnic differences, Dr. Levy says in his report, but other factors such as diet, smoking and cultural perceptions of illness may affect how a patient responds to a drug.

Dr. Levy's report is challenged by officials of managed-care plans. "Our guidelines for switching would factor in that certain subsets of the population might respond differently, and that should be taken into consideration," says James Chan, product-evaluation pharmacist for Kaiser Permanente Medical Care Program in Livermore, Calif.

Henry F. Blissenbach, president of Diversified Pharmaceutical Services Inc., Bloomington, Minn., which manages prescription-drug programs for health plans, says, "We pay primary attention to antihypertensive drugs with the black population in mind, so we make sure those drugs are in there." In addition, formularies usually allow exceptions when requested by a physician, he says.

Racial differences are apparent in antidepressants, but can be accommodated simply by adjusting the dosage, says Douglas Kay, a practicing psychiatrist and senior vice president of quality assurance at CMG Health Inc. in Owings Mills, Md., which runs mental-health programs for health plans. CMG doesn't use formularies or therapeutic-substitution rules. But Dr. Kay says a formulary limiting physicians to eight key drugs, out of the couple of dozen available, wouldn't hurt patient care.

9/17

^bc-health-minorities - a1747
^(bal) (ATTN: National editors) (Includes optional trims)
^Blacks in Congress Question Fairness of Clinton Health Plan (Washn)
^By Karen Hosler= ^(c) 1993, The Baltimore Sun=

AFRICAN AMERICANS & HEALTH CARE REFORM

WASHINGTON Health care reform was described Thursday as a ``life and death'' issue for black Americans, but members of the Congressional Black Caucus are not convinced that President Clinton's proposal is the best approach.

The proposed new system of guaranteed access to a standard package of basic health benefits, emphasizing primary and preventive care, could potentially rescue millions of uninsured African-Americans from needless disease and premature death, supporters of the plan say.

At a meeting with first lady Hillary Rodman Clinton Thursday, key black legislators questioned, though, whether the administration plan to blend a private system of managed competition with an overlay of government regulation might continue or even aggravate discrimination against the poor.

``There are cultural, linguistic, racial, educational, and attitudinal differences that impose special barriers to effective delivery of care to our community,'' said Rep. Louis Stokes, the Ohio Democrat who chairs the Black Caucus Health Braintrust. ``We must be assured that any new system does not continue to differentiate between the haves and the have-nots, the unemployed and the working, minorities and whites.''

The Clinton program would allow people to pay more to purchase a traditional health care plan that allows them to see any doctor. Most people, however, will be forced by cost to select a cheaper health maintenance organization, which provides the same benefits but does not permit as much choice of physicians or hospitals.

Black lawmakers warned that the intense competition between health care providers would squeeze out inner-city health centers that for years have catered to black communities for little or no profit.

Risa Lavizzo-Maurey, deputy administrator of the agency for health care policy and research of the U.S. Public Health Service, noted that the administration's proposal includes a provision that would forbid discrimination by health care providers or the alliances that provide insurance.

But many black lawmakers favor an alternative proposal sponsored by Democratic Rep. John Conyers of Michigan to establish a single, government-run health insurance program because they believe it would screen out more subtle racism that might otherwise creep into a blended system.

Mrs. Clinton observed that the Conyers proposal would require a major new tax increase to pay for it, which would probably be impossible to pass. But the first lady assured the caucus members the administration shares their goals.

``We're all trying to get to the same place,'' Mrs. Clinton said.

^(Optional add end)

Stokes called health care reform a ``life and death'' issue for blacks because they are most likely to fall through holes in the current health care system, which has left between 35 and 37 million Americans without any health coverage.

Twenty-one percent of black Americans currently fall into that category compared with 11 percent of whites, according to government figures released earlier this week. They are mostly working poor who neither have private insurance nor qualify for care through the federal programs of Medicare for the elderly and Medicaid for the poor.

The lack of primary care and preventive care, which is not even available to those who have Medicaid, is believed to be directly responsible for the disportionately high death rate among blacks.

Rep. Robert C. Scott, D-Va., noted that 1.58 black adults die of heart disease, cancer and strokes for every white adult who dies from those causes. Life expectancy for blacks is 70 compared to 76 for whites.

^Distributed by the Los Angeles Times-Washington Post News Service=

WASHINGTON EDITION / LOS ANGELES TIMES

MONDAY, DECEMBER 20, 1993

Studies Find Double Standard in Treatment

■ Medicine: Schools are trying to sensitize students to 'bedside bias.' Studies show that the effects on women and minorities can mean ruder treatment and less access to better care.

By SONIA NAZARIO
TIMES URBAN AFFAIRS WRITER

When Althea Alexander broke her arm, the attending resident at Los Angeles County-USC Medical Center told her to "hold your arm like you usually hold your can of beer on Saturday night."

Alexander, who is black, exploded. "What are you talking about?" she demanded. "Do you think I'm a welfare mother?"

The white resident shrugged: "Well, aren't you?"

Wrong. Alexander was a top official at the USC School of Medicine, where the resident was studying.

In response to such incidents, medical schools including pioneers USC and UC San Francisco have launched efforts to tackle a malady that may undermine the health care of women and minorities. Aimed at curing doctors of "bedside bias," these schools are prodding their pupils to recognize their prejudices and learn to keep them out of the examination room.

The actions follow recent studies that show that even when minority and female patients have the same health insurance and income as white men, they are much less likely to receive lifesaving medical treatments.

Although the studies suggest that such gaps may in part be caused by cultural

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factors or physical differences, most raise the specter of bias.

In a state where minorities make up 43% of the population, California medical schools have been in the forefront of such reforms.

Some deride the schools' programs as political correctness run amok. "I can't see how people can change their prejudice," scoffs one white USC medical student. "I don't see how this will change anyone."

Medical school officials emphasize that doctors are not more inclined to exhibit bias on the job than other groups, but say that physicians have a special duty to keep prejudices in check because their patients rely on them not only for their health, but for their very lives.

"The kind of information a doctor gets from you, how long they spend with you, the kinds of treatments they offer—all are affected by bias," said Herbert Nickens, vice president for minority health education and prevention at the Assn. of American Medical Colleges.

"Discrimination and bias are very prevalent," said Judith Barker, a UC San Francisco medical anthropologist whose students discuss cultural barriers to treating black patients. "It is quite insidious. It comes in tiny pieces. But those tiny pieces add up."

Recent studies have shown that the toll bias can take on female and minority patient care:

- Older whites are 3½ times more likely than older blacks to get potentially lifesaving surgery to bypass blocked arteries, said a 1992 study of 86,000 patients under Medicare, the government's health insurance program for the elderly. The gap widens in Southeastern states, where whites are more than six times as likely to have the operation.
- Asian American, Latino and African American patients of the same income levels and health insurance as whites are 20% to 50% less likely to get three critical types of heart procedures, a 1993 UCLA study found. Women are 30% less likely than men to get the procedures.
- Black kidney patients are 45% less likely than whites to get transplants, a 1991 New York State Health Department study found.
- Latino patients who arrive at UCLA's emergency department with arm and leg bone fractures are half as likely as whites to get pain medicine, a 1993 study found.

Although women visit their doctors more often than men, a gender gap in health care is equally clear, a survey by the American Medical Assn.'s Council on Ethical and Judicial Affairs found:

- Women ages 46 to 60 undergoing dialysis are half as likely to get a kidney transplant.
- For patients with similar smoking habits, physicians were twice as likely to order lung cancer tests for men.
- Men are 6½ times more likely to be referred for cardiac catheterization, where a tube is inserted into the heart to check its condition, even though men are only three times as likely to have heart disease. Women are much more likely to have their heart pains attributed to emotional causes.

In some cases, bedside bias may be deadly. Death rates from coronary heart disease between 1980 and 1991 dropped about 34% among whites, far outpacing the 25% drop in deaths among blacks, a gap many attribute in part to physician bias. Coronary heart disease kills nearly 500,000 people each year in the United States. Blacks remain twice as likely as whites to suffer cardiac arrest, and more than three times as likely to die from it, a recent University of Chicago study found.

Women are more likely to die during bypass surgery or when they have a heart attack, evidence that their cardiovascular disease is not diagnosed or treated early enough, said the AMA's Council on Ethical and Judicial Affairs. Half of women who have heart attacks die within a year, compared to 31% of men.

At the root of gender disparities in treatment, the American Medical Assn. said in its review of the data, is the sense that men are more valuable and contribute more to society than women.

USC's battle against bias began six years ago, when Carletta Bullock, an African American medical student, noticed that a white male colleague looked shell-shocked as he made his first rounds at County-USC Medical Center. There, 90% of patients are minorities. "I feel like I'm on Mars," he confided.

She surveyed fellow students and found that half felt unprepared to handle the cultural barriers they faced. Bullock started an informal four-hour workshop in which students talked about coping with biases and when it is appropriate to refer a patient who triggers such biases to another physician.

In a trial program just completed in conjunction with Los Angeles' Museum of Tolerance, USC's second-year medical students swapped clinical discussions of cell biology and anatomy for heated exchanges about race.

'We come to the patient with all the things we have been programmed with our entire lives. It affects how far you go in treatment. There is basic treatment, and there is more.'

CARLETTA BULLOCK
Medical student

Sitting in a circle at the museum, Los Angeles' monument against prejudice, 10 students squirmed as their professor asked them to confess biases that may affect their patients' care. Two white women confided that they rush through physical exams of "scary looking" black men. A third student voiced anger at Latinas on welfare who have baby after baby.

In another workshop, student T.J. Jirasevijinda angrily recalled how doctors at one medical clinic he worked at treated Asian Americans without their informed consent and did not explain prescription drugs' side effects. When the professor asked if the doctors treated white patients better, Jirasevijinda tersely replied: "Yes."

"There are people who are bigots and [the workshops] make no difference. But there are people in the middle who learn," said Bullock, a physician at Albuquerque Indian Hospital.

At UC San Francisco, a mandatory workshop on ethnic identity is followed by a 10-week "cross-cultural communications" course that half its medical students take.

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THE HEALTH STATUS OF WOMEN OF COLOR

(Black Women)

A Women's Health Report of the Women's Research and Education Institute

Betty Dooley, President

by

Wilhelmina A. Leigh

Joint Center for Political and Economic Studies

W·R·E·I

1994

This analysis is the author's own and should not be attributed to the Joint Center for Political and Economic Studies, its board of governors, or its sponsors. The author would like to thank the following people for their assistance during the preparation of the report: Hortensia Amaro, I. Evelyn Baez, Linda Burhansstipanov, Susan Chu, Tylene Harrell, Wendy Hee, Laurin Mayeno, Socorro Sosa, Elena Yu, and Ruth Zambrana. Any errors or other shortcomings of this report are, of course, the sole responsibility of its author.

HIGHLIGHTS

IN THIS REPORT THE TERM WOMEN OF COLOR encompasses four major groups of women—Native, Hispanic, Black, and Asian and Pacific Islander Americans—with subgroups within each of the major groups. These four groups include many subpopulations whose health status varies from better than the U.S. average (e.g., Japanese and Cuban Americans with prenatal care) to worse than the U.S. average (e.g., Black and Native American women with amputations due to diabetes).

Because all people of color have experienced both deculturation (relative to their place of origin) and acculturation to American society, women of color have confronted not only the stresses associated with trying to be the preservers of culture and bulwarks of family life—but also the prejudice, discrimination, and racism that seem to come hand-in-hand with minority status in the United States. As a result, women of color experience high rates of poverty and depression as well as inadequate housing—all of which have implications for their health status.

The following points highlight some of the important issues relating to the health status of women of color today:

- Hispanic American women have the longest life expectancy of all women of color, followed by Native American and then by Black American women. (Data for Asian and Pacific Islander American women are not available.)
- Obesity, defined as excess body weight for height, is a problem for all women of color, but especially for Native American, Pacific Islander, and Black American women. The high incidence of adult-onset diabetes is a major problem for women of color (especially Native American and Native Hawaiian women), in part because of obesity.
- For a variety of reasons (financial, cultural, informational, and access-related among them), less than half of all women of color regularly avail themselves of preventive tests such as Pap smears or mammograms. This translates into higher death rates from breast and cervical cancer among women of color than among White women. Black and Native Hawaiian women, especially, have higher death rates and lower five-year survival rates than White women for most types of cancer.
- Although the human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) has infected and killed many women of color, its incidence is much greater among Black and

Hispanic (mainly Puerto Rican) American women than among other women of color.

- Heart disease and cancer are the major killers among women of color, as they are among the rest of the population. Other prominent causes of death among women of color include: HIV/AIDS (as mentioned above); homicide and unintentional injuries (especially among Black, Hispanic, and Native American women); and alcohol-related diseases (especially among Native American and Pacific Islander American women).
- Undercounting, failing to collect subpopulation data, and misidentifying women of color are the major problems associated with collecting data on them.
- Guidelines for preventive medical testing and for research often fail to incorporate and reflect the distinct needs of women of color.
- A greater number of community-based medical facilities with culturally sensitive health care providers are needed to serve women of color.

INTRODUCTION

WOMEN IN THE UNITED STATES address their health care needs through several filters. Filters imposed outside of their family context include:

- a biomedical knowledge base that presumes that women can be treated the same as men for conditions that afflict them both;
- a health care system oriented to viewing and treating women as vessels for reproduction;
- a federal health insurance program for the elderly (Medicare) that provides better coverage for the acute illnesses more common in men than for the chronic diseases more common in women; and
- a medical profession that has been slow to acknowledge and develop responses to the impacts of domestic violence on both physical and mental health.

In addition to these external filters, women access health care not simply as individuals but in the context of the families in which they perform multiple caregiving roles—as wives, mothers, daughters, widows, etc. These caregiving roles often translate into interrupted employment histories and limited access to health insurance, and place time constraints on women's ability to seek care for themselves. Dependence on a husband for health insurance coverage leaves the caregiver wife vulnerable if the marriage dissolves or if the employer cuts back on or eliminates dependent coverage.

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These general problems and characteristics of women as caregivers and consumers of health care services are compounded for women of color by the special circumstances of their lives and those of the men with whom they live. Prejudice, discrimination, poverty, lack of language skills, and varying degrees of acculturation all interact to generate the daily diet of stresses that have further bearing on the health status of women of color.

FACTORS AFFECTING THE HEALTH OF WOMEN OF COLOR

Ethnic and Racial Heritage[1]

Before moving into a discussion of the factors influencing the health of the four primary groups of women of color, the population groups need to be briefly described. Of the nearly 249 million people counted as U.S. residents in the 1990 Census, 51.3 percent of them were women, and over 31 million were women of color. These 31 million women of color are distributed as follows: 50 percent Black, 35 percent Hispanic, 11.8 percent Asian and Pacific Islander, and three percent Native American (Bureau of the Census 1992d). Women of color are nearly a fourth of all U.S. women; in raw numbers, there are nearly 16 million Black American women, nearly 11 million Hispanic American women, nearly one million Native American women, and over 3.7 million Asian and Pacific Islander women.

The fastest growing minority group is Asian and Pacific Islander Americans, increasing by nearly 108 percent between 1980 and 1990. The group that is a distant second in its growth rate is Hispanic Americans, growing by 53 percent over the 1980-1990 period. The Native American population increased by nearly 38 percent over the decade, while Blacks grew by only 13 percent and Whites by six percent (Bureau of the Census 1992f).

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[1] *Women of color are discussed in rough chronological order of the arrival of any member of their group in the United States. Native American refers to American Indians and Alaskan Natives (Eskimos and Aleuts). Hispanic refers to the Spanish-surnamed and Spanish-speaking residents of the United States. This term is chosen rather than Latino or Latina because it is used in most of the data sources on which this report is based. Black is used instead of African American to signify that this group includes Black West Indians and other members of the African diaspora who might not be both of African descent and American. Asian and Pacific Islander refers to both the Asian subpopulations (Chinese, Japanese, Filipino, Korean, Vietnamese, etc.) and the Pacific Islander subpopulations (Native Hawaiians, Samoans, Guamanians, and Tongans, etc.) who are U.S. residents.*

encourage their sex partners who are intravenous drug users to use condoms, ignore the riskiness of speaking out for Latinas. Suggesting the use of a condom may cause her partner to believe that the Latina either knows too much about sex or is being unfaithful, and may place her at risk of either physical or emotional abuse from her partner. Successful educational programs for poor Hispanic (and Black) women have been difficult to establish, partly because these women need help in surviving in their daily environments before they can become receptive to skill building and informational strategies (Nyamathi et al. 1993).

Black Americans

The African ancestors of the group known today as Black Americans or African Americans were brought to the shores of what is now the United States as slaves by Europeans, beginning in 1619. Today, there are 30 million Black Americans in this country, 12.1 percent of the total population, and they are currently the largest minority group (Bureau of the Census 1992d). Over half of all Black Americans (nearly 16 million) are females. Approximately three percent of Black Americans are foreign born, mainly comprised of French-speaking Haitians and other non-Spanish-speaking Caribbean people, some of whom are farmworkers in the United States. Though seldom studied, marked differences in acculturation exist among Black women and contribute to the diversity of their health (Nyamathi et al. 1993). Black Americans are a largely urban population (84 percent in 1990) but can be found in most parts of the United States (Bureau of the Census 1992f).

Differences in the health status of Blacks and Whites are many and varied. Blacks have more undetected diseases, higher disease and illness rates, and more chronic conditions (such as hypertension and diabetes) than Whites (Leffall 1990). Mortality rates for Blacks from many conditions (cancer, HIV/AIDS, and homicide) exceed those for Whites. Explanations for these racial differences have been sought by experts, and many contributing factors have been identified. The major factors—genetics, poverty, and racism—are discussed below.

The murkiness of race as a concept to define Black Americans, who range from fair-skinned and blue-eyed to dark-skinned with coarse hair, makes purely genetic explanations of the health differences between Blacks and Whites questionable. Biology appears to explain very little of the differences in health status between Blacks and Whites, if the proportion of excess deaths among Blacks—that is, deaths that would not have occurred if Blacks experienced the same age- and sex-related death rates as Whites—due to hereditary conditions is examined. Less

than one percent of Black deaths have been attributed to hereditary conditions such as sickle cell anemia, for which genetic patterns have been established (Jaynes and Williams 1989). On the other hand, researchers studying the incidence of hypertension among Blacks have found that it varies with skin color. That is, lighter pigmented Blacks have a lower prevalence of hypertension than darker skinned Blacks, and pigment is related to the degree of admixture with Whites, whose overall incidence of hypertension is lower than that of Blacks (Wilkinson and King 1989).

Instead of looking at population-related genetic differences, others link the racial differences in health status to Black subpopulations that are exposed to multiple risks—such as intravenous drug users, those living and working in hazardous environments, and the like. Those health conditions common among Blacks that are considered to be genetic in origin are likely to receive more public attention and resources than conditions that arise from behavior or life style choices. For example, conditions such as sickle cell anemia receive more research attention and public support than health conditions attributable to accidents, substance abuse, and environmentally caused illnesses (Wilkinson and King 1989).

Poverty affected nearly one-third of all Black Americans (31.9 percent) and 35.5 percent of all Black women in 1990. Single-parent, female-headed households, 44 percent of all Black households in 1990, were mired in poverty to a greater degree than the entire Black population (Bureau of the Census 1992d). Forty-eight percent of all Black female-headed families had incomes below the poverty level in 1990, and 75 percent of the two million Black families in poverty were maintained by women with no husbands present (Bureau of the Census 1992b). Inadequate income carries over into other aspects of daily life that impinge upon health. These include inadequate housing (which may quicken the spread of communicable diseases), malnutrition, the stress of constantly struggling to make ends meet, dangerous jobs, and little or no preventive medical care. Malnutrition in little Black girls may later result in low birth weight babies and high infant mortality rates when these girls become mothers. The stresses of constantly struggling to make ends meet may translate directly into the finding that Blacks below the poverty level have the highest rate of depression for any group (Liu and Yu 1985). Dangerous jobs (and living environments) may expose Blacks to certain cancers to a much greater extent than Whites (Miller 1989). Little or no preventive care may come about for a variety of reasons, including:

- parental ignorance of disease symptoms and when to seek medical care;
- lack of health insurance to enable access to health care;
- lack of neighborhood facilities in which to seek health care;
- persistent use of emergency rooms to treat chronic conditions, which are better managed in other settings; and
- racial discrimination encountered when seeking care (Jaynes and Williams 1989; Headen and Headen 1985-86).

Racial discrimination and racism have remained significant operative factors in the health status and health care of Blacks over time. From as early as 1867, Black spokespersons concluded that racism was a major contributor to the poor health of Black America in two significant ways. First, "structural racism" creates barriers to getting access to adequate care, and second, dealing with both structural barriers and racial insults may contribute to stress-related health problems such as pregnancy-induced hypertension among Black women (Hogue and Hargraves 1993).

"John Henryism," defined as the behavioral predisposition to work hard and strive determinedly against the constraints of one's environment, has been advanced as an explanation for the Black-White differences in hypertension rates. High blood pressure in Blacks is a response to the incongruity between the social position one's work would typically merit and the position one actually occupies (Smith and Egger 1992).

Racial discrimination has limited the access of Blacks to higher incomes, improved health care, adequate housing, and better education—all of which are necessary to achieve modern levels of health and mortality (Ewbank 1989). Racial discrimination probably "...exacerbates the mental health-damaging effects of poverty status among Blacks" (Miller 1989: 511). Being Black impinges upon health status, even at higher income levels. A study of stress found its severity highest in lower-class Blacks and lowest in middle-class Whites. Even more notable is the fact that middle-class Blacks and lower-class Whites had similar levels of stress (Miller 1989).

Another example of what may be a physiological response to racism is pregnancy outcome. Mortality rates for infants born to college-educated Black parents (from 1983 to 1985) were 90 percent higher than the rates among infants born to college-educated White parents. This excess mortality was due primarily to higher rates of death associated with premature delivery of Black babies (Schoendorf et al. 1992). In addition, immigrant Black couples have a lower incidence of low birth weight babies when compared to the incidence among native Black

couples. The incidence of low birth weight babies among immigrant Blacks is similar to the incidence among White couples. Moreover, Black babies born in more segregated cities have higher rates of infant mortality than their Black counterparts born in less segregated cities (Hogue and Hargraves 1993).

Further, the impact on health of responses to racism can be seen by the high mortality rates for Blacks from cancer and HIV/AIDS. Blacks are both less educated about the danger signs for cancer and more pessimistic about treatment for cancer than are Whites. Both of these facts interact to make cancer the terminal disease Blacks conceive it to be (Manton 1989).

It has been suggested that the experience of fighting HIV/AIDS is different for most Whites than for minorities and the poor. For Whites with HIV/AIDS, the fact that they have education and employment contributes to their sense of outrage about the disease and motivates them to fight for what is being lost. Blacks and members of other minority groups, who may never have had these advantages, lack this sense of loss, the associated drive to fight against the loss, and the educational tools with which to wage the fight. Delays in seeking medical care, differences in preexisting health status, and differences in drugs administered as treatment generate a mean survival time of six months for Blacks after diagnosis with HIV/AIDS, while Whites have a mean survival time of 18 to 24 months (Friedman et al. 1989).

Resentment by others at the unfair advantages presumably accorded Blacks under affirmative action programs contributes to the sense of exclusion from and inequality in mainstream America felt by Blacks, a sense that bears on them economically, socially, and physically. Even if poverty in America is reduced, as long as economic, social, and political inequalities persist, the health status of Black Americans is likely to remain impaired (Miller 1989).

Asian and Pacific Islander Americans

The population known as Asian and Pacific Islander Americans is comprised of immigrants and their descendants from over 43 countries who speak over 100 different languages. Asians come from more than 20 countries (including China, India, Japan, the Philippines, Korea, Laos, Cambodia, Vietnam, and Thailand) with over 60 different ethnicities and a multitude of languages and dialects. Pacific Islanders have immigrated from over 22 territories and nations (including the U.S. territories of Guam, American Samoa, and Tonga) with up to 1,000 different languages (Ponce 1990).

The numbers of Asian and Pacific Islanders in the United States have grown from 1.5 million in 1970 to over 7.2 million in 1990; they are currently almost three percent of the total population and 12

Asian and Pacific Islander Americans are not available.) The life expectancy for White men exceeded that of all men of color, while the life expectancy of White women exceeded that of all women of color.

Table 1 **· Life expectancy at birth by sex, race, and Hispanic origin[1]**

Race and Hispanic Origin[2]	*Females*	*Males*
White	79.2	72.7
Black	73.5	64.8
Hispanic origin[3]	77.1	69.6
Native American[4]	76.2	67.2
All races	78.6	71.8

[1]*Life expectancy is the number of expected remaining years of life. Life expectancies are based on population counts by age and sex enumerated during the 1980 Decennial Census and on mortality experienced during the 1986-1988 period.*
[2]*Data for Asian and Pacific Islander Americans are not available.*
[3]*Persons of Hispanic origin may be of any race.*
[4]*Data do not include Native Hawaiians, and are based on Native Americans on reservations only.*

Source: National Institutes of Health 1991; Indian Health Service 1992.

Habits and Life Styles

Habits and life style patterns influence the health and incidence of disease in all Americans. Among these are overeating (which can lead to obesity and high serum cholesterol), smoking, alcohol consumption, and substance abuse.

Obesity

A condition associated with diabetes, hypertension, and cardiovascular disease, obesity is a problem for all women of color and is related in part to the "diets of poverty"—high in fat and low in fruits and vegetables—that many of these women consume. Defined as excess body weight for height, or being overweight, obesity was found among nearly 60 percent of all Native American women on reservations in 1987 and among 63 percent of urban Native American woman (Lefkowitz and Underwood 1991; Scott 1991). Among Pacific Islanders, Native Hawaiians and Samoans are some of the most obese populations in the world. Based on the data from 1976-1980 and 1982-1984 in Table 2 for women 20 to 74 years of age, the percentage of overweight women ranged from 24 percent for White women, to 44 percent for Black women, with the major Hispanic subpopulations arrayed in between.

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High Cholesterol

Although sometimes associated with obesity, high serum cholesterol (a factor in cardiovascular disease) is a problem for White women 20 to 74 years of age more than for women of color in that age group. Twenty-eight percent of White non-Hispanic women have high serum cholesterol, nearly double the 14.6 percent of urban Native American women who had it (National Center for Health Statistics [NCHS] 1991; Scott 1991). Seventeen percent of Cuban American women report high cholesterol, with 20 percent of Mexican American and 23 percent of Puerto Rican women reporting high cholesterol. The more acculturated Mexican Americans have greater incidence of high serum cholesterol, while less educated Mexican Americans and those living below the poverty line have lower levels (Delgado and Trevino 1985). Among Black non-Hispanic women, 25 percent have elevated levels of serum cholesterol.

***Table 2* · Overweight women age 20 to 74 by race and Hispanic origin, 1976-1980 and 1982-1984**

Race and Hispanic Origin	*Percentage Overweight*
Hispanic origin[1]	
Mexican American	41.6
Puerto Rican	40.2
Cuban American	31.6
Non-Hispanic Black	44.4
Non-Hispanic White	23.9

[1]*Persons of Hispanic origin may be of any race.*

Source: National Center for Health Statistics 1991.

Smoking

Although the data tend to differ slightly from survey to survey, the percentages of women age 18 and over who reported "currently smoking cigarettes" in 1985 and 1987 (see Table 3) ranged from a low of 12 percent (Asian and Pacific Islander American women) to a high of 31 percent (Native American women). Although 31 percent of Native American women smoke cigarettes, 54 percent of Native American women living on reservations have never smoked (Lefkowitz and Underwood 1991). In addition, smoking prevalence varies by reservation for Native Americans, from relatively low percentages in Arizona and New Mexico to highs of 50 percent among Native Americans in the Plains states and over 60 percent among Alaskan

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proportions drink heavily (U.S. Department of Health and Human Services n.d.). When looking at Hispanic subpopulations, the percentage of women reporting that they are current alcohol users ranges from 35 percent among Mexican Americans and 33 percent among Puerto Ricans to 23 percent among Cuban Americans. With Asian and Pacific Islander Americans, considerable variation exists in the likelihood both of alcohol consumption and of reporting symptoms of alcoholism. Native Hawaiian women are more likely to drink alcohol than Hawaiian women of Filipino, Chinese, or Japanese descent. In addition, Native Hawaiian women in the youngest (18 to 19) and oldest (over 30) age groups tend to consume more alcohol during pregnancy (Bell, Nordyke, and O'Hagan 1989).

Substance Abuse

Some women of color and White women have used illicit substances, risking their own health and that of their unborn children. More White women (35 percent) and Black women (33 percent) report using illicit drugs at some point in their lives than do Hispanic women (25 percent). Current use of any illicit drug is slightly higher among Black non-Hispanic women (seven percent) than among either White non-Hispanic or Hispanic women (Horton 1992).

Preventive Health Measures

Often women of color, for many of the cultural reasons discussed previously, do not avail themselves of preventive health tests such as Pap smears and breast exams. For example, although breast, lung, and cervical cancer (in that order) are the three most commonly occurring cancers in Asian and Pacific Islander American women, approximately two-thirds of Asian and Pacific Islander immigrant women have never had Pap smears and roughly 70 percent have never had mammograms (Lee 1992). In answer to the question, "When was your last Pap smear," only 43 percent of Asian and Pacific Islander American women reported "less than a year ago," the smallest share among all women of color. Only 47 percent of Asian and Pacific Islander American women (who were 45 years of age and older) reported ever having a mammogram (Communications Consortium Media Center [CCMC] and National Council of Negro Women [NCNW] n.d.).

Although the incidence of cervical cancer among Blacks is twice that among Whites, and the rates for Hispanics and Native Americans also exceed the rates for Whites, these women of color underutilize Pap smears and mammography. Sixty-six percent of Black women report that their last Pap smear was less than a year ago, as do 72 percent of Hispanic women. Seventy-one percent and 78 percent, respectively, of

Hispanic and Black women in the 45 years and older age group report ever having had a mammogram (CCMC and NCNW n.d). Although Mexican American women are more likely than either Cuban American or Puerto Rican women to have had a recent Pap smear and breast exam, less than 50 percent of all Mexican American women report having had a routine physical exam within the last two years, and approximately 20 percent report never having had a regular physical exam (Solis et al. 1990).

Table 4 **· Prenatal care for mothers with live births by race and Hispanic origin of mothers, 1989**

Race and Hispanic Origin	*Percentage of Live Births for Which Mothers Received*	
	Late or No Prenatal Care	*Early Prenatal Care*
Hispanic origin[1]		
Mexican American	14.6	56.7
Puerto Rican	11.3	62.7
Cuban American	4.0	83.2
Central and South American	11.9	60.8
Asian and Pacific Islanders		
Chinese American	3.6	81.5
Japanese American	2.7	86.2
Filipino American	4.7	77.6
Native American	13.4	57.9
Black	11.9	60.0
White	5.2	78.9

[1]*Persons of Hispanic origin may be of any race.*

Source: National Center for Health Statistics 1992a.

Nearly 83 percent of Native American women on reservations (as opposed to more than 90 percent of all U.S. women) have had at least one Pap test. For these women and all women, being married and having a high school education are associated with higher screening rates. Among Native American women on reservations, 78 percent report ever having mammography, while 89 percent of urban Native American women report the same (Lefkowitz and Underwood 1991; Scott 1991). Only 10 percent of urban Native American women report never having a Pap smear. For both groups of Native American women and among all women, the likelihood of getting these preventive tests declines as they age.

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3.6	81.5
2.7	86.2
4.7	77.6
13.4	57.9
11.9	60.0
5.2	78.9

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Another example of preventive care that many believe contributes to the delivery of a healthy baby is prenatal care in the first trimester of pregnancy. In 1989, although over half of all women of color (in the major racial and ethnic groups) received prenatal care in the first trimester, large percentages did not. Over 86 percent of Japanese American women began prenatal care in the first trimester as seen in Table 4. At the other extreme, however, the table shows that only 58 percent of Native American, 57 percent of Mexican American, and 60 percent of Black mothers received early care. Data from California reveals that the following women usually receive late or no prenatal care: 59 percent of Samoans, 48 percent of Laotians, 47 percent of Cambodians, 32 percent of Vietnamese, and 25 percent of women of all racial groups combined (Association of Asian Pacific Community Health Organizations [AAPCHO] n.d.). Women who receive late or no prenatal care are more likely to be poor, adolescent, unmarried, rural dwellers, or over 40 years of age—characteristics that place their pregnancies at high risk from other causes as well (Jaynes and Williams 1989).

Diseases

Although the incidence of most infectious diseases has been reduced since the 1940s (with the exception of HIV/AIDS), people of color continue to have rates in excess of the national average for such conditions as tuberculosis and hepatitis B. For example, 48 percent of all births to women who were hepatitis B positive were to Asian and Pacific Islander American women, while only three percent of all births were to these women (AAPCHO n.d.). In addition to infectious diseases, conditions such as cancer, diabetes, and hypertension impair the health of people of color.

Cancer

Cancer is the second leading cause of death for women in the United States (second to heart disease). Moreover, breast cancer was the leading cause of death due to cancer among White and Black females age 25 to 54 and for those 85 years and older in 1987. For all other age groups, breast cancer ranked second to lung cancer in 1987 as the leading cause of cancer deaths among women (NCHS 1991). Native Hawaiian women have the highest cancer incidence of all women in Hawaii, while Black and Native Hawaiian women have higher death rates and lower five-year survival rates than White women for most types of cancer.

White and Native Hawaiian women have the highest risk of breast cancer among the major racial/ethnic groups in the United States. Japanese, Shanghai Chinese, Singapore Chinese, and Hawaiian Filipino

women have the lowest risk of breast cancer (Petrakis 1988). The five-year survival rate for women with breast cancer is greater than 70 percent in all groups except Native Americans (less than 45 percent) and Blacks (64 percent) (Horton 1992).

Cervical cancer also takes a large toll on women of color. Although the rate of cervical cancer is twice as high for Hispanic women as for White women, Black non-Hispanic, Native American, and Chinese American women have even higher rates than Hispanic women (Delgado and Trevino 1985). The five-year survival rate for Black women is 10 percentage points lower than the comparable rate for White women (57 percent versus 67 percent) (Horton 1992).

Diabetes Mellitus

Diabetes mellitus—a chronic condition characterized by abnormal glucose metabolism—is a major health problem for all women of color. Diabetes primarily affects the circulatory system, and is frequently associated with conditions such as arteriosclerosis (hardening of the arteries) and kidney failure. While the incidence of diabetes among Black non-Hispanic women is double that for White non-Hispanic women, the incidence for Hispanics is 2.5 times the rate for Whites, and the incidence for Native Americans is five times that for Whites (IHS 1991b). Among the populations in Hawaii, Native Hawaiians, Filipinos, Japanese, Koreans, and Chinese Americans have incidence rates for diabetes at least double the rate for Whites (AAPCHO n.d.).

Because compliance with the regimen to treat diabetes requires monitoring by health care providers and family support, treatment poses particular challenges for Native Hawaiians. Treatment practices that focus on the individual rather than others and alter diet and eating times violate many of the cultural practices of Native Hawaiians.

The estimated age-adjusted death rate for all women of color from diabetes in 1987 (18.8 per 100,000) was more than double that for White women (8.1 per 100,000). For Native American women, the rate was 2.7 times that of White women (Horton 1992; IHS 1992).

The manifestations of the disease vary only slightly among women of color. Perinatal mortality (infant mortality at birth) for pregnant Black women with diabetes is three times higher than for pregnant White women with diabetes (Headen and Headen, 1985-86). Gestational diabetes (diabetes occurring in a pregnant woman) is present in one to three percent of all pregnancies in the White and Black populations. However, in one study of Navajos, 6.1 percent of pregnancies were identified with gestational diabetes (IHS 1991b). Among Native American mothers with gestational diabetes, nearly 60 percent will develop freestanding diabetes within 16 years of delivery.

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For Mexican American women, with greater acculturation comes reduced obesity and a lower incidence of diabetes (Delgado and Trevino 1985).

Hypertension

People are classified as hypertensive if their average systolic blood pressure is greater than 140 mm mercury, or their average diastolic blood pressure is greater than 90 mm mercury, or they report taking high blood pressure medicine. Hypertension, a major risk factor for coronary heart disease and cerebrovascular disease, infringes upon the health of Black women much more than it does upon the health of other women of color.

Using data collected in 1976-1980 and 1982-1984, Table 5 shows that 44 percent of Black non-Hispanic women were found to be hypertensive, more than double the rates for Mexican American women (20 percent) and Puerto Rican women (19 percent), and more than triple the rate among Cuban American women (14 percent). The rate of hypertension among Black females was 1.7 times the rate among non-Hispanic White females. Among Native American women living on or near reservations and eligible for services provided or supported by the Indian Health Service, 22 percent reported hypertension in 1987. Selected Asian and Pacific Islander American populations experience high rates of hypertension and are less likely to be aware that they have the disease or to be under medical supervision than are members of other racial/ethnic groups. Filipino women over 50 years of age who live in California have a slightly higher incidence of hypertension (65 percent) than Black women in the same age cohort (63 percent) (AAHF 1990). Sizable percentages of adult Samoan women in Hawaii and California have hypertension as well. Using the systolic

Table 5 **· Hypertension among women age 20 to 74 by race and Hispanic origin, 1976-1980 and 1982-1984**

Race and Hispanic Origin	*Percentage With Hypertension*
Hispanic origin[1]	
Mexican American	20.3
Puerto Rican	19.2
Cuban American	14.4
Non-Hispanic Black	43.8
Non-Hispanic White	25.1

[1]*Persons of Hispanic origin may be of any race.*

Source: National Center for Health Statistics 1991.

criterion, 13 percent are hypertensive, while 18 percent are hypertensive by the diastolic criterion (Bindon and Crews 1990). In Hawaii, Native Hawaiians and Japanese Americans report high rates of hypertension, with a higher incidence among Native Hawaiian women than any other ethnic group in the state (Alu Like, Inc. 1985; Papa Ola Lokahi 1992).

HIV/AIDS

Although the reported patterns of transmission of the human immunodeficiency virus (HIV) that cause acquired immune deficiency syndrome (AIDS) vary by racial and ethnic group, all women of color have been affected by this disease. The number of cases reported among women of color who were 15 to 44 years old from 1981 to 1989 was greatest for Black non-Hispanic women and for Hispanic women (4,911 and 1,434 cases, respectively) with lesser incidence among Native American and Asian and Pacific Islander American women. The number of cases reported among all women age 15 to 44 over the 1981 to 1989 period was 8,556; the number of cases reported among all women of color over that period was 6,409 (Gayle, Selik, and Chu 1990).

As seen in Table 6, from 1981 to 1989 among women 15 to 44 years of age, Black non-Hispanic and Hispanic women were overrepresented in the proportion of reported HIV/AIDS cases when compared against their proportion in the total female population, while White, Native American, and Asian and Pacific Islander American women were underrepresented. Although Black non-Hispanic women comprised only 13.3 percent of all women, they accounted for nearly three-fifths of all HIV/AIDS cases among women. And while Hispanic women comprised only 7.9 percent of all women, they accounted for nearly 17 percent of

***Table 6* · Distribution of HIV/AIDS cases among women age 15 to 44 by race and Hispanic origin, 1981-1989**

Race and Hispanic Origin	*Percent Distribution of HIV/AIDS Cases*	*Percent Distribution of All Women Age 15-44*
Non-Hispanic White	24.9	75.1
Non-Hispanic Black	57.6	13.3
Hispanic origin[1]	16.8	7.9
Asian and Pacific Islander	0.5	2.6
Native American	0.3	1.1
Total percent	100.0	100.0

[1]*Persons of Hispanic origin may be of any race.*

Source: Gayle, Selik, and Chu 1990.

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	75.1
	13.3
	7.9
	2.6
	1.1
	100.0

all HIV/AIDS cases among women. According to Selik, Castro, and Pappaioanou (1988), AIDS is 13.2 times more common among Black non-Hispanic women and 8.1 times more common among Hispanic women than among White women.

When female AIDS cases reported through October 1991 were examined by methods of transmission, for almost all racial/ethnic groups the dominant mode of infection was intravenous drug use. The exception was among Asian and Pacific Islander women (see Table 7). Most of the HIV/AIDS cases among Hispanics are among Puerto Ricans, who are seven times more likely than non-Hispanic Whites to be diagnosed with HIV/AIDS.

***Table 7* · Sources of AIDS infection among women by race and Hispanic origin through October 1991 (percent distribution)**

Race and Hispanic Origin	*Intravenous Drug Use*	*Heterosexual Contact*	*Blood Transfusion*	*Other/ Undetermined*
Non-Hispanic Black	56	34	3	7
Non-Hispanic White	42	31	20	7
Hispanic origin[1]	50	38	5	7
Native American	55	21	12	12
Asian and Pacific Islander	16	35	31	17

[1]*Persons of Hispanic origin may be of any race.*

Source: Asian American Health Forum, Inc. 1992.

Acculturation among Hispanics also seems to play a role in the transmission of HIV/AIDS, with intravenous drug use most prevalent among more acculturated Latinas. Less acculturated Latinas report a low perceived risk of AIDS and less likelihood of using illegal drugs or engaging in sexual activity with multiple partners (Nyamathi et al. 1993).

Because it is difficult to conduct controlled experiments on intravenous drug users, this group of HIV/AIDS patients is less likely to be included in experimental protocols. This means that Black and Hispanic women may be less likely to receive antiviral medications in the future than other groups of HIV/AIDS patients, whose ranks are less dominated by intravenous drug users (Friedman et al. 1989).

Although heterosexual transmission is the second most frequently reported mode of AIDS infection for White, Black, Hispanic, and Native American women (and the dominant mode of transmission for Asian and Pacific Islander women), Black and Hispanic women may be more

vulnerable than White women to heterosexual transmission of HIV/AIDS through sex with bisexual men. This is possible because, compared to White gay men, larger proportions of Black and Hispanic gay men report having sex with both men and women—30 percent for Black, 20 percent for Hispanic, and 13 percent for White gay men (Friedman et al. 1989).

Although only 22 cases of HIV/AIDS were reported among Native American women over the 1981 to 1989 period, this figure is probably an underestimate, due to the difficulty in counting and tracking health conditions among Native Americans, some of whom are very mobile (Gayle, Selik, and Chu 1990). Men who have sex with men account for over half of all Native American cases, and Alaskan Native communities have been the hardest hit so far (HRSA 1992a). Between February 1991 and September 1992, the total number of cases reported among Native Americans increased from 244 to 416 (IHS 1991a; American Indian Health Care Association 1992).

Among women with HIV/AIDS, others in their households—lovers, spouses and/or children—are also likely to have the disease. Women with AIDS who must also fulfill their traditional roles as caregivers are likely to live shorter periods of time than women who do not have the added stress of providing care to others. In addition, women with AIDS often leave behind orphans with HIV/AIDS, many of whom subsequently are raised by their grandmothers, a fact that increases the stresses in the lives of these older women.

Access to Health Insurance and Health Care Services

Access to health care includes both access to health insurance coverage and access to providers and facilities that render services. Adequate access to providers and facilities encompasses the existence of conveniently located services and the availability of child care (to enable mothers to seek medical attention), transportation, and health care providers capable of giving sensitive and competent care.

Obtaining Health Insurance

Although wives are often insured as dependents of their husbands, estimates show that between 13 and 14 percent of all women, or 16 to 17 million women, lack insurance (Horton 1992). Just as people of color make up a sizable proportion of the uninsured—39 percent of the uninsured while they comprise only 24 percent of the total population—women of color make up a sizable proportion of all uninsured women.

Lack of health insurance varies markedly by race and ethnicity, with Hispanics and Asians 2.5 times and Blacks 1.8 times as likely to be

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uninsured as Whites (Horton 1992; AAPCHO n.d.). In 1990, over 6.9 million Hispanics (or 32.4 percent of the entire Hispanic population), nearly 6.1 million Blacks (or about 20 percent of all Blacks), and 26.9 million Whites (or 12.9 percent of the entire White population) were uninsured (Bastida 1992; National Council of La Raza 1992). For certain racial and ethnic groups, as for the entire population, the proportions uninsured are slightly higher for persons under age 65 (because of the existence of Medicare for the elderly)—35 percent of Hispanics, 25 percent of Blacks, and 15 percent of Whites (Short, Cornelius, and Goldstone 1990). As one representative group of Asian and Pacific Islander Americans, half of Koreans under age 65 are estimated to lack health insurance (Han 1990).

Blacks and Hispanics are also considerably less likely to have private health insurance (and the additional options and greater coverage it often affords) and are more likely to have public insurance than are Whites. In 1987, while 80 percent of Whites had private health insurance, less than half (49 percent and 46 percent, respectively) of Blacks and Hispanics did (Short, Cornelius, and Goldstone 1990).

Among subpopulations of Hispanics, health insurance coverage also varied considerably. In 1989, over half of Cuban Americans (56 percent) had private health insurance, while only 44 percent of both Mexican Americans and Puerto Ricans had private coverage. On the other hand, a third of Puerto Ricans (all of whom are citizens) received Medicaid—health insurance for lower-income persons funded partly by the federal government and partly by the states, and administered by the states—while only 14 percent and 12 percent, respectively, of Mexican Americans and Cuban Americans were enrolled in the Medicaid program. This difference reflects in part lower proportions of legal residents among Mexican Americans and Cuban Americans than among Puerto Ricans.

In addition, between February 1987 and May 1989, 46 percent of Hispanics, 40 percent of Blacks, and 24 percent of Whites were without health insurance coverage for at least a month. Women were slightly less likely than men (25 percent versus 28 percent) to have had gaps in coverage for two reasons. First, it was more common for women to live in families with incomes below the poverty level and, therefore, to be eligible for and to be enrolled in Medicaid. Second, a higher percentage of women than men were over 65 years of age and were likely to be enrolled in Medicare (Bureau of the Census 1992c).

Blacks also heavily use public insurance (Medicaid, Medicare, and public coverage through the Department of Veterans Affairs and the military). Twenty-six percent of Blacks under 65 years of age had public

insurance in 1987 and Blacks are roughly 40 percent of all Medicaid enrollees (Rice and Winn 1991; Short, Cornelius, and Goldstone 1990). However, many Blacks reside in southern states where Medicaid is the least generous. Although all states place constraints on enrollment and limits on health services, the southern states impose the most severe ones (Leffall 1990). Many health care providers refuse to accept Medicaid reimbursement because it falls too far short of the actual costs incurred to provide services. Thus, Blacks who receive coverage through Medicaid might more properly be called underinsured and be added to the estimated one to two million Black Americans whose health insurance coverage is inadequate for their needs (Jaynes and Williams 1989).

Obtaining Health Care Services

One step beyond health insurance coverage is making contact with physicians or other providers. In the 1977 National Medical Care Expenditure Survey, the percentages of Whites, Blacks, and Hispanics who stated that a physician's office was their usual source of care were 70 percent, 46 percent, and 54 percent, respectively (Delgado and Trevino 1985). In contrast, in 1990, 48 percent of Blacks and 62 percent of Whites reported the physician's office as the usual place of contact for care.

Among Hispanics, substantially higher percentages of Puerto Ricans (than Mexican Americans and Cuban Americans) report hospital outpatient clinics and emergency rooms to be their usual source of care (Solis et al. 1990). Double the percentage of Blacks than of Whites (24 percent versus 12 percent) report that the hospital outpatient department (including hospital outpatient clinic, emergency room, and other hospital contacts) is their usual place of physician contact.

Among Asian and Pacific Islander Americans, 22 percent of Korean households in Southern California report that at one time or another since coming to the United States a family member has failed to get appropriate care. Although the most common barrier is financial, an additional 18 percent of Koreans reported not knowing where to go for care at some time since immigrating to the United States (Han 1990).

Native American Health Care System

The issues related to insurance coverage and access to care for Native Americans differ from those of other people of color because of the system for delivering care to them, which includes:

- Indian Health Service (IHS) clinics and hospitals;
- tribal clinics and hospitals;

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- urban Indian clinics;
- local referral hospitals;
- tertiary medical centers (i.e., specialized facilities treating burns, trauma, etc.);
- Indian and non-Indian substance abuse treatment centers; and
- traditional Indian healers.

IHS hospitals and clinics are available only for use by Native Americans living on or near reservations—approximately 38 percent of all Native Americans in 1990. Because of geographic definitions, some Native Americans in urban areas are covered (Scott and Suagee 1992).

Government health care services for Native Americans in urban and nonreservation rural areas often are very limited and uncoordinated. For example, Native Americans living in urban areas can get treatment at IHS direct care facilities, but they are not eligible for the more specialized services that may be provided elsewhere (i.e., "contract care" services). By contrast, Native Americans on or near reservations—who are therefore eligible for the full range of IHS services—have access to both routine care and to the more specialized contract care services. Because of their eligibility for IHS services, nearly 55 percent of the eligible IHS population has neither private health insurance nor public coverage (other than IHS) (Beauregard, Cunningham, and Cornelius 1991).

Native Americans who do have private insurance (less than one-third of the Indian population in 1987), in fact, have a choice that most other Americans don't have—whether to get free health care where the choice of providers and services is limited, or whether to obtain private care elsewhere. The options for both private care and treatment at IHS facilities are limited by the distances that must be traveled to get to either. However, because the waiting times reported for treatment at IHS facilities exceed waiting times reported for services with other providers, Native Americans with private insurance often prefer to seek private care (Beauregard, Cunningham, and Cornelius 1991).

Mortality

The mortality (or death) rate in a specific population—determined by the quality of available medical care, income, nutritional status, environmental quality, and cultural habits—is a basic measure of the standard of living (Ewbank 1989). *Infant* mortality reflects not only the standard of living of a population but also mirrors the health of the mother. As seen in Table 8, among all women of color from 1984 to 1986, infant mortality rates were highest for the babies of Black women—at 18.3 deaths per 1,000 live births, more than double the 8.8

rate for White mothers and significantly greater than the rate for all mothers of 10.3 deaths per 1,000 live births.

Although associated with the high percentage of low weight infants born to Black women, the high Black infant mortality rate is also related to the intergenerational effects of socioeconomic conditions on the growth and development of a mother from prebirth to childhood, which may influence the intrauterine growth of her child (Schoendorf et al. 1992). Since many middle-class Blacks are the first generation in their families to achieve that status, a Black middle-class mother may be giving birth to an infant whose health is markedly determined by maternal childhood poverty (Jaynes and Williams 1989).

Table 8 **· Infant, neonatal, and postneonatal mortality rates by mother's race and Hispanic origin, 1984-1986 birth cohorts (in numbers)[1]**

Race and Hispanic Origin	Total Infant Deaths[2]	Neonatal Deaths[2]	Postneonatal Deaths[2]
Total	10.3	6.7	3.6
RACE			
White	8.8	5.7	3.1
Black	18.3	12.0	6.3
Native American	13.5	6.2	7.3
Total Asian and Pacific Islander	8.1	5.1	3.0
Chinese American	6.3	3.6	2.7
Japanese American	6.5	3.8	2.7
Filipino American	7.8	5.1	2.7
Other Asian and Pacific Islander[3]	8.9	5.7	3.2
HISPANIC/NON-HISPANIC ORIGIN			
Total Hispanic origin[4]	8.8	5.8	3.1
Mexican American	8.5	5.4	3.0
Puerto Rican	11.9	7.9	4.0
Cuban American	8.0	5.9	2.1
Central and South American	8.0	5.5	2.5
Other and unknown	9.4	6.0	3.4
Non-Hispanic White[5]	8.6	5.6	3.0
Non-Hispanic Black[5]	18.2	11.7	6.5

[1]*Mortality rates are the number of deaths per 1,000 live births.*
[2]*Infant deaths are the sum of neonatal and postneonatal deaths; neonatal deaths occur within the first 28 days of life; and postneonatal deaths occur after the 28th day but before the 365th day of life.*
[3]*Includes Native Hawaiians.*
[4]*Persons of Hispanic origin may be of any race.*
[5]*These data apply only to births in those states that specify Hispanic origin as well as race on birth certificates. In the period from 1984 to 1986, 23 states and the District of Columbia did so.*

Source: National Center for Health Statistics 1992a.

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Neonatal Deaths[2]	Postneonatal Deaths[2]
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5.7	3.1
12.0	6.3
6.2	7.3
5.1	3.0
3.6	2.7
3.8	2.7
5.1	2.7
5.7	3.2
5.8	3.1
5.4	3.0
7.9	4.0
5.9	2.1
5.5	2.5
6.0	3.4
5.6	3.0
11.7	6.5

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As Table 8 reveals, most infant deaths between 1984 and 1986 were neonatal for all groups except Native American infants. Of the 13.5 deaths of Native American infants (per 1,000 live births), 7.3—or 54 percent—occurred in the postneonatal period, often as the result of accidents or environmental hazards.

Native Americans had the second highest total infant mortality rate, followed by Puerto Ricans with 11.9 infant deaths per 1,000 live births. All the Asian and Pacific Islander American groups (for which data were reported) had infant mortality rates close to or lower than the infant mortality rates for Whites.

Mortality for women of color themselves results from a variety of differing causes, although heart disease and cancer are the leading killers. For all women 15 to 44 years of age, death rates from AIDS have increased steadily since 1985, with the majority of deaths occurring in women age 25 to 34. As Table 9 demonstrates, the rates for Black women of all ages are at least seven times greater than the rates for White women.

Table 9 **· Mortality rates from AIDS for Black and White women by age, 1990 and 1991**[1]

	1990	*1991*
Black women		
All ages	10.6	12.2
Under age 15	-	-
15-24	4.4	-
25-34	23.3	29.0
35-44	28.2	25.9
45-54	-	17.9
55 and over	-	-
Age-adjusted rates	10.2	12.0
White women		
All ages	1.1	1.5
Under age 15	-	-
15-24	-	-
25-34	3.0	3.4
35-44	2.0	3.2
45-54	1.1	1.6
55 and over	0.6	0.8
Age-adjusted rates	1.1	1.5

[1]*Mortality rates are per 100,000 population.*

Source: National Center for Health Statistics 1992b.

women in the U.S. population. The death rate from liver disease and cirrhosis was five times that of other women, and the death rate from homicide was three times that of other women. Native American women often cope with prior victimization (from incest, rape, and other forms of sexual assault) by escaping into alcohol and drugs; doing so, though, contributes to higher mortality rates (Horton 1992).

The overall rate of cancer mortality among Native American women is lower than for the general population. However, aggregate data from all the IHS regions masks the fact that several areas—Alaska; Aberdeen, South Dakota; Bimidji, Minnesota; and Billings, Montana—have higher cancer mortality rates among Native American women than among the general population of women (Scott and Suagee 1992).

A dramatic increase in mortality from lung cancer has also occurred among Native American women. In three regions—Alaska, North Dakota/South Dakota/Montana, and Michigan/Minnesota/Wisconsin—lung cancer mortality rates for Native American women have risen from rates lower than the national average to rates 2.5, 1.5, and 1.5 times the U.S. rates, respectively. Rates for Arizona and New Mexico have remained relatively flat, at less than one-third the national rate. For Alaska and the southwest region jointly, however, excess gallbladder cancer mortality is found among Native American women. All the IHS areas had cervical cancer mortality rates higher than the U.S. average. In the Billings, Montana IHS area, the death rate is over five times the national rate (IHS n.d.). The death rate for Native American women from cervical cancer is high because they are often diagnosed later and have a poorer survival rate than other women (IHS 1991b).

ISSUES RELATED TO IMPROVING THE HEALTH OF WOMEN OF COLOR

Data Collection Problems

Many subpopulations of women of color are only known by the absence of data on them. Because Native Americans, Hispanics, and Asian and Pacific Islander Americans are not broadly distributed across the United States, large national surveys do not sample these groups sufficiently to collect reliable data. Mortality data, for example, are collected in only 30 states for Hispanics, and poor reporting practices minimize the usefulness of the statistics that are available (GAO 1992).

In addition, aggregating data for these racial/ethnic groups often obscures the more meaningful differences among their subpopulations. For example, the mortality rate for Puerto Rican infants is higher than

for Mexican American infants, while Chinese and Japanese Americans have infant mortality rates lower than other Asian and Pacific Islander American groups. Small populations without great geographic dispersion and with great cultural diversity within them create a challenging research setting. It is difficult to collect readily generalizable data that can be applied to the development of universally applied treatment responses (Levy 1992).

Two solutions are commonly employed to collect high quality data for small population subgroups not broadly distributed. First, one can use national sample survey techniques and oversample in areas with sizable populations of the minority groups of interest. To do so requires the use of many racial and ethnic identifiers and is likely to increase both the size of the sample and the cost of the survey.

Another approach is to survey the major racial/ethnic population subgroups in the areas where they dominate. This technique was employed in the Hispanic Health and Nutrition Evaluation Survey, which covered approximately 76 percent of the 1980 Hispanic-origin population in the United States, by surveying the three major subgroups in selected areas. Mexican Americans were surveyed in Arizona, California, Colorado, New Mexico, and Texas; Puerto Ricans were surveyed in the New York City metropolitan area (New York, New Jersey, and Connecticut); and Cuban Americans were surveyed in Dade County, Florida (Delgado et al. 1990).

Because over 70 percent of the Asian and Pacific Islander Americans are clustered in California, Hawaii, Illinois, New Jersey, New York, Texas, and Washington, this group might be amenable to a nationally representative analysis done in these seven states.

California, the state with the largest number of Asian and Pacific Islander Americans (2.8 million), currently collects data for 14 different Asian and Pacific Islander groups (Filipino, Chinese, Vietnamese, Japanese, Korean, Asian Indian, Khmer [Cambodian], Thai, Laotian, Samoan, Native Hawaiian, Tongan, Guamanian, and other Pacific Islanders). But in published reports, it lumps these groups into the category of "Asian and Other," a category that also includes Native Americans (American Indians, Eskimos, and Alaskan Aleuts). Reporting data in this manner obscures important differences among these groups and negates the possible benefit from the use of multiple ethnic identifiers during data collection (Ponce 1990).

When the relevant populations are surveyed, data on the degree of acculturation and immigration history need to be collected. For example, if survey respondents are overwhelmingly the more assimilated and American-born Asians, then their health profiles may obscure the morbidity and behavioral risk-factor patterns of newly

research leave out Asian and Pacific Islander Americans because their health problems are not acknowledged.

Research and Treatment Needs

Even medical officialdom has begun to acknowledge its lack of attention to the health needs of women in the formulation of research designs and treatment protocols (NIH 1991). For women of color, the issue is even more dramatic: including White women in an experimental group may yield knowledge and results relevant to treating White women, but not for treating women of color. For example, how frequently should women be screened for breast cancer? Although in dispute, current guidelines suggest mammograms every other year for women 40 to 49 years of age and annually for women 50 and older. Because sizable numbers of Black women younger than 40 are diagnosed with and die from breast cancer, should different guidelines be established for Black women? What guidelines should be set to screen Native American women for whom diabetes, tuberculosis, and liver disease are more common than among the general population (Lefkowitz and Underwood 1991)? Why is hypertension a problem among Native Hawaiian women beginning very early in life, and what is the best way to control it? Questions such as these cannot be addressed without integrating knowledge of the needs of racial/ethnic minority women into research and treatment evaluations.

The issues of alcohol and substance abuse, and HIV/AIDS also highlight the need for research and treatment oriented to the female client population. Addiction treatment alone for Native American women suffering from alcoholism is not enough. The cultural and social experiences of Native American women must be incorporated into the treatment setting in order to adequately answer the question, "What is the pain she is trying to numb?" (IHS 1991b: 8).

Facilities to Serve People of Color

In what settings are research and treatment being applied to meet the needs of women of color? The policy of targeting resources and facilities to people of color has encountered snags throughout history. The provision of hospitals for Blacks, the designation of service areas for Native Americans, and the targeting of health care services for Native Hawaiians all illustrate these problems.

The closing of hospitals serving predominantly Black communities is controversial and often has been found to be driven more by the racial composition of the hospitals' neighborhoods than by economic conditions (Rice and Payne 1981). The concept of these hospitals dates from an era when racial/ethnic minority populations were more highly segregated in

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America's cities than many of them are today. As newer waves of immigrants have come to America who are able to choose increasingly not to live in racial/ethnic ghettos, it has become harder to define territorial "communities" for specific racial/ethnic groups and to meet their needs by placing facilities in these areas.

For example, the IHS regional designations reflect the population distribution of Native Americans in 1955 and are outdated today, when only 22 percent of Native Americans live on reservations and 67 percent live elsewhere, with a growing share in cities (Bureau of the Census 1992f). For Alaskan Natives who derive their livelihoods from seasonal employment such as fishing, it is difficult to get care during fishing season if the IHS facility is several hundred miles and several days journey from home. In most of Alaska, transportation poses a nearly insurmountable barrier to care, since there are only three urban IHS clinics to serve all the eligible people in the state. Many Alaskan Natives need temporary housing when they seek care at IHS medical facilities, since they are unable to return home the same day (HRSA 1992a).

Native Hawaiians must solve problems similar to those faced by American Indians. Although recognized as a high-risk group and in need of targeted health care services, because the living patterns on the Hawaiian Islands are racially/ethnically mixed, it is unrealistic to locate facilities to serve Native Hawaiians alone. On islands other than Oahu (the island on which Honolulu is located), Native Hawaiians are more likely to postpone care until they perceive a crisis in order to avoid travel problems.

Community-based, consumer-friendly facilities are often at a disadvantage when competing against larger organizations for resources to serve their clients. For instance, when seeking funds under the Ryan White Comprehensive Resources Emergency (CARE) Act of 1990, many smaller community groups oriented to serving women with HIV/AIDS complain of losing out to hospitals and larger organizations. In addition, the "AIDS establishment" of service organizations often fails to recognize local targeted groups serving women of color with AIDS, making case referrals difficult (HRSA 1991; HRSA 1992b). Programs developed by organizations such as the National Black Women's Health Project and the National Latina Health Network seek to bridge this gap in health care funding and services for their constituents.

The "one-stop shopping" model to provide health services for women has not caught on. Such centers would provide child care along with comprehensive services for the needs of women including reproductive, internal medicine, mental health, substance abuse, and HIV/AIDS care (HRSA 1992a).

Need for Minority Physicians and Providers

The federal government has designated several racial/ethnic groups as underrepresented in the population of physicians (and other health care providers) and has offered incentives to change this, based on the dual beliefs that minority doctors tend to locate in underserved areas and that they tend to care for more minority patients. In 1980, although Black Americans were three percent of all physicians (as opposed to nearly 12 percent of the general population), their share of the physician population had increased very little since 1950. Similarly, Mexican Americans and Puerto Ricans were only four percent of physicians in 1980, although they were then 5.5 percent of the total U.S. population; and Native Americans were only 0.1 percent of all physicians, while they comprised 0.6 percent of the population. Asian and Pacific Islander Americans, however, were 10 percent of all physicians, but only 1.6 percent of the U.S. population (Hanft and White 1989).

The belief that increasing minority representation among doctors will increase access of minorities to health care is supported by data on Black physicians. Although more than 80 percent of Blacks report having a White physician as their primary provider, 80 percent of the patients of Black physicians are Black (Jaynes and Williams 1989). The regional distribution of Black and Native American physicians, in particular, seems to be influenced by the location of substantial numbers of like minorities. It is estimated that 60 to 80 percent of the underrepresented students trained in the health professions voluntarily practice in or close to designated shortage areas with overwhelming minority populations (Scott and Suagee 1992). Although research on matching providers and patients on the basis of race or ethnicity is generally inconclusive, there seems to be consensus that the effectiveness of treatment (especially for substance abuse) is enhanced when the provider is culturally knowledgeable.

Although the federal government considers Asian and Pacific Islander Americans to be overrepresented among physicians, this assessment rests in part on the belief that all Asian and Pacific Islander American groups can be served by "generic" Asian and Pacific Islander health professionals. Gains in the number of health care workers among Asian and Pacific Islander Americans have occurred primarily among second and third generation Asian Americans, specifically Japanese and Chinese Americans. However, in the Pacific Trust territories, "...no single jurisdiction comes close to its marginally adequate level of health manpower." In the Republic of the Marshall Islands, for example, the minimum required number of physicians is 40, but only 14 are available (Forman 1990). Among psychiatrists, Asians

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were 8.6 percent of the total in the United States in 1984. Half of these (51 percent) were Asian Indians, however, and only 23 percent were of either Chinese or Japanese ancestry. This mix of providers differs markedly from the representation of Asian and Pacific Islander Americans in the United States.

The unmet demand for multicultural and multilingual health professionals needs to be addressed. However, discrimination in residency placement and licensure limits the ability of foreign-trained medical professionals to serve in the United States and help meet this need (Leung and Lu 1990). In addition, although the failure of facilities supported by federal funds to have medically trained translators to meet the needs of patients whose primary language is not English violates civil rights statutes, this is the status quo at many American health care centers. Continued failure to support the development of multicultural and multilingual health professionals discounts the degree to which language and culture influence access to and utilization of services, and can contribute to continued unnecessary disease and death.

CONCLUSION

WOMEN OF COLOR ARE MEMBERS of extremely heterogeneous groups. For example, Hispanic women include both Puerto Rican women, born with citizenship but also having a high incidence of AIDS and higher than average infant mortality rates, and Mexican American women, many of whom are foreign-born and who have lower infant mortality rates. Asian and Pacific Islander American women, in another example, include Native Hawaiian women with high rates of obesity, hypertension, and infant mortality—as well as Japanese American women, 86 percent of whom get prenatal care in the first trimester of pregnancy and whose low infant mortality rates may reflect this. In addition, Native American women in the Southwest have low cancer rates while their sisters in the Plains states and Alaska have extremely high rates. Finally, babies born to Black immigrant couples are of low weight less often than babies born to Black native couples.

Generalizations that create health profiles for these groups of women are dangerous because exceptions to the rules are numerous. The challenge instead is to refine the knowledge and understanding about these groups to the point that individualized care can be provided to each and every woman of color, regardless of race or ethnicity and health problem.

During the 1960s and much of the 1970s, increasing access was a major health policy objective. Since the 1980s, the emphasis has shifted

to cost containment, and this focus may ultimately reduce access to care for women of color. If, under the guise of cost containment, renewed emphasis is placed on changing individuals' behavior, it would be all too easy to cross the line to "victim blaming."

Structural problems—such as limited employment opportunities, the lack of resources beyond those to meet basic needs, and the lack of public transportation—all contribute adversely to an individual's ability to change high-risk health behaviors. Programs designed to respect cultural norms and values that are cognizant of structural limits will be the most effective means to enhance the health of women of color.