



Minority Populations and Health

An Introduction to
Health Disparities
in the United States



Thomas A. LaVeist



“With clarity and insight, Professor LaVeist provides a desperately needed comprehensive overview of the nature, magnitude, and causes of racial/ethnic disparities in health. This is an important and valuable new resource that will fill an important void in the field.”

—David R. Williams, Ph.D., M.P.H., Harold Cruse Collegiate Professor of Sociology, professor of epidemiology, senior research scientist, Institute for Social Research, University of Michigan

“The book provides a thoughtful introduction to the many factors that contribute to racial/ethnic disparities in health and in health care. It is a timely and important textbook that can help students understand basic terms used in the field as well as the complexity of the issues that give rise to inequities in the U.S. health system.”

—Marsha Lillie-Blanton, vice-president, health policy, Kaiser Family Foundation

“This text provides a timely and comprehensive discussion that raises critical insights about the contexts, complexities, and nuances of race and health. It will be a welcomed resource for a course that examines health disparities in public health, sociology, psychology, and medicine.”

—David Takeuchi, Ph.D., professor, University of Washington

“Professor LaVeist has assembled an impressive array of information, drawing on state-of-the-art theory and research, that will help advanced undergraduates and graduate students in public health and other professional programs to take the next steps from theory to research to action. This text will be an invaluable tool in generating new strategies to advance the nation’s goals of health equity.”

—Brian D. Smedley, Ph.D., research director, The Opportunity Agenda, lead editor,
Institute of Medicine report, *Unequal Treatment*

“This is a fine book that provides a comprehensive overview of the health and health care needs of all major minority populations in the United States. While the book is primarily intended for advanced undergraduate and graduate students, it will be an invaluable resource for all scholars of health disparities and minority health.”

—Kyriakos S. Markides, Ph.D., Annie and John Gnitzyng Professor of Aging Studies, director,
Division of Sociomedical Science Preventive Medicine and Community Health,
and editor, *The Journal of Aging & Health*

MINORITY POPULATIONS AND HEALTH



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Disparities in the United States

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PREFACE

For fifteen years I have been teaching courses on health inequality at both the undergraduate and graduate level at Johns Hopkins. I have long bemoaned the fact that nobody had written a textbook I would use in the class. I made do with article reprints and my own notes. As I compared experiences with colleagues who teach similar classes at other universities, it became clear that a textbook needed to be written.

The field has evolved and the number of people interested in health disparities and health inequalities has grown. And there is every reason to believe that it will continue to grow for the foreseeable future. Now we need the curricula to support the expanding interest. I hope this book is a step toward creating those curricula.

Completing a book of this scope largely depends on how well you can convince others to help. Naturally, I did not possess all of the necessary knowledge to write this book alone. My learning curve was *very* steep for some of the chapters. In those cases I benefited greatly from consultations with colleagues and friends who helped me to make sense of what I was reading and writing.

At the risk of missing someone important, I would like to acknowledge each of the people who helped me along the way. Without their help I certainly could not have completed this project. It is also important that I be clear that I am listing them in alphabetical order.

I would like to thank Phillip Blanc (University of Medicine and Dentistry of New Jersey), Tamarya Carroll (Spelman College), and Paulina Lopez (Johns Hopkins University), my team of dedicated students who read drafts and ripped them apart.

Their help definitely made this a better book! I am particularly grateful to them for their input regarding what features make a textbook most usable. They helped me to view the book through the student's eye.

I am grateful for the assistance of many colleagues who graciously lent their expertise by responding to questions, sending reprints, giving me figures and charts, forwarding articles, and reading drafts of chapters. Specifically, they are Cheryl Alexander (Johns Hopkins Bloomberg School of Public Health), Lori Edwards (Shaw University), Tiffany Gary (Johns Hopkins Bloomberg School of Public Health), Darrell Gaskin (Johns Hopkins Bloomberg School of Public Health), Miryam Granthen (U.S. Department of Health and Human Services), Daniel L. Howard (Shaw University), John Lynch (University of Michigan), Katrina McDonald (Johns Hopkins University), Thomas McGuire (Harvard University), Kim Nickerson (American Psychological Association), Brian Smedley (Institute of Medicine), Sharon Smith (Johns Hopkins Bloomberg School of Public Health), David R. Williams (University of Michigan), and John M. Wallace, Jr. (University of Pittsburgh School of Social Work).

I would like to single out Dr. Duane Thomas (Johns Hopkins Bloomberg School of Public Health) for a special thank-you. Without Duane's help on the mental health chapter it might have taken me another year to complete this book. Duane was a godsend! I got a great deal of helpful advice from my fellow participants on the Spirit of 1848 (American Public Health Association Caucus) listserv. The participants on that listserv are some of the most knowledgeable and helpful people around.

The staff at Jossey-Bass were patient and understanding each time I missed deadlines (which I did often). I am grateful to them for alleviating the anxiety and helping reduce the stress associated with writing a book. They were great to work with!

I am particularly indebted to the staff of the Hopkins Center for Health Disparities Solutions for their assistance, particularly Devony Blyden, John Jackson, and Lydia Isaac. I am most indebted to Lydia Isaac for "keeping the ship afloat" during the times that I was away writing, reading drafts, and helping me to stay organized.

I would like to acknowledge my family, who are always both a help and a hindrance. My wife, Bridgette LaVeist, herself a public health professional, read drafts of several chapters while constantly asking when I would be finished. And my children: Clay, Naomi, Randall, and Carlton, your very existence drives me to work harder, while at the same time reminding me to stop and smell the roses. My first act after completing this book will be to take my four-year-old son Clay to the store to buy the model car he has been asking me about, so we can build it together.

Finally, I thank God, who continues to bless me even when I least deserve it! Thank you for the unconditional love.

T.L.

ABOUT THE AUTHOR

Thomas A. LaVeist is director of the Center for Health Disparities Solutions and professor of health policy and management at the Johns Hopkins Bloomberg School of Public Health. He teaches courses in health inequality, health disparities, and public health policy. LaVeist is a frequent visiting lecturer on minority health issues at other universities and at professional conferences and workshops. He often consults to federal agencies on minority health issues and racial disparities in health. LaVeist has conducted several important studies on related topics; his research has been funded by the National Institutes of Health, the National Center for Minority Health and Health Disparities, the Center for Disease Control, the Commonwealth Fund, the Russell Sage Foundation, the Kellogg Foundation, and the Robert Wood Johnson Foundation.

LaVeist received his bachelor of arts degree from the University of Maryland, Eastern Shore, and his doctorate in medical sociology from the University of Michigan. His dissertation was awarded the Roberta G. Simmons Outstanding Dissertation Award, for the best doctoral dissertation in medical sociology, by the American Sociological Association in 1989. He held a postdoctoral fellowship in public health at the University of Michigan, School of Public Health. LaVeist joined the Johns Hopkins faculty in 1990. He has published numerous articles in scientific journals and is author of *The DayStar Guide to Colleges for African American Students* (Kaplan Interactive, 2000), coauthor of *Eight Steps to Help Black Families Pay for College* (Princeton Review, 2003), and editor of *Race, Ethnicity, and Health: A Public Health Reader* (Jossey-Bass, 2002).

MINORITY POPULATIONS AND HEALTH



CHAPTER ONE

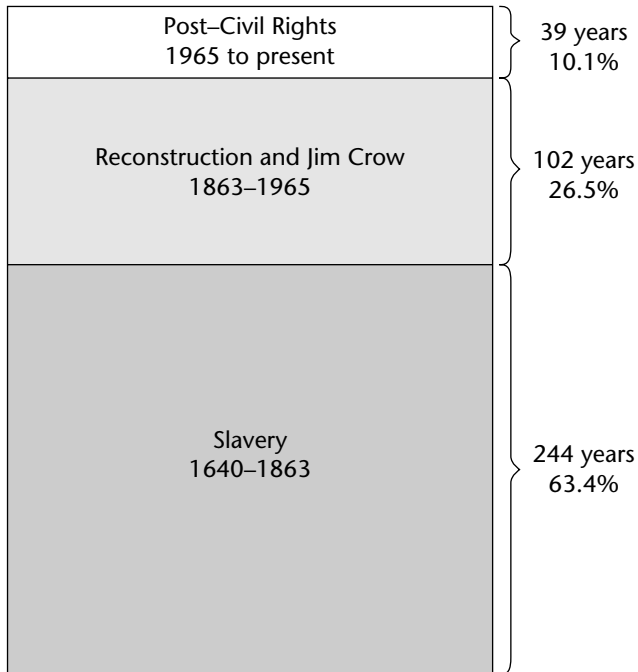
HISTORICAL ASPECTS OF RACE/ETHNICITY AND HEALTH

The history of the relationship between the U.S. government and racial/ethnic minorities plays an important role in understanding why health disparities exist and how they might be eliminated. In this introduction I will provide a brief overview of the history that has led to the contemporary state of health disparities. I will then discuss likely future trends and why the study of minority health is important. I will then end the chapter with a discussion of decisions made in deciding the terminology that will be used to refer to the various racial/ethnic groups to be discussed in this book.

Historical Background

Figure 1.1 summarizes the status of African Americans throughout the history of the United States. The exact date the first Africans arrived in the country is in dispute. Some historians place this as early as Columbus's first voyage, but the most commonly cited date is August 1619 (Quarles, 1987). From that point until President Lincoln issued the Emancipation Proclamation in 1863 (freeing the Africans who lived in the states that had seceded from the country, but not those in states that were not part of the confederacy), the country's African population was primarily slaves, although in every state there were some who were not slaves. The period of slavery lasted 244 years—63.4 percent of the time between 1619 and 2004.

FIGURE 1.1. CHANGING STATUS OF AFRICAN AMERICANS IN U.S. HISTORY, 1619–2004.



BOX 1.1. THIRTEENTH, FOURTEENTH, AND FIFTEENTH AMENDMENTS TO THE U.S. CONSTITUTION.

The Thirteenth Amendment, ratified in 1865, outlawed slavery in the United States and all territories.

The Fourteenth Amendment, ratified in 1868, gave citizenship to all persons born in the U.S. or naturalized.

The Fifteenth Amendment, ratified in 1870, barred states from prohibiting any male citizen from voting. All females received the right to vote with the ratification of the Nineteenth Amendment in 1920.

The end of slavery throughout the country came when the Thirteenth Amendment to the U.S. Constitution was ratified in 1865. This also began the Reconstruction era and the “Jim Crow” period, in which the black codes relegated racial and ethnic minorities to second-class citizenship. These state laws limited or even prohibited racial minorities from exercising voting rights, reducing them to receiving substandard health care and education (Quarles, 1987; Smith, 1999).

In the early twentieth century, separate health care facilities for African Americans began to be developed, mainly by churches. Medical schools for Black doctors were created because most existing medical schools would not admit African Americans. These medical schools and Black hospitals were not as well funded as their segregated counterparts. When African Americans did have interactions with the White medical system (typically in segregated wards), the discourteous nature of the interpersonal communications during these medical encounters produced inequalities in medical treatment. These factors, along with other historical events such as the Tuskegee Syphilis Study, led to racial and ethnic disparities in the access to and utilization of health services and to distrust of the medical care system among racial and ethnic minorities.

In many ways the history of African Americans parallels the history of Native Americans. The arrival of the European settlers in the New World led to the introduction of diseases not native to the continent (such as measles and yellow fever). Disease outbreaks along with war led to the decimation of the Native American population. The importation of Africans to serve as free labor introduced a new group who, along with Native Americans, were barred from access to state-of-the-art health care, clean water, and good quality housing. In 1830, thirty-three years before the Emancipation Proclamation, the United States Congress passed the Indian Removal

BOX 1.2. THE FIVE CIVILIZED TRIBES.

The *Civilized Tribes* were the five American Indian tribes living in the southeastern United States before forced relocation. They were among the first tribes to encounter European settlers. Over time the settlers and tribe members intermarried. By the early 1800s, these tribes had established businesses and their own constitutions, codes of law, and judicial systems. The Civilized Tribes are

Cherokee (Muskogee Confederation): Georgia

Seminole: Florida

Creek: Alabama and Georgia

Chickisaw: Mississippi

Choctaw: Mississippi

Act, which was signed into law by President Andrew Jackson. The act ushered in a period of forcible removal of the so-called five Civilized Tribes and their relocation (referred to as the Trail of Tears) to reservations in the Oklahoma territory.

BOX 1.3. BLACK MEDICAL SCHOOLS.

Today there are four historically Black medical schools: Howard University College of Medicine in Washington, D.C.; Meherry Medical College in Nashville, Tennessee; Charles R. Drew University of Medicine and Science in Los Angeles, California; and Morehouse School of Medicine in Atlanta, Georgia.

BOX 1.4. THE TUSKEGEE SYPHILIS STUDY.

The Tuskegee Syphilis Study, carried out in Macon County, Alabama, from 1932 to 1972, is an example of medical research gone wrong. The United States Public Health Service, in trying to learn more about syphilis and justify treatment programs for blacks, withheld adequate treatment from a group of poor black men who had the disease, causing needless pain and suffering for the men and their loved ones. . . .

The study involved 600 black men—399 with syphilis and 201 who did not have the disease. Researchers told the men they were being treated for “bad blood,” a local term used to describe several ailments, including syphilis, anemia, and fatigue. In truth, they did not receive the proper treatment needed to cure their illness. In exchange for taking part in the study, the men received free medical exams, free meals, and burial insurance. Although originally projected to last 6 months, the study actually went on for 40 years. . . .

In the summer of 1973, a class-action lawsuit filed by the National Association for the Advancement of Colored People (NAACP) ended in a settlement that gave more than \$9 million to the study participants. As part of the settlement, the U.S. government promised to give free medical and burial services to all living participants. The Tuskegee Health Benefit Program was established to provide these services. It also gave health services for wives, widows, and children who had been infected because of the study.

Source: Centers for Disease Control and Prevention, “CDC Tuskegee Syphilis Study Page,” <http://www.cdc.gov/nchstp/od/tuskegee/index.html>.

BOX 1.5. THE CIVIL RIGHTS AND VOTING RIGHTS ACTS.

The Civil Rights Act of 1964 prohibited discrimination in public accommodations such as mass transportation, restaurants, and hotels on the basis of race, color, religion, or national origin.

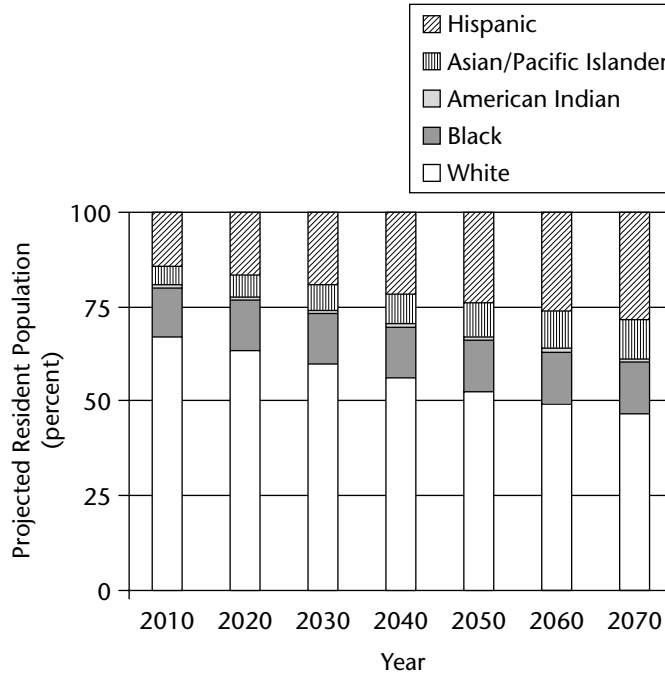
The Voting Rights Act of 1965 eliminated discriminatory election practices. Specifically, it suspended literacy tests and provided for the appointment of federal examiners (with the power to register qualified citizens to vote) in those jurisdictions that were “covered,” according to a formula provided in the statute. In addition, under Section 5 of the Act, covered jurisdictions were required to obtain “preclearance” for new voting practices and procedures from either the District Court for the District of Columbia or the United States Attorney General. Section 2 of the Act, which closely followed the language of the Fifteenth Amendment, applied a nationwide prohibition of denial or abridgment of the right to vote on account of race or color.

Treaties between the U.S. government and the various American Indian tribes typically promised education and health care. The responsibility for provision of health care was left to the U.S. Army, which was neither equipped nor provided the resources necessary to provide adequate care. Later the U.S. government established the Bureau of Indian Affairs (BIA), which assumed responsibility for providing health care to the American Indian population. The establishment of the Indian Health Service in 1955 led to the creation of a federal agency whose primary mission was the provision of health care to Native Americans. That same year, Rosa Parks’s refusal to give up her seat on a Montgomery, Alabama, bus sparking the bus boycott that ignited the Civil Rights movement of the 1950s and 1960s (Morris, 1986).

Coming out of the civil rights movement were the Civil Rights Act of 1964 and the Voting Rights Act of 1965. These acts dismantled the most limiting components of the “Jim Crow” laws (black codes) and fulfilled the constitutional guarantees contained in the Fourteenth and Fifteenth Amendments. The Civil Rights movement shifted governmental policy away from support of racially discriminatory social norms such as racially segregated hospitals. As governmental policy shifted, the power of government shifted away from support of discrimination in favor of the enforcement of policies to dismantle discrimination in health care settings.

Today, health care facilities face the threat of government sanctions if they are found to be engaging in racially discriminatory practices. Minority health care providers can be found treating White patients, and it is not unusual to find White and non-White patients sharing hospital rooms. Yet although rigid segregation and overt discrimination are now illegal, the consequences are still with us. The health status disparities and health care disparities that have resulted are outlined in the chapters that follow.

FIGURE 1.2. PROJECTED PERCENTAGE OF RESIDENT U.S. POPULATION BY RACE/ETHNICITY, 2010–2070.



Source: U.S. Bureau of the Census, "Projections of the Resident Population by Race, Hispanic Origin, and Nativity: Middle Series, 1999 to 2100" (NP-T5).

Why Is It Important to Study Minority Health?

The last few decades of the twentieth century witnessed an explosion in the number of racial/ethnic minorities, particularly Hispanics/Latinos/Chicanos and Asians. This increase has occurred largely because of immigration, but that's not the only reason. Every major racial/ethnic group for which the U.S. government keeps records (African American-Black, Native American-American Indian-Alaska Native, Asian-Pacific Islander, and Hispanic-Latino-Chicano) has a higher fertility rate than White Americans. For this reason the U.S. Bureau of the Census projects that by the middle of the twenty-first century the United States will be a "majority-minority" country (see Figure 1.2). Whites will make up less than 50 percent of the U.S. population, and racial/ethnic groups that we now consider minorities will total more than 50 percent.

As the country undergoes this transition, health statistics for the nation as a whole will become a reflection of the health status of racial minorities. What we now call minority health will become the nation's health. And, as we will learn in the chapters that follow, racial/ethnic minorities generally have a worse health status than Whites.

At the same time, the United States is undergoing another demographic transition. The baby boomers will soon be entering their senior years—the first wave of Boomers will celebrate their sixty-fifth birthdays in 2011. As this happens, the ranks of the elderly will expand tremendously, and this will continue for several decades. These two demographic trends—an aging society combined with increasing proportions of minorities—will place increasing demands on a health care system that seems ill-prepared to handle it. Thus it's important for minority health to be a central feature of training programs in public health, medicine, nursing, social work, pharmaceutical science, and other disciplines that relate to health, such as the biological and the social sciences. We must prepare the next generation of health professionals to work with and in minority populations.

A Note on Terminology and Placing Humans in Categories

Group identity is very important to humans. It goes to the core of who we are and where we see ourselves fitting into the world. There is nothing more human than to think in terms of in-groups. At a fundamental psychological level, we think of ourselves as belonging to *this* group and *not* belonging to *that* group. And we all belong to many groups.

We know how to identify others in our in-groups. Sometimes we can identify in-group members via a secret handshake. Other times we determine membership by more subtle means, such as physical appearance. The process of identifying in-group members is easiest when there is a secret handshake, password, or similar objective process. It is easier to tell who is in the group and who is not; either they know the

BOX 1.6. HISPANIC/LATINOS CROSS ALL OTHER MAJOR RACIAL/ETHNIC GROUPS.

Black Hispanic	Cuba, Dominican Republic, Puerto Rico
White Hispanic	Cuba, Dominican Republic, Puerto Rico, Argentina, Colombia
Indian Hispanic	Latin American Indians, Peru, Ecuador, Mexico
Asian Hispanic	Filipinos

BOX 1.7. OMB DIRECTIVE 15.

The Office of Budget and Management's Directive 15 established standards for the collection of data on race and ethnicity. The original version of OMB Directive 15 was released in 1977; version 2 was issued in 1997.

BOX 1.8. THE QUESTION ON RACE FROM CENSUS 2000.

6. What is this person's race? *Mark one or more races to indicate what this person considers himself/herself to be.*

- White
- Black, African Am., or Negro
- American Indian or Alaska Native—*Print name of enrolled or principal tribe.*
- Asian Indian Japanese Native Hawaiian
- Chinese Korean Guamanian or Chamorro
- Filipino Vietnamese Samoan
- Other Asian—*Print race.* Other Pacific Islander—*Print race.*
- Some other race—*Print race.*

Source: U.S. Bureau of the Census, Census 2000 questionnaire.

handshake or they don't. But when it comes to racial or ethnic groups, there is no secret handshake. Instead, we try to identify groups by appearance, culture, nationality, and so on.

Variation in humans exists across many domains, such as skin color, hair texture, nationality, culture, shared history, language, or religion. These domains overlap. A person could be a Cuban American of African descent who has lived most of his or her life in a predominantly Chamorro community in the Marianas Islands and speaks mainly Chamoru on a daily basis. Which group does this person belong to?

An extreme example? Yes. But the point is that human variation does not conform to categories. However, categories are all we have to work with.

The United States' Office of Management and Budget (OMB) went through a multiyear process of determining how to create a set of categories that capture human variation within the United States. This process included countless hearings and studies and

many hours of deliberation. It was a serious process undertaken by serious people. In the end those categories serve the purpose of being broad enough that nearly everyone can find their place in them. But the categories do not work for everyone. No set of categories can.

Often categories are too broad, combining people who really shouldn't be combined, thus obscuring the diversity of the group. For example, the Asian group includes many people from many different countries who speak very different languages. When you add Pacific Islanders (Asian/Pacific Islanders), the problem is exacerbated.

Which brings me to the question that defines my point: how do you write a book about the health of racial/ethnic minority groups in the United States while having to rely on statistics that combine individuals into categories that are less than ideal?

The second issue that one must consider is terminology. What do you call the groups?

- Black or African American?
- Hispanic or Latino or Chicano or persons of Spanish descent?
- Native American or American Indian?

The problem is a serious one because, as I have found, those who have an opinion on this issue tend to hold that opinion very strongly. That would be OK if the opinions were consistent, but they are not. I talked with many people about this issue—scholars, activists, students, cafeteria workers—even my mother. I sent out emails to people I know would have thought about these issues. I read everything I could find on the subject. I must say, nearly every one of them made a compelling argument for his or her point of view. Unfortunately, I found starkly conflicting opinions. Here is a sample of quotes from people I talked with or exchanged emails with.

- “I think I like Hispanic; Latino is for Mexicans, not us.”
- “Latino is the only proper name, because Hispanic is a name created by the U.S. government.”
- “We use the term American Indian—period.”
- “American Indian denotes affiliation with the oppressor; you should use ‘indigenous people.’”
- “Nobody uses African American in normal conversation; that’s more for formal writing.”
- “African American excludes native Africans living in the United States.”

I could go on, but I think you see my point. No matter what terms I use, I will be making some set of readers unhappy. So as not to insult anyone, I even considered using all of the names separated by a hyphen (that is, African American-Black, Native American-American Indian-Alaska Native, Asian-Pacific Islander, and Hispanic-Latino-Chicano). Obviously that won't work for an entire book.

Census Terminology Study

In 1996 the U.S. Bureau of the Census conducted a survey to determine preferences for terms to designate racial/ethnic groups. People who identified themselves as Hispanic, White, Black, American Indian, Eskimo, Aleut, or multiracial were given a list of terms describing their respective racial or ethnic group and were asked to choose which term they preferred, or to indicate whether they preferred some other term or had no preference. Table 1.1 gives the percentage from each group preferring a particular term. These results have been collapsed across the panels.

The majority of Hispanic respondents chose *Hispanic* as the term they preferred, and about 10 percent of the Hispanics chose each of the other terms. A majority of Whites chose *White*. A large plurality of Blacks preferred the term *Black*, but almost as many chose *African American* or *Afro-American*. More than half of those identifying as American Indian or one of the classes of Alaska Native preferred either *American Indian* or *Alaska Native*, but over a third chose the more generic *Native American*. Almost 30 percent of those identifying as multiracial preferred the term *multiracial*, but about as many had no preference.

There is no consensus term that will satisfy everyone in all cases. In spite of the fact that I will be using terminology that is not favored by some set of readers, I had to make decisions that I hope will minimize the number of readers that are put off. If you are one who does not like the choices I made, I apologize. I hope you will be sympathetic to my plight and use this chapter as an opportunity to address the issue in the classroom. Ask students how they would have handled the problem. I think this will lead to a worthwhile class discussion.

I applied the following usage rules to address the various populations:

- The term *race/ethnicity* refers to the set of categories used to group individuals.
- The term *minority* refers to all of the groups generically.
- *Black* and *African American* are used interchangeably to refer to people of African descent (including African Americans, native Africans, and persons from the Caribbean and South America).
- When referring to a specific subgroup such as native Africans, I use the generic term *African* or the specific country or tribal affiliation.
- *Hispanic/Latino* is used in combination to refer to persons from Central and South America (including Mexico), the Spanish-speaking Caribbean (Puerto Rico, Cuba, and the Dominican Republic), and Brazil.
- *American Indian* refers to all indigenous Americans from what is now the continental United States.
- *Alaska Natives* refers to indigenous populations of Alaska.

**TABLE 1.1. PREFERENCE FOR RACIAL OR ETHNIC TERMINOLOGY
(PERCENT DISTRIBUTION).**

Preferred Terminology	Percent
<i>Hispanic Origin</i>	
Hispanic.....	57.88
Latino.....	11.74
Of Spanish origin.....	12.34
Some other term.....	7.85
No preference.....	10.18
<i>White</i>	
White.....	61.66
Caucasian.....	16.53
European American.....	2.35
Anglo.....	0.96
Some other term.....	1.97
No preference.....	16.53
<i>Black</i>	
Black.....	44.15
African American.....	28.07
Afro-American.....	12.12
Negro.....	3.28
Colored.....	1.09
Some other term.....	2.19
No preference.....	9.11
<i>American Indian</i>	
American Indian.....	49.76
Alaska Native.....	3.51
Native American.....	37.35
Some other term.....	3.66
No preference.....	5.72
<i>Multiracial</i>	
Multiracial.....	28.42
More than one race.....	6.03
Biracial.....	5.67
Mixed race.....	16.02
Mestizo or mestiza.....	2.25
Some other term.....	13.87
No preference.....	27.76

Note: Percentages may not add to 100 due to rounding.

Source: U.S. Bureau of the Census, Decennial Statistical Studies Division, "Results of the 1996 Race and Ethnic Targeted Test," Population Division Working Paper No. 18, May 1997.

- The generic terms *American Indian/Alaska Native* and *Native American* are used interchangeably.
- *Asian/Pacific Islander* refers to persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example, China, India, Japan, Korea, the Philippine Islands, and Samoa.
- If the data are for Asians only, I refer to the category as *Asian* without *Pacific Islander*.
- When data on Native Hawaiians are available, I use those data. Otherwise, Native Hawaiians are combined with Pacific Islanders.
- In each case I use the lowest level of categorization available. For example, if the data allow me to talk about a specific Native American tribe, I use the tribal name. If the data are categorized only as American Indian (and specifically not Alaska Native), I use American Indian. If it is not possible to specify tribal affiliation or whether the data are for Alaska Natives or American Indians, I use the generic terms *Native American* or *American Indian/Alaska Native*.
- Finally, when referring to a specific report, study, book, or other document, I use whichever term was used in that document, even if it does not conform to the above usage rules. (See Appendix B for additional readings.)



PART ONE

CROSSCUTTING ISSUES



CHAPTER TWO

CONCEPTUAL ISSUES IN RACE/ETHNICITY AND HEALTH

Outline

- Introduction
- Origins of the Race Concept
- Problems with the Race Concept
 - Inconsistency of Race Conceptualizations
 - Confounding of Race, Ethnicity, and Nationality
 - Attempting to Define Race
 - The Changing Measurement of Race in the U.S. Census
- Office of Management and Budget Directive 15
- A Conceptual Model of Race/Ethnicity and Health
- Summary

Introduction

In the United States, race and ethnicity is a factor in nearly every aspect of society, including politics, economics, music, art, and literature. Race is also among the most frequently used concepts in research conducted by public health, nursing, and medical scientists. A series of studies of three leading U.S.-based scientific journals found that more than 60 percent of the studies published in these journals included race or ethnicity (Jones, LaVeist, & Lillie-Blanton, 1991; Williams, 1994). In fact, not only was race or ethnicity included in the majority of studies; the use of race/ethnicity increased during the second half of the twentieth century and is showing no sign of letting up in the twenty-first century. Because race/ethnicity is so frequently used in the health sciences, one might think that there is general agreement on the meaning of these concepts; however, this is not the case. In fact there is a great deal