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## Reported Importance and Access to Health Care Providers Who Understand or Share Cultural Characteristics With Their Patients Among Adults, by Race and Ethnicity

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### Abstract

**Objective**—This report examines racial and ethnic differences in the reported importance and frequency of seeing culturally competent health care providers among U.S. adults.

**Methods**—Using the 2017 National Health Interview Survey, estimates of the importance and frequency of seeing health care providers who shared or understood respondents' culture were examined by race and Hispanic ethnicity, and stratified by other demographic characteristics.

**Results**—Among adults who had seen a health care professional in the past 12 months, the percentage of non-Hispanic white adults who thought it was very important to have a health care provider who shared or understood their culture was significantly lower than that among all other race and Hispanic-ethnicity groups. Among those who thought it was at least slightly important to have a health care provider who shared or understood their culture, minority groups were generally more likely to report never being able to see a culturally similar health care provider compared with non-Hispanic white adults, and this pattern persisted regardless of sex, age group, or urbanicity.

**Keywords:** cultural competence • CLAS standards • National Health Interview Survey

### Introduction

Racial and ethnic disparities in the quality of health care are associated with poorer health and higher mortality rates among minority groups (1–3). Among the many factors that may contribute to these disparities, lack of diversity in the health care workforce, as well as perceptions, attitudes, and beliefs of both patients and providers have been shown to influence the quality of care received (3–5). Previous research has shown

that patients may be more comfortable in settings where the providers share or understand their language, race, ethnicity, or other cultural characteristics (6–9). Hence, the U.S. Department of Health and Human Services Office of Minority Health (OMH) released the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. The CLAS standards establish a blueprint

for health care organizations to follow through respecting the entire individual and responding to his or her health needs and preferences by providing culturally competent services (10–12). Cultural competence includes the alignment of behaviors, attitudes, and policies in the health care setting in order to more effectively serve persons of all cultures, and subsequently advance health equity and health care quality (10).

Although OMH originally released the National Standards for CLAS in Health and Health Care in 2000 (10,11), nationally representative data on perceived cultural competence in health care settings and the importance of cultural competence among patients are still lacking. To address this gap, sample adult respondents aged 18 and over who had seen a health care professional in the past 12 months were asked questions related to the CLAS standards in the 2017 National Health Interview Survey (NHIS). These questions asked about patients' experiences with health care providers in order to measure perceptions of whether or not cultural competence by health care providers is being achieved. This report provides nationally representative estimates for two of these questions, which measure the reported importance and frequency of seeing



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providers who shared or understood respondents' cultures. Given prior research on cultural competence of care, it was hypothesized that these measures would differ by race and Hispanic ethnicity (2–4). Therefore, race and Hispanic ethnicity was selected as the main covariate of interest, stratifying by other demographic characteristics.

## Methods

### Data source

Data from the 2017 NHIS were used to generate the estimates presented in this report. NHIS is a multipurpose health survey of the U.S. civilian noninstitutionalized population. It is conducted continuously by the National Center for Health Statistics (NCHS) using trained interviewers from the U.S. Census Bureau. Data are collected in person at the respondent's home using computer-assisted personal interviewing, but follow-ups to complete interviews may be conducted over the telephone. A detailed description of the 2017 NHIS sample design and survey questionnaire is available elsewhere (13).

NHIS consists of both a core set of questions that remain relatively unchanged from year to year, as well as supplemental questions that are not asked every year. The core consists of four main components: the Household Composition Section, the Family Core, the Sample Adult Core, and the Sample Child Core. The Household Composition Section collects basic demographic and relationship information about all members of all families living in a household. The Family Core collects demographic, health insurance information, and basic health information about all family members from a single family member (the "family respondent"). For the Sample Adult Core, one adult per family (the "sample adult") is randomly selected to respond to detailed health questions. For the Sample Child Core, one child per family (the "sample child") is randomly selected, and a knowledgeable adult (usually the parent) responds on the child's behalf. More information on the survey is available from: <https://www.cdc.gov/nchs/nhis/index.htm>.

Analyses in this report were based on data collected from 26,742 sample adults aged 18 and over in 2017. The overall response rate for sample adults (of all ages) was 53.0% in 2017 (13).

### Cultural competence (CLAS) questions

Questions regarding respondents' perceptions of the cultural competence of their health care providers were included as a 1-year supplement in the "Adult Access and Utilization" section of the Sample Adult interview in the 2017 NHIS. Sample adults who had seen a health professional in the past 12 months were asked, "Some people think it is important for their providers to understand or share their race or ethnicity or gender or religion or beliefs or native language. How important is it to you that your health care providers understand or are similar to you in any of these ways? Would you say... very important, somewhat important, slightly important, or not important at all?" Those who answered that it was at least slightly important that health care providers share or understand their culture were asked the follow-up question, "How often were you able to see health care providers who were similar to you in any of these ways? Would you say... always, most of the time, some of the time, or none of the time?"

### Race and ethnicity

The main covariate of interest in this report is race and Hispanic ethnicity, as it was hypothesized that perceptions of cultural competence in the health care setting would differ by one's race and ethnicity. Estimates are shown for four specific race and ethnicity groups: non-Hispanic white, non-Hispanic black, non-Hispanic other race(s), and Hispanic. Adults categorized as Hispanic may be of any race or combination of races. Adults categorized as non-Hispanic white and non-Hispanic black indicated one race only. Estimates for non-Hispanic persons of races other than white only or black only, or of multiple races, are combined into the non-Hispanic other race(s) category.

### Other demographic characteristics

It was hypothesized that certain characteristics (sex, age, and metropolitan or nonmetropolitan residence) may also affect perceptions of cultural competence and so, the analysis was stratified by these covariates. Age was categorized into two groups (18–64 and 65 and over). Sex was categorized into two groups (men and women). Location was categorized into two groups (metropolitan and nonmetropolitan), based on the household residence location. Metropolitan or nonmetropolitan status is determined using the 2013 NCHS urban–rural classification scheme for counties (14), by merging the county of household residence geographic federal information processing standard (FIPS) codes with county-level FIPS codes from the 2013 NCHS urban–rural classification scheme data set. Metropolitan counties include large central counties, the fringes of large counties (suburbs), medium counties, and small counties. Nonmetropolitan counties include micropolitan statistical areas and noncore areas.

### Statistical analyses

This report presents differences in the perceived cultural competence of health care providers by race and Hispanic ethnicity among the U.S. civilian noninstitutionalized population of adults aged 18 and over.

NHIS is designed to provide national estimates by applying weights to a nationally representative sample. Point estimates and estimates of their variances were calculated using SAS-callable SUDAAN version 11.0.1 (RTI International, Research Triangle Park, N.C.), a software package that accounts for the complex sample design of NHIS. All estimates for adults were weighted using the annual sample weights for adults and so, are representative of the U.S. civilian noninstitutionalized population of adults aged 18 and over. Data weighting procedures are described in more detail elsewhere (13). Calculations of estimates excluded in-universe sample adults with missing information for CLAS questions (around 1%).

Unless otherwise noted, all estimates in this report meet NCHS standards of reliability as specified in “National Center for Health Statistics Data Presentation Standards for Proportions” (15). Estimates by race and Hispanic ethnicity, sex, age, and urbanicity were compared for statistically significant differences using two-tailed tests with no adjustments for multiple comparisons. The critical value used for two-sided tests at the 0.05 level of significance was 1.96.

## Results

Among the 87% of adults who had seen a health care professional in the past 12 months, less than one-half thought it was either very important (19.2%) or somewhat or slightly important (29.3%) to have a health care provider who shared or understood their culture; however, this differed by race and Hispanic ethnicity (Figure 1, Table 1). More than one-half of non-Hispanic white adults thought it was not important to have a health care provider who shared or understood their culture (57.9%). By comparison, the

majority of non-Hispanic black adults thought it was either very important (31.7%) or somewhat or slightly important (29.4%) to have a health care provider who shared or understood their culture. Similarly, the majority of Hispanic adults and non-Hispanic adults of other race(s) thought it was either very important (32.9% and 27.0%, respectively) or somewhat or slightly important (28.4% and 32.6%, respectively) to have a health care provider who shared or understood their culture. The percentage of non-Hispanic white adults who thought it was very important to have a health care provider who shared or understood their culture was significantly lower compared with all other race and Hispanic-ethnicity groups.

As shown in Figure 1, nearly one-half of adults who had seen a health care professional in the past 12 months thought it was at least slightly important to have a health care provider who shared or understood their culture. Among these adults, approximately 70% reported that they were able to see a similar health care provider always or most of the time, but this differed by race and Hispanic

ethnicity (Figure 2, Table 2). More than three-quarters of non-Hispanic white adults were able to see a health care provider who shared their culture always or most of the time (78.4%). A significantly lower percentage of non-Hispanic black adults, Hispanic adults, and non-Hispanic other adults were able to see a health care provider who shared their culture always or most of the time (59.6%, 59.1%, and 58.8%, respectively). Similarly, among non-Hispanic black, Hispanic, and non-Hispanic other adults, the percentages who never were able to see a health care provider who shared their culture (12.8%, 13.7%, and 15.2%, respectively) were significantly higher than the percentage of non-Hispanic white adults who never were able to see such a provider (4.0%).

Among adults who thought it was at least slightly important to have a health care provider who shared or understood their culture, men and women were equally likely to report never being able to see a health care provider who shared their culture

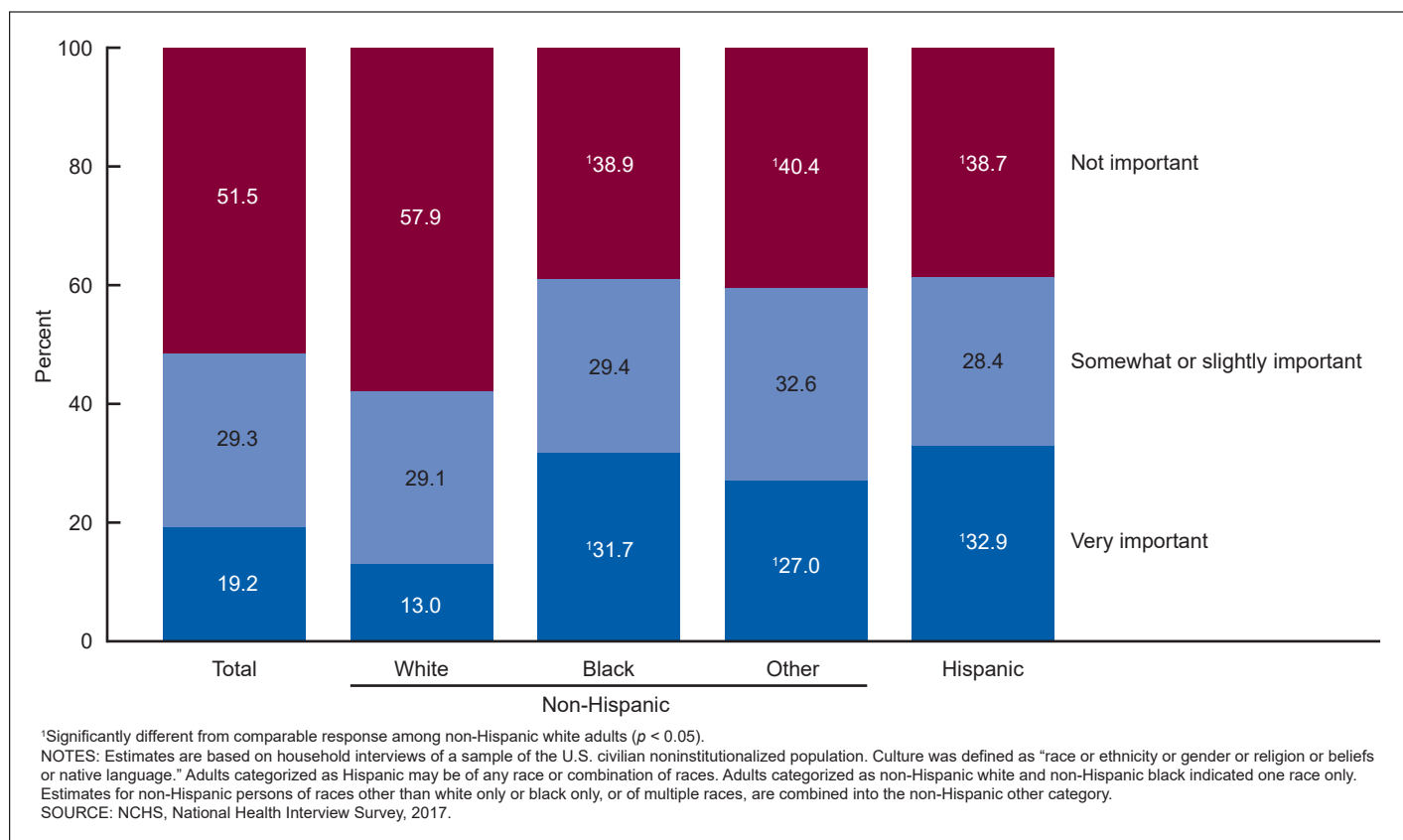
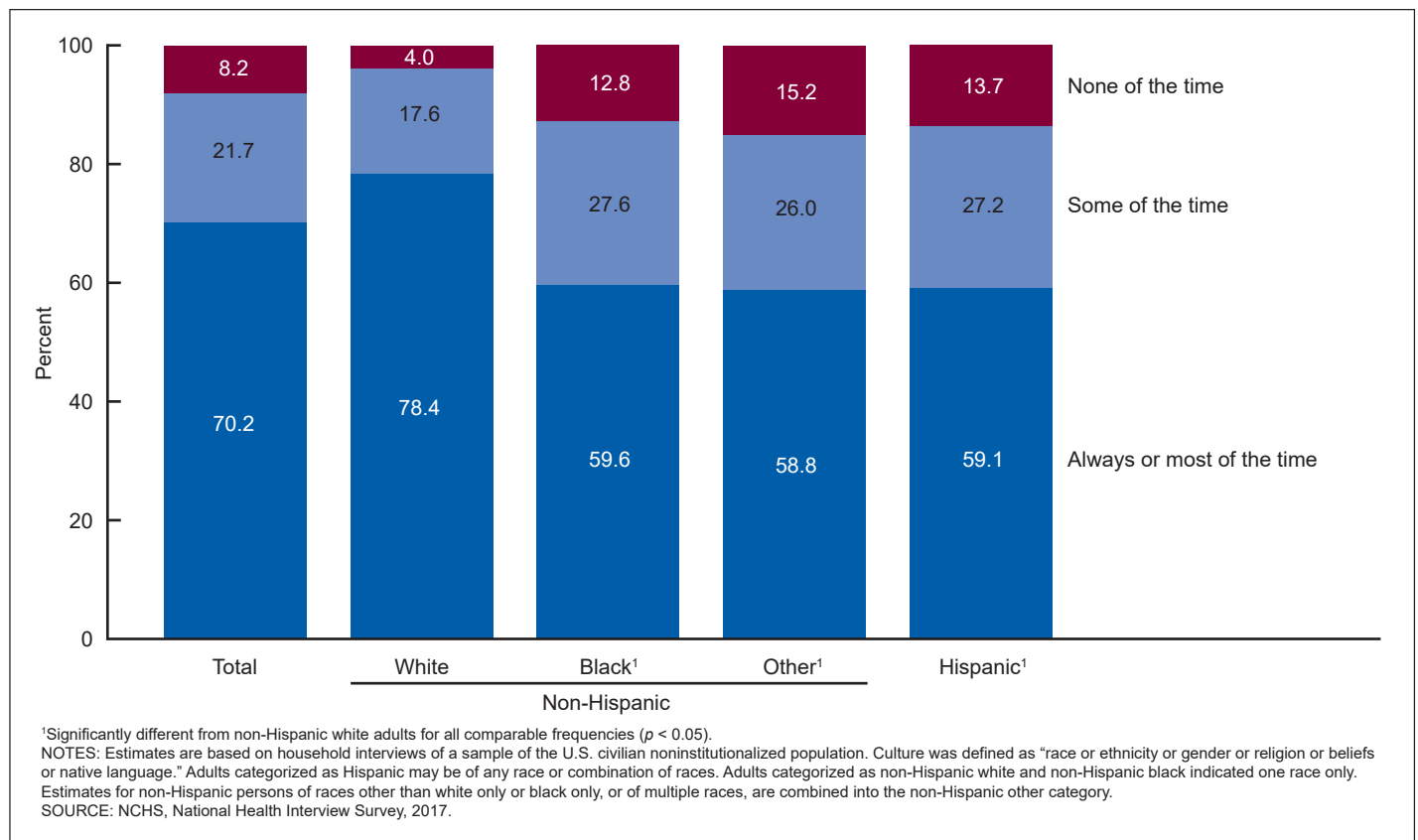


Figure 1. Percent distributions of importance of having a health care provider who shared or understood their culture among adults aged 18 and over who had seen a health care professional in the past 12 months, by race and Hispanic ethnicity: United States, 2017



**Figure 2. Percent distributions of frequency of seeing a health care provider who shared their culture among adults aged 18 and over who thought it was at least slightly important to have a health care provider who shared or understood their culture, by race and Hispanic ethnicity: United States, 2017**

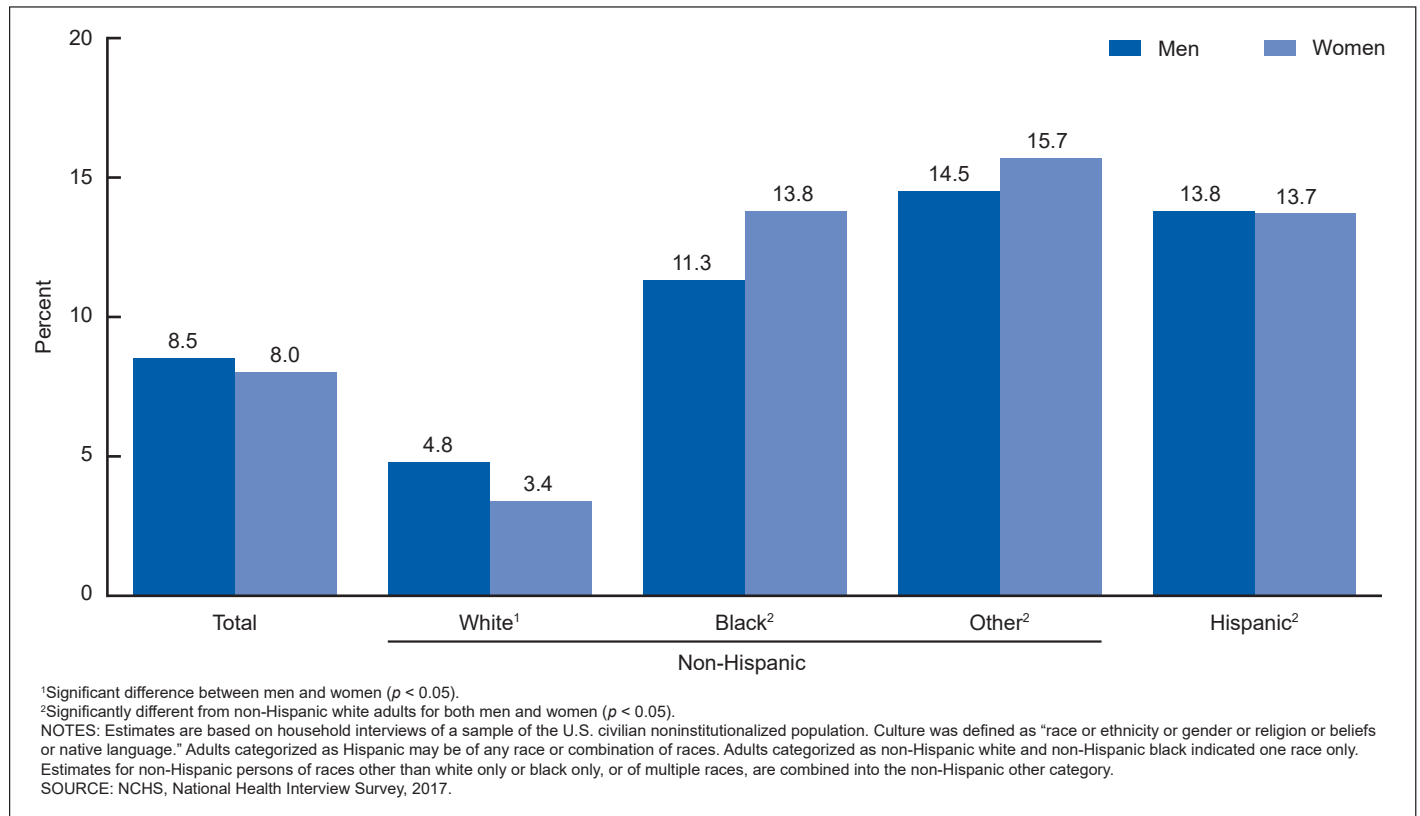
(8.5% and 8.0%, respectively), but this differed by race and Hispanic ethnicity (Figure 3, Table 3). Non-Hispanic white men were more likely to never be able to see a health care provider who shared their culture (4.8%) compared with non-Hispanic white women (3.4%). However, among non-Hispanic black, Hispanic, and non-Hispanic other adults, the percentages who never were able to see a health care provider who shared their culture did not differ significantly between men and women (11.3% and 13.8%, 13.8% and 13.7%, and 14.5% and 15.7%, respectively). Regardless of sex, non-Hispanic white adults were less likely to never be able to see a health care provider who shared their culture compared with all other race and Hispanic-ethnicity groups.

Among adults who thought it was at least slightly important to have a health care provider who shared or understood their culture, those aged 18–64 were more likely to report never being able to see a health care provider who shared their culture compared with

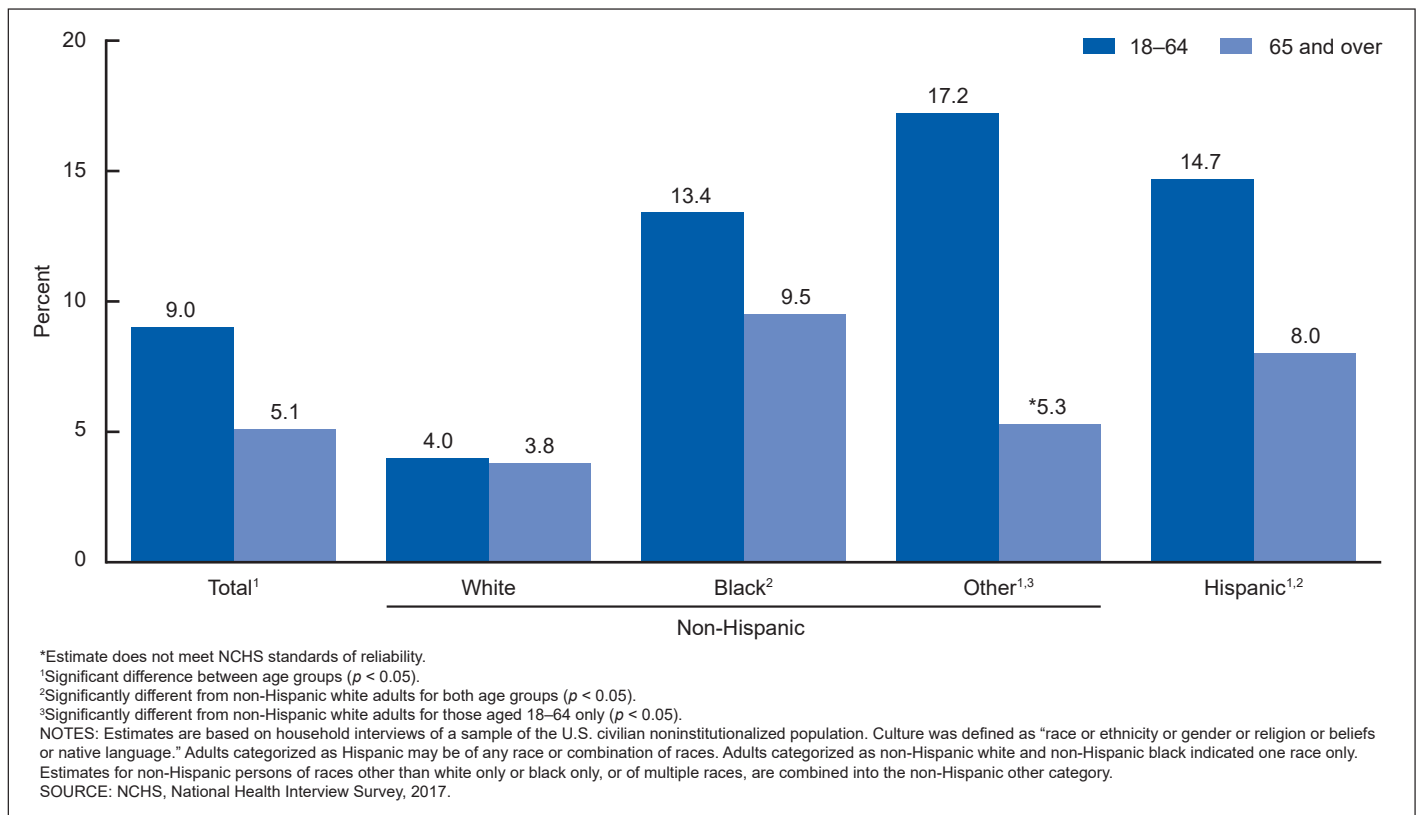
adults aged 65 and over (9.0% compared with 5.1%); however this differed by race and Hispanic ethnicity (Figure 4, Table 4). Hispanic adults aged 18–64 were nearly twice as likely to never be able to see a health care provider who shared their culture compared with Hispanic adults aged 65 and over (14.7% compared with 8.0%). Non-Hispanic adults of other race(s) aged 18–64 were more than three times as likely to never be able to see a health care provider who shared their culture compared with non-Hispanic adults of other race(s) aged 65 and over (17.2% compared with 5.3%), although the latter estimate did not meet NCHS standards of reliability. Among non-Hispanic white adults (aged 18–64: 4.0%, and 65 and over: 3.8%) and non-Hispanic black adults (aged 18–64: 13.4%, and 65 and over: 9.5%), no significant differences were observed by age group between the percentages who never were able to see a health care provider who shared their culture. Among adults aged 65 and over, non-Hispanic black (9.5%) and Hispanic (8.0%) adults

were more than twice as likely to never be able to see a health care provider who shared their culture compared with non-Hispanic white adults (3.8%). The percentage of non-Hispanic adults of other race(s) aged 65 and over who never were able to see a health care provider who shared their culture (5.3%) was not significantly higher than that among non-Hispanic white adults of the same age group (3.8%); however, the former estimate did not meet NCHS standards of reliability. Among adults aged 18–64, non-Hispanic black (13.4%), Hispanic (14.7%), and non-Hispanic other (17.2%) adults were more than 3.5 times as likely to never be able to see a health care provider who shared their culture compared with non-Hispanic white adults (4.0%).

Among adults who thought it was at least slightly important to have a health care provider who shared or understood their culture, those residing in metropolitan areas were more likely to report never being able to see a health care provider who shared their culture



**Figure 3. Percentage who never were able to see a health care provider who shared their culture among adults aged 18 and over who thought it was at least slightly important to have a health care provider who shared or understood their culture, by sex and race and Hispanic ethnicity: United States, 2017**



**Figure 4. Percentage who never were able to see a health care provider who shared their culture among adults aged 18 and over who thought it was at least slightly important to have a health care provider who shared or understood their culture, by age group and race and Hispanic ethnicity: United States, 2017**



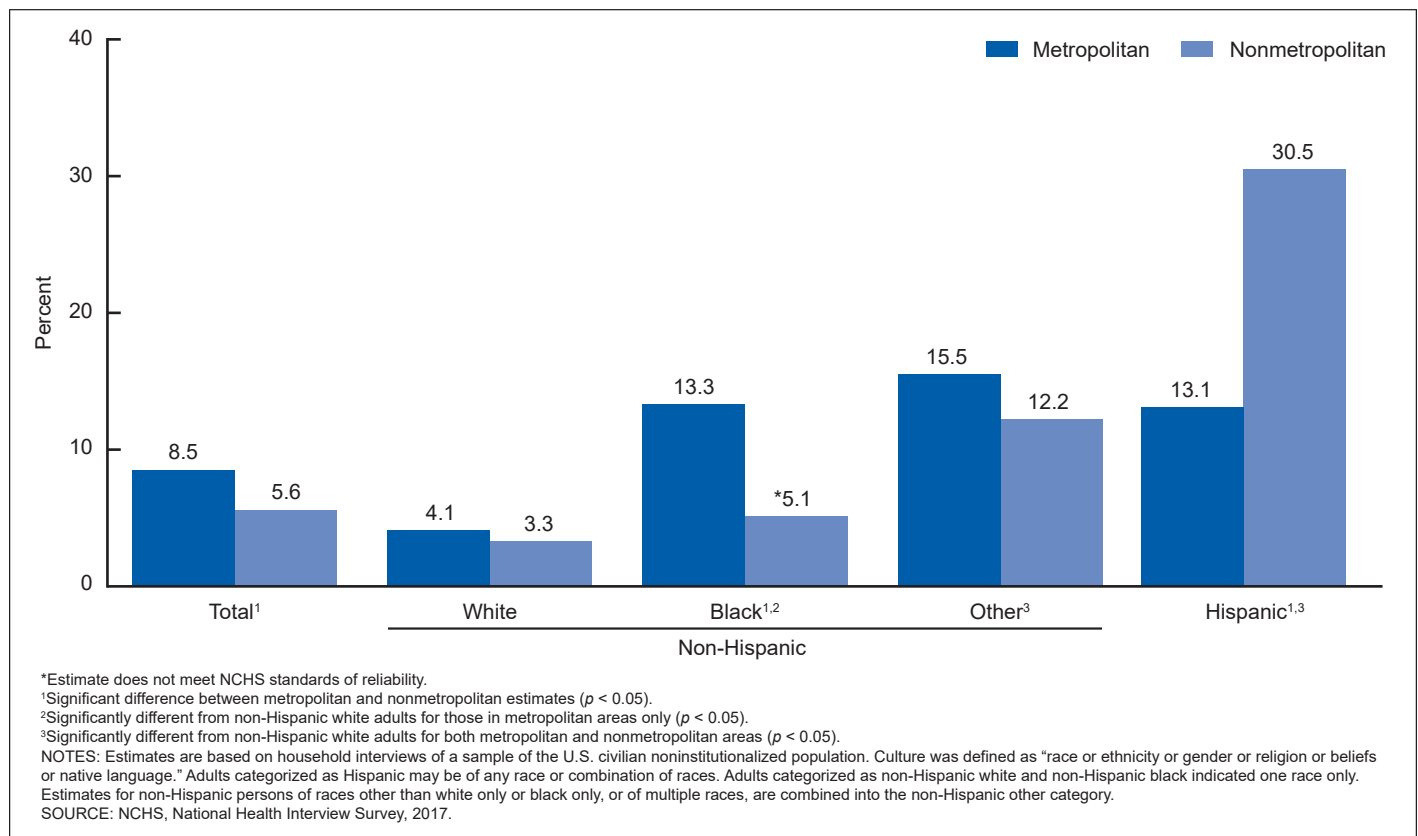
compared with those in nonmetropolitan areas (8.5% compared with 5.6%) (Figure 5, Table 5). The percentage of adults who never were able to see a health care provider who shared their culture did not significantly differ by urbanicity among non-Hispanic white adults (4.1% compared with 3.3%) or non-Hispanic adults of other race(s) (15.5% compared with 12.2%). Among Hispanic adults living in nonmetropolitan areas, the percentage who never were able to see a health care provider who shared their culture (30.5%) was more than twice that among those living in metropolitan areas (13.1%). Conversely, non-Hispanic black adults living in metropolitan areas were more than twice as likely to report never being able to see a provider who shared their culture compared with non-Hispanic black adults living in nonmetropolitan areas (13.3% compared with 5.1%), although the latter estimate did not meet NCHS standards of reliability. Non-Hispanic black (13.3%), Hispanic (13.1%), and non-Hispanic other (15.5%) adults living

in metropolitan areas were more than three times as likely to never be able to see a health care provider who shared their culture compared with non-Hispanic white adults living in metropolitan areas (4.1%). In addition, Hispanic adults residing in nonmetropolitan areas were more than nine times as likely to never be able to see a health care provider who shared their culture (30.5%) compared with non-Hispanic white adults living in nonmetropolitan areas (3.3%). Nonmetropolitan non-Hispanic adults of other race(s) (12.2%) were 3.5 times as likely to never be able to see a health care provider who shared their culture compared with non-Hispanic white adults living in nonmetropolitan areas (3.3%). The percentage of non-Hispanic black adults living in nonmetropolitan areas who never were able to see a health care provider who shared their culture (5.1%) was not significantly higher than that among non-Hispanic white adults living in nonmetropolitan areas (3.3%); however, the former estimate did not meet NCHS standards of reliability.

## Discussion

The aim of this study was to investigate racial and ethnic differences in reported importance and frequency of shared or understood culture between patients and providers and to examine these differences by sex, age group, and urbanicity.

In 2017, 19.2% of adults who had seen a health care professional in the past 12 months thought having a health care provider who shared or understood their culture was very important, while more than one-half (51.5%) did not think it was important at all. This varied significantly by race and Hispanic ethnicity, with at least 27.0% of minority adults reporting shared culture to be very important. Among adults who thought it was at least slightly important to have a health care provider who shared or understood their culture, 70.2% reported that they were able to see a health care provider who shared their culture always or most of the time. However, 78.4% of non-Hispanic white adults were able to see a health



**Figure 5. Percentage who never were able to see a health care provider who shared their culture among adults aged 18 and over who thought it was at least slightly important to have a health care provider who shared or understood their culture, by urbanicity and race and Hispanic ethnicity: United States, 2017**

care provider who shared their culture always or most of the time, which was significantly less likely among minority adults (nearly 60%). Similarly, minority groups were generally more likely to never be able to see a similar health care provider compared with non-Hispanic white adults, and this pattern did not differ by sex, age group, or urbanicity.

Among adults who thought it was at least slightly important to have a health care provider who shared or understood their culture, there were a few differences among subgroups. Firstly, among Hispanic adults and non-Hispanic adults of other race(s), those aged 18–64 were significantly more likely to report never being able to see a similar health care provider compared with those aged 65 and over. Secondly, among non-Hispanic white adults, men were significantly more likely to never be able to see a similar health care provider compared with women. Among non-Hispanic black adults, those living in metropolitan areas were significantly more likely to never be able to see a similar health care provider compared with those living in nonmetropolitan areas. Lastly, among Hispanic adults, those living in nonmetropolitan areas were significantly more likely to never be able to see a similar health care provider compared with those living in metropolitan areas.

This analysis is not without limitations. Firstly, sample size for some population subgroups was limited. Given that questions from the CLAS supplement were only included in the 2017 NHIS, pooling years of data to increase reliability of estimates was not possible. Secondly, while self-reported data are essential when gaining information on perspectives and beliefs, they may be subject to reporting biases. Lastly, this study classified respondents into broad racial and ethnic groups. However, people in one racial or ethnic group may experience the health care system very differently than others in their same group as a result of within-group diversity, other identities or characteristics, or personal experiences. This study's classification of race and Hispanic ethnicity does not allow for examination of these finer within-group differences. Further research could look into these differences, as well as

additional ways of measuring cultural competence and its relationship with the quality of care received. Despite these limitations, this study is one of few using nationally representative data to examine perceived cultural competence in health care settings and to measure progress toward the CLAS standards.

Previous research has shown that patients are more satisfied with their care when they view their physician as similar to them in a number of ways (6–9). If they perceive their physicians as sharing their race, ethnicity, or language, or if they believe they share their values or beliefs, patients are more likely to trust and engage with their physicians (6–9). Previous research also suggests that this increase in trust and participation may even result in increased adherence with health recommendations, which may lead to better eventual health outcomes (8).

In this report, the data show that racial and ethnic minorities were more likely to find it important that their provider share or understand their culture, but were less likely to be able to see a provider who met these criteria.

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**Table 1. Percent distribution (and 95% confidence intervals) of importance of having a health care provider who shared or understood their culture among adults aged 18 and over who had seen a health care professional in the past 12 months, by race and Hispanic ethnicity: United States, 2017**

Race and Hispanic ethnicity	Very important	Somewhat or slightly important	Not important
Total . . . . .	19.2 (18.4–19.9)	29.3 (28.5–30.2)	51.5 (50.5–52.5)
Non-Hispanic white. . . . .	13.0 (12.2–13.7)	29.1 (28.2–30.1)	57.9 (56.9–59.0)
Non-Hispanic black. . . . .	31.7 (28.9–34.5)	29.4 (26.9–32.0)	38.9 (36.1–41.8)
Non-Hispanic other. . . . .	27.0 (23.8–30.4)	32.6 (29.8–35.5)	40.4 (37.2–43.7)
Hispanic . . . . .	32.9 (30.3–35.7)	28.4 (26.1–30.8)	38.7 (36.1–41.4)

NOTES: Estimates are based on household interviews of a sample of the U.S. civilian noninstitutionalized population. Culture was defined as "race or ethnicity or gender or religion or beliefs or native language." Adults categorized as Hispanic may be of any race or combination of races. Adults categorized as non-Hispanic white and non-Hispanic black indicated one race only. Estimates for non-Hispanic persons of races other than white only or black only, or of multiple races, are combined into the non-Hispanic other category.

SOURCE: NCHS, National Health Interview Survey, 2017, Sample Adult Core component.

**Table 2. Percent distribution (and 95% confidence intervals) of frequency of seeing a health care provider who shared their culture among adults aged 18 and over who thought it was at least slightly important to have a health care provider who shared or understood their culture, by race and Hispanic ethnicity: United States, 2017**

Race and Hispanic ethnicity	Always or most of the time	Some of the time	None of the time
Total . . . . .	70.2 (68.9–71.4)	21.7 (20.6–22.7)	8.2 (7.4–9.0)
Non-Hispanic white. . . . .	78.4 (77.1–79.7)	17.6 (16.4–18.8)	4.0 (3.4–4.6)
Non-Hispanic black. . . . .	59.6 (55.9–63.2)	27.6 (24.6–30.8)	12.8 (10.3–15.6)
Non-Hispanic other. . . . .	58.8 (54.5–63.0)	26.0 (22.6–29.7)	15.2 (12.3–18.5)
Hispanic . . . . .	59.1 (55.9–62.3)	27.2 (24.3–30.2)	13.7 (11.3–16.5)

NOTES: Estimates are based on household interviews of a sample of the U.S. civilian noninstitutionalized population. Culture was defined as "race or ethnicity or gender or religion or beliefs or native language." Adults categorized as Hispanic may be of any race or combination of races. Adults categorized as non-Hispanic white and non-Hispanic black indicated one race only. Estimates for non-Hispanic persons of races other than white only or black only, or of multiple races, are combined into the non-Hispanic other category.

SOURCE: NCHS, National Health Interview Survey, 2017, Sample Adult Core component.

**Table 3. Percentage (and 95% confidence intervals) who never were able to see a health care provider who shared their culture among adults aged 18 and over who thought it was at least slightly important to have a health care provider who shared or understood their culture, by sex and race and Hispanic ethnicity: United States, 2017**

Race and Hispanic ethnicity	Men	Women
Total	8.5 (7.4–9.6)	8.0 (7.1–9.0)
Non-Hispanic white	4.8 (3.9–5.8)	3.4 (2.7–4.2)
Non-Hispanic black	11.3 (8.0–15.5)	13.8 (10.6–17.4)
Non-Hispanic other	14.5 (10.3–19.6)	15.7 (11.8–20.3)
Hispanic	13.8 (10.3–18.0)	13.7 (10.8–16.9)

NOTES: Estimates are based on household interviews of a sample of the U.S. civilian noninstitutionalized population. Culture was defined as "race or ethnicity or gender or religion or beliefs or native language." Adults categorized as Hispanic may be of any race or combination of races. Adults categorized as non-Hispanic white and non-Hispanic black indicated one race only. Estimates for non-Hispanic persons of races other than white only or black only, or of multiple races, are combined into the non-Hispanic other category.

SOURCE: NCHS, National Health Interview Survey, 2017, Sample Adult Core component.

**Table 4. Percentage (and 95% confidence intervals) who never were able to see a health care provider who shared their culture among adults aged 18 and over who thought it was at least slightly important to have a health care provider who shared or understood their culture, by age group and race and Hispanic ethnicity: United States, 2017**

Race and Hispanic ethnicity	18–64	65 and over
Total	9.0 (8.1–10.0)	5.1 (4.2–6.0)
Non-Hispanic white	4.0 (3.3–4.8)	3.8 (3.0–4.8)
Non-Hispanic black	13.4 (10.6–16.6)	9.5 (6.3–13.6)
Non-Hispanic other	17.2 (13.8–21.2)	*5.3 (2.5–9.7)
Hispanic	14.7 (11.9–17.7)	8.0 (4.9–12.1)

\*Estimate does not meet NCHS standards of reliability.

NOTES: Estimates are based on household interviews of a sample of the U.S. civilian noninstitutionalized population. Culture was defined as "race or ethnicity or gender or religion or beliefs or native language." Adults categorized as Hispanic may be of any race or combination of races. Adults categorized as non-Hispanic white and non-Hispanic black indicated one race only. Estimates for non-Hispanic persons of races other than white only or black only, or of multiple races, are combined into the non-Hispanic other category.

SOURCE: NCHS, National Health Interview Survey, 2017, Sample Adult Core component.

**Table 5. Percentage (and 95% confidence intervals) who never were able to see a health care provider who shared their culture among adults aged 18 and over who thought it was at least slightly important to have a health care provider who shared or understood their culture, by urbanicity and race and Hispanic ethnicity: United States, 2017**

Race and Hispanic ethnicity	Metropolitan	Nonmetropolitan
Total	8.5 (7.7–9.4)	5.6 (4.1–7.5)
Non-Hispanic white	4.1 (3.5–4.8)	3.3 (2.2–4.8)
Non-Hispanic black	13.3 (10.7–16.3)	*5.1 (1.9–10.5)
Non-Hispanic other	15.5 (12.3–19.0)	12.2 (6.9–19.5)
Hispanic	13.1 (10.7–15.9)	30.5 (20.0–42.8)

\*Estimate does not meet NCHS standards of reliability.

NOTES: Estimates are based on household interviews of a sample of the U.S. civilian noninstitutionalized population. Culture was defined as "race or ethnicity or gender or religion or beliefs or native language." Adults categorized as Hispanic may be of any race or combination of races. Adults categorized as non-Hispanic white and non-Hispanic black indicated one race only. Estimates for non-Hispanic persons of races other than white only or black only, or of multiple races, are combined into the non-Hispanic other category.

SOURCE: NCHS, National Health Interview Survey, 2017, Sample Adult Core component.

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