Table 3-1

United States Population by Race From 2000 to 2050

(Numbers in Thousands)						
POPULATION	**2000**	**2010**	**2020**	**2030**	**2040**	**2050**
Total	282,125	310,233	341,387	373,504	405,655	439,010
	(100.00)	(100.00)	(100.00)	(100.00)	(100.00)	(100.00)
White alone	228,548	246,630	266,275	286,109	305,247	324,800
	(81.0)	(79.5)	(78.0)	(76.6)	(75.2)	(74.0)
Black alone	35,818	39,909	44,389	48,728	52,868	56,944
	(12.7)	(12.9)	(13.0)	(13.0)	(13.0)	(13.0)
Asian alone	10,684	14,415	18,756	23,586	28,836	34,399
	(3.8)	(4.6)	(5.5)	(6.3)	(7.1)	(7.8)
All other races*	7,075	9,279	11,967	15,081	18,704	22,867
	(2.5)	(3.0)	(3.5)	(4.0)	(4.6)	(5.2)

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Notes: In thousands, except as indicated. As of July 1. Resident population. Numbers may not add correctly due to rounding.

* "All other races" includes American Indian and Alaska Native alone, Native Hawaiian and Other Pacific Islander alone, and persons of two or more races.

ity groups have poorer health and poorer outcomes of care, regardless of the type of health care coverage to which they may be entitled (Blas & Kurup, 2010). These health disparities occur in countries like Australia (Nagel, Robinson, Condon, & Trauer, 2009) with universal, government-sponsored health care, as well as in countries like the United States, where ability to pay for care may greatly affect the receipt of appropriate services (Fortier & Bishop, 2003). Australia (World Health Organization [WHO], 2008), Canada (Lasser & Himmelstein, 2006), many of the European countries (Gibbons, 2005), and many developing nations (Danso, 2007) report similar differences in disease rates and outcomes of care. Thus, identifying strategies for remediating health disparities is a challenge of global proportions.

Many reports demonstrate that individuals representing minority groups have a disproportionate incidence of serious diseases like diabetes and heart disease, poorer access to health care, less satisfaction with health care encounters, and worse outcomes of care. Disparities can be seen in health status, access to care, type of care, and outcomes. These findings are consistent even when socioeconomic factors are controlled, suggesting that there are some factors, as yet not well understood but perhaps cultural in nature, that contribute to the documented disparities. Differences have been attributed to race and ethnicity, but also to the level of education and to socioeconomic status. Davis, Cohen, and Mikkelsen (2003) argue that health disparities are likely the result of a complex interplay of factors that include the following:

- Built environments
- Social capital
- Services and institutions
- Structural factors

Health disparities have profound consequences and are troubling for many reasons, both moral and economic. The moral imperatives are evident. It seems wrong that wealthy countries like the United States cannot or do not provide basic care to their citizens as