
LETTERS

Multi-Ethnicity

I enjoyed Trude Bennett's well-written article, "Two Steps Forward and One Step Back?" on "racial" and ethnic data [*PHR*, Nov./Dec. 1997;112:477-9]. I very much agree with her statement that we, as public health professionals and researchers, must "search for causal explanations of health disparities experienced by 'racial' and ethnic groups and frequently (but mistakenly) attributed to 'race' or ethnicity."

There is always the danger that when agencies such as state health departments present health statistics by "race" or ethnicity that these will be (mistakenly) interpreted as evidence of true "racial" disparities even if, more realistically, differences by "race" are artifacts of differences in income, education, housing, access to health care, and other factors. Many of us are cognizant that data presented by "race" are intended to serve as (perhaps poor) proxies for some of these underlying characteristics, but it is all too easy to lose sight of this fact.

In Illinois's annual state compendium of vital statistics, we report vital events by "race" and ethnicity because there is a strong demand from the data user community for them. In our quarterly, *Vital Statistics Basic Research Series*, however, we have been careful not to cite vital event data by "race" or ethnicity as evidence of outcome disparities if these variables were not key in explaining those outcomes.

To give an example in which ethnicity (as it relates to cultural practices) could be key in explaining outcomes, various researchers have suggested that there is evidence with regard to the 1995 heat wave-related deaths in Chicago that the strong extended family ties among Hispanics helped to minimize situations in

which elderly or otherwise vulnerable people became isolated and overstressed by heat conditions.

Regarding the as-yet unannounced tabulation recommendations from the Federal Office of Management and Budget (OMB) on the multiple-race response option (check all that apply), one possible scenario is that multiple responses could be prorated to each of the "races" instead of creating new categories such as "Black or African American/White" or "Asian/Native Hawaiian or Other Pacific Islander/American Indian or Alaska Native," at least for many applications such as health statistics.

Conceptually, this is not much different from the retabulation of recent past decennial Census data for the responses to the "other race" category that were reassigned to one of the other four categories based on write-ins or other imputation processes (for example, 1980 "OMB-modified" and 1990 "MARS" retabulations). Such a tabulation procedure might have some biases but, on the collection side, I can see how OMB felt it needed to address the plight of the "multiracial" respondent in having to make one choice and hence forsake the other(s). For the same reasons, perhaps a "multi-ethnicity" response also should have been considered.

Within a public health context, "racial" and ethnic categories will be a vexing issue for some time to come until the concept of race is supplanted by more meaningful indicators of social and economic disparity or it simply is abandoned because of its uselessness.

As generations of offspring are added to our planet, one thing seems true: the concepts of "racial" and ethnic categories will never become any clearer than they are now.

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Smoking Estimate Correction

We are writing to advise readers of two corrections to our article State Estimates of Medicaid Expenditures Attributable to Cigarette Smoking, Fiscal Year 1993, which appeared in the March/April issue of *Public Health Reports*. The corrections relate to the description in the Technical Appendix of the method used in the jackknife interval estimation and to the results of that estimation. In contrast to our description in the article, after an initial estimation, the jackknife specification included all variables that were in the specification producing the point estimate. However, if a smoking history variable was estimated as statistically significant (α equals 0.05) in the point estimation, in every one of the 202 jackknife estimates we evaluated the model as if the smoking category was statistically significant. If the smoking category was not significant in the point estimate, then in every one of the 202 jackknife estimations we substituted mean values for the smoking category and proceeded as if the smoking category was not significant. This procedure limits the variation in the estimates of smoking-attributable expenditures. Accordingly, these jackknife estimates are conservative.

In Table 3, the column titled "Minus one standard deviation" is in error. As shown, the column reports the standard deviation. Instead, it should report the difference between the point estimate, the content of the first column, and the standard deviation. For example, in thousands of dollars, for Alabama, the point estimate is \$107,304 and the standard deviation is \$43,244; thus the value for Minus one standard deviation should be \$64,060 (\$107,304-\$43,244), not \$43,244.

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ERRATUM

There were 4500 certified nurse-midwives practicing in the United States in 1996—not 1966, as stated in Mary Gabay and Sidney Wolfe's article on nurse-midwives in the Sept./Oct. 1997 issue on page 393. We regret the error. ■

TO OUR REVIEWERS, A NOTE OF THANKS

The manuscripts sent to *Public Health Reports* cover a broad range of scientific inquiry—from Medicare finances to global smoking prevention efforts. To sort out important scientific pieces and uncover lapses in logic, we require the education, experience, and judgment of many people—we could not do it without them. Thank you, reviewers of 1997.

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Bailer, A.J.
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