Populations of Color in Minnesota

Health Status Report

Update Summary

Fall 2003

Center for Health Statistics
Minnesota Department of Health

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Background

The health and life expectancy of Minnesotans consistently rank number one in the nation. Despite the overall health status of our state, populations of color (African Americans, Asians and Hispanics*) and American Indians continue to experience poorer health and disproportionately higher rates of illness and death.

In the Spring of 1997, the Minnesota Department of Health, Office of Minority Health and the Center for Health Statistics, in collaboration with the Urban Coalition published the *Populations of Color in Minnesota Health Status Report*. This report documented the disparities in health status of populations of color and American Indians as compared to Whites.

This annual update summary is a compendium of key information derived from the 1997 report which includes data on the current health status of populations of color and American Indians in the state of Minnesota.

The annual update summary is divided into four sections.

- Birth-related health indicators: low birth weight, prenatal care, infant mortality and teen birth rates
- Mortality rates and the major causes of death within populations of color.
- Cancer incidence in Minnesota by race/ethnicity.
- Health insurance rates among populations of color compared to Whites.

The primary data sources for the annual update summary are the U.S. Census, birth and death records, Minnesota Cancer Surveillance System and 2001 Minnesota Health Access Survey.

The data in this report are updated annually by the Center for Health Statistics of the Minnesota Department of Health.

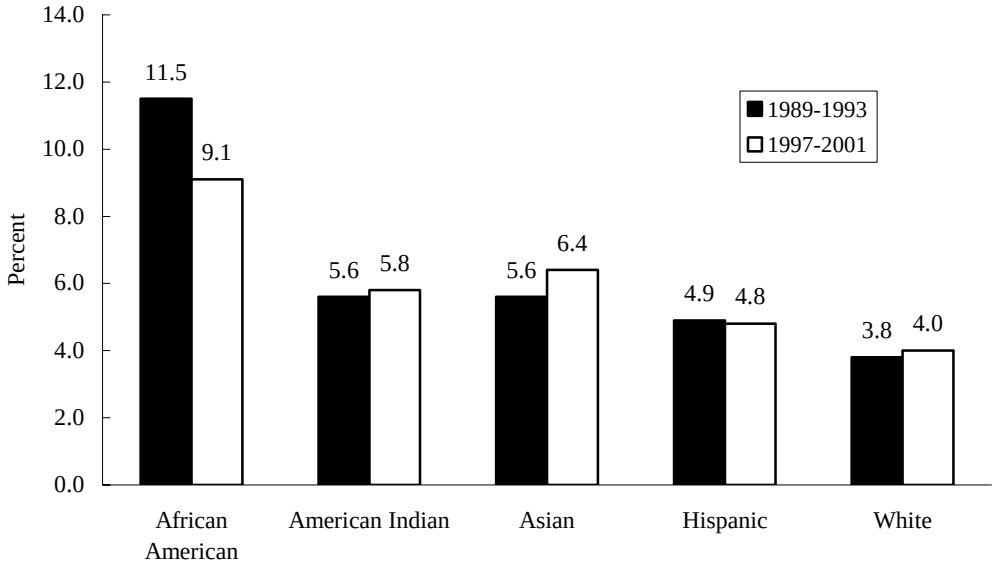
*Hispanic is an ethnicity and may include individuals of any race

Part I: Birth-Related Health Indicators

Low Birthweight Births

Infants that weigh less than 2,500 grams at birth are considered low birthweight. Low birthweight can occur as a result of premature birth or growth restriction prior to birth. Infant mortality or serious health and developmental complications are closely associated with low birthweight.

Low Birth Weight Births by Race/Ethnicity:
Minnesota 1989-1993 and 1997-2001
(Percent of Singleton Births under 2500 grams)



Source: Center for Health Statistics, Minnesota Department of Health

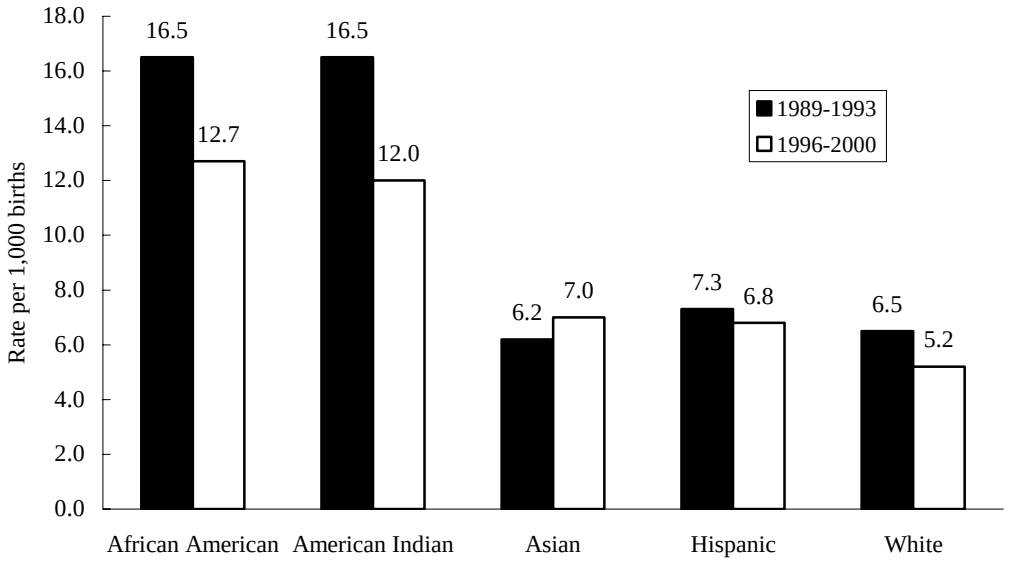
Recent Minnesota data indicate the only racial/ethnic group to experience a noticeable decline in low birth weight births is the African American group. The percent of low birth weight African American infants decreased from 11.5% in 1989-1993 to 9.1% in 1997-2001. While the percentage of low birthweight births for African Americans has decreased, low birthweight births among African Americans in Minnesota are greater than 2 times that of Whites.

Infant Mortality

An infant death is defined as a death to an infant under 1 year of age. The infant mortality rate is the number of infant deaths per 1,000 births. Over the years, there have been significant reductions in the infant mortality rate. In Minnesota, the infant mortality rates for African Americans and American Indians have decreased from 16.5 for both groups in 1989-1993 to 12.7 and 12.0 respectively in 1996-2000. There was also a slight decrease in the Hispanic infant mortality rate for the same time periods while the White rate decreased from 6.5 to 5.2. Only the Asian infant mortality rate increased (from 6.2 to 7.0). This increase brought the Asian rate above the White rate in the 1996-2000 time period.

The disparities between the Asian and Hispanic infant mortality rates as compared to Whites are relatively small. Yet, in recent years, these disparities have widened. In contrast, the disparities between African Americans and American Indians as compared to Whites are considerable but have narrowed. Despite the decreases in the disparities in infant mortality rates between American Indians and African Americans as compared to Whites, American Indian and African American infant mortality rates are still two times higher than the White rate.

Infant Mortality Rate by Race/Ethnicity:
Minnesota 1989-1993 and 1996-2000



Source: Center for Health Statistics, Minnesota Department of Health

Prenatal Care

Adequate prenatal care can contribute to improved birth outcomes. Current data indicate increases in the percent of Minnesota women receiving intensive and adequate prenatal care. This holds true for women from all racial/ethnic groups. Even with these increases, White women are still more likely to receive adequate and intense prenatal care than women of any other racial/ethnic group. The latest data also indicate that there have been considerable decreases in the percent of women receiving inadequate or no care. Asian women receiving inadequate or no prenatal care has decreased by half from 20.6% in 1989-1993 to 9.8% in 1997-2001. Overall more women are seeking adequate prenatal care, yet large disparities between White women and women of color and American Indian women still exist.

Adequacy* of Prenatal Care in Minnesota by Race/Ethnicity, 1989-1993 and 1997-2001

	Intensive or Adequate		Inadequate or No Care	
Race/Ethnicity	1989-1993	1997-2001	1989-1993	1997-2001
African American	47.0	57.1	20.1	12.4
American Indian	37.3	49.2	27.2	17.4
Asian	43.1	57.0	20.6	9.8
Hispanic	51.8	54.4	14.7	11.2
White	78.4	80.0	3.3	3.2

Source: Center for Health Statistics, Minnesota Department of Health

*The prenatal care index, GINDEX, was used to measure the adequacy of prenatal care. Adequacy of care is determined by combing the measures of the month or trimester prenatal care began, the number of prenatal care visits, and the gestational age of the infant/fetus at the time of birth. GINDEX includes gestational age over 36 weeks, and the number of prenatal care visits greater than nine to impute adequacy of prenatal care.

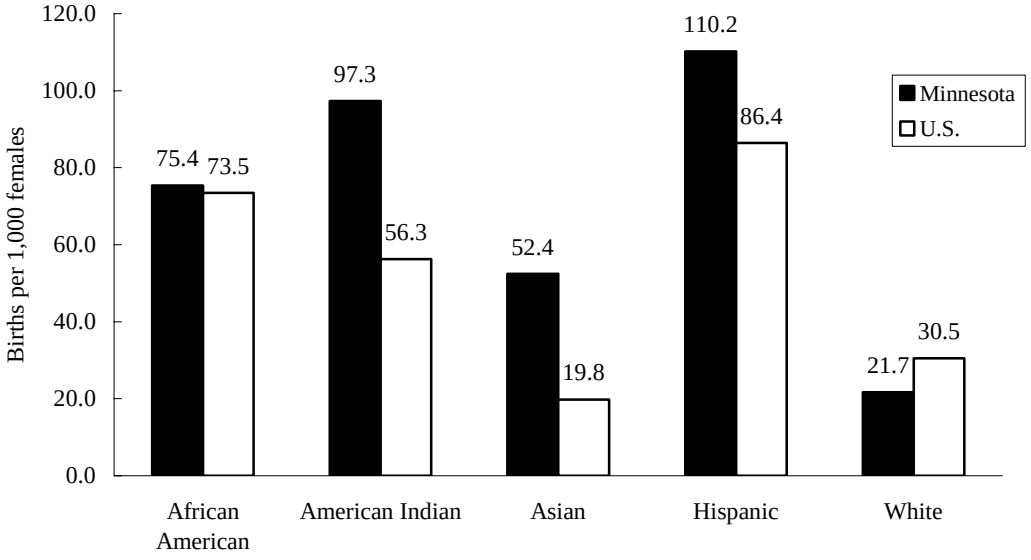
American Indian women suffer the greatest disparity in prenatal care. While this disparity has narrowed, American Indian women are still five and a half times more likely to receive inadequate care or no care during their pregnancies than White women. African Americans, Asians and Hispanics also continue to receive prenatal care at a much lower rate than Whites. These racial and ethnic groups were over three to four times more likely to receive inadequate or no prenatal care during their pregnancies.

Teen Births

Teen Birth Rates: Minnesota vs U.S.

The 15-19 year old teen birth rate in Minnesota is consistently among the lowest in the United States and well below the U.S. average. In 2001, the U.S. White teen birth rate was 30.3 per 1,000 females compared to 21.7 in Minnesota. However, for all other racial and ethnic groups the Minnesota teen birth rate is higher than the corresponding U.S. rate. In the case of African Americans, the Minnesota rate (75.4) is very close to the U.S. rate (73.5). However, the Minnesota rates for Asian and American Indian are 2.5 and 1.5 times higher than the U.S. rates.

Teen (15-19 year olds) Birth Rates by Race/Ethnicity: Minnesota and the U.S., 2001

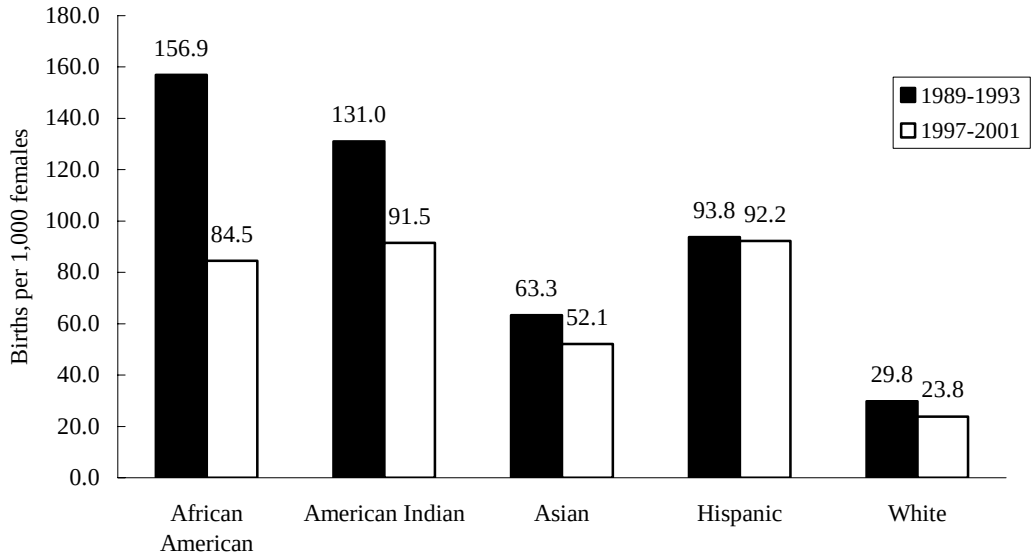


Source: Center for Health Statistics, Minnesota Department of Health and National Center for Vital Statistics

Teen Births: Minnesota Trends

Recent data trends for Minnesota indicate a decline in teen birth rates among all populations. The African American teen birth rate has decreased by 46.1% from 1989-1993 to 1997-2001 and the decrease in the American Indian teen birth rate was almost as dramatic at 30.1%. These new rates bring African American and American Indians teens just below the Hispanic teen birth rate Though these decreases are considerable, the Hispanic, African American and American Indian teen birth rates are approximately 4 times that of the Whites rate. The Asian teen birth rate declined by 17.7% from 1989-1993 to 1997-2001 but still is twice the rate of White teens.

Minnesota Teen (15-19 year olds) Birth Rates by Race/Ethnicity: 1989-1993 and 1997-2001



Source: Center for Health Statistics, Minnesota Department of Health

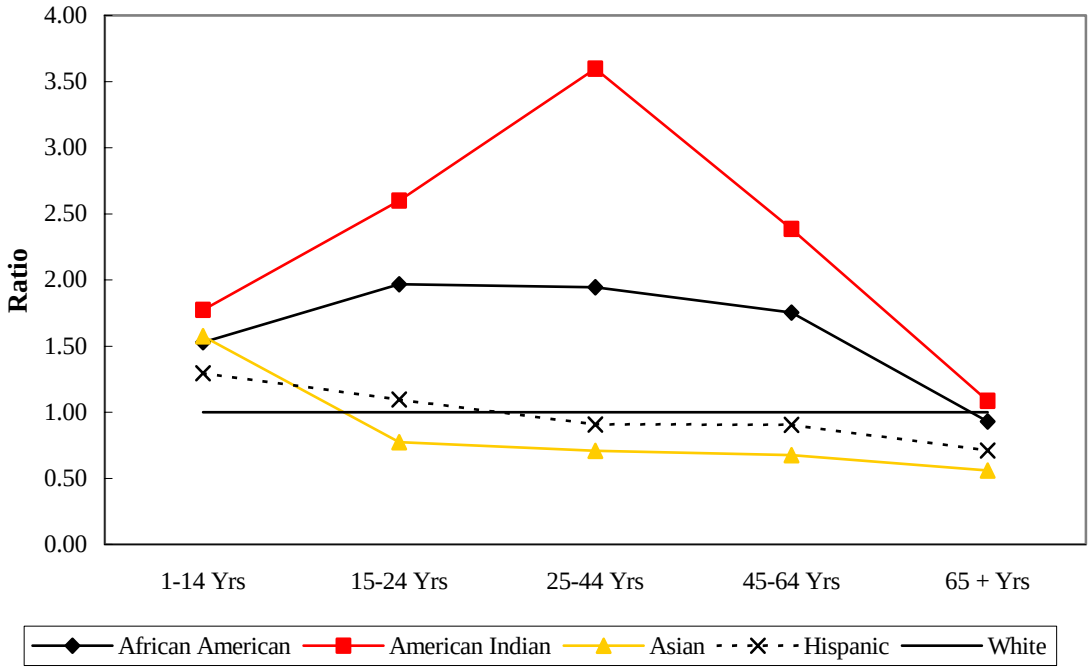
Part II: Death Rates and Causes of Death

Death Rate Ratio

Mortality rates were obtained by analyzing data on all deaths to Minnesota residents occurring between 1997 and 2001 and, where appropriate, were compared with deaths occurring between 1989 and 1993.

The graph shows the ratio of age-specific death rates of racial/ethnic groups as compared to Whites. This measure shows how many times higher the death rate is for populations of color than it is for Whites within several age groupings. This graph indicates that the greatest disparities in death rates occur in the age range of 25-44 years old, though disparities exist in most age groups for African Americans and American Indians.

Ratio of Non-White to White Minnesota Death Rates
Five Year Average (1997 - 2001)



Source: Center for Health Statistics, Minnesota Department of Health

Death rates for American Indians in the 15-24, 25-44, and 45-64 year age ranges were two to three and a half times higher than death rates for Whites. Death rates for African Americans in the 15-24, 25-44, and 45-64 year age ranges were more than one and a half times higher than death rates for Whites. Hispanic and Asian death rates were most often lower than Whites among all age groups.

Cause of Death

Age-specific or crude mortality rates are the number of deaths per 100,000 population. While these rates provide an estimate of the causes of death in a population, it may not be the best indicator of mortality in a population because of age differences within populations. Age adjusted mortality rates provide unbiased comparisons that are not influenced by differences in age distribution in populations. Age-adjustment is used to reduce the effect of having older individuals in one group (where the risk of mortality is naturally higher) compared to another group which has younger persons. Age-adjusted death rates provide a reliable basis for comparison between populations and are used to eliminate the bias of age in the make-up of a population.

Age Adjusted Mortality Rates By Race
Minnesota 1997-2001

	White	African American	American Indian	Asian	Hispanic
Cause	**1997-01**	**1997-01**	**1997-01**	**1997-01**	**1997-01**
AIDS/HIV	0.9	10.2	5.7	0.6	5.3
Alzheimer's Disease	16.8	12.8	18.1	6.5	0.0
Cancer	184.6	244.6	228.7	137.8	153.0
Chronic Obstructive Pulmonary Disease	37.7	33.5	58.7	19.1	14.8
Cirrhosis	6.4	6.6	38.4	4.1	11.3
Congenital Anomalies	4.0	4.5	3.7	4.5	3.8
Diabetes	23.0	57.7	94.4	20.1	39.9
Heart Disease	183.9	181.1	246.2	81.5	153.0
Homicide	1.6	18.9	13.8	4.0	4.6
Influenza, Pneumonia	21.0	22.5	26.9	12.4	12.6
Nephritis	11.6	19.5	26.3	20.0	14.6
Perinatal Conditions	2.7	6.8	5.5	3.2	4.0
SIDS	0.7	1.5	2.8	0.2	0.9
Stroke	56.0	76.7	57.3	66.6	44.2
Suicide	9.1	7.2	19.1	9.2	7.4
Unintentional injuries	33.9	38.7	81.7	23.0	30.0

Source: Center for Health Statistics, Minnesota Department of Health
Rates presented are per 100,000 population (i.e. AIDS/HIV mortality rate for Whites is 0.9 per 100,000.)
The age-adjustment standard used is the US 2000 standard population.
The shaded area on the graph identifies those rates that are more than twice those of Whites.

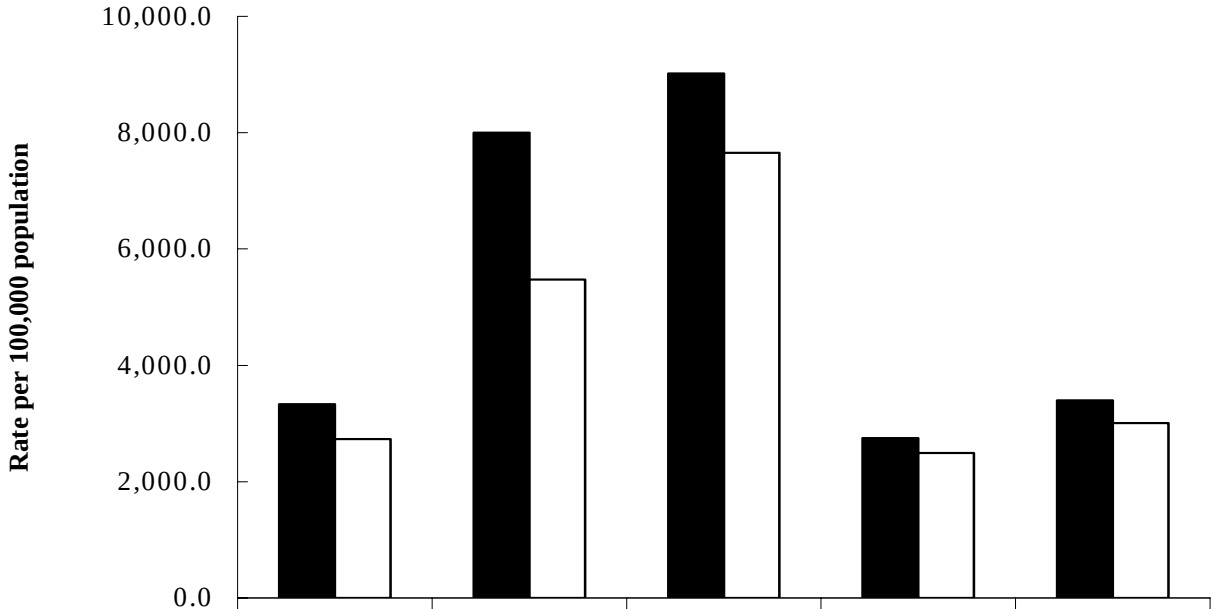
Age-adjusted mortality rates for African Americans due to AIDS/HIV, diabetes, homicide, perinatal conditions and SIDS are more than twice the rates for Whites. For American Indians, age-adjusted mortality rates for AIDS/HIV, cirrhosis, diabetes, homicide, nephritis, SIDS, suicide, and unintentional injuries are more than twice those of Whites. Age-adjusted mortality rates for Hispanics and Asians are similar to those of the White population, except for AIDS/HIV among Hispanics and homicide among Asians and Hispanics, which are more than twice those of Whites.

Years of Potential Life Lost

Years of Potential Life Lost (YPLL) measures premature mortality or the total sum of years of life lost annually to persons who suffered early deaths. For the purpose of calculating YPLL, premature death is defined as death occurring before the age of 65. The YPLL rate is the number of years of life lost before age 65 per 100,000 population ages 0-64.

The following graphic presents the YPLL rates by race/ethnicity for 1997-2001 and for 1989-1993. This chart indicates that in the most recent 5-year period, YPLL rates for all populations of color (African American, American Indian, Asian, and those of Hispanic ethnicity), and Whites have decreased. However, YPLL rates for African Americans and American Indians are more twice as high as those for Whites.

Years of Potential Life Lost Rate by Race/Ethnicity
1989-1993 vs 1997-2001



	White	African American	American Indian	Asian	Hispanic
■ 1989-1993	3,329.6	8,001.3	9,021.5	2,749.1	3,397.3
□ 1997-2001	2,730.8	5,474.8	7,654.2	2,493.0	3,007.8

Source: Center for Health Statistics, Minnesota Department of Health
The US 2000 standard population age-adjustment standard was used to adjust the YPLL rates.

Part III: Cancer Incidence

The Minnesota Cancer Surveillance System (MCSS) is the state's cancer registry. The MCSS systematically collects demographic and diagnostic information on all Minnesota residents with newly-diagnosed cancers. The MCSS monitors the occurrence of cancer in Minnesota and describes the risks of developing cancer, informs health professionals and educates citizens regarding specific cancer risk. A recent report of the MCSS indicates racial disparities in the incidence rates of some cancers.

Overall cancer incidence rates are highest among African American males and lowest among Asian/Pacific Islander females. African American and American Indian males have the highest rates of cancers of the lung and bronchus while Asian females have the lowest incidence rate of this type of cancer. The risk of African American and American Indian men dying of lung cancer is nearly twice that of White men. American Indian and African American males also have the highest incidence rates of colorectal cancer. Their risk of being diagnosed with colorectal cancer is more than 35 percent higher than White men. African American males also have the highest rate of prostate cancer. Their risk of dying from prostate cancer is more than two and a half times that of White men.

Among females, White women have the highest incidence rate of breast cancer. However, African American women are at the greatest risk of dying of this disease. The breast cancer mortality rate among African American women is 30 percent higher than among White women, despite the fact that their incidence rate is 25 percent lower. Cervical cancer incidence rates are also higher among some populations of color. The incidence rates among African American and Asian/Pacific Islander females in Minnesota is over twice as high as that of Whites.

Cancer Incidence, Minnesota, 1996-2000

Rates per 100,000 population

All Sites	All	Male	Female
White	459.3	538.9	407.2
Black	518.2	689.3	394.5
American Indian	398.0	528.5	309.7
Asian/Pacific Islander	275.2	302.0	259.0
All Races	464.8	547.3	410.4
Lung and Bronchus	All	Male	Female
White	56.0	72.2	44.1
Black	91.2	132.8	58.2
American Indian	88.9	119.3	67.5
Asian/Pacific Islander	32.9	45.9	23.4
All Races	56.6	73.3	44.5
Colon and Rectum	All	Male	Female
White	52.7	61.6	46.0
Black	64.5	83.5	52.4
American Indian	68.6	91.7	51.8
Asian/Pacific Islander	23.3	22.8	23.4
All Races	53.2	62.1	46.5
Breast	All	Male	Female
White	74.3	1.2	137.3
Black	55.8	^	104.5
American Indian	27.1	^	49.9
Asian/Pacific Islander	37.1	^	67.1
All Races	74.3	1.2	137.3
Prostate	All	Male	Female
White	~	175.1	~
Black	~	233.8	~
American Indian	~	125.1	~
Asian/Pacific Islander	~	54.9	~
All Races	~	178.6	~
Cervix	All	Male	Female
White	~	~	6.6
Black	~	~	18.0
American Indian	~	~	9.6
Asian/Pacific Islander	~	~	16.5
All Races	~	~	7.1

Source: Minnesota Cancer Surveillance System

Rates are per 100,000 and age-adjusted to the 2000 U.S. (18 age groups) standard.

~Statistic could not be calculated.

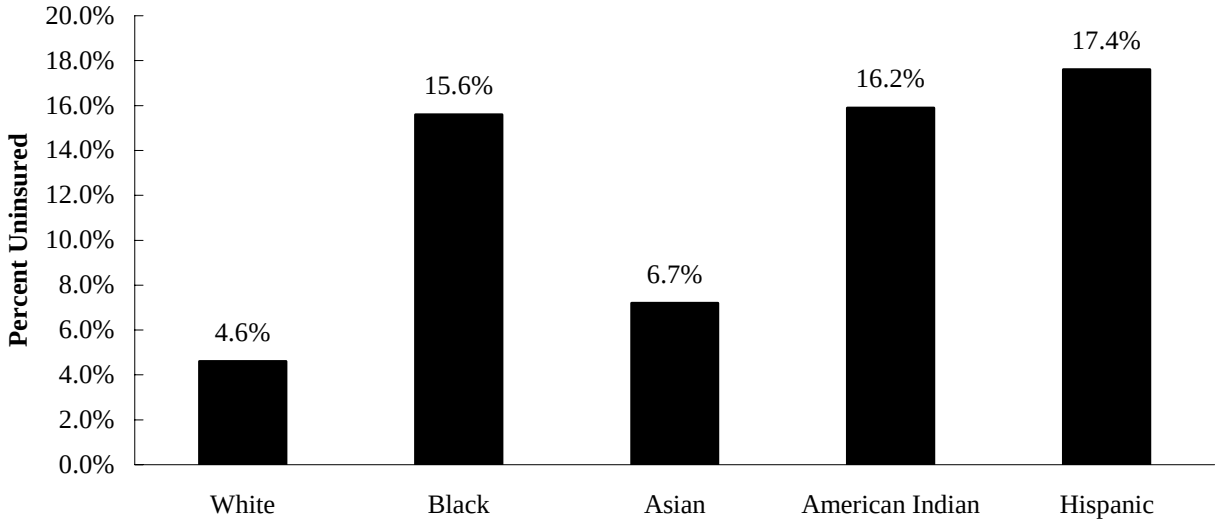
^Statistic not displayed due to less than 10 cases.

Part IV: Health Insurance

Health Insurance

The Health Economics Program of the Minnesota Department of Health recently conducted an in-depth study of Minnesota's uninsured population.* Study findings indicated that 5.4 percent of Minnesotans (approximately 266,000 people) were uninsured at the time of the survey in 2001. However, rates of uninsured vary widely across racial and ethnic groups. Because this study allowed the selection of multiple races, the race/ethnicity definitions include anyone who reported a single race or a single race and any other race/ethnicity (e.g., those included in "White", include those who reported White only and those who reported White and any other race/ethnicity.) As the following graph indicates, the results of the study indicate that African American, American Indian, and Hispanic/Latinos were up to four times less likely to be insured as compared to Whites.

Percent of Uninsured by Race (All Ages)
Minnesota, 2001



Source: 2001 MN Health Access Survey, MDH Health Economics Program

* Data Source: 2001 MN Health Access Survey, MDH Health Economics Program. Please contact the Health Economics Program at 651-282-6367 for more information on the results of the study.

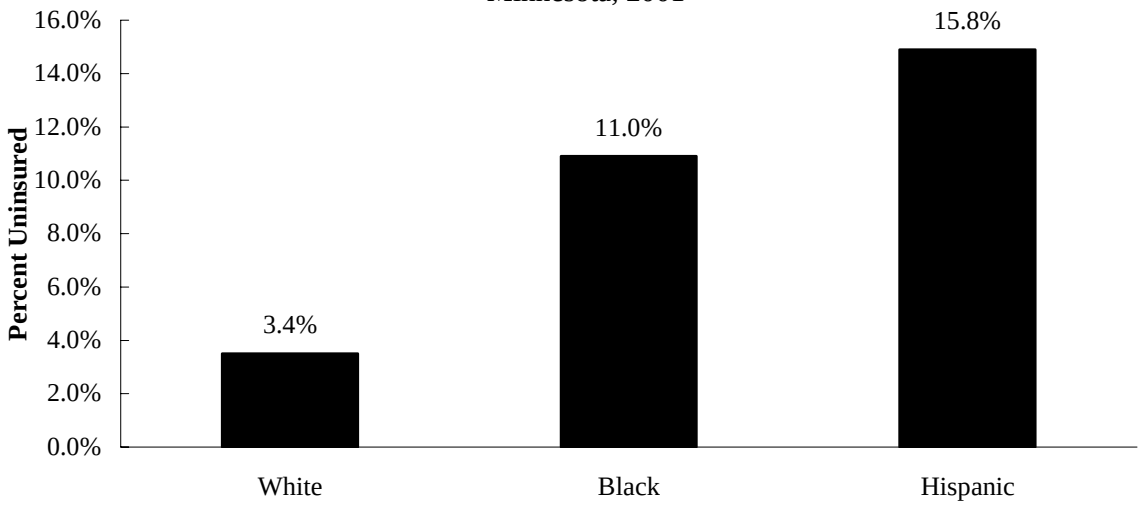
Uninsured Children

Another significant finding of the study is that the number of uninsured children is larger overall, than had previously been thought. About 4.4 percent of all Minnesota children, or 57,000 children under the age of 18, lack health insurance.

Among those populations of color that the study was able to report, African American children were over three times and Hispanic children were over four times less likely to be covered by health insurance.

Uninsured Children by Race

Minnesota, 2001

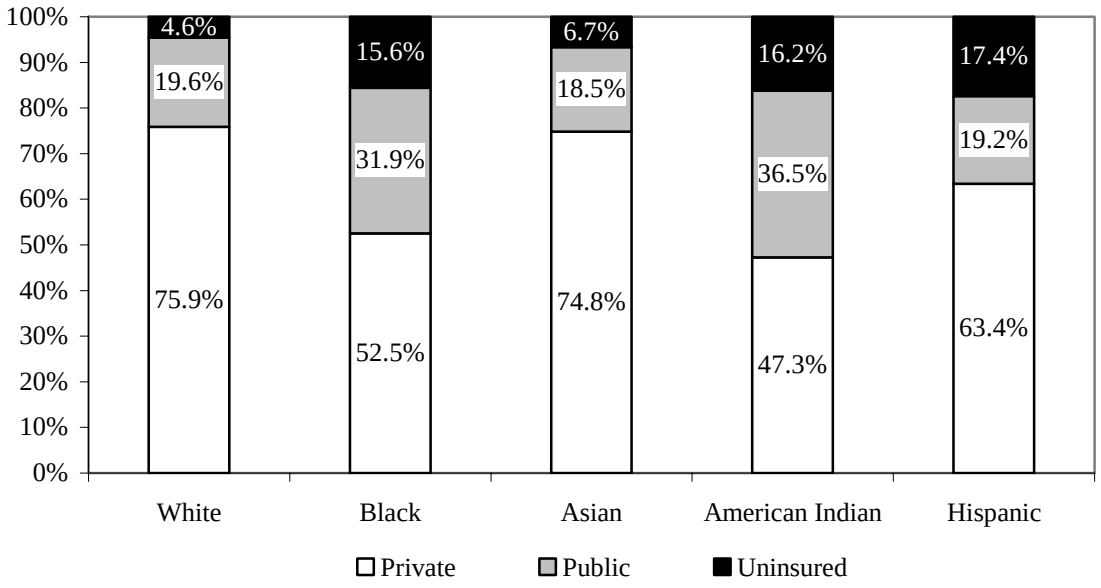


Source: 2001 MN Health Access Survey, MDH Health Economics Program.

Uninsured by Type of Insurance Coverage

Additional study results indicate disparities in the type of insurance coverage identified by study participants. Whites were more often covered by group insurance, generally through their own or a family member's employer. More African American and American Indians than Whites reported coverage through public health insurance which included Medicaid, MinnesotaCare, GAMC, MCHA, CHIP, CHAMPUS, Veterans Affairs or Military Health Care, Railroad Retirement Plan, or Medicare.

Sources of Insurance Coverage by Race/Ethnicity
Minnesota, 2001



Source: 2001 MN Health Access Survey, MDH Health Economics Program