Populations of Color in Minnesota

Health Status Report

Update Summary
Spring 2007

Center for Health Statistics
Minnesota Department of Health

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Background

The 2006 edition of America's Health Rankings once again identified Minnesota as the healthiest state in the nation. Since the annual state health rankings began in 1990, Minnesota has ranked first in health 11 times, and it has never ranked lower than second.[1] Despite the overall health status of our state, Populations of Color (African Americans, Asians and Hispanics[2]), and American Indians continue to experience poorer health and disproportionately higher rates of illness and death.

"*Populations of Color in Minnesota Health Status Report*", the full report originally published in 1997 and again in 2004 provides an account of key indicators in mortality and natality for Populations of Color as compared to Whites in Minnesota. Annual updates document improvements and monitor continuing disparities in the health status of these populations.

This annual update summary is a compendium of key information derived from both the 1997 and 2004 reports. It provides updated information 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 and American Indians
- Cancer incidence in Minnesota by race/ethnicity
- Health insurance rates among Populations of Color and American Indians as compared to Whites.

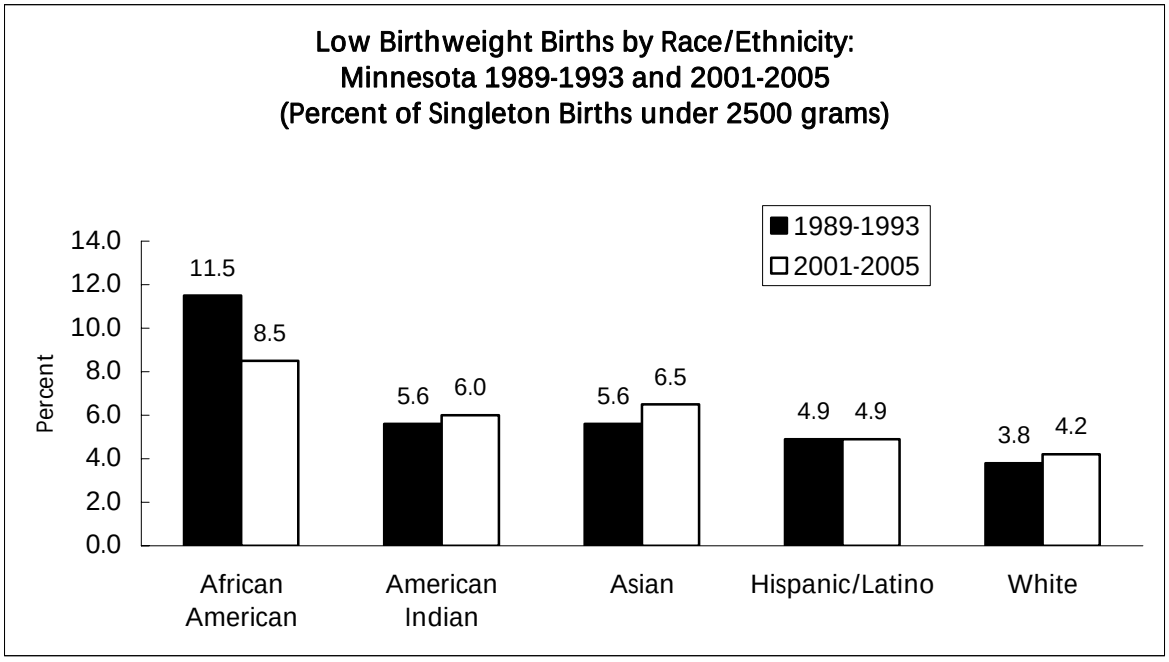
The primary data sources for the annual update summary are the U.S. Census, birth and death records, Minnesota Cancer Surveillance System and Minnesota Health Access Surveys.

[1] 2006 edition of "America's Health" published by the United Health Foundation, the American Public Health Association and the Partnership for Prevention.
[2] Hispanic is an ethnicity and may include individuals of any race.

Part I: Birth-Related Health Indicators

Low Birthweight Births

Low birthweight Infants weigh less than 2,500 grams at birth. Causes of low birthweight include premature birth or growth restriction prior to birth. Infant mortality or serious health and developmental complications are closely associated with low birthweight.

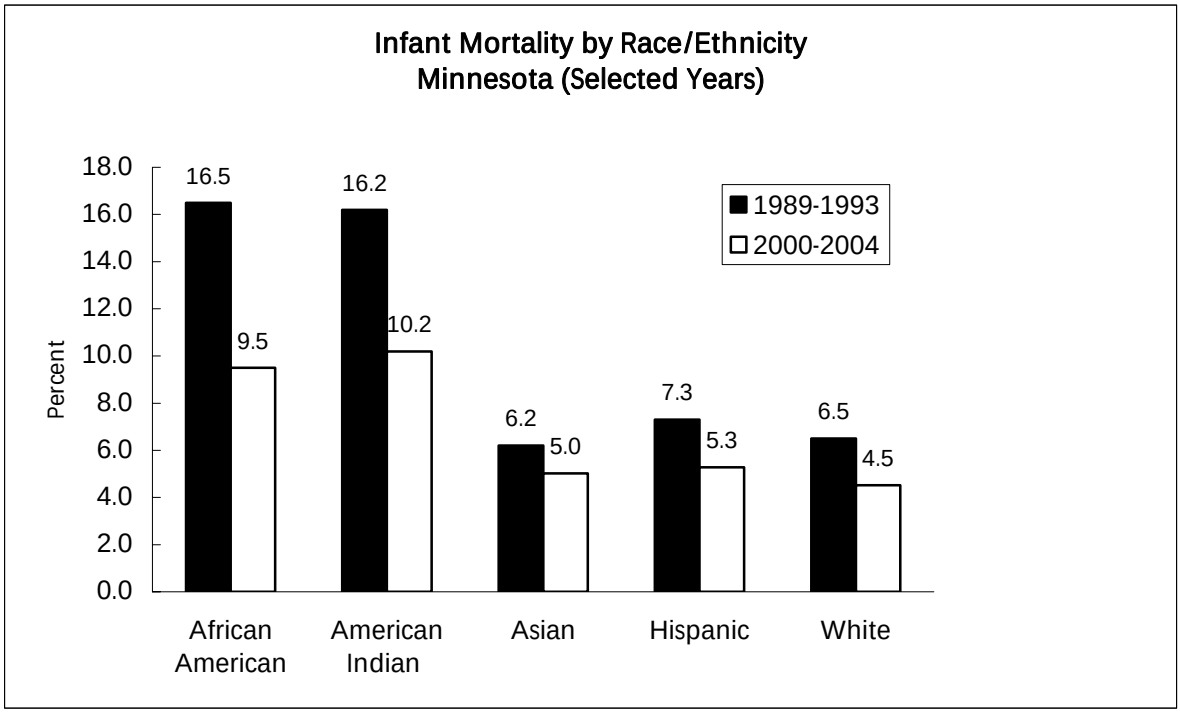


Source: Center for Health Statistics, Minnesota Department of Health

- African Americans are the only group to experience a noticeable decline in low birthweight (From 11.5 percent in 1989-1993 to 8.5 percent in 2001-2005).
- LBW increased for American Indians, Asian, and Whites and remained the same for Hispanic/Latinos.
- Low birthweight births among African Americans in Minnesota remain 2 times greater than Whites.

Infant Mortality

An infant death is defined as a death of an infant less than one year of age. Many risk factors have been associated with infant mortality including low birthweight, preterm infants, lack of adequate and timely prenatal care, substance abuse, and lack of access to care.



- For both time periods, Infant mortality rates for Whites are lowest as compared to all other racial/ethnic groups.

- Infant mortality rates for African Americans and American Indians have decreased from 16.5 for African Americans and 16.2 for American Indians in 1989-1993 to 9.5 and 10.2 respectively in 1999-2003.

- A decrease in infant mortality rates occurred for Asians, Hispanics, and Whites from the previous reporting period.

- Disparities between the Asian and Hispanic infant mortality rates as compared to Whites are relatively small but despite decreases in the disparities — American Indian and African American infant mortality rates are more than two times higher than the White rate.

Note: Infant mortality rate is the number of infant deaths per 1,000 births.
Source: Minnesota Department of Health, Center for Health Statistics

Prenatal Care

Early and consistent prenatal care can contribute to improved birth outcomes.

Adequacy* of Prenatal Care in Minnesota by Race/Ethnicity, 1989-1993 and 2001-2005

	% Intensive/Adequate		% Inadequate/No Care	
Race/Ethnicity	1989-1993	2001-2005	1989-1993	2001-2005
African American	47.0	61.6	20.1	9.0
American Indian	37.3	50.6	27.2	15.9
Asian	43.1	67.0	20.6	6.1
Hispanic	51.8	59.1	14.7	8.4
White	78.4	81.6	3.3	2.6

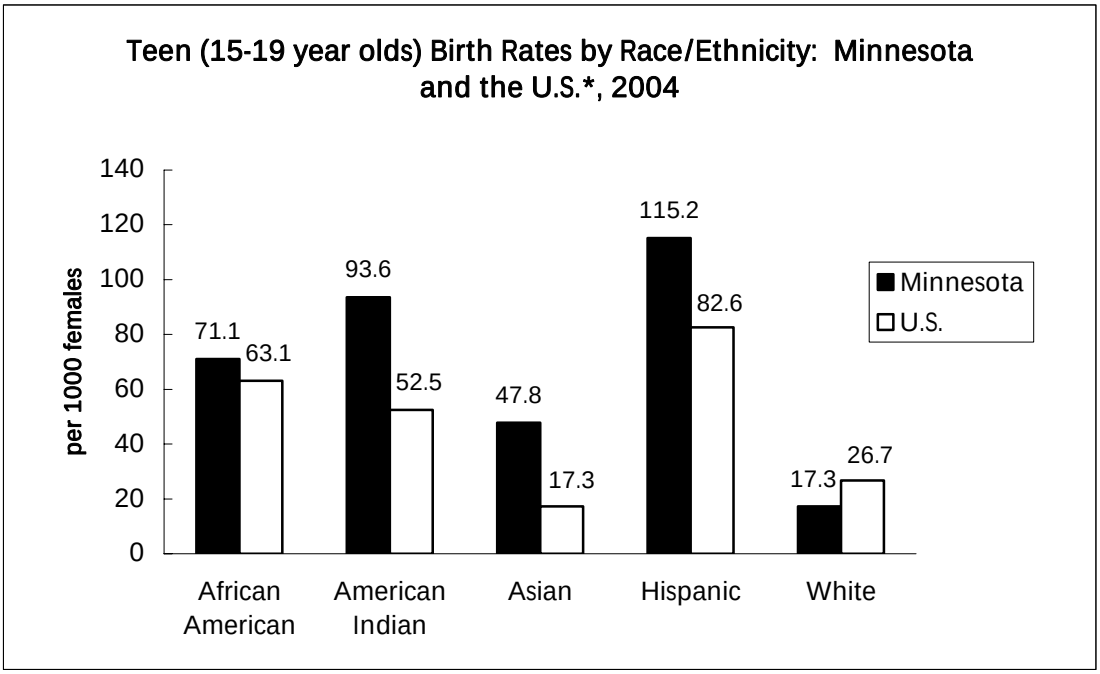
Source: Minnesota Department of Health, Center for Health Statistics

*The prenatal care index, GINDEX, was used to measure the adequacy of prenatal care. Adequacy of care is determined by combining 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.

- Overall more women are seeking intensive and adequate prenatal care, yet large disparities continue to exist between Whites and People of Color and American Indian women.
- There are decreases in the percent of women receiving inadequate and no prenatal care. Asian women receiving inadequate and no prenatal care decreased by more than half from 20.6% in 1989-1993 to 6.1% in 2001-2005.
- American Indian women are six times more likely to receive inadequate care or no care during their pregnancies than White women.
- Women of Color were two to three times more likely to receive inadequate or no prenatal care during their pregnancies. In 2001-2005, only 2.6 percent of White women received inadequate or no care.

Teen Births

Teen Birth Rates: Minnesota vs. U.S.



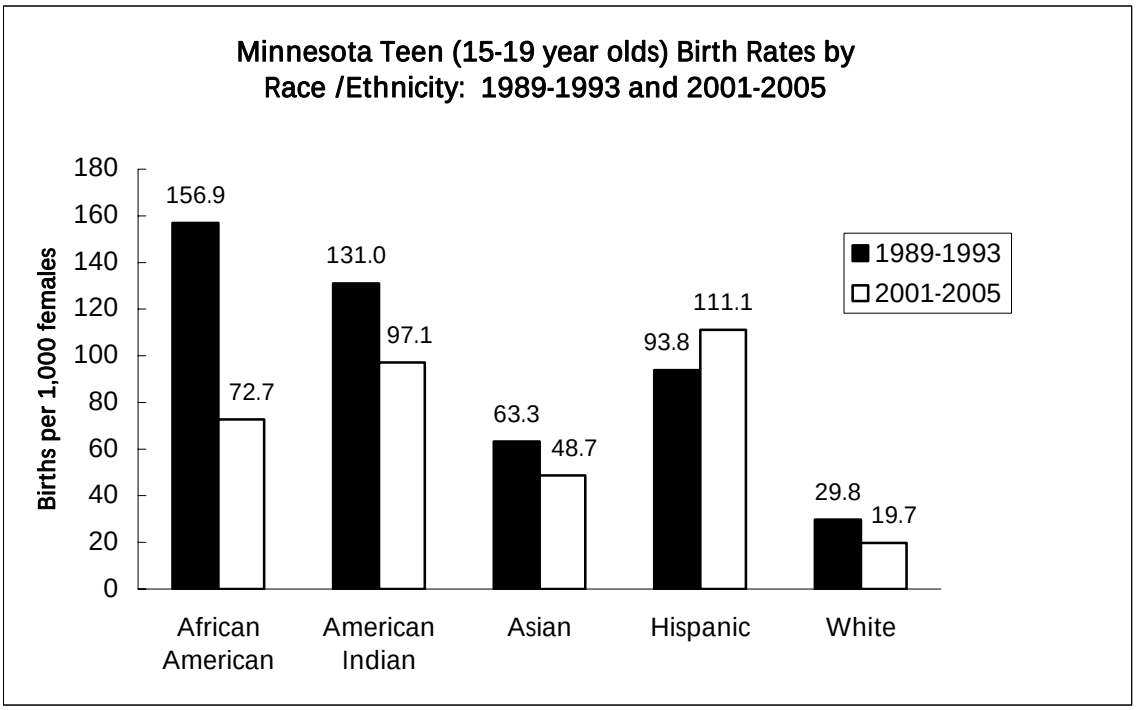
Source: Minnesota Department of Health, Center for Health Statistics, and National Center for Vital Statistics, Preliminary birth data for 2003
Note: U. .S. figures are for non-Hispanic White and non-Hispanic African American

- The teen birth rate for Whites in Minnesota is lower than the U.S. rate. In 2004, the U.S. White teen birth rate was 26.7 per 1,000 females compared to 17.3 in Minnesota.

- For other racial and ethnic groups in Minnesota, the teen birth rate is higher than the corresponding U.S. rate. The African American rate 71.1 is very close to the U.S. rate (63.1), while the rates for Asians and American Indians are 2.5 and 1.5 times higher than the U.S. rates.

- The Hispanic teen birth rate for Minnesota is higher than all other racial ethnic groups for both Minnesota and U.S. teen births. The U.S. teen birth rate for Hispanics is higher than the U.S. rates for all other racial ethnic groups.

Teen Births: Minnesota Trends



- Compared to 1989-1993 figures, the rate of teen births in Minnesota declined for African American, American Indian, Asian, and White populations. The teen birth rate for Hispanics increased during this same time period.

- The African American teen birth rate decreased from 156.9 in 1989-1993 to 72.7in 2001-2005. The decrease in the American Indian teen birth rate decreased from a rate of 131.0 in 1989-1993 to 97.1 per 1,000 births in 2001-2005.

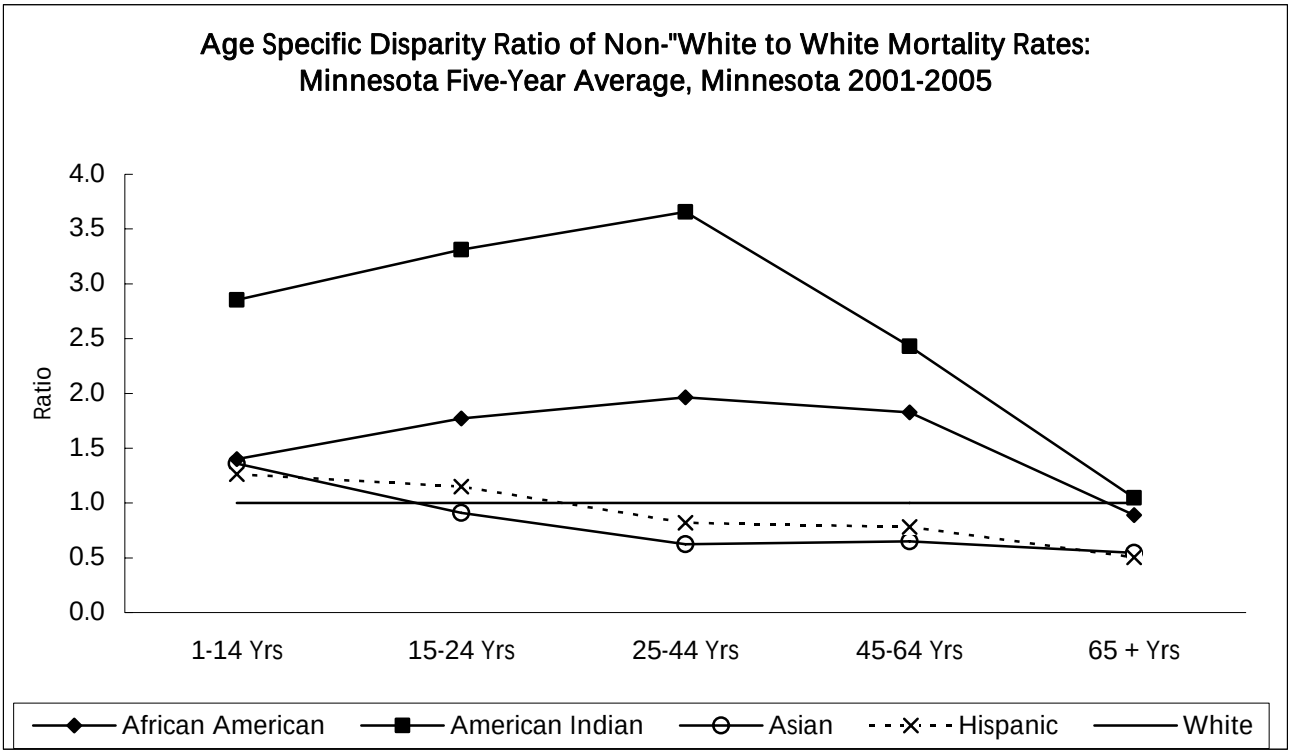
- Although rates decreased for African Americans and American Indians for these time periods, the rates for these groups remain three to four times that of the White rate.

- The Hispanic teen birth rate is 5.6 times the White rate.

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 2001 and 2005. The following 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 for Whites within several age groupings.



Source: Center for Health Statistics, Minnesota Department of Health

- The greatest disparities in death rates occur in the age range of 25-44 years old. Disparities exist in most age groups for African Americans and American Indians.

- American Indian death rates were two to three and a half times higher than death rates for Whites for most age groups. Death rates for African Americans were more than one and a half times higher than Whites in most age groups.

- Asian death rates were lower than Whites among the 15-24, 25-44, 45-64, and 65+ year age groups. Hispanic death rates were lower in the 25-44, 45-64, and 65+ year age groups.

Cause of Death

Age adjusted mortality rates provide unbiased comparisons in age distribution in populations.

Age Adjusted Mortality Rates per 100,000 by Race/Ethnicity
Minnesota 2000-2004

Cause	White	African American	American Indian	Asian	Hispanic
AIDS/HIV	0.7	9.5	*	*	*
Alzheimer's Disease	22.2	17.4	*	*	*
Cancer	177.5	221.8	223.6	122.4	107.9
CLRD	37.1	32.7	51.4	16.2	13.8
Cirrhosis	6.3	7.6	32.9	*	8.8
Congenital Anomalies	3.9	5.8	*	2.2	3.6
Diabetes	23.0	54.1	89.2	19.8	38.9
Heart Disease	153.5	152.4	217.6	70.5	90.0
Homicide	1.4	17.9	19.7	3.8	4.3
Nephritis	12.3	23.6	24.2	13.2	*
Perinatal Conditions	2.7	6.3	5.1	3.6	4.3
Pneumonia and Influenza	14.9	11.1	27.8	11.9	*
Septicemia	4.8	9.0	16.9	7.7	*
SIDS	0.5	1.4	*	*	*
Stroke	46.8	69.6	56.8	51.2	28.0
Suicide	9.8	5.0	21.4	7.7	7.2
Unintentional Injury	34.8	33.2	94.1	20.6	28.5

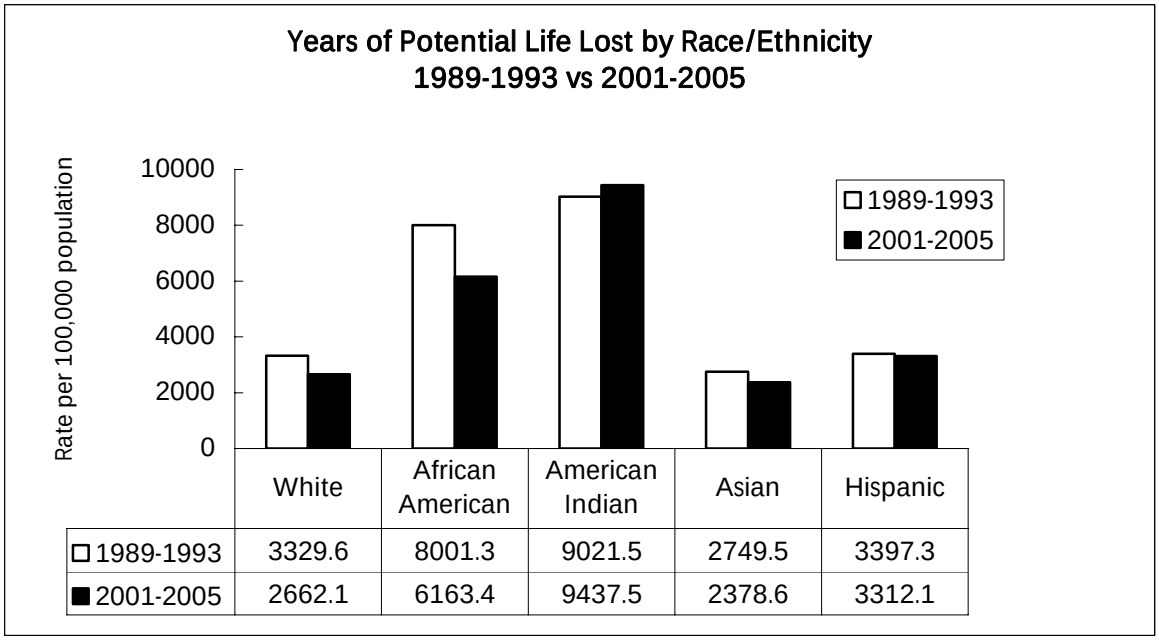
Source: Source: Center for Health Statistics, Minnesota Department of Health
Age-adjustment standard used is the US 2000 standard population.
*Rates not calculated for 20 or fewer deaths
CLRD: Chronic lower respiratory disease

- 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 cirrhosis, diabetes, homicide, nephritis, septicemia, suicide, and unintentional injuries are more than twice the rate of Whites.
- Age-adjusted mortality rates for Hispanics and Asians are similar and at times, lower than the rates for the White population though homicide rates for both groups are more than two and half times the rate for 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 graph presents the YPLL rates by race/ethnicity for 2001-2005 and 1989-1993.



	White	African American	American Indian	Asian	Hispanic
1989-1993	3329.6	8001.3	9021.5	2749.5	3397.3
2001-2005	2662.1	6163.4	9437.5	2378.6	3312.1

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

- Since 1989-1993, YPLL rates increased for American Indians.
- Rates for African Americans, Whites, Asians decreased from 1989-1993 time period.
- Comparing the most recent YPLL rates by race ethnicity indicates that American Indian and African American YPLL rates remain more than twice as high as the White rate.
- YPLL rates for Asians remain lower than the White rate.

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. Recent MCSS data indicates continued racial disparities in the incidence rates of some cancers.

Overall cancer incidence rates are highest among American Indian 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. American Indian males also have the highest incidence rates of colorectal cancer. The risk of an American Indian men being diagnosed with colorectal cancer is more than one and a half times higher than White men. African American males have the highest rate of prostate cancer.

Among females, White women have the highest incidence rate of breast cancer although breast cancer rates for African Americans. American Indians and Hispanics are also elevated. Incidence rates for cervical cancer were highest among racial/ethnic groups more than twice as high than Whites for American Indians, African Americans, and Hispanics. Asian rates were almost twice as high as for Whites. Incidence rates for several other cancers were also highest among American Indian females including lung and bronchus, which was over two times the rate of Whites. Cancer incidence rates were oftentimes lower among Asian females, although rates may vary within the Asian population (i.e. Vietnamese, Hmong).

Cancer Incidence, Minnesota 1999-2003
Average Annual Age-Adjusted Incidence Rate by Race*

All Sites Combined	Male	Female	Total
American Indian	679.1	440.5	534.1
Asian/Pacific Islander	268.6	247.3	255.8
African American	662.3	398.7	512.3
Hispanic (all races)	383.5	317.2	342.2
Non-Hispanic White	551.2	409.9	467.8
Total	559.3	412.2	472.6

Breast	Male	Female	Total
American Indian	~	89.2	48.7
Asian/Pacific Islander	~	59.4	32.4
African American	~	105.5	55.2
Hispanic (all races)	~	83.4	43.5
Non-Hispanic White	1.3	136.1	73.1
Total	1.3	135.8	73.0

Colon and Rectum			
American Indian	108.9	59.8	81.2
Asian/Pacific Islander	25.9	26.3	26.8
African American	59.5	52.1	55.7
Hispanic (all races)	51.6	31.2	40.3
Non-Hispanic White	59.8	44.0	51.0
Total	60.3	44.6	51.6

Corpus Uteri			
American Indian	~	9.2	~
Asian/Pacific Islander	~	14.2	~
African American	~	17.3	~
Hispanic (all races)	~	19.6	~
Non-Hispanic White	~	26.3	~
Total	~	26.4	~

Leukemia			
American Indian	15.6	13.5	14.7
Asian/Pacific Islander	13.2	5.7	8.7
African American	9.1	6.1	7.8
Hispanic (all races)	10.2	7.3	8.3
Non-Hispanic White	18.6	10.3	13.9
Total	18.9	10.5	14.1

Lung and Bronchus			
American Indian	125.4	109.4	113.7
Asian/Pacific Islander	36.4	22.0	28.1
African American	114.0	63.3	85.5
Hispanic (all races)	48.9	47.0	47.2
Non-Hispanic White	71.7	47.4	57.7
Total	72.2	47.9	58.2

Prostate			
American Indian	192.3	~	~
Asian/Pacific Islander	53.9	~	~
African American	228.9	~	~
Hispanic (all races)	123.9	~	~
Non-Hispanic White	184.1	~	~
Total	188.6	~	~

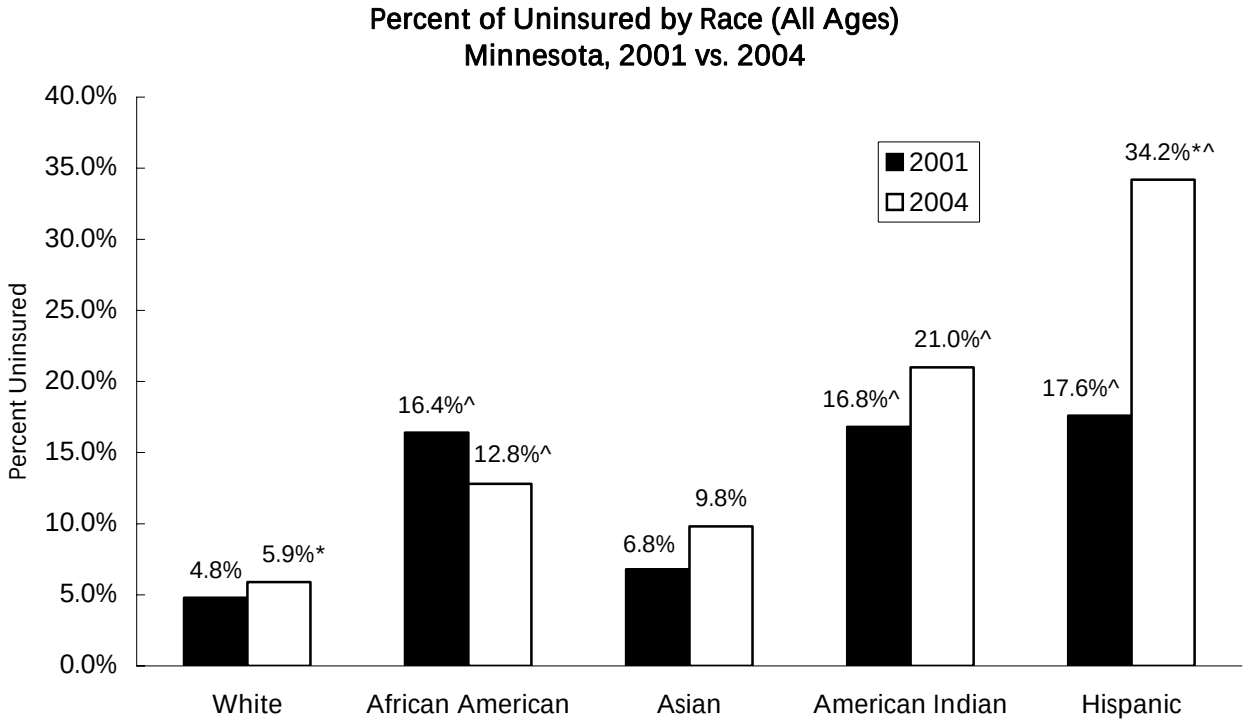
Cervix			
American Indian	~	12.8	~
Asian/Pacific Islander	~	12.3	~
African American	~	12.6	~
Hispanic (all races)	~	13.4	~
Non-Hispanic White	~	6.2	~
Total	~	6.8	~

*Rates are age-adjusted to the US 2000 standard population and are per 100,000 persons.
~ Sex-specific site or fewer than 10 cases.
Source: Minnesota Cancer Surveillance System, February 2006. All cases were microscopically confirmed or identified solely through death certificates. In situ cancers except those of the urinary bladder were excluded. Population estimates for 1988-2002 were from http://seer.cancer.gov, and for 2003 were from http://www.cdc.gov/nchs/about/major/dvs/ popbridge/popbridge.htm. Persons of unknown or other race are excluded from race-specific data, but are included in the total. Race/ethnicity categories are not mutually exclusive and do not sum to the total.

Part IV: Health Insurance

Health Insurance

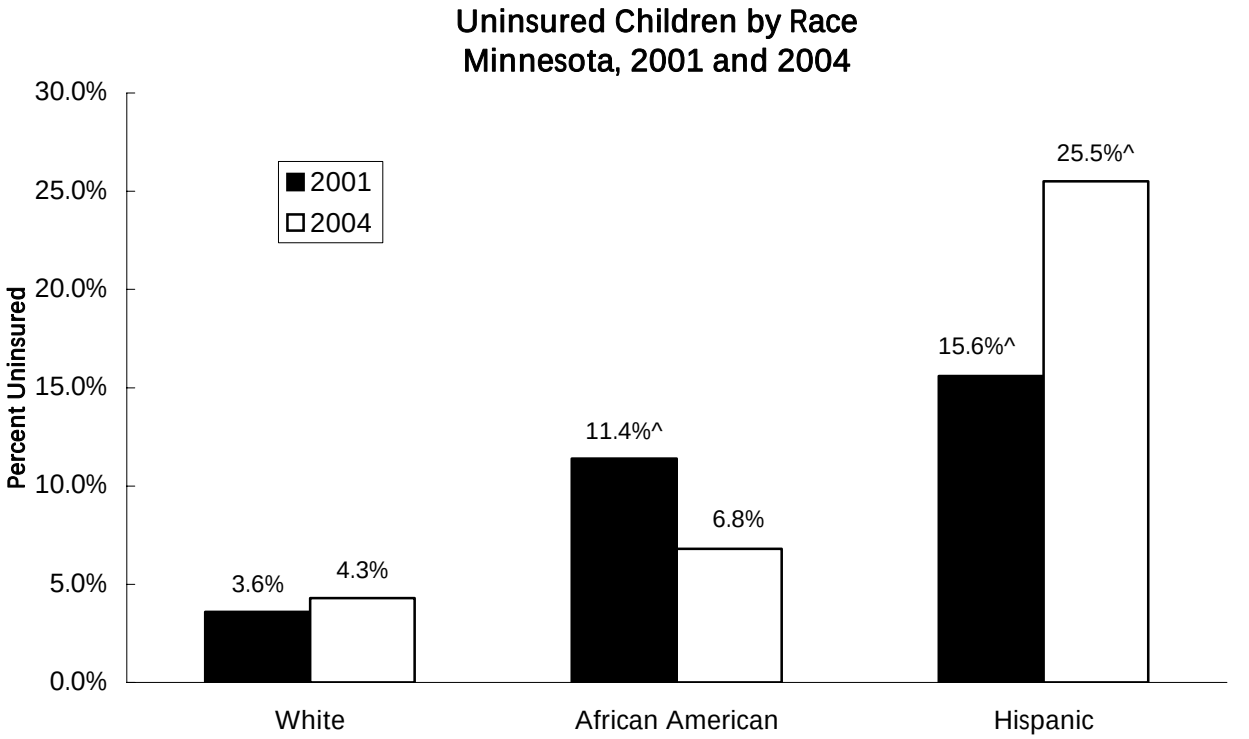
Rates of uninsured vary widely across racial and ethnic groups. Because this study allowed the selection of multiple races, the race/ethnicity definitions include anyone who reported a single race or a single race and any other race/ethnicity (e.g., those included in "White", include those who reported White only and those who reported White and any other race/ethnicity.) As the following graph indicates, White Minnesotans were consistently less likely to be uninsured compared to other racial and ethnic groups. All racial and ethnic groups except Asians experienced significantly higher rates of uninsurance compared to Whites in 2001 and 2004. In fact African Americans, American Indians, and Hispanic/Latinos were up to five times less likely to be insured as compared to Whites. As compared to 2001 rates, 2004 rates indicate statistically significant increases in uninsured rates for Hispanic and White populations.



Source: 2001 and 2004 MN Health Access Survey, MDH Health Economics Program
*Indicates statistically significant difference in level from 2001to 2004 at the 95% level
^Indicates a statistically signficant difference between a given race/ethnic group and white within year at the 95% level
^Indicates statistically significant idifference between a given race/ethnic group and white within year at the 95% level

Uninsured Children

The 2004 Health Access Survey results indicate that children under 18 from racial/ethnic groups other than White were disproportionately represented among the uninsured. In 2004, African American children were one and a half times more likely to be uninsured as compared to Whites. Survey results indicate that Hispanic children in 2004 were almost six times as likely to be uninsured as compared to Whites. Significant differences in the rate of uninsured were found to exist among Hispanics and Whites in both 2001 and 2004 and among African Americans and Whites in 2001.

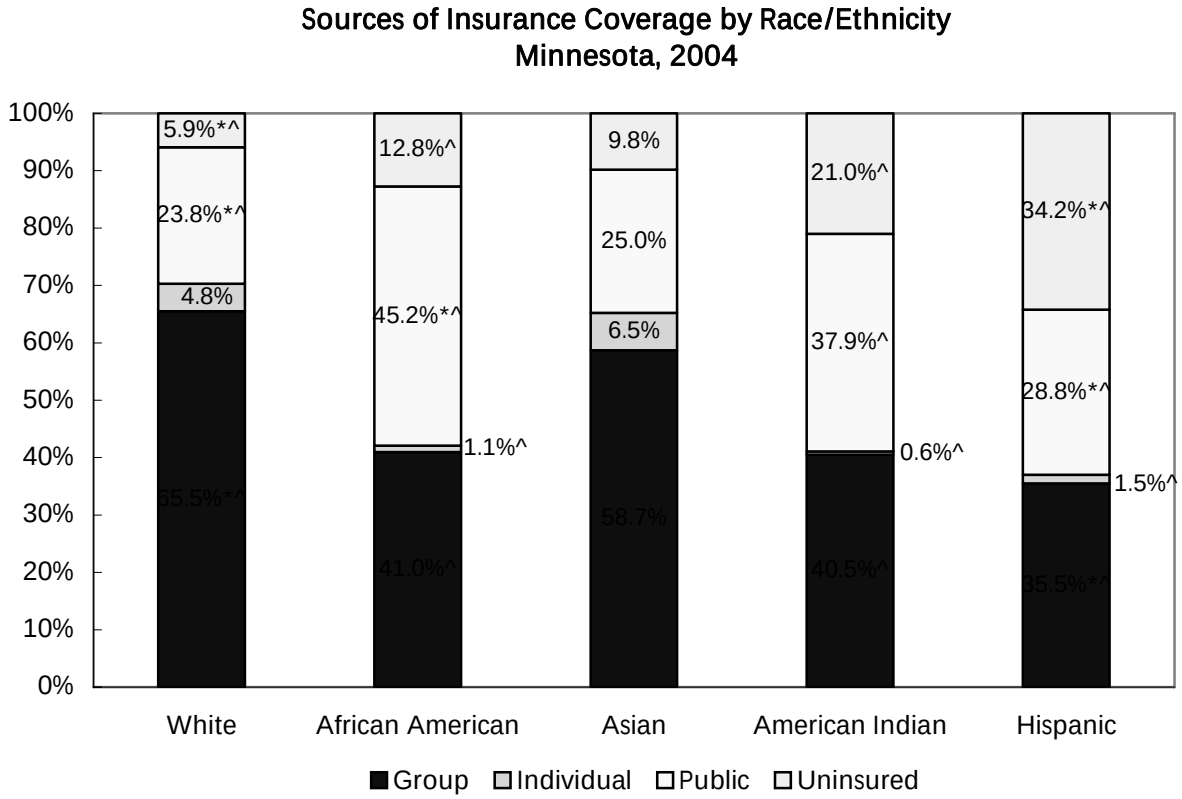


Source: 2001 MN Health Access Survey, MDH Health Economics Program.
^Indicates a significant difference between the racial/ethnic group and whites for the same year at a 95% level.

Uninsured by Type of Insurance Coverage

Additional study results indicate disparities in the type of insurance coverage identified by study participants. Compared to African Americans, American Indians, and Hispanics, Whites were more likely to be covered by group insurance, generally through their own or a family member's employer. More African Americans and American Indians than Whites reported coverage through public health insurance including Medicaid, MinnesotaCare, GAMC,

MCHA, CHIP, CHAMPUS, Veterans Affairs or Military Health Care, Railroad Retirement Plan, or Medicare.



* Indicates a statistically significant difference between 2001 and 2004 at the 95% level
^ Indicates a statistically significant difference between a given race/ethnic group and white within year at the 95% level

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