

Populations of Color in Minnesota

Health Status Report

Update Summary
Spring 2006

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 Fall of 2004, the Minnesota Department of Health, Center for Health Statistics updated the *Populations of Color in Minnesota Health Status Report* that was originally published in 1997. This report documented improvements in some health status areas but identified continuing disparities in the 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 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.
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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.

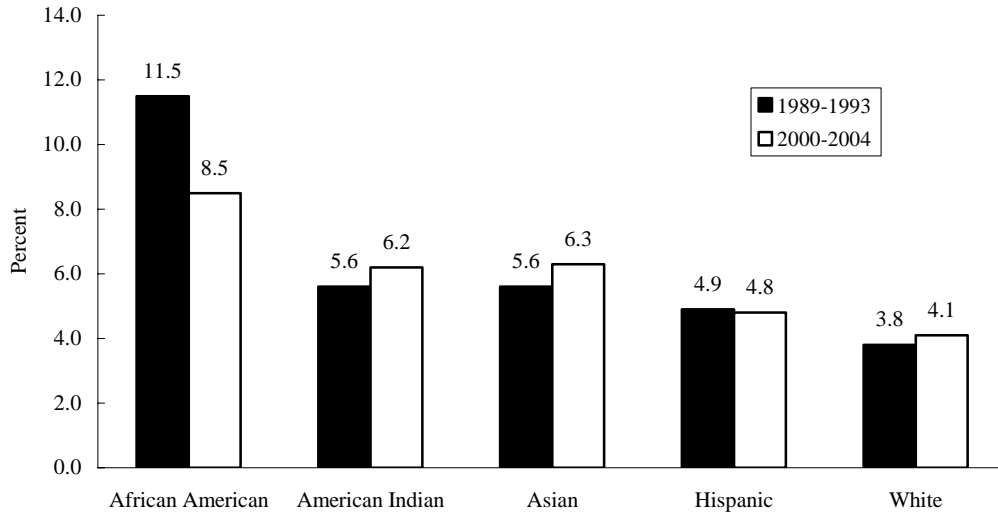
* Hispanic is an ethnicity and may include individuals of any race

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 Birthweight Births by Race/Ethnicity:
Minnesota 1989-1993 and 2000-2004**
(Percent of Singleton Births under 2500 grams)



Source: Center for Health Statistics, Minnesota Department of Health

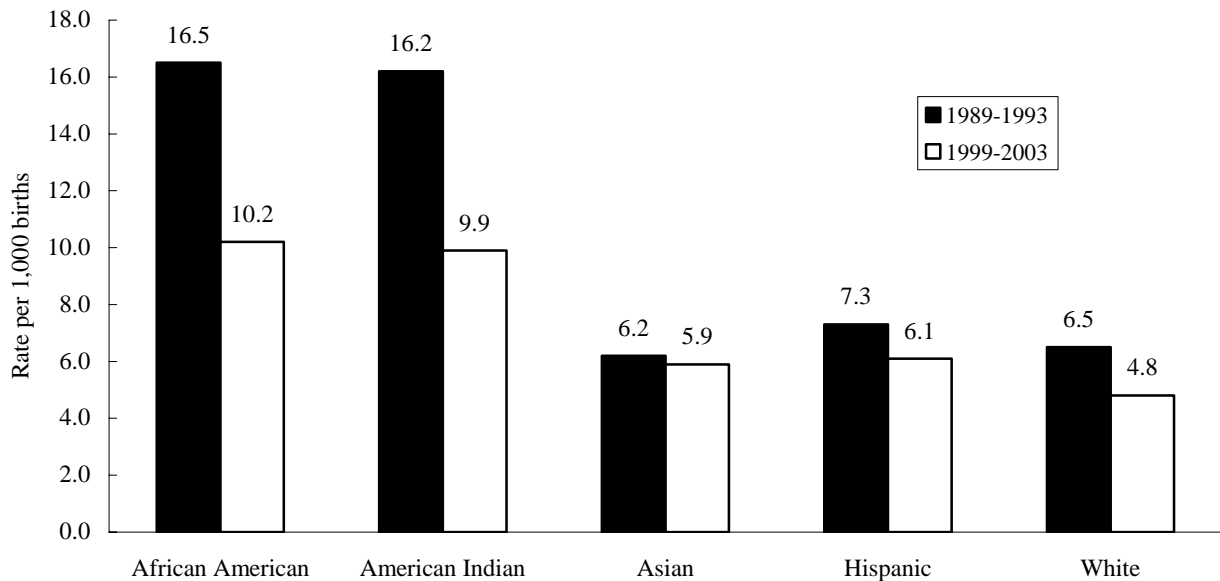
Most recent Minnesota data indicates that the only racial/ethnic group to experience a noticeable decline in low birthweight is the African American group. The percent of low birth weight African American infants decreased from 11.5 percent in 1989-1993 to 8.5 percent in 2000-2004. While the percentage of low birthweight births for African Americans has decreased, low birthweight births among African Americans in Minnesota are still more than 2 times greater than Whites.

Infant Mortality

An infant death is defined as a death of an infant under one 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 African Americans and 16.2 for American Indians in 1989-1993 to 10.2 and 9.9 respectively in 1999-2003. There was also a slight decrease in the Asian, Hispanic, and White infant mortality rates over the same time periods. White rates remain the lowest of all racial/ethnic groups for both time periods.

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 these decreases in the disparities — American Indian and African American infant mortality rates are still more than two times higher than the White rate.

**Infant Mortality Rate by Race/Ethnicity:
Minnesota 1989-1993 and 1999-2003**



Source: Minnesota Department of Health, Center for Health Statistics

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 intensive 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 and no care. Asian women receiving inadequate and no prenatal care has decreased by more than half from 20.6% in 1989-1993 to 7.1% in 2000-2004. 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.

Adequacy* of Prenatal Care in Minnesota by Race/Ethnicity, 1989-1993 and 2000-2004

Race/Ethnicity	% Intensive/Adequate		% Inadequate/No Care	
	1989-1993	2000-2004	1989-1993	2000-2004
African American	47.0	59.8	20.1	10.3
American Indian	37.3	50.5	27.2	16.0
Asian	43.1	64.4	20.6	7.1
Hispanic	51.8	57.6	14.7	9.1
White	78.4	81.0	3.3	2.9

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.

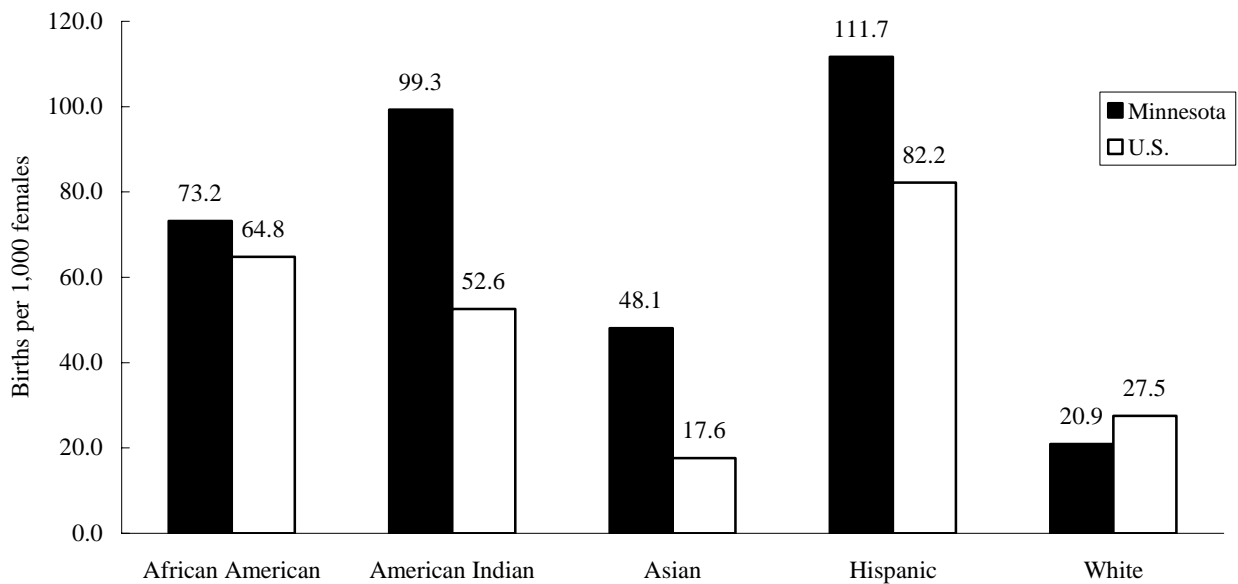
American Indian women continue to experience the greatest disparity in receiving intensive or adequate prenatal care. While this disparity has narrowed, American Indian women are still five and a half times more likely to receive inadequate care or no care during their pregnancies than White women. African Americans, Asians and Hispanics also receive inadequate or no prenatal care at higher rates than Whites. In 2000-2004, only 3 percent of White women received inadequate or no care. Women of Color were 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. In 2003, the U.S. White teen birth rate was 27.5 per 1,000 females compared to 20.9 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 (73.2) is very close to the U.S. rate (64.8), while the Minnesota rates for Asians and American Indians 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., 2003**

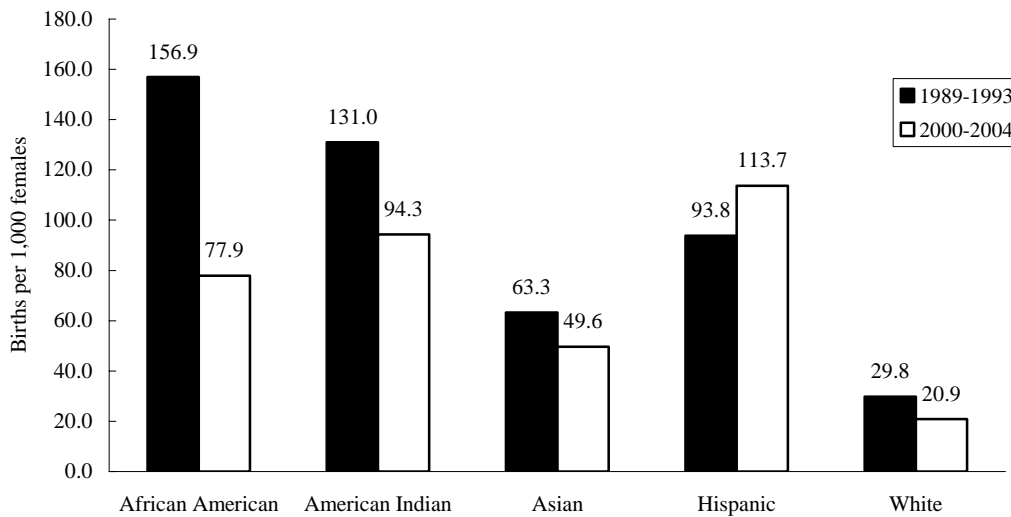


Source: Minnesota Department of Health, Center for Health Statistics, and National Center for Vital Statistics, Preliminary birth data for 2003
U. S. figures are for non-Hispanic White and non-Hispanic African American

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 from 156.9 in 1989-1993 to 77.9 in 2000-2004. The decrease in the American Indian teen birth rate was almost as dramatic with a rate of 131.0 in 1989-1993 down to 94.3 per 1,000 births in 2000-2004. The Hispanic teen birth rate is the only teen birth rate that has actually increased during this time period. Though decreases among African Americans and American Indians are considerable, teen birth rates for all of the racial/ethnic groups remain two to four times that of the White rate.

**Minnesota Teen (15-19 year olds) Birth Rates by Race/Ethnicity:
1989-1993 and 2000-2004**



Source: Center for Health Statistics, Minnesota Department of Health

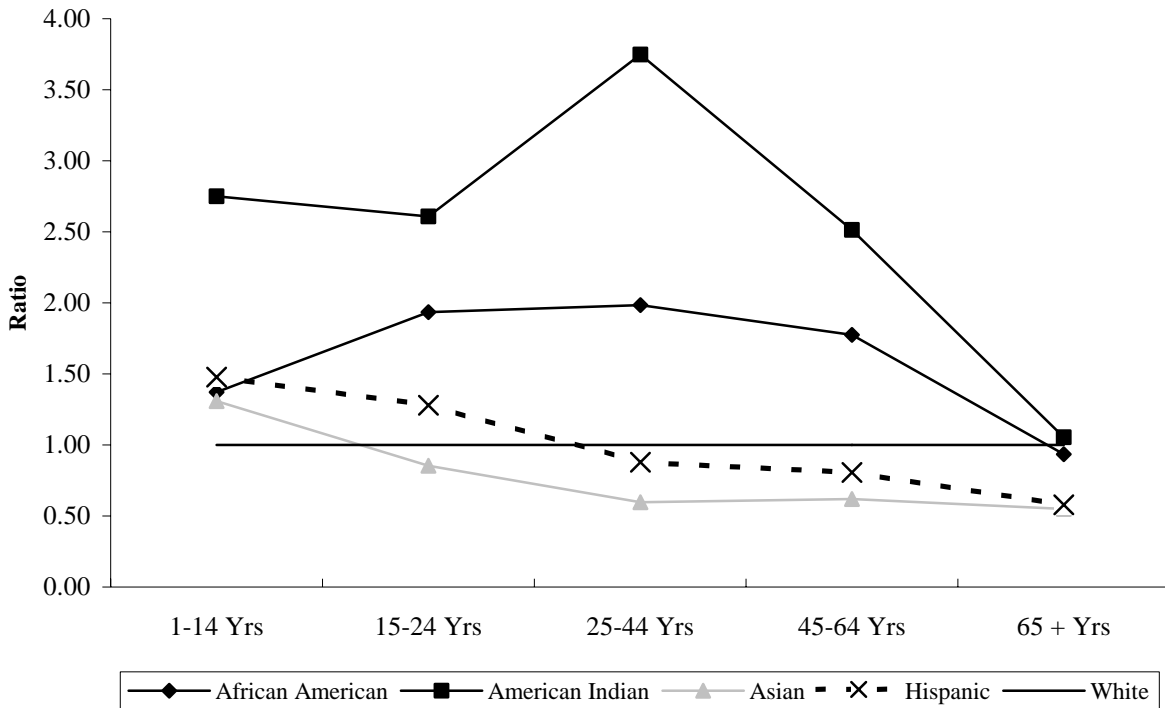
Part II: Death Rates and Causes of Death

Death Rate Ratio

Mortality rates were obtained by analyzing data on all deaths to Minnesota residents occurring between 2000 and 2004 and, where appropriate, were compared with deaths occurring between 1989 and 1993.

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. 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 as compared to Whites.

**Ratio of Non-White to White Minnesota Death Rates
Five-Year Average (2000-2004)**



Source: Center for Health Statistics, Minnesota Department of Health

American Indian death rates were two to three and a half times higher than death rates for Whites except the 65+ year age group. 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 Whites. Hispanic and Asian death rates were lower than Whites among the 25-44, 45-64, and 65+ year age groups. Asian death rates were also lower than Whites among the 15-24 year age group.

Cause of Death

Crude mortality rates are the number of deaths per 100,000 population. While these rates provide an estimate the number of deaths due to a particular cause 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 Adjusted Mortality Rates per 100,000 by Race/Ethnicity
Minnesota 2000-2004**

Cause	White	African American	American Indian	Asian	Hispanic
AIDS/HIV	0.8	10.1	*	*	4.5
Alzheimer's Disease	22.2	18.0	*	*	*
Cancer	182.2	229.2	230.6	135.5	120.6
CLRD	37.4	36.4	62.3	18.7	17.0
Cirrhosis	6.5	8.1	34.3	*	12.2
Congenital Anomalies	4.0	5.6	*	2.7	4.1
Diabetes	23.3	54.6	86.5	22.5	37.5
Heart Disease	160.8	159.4	239.7	71.4	107.8
Homicide	1.6	17.2	14.6	3.8	5.0
Nephritis	12.5	23.3	32.4	17.2	14.5
Perinatal Conditions	2.7	5.7	6.4	3.1	4.3
Pneumonia and Influenza	15.2	14.9	26.0	14.3	*
Septicemia	4.8	9.9	16.7	7.3	*
SIDS	0.4	1.2	*	*	*
Stroke	49.5	80.4	58.5	52.2	33.8
Suicide	9.5	6.3	20.1	8.7	6.8
Unintentional Injury	34.7	35.7	95.4	24.0	31.0

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

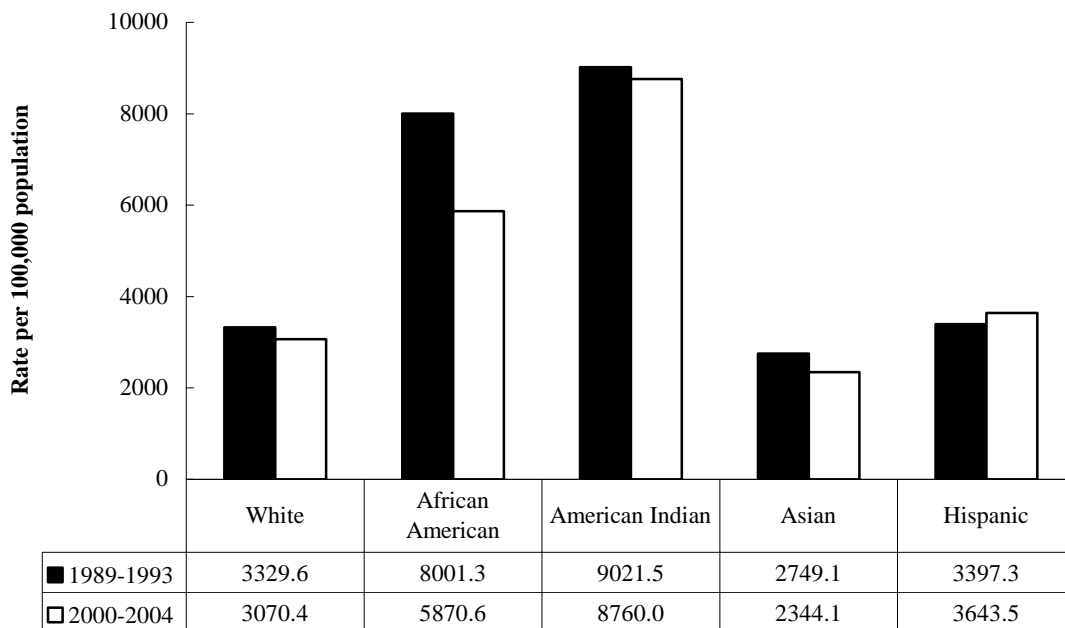
Age-adjusted mortality rates for African Americans due to AIDS/HIV, diabetes, homicide, perinatal conditions, septicemia, and SIDS are more than twice the rates for Whites. For American Indians, age-adjusted mortality rates for cirrhosis, diabetes, homicide, nephritis, perinatal conditions, septicemia,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

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 2000-2004 and 1989-1993. This chart indicates that in the most recent 5-year period, YPLL rates for African Americans, American Indians, Asians and Whites have decreased. Only Hispanic YPLL rates have increased. However, YPLL rates for American Indians are more twice as high as those for Whites and rates for African Americans are more than one and one half times that of Whites.

Years of Potential Life Lost by Race/Ethnicity 1989-1993 vs 2000-2004



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. 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	Breast	Male	Female	Total
American Indian	679.1	440.5	534.1	American Indian	~	89.2	48.7
Asian/Pacific Islander	268.6	247.3	255.8	Asian/Pacific Islander	~	59.4	32.4
African American	662.3	398.7	512.3	African American	~	105.5	55.2
Hispanic (all races)	383.5	317.2	342.2	Hispanic (all races)	~	83.4	43.5
Non-Hispanic White	551.2	409.9	467.8	Non-Hispanic White	1.3	136.1	73.1
Total	559.3	412.2	472.6	Total	1.3	135.8	73.0

Colon and Rectum	Male	Female	Total	Corpus Uteri	Male	Female	Total
American Indian	108.9	59.8	81.2	American Indian	~	9.2	~
Asian/Pacific Islander	25.9	26.3	26.8	Asian/Pacific Islander	~	14.2	~
African American	59.5	52.1	55.7	African American	~	17.3	~
Hispanic (all races)	51.6	31.2	40.3	Hispanic (all races)	~	19.6	~
Non-Hispanic White	59.8	44.0	51.0	Non-Hispanic White	~	26.3	~
Total	60.3	44.6	51.6	Total	~	26.4	~

Leukemia	Male	Female	Total	Lung and Bronchus	Male	Female	Total
American Indian	15.6	13.5	14.7	American Indian	125.4	109.4	113.7
Asian/Pacific Islander	13.2	5.7	8.7	Asian/Pacific Islander	36.4	22.0	28.1
African American	9.1	6.1	7.8	African American	114.0	63.3	85.5
Hispanic (all races)	10.2	7.3	8.3	Hispanic (all races)	48.9	47.0	47.2
Non-Hispanic White	18.6	10.3	13.9	Non-Hispanic White	71.7	47.4	57.7
Total	18.9	10.5	14.1	Total	72.2	47.9	58.2

Prostate	Male	Female	Total	Cervix	Male	Female	Total
American Indian	192.3	~	~	American Indian	~	12.8	~
Asian/Pacific Islander	53.9	~	~	Asian/Pacific Islander	~	12.3	~
African American	228.9	~	~	African American	~	12.6	~
Hispanic (all races)	123.9	~	~	Hispanic (all races)	~	13.4	~
Non-Hispanic White	184.1	~	~	Non-Hispanic White	~	6.2	~
Total	188.6	~	~	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.

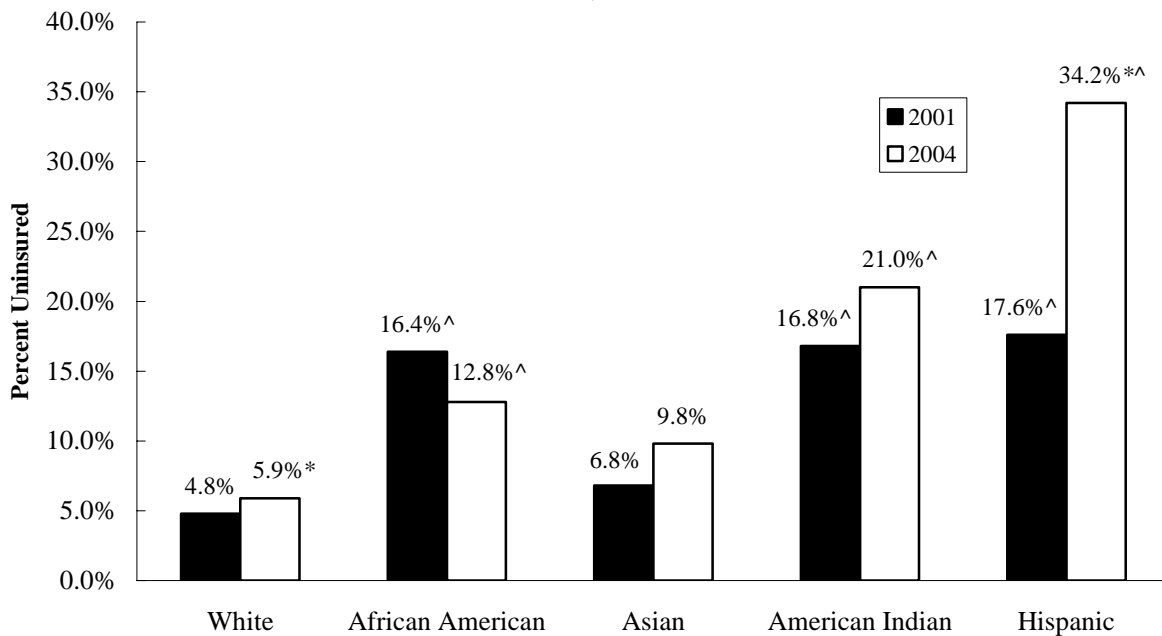
Source: Minnesota Cancer Surveillance System, February 2006. All cases were microscopically confirmed or identified solely through death certificates. *In situ* cancers except those of the urinary bladder were excluded. Population estimates for 1988-2002 were from <http://seer.cancer.gov>, and for 2003 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.

**Percent of Uninsured by Race (All Ages)
Minnesota, 2001 vs. 2004**



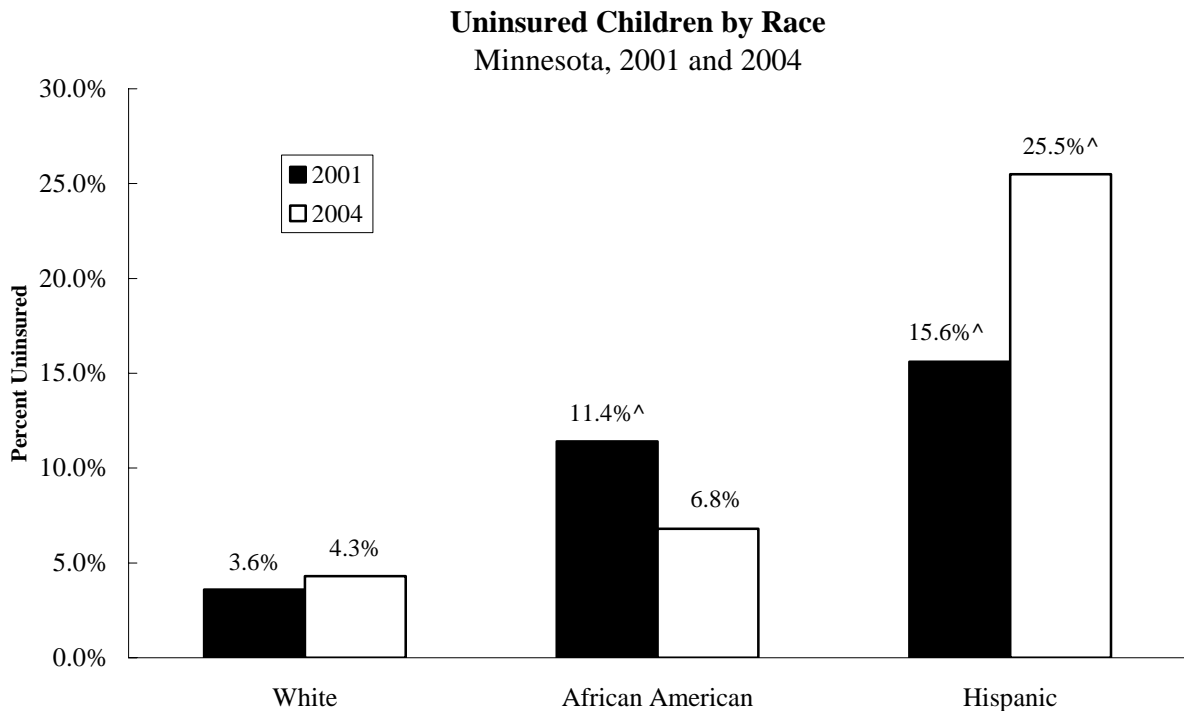
Source: 2001 and 2004 MN Health Access Survey, MDH Health Economics Program

*Indicates statistically significant difference in level from 2001 to 2004 at the 95% level

^Indicates a statistically significant difference 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 was found to exist among Hispanics and Whites in both 2001 and 2004 and among African Americans and Whites in 2001.



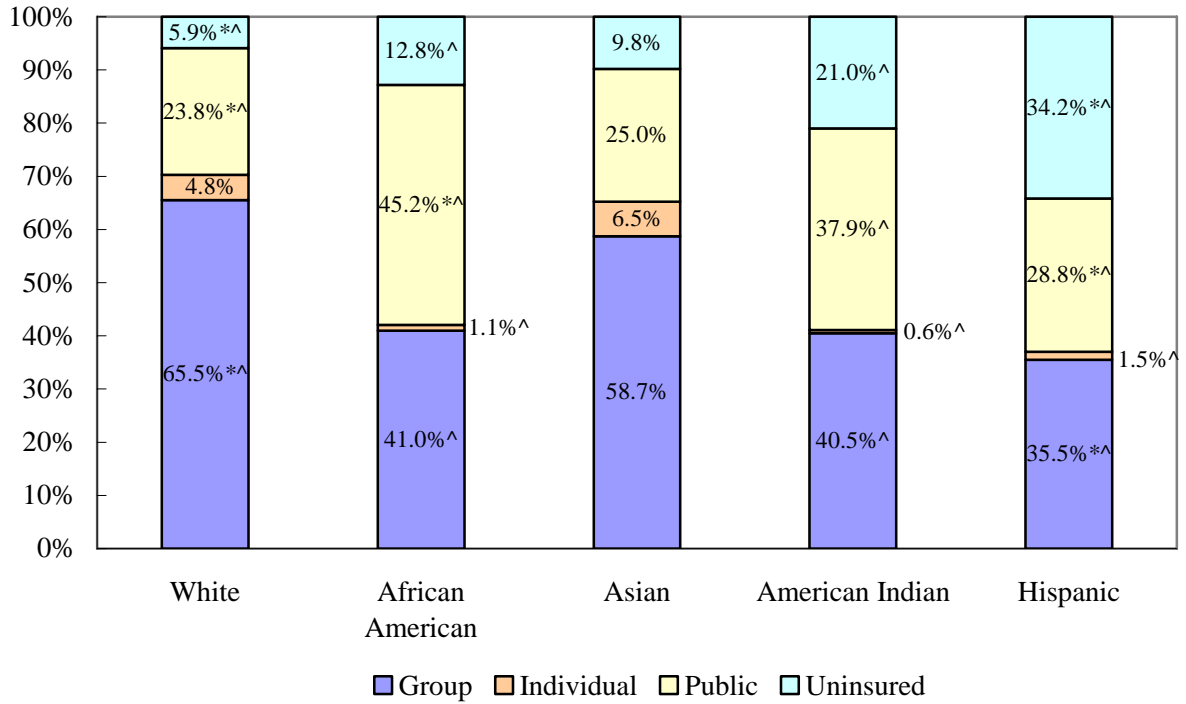
Source: 2001 MN Health Access Survey, MDH Health Economics Program.

^Indicates a significant difference between the racial/ethnic group and whites for the same year at a 95% level.

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.

Sources of Insurance Coverage by Race/Ethnicity Minnesota, 2004



* 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