

Populations of Color in Minnesota

Health Status Report

Update Summary
Spring 2008

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Background

The 2007 edition of America's Health Rankings identified Minnesota as the second 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 Hispanics²), 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.

Annual Update Summaries are 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.

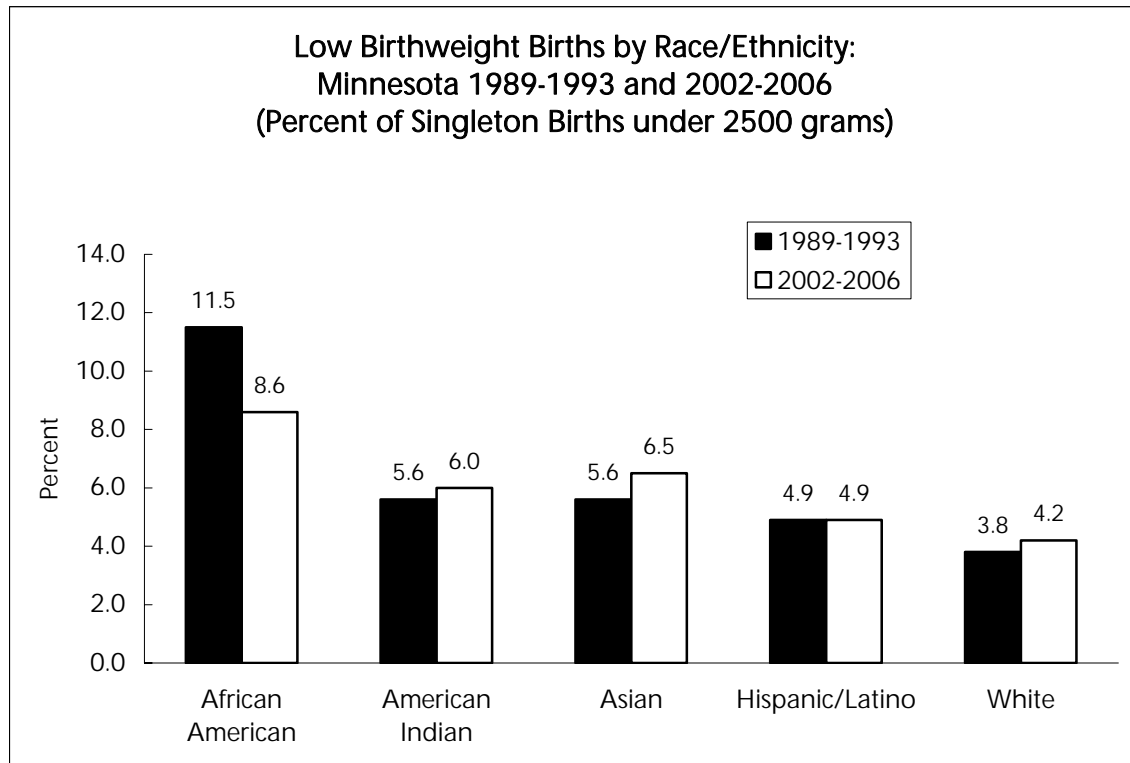
¹ 2006 edition of "America's Health" published by the United Health Foundation, the American Public Health Association and the Partnership for Prevention.

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.

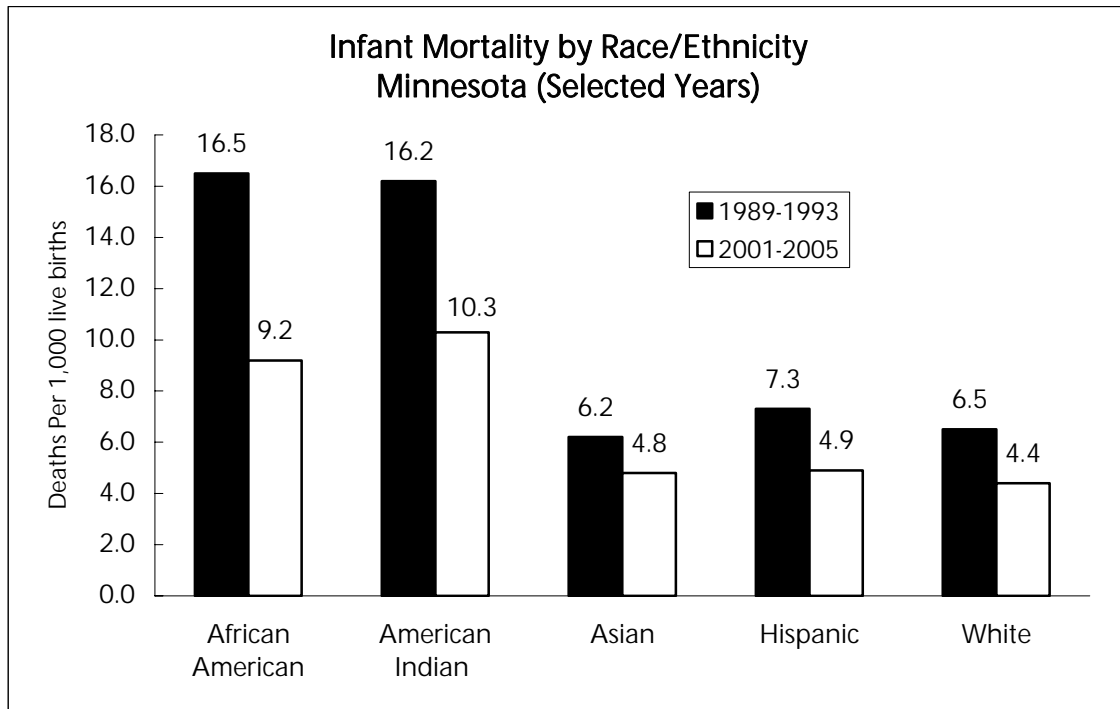


Source: Center for Health Statistics, Minnesota Department of Health

- African Americans were the only group to experience a noticeable decline in low birthweight (From 11.5 percent in 1989-1993 to 8.6 percent in 2002-2006).
- Low birth weight increased for American Indians, Asian, and Whites and remained the same for Hispanic/Latinos.
- Low birthweight births among African Americans in Minnesota remain two times greater than Whites.

Infant Mortality

An infant death is the 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.



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

- Infant mortality rates for Whites are lowest as compared to all other racial/ethnic groups (2001-2005).
- Infant mortality rates for African Americans and American Indians have declined from 16.5 for African Americans and 16.2 for American Indians in 1989-1993 to 9.2 and 10.3 respectively in 2001-2005.
- A decline in infant mortality rates also 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. Despite a decline in infant mortality rates among American Indian and African Americans, infant mortality rates for these groups are still more than two times higher than the White rate.

Prenatal Care

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

Adequacy* of Prenatal Care in Minnesota by Race/Ethnicity, 1989-1993 and 2002-2006

Race/Ethnicity	% Intensive/Adequate		% Inadequate/No Care	
	1989-1993	2002-2006	1989-1993	2002-2006
African American	47.0	63.2	20.1	8.5
American Indian	37.3	49.1	27.2	15.7
Asian	43.1	69.3	20.6	5.6
Hispanic	51.8	60.8	14.7	7.5
White	78.4	82.4	3.3	2.4

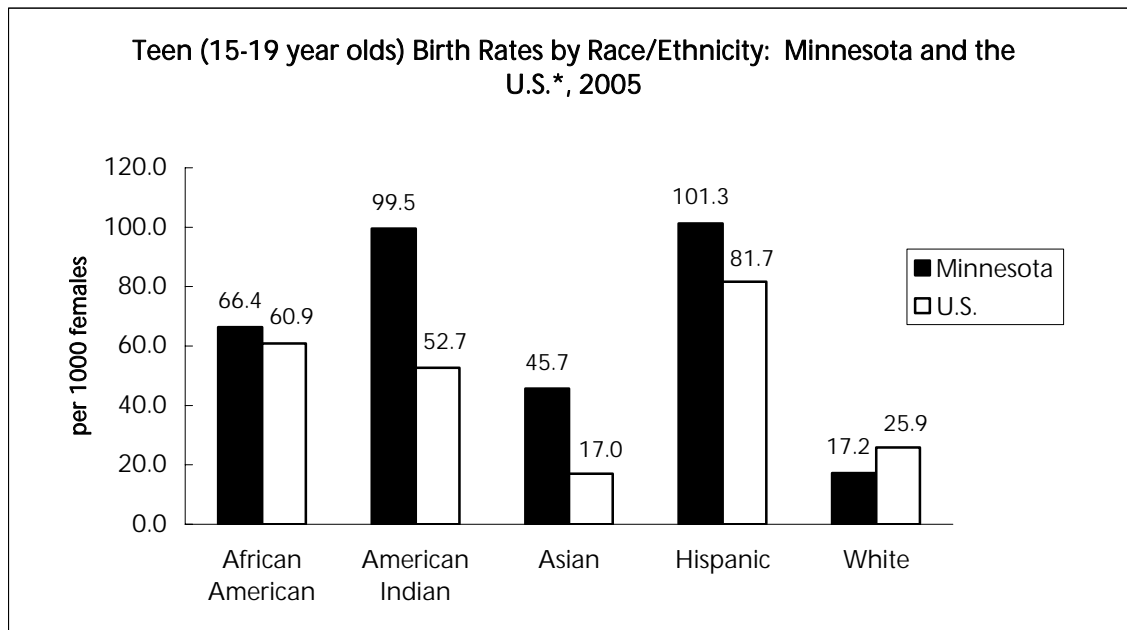
Source: Minnesota Department of Health, Center for Health Statistics

*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.

- For all race/ethnic groups, 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 5.6% in 2002-2006.
- 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 2002-2006, only 2.4 percent of White women received inadequate or no care.

Teen Births

Teen Birth Rates: Minnesota vs. U.S.

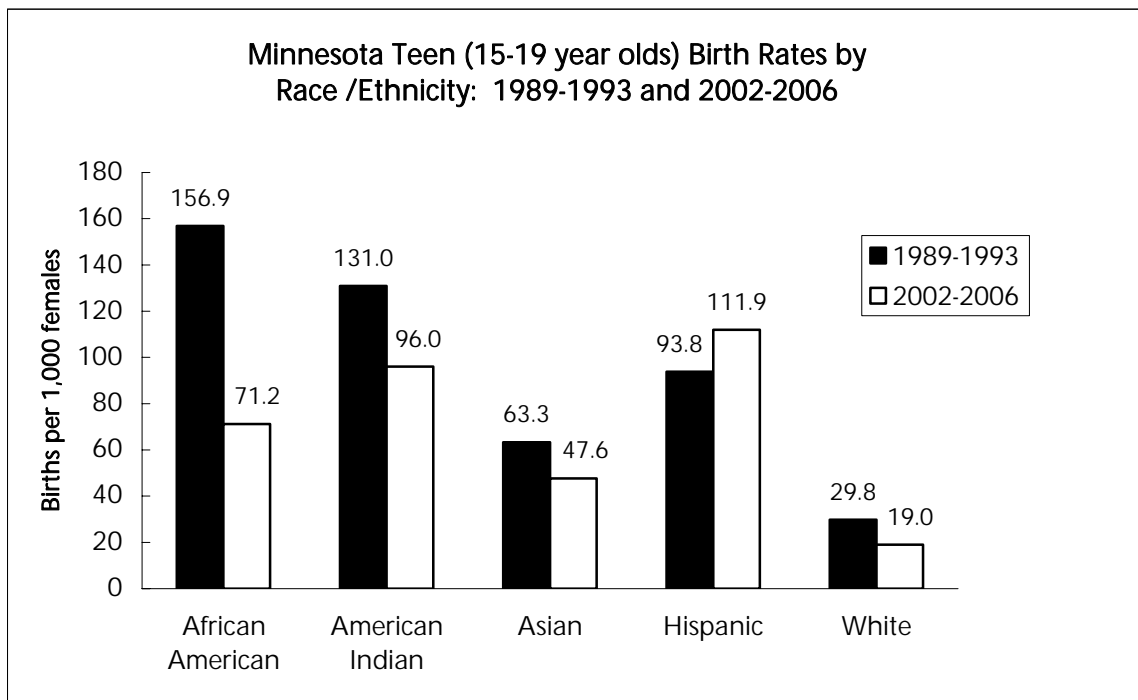


Source: Minnesota Department of Health, Center for Health Statistics, and National Center for Vital Statistics, Preliminary birth data for 2003

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 2005, the U.S. White teen birth rate was 25.9 per 1,000 females compared to 17.2 in Minnesota.
- For other racial and ethnic groups in Minnesota, the rate of teen births is higher than the corresponding U.S. rate. The African American rate (66.4) is very close to the U.S. rate (60.9), while the rates for Asians and American Indians are over one and half to more than two times higher than the U.S. rate.
- The Hispanic teen birth rate for Minnesota is higher than all other racial/ethnic groups for both Minnesota and U.S. 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



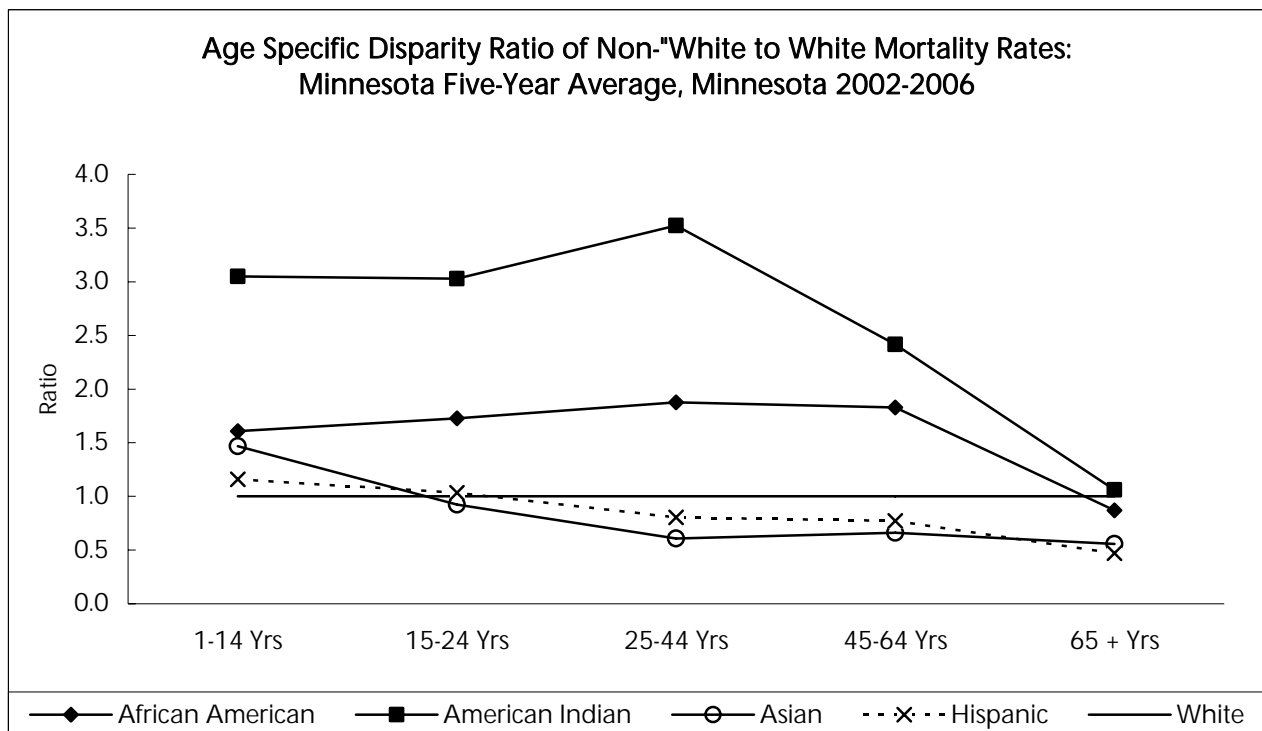
Source: Minnesota Department of Health, Center for Health Statistics

- 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 71.2 in 2002-2006. The American Indian teen birth rate decreased from a rate of 131.0 in 1989-1993 to 96.0 per 1,000 births in 2002-2006.
- Although rates decreased for African Americans and American Indians for these time periods, these rates remain three to four times that of the White rate.
- The Hispanic teen birth rate is nearly six 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 2002 and 2006. 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: Minnesota Department of Health, Center for Health Statistics

- 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 are two and a half to three and a half times higher than death rates for Whites for most age groups. Death rates for African Americans are 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 of death by adjusting for differences in age distribution between populations.

**Age Adjusted Mortality Rates per 100,000 by Race/Ethnicity
Minnesota 2002-2006**

Cause	White	African American	American Indian	Asian	Hispanic
AIDS/HIV	0.7	8.9	3.4	0.3	3.6
Alzheimer's Disease	22.3	17.6	11.0	8.6	9.5
Cancer	175.2	224.6	217.5	122.2	109.5
CLRD	36.1	31.8	46.1	19.0	11.9
Cirrhosis	6.0	6.4	33.0	4.1	7.0
Congenital Anomalies	3.8	5.6	4.6	1.9	3.6
Diabetes	22.4	53.4	92.7	20.7	33.9
Heart Disease	146.1	147.0	225.3	72.5	74.5
Homicide	1.3	17.7	19.2	3.3	3.9
Nephritis	11.9	24.6	26.0	15.1	10.0
Perinatal Conditions	2.6	6.4	3.5	2.9	3.8
Pneumonia and Influenza	14.0	9.0	26.8	11.2	3.4
Septicemia	4.9	10.2	17.3	7.7	3.8
SIDS	0.5	1.4	2.5	0.2	0.5
Stroke	44.3	63.3	63.3	47.4	28.3
Suicide	10.1	5.3	19.7	6.9	7.0
Unintentional Injury	34.8	32.4	88.5	23.4	27.9

Source: Source: Center for Health Statistics, Minnesota Department of Health

Age-adjustment standard used is the US 2000 standard population.

CLRD: Chronic lower respiratory disease

SIDS: Sudden Infant Death Syndrome

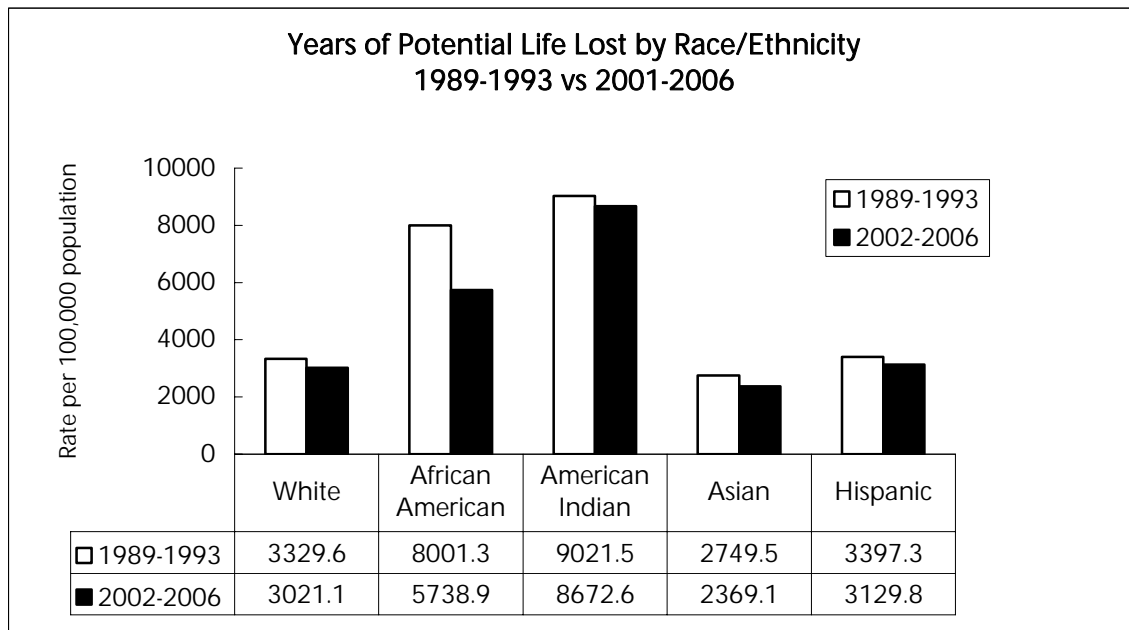
- The age-adjusted mortality rates for African Americans due to homicide is 13.6 times higher than the rate for Whites and the rates for AIDS/HIV is 12.7 times the rate for Whites. Rates for diabetes, nephritis, perinatal conditions, septicemia and SIDS are more than two times the rate of Whites.
- For American Indians, age-adjusted mortality rate for homicide is 14.8 times the rate for Whites. Also for this group, the rates for AIDS/HIV, CLRD, diabetes, nephritis, septicemia, SIDS, suicide, and unintentional injury are two to five times the rates for 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 to three times the rates for Whites. The Hispanic AIDS/HIV rates is 5.1 times the White rate.

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 1989-1993 and 2002-2006.



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 for all racial/ethnic groups decreased.
- Comparing the most recent YPLL rates by race ethnicity indicates that the American Indian YPLL rate remains more than twice as high as the White rate. The YPLL rate for African Americans is one and a half times higher than Whites, while the Hispanic rate is only slightly higher than whites.
- The YPLL rate for Asians remains lower than the White rate.

Part III: Cancer Incidence

The Minnesota Cancer Surveillance System (MCSS) is the state's population-based cancer registry. The MCSS systematically collects demographic, diagnostic and treatment 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 African American and American Indian males, and are lowest among Asian/Pacific Islander males and females. American Indian males have the highest rate 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 rate of colorectal cancer. The risk of an American Indian man being diagnosed with colorectal cancer is more than one and a half times higher than a White man. African American males have the highest rate of prostate cancer, more than two times higher than White males.

White women have the highest incidence rate of breast cancer. Incidence rates for cervical cancer are more than twice as high for American Indians, African Americans, Hispanics, as compared to the rate for Whites. The rate for Asians is nearly twice as high as the rate for Whites. Among females, 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 2001-2005
Average Annual Age-Adjusted Incidence Rate by Race*

All Sites Combined	Male	Female	Total	Breast	Male	Female	Total
American Indian	633.8	449.6	524.7	American Indian	~	94.8	50.9
Asian/Pacific				Asian/Pacific			
Islander	268.6	247.2	254.7	Islander	~	54.1	29.4
African American	640.3	375.6	491.5	African American	~	100.0	51.4
Hispanic (all races)	343.7	337.0	335.0	Hispanic (all races)	~	82.6	41.8
Non-Hispanic White	551.4	409.7	468.6	Non-Hispanic			
Total	557.8	411.5	472.3	White	1.3	129.8	69.6
				Total	1.3	129.3	69.3
Colon and Rectum				Corpus Uteri			
American Indian	86.8	54.0	69.7	American Indian	~	16.3	~
Asian/Pacific				Asian/Pacific			
Islander	34.1	28.1	31.1	Islander	~	15.3	~
African American	56.8	37.4	45.9	African American	~	18.2	~
Hispanic (all races)	44.4	32.6	37.9	Hispanic (all races)	~	20.7	~
Non-Hispanic White	57.5	42.6	49.3	Non-Hispanic			
Total	57.9	43.1	49.8	White	~	27.4	~
				Total	~	27.4	~
Leukemia				Lung and Bronchus			
American Indian	26.6	12.2	18.5	American Indian	122.7	113.6	115.2
Asian/Pacific				Asian/Pacific			
Islander	12.8	5.4	8.4	Islander	34.4	23.8	28.2
African American	13.3	9.7	11.8	African American	98.4	57.0	75.0
Hispanic (all races)	9.4	10.0	9.5	Hispanic (all races)	35.5	42.5	39.0
Non-Hispanic White	19.4	11.0	14.6	Non-Hispanic			
Total	19.7	11.1	14.8	White	71.1	48.9	58.2
				Total	71.4	49.3	58.6
Prostate				Cervix			
American Indian	173.6	~	~	American Indian	~	12.1	~
Asian/Pacific				Asian/Pacific			
Islander	51.0	~	~	Islander	~	11.5	~
African American	220.8	~	~	African American	~	12.6	~
Hispanic (all races)	106.9	~	~	Hispanic (all races)	~	16.9	~
Non-Hispanic White	181.5	~	~	Non-Hispanic			
Total	185.6	~	~	White	~	6.0	~
				Total	~	6.6	~

*Rates are age-adjusted to the US 2000 standard population and are per 100,000 persons.

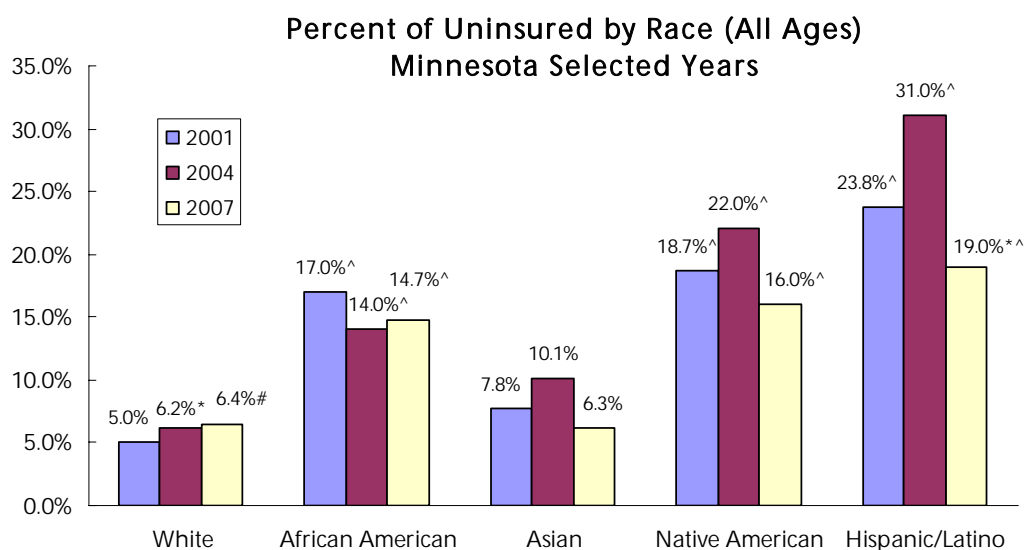
~ Sex-specific site or fewer than 10 cases.

Source: Minnesota Cancer Surveillance System, June 2008. All cases were microscopically confirmed or identified solely through death certificates. In situ cancers except those of the urinary bladder were excluded. Population estimates were from <http://seer.cancer.gov>. 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 may 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 except for Asians in 2007. For all three time periods reported, 2001, 2004, and 2007, African American, American Indian, and Hispanic groups experienced significantly higher rates of uninsurance compared to Whites. In fact, for all three years reported, 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, 2007 rates indicate statistically significant increases in uninsured rates for Whites. Compared to previous years reporting (2004), rates of uninsured have not changed significantly for any group.



Source: MDH Health Economics Program and University of Minnesota School of Public Health, Minnesota Health Access Surveys

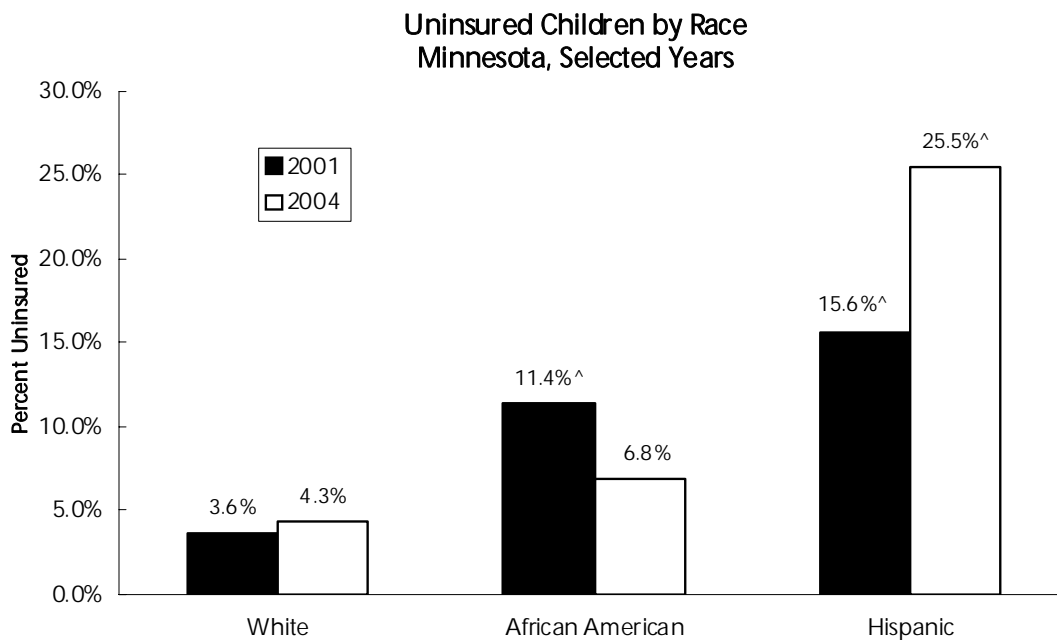
*Indicates statistically significant difference from previous year at the 95% level.

^ Indicates statistically significant difference from White within year at the 95% level.

Indicates statistically significant difference between 2001 and 2007 at the 95% level.

Uninsured Children

Results from the 2007 Health Access Survey are unavailable for children by race/ethnicity due to small numbers. 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.



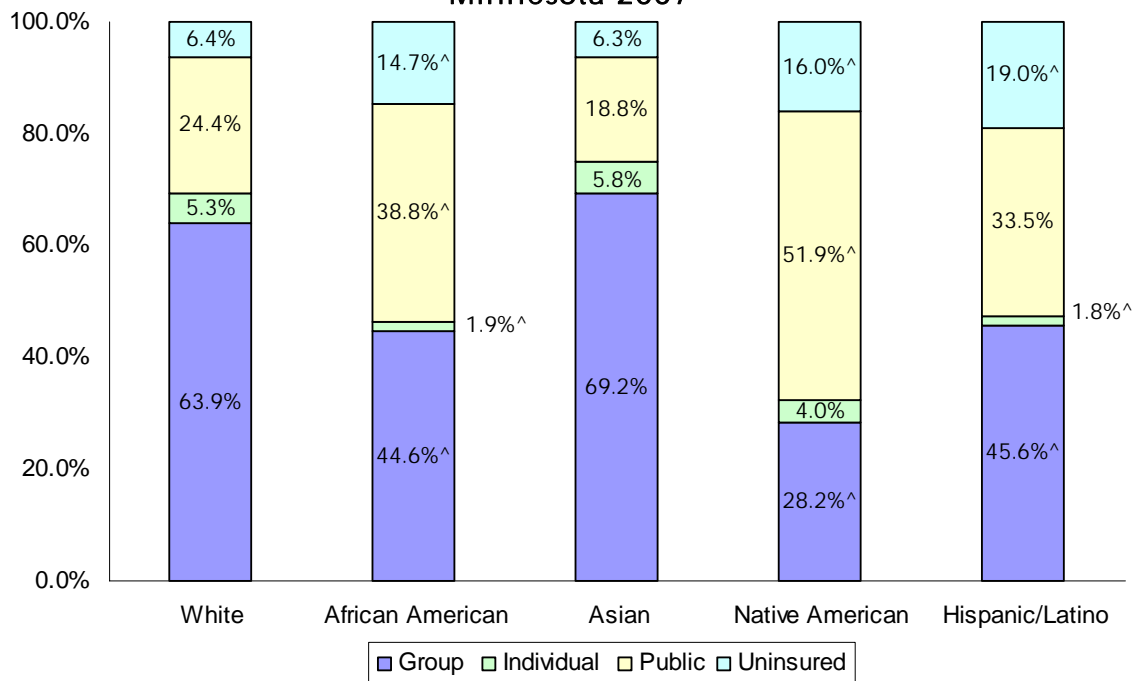
Source: 2001 and 2004 MN Health Access Survey, MDH Health Economics Program.

[^]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.

Sources of Insurance Coverage by Race/Ethnicity, Minnesota 2007



* 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: 2007 MN Health Access Survey, MDH Health Economics Program