
Populations of Color in Minnesota

Health Status Report

Update Summary
Fall 2002

Center for Health Statistics
Minnesota Department of Health



Table of Contents

Part I: Birth Related Indicators	1
Low Birthweight	1
Infant Mortality	2
Prenatal Care	3
Teen Birth Rates	4
Part II: Death Rates and Cause of Death	6
Death Rate Ratio	6
Cause of Death	6
Years of Potential Life Lost	7
Part III: Injury and Violence	9
Part IV: Breast and Cervical Cancer	10
Breast Cancer Mortality	10
Cervical Cancer Incidence	11
Other Cancers	11
Part V: Minnesota's Uninsured	12
Rates of Uninsured	12
Uninsured Children	13
Uninsured by Race and Income	13
Uninsured by Type of Insurance Coverage	14
Part VI: Notes	16

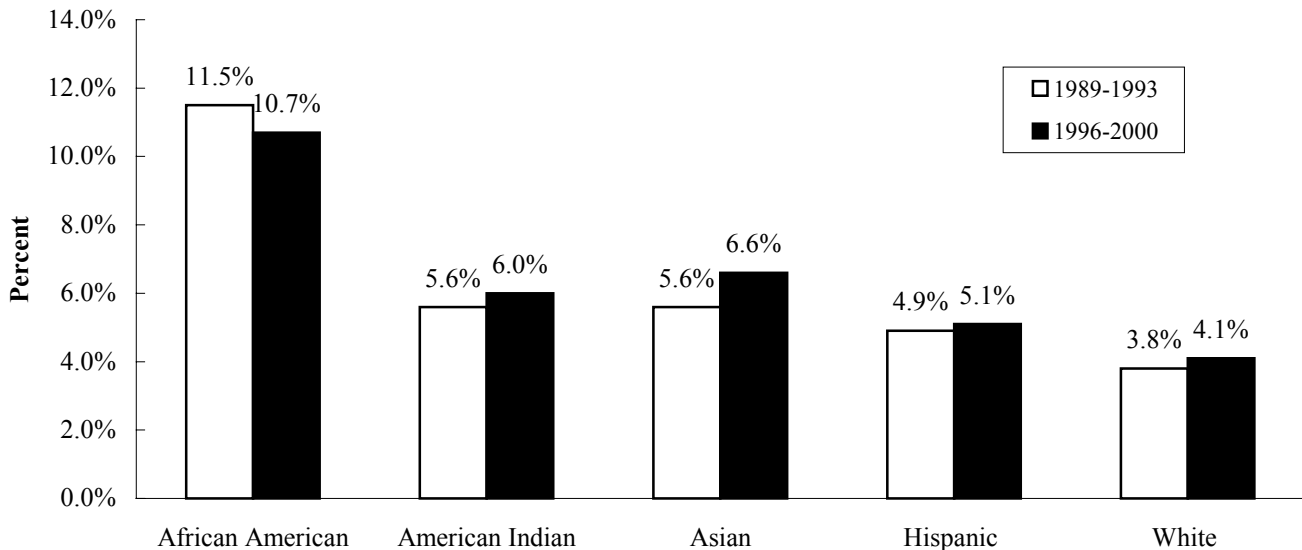
Part I: Birth-Related Health Indicators

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 births or growth restriction prior to birth. Infant mortality or serious health and developmental complications are closely associated with low birthweight. The rates of low birthweight births among some populations of color, especially those to African American women, are substantially higher than those of White women.

Although overall rates of infant mortality have improved greatly in the past decade, recent Minnesota data indicates that the percentage of low birthweight births has increased in all groups, except African Americans. While the percentage of low birthweight births for African Americans has decreased in the most current 5-year period, low birthweight births among African Americans in Minnesota (10.7%), are greater than 2 ½ times that of Whites (4.1%) and higher than any other racial/ethnic group.

Low Birthweight Births-Minnesota
(Percent of Singleton Births Under 2,500 grams)



Source: Center for Health Statistics, Minnesota Department of Health

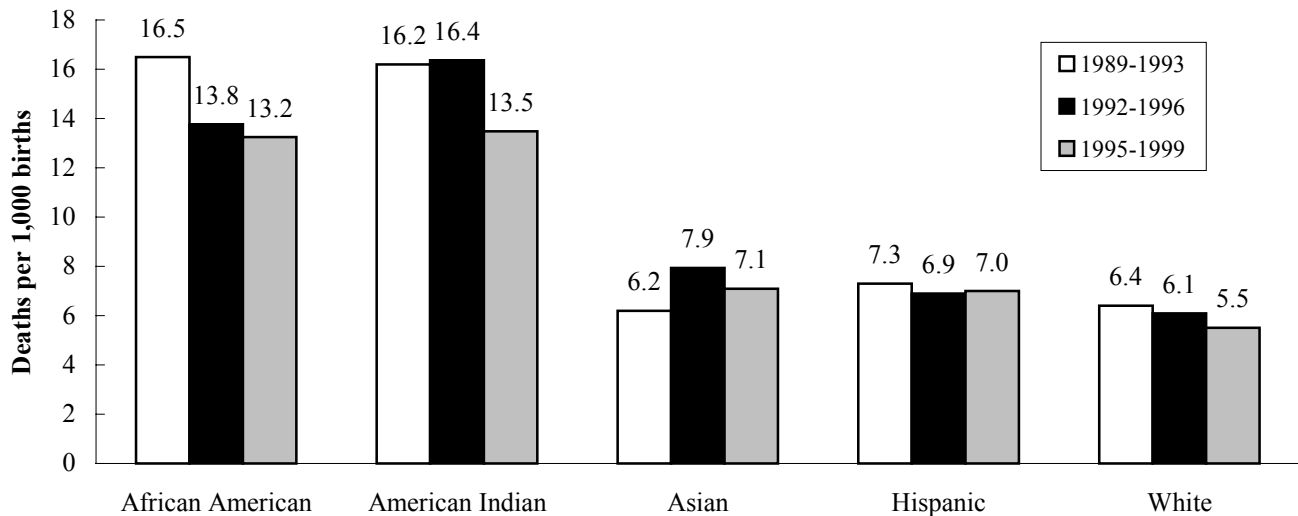
Discussion on the multiple etiologies, prevention interventions, and research and literature on this topic are presented in “Low Birthweight in Minority and High-Risk Women,” a Report by the Patient Outcomes Research Team (1998).

Infant Mortality

A review of the latest data indicates that disparities in infant mortality rates for populations of color and Whites are evident on the national as well as the state levels. While 1995-99 infant mortality rate for Whites in Minnesota (5.4/1,000) was lower than the national rate in 1999 (7.1/1,000), the rates for African American and American Indians in Minnesota are more than two times that of Whites. In the 1995-99 period, nearly 2000 infants died prior to their first birthday, almost 25 percent of those infants were of African American, American Indian, Hispanic, or Asian descent (Minnesota figures). In 1999, these populations of color comprised only 8.8 percent of the total population.

National Vital Statistics System (NVSS) reports indicate that for the 3-year period of 1997-99 linked files, African Americans had the highest rate of infant mortality (13.8/1,000). This rate was higher than any other racial ethnic group at the national level including American Indians (9.1/1,000), Asian/Pacific Islander (5.1/1,000), or Hispanic (5.8/1,000). A comparison of Minnesota to other states indicates that of the 16 states reporting, Minnesota had the 5th highest infant mortality rate for American Indians (10.9/1,000). In addition, while the rate for African Americans in Minnesota (12.7/1,000), was lower than the national average for African Americans (13.8/1,000), this rate was more than twice the rate reported overall for Minnesota (6.0/1,000).

**Infant Mortality Rate
Minnesota**



Source: Center for Health Statistics, Minnesota Department of Health

Using 5-year periods to examine trends in infant mortality rates among Minnesota’s populations of color, White rates are at their lowest rate at 5.5/1,000, decreasing in consecutive 5-year periods. African American (13.2/1,000) and American Indian (13.5/1,000) rates have also decreased in the last 5-year time period but both rates remain more than 2 ½ times that of Whites. The rates for Asian and Hispanic (7.1 and 7.0/1,000 respectively) also remain higher than that of Whites.

Prenatal Care

Current data indicates increases in the percent of Minnesota women that receive intensive and adequate prenatal care. This holds true for women from all racial/ethnic groups. Yet 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 indicates that although there have been improvements in the percent of women from all groups for receiving intensive and adequate prenatal care, greater percentages of women from populations of color are receiving inadequate or no care during their pregnancies.

Adequacy of Prenatal Care: Minnesota
(Singleton Births Only)

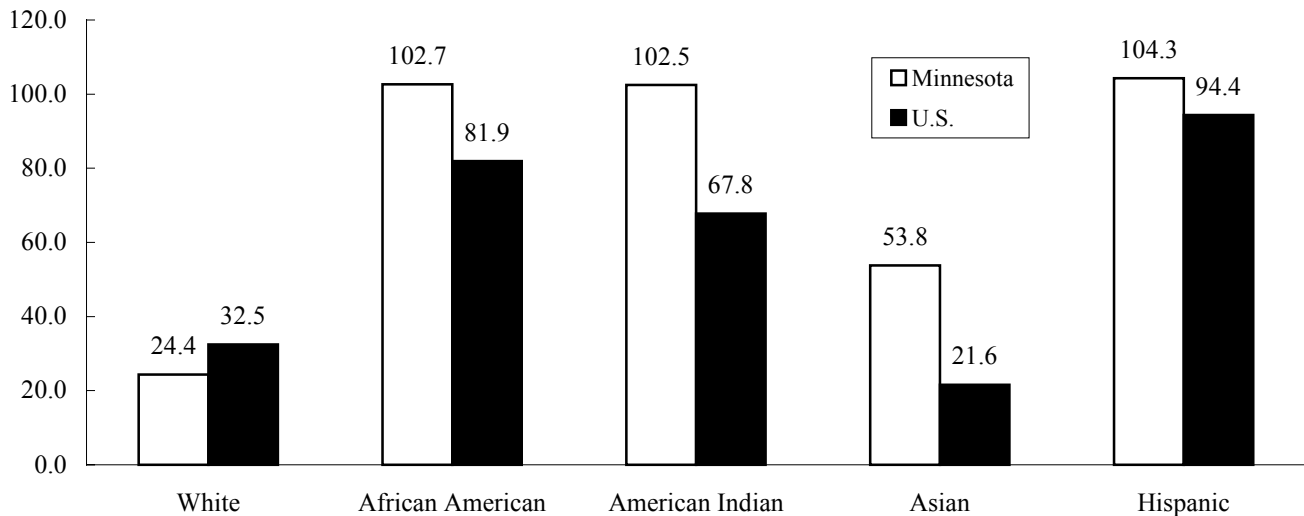
Race/Ethnicity	Intensive/Adequate		Inadequate or No Care	
	1989-1993	1996-2000	1989-1993	1996-2000
African American	46.7%	58.0%	20.4%	12.5%
American Indian	36.9%	48.5%	27.5%	17.8%
Asian	43.0%	54.5%	20.8%	10.7%
Hispanic	51.8%	54.6%	14.8%	11.4%
White	78.4%	79.9%	3.3%	3.2%

These figures indicate that American Indian women suffer the greatest disparity from White women. While this latest data indicates that greater disparities existed at the beginning of the decade, American Indian women are still six times more likely to receive inadequate or no care during their pregnancies. All other racial ethnic groups were over three times more likely to receive inadequate or no prenatal care during their pregnancies.

Teen Births

The most recent data on teen births in the U.S. shows an overall decline in the percent of births to teens (15-19 years) for all racial/ethnic groups, the greatest decrease occurring among African Americans. However, as the following chart indicates, the birth rate for African Americans in the U. S. (81.9/1,000) was still 2 ½ times greater than that of Whites (32.5/1,000). The rate for Hispanics (94.4/1,000) was almost three times, and American Indians (67.8/1,000) twice as high as the White rate. This chart also indicates that while Minnesota teen birth rates for Whites is lower than the national rate, rates for all populations of color and Hispanics are higher than the White rate and are higher than their respective groups at the national level.

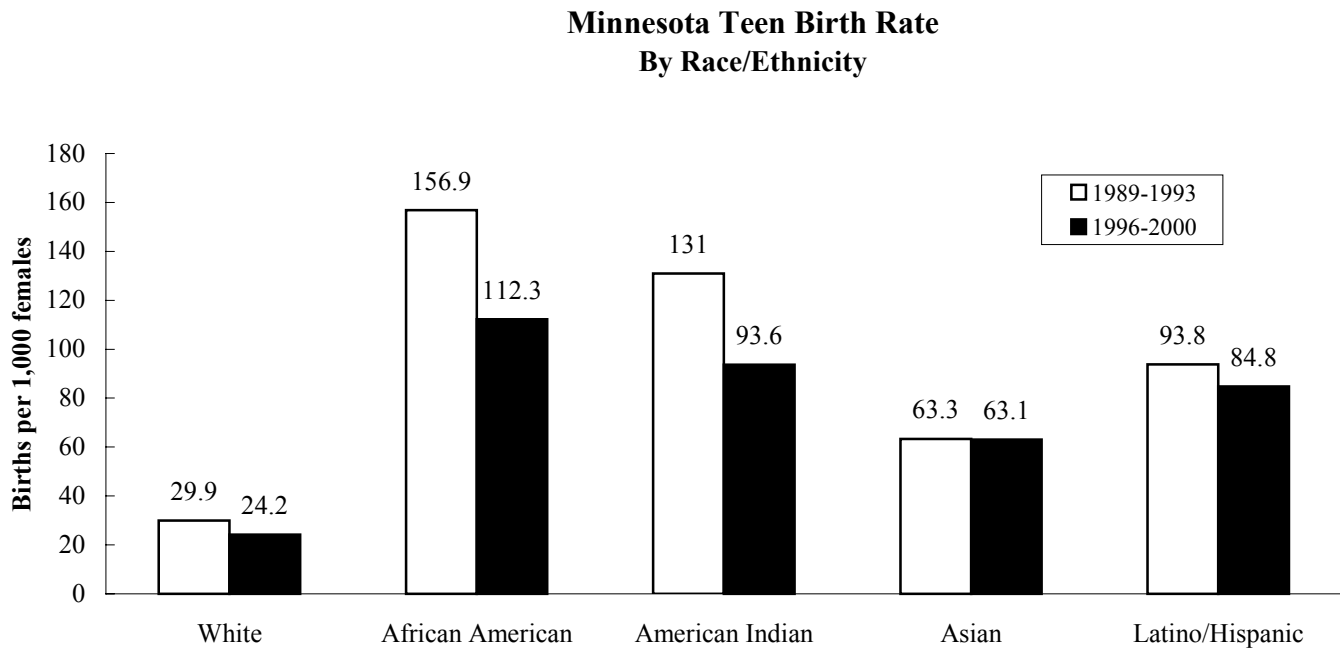
Teen Births Rates
Minnesota and U.S 2000



Source: Center for Health Statistics, Minnesota Department of Health. "Hispanic" is an ethnicity and may include individuals of any race.

Recent data trends for Minnesota, as at the national level, indicate a decline in teen pregnancy rates among all populations. Minnesota figures indicate that although there has been a general decline in teen birth rates among all race/ethnic groups, African Americans teens are having babies at a rate that is over four times that of Whites. American Indian and Hispanics are three times as likely and Asians over twice as likely as Whites to have children during their teen years.

Minnesota Birth Rates are as follows:



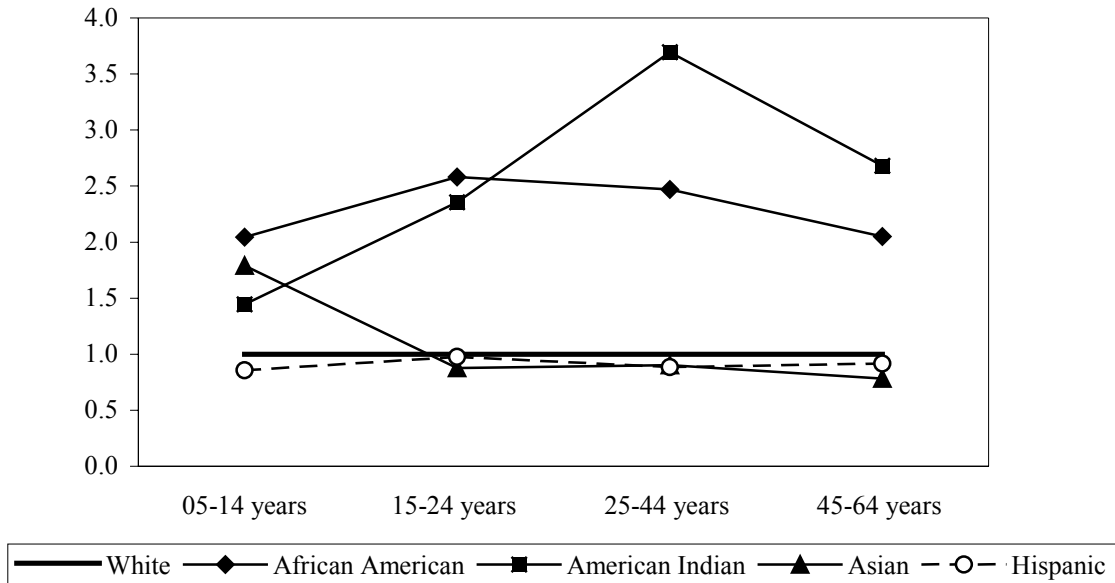
Part II: Death Rates and Causes of Death

Death Rate Ratio

Mortality rates were obtained by analyzing data on all deaths to Minnesota residents occurring between 1996 and 2000 and where appropriate as compared with 1995 and 1999 data.

The graph shows the ratio of death rates of racial/ethnic groups as compared to Whites. 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 all age groups for several groups of populations of color.

Ratio of Non-White to White Minnesota Death Rates
Five Year Average (1996-2000)



Death rates for African Americans and 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. Hispanic and Asian death rates were most often lower than Whites among all age groups.

Cause of Death

Crude mortality rates are the number of deaths per 1,000 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 differing compositions of various populations. Populations with large numbers of older people may have higher crude mortality rates as

compared to populations with larger numbers of young people. Age-adjusting is used to adjust for these differences most commonly used in comparative mortality analyses since age is a prime factor in mortality. This is particularly true with mortality due to chronic diseases such as heart disease and diabetes. 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 1996-2000**

Cause	White	African American	American Indian	Asian	Hispanic
	1996-00	1996-00	1996-00	1996-00	1996-00
HIV/AIDS	1.3	14.3	7.2	0.8	6.5
Alzheimers Disease	4.4	3.9	4.1	2.1	3.7
Cancer	113.3	177.8	163.6	95.7	111.8
Cirrhosis	4.8	7.3	35.8	2.1	9.3
Congenital Anomalies	4.2	7.1	6.7	4.7	4.3
COPD	18.2	18.6	32.1	10.5	9.2
Diabetes	11.8	36.8	65.7	11.1	21.3
Heart Disease	90.5	125.5	148.1	56.4	77.3
Homicide	1.9	30.6	19.5	4.7	4.7
Nephritis	4.2	10.0	15.2	8.7	7.0
Perinatal Conditions	3.0	12.9	7.6	3.1	4.3
Influenza-Pneumonia	7.8	11.2	15.6	5.6	8.2
Septicemia Total	2.1	4.6	6.4	1.9	2.6
Stroke	22.5	38.3	26.2	35.2	23.8
Suicide	9.0	8.8	18.4	9.3	7.4
Unintentional Injury	25.7	38.3	76.0	24.5	25.2

Rates presented are per 100,000 population (i.e. AIDS/HIV mortality rate for Whites is 1.3 per 100,000.)

African Americans age-adjusted mortality rates due to HIV/AIDS, homicide and perinatal conditions are several times greater than those for Whites in Minnesota. Among American Indians death rates for homicide, cirrhosis, and diabetes are higher than those of Whites. Hispanic and Asian figures are more consistent with those of the White population though these rates do not reflect rates for specific groups within these categories (e.g. Hmong, Vietnamese, Mexican, Puerto Rican).

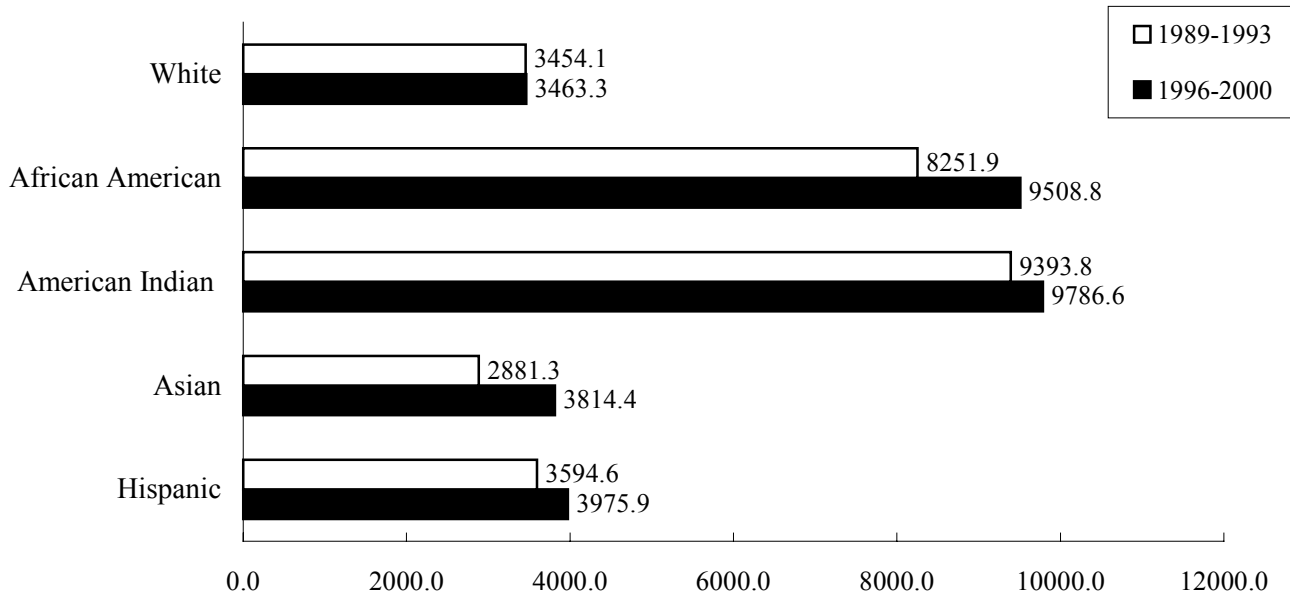
Years of Potential Life Lost

Years of Potential Life Lost (YPLL), measures premature mortality or the total sum of years of life lost annually to a person who dies prematurely or prior to the age of 65

years. The YPLL rate Type your question here and then click Search is the number of years of life lost before age 65 per 1,000 population ages 0-64.

The following illustration calculates the most recent YPLL rates by race and ethnic groups for 1996-2000 and for comparison purposes, rates for the beginning of the decade are included. This chart indicates that in the most recent 5-year period, while the YPLL rates for all populations of color (African American, American Indian, Asian, and those of Hispanic ethnicity), has increased while White rates have remained the same. Additionally, rates of African Americans and American Indians are over twice as high as that of Whites.

Years of Potential Life Lost Rate by Race/Ethnicity*
Minnesota 1989-93 & 1996-2000



	Hispanic	Asian	American Indian	African American	White
□ 1989-1993	3594.6	2881.3	9393.8	8251.9	3454.1
■ 1996-2000	3975.9	3814.4	9786.6	9508.8	3463.3

*An example of the YPLL calculation is included in Section VI Notes provided at the end of this document.

Part III: Injury and Violence

A recent report by the Injury and Violence Prevention Unit at MDH indicates that the existence and extent of disparities among populations of color and Whites. While most injury-related deaths are preventable, extensive review of the data can provide some insight into the causes and preventative strategies of injury related deaths. Among findings from this recent study are the following:

- **American Indians** and **African Americans** are over-represented in injury-related mortality from all causes. The injury mortality rate per 100,000 people is 2.5 times greater for American Indians than for Whites and 1.5 times greater from African Americans than for Whites.
- For **American Indians**, motor vehicle crashes were the leading cause of injury death for all age groups from 10-44. Homicide appears among the first four leading causes of death in all age groups up to age 54. For teens and young adults, firearm homicide was among the three leading causes.
- For **African Americans**, firearm homicide was the first or second leading cause in all age groups from 10-54, and was the first leading cause when all age groups were combined.
- For **Asians**, suicide was the first, second, or third leading cause in most age groups. Firearm homicide was also a leading cause for Asian children and young adults and was the second leading cause of injury death overall among Asians.
- For **Hispanics (all races)**, the second leading cause of injury death of all ages was firearm homicides and the third leading cause was firearm suicides. Homicidal cut/pierce injuries (most often knifing) appeared frequently as a leading cause for all Hispanic adult age groups. Unintentional fires were the leading cause of injury death for Hispanics under the age of 9.

This information is part of a summary of data in *Injury-Related Mortality in Minnesota, 1990-00*, which is available on the MDH Injury and Violence Prevention website at:

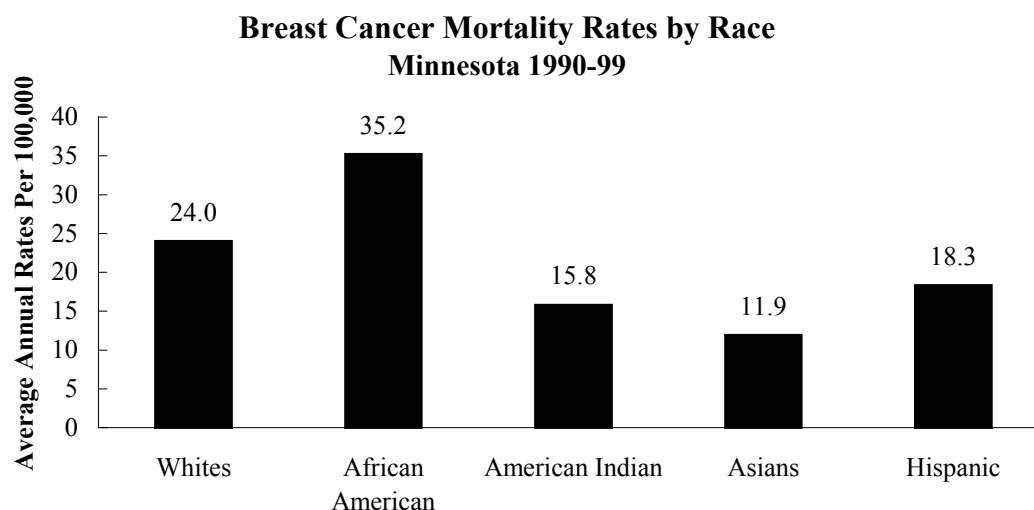
<http://www.health.state.mn.us/divs/fh/chp/injury.htm>

You may print portions of the databook or obtain a copy of the report by calling 651-281-9857.

Part IV: Breast Cancer Mortality and Cervical Cancer Incidence*

Breast Cancer Mortality

A recent MDH report indicates that breast cancer is the most common form of cancer in Minnesota women and the second leading cause of cancer death. The breast cancer mortality rate of African Americans in Minnesota is 50% higher than for White non-Hispanic women. A greater proportion of African American women have cancers diagnosed at a later, less treatable stage. One-third of breast cancer deaths can be prevented through routine screening using mammography and clinical breast examination. These figures indicate the need for increased screening efforts, and appropriate follow-up and treatment. (For further information on breast, cervical, and other cancer information, see, "Cancer in Minnesota, Racial and Ethnic Disparities," MDH Division of Chronic Disease Prevention and Control, 2001.)



Note: Hispanic includes Hispanic White Only.

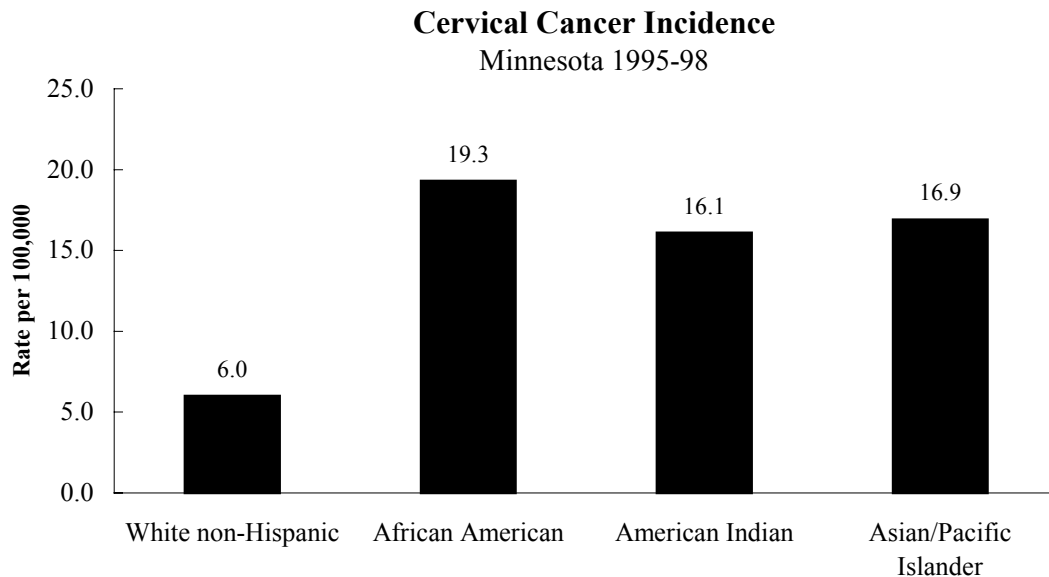
Source: Minnesota Cancer Surveillance, MDH

Cervical Cancer Incidence

Each year, approximately 200 women in Minnesota develop invasive cervical cancer and 50 die from it. Virtually all invasive cervical cancer occurrence and death is preventable through regular screening with Pap smears followed by treatment of precancerous cervical abnormalities.

* "Cancer in Minnesota, Racial and Ethnic Disparities," MDH Division of Chronic Disease Prevention and Control, 2001. Minnesota Department of Health, Minnesota Center for Health Statistics, mortality data. Data by race and ethnicity are reported here for the years 1990-99.

African American, American Indian, and Asian/Pacific Islander women have three to four times higher cervical cancer incidence rates than White women in Minnesota. Deaths due to cervical cancer are three to five times higher among African Americans and Asian/Pacific Islanders as compared with White (non-Hispanic) women. Regular screening, outreach to non-White women for screening, and referral when necessary, should be emphasized.



Note: Hispanic Rates were not available
Source: Minnesota Cancer Surveillance System,

Other Cancers

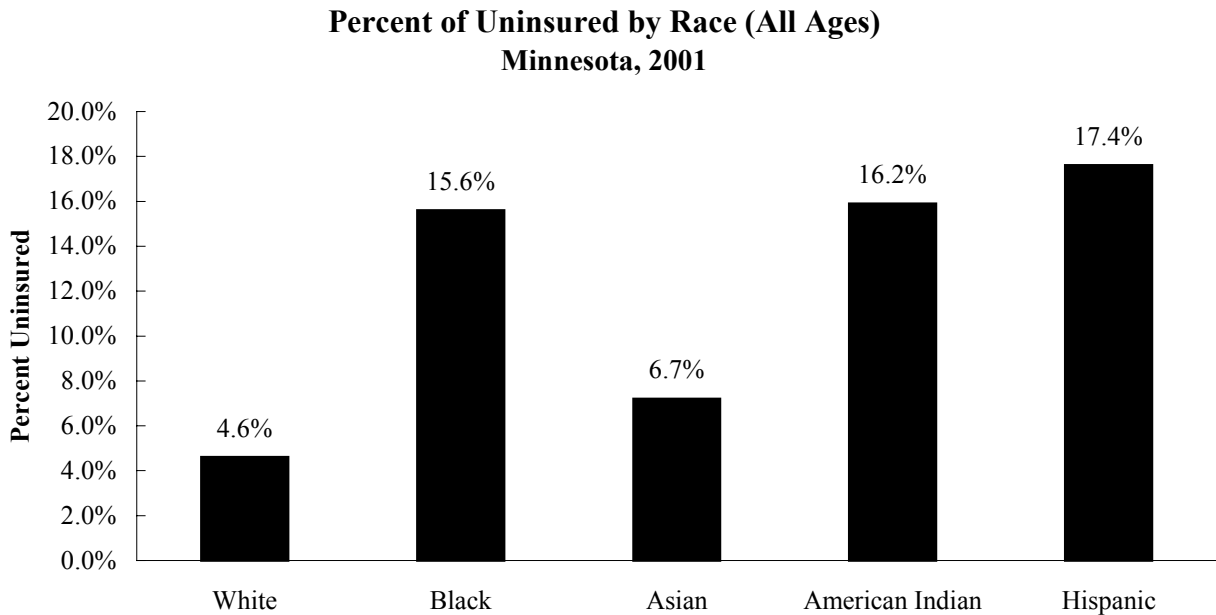
Incidence and mortality rates for lung, prostate, colon, rectal, and skin cancers are available in a recent report by the Minnesota Department of Health Division of Chronic Disease Prevention and Control, in “Cancer in Minnesota: Racial and Ethnic Disparities.” For more information contact the following:

Minnesota Department of Health
Division of Chronic Disease Prevention and Control
PO Box 9441, Minneapolis, Minnesota 55440
612-676-5500 (phone), 612-676-5520 (fax), 651-215-8980 (TDD)

Part V: Health Insurance

Rates of Uninsured

The Health Economics Program of the Minnesota Department of Health is currently conducting an in-depth study of Minnesota's uninsured population.* According to these study findings, 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.



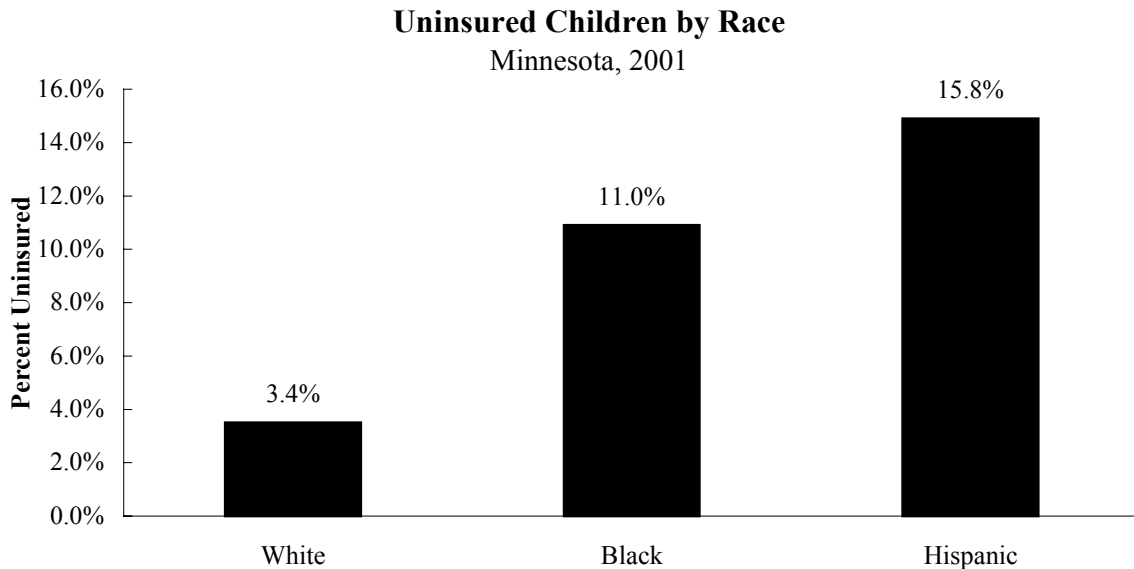
Source: 2001 MN Health Access Survey, MDH Health Economics Program

* 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.

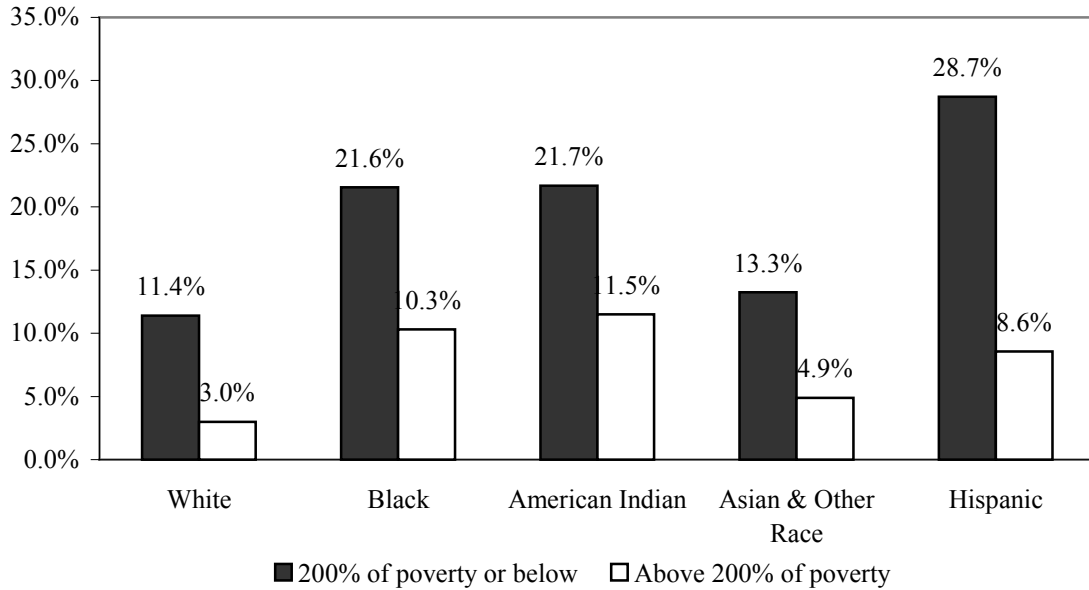


Source: 2001 MN Health Access Survey, MDH Health Economics Program.

Uninsured by Race and Income

One possible reason why uninsured rates are disproportionately high for populations of color and American Indians is that people in these groups have lower incomes on average than the White population. Uninsured rates for people with incomes less than 200% of the poverty level are higher than the uninsured rates for people with higher incomes, regardless of race. However, within the population that has income above 200% of the poverty level, non-White Minnesotans are more likely to be uninsured than White Minnesotans.

**Uninsurance Rates by Race/Ethnicity and Income
Minnesota, 2001**

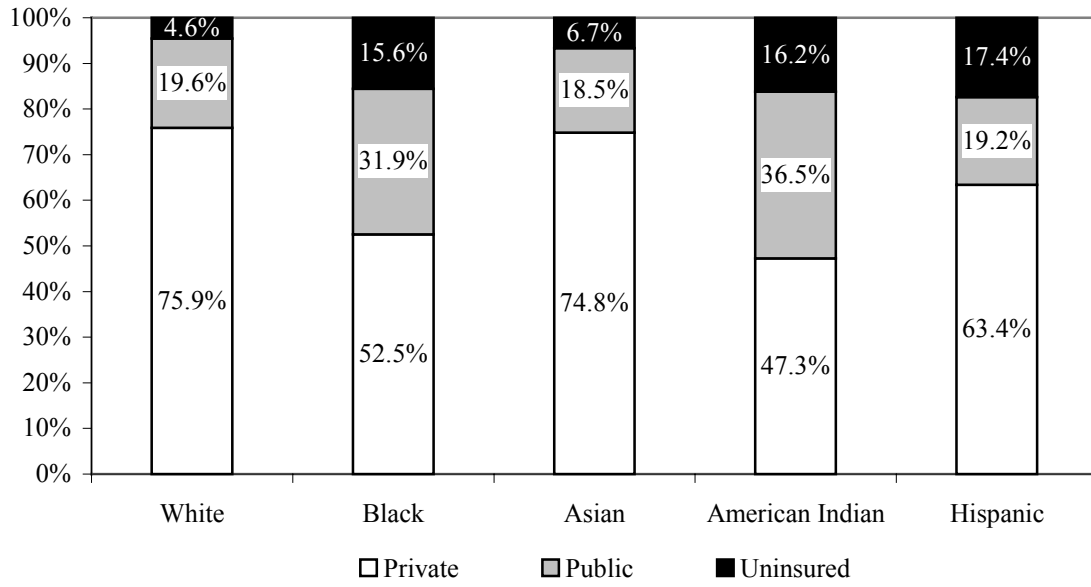


Source: 2001 MN Health Access Survey, MDH Health Economics Program

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

Part VI: Notes

Example of Calculation of YPLL for Heart Disease

A	B	C	D
Age Group	Number of Deaths	Factor (total population in age group)	YPLL by Age (B*C)
0-4	9	62.5	562.5
5-14	7	55	385
15-24	15	45	675
25-34	98	35	3430
35-44	100	25	2500
45-54	426	15	6390
55-64	700	5	3500
Total YPLL for Heart Disease			17442.5