VI. Health

Advances in public health practice and medical technology have contributed to dramatic improvements in the longevity of the U.S. population. On average, Americans in 1900 could not expect to live to the age of 50. By 1996 they could expect to live past the age of 76. Although all racial and ethnic groups have experienced gains in life expectancy, differences between groups in longevity and in many other measures of health status have been apparent for as long as these measures have been collected separately by race. This is true for measures of health status at the beginning, middle, and end of the life span. For some groups and some measures, these differences are persistently large. For others, the differences are small.

In general, blacks fare worse than any other group, and American Indians and Hispanics are often disadvantaged in health status relative to whites. On average, Asians fare as well as and sometimes better than non-Hispanic whites on most measures of health. While many of the observed differences are large, average differences between racial and ethnic groups may mask important differences within the society. For instance, there is evidence that blacks who live in very poor urban areas suffer extreme health disadvantages not only relative to non-Hispanic whites but also relative to blacks who live in poor rural areas or middle class urban neighborhoods.[1] In addition, health differences by national origin, socioeconomic status, and age, particularly within the Hispanic and Asian populations, are not apparent when statistics are reported at this level of aggregation. For example, there is some evidence that the health status of younger cohorts of Hispanics may be declining,[2] and among Asian/Pacific Islanders, those with low incomes and those with origins in south and southeast Asia are disadvantaged relative to other Asian groups and non-Hispanic whites.[3]

Infant mortality is often used to compare the health and well-being of populations across countries as well as within countries. Although the United States has a lower rate of infant mortality than a typical developing country, it has long had one of the highest infant mortality rates among the industrialized countries. Within the United States, blacks and American Indians have higher infant mortality rates than other groups, and although infant mortality rates have been falling for all groups, differences between groups have persisted (Health 1).

Declines in infant mortality and infectious diseases among the young contributed much to the increase in overall life expectancy in the early part of the 20th century. In the latter part of the century, the large declines in chronic disease death rates among the middle aged and older groups have led to an acceleration of life expectancy. However, differences in life expectancy between whites and blacks have persisted throughout the period, and, among men, they actually grew in the 1980s (Health 2).

Childhood infectious diseases, once a significant cause of illness and death among children, have largely been conquered through widespread use of vaccination. Mandatory vaccination requirements for enrollment in most schools in the United States virtually assure vaccination by age five. However, a large majority of children in the United States receive vaccinations much earlier, following the recommended schedule that begins at birth and is largely complete by 18 months. Whether or not a child aged 19 to 35 months is up to date with this schedule is a key indicator of access to and use of basic medical care. Although there are differences among racial and ethnic groups in the United States, these are largely a reflection of differences in their economic status (Health 3).

Smoking contributes to nearly 400,000 cancer and heart disease deaths annually, and reducing smoking has been an important goal of public health efforts for many years.[4] Because of the addictive property of nicotine, and because most current smokers began smoking at young ages, efforts to reduce smoking have focused on youth. Between 1965 and 1990, there were large reductions in smoking among 18- to 24-year olds, especially for blacks (Health 4). Since 1990, however, there is concern that this decline has stopped. Rates of smoking among 18- to 24-year olds are higher for whites than for blacks and Hispanics. Data for this age group are not available for Asians and American Indians; however, among persons aged 18 to 34, smoking rates for Asians are lower than those for all other groups, and rates for American Indians are higher than those of all other groups.[5]

The other major areas of concern for adolescent and young adult health are unintentional injuries (primarily motor vehicle injuries), homicides, suicides, and HIV (Human Immunodeficiency Virus, the virus that causes AIDS). There are also racial and ethnic differences within this age group. American Indians face much higher death rates due to suicides and unintentional injuries than any other group, while blacks face much higher rates of homicide than any other group (Health 5). Hispanics and American Indians also face higher than average homicide rates. HIV disease kills black and Hispanic young adults at significantly higher rates than non-Hispanic whites, Asians, or American Indians.

At middle age, chronic diseases are among the most important indicators of health. Heart disease and cancer are the two leading causes of premature death for those aged 45 to 64, and much of this mortality is directly attributable to smoking.[6] Asians in this age range face the lowest death rates due to heart disease (Health 6). Blacks, on the other hand, are at greater risk of mortality from these chronic diseases than any other group in this age range. These differences in death rates from chronic diseases are responsible for a majority of the disparity between blacks and whites in the probability of survival to age 65.[7]

There is also evidence that health differences persist into old age, although these data are not presented in this book. Black and Hispanic elderly are more likely to have disabilities and chronic diseases than white elderly, but to some extent these differences are explained by differences in socioeconomic status.[8]

Research into the reasons for health differences between racial and ethnic groups has focused largely on differences in socioeconomic status.[9] On average, white Americans have better access to the social and economic resources necessary for healthy environments and lifestyles and better access to preventive medical services. Other research suggests that discrimination and racism create stress leading to poorer health among members of racial minority groups.[10] For instance, the higher prevalence of hypertension among blacks relative to whites has been linked to personal experiences of discrimination.[11]

To the extent that access to medical care can prevent the onset of disease or ameliorate its effects, the portion of the population without health insurance (either public or private) will be correlated with ill health. Especially among men, Hispanics and blacks are less likely to have health insurance than non-Hispanic whites (Health 7). Insurance coverage is highly correlated with income, however, and the difference in insurance coverage between white and black men (though not the difference between Hispanic and non-Hispanic white men) can be almost entirely explained by differences in income.

Disparities in health status also have economic consequences. For example, poor health can lead to high expenditures on medical care at the expense of other goods (for example, housing or education). Perhaps more important, poor health can also reduce earning potential and lower quality of life. Thus, the disparities observed in health between racial and ethnic groups in the United States are tied to differences in many other economic and social realms.

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2. Liao, Youlian, et al. 1998. "Mortality Patterns among Adult Hispanics: Findings from the NHIS, 1986–1990." *American Journal of Public Health* 88 (2):227–32.

3. Tanjasiri, Sora P., Steven P. Wallace, and Kazue Shibata. 1995. "Picture Imperfect: Hidden Problems among Asian Pacific Islander Elderly." *The Gerontologist* 35 (6):753–60; Klatsky, Arthur L., et al. 1994. "The Risk of Hospitalization for Ischemic Heart Disease among Asian Americans in Northern California." *American Journal of Public Health* 84 (10):1672–75.

4. Centers for Disease Control and Prevention. 1997. "Smoking-Attributable Mortality and Years of Potential Life Lost—United States, 1984." *Morbidity and Mortality Weekly Report* 46 (20):444–51.

5. U.S. Department of Health and Human Services. 1998. *Tobacco Use Among U.S. Racial/Ethnic Minority Groups–African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General*. Atlanta, Georgia: U.S. Department of Health and Human Services.

6. Centers for Disease Control and Prevention. 1993. "Cigarette Smoking-Attributable Mortality and Years of Potential Life Lost—United States, 1990." *Morbidity and Mortality Weekly Report* 42 (33):645–48.

7. Geronimus, et al. "Excess Mortality among Blacks and Whites in the United States."

8. Schoenbaum, Michael and Timothy Waidmann. 1997. "Race, Socioeconomic Status, and Health: Accounting for Race Differences in Health." *Journals of Gerontology* 52B (Special issue):61–73; Smith, James P. and Raynard Kington. 1997. "Demographic and Economic Correlates of Health in Old Age." *Demography* 34 (1):159–70.

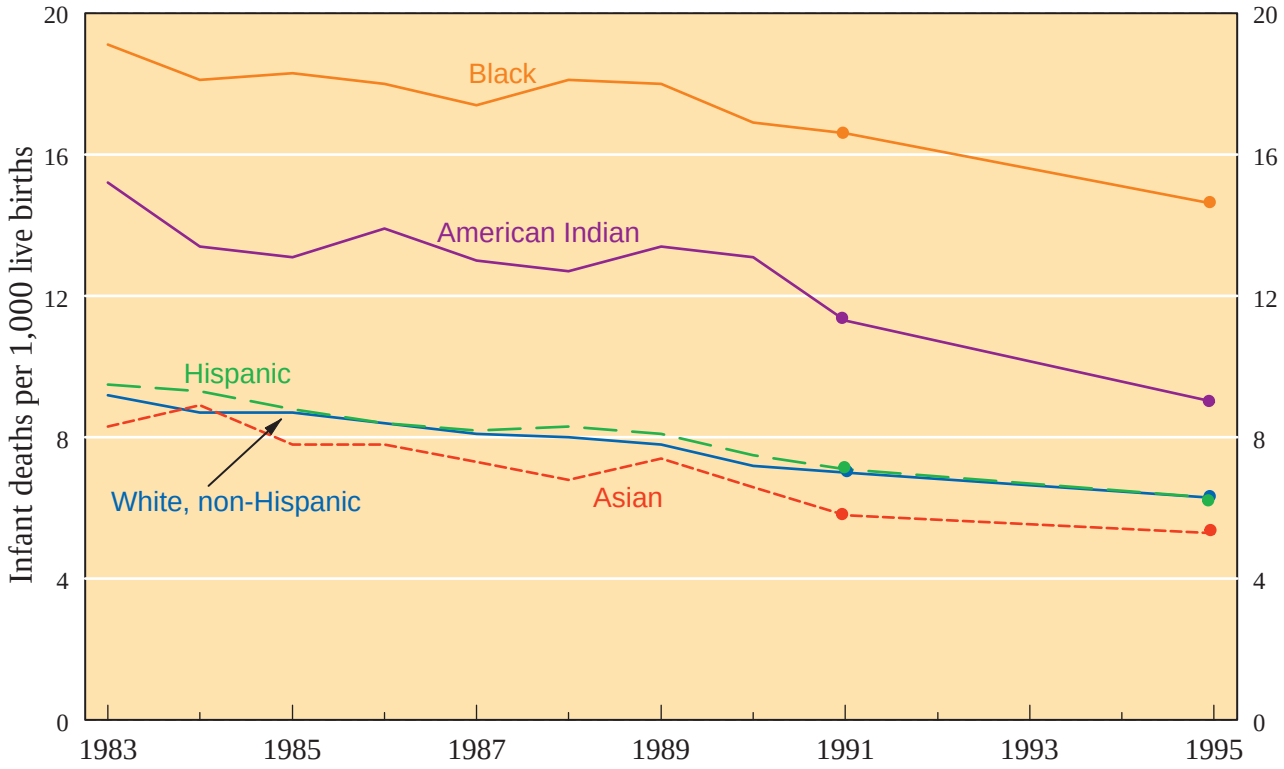
9. Williams, David R. 1990. "Socioeconomic Differentials in Health: A Review and Redirection." *Social Psychology Quarterly* 53 (2):81–99.

10. Williams, David R., Risa Lavizzo-Mourey, and Rueben C. Warren. 1994. "The Concept of Race and Health Status in America." *Public Health Reports* 109 (1):26–41.

11. James, Sherman A. 1994. "John Henryism and the Health of African-Americans." *Culture, Medicine, and Psychiatry* 18:163–82; Krieger, Nancy and Stephen Sidney. 1996. "Racial Discrimination and Blood Pressure: The CARDIA Study of Young Black and White Adults." *American Journal of Public Health* 86 (10):1370–78.

1. Infant Mortality Rates

Source: National Center for Health Statistics

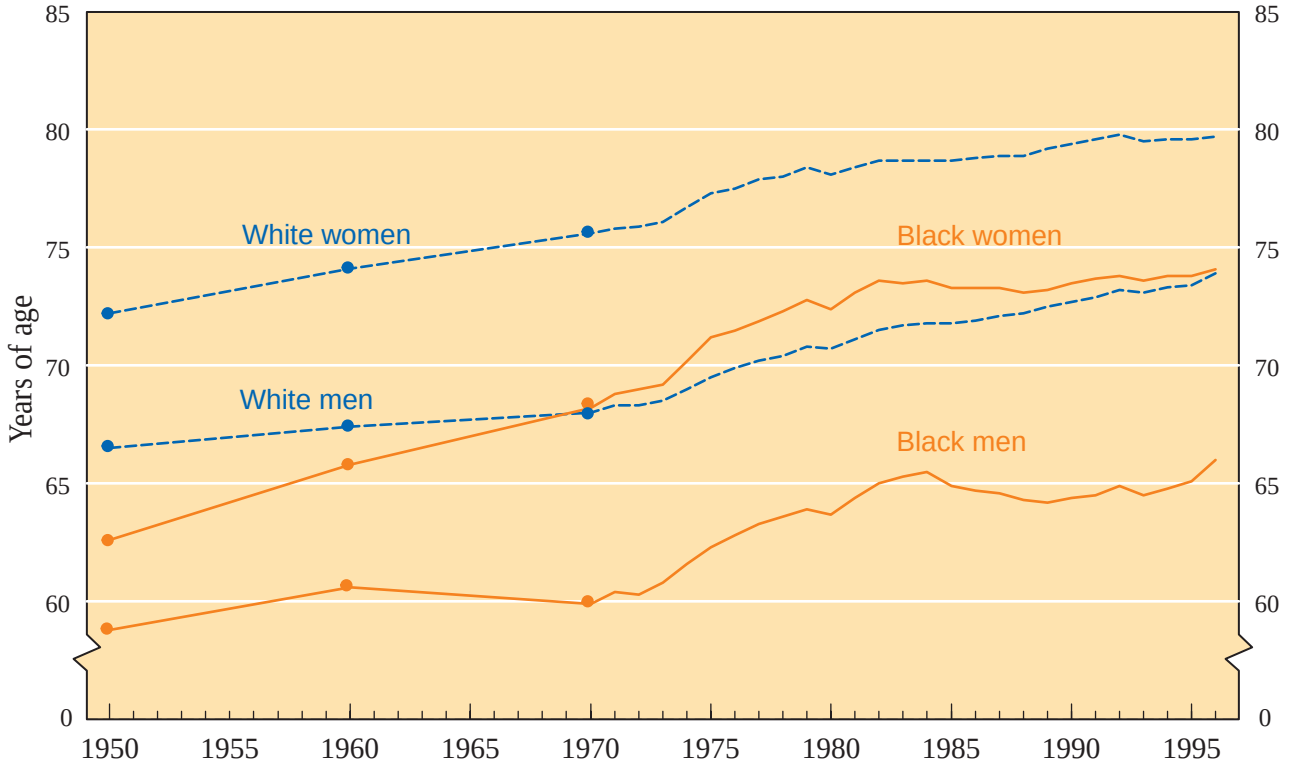


- The infant mortality rate is often used as a primary indicator of the overall health status of a population. It is defined as the number of deaths that occur before a child's first birthday per 1,000 live births. Rates presented here are categorized by race and Hispanic origin of mother.
- Although infant morality rates have fallen over time for all racial and ethnic groups, differences between groups have persisted for many years. In 1950, for example, white infants died at a rate of approximately 27 per thousand, while black infants died at a rate of nearly 44 per thousand (not shown in chart).
- Wide disparities in infant mortality among racial and ethnic groups remain. In 1995 the rate for blacks was more than twice the rate for non-Hispanic whites, Hispanics, and Asians. American Indians also had relatively high rates. It is notable that Hispanic infant mortality rates are equivalent to those of non-Hispanic whites, despite the considerably lower socioeconomic status of Hispanics.
- For most groups, the infant mortality rate is much higher for babies born to teenage mothers (not shown in chart). The notable exception is black mothers, for whom the infant mortality rate is no higher for teenage mothers than for other mothers. This means that higher teenage birth rates do not account for the higher overall black infant mortality rate.

Note: Straight line between dots indicates data are not available for intervening years.

2. Life Expectancy at Birth

Source: National Center for Health Statistics

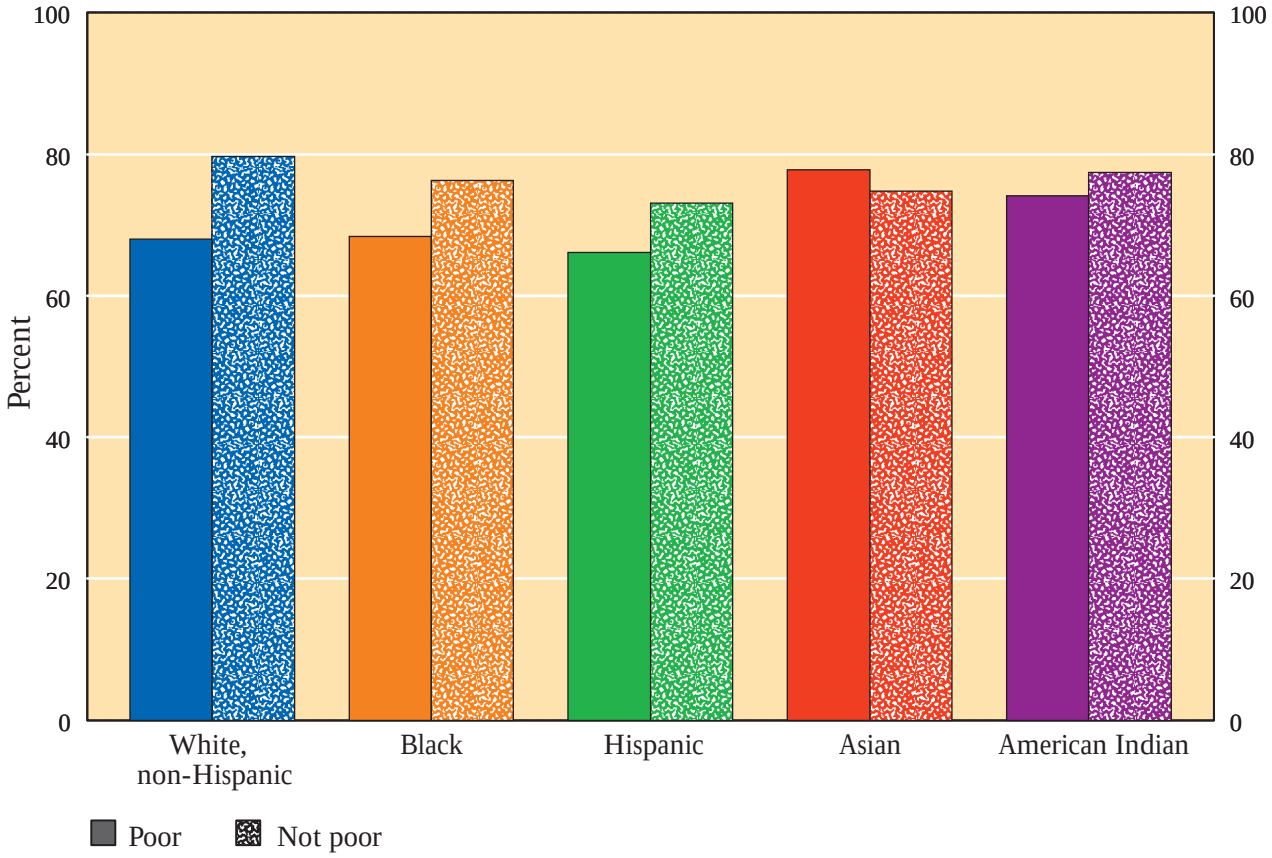


- A key summary measure of mortality risk is life expectancy at birth. This represents the average length of time that a baby born today would live if current death rates at each age remained constant.
- For both men and women, whites can expect to live longer than blacks.
- Women of both race groups can expect to live longer than their male counterparts.
- Although life expectancy has increased substantially for all groups, the differences between groups increased during the 1980s, particularly among men. Recently, however, the gap has narrowed slightly.

Note: Straight line between dots indicates data are not shown in intervening years.

3. Children Aged 19 to 35 Months Who Are Up to Date with Recommended Vaccinations, 1995–96

Source: National Center for Health Statistics

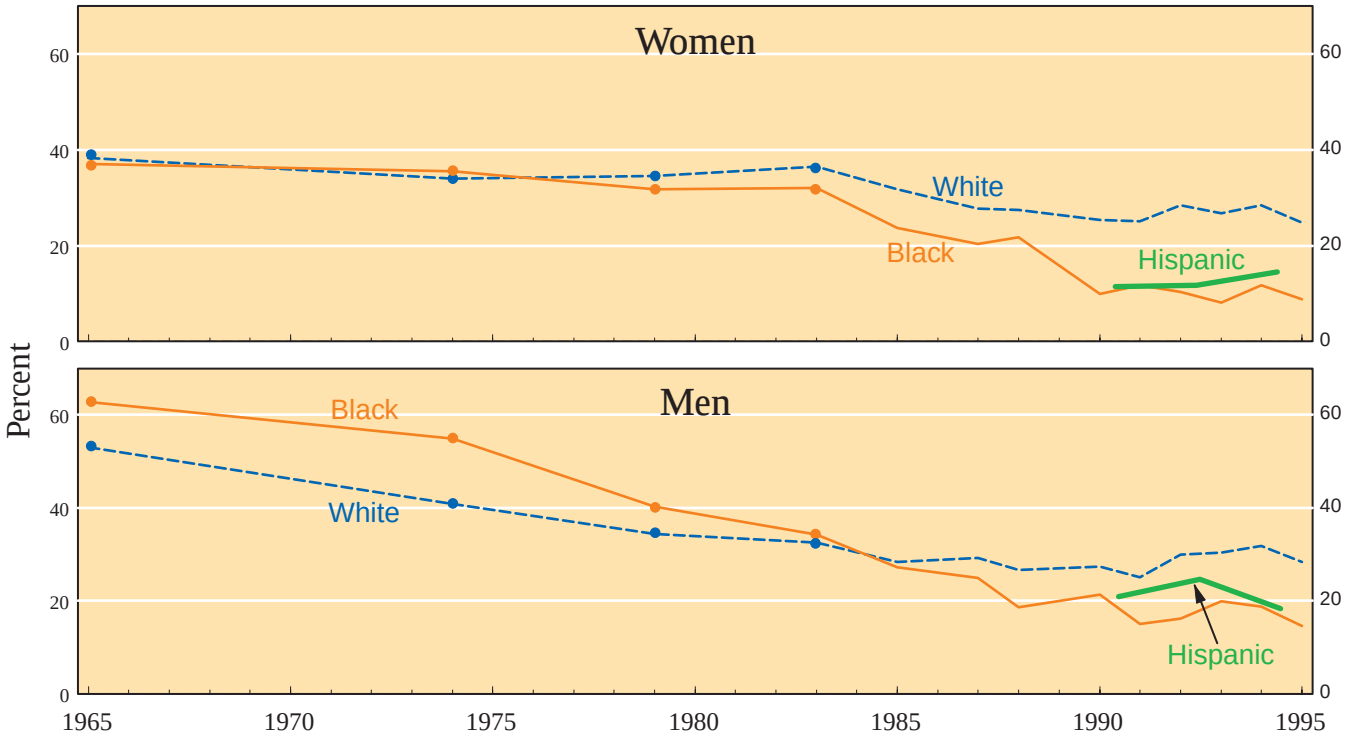


- Immunization is a fundamental component of regular medical care for children. In addition to measuring the extent to which children are protected from childhood diseases, this measure also indicates whether children have at least some access to medical care. This chart shows the percentage of children aged 19 to 35 months who were up to date with the recommended schedule of vaccinations in 1995 and 1996.
- Non-Hispanic white, black, and Hispanic children who live in poverty are significantly less likely than nonpoor children to be up to date with recommended vaccinations.
- Among children in similar economic circumstances, there are relatively small differences between racial and ethnic groups. Non-Hispanic white, black, and Hispanic children in poverty have roughly equal chances of being currently vaccinated.

Note: Data for 1995 and 1996 are averaged to provide more reliable estimates.

4. Prevalence of Smoking Among Persons Aged 18 to 24

Source: National Center for Health Statistics

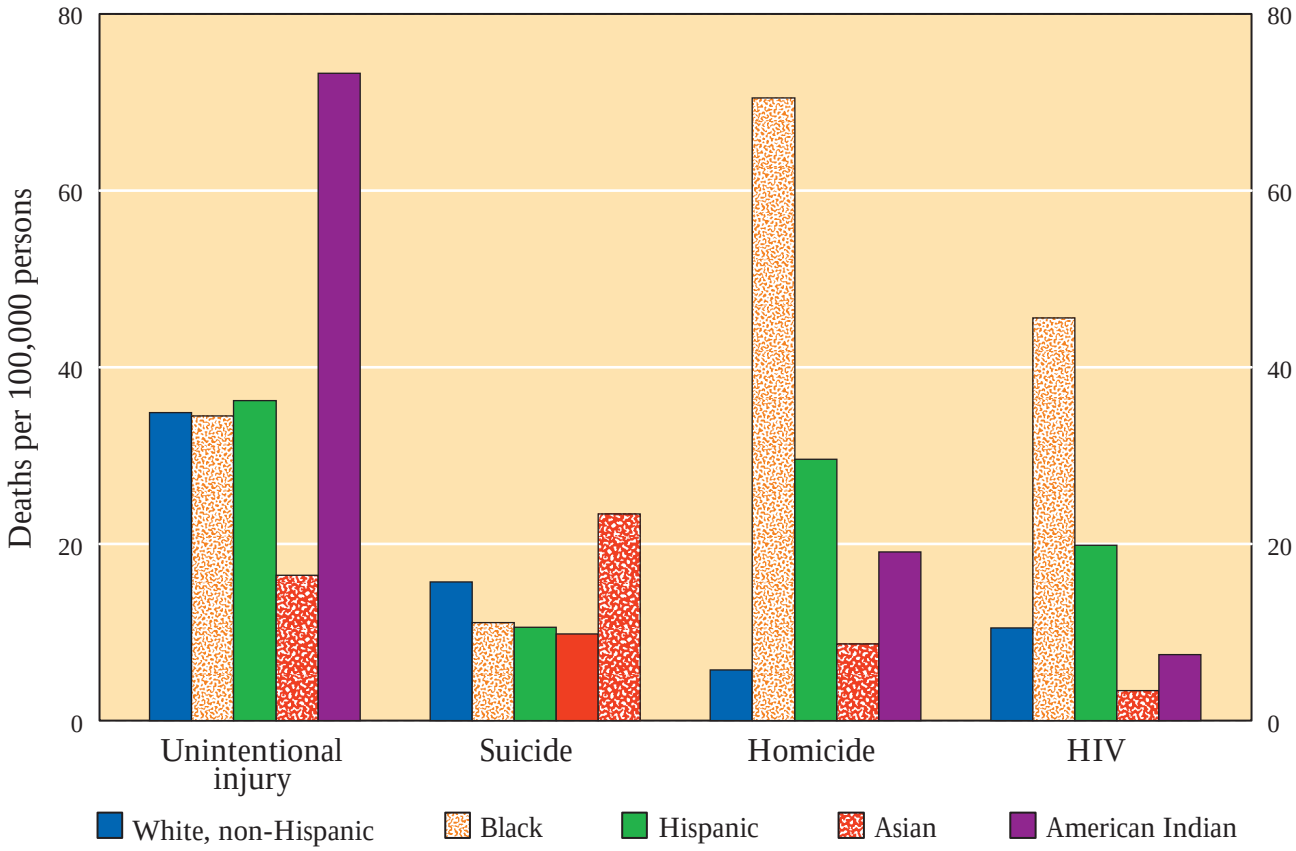


- Cigarette smoking is one of the most important public health concerns in the United States, contributing to nearly 400,000 deaths each year. Most smokers begin smoking early in life, and much effort to reduce smoking has been focused on young people.
- Smoking rates for white young persons exceed rates for black and Hispanic young persons. Black females have the lowest smoking rates. For men, and for black men in particular, smoking rates have fallen substantially since 1965, when more than 60 percent of black males and more than 50 percent of white males smoked. Reductions in smoking have been much greater for black than for white women.
- Since the mid-1980s, smoking prevalence among black young adults has fallen faster than among whites.
- Data for Hispanics are only available beginning in 1990–91. Smoking is less prevalent among Hispanics than among whites but is slightly more prevalent than among blacks.

Note: Straight line between dots indicates data are not available for intervening years. Data for Hispanics are for 1990–91, 1992–93, and 1994–95.

5. Death Rates by Cause for Persons Aged 15 to 34, 1994–95

Source: National Center for Health Statistics

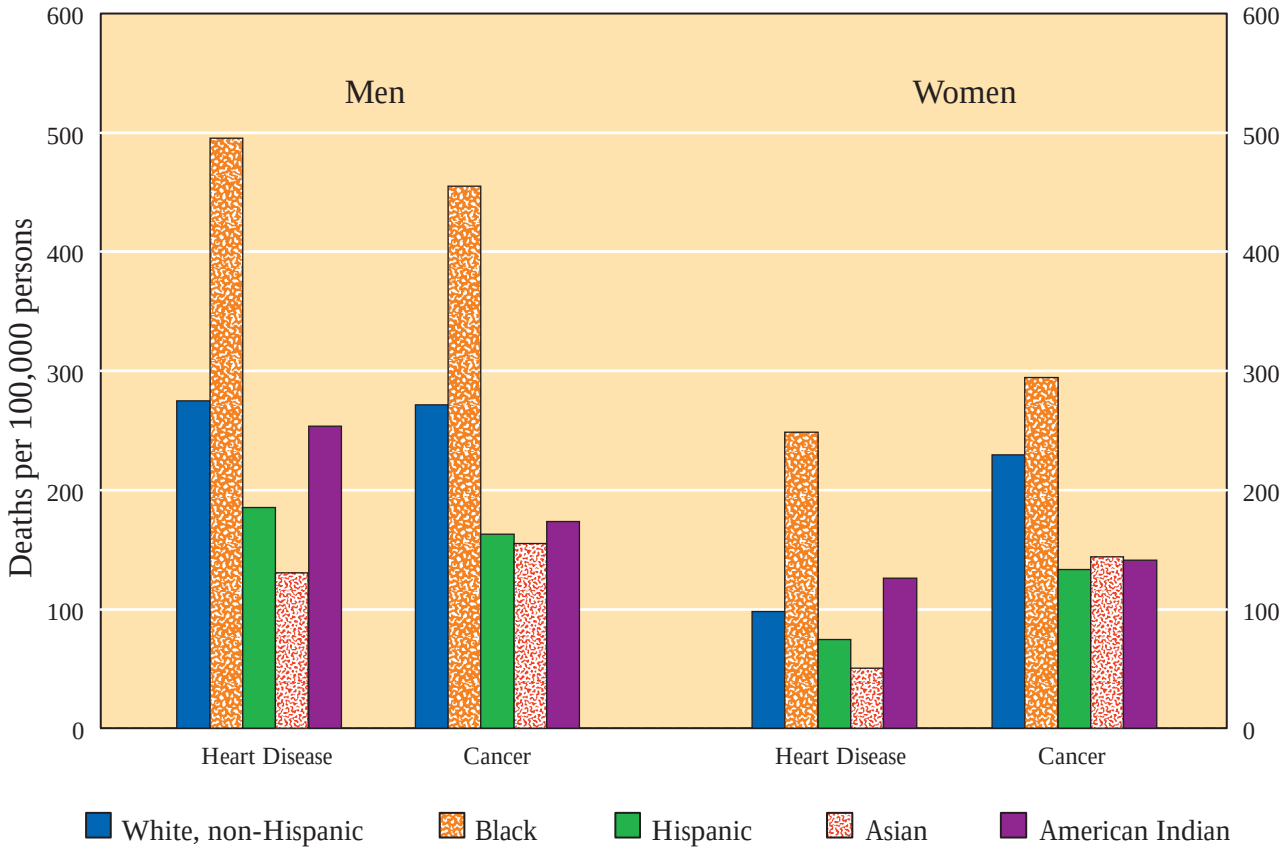


- Although deaths among adolescents and young adults are rare relative to deaths among older adults and the elderly, several causes of death are particularly important for this age group. The most common cause of death in this group is not disease but injury, either intentional or unintentional (accounting for more than half of deaths). The one fatal disease that affects this age group significantly is HIV.
- Deaths due to injuries (unintentional and intentional) are more prevalent among men than women in all age groups (not shown in chart), but this difference is particularly apparent for persons between the ages of 15 and 34. In this group, nearly 80 percent of injury deaths are to men.
- American Indians are much more likely than members of other groups to die as the result of an unintentional injury (the most common cause is motor vehicle-related injuries) or to commit suicide. Blacks are much more likely than members of any other group to be victims of homicide. Blacks and Hispanics are also more likely to die from HIV-related diseases than members of other groups. Asians have the lowest rates of death due to injuries and HIV in this age group.

Note: Data for 1994 and 1995 are averaged to provide more relialbe estimates.
HIV data on American Indians are for 1993–95.

6. Death Rates by Cause for Persons Aged 45 to 65, 1995

Source: National Center for Health Statistics

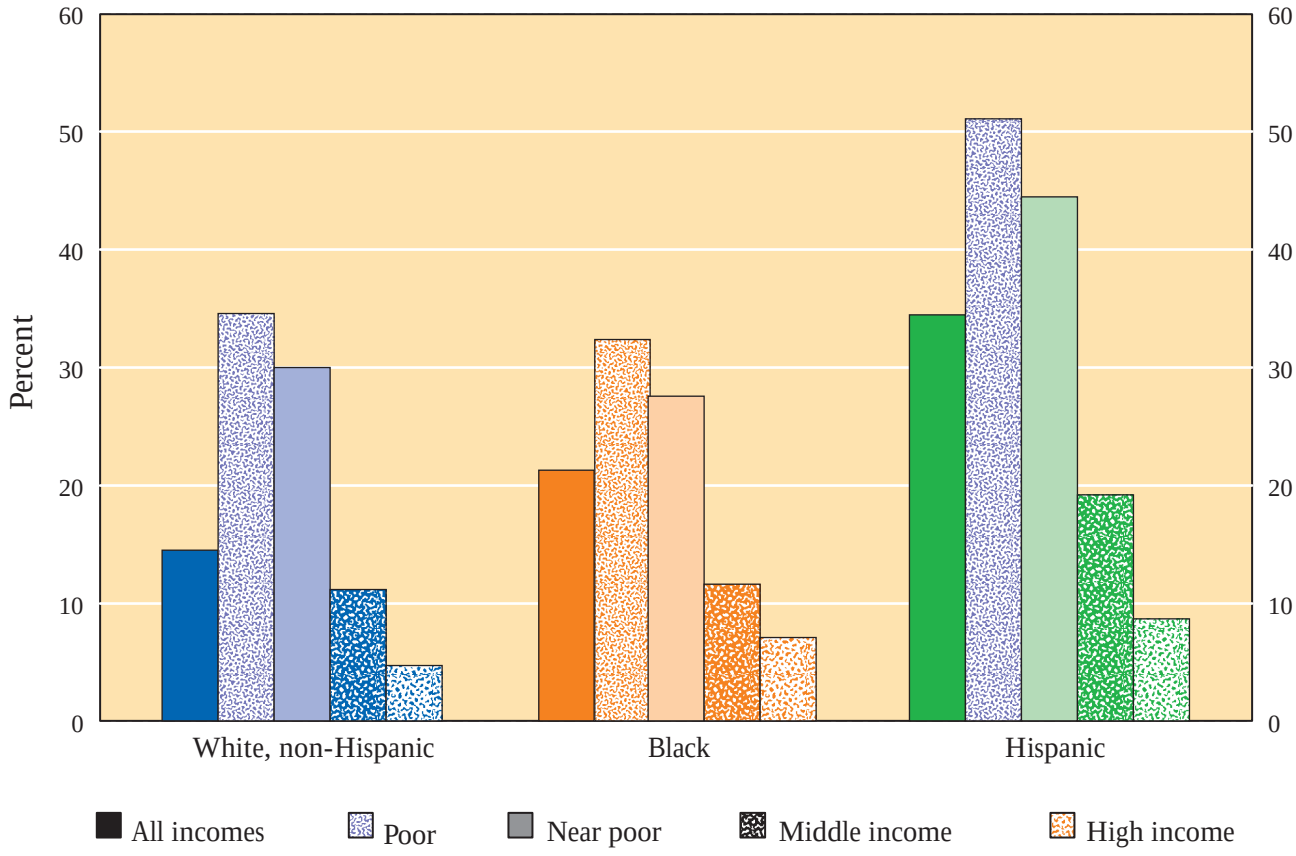


- Chronic diseases such as heart disease and cancer account for the largest fraction of deaths among those aged 45 to 64. Smoking is implicated in many of these deaths.
- Black men and women have the highest death rates from heart disease and cancer. Hispanics have lower death rates than non-Hispanic whites for these diseases. Asians generally have the lowest death rates, particularly for heart disease. American Indians have high rates of heart disease mortality relative to Hispanics and Asians.
- Overall, death rates among 45- to 64-year olds are higher for men than for women, largely because of differences in rates of death from these diseases, particularly heart disease.

Note: Rates are age-adjusted.

7. Persons Aged 18 to 64 without Health Insurance Coverage, 1994–95

Source: National Center for Health Statistics



- Coverage by health insurance, either private or public (for example, Medicaid), is a key indicator of access to medical care.
- Hispanics are the most likely to be uninsured, and non-Hispanic whites are the least likely to be uninsured. For every group, the rate of uninsurance is lower for those with higher incomes.
- The overall difference in uninsurance rates between non-Hispanic whites and blacks stems from the relative concentration of blacks in lower income categories, as non-Hispanic whites and blacks with similar incomes have similar rates of uninsurance. Hispanics, on the other hand, have higher rates of uninsurance at every level of income.
- In large part because they are more likely to be eligible for Medicaid, women tend to have lower rates of uninsurance than men (not shown in chart).

Note: Percentages are age-adjusted.