Closing the Gap:
A Public Health Report on Health Disparities

Summary and Recommendations of the Twin Cities Metro Minority Health Assessment Project

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The Metro Minority Health Assessment Project is a collaborative effort of the Minneapolis Department of Health and Family Support, Hennepin County Community Health Department, Anoka County Community Health and Environmental Services, Bloomington Health Division, Carver County Community Health Services, Dakota County Public Health Department, Saint Paul-Ramsey County Department of Public Health, Scott County Public Health, and the Washington County Department of Health and Environment.

This report summarizes the key findings of the Metro Minority Health Assessment Project. Complete project findings are in the *Data Report of the Twin Cities Metro Minority Health Assesmant Project* and the *Report on Immigrant and Refugee Health of the Twin Cities Minority Health Assessment Project.* For more information about the project or copies of the project reports, please visit our website at www.mncounties.org/metroplan/MinHealth.htm or call 612-673-5438.

“Working together to eliminate health disparities in the metro area.”

Introduction

While Minnesota consistently ranks as one of the healthiest states in the country, Minnesota’s populations of color do not share equally in the good health. The Minnesota Department of Health’s *1997 Populations of Color in Minnesota – Health Status Report* found tremendous disparities between the health of Whites and people of color in Minnesota. In January 2000, the Minnesota Department of Health (MDH), Office of Minority Health funded Community Health Service (CHS) agencies statewide to conduct local-level health assessments of populations of color to better understand the health disparities identified in the 1997 report. In the Twin Cities, the nine CHS agencies in the Seven County Metro Area joined together to conduct a metro-wide health assessment of populations of color. This report presents the key data findings and recommendations for action of the Metro Minority Health Assessment Project.

Project Overview

The Metro Minority Health Assessment Project (MHAP) is a collaborative effort among the nine CHS agencies in the Seven County Metro Area to conduct a health assessment and develop recommendations for improving the health of populations of color in the metro area. The MHAP is the first comprehensive assessment of the health of populations of color in the Seven County Metro Area, and forms the basis for evaluating future progress on improving the health of populations of color and reducing health disparities. In addition to the health assessment, the project is working to build commitment to take the actions needed to improve the health of metro populations of color.

A Minority Health Community Advisory Committee (MHAC) made up of community representatives from each of the seven counties provided leadership for the project, and developed the recommendations for action presented in this report. MHAC members also organized a series of six multicultural community forums to gather broader community input. Forums were held in Anoka, Hennepin, Ramsey, Dakota, Washington, and Scott Counties, and brought together a diverse cross section of community residents. Forum discussions were conducted in English, Spanish, and Russian. Community responses at these forums provided the basis for the recommendations developed by the MHAC.

Each of the participating CHS agencies has committed to incorporate the recommendations for action into their agency work plans, and work together to eliminate health disparities in the metro area.

MHAP Participants

- ***Anoka County Community Health & Environmental Services Department***
- ***Bloomington Health Division, including the cities of Edina and Richfield***
- ***Carver County Community Health Services***
- ***Dakota County Public Health Department***
- ***Hennepin County Community Health Department***
- ***Minneapolis Department of Health & Family Support***
- ***Saint Paul-Ramsey County Department of Public Health***
- ***Scott County Public Health***
- ***Washington County Department of Health and Environment***

Definitions

Race and Ethnicity

Data sources used in the MHAP utilized the 1977 White House Office of Budget and Management (OMB) Race and Ethnic Standards for Federal Statistics and Administrative Reporting, which required federal agencies to collect and report data based on four racial categories: Black, White, American Indian, and Asian/Pacific Islander as well as the ethnicity category Hispanic Origin. It is important to note that these racial categories combine diverse individuals with different cultural and national backgrounds. For example, people of African ancestry that have lived in the United States

for generations and recent refugees from Somalia would both be classified as Black. In addition, many people would prefer to be identified using different terminology that better reflect their cultural background or heritage; for example, Chicano or Latino instead of Hispanic.

In response to public criticism, the OMB Race and Ethnicity Standards were revised in 1997. However, most data available for analysis at this time do not yet use the new standard. Since the data sources analyzed in this project utilize the original OMB classification system (Black, White, American Indian, Asian/Pacific Islander, and Hispanic Origin), the 1977 OMB language is used in this report.

The term populations of color is used in this report to describe the aggregate of individuals classified as Black, American Indian, Asian/Pacific Islander, and Hispanic Origin.

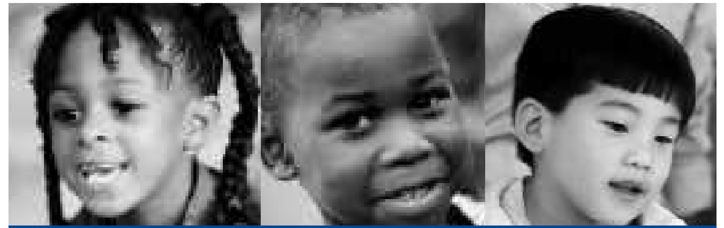
Geographic Area

Despite the rapid rate of growth of populations of color in the Seven County Metro Area, the number of persons of color living outside of Hennepin and Ramsey counties remains relatively small. Small populations and limited numbers of events (such as births and deaths) produce unstable rates and unreliable information about trends. For these reasons, the data presented in this report were divided into three geographic areas: Hennepin County, Ramsey County, and Other Metro Region. The Other Metro Region includes Anoka, Carver, Dakota, Scott, and Washington counties. Combining these counties into one Other Metro Region was necessary to permit analysis by race.

Population Estimates

2000 Census data are not yet available for inclusion in the MHAP. Between the censuses, the U.S. Census Bureau provides county population estimates broken down by age, race, Hispanic ethnicity, and sex. This report reflects 1998 U.S. Census Bureau population estimates. Rates were calculated using U.S. Census Bureau estimates updated on September 15, 1999.

"Populations of color have grown dramatically in all counties within the Seven County Metro Area."



"People of color also tend to be concentrated in areas with higher concentrations of poverty."

Key Findings

Populations of Color in the Seven County Metro Area

An overwhelming majority of people of color in the Seven County Metro Area live in the central cities of Minneapolis and St. Paul (Figure 1). The cities of Minneapolis and St. Paul have the highest percentage of persons of color as a proportion of the total population in the Seven County Metro Area. People of color also tend to be concentrated in areas with higher concentrations of poverty. Persons of color living outside the city limits of Minneapolis and St. Paul are more likely to be dispersed throughout the Seven County Metro Area, but the distribution patterns vary significantly by race or ethnicity. Asian/Pacific Islanders are the most dispersed group across the Seven County Metro Area, and American Indians are the most highly concentrated.

Since 1990, populations of color have grown dramatically in all counties within the Seven County Metro Area. Black, Asian/Pacific Islander, and Hispanic populations have grown by 78 to 85 percent since 1990 in the Other Metro Region. These populations have also grown in Hennepin and Ramsey counties by an average of 40 to 45 percent. The American Indian population grew by 30 percent in the Other Metro Region and remained stable in Hennepin and Ramsey counties. In contrast, the White population has shown relatively little growth in the Seven County Metro Area, and the percentage of White persons residing in Hennepin and Ramsey counties has declined since 1990.

The Seven County Metro Area is becoming home to an increasing number of immigrants and refugees (Figure 2). The Hispanic, Hmong, Somali, Russian, and Vietnamese make up the largest immigrant and refugee populations in the Seven County Metro Area. Due to the lack of data and high mobility of immigrant families, population estimates for immigrant and refugee groups vary widely. 2000 Census data should provide a more accurate picture of immigrant and refugee populations in the Seven County Metro Area.

Figure 1 ***Distribution of Populations of Color by Race/Ethnicity, 1990*** • Twin Cities Seven County Metropolitan Area

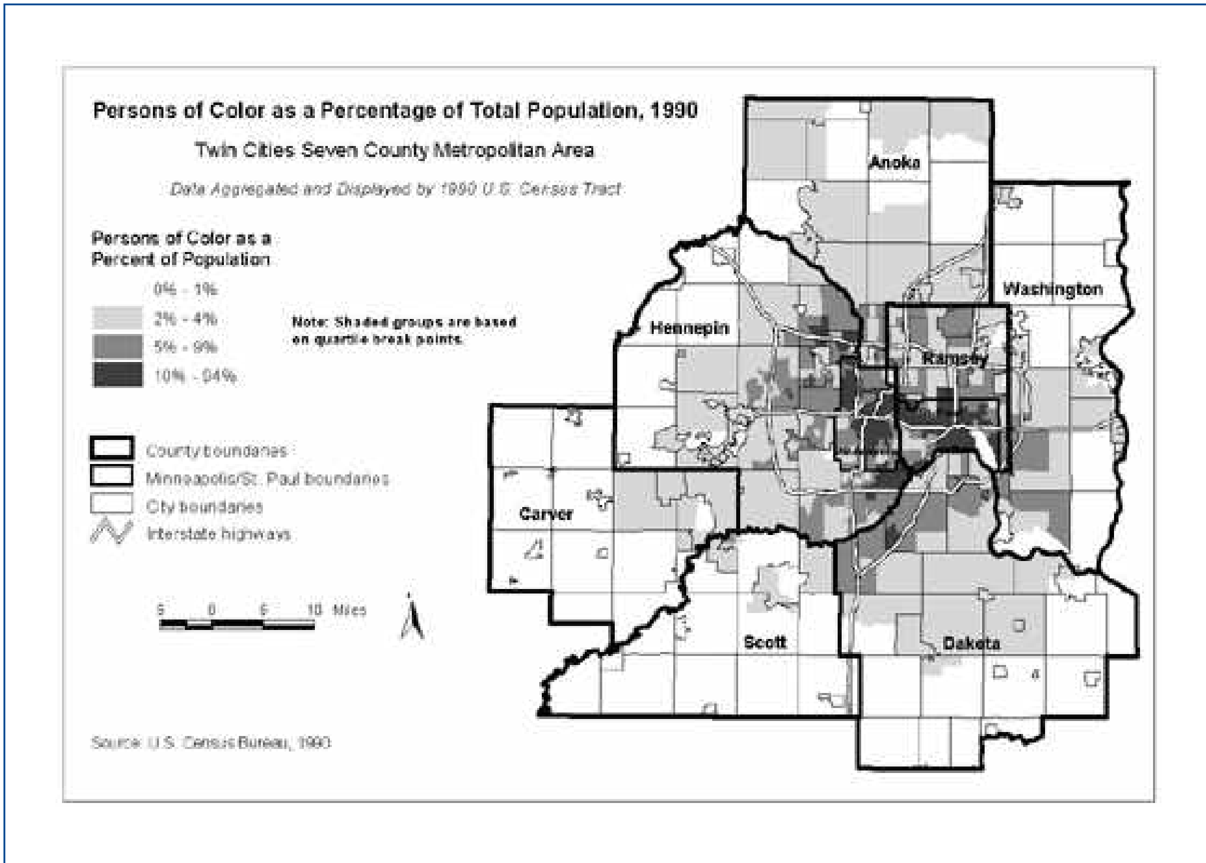
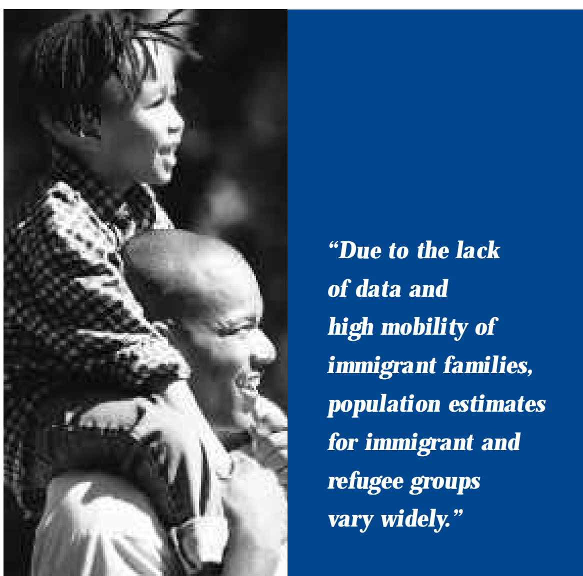


Figure 2 ***High and Low Minnesota Population Estimates for Selected Refugee/Immigrant Groups***



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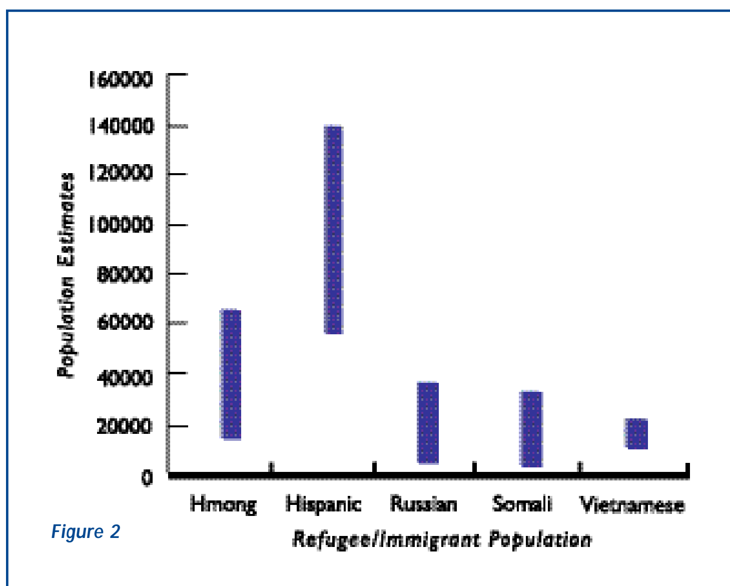


Figure 2

"Mothers and children of color are less likely to receive adequate prenatal care and immunizations than White mothers and children."

Women and Children's Health

Women of color giving birth in the Seven County Metro Area are more likely to be younger, unmarried, and have less education than White women. However, substantial variation exists among populations of color. American Indians and Blacks have the highest proportion of teenage births across the Seven County Metro Area, while Hispanic mothers are the least likely to have a high school education. With the exception of Hispanics, mothers of color living outside of Hennepin and Ramsey counties tend to be older, more likely to be married, and have a high school education. Asian mothers in the Other Metro Region are very similar to White mothers in terms of education and marital status.

American Indian and Black infants are more likely to die before their first birthday than other infants (figure 3). The infant mortality rate for American Indians and Blacks is two to four times greater than for Whites across the seven counties. In the Seven County Metro Area, Whites have the lowest infant mortality rate. However, in Ramsey County, Hispanics have a lower infant mortality rate than Whites.

Mothers and children of color are less likely to receive adequate prenatal care and immunizations than White mothers and children. Mothers of all racial groups living in the Other Metro Region are more likely to receive adequate prenatal care than their counterparts living in Hennepin and Ramsey counties. Children of color in the Seven County Metro Area are less likely than White children to be up-to-date on immunizations.

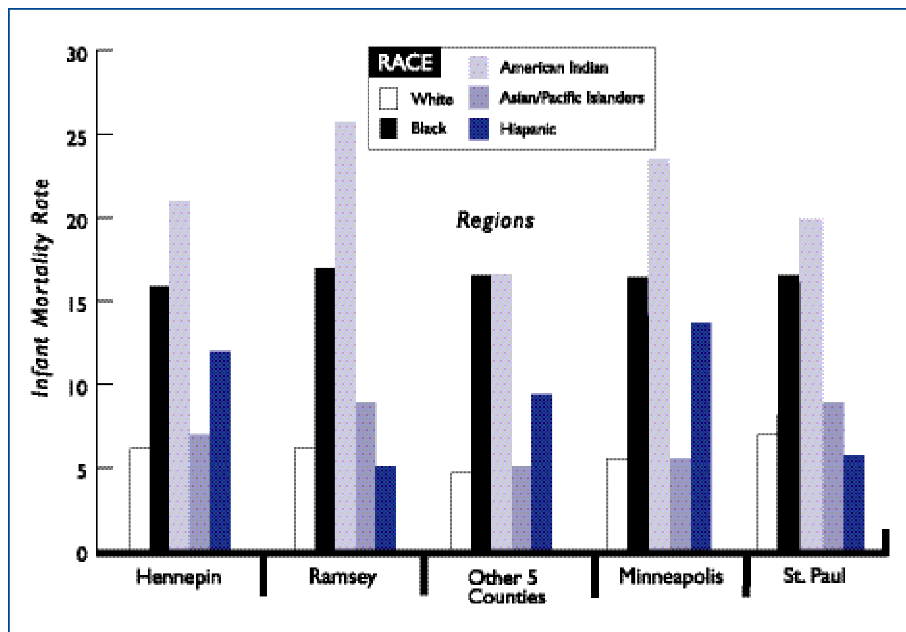
Children of color are more likely than White children to die from violent and preventable causes. Children of color in the Seven County Metro Area aged 1-14 are more likely to die from homicide, motor vehicle crashes, and unintentional injuries than White children. Nearly one-fifth of deaths of children of color can be attributed to violence as compared to one in twenty-five deaths of White children.

Foreign-born women of color giving birth in the Seven County Metro Area have different characteristics than U.S.-born women of color. Foreign-born women of color giving birth in the Seven County Metro Area are less likely to be teenagers and more likely to be married than U.S.-born mothers of color. Among foreign-born women, Hispanic mothers tend to be younger and less likely to be married.

Foreign-born women of color who gave birth tend to have better birth outcomes than U.S.-born women of color. Despite higher rates of poverty and lower rates of prenatal care utilization, foreign-born mothers of color are generally less likely to have low birth weight babies than U.S.-born women of color. The most striking difference in low birth weight births exists between U.S.-born and foreign-born Blacks.

The percentage of low birth weight births for U.S.-born Blacks is at least twice as high as for foreign-born Black mothers. However, foreign-born Asians in Ramsey County and foreign-born Hispanics in Hennepin County have a slightly higher percentage of low birth weight babies than their U.S.-born counterparts.

Figure 3 *Infant Mortality Rate broken down by geographic area during the period 1994-1998*



Adolescent and Young Adult Health (Ages 15-24)

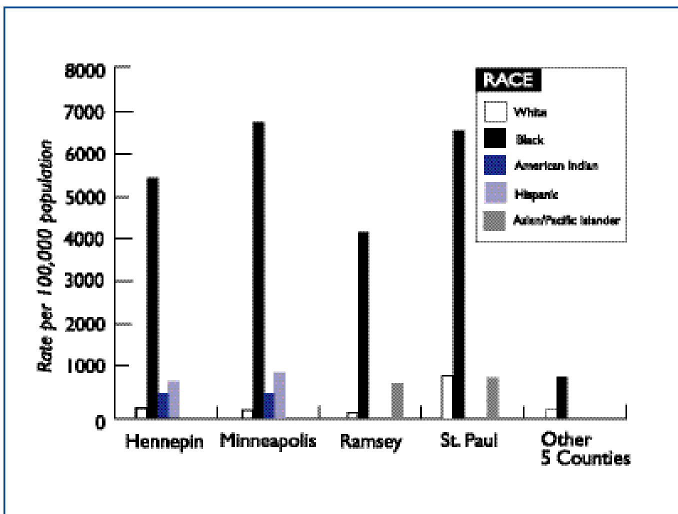
Adolescents and young adults of color are more likely to be victims of homicide than White adolescents. Over half (51.1 percent) of all deaths among 15-24 year olds of color in the Seven County Metro Area are due to homicide, as compared to 7.5 percent of Whites in the same age group. Both White adolescents and adolescents of color are most likely to die from preventable causes.

RANK	WHITE (718 Total Deaths)	POPULATIONS OF COLOR (268 Total Deaths)
1	MOTOR VEHICLE (252 Deaths,35.1%)	HOMICIDE (137 Deaths,51.4%)
2	SUICIDE (131 Deaths,18.2%)	SUICIDE (34 Deaths,12.7%)
3	UNINTENTIONAL INJURIES (82 Deaths,11.4%)	MOTOR VEHICLES (24 Deaths,9.0%)
4	HOMICIDE (54 Deaths,7.5%)	UNINTENTIONAL INJURIES (19 Deaths,7.1%)
5	MALIGNANT NEOPLASMS (47 Deaths,6.5%)	MALIGNANT NEOPLASMS (9 Deaths,3.4%)

Table 1 ***Leading Causes of death for people aged 15-24 in the Seven County Metro Area by race (1994-1998)***
The numbers and percents listed in Table 1 are the number and percent of all deaths within that racial group.

Adolescents of color have higher rates of sexually transmitted infections than White adolescents (Figure 4). Black adolescents are far more likely to have a sexually transmitted infection than any other group in the Seven County Metro Area. For example, the Gonorrhea rate among Black adolescents aged 15-19 in the Seven County Metro Area is about seventy times higher than that of Whites. The Chlamydia rate among Black adolescents aged 15-19 in the Seven-County Metro Area is about nineteen times higher than that of Whites.

Figure 4 ***Gonorrhea rates by race/ethnicity by geographic area, during 1998 in the age group 15-19.***



Adolescents of color feel more stressed, nervous, and depressed than White adolescents. Data from the Minnesota Student Survey indicate that adolescents of color across the Seven County Metro Area are more likely to experience feelings of worry and discouragement than White students.

American Indian adolescents are the most likely to have thought about committing suicide. Nearly half of all American Indian ninth graders surveyed in the metro area have thought about killing themselves.

Adult Health

People of color in the Seven County Metropolitan Area are more likely to die at younger ages than Whites. Blacks and American Indians age 15-24, 25-44, and 45-64 have death rates that are two to three times greater than the death rates for persons of any other racial group. Over half of all deaths among people of color occur before age 64, as compared to about 20 percent for Whites. Most deaths in the age groups 15-24 and 25-44 are preventable.

Adults of color are more likely to die from violence than White adults. Homicide is the leading cause of death for people of color age 25-44 living in the Seven County Metro Area, accounting for one-sixth of all deaths in this age group.

"Develop interest and opportunities for youth for future work in the health professions through mentoring, scholarships, and special educational opportunities."

“Community cohesiveness allows people to feel connected, supported and safe within their community, and creates additional resources to support and maintain health.”

Discussion

Health is determined by the complex interaction of multiple factors, including individual biology and behavior, physical and social environments, and access to health care. Scientific literature suggests race is a social determinant of health, and that health disparities result primarily from social, economic, and environmental factors. Similarly, community input gathered at the six community forums hosted by the MHAC identified poverty, racism and discrimination, and barriers to healthcare–including lack of health care providers of color and interpreters–as key factors contributing to poor health. This section summarizes what we know from the scientific literature about the causes of health disparities.

Poverty

Poverty has long been linked to poor health, and populations of color disproportionately experience poverty compared to their White counterparts (1, 2). Persons with incomes at or below the poverty level are more likely to live in inadequate housing, experience hunger, be exposed to environmental hazards, lack access to health care, and engage in health compromising behaviors than wealthier people (3-4). However, at every level of income, the health of populations of color is consistently worse than that of Whites (5).

Racism and Discrimination

Racism and discrimination play significant roles in the health of populations of color. Discrimination can dictate where people live, limit economic opportunities, define the type of medical treatment they receive, and lead to social isolation (6-8). Segregation is one consequence of racism and discrimination. Geographic segregation confines populations of color to communities that often lack the infrastructure and resources that are readily available in other communities such as adequate housing, good schools, playgrounds and parks, safe neighborhoods, and health care services.

The psychological impact of racism affects the health of populations of color as well. The presence of chronic race-related stress has been linked to physical manifestations like hypertension, feelings of depression, and social isolation (9, 10). Racial discrimination, a form of social exclusion, fosters distrust and oppression within a community and erodes social support and community cohesiveness.

Community cohesiveness allows people to feel connected, supported and safe within their community, and creates additional resources to support and maintain health (11). Community cohesiveness also fosters participation in civic activities, such as voting, where residents can influence policies that address healthcare and other needs (11).

Health Behavior

Individual behaviors such as diet and exercise are important factors in determining health. However, health behaviors alone do not account for the disproportionate burden of death and disease experienced by populations of color. In a recent study, health behaviors explained less than 20 percent of the difference in death rates across different racial and ethnic populations (12).

Health Insurance

Populations of color are at greater risk of being uninsured than their White counterparts (13). While being poor increases the risk of being uninsured, differences in income only partially explain the gap in the health insurance coverage of populations of color. At any level of income above the federal poverty level, populations of color are at far greater risk of being uninsured than Whites (13). The uninsured person is less likely than the insured person to have a regular doctor and to utilize preventive health care services. The uninsured population is also more likely to delay seeking care, usually because of cost.

Human Biology

Research on the human genome has revealed that genetic differences between racial groups account for only a small fraction of the variation within the same population, with 85 percent of human genetic diversity occurring within national populations and only 7.5 percent between major racial groups (14).

Culture

Culture refers to a set of beliefs and attitudes that shapes and influences perception and behavior and impacts health in many ways, including dietary habits, ritual and spiritual practices, and health beliefs. Culture shapes people’s beliefs about the causes of health and illness, and can influence decisions related to seeking medical care (15).

Recommendations for Action

Based on the health assessment data, scientific literature, and community input gathered at the six community forums, MHAC members developed the following recommendations for addressing health disparities in the metro area.

Take action on addressing health disparities.

There is impatience in communities of color with the continued study of health disparities and limited action to address the issues. MHAP members and community forum participants stressed that it is time for public health to act on reducing health disparities by engaging leaders to figure out how to do things differently including redirecting funds to better address health disparities.

One strategy proposed by the MHAP is to bring together the various groups working on issues related to health disparities in the Twin Cities to plan a venue in which leaders in the community, public health, and health care come together to develop a plan to address health disparities.

Work outside of traditional public health roles to address social and economic determinants of health.

Feedback from the community forums and a growing body of scientific literature suggests that health is strongly influenced by social and economic factors, and reducing disparities will require actions outside of what has traditionally been considered the realm of public health. The MHAC recommends that public health and health care organizations work outside of their traditional roles to reduce health disparities. Specifically, the MHAC recommends that public health agencies do the following:

Work more with others outside of their 'silos' to address issues that lead to health disparities such as discrimination, housing, employment, and education.

Create an entity to coordinate and focus efforts of the many diverse groups in the Twin Cities working on reducing health disparities to achieve common goals.

Increase the participation and leadership of people of color in the health professions.

People of color are under-represented in the health professions, and particularly in positions of leadership. The MHAC recommends that efforts be made to develop health professionals in populations of color, and prepare and promote people of color for leadership positions. Recommended strategies include the following:

Build capacity in the minority workforce and foster leadership through mentoring, on-the-job training, and intentional career laddering.

Create an environment where all employees feel welcome, accepted, and valued through cultural competency training and ongoing efforts to emphasize the value of diversity and create a welcoming work place.

Ensure that applicants of color and diverse national origins are given full consideration in the hiring process by reviewing and revising hiring requirements that exclude people of color or who have limited English proficiency.

Develop interest and opportunities for youth for future work in the health professions through mentoring, scholarships, and special educational opportunities.

Educate community leaders and the public about why it is in everyone's best interest to reduce health disparities.

The MHAC believes that in order to impact change, business and government leaders need to understand why it is in everyone's best interest to work to reduce health disparities. There is limited public awareness of health disparities and understanding about how disparities negatively impact the entire community. Therefore, the MHAC recommends that public health take the lead in developing the following:

A method to show how reducing health disparities would benefit the overall community in ways that are meaningful to business and civic leaders (e.g., lead to increased productivity, profits, tax revenues, etc.).

A strategy to deliver the message about health disparities to business and government leaders and the public.

"The MHAC recommends that public health and health care organizations work outside of their traditional roles to reduce health disparities."

Increase quality and availability of spoken-language interpreter services in health and social service settings.

Lack of funding for and availability of quality spoken-language interpreter services were identified in the community forums as an important barrier to health care access for immigrants and refugees in the Twin Cities. The MHAC recommends that public health agencies work to address this key barrier to health care by actively advocating for:

Health insurance companies to cover the cost of spoken-language interpreter services.

The development of standards and certification for spoken-language interpreters in a health care setting.

Increased opportunities for interpreter training and certification.

Combat discrimination.

Racial, economic, and linguistic discrimination were identified in the community forums as barriers to health. The MHAC recommends that efforts be made to combat discrimination through increasing the cultural competency of health and human service providers, including the police, and by creating opportunities for cross-cultural dialogues in the community. Recommended strategies include the following:

Encourage professions which are regulated to require Continuing Education Units (CEUs) in cultural competency.

Public health should require contracted service provider organizations to conduct self-assessments to identify and address discrimination (several self-assessment tools have been developed for this purpose).

Include cultural competency as a measure of employee performance.

Sponsor cross-cultural dialogues to bring people together in communities to get to know each other and talk about living together.

Advocate for agency licensure to be tied with training in cultural competency and diversity.

Work to change the culture of police by changing the philosophy of hiring and requiring cultural competency training.

Improve racial/ethnic information in health data.

The MHAC believes that public health should make improving racial and ethnic information in health data a key priority. Specifically, the MHAC recommends the following:

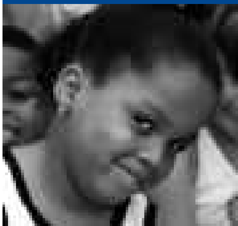
All data sources at the state and local level which collect information on race/ethnicity, should adopt the Census 2000 format for collection of race and ethnicity data. This will provide for consistent race and ethnicity data across data sets.

Data sources should collect information on country of origin as well as race/ethnicity. Foreign-born persons often experience substantially different health issues than U.S.-born persons of the same racial/ethnic group.

Efforts should be made to ensure that address information is complete in the data sources. Special efforts should be made to educate people who fill out data collection forms about the importance of correctly completing the address portion of these forms so that information may be geocoded.

State and local data sources should be geocoded to generate aggregate information at various geographic levels (e.g., census tract, zip code, etc.). The aggregated socio-economic information can then be used to further describe the environment in which people reside.

The project team gratefully acknowledges the Minority Health Community Advisory Committee members who volunteered their time and insight to this project and the community members that contributed their input at the six community forums. This project would not have been possible without their support. Advisory committee members who contributed to this report are listed to the right:



More Thanks...

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