# Health Disparities Issue

## *The* Advocate

TENNESSEE COMMISSION ON CHILDREN AND YOUTH

**Vol. 17  No. 2**            *A  newsletter on children's issues*            **May 2007**

> "Of all the forms of inequality, injustice in health is the most shocking and the most inhuman."
> —*Martin Luther King, Jr.*

# Health Disparities in Children

**By Molly Griggs**

Wide and persistent health disparities exist in America; they are well documented by research. As recently reported by the Census Bureau, the number of people in this country identified as members of a minority group now exceeds 100 million, approximately a third of the nation. Health problems among minority groups are increasingly problems for us all.

**What We Can Do**

The causes of health disparities are varied and complex. While interventions aimed at a particular cause of or risk factor for racial disparities have been effective in reducing these disparities, only comprehensive interventions focusing on multiple levels of influences will be effective in eliminating them.

By understanding the factors that contribute to disparities, such as "biologic and genetic predispositions to disease and health, access to care, quality of care and services, and language and communication barriers affecting care" (*Public Health Reports, 120*, 373), we can construct interventions that adequately address both the individual influences and the interactive nature of multiple factors.

*Adolescent and Young Adult Health in Tennessee, 2006*, outlines the recommendations of the Institute of Medicine's investigations into health disparities and those of the Commonwealth Fund's report *A State Policy Agenda to Eliminate Racial and Ethnic Disparities*, which seek to address the health disparities described previously.

**Contents**

**Calendar of Events**

Events relating to helping children are available at: www.tennessee.gov/tccy/webcalen.pdf.

**TCCY**

For more information on the Tennessee Commission on Children and Youth and its programs, check out the website at: www.tennessee.gov/tccy.

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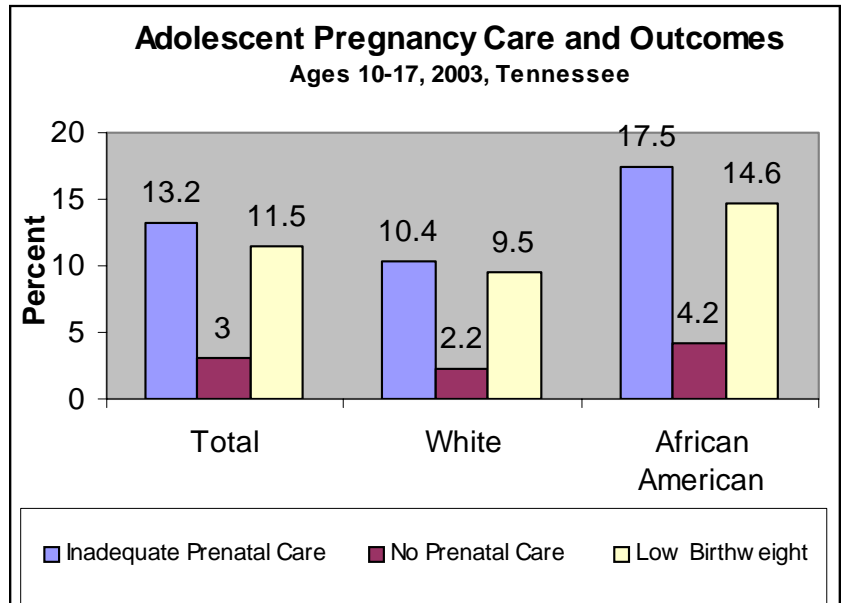
Some future directions to consider include:

1. Developing and applying data on disparities in child health and health care;
2. Bridging the communication divide;
3. Addressing concerns specific to the child life stages of development;
4. Recognizing the significant influence of culture on health;
5. Integrating disparities and cultural competence into quality of care.

*Unequal Treatment* included a list of policy areas for change:

- Raising public and provider awareness of racial and ethnic disparities in care;
- Expanding health insurance coverage;
- Improving the number and capacity of providers in underserved communities;
- Improving the quality of care;
- Increasing knowledge of causes and of interventions to reduce disparities.

### Adolescent Pregnancy Care and Outcomes
#### Ages 10-17, 2003, Tennessee



Chart legend: Inadequate Prenatal Care, No Prenatal Care, Low Birthweight

Values shown:
Total — 13.2, 3, 11.5
White — 10.4, 2.2, 9.5
African American — 17.5, 4.2, 14.6

## Tennessee Department of Health Services to Mitigate Disparities

The Tennessee Department of Health, reinforcing its commitment to addressing gaps in health outcomes, announced the creation of a new division, the Division of Minority Health and Disparity Elimination. The new division will include the offices of Minority Health, Disparity Elimination, Faith-Based Health Initiatives and Title VI. Cherry L. Houston, PhD, MPH, RN, has been selected to lead the division.

### Current Tennessee Department of Health Efforts

The Department of Health has a number of programs, including health education programs on diabetes and heart health, to help to eliminate health disparities.

- **Black Health Initiative Programs**. The Office of Minority Health funds community based organizations that develop demonstration projects targeting African-American and Hispanic youth aged 10 to 19, and offer structured activities focusing on education, health care, violence reduction, appropriate social development, substance abuse prevention and employment and business skills.
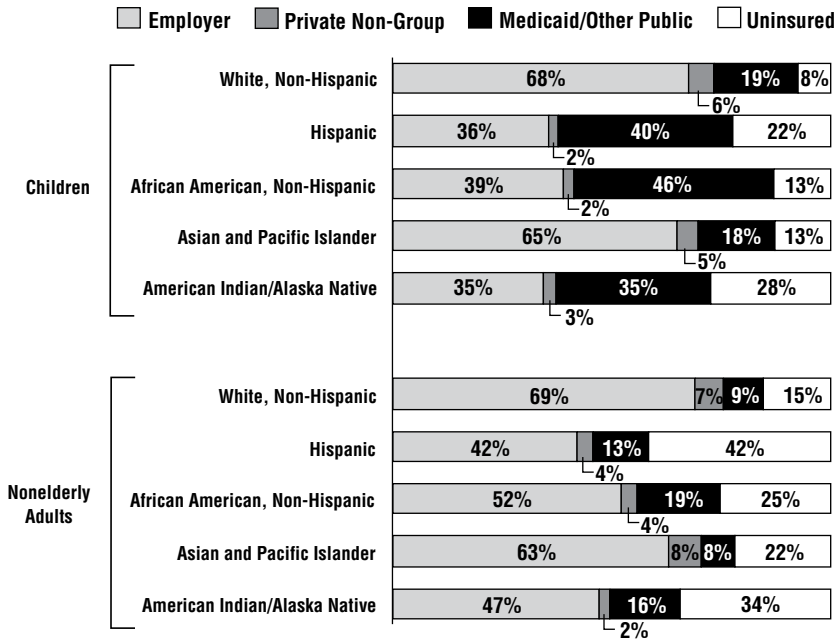
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- ✚ **Search Your Heart**, a faith-based program to prevent heart disease and stroke in African-American communities;
- ✚ **Count on Me: Heart Health Is a Numbers Game!** media campaign to prevent and control heart disease and stroke in African-American and other racial/ethnic minority communities;
- ✚ **Early and Periodic Screening, Diagnosis and Treatment** (EPSDT), well-child exams for infants from birth to age 1;
- ✚ **Healthy Start**, an intensive home visiting program for first-time parents;
- ✚ Women, Infants and Children (**WIC**), Food, nutrition counseling and access to health services are provided to low ýincome women, infants and children;
- ✚ **Family Planning** Program;
- ✚ **Prenatal Care** Program, basic prenatal care services are provided at all local health department clinics;

## Health Insurance Coverage of the Nonelderly by Age and Race/Ethnicity, 2005

Legend: ☐ Employer  ▨ Private Non-Group  ■ Medicaid/Other Public  ☐ Uninsured

**Children**

| Group | Employer | Private Non-Group | Medicaid/Other Public | Uninsured |
|---|---|---|---|---|
| White, Non-Hispanic | 68% | 6% | 19% | 8% |
| Hispanic | 36% | 2% | 40% | 22% |
| African American, Non-Hispanic | 39% | 2% | 46% | 13% |
| Asian and Pacific Islander | 65% | 5% | 18% | 13% |
| American Indian/Alaska Native | 35% | 3% | 35% | 28% |

**Nonelderly Adults**

| Group | Employer | Private Non-Group | Medicaid/Other Public | Uninsured |
|---|---|---|---|---|
| White, Non-Hispanic | 69% | 7% | 9% | 15% |
| Hispanic | 42% | 4% | 13% | 42% |
| African American, Non-Hispanic | 52% | 4% | 19% | 25% |
| Asian and Pacific Islander | 63% | 8% | 8% | 22% |
| American Indian/Alaska Native | 47% | 2% | 16% | 34% |

NOTES: Nonelderly includes individuals up to age 65. Does not include those identifying themselves as "two or more races." "Other public" includes Medicare and military-related coverage; SCHIP is included in Medicaid.

DATA: March 2005 Current Population Survey.

SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates.

- ✚ Help Us Grow (**HUG**) access to medical, social and educational services for pregnant women, postpartum women for up to two years and infants and children up to age 6;
- ✚ Child Health and Development (**CHAD**), parent support and education services available in 41 counties for pregnant women and children ages birth to six;
- ✚ **Teen Hotline**, a hotline for teenagers or others who have questions about teen pregnancy, sexuality, etc;
- ✚ **Resource Mothers**, lay home health visitors for pregnant and parenting teenagers (17 and under) in six West Tennessee counties;
- ✚ **Community Prevention Initiative** (CPI) Programs target children birth to 12 years and their families in designated counties who are at greatest risk for teen pregnancy;
- ✚ The **Diabetes Control** Program, community interventions, health communications;
- ✚ The **Diabetes Advisory Council**;
- ✚ The **Governor's Council on Physical Fitness and Health**;
- ✚ **Tennessee Heart Disease and Stroke Prevention Program**, prevention and raising awareness.

More information is available at www.tennessee.gov/health. ⚕

# Best Practices in Eliminating Health Disparities

Best practices are those strategies, activities or approaches that have been shown through research and evaluation to be effective at preventing and/or delaying a risky/undesired health behavior or conversely, supporting and encouraging a healthy/desired behavior.

## State Level

The Commonwealth Fund produced *A State Policy Agenda to Eliminate Racial and Ethnic Health Disparities* report that provides the following priorities for states to use to build infrastructure and capacity to address health disparities.

**Cultural and Linguistic Competency.** States can develop standards tailored to community needs, collect data to identify service needs, finance interpreter services, and increase the supply of minority health providers.

**Data.** States have a critical role in fostering collection, analysis, and use of minority health data for the identification and amelioration of disparities. Some state surveillance systems' racial and ethnic classifications, however, are very narrow. Some states still categorize all racial and ethnic groups as Black or White only. The accepted national standard for data collection is the race and ethnicity categories in the Office of Management and Budget's Directive 15.

**Insurance Coverage.** More than half of U.S. uninsured belong to racial and ethnic minorities. For them, Medicaid and State Children's Health Insurance Programs make available important and otherwise unobtainable coverage. States should expand eligibility, encourage enrollment, and eliminate administrative obstacles to promote wider coverage.

**Primary Care.** States can expand the number and capacity of community health centers, reduce financial barriers to obtaining primary care, and increase research efforts to address disparities in primary care for minority populations.

**Purchasing.** States can use their extensive purchasing power to require data collection and reporting, mandate consumer satisfaction surveys, and require specific health interventions.

**Regulatory Approaches.** States can influence professionals, institutions, and health plans by using licensure and other regulatory requirements to address provider and facility shortages in minority communities.

**State Infrastructure.** States can help minority health offices reduce disparities by ensuring that these offices have adequate financial resources (many are channeling revenue from the Tobacco Settlement), limit staff turnover, foster good relations with other state agencies, legislative and/or regulatory grounding, access to data, and clear performance measures.

**Workforce Development.** States can foster a more diverse health workforce by diversifying applicant pools, developing incentive programs, ensuring adequate data collection and using Graduate Medical Education funds more creatively.
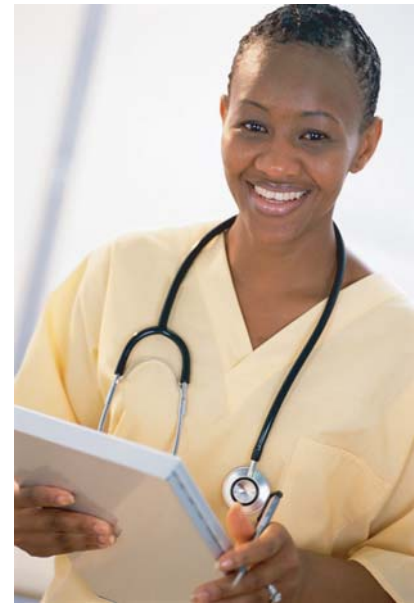
**Involve All Health System Stakeholders.** Issues related to minority health and health disparities can be easily pigeon-holed so policymakers have only limited exposure to them. Yet any effective strategy requires the full engagement of state governments – including executive and legislative branch leaders – and the broader health sector – including hospitals, physicians, community health centers, nurses, home health providers, the public health community, community-based organizations and more. An effective strategy must also engage the broader public through community-based public education activities and programs.

## Program Level

Programs can strive to address health disparities by assuring their organization/staff are culturally competent. Cultural competence at the organizational level is not solely a program or initiative. Instead, it is a commitment that is widely shared among program board members and staff, and reinforced in all aspects of policy development, program management, and service delivery. Those organizations that are culturally competent generally share a common set of values that includes:

- Understanding and accepting the diverse cultures represented in the community;
- Recognizing the social, political, and economic climates of the community within cultural contexts;
- Honoring the inherent ability of communities to recognize their own problems and intervene appropriately on their own behalf;
- Sharing limited resources effectively and equitably among competing needs;
- Sharing power with the community and ensuring that the contributions of community residents are valued and respected; and
- Providing community residents with full and timely access to information.

How these values are embedded in the policies and programs of culturally competent organizations is based on their unique communities, strengths and organizational structures. While no one approach is universally best, there are a number of strategies that have been used successfully by organizations to develop their capacities to work effectively with diverse groups within their communities. Some examples include:

- Integrating awareness of and sensitivity to diverse community residents in organizational policies and procedures;
- Involving representative groups of community residents in a meaningful way in the planning and program development processes;
- Conducting organizational self-assessments of the level of cultural competency among Board members and staff;
- Developing performance objectives for outreach and service to diverse community groups, and measuring progress towards their attainment;
- Recruiting and retaining Board members that are representative of the population of the organization's target area;
- Employing program and management staff throughout the organization that are reflective of the diversity within the community; and
- Offering staff and Board members opportunities for participation in professional development activities related to diversity and cultural competence.

# The Health Disparity Problem

**By Molly Griggs**

Disparities begin before birth, with lower rates of prenatal care and higher rates of infant mortality among minority populations, and continue through childhood into adulthood and result in shorter life spans.

Minority American populations tend to have poorer overall health, worse outcomes for specific health issues and shorter life expectancies than do White Americans. Significant differences exist between the races, with American Indian, African-American and Latino populations fairing the worst.

Eliminating health disparities begins with an evaluation of its causes. Major disparities exist in health based on income and education level. Since most minority groups tend, on average, to have lower incomes and levels of education than does the White population, the most rigorous evaluations of the problem attempt to mitigate the influence of these issues.

The Institute of Medicine, at the request of Congress, evaluated over 100 studies on health care disparities and issued a report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, in 2002. The evaluation found differences in the treatment received by different races. The report found little variation in racial differences in attitudes to treatment, which it said did not explain the disparities in outcomes. It did, however, find African Americans were slightly (3 to 6 percent) more likely to reject treatment. The Tuskegee syphilis experiment is the best known example treatment that led to minorities' distrust. A recent book, *Medical Apartheid*, lists a number of incidents where, prior to the research reforms of the 1970s, African Americans were harmed by medical experimentation.

## Disparities in Children

To date, researchers have documented a number of areas in which childhood health disparities exist, including but not limited to:

- Health Insurance Coverage;
- Access to Care;
- Quality of Health Care;
- Prenatal Care;
- Low Birth Weight;
- Infant Mortality Rates;
- Obesity;
- Immunization Rates;
- Breast-feeding Rates and Duration;
- Usual Source of Care (primary care physician, etc.);
- Dental Health;
- Asthma;
- Sexually Transmitted Diseases;
- Teenage Pregnancies.

## Asthma: Health Care Use and Outcomes, 2000
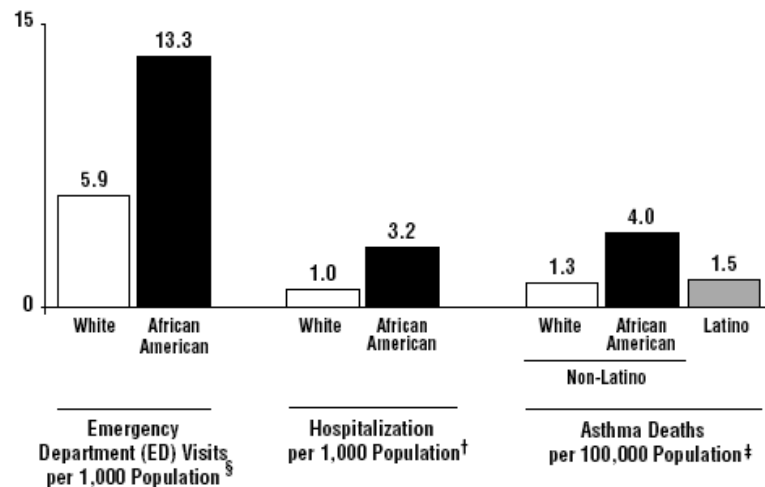


NOTE: Age-adjusted to the 2000 population.
DATA: § National Hospital Ambulatory Medical Care Survey, † National Hospital Discharge Survey,
‡ Mortality Component of the National Vital Statistics System, NCHS, CDC.
SOURCE: CDC, NCHS, 2003.

# Problem
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> "The (Institute of Medicine) study committee was struck by the consistency of research findings: even among the better-controlled (of well over 100) studies, the vast majority indicated that minorities are less likely than whites to receive needed services, including clinically necessary procedures."

**Prenatal Care, Low Birth Weight and Infant Mortality Rates.** Nationally, the infant mortality rates by race and ethnicity indicate that across education levels, African-American and American Indian populations have significantly higher rates of infant mortality than do White and other minority populations.

Researchers disagree on the extent to which current risk factors (i.e., ones occurring during pregnancy) can explain the disparities in maternal and infant health. According to a study of racial and ethnic disparities in birth outcomes, risk factors including current socioeconomic status, risky maternal behaviors, prenatal care, psychosocial stress or perinatal infections, did not fully explain the disparities. The authors of this study suggested that consideration of the mother's health and situation over her lifetime as well as her conditions while pregnant is needed to fully understand why disparities exist.

These researchers suggested it may take more than one generation to overcome socioeconomic disparities in birth outcomes. The Centers for Disease Control and Prevention suggested individuals consider preconception health prior to becoming pregnant in order to improve birth outcomes. Less focus has been made on the father's health, but men are encouraged to consider the health of their unborn children when making health-related decisions, and research has shown that some factors, like age of the father, contribute to infant health.

Infant mortality rates are influenced by prenatal care and low birthweights, which research has also shown to vary by races. Some explanations for these differences have been suggested. Black low birthweight was about 1.5-1.9 times higher in cities and suburbs. Births were more than 200 percent higher in Black teens in both areas, and Black women received less prenatal care than White women.

**Obesity.** Obesity is a strong example of the complexity of factors leading to or associated with health disparities. Research has shown a higher prevalence of overweight found among Black, Hispanic and low socioeconomic status youth, which correlated with a lower proportion of youth from these groups who regularly eat breakfast or exercise regularly and a higher proportion who watch a lot of television. In addition to nutrition and levels of physical exercise, family and

environmental factors seem to play a significant role in obesity. Breast feeding, lower among minority and low socioeconomic populations, is correlated with lower rates of obesity.

Recent research identified genes associated with obesity, including genetic links between obesity and asthma and obesity and certain sleep patterns. A report from the American Academy of Family Physicians reported that 40 percent of the differences in weight were caused by genetics.

Other environmental and community factors that may affect obesity rates include location and availability of

## Comparative Health Care Expenses, 2004

**Total health care spending per capita**



[a]2003
[b]2003 Total Health Care Spending, 2002 OOP Spending

Source: The Commonwealth Fund, calculated from OECD Health Data 2006.

playgrounds, accessibility to supermarkets, availability of fast food restaurants and television advertisement targeting minority populations, according to a paper presented at the 2005 annual Harvard University Diversity Workshop. Shopping at convenience stores is associated with poorer nutritional patterns, but due to lower numbers of supermarkets in poor neighborhoods, many poor and minority families are forced to shop at convenience stores. Additionally, one paper reported "predominately black neighborhoods have 2.4 fast-food restaurants per square mile compared to 1.5 restaurants in predominately white neighborhoods." The increased availability of nutritionally deprived food options may also contribute to obesity rates in minority populations. Finally, research has found that "more food commercials are aired during Black prime time than general prime time (4.78 per 30-minute program versus 2.89 per 30-minute program on general prime time) [and that] 30 percent of the food commercials featured candy and 13 percent featured soda, significantly more than on general prime time television."

**Asthma.** Asthma is now the most common chronic illness in children, with higher rates among African-American children than White children. However, some research indicates that this correlation disappears when location is considered, finding that children of both races living in the congested urban areas have high rates of asthma.

Along with obesity, this disparity also exemplifies the difficulty in explaining and reducing health disparities. Often interventions focus on a specific factor related to a condition, but in order to eliminate disparities entirely, all the related and possible causal factors and ways in which they interact must be considered.

It has been pointed out that the complex interplay among a lack of access to health care, especially at school; exposure to polluted air; a lack of a relationship with a primary care giver; and stereotypical decision-making by clinicians may result in poor asthma control.

Despite its prevalence, adequately managed asthma rarely requires hospitalization. Researchers have suggested reliance on emergency rooms for primary care increases the likelihood of hospitalization. African-American children are three times more likely to be hospitalized for or to die as a result of asthma than White children.
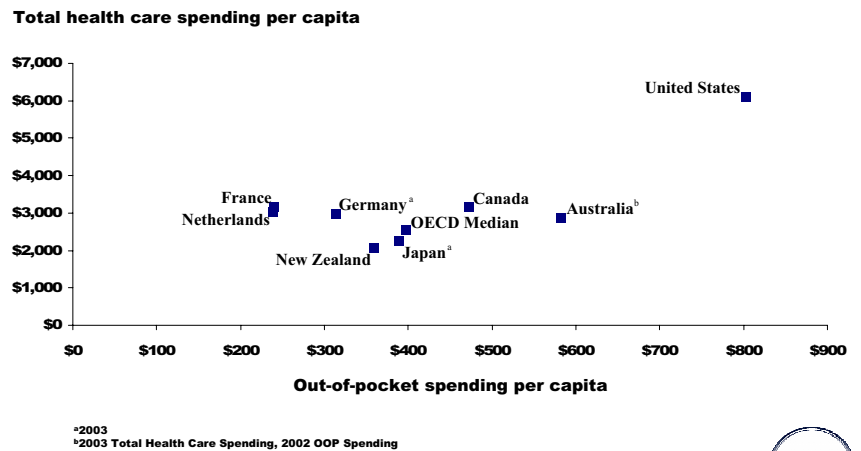
# Problem

**Dental Health.** Disparities also exist in the area of dental health, with Latinos the least likely to report having a dental visit in the past year.

**Breast Feeding Rates and Duration.** The Centers for Disease Control (CDC) , using data from the 2004 National Immunization Survey (NIS), reported 71.5 percent of non-Hispanic White children and 50.1 percent of non-Hispanic Black children were ever breast fed. A slight majority (54 percent) of  non-Hispanic White and 44 percent of non-Hispanic Black children who had been breast fed continued breast feeding until they reached 6 months or older (*Morbidity and Mortality Weekly Report*, 55, 2006).

**Estimated Vaccination Coverage\* Among Children 19-35 Months of Age by Race/Ethnicity† – US, National Immunization Survey, 2000-2004 4:3:1:3:3‡**



\*   Estimate=NA (Not Available) if the unweighted sample size for the numerator was <30 or (CI half width)/Estimate >0.5 or (CI half width)>10
†   Self-reported by respondent.  Individual racial groups do not include Hispanic children. Children of Hispanic ethnicity may be of any race
‡   4 or more doses of DTP, 3 or more doses of poliovirus vaccine, 1 or more doses of any MCV, 3 or more doses of Hib, and 3 or more doses of HepB

Breast feeding is associated with a number of health benefits. Research has found that "barriers to breast feeding initiation and continuation include lack of social support, lack of proper guidance from health-care providers, lack of adequate or timely postpartum follow-up care, and disruptive hospital maternity-care practices (e.g., delays in breast feeding initiation, use of pacifiers by newborns, and hospital promotion of formula through the provision of free formula in hospital discharge packs" (*Morbidity and Mortality Weekly Report*, 55, 2006).
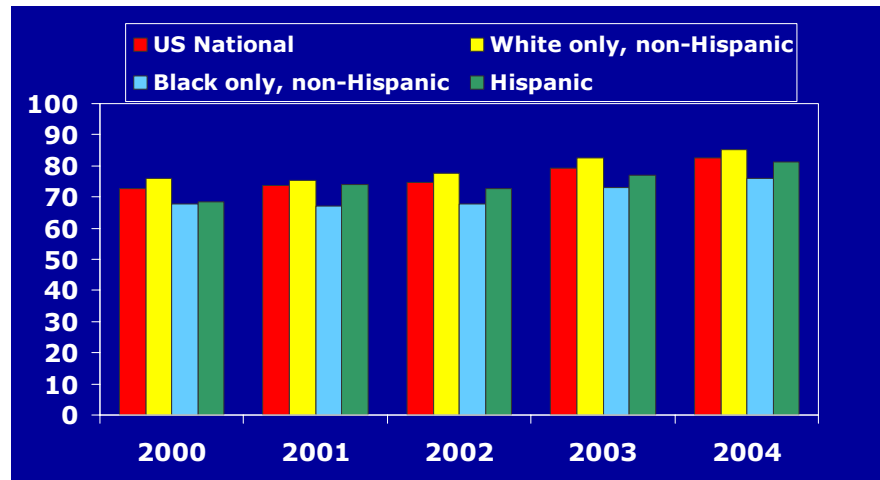
Research finds lower rates of breast feeding by employed mothers and a lack of support from employers, and lower rates associated with financial and social uncertainty. Single women are less likely to breast feed.

**Health Insurance Coverage.** Health insurance coverage remains an important issue in America. As presented by Marian Wright Edelman at TCCY's Children's Advocacy Days, more than 9 million children in America are still uninsured. Research indicates "Hispanic children were the most likely racial/ethnic group to be uninsured (20.6 percent) compared to Blacks (10.3 percent), Asians (7.1 percent) and Whites (6.9 percent) in 2000" (*Public Health Reports, 120,* 431-441).

According to the Kaiser Family Foundation's *Key Facts: Race, Ethnicity and Medical Care* report for 2007, Tennessee of all the states had the highest percentage of its Hispanic population (56 percent) uninsured.

The problems associated with a lack of insurance are significant. "Emergency rooms frequently become the point of entry to the health care system, especially for those without insurance – a status that tends to be higher

# Problems

among diverse populations. Those without insurance are also more likely to postpone needed care due to cost" (*Public Health Reports, 120*, 370-377).

Medicaid and the State Children's Health Insurance Program (SCHIP) are federal and state programs, and "substantial evidence has demonstrated that the availability of Medicaid has improved access to care among low-income children, and early evidence suggests that the SCHIP program is producing similar results." (*Public Health Reports, 120,* 455-462). An additional study found that "enrollment in SCHIP was associated with (1) improvement in access, continuity and quality of care for all racial/ethnic groups and (2) reduction in preexisting racial/ethnic disparities in access, unmet need, and continuity of care" (*Pediatrics, 115,* 697-705). These findings are promising in the fight against health disparities.

The uninsured are frequently charged much more for health procedures and services.

**Access to Care.** Despite programs like Medicaid and SCHIP, disparities in access to care still remain. According to one researcher:

> One explanation might be that most federal interventions in the past and present are related to health insurance (e.g., Medicaid, SCHIP), but *the provision of health insurance alone does not ensure equity in access*. Aside from the cost barrier to medical care, racial/ethnic minorities encounter barriers due to problems of availability of care (e.g., lack of a USC [usual source of care] and differences in the setting where care is delivered), convenience of services (e.g., travel time to and waiting time at the provider office), and language and cultural barriers. Providers may also lack cultural competence in their interaction with minority patients, a potential cause for dissatisfaction. Thus, in addition to expanding insurance coverage, policy makers need to be concerned with nonfinancial barriers to access that contribute to disparities (*Public Health Reports, 120,* 439).

Additionally, providers may be unwilling to take Medicaid and SCHIP patients due to lower reimbursement rates, burdensome paperwork, etc. Until interventions address this lack of available providers willing and able to take public insurance and able to communicate effectively with minority populations, no amount of federal funding will completely eliminate health disparities.

**Usual Source of Care**. Research has shown that "in general, minority children were more likely to lack a USC, have no health professional or doctor visit in the past year and lack a dental visit in the past year" (*Public Health Reports, 120,* 433) A usual source of care is associated with obtaining timely and effective medical services, which can lead to improved health.

**Quality of Health Care.**
Many studies report that even when members of minority populations obtain services, disparities exist in the quality of the care they receive. An example of this disparity is the finding that "black women may be at greater risk for not receiving information from their prenatal care providers that could reduce their chance of an adverse pregnancy outcome. They are also less likely to receive a pelvic examination, blood or urine test, and blood

pressure check during their prenatal care visits. They receive less ultrasound, amniocentesis and medications to inhibit premature labor treatment than do White women. Thus, the same level of utilization may not indicate the same content or quality of care for black and white women" (*Maternal and Child Health Journal, 7*, 13-30).

**Education.** According to the 2005 National Health Interview Survey, as in earlier surveys, as education levels increase so does the percentage of people in excellent health. The same finding is true for family income, but in addition, people with the least education and lowest family incomes were more likely to have activity limitation and were the most likely to be unable to work due to health problems. People with less than a high school education were twice as likely to have experienced a lack of health care coverage during the past year as those with at least a bachelor's degree and were one and a half times as likely to have lost health care coverage because of a job loss or change in employment.

**Immunization Rates.** According to the U.S. National Immunization Survey, disparities exist between minority and White populations in childhood immunization rates. Although improvements in vaccination coverage have been made for all populations since 2000, disparities remain.

Like most disparities discussed in this summary, disparities in immunization rates have multiple and complex causes. One study suggested that "the biological impacts coupled with the social implications of low SES [socioeconomic status] affect families' ability to access health care services and understand the implications of following health care recommendations, such as immunization schedules. Furthermore, limited access to health -care providers in the more rural areas and lack of Medicaid providers compound the problem" (*Pediatric Nursing, 31*, 383) Because of the multiple influences on immunization rates, this same study proposed that "the most effective interventions will be the ones that address both the individual family and the contextual factors such as their neighborhoods and social networks (formal and informal)."

Effective interventions in reducing disparate immunization rates address or utilize the following factors:
- Reminder and recall systems;
- Increasing parental immunization knowledge;
- Standard orders for immunizations;
- Home visits;
- Community supports;
- Cultural competence in providers;
- School entry requirements;
- Culturally relevant educational materials;
- Literacy levels for education materials;
- Translation and other linguistic resources;
- Offering immunizations at locations other than primary providers;
- Transportation difficulties.
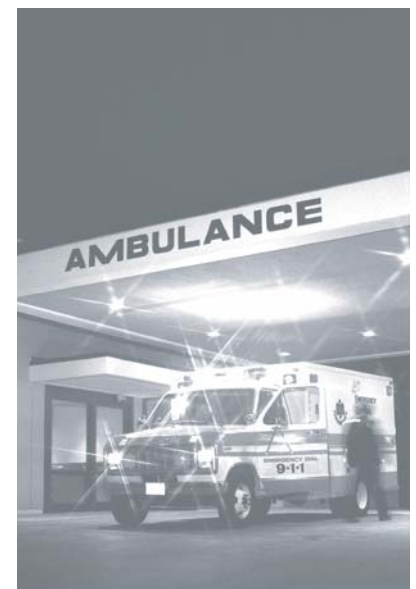
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**Alcohol and Tobacco.** Members of minority groups generally have lower rates of alcohol and tobacco use, as Whites tend to have higher rates. White high school students report binge drinking at a higher rate than do African-American students (30 percent for White students and 11 percent for African Americans).

**Biological and Genetic Predispositions to Disease and Health**. Family genetic history can affect the occurrence of illnesses in children.

### Overall Findings

The National Healthcare Disparities Report (2004) summarized seven findings concerning research about minority health disparities, which follow:

1. Inequality in quality persists.
2. Disparities come at a personal and societal price.
3. Differential access may lead to disparities in quality.
4. Opportunities to provide preventive care are frequently missed.
5. Knowledge of why disparities exist is limited.
6. Improvement is possible.
7. Data limitations hinder targeted improvement efforts.

# Resources

Agency for Healthcare Research and Quality. 2005. *2005 National Health Care Disparities Report*, Rockville, MD: U.S. Department of Health and Human Services. http://www.ahrq.gov/qual/nhdr05/nhdr05.htm.

Andrulis, D.P. 2005. Moving beyond the status quo in reducing racial and ethnic disparities in children's health. *Public Health Reports, 120*, 370-377.

Commonweath Fund. 2004. A State Policy Agenda to Eliminate Racial and Ethnic Disparities. New York: Author. www.cmwf.org/programs/minority/mcdonough_statepolicyagenda_746.pdf.

Institute of Medicine. 2003. *Unequal Treatment: Confronting Racial and Disparities in Health Care*. Washington, DC: Author. http://www.iom.edu/CMS/3740/4475.aspx.

Lu, M. C., & Halfon, N. (2003). Racial and ethnic disparities in birth outcomes: A life-course perspective. *Maternal and Child Health Journal, 7*, 13-30.

Tennessee Department of Health. 2006. Populations of Color in Tennessee: Health Status Report. Nashville, TN: Author. www2.state.tn.us/health/minorityhealth/Populations_of_Color.pdf.

The Kaiser Family Foundation. (2007, January). Key Facts: Race, Ethnicity, & Medical Care. Retrieved April 20, 2007, from http://www.kff.org/minorityhealth/index.cfm.

Youth Risk Behavior Surveillance Survey 2005, Centers for Disease Control, http://www.cdc.gov/healthyyouth/yrbs/.

**GIS Day on the Hill.** KIDS COUNT Director Pam K. Brown and Emel Eff, KIDS COUNT statistical research specialist, presented KIDS COUNT data at the GIS Day on the Hill this year. Geographic information system software has made it possible for TCCY to present county-by-county and regional data in an easy to understand map format.

# Disparities in Tennessee

The following Tennessee statistics and figures are quoted from *Adolescent and Young Adult Health in Tennessee*, *2006*, and illustrate the current status of health disparities in Tennessee.

- White youth (28.6%) were more likely to report depression than African-American youth (26.8%). Females (37.4%) were almost twice as likely to report depression as males (19.6%). White females (38.1%) are most at risk
  for depression closely followed by African-American females (35.5%).
- White males ages 10-24 are more likely to die from unintentional injuries, the vast majority of which are motor vehicle crashes. African-American males ages 10-24 are almost twice as likely to die by homicide as from an unintentional injury.
- African-American males ages 10-24 are 15 times more likely to die from homicide than White males. There is a large gap between homicide rates for boys (62.6 per 100,000 in 2003) and girls (9.1 per 100,000 in 2003).
  Homicide rates for African-American and White males have declined over the past decade while rates for females have remained steady. Rates for African-American teens have declined sharply since their peak in 1995 of 97.8 per 100,000 to 58.8 per 100,000 in 2003.
- African-American males (19.1%) were more than twice as likely to have
  engaged in sexual intercourse before age 13 than White males (8.2%). African-American males (21.4%) were significantly more likely to have had sex with four or more partners than White males (13.3%).
- Pregnancy rates for Tennessee's African-American females ages 10-17 (25.4) are two and one-half times higher than their White (10.6) counterparts. Another significant trend is that teen pregnancies among Hispanic youth are increasing but are decreasing for all other races.
- White high school students (30%) report binge drinking three times more than African-American students (11%).
- African-American males (55.1%) were more frequent marijuana users than White males (46%), African-American females (39.6%) and White females (37.5%).
- White males are most likely to try smoking (66.5%) compared to White females (60.3%), African-American males (59.8%), and African-American females (50.2%). White males are most likely to be regular smokers (24%) followed by White females (21.8%), African-American males (9.9%) and African-American females (6.9%).