

# Fact Sheet — CDC Health Disparities and Inequalities Report — U.S., 2011



*Persistent health disparities in our country are unacceptable and correctable. The problem must be addressed with dual strategies – both universal interventions available to everyone and targeted interventions for populations with special needs.*

In recent decades, the United States has made substantial progress in improving our residents' health and reducing disparities, but ongoing economic, racial/ethnic, and other social disparities in health still exist. Now, for the first time, the Centers for Disease Control and Prevention (CDC) has issued the *CDC Health Disparities and Inequalities Report — United States, 2011*, which represents a milestone in CDC's long history of working to eliminate disparities.

Released as an *MMWR Supplement*, the report addresses disparities in health-care access, exposure to environmental hazards, mortality, morbidity, behavioral risk factors, disability status, and social determinants of selected health problems at the national level. The report provides an analysis of the recent trends and ongoing variations in health disparities and inequalities in selected social and health indicators. The data highlight the considerable and persistent gaps between the healthiest people and the least healthy.

This fact sheet highlights the results of the report, pointing out how common health disparities and inequalities still are and what can be done about them.



Centers for Disease Control and Prevention  
Office of the Director

# Data Highlights from the CDC Health Disparities and Inequalities Report— United States, 2011

## Social Determinants of Health

- *Education and Income:* Striking disparities in noncompletion of high school and poverty exist within the U.S. adult population and no improvement has been realized from 2005 to 2009. The racial/ethnic disparity in both income and education, compared with non-Hispanic whites, was greatest for Hispanics and non-Hispanic American Indians/Alaska Natives, lowest for non-Hispanic mixed races and Asian/Pacific Islanders, and intermediate for non-Hispanic blacks. Income disparity in noncompletion of high school was greatest for the group with family income below the federal poverty level (poverty-to-income ratio <100%). The percentage of adults with disabilities who did not complete high school was approximately double that of adults without disabilities in both 2005 and 2009 and the proportion of people with disabilities living below the poverty level was more than twice that of people without disabilities.

## Environmental Hazards

- *Inadequate and Unhealthy Housing:* The proportion of unhealthy housing units decreased from 2007 to 2009. Among housing units classified as unhealthy, the magnitude of disparities decreased across racial/ethnic, income, and education-level categories. The disparity by race/ethnicity, socioeconomic status, disability status, and education level, however, is still substantial. Non-Hispanic blacks had the highest percentage of householders living in inadequate, unhealthy housing, followed by Hispanics and American Indians/Alaska Natives.
- *Unhealthy Air Quality:* Particulate matter and ozone have been well-documented as air pollutants that can adversely affect health. During 2006–2008, a total of 53 counties did not meet the standard for fine particulate matter and during 2007–2009, a total of 201 counties did not meet the standard for ozone. For both pollutants, approximately half of these counties are in metropolitan statistical areas of  $\geq 1$  million population. Minority groups, including Asians and Hispanics, were more likely to reside in these counties in comparison with non-Hispanic whites.

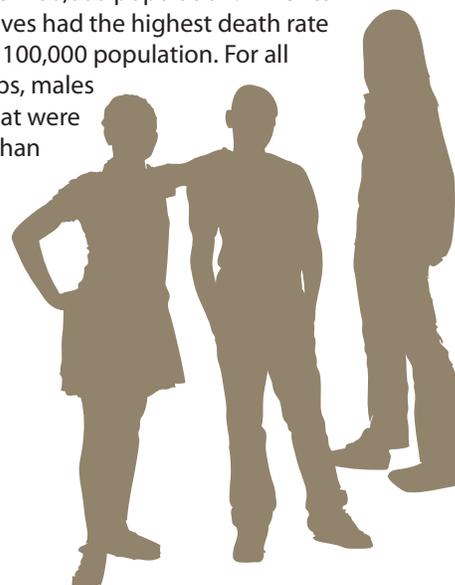
## Health-Care Access and Preventive Health Services

- *Health Insurance Coverage:* Insurance coverage is strongly related to better health outcomes. Substantial disparities in uninsured rates were observed among all the demographic and socioeconomic groups. Disparities by sex existed during both 2004 and 2008, with a higher percentage of males being uninsured. The uninsured rate for young adults aged 18–34 years was approximately double the uninsured rate for adults aged 45–64 years. Hispanics and non-Hispanic blacks had substantially higher uninsured rates, compared with Asian/Pacific Islanders and non-Hispanic whites.

- *Influenza Vaccination Coverage:* During the 2009–2010 influenza season, lower influenza vaccination coverage was observed for non-Hispanic blacks and Hispanics, compared with non-Hispanic whites among all persons aged  $\geq 6$  months. Although racial/ethnic disparities in childhood vaccination coverage have improved throughout the past decade, substantial disparities among adults aged  $\geq 65$  years have persisted.
- *Colorectal Cancer Screening:* Although overall use of colorectal cancer tests increased from 2002 to 2008, disparities exist in the prevalence of colorectal cancer testing among certain groups. Persons aged  $\geq 50$  years who reported having had tests within recommended intervals was greater among persons aged  $\geq 65$  years, than among those aged 50–64 years. The proportion was greater for non-Hispanic whites compared with all other races; men compared with women; persons with a disability compared with those with no disability; and persons with health insurance, compared with those without any type of health insurance coverage.

## Health Outcomes — Mortality

- *Infant Deaths:* In 2006, the overall U.S. infant mortality rate was 6.68 infant deaths per 1,000 live births, with considerable disparities by race and Hispanic origin. The highest infant mortality rate was for non-Hispanic black women with a rate 2.4 times that for non-Hispanic white women. Analysis on trends and variations in infant mortality reveals not only considerable differences in infant mortality rates among racial/ethnic groups but the persistence of disparities over time.
- *Motor Vehicle-Related Deaths:* In 2007, the overall motor vehicle-related age-adjusted death rate for the United States was 14.5 deaths per 100,000 population. American Indian/Alaska Natives had the highest death rate at 29.1 deaths per 100,000 population. For all racial/ethnic groups, males had death rates that were 2–3 times higher than that of females.



- **Suicides:** In 2007, a total of 34,598 suicides occurred in the United States — 83.5% of the suicides were among non-Hispanic whites, 7.1% among Hispanics, 5.5% among non-Hispanic blacks, 2.5% among Asian/Pacific Islanders, and 1.1% among American Indians/Alaska Natives. Suicide rates by race/ethnicity and age group demonstrated different patterns. Though the greatest percentage of suicides occurred among non-Hispanic whites, the highest race/ethnicity and age-specific rates were among American Indian/Alaska Native adolescents and young adults. In each of the racial/ethnic groups, suicide rates were higher for males than for females.
- **Drug-Induced Deaths:** In 2007, a total of 38,371 drug-induced deaths occurred in the United States. Prescription drugs caused more deaths than illicit drugs. Other than Hispanics, all racial/ethnic groups have had increases in drug-induced death rates in recent years. The highest rates overall were among non-Hispanic whites for each year examined.
- **Coronary Heart Disease (CHD) and Stroke:** A comparison of rates by race reveals that black women and men have much higher CHD death rates in the 45–74 age group than women and men of the three other races. A higher percentage of black women (37.9%) than white women (19.4%) died before age 75 as a result of CHD, as did black men (61.5%) compared with white men (41.5%). The same black-white difference was seen among women and men who died of stroke: a higher percentage of black women (39%) died of stroke before age 75 compared with white women (17.3%) as did black men (60.7%) compared to white men (31.1%).
- **Homicides:** In 2007, disparities in homicide deaths by age, race/ethnicity, and sex were evident, and the homicide rate was particularly high among young black males. Homicide rates were highest among persons aged 15–34 years, and the overall rate for males was approximately 4 times that of females. During the 9-year study period, homicide rates were consistently highest among non-Hispanic blacks, but their rates were half of those reported for this demographic group in the early 1990s.
- **Preterm Births:** Approximately one of every five infants born to non-Hispanic black mothers in 2007 was born preterm, compared with one of every eight to nine infants born to non-Hispanic white and Hispanic women. The 2007 preterm birth rate for non-Hispanic black infants was 59% higher than the rate for non-Hispanic white infants and 49% higher than the rate for Hispanic infants.
- **Potentially Preventable Hospitalizations:** During 2004–2007, the rate of preventable hospitalizations was higher among non-Hispanic blacks and Hispanics, compared with non-Hispanic whites. In addition, the rate was lower among Asian/Pacific Islanders, compared with non-Hispanic whites. During the same period, the rate of preventable hospitalizations was higher among residents of the two lower income neighborhood quartiles compared with residents of the highest income neighborhood quartile. Data from the Agency for Healthcare Research and Quality (AHRQ) indicates that eliminating income-related disparities would prevent 1 million hospitalizations and save \$6.7 billion in healthcare costs each year.
- **Current Asthma:** During 2006–2008, an estimated 7.8% of the U.S. population had current asthma. Current asthma prevalence was higher among the multiracial, Puerto Rican Hispanics and non-Hispanic blacks than among non-Hispanic whites. Current asthma prevalence also was higher among children than adults; among females than males; and among the poor than the near-poor and non-poor.
- **HIV Infection:** A total of 35,526 persons aged ≥13 years received a diagnosis of HIV infection in 2005 in the 37 states analyzed, compared with a total of 34,038 in 2008. Racial/ethnic minorities, except Asians, continue to experience a disproportionate burden of HIV diagnoses, as do men who have sex with men (MSM). In addition, disparities continue to widen among black/African-American and American Indian/Alaska Native males, compared with white males, as well as among MSM compared to other males.
- **Diabetes:** Marked disparities in age-standardized prevalence of diagnosed diabetes among U.S. adults were found for all domains. Statistically significant socioeconomic, age, and disability disparities in the age-standardized incidence of diagnosed diabetes also were identified. No evidence indicated that racial/ethnic disparities in prevalence and incidence of diagnosed diabetes decreased from 2004 to 2008; however, socioeconomic disparities worsened during the same interval.

## Health Outcomes — Morbidity

- **Obesity:** Racial/ethnic differences have not changed substantially during 1988–1994 and 2007–2008. Among the majority of sex-age groups, the prevalence of obesity is lower among whites than among blacks and Mexican-Americans. Among females, the prevalence of obesity is highest among blacks, whereas the prevalence among males aged ≤20 years is highest among Mexican-Americans. Differences are limited regarding obesity prevalence across racial/ethnic groups among men aged ≥40 years. An inverse association exists between family income and obesity prevalence among white females (all ages) and white males (aged 2–19 years), but the association is weak or positive (black men aged ≥20 years) among other groups. Racial/ethnic differences in obesity prevalence persist after controlling for differences in family income.
- **Hypertension and Hypertension Control:** During 2005–2008, the age-adjusted prevalence of hypertension among all U.S. adults aged ≥18 years was 29.9%. Among adults with high blood pressure, the overall percentage of adults who had controlled blood pressure was 43.7% in 2005–2008. Substantial differences in hypertension by age group, race/ethnicity, education, family income, foreign-born status, health insurance status, and diabetes, obesity, and disability status existed during 2005–2008. Men, adults aged 18–44 years, Mexican Americans, foreign-born, non-obese persons, persons without health insurance, and persons with diabetes or a disability had a lower prevalence of hypertension control than their counterparts.

## Health Outcomes — Behavioral Risk Factors

- **Binge Drinking:** Binge drinking is common among U.S. adults, especially among males, persons aged 18–34 years, whites, and those with annual household incomes  $\geq$ \$50,000. After adjustment for sex and age, the highest average number of binge drinking episodes during the preceding 30 days (4.9) was reported by binge drinkers whose household income was  $<$ \$15,000, and the average largest number of drinks consumed by binge drinkers (8.4) was reported by American Indians/Alaska Natives.
- **Adolescent Pregnancy and Childbirth:** U.S. birth rates for adolescents vary considerably by race and Hispanic origin. In 2008, the birth rate for Hispanic adolescents was approximately 5 times the rate for Asian/Pacific Islander adolescents, 3 times the rate for non-Hispanic white adolescents, and somewhat higher than the rates for non-Hispanic black and American Indian/Alaska Native adolescents.
- **Cigarette Smoking:** Smoking rates have declined among both male and female non-Hispanic white and non-Hispanic black smokers aged  $\geq$ 18 years. Despite these declines, data for 2006–2008 indicate a much higher smoking prevalence among American Indian/Alaska Native men and women. Persons whose household incomes were below or near the federal poverty level had substantially higher prevalence of smoking, compared with persons whose household incomes were above the federal poverty level. Smoking significantly decreased with increasing levels of educational attainment. Persons who were unemployed also had a high prevalence of smoking.

## What Can Be Done

The data presented throughout the *CDC Health Disparities and Inequalities Report – United States, 2011* provide a compelling argument for action. Some articles identify promising programs and interventions that have been demonstrated to be effective in reducing the burden of disease or risk factors for a specific health problem.



CDC will accelerate its efforts to eliminate health disparities with a focus on surveillance, analysis, and reporting of disparities and the identification and application of evidence-based strategies to achieve health equity.

CDC and its partners can use the findings in this periodic report to raise awareness and understanding of groups that experience the greatest health disparities. The findings also can help motivate increased efforts to intervene at the state, tribal, and local levels to address health disparities and inequalities.

Awareness of the problem is insufficient for making changes, however, and universally applied interventions will seldom be sufficient to address the problems effectively. To reduce health disparities and prevent their recurrence among future generations, the problem must be addressed with dual intervention strategies that include national and locally determined interventions universally available to everyone, as well as targeted interventions available to populations with special needs.

## Actions to Reduce Health Disparities

1. Increase community awareness of disparities as problems with solutions
2. Set priorities among disparities to be addressed at the federal, state, tribal, and local levels
3. Articulate valid reasons to expend resources to reduce and ultimately eliminate priority disparities
4. Implement the dual strategy of universal and targeted intervention strategies based on lessons learned from successes in reducing certain disparities (e.g., the virtual elimination of disparities in certain vaccination rates among children)
5. Aim to achieve a faster rate of improvement among vulnerable groups by allocating resources in proportion to need and a commitment to closing gaps in health, longevity, and quality of life

## For More Information

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*The CDC Health Disparities and Inequalities Report – United States, 2011* is available online at [www.cdc.gov/mmwr](http://www.cdc.gov/mmwr).