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## HEALTH DISPARITIES BY RACE AND ETHNICITY IN NEW JERSEY

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### Abstract

Major disparities exist in health status, access to health care, and health outcomes among the various racial and ethnic groups that comprise New Jersey's population. Data from a number of sources are presented on health measures contrasting status among the major racial groups in the state, as well as for Hispanics, the largest ethnic group in New Jersey. The national health objectives created in *Healthy People 2010* and the related state document, *Healthy New Jersey 2010*, were used as guides. Important findings from the study are that the rate of health insurance coverage is lower among minority populations than in the white non-Hispanic population, mortality and morbidity rates among most minority groups exceed those in the majority white non-Hispanic population and minorities fare worse than the non-minority population in overall measures of health status. Except for two of the leading causes of death and four of the cancer sites studied, indicators for non-Hispanic blacks were always worse than for white non-Hispanics. A particularly wide gap in the premature death rate between black and white non-Hispanics was found. The study also identifies areas where reporting of race and ethnicity is inadequate, leaving unanswered questions regarding health disparities for segments of the state's population.

### Introduction

Despite advances in medical technology and expansion of programs to provide coverage for the costs of health care, major disparities still exist in health status among subgroups of the American population. Health disparity is complex and known to be influenced by many behavioral, social, economic, cultural, biological, and environmental factors.<sup>1</sup> It has long been recognized in the public health community that access to and utilization of health care, health status and outcomes are different depending on, among other factors, the age, gender, race, ethnicity, income and education distributions of the population being assessed. For example, overall death rates and rates for many of the leading causes of death are highest in the oldest age groups. When differences in the age distributions of the populations are taken into account, age-adjusted death rates for each of the ten leading causes of death are higher in males than in females.<sup>2(p93)</sup> Life expectancy at birth for females is six years greater than for males in the U.S.<sup>3(p10)</sup> Death rates among Asians and Pacific Islanders are lowest of the three major racial groups for most causes of death in New Jersey, although there is known to be under-reporting of Asians and Pacific Islanders on the death certificate.<sup>4(p8)</sup> Black death rates are highest for each of the ten leading causes of death.<sup>2(p94)</sup> As stated in *Healthy People 2010, Volume I*, "In general, population groups that suffer the worst health status are also those that have the

highest poverty rates and least education”.<sup>3(p12)</sup> Age, race, ethnicity, gender, income and education are the variables for which data are most likely to be available. Many of the other factors known to be related to health disparities (e.g., attitudes and beliefs about health care, cultural influences) are not routinely collected and the ways in which all of these factors interact to affect health status are poorly understood.

Much of the current effort at the governmental level (both state and federal) is centered on health disparities by race and ethnicity. In 1998, President Clinton launched the Racial and Ethnic Health Disparities Initiative to eliminate racial/ethnic differences in six health areas by the year 2010. This initiative served to focus attention on the degree to which minority populations face higher disease incidence and mortality rates than whites, despite considerable improvements in the nation’s overall health during recent decades.<sup>5</sup> Two years later, the U.S. Department of Health and Human Services released *Healthy People 2010* (HP2010) a set of health objectives for the nation to be met by the end of the decade. One of two goals which guide and direct this process is the elimination of “health disparities among different segments of the population”.<sup>3(p11)</sup> New Jersey’s response to this process was the development in 2001 of *Healthy New Jersey 2010: A Health Agenda for the First Decade of the New Millennium* (HNJ2010). For this initiative, New Jersey adopted the same framework as HP2010, including a goal of elimination of health disparities by 2010. Major emphasis in the set of objectives developed for HNJ2010 was placed on eliminating health disparities by race and ethnicity.

The classification of populations by race and ethnicity for purposes of targeting those groups with the least access and the greatest health problems is not without controversy.<sup>6(p2)</sup> Some researchers say that the underlying concept of race/ethnicity and the manner in which it is derived (generally through self reports) are imprecise and arbitrary. Others respond that race/ethnicity is intended as a surrogate measure for those factors influencing disparities which can’t be measured. Whatever the merits of these arguments, major disparities are identified upon analysis of health data by race/ethnicity and these data enable development and implementation of programs targeted to groups most in need. Therefore, race/ethnicity will continue to be used as a variable for analysis, until more precise measurement of the factors affecting health is possible. Data will be presented here for the major racial and ethnic groups in New Jersey: white; black (or African American); Asian and Pacific Islander; and Hispanic (or Latino) ethnicity.

## **Data and Methods**

Data on race from vital statistics records in New Jersey (births and deaths) are reported in fifteen categories: White, Black, American Indian, Chinese, Japanese, Hawaiian, Filipino, Asian Indian, Korean, Samoan, Vietnamese, Guamanian, Other Asian or Pacific Islander, Other Races and Not Classifiable. Hispanic ethnicity is recorded separately from race, specific to the country of origin. Other major New Jersey governmental data systems generally provide fewer racial categories. Some important data systems treat race and ethnicity as a single characteristic.

Equally important for the computation of rates are the values of race and ethnicity available for denominators. Detailed race and Hispanic ethnicity data are available every ten years with the release of data from the decennial censuses. Intercensal estimates for the decade of the 1990s are available from the U.S. Census Bureau in four racial categories: (1) White, (2) Black, (3) American Indian or Alaskan Native and (4) Asian or Pacific Islander. Estimates of the Hispanic and non-Hispanic components of each of the four racial groups are provided. Computation of rates for recent years is thus limited to eight categories: White Hispanic; White

non-Hispanic; Black Hispanic, Black non-Hispanic; American Indian/Alaskan Native Hispanic; American Indian/Alaskan Native non-Hispanic; Asian/Pacific Islander Hispanic; and Asian/Pacific Islander non-Hispanic.

A major obstacle to a detailed investigation of disparities among racial and ethnic groups is the small frequencies of events for some groups. Population counts from the U.S. Census of 2000<sup>7</sup> indicate that there were 6,104,705 whites, 1,141,821 blacks, 480,276 Asians, 3,329 native Hawaiian and other Pacific Islanders, 19,492 American Indians and Alaskan natives, 450,972 persons of other races and 213,755 residents who reported two or more races living in New Jersey. The number of Hispanics of any race was 1,117,191. Vital events which occur at low rates in the total population are relatively rare in smaller racial groups. Computation of rates for smaller racial groups in cases where frequencies are rare results in unstable rates. For this reason, rates with fewer than twenty occurrences in the numerator will not be presented in this study. In addition, to minimize fluctuations that occur in working with small numbers, rates in general will be computed as three-year averages. Age-adjusted death rates will not be presented when the total number of deaths over three years is less than 50.

Under-reporting of some racial groups and Hispanic ethnicity causes another limitation on health data reported by race and ethnicity. In a recent study of the quality of reporting of race and Hispanic ethnicity in death records and population estimates,<sup>4(p8)</sup> it was found that biases in the numerators and denominators of death rates tend to offset each other to some degree. However, net effects of race misclassification and under coverage remain, particularly for smaller minority populations. Specifically, it was found that, for the U.S., published death rates for the white and black populations are overstated by 1.0 and 5.0 percent, respectively (primarily due to undercounting of these populations in the census), while rates for minority groups other than black were understated: American Indians by 21 percent; Asian or Pacific Islanders by 11 percent; and Hispanics by 2 percent. These findings apply to the country as a whole; comparable percentages of understatement for specific racial groups and Hispanics are not available for states. No conclusions should be drawn as to the applicability of these results to New Jersey death and population data.

Quantification of the bias in race and ethnicity reporting in other data sets used in this report is not available. However, in view of the current state of the art in data collection, there is reason to believe that misclassification and under-reporting exist to some degree in all of the major health data systems available for this type of analysis. No attempt to correct for the inaccuracies in reporting of race and ethnicity has been made in the data used in this report. Therefore, the potential biases in the data should be considered when utilizing the results.

## **Results**

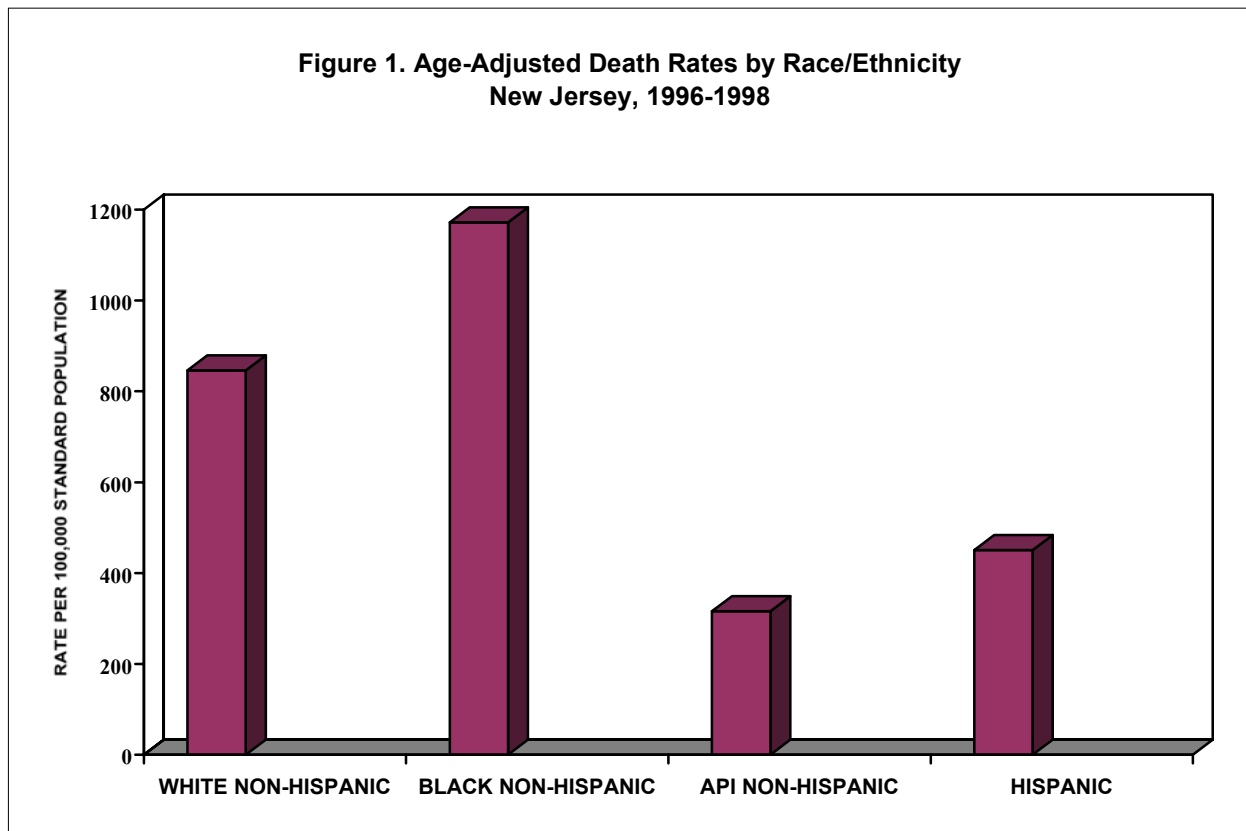
### **Overall Health Status and Access to Health Care**

When the effect of the age distributions of the populations are removed through age-adjustment (using the direct method and the year 2000 standard population), the overall death rate for all causes is highest in the black non-Hispanic population (Figure 1 and Table 1). The lowest age-adjusted death rates are found in the non-Hispanic Asian/Pacific Islander population. A study of variation in death rates in another state suggested that there is a “healthy migrant effect” that may have a positive impact on death rates for racial and ethnic groups with a large proportion of recent immigrants.<sup>6(p15)</sup> Additional study has shown under-reporting on death certificates of race and ethnicity in the Hispanic and Asian/Pacific Islander populations.<sup>4</sup> There may be other

factors, currently not quantifiable, that are responsible for the low overall death rates in these two minority groups.

These same disparities pertain to other measures of overall health. Health disparities are particularly evident in deaths at early ages. One measure of premature death is the rate of Years of Potential Life Lost to Age 65 (YPLL). The rate of YPLL in the black non-Hispanic population in 1996 through 1998 was 2.7 times the YPLL rate in the white non-Hispanic population (Table 1). The high YPLL rate in the black population is particularly influenced by relatively high rates of deaths at young ages from homicide, HIV infection and stroke compared to the rates from these causes in the white population.<sup>2(p99)</sup> The YPLL rate for Hispanics during the three years, 1996 through 1998, is very close to the white non-Hispanic rate and the YPLL rate for Asians and Pacific Islanders is the lowest of all the racial and ethnic groups examined. Again, under-reporting of Hispanic ethnicity and Asian and Pacific Islander racial groups on death certificates may be at least partly responsible for the low YPLL rates in these two groups. Life expectancy at birth for white and black populations (including Hispanics in both cases) is quite different: the life expectancy for whites is 6.5 years or 9.1 percent greater than that for blacks (Table 1). This difference is due to the differential mortality rates between these two populations, particularly at early ages.

Lack of health insurance in the population under the age of 65 by race and ethnicity point out a critical area of disparity related to access to health care. The uninsured rate among



**Source: New Jersey Department of Health and Senior Services, Center for Health Statistics** the Hispanic population in 1999 was more than twice the white non-Hispanic rate. The rate of uninsured in the Asian/Pacific Islander population was particularly high, and the black rate of uninsured was also elevated (Table 1). The percentage of children under the age of 19 without

health insurance was also more than twice as high among Hispanics as in white non-Hispanics. While increased government support for children's health insurance has increased overall insurance rates for children in recent years, largely immigrant populations may have lower insurance rates due to ineligibility. Unlike the rates among the population under 65 years, the rate of uninsured non-Hispanic black children under 19 was not substantially greater than in white non-Hispanic children. Government-sponsored programs of health insurance for children may have served to diminish the difference in coverage found in this population. Among workers with children, there were major differences in the uninsured populations: the Hispanic uninsured rate approached three times and the black non-Hispanic uninsured rate was higher than the white non-Hispanic rate.

<b>Table 1. Selected Overall Health Measures New Jersey, By Race And Hispanic Ethnicity</b>				
<b>Measure (Years)</b>	<b>White non-Hispanic</b>	<b>Black Non-Hispanic</b>	<b>Asian/Pacific Islander Non-Hispanic</b>	<b>Hispanic</b>
Total Age-Adjusted* Death Rate (1996-1998)	845.8	1,172.0	315.7	450.7
Rate Of Years of Potential Life Lost To Age 65 (1996-1998)	3,643.7	9,711.0	1,650.0	3,617.2
Life Expectancy at birth (1996-1998)	78.1**	71.6**	DSU	DSU
% Population <65 Without Health Insurance (1999)	11.5	17.5	22.2	28.9
% Children <19 Without Health Insurance (1999)	8.1	10.0	13.6	19.6
% Uninsured Workers 19-64 With Uninsured Children (1999)	10.0	13.3	8.9	29.2
% Persons 18+ With Source Of Primary Care (1996)	84.9	80.8***	DSU	73.9***
% Persons Using A Dentist or Dental Clinic Within Past Year (1996-1998)	75.9	62.2	DSU	66.0***
Ambulatory Care Sensitive Admission Rate, Population <65 (1998)	12.4	29.6	DSU	15.0
Ambulatory Care Sensitive Admission Rate, Children <5 (1998)	21.4	51.9	DSU	37.8
% Newborns Enrolled In the Immunization Information System (1998)	41.3	39.3	35.4	40.6
% Of Persons 18+ Reporting Good, Very Good or Excellent Health (1996-1999)	88.1	79.0	DSU	84.6
*Year 2000 Projected Population Used As Standard Population For Age-Adjustment				
**Includes Hispanics				
***Estimate Has Standard Error Greater Than 2.0 Percent				
DSU = Data statistically unreliable				

Sources: New Jersey Department of Health and Senior Services: Center for Health Statistics, Division of Communicable Disease, Division of Health Care System Analysis, Behavioral Risk Factor Surveillance System  
U.S. Bureau of the Census, Current Population Survey

Given the differences among race/ethnicity groups in insurance coverage, it is not surprising that the white non-Hispanic population more frequently reported having a source of primary care. Non-Hispanic whites were also more likely to report using the oral health care system than were blacks and Hispanics. Enrolling newborns in the Immunization Information System at the time of birth is the first step in a program of prevention of communicable diseases for which vaccines are available. In 1998, rates of enrollment were low among all racial/ethnic groups, but did not vary much except among Asian and Pacific Islander newborns who had a somewhat lower rate than other groups.

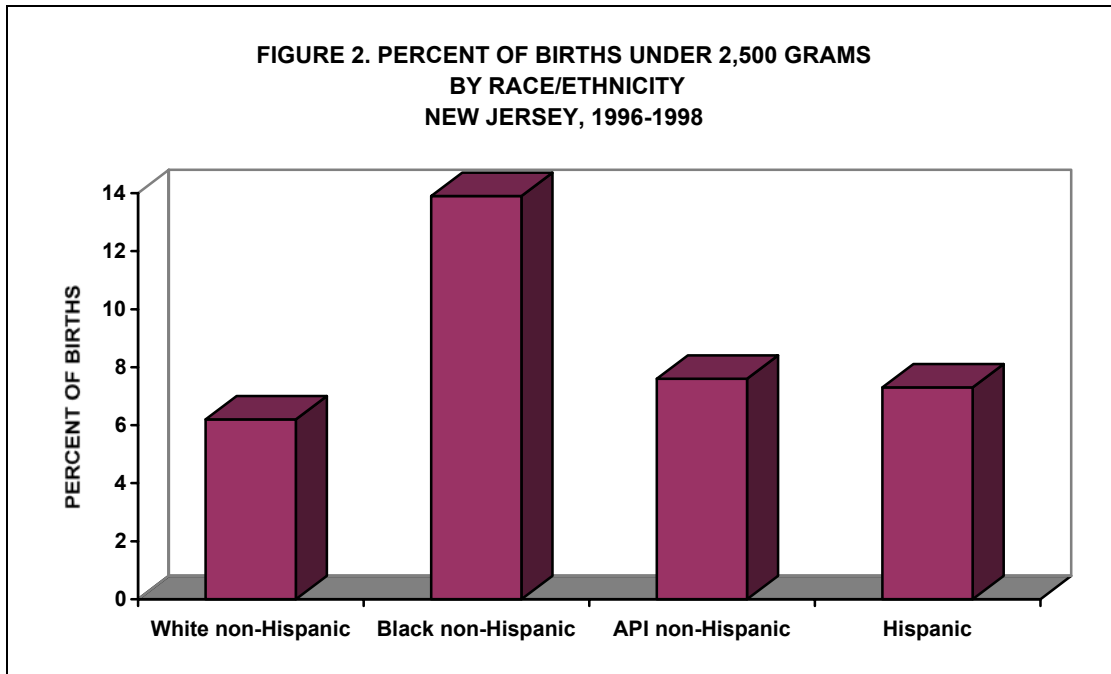
Ambulatory care sensitive (ACS) conditions are those for which most hospitalizations are thought to be avoidable if adequate primary care has been received. Thus rates of hospitalization for these conditions can be viewed as a measure of access to primary care. Among conditions classified as ACS are immunization preventable conditions, severe ear, nose throat infections, chronic obstructive pulmonary diseases, and bacterial pneumonia. As shown in Table 1, the admission rates for these conditions are more than twice as high in black as in white non-Hispanic populations. Rates of hospitalization for ACS conditions in Hispanic populations were also higher than in non-Hispanic whites, and the disparity was more pronounced in children under five than in the population under 65. Not surprisingly, the percentages of the population 18 and over in the various race/ethnicity groups reporting good, very good or excellent health show considerable variation: 88.1 percent of non-Hispanic whites compared to 79.0 percent of non-Hispanic blacks, with an intermediate rate of 84.6 for Hispanics.

## Natality

Important indicators of the health of pregnant women and newborns are weight at birth, receipt of early prenatal care, use of tobacco during pregnancy, breastfeeding, and births to teen mothers. Each of these indicators shows disparities among the race/ethnicity groups under study.

The usual definition of low birth weight is weight at birth under 2,500 grams. The percent of newborns who weigh less than 2,500 grams has been slowly, but steadily, increasing in New Jersey during recent years. This has occurred despite a decline in the infant mortality rate over the same time period.<sup>2</sup> Disparities exist in the percent of low birth weight among newborns to mothers of different race and ethnicity. In 1996 through 1998, the percent of births to non-Hispanic black mothers that were of low birth weight was more than twice the comparable rate in non-Hispanic white mothers (Figure 2 and Table 2). The percentages of low birth weight births to Asian/Pacific Islander and Hispanic mothers were each slightly higher than the rate among non-Hispanic white births.

A number of factors are known to be related to the birth weight of a newborn. Smoking of cigarettes during pregnancy is among the factors having an effect on birth weight. Estimates of the percent of mothers who reported abstaining from smoking during pregnancy are shown in Table 2. More than ninety percent of Asian/Pacific Islander and Hispanic mothers say they did not smoke, while just over eighty percent of non-Hispanic black and white mothers reported that they abstained from smoking.



Source: New Jersey Department of Health and Senior Services, Center for Health Statistics

Breastfeeding is thought to be the ideal source of nourishment for infants for the first four to six months of life. Breast milk is known to impart a wide range of benefits for infants' health, growth and development, as well as providing immunity from a number of infectious diseases. At discharge from the hospital, at best only slightly more than half of mothers were breastfeeding (white non-Hispanic mothers); at worst, just over 20 percent were (black non-Hispanic mothers). Non-Hispanic white and Asian/Pacific Islander mothers were breastfeeding at the highest rate upon leaving the hospital after delivery, while non-Hispanic black and Hispanic mothers had the lowest rates of breastfeeding (Table 2).

MEASURE (YEARS)	WHITE NON-HISPANIC	BLACK NON-HISPANIC	ASIAN/PACIFIC ISLANDER NON-HISPANIC	HISPANIC
Percent Low Birth Weight Births (1996-1998)	6.2	13.9	7.6	7.3
Abstaining from Smoking During Pregnancy (1996-1998)	82.7	82.2	96.9	82.2
Breastfeeding at Discharge (1998)	52.0	22.4	48.3	29.4
Rate of Births to Teens/1000 Population (1996-1998)	6.6	42.6	2.9	40.4
Percent 1 <sup>ST</sup> Trimester Prenatal Care (1996-1998)	83.5	59.8	79.4	68.7

Source: New Jersey Department of Health and Senior Services, Center for Health Statistics

Infants born to teenaged mothers are more likely to be of low birth weight, have low five-minute Apgar scores, and die before the first birthday. Teenaged mothers are less likely to receive early prenatal care and more likely to be unmarried.<sup>2(pp38,45)</sup> Major differences exist in the teen birth rates by race and ethnicity: non-Hispanic Asian and Pacific Islander teens have very low birth rates, followed closely by non-Hispanic whites, while Hispanic and black non-Hispanic adolescent females have elevated rates (Table 2).

Early prenatal care can prevent many negative pregnancy outcomes, but here too disparities exist among race/ethnicity groups. White and Asian/Pacific Islander non-Hispanics make a first prenatal care visit within the first trimester of pregnancy at higher rates than other groups, and non-Hispanic blacks have the lowest rates of early prenatal care. Hispanic mothers have an intermediate early prenatal care rate (Table 2).

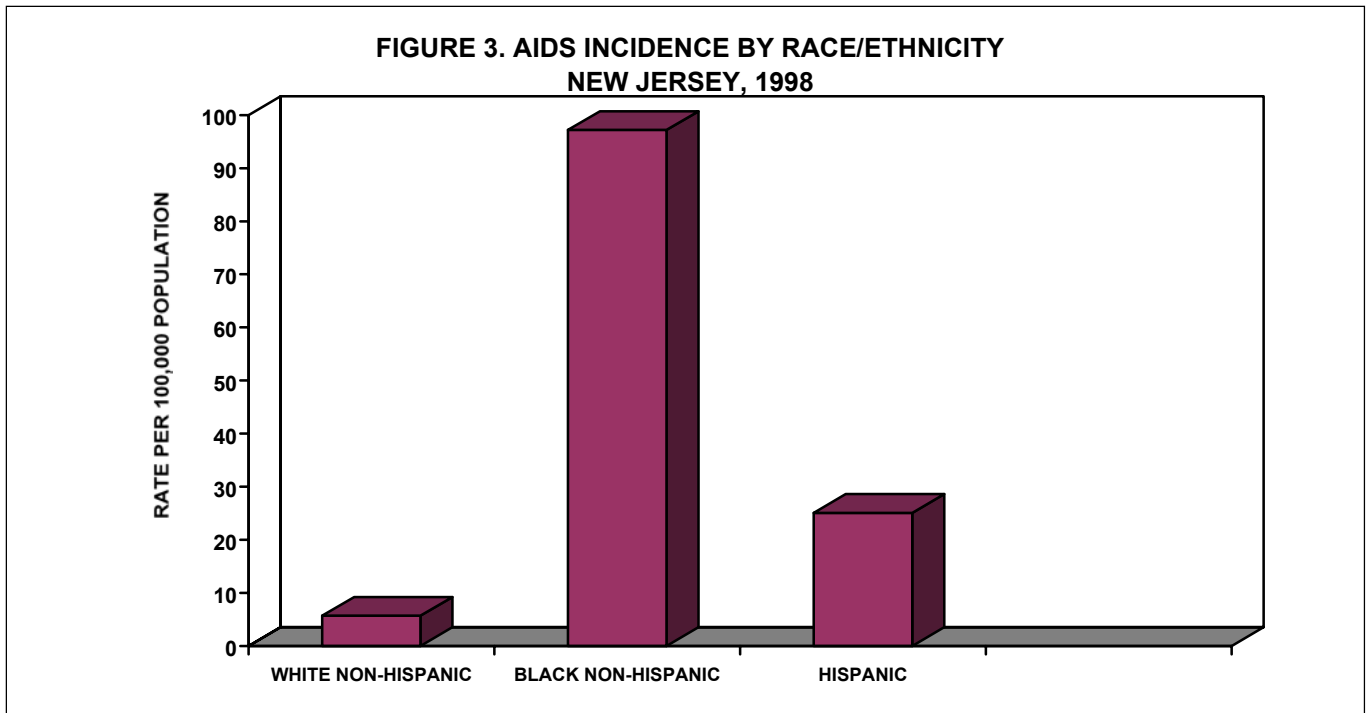
### Morbidity

Major disparities by race and ethnicity are found in the incidence of reportable diseases, both communicable and chronic. Incidence rates of AIDS in the total population are almost twenty times as high among black non-Hispanics as in non-Hispanic whites. AIDS incidence rates in Hispanics are intermediate between the other two groups (Figure 3 and Table 3). The incidence of HIV disease is defined as including both persons diagnosed as having AIDS and persons diagnosed with HIV during the year and still alive who have not progressed to symptoms associated with AIDS. In 1998 the disparity in the incidence rate of HIV disease among females was particularly wide: the incidence rate in black non-Hispanic females 15 through 44 years of age was about 23 times the rate in same-age non-Hispanic white females. The gap in the HIV disease incidence rate in males 15 through 44 years, while wide, was not as great as in females (Table 3).

The New Jersey tuberculosis incidence rate in 1998 was almost nine times as high in Asian/Pacific Islanders as in whites. Incidence rates in black and Hispanic populations, while high, were about one-half as high as the Asian and Pacific Islander rate (Table 3).

Cancer incidence data for Asian/Pacific Islanders and Hispanics are either not sufficiently stable or are under-reported, so that valid incidence rates for these groups cannot be presented. Table 3 presents age-adjusted black and white incidence rates for three selected cancer sites: invasive cervical cancer; cancer of the rectum and rectosigmoid; and invasive melanoma. The incidence rate of invasive cervical cancer is 71 percent higher in black females than in whites, but in the other two types of cancer, cancer of the rectum and rectosigmoid and invasive melanoma, the white incidence rate is higher than the black rate.





Source: New Jersey Department of Health and Senior Services, Division of AIDS Prevention and Control

Estimates of the prevalence of asthma in the population are not readily available, so rates of medical care utilization are viewed as an acceptable indicator for the volume of asthma problems in the population. Outpatient and emergency department data are not currently available in this state, however, thus inpatient hospital rates are used to estimate the gap in prevalence and/or in access to primary care for this condition. Hospitalization rates for this condition evidence large disparities by race, in both the total population and in children under the age of five (Table 3). The asthma hospitalization rates for Hispanics fall between the high rates found in black non-Hispanics and the lower rates in non-Hispanic whites. The hospital discharge file does not provide data of adequate quality for the Asian/Pacific Islander population.

The most frequent cause of end-stage renal disease (ESRD) is diabetes. This condition is preventable through early diagnosis of kidney disease. Disparities exist in this condition by race and ethnicity: the 1999 incidence rate in non-Hispanic blacks was almost three times the rate in white non-Hispanics. Rates of ESRD in Hispanics with diabetes were also high relative to the lowest rate: the 1999 rate was about twice the rate in non-Hispanic whites.

**TABLE 3. SELECTED MORBIDITY MEASURES  
NEW JERSEY, BY RACE AND HISPANIC ETHNICITY**

MEASURE (YEARS)	WHITE NON-HISPANIC	BLACK NON-HISPANIC	ASIAN/PACIFIC ISLANDER NON-HISPANIC	HISPANIC
AIDS Incidence Per 100,000 Population (1998)	5.7	97.2	DSU	25.1
HIV Disease Incidence in Females 15-44 Per 100,000 Population (1998)	7.3	166.3	DSU	32.5
HIV Disease Incidence In Males 15-44 Per 100,000 Population (1998)	18.2	229.3	DSU	91.6
Tuberculosis Incidence Per 100,000 Population (1998)	4.3	17.5	35.0	15.1
Age-Adjusted Incidence Rate Of Invasive Cervical Cancer Per 100,000 (1996)*	9.0	15.4	DSU	DSU
Age-Adjusted Incidence Rate Of Cancer Of the Rectum and Rectosigmoid Per 100,000 (1996)*	15.0	10.9	DSU	DSU
Age-Adjusted Incidence Rate Of Invasive Melanoma Per 100,000 (1996)	9.0	0.4	DSU	DSU
Total Asthma Hospitalization Rate Per 100,000 Population (1998)	101.3	428.0	DSU	241.6
Asthma Hospitalization Rate Of Children <5 PER 100,000 Population (1998)	278.6	1,306.2	DSU	550.5
ESRD Due To Diabetes Incidence Per 1,000 Persons 18+ With Diabetes (1999)	3.8	10.5	DSU	7.3
* Cancer incidence data are presented for persons of black and white races, including Hispanics. DSU = Data statistically unreliable.				

Sources: New Jersey Department of Health and Senior Services: Division of AIDS Prevention and Control, Division of Epidemiology, Environmental and Occupational Health, Division of Health Care System Analysis  
The Trans-Atlantic Renal Council

### Leading Causes of Death

Death rates adjusted to the year 2000 standard population are higher for blacks than for whites, Asian Pacific Islanders or Hispanics for each of selected leading causes of death except COPD and suicide. (Table 4). The ratios of the non-Hispanic black age-adjusted rates to the comparable white rates are particularly high for HIV infection (a ratio of 15.1) and for homicide and legal intervention (a ratio of 8.6). Additionally, the non-Hispanic black death rates from diabetes, nephritis and nephrosis and unintentional injuries other than those related to motor vehicles are each two times or more the non-Hispanic white rate, when the effect of age

differences in the two populations has been removed. A major factor in the disparity in unintentional injury deaths not related to motor vehicles is drug poisoning, which includes

<b>Cause of Death (ICD-9)</b>	<b>Black non-Hispanic</b>	<b>White non-Hispanic</b>	<b>Asian/Pacific Islander Non-Hispanic</b>	<b>Hispanic</b>	<b>Ratio of Black/White Rates</b>
Diseases of the heart (390-398,402, 404-429)	310.8	286.8	93.0	127.5	1.1
Malignant Neoplasms (140-208)	271.0	217.9	86.0	96.9	1.2
Cerebrovascular Diseases (430-438)	72.5	49.3	30.3	24.1	1.5
HIV Infection (042-044)	72.3	4.8	DSU	16.4	15.1
Diabetes Mellitus (250)	59.5	25.4	13.6	23.7	2.3
Pneumonia/Influenza (480-487)	34.5	29.9	DSU	14.5	1.2
Chronic Obstructive Pulmonary Diseases (490-496)	31.7	33.9	DSU	14.5	0.9
Septicemia (038)	28.3	14.6	DSU	11.0	1.9
Motor Vehicle-Related Injury (E810-E825)	12.9	10.2	5.2	7.2	1.3
Other Unintentional Injury (E800-E807, E826-E949)	28.1	14.3	DSU	12.2	2.0
Nephritis & Nephrosis (580-589)	25.2	11.8	DSU	8.9	2.1
Homicide & Legal Intervention (E960-E978)	16.4	1.9	DSU	5.0	8.6
Chronic Liver Disease & Cirrhosis (571)	11.2	8.9	DSU	9.1	1.3
Suicide (E950-E959)	5.2	8.0	DSU	4.4	0.7

DSU = Data statistically unreliable. The total number of deaths over 3 years was less than 50.

Source: New Jersey Department of Health and Senior Services, Center for Health Statistics

drug overdoses. Drug poisoning was the leading cause of unintentional injury deaths in non-Hispanic blacks and Hispanics in 1998 and was the second leading cause of unintentional injury deaths among non-Hispanic whites, following motor vehicle-related injuries.

There is substantial variation in cancer death rates by site by race (Table 5). For a few sites, three-year average age-adjusted death rates are lower for non-Hispanic blacks than for white non-Hispanics (bone, skin, connective tissue, nervous system, and urinary organ cancer and leukemia). For the remaining sites, the black non-Hispanic rate was higher than the comparable

<b>TABLE 5. AGE-ADJUSTED RATES FOR CANCER DEATHS BY SITE AND RACE/ETHNICITY NEW JERSEY, 1996-1998</b>					
<b>Cancer Site (ICD-9)</b>	<b>Black non- Hispanic</b>	<b>White non- Hispanic</b>	<b>Asian/Pacific Islander Non-Hispanic</b>	<b>Hispanic</b>	<b>Ratio of Black/White Rates</b>
Colon and Rectum (153-154, 159.0)	31.8	24.9	DSU	10.1	1.3
Other Digestive Organs (150-152, 155- 158, 159.1-159.9)	39.7	27.8	24.8	16.1	1.4
Lung Including Bronchus (162.2-162.9)	70.1	59.1	17.1	19.5	1.2
Bone, Skin, Connective Tissue (170-173)	3.2	6.3	DSU	DSU	0.5
Female Breast (174)	41.3	33.4	DSU	14.7	1.2
Cervix Uteri (180)	6.7	2.7	DSU	DSU	2.5
Prostate (185)	69.4	32.3	DSU	17.2	2.1
Urinary Organs (188-189)	9.4	10.1	DSU	4.1	0.9
Nervous System (191-192)	3.3	5.4	DSU	DSU	0.6
Leukemia (204-208)	6.6	8.0	DSU	4.5	0.8
Other Hematopoietic Tissue (200-203)	15.2	13.4	DSU	7.7	1.1

DSU = Data statistically unreliable. The total number of deaths over 3 years was less than 50

Source: New Jersey Department of Health and Senior Services, Center for Health Statistics

white rate. The ratio of the black non-Hispanic and white non-Hispanic death rates were particularly high for cervical (a ratio of 2.5) and prostate (a ratio of 2.1) cancer. Cancer death rates for non-Hispanic blacks were also substantially higher than comparable white rates for cancers of the colon and rectum and other digestive organs.

Death rates from the various cancer sites for Asians/Pacific Islanders and persons of Hispanic origin are either lower than rates for either black or white non-Hispanics or not presented because of small numbers of deaths. Due to known under-reporting of these groups on death certificates, it is not possible to draw conclusions about the relative magnitude of cancer deaths by site for these two groups.

## **Discussion**

This examination of a number of measures of health status and outcomes has revealed a dramatic disparity in these selected measures between racial groups in New Jersey. On almost every measure examined, the black non-Hispanic population exhibits poorer health status. Indicators studied included morbidity, mortality, natality, self-assessment of health status, and health insurance coverage. With the exception of two major causes of death – chronic obstructive pulmonary disease and suicide – and death rates from four of the cancer sites studied, indicators for non-Hispanic blacks were always worse than for white non-Hispanics. Particularly disturbing is the wide gap in the premature death rate between black and white non-Hispanics. Major contributors to the elevated premature death rates for non-Hispanic blacks are HIV infection deaths, homicides, stroke and deaths from drug overdoses.

Small numbers of cases prevented a thorough examination of many health measures for Asians and Pacific Islanders, the fastest growing racial group in New Jersey. Additionally, the under-reporting of this racial group on the death certificate results in death rates that are known to be understated. These limitations restrict the comprehensiveness of the analysis of health measures within this population. However, for the indicators for which the Asian/Pacific Islander population may be adequately represented, some disparities are evident. When compared to the non-Hispanic white population, the uninsured rate is higher, enrollment in the Immunization Information System is lower, the percent of low birth weight births is higher, and tuberculosis incidence is much higher in non-Hispanic Asian/Pacific Islanders.

The fastest growing minority group in New Jersey is comprised of persons of Hispanic ethnicity. Some of the same reporting problems that exist in the reporting of the Asian/Pacific Islander population exist also for Hispanics, particularly regarding reporting on the death certificate. Death rates derived from death records are known to be understated for Hispanics.<sup>4(p8)</sup> However, other types of health data reveal substantial disparities in access and outcomes for Hispanics. The percentage of the population without health insurance is higher in the Hispanic population in New Jersey than in the other groups studied. It follows that this group also has the lowest percent of adults with a source of primary care. The hospitalization rate of Hispanics for ambulatory care sensitive conditions is also higher than in non-Hispanic whites, particularly for children under the age of five. Hispanics also have a relatively high percent of low birth weight births, as well as high rates of births to teen mothers. Low rates of early prenatal care and breastfeeding at discharge from hospital compared to white non-Hispanic mothers were revealed. The rates of HIV disease, hospitalizations for asthma and end stage renal disease due to diabetes are high in the Hispanic population, compared to white non-Hispanics.

Presentation of health status and outcome indicators for major race and ethnicity groups is intended to highlight a number of the existing health disparities in the state. The expectation is that this knowledge will be used to develop and implement policies and programs which will address and eliminate the wide gaps in health status that exist among residents of the state.

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