

Health inequities in the Twin Cities

An update to the 2010 report, *The unequal distribution of health in the Twin Cities*

In 2010, the Blue Cross and Blue Shield of Minnesota Foundation commissioned a report called *The Unequal Distribution of Health in the Twin Cities*. Wilder Research used 2000 Census data to look at the influence of race, income, education and neighborhood conditions on health outcomes. This report found that, among other things:

- An 8-year difference in average life expectancy exists between residents living in our region's highest income areas and residents living in our region's lowest income areas.
- Overall, poorer health outcomes were tied to both poverty and lower levels of education.
- Average life expectancy varied widely by race, from 83 years for Asians to 61.5 years for American Indians.

These findings suggested that in our region, just as in other places, social determinants – the economic and social factors that influence the neighborhood conditions in which we live, work and play – are strongly connected to our health and contribute to health inequities. This updated report uses the most recent census data available to look at changes in health inequities in our region since 2000 and highlight recent demographic trends that offer both opportunity and challenges down the road.

Reducing health inequities continues to be an important issue if we are to ensure that all people reach their full health potential. The updated report found that since 2000:

- The gap in life expectancy rates between the most and least affluent neighborhoods in our region has narrowed, yet children born in the highest income areas are still expected to live six years longer on average than those born into the lowest income areas.
- Poorer health outcomes continue to be tied to both poverty and lower levels of education. While life expectancy has generally improved throughout the region, the greatest increases in life expectancy were made in poorer neighborhoods. Worsening socioeconomic conditions in our region may threaten these gains.
- Age-adjusted mortality rates improved among all racial/ethnic groups except U.S.-born African American residents. In addition, considerable differences in health outcomes remain between different racial and ethnic groups. Mortality rates among American Indian and U.S.-born African American residents are notably higher than the regional average.

In short, both encouraging and discouraging changes in health outcomes have occurred over time, but the underlying factors that influence these health outcomes remain the same. In our region, we continue to see that neighborhood, income, education and race all matter to health.

Key findings

Overall, Twin Cities residents are living longer.

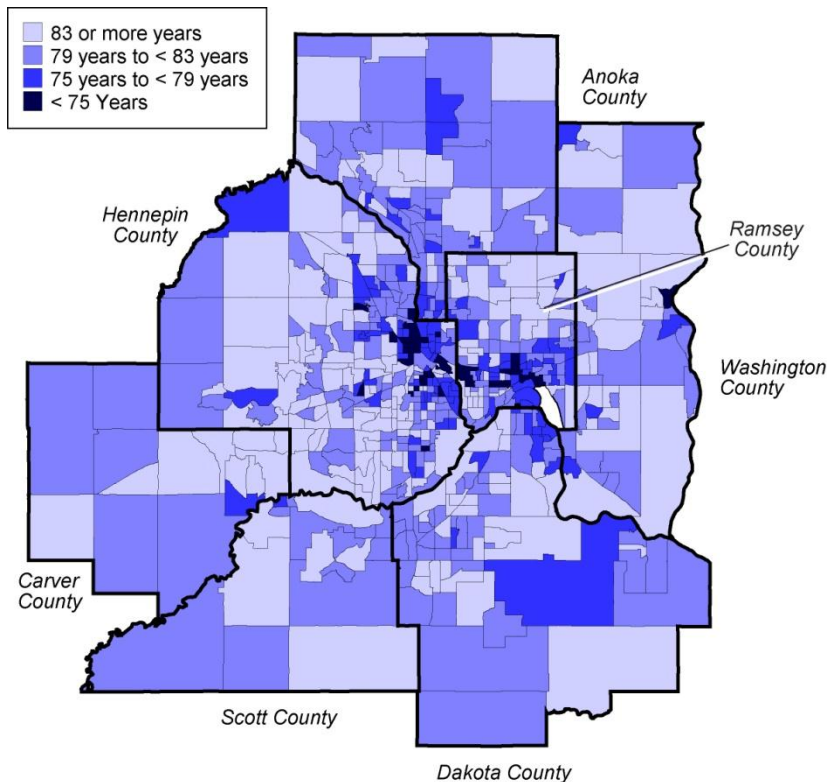
The average life expectancy in our region is 81 years, higher than the national average of 76.5. Between 2000 and 2007, average life expectancy in our region increased just over 1.5 years, similar to national averages.



In our region, place, income, education and race all matter to health.

Where you live matters. Neighborhoods with the longest life expectancies tend to be located in more affluent neighborhoods located in second- and third-ring suburban communities. Neighborhoods with the shortest life expectancies continue to be located predominantly in the central cities of Minneapolis/St. Paul – which contain neighborhoods with the lowest incomes and also with the highest concentrations of communities of color.

Figure 1. Life expectancy by median household income group of census tract neighborhoods (2007)



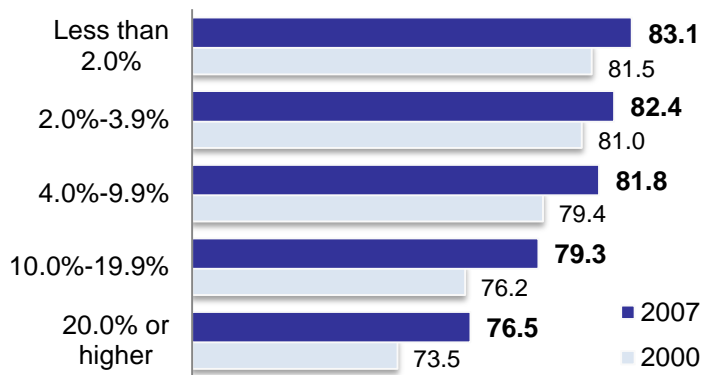
There are strong associations between socioeconomic status, place and health. Health outcomes tend to be better in areas with higher household incomes, less concentrated poverty and higher levels of education. When we compared life expectancies between groups of neighborhoods in our region, we found:

- Children born into neighborhoods with the lowest average household incomes (less than \$35,000) have a life expectancy of 76 years, compared to 84 years for children born into more affluent neighborhoods with average annual household incomes of \$75,000 or more.
- Life expectancy for children born in federal poverty areas (meaning more than 20% of residents lived in poverty) was 77 years, compared to 83 years for children born into neighborhoods with the lowest rates of poverty.

- Similarly, average life expectancy was 77 years for children born into neighborhoods with the fewest adults with a post-secondary education (a bachelor's degree or higher), six years less than for children in the region's most educated neighborhoods.

The gap in life expectancies between the most and least affluent communities in our region may have narrowed, but health inequities persist. Life expectancies improved across the region, with data suggesting greater gains occurring in the least affluent neighborhoods. While this change is positive, children born into neighborhoods with the highest concentrations of poverty are still expected to live an average of 6.6 years less than those born into neighborhoods with the lowest poverty rates. Similar inequities are found when comparisons are made based on other measures of socioeconomic status (median household income and educational attainment).

Figure 2. Life expectancy by poverty rate group of census tract neighborhoods (2000, 2007)



Mortality rates for American Indian and African American (U.S.-born) residents are much higher than the average of any other racial/ethnic group and for all Twin Cities residents combined. In 2007, the mortality rates for African American (U.S.-born) and American Indian residents were 3 – 3.5 times higher than the average for other racial and ethnic groups.

Mortality rates improved among most, though not all, racial/ethnic groups. While age-adjusted mortality rates improved overall and for most racial/ethnic groups, this measure of health was slightly worse for African American (U.S.-born) residents in 2007, compared to 2000 (Figure 3).

Figure 3. Changes in age-adjusted mortality rates per 100,000 residents, by race ethnicity (2000, 2007)

	2000	2007	% change
All	278	244	+12%
African-American (foreign-born)	375	199	+47%
Asian (not Southeast Asian)	183	130	+30%
American Indian	1123	869	+23%
Southeast Asian	272	243	+11%
White (non-Hispanic)	208	197	+13%
Hispanic (any race)	208	197	+5%
African-American (U.S.-born)	682	701	-3%

Economic and demographic changes in our region may impact future health outcomes

Worsening socioeconomic conditions threaten gains made in reducing health inequities. Over the past decade (2000-2010), our region has experienced growing economic hardship:

- The percentage of residents living below the poverty level increased from 7 percent to 11 percent and the median household income in our region has decreased nearly \$9,000.
- In 2010, over one-third of households were “housing cost-burdened” — meaning they paid 30 percent or more of their household income for housing costs — compared with 24 percent in 2000.
- Three-quarters of residents (74%) were employed in 2010, a drop from 80 percent in 2000.

Poorer socioeconomic conditions may limit resources available in neighborhoods, lead to reductions in health care coverage and change the choices families and individuals make about core health habits, such as food and exercise. However, the long-term impact of these changes on neighborhood infrastructure and overall health may not be realized until years from now.

Large demographic shifts have also occurred, leading to opportunities and challenges. The Twin Cities region is becoming increasingly culturally diverse and is home to many immigrant populations. In 2010, 24 percent of residents were people of color, an increase from 17 percent one decade earlier. By 2035, it is projected over one-third of residents will be people of color. Increased cultural diversity strengthens our region’s workforce and enriches our communities. Yet, these trends contribute to a growing sense of urgency to fully understand and modify the underlying factors that contribute to racial health inequities in the region.

At the same time, our region faces the challenges of providing care to a markedly aging population. By 2030 the number of residents age 65 or older is expected to double. Additional state expenditures will be needed to support their care.

Where people live, work and play influences overall health

Social determinants of health refer to a range of complex and overlapping social and economic factors in communities, including community safety, features of the built environment, access to resources and services, social support and racial discrimination. In the report supplement, published as an appendix section to the full report, we explore this issue further by describing how poverty is related to differential access to healthy foods, opportunities for exercise and social connections.



In many ways, our observations about the relationships between place, income, race and health are not new. Over one hundred years ago, African American sociologist W.E.B. Du Bois observed that the racial disparities in health among African American residents living in Philadelphia were the result of the “vastly different conditions” under which African American and white residents lived. Yet, our nation tends to focus its resources and efforts on strategies that fall into the medical model of treating disease rather than focusing on underlying social inequalities and neighborhood conditions that contribute to morbidity and mortality.

As we concluded in our 2010 report, reducing health inequities is an issue of social justice. Intentional and coordinated efforts, done in partnership with community residents, are needed in order to understand the root causes of health inequities in local communities and identify effective, creative solutions to modify the underlying societal and economic factors that influence health.

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For more information

This summary presents highlights of the report, *Health inequity in the Twin Cities: An update to “The unequal distribution of health in the Twin Cities.”* For more information about this report, contact Melanie Ferris at Wilder Research, 651-280-2660.

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