

Fact Sheet

Health Disparities Among Youth and Young Adults

According to the Institute of Medicine's *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, "socioeconomic, racial, and ethnic disparities in health status are large, persistent, and ever increasing in the United States." When elements of racism, poverty, and community environment converge, greater overall threats to health develop. Most communities and ethnic groups that experience disparate health status have worse outcomes than whites across a broad spectrum of illnesses, injuries and treatment outcomes.

There are many factors that contribute to disparities in health. Some factors include: poverty, racial segregation, lower educational attainment, high unemployment, single parent households, limited access to care, lower quality housing, poorer environmental conditions, limited social opportunities, cultural differences, beliefs and norms, lack of language translation services, acculturation – seeking care and citizenship, lack of culturally diverse workforce, unfamiliarity with biomedicine, culturally insensitive providers, limited policies to address disparities, neighborhood context, nutritional differences, stress from discrimination, lack of hope, social support networks, mistrust, confidentiality, concentrated poverty, fragmentation of services, lower cost, lower quality medical care, provider bias/stereotyping, long waits and lack of transportation.

Tennessee Data

- The death rate for African American youth ages 10 to 14 for 2006 was 19.96 per 100,000 compared to white youth at 18 per 100,000 and 14.06 per 100,000 for all other races.
- African American males ages 10-24 were more than 9 times more likely to die from homicide than white males in 2006.
- In 2006, whites aged 10-24 died in motor vehicle accidents at rates of 42.44% for males and 20.70% for females; while Africans Americans died at rates of 22.87% for males and 10.29% for females.
- The 2005 YRBSS reports that partner violence among high school teens is higher in African Americans (13.5%) than in whites (8.8%).
- In 2006 three times as many white high school students (30%) reported binge drinking compared to African American students (11.0%).
- African American high school males (55.1%) report more frequent marijuana use than white males (46.0%), African American females (39.6%) and white females (37.5%) according to the Adolescent and Young Adult Health in Tennessee, 2006.

- The suicide rate was highest among young adults ages 20-24 (7.97 per 100,000) compared to youth ages 15-19 (8.61 per 100,000) and 10-14 (.25 per 100,000) in 2006.
- Males ages 10-24 completed suicide at rates more than 11 times higher than females in 2006.
- White males ages 10-24 (75 per 100,000) were nearly 6 times more likely to die from suicide than African American males (13 per 100,000) in 2006.
- More female high school students (17.8%) had made a suicide plan than males (10.3 %) according to the 2005 YRBSS.
- The birth rate in 2006 for African American females (18.2% per 100,000) ages 10-17 is almost twice the rate of white teens (9.4% per 100,000).
- Pregnancy rates in 2006 for Tennessee's African American females ages 10-17 were 23.6% for African Americans and 10.9% for their white counterparts.
- Teen pregnancies among Hispanic youth are increasing whereas rates are decreasing for all other races in 2006.
- Tennessee's Racial Disparity in Infant Mortality 2006 Report revealed Africans Americans consistently have a higher infant mortality rate than whites across the age spectrum. However infant mortality is at its lowest when the mother is her mid-twenties to early thirties.
- As of 2005 there were 646 Tennessee youth, ages 10 to 24 who were living with HIV/AIDS according to the Tennessee Department of Health HIV aggravate data. Four deaths were reported in this population in the same year.
- The 2005 YRBSS reported more high school females (38%) described themselves as overweight than males (25.7%) in Tennessee.
- The 2005 YRBSS reported more African American high school students are at risk for becoming overweight. The rate for African American males was 19.9% and for white males 18.4%. The rate for African American females was 22.0% and for white females 13.8%.

Best Practices

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.

Insurance coverage

- More than half of the uninsured youth in the United States belong to the racial and ethnic minorities. States should expand eligibility, encourage enrollment, and eliminate administrative obstacles to promote wider coverage.

Primary care

- States can expand 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 that 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.

Websites

Adolescent and Young Adult Health in Tennessee, 2006

<http://tennessee.gov/tccy/adv0705.pdf>

Center for Linguistic and Cultural Competence in Health
Care, Office of Minority Health

<http://www.omhrc.gov/cultural/index.htm>

Tennessee Department of Health, Health Information Tennessee (HIT)

<http://hit.state.tn.us/Home.aspx>

National Alliance for Hispanic Health

<http://www.hispanichealth.org/>

National Center for Cultural Competency

<http://gucchd.georgetown.edu/nccc/index.html>

National Center on Minority Health and Health Disparities

<http://www.nih.gov/about/almanac/organization/NCMHD.htm>

Tennessee HIV Aggregate Data

http://www.coetenn.com/PDFfiles/2005_TNSTATEWIDE.pdf

Tennessee Office of Minority Health

<http://www2.state.tn.us/health/minorityhealth/index.html>

Tennessee's Racial Disparity in Infant Mortality

<http://health.state.tn.us/statistics/PdfFiles/IM2006.pdf>

Youth Risk Behavior Survey

<http://apps.nccd.cdc.gov/yrbss/SelHealthTopic.asp?Loc=TN>